NUTRITION COMMUNICATION STRATEGY

MINISTRY OF HEALTH AND CHILD CARE

The National Nutrition Communication Strategy was developed by the National Nutrition Department, Ministry of Health and Child Care. The funding to facilitate development of this strategy was provided by the Government of Zimbabwe (GoZ), Health Development Fund and United Nations Children's Fund (UNICEF).

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FOREWORD

The Government of Zimbabwe recognises the importance of addressing hunger and malnutrition and has set this as one of the top priorities of the country. This is highlighted in the National Nutrition Strategy (NNS) 2014-2018 aimed to inform evidence-based nutrition interventions and inclusion of nutrition in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET). Effective nutrition programming comprises both nutrition-specific interventions that include care and adequate infant and young child nutrition, adequate maternal and adolescent nutrition services, appropriate clinical nutrition services, enhanced quality of nutrition information systems and effective nutrition advocacy; and nutrition-sensitive interventions including strengthening multisectoral coordination and collaboration with other sectors such as Agriculture, Social Protection and Education for integrated nutrition response.

These nutrition development programmes cannot produce change without an ongoing, culturally and socially relevant communication dialogue among nutrition-service providers and communities. The Ministry of Health and Child Care through coordination by the National Nutrition Department has developed a Nutrition Communication Strategy as a guiding instrument to comprehensive communication support towards implementation of the National Nutrition Strategy, National Food Fortification Strategy, and the Infant and Young Child Feeding National Policy to ensure positive and sustained behavior change in nutrition practices among population groups in Zimbabwe.

The Nutrition Communication Strategy was developed through a highly multi-stakeholder consultative process intentionally done to broaden the ownership, responsibility and commitment towards its implementation among stakeholders.

Ensuring nutrition security in Zimbabwe remains top on the agenda of Government, and as such Ministry of Health and Child Care is committed to provision of adequate communication strategies in nutrition programming and facilitating desired behavior change that promote optimal nutrition practices among communities. It is gratifying to note that all stakeholders and partners have committed to work together to support implementation of this Nutrition Communication Strategy to eliminate all forms of malnutrition and improve the health of the Zimbabwean population.

Together we can do it!

David P Parirenyatwa (Dr)
Minister of Health and Child Care

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1. Ministry of Health and Child Care officers from the National Nutrition Department, Health Promotion Unit, Family Health Unit, Non-Communicable Diseases (NCDs) Department and Nursing Department (see Annexe 1 for the NCS National Taskforce)

2. Government Ministries and Agencies including Ministry of Women Affairs Gender and Community Development (MoWAGCD), Ministry of Public Service, Labour and Social Welfare (MoPSLSW), Ministry of Primary and Secondary Education (MoPSE), Ministry of Industry and Commerce (MoIC), Food and Nutrition Council (FNC)

3. U.N. Agencies including United Nations Children's Fund (UNICEF) and World Health Organization (WHO)

4. Key stakeholders including United States Agency for International Development (USAID), Maternal and Child Health Integrated Program (MCHIP), Department of International Development (DFID), Adventist Development and Relief Agency (ADRA), Care International, ZVITAMBO, National AIDS Council (NAC), Harare City Health Department, World Vision, Goal as well as other organisations working on Nutrition in Zimbabwe

5. Ministry of Health and Child Care would also like to acknowledge H4+ funding received to support development of the Nutrition Communication Strategy

The strategy development process was aided by women, men and adolescents/young people who were consulted and provided valuable insights around existing barriers to adoption of optimum nutrition practices.

The Nutrition Communication Strategy is a reflection of collaboration required to effectively and sustainably implement the National Nutrition Strategy through a multi-sectoral approach.

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

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
ANC	Antenatal Care
BCC	Behaviour Change Communication
BMFHI	Baby and Mother Friendly Hospital Initiative
BRTI	Biomedical Research & Training Institute
CBNCP	Community Based Nutrition Care Programme
cIYCF	Community Infant and Young Child Feeding
cMAM	Community-based Management of Acute Malnutrition
DFID	Department of International Development
DFNSC	District Food and Nutrition Security Committee
DHE	District Health Executive
FAO	Food and Agricultural Organization
FGDs	Focus Group Discussions
FNC	Food and Nutrition Council
GoZ	Government of Zimbabwe
HFSS	Health Food Services Supervisor
HIV	Human Immunodeficiency Virus
HPO	Health Promotion Officer
IEC	Information, Education and Communication
IYCF	Infant and Young Child Feeding
ICT	Information Communication Technology
KABP	Knowledge, Attitudes, Beliefs, and Practices
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MIMS	Multiple Indicator Monitoring Survey
MoHCC	Ministry of Health and Child Care
MoIC	Ministry of Industry and Commerce
MoPSE	Ministry of Primary and Secondary Education
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
MoWAGCD	Ministry of Women Affairs Gender and Community Development
NCDs	Non-Communicable Diseases
NAC	National AIDS Council
NCS	Nutrition Communication Strategy
NFNSP	National Food and Nutrition Security Policy
NGOs	Non-Governmental Organizations
NMNS	National Micronutrient Survey
NNPSP	National Nutrition Policy and Strategic Plan
NNS	National Nutrition Strategy
PFNSC	Provincial Food and Nutrition Security Committee
PHHE	Participatory Health and Hygiene Education

PMTCT	Prevention of Mother To Child Transmission
POTRAZ	Postal and Telecommunications Regulatory Authority of Zimbabwe
PPP	Private Public Partnerships
RNI	Recommended Nutrition Intakes
SAM	Severe Acute Malnutrition
SMS	Short Message Services
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
VHW	Village Health Worker
WASH	Water, Sanitation and Hygiene
WBW	World Breastfeeding Week
WFP	World Food Programme
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMSTAT	Zimbabwe National Statistics Agency
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZNASP	Zimbabwe National Aids Strategic Plan

1. INTRODUCTION

Zimbabwe faces several nutrition-related challenges. To address the challenges in a holistic manner, the Ministry of Health and Child Care (MoHCC) has developed the National Nutrition Strategy (NNS) (2014-2018) to inform evidence-based nutrition interventions. The overall objective of the communication strategy is to provide comprehensive communication support towards implementation of the NNS.

1.1 Background

Globally, stunting, severe wasting and intra-uterine growth retardation are the major contributors to child mortality, accounting for about 3.1 million deaths of under-fives annually (The Lancet Series, 2013). Stunting remains a key challenge in Zimbabwe with nearly one in every three children under the age of five (27.6%) being stunted[1]. Evidence shows that the prevalence of stunting initially increases with a child's age, with prevalence highest between 18 and 35 months of age, and declines thereafter[1]. Although stunting levels have decreased during the period 2011 to 2014, evidence from 2011 showed disparities between rural and urban populations with 33% of children living in rural areas being stunted, compared to28% for their urban counterparts. Stunting as at 2010/11 was higher in boys (36%) than in girls (28%). Although stunting prevalence was higher among the poor (36.8%) wealth does not protect children from stunting as nearly one in four (23.8%) children in the highest wealth quintile were stunted[2].

Effective nutrition-specific interventions to address stunting include care and adequate maternal nutrition, promotion of early initiation of breastfeeding, six months exclusive breastfeeding, continued breastfeeding from six months up to 24 months or beyond with adequate complementary feeding, micronutrient supplementation, deworming, management of moderate acute malnutrition and treatment of severe acute malnutrition (Lancet nutrition series 2013). However there are gaps in the provision and uptake of these services in Zimbabwe.

Zimbabwe has near universal (98.1%) breastfeeding though there are still gaps in adoption of exclusive breastfeeding with less than half (41%) of infants under 6 months of age being exclusively breastfed. There are challenges in relation to complementary feeding with 17.3% of breastfed children age 6-23 months having a minimum acceptable diet[1]. Analysis of vitamin and mineral content of FAO Food Balance Sheets for Zimbabwe shows average intake of iron, zinc, folate, vitamin B12 and vitamin A among both children and women provided just 27%-64% of WHO Recommended Nutrition Intakes (RNI). These dietary deficits in micronutrient intake, along with other threats including infection, intestinal parasite, malaria, HIV and other factors, suggest very high risk of widespread micronutrient deficiencies[3].The country has made progress in eliminating Severe Acute Malnutrition (SAM) with the MICS[1] reporting 0.2% prevalence of Oedema which is a clinical sign of SAM.

[1] Zimbabwe National Statistics Agency (ZIMSTAT). 2014. Multiple Indicator Cluster Survey 2014, Key Findings. Harare, Zimbabwe: ZIMSTAT.

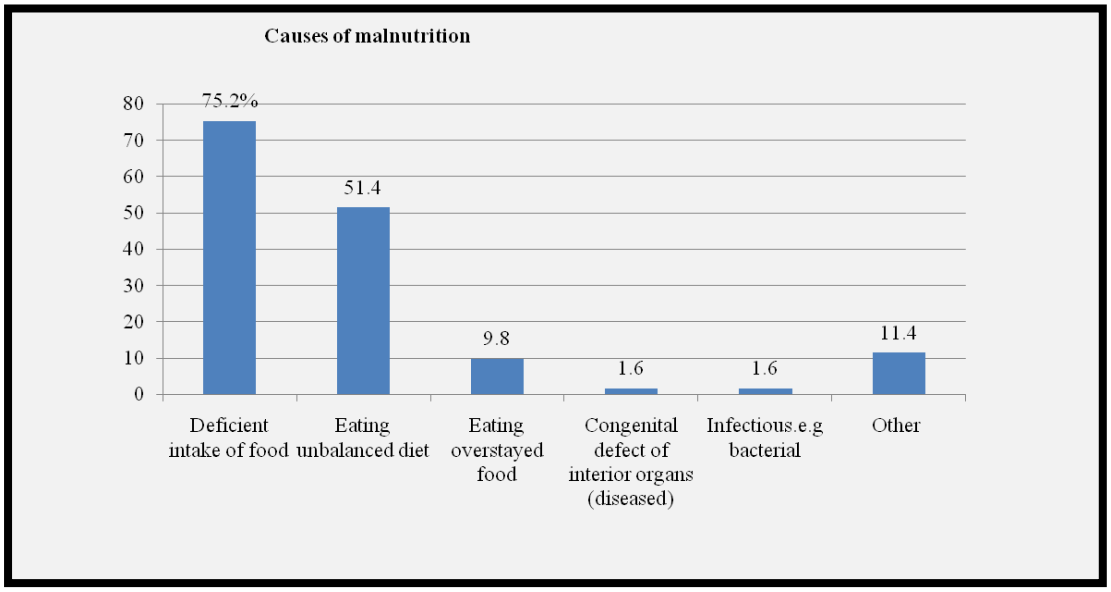
[2]Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2012. Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland: ZIMSTAT and ICF International Inc.

[3] Government of Zimbabwe, Ministry of Health and Child Care, (2014). National Food Fortification Strategy Feasibility Assessment, 2014)

1.2 The Nutrition Communication Problem

Although key nutrition challenges have been well documented through various studies, there are still key gaps around generating evidence around nutrition communication approaches as well as their efficacy. A key source of evidence around nutrition communication in Zimbabwe is the Community Based Nutrition Care Programme (CBNCP) KABP Study[4] which documented nutrition knowledge along with sources of nutrition information. As part of developing this communication strategy data was collected on nutrition knowledge along with sources of information.

An average of 65.6% of the respondents had heard about malnutrition with the highest proportion coming from the resettlement areas (85.7%). Small scale farms had the highest proportion of respondents who had never heard about malnutrition (66.7%). The majority (75%) of respondents outlined that malnutrition was a result of deficiencies in food intake as well as eating an unbalanced diet. The figure below shows perceptions about causes of malnutrition:



*Source: Community Based Nutrition Care Programme (CBNCP) KABP Study (2009)

Figure 1: Perception on the causes of Malnutrition in Zimbabwe

The KABP study[4] concluded that sources of information varied for different aspects of nutrition with siblings being the most cited source of information on breastfeeding practices. Most of the respondents had heard about exclusive breastfeeding from a sibling (99%), followed by nurses 93.6%.In Kwekwe and Bulawayo, 97.8% got their information from the nurses. Few respondents had heard the information from a nutritionist (1.6%), village health worker (2.3%), doctor (1.9%) and 1.3% pamphlet/poster. None of the respondents in Gwanda, Kwekwe and Mutasa had heard the information from a doctor. None from Gwanda, Harare, Kwekwe and Mutasa had learnt about exclusive breastfeeding in school. Consultations with lactating mothers as part of the strategy development process showed that most of them received information on exclusive breastfeeding from clinics/health facilities.

The 2009 KABP survey concluded that 37.5% of respondents had ever heard or seen messages on exclusive breastfeeding. The highest proportion of the respondents who had seen the messages were in Harare (69%) and the least proportion was in Mutasa and Gwanda (26%).All key strategic documents

[4] Biomedical Research & Training Institute (BRTI), (2009). Community Based Nutrition Care Programme (CBNCP) KABP Study/Formative Research Study. Government of Zimbabwe Ministry of Health and Child Care

related to nutrition, outline the need for communication at different levels. This includes communication to health workers for them to adequately support women, communication with women to adopt optimum nutrition practices. However, there is no overall guidance on nutrition communication which presents challenges of harmonisation and consistency.

1.3 Rationale

There is limited evidence around communication-specific gaps and there is no specific package or tool kit available to promote contextualized and standardized nutrition practices. This communication strategy is further necessitated by gaps in nutrition communication interventions related to key behaviours along with limited evidence around key messages for different target groups (for example breastfeeding mothers, mothers in law and youth). The nutrition communication strategy will respond to challenges emanating from the absence of standardised guidance relating to communicating nutrition related messages as well as monitoring and evaluation.

1.4 The Nutrition Policy Framework

Preventing and reducing stunting, especially during the 1000 day period; (from conception to 2 years of age) is a national priority. This is reflected in its inclusion in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET). The National Food and Nutrition Policy provides the basis for mobilizing all stakeholders towards investing in improving nutrition. The policy includes seven (7) commitments which includes Policy Advice and Analysis, Agriculture and Food Security, Social Assistance and Social Protection, Food Safety and Standards, Nutrition Security, Food and Nutrition Security Information, Enhancing and Strengthening national capacity for food and nutrition security. The seven commitments illustrate the breadth of stakeholders who are involved/should be involved within nutrition communication.

2. OVERVIEW OF NUTRITION COMMUNICATION IN ZIMBABWE

2.1 Overview of Nutrition Programme in Zimbabwe

The National Nutrition Strategy (2014-2018) provides a guiding framework for nutrition interventions in the country. The strategy outlines main areas of investment to achieve results for nutrition and outlines the following six (6) key priorities:

i. *Improved adolescent and maternal nutrition*
ii. *Infant and young child nutrition*
iii. *Strengthened clinical nutrition services*
iv. *Quality nutrition information systems and advocacy*
v. *Strengthened multi-sectoral coordination and collaboration for integrated nutrition response*
vi. *Capacity development for nutrition service delivery and resource mobilization.*

The country has conducted a Feasibility Assessment and background analysis for the Zimbabwe National Food Fortification Strategy[3]. This provides a Strategic Framework for addressing micronutrient deficiencies. The Ministry of Health and Child Care conducted a review of the Infant and Young Child Feeding programme [5](2012). The review documented key findings and recommendations which will guide IYCF programming.

2.2 Overview of Communication Strategy Development Process

The Nutrition Communication Strategy was developed through a multi-stakeholder consultative process. This included inception discussions to agree on the overall purpose of the strategy as well as to agree on the approach. Initial processes included a comprehensive review of national and international literature. This included a data gap analysis and informed development of data collection tools to guide consultations on specific barriers, behaviours and communication for different target audiences including lactating mothers, males, mothers-in-law, and young people along with policy makers. Data gap analysis was conducted through identifying key nutrition communication strategy priorities, determining evidence required, reviewing available literature and understanding available evidence as well as noting key components lacking in evidence or requiring additional primary evidence. Consultations were conducted at national, provincial, district and community level. These were conducted using a combination of stakeholder workshops/meetings, key informant interviews (with experts, nutrition technical partners, development funding partners, academics and policy makers), focus group discussions (with lactating mothers, mothers in law, adolescents and adult males). Data from consultations was analysed through qualitative content analysis with a focus on communication gaps, channels, barriers along with motivational appeal. A draft strategy was developed and reviewed in a multi-stakeholder workshop. Feedback was incorporated into the final strategy.

2.3 Structure of the Nutrition Communication Strategy

The nutrition communication strategy is organised into different sections starting with the introduction, background, rationale and an overview of the nutrition policy and programme framework. The second section presents the strategy purpose and objectives, gaps, communication approaches and challenges. It further presents audiences as well as messages for the different target groups.

[5]Ministry of Health and Child Care, (2012). Zimbabwe Infant and Young Child Feeding Programme Review (1991-2011)

2.4 Key Players in Nutrition Communication

Promoting optimum nutrition practices cuts across different sectors and implementation of this communication strategy will include a broad range of stakeholders. These will include the Ministries responsible for Health, Education, Agriculture, Women Affairs and Youth, The Food and Nutrition Council, United Nations Agencies, Development Funding Partners, Non-Governmental Organisations and Communities.

2.5 Gaps in Nutrition Communication

Evidence emanates from the Zimbabwe IYCF Programme Reviews (1991-2011) along with the Barriers and Facilitators of Optimal Infant and Young Child Feeding in Zimbabwe: Beliefs, Influences and Practices6 (2012). The study outlined broad categories of factors which mediate IYCF practices and behaviors and these are outlined below:

i. Social context within which caregivers, primarily mothers, function determines feeding behaviors and practices while grandmothers and fathers/partners serve as support systems and influential actors in maternal and child health and nutrition;
ii. Convenience as a factor shaping feeding behaviour and practice;
iii. Mixed/conflicting messages on feeding age specific groups, and notably the issue of HIV and infant feeding;
iv. Limited awareness/knowledge about optimal feeding or appropriate alternative foods;
v. Interest in the welfare of the child influence feeding behaviors, practices and care;
vi. Resource availability; and
vii. Health providers as sources of advice and support, and potentially facilitating or constraining improved behaviors.

The common barriers of optimal breastfeeding for 0-6 months were outlined as delayed initiation of breastfeeding which is attributed to knowledge gaps among health workers. Additional barriers include the perception that colostrum is dirty milk and the social acceptability of pre-lacteal feeds.

The social acceptability of giving water, other liquids and foods in the first few months of life was cited as a key barrier to optimal breastfeeding practices. Findings further outline that some mothers noted sore nipples, ill-health, poor nutrition and not producing enough milk as reasons for supplementing the infant earlier with solid foods and liquids.

Additional barriers noted relate to social influence especially of grandmothers/mothers-in-law, fathers and community members who influence mothers in giving pre-lacteals and early introduction of complimentary foods and liquids. Mothers and caregivers interviewed as part of the barriers and facilitators study further outlined that mixed messages on HIV and infant feeding sometimes entrench stigmatization and mothers are pressured to practice mixed feeding.

The barriers noted on complementary feeding (6-23 months) include poor quality complimentary foods emerging from a general prevalence of limited knowledge and information on good quality complimentary feeding. This results in provision of bulky starches and relatively sub-standard foods. In addition, both parents and caregivers are often not capacitated to leverage locally-available foods and existing family diets as means to improve complimentary feeding. Additional barriers relate to

[6] Ministry of Health and Child Care, (2012). Barriers and Facilitators of Optimum Infant and Young Child Feeding in Zimbabwe: Beliefs, Influences and Practices

resource constraints emanating from poverty, economic factors along with resource and time constraints.

Beyond the barriers, there are also facilitators which can be leveraged in developing the communication strategy. These include health providers' support, breastfeeding as a social norm, maternal knowledge and awareness of benefits of breastfeeding, social support, feeding sick children along with the social influence of family, health workers and community members.

2.6 Exposure to Mass Media

Access to the mass media is critical in determining the communication channels for the different messages and audiences. Evidence shows that men have better access than women to mass media as shown in the table below. New Information and Communication Technologies (ICTs) have provided enhanced avenues for communication though their effectiveness as communication mediums depends largely on levels of access and penetration. Evidence shows that 21.6% of women (15-24 years) compared to 30.8% of men (15-24 years) reported using the internet during the 12 months preceding the MICS, 2014. Access to the mass media as well as ICTs provides key guidance on the channels to be utilised for the communication strategy.

Table 1: Access to Mass Media and ICTs in Zimbabwe

	Men (15-54 years) %	Women (15-54 years) %
Newspapers	29.6	17.7
Radio	57.4	44.5
Television	41.9	37.6

*Source (MICS; 2014)

3. BARRIER ANALYSIS

There has been work around determining barriers to optimum nutrition practices with one study[6] confirming age and gender of infant, occurrence of diarrhoea and fever, age at union and age difference between parents, parity, mother's religion, contraceptive usage, mother's and father's age, employment status of head of household, antenatal care (ANC) attendance, skilled birth attendance, availability of safe drinking water and area of residence as key determinants of exclusive breastfeeding[7].
The study concluded that mothers who were attended by skilled health workers during delivery were significantly more likely to exclusively breastfeed their babies and that appropriate messages about breastfeeding were being delivered by ANC staff.

Another study on barriers and facilitators to optimal infant and young child feeding in Zimbabwe cited key barriers which include knowledge gaps among health workers, social acceptability of pre-lacteal feeds along with conflicting messaging around mixed feeding and HIV. Additional barriers noted in relation to complimentary feeding include poor quality complimentary feeds and resource constraints. At the system level, the NNS (2014-2018) [8]highlights the absence of systematic nutrition communication for hospitals, schools, prisons, orphanages, military and police camps and institutional settings. The gaps outlined point to the need for targeted communication focusing on the individuals, communities and the broader environment.

Consultations as part of the strategy development process demonstrate that different groups have different sources of information on nutrition while the sources also varied by location (urban/rural). Rural lactating women mostly cited the clinic, siblings and mothers-in-law as sources of nutrition information while those in urban areas cited nurses, nutritionists, doctors and the media as their sources of information. Young people on the other hand cited schools, health facilities, the media, text books and the internet as sources of nutrition information. Policy makers cited multi-stakeholder meetings as their sources of information on nutrition. Consultations with lactating mothers as part of the strategy development process showed that most of them received information on exclusive breastfeeding from health facilities. The section below provides key behaviours to be transformed as well as those to be reinforced in relation to the different thematic areas.

3.1 Improving the quality of Adolescent and Maternal Nutrition Services

Uptake of and compliance to iron and folate supplementation
Most of the women expressed positive attitudes towards uptake of iron and folate supplementation. However, there were challenges around compliance with various reasons being provided for non-compliance along with limited uptake. These are outlined below:

- The women cited that iron tablets cause nausea; and
- There is limited information provided to women on the benefits of iron and folate supplements. This affects their compliance.

Consumption of nutritious foods by adolescents
Adolescents demonstrated high understanding of good nutrition as well as what constitutes a balanced diet. They further outlined the key benefits of a good nutritional status. Schools and NGOs were cited as key sources of nutrition information while some cited the internet. The key issues outlined relating to low consumption of nutritious foods by adolescents included:

[7]UNICEF/CCORE, (2011). Determinants of exclusive breastfeeding practices in Zimbabwe: An analysis of secondary quantitative data from the Multiple Indicator Monitoring Survey 2009 (MIMS 2009) and the National Nutritional Survey (NNS 2010)
[8]Government of Zimbabwe, (2014). Zimbabwe National Nutrition Strategy, 2014-2018

- High availability of junk food especially at school "tuck shops";
- Limited availability of fruits and vegetables;
- Limited information and communication on the importance of consuming nutritious foods and disadvantages of not doing so.

To promote recommended breastfeeding practices

Early Initiation of Breastfeeding

There were variations on practices related to early initiation of breastfeeding. Mothers during FGDs outlined that breastfeeding was initiated within one (1) to three (3) hours of delivery. Similarly, attitudes towards feeding colostrum were largely positive. Reasons given for early initiation and feeding colostrum are summarised below:

- Early initiation of breastfeeding ensures the baby is well fed and it is the basis for the long term health of the child;
- Feeding colostrum is good and contributes towards ensuring the child's immune system is strengthened;
- Health workers encourage mothers to initiate breastfeeding early and to feed colostrum.

Despite positive attitudes towards early initiation and feeding colostrum, some mothers expressed negative attitudes and reasons provided are summarised below:

- Colostrum is dirty and the child should only start breastfeeding once the milk is clean;
- Some cultural beliefs dictate that the child should have pre-lacteal feeds (usually including traditional medicines) before they start breastfeeding.

Exclusive Breastfeeding

Consultations revealed that lactating mothers practise mixed feeding with some reportedly starting when the child is 2 months old. Factors behind mixed feeding include:

- The social acceptability of mixed feeding especially where mothers in law and the general community encourage young mothers to practise mixed feeding;
- Perceptions that the mother did not have sufficient milk especially when the child cries a lot mothers felt it was because the milk would be inadequate for the child;
- Mixed messages from health workers where in some instances mothers reported health workers encouraging mixed feeding and in some instances mothers reported not receiving any guidance on exclusive breastfeeding;
- The positive effects of exclusive breastfeeding and the negative effects of mixed feeding are not well explained to mothers so that they understand why they are encouraged to adopt exclusive breast feeding over mixed feeding.

While the practices above need to be transformed, there were also some attitudes and practices outlined by lactating mothers which should be reinforced. There are mothers who reported practising exclusive breastfeeding and the major reason cited was that exclusive breastfeeding is good for the overall health of an infant.

Complementary feeding

Women during consultations as part of strategy development expressed positive attitudes towards complementary feeding though the quality of complementary foods needs to be addressed. Attitudes expressed by women demonstrated that complementary feeding is done more as a way of ensuring that

the child "is full" not as a way of enhancing the child's nutrition. The key communication focus should be on addressing the following issues:

- The perception that it is not important to have minimum meal frequency for children;
- The perception that feeding the child can only be done once all the other "important" chores have been completed;
- Cultural practices that discourage feeding children animal source foods;
- Limited knowledge on how to ensure the child has minimum dietary diversity;
- Limited knowledge on how to ensure the child has a minimum acceptable diet; and
- Lack of resources to ensure the child has minimum dietary diversity and a minimum acceptable diet.

3.2 Strengthening uptake of clinical nutrition services

Based on literature review as well as consultations with experts, the following priorities were identified on strengthening uptake of clinical nutrition services:

- Information of the health benefits of limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity;
- Information around the nutritional risk factors for non-communicable diseases (Nutrition-related NCDs);
- Information and communication around the preventive effects of nutrition on nutrition-related NCDs.

Overall, most of the barriers above relate to the absence of information on the importance of adopting behaviours (motivational appeal)that promote optimum nutrition, limited information on the dangers associated with poor nutrition practices, the social acceptability of poor nutritional practices along with the misconceptions on the efficacy of optimal nutrition practices (for example exclusive breastfeeding). There are also factors that are not related to communication which will contribute towards successful implementation of the strategy. This includes supply side components like facilitating access to food.

4. COMMUNICATION CHANNELS

Analysis of available evidence on nutrition communication shows that there are multiple communication channels which can be used. Barrier analyses (2014) conducted as part of the strategy development further showed that different audiences preferred different communication channels for different messages. The communication matrix will provide proposed communication channels for different messages but the overall determining factor will be the potential to deliver the message effectively and at the lowest possible cost. The communication channels are outlined below and the broader messages they are likely to be used to convey.

4.1 Mass media (Television, Radio, Public Announcement System)

Although evidence shows limited access to the mass media, participants during consultations for the barrier analyses cited them as key communication channels especially for messages aimed at creating an enabling environment and reinforcing attitudes. The mass media was further suggested for advocacy messages and all messages that do not require adaptation based on the micro-context.

4.2 The Internet (social media)

The internet and in particular social media was further cited as potential channels of communicating nutrition information. This would however require firstly determining levels of access for a specific group being targeted. Use of social media platforms have generally improved especially among young people through use of mobile phones to access the internet. About 22 percent of women and 31 percent of men aged 15-24 years were reported to have used the internet in the 12 months preceding the MICS survey (MICS, 2014). In Zimbabwe the internet penetration rate is currently estimated at 44% according to the Postal and Telecommunications sector performance report (POTRAZ, 2015).

4.3 Mobile Phones (bulk SMS)

The high level of mobile phone penetration in Zimbabwe means that this is a potential communication channel to be utilised. Key approaches include sending bulk messages on nutrition especially for messages aimed at the entire population. Private-Public Partnerships (PPP) can be formed with telecommunication companies and have targeted messages for various population groups or certain geographic locations. The mobile penetration rate of active subscribers is increasing currently estimated at 91% (POTRAZ, 2015) and this highlights the potential of utilizing mobile phones for communication.

4.4 Inter Personal Communication

Consultations and available evidence cited interpersonal communication as the key way through which people are receiving nutrition related information. Target audiences include health workers, friends, siblings, colleagues, parents, mothers-in-law, community and religious leaders. Interpersonal communication was the most preferred for messages that targeted behaviour change at the individual level for example encouraging exclusive breastfeeding, promoting uptake of and adherence to iron and folate supplementation as well as promoting consumption of nutritious foods.

4.5 Posters and Pamphlets

These were cited as potential communication channels and use of simple language easy to understand was emphasized. Posters were proposed for use within institutions where the targeted population often visits like the clinics where lactating mothers visit. In addition, pamphlets were proposed in circumstances where the health workers will be too busy to explain nutrition information.

5. AUDIENCES

The communication strategy intends to provide knowledge, transform attitudes and ultimately influence behaviour change in relation to nutrition. Given the different communication requirements for the behaviour change continuum, there are primary, secondary and tertiary audiences.

5.1 Primary Audiences

These are target groups whose behaviour is expected to change as a result of the communication messages. They include the pregnant and lactating mothers, mothers in law, and adolescents along with health workers.

5.2 Secondary Audiences

The secondary audiences are those who will be critical in ensuring positive interpersonal support to the primary audience. The role of secondary audiences is to ensure positive behaviours are adopted or that existing positive behaviours are reinforced. These will include mothers-in law, parents, husbands, health workers and others depending on the context.

5.3 Tertiary Audiences

These are found at the macro-level and they will be critical in creating an enabling environment for adoption or reinforcement of desired behaviours. These will include policy makers, opinion leaders, traditional leaders along with key health workers, teachers and others as will be identified within specific contexts. The figure below shows the audience mapping and communicative focus as described above.

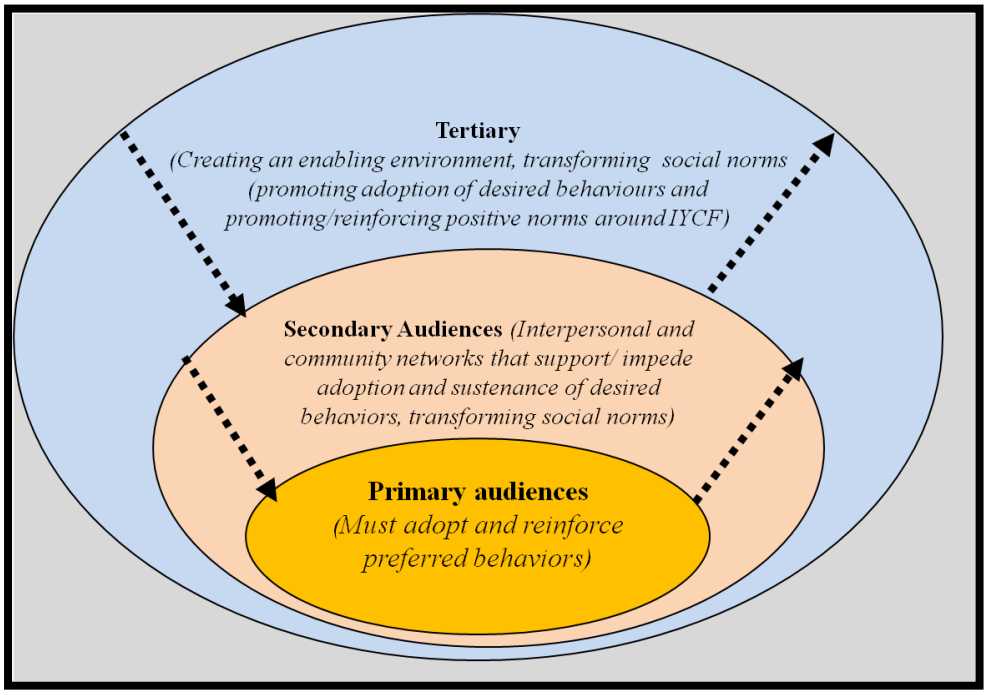


Figure 2: Audience Mapping

5.4 Segmentation

Audiences will be targeted at different levels starting with the household level, followed by the community level, district and provincial levels and finally at national level. Different audience groups will be identified for each of the levels as outlined below:

Table 2: Audiences at different levels

HOUSEHOLD LEVEL	COMMUNITY LEVEL
• Pregnant Women • Adolescents • Lactating Mothers • Women in the family • Elderly women • Mothers in law • Husband • Siblings (sisters)	• Mother and Child • Men and women • Adolescents • Elderly women in the family • Grassroots service providers • Community workers • NGO workers.
DISTRICT AND PROVINCIAL LEVEL	**NATIONAL LEVEL**
• Partners • NGOs • Government officials • Policy makers • Traditional leaders • Decision makers	• Partners • NGOs, Government officials • Policy makers • Decision makers

6. COMMUNICATION APPROACHES

The strategy is based on three key mutually reinforcing communication approaches which are advocacy, social mobilisation along with social and behaviour change communication. Advocacy will focus on influencing decision makers and opinion leaders to support messages communicated by the nutrition strategy as well as creating an enabling operating environment.

Social mobilisation will involve enlisting the participation of institutions, community networks and social and religious groups to use their membership and other resources to raise awareness of optimum nutrition practices. Social and behaviour change communication will focus on interpersonal dialogue with individuals and groups to inform, motivate, problem-solve or plan, with the objective of promoting optimal nutrition related behaviour change. The table below shows communication approaches, focus and target audiences.

Table 3: Communication Approaches

COMMUNICATION APPROACH	FOCUS	TARGET
Advocacy (Influencing policy/decision makers to support objectives of the nutrition strategy)	Creating an enabling environment for adoption and sustenance of optimal nutrition behaviours	Parliamentarians, Religious Leaders Traditional/Community Leaders Research Institutions, NGOs, Private Sector
Social Mobilisation (Enlisting the participation of institutions, community networks and social and religious groups to use their membership and other resources to strengthen participation in activities at the grass-roots level)	Utilising social networks and structures to introduce, reinforce or sustain optimal nutrition behaviours	Religious groups, Community Groups, Schools, NGOs
Behaviour Change Communication (Interpersonal dialogue with individuals and groups to inform, motivate, problem-solve or plan, with the objective to promote nutrition related behaviour change)	To equip individuals with the knowledge and skills necessary for adoption of optimal nutrition behaviours	Mothers, Mothers in law, Husbands, Adolescents, Women of child bearing age

6.1 Focus

The strategy focuses on changing behaviour of individuals on the following four thematic areas:

i. Adolescent and Maternal nutrition
ii. Infant and Young Child nutrition
iii. Strengthening uptake of clinical nutrition services
iv. Mainstreaming nutrition in multi – sectoral interventions

7. THE STRATEGY

7.1 Purpose of the Strategy

The communication strategy is a package to promote behaviour change focusing on changing behaviours of individuals on adolescent and maternal nutrition, infant and young child nutrition, strengthening uptake of clinical nutrition services along with mainstreaming nutrition in multi-sectoral interventions.

7.2 Objectives of the Strategy

THEMATIC AREA 1: - IMPROVING ADOLESCENT AND MATERNAL NUTRITION.
ISSUES TO BE ADDRESSED BY THE COMMUNICATION STRATEGY:

a) Lack of knowledge on the benefits of iron and folate supplementation
b) Adherence to iron and folate supplements
c) Non- availability of fortified foods
d) Low demand for nutritious foods among adolescents and women of child bearing age

OBJECTIVE 1.1
To contribute towards adoption of improved adolescents and maternal nutrition practices among women of child bearing age and adolescents by 2018

OUTCOME 1.1
Women of child bearing age and adolescents adopting recommended nutrition practices

ACTIONS

i. Raising awareness on the benefits of iron and folate supplementation
ii. Promoting adherence to iron and folate supplementation
iii. Advocacy for ensuring availability of fortified foods
iv. Raising awareness and promoting consumption of nutritious foods among adolescents and women of child bearing age
v. Advocacy to promote improved adolescents and maternal nutrition practices

THEMATIC AREA 2:- INFANT AND YOUNG CHILD NUTRITION.
ISSUES TO BE ADDRESSED BY THE COMMUNICATION STRATEGY:

a) Low exclusive breastfeeding rate
b) Low minimum acceptable diet
c) Low continued breastfeeding levels
d) Low coverage of vitamin A supplementation
e) Low consumption of iron rich foods – animal source foods

OBJECTIVE 2.1
To contribute towards adoption of improved infant and young child nutrition practices by communities by 2018

OUTCOME 2.1
Improved infant and young child nutrition practices by communities

ACTIONS

i. Increasing knowledge on and promoting adoption of exclusive breastfeeding
ii. Increasing knowledge on and promoting adoption of a minimum acceptable diet for infants and children
iii. Increasing knowledge on and promoting continued breastfeeding
iv. Increasing knowledge on and promoting uptake of vitamin A supplementation-annually
v. Increasing knowledge of the benefits and promoting consumption of a variety of foods from different food groups
vi. Advocacy to promote improved infant and young child nutrition practices

THEMATIC AREA 3: STRENGTHENING UPTAKE OF CLINICAL NUTRITION SERVICES

ISSUES TO BE ADDRESSED BY THE COMMUNICATION STRATEGY

a) Low adoption of healthy lifestyles (diversified diets and decreased consumption of sugary beverages)
b) Limited awareness on ways of preventing Nutrition-related NCDs
c) Limited access to infrastructure and equipment for screening and treatment of Nutrition-related NCDs
d) Low health worker knowledge and skills on the prevention and management of Nutrition-related NCDs
e) Limited adoption of physical activity

OBJECTIVE 3.1

To promote uptake of clinical nutrition services among the population by 2018

OUTCOME 3.1

Adoption of behaviors that contribute towards prevention of non-communicable diseases

ACTIONS

i. Raising awareness and promoting adoption of healthy lifestyles
ii. Advocacy towards prevention of Nutrition-related NCDs

THEMATIC AREA 4: MAINSTREAMING NUTRITION IN MULTI-SECTORAL INTERVENTIONS.

ISSUES TO BE ADDRESSED

a) Low awareness of the 1000 days window of opportunity for preventing stunting
b) Limited mainstreaming of nutrition in all multi-sectoral plans
c) Use of contaminated/unsafe water
d) Unhygienic practices in food preparation
e) Unhygienic practices in disposal of human and animal excreta

OBJECTIVE 4.1

To promote mainstreaming of nutrition in multisectoral interventions by 2018

OUTCOME 4.1

Improved mainstreaming of nutrition in multisectoral interventions by 2018

ACTIONS

i. Increasing knowledge on the importance of 1000 days for preventing stunting
ii. Advocacy to ensure mainstreaming of nutrition in all multi-sectoral plans
iii. Raising awareness on the health hazards of using contaminated water and unhygienic practices in food preparation and disposal of excreta
iv. Promoting use of safe water
v. Promoting adoption and sustenance of hygienic food preparation practices
vi. Promoting adoption and sustenance of hygienic disposal of excreta
vii. Advocacy to promote adoption and sustenance of safe water, sanitation and hygiene practices

8. COMMUNICATION MATRIX

Table 4: Communication Matrix

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
To contribute towards Improved quality of adolescent and maternal nutrition services						
To increase knowledge on the benefits of iron and folate supplementation.	Improved uptake of iron and folate supplementation.	Limited information on the benefits of iron and folate supplementation	Taking iron and folate supplements improves your health and your chances of delivering a healthy baby.	Women of child bearing age and adolescents.	Interpersonal communication (with Health Workers, Village Health Workers etc.) Utilising platforms like ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations, Media Organisations.
			Women should ensure the health of their children by taking iron and folate tablets which are provided for free at health facilities.	Women of child bearing age and adolescents	Interpersonal communication Utilising platforms like ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations,

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
						Media Organisations.
			Health workers should be able to give health education to adolescents and Women of child bearing age on the benefits of iron and folate supplementation	Health workers	Interpersonal (trainings) Job aids Posters Pamphlets	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations.
To promote compliance for iron and folate supplements.	Improved compliance for iron and folate supplements.	Adverse effects after taking iron and folate tablets	Ensuring compliance for iron and folate supplements is the only way to safeguard your child's health. Take iron and folate tablets after eating to reduce nausea and vomiting.	Women of child bearing age and adolescents.	Interpersonal communication (with Health Workers, Village Health Workers etc.). Utilising platforms like ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Males,	Interpersonal communication (with Health Workers, Village Health Workers etc.),	Development partners, NGOs

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
					Community opinion leaders, role models, Radio and Television; Social Media; Pamphlets, Billboards.	working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Elderly women	Interpersonal communication (with Health Workers, Village Health Workers etc.), Posters at health facilities, community centres and churches);Radio and Television; Social Media; Pamphlets, Billboards.	
				Community Members	Radio and Television; Social Media; Pamphlets, Billboards. Health Workers etc.); Posters at health facilities, community centres and churches).	
To create demand for fortified foods by the community.	Communities to have fortified foods as their first choice.	Lack of knowledge on benefits of fortified foods. Perceptions of possible side effects	Fortified foods have enhanced nutrition value. Fortified foods are safe and approved for human consumption	All members of communities including women of child bearing age	Interpersonal communication (with Health Workers, Village Health Workers etc.) Utilising platforms like ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards; Retailers. Community media (edutainment)	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations; Private Sector.

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
Creating demand for consumption of nutritious foods among adolescents.	Consumption of nutritious foods by adolescents.	Lack of information on the benefits of consuming nutritious foods by adolescents.	Consumption of a variety of nutritious foods is important for healthy growth and development	Adolescents	Interpersonal communication (with Health Workers, Peer Educators) Utilising platforms like Youth Friendly Centres, Posters at Youth Friendly Centres, Community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards, edutainment.	Ministry responsible for Education Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
		Limited access to nutritious foods.	Providing a variety of nutritious foods for children is important for ensuring their healthy growth and development	Policymakers, Parents, Communities.	Interpersonal communication Utilising opinion leaders; Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
To contribute towards improved Infant and Young Child Nutrition by 2018						
To promote adoption of recommended breastfeeding practices	Initiating breastfeeding within the first hour of delivery Exclusive breastfeeding for the first six months of life Continued breastfeeding from 6 months up to 24 months and beyond with adequate complementary feeding	Perception that mothers will be tired and need rest soon after delivery The social acceptability of giving water, other liquids and foods in the first few months of life. Limited communication on the benefits of recommended breastfeeding practices.	Starting to breastfeed soon after delivery is the first immunization. Feeding children breast milk only in the first 6 months helps brain development and prevents diseases. Continued breastfeeding to two years and beyond helps in a child's growth and development and prevents disease	Lactating Mothers, Women of child bearing age Elderly women.	Interpersonal communication (with Health Workers, Village Health Workers etc.). ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Mothers in law	Interpersonal communication (with Health Workers, Village Health Workers etc.), Radio and Television;	
				Men	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	
				Communities	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	
		Negative attitudes by health providers.	Supporting women to practise exclusive breastfeeding shows	Health workers.	Interpersonal communication through in-service trainings, Job AIDS, Posters, Information Packs.	Development partners, NGOs working on

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
			excellence in healthcare provision.			Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
To promote uptake of a minimum acceptable diet for children 6-24 months.	Families feed children 6-24monthsthe minimum number of meals per day. Families feed children 6-24 months the minimum number of food groups per day Food security	Limited information on how to plan meals for children. Caregivers lack time to prepare meals for children. Limited information on use of locally available foods, fruits and vegetables in season	Feeding children the right number of meals and the right food groups ensures adequate growth and development.	Lactating mothers;	Interpersonal communication (with Health Workers, Village Health Workers etc.). ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Mothers in law;	Interpersonal communication (with Health Workers, Village Health Workers etc.), Radio and Television; ANC, support groups	
				Men	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards, workplace.	

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
				Community members;	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	
To promote improved uptake of vitamin A supplementation	Biannual uptake of vitamin A supplementation for children 6-59months.	Limited knowledge about frequency of Vitamin A supplementation and benefits.	Vitamin A supplementation improves eyesight, and reduces the likelihood of dying from childhood infections	Lactating mothers	Interpersonal communication (with Health Workers, Village Health Workers etc.). ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Mothers in law	Interpersonal communication (with Health Workers, Village Health Workers etc.), Radio and Television;	
				Men	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	
				Community members	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
		Religious beliefs		Religious leaders	Interpersonal communication (with Health Workers, Village Health Workers etc.).	
		Poor documentation of vitamin A supplementation				
To promote improved consumption of iron rich foods – animal source foods.	Improved uptake of iron rich foods and animal source foods.	Negative myths that discourage feeding children iron rich foods and animal source foods. Lack of knowledge and skills to prepare iron rich foods and animal foods for children (mothers fear children can choke)	Iron deficiency reduces an individuals' wellbeing, causes fatigue and lethargy, and impairs physical capacity and work performance.	Lactating mothers	Interpersonal communication (with Health Workers, Village Health Workers etc.). ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Mothers in law.	Interpersonal communication (with Health Workers, Village Health Workers etc.), Radio and Television;	
				Men	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	
				Community Members	Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
To promote a culture of having a child's growth assessed regularly.	Regular child growth assessments.	Limited information and communication on the importance of regular growth assessment. Attitude of service provider to growth assessments. Long distance to health facility	Take your child for regular growth assessments to ensure they grow up healthy.	Lactating mothers, community members, husbands and Mothers in law.	Interpersonal communication (with Health Workers, Village Healthy Workers etc.). Utilising platforms like ANC clinics, PMTCT sessions; Posters at health facilities, community centres and churches); Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
To contribute towards strengthening uptake of clinical nutrition services						
To promote the practising of at least one or a combination of the top 5 healthy lifestyles(limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity).	Improved practice of healthy lifestyles (limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity).	Diet at home, work and at institutions (hospitals, commercial catering services, schools, prisons, old people's homes, orphanages)	A balanced diet ensures the long term health of the nation.	Entire Population.	Radio and Television; Social Media; Pamphlets, Posters, Billboards and Role Models.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
		Attitude towards a healthy life style	Practising healthy lifestyles is important for long term health.	Entire Population.	Radio and Television; Social Media; Pamphlets, Posters, Billboards and Role Models.	

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
			▪ Reduce consumption of fats, salt and alcohol ▪ Limit tobacco use. ▪ Do moderate intensity exercise (30mins a day for at least 5 days a week)			
		Religious / cultural dietary restrictions.	A balanced diet is important for long term physical and spiritual well-being.	Religious groups	Religious leaders	Umbrella organisations for religious groups.
To contribute towards improved awareness and prevention of Nutrition-related NCDs.	Improved awareness of and prevention of Nutrition-related NCDs.	Limited information on prevention of Nutrition-related NCDs.	Regular health checks and healthy lifestyles helps prevent Nutrition-related NCDs.	Entire Population.	Radio and Television; Social Media; Pamphlets, Posters, Billboards and Role Models.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
To promote mainstreaming of nutrition in multi-sectoral interventions by 2018						
To increase knowledge on the importance nutrition within	Prioritisation of the first1000 days of a child's life in all social	Limited awareness on the importance of the first 1000	Good Nutrition is an outcome of multiple stakeholders.	All stakeholders involved in social	Policy dialogue platforms, Policy advocacy briefs, regional and international conferences, Provincial Minister's monthly	Development partners, NGOs working on

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
the first 1000 days of a child's life	protection targeting	days of a child's life		protection interventions	meetings parliamentary breakfast meetings, newsletters.	Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
To promote mainstreaming of nutrition in all multi-sectoral plans.	Mainstreaming of nutrition in all multisectoral plans	Limited information on the importance of mainstreaming nutrition in multisectoral plans and the benefits of good nutrition for other sectors.	Multisectoral plans that address nutrition have more potential to contribute towards multisectoral outcomes. Good nutrition contributes to development of Zimbabwe.	Water and Sanitation, Agriculture, Health, Social Protection, Women Empowerment stakeholders.	Policy dialogue platforms, Policy advocacy briefs, national and international conferences, provincial ministers' monthly meetings, parliamentary breakfast meetings, newsletters.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
Promoting use of clean and safe water	Improved use of clean and safe water	Limited access to safe water; Limited knowledge about household level water purification.	Make your water safer before drinking to prevent diseases.	Lactating mothers,	Interpersonal communication (with Health Workers, Village Health Workers etc.); ANC clinics, Posters at health facilities, Radio and Television; Social Media; Pamphlets, Billboards.	

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
				Women,	Interpersonal communication (with Health Workers, Village Health Workers etc.); ANC clinics, Posters at health facilities, Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT, Community Based Organisations; Media Organisations.
				Community members.	Community role models, Community centres and religious groupings	
			Providing access to safe drinking water contributes towards improving the overall health of the country	Policy makers;	Policy advocacy briefs	
			Encouraging households to drink clean water prevents disease outbreaks.	Health workers, community-based NGOs	Interpersonal communication through in-service trainings, Job AIDS, Posters, Information Packs.	
Promoting adoption and sustenance of hygienic food preparation practices.	Adoption and sustenance of hygienic food preparation practices.	Limited cleaning resources and knowledge on hygienic food preparation practices;	Hygienic food preparation practices contribute towards good health and well-being.	Pregnant and Lactating women	Interpersonal communication (with Health Workers, Village Health Workers etc.); ANC clinics, Posters at health facilities, Radio and Television; Social Media; Pamphlets, Billboards.	Development partners, NGOs working on Nutrition, NGOs working on PMTCT,

OBJECTIVE	DESIRED BEHAVIOUR/ PRACTICE	BARRIERS TO ADOPTION OF DESIRED BEHAVIOUR/ PRACTICE	OVERALL MESSAGE	AUDIENCES	COMMUNICATION CHANNEL	POTENTIAL PARTNERS
		Absence of social structures that support hygienic food preparation practices.		Women	Interpersonal communication (with Health Workers, Village Health Workers etc.); ANC clinics, Posters at health facilities, Radio and Television; Social Media; Pamphlets, Billboards.	Community Based Organisations; Media Organisations.
				Community Members,	Community role models, Community centres and religious groupings.	

9. MONITORING AND EVALUATION FRAMEWORK

The monitoring of this strategy will be tracked on monthly basis by implementation partners and reported on quarterly basis to the Ministry of Health and Child Care Nutrition Department at district, provincial and national levels. An indicator performance tracking table will be developed and shared with all stakeholders. The Communication Strategy will conduct a *Mid Term Evaluation at the end of 2016* and *End of Term Evaluation at the end of 2018*.

Table 5: Monitoring and Evaluation Plan

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
1. IMPROVING ADOLESCENT AND MATERNAL NUTRITION.	**OBJECTIVE 1.1** To contribute towards adoption of improved adolescent and maternal nutrition practices among women of child bearing age and adolescents by 2018 **OUTCOME 1.1** Women of child bearing age and adolescents adopting improved nutrition practices										
	i. Increasing knowledge of and promoting the benefits of iron and folate supplementation;	• Number of awareness raising activities conducted on the benefits of iron and folate supplementation • Number of Women of child bearing age reached with awareness activities on the benefits of iron and folate supplementation	• Proportion of women of child bearing age aware of the benefits of iron and folate supplementation	• Proportion of women of child bearing age with favourable attitude towards using iron and folate supplements. • Proportion of women of child bearing age expressing the intention to use iron and folate supplements; • Proportion ofwomen of child bearing age using iron and folate supplements.	Awareness and promotion Reports; Materials distributed; National Nutrition Survey; ANC records		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*
	ii. Increasing knowledge on and promoting	• Number of awareness raising activities conducted on consumption of consuming fortified foods	• Proportion of women of child bearing age and adolescents aware	• Proportion of women of child bearing age and adolescents	Awareness and promotion Reports;		X	X	X	X	*MoHCC, Food & Nutrition*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
	consumption of fortified foods;	• Number of women of child bearing age and adolescents reached with awareness activities on consumption of fortified foods	of the benefits of consumption of fortified foods	expressing the intention to consume fortified foods; • Proportion of women of child bearing age and adolescents reporting favourable attitude towards consuming fortified foods. • Proportion of women of child bearing age and adolescents who believe that consuming fortified foods will reduce risk of micronutrient deficiencies. • Proportion of women of child bearing age and adolescents consuming fortified foods	Materials distributed; National Nutrition Survey						*Council, Stakeholder, Partners*
	iii. Increasing knowledge of and promoting consumption of nutritious foods among adolescents;	• Number of awareness raising activities conducted on consumption of nutritious foods among adolescents • Number of adolescents reached with awareness activities on consumption of nutritious foods	• Proportion of women of child bearing age aware of the benefits of consumption of nutritious foods	• Proportion of adolescents expressing the intention to consume nutritious foods; • Proportion of adolescents encouraging others to	Awareness and promotion Reports; Materials distributed; National Nutrition Survey		X	X	X	X	*MoHCC,, Food &Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
				consume nutritious foods. • Proportion of adolescents consuming nutritious foods							
	iv. Advocacy to promote improved adolescent and maternal nutrition practices.	• Number of advocacy activities to promote improved adolescents and maternal nutrition practices • Number of decision/ policy makers reached with advocacy activities to promote improved adolescents and maternal nutrition practices • Development of food fortification regulatory framework	• Food fortification regulatory framework in place • Number of industry decision makers reached with food fortification advocacy activities	• Number of decision/ policy makers publicly speaking on the importance of adopting improved nutrition practices by women of child bearing age and adolescents • Proportion of women of child bearing age using iron and folate supplementation • Proportion of food manufacturers reporting favourable attitude to initiate fortifying their food products. • Number of food manufacturers producing fortified foods • Proportion of women of child bearing age and adolescents who believe	Advocacy activities Reports; Food fortification regulatory framework in place; Parliamentary Reports		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
				consuming fortified foods will prevent them from developing micronutrient deficiencies. • Proportion of women of child bearing age and adolescents consuming fortified foods • Proportion of adolescents consuming nutritious foods						
2.INFANT AND YOUNG CHILD NUTRITION	**OBJECTIVE 2.1** To contribute towards adoption of improved infant and young child nutrition practices among lactating mothers by 2018 **OUTCOME 2.1** Improved infant and young child nutrition practices among lactating mothers.										
	i. Increasing knowledge on the benefits of exclusive breastfeeding;	• Number of awareness raising activities conducted on the benefits of exclusive breastfeeding • Number of lactating mothers reached with awareness activities on the benefits of exclusive breastfeeding	• Proportion of lactating mothers aware of the benefits of exclusive breastfeeding	• Proportion of women of child bearing age expressing intention to practice exclusive breastfeeding; • Proportion of women of child bearing age encouraging other women to practice exclusive breastfeeding. • Proportion of lactating mothers practising	Awareness and promotion Reports; Materials distributed; National Nutrition Survey		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
				exclusive breastfeeding							
	ii. Increasing knowledge of and promoting adoption of a minimum acceptable diet for infants and children;	• Number of awareness raising activities conducted on a minimum acceptable diet for infants and children • Number of child bearing women reached with awareness activities on a minimum acceptable diet for infants and children	• Proportion of child bearing women aware of a minimum acceptable diet for infants and children	• Proportion of women of child bearing age expressing intention to provide a minimum acceptable diet for infants and children; • Proportion of women of child bearing age who believe feeding children with minimum acceptable diets improves prevents malnutrition. • Proportion of children having minimum acceptable diet	Awareness and promotion Reports; Materials distributed; National Nutrition Survey		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholder, Partners*
	iii. Increasing knowledge of and promoting continued breastfeeding up to 24 months	• Number of awareness raising activities conducted on continued breastfeeding • Number of women reached with awareness activities on continued breastfeeding.	• Proportion of women of child bearing age aware of the importance of continued breastfeeding	• Proportion of women of child bearing age expressing intention to prioritise continued breastfeeding; • Proportion of women breastfeeding up to 24 months.	Awareness and promotion Reports; Materials distributed; National Nutrition Survey		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
	iv. Increasing knowledge on and promoting consumption of the benefits of consuming iron rich-animal source foods	• Number of awareness raising activities conducted on the benefits of consuming iron rich-animal source foods • Number of child bearing women reached with awareness activities on the benefits of consuming iron rich-animal source foods	• Proportion of child bearing women aware of the benefits of consuming iron rich-animal source foods	• Proportion of women expressing intention to consume iron rich animal source foods; • Proportion of child bearing women consuming iron rich-animal source foods	Awareness and promotion Reports; Materials distributed; National Nutrition Survey		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*
	v. Advocacy to promote improved infant and young child nutrition practices	• Number of advocacy activities to promote improved infant and young child nutrition practices • Number of decision/ policy makers reached with advocacy activities to promote improved infant and young child nutrition practices	• Number of decision/ policy makers publicly speaking on the importance of adopting improved infant and young child nutrition practices	• Proportion of decision/ policy makers publicly speaking on the importance of adopting improved infant and young child nutrition practices; • Proportion of child bearing women adopting a minimum acceptable diet for infants and children • Proportion of child bearing women taking vitamin A supplementation • Proportion of lactating mothers practising exclusive breastfeeding	Advocacy activities Reports; Parliamentary Reports District Mentorship reports National Nutrition Survey		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
				• Proportion of lactating mothers practising continued breastfeeding for two years or beyond. • Proportion of child bearing women consuming iron rich-animal source foods							
3.PREVENTION OF NON-COMMUNICABLE DISEASES (Nutrition-related NCDs)	**OBJECTIVE 3.1** To contribute towards strengthening uptake of clinical nutrition services among the population by 2018 **OUTCOME 3.1** Improved uptake of clinical nutrition services										
	i. Increasing knowledge on and promoting adoption of healthy lifestyles(limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity)	• Number of awareness raising activities conducted on adoption of healthy lifestyles • Number of people disaggregated by age and gender reached with messages aimed at promoting healthy lifestyles	• Proportion of the population demonstrating awareness of 2 of the 5 healthy lifestyles (limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity)	• Proportion of the population expressing intention to adopt healthy lifestyles • Proportion of the population who believe adopting 2 of any 5 healthy lifestyles will improve their health (limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity) • Proportion of the population adopting 2 of the 5 healthy lifestyles (limiting	Awareness and promotion Reports; Materials distributed; National Nutrition Survey;		X	X	X	X	*MoHCC, Food &Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
				consumption of alcohol, fats, salts, tobacco use and encouraging physical activity)							
	ii. Increasing knowledge on and promoting prevention of Non communicable diseases.	• Number of activities on raising awareness and promoting prevention of Nutrition-related NCDs; • Number of people by age and gender reached with awareness raising and prevention messages.	Proportion of the population demonstrating awareness of 2 of the 5 healthy lifestyles	Proportion of the population with favourable attitude towards preventing nutrition-related NCDS. Proportion of the population adopting 2 of the 5 healthy lifestyles (limiting consumption of alcohol, fats, salts, tobacco use and encouraging physical activity	Awareness and promotion Reports; Materials distributed NCDS department reports		X	X	X	X	*MoHCC, Development partners, Food & Nutrition Council, Stakeholders, Partners*
4.PROMOTING ADOPTION OF SAFE WATER, SANITATION AND HYGIENE PRACTICES	**OBJECTIVE 4.1** To promote mainstreaming of nutrition in multisectoral interventions by 2018 **OUTCOME 4.1** Adoption and sustenance of safe water, sanitation and hygiene practices among households.										
	i. Increasing knowledge on and promoting prioritization of 1000 days in all social protection targeting.	• Number of awareness raising activities conducted on promoting prioritization of 1000 days in social protection • Number of stakeholders reached with information on the first 1000 days.	• Number of stakeholders with an understanding of the importance of the first 1000 days	• Proportion of stakeholders who have prioritised the 1000 days in their sector plans.	Activity Reports; Social Protection targeting criteria;		X	X	X	X	
	ii. To promote mainstreaming of nutrition in all multi-sectoral plans.	• Number of activities implemented to mainstream nutrition in all multi-sectoral plans • Number of stakeholders reached through activities	• Number of stakeholders with an understanding on the importance of mainstreaming nutrition in all	• Proportion of multisectoral plans that mainstream nutrition.	Activity Reports; Multi-sectoral plans		X	X	X	X	

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
		on mainstreaming nutrition in all multi-sectoral plans.	multi-sectoral plans.								
	iii. Increasing knowledge on the health hazards of using contaminated water and unhygienic practices in food preparation	• Number of awareness raising activities conducted on the health hazards of using contaminated water and unhygienic practices in food preparation • Number of child bearing women reached with awareness activities on the health hazards of using contaminated water and unhygienic practices in food preparation	• Proportion of child bearing women aware of the health hazards of using contaminated water • Proportion of child bearing women aware of the health hazards of using unhygienic practices in food preparation	• Proportion of women expressing the intention to use safe water and practice safe food preparation practices; • Proportion of marginalised/vulnerable women of child bearing age demanding safe water • Proportion of women of child bearing age using contaminated water • Proportion of women of child bearing age using unhygienic practices in food preparation	Awareness and promotion Reports; Materials distributed; National Nutrition Survey;		X	X	X	X	*MoHCC, Food & Nutrition Council, Stakeholders, Partners*
	iv. Promoting adoption and sustenance of hygienic disposal of excreta	• Number of awareness raising activities conducted on hygienic disposal of excreta • Number of child bearing women reached with awareness activities on hygienic disposal of excreta	• Proportion of child bearing women aware of hygienic disposal of excreta	• Proportion of women of child bearing age who believe hygienic disposal of excreta will reduce risk to illnesses. • Proportion of women of child bearing age employing	Awareness and promotion Reports; Materials distributed; National Nutrition Survey;		X	X	X	X	*MoHCC, Food &Nutrition Council, Stakeholders, Partners*

THEMATIC AREA	Activities	Process Indicator (s)	Output Indicator (s)	Outcome Indicator (s)	Means of Verification	Target	Timeframe				Responsible
							2015	2016	2017	2018	
				hygienic disposal of excreta							
	v. Advocacy to promote adoption and sustenance of safe water, sanitation and hygiene practices	• Number of advocacy activities on promotion of safe water, sanitation and hygiene practices • Number of decision/ policy makers reached with advocacy activities on promotion of safe water, sanitation and hygiene practices	Number of decision/ policy makers publicly speaking on promotion of safe water, sanitation and hygiene practices	• Proportion of decision/ policy makers publicly speaking on promotion of safe water, sanitation and hygiene practices • Proportion of child bearing women using safe water • Proportion of women of child bearing age employing hygienic practices in food preparation • Proportion women of child bearing age adopting hygienic disposal of excreta	Advocacy activities Reports; Parliamentary Reports		X	X	X	X	*MoHCC,, Food & Nutrition Council, Stakeholders, Partners*

10. SAMPLE DISTRICT COMMUNICATION PLAN

Table 6: Sample District Plan

Specific objective	Activities	Resources	Responsibility	Time-frame
OBJECTIVE 1.1 To contribute towards adoption of improved adolescents and maternal nutrition practices among women of child bearing age and adolescents by 2018 **OUTCOME 1.1** Women of child bearing age and adolescents adopting improved nutrition practices				
Specific objective	**Activities**	**Resources**	**Responsibility**	**Time-frame**
Women of child bearing age and adolescents having increased knowledge on the benefits of iron and folate supplementation	Edutainment (road shows, Drama)	- Financial resources (fuel,	- DFNSC - Partners	Quarterly
	Inter-personal communication (nutrition counselling, Community visits)	- Fuel, IEC material - Financial resources	- Nutritionist - HPO - Community Nurse	On-going
	School health programmes	- Fuel , IEC material	- Nutritionist - HPO - Community Nurse	Quarterly
	Media campaigns (newspaper articles, radio programmes and TV programmes)	- Financial resources	- National Department of Nutrition - Health promotion unit	Monthly
	In-service refresher trainings for health workers	- Financial resources for trainings for health workers, job aids and information flier	- Nutritionist - HPO - Community nurse	Annually
	Advocacy at policy level and community leaders (parliamentarians, Chiefs, Village Heads)	- Fuel, refreshment	- Nutritionist - HPO - Community nurse	Annually
Women of child bearing age consuming iron and folate supplements	Edutainment	- Financial resources	- DFNSC - Partners	Quarterly
	Inter-personal communication	- Fuel, IEC material	- Nutritionist - HPO - Community Nurse	On-going
	School health programmes	- Fuel , IEC material	- Nutritionist	Quarterly

Specific objective	Activities	Resources	Responsibility	Time-frame
			- HPO - Community Nurse	
	Media campaigns (newspaper articles, radio programmes and TV programmes)	- Financial resources	- National Department of Nutrition - Health promotion unit	Monthly
	In-service refresher trainings for health workers	- Financial resources for trainings for health workers, job aids and information flier	- Nutritionist - HPO - Community nurse	Annually
	Advocacy at policy level	- Fuel, refreshment	- Nutritionist - HPO - Community nurse	Annually
Increasing knowledge on and promoting consumption of fortified foods	Edutainment	- Financial resources	- DFNSC - Partners	Quarterly
	Inter-personal communication	- Fuel, IEC material	- Nutritionist - HPO - Community Nurse	On-going
	School health programmes	- Fuel , IEC material	- Nutritionist - HPO - Community Nurse	Quarterly
	Media campaigns (newspaper articles, radio programmes and TV programmes)	- Financial resources	- National Department of Nutrition - Health promotion unit	Monthly
	In-service refresher trainings for health workers	- Financial resources for trainings for health workers, job aids and information flier	- Nutritionist - HPO - Community nurse	Annually
	Advocacy at policy level	- Fuel, refreshment	- Nutritionist - HPO - Community nurse	Annually
Increasing knowledge of and promoting consumption of nutritious foods among adolescents	Edutainment	- Financial resources	- DFNSC - Partners	Quarterly
	Inter-personal communication	- Fuel, IEC material	- Nutritionist - HPO	On-going

Specific objective	Activities	Resources	Responsibility	Time-frame
			- Community Nurse	
	School health programmes	- Fuel , IEC material	- Nutritionist - HPO - Community Nurse	Quarterly
	Media campaigns (newspaper articles, radio programmes and TV programmes)	- Financial resources	- National Department of Nutrition - Health promotion unit	Monthly
	In-service refresher trainings for health workers	- Financial resources for trainings for health workers, job aids and information flier	- Nutritionist - HPO - Community nurse	Annually
	Advocacy at policy level	- Fuel, refreshment	- Nutritionist - HPO - Community nurse	Annually
Advocacy to promote improved adolescents and maternal nutrition practices	Advocacy dialogues, Edutainment	- Financial resources	- DFNSC - Partners	Quarterly
	Inter-personal communication	- Fuel, IEC material	- Nutritionist - HPO - Community Nurse	On-going
	School health programmes	- Fuel , IEC material	- Nutritionists - HPO - Community Nurse	Quarterly
	Media campaigns (newspaper articles, radio programmes and TV programmes)	- Financial resources	- National Department of Nutrition - Health promotion unit	Monthly
	In-service refresher trainings for health workers	- Financial resources for trainings for health workers, job aids and information flyers	- Nutritionist - HPO - Community nurse	Annually
	Advocacy at policy level	- Fuel, refreshment	- Nutritionist - HPO - Community nurse	Annually

Activity	Target Audience	Output	Resources	Responsibility	Time frame
OBJECTIVE 2.1 To contribute towards adoption of improved infant and young child nutrition practices among lactating mothers by 2018 **OUTCOME 2.1** Improved infant and young child nutrition practices among lactating mothers					
Activity	**Target Audience**	**Output**	**Resources**	**Responsibility**	**Time frame**
Launch the nutrition communication strategy	Different stakeholders	Number of village leaders, legislators and advocacy persons reached	Copies of the strategy Venue Refreshments Fuel Stationary IEC materials (banners, t-shirts, caps, wraps (mazambia), rulers for school children, pamphlets) Allowances	HPO Nutritionist	3rd quarter of 2015
Training of health workers on IYCF	Health workers	Number of health workers trained	Training manuals Venue Refreshments Stationary Fuel Allowances	Nutritionist	By end of 4th Quarter 2015
Counsel pregnant and lactating women on IYCF	Pregnant and lactating women	Number of pregnant and lactating women reached (register)	Counselling registers IEC material	Health workers	On going
Training or refresher courses on cIYCF	Village health workers	Number of village health workers trained	Training manuals Venue Refreshments Stationary Fuel Allowances	Nutritionist	By end of 4th quarter 2015

Activity	Target Audience	Output	Resources	Responsibility	Time frame
Community activities by village health worker (Home visits, individual counselling, action oriented groups, support groups and mobilisation for growth monitoring)	Pregnant and lactating women, men, elderly, adolescence	Number of households visited Number of people attending support groups and action oriented groups	Counselling cards Picture rolls IEC materials (pamphlets,) Models e.g. breast and food models cIYCF registers	Nutritionist HPO Nurse in charge	ongoing
Branding on IYCF (erect a billboard at district hospital/town centre,) Smaller billboards erected at rural health centres and growth points, economic centres (cattle sales, fruit and vegetable markets) Branding of shops, kombis, MOHCC vehicles, schools and rural health centres on IYCF Branded stationary (books, rulers, pens)	Community	Number of books, pens and rulers distributed	subscriptions for billboards and kombis stationary stickers artists paint fuel maintenance	Nutritionist HPO	Branding, by end of year Maintenance once a year
Edutainment activities (dramas, roadshows) use of social role models	Community School children	Number of people reached Number of school children reached and those who participated	Fuel Allowances T-shirts, caps, wraps (mazambia) Social role models	Nutritionist HPO	annually
District commemoration of WBW	Community		Venue Refreshments Fuel	Nutritionist HPO	Every 1st week of August

Activity	Target Audience	Output	Resources	Responsibility	Time frame
			Stationary IEC materials (banners, t-shirts, caps, wraps (mazambia), rulers for school children, pamphlets) Allowances		
Support and supervision activities	Health workers Villager Health Workers		Fuel Allowances stationery	Nutritionist HPO DNO	Quarterly
CD4 review meeting	Health workers		Venue Refreshments Stationary Fuel Allowances	nutritionist	Annually

Activity	Inputs	Outputs	Responsibility	Time Frame
OBJECTIVE 3.1 To promote uptake of clinical nutrition services among the population by 2018 **OUTCOME 3.1** Adoption of behaviors that contribute towards prevention of non-communicable diseases				
Activity	**Inputs**	**Outputs**	**Responsibility**	**Time Frame**
Advocacy meeting with multi sectorial team (DFNSC, DHE, PFNSC, partners)	Refreshments Stationery	Number of people reached	Nutritionist	Biannually
Sensitisation meeting with community leaders (political, church and traditional leaders)	Fuel, Bus fares, Stationery, Refreshments	Number Leaders reached	Nutritionist HPOs Community sister	Biannually
Community sensitisation meetings	Allowances, refreshments	Number of community members reached	HPO	On going

Activity	Inputs	Outputs	Responsibility	Time Frame
Commemorate nutrition related NCD days e.g. World Diabetes Day, Cancer Month,	Refreshments, Fuel, IEC materials	Number of commemorations done Number of people reached	HPO	On going
Training of health workers on healthy lifestyle modification	Allowances, fuel, stationery	Number of health workers trained	Nutritionist	Quarterly
Developing and distributing IEC materials on healthy lifestyles	Allowances Production and distribution costs	Materials produced	HPO	On going
Counselling of clients with nutrition related NCDs	Stationery	Proportion of clients reached	Nutritionist HFSS	On going

Activity	Inputs	Outputs	Responsibility	Time Frame
OBJECTIVE 4.1 To promote mainstreaming of nutrition in multisectoral interventions by 2018 **OUTCOME (s) 4.1** Mainstreaming of nutrition in different sectors To increase knowledge on the importance of nutrition within the first 1000 days of a child's life				
Conduct stakeholder social protection meetings	Venue Stationery Refreshments T & S	Number of stakeholders reached	DFNSC Partners Nutritionist	Quarterly
Promoting mainstreaming of nutrition in all multi-sectoral plans.				
sensitise stakeholders on nutrition communication strategy	Stationery Venue Refreshments T & S	Number of stakeholders sensitised	DFNSC Partners Nutritionist	Monthly
Promoting use of clean and safe water				
Training of VHWs on PHHE	IEC materials	Number of VHWs trained	Nutritionist	Quarterly

Activity	Inputs	Outputs	Responsibility	Time Frame
	PHHE tools T & S Stationery venue		HFSS DFNCs, Community based workers	
Standalone text messaging on hygiene	Funds Messages meetings	Number of people reached by text messaging	Partners Nutritionist Service Providers	Monthly
Promoting adoption and sustenance of hygienic food preparation practices.				
Training of women on hygienic food preparation during women gatherings (churches, wards, exhibitions, clubs) Video programmes on hygienic preparation of food.	Training manuals IEC material Venue Stationery T & S, CDs Recording equipment, Food ingredients Home setting venue	Number of women participating in hygienic preparation of food trainings. Number of CDs distributed to households on hygienic preparation of foods	Community based NGOs, DFNCs, Community based workers, City health departments DFNCs, City health departments, District health workers e.g. HFSS	Monthly

Annexe 1: Nutrition Communication Strategy National Taskforce Team

Name	Designation	Name	Designation
MOHCC Head Office			
Ancikaria Chigumira	Deputy Director Nutrition	Siboniso Chigova	HFSS Training Coordinator
Monica Muti	Nutrition Interventions Manager	Sharon T. Mvududu	HFSS Training Officer
Dexter Chagwena	Advocacy and Communication Officer	Machacha Lloyd	Monitoring & Evaluation Officer
Miriam Banda	National Nutritionist	Samuel Tsoka	Deputy Director Health Promotion
MoWAGCD			
Loyce M Kadzunge	Principal Admin Officer	Richard Chinjeke	Principal Admin Officer
UNICEF			
Vandana Argawal	Nutrition Manager	Natsayi Nembaware	Nutrition Officer
Charity Zvandaziva	Nutrition Specialist	Dr Mandi Chikombero	C4D Specialist
Thokozile Ncube	Nutrition Specialist		
MoHCC Provincial Medical Directorate Representatives			
Zanele Moyo	Provincial Nutritionist	Emily Mbanga	Provincial Nutritionist
Nhemachena K	Provincial Health Promotion Officer	Chigumbu Walter	Provincial Nutritionist
Rutendo Kandawasvika	Provincial Nutritionist	Elizabeth Katuruza	Provincial Nutritionist
Sifelani Kudehama	Health Promotion Officer	Cynthia Ncube	Provincial Health Promotion Officer
Chamunorwa Kahomwe	Health Promotion Officer	Faith Kamusono	Nutritionist
George Kambondo	Provincial Health Promotion Officer	Innocent Mazarura	Provincial Nutritionist
Charity Chikwiriro	Nutritionist	Sitshengisiwe Ruzibe	Health Promotion Officer
Austin Chivaraidze	Nutritionist	Ruvimbo Danda	Dietician
Lenin Makenga	Nutritionist	Cashington Siameja	Nutritionist
Honest Mahlatini	Nutritionist	Handrea Njovo	Provincial Nutritionist

Servious Mudyangwe	Nutritionist	Isheunesu Matimbira	Nutritionist
Getrude Simbarewamwe	Provincial Health Promotion Officer	Mercy Marimirofa	Biostatistician
Mufaro Chiriga	Nutritionist	Rumbidza Chituwu	Nutritionist
Zephenia Gomora	Provincial Nutritionist	Nemaramba Mildred	Nutritionist