ZIMBABWE'S AGRICULTURAL REVOLUTION REVISITED

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Children in difficult circumstances are most vulnerable to malnutrition.
The food and nutrition situation in Zimbabwe

Julia Tagwireyi

The current levels of food and nutrition insecurity in Zimbabwe condemn a large section of the population to reduced intellectual and physical capacity and ill health, resulting in limited productivity and worsening poverty. The gains in nutrition during the 1980s have largely been eroded. This chapter discusses the food and nutrition situation in Zimbabwe by closely examining the patterns and impact on vulnerable populations. The nutrition situation is then related to the HIV and AIDS pandemic and poverty. Poverty makes HIV worse and AIDS makes poverty worse (Ray and Kureya, 2003). The increase in HIV infections and poverty has resulted in some doubts about the ability of the country to improve nutrition and food security.

The chapter then elaborates on the nutrition policy as well as the institutional set-up responsible for monitoring and addressing the nutrition problems. Emerging strategic partnerships are examined from the national (state and private) perspective and at the local level where the zunde ramambo concept has emerged as a crucial social safety-net for many vulnerable people. Social groups that have been identified as most prone to food shortages and hence malnutrition even in times of plenty are families working seasonally in existing and former large-scale commercial farming areas (Mehretu, chapter 5), some families in communal and resettlement areas, and low-income urban dwellers. Nutrition policy making was mooted with the aim of reducing the severity of the problem. The last two sections of the chapter examine the lessons learnt and the challenges that face the country in dealing with the problems of nutrition.

Background

Reducing malnutrition is an important goal of development for any nation. In line with global developments and the need to reduce poverty and underdevel-

Zunde ramambo is a traditional practice whereby the traditional leader, such as a chief, kept a strategic grain reserve that was intended to support the needy and vulnerable within the community such as the elderly, orphans, the disabled and widows. This food would also be used for village ceremonies and functions. The community provided the labour and worked on a piece of land allocated by the chief for that purpose.
opment, the Government of Zimbabwe adopted the United Nations Millennium Development Goals in 2000 (table 25.1). These goals set targets and indicators for poverty reduction, combating HIV and AIDS, improvements in health, education, gender equality and women’s empowerment, the environment, and other aspects of human welfare and social development. These targets are set to be achieved by 2015. Adequate nutrition is a necessary condition to the achievement of the millennium development goals.

Table 25.1 The role of nutrition in achieving the millennium development goals

<table>
<thead>
<tr>
<th>Goals</th>
<th>Relevance of nutrition to the attainment of millennium development goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Eradicate extreme poverty and hunger</td>
<td>Contributes to human capacity and development throughout the life cycle and across generations.</td>
</tr>
<tr>
<td>2 Achieve universal primary education</td>
<td>Improves readiness, capacity to learn and achievement in school</td>
</tr>
<tr>
<td>3 Promote gender equity and empower women</td>
<td>Empowers women to make informed choices about food and nutrition issues that improve their quality of life and that of their families and communities.</td>
</tr>
<tr>
<td>4 Reduce child mortality</td>
<td>Reduces child mortality (in Zimbabwe 34% of child deaths are attributable to malnutrition)</td>
</tr>
<tr>
<td>5 Improve maternal health</td>
<td>Contributes to maternal health by addressing specific nutritional and diet-related problems affecting women – undernourishment and micronutrient deficiencies like iron and vitamin A, diet-related chronic diseases – diabetes and cardiovascular disorders.</td>
</tr>
<tr>
<td>6 Combat HIV and AIDS, malaria and other diseases</td>
<td>Slows onset and progression of AIDS. An important component of disease management and care. Highlights the importance of local food crops and diet diversity and quality.</td>
</tr>
<tr>
<td>7 Ensure environmental sustainability</td>
<td>Nutrition also highlights the need to address community needs through the food cycle from production, harvesting, storage, processing, preparation and consumption in a way that ensures environmental sustainability.</td>
</tr>
<tr>
<td>8 Develop a global partnership for development</td>
<td>Nutrition brings together many stakeholders around a common problem and many lessons can be drawn from the nutrition field in this regard.</td>
</tr>
</tbody>
</table>

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In general, deficiencies in protein and energy as well as key micro-nutrients such as iron and iodine tend to reduce the work capacity and productivity of adults. In young children they limit the capacity to learn and develop to full potential. Malnutrition will slow down development of a nation if unchecked. Since the 1990s, nutrition has no longer been viewed as a matter for the health sector alone to confront. New strategic partnerships were forged that led to a consensus on the multisectoral approach needed to address the prevailing food security and nutrition problems in Zimbabwe. Unfortunately this change in thinking and strategy occurred when the resources base to forge ahead with this new thrust was not available. The international isolation following contested land reforms and elections in 2000 took its toll on the availability of resources and technology to address the nutritional problems of Zimbabwe. Furthermore the disease burden was worsened as the HIV and AIDS pandemic made more demands on the already inadequate health budget. This reduced available technical capacity as well as institutional memory.

In Zimbabwe, there has been a marked deterioration in nutrition indicators amongst children under five years since 1994. The results of analysis of trend data of undernutrition in young children indicates that malnutrition continued to worsen from 1994 through to 2002. Whilst the 2003 national nutrition survey indicated some improvement, the situation was still worse by 2004 than it was in 1999, 1994 and 1988 for some of the indicators. One of the most prevalent micronutrient deficiencies in Zimbabwe is iron deficiency anaemia, affecting over 50 per cent of women of child-bearing age and children under five years. Vitamin A deficiency now constitutes a public health problem of significance. Pellagra, the result of niacin deficiency from the consumption of a predominantly maize-based diet which is not supplemented by sources of this essential vitamin B, namely legumes or animal products, continues to plague the nation, especially during droughts. Iodine deficiency disorder was successfully resolved through a mandatory policy of salt iodization. Zimbabwe was one of the few countries that met the goal of universal salt iodization in 1990. The impact of this achievement was the marked reduction in goitre and iodine deficiency disorder and an optimal iodine nutrition status in the country (World nutrition situation report, 2004).

In addition to problems of undernutrition, Zimbabwe has to grapple with diet-related disorders such as diabetes and cardiovascular disorders in adulthood. Early childhood malnutrition contributes to increased risk of diet-related chronic diseases in adults. These diet-related chronic diseases are costly, not only to individuals but also to the health sector. It is estimated that these diseases contribute to 28 per cent of morbidity and about 35 per cent of mortality. With respect to diet-related chronic diseases that have now assumed public health crisis proportions, changes in diet and activity patterns are the main contributory factors. The traditional diet which was characterized by the con-
assumption of cereals such as sorghums and millets, straight-run maize meal (roller meal), vegetables and legumes, provided more roughage, less refined starches and animal products, and was accompanied by a more active lifestyle. However, such lifestyles are disappearing for a number of reasons, mostly to do with urbanization and modernization.

Ironically the developed world has rediscovered the health value of traditional African diets and lifestyles in the control of diabetes and cardiovascular diseases. Zimbabwe has followed the rest of the developing world in adopting less healthy aspects of western food consumption patterns, such as over-processed cereals like white bread and over-refined maize meal, and the obsession with fatty foods sold in fast-food outlets that mushroomed in most urban centres after economic liberalization in the 1990s. The result is an unhealthy legacy that is not only costly to the individual but also to the nation as these disorders absorb a disproportionate amount of resources in an already stressed health delivery system. For example, in August 2004, the average cost of a month’s supply of insulin for a diabetic was US$500.

Causes of the deterioration in the nutrition situation

The deterioration of the nutrition situation in the country can be attributed to various factors, including recurrent droughts that have seen Zimbabwe, a once net exporter of food, having to import cereals and food aid. The poor performance of the economy from 2000 has resulted in reduced investments in the public sector that have severely eroded public health and education systems. A functional health infrastructure, especially at the primary level, is crucial for effective community-based nutrition programmes. Large-scale community-based nutrition programmes and primary health care strategies that were features of the 1980s were largely discontinued because available government resources were inadequate and donor support had drastically dwindled or been curtailed.

The recurrent droughts and economic reforms in the 1990s led to a loss of jobs in urban areas as industries closed down. At independence, urban areas were not targeted for special attention as they had better social indicators than the neglected rural areas. Government sought to redress the inequities of the pre-independence era in both rural and urban areas but with limited resources available chose to give priority to the rural areas. Whilst this was a noble policy decision at the time, there was no mechanism put in place to adequately monitor the situation in urban areas so that appropriate interventions could be made as the need arose. Vulnerability assessments in 2004 indicated serious erosion in the food security situation in urban areas. Poverty increased in both rural and urban areas and the 1995 poverty assessment study indicated that 57 per cent of the population fell below the food poverty line. This figure rose to 69 per cent in 2002. The *Zimbabwe human development report* of 2003 showed that the
human poverty index had risen from 24 in 1995 to 29 in 1999.

The high disease burden, especially of HIV and AIDS, has affected the food security nutritional status. The 2003 national nutrition survey indicated that the nutritional status of orphans was worse than that in households where both parents were alive. Malnutrition in itself compromises the immune system making the malnourished individual more susceptible to infections. HIV attacks an already immune compromised individual because of the prevailing malnutrition and the capacity to withstand the onslaught of opportunistic infections is limited.

Those affected by HIV and AIDS are more vulnerable as their ability to withstand hunger has been severely compromised by their low health circumstances. The frequent illness of the breadwinner erodes the family’s asset base and livelihoods as often the head of the family is no longer able to work and provide for the family. Young children under five who need special attention from an adult to ensure that they eat properly may end up being fed by a slightly older sibling as the mother has to take care of a sick husband and she herself may be unwell (figure 25.1). Not only is HIV and AIDS worsening the nutrition situation, the underlying malnutrition is worsening the impact of HIV and AIDS on the social strata of Zimbabwe, given the rise in child-headed and elderly-headed households.

HIV and AIDS has direct impacts on nutrition for the individual, the household and the community. For the individual, HIV infection, compounded by

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**Figure 25.1 Orphan and nutritional status 2003**

<table>
<thead>
<tr>
<th></th>
<th>Underweight</th>
<th>Stunting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents alive</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Orphans</td>
<td>20</td>
<td>30</td>
</tr>
</tbody>
</table>

inadequate dietary intake, rapidly leads to malnutrition. Persons living with HIV have higher than normal nutritional requirements; approximately 50 per cent more protein and 10–15 per cent more energy per day is needed (Woods, 1999; James and Schofield, 1990). Poor households may not be able to have a diet with protein and energy. Such interactions have serious consequences for the poor who are more likely to be malnourished even before they become infected. Malnutrition may hasten the onset of AIDS and ultimately death, and may also increase the risk of vertical HIV transmission from mother to child. The consequences of malnutrition are:

- **High mortality and morbidity, especially among young children**: Demographic health surveys estimated that 23 per cent of deaths of children under five years are attributable to malnutrition. Furthermore, the impact of HIV and AIDS is much more severe when the immune system has already been compromised by malnutrition;

- **Increased poverty**: Malnutrition contributes to poverty since it reduces physical and intellectual capacity and reduces the individual’s options for livelihood strategies;

- **Increased health care costs**: The burden of health care costs for the individual as well as the nation as the result of frequent illness is high. It is estimated that 70 per cent of hospital admissions have nutrition as the underlying cause.

Policy and institutional environment for food and nutrition

**Policy framework**

The recurrent droughts – and in particular the drought in 1992 which was dubbed the worst in living memory – served to further highlight the nutrition problems facing the nation. Whilst the planning and implementation of nutrition programmes in the 1980s had been done primarily through the nutrition unit in the Ministry of Health, there was a growing appreciation that nutrition was not simply a health issue but a developmental issue that required multisectoral action. The need for an appropriate policy and institutional framework to address food and nutrition problems, given the multisectoral nature of the problem, was recognized. To this end, an intersectoral task force was established in 1995 by the late vice-president Simon Muzenda to recommend to government a sustainable policy and institutional framework and strategies to reduce hunger and malnutrition in Zimbabwe. Under the chairpersonship of Professor Mandivamba Rukuni, a policy framework paper which articulated the range of actions needed to reduce hunger and malnutrition as well as the institutional framework needed to achieve this goal was developed. The framework paper was approved by Cabinet in 1998. The key features of the policy framework paper were:

- The acknowledgement that food and nutrition were key to development
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and needed the participation of different stakeholders in the public, private and civic society. The multisectoral nature of the food security and nutrition problem needed an effective policy and institutional framework to address the problem;

- The establishment of an autonomous and statutory Food and Nutrition Council through an Act of Parliament under the auspices of the Office of the President and Cabinet. The council was to be serviced by a secretariat made up of a multidisciplinary team of professionals. The Food and Nutrition Council would be financed through an annual government grant to underscore government commitment and other financing mechanisms including private sector and donor community;

- The development of strategies that would provide a permanent mechanism for responding to food and nutrition issues in drought and non-drought years. This included maintaining a state of preparedness over matters affecting the food and nutrition situation in Zimbabwe.

The environment for comprehensive and holistic nutritional planning has been generally enabling. Some of the following factors greatly facilitated the transition from nutrition being viewed as a health issue to an effective multisectoral action programme:

- The international food and nutrition conference of 1992 was the turning point for key development sectors that participated and gave a strong mandate to the Ministry of Health to spearhead efforts for the establishment of a national coordinating body for food and nutrition. This led to the approval by Cabinet of a food and nutrition policy framework paper;

- The country had over ten years of practical experience in intersectoral programme planning and implementation for community-based nutrition programmes from which to draw important lessons;

- The decentralization and devolved process of government structures provided a good opportunity for placing nutrition onto the district development agenda and providing technical leadership in nutrition closer to the community. District nutritionist posts were established in all 58 districts to serve and provide nutrition and technical support closer to the community;

- The recurrent droughts in 2001/02 and 2004/05 served to highlight nutrition issues, as the resultant food insecurity led to increased malnutrition. Thus harnessing water resources for irrigation was prioritized;

- The rediscovery of indigenous community-based coping strategies for food security and social welfare, *zunde ramambo*, provided hope for community-driven and sustainable interventions that held communities and their traditional leaders accountable for the food security and nutrition outcomes in their communities.
Institutional framework
The Food and Nutrition Council was set up in 2003 under the auspices of the Office of the President and Cabinet and it is based at the Scientific Industrial Research and Development Centre. The overall functions of the council are to develop, coordinate and harmonize the implementation of policies and strategies for attaining household food and economic security outlined in the food and nutrition policy framework document and to increase efficiency and minimize duplication of effort. The specific functions of the Food and Nutrition Council are as follows:

- To advise the nation on food and nutrition issues in general and how food and nutrition can be integrated into other policies, especially in the economic sectors in government and private sector organizations;
- To develop standards and norms and promote effective programme strategies to reduce food insecurity and malnutrition and contribute to the elimination of poverty through stakeholders;
- To mobilize and manage financial and technical resources to support a coordinated national response to household food insecurity and malnutrition;
- To develop and promote appropriate regulations through the relevant implementing agencies to ensure a safe, adequate and stable food supply which is accessible to the domestic market and which meets international standards for export;
- To increase awareness on food and nutrition issues in general as well as the activities of the council and its stakeholders through an advocacy, information, education and communication strategy. As a result of this strategy, the council launched the first ever Food Fair in January 2005 in which stakeholders promoted indigenous local foods to the general public;
- To enhance and develop capacity of stakeholder implementing institutions to enable them to fulfil their role and mandate in food and nutrition issues;
- To monitor regularly the food and nutrition situation of the nation and give feedback to stakeholders as well as report to parliament periodically through the relevant minister.

Emergence of new strategic partnerships for food and nutrition
Private sector involvement and participation in nutrition programmes increased considerably from the 1990s. Participation was not only through membership of the task force for food and nutrition as the Food Manufacturers’ Association but also on the infant nutrition committee. Salt traders and processors actively participated in the salt iodization programme and the success of salt iodization in Zimbabwe is attributed to a successful partnership and cooperation between government and the private sector. Different forms of public–private partnerships have grown from strength to strength within defined parameters and frameworks. The private sector has been included in the task force established by the
Ministry of Health and Child Welfare to develop a comprehensive strategy for food fortification to address the prevailing micronutrient problems in the country. The drought has also seen the development of technical capacity by local manufacturers in the production of good quality supplementary foods that are used in food relief programmes by government and non-governmental organizations.

Traditional knowledge systems and coping mechanisms for food security and social welfare in the wake of recurrent droughts have been rediscovered. In response to the dwindling community coping capacity with successive food insecurity crises and HIV and AIDS, traditional leaders rediscovered a useful tradition for enhancing food security. In 1996, the nutrition unit in the Ministry of Health through its intersectoral community-based food and nutrition programme worked with the chiefs council to revive the *zunde ramambo* concept.

**Technical and financial resources base for nutrition activities**

The technical capacity for nutrition has increased considerably with the University of Zimbabwe producing graduates in nutrition. These graduates have been largely absorbed within the public and private sectors. In addition, the technical capacity vested in many non-governmental organizations and international organizations has expanded considerably. Mechanisms to try and harness this capacity for the overall benefit of the country have however met with limited success. A nutrition working group with membership from government, international agencies and non-governmental organizations was established initially to develop a common framework for operating as well as for information sharing and developing guidelines for emergency food relief activities. The combined resources available for food and nutrition activities from government and the international community were quite considerable. Unfortunately the bulk of the resources were for assessments and establishing parallel non-governmental organization and international agency infrastructure for food relief activities. Very little of these resources was earmarked for sustainable local nutrition programmes to achieve self-sufficiency. In most cases the strategy remained to mobilize short-term relief activities.

**International isolation, change in the nature of and withdrawal of donor support**

Donor support for nutrition programmes diminished dramatically from 2000 and at the same time government resources were diverted to much-needed drought relief programmes. Following the land reform programme, several agreements for donor support were rescinded and many donor-supported programmes collapsed. However, the withdrawal of donor support affected infrastructure, such as transport for monitoring, and supervision of nutritional programmes also collapsed. The cooperating environment altered with partners
diverting their support to humanitarian assistance and HIV and AIDS through non-governmental organizations where capacity was limited, instead of through government structures.

Harnessing and coordinating international agencies and private and voluntary organizations
Since 2000, many non-governmental organizations have mushroomed in the name of the humanitarian response to drought and the HIV and AIDS pandemic. Many of these organizations engaged in food relief activities and recruited nutritionists. This was a strong acknowledgement of the need for the technical skills that nutritionists could provide. Unfortunately this development accelerated the exodus of nutritionists from the public sector and the Ministry of Health and Child Welfare was most affected. Not only did the ministry lose some of its most experienced staff, even the newly recruited district nutritionists were lured away by attractive remuneration packages government could not match. Some international non-governmental organizations even brought in their own nutritionists.

Unfortunately, the framework for harnessing and maximizing the impact of all this existing technical capacity available to the country as a whole was not in place. It took a long time for consensus to be reached on a framework for cooperation between all the stakeholders involved in food relief activities. Time was lost as consensus on the magnitude of the problem could not be reached. The political environment from 2000 fuelled a lot of mistrust between government and other partners. This led to non-governmental organizations developing in-house capacity in order to carry out their own 'unbiased' food security and nutrition assessment. This development led to duplication of effort and waste of available resources and, more importantly, the abuse of communities that had to endure frequent assessments by different groups.

The government did not exercise its leadership role early enough to control this mayhem. When the government structures were finally activated to try and coordinate humanitarian assistance, some of the actions were not well received by partners as they were perceived as politically motivated.

The establishment of the Zimbabwe vulnerability assessment committee (ZIMVAC) under the chairpersonship of the Food and Nutrition Council was an important milestone in the coordination of assessments as well as in harnessing available technical and financial resources from government, the non-governmental organization community, the international donor community and the United Nations agencies. It also served to bring some sanity to the situation as well as consensus on food security information. Four vulnerability assessments were undertaken between 2002 and 2004 under the leadership of the Food and Nutrition Council as chair of the Zimbabwe vulnerability assessment committee. Membership of the committee was broad based and included all partners which enabled the committee to become a subcommittee of the cabi-
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net social services action committee. Whilst the humanitarian programmes had overwhelming support, the opportunity to integrate sustainable community-based nutrition activities within the context of these programmes was largely lost.

The high disease burden of HIV and AIDS
HIV and AIDS affects productivity and estimates indicate that at least 30 per cent of the reduction in agricultural productivity can be attributed to HIV and AIDS. The Food and Agriculture Organization estimated a 23 per cent loss in agricultural labour force in Zimbabwe in 2002. There has also been a drastic reduction in livestock in rural areas as families sell their livestock and other assets to pay for health care for family members and to pay other costs such as school fees and funeral expenses. This affects agricultural productivity since the size of land cultivated is determined by the resources available to purchase inputs and the labour and draught power available.

Agricultural extension services have also been severely compromised through staff absenteeism as a result of people attending funerals, staff sickness and death of experienced and skilled staff whose timely replacement is becoming more difficult. HIV and AIDS has impacted negatively on household incomes as many key breadwinners have become too ill to work. Studies have indicated drops in income of between 52 and 65 per cent. Communities' asset bases and coping capacity have been drastically eroded, contributing to growing poverty. The available government social safety-nets have failed to cope with the increased demand for support.

HIV and AIDS has a more direct impact on young child nutrition through a reduction in the caring capacity of the primary care-giver – the mother. The many demands being made on the primary care-giver through caring for and supporting those affected by AIDS, compromises her capacity to ensure that young children are fed with the frequency recommended.

Lessons learnt
Addressing food and nutrition issues requires a holistic approach. The government has a leadership role to play in coordinating available technical, material and financial resources, especially in an emergency. There has to be a state of preparedness that triggers appropriate and timely action to minimize confusion amongst the different stakeholders. Over-reliance on donor support is not healthy but there is a need to find sustainable support for national and local nutrition programmes. Food security and nutrition should be viewed as national strategic issues that require sustainable national resources. Partners may be asked to assist but should not have to bear the main burden of the cost.

Zimbabwe needs to have in place a comprehensive national food and nutri-
tion information system that provides credible and timely food security and nutrition information, facilitates appropriate decision making at all levels – from the community level through to policy makers – for improved food security and nutrition outcomes. Such a system would minimize the need for costly and time-consuming national assessments that have delayed humanitarian aid as development agencies and government argued over the severity of the food insecurity problem and the population that needed support. Responses to the prevailing food security and nutrition problems require that planning and implementation of strategies be done using an HIV and AIDS ‘lens’.

Conclusion

The potential for improving the food security and nutrition situation in Zimbabwe exists. The country needs to address food insecurity which significantly contributes to nutrition problems. The prevailing worsening trends in food insecurity and nutrition status should provide the added stimulus for concerted action by all stakeholders. Policy makers tend to be more responsive and supportive to initiatives proposed during a crisis. Government is also a signatory to various conventions and statutes which are supportive of food security and nutrition issues. However, there is still need to find creative ways to advocate for nutrition and to keep it relevant to the prevailing development agenda. A holistic approach that harnesses multisectoral action is needed to effectively address the nutritional challenges that face Zimbabwe. It should address malnutrition in all its forms and define stakeholders’ roles and responsibilities in responding to the prevailing food security and nutritional problems.
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References


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