UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (NMNAP)

From Evidence to Policy to Action

JULY 2016 - JUNE 2021



OCTOBER, 2016

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"Great things are done by a series
of small things put together"

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KEYNOTE

This National Multisectoral Nutrition Action Plan (NMNAP) reflects Tanzania's commitment to addressing the unacceptably high levels of malnutrition and translates into a single comprehensive national plan the nutrition relevant national, regional and international commitments that Tanzania has made. It continues Tanzania's longstanding political will and commitment for nutrition since independence in 1961. The first phase Government (1961-1985) under President Julius Nyerere, declared that the country faced three major enemies: poverty, disease and ignorance, all of which are the manifestations and causative factors of malnutrition. To demonstrate commitment for nutrition, the Government established the Tanzania Food and Nutrition Centre (TFNC) in 1973 to coordinate nutrition activities in the country. With the support of development partners, the Government developed various nutrition relevant policies, strategies and programs with a specific Food and Nutrition Policy approved in 1992. Despite much progress made, undernutrition in children is still a major contributor to the persistence of all three of the enemies and a double burden of malnutrition is emerging with increasing levels of overweight, obesity and diet related non-communicable diseases including, type-2 diabetes, hypertension, heart diseases and several types of diet related cancers in adults.

Recognizing that malnutrition is a developmental challenge and a threat to achieving our national socio-economic goals, including establishing ourselves as an industrial, knowledge-driven Middle Income Country by 2025, this NMNAP complements the 2016 Food and Nutrition Policy, within the Government's Five Year Development Plan II (FYDP II) 2016-2021. The FYDPII theme is ***Nurturing an industrial economy and human development,*** seen within the context of the long term National Development Vision 2025 on Economic and Social Growth (MKUKUTA). A "double duty action" plan in that it addresses malnutrition in all its forms, the NMNAP reflects Tanzania's commitment to developing a healthy, well-nourished and productive human resource capital capable of "creating, innovating and competing" in an industrially based middle income country economy.

Thus, the long-term desired change expected from scaling-up a broad portfolio of nutrition interventions within the NMNAP is that **"Children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development".** A primary target of this NMNAP is to reduce the prevalence of stunting from the current 34 percent to 28 percent by 2021, which will be a critical step towards the achievement of the 2025 MKUKUTA and the World Health Assembly nutrition goals. The NMNAP is expected to also contribute to the Sustainable Development Goals (SDGs), specifically goal 2 on "zero hunger" aiming at ending all forms of malnutrition by 2030.

Lastly, I would like to reiterate the Government's commitment to supporting the NMNAP through the FYDPII (2016-2021), where an allocation of 254 billion TZS (115 million US$) has been made. We shall improve our nutrition multisectoral coordination system at all levels and track progress through the common results, resources and accountability framework of the NMNAP. Our commitment to addressing malnutrition will be with the same vigour to route-out corruption and collecting taxes for national development; and same energy as we build our physical infrastructure. In particular, ending undernutrition is a great way to developing our children's **"grey matter infrastructure".** To ensure that every citizen has the potential to lead a healthy and productive life, we shall leave no one behind. While we will emphasize allocation of domestic resources for nutrition, we ask our development partners, civil society organizations and the private sector to join us to make financial investments in those areas where domestic resources are not adequate.

Hon. Kassim Majaliwa Majaliwa,
Prime Minister

FOREWORD

Although Tanzania has made some good progress in addressing the problem of undernutrition in children, the pace of improvement, especially for the alleviation of stunting, has been slow, with data showing that the prevalence of stunting reduced from about 50 percent in 1992 to about 34 percent in 2015/16. This current level of stunting is categorized as "high" in terms of its public health significance and is higher than the 30 percent average observed for Africa. Moreover, a double burden of malnutrition has emerged where undernutrition exists together with a rapidly increasing problem of diet-related non-communicable diseases, especially overweight, obesity, hypertension and type-2 diabetes that have doubled in adults over the last decade.

The slow progress in alleviating stunting has taken place despite the existence of evidence based high impact nutrition interventions, a strong political commitment to address undernutrition and a robust economic growth of about 7 percent for the last decade. One of the key factors implicated in the slow progress has been a limited capacity at all levels to translate the political committment and economic growth into effective, impactful and sustainable policies and strategies, and an ability to implement community-centred actions that are at scale, multisectoral, well-coordinated, integrated, resourced and monitored. To address this challenge, the Government strengthened its leadership in nutrition and took several steps in recent years. This included the launching of the National Nutrition Strategy (NNS) 2011/12-2015/16, the inclusion of nutrition in national planning and budgeting, and the formation of a Multisectoral High-Level Steering Committee on Nutrition (HLSCN) to ensure participation of key nutrition stakeholders in developing and tracking progress of multisectoral approaches to address malnutrition. The HLSCN is chaired by the Permanent Secretary in the Prime Minister's Office with members being the Permanent Secretaries of several key "nutrition sensitive" ministries, development partners, civil society organizations and representatives from the private sector. Nutrition Steering Committees at the Regional and Local Government Authorities have also been formed to facilitate multisectoral coordination and the participation of key stakeholders at those levels.

Three key outputs by the HLSCN standout: (i) including nutrition in the FYDP-II, (ii) developing the 2016 Food and Nutrition Policy, and (iii) this National Multisectoral Nutrition Action Plan, which is the FNP's strategic implementation action plan for the period 2016/17-2020/21. The NMNAP is evidence-informed, results-oriented, consistent with the theory of change and based on the three ONES principle at all levels: one plan, one coordinating mechanism and one monitoring and evaluation framework. The NMNAP also provides an effective framework for common results, resources and accountability for nutrition and localises the World Health Assembly nutrition targets and the nutrition-relevant Sustainable Development Goals. The NMNAP's desired change is that ***"Children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development".***

To achieve that change, the NMNAP has identified seven key results areas and developed action plans for each. These are: (i) scaling-up maternal, infant, young child and adolescent nutrition, (ii) scaling up prevention and control of micronutrient deficiencies, (iii) scaling up integrated management of acute malnutrition, (iv) scaling up prevention and management of diet related non-communicable diseases, (v) integration of multisectoral nutrition sensitive interventions, (vi) improving multisectoral nutrition governance, and (vii) establishing a multisectoral nutrition information system.

I call upon all internal and external stakeholders to support Tanzania in the implementation of this National Multisectoral Nutrition Action Plan.

Hon. Ummy Mwalimu
Minister of Health, Community Development, Gender, Elderly and Children.

STATEMENT OF COMMITMENT

We, the Permanent Secretaries from the Line Ministries forming the High Level Steering Committee on Nutrition (HLSCN) and the Managing Director of the Tanzania Food and Nutrition Centre:

Recognizing that the current levels of chronic malnutrition in children under the age of five years are unacceptably high;

Aware that despite the good progress made in addressing malnutrition in Tanzania, undernutrition continues to affect the most vulnerable population groups especially children underfive, pregnant and lactating women and adolescents;

Concerned that a double burden of malnutrition is emerging with diet-related non-communicable diseases (DRNCDs) increasing at a fast pace alongside high levels of undernutrition;

Acknowledging the grave consequences of all forms of malnutrition on national social and economic development, which will impede our aspiration of transiting into a middle income country by 2025;

Understanding that there is adequate national and global scientific evidence and experience in scaling-up high impact nutrition specific and nutrition sensitive interventions;

Confident that this National Multisectoral Nutrition Action Plan (NMNAP) translates well the 2016 National Food and Nutrition Policy into an evidence-based strategic action plan that also contextualizes adaption of the global Sustainable Development Goals (SDGs) and regional nutrition relevant strategies that Tanzania is a state party to;

Accepting that it is possible to make significant progress in addressing malnutrition in all its forms during the Five-Year Development Plan II of 2016/17 – 2020/21 as an important step towards making Tanzania a middle income country by 2025 and the national goal of ending malnutrition as a problem of public health significance by 2030;

THEREFORE, THROUGH OUR SIGNATURES ATTACHED HERETO, WE COMMIT OURSELVES TO THE FOLLOWING:

We shall take practical steps to ensure our sector policies, strategies, programmes and budgets are nutrition sensitive;

We shall actively participate in the implementation of the NMNAP through the High Level HLSCN; and

We shall take the necessary leadership in the implementation of the areas that our sectors have been assigned by the 2016 Food and Nutrition Policy and this NMNAP.

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Permanent Secretary, President's Office,
Regional Administration and Local Governments,
Authority – TAMISEMI

Dr. Hamisi Mwinyimvua
Permanent Secretary (Policy and Coordination
– Chair of HLSCN)
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Dr. Joyceline Kaganda
Ag. Managing Director,
Tanzania Food and Nutrition Centre (Secretariat to HLSCN)

ACKNOWLEDGEMENTS

Steered by the Prime Minister's Office (Mr. Obey Assery Nkya and Ms Sarah Mshiu) and coordinated by the Tanzania Food and Nutrition Centre, the development of this National Multisectoral Action Plan (NMNAP) involved an extensive consultation process of many nutrition stakeholders. Those who made significant contributions are listed in appendix 4 and we would like to acknowledge their inputs.

As in all big things, there have been movers of the NMNAP, whom we would like to mention in person. Dr. Joyceline Kaganda, Acting Managing Director of TFNC was instrumental in coordinating all aspects of the process. Dr. Festo P. Kavishe an Independent Human Development Consultant was the Lead Facilitator and synthesizer writer. Dr. Biram Ndiaye, Chief Nutrition at UNICEF Tanzania and Mr. Mauro Brero, Nutrition specialist at UNICEF, Tanzania, not only facilitated the two key result areas on Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) and Integrated Management of Acute Malnutrition (IMAM), but also facilitated the overall analysis of costs and the Common Results, Resources and Accountability Framework (CRRAF) and review of the NMNAP drafts. The UNICEF Tanzania Country Office provided additional support with Ms. Rikke le Kirkegaard, Nutrition Officer who supported drafting of the IMAM scale up plan and Ms. Elizabeth Macha, Nutrition Specialist who supported the development of the MIYCAN scale up action plans. Ms Neema Joshua and Ms Maria Msangi both from TFNC chaired these two Key Result Areas. The Micronutrients Key Result Area was chaired by Dr. Fatma Abdallah of TFNC and facilitated by Prof. Jonathan Gorstein of the University of Washington and Executive Director of the Iodine Global Network who also acted as the main external reviewer of the NMNAP. Prof. Andrew Swai of the Tanzania Diabetic Association and NCD Alliance, facilitated the Diet Related Non-Communicable Diseases (DRNCDs) Key Result Area with Ms Julieth Kitali of TFNC as the chair.

The Key Result Areas on Nutrition Sensitive Interventions (NSI) and Multisectoral Nutrition Governance (MNG) were chaired by Mr. Geoffrey Chiduo of TFNC and facilitated by Mr. David Katusabe, Mr. Benedict Jeje and Mr. Tumaini Charles all from Fhi360-FANTA. Mr. David Charles of USAID and Dr Deborah Ash and Ms. Caroline Mshanga both of FHI 360/FANTA provided technical guidance and review of these Key Result Areas. Mr. Adam Hancy chaired the Key Result Area on Nutrition Information System (NIS), facilitated by Mr. Cletus Mkai, an Independent Consultant. Mr. Giulio Ghirardo of IMA International led the theory of change workshop and contributed to chapter 3 and associated appendix on the theory of change. Mr. Enock Musinguzi, Country Representative and SUN Business Network Coordinator for the Global Alliance for Improved Nutrition (GAIN) organized the consultation with the private sector.

TFNC provided the overall logistical and organizational support. UNICEF with the support from DFID, CIFF and Irish Aid funded the overall NMNAP process and facilitation, including of the four Key Result Areas of MIYCAN, IMAM, DRNCDs and Multisectoral Nutrition Information System (MNIS), the workshop on the "Theory of Change" and overall development and finalization of the NMNAP. FHI360-FANTA with the support from USAID funded the facilitation of the two Key Result Areas on NSI and MNG, while the Micronutrient Initiative (MI) funded the facilitation of the Key Result Area on Micronutrients as well as support for the main external review of the NMNAP. We would like to thank them all.

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EXECUTIVE SUMMARY

Purpose of the NMNAP

1. This National Multisectoral Nutrition Action Plan (NMNAP) covering the five-year period between 2016/17 and 2020/21 is the implementation plan for the 2016 National **Food and Nutrition Policy (FNP)** and its ten-year **Implementation Strategy (2015/16-2025/26)**. **It is an evidence-based "double duty action" multisectoral action plan** to address the unacceptably high levels of malnutrition in Tanzania in all its forms – both **undernutrition** and the **increasing burden of diet related non-communicable diseases (DRNCDs)** such as overweight, obesity and diabetes.

2. Anchored within the Government's Five-Year Development Plan II (2016/17 – 2020/21) the NMNAP's broad goal is to accelerate scaling up of high impact multisectoral nutrition specific and nutrition sensitive interventions and creating an enabling environment for improved nutrition, to contribute to the building of a healthy and wealthy nation. Though all population groups are considered, the focus is on the most vulnerable groups – infants, children under-five years of age, adolescent girls, pregnant and lactating women and other women of reproductive age (15-49 years of age). By developing a productive human capital that focuses on the most vulnerable groups in society, the NMNAP will contribute significantly to the nation's aspiration of attaining and sustaining middle income country (MIC) status by 2025 in conditions of peace, stability, equality, opportunity and social justice. Moreover, a well-nourished population will have the productive and learning capacity necessary to compete in a knowledge based MIC economy.

3. The transformative NMNAP builds on Tanzania's successes in improving nutrition, fills the gaps identified and addresses emerging challenges and priorities. The conceptual framework used, facilitates the incorporation of global and national evidence and experience in addressing malnutrition into concrete actions. Above all it facilitates translation of political will and commitment into tangible portfolio of services and actions including resource allocation, to be delivered to the population.

4. The NMNAP is planned as a flexible living document that is able to respond to the dynamic environment expected during its period of implementation. **Given that only about 26 percent of the estimated budget is already resourced,** much effort will be needed to mobilise more funds to achieve the objectives and targets of the NMNAP.

Process for developing the NMNAP

5. The process for developing this NMNAP was **guided by a roadmap** that ensured broad participation of all key players in the multisectoral nutrition system through extensive stakeholder consultations and scientific evidence reviews. Stakeholders who participated in the development of the plan included: The Prime Minister's Office (PMO); President's Office-Regional Administration and Local Government at central, regional and LGA levels; sector ministries; donors; United Nations agencies; civil society organizations (national and international); academic and research institutions; the private sector; and individual nutrition stakeholders not affiliated with any institution.

6. **The Prime Minister's Office**, specifically the Director of Government Business Coordination, who is also the Scaling Up Nutrition (SUN) focal point, **oversaw the entire process** of developing the NMNAP. **A Lead Facilitator provided overall technical harmonization, coordination and facilitation, and drafted the NMNAP document**. **TFNC chaired and acted as the secretariat (the engine) for the coordination** meetings held every two weeks and for the six task teams that developed the action plans for the seven key result areas (KRAs). **Task team facilitators and chairs supported the development of logical and results**

frameworks, and results-based action plans and budgets. UNICEF facilitated orientations for results based management (RBM), results based budgeting (RBB) and the "theory of change" to ensure articulation of SMART results. A **consolidation workshop** synthesized the work from the different task teams and a **validation workshop** reviewed the initial draft document. The **High Level Steering Committee on Nutrition (HLSCN) adopted the NMNAP at its meeting held on 21st October 2016** that was chaired by the Permanent Secretary in charge of Policy and Coordination in the Prime Minister's Office.

Key Result Areas of the NMNAP

7. The NMNAP is organized in seven key result areas (KRAs) to reflect both life-course and multisectoral approaches. The interventions cover a series of complementary nutrition specific and nutrition sensitive interventions and an enhancement of the enabling environment for improved nutrition. Six task teams led by subject matter experts in the KRAs developed operational action plans on one or two KRAs. The operational action plans are summarized in chapter 5 and available separately as annexes 1-7. The prioritized KRAs of the NMNAP are:

    1) Scaling up Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN);
    2) Scaling-up Prevention and Management of Micronutrient Deficiencies;
    3) Scaling up Integrated Management of Acute Malnutrition (IMAM);
    4) Scaling-up Prevention and Management of Diet Related Non-Communicable Diseases (DRNCDs);
    5) Promoting Multisectoral Nutrition Sensitive Interventions (NSI);
    6) Strengthening Multisectoral Nutrition Governance (MNG); and
    7) Establishing Multisectoral Nutrition Information System (MNIS).

Key expected results of the NMNAP

8. The expected long-term impact of the full implementation of the NMNAP is that **"Children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development".**

Planned NMNAP targets

9. The key planned targets are adapted from the globally agreed World Health Assembly (WHA) nutrition targets by 2025, the SDGs by 2030 and the global voluntary Non-Communicable Diseases (NCDs) targets by 2025 that Tanzania will report upon. Thus, by June 2021, the NMNAP aims to achieve 12 key nutrition targets as shown in table 1.

Table 1: Key targets for the NMNAP 2016/17-2020/21

NMNAP Key targets by 2020/21

1. Reduce prevalence of **stunting** among children 0-59 months from 34% in 2015 (TDHS 2015/16) to 28% in 2021 (WHA indicator target 1);
2. Maintain prevalence of **global acute malnutrition** among children 0-59 months under 5% in 2021 (WHA indicator target 6);
3. Reduced prevalence of **low birthweight** from 7% in 2010 (TDHS 2010) to less than 5% in 2021 (WHA indicator target 6);
4. Reduced proportion of women 15-49 years with **anaemia** from 44.7% in 2015 (TDHS 2015/16) to 33% in 2021 (WHA indicator target 2);
5. Reduced prevalence of **Vitamin A deficiency** among children aged 6-59 months from 33% in 2010 (TDHS 2010) to 26% in 2021;
6. Maintain median urinary **iodine** of women of reproductive age between 100-299 µg/L by 2021;
7. Maintain prevalence of **diabetes** among adults under 10% by 2021;
8. Maintain prevalence of **overweight among children** under five under 5% by 2021;
9. Maintain prevalence of **overweight among adults** under 30% by 2021.

10. There are seven key expected outcomes of the NMNAP, divided among the three broad intervention areas. These are: -

I. Nutrition specific outcome results:

1) Increased proportion of adolescents, pregnant women and mothers/caregivers of children under two years who practice optimal maternal, infant, young child and adolescent nutrition behaviours[1];

2) Optimal intake of essential vitamins and minerals to meet physiological requirements and prevent deficiency (focus on vitamin A, iron, iodine, zinc, folic acid and vitamin B12);

3) Increased coverage of integrated management of acute malnutrition (IMAM) services;

4) Increased physical activity and healthier dietary habits by the Tanzanian community.

II. Nutrition sensitive outcome results:

5) Increased coverage of nutrition sensitive interventions from six key development sectors: (i) agriculture and food security; (ii) health and HIV; (iii) water, sanitation and hygiene; (iv) education and early childhood development; (v) social protection; and (vi) environment and climate change.

III. Enabling environment outcome results:

6) Improved effectiveness and efficiency of nutrition governance (including coordination and leadership) and response across all sectors, actors and administrative levels;

7) Increased access to quality nutrition related information to help the Government of Tanzania and partners to make timely and effective evidence informed decisions.

1 Behavioural practices for optimal maternal, infant and young child and adolescent nutrition include: attending ante-natal clinic (ANC) at least 4 times during pregnancy; being delivered by a skilled helper; exclusively breastfeeding infants for six months; adding appropriate nutrient dense complementary foods after six months and feeding the child at least 4 times a day. Others are practicing good sanitation and hygiene like appropriate faecal disposal, washing hands with soap at the three critical times (after defaecation, when preparing food and when eating); ensuring pregnant and lactating women and children under-five sleep under an insecticide treated net (ITN); seeking medical help when the child is sick; going to the MCH clinic for growth monitoring and ensuring adolescents receive reproductive health support and adopt healthy eating and lifestyle habits.

Key strategies of the NMNAP

11. The **overarching strategy for the NMNAP is a community-centred[2] multisectoral nutrition system** that explicitly embraces simultaneous actions for nutrition specific interventions at the level of immediate and underlying causes and nutrition sensitive interventions at the levels of underlying and basic causes of malnutrition. A **multisectoral nutrition system** is composed of ***multiple sectors*** (e.g. agriculture; health; water, sanitation and hygiene; education; social protection; environment); ***multiple levels*** (national, regional/district, local government and importantly the community) and ***multiple partners*** (Government, development partners – UN/multi-laterals, bilaterals, NGOs, CSOs, academia and private sector). The multisectoral community-centred strategy is based on the overwhelming scientific evidence that achieving high coverage of high impact nutrition interventions (Lancet Nutrition Series 2008 and 2013) requires multisectoral harmonization and collaboration with key nutrition stakeholders.

12. The overarching multisectoral approach will be supported by **ten key cross-cutting strategies**:

i. **Social and behaviour change communication (SBCC)** to promote adoption of appropriated behaviours and practices and commitment to achieving common nutrition results for everyone and throughout in the country.

ii. **Advocacy and social mobilization** to sustain political will and commitment for nutrition at all levels.

iii. **Community-centred capacity development (CCCD)** to improve human, institutional, organizational and functional capacity for nutrition to ensure efficient and effective multisectoral and multi-stakeholder collaboration focusing at the community level;

iv. **Developing functional human resource capacity** to ensure that the NMNAP is strategically led and managed well at all levels.

v. Aligning all stakeholders with government policies, strategies and plans, including this NMNAP through public-private partnerships (PPP), facilitated by using the "three ONES principle" of ONE plan, ONE coordinating mechanism and ONE monitoring and evaluation framework, so that every stakeholder come together to tackle malnutrition and build an enabling environment for improved nutrition with equity.

vi. **Delivery of quality and timely nutrition services** to ensure nutrition services proposed in the NMNAP are efficiently, effectively and timely delivered and/or legally enforced as appropriate.

vii. **Mainstreaming equality in** all the seven key result areas without discrimination, **with women, children and adolescent girls** at the centre of the efforts.

viii. **Developing a resource mobilization strategy** to advocate for resource allocation to the NMNAP by both Government and Partners using the NMNAP investment plan elaborated in chapter 8.

ix. **Tracking progress and developing operational research** to ensure key lessons and insights gained from the implementation of the NMNAP are learnt and used in adjusting and improving the proposed interventions at regular intervals and linking research with programmes and training; and

x. Improving overall **planning and coordination** to align implementation of the NMNAP to achieve far greater results than what single sectors could achieve alone.

Leadership and management structure of the NMNAP

13. The leadership and management structure of the NMNAP is guided by the roles and responsibilities assigned by the 2016 Food and Nutrition Policy. **The PMO will lead and coordinate the overall NMNAP, provide oversight to ensure that nutrition is a key Government priority, and chair the HLSCN**. Ministries, Departments and Agencies (MDAs) will ensure nutrition is reflected in their relevant policies, strategies, programmes, legislation, regulations and

2 A community can be defined as an organized group of people who share a sense of belonging, beliefs, norms and leadership and who usually interact within a common geographical area. Some communities share common goals and interests and usually are supportive of each other and distinguished by what they do (Source: Urban Jonsson, 2003: Human Rights Approach to Development Programming, Pg 64).

guidelines; and allocate adequate resources to implement their relevant parts of the NMNAP. The Ministry in charge of Regional Administration and Local Government (PO-RALG) will ensure implementation at sub-national levels through the Decentralization and Devolution (D & D) approach paying particular attention to community participation. PO-RALG will coordinate, supervise, support, monitor and integrate the NMNAP in the programmes and by-laws at the regional and local Government levels. In collaboration with relevant actors, TFNC will monitor, evaluate, advocate, mobilise resources, provide overall strategic technical leadership and support to the Government and all sectors and actors identified in this NMNAP. In addition, TFNC will be the institutional base for the multisectoral nutrition information system for tracking and reporting on progress.

Monitoring and Evaluation of the NMNAP

14. The Common Results, Resources and Accountability Framework (CRRAF) will be used as the overall framework to monitor the NMNAP (see appendix 2). Specific monitoring and evaluation milestones will be assessed through: -

i. Annual Joint Multisectoral Nutrition Reviews (JMNRs);

ii. The **multisectoral nutrition scorecard** and **bottleneck analysis** for selected nutrition interventions will be use to monitor progress every six months. Data gathered from routine systems will be analysed and discussed by the multisectoral coordinating committees at the national and sub-national levels. The institutionalization of these committees as proposed by the NMNAP is, therefore, a crucial step in facilitating routine monitoring of progress at the operational level. Such monitoring will generate data, which will help fine tune and adjust the implementation of the NMNAP at the different levels.

iii. Mid-term review (MTR) of the NMNAP will be done during the 2019 JMNR using the results of the 2018 National Nutrition Survey and Public Expenditure Review on Nutrition (PER-N) for 2016-2018.

iv. Endline evaluation of the NMNAP will be base on the results of the 2020/21 **Tanzania Demographic and Health Survey.**

The NMNAP to adhere to the THREE ONEs principle

15. The development of the NMNAP accomplishes key recommendations from the Joint Multisectoral Nutrition Reviews of 2014 and 2015, which recommended for nutrition stakeholders to adhere to the principle of **the three ONEs: One plan; One coordinating mechanism and One monitoring and evaluation (M&E) framework.** The three Ones principle requires stakeholders to work in ways that enhance coordination and result in **synergy**, **integration, harmonization and collaboration.**

Cost of implementing the NMNAP

16. The overall financial requirement for the NMNAP is about TZS 590 billion (US$268 million) excluding the Nutrition Sensitive interventions already budgeted for in the 2016/17-2020/21 Five-Year Development Plan-II (FYDP-II) in the areas of Agriculture and Food Security, Health and HIV, WASH (Water, Sanitation and Hygiene), Education, Social Protection and Environment and Climate Change. If the Nutrition Sensitive Interventions (NSI) are included, the overall budget goes up to about TZS 22,262 billion (US$10,119 million). Assuming that the Health and HIV/AIDS costs (TZS 6,522.1 billion) are nutrition specific interventions, **the proportion of the budget allocated to nutrition specific interventions is 32 percent while nutrition sensitive interventions is 68 percent.** The greatest share of the FYDP-II budgetary allocation for NSI is for health (30 percent), followed by WASH (26 percent), social protection (19 percent) mainly for TASAF, agriculture (17 percent), education and early childhood development (8 percent) and environment is less than 1 percent.

17. As part of the process for developing the NMNAP investment plan, information was gathered from different stakeholders (Government, UN, Development Partners, CSOs, and Private Sector) about their current financial commitments aligned with the NMNAP for the next five years. The **total resources available from these sources is TZS 155.18 billion (US$ 70.5 million)**

against a planned budget of TZS 590 billion (US$ 268 million) giving a funding gap of TZS 434.77 billion (US$ 197.6 million). In proportional terms, about 26 percent of the NMNAP funds is available leaving a gap of 74 percent to be mobilized. The biggest funding gaps are seen in the Key Result Areas of Maternal, Infant, Young Child and Adolescent Nutrition (US$ -54.97 million), Micronutrients (US$ -43.81 million), Integrated Management of Acute Malnutrition (US$ -40.45 million), Diet Related Non-Communicable Diseases (US$32.48 million) and Multisectoral Nutrition Information System (US$ -21.87 million). It should be noted that community contributions to the NMNAP, which are substantial, have not been estimated in developing the investment plan.

Prioritized interventions in case of resource constraints

18. Since the NMNAP is results-based, the interventions proposed are necessary to achieve the articulated results. If further prioritization is done, it also means that the planned results will have to be reduced. However, given the high funding gap of about 74 percent, the NMNAP prioritizes the following intervention areas in case of resource constraints:
    i. Increase coverage of Maternal Infant, Young Child and Adolescent Nutrition (MIYCAN) activities;
    ii. Scale up of Integrated Management of Acute Malnutrition (IMAM) among children under five; and
    iii. Prevention of anaemia among women of reproductive age (15-49 years).

19. The main reasons for prioritizing the above areas is to ensure nutrition investment in the early years of children to assure quality human capital formation. The areas prioritized are also amenable to immediate scale-up, and the interventions impact highly on reducing the high burden of stunting and acute malnutrition in children underfive and the high levels of anaemia in women of reproductive age. Progress in these areas has been slow in the past, and ensuring they are funded is likely to result in quick gains in child survival, growth and improved human capital formation.

A call to stakeholders to support the NMNAP

20. Having adopted the Food and Nutrition Policy, developed this NMNAP with wide stakeholder consultation and made modest secure financial commitment for investing in nutrition, the Government pledges continued political leadership and accountability in the fight against malnutrition and calls upon partners, including the private sector to support this NMNAP. The resource mobilization plan calls for about 30 percent of the resource gap to be provided by the Government of Tanzania, 60 percent from Development Partners and 10 percent from the Private Sector. With this support, the NMNAP will be fully funded, which will enable implementation and its targets hopefully achieved and even exceeded.

Organization of the NMNAP document

21. This NMNAP document provides a synthesized high-level strategic overview of the individual action plans developed by the key result area (KRAs) task teams. The detailed KRA action plans are available separately as Annexes 1-7 to this NMNAP. The NMNAP document is organized in nine chapters with a bibliography, six appendices and 7 annexes as follows: -

    Chapter 1 introduces the NMNAP with a brief overview of what the action plan is about, why it was developed and leveraged the context of the Five-Year Development Plan II (FYDP-II), the process for its development and the main audiences.

    Chapter 2 provides a situation analysis and strategic context looking at Tanzania's development context, the evidence base used, the nutrition trends as well as the policy basis for the NMNAP.

    Chapter 3 provides the conceptual framework used and the theory of change describing the rationale and pathways for the different proposed activities to reach the desired change.

    Chapter 4 indicates the expected high level key results of the NMNAP, the key targets and the key strategies.

Chapter 5 is a synthesized summary of the action plans for the first five of the seven Key Result Areas indicating the key actions, timelines and budget.

Chapter 6 describes the sixth KRA: the governance of the NMNAP and the proposed framework for coordinating, leading and managing the NMNAP from a strategic perspective. It includes the key actions, timelines and budget for the Multisectoral Nutrition Governance action plan.

Chapter 7 outlines the Monitoring, Evaluation, Accountability and Learning (MEAL) framework and is derived from Key Result Area seven on Multisectoral Nutrition Information Systems with its action plan, timelines and proposed budget.

Chapter 8 lays out the investment plan for the NMNAP and analyses the financial, human and organizational resource requirements and gaps with a view to develop a resources mobilization plan.

Chapter 9 provides a risk analysis and mitigation measures.

22. After a **bibliography and appendixes**, there is a list of the seven Annexes (1-7), which are the separate "detailed action plans" for the seven Key Result Areas. These Annexes, which are available separately are:

Annex 1: Scaling up maternal, infant, young child and adolescent nutrition (MIYCAN);

Annex 2: Scaling up the prevention and management of micronutrient deficiencies

Annex 3: Scaling up of Integrated Management of Acute Malnutrition (IMAM)- includes during emergency situations and people affected by HIV and AIDS;

Annex 4: Scaling up Prevention and Management of Diet Related Non-Communicable Diseases (DRNCDs);

Annex 5: Multisectoral Nutrition Sensitive Interventions

Annex 6: Multisectoral Nutrition Governance; and

Annex 7: Establishing a Multisectoral Nutrition Information System.

23. While the overall NMNAP is meant to be a strategic guide, each of the costed Key Result Area Action Plans (Annexes 1-7) can serve the following objectives: (a) as a guiding tool for developing operational plans at all levels by lead and collaborating institutions as indicated in the specific accountability frameworks (b) as a framework for coordinating the actions of various sectors and partners; (c) as an integrated framework for common results, resources and accountability that will help tracking progress; and (d) as a basis to mobilize resources for the individual Key Result Areas.

CHAPTER 1

INTRODUCTION

INTRODUCTION

1.1 Overview

1. This document articulates the Tanzania **National Multisectoral Nutrition Action Plan (NMNAP**) for the period 2016/17-2020/2021. The period coincides with the second Five-Year Development Plan of the Government's long term strategic plan (2010-2025) for economic and social growth (MKUKUTA) and provides a logical continuation of the five-year National Nutrition Strategy (NNS) 2011/2012-2015/2016. The NMNAP was developed to translate into concrete actions the policy objectives and basic principles included in the 2016 Tanzania National Food and Nutrition Policy to address the unacceptably high levels of **malnutrition**.

2. The term **malnutrition** is used here to refer to both **undernutrition** and **overnutrition. Undernutrition manifests itself** mainly as **stunting** (low height-for-age or chronic undernutrition); **wasting** (low weight-for-height or acute undernutrition); **underweight** (low weight-for age, a combination of stunting and wasting); and **low birth weight** (of less than 2.5kg). M**icronutrient deficiencies** (often called hidden hunger) caused by deficiencies of essential vitamins and minerals also fall in the category of undernutrition. The main essential vitamins and mineral deficiencies in Tanzania are: vitamin A, folic acid, vitamin B12 and iodine, iron and zinc. **Overnutrition manifests** mainly as **overweight and obesity**, which lead to the development of **diet related non-communicable diseases (DRNCDs)** including diabetes, high blood pressure, cardio-vascular diseases, weight related joint pains and several types of cancer.

3. The NMNAP is a "double duty action" plan that for the first time in Tanzania integrates actions to combat undernutrition with those which aim to prevent and control overweight/obesity and related non-communicable diseases into one plan. "Double duty-actions" have the potential for greater impact on malnutrition in all its forms, than actions addressing specific types of malnutrition in isolation through vertical interventions. The NMNAP galvanizes recent scientific evidence and national and global political attention on nutrition into integrated inter-sectoral transformative actions and multi-stakeholder collaboration for improved nutrition.

1.2 Political Will and Government Commitment to addressing malnutrition

4. Tanzania's commitment for nutrition is longstanding. Since independence in 1961 the declared major enemies of Tanzania were poverty, disease and ignorance, all major causes and consequences of malnutrition. Despite progress made, undernutrition is still a major impediment to the alleviation of all the three enemies. The key challenge has been to translate the political will and state commitment into evidence-based, effective, impactful and sustainable policies, strategies and actions that are implemented at scale, well-coordinated, resourced and monitored.

5. Committed to providing leadership in nutrition in recent years, the Government formally adopted a multisectoral approach and increased its commitment to improve nutrition by:
   i. Developing a National Action Plan for NCDs 2008-2015;
   ii. Launching the National Nutrition Strategy (NNS) 2011/12-2015/16 and its Implementation Plan;
   iii. Reviewing and updating the 1992 into a 2016 National Food and Nutrition Policy;
   iv. Actively participating in the Global SUN Movement at Presidential level after joining in 2011 as one of the 26 Early Riser Countries;
   v. Creating a Multisectoral High-Level Steering Committee for Nutrition (HLSCN) coordinated by the Prime Minister's Office and multisectoral steering committees for nutrition at regional and district levels;
   vi. Creating a Nutrition Section in the Ministry of Health, Community Development, Gender, Elderly and Children;

vii. Creating a Nutrition Section in the Ministry of Regional Administration and Local Government (RALG) initially in the Prime Minister's Office and from 2016 in the President's Office to ensure effective decentralization of nutrition actions and resources.

viii. Establishing and funding the posts of Regional and District Nutrition Officers (RNuO and DNuOs) and recruiting qualified people in these positions for all regions and districts.

ix. Developing guidelines for nutrition planning and budgeting by regional and district/council nutrition officers for inclusion in the council's comprehensive plans since 2012.

x. Developing tools to track progress towards scaling-up nutrition by tracking both results and financial expenditures: e.g. the Public Expenditure Review (PER) of the Nutrition Sector in 2013 expected to be repeated every 2-3 years, developing and adoption of the **Nutrition Scorecard** in 2015 and organizing annual Joint Multisectoral Nutrition Reviews (JMNRs) since 2014.

6. The **Government's efforts to decentralize public financing for nutrition** to the Local Government Authorities resulted in a steady increase in funds for nutrition at the district/municipal councils with financial allocations for nutrition per district/municipal council increasing from TZS 58 million in Financial Year 2011/12 to TZS 217 million in Financial Year 2014/15 for each district/municipal council.

1.3 The evidence base for the NMNAP

7. Although no formal evaluation of the implementation of the National Nutrition Strategy (NNS) of 2011/12 - 2015/16 was done, there were several reviews, surveys and studies undertaken that together with global programme assessments provide the evidence-base for the NMNAP. These included the Landscape analysis to asses Tanzania's readiness to scale-up nutrition (TFNC 2012)[3] ; the 2014 and 2015 Joint Multisectoral Nutrition Reviews[4]; the 2014 Technical Review Paper (Vision 2025) on "Towards Eliminating Malnutrition in Tanzania" by 2030[5]; the 2014 National Nutrition Survey (SMART Survey); the 2015/16 Tanzania Demographic and Health Survey and Malaria Survey (TDHS-MS) and the 2016 Scaling Up Nutrition (SUN) Movement Joint Assessment for Tanzania. Moreover, as part of the process for developing the NMNAP, several bottleneck analyses (BNA) were done to assess the operational challenges and key constraints to the effective delivery and of scaling-up of interventions at the Local Government Authority (LGA) Council level. Additionally, extensive global literature reviews provided the scientific evidence. Desk reviews of the National Nutrition Multisectoral Plans for Ethiopia, Nepal and Sri Lanka provided global experience in developing such plans.

1.4 The NMNAP and the National Development Agenda

8. Tanzania's system of general policies, legislation, strategies and programmes for development is generally favourable to the improvement of nutrition. The overarching policy framework used in developing this NMNAP is the Government's 2016 Food and Nutrition Policy (FNP). The FNP's desired change is to have "Tanzanians with good nutrition for a healthy, productive and prosperous nation" through providing "a favourable environment for delivery of quality, equitable, cost effective, large scale and sustainable multisectoral nutrition interventions".

9. The NMNAP is also aligned with the Government's Five-Year Development Plans to ensure anchorage within the national economic and social development agenda. The National Five Year Development Plan II of 2016/17 – 2020/21 (**FYDP II)** was prepared in the context of the long-term National Strategy for Growth and Reduction of Poverty (Development Vision 2025) known

3 TFNC (2012): Landscape Analysis of country's readiness to accelerate action in nutrition: Tanzania assessment for scaling up nutrition 2012 http://apps.who.int/nutrition/landscape_analysis/TanzaniaLandscapeAnalysisFinalReport.pdf?ua=1

4 Kavishe F.P (2014 & 2015): https://www.researchgate.net/publication/267252935_Report_on_the_First_Tanzania_Multisectoral_Nutrition_Review_August_19-21_2014 and https://www.researchgate.net/publication/283122986_Report_on_the_2015_and_Second_Tanzania_Joint_Multisectoral_Nutrition_Review

5 Kavishe F.P (2014): https://www.researchgate.net/publication/267309649_Towards_Eliminating_Malnutrition_in_Tanzania_Vision_2025

in Kiswahili as MKUKUTA **- to transform Tanzania into a Middle Income Country (MIC)[6].** The long Term Perspective Plan (LTPP) attendant to MKUKUTA covering the period 2011/12-2025/26 is divided into three Five-Year Development Plans (FYDP). FYDP-I covers the 2011/12 - 2015/16 period (Unleashing Tanzania's Growth Potential); ***FYDP-II 2016/17-2020/21(Nurturing an industrial economy and Human Development)*** and FYDP-III 2021/22-2025/26 (Competitiveness led export growth). **This NMNAP falls within the FYDP-II and aims to contribute to the achievement of the following FYDP-II five overarching objectives:** (1) High quality livelihood; (2) Peace, stability and unity; (3) Good governance; (4) A well-educated and learning society; and (5) a semi-industrialized competitive economy capable of producing sustainable growth and shared benefits. **To achieve the objectives of FYDP-II, Tanzania requires a well-nourished population with the knowledge to make, create and innovate and the capacity to produce and compete efficiently and effectively.**

10. Moreover, a well-nourished and healthy population contributes to all of the five overarching objectives of FYDP-II because good health and nutrition (1) improves the quality of livelihoods by increasing their educability, employability, creativity and innovation; (2) increases the likelihood of peace, stability and unity by reducing poverty and inequalities, thus enhancing human dignity and self-worth; (3) improves good governance because well- nourished people are more likely to participate in the system of governance; (4) improves the chances of creating a well-educated and learning society by improving school performance and capacity to learn; and lastly (5) enhances the development of a knowledge-based economy, which is critical for economic competitiveness by improving the intelligent quotient (IQ) of the population and the productivity of adults.

11. It was, therefore, a sound political and economic decision for the FYDP-II to include nutrition as one of the areas within the four "human development and social transformation" priority general areas of focus. The others are growth and transformation, improving the business environment and fostering implementation effectiveness. The selection criteria of the general priority areas of focus, which all contribute to good nutrition include: education; health; water and sanitation; human settlement and sustainable urban management; and strengthening capability and social protection. The selection of these human development priority areas was based on their potential to contribute to the realization of the national development aspirations and the need for sustaining and consolidating current social development achievements, including nutrition and social protection. The high priority given to the role of the private sector in FYDP-II was also taken into consideration in the process for the development of this NMNAP, which included private sector consultations[7].

12. Poverty, malnutrition, diseases and inequality are intricately linked, and if not addressed are often transferred from one generation to the next. Thus, **effectively addressing the challenge of malnutrition may help to interrupt the vicious cycle of malnutrition-disease-poverty-inequality now and for future generations**. In conjunction with efforts to reduce poverty and inequality, eliminating malnutrition can accelerate Tanzania's accession to MIC status, promote and foster political stability, reduce the chances of social conflict, accelerate the achievement of the objectives of FYDP-II, MKUKUTA and promote fairness, social justice and social mobility.

1.5 The NMNAP and the international development agenda

13. Every nation is affected by malnutrition, some more so by undernutrition, others by overnutrition (overweight, obesity and diet related non-communicable disease) and still others, like Tanzania, by a double

6 As of 1st July 2015, the World Bank re-defined Middle-Income-Countries (MIC) as those countries with a Gross Annual National Income (GNI) per capita of US$1,045-12,736 as from 2014. Lower-middle-income (LMI) and upper-middle-income (UMI) economies are separated at a GNI per capita of US$4,125. Using that criteria, the World Bank estimates Tanzania's GNI/capita of US$920 in 2014 falling in the Low Income Country (LIC) category.

7 Kavishe F.P (2016): Report on the Private Sector Consultation on the Development of the Tanzania National Multisectoral Nutrition Action Plan (NMNAP) for 2016/17-2020/21

burden of both under-and overnutrition. Given that malnutrition is a serious barrier to the development of full human potential and equitable and sustainable social and economic development the international development agenda has rightly given high priority to addressing the malnutrition challenge.

14. At the global level, the burden of malnutrition is enormous. The Global Nutrition Report 2016[8] recognized that the number of people affected by the different types of malnutrition cannot simply be added because an individual may suffer from more than one type of malnutrition at the same time. The report sums up the global scale of malnutrition in 2016 as follows: (1) out of a world population of 7 billion, about 2 billion are at risk of micronutrient malnutrition and nearly 800 million are classified with "hunger" and are unable to meet their basic calorie requirements from the diet; (2) out of 667 million children under the age of five years worldwide, 159 million are stunted (too short for their age), 50 million are wasted (too thin for their height), and 41 million are overweight; and (3) out of 5 billion adults worldwide, nearly 2 billion are overweight or obese and one in 12 has type 2 diabetes. Moreover, undernutrition is associated with about 45 percent of deaths of children under-five years (3 million deaths per annum). The economic burden is also huge: up to 11 percent of GDP is lost to maternal and child undernutrition and 2.8 percent of GDP is lost to obesity. At the same time the benefits of good nutrition are significant: 33 percent of well-nourished children are more likely to escape poverty and the benefit-cost returns on investing in nutrition is 16-to-1 and often, even higher.

15. Thus, while the NMNAP is focused on the national development agenda and national priorities, it is heavily informed by the regional and global nutrition-relevant development agenda and incorporate critical elements into the national action plan. The key regional ones are: The East African Food and Nutrition Policy, the Southern Africa Development Community (SADC) Food and Nutrition Security and the African Union (AU) Food and Nutrition Strategy (2015-2025). Globally, they include inter alia: **Agenda 2030 on Sustainable Development Goals (SDGs)**; **the 2012 World Health Assembly nutrition targets for 2025**; the **UN Network for Scaling Up Nutrition (SUN) Strategy (2016-2020)**[9]; the **UN Decade (2016-2025) of Action on Nutrition**; the second **International Conference on Nutrition (ICN2) Plan of Action**; the **2011 UN Political Declaration and 2014 UN Outcome Document on Non Communicable Diseases (NCDs).** Other key global plans and strategies include the WHO comprehensive implementation plan on maternal, infant and young child nutrition[10] and the WHO global strategy for women's, children's and adolescent health 2016-2030[11].

16. The United Nations Agenda 2030 (SDGs) challenges countries to end all forms of malnutrition by 2030 by including as the second SDG," End **hunger, achieve food security and improved nutrition and promote sustainable agriculture"**. Clearly, nutrition is central to the SDGs with at least 12 of the 17 SDGs containing indicators vital for nutrition improvement. These are SDGs 1, 2, 3, 4, 5, 6, 8, 10, 13, 15, 16 &17 (figure 1), which reflect an appreciation of the importance of nutrition in sustainable development.

17. The Global Nutrition Report of 2016 calls on countries to take five critical actions to address the problem of malnutrition: (1) Make the political choice to end all forms of malnutrition (2) Invest more and allocate better for nutrition (3) Collect the right data to maximize investments in nutrition (4) Invest in carrying out proven and evidence informed solutions – and identify new ones; and (5) Tackle malnutrition in all its forms. This NMNAP recognizes and incorporates all five of these critical actions.

8 International Food Policy Research Institute. 2016. *Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030*. Washington, DC.. http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/130354/filename/130565.pdf

9 SUN Movement (2016): Strategy and Roadmap (2016-2020)

10 http://www.who.int/nutrition/publications/CIP_document/en/

11 http://www.who.int/life-course/partners/global-strategy/en/.

18. Moreover, the NMNAP is aligned with the SUN Movements Vision of a "world free from malnutrition in all its forms by 2030, to be led by governments and supported by organizations and individuals to take collective action to ensure every child, adolescent, mother and family can realise their right to food and nutrition, reach their full potential and shape sustainable and prosperous societies". The proposed actions of the NMNAP also align with the SUN Movement's 2016-2020 Strategy for transformational pathway of change: (i) Multiple stakeholders come together to tackle malnutrition and build an enabling environment for improving nutrition with equity, (ii) The actors change their behaviours and commit to achieving common nutrition results for everyone, everywhere, (iii) Resources are mobilized and coverage of locally relevant nutrition specific actions and nutrition sensitive contributions are scaled up, (iv) Aligned implementation achieves results far greater than what could have been achieved alone, (v) women, children, adolescents and families thrive leading to the end of malnutrition by 2030 and (vi) contributing to the achievement of all SDGs.

19. The key international normative agenda that this NMNAP addresses are the health and nutrition human rights articulated in the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW). As the ultimate state duty bearer, the Government of Tanzania will ensure that the nutrition rights of Tanzanians to achieve optimal nutrition and health are respected, protected and fulfilled adequately within the national, regional and global nutrition relevant frameworks and will mobilize national and international resources and collaboration towards that end.

Figure 1: Agenda 2030: The 17 Sustainable Development Goals (SDGs)

1.6 Why invest in nutrition?

20. In addition to being a requirement by the 2016 Food and Nutrition Policy, there are several other important reasons for investing in nutrition through the NMNAP.

I. First, the economic rationale: investing in nutrition contributes to national economic prosperity in four main ways.

1) Improving nutrition increases productivity, economic growth and facilitates poverty reduction through improved physical work capacity, cognitive development, school performance, economic activity and health by reducing sickness and deaths.

2) Addressing malnutrition increases GDP growth and reduces national budgetary costs for custodial care and malnutrition-related lost lives. According to WHO, in 2012, nutritional deficiencies (protein-energy deficiency and deficiencies of iron, vitamin A and iodine) were responsible for as much as 5 percent of the total DALYs (disability-adjusted life years) losses in the low income WHO African region countries[12]. The proportion of DALYs lost is significantly higher if DRNCDs are included.

3) **Investing in nutrition is one of the "best buys" for economic development.** The 2012 Copenhagen Consensus[13] concluded that undernutrition should be a top priority for policy makers because it is the best buy for development. Three types of key investments were proposed to impact on nutrition: (1) Accelerating yield enhancements, (2) Market innovations that reduce hunger, and (3) Interventions that reduce micronutrient malnutrition and reduce the prevalence of stunting.

4) Interventions to improve nutrition have cost-benefit ratios of around 1:20, comparable for example to investments in roads, irrigation, and health, and generate growth that directly benefits the poor and reduces inequality. Investing in nutrition also helps businesses and assists in social mobility, through a more productive workforce and a more affluent consumer base.

II. Second, **nutrition is a human right.** The 2016 Food and Nutrition Policy makes frequent reference to nutrition as a fundamental human right in its identification of the most pertinent strategic policy issues to address.

III. Third, **addressing malnutrition is a political choice to foster security, peace and stability.** Nationally, it will greatly contribute to Tanzania's political agenda of peace and stability and propelling the country into middle income country (MIC) status by 2025. Globally, it contributes to global security and peace and provides national anchor for the implementation of the global development and normative agendas.

1.7 Who are the main audience for the NMNAP?

21. The NMNAP main audience is policy makers (and their technical staff) at all levels (national & sub-national), who are involved in the design of policies for, and responsible for the allocation of resources towards improving the health and wellbeing of the population. At the operational level, the NMNAP targets those responsible for programme implementation and service delivery at all levels with strategic direction. Furthermore, the NMNAP addresses donors, development partners and other state and no-state actors in nutrition, including civil society organizations and the private sector, who finance nutrition improvement initiatives and projects will find this NMNAP useful in setting priority investments and implementing their country strategies.

1.8 The process for developing the NMNAP

22. The process was initiated by a NMNAP steering committee, which was formed as a sub-committee of the High Level Steering Committee on Nutrition (HLSCN). Led by the Prime Minister's Office (PMO), specifically by the Director of Government Business Coordination, who is also the Scaling Up Nutrition (SUN) focal point and with the executive coordination by the Tanzania Food and Nutrition Centre (TFNC), the process was informed by extensive stake-holder consultations – Government Ministries, Departments and Agencies (MDA), United Nations agencies, Development Partners, Civil Society Organizations, Academia, Research Institutions and the Private Sector. It drew on lessons from most current scientific evidence, bottleneck analysis for the Key Result Areas and experience, lessons and insights from the 2014 and 2015 Joint Multisectoral Nutrition Reviews (JMNR) of the five-year National Nutrition Strategy (NNS) ending in 2016.

12 WHO (2014): Global Health Estimates 2014 Summary Tables: DALY by Cause, Age, and Sex by World Bank Income Category and WHO Region, 2000 and 2012. http://www.who.int/healthinfo/global_burden_disease/estimates/en/index2.html

13 Copenhagen Consensus, 2012. Challenge Paper, Hunger and Malnutrition, Available from: http://copenhagenconsensus.com/sites/default/files/Hunger%2Band%2BMalnutrition.pdf

23. After developing a roadmap that provided the foundation for establishing seven Key Result Areas (KRA), each KRA was steered by task teams that were led by an expert facilitator and chaired by a TFNC subject area expert. A Lead Facilitator who is a senior nutrition expert with extensive national and international experience in nutrition provided critical technical analysis, quality assurance, coordination and synthesis of the task teams' outputs into this coherent NMNAP. The TFNC Acting Managing Director provided administrative coordination and chaired multi-task team strategic forums.
24. A great amount of dynamic flexibility was built into the process to allow for incorporation of new and emerging ideas including doing a consultation with the private sector and holding two workshops on the "Theory of Change and Complexity". The flexibility helped to widen stakeholder participation, sharpened the capacity for articulating results-based planning and budgeting and allowed for reflective in-depth contributions by stakeholders. The NMNAP document finalization process included consolidation and validation workshops of key stakeholders and external peer review of the drafts. The High Level Steering Committee on Nutrition (HLSCN) adopted the NMNAP at its meeting held on 21st October 2016, which was chaired by the Permanent Secretary in the Prime Minister's Office responsible for Policy and Coordination.

CHAPTER 2

SITUATION ANALYSIS AND STRATEGIC CONTEXT

2.1 Tanzania's development context

25. The planning and implementation of this NMNAP should be seen within Tanzania's development context. The World Bank categorizes Tanzania as a low-income country (LIC). **In 2015 the Gross National Income (GNI) per capita was estimated to be US$ 920, the population was 53.47 million and life expectancy at birth was 65 years.** The World Bank also forecasts Tanzania's decade Gross Domestic Product (GDP) growth of about 7 percent to continue and even grow at a more rapid rate between 2014-2018 if economic volatility and inflation are controlled. This trajectory is consistent with Tanzania's decade of economic growth and aspiration of becoming a low-middle-income country by 2025 with an anticipated GNI per capita of $3,000. In May 2016, the Ministry of Finance and Planning estimated a GDP growth of 7.2 percent for 2015 and projected the GNI per capita to grow from an estimated US Dollars 1,006 in 2015 to US Dollars 1,500 in 2020, an indication that Tanzania is likely to graduate into a Low Middle Income Country (LMIC) status, crossing the US$ 1045 GNI per capita threshold, during the period of this NMNAP.

26. In its 2016 Tanzania Economic Update[14], the World Bank estimated a poverty headcount of about 12 million Tanzanians (23 percent of the population) for 2015 compared to 28.2 percent in 2012 and 34 percent in 2007. Although this represents an improvement, the majority of the non-poor are only marginally above the poverty line with the risk of sliding back into poverty in the event of even the slightest shock. Moreover, the World Bank estimates that about 44 percent of the population lived on less than US$1.25 per day (much higher if the new cut-off point for poverty of US$1.90 is used) and 90 percent of the population lives on less than US$3 per day. The slow progress in poverty reduction despite a decade's robust GDP growth can be explained by the slow pace of employable human capital formation and lack of growth in the labour intensive sectors like in agriculture in rural areas where about 80 percent of the population lives. Most of Tanzania's GDP growth has been driven by increased private consumption and public investment, together with the rapidly growing sectors of communication, construction, financial services, the service industry and mining (including gas and oil), which do not have an immediate effect on improving nutrition.

27. Typically, low-income countries like Tanzania, become middle-income when their economies shift from agriculture and informal services and begin relying on low-wage and low-tech manufacturing. This can create new challenges, such as an increase in inequalities and subsequent difficulties to translate economic growth into poverty reduction, an issue already apparent in Tanzania. Unemployment is high, with about 800,000 youth eligible to enter the job market every year finding it difficult to get jobs because employment opportunities remain scarce. Moreover, inequality is increasing and the Gini-coefficient[15] (a measure of equality) was at 0.35 in 2011 and rising.

28. The 2014 UNDP Human Development Report shows some progress in the Human Development Index (HDI)[16], which increased from below 0.4 in the 1990s to 0.521 in 2014, but still ranks Tanzania very low at 151 out of over 190 countries. The Gender Development Index (GDI) is, however, good at 0.938 an indication of good progress in the empowerment of women. The average expected years of schooling was 9.2 years in 2014 and the gross primary school enrolment ratio was 87 percent in 2015 and expected to rise with the Government's

14 The World Bank, 20 May 2016: The eighth Tanzania Economic Update (TEU): The Road Less Traveled: Unleashing Public Private Partnerships in Tanzania

15 The Gini-coefficient or index is a measure of inequality. As a coefficient the values are on the scale 0-1 with 0 indicating complete equality and 1 complete inequality. Stated as an index the values are from 0-100 with 0 indicating complete equality and 100 complete inequality. No country has ever attained either extreme.

16 The Human Development Index (HDI) is published annually by the UN. It measures the average achievement in a country of three composite basic human development dimensions: life expectancy at birth, adult literacy and GDP per capita (PPP in US$). The values range from 0 -1 with 0 being the lowest and 1 the highest.

commitment to provide free schooling for all children through 11 years (up to Form 4). Studies show a strong correlation between the level of education starting at 5 years of schooling, especially of women and the levels of malnutrition and childhood and adult mortality.

29. Of concern is that Tanzania is currently on track to become a MIC without the shifts that typically characterize middle income countries like – reaching an advanced stage in the demographic shift (fertility and population growth lower than the world average); technological indicators being close to the world average; intermediate positioning of the human development index (HDI); and an exhibition of greater equality and institutional quality. **The fact that the nature of Official Development Assistance (ODA) changes when a country attains MIC status could mean a potential sliding back of social indicators in Tanzania including for nutrition, given that the aid architecture favours investments in human development like health, nutrition, education and water and sanitation.** Recognizing this potential development challenge, this NMNAP places significant emphasis on ensuring that Tanzania enters MIC status by making critical pro-active investments in its human capital development. The plan contributes to the investment in skilled human resources necessary for Tanzania to design, implement and monitor programmes which aim to improve life expectancy, accelerate economic growth and improve not only the productive capacity of its population, but also to reduce poverty, inequality, improve social mobility and the employability of the young Tanzanians entering the job market. Such an enhancement in human and institutional capacity will provide the structure and systems needed to sustain the progress achieved through the initial implementation of the NMNAP.

2.2 Tanzania's Vital Nutrition Trends

30. The extent, causes, impact, trends, patterns and challenges of the problem of malnutrition in Tanzania are already captured in the 2016 Food and Nutrition Policy and more elaborately in "Nutrition Vision 2025 on Towards Eliminating Malnutrition in Tanzania by 2030[17]; so only the key trends will be summarized here. Taking a long-term 30-year perspective, through Government-led partner supported nutrition programmes, Tanzania's undernutrition trends have greatly improved, though the level of those with suboptimal nutritional status is still unacceptably high both in terms of prevalence rates and in absolute numbers. Of concern is that like most other low-income countries (LIC) transiting into Middle Income Country (MIC) status, Tanzania has entered an epidemiological and nutritional transition with a double burden of malnutrition where undernutrition exists in tandem with high levels of overweight, obesity and diet related non-communicable disease (DRNCDs).

2.2.1 Who are those with suboptimal nutritional status?

31. Children underfive, women of reproductive age especially pregnant and lactating women and adolescent girls are the most affected by undernutrition due to their physiological needs for growth and reproduction. There is not much information on the nutrition status of school age children, adolescents and the elderly. In pregnant women and children, the 1,000 day-period, from conception to two years, is crucial and offers a critical window for actions that result in high impact. Poor nutrition often begins *in the womb* and extends, particularly for girls and women, well into adolescent and adult life. It also spans interminably into future generations. These intergenerational effects are cyclical, reinforcing and often devastating. If improvements in nutrition of women and adolescent girls could be accelerated, multiple impacts and positive feedback linkages could be achieved, including: avoidance of early pregnancies at a young age (teenage pregnancies), better birth outcomes for both mother and newborn, declines in low birth weight, and improvements in child growth.

17 Kavishe F.P (2014): Towards Eliminating Malnutrition in Tanzania: Nutrition Vision 2025, September 2014. TFNC Monograph Series Number 2.

2.2.2 Undernutrition improving but levels still unacceptably high

32. Taking a long-term perspective, the undernutrition situation could best be described as (i) very high and constant over time and in all regions of the country during the 1960s, 1970s and early 1980s; (ii) responding to specific interventions during the mid-1980s and 1990s; (iii) progressing too slowly despite good economic progress in the early 2000s; and (iv) improving but still unacceptably high with a double burden of undernutrition and overnutrition during the 2010s.

33. A review of the nutrition status trends based on anthropometric measurements confirms that there have been some significant declines in the prevalence of undernutrition during the last two decades (see figure 2). The levels of stunting in children 0-59 months reduced from a prevalence of 50 percent in the 1990s to 34 percent in the 2015/16 TDHS, but still above the average of 30 percent for Africa and falls within the category of "high" in public health significance. Due to the rate of population growth outstripping the rate of reduction, the absolute numbers of stunted children increased from below 2.0 million in the early 2000's to about 3.0 million in 2010. However, a decline was observed in 2015 with 2.7 million stunted children. During the same period, the prevalence of underweight declined from 25 percent to 14 percent close to meeting the MDG1 target of halving underweight by 2015.

34. In the same vein, wasting in children 0-59 months, declined from 8 percent in 1992 to 4.5 percent in 2015/16 reaching the WHA 2025 target of below 5 percent (see figure 3). However, due to the huge population and rapid population increase, the absolute numbers of those acutely malnourished are high and also increasing, with some 600,000 children under five years of age estimated to be acutely malnourished in 2015 of whom 100,000 were categorized as severe. The risk of death is much higher amongst children with severe acute undernutrition, and as such require concomitant efforts as part of a comprehensive program which focuses on the alleviation of chronic undernutrition.

Figure 2: Prevalence trends of stunting, wasting and underweight in children underfive years in Tanzania (1992-2015/16). *Source: WHO Global data base, TDHS 1992-2015/16, TNNS 2014*

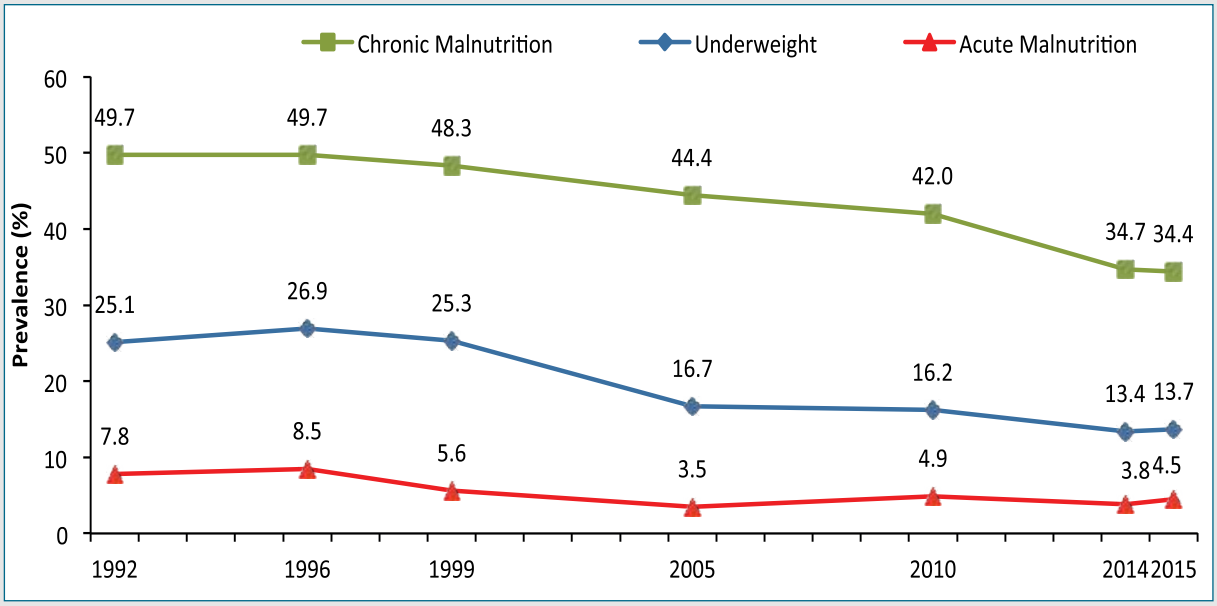
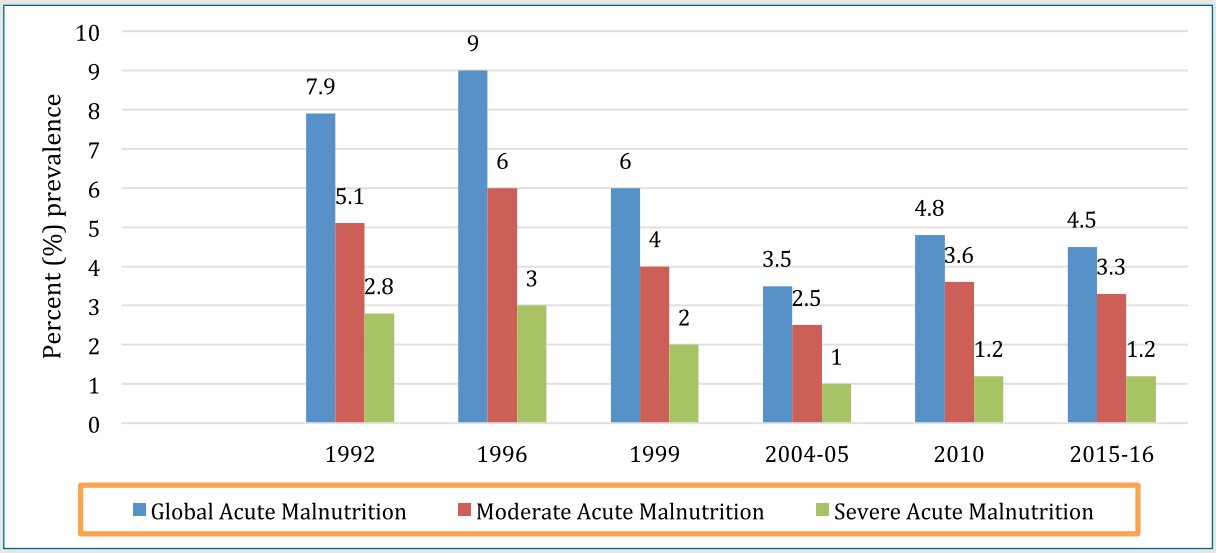


Figure 3: Trends in wasting in children underfive years in Tanzania 1992-2015/16.
Source: TDHS 1992-2015/16



35. Although practices with regard to Infant and Young Child Feeding (IYCF) show some improvement in complementary feeding, it appears that there is a decline in the key practice of exclusive breastfeeding for the first six months of an infant's life. T**he prevalence of exclusive breastfeeding during the first six months of life declined from about 50 percent in 2010 (TDHS) to about 43 percent in 2014 (TNNS)**. Though the 2015/16 TDHS shows an improvement to a prevalence of 59 percent, there are concerns about the quality of the collection of the data on exclusive breastfeeding, for it is unlikely that the prevalence could increase by 16 percent points in just one year.

36. Complementary feeding after six months of exclusive breastfeeding appears to be satisfactory in terms of the timely introduction of complementary foods. The latest TDHS-MS (2015/16) shows that as high as 90 percent of children 6-8 months and 97 per cent of children 9-11 months received timely complementary foods and almost half (47 percent) of children aged 18-23 months were no longer breastfeeding. However, only about 8 percent of children 6-23 months met the minimum acceptable diet criteria appropriate for their age. These indicators include **frequency** of feeding and **dietary diversity** of complementary feeding. Improvements in complementary feeding have almost wiped out marasmus and kwashiorkor, the severe forms of protein energy malnutrition, where in the 1970s and 1980s, hospitals used to have special nutrition rehabilitation units (NURU- which means beam of light in Kiswahili) for their treatment.

37. National programmes to prevent and control micronutrient deficiencies have had a profound impact, resulting in the reduction of the prevalence of micronutrient deficiencies especially of the severe clinical forms, through the achievement of optimal intakes. Cretinism due to iodine deficiency and nutritional blindness due to vitamin A deficiency, commonly seen during the 1980s, are now rare. Moreover, the severe forms of nutritional anaemia in children and pregnant women (mainly due to iron deficiency) common in the 1970s and 1980s necessitating hospitals to have special "anaemia" wards are also rare. However, improvement in the prevalence of moderate anaemia has been slow.

38. As of 2015, the trends in the three main micronutrient deficiencies could be summarized as follows: -

1) The median urinary iodine concentration for women of reproductive age (15-49 years) increased from 160 µg/L (TDHS 2010) to 180 µg/L (TDHS-MIS 2015-16). The desirable range is 100-200 µg/L.
2) Using Rapid Test Kits to measure presence of iodine in salt, the proportion of households

with iodized salt increased from 73 percent in 2005 (TDHS 2004-05) to 82 percent in 2010 (TDHS 2010) where it has remained the same (81 percent) in the TDHS-MIS 2015-16.

3) Data from laboratory analysis indicated that the proportion of households with iodized salt increased from 90 percent in the 2010 TDHS to 96 percent in 2015 TDHS. During the same period, households with adequately iodised salt (15+ ppm) increased from 47 percent in 2010 to 61 percent in 2015.
4) The proportion of women who gave birth in the 5 years before the survey who took iron supplements or syrup for 90 days or more as recommended during pregnancy increased from 5 percent in 2010 to 21 percent in the 2015-16 TDHS – MIS .
5) The prevalence of any anaemia in women aged 15-49 years declined from 48 percent in 2004-05 to 41 percent in 2010; however, it increased to 45 percent in the 2015-16 TDHS – MIS.
6) With regard to iron deficiency, the 2010 TDHS showed a 30 percent prevalence of iron deficiency in women aged 15 - 49 years, of whom 16 percent were iron deficient without having anaemia and 14% were iron deficient and having anaemia. It also showed that 35% of children aged 6 - 59 months were iron deficient, while 11% were iron deficient without having anaemia and 24% were iron deficient and having anaemia.
7) The prevalence of anaemia in children 6-59 months declined from 72 percent in TDHS 2004-05 to 59 percent in 2010 TDHS; where it remained the same (58 percent) in the 2015-16 TDHS-MIS.
8) A review of the Vitamin A Supplementation (VAS) programme in children age 6-59 months in Tanzania for purposes of drawing lessons for decentralized nutrition planning and budgeting[18], showed that the coverage of VAS during the 2001-2010 decade was consistently over 80 percent. However, the 2015/16 TDHS-MIS shows coverage has declined to 41 percent.
9) The prevalence of Vitamin A Deficiency (VAD) in the 2010 TDHS was 33 percent in children 6-59 months and 36 percent in women of reproductive age 15 -49 years. Though no data for 2015/16 TDHS-MIS is available, an improvement of the situation is expected to have occurred given the high supplementation coverage.
10) The coverage of Vitamin A supplementation among children 6-59 months increased from 46% in 2005 (TDHS) to 72% in 2014 (TNNS).

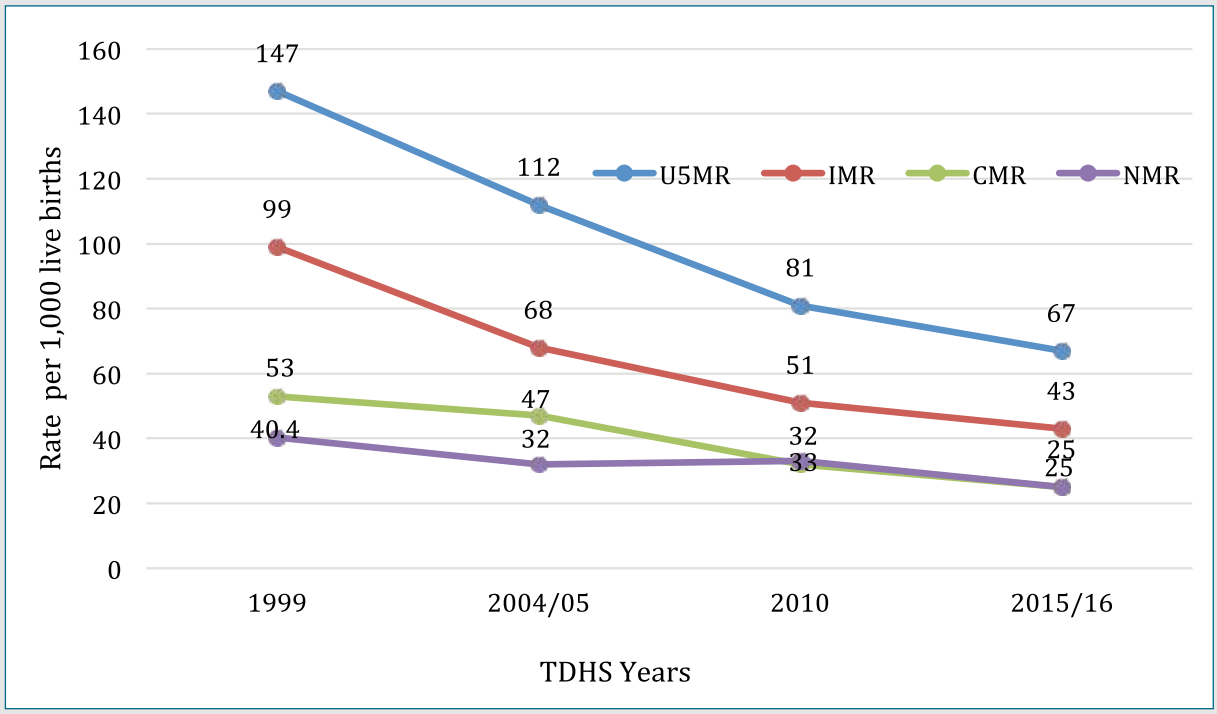
39. The high-impact interventions used to realize these improvements included micronutrient supplementation, food fortification, food-based dietary diversity strategies, together with efforts to reduce the transmission and treatment of infectious diseases that deplete micronutrients like measles, diarrhoea, acute respiratory infections (ARI), hookworms and malaria. However, in spite of this progress, the country has yet to ensure optimal intake of these vitamins and minerals in all population groups, leading to mild and moderate deficiencies, which also have profound adverse health effects. Consequently, there is a need for scaling-up and sustaining the high impact interventions for preventing and managing micronutrient deficiencies.

2.2.3 Childhood mortality reducing rapidly but levels still unacceptably high.

40. The overall impact of the progress Tanzania has made in addressing undernutrition is also reflected in reductions in infant and under-five mortality and improvements in life expectancy, given that undernutrition especially acute malnutrition is associated with as high as 50 percent of underfive mortality. Young child mortality rates, have improved tremendously between 1992-1996 and 2006-2010 *(see figure 4)* and life expectancy at birth increased from 35 years at Independence in 1961 to about 65 years in 2015 according to World Bank estimates. These overall declines in Infant Mortality Rate (IMR) and Underfive Mortality Rate (U5MR) reflect progress in the reach and penetration of maternal and child public health measures, especially progress in immunization, undernutrition, control of communicable diseases (like measles, diarrhoea, ARI, malaria, worms), improvements in medical care, which have taken place parallel to overall social and economic development.

18 Lyatuu M.B, Mkumbwa T and Stevenson et al (2016): Planning and Budgeting for Nutrition Programs in Tanzania: Lessons learned from the National Vitamin AA Supplementation Program. Int J Health Policy Manag 2016, 5(10), 583-588.

Figure 4: Trends in Infant, Child and Underfive Mortality Rates 1999-2015. Source: TDHS 199-2015



2.2.4 Slow progress in neonatal and maternal mortality

41. Of great concern is that the maternal mortality ratio (MMR) per 100,000 live births has stagnated at about 450/100,000 for the past decade and neonatal mortality (NMR) has declined slightly from about 40 per 1,000 live births in 1999 to 25/1,000 live births in 2015/16 against a backdrop of an increasing trend of teenage pregnancies and low coverage of health facility deliveries and family planning. The proportion of adolescent girls 15-19 years who have begun childbearing rose from 23 percent in 2010 TDHS to 27 percent in 2015 TDHS. Overall, the proportion of teenagers who have begun childbearing rises rapidly with age from 4 percent at 15 years to 57 percent at 19 years (TDHS 2015/16). The fertility of adolescents is important on both health and social grounds. In addition to constraining their opportunities to purse education, adolescent mothers are at greater risk of experiencing adverse pregnancy outcomes for both mother and child, including maternal and neonatal deaths and sicknesses than adult women. Moreover, children of teenagers are more likely to be undernourished than those of adult women of similar social status.

2.2.5 The emerging double burden of malnutrition

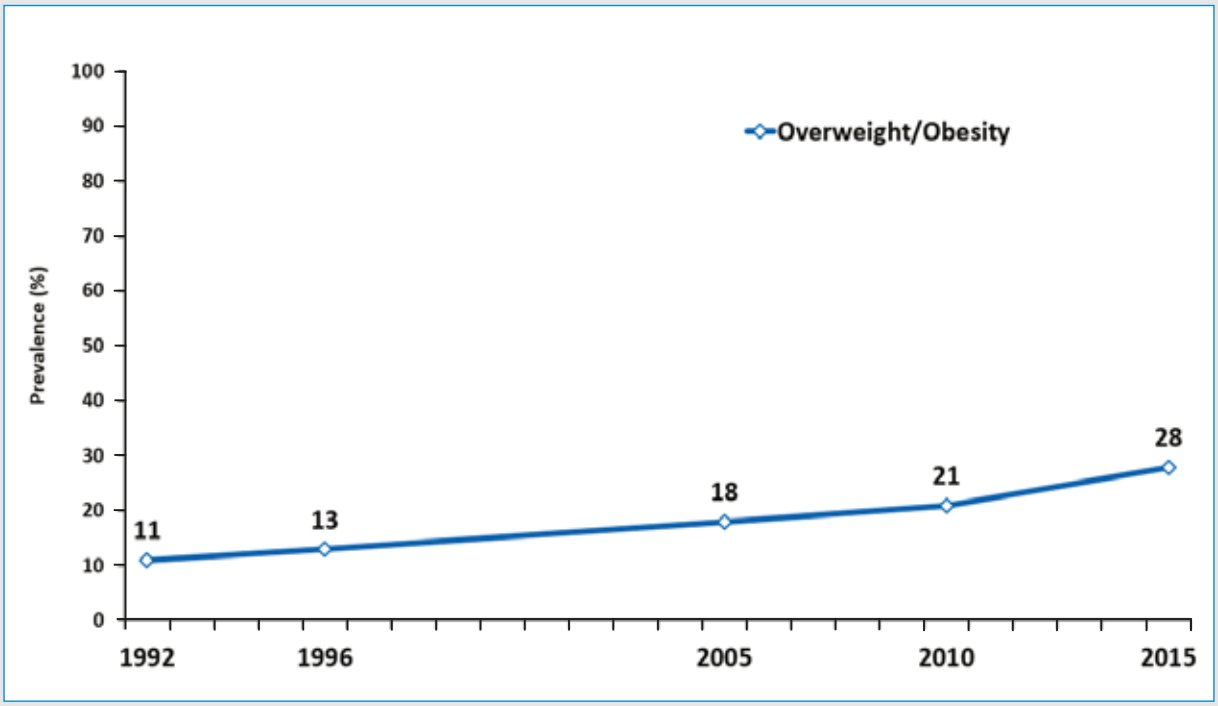
42. While there has been some progress towards reduction in the burden of undernutrition, the problem of overweight and obesity, which is associated with diet related non-communicable diseases (DRNCDs) has been increasing in children and adults, especially women of reproductive age. Overweight in children underfive years increased from a prevalence of below one percent in the 1990s to about 4-5 percent in the 2010-2015 according to the TDHS. The 2015 level is at the cut-off of the WHA target for 2025 of keeping overweight in children to a prevalence of below 5 percent. However, while the prevalence of undernutrition in women of reproductive age as measured by Body Mass Index (BMI) of below 18.5 declined from 11.4 percent (TDHS 2010) to 5.9 percent (TNNS 2014), during the same period overweight (BMI>25) remained at the same level of about 20 percent and obesity (BMI>30) increased from 6.2 percent to 9.7 percent. The 2012 National STEPS survey showed the **prevalence of obesity** in men to be 2.5 percent while that of women was 15 percent. The **overweight prevalence** was 15 percent in men and 37 percent in women, an indication of future higher levels

of obesity. *Figure 5* shows the BMI changes in Tanzania between 2005 and 2010: there is an increase in BMI in almost all regions.

43. Thus, Tanzania is clearly undergoing a "nutrition transition" which is likely to accelerate as the country develops into a Middle-Income Country (MIC) a trend that the NMNAP aims to prevent and control. A **nutrition transition occurs** when the epidemiological health scenario shifts from one dominated by undernutrition and communicable diseases (e.g. malaria, measles, diarrhoea, ARI, intestinal worms) to one increasingly dominated by overweight, obesity and other diet related non-communicable diseases (DRNCDs).

44. The four major DRNCDs in Tanzania are diabetes (mainly adult onset type 2-diabetes) cardiovascular diseases, several types of cancer and chronic respiratory diseases. These diseases take long to develop and may be related to childhood undernutrition experiences and the unhealthy lifestyles "liked" by many people, many of whom are at the prime of their productive lives. Other problems caused by overweight and obesity include pain in weight bearing joints, difficulties in breathing when asleep, and low fertility both in women and men. Moreover, obese women, especially those who were stunted in childhood are at a higher risk of poor birth outcomes for both the mother and newborn that may include maternal and newborn deaths.

Figure 5: National trends in overweight / obesity in women of reproductive age, Tanzania, 1992-2015 (Source: TDHS)



45. Non-communicable diseases (NCDs) usually have no symptoms until well advanced and the systems for health-care delivery in many low-income countries including Tanzania are not well oriented towards dealing with them. Evidence-based strategies to decrease energy intake and increase physical activity are now well established[19] and their urgent adoption by the population is essential. Education starting from childhood is an important component of any strategy to prevent and control DRNCDs.

19 Popkin, BM. Now and Then: Nutrition Transition: The Pandemic of Obesity in Developing Countries. Nutrition Reviews (2012) 70 (10: 3-21).

46. Globally, overweight and obesity have reached epidemic proportions prompting the UN to hold two High Level Meetings on NCDs with a third consultation planned for 2018. The UN set four time-bound commitments in its 2014 UN Outcome Document on NCDs which this NMNAP will implement; (i) consider setting up national NCD targets for 2025 (ii) consider developing national multisectoral policies and plans to achieve the national targets by 2025; (iii) reduce risk factors for NCDs, building on guidance set out by WHO Global NCD Action Plan and (iv) strengthen health systems to address NCDs through people oriented primary health care and universal health coverage, building on guidance set out in the WHO Global Action Plan.

47. The most important contributors to the rise in diet related non-communicable diseases are an increase in the mean food energy intake and a decrease in physical activity in households, communities and populations that have reached abundant food security and developed unhealthy dietary practices like eating too much foods rich in fats, sugar and carbohydrates. In such environments, food is used not only to meet nutrition needs, but also for social reasons like relaxing, reducing stress and socialization accompanied by sedentary lifestyles. In the Tanzanian context, there is the additional cultural perception that being obese is admirable, a sign of being wealthy and healthy.

2.2.6 The pattern of malnutrition in Tanzania: Where are the malnourished?

48. All regions of Tanzania suffer from all types of malnutrition, though the severity of the problems differ. There are three key drivers of the pattern of malnutrition in Tanzania. These are geographical location, level of education and income disparity. These three drivers and their role in the aetiology of undernutrition is described in the next sections.

49. **Geographical location:** In general, rural areas are more affected by undernutrition than urban areas, while urban areas are more affected by overweight and obesity than rural areas. According to the 2015/16 TDHS, the prevalence of stunting among children living in urban areas was 24.7 percent compared to 37.8 percent for children living in rural residences. Very high prevalence of stunting (of above 40 percent) were seen in five mainly rural regions: Rukwa (56.3 percent), Njombe (49.4 percent), Kagera (41.7 percent), Iringa (41.6 percent) and Geita (40.5 percent). Ironically, Rukwa, Njombe, and Iringa are known to be the food basket regions in Tanzania. As such the implication is that factors other than food are responsible for these high prevalence of stunting. Stunting prevalence of above 30 percent are categorized as severe in terms of public health significance.

50. The geographical distribution of the burden of stunting could be categorized by zones and regions as per *table 2*. Only the Eastern zone (out of 7 zones) and five regions (out of 24 excluding the new regions) have stunting prevalence of below 30 percent. With a stunting prevalence of 14 percent, Dar es Salaam has the lowest prevalence of stunting.

Table 2: The geographical pattern of malnutrition, Tanzania (Source: TDHS-MS 2015/16)

Geographic Category	Prevalence of stunting in percent (%) (Source: TDHS 2015/16)		
	<30	30 - <40	40 and above
Zones	Eastern (23.2)	Western (32.2); Northern (36.2); Central (34), Southern (36.6); Lake (35.6);	Southern Highlands (44.7); South West Highlands (43.1)
Regions	Kilimanjaro (29); Singida (29.2); Tabora (27.9) Mara (29.2); Dar es Salaam (14)	Tanga (39.4); Dodoma (36.5) Arusha (36.0); Mtwara (37.7); Mbeya (37.7); Lindi (35.2); Morogoro (33.4), Kigoma (37.9); Pwani (30); Mwanza (38.6); Manyara (36.0); Katavi (38.8); Simiyu (33.3)	Rukwa (56.3); Ruvuma (44.4); Iringa (41.6); Kagera (41.7); Njombe (49.4); Geita (40.5);

51. In terms of the geographical distribution of the numbers of malnourished children, 58 percent of the 2.7 million stunted children live in only 10 of Tanzania's 30 regions (Dodoma, Morogoro, Dar es Salaam, Ruvuma, Mbeya, Tabora, Kigoma, Kagera, Mwanza and Geita -*see figures 6 and 7)*. Half of the children suffering from severe acute malnutrition live in only five regions (Dar es Salaam, Rukwa, Mwanza, Simiyu and Kilimanjaro). *Figure 8* shows the regional distribution of the combined burden of stunting and severe wasting categorized in terms of both prevalence levels and absolute numbers.

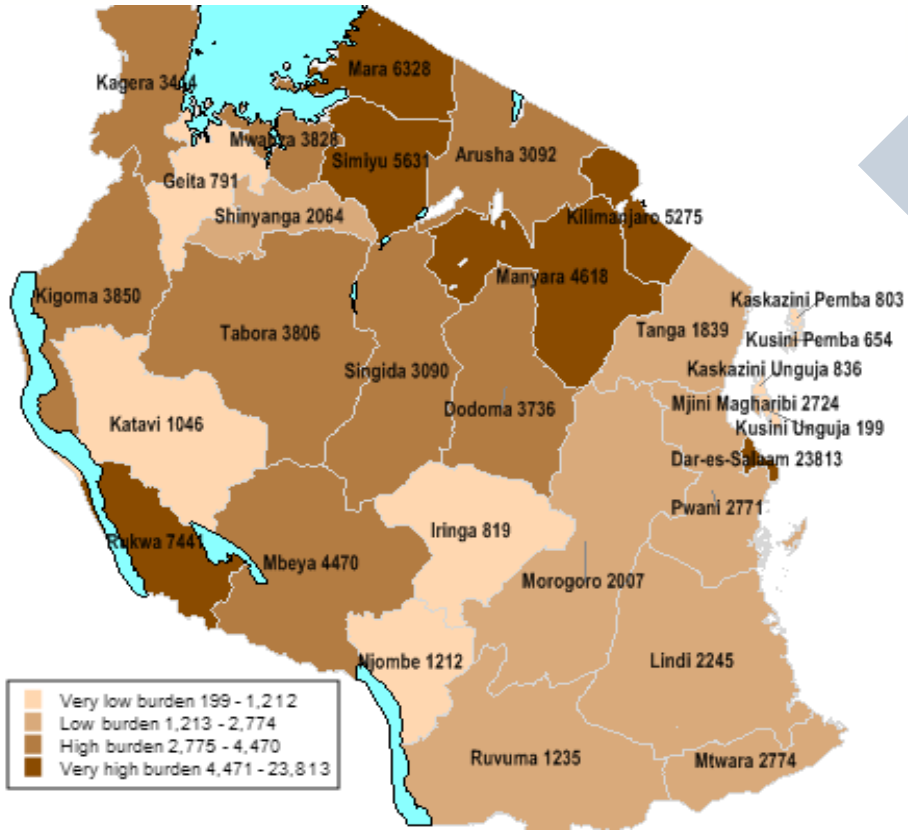
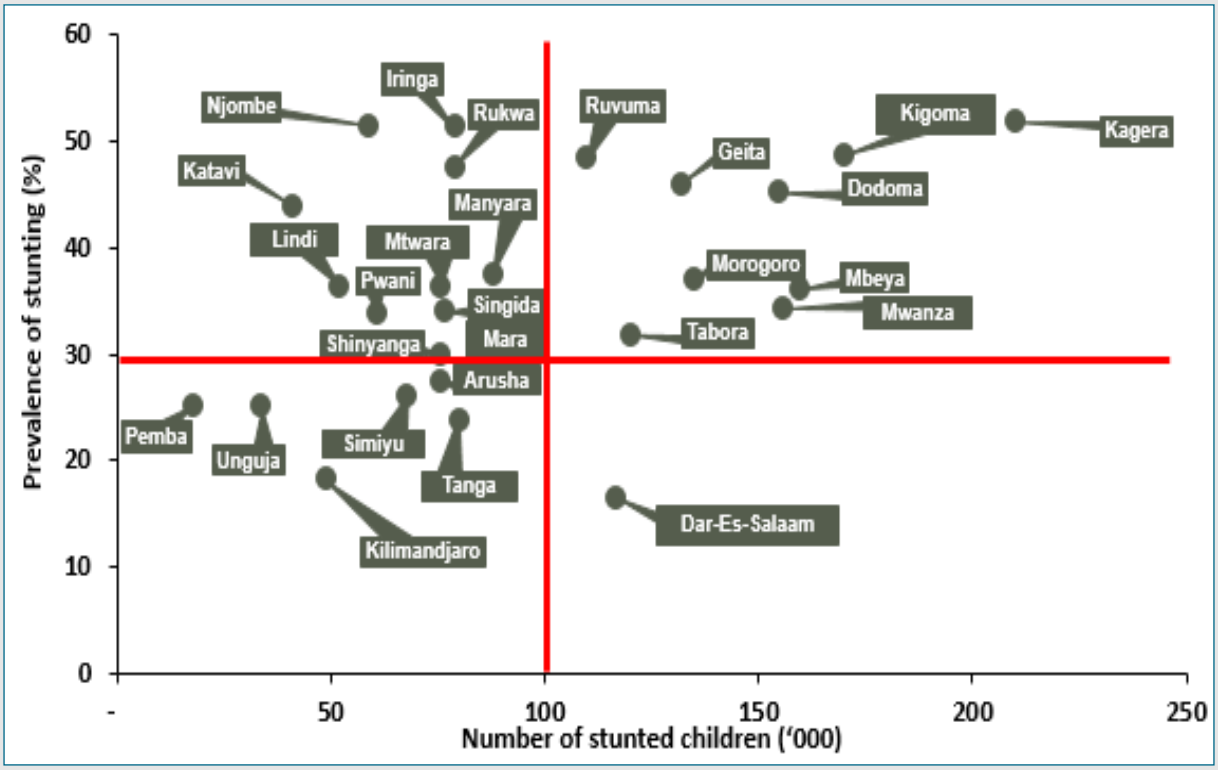


Figure 6: Geographical distribution of the number of stunted children in Tanzania (2014 TNNS)

Figure 7: Geographical distribution of children underfives with severe acute malnutrition (TNNS 2014)

Figure 8: Under –five stunting prevalence and burden by region

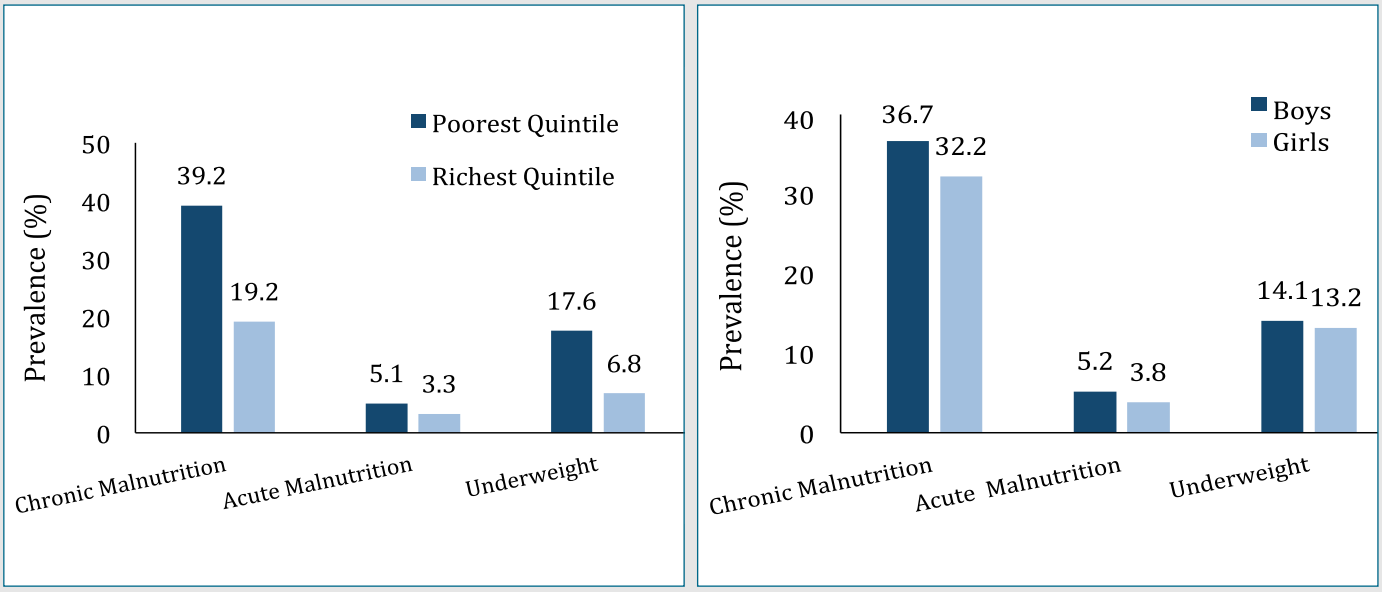


Source: TNNS 2014 and Census 2012

52. With regard to overweight the geographical distribution is in reverse order of that of undernutrition. While undernutrition is mainly rural, overweight is a mainly urban. The STEP surveys of 2005 and 2010 show that regions with overweight (BMI 25-29) prevalence of above 20 percent of women of reproductive age (15-49 years) are predominantly urban: Dar es Salaam (45 percent), Kilimanjaro (35 percent), Mbeya (30 percent), Morogoro (28 percent), Pwani (26 percent), Tanga (25 percent) and Arusha (22 percent). The regional distribution of BMI is already shown in *figure 5 above*. Contributing factors to this high burden of overweight in urban areas are mainly related to sedentary lifestyles, lack of exercises and excessive intake of unhealthy foods with high levels of fats and carbohydrates.

53. **Income disparity** is the second critical driver for malnutrition. As seen in *figure 9*, the 2015/16 TDHS shows that while the highest income quintile had 19.2 percent of their children stunted, the lowest income quintile prevalence of stunting was more than twice as high (39.2 percent). Thus, addressing poverty and inequality are very important in improving nutrition. The corollary, is also true: that addressing malnutrition reduces poverty and inequality. Overall, higher wealth income sections of population have higher prevalence rates of overweight and obesity than lower income sections. As seen in *figure 9,* **gender does not seem to be an important factor though boys are slightly more affected by** stunting, wasting and underweight, than girls.

Figure 9: Prevalence of stunting by wealth quintile and gender (TDHS 2015/16)



54. **Education of the mother or caregiver** is the third major driver. The stunting prevalence of children whose mothers have no education was 39.2 percent as compared to 34.7 percent of mothers with primary education and 23.1 percent of mothers with secondary education, in the 2015/16 TDHS. It has been well established that mothers with higher education are more likely to have high income, knowledge about the importance of nutrition and the key factors to ensure optimal intakes and disease prevention, hence are less likely to have undernourished children.

2.3 Major causes of malnutrition in Tanzania

55. Malnutrition is the biological manifestation of various social processes in society. UNICEF developed a useful model which categorizes the key determinants of poor nutrition according to three distinct levels of causality: immediate, underlying and basic. While the immediate factors act at the individual and household level, the underlying and basic factors operate predominantly at the higher levels of society starting with the community and extending to the political and economic structures at the district, regional, national and international levels. According to the conceptual framework used in developing this NMNAP, **interventions at the level of immediate causes are referred to as nutrition specific; while those targeting the underlying causes are nutrition sensitive interventions; and finally, those that focus on the basic causes as enabling environment interventions. To have high and sustainable impact, simultaneous actions must be taken at all levels of causality (immediate, underlying and basic) and levels of society (household, community, national and international)** as done in this NMNAP.

56. **In Tanzania, the immediate causes of malnutrition** can be categorized into two: **dietary causes and diseases** which reinforce each other. Dietary causes relate to low or excessive frequency of feeding, dietary diversity and adequacy of the food taken in relation to physiological and physical needs.

Frequent clinical and sub-clinical diseases like diarrhoea, environmental enteropathy, helminths, pneumonia, malaria, AIDS, etc. influence food intake and utilization by the body. Excessive feeding, especially of fats and carbohydrates without commensurate physical activity leads to overweight and obesity and the development of dietary related non-communicable diseases (DRNCDs).

57. The underlying causes of malnutrition can be clustered into three determinants: food security, caring capacity and access to basic services like health, education, and safe water, sanitation and hygiene (WASH). While each category is a necessary causative factor, none acts entirely independently. Food security refers to diversified food availability throughout the year, its economic and cultural accessibility and its biological utilization to meet nutritional needs. The care of children, pregnant and lactating women, the elderly and those suffering from diseases including AIDS and tuberculosis is important to improve nutrition in those population groups. Recent studies show that inadequate access to safe water and sanitation and poor hygiene practices increase the burden of infectious pathogens and lead to growth retardation and stunting.

58. **Basic causes of malnutrition in Tanzania** are predominantly in the area of enabling environment. They include among others: income disparity, poverty, inadequate nutrition and general political governance, ignorance due to low education, nutrition unfriendly customs and traditions, and inadequate functional institutional capacity at all levels for nutrition. Others are inadequate linkages with nutrition of sectoral policies, strategies and programmes especially in the key nutrition sensitive sectors of agriculture, education, WASH, social protection and climate change and environment. Moreover, enforcement of nutrition relevant laws and regulations is inadequate and tracking of both nutrition specific and nutrition sensitive interventions for results and investments is not systematized and institutionalized.

2.4 The impact of malnutrition on national development in Tanzania

59. Malnutrition constrains all aspects of national development. By contributing to child and maternal illnesses and deaths, it reduces the rates of survival and, therefore, reduces overall life expectancy of the population. Secondly, malnutrition impairs physical and mental growth leading to poor performance in school and the ability to develop essential survival and development skills due to poor cognitive development. Thirdly, for those who survive to adulthood, they become small in stature and are unable to reach their productive potential. They earn less than their counterparts, their limited skills development make it difficult to be employed and many remain in abject poverty. Of the multidimensional causes of child poverty[20], malnutrition stands out as one of the most serious dimensions.

60. Moreover, malnutrition in childhood has a cumulative impact along the life course. For women who were stunted in childhood, their short stature can result in poor birth outcomes including a higher risk for maternal and neonatal mortality. Malnutrition in pregnant women explains to a large extent the slow progress in the reduction of the high levels of maternal mortality ratio (MMR) and neonatal mortality in the country.

61. Stunting in childhood is also related to overweight and obesity later in life. People who were stunted in childhood, have a higher risk of developing overweight, obesity and diet related non-communicable diseases (DRNCDs). The cumulative effect of malnutrition during the life course leads to intergenerational cycles of malnutrition, poverty and inequality and thus drags down national development.

62. The economic burden of malnutrition in Tanzania is significant. It is estimated that malnutrition annually reduces Tanzania's GDP growth by about 2.5 percent, and if the impact of poor sanitation and hygiene on stunting is added, the effect may reach up to 10 percent reduction of GDP growth. This

20 UNICEF (February 2011): A Multidimensional Approach to Measuring Child Poverty. Social and Economic Policy Working Briefs. UNICEF Policy and Practice http://www.unicef.org/socialpolicy/files/A_Multidimensional_Approach_to_Measuring_Child_Poverty(2).pdf

is further illustrated by the 2014 PROFILES[21] data for Tanzania. PROFILES consist of a set of computer-based models that generate estimates of the benefits of improved (or compromised) nutrition on health and development outcomes. Taking 2025 as the target date and an improving nutrition scenario (as is anticipated through the NMNAP), about 900,000 children would have been saved from mild to severe brain damage due to maternal iodine deficiency and over 120,000 children saved from death due to the impact of stunting. Again using an improved nutrition scenario, the estimated future economic gain is a total of about US$4.8 billions of which $3.9 billion is the result of reduction in stunting; US$382 million due to improvements in anaemia among no-pregnant women and $479 million gained as a consequence of improvements in iodine nutrition. The figures underscore the fact that investing in nutrition is not only a health investment, but an economic investment with huge economic returns.

2.5 Why is progress in reducing malnutrition relatively slow in Tanzania?

63. Based on evidence, it is clear what works and what does not. In spite of this evidence, high political will and robust economic growth, progress on reducing malnutrition in Tanzania has remained slow. To address this discrepancy, the NMNAP specifically acknowledges the key factors that have been identified by recent analyses, and develops concrete actions to remove these bottlenecks. The main factors could be divided into two categories: (a) contextual factors; and (b) programmatic factors.

2.5.1 Contextual factors

64. The main contextual factors include: -

1) **Low awareness of the problem of malnutrition** by policy makers, the media and the public at large (e.g. stunting and micronutrient deficiencies largely not recognized as problems).

2) **Low investment in nutrition:** currently nutrition is not adequately prioritized in the allocation of financial resources. The 2013 Public Expenditure Review on Nutrition (PE-N) showed that only about 23 percent of expenditure on nutrition is from public funds, the rest is from donors. A Government review of nutrition funding for the FY 2011/12 - FY 2015/16 (Nutrition Budget Brief 2016) concludes that although resources for nutrition-related activities increased and even doubled during the period reviewed, spending on nutrition accounted for only 0.03 percent of GDP and 0.13 percent of total public spending. Moreover, **only 12 percent of the National Nutrition Strategy (NNS) for 2011/12-2015/16 total budget of about TZS 825 billion (US$520 million) was funded and mostly by donors**. Over reliance on donor funds for nutrition introduces a large amount of uncertainty into nutrition planning given the sometimes erratic nature of donor funding. A robust resource mobilization strategy that emphasizes increased domestic resources will be developed in the implementation of the NMNAP.

3) **Inadequate nutrition governance**: e.g. inadequate multisectoral coordination of interventions at all levels, lack of common results, resources and accountability framework for nutrition, poor enforcement of relevant laws, low use of technology for nutrition;

4) **Inadequate focus on the Community and life course:** reaching communities with large scale nutrition interventions has been slow and some vulnerable groups like adolescent girls were not covered;

5) **Low functional institutional capacity for nutrition at all levels.** Although institutions for nutrition have satisfactory technical capacity, functional and strategic capacity is low at all levels.

6) **Inadequate attention to the social determinants of malnutrition** to effect social change for nutrition improvement. Social determinants are the conditions into which people are born, live, work and age. They include behaviour, practices, formal and informal structures and systems some of which are good and others bad for nutrition.

21 PROFILES is an evidence-based tool that was developed by USAID in the 1990s for the purpose of nutrition advocacy. The USAID-funded Food and Nutrition Technical Assistance (FANTA) project III developed the 2014 PROFILES for Tanzania on request by the Government of Tanzania and in collaboration with the Prime Minister's Office (PMO) and TFNC, aiming at developing a national nutrition advocacy strategy and related materials.

Some examples include social protection measures and systems; practices related to child rearing; sanitation and hygiene practices; lifestyles and food preferences;

7) Distorted application of the conceptual framework with an overemphasis on nutrition specific interventions and the food security sector without adequate attention to other important nutrition sensitive sectors. Key nutrition sensitive sectors addressed in this NMNAP include (a) Agriculture and Food Security, (b) Education and Early Childhood Development, (c) Health and HIV, (d) Water, Sanitation and Hygiene (WASH) and (e) Climate Change and Environment. Enabling environment interventions have progressed in recent years, but are not adequately institutionalized or enforced.

2.5.2 Programmatic factors

65. The 2014 and 2015 Joint Multisectoral Reviews (JMNR) provided in-depth reviews of the operational challenges that faced the implementation of the eight strategic objectives of the National Nutrition Strategy (2011/12-2015/26) using a **bottleneck analysis (BNA)** approach for selected nutrition specific interventions covering both Tanzania mainland and Zanzibar. The four selected interventions submitted to BNA were coverage or implementation status of (i) Infant and Young Child Feeding (IYCF) practices, (ii) Integrated Management of Acute Malnutrition (IMAM) (iii) Vitamin A distribution (VAD) and (iv) distribution of Iron and Folic Acid (IFA) to pregnant women.

66. The bottleneck analysis used the Tanahashi model[22] applicable for identifying key constraints in the effective delivery of interventions, especially for health and looked at five bottlenecks: (a) commodity availability, (b) human resources capacity, (c) geographical access to interventions (d) utilization of interventions by targeted groups and (e) the quality of interventions provided. Data was collected by District and Regional Nutrition Officers from 148 districts (86 percent, out of 186 districts) and analysed by a team of experts from TFNC, Ministries responsible for Health (mainland and Zanzibar), selected Regions/Districts, UNICEF and UN-REACH. The 2012 Census, the 2014 Tanzania National Nutrition Survey (TNNS) and the 2015/16 TDHS Key Indicators provided the population reference points for purposes of calculating coverage.

67. The results of the bottleneck analysis provide a clue as to the major operational challenges that the NMNAP has tried to address. These were: -

1) Low coverage of high impact interventions, both nutrition specific and nutrition sensitive;
ii) Inadequate alignment of the level of implementation with the geographical burden of the problem of malnutrition for stunting and acute malnutrition; and
iii) Inadequate skilled human resource capacity affecting the quality of interventions for all the five areas subjected to BNA.
iv) Commodities, utilization by the target groups and the quality of interventions provided did not appear to be major bottlenecks.

2.6 The 2016 National Food and Nutrition Policy

68. The 2016 National Food and Nutrition Policy (FNP) addresses the major challenges that emerged during the implementation of the 1992 Policy and the key changes that have taken place on the national and international nutrition landscape. These include advances in scientific knowledge, lessons learned in combating malnutrition, the emergence of the double burden of malnutrition and, perhaps most importantly, the emerging recognition of nutrition as a multisectoral development issue. Thus, the policy provides for a broader framework for increased multisectoral collaboration and coordination towards better nutrition.

69. The FNP has 22 policy objectives that this NMNAP has addressed. These are: -

1) To improve household food security
2) To improve food safety and quality for enhancement of nutrition status at individual, household and community level.
3) To improve and scale up access to quality nutrition interventions along the life course;
4) To improve adolescent and maternal nutritional care and support;
5) To improve infants' and young child nutrition.
6) To reduce the prevalence of micronutrient

22 Tanahashi T (1978): Health service coverage and its evaluation. Bull World Health Organ. 1978; 56(2) 295-303.

deficiencies in the population.

7) To improve the nutrition status of vulnerable groups
8) To strengthen prevention and management of Diet Related Non-Communicable Diseases (DRNCDs)
9) To provide appropriate nutritional care and support to communities during emergencies and disasters;
10) To enhance national capacity for improvement of nutrition;
11) To strengthen multisectoral coordination of nutrition interventions in the country;
12) To strengthen private sector contribution to improve nutrition in the country;
13) To increase the availability and accessibility of reliable, timely and sustainable data on the nutrition situation in the country at all levels;
14) To improve nutrition knowledge, behaviours, attitudes and practices in the country;
15) To promote regional and international cooperation for improvement of nutrition;
16) To enhance national capacity for generation of new knowledge and solutions to nutritional needs in the country;
17) To promote safe water, sanitation, and hygiene practices as key strategies for improved nutrition.
18) To ensure that nutrition interventions at all levels are gender sensitive;
19) To enhance sustainable use and management of the environment for improvement of food and nutrition security;
20) To improve nutritional care and support for people living with HIV and AIDS and their households;
21) To decentralize planning, management and coordination of nutrition services to local Governments; and
22) To strengthen good governance in nutrition at all levels.

70. To ensure that all of the 22 policy objectives have been addressed, each of the action plan of the seven Key Result Areas (KRAs) starts with an indication of the policy objectives that the KRA action plan addresses.

CHAPTER 3

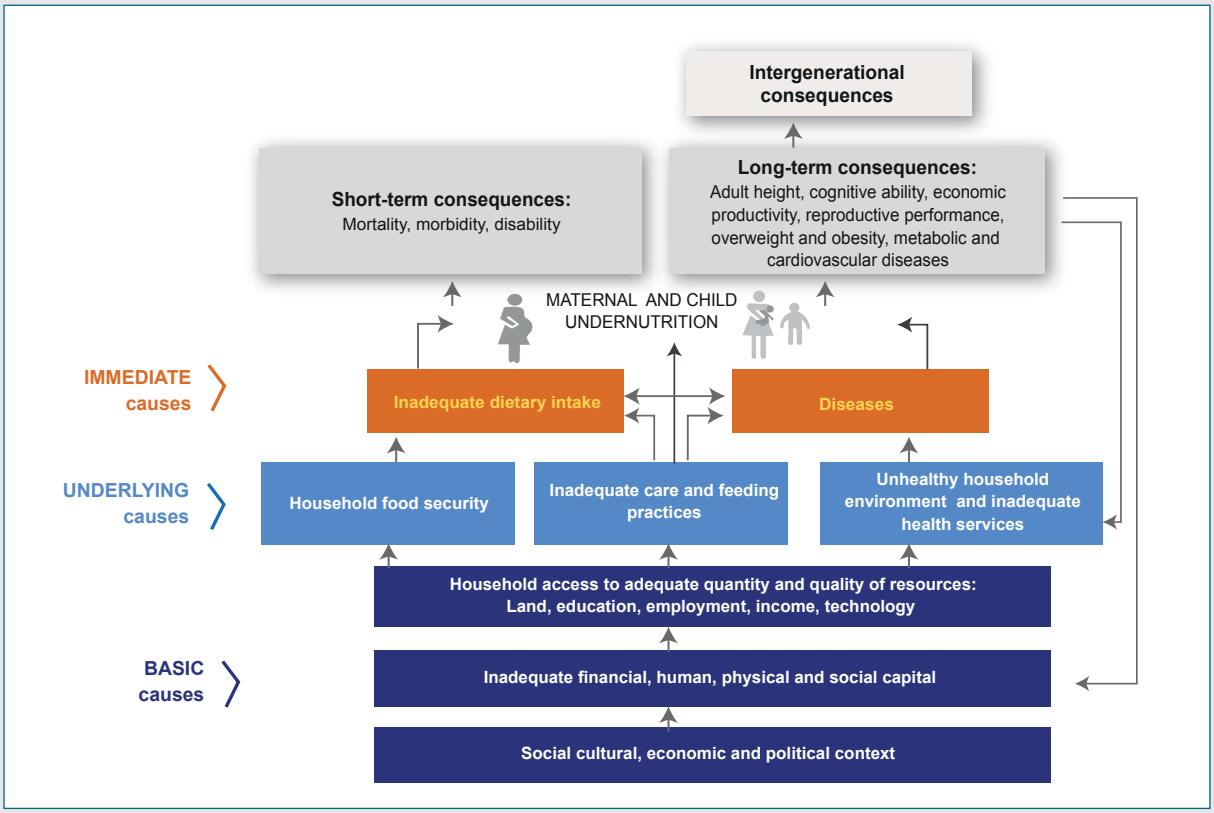
CONCEPTUAL FRAMEWORK FOR THE NMNAP

CONCEPTUAL FRAMEWORK FOR THE NMNAP

3.1 The conceptual basis

71. A co mprehensive conceptual framework describing the key determinants of malnutrition in children and women was first developed in Tanzania during the mid-1980s in the Iringa Joint Government UNICEF/WHO Support Nutrition Programme (JNSP)- *see figure 10)*. The framework saw malnutrition as the manifestation of various individual, community and social processes in society with multiple determinants classified as immediate, underlying and basic. This causality framework was used to analyse determinants of malnutrition in any context, and was accompanied by a cyclic process of **assessment**, **analysis**, and **actions**. The **Triple 'A' Process** – which is adopted within the NMNAP - allows an *adaptive approach to programming* as it enables NMNAP implementers to adjust the course of actions as new evidence is gathered, or new experience is gained.

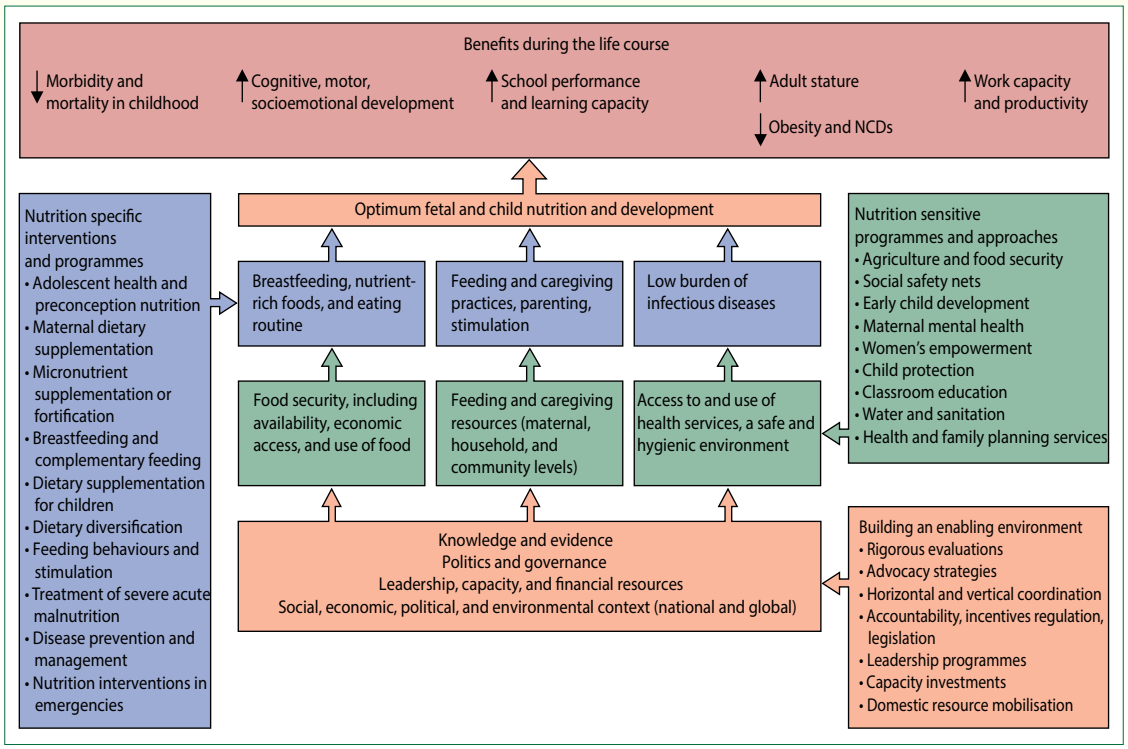
Figure 10: The 2015 UNICEF Conceptual Framework of the Determinants of Maternal and Child Undernutrition



72. Based on a comprehensive review of the literature, the 2013 Lancet Nutrition Series further developed the Conceptual Framework of the determinants of maternal and child undernutrition to show the key interventions that should be implemented to address the multiple causes of undernutrition at the different levels causality. The result was a conceptual framework of interventions to address malnutrition *(see fig 11)* that categorized interventions into three major areas: -

1) Nutrition specific interventions
2) Nutrition sensitive interventions; and
3) Enabling environment interventions.

Figure 11: The Conceptual Framework adopted by the NMNAP for developing the action plan



Source: The Lancet Series on Maternal and Child Undernutrition 2013

73. A key lesson learned in using the "Conceptual Causality Framework" in previous policies, strategies and programmes in Tanzania is that, given the complex nature of the nutrition challenge, there is no single magic bullet or single intervention that will address all the problems of malnutrition. Instead, the interventions in the NMNAP were selected based on evidence and coherence with the Conceptual Framework for addressing malnutrition, targeting all levels (from the community to the national level), and articulated within a complex coordination system. During the implementation of the NMNAP, the Triple 'A' Process will be used to re-assess, re-analyse and adjust actions according to the changing landscape of nutrition in Tanzania. The Triple 'A' Process will be carried out both at the central and decentralized level, and will be inclusive of nutrition sensitive sectors represented within local government authorities. In this way, the NMNAP is not conceived as a static blue print, but as a dynamic strategic guide that will be contextually modified and adapted by the various actors in their own nutrition plans, as conditions evolve and changes are warranted.

3.2 The NMNAP Theory of Change

78. The NMNAP is articulated through the perspective of both a *Theory of Change* (ToC) *approach*[23] (chapter 3) and *Logical Framework approach* (Chapter 4). The NMNAP theory of change shows how the *desired change* (or *impact* in the logical framework terminology) will be achieved by realizing certain *conditions for change* (or *outcomes* in the logical framework terminology). The theory of change approach recognises that the conditions for change are not completely under the control of the actors implementing the NMNAP, but also depend on other unpredictable factors embedded in the complex reality of nutrition in Tanzania, which among others are historical, individual, relational, cognitive, economic, social, geographical, political, cultural and institutional. What are in the sphere of control of the NMNAP are the *contributions to conditions* (or *outputs* in the logical framework terminology) that are realized through the implementation of activities, which will *contribute* to accomplish the conditions that

23 The theory of change (2016): A journey to understand complexity and our role in social change processes, IMA International.

are deemed necessary to achieve the desired change.

79. A distinctive element of the theory of change approach – compared to the logical framework approach – is the critical analysis of *assumptions*. While the *logical framework* assumptions are the external conditions needed to achieve a result (for example: 'political stability'), the *theory of change assumptions* are those *theoretical assumptions* that govern our way of thinking, and, therefore, determine the way we design our p*athway to change*. The pathway of change in ToC terminology is from contributions, to conditions, to desired change, which in the logical framework terminology the pathway is from outputs, outcomes to impact. The NMNAP *theory of change* makes those assumptions explicit, in order to understand the rationale between those contributions and conditions needed to achieve the desired change. *Table 3* gives the definitions of the key components and terminology used in the ToC language.

Table 3: Definition of key components of the Theory of Change

Key definitions of the components of the Theory of Change	
Desired Change	This is a positive visualization of a situation to be attained at a later time (corresponding to the **expected impact in the logical framework**). It represents a confluence of conditions, relationships, and results that we wish to help occur as a result of our actions[1].
Assumptions	These are the theoretical assumptions that we generally accept as true without questioning. They can be ***scientific assumptions***, therefore, proven and solid, or just assumptions, unverified and weak. They can sit between the desired change and conditions for change, as well as between conditions and contributions to conditions. The strength of a Theory of Change greatly depends on the strength of its assumptions. **There is <u>not</u> a corresponding concept in the logical framework approach**.
Conditions for Change	These are circumstances and situations that need to occur in order for the desired change to happen. **They correspond to the outcomes in the logical framework**. They are not only determined by the actions planned in the NMNAP, but on many other factors often beyond our control.
Contributions to Conditions	These are in the sphere of control of the implementers of the NMNAP. They are the contributions that individuals and organisations make ***to influence*** the conditions for change. **They correspond to the outputs in the logical framework**, and directly result from the activities planned in the NMNAP.

80. The *desired change* of the NMNAP is that children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development. As described in Chapter 4, the desired change will be measured through impact level indicators which were selected to match with the national and international nutrition priorities and targets (i.e. FYDP II; WHA nutrition targets 2025 and SDGs 2030). The key elements of the NMNAP desired change can be unpacked as follows:

a. *Children, adolescents, women and men* are listed in this order to refer to the life course and to show priority targeting in terms of efficiency (investing in nutrition early, within the 1,000 days' window of opportunities), inclusiveness (adolescents were often neglected by previous nutrition programmes), gender (targeting both women and men) and equity (targeting the poorest and the most marginalised first).

b. *Better nourished* refers to a desired reduction in the prevalence levels of undernutrition (stunting, wasting, underweight, low birth weight, micronutrient deficiencies), as well as of overweight,

obesity and diet related non-communicable diseases (DRNCDs).

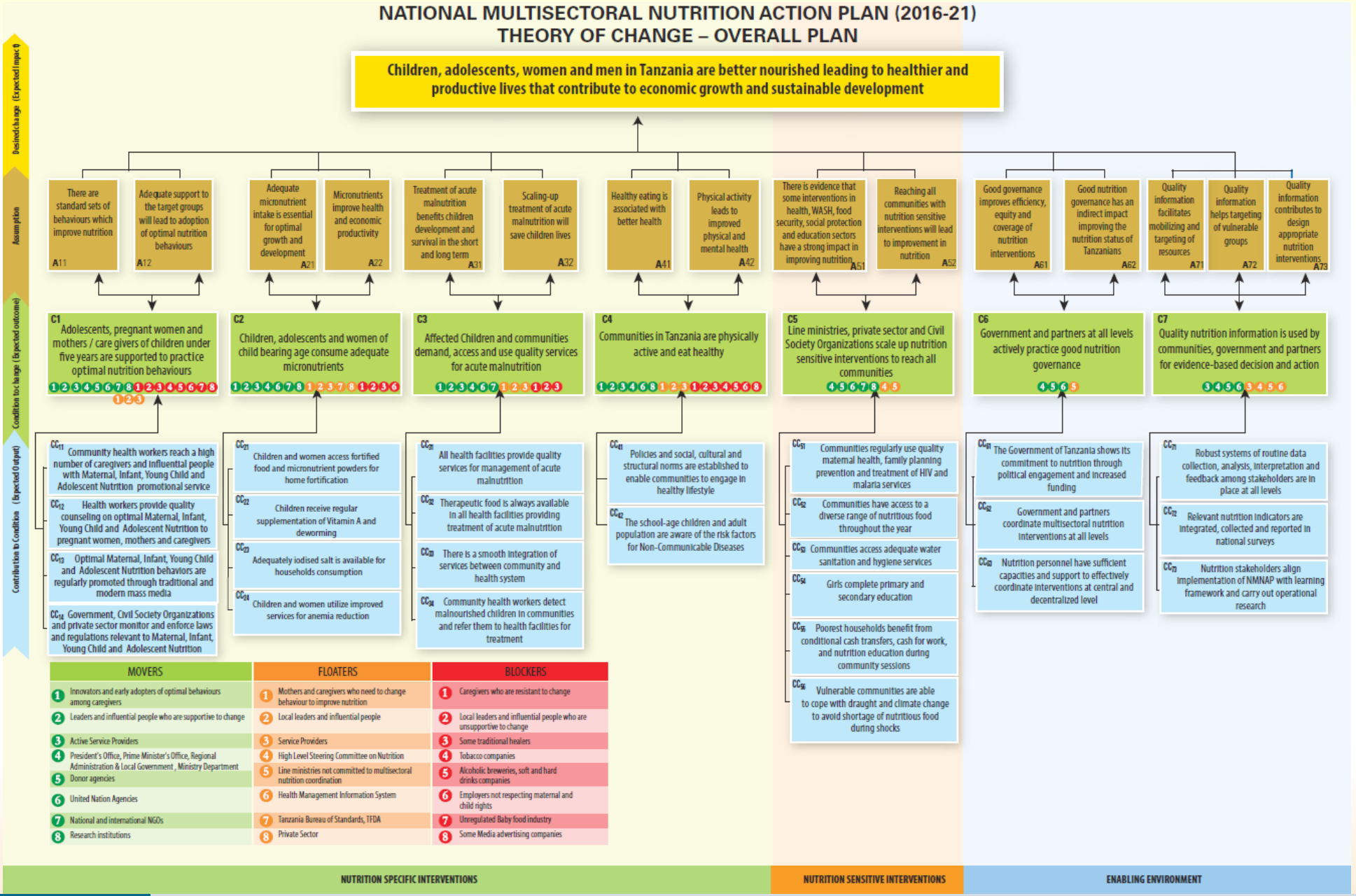
c. *Healthier and more productive lives that contribute to economic growth and sustainable development* refers to the contribution of better nutrition to improved mental and cognitive child development, improved learning capacity and school performance, improved individual productivity and earning capacity, which contribute to increased national productivity, leading to economic growth and to reductions in poverty and inequalities.

81. Seven different ***Conditions for Change*** are outlined in the NMNAP in order to achieve the desired change based on the prioritized seven KRAs. These are:

1) Adolescents, pregnant women, mothers and care givers of children under five years are supported to practice optimal nutrition behaviours;
2) Children, adolescents and women of child bearing age consume adequate micronutrients;
3) Affected Children and communities demand, access and use of quality services for the prevention and treatment of acute malnutrition;
4) Communities in Tanzania are physically active and eat healthy diets;
5) Line ministries, private sector and civil society organizations scale up nutrition sensitive interventions to reach all communities;
6) Government and partners at all levels actively practice good nutrition governance;
7) Quality nutrition information is used by communities, government and partners for evidence informed decisions and actions.

82. *Figure 12* summarizes the key elements of the NMNAP's theory of change categorized into the three main areas of interventions that the NMNAP has adopted: nutrition specific interventions, nutrition sensitive interventions and enabling environment interventions.

Figure 12: The NMNAP summarized theory of change



83. The NMNAP theory of change also includes a **stakeholders' analysis**, showing how implementers should engage different groups of key actors, and leverage their potential to contribute to the NMNAP desired change. Key stakeholders are associated with each condition for change of the plan, divided into three categories: **Movers, Floaters and Blockers.** Specific **relational strategies** with each group of stakeholders were designed in order to guide implementers on how to engage with key actors to contribute to the NMNAP desired change.

84. **Movers** are key groups and individuals committed to contributing to the NMNAP desired change. They are strategic partners that should be encouraged, supported and alliances built with them, in order to collectively promote the shared desired change. Key Movers identified in the NMNAP include: the President's Office, Prime Minister's Office, Regional Administration & Local Government, Ministry Departments and Agencies (TFNC, TFDA, TBS); the High Level Steering Committee on Nutrition; donor agencies; United Nations Agencies; national and international NGOs; academia and research institutions; innovators and early adopters of optimal behaviours among caregivers; leaders and influential people who are supportive of change; and active service providers (i.e. active community health workers and health staff).

85. **Floaters** are neutral groups and individuals that are not aligned and not engaged with the overall desired change of the NMNAP. They do not block the process, but neither do they actively support it. They are subject to change position and become Blockers or Movers, depending on what groups influence them. It is important to build alliances with these groups and try to convert them into Movers, as this will strongly help to achieve the NMNAP desired change. Key floaters identified in the NMNAP include: line ministries, development partners and CSOs not committed to multisectoral nutrition coordination; some mothers and caregivers who need to change their behaviours to improve nutrition; local leaders and influential people who are not engaged; service providers who are not active; some media advertising companies; and the private sector in general.

86. **Blockers**: are groups and individuals who are against the desired change and do not want the change to happen (e.g. for historical rivalry with the Movers, or for considering that their own interests are at stake). The NMNAP implementers will develop mechanisms to have Blockers interact and engage with Movers and Floaters in order to prevent and counter-balance their impact on the program, and to try to dilute their influence. Key floaters identified in the NMNAP include: caregivers who are resistant to change; local leaders and influential people who are unsupportive and resistant to change; some traditional healers; tobacco companies; alcoholic breweries, soft and hard drinks companies; employers not respecting maternal and child rights; and some unregulated baby food industry companies.

87. As the Theory of Change is a dynamic approach, the role of some key stakeholders identified is likely to change during the implementation of the NMNAP, as a result of the relational strategies put in place, or external factors beyond the control of the implementers of the NMNAP. *Appendix 1* analytically describes the theory of change and the role of the different stakeholders in detail for each of the seven conditions for change identified within the NMNAP's KRAs. It analyses the pathway of change and the main theoretical assumptions that support the implementation of the key components (contributions for change and outcomes) of the NMNAP.

CHAPTER 4

EXPECTED RESULTS AND KEY STRATEGIES

EXPECTED RESULTS AND KEY STRATEGIES

4.1 Guiding principles

74. Implementation of the NMNAP will be guided by the following key principles: -

i) Government is in the driving seat;
ii) Human rights orientation;
iii) Focus on all dimensions of equality, especially gender and economic equality;
iv) Balanced centralized, national advocacy of goals with Local Government Authority/ community-centred assessment, analysis, action and active participation;
v) Build and reinforce effective Community-Public-Private-Partnerships.
vi) Quality, accountability and impact – through evidence led, results oriented, scalable and sustainable approaches.
vii) Adhere to the three "Ones": One Plan; One Coordinating mechanism and One Monitoring, Evaluation and Learning Framework to ensure coherence;
viii) Proposed actions and investments to meet the following criteria:
- ❖ Must be evidence-based
- ❖ Results oriented
- ❖ Can be implementable at large scale
- ❖ Results, roles, responsibilities and accountabilities are well defined;
- ❖ Progress can be monitored on the basis of the theory of change.
- ❖ Empowering and sustainable

75. The NMNAP has developed some concrete metrics in order to enable determination of progress and overall program performance. These include **ONE impact/desired change**, **7 outcomes/conditions** (one outcome for each of the seven key result areas), and **26 outputs/contributions to change.** In addition, there are a number of process-related indicators to demonstrate effective delivery of key activities. In articulating results, the NMNAP adopted a number of different criteria normally used in designing monitoring and evaluation (M&E) systems for large-scale programmes:

1) Appropriate level of results (impact, outcome, output);
2) Appropriate ratio of outputs per outcome;
3) Appropriate ratio of indicators to output-outcome-impact;
4) The quality of results;
5) The SMART (specific, measurable, attributable, replicable and time-bound) principle;
6) Formulation of indicators is neutral and specific; and
7) The soundness of horizontal logic (baseline, milestones, reliable source)

76. Key targets were proposed for each of the outcome and output indicators based on several criteria including:

1) Baseline data from population based surveys (e.g. TDHS 2010, 2015/16, Tanzania National Nutrition Survey (TNNS) of 2014, Population Census and Household Survey 2012), STEPS 2012);
2) Target for stunting reduction is based on the calculation of the annual average reduction rate (AARR)[24] of 3.4 percent for 2015-2020 using the 2015/16 TDHS as baseline and the NMNAP 2020/21 prevalence target of 28 percent. The NMNAP did not use the WHA 2025 global nutrition target of reducing the numbers of children underfive who are stunted by 40 percent given the high population growth for Tanzania;
3) Continued political will and Government commitment to nutrition; and
4) The consensus reached during the consultations in developing the NMNAP on coordination, harmonization and collaboration by various stakeholders using the three ONES principle of ONE plan, One Coordinating Mechanism and ONE M&E framework at all levels.

4.2 Expected impact and targets

77. The main expected impact or desired change is that "children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development". The 12 key indicators associated targets to demonstrate progress towards the achievement of the desired change for 2021 are shown in *table 4.*

24 The Annual Average Rate of Reduction (AARR) is the average relative percent decrease per year in prevalence or rate. A positive sign indicates reduction or downward trend, while a negative sign indicates increase, or upward trend.

Table 4: NMNAP Key targets by 2020/21

Planned target on selected Indicators	Baseline	NMNAP Target
Reduce prevalence of stunting among children 0-59 months from 34% in 2015 to 28% in 2021 (***WHA target 1***)	34.4% (TDHS, 2015/16)	28%
Maintain prevalence of global acute malnutrition among children 0-59 months under 5% in 2021 (***WHA target 6***)	4.5% (TDHS, 2015/16)	<5%
Reduced prevalence of low birthweight from 7% in 2010 (TDHS 2010) to less than 5% in 2021 (***WHA target 6***)	7% (TDHS, 2010)	<5%
Reduced proportion of women 15-49 years with anaemia from 44.7% in 2015 (TDHS 2015/16) to 33% in 2021 (***WHA target 2***)	44.7% (TDHS, 2015)	33%
Reduced prevalence of Vitamin A deficiency among children aged 6-59 months from 33% in 2010 to 26% in 2021	33% (TDHS, 2010)	26%
Maintain median urinary iodine of women of reproductive age between 100-299 µg/L by 2021	160µg/L (TDHS, 2010)	100-299 µg/L
Maintain prevalence of diabetes among adults under 10% by 2021	9.1% (STEPS, 2012)	<10%
Maintain prevalence of overweight among children under five under 5% by 2021	3.6 (TDHS, 2015/16)	<5%
Maintain prevalence of overweight among adults under 30% by 2021	29% (STEPS, 2012)	<29%

4.3 Seven Priority Key Result Areas and Expected outcomes

78. The seven priority KRAs of the NMNAP cover all the critical areas of the nutrition specific, nutrition sensitive and enabling environment interventions and require engagement of multiple sectors. These KRAs are presented in *text box 1*.

Text box 1: The 7 priority key result areas (KRAs) of the NMNAP

1) Scaling Up Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN)
2) Scaling Up Prevention and Management of Micronutrient Deficiencies
3) Scaling Up Integrated Management of Acute Malnutrition (IMAM)
4) Scaling Up Prevention and Management of Diet-Related Non-Communicable Diseases (DRNCDs)
5) Scaling Up Multisectoral Nutrition Sensitive Interventions (Agriculture and Food Security; Health and HIV; Water Sanitation and Hygiene (WASH); Education; Social Protection; and Environment and Climate Change)
6) Strengthening Multisectoral Nutrition Governance
7) Establishing a Multisectoral Nutrition Information System

79. The seven expected outcomes associated with the seven key results areas are as follows: -

I. Nutrition specific outcome results:
   1) Increased proportion of adolescents, pregnant women and mothers/caregivers of children under two years who practice optimal maternal, infant and young child nutrition behaviours;
   2) Increased micronutrient consumption by children, adolescents and women of reproductive age (15-49 years);

3) Increased coverage of Integrated Management of Acute Malnutrition (IMAM).
4) Communities in Tanzania are physically more active and eat healthier diet.

II. Nutrition sensitive outcome result:
5) Increased coverage of nutrition sensitive interventions from i. Agriculture and Food Security; ii. Health and HIV; iii. Water, Sanitation and Hygiene; iv. Education and Early Childhood Development; v. Social Protection and vi. Environment and Climate Change.

I. Enabling environment outcome results:
1) Improved effectiveness and efficiency of nutrition Governance (including coordination and leadership) and response across all sectors, actors and administrative levels;
2) Increased access to quality nutrition related information to allow Government of Tanzania and partners to make timely and effective evidence informed decisions.

4.4 Expected outputs per outcome

80. This section presents key outputs and targets for each of the seven outcomes listed above. For ease of reference, the numbering of the outputs corresponds to those in the NMNAP's Common Results, Resources and Accountability Framework *(see appendix 2)*.

4.4.1 Key outputs and targets for MIYCAN outcome

Output 1.1: Increased coverage and quality of MIYCAN services at the community level to reach 65 percent coverage by June 2021 from a baseline of 15 percent.

Output 1.2: Improved quality of MIYCAN services at the health facilities level to reach 65 percent by June 2021 from a baseline of 20 percent.

Output 1.3: MIYCAN is promoted at all levels through mass-media and the use of new technologies to reach at least 50 percent of the population by June 2021.

Output 1.4: Improved MIYCAN law enforcement through advocacy and capacity building of key institutions. The target by 2021 is to have at least 50 percent of employers providing minimum requirement of maternity benefits (maternity leaves, breastfeeding breaks, breastfeeding corners at workplaces).

4.4.2 Key outputs and targets for Micronutrients outcome

Output 2.1: Increased access to food fortification (home and mass) for children aged 6-23 months, pregnant women and women of childbearing age by 2021. More specifically, increased proportion of districts with access to Micronutrient Powders (MNPs) from 10% in 2015 to 35% by 2021 and increased proportion of iron fortified flour produced in Tanzania from 36% in 2015 to 50% by 2021.

Output 2.2: Children receive regular supplementation of Vitamin A and deworming, with percentage of children receiving vitamin A supplementation increasing from 89% in 2015 and being sustained at least at 95% by 2021.

Output 2.3: Adequately iodised salt is available for households' consumption with an increased percentage of the edible salt produced in Tanzania which is iodized from 70% in 2014 to 80% by 2021.

Output 2.4: Children and women utilize improved services for anaemia reduction, reflected by an increased proportion of women 15-49 years of age who took iron and folic acid (IFA) supplementation during pregnancy for past birth from 9% in 2014 to 20% by 2021.

4.4.3 Key outputs and targets for IMAM outcome

Output 3.1: Improved quality of services for management of severe and moderate acute malnutrition in at least 75 percent of health facilities by 2021.

Output 3.2: At least 75 percent of children under five years old are reached through screening for severe and moderate acute malnutrition at community level by 2021.

Output 3.3: Essential therapeutic nutrition supplies and equipment are available in at least 90 percent of health facilities providing services for management of severe and moderate acute malnutrition by June 2021.

Output 3.4: Strengthened integration of

management of severe and moderate acute malnutrition at the national and subnational level by June 2021.

4.4.4 Key outputs and targets for DRNCDs outcome

Output 4.1: At least 50 percent of the school-age children and adult population are sensitized on the risk factors for NCDs by 2021.

Output 4.2: Policies, social, cultural and structural norms are established to enable at least 50% of the community to engage in healthy lifestyles by 2021.

4.4.5 Key outputs and targets for nutrition sensitive interventions outcome

Output 5.1: Communities have access to a diverse range of nutritious foods throughout the year.

Output 5.2: Communities regularly use quality maternal health, family planning prevention services and treatment of HIV and malaria.

Output 5.3: Communities and schools access adequate water, sanitation and hygiene services.

Output 5.4: Girls complete primary and secondary education.

Output 5.5: Poorest households benefit from TASAF conditional cash transfers, cash for work, and nutrition education during the community sessions.

Output 5.6: Vulnerable communities are able to cope with drought and climate change to avoid shortage of nutritious food during shocks.

4.4.6 Key outputs and targets for nutrition governance outcome

Output 6.1: The Government of Tanzania shows its commitment to nutrition through political engagement and increased funding.

Output 6.2: Government and partners coordinate multisectoral nutrition interventions efficiently and effectively at all levels.

Output 6.3: Nutrition personnel have sufficient capacities and support to effectively coordinate interventions at central and decentralized level.

4.4.7 Key outputs and targets for multisectoral nutrition information system outcome

Output 7.1: Robust systems of routine data collection, analysis, interpretation and feedback among stakeholders are in place at all levels.

Output 7.2: Relevant nutrition indicators integrated, collected and reported in national surveys.

Output 7.3: Capacities of nutrition stakeholders developed to align implementation of NMNAP with learning framework and carry out operational research.

4.5 Key strategies

4.5.1 Community-centred multisectoral approach as overarching strategy

81. Acknowledging that nutrition is a crosscutting issue that requires the effective contribution of multiple actors, sectors and administrative levels, the NMNAP is based on a national multisectoral strategic nutrition framework for planning, implementation and coordination. Thus, the **overarching strategy for the NMNAP is a community-centred multisectoral nutrition approach** that explicitly embraces simultaneous actions for nutrition specific interventions at the level of immediate causes and nutrition sensitive interventions at the levels of underlying and basic causes of malnutrition. A **multisectoral nutrition system** is composed of ***multiple sectors*** (e.g. agriculture, health, WASH (water, sanitation and hygiene), education, social protection, environment); ***multiple levels*** (national, regional, Local Government Authorities and importantly the community); and ***multiple partners*** (Government, development partners – UN/multi-laterals, bilaterals, NGOs, CSOs, academia and private sector). The multisectoral community-centred strategy is based on the overwhelming scientific evidence that achieving high coverage of the evidence-based high impact nutrition interventions (Lancet Nutrition Series 2008 and 2013) requires multisectoral harmonization and collaboration with key nutrition stakeholders.

4.5.2 Supportive cross-cutting strategies

82. The overarching multisectoral approach is complemented by several supportive strategies which are relevant and applicable to each of the seven key result areas. These include**: -**

1) **Social and Behaviour Change Communication (SBCC) for nutrition** through interpersonal communication and mass media to promote adoption of appropriated behaviours and practices and commitment to achieving common results for everyone and everywhere in the country for improved nutrition. The NMNAP will use the SBCC Strategy for 2013-2018.

2) **Advocacy and Social mobilization** to sustain political will and Government commitment for nutrition and to mobilise adequate resources for nutrition. Social mobilisation activities are important to create awareness of the problems of malnutrition among decision makers and community members to improve nutrition. For example, a 2013 landscape analysis by TFNC found that policy makers and communities do not perceive stunting and micronutrient deficiencies as problems to be addressed. Since many of the actions in advocacy and social mobilization require behavioural, attitude and practice changes by policy makers and communities for overall societal change all types of media need to be involved. Social mobilization will also increase the **participation of communities in the implementation of the NMNAP.** Since the key actors for improved nutrition are households and communities ensuring their active participation of communities is a critical success factor for the NMNAP.

3) **Community-Centred Capacity Development (CCCD):** The development of human, institutional and organizational capacity is critical in the implementation of the NMNAP especially at the community level. **Community participation** in doing their own triple A processes of assessment, analysis and action can be greatly enhanced by developing the capacity of the community and that of community-based organisations to support **social accountability** mechanisms *(see section 6.1 for definition of social accountability)*. Recognizing that communities constitute the greater whole of society and that they exist in relationship with society as a whole, development of capacity of communities should go hand in hand with developing capacity at the higher levels – council, district, region, national.

4) **Developing functional human resource capacity:** Although human resource technical capacity in nutrition is fairly adequate, functional capacity in communication skills, coordination and strategic leadership and management requires further development. System-wide development of nutrition relevant institutions, especially for TFNC as the institutional leader in the implementation of this NMNAP will be given priority. Institutionalization of the nutrition steering committees at all levels and developing their functional capacity will be further explored.

5) **Aligning all stakeholders with the NMNAP through Community-Public-Private Partnerships (C-PPP)** using the "three ONES principle" of ONE plan, ONE coordinating mechanism and ONE monitoring and evaluation framework, so that every stakeholder come together to tackle malnutrition and build an enabling environment for improved nutrition with equity**.** Capacities will be developed to conduct and manage C-PPPs as part of a collaborative leadership strategy. Forming strategic partnerships at all levels of the nutrition system will enhance coordination and accountability. Strategic collaboration, including the engagement of the private sector through implementation of appropriate principles of social and corporate responsibility, is likely to result in cost-efficiency and effectiveness and promote ownership and sustainability.

6) **Delivery of quality and timely nutrition services:** This NMNAP will promote the delivery of nutrition and nutrition-relevant services that are timely and of high quality. Tools will be put in place to assess the effective implementation and delivery of services, and where bottlenecks are

identified, remedial and corrective measures will be adopted including legal enforcement as appropriate.

7) **Mainstream equality in all the seven Key Result Areas of the NMNAP** without discrimination, **focusing on women, children and adolescent girls**. Although generally Tanzania has made good progress in empowering women, traditional patriarchal practices remain, that favour men, including in nutrition relevant practices, and are often reflected in both formal and informal systems and institutions especially in the rural areas.

8) **A resource mobilization strategy** will be developed to advocate for resource allocation to the NMNAP by both Government and partners.

9) **Tracking progress and operational research and development** will be promoted to ensure key lessons and insights gained from the implementation of the NMNAP are learnt and used in adjusting and improving the proposed interventions at regular intervals and linking research with programmes and training. Research will also provide quality assurance, robust data on program performance and support learning. Linking research to the programmes and to training will assure evidence-based sharing of experience and intergenerational transfer of knowledge. Efforts will be made to link the implementation of the NMNAP with nutrition-relevant centres of excellence both nationally and internationally.

10) Overall **planning and coordination** is a key strategy to align implementation of the NMNAP to achieve far greater results than what single sectors could achieve alone.

CHAPTER 5

COSTED ACTION PLANS TO SCALE UP NUTRITION INTERVENTIONS IN THE KEY RESULT AREAS OF THE NMNAP

COSTED ACTION PLANS TO SCALE UP NUTRITION INTERVENTIONS IN THE KEY RESULT AREAS OF THE NMNAP

5.1 Overview

83. This chapter summarizes the action plans for the first five of the seven key result areas (KRAs) categorized into "nutrition specific interventions" and "nutrition sensitive interventions". The nutrition specific intervention action plans are for (i) maternal, infant, young child and adolescent nutrition (MIYCAN), (ii) micronutrients, (iii) integrated management of acute malnutrition (IMAM), and (iv) diet related non-communicable diseases (DRNCDs). The nutrition sensitive Interventions (NSI) are for agriculture and food security; health and HIV; water, sanitation and hygiene (WASH); education and early childhood development; social protection; and environment and climate change. Enabling environment intervention action plans are in chapter 6 - action plan for multisectoral nutrition governance (MNG), and chapter 7 - action plan for the multisectoral nutrition information system (MNIS). Each KRA action plan starts with the policy objectives that the plan aims to achieve out of the 22 policy objectives of the 2016 Food and Nutrition Policy (FNP).

5.2 Costed action plans to scale-up nutrition specific interventions

5.2.1 Actions to scale-up maternal, infant, young child and adolescent nutrition (MIYCAN)

84. The proposed MIYCAN action plan is expected to address the following 2016 FNP objectives:

1) To improve and scale up access to quality nutrition interventions along the life course;
2) To improve adolescent and maternal nutritional care and support;
3) To improve infants' and young child nutrition.
4) To improve the nutrition status of vulnerable groups
5) To improve nutrition knowledge, behaviours, attitudes and practices for improved nutrition.

85. The MIYCAN action plan is based on the previous National Infant and Young Child Feeding (IYCF) strategy with the following important additions: promotion of optimal maternal and adolescent nutrition in key practices; an explicit multisectoral approach which will incorporate elements of health, WASH, early childhood development and adds new strategic stakeholders like local leaders, grandmothers, mothers-in-law and husbands.

86. Actions in the MIYCAN key results area will be progressively scaled-up geographically using two main criteria: (i) the burden of stunting in the regions; and (ii) the availability of funding and partners to support the regions.

87. As a result, the following groups of regions will be progressively covered by the action plan *(see figure 13 below for regional scaling-up prioritization per year)*:

1) First year (2016/17): Dodoma, Morogoro, Mbeya, Iringa, Songwe and Njombe;
2) Second year (2017/18): Geita, Kagera, Kigoma, Mwanza, Ruvuma, Shinyanga, Simiyu;
3) Third year (2018/19): Dar Es Salaam, Arusha, Manyara, Mara, Rukwa, Tabora, Tanga;
4) Fourth year (2019/20): Katavi, Kilimanjaro, Lindi, Mtwara, Pwani, Singida. By fourth year all regions will be covered.

88. *Table 5* shows the detailed workplan indicating outputs, activities, accountable and responsible institutions, and the timelines, while *table 6* shows the expected output results with the associated budget. *Figure 14* shows the budget trend.

Figure 13: Proposed regional prioritization of scaling-up of MIYCAN interventions per year

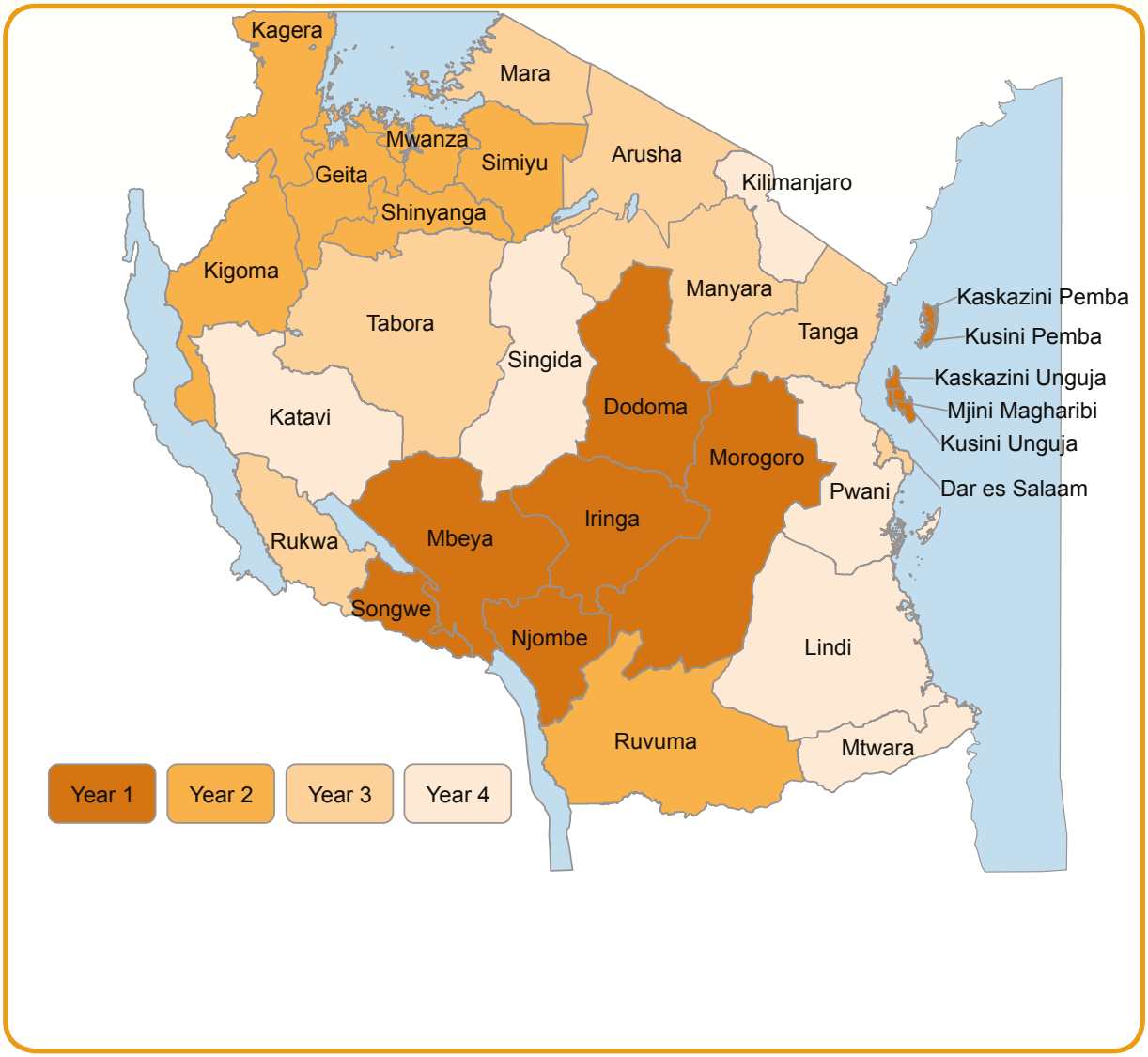


Table 5: Proposed workplan for MIYCAN with associated accountability and timeline

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1.1	Increased coverage and quality of MIYCAN services at the community level by June 2021																						
1.1.1	Review the integrated MIYCAN training packages and orient MDAs, Regional and district nutrition officers and Development partners on the packages	TFNC	MOHCDGEC, PORALG UN, PANITA, NGOs																				
1.1.2	Identify and train 2CHWs/village	PORALG	TFNC, NGOs, UN, MOHCDGEC																				
1.1.3	Map eligible households and conduct home visits, group counselling on MIYCAN and cooking demonstrations	PORALG,	LGA, NGOs TFNC																				
1.1.4	Develop supervision & monitoring tools for CHWs and conduct quarterly supportive supervision	TFNC	MOHCDGEC, PORALG, NGOs																				
1.1.5	Conduct quarterly behaviour change edutainment activities at ward level and social mobilization for MIYCAN at village level every six months	PORALG	TFNC, CSOs																				
1.2	Improved quality of MIYCAN services at the health facilities level by June 2021																						
1.2.1	Review the MIYCAN content of the existing pre service curricula for nurses and doctors	MOHCDGEC	PORALG, TFNC, UN, Academia, NACTE, TEA, MOESTVT																				
1.2.2	Develop nutrition standard of service for inclusion in the health facility standard	MOHCDGEC	PORALG, TFNC, UN, Academia, NGOs																				
1.2.3	Conduct in-service training to health service providers (HSPs) on SBCC for MIYCAN and Growth Monitoring using the New WHO Growth	MOHCDGEC	TFNC, PORALG, UN, Academia, NGOs																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	charts/cards																						
1.2.4	Review supportive supervision tools and include SBC for MIYCAN in the quarterly supportive supervision at facility level	MOHCDGEC	TFNC, PORALG, NGOs, , UN, Academia																				
1.2.5	Review BFHI tools and guidelines, train health workers and conduct BFHI assessment	MOHCDGEC	PORALG, NGOs, TFNC, UN, Academia																				
1.2.7	Review quality assurance protocol of HFs and advocate to incorporate BFHI status	MOHCDGEC	PORALG, TFNC, UN, Academia, NGOs																				
1.3	MIYCAN is promoted at all levels through mass-media and the use of new technologies by June 2021																						
1.3.1	Prepare a national MIYCAN briefing kit for journalists	TFNC	MOHCDGEC, PMO, PORALG, Media houses, PANITA, NGOs																				
1.3.2	Conduct press conference and media seminar MIYCAN and other relevant nutrition issues for journalists and editors	TFNC	MOHCDGEC, PMO, PORALG, Media houses, PANITA, NGOs																				
1.3.3	Advocate for nutrition through ambassadors / celebrities	TFNC	MOHCDGEC, PMO, PORALG, Media houses, PANITA, NGOs																				
1.3.4	Support the World Breastfeeding Week every year to advocate appropriate child feeding practices	TFNC	MOHCDGEC, PMO, PORALG, Media houses, PANITA, NGOs																				
1.3.5	Design and broadcast MIYCAN programs and messages through TV, radios, cell phones, social	TFNC	MOHCDGEC, PMO, PORALG,																				

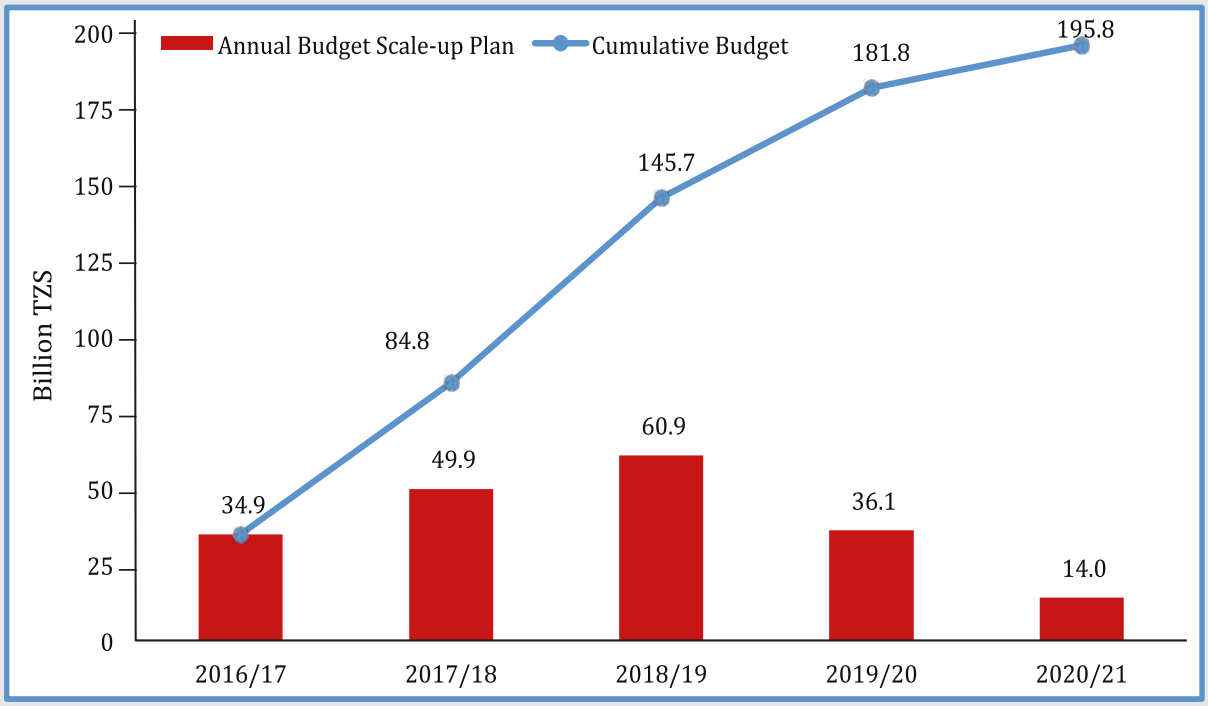
	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	medias and gathering (busses, football games, concerts)		Media houses, PANITA, NGOs																				
1.3.6	Conduct quarterly network meetings with private media and communication companies to strengthen synergies at national and regional level	TFNC	Media houses, PANITA, NGOs																				
1.4	Improved MIYCAN law enforcement through advocacy and capacity building of key institutions																						
1.4.1	Establish status of implementation, prepare a business case and advocate for enforcement of the three months maternity leave; create awareness on maternity protection in formal/informal sectors	TFNC	TFDA, UN, MoLED, PANITA, NGOs, ATE																				
1.4.2	Sensitize private commercial partners on compliance with regulation and standards for IYCF products	TFNC	PORALG, MOHCDGEC, , TBS, TFDA, UN, MoLED, PANITA, NGOs, ATE																				
1.4.3	Develop a Swahili booklet of BMS regulations; Create awareness and advocate for monitoring of the regulations at all levels.	TFNC	TFDA, UN, MoLED, PANITA, NGOs, ATE																				

Table 6: Financial requirements of the MIYCAN action plan disaggregated by expected results (Outcome and outputs)

Expected Results		Budget in Billion TZS						Total Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 1:	Increased proportion of adolescents, pregnant women and mothers / caregivers of children under two years who practice optimal maternal, infant and young child nutrition behaviours	34.9	49.9	60.9	36.1	14.0	195.8	89.0
Output 1.1:	Increased coverage and quality of MIYCAN services at the community level by June 2021	23.8	38.1	46.7	26.1	10.6	145.4	66.10
Output 1.2:	Improved quality of MIYCAN services at the health facilities level by June 2021	10.2	10.7	13.2	9.2	2.5	45.8	20.83
Output 1.3:	MIYCAN is promoted at all levels through mass-media and the use of new technologies by June 2021	0.6	0.6	0.6	0.6	0.6	2.9	1.30
Output 1.4:	Improved MIYCAN law enforcement through advocacy and capacity building of key institutions	0.3	0.5	0.3	0.3	0.3	1.7	0.78

**: Exchange rate 1 USD = 2200 TZS

Figure 14: Estimated budget and trend for maternal, infant, young child and adolescent nutrition



5.2.2 Action plan to promote optimal intake of essential micronutrients

89. The 2016 Food and Nutrition Policy objectives which are covered by the micronutrient KRA action plan are: -

1) To improve and scale up access to quality nutrition interventions along the life course;
2) To improve infants' and young child nutrition.
3) To reduce the prevalence of micronutrient deficiencies in the population.
4) To improve the nutrition status of vulnerable groups

90. Multi-sectorial approaches are necessary to address micronutrient malnutrition and provide long-term sustainable improvements in the availability and consumption of adequate vitamins and minerals in the diet. It has become increasingly appreciated that universal approaches may not be appropriate in all settings, and it is important that the design of a portfolio of interventions take into consideration the key factors which lead to the deficiencies in the first place. Efficacious interventions should be combined and adapted to meet the needs and context.

91. Evidence based interventions to address micronutrients deficiencies include both nutrition-specific and nutrition-sensitive interventions. These include **supplementation, fortification and dietary diversification** enhancements which focus on increasing the supply, availability and utilization of foods rich in vitamins and minerals, bio-diversification, improved dietary behaviours and care, emphasizing infant and young child feeding practices. **Public health measures** such as deworming, immunization especially for measles and control of diarrhoea through safe water, sanitation and hygiene reduce the risk of micronutrient losses from the body and increase the bioavailability and absorption of the nutrients consumed. Such activities need to be complimented by a strong enabling environment with robust political commitment, policies and regulatory mechanisms as well as an awareness amongst policy makers, health care providers, caregivers and the public at large about the importance of micronutrients and strategies available to ensure optimal intake.

92. In order to arrest the intergenerational vicious cycle of micronutrient deficiency, there is a need for particular attention on adolescent girls, both in terms of encouraging their participation in schools as well as to target communications to increase their knowledge and adopt appropriate positive dietary behaviours. These will increase their intake of vitamins and minerals, building stores as they get older, married and increase the likelihood of a positive pregnancy outcome.

93. The Micronutrients Action Plan has been developed with four complementary components, three of which focus on individual nutrients and one which aims to fill the gap for multiple vitamins and minerals. These components are: -
    1) Filling the micronutrient gap
    2) Improved vitamin A status
    3) Improved iodine status
    4) Improved iron and folate status and overall prevention of anaemia

94. Taken together, these four components aim to scale-up and increase the reach of interventions which have been in place, recognizing and addressing constraints in their effective delivery, as well as broadening the landscape to include emerging approaches. For the former, comprehensive situation analyses will be carried out to identify and inform specific opportunities for program improvement. For the latter, the NMNAP will explore the feasibility of innovative and novel strategies, such as multiple-crop bio-fortification and activities to reach adolescent girls, initially through pilot studies to define implementation guidance and then slowly expanding to other regions of the country. Actions to develop multiple crop bio-fortification are integrated in the section 5.3.1 related to nutrition sensitive agriculture and food security.

95. The key actions and timeline for preventing and managing micronutrient deficiencies are shown by output in *table 7*, the budget in *table 8* and the annual budget trend in *figure 15* below. *Figure 16* shows the proportional budget planned for the five components of the micronutrient action plan.

Table 7: Proposed activities and timeline to promote optimal intake of essential micronutrients

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
2.1	Increased access to fortified food (home and mass) for children aged 6-23 months, women of childbearing age and pregnant women in by 2021																						
2.1.1	Advocate and develop guidelines for multiple micronutrients supplements	TFNC	MOHCDGEC, PORALG, MoALF, MOEST, MOI, Private Sector, DPs																				
2.1.2	Review of the National Micronutrient Powder guidelines for home fortification	MOHCDGEC	TFNC, TFDA, PORALG, TBS, NFFA, DPs, Private Sector, DPs																				
2.1.3	Procurement of Micronutrient sachets for Scaling-up of Home Fortification Programme in 3 Regions	MOHCDGEC	PO-RALG, TFNC , TFDA, TBS; DP, Private Sector																				
2.1.4	Conduct mapping for large, medium and small scale cereal based millers for fortification	TFNC	PORALG, MOHCDGEC, TFDA, Private Sector, DPs																				
2.1.5	Conduct training for large, medium and small scale cereal based millers on product quality control/assurance during fortification	TFNC	TFDA, TBS, MOHCDGEC, PORALG, Private Sector, DPs																				
2.1.6	Conduct public campaigns through radio and TV programmes on the importance of consumption of micronutrient rich/fortified foods	TFNC	NFFA, TFDA, TBS, MOALF MOHCDGEC, DPs, Private Sector,																				
2.1.7	Promote and engage more Oil mills to fortify Oil with Vitamin A, particularly SMEs	PORALG	MOHCDGEC, TFNC, , NGOs, Private Sector																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
2.2	Enhanced services for Vitamin A supplementation among children aged 6-59 months by 2021																						
2.2.1	Train health care providers on Child Health and Nutrition Month	PORALG	TFNC, DPs, MOHCDGEC,																				
2.2.2	Conduct public campaigns on Vitamin A supplementation through Radio/TV programmes, SBCC materials, road shows, celebrities/artists and phone messaging	TFNC	TFNC, MOHCDGEC, MOALF, TFDA, LGA																				
2.2.3	Conduct media seminars on Vitamin A and its prevention to journalist and editors and media owners	PORALG	TFNC, MOHCDGEC, LGA																				
2.3	Increased availability of adequately iodized salt by 2021																						
2.3.1	Sensitize LGA including members of regional defence and security on the importance of community consumption of iodized salt and enforcement of the salt law and regulations	TFNC	MOHCDGEC, TASPA, PORALG, DPs, TBS, TFDA																				
2.3.2	Register salt producing sites, whole sellers and vendor groups in all districts	TFNC	MOHCDGEC, DPs, MEM, TASPA, TBS, TFDA, MITI																				
2.3.3	Undertake a salt situation analysis including production of iodized salt/food	TFNC	MOHCDGEC, DPs, MEM, TASPA, TBS, TFDA, MITI																				
2.3.4	Support and strengthen existing TASPA's KIO3 cost-recovery model	TFNC	MOHCDGEC, DPs, MEM, TASPA, TBS, TFDA, MITI																				
2.3.5	Support and strengthen the formation of small scale salt producer (SSSP) groups	TFNC	MOHCDGEC, DPs, MEM, TASPA, TBS,																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
			TFDA, MITI																				
2.3.6	Sensitize Local government officials (DNuOs, DHOs, Ward Health Officers and CHW/VHWs) to support salt monitoring and law enforcement	TFDA	MOHCDGEC, PORALG, TASPA, TBS, TFDA, TFNC																				
2.3.7	Conduct regular salt monitoring and inspections in all salt producing/processing sites, importers, wholesalers, retailers, and salt vendors according to the Act and salt regulations	PORALG	MOHCDGEC, TASPA, TBS, TFDA, TFNC																				
2.3.8	Procure and distribute test kits, WYD machines and reagents in all councils country wide	TFNC	MOHCDGEC, DPs, TASPA, TFDA																				
2.3.9	Train council health staff including laboratory technicians in the use of WYD iodine checker machines in district hospitals	TFNC	MOHCDGEC, TASPA, TBS, TFDA																				
2.3.10	Undertake formative research to identify barriers and motivating factors that influence behaviours which increase demand for iodized salt	TFNC	PORALG, MOHCDGEC, MEM, TASPA, TBS, TFDA, MITI																				
2.3.11	Sensitize community on importance of consuming adequately iodized salt through community social gatherings	TFNC	PORALG, MOHCDGEC, DPs, MEM, TASPA, TBS, TFDA, MITI																				
2.3.12	Conduct media seminars on IDD and its prevention to journalist and editors and media owners including preparation of briefing kit to journalist, editors and media owners	TFNC	PORALG, MOHCDGEC, MEM, TASPA, TBS, TFDA, MITI																				
2.4	Improved anaemia prevention and control interventions among women of childbearing age and children under 5 years old by 2021																						
2.4.1	Conduct sensitization meetings with community leaders on importance of production and consumption of iron/folate rich foods, use of bio-	TFNC	MOHCDGEC, PORALG, NGOs, DPs																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	fortified food crops and raising small animals																						
2.4.2	Conduct public campaigns through mass media on the importance of consumption of iron/folate rich foods and deworming	TFNC	MOHCDGEC, PORALG, NGOs, DPs																				
2.4.3	Conduct training of HSPs and CHWs on control and prevention of anaemia in pregnant women, adolescent girls and children under five	MOHCDGEC	TFNC PORALG, NGOs, DPs																				
2.4.4	Undertake assessment of current IFA supplementation program and factors associated with compliance among pregnant women attending antenatal clinics	MOHCDGEC	TFNC, DPs MOHCDGEC, LGA, NGOs, Media, MOE																				

Table 8: Financial requirements of the micronutrient action plan disaggregated by expected results (Outcome and outputs)

Expected Results		Budget in Billion TZS						Total Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 2:	Children, adolescents and women of child bearing age consume adequate micronutrients	21.9	23.4	24.3	25.3	24.9	119.8	54.46
Output 2.1:	Increased access to food fortification (home and mass) for children aged 6-23 months, pregnant women and women of childbearing age by 2021	15.9	16.3	17.0	17.9	17.7	84.8	38.54
Output 2.2:	Enhanced services for Vitamin A supplementation among children aged 6-59 months by 2021	3.2	3.4	3.4	3.4	3.2	16.6	7.54
Output 2.3:	Increased availability of adequately iodized salt in by 2021	0.98	1.53	1.71	1.72	1.55	7.48	3.40
Output 2.4:	Improved anaemia prevention and control interventions among women of childbearing age and children under 5 years old by 2021	1.85	2.24	2.27	2.25	2.36	10.96	4.98

Figure 15: Annual distribution of budget for micronutrient action plan

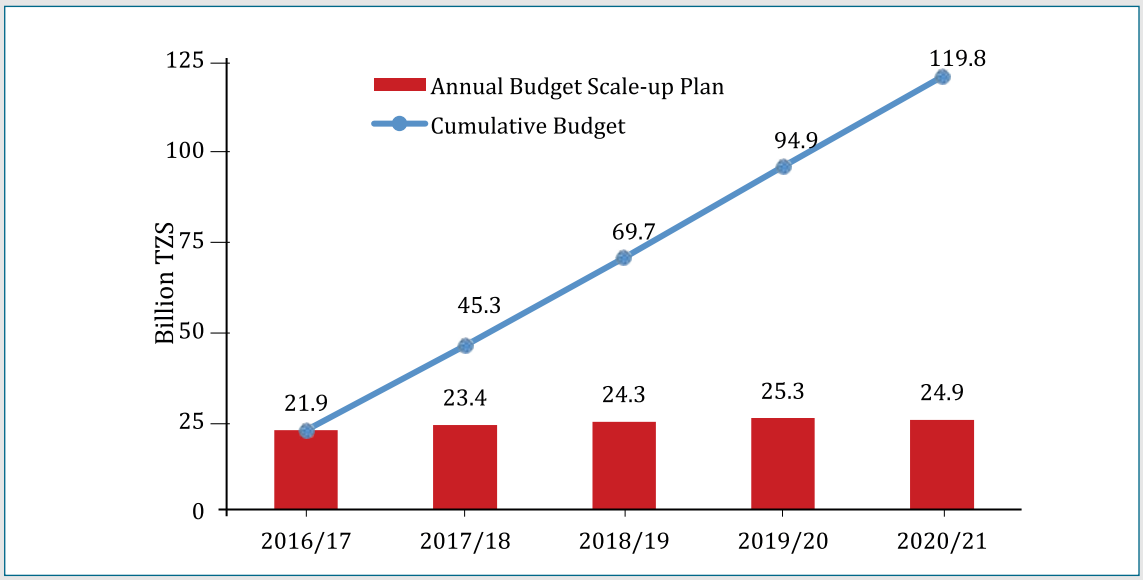
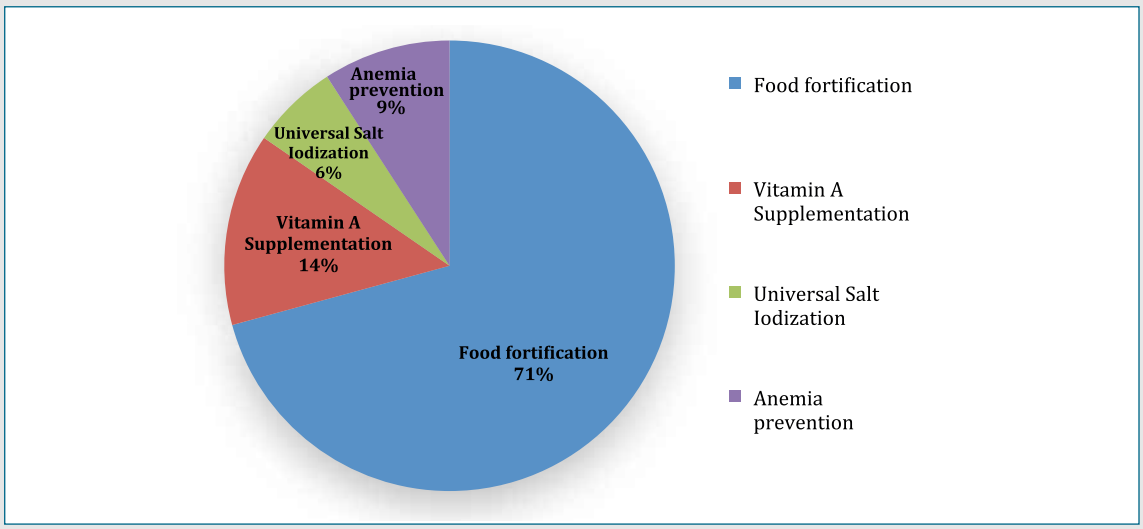


Figure 16: Proportional budget distribution for the micronutrient plan components



5.2.3 Action plan to scale-up the integrated management of acute malnutrition (IMAM)

96. The IMAM action plan will address the following policy objectives of the 2016 Food and Nutrition Policy: -

1. To improve the nutrition status of vulnerable groups
2. To improve infants'and young child nutrition.
3. To provide appropriate nutritional care and support to communities during emergencies and disasters;

97. This scale-up action plan aims to institutionalise quality IMAM services in Tanzania and strengthening the links between communities and health facilities across the continuum of care. By simultaneously targeting severe and acute malnutrition, life-saving interventions for the treatment of acute malnutrition will be implemented whilst broadening efforts to prevent moderate acute malnutrition (MAM) from progressing into the more serious condition of severe acute malnutrition (SAM). All outputs and activities – apart from procurement and distribution of supplies for IMAM – will be developed and jointly delivered to manage severe and moderate acute malnutrition.

98. The key actions and timelines are shown in *table 9;* the planned budget in *table 10* and the annual budget distribution in *figure 17* below.

Table 9: Proposed activities and timeline for integrated management of acute malnutrition (IMAM)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
3.1	Improved quality of services for management of severe and moderate acute malnutrition in at least 75 percent of health facilities by 2021																						
3.1.1	Develop/update pre-service IMAM training curriculum and revise in-service IMAM training package (guidelines, protocol, monitoring tools and job aids)	TFNC	UN, DPs, MUHAS, SUA, NACTE, TCU, MOHCDGEC																				
3.1.2	Revise in-service IMAM training package (guidelines, protocol, monitoring tools and job aids)	TFNC	UN, TCU MUHAS, SUA NACTE, NGOs, MOHCDGEC, PORALG																				
3.1.3	Train a national team of trainers (ToT) on IMAM	TFNC	UN, MUHAS, MOHCDGEC, PORALG																				
3.1.4	Train two Health service providers per lower facility level (OTC) and for 4 at hospital level on IMAM	PORALG	TFNC, NGOs, MUHAS																				
3.1.5	Conduct quarterly supportive supervision of health service providers on application of the IMAM protocol	PORALG	LGA, NGOs																				
3.1.6	Establish an HR training database on IMAM	TFNC	MOHCDGEC																				
3.2	At least 75 percent of children under five years old are reached through screening for severe and moderate acute malnutrition at health facility level and at community level by 2021																						
3.2.1	Develop a comprehensive community outreach and mobilization package to address negative social norms, IMAM barriers, early SAM/MAM detection and treatment	TFNC	UN, MOHCDGEC, PORALG																				
3.2.2	Train community health workers on IMAM community outreach and mobilization package	TFNC	RS, LGA, NGOs,																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
3.2.3	Conduct quarterly screening and timely referral for eligible SAM and MAM children at all levels	LGA	NGOs, LGA																				
3.2.4	Support referral of SAM and MAM cases to relevant health facilities via cell phones	LGA	NGOs, LGA																				
3.2.5	Conduct quarterly supervision of trained community health workers	LGA	LGA NGOs																				
3.3	Essential therapeutic nutrition supplies and equipment are available in at least 90 percent of health facilities providing services for management of severe and moderate acute malnutrition by June 2021																						
3.3.1	Integrate IMAM therapeutic nutrition supplies into central procurement logistics system (ILS)	TFNC	MOHCDGEC, TFNC, MSD, PORALG, DPs																				
3.3.2	Harmonize clearance procedures for IMAM therapeutic commodities amongst the different regulatory bodies and revise the existing MoU on supplies	TFNC	Regulatory boards, DPs, UN, TFDA TFNC, MSD																				
3.3.3	Procure RUTF, therapeutic milk, medicines, anthropometric material, tools and equipment for IMAM annually	MOHCDGEC	TFNC, MSD, TFDA UN																				
3.3.4	Purchase commodities for outreach services (cell phones, badges, rain coats and bicycles) annually	TFNC	Development Partners																				
3.3.5	Train regional and district supply officers / pharmacists / pharmaceutical technicians on IMAM supply chain management annually	TFNC	MSD, UN, NGOs																				
3.4	Strengthened integration of management of severe and moderate acute malnutrition at the national and subnational level by June 2021																						
3.4.1	Conduct advocacy with the Government and Development Partners to ensure adequate funding and prioritization of IMAM in Tanzania	TFNC	PORALG, MOHCDGEC, DPs																				

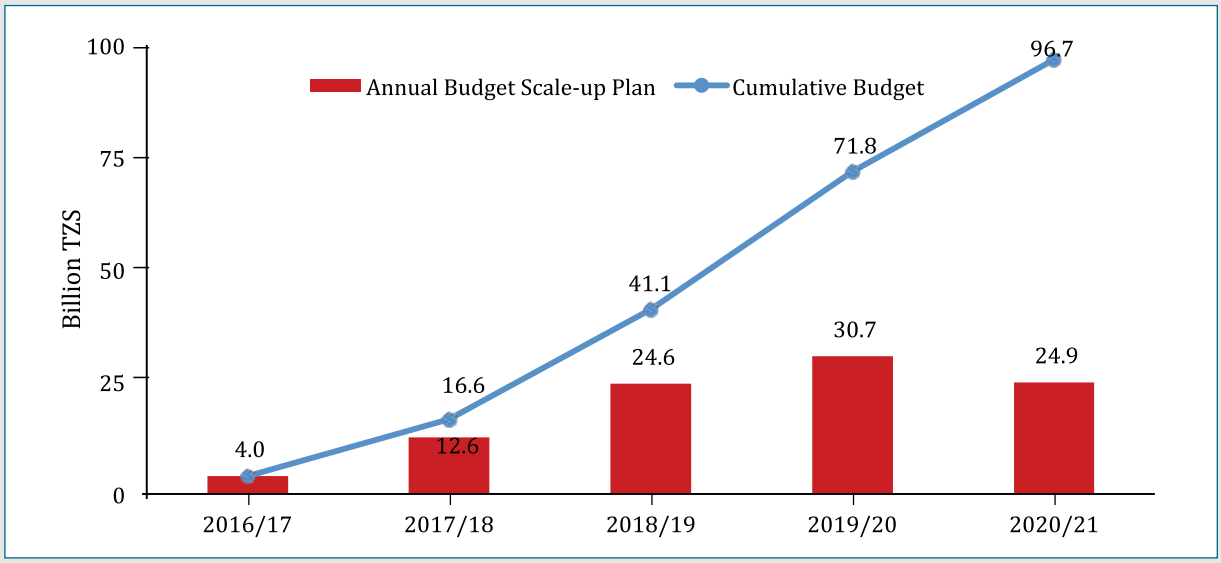
	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
3.4.2	Support the National Consultative Group on IMAM	TFNC	UN																				
3.4.3	Support Zonal meeting on IMAM annually	TFNC	UN & DPs, PORALG																				
3.4.4	Integrate IMAM into the agenda of the District Nutrition Steering Committee (within CHMT)	RNSC	TFNC, PORALG																				
3.4.5	Integrate IMAM in health facilities package	TFNC	MOHCDGEC																				

Table 10: Financial requirements of the IMAM action plan disaggregated by expected results (Outcome and outputs)

Expected Results		Budget in Billion TZS						Total in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 3:	Increased coverage of integrated management of severe and moderate acute malnutrition by 2021	4.0	12.6	24.6	30.7	24.9	96.7	43.94
Output 3.1:	Improved quality of services for management of severe and moderate acute malnutrition in at least 75% of health facilities by 2021	1.5	2.0	2.4	2.2	1.3	9.3	4.23
Output 3.2:	At least 75% of children under five years old are reached through screening for severe and moderate acute malnutrition at community level by 2021	0.1	2.4	4.0	6.4	7.2	20.1	9.16
Output 3.3:	Essential therapeutic nutrition supplies and equipment are available in at least 90% of health facilities providing services for management of severe and moderate acute malnutrition by June 2021	2.4	8.1	18.0	22.1	16.4	67.1	30.48
Output 3.4:	Strengthened integration of management of severe and moderate acute malnutrition at the national and subnational level by June 2021	0.024	0.024	0.049	0.024	0.024	0.15	0.07

**: Exchange rate 1 USD = 2200 TZS

Figure 17: Annual budget distribution for integrated management of malnutrition (IMAM) action plan



5.2.4 Action plan to prevent and manage diet-related non-communicable diseases (DRNCDs)

100. The DRNCDs action plan aims to achieve the following policy objectives of the 2016 Food and Nutrition Policy: -

1) To strengthen prevention and management of diet related non-communicable diseases (DRNCDs);
2) To improve and scale up access to quality nutrition interventions along the life course;
3) To improve the nutrition status of vulnerable groups.

101. The DRNCDs action plan proposes a series of feasible and cost-effective interventions aimed at contributing to achieving the voluntary global World Health Assembly (WHA) NCD targets in Tanzania, including addressing unhealthy diets, physical inactivity, harmful use of alcohol and tobacco use. **The interventions include:**

1) Increasing community awareness on preventive measures and early diagnosis of NCDs;
2) Creating an enabling environment for healthy lifestyles including incentives for producing and buying healthier foods and building and organizing cities to encourage physical activity;

102. The plan will promote the notion that **being physically active for at least 30 minutes a day, in any way**, in addition to reducing weight, decreases the risk of several diet related non-communicable diseases including diabetes, hypertension, heart diseases and several types of cancers. Activity helps prevent the build-up of fat, a risk factor for obesity. It increases blood flow, thus preventing the build-up of blood clogging cholesterol in the blood vessels, and therefore, reducing the risk to hypertension and heart diseases. By regulating blood levels of hormones that contribute to the development of diabetes and cancer risk; and by speeding up food through the colon, physical activity reduces exposure risk to dietary carcinogens (cancer causing agents). Physical activity and many of the other actions that prevent NCDs like stopping smoking and drinking alcohol in moderation also increase longevity. These actions need to be adopted by individuals themselves, while population level actions are mainly done to create an enabling environment.

103. The key activities identified for the DRNCDs action plan at the population level and their timeline are shown in *table 11*, the planned budget in *table 12* and the annual budget distribution in *figure 18* below. However, it is important to note that most of the actions to address NCDs will be covered in section 5.3.2 on nutrition sensitive interventions in the health sector.

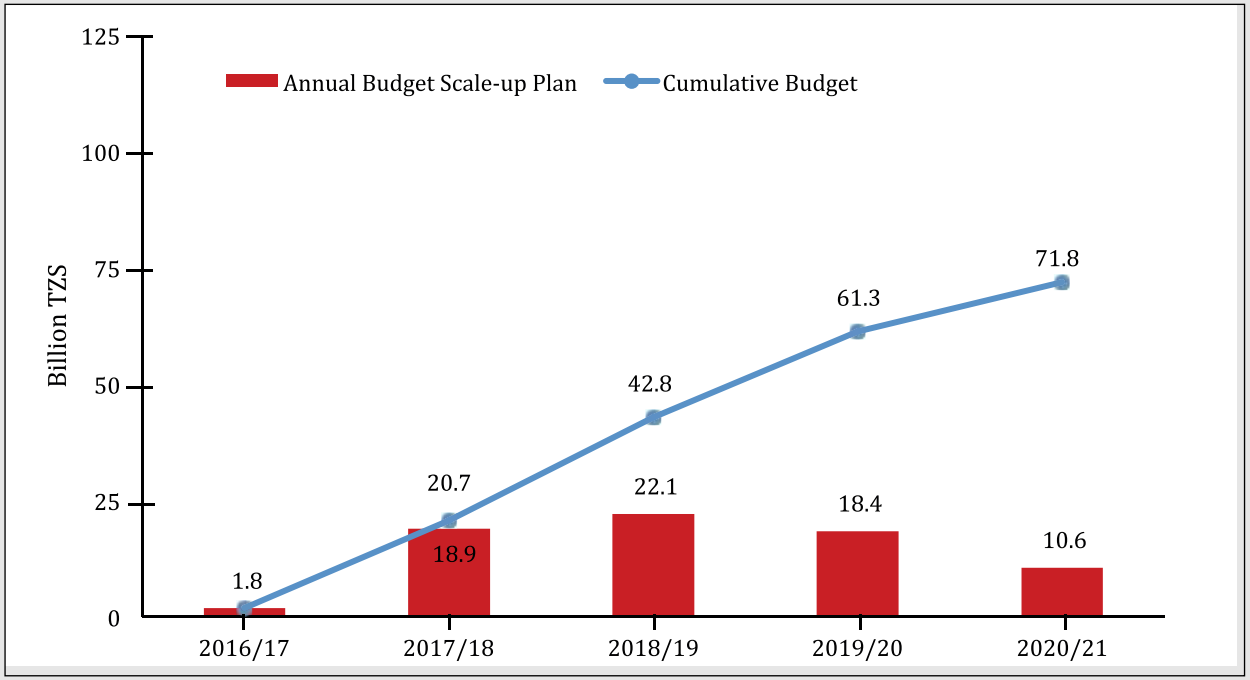
Table 11: Proposed activities and timeline to prevent and manage diet-related non-communicable diseases (DRNCDs)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
4.1	At least 50 percent of the school-age children and adult population are sensitized on the risk factors for NCDs by 2021																						
4.1.1	Review/develop and validate and print comprehensive guidelines (for community, clinical and e-learning) on healthy lifestyles for Tanzania	TFNC	MOHCDGEC, MUHAS, SUA, MoESTVT, MALF, PORALG				■	■	■														
4.1.2	Train Health Care Providers on Diet and Nutrition Related Non-communicable Diseases at all levels	TANCDA	TFNC, MUHAS, LGA, APHFTA, NGOs					■	■	■	■	■	■	■	■	■	■						
4.1.3	Conduct sensitization seminars on healthy lifestyles to journalists, editors and media owners	MOHCDGEC	MUHAS, SUA, MoESTVT, MALF, PO-RALG, TANCDA						■	■	■	■	■	■	■								
4.1.4	Conduct public awareness campaigns to inform the community about healthy lifestyles for all ages including pregnancy (Advertising and publication) at national and 30 regions	MOHCDGEC	MUHAS, SUA,TBS, TFDA, MoESTVT, MALF, PORALG, TANCDA					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
4.1.5	Sensitize food vendors/hoteliers, school children and employees in work places on healthy lifestyles	TFNC	MoHCDGEC, MEDIA, LGA, MoESTVT, TANCDA						■														
4.2	Policies, social, cultural and structural norms are established to enable at least 75 percent of the community to engage in healthy lifestyles by 2021																						
4.2.1	Sensitize policy makers, urban planners and highway and road designers on healthy lifestyles	MOHCDGEC	TFNC, MoLHS, MoWTC LGA, TFDA, PARLIAMENT, PO-RALG, TANCDA					■	■			■				■				■			
4.2.2	Develop/review standards and bylaws and sensitize law enforcers on issues related to healthy lifestyles	MOHCDGEC	TBS, TANCDA, TFNC, TFDA, TPHA					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Table 12: Financial requirements of the DRNCDs action plan disaggregated by expected results (Outcome and outputs)

Expected Results		Budget in Billion TZS						Total Budget in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 4:	Communities in Tanzania are physically active and eat healthy	1.8	18.9	22.1	18.4	10.6	71.8	32.65
Output 4.1:	At least 50% of the school-age children and adult population are sensitized on risk factors for non-communicable diseases by 2021	0.04	17.0	20.3	16.6	8.7	62.7	28.48
Output 4.2:	Policies, social, cultural and structural norms are established to enable at least 50% of the community to engage in healthy lifestyles by 2021	1.8	1.9	1.8	1.8	1.8	9.2	4.17

Figure 18: Annual budget distribution for the diet-related non-communicable diseases (DRNCDs) action plan



5.3 Costed action plans to strengthen nutrition sensitive interventions (NSI)

105. Nutrition-sensitive interventions can help enhance the penetration and impact of nutrition-specific interventions by creating a stimulating environment in which young children can grow and develop to their full potential and adults become more productive. Different sectors can take practical steps to develop nutrition sensitive policies, strategies and programmes. To make them nutrition-sensitive, sectors should:

1) Strengthen their nutrition focused goals, design, and encourage greater integration in implementation. For example, food security programmes can explicitly articulate their nutrition goals, adopt agricultural practices that diversify nutrient content and integrate their work with micronutrient programmes.
2) Improve targeting, timing, and duration of exposure to interventions. For example, integrating nutrition into safe water and sanitation programmes that reach families with pregnant and lactating women and children between 0 and 24 months of age will reduce the risk of diarrhoea.
3) Use conditions to stimulate demand for human capital development, while ensuring delivery of quality services. For example, cash transfer programmes provide cash to extremely poor households to ensure access to health, education services and food security like the Tanzania Social Action Fund (TASAF's) Productive Social Safety Net (PSSN) programme.
4) Optimise focus on women's nutrition and empowerment. For example, when programmes are designed from the outset to increase women's decision-making power, it can increase investments in better nutrition for the whole family. Education of girls, enforcement of laws against teenage marriages are other examples.

106. The NMNAP identified nutrition sensitive actions in the following sectors: agriculture and food security; health and HIV; water, sanitation and hygiene (WASH); education and early childhood development; social protection; and environment and climate change. The NMNAP recognizes that there are already ongoing activities being implemented by these sectors which are nutrition sensitive and these are encouraged to continue. In order to support these sectors to strengthen the alignment of these activities with the NMNAP, the NMNAP proposes holding of sector-specific workshops that will impart knowledge and skills in nutrition sensitive programming for sector planners and decision makers. Such an activity is planned under the Multisectoral Nutrition Governance (MNG) action plan that will "review sector policies and plans to make them more nutrition sensitive."

5.3.1 Actions to strengthen nutrition sensitive interventions in agriculture and food security

107. The proposed actions aim to address the following 2016 Food and Nutrition Policy objectives: -

1) To improve household food security.
2) To improve food safety and quality for enhancement of nutrition status at individual, household and community level.

108. The key actions in Agriculture and Food security aim to ensure **communities have access to a diverse range of nutritious food throughout the year.** It involves increased production of diversified nutritious foods using modern technological methods, bio-diversification, post-harvest prevention of losses and quality (e.g. addressing the issue of mycotoxin contamination especially of aflatoxins), promotion of agro-industries to add value and finding easy access to markets. Other complementary measures include the promotion of consumption of these foods, agriculture extension training and improving food safety. All these are already included in the Agriculture and Food Security sector in the 5-Year Development Plan 2016/17-2020/21 and this NMNAP will promote linkages with its objectives.

109. **The key actions and timelines** to strengthen nutrition sensitive agriculture and food security are shown in *table 13* below.

Table 13: Proposed activities and timeline to strengthen nutrition sensitive interventions in agriculture and food security sector plans (source: FYDP 2016-2021)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.1	Communities have access to a diverse range of nutritious food throughout the year																						
5.1.1	Maize: Increase use of modern technology	MALF	PORALG																				
5.1.2	Rice: Project for supporting rice industry Development in Tanzania	MALF																					
5.1.3	Rice: Linking Kilombero Plantation Limited commercial Farm with smallholder farmers	MALF																					
5.1.4	Pulses: Stakeholders skill building throughout the different stages of the value chain.	MALF																					
5.1.5	Pulses: Scale up production and trade by strengthening Public -Private Partnership for seed development, access to finance, and technology transfer and farmer support services	MALF																					
5.1.6	Extension officers: Providing training to the farmers and improving cultivation practices through increasing the number of extension officers	MALF																					
5.1.7	Women and youth empowerment through agriculture	MALF																					
5.1.8	Market availability for crops: Construction of strategic markets at the borders, improving and empowering corporative unions	MALF																					
5.1.9	Market availability for crops: Encouraging cooperative unions and private sector to establishing agro processing industries	MALF																					
5.1.10	Skills development for improved livestock productivity	MALF																					
5.1.11	Regulatory Framework for Animal Health services	MALF																					
5.1.12	Beef and others: Meat quality and marketing improvement	MALF																					

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.1.13	Beef Industry Development	MALF																					
5.1.14	Poultry: Establishment of Multi-Stakeholder innovation Platforms (MSIP)	MALF																					
5.1.15	Dairy: School milk feeding programme	MALF																					
5.1.16	Deep sea fishing	MALF																					
5.1.17	Sea fishing	MALF																					
5.1.18	Aquaculture	MALF																					
5.1.19	Empowerment of artisanal fishers	MALF																					
5.1.20	Promote multiplication of seeds, seedlings and cuttings of nutrient rich varieties (Orange fleshed sweet potatoes, high protein maize and cassava and vitamin A rich bananas) and distribute to farmers	MALF	TFNC, PORALG, DPs,, NGOs, Private Sector																				
5.1.21	Promote small scale livestock keeping and fish farming for domestic consumption in regions with high prevalence of malnutrition	MALF	TFNC, PORALG, DPs, Private																				
5.1.22	Promote the use of appropriate technology, such as milling machines, solar dryers, and irrigation to reduce women's workloads and increase food availability	MALF/MIT	SIDO, PORALG, TFNC, TFDA, TB, DPs																				
5.1.23	Promote consumption of bio-fortified and high nutrient value food varieties at community level to increase nutrient intake	MALF	PORALG, TFNC, DPs, Private																				
5.1.24	Conduct training to large and small scale food processors on value addition to ensure availability and consumption of diverse, nutritious food at community level	MALF	SIDO, PORALG, TFNC, TFDA, TBS, DPs																				
5.1.25	Promote food safety and quality throughout the food supply chain to reduce consumption of unsafe food	MALF	LGA, TFNC, DPs, NGOs, TFDA, TPRI																				
5.1.26	Conduct social and behaviour change	MOHCDGE	PORALG,																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	communication to increase production and consumption of diverse range of nutritious food at community level	C	MALF, NGOs,, Private sector																				
5.1.27	Train agricultural officers as TOTs of agricultural extension workers on production of nutritious food crops	MALF	MoFP, NGOs, TASAF, DPs																				
5.1.28	Review certificate and diploma curricula in Agriculture, Livestock and Fisheries training to improve the existing nutrition components	MALF	TFNC, Training institutions, Professional bodies, DPs																				

NB: Activities in italic are additional activities identified by NMNAP task team as they were not included in sectoral plan

5.3.2 Actions to strengthen nutrition sensitive interventions in health and HIV sectoral plans

111. Actions in this area are aimed at addressing the following strategic policy objectives of the 2016 Food and Nutrition Policy: -

1) To improve nutritional care and support for people living with HIV and AIDS and their households;
2) To improve the nutrition status of vulnerable groups

112. Actions in the health sector aim at strengthening the nutrition component of the ongoing Health Sector Strategic Plan IV (HSSP-IV), which also addresses HIV and AIDS; NCDs; mental health; malaria; maternal, newborn and reproductive health; child and adolescent health; and health promotion. Since all the important nutrition relevant health interventions are already included in the health sector's 5-Year Development Plan 2016/17-2020/21 in the HSSP-IV, the expected outcome from the NMNAP is that "**communities regularly use quality maternal health services including family planning, prevention and treatment of HIV and malaria."**

113. The key actions proposed in strengthening health and HIV sectoral plans and their timeline are shown in *table 14*. The prioritized action for funding in this NMNAP is to "*Review certificate and diploma curricula in health training to improve the existing nutrition components*". The other actions are already included in the HSSP-IV and in the Government's Five-Year Plan 2016/17-2020/21.

Table 14: Proposed activities and timeline to strengthen nutrition sensitive health and HIV and AIDS interventions (source: HSSP IV 2015-2020)

	Output/activities	Lead institution	Collaborating agencies	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.2	Communities regularly use quality maternal health including family planning, prevention and treatment of HIV and malaria services																						
5.2.1	HIV and AIDS	MOHCDGEC																					
5.2.2	NCDs and Mental health	MOHCDGEC																					
5.2.3	Malaria	MOHCDGEC																					
5.2.4	Maternal, newborn, and reproductive health	MOHCDGEC																					
5.2.5	Child and adolescent health	MOHCDGEC																					
5.2.6	Health promotion	MOHCDGEC																					
5.2.7	Review certificate and diploma curricula in Health training to improve the existing nutrition components	MOHCDGEC	TFNC, Academia, DPs																				
5.2.8	Introduce certificate and diploma training for nutrition cadre in the MOHCDGEC	MOHCDGEC	NACTE																				

NB: Activities in italic are additional activities identified by NMNAP task team as they were not included in the HSSP-IV plans

5.3.3 Actions to strengthen nutrition sensitive intervention in water, sanitation and hygiene (WASH) sectoral plans

114. Proposed actions in WASH aim to address the following strategic policy objectives of the 2016 Food and Nutrition Policy: -

1) To promote safe water, sanitation, and hygiene practices as key strategies for improved nutrition.
2) To improve food safety and quality for enhancement of nutrition status at individual, household and community level.
3) To improve nutrition knowledge, behaviours, attitudes and practices for improved nutrition

115. Actions directed towards WASH aim to ensure that c**ommunities have sufficient access to adequate safe water, sanitation and hygiene services** as these will decrease the proliferation and transmission of infectious pathogens which have adverse effects on nutrition through a number of mechanisms**. The key action and timeline for funding by this NMNAP is for the Ministry of Water and Irrigation (MOWI) with assistance of TFNC, professional bodies and development partners (DPs) to** review certificate and diploma curricula in Water Resource Management training to improve and include nutrition components **during the third quarter of 2018/19 as seen in** *table 15***.** Some other key activities will include campaigns for zero open defaecation and to promote key sanitation and hygiene practices like proper faeces disposal and handwashing with soap during the three critical periods (after defaecation, during food preparation and before eating with hands).

Table 15: Proposed activities and timeline to strengthen nutrition sensitive water, sanitation and hygiene (WASH) (source: FYDP 2016-2021)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.3	Communities access adequate safe water sanitation and hygiene services																						
5.3.1	Improvement of water supply and sanitation services in Regional centres	MOWI	MOHCDGEC, PORALG																				
5.3.2	Water quality management and pollution control	MOWI	MOHCDGEC, PORALG																				
5.3.3	Scale up water supply in Rural areas	MOWI	PORALG, WATER AUTHORITIES																				
5.3.4	Urban water supply Strategic Choices	MOWI	MOHCDGEC, PORALG, WATER AUTHORITIES																				
5.3.5	Advocacy and orientation of key government and non-government stakeholders for sanitation and hygiene	MOHCDGEC	MOWI, PORALG, WATER AUTHORITIES																				
5.3.6	Engagement of households through CLTS and Sanitation Marketing	MOHCDGEC	MOWI, PORALG, WATER AUTHORITIES																				
5.3.7	Manage Sanitation and Hygiene competition	MOHCDGEC	MOWI, PORALG, WATER AUTHORITIES																				
5.3.8	Promotion of Household Water Treatment and safe Storage	MOHCDGEC	MOWI, PORALG, WATER AUTHORITIES																				
5.3.9	Promotional events targeting the peri-urban settings on sanitation and hygiene, and HWTS	MOHCDGEC	MOWI, PORALG,																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
			WATER AUTHORITIES																				
5.3.10	Construction of WASH facilities in 8 highway bus stops	MOHCDGEC	MOWI, PORALG, WATER AUTHORITIES																				
5.3.11	Strengthen system for solid waste management in the outskirts of Cities and Municipalities in the country.	MOHCDGEC	MOWI, PORALG, WATER AUTHORITIES																				
5.3.12	Review Certificate and Diploma curricula in Water Resource Management training to improve/include nutrition components	MOWI	TFNC, Professional Bodies, DPs																				

NB: Activities in italic are additional activities identified by NMNAP task team as they were not included in sectoral plans

5.3.4 Actions to strengthen nutrition sensitive interventions in education and early childhood development sectoral plans

116. Nutrition sensitive education and early childhood development aims to address the following strategic objectives of the 2016 Food and Nutrition Policy: -

1) To improve nutrition knowledge, behaviours, attitudes and practices in the country;

2) To enhance national capacity for improved nutrition; investing in the early years is one of the smartest investments a country can make to eliminate extreme poverty, boost shared prosperity, and create the human capital needed for economies to diversify and grow.

117. Early childhood experiences have a profound impact on brain development—affecting learning, health, behaviour and ultimately, income. An increasingly digital economy places even greater premiums on the ability to reason, continually learning, effectively communicating and collaborating. Early child education and development develops cognitive and learning abilities critical for future learning and educational performance. Thus, investing in the early years is one of the smartest investments a country can make to eliminate extreme poverty, boost shared prosperity, and create the human capital needed for economies to diversify and grow. Effective policies identified by the 2016 Lancet Series on early childhood development include (i) free early education, especially when linked with nutrition support (ii) paid parental leave to support bonding and care of young children, (iii) guaranteed breast feeding breaks to allow for exclusive breastfeeding during the first six months, and (iv) a minimum wage to provide basic income to provide children with basic needs including nutritious food, healthcare and education.

118. The nutrition sensitive education and early childhood development component in the FYDP-II aims at improving early education and child development, literacy and numeracy strategy in primary education; construction of class rooms and latrines and improve availability of safe water and electricity in primary and secondary schools; and implement comprehensive plan for free basic education up to form IV. Many of the key nutrition sensitive actions in education are already included in the education FYPD-II sector plans. However, the multisectoral nutrition sensitive interventions (MNSI) task team identified three key actions that this NMNAP will need to prioritize and fund to achieve a truly nutrition sensitive education and early development sector. These are: (a) Promote girl-friendly water and sanitation facilities in primary and secondary schools (b) Build capacity of school health and nutrition program coordinators of primary and secondary school on effective implementation of nutrition sensitive activities in the schools, and (c) Promote physical activities in primary and secondary schools to reduce the risk of diet related non-communicable diseases among school children and teachers and later in adulthood.

119. The key activities and timelines for the education and early childhood development output of the MNSI action plan are shown in *table 16* below.

Table 16: Workplan to strengthen nutrition sensitive interventions in education and early childhood development sectoral plans (source: FYDP 2016-2021)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.4	Girls complete primary and secondary education																						
5.4.1	Early Education	MoEST																					
5.4.2	Primary School: Improvement of Literacy and Numeracy Strategy (LANES)	MoEST																					
5.4.3	Primary School: Construct class rooms and latrines	MoEST																					
5.4.4	Primary School: Improve availability of water, electricity																						
5.4.5	Primary school: Implement comprehensive plan for free education	MoEST																					
5.4.6	Secondary Education Development Programme (SEDP II)	MoEST																					
5.4.7	Secondary school: Implement comprehensive plan for free education	MoEST																					
5.4.8	Secondary school: Construct classrooms and Latrines	MoEST																					
5.4.9	Secondary school: Improve availability of water, electricity and latrines	MoEST																					
5.4.10	Promote girl-friendly water and sanitation facilities in primary and secondary schools	MoEST	PORALG, TFNC, MOHCDGEC, LGA,																				
5.4.11	Build capacity of school health and nutrition program coordinators of primary and secondary school on effective implementation of nutrition sensitive activities in the schools	MoEST	PORALG, TFNC, LGA,																				
5.4.12	Promote physical activities in primary and secondary schools to reduce the risk of diet related among school children and teachers	MoESTVT	LGA, PARLIAMENT, PO-RALG, TANCDA																				

NB: Prioritized activities for this NMNAP are in italics as they were not included in sectoral plans

5.3.5 Actions to strengthen nutrition sensitive interventions in social protection sectoral plans

121. The 2016 Food and Nutrition Policy objectives that actions in social protection aim to address is "to improve the nutrition status of vulnerable groups." The main vulnerable group that the social protection component addresses is the extremely poor households that live below the food poverty line, which is about 9.7 percent of households according to the 2012 Household Budget Survey.

122. The key nutrition sensitive actions already included in the FYDP II on social protection include the economic empowerment of women, ending child marriages and early child pregnancies, livelihood and capacity enhancements and the Tanzania Social Action Fund's (TASAF) conditional cash transfers and cash for work through the Productive Social Safety Net (PSSN) program. The NMNAP has identified two additional key activities to be prioritized to assure synergy. These are (i) review certificate and diploma curricula in community development training to improve/include nutrition components and (ii) review certificate and diploma curricula in social welfare training to improve/include nutrition components.

123. **The key actions and timelines** to strengthen nutrition sensitive interventions social protection sectoral plans are shown in *table 17* below:

Table 17: Proposed activities and timeline to strengthen nutrition sensitive interventions in social protection sectoral plans (source: FYDP 2016-2021)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.5	Poorest households benefit from social protection programmes (conditional cash transfers, cash for work, and nutrition education during community sessions)																						
5.5.1	Women Economic Empowerment	MOHCDGEC																					
5.5.2	End Child Marriage and Early Pregnancies	MOHCDGEC																					
5.5.3	Develop and implementation of Local Economic Development (LED) initiatives	MOHCDGEC																					
5.5.4	TASAF - Cash Transfer	TASAF	PORALG																				
5.5.5	TASAF - Cash for Work	TASAF																					
5.5.6	Review Certificate and Diploma curricula in Community development training to improve/include nutrition components.	MOHCDGEC	TFNC, Professional Bodies, DPs																				
5.5.7	Review Certificate and Diploma curricula in social Welfare training to improve/include nutrition components	MOHCDGEC	TFNC, Professional Bodies, DPs																				

NB: Activities in italic are additional activities identified by NMNAP task team as they were not included in sectoral plan

5.3.6 Action plan to strengthen the links between the environment, climate change and nutrition

124. The 2016 Food and Nutrition Policy objective addressed by this action plan is "to enhance sustainable use and management of the environment for improvement of food and nutrition security."

125. The link between climate change and nutrition is an area where research may be particularly helpful. There is scope to undertake operations research to better understand the link between climate change, temperature, rainfall and agriculture output. By extension what is the impact of climate change on food security, food availability and intakes which then contribute to nutritional status? Empirical evidence suggests that climate change impacts on nutrition in four main ways: First, it affects food security through reducing food production; hampering transportation, storage, marketing systems and increase price volatilities. Second, it impacts on health through changes in the vector environment (e.g. increased breeding of mosquitoes that transmit malaria), increased risk of water borne diseases (e.g. diarrhoea) or airborne diseases (e.g. respiratory infections including tuberculosis). Third, it reduces the caring capacity for children and women through increased workload of women (e.g. going long distances to fetch water or firewood). Fourth, climate change affects mainly those at greatest risk of poverty and malnutrition: those dependent on climate-sensitive resources and livelihoods (e.g. subsistence farmers, pastoralists, fisheries, forest-based livelihoods, agricultural labour); those who lack the capacity to cope (e.g. with few assets) further depleting their resilience necessitating resorting to negative adaptive and coping mechanism like deforestation and transactional sex increasing the risk of contracting HIV (World Bank 2004). **The main nutrition sensitive action included in the FYDP-II with regard to climate change is "***Implementation of concrete adaptation measures to reduce vulnerability of livelihoods and economy of the coast communities of Tanzania".* To cover the whole country and link actions taken with improved nutrition, the NMNAP has prioritized an additional activity which is *"develop a strategy for addressing nutrition needs of populations that are prone to climate change hazards".*

126. **The key actions and timelines** for action plans to strengthen the links between environment, climate change and nutrition are shown in *table 18* below.

Table 18: Proposed activities and timeline to strengthen nutrition sensitive interventions in environment and climate change sectoral plans (source: FYDP 2016-2021)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
5.6	Vulnerable communities are able to cope with drought and climate change to avoid shortage of nutritious food during shocks																						
5.6.1	Implementation of concrete adaptation measures to reduce vulnerability of livelihoods and Economy of the coast communities of Tanzania	VPO																					
5.6.2	Research and develop a strategy to address nutrition needs of populations that are prone to climate change hazards	PMO	VPO, NEMC, MALF, PORALG, DPs, TMA, LGA																				

NB: Activities in italic are additional activities identified by NMNAP task team as they were not included in sectoral plan

5.3.7 Summary cost of the six outputs of the nutrition sensitive action plans

123. The **overall budget for the six outputs of the Nutrition Sensitive KRA** is shown in *table 19* and the annualized budget distribution plan in *figure 19*.

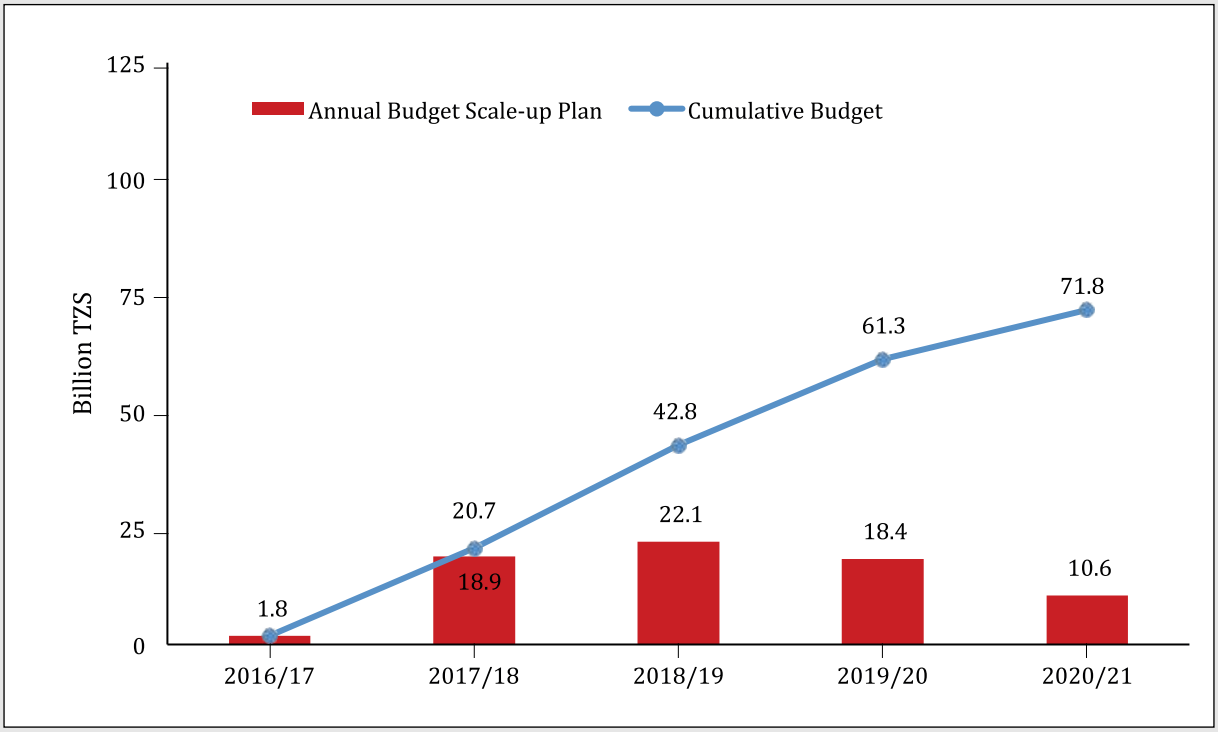
Table 19: Budget for action plan to strengthen nutrition sensitive interventions (NSI): Agriculture and food security, health and HIV, WASH, education and early childhood development, social protection and environment and climate change

Expected Results		Budget in Billion TZS						Total budget in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 5:	Line sectors, private sector and CSOs scale-up nutrition sensitive interventions to reach all communities to improve nutrition	4,128.4	4,287.0	4,950.9	5,058.2	3,247.2	21,671.7	9,850.78
Output 5.1: *	Communities have access to a diverse range of nutritious food throughout the year	728.1	737.0	723.5	720.5	713.1	3,622.3	1,646.48
Output 5.2: *	Communities regularly use quality maternal health including family planning, prevention and treatment of HIV and malaria services	1,461.0	1,556.0	1,704.0	1,801.0	NA	6,522.1	2,964.59
Output 5.3: *	Communities access adequate water sanitation and hygiene services	1,149.0	1,149.0	1,149.0	1,148.8	1,148.0	5,743.9	2,610.86
Output 5.4: *	Girls complete primary and secondary education	351.8	351.8	351.4	353.1	351.3	1,759.4	799.73
Output 5.5: *	Poorest households benefit from conditional cash transfers, cash for work, and nutrition education during community sessions	436.9	491.5	1,021.3	1,033.2	1,033.2	4,016.2	1,825.56
Output 5.6: *	Vulnerable communities are able to cope with drought and climate change to avoid shortage of nutritious food during shocks	1.56	1.56	1.56	1.58	1.56	7.82	3.55

**: Data were extracted from Five Year Development Plan (FYDP 2016-21) and sectoral plans (e.g. HSSP IV, TASAF) plus additional nutrition sensitive activities identified by NMNAP task team as they were not included in sectoral plans*

***: Exchange rate 1 USD = 2200 TZS*

Figure 19: Annual budget distribution and scale up for nutrition sensitive interventions (NSI)



CHAPTER 6

GOVERNANCE AND MANAGEMENT OF THE NMNAP

GOVERNANCE AND MANAGEMENT OF THE NMNAP

6.1 Overview

128. Good governance is a critical component of nutrition improvement as it creates the necessary enabling environment for scale-up and sustainability of interventions. Although in nutrition we understand what interventions work and, in many ways, how these should work, the challenge is to ensure interventions are delivered through systems that are efficient, cost-effective and adheres to the principles of good governance. **Human rights (HR) principles inform the content of good governance efforts including for nutrition.** The HR framework[25] addresses all the key dimensions of good governance, including **public participation**, **access to information**, and **accountability**. A critical aspect of good nutrition governance is the Government's **capacity to respect, protect, and fulfil human rights**, and by extension, food and nutrition rights. Ultimately, **it is the simultaneous realization of all civil, political, economic, social and cultural rights that contributes most to good governance, including for nutrition.**

129. Good governance sustains political will and Government commitment, increases allocation of financial and human resources, develops institutional response capacity, **ensures accountability** and coalesces advocacy and communication efforts around a common narrative to reduce malnutrition. Moreover, strong attention to nutrition governance ensures the multiple determinants of malnutrition (biological, social, cultural, economic, political) are addressed, increases the understanding of policy makers on the impact of malnutrition on national development and links improved nutrition to policy and implementation action plans.

130. **Ensuring accountability** is an important component of this NMNAP. While the state and other stakeholder accountability for results and resources is included in the integrated "Common Results, Resources and Accountability Framework (*CRRAF – see appendix 2*) good governance will help ensure **social accountability**. This will assist in responding to the emerging contours of a new social contract where citizens are seeking a relationship with their government based on transparency, accountability, and participation.

131. The World Bank (2013)[26] defines "**social accountability"** as an approach towards building **accountability** that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting **accountability".** The aim of civic engagement is to stimulate demand from citizens for improved nutrition and thus put pressure on the state and other stakeholders including the private sector to meet their obligations to provide quality services. The supply side of this equation is about building **state capability and responsiveness,** as well as that of public and private providers, to meet their obligations under this NMNAP. Social accountability mechanisms for nutrition could include the use of a "Nutrition Score Card" at the council level and participation of communities in monitoring implementation of the NMNAP (e.g. through the TASAF nutrition community sessions). Lessons from the experiences gained in the use of social accountability mechanisms in Tanzania by some stakeholders include Care's Community Score Card[27], CUAMM's (Doctors with Africa-Italian NGO) Beneficiary Feedback mechanism and Irish Aid's support to CSO on social accountability. Each of these provide potential applications of social accountability in the implementation of the NMNAP.

25 The international human rights framework has two components: the first is the international or universal components that have been established by the United Nations, with actual or potential authority to review the human rights practices of all its 193 UN Member States; and the second is the regional components established by regional intergovernmental bodies like the organization of American States, European Union, African Union (AU), Association of South East Asia Nations (ASEAN)

26 World Bank (2013): Social Accountability and Demand for Good Governance. August 15, 2013 (http://www.worldbank.org/en/topic/socialdevelopment/brief/social-accountability)

27 Care: http://governance.care2share.wikispaces.net/Social+Accountability

132. The **framework used** in developing nutrition governance actions in this NMNAP is adapted from that developed by the U.K's Institute of Development Studies (IDS) at Sussex[28], which synthesized studies from 4 countries: Brazil, Peru, Bangladesh, Ethiopia and Zambia. The evidence from those studies clearly demonstrates how governance is key to achieving progress towards the reduction of undernutrition. The framework focuses on four key factors: -

1) **Intersectoral cooperation** of Government and non-Government sectors, including government oversight for the engagement of private sector partners, such as the food industry;

2) **Vertical coordination** between the different levels of Government from local to national levels;

3) **Sustainable funding** from all levels of Government and well managed and transparently tracked.

4) **Monitoring and advocacy:** Advocacy amongst the Government and civil society is critical to maintain political will and a commitment to nutrition. To ensure evidence-informed advocacy, there is need for timely and quality nutrition information.

133. The IDS research findings made 10 recommendations regarding governance that have been adopted by the NMNAP. These are: -

1) **Involve the executive branch of Government in nutrition polices:** For Tanzania, both the Office of the President (PO-RALG) and that of the Prime Minister (PMO) have taken active leadership role in developing the NMNAP and will do the same in its implementation;

2) **Establish effective bodies to coordinate actions:** There are the multisectoral coordinating steering committees on nutrition in place from the national (HLSCN) to the LGA levels, but these need to be further strengthened and empowered with greater functionality and capacity.

3) **Frame nutrition as an integral part of the national development agenda**: Nutrition is already an element of the Development Vision 2025 (MKUKUTA) and is incorporated into the Five-Year Development Plan II (2016/17-2020/21). This NMNAP 2016/17-2020/21 is anchored in the corresponding Five-Year Development Plan.

4) **Develop a single narrative about the severity of the malnutrition problem:** The narrative in this NMNAP with its Common Results, Resources and Accountability Framework (CRRAF) and consensus nutrition targets, updates and, therefore, super-cedes the 2011/12-205/16 National Nutrition Strategy (NNS) narrative.

5) **Ensure that local Governments have the capacity to deliver nutrition services:** the decentralization of nutrition interventions through PO-RALG with regional and council nutrition steering committees, nutrition officers and annual planning and budgeting cycles provides a solid administrative basis for the implementation of the NMNAP and delivery of services at the community level.

6) **Encourage local ownership of nutrition programme and their outcomes:** this has already been established and will continue to be implemented through the decentralized PO-RALG structure.

7) Support civil society groups to develop social accountability mechanisms.

8) **Collect nutrition outcome data at regular intervals:** This is already being done through the TDHS, SMART Surveys and PER-Nutrition, though at infrequent intervals. The national multisectoral nutrition information system (MNIS) to be established under the NMNAP will ensure better quality and more timely collection and dissemination of outcomes (and program performance) data for evidence informed advocacy, communication and adaptive management of the NMNAP.

9) Use centralised funding mechanisms to generate greater incentives to cooperate in the design, implementation and monitoring of nutrition interventions. The protocols and process for resource allocation decision making for nutrition by the Government will build on cooperation of the multi-sectoral design of the NMNAP at both the central and LGA level.

10) **Governments should create financial mechanisms to protect (earmark) nutrition funding and use it in a**

28 Institute of Development Studies (IDS)-UK (2012): Accelerating Reductions in Undernutrition: What can nutrition governance tell us? In: IDS in Focus, Policy Briefs, Research and analysis from the Institute of Development Studies, Issue 22 April 2012.

transparent way. The Government has already created a nutrition code for budgeting at the LGA levels which earmarks funds for nutrition and should assist also in tracking of those funds. The issue of developing a nutrition basket fund and **ring-fencing**[29] the nutrition budget will be considered as part of nutrition governance.

6.2 Leadership, management and coordination structure

134. Ensuring functional, efficient, effective and strategic leadership, management and coordination that adequately supports implementation of the NMNAP is critical to its success. A strategic multisectoral coordination system will help put in place the "three Ones" (One Plan, One coordination system and One M&E mechanism). The NMNAP (2016-21) represents the "one plan"; a revised coordination system as the "One Coordinating mechanism and the Common Results, Resources and Accountability Framework (CRRAF- *see appendix 2*) can be used as the "one M&E" System.

135. The Government already established robust multisectoral and multi-stakeholder coordination mechanisms at the different levels during the implementation of the National Nutrition Strategy 2013-2016 *(see figure 19),* which also facilitates Public-Private-Partnerships. To strengthen accountability, the Government will **update and institutionalize** these multi-sectoral coordination structures as shown in *figure 20.*

136. The revised leadership, management and coordination structure for the NMNAP derive from the accountability framework articulated in the 2016 Food and Nutrition Policy. The new structure streamlines and harmonizes the previous coordination structures to improve on strategic leadership, management, coordination, and functional linkages. At the national level, the Prime Minister's Office (PMO) will chair the HLSCN and provide overall policy and coordination leadership for the NMNAP. A sub-committee of the HLSCN will monitor large scale CSO and private sector nutrition programs to ensure harmonization with the NMNAP. A multisectoral nutrition technical working group (MNTWG) will provide technical support to the HLSCN. At the operational level, PO-RALG will lead the Regional and Council level response with the support of the chairs of the nutrition steering committees at these levels and down to the community level. As the technical arm of Government, the **TFNC will provide overall technical leadership in the management of the NMNAP** at all levels including serving as the Secretariat to the HLSCN and serving as chair and secretariat to the Thematic Working Groups (TWGs). **Thus, it is critical to develop TFNC's capacity to execute this critical function.**

29 Ring-fencing funds means allocating funds to a particular intervention area or project/programme and ensuring it is used for that purpose alone.

Figure 19: Current leadership, management and coordination structures of the NNS 2013-2016

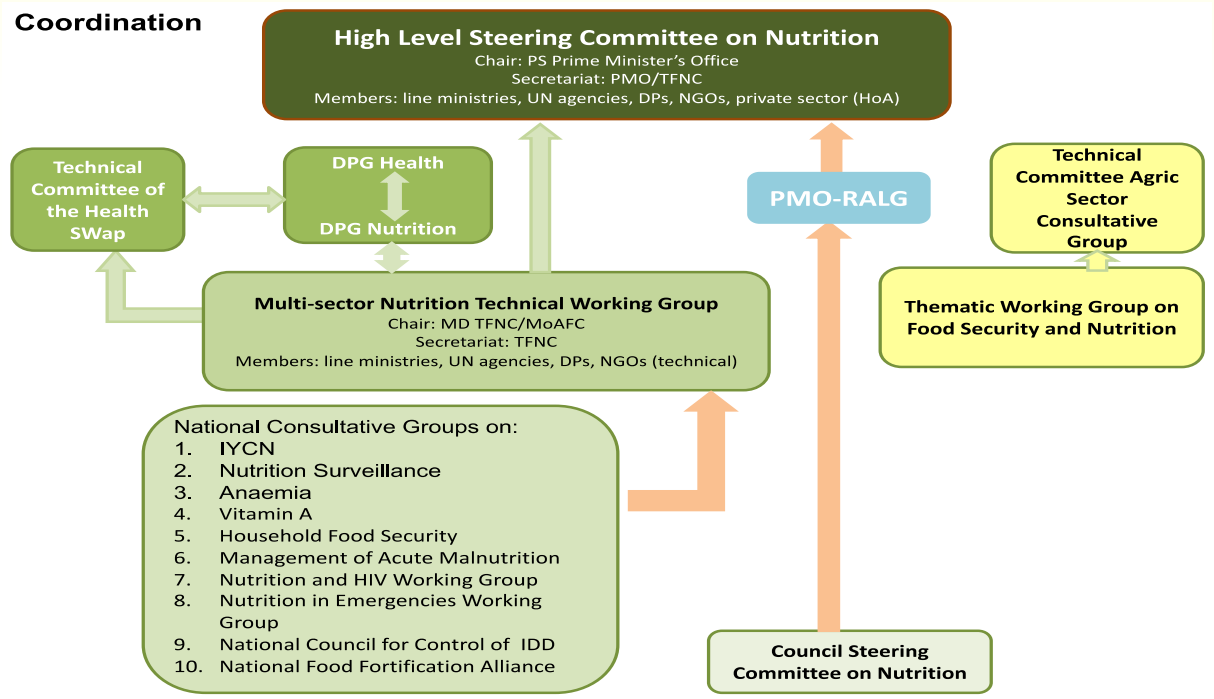
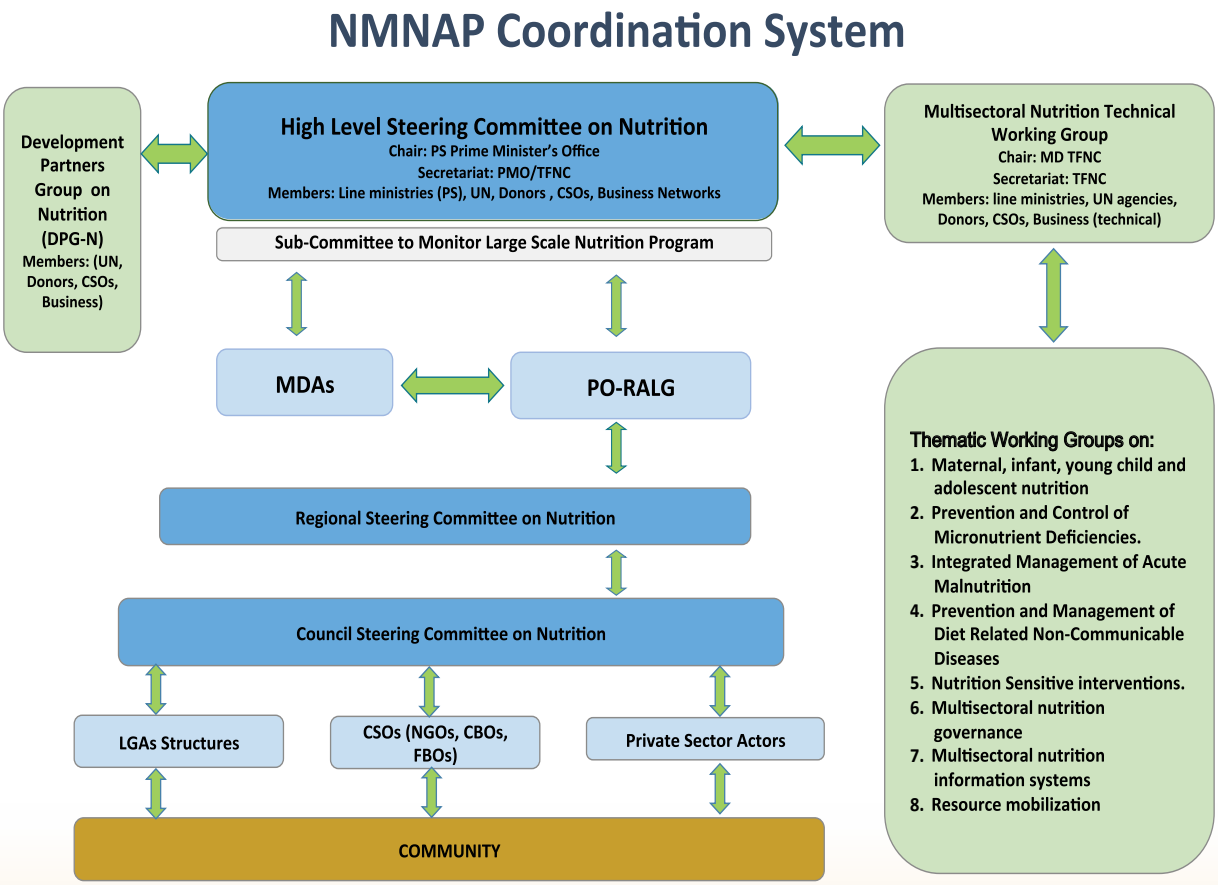


Figure 20: Proposed leadership, management and coordination structure for the NMNAP 2016/17-2020/2021



137. The formation of the current nutrition coordinating structures was initiated in 2013, when a series of **national level coordinating structures was established.** These include: -

1) A **High Level Steering Committee on Nutrition (HLSCN)** composed of the Permanent Secretaries (PS) from nine key nutrition relevant Ministries and chaired by the PS, Prime Minister's Office (PMO) with TFNC as Secretariat;
2) **Multisectoral Nutrition Technical Working Group (MN-TWG)** which was linked to the Health Sector Strategic Plan (HSSP) III and chaired by TFNC;
3) **Ten National Consultative groups:** (i) Infant and Young Child Feeding, (ii) Nutrition surveillance, (iii) Iodine Deficiency Disorders, (iv) Anaemia, (v) Vitamin A Supplementation, (vi) Food Fortification Alliance, (vii) Household food security, (viii) Integrated Management of Acute Malnutrition, (ix) Nutrition and HIV, and (x) Emergency nutrition.

138. Some of these structures were put in place before the finalization of the National Nutrition Strategy (NNS) of 2011-2016 with no clearly defined role in its implementation. While the 2013-2016 coordinating mechanism of having nutrition steering committees at the LGA and regional levels are adequate for those levels for the NMNAP, the national coordinating structure will need to be reviewed to ensure harmonization with both the 2016 Food and Nutrition Policy and the NMNAP.

139. In order to effectively align the coordinating structures with the implementation of the NMNAP 2016/17-2020/21, the system will be restructured and institutionalized as follows: -

1) **Sub-national level:** the nutrition steering committees at Regional and Council levels will be institutionalized and their composition and terms of reference reviewed to support implementation of the NMNAP;

2) **At the national level: The High Level Steering Committee on Nutrition (HLSCN)** chaired by the Permanent Secretary in the Prime Minister's Office (PMO) will be institutionalized for intersectoral coordination of the 2016 Food and Nutrition Policy and the NMNAP. The role of the **HLSCN will be:**

a. To serve as the inter-ministerial coordinating and monitoring body for implementation of the 2016 National Food and Nutrition Policy and the NMNAP;
b. To develop consensus among ministries and other actors on the key NMNAP milestones and monitor their achievement;
c. To advise the Government on appropriate response and actions to address policy and strategic challenges identified in the course of implementing the NMNAP;
d. To promote the multisectoral approach and coordination of the NMNAP; and
e. To ensure all nutrition programs in the country including large programs like Mwanzo Bora, ASTUTE, ASRP etc. are harmonized with the NMNAP.
f. The HLSCN will meet twice a year, in October-November and in April-May. The first meeting of the HLSCN in October – November will be an opportunity to share the results of the Joint Multisectoral Nutrition Review for the previous year (N-1) and validate the recommendations for planning the next Fiscal Year (N+1). The second meeting, in April-May can be used to review progress on implementation of Annual Work Plans (AWP) for first semester of year N and present the consolidated AWP for the next Fiscal Year (N+1). These points will be the core issues of the HLSCN agenda, but additional points can be integrated in the agenda.
g. **A Multisectoral Nutrition Technical Working Group (MNTWG) chaired by the TFNC Managing Director** and with TFNC as the secretariat will meet twice a year and will provide overall coordination, technical guidance and scientific support to the **Thematic Working Groups (TWGs)**. The **TWGs** will be formed based on the seven key result areas of the NMNAP. An eight TWG on **"resource mobilization"** will be established given the critical need to mboilize resource for the implementation of the NMNAP. TFNC will take the leadership in forming the TWGs and oversee the development of their terms of reference. The eight TWGs will be: -

1) **TWG 1: Maternal, infant, young child and adolescent nutrition (MIYCAN):**

The group will review progress on the implementation of the operations plans of the NMNAP bearing the same name. Current technical consultative groups to be incorporated will include the Infant and Young Child Feeding.

2) **TWG 2: Prevention and Control of Micronutrients.** This will incorporate the following current consultative groups: IDD, Vitamin A supplementation, Anaemia and Food Fortification Alliance. The group will review progress on the implementation of the operational plans of the NMNAP bearing the same name.
3) **TWG 3: Integrated Management of Acute Malnutrition (IMAM):** to incorporate current consultative groups on Emergency nutrition and Integrated Management of Acute Malnutrition (IMAM). The group will review progress on the implementation of the operational plans of the NMNAP bearing the same name. Existing technical consultative groups on iodine and iron will be integrated into the new TWG, while retaining specific focus on individual nutrients and interventions.
4) **TWG 4: Prevention and Management of Diet Related Non-Communicable Diseases (DRNCDs):** The group will review progress on the implementation of the operational plans of the NMNAP bearing the same name.
5) **TWG 5: Nutrition Sensitive interventions.** The group will review progress on the implementation of the operational plans of the NMNAP bearing the same name.
6) **TWG 6: Multisectoral nutrition governance:** The group will review progress on the implementation of the operational plans of the NMNAP bearing the same name.
7) **TWG 7: Multisectoral nutrition information systems.** The group will review progress on the implementation of the operational plans of the NMNAP bearing the same name.
8) **TWG 8: Resource mobilization.** Although no task team was formed for resource mobilization in the development of the NMNAP, this technical group will develop a resource mobilization strategy and track utilization of resources to ensure good value for money.

140. During the process for institutionalizing the various coordinating structures, it will be important to review the terms of reference of existing structures that will remain, while developing new ones for the new structures. Throughout this process it will be important to ensure that the structures are complementary and not redundant.

6.3 Key actors, their roles and responsibilities

141. The Food and Nutrition Policy already identified the key actors and their roles in the policy implementation. These roles and responsibilities are divided into 4 broad categories: 1) oversight and coordination; 2) nutrition services delivery; 3) food production; and 4) provision of basic services and supportive services for nutrition improvement. The key implementers across these domains include Government Ministries, Departments and Agencies (MDA); Regional Administrations and Local Government Authorities (LGA); communities, development partners; civil society organisations (CSO) including NGOs and faith-based organizations (FBO); the private sector and political parties. Since this NMNAP is the implementation action plan for the 2016 Food and Nutrition Policy, the same actors and roles identified in the policy apply in the governance and management of the NMNAP. The specific mandates and functions of each of these implementing partners is described below without the strict categorization by roles and responsibilities described above: -

(i) **The Prime Minister's Office (PMO)**

- Coordinate the overall national response to nutrition including ensuring effective contribution by Ministries, Departments and Agencies (MDAs) to the NMNAP;
- Support the multisectoral response to nutrition and ensuring that Nutrition is adequately mainstreamed in policies and strategies of the key line ministries;
- Provide oversight for governance and accountability of all sectors and actors in nutrition; and
- Chair and host the High Level National Steering Committee for Nutrition (HLSCN).

(ii) **Ministries, Departments and Agencies (MDA)**

General responsibilities for all MDA

- Ensure that nutrition is adequately reflected in MDA policies, strategic plans, programs, legislation, regulations and guidelines;
- Identify, mobilize and allocate human, financial and organizational resources to the NMNAP in the discharge of their responsibilities under the 2016 Food and Nutrition Policy;
- Report on the implementation of their nutrition interventions done in the context of the NMNAP to the PMO, PO-RALG and to TFNC as appropriate; and
- Collaborate with TFNC, other key sector line ministries and actors to realize the NMNAP goals, objectives and targets.

Specific responsibilities for MDA in line with their mandates:

1. President's Office - Ministry responsible for Regional Administration and Local Government Authorities (PO-RALG)

- Guide and monitor the integration of nutrition interventions in regional and local Government authorities plans and by-laws;
- Coordinate and facilitate capacity development of regional and local Government administrations to plan and implement nutrition improvement programs at the community level; and
- Coordinate and monitor nutrition interventions by all actors in regional and local Government authorities using the principle of the three ones: One Plan, One Coordinating Mechanism and One Monitoring and Evaluation Framework.

2. President's Office – Ministry responsible for Public Service and Good Governance

- Facilitate the establishment, recruitment and development of nutrition cadres at all levels.
- Prioritize nutrition in the ongoing government structural/institutional reforms.

3. Ministry Responsible for Health, Community Development, Gender, Elders and Children

- Scale-up quality basic health services (health promotion, prevention, curative and rehabilitation services) essential for improvement of nutrition in the country up to the health facility and community level;
- Implement, monitor and coordinate the essential health interventions for improving the nutritional status at all levels;
- Develop legislation, regulations and guidelines relevant to health and nutrition in line with the 2016 Food and Nutrition Policy and its implementation plan (NMNAP);
- Integrate nutrition components in school health, reproductive health and other relevant programs;
- Strengthen food and nutrition services for vulnerable groups, including children with multiple vulnerabilities (MVC), people with disability (PWD), the elderly and people living with AIDS;
- Promote integration of nutrition objectives in social protection programs;
- Promote household-based strategies to increase food and nutrition security;
- Promote nutrition supportive behaviours and discourage behaviours that are barriers to improving nutrition; and
- Advocate for mainstreaming nutrition issues in community development.
- Promote mainstreaming of gender equality in all policies, strategies and programmes done by the MDAs, which are relevant to nutrition.

4. Ministry Responsible for Agriculture, Livestock and Fisheries

- Ensure that national food security plans and programs have explicit objectives to improve household food and nutrition security;
- Promote and support increased production and consumption of diverse high nutrient dense food crops;
- Promote increased agro-processing,

preservation and storage of food crops to reduce post-harvest losses and contamination and preserve nutritional quality;
- Enhance research on food crops with high nutrient value;
- Ensure mainstreaming of nutrition in agriculture training programmes;
- Ensure good agricultural practices and food safety along the production chain;
- Promote increased production and consumption of high nutrient value livestock, dairy and fisheries products;
- Enhance training and research for small scale production and processing of livestock, dairy and fisheries products to increase nutritional outcomes in households;
- Facilitate good marketing of livestock, dairy and fisheries products across the country; and
- Ensure the safety of livestock and fisheries food products along the production chain.

5. Ministry Responsible for Water and Irrigation
- Ensure sustainable supply of adequate safe and clean water up to household level; and
- Promote safe water, sanitation and Hygiene (WASH) practices for improved nutrition outcomes.

6. Ministry Responsible for Education, Science, Technology and Vocational Training
- Integrate nutrition education in school and college curricula;
- Promote nutritious feeding programs in schools, colleges and other educational institutions;
- Promote innovation and optimal application of communication, science and technology at all levels to improve food and nutrition in the country; and
- Strengthen the monitoring of food and nutrition services in day and boarding schools, colleges and other educational institutions.
- Promote physical activity and healthy life styles at all levels of the education system.

7. Ministry Responsible for Energy and Minerals
- Promote better and cheaper energy in both rural and urban areas to reduce women's workload, prevent deforestation and increase nutritional outcomes in households;
- Ensure increased production of quality salt and adherence to the mining regulation on salt iodation; and
- Ensure safe mining practices to reduce the risk of mineral contamination of food and nutrition resources.

8. The Ministry Responsible for Natural Resources Management
- Ensure integration of the nutritional rights of communities surrounding wildlife and forest reserves in their resources sustainable management plans; and
- Promote increased small-scale production and processing of quality honey, fruits and animal products to enhance nutritional outcomes at household level.

9. Ministry Responsible for Industry and Trade
- Promote increased processing, storage and marketing of agricultural, livestock and fisheries products;
- Promote appropriate fortification of commonly eaten foods;
- Promote increased nutrition-relevant small and medium enterprise (SME) participation in the food industry subsector; and
- Promote consumer protection and traceability.
- Ensure imported and exported food products meet the minimum food standards.

10. Ministry Responsible for Finance and Planning
- Mobilize and allocate funds for the implementation of the NMNAP;
- Expedite timely disbursement of allocated funds to the responsible sectors and institutions;
- Monitor public expenditure on food and nutrition with specific reference to the NMNAP; and
- Promote harmonization and alignment of sector financing to ensure optimal impact of nutrition in national development.
- Mobilize, allocate and 'ring fence' resources for implementation of nutrition activities in the council;

11. The Ministry Responsible for Labour

- Sensitize employers and the national labour force on the importance of good nutrition to good health and high productivity;
- Monitor the nutrition situation in the labour force ad take appropriate actions;
- Promote work-place based nutritional improvement initiatives including safe water for drinking, sanitation, breastfeeding and other feeding programs; and
- Promote the right to maternity and paternity leave.

12. Ministry Responsible for Home Affairs

- Strengthen enforcement of laws and regulations that facilitate food and nutrition security in the country;
- Ensure that the food and nutrition rights of people under incarceration, including prisoners are met. These rights include adequate access to health services, healthy nutritious diets and safe water for drinking, hygiene and sanitation;
- Enhance training in production of high value nutritious products through prison farming systems.

13. Ministry Responsible for Information, Culture and Sports

- Promote increased media coverage of the NMNAP and overall nutrition issues across the country;
- Promote traditions and customs that positively impact on nutrition, including production and consumption of indigenous nutritious foods;
- Identify traditions and customs that undermine nutrition and support interventions and actions to address them;
- Promote sports for healthy living for the prevention of overweight, obesity and other diet related non-communicable diseases (DRNCDs) at all levels in the country; and
- Integrate nutrition in sports development programmes.

14. Ministries Responsible for Infrastructure Development

- The main responsibilities of this sector ministry will include ensuring that a functional road network, railway and water transport services (where applicable) are in place to facilitate access and food transportation between producing areas and markets across the country throughout the year.
- Provide an effective link between food producing and consumption areas, reduce seasonal variations in food availability and improve food security.
- Infrastructure development, especially in urban settings should facilitate people to do physical exercises like walking, jogging and cycling.

Government Agencies

A. **Tanzania Food and Nutrition Centre (TFNC)**

TFNC coordinated the development of the NMNAP, thus its leadership role will continue during its implementation. Moreover, the 2016 Food and Nutrition Policy and in particular Act 24 of 1973 that established TFNC and its 1995 amendment provides TFNC with a critical mandate in the implementation of the 2016 Food and Nutrition Policy and its associated NMNAP. The mandate includes: -

- To regulate all matters relating to nutrition in the country;
- To monitor and evaluate all nutrition interventions and resources in the country;
- To provide the secretariat to High Level Steering Committee on Nutrition (HLSCN) and chair the Thematic Working Groups;
- To coordinate, advocate and mobilize resources for nutrition;
- To coordinate nutrition research in the country;
- To promote integration of nutrition objectives in relevant sectors; and
- To advise the Government and other stakeholders on all key matters relating to nutrition in the country including training, human resources deployment and accreditation of nutritionists.

B. **Tanzania Food and Drugs Authority (TFDA)**

- Ensure the right of consumers to adequate nutritional information on all pre-packaged food products;
- In collaboration with the producer, manufacturers and distributors of articles of food, to ensure proper nutritional value of the food marketed in the United Republic or exported to foreign countries;
- Monitor the safety of all food imports and exports, and food products in markets

and other outlets in the country to reduce nutritional risks and take legal action as appropriate.

C. **Tanzania Bureau of Standards (TBS)**

- Ensure nutritional concerns are addressed in the development and monitoring of quality and standards for food products.

Regional Administration and Local Government Authorities (LGA)

a. **Regional Secretariats**

- Identify nutrition problems, challenges and solutions in the regions;
- Integrate food and nutrition objectives in Regional Secretariat plans and strategies;
- Interpret policies and policy guidelines on nutrition for implementation;
- Provide technical guidance and supportive supervision on nutrition to LGA; and
- Coordinate, monitor and evaluate the implementation of NMNAP by different stakeholders at regional level.

b. **Local Government Authorities (LGA)**

- Strengthen Multisectoral Coordination Committee for Nutrition at LGA level.
- Establish and facilitate a Nutrition Unit in the Council to provide technical support;
- Facilitate identification of nutrition problems, challenges and solutions in the LGA;
- Integrate nutrition activities into the Comprehensive Council Development Plans;
- Strengthen community-based activities to fight malnutrition;
- Support ward, village/*mtaa* levels to integrate nutrition into their development plans and implement and monitor nutrition activities at their respective levels; and
- Coordinate the implementation, monitoring and evaluation of nutrition interventions in the council in the context of the NMNAP.

c. **Ward and Village/Mtaa Levels**

- Identify food and nutrition opportunities and challenges at the respective level;
- Ensure the integration of food and nutrition issues in ward/village/*mtaa* plans and strategies;
- Ensure adequate community sensitization to increase demand for and uptake of nutrition services;
- Initiate appropriate community-based food and nutrition interventions and mobilize resources for implementation; and
- Coordinate monitoring and evaluation of nutrition improvement activities at the respective level in the context of the NMNAP.

Higher Learning, Training and specialized Research Institutions

- Review and update curricula for pre-service, in-service and continuing education to ensure that nutrition is adequately integrated;
- Increase opportunities for training in nutrition;
- Mobilise funding for research in nutrition, undertaking research and dissemination of research findings to stakeholders;
- Participate in monitoring and evaluation of food and nutrition interventions in the country; and
- Provide technical advice and consultancy services on implementation of the NMNAP.

Civil Society Organizations (CSO)

NGOs, CBOs, FBOs

Civil Society include national and international NGOs, CBOs, FBOs and political parties. In addition to providing financial and technical support, CSO will: -

- Advocate for the prioritisation of nutrition in national, regional, LGA and community development plans;
- Support community mobilization and implementation of nutrition interventions up to household level;
- Support capacity development for improvement of food and nutrition at all levels in the LGA;
- Integrate nutrition issues in their programs, projects and activities targeting communities and households; and
- Align their nutritional plans with the Government plans at the respective level within the context of the NMNAP.

Professional Bodies

- Professional bodies and associations such as Paediatrics, Nurses, Food and Nutrition, Public Health, Medical Association, will include promoting the NMNAP among their members.
- They will issue professional guidance in nutrition, conduct research, set professional standards and participate in the

development of nutrition curricula for pre-service, in-service and continuing education; and supporting outreach activities on nutrition in communities.

Political Parties

- Political parties are in a unique position to promote nutrition improvement, given their reach and influence in mobilizing for social goals. In implementing the NMNAP, political parties will: -
- Incorporate food and nutrition improvement issues in their election manifestos and campaigns;
- Support mobilization for improved food and nutrition security:
- Support initiatives for improvement of food and nutrition especially in vulnerable groups; and
- Advocate for the prioritisation of nutrition in national, regional, LGA and community development plans.

Private Sector Institutions

- The private sector will partner with Government in the provision of nutrition-relevant services at all levels in the implementation of the NMNAP. Specific contributions could include: -
- Increase investments in production, processing, storage and marketing of high-value nutritious and healthy products and in the provision of essential basic social services (food, health, water, sanitation and hygiene) for nutrition improvement;
- Invest in production and marketing of appropriate low cost-labour saving technologies that enhance food and nutrition improvement at community level;
- Integrate nutritional support in corporate social responsibility plans and activities;
- Make available appropriate technologies for nutrition improvement including for advocacy, creation of public awareness and for tracking progress;
- Initiate and improve workplace nutrition programmes for their labour force; and
- Ensure compliance with all national laws, regulations, guidelines and international protocols for protection of consumer rights, health and the environment.

The Media

- In line with National Social and Behavioural Change Communication (SBCC) Strategy, the mass media will be responsible for advocating and conveying accurate information to the public and create awareness so as to influence positive behavioural changes for nutrition improvement. Mass media includes the print, radio, TV and computer networks (websites, emails and e-social forums).

Households

- Ensure availability of adequate and diverse nutritious food to meet the basic needs of all household members;
- Distribute equitably nutritious food among family members and address the specific needs of infants, young children, pregnant and lactating mothers;
- Ensure proper handling and management of food to avoid contamination and wastage;
- Ensure safe water, sanitation and hygiene practices in the household to reduce the risk of related diseases;
- Demand for information, education and essential basic social services to improve Nutritional care in their households and communities; and
- Participate in nutrition improvement activities implemented by different actors in the ward/villages/*mitaas*.

Development Partners

- Development Partners, including the UN agencies, multilateral and bilateral organizations will advocate for, promote and place implementation of the NMNAP high on their global and national agenda. Their role will include mobilizing for technical and financial resources for implementation, capacity development, monitoring and evaluating the NMNAP. Development partners can also bring in international experience, norms and standards, evidence-based guidance and insights to adjust strategy and promote international cooperation in the implementation of the NMNAP including global reporting.

6.4 Human Resources and Institutional Capacity requirements

142. In recent years, the Government has established a cadre of Nutrition Officers at the Regional and LGA levels with commensurate

allocation of resources for their salaries. With the direction of the Ministry of Finance and Planning, and through these Nutrition Officers, nutrition has been systematically included in the Government planning and budgeting process, for the first time at all levels. The key issue for the implementation of the NMNAP is for the Government to guarantee that all regions and LGA have skilled Nutrition Officers. As of August 2016, about 70 percent of the 185 LGA have Nutrition Officers/Focal Points, but the remaining gap will need to be filled. Pre-service and in-service training on nutrition is included in the action plan of the Nutrition Governance section of the NMNAP. In order to strengthen the quality assurance of human resources, TFNC, which has the legal mandate, should consider establishing a system of accreditation for Nutrition Officers, similar to that of South Africa, to ensure that all Nutrition Officers have the basic proficiencies and competencies which will enable them to be effective in supporting implementation of all aspects of the NMNAP.

143. In addition to human resources, institutional capacity for leading and managing the NMNAP in a dynamic context, especially as the country transitions into a middle-income country, is very important. It will thus, be critical for the coordinating structures at all levels (HLSCN, regional/LGA steering committees on nutrition) to be institutionalized and provided with the needed recognition responsible for priority Government work. An immediate emphasis should include the development of TFNC capacity and institutionalization of the SUN focal point in the Prime Minister's Office. Already the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) and PO-RALG have institutionalized Nutrition Units, whose capacities also require to be developed. The implication is that institutional and individual capacities across governance structures will need to strive for a collective effort of social innovation, by including the development of *nutrition collaborative leadership* capacities of the nutrition community through action-learning, soft skills development, upholding of quality and accountability and capturing the impact of the NMNAP coordination space.

6.5 Action Plan for Multisectoral Nutrition Governance

144. The Multisectoral Nutrition Governance (MNG) Action Plan addresses the following objectives of the 2016 Food and Nutrition Policy: -

1) To enhance national capacity for improved nutrition.
2) To strengthen multisectoral coordination of nutrition services and interventions in the country.
3) To improve regional and international collaboration for nutrition improvement.
4) To ensure that nutrition services at all levels in the country are gender sensitive.
5) To decentralize planning, management, and coordination of nutrition services to the local Government level
6) To strengthen good governance in nutrition at all levels.

145. The MNG Action Plan addresses the core governance needs for implementation of the NMNAP to ensure an enabling environment for nutrition improvement. They include: efficient leadership and management, policy guidance, enabling legislations and regulations, appropriate structures for coordination and service delivery, sufficient resources (human and financial) for implementation of interventions, and good governance at all levels. The MNG action plan also addresses the need for increased and sustainable political commitment and national response to prioritize nutrition and create better enabling environment for improved nutrition, through advocacy and social mobilisation.

146. The proposed activities and timeline for multisectoral nutrition governance is shown in *table 20*, the output based budget in *table 21* and the annualized budget distribution in *figure 21* below.

Table 20: Proposed activities and timeline for Multisectoral Nutrition Governance

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
6.1	Increased Government political and financial commitment to Nutrition																						
6.1.1	Disseminate the Revised Food and Nutrition Policy, Policy Implementation Strategy and NMNAP to all levels	TFNC	PORALG, Key ministries, DPs, PANITA																				
6.1.2	Review key line sectoral policies, strategies and guidelines	TFNC	PMO, PORALG, MDAs, DPs																				
6.1.3	Conduct sensitization campaigns to the public and community on laws and regulations related to food and nutrition	TFNC	PMO, TFDA, TBS, Media agencies, MoI																				
6.1.4	Prepare and disseminate policy briefs on key nutrition issues to guide policy makers and other actors	PMO	MOHCDGEC, MDAS, PANITA																				
6.1.5	Review and develop Nutrition Advocacy materials and tools (Radio programs, TV documentaries, printed materials, power point presentations)	TFNC	PMO, PORALG, DPs, PANITA																				
6.1.6	Conduct capacity building among MP nutrition champions on nutrition specific and sensitive interventions (meetings, trainings, field visits)	TFNC	PMO, PORALG, DPs, PANITA																				
6.1.7	Support the MP nutrition champion group to review their nutrition strategic plan	PANITA	PMO, TFNC, CSOs, DPs																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
6.1.8	Conduct advocacy meetings on nutrition for MPs, RCs, DCs, Counsellors, RAS, DEDs and other influential people	PANITA	PMO, TFNC, CSOs, DPs, PO-RALG,																				
6.1.9	Orient nutrition focal points and key decision makers in line ministries on planning and budgeting of nutrition sensitive activities in relevant sectors	PMO	PORALG, Key Ministries, TFNC, DPs,																				
6.1.10	Conduct annual zonal planning and budgeting meetings with region and LGA multisectoral teams	PORALG	RS, LGA, TFNC, DPs, NGOs, PANITA																				
6.1.11	Establish a Joint National NMNAP Resource Mobilisation Committee (JNRMC)and conduct quarterly working sessions	PMO	MOHCDGEC, MDAs, TFNC, PORALG, DPs, PANITA																				
6.1.12	Facilitate JNRMC to organize fundraising events for resource mobilisation to implement NMNAP	PMO	MOHCDGEC, MDAs, TFNC, PORALG, DPs																				
6.1.13	Conduct meetings with the Government budget preparatory committee to advocate integration of nutrition priorities into budget guideline	MOFP	PMO, PORALG TFNC																				
6.1.14	Support representation of Tanzania nutrition teams in relevant regional, international and global cooperation frameworks to enhance scaling up of nutrition in the country	MFAECRIC	PMO, PORALG, TFNC, MOHC-DGEC																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
6.1.15	Develop operational guidelines on good governance for effective implementation of NMNAP	PMO	TFNC, PORALG, DPs, PANITA					■	■														
6.2	Functional multisectoral coordination at all levels																						
6.2.1	Review composition and terms of reference for HLSCN	PMO	PORALG, MDA, TFNC, DPs, PANITA			■	■																
6.2.2	Establish and operationalise HLSCN Secretariat (Full time staff, office set up, equipment)	PMO	MDAs, TFNC, DPs					■	■						■								
6.2.3	Conduct HLSCN meetings every six months	PMO	PORALG, MDAs, TFNC, NGOs, PANITA, DPs		■		■		■		■		■		■		■		■		■		■
6.2.4	Review the composition and ToR of the Multi Sectoral Nutrition Technical Working Group (MNTWG) and its Consultative Groups based on the NMNAP's structure	PMO	PORALG, MDAs, TFNC, DPs, NGOs			■	■																
6.2.5	Conduct MNTWG and Consultative Groups meetings every six months	TFNC	MDAs, DPs	■		■		■		■		■		■		■		■		■		■	
6.2.6	Review ToR for Regional and Council Nutrition Steering Committees (R/CNSCs)	PORALG	PMO, TFNC, RS, LGA, PANITA			■																	
6.2.7	Establish and conduct R/CNSC meetings in all regions and councils according to revised ToR	PORALG	PMO, TFNC, RS		■		■		■		■		■		■		■		■		■		■

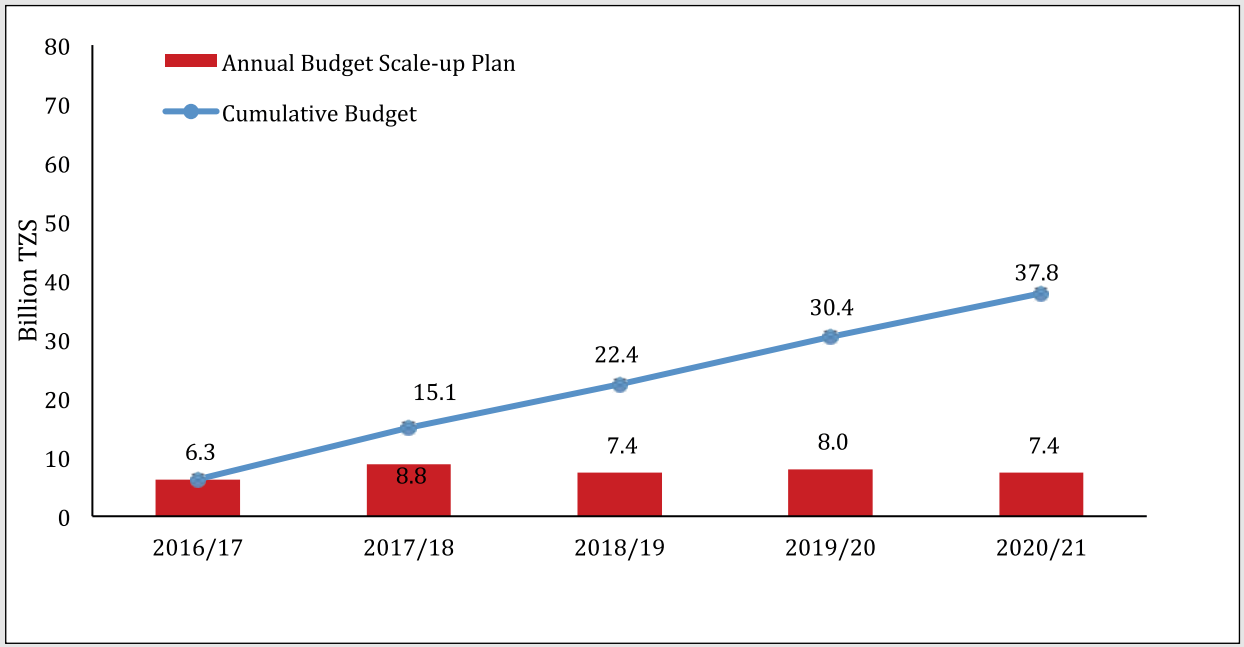
	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
6.2.8	Review Food and Nutrition Act No. 24 of 1973 to provide TFNC with the necessary mandate as a regulatory authority	MOHCDGEC	PMO, TFNC,																				
6.2.9	Conduct mapping of nutrition stakeholders (interventions and geography)	TFNC	PORALG, RS, LGA, DPs, PANITA																				
6.3	Improved human resources and capacities for nutrition																						
6.3.1	Review Terms of Reference for nutrition focal persons in all nutrition sensitive ministries	PMO	TFNC, MDAs, DPs																				
6.3.2	Employ regional and district nutrition officers in all regions and councils and nutrition officers at the central level (TFNC, MOHC-DGEC, PO-RALG)	PORALG	TFNC, MOHC-DGEC, PO-PSM, LGA																				
6.3.4	Review pre-service curricula for nutrition related training schools	MOHCDGEC,	TFNC, LGA MOHCDGEC, PO-PSM, SUA																				
6.3.5	Review in-service training programme for Regional and District Nutrition Officers	TFNC	P0RALG, SUA, Professional Bodies, DPs																				
6.3.6	Provide nutrition in-service training to all district & Regional nutrition, extension officers and nutrition focal persons from the key line sectors	TFNC	PORALG, RS, LGA, SUA, DPs																				

Table 21: Output based budget for Nutrition Governance

Expected Results		Budget in Billion TZS						Total USD (million)
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 6:	Efficient and effective nutrition governance	6.3	8.8	7.4	8.0	7.4	37.8	17.18
Output 6.1:	Increased Government political and financial commitment to Nutrition	0.65	2.24	1.70	1.70	1.70	7.98	3.63
Output 6.2:	Functional multisectoral coordination at all levels	0.47	0.76	0.52	0.52	0.52	2.78	1.26
Output 6.3:	Improved human resources and capacities for nutrition	5.15	5.81	5.15	5.78	5.15	27.04	12.29

***: Exchange rate 1 USD = 2200 TZS*

Figure 21: Annual budget distribution for multisectoral nutrition governance



CHAPTER 7

MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)

MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)

7.1 Overview

147. The Government recognizes the importance of monitoring and evaluation not only for tracking program performance and implementation, but also for tracking financial resources and building an evidence base for decision making. Thus, this NMNAP proposes a harmonized Nutrition Information System which generates data reflecting the multisectoral approach to nutrition, embracing the national, regional, district and community levels.

148. Currently, there is an "informal" multisectoral nutrition information system (MNIS) in Tanzania which is made up of a series of large-scale national surveys such as the Tanzania Demographic and Health Surveys (TDHS) started in 1992 and carried out every five years, the STEP surveys started in 2009 and implemented every four years, the Nutrition Public Expenditure Review (PER-N) started in 2013 and the recent National Nutrition Surveys (NNS) started in 2014 and planned to be repeated every four years. However, these cross-sectional systems are evaluative in nature given the long intervals between the surveys and are best used for policy and strategy development and not for tracking operational progress nor for the assessment of critical bottlenecks constraining effective delivery of interventions. Moreover, these regular surveys provide information that is statistically representative only at the regional and national levels without data relevant to districts/councils and communities, thereby making it difficult to track progress at these crucial levels. For operational monitoring, there are several systems that collect nutrition-relevant data on a routine basis, like the Food Security Information System, the Health Management Information System (HIMS), Growth Monitoring, the Education Information Management System (EIMS) and the Tanzania Commission for AIDS (TACAIDS) information system among others, although these have not been leveraged nor analysed for their maximum value from a nutrition perspective.

149. The full potential of a nutrition information system can be harnessed if the system covers all administrative levels, from national to council and community levels; if the data can be analysed quickly and used at the point of collection and if the timeliness and quality of the information collected is robust. The value of information systems is also a function of the specific indicators employed and the extent to which data collected to inform these indicators have direct program relevance and can lead to appropriate remedial actions. The capacity to undertake such practical and timely analyses and interpretation is critical in order to provide feedback in ways that can improve the design and refinement of strategic priorities of the program.

150. Establishing an effective nutrition information system requires a strong institutional base and capacity. Currently, there are two key national institutions that collect specific nutrition data: The Tanzania Food and Nutrition Centre (TFNC) and the National Bureau of Statistics (NBS). However, to improve harmonization and coordination of all data contributing to a Multisectoral Nutrition Information System, as required by this NMNAP, there is need to have a single entity with the mandate and the expertise for nutrition information. This will ensure that data collection, analysis and use of information can be better streamlined and integrated with program implementation. For the NMNAP, this institution should be TFNC and should be provided with the training and resources to build capacity to do this work.

151. A good multisectoral nutrition information system (MNIS) requires a robust performance framework which includes indicators at the three key levels of results articulated in this NMNAP: **output, outcome and impact**. For operational purposes, results at the activity level (program inputs) have also been included in the action plan of the Key Result Area of Multisectoral Nutrition Information

System *(Annex 7* to this NMNAP). Monitoring progress against these results will ensure that both outputs/outcomes and process are captured to assess not only achievements, but also to understand the key factors which contribute to these achievements. An information system will be most effective if it is able to balance results-based data on both program performance (process) and outcomes, rather than focus exclusively on outcomes which is the approach taken by most countries.

152. Lastly, the use of mobile phone technology may offer an innovative opportunity to strengthen the quality, timeliness, availability and response of the system, especially at the community level. The rapid expansion of mobile network coverage, growing mobile phone penetration and decreasing service costs in Tanzania could enable the use of this technology to strengthen and broaden community-based monitoring for caregivers, communities, the Government and other stakeholders. As of 2016, there were about 27 million mobile phones (53 percent of the total population of 51 million) and a third of the population (about 17 million people) are connected to the internet. It is in this respect that a key action in the MNIS is to develop specific technological tools to expand the collection and availability of nutrition data which take advantage of the extensive mobile phone connectivity.

153. The NMNAP also considers monitoring actions in the four key Scaling-Up Nutrition (SUN) Movement processes that are tracked annually: (i) Bringing people together in the same space for action (ii) ensuring a coherent policy and legal framework, (iii) aligning actions around a Common Results Framework, and (iv) Financial Tracking and Resource Mobilization. The tracking of the performance of these processes will also support the annual joint SUN country assessments for Tanzania.

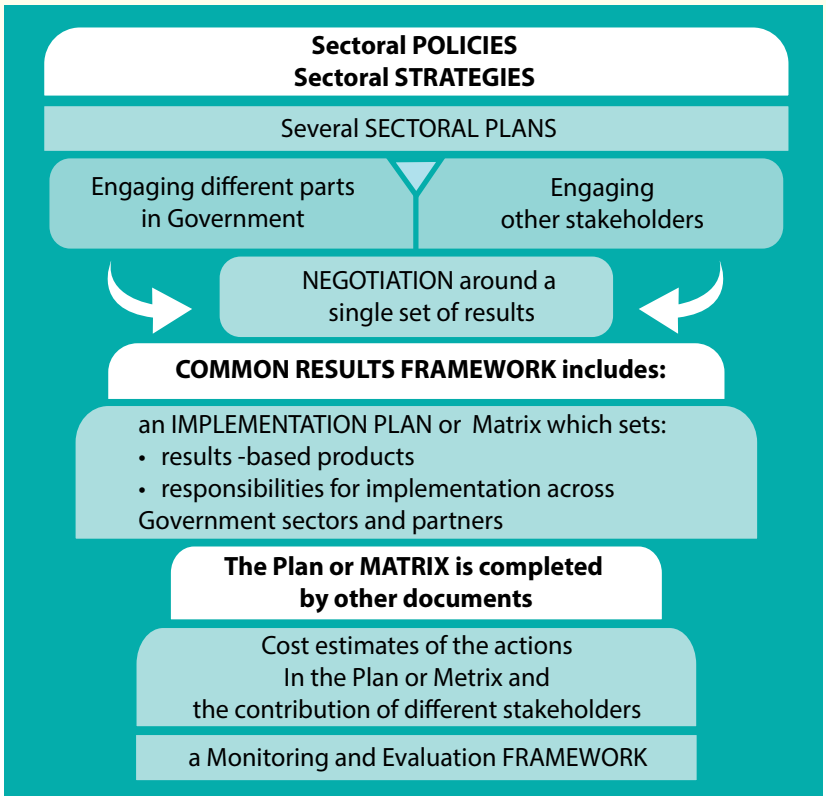
7.2 Common results, resources and accountability framework (CRRAF)

154. In developing the NMNAP, an agreement was reached to develop a single set of nutrition results – a **Common Results, Resources and Accountability Framework (CRRAF)** – which served as the basis for developing, aligning and securing consensus for the NMNAP. According to the Scaling Up Nutrition (SUN) Movement, a CRRAF should ideally have the following features:

1) Expected results for improvement of nutritional status;
2) Defined populations in which these improvements will be seen;
3) Interventions necessary to achieve the results and clear indications on the current coverage level and on the goal coverage;
4) Identified responsibilities of line ministries and sectors within Government for implementing the interventions;
5) The roles and responsibilities of non-Government partners;
6) A shared framework for performance monitoring and evaluation; and
7) A matrix of costs which identifies the contribution of Government (including human resources) and of other implementers.

155. *Figure 22* below presents the key ingredients of a Common Results, Resources and Accountability Framework (CRRAF). Note that the CRRAF can only be designed once there is agreement and consensus on a core set of results which emerge from the process of developing individual sectoral policies and strategies, and engaging all partners who will contribute to the NMNAP.

Figure 22: Key ingredients of common results frameworks (SUN)



156. *Appendix 2* summarizes the **Common Results, Resources, and Accountability Framework for the NMNAP,** which fulfils all the features and ingredients identified as ideal by the SUN Movement.

7.3 Monitoring, reviews and evaluation

157. The NMNAP will be monitored based on the CRRAF primarily using the annual **Joint Multisectoral Nutrition Reviews (JMNRs),** which will be used to review operational progress, challenges and opportunities and recommend ways forward.

1) The JMNR 2019 will serve as the Mid-term Review (MTR) of the NMNAP. This JMNR/MTR will review progress after implementation of FY2016/17, FY2017/18, and FY 2018/19 and will be preceded by a *Public Expenditure Review on Nutrition (PER-N) for FY 2016/17 and 2017/18 and the National Nutrition Survey (SMART survey) in 2018*. These two key studies will provide the necessary evidence for any adjustments in strategy and articulated results including targets. The preparation of the NMNAP (2021-2026) will be initiated following the JMNR 2019 and finalized in June 2021.
2) The JMNR 2021 will be used to evaluate the NMNAP (2016-21). It is expected that this JMNR will be preceded by the *Tanzania Demographic and Health Survey (TDHS) or a National Nutrition Survey in 2020*.

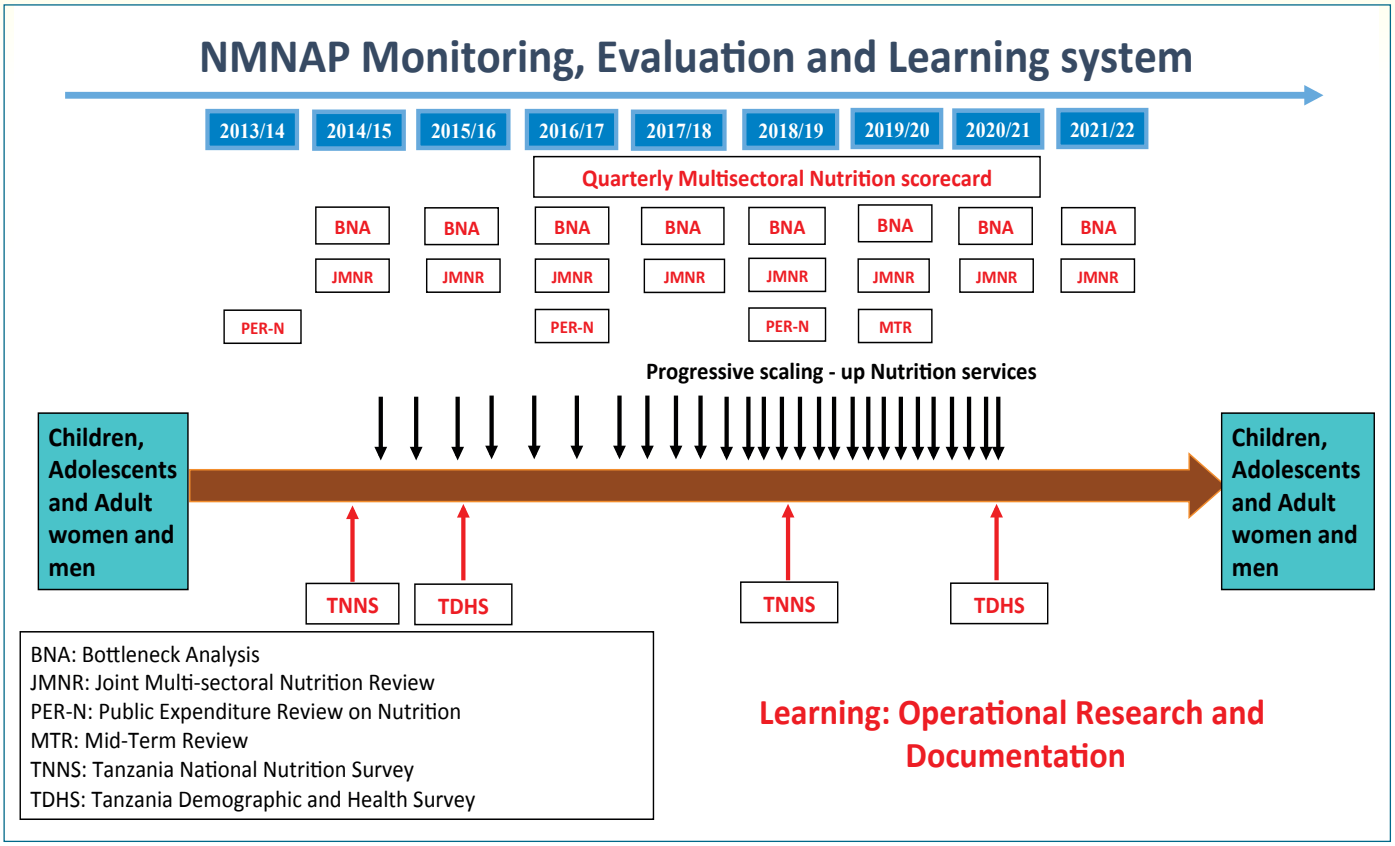
158. The action plans for each of the key result areas include a number of critical performance indicators which will be tracked and will help determine whether activities are being implemented as expected, leading to expected outputs. This tracking is an essential component of a M&E system and should be reviewed on an annual basis and should lead to modification of plans and investments if needs be.

7.4 Learning and operational research

159. Operational research focusing on identification of challenges in implementing the NMNAP will be designed and implemented by relevant national and international academic institutions. Students doing their theses will be encouraged to identify specific areas of research that will help address particular challenges in the implementation of the NMNAP. A critical component of the annual JMNRs will be to identify any areas that require more detailed operational research which could then be taken up during the succeeding years. Learning will be enhanced by linking implementation not only to research, but also to pre-service and in-service training.

160. *Figure 23* summarizes the monitoring, evaluation and learning framework that will be used for the NMNAP. Since 2014, the Government, with support from UNICEF, has been conducting bottle neck analysis (BNA) of some key areas of the NNS as a critical input into the annual Joint Multisectoral Reviews (JMNR) and these will be expanded to cover all the seven NMNAP key result areas.

Figure 23: Monitoring, evaluation and learning framework



7.5 Action plan for multisectoral nutrition information system (MNIS)

161. The Food and Nutrition Policy objective that the MNIS will address is: "to enhance national capacity for generation of new knowledge and solutions to nutritional needs in the country." To achieve this, the NMNAP proposes several complementary strategic actions:

1) To establish and build the capacity of TFNC as the institutional base for the multisectoral nutrition information system;
2) To review and strengthen existing routine data collection, analysis and interpretation capacity in Government and among stakeholders at national, regional, district and LGA and determine the potential contribution to on the multisectoral nutrition information needs;
3) To include, collect and report on relevant nutrition indicators in the appropriate national surveys;
4) To align implementation of the NMNAP with a learning framework that guides monitoring and evaluation for continuous improvement of the nutrition response; and
5) To strengthen the capacity of nutrition stakeholders to carry out operational research to improve nutrition programming and training.

162. *Table 22* shows the MNIS proposed activities and timelines; *table 23* the planned budget and *figure 24* the annualized distribution of the budget.

Table 22: Proposed activities and timeline for multisectoral nutrition information system (MNIS)

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
7.1	Robust systems of data collection, analysis, interpretation and feedback among stakeholders are in place at all levels																						
7.1.1	revised nutrition indicators and build capacity to use mobile application to facilitate data collection among DHIS 2 focal persons, nutrition officers and Community Health Workers	TFNC	MOHCDGEC, ICT Institute			■		■	■	■	■	■	■						■	■	■	■	■
7.1.2	Review Growth Monitoring and Promotion guidelines and provide growth standards booklets to mothers of children under 2 years old	MOHCDGEC	FNC, LGA, DPs, NGOs, PANITA			■	■	■	■	■	■	■	■	■	■	■	■	■	■				
7.1.3	Equip all health facilities and each community health worker with anthropometric equipment (weighing scale, length measuring boards, MUAC)	TFNC	MOHCDGEC, LGA and NGOs			■				■				■				■				■	
7.1.4	Train 2 health staff annually per health facility and 2 CHWs per village on the use of anthropometric equipment and on Growth Monitoring and Promotion	TFNC	MOHCDGEC, LGA, NGOs			■	■			■	■			■	■			■	■			■	■
7.1.5	Train national trainers, regional and district nutrition officers and undertake annual bottleneck analysis of coverage of key nutrition interventions	TFNC	Key line Ministries, LGA	■			■	■			■	■			■	■			■	■			■
7.1.6	Advocate and support strengthening of nutrition relevant indicators into other sectors' information systems (Health, WASH, Education, Social Protection, Food Security, Finances)	TFNC	MDAs, LGA, NGOs, PANITA			■				■				■				■				■	

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
7.1.7	Develop multisectoral nutrition scorecard, its database and train regional and council nutrition officers on its use, data analysis and interpretation	TFNC	PORALG, MOHCDGEC, LGA																				
7.1.8	Equip TFNC, nutrition focal points in MDAs, regional and council nutrition officers with IT material (server, laptop, modem and printers)	TFNC	PORALG, MOHCDGEC, DPs, LGA																				
7.1.9	Develop and harmonize data elements and nutrition data collection tools at all levels	TFNC	MDAs, LGA, DPs, NGOs																				
7.2	Relevant nutrition indicators integrated, collected and reported in national surveys																						
7.2.1	Equip TFNC with anthropometric and IT (laptops, tablets, modem) equipment; and train TOT and enumerators to undertake national nutrition surveys using SMART methodology	TFNC	PORALG, NBS, LGA, UN and Other DPs																				
7.2.2	Train enumerators and supervisors on measurement of anthropometric and biological indicators and provide supportive supervision during 2020 TDHS	NBS	MOHCDGEC, TFNC, LGA, MDAs & DPs																				
7.2.3	Train enumerators and supervisors on anthropometric measurements, provide supportive supervision and the use of nutrition software during 2017 Household Budget Survey	NBS	TFNC, MoFP, LGA, REPOA, DPs																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
7.2.4	Train enumerators and supervisors on anthropometric measurements, provide supportive supervision and the use of nutrition software during the 2017 and 2019 National Panel Surveys	NBS	MOHCDGEC, MoFP, TFNC, LGA, REPOA, DPs																				
7.2.5	Review national guidelines for food security and nutrition surveys to integrate SMART methodology and develop data quality assessment tool	TFNC	PMO, Line Ministries, LGA, LGA, DPs, PANITA, NGOs																				
7.2.6	Conduct regular rapid nutrition assessments in food insecure districts and integrate relevant anthropometric indicators into the food security and nutrition analysis system (MUCHALI)	MALF	PMO, TFNC																				
7.2.7	Support training of enumerators and supervisors and undertake assessment of acute malnutrition in selected heavy burdened councils using SQUEAC methodology	TFNC	PORALG, PMO, RSs, LGA																				
7.2.8	Support collection of indicators for diet related Non Communicable Diseases (NCDs) in STEPS survey	NIMR	PORALG, PMO, RSs, LGA																				
7.3	Capacity of nutrition stakeholders developed to align implementation of NMNAP with learning framework and carry out operational research																						
7.3.1	Carry out annual joint multisectoral nutrition review meeting (review of implementation of nutrition activities, common result framework of the NMNAP, analyse, document progress, challenges and lesson learnt by LGA, MDAs and SCO in the country	TFNC	PORALG, PMO, MOHCDGEC, LGA, DPs, NGO's, PANITA																				

	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
7.3.2	Carry out public expenditure review on nutrition in 2017 and 2019, disseminate results and develop policy brief	MoFP	MoHCDGEC, TFNC, LGA, PANITA, NGO's																				
7.3.3	Undertake mid-term (2018/19) and end-line review of the NMNAP (2016-21); and formulate recommendations for the preparation of NMNAP (2021 - 2016)	PMO	PO-RALG, MOHCDGEC, TFNC, LGA, DPs, PANITA, NGO's																				
7.3.4	Develop and maintain an integrated platform for multisectoral nutrition management information system for knowledge sharing	TFNC	PORALG, PMO, MOHCDGEC, LGA, DPs																				
7.3.5	Develop, implement, monitor and evaluate the implementation of the learning framework and improve learning along the course of implementation of the NMNAP	TFNC	PO-RALG, PMO, MOHCDGEC, LGA, DPs																				
7.3.6	Develop nutrition research priorities list, conduct formative research, share research findings and best practises for nutrition in Tanzania	TFNC	LGA, NIMR, COSTECH, DPs, NGO's																				
7.3.7	Strengthen statistical analysis capacity across sectors and carry out studies to identify drivers of stunting in Tanzania using various datasets	NBS	TFNC, NIMR, COSTECH, DPs																				

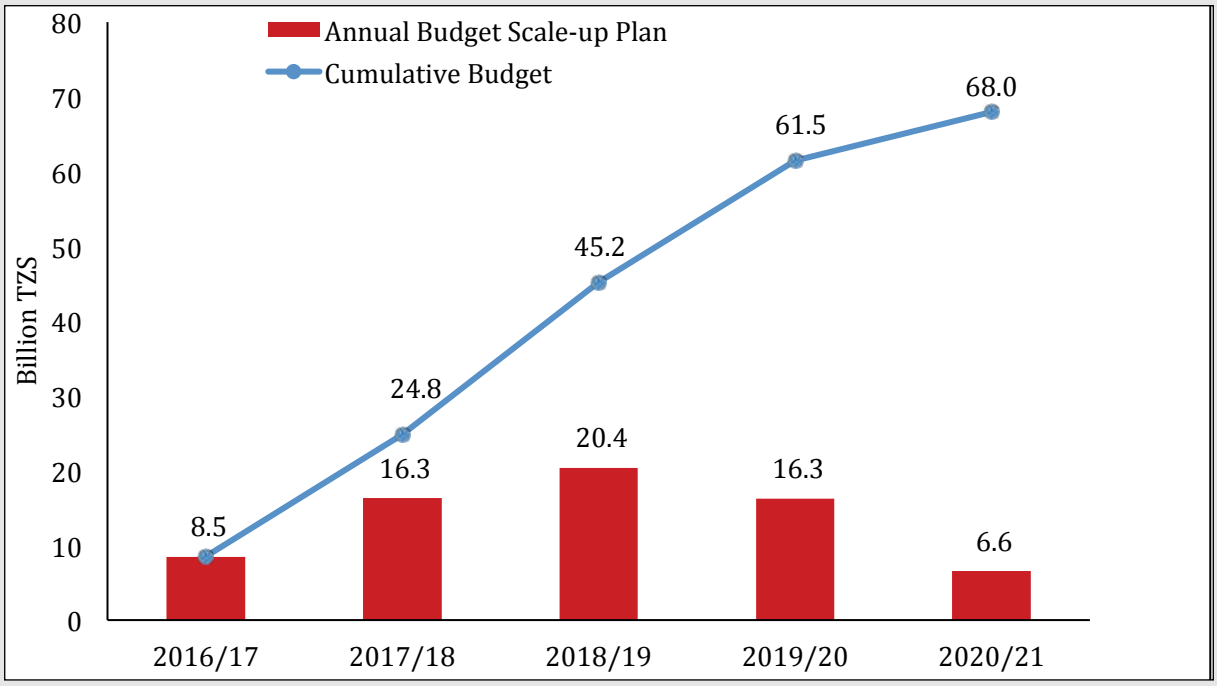
	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2021/21			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
7.3.8	Strengthen capacities (human resource, equipment and supplies) of nutrition laboratories (TFNC, SUA) as per needs assessment	TFNC	SUA																				

Table 23: Annualized budget to Key Result Area of Nutrition Information System per output

Expected Results		Budget in Billion TZS						Total Budget in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 7:	Quality nutrition related information is accessible and used to allow Government and partners to make timely and effective evidence informed decisions	8.5	16.3	20.4	16.3	6.6	68.0	30.91
Output 7.1:	Robust systems of data collection, analysis, interpretation and feedback among stakeholders are in place at all levels	5.44	12.59	16.32	14.55	2.53	51.43	23.38
Output 7.2:	Relevant nutrition indicators integrated, collected and reported in national surveys	1.52	0.39	2.51	0.27	2.59	7.28	3.31
Output 7.3:	Capacity of nutrition stakeholders developed to align implementation of NMNAP with learning framework and carry out operational research	1.53	3.32	1.57	1.44	1.43	9.29	4.22

***: Exchange rate 1 USD = 2200 TZS*

Figure 24: Annual budget distribution for multisectoral nutrition information system key result area



CHAPTER 8

STRATEGIC INVESTMENT PLAN FOR THE NMNAP

STRATEGIC INVESTMENT PLAN FOR THE NMNAP

8.1 Overview

164. Financing the NMNAP has to take into account the changing global aid architecture: e.g.

1) the emergence of new actors in the donor community like the global funds, private foundations; non-DAC[30] bilateral donors;
2) the development of new financing instruments e.g. budget support, domestic financing; and
3) new forms of dialogues that require improved donor coordination, harmonization and alignment with national priorities.

165. The new aid architecture requires a framework that is strategically focused, results-oriented, inclusive of all actors and one that enhances national ownership, leadership and participation. With reference to this NMNAP, the framework should ensure that nutrition is a Government priority included in strategic discussions and is part and parcel of the monitoring, reporting and evaluation of the medium and long term development planning, such as the FYDP-II 2016/17-2020/21 and Development Vision 2025 (MKUKUTA). It should also be noted that when Tanzania transitions from a low income country (LIC) into a middle income country (MIC), which is expected to be during the period of this NMNAP, the aid structure and funding opportunities are likely to shift from grants, normally targeted at human development, to physical infrastructure loans. This aspect needs to be part of the strategic discussions.

8.2 Financial requirements of the NMNAP

166. *Table 24* provides a summary of the minimum financial requirements to implement the NMNAP disaggregated by key result areas and *table 25* shows the same by category of interventions based on the adopted conceptual framework. Excluding the nutrition sensitive interventions (NSI) already budgeted for in the Government's Five-Year Development Plan 2016/17-2020/21, the overall financial requirement for the NMNAP is TZS 590 billion (US$268 million). The budget spread *(figure 26)* follows the normal distribution, indicating that costing was done more or less realistically.

167. Looking at the budget from the perspective of the thematic key result areas, **t**he highest allocation is for maternal, infant, young child and adolescent nutrition (33 percent), followed by micronutrient malnutrition (20 percent) and integrated management of acute malnutrition (16 percent). The allocation for the prevention and management of diet-related non-communicable diseases is 12 percent, multisectoral nutrition governance seven percent, and multi-sectoral nutrition information system 12 percent *(see figure 27)*. If the Nutrition Sensitive Interventions (NSI) are included, the overall budget increases to about TZS 22,262billion (US$10,119 million). The sector distribution of the NSI (including health) is shown in *figure 28*. The greatest share of the allocation is for health (30 percent), followed by WASH (26 percent), social protection (19 percent) mainly for TASAF, agriculture (17 percent), education (8 percent) and environment is less than 1 percent.

30 DAC = Development Assistance Committee of the European Union's Organization for Economic Co-operation and Development –OECD-. The DAC's mandate is to promote development co-operation and other policies so as to contribute to sustainable development, including pro-poor economic growth, poverty reduction, improvement of living standards in developing countries, and a future in which no country depend on aid.

Table 24: Financial requirements of the NMNAP disaggregated by expected results (outcome and outputs)

Expected Results		Budget in Billion TZS						Total Budget in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Expected Outcome 1:	Increased proportion of adolescents, pregnant women and mothers / caregivers of children under two years who practice optimal maternal, infant and young child nutrition behaviours	34.9	49.9	60.9	36.1	14.0	195.8	89.0
Output 1.1:	Increased coverage and quality of MIYCAN services at the community level by June 2021	23.8	38.1	46.7	26.1	10.6	145.4	66.10
Output 1.2:	Improved quality of MIYCAN services at the health facilities level by June 2021	10.2	10.7	13.2	9.2	2.5	45.8	20.83
Output 1.3:	MIYCAN is promoted at all levels through mass-media and the use of new technologies by June 2021	0.6	0.6	0.6	0.6	0.6	2.9	1.30
Output 1.4:	Improved MIYCAN law enforcement through advocacy and capacity building of key institutions	0.3	0.5	0.3	0.3	0.3	1.7	0.78
Expected Outcome 2:	Children, adolescents and women of child bearing age consume adequate micronutrients	21.9	23.4	24.3	25.3	24.9	119.8	54.46
Output 2.1:	Increased access to food fortification (home and mass) for children aged 6-23 months, pregnant women and women of childbearing age by 2021	15.9	16.3	17.0	17.9	17.7	84.8	38.54
Output 2.2:	Enhanced services for Vitamin A supplementation among children aged 6-59 months by 2021	3.2	3.4	3.4	3.4	3.2	16.6	7.54
Output 2.3:	Increased availability of adequately iodized salt in by 2021	0.98	1.53	1.71	1.72	1.55	7.48	3.40
Output 2.4:	Improved anaemia prevention and control interventions among women of childbearing age and children under 5 years old by 2021	1.85	2.24	2.27	2.25	2.36	10.96	4.98
Expected Outcome 3:	Increased coverage of integrated management of severe and moderate acute malnutrition by 2021	4.0	12.6	24.6	30.7	24.9	96.7	43.94
Output 3.1:	Improved quality of services for management of severe and moderate acute malnutrition in at least 75% of health facilities by 2021	1.5	2.0	2.4	2.2	1.3	9.3	4.23

Expected Results		Budget in Billion TZS						Total Budget in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Output 3.2:	At least 75% of children under five years old are reached through screening for severe and moderate acute malnutrition at community level by 2021	0.1	2.4	4.0	6.4	7.2	20.1	9.16
Output 3.3:	Essential therapeutic nutrition supplies and equipment are available in at least 90% of health facilities providing services for management of severe and moderate acute malnutrition by June 2021	2.4	8.1	18.0	22.1	16.4	67.1	30.48
Output 3.4:	Strengthened integration of management of severe and moderate acute malnutrition at the national and subnational level by June 2021	0.024	0.024	0.049	0.024	0.024	0.15	0.07
Expected Outcome 4:	Communities in Tanzania are physically active and eat healthy	1.8	18.9	22.1	18.4	10.6	71.8	32.65
Output 4.1:	At least 50% of the school-age children and adult population are sensitized on risk factors for non-communicable diseases by 2021	0.04	17.0	20.3	16.6	8.7	62.7	28.48
Output 4.2:	Policies, social, cultural and structural norms are established to enable at least 50% of the community to engage in healthy lifestyles by 2021	1.8	1.9	1.8	1.8	1.8	9.2	4.17
Expected Outcome 5:	Line sectors, private sector and CSOs scale-up nutrition sensitive interventions to reach all communities to improve nutrition	4,128.4	4,287.0	4,950.9	5,058.2	3,247.2	21,671.7	9,850.78
Output 5.1: *	Communities have access to a diverse range of nutritious food throughout the year	728.1	737.0	723.5	720.5	713.1	3,622.3	1,646.48
Output 5.2: *	Communities regularly use quality maternal health including family planning, prevention and treatment of HIV and malaria services	1,461.0	1,556.0	1,704.0	1,801.0	NA	6,522.1	2,964.59
Output 5.3: *	Communities access adequate water sanitation and hygiene services	1,149.0	1,149.0	1,149.0	1,148.8	1,148.0	5,743.9	2,610.86
Output 5.4: *	Girls complete primary and secondary education	351.8	351.8	351.4	353.1	351.3	1,759.4	799.73

Expected Results		Budget in Billion TZS						Total Budget in Million USD**
		2016/17	2017/18	2018/19	2019/20	2020/21	Total	
Output 5.5: *	Poorest households benefit from conditional cash transfers, cash for work, and nutrition education during community sessions	436.9	491.5	1,021.3	1,033.2	1,033.2	4,016.2	1,825.56
Output 5.6: *	Vulnerable communities are able to cope with drought and climate change to avoid shortage of nutritious food during shocks	1.56	1.56	1.56	1.58	1.56	7.82	3.55
Expected Outcome 6:	Efficient and effective nutrition governance	6.3	8.8	7.4	8.0	7.4	37.8	17.18
Output 6.1:	Increased Government political and financial commitment to Nutrition	0.65	2.24	1.70	1.70	1.70	7.98	3.63
Output 6.2:	Functional multisectoral coordination at all levels	0.47	0.76	0.52	0.52	0.52	2.78	1.26
Output 6.3:	Improved human resources and capacities for nutrition	5.15	5.81	5.15	5.78	5.15	27.04	12.29
Expected Outcome 7:	Quality nutrition related information is accessible and used to allow Government and partners to make timely and effective evidence informed decisions	8.5	16.3	20.4	16.3	6.6	68.0	30.91
Output 7.1:	Robust systems of data collection, analysis, interpretation and feedback among stakeholders are in place at all levels	5.44	12.59	16.32	14.55	2.53	51.43	23.38
Output 7.2:	Relevant nutrition indicators integrated, collected and reported in national surveys	1.52	0.39	2.51	0.27	2.59	7.28	3.31
Output 7.3:	Capacity of nutrition stakeholders developed to align implementation of NMNAP with learning framework and carry out operational research	1.53	3.32	1.57	1.44	1.43	9.29	4.22
TOTAL WITHOUT NUTRITION SENSITIVE INTERVENTIONS		77.4	129.9	159.6	134.7	88.3	589.9	268.16
TOTAL WITH NUTRITION SENSITIVE INTERVENTIONS		4,205.8	4,416.9	5,110.5	5,193.0	3,335.5	22,261.7	10,118.93

**: Data were extracted from Five Year Development Plan (FYDP 2016-21) and sectoral plans (e.g. HSSP IV, TASAF) plus additional nutrition sensitive activities identified by NMNAP task team as they were not included in sectoral plans*

***: Exchange rate 1 USD = 2200 TZS.*

Table 25: NMNAP Budget overview by category of intervention and key results areas

Category of intervention	Key Results Areas	Annual Budget in TZS Billion					Total in TZS Billion	Total in USD Million
		2016/17	2017/18	2018/19	2019/20	2020/21		
Nutrition Specific Interventions	Maternal Infant, Young Child and Adolescents Nutrition	34.9	49.9	60.9	36.1	14.0	195.8	89.01
	Micronutrients	21.9	23.4	24.3	25.3	24.9	119.8	54.46
	Integrated Management Acute Malnutrition	4.0	12.6	24.6	30.7	24.9	96.7	43.94
	Diet related Non communicable Disease	1.8	18.9	22.1	18.4	10.6	71.8	32.65
Nutrition Sensitive Interventions	Agriculture sector	728.1	737.0	723.5	720.5	713.1	3,622.3	1,646.48
	Health and HIV sector	1,461.0	1,556.0	1,704.0	1,801.0	-	6,522.1	2,964.59
	WASH sector	1,149.0	1,149.0	1,149.0	1,148.8	1,148.0	5,743.9	2,610.86
	Education sector	351.8	351.8	351.4	353.1	351.3	1,759.4	799.73
	Social Protection sector	436.9	491.5	1,021.3	1,033.2	1,033.2	4,016.2	1,825.56
	Environment sector	1.6	1.6	1.6	1.6	1.6	7.8	3.55
Enabling Environment	Multispectral Nutrition Governance	6.3	8.8	7.4	8.0	7.4	37.8	17.18
	Multisectoral Nutrition Information System	8.5	16.3	20.4	16.3	6.6	68.0	30.91
Total Budget without Nutrition Sensitive Interventions		77.4	129.9	159.6	134.7	88.3	589.9	268.16
Total Budget with Nutrition Sensitive Interventions		4,205.8	4,416.9	5,110.5	5,193.0	3,335.5	22,261.7	10,118.93

**: Data were extracted from Five Year Development Plan (FYDP 2016-21) and sectoral plans (e.g. HSSP IV, TASAF) plus additional nutrition sensitive activities identified by NMNAP task team as they were not included in sectoral plans*

***: Exchange rate 1 USD = 2200 TZS*

Figure 26: NMNAP Budget overview without nutrition sensitive interventions

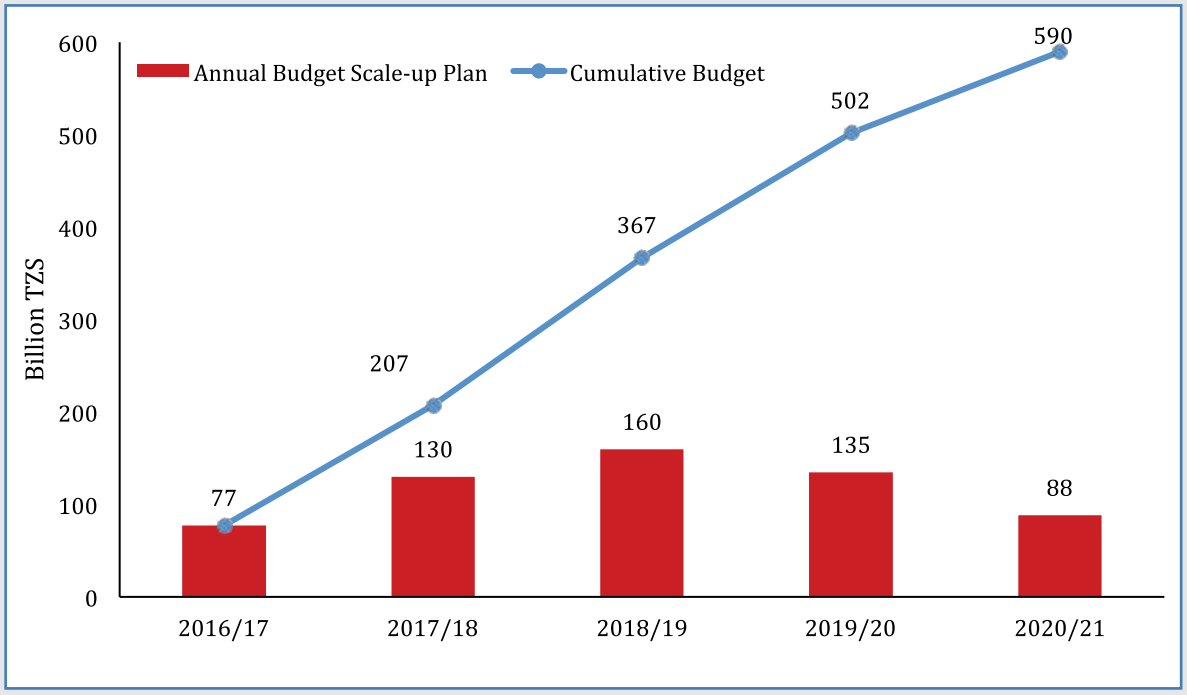


Figure 27: NMNAP Budget distribution by thematic Key Result Areas without Nutrition Sensitive Interventions

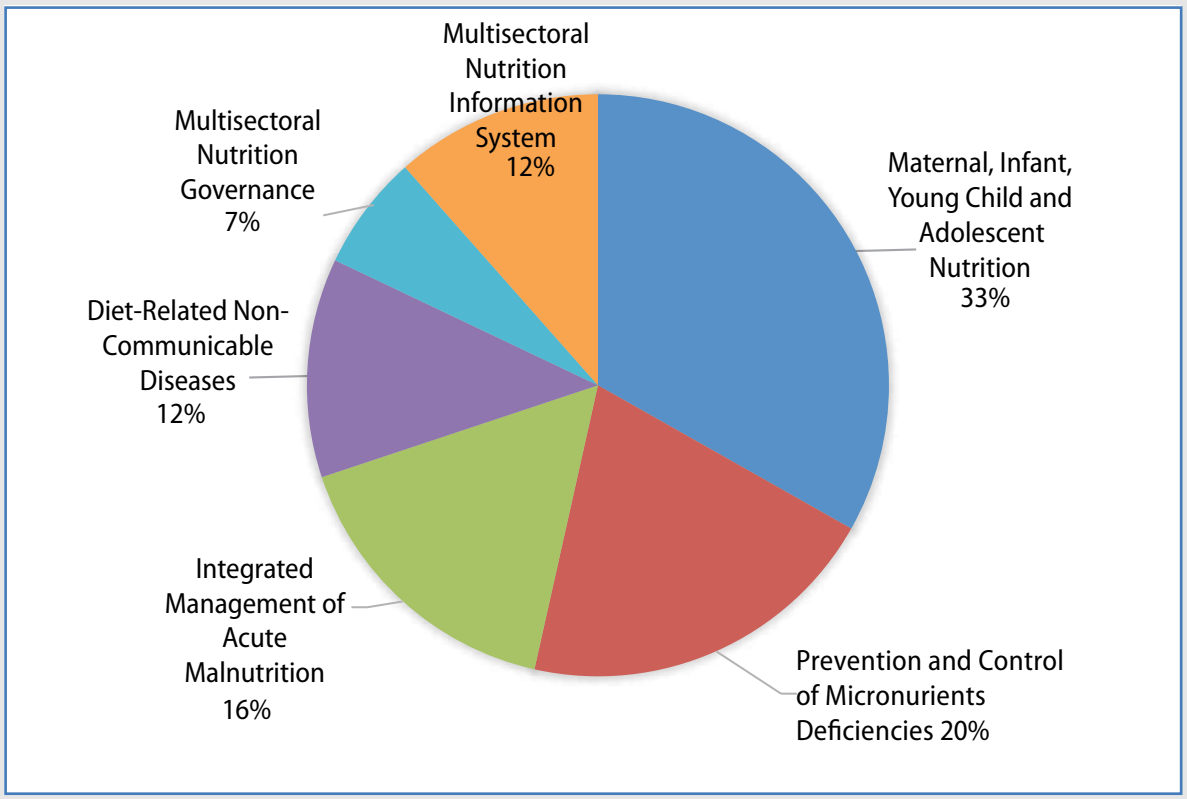
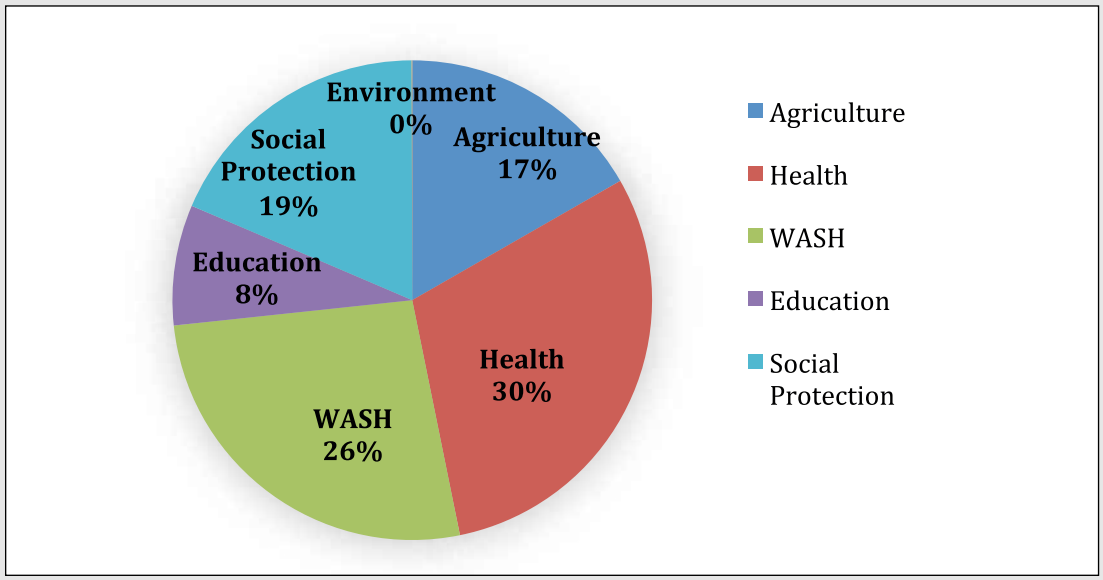


Figure 28: Budget distribution to nutrition sensitive interventions FYDP 2016/17-2020/21



8.3 Financial resources available and the funding gap

168. The process of developing the NMNAP also estimated the resources available from Government, development partners, civil society organizations and the private sector. This was done through a consultative process which included presentation of the key result areas and requesting stakeholders to describe their estimated financial commitments for the period of the NMNAP (2016/17-2020/21). Responses were received from the Government (from TFNC and LGA), UN agencies (FAO, WHO, WFP, UNICEF and IAEA), and some private sector companies that fortify flour and oil or import fortification premixes, micronutrient powders, and the salt iodation alliance comprising of MOHCDGEC/TFNC/TASAP). Responses from CSOs included GAIN, IMA World Health, CUAMM, Feed the Children, the International Potato Centre, Save the Children, COUNSENUTH and Mwanzo Bora (estimated by USAID).

169. The main reason for comparing the financial requirements against available resources was to determine the funding gap required to be mobilized to assure full implementation of the NMNAP. *Table 26* shows **the total resources available from the Government, development partners and the private sector is TZS 155.18 billion (US$ 70.5 million) against a planned budget of TZS 590 billion (US$ 268 million) giving a total funding gap of TZS 434.77 billion (US$ 197.6 million). In proportionate terms, about 26.3 percent of the NMNAP funds is available leaving a gap of 73.7 percent yet to be mobilized.**

170. The biggest funding gaps are seen in the key result areas of maternal, infant, young child and adolescent nutrition (US$ -54.97 million), micronutrients (US$ -43.81 million), integrated management of acute malnutrition (US$ -40.45 million), diet related non-communicable diseases (US& -32.48 million) and multisectoral nutrition information system (US$ -21.87 million).

Table 26: National Multisectoral Nutrition Action Plan (2016-2021) – Resources available and funding gap

Areas	Key Result Areas	NMNAP Financial Requirements	Resources Available for NMNAP				Funding Gap NMNAP	Funding Gap NMNAP	Proportion of Resources Available (%)	Proportion of Funding Gap (%)
			Government of Tanzania	Development Partners	Private Sector	Total Available				
		TZS billion						USD million		
Nutrition Specific Interventions	Maternal Infant, Young Child and Adolescents Nutrition	196	2.54	72.35	-	74.90	-120.93	-54.97	38%	-62%
	Micronutrients	120	0.51	10.69	12.23	23.43	-96.38	-43.81	20%	-80%
	Food Fortification (MNP, Flour and Oil)	85	0.36	0.77	12.17	13.30	-71.48	-32.49	16%	-84%
	Vitamin A Supplementation	17	0.07	10.31	-	10.38	-6.21	-2.82	63%	-37%
	Salt Iodization	8	0.03	2.25	0.06	2.34	-5.14	-2.34	31%	-69%
	Anaemia Prevention	11	0.05	6.49	-	6.53	-4.43	-2.01	60%	-40%
	Integrated Management Acute Malnutrition	97	1.24	6.43	-	7.67	-89.00	-40.45	8%	-92%
	Diet related Non communicable Disease	72	-	0.37	-	0.37	-71.46	-32.48	0.5%	-99.5%
Nutrition Sensitive Interventions	Agriculture sector	NA								
	Health and HIV sector									
	WASH sector									
	Education sector									
	Social Protection sector									
	Environment sector									
Enabling Environment	Multisectoral Nutrition Governance	38	15.12	13.81	-	28.93	-8.87	-4.03	77%	-23%
	Multisectoral Nutrition Information System	68	0.85	19.04	-	19.88	-48.12	-21.87	29%	-71%
TOTAL		590	20.3	122.70	12.23	155.18	-434.77	-197.62	26.3%	73.7%
PROPORTION (%)		100%	3.4%	20.8%	2.1%	26.3%	73.7%			

**: Exchange rate 1 USD = 2200 TZS

8.4 Resources mobilization plan

171. *Table 27* shows the resources mobilization plan. About 30 percent of the resources are planned to be obtained from the Government of Tanzania, 60 percent from development partners and 10 percent from the private sector. A key strategy for resource mobilization is the formation of a "thematic working group on resource mobilisation" that will develop a "Resource Mobilisation Strategy." Important issues to consider in developing the strategy will be to: review the global and national aid architecture with a view of including the NMNAP in strategic discussions; facilitate alignment of DPs, CSOs and private sector strategies and programmes with the NMNAP, establish mechanism for NMNAP financial tracking, and follow up on the Government's commitment to allocate TZS 1000 per child underfive per annum by councils starting in 2017/18 with a view to raising it gradually as resources permit.

Table 27: National Multisectoral Nutrition Action Plan (2016-2021) – Financial Resource Mobilization Plan

Areas	Key Result Areas	Funding Gap to be mobilized		Resources to be mobilized from Government of Tanzania		Resources to be mobilized from Development Partners		Resources to be mobilized from Private Sector	
		TZS Billion	USD Million	TZS Billion	USD Million	TZS Billion	USD Million	TZS Billion	USD Million
Nutrition Specific Interventions	Maternal Infant, Young Child and Adolescents Nutrition	-120.93	-54.97	36.28	16.49	72.56	32.98	12.09	5.50
	Micronutrients	-96.38	-43.81	28.92	13.14	57.83	26.29	9.64	4.38
	Food Fortification (MNP, Flour and Oil)	-71.48	-32.49	21.44	9.75	42.89	19.49	7.15	3.25
	Vitamin A Supplementation	-6.21	-2.82	1.86	0.85	3.73	1.69	0.62	0.28
	Salt Iodization	-5.14	-2.34	1.54	0.70	3.09	1.40	0.51	0.23
	Anaemia Prevention	-4.43	-2.01	1.33	0.60	2.66	1.21	0.44	0.20
	Integrated Management Acute Malnutrition	-89.00	-40.45	26.70	12.14	53.40	24.27	8.90	4.05
	Diet related Non communicable Disease	-71.46	-32.48	21.44	9.74	42.88	19.49	7.15	3.25
Nutrition Sensitive Interventions	Agriculture sector	NA							
	Health and HIV sector								
	WASH sector								
	Education sector								
	Social Protection sector								
	Environment sector								
Enabling Environment	Multisectoral Nutrition Governance	-8.87	-4.03	2.66	1.21	5.32	2.42	0.89	0.40
	Multisectoral Nutrition Information System	-48.12	-21.87	14.44	6.56	28.87	13.12	4.81	2.19
TOTAL		-434.77	-197.62	130.43	59.29	260.86	118.57	43.48	19.76
PROPORTION (%)			100%		30%		60%		10%

**: Exchange rate 1 USD = 2200 TZ*

8.5 Strategic prioritization of proposed action plans

172. Given the large funding gap of about US$ 198 million (74 percent of the US$268 million required), there will be need to prioritize interventions and activities in case of funding constraints, with the recognition that the NMNAP is already strategically prioritized for the results articulated. Specific activities that will be prioritized in case of funding constraints are those that contribute to: (1) increased coverage of maternal infant, young child and adolescent nutrition; (2) scale-up integrated management of acute malnutrition among children under five; (3) prevent anaemia among women of reproductive age (15-49 years); and (4) those that develop functional human resources and institutional capacity. The funding for these three result areas represents about 97 million USD over the 5-year period of the NMNAP.

173. The main reasons for prioritizing the above areas is to ensure nutrition investment in the early years of children to assure quality human capital formation. The areas prioritized are also amenable to immediate scale-up (quick wins), and the interventions impact highly on reducing the high burden of stunting, acute malnutrition in children underfive and the high levels of anaemia in women of reproductive age. Progress in these areas has been slow in the past, and ensuring they are funded is likely to result in quick gains in child survival, growth and improved human capital formation.

CHAPTER 9

RISK ANALYSIS AND MITIGATION (RAM)

RISK ANALYSIS AND MITIGATION (RAM)

9.1 Risks analysis

175. An important component of the NMNAP is to be able to identify and manage risks that may affect its smooth implementation. Risk analysis and management is one of the cornerstones of modern scientific and risk based approach to planning. It is the process of developing options and actions to enhance opportunities and reduce threats to the achievement of objectives. The process involves: -

1) **Risk identification** – define risk events and their relationship
2) **Risk impact assessment** - assessing probability (likelihood) of their occurrence and their consequences (impact). Consequences may include cost, schedule, technical performance, impacts as well as capability or functionality.
3) **Risk prioritization analysis**: identify risk events from most to least critical.
4) **Risk mitigation:** The ultimate purpose of risk identification and analysis is to prepare for risk mitigation. Mitigation includes reduction of the likelihood that a risk event will occur and/or reduction of the effect of a risk event if it does occur.

176. The interpretation of risk is based on the likelihood of its occurrence and the level of its consequences as shown in *table 28*.

9.2 Risk mitigation

177. Risk mitigation handling options include:

1) Assume/accept: Acknowledge the existence of a particular risk, and make a deliberate decision to accept it without engaging in special efforts to control it.
2) Avoid: Adjust program requirements or constraints to eliminate or reduce the risk. This adjustment could be accommodated by a change in funding, schedule, or technical requirements.
3) Control: Implement actions to minimize the impact or likelihood of the risk.
4) Transfer: Reassign organizational accountability, responsibility, and authority to another stakeholder willing to accept the risk.
5) Watch/monitor: Monitor the environment for changes that affect the nature and/or the impact of the risk and respond as appropriate.

178. Using the risk analysis framework in *table 28*, the risk analysis for the NMNAP can be summarized as shown in *table 32*, looking at their likelihood of occurrence, the consequence if it occurs, the overall risk prioritization and possible mitigation measures.

Table 28: The risk analysis framework

Likelihood level	5-Near certain	Low	Medium	High	High	High
	4-Highly likely	Low	Medium	Medium	High	High
	3-Likely	Low	Low	Medium	Medium	High
	2-Unlikely	Low	Low	Low	Medium	Medium
	1-Remote	Low	Low	Low	Low	Low
		1- Negligible	2-Minor	3-Marginal	4-Critical	5-Catastrophic
	Consequence/impact level					

Table 29: Risk analysis and mitigation table for the NMNAP

Identified risk	Likelihood of occurrence	Impact if it occurs	Overall risk	Risk mitigation
1. Low institutional capacity to lead and manage the NMNAP.	High	High	High	Develops capacity of the NMNAP lead institutions to be able to effectively lead, coordinate and manage implementation of the NMNAP. Include the capacities of TFNC, PMO-SUN Focal point, PO-RALG and MOHCDGEC nutrition sections.
2. Low functional skilled human resource capacity especially at community level.	High	High	High	Government to prioritize human resource development in nutrition and allocate adequate number of skilled staff to implement the NMNAP at all levels especially at the community level.
3. Inadequate funding of NMNAP.	Medium	High	Medium	Prioritize interventions and activities. TFNC in collaboration with MoHCDGEC, PMO, PO-RALG and development partners to develop a funding mobilization strategy.
4. Low commitment and collaboration by some key stakeholders.	High	High	High	Continue to advocate and actively coordinate with stakeholders to ensure their policies, strategies and plans on nutrition are aligned with the NMNAP.
5. Political Will and Government commitment wavers.	Low	High	Low	Advocacy to continue keeping nutrition high on the country's development agenda. Monitor and track inclusion of nutrition in nutrition relevant MDAs, parliament and political parties.
6. Occurrence of natural disasters (e.g. floods, drought, earthquake).	Medium	High	Medium	Accept and prepare for natural related disasters. They are likely to be localized in drought/flood prone areas. Such areas should be prioritized in emergency/disaster response plans. Need to monitor all possible disasters closely and respond appropriately. Develop a strategy for nutrition and climate change.
7. Political instability or civil conflict.	Low	High	Medium	Monitor closely. Though the likelihood of occurring is low overall risk is medium for low-intensity political tensions. The consequences are critical/catastrophic if political instability occurs.
8. Global and/or national economic shocks.	Medium	High	Medium	Monitor closely and adjust plan as appropriate

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APPENDIXES

APPENDIX 1: NMNAP THEORY OF CHANGE: ANALYSIS OF MAIN CONDITIONS FOR CHANGE

Condition 1: Adolescents, pregnant women and mothers/care givers of children under five years are supported to practice optimal nutrition behaviours

The **Condition #1 (C1)** of the NMNAP is about scaling-up promotional services to improve maternal, infant, young child and adolescent nutrition (MIYCAN). The key **assumptions** for scaling up MIYCAN services as a condition to achieve the NMNAP desired change are that*:*

- (A1.1) Adequate support to adolescents, pregnant women and care givers of children under five years will lead to adoption of optimal nutrition behaviours;
- (A1.2) There are standard sets of behaviours which improve nutrition.

The first is an assumption based on the experience of development practitioners, as well as on specific literature related to Scaling-Up Nutrition (SUN). The second is a scientific assumption, based on evidence that specific nutrition practices such as optimal breastfeeding and complementary feeding strongly contribute to improve nutrition and child survival and development (i.e. The Lancet Maternal and Child Nutrition series 2008, 2013, among others).

In order to contribute to realize Condition #1, the NMNAP implementers should attain four **Contributions to Conditions**:

- (CC1.1): Community health workers reach a high number of caregivers and influential people with MIYCAN promotional services;
- (CC1.2): Health workers provide quality counselling on optimal MIYCAN behaviours to pregnant women, mothers and caregivers of children under five;
- (CC1.3): Optimal MIYCAN behaviours are regularly promoted through traditional and modern mass media;
- (CC1.4): Government, civil society organizations and private sector monitor and enforce laws and regulations relevant to MIYCAN.

For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA1.1): High coverage and quality promotional services are necessary for adoption of optimal MIYCAN behaviours;
- (LA1.2): Traditional & modern channels of communication can reach a large proportion of population with nutrition messages;
- (LA1.3): Laws and regulations enforcement creates conducive environment for adoption of optimal nutritional behaviour

The NMNAP Condition #1 targets 75% of adolescent girls, pregnant women and mothers/caregivers (fathers, mothers-in-law, grand-mothers, siblings) of children under five years to prevent stunting in the first 1,000 days of life (window of opportunity) through social behaviour change communication (SBCC). Coverage will be progressively increased starting from the highest burden regions.

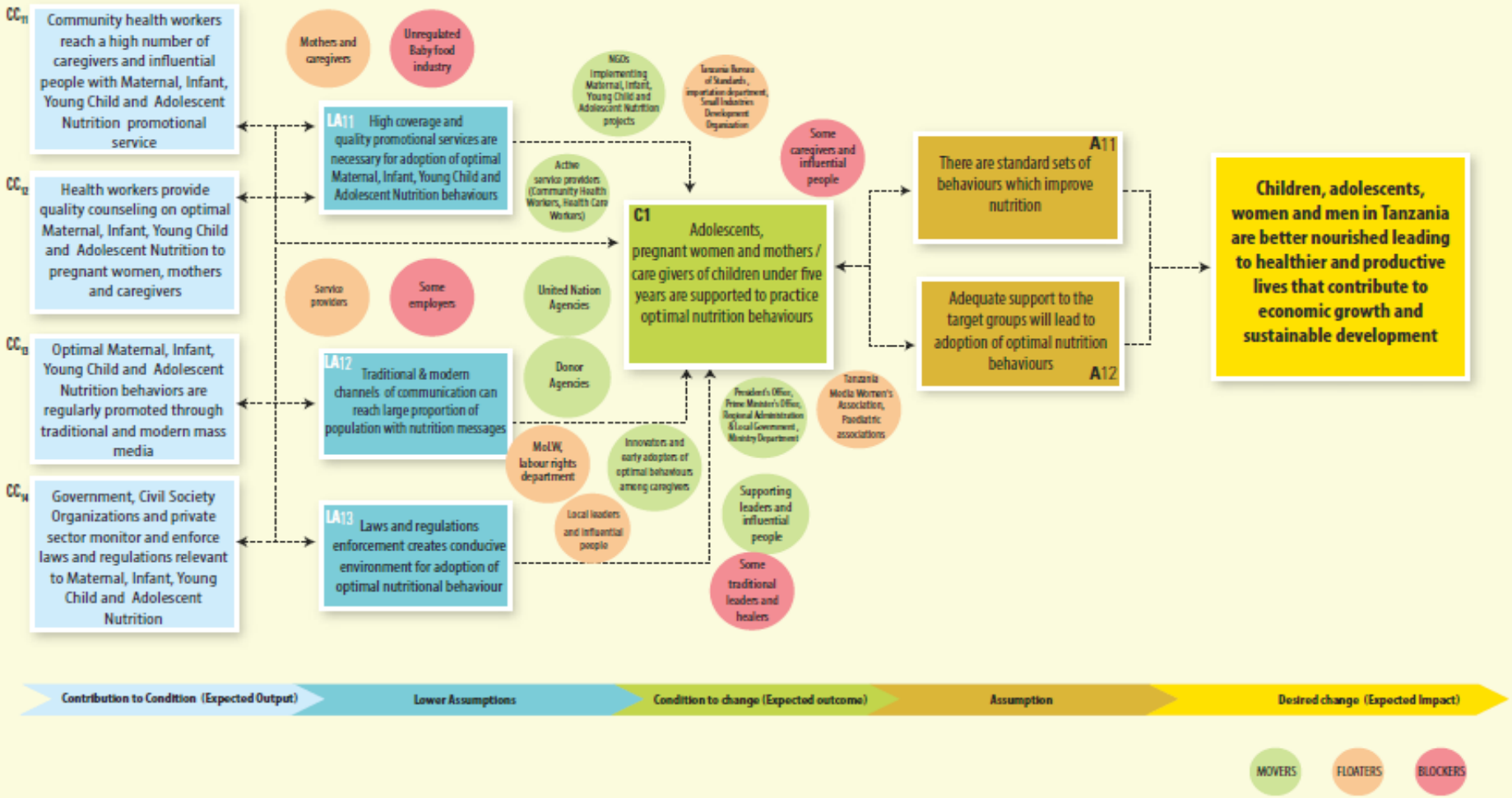
The **key implementers** are those people closer to the communities: within CC1.1, community health workers (CHW) will be trained on SBCC for MIYCAN and will establish peer support groups to discuss ***every month*** optimal MIYCAN practices, including IYCF, WASH, ECD and health. Within CC1.2, health service providers will also be trained and will provide SBCC on MIYCAN during antenatal and postnatal care visits. They will also coordinate the promotional activities with CHWs. In this way, the beneficiaries will receive coherent messages on MIYCAN both at the community and health facility level. Husbands, grandmothers, local leaders and other influential people will also be targeted by CHWs with SBCC on MIYCAN to create an enabling environment for behaviour change. CHWs and health service providers will be trained, coached and supervised by the Government (especially TFNC, regional and district nutrition officers and Ward level officers), UN agencies, international NGOs and local CSOs. To strengthen the messages provided through proximity SBCC by CHWs and health service providers, within CC1.3, communities will be regularly reached with traditional and modern mass media, including educational theatre, music, social mobilization events, radio and TV spots, radio and TV programs, ad hoc video

clips, educational SMS, etc. in fact, it has been proven that education through entertainment (***edutainment***) is among the most effective approaches for behaviour change.

Finally, within CC1.4, the Tanzania nutrition community will work closely with the private sector to ensure enforcement of laws and regulations relevant to MIYCAN, including the International Code of Marketing of Breastmilk Substitutes and the national Maternity Leave legislation. These have an important impact in creating an enabling environment to allow adolescents, pregnant women and mothers/ care givers of children under five years to practice optimal nutrition behaviours.

Concerning the **relational strategies** adopted within this condition for change, the key **movers** are active CHWs and health service providers, who need to be engaged with motivations such as monetary incentives, training that improves their skills, and recognition vis-a-vis the community and local authorities. Innovators and early adopters of optimal nutrition practices among mothers and caregivers and influential people (grandparents, husbands, local leaders) are also key movers with high potential to expand the good practices in their communities, and need to be publically recognised by the programme in order to maintain their engagement. Among the main **floaters**, are the same mothers, caregivers and influential people who need to be informed and engaged in order to adopt optimal practices, and those service providers who are not active. The key **blockers** were identified among community members resistant to change, or service providers who do not do their job well. Within the legal framework, some employers and business companies were identified as blockers of the implementation/improvement of maternity leave and the enforcement of the International Code of Marketing of Breastmilk Substitutes go against their monetary interests. They need to be engaged for them to understand the importance of those laws and regulations. The implementation of the best relational strategies will be key for the realization of this contribution for change within the NMNAP.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 1: MATERNAL, INFANT, YOUNG CHILD AND ADOLESCENT NUTRITION



Condition 2: Children, adolescents and women of child bearing age consume adequate micronutrients.

The **Condition #2 (C2)** of the NMNAP is about scaling-up services to ensure adequate consumptions of key micronutrients through awareness raising, supplementation, food fortification and other food-based strategies.

The key **assumptions** for scaling up micronutrient interventions as a condition to achieve the NMNAP desired change are that*:*

- (A2.1): Adequate micronutrient intake is essential for optimal growth and development;
- (A2.2): Micronutrients improve health and economic productivity.

Both are scientific assumptions, based on solid evidence that micronutrients are not only essential for optimal physical and mental development, but are also essential for leading an active and productive life, which is part of the desired change of the NMNAP.

In order to contribute to realize Condition #2, the NMNAP implementers should attain four **Contributions to Conditions**:

- (CC2.1): Children and women access fortified food and micronutrient powders for home fortification;
- (CC2.2): Children receive regular supplementation of Vitamin A and deworming;
- (CC2.3): Adequately iodised salt is available for households' consumption.
- (CC2.4): Children and women utilize improved services for anaemia reduction;

These contributions to conditions address the key micronutrient deficiencies in Tanzania, such as vitamin A deficiency, iron deficiency and iodine deficiency, and are articulated to ensure that micronutrient deficiencies are addressed through promotional activities, micronutrients supplementation, food fortification and other food based strategies, including at the household level.

For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA2.1): Informed community will be more likely to utilize micronutrients;
- (LA2.2): Regular Vitamin A supplementation and deworming improve child nutrition.
- (LA2.3): Availability of iodised salt will lead to increased consumption by communities.
- (LA2.4): Iron folate supplementation and food fortification have an important impact on anaemia reduction;
- (LA2.5): Integrated interventions for prevention and control of micronutrients deficiencies have higher impact than single micronutrient vertical interventions;

The NMNAP Condition #2 targets all children under five years with Vitamin A supplementation and deworming, all adolescent girls and pregnant women with iron-folate supplementation and home fortification through micronutrient powders, and all households of Tanzania through oil fortification, flour fortification, salt iodization, and awareness raising on the importance to consume key micronutrients using media and social campaigns. The **key implementers** and of micronutrient interventions are multiple.

For food fortification (CC2.1), mainly the private sector, TFNC with CSOs will promote fortification of flour with iron, oil and vitamin A. A key role will be played by the Tanzania Food and Drugs Authority (TFDA) and Tanzania Bureau of Standard (TBS) to ensure quality of fortified foods. Additionally, food fortification will be promoted at the household level through the distribution of micronutrient powders for use among adolescent girls, pregnant women and children under five years old. This will be accompanied by adequate communication on the use and benefits of micronutrient powders.

For Vitamin A supplementation and deworming (CC2.2), mainly CHWs for social mobilization, and health service providers for supplementation. Vitamin A supplementation will be implemented during Child Health and Nutrition Months (CHNMs) every six months in all the communities of Tanzania. The CHNMs initiative also includes services such as deworming, screening of acute malnutrition of children under five years old, as well as awareness raising on key MIYCAN behaviours for mothers and caregivers.

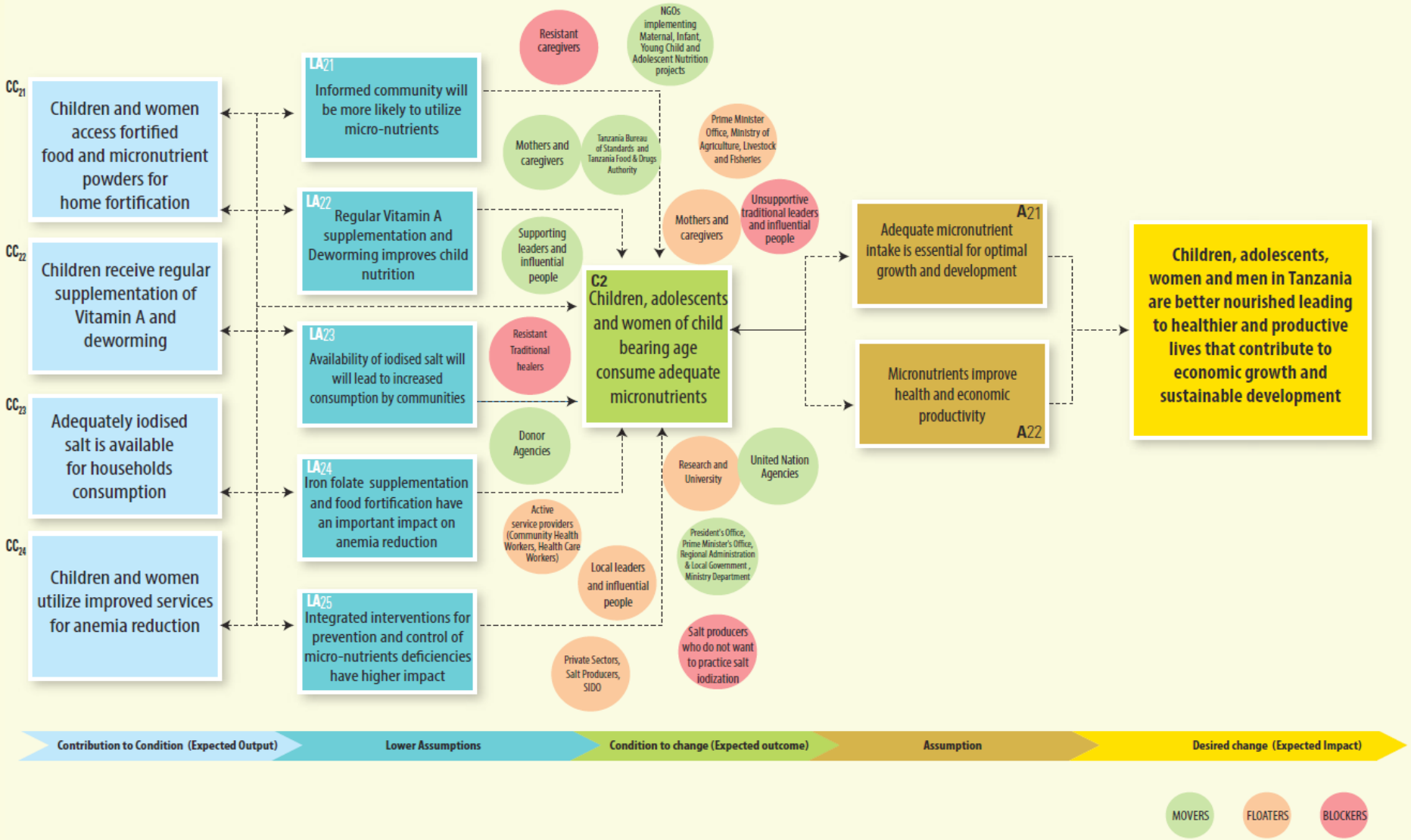
For salt iodisation (CC2.3): Salt producers, Tanzania Salt Producers Association (TASPA), district and

regional nutrition officers and CHWs will play a key role to support and supervise small scale salt producers to adequately iodise salt, and raise awareness in communities on the importance of consuming adequately iodised salt. The Tanzania Food and Drugs Authority (TFDA) and security forces will enforce the salt iodization legislation.

For anaemia prevention (CC2.4), the key implementers will be the health service providers, who will be trained on SBCC to increase consumption of iron folate tablets by pregnant women during at least three months during pregnancy. This activity will be complemented by food fortification activities outlined above, deworming, malaria prevention (see condition 5) and promotion of other food-based strategies.

Overall, the MOHCDGEC, PO-RALG, TFNC, Regional Secretariat and LGA will ensure coordination and integration of the different micronutrients interventions. They are key **movers** at the central and decentralized level. Other important movers are the UN agencies and NGOs which support micronutrient interventions, including the building of the capacities of LGA, health service providers and private sector. Among the main **floaters** are some Government ministries and donors who are not providing the necessary funds to scale-up these interventions, which are particularly underfunded (especially anaemia prevention and salt iodization). They need to be further engaged by the movers, with evidence and investment plans (such as the NMNAP itself). Among the main **blockers** are those influential people and individuals who do not trust micronutrients interventions and often spread misguided stories in the communities about the micronutrients supplements. They need to be engaged with adequate communication. Small scale salt producers unwilling to invest in salt iodization have also been identified as blockers, and they need to be monitored and supported by relevant authorities at the central and decentralized level.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 2: PREVENTION OF MICRONUTRIENT DEFICIENCIES



Condition 3: Affected Children and communities demand, access and use quality services for acute malnutrition

Condition #3 (C3) of the NMNAP is about scaling-up services for integrated management of acute malnutrition in order to identify, refer and treat – within the health system - all children with acute malnutrition.

The key **assumptions** for scaling up interventions for the treatment of acute malnutrition as a condition to achieve the NMNAP desired change are that*:*

- (A3.1): Treatment of acute malnutrition benefits children's development and survival in the short and long term;
- (A3.2): Scaling-up treatment of acute malnutrition will save children's lives.

Both are scientific assumptions. In fact, there is increasing evidence that treatment of acute malnutrition also reduces the risk of stunting (Lancet 2013 Series on Maternal and Child Nutrition) and is, thus, included among the ten interventions with the highest potential to reduce stunting. Furthermore, children with severe acute malnutrition are at a higher risk of dying than children with the other forms of malnutrition.

In order to contribute to realize Condition #3, the NMNAP implementers should attain four **Contributions to Conditions**:

- (CC3.1): All health facilities provide quality services for management of acute malnutrition;
- (CC3.2): Therapeutic food is constantly available in all health facilities providing treatment of acute malnutrition;
- (CC3.3): There is an effective integration of services between community and health system;
- (CC3.4): Community health workers detect malnourished children in communities and refer them to health facilities for treatment.

These contributions to conditions address the key steps of integrated management of acute malnutrition (IMAM), including screening, referral, availability of supplies, capacities of service providers, integration, monitoring and data analysis for improving the coverage and quality of the service.

For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA3.1): Individuals want to use quality services if they are available and accessible;
- (LA3.2): Availability of therapeutic food leads to continuity in utilization of IMAM services;
- (LA3.3): Integrated services lead to more efficient and sustainable management of acute malnutrition
- (LA3.4): Timely detection of malnourished children and referral to health facilities leads to increased services utilization and successful treatment;

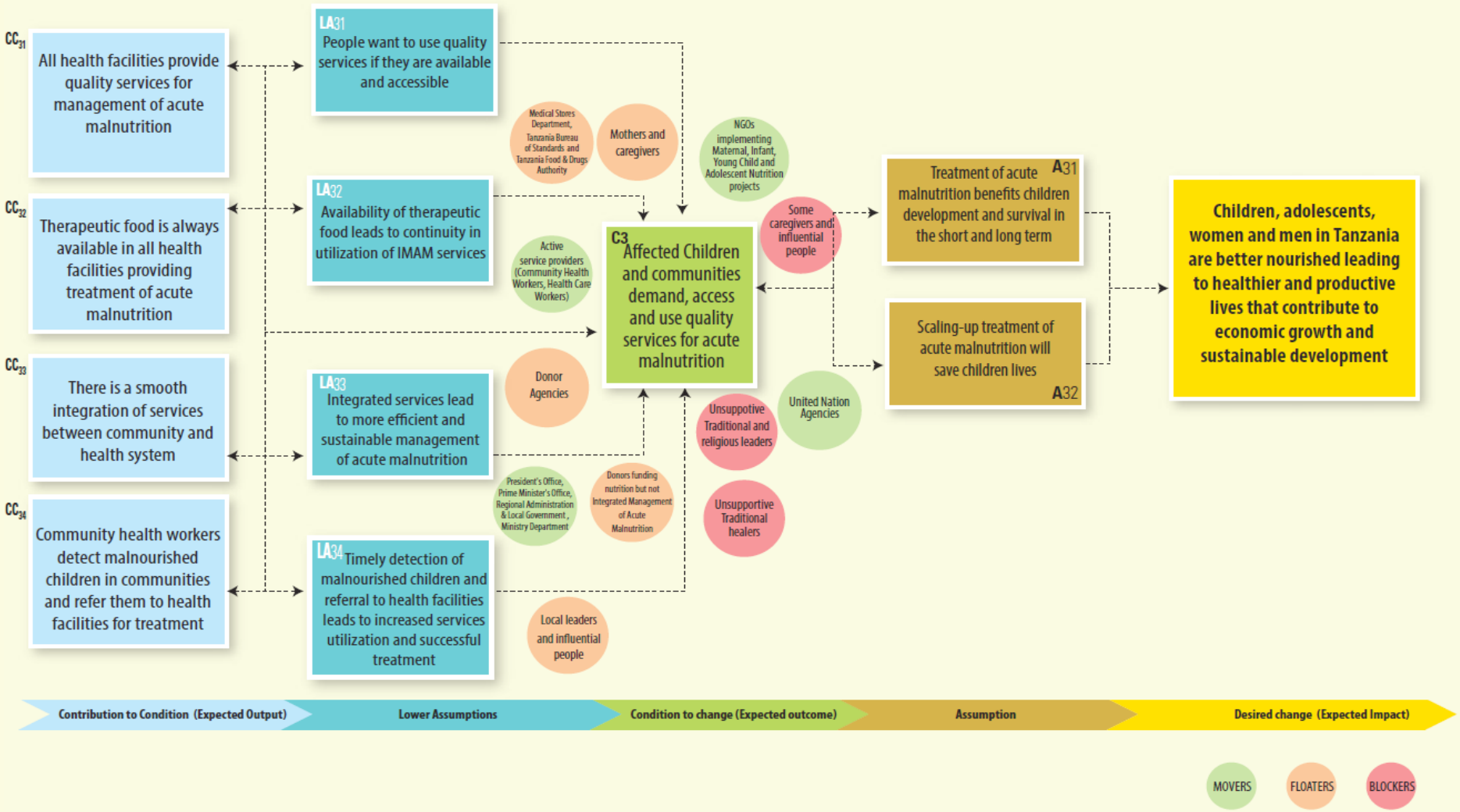
The NMNAP Condition #3 targets the about 600,000 children under five years affected by acute malnutrition (100,000 with severe acute malnutrition and 500,000 with moderate acute malnutrition in 2015), and aims at gradually increasing the coverage of children with acute malnutrition treated from the current less than 10% in 2015 to 75% in 2021.

The **key implementers** of IMAM services are multiple. At the community level (CC3.4), trained CHWs have a key role of ensuring quarterly screening for malnutrition using MUAC tapes in their catchment area, targeting all children under five years old and referring malnourished children to health facilities for treatment. Here, the coordination between CHWs and health service providers (CC3.3) is key to ensure that referred children are actually brought to the health facilities by their caregivers, to provide CHW additional support, coaching and motivation to perform their important job, and to share and analyse data (including with communities) about screening and coverage. Another essential aspect to improve the service is the availability of essential supplies for treatment of malnutrition (CC3.2). In fact, if these are not available, there will be a drop in the utilization of the service by caregivers who invested time and resources to attend the health facilities. Another important aspect is the quality of the service provided (CC3.1); therefore, it will be crucial to invest in the training, monitoring and coaching of health service providers in the dispensaries, health centres and hospitals delivering IMAM.

The key **movers** within this condition for change are TFNC and those UN agencies who support IMAM at the national level, such as UNICEF,

WFP and WHO, those NGOs who implement IMAM projects at the community and health facility level, with a health system strengthening approach, and especially those few donors who actually support this activity, such as Irish Aid, USAID and CIFF. Key movers are also the active service providers (CHWs and health facilities staff) who implement the service and coordinate among each other. These need to be supported as their engagement is vital for the effective provision of IMAM services. Other donors who support interventions to reduce malnutrition, but not IMAM, have been recognised as **floaters**, and they need to be engaged to provide extra support to these important activities. PO-RALG and LGA are also classified among the floaters, as they generally do not recognise IMAM as cost-effective activities which can be quite easily managed by the districts and regional authorities. Among the **blockers**, the implementers of the NMNAP need to engage with those caregivers, influential people, traditional leaders and traditional healers and those community members who do not recognise acute malnutrition as a medical problem, but link it to other causes (such as witchcraft). Their actions risk to delay treatment and to seriously endanger the survival of children affected by SAM.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 3: INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION



Condition 4: Communities in Tanzania are physically active and eat healthy diets

Condition #4 (C4) of the NMNAP recognises the double burden of malnutrition in Tanzania, and addressing diet related non communicable diseases (DRNCDs) at an early stage, avoiding to keep the focus only on undernutrition, as it traditionally happens in the national strategies of Sub-Saharan developing countries. Issues such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, related to overweight and obesity are generally ignored by development practitioners in these countries.

The key **assumptions** for addressing nutrition related non communicable diseases as a key condition to achieve the NMNAP desired change are that*:*

- (A4.1): Healthy eating is associated with better health;
- (A4.2): Physical activity leads to improved physical and mental health.

These are evidence-based assumptions showing the link between physical activity, healthy diet and good mental and physical health, preventing the insurgence of nutrition related non communicable diseases, and allowing individuals to live productive lives, contributing to the country's economic development.

In order to contribute to realize Condition #4, two **Contributions to Conditions** have been identified:

- (CC4.1): Policies and social, cultural and structural norms are established to enable communities to engage in healthy lifestyles;
- (CC4.2): School-age children and the adult population are aware of the risk factors for non-communicable diseases.

These contributions to conditions address two main issues related to NCDs: an institutional, policy and socio-cultural environment promoting healthy life-style, including physical activity and banning unhealthy behaviours, such as tobacco, drugs use, alcohol abuse and unhealthy foods; and increased communities' awareness on the risk factors of NCDs, as well as the key role of each individual to adopt healthy behaviours.
For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA4.1): Policy/regulations are effective in shaping behaviour;
- (LA4.2): Awareness is essential in creating behaviour change;
- (LA4.3): School children are effective in creating awareness in the community;
- (LA3.4): Behaviour is best moulded during childhood.

The NMNAP Condition #4 targets all Tanzanians, men and women, elderlies, adolescents and children that will be reached through improved legislation and regulations to prevent nutrition related non-communicable diseases, as well as tailored messages at school, at work and through the mass-media to foster behaviour change towards a healthier life-style. There is also a recognition that children are the key target not only because there are more permeable to receive messages on improved life-styles than adults, but also because they can be important communicators on healthy diets and lifestyles within their communities.

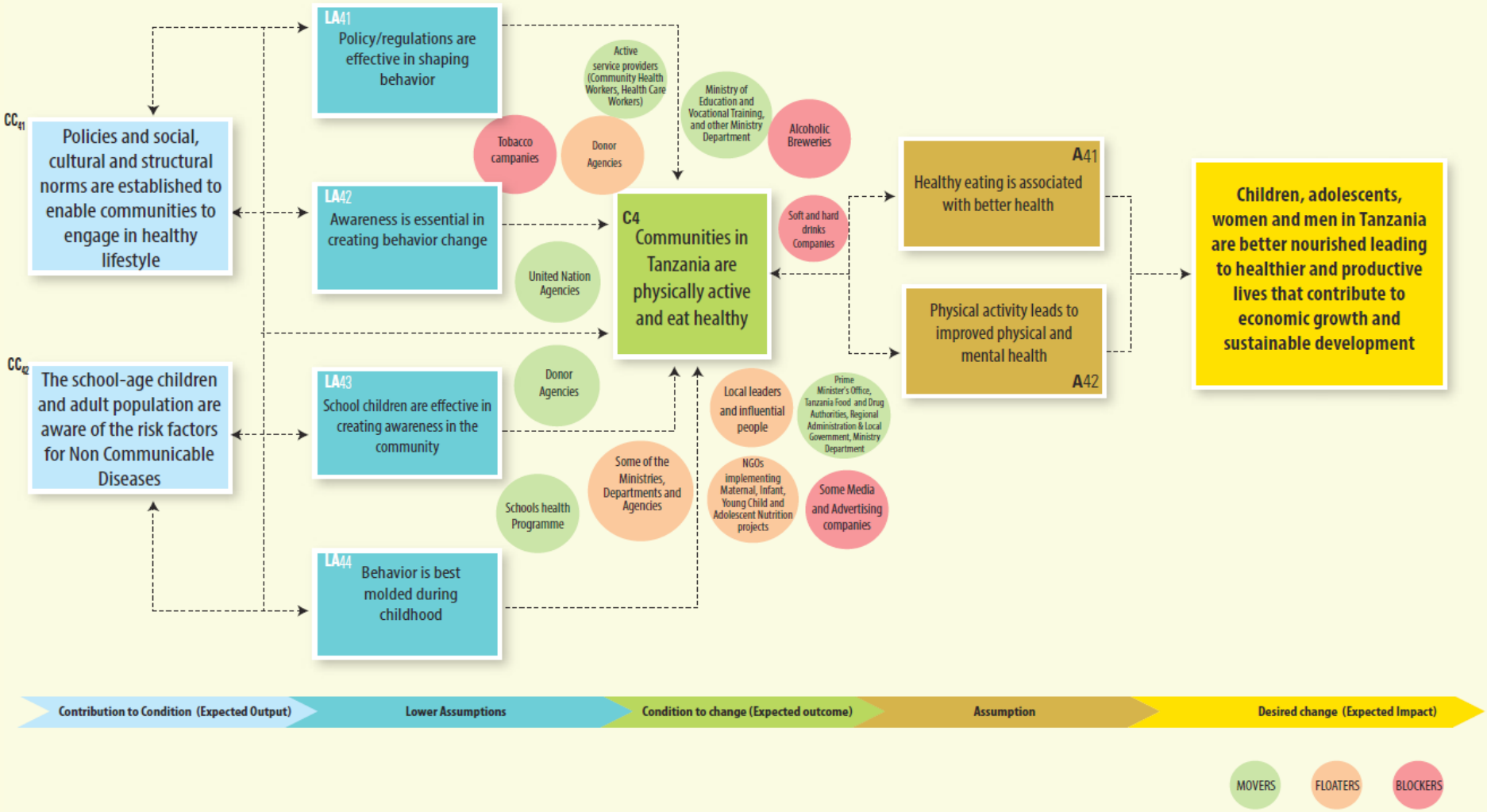
The **key implementers** are multiple and very different in nature. On one side (CC4.1), the NCDs experts play a key role in advocating with decision makers to improve laws and regulations on unhealthy behaviours leading to DRNCDs, such as tobacco use, alcohol abuse, excessive consumption of sugary drinks, etc. Legislation enforcement by government has a key role to play in the prevention of DRNCDs. In the long term, this will also have an impact on the creation and adoption of healthy social norms, condemning all sorts of unhealthy life styles and encouraging moderation, physical activity and those moral values that contribute to mental health.

On the other side (CC4.2), there is a key role to play within the health sectors, by those health service providers that should inform the Tanzanian people about the risks of unhealthy life styles, and the consequences of DRNCDs on their lives. Health service providers have also an important role in the treatment of DRNCDs, and their capacities should be strengthened. Furthermore, mass media should contribute as a corporate social responsibility to pass promotional messages on importance of physical activity, healthy diets and lifestyles in the prevention of DRNCDs. Finally, and most importantly, schools should be an important arena for these discussion as children

and adolescents are more likely to adopt healthy behaviours than adults.

Children are the key **movers** within this condition for change, as not only are they more open to receive messages on healthy diets and life-styles, but also have the capacity to spread these messages within their communities through being an example. Therefore, they should be targeted, supported and actively involved in awareness raising activities. Other key movers are medical doctors and nutrition specialists who are aware of the risk of DRNCDs and are committed to dedicate their energies to raising population awareness and advocating with decision makers. Politicians and parliamentarians are **floaters** towards DRNCDs. They should be sensitized, and their support should be sought to pass specific legislations and regulations, addressing unhealthy habits and lifestyle, as it has recently been the case in Tanzania for smoking in public places. Other floaters are traditional development practitioners among the government, donors, UN agencies and NGOs, who are not used to address problems such as overweight and obesity in low-income countries. The NMNAP implementers should engage them in order to obtain their financial and technical support. Among the key blockers are those private companies who make profit selling products which are nefarious for health, such as tobacco companies, alcohol breweries, soft and hard drink companies and fast food companies. They are identified as **blockers** because of the realization of this condition for change is against their monetary interests. Other blockers are some media and advertising companies promoting unhealthy products and behaviours, and those individuals who do not want to change behaviour despite acknowledging the possible risk of DRNCDs. The NMNAP implementers will engage with these blockers through awareness raising activities, advocacy and campaigns that promote healthy, active and productive life styles and diets for all Tanzanians.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 4: DIET RELATED NON COMMUNICABLE DISEASES



Condition 5: Line ministries, private sector and CSOs scale up nutrition sensitive interventions to reach all communities

Condition #5 (C5) of the NMNAP addresses the underlying causes of malnutrition and regroups all interventions within key nutrition sensitive sectors, such as health and HIV, agriculture and food security, WASH (water, sanitation and hygiene), education and early childhood development, social protection and environment and climate change. The gender component is cross-cutting, and is especially strong within the education and social protection interventions.

The key **assumptions** for scaling up nutrition sensitive interventions as a key condition to achieve the NMNAP desired change are that*:*

- (A5.1): There is evidence that some interventions in health, WASH, food security, social protection and education sectors have a strong impact in improving nutrition.
- (A5.2): Reaching all communities with nutrition sensitive interventions will lead to improvement in nutrition;

These assumptions are supported by evidence generated by research institutes (such as IDS and IFPRI among others) and scientific journals (such as The Lancet). Evidence suggests that in order to have a significant impact in reducing malnutrition – and especially stunting, which is the major nutrition problem in Tanzania – it is necessary to scale-up the coverage of high-impact nutrition specific and nutrition sensitive interventions.

In order to contribute to realize Condition #5, the NMNAP implementers should attain six **Contributions to Conditions**:

- (CC5.1): Communities regularly use quality maternal health, family planning, prevention and treatment of HIV and malaria services;
- (CC5.2): Communities have access to a diverse range of nutritious food throughout the year;
- (CC5.3): Communities access adequate safe water, sanitation and hygiene services;
- (CC5.4): Girls complete primary and secondary education;
- (CC5.5): Poorest households benefit from conditional cash transfers, cash for work, and nutrition education;
- (CC5.6): Vulnerable communities are able to cope with drought and climate change to avoid shortage of nutritious food during shocks.

These contributions to conditions address all the key nutrition sensitive sectors to increase coverage of the most effective nutrition sensitive interventions to improve nutrition.

For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA5.1): Birth spacing has a strong impact on reducing the intergenerational burden of malnutrition;
- (LA5.2): A diverse range of nutritious foods improves nutrition status of the community;
- (LA5.3): WASH interventions have a high impact on stunting reduction;
- (LA5.4): Child malnutrition is significantly lower when mothers have a secondary education level;
- (LA5.5): The prevalence of malnutrition is higher among the poorest quintile of the population;
- (LA5.6): Developing resilience within vulnerable communities protect them from malnutrition.

The NMNAP Condition #5 targets all the communities in Tanzania. However, each sectoral nutrition sensitive interventions have its specific targets.

Within the **health and HIV** sector (CC5.1), the main target groups are adolescents, pregnant women, mothers and caregivers of children under five years. Interventions such as malaria prevention and treatment have been proven to be very effective in reducing malnutrition, and especially anaemia. Another important intervention with the high impact on stunting reduction is family planning. Birth spacing allows mothers to focus their resources and energies on a smaller number of children. In promoting family planning, boys and men are also among the key target groups, as they are often influential in the power relation with girls and women on sexual and reproductive health. Another key area is the prevention and treatment of HIV, which will be linked with promotion of optimal infant and young child feeding among HIV positive parents both at the community and health facilities level, based on the last WHO guidelines. Treatment of HIV positive individuals with antiretroviral drugs

will also be supported with food supplementation, including ready to use therapeutic food (RUTF). Attendance of reproductive, maternal, new-born and child health services by families is also very important to ensure optimal maternal, new-born and child nutrition, and will be promoted within the NMNAP. A special focus will be on sexual and reproductive health for adolescents, in order to prevent early pregnancies, and contribute to the fight against child marriages.

The **agriculture and food security** sector (CC5.2) includes livestock and fisheries and the main target group is farmers. Nutrition sensitive food security interventions aim at increasing production of nutritious foods for home consumption throughout the year. To a minor extent they also include increased production for selling hoping that the income generated is used for the care of women and children and for education. Livestock and fisheries interventions are important as they can improve households' access to animal protein. In addition to increased food production year-round, food security interventions should ensure effective linked to nutrition improvement.

Within the **WASH** sector (CC5.3), the target groups are mainly communities, as 'WASH in school' activities are implemented within the education sectors. Key activities include water treatment to make it safe for human consumption, improved hygiene practices (i.e. handwashing with soap), and community-led total sanitation. Activities such as construction of latrines and improved water sources are mainly done by men. WASH interventions have a strong impact on reducing the incidence of diarrhoea among children and thus on stunting reduction. WASH in schools is also part of the activities included in the NMNAP, especially the construction of latrines – with gender lens, in order to ensure an adequate number of latrines for girls – as well as through the SBCC on hygiene provided by trained teachers at schools.

Within the **Education** sector (CC5.4), the key target groups are adolescent girls. In fact, evidence shows that child malnutrition is significantly lower when mothers have a secondary education level, as they acquire better knowledge and skills for optimal childcare practices. However, due to gender inequalities, less girls than boys complete education in Tanzania. Girls who do not attend school are more likely than those who attend, to engage in in early marriages, carry early pregnancies or find good paying jobs, with very bad consequences for their health (increased risk of maternal mortality) and the wellbeing of their children. In fact, early pregnancy is often associated with low-birth weight and child malnutrition. Therefore, increasing secondary school attendance by girls was selected in the NMNAP as the most important intervention in the education sector. Another component that will be addressed in the NMNAP within the education sector is school feeding and school gardens in primary and secondary schools, which are essential in providing the needed energy for active student learning.

Furthermore, promotion of optimal early child development (ECD) practices through parents' education is an important component in the education sector. ECD combined with good nutrition boosts brain, cognitive and physical development in young children. Early learning can start through the use of simple techniques adapted to the age of the child, such as talking to the new-born, singing to the child, playing with the child, and engaging in specific games that will strengthen their psycho-motor development.

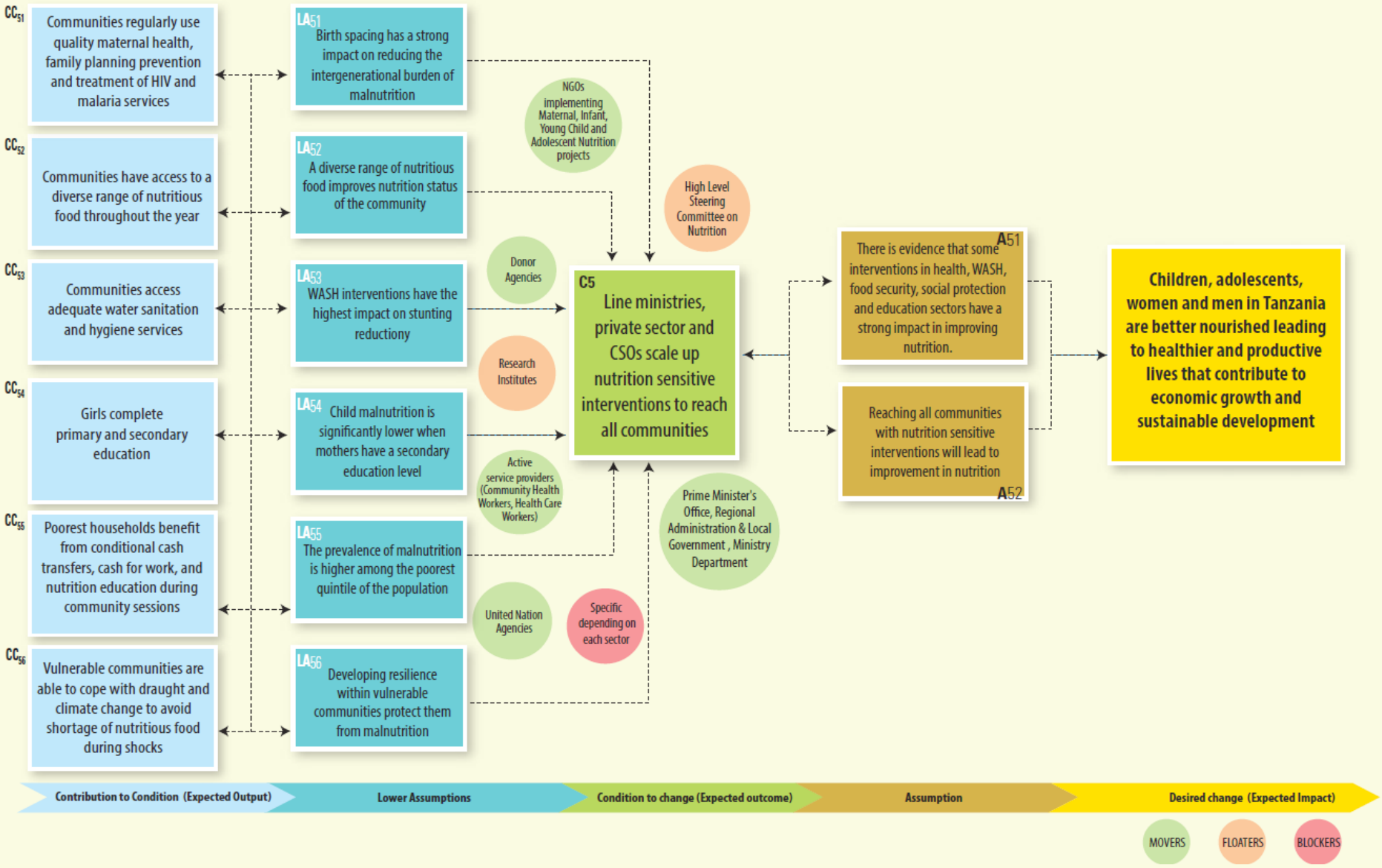
Within **the social protection** sector (CC5.5), the target population are the poorest households in Tanzania. The Tanzania Social Action Fund (TASAF) carried out a national study to identify the poorest households and included them in the Productive Social Safety Net (PSSN) programme. PSSN beneficiaries receive monthly cash transfers, conditional on attending health, education and nutrition services. Cash transfer is generally provided to women, as they are more likely to use the cash for the wellbeing of the households and children than men. Furthermore, PSSN beneficiaries also receive 'cash for work', a form of payment for public works such as building latrines, health centres and schools. PSSN activities have a strong impact on reducing malnutrition as they promote key nutrition sensitive interventions such as WASH, gender and girls schooling. Furthermore, by establishing a synergy between TASAF and nutrition specific interventions, it is possible to identify and target the poorest households for priority provision of promotional and curative nutrition services.

Within the **environment and climate change** sector (CC5.6), the main targets are the most vulnerable communities to shocks such as droughts and meteorological phenomena linked to climate change, like flooding. Communities vulnerable to shocks are at high risk of malnutrition and need extra support. This will be provided within the NMNAP through targeted agricultural programmes in the affected areas, aiming at building the capacities of communities to understand and cope with shocks. Food supplementation will also be provided during emergencies.

Within this condition for change (C5) of the NMNAP, the **key implementers** are multiple and specific to each sector. In fact, the interventions under this component are already included and costed in the specific plans and policies of each sector, and will not be replicated by the NMNAP. On the contrary, they are reflected in the NMNAP to show the complexity and the actual cost of effectively reducing malnutrition in Tanzania.

Among the key **stakeholders** within this condition for change, the key **movers** are the sectoral ministries, agencies and departments coordinating the nutrition sensitive interventions, as well as regional and council level authorities ensuring decentralized level leadership. The Prime Minister Office plays a key role in supporting these interventions, especially those related to social protection and education, which are under its direct coordination. NGOs implementing specific projects in the communities also play an essential role as movers, by raising funds, and addressing the gaps in the remotest areas of Tanzania. The **floaters** are very specific to each sector. For example, decision makers within the WASH and nutrition sectors at all levels (within the Government and development partners) are not sufficiently engaged to build a synergy between the two sectors which has the highest potential in terms of stunting reduction, but continue to work separately. They should be engaged by the movers to move beyond their sectoral approach. The **blockers** are also very specific to each sectors, but they are mainly those actors within the communities who are resistant to change. Some men who take advantage from gender inequalities and want to maintain this situation might fall into this category. A process of engaging with those should be a priority by the implementers of the NMNAP in order to ensure the achievement of the NMNAP impact through social change.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 5: NUTRITION SENSITIVE INTERVENTIONS



Condition 6: Government and partners at all levels actively practice good nutrition governance

Condition #6 (C6) of the NMNAP is one of the two conditions for change addressing the enabling environment for nutrition, and specifically the issue of multisectoral nutrition governance, including capacity building, decision making, planning, coordination, monitoring, supervision, and accountability.

The key **assumptions** for scaling up multisectoral nutrition governance as a condition to achieve the NMNAP desired change are that:

- (A6.1): Good governance improves efficiency, equity and coverage of nutrition interventions;
- (A6.2): Good nutrition governance has an indirect impact on improving the nutrition status of Tanzanians.

Both assumptions are solidly grounded on experiences as well as studies and reviews on governance (i.e. SUN movement guidelines). In fact, evidence informed decision making improves the results of interventions, targeting the most vulnerable individuals and communities and improves equity. Strategic planning and fundraising are necessary to increase the coverage of interventions, improve multisectoral coordination and boost the impact of sectoral interventions.

In order to contribute to realize Condition #6, the NMNAP implementers should attain three **Contributions to Conditions**:

- (CC6.1): The Government of Tanzania shows its commitment to nutrition through political engagement and increased funding;
- (CC6.2): Government and partners efficiently and effectively coordinate multisectoral nutrition interventions at all levels;
- (CC6.3): Nutrition personnel have adequate capacities and support to effectively implement interventions at central and decentralized level.

These contributions to conditions address the key elements of multisectoral nutrition governance and foster collaboration between sectors and among Government and development partners.

For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA6.1): High level political support to nutrition leads to increased commitment of line ministries to achieve results for nutrition;
- (LA6.2): Increased funding is necessary to implement high impact nutrition interventions at scale;
- (LA6.3): Coordinated implementation of multisectoral nutrition interventions maximizes the results for nutrition;
- (LA6.4): Capable nutrition personnel is necessary to ensure efficient implementation of nutrition interventions.

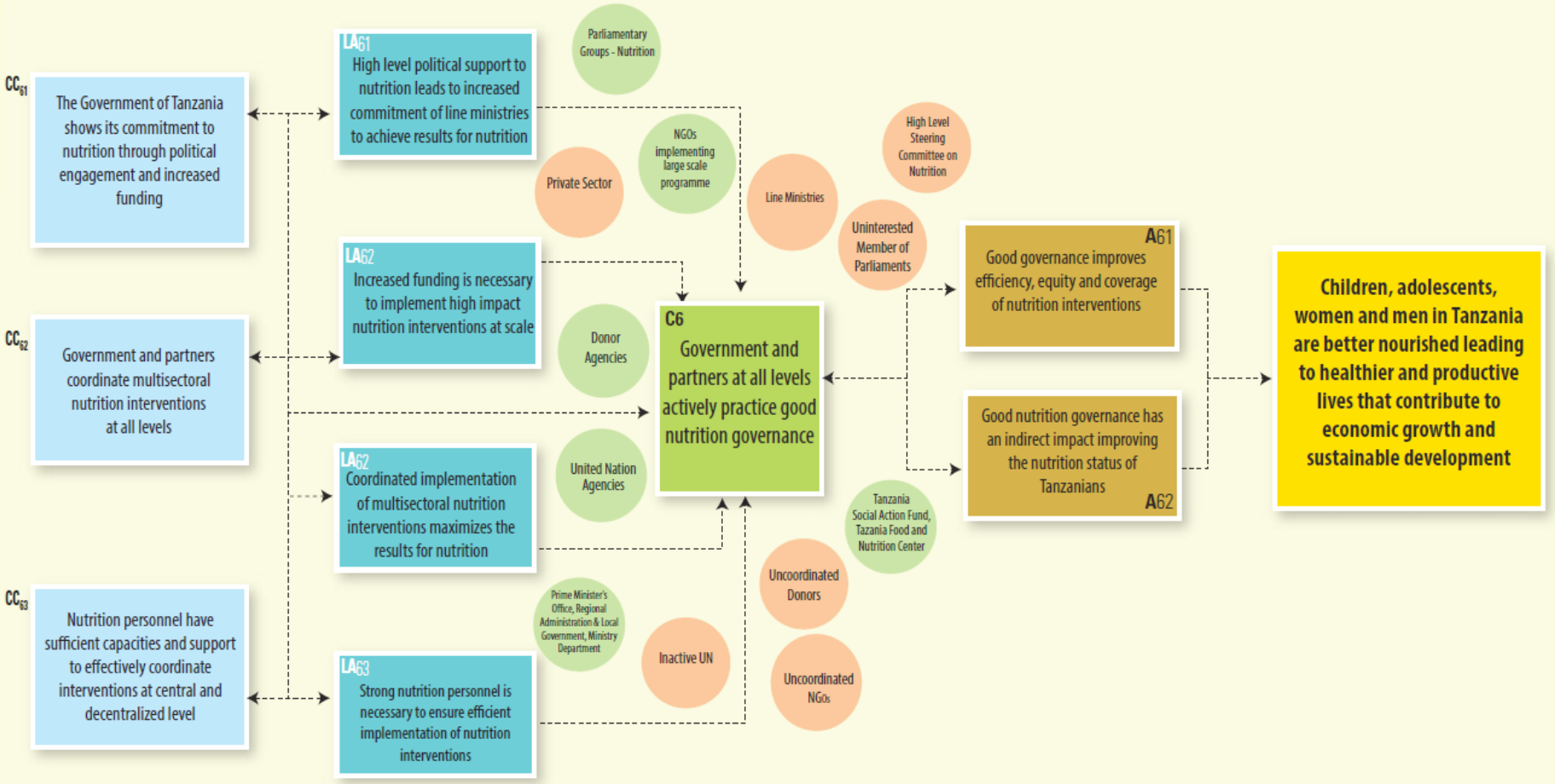
The NMNAP Condition #6 **targets** high level decision makers within the Government, from His Excellency the President of the United Republic of Tanzania, to the Prime Minister Ministers, Permanent Secretaries and technical staff of all key nutrition sensitive ministries and departments, to regional and council level officers, especially nutrition officers, but also health officers, agriculture, livestock and fisheries officers, WASH focal points, education officers, TASAF coordinators, and planning officers. Within this component, **relational strategies** are particularly important, in order to create the political, institutional and financial enabling environment to efficiently scale-up nutrition interventions.

The **key implementers** within this condition for change are TFNC and the development partners in nutrition, including donors, UN agencies, CSOs and research institutions. A key achievement to be sought within this component (CC6.1) is political and financial support to implement the NMNAP. Furthermore, the country should maintain its high level commitment to nutrition, endorse and support improved nutrition policies and programmes – such as the NMNAP – and strengthen its nutrition departments and agencies. Additionally, (CC6.2), multisectoral coordination – including multisectoral planning and budgeting for nutrition, multisectoral nutrition steering committees at the national, regional and council level, and joint monitoring and supervision, are key elements that will be prioritized within the NMNAP. Capacity building (CC6.3) of the nutrition workforce at all levels, will also be crucial to attain the desired change of the NMNAP. The posts of existing regional and district

nutrition officers need to be maintained, and their capacities strengthened. The missing nutrition officers should be recruited to cover every region and council, and their pre-service and in-service curricula should be improved and implemented. At the same time, officers in the key nutrition sensitive sectors should also receive training and orientation on nutrition.

The key **movers** within this condition for change are PMO, PO-RALG, TFNC and the development partners in nutrition, who constantly promote multisectoral nutrition governance by involving representatives from nutrition sensitive sectors in the different steps of decision making for nutrition. However, some of the key actors at both the national and sub-national levels who do not understand well their role in nutrition are **floaters**, because they are poorly engaged in the multisectoral nutrition governance. All these actors need to be engaged by the movers, in order to understand the key role that they have to play to achieve the desired change for the NMNAP. This condition for change does not have specific **blockers** who have an interest to impede the desired change.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 6: MULTISECTORAL NUTRITION GOVERNANCE



Condition 7: Quality nutrition information is used by communities, government and partners for evidence-based decision and action

Condition #7 (C7) of the NMNAP is the second condition for change addressing the enabling environment for nutrition, and specifically aiming at generating, sharing and using quality nutrition data and information in order to inform decision making and being accountable towards the Tanzania population.

The key **assumptions** for strengthening the multisectoral nutrition information system as a condition to achieve the NMNAP desired change are that*:*

- (A7.1): Quality information facilitates mobilizing and targeting of resources;
- (A7.2): Quality information helps targeting of vulnerable groups;
- (A7.3): Quality information contributes to designing appropriate nutrition interventions.

These are solid assumptions, based on experience as well as reviews and studies on management of nutrition programmes (i.e. SUN movement guidelines). In fact, regular information on the situation of nutrition, the geographical distribution of malnutrition, the key bottlenecks to the coverage of nutrition interventions – among others – are crucial for evidence based targeting where the needs are higher, addressing inequity, and are very useful for fundraising. The design of the NMNAP itself, was based on extensive evidence collected during the years.

In order to contribute to realize Condition #7, the NMNAP implementers should attain four **Contributions to Conditions**:

- (CC7.1): Robust systems of routine data collection, analysis, interpretation and feedback among stakeholders are in place at all levels;
- (CC7.2): Relevant nutrition indicators are integrated, collected and reported in national surveys;
- (CC7.3): Nutrition stakeholders align implementation of NMNAP with learning framework and carry out operational research.

These contributions to conditions address the key elements of the multisectoral nutrition information system, including routine systems, nutrition surveys, sector reviews, data analysis, dissemination and learning.

For the above contributions to conditions, the following **lower level assumptions** were made explicit, critically analysed, and formulated to describe the pathway of change:

- (LA7.1): Quality routine data is essential for monitoring the NMNAP, assess the bottlenecks and adjust course of action as necessary;
- (LA7.2): National nutrition surveys provide detailed information for in depth analysis of the nutrition situation and evidence based decision making;
- (LA7.3): Nutrition reviews, operational research and data analysis are essential for learning and for accountability in the NMNAP.

The NMNAP Condition #7 **targets** the national multisectoral nutrition information system at national and decentralised level, aiming at making available quality information from nutrition and nutrition sensitive sectors on a regular basis.

The **key implementers** within this condition for change are TFNC, the National Bureau of Statistics (NBS), relevant departments within sectoral ministries and the PMO, PO-RALG, regional and council level nutrition officers, as well as development partners in nutrition, including donors, UN agencies, CSOs and research institutions.

The first component within this condition for change (CC7.1) is about strengthening the multisectoral nutrition routine information system. This will be done through capacity building of regional and district nutrition officers, as well as health officers, agriculture, livestock and fisheries officers, WASH focal points, education officers, TASAF coordinators, and planning officers. They will collect key indicators to track the progress of specific and sensitive nutrition interventions every quarter. These indicators already exist in the National Multisectoral Nutrition Scorecard. Another key tool is the Bottleneck Analysis (BNA) of key nutrition interventions, which is carried out annually by nutrition officers in each district with support from TFNC and partners. These will be the main tools to monitor the NMNAP, assess the bottlenecks and quickly adjust interventions

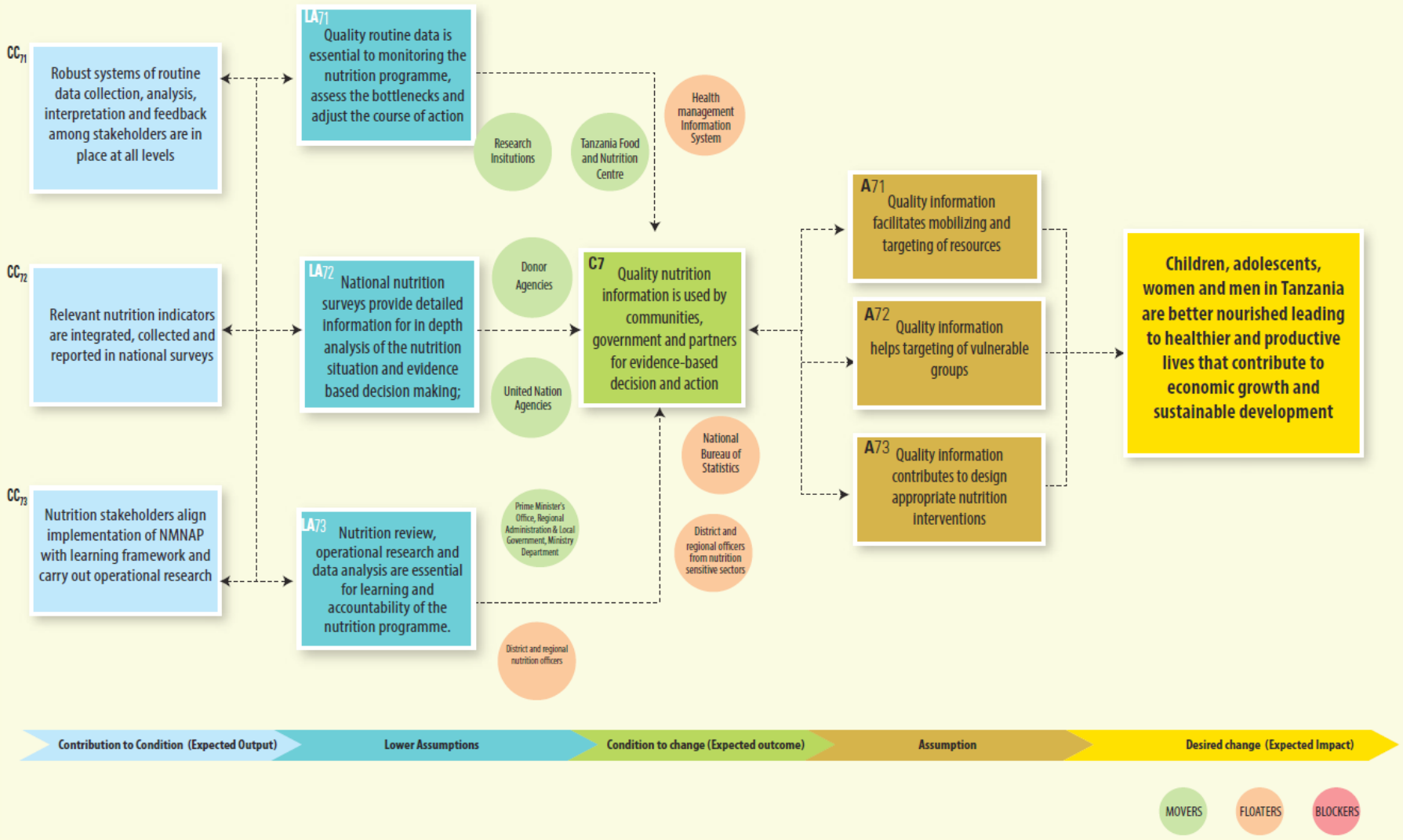
as appropriate.

The second component (CC7.2) is about the implementation of regular nutrition surveys, including key indicators necessary to track the situation of nutrition in Tanzania and for in-depth analysis for decision making (i.e. on geographical targeting and which interventions to prioritize) and resources mobilization. The Tanzania Demographic and Health Survey (TDHS) is implemented every five years, and the Tanzania National Nutrition Survey (TNNS) is implemented in between the TDHS, led by TFNC, using national surveyors, to make the necessary information regularly available.

The third component (CC7.3) is about regular review of the NMNAP, including nutrition sector review to analyse the activity and financial implementation, which is carried out by district and regional nutrition officers supported by TFNC and development partners, and the Public Expenditure Review of the Nutrition sector which is carried out by external consultants. These reviews will allow accountability towards nutrition spending, identification of innovation and best practices from the councils, and will be part of a learning framework that will constantly inform and adjust implementation of the NMNAP.

Within this condition for change, the key **movers** are TFNC, and development partners with technical capacities on nutrition information systems. There are not specific **blockers** having interest to impede the desired change. However, there are a number of important **floaters** – such as the NBS, HMIS, nutrition officers and officers from key nutrition sensitive sectors at the district level who are not engaged mainly due to lack of capacities to collect and analyse data, lack of interest and insufficient understanding of their role. Therefore, it will be crucial for the movers to capacitate and motivate the floaters in order to realize this condition for change and contribute to attain the desired change of the NMNAP.

NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21)
THEORY OF CHANGE - CONDITION 7: MULTISECTORAL NUTRITION INFORMATION SYSTEM



APPENDIX 2: COMMON RESULTS, RESOURCES AND ACCOUNTABILITY FRAMEWORK (CRRAF) FOR THE NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-2021)

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
Expected Impact	**Children, adolescents, women and men in Tanzania are better nourished leading to healthier and productive lives that contribute to economic growth and sustainable development**									
	Reduced prevalence of stunting among children 0-59 months from 34% in 2015 to 28% in 2021	Prevalence of stunting among children under five	34.4% (TDHS, 2015)	32%	28%	TDHS, TNNS				
	Maintain prevalence of Global Acute Malnutrition among children 0-59 months under 5% in 2021	Prevalence of Global Acute Malnutrition among children under five	4.5% (TDHS, 2015)	<5%	<5%	TDHS TNNS				
	Reduced prevalence of low birthweight from 7% in 2010 to less than 5% in 2021	Prevalence of low birthweight	7% (TDHS, 2010)	<5%	<5%	TDHS				
	Reduced proportion of women 15-49 years with anaemia from 44.7% in 2015 to 33% in 2021	Proportion of women of reproductive age with anaemia	44.7% (TDHS, 2015)	40%	33%	TDHS				
	Reduced prevalence of Vitamin A deficiency among children aged 6-59 months from 33% in 2010 to 26% in 2021	Prevalence of Vitamin A deficiency among children aged 6-59 months	33% (TDHS, 2010)	30%	26%	TDHS				
	Maintain median urinary iodine of women of reproductive age between 100-299 µg/L by 2021	Median urinary iodine of women of reproductive age ranging between 100 and 299µg/L	160µg/L (TDHS, 2010)	100-299 µg/L	100-299 µg/L	TDHS				
	Maintain prevalence of Diabetes among adults under 10% by 2021	Prevalence of Diabetes among adults 25-69 years of age	9.1% (STEPS, 2012)	<10%	<10%	STEPS Survey				

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
	Maintain prevalence of overweight among children under five under 5% by 2021	Prevalence of Overweight among children under five	3.6 (TDHS, 2015)	<5%	<5%	TDHS, TNNS				
	Maintain prevalence of overweight among adults under 30% by 2021	Prevalence of overweight in adults aged 25-69 years	29% (STEPS, 2012)	<29%	<29%	DHS, STEPS Survey				
Expected Outcome 1:	**Increased proportion of adolescents, pregnant women and mothers / caregivers of children under two years who practice optimal maternal, infant and young child nutrition behaviours**	Proportion of children aged 0-5 months who are exclusively breastfed	41% (TNNS, 2014)	45%	50%	TDHS TNNS				
		Proportion of children aged 6-23 months who receive a minimum acceptable diet	20% (TNNS 2014)	25%	30%	TDHS TNNS	**146**	**196**		
Output 1.1:	Increased coverage and quality of MIYCAN services at the community level by June 2021	% mothers / caregivers of children under two years who received counselling on optimal feeding from CHWs	15% (BNA, 2015)	33%	65%	Annual BNA reports on nutrition	109	145	PORALG	TFNC, LGAs, MOHCDGEC, UN, CSOs PANITA
Output 1.2:	Improved quality of MIYCAN services at the health facilities level by June 2021	% of pregnant women who have received counselling on exclusive breastfeeding from a health worker during the last fiscal year	20% (BNA, 2015)	36%	65%	Annual BNA reports on nutrition	34	46	MOHCDGEC	TFNC, PORALG, LGAs, DPs UN
Output 1.3:	MIYCAN is promoted at all levels through mass-media and the use of new technologies by June 2021	% of Tanzania population reached with relevant MIYCAN promotional messages through mass media and social media	0% (IMA/ ASTUTE Baseline)	25%	50%	Media program transmis-sion reports / surveys	1.73	2.86	TFNC	Media Houses NGOs,PANITA, PORALG, MOHCDGEC, Private Sector

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
Output 1.4:	Improved MIYCAN law enforcement through advocacy and capacity building of key institutions	% of employers providing minimum requirement of maternity benefits (maternity leave, bf breaks, bf corners)	0% (IMA/ ASTUTE Baseline)	25%	50%	Periodic assessment reports (MOHC-DGEC, ATE)	1.10	1.71	TFNC	TFDA, MoLED, PMO, PO-RALG, ATE, UN, NGOs, PANITA, Private Sector
Expected Outcome 2:	**Children, adolescents and women of child bearing age consume adequate micronutrients**	Proportion of children aged 6-59 months who received Vitamin A Supplement during the last 6 months	72% (TNNS, 2014)	80%	90%	TDHS, TNNS				
		Proportional of households consuming iodized salt	64.2% (TNNS, 2014)	70%	85%	TDHS, TNNS				
		Proportion of pregnant women taking iron and folic acid (IFA) for 90+ days during pregnancy	8% (TNNS, 2014)	20%	50%	TDHS, TNNS	**70**	**120**		
Output 2.1:	Increased access to food fortification (home and mass) for children aged 6-23 months, pregnant women and women of childbearing age by 2021	% of districts with MNP supplementation programme	10% (TFNC 2015 AR)	25%	35%	TFNC Reports	49	85	TFNC	MOHC-DGEC, PO-RALG, LGAs, MoALF, MoIT, DP, Private Sector
		% of flour produced in Tanzania that is fortified with iron	36% (TFNC 2015 AR)	42%	50%	TFNC Annual Reports				

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
Output 2.2:	Enhanced services for Vitamin A supplementation among children aged 6-59 months in by 2021	Proportion of children 6-59 months who have received Vitamin A supplementation during the previous 6 months	89% (CHNM campaign report 2015)	95%	95%	CHNM campaign report	9.96	16.59	TFNC	PORALG, MOHDGEC, DPs
Output 2.3:	Increased availability of adequately iodized salt by 2021	Proportion of household with iodized salt	64% (TNNS 2014)	70%	80%	TNNS, TDHS	4.21	7.48	TFNC	MOHCDGEC, PORALG, TBS, TFDA, TASPA
Output 2.4:	Improved anemia prevention and control interventions among women of childbearing age and children under 5 years old by 2021	Proportion of women 15-49 years of age with children under five years of age who took an IFA supplementation during pregnancy for past birth	9% (TNNS 2014)	15%	20%	TNNS, TDHS	6.36	10.96	TFNC	PORALG, MoALF, MoEVET, MOHCGEC, DPs, Private sector
Expected Outcome 3:	**Increased coverage of integrated management of severe and moderate acute malnutrition**	Proportion of children under five in need of SAM treatment who are admitted in the program annually	9% (BNA/ SAM, 2015/16)	35%	75%	Annual BNA reports on nutrition				
		Proportion of children under five in need of MAM treatment who are admitted in the program annually	<1% (WFP Project Report, 2015)	35%	75%	WFP Annual Reports	**41**	**97**		
Output 3.1:	Improved quality of services for management of severe and moderate acute malnutrition in at least 75% of health facilities by 2021	Proportion of health facilities providing out-patient treatment (OTP) of SAM	25% (BNA/ SAM, 2015/16)	50%	90%	Annual BNA reports on nutrition	5.90	9.31	TFNC	MOHCDGEC, TFDA, MSD, PORALG, TCU, MUHAS, SUA, NACTE, DPs

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
		Proportion of health facilities food insecure districts providing integrated management of MAM	<5% (WFP PR, 2015)	20%	50%	WFP Annual Reports				
Output 3.2:	At least 75% of children under five years old are reached through screening for severe and moderate acute malnutrition at community level by 2021	Proportion of children with SAM who are identified through screening annually	19% (BNA/ SAM, 2015)	35%	75%	HMIS	6.59	20.15	TFNC	MOHCDGEC, PORALG, UN, DPs/ NGOs
Output 3.3:	Essential therapeutic nutrition supplies and equipment are available in at least 90% of health facilities providing services for management of severe and moderate acute malnutrition by June 2021	Proportion of health facilities with no stock-out of RUTF lasting more than one month during last fiscal year	46% (BNA/ SAM, 2015/16)	60%	90%	Annual BNA reports on IMSAM interventions	28.55	67.06	TFNC	MOHCDGEC (NU, RCH, PHU, TFDA, MSD), PORALG, DPs
Output 3.4:	Strengthened integration of management of severe and moderate acute malnutrition at the national and subnational level by June 2021	Proportion of Councils implementing at least two IMAM key activities (training, screening, supervision) annually	0% (2015)	>50%	>75%	District annual plan CCHP activity report	0.10	0.15	TFNC	MOHCDGEC, PORALG, UN, DPs/ NGOs
Expected Outcome 4:	**Communities in Tanzania are physically active and eat healthy**	Proportion of people who drink alcohol among adults 25-69 years of age	14% (2012)	<14%	<14%	STEPS Survey				
		Prevalence of tobacco use in adults 25-69 years of age	18% (2012)	<18%	<18%	STEPS Survey	**43**	**72**		
Output 4.1:	At least 50% of the school-age children and adult population are sensitized on the risk factors for non-communicable diseases by 2021	Proportion of school-age children and adults reached with information on healthy lifestyles through mass media	5% (2012)	30%	50%	Mass media reports	37	63	TFNC	MoEVT, MOHCDGEC, MoICAS, TANCDA, Media, Private Sector

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
Output 4.2:	Policies, social, cultural and structural norms are established to enable at least 50% of the community to engage in healthy lifestyles by 2021	Proportion of school-age children and adult population that are physically inactive	7.5% (2012)	7.1%	6.8%	Yearly reports	5.52	9.18	MOH-CDGEC	MoLHS, TFDA, TBS, TANCDA, PO-RALG, TPHA, ATE, Private Sector
Expected Outcome 5:	**Line sectors, private sector and CSOs scale-up nutrition sensitive interventions to reach all communities to improve nutrition**	Proportion of planned budget spent on nutrition sensitive interventions between 2016/17 and 2020/21	0%	40%	60%	PER Nutrition JMNR Annual Sector reports	**13,366**	**21,672**		
Output 5.1:*	Communities have access to a diverse range of nutritious food throughout the year	Proportion of households with low dietary diversity	Rural: 21.4% Urban: 8.6% (2012)	Rural: 20% Urban: 8%	Rural: 15% Urban: 6%	CFSVA reports HHBS	2,189	3,622	MALF	TFNC, DP, Private Sector
Output 5.2: *	Communities regularly use quality maternal health including family planning, prevention and treatment of HIV and malaria services	Proportion of women (15-49 years of age) attending at least 4 ante-natal care (ANC) visits	51% (TDHS, 2015)	55%	60%	HMIS, TDHS	4,721	6,522	MOH-CDGEC	DP, NGOs
		Proportion of women of reproductive age who are using (or whose partner is using) a modern family planning method	32% (2015/16)	40%	50%	HMIS, TDHS				
		Proportion of pregnant women using IPT for malaria prevention	35% (2015/16)	42%	50%	HMIS, TDHS				

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
Output 5.3: *	Communities access adequate water sanitation and hygiene services	Rural population with access to piped or protected water as their main source (%)	72% (2014/15)	80%	85%	TDHS, HBS,	3,447	5,744	MoH-CDGEC, MoWI	DP, NGOs
		Proportion of the households with improved sanitation facilities (latrines) in rural areas	25% (2014/15)	60%	75%	TDHS, HBS				
Output 5.4: *	Girls complete primary and secondary education	Net enrolment ratio for Girls at higher secondary education (% of eligible)	0.9 % (2014/15)	1.6%	2%	MoEVT	1,055	1,759	MoEST	DP, NGOs
Output 5.5: *	Poorest households benefit from conditional cash transfers, cash for work, and nutrition education during community sessions	Proportion of vulnerable households benefiting from social protection programmes (conditional cash transfers, cash for work, and nutrition education during community sessions)	83% (5,011,335 out of 6,000,000)	95%	100%	PSSN Results Framework Reports	1,950	4,016	TASAF	DP, NGOs
Output 5.6: *	Vulnerable communities are able to cope with draught and climate change to avoid shortage of nutritious food during shocks	Poor dietary intake prevalence (rural and urban)	Rural: 10.5% Urban: 3.4% (2012)	Rural: 8.5% Urban: 2.8%	Rural: 7% Urban: 2.5%	CFSVA reports	4.68	7.82	MALF	DP, NGO, VPO
Expected Outcome 6:	**Efficient and effective nutrition governance**	Proportion of districts implementing the minimum budget allocation to nutrition	NA (2015/16)	30% increase from baseline	50% increase from baseline	PER Nutrition JMNR	**22**	**38**		
Output 6.1:	Increased Government political and financial commitment to Nutrition	Average nutrition spending on nutrition at council level	TZS 128 million (2014/15)	TZS 250 million	TZS 400 million	PER Nutrition JMNR	4.58	7.98	PMO	PORALG, MOFP, TFNC LGAs, DP, PANITA
Output 6.2:	Functional multisectoral coordination at all levels	Proportion of councils that hold at least two council nutrition steering committee meetings per year	<10% (2015/1)	35%	60%	District quarterly reports	1.74	2.78	PMO	TFNC, PORALG, MDAs, LGAs, DP' PANITA

	Expected Results	Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicator		Sources	Cumulative Funding Requirements (Billion TZS		Accountability of institutions and organizations	
				2018/19	2020/21		2018/19	2020/21	Lead	Collaborating
Output 6.3:	Improved human resources and capacities for nutrition	Proportion of LGAs employing at least one full time professional nutritionist	60% (2015/16)	80%	100%	PO-RALG reports	16.11	27.04	PO-RALG	PMO, LGAs, SUA, TFNC, DP
Expected Outcome 7:	**Quality nutrition related information is accessible and used to allow government and partners to make timely and effective evidence informed decisions**	Proportion of councils using nutrition information in their respective plans, budgets and reports	NA (2015/16)	30%	100%	100%	**45**	**68**		
Output 7.1:	Robust systems of data collection, analysis, interpretation and feedback among stakeholders are in place at all levels	Proportion of regions and councils producing semi-annual and annual multi-sectoral nutrition scorecards	12% (2015)	30%	50%	Regional Semi-Annual & Annual Scorecard	34.34	51.43	TFNC	PMO, MDAs, LGAs, DPs
Output 7.2:	Relevant nutrition indicators integrated, collected and reported in national surveys	Number of regular national surveys that incorporate nutrition indicators (including biological indicators of micronutrient deficiencies and diet related NCDs) conducted	1 (TDHS, 2015)	1 (TNNS)	2 (HBS, TDHS)	TDHS, HBS, TNNS	4.42	7.28	NBS	TFNC and Partners
Output 7.3:	Capacity of nutrition stakeholders developed to align implementation of NMNAP with learning framework and carry out operational research	Number of multi-sectoral nutrition reviews and public expenditure reviews (PER) on nutrition conducted	1 (2015/16)	2	2	Review Reports	6.42	9.29	TFNC	PMO, PO-RALG, MOFP, RS, LGAs and Partners
TOTAL WITHOUT NUTRITION SENSITIVE INTERVENTIONS							**367**	**590**		
TOTAL WITH NUTRITION SENSITIVE INTERVENTIONS							**13,733**	**22,262**		

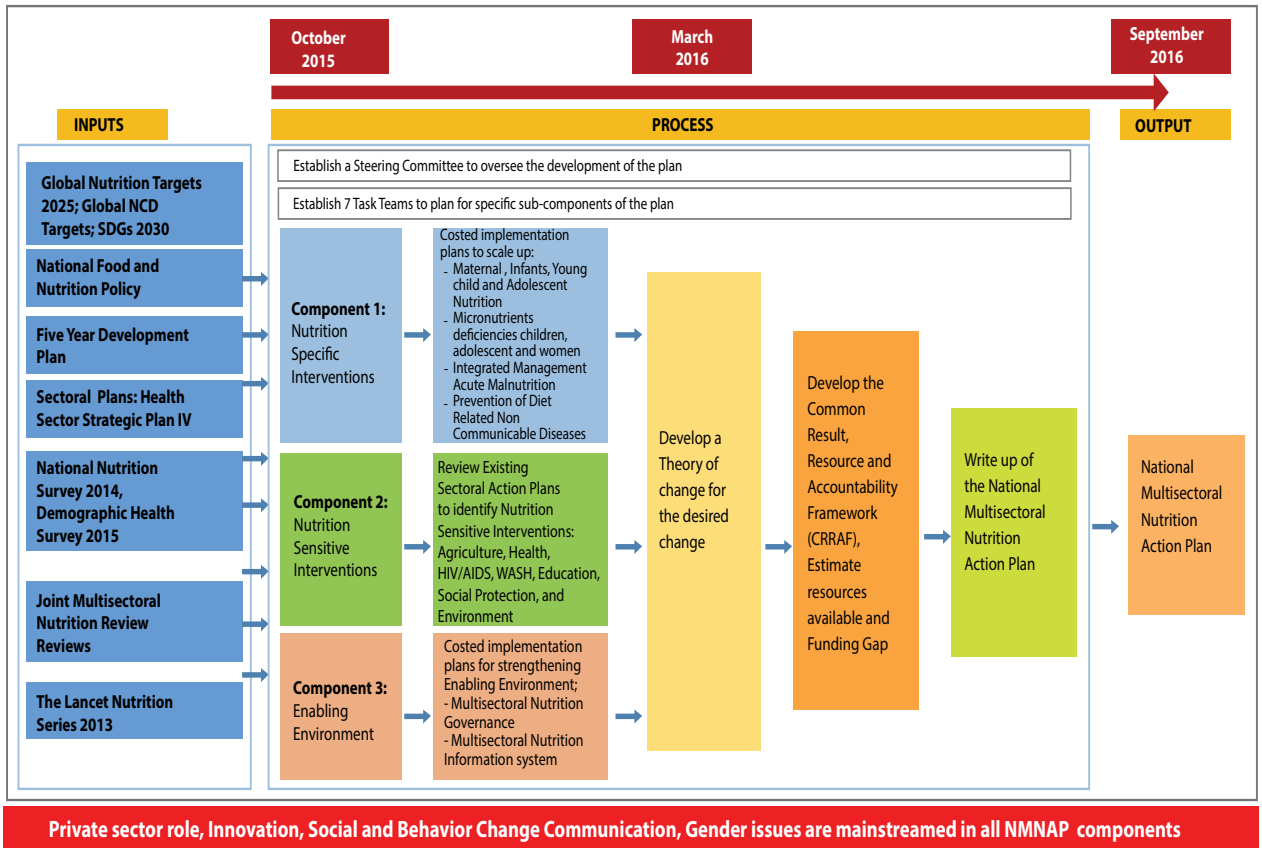
*: Data were extracted from Five Year Development Plan (FYDP 2016-21) and sectoral plans (eg. HSSP IV, TASAF) plus additional nutrition sensitive activities identified by NMNAP task team as they were not included in sectoral plans

APPENDIX 3: METHODOLOGY USED IN DEVELOPING THE NMNAP

The roadmap for the preparation of the NMNAP

The 2015 Joint Multisectoral Nutrition Review (JMNR) adopted a roadmap for the development of the NMNAP that was adjusted during the course of NMNAP process to address challenges and issues identified (see figure below for final roadmap). The objective of the Roadmap was to provide a clear working structure, workplan and budget.

Roadmap for the preparation of the multisectoral nutrition action plan (NMNAP)



Formation of thematic task teams

The roadmap provided for a "steering structure" for policy guidance, sectoral and partner coordination, strategic decisions and quality assurance. Structurally, the NMNAP steering committee was formed as a sub-committee of the High Level Steering Committee on Nutrition (HLSCN) and chaired by the Prime Minister Office (PMO), specifically the Scaling Up Nutrition (SUN) focal point. Members included TFNC (as Secretariat), representatives from nutrition sensitive sectors (ministries and departments) in Mainland and key partners in nutrition (UN agencies, development partners, NGOs, academia).

To ensure key areas for nutrition intervention are adequately covered by the NMNAP, the steering committee established six task teams with the mandate to develop costed implementation plans for actions in the seven key result areas (KRA). Common terms of reference (TOR) were developed for the task teams with their formation and work overseen by TFNC. In forming the task teams, the steering committee used the 2013 Lancet Conceptual Framework for addressing malnutrition and categorized the key result areas into three categories: nutrition specific, nutrition sensitive and enabling environment interventions.

1) **Nutrition specific interventions KRAs**: Four task teams were formed to develop

costed action plans to scale-up high impact nutrition specific interventions. These were: -

i. Maternal infant, young child and adolescent nutrition (MIYCAN) - task team 1;
ii. Micronutrients - task team 2;
iii. Integrated management of acute malnutrition (IMAM) – task team 3;
iv. Diet-related non-communicable diseases (DRNCDs) – task team 4.

2) Nutrition sensitive interventions KRA:
v. **Task team 5** was tasked to develop **multisectoral nutrition sensitive Interventions** in six key sectors: (a) agriculture and food security; (b) health and HIV; (c) water, sanitation and hygiene (WASH); (d) education and early childhood development; (e) social protection and (f) environment and climate change.

3) Enabling environment interventions
vi Multisectoral Nutrition Governance - task team 5; and
vii Multisectoral Nutrition Information System - task team 6.

Each task team was composed of at least eight (8) core members drawn from key stakeholders, a chair from TFNC and a KRA expert task team facilitator. The task team expert facilitators and chairs ensured all key stakeholders were consulted and that proposed actions were evidence-based. Appendix 4 provides a list of participants in the task teams.

Coordination of the task teams

A senior level nutrition expert lead facilitator provided technical harmonization, coordination, quality assurance and cross-theme conceptual standardization. The Acting Managing Director of TFNC chaired frequent meetings of the facilitators and the chairs of the task teams to discuss progress and address any emerging issues in order to build consensus on issues and strategize on key milestones.

The collection of evidence

A key approach in the development of the NMNAP was the emphasis given to evidence-based actions. Evidence was collected using desk reviews, and where appropriate new operational evidence was collected through bottleneck analysis.

A bottleneck analysis was carried out nationally in January-February 2016 looking specifically at (i) promotion of exclusive breastfeeding for children 0-5 months (ii) promotion of appropriate complementary feeding for children 6-23 months (iii) supplementation of children 6-59 months with vitamin A and (iv) supplementation of pregnant women with iron-folic acid. The results of the bottleneck analysis were discussed with other evidence in a workshop that was held on 23-24 February 2016 as part of the development of this NMNAP.

A desk review of the global scientific evidence on appropriate interventions for child and maternal nutrition and on DRNCDs was done. Particular attention was paid to the Lancet Nutrition Series of 2008, 2013 and 2016 and UN, development partner and other nutrition relevant research organizations. Examples of other Multisectoral Nutrition Action Plans like the ones in Ethiopia, Nepal and Sri Lanka were consulted.

Stakeholder participation

The process engaged all key actors in the multisectoral, multi-layer and multi-stakeholder nutrition system at all levels. Consultations were based on the SUN stakeholder platforms (MDAs-national/regional/ district/LGA), the UN System (UNICEF, WHO, UN-REACH, WFP and FAO), key development partners (Fhi360, Irish Aid, DFID, USAID), NGOs (PANITA, HKI, COUNSENUTH), Civil Society Organizations (Tanzania Public Health Association - TPHA, Tanzania Diabetic Association – TDA, Tanzania NCD Alliance), Academia (SUA, MUHAS) and Research Institutions (Ifakara Health Institute) and the private sector. The stakeholders were involved as core members of the task teams, participants in the bottleneck analyses, or as participants in the various workshops held (e.g. on theory of change, NMNAP consolidation and validation) or specific platform consultations. A consultation with the SUN Business network coordinated by GAIN ensured inputs from the private sector.

Articulating desired change: The theory of change

A key issue that emerged during the process of developing the NMNAP was the articulation of SMART results. To address this TFNC with support of UNICEF organized two workshops on the "Theory of Change". The first held on 15th April

2016 was facilitated by the lead and task team facilitators and the second done 7-10 June 2016 was facilitated by two international experts on the subject from IMA International. The overall purpose of the workshops was to develop a theory of change model for the NMNAP as well as harmonise the overall conceptual framework for change among different stakeholders and partners. Some learning objectives included (i) to have an overall understanding of the concept of Theory of Change (ii) to understand our role in ***social change processes*** and (iii) to understand how to relate in productive ways with different stakeholders through a common vision and action like the NMNAP.

The workshops explored tools for assessing output-outcome and impact under a complexity approach given that nutrition belongs to the science of complexity. Borrowing from different techniques that use participatory approaches the workshop built a framework to assess and evaluate the impact that the NMNAP will contribute to, using the "Theory of Change" approach. The assumption behind the rationale of "Theory of Change" is that if we can collectively identify with the participation of different stakeholders, the patterns of how change happens, it is easier to see whether current practices, operations, structures, values, communications systems and relations respond to these patterns or whether they should be rethought in order to enhance effectiveness and impact of a particular project/ programme/action plan. This is particularly useful for actions/interventions like the NMNAP that require and lead to social change. Participants in the workshops were task team chairs, facilitators, core task team members and some other TFNC and NGO staff.

Developing the NMNAP document

The task teams consolidated their work in a workshop facilitated by the Lead Facilitator who then used the output from the workshop to develop draft-1 of the NMNAP. This draft was peer reviewed and validated in a second workshop. The Lead Facilitator incorporated inputs from the reviewers and the validation workshop into draft-2, which was then submitted to the HLSCN for final inputs. The HLSCN approved the NMNAP on 21st October 2016, after which the lead facilitator incorporated the HLSCN comments and observations into this final NMNAP document.

APPENDIX 4: MEMBERSHIP OF TASK TEAMS

Members of the overall NMNAP coordinating committee

No.	Name	Organization	Role
1.	Dr. Joyceline Kaganda	TFNC	Ag. Managing Director, Chair
2.	Dr. Festo P. Kavishe	Independent Human Development Consultant	NMNAP Lead Facilitator and writer of the NMNAP document
3.	Ms. Sarah Mshiu	PMO	Representing HLSCN
4.	Dr. Biram Ndiaye	UNICEF	UNICEF Focal point for NMNAP
5.	Ms Neema Joshua	TFNC	Chair, MIYCAN
6.	Mr. Mauro Brero	UNICEF	Facilitator, MIYCAN
7.	Dr. Fatima Abdallah	TFNC	Chair, Micronutrients
8.	Prof. Jonathan Gorstein	Washington University & Global IDD Network	Facilitator of Micronutrients key result area and reviewer of the NMNAP
9.	Ms. Mary Msangi	TFNC	Chair, IMAM
10.	Ms. Rikke Le Kirkegaard	UNICEF	Facilitator, IMAM
11.	Ms. Julieth Kitali	TFNC	Chair, DRNCDs
12.	Prof. Andrew Swai	Tanzania Diabetes Association (TDA)	Facilitator, DRNCDs
13.	Mr. Jeoffrey Chiduo	TFNC	Chair, Nutrition sensitive interventions and governance
14.	Mr. David Katusabe	Fhi360	Facilitator, Nutrition sensitive interventions and governance
15.	Mr. Benedict Jeje	Fhi360	Co-Facilitator, Nutrition sensitive interventions and governance
16.	Mr. Tumaini Charles	Fhi360	Fhi360 focal point for Nutrition sensitive interventions and governance
17.	Mr. Adam Hancy	TFNC	Chair, Multisectoral Nutrition Information Systems
18.	Mr. Cletus Mkai	Independent Consultant	Facilitator, Multisectoral Nutrition Information Systems

List of MIYCAN task team members

No.	Name	Organization	Role
1	Neema Joshua	TFNC	Chair
2	Mary V. Kibona	TFNC	Co-Chair
3	Mauro Brero	UNICEF	Facilitator
4	Elizabeth Macha	UNICEF	Co-Facilitator
5	Ruth Mkopi	TFNC	Secretary
6	Freddy Lwoga	TFNC	Member
7	Hilda Missano	NUDEC	Member
8	Erin Smith	HKI	Member
9	Victoria Kariathi	TFNC	Member
10	Ester Elisaria	IHI	Member
11	Belinda Liana	COUNSENUTH	Member
12	Joyce Ngegba	UN-REACH	Member
13	Doris Katana	TFNC	Member
14	Ester Elisaria	IHI	Member
15	Onesmo Mella	TFNC	Member
16	Margreth Benjamin		Member
17	Lydia Mushegezi	CUAMM	Member
18	Julieth Itatiro	TFNC	Member
19	France Begin	UNICEF	Expert Advisor

List of Micronutrient task team members

No.	Name	Organization	Role
1	Dr Fatma Abdallah	TFNC	Chair
2	Prof. Jonathan Gorstein	Washington University and Executive Director of Iodine Global Network	Facilitator
3	Bupe Ntoga	TFNC	Member
4	Anna John	TFNC	Member
5	Margareth Rwenyagira	TFNC	Member
6	Vumilia Lyatuu	TFNC	Member
7	Anneth Nombo	TFNC	Member
8	Bernard Makene	TFNC	Member
9	Devota Mushumbusi	TFNC	Member
10	Aika Lekey	TFNC	Member
11	Dr. Ladislaus Kansankala	TFNC	Member
12	Gwao O. Gwao	MOHCDGEC	Member
13	George Kaishozi	HKI	Member
14	Dr. Zuberi Seagal	TASPA	Member
15	Dr L. M. Mmbando	Ministry Of Agriculture, Live-stock and Fisheries	Member
16	Moses Mnzava	BNFB Project	Member
17	Dr. Generose Mulokozi	IMA World Health, Dar Es Salaam	Member

List of IMAM task team members

No.	Name	Organization	Role
1.	Dr M. Azzayo	MOH- RCHS	Member
2.	Peter Kaswahili	MOH- Nutrition Unit	Member
3.	Anneth Wilbroad	MOH- PSU	Member
4.	Samson Marwa	MSD	Member
5.	Jason Kyaruzi	TFDA	Member
6.	Dr. Evalyne N. Assenga	MUHAS	Member
7.	Dr. Issabella Swai	MNH	Member
8.	Flora Mgimba	DNuO- Ilala	Member
9	Dr. Lulu Chirande	PAT	Member
10.	Mwita Waibe	RNuO	Member
11.	Bertha Mwakabage	RNuO	Member
12.	Dr. D. Mnzava	Regional Hospital -Dodoma	Member
13.	Masawe Gabriel	DNuO -Bagamoyo	Member
14.	Victoria Gowele	SUA	Member
15.	Shaib Itibar Mzee,	Pemba -Nutrition	Member
16.	Shemsa N. Msellem,	Zanzibar -Nutrition Unit	Member
17.	Asha Hassan Salmin	Zanzibar -Nutrition Unit	Member
18.	Dr. Mariam J. Bakar	Zanzibar –RCH	Member
19.	Othman A. Ussi	Zanzibar –CMS	Member
20.	Rogers Wanyama	WFP	Member
21.	Rikke Le Kirkegaard	UNICEF	Facilitator
22.	Isiaka Alo	WHO	Member
23.	Lydia Mshengezi	CUAMM	Member
24.	Idda Katigula	BPI	Member
25.	Maria. J.Msangi	TFNC	Chair
26.	Bupe A.Ntoga	TFNC	Member
27.	Elizabeth Lymo	TFNC	Member

List of Diet Related Non-Communicable Diseases (DRNCDs) task team members

No.	Name	Organization	Role
1.	Abela Twin'Omujuni	Tanzania Food and Nutrition Centre (TFNC)	Member
2,	Adeline Munuo	Tanzania Food and Nutrition Centre	Member
3.	Aika S Lekey	Tanzania Food and Nutrition Centre	Member
4..	Akwilina Mwanri	Sokoine University of Agriculture	Member
5.	Andrew Swai (Prof.)	Tanzania Diabetes Association & Tanzania NCD Alliance	Facilitator
6.	Anneth J Nombo	Tanzania Food and Nutrition Centre	Member
7.	Beatrice Lyimo	Ministry of Information	Member
8.	Bertha Maega	Tanzania Public Health Association (TPHA)	Member
9.	Chibole Manumbu	Ministry of Industry Trade & Investment	Member
10.	Cypriana Cyprian	Tanzania Food and Nutrition Centre	Member
11.	E. M. Urio	TFNC	Member
12.	Elifatio Towo	Tanzania Food and Nutrition Centre	Member
13.	Elizabeth J Lyimo	Tanzania Food and Nutrition Centre	Member
14.	Fatma Abdalla	Tanzania Food and Nutrition Centre	Member
15.	Faustin Njau	Tanzania Public Health Association	Member
16.	Festo Kavishe, Dr.	Independent Human Development Consultant	NMNAP Lead Facilitator
17.	Freddy Lwoga	Tanzania Food and Nutrition Centre	Member
18.	Frederick Mashili	Muhimbili University of Health and Allied Sciences	Member
19.	Grace J Munhambo	Tanzania Social Action Fund (TASAF)	Member
20.	Helen Semu	Ministry of Health, Community Development, Gender, elderly and Children (MOHCDGEC)	Member
21.	Herbert Gowelle	TFNC	Member
22.	Hindu M Augossy	Ministry of Works	Member
23.	Jasson Joel Kyaruzi	TFDA	Member
24.	Jasson Ndanguzi	Ministry of Works, Transport and Communications	Member
25.	Judith Njau	APHFTA	Member
26.	Julieth J Shine	Tanzania Food and Nutrition Centre	Chair
27.	Kaushik Ramaiya	Tanzania Diabetes Association, Tanzania NCD Alliance, Association of Private Health Facilities in Tanzania	Member
28.	Laureta Lucas	COUNSENUTH	Member

No.	Name	Organization	Role
29.	Maria J Msangi	TFNC	Member
30.	Maria Ngilisho	TFNC	Member
31.	Mariam Kalomo	Ministry of Health, Community Development, Gender, elderly and Children	Member
32.	Mtawajibu Athumani	Elimu - Msingi	Member
33.	Neema Joshua	TFNC	Member
34.	Samson Marwa	MSD	Member
35.	Sara Mahena Mbise	MOHCDGEC	Member
36.	Sara Simba	Health promotion Unit	Member
37.	Stephen Motambi	President's Office, Regional Administration and Local Government	Member
38.	Suzana Godwin Mwangoka	Ministry of Lands, Housing & Human Settlement Development	Member
39.	Tatizo Waane	Jakaya Mrisho Heart Institute, Tanzania Heart Foundation, Tanzania NCD Alliance	Member
40.	Tumaini Kiyola	ATE	Member
41.	Valeria P Milinga	Ministry of Health, Community Development, Gender, elderly and Children	Member
42.	Waziri Ndonde	Physical Activity Association of Tanzania	Member
43.	Zena Issa	Tanzania Bureau of Standards (TBS)	Member
44.	Zohra Lukmanji	Independent Nutritionist	Member

List of the Multisectoral Nutrition Sensitive Interventions and Nutrition Governance task team members

No.	Name	Organization	Role
1	Sarah Mshiu	PMO - Government Business Coordination	Member
2	Geoffrey Chiduo	TFNC	Chair
3	Tumaini Charles	FHI360 - FANTA	Co-Facilitator
4	Rachel Magafu	Makambako TC	Member
5	Hellen Semu	MOHCDGEC - Health Promotion	Member
6	Dr. Vincent Assey	MOHCDGEC - Nutrition Section	Member
7	Margareth Natai	MALF - Agriculture	Member
8	Theresia Jumbe	SUA	Member
9	Mbaraka Stambuli	MALF - Livestock	Member
10	Kalistus Chonya	MESTVT - Education	Member
11	Mauro Brero	UNICEF	Member
12	Mariana Merelo Lobo	ACF	Member
13	David Katusabe	FHI360 - FANTA	Facilitator
14	Benedict Jeje	FHI360 - FANTA	Co-Facilitator
15	Deogratious Poul	VPO - Environment	Member
16	Mwita Waibe	PORALG	Member
17	Wambura M. Yamo	Kibaha DC	Member
18	Stephen Kibiriti	MOHCDGEC - WASH	Member
19	Tumpe Lukongo	TASAF	Member
20	Julitha Masanja	MOHCDGEC - Community Development	Member
21	Henry Kandore	Local Government Training Institute - Hombolo	Member
22	Maulida Hassan	MFA, E.A.C.RI and Cooperation	Member
23	Undole P.M	MITI	Member
24	Mohamed Chikawe	MALF - Fisheries	Member
25	Bariki Mwasaga	PMO - Policy and Planning	Member
26	Neema Shosho	IRISH AID	Member
27	Temina Mkumbwa	USAID	Member
28	Joyce Ngegba	UN-REACH	Member

List of Multisectoral Nutrition Information System task team members

No.	Name	Organization	Role
1	Adam Hancy	TFNC	Chair
2	Cletus Mkai	Facilitator	Facilitator
3	Catherine Kimalando	TFNC	Member
4	Samson Ndimanga	TFNC	Member
5	Deborah Charwe	TFNC	Member
6	Josephine Manase	TFNC	Member
7	Valerian Kidole	MALF	Member
8	Peter Kaswahili	MoHCDGEC	Member
9	Mary Manzawa	TACAIDS	Member
10	Angela Shija	NIMR	Member
11	Evelyne Assenga	MUHAS	Member
12	Theresia Jumbe	SUA	Member
13	Biram Ndiaye	UNICEF	Member
14	Domina Kambarangwe	WFP	Member
15	Joyce Ngegba	REACH	Member
16	Touma Ngwanakilala	CUAMM	Member
17	Magreth Paul	PANITA	Member
18	Mariana Merelo Lobo	ACF	Member
19	Caroline Shayo	IHI	Member

Additional List of people who made significant contributions

Organization	Name and Position	Contribution
UNICEF New York	Dr. France Begin, Senior Nutrition Advisor	Supported development of MIYCAN scale up plan and global review of the draft NMNAP
	James Hedges, Monitoring and Evaluation Specialist	Supported the BNA for IMAM and development of IMAM Logframe
UNICEF ESARO Nairobi	Juliawati Untoro, Nutrition Specialist	Supported the BNA for MIYCAN and micronutrients interventions
	Patrick Codjia, Nutrition Specialist	Supported the BNA for IMAM and development of IMAM scale up plan
	Eric Ribaira, Health Specialist	Supported the BNA for IYCN and Micronutrients
	Yu Shibui, Health Officer,	Supported the BNA for IYCN and Micronutrients
	Dr. Joan Matji, Regional Nutrition Adviser,	Provided cross cutting support to all components of the NMNAP and review of drafts
UNICEF Burkina Faso Country Office	Fatoumata Lankoande, Nutrition Specialist	Supported costing of IMAM scale up plan
USAID	David Charles	Technical guidance on NSI and MNG Key Result Areas
FHI 360/FANTA	Dr. Deborah Ash	Technical review of NSI and MNG Key Result Areas
	Caroline Mshanga	Technical review of NSI and MNG Key Result Areas
Independent Consultant	Dr. Olivia Yambi, Senior Expert – Nutrition and Sustainable Development	Reviewed NMNAP drafts
The World Bank	Yi-Kyoung Lee, Health, Nutrition & Population, Eastern & Southern Africa Africa Region	Reviewed NMNAP drafts

APPENDIX 5: LIST OF ABBREVIATIONS

Abbreviation	Full name
AARR	Average Annual Reduction Rate
ACF	Action Against Hunger
AIDS	Acquired Immunological Deficiency Syndrome
ATE	Association of Tanzania Employers
BFHI	Baby Friendly Hospital Initiative
BNA	Bottle-Neck Analysis
CCCD	Community-Centred Capacity Development
CSO	Civil Society Organizations
CHWs	Community Health Workers
C-PPP	Community-Public-Private Partnership
COSTECH	Commission of Science and Technology
CRC	Convention on the Rights of the Child
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CRRAF	Common Results, Resources and Accountability Framework
COUNSENUTH	Centre for Counselling on Nutrition and Health
CUAMM	Doctors with Africa
DCDO	District Community Development Officer
DED	District Executive Director
DfID	Department for International Development (UK)
DMO	District Medical Officer
DNuO	District Nutrition Officer
DP	Development Partners
DPG	Development Partners Group
DPG-N	Development Partners' Group on Nutrition
FAO	Food and Agricultural organization (of the United Nations)
FBOs	Faith Based Organizations
FY	Financial Year
GAIN	Global Alliance In Nutrition
FYDP	Five-Year Development Plan
GDI	Gender Development Index
GNI	Gross National Income
IMAM	Integrated Management of Acute Malnutrition
LGA	Local Government Authorities

Abbreviation	Full name
HCWs	Health Care Workers
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HLSCN	High Level Steering Committee on Nutrition
HMIS	Health Management Information System
HBS	Household Budget Survey
HSP	Health Strategic Plan
IFAD	International Food and Agriculture Development (of UN)
IHI	Ifakara Health Institute
IMSAM	Integrated Management of Severe Acute Malnutrition
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
JMNR	Joint Multisectoral Nutrition Review
LGA	Local Government Authority
MALF	Ministry of Agriculture, Livestock and Fisheries
MAM	Moderate Acute Malnutrition
MDAs	Ministries, Departments and Agencies
MEM	Ministry of Energy and Minerals
MIYCAN	Maternal, Infant, Young Child and Adolescent Nutrition
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MIC	Middle Income Country
MN	Micronutrients
MNG	Multisectoral Nutrition Governance
MNIS	Multisectoral Nutrition Information System
MNSI	Multisectoral Nutrition Sensitive Interventions
MMR	Maternal Mortality Ratio (Rate)
MOAFSF	Ministry of Agriculture, Food Security and Fisheries
MOESTVT	Ministry of Education, Science and Technology and Vocational Training
MOFP	Ministry of Finance and Planning
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOI	Ministry of Information (Sports and Culture)
MOWI	Ministry of Water and Irrigation
MSD	Medical Supplies Department

Abbreviation	Full name
MUHAS	Muhimbili University of Health and Allied Sciences
NACTE	National Council of Technical Education
NBS	National Bureau of Statistics
NECTA	National Examinations Council of Tanzania
NEMC	National Environmental Monitoring Council
NGOs	Non-Governmental Organizations
NIMR	National Institute for Medical Research
NMNAP	National Multisectoral Nutrition Action Plan
NNS	National Nutrition Strategy
NSI	Nutrition Sensitive Interventions
PANITA	Partnership for Nutrition in Tanzania
PER-N	Public Expenditure Review on Nutrition
PMO	Prime Minister's Office
PO-RALG	President Office – Regional Administration and Local Government (Ministry)
PSSN	Productive Social Safety Net
PSU	Planning Support Unit
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RS	Regional Secretary
SAM	Severe Acute Malnutrition
SBCC	Social and Behavioural Change Communication
SIDO	Small Industries Development Organization
SME	Small and Medium Enterprises
SUA	Sokoine University of Agriculture
SDGs	Sustainable Development Goals
SUN	Scaling Up Nutrition
TACAIDS	Tanzania Commission on AIDS
TAHEA	Tanzania Home Economics Association
TASAF	Tanzania Social Action Fund
TASPA	Tanzania Salt Producers Association
TBS	Tanzania Bureau of Standards
TCU	Tanzania Commission of Universities
TDA	Tanzania Diabetes Association
TDHS	Tanzania Demographic and Health Survey

Abbreviation	Full name
TFDA	Tanzania Food and Drug Administration
TFNC	Tanzania Food and Nutrition Centre
TMA	Tanzania Medical Association
TNNS	Tanzania National Nutrition Survey
TPHA	Tanzania Public Health Association
TOT	Training of Trainers
TZS	Tanzanian Shilling
TWG	Thematic Working Group
RAM	Risk Assessment and Mitigation
RBB	Results Based Budgeting
RBM	Results-Based Management
RCHS	Reproductive Child Health Services
U5MR	Under-five Mortality Rate
VPO	Vice President's Office
UN	United Nations
UN-REACH	United Nations – Reaching All Children against Hunger
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
VPO	Vice President's Office
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WFP	World Food Programme
WHO	World Health Organization

ANNEXES (AVAILABLE AS SEPARATE DOCUMENTS)

Annex 1: Action Plan to Scale Up Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN)

Annex 2: Action Plan to Promote Optimal Intake of Essential Micronutrients

Annex 3: Action Plan to Scale Up Integrated Management of Acute Malnutrition (IMAM)

Annex 4: Action Plan to Scale Up Prevention and Management of Diet Related Non-Communicable Diseases (DRNCDs)

Annex 5: Action Plan to Promote Multisectoral Nutrition Sensitive Interventions

Annex 6: Action Plan to Strengthen Multisectoral Nutrition Governance

Annex 7: Action Plan to Establish a Multisectoral Nutrition Information System


WASH
Food Security
Education
Health
Nutrition for
Economic Growth and
Sustainable
Development
Civil Society
Social Protection
Environment
Business