UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

MID-TERM REVIEW OF THE NATIONAL MULTISECTORAL NUTRITION ACTION PLAN 2016/17–2020/21

FROM EVIDENCE TO POLICY TO ACTION

FINAL REPORT

SEPTEMBER 2019

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Additional information about Mid-Term Review of the National Multisectoral Nutrition Action Plan 2016-21 may be obtained from Dr. Germana Leyna, Managing Director, Tanzania Food and Nutrition Centre, 22 Barack Obama Drive, P.O. Box 977, Dar es Salaam. Telephone: +255 22 2118137, Fax: +255 22 2116713, Email: info@tfnc.go.tz; the Prime Minister's Office, 2 Railway Street, P.O. Box 980, Dodoma. Telephone: +255262322480, Fax: +255262324534 email: ps@pmo.go.tz.

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Foreword

It is evidenced that the fight against malnutrition requires a well-coordinated and monitored multisectoral response. In this regard, in 2016, the Prime Minister's Office, as the Chair of High-Level Steering Committee on Nutrition in collaboration with Tanzania Food and Nutrition Centre, led the process of developing a National Multisectoral Nutrition Action Plan (NMNAP 2016/17–2020/21). It is a One plan, One coordinating mechanism and One monitoring, evaluation and learning framework that reflects Tanzania's commitment to addressing the unacceptably high levels of malnutrition. The NMNAP was developed in a participatory and consultative process recognizing contribution of each sector and stakeholders. The process involved Central and Sector Ministries, Regional Secretariat, LGAs, Donors, National and International NGOs, United Nations Agencies, Academia and Research, Private sector and individual's nutrition stakeholders not affiliated with any institutions.

NMNAP aligns to Global, Regional and National strategies and plans; Sustainable Development Goals (SGDs) , World Health Assembly (WHA) targets, SUN Movement, African Union Nutrition Strategy (2015-2025), , Tanzania Vision 2025, National Five Years Development Plan, 2016/17 – 2020/21 among others. Its interventions are evidence based, with targets at national and sub-national levels. It has one desired change (impact), 7 Key Results Areas (outcomes), and 26 measurable outputs. 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. The NMNAP is monitored based on the CRRAF annually through the Joint Multisectoral Nutrition Reviews (JMNRs), which is used to review operational progress, challenges and opportunities and recommends ways forward.

Given implementation of the NMNAP 2016-2021 is now at mid-term, the Government decided to assess its progress. This Mid-Term Review (MTR) gathers evidences and factors for the success, challenges and areas that need more attention to realize the targets set for 2020/21. The overall objective of the mid-term review of the NMNAP 2016-21 is to review progress towards expected results after the first phase of implementation and propose relevant measures to accelerate achievement of NMNAP results.

The MTR was mandated by the High-Level Steering Committee on Nutrition (HLSCN), chaired by the Permanent Secretary (PS) Prime Minister's Office (PMO). A Technical Committee to guide and oversee the MTR was established under leadership of the Scaling up Nutrition (SUN) Focal Person at PMO and co-chaired by Tanzania Food and Nutrition Centre (TFNC) and facilitated by two National Facilitators. Three Task Teams were established to support the MTR based on the structure of the NMNAP: one Task Team focused on Nutrition Specific Interventions, one on Nutrition-Sensitive Interventions and one on Enabling environment for Nutrition.

Technical Committee and Task Team members were selected among relevant Ministries, Departments and Agencies (MDAs), Regional Secretariats (RS), Local Government Authorities (LGAs), UN Agencies, Donors, Civil Society Organizations (CSOs), Academia and Private Sector. They jointly reviewed existing evidence, held consultative meetings and conducted field visits in selected regions. Evidence assessed during the MTR included national surveys, studies, and information issued from routine information system and program reports.

Generally, the results of the review show that NMNAP implementation is on track: 80 percent of the tracked impact indicators met the midterm targets and 20 percent were slightly delayed. Findings indicate reduction in the proportion of stunting among children from 34 per cent to 32 per cent (which was the planned target for 2018/19) hence if the momentum to accelerate stunting reduction is kept, the endline target of 28 per cent will be achieved. In addition, there is increased accountability, commitment and political will at all levels, infrastructure development such as WASH facilities and roads which may have contributed to the achievement of the observed changes. Congratulations to all stakeholders who have made these achievements possible. However, much is needed to ensure that the final targets are met by 2021.

The report of MTR has come out with various recommendations to speed up implementation of NMNAP. These include; fighting the triple burden of malnutrition, strengthening linkages with food systems, increasing financial investment especially in nutrition specific interventions, and further strengthen nutrition coordination to ensure complementarities and continuous deployment of Nutrition officers. We all have a stake in implementing the recommended actions. I call upon both internal and external stakeholders to take recommendations for their sector and implement them accordingly.

Acknowledgements

We are pleased to present the report of the Mid-Term Review (MTR) of the implementation of the National Multi-sectoral Nutrition Action Plan, NMNAP (2016/17 – 2020/21). This work is the outcome of high-level commitment from the Government and developing partners who made sure that the review was conducted successfully. Our appreciation goes to all individuals who were involved, for their commitment and technical advice.

Sincere gratitude is expressed to the Government of the United Republic of Tanzania for its support through the whole process of undertaking this review. Also, we extend our appreciation to the Ministries, Departments and Agencies (MDAs), Regional Secretariats (RS), Local Government Authorities (LGAs), UN Agencies, Donors, Civil Society Organizations (CSOs), Academia and the Private Sector for their participation in making this review a success.

Sincerely, our heartfelt gratitude is expressed to the High-Level Steering Committee on Nutrition (HLSCN) for the overall chairmanship of the process. In addition, we would like to recognize the good work of the members of the Technical Committee, which was set to guide and oversee the MTR and was established under the leadership of the Scaling up Nutrition (SUN) Focal Person at PMO, co-chaired by Tanzania Food and Nutrition Centre (TFNC).

We recognize and appreciate contributions provided by the members Technical Committee from various Government Ministries including the Ministry of Health, Community Development, Gender, Elderly and Children; Ministries of Agriculture; Ministry of Livestock and Fisheries, Ministry of Water and Irrigation, Ministry of Education, Science, Technology and Vocation Training, Ministry of Industry, Trade and Investment, President Officer – Regional Authorities and Local Government, Ministry of Finance and Planning, National Bureau of Statistics, the Sokoine University of Agriculture and University of Dodoma.

Likewise, we utter a sincere gratitude to the facilitators of the MTR of the NMNAP, Mr Sima Mwiru (Independent Consultant) and Dr Teddy Jumbe (Sokoine University) for their tireless efforts to ensure that the review is conducted in the highest possible standard. In addition, the success in terms of the information presented in this report was substantially the contribution of the three task teams established to support the MTR based on the structure of the NMNAP.

Our sincere appreciation goes to DPG-N, for the overall financial patronage of the review. The specific note goes to UNICEF, UK Aid, Irish Aid, WFP, GAIN, ASPIRES, NI, CUAMM, CRS and ACF for their financial contribution and technical support; Indeed, your enormous support enabled us to realize our expectation of having a considerably smooth, rapid and transparent MTR.

Finally, we expect that this report will play a vital role in expediting the implementation of NMNAP, to realize the targets that have been set for FY 2020/21; as well as the realization of the targets for the Second Five Year Development Plan (FYDP II), the 2025 World Health Assembly (WHA) targets and on the 2030 Sustainable Development Goals (SDGs). Advantage should be taken of the availability of this information in this report to further strengthen nutrition programming in Tanzania.

Abbreviations

AARR	average annual stunting reduction rate
ANC	antenatal care
ARI	agricultura research institution
ART	antiretroviral therapy
ASDP	Agriculture Sector Development Plan
AWP	annual work plan
BCC	behaviour change communication
BEST	Basic Education Statistics in Tanzania
BFHI	baby-friendly health facility
BMI	body mass index
BMS	breast milk substititues
BNA	bottleneck analysis
BOT	Bank of Tanzania
CCCD	community-centred capacity development
CCD	care for child development
CCHP	Comprehensive Council Health Plan
CDO	community development officer
CHF	Community Health Fund
CHND	community health and nutrition day
CHNM	child health and nutrition month
CHW	community health worker
CLTS	community-led total sanitation
CREDI	Caregiver Reported Early Development Instruments
CRRAF	common results, resources and accountability framework
CSA	climate-smart agriculture
CSO	civil society organization
CTC	care and treatment centre
DAICO	district agriculture irrigation and cooperatives officer
DC	district commissioner
DED	district executive director
DHFF	direct health facility financing
DHIS	District Health Information System
DLDO	district livestock and fisheries development officer
DMNSC	district multisectoral nutrition steering committee
DMO	district medical officer
DNuO	district nutrition officer
DP	development partner
DRNCD	diet-related non-communicable disease
DT	district treasury
ECD	early childhood development
FAO	Food and Agriculture Organization
FFE	Fee-Free Education

FSR	food sufficiency rate
FYDP	Five Year Development Plan
GAIN	Global Alliance for Improved Nutrition
GAM	global acute malnutrition
GCR	gross competition rate
GDP	gross domestic product
GFF	Global Financing Facility
GMP	growth monitoring and promotion
GoT	Government of Tanzania
HBP	high blood pressure
HBS	Household Budget Survey
HCWs	health-care workers
HIV	human immunodeficiency virus
HKI	Helen Keller International
HLSCN	High-Level Steering Committee on Nutrition
HMIS	Health Management Information System
HR	human resource
HSP	health service provider
HSSP	Health Sector Strategic Plan
HW	health worker
ICT	information communication technology
IDD	iodine deficiency
IFA	iron and folic acid
IFPRI	International Food Policy Research Institute
IMAM	integrated management of acute malnutrition
IMCI	integrated community case management of childhood illnesses
IMES	integrated monitoring and evaluation system
IPT	intermittent presumptive treatment
IT	information technology
IYCF	infant and young child feeding
IYCN	infant and young child nutrition
JMNR	Joint Multisectoral Nutrition Review
KII	key informant interview
KRA	key result area
LBW	low birth weight
LED	Local Economic Development
LGA	local government authority
M&E	monitoring and evaluation
MAD	minimum acceptable diet
MAM	moderate acute malnutrition
MDA	ministries, departments and agencies
MDG	Millennium Development Goal
MEAL	monitoring, evaluation and learning
MIYCN	maternal, infant and young child nutrition
MIYCAN	maternal, infant, young child and adolescent nutrition
MMS	micronutrients supplementation
MN	micronutrients

MNIS	multisectoral nutrition information system
MNP	micronutrient powders
MNSC	multisectoral nutrition steering committee
MNSI	multisectoral nutrition information system
MNTWG	Multisectoral Nutrition Technical Working Group
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
MoU	memorandum of understanding
MoWI	Ministry of Water and Irrigation
MTEF	medium-term expenditure framework
MTR	mid-term review
MSD	Medical Supplies Department
MUAC	mid-upper arm circumference
NAIA	National Accelerated Investment Agenda for Adolescents
NBS	National Bureau of Statistics
NCD	non-communicable disease
NEMLIT	National Essential Medicines List Tanzania
NGO	non-governmental organization
NHIF	National Health Insurance Fund
NMNAP	National Multisectoral Nutrition Action Plan
NMNTWG	National Multisectoral technical Working Group
NNS	National Nutrition Strategy
NSI	nutrition-sensitive interventions
NTWG	Nutrition Technical Working Group
OC	other charges
OPD	outpatient department
OTC	over the counter
OTP	outpatient therapeutic programme
PANITA	Partnership for Nutrition in Tanzania
PER-N	Public Expenditure Review on Nutrition
PHC	Project Healthy Children
PLANREP	planning and reporting
PLHIV	people living with HIV
PMO	Prime Minister's Office
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
PO–RALG	President's Office – Regional Administration and Local Government
PPP	public–private partnership
PS	Permanent Secretary
PSSN	Productive Social Safety Net
PWLHIV	pregnant women living with HIV
PWP	public works programme
RAS	Regional Administrative Secretary
RC	regional commissioner
RMNSC	regional multisectoral nutrition steering committees

RMO	regional medical officer
RNuO	regional nutrition officer
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
SBC	social and behaviour change
SBCC	social and Behaviour change communication
SDG	Sustainable Development Goal
SHINE	sanitation hygiene infant nutrition efficacy
SMART	sustainable, measurable, achievable, reachable, time-bound
SOLEO	Social Liberation and Empowerment Organization
SP	social protection
SQUEAC	semi-quantitative evaluation of access and coverage
STEPS	STEP-wise approach to surveillance
SUN	Scaling Up Nutrition
TANCDA	Tanzania Non-Communicable Diseases Alliance
TARI	Tanzania Agriculture Research Institute
TASAF	Tanzania Social Action Fund
TASPA	Tanzania Salt Producers Association
TC	town council
TDHS	Tanzania Demographic and Health Survey
TFNC	Tanzania Food and Nutrition Centre
TM	Tanzania Meteorological Authority (originally TMA)
TMIS	Tanzania Malaria Indicator Survey
TNNS	Tanzania National Nutrition Survey
ToR	terms of reference
TWG	Thematic Working Group
TSh	Tanzanian Shilling
TWG	Thematic Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
USI	universal salt iodization
VAD	vitamin A deficiency
VAS	vitamin A supplementation
VASD	vitamin A supplementation and deworming
VHND	village health nutrition day
VHW	village health worker
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WIFA	weekly iron folic acid
WIFAS	weekly IFA supplementation
WRA	women of reproductive age
WSSR	Water Sector Situation Report
WYD	Iodine Test Checker (WYD is a trademark)

Executive summary

With the National Multisectoral Nutrition Action Plan (NMNAP 2016/17–2020/21) being implemented for almost three years now, this report reveals findings on the progress achieved at midterm. It presents assessment results at the impact, outcome and output levels, as per the seven key result areas (KRAs) of the NMNAP. It also highlights the strategies that were implemented to achieve those results and the drivers that contributed to change. Overall, the midterm review (MTR) shows that good progress is being made against most of the expected targets, including at the impact level. Tanzania is on track to achieve most of the national and global targets at the national aggregated level. However, the evidence generated shows clear disparities among and within regions, and delays in achieving some of the global targets. For example, while the NMNAP target for stunting reduction among children under five years was achieved, the reduction in stunting prevalence (from 35 per cent in 2014 to 32 per cent in 2018) was accompanied by an increase in the number of stunted children (from 2.7 million in 2014 to 3 million in 2018). On the other hand, overweight, obesity, hypertension and diabetics are on the rise, which implies emerging nutrition-related challenges. There is an urgent need to prioritize interventions to prevent diet-related non-communicable diseases (DRNCDs). While there has been a significant reduction in anaemia among women aged 15-49 years, micronutrient deficiencies still affect a majority of women and children in Tanzania. With about one third of children suffering from stunting, one third of women aged 15–49 years overweight or obese, and one third affected by anaemia, Tanzania must deal with the triple burden of malnutrition. The multisectoral approach adopted by the country has established a strong foundation to address this challenge, while the overarching NMNAP strategy of community-centred capacity development has been instrumental in ensuring access to nutrition-related interventions and needs, which need to be pursued and further scaled-up in the second term of the NMNAP.

Key findings

Childhood stunting has reduced from 34.7 per cent to 31.8 per cent in 2014. This was contributed by an improvement in infant and young child nutrition (IYCN) practices, as the percentage of children aged 0–5 months who were exclusively breastfed increased from 41 per cent (Tanzania National Nutrition Survey [TNNS] 2014) to 58 per cent (TNNS 2018), while the percentage of those aged 6–23 months who received a minimum acceptable diet increased from 20 per cent (TNNS 2014) to 30 per cent (TNNS 2018). Such improvements were due to a significant increase in the coverage of IYCN services, especially in regions supported by partners through large-scale stunting reduction programmes (in about half of the country). However, regional variations exist. Trained community health workers (CHWs) were instrumental in providing regular promotional nutrition services. They were able to deliver comprehensive IYCN within the maternal, infant, young child and adolescent (MIYCAN) KRA of the NMNAP. IYCN services were integrated with promotion of other key practices for stunting reduction in the following areas – health and human immunodeficiency virus (HIV); water, sanitation and hygiene (WASH); early childhood development (ECD); and social protection (especially cash transfer to vulnerable populations).

Although MIYCAN has a specific component for adolescents' nutrition, all the focus was on children and secondly on mothers. It had insufficient programming to reach adolescents and school-age children with adequate nutrition interventions, including nutrition promotion/education, food fortification and micronutrients supplementation.

Over the three years of NMNAP implementation, global acute malnutrition has reduced from 3.8 per cent to 3.5 per cent. However, coverage of management of moderate acute malnutrition (MAM) stagnated at 8 per cent. Similarly, coverage of severe acute malnutrition (SAM) services was at 13 per cent. The NMNAP target of reaching 35 per cent children with SAM and MAM at midterm has not been met. Today, out of approximately 90,000 children with SAM every year, only 15,000 are reached with integrated management of acute malnutrition (IMAM) services, and the remaining ones face a high risk of dying from this life-threatening condition.

Anaemia among women of reproductive age [(WRA) aged 15–49 years) reduced from 44 per cent in 2016 to 29 per cent in 2018, surpassing both midterm (40 per cent) and endline NMNAP targets (33 per cent). No new data was available for anaemia among children at midterm, which was 58 per cent in 2015/16. Coverage of supplementation programmes (iron and folic acid [IFA]) among pregnant women increased from 8 per cent in 2014 to 29 per cent in 2018, surpassing the midterm target. As part of these large-scale stunting reduction programmes, there was also an increase in the promotion of, and education on, nutrition among mothers.

However, micronutrient deficiencies remain high in Tanzania. There is a need for generating new evidence, as the last micronutrients survey among women and children was conducted in 2010. Access to nutritious foods (especially vegetable and animal source foods) is another challenge throughout the country. Hence, the synergy between nutrition and the agriculture, livestock and fisheries sectors must be strengthened.

The most affordable sources of nutrients and energy that can reduce deficiencies are dark green leafy vegetables, dried beans, peas and lentils, beef liver, small dried fish, orange/yellow-fleshed vegetables, chicken liver, beef, eggs and milk. However, most of these are affordable only to 10–40 per cent of the population. The animal source foods supply chain (i.e., poultry and eggs) is largely informal and faces issues such as high consumer prices, production risks (low yields, high cost of inputs and lack of capital), food safety risks (from food production to distribution and retail), and poor processing, storage and transportation infrastructure (Food Diversity Landscape Analysis, UNICEF).

Overweight and obesity among women is increasing – over 32 per cent of women aged 15–49 years in Tanzania are overweight or obese. At midterm, it was not possible to track the performance of interventions planned in the NMNAP to address DRNCDs. This issue highlights an existing gap within the nutrition community in Tanzania, where interventions to address overnutrition are not sufficiently prioritized.

Significant progress was made in the implementation of nutrition-sensitive interventions. The proportion of planned budget spent on nutrition-sensitive interventions was 34 per cent in 2018/19 against a target of 40 per cent. Notable achievements were also noted in several sectors that contributed to the NMNAP. These are detailed in the subsequent sections.

Agriculture, livestock, fisheries and environment

There has been an improvement in the production of milk, fish and meat at the national level. Improvements have also been observed in national food inflation rate (which decreased from 9.5 per cent in 2015/16 to 3.5 per cent

in 2018/19) and national food self-sufficiency ratio (which was maintained above 120 per cent). However, no data is available to track food diversity at the household level. Overall, there is limited promotion of homestead production of nutritious foods, which is essential to ensure dietary diversification. Agriculture Sector Development Programme (ASDP II) focuses mainly on agricultural production. Essential foods (especially micronutrient-rich foods/ animal sources foods) are not accessible by communities, especially by women and children.

Health/HIV

Adequate antenatal and postnatal care have strong effects in breaking the intergenerational cycle of malnutrition. There has been good progress in most health-related indicators in Tanzania. Improved coverage was observed for malaria prevention and control services and HIV/ AIDS screening during pregnancy. In addition, significant improvement was reported in the proportion of women attending four or more antenatal care (ANC) services, from 39 per cent in 2015/16 to 64 per cent in 2018/19 (HMIS). Free maternal and child health services and involvement of males have contributed to the uptake of ANC services. However, nutrition education and counselling are not systematically provided during ANC and postnatal care (PNC) services. Key nutrition interventions, such as IMAM and vitamin A supplementation and deworming (VASD), are not sufficiently integrated in the health system.

WASH

Reduction of diarrhoea incidence through improved WASH is among the main contributors to reduction of stunting and anaemia. However, there has been delayed progress in key hygiene indicators related to behaviours especially handwashing with soap, which is only 3 per cent of households in 2018 (TNNS). Access to piped/ protected water and improved toilets is slightly increasing. This is mainly due to the engagement of regional and district commissioners in promotion of WASH as well as the engagement of CHWs in community-level efforts to improve WASH. However, social and behaviour change communication (SBCC) to improve WASH practices focuses mainly on improved water and sanitation facilities. It has limited focus on handling of animal faeces to prevent faecal contamination among young children, which is among the main determinants of stunting as it increases the incidence of diarrhoea and environmental enteropathy (a condition that limits absorption of nutrients).

Education

Secondary school completion by girls is the single most effective intervention to reduce stunting. ECD interventions provided during pre-school years have strong potential to support brain development. Lower secondary education completion rate by girls and boys is slightly delayed (38 per cent achieved as against 43 per cent target in 2018). Net enrolment rate in pre-primary education is also slightly delayed (40 per cent achieved as against 55 per cent target in 2018). The country has made great efforts to create an enabling environment for child education, such as mandatory pre-primary and primary education and fee-free education policy. This has contributed to increased enrolment in both primary and lower secondary schools. Schools are key platforms for reaching out to a high number of children with nutrition and related interventions, including promotion of dietary diversity and physical activity, school-feeding and micronutrient supplementation programmes. However, there are challenges related to low coverage and poor quality of the National School Health Programme, persistent social norms that prioritize boys over girls' education and non-availability of pre-school services at the national level.

Social protection and gender

Malnutrition is most prevalent among the poorest and most vulnerable people. Reaching them is key to accelerating nutrition improvements, which can save significant funds through improved targeting of beneficiaries. The country is on track to reach the most vulnerable households with social protection programmes: cash transfers (89 per cent) and public works (87 per cent). It is also making progress through establishment of specific programmes for women economic empowerment. Performance of Council Women Development Fund has improved between 2015/16 (funds disbursed: TSh 3,388,747,160; women reached: 21,167) and 2018/19 (funds disbursed: TSh 11,128,114,993; women reached: 44,210).

Environment

There were not significant climate-related shocks during the midterm period, which considerably affected food and nutrition security among vulnerable communities in Tanzania. However, the food system in Tanzania is inadequate in providing the required nutritious food to the majority of women and children, who still suffer the consequences of insufficient dietary diversity. Thus, it cannot ensure the population's access to sufficient food diversity for optimal nutrition. The effects of climate change can further worsen this reality, especially among vulnerable communities.

The complex structure for multisectoral coordination that was established in 2013 has been strengthened through the NMNAP. Multisectoral steering committees on nutrition meet regularly in over 85 per cent of councils, which represents a significant improvement compared to less than 10 per cent in 2015/16. The capacity of these committees to plan, coordinate and review multisectoral nutrition interventions will be further improved. At the national level, thematic working groups (TWG) coordinate the 7 KRAs of the NMNAP. However, there is variation in the leadership of the TWG, depending on the groups. Some of them do not meet regularly and are therefore unable to lead and coordinate implementation of nutrition interventions under each KRA. During the midterm period, the National Multisectoral Nutrition Technical Working Group (NTWG) and the High-Level Steering Committee on Nutrition (HLSCN) each met only once a year, as against the TOR which stipulates that they should meet at least twice a year. Regular meetings will help to reduce any lack of clarity about mandates and help coordinate joint actions in the implementation of nutrition programmes among the government ministries, departments and agencies (MDAs) in charge of nutrition (Prime Minister Office [PMO]; the Nutrition Section of the Ministry of Health, Community Development, Gender, Elderly and Children [MOHCDGEC]; Tanzania Food and Nutrition Centre [TFNC]; the Nutrition Section of the President's Office – Regional Administration and Local Government [PO–RALG]).

The World Bank recommends spending at least USD 8 per child in nutrition-specific interventions and enabling environment for nutrition in order to meet the Sustainable Development Goal (SDG) for stunting reduction. To this end, Tanzania increased the minimum budget allocation for nutrition at the local government authority (LGA) level from TSh 500 per child in each council to about TSh 22,000 per child in each council by 2030 through the PO–RALG and Ministry of Finance and Planning (MOFP). The proportion of LGAs that actually disburse such budget allocations has increased from 1 per cent in 2016/17 to 7 per cent in 2018/19. However, the NMNAP midterm target of 30 per cent was not met. Additionally, the minimum budget allocation was only increased from TSh 500 in 2015/16 to TSh 1,000 in 2016/17 and was not further increased as planned in the subsequent years. There is, therefore, a need to increase allocations and improve disbursements.

In terms of professional human resources for nutrition, Tanzania is one of the countries in the world that appointed professional nutritionists in the regions and councils. However, during the first half of NMNAP implementation, there was no increase in the number of professional nutritionists enrolled at the LGA level. Only 53 per cent of councils have professional nutrition officers who are responsible for providing technical support and coordinating nutrition interventions in their respective regions. However, various efforts were put in place to strengthen the capacity of these nutrition officers.

The capacities of MDAs and LGAs to use evidence for informed decision-making have increased during the midterm period. The proportion of councils using nutrition information in their respective plans, budgets and reports increased from 0 per cent in 2015/16 to over 95 per cent in 2018/19. LGAs regularly produce nutrition-related reports, such as bottleneck analysis (BNA) reports for selected nutrition-specific interventions; annual workplan (AWP) reviews to track activities implementation and expenditure; multisectoral nutrition scorecards and nutrition compact reports to assess the performance of NMNAP indicators and budget expenditure in every region and council. The government has recently established nutrition as an objective in its Planning and Reporting Database (PLANREP), which formalizes the planning process for nutrition and facilitates generation of planning data and reports on budget and expenditure, disaggregated as per the various KRAs and outputs under the NMNAP.

Government-led national nutrition surveys (i.e., TNNS) were implemented in between Tanzania Demographic and Health Surveys (TDHS) of 2014 and 2018 as planned. These surveys generated data for tracking progress on nutrition in Tanzania, evaluating the performance of the NMNAP and informing decision-makers to take adequate action. For example, data from the TNNS 2014 were used by the government and donors to agree on priority regions to implement stunting reduction programmes, which resulted in improved IYCN practices and reduced stunting prevalence.

Annual joint multisectoral nutrition reviews (JMNR) were institutionalized in 2014 and maintained under the NMNAP. TJMNR is the main nutrition event every year, chaired by the Honourable Prime Minister, where the nutrition community assesses the progress of the nutrition programme and provides key recommendations to improve performance.

The multisectoral nutrition information system (MNIS) was put in place within the NMNAP. It can regularly generate data to track the progress towards nutrition targets at impact, outcome and output levels as well as on expenditures against budget. It has been instrumental in generating data during this MTR. However, various informal data collection systems still coexist and a newly developed MNIS on an online platform, which is supposed to harmonize all data systems, has not been launched yet.

Performance of NMNAP strategies

The NMNAP has an overarching community-centred multisectoral approach and eight strategies to achieve its results.

The key strategies that were systematically utilized include:

- **SBCC for nutrition:** It contributed towards achieving high level of MIYCAN services coverage and significant improvements in infant and young child feeding (IYCF) practices
- **Advocacy and social mobilization:** It resulted in the establishment of the national-, regional-, council- and ward-level Nutrition Compact
- **Community-centred capacity development:** It led to increased capacities of CHWs to provide

intensive nutrition services, which in turn led to nutrition improvements

- **Functional human resource capacity development:** It led to increased capacities of nutrition officers to manage complex multisectoral nutrition programmes

The main strategies that were not sufficiently utilized include:

- **Alignment of all stakeholders with the NMNAP through community–public–private partnerships:** due to low level of collaboration with business
- **Delivery of quality and timely nutrition services:** due to very low coverage of SAM services (among others)
- **Mainstreaming of equality in all seven KRAs of the NMNAP without discrimination and with a focus on women, children and adolescent girls:** due to inadequate focus on, and involvement of, adolescents and men in the NMNAP. The equity approach was established only in a few regions through the synergy with Productive Social Safety Net (PSSN)
- **Resource mobilization strategy:** which was ineffective due to execution of only 40 per cent of the overall NMNAP budget

Financial analysis

Budget execution

The NMNAP budget execution at midterm is 41 per cent of the overall budget. There is a large gap between the planned budget and actual expenditure due to non-release of over half of the targeted investment. The budget analysis per KRA shows a varying trend (see Figure 1). Multisectoral nutrition governance and MIYCAN KRAs performed above average in terms of budget execution, whereas micronutrients interventions, IMAM, DRNCDs and information system were below average. Budget execution for nutrition-sensitive interventions is issued from sectoral budget briefs approved by MOFP, and its level has largely influenced the overall achievements. KRAs with higher budget execution had higher achievements while KRAs with below-average budget execution had lower achievements.

Source of funds for nutrition interventions

The NMNAP established that 30 per cent of the budget will be mobilized by the government, 70 per cent by external donors and 10 per cent by the private sector. However, the government mobilized only 3 per cent of the budget, while nutrition interventions remain heavily dependent on donor's funding. Development partners funded 100 per cent of MIYCAN, 96 per cent of IMAM and 95 per cent of MNIS interventions during the past three years. Donors were only able to mobilize 50 per cent of the NMNAP budget under their responsibility. Over-reliance on donors' funds are inconsistent in terms of both quantity and timing, which introduces a large degree of uncertainty in implementing nutrition activities. Contributions from the private sector could not be tracked.

Main conclusions

At the impact level, four out of five (80 per cent) NMNAP targets that could be measured (out of nine targets) at MTR were achieved, including two key indicators (childhood stunting and women anaemia). However, the adults' overweight target was not achieved and overnutrition is on the rise in Tanzania. This highlights the triple burden of malnutrition (undernutrition, micronutrient deficiencies and overnutrition). Indicators related to micronutrient deficiencies among children and women could not be tracked but are planned to be included in the micronutrients survey within the TDHS 2020.

At the outcome level, 68 per cent of the targets were achieved, which contributed to satisfactory performance at the impact level. Among the key

achievements were significant improvements in exclusive breastfeeding rates and minimum acceptable diet, coverage of micronutrients supplementation interventions and national food fortification programmes. However, IMAM KRA showed low achievement due to stagnant coverage of life-saving SAM treatment services between 12–14 per cent in the past three years, which means that almost 90 per cent of children with SAM are not reached and have a high risk of dying. No data DRNCDs were available to track progress as these interventions were not prioritized. It is thus likely that increases in adults' overweight and obesity are strictly linked with poor prevention and response in Tanzania. Within nutrition-sensitive interventions, there was progress in the health sector (especially antenatal care, malaria prevention and treatment and HIV programmes) and, to a lesser extent, in the education and social protection sectors. There were more challenges in the agriculture, livestock and fisheries sector, where increased production of diverse food was not being translated into increased consumption by vulnerable groups, especially children and women. There is, therefore, a need to strengthen the synergy between nutrition and food security. At the enabling environment level, the political and financial commitment showed sustained progress, with the establishment of minimum budget allocations for nutrition and the Nutrition Compact. LGAs also have increased capacities to use evidence for planning, budgeting, implementing and reporting for nutrition programmes.

At the output level, 85 per cent of targets that could by tracked during this MTR were achieved. Increase in coverage of preventive services promoting optimal MIYCAN was noted in over half the regions of Tanzania, which contributed to improved IYCF practices, which in turn contributed to stunting reduction. Similar trends were observed in the area of prevention and control of micronutrient deficiencies, where increased coverage of nutrition education, food fortification and micronutrient supplementation services likely contributed to the reduction of anaemia among women. However, IMAM and DRNCDs services performed poorly, which resulted in poor performance at the outcome level and did not address the increase in adults' overweight. Considerable efforts were made in the area of nutrition governance and information system, with over 85 per cent of councils now conducting regular nutrition steering committees. Strong advocacy at all levels to increase investment in nutrition is gradually reaping positive results. Significant investment in the information system also resulted in increased government capacities to conduct national surveys and strengthen the routine information system. The large amount of data that was used in this review is the best evidence of the performance of the MNIS.

Policy-level recommendations

Based on the findings and conclusions outlined in the previous sections, the following policy recommendations were formulated for consideration of the Government of Tanzania. The aim was to accelerate the achievements of the NMNAP and ensure that the 2020/21 targets are met.

- Increase investment in the promotion of MIYCAN using domestic funds, especially at the community level, to maintain high coverage and intensity of promotion of MIYCAN services
- Scale-up comprehensive programmes to address micronutrient deficiencies among school-age children, adolescents and mothers, including nutrition education, food fortification and micronutrients supplementation
- Use existing funding mechanisms, such HBF and WB GFF, and increase donors' contributions to fund IMAM services and supplies, especially through direct health facility financing (DHFF)

- Strengthen the national DRNCDs programme under MOHCDGEC/DPS, using all key delivery platforms (community, school, workplace, health system, media)
- Develop a roadmap towards improved nutrition-sensitive agriculture and inter-sectorial coordination between nutrition and agriculture sectors to increase consumption of diversified, micronutrients rich food among women and children
- Strengthen the child, adolescent and maternal nutrition package delivered through the health system at the facility (ANC/ PNC) and community levels (through CHWs)
- Systematically include an animal-keeping component in all SBCC activities and campaigns that promote WASH to reduce exposure to animal faeces and thus the incidence of infectious diseases among young children
- Scale-up the National School Health Programme in all pre-primary, primary and secondary schools as schools are key platforms to reach a high number of children and adolescents
- Scale-up the synergy between Nutrition Programme and PSSN Programme (Equity Nexus) to all regions of Tanzania to ensure systematic reach to vulnerable households
- Ensure gradual increase of the minimum budget allocation for nutrition per child aged under five years per council
- Increase donors' contributions to nutrition especially in key underfunded areas: IMAM (KRA 3), DRNCDs (KRA 4) and nutrition of school-aged children and adolescents
- Roll-out the unified multisectoral nutrition information system (MNIS) through the online platform.

Section 9 of this report summarizes the key conclusions, recommendations, timeline and responsible agencies for implementation.

1 Background and objectives of the midterm review (MTR)

1.1 Background

Tanzania has achieved notable progress in addressing malnutrition between 1992 and 2015. Among children aged 0–59 months, chronic malnutrition decreased from 50 to 34 per cent, acute malnutrition from 7 to 5 per cent and underweight from 24 to 14 per cent (TDHS 1992/93–2015/16). However, the prevalence of anaemia among WRA (aged 15–49 years) increased from 40 per cent in 2010 to 45 per cent in 2015. Among children aged 0–59 months, it was nearly at 59 per cent between 2010 and 2015 (TDHS 2010, 2015/16). Additionally, vitamin A deficiency among children aged 0–59 months stands at 33 per cent (TDHS 2010). The results of the TNNS (2018) have revealed a further reduction in stunting from 34.7 per cent in 2015/16 to 32 per cent, a slight reduction in global acute malnutrition from 3.6 per cent to 3.5 per cent in 2018 and a decrease in prevalence of anaemia from 45 per cent to 28.8 per cent in 2018.

Despite the good progress in reducing undernutrition, overnutrition is on the increase, particularly overweight and obesity. Among women of reproductive age, national trends in overweight and obesity show an increase from 11 per cent in 1992 to 28 per cent in 2015. About 3.6 per cent of children aged under five years are overweight and obese (TDHS 2015/16). The problem of overweight and obesity (which is associated with DRNCDs and, particularly, hypertension and type 2 diabetes) has also doubled among adults over the last decade.

The fight against malnutrition requires a well-coordinated and monitored multisectoral response. In this regard, Tanzania developed the NMNAP in 2016 through a participatory consultative process. The purpose is to guide the implementation of food and nutrition interventions by operationalizing the food and nutrition policy as well as other sectoral policies into a single concerted plan with concrete actions to address all forms of malnutrition. The NMNAP reflects Tanzania's commitment to addressing the unacceptably high levels of malnutrition in a 'three ones' approach, i.e., one plan; one coordination mechanism; and one monitoring, evaluation and learning framework. The plan is set to cover the period of five years between 2016/2017 to 2020/2021; currently, it is on its third year of implementation.

The NMNAP interventions were selected based on current evidence and in coherence with the conceptual framework for addressing malnutrition while targeting all levels (from the community to the national level) and are positioned within a multisectoral coordination system. To ensure a well-coordinated system, the plan made use of three key thematic areas of interventions – nutrition-sensitive, nutrition-specific and enabling environment.

In developing the NMNAP, an agreement was reached to develop a single set of nutrition results – common results, resources and accountability framework (CRRAF) – which served as the basis for developing, aligning and securing consensus for the NMNAP. The NMNAP is monitored annually based on the CRRAF through the JMNRs, which are used to review progress against targets and expenditure, identify challenges and opportunities and make solid recommendations to inform decision-makers.

Furthermore, a routine monitoring system has been established, including biannual reports using multisectoral nutrition scorecards, BNA of selected nutrition-specific interventions and AWP reviews. The scorecard ensures accountability and action for priority nutrition interventions in each council by tracking key indicators from health, education, gender, social welfare, agriculture, water and sanitation to nutrition coordination and spending at the LGA level.

The BNAs systematically assess the main determinants of effective coverage for selected nutrition-specific interventions to identify problem areas and purposely act on them, through evidence-based planning and budgeting for nutrition. Reviews of the annual nutrition workplans of LGAs and MDAs identify gaps in the implementation of nutrition activities in order to strengthen evidence-based planning and budgeting for nutrition at all levels. In December 2017, a Nutrition Compact (2018–2021 was signed between the Minister of State – PO–RALG on behalf of the Vice-President and all the regional commissioners. It aimed at increasing the accountability and effectiveness of nutrition interventions at the regional and district levels. A set of indicators and responsibilities are outlined in the compact.

Given that the implementation of the NMNAP 2016–2021 is now at midterm, the Government of Tanzania, through the HLSCN, decided to assess progress after the implementation of the NMNAP from 2016–2018. The MTR gathered evidence of, and factors related to, the success, challenges and areas needing more attention to realize the targets set for 2020/21.

The NMNAP MTR measured the progress made through the implementation of the priority interventions that were identified by the KRA outcomes, which are:

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

1.2 Objectives

The overall objective of the NMNAP MTR 2016–2021 is to review progress towards expected results after the first phase of implementation and to propose relevant changes to accelerate the achievement of NMNAP targets.

The specific objectives are to:

- Review progress towards the impact-, outcome- and output-level results (including funding) and analyse the reasons for high or low levels of achievement in relation to key NMNAP strategies
- Propose and justify changes in activities, budgets, strategies and/or indicators within each KRA for the overall expected impact of the NMNAP
- Present the proposed changes in a succinct report and clearly outline the priorities for NMNAP implementation during its second phase
- Outline some of the key elements that should be considered in the development process of the NMNAP II 2021–2025, which will begin in mid-2020

2 Context of nutrition in Tanzania

2.1 Factors that led to the development of NMNAP

When the NMNAP was being developed, Tanzania had a stunting prevalence of 34 per cent; this was categorized as 'high' in terms of its public health significance and was higher than the 30 per cent average observed in Africa. A double burden of malnutrition has emerged, where undernutrition exists together with the rapidly increasing problem of DRNCDs, especially overweight, obesity, hypertension and type 2 diabetes, which have doubled in adults over the last decade.

The contextual factors that called for the development of NMNAP include:

- Low awareness of the problem of malnutrition among policymakers, the media and the public at large – e.g., stunting and micronutrient deficiencies were largely not recognized as problems)
- Low investment in nutrition – nutrition was not adequately prioritized in the allocation of financial resources

The 2013 Public Expenditure Review on Nutrition (PER-N) showed that only about 23 per cent of expenditure on nutrition was from public funds while the rest was from donors. A government review of nutrition funding for the FY 2011/12–2015/16 (Nutrition Budget Brief 2016) concluded that although the resources allocated for nutrition-related activities increased and even doubled during the period reviewed, spending on nutrition accounted for only 0.03 per cent of GDP and 0.13 per cent of total public spending. Moreover, only 12 per cent of the total budget of the National Nutrition Strategy (NNS) for 2011/12–2015/16 was funded. This amounted to approximately TSh 825 billion (USD 520 million) and most of these funds came from donors. Given the uncertain nature of donor funding, overreliance on donor funds for nutrition introduces significant uncertainty into nutrition planning. There were also other factors that acted as barriers to achieving better nutrition outcomes in the country:

- **Inadequate nutrition governance:** These included inadequate multisectoral coordination of interventions at all levels; lack of a CRRAF for nutrition; poor enforcement of relevant laws; and low use of technology for nutrition.
- **Inadequate focus on the community and life course:** Reaching communities with large-scale nutrition interventions has been slow. Some vulnerable groups such as adolescent girls were not covered.
- **Low functional institutional capacity for nutrition at all levels:** Although institutions for nutrition have satisfactory technical capacity, their functional and strategic capacities were low at all levels.

- **Inadequate attention to the social determinants of malnutrition:** Social determinants include behaviour, practices and formal and informal structures and systems, some of which promote good nutrition while others act as barriers for good nutrition.

2.2 Main changes in the operating context

Since the inception of the NMNAP in 2016, significant changes have occurred in the context surrounding the nutrition sector, some of which are outlined here:

- **Strengthened coordination:** The NMNAP 2016–2021 provides defined coordination frameworks with an outlined CRRAF. This has been the foundation of the 'three ones', i.e., one plan, one coordination mechanism and one monitoring and evaluation framework. Overall coordination is under the leadership of the Scaling Up Nutrition movement (SUN) country lead based at the PMO. This facilitates coordination between stakeholders engaged in nutrition at different levels for improvements in national resource mobilization, creation of synergies, harmonization and collaboration.

- **Established coordination frameworks:** Multisectoral nutrition steering committees (MNSCs) are established at all levels. Detailed terms of reference (ToRs) have outlined the expected members and respective roles required to ensure coordination at the national, regional and LGA levels. All 26 regions and 184 councils have established MNSCs, including those at the national level. In addition to the MNSCs, national-level coordination is also provided by the NMNAP TWGs responsible for the various KRAs. The Multisectoral Nutrition Technical Working Group (MNTWG) informs the HLSCN, which is comprised of permanent secretaries from line ministries and development partners (DPs).

- **Multisectoral approach to nutrition:** Actors in different sectors recognize the fact that improving nutrition requires the participation of not only the health sector but also many others (including agriculture, education, social protection, water and sanitation and gender and community development) for the adaptation of environment-sensitive interventions for sustainable food and nutrition systems. To align the efforts with the country's decentralized nature, the PO–RALG now leads the planning and implementation of nutrition action in different sectors.

- **Increased political commitment across levels:** Despite being among the first countries to join SUN, Tanzania remained an active member and has been implementing annual country progress reviews in a participatory manner. Moving forward, Tanzania is among the few countries that have engaged parliamentarians in developed strategic plans, which are focused on addressing policy matter related to nutrition. Further, to tie together efforts at the regional and district levels, the Nutrition Compact – an accountability tool – was developed and implemented across all levels. This has elevated the awareness and understanding of nutrition among leaders and increased coherence in nutrition action and in the roles that every leader is expected to play.

- **Increased financial commitment for nutrition:** All councils are engaged in nutrition planning and budgeting. Nutrition has been integrated into routine planning and budgeting tools with the creation of a cost centre. Such efforts ensure minimum budget allocations for nutrition to meet the threshold proposed by the World Bank – investing an additional USD 8 per child (approximately TSh 20,000), which would help meet the SDG objective of reducing stunting among children by 40 per cent by 2030. The nutrition budget allocation for children aged under five years increased from TSh 500 (USD 0.25) per child per year in 2016/17 to TSh 1,000 (USD 0.5) per child per year in 2017/18. However, this still falls short of the Word Bank recommendations of USD 8.0 per child per year; this means that not all aspects of nutrition will be adequately addressed.

3 Approach and methods

3.1 Review approach

The NMNAP MTR was chaired by the permanent secretary (PS) of the PMO. A technical committee was established to guide and oversee the MTR under the leadership of the SUN focal person at the PMO, co-chaired by the TFNC and facilitated by two national facilitators. Three task teams were established to support the MTR; they were assigned to nutrition-specific interventions, nutrition-sensitive interventions and creation of an enabling environment for nutrition.

The review was inclusive and participatory. Technical committee and task team members were selected from the relevant MDAs, regional secretariats (RS), LGAs, United Nations (UN) agencies, donors, civil society organizations (CSOs), academia and the private sector. They jointly reviewed existing evidence, held consultative meetings and conducted field visits in selected regions. Evidence assessed during the MTR included national surveys, studies and information issued from routine information system and programme reports. The review employed quantitative and qualitative research methods. Quantitative data were obtained mainly from national reports, including surveys, previous JMNR reports, BNA reports, sector reports from all nutrition-sensitive sectors (agriculture, health, community development, livestock, WASH and education) and routine annual reports from various stakeholders.

Qualitative information to further analyse the quantitative information was obtained from the field assessments. Ethnographic approaches intended to triangulate information were used to examine the important features of improvements in the nutrition situation among populations. Both nutrition-specific and nutrition-sensitive actions were looked at along with the enabling environment that would allow the achievement of the expected impact. Triangulation between quantitative and qualitative data was done to check data reliability and consistency.

3.2 Review methods and tools

The MTR team applied the methods set out in the ToR, which are listed as follows:

- **Desk review:** Relevant reports that inform the progress on NMNAP implementation were obtained from different sectors and development partners (DPs). The desk review was conducted according to the three thematic areas outlined in the NMNAP.
- **Consultative meetings:** Given the diverse partnership in NMNAP implementation, several meeting forums were organized with agendas of providing feedback on NMNAP progress. Meetings allowed partners to revisit the set targets and achievements as outlined in the CRRAF with key stakeholders including DPs,

MDAs, UN agencies, CSOs and participants from academia and the private sector.

- **Field visits:** Two lead facilitators and task team members visited five regions (10 districts). The selection criteria for the visited regions and districts was based on the performance of impact indicators, including the prevalence of stunting among children and overweight and anaemia among women (see Table 1).

  In the field, key informant interviews (KII) were conducted with stakeholders such as regional commissioners (RCs), regional administrative secretariats (RAS), regional medical officers (RMOs), regional nutrition officers (RNuOs), district commissioners (DCs), district executive directors (DEDs), district medical officers (DMOs), district nutrition officers (DNuOs), CSOs, district agriculture irrigation and cooperatives officers (DAICOs), district livestock and fisheries development officers (DLDOs) and district treasuries (DTs).

Focus group discussions were also conducted in regional and district multisectoral nutrition steering committees (RMNSCs and DMNSCs) of the visited regions and districts. The interviews aimed to ascertain the factors associated with the observed performance. As part of the assessment, some preliminary feedback (exit meeting) was given to the authorities before leaving the field site.

- **Information gathering tools:** Interview and discussion guides were developed by the facilitators and validated by the task and technical teams.

Table 1: Field assessment: region selection criteria

Region	Justification (why is this region proposed for in-depth assessment?)	Main question(s) to be answered
Njombe (Makambako TC and Njombe DC)	• Stunting among children worsened/stagnated – it has the highest levels in Tanzania • Overweight among women increased quite significantly • Low levels of anaemia	Why is stunting so persistent in this region? Why has overweight among women and children also significantly increased?
Tanga (Handeni TC and Muheza DC)	• Increase in stunting and overweight levels among women • Good reduction in wasting	Why did stunting increase so significantly during this period, while wasting reduced so significantly?
Lindi (Nachingwea DC and Marambo HC)	• Best improvement in stunting levels • Relatively low partner support in nutrition	How did stunting improve so significantly? How did wasting and children overweight also decrease?
Mwanza (Mwanza CC and Misungwi DC)	• Good improvement in stunting levels • Good reduction in overweight among children and women • High levels of anaemia	What were the factors that helped Mwanza to perform well in stunting and overweight even though it has high anaemia?
Katavi (Nsimbo DC and Mpanda MC)	• Remarkable improvements in reducing stunting • Reduction in overweight and obesity among children • Poor vitamin A supplementation (VAS) among children and IFA utilization among pregnant women • Relatively low-level partner support in nutrition	How did stunting and overweight status among children improve so significantly? Why is the coverage of VAS in children and IFA in pregnant women low?

Source: Authors' analysis, MTR 2019

3.3 Analysis and reporting

The task team members analysed the NMNAP CRRAF and NMNAP activity workplan based on the assessment criteria. The analysis criteria of the CRRAF were based on:

- **Progress on the indicator:** The assessment compared the baseline with the target set for the midterm to understand whether the indicator was on track, delayed, achieved or exceeded the target.
- **Main drivers of the observed performance:** Qualitative information from the field was consolidated to estimate the contributing factors for the observed situation. Regions and districts were clustered based on high or low performance for in-depth analysis and triangulation.
- **Scoring of the indicator:** This was a rather qualitative process that showed whether the indicator was to be maintained, modified or removed/replaced. In addition, an assessment of whether the defined indicators were aligned and informing the outcome and impact indicators was conducted.
- **Collation of the budget information:** Reported budget figures were organized according to KRAs; data that was not linked to KRAs were removed from the analysis. The reported DPs' budget information, which was already reported through MDA sector reports, was not included to avoid double counting.

Facilitators compiled and conducted further analyses of the CRRAF and AWP data and summarized the findings.

4 Findings

4.1 Impact-level progress and challenges

The NMNAP adopted all six global recommended targets and indicators for nutrition of the World Health Assembly[1] (WHA), making a total of nine impact-level indicators (*see Table 3*). Of the 10 impact indicators, five indicators (56 per cent) were assessed by comparing data mainly from TNNS 2014 and TNNS 2018. Four indicators (44 per cent) were not assessed, due to pending data availability through STEP-wise approach to surveillance (STEPS) and TDHS planned for implementation in 2020/21.

Table 2 summarizes the scoring system that has been used to assess the achievement of NMNAP targets against set indicators and budgets.

The results of the national nutrition surveys of 2014 and 2018 were compared and the rate of change was calculated to show the performance from the baseline. Table 3 presents the performance of all impact-level indicators. A summary is presented for two different scenarios. First, overall performance was calculated based on all the indicators with results, showing that 44 per cent of the assessed impact-level indicators attained the target set. Second, performance was calculated without the inclusion of indicators

Table 2: NMNAP performance assessment

Colour code	Percentage achievement of planned target	Score
	100% or above of 2017/18 planned results	Target met
	75–99% of 2017/18 planned results	Target slightly delayed
	50–74% of 2017/18 planned results	Target delayed
	0–50% of 2017/18 planned results	Target highly delayed
	Data not available	Data not available

Source: Authors' analysis, MTR 2019

[1] 1. Reduce the number of children aged under five years who are stunted by 40 per cent
2. Reduce and maintain childhood wasting to less than 5 per cent
3. No increase in childhood overweight among children aged under five years
4. Reduce anaemia in women of reproductive age (pregnant and non-pregnant) by 50 per cent
5. Increase the rate of exclusive breastfeeding in the first six months to at least 50 per cent
6. Reduce low birth weight by 30 per cent

Table 3: NMNAP impact-level indicators

S. No.	NMNAP impact indicators	Baseline	NMNAP MTR target 2018	NMNAP MTR target 2018	Global WHA target 2025	Progress against WHA targets
1	Prevalence of stunting among children aged under five years	34.4%	32%	31.7%	40% reduction in burden	Off track. Stunting burden increased from 2.7 to 3 million CU5*
2	Prevalence of global acute malnutrition among children aged under five years	4.5%	<5%	3.5%	<5%	On track
3	Prevalence of low birth weight	7%	<5%	7%	30% reduction	Off track
4	Percentage of women of reproductive age with anaemia	44.7%	40%	28.7%	50% reduction	On track
5	Prevalence of vitamin A deficiency (VAD) among children aged 6–59 months	33%	30%	NA	NA	NA
6	Median urinary iodine of women of reproductive age between 100 and 299 µg/L	160 µg/L	100 and 299 µg/L	NA	NA	NA
7	Prevalence of diabetes among adults aged 25–69 years	9.1%	<10%	NA	NA	NA
8	Prevalence of overweight among children aged under five years	3.6%	<5%	2.8%	<5%	On track
9	Prevalence of overweight/obesity in adults 25–69 years of age	29%	<30%	NA	NA	NA
10	Proportion of women in reproductive age who are overweight (body mass index [BMI] ≥ 25)	29%	<30%	31.7%	<30	Off track

Source: Authors' analysis, MTR 2019

***CU5:** Children under five years of age

with missing information, indicating that 80 per cent of the assessed impact-level indicators met the set targets, while 20 per cent have not met the targets.

It must be noted that for some indicators, the source of the baseline data was TDHS 2015/16, while the MTR drew on TNNS. To a large extent, the results were comparable as all the surveys were nationally representative and were implemented by the same entity – the National Bureau of Statistics (NBS). In the analysis of the impact-level indicators, efforts were made to assess progress towards the achievement of WHA targets at midterm. The findings reveal that Tanzania is on track to achieve the NMNAP targets by 2020/21. There is generally good progress at midterm and Tanzania is also on track to achieve the endline targets for all impact indicators, except the indicators on birth weight and overweight among women of reproductive age. With regard to stunting reduction, although Tanzania is doing well in terms of reduction in the proportions of affected children, the number of children who are stunted has increased. Similarly, the proportion of women who are overweight is increasing, while the target was to maintain it; hence, progress is off track for WHA targets for two indicators – stunting and overweight.

Prevalence of stunting among children aged under five years

The NMNAP target for reduction of stunting from 34 per cent (2015) to 32 per cent (2018) has been met. According to TNNS data, prevalence of stunting reduced from 34.7 per cent in 2014 to 32 per cent in 2018. The WHA target for stunting reduction for 2025 is a 40 per cent reduction among children aged under five years. The average annual stunting reduction rate (AARR) in Tanzania is higher compared to the other countries in eastern and southern Africa. However, the prevalence of stunting in Tanzania is much higher than the global level of stunting prevalence, which was estimated at 22.2 per cent in 2018.[2] Furthermore, despite the reduction

Figure 1: Status of prevalence of stunting

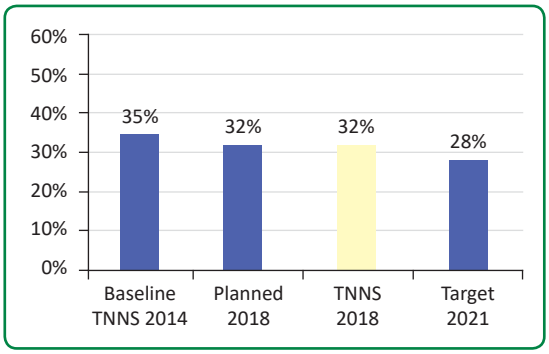


Table 4: Performance of impact-level indicators and overall budget execution (% and billion TSh)

Performance	Target met	Slightly delayed	Delayed	Highly delayed	No data	Performance of reported indicators	Budget performance with NSI	Budget performance without NSI
Overall impact	4	0	1	0	4	92%	41% (4,625/11,179)	43% (123/289)
Overall performance (all indicators)	44%	0%	11%	0%	44%			
Overall performance (available indicators)	80%	0%	20%	0%	NA			

Source: Authors' analysis, MTR 2019

[2] GNR, 2018

in the prevalence, the number of stunted children has increased from 2.7 million in 2014 to 3 million in 2018. Therefore, Tanzania is not on track for achieving the WHA 2025 target of stunting reduction. More investment is required to achieve this target.

Despite the positive progress in the reduction of stunting, regional variations have been observed. Some regions have shown significant progress in stunting reduction while other regions have shown increased prevalence of stunting. The top five regions with high reductions in stunting include Lindi, Pwani, Morogoro, Kagera and Mwanza (*see Figure 2*) while Tanga, Dar es Salaam, Simiyu, Songwe and Kilimanjaro show increased prevalence of stunting from the baseline (*see Figure 3*). At midterm, only two rural regions (Kagera and Geita), which had a 'high' prevalence of stunting (of above 40 per cent) as outlined in NMNAP, have reduced the prevalence to below 40 per cent. Unfortunately, Njombe (53.6 per cent), Rukwa (47.9 per cent), Iringa (47.1 per cent), Songwe (43.3 per cent), Kigoma (42.3 per cent) and Ruvuma (41.0 per cent) are reported to have a high prevalence of stunting (of above 40 per cent).

Overall, the achievement of these results shows promising trends. That said, the momentum gained needs to be maintained and further enhanced, particularly in regions where

Figure 2: Top five regions with increased prevalence of stunting

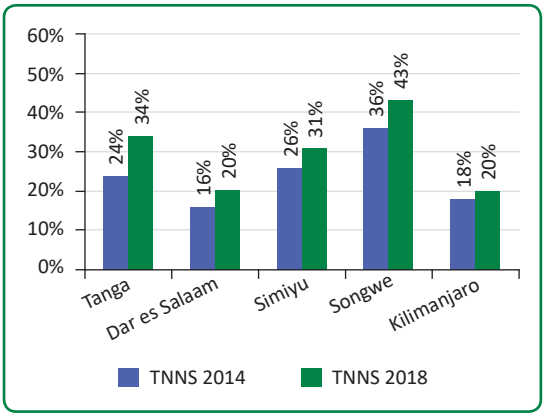
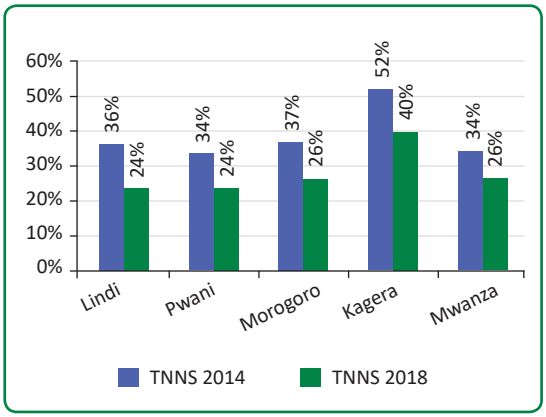


Figure 3: Top five regions with increased reduction in stunting



prevalence is still far above 40 per cent, to achieve the NMNAP endline target of 28 per cent.

Prevalence of global acute malnutrition among children aged under five years

Good progress was observed in 2018. Over the three years of NMNAP implementation, global acute malnutrition (GAM) has reduced from 3.8 to 3.5 per cent. In terms of progress, regional variations are still observed. Mara, Kilimanjaro, Rukwa and Mtwara (see Figure 4) have shown increased reduction in GAM, while Iringa, Mwanza, Katavi, Geita and Tabora (see Figure 5) are reported to have increased GAM prevalence. Food-insecure regions such as Singida, Dodoma and Manyara have greater GAM compared to other regions. At midterm, Kigoma (37,116; 4.9 per cent) and Simiyu (36,364; 4.6 per cent) had a higher burden of GAM both in terms of the absolute number of acutely malnourished children and the prevalence global acute malnutrition in comparison to the national prevalence. The NMNAP adopted the WHA target of reducing and maintaining childhood wasting to less than 5 per cent. Since the country is within the targets, IMAM interventions should be prioritized in regions with a higher number of acutely malnourished children and a higher prevalence of acute malnutrition at midterm. These regions include Kigoma, Simiyu, Singida, Arusha, Dar es Salaam, Shinyanga and Dodoma.

Figure 4: Top five regions with increased reduction in GAM

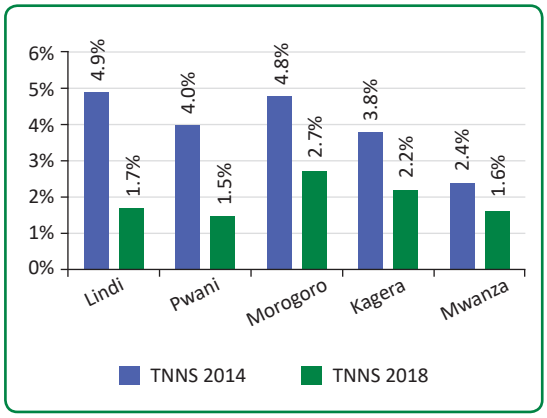
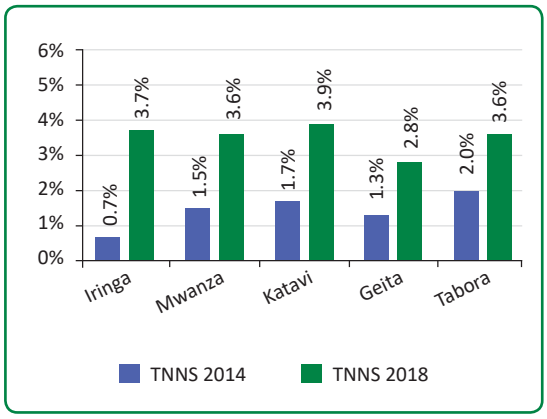


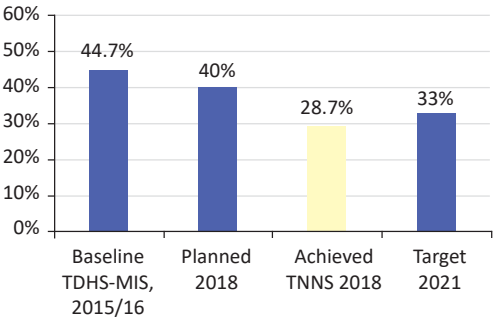
Figure 5: Top five regions with increased GAM prevalence



Proportion of women of reproductive age with anaemia

Prevalence of anaemia has decreased from 44.7 per cent in 2015[3] to 28.8 per cent in 2018. However, the TDHS-MIS 2015/16 sample included both pregnant and non-pregnant women, while in TNNS (2018), the sample included only non-pregnant women (see Figure 6). Data from TNNS and TDHS-MIS are not fully comparable and hence, data from TDHS-MIS 2020 will be used to assess trends. Since both midterm and endline targets have already been achieved, more efforts should be given to regions with a higher prevalence of anaemia. Further, based on the findings that the reduction of anaemia is 44 per cent, Tanzania is on course to achieve the WHA target of anaemia reduction by 50 per cent. Considering the differences in data sources and methodologies used in the two surveys, careful interpretation of this information is needed to avoid over- or under-estimations.

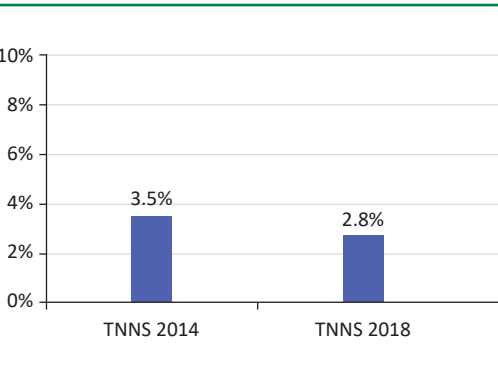
Figure 6: Proportion of WRA with anaemia



Prevalence of overweight among children aged under five years

The NMNAP baseline for this indicator was set using the results from TDHS 2015/16; however, at the inception of the MTR, the source of the information for the indicator was changed to TNNS 2014. The results from TNNS 2018 report the prevalence of overweight among under-five children to be 2.8 per cent, a decline from 3.5 per cent (TNNS 2014). At midterm, the endline target has already been met (<5 per cent). These results

Figure 7: Prevalence of overweight among children



[3] TDHS-MIS 2016

[4] TNNS, 2018

are in line with WHA global targets to ensure no increases in childhood overweight. Katavi, Rukwa, Mwanza, Songwe and Shinyanga have shown a significant reduction of overweight among children. Regions like Dodoma, Simiyu, Morogoro, Kagera and Mtwara, which had low proportions of overweight in 2014, are reported to have increased prevalence in 2018.

Figure 8: Top five regions with decreased prevalence of overweight among children in 2014–2018

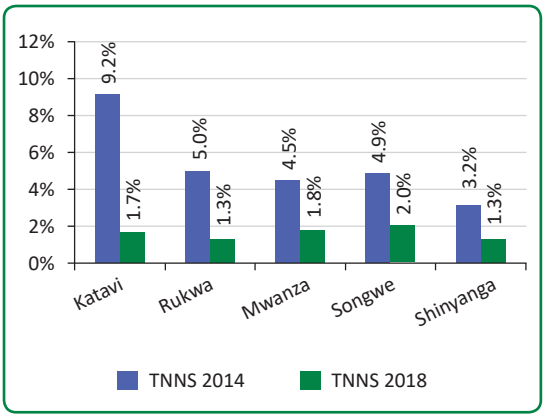
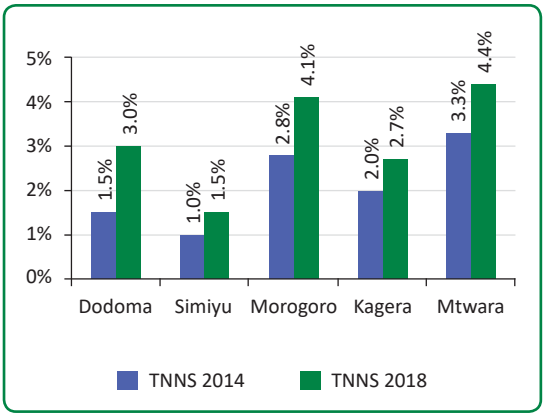


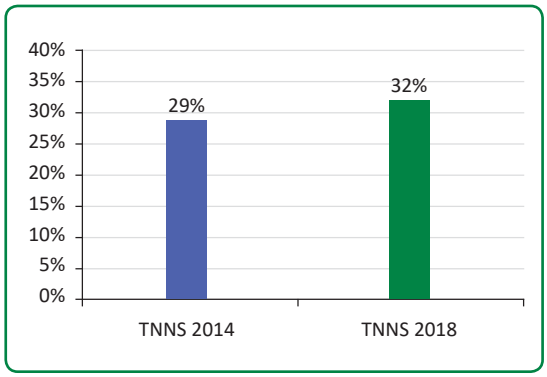
Figure 9: Top five regions with increased prevalence of overweight among children in 2014–2018



Percentage of women in reproductive age who are overweight (BMI>/= 25)

There has been an increase in the prevalence of overweight among women from 29 per cent in 2014 to 32 per cent in 2018. The targets for 2018/19 and the endline (2020/21) are to ensure that the prevalence of overweight among women does not exceed 30 per cent. Unfortunately, at MTR, data indicate an increase in prevalence of overweight. These findings follow global trends of an increase in the prevalence of overweight and obesity.[5]

Figure 10: Prevalence of overweight among women



Although national data indicate an increase in overweight, the top five regions with reductions in overweight since 2014 include Tabora, Mara, Singida, Manyara and Dar es Salaam. Regions that have shown increased prevalence of overweight are Kagera, Mwanza, Mtwara, Kilimanjaro and Tanga. Field assessments conducted in Tanga revealed the non-availability of specific activities to address the challenge of overweight and obesity among women; in contrast, primary and secondary school students engage in physical activities at school.

Figure 11: Top five regions with increased prevalence of overweight among WRA

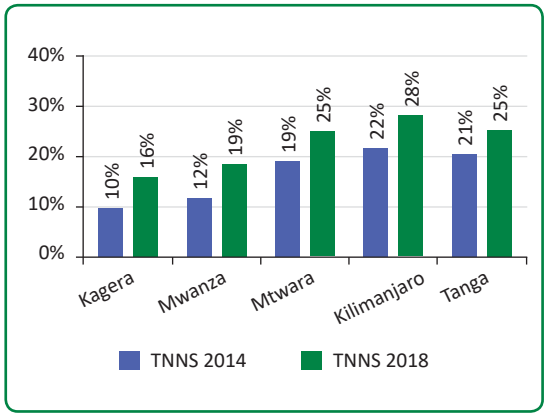
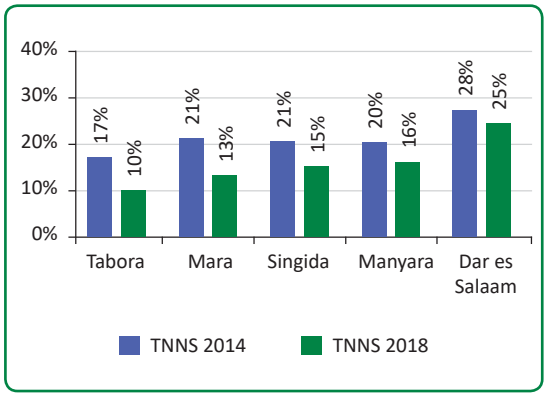


Figure 12: Top five regions with increased reduction in overweight among WRA



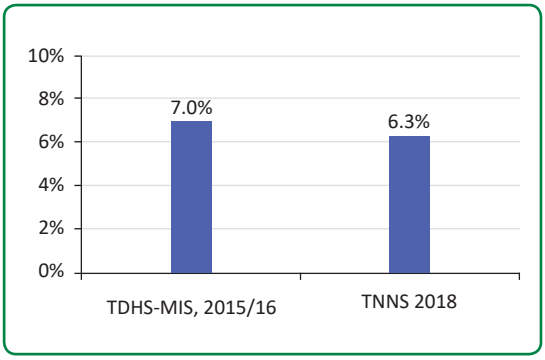
Prevalence of low birth weight (LBW)

TNNS data indicate that the prevalence of LBW has reduced from 7 per cent in 2015[6] to 6.3 per cent in 2018.[7] Thus, the NMNAP target for reduction of LBW to <5 per cent (2018) is far from being met. However, routine data from HMIS indicates a prevalence of 5.7 per cent. At midterm, Tanzania is off track on the WHA 2025 target of 30 per cent reduction on LBW from the baseline.

4.2 Outcome- and output-level progress

This section presents the findings and the possible drivers and barriers/bottlenecks to achieving the targets set for 2018/19. These drivers and bottlenecks have been summarized from field reports and have been validated by the government and partners programme implementation reports as well as individual interviews from KIIs. The drivers and bottlenecks are summarized based on the KRA and the level of progress made under each KRA in terms of indicators and budget (*see Table 5*).

Figure 13: Progress in prevalence of LBW



KRA 1: Increased proportions of adolescents, pregnant women and mothers/caregivers of children aged under two years who practise optimal maternal, IYCN behaviours

This outcome aimed at increasing the proportion of adolescents, pregnant women and mothers/caregivers of children aged under two years who practise optimal maternal and IYCN behaviours. Overall, there has been positive performance towards achieving the targets – findings from outcome indicators have already exceeded the endline target. At the output level, the targets of three indicators were met and one indicator was not tracked (see Table 4). However, there are no indicators to track maternal and adolescent nutrition behaviours. The findings for each indicator are presented below.

Outcome-level findings

Indicator: Proportion of children aged 0–5 months who are exclusively breastfed

The NMNAP midterm (45 per cent) and endline targets (50 per cent) for the proportion of

[6] TDHS-MIS, 2015

[7] TNNS, 2018

[8] Ideally programmatic performance would be correlated by budget performance if the interventions were realistically budgeted but because of the relatively poor financial data capture the two may not represent this scenario.

Table 5: Performance of outcome- and output-level indicators and overall budget execution (% and billion TSh)

Key results area	Indicators (n)	Target met	Slightly delayed	Delayed	Highly delayed	No data	Overall score	Budget performance[8]
KRA 1: MIYCAN	Outcome level (2)	2	0	0	0	0	100%	67% (71/155)
	Output level (4)	3	0	0	0	1	75%	
KRA 2: Micronutrient	Outcome level (3)	1	0	2	0	0	70%	28% (16/58)
	Output level (5)	4	0	0	0	1	80%	
KRA 3: IMAM	Outcome level (2)	0	0	0	2	0	25%	34% (10/29)
	Output level (5)	1	0	3	1	0	62%	
KRA 4: DRNCD	Outcome level (2)	0	0	0	0	2	NA	16% (5/32)
	Output level (2)	0	0	0	0	2	NA	
KRA 5: NSI	Outcome level (1)	0	1	0	0	0	75%	41% (4,502/ 10,891)
	Output level (9)	2	5	0	0	2	71%	
KRA 6: Governance	Outcome level (1)	0	0	0	1	0	25%	84% (16/19)
	Output level (3)	1	0	1	1	0	62%	
KRA 7: MNIS	Outcome level (1)	0	0	0	1	0	100%	14% (5/36)
	Output level (3)	3	0	0	0	0	100%	

Source: Authors' analysis, MTR 2019

children who were exclusively breastfed have been surpassed. According to TNNS, there was an increase from 41 per cent in 2014 to 58 per cent in 2018 at the national level. Regional variations are also noted – Tanga, Ruvuma, Mbeya, Songwe and Mtwara have shown a greater improvement in exclusive breastfeeding while Morogoro, Arusha, Iringa, Singida and Rukwa have not performed as well. Although there is overachievement of the endline targets, it was decided that the targets be maintained because there are some regions that are not progressing well. This calls for greater efforts to ensure that all regions reach the endline target.

Table 6: Progress of outcome-level indicators for KRA 1 MIYCAN

Indicators	Baseline 2014	Planned 2018	Achieved 2018	Target 2021
Proportion of children aged 0–5 months who are exclusively breastfed (TNNS reports)	41%	45%	58%	50%
Proportion of children aged 6–23 months who receive a minimum acceptable diet (TNNS reports)	20%	25%	30%	30%

Source: Authors' analysis, MTR 2019

Indicator: Proportion of children aged 6–23 months who received a minimum acceptable diet (MAD)

The proportion of children aged 6–23 months who received MAD has increased from 20 per cent (TNNS 2014) to 30 per cent (TNNS 2018). According to TNNS 2018, the midterm target (25 per cent) was already surpassed and the endline target was met. Differences in regional performances have been observed – Katavi, Tabora, Simiyu, Songwe and Mbeya have shown high improvements in MAD while Lindi, Tanga, Dar es Salaam, Ruvuma and Kilimanjaro have reported a decrease in MAD.

Output-level findings

KRA 1 – MIYCAN has four outputs:

1.1 Increased coverage and quality of MIYCAN services at the community level by June 2021

1.2 Improved quality of MIYCAN services at the health facilities level by June 2021

1.3 Promotion of MIYCAN at all levels through mass media and the use of new technologies by June 2021

1.4 Improved MIYCAN law enforcement through advocacy and capacity-building of key institutions

Progress towards each output is tracked by one output-level indicator. Table 7 summarizes the achievements against KRA 1 – MIYCAN output-level indicators.

Output 1.1: Increased coverage and quality of MIYCAN services at the community level

Indicator: Proportion of mothers/caregivers of children aged under two years who received counselling on optimal feeding from CHWs

Table 7: Progress of output-level indicators for KRA 1 – MIYCAN

Indicators	Baseline 2014	Planned 2018	Achieved 2018	Target 2021
Proportion of mothers/caregivers of children aged under two years who received counselling on optimal feeding from CHWs (BNA reports)	15%	33%	36%	65%
Proportion of pregnant women who have received counselling on exclusive breastfeeding from a health worker (HW) during the last fiscal year (Compact reports)	20%	36%	54%	65%
Proportion of Tanzanian population reached with relevant MIYCAN promotional messages through mass media and social media (IMA/ASTUTE reports)	0%	25%	38%	50%
Proportion of employers providing the minimum requirement of maternity benefits (maternity leaves and breastfeeding breaks and areas at workplaces) (MOHSDGEC, ATE reports)	0	25%	NA	50%

Source: Authors' analysis, MTR 2019

According to BNA, the coverage of counselling on optimal feeding (IYCF) services provided to mothers/caregivers of children under two years at the community level by CHWs increased from 15 per cent in 2015 to 36 per cent in 2017. At MTR, the planned target for 2018 (33 per cent) was surpassed.

Output 1.2: Improved quality of MIYCAN services at the health facilities level by June 2021

Indicator: Proportion of pregnant women who received counselling on exclusive breastfeeding from a health worker (HW) during the last fiscal year

According to the Nutrition Compact assessment, the proportion of pregnant women who have received counselling on exclusive breastfeeding from a HW during the last fiscal year increased from 20 per cent in 2014/15 (BNA reports) to 54 per cent in 2018, thus surpassing the midterm target. This indicator is on track to achieve the final NMNAP target of 65 per cent by 2020/21.

Output 1.3: Promotion of MIYCAN at all levels through mass media and the use of new technologies

Indicator: Proportion of Tanzanian population reached with relevant MIYCAN promotional messages through mass media and social media

The proportion of the Tanzanian population reached with relevant MIYCAN promotional messages through mass media and social media has increased from 0 per cent at baseline in 2015 to 37.5 per cent in 2018. The planned target for 2018/19 was 25 per cent, which has been surpassed.

Output 1.4: Improved MIYCAN law enforcement through advocacy and capacity-building of key institutions

Indicator: Proportion of employers providing the minimum requirement of maternity benefits (maternity leaves, breastfeeding breaks and breastfeeding areas at workplaces)

This indicator was not assessed at MTR; however, it was proposed that the indicator should be maintained and a reliable means of reporting found.

Drivers of achievement and bottlenecks for KRA 1 – MIYCAN

A BNA of selected specific nutrition interventions is carried out every year in every council of

Figure 14: Trends in BNA of MIYCAN services

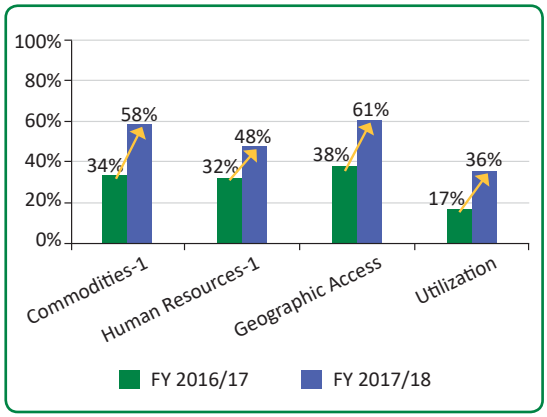


Table 8: Description of MIYCAN BNA indicators

Commodities-1	Proportion of health facilities with flip charts on IYCF in the reporting period
Human resources-1	Proportion of relevant HWs in health facilities trained in IYCF counselling in the past five years
Geographic access	Proportion of villages with at least one active CHW trained in IYCF in the reporting period
Utilization	Proportion of mothers of children aged 0–23 months who have received counselling on IYCF from a CHW in the reporting period

Tanzania to assess bottlenecks and increase the coverage of key nutrition interventions. The results are useful for interpreting key drivers and bottlenecks in target achievement.

Table 9: Dashboard of bottlenecks status for MIYCAN services by determinants and region

	Commodities-1	Human Resources-1	Geographic Access	Utilization	Continuity	Quality
Arusha	25%	14%	24%	0%	88%	43%
Dar es Salaam	7%	23%	19%	0%	28%	33%
Dodoma	56%	31%	68%	52%	50%	9%
Geita	89%	85%	100%	47%	19%	7%
Iringa	91%	97%	92%	68%	35%	7%
Kagera	90%	88%	100%	38%	57%	11%
Katavi	80%	7%	0%	0%	69%	1%
Kigoma	97%	97%	116%	26%	54%	16%
Killmanjaro	0%	0%	11%	35%	70%	64%
Lindi	82%	67%	20%	19%	53%	12%
Manyara	33%	50%	107%	47%	78%	5%
Mara	14%	4%	21%	5%	23%	12%
Mbeya	83%	53%	87%	64%	47%	5%
Morogoro	44%	68%	57%	54%	52%	12%
Mtwara	0%	27%	0%	13%	63%	18%
Mwanza	91%	90%	96%	45%	63%	11%
Njombe	94%	75%	70%	60%	50%	24%
Pwani	33%	15%	37%	32%	48%	41%
Rukwa	11%	9%	55%	44%	44%	10%
Ruvuma	68%	100%	73%	24%	60%	28%
Shinyanga	97%	100%	100%	49%	30%	11%
Simiyu	82%	35%	81%	57%	33%	7%
Singida	65%	42%	51%	38%	36%	5%
Songwe	75%	67%	73%	64%	37%	5%
Tabora	87%	50%	51%	29%	44%	4%
Tanga	60%	49%	28%	17%	56%	63%

Colour coding legend <25% 25–50% 50–75% 75%

Availability of CHWs

Capacity-building of CHWs resulted in improved delivery of nutrition messages. MIYCAN interventions are delivered through community platforms and health facilities. CHWs have direct contact with community members and use several approaches to deliver these messages, such as community support groups, farmers groups and peer support groups (especially for adolescents). Trained CHWs and HWs have provided IYCF counselling services to 36 per cent of mothers and caregivers of children aged under two years in Tanzania mainland. This represents significant progress, as it is above the planned NMNAP target (33 per cent) in 2018/2019. Until the reporting period, 62 per cent (as of Sem 1 of 2018/19) (BNA 2015/16–2018/19) of villages reported having an active CHW, which has been increasing since the beginning of NMNAP implementation.

The quality of nutrition counselling and education provided in the community has also improved. Availability and engagement of male CHWs contributed in raising nutrition awareness among men. This has also led to increased participation of couples in ANC visits and better PNC. In addition, there has been increased male participation in providing care and support to babies and mothers.

Integration of services in a stunting reduction programme

WASH, health, care for child development (CCD), growth monitoring and promotion (GMP) and gender topics (with a focus on male involvement in caregiving) were progressively integrated into IYCF programming to maximize the impact of nutrition on stunting reduction. The integrated SBCC package for stunting reduction was reviewed to integrate multisectoral services. Availability of MIYCAN communication tools like Mkoba wa Siku 1000 and integrated flipcharts has enabled the CHWs to deliver quality and consistent nutrition messages. As reported in the BNA, 50 per cent of health facilities had updated flipcharts that were used to deliver quality nutrition messages.

Large-scale stunting reduction programmes focusing on MIYCAN

Over the three years of NMNAP implementation, the number of community-based programmes implemented on a large scale with support from partners has increased. These programmes target all nutrition-specific interventions, i.e., MIYCAN, micronutrients, IMAM and DRNCDs. The support of partners has been tremendous in the past three years. However, it is also important to acknowledge that this support is sometimes scattered and, in some situations, has led to a duplication of efforts in the delivery of interventions.

Synergy with social protection programmes

To ensure equity, the Tanzania Social Action Fund (TASAF) contributed towards reaching the highest number of beneficiaries from the most vulnerable households with nutrition counselling services in some regions. A synergy, named the Equity Nexus, was established between TASAF and large-scale stunting reduction programmes, where the latter could systematically prioritize the most vulnerable households identified by TASAF. The contribution of the community development officers is notable as they participate in identification of the vulnerable households at the village level.

Increased availability and access of nutrition services in the health sector

Since the implementation of NMNAP and the implementation of the Health Sector strategic

[9] MOHCDGEC, Health Facility Report

Plan (HSSP IV), the number of health facilities has increased from 7,320 (242 hospitals, 660 health centres and 6,418 dispensaries) in 2016/17 to 285 hospitals, 834 health centres and 6,700 dispensaries (as well as 246 clinics and 54 maternity/nursing homes) in 2018/19.[9] Access to health services also increased after the introduction of various health insurance schemes such as National Health Insurance Fund (NHIF) through Toto Afya Kadi or Community Health Fund (CHF) in rural areas or Tiba Kwa Kadi in urban areas implemented under the RAS office countrywide.

Sensitization and awareness creation

Sensitization and awareness creation programmes have also contributed to the achievement reported. The use of media campaigns is reported to be a major contributor towards reaching out to a large proportion of the population. MIYCAN interventions particularly benefited from the use of local radio such as Mpanda Radio. According to IMA/ASTUTE project reports, about 37.5 per cent of the national-level population was reached through media and e-Messaging (mHealth), from the 0 per cent at baseline. Awareness creation through celebrating village health and nutrition days (VHNDs) and commemorating breastfeeding week were also among the drivers of the continuous uptake of nutrition messages.

Sociocultural values and religious belief barriers hinder the adoption of optimal feeding and caring practices. To reinforce positive social norms and create an enabling environment for behaviour change, local leaders and influential people were reached through social mobilization events such as VHNDs. They were enabled to communicate IYCF messages to men. As an example of gender influence on MIYCAN, male participation in IYCF counselling groups were highlighted in the Tanga and Lindi regions since they are considered the primary caregivers. Mass media and social media campaigns reached 38 per cent of Tanzanians with relevant MIYCAN promotion messages – this exceeds the NMNAP target, which is 25 per cent.

The BNA revealed that despite progress made on MIYCAN, there are still inadequate capacities among service providers (CHWs and HWs) and gaps in supplies (SBCC materials such as flipcharts) required during the nationwide promotion of optimal IYCF practices. MIYCAN services are not implemented in all the regions of Tanzania mainland (see Figure 12). Additionally, MIYCAN output indicators are still not integrated in the health routine information system, leading to access, validation and sustainability issues. The indicator related to maternal protection was not tracked due to lack of data. No indicator exists in the NMNAP to track MIYCAN services to adolescents.

KRA 2: Children, adolescents and women of childbearing age consume adequate micronutrients

This outcome is aimed at ensuring all children, adolescents and women of childbearing age have access to and consume adequate micronutrients. Overall, there has been positive progress towards achieving the midterm targets for this outcome – two outcome indicators are slightly delayed, while one indicator has been overachieved. At the output level, the targets for three indicators were overachieved and one indicator was not tracked (see Table 5). It is suggested that the non-tracked indicator be modified to read ‘percentage of (maize + wheat) flour produced in Tanzania that is fortified with iron’. The specific findings for each indicator are presented in the subsequent sections.

Outcome-level findings

Table 10 summarizes the achievements against KRA 2 – Micronutrients outcome-level indicators.

Table 10: Progress of outcome-level indicators for KRA 2 – Micronutrients

Indicators	Baseline	Planned 2018	Achieved 2018	Target 2021
Proportion of children aged 6–59 months who received vitamin A supplements during the last six months (TNNS reports)	72%	80%	64%	90%
Percentage of households consuming adequately iodized salt (TNNS reports)	61%	70%	61%	80%
Proportion of pregnant women taking IFA for 90+ days during pregnancy (in %) (TDHS and TNNS reports)	8%	20%	29%	50%

Source: Authors' analysis, MTR 2019

Indicator: Proportion of children aged 6–59 months who received vitamin A supplements during the last six months

About 64 per cent of children aged 6–59 months received vitamin A supplements during the last six months (see Table 5). This data is lower than the baseline value reported in TNNS (2014). Singida, Mwanza, Manyara, Morogoro and Njombe regions have shown an increase in coverage from 2014 value, while Arusha, Shinyanga, Katavi, Kagera and Kigoma have shown a decrease in coverage compared to 2014.

Indicator: Proportion of households consuming adequately iodized salt

The proportion of households consuming adequately iodized salt has not improved from 2014. Only 61 per cent of households consume adequately iodized salt in 2014, as against the planned target of 70 per cent for 2018. Efforts need to be increased to ensure the availability and consumption of adequately iodized salt. During the MTR, the proposition was to use this indicator at the outcome level instead of output level.

Indicator: Proportion of pregnant women taking IFA for 90+ days during pregnancy

The proportion of women taking IFA for 90+ days during pregnancy increased from 9 per cent at baseline (TNNS 2014) to 29 per cent (TNNS 2018). Since the planned target was to reach 20 per cent in 2018/19, the midterm target has been reached. Regions such as Mwanza, Mtwara, Lindi, Mbeya and Pwani have shown significant

Figure 15: Top five regions with increased coverage of Vitamin A

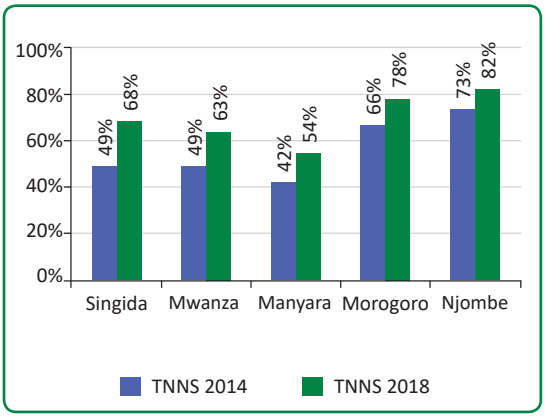
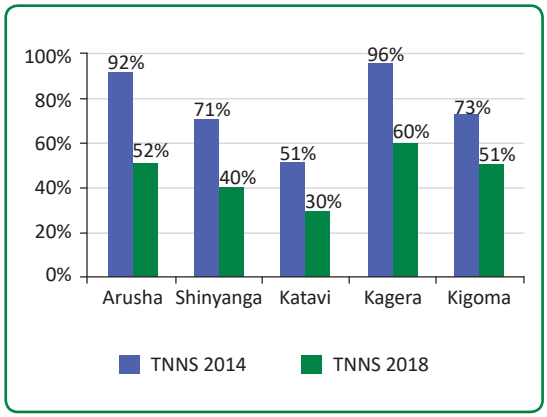


Figure 16: Top five regions with decreased coverage of Vitamin A



improvements from 2014 to 2018. While other regions are making progress, the coverage in Katavi, Arusha, Tanga, Kilimanjaro and Mara have decreased.

Output-level findings

KRA 2 – Micronutrients has four outputs:

2.1 Increased access to food fortification (home and mass) for children aged 6–23 months, pregnant women and women of childbearing age

2.2 Enhanced services for VAS among children aged 6–59 months

2.3 Increased availability of adequately iodized salt

2.4 Improved anaemia prevention and control interventions among women of childbearing age and children aged under five years

Progress towards each output is tracked by two output-level indicators for output 2.1 and by one output-level indicator for the other outputs. Table 11 summarizes the achievements against KRA 2 – Micronutrients outcome and output-level indicators.

Output 2.1 Increased access to food fortification (home and mass) for children aged 6–23 months, pregnant women and women of childbearing age in Tanzania

Indicator: Proportion of districts with MNP supplementation programme

During the development of NMNAP, the MNP supplementation programme was being piloted in 10 per cent of all districts. At the time of the review, this increased to 62 per cent through the public–private partnership. The programme is being implemented in 115 districts in the mainland.

Table 11: Progress of outcome-level indicators for KRA 2 – Micronutrients

Indicators	Baseline	Planned 2018	Achieved 2018	Target 2021
Percentage of districts with micronutrient powders (MNP) supplementation programme (TFNC annual reports, SOLEO reports) Rephrased: Percentage of councils with MNP supplementation services (TFNC annual reports, SOLEO reports)	10%	25%	62%	35%
Percentage of flour produced in Tanzania that is fortified with iron (TFNC annual reports)	36%	42%	NA	50%
Proportion of children aged 6–59 months who have received vitamin A supplements during the last six months (CHNM campaign report 2015)	89%	90%	96%	90%
Proportional of households consuming iodized salt (TNNS reports)	62%	70%	90%	85%
Proportion of women aged 15–49 years with children aged under five years who took an IFA supplement during pregnancy for past birth (BNA)	21%	40%	50%	75%

Source: Authors' analysis, MTR 2019

Indicator: Proportion of flour produced in Tanzania that is fortified with iron

The proportion of flour that is produced and fortified in the country was not tracked because data were not available. However, data from the Global Alliance for Improved Nutrition (GAIN) indicates that Sanku Project Healthy Children (PHC) supports about 95 small-scale processors who fortify an average of 300 MT/year of maize through the Sanku PHC dosifier tracker. There are also five large-scale processors/suppliers who fortify about 145,800 MT/year of maize and three medium processors with an estimated total of 22,500 MT/year of maize flour and 1,265,600 MT/year (of this, 75,000 MT is estimated and not actual amount) of wheat flour is also fortified. The proportion of fortified flour could not be calculated because data on the total flour (maize and wheat) was not available (see Table 4).

Output 2.2 Enhanced services for VAS among children aged 6–59 months in Tanzania

Indicator: Proportion of children 6–59 months who have received VAS during the previous six months

This output indicator states the same as the outcome indicator using a different source of data (routine data). According to the CHNM report (2018), the coverage of VAS is 96 per cent, which has surpassed the planned target of 90 per cent for 2018.

Output 2.3 Increased availability of adequately iodized salt in Tanzania

Indicator: Proportional of households consuming iodized salt

According to TNNS, significant progress has been made in the proportion of households consuming iodized salt from 64.2 per cent in 2014 to 95 per cent in 2018. The planned target in 2018 was to reach 70 per cent of households. Findings indicated that the endline target is overachieved. During the MTR, the proposition was to use this indicator at the output level instead of outcome level.

Output 2.4 Improved anaemia prevention and control interventions among women of childbearing age and children aged under five years in Tanzania

Indicator: Proportion of women 15–49 years of age with children under five years of age who took IFA supplementation during pregnancy for past birth

The routine data collected through BNA indicates that 50 per cent of women aged 15–49 years with children under five years of age took an IFA

Table 12: Description of VAS BNA indicators

Commodities	Proportion of health facilities with no stockouts of vitamin A capsules lasting more than one week in the last round
Human resources	Proportion of relevant HWs trained in the national protocol of vitamin A supplementation in the past five years
Geographic access	Proportion of villages with at least one health facility providing vitamin A supplementation
Utilization	Proportion of children aged 6–59 months who have received vitamin A supplementation during the previous six months (coverage level of the round with the highest performance)
Quality	Proportion of children aged 5–59 months who received two annual doses of vitamin A supplementation (coverage level of the round with the lowest performance)

Table 13: Dashboard of bottleneck status for VAS to children aged under five years by determinants and region

	Commodities-1	Human Resources-1	Geographic Access	Utilization	Quality
Arusha	97%	45%	61%	99%	97%
Dar es Salaam	98%	37%	48%	96%	91%
Dodoma	97%	32%	45%	94%	85%
Geita	93%	8%	24%	98%	90%
Iringa	93%	10%	40%	96%	91%
Kagera	97%	2%	36%	93%	85%
Katavi	100%	44%	34%	97%	87%
Kigoma	100%	10%	84%	98%	83%
Killmanjaro	100%	25%	63%	96%	93%
Lindi	100%	61%	56%	100%	70%
Manyara	100%	3%	38%	99%	95%
Mara	99%	0%	43%	99%	87%
Mbeya	100%	0%	35%	90%	85%
Morogoro	98%	0%	42%	100%	78%
Mtwara	100%	53%	30%	100%	94%
Mwanza	100%	78%	41%	100%	94%
Njombe	100%	15%	57%	97%	94%
Pwani	100%	32%	72%	99%	92%
Rukwa	100%	14%	54%	91%	82%
Ruvuma	99%	2%	45%	100%	78%
Shinyanga	100%	3%	30%	100%	100%
Simiyu	100%	37%	41%	100%	100%
Singida	100%	3%	61%	95%	77%
Songwe	94%	16%	51%	100%	87%
Tabora	100%	30%	41%	94%	83%
Tanga	93%	4%	31%	100%	100%

Colour coding legend <25% 25–50% 50–75% 75%

supplementation during pregnancy for their past birth in 2018.[10] This indicator has overachieved the target for 2018/19, which was set at 40 per cent. Thus, coverage has continued to increase, and the indicator is on track for achievement in 2020/21.

Drivers of achievement and bottlenecks for KRA 2 – Micronutrients

A BNA of selected specific nutrition interventions is carried out every year in every council of Tanzania to assess bottlenecks and increase the

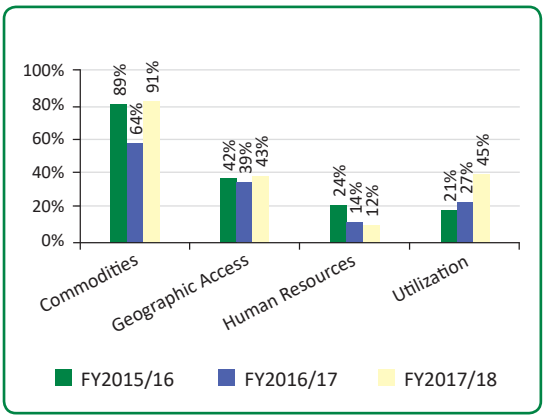
[10] BNA 2016/17–18/19

Table 14: Description of IFAS BNA indicators

Commodities	Proportion of health facilities with no stockout of IFA lasting more than one month in the last three months
Geographic access	Proportion of villages with at least one health facility providing ANC services for pregnant women
Human resources	Proportion of relevant HWs trained in the national protocol of IFA supplementation for pregnant women in the past five years
Utilization	Proportion of pregnant women who received any IFA during the last fiscal year at an ANC clinic*

*Denominator (expected number of pregnant women) was multiplied by three considering the frequency of ANC visit.

Figure 18: Trend of BNA of IFA supplementation for pregnant women



coverage of key nutrition interventions. The results are useful to interpret the key drivers and bottlenecks in target achievement.

Micronutrient supplementation programme

Improved availability and access of IFA supplements to pregnant women might have contributed to the increased uptake of IFA among pregnant women. The proportion of pregnant women who made more than four ANC visits increased to 64 per cent in 2018 compared to 38.4 per cent in 2015. Trained CHWs and HWs provided counselling on anaemia prevention among pregnant women and adolescents. As a result, the coverage of pregnant women (including adolescents) who took an IFA supplement during a past birth is 50 per cent, as against the NMNAP target of 40 per cent in 2018/2019. However, only 29 per cent of pregnant women took IFA for 90+ days. Efforts are being made by partners to implement interventions aimed at reducing anaemia among adolescent girls through weekly iron folic acid (WIFA) supplementation in some parts of the country, e.g., Simiyu region. There is no indicator in the NMNAP to track micronutrients services to adolescents.

A strengthened vitamin A supply system and support to low performing districts contributed to increased coverage of vitamin A supplementation in over six months among children aged 6–59 months in 2018/2019. In total, 96 per cent of children received vitamin A supplements, which is above the NMNAP target of 90 per cent.

Large- and small-scale fortification programmes

Food fortification programmes (home and mass) mainly included MNP for children aged 6–23 months, flour fortification and salt iodization. The MNP supplementation programme has been introduced in 62 per cent of councils, which is higher than the target of 25 per cent by 2018/2019.

Table 15: Dashboard of bottlenecks status of IFAS for pregnant women by determinants and region

	Commodities-1	Human Resources-1	Geographic Access	Utilization	Quality
Arusha	92%	65%	7%	41%	17%
Dar es Salaam	96%	44%	0%	54%	7%
Dodoma	64%	45%	17%	51%	10%
Geita	64%	24%	10%	50%	3%
Iringa	80%	40%	37%	49%	16%
Kagera	97%	37%	2%	62%	18%
Katavi	90%	30%	2%	41%	8%
Kigoma	98%	83%	7%	30%	22%
Killmanjaro	98%	60%	14%	15%	19%
Lindi	100%	56%	30%	38%	7%
Manyara	95%	35%	0%	54%	15%
Mara	83%	43%	0%	47%	12%
Mbeya	100%	35%	0%	66%	6%
Morogoro	96%	41%	0%	57%	4%
Mtwara	100%	30%	10%	23%	0%
Mwanza	93%	39%	42%	35%	21%
Njombe	97%	57%	11%	28%	8%
Pwani	82%	69%	23%	30%	20%
Rukwa	72%	54%	2%	61%	15%
Ruvuma	78%	45%	0%	39%	10%
Shinyanga	96%	30%	0%	78%	1%
Simiyu	100%	40%	0%	41%	3%
Singida	94%	43%	2%	46%	3%
Songwe	99%	50%	26%	29%	3%
Tabora	97%	41%	27%	35%	11%
Tanga	95%	30%	0%	19%	14%

Colour coding legend <25% 25–50% 50–75% 75%

Although progress on fortification of flour could not be assessed at MTR based on the NMNAP indicators, information collected through GAIN indicates an increased number of both large- and small-scale processors fortifying large volumes of maize and wheat flour (SANKU/GAIN). The engagement of the private sector in fortification is, therefore, key towards achieving the desired endline targets.

The national agenda of industrialization strengthened the partnership with the private

sector and attracted new investors in food industries, including salt. Through a fruitful collaboration, a significant amount of salt has been gradually iodized. This has led to improved access and utilization of adequately iodized salt at the household level. A total of 61 per cent of households consume adequately iodized salt, which is lower than the target of 70 per cent in 2018/2019. A strengthened surveillance system in the salt sector might yield significant results.

High investment in SBCC

The sensitization and awareness creation campaign led to increased awareness on the importance of MNPs. Promotional messages that were aired, printed and distributed in schools and health facilities and those used by CHW in delivering nutrition messages might have also contributed to the increased distribution of MNP sachets. SOLEO reports show increased media coverage, mainly through local radios and television channels as well as digital marketing companies who covered social media promotions through Instagram, Facebook, YouTube, websites and WhatsApp groups. Information on utilization of the MNP show that households have consumed MNPs. However, data on utilization of these MNP supplements is yet to be available. Tax exemptions on fortificants also led to a higher uptake of the MNPs because they were made available at an affordable price. Reports[11] indicate that communities can afford to purchase the MNP sachet at an affordable retail price of TSh 200 per sachet.

The main bottlenecks towards achievement of food fortification are the lack of a well-established monitoring and surveillance system and poor enforcement of the legislation. The main challenge is shifting the mode of delivery of VAS from the campaign to the routine system while maintaining high coverage. Full engagement of the private sector, including tracking their contribution, is another key bottleneck which poses a challenge in achieving NMNAP targets for 2020/21, as data is not tracked through the CRRAF.

KRA 3: Increased coverage of integrated management of severe and moderate acute malnutrition

Based on the MTR target, the progress in implementing IMAM has not been satisfactory. Table 6 shows the indicators used to track progress in KRA 3, which aims at ensuring increased coverage of IMAM by 2021. The key finding from this result area is that progress is still very slow and significant efforts are required to achieve the endline target set for this.

Outcome-level findings

Table 16 summarizes the achievements against KRA 3 – IMAM outcome-level indicators.

Table 16: Progress of outcome-level indicators for KRA 3 – IMAM

Indicators	Baseline	Planned 2018	Achieved 2018	Target 2021
Proportion of children under five years in need of SAM treatment who are admitted in the programme annually (%) (BNA reports)	9%	35%	13%	75%
Proportion of children under five years in need of MAM treatment who are admitted in the programme annually (%) (WFP Standard Project Report)	<1%	35%	8%	75%

Source: Authors' analysis, MTR 2019

[11] SOLEO Annual Report, 2019

Indicator: Proportion of children under five years in need of SAM treatment who are admitted in the programme annually

According to BNA 2018, only 13 per cent of all children under five years of age in need of SAM treatment were admitted to the programme. This is a very low coverage at midterm as the target was set at 35 per cent by 2018/19.

Indicator: Proportion of children under five years in need of MAM treatment who are admitted in the programme annually

The MAM treatment is currently being implemented in only two regions, i.e., Singida and Dodoma, and covers 40 health facilities. The proportion of children in need of MAM treatment who are admitted to the programme annually has increased from <1 per cent at baseline in 2014 to 28 per cent in 2018 in those regions.

Output-level findings

KRA 3 – IMAM has four outputs:

3.1 Improved quality of services for management of SAM and MAM in at least 75 per cent of health facilities

3.2 Increased coverage of screening for SAM and MAM at the community level for at least 75 per cent of children under five years of age

3.3 Availability of essential therapeutic nutrition supplies and equipment in at least 90 per cent of health facilities providing services for the management of SAM and MAM

3.4 Strengthened integration of management of SAM and MAM at the national and subnational level

Progress towards each output is tracked by two output-level indicators for output 3.1 and by one

Table 17: Progress of output-level indicators for KRA 3 – IMAM

Indicators	Baseline	Planned 2018	Achieved 2018	Target 2021
Proportion of health facilities providing outpatient treatment (outpatient therapeutic programme [OTP]) of SAM (%) (BNA reports)	25%	50%	35%	90%
Proportion of health facilities in food insecure districts[12] providing integrated management of MAM (%) (WFP Standard Project Report)	<5%	20%	21%	50%
Proportion of children with SAM who are identified through screening annually (%) (CHNM campaign report)	19%	35%	99%	75%
Proportion of health facilities with no stockouts of ready-to-use therapeutic food (RUTF) lasting more than one month during the last fiscal year (%) (BNA)	46%	60%	48%	90%
Proportion of councils implementing at least two IMAM key activities (training, screening and supervision) annually (%) (AWP reviews)	0%	>50%	20%	>75%

Source: Authors' analysis, MTR 2019

[12] **The coverage is only in four districts; In Singida,** Singida DC and Ikungi DC) and Dodoma (Chamwino DC and Bahi DC) and the programme covers only 40 health facilities.

output-level indicator for the other outputs. Table 17 summarizes the achievements against KRA 3 – IMAM outcome- and output-level indicators.

Output 3.1 Improved quality of services for the management of SAM and MAM in at least 75 per cent of health facilities

Indicator: Proportion of health facilities providing outpatient therapeutic programme (OTP) for SAM

The proportion of health facilities providing OTP for SAM is not satisfactory. According to BNA 2018, only 35 per cent of the health facilities provided treatment for SAM as compared to 50 per cent planned for 2018/19.

Indicator: Proportion of children with SAM who are identified through screening annually

The proportion of children with SAM who are identified through screening annually has increased from 90 per cent in 2015 (BNA) to 99 per cent in 2018/19 (CHNM). Despite the increase in screened children, few facilities were able to provide services to children (only 35 per cent). A significant effort is required to increase the number of health facilities that provide SAM treatment.

Output 3.2 Increased coverage of screening for SAM and MAM at the community level for at least 75 per cent of children under five years of age

Indicator: Proportion of health facilities in food-insecure districts providing integrated management of MAM (in percentage)

Integrated management of MAM is currently provided in only two regions, i.e., Singida (Singida DC and Ikungi DC) and Dodoma (Chamwino DC and Bahi DC) and covers only 40 health facilities. The proportion of health facilities in those food-insecure districts providing integrated management of MAM increased from less than 5 per cent in 2015 to 21 per cent in 2018. This is a programme-based indicator and does not provide an overview of the whole country. To achieve the endline target, integrated management of MAM needs to be scaled up to other parts of the country.

Output 3.3 Availability of essential therapeutic nutrition supplies and equipment in at least 90 per cent of health facilities providing services for management of SAM and MAM

Indicator: Proportion of health facilities with no stockouts of RUTF lasting more than one month during the last fiscal year

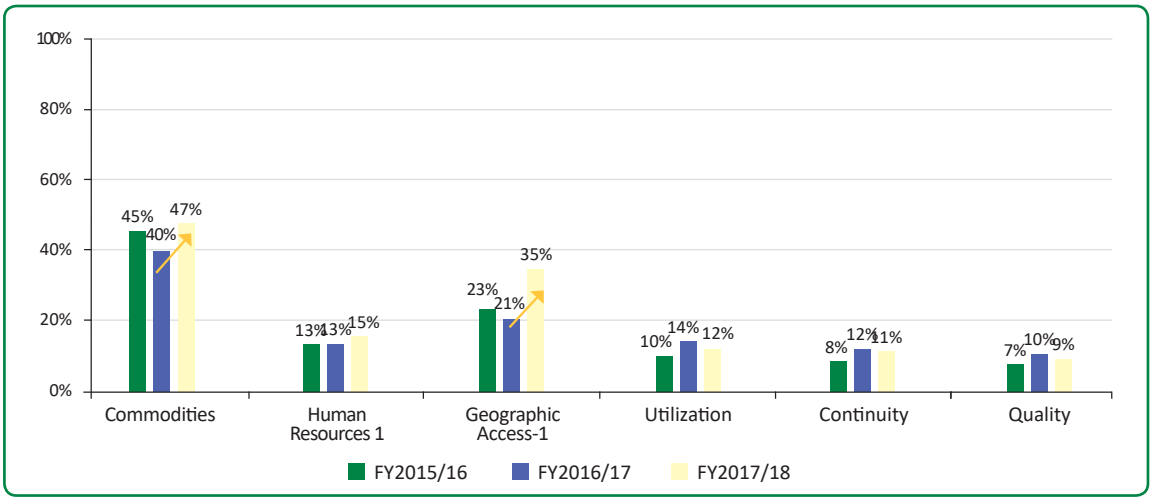
According to BNA 2018, only 48 per cent of health facilities were reported to have no stockouts of RUTF lasting more than one month in the past fiscal year. The target for 2018 was 60 per cent; however, that was not reached. With this trend, the endline target may not be reached unless strategies to scale up IMAM are strengthened. The bottlenecks are further explained in the section on the drivers and bottlenecks for IMAM.

Output 3.4 Strengthened integration of management of SAM and MAM at the national and subnational levels

Indicator: Proportion of councils implementing at least two IMAM key activities (training, screening and supervision) annually

Progress on implementing key IMAM activities is unsatisfactory. Only 20 per cent of councils implement at least two IMAM key activities

Figure 19: Trend in BNA of IMAM services among under-five children



(training, screening and supervision) annually at midterm compared to a target of at least 50 per cent (*see Table 6*).

Drivers of achievement and bottlenecks for KRAs 3 – IMAM

A BNA of selected, specific nutrition interventions is carried out every year in every council of Tanzania to assess bottlenecks and increase coverage of key nutrition interventions. The results are useful to interpret the key drivers and bottlenecks in the achievement of results.

Progress on KRA 3 is not on track to meet the 2018/19 and endline targets. All indicators, both at the outcome and output levels, have not performed well except for one output indicator on screening of SAM cases. Management of acute malnutrition (severe and moderate), especially rehabilitation of SAM/MAM cases, is very important, which affects the achievements of targets for this KRA.

Low coverage of IMAM interventions is due to inadequate skilled human resources, a weak referral mechanism for SAM and MAM cases

Table 18: IMAM BNA indicator description

Commodities	Proportion of health facilities with no stockouts of RUTF lasting more than one month in the reporting period
Human resources-1	Proportion of relevant HWs who have been trained on the treatment of SAM in the past five years
Geographic access-1	Proportion of health facilities offering OTP of SAM in the reporting period
Utilization	Proportion of expected cases of SAM among children 0–59 months who were admitted for treatment under the IMAM programme in the reporting period
Continuity	Proportion of children with SAM aged 0–59 months who did not default from treatment in the reporting period
Quality	Proportion of children aged 0–59 months with SAM who were cured in the reporting period

within the health system, and the insufficient and irregular supply of therapeutic foods and equipment. The overall challenge remains the mobilization of sufficient predictable funding for effectively scaling up IMAM services. IMAM is also not integrated in the integrated community case management of childhood illnesses (IMCI).

Table 19: Dashboard of bottleneck status for IMAM services among children under five years of age by determinants and region

	Commodities-1	Human Resources-1	Geographic Access	Utilization	Continuity	Quality
Arusha	35%	6%	38%	17%	17%	17%
Dar es Salaam	44%	2%	14%	3%	2%	2%
Dodoma	74%	6%	35%	9%	7%	7%
Geita	32%	1%	52%	1%	0%	1%
Iringa	100%	24%	37%	98%	98%	97%
Kagera	23%	0%	36%	17%	17%	6%
Katavi	25%	1%	44%	13%	12%	12%
Kigoma	17%	3%	77%	11%	11%	18%
Killmanjaro	37%	6%	15%	2%	2%	2%
Lindi	71%	22%	91%	35%	35%	19%
Manyara	1%	0%	22%	2%	2%	3%
Mara	10%	0%	0%	2%	1%	2%
Mbeya	100%	33%	36%	78%	73%	42%
Morogoro	29%	16%	49%	19%	16%	15%
Mtwara	100%	46%	66%	26%	26%	22%
Mwanza	33%	35%	15%	5%	5%	4%
Njombe	84%	20%	17%	65%	40%	39%
Pwani	35%	1%	1%	4%	3%	6%
Rukwa	0%	4%	72%	1%	1%	2%
Ruvuma	44%	11%	14%	31%	29%	28%
Shinyanga	17%	62%	67%	21%	20%	19%
Simiyu	33%	24%	22%	14%	12%	12%
Singida	96%	35%	25%	100%	42%	31%
Songwe	100%	35%	29%	61%	42%	31%
Tabora	10%	28%	28%	4%	4%	4%
Tanga	68%	9%	44%	12%	8%	13%

Colour coding legend <25% 25–50% 50–75% 75%

IMAM scaling-up plan not implemented as planned

There is low coverage of IMAM in the country. Although the objective of NMNAP was to scale up IMAM coverage, this has not been implemented as intended due to inadequate allocation of the minimum budget for nutrition-specific interventions by councils. The financial analysis shows that IMAM is highly funded by DPs. However, there is an effort to increase LGAs' domestic resources allocation: almost 80 per cent of councils have included IMAM activities/ supplies in their 2019/20 budgets. Through DHFF, it is expected that facilities will be able address IMAM. However, coverage remains a challenge.

Lack of rehabilitation units, supplies and anthropometric tools

The BNA noted the non-availability of rehabilitation units. Even in health facilities that could offer IMAM services, field reports indicate that very few health facilities have rehabilitation units in their facilities, hence limiting their services. For example, the hospital in Misungwi DC has the human resource capacity to manage MAM/SAM cases. However, they lack the infrastructure (no rehabilitation unit, no refrigerator, etc.).

Health facilities reported lack of therapeutic foods to allow management of complicated SAM/MAM cases. However, as of 2019/20, nutrition commodities (RUTF, F100, F75) have been integrated into the national system in the National Essential Medicines List Tanzania (NEMLIT), and the Medical Supplies Department (MSD catalogue will be available at all levels through DHFF).

Referral and human resource personnel challenges

Adequate referral for SAM and MAM cases is a challenge. Sometimes, health-care providers offer a referral to a client. But usually, the feedback mechanism and reporting system for engaging the implementing partners and referral health facilities to the council is not clear. Hence, some MAM and SAM cases either are left unattended and may recur or result in death or are lost during follow-up. Health workers are usually overwhelmed with the large number of clients in the health facilities and may sometimes miss out on MAM and SAM cases as indicated by field visit reports. This has contributed to poor performance of these indicators.

KRA 4: Communities in Tanzania are physically active and eat healthy

The key aim of this outcome is to ensure that communities in Tanzania are physically active and eat healthy. This is a very important KRA to address the emerging problem of overnutrition in Tanzania but was one of the most overlooked areas in the NMNAP.

Outcome-level findings

Table 20 summari`zes the achievements against KRA 4 – DRNCDs outcome-level indicators.

The main source of data for this outcome was the STEPS survey. However, all indicators have not been assessed as there were no STEP surveys conducted after 2012 (baseline). A STEP survey has been planned for 2019/20 and will be used to track the outcome-level indicators of KRA 4 by 2021 (NMNAP endline). At the outcome level, the following indicators were proposed to be added, which will also be collected by the STEPS survey.

Output-level findings

With the increased prevalence of non-communicable diseases (NCDs), there is an urgent need to boost the implementation of key activities to reduce the burden of DRNCDs, especially through the promotion of healthy lifestyles (healthy diets and physical activity) among the general population using a variety of

Table 20: Progress of outcome-level indicators for KRA 4 – DRNCDs

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of people who drink alcohol among adults 25–69 years of age (STEP survey)	29%	29%	NA	29%
Prevalence of tobacco use in adults 25–69 years of age (STEP survey)	14%	<14%	NA	<14%

Source: Authors' analysis, MTR 2019

platforms: community, schools, workplaces, mass media and social gatherings.

KRA 4 – DRNCDs has two outputs:

4.1 Sensitization of at least 50 per cent of school-age children and adult populations to the risk factors of NCDs by 2021

4.2 Establishment of policies and social, cultural and structural norms to enable at least 50 per cent of the community to engage in healthy lifestyles by 2021

Progress towards each output is tracked by one output-level indicator. Table 22 summarizes the achievements against KRA 4 – DRNCDs outcome- and output-level indicators.

The main source of data for this outcome was the STEP survey. However, all indicators have not

Table 21: Additional outcome-level indicators for KRA 4 – DRNCDs

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Prevalence of high blood pressure in the general population (STEP survey)	26%	NA	NA	<25%
Prevalence of type 2 diabetes mellitus in the general population (STEP survey)	9.1%	NA	NA	<9%
Proportion of adults (aged 25–64 years) who are physically inactive (STEP survey)	7.5%	NA	NA	<7%

Source: Authors' analysis, MTR 2019

Table 22: Progress of output-level indicators for KRA 4 – DRNCDs

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of school-age children and adults reached with information on healthy lifestyles through mass media (STEP survey)	5%	30%	NA	50%
Proportion of school-age children and adult population that are physically inactive (STEP survey)	7.5%	7.1%	NA	6.8%

Source: Authors' analysis, MTR 2019

been assessed as there were no STEP surveys conducted after 2012 (baseline). The Health Management Information System (HMIS) collects information on diabetes and hypertension, which are proxy indicators. It was therefore proposed to include additional output-level indicators as shown in Table 23.

According to HMIS, the number of new diagnoses of high blood pressure at the OPD level among children under five years of age has almost doubled from 509,539 in 2015 to 930,345 in 2018. The number of new diagnoses of diabetes mellitus at the OPD level among children under five years of age has also almost doubled from 248,373 in 2015 to 409,402 in 2018. Also, 70–75 per cent of health facilities had either dedicated space for diabetes and hypertension or a dedicated clinic day(s). This increase is highly related to the increase in overweight and obese adult populations in recent years and needs to be urgently addressed. It was proposed to add these two indicators as proxies for DRNCDs, which can be tracked quarterly through the national HMIS.

Drivers of achievement and bottlenecks for KRA 4 – DRNCDs

Scaling-up of prevention and management of DRNCDs in school-age and adult populations was stated as a key priority area in NMNAP. The MTR highlighted some challenges in tracking the indicators in the NMNAP because neither are they part of any routine system nor was the STEP survey conducted. TNNS 2018 shows that 31.7 per cent of WRA and 2.8 per cent of children under five years of age are overweight. Data are missing for school-age children and adolescents. As Tanzania is transitioning into a middle-income country, prevention of DRNCD is becoming more crucial. Scientific evidence has also proven the link between early childhood malnutrition and DRNCD in adults.

Programmes that target both the obesogenic environment and critical elements in one's life course are required. School and community platforms need to be used to promote a healthy diet and physical activity and prevent excess weight and obesity. Some opportunities to establish a DRNCD programme are as follows:

High-level political advocacy for physical activities

The Vice President of Tanzania emphasized the importance of physical activity as she declared that one day would be dedicated to physical activities every second week of the month.

Launching of the NCD Action Plan

The launching of the NCD Action Plan for 2016–2020, which aims at promoting measures that encourage a change in lifestyle, is a great

Table 23: Additional output-level indicators for KRA 4 – DRNCDs

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Number of new diagnoses of high blood pressure at the OPD level among under-five children (HMIS)	509,539	NA	930,345	<1,000,000
Number of new diagnosis of diabetes mellitus at the OPD level among under-five children (HMIS)	248,373	NA	409,402	<450,000

Source: Authors' analysis, MTR 2019

move towards combating the rising prevalence of obesity and other DRNCDs. However, there is a need to leverage the NCD Plan with NMNAP to ensure tracking and monitoring of progress.

SBCC programmes

TFNC, in collaboration with partners, has developed educational materials which are distributed to communities. Awareness and sensitization programmes aiming at behaviour change are also delivered through radio and TV programmes. The Tanzania Non-Communicable Diseases Alliance (TANCDA) has developed a booklet for general public education on NCDs, which is being used as a resource material to address NCDs.

Currently, TFNC, Food and Agriculture Organization (FAO) and other stakeholders are developing food-based dietary guidelines, which will provide diet-related and healthy living messages to the general community.

KRA 5: Line sectors, private sector and CSOs scale up nutrition-sensitive interventions to reach all communities to improve nutrition

KRA 5 addresses the causes of malnutrition and groups all interventions within key nutrition-sensitive sectors: health, HIV, agriculture, WASH, education and ECD, social protection, environment and climate change. Line ministries, private sector and CSOs shall scale up nutrition-sensitive interventions to reach all communities.

Outcome-level findings

Table 24 summarizes the achievements against KRA 5 – Nutrition-sensitive interventions (NSI) outcome-level indicators.

Indicator: Proportion of planned budget spent on nutrition-sensitive interventions between 2016/17 and 2020/21

At the outcome level, the KRA 5 indicator tracks actual expenditure on nutrition-sensitive interventions against the planned budget. The planned budget for each of the nutrition-sensitive sectors was extracted from sectoral plans (i.e., HSSP IV, ASDP, etc.) as well as from the Five-Year Development Plan (FYDP) 2016/21. All these plans align with the timeline of the NMNAP. Actual expenditure was extracted from the sectoral budget briefs for health, HIV/AIDS, WASH and education, which are prepared annually by the Minister of Finance with support from UNICEF.

Data shows that the target of spending at least 40 per cent of the planned budget on nutrition-sensitive interventions was delayed as TSh 4,502 million were spent in FY 2016/17 to 2018/19 against a planned budget of TSh 13,366, representing 33.7 per cent of the expenditure.

Table 24: Progress of outcome-level indicators for KRA 5 – NSI

Indicators	Baseline	Planned 2018	Achieved 2018	Target 2021
Proportion of planned budget spent on nutrition-sensitive interventions between 2016/17 and 2020/21 (Sector reports)	0%	40%	33.7%	60%

Source: Authors' analysis, MTR 2019

Table 25: Additional outcome-level indicators for KRA 5 – NSIs

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of households with low dietary diversity (Comprehensive Food Security and Vulnerability Analysis [CFSVA])	Rural: 21.4% Urban: 8.6% (CFSVA, 2012)	Rural: 20% Urban: 8%	NA	Rural: 15% Urban: 6%
Proportion of households that practice hand washing at critical times (TNNS, TDHS)	11.7% (TNNS 2014)	20%	2.7% (TNNS 2018)	30%
Proportion of teenage mothers (aged 15–19 years) (TDHS)	26.7% (TDHS 2015/16)	NA	NA	< 20%
Women with secondary or higher education (TDHS)	23.4% (TDHS 2015/16)	NA	NA	> 30%

Source: Authors' analysis, MTR 2019

Details of expenditure by sector and by year are available in the MTR analysis of the NMNAP CRRAF.

To track the impact of NSIs on key conditions, behaviours and practices that strongly influence the nutritional status of Tanzanians, it was recommended to add new indicators at the outcome level that would be tracked by the end of the NMNAP through the TDHS 2020/21. Indicators were chosen among those that have the highest demonstrated impact on reduction of malnutrition, such as improving households' dietary diversity, improving households' hygiene practices, reducing teenage pregnancies and increasing the proportion of women completing secondary (or higher) education. The last two indicators are clearly related to gender issues, which were identified as among the main basic causes of malnutrition globally and in Tanzania. Table 25 shows that targets for three out of four indicators are set at the endline level, as these will be available through TDHS 2020/21. However, data on the proportion of households that practise hand washing at critical times was collected during TNNS 2018. An analysis of this data shows that the achievement towards this indicator is highly delayed, which is a serious barrier towards accelerating the reduction of stunting.

Output-level findings

KRA 5 – NSIs has five outputs:

5.1 Communities have access to a diverse range of nutritious food throughout the year

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

5.3 Communities access adequate water, sanitation and hygiene services

5.4 Girls complete primary and secondary education

5.5 The poorest households benefit from conditional cash transfers, cash for work and nutrition education during community sessions

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

Table 26: Additional outcome-level indicators for KRA 5 – NSIs

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Agriculture, livestock and fisheries				
Proportion of households with low dietary diversity	Rural: 21.4% Urban: 8.6% (CFSVA 2012)	Rural: 20% Urban: 8%	NA	Rural: 15% Urban: 6%
Health and HIV				
Proportion of women (aged 15–49 years of age) attending at least four antenatal care (ANC) visits (DHS)	51% (TDHS 2015/16)	55%	63.7% (HMIS 2018/19)	60%
Pregnant women attending four or more antenatal care visits (ANC4) (%) (HMIS)	38.4% (HMIS 2015/16)			
Proportion of WRA who are using (or whose partner is using) a modern family planning method (DHS)	32% (TDHS 2015/16)	40%	35.4% (HMIS 2018/19)	60%
WRA (aged 15¬–49 years) using modern family planning methods (%) (HMIS)	36.9% (HMIS 2015/16)			
Proportion of pregnant women using preventive intermittent treatment (IPT) for malaria prevention (DHS)	35% (TDHS 2015/16)	42%	81.1% (HMIS 2018/19)	80%
Mothers who received two doses of IPT for malaria during pregnancy (%) (HMIS)				
WASH				
Rural population with access to (an improved source of) piped or protected water as their main source (%) (Water Sector Situation Reports – WSSR)	72% (2014/15)	80%	65% (2018/19)	65% (2018/19)
Households with improved toilets (%) (HMIS)	25% (2014/15)	60%	54% (2018/19)	75%
Education				
Lower secondary education completion rate (Basic Education Statistics in Tanzania [BEST])	Total: 42.4% Boys: 46.5% Girls: 38.5% (2013)	Total: 42.6% Boys: 42.5% Girls: 42.7%	Total: 38.4% Boys: 38.3% Girls: 38.5% (2018/19)	Total: 50% Boys: 51.5% Girls: 48.5%
Social protection				
Proportion of vulnerable households benefiting from social protection programmes (conditional cash transfers, cash for work and nutrition education during community sessions) (TASAF)	83% (5,011,335 out of 6,000,000), (TASAF 2016)	95%	89% (March 2019)	100%
Environment				
Poor dietary intake prevalence (rural and urban) (CSFVA)	Rural: 10.5% Urban: 3.4% (CFSVA 2012)	Rural: 8.5% Urban: 2.8%	NA	Rural: 7% Urban: 2.5%

Source: Authors' analysis, MTR 2019

Each output represents a nutrition-sensitive sector, and progress towards each output is tracked by several output-level indicators. Table 26 summarizes the achievements against KRA 5 – DNSI outcome- and output-level indicators. Indicators that have been rephrased are shown in blue font.

An issue related to the NMNAP design was also addressed under this KRA during the MTR. In fact, indicators included at the output level for outputs 5.1, 5.2 and 5.6 were mostly outcome-level indicators. It was not possible to track them annually as the indicated data sources were surveys that are carried out every five years (such as the Demographic and Health Survey [DHS]). Therefore, the task team in charge of KRA 5 reviewed the indicators and moved or added new indicators at the outcome level, as shown in the tables above. In this way, most of the indicators were maintained (except those related to outputs 5.1 and 5.6, which were moved to the outcome level), but the source of information was changed to a routine information system (such as the HMIS). Table 27 shows the revised set of indicators for KRA 5 outputs (new indicators are in blue font):

Table 27: Revised output-level indicators for KRA 5 – NSI

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Agriculture, livestock and fisheries				
Food inflation rate (Annual Bank of Tanzania Report)	9.5% (2015/16)	5.0%	3%	5.0%
Milk production (litres) Eggs production (units) Meat production (tons) Fish production and import (tons) (Tanzania Livestock Master Plan 2017/18–2021/22 and budget speeches of the MOLF 2018/19 and 2019/20)	1,096,109 101,990,000 484,355 376,513 (2016/17)	1,409,707 146,400,000 551,679 NA	2,678,461 3,575,621 690,629 NA (2018/19)	1,815,6482 41,100,000 629,726 NA
Health and HIV				
Pregnant women attending four or more antenatal care visits (ANC4) (%) (HMIS)	38.4% (2015/16)	55%	63.7% (2018/19)	60%
WRA (15–49 years) using modern family planning methods (%) (HMIS)	36.9% (2015/16)	40%	35.4% (2018/19)	60%
Mothers who received two doses of preventive intermittent treatment (IPT) for malaria during pregnancy (%) (HMIS)	57.0% (2015/16)	42%	81.1% (2018/19)	80%
Proportion of pregnant women tested for HIV and who know their status (PMTCT)	86% (2015/16)	98%	99% (2018/19)	98%
Proportion of pregnant women living with HIV (PWLHIV) receiving antiretroviral therapy (ART) to prevent vertical HIV transmission (PMTCT)	86% (2016/17)	96%	99% (2018/19)	>98%

(Continued)

(Continued)

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
WASH				
Rural population with access to (an improved source of) piped or protected water as their main source (%) (Water Sector Situation Reports – (WSSR 2018/19)	72% (2014/15)	80%	65% (WSSR 2018/19)	85%
Households with improved toilets (%) (HMIS)	25% (2014/15)	60%	54% (2018/19)	75%
Households with functional handwashing facilities and soap (%) (HMIS)	12.43% (2015/16)	20%	19% (2018/19)	45%
Education				
Lower secondary education completion rate (BEST)	Total: 42.4% Boys: 46.5% Girls: 38.5% (2013)	Total: 42.6% Boys: 42.5% Girls: 42.7%	Total: 38.4% Boys: 38.3% Girls: 38.5% (2018/19)	Total: 50% Boys: 51.5% Girls: 48.5%
Net enrolment rate in pre-primary education (BEST)	Total: 35.5% Boys: 35.7% Girls: 35.3% (2013)	Total 54.8%	Total: 39.9% Boys: 39.6%, Girls: 40.3% (2018/19)	Total: 60.0%
Social protection				
Proportion of vulnerable households benefiting from social protection programmes (conditional cash transfers, cash for work and nutrition education during community sessions) (TASAF)	83% (5,011,335 out of 6,000,000) (TASAF June 2016)	95%	89% (March 2019)	100%
Proportion of households receiving cash transfers through public works programmes (PWP) (TASAF)	250,402 out of 305,1600 (82%) (2015/16)	60%	87% (March 2019)	84%
Performance of Council Women Development Fund (MoHCDGEC reports)	Funds disbursed: TSh 3,388,747,160 Women reached: 21,167 (2015/16)	NA	Funds disbursed: TSh 11,128,114,993 Women reached: 44,210 (2018/19)	NA
Environment				
Food self-sufficiency ratio (Food Crop Production Reports for Food Security – MOA)	120% (2015/16)	120%	124% (2018/19)	140%

Source: Authors' analysis, MTR 2019

Output 5.1 Communities have access to a diverse range of nutritious food throughout the year

Indicator: Proportion of households with low dietary diversity

This indicator was modified during the MTR. The original indicator – proportion of households with low dietary diversity – could not be tracked during the MTR as it depended on periodic data from the survey, CFSVA, which is planned for 2020/21. The modified indicator was elevated to the outcome level and will be tracked when the CFSVA is conducted. New indicators have been proposed to track progress towards output 5.1 as per Table 28. All new indicators were assessed, and the performance was impressive.

An observation of the two indicators shows an improvement in this sector. Food inflation declined from 2015/16 largely due to an improved supply of food, notably of maize flour, green and yellow bananas and sugar. The target of headline inflation below 5 per cent was reached. The indicator related to family dairy sub-systems in coastal lake and highland zones shows an improvement in milk and meat production. In 2017/18, the target was to produce 1,242,836 litres but the actual produce was 2,400,134 litres. In the same year, the target for meat production was 5,167,94 tons, while the actual produce was 6,799,92 tons. The food inflation rate was 3 per cent, surpassing both midterm and endline targets, which was set at 5 per cent. Data for eggs was not available and hence could not be assessed. The overachievement of targets could be due to underestimation during projection.

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

Indicator: Pregnant women attending four or more antenatal care visits (ANC4)

Data on the ANC indicator was initially collected using the TDHS, from which the baseline was established. During the MTR, the HMIS was used to source this data. For purposes of consistency, the baseline extracted was set at 38.4 per cent (HMIS) as opposed to the original 51 per cent (TDHS 2015/16). Findings from the MTR indicated that the target was met (63.7 per cent), surpassing both the MTR target (55 per cent) and endline target (60 per cent). The achievement and the set target are consistent with survey-generated data.

Indicator: WRA (15–49 years) using modern family planning methods

Data on the family planning indicator was initially collected (at baseline) using the TDHS. During the MTR, the HMIS was used to source this data. For

Table 28: New indicators proposed for Output 5.1

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Food inflation rate (Annual Bank of Tanzania Report)	9.5% (2015/16)	5.0%	3% (2018/19)	5.0%
Milk production (litres) Eggs production (units) Meat production (tons) Fish production and import (tons) (Tanzania Livestock Master Plan (2017/18–2021/22) and Budget speeches of the MoLF 2018/19 and 2019/20)	1,096,109 101,990,000 484,355 376,513 (2016/17)	1,409,707 146,400,000 551,679 NA	2,678,461 3,575,621 690,629 NA (2018/19)	1,815,6482 41,100,000 629,726 NA

Source: Authors' analysis, MTR 2019

purposes of consistency, the baseline extracted was set at 36.9 per cent (HMIS) as opposed to the original 32 per cent (TDHS 2015/16). The HMIS data shows that 35.4 per cent of WRA were using modern family planning methods, which is slightly lower than the MTR target (36 per cent). This could be due to different data sources. However, the estimated results from the survey seems to be consistent with the routine data. Although the indicator appears to be on track during the MTR, the progress from the baseline is very slow and greater effort is needed to achieve the 2020/21 NMNAP target of 50 per cent.

Indicator: Mothers who received two doses of IPT for malaria during pregnancy

Malaria during pregnancy may cause maternal anaemia and consequently affect foetal development. Provision of IPT prevents pregnant mothers from getting malaria. At midterm, the percentage of pregnant women who were given IPT increased to 81.1 per cent in 2018/19 from a baseline of 57 per cent in 2015/16, thus surpassing the midterm NMNAP target of 42 per cent as well as the final 2020/21 NMNAP target of 50 per cent.[13] This high achievement can be attributed, among other reasons, to high attendance at the first ANC, which was at 98 per cent among pregnant women. The performance is consistent with the newly released Tanzania Malaria Indicator Survey (TMIS) 2017/18, which reported that 83 per cent of pregnant women were given IPT for malaria prevention in their first ANC visit. Coverage of IPT2 and above reduces as ANC attendance also decreases from the first ANC visit where many pregnant women attend the first ANC. Results from TMIS 2017/18 indicate the coverage of IPT1, IPT2 and IPT3 at 83 per cent, 56 per cent and 26 per cent respectively. Despite these achievements, some disparities remain. In total, 90.2 per cent (urban) and 80.5 per cent (rural) (HMIS) pregnant women received at least one dose of IPT.

New indicators to track progress specifically on HIV/AIDS interventions were added during the MTR with the aim of recognizing the key impact of these AIDS interventions on improving nutrition and especially reducing stunting in countries with a high burden of HIV infections. This is shown by a study on drivers of nutritional changes among women and children in Tanzania (International Food Policy Research Institute [IFPRI], 2019).

PMTCT annual reports measure the HIV/AIDS indicators, which show an increased steady high coverage of HIV/AIDS interventions. This has been among the main determinants of stunting reduction in the past years. Among the success factors resulting from this increased coverage are: knowledge on HIV/ PMTCT, availability of HIV services, good area coverage of HIV/PMTCT services in the country (about 98 per cent of health facilities provide PMTCT services) and availability of trained staff.

Table 29: New indicators proposed for Output 5.2

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of pregnant women tested for HIV who know their status (PMTCT reports)	86% (2015/16)	98%	99% (2018/19)	98%
Proportion of PWLHIV receiving ART to prevent vertical HIV transmission (PMTCT reports)	86% (2016/17)	96%	99% (2018/19)	>98%

Source: Authors' analysis, MTR 2019

Output 5.3 Communities access adequate water sanitation and hygiene services

Diarrhoea is the most serious public health problem related to sanitation in Tanzania, causing thousands of deaths among children every year (National Guideline for Water, Sanitation and Hygiene for Tanzania Schools 2016). Access to clean and safe water is key to protecting communities against waterborne diseases such as diarrhoea, particularly among under-five children. Lack of access to these facilities not only leads to child morbidity and mortality but repeated episodes of diarrhoea diseases make children more vulnerable to other diseases and malnutrition.

Indicators on the proportion of the rural population with access to piped or protected water as the main source have been fluctuating. In 2016/17, 72 per cent accessed the service, while in 2017/18, the number went down to 50.1 per cent and later fluctuated to 64.8 per cent. The situation on households with improved toilets has been improving over the years. However, progress has been slightly delayed: 54 per cent of households reported having improved toilets during the midterm against the target of 55 per cent. Although the share of households with functional handwashing facilities and soap has been increasing over the years, it has not reached the set target of 20 per cent for 2018/19 since the actual target achieved was 18.56 per cent. The observed change may be attributed to changes in the indicator where the indicator used earlier was rural population with access to water and now the indicator is rural population with piped or protected water.

Indicator: Rural population with access to piped or protected water as their main source

During the MTR, access to piped or protected water in mainland Tanzania improved. According to the Household Budget Survey (HBS 2017/18), nearly nine in ten households (87.8 per cent) use water from improved water sources during the rainy season while 73.0 per cent use such water during the dry season. The same survey found that the rural population performance was 83.5 per cent during the rainy season and 65 per cent during the dry season as compared to urban areas, which reported 95.6 per cent and 85.6 per cent, respectively. The baseline was 72 per cent (2014/15); however, the indicators were not disaggregated by season. Ruvuma was the highest performing region for this indicator, with 97.5 per cent of households using water from improved sources in the rainy season and 90.8 per cent in the dry season. Despite this high achievement, disparities among regions persist. Tabora performed the lowest, with 70.8 per cent of households using water from improved sources during the rainy season and only 59.2 per cent during the dry season. Kagera was the worst performing region in the use of improved water during the dry season, at only 39.8 per cent, way below the national average. Among the reasons reported for improved water use was the influence of top leaders at the sub-national level.

Households with improved toilets (percentage)

In Tanzania mainland, 24 per cent of all households use improved toilet facilities on their own while about 20 per cent use the shared improved toilet facility, which is usually shared among two or more households. The remaining 56 per cent households use unimproved health facility (TNNS, 2018). Regional differences are still observed. Regions with relatively larger percentages of households with unimproved toilet facilities are Kagera (95.9 per cent), Singida (85.4 per cent) and Manyara (80.1 per cent) (TNNS, 2018). Households in urban areas (87.8 per cent) are more likely to have improved toilet facilities than households in rural areas (8.9 per cent). About 41.2 per cent of urban dwellers have improved toilet facilities compared to their rural counterparts at 16.0 per cent (HBS, 2017/18).

Table 30: New indicators proposed for Output 5.3

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Households with functional handwashing facilities and soap (HMIS)	12.43% (2015/16)	20%	19% (2018/19)	45%

Source: Authors' analysis, MTR 2019

The NMNAP baseline (2014/15) was 25 per cent and the MTR target was 60 per cent, while the endline target is 75 per cent. Data from routine systems shows that households with improved toilets is 18.56 per cent, which is slightly higher than the national average of 18.0 per cent (HBS 2017/18). This indicator has very low performance, and the achievement of its 2020/21 target is at risk. Disparities among regions has also been observed: the highest performing region is Njombe at 46.3 per cent and the worst performing region is Kagera at 7.7 per cent.

A new indicator to track progress, specifically the key practice of handwashing, was added to be measured using the routine system, as shown in Table 30.

The indicator is tracked through HMIS and is on course. However, availability of handwashing facilities with soap alone is not sufficient if it is not accompanied with the actual good hygiene practice of handwashing. Therefore, there is an urgent need to strengthen SBCC to improve this key practice.

Output 5.4 Girls complete primary and secondary education

The country has made great efforts to create an enabling environment for child education through investments in education: the mandatory Pre-primary and Primary Education Policy has increased enrolment at these education levels while Fee-Free Education (FFE) policy has increased enrolment both in primary and lower secondary schools. However, the education sector is still not performing well in terms of the secondary school completion rate for girls. The proportion of girls who completed secondary school decreased by 7.4 per cent, from 38.5 per cent in 2013 to 31.1 per cent in 2017/18. The proportion of women with secondary education was 23.4 per cent (TDHS 2015/16). Field assessments have noted an increase in girls' hostels, WASH facilities, feeding programmes, teenage pregnancy interventions and health clubs in schools. However, progress on girls' secondary and pre-primary education is slightly delayed. Both indicators are tracked annually by the BEST and the Education Sector Performance Review Report.

Indicator: Lower secondary education completion rate

The gross completion rate (GCR) for girls in lower secondary education is still low compared to the set targets. The reason is that unlike pre-primary and primary education, secondary education is not compulsory; rather, it is fee-free. Therefore, the transition rate from primary to secondary education is still low. However, full implementation of the policy for compulsory lower secondary education can increase the GCR. Again, efforts are required to reduce dropout rates among girls due to several factors at all levels of basic education.

Table 31 highlights a new indicator for tracking progress specifically on the key service of pre-primary schooling for children.

The net enrolment rate for girls in pre-primary education appears to decline. This is because of the introduction of FFE from pre-primary to lower secondary education and the reduction of academic years from the former two years

Table 31: New indicators proposed for Output 5.4

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Net enrolment rate in pre-primary education (BEST)	Total: 35.5% Boys: 35.7% Girls: 35.3% (2013)	Total: 54.8%	Total: 39.9% Boys: 39.6% Girls: 40.3% (2018/19)	Total: 60.0%

Source: Authors' analysis, MTR 2019

of pre-primary to one year as per the Education and Training Policy, 2014. This means that most pupils who were supposed to be in Year Two were enrolled in Standard One, thus reducing the number of pre-primary enrolments.

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

The social protection programme supports the most vulnerable households in Tanzania through a variety of interventions, including health insurance and the PSSN programme. PSSN, through TASAF, is on track to meet its targets in terms of cash transfers and PWP. An Equity Nexus was created within the PSSN by linking cash transfer beneficiaries with beneficiaries of large-scale stunting reduction programmes, who systematically receive nutrition education where these programmes exist.

Indicator: Proportion of vulnerable households benefiting from social protection programmes (conditional cash transfers, cash for work and nutrition education during community sessions)

The available data indicates that 89 per cent (5,338,538 of 6,000,000) of the targeted vulnerable beneficiaries were supported through cash transfers.

During the MTR, two additional key indicators were added and assessed to measure the proportion of households receiving cash transfers through the PWP, as well as women's empowerment through the performance of the Council Women Development Fund.

The available data indicates that 87 per cent (250,402) of households received cash transfers through PWPs, surpassing both midterm (60 per cent) and endline targets (84 per cent). Although there was no target set for women's

Table 32: New indicators proposed for Output 5.5

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of households receiving cash transfers through the PWP (TASAF reports)	250,402 out of 305,1600 (82%) (2015/16)	60%	87%	84%
Performance of Council Women Development Fund (MOHCDGEC reports)	Funds disbursed: TSh 3,388,747,160 Women reached: 21,167 (2015/16)	NA	Funds disbursed: TSh 11,128,114,993 Women reached: 44,210	NA

Source: Authors' analysis, MTR 2019

empowerment, councils disbursed a total of TSh 11,128,114,993 that reached 44,210 beneficiaries from the baseline, where TSh 3,388,747,160 were disbursed reaching 21,167 women. Targets for the performance of Council Women Development Fund were not set but a clear improvement is visible over the years. The PWP related indicator is tracked by TASAF PSSN quarterly reports and PSSN Result Framework, and has made tremendous progress due to the availability of funds to enrol many beneficiaries in the programme.

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

Indicator: Poor dietary intake prevalence (rural and urban)

This indicator could not be assessed at the MTR due to non-availability of data. The source of the data is the CFSVA reports, which were not conducted yet during the MTR.

Relevant new indicators such as the food self-sufficiency ratio (sourced from the Food Crop Production Reports for Food Security, MOA) were proposed to track progress towards output 5.6.

Environmental factors, notably drought and climate change, adversely impact household food security and aggravate malnutrition. According to the NMNAP theory of change, environment output envisioned vulnerable communities in Tanzania being able to cope with drought and climate change to avoid shortages in nutritious food. Although there were pockets of hunger in several drought-stricken districts, by midterm, the country had managed to forge ahead without experiencing remarkable national environmental crises that impacted national and household food security. The food sufficiency rate (FSR) by midterm was at 124 per cent, having surpassed the planned target of 120 per cent. The observed improvement is attributed to good weather, use of good agriculture practices, improved policy environment and other government interventions, particularly input subsidies and extension services. National food security bulletins are regularly issued, showing regions and areas of vulnerability in relation to crop conditions, rainfall, food prices and eventual shocks. The sustainable, measurable, achievable, reachable, time-bound (SMART)[14] agriculture initiative is being implemented in some regions while crop insurance to protect farmers who may be negatively affected by climate shocks has been launched.

Drivers of achievement and bottlenecks for KRA 5 – NSIs

Food security (agriculture, livestock and fisheries)

Improved food security is related to increased agricultural and animal-related food products due to the availability of improved seeds, good weather conditions and the availability of extension services coupled with private sector involvement. However, despite the increased availability of foods, especially plant-based foods (e.g., cereals), many animal-source foods are still not accessible to many households. Also, most of the foods produced are meant for income-generation and the households are sometimes

Table 33: New indicator for Output 5.5

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Food self-sufficiency ratio (Food Crop Production Reports for Food Security, MOA)	120% (2015/16)	120%	124%	140%

Source: Authors' analysis, MTR 2019

[14] According to FAO, climate-smart agriculture (CSA) is an approach that helps to guide actions needed to transform and reorient agricultural systems to effectively support development and ensure food security in a changing climate. CSA aims to tackle three main objectives: sustainably increasing agricultural productivity and incomes; adapting and building resilience to climate change; and reducing and/or removing greenhouse gas emissions, where possible.

left with less amount of food for household consumption until the next harvest.

Further analysis of this KRA reveals that the National Agriculture Policy emphasizes production for export and makes few references to child nutrition/complementary feeding. There was limited promotion of homestead production of nutritious foods, which is essential to addressing child undernutrition among resource-constrained households, while no data existed on dietary diversity at the household level. Low dietary diversity in the country was reported in various regions that produce a limited number of crops. The most affordable sources of nutrients and energy needed to address deficiencies are dark green leafy vegetables, dried beans, peas, lentils, beef liver, small dried fish, orange/yellow-fleshed vegetables, chicken liver, beef, eggs and milk. However, most of these are affordable only to 10–40 per cent of the population (Complementary Feeding Landscape Analysis in Tanzania, 2019).

In the livestock sector, there is increased livestock in some regions due to either migration of communities or the improvement of breeds through the available agricultural research institutions (ARIs) in the country. However, the affordability of animal-source foods remains an issue. The animal-source foods supply chain (i.e., poultry and eggs) is largely informal and has issues such as high consumer prices, production risks (low yields, high cost of inputs and lack of capital), food safety (from food production to distribution and retail), poor processing, storage and transportation infrastructure. Many children between 6–23 months of age do not consume enough iron, vitamin A, calcium or animal-source protein. Animal-source protein, iron and calcium are known dietary complementary feeding gaps that cannot be affordably met by most households (Complementary Feeding Landscape).

Health and HIV services

Government investments in the construction of health facilities countrywide has increased access to health services through decentralization where facilities operate at the village level. High vertical coverage of HIV/AIDS programmes has been witnessed throughout the country, leading to increased availability of health services in villages. Further, the use of male volunteers to deliver some of these interventions has been mentioned as a factor during field visits for increased coverage.

The increment of ANC4 is mainly due to early ANC initiation (the number of women who start ANC with gestational age below 12 weeks has been doubled). There has been improvement in quality of care based on star rating assessment: facilities with three stars have increased from 1 per cent to 20 per cent and over 60 facilities scored two stars. Geographical accessibility has also improved. There is an increasing number of dispensaries and health centres providing ANC services. Although ANC4 coverage has increased, most of the pregnant women attending the clinics were not tested for haemoglobin (due to lack of HemoCue machine) and urine (due to lack of albustick).

Lower performance in family planning indicators is mainly due to the misconception that the contraceptive devices used in family planning can cause cancer and increase weight. Other reasons include the side effects of contraception and poor documentation by users.

Good performance of IPT indicators is linked to increased knowledge on malaria prevention. Availability of IPTp (SP) is also a key factor, as this is among the 10 tracer medicines and its availability is now at 95 per cent. SP was available in most of the facilities. Health facilities now provide IPT2 and folic acid at the same time.

HIV indicators have performed well due to the increased knowledge on HIV and PMTCT among communities, availability of trained staff, HIV services and social support systems, mother mentors and mother support groups (although not enrolled countrywide).

Water, sanitation and hygiene (WASH) services

Among the factors that contributed to the increase in coverage of WASH services is the use of community-level efforts. This includes the

use of CHWs who conduct house-to-house visits on a quarterly basis to update registers, check sanitation and hygiene in homes and emphasize their importance. More households, particularly in Njombe, have improved toilets and "tippy taps". However, SBCC messaging emphasizes only one component – improved toilet facilities – and excludes several other important WASH components such as clean environments for children's play areas.

Education services

While pre- and primary education are compulsory, secondary education is not; rather, it is fee-free. This means that the transition rate from primary to secondary education is still low and hence, the GCR is low. This could be raised by ensuring full implementation of the policy for compulsory lower secondary education. Efforts are also required to reduce dropping out of girls at all levels of basic education.

One of the main reasons for the low net enrolment for the pre-primary education is the introduction of the FFE policy for pre-primary to lower secondary education, together with the change of academic years from the former two years of pre-primary to one year as per the Education and Training Policy, 2014. Thus, most pupils who were expected to enrol in pre-primary were enrolled in Standard One, which reduced the number of pre-primary enrolments.

Social protection and women economic empowerment

Social protection initiatives are available to poor families through TASAF and Council Women Development Fund to empower women and families. CDOs have been instrumental in providing support by ensuring that poor households are identified and reached.

Environment

Generally, the country has been observed to produce surplus food in the range of 120–124 per cent. This improvement is due to, among other reasons, good weather (Vuli, Masika and Msimu), the use of good agricultural practices, an improved policy environment and government interventions, particularly inputs and extension services. However, climate change can result in increased natural disasters, such as floods and droughts, which will especially affect the most vulnerable communities, The country might be unprepared to address them.

KRA 6: Efficient and effective nutrition governance

Tanzania is globally recognized for its high-level commitment to nutrition and for having an adequate system of multisectoral nutrition governance in place. It has established a multisectoral nutrition coordination structure from the central to the community level, accountability mechanisms through Nutrition Compacts at all levels and a policy of investing in nutrition. However, the system is not yet operating at its full potential.

This KRA addresses the governance of the NMNAP. It also looks into the proposed framework for coordinating, leading and managing the NMNAP from a strategic perspective. It is aimed at improving leadership, management and coordination structures for nutrition, human resources, institutional capacity strengthening, accountability and financial resources for nutrition. The MTR assessed progress made in nutrition governance in three key areas: nutrition budgeting and expenditure, coordination and human resources for nutrition at the LGA level.

Outcome-level findings

Table 34 summarizes the achievements against KRA 6 – Multisectoral nutrition governance outcome-level indicators.

This indicator assesses the proportion of councils spending a minimum budget per child aged under five years for nutrition using domestic resources.

Table 34: Progress of outcome-level indicators for KRA 6 – Multisectoral nutrition governance

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of districts implementing the minimum budget allocation to nutrition	NA (2015/16)	30%	7%	50%

Source: Authors' analysis, MTR 2019

At midterm, the indicator was slightly modified to reflect this meaning, and a second indicator was proposed to assess the percentage of the nutrition budget spent at LGAs against the planned budget (see Table 20). Overall, the implementation of the minimum budget for children in LGAs was only achieved by 7 per cent of the councils at midterm. The proportion of councils spending a minimum budget for nutrition per child using domestic resources increased from 4 per cent in 2017/18 to 7 per cent in 2018/19, against the NMNAP target of 30 per cent increase from the baseline. At the sub-national level, guidance on minimum budget allocations for nutrition has been effective and is well-known by decision makers. However, minimum budget allocations at TSh 1,000 per child under five years and spending are not increasing as planned to gradually reach the equivalent of USD 8 per child per year as recommended by the World Bank to meet WHA nutrition objectives. When allocations are made by the councils, funds are not disbursed, and nutrition activities are not implemented as planned.

Output-level findings

KRA 6 – Multisectoral nutrition governance has three outputs.

6.1 Increased political and financial commitment to nutrition by the Government

6.2 Functional multisectoral coordination at all levels

6.3 Improved human resources and capacities for nutrition

Table 35 summarizes the achievements against KRA 6 – Multisectoral nutrition governance output-level indicators.

Output 6.1 Increased political and financial commitment to nutrition by the government

Indicator: Average spending on nutrition at the council level

Since 2014/15, the JMNR has been tracking the average spending on nutrition at the council level

Table 35: Progress of output-level indicators for KRA 6 – Multisectoral nutrition governance

Indicators	Baseline	Planned 2018	Achieved 2018	Target 2021
Average spending on nutrition at the council level	TSh 128 million (AWP Review 2014/15)	TSh 250 million	TSh 70 million	TSh 400 million
Proportion of councils that hold at least two meetings of the council nutrition steering committee per year	<10% (AWP Review 2015/16)	35%	85%	60%
Proportion of LGAs employing at least one full-time professional nutritionist	60% (PO–RALG 2015/16)	80%	53%	100%

Source: Authors' analysis, MTR 2019

Table 36: New output-level indicators for KRA 6 – Multisectoral nutrition governance

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of regions spending at least 50 per cent of the planned government budget (domestic resources)	NA (2015/16)	30%	27%	50%

Source: Authors' analysis, MTR 2019

in the form of average amount of funds (TSh) spent on nutrition in the respective financial year. At midterm, progress on this indicator has been found inadequate, as on average, TSh 70 million is spent on nutrition compared to the planned target of TSh 250 million.

At midterm, a new indicator was proposed to track the proportion of regions spending at least 50 per cent of the planned government budget (domestic resources). Based on available data, there has been a slight delay as the indicator showed a 27 per cent performance against the target of 30 per cent. In addition, the Nutrition Compact Assessment report of 2018/19 showed that only 45 per cent of the total planned budget in LGAs was spent from own source, other charges (OC) and Heath Basket Fund (HBF) at midterm. Despite this delay, it is important to note that the quality of data on average spending on nutrition is an area that needs further exploration and development due to complexities associated with tracking of nutrition interventions and spending across sectors. Recently, the PO–RALG has established mechanisms to track nutrition spending through the PLANREP and the integrated monitoring and evaluation system (IMES). These efforts should be strengthened to ensure data quality.

Output 6.2 Functional multisectoral coordination at all levels

Indicator: Proportion of councils that hold at least two meetings of the council nutrition steering committee per year

The number of functional councils multisectoral steering committees on nutrition have continuously increased and the indicator is on track. At 85 per cent, performance of the committees surpassed both midterm (35 per cent) and endline (60 per cent) targets. Between 2017 and 2018, the PO–RALG developed and disseminated ToR for regional and council steering committees, which may have contributed to their increased numbers and effectiveness. The ToR also require ward and village development committees to coordinate by making nutrition a standing agenda in their meetings. However, data on the functions of the ward and village development committees on nutrition was not included in the MTR.

Despite the progress, field assessments in the five regions have reported inconsistencies in holding meetings. Neither the leadership of nutrition officers in councils nor the regular participation of DEDs in multi-sectoral nutrition steering committee meetings as chairmen are consistently ensured. Some committees meet without sitting allowances while some still depend on sitting allowances to conduct quarterly meetings. Field findings also have revealed that some committees have been represented with a notably consistent delegation while others have not.

Output 6.3 Improved human resources and capacities for nutrition

Indicator: Proportion of LGAs employing at least one full-time professional nutritionist

At the baseline, this indicator was set to capture the presence of both nutrition professionals and the nutrition focal person in LGAs. With this mix, the planned target was estimated at 80 per cent. However, at midterm, this indicator was

rephrased to focus on nutrition professionals only. By 2015/16, 60 per cent of LGAs had a mix of nutrition officers and nutrition focal points, which was included in the NMNAP as a baseline value for nutrition officers. However, the NMNAP indicator in this aspect requires the monitoring of the "proportion of LGAs employing at least one full-time professional nutritionist (sourced from PO–RALG Nutritionists database)". The MTR used this indicator and found that by 2018/19, the LGAs that had employed at least one full-time professional nutrition officer where 98 out of 185 LGAs equivalent to 53 per cent had at least one professional nutritionist. Overall, this is a significant improvement in the employment of nutrition officers compared to 2015/16, whereby this indicator included both nutrition officers and focal persons. Trainings with continuous orientation on evidence-based planning, budgeting, monitoring and reporting on nutrition including regular coaching supervision have resulted in the increased capacities of existing nutrition officers to manage nutrition programmes after training. Almost 100 per cent of councils produce plans, budgets and reports (i.e., BNA, AWP review, Compact) based on evidence.

Drivers and bottlenecks for KRA 6 – Multisectoral nutrition governance

Strong leadership by the PMO and establishment of the HLSCN

The PMO has played a key role in leading nutrition governance since 2011 when the HLNSC was established. Through this strategic leadership, the multisectoral nutrition response is implemented with coordination of sensitive MDAs and development partners and in collaboration with the private sector. The HLSCN oversees the implementation of the NMNAP and monitors progress through the annual JMNRs.

National and subnational nutrition accountability

The government has established important initiatives to ensure the implementation of the NMNAP. For example, in December 2017, the PO–RALG introduced a Nutrition Compact with 26 RSs aimed at accelerating the implementation of NMNAP through increased financial resources, focused priority nutrition interventions and improved coordination and accountability. Implementation of the Nutrition Compact and tracking of its progress from the national level to the village level is an area that should be looked at closely during the second phase of the NMNAP implementation.

Human resources for nutrition

Tanzania has an outstanding number of nutrition officers in regions and councils responsible for providing technical support and coordinating nutrition interventions in their respective regions (see Table 23). Various efforts are in place to strengthen the capacities of the nutrition officers. The PO–RALG developed a toolkit for comprehensive supportive supervision, which supports nutrition officers in monitoring nutrition interventions in health facilities and communities. Furthermore, the PO–RALG and TFNC provide regular mentoring and coaching to nutrition officers. Despite the outstanding human resources, 47 per cent of councils have not yet employed professional nutrition officers. This is a significant human resource gap that needs to be prioritized to accelerate the scaling-up of nutrition. The government and DPs should provide continued support for capacity building of nutrition officers.

Improvement in planning and budgeting systems for nutrition

Improvements in the financial system within the PO–RALG – such as the revision of the PLANREP, the inclusion of the nutrition objective and outcome and output targets in the PLANREP and the implementation of the Nutrition Compact – are key to increased nutrition funding and implementation. The increased spending could also be associated with the continued efforts to strengthen the capacity of nutrition officers, multisectoral nutrition steering committees and other key government officials in evidence-based nutrition planning and budgeting. Through the

improvement of financial systems, capacity strengthening and implementation of the Nutrition Compact, significant improvement has been noted on nutrition spending per child between 2017/18 and 2018/19. In 2018/19, 45 per cent of the total planned nutrition budget from own source, other charges and Health Basket Fund at all LGAs was spent for nutrition in LGAs. Despite the progress, nutrition funding is still overall low compared to planned budgets and is associated with delays in the realization of some of the NMNAP KRA targets.

KRA 7: Quality nutrition-related information is accessible and used to allow government and partners to make timely and effective evidence-informed decisions

The KRA on MNIS was established to ensure availability and accessibility of better quality and more timely collection and dissemination of outcomes (and programme performance) data. This will help ensure evidence-informed advocacy, communication and adaptive management of the NMNAP. Data sources include routine system, national surveys, reviews and research. Progress towards achieving the intended results is explained in the subsequent sections.

Outcome-level findings

Table 37 summarizes the achievements against KRA 7 – MNIS outcome-level indicators.

The MTR findings indicate that the proportion of councils using nutrition information in their respective plans, budgets and reports increased from 90 per cent in 2017/18 to 95 per cent in 2018/19, which surpassed the set midterm target of 30 per cent. Positive progress has been made in this KRA, as evidenced by the improved quality of annual LGAs' nutrition AWPs, consisting of plans and budgets that are integrated in their medium-term expenditure frameworks (MTEFs). This has been largely due to the involvement of nutrition officers in reviewing indicators, following-up data-collection and consolidation at the facility level and validating data. Despite the progress, the definition of this indicator needs to be improved to ensure better quality of data reporting on the indicator. Overall, there is an increased availability and quality of nutrition data across sectors. Some nutrition indicators are also now included in the DHIS2, the PLANREP and the IMES, which helps to inform evidence-based planning.

Thus, addition of one new indicator at the outcome level was suggested, as shown in Table 38.

Table 37: Progress of outcome-level indicators for KRA 7 – MNIS

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of councils using nutrition information in their respective plans, budgets and reports	NA (2015/16)	30%	95%	100%

Source: Authors' analysis, MTR 2019

Table 38: New output-level indicators for KRA 7 – MNIS

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Proportion of councils using the MNIS online platform to produce multisectoral nutrition scorecards and BNA		0%	0	100%

Source: Authors' analysis, MTR 2019

Output-level findings

KRA 7 – MNIS has three outputs:

7.1 Established robust systems of data collection, analysis, interpretation and feedback among stakeholders at all levels

7.2 Relevant nutrition indicators that are integrated, collected and reported in national surveys

7.3 Developed capacity of nutrition stakeholders to align implementation of NMNAP with learning framework and carry out operational research

Progress towards each output is tracked by one output-level indicator for the other outputs. Table 39 summarizes the achievements against KRA 7 – MNIS output-level indicators.

Output 7.1 Established robust systems of data-collection, analysis, interpretation and feedback among stakeholders at all levels

Indicator: Number of regular national surveys that incorporate nutrition indicators (including biological indicators of micronutrient deficiency and DRNCDs) conducted

Good progress has been made in survey implementation. TNNS and SMART surveys were implemented in 2018 to track progress on nutrition outcomes and impact, and their results are used for this midterm review. Wherever possible, nutrition indicators were included in surveys. E.g., the school-based malaria and nutrition survey. Delay in the implementation of the STEP survey and the CFSVA resulted in the lack of generated data to monitor the CRRAF. However, this was beyond the control of the nutrition programme.

Output 7.2 Relevant nutrition indicators that are integrated, collected and reported in national surveys

Indicator: Proportion of regions and councils producing semi-annual and annual multisectoral nutrition scorecards

Performance at midterm has shown that 100 per cent of the regions and councils produced semi-annual and annual multisectoral nutrition scorecards as compared to the set target of 85 per cent and the baseline of 12 per cent (2015). During the MTR, this indicator was slightly modified to read “Proportion of regions and councils producing semi-annual and annual

Table 39: Progress of output-level indicators for KRA 7 – MNIS

Indicators	Baseline 2012	Planned 2018	Achieved 2018	Target 2021
Number of regular national surveys that incorporate nutrition indicators (including biological indicators of micronutrient deficiency and DRNCDs) conducted	0	2	1 (TNNS 2018)	2
Proportion of regions and councils producing semi-annual and annual multisectoral nutrition scorecards	12% (2015/16)	85%	100%	100%
Number of multisectoral nutrition reviews and public expenditure review on nutrition (PER-N) conducted	2 (JMNR and PER Nutrition)	1 (JMNR)	2 (JMNR and NMNAP MTR)	1

Source: Authors’ analysis, MTR 2019

multisectoral nutrition scorecards, BNA, Compact, CRRAF". Introduction of scorecards at the council level created awareness and accountability on nutrition issues at all levels. Increasingly, regional and council nutrition steering committees are using the findings from BNA and scorecards, which might have accelerated utilization.

The field assessment report showed that regional and council scorecards were developed and implemented to inform the authorities about areas requiring focus to improve nutrition interventions. The collected data was used by the authorities during annual review to inform internal assessments; hence, performance increased in the regions visited.

Output 7.3 Developed capacity of nutrition stakeholders to align implementation of NMNAP with learning framework and carry out operational research

Indicator: Number of multisectoral nutrition reviews and PER-N conducted

At the MTR, two main multisectoral reviews – JMNR and PER – were conducted, cumulatively for the past two and half years. JMNR brings together partners to discuss NMNAP progress and recommend areas of improvement. In 2018, the second PER report provided key information covering nutrition spending from the government's own sources, both at national and subnational levels, and DPs for 2014/15 and 2015/16.

Drivers and bottlenecks for KRA 7: MNIS

A complex MNIS is in place to regularly generate data and track progress towards nutrition as well as expenditure. However, the nutrition information system is a parallel system. Various data collection systems exist and the newly developed MNIS online platform, which is supposed to harmonize all data systems, has not yet been launched. This includes financial data. Nutrition has been recently established as one objective in the PLANREP, which will make it very easy to generate data on budget and expenditure.

Achievements have been made in this KRA due to availability of funds and technical support from DPs to develop data collection tools and systems as well as the ability of the TFNC and NBS to design and implement national-level surveys such as TNNS. Data availability and quality have improved through the capacity building of trained nutrition officers at regional and LGA levels and the oversight and supportive supervision of PO–RALG.

According to the field assessment findings, data utilization in decision-making, especially the scorecards, coupled with inadequate interpretation of indicators and computation, especially at the LGA level, remain a challenge. On the other hand, this review found difficulty in acquiring data from other sectors, which pointed to the need for a unified MNIS.

4.3 Financial analysis

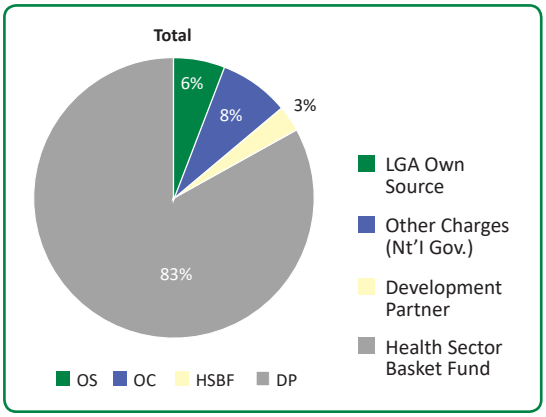
Overall budget execution

NMNAP budget execution at midterm was 41 per cent for the overall budget.[15] This stands at 43 per cent, excluding nutrition-sensitive interventions. DPs contributed 83 per cent of the total budget execution while the Government contributed 17 per cent, of which 6 per cent is from LGAs' own source (*see Figure 20*).

There is a large gap between the planned budget and actual expenditure, as over half of the targeted investment in nutrition activities was not released for the implementation of planned activities. Non-release or delay in the release of funds was identified as the main challenge, leading to either partial implementation or no implementation of the planned activities.

[15] Expenditure for KRA 5 (NSI) for the period July–December 2018 is largely incomplete, as it was not available at the time of the review.

Figure 20: Source of funds for nutrition interventions



Source: Authors' analysis, MTR 2019

Budget execution by KRA

At the KRA level, execution shows a varying trend. Out of the seven NMNAP KRAs, governance had the highest execution rate of 84 per cent, followed by MIYCAN at 62 per cent. MNIS and DRNCD, with 14 per cent and 16 per cent respectively, were the lowest (*see Figure 21*); micronutrient and IMAM were also below average in budget execution. The same trend is noted regarding progress in achievements of targets where those outcomes indicators with higher budget execution had impressive achievements compared to indicators with below-average budget execution, which showed low achievements.

Nutrition expenditure per child under five years (excluding NSI) was TSh 4,889 (equivalent to USD 2.13)[16] in 2017/18. This was almost the same in 2016/17 and is far below the recommended amount of USD 8[17] per capita that is required to reach the WHA Global Nutrition Targets for 2025. There is a need to significantly further increase nutrition expenditure, especially considering that over 95 per cent of funding for nutrition (excluding NSI) in Tanzania comes from DPs (*see section on sources of funding*).

Yearly budget execution by KRA

Yearly average execution rates show a declining trend from 2016/17, where overall budget execution was 67 per cent and 57 per cent without NSI, to 40 per cent overall budget execution in 2017/18, and 35 per cent without NSI (*see Figures 22 and 23*). At midyear FY 2018/19 (*see Figure 24*), data is available only for nutrition-specific interventions (KRAs 1–4) and enabling environment interventions (KRA 6 and 7). Only 41 per cent of the budget planned between July and December 2018 was spent. KRA 2 (micronutrients), KRA 3 (IMAM), KRA 4 (NCDs) and KRA 7 (information system) are particularly underfunded. The declining trend should forewarn of the worsening budget performance as the programme implementation unfolds. Poor

Figure 21: Targeted versus actual expenditure July 2016–December 2018 (in billion TSh)

NMNAP Outcome	Targeted	Expenditure	Achievement
Outcome1: MIYCAN	115	71	62%
Outcome2: Micronutrient	58	16	28%
Outcome3: IMAM	29	10	16%
Outcome4: NCD	32	5	41%
Outcome5: Nutrition Sensitive	10,891	4,502	84%
Outcome6: Governance	19	16	84%
Outcome7: Information System	36	5	14%
Total	**11,179**	**4,625**	**41%**
Total without NSI	**289**	**123**	**43%**

Source: Authors' analysis, MTR 2019

[16] USD 1 = TSh 2,293

[17] World Bank, 2015, WHA

Figure 22: Targeted versus actual expenditure, July 2016/17 (in billion TSh)

NMNAP Outcome	Targeted	Expenditure	Achievement
Outcome1: MIYCAN	35	25	71%
Outcome2: Micronutrient	22	6	27%
Outcome3: IMAM	4	5	125%
Outcome4: NCD	2	1	50%
Outcome5: Nutrition Sensitive	4,128	2,756	67%
Outcome6: Governance	6	6	103%
Outcome7: Information System	8	1	14%
Total	**4,206**	**2,800**	**67%**
Total without NSI	**77**	**44**	**57%**

Source: Authors' analysis, MTR 2019

Figure 23: Targeted versus actual expenditure, July 2017/18 (in billion TSh)

NMNAP Outcome	Targeted	Expenditure	Achievement
Outcome1: MIYCAN	50	27	54%
Outcome2: Micronutrient	23	5	22%
Outcome3: IMAM	13	4	31%
Outcome4: NCD	19	1	5%
Outcome5: Nutrition Sensitive	4,287	1,734	40%
Outcome6: Governance	9	6	67%
Outcome7: Information System	18	2	11%
Total	**4,418**	**1,779**	**40%**
Total without NSI	**132**	**46**	**35%**

Source: Authors' analysis, MTR 2019

Figure 24: Targeted versus actual expenditure, July 2018/19 (in billion TSh)

NMNAP Outcome	Targeted	Expenditure	Achievement
Outcome1: MIYCAN	30	19	63%
Outcome2: Micronutrient	12	5	38%
Outcome3: IMAM	12	1	6%
Outcome4: NCD	11	3	24%
Outcome5: Nutrition Sensitive	2,475	12	0%
Outcome6: Governance	4	3	85%
Outcome7: Information System	9	2	21%
Total	**2,553**	**44**	**2%**
Total without NSI	**78**	**32**	**41%**

Source: Authors' analysis, MTR 2019

budget performance can have a detrimental effect in achieving the targeted changes at the end of the implementation period.

Budget execution by LGAs

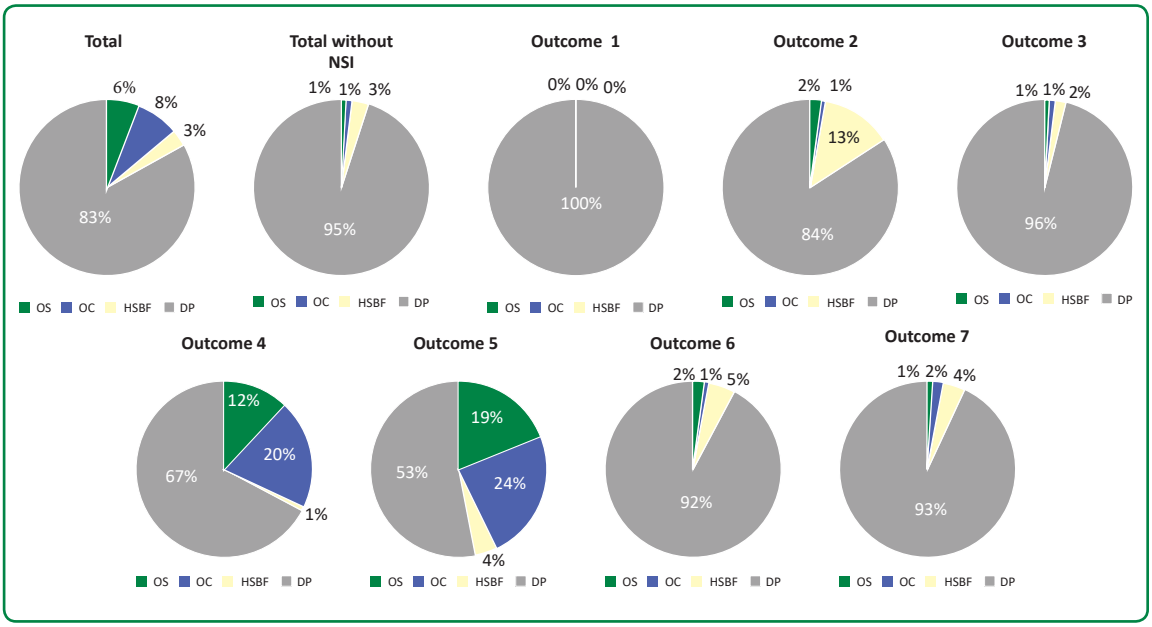
According to the Nutrition Compact assessment reports, overall expenditure (excluding NSI) at the LGA level significantly dropped from TSh 7.1 billion (out of TSh 18.1 million planned) in 2017/18 to TSh 3.8 billion in 2018/19 (out of TSh 8.5 million planned). However, overall budget execution (excluding NSI) improved from 38 per cent in FY 2017/18 to 45 per cent in FY 2018/19. Also, the percentage of regions in Tanzania mainland spending over 50 per cent of planned budget using domestic resources increased from 1 per cent out of 26 per cent in 2017/18 (4 per cent) to 7 per cent out of 26 per cent in 2018/19 (27 per cent), while the planned budget at LGA level increased from TSh 8.5 million in 2018/19 to TSh 16 million in 2019/20. The percentage of councils spending a minimum budget allocation of TSh 1,000 per child increased from 1 per cent in 2016/17 to 4 per cent in 2017/18 to 7 per cent in 2018/19.

This trend in budget execution at LGA level is similar to the overall trend. The bottleneck appears to be related to disbursement, as most LGAs, despite having budgeted for nutritional activities, did not release funds for implementation. Non-release or lower release rates can occur because the budget was overestimated or there was reallocation to other activities. Ring-fencing the budgeted amount for nutritional activities can help in overcoming reallocation of funds budgeted for nutritional activities – as was suggested by the PER on nutrition, 2018. Also, since the Nutrition Compact was signed with all RCs in December 2017, it is possible to observe improvement in budget execution rate (especially for domestic funds) between 2017/18 (38 per cent) and 2018/19 (45 per cent), and a significant increase in the budget planned for nutrition between 2018/19 (TSh 8.5 billion) and 2019/20 (TSh 16 million).

Budget execution by source of fund

DPs account for over half of the total funding for nutrition, and about 95 per cent of the total funding for nutrition excluding NSI (see Figure

Figure 25: Composition of sources of fund in total and for each outcome Indicator



Source: Authors' analysis, MTR 2019

Table 40: Actual budget spent per outcome by funding source (TSh)

KRA	OS	OC	HSBF	DP
KRA 1	128,854,312	104,021,152	107,072,025	70,683,696,841
KRA 2	351,828,621	119,927,500	2,038,022,105	13,094,982,878
KRA 3	153,515,928	56,404,401	173,695,229	9,743,047,530
KRA 4	625,449,759	985,857,555	43,778,900	3,402,941,908
KRA 5	10,241,428,391	15,553,251,256	1,770,659,460	26,000,538,914
KRA 6	282,088,165	149,625,500	788,846,350	14,814,140,204
KRA 7	57,826,500	109,455,000	179,193,941	4,630,872,427
Total	**11,840,991,676**	**17,078,542,364**	**5,101,268,010**	**142,370,220,703**

Source: Authors' analysis, MTR 2019

25 and Table 40). Nutrition-specific interventions are heavily dependent on funding from DPs. Outcome 1 (MIYCAN), outcome 3 (IMAM) and outcome 7 (information system) are worth noting as their investments from DP sources were 100 per cent, 96 per cent and 95 per cent, respectively. Figure 25 shows the composition of sources of fund in total, total excluding NSI and for each outcome. Overreliance on DPs' funds, which are erratic in terms of both quantity and timing, introduces a large degree of uncertainty into funding for nutrition-related activities in Tanzania. Strategic initiatives need to be considered when advocating for increased share of domestic source of fund for nutritional activities in Tanzania.

4.4 NMNAP strategies analysis

The NMNAP has one overarching strategy and 10 additional strategies to achieve its objectives. The overarching strategy is: **community-centred multisectoral approach is an overarching strategy of the NMNAP**. It recognizes the central role of community services to promote good nutrition and related practices and obtain behavioural changes that will contribute to improving the nutritional status of the population. At midterm implementation of the NMNAP, the implementation of the nutrition services is well centred at the community level. For example, most of the services provided through the different KRAs are delivered to the communities through CHWs. The effect of these services was proved by the TNNS 2018, which revealed important changes in key behaviours such as exclusive breastfeeding and MAD for young children.

The other 10 NMNAP supportive cross-cutting strategies are described in the subsequent sections, which cut across all KRAs. At MTR, some strategies worked well, others worked moderately while some were not implemented or did not work as expected. These have been employed in different ways to achieve set targets.

SBCC for nutrition

It is evident that SBCC is among the important strategies for promoting positive nutrition and the related behaviour changes for improved nutrition outcomes. It was observed during the MTR that through the large-scale stunting reduction programmes, integrated training and communication packages were developed and used to build capacity of CHWs and health workers for providing quality integrated counselling services and promoting pro-nutrition

social and behaviour change. A combination of different communication approaches has been used to increase adoption of promoted practices.

Interpersonal communication (through individual and group counselling sessions) and mass media communication (using radio, TV and text SMS platforms) were the major means used to deliver key messages to promote individual and collective behaviour changes. However, it was reported that there is still inadequate male participation in nutrition social and behaviour change communication interventions implemented at both community and health facility levels.

Based on the progress made so far, this strategy is still relevant for continuing the influence of positive attitudes, perceptions and individual behaviour and social change. However, there is a need to explore ways of reaching more men and strategically use social media to promote shifting of the social attitudes, perceptions, and norms regarding nutrition and sustain the adopted behaviours.

Advocacy and social mobilization

The NMNAP strategy on advocacy and social mobilization aims to sustain political will and government commitment for nutrition, mobilize adequate resources for nutrition and create awareness of the problems of malnutrition among decision makers and community members to improve nutrition.

At MTR, this strategy is associated with the high performance observed across the KRAs. Between 2016–2018, there has been increased political will for nutrition led by the PMO as the SUN focal person through multisectoral coordination by bringing together MDAs, development partners, CSOs and the private sectors. Driven by outstanding leadership of the PMO, there has been progress such as improved financial resources allocation for nutrition, increased awareness and involvement of communities.

Advocacy and high social mobilization with top leaders, such as the Prime Minister, Vice-President, Minister of State in the PO–RALG, members of parliament and CSOs, have been witnessed on different platforms to mobilize the entire nation for nutrition. For example, the Vice-President, through the Minister of State in the PO–RALG, established the Nutrition Compact (2018–2021) to scale up the implementation of the NMNAP. By the midterm, all 25 regions and 184 councils are implementing the Nutrition Compact, while efforts are ongoing to ensure the ward leaders' oversight of the implementation of the Compact in their areas. The introduction of the compact was associated with increased domestic resources for nutrition, as shown in the findings section of the MTR report.

The Minister of PO–RALG has declared every 7th August as a National Nutrition Day, which entails wider advocacy efforts and social mobilization activities across the country in the next phase of the NMNAP. The Parliamentarians' Group on nutrition advocating for more resource allocation is another example of the working of this strategy. There has been an increased momentum in their advocacy work, with a focus on nutrition awareness within the parliament and their constituencies and prioritization of nutrition in Government annual budgets and disbursements.

While national-level advocacy should be sustained and even increased especially with MDAs and members of parliament, in the second phase of the implementation of the NMNAP, efforts should be directed to subnational levels, such as in wards and villages. Social mobilization should be scaled up up among communities through CHWs, subnational government leaders, influencers and local radios with toiled nutrition messages and interventions. Advocacy and social mobilization agenda should be identified by TFNC and communicated to relevant partners to ensure consistency of messaging and tracking of results.

Community-centred capacity development (CCCD)

The CCCD strategy involves developing the capacity of the community and community-based organizations (CBOs), which will result in community participation and social accountability. This was key to the implementation of the NMNAP, as evidenced by the field assessment reports.

At the midterm, notable good practices on the use of this strategy was reported. International non-governmental organizations (NGOs) partnered with CBOs to support the implementation of community-based integrated nutrition projects/programmes with the objective of building their capacity and strengthening these institutions. CBOs worked closely with CHWs to deliver nutrition services in communities. Peer groups and community-based supervisors were trained and actively involved to deliver services in the community. Other aspects that worked through the CCCD strategy were involvement of communities in supporting delivery of services such as school-feeding programmes, whereby parents contribute to the feeding programme; collaboration between the CSOs and local government leaders to address nutrition issues; introduction of incentives and by-laws at the community level for greater male involvement to enable service uptake by pregnant mothers; and use of existing health committees to deliver services.

The CCCD strategy should be maintained in the next phase of the NMNAP. However, the capacity of CHWs should be enhanced to provide integrated nutrition, WASH and other health-related services. Community extension workers are key resources who are well established in the community. Their capacity should be developed to deliver multisectoral nutrition services. Social accountability for nutrition is another aspect that should be considered, especially in NMNAP II. A similar scorecard that is used in the councils should be considered for use in the community to accelerate community actions for nutrition. Furthermore, the development of capacity of communities should go hand in hand with continued development of capacities at council, district, regional and national levels.

Development of functional human resource capacity

Human resource capacity strategy can be analysed by analysing indicators related to the number, qualification and distribution of nutrition professionals at different levels in the country.

Availability and qualification of human resource for nutrition

Deliberate efforts have been made to recruit and capacitate nutrition officers at all levels. The MTR process reaffirmed the availability of nutrition focal persons with relevant qualifications across government MDAs. The available team has been central in supportive supervisions and monitoring of the CRRAF. The national team is capacitated in various aspects beyond nutrition, including leadership, analytics and survey methodologies, to drive country nutrition agenda. National nutrition surveys, nutrition planning cycles and COMPACT tools development and implementation portray leadership instances provided by different MDAs. This is an important milestone to reflect on the functional human capacity strategy. In addition, national-level teams provide updates to inform discussions in the TWGs as part of the coordination structure of the NMNAP. Beside the national level, the strategy to strengthen human resource capacity was also implemented across councils. Another milestone of this strategy is reflected in the nutrition capacity assessment and training to address observed challenges. District teams have also benefited from mentorship and coaching from not only the MDAs but also nutrition stakeholders who implement interventions in their areas. As a result, there is vital progress on implementation of nutrition interventions at council levels as reflected in various KRAs of this report. Despite the success, specific areas related to MNIS may require specific

stock-taking to understand the specific challenges that hamper quality reporting. As reported elsewhere in this report, part of the challenges emanates from availability of tools. But there is also a need to capacitate the teams on setting relevant indicators to inform progress in the areas of nutrition-sensitive nutrition at the community level.

Distribution of human resource for nutrition

The strategy focus detailed the need for availability of nutrition officers in each council and region. The implementation has realized the current coverage as currently 53 per cent of all councils and all regions have professional nutrition officers. Findings from the field indicate that the role of nutrition officers has been recognized and they are now part of the councils and regional management teams. More efforts are required to capacitate and deploy additional nutrition officers to cover the remaining 43 per cent of the councils.

Also, nutrition steering committees, established at each level and across council, is an additional support to increase nutrition capacity. They ensure that nutrition is given priority and is discussed at different levels. A TOR for these committees was developed and revised at different stages as part of their capacity strengthening efforts to work towards fulfilling the nutrition agenda.

Alignment of all stakeholders with the NMNAP through community–public–private partnerships

This strategy has contributed to increased participation of private sector, specifically food processing industries in fortification of maize flour, wheat flour and salt. There has been a notable involvement of small-scale processors in maize flour fortification, with strengthened fortification capacity through supply of dosifier from SANKU. Salt producers and processors have been reached to ensure availability of quality and adequately iodized salt. Public–private partnership (PPP) will be more strengthened as the country is moving towards a consolidation approach in salt production. Through SOLEO business model, the coverage of MNPs has increased to 62 per cent of the councils.

Although the strategy worked quite well in the area of fortification, it was not fully utilized to ensure private sector engagement in other KRAS of the NMNAP. Therefore, the alignment of stakeholders with the NMNAP through community–public–private partnerships was inadequate. Although some PPP arrangements exist, further efforts need to be undertaken to ensure full PPP within the NMNAP.

Delivery of quality and timely nutrition services

Timely and quality delivery of nutrition service is still an essential strategy to ensure NMNAP targets are met. However, this strategy has not been very successfully as it depends on the availability of human resource and commodities. Based on BNA, the quality of key nutrition interventions such as MIYCAN, IMAM and IFAS has not improved mainly due to insufficient trained human resources at both facility and community levels; shortage of commodities such as IFA supplements and IMAM supplies (F75, F100 and RUTF); and accessibility of services (geographical access). Variations have been observed among interventions, as the quality of some interventions particularly vitamin A supplementation has been improved.

There is potential to deliver quality and timely nutrition services through continued capacity building of health workers at facility and community levels. This will ensure timely availability of commodities. Moving forward, there is a need to generate more evidences on quality of services delivered with special emphasis on DRNCD services.

Mainstreaming of equality in all seven KRAs of the NMNAP without discrimination, focusing on women, children and adolescent girls

The NMNAP was developed to ensure that all children, adolescents, women and men in Tanzania are better nourished. However, not all groups received the required attention according to their specific nutrition issues even though these have been mentioned in the NMNAP. Vulnerable groups included adolescent girls who were not adequately addressed with nutrition-specific interventions. Men were completely out of the scope of the NMNAP targets as there were no interventions or guidance on their involvement in nutrition issues.

Equality has been slightly mainstreamed in some nutrition-sensitive interventions, e.g., constructing WASH facilities such as toilets/special rooms for adolescent girls to manage menstruation and ensure they stay in school. Men have been involved in ANC services through the health sector to ensure uptake of ANC services during pregnancy.

Although equality and equity are key to eliminating all forms of malnutrition in the country, this is one of the strategies that have not been effectively applied from planning up to the implementation stage of nutrition interventions. With the rising triple burden of malnutrition, this strategy needs to be maintained and applied in all KRAs to ensure that at least specific nutrition problems for each group are addressed and evidences are generated to guide decisions in designing specific interventions.

A resource mobilization strategy

The government has committed several initiatives to ensure adequate resources, both in terms of financial and human resources. This has been complemented by massive contributions from the DPs as part of their commitment in the implementation of the NMNAP. Despite all these efforts, resources mobilization strategy has still not been fully developed. The current focus is on funding commitment as per NMNAP financial resource mobilization plan, whereby the government is expected to mobilize 30 per cent, development partners 60 per cent and the private sector 10 per cent of the total budget to fully fund the implementation of NMNAP.

As part of an initiative for resources allocation, the government has mainstreamed nutrition in the national budget guideline. It has also issued a guideline to councils to ensure that a minimum budget of TSh 500 per child, which later increased to TSh 1,000 per child, is set aside from the government sources for nutrition activities. Other efforts around resource mobilization include the engagement of donors in nutrition through in-country meetings and international visits, which in turn has contributed to increased investments in nutrition from the donors. The major drawback of this strategy is the lack of the role of private sectors in terms of funding commitment as part of SUN business network. It is recommended that the resource mobilization strategy be developed and operationalized to ensure greater clarity in the roles of relevant stakeholders with a view to increase commitments and investments for nutrition.

Tracking progress and operational research and development

Concerted efforts have been made to ensure the existence of a comprehensive mechanism for facilitating availability of evidence-based information that tracks the implementation of NMNAP and establishes a learning framework. Some key mechanism in this strategy includes undertaking of annual JMNRs; monitoring of Nutrition Compact; bi-annual and annual BNA; bi-annual and annual AWP; inclusion of nutrition component in PLANREP and iMES; development of nutrition scorecards; and development of MNIS. During this period, two major surveys, TNNS and HBS, studies such as the drivers of stunting were undertaken. Among the issues that needs to be addressed in this strategy is the

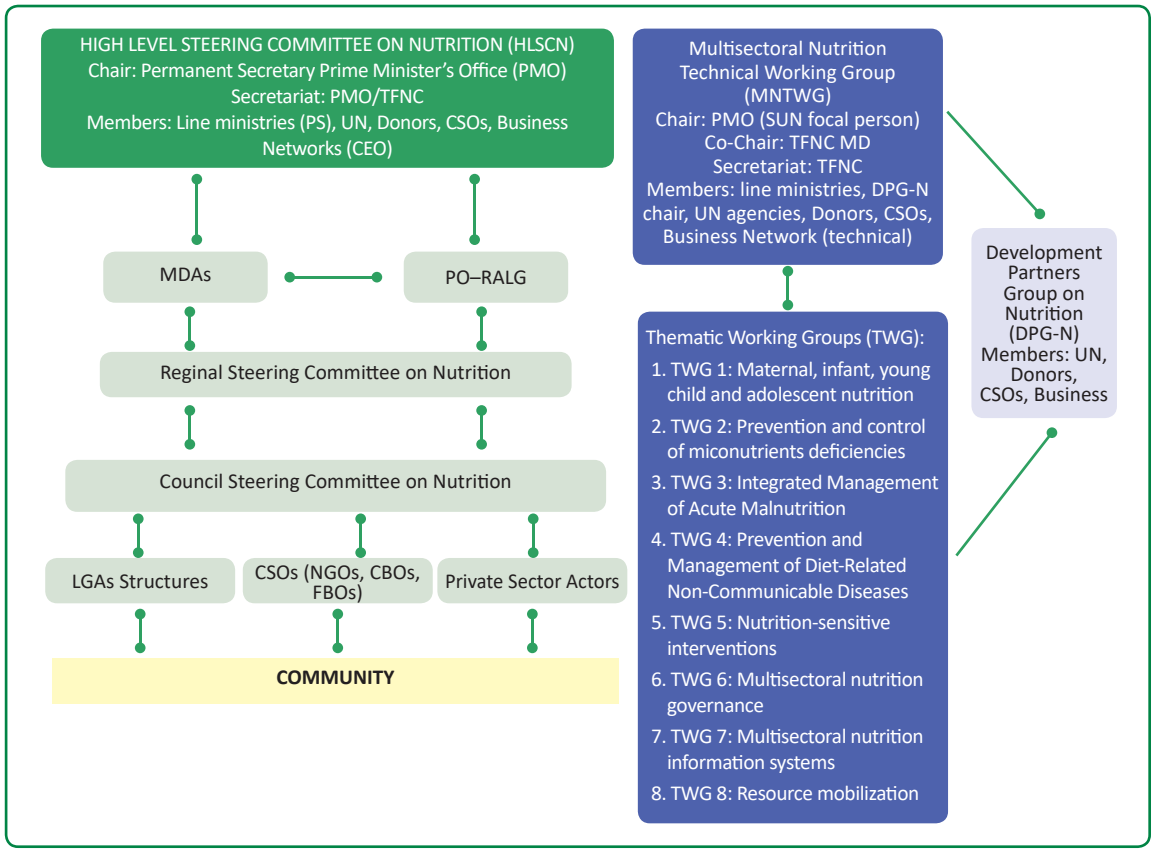
mechanism to capture data on micronutrient deficiency and DRNCDs. Generally, this strategy worked well during this implementation period, and it is highly recommended during the use of evidences generated to inform the implementation of NMNAP as well as planning for future undertakings.

Overall planning and coordination

The government has continued to provide guidance in the overall planning and budgeting for nutrition through annual planning and budgeting guidelines provided by the MoFP. Guidelines on planning and budgeting for nutrition from the PO–RALG has been among the key driving factors in this strategy. Through an overall coordination schematic of the NMNAP, an overall coordination structure that cuts across national and subnational levels has been established and operationalized. At the national level, the HLSCN has been formed to provide an overall policy and coordination role in the implementation of NMNAP, while the National Multisectoral technical Working Group (NMNTWG) functions as its technical platform. In line with this, eight TWGs were formed through the developed ToRs. All TWGs have been conducting their periodic meetings, except for TWG on Resources Mobilization that had not met yet. Challenges persist in timely undertaking of these coordination meetings, specifically for the NMSTWG and the eight TWGs.

Through this strategy, it has been observed that MNSCs at RS and LGA levels have been formed and regular meetings are undertaken. Currently, over 85 per cent of LGAs are conducting the meetings. The development and operationalization of Nutrition Compact between PO–RALG and RSs have been a catalyst towards improved planning, coordination and accountability. However, challenges still exist on the systematic discussion on issues related to planning, budget allocations and multisectoral coordination of nutrition activities.

Figure 26: Leadership, management and coordination structure for the NMNAP.



5 Cross-cutting issues

Gender

During MTR, gender-related elements, such as male involvement, contributed to the uptake of services. Although gender issues were mentioned in the NMNAP, these were not adequately addressed. Among issues noted are lack of a gender-responsive budgeting lens on nutrition-related interventions; lack of disaggregated financial data to show the extent of the benefit of the allocated and disbursed funds towards women, men, youth and children; and lack of gender analysis to identify gaps and needs on nutrition among men, women, young people and children. Further efforts are needed to ensure more women representation in health and nutrition committees at different committee and leadership positions, among others. Involvement of men in nutrition interventions should be highly encouraged.

A specific gender review of the NMNAP was conducted. It identified the same need to incorporate gender considerations at all levels and recognized such efforts as an opportunity to improve effectiveness and nutritional impact. Gender considerations should be included to enhance the impact on both women and men, thereby improving the impact of the NMNAP and its associated programmes. The review calls for more nuanced targeting strategies in nutrition policies, programming and project activities, recognizing that there is more to gender than just gender parity or targeting women. Gender-sensitive elements in integrated/multisectoral nutrition policies, programmes and actions should be actively and continuously promoted. Multisectoral stakeholders need to collaborate to explore and successively use the way these components influence each other.

Equity

There are noted disparities among and within regions in terms of nutrition-related burden. This was strongly considered in the development of scaling-up plan, especially for MIYCAN interventions (KRA 1) which prioritized regions with high prevalence and high burden of malnutrition to be reached in Years 1 and 2 of the NMNAP, and which have been reached with large-scale stunting reduction programmes. Efforts to allocate resources based on the nutrition related burden will continue and be extended to all KRAs.

The main equity focus in the NMNAP was through the synergy between nutrition programme and PSSN, where the beneficiaries of cash transfers that were reached through TASAF were shared with nutrition officers and programme managers implementing large-scale nutrition programmes. This allowed such nutrition programmes to systematically target the most vulnerable households, where malnutrition is notably more prevalent.

In the NMNAP, data is not consistently disaggregated to capture information in various segments of the population, e.g., rural/urban, high/low socioeconomic status, age or sex. There is one indicator focusing on food-insecure regions under KRA 3 (IMAM).

It has been further noted that the nutritional needs of school-age children, adolescents and other vulnerable groups are not adequately prioritized.

Sustainability

Implementation of most of the nutrition-specific interventions is still highly donor-dependent. The government is making efforts to increase funds for nutrition. LGAs set aside funds for implementation of nutrition interventions, mostly from their own source, which is highly unreliable. In the NMNAP, the government is expected to contribute to 30 per cent of the total budget (excluding nutrition-sensitive interventions). However, financial analysis of expenditure shows that the government contributed to about only 3 per cent of total expenditure tracked within the NMNAP during the MTR period.

The utilization of community structures and involvement of communities in nutrition activities ensures sustainability of these programmes. In addition, implementing partners are working using the existing government systems, which is promotes sustainability.

Significant progress was made in increasing ownership, commitment and accountability of regional and district commissioners to nutrition and specifically to NMNAP implementation, mainly through the development and regular assessment of the Nutrition Compact. This still needs to translate into financial commitment, but the foundations were placed. It is likely that the next period of NMNAP implementation will witness an increase in expenditure.

Resources mobilization

NMNAP expenditure was only 43 per cent of the planned budget for the first two and half years, and about 97 per cent of the funds (excluding nutrition-sensitive interventions) came from DPs. The NMNAP states that 30 per cent of the budget (excluding nutrition-sensitive interventions) shall be mobilized by the government, 60 per cent by DPs and 10 per cent by the private sector. However, a specific resource mobilization strategy was not fully developed as it was planned in the NMNAP and the TWGs in charge of resources mobilization were not established.

Government contribution was about 3 per cent of the total expenditure at MTR. The government had started several initiatives to mobilize resources for nutrition both inside and outside the country. Nutrition was mainstreamed in the national budget guideline, and specific guidelines were issued by MoFP to councils to ensure a minimum budget of TSh 500 per child, which later increased to TSh 1,000 per child using domestic resources. The government also contributed to bear the full costs of human resources, offices and other logistics needs for the implementation of the NMNAP. Other efforts around resource mobilization by the government were made through the engagement of several DPs nationally and abroad, which in turn contributed to the increase of investments in nutrition.

DPs contributed to a large share of expenditure for NMNAP implementation, which was driven by evidence from the NNS 2014. The contribution targeted regions with the highest rates and burden of malnutrition. However, the funds mobilized were less than 50 per cent of the planned budget.

The contribution of the private sector was difficult to evaluate as there were no mechanisms in place to track its contribution to nutrition. However, the

SUN Business Network invests and contributes to nutrition activities. The main food-producing industries ensures food fortification, and other relevant programmes (such as the sale of micronutrients powders by SOLEO) are in place.

In the second phase of the NMNAP, it will be important to develop a specific resources mobilization strategy that clearly outlines the expected contributions of government, DPs and private sector to the different KRAs of the NMNAP.

6 Monitoring, evaluation and learning

NMNAP is complex in nature and requires a robust monitoring and evaluation (M&E) system to track progress towards planned results. During review of the NMNAP, good progress has been made in tracking, which includes development of data collection tools and systems.

Routine data system and tools

Since 2016, an MNIS has been under development to address the persistent challenge of nutrition related data collection. It is an online-based system that extracts nutrition-relevant data from different existing routine information systems. Functions for data analysis and visualization for BNA, scorecard and Nutrition Compact are included within the system. MNIS is expected to be positioned as a mother system for nutrition, which enables a simplified data collection process for nutrition programming and to track progress on a routine basis without making exhausting effort for data collection from multiple information systems. Linking MNIS with different information systems will help reduce the effort and time taken for data collection, data analysis and visualization, and allow nutrition officers to spend more time on data interpretation and reflection for better prioritization and programming.

Progress reviews tools and platforms

Reviews are done using JMNRs, which bring together stakeholders to review progress using the data collected through the M&E systems. CRRAF has been used as a tool to track progress against indicators and is updated annually, based on the available data.

Surveys and studies

Periodic surveys are planned to assess progress towards achievement of the impact-level indicators. During the review period, one survey (TNNS) was conducted and used to assess progress towards the impact of NMNAP at midterm. An NMNAP gender study was conducted in 2018 and used to assess the extent to which gender mainstreaming was taken into consideration during implementation of the NMNAP. The results will be used to further incorporate gender in the implementation of NMNAP II.

Challenges related to monitoring, evaluation and learning (MEAL)

Despite progress made so far, there are still areas that require improvement. According to

JMNR results, challenges related to MEAL were identified and can be categorized as follows:

Indicator design

The review has found weaknesses in some of the output indicators that were pitched at the outcome level, thus making it difficult to track progress on an annual basis. During the review, some indicators were modified, and the routine system data sources were used to assess progress. As some indicators measured more than one variable, it was difficult to measure progress. Reported progress may also not accurately represent the result due to the different methodologies.

Data collection systems, tools and capacities

The field assessment found multiple data collection tools at LGA and community levels. In some instances, there were no data collection tools, especially at the community level. As a result, progress made at the community level may not be adequately captured. It was noted that there were varying levels of understanding of the indicators among those who compile data. This calls for clear definition of the indicators and capacity building of those who collect information for nutrition-specific routine data. It was also found that some nutrition officers could not access DHIS 2 and some were not trained on how to use.

Data from nutrition-sensitive sectors need to be standardized within their systems so that the same source is used. This will help to avoid inconsistencies. Data quality mechanisms are required to ensure high quality of data collected. Emphasis on data utilization at all levels is a priority. Stakeholders M&E TWG must be formed with clear ToR to address M&E related issues during phase II implementation. The group will, among other things, discuss data quality issues. Sector M&E experts will help the sector nutrition focal person to access nutrition-related data for NMNAP.

7 Lessons learned and conclusions for each KRA

Key lessons learned were discussed during the consultative process of the MTR, including during the field visits. They are outlined in the subsequent sections for the various KRAs.

KRA 1: Scaling up maternal, infant, young child and adolescent nutrition

Community-based programmes implemented at large scale with support from partners contributed to increased coverage of MIYCAN services at both community and facility levels. The success of these programmes was partly contributed by community involvement and participation during the planning and implementation phases. Field assessments indicated that full involvement of the community in implementation of school-feeding programmes in Njombe and Mwanza regions led to their successful sustenance. The use of media in delivering nutrition education is cost-effective and ensures that many people are reached within a short time. Use of radio to broadcast nutrition education messages have brought improvements in nutrition indicators (in Katavi, Lindi, Tanga), and the use of cultural dances has had similar impact in Njombe.

The use of male CHWs has also facilitated in raising awareness and motivated male participation in MIYCAN services, specifically in Lindi and Tanga. CHWs helped to bridge the gap between health facilities and the community. They also carried out nutrition activities in the community, following up with children and women with nutritional needs and providing nutrition education (in Tanga, Lindi and Mwanza). The 'M' and the 'A' aspects in MIYCAN are overlooked. Few services focused on adolescents and there were few indicators to track maternal nutrition.

KRA 2: Scaling up prevention and management of micronutrient deficiencies

Under this KRA, emphasis is given to fortification and supplementation. More needs to be done to promote consumption of nutritious and diversified diets. The best platform to reach out to adolescent girls and boys is school, while organized groups can be formed for those who are out of school. Through schools or organized groups, adolescents can access nutrition education, micronutrient supplementation services and deworming. They can also learn best practices to improve nutrition such as WASH, gardening and cooking.

Successful implementation of adolescent programmes needs multisectoral collaboration and adolescent engagement and participation. For example, in Tanga region, schools have been used as an avenue for a multisectoral approach to enhance adolescents' health. This includes the involvement of staff from health sectors to provide education on reproductive health, WASH and menstrual hygiene. Schools are also working closely with agriculture extension workers to provide education about crop and livestock production. It was noted that PPP facilitates the scale-up of micronutrient interventions (universal salt iodization [USI] and MNP), whereas collaborative efforts between different partners and councils ensure the availability of supplies and facilitate the implementation of nutrition interventions

KRA 3: Scaling up integrated management of acute malnutrition

Management of IMAM supplies outside the national supply chain system is weak and non-sustainable. IMAM supplies are highly donor-dependent, which affects management of children with both MAM and SAM. Scaling-up of IMAM did not happen as planned, which resulted in the reduction of acute malnutrition in only a few districts with IMAM coverage. The IMAM programme did not receive the expected funding, leading to low coverage of IMAM. CHNM is a good platform for identification of children affected by acute malnutrition. However, in areas where IMAM services were not available (including F-75, F-100 and RUTF supplies), there were challenges in following-up cases of SAM/MAM.

KRA 4: Scaling up prevention and management of diets related noncommunicable diseases

Progress on NMNAP CRRAF indicators could not be tracked through routine data because these were survey-based indicators that were collected after every 4–5years. Engagement of political leaders is key in awareness creation. NCDs have recently received attention and the Prime Minister has emphasized the allocation of a specific day for physical activities in the country (in 2019). This shows that political commitment is crucial in increasing coverage and raising awareness, as witnessed by the increased numbers of different population groups participating in physical activities.

KRA 5: Scaling up multisectoral nutrition-sensitive interventions

The main lessons learned here were in the areas of education and WASH. In the education sector, school-feeding programmes improved attendance as children were more likely to attend school to access nutritious food. Linking the school-feeding programme with wider food security systems is therefore an important approach to achieve better nutrition and education outcomes. Coupled with an enabling environment in the education sector, allocation of more resources and removal of school fees (Fee-Free Policy for pre-primary and lower secondary education) along with an inclusive education policy are all geared towards addressing nutrition in school settings.

Regarding the WASH sector, involvement of regional and district commissioners in both nutrition and WASH campaigns at the subnational level is bearing fruit. District and RCs are engaged in sensitization on sanitation and hygiene as part of the behaviour change campaign "Usichukulie Poa Nyumbani Choo", which translates as "don't consider households toilets as unimportant".

KRA 6: Strengthen multisectoral nutrition governance

Political commitment is key to achieving better nutrition outcomes. During the review of the NMNAP, it was found that more than ever before, there is an increase in political commitment, including endorsement of the NMNAP by high-level government leaders at the ministerial level (ministries and permanent secretaries); nutrition coordination by the PMO, SUN Focal Point. The Parliamentarian Group on nutrition advocated for increased budget allocations. Nutrition activities are now progressively prioritized. The Nutrition Compact was signed by RCs, DCs and community-level leaders; nutrition objective was included in the PLANREP (the Local Government Planning and Reporting Database); budget has been increased at the LGA level; and nutrition is being prioritized in the budget guidelines. However, mere allocation of funds does not necessarily mean that spending is guaranteed. While political commitment is greatly felt, translation into practical action is required. Documented experiences suggest that with political will and the right mix of policies and adequate resources, it is feasible to make dramatic improvements in maternal and child nutrition.

KRA 7: Establishing a multisectoral nutrition information system (MNIS)

Introduction of tracking tools such as scorecards, BNA and Nutrition Compact not only increases data use and accountability but also raises awareness on the nutrition agenda. RCs and DCs are holding LGAs accountable to prioritize nutrition interventions on the identified bottlenecks. JMNRs are chaired by the Prime Minister and provide avenues for learning and improve nutrition interventions. They have been an instrumental platform to learn what works and what does not, using the evidence generated.

8 Conclusions

Overall, the MTR revealed good progress in most of the NMNAP indicators including, stunting and wasting. Some of the progress made is on track to achieve both national and global targets at national aggregated targets. However, the evidence generated has shown clear disparities between and within regions as well as between urban and rural locations, which call for more targeted interventions. Progress on the nutrition situation of adolescents and school-age children are not tracked as evidenced by the lack of indicators tracking their progress. Conclusions per KRA are outlined in the table on recommendations in the subsequent chapter.

Nutrition-specific interventions (KRAs 1–4)

Increased coverage of IYCN services (promotional/preventive services) led to the improvement of IYCN practices, which in turn contributed to stunting reduction. Integration of nutrition components (IYCN, ECD, WASH, health, cash tra`nsfer and child protection services) and large-scale stunting reduction programmes helped to achieve greater impact in stunting reduction. Trained CHWs have been instrumental in delivering messages at the community level, which is key for behaviour change towards nutrition practices. Although stunting is reported to be reducing in proportion, the numbers are increasing. Thus, there are more stunted children now than they were in the previous years. This means that the burden has increased despite the reduction in proportion. Tanzania is implementing the global guideline to address micronutrient deficiencies by combining promotion, fortification and supplementation. Availability and accessibility of micronutrients has improved. Coverage of VAS, IFA and salt iodization has improved during the NMNAP implementation. However, challenges still exist in compliance and utilization of IFA among pregnant women and consumption of adequately iodized salt among households. Also, the component of promotion of consumption of rich and diversified diets has not been prioritized despite the adoption of the global guideline to address micronutrient deficiencies. Scaling-up of IMAM was not conducted as planned by NMNAP, which led to the low performance of this KRA. Its low achievement has been attributed to the lack of infrastructure such as rehabilitation units, stock-out of nutrition commodities and lack of skills among health workers in managing MAM and SAM. Effective IMAM interventions would lead to reduction of infant and child mortality. Similarly, overweight, obesity, hypertension and diabetics were on the rise during the MTR. Prevalence of overweight among women has increased. According to the new UNICEF and WHO threshold

(2019), having a prevalence of above 30 per cent is classified as "high burden". Hence, there is an urgent need to prioritize interventions to prevent DRNCDs. Generally, interventions and indicators targeting maternal, school-age children and adolescent nutrition were overlooked in the NMNAP. Greater achievement on nutrition would be realized if they are systematically addressed.

Nutrition-sensitive interventions (KRA 5)

Key nutrition-sensitive sectors have also contributed much in providing an enabling environment for delivery of nutrition services, e.g., CDOs have assisted in identifying poor households in PSSN and linking them to nutrition services if they have a child below five years. It is crucial to ensure increased production of food varieties and accessibility for local consumption of diversified food. At the MTR, these were reported to have increased since the implementation of the NMNAP. However, indicators for tracking consumption of these foods are lacking, which leads to information gaps. As it is known, increase in production does not necessarily mean increase in consumption. More efforts are needed to ensure increased consumption of diversified diets. The government has increased efforts in the education sector to remove barriers for children to access education through investment and creation of an enabling environment (i.e., mandatory education and fee-free policies). Various efforts such as girls' hostels and school-feeding programmes have increased both enrolment and retention. Schools are good platforms for disseminating nutrition messages, and linkages to the food systems will have greater impact. Community engagement in school-feeding programmes creates a sustainable environment for ensuring food availability throughout the school year. Availability and decentralization of health services to the village level and trained CHWs have also increased. Free ANC services has increased service uptake among pregnant women and WRA. Although nutrition education and counselling is offered in ANC clinics, there is a need to improve quality of ANC services by systematically including nutrition education and counselling. The WASH infrastructure has improved, and behaviour change is taking shape due to availability and intensity of the SBBC interventions, which focused on availability of toilets in each household. Other domains of WASH, such as ensuring clean environment especially around children's play area, should be strengthened.

Enabling environment for nutrition (KRAs 6 and 7)

The NMNAP budget execution at midterm is 41 per cent of the overall budget. There is a large gap between the planned budget and actual expenditure, as over half of the targeted investment was not released. The NMNAP established that 30 per cent of the budget shall be mobilized by the government, 60 per cent by external donors and 10 per cent by the private sector. However, the government only mobilized 3 per cent of the budget and nutrition interventions remain heavily dependent on donor funding. Donors were able to mobilize only 50 per cent of their share of NMNAP budget. Overreliance on donors' funds, which are inconsistent in terms of both quantity and timing, introduces a large degree of uncertainty in implementing nutrition activities. Contributions from the private sector could not be tracked. Virtually all councils adhere to allocations of minimum budgets for nutrition. However, the main bottleneck is currently funds disbursement and spending on nutrition. Recent developments have shown that the Nutrition Compact is a powerful tool to track and improve disbursement of funds for nutrition. Although government investment on nutrition is increasing, most of the nutrition budget is still contributed by DPs. The multisectoral approach in nutrition coordination has created a strong

foundation to fight malnutrition in the country. Hence, there has been visible progress. Despite the improvement in human resource over the three years of NMNAP implementation, both regional and district nutritionists reported the need for capacity development. The NMNAP coordination structure is functioning at region and district levels. Meetings are held and almost all sectors virtually participate and plan for nutrition activities. However, ensuring continuity and follow-up of matters that arise in these meetings remains a challenge. Availability of nutrition focal points in every sensitive ministry should ensure that nutrition indicators and matters are integrated in sectoral plans. The overarching NMNAP strategy of CCCD has been instrumental in ensuring access to nutrition-related interventions through involvement of key actors in the community, such as CHWs, CDOs and other stakeholders, in delivering services. Good progress has been made in MNIS at MTR. The nutrition information system generates regular and reliable data and information, which is systematically used to inform decision-making, i.e., through planning and budgeting processes as well as regular reviews. However, lack of unified data collection systems lead to parallel data collection systems. Therefore, a unified routine data-collection system integrated with other sector systems is necessary to improve data availability, quality and use for planning and decision-making.

9 Recommendations

KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
MIYCAN	There is significant increase in coverage of IYCN services, especially in regions supported by partners through large-scale stunting reduction programmes (about half the country). Regional variations exist. Children aged 0–5 months who were exclusively breastfed increased from 41 per cent (TNNS 2014) to 58 per cent (TNNS 2018). Children aged 6–23 months who received a MAD increased from 20 per cent TNNS 2014) to 30 per cent (TNNS 2018). Government expenditure in MIYCAN is almost 0 per cent as most of the budget is covered by DPs.	Increased coverage of IYCN services (promotional / preventive services) led to improvement in IYCN practices, which in turn contributed to reduction of stunting. Funding of MIYCAN is highly dependent on partners' funding and is not sustainable. There is a risk that coverage will decrease at the end of the programmes.	**Policy level:** • Increase investment in promotion of MIYCAN especially at the community level, including in those regions where partners' programmes are about to end, to maintain high coverage of MIYCAN services. **Technical level:** • Start implementation of MIYCAN services in those regions where there is no or low coverage	MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21
	As per the MIYCAN package defined in the NMNAP, MIYCN services are often integrated with other components, i.e., IYCN, ECD, WASH, health, cash transfer and child protection services. Trained CHWs, supported with monthly incentives, were able to learn and deliver the overall MIYCAN package and were instrumental in delivering regular promotional nutrition services.	Large-scale stunting reduction programmes integrate all key components (IYCN, ECD, WASH, health, cash transfer and child protection services). As IYCN services are mainly delivered at community level, CHWs were key in delivering nutrition messages with enough intensity to improve nutrition practices.	**Policy level:** • Issue a standard, comprehensive package of services to be delivered by CHWs, and support CHWs with adequate training, incentives and supervision. **Technical level:** • Use stunting reduction programmes (delivering MIYCAN services) as entry points to deliver more comprehensive ECD services.	MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
	It is not well known whether or not the nutritional status of middle-age children, adolescents, women and mothers is progressing. It is likely that adolescent and maternal undernutrition and micronutrient deficiencies are among the main causes of high maternal mortality rates in Tanzania. There are few indicators in the CRRAF to measure progress in nutrition among middle-age children, adolescents, women and mothers and data are mostly unavailable.	The 'M' and the 'A' in MIYCAN are overlooked. The services focus mostly on children, and address nutrition among women and mothers mainly as a function of increasing health and nutrition of their children.	**Policy level:** • Include adolescent and maternal nutrition among key national priorities, together with child nutrition, both in terms of programming and investment. **Technical level:** • Develop a renewed approach to maternal nutrition, including all the key components of diet promotion, food fortificants and micronutrients supplementation. • Scale up nutrition interventions targeting school-age children and adolescents as per the NAIA (promotion of healthy lifestyle, increased access to fortified food, micronutrient supplementation, physical activities) using all available platforms (communities, schools, health services, mass media). • Review and adopt new indicators specific to maternal and adolescent nutrition in the CRRAF as well as in the upcoming MNIS to be collected at community and facility level.	MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
MNs	**Anaemia** Reduction of anaemia among WRA from 44 per cent (2016) to 28 per cent (2018) surpassed both midterm (40 per cent) and endline targets (33 per cent). No new data on anaemia among children, which was at 58 per cent in 2015/16. The determinants of such reduction are not clear. As described above, MIYCAN programmes do not target adolescent girls and women with nutrition promotion. Increased coverage was observed in supplementation programmes (IFA) among pregnant women from 8 per cent (2014) to 29 per cent (2018) surpassed the midterm target. Other supplementation (MNPs for children, WIFAS for adolescents) exists but has very low coverage. Fortification programmes (fortification of wheat and maize flour) exist but are not well coordinated or tracked, so it is difficult to understand coverage.	Improvements in prevalence of anaemia among women shall be taken cautiously, as the methodology used in DHS 2015/15 (baseline) and TNNS 2018 (midterm) are not comparable. Anaemia is still a priority problem in Tanzania, for both maternal and child nutrition. Nutrition education / promotion programmes are mainly for children and not for women. Promotion, fortification and supplementation programmes are not implemented in synergy as they should be. There is little coordination and some missed opportunities.	**Policy level (repeated as above):** • Issue adequate policies and guidelines to ensure that children, adolescents and women benefit from nutrition education (i.e., on consumption of adequate locally available foods), food fortification and micronutrient supplementation. **Technical level:** • Strengthen the monitoring and surveillance system of the national fortification programme for mandatory foods (salt, maize flour, wheat flour and cooking oil) and for the MNP supplementation programme. • Review the challenges on compliance with Iron Folic Acid (IFA)during pregnancy to improve antenatal micronutrients supplementation.	MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
	Vitamin A VAS is mainly delivered as a campaign during CHNMs. CHNM campaign data show that VAS coverage continues increasing. However, there is a discrepancy with survey data, which show a significantly lower coverage of VAS compared to routine. CHNM mainly focus on VAS, while the nutrition promotion component and the MUAC screening component are not sufficiently prioritized	There is a missed opportunity in the delivery of CHNMs. They ensure high coverage, but nutrition promotion is neglected. There is a strong appetite in Tanzania (MoHCDGEC) to move from VAS campaign mode to routine mode to reduce costs and ensure sustainability and integration of this intervention within the health system.	**Technical level:** • Increase the component of nutrition promotion during CHNM: define and implement an adequate approach. • Accelerate ongoing efforts to move from CHNM campaign to routine vitamin A supplementation (and nutrition education), starting with children 6–11 months who are better covered by health services.	MoHCDGEC, TFNC	2019/20 to 2020/21
	Iodine Universal Salt Iodization programme is progressing, but targets in terms of adequate salt iodization were not met. To ensure quality (and thus adequate salt iodization) the country is moving to a consolidation approach, which implies industrialization of the salt producing sector. Legislation / taxation is favourable to this new approach as it supports new national business (i.e., with reduced taxes).	Not all results are on track, but the national strategy is adequate Strong partnership with private sector is key, but it is not always visible. The SUN Business Network does not always play its part.	**Technical level:** • Increase the dialogue and engagement with the private sector through the SUN Business Network to support professionalization of the salt producing sector.	SUN Business Network, MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21
	Data No data on vitamin A deficiencies iron deficiencies and iodine deficiencies among children under five years and women were collected since 2010.	Government and other stakeholders would benefit from additional evidence to improve nutrition interventions aimed at reducing micronutrient deficiencies among women and children.	**Policy level:** • Implement a micronutrients survey during TDHS 2020 to raise additional evidence on the burden of micronutrient deficiencies among children and women in Tanzania.	TFNC, NBS	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
IMAM	At midterm integrated management of both MAM and SAM is very low. Management of MAM is only 8 per cent, while that of SAM is 13 per cent. The target for both SAM and MAM was 35 per cent each at midterm. There was increased coverage in screening of MAM from 19 per cent (2015) to 99 per cent (2018). The main bottleneck identified is the low prioritization of IMAM by both GoT and DPs, especially in terms of funding. The main cost of IMAM is for commodities.	Coverage of IMAM is very low. The targets are highly delayed at midterm and far from reaching the endline target of 75 per cent. IMAM scale up plan is not being implemented as planned due to a lack of funding. IMAM is not being scaled up through the health system due to lack of prioritization by MoHCDGEC. Children with SAM are at high risk of dying. It is likely that they are among the main contributors to the persisting high rates of infant and child mortality in Tanzania.	**Policy level:** • Existing funding mechanisms such as the HBF and the World Bank Global Financing Facility (GFF) should be used to fund services and supplies for life-saving treatment of children with SAM, especially through DHFF. **Technical level** • Integrate IMAM training in pre-service training curricula of health care providers especially nurses. • Integrate IMAM in IMCI. • Review IMAM guideline to allow management of complicated SAM/MAM in lower level health facilities and include feedback mechanisms. • Integrate IMAM commodities into the national supply chain system and capacitate LGAs and health facilities to conduct forecasting, quantification, budgeting and planning on IMAM commodities. • Train more health care providers on SAM and MAM treatment (prioritize regions that have not received such capacity-building: Katavi, Rukwa, Tabora and Manyara).	MoHCDGEC, TFNC, PO–RALG, LGAs, RS, World Bank, Academic institutions	2019–June 2021

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
DRNCD	Overweight and obesity are among the main determinants of DRNCDs which represent a huge burden for the Government in terms of cost of treatment and loss of human capital. Overweight and obesity among women are the only forms of malnutrition which are increasing in Tanzania. Over 32 per cent of women 15–49 years in Tanzania are overweight / obese. In 2018, they matched the prevalence of childhood stunting (which is also 32 per cent). However, while childhood stunting is progressively decreasing, overweight and obesity among women is rapidly increasing. No data was available during the MTR to track progress of the DRNCD programme. This is because the STEP Survey was planned as the only source of data, but it was delayed (taking place in 2019/20).	Tanzania is strongly affected by the triple burden of malnutrition, as childhood stunting; anaemia among children and women; and overweight and obesity among adults are all above 30 per cent and therefore classified as 'high burden' according to the new (2019) UNICEF and WHO threshold. It is not clear if a national programme to prevent DRNCDs exists and who is in charge. There is an urgent need to prioritize interventions to prevent DRNCDs.	**Policy level:** • Initiate a national programme to prevent DRNCDs under the MoHCDGEC / Department of Preventive Services. **Technical level:** • Develop and scale up intervention to promote healthy lifestyle (healthy diet, physical activity, medical checks) among adult women and men. • Improve national legislation and control over unhealthy foods, alcohol and tobacco. • Include proxy- indicators to monitor coverage of interventions to reduce DRNCDs.	MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21
Agriculture	In the National Agriculture Policy emphasis is on producing for export and there are Few references related to child nutrition / complementary feeding. There is limited promotion of homestead production of nutritious foods, which is essential to addressing child undernutrition among resource-constrained households. No data was available on dietary diversity at household level. Low dietary diversity in the country was reported in various regions which produce a limited number of crops.	Policy environment is not favourable to nutrition-sensitive agriculture: NMNAP and ASDP 'do not speak to each other'. Limited production of adequate varieties of foods for local consumption affects availability, affordability and access to diversified food.	**Policy level:** • Establish a Task Team comprising members from MOA, MOLF, MoHCDGEC to develop a road map towards nutrition-sensitive agriculture and improved intersectoral coordination. • Review agriculture policies and programmes to increase focus on production of diversified food, establishing synergies with health and nutrition programmes which promote dietary diversity.	PMO, MOA, MOLF, MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
	The most affordable sources of nutrients and energy to address deficiencies are dark green leafy vegetables, dried beans, peas, lentils, beef liver, small dried fish, orange/yellow-fleshed vegetables, chicken liver, beef, eggs and milk. However, only 10-40 per cent of the population can afford these foods (source: Complementary feeding landscape analysis in Tanzania, 2019). Livestock increased in some regions due to either migration of the community or improvement in the breeds TARI. However, affordability of animal-source food remains an issue. Animal-source foods supply chain (i.e. poultry, eggs) is largely informal and has issues such as high consumer prices, production risks (low yields, high cost of inputs and lack of capital), food safety (from food production to distribution and retail), poor processing, storage and transportation infrastructure. Many children 6–23 months of age do not consume enough iron, vitamin A, calcium or animal-source protein. Animal-source protein, iron, and calcium are known dietary complementary feeding gaps that cannot be affordably met by most households (source: Complementary feeding landscape analysis in Tanzania, 2019).	Increased livestock potentially brings animal-source foods to the communities and increases income, which enables households to access health care, education and food diversification. Improvement in animal breeds leads to more production in quantity and quality of animal-source foods. Availability of extension services close to the communities supports good practices in animal rearing. Eggs, poultry, dairy and freshwater fish are dominated by the informal sector. Domestic production has low productivity due to poor access to inputs, their high costs, biosecurity risks and lack of capital. Poor infrastructure and food safety risks are common across many supply chains.	**Technical level:** • Promote horticultural corps that will contribute to improving production/ availability of micronutrient rich foods to alleviate deficiencies. • Focus SBCC programmes on the promotion of foods representing the most affordable sources of required nutrients. • Promote safe food processing that will ensure preservation of food nutritional value, extend the availability of diverse seasonal foods, reduce food losses and improve food for sustainable food and nutritional security. • Prioritize adequate animal rearing avoiding faecal contamination and use animals as food source or income source. • Strengthen research and development on biofortified crop varieties that can improve micronutrient status of the people of Tanzania. • Integrate nutrition in pre- and in-service curricula for agronomists and agriculture extension officers. • Monitor the potential consequences of women's workload in agriculture that affects childcare practices.		

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
Health	Good progress was found to be made in most health-related indicators during the MTR, especially malaria and HIV. However, progress in coverage and effectiveness of family planning services is delayed. Existing enabling environment such as free maternal and child health ensures access to the uptake of ANC services. Increased male involvement is observed which has contributed to the service uptake. However, nutrition education is not systematically provided during ANC and PNC services. Teenage pregnancies are still unacceptably high and have serious consequences on intergenerational malnutrition.	There is increased availability and decentralization of health services at the village level with the availability of trained HCWs. Free ANC services are also provided. However, there is a need to improve quality of ANC services by systematically including nutrition counselling. There is also a need to increase programmes to prevent teenage pregnancies.	**Technical level:** Strengthen the child, adolescent and maternal nutrition package delivered through the health system at facility (ANC / PNC) and community levels (through CHWs).	MoHCDGEC, TFNC, PO–RALG, LGAs	2019/20 to 2020/21
WASH	Slight progress on WASH indicators has been observed. Progress towards some key hygiene indicators related to behaviours – such as handwashing with soap – is highly delayed. Other indicators related to water (such as rural population with access to piped or protected water) and sanitation (such as households with improved toilets) have improved slightly. There is no system to track key issues influencing nutrition, such as animal rearing – to avoid children playing in the households from coming in contact and ingesting animal faeces	Engagement of regional and district commissioners in sensitizing on sanitation and hygiene was among the main drivers of improvements in WASH. The other driver was community-level efforts through CHWs engagement in WASH. Recent evidence (Source: The WASH Benefits and SHINE trials: interpretation of WASH intervention effects on linear growth and diarrhoea, Lancet 2019) shows that quality of WASH infrastructures and intensity of SBCC are essential components for impact of WASH programmes on nutrition.	**Technical level:** • Ensure that WASH programmes for development of water and sanitation infrastructures are complemented by intense SBCC on best practices. • Ensure that the animal rearing component is systematically included in SBCC and campaigns promoting WASH. This can also provide a fertile ground for synergy with food security programmes.	MoHCDGEC, MOWI, TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
Education	The country has made great efforts to create an enabling environment for child education through investment in education (Mandatory pre-primary and primary education policy and the FFE policy has increased enrolment in per-primary, primary and lower secondary). There is increase in the number of girls' hostels, WASH facilities in schools, school feeding programmes, teenage pregnancy interventions and health clubs in schools. Many schools have started school kitchen gardens for their own consumptions and for sale to the surrounding communities. However, targets on girls' secondary education and pre-primary education are slightly delayed.	Enabling environment (i.e., mandatory education and fee free policies) removes barriers for children to access education. School feeding programmes increase attendance. Schools are good platforms for passing nutrition messages and linkages to the food systems will have greater impact. Addressing nutrition in school settings may be cost-effective and could multiply the impact to communities and households.	**Technical level:** • Scale up the National School Health Programme in all pre-primary, primary and secondary schools. • Ensure that the National School Health Programme systematically includes promotion of healthy diets, promotion of physical activity, synergies with food system (i.e., through school gardening and / or school feeding programmes) and micronutrients supplementation (i.e., WIFAS) as relevant.	MOEST, MoHCDGEC, TFNC, PO–RALG, LGAs	2019/20 to 2020/21
Social protection	The social protection programme supports the most vulnerable households in Tanzania through a variety of interventions, including health insurance and PSSN programme. PSSN through TASAF is on track for meeting its targets in terms of cash transfer and public work programmes. An Equity Nexus was created within the PSSN by linking cash transfer beneficiaries with beneficiaries of large-scale stunting reduction programmes, who systematically receive nutrition education where these programmes exist.	Social interventions address inequalities by reaching the most vulnerable households for economic empowerment. Linkages with existing nutrition programmes were established to ensure that nutrition programmes reach the most vulnerable households, where malnutrition is more prevalent, and thus have the potential to accelerate nutrition improvements.	**Policy level:** • Scale up the synergy between social protection programmes (PSSN) and large-scale nutrition programmes to ensure systematic reach of vulnerable households in nutrition programmes.	TASAF, MoHCDGEC, TFNC, PO–RALG, LGAs	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
Environment	FSR has improved significantly in recent years. Good performance has led to the FSR standing at 2.8 per cent surpassing the target of 5 per cent. However, variations among and within regions still exist especially for regions vulnerable to climate change. National food security bulletins are regularly issued, showing the regions and areas of vulnerability in relation to crop conditions, rain fall, food prices and eventual shocks. The SMART agriculture initiative exists in some regions. Crop insurance initiative is being launched to insure farmers who may be negatively affected by climate shocks.	Protecting the environment improves food security. Regions vulnerable to climate change are more exposed to food insecurity and have fewer variety of food produced. Monitoring the situation of food security and vulnerability at household level is necessary especially in those regions with high food insecurity and which are vulnerable to climate change.	**Technical level:** • Protect natural resources to ensure availability of locally available vegetables and crops that can be used to improve family diets especially in rural settings. • Develop plans in most vulnerable regions to strengthen communities' resilience to shocks and for disaster preparedness.	VPO, MOA, MOLF, MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21
Gender	Economic empowerment among women through council set funds is improving although at a slow pace reaching only 44,210 by MTR. Male involvement, especially in childcare, is still minimal.	Addressing gender inequalities including women's empowerment and male involvement will have high impact on improving nutrition. Gender stereotypes arise during childhood and teenage and should be addressed during those critical periods Evidence from other programmes such as ANC has shown that male involvement increases service uptake.	**Technical level:** • Scale up interventions to improve women's economic empowerment (i.e., through economic activities). • Include a gender component in all programmes targeting school-age children and adolescents, to address gender stereotypes and promote gender equality. • Mainstream male involvement in caregiving in all nutrition programmes, having men as primary targets of SBCC interventions.	MOITI, MoHCDGEC, TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
Governance	Guidance on minimum budget allocations for nutrition has been effective and is well known by decision makers at all levels. However, minimum budget allocations are still low at TSh 1,000 per child under five years of age and are not increasing as per the plan, to gradually reach the equivalent of the USD 8 per child per year recommended by the World Bank to meet the WHA nutrition objectives When allocations are made by the councils, funds are not disbursed and thus nutrition activities are not implemented.	Virtually all councils adhere to allocation of minimum budgets for nutrition. However, the main bottleneck is currently fund disbursement. The Nutrition Compact is a powerful tool to track and improve disbursement of funds for nutrition.	**Policy recommendation:** • Increase the minimum budget allocations for nutrition to at least TSh 2,500 per child under five years per council. **Technical level:** • Continue tracking investment in nutrition using domestic resources to hold decision makers at all levels accountable for annual minimum budget expenditure	PO–RALG, MOFP, LGAs	2019/20 to 2020/21
	Only 53 per cent of councils have professional nutrition officers. The capacities of existing nutrition officers to manage nutrition programmes have increased, as they have been continuously oriented on evidence-based planning, budgeting, monitoring and reporting on nutrition. Almost 100 per cent of councils produce plans, budgets and reports (i.e. BNA, AWP review, Compact) based on evidence.	Nutrition officers are key to scaling up coverage of nutrition services countrywide. PO–RALG and TFNC played a key role in strengthening the capacities of nutrition officers. There are still significant gaps in terms of recruitment and capacities of nutrition officers. Many nutrition officers still see their role in terms of service delivery instead of programme management.	**Policy level:** • Increase deployment of nutrition officers in 100 per cent of LGAs and regions. **Technical level:** • Implement in-service training initiatives to improve capacities of nutrition officers and focal points in MDAs and LGAs on management of multisectoral nutrition programmes.	TFNC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
	At subnational level, the proportion of councils holding Multisectoral Steering Committees on Nutrition has continuously increased and is on track. However, leadership of nutrition officers is not consistently ensured and nor is the regular participation of DEDs as chairs. At the national level, NMNAP TWGs do not meet regularly and are hence unable to execute their roles of leading and coordinating implementation of nutrition interventions under each KRA. National Multisectoral Nutrition Technical Working Group (NMNTWG) and High-Level Steering Committee on Nutrition (HLSCN) do not meet regularly and key expected participants often do not attend. There is a lack of clarity on mandates and responsibilities between key nutrition players (MoHCDGEC-NS; TFNC; PO–RALG-NS) which generate overlaps, tensions and delays in implementation of nutrition programme.	Council / regional level Multisectoral Steering Committees on Nutrition are key to implementing the NMNAP at the decentralized level, including through the Nutrition Compact. TWGs are key to pushing the nutrition agenda through their expertise. KRAs need to be overseen such that challenges will be discussed, and action taken. PS' from all line ministries are supposed to regularly attend HLSCN meetings, but this rarely happens. MoHCDGEC-NS, TFNC and PO–RALG-NS all have a key role to play which shall be coordinated by PMO.	**Policy level:** • Ensure that MoHCDGEC-NS, TFNC and PO–RALG all act based on their specific mandate, with no overlaps. **Technical level:** • Strengthen the functioning of the TWGs to adequately guide the implementation of the NMNAP in each KRA (i.e., develop AWPs for each TWG to ensure implementation of their ToRs).	TFNC, PMO	2019/20 to 2020/21
MNIS	There is a complex nutrition information system in place which can regularly generate data to track progress towards improved nutrition as well as expenditure. However, the nutrition information system is a parallel system. Various data-collection systems exist and newly developed MNIS – which is supposed to harmonize all data systems – is not yet launched. This includes financial data.	The nutrition information system in Tanzania can generate regular, reliable data, although nutrition is not a formal sector. Such data and information can be systematically used to inform decision-making, i.e., through planning and budgeting processes, as well as regular reviews.	**Technical level**: • Roll out the unified MNIS through the online platform. • Include missing indicators on MIYCAN, MNs, IMAM and DRNCDs in HMIS / DHIS2.	TFNC, MoHCDGEC, PO–RALG	2019/20 to 2020/21

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KRA	Findings	Conclusions	Recommendation	Responsibility	Time frame
	Gaps exist in routine data to monitor progress of nutrition indicators. DHIS 2 do not capture all nutrition related indicators Nutrition has been recently established as one objective in the PLANREP, which will make it very simple to generate data on budget and expenditure (i.e., no need of PER Nutrition anymore, to track budget and expenditure.)	Lack of a unified data-collection system leads to parallel data-collection systems which lead to unclear information for decision-making. Having a unified routine data-collection system integrated with other sector systems is necessary to improve data availability, quality and use for planning and decision-making.	• Continue strengthening nutrition in PLANREP to generate budget and expenditure information using the routine system instead of PER Nutrition.		
	Good progress has been made in survey implementation. TNNS – SMART survey was implemented in 2018 to track progress on nutrition outcomes and impact and used for this midterm review to inform policy and programming for nutrition. Nutrition indicators were included in surveys whenever there is a possibility, i.e., the school-based malaria and nutrition survey. Implementation of the STEP Survey as well as the CFSVA was delayed and some of the data to monitor the CRRAF could not be generated. However, this was beyond the control of the nutrition community.	Quality surveys are the source to track progress against the set target. TNNS has allowed comparison of baseline data and performance, it brings evidence on performance and shows where there are more problems on nutrition, hence allowing targeted interventions to address inequities – geographically, by age group and sex and according to the type of nutrition challenges that exist. Capacity-building of national staff ensured full ownership of TNNS-SMART.	**Technical level:** • Continue implementing SMART surveys between rounds of DHS and ensuring that key nutrition indicators are included in DHS.	TFNC, NBS, MoHCDGEC, PO–RALG	2019/20 to 2020/21

10 General recommendations for NMNAP II

Recommendation	Responsibility	Time frame
The current structure of the NMNAP is articulated around interventions (i.e., nutrition-specific, sensitive and enabling environment interventions) and sectors (i.e., the six sectors under KRA 5). This structure implies that the interventions shall be delivered in silos or compartments and poses a challenge to synergistic programming and multisectoral coordination. It is therefore recommended to structure NMNAP II around: (i) the people, specifically young children, school-age children, adolescents and adults (with a special focus on mothers); (ii) the systems, i.e., community systems, health system, food system, school system, social protection system, among others. In this way, intervention shall be implemented in synergy to reach the same person through a system approach, which strengthens government ownership and sustainability.	PMO, TFNC	December, 2020
In the NMNAP, there are no specific indicators to track nutritional status and progress of interventions for school-age children, adolescents and mothers. The NMNAP II should include specific indicators for those groups.	TFNC, PO–RALG	December, 2020
In the NMNAP 2016–2021, the costed plan was very detailed and realistic, but the contribution of the private sector was not clearly outlined, and thus could not be tracked. It is recommended that the NMNAP II clearly outlines what will be the role of the private sector in its contribution towards improving nutrition.	PMO, TFNC, SUN Business Network	December, 2020

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Annex 1 Revised NMNAP CRRAF – Progress analysis at MTR and new proposed indicators

Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
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															
Planned	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, 2015/16)			32%		28%	TDHS TNNS							
Achieved	disaggregated by gender		34.7% (TNNS, 2014)			31.8%			TNNS							
Planned	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, 2015/16)			<5%		<5%	TDHS TNNS							
Achieved	disaggregated by gender		3.8% (TNNS, 2014)			3.5%			TNNS							
Planned	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							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved	disaggregated by gender		6.9% (TDHS, 2015/16)			6.3%			TNNS							
Planned	Reduced proportion of women 15-49 years with anemia from 44.7% in 2015 to 33% in 2021	Percentage of WRA with anaemia	44.7% (TDHS, 2015/16)			40%		33%	TDHS							
Achieved	disaggregated by age (15-19)					28.8%			TNNS							
Planned	Reduced prevalence of Vitamin A deficiency (VAD) among children aged 6-59 months from 33% in 2010 to 26% in 2021	Prevalence of Vitamin A deficiency (VAD) among children aged 6-59 months	33% (TDHS, 2010)			30%		26%	TDHS							
Achieved	disaggregated by gender					NA										
Planned	Maintain median urinary iodine of WRA between 100-299 µg/L	Median urinary iodine of WRA ranging between 100 and 299µg/L	160µg/L (TDHS, 2010)			100-299 µg/L		100-299 µg/L	TDHS							
Achieved	disaggregated by age (15-19)		180.0 µg/L (TDHS 2015/16)			NA										

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	Maintain prevalence of Diabetes among adults under 10%	Prevalence of Diabetes among adults 25-69 years of age	9.1% (STEPS, 2012)			<10%		<10%	STEPS Survey							
Achieved	disaggregated by age (15-19)					NA										
Planned	Maintain prevalence of overweight among children under five under 5%	Prevalence of Overweight among children under five	3.6 (TDHS, 2015/16)			<5%		<5%	TDHSTNNS							
Achieved	disaggregated by gender		3.5% (TNNS, 2014)			2.8%			TNNS							
Planned	Maintain prevalence of overweight/ obesity among adults under 30%	Prevalence of overweight/ obesity in adults 25-69 years of age	29% (STEPS, 2012)			<30%		<30%	DHS, STEPS Survey							
Achieved	disaggregated by age (15-19)					NA										
Planned	Maintain prevalence of overweight/ obesity among women aged 15-49 years under 30%	Proportion of women in reproductive age who are overweight (BMI >/= 25)	29.7% (TNNS, 2014)			<30%		<30%	TDHS TNNS							
Achieved	disaggregated by age (15-19)					31.7%			TNNS							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
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	Percentage of children aged 0-5 months who are exclusively breastfed	41% (TNNS, 2014)			45%		50%	TDHS TNNS							
						58%										
		Percentage of children aged 6-23 months who receive a minimum acceptable diet	20% (TNNS, 2014)			25%		30%	TDHS TNNS	34.9	84.8	145.7	182	196		
						30%				24.7	52.1	71.0				
Planned	In NMNAP II	Dietary diversity among middle-age children							School-based malaria and nutrition survey							
Planned	In NMNAP II	Dietary diversity among adolescents							School-based malaria and nutrition survey							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
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, 2015/16)	17%	22%	33%	48%	65%	Annual BNA reports on nutrition	23.8	62.0	108.7	135	145	NGOs, LGAs	TFNC UN, DPs
Achieved		% mothers / caregivers of children 0-23 months who received counselling on Infant and Young Child Feeding (IYCF) from CHWs		18%	36%	36%			BNA Reports 2018/19	23.5	48.5	65.6				
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 breast-feeding from a health worker (HW) during the last fiscal year	20% (BNA, 2015/16)	21%	25%	36%	51%	65%	Annual BNA reports on nutrition	10.2	20.9	34.1	43	46	MoH/TFNC	LGAs, DPs UN

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved		% of mother/ caregivers of children 0-23 months who received counselling on IYCF from a health services provider at the health facility (Compact indicator)		NA	NA	54%			Compact Assessment report 2018/19	0.7	1.7	3.0				
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 2015/16)	10%	15%	25%	35%	50%	Media programme transimission reports and surveys	0.6	1.2	1.7	2	3	TFNC	Media Houses NGOs
Achieved				2.5%	30%	38%			IMA/ASTUTE Report 2019	0.5	1.8	2.4				
Output 1.4:	Improved MIYCAN law enforcement through advocacy and capacity building of key institutions	% of employers providing minimum requirement of maternity benefits (maternity leaves, bf breaks, bf corners at workplaces)	NA	5%	15%	25%	35%	50%	Periodical assessment reports (MoHCDGEC, ATE)	0.3	0.8	1.1	1	2	TFNC	TFDA,MoLED NGOs, ATE, UN
Achieved				NA	NA	NA			NA	0.0	0.1	0.1				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	In NMNAP II	% of middle-age children receiving nutrition counselling							Updated BNA reports / MNIS							
Planned	In NMNAP II	% of middle-age children receiving nutrition counselling							Updated BNA reports / MNIS							
Expected Outcome 2:	Children, adolescents and women of childbearing age consume adequate micronutrients	Percentage of children aged 6-59 months who received Vitamin A Supplement during the last 6 months	72% (TNNS, 2014)			80%		90%	TDHS TNNS							
			41% (TDHS 2015/16)			64%			TNNS 2018							
		Proportion of households consuming adequately iodized salt	61% (TDHS 2015/16)			70%		80%	TDHS TNNS							
						61%			TNNS 2018							
		Percentage of pregnant women taking iron and folic acid (IFA) for 90+ days during pregnancy (%)	8% (TNNS, 2014)			20%		50%	TDHS TNNS	21.9	45.3	69.7	95	120		

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
		Percentage of women 15-49 years of age with children under five years of age who took an IFA supple-mentation for 90+ days during pregnancy for past birth	21% (TDHS 2015/16)			29%			TNNS 2018	6.1	11.1	15.6				
Planned	In NMNAP II	Percentage of women 15-49 years of age with children under five years of age who took multiple micro-nutrients supple-mentation including IFA for 90+ days during pregnancy for past birth							TNNSTDHS							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	In NMNAP II	Percentage of adolescent girls (10-19 years) who consumed recommended scheme of iron & folic acid supplements							TNNS TDHS							
Output 2.1:	Increased access to food fortification (home and mass) for children aged 6-23 months, pregnant women and women of childbearing age in Tanzania by 2021	% of districts with MNP supplementation programme	10% (TFNC Annual Reports 2015)	15%	20%	25%	30%	35%	DPGN Reports Councils reports	15.9	32.2	49.1	67	85	TFNC	MOHCDGEC LGAs, MoALF, MoIT, Development Partners
Achieved		% of councils with MNP supplementation services		33%	30%	62%			SOLEO Reports	0.2	1.0	3.5				
Planned		% of flour produced in Tanzania that is fortified with iron	36% (TFNC Annual Reports 2015)	38%	40%	42%	45%	50%	TFNC Annual Reports							
Achieved				36.6%	NA	NA			NA							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Output 2.2:	Enhanced services for Vitamin A supplementation among children aged 6-59 months in Tanzania by 2021	% of children 6-59 months who have received Vitamin A supple-mentation during the previous 6 months	89% (CHNM campaign report 2015)	89%	89%	90%	90%	90%	CHNM campaign reports	3.2	6.6	10.0	13	17	TFNC	PORLAG, MOHDGEC, Development partners
Achieved				92%	93%	96%			CHNM campaign report Dec 2018	5.0	8.4	9.1				
Output 2.3:	Increased availability of adequately iodized salt in Tanzania by 2021	Percentage of households consuming iodized salt	64.2% (TNNS, 2014)			70%		85%	TDHS TNNS	1.0	2.5	4.2	6	7	TFNC	MoHCDGEC, TASPA, PO–RALG, DEVELOP-MENT PARTNER, TBS, and TFDA
Achieved			96% (TDHS 2015/16)			95%		>95%	TNNS 2018	0.4	0.8	1.1				
Output 2.4:	Improved anaemia prevention and control inter-ventions among women of childbearing age and children under 5 years old in Tanzania by 2021	% of women 15-49 years of age with children under five years of age who took an IFA supple-mentation during pregnancy for past birth	21% (BNA 2016)	10%	20%	40%	60%	75%	BNA Reports	1.8	4.1	6.4	9	11	TFNC	PO–RALG, Develop-ment Partners, Private Partners, MoALF, MoEVET, MOHCGEC

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved				27%	45%	50%			BNA Reports	0.5	0.9	1.8				
Planned	In NMNAP II	Proportion of women 15-49 who took multiple micro-nutrients supple-mentation including IFA during pregnancy for past birth							Updated BNA reports / MNIS							
Planned	In NMNAP II	Proportion of adolescents 15-19 years who took weekly iron and folic acid supple-ments (IFAS)							Updated BNA reports / MNIS							
Expected Outcome 3:	Increased coverage of integrated management of severe and moderate acute malnutrition by 2021	Percentage of children under five in need of SAM treatment who are admitted in the programme annually	9% (BNA/ SAM, 2015/16)	15%	25%	35%	60%	75%	Annual BNA reports on nutrition							
				14%	12%	13%			BNA reports 2018/19							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
		Percentage of children under five in need of MAM treatment who are admitted in the programme annually	<1% (WFP Standard Project Report, 2015)	3%	26%	35%	63%	75%	WFP Annual Reports	4.0	16.6	41.1	72	97		
				8%	8%	8%			WFP Annual Reports 2018/19	4.9	9.0	10.1				
Planned	NMNAP II	Percentage of PLHIV with acute malnutrition who received therapeutic or supple-mentary foods							DHIS2							
Output 3.1:	Improved quality of services for management of severe and moderate acute malnutrition in at least 75% of health facilities by 2021	% of health facilities providing outpatient treatment (OTP) of SAM	25% (BNA/ SAM, 2015/16)	30%	40%	50%	75%	90%	Annual BNA reports on nutrition	1.5	3.5	5.9	8	9	TFNC	MoHCDGEC (NU, RCH, PHU, TFDA, MSD), PO–RALG, TCU, MUHAS, SUA, NACTE, UNICEF, WFP, DPGN
Achieved				22%	35%	35%			BNA Reports 2018/19	0.8	1.4	1.8				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned		% of health facilities in food insecure districts providing integrated management of MAM	<5% (WFP Standard Project Report, 2015)	10%	15%	30%	40%	50%	WFP Annual Reports							
Achieved				13%	13%	21%			WFP Annual Report 2018/19							
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	% of children with SAM who are identified through screening annually	19% (BNA 2015/16)	25%	26%	35%	53%	75%	HMIS	0.1	2.5	6.6	13	20	TFNC	MoHCDGEC, PO–RALG, UNICEF, WFP, DPGN, CUAMM Doctors with Africa, Baylor College of Medicine, ACF
Achieved		% of children under five years old who were screened for malnutrition		73%	72%	99%			CHNM December 2018	0.6	1.8	2.2				
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	% of health facilities with no stock-out of RUTF lasting more than one month during last fiscal year	46%(BNA 2015/16)	50%	55%	65%	75%	90%	Annual BNA reports on nutrition	2.4	10.5	28.6	51	67	TFNC	MoHCDGEC (NU, RCH, PHU, TFDA, MSD), PO–RALG, UNICEF, WFP, DPGN, CUAMM Doctors with Africa, Baylor College of Medicine, ACF

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved				42%	48%	48%			BNA Reports 2018/19	3.2	5.1	5.2				
Output 3.4:	Strengthened integration of management of severe and moderate acute malnutrition at the national and subnational level by June 2021	% of Councils implementing at least two IMAM key activities (training, screening, supervision) annually	0% (AWP Review 2015/16)	>15%	>35%	>50%	>60%	>75%	District annual plan CCHP (Comprehensive Council Health Plan) activity report	0.0	0.0	0.1	0.12	0.15	TFNC	MoHCDGEC, PO–RALG, UNICEF, WFP, DPGN, CUAMM Doctors with Africa, Baylor College of Medicine, ACF
Achieved				16%	32%	20%			AWP Review December 2018	0.3	0.8	1.0				
Expected Outcome 4:	Communities in Tanzania are physically active and eat healthy	Percentage of people who drink acohol among adults 25-69 years of age	14% (STEP Survey 2012)			<14%		<14%	STEPS Survey							
						NA			NA							
		Prevalence of tobacco use in adults 25-69 years of age	18% (STEP Survey 2012)			<18%		<18%	STEPS Survey	1.8	20.7	42.8	61	72		
						NA			NA	1.1	2.4	5.1				
Planned		Prevalence of high blood pressure in the general population	26% (STEP Survey 2012)					<25%	STEPS Survey							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned		Prevalence of Type 2 Diabetes mellitus in the general population.	9.1% (STEP Survey 2012)					<9%	STEPS Survey							
Planned		Proportion of adults (25-64) who are physically inactive	7.5% (STEP Survey 2012)					< 7%	STEPS Survey							
Output 4.1:	At least 50% of the school-age children and adult population are sensitized on the risk factors for non-communicable diseasess by 2021	% of school-age children and adults reached with information on healthy lifestyles through mass media	5% (STEP Survey 2012)	10%	20%	30%	40%	50%	Mass media reports	0.0	17.0	37.3	54	63	TFNC	MoEVT, MoHCDGEC, Ministry of Information, Culture, Artists and Sports, TANCDA, Universities, Media
Achieved				NA	NA	NA			NA	0.6	0.7	2.9				
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	% of school-age children and adult population that are physically inactive	7.5% (STEP Survey 2012)	7.4%	7.2%	7.1%	6.9%	6.8%	Yearly reports	1.8	3.7	5.5	7	9	MoH CDGEC	Ministry of Land & Human Settlement, TFDA, TBS, TANCDA, PO–RALG, TPHA, ATE
Achieved				NA	NA	NA			NA	0.5	1.7	2.1				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned		Number of new diagnosis of HBP at OPD level among >5 years old	509,539 (HMIS 2015)					<1,000,000	HMIS							
Achieved				654,951	733,461	930,345			HMIS 2018							
Planned		Number of new diagnosis of Diabetes mellitus at OPD level among >5 years old	248,373 (HMIS 2015					<450,000	HMIS							
Achieved				305,395	354,074	409,402			HMIS 2018							
Planned	NMNAP II	% of middle-age children and adolescents reached by school health and nutrition programme including physical activity (disaggre-gated by sex)														

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	NMNAP II	% of middle-age children, adolescents and adults reached with information on healthy lifestyle through mass-media (disaggre-gated by sex)														
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%	20%	30%	40%	50%	60%	PER Nutrition reportsJMNR Reports Annual Sectors reports	4,128	8,415	13, 366	18,425	21,672		
				66.8%	53.4%	33.7%			Sectoral Budget Briefs	2,756	4,490	4,502				
Planned		Proportion of households with low dietary diversity	Rural: 21.4% Urban: 8.6% (CFSVA, 2012)					Rural: 15% Urban: 6%	Compre-hensive Food Securiry and Vulnerability Analysis (CFSVA) reports							
Achieved																
Planned		Proportion of Households who practices handwashing at critical times	11.7% (TNNS 2014)			20%		30%	TNNS TDHS							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved						2.7% (TNNS 2018)			TNNS 2018							
Planned		Proportion of teenage mothers (15-19 years old)	26.7% (TDHS 2015/16)					< 20%	TDHS							
Achieved																
Planned		Women with secondary or higher education	23.4% (TDHS 2015/16)					> 30%	TDHS							
Achieved																
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% (CFSVA 2012)			Rural: 20% Urban: 8%		Rural: 15% Urban: 6%	Compre-hensive Food Securiry and Vulnerability Analysis reports HHBS	728	1,465	2,189	2,909	3,622	MALF	DP Food Security
Achieved						NA			NA	142	276	281				
Planned		Food Inflation Rate	9.5% (2015/ 16)	Head-line Infla-tion 5.0%	Head-line Infla-tion 5.0%	Head-line Infla-tion 5.0%	Head-line Infla-tion 5.0%	Head-line Infla-tion 5.0%	Annual report, BOT							
Achieved			Achieved	9%	7%	3%										

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	(Livestock and Fisheries) Communities have access to a diverse range of animal-source food throughout the year	Milk production (litres) Eggs production (units) Meat production (tonnes) Fish production and import (tonnes)	1,096,109 101,990,000 484,355 376,513 (2016/ 17)	1,096,109 101,990,000 484,355 NA	1,242,836 121,400,000 516,794 NA	1,409,707 146,400,000 551,679 NA	1,599,561 182,100,000 589,236 NA	1,815,648 241,100,000 629,726 NA	Tanzania Livestock Master Plan (2017/18 – 2021/22) and Budget speeches of the MoLF 2018/19 and 2019/20							
Achieved			Achieved	NA	2,400,134 3,156,692 679,992 410,505	2,678,461 3,575,621 690,629 N/A										
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 four antenatal care (ANC) visits	51% (TDHS 2015/16)			55%		60%	TDHS, HMIS	1,461.0	3,017.0	4,721.1	6,522	6,522	MoH CDGEC	DP Health

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved		Pregnant women attending four or more antenatal care visit (ANC4) (%)	38.4% (HMIS 2015/16)	42%	46%	64%			HMIS (Q4 - Oct-Dec reports)	1,029.9	1,667.3	1,668.2				
Planned	Proportion of WRA who are using (or whose partner is using) a modern family planning method	32% (TDHS 2015/2016)				40%		50%	TDHS, HMIS							
Achieved		Women aged of reproductive age (15-49 years) using modern family planning methods (%)	36.9% (HMIS 2015/ 16)	38%	32%	35%			HMIS (Q4 - Oct-Dec reports)							
Planned		Proportion of pregnant women using IPT for malaria prevention	35% (TDHS 2015/16)			42%		50%	TDHS, HMIS							
Achieved		Mothers who received two doses of preventive intermittent treatment (IPT2) for malaria during pregnancy (%)	57% (HMIS 2015/16)	61%	66%	81%		80%	HMIS (Q4 - Oct-Dec reports)							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	HIV-AIDS	Proportion of Pregnant Women tested for HIV and who know their status	86% (2015/16)	94%	96%	98%	98%	98%	PMTCT Annual Reports							
Achieved			Achieved	94%	98%	99%										
Planned	HIV-AIDS	Proportion of Pregnant Women living with HIV (PWLHIV) receiving ART to prevent vertical HIV transmission	86% (2015/16	90%	94%	96%	>98%	>98%	PMTCT Annual Reports							
Achieved			Achieved	100%	100%	99%										
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)	75%	78%	80%	82%	85%	TDHS, HBS, Water Sector Situation Reports	1,149	2,298	3,447	4,596	5,744	MoH CDGEC, MoWI	DP WASH
Achieved			68% (Water Sector Situation Report 2015/16	72%	50%	65%			Water Sector Situation Reports	495	869	870				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned		Proportion of the households with improved sanitation facilities (latrines) in rural areas (%)	25% (2014/15)	35%	50%	60%	70%	75%	TDHS, HBS, HMIS							
Achieved		Households with improved toilets (%)	32% (HMIS 2015/16)	39%	46%	54%			HMIS (Q4 - Oct-Dec reports)							
Achieved		Households with functional handwashing facilities and soap (%)	12.43% (HMIS 2015/16)	11%	13%	20%	40%	45%	HMIS (Q4 - Oct-Dec reports)							
Planned				15%	15%	19%										
Output 5.4:	Girls complete primary and secondary education	Lower secondary education completion rate	Total: 42.4% Boys: 46.5% Girls: 38.5% (2013)	Total 38.6% Boys 38.5% Girls 38.7%	Total 40.6% Boys 40.5% Girls 40.7%	Total - 42.6% Boys 42.5% Girls 42.7%	Total 44.6% Boys 44.5% Girls 44.7%	Total 50% Boys 51.5% Girls 48.5%	Basic Education Statis-tics in Tanza-nia (BEST)	352	704	1,055	1,408	1,759	MoEST	DP Education
Achieved				Total 38.6% Boys 38.5% Girls 38.7%	Total 31.4% Boys 31.7% Girls 31.1%	Total 38.4% Boys 38.3% Girls 38.5%			Basic Education Statistics in Tanzania (BEST)	821	1,407	1,411				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned		Net enrolment rate in pre-primary education	Total: 35.5% Boys: 35.7% Girls: 35.3% (2013)	Total 49.4%	Total 52.1%	Total 54.8%	Total 57.5%	Total 60.0%	Basic Education Statistics in Tanzania (BEST), Education Sector Performance Review Report							
Achieved				Total 46.7%; Boys 46.2%; Girls 47.1%	Total 44.6%; Boys 43.9%, Girls 45.3%	Total: 39.9% Boys: 39.6%, Girls: 40.3%			Basic Education Statistics in Tanzania (BEST), Education Sector Performance Review Report							
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), TASAF report June 2016	85%	92%	95%	98%	100%	PSSN Results Framework Reports	436.9	928.5	1,949.8	2,983	4,016	TASAF	DP Social Protection

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved		Proportion of beneficiaries from vulnerable households benefiting from cash transfers		84% (5,037,632 out of 6,000,000) TASAF Re-port June 2017	88% (5,267,031 out of 6,000,000) TASAF Re-port June 2018	89% (5,338,538 out of 6,000,000) TASA F Repo rt Marc h 2019			TASAF PSSN quarterly reports & PSSN Result Frame work 2019	268.6	269.7	270.6				
Planned		Proportion of household receiving cash transfers through public works programme (PWP)	250,402 out of 305,1600 (82%)	55%	59%	60%	84%	84%	TASAF PSSN quarterly reports							
Achieved			Achieved	82%	82%	87%			TASAF PSSN quarterly reports & PSSN Result Frame work 2019							
Planned	Women economic empowerment	Performance of Council Women Development Fund	Funds disbursed: TSh 3,388,747,160 Women Reached: 21,167	NA	NA	NA	NA	NA	LGAs reports							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Achieved			Achieved	Funds disbursed: TSh 8,816,700,165, Women Reached: 772,245	Funds disbursed: TSh 16,319,517,502, Women reached: 39,449	Funds disbursed: TSh 11,128,114,993, Women reached: 44,210										
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% (CFSVA 2012)			Rural: 8.5% Urban: 2.8%		Rural: 7% Urban: 2.5%	Comprehensive Food Securiry and Vulnerability Analysis reports	1.6	3.1	4.7	6	8	MALF	DP Food Security and Environment
Achieved						NA			NA	0.2	1.2	1.3				
Planned		Food Self-Sufficiency Ratio	120% (2015/16)	1.2	120%	120%	130%	140%								
Achieved				1.23	120%	124%			Food Crop Production Reports for Food Security-MOA							

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Expected Outcome 6:	Efficient and effective nutrition governance	Proportion of districts imple-menting the minimum budget allocation to nutrition	NA (2015/16)	10%	20%	30%	40%	50%	PER Nutrition Reports;JMNR Reports	6.3	15.1	22.4	30	38		
		Propotion of councils spending a minimum budget per child underfive for nutrition using domestic resources		1%	4%	7%			Nutrition Compact 2018/19	6.4	12.6	16.0				
Planned	NMNAP II	Total annual Government expenditure on nutrition specific interventions														
Output 6.1:	Increased Government political and financial commitment to Nutrition	Average spending on nutrition at council level	TSh 128 million (AWP Review 2014/15)	TSh 145 million	TSh 155 million	TSh 250 million	TSh 325 million	TSh 400 million	AWP Review Reports	0.6	2.9	4.6	6	8	TFNC	PMO, PO–RALG, TFNC, LGAs, DP Nutrition
Achieved				TSh 147 million	TSh 47 million	TSh 70 million			AWP Review Reports 2018/19	1.9	3.0	4.3				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned		Proportion of regions spending at least 50% of planned government budget (domestic resources)	NA (2015/ 16)	10%	20%	30%	40%	50%	Nutrition Compact assessments							
Achieved				NA	4%	27%			Nutrition Compact 2018/19							
Output 6.2:	Functional multisectoral coordination at all levels	Proportion of councils that hold at least two meetings of the council nutrition steering committee per year	<10% (AWP Review 2015/16)	15%	25%	35%	50%	60%	AWP Review Reports	0.5	1.2	1.7	2	3	TFNC	PMO, PO–RALG, Line ministries, TFNC, LGAs, DP Nutrition
Achieved				17%	48%	85%			JMNR Reports	2.6	4.9	6.0				
Output 6.3:	Improved human resources and capacities for nutrition	Proportion of LGAs employing at least one full-time professional nutritionist	60% (PO–RALG 2015/16)	70%	75%	80%	90%	100%	PO–RALG Reports	5.2	11.0	16.1	22	27	TFNC	PMO, PO–RALG, TFNC, LGAs, SUA, DP Nutrition
Achieved				57%	74%	53%			PO–RALG Nutritionist Database	2.0	4.7	5.8				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
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)	NA	0%	30%	75%	100%	Councils reports	8.5	24.8	45.2	61	68		
				NA	90%	95%			Councils Nutrition AWPs, Compact Reports	1.2	3.1	5.0				
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% (2015/16)	31%	58%	85%	96%	100%	Regional Semi-Annual and Annual Scorecards	5.4	18.0	34.3	49	51	TFNC	Sectors Focal Persons, RNuOs and DNuOs and Partners
Achieved				62%	70%	100%			Semi-Annual and Annual MN Scorecards and Compact Assessments	0.9	1.7	2.1				
Planned		Proportion of councils using the multisectoral nutrition information system (MNIS) online platform to produce multisectoral nutrition scorecards and BNA				0%	75%	100%								

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
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 micro-nutrient deficiency and DRNCDs) conducted	1 (TDHS, 2015/16)	0	1 (STEPS)	1 (TNNS)	1 (STEPS)	1 (TDHS)	Tanzania Demographic and Health Survey, HBS, TNNS	1.5	1.9	4.4	5	7	NBS	TFNC and Partners
Achieved				0	1 (HBS)	1 (TNNS)			TNNS 2018	0.1	0.4	1.7				
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 review (PER) on nutrition conducted	1 (2015/ 16)	2	1	2	1	2	Review Reports	1.5	4.9	6.4	8	9	TFNC	RNuOs, DNuOs and Partners
Achieved				2 (JMNR and PER Nutrition)	1 (JMNR)	2 (JMNR and NMNAP MTR)			Review Reports	0.2	1.0	1.2				

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Expected Results		Objectively Verifiable Indicators	Baseline value (Year)	Expected Targets for each Indicators					Sources	Cumulative Funding Requirements (Billion TSh)					Accountability	
				2016/17	2017/18	2018/19	2019/20	2020/21		2016/17	2017/18	2018/19	2019/20	2020/21	Lead Institution	Collaborating agencies
Planned	TOTAL WITHOUT NUTRITION-SENSITIVE INTERVENTIONS									77	207	367	502	590		
Achieved										44	90	123				
Planned	TOTAL WITH NUTRITION-SENSITIVE INTERVENTIONS									4,206	8,623	13,733	18,926	22,262		
Achieved										2,800	4,581	4,625				

Annex 2 Revised NMNAP activities plan

S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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 DPs on the packages	TFNC	MoHCDGEC, PO–RALG, UN, PANITA, NGOs																				
1.1.2	Identify and train 2CHWs/ village	PO–RALG,	TFNC, NGOs, UN, MoHCDGEC																				
1.1.3	Map eligible households and conduct home visits, group counselling on MIYCAN and cooking demonstrations	PO–RALG	LGA, NGOs TFNC																				
1.1.4	Develop supervision & monitoring tools for CHWs and conduct quarterly supportive supervision	PO–RALG	MoHCDGEC, PO–RALG, NGOs																				
1.1.5	Conduct quarterly behaviour change edutainment activities at ward level and social mobilization for MIYCAN at village level every six months	PO–RALG	TFNC, CSOs																				
	New proposed activities and timeline																						

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.1.6	Conduct quarterly VHND	PO–RALG	TFNC, MoHCDGEC, NGOs, UN																				
1.1.7	Conduct review and harmonization of Community reporting tools	PO–RALG	TFNC, MoHCDGEC, NGOs, UN																				
1.1.8	Review of MIYCAN training packages to include emerging evidences	PO–RALG	TFNC, MoHCDGEC, NGOs, UN																				
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	PO–RALG, TFNC, UN, academia, NACTE, TEA, MOESTVT																				
1.2.2	Develop nutrition standard of service for inclusion in the health facility standard	MoHCDGEC	PO–RALG, 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 charts/cards	MoHCDGEC	TFNC, PO–RALG, UN, academia, NGOs																				
1.2.4	Review supportive supervision tools and include SBC for MIYCAN in the quarterly supportive supervision at facility level	MoHCDGEC	TFNC, PO–RALG, NGOs, UN, academia																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.2.5	Review BFHI tools and guidelines, train health workers and conduct BFHI assessment	MoHCDGEC	PO–RALG, NGOs, TFNC, UN, academia																				
1.2.7	Review quality assurance protocol of HFs and advocate to incorporate BFHI status	MoHCDGEC	PO–RALG, TFNC, UN, academia, NGOs																				
	New proposed activities and timeline																						
1.2.8	Review of MIYCN national guideline	TFNC	PO–RALG, TFNC, UN, academia, NGOs																				
1.2.9	Develop ECD Checklist	MoHCDGEC/ Social Welfare	PO–RALG, TFNC, UN, academia, NGOs																				
1.2.10	Development of guide for establishment of breastfeeding corner/ room at workplace	MoHCDGEC	TFNC, MOEL, UN																				
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, PO–RALG, 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, PO–RALG, media houses, PANITA, NGOs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.3.3	Advocate for nutrition through ambassadors / celebrities	TFNC	MoHCDGEC, PMO, PO–RALG, media houses, PANITA, NGOs																				
1.3.4	Support the World Breastfeeding Week every year to advocate appropriate child feeding practices	TFNC	MoHCDGEC, PMO, PO–RALG, media houses, PANITA, NGOs																				
1.3.5	Design and broadcast MIYCAN programmes and messages through TV, radios, cell phones, social medias and gathering (buses, football games, concerts)	TFNC	MoHCDGEC, PMO, PO–RALG, 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																				
	New proposed activities and timeline																						
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																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.4.2	Sensitize private commercial partners on compliance with regulation and standards for IYCF products	TFNC	PO–RALG, 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																				
	New proposed activities and timeline																						
1.4.4	Conduct annual online survey to employers and employees to document status of minimum requirement of maternity benefit		MoHCDGEC, UN, PO–RALG																				
1.4.5	Develop a supervision checklist/monitoring tool for implementation of BMS regulations and reporting	TFNC	MoHCDGEC, UN, PO–RALG																				
1.4.6	Review of the nutrition - emergency preparedness plan and integrate into MoHCDGEC Emergency Section Action Plan	TFNC/MoH	MoHCDGEC, UN, PO–RALG																				
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, PO–RALG, MOALF, MOEST, MOI, private sector, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.1.2	Review of the national micronutrient powder guidelines for home fortification	MoHCDGEC	TFNC, TFDA, PO–RALG, 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	PO–RALG, 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, PO–RALG, 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	PO–RALG	MoHCDGEC, TFNC, NGOs, private sector																				
	New proposed activities and timeline																						
2.1.8	Conduct post market surveillance to establish fortification compliance	TFNC	NFFA, TFDA, TBS, MOALF MoHCDGEC, DPs, private sector																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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	PO–RALG	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	PO–RALG	TFNC, MoHCDGEC, LGA																				
	New proposed activities and timeline																						
2.2.3	Training to HSPs of low performing facilities (dispensaries and health centres) in the priority low performing districts on CHNM program	TFNC	PO–RALG, LGA																				
2.2.4	Support VHW from hard to reach village from the priority low performing districts so as they support CHNM service delivery	TFNC	PO–RALG, LGA																				
2.2.5	Conduct CHNM reviews and microplanning in low performing districts	TFNC	PO–RALG, LGA																				
2.2.6	Conduct supportive supervision on CHNM program to low performing districts	TFNC	PO–RALG, LGA																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.2.7	Support pilot and scale up of shift from campaign to routine vitamin A supplementation and deworming	TFNC	MoHCDGEC, PO–RALG, 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, PO–RALG, 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, 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, PO–RALG, TASPA, TBS, TFDA, TFNC																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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	PO–RALG	MoHCDGEC, TASPA, TBS, TFDA, TFNC																				
2.3.8	Procure and distribute test kits, WYD machines and reagents in all councils countrywide	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	PO–RALG, MoHCDGEC, MEM, TASPA, TBS, TFDA, MITI																				
2.3.11	Sensitize community on importance of consuming adequately iodized salt through community social gatherings	TFNC	PO–RALG, 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	PO–RALG, MoHCDGEC, MEM, TASPA, TBS, TFDA, MITI																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	New proposed activities and timeline																						
2.3.13	Establish and implement routine USI monitoring system of adequately iodized salt according to the Act and salt regulation focusing on large and medium salt producers	TFNC	PO–RALG, MoHCDGEC,																				
2.3.14	Support salt sector industrialization/ professionalization	Mo T&I	MoHCDGEC, PO–RALG, TASPA, TBS, TFDA, TFNC																				
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 biofortified food crops and raising small animals	TFNC	MoHCDGEC, PO–RALG, NGOs, DPs																				
2.4.2	Conduct public campaigns through mass media on the importance of consumption of iron/folate rich foods and deworming	TFNC	MoHCDGEC, PO–RALG, 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 PO–RALG, 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																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	New proposed activities and timeline																						
2.4.5	Conduct training to national facilitators (national team) on anaemia prevention including IFA Supplementation to pregnant women	TFNC	MoHCDGEC																				
2.4.6	Conduct training to regional and district facilitators (two participants per council and two per region) on anaemia prevention including IFA Supplementation to pregnant women	TFNC	MoHCDGEC																				
2.4.7	Review of nutrition pillars of the National Agenda to Accelerate Investment for Adolescent Health and well-being (NAAIA)	TFNC	MoHCDGEC																				
2.4.8	Conduct study on factors contributing to non-adherence on IFA supplements up to 90+ days among pregnant women in Tanzania	TFNC																					
2.4.9	Scale up nutrition education for school-age children (6 to 19 years old) with focus on prevention of anaemia, underweight and overweight, and weekly IFA supplementation (WIFAS) to adolescent girls aged 10 - 19 years	TFNC	MoHCDGEC, PO–RALG, LGA																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.4.10	Development and testing of a comprehensive maternal nutrition package including counselling on diversified diet, use of fortified foods and multiple micronutrients supplementation (MMS) during pregnancy	TFNC	MoHCDGEC, PO–RALG, LGA, DPs																				
3.1	**Improved quality of services for management of severe and MAM in at least 75 per cent 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, PO–RALG																				
3.1.3	Train regional teams of trainers (ToT) on IMAM	TFNC	UN, MUHAS, MoHCDGEC, PO–RALG, UDOM																				
3.1.4	Train two HSPs per lower facility level (OTC) and for 4 at hospital level on IMAM	PO–RALG	TFNC, NGOs, MUHAS																				
3.1.5	Conduct quarterly supportive supervision of HSPs on application of the IMAM protocol	PO–RALG	LGA, NGOs																				
3.1.6	Establish an HR training database on IMAM	TFNC	MoHCDGEC																				
	New proposed activities and timeline																						

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.2	**At least 75 per cent of children under five years old are reached through screening for severe and MAM 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, PO–RALG																				
3.2.2	Train community HWs on IMAM community outreach and mobilization package	TFNC	RS, LGA, NGOs,																				
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																				
	New proposed activities and timeline																						
3.2.6	Train Health care providers on Growth monitoring to identify malnourished children for treatment and counselling	TFNC	RS, MoH, LGA, NGOs,																				
3.3	**Essential therapeutic nutrition supplies and equipment are available in at least 90 per cent of health facilities providing services for management of severe and MAM by June 2021**																						
3.3.1	Integrate IMAM therapeutic nutrition supplies into central procurement logistics system (ILS)	TFNC	MoHCDGEC, TFNC, MSD, PO–RALG, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.3.2	Harmonize clearance procedures for IMAM therapeutic commodities among 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	DPs																				
3.3.5	Train regional and district supply officers / pharmacists / pharmaceutical technicians on IMAM supply chain management annually	TFNC	MSD, UN, NGOs																				
	New proposed activities and timeline																						
3.2.6	Integrate IMAM supplies in the national supplies system and support procurement through existing mechanisms (HBF, DHFF)	TFNC	RS, MoH, LGA, NGOs,																				
3.4	**Strengthened integration of management of severe and MAM at the national and subnational level by June 2021**																						
3.4.1	Conduct advocacy with the Government and DPs to ensure adequate funding and prioritization of IMAM in Tanzania	TFNC	PO–RALG, MoHCDGEC, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.4.2	Support the National Consultative Group on IMAM	TFNC	UN																				
3.4.3	Support Zonal meeting on IMAM annually	TFNC	UN & DPs, PO–RALG																				
3.4.4	Integrate IMAM into the agenda of the District Nutrition Steering Committee (within CHMT)	RNSC	TFNC, PO–RALG																				
3.4.5	Integrate IMAM in health facilities package	TFNC	MoHCDGEC																				
	New proposed activities and timeline																						
3.4.6	Advocate for screening of PLHIV among Managers (CTC in charges, coordinators) at council level	TFNC	NACP, PO–RALG, MoHCDGEC																				
3.4.7	Conduct mentorship/ supportive supervision to health providers on nutrition care and support for PLHIV	TFNC	NACP, PO–RALG, MoHCDGEC																				
3.4.8	Review and print of protocols for Management of Acute Malnutrition and nutrition care and support for PLHIV	TFNC	NACP, PO–RALG, MoHCDGEC																				
3.4.9	Conduct sensitization meeting to RHMT & CHMT members on nutrition and HIV including management of acute malnutrition in PLHIV in six regions	TFNC	NACP, PO–RALG, MoHCDGEC																				
3.4.10	Orient service providers on management of acute malnutrition and nutrition care and support for PLHIV in six regions	TFNC	NACP, PO–RALG, MoHCDGEC																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.4.11	Procure and distribute supplies (weighing scales, Height boards, MUAC Tapes)	MSD	NACP, PO–RALG, MoHCDGEC, TFNC																				
4.1	**At least 50 per cent of the 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, PO–RALG																				
4.1.2	Train health care providers on diet and nutrition related NCDs 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, PO–RALG, TANCDA																				
4.1.5	Sensitize employees in workplaces on healthy lifestyles	TFNC	MoHCDGEC, MEDIA, LGA, MOESTVT, TANCDA																				
	New proposed activities and timeline																						
4.1.6	Review the package on healthy lifestyles for school-age children and adolescents as part of the of the National School Programme	TFNC	LGA, TANCDA MOESTVT, MoHCDGEC, MEDIA																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4.1.7	Promote healthy diets and physical activities in primary and secondary schools through implementation of the National School Programme	MOESTVT	MoHCDGEC, MEDIA, LGA, TFNC, TANCDA																				
4.1.8	Conduct national campaign for screening major risk factors for DRNCDs in adult population annually	TANCDA	MoHCDGEC, MEDIA, LGA, TFNC																				
4.2	**Policies and legislations are reviewed to enable at least 75 per cent of the community to engage in healthy lifestyles by 2021**																						
4.2.1	Sensitize policymakers, urban planners, law enforcers and highway and road designers on healthy lifestyles	MoHCDGEC	TFNC, MoLHS, MoWTC LGA, TFDA, Parliament, PO–RALG, TANCDA																				
4.2.2	Review policies and legislations on issues related to healthy lifestyles	MoHCDGEC	TBS, TANCDA, TFNC, TFDA, TPHA																				
5.1	**Communities have access to a diverse range of nutritious food throughout the year**																						
5.1.1	Maize: Increase use of modern technology	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.2	Rice: Project for supporting rice industry Development in Tanzania	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.3	Rice: Linking Kilombero Plantation Limited commercial Farm with smallholder farmers	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.1.4	Pulses: Stakeholders skill building throughout the different stages of the value chain	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
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	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.6	Extension officers: Providing training to the farmers and improving cultivation practices through increasing the number of extension officers	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.7	Women and youth empowerment through agriculture	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.8	Market availability for crops: Construction of strategic markets at the borders, improving and empowering corporative unions	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.9	Market availability for crops: Encouraging cooperative unions and private sector to establishing agro processing industries	MOA	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.10	Skills development for improved livestock productivity	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.1.11	Review/ strengthen Regulatory Framework for Animal Health services	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.12	To improve meat quality and marketing	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.13	Beef industry development	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.14	Poultry: Establishment of Multi-Stakeholder Innovation Platforms (MSIP)	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.15	Scale up school milk feeding programme	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.16	Deep sea fishing	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.17	Sea fishing	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
5.1.18	Promote aAquaculture	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.1.19	Empowerment of artisanal fishers	MALF	TFNC, PO–RALG, DPs, NGOs, private sector																				
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	MOA	TFNC, PO–RALG, 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	MLDF	TFNC, PO–RALG, 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	MOA	SIDO, PO–RALG, TFNC, TFDA, TB, DPs																				
5.1.23	Promote consumption of biofortified and high nutrient value food varieties at community level to increase nutrient intake	MOA	PO–RALG, 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	MOA	SIDO, PO–RALG, TFNC, TFDA, TBS, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.1.25	Promote food safety and quality throughout the food supply chain to reduce consumption of unsafe food	MOA	LGA, TFNC, DPs, NGOs, TFDA, TPRI																				
5.1.26	Conduct SBCC to increase production and consumption of diverse range of nutritious food at community level	MoHCDGEC	PO–RALG, MALF, NGOs, private sector																				
5.1.27	Train agricultural officers as ToTs of agricultural extension workers on production of nutritious food crops	MOA	MoFP, NGOs, TASAF, DPs																				
5.1.28	Review certificate and diploma curricula in Agriculture, Livestock and Fisheries training to improve the existing nutrition components	MOA	TFNC, Training institutions, Professional bodies, DPs																				
	New proposed activities and timeline																						
5.1.29	Finalize and disseminate biofortified guidelines to stakeholders in agroecological zones to promote production and utilization of biofortified crops	MOA	TFNC, Training institutions, Professional bodies, DPs																				
5.1.30	Finalize and disseminate the postharvest management strategy to stakeholders to reduce crop losses and ensure food and nutrition security	MOA	TFNC, Training institutions, Professional bodies, DPs																				
5.1.31	Promote agriculture related nutrition interventions to farmers through agriculture shows (Nanenane, world food days) annually	MOA	TFNC, Training institutions, Professional bodies, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.2	**Communities regularly use quality maternal health including family planning, prevention and treatment of HIV and malaria services**																						
5.2.1	To strengthen, prevention and treatment of HIV	MoHCDGEC	MoHCDGEC, LGAs, DPs																				
5.2.2	To strengthen, prevention and treatment of NCDs and mental health	MoHCDGEC	MoHCDGEC, LGAs, DPs																				
5.2.3	Malaria	MoHCDGEC	MoHCDGEC, LGAs, DPs																				
5.2.4	Maternal, newborn and reproductive health	MoHCDGEC	MoHCDGEC, LGAs, DPs																				
5.2.5	Child and adolescent health	MoHCDGEC	MoHCDGEC, LGAs, DPs																				
5.2.6	Health promotion	MoHCDGEC	MoHCDGEC, LGAs, DPs																				
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																				
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, PO–RALG																				
5.3.2	Water quality management and pollution control	MOWI	MoHCDGEC, PO–RALG																				
5.3.3	Scale up water supply in rural areas	MOWI	PO–RALG, WATER AUTHORITIES																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.3.4	Urban water supply strategic choices	MOWI	MoHCDGEC, PO–RALG, WATER AUTHORITIES																				
5.3.5	Advocacy and orientation of key government and non-government stakeholders for sanitation and hygiene	MoHCDGEC	MOWI, PO–RALG, WATER AUTHORITIES																				
5.3.6	Engagement of households through CLTS and sanitation marketing	MoHCDGEC	MOWI, PO–RALG, WATER AUTHORITIES																				
5.3.7	Manage sanitation and hygiene competition	MoHCDGEC	MOWI, PO–RALG, WATER AUTHORITIES																				
5.3.8	Promotion of household water treatment and safe Storage	MoHCDGEC	MOWI, PO–RALG, WATER AUTHORITIES																				
5.3.9	Promotional events targeting the peri-urban settings on sanitation and hygiene, and HWTS	MoHCDGEC	MOWI, PO–RALG, WATER AUTHORITIES																				
5.3.10	Construction of WASH facilities in 8 highway bus stops	MoHCDGEC	MOWI, PO–RALG, WATER AUTHORITIES																				
5.3.11	Strengthen system for solid waste management in the outskirts of cities and municipalities in the country	MoHCDGEC	MOWI, PO–RALG, 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																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.4	**Girls complete primary and secondary education**																						
5.4.1	Education and ECD activities being implemented under the Five-Year Development Plan II 2016/17-2020/21	MOEST	MOEST, LGAs, DPs																				
5.4.2	Primary School: Improvement of Literacy and Numeracy Strategy (LANES)	MOEST	MOEST, LGAs, DPs																				
5.4.3	Primary School: Construct classrooms and latrines	MOEST	MOEST, LGAs, DPs																				
5.4.4	Primary School: Improve availability of water, electricity	MOEST	MOEST, LGAs, DPs																				
5.4.5	Primary school: Implement comprehensive plan for free education	MOEST	MOEST, LGAs, DPs																				
5.4.6	Secondary Education Development	MOEST	MOEST, LGAs, DPs																				
5.4.7	Secondary school: Implement comprehensive plan for free education	MOEST	MOEST, LGAs, DPs																				
5.4.8	Secondary school: Construct classrooms and latrines	MOEST	MOEST, LGAs, DPs																				
5.4.9	Secondary school: Improve availability of water, electricity and latrines	MOEST	MOEST, LGAs, DPs																				
5.4.10	Promote girl-friendly water and sanitation facilities in primary and secondary schools	MOEST	PO–RALG, TFNC, MoHCDGEC, LGA,																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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	PO–RALG, 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	MOEST	LGA, Parliament, PO–RALG, TANCDA																				
	New proposed activities and timeline																						
5.4.13	Develop national school feeding guidelines																						
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's economic empowerment	MoHCDGEC	DPs																				
5.5.2	End child marriage and early pregnancies	MoHCDGEC	DPs																				
5.5.3	Develop and implementation of Local Economic Development (LED) initiatives	MoHCDGEC	DPs																				
5.5.4	TASAF – cash transfer	TASAF	PO–RALG																				
5.5.5	TASAF – cash for work	TASAF	DPs																				
5.5.6	Review certificate and diploma curricula in community development training to improve/include nutrition components	MoHCDGEC	TFNC, Professional Bodies, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.5.7	Review certificate and diploma curricula in social Welfare training to improve/include nutrition components	MoHCDGEC	TFNC, Professional Bodies, DPs																				
	New proposed activities and timeline																						
5.5.8	TASAF- PSSN II Targeting 30% remained villages in 3 pilot PAAs (Siha DC,Mtwara DC and Nanyamba DC)	TASAF	DPs																				
5.6	**Vulnerable communities are able to cope with drought and climate change to avoid shorta ge of nutritiou s food during shock s**																						
5.6.1	Implementation of concrete adaptation measures to reduce vulnerability of livelihoods and economy of the coast communities of Tanzania	VPO	VPO, NEMC, MALF, PO–RALG, DPs, TM A,																				
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, PO–RALG, DPs, TM A,																				
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	PO–RALG, Key ministries, DPs, PANITA																				
6.1.2	Review key line sectoral policies, strategies and guidelines	TFNC	PMO, PO–RALG, MDAs, DPs																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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 policymakers and other actors	PMO	MoHCDGEC, MDAS, PANITA																				
6.1.5	Review and develop Nutrition Advocacy materials and tools (Radio programmes, TV documentaries, printed materials, power point presentations)	TFNC	PMO, PO–RALG, DPs, PANITA																				
6.1.6	Conduct capacity-building among MP nutrition champions on nutrition specific and sensitive interventions (meetings, trainings, field visits)	TFNC	PMO, PO–RALG, DPs, PANITA																				
6.1.7	Support the MP nutrition champion group to review their nutrition strategic plan	PANITA	PMO, TFNC, CSOs, DPs																				
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	PO–RALG, Key Ministries, TFNC, DPs,																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6.1.10	Conduct annual zonal planning and budgeting meetings with region and LGA multisectoral teams	PO–RALG	RS, LGA, TFNC, DPs, NGOs, PANITA																				
6.1.11	Establish a Joint National NMNAP Resource Mobilization Committee (JNRMC) and conduct quarterly working sessions	PMO	MoHCDGEC, MDAs, TFNC, PO–RALG, DPs, PANITA																				
6.1.12	Facilitate JNRMC to organize fundraising events for resource mobilization to implement NMNAP	PMO	MoHCDGEC, MDAs, TFNC, PO–RALG, DPs																				
6.1.13	Conduct meetings with the government budget preparatory committee to advocate integration of nutrition priorities into budget guideline	MOFP	PMO, PO–RALG 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, PO–RALG, TFNC, MoHCDGEC																				
6.1.15	Develop operational guidelines on good governance for effective implementation of NMNAP	PMO	TFNC, PO–RALG, DPs, PANITA																				
	New proposed activities and timeline																						
6.1.16	Support implementation and assessment of Nutrition Compact at ward, council, regional and national level	PO–RALG	TFNC, PO–RALG, DPs, PANITA																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6.1.17	Conduct National Nutrition Day every year in August	PO–RALG	TFNC, PO–RALG, DPs, PANITA																				
6.2	**Functional multisectoral coordination at all levels**																						
6.2.1	Review composition and terms of reference for HLSCN	PMO	PO–RALG, MDA, TFNC, DPs, PANITA																				
6.2.2	Establish and operationalize HLSCN Secretariat (Full-time staff, office set up, equipment)	PMO	MDAs, TFNC, DPs																				
6.2.3	Conduct HLSCN meetings every six months	PMO	PO–RALG, MDAs, TFNC, NGOs, PANITA, DPs																				
6.2.4	Review the composition and ToR of the MNTWG and its Consultative Groups based on the NMNAP's structure	PMO	PO–RALG, 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)	PO–RALG	PMO, TFNC, RS, LGA, PANITA																				
6.2.7	Establish and conduct R/CNSC meetings in all regions and councils according to revised ToR	PO–RALG	PMO, TFNC, RS																				
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,																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
6.2.9	Conduct mapping of nutrition stakeholders (interventions and geography)	TFNC	PO–RALG, RS, LGA, DPs, PANITA																				
	New proposed activities and timeline																						
6.2.10	Develop multisectoral nutrition supervision checklist/guideline	PO–RALG	PO–RALG, RS, LGA, DPs, PANITA																				
6.3	**Improved human resources and capacities for nutrition**																						
6.3.1	Review ToR 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, MoHCDGEC, PO–RALG)	PO–RALG	TFNC, MoHCDGEC, 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	PO–RALG, RS, LGA, SUA, DPs																				
7.1	**Robust systems of data-collection, analysis, interpretation and feedback among stakeholders are in place at all levels**																						

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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 CHWs	TFNC	MoHCDGEC, ICT Institute																				
7.1.2	Review GMP 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 HW 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 BNA 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																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
7.1.7	Develop multisectoral nutrition scorecard, its database and train regional and council nutrition officers on its use, data analysis and interpretation	TFNC	PO–RALG, 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	PO–RALG, MoHCDGEC, DPs, LGA																				
7.1.9	Develop and harmonize data elements and nutrition data-collection tools at all levels	TFNC	MDAs, LGA, DPs, NGOs																				
	New proposed activities and timeline																						
6.1.16	Finalize and roll out the online platform for the MNIS	TFNC	PO–RALG, MoHCDGEC, DPs																				
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	PO–RALG, 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																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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																				
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	PO–RALG, PMO, RSs, LGA																				
7.2.8	Support collection of indicators for diet-related NCDs in STEPS survey	NIMR	PO–RALG, PMO, RSs, LGA																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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 learned by LGA, MDAs and SCO in the country	TFNC	PO–RALG, PMO, MoHCDGEC, LGA, DPs, NGO's, PANITA																				
7.3.2	Carry out PER on nutrition in 2017 and 2019, disseminate results and develop policy brief	MoFP	MoHCDGEC, TFNC, LGA, PANITA, NGO's																				
7.3.3	Undertake midterm (2018/19) and endline 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	PO–RALG, 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																				

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S. No.	Output/activities	Lead institution	Collaborating organizations	2016/17				2017/18				2018/19				2019/20				2020/21			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
7.3.6	Develop nutrition research priorities list, conduct formative research, share research findings and best practices 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 data sets	NBS	TFNC, NIMR, COSTECH, DPs																				
7.3.8	Strengthen capacities (human resource, equipment and supplies) of nutrition laboratories (TFNC, SUA) as per needs assessment	TFNC	SUA																				

Annex 3 Summary of new activities suggested for the NMNAP

KRA 1: Increased proportion of adolescents, pregnant women and mothers / caregivers of children under two years who practice optimal maternal, IYCN behaviours

To accelerate achievement of results related to KRA 1, adding the following key interventions was suggested:

The first intervention is the **review of national MIYCAN guideline and training package** to include emerging evidence on early childhood nutrition (i.e., in relation to food system) and to include a specific module for nutrition of school-age children and adolescents.

The second additional interventions that shall be prioritized in the second term of the NMNAP is to conduct quarterly **VHNDs.** VHNDs take place in the main meeting area available in the community (i.e., football pitch, marketplace, village executive office, etc.) CHNDs are organized by village- and ward-level authorities and are delivered by CHWs (volunteers) and health service providers (HSPs) from the closest health facilities. VHNDs are social mobilization events that bring the community together and offer several services to children through their caregivers. Services are also offered to adult men and women. The services provided include:

- Taking anthropometric measurements of children (age, weight, height/length) and BMI of adults
- Specific counselling to male and female caregivers based on the results of anthropometric measurements for their children. Counselling includes MIYCN, WASH, health and ECD
- Nutrition counselling to adult men and women based on the results of BMI
- Cooking demonstrations to male and female caregivers
- Demonstrations on early stimulation for children aged under 2 years, using the ECD corner, which is established during VHNDs to also allow adults to go through health and nutrition checks and counselling (children are taken care of by trained CHWs)
- VAS and deworming for children who missed it (delivered by HSPs who will come to support VHNDs)
- Direct targeting of vulnerable groups by specifically targeting households that benefit from social protection policies, such as cash transfers and cash for work

- Public show of growth monitoring results (i.e., sex-disaggregated trends in stunting, wasting and overweight) by displaying them in the community (i.e., on the door of the Village Executive Office)

VHNDs also have a gender approach, as males and females are targeted for the services both as beneficiaries of the service and as caregivers of young children, who share responsibility. In terms of community ownership, village- and ward-level authorities pay some of the costs of this activity and support the community (and especially the families with stunted and wasted children) to attend additional counselling sessions and adhere to the advice received.

VHNDs also offer a key platform to deliver ECD interventions. The third proposed intervention that shall be prioritized in the second term of the NMNAP is to **develop an ECD checklist**, which shall be regularly used by CHWs or HSPs during their contacts with caregivers to track development milestones among young children, based on international tools such as the Caregiver Reported Early Development Instruments (CREDI)

The fourth proposed additional intervention is to conduct a **review and harmonization of community reporting tools,** in line with the MNIS. The community information system is progressively being digitalized, which shall include nutrition information that will flow into the online MNIS platform.

A fifth set of proposed interventions aims at **improving breastfeeding practices at the workplace and compliances with national regulations on breastfeeding at the workplace as well as regulations on breast milk substitutes (BMS).** These include development of guidelines for establishment of breastfeeding corner/ room at workplace, conducting annual online surveys to employers and employees to document status of minimum requirement of maternity benefit, developing a supervision checklist/ monitoring tool for implementation of BMS regulations and reporting.

The last key activity proposed was related to **Review of the Nutrition in Emergency Preparedness Plan** and integration it into MoHCDGEC Emergency Section Action Plan. Key guidelines for IYCF in emergencies, especially among refugees, in the context of natural disasters (droughts, floods), or in the context of infection (such as ebola virus disease) must be made available for immediate use during emergencies.

KRA 2: Children, adolescents and women of childbearing age consume adequate micronutrients

To accelerate achievement of results related to KRA 2, adding the following key interventions was suggested:

1. Improve food fortification coverage through **subsidized procurement of multiple micronutrient powders for children aged 6–23 months** (for home fortification) and conduct post market surveillance to establish fortification compliance and **strengthen the information on the availability and consumption of fortified food** (especially flour and oil).

2. Improve coverage and sustainability of VAS programme, through support of a pilot and subsequent scale-up of **shift from campaign to routine VAS and deworming,** starting with the children in the age group of 6–11 months. To prioritize promotion of diversified diet and micronutrients rich food, it was also proposed to **prioritize the nutrition education component during child health and nutrition months (CHNMs),** which currently focus mainly on the VAS and deworming component.

3. Improve achievement and sustainability of USI through **support for salt sector industrialization/professionalization**, and

establish and implement **routine monitoring systems of adequately iodized salt** according to the national legislation and salt regulation with a focus on large- and medium-scale salt producers.

To strengthen anaemia prevention programme among school-age children, adolescents and pregnant women, adoption of the following interventions was suggested:

i) Training for HSPs on **counselling to pregnant women on adequate diet and IFA supplementation** (possibly upon screening for anaemia)

ii) **Re-assessment of factors contributing to non-adherence on IFA supplements** up to 90+ days among pregnant women in Tanzania

iii) Development and testing of a **comprehensive maternal nutrition package including counselling on diversified diet, use of fortified foods and multiple micronutrient supplementation (MMS) during pregnancy**

iv) Scale-up of **nutrition education for school-age children (aged 6–19 years), with a focus on prevention of anaemia, underweight and overweight, and weekly IFA suuplementation (WIFAS)** for adolescent girls aged 10–19 years.

KRA 3: Increased coverage of integrated management of SAM and MAM

To accelerate achievement of results related to KRA 3, adding the following key interventions was suggested:

1. Support the scale-up of IMAM services and address the main bottlenecks, i.e., funding for procurement of IMAM supplies, by prioritizing **integration of IMAM supplies in the national supplies system**

2. Support LGAs **planning for IMAM supplies and activities through DHFF** mechanism

3. Support **procurement through existing funding mechanisms such as the HBF**

4. Give **special focus to people living with HIV (PLHIV) who are in need of treatment of SAM.** The second term of the NMNAP shall adopt activities to regularly screen PLHIV for malnutrition and provide therapeutic feeding.

KRA 4: Communities in Tanzania are physically active and eat healthy

To accelerate achievement of results related to KRA 4, adding the following key interventions was suggested:

1. Ensure a higher coverage of DRNCD preventive services among school-age children and adolescents. This will be done by reviewing the package on healthy lifestyles for school-age children and adolescents as part of the of the National School Programme, and **promoting healthy diets and physical activities in primary and secondary schools through implementation of the National School Programme.**

2. Ensure a higher coverage of DRNCD preventive services among adult population by **conducting an annual national campaign for screening major risk factors for DRNCDs in the adult population.**

KRA 5: Line sectors, private sector and CSOs scale up nutrition-sensitive interventions to reach all communities to improve nutrition

To accelerate achievements of results related to KRA 5, adding the following key interventions was suggested:

Enhance the **synergy between nutrition and agriculture** and ensure increased utilization of micronutrient-rich foods by women and children through the following activities:

i) Finalize and disseminate biofortified guidelines to stakeholders in agroecological zones to promote production and utilization of biofortified crops

ii) Finalize and disseminate the Postharvest Management Strategy to stakeholders to reduce crop losses and ensure food and nutrition security

iii) Promote agriculture related nutrition interventions to farmers through agriculture shows (Nanenane , world food days) annually.

Strengthen the **synergy between nutrition and health** by including and prioritizing integration and provision of nutrition counselling to mothers and children during all contacts with HSPs at ANC and PNC.

Enhance the **synergy between nutrition and WASH** by including and prioritizing animal handling within baby WASH packages to reduce ingestion of animal faeces by children and thus reduce the impact of diarrhoea.

Strengthen the **synergy between nutrition and education** and ensure increased coverage of nutrition education at schools by prioritizing scale-up of the National School Health Programme and finalizing and implementing the national school-feeding guidelines.

Enhance the **synergy between nutrition and social protection** by including activities to scale up the Equity Nexus between large-scale nutrition programmes and PSSN interventions to all regions of Tanzania.

Strengthen the **synergy between nutrition and environment** by prioritizing nutrition interventions in those regions that chronically suffer from food insecurity, in order to strengthen the population's resilience.

KRA 6: Efficient and effective nutrition governance

To accelerate achievements of results related to KRA 6, adding the following key intervention was suggested:

1. Further strengthen the operationalization of the NMNAP at the council and regional levels and increase political accountability towards nutrition by **prioritizing implementation and assessment of the Nutrition Compact.** The Nutrition Compact shall be implemented and assessed at the ward, council, regional and national levels. It was also suggested to conduct National Nutrition Day every year in August.

KRA 7: Quality nutrition-related information is accessible and used to allow government and partners to make timely and effective evidence-informed decisions

To accelerate achievement of results related to KRA 7, adding the following key interventions was suggested:

1. Ensure sustainability and efficiency of the multisectoral nutrition information system by **prioritizing implementation of the national online platform for the MNIS.**

Annex 4 List of people who contributed to the MTR

List of technical committee members

Name	Institution	Role
Paul Sangawe	PMO	Lead (August 2019 onward)
Joseph Kiraiya	PMO	Lead (Up to August 2019)
Dr Vincent Assey	TFNC	**Secretariat** (July 2019 onward)
Dr Germana Leyna	TFNC	**Secretariat** (Up to July 2019)
Sarah Mshiu	PMO	Member
Novatus Tesha	PMO	Member
Mwita Waibe	PO–RALG	Member
Grace Moshy	MoHCDGEC	Member
Peter Kaswahili	MoHCDGEC	Member
Dr Charles Mwamaja	MOFP	Member
Emmanuel D. Mwabulambo	MOFP	Member
Evode Kanyamyoga	MOFP	Member
Margareth Natai	MOA	Member
Geoffrey Chiduo	TFNC	Member
Hancy Adam	TFNC	Member
Josephine Manasse	TFNC	Member
Julith Itatiro	TFNC	Member
Abass Mlemba	NBS	Member
Prof John Msuya	SUA	Member
Dr Theresia Jumbe	SUA	Facilitator
Dr Leonard Katalambula	UDOM	Member
Henry Kalisti	UDSM	Member

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Name	Institution	Role
Mauro Brero	UNICEF	Member
Fatoumata Lankoande	UNICEF	Member
Joyce Ngegba	UNICEF	Member
Neema Shosho	WFP	Member
Temina Mkumbwa	USAID	Member
Prof Isaac Minde	MSU/ASPIRES	Member
Tumaini Charles	MSU/ASPIRES	Member
Dr Joyceline Kaganda	SC	Member
Dr Daniel Nyagawa	NI	Member
Tumaini Mikindo	PANITA	Member
Dr Generose Mulokozi	IMA	Member
Joseph Mugyabuso	IMA	Member
Dr Esther Elisaria	IHI	Member
Lusekelo Njonge	JHPIEGO	Member
Dr Festo Kavishe	Independent Consultant	Member
Mwiru Sima	Independent Consultant	Facilitator
David Katusabe	Independent Consultant	Member

List of team members from the Nutrition-Specific Interventions (KRAs 1–4) Task Team

Name	Institution/organization	Role
Dr Fatma Abdallah	TFNC	**Lead**
Mariam Nakuwa	PO–RALG	**Co-Lead**
Fatoumata Lankoande	UNICEF	**Co-Lead**
Grace Moshy	MoHCDGEC – Nutrition	**Secretariat**
Dr Makuani	MoHCDGEC - RCH	Member
Mary Anjelo	MoHCDGEC – Health Promotion	Member
Mariam Mashimba	MoHCDGEC - WASH	Member
Neema Joshua	TFNC	Member
Maria Ngilisho	TFNC	Member
Maria Msangi	TFNC	Member
Zephania Henry	Ministry of Minerals	Member
Mr Kyaruzi	TFDA	Member

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Name	Institution/organization	Role
Mr Mndeme	MSD	Member
Dr Bruno Sunguya	MUHAS	Member
Neema Kweba	RNuO - Dar es Salaam	Member
Bertha Mwakabage	DNuO - Kigamboni	Member
Abraham Sanga	UNICEF	Member
Tuzie Edwin	UNICEF	Member
Ramadhani Mwiru	UNICEF	Member
Dr Iria Nemes	WHO	Member
Juliana Muiruri	WFP	Member
Giulia Segafredo	CUAMM	Member
Dr Generose Mulokozi	IMA	Member
Sylvester Nandi	NI	Member
Enock Musimbuzi	GAIN	Member
Prof Andrew Swai	TDA/NCD Alliance	Member
Dr Lunna Kyungu	COUNSENUTH	Member
Brenda Mshiu	JHPIEGO	Member
Dr Pius	PAT	Member
Dr Lulu Chirande	PAT	Member
Gloria Kisia	Action Against Hunger	Member

List of team members from the Nutrition-Sensitive Interventions (KRA 5) Task Team

Name	Institution/organization	Role
Margareth Natai	Ministry of Agriculture	**Lead**
Mauro Brero	UNICEF	**Co-Lead**
Neema Shosho	WFP	**Co-Lead**
Ephron Sanga	MLF	**Secretariat**
Sarah Mshiu	PMO	Member
Jeremiah Mwanbange	PO–RALG	Member
Grace Sheleringo	MOEST	Member
Julita Masanja	MHCDGEC	Member
Remiguis Mazigwa	MOWI	Member
Fundikira Ekerege	MOESTVT	Member

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Name	Institution/organization	Role
Zahara Daudi	TFNC	Member
Dr Elifatio Towo	TFNC	Member
James Mganga	MLF	Member
Kweji Kasulende	TASAF	Member
Neema Lugangira	SAGCOT/Agri Thamani	Member
Fadhili Mtengela	FAO	Member
Chiho Suzuki	World Bank	Member
Fortunata Chuwa	ASPIRE	Member
Irene Murega	WHO	Member
Dr Jamal Kussaga	SUA	Member
Enock Musimbuzi	GAIN	Member

List of team members from the Enabling Environment (KRAs 6–7) Task Team

NAME	Institution/Organization	Role
Paul Sangawe	PMO	**Lead** (August 2019 onward)
Joseph Kiraiya	PMO	**Lead** (Up to August 2019)
Mwita Waibe	PO–RALG	**Co-Lead**
Temina Mkumbwa	USAID	**Co-Lead**
Novatus Tesha	PMO	**Secretariat**
Geoffrey Chiduo	TFNC	Member
Josephine Manasse	TFNC	Member
Adam Hancy	TFNC	Member
Peter Kaswahili	MoHCDGEC	Member
Lusajo Ndagile	MOHCDGEC - DHIS	Member
Evode Kanyamyoga	MOFP	Member
Emmanuel D. Mwabulambo	MOFP	Member
Abass Mlemba	NBS	Member
Joyce Ngegba	UNICEF	Member
Margaret Benjamin	UNICEF	Member
Neema Shosho	WFP	Member
Juliana Muiruri	WFP	Member
Tumaini Charles	MSU/ASPIRES	Member

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NAME	Institution/Organization	Role
Dr Joyceline Kaganda	SC	Member
Tumaini Mikindo	PANITA	Member
Lusekelo Njonge	JHPIEGO	Member
Dr Theresia Jumbe	SUA	Member
Henry Kalisti	UDSM	Member
Dr Leonard Katalambula	UDOM	Member
Dr Esther Elisaria	IHI	Member

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