



UNITED REPUBLIC OF TANZANIA  
**PRIME MINISTER'S OFFICE**

# **NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (NMNAP)**

**FROM EVIDENCE TO POLICY TO ACTION**

JULY 2016 - JUNE 2021



**OCTOBER, 2016**



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# NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (NMNAP)

JULY 2016 –JUNE 2021

From Evidence to Policy to Action

“Great things are done by a series  
of small things put together”

Suggested citation:  
United Republic of Tanzania (2016): National Multisectoral  
Nutrition Action Plan (NMNAP)  
for the period July 2016 – June 2021

Dar es Salaam, October 2016

## KEYNOTE

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

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

income country economy.

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

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



**Hon. Kassim Majaliwa Majaliwa,**  
Prime Minister

## FOREWORD

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

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

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

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

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



**Hon. Ummu Mwalimu**

Minister of Health, Community Development, Gender, Elderly and Children.

## STATEMENT OF COMMITMENT

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

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

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

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

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

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

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

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

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

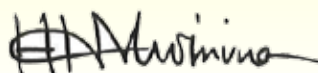
We shall take practical steps to ensure our sector policies, strategies, programmes and budgets are nutrition sensitive;

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

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



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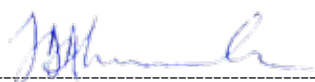
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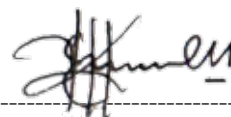
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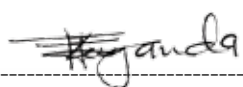
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## ACKNOWLEDGEMENTS

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

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

and NCD Alliance, facilitated the Diet Related Non-Communicable Diseases (DRNCDs) Key Result Area with Ms Julieth Kitali of TFNC as the chair.

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

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



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## EXECUTIVE SUMMARY

### Purpose of the NMNAP

1. This National Multisectoral Nutrition Action Plan (NMNAP) covering the five-year period between 2016/17 and 2020/21 is the implementation plan for the 2016 National **Food and Nutrition Policy (FNP)** and its ten-year **Implementation Strategy (2015/16-2025/26)**. It is an evidence-based “double duty action” multisectoral action plan to address the unacceptably high levels of malnutrition in Tanzania in all its forms – both **undernutrition** and the **increasing burden of diet related non-communicable diseases (DRNCDs)** such as overweight, obesity and diabetes.
2. Anchored within the Government’s Five-Year Development Plan II (2016/17 – 2020/21) the NMNAP’s broad goal is to accelerate scaling up of high impact multisectoral nutrition specific and nutrition sensitive interventions and creating an enabling environment for improved nutrition, to contribute to the building of a healthy and wealthy nation. Though all population groups are considered, the focus is on the most vulnerable groups – infants, children under-five years of age, adolescent girls, pregnant and lactating women and other women of reproductive age (15-49 years of age). By developing a productive human capital that focuses on the most vulnerable groups in society, the NMNAP will contribute significantly to the nation’s aspiration of attaining and sustaining middle income country (MIC) status by 2025 in conditions of peace, stability, equality, opportunity and social justice. Moreover, a well-nourished population will have the productive and learning capacity necessary to compete in a knowledge based MIC economy.
3. The transformative NMNAP builds on Tanzania’s successes in improving nutrition, fills the gaps identified and addresses emerging challenges and priorities. The conceptual framework used, facilitates the incorporation of global and national evidence and experience in addressing malnutrition into concrete actions. Above all it facilitates translation of political

will and commitment into tangible portfolio of services and actions including resource allocation, to be delivered to the population.

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

### Process for developing the NMNAP

5. The process for developing this NMNAP was **guided by a roadmap** that ensured broad participation of all key players in the multisectoral nutrition system through extensive stakeholder consultations and scientific evidence reviews. Stakeholders who participated in the development of the plan included: The Prime Minister’s Office (PMO); President’s Office-Regional Administration and Local Government at central, regional and LGA levels; sector ministries; donors; United Nations agencies; civil society organizations (national and international); academic and research institutions; the private sector; and individual nutrition stakeholders not affiliated with any institution.
6. **The Prime Minister’s Office**, specifically the Director of Government Business Coordination, who is also the Scaling Up Nutrition (SUN) focal point, **oversaw the entire process** of developing the NMNAP. **A Lead Facilitator provided overall technical harmonization, coordination and facilitation, and drafted the NMNAP document. TFNC chaired and acted as the secretariat (the engine) for the coordination** meetings held every two weeks and for the six task teams that developed the action plans for the seven key result areas (KRAs). **Task team facilitators and chairs supported the development of logical and results frameworks, and results-based action plans and budgets. UNICEF facilitated orientations for results based management (RBM), results based budgeting (RBB) and the “theory of change”** to ensure articulation of SMART

results. A **consolidation workshop** synthesized the work from the different task teams and a **validation workshop** reviewed the initial draft document. The **High Level Steering Committee on Nutrition (HLSCN) adopted the NMNAP at its meeting held on 21<sup>st</sup> October 2016** that was chaired by the Permanent Secretary in charge of Policy and Coordination in the Prime Minister's Office.

### Key Result Areas of the NMNAP

7. The NMNAP is organized in seven key result areas (KRAs) to reflect both life-course and multisectoral approaches. The interventions cover a series of complementary nutrition specific and nutrition sensitive interventions and an enhancement of the enabling environment for improved nutrition. Six task teams led by subject matter experts in the KRAs developed operational action plans on one or two KRAs. The operational action plans are summarized in chapter 5 and available separately as annexes 1-7. The prioritized KRAs of the NMNAP are:
  - 1) Scaling up Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN);
  - 2) Scaling-up Prevention and Management of Micronutrient Deficiencies;
  - 3) Scaling up Integrated Management of Acute Malnutrition (IMAM);
  - 4) Scaling-up Prevention and Management of Diet Related Non-Communicable Diseases (DRNCDs);
  - 5) Promoting Multisectoral Nutrition Sensitive Interventions (NSI);
  - 6) Strengthening Multisectoral Nutrition Governance (MNG); and
  - 7) Establishing Multisectoral Nutrition Information System (MNIS).

### Key expected results of the NMNAP

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

### Planned NMNAP targets

9. The key planned targets are adapted from the globally agreed World Health Assembly (WHA) nutrition targets by 2025, the SDGs by 2030 and the global voluntary Non-Communicable Diseases (NCDs) targets by 2025 that Tanzania will report upon. Thus, by June 2021, the NMNAP aims to achieve 12 key nutrition targets as shown in table 1.
10. There are seven key expected outcomes of the NMNAP, divided among the three broad intervention areas. These are: -
  - I. Nutrition specific outcome results:
    - 1) Increased proportion of adolescents, pregnant women and mothers/caregivers of children under two years who practice optimal maternal, infant, young child and adolescent nutrition behaviours<sup>1</sup>;
    - 2) Optimal intake of essential vitamins and minerals to meet physiological requirements and prevent deficiency (focus on vitamin A,

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

**Table 1: NMNAP Key impact and outcome targets by 2020/21**

Planned targets	Baseline	NMNAP target
<b>Impact results</b>		
Reduce prevalence of stunting among children 0-59 months from 34% in 2015 to 28% in 2021 ( <b>WHA target 1</b> )	34.4% (TDHS, 2015)	28%
Maintain prevalence of global acute malnutrition among children 0-59 months under 5% in 2021 ( <b>WHA target 6</b> )	4.5% (TDHS, 2015)	<5%
Reduced prevalence of low birthweight from 7% in 2010 (TDHS 2010) to less than 5% in 2021 ( <b>WHA target 3</b> )	7% (TDHS, 2010)	<5%
Reduced proportion of women 15-49 years with anaemia from 44.7% in 2015 (TDHS 2015) to 33% in 2021 ( <b>WHA target 2</b> )	44.7% (TDHS, 2015)	33%
Reduced prevalence of Vitamin A deficiency among children aged 6-59 months from 33% in 2010 to 26% in 2021	33% (TDHS, 2010)	26%
Maintain median urinary iodine of women of reproductive age between 100-299 µg/L by 2021	100-299 (TDHS 2010)	100-299 µg/L
Maintain prevalence of diabetes among adults under 10% by 2021	9.1% (STEPS, 2012)	<10%
Maintain prevalence of overweight among children under five under 5% by 2021	3.6 (TDHS, 2015)	<5%
Maintain prevalence of overweight among adults under 30% by 2021	29% (STEPS, 2012)	<29%
<b>Outcome results</b>		
Increased proportion of children aged 0-5 months who are exclusively breastfed from 41% (TNNS 2014) to at least 50% by 2021	41% (TNNS, 2014)	50%
Increased proportion of children aged 6-23 months who receive a minimum acceptable diet from 20% (TNNS 2014) to 30% by 2021	20% (TNNS 2014)	30%
Increased proportion of children aged 6-59 months who received Vitamin A Supplement during the last 6 months from 72% (TNNS 2014) to 90% by 2021	72% (TNNS, 2014)	90%
Increased Proportion of households consuming adequately iodized salt from 61 (TDHS 2015) to 80% by 2021	61% (TDHS, 2015)	80%
Increased proportion of pregnant women taking iron and folic acid (IFA) for 90+ days during pregnancy from 8% in 2014 to 50% by 2021	8% (TNNS, 2014)	50%
Increased proportion of children under five in need of SAM treatment who are admitted in the program annually from 9% in 2015 to 75% in 2021	9% (BNA/SAM, 2015/16)	75%
Increased proportion of children under five in need of MAM treatment who are admitted in the program annually from less than 1% in 2015 to 75% by 2021	<1% (WFP Project Report, 2015)	75%
Reduced proportion of people who drink alcohol among adults 25-69 years of age to less than 14%	14% (2012)	<14%
Reduced prevalence of tobacco use in adults 25-69 years of age to less than 18%	18% (2012)	<18%
Increased proportion of planned budget spent on nutrition sensitive interventions by 60% between 2016/17 and 2020/21	0%	60%
Increased proportion of districts implementing the minimum budget allocation to nutrition by 50% between 2016/17 and 2020/21	NA (2015/16)	50% increase from baseline
Increased proportion of councils using nutrition information in their respective plans, budgets and reports to 100% by 2021	NA (2015/16)	100%

- iron, iodine, zinc, folic acid and vitamin B12);
- 3) Increased coverage of integrated management of acute malnutrition (IMAM) services;
- 4) Increased physical activity and healthier dietary habits by the Tanzanian community.
- II. Nutrition sensitive outcome results:
  - 5) Increased coverage of nutrition sensitive interventions from six key development sectors: (i) agriculture and food security; (ii) health and HIV; (iii) water, sanitation and hygiene; (iv) education and early childhood development; (v) social protection; and (vi) environment and climate change.
- III. Enabling environment outcome results:
  - 6) Improved effectiveness and efficiency of nutrition governance (including coordination and leadership) and response across all sectors, actors and administrative levels;
  - 7) Increased access to quality nutrition related information to help the Government of Tanzania and partners to make timely and effective evidence informed decisions.

### Key strategies of the NMNAP

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

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

12. The overarching multisectoral approach will be supported by **ten key cross-cutting strategies**:
  - i. **Social and behaviour change communication (SBCC)** to promote adoption of appropriated behaviours and practices and commitment to achieving common nutrition results for everyone and throughout in the country.
  - ii. **Advocacy and social mobilization** to sustain political will and commitment for nutrition at all levels.
  - iii. **Community-centred capacity development (CCCD)** to improve human, institutional, organizational and functional capacity for nutrition to ensure efficient and effective multisectoral and multi-stakeholder collaboration focusing at the community level;
  - iv. **Developing functional human resource capacity** to ensure that the NMNAP is strategically led and managed well at all levels.
  - v. Aligning all stakeholders with government policies, strategies and plans, including this NMNAP through public-private partnerships (PPP), facilitated by using the “three ONES principle” of ONE plan, ONE coordinating mechanism and ONE monitoring and evaluation framework, so that every stakeholder come together to tackle malnutrition and build an enabling environment for improved nutrition with equity.
  - vi. **Delivery of quality and timely nutrition services** to ensure nutrition services proposed in the NMNAP are efficiently, effectively and timely delivered and/or legally enforced as appropriate.
  - vii. **Mainstreaming equality in** all the seven key result areas without discrimination, **with women, children and adolescent girls** at the centre of the efforts.
  - viii. **Developing a resource mobilization strategy** to advocate for resource allocation to the NMNAP by both Government and Partners using the NMNAP investment plan elaborated in chapter 8.
  - ix. **Tracking progress and developing operational research** to ensure key lessons and insights gained from the implementation of the NMNAP are learnt and used in adjusting and improving the proposed interventions at regular intervals and linking research with



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

### Leadership and management structure of the NMNAP

13. The leadership and management structure of the NMNAP is guided by the roles and responsibilities assigned by the 2016 Food and Nutrition Policy. **The PMO will lead and coordinate the overall NMNAP, provide oversight to ensure that nutrition is a key Government priority, and chair the HLSCN.** Ministries, Departments and Agencies (MDAs) will ensure nutrition is reflected in their relevant policies, strategies, programmes, legislation, regulations and guidelines; and allocate adequate resources to implement their relevant parts of the NMNAP. The Ministry in charge of Regional Administration and Local Government (PO-RALG) will ensure implementation at sub-national levels through the Decentralization and Devolution (D & D) approach paying particular attention to community participation. PO-RALG will coordinate, supervise, support, monitor and integrate the NMNAP in the programmes and by-laws at the regional and local Government levels. In collaboration with relevant actors, TFNC will monitor, evaluate, advocate, mobilise resources, provide overall strategic technical leadership and support to the Government and all sectors and actors identified in this NMNAP. In addition, TFNC will be the institutional base for the multisectoral nutrition information system for tracking and reporting on progress.

### Monitoring and Evaluation of the NMNAP

14. The Common Results, Resources and Accountability Framework (CRRAF) will be used as the overall framework to monitor the NMNAP (see appendix 2). Specific monitoring and evaluation milestones will be assessed through: -
  - i. Annual Joint Multisectoral Nutrition Reviews (JMNRS);
  - ii. The **multisectoral nutrition scorecard and bottleneck analysis** for selected nutrition interventions will be use to monitor progress

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

- iii. Mid-term review (MTR) of the NMNAP will be done during the 2019 JMNR using the results of the 2018 National Nutrition Survey and Public Expenditure Review on Nutrition (PER-N) for 2016-2018.
- iv. Endline evaluation of the NMNAP will be base on the results of the 2020/21 **Tanzania Demographic and Health Survey.**

### The NMNAP to adhere to the THREE ONEs principle

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

### Cost of implementing the NMNAP

16. The overall financial requirement for the NMNAP is about TZS 590 billion (US\$268 million) excluding the Nutrition Sensitive interventions already budgeted for in the 2016/17-2020/21 Five-Year Development Plan-II (FYDP-II) in the areas of Agriculture and Food Security, Health and HIV, WASH (Water, Sanitation and Hygiene), Education, Social Protection and Environment and Climate Change. If the Nutrition Sensitive Interventions (NSI) are included, the overall budget goes up to about TZS 22,262 billion (US\$10,119 million). Assuming that the Health and HIV/AIDS costs (TZS 6,522.1 billion) are nutrition specific interventions, **the proportion of the budget allocated to nutrition specific interventions is 32 percent while**



**nutrition sensitive interventions is 68 percent.**

The greatest share of the FYDP-II budgetary allocation for NSI is for health (30 percent), followed by WASH (26 percent), social protection (19 percent) mainly for TASAF, agriculture (17 percent), education and early childhood development (8 percent) and environment is less than 1 percent.

17. As part of the process for developing the NMNAP investment plan, information was gathered from different stakeholders (Government, UN, Development Partners, CSOs, and Private Sector) about their current financial commitments aligned with the NMNAP for the next five years. **The total resources available from these sources is TZS 155.18 billion (US\$ 70.5 million) against a planned budget of TZS 590 billion (US\$ 268 million) giving a funding gap of TZS 434.77 billion (US\$ 197.6 million). In proportional terms, about 26 percent of the NMNAP funds is available leaving a gap of 74 percent to be mobilized.** The biggest funding gaps are seen in the Key Result Areas of Maternal, Infant, Young Child and Adolescent Nutrition (US\$ -54.97 million), Micronutrients (US\$ -43.81 million), Integrated Management of Acute Malnutrition (US\$ -40.45 million), Diet Related Non-Communicable Diseases (US\$32.48 million) and Multisectoral Nutrition Information System (US\$ -21.87 million). It should be noted that community contributions to the NMNAP, which are substantial, have not been estimated in developing the investment plan.

**Prioritized interventions in case of resource constraints**

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

reproductive age (15-49 years).

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

**A call to stakeholders to support the NMNAP**

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

**Organization of the NMNAP document**

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

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

**Chapter 2 provides a situation analysis and strategic context** looking at Tanzania's development context, the evidence base used,

the nutrition trends as well as the policy basis for the NMNAP.

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

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

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

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

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

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

Chapter 9 provides a risk analysis and mitigation measures.

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

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

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

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

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

**Annex 5:** Multisectoral Nutrition Sensitive Interventions

**Annex 6:** Multisectoral Nutrition Governance; and

**Annex 7:** Establishing a Multisectoral Nutrition Information System.

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

# CHAPTER 1

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## INTRODUCTION

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# INTRODUCTION

## 1.1 Overview

1. This document articulates the Tanzania **National Multisectoral Nutrition Action Plan (NMNAP)** for the period 2016/17-2020/2021. The period coincides with the second Five-Year Development Plan of the Government's long term strategic plan (2010-2025) for economic and social growth (MKUKUTA) and provides a logical continuation of the five-year National Nutrition Strategy (NNS) 2011/2012-2015/2016. The NMNAP was developed to translate into concrete actions the policy objectives and basic principles included in the 2016 Tanzania National Food and Nutrition Policy to address the unacceptably high levels of **malnutrition**.
2. The term **malnutrition** is used here to refer to both **undernutrition** and **overnutrition**. **Undernutrition manifests itself** mainly as **stunting** (low height-for-age or chronic undernutrition); **wasting** (low weight-for-height or acute undernutrition); **underweight** (low weight-for age, a combination of stunting and wasting); and **low birth weight** (of less than 2.5kg). **Micronutrient deficiencies** (often called hidden hunger) caused by deficiencies of essential vitamins and minerals also fall in the category of undernutrition. The main essential vitamins and mineral deficiencies in Tanzania are: vitamin A, folic acid, vitamin B12 and iodine, iron and zinc. **Overnutrition manifests** mainly as **overweight and obesity**, which lead to the development of **diet related non-communicable diseases (DRNCDs)** including diabetes, high blood pressure, cardio-vascular diseases, weight related joint pains and several types of cancer.
3. The NMNAP is a "double duty action" plan that for the first time in Tanzania integrates actions to combat undernutrition with those which aim to prevent and control overweight/obesity and related non-communicable diseases into one plan. "Double duty-actions" have the potential for greater impact on malnutrition in all its forms, than actions addressing specific types

of malnutrition in isolation through vertical interventions. The NMNAP galvanizes recent scientific evidence and national and global political attention on nutrition into integrated inter-sectoral transformative actions and multi-stakeholder collaboration for improved nutrition.

## 1.2 Political Will and Government Commitment to addressing malnutrition

4. Tanzania's commitment for nutrition is longstanding. Since independence in 1961 the declared major enemies of Tanzania were poverty, disease and ignorance, all major causes and consequences of malnutrition. Despite progress made, undernutrition is still a major impediment to the alleviation of all the three enemies. The key challenge has been to translate the political will and state commitment into evidence-based, effective, impactful and sustainable policies, strategies and actions that are implemented at scale, well-coordinated, resourced and monitored.
5. Committed to providing leadership in nutrition in recent years, the Government formally adopted a multisectoral approach and increased its commitment to improve nutrition by:
  - i. Developing a National Action Plan for NCDs 2008-2015;
  - ii. Launching the National Nutrition Strategy (NNS) 2011/12-2015/16 and its Implementation Plan;
  - iii. Reviewing and updating the 1992 into a 2016 National Food and Nutrition Policy;
  - iv. Actively participating in the Global SUN Movement at Presidential level after joining in 2011 as one of the 26 Early Riser Countries;
  - v. Creating a Multisectoral High-Level Steering Committee for Nutrition (HLSCN) coordinated by the Prime Minister's Office and multisectoral steering committees for nutrition at regional and district levels;
  - vi. Creating a Nutrition Section in the Ministry of Health, Community Development, Gender, Elderly and Children;

- vii. Creating a Nutrition Section in the Ministry of Regional Administration and Local Government (RALG) initially in the Prime Minister's Office and from 2016 in the President's Office to ensure effective decentralization of nutrition actions and resources.
  - viii. Establishing and funding the posts of Regional and District Nutrition Officers (RNUO and DNUOs) and recruiting qualified people in these positions for all regions and districts.
  - ix. Developing guidelines for nutrition planning and budgeting by regional and district/council nutrition officers for inclusion in the council's comprehensive plans since 2012.
  - x. Developing tools to track progress towards scaling-up nutrition by tracking both results and financial expenditures: e.g. the Public Expenditure Review (PER) of the Nutrition Sector in 2013 expected to be repeated every 2-3 years, developing and adoption of the **Nutrition Scorecard** in 2015 and organizing annual Joint Multisectoral Nutrition Reviews (JMNRS) since 2014.
6. The **Government's efforts to decentralize public financing for nutrition** to the Local Government Authorities resulted in a steady increase in funds for nutrition at the district/municipal councils with financial allocations for nutrition per district/municipal council increasing from TZS 58 million in Financial Year 2011/12 to TZS 217 million in Financial Year 2014/15 for each district/municipal council.

### 1.3 The evidence base for the NMNAP

7. Although no formal evaluation of the implementation of the National Nutrition Strategy (NNS) of 2011/12 - 2015/16 was done, there were several reviews, surveys and studies undertaken that together with global programme assessments provide the evidence-base for the NMNAP. These included the Landscape analysis to assess Tanzania's readiness to scale-up nutrition (TFNC 2012)<sup>3</sup> ; the 2014 and 2015 Joint

Multisectoral Nutrition Reviews<sup>4</sup>; the 2014 Technical Review Paper (Vision 2025) on "Towards Eliminating Malnutrition in Tanzania" by 2030<sup>5</sup>; the 2014 National Nutrition Survey (SMART Survey); the 2015/16 Tanzania Demographic and Health Survey and Malaria Survey (TDHS-MS) and the 2016 Scaling Up Nutrition (SUN) Movement Joint Assessment for Tanzania. Moreover, as part of the process for developing the NMNAP, several bottleneck analyses (BNA) were done to assess the operational challenges and key constraints to the effective delivery and of scaling-up of interventions at the Local Government Authority (LGA) Council level. Additionally, extensive global literature reviews provided the scientific evidence. Desk reviews of the National Nutrition Multisectoral Plans for Ethiopia, Nepal and Sri Lanka provided global experience in developing such plans.

### 1.4 The NMNAP and the National Development Agenda

8. Tanzania's system of general policies, legislation, strategies and programmes for development is generally favourable to the improvement of nutrition. The overarching policy framework used in developing this NMNAP is the Government's 2016 Food and Nutrition Policy (FNP). The FNP's desired change is to have "Tanzanians with good nutrition for a healthy, productive and prosperous nation" through providing "a favourable environment for delivery of quality, equitable, cost effective, large scale and sustainable multisectoral nutrition interventions".
9. The NMNAP is also aligned with the Government's Five-Year Development Plans to ensure anchorage within the national economic and social development agenda. The National Five Year Development Plan II of 2016/17 – 2020/21 (**FYDP II**) was prepared in the context of the long-term National Strategy for Growth and Reduction of Poverty (Development Vision 2025) known

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

4 Kavishe F.P (2014 & 2015): [https://www.researchgate.net/publication/267252935\\_Report\\_on\\_the\\_First\\_Tanzania\\_Multisectoral\\_Nutrition\\_Review\\_August\\_19-21\\_2014](https://www.researchgate.net/publication/267252935_Report_on_the_First_Tanzania_Multisectoral_Nutrition_Review_August_19-21_2014) and [https://www.researchgate.net/publication/283122986\\_Report\\_on\\_the\\_2015\\_and\\_Second\\_Tanzania\\_Joint\\_Multisectoral\\_Nutrition\\_Review](https://www.researchgate.net/publication/283122986_Report_on_the_2015_and_Second_Tanzania_Joint_Multisectoral_Nutrition_Review)

5 Kavishe F.P (2014): [https://www.researchgate.net/publication/267309649\\_Towards\\_Eliminating\\_Malnutrition\\_in\\_Tanzania\\_Vision\\_2025](https://www.researchgate.net/publication/267309649_Towards_Eliminating_Malnutrition_in_Tanzania_Vision_2025)

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

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

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

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

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

### 1.5 The NMNAP and the international development agenda

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

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



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

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

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

African Food and Nutrition Policy, the Southern Africa Development Community (SADC) Food and Nutrition Security and the African Union (AU) Food and Nutrition Strategy (2015-2025). Globally, they include inter alia: **Agenda 2030 on Sustainable Development Goals (SDGs); the 2012 World Health Assembly nutrition targets for 2025; the UN Network for Scaling Up Nutrition (SUN) Strategy (2016-2020)**<sup>9</sup>; the **UN Decade (2016-2025) of Action on Nutrition**; the second **International Conference on Nutrition (ICN2) Plan of Action**; the **2011 UN Political Declaration and 2014 UN Outcome Document on Non Communicable Diseases (NCDs)**. Other key global plans and strategies include the WHO comprehensive implementation plan on maternal, infant and young child nutrition<sup>10</sup> and the WHO global strategy for women’s, children’s and adolescent health 2016-2030<sup>11</sup>.

16. The United Nations Agenda 2030 (SDGs) challenges countries to end all forms of malnutrition by 2030 by including as the second SDG, “End **hunger, achieve food security and improved nutrition and promote sustainable agriculture**”. Clearly, nutrition is central to the SDGs with at least 12 of the 17 SDGs containing indicators vital for nutrition improvement. These are SDGs 1, 2, 3, 4, 5, 6, 8, 10, 13, 15, 16 & 17 (figure 1), which reflect an appreciation of the importance of nutrition in sustainable development.
17. The Global Nutrition Report of 2016 calls on countries to take five critical actions to address the problem of malnutrition: (1) Make the political choice to end all forms of malnutrition (2) Invest more and allocate better for nutrition (3) Collect the right data to maximize investments in nutrition (4) Invest in carrying out proven and evidence informed solutions – and identify new ones; and (5) Tackle malnutrition in all its forms. This NMNAP recognizes and incorporates all five of these critical actions.

9 SUN Movement (2016): Strategy and Roadmap (2016-2020) [http://www.who.int/nutrition/publications/CIP\\_document/en/](http://www.who.int/nutrition/publications/CIP_document/en/)  
 10 <http://www.who.int/life-course/partners/global-strategy/en/>  
 11



18. Moreover, the NMNAP is aligned with the SUN Movements Vision of a “world free from malnutrition in all its forms by 2030, to be led by governments and supported by organizations and individuals to take collective action to ensure every child, adolescent, mother and family can realise their right to food and nutrition, reach their full potential and shape sustainable and prosperous societies”. The proposed actions of the NMNAP also align with the SUN Movement’s 2016-2020 Strategy for transformational pathway of change: (i) Multiple stakeholders come together to tackle malnutrition and build an enabling environment for improving nutrition with equity, (ii) The actors change their behaviours and commit to achieving common nutrition results for everyone, everywhere, (iii) Resources are mobilized and coverage of locally relevant nutrition specific actions and nutrition sensitive contributions are scaled up, (iv) Aligned implementation achieves results far greater than what could have been achieved alone, (v) women, children, adolescents and families thrive leading to the end of malnutrition by 2030 and (vi) contributing to the achievement of all SDGs.
19. The key international normative agenda that this NMNAP addresses are the health and nutrition human rights articulated in the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW). As the ultimate state duty bearer, the Government of Tanzania will ensure that the nutrition rights of Tanzanians to achieve optimal nutrition and health are respected, protected and fulfilled adequately within the national, regional and global nutrition relevant frameworks and will mobilize national and international resources and collaboration towards that end.

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



## 1.6 Why invest in nutrition?

20. In addition to being a requirement by the 2016 Food and Nutrition Policy, there are several other important reasons for investing in nutrition through the NMNAP.
  - I. First, the economic rationale: investing in nutrition contributes to national economic prosperity in four main ways.
    - 1) Improving nutrition increases productivity, economic growth and facilitates poverty reduction through improved physical work capacity, cognitive development, school performance, economic activity and health by reducing sickness and deaths.

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

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

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

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

- III. Third, **addressing malnutrition is a political choice to foster security, peace and stability.** Nationally, it will greatly contribute to Tanzania’s political agenda of peace and stability and propelling the

country into middle income country (MIC) status by 2025. Globally, it contributes to global security and peace and provides national anchor for the implementation of the global development and normative agendas.

### 1.7 Who are the main audience for the NMNAP?

21. The NMNAP main audience is policy makers (and their technical staff) at all levels (national & sub-national), who are involved in the design of policies for, and responsible for the allocation of resources towards improving the health and wellbeing of the population. At the operational level, the NMNAP targets those responsible for programme implementation and service delivery at all levels with strategic direction. Furthermore, the NMNAP addresses donors, development partners and other state and non-state actors in nutrition, including civil society organizations and the private sector, who finance nutrition improvement initiatives and projects will find this NMNAP useful in setting priority investments and implementing their country strategies.

### 1.8 The process for developing the NMNAP

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

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

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

23. After developing a roadmap that provided the foundation for establishing seven Key Result Areas (KRA), each KRA was steered by task teams that were led by an expert facilitator and chaired by a TFNC subject area expert. A Lead Facilitator who is a senior nutrition expert with extensive national and international experience in nutrition provided critical technical analysis, quality assurance, coordination and synthesis of the task teams' outputs into this coherent NMNAP. The TFNC Acting Managing Director provided administrative coordination and chaired multi-task team strategic forums.
24. A great amount of dynamic flexibility was built into the process to allow for incorporation of new and emerging ideas including doing a consultation with the

private sector and holding two workshops on the "Theory of Change and Complexity". The flexibility helped to widen stakeholder participation, sharpened the capacity for articulating results-based planning and budgeting and allowed for reflective in-depth contributions by stakeholders. The NMNAP document finalization process included consolidation and validation workshops of key stakeholders and external peer review of the drafts. The High Level Steering Committee on Nutrition (HLSCN) adopted the NMNAP at its meeting held on 21<sup>st</sup> October 2016, which was chaired by the Permanent Secretary in the Prime Minister's Office responsible for Policy and Coordination.

# CHAPTER 2

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## SITUATION ANALYSIS AND STRATEGIC CONTEXT

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## SITUATION ANALYSIS AND STRATEGIC CONTEXT

### 2.1 Tanzania's development context

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

26. In its 2016 Tanzania Economic Update<sup>14</sup>, the World Bank estimated a poverty headcount of about 12 million Tanzanians (23 percent of the population) for 2015 compared to 28.2 percent in 2012 and 34 percent in 2007. Although this represents an improvement, the majority of the non-poor are only marginally above the poverty line with the risk of sliding back into poverty in the event of even the slightest shock. Moreover, the World Bank estimates that about 44 percent of the population lived on less than US\$1.25 per day (much higher if the new cut-off point for poverty of US\$1.90 is used) and 90 percent of the population lives on less than US\$3 per day. The slow progress in poverty reduction despite a decade's robust GDP growth can be explained by the slow pace of employable human capital formation

and lack of growth in the labour intensive sectors like in agriculture in rural areas where about 80 percent of the population lives. Most of Tanzania's GDP growth has been driven by increased private consumption and public investment, together with the rapidly growing sectors of communication, construction, financial services, the service industry and mining (including gas and oil), which do not have an immediate effect on improving nutrition.

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

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

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

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

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

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

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

## 2.2 Tanzania's Vital Nutrition Trends

30. The extent, causes, impact, trends, patterns and challenges of the problem of malnutrition in Tanzania are already captured in the 2016 Food and Nutrition Policy and

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

### 2.2.1 Who are those with suboptimal nutritional status?

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

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

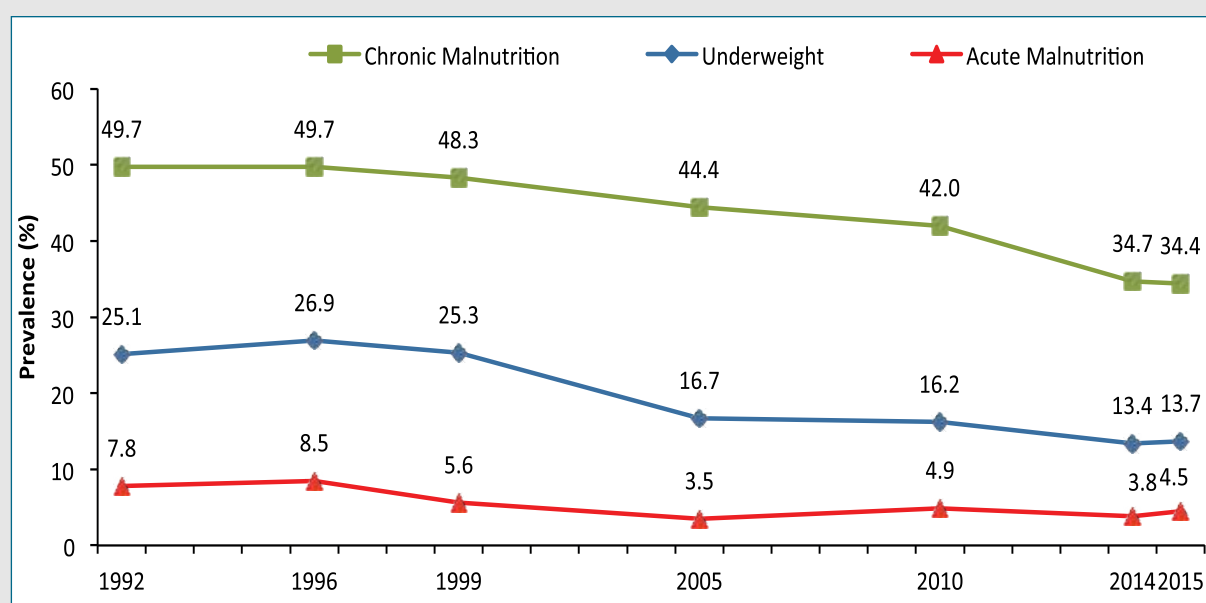
## 2.2.2 Undernutrition improving but levels still unacceptably high

32. Taking a long-term perspective, the undernutrition situation could best be described as (i) very high and constant over time and in all regions of the country during the 1960s, 1970s and early 1980s; (ii) responding to specific interventions during the mid-1980s and 1990s; (iii) progressing too slowly despite good economic progress in the early 2000s; and (iv) improving but still unacceptably high with a double burden of undernutrition and overnutrition during the 2010s.
33. A review of the nutrition status trends based on anthropometric measurements confirms that there have been some significant declines in the prevalence of undernutrition during the last two decades (see figure 2). The levels of stunting in children 0-59 months reduced from a prevalence of 50 percent in the 1990s to 34 percent in the 2015/16 TDHS, but still above the average of 30 percent for Africa and falls within the category of "high" in public health significance. Due to the rate of population growth outstripping the

rate of reduction, the absolute numbers of stunted children increased from below 2.0 million in the early 2000's to about 3.0 million in 2010. However, a decline was observed in 2015 with 2.7 million stunted children. During the same period, the prevalence of underweight declined from 25 percent to 14 percent close to meeting the MDG1 target of halving underweight by 2015.

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

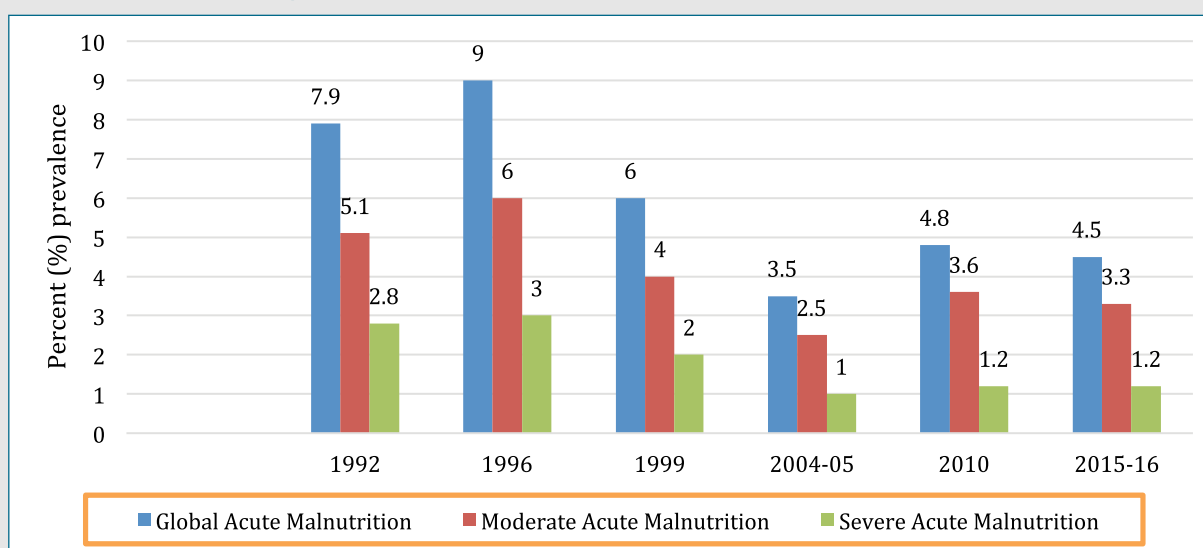
**Figure 2: Prevalence trends of stunting, wasting and underweight in children under five years in Tanzania (1992-2015/16). Source: WHO Global data base, TDHS 1992-2015/16, TNS 2014**





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

Source: TDHS 1992-2015/16



35. Although practices with regard to Infant and Young Child Feeding (IYCF) show some improvement in complementary feeding, it appears that there is a decline in the key practice of exclusive breastfeeding for the first six months of an infant's life. **The prevalence of exclusive breastfeeding during the first six months of life declined from about 50 percent in 2010 (TDHS) to about 43 percent in 2014 (TNNS).** Though the 2015/16 TDHS shows an improvement to a prevalence of 59 percent, there are concerns about the quality of the collection of the data on exclusive breastfeeding, for it is unlikely that the prevalence could increase by 16 percent points in just one year.

36. Complementary feeding after six months of exclusive breastfeeding appears to be satisfactory in terms of the timely introduction of complementary foods. The latest TDHS-MS (2015/16) shows that as high as 90 percent of children 6-8 months and 97 per cent of children 9-11 months received timely complementary foods and almost half (47 percent) of children aged 18-23 months were no longer breastfeeding. However, only about 8 percent of children 6-23 months met the minimum acceptable diet criteria appropriate for their age. These indicators include **frequency** of feeding and **dietary diversity** of complementary feeding. Improvements in complementary feeding have almost wiped out marasmus

and kwashiorkor, the severe forms of protein energy malnutrition, where in the 1970s and 1980s, hospitals used to have special nutrition rehabilitation units (NURU- which means beam of light in Kiswahili) for their treatment.

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

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

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

- with iodized salt increased from 73 percent in 2005 (TDHS 2004-05) to 82 percent in 2010 (TDHS 2010) where it has remained the same (81 percent) in the TDHS-MIS 2015-16.
- 3) Data from laboratory analysis indicated that the proportion of households with iodized salt increased from 90 percent in the 2010 TDHS to 96 percent in 2015 TDHS. During the same period, households with adequately iodised salt (15+ ppm) increased from 47 percent in 2010 to 61 percent in 2015.
  - 4) The proportion of women who gave birth in the 5 years before the survey who took iron supplements or syrup for 90 days or more as recommended during pregnancy increased from 5 percent in 2010 to 21 percent in the 2015-16 TDHS – MIS .
  - 5) The prevalence of any anaemia in women aged 15-49 years declined from 48 percent in 2004-05 to 41 percent in 2010; however, it increased to 45 percent in the 2015-16 TDHS – MIS.
  - 6) With regard to iron deficiency, the 2010 TDHS showed a 30 percent prevalence of iron deficiency in women aged 15 - 49 years, of whom 16 percent were iron deficient without having anaemia and 14% were iron deficient and having anaemia. It also showed that 35% of children aged 6 - 59 months were iron deficient, while 11% were iron deficient without having anaemia and 24% were iron deficient and having anaemia.
  - 7) The prevalence of anaemia in children 6-59 months declined from 72 percent in TDHS 2004-05 to 59 percent in 2010 TDHS; where it remained the same (58 percent) in the 2015-16 TDHS-MIS.
  - 8) A review of the Vitamin A Supplementation (VAS) programme in children age 6-59 months in Tanzania for purposes of drawing lessons for decentralized nutrition planning and budgeting<sup>18</sup>, showed that the coverage of VAS during the 2001-2010 decade was consistently over 80 percent. However, the 2015/16 TDHS-MIS shows coverage has declined to 41 percent.
  - 9) The prevalence of Vitamin A Deficiency (VAD) in the 2010 TDHS was 33 percent in children 6-59 months and 36 percent in women of reproductive age 15 -49 years.

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

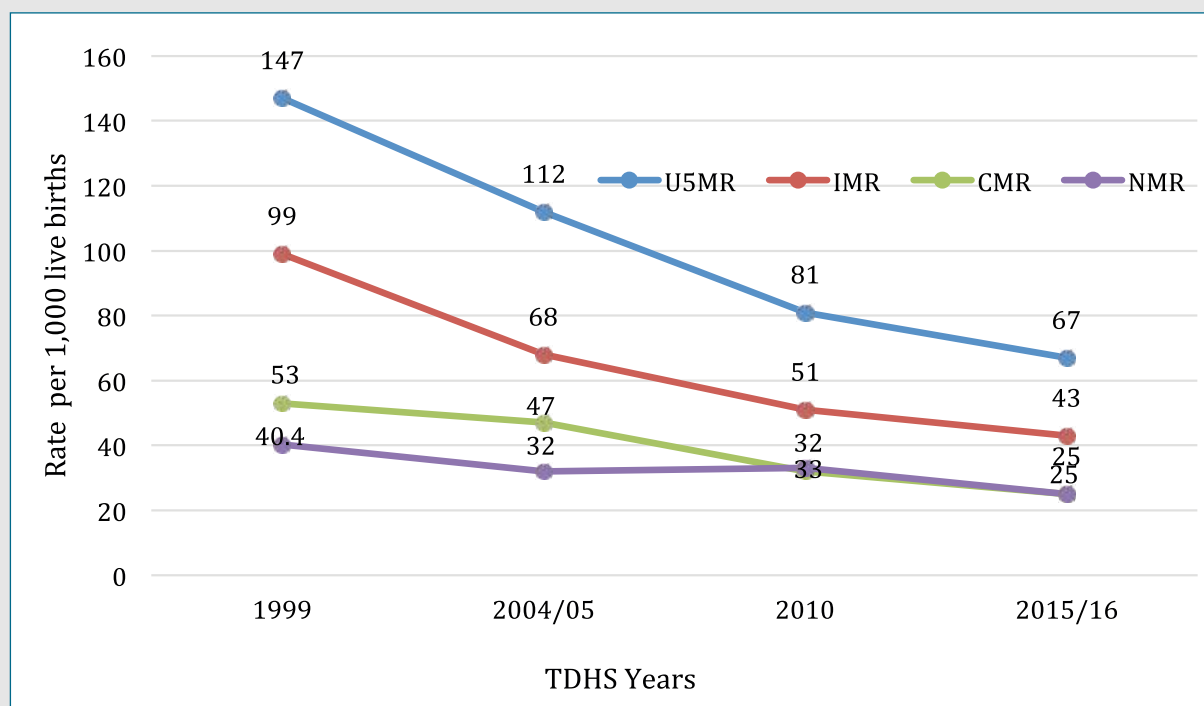
Though no data for 2015/16 TDHS-MIS is available, an improvement of the situation is expected to have occurred given the high supplementation coverage.

- 10) The coverage of Vitamin A supplementation among children 6-59 months increased from 46% in 2005 (TDHS) to 72% in 2014 (TNNS).
39. The high-impact interventions used to realize these improvements included micronutrient supplementation, food fortification, food-based dietary diversity strategies, together with efforts to reduce the transmission and treatment of infectious diseases that deplete micronutrients like measles, diarrhoea, acute respiratory infections (ARI), hookworms and malaria. However, in spite of this progress, the country has yet to ensure optimal intake of these vitamins and minerals in all population groups, leading to mild and moderate deficiencies, which also have profound adverse health effects. Consequently, there is a need for scaling-up and sustaining the high impact interventions for preventing and managing micronutrient deficiencies.

### **2.2.3 Childhood mortality reducing rapidly but levels still unacceptably high.**

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

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



#### 2.2.4 Slow progress in neonatal and maternal mortality

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

#### 2.2.5 The emerging double burden of malnutrition

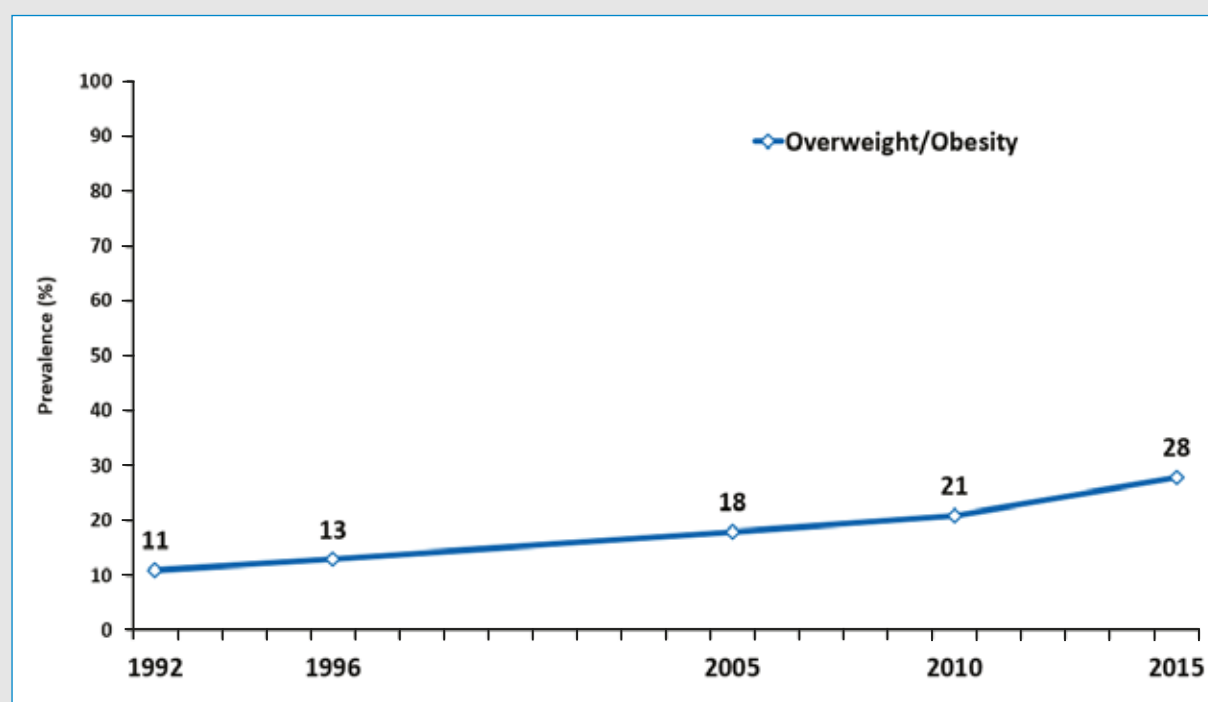
42. While there has been some progress towards reduction in the burden of undernutrition, the problem of overweight and obesity, which is associated with diet related non-communicable diseases (DRNCDs) has been increasing in children and adults, especially women of reproductive age. Overweight in children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

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

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

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

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



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

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

46. Globally, overweight and obesity have reached epidemic proportions prompting the UN to hold two High Level Meetings on NCDs with a third consultation planned for 2018. The UN set four time-bound commitments in its 2014 UN Outcome Document on NCDs which this NMNAP will implement; (i) consider setting up national NCD targets for 2025 (ii) consider developing national multisectoral policies and plans to achieve the national targets by 2025; (iii) reduce risk factors for NCDs, building on guidance set out by WHO Global NCD Action Plan and (iv) strengthen health systems to address NCDs through people oriented primary health care and universal health coverage, building on guidance set out in the WHO Global Action Plan.
47. The most important contributors to the rise in diet related non-communicable diseases are an increase in the mean food energy intake and a decrease in physical activity in households, communities and populations that have reached abundant food security and developed unhealthy dietary practices like eating too much foods rich in fats, sugar and carbohydrates. In such environments, food is used not only to meet nutrition needs, but also for social reasons like relaxing, reducing stress and socialization accompanied by sedentary lifestyles. In the Tanzanian context, there is the additional cultural perception that being obese is admirable, a sign of being wealthy and healthy.

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

48. All regions of Tanzania suffer from all types

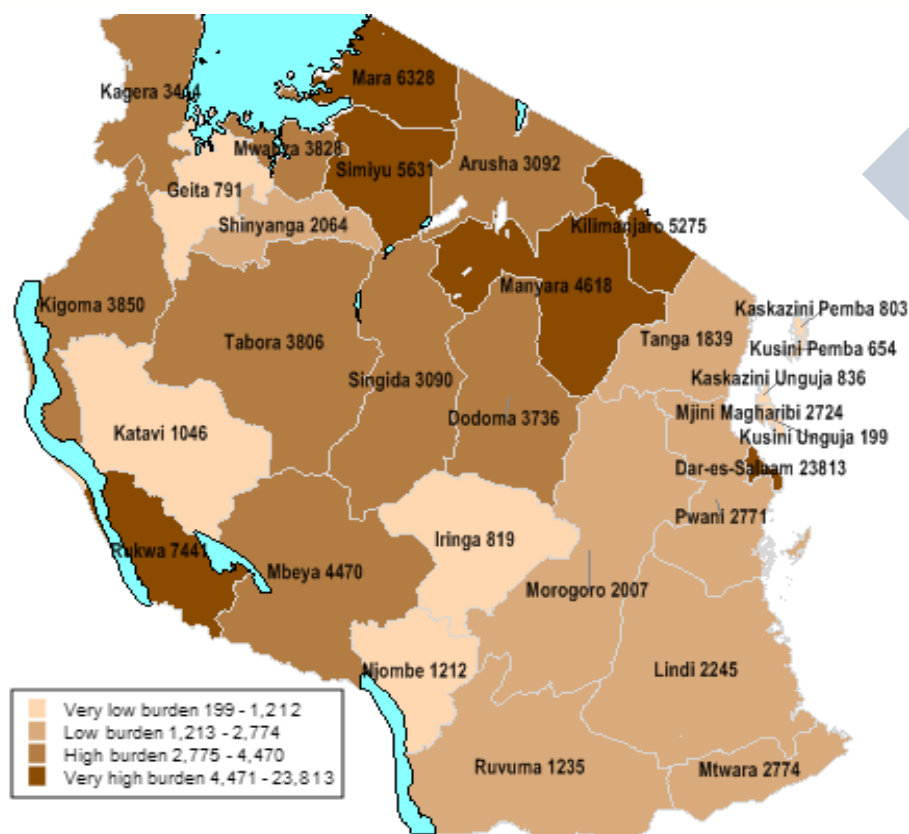
of malnutrition, though the severity of the problems differ. There are three key drivers of the pattern of malnutrition in Tanzania. These are geographical location, level of education and income disparity. These three drivers and their role in the aetiology of undernutrition is described in the next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

49. **Geographical location:** In general, rural areas are more affected by undernutrition than urban areas, while urban areas are more affected by overweight and obesity than rural areas. According to the 2015/16 TDHS, the prevalence of stunting among children living in urban areas was 24.7 percent compared to 37.8 percent for children living in rural residences. Very high prevalence of stunting (of above 40 percent) were seen in five mainly rural regions: Rukwa (56.3 percent), Njombe (49.4 percent), Kagera (41.7 percent), Iringa (41.6 percent) and Geita (40.5 percent). Ironically, Rukwa, Njombe, and Iringa are known to be the food basket regions in Tanzania. As such the implication is that factors other than food are responsible for these high prevalence of stunting. Stunting prevalence of above 30 percent are categorized as severe in terms of public health significance.
50. The geographical distribution of the burden of stunting could be categorized by zones and regions as per *table 2*. Only the Eastern zone (out of 7 zones) and five regions (out of 24 excluding the new regions) have stunting prevalence of below 30 percent. With a stunting prevalence of 14 percent, Dar es Salaam has the lowest prevalence of stunting.

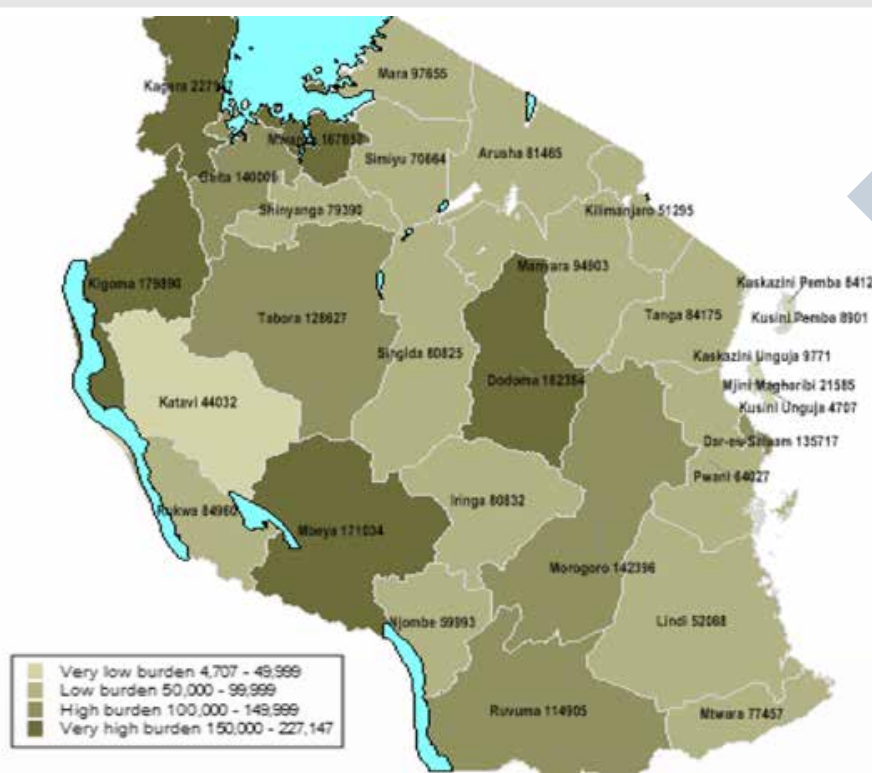
**Table 2: The geographical pattern of malnutrition, Tanzania (Source: TDHS-MS 2015/16)**

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

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



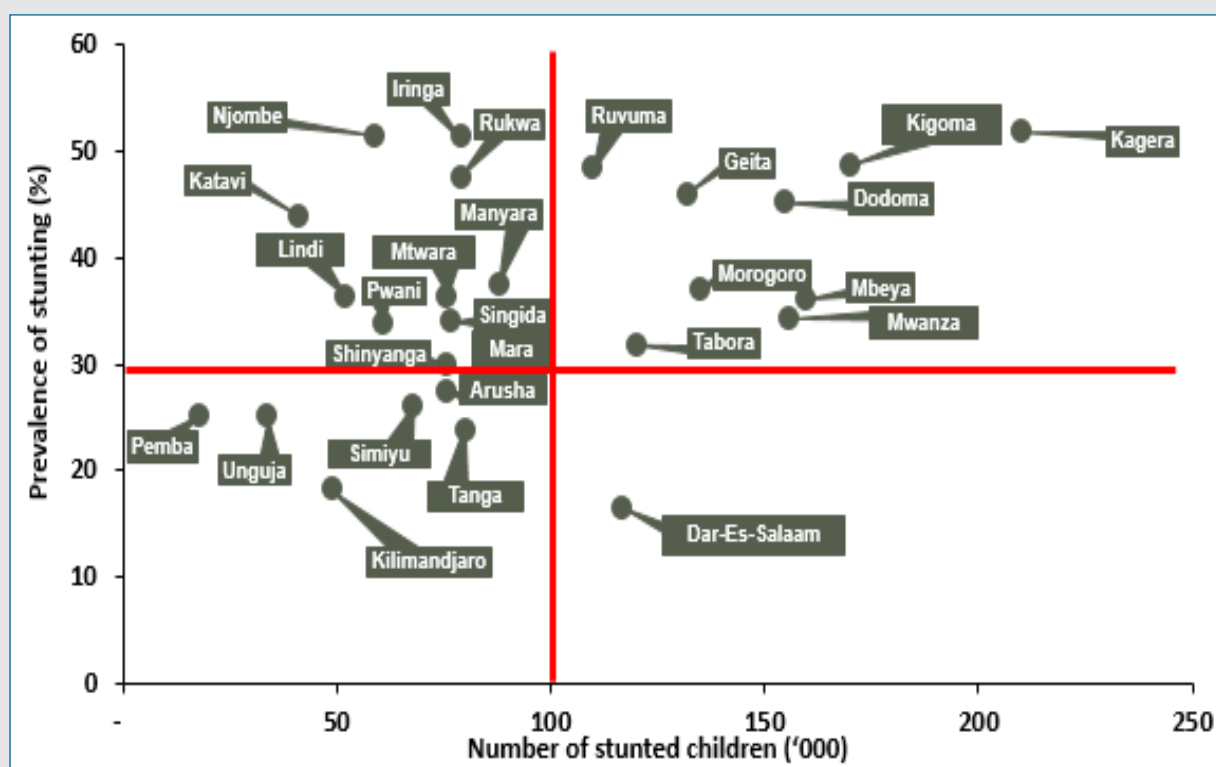
**Figure 6: Geographical distribution of the number of stunted children in Tanzania (2014 TNS)**



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



**Figure 8: Under-five stunting prevalence and burden by region**



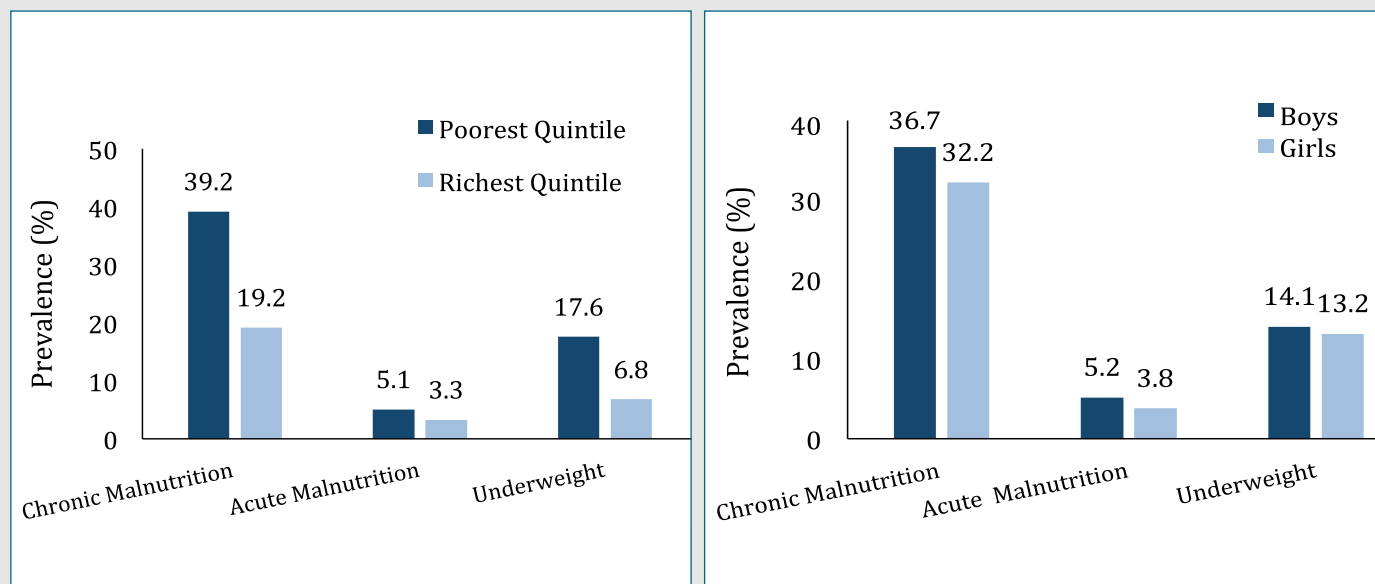
Source: TNS 2014 and Census 2012

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

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



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



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

### 2.3 Major causes of malnutrition in Tanzania

55. Malnutrition is the biological manifestation of various social processes in society. UNICEF developed a useful model which categorizes the key determinants of poor nutrition according to three distinct levels of causality: immediate, underlying and basic. While the immediate factors act at the individual and household level, the underlying and basic factors operate predominantly at the higher

levels of society starting with the community and extending to the political and economic structures at the district, regional, national and international levels. According to the conceptual framework used in developing this NMNAP, **interventions at the level of immediate causes are referred to as nutrition specific; while those targeting the underlying causes are nutrition sensitive interventions; and finally, those that focus on the basic causes as enabling environment interventions. To have high and sustainable impact, simultaneous actions must be taken at all levels of causality (immediate, underlying and basic) and levels of society (household, community, national and international)** as done in this NMNAP.

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

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

57. The underlying causes of malnutrition can be clustered into three determinants: food security, caring capacity and access to basic services like health, education, and safe water, sanitation and hygiene (WASH). While each category is a necessary causative factor, none acts entirely independently. Food security refers to diversified food availability throughout the year, its economic and cultural accessibility and its biological utilization to meet nutritional needs. The care of children, pregnant and lactating women, the elderly and those suffering from diseases including AIDS and tuberculosis is important to improve nutrition in those population groups. Recent studies show that inadequate access to safe water and sanitation and poor hygiene practices increase the burden of infectious pathogens and lead to growth retardation and stunting.
58. **Basic causes of malnutrition in Tanzania** are predominantly in the area of enabling environment. They include among others: income disparity, poverty, inadequate nutrition and general political governance, ignorance due to low education, nutrition unfriendly customs and traditions, and inadequate functional institutional capacity at all levels for nutrition. Others are inadequate linkages with nutrition of sectoral policies, strategies and programmes especially in the key nutrition sensitive sectors of agriculture, education, WASH, social protection and climate change and environment. Moreover, enforcement of nutrition relevant laws and regulations is inadequate and tracking of both nutrition specific and nutrition sensitive interventions for results and investments is not systematized and institutionalized.

## 2.4 The impact of malnutrition on national development in Tanzania

59. Malnutrition constrains all aspects of national development. By contributing to child and maternal illnesses and deaths, it reduces the rates of survival and, therefore, reduces overall life expectancy of the population. Secondly, malnutrition impairs physical and mental growth leading to poor performance in school and the ability to develop essential survival and development skills due to poor cognitive development. Thirdly, for those who survive to adulthood, they become small in stature and are unable to reach their productive potential. They earn less than their counterparts, their limited skills development make it difficult to be employed and many remain in abject poverty. Of the multidimensional causes of child poverty<sup>20</sup>, malnutrition stands out as one of the most serious dimensions.
60. Moreover, malnutrition in childhood has a cumulative impact along the life course. For women who were stunted in childhood, their short stature can result in poor birth outcomes including a higher risk for maternal and neonatal mortality. Malnutrition in pregnant women explains to a large extent the slow progress in the reduction of the high levels of maternal mortality ratio (MMR) and neonatal mortality in the country.
61. Stunting in childhood is also related to overweight and obesity later in life. People who were stunted in childhood, have a higher risk of developing overweight, obesity and diet related non-communicable diseases (DRNCDs). The cumulative effect of malnutrition during the life course leads to intergenerational cycles of malnutrition, poverty and inequality and thus drags down national development.
62. The economic burden of malnutrition in Tanzania is significant. It is estimated that malnutrition annually reduces Tanzania's GDP growth by about 2.5 percent, and if the impact of poor sanitation and hygiene on stunting is added, the effect may reach up to 10 percent reduction of GDP growth. This

20 UNICEF (February 2011): A Multidimensional Approach to Measuring Child Poverty. Social and Economic Policy Working Briefs. UNICEF Policy and Practice [http://www.unicef.org/socialpolicy/files/A\\_Multidimensional\\_Approach\\_to\\_Measuring\\_Child\\_Poverty\(2\).pdf](http://www.unicef.org/socialpolicy/files/A_Multidimensional_Approach_to_Measuring_Child_Poverty(2).pdf)

is further illustrated by the 2014 PROFILES<sup>21</sup> data for Tanzania. PROFILES consist of a set of computer-based models that generate estimates of the benefits of improved (or compromised) nutrition on health and development outcomes. Taking 2025 as the target date and an improving nutrition scenario (as is anticipated through the NMNAP), about 900,000 children would have been saved from mild to severe brain damage due to maternal iodine deficiency and over 120,000 children saved from death due to the impact of stunting. Again using an improved nutrition scenario, the estimated future economic gain is a total of about US\$4.8 billions of which \$3.9 billion is the result of reduction in stunting; US\$382 million due to improvements in anaemia among non-pregnant women and \$479 million gained as a consequence of improvements in iodine nutrition. The figures underscore the fact that investing in nutrition is not only a health investment, but an economic investment with huge economic returns.

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

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

### 2.5.1 Contextual factors

64. The main contextual factors include: -
  - 1) **Low awareness of the problem of malnutrition** by policy makers, the media and the public at large (e.g. stunting and micronutrient deficiencies largely not recognized as problems).

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

- 2) **Low investment in nutrition:** currently nutrition is not adequately prioritized in the allocation of financial resources. The 2013 Public Expenditure Review on Nutrition (PE-N) showed that only about 23 percent of expenditure on nutrition is from public funds, the rest is from donors. A Government review of nutrition funding for the FY 2011/12 - FY 2015/16 (Nutrition Budget Brief 2016) concludes that although resources for nutrition-related activities increased and even doubled during the period reviewed, spending on nutrition accounted for only 0.03 percent of GDP and 0.13 percent of total public spending. Moreover, **only 12 percent of the National Nutrition Strategy (NNS) for 2011/12-2015/16 total budget of about TZS 825 billion (US\$520 million) was funded and mostly by donors.** Over reliance on donor funds for nutrition introduces a large amount of uncertainty into nutrition planning given the sometimes erratic nature of donor funding. A robust resource mobilization strategy that emphasizes increased domestic resources will be developed in the implementation of the NMNAP.
- 3) **Inadequate nutrition governance:** e.g. inadequate multisectoral coordination of interventions at all levels, lack of common results, resources and accountability framework for nutrition, poor enforcement of relevant laws, low use of technology for nutrition;
- 4) **Inadequate focus on the Community and life course:** reaching communities with large scale nutrition interventions has been slow and some vulnerable groups like adolescent girls were not covered;
- 5) **Low functional institutional capacity for nutrition at all levels.** Although institutions for nutrition have satisfactory technical capacity, functional and strategic capacity is low at all levels.
- 6) **Inadequate attention to the social determinants of malnutrition** to effect social change for nutrition improvement. Social determinants are the conditions into which people are born, live, work and age. They include behaviour, practices, formal and informal structures and systems some of which are good and others bad for nutrition.

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

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

### 2.5.2 Programmatic factors

65. The 2014 and 2015 Joint Multisectoral Reviews (JMNR) provided in-depth reviews of the operational challenges that faced the implementation of the eight strategic objectives of the National Nutrition Strategy (2011/12-2015/26) using a **bottleneck analysis (BNA)** approach for selected nutrition specific interventions covering both Tanzania mainland and Zanzibar. The four selected interventions submitted to BNA were coverage or implementation status of (i) Infant and Young Child Feeding (IYCF) practices, (ii) Integrated Management of Acute Malnutrition (IMAM) (iii) Vitamin A distribution (VAD) and (iv) distribution of Iron and Folic Acid (IFA) to pregnant women.
66. The bottleneck analysis used the Tanahashi model<sup>22</sup> applicable for identifying key constraints in the effective delivery of interventions, especially for health and looked at five bottlenecks: (a) commodity availability, (b) human resources capacity, (c) geographical access to interventions (d) utilization of interventions by targeted groups and (e) the quality of interventions provided. Data was collected by District and Regional Nutrition Officers from 148 districts (86 percent, out of 186 districts) and analysed by a team of experts from TFNC, Ministries responsible for Health (mainland and Zanzibar), selected Regions/Districts,

UNICEF and UN-REACH. The 2012 Census, the 2014 Tanzania National Nutrition Survey (TNNS) and the 2015/16 TDHS Key Indicators provided the population reference points for purposes of calculating coverage.

67. The results of the bottleneck analysis provide a clue as to the major operational challenges that the NMNAP has tried to address. These were: -
  - 1) Low coverage of high impact interventions, both nutrition specific and nutrition sensitive;
  - ii) Inadequate alignment of the level of implementation with the geographical burden of the problem of malnutrition for stunting and acute malnutrition; and
  - iii) Inadequate skilled human resource capacity affecting the quality of interventions for all the five areas subjected to BNA.
  - iv) Commodities, utilization by the target groups and the quality of interventions provided did not appear to be major bottlenecks.

### 2.6 The 2016 National Food and Nutrition Policy

68. The 2016 National Food and Nutrition Policy (FNP) addresses the major challenges that emerged during the implementation of the 1992 Policy and the key changes that have taken place on the national and international nutrition landscape. These include advances in scientific knowledge, lessons learned in combating malnutrition, the emergence of the double burden of malnutrition and, perhaps most importantly, the emerging recognition of nutrition as a multisectoral development issue. Thus, the policy provides for a broader framework for increased multisectoral collaboration and coordination towards better nutrition.
69. The FNP has 22 policy objectives that this NMNAP has addressed. These are: -
  - 1) To improve household food security
  - 2) To improve food safety and quality for enhancement of nutrition status at individual, household and community level.
  - 3) To improve and scale up access to quality nutrition interventions along the life course;
  - 4) To improve adolescent and maternal nutritional care and support;
  - 5) To improve infants' and young child nutrition.
  - 6) To reduce the prevalence of micronutrient

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

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

# CHAPTER 3

## CONCEPTUAL FRAMEWORK FOR THE NMNAP



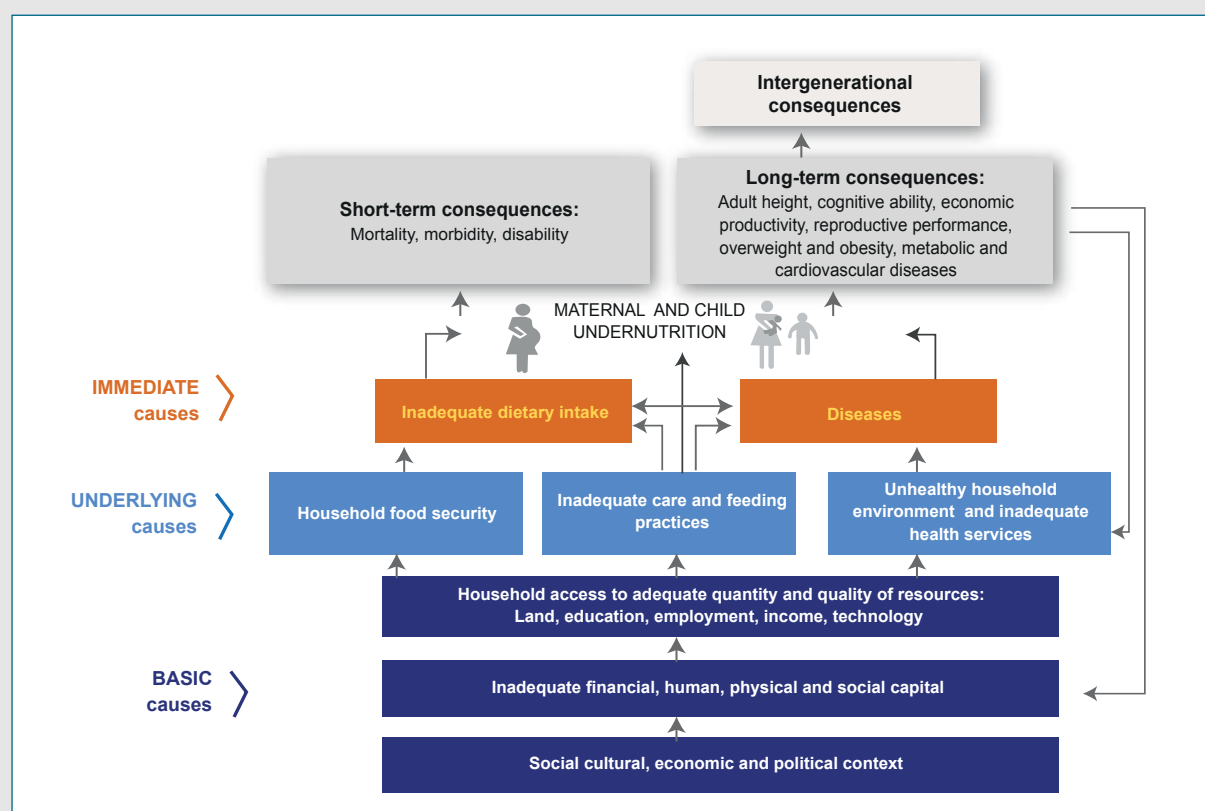
## CONCEPTUAL FRAMEWORK FOR THE NMNAP

### 3.1 The conceptual basis

71. A comprehensive conceptual framework describing the key determinants of malnutrition in children and women was first developed in Tanzania during the mid-1980s in the Iringa Joint Government UNICEF/WHO Support Nutrition Programme (JNSP)- *see figure 10*). The framework saw malnutrition as the manifestation of various individual, community and social processes in society with multiple determinants

classified as immediate, underlying and basic. This causality framework was used to analyse determinants of malnutrition in any context, and was accompanied by a cyclic process of **assessment, analysis, and actions**. The **Triple 'A' Process** – which is adopted within the NMNAP – allows an *adaptive approach to programming* as it enables NMNAP implementers to adjust the course of actions as new evidence is gathered, or new experience is gained.

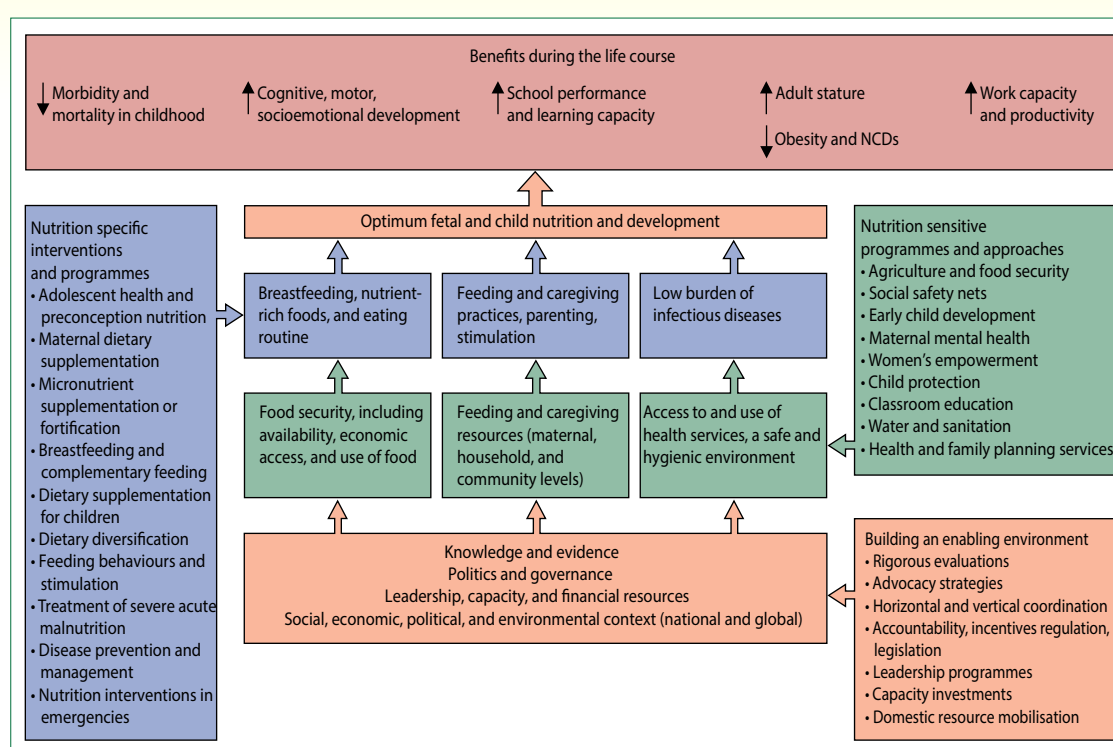
**Figure 10: The 2015 UNICEF Conceptual Framework of the Determinants of Maternal and Child Undernutrition**



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

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

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



Source: The Lancet Series on Maternal and Child Undernutrition 2013

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

### 3.2 The NMNAP Theory of Change

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

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

are deemed necessary to achieve the desired change.

79. A distinctive element of the theory of change approach – compared to the logical framework approach – is the critical analysis of *assumptions*. While the *logical framework* assumptions are the external conditions needed to achieve a result (for example: ‘political stability’), the *theory of change assumptions* are those *theoretical assumptions* that govern our way of thinking, and, therefore, determine the

way we design our *pathway to change*. The pathway of change in ToC terminology is from contributions, to conditions, to desired change, which in the logical framework terminology the pathway is from outputs, outcomes to impact. The NMNAP *theory of change* makes those assumptions explicit, in order to understand the rationale between those contributions and conditions needed to achieve the desired change. *Table 3* gives the definitions of the key components and terminology used in the ToC language.

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

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

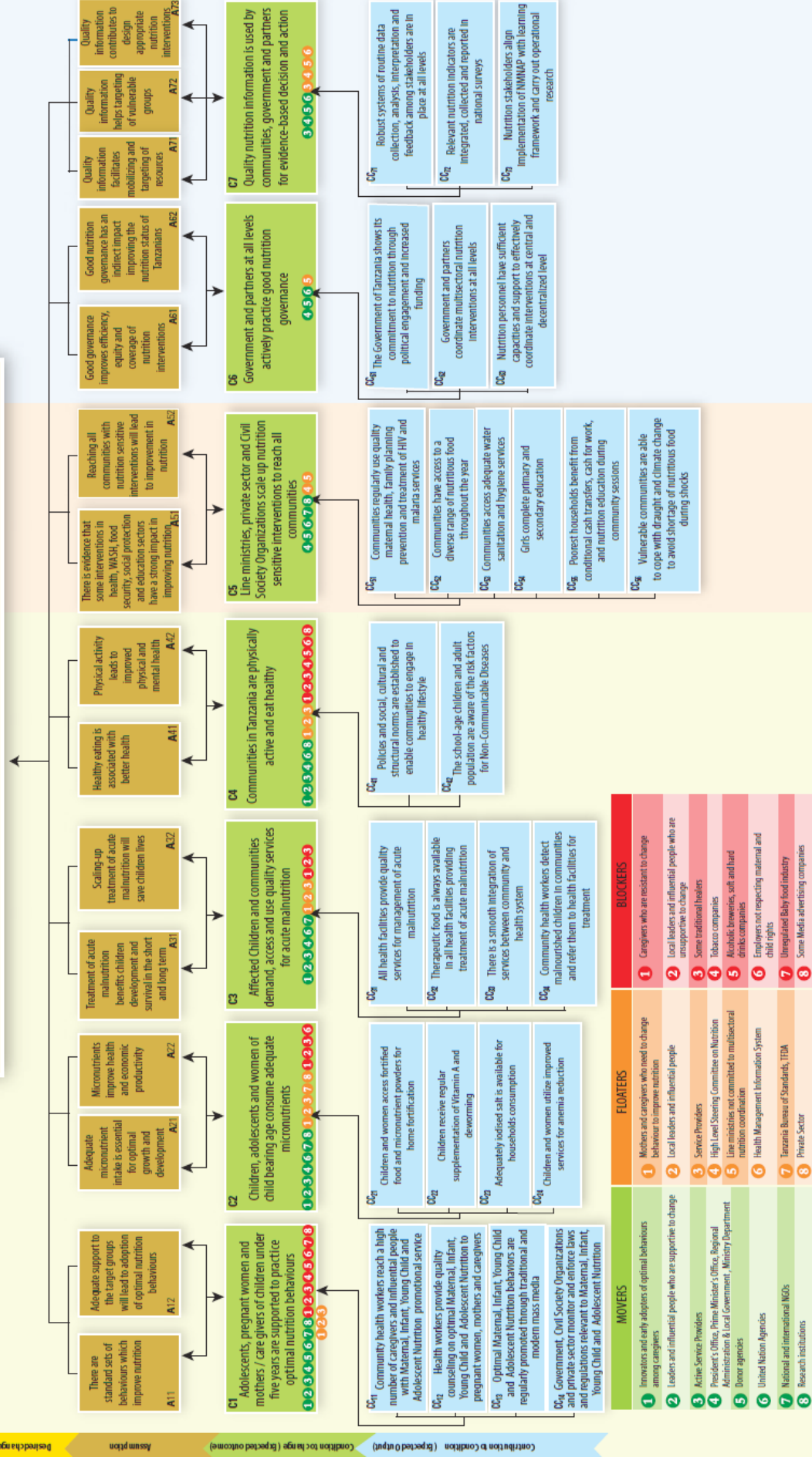
80. The *desired change* of the NMNAP is that children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development. As described in Chapter 4, the desired change will be measured through impact level indicators which were selected to match with the national and international nutrition priorities and targets (i.e. FYDP II; WHA nutrition targets 2025 and SDGs 2030). The key elements of the NMNAP desired change can be unpacked as follows:
- Children, adolescents, women and men* are listed in this order to refer to the life course and to show priority targeting in terms of efficiency (investing in nutrition early, within the 1,000 days’ window of opportunities), inclusiveness (adolescents were often neglected by previous nutrition programmes), gender (targeting both women and men) and equity (targeting the poorest and the most marginalised first).
  - Better nourished* refers to a desired reduction in the prevalence levels of undernutrition (stunting, wasting, underweight, low birth weight, micronutrient deficiencies), as well as of overweight,

- obesity and diet related non-communicable diseases (DRNCDs).
- c. *Healthier and more productive lives that contribute to economic growth and sustainable development* refers to the contribution of better nutrition to improved mental and cognitive child development, improved learning capacity and school performance, improved individual productivity and earning capacity, which contribute to increased national productivity, leading to economic growth and to reductions in poverty and inequalities.
81. Seven different **Conditions for Change** are outlined in the NMNAP in order to achieve the desired change based on the prioritized seven KRAs. These are:
- 1) Adolescents, pregnant women, mothers and care givers of children under five years are supported to practice optimal nutrition behaviours;
  - 2) Children, adolescents and women of child bearing age consume adequate micronutrients;
  - 3) Affected Children and communities demand, access and use of quality services for the prevention and treatment of acute malnutrition;
  - 4) Communities in Tanzania are physically active and eat healthy diets;
  - 5) Line ministries, private sector and civil society organizations scale up nutrition sensitive interventions to reach all communities;
  - 6) Government and partners at all levels actively practice good nutrition governance;
  - 7) Quality nutrition information is used by communities, government and partners for evidence informed decisions and actions.
82. *Figure 12* summarizes the key elements of the NMNAP's theory of change categorized into the three main areas of interventions that the NMNAP has adopted: nutrition specific interventions, nutrition sensitive interventions and enabling environment interventions.

Figure 12: The NMNAP summarized theory of change

## NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (2016-21) THEORY OF CHANGE – OVERALL PLAN

Children, adolescents, women and men in Tanzania are better nourished leading to healthier and productive lives that contribute to economic growth and sustainable development



83. The NMNAP theory of change also includes a **stakeholders' analysis**, showing how implementers should engage different groups of key actors, and leverage their potential to contribute to the NMNAP desired change. Key stakeholders are associated with each condition for change of the plan, divided into three categories: **Movers, Floaters and Blockers**. Specific **relational strategies** with each group of stakeholders were designed in order to guide implementers on how to engage with key actors to contribute to the NMNAP desired change.
84. **Movers** are key groups and individuals committed to contributing to the NMNAP desired change. They are strategic partners that should be encouraged, supported and alliances built with them, in order to collectively promote the shared desired change. Key Movers identified in the NMNAP include: the President's Office, Prime Minister's Office, Regional Administration & Local Government, Ministry Departments and Agencies (TFNC, TFDA, TBS); the High Level Steering Committee on Nutrition; donor agencies; United Nations Agencies; national and international NGOs; academia and research institutions; innovators and early adopters of optimal behaviours among caregivers; leaders and influential people who are supportive of change; and active service providers (i.e. active community health workers and health staff).
85. **Floaters** are neutral groups and individuals that are not aligned and not engaged with the overall desired change of the NMNAP. They do not block the process, but neither do they actively support it. They are subject to change position and become Blockers or Movers, depending on what groups influence them. It is important to build alliances with these groups and try to convert them into Movers, as this will strongly help to achieve the NMNAP desired change. Key floaters identified in the NMNAP include: line ministries, development partners and CSOs not committed to multisectoral nutrition coordination; some mothers and caregivers who need to change their behaviours to improve nutrition; local leaders and influential people who are not engaged; service providers who are not active; some media advertising companies; and the private sector in general.
86. **Blockers** are groups and individuals who are against the desired change and do not want the change to happen (e.g. for historical rivalry with the Movers, or for considering that their own interests are at stake). The NMNAP implementers will develop mechanisms to have Blockers interact and engage with Movers and Floaters in order to prevent and counter-balance their impact on the program, and to try to dilute their influence. Key floaters identified in the NMNAP include: caregivers who are resistant to change; local leaders and influential people who are unsupportive and resistant to change; some traditional healers; tobacco companies; alcoholic breweries, soft and hard drinks companies; employers not respecting maternal and child rights; and some unregulated baby food industry companies.
87. As the Theory of Change is a dynamic approach, the role of some key stakeholders identified is likely to change during the implementation of the NMNAP, as a result of the relational strategies put in place, or external factors beyond the control of the implementers of the NMNAP. *Appendix 1* analytically describes the theory of change and the role of the different stakeholders in detail for each of the seven conditions for change identified within the NMNAP's KRAs. It analyses the pathway of change and the main theoretical assumptions that support the implementation of the key components (contributions for change and outcomes) of the NMNAP.



# CHAPTER 4

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## EXPECTED RESULTS AND KEY STRATEGIES

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## EXPECTED RESULTS AND KEY STRATEGIES

### 4.1 Guiding principles

74. Implementation of the NMNAP will be guided by the following key principles: -
  - i) Government is in the driving seat;
  - ii) Human rights orientation;
  - iii) Focus on all dimensions of equality, especially gender and economic equality;
  - iv) Balanced centralized, national advocacy of goals with Local Government Authority/ community-centred assessment, analysis, action and active participation;
  - v) Build and reinforce effective Community-Public-Private-Partnerships.
  - vi) Quality, accountability and impact – through evidence led, results oriented, scalable and sustainable approaches.
  - vii) Adhere to the three “Ones”: One Plan; One Coordinating mechanism and One Monitoring, Evaluation and Learning Framework to ensure coherence;
  - viii) Proposed actions and investments to meet the following criteria:
    - ❖ Must be evidence-based
    - ❖ Results oriented
    - ❖ Can be implementable at large scale
    - ❖ Results, roles, responsibilities and accountabilities are well defined;
    - ❖ Progress can be monitored on the basis of the theory of change.
    - ❖ Empowering and sustainable
75. The NMNAP has developed some concrete metrics in order to enable determination of progress and overall program performance. These include **ONE impact/desired change, 7 outcomes/conditions** (one outcome for each of the seven key result areas), and **26 outputs/contributions to change**. In addition, there are a number of process-related indicators to demonstrate effective delivery of key activities. In articulating results, the NMNAP adopted a number of different criteria normally used in designing monitoring and evaluation (M&E) systems for large-scale programmes:
  - 1) Appropriate level of results (impact, outcome, output);
  - 2) Appropriate ratio of outputs per outcome;
  - 3) Appropriate ratio of indicators to output-outcome-impact;
  - 4) The quality of results;

- 5) The SMART (specific, measurable, attributable, replicable and time-bound) principle;
  - 6) Formulation of indicators is neutral and specific; and
  - 7) The soundness of horizontal logic (baseline, milestones, reliable source)
76. Key targets were proposed for each of the outcome and output indicators based on several criteria including:
    - 1) Baseline data from population based surveys (e.g. TDHS 2010, 2015/16, Tanzania National Nutrition Survey (TNNS) of 2014, Population Census and Household Survey 2012), STEPS 2012);
    - 2) Target for stunting reduction is based on the calculation of the annual average reduction rate (AARR)<sup>24</sup> of 3.4 percent for 2015-2020 using the 2015/16 TDHS as baseline and the NMNAP 2020/21 prevalence target of 28 percent. The NMNAP did not use the WHA 2025 global nutrition target of reducing the numbers of children underfive who are stunted by 40 percent given the high population growth for Tanzania;
    - 3) Continued political will and Government commitment to nutrition; and
    - 4) The consensus reached during the consultations in developing the NMNAP on coordination, harmonization and collaboration by various stakeholders using the three ONES principle of ONE plan, One Coordinating Mechanism and ONE M&E framework at all levels.

### 4.2 Expected impact and targets

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

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

**Table 4: NMNAP Key impact and outcome targets by 2020/21**

Planned targets	Baseline	NMNAP target
<b>Impact results</b>		
Reduce prevalence of stunting among children 0-59 months from 34% in 2015 to 28% in 2021 ( <b>WHA target 1</b> )	34.4% (TDHS, 2015)	28%
Maintain prevalence of global acute malnutrition among children 0-59 months under 5% in 2021 ( <b>WHA target 6</b> )	4.5% (TDHS, 2015)	<5%
Reduced prevalence of low birthweight from 7% in 2010 (TDHS 2010) to less than 5% in 2021 ( <b>WHA target 3</b> )	7% (TDHS, 2010)	<5%
Reduced proportion of women 15-49 years with anaemia from 44.7% in 2015 (TDHS 2015) to 33% in 2021 ( <b>WHA target 2</b> )	44.7% (TDHS, 2015)	33%
Reduced prevalence of Vitamin A deficiency among children aged 6-59 months from 33% in 2010 to 26% in 2021	33% (TDHS, 2010)	26%
Maintain median urinary iodine of women of reproductive age between 100-299 µg/L by 2021	100-299 (TDHS 2010)	100-299 µg/L
Maintain prevalence of diabetes among adults under 10% by 2021	9.1% (STEPS, 2012)	<10%
Maintain prevalence of overweight among children under five under 5% by 2021	3.6 (TDHS, 2015)	<5%
Maintain prevalence of overweight among adults under 30% by 2021	29% (STEPS, 2012)	<29%
<b>Outcome results</b>		
Increased proportion of children aged 0-5 months who are exclusively breastfed from 41% (TNNS 2014) to at least 50% by 2021	41% (TNNS, 2014)	50%
Increased proportion of children aged 6-23 months who receive a minimum acceptable diet from 20% (TNNS 2014) to 30% by 2021	20% (TNNS 2014)	30%
Increased proportion of children aged 6-59 months who received Vitamin A Supplement during the last 6 months from 72% (TNNS 2014) to 90% by 2021	72% (TNNS, 2014)	90%
Increased Proportion of households consuming adequately iodized salt from 61 (TDHS 2015) to 80% by 2021	61% (TDHS, 2015)	80%
Increased proportion of pregnant women taking iron and folic acid (IFA) for 90+ days during pregnancy from 8% in 2014 to 50% by 2021	8% (TNNS, 2014)	50%
Increased proportion of children under five in need of SAM treatment who are admitted in the program annually from 9% in 2015 to 75% in 2021	9% (BNA/SAM, 2015/16)	75%
Increased proportion of children under five in need of MAM treatment who are admitted in the program annually from less than 1% in 2015 to 75% by 2021	<1% (WFP Project Report, 2015)	75%
Reduced proportion of people who drink alcohol among adults 25-69 years of age to less than 14%	14% (2012)	<14%
Reduced prevalence of tobacco use in adults 25-69 years of age to less than 18%	18% (2012)	<18%
Increased proportion of planned budget spent on nutrition sensitive interventions by 60% between 2016/17 and 2020/21	0%	60%
Increased proportion of districts implementing the minimum budget allocation to nutrition by 50% between 2016/17 and 2020/21	NA (2015/16)	50% increase from baseline
Increased proportion of councils using nutrition information in their respective plans, budgets and reports to 100% by 2021	NA (2015/16)	100%

### 4.3 Seven Priority Key Result Areas and Expected outcomes

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

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

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

79. The seven expected outcomes associated with the seven key results areas are as follows: -
- I. Nutrition specific outcome results:
    - 1) Increased proportion of adolescents, pregnant women and mothers/ caregivers of children under two years who practice optimal maternal, infant and young child nutrition behaviours;
    - 2) Increased micronutrient consumption by children, adolescents and women of reproductive age (15-49 years);
    - 3) Increased coverage of Integrated Management of Acute Malnutrition (IMAM).
    - 4) Communities in Tanzania are physically more active and eat healthier diet.
  - II. Nutrition sensitive outcome result:
    - 5) Increased coverage of nutrition

sensitive interventions from i. Agriculture and Food Security; ii. Health and HIV; iii. Water, Sanitation and Hygiene; iv. Education and Early Childhood Development; v. Social Protection and vi. Environment and Climate Change.

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

### 4.4 Expected outputs per outcome

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

#### 4.4.1 Key outputs and targets for MIYCAN outcome

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

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

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

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

#### 4.4.2 Key outputs and targets for Micronutrients outcome

**Output 2.1:** Increased access to food fortification

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

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

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

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

#### **4.4.3 Key outputs and targets for IMAM outcome**

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

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

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

**Output 3.4:** Strengthened integration of management of severe and moderate acute malnutrition at the national and subnational level by June 2021.

#### **4.4.4 Key outputs and targets for DRNCDs outcome**

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

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

#### **4.4.5 Key outputs and targets for nutrition sensitive interventions outcome**

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

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

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

**Output 5.4:** Girls complete primary and secondary education.

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

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

#### **4.4.6 Key outputs and targets for nutrition governance outcome**

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

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

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

#### 4.4.7 Key outputs and targets for multisectoral nutrition information system outcome

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

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

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

### 4.5 Key strategies

#### 4.5.1 Community-centred multisectoral approach as overarching strategy

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

#### 4.5.2 Supportive cross-cutting strategies

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

- 1) **Social and Behaviour Change Communication (SBCC) for nutrition** through interpersonal communication and mass media to promote adoption of appropriated behaviours and practices and commitment to achieving common results for everyone and everywhere in the country for improved nutrition. The NMNAP will use the SBCC Strategy for 2013-2018.
- 2) **Advocacy and Social mobilization** to sustain political will and Government commitment for nutrition and to mobilise adequate resources for nutrition. Social mobilisation activities are important to create awareness of the problems of malnutrition among decision makers and community members to improve nutrition. For example, a 2013 landscape analysis by TFNC found that policy makers and communities do not perceive stunting and micronutrient deficiencies as problems to be addressed. Since many of the actions in advocacy and social mobilization require behavioural, attitude and practice changes by policy makers and communities for overall societal change all types of media need to be involved. Social mobilization will also increase the **participation of communities in the implementation of the NMNAP**. Since the key actors for improved nutrition are households and communities ensuring their active participation of communities is a critical success factor for the NMNAP.
- 3) **Community-Centred Capacity Development (CCCD):** The development of human, institutional and organizational capacity is critical in the implementation of the NMNAP especially at the community level. **Community participation** in doing their own triple A processes of assessment, analysis and action can be greatly enhanced by developing the capacity of the community and that of community-based organisations to support **social**



- accountability** mechanisms (*see section 6.1 for definition of social accountability*). Recognizing that communities constitute the greater whole of society and that they exist in relationship with society as a whole, development of capacity of communities should go hand in hand with developing capacity at the higher levels – council, district, region, national.
- 4) **Developing functional human resource capacity:** Although human resource technical capacity in nutrition is fairly adequate, functional capacity in communication skills, coordination and strategic leadership and management requires further development. System-wide development of nutrition relevant institutions, especially for TFNC as the institutional leader in the implementation of this NMNAP will be given priority. Institutionalization of the nutrition steering committees at all levels and developing their functional capacity will be further explored.
  - 5) **Aligning all stakeholders with the NMNAP through Community-Public-Private Partnerships (C-PPP)** using the “three ONES principle” of ONE plan, ONE coordinating mechanism and ONE monitoring and evaluation framework, so that every stakeholder come together to tackle malnutrition and build an enabling environment for improved nutrition with equity. Capacities will be developed to conduct and manage C-PPPs as part of a collaborative leadership strategy. Forming strategic partnerships at all levels of the nutrition system will enhance coordination and accountability. Strategic collaboration, including the engagement of the private sector through implementation of appropriate principles of social and corporate responsibility, is likely to result in cost-efficiency and effectiveness and promote ownership and sustainability.
  - 6) **Delivery of quality and timely nutrition services:** This NMNAP will promote the delivery of nutrition and nutrition-relevant services that are timely and of high quality.
- Tools will be put in place to assess the effective implementation and delivery of services, and where bottlenecks are identified, remedial and corrective measures will be adopted including legal enforcement as appropriate.
- 7) **Mainstream equality in all the seven Key Result Areas of the NMNAP** without discrimination, **focusing on women, children and adolescent girls.** Although generally Tanzania has made good progress in empowering women, traditional patriarchal practices remain, that favour men, including in nutrition relevant practices, and are often reflected in both formal and informal systems and institutions especially in the rural areas.
  - 8) **A resource mobilization strategy** will be developed to advocate for resource allocation to the NMNAP by both Government and partners.
  - 9) **Tracking progress and operational research and development** will be promoted to ensure key lessons and insights gained from the implementation of the NMNAP are learnt and used in adjusting and improving the proposed interventions at regular intervals and linking research with programmes and training. Research will also provide quality assurance, robust data on program performance and support learning. Linking research to the programmes and to training will assure evidence-based sharing of experience and intergenerational transfer of knowledge. Efforts will be made to link the implementation of the NMNAP with nutrition-relevant centres of excellence both nationally and internationally.
  - 10) Overall **planning and coordination** is a key strategy to align implementation of the NMNAP to achieve far greater results than what single sectors could achieve alone.

# CHAPTER 5

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

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