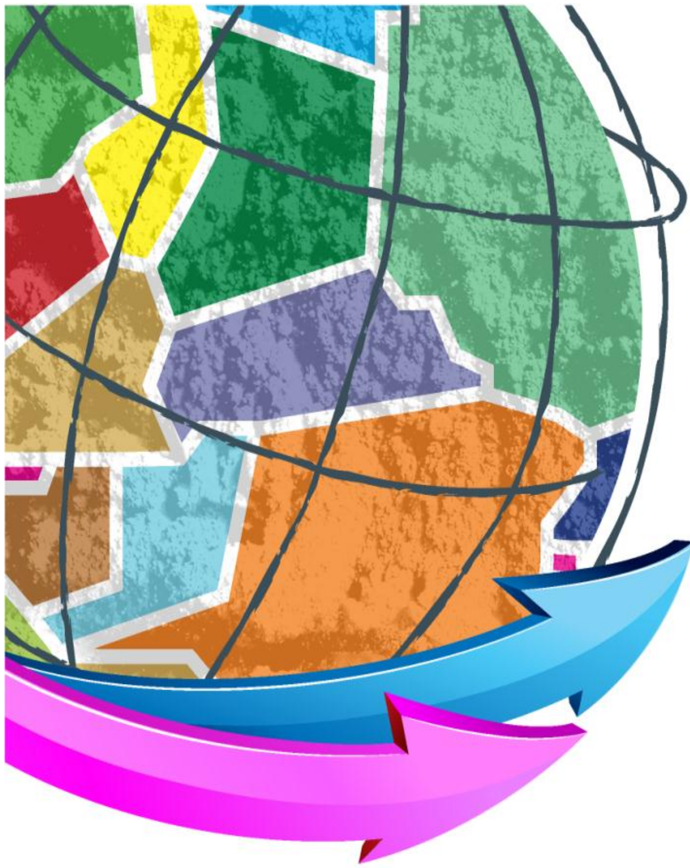

Landscape Analysis of countries' readiness to accelerate action in nutrition

Tanzania Food and Nutrition Centre

# Tanzania assessment for scaling up nutrition

2012

# Foreword

In June 2011 President Kikwete of Tanzania made commitments to scale up nutrition to the National Assembly and strengthened that commitment by joining the SUN Lead Group. The Prime Minister launched the National Nutrition Strategy (NNS) in 2011 and formed the high level steering committee on nutrition. These are clear examples that the nutrition agenda has been strengthened and there is considerable interest in scaling up nutrition in Tanzania. Malnutrition is one of the most serious health problems affecting infants, children and women of reproductive age. Addressing this problem is thus crucial for a healthy nation. There are several on-going actions to rectify the problem but the burden is still considerable throughout the country. Some of the main challenges are low birth weight, stunting, vitamin A deficiency, iodine deficiency disorders and anaemia.

The Landscape Analysis is a participatory approach that seeks to identify gaps, constraints and opportunities for scaling up nutrition interventions and facilitates an analysis of existing capacities and resources available in the country. The analytical framework of the landscape analysis provides indicators for assessing readiness as a function of the critical components for success of “commitment” and “capacity” to scale up nutrition actions. This readiness analysis constitutes a systematic and scientific approach to assess where and how to best invest in order to accelerate action in nutrition, following the Lancet Nutrition Series, where Tanzania was identified as one of the 36 high-burden countries accounting for 90% of the global burden of stunting. It builds on the work and experiences of countries in developing and implementing national nutrition policies and plans developed as a follow-up to the 1992 International Conference on Nutrition (ICN) and builds on interventions proven to be effective in addressing maternal and child undernutrition that are summarized in the WHO electronic Library of Evidence for Nutrition Actions (eLENA).

The Landscape Analysis in Tanzania involved key nutrition stakeholders in the public, civil society organizations, higher learning institutions, development partners and representatives from the regional and district levels. This participatory approach was crucial to foster ownership to the results and commitment to the recommendations. Its findings will be used in the development of Implementation plan of National Nutritional Strategy and for guiding districts in scaling up implementation of nutrition interventions.

Involving all sectors in the reduction of malnutrition by scaling up sectoral planning for nutrition interventions is crucial. Malnutrition can be reduced in Tanzania by a coordinated, multi-sectoral response from national to district and village level. Together we can fight Malnutrition.

# Acknowledgements

This work was the product of six distinct stages of activities which involved many institutions and individuals. The stages of activities included

1. Desk review on nutrition situation, policies and previous assessments
2. Data collection and analysis at district level and discussion of findings with District Management Team
3. National level interviews with key stakeholders
4. Participatory analysis and aggregation of results from all study districts and formulation of draft recommendations for discussion
5. Presentation of results at a stakeholders' meeting on 6 March and agreement on final recommendations
6. Report writing

We extend our sincere thanks to all individuals who were involved for their enthusiasm, advice technical and financial assistance. It is not our intention to leave the name of any person who contributed to make this work happen but it is due to space provided for acknowledgement. We sincerely thank all members of the task force established under the Nutrition Multi-sectoral Technical Working Group with members from TFNC, WFP (Rosemary Mwaisaka), FAO (Vedasto Rutachokozibwa), UNICEF (Harriet Torlesse and Brenda Muwaga), COUNSENUTH (Dr. Lunna Kyungu) and USAID (Tanya Trevors). A process of development of the final report manuscript were done under leadership of Tanzania Food and Nutrition Centre through collaboration with Dr. Mike Zangenberg of WHO Tanzania and Dr. Lunna Kyungu of Centre for Counselling, Nutrition and Health Care (COUNSENUTH) as well as Dr. Faith Magambo of Tanzania Food and Nutrition Centre (TFNC), Dr. Alfred Baraka Sanga, Dr. Onesmo Mella, Mr. Walbert Mgeni, Ms. Catherine Kimarandu, Mr. Fred Lwoga, Mr. Geoffrey Chiduo, Ms. Teddy Mamboleo all of TFNC, Mr. Clepin B Josephat of Ministry of Agriculture, Food security and Cooperatives, Dr. Peter Mamiro from Sokoine University of Agriculture. Lastly we thank and acknowledge the support and participation of the District Executive Directors and their staff of Rukwa, Makete, Lindi Municipal and Chamwino.

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# Abbreviations

| | |
|---|---|
| AIDS | Acquired Immune-Deficiency Syndrome |
| ASDP | Agriculture Sector Development Programme |
| BCC | Behaviour Change Communication |
| BFHI | Baby Friendly Hospital Initiative |
| BMI | Body Mass Index |
| CAADP | Comprehensive Africa Agriculture Development Programme |
| CCHP | Comprehensive Council Health Plan |
| CFSNA | Comprehensive Food Security and Nutrition Assessment |
| CORPS | Community Owned Resource Persons |
| COUNSENUTH | Centre for Counselling, Nutrition and Health Care |
| CPA | Certified Public Accountancy |
| CSO | Civil Society Organisation |
| DALDO | District Agriculture and Livestock Development Officer |
| DCDO | District Community Development Officer |
| DED | District Executive Director |
| DEO | District Education Officer |
| DMD | Coordination of Prime Minister's Office |
| DMO | District Medical Officer |
| DPLO | District Planning Officer |
| DPs | Development Partners |
| ECD | Early Child Development |
| ENA | Essential Nutrition Action |
| FANC | Focused Antenatal Care |
| FAO | Food and Agriculture Organisation |
| FSIT | Food Security Information Team |
| FSNA | Food Security and Nutrition Assessment |
| GoT | Government of Tanzania |
| HBC | Home Based Care |
| HIV | Human Immuno-deficiency Virus |
| HKI | Helen Keller International |
| HLSC | High Level Steering Committee |
| HMIS | Health Management Information System |
| IDD | Iodine Deficiency Disorders |
| IEC | Information Education and Communication |
| IMCI | Integrated Management of Childhood Illness |
| IPC | Integrated Food Security Phase Classification |
| ITN | Insecticides Treated Nets |
| IYCF | Infant and Child Feeding |
| IYCN | Infant and Young Child Nutrition |
| LBW | Low Birth Weight |
| LFSNIS | Livelihoods-based Food Security and Nutrition Information Systems |
| LGAs | Local Government Authorities |
| MAFC | Ministry of Agriculture, Food and Cooperative |
| MAFSAN | Mapping Actions for Food Security and Nutrition |

| | |
|---|---|
| MAM | Mild Acute Malnutrition |
| MCDGC | Ministry of Community Development Gender and Children |
| MDAs | Ministries, Departments and Agencies |
| MDG | Millennium Development Goals |
| MKUKUTA | Mkakati wa Kukuza Uchumi na Kuondoa Umaskini [Tanzania National Strategy for Growth and Reduction of Poverty] |
| MOHSW | Ministry of Health and Social Welfare |
| MTUHA | Mfumo wa Taarifa za Uendeshaji za Afya [Health Information Management System] |
| MUAC | Mid Upper Arm Circumference |
| MUCHALI | Mfumo wa Uchambuzi wa Uhakika wa Chakula na Lishe [Tanzanian Food Security and Nutrition Analysis System] |
| NBS | National Bureau of Statistics |
| NCDs | Non Communicable Diseases |
| NGO | Non-Government Organization |
| NSS | National Nutrition Strategy |
| PECS | Post Event Coverage Survey |
| PEM | Protein energy Malnutrition |
| PLWHIV | People Living with HIV |
| PMO | Prime Minister’s Office |
| PMO-RALG | Prime Minister’s Office Regional Administration and Local Governments |
| PMTCT | Preventive of Mother to Child Transmission |
| RAA | Regional Agriculture Advisor |
| RALG | Regional Administration and Local Government |
| RCH | Reproductive and child health |
| REACH | Renewed Efforts Against Child Hunger |
| RMO | Regional Medical Officer |
| RUTF | Ready to Use Therapeutic Food |
| RVA | Rapid Vulnerability Assessment |
| SAM | Severe Acute Malnutrition |
| SUA | Sokoine University of Agriculture |
| SUN | Scaling Up Nutrition |
| TANDREC | Tanzania Disaster Relief Committee |
| TASAF | Tanzania Social Action Fund |
| TDHS | Tanzania Demographic and Health Survey |
| TFNC | Tanzania Food and Nutrition Centre |
| TWG | Nutrition Technical Working Group |
| UN | United Nations |
| UNICEF | United Nations Children’s Fund |
| URC | University Research Centre |
| USAID | United States Agency for International Development |
| VAD | Vitamin A Deficiency |
| VASD | Vitamin A Supplementation and Deworming |
| VC | Village Council |
| WDC | Ward Development Council |
| WFP | World Food Programme |
| WHO | World Health Organisation |

# Background

## *Overview of nutrition context*

Tanzania mainland has 26 administrative regions, 113 districts with 145 Councils. Each region in the mainland comprises of 3 to 8 districts. The regions act as extended arms of the central ministry and are responsible for coordination, supportive supervision, and technical backup to districts, capacity building and monitoring of services. Thus, the regions ensure that there is effective translation of national policies and guidelines into quality services accessible to the whole population within the region. Each region is sub divided into districts in the mainland which in turn have 4-5 divisions, each composed of 3-4 wards. Each ward is comprised of 5-7 villages. There are a total of about 11,000 villages. Government activities within wards are managed by Local Government Authorities (Councils).

Malnutrition is one of the most serious health problems affecting infants, children and women of reproductive age. Despite progress made, millions of children and women in Tanzania continue to suffer from one or more forms of undernutrition, including low birth weight, stunting, underweight, wasting, anaemia, iodine and vitamin A deficiency. Tanzania has made progress in reducing child undernutrition with reduction of child underweight to 16% (2010) from 27% (1996) and child stunting to 42% (2010) from 48 % (1996)[1]. Nevertheless, the prevalence of child underweight and stunting in 2010 are still unacceptably 'high' according to criteria of the World Health Organization (WHO, 1995).

The National Nutrition Strategy (NNS) was launched by the Prime Minister in 2011 and the government is now looking into how to operationalize this at national and district level.

The strategy is in-line with, and will contribute to, the National Development Vision 2025, National Strategy for Growth and Reduction of Poverty (MKUKUTA II), the Africa Regional Nutrition Strategy (2005-2015) and Nutrition is also included in the Comprehensive Africa Agriculture Development Programme (CAADP) and the Tanzania Agriculture and Food Security Investment Plan (TAFSIP). The National Nutrition Strategy (NSS) identifies a set of services that sectors and agencies need to provide in a harmonized manner in order to establish the conditions under which all can be properly nourished.

The National Nutrition Strategy has eight priority areas:

- Infant and young child feeding
- Vitamin and mineral deficiencies
- Maternal and child malnutrition
- Nutrition and HIV and AIDS
- Household food security
- Nutrition surveillance, surveys and information management

To address these, the Strategy has the following strategies:

- Accessing quality nutrition services
- Behaviour change communication

[1] Based on the WHO Growth Standards

- Legislation for a supportive environment for optimal nutrition
- Mainstreaming nutrition interventions into national and sectoral policies, plans and programs
- Technical capacity for nutrition
- Advocacy and resource mobilization
- Research, monitoring and evaluation
- Coordination and partnerships

These strategies and their objectives are described and budgeted in the Implementation Plan for the National Nutrition Strategy which is currently being finalized. This assessment will assist in guiding the finalization and aim to provide useful recommendations for each strategic objective.

Prime Minister Mizengo Pinda has fully endorsed Tanzania's support for scaling up nutrition and has announced six steps that will be undertaken by the Government of Tanzania to address the nutrition situation and make progress towards achieving the Millennium Development Goals. These steps include:

1. Finalization of the implementation plan for the National Nutrition Strategy, which will include clear responsibilities for the ministries, development partners, the private sector and civil society;
2. Establishment of a new High Level National Nutrition Steering Committee led by Government with participation from selected development partners and civil society organizations.
3. Effective in FY 2012/2013, establishment of a designated line in the national budget for nutrition.
4. Stronger integration of nutrition into agriculture activities as outlined in the Tanzania Agriculture and Food Security Investment Plan.
5. Rapid establishment of Nutrition Focal Points at the district level.
6. Gazetting, finalization and enforcement of the national standards for oil, wheat and maize flour that were set in 2010 so that millers will begin fortifying.

These steps are the key area of focus for the newly established High Level Steering Committee for nutrition.

## *Nutrition situation in Tanzania*

**Multiple of causes of malnutrition in Tanzania**

The figure below presents the conceptual framework for malnutrition and illustrates the immediate, underlying and basic causes of malnutrition. The immediate causes are inadequate dietary intake and disease and these are influenced by the underlying factors which include inadequate access to food, inadequate care for children and women and inadequate access to essential health services and a healthy environment. While prevailing socio-economic and cultural conditions predispose a society to particular nutritional outcomes, these may be mediated by effective institutions, policies and strategies that mitigate the underlying factors.

**Conceptual framework for analysing the causes of malnutrition**

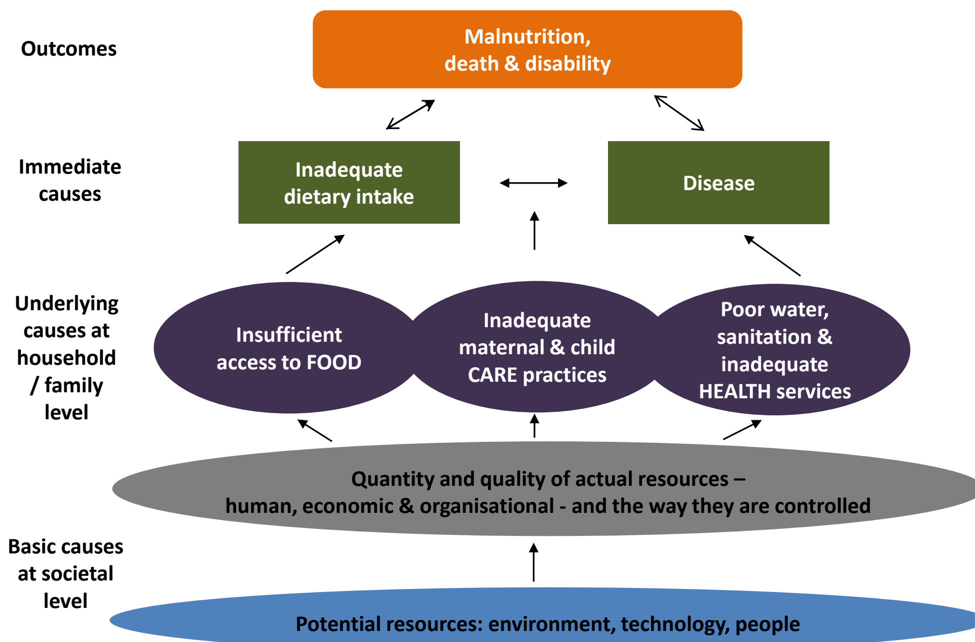


**Figure 1 Conceptual Framework for malnutrition**

UNICEF and TFNC have provided a detailed description of the conceptual framework and states that malnutrition has impacts across the whole life cycle and begins in the womb with intra-uterine growth retardation, caused by disease (e.g. malaria) and maternal malnutrition which leads to low birth weight. The international recommended focus on the window of opportunity (1000 days) means that ensuring good nutrition among girls and women is crucial and malnourished girls are more likely to be malnourished as women and more likely to give birth to low birth weight infants, thus transferring malnutrition from one generation to the next – as stated in the UNICEF/TFNC Situation Analysis. The linkages between malnutrition, inadequate dietary intake and recurrent illness are well established,

forming a vicious cycle in which dietary intake contributes directly to malnutrition and increases susceptibility to disease, while disease reduces dietary intake and increases malnutrition.

UNICEF/TFNC states that these first 1000 days is most critical for growth, breastfeeding and complementary feeding practices and that inadequate dietary intake increases susceptibility to diseases by denying the child the nutrients it needs for effective immune function. The importance of micronutrients in safeguarding health has become better understood in recent decades. Vitamin A improves immune status and has protective efficacy against recurrent illness and mortality. Zinc has been implicated in aetiology of, and recuperation from, diarrhoea and the consequences of anaemia include growth retardation, reduced school achievement, impaired motor and cognitive development, and increased morbidity from a variety of causes including diarrhoea and acute respiratory infections[2,3].

**Under 5 and infant mortality and morbidity**

Tanzania has reduced the under-five-mortality to 81 deaths per 1000 live births in 2010 after a decade of stagnation during the 1980s and 1990s. In 2004/5 major gains in child survival was recorded and the current data confirms this trend. The MKUKUTA target of 85 in 2010 has been met and the mortality may even reach the MDG target of 50 in 2015.

Infant mortality ranges from a low of 40 in the Northern zone to a high of 70 in the Eastern and Southern Highlands zones. A similar pattern is observed for the under-5 mortality rate; the highest rates are 109 and 102 deaths per 1,000 live births in the Lake and Southern Highlands zones, while the lowest rate is 58 deaths per 1,000 live births in the Northern zone. [4]

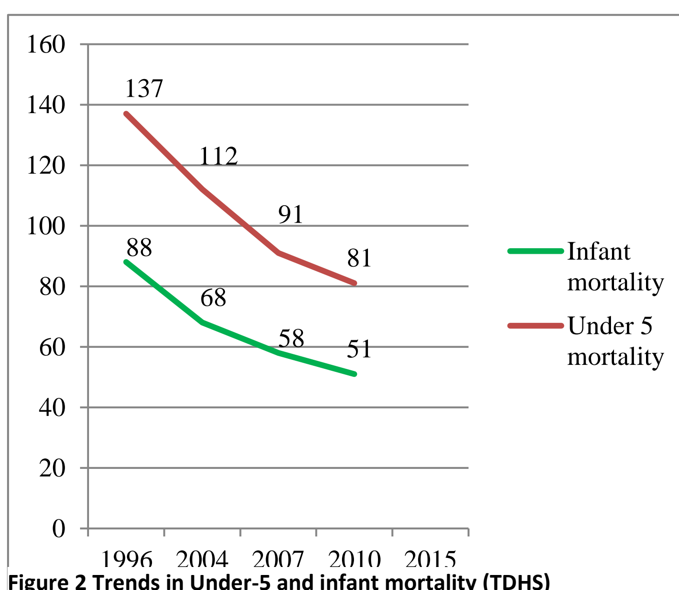

Figure 2 Trends in Under-5 and infant mortality (TDHS)

The mayor causes of child mortality are pneumonia, malaria and diarrhoea. 15 % of children assessed in the recent DHS from 2010 reported to have had diarrhoea within the last two weeks and it is noted that there are strong differences in prevalence by region, with Kigoma showing having 29 % and Shinyanga only 4 %. The prevalence of HIV in pregnant women is 6.2 % and the current estimated rate of mother to child transmission of HIV is 26% at 18 months[5].

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[2] UNICEF and TFNC, Children and Women in Tanzania

[3] De-Regil Luz Maria et al, Intermittent iron supplementation for improving nutrition and development in children under 12 years of age, Cochrane Database of Systematic Reviews, 2011 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009085.pub2/full

[4] Tanzania Demographic and Health Survey 2010

[5] NACP Spectrum analysis Year: 2010

## Stunting

The 2010 TDHS indicates that chronic malnutrition is endemic with 42% of children aged less than five years in Tanzania stunted. This makes Tanzania to be one of the 10 worst affected countries in the world. However stunting declined considerably (4% points) between 1999 and 2004-2005, only slightly (2% points) between 2004-2005 and 2010 TDHS surveys. As explained below there are great variations between the regions and between the improvements over the last years. In Mara for example the prevalence has changed from 46 % in 2004/05 to 31% in 2010 whereas Dodoma has increased from 50% in 2004/05 to 57 % in 2010. [6] Figure 4 gives examples of the difference in relative and absolute numbers of stunted children with absolute numbers on the left and percentages on the right map. The arrows indicate the relative difference between 2004 and 2009/10 with red indicating increase, yellow stagnation and green decrease in stunting. Dodoma (14 %), Arusha (34 %) and Mbeya (15 %) accounts for the highest relative increases in stunting and Tabora (-22 %), Mtwara (-24 %) and Mara (-33 %) accounts for the highest decreases.

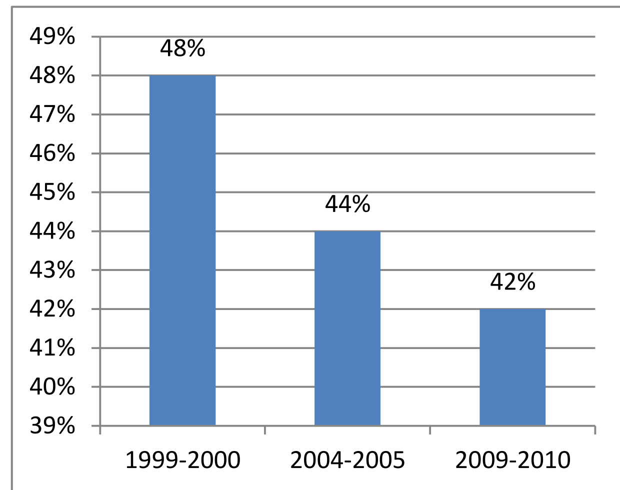
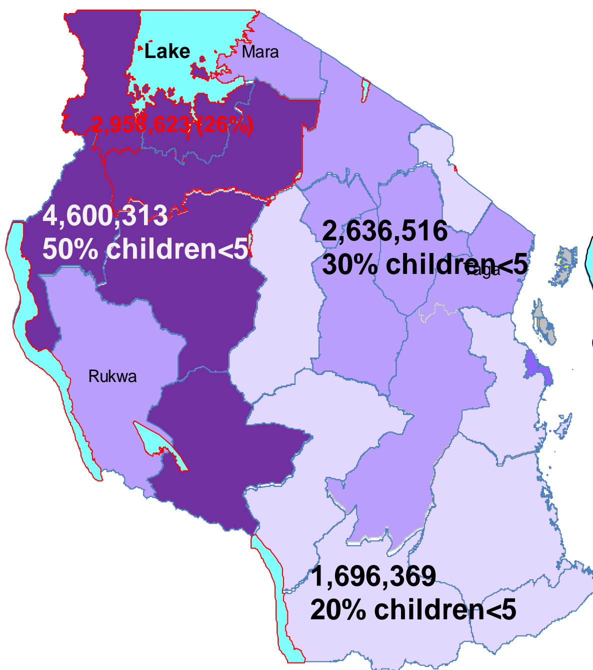
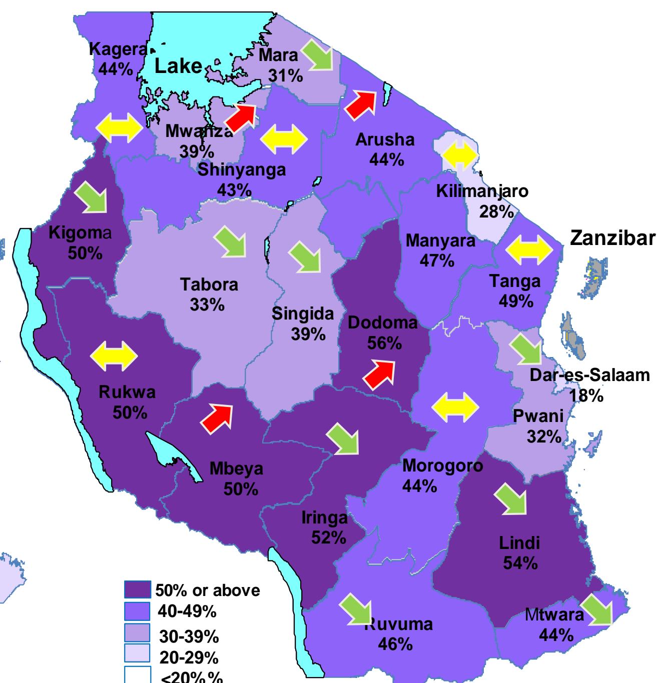



**Figure 3 Stunting prevalence based on new growth standards**

Estimated number of stunted children <5 (2010)
*(darker colors=higher population)*




Stunting prevalence per region
*(darker colors=higher prevalence)*




[6] WHO Global Database on Child Growth and Malnutrition

**Figure 4 Stunting prevalence and estimated number of stunted children**

It is evident that stunting prevalence may not give adequate information on where to focus efforts since it may mask information about the actual number of children affected. As it is revealed in the above maps there is a striking difference between prevalence and actual number of children. A region with low prevalence of stunting might have a large number of children affected by stunting because of variation of population size. An example, as shown in Figure 4, is the North Western zone where the majority of stunted children live, but the prevalence in some of these regions is relatively lower. This comparison is of course arbitrary, but it gives a good example that selection of focus areas should not only rely on stunting prevalence.

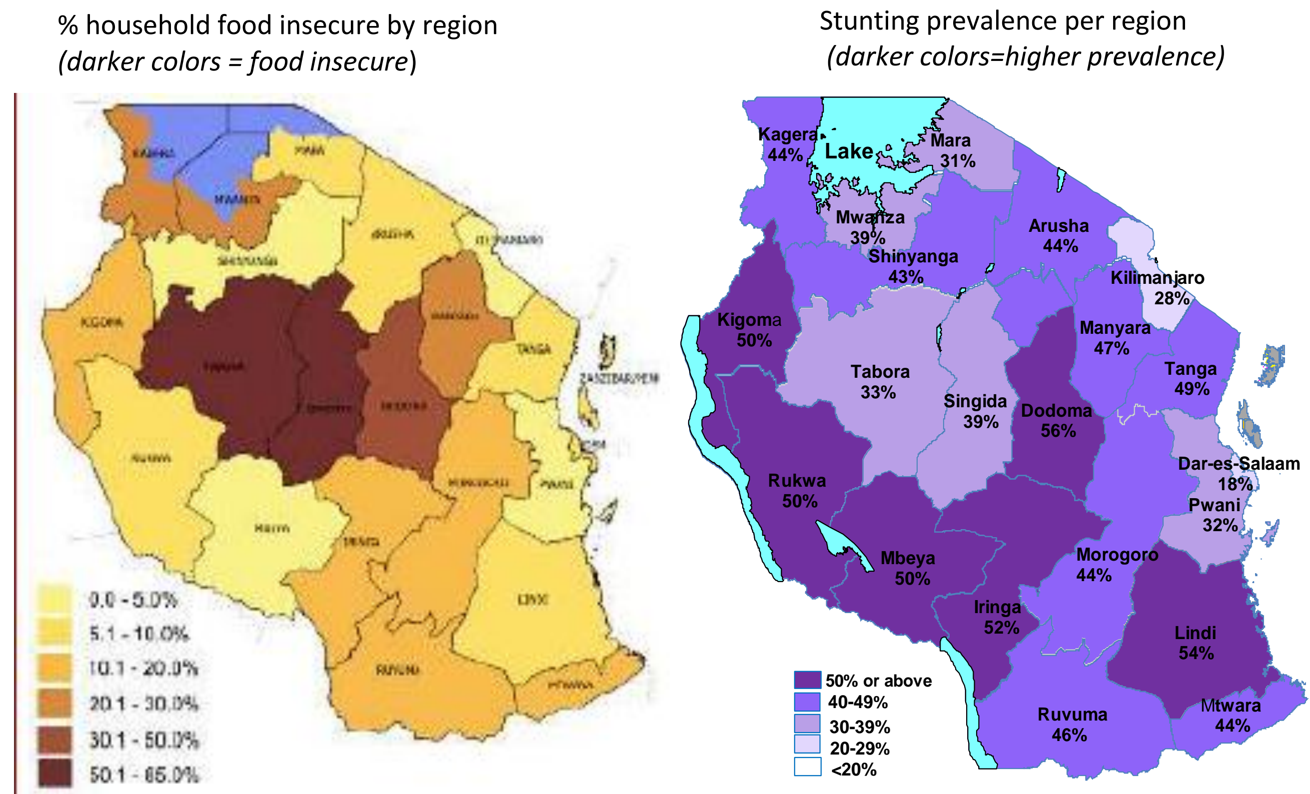



**Figure 5 Prevalence of stunting and food insecurity**

Figure 5 reveals that, the availability of food is not a sufficient indicator to address the nutrition problem. This is verified by the fact that regions with sufficient food, such as in the Southern Highland regions (Iringa, Mbeya and Rukwa) are still affected by chronic malnutrition (stunting) with prevalences surpassing 50%. Furthermore, regions with frequent food insecurity (Tabora and Singida) are less affected by chronic malnutrition in comparison. This concludes that stunting is due to a combination of additional factors including maternal malnutrition, inadequate infant feeding practices, and low quality of health care and poor hygiene.

**Low birth weight**

Low Birth Weight (LBW) refers to birth weight below 2.5 kg. LBW is the single most important factor that links maternal nutrition to birth outcome and subsequent survival, growth and development of the child. Intrauterine Growth Restriction which leads to low birth weight is predominantly due to maternal undernutrition. Variations in the children's weight and size at birth are seen among regions; the prevalence of children born with a weight below 2.5 kg ranges from less than 1 % in Shinyanga to 12 % in Lindi, Rukwa, and Mara (TDHS 2010). Children born in rural areas are less likely than those born in urban areas to weigh less than 2.5 kg or to be described as very small in size or smaller than average. LBW has been declining slowly in between 1996-2004, however from 2005-2010 there was a sharp increase of low birth weight for infants born in both rural and urban areas.

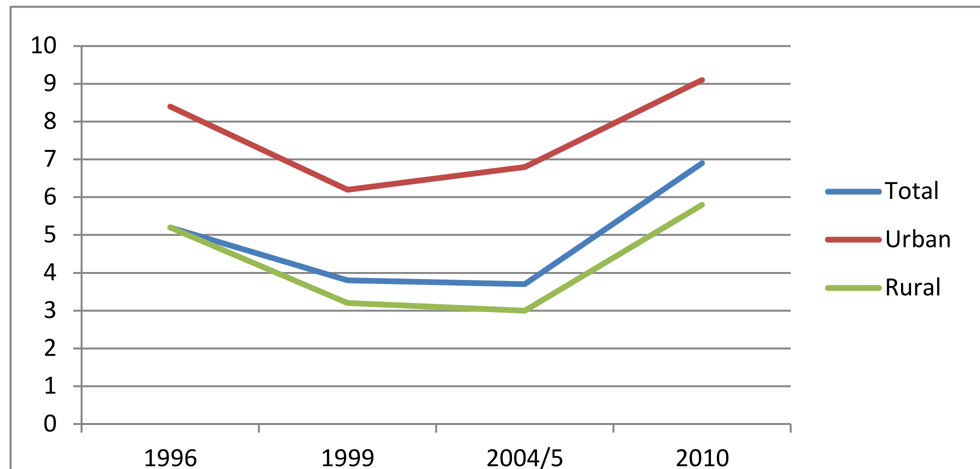


**Figure 6 Percentage of births with a reported birth weight below 2.5 kg**

**Underweight**

A child is classified as underweight if his or her weight-for-age falls below minus two standard deviations (-2SD) of the median of the reference population. Weight-for-age reflects body mass relative to chronological age. It is influenced by both the height of the child (height-for-age) and his or her weight (weight-for-height), and its composite nature makes interpretation complex. However, in the absence of significant wasting or overweight in a community, similar information is provided by weight-for-age and height-for-age, in that both reflect the long-term health and nutritional experience of the individual or population. In average the underweight in Tanzania is 15.8 %, but with a large variation between regions – from 13.5 % in Rukwa and 18.2 in Iringa to 24.3 % in Lindi and 26.8 in Dodoma – all regions in the country are higher than the recommended criteria for public health significance of 10 %.

**Wasting**

The weight-for-height reflects body weight relative to height. A child whose weight-for height falls below minus two standard deviations (-2SD) from the median of the reference values is considered thin or "wasted" for his or her age. Wasting indicates a recent and severe process that has led to significant weight loss, usually as a consequence of acute starvation and/or severe disease. Wasting represents recent failure to receive adequate nutrition and varies from 1.2 % in Iringa over 5.2 % in Dodoma to 9.5 % in Arusha and 9.1 in Singida. The national average is 4.9 % with several regions above the threshold for public health significance of 5 %.

## Maternal BMI

BMI is used to measure thinness or obesity. BMI is defined as weight in kilograms divided by height squared in meters ($kg/m^2$). A BMI below 18.5 indicates thinness and a BMI of 25.0 or above indicates overweight or obesity. A BMI that is below 16 $kg/m^2$ indicates severe undernutrition and is associated with increased mortality. Low pre-pregnancy BMI, as well as short stature, is associated with poor birth outcomes and obstetric complications. Trends of BMI less than 18.5 for both urban and rural areas are marked by slow changes between 1996 and 2010.

**Table 1 Maternal under- and overweight**

| | < 18,5 | | | ≥ 25 | | |
|---|---|---|---|---|---|---|
| | Urban | Rural | Total | Urban | Rural | Total |
| **1996** | 8,1 | 9,2 | 9,2 | | | |
| **2004/5** | 7,9 | 11,5 | 10,4 | 32,5 | 11,5 | 17,7 |
| **2010** | 8,1 | 12,8 | 11,4 | 36,3 | 15,2 | 21,5 |

There is considerable difference in maternal undernutrition between regions with only 4.5 and 5 % in Mbeya and Iringa respectively to 20.4 % in Lindi and 24.5 % in Dodoma. Overweight is to some extent still a major problem in the urban regions, with 44.6 in Dar Es Salaam, but in the rural areas the lowest prevalence is still as high as 9.5 % (Dodoma and Lindi).

## Exclusive Breastfeeding (EBF)

UNICEF and WHO recommend that children are exclusively breastfed (no other liquid, solid food, or plain water) during the first six months of life (World Health Assembly, 2001). Introducing breast milk substitutes to infants before 6 months can contribute to malnutrition as well as breastfeeding failure. Substitutes, such as formula, other kinds of milk or porridge, are often watered down and provide too few calories. In Tanzania, exclusive breastfeeding for the first six months is not widely practiced. The data show that only 50 % of infants under 6 months are exclusively breastfed. This is though still an improvement compared with the prevalence shown by the 2004-05 TDHS, which was 41 %.

**Table 2 Trend in exclusive breastfeeding according to age of child in months**

| | 0-1 months | 2-3 months | 4-5 months | 6-7 months | < 6 months |
|---|---|---|---|---|---|
| **1996** | 55.2 % | 27.4 % | 8.0 % | 4.1 % | 28.9 % |
| **1999** | 57.8 % | 25.4 % | 15.5 % | 1.9 % | |
| **2004/2005** | 70.0 % | 42.4 % | 13.5 % | 1.7 % | 41.3 % |
| **2010** | 80.5 % | 51.1 % | 22.9 % | 2.3 % | 49.8 % |

**Anaemia**

Anaemia, characterized by a low level of haemoglobin in the blood, is a major health problem in Tanzania, especially among pregnant women and young children. Anaemia may be an underlying cause of maternal mortality, spontaneous abortions, premature births, and low birth weight. The most common cause of anaemia is nutritional anaemia resulting from inadequate dietary intake of nutrients necessary for synthesis of haemoglobin, such as iron, folate or vitamin B12. Anaemia also results from sickle cell disease, malaria, or parasitic infections. While the anaemia levels have been reduced through the last 5 years, the prevalence is still high and needs considerable efforts.

**Table 3 Trend in anaemia prevalence**

| | Children | | | Women | | |
|---|---|---|---|---|---|---|
| | Mild | Moderate | Severe | Mild | Moderate | Severe |
| 2004/5 | 24.6 % | 43.0 % | 4.2 % | 32.6 % | 14.5 % | 1.2 % |
| 2010 | 27.3 % | 29.4 % | 1.9 % | 29.0 % | 10.1 % | 1.0 % |

**Vitamin A**

Vitamin A is an essential micronutrient for the immune system that plays an important role in maintaining the epithelial tissue in the body. Severe vitamin A deficiency (VAD) can cause eye damage. VAD can also increase the severity of infections, such as measles and diarrhoeal diseases in children, and slow recovery from illness. The prevalence of vitamin A deficiency in children below 5 years was 24 % in The National Vitamin A Survey 1997 (serum retinol levels) and in 2010 it is 34 % (RBP). About 69 % lactating women had breast milk retinol levels below 30 µg/dl in 1997 and the prevalence in women of reproductive age in 2010 is 36 % (RBP). Such information suggested that the proportion of children and lactating women with VAD are higher than the WHO cut-off levels for public health significance (> 20 %). Conversely, the long objective of vitamin A program in Tanzania is to reduce Vitamin deficiency and its consequences to levels where they are no longer of public health significance. Achieving this objective, a periodic dosing (usually every six months) of vitamin A supplements to children aged 6 to 59 months. The program was integrated with de-worming four years after its inception which

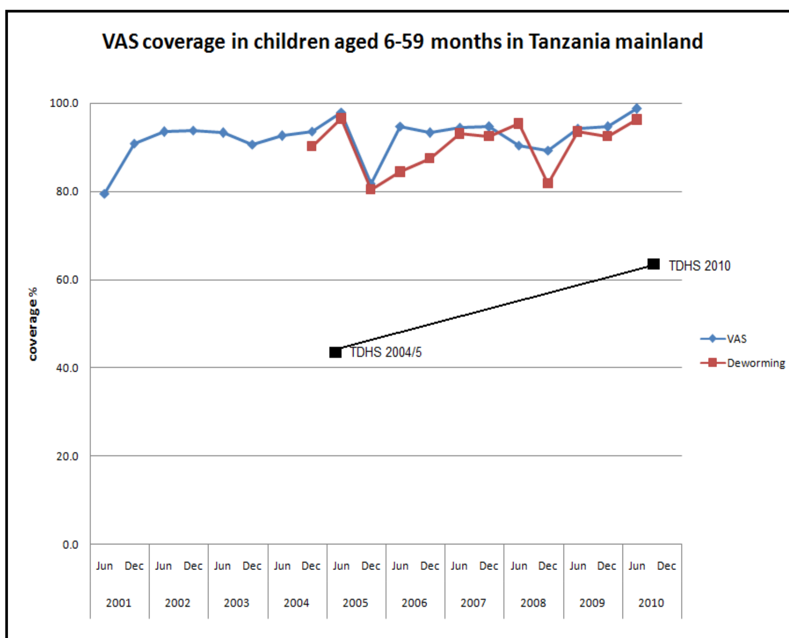


**Figure 7 VAS coverage in children aged months in Tanzania**

helped to improved coverage. Although, there has been evidence of improvements in coverage there exist inconsistencies inconsistence data sources. While the Tanzania Demographic and Health Survey (TDHS) of 2010 reported a national coverage of VAS was 61%, Post Event Coverage Survey (PECS) which was done in collaboration with Hellen Keller International (HKI) in the same year reported coverage of 65%. In addition to that, administrative data from regions has been consistently indicating coverage of over 90%. The Tanzania Food and Nutrition Centre (TFNC) and Hellen Keller International (HKI) have decided to conduct data audit exercise to shed the light about possible sources of this inconsistence. [7]

**Iodine**

Iodine deficiency has serious effects on body growth and mental development including mental and physical congenital defects in newborns, low learning capacity, impaired growth, and poor health and low productivity among the general population. The principal cause of iodine deficiency is inadequate iodine in foods. From the national survey conducted by TFNC in 2003 established that goiter prevalence was 8.1% (down from 25% in 1980s), and that 83.8% of households were consuming iodised salt. The World Health Organization (WHO) recommends that 90 % of the households in a country should use iodised salt before the program is considered on course (poised to attain the goal of eliminating iodine deficiency). Fortified salt that contains 15 parts of iodine per million parts of salt (15 ppm) is considered adequate for the prevention of iodine deficiency. In contemplation of the IDD problem in the country, universal iodation of edible salt was adopted in Tanzania as a strategy for the control of iodine deficiency disorders (IDD). Legislation prohibiting the use and commercial trade of non-iodised salt for both human and animal consumption was enacted and became effective on 1 January 1995. Perhaps due to various initiatives undertaken to address low iodisation there has been an improvement in coverage marking a noted change from earlier assessments. TDHS 2010 reports that 59 % are using salt that is adequately iodised (15+ ppm) which is an improvement from 2004-2005 when only 43 % of households were using adequately iodised salt. Data from 2010 also shows that 23 % are using salt that is inadequately iodised (< 15 ppm), thus indicating that 82 % of the households are using salt that is adequately iodised. The availability of iodised salt shows a large increase of 8 % when compared with the findings of the 2004-2005 TDHS.

[7] Vitamin A Supplementation & De-worming, Post Event Coverage Survey, April 2010, Tanzania Mainland, Final Report on Research Findings, HKI et al

# Objectives and methodology

The objective of the Landscape Analysis was to provide a methodology for a participatory approach to assess challenges and opportunities for scaling up nutrition. The aim of the Country Assessment in Tanzania was to provide input in finalizing the National Nutrition Strategy's Implementation Plan as well as to make recommendation for district level scale up and international assistance and investments for accelerating nutrition actions. The analysis also established a baseline on current status of nutrition action, allowing tracking of the progress in the future.[8] To scale up nutrition intervention all stakeholders at all levels need to be committed. The Landscape Analysis assessed this through a range of indicators from awareness of causes, problems and policies through planning and budgeting to coordination and supervision. The aim of the analysis was to guide policy and institutional change and thereby create an environment to scale up nutrition interventions.

A task force charged with developing and endorsing the analysis methodology was formed drawn from the multi-sectoral nutrition working group meeting with representatives from government, UN, bilateral donors and NGOs. The assessment task force was led by TFNC and consisted of partners from MAFC, UNICEF, WFP, FAO, USAID, COUNSENUTH and WHO. The Landscape Analysis brought together methodologies and experience from FAOs Mapping Actions for Food Security and Nutrition and REACHs situation analysis tools to enable a harmonized data collection tool. The result is a thorough picture of the current context for scaling-up nutrition action and the readiness to scale up interventions which will assist the government as well as partners, to guide the future work including finalization of the NNS implementation plan and development of district scale up plans.

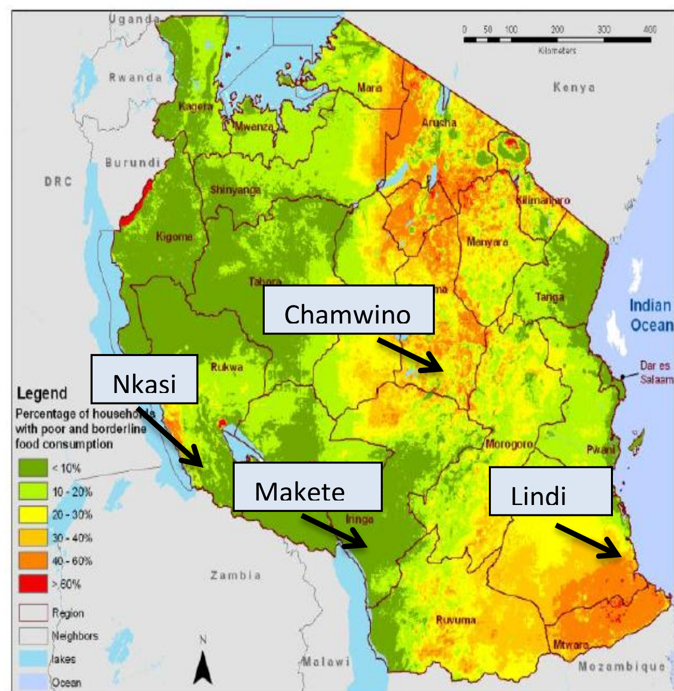



**Figure 8 Food consumption**

The task force decided to assess relevant stakeholders in 4 regions and districts as well as national level (Table 4). Information on socio-demographic characteristics does only exist at regional level and not district. Dodoma, Lindi and Rukwa all have low education attainment and are of the poorer regions in the country. Iringa has higher education attainment and wealth index, but also a much higher HIV prevalence. The four regions are the highest in the country

[8] For more information see http://apps.who.int/nutrition/landscape_analysis/en/index.html

in terms of stunting (all above 50 %)[9]. To give a representative picture of management of nutrition programs two districts with high level of external support (UNICEF in Makete and WFP in Chamwino) and two with limited support were selected (Lindi and Nkasi) – Lindi has been categorized with some external support because of presence of a strong NGO. In these two categories two districts have low food production and two have high food production based on potential food needs met data from FAO/MAFC. Lastly one of the four districts is only medium food insecure. The Landscape Analysis is being completed on Zanzibar during the finalization of this report and will provide valuable input in the finalization of their nutrition strategy.

**Table 4 Districts selected for the Landscape Analysis**

| Region | District | Stunting | External Support | Food security | Food production |
|---|---|---|---|---|---|
| Iringa | Makete | ↑ | ↑ | → | ↑ |
| Dodoma | Chamwino | ↑ | ↑ | ↓ | ↓ |
| Lindi | Lindi Municipal | ↑ | → | ↓ | ↓ |
| Rukwa | Nkasi | ↑ | ↓ | ↓ | ↑ |

↑- *high stunting, high level of external support, food secure and high level of food production*
↓ - *low stunting, limited/no external support, food insecure and low level of food production*

*Country assessment tool*

A country assessment questionnaire and mapping package was adapted from the generic WHO tool set by teams with representatives from TFNC, MAFC, MOCDG, COUNSENUTH and WHO. The adapted Landscape Analysis Country Assessment Tools in Tanzania consisted of questionnaires for obtaining information from key stakeholders at national, regional, district, ward, village and service delivery level, stakeholder mapping tool and analysis sheets for assessing strengths and weaknesses in commitment and capacity to accelerate actions to reduce maternal and child under-nutrition. Overall, the assessment team conducted 119 interviews at these various levels (Table 5).

*Stakeholder mapping tool*

The Landscape Analysis stakeholder mapping tool was adapted to capture interventions implemented by all partners so it would also fit the formats of other nutrition action mapping activities on-going in the country and complement these efforts, i.e. the FAO/MAFC platform Mapping Actions in Food Security and Nutrition (MAFSAN) and REACH. It includes geographical areas, type of intervention, target group, budget, M&E, delivery channel and estimated coverage. Data was collected from all relevant international and local agencies and NGOs and some central and local ministries.

[9] TDHS 2010

*National level*

Relevant ministries and government institutions were interviewed with a focus on assessing government priorities, coordination and commitment. Furthermore relevant UN agencies, bilateral donors and NGOs were interviewed and their activities thoroughly mapped.

*Regional level*

The Regional Administrative Secretaries as well as regional health and agriculture focal officers, who are in charge of supervising implementation at district level, were interviewed to assess regional priorities, commitment, coordination and support to districts.

*District level*

The district management and sectoral officers are in charge of planning and budgeting, supervising and coordinating actual implementation in their respective area at district level. Thorough information of programs implemented was collected during interviews with the district agriculture, health, community development, education and planning officers in the four districts. Furthermore, coordination, roles and responsibilities, training, supervision from regional level and national level and information management systems were assessed and lastly staffs perceptions of the nutrition situation and views in how to strengthen the nutrition interventions were collected.

*Facility manager & Health worker*

Besides perceptions and priorities, all facilities visited in the four districts were comprehensively mapped for each relevant intervention in terms of target groups, advice given and supplies, IEC material and guidelines available. Furthermore, training material and support available was assessed. The Health Workers interviewed in these facilities knowledge of selected nutrition protocols and their confidence in delivering these services was assessed.

*NGO field office*

All NGOs/CSOs in the four districts who implemented nutrition or nutrition sensitive programs were interviewed to map their activities and budgets, but also their partnerships, training and data collection.

*Ward and village level*

Recognizing the importance of ward and village level, the taskforce decided to develop special tools or interviews at these levels. Hence questionnaires were developed to capture the priorities, planning, resources, coordination, training and challenges for scaling up nutrition. At village level the Village Councils were interviewed who are appointed by all village adults and has legislative and executive powers in the village. At ward level the Ward Development Committee was interviewed which is a committee responsible for coordinating development activities and planning in the ward and linking with the district level.

*Participatory analysis and stakeholder meeting*

The analysis sheets were completed for each district during the field work by the assessment teams summarizing the findings according to the analytical framework of indicators. The results were then discussed with the district management in all the four districts in order to enable their immediate

feedback. Upon completing all district and national level interviews, the task force met to analysis findings in strengths and weaknesses in relation to the analytical framework with indicators for commitment and capacity. After the quantitative and qualitative analysis a preliminary report was developed and presented to all relevant government (Prime Minister's Office and relevant line ministries) and non-government stakeholders. The outcome of the meeting was to agree on the key recommendations for national and sub-national scale up to be incorporated in the implementation plan.

**Table 5 Stakeholders interviewed**

| Level | Respondents per level | Number of questionnaires |
|---|---|---|
| **National level** | | |
| Government | PMO, PMO-RALG, MoAFSC, MOHSW, MOCDG, TBS | 10 |
| Bilateral donor | USAID, IrishAid, DFID, World Bank | 4 |
| NGO | HKI, Counsenuth, Africare, World Vision, URC, Save the Children, AMREF | 7 |
| UN | UNICEF, WFP, FAO, WHO | 4 |
| **Regional level** | RAS, RMO, RAA | 9 |
| **District level** | DED, DMO, DALDO, DCDO, DEO, DPLO | 24 |
| **Facility level** | | |
| Facility Manager And checklist | Person in charge, Nutrition responsible, RCH coordinator. Physical check and observations of equipment and supplies available at the facility | 15 |
| Health Worker | Clinical staff | 13 |
| **NGO field office** | Managers or program managers in field office of NGO providing services to women and children | 8 |
| **Ward** | WDC | 8 |
| **Village** | VC | 17 |
| **Total** | | **119** |

## *Previous assessments*

In the past, several assessments on nutrition have been conducted by various stakeholders and organisations/institutions and most of these endorsed by the MOHSW. The Landscape Analysis builds on and adds further insights to these assessments. Some of the recommendations are summarized below:

These assessments have been undertaken for many years and *Thoughts for food, an evaluation of the Tanzania Food and Nutrition Centre, SIDA,* from 1992 recommended that advocating the use of the National Food and Nutrition Policy and the conceptual framework to ensure in-house training on the framework and emphasised to place more emphasis on PEM as the most important nutritional problem of the country. They recommended that MoHSW to appoint a Senior Medical Officer responsible for nutrition and to strengthen and scaling up of IDD, VAD, anaemia and infant feeding programs. Some of these recommendations have been implemented e.g. the establishment of Nutrition Officer, but there is still a lot of work in strengthening the programs.

*TFNC and UNICEF in their assessment on Women and Children in Tanzania from 2010* recommends that the National Food and Nutrition policy need to be completed and approved and nutrition need to be firmly accommodated. They also recommended the needy of legislation, regulation and standard to create a supportive environment for nutrition food fortification being inclusive. The Policy is still not finalized, but the fortification agenda has moved considerably.

Valerie and Blandina suggest in their *Institution Analysis of Nutrition in Tanzania from 2009* that pregnant and lactating women in particular young girls need to be given priority on nutrition support. They further recommended promotion and support of lactating women on the exclusive and continued breastfeeding and emphasize on the continuous support for de-worming, rehydration for diarrhoea and sustaining the high rate of immunisation. Lastly but not the least they recommended working within the national strategies especially MKUKUTA.

HKI and TFNC give recommendation based on their assessment of district budget allocations for nutrition activities (*A Review of Comprehensive Council Health Plans 2010/2011*). Some of these include tracking the actual costs of activities to help providing more information on allocation sufficiency and empowerment of district to follow up and monitor the actual cost for implementing Vitamin A Supplementation. A lot of work is currently being started to support the district planning and budgeting for nutrition (see section below).

Charles et al, assessed the institutional arrangements in their assessment on *Strengthening Nutrition within the Ministry of Health and Social Welfare (2011).* They recommended that district nutritionists should be responsible to the District Executive Director (DED), but provide regular reports to the Regional Medical Officer through the District Medical Officer. They also suggested that discussions be held among senior management of the MoHSW to resolve the issues and assign clear responsibilities to TFNC versus the Nutrition Sub-section at the Health Promotion and Education Section, MoHSW. The reporting lines for district/regional nutrition officers are still not finalized and the collaboration between the nutrition unit and TFNC is not yet formalized.

# Results

## *Summary*

The results are grouped in commitment, with political directions, strategies, financial considerations and coordination challenges and capacity, with training needs and challenges, health worker knowledge and information systems.

The awareness amongst key stakeholders varies considerably between the different sectors and between levels. Whereas stunting was seen as a mayor problem amongst most stakeholders at national and to some extent district level, fewer recognizes this at village and especially wards level. The districts have all been guided in planning and budgeting for nutrition interventions, but few to date, are doing so comprehensively and furthermore village and ward levels are rarely involved. The districts that actual plan and implement nutrition interventions are still the districts with external support. Partners, both UN and bilateral donors, do contribute substantially to the delivery of nutrition interventions with an estimated annual budget of 16.5 million $ and an interest in increasing this further over the years to come. This is though substantially lower than the draft estimated annual budget for the National Nutrition Strategy's Implementation Plan of almost 68 million $. Recently, a budget line for nutrition was established, but there are still limited knowledge and measures taken at district level to actually increase the funding for nutrition interventions. Effective, multi-sectoral coordination mechanisms have been raised as a key challenge and districts have been directed to establish nutrition steering committees. To date 94 councils, approximately 60 %, has confirmed the establishment of such committees, but concerns have been raised that these need further guidance. It is crucial that the recent efforts in strengthening coordination at national level will continue and spread to the lower levels.

Ministries, regions and districts have all appointed staff to be responsible for nutrition in their respective institutions, but nutrition focal points still need considerable support, training, clear responsibilities and lines of reporting to effectively coordinate and ensure scaling up of nutrition interventions. Comprehensive plans to develop training programs for district nutrition staff are in the pipeline, however efforts need to be taken immediately to ensure effective management. Priorities, interest and commitment from district management and central level ministry leadership is crucial if nutrition interventions are to be scaled up in all districts within a reasonable timeframe. Some of the most common nutrition supplies, guidelines and material are available, health workers do have knowledge about most nutrition interventions and facilities do already implement some nutrition activities. **Hence, there is a good environment for scaling up these interventions and if prioritized by the district management, supported by central level ministries and partners it is possible to ensure evidence-based interventions are reaching all children and mothers throughout the country**.

## *Commitment to accelerate action in nutrition*

**Awareness of nutrition problems among stakeholders**

If stakeholders are to prioritise and address the main nutrition problems (e.g. stunting, anaemia and vitamin A deficiency) then they must be aware of these problems and understand their causes. From the data presented in the background section it is evident that stunting, anaemia and vitamin A deficiency are some of the main nutrition problems.

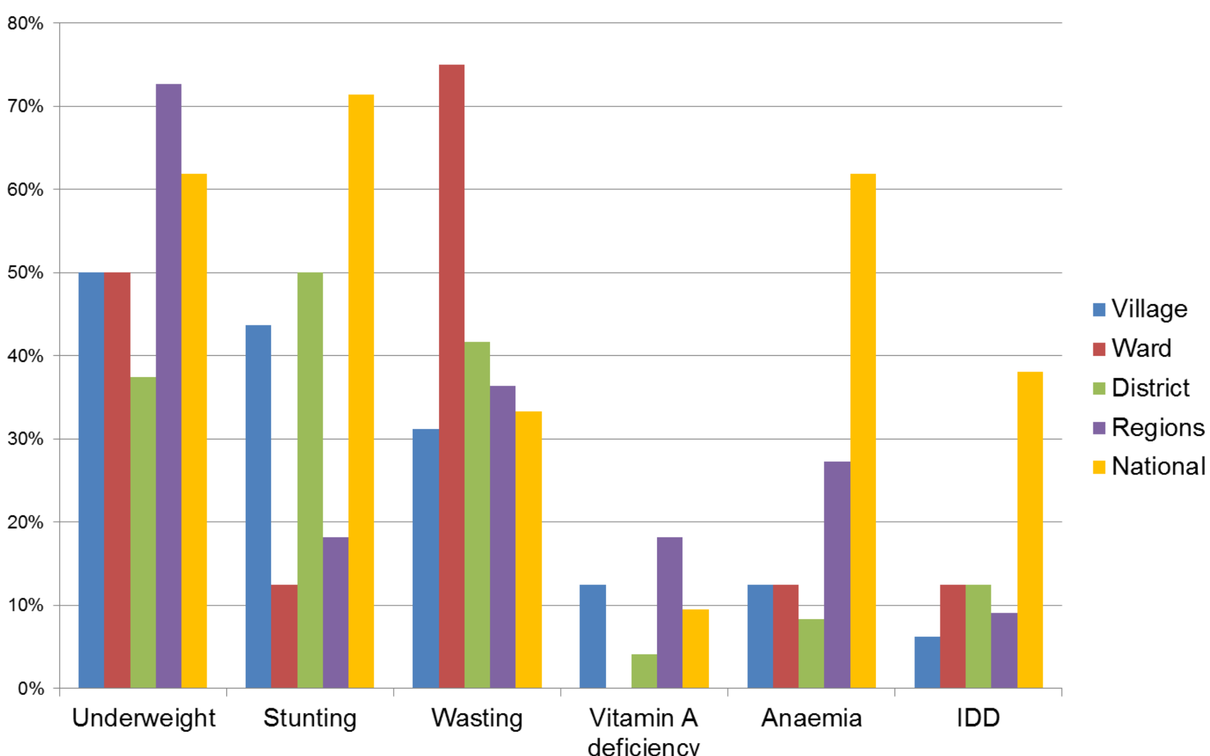



**Figure 9 Awareness of nutrition problems**

For most of the problems assessed the results showed the same picture, with higher awareness at national and regional level compared to ward and village. There was a striking difference between the perceptions of stunting as a major nutrition problem at the different levels. It was mentioned by more than 50 % of respondents at district and national level, but by less than 20 % at ward and regional level. A possible explanation is that national support from government and partners have focused on district and village levels and to a lesser extent on regions and wards. More than 70 % of national level stakeholders mentioned stunting as a key problem. This distinct between the difference in government and partner perceptions where only 30 % of the government stakeholders interviewed mentioned stunting against more than 90 % of partners. On the contrary, underweight is thought by the majority of levels, to be a major problem. Even though the prevalence of vitamin A deficiency in children is more than 30 % in all assessed regions[10], very few perceived this as a major problem. This, and the fact that only 30 % of government stakeholders were aware of stunting problems, is a serious challenge and

[10] From TDHS, 2010

advocacy might be needed. A reason for not seeing VAD as a problem might be the national vitamin A campaign and hence a perception that the problem is already dealt with.

The prevalence of stunting, wasting and vitamin A deficiency is approximately the same in all assessed districts which is in line with the very limited difference in perceptions between the districts. More surprising, there is no difference in perception of nutrition problems between the districts with limited external support and districts with substantive external support.

**Awareness of underlying causes among stakeholders**

From the conceptual framework we know that the major causes can be grouped in inadequate caring practices, inadequate health services and inadequate access to food.

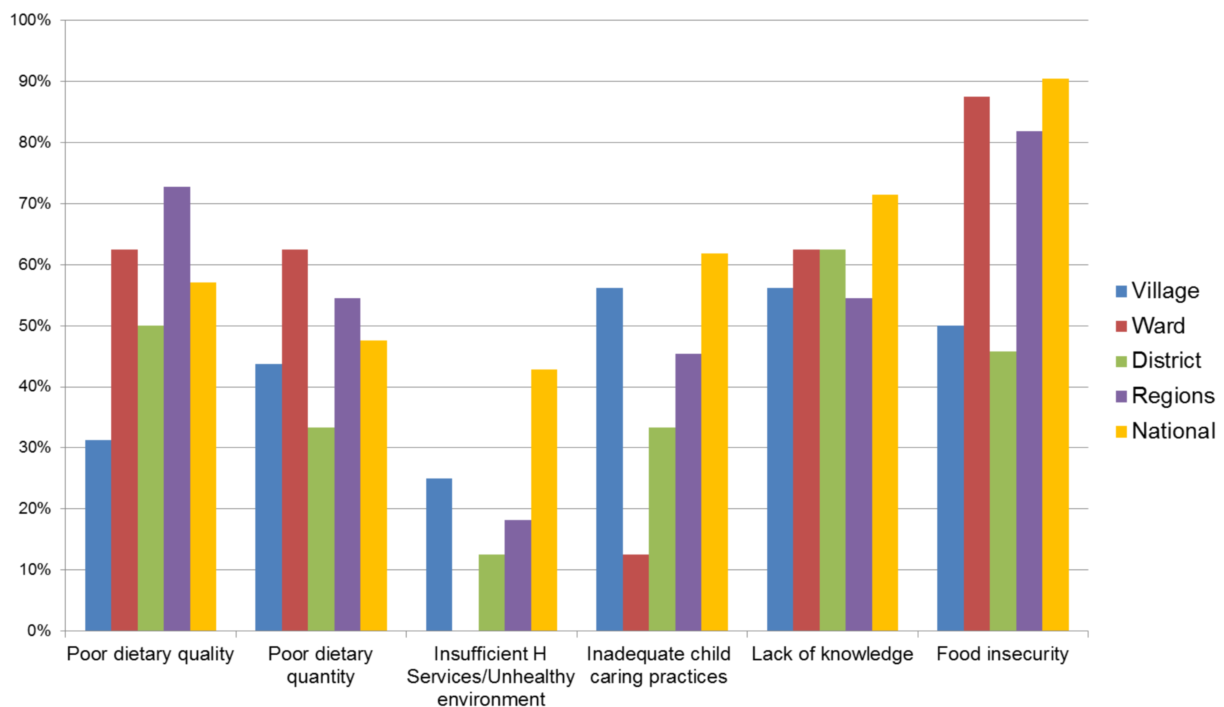



**Figure 10 Awareness of causes**

The majority of stakeholders mentioned food insecurity as one of the major causes for malnutrition. Almost all stakeholders at districts and village level in Dodoma region mention food insecurity, which is in line with the fact that the region is chronically food insecure. Insufficient health services were mentioned by very few stakeholders at all levels from national to regional, district ward and village level and there was no significant difference between the different districts. Few stakeholders from regional level and down recognized inadequate care as a mayor cause. Lack of knowledge and poor dietary quality were commonly mentioned, but it is evident that the multiple causes of malnutrition are not widely understood.

**Political commitment**

The high level of acknowledgement and commitment to nutrition is evident through the President's participation in the SUN leading group and through the Prime Minister launch of the NNS in September

2011. This has led to the formation of the High Level Steering Committee which is led by PMO and emphasizes on a multi-sectoral response through the establishment of nutrition focal persons within relevant ministries. These initiatives are still very recent and have not yet been reflected in actual improved nutrition activities at implementation level in districts. Through the Landscape Analysis it is clear that stakeholders, at all levels, are willing to scale-up nutrition activities and acknowledge their role in implementation and coordination.

Nutrition has not yet been given enough attention during parliamentarian sessions; however a group of MPs have indicated interest to form a Parliamentary Committee on Nutrition. Despite a high declared interest in scaling up nutrition, the multi-sectoral nature leads to nutrition being nobody's sole responsibility and actors wait for action from other sectors.

**Nutrition coordination mechanisms at central level**

The Multi Stakeholder Platform consists of the High Level Steering Committee for nutrition and the Technical Working Group for Nutrition. The High Level Steering Committee is a structured high- level mechanism comprised of Permanent Secretaries from relevant sectors (health, agriculture, education, industry, finance, community development, livestock and fisheries and local government) and representatives from development partners, civil society and the private sector. It is chaired by the Permanent Secretary in the Prime Minister's office. Roles include policy making, coordination, advocacy, advisory role and resource mobilization.

The advantages of the multi-stakeholder platform in Tanzania are that the group is 'multi-sectoral' and 'high level'. It is being formed at a time when nutrition is high on the national agenda. The High Level Steering Committee is being presided over by the office of the Prime Minister, a strategic position for rallying relevant sectors and ministries for action on nutrition.

The multi-stakeholder platform has the potential to be a strong voice in advocating for nutrition as a requisite for national development. It will also facilitate the mainstreaming of nutrition in the different sectors, ministries and organizations as well as elicit issues of concern from the perspectives of the different sectors.

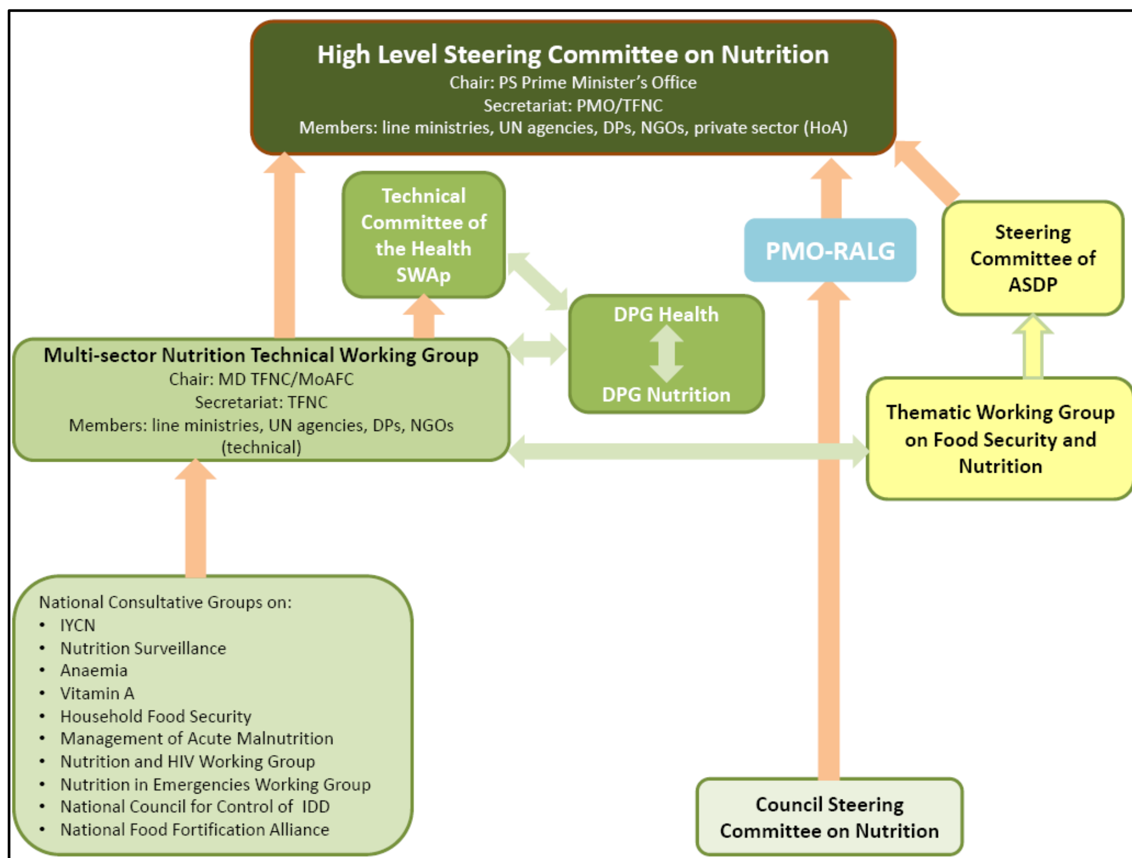



**Figure 11 Coordination structure of multi-sectoral platform**

The high level steering committee is emphasising on key cross-cutting issues, where some are:

- Inclusion of nutrition in the national budget guidelines and establishment of a budget line for nutrition
- Inclusion of nutrition in the plans and budgets for the relevant sectors
- Inclusion of nutrition in Tanzania Agriculture and Food Security Investment Plan (TAFSIP)
- Designation of nutrition focal persons within lead ministries
- Designation of nutrition focal persons at district level
- Recruitment of nutrition officers within the regions and councils

Tanzania Food and Nutrition Centre (TFNC) is a Government institution established by Act of Parliament and mandated to guide, coordinate and catalyse nutrition work in the country. It has existed for many years and provided technical nutrition advice through decades of implementation in the country. The Centre is semi-autonomous and is the secretariat and chair for the technical working group on nutrition. The nutrition consultative groups mentioned in figure 11 presides over all major national nutrition programmes and reports to the TWG. The consultative groups are the steering body for the implementation of the respective programme and play a policy advisory role to the relevant government body. The consultative groups are multi-sectoral and membership is institutional. Each Group is chaired by the relevant sector Ministry or institution with TFNC as the secretariat. TFNC (where the respective

programmes are based) acts as the 'hub' – coordinating the rest of the group members. The group advises on policy, implementation guidelines and resource sourcing.[11]

There are other mechanisms of interagency collaboration on nutrition actions and development partners, UN agencies and CSOs are meeting regularly on the DPG Nutrition group. This group is currently under review to, among other things to accommodate the recommendations from the SUN movement. Tanzanian CSOs and PSOs recently formed a partnership for nutrition, *Partnership for Nutrition in Tanzania*, PANITA, with the objectives of *advocacy and improved coordination… by strengthening the capacity and increased mobilization and coordination of CSOs, PSOs, the media and other development partners..*.[12]. Tanzania is one of the countries where UN agencies are *delivering as one* and jointly develops development assistance plans (UNDAP)[13]. Furthermore, nutrition UN agencies (WHO, UNICEF, FAO and WFP) are jointly strengthening the nutrition agenda through REACH and have recently formed the SUN DP/UN network with bilateral donors and World Bank.

Amongst development partners there was a high awareness of the coordination bodies however to an extent, ministries and some stakeholders were concerned that the TWG does not adequately reflect ministries currently represented in HLSC. The ministries that are absent from the meetings do not to see nutrition as their responsibility, but believe that the implementation of nutrition activities and initiatives is the role of other sectors. Some partners raised concerns about the inconsistency of both the TWG and the consultative group meetings and that the agenda is often set by DPs/NGOs. Others were concerned of having too many coordination mechanisms and not enough linkages between the groups and suggest a harmonization of the coordination structure.

The role of TFNC as the coordinating body was recognized as a key strength by most stakeholders, but many have concerns that TFNC is not playing its role in coordinating nutrition issues effectively. The comprehensive coordination structure was recognized by most stakeholders, but no one mentioned decision-making and actual implementation of these decisions as a key strength.

The HLSC was established in June 2011 and have met only three times, the first meeting was attended by several Permanent Secretaries, but many sent representatives to the second meeting. Many stakeholders were worried if high level interest can be sustained and recognized that this involves significant efforts by all nutrition stakeholders. The Presidents active participation in the SUN leading group is recognized as an indication of the country's willingness to scale up nutrition interventions, but this needs to be adopted and sustained by all concerned parties to have an impact on the nutrition situation in the country.

[11] SUN progress report, TFNC
[12] http://www.nutritiontanzania.org/cms/index.php
[13] http://tz.one.un.org/index.php

**Nutrition coordination mechanisms at sub-national level**

Recently all councils were directed to appoint a nutrition focal person/nutrition officer as well as establishing a council multi-sectoral committee on nutrition to reflect the direction at national level. Most stakeholders at regional, district, ward and village level were aware of the nutrition directives on establishing multi-sectoral coordination committees and appointing nutrition focal person/officers sent by the PMO. Only 1 out of the 4 regions/districts assessed has to this date established a well-functioning nutrition working group, data from other sources, May 2012, reports 94 councils with an established steering committee. Concerns have been brought by stakeholders that guidance on membership, terms of reference and reporting of the steering committees is lacking and further support to councils is needed to effectively coordinate nutrition issues.  Other working groups exist and involve important sectors like health, agriculture and community development as well as NGOs, but nutrition is still not on the agenda. In all wards and villages visited, coordination groups did either not exist or did not discuss nutrition.

**Nutrition policies, strategies and action plans**

The table in annex 1 presents a review of key polices including the target group and any policy statements relevant for nutrition. Each policy has been reviewed to assess whether it addresses maternal and child undernutrition.

First of all, nutrition is well reflected in MKUKUTA II and the nutrition component has recently been graded as medium compared to weak in MKUKUTA I[14] on a grading using international indicators for evaluating Poverty Reductions Strategy Papers. MKUKUTA II includes nutrition relevant food security targets under cluster I, goal 4 and more specific nutrition under cluster II, goal 3 with an indicator on reducing child mortality and reducing the proportion of stunted children to 22 % in 2015. Nutrition is furthermore mentioned under maternal health in providing nutrition education and micronutrient supplementation to women of reproductive age, especially during pregnancy and breastfeeding.

In order to improve the health of people by ensuring adequate intake of nutritious food and reduction of infectious diseases, various policies and strategies in different sectors have been formulated. These policies include the Food and Nutrition Policy (1992) which is currently under review and the National Health Policy (2007). Other relevant policies include the Community Development Policy (1996), Child Development Policy (1998), the National HIV/AIDS, National Livestock policy (2006), The National Agriculture Policy (draft) and the Water Policy (2002). The National Nutrition Strategy translates the relevant policies into strategic objectives as mentioned in the background section.

PANITA and SUA recently undertook a substantive policy analysis where they assessed the extent to which nutrition problems and causes were mentioned in relevant policies from health, to water, transport and land and concluded that ...*close to 43% of the policy documents did not include any nutrition issues. Five policies and 4 strategies/programmes (25.7%) covered nutrition issues more frequently (>4 times) than others. These policies were* (besides MKUKUTA, CAADP/TAFSIP) *related to health, food and nutrition, agriculture, child and community development sectors….* The report further

[14] http://apps.who.int/nutrition/landscape/report.aspx?iso=TZA&rid=161&template=nutrition&goButton=Go

concludes on the gaps... *some of these include lack of monitoring and evaluation plan and limited inter-sectoral collaboration during formulation and implementation of policies* and gives recommendations on advocacy for each sector.

Many relevant policies and strategies exist, but most of them do not substantially include nutrition issues. From the brief review on the key policies it was evident that only the Health Policy and the Food and Nutrition Policy include considerable aspects of nutrition and policies on agriculture, community development and child development just include nutrition to some extent. Most other policies, including community development and HIV/AIDS do not include any aspects of nutrition. The existing national Food and Nutrition Policy and the recently launched National Nutrition Strategy was recognized and mentioned as key documents by almost all development partners, but by few ministries and government institutions. Many stakeholders expressed a need for a common agenda, but no one mentioned the NNS as a guiding policy document, possibly because of lack of awareness.

The majority of stakeholders mentioned that nutrition is adequately addressed in the policies and strategies and acknowledged that nutrition is included in other health plans as well as in non-health plans (e.g. school feeding, ECD in education). Some relevant policies and strategies are not updated, well disseminated or fully implemented. In most sectoral policies and plans the link between sectors is not clear and nutrition activities are often not directed to improving nutrition among mothers, children and vulnerable groups. Stakeholders at sub-national level were not aware of nutrition policies and strategies and it is clear that there is a need to translate these into more action-oriented plans.

For legislations, there is a platform for enabling a strong environment in Tanzania with the Food Fortification standards recently endorsed and gazetted and Maternity Protection and Salt Iodization Acts in place. The National Regulation for BMS was developed in 1994 and has been reviewed and is in its final draft, but the actual endorsement has been severely delayed. There is generally a very poor awareness of the legislation including the National Regulation for BMS at all levels and in most sectors.

**Planning and budgeting**

The planning and budgeting process is decentralized in Tanzania and each district develops annual sectoral plans and budgets, guided by central ministries, and submitted to Prime Minister's Office Regional Administration and Local Governments (PMO-RALG).

As an example from the health sector, the health reform aims at improving health services and MOHSW has developed a framework which provides LGAs with more autonomy and accountability, hence decentralization of decision making. The Comprehensive Council Health Plan (CCHP) is an instrument used by district councils for annual planning and budgeting of health activities. CCHP also assists the districts during implementation of health activities as it serves as a work plan and indicates committed funds. Within the CCHP, for each specific activity, the source of funds and amount allocated is indicated. In this way it encourages transparency and accountability of the funds allocated and how they are used. Support to LGA is provided by the MOHSW in prioritizing and planning their health interventions based on priority needs. The LGAs mobilize, manage and account for health resources and implement health activities in line with National Health Policy. The LGAs prepare CCHP using national guidelines and Plan

Rep 2 software. These two tools ensure CCHP links with other national strategies and policies. However, clear information and guidance on nutrition planning and budgeting has lacked throughout the last years.

Funds for the implementation of the annual CCHP have to be integrated into the Council's budget. The CCHP contains both recurrent and development activities within the sector, identifying the funding source for each activity. The Health Block Grants and the Health Basket Funds finance health activities identified in the Health Sector Strategic Plan and in the National Essential Health Package.

Districts have recently been encouraged to plan and budget for nutrition and directed by the Prime Minister's Office to establish a budget line for nutrition. Not all districts were aware of this, but all districts, regardless of whether or not they were aware of the directive, were committed to follow. Different funding opportunities exist at district level such as health basket fund, Tanzania Social Action Fund (TASAF), Agriculture Sector Development Programme (ASDP), development partners, NGOs, local government block grant, and own fund raising/revenue. Most districts were interested in budgeting for nutrition, but actual funding and allocation does not always follow. None of the districts actively raised funds for nutrition and further advocacy is needed to ensure districts prioritize nutrition and innovatively mobilize resources.

TFNC and partners recently developed and disseminated a *Guideline for councils for the preparation of plan and budget for nutrition 2012-13* to assist districts in following the directive from PMO to plan and budget for nutrition activities. All districts were oriented on this through regional meetings and the guidance includes recommendations for each sector. More detailed and sustainable guidance for districts is needed and partners are in the process of developing this. A revised planning and budgeting guideline has been produced and disseminated to districts to address this shortcoming and TFNC will send teams to the regions and districts in the coming months to facilitate the process.

Nutrition was incorporated in some district plans, but not comprehensively in all relevant sectors, even in districts with external support. Most districts were weak in integrating nutrition in a comprehensive manner partly because of vertical funding which does not support the implementation of a complete set of essential nutrition interventions to all mothers and children. The few activities implemented were mainly in the health sector, the coverage is low and the activities were often either national level programs such as Vitamin A supplementation and deworming or programs funded by development partners or NGOs. In Tanzania nutrition services are mainly delivered through health programs such as IMCI, PMTCT, RCHS. Only limited nutrition integration was noted in other health programs such as malaria and in other sectors such as agriculture, education or community development.

Nutrition was generally not included in ward and village plans and the few nutrition activities implemented at community level was most commonly led by CSOs. Some districts did not fully follow the recommended planning and budgeting process and hence some wards and villages were not involved in planning for nutrition interventions.

A variety of community based nutrition and nutrition related activities exist in the districts assessed including home gardening, Vitamin A Supplementation, Immunization, Salt iodisation, supplementary feeding and nutrition education. Most of the activities were not included in the comprehensive council health plans thus hindering sustainability. Most of the nutrition relevant agriculture interventions were aimed at income generation and not at improving household food and nutrition security. Moreover trained Community Owned Resource Persons (CORPS), such as community health workers, in sectors for supporting communities to implement nutrition activities are lacking. Community mother support groups are not existent and guidance from central level on implementing community based interventions is weak.

**Table 6 List of nutrition activities in CCHPs assessed by HKI**

| Activity | Number of Districts allocated fund | Percent |
|---|---|---|
| 1. VASD | 133 | 100% |
| 2. Community mobilization on use of iodine and iodine inspection | 7 | 5.3% |
| 3. Proving nutritional support to people living with HIV AIDS | 2 | 1.5% |
| 4. Screening for SAM and management of malnutrition | 9 | 6.8% |
| 5.Providing inpatients with food | 7 | 5.3% |
| 6.Training on infant and young child feeding | 10 | 7.5% |
| 7.Purchasing iron tablets and folic acid | 9 | 6.8% |
| 9. Training on ENA | 6 | 4.5% |
| 10. Providing ANC women with food and addressing food security | 1 | 0.8% |
| 11 Advocacy on emergency obstetric, nutrition and child care | 1 | 0.8% |
| 12. Training and mobilizations on food handling and food hygiene | 2 | 1.5% |
| 13. Nutrition survey | 2 | 1.5% |

A recent review of 133 district comprehensive health plans compiled by Helen Keller International (HKI) showed that all districts plan for the extensively supported Vitamin A supplementation, but less than 10 % plan for most other nutrition interventions. Some districts take efforts in planning for nutrition interventions, but almost all of these activities (e.g. training on ENA) are either supported by external partners or not direct nutrition interventions (e.g. kangaroo care or IMCI). HKI concludes '*that there is still lack of consistency and connection of activities across districts as well as within a district budget ... districts allocating funds to conduct staff training for severe acute malnutrition (SAM) screening and management yet no budget for supplies related to management of SAM'.* The study further concludes that tracking the actual costs of activities would help to provide more information on allocation sufficiency.[15]

It is evident that districts need guidance in prioritizing nutrition interventions and need support to operationalize the national policies and strategies. When districts do plan for nutrition interventions the

[15] District budget allocations for nutrition activities, A Review of Comprehensive Council Health Plans 2010/2011, Report compiled by Helen Keller International Tanzania, March 2011

central government, PMO-RALG, MOHSW and other ministries, need to be better in prioritizing these to ensure the planned activities are actually funded.

There is limited funding from government committed to nutrition. During the period of writing this report, PMO and TFNC are, with the support of UNICEF and WB, conducting a Public Expenditure Review for nutrition. The Landscape Analysis data showed that the key donors support nutrition activities for a total of approximately 16.5 million $ for 2012 and that this amount is either increasing or stagnant. The majority of donors (both bilateral and international) report their willingness to increase their funding for nutrition interventions. The ministries and government institutions show interest in developing new proposals, so from an economic resources point of view there seems to be a favourable environment to scale up nutrition interventions. The current amount from donors is though still far from the current draft budget in the National Nutrition Strategy's Implementation Plan of almost 68 million $ per year. The finalization of the National Nutrition Strategy's Implementation Plan might involve more sectors and make it easier for donors to select and fund specific nationwide activities.

**Mapping of partners and their interventions**

Data on where partners support or implement interventions was collected through the stakeholder mapping tool. The interventions included both activities implemented by the partners directly, e.g. Save the Children in Lindi, and activities implemented through the government system but supported by partners, e.g. HKIs Vitamin A and Iron supplementation. As seen on figure 13 and 14, there is a tendency for partners to concentrate in the Central and South-Western regions and to a lesser extent the far South and North West. As mentioned above all regions have a high prevalence of stunting, but when estimating the actual numbers of stunted children is shows that the majority is in the North and Western part of the country which has fewer partners.

Wasting is a severe problem in the Northern and Central zones which have a lower density of nutrition partners. For indicators such as exclusive breastfeeding and maternal under-nutrition there is also only limited correlation with partner focus areas (figure 12, 13 and 14). HIV prevalence and food security, or a combination of these, might be used by partners to select their nutrition focus areas, which is not in line with the complexity of underlying causes of stunting.

Interestingly, in the regions and areas that have had substantive external support the level of stunting is still amongst the highest in the country – e.g. 52 % in Iringa and 56 % in Dodoma.

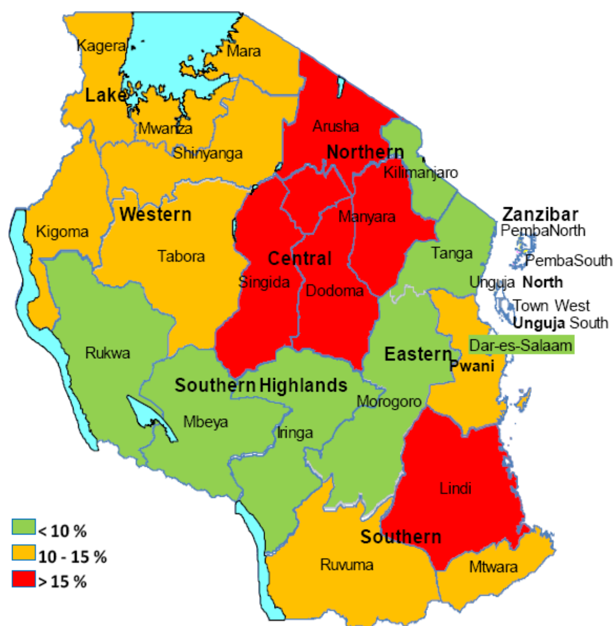



Figure 12 Percentage of women in reproductive age with BMI < 18.5

The mapping of interventions in Figure 14 only includes the interviewed UN agencies and NGOs and is not a comprehensive picture of interventions being implemented. It provides a quick picture on which geographical areas the interventions supported by the most important partners are being implemented. The highest number of interventions is in Central and to some extent Southern Highlands and the North-East. This is not in line with stunting prevalence, estimated number of stunted children, wasting or maternal undernutrition and exclusive breastfeeding. To enable more detailed analysis a more thorough review of government and partner's interventions is needed.

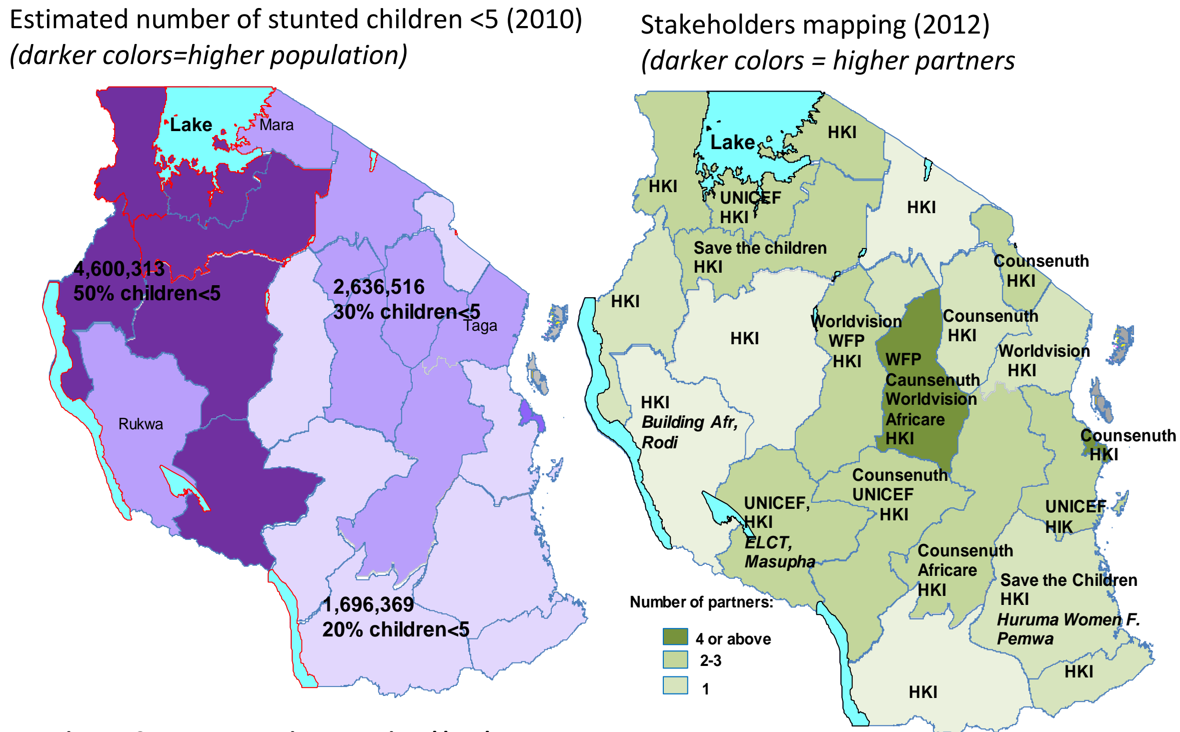



**Figure 13 Partner mapping on regional level**

The interventions are implemented in various partnerships – from large scale partner supported Vitamin A supplementation campaign with strong ownership of central and local government to interventions implemented in specific districts with local partners. The government partners mentioned that full involvement in the program planning and implementation is crucial to ensure a successful partnership. At sub-national level there were good examples of CSOs involvement on the LG planning and implementation. However, there were less partnerships and involvement at ward and village level. There were few examples of private sector partnerships in nutrition and mechanisms that can advise on public-private partnerships. The private sector was involved in some district coordinating committee (e.g. Lindi and Iringa), but these partnerships were mostly with NGOs/CSOs and not the government. Generally, there was a high interest from both central, local governments and partners (e.g. NGOs and CSOs) to implement programs jointly, but lack of a fully functioning coordination mechanism seems to be a limiting factor. With proper support and follow up, the recently established steering committees

and nutrition focal persons/officers at district level might be able to strengthen the nutrition coordination and partnerships.

Estimated number of stunted children <5 (2010)
*(darker numbers = higher population of stunted<5)*

Interventions distribution
*(dark colors=higher concentration)*

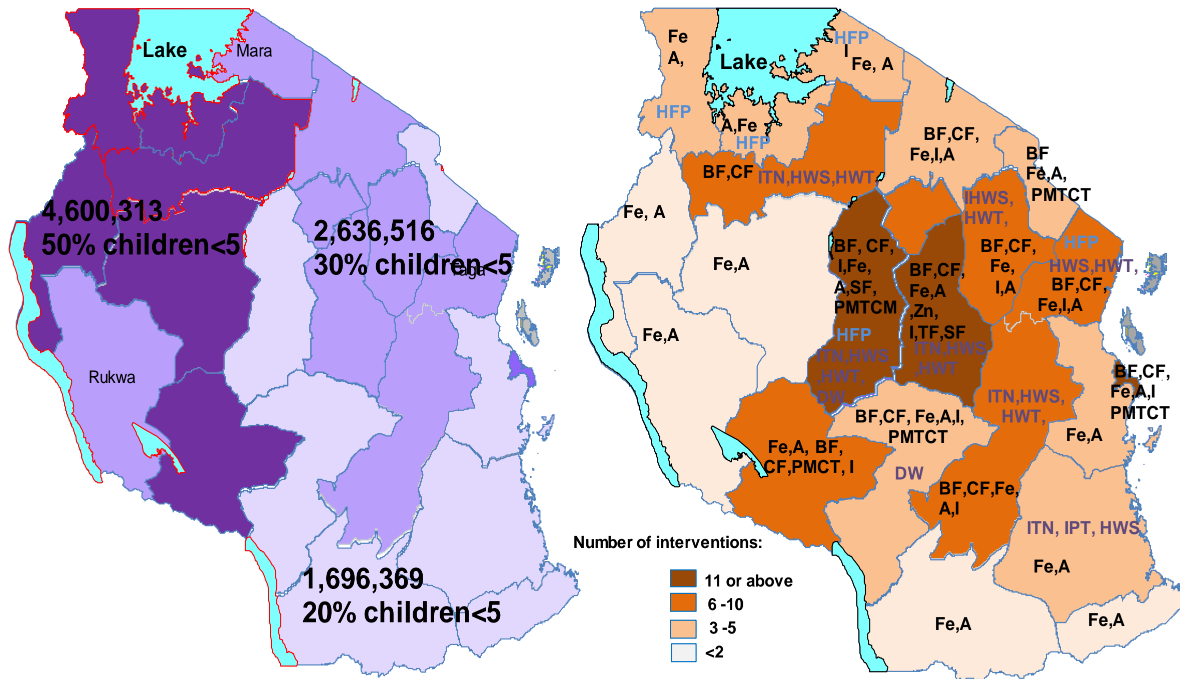



**Figure 14 Partners intervention distribution per region**

## Implementation of nutrition activities in the facilities

Nutrition interventions are implemented to a varying extent in facilities (fig 15). All of the facilities assessed implemented de-worming and most Vitamin A supplementation, but mainly through campaigns twice per year. Zinc supplementation and nutrition education is implemented within the RCH department which is present in all levels from dispensary to hospitals. The low level of management of SAM and MAM interventions is most likely because this is only implemented at health centres and hospitals. The data in figures 15 to 19 below is not disaggregated between the types of facilities, but it is evident that some of the most common nutrition supplies, guidelines and material are available, that health workers do have knowledge about most nutrition interventions and that facilities do implement some nutrition activities, hence there is a good environment for scaling up these interventions in all facilities throughout the country.

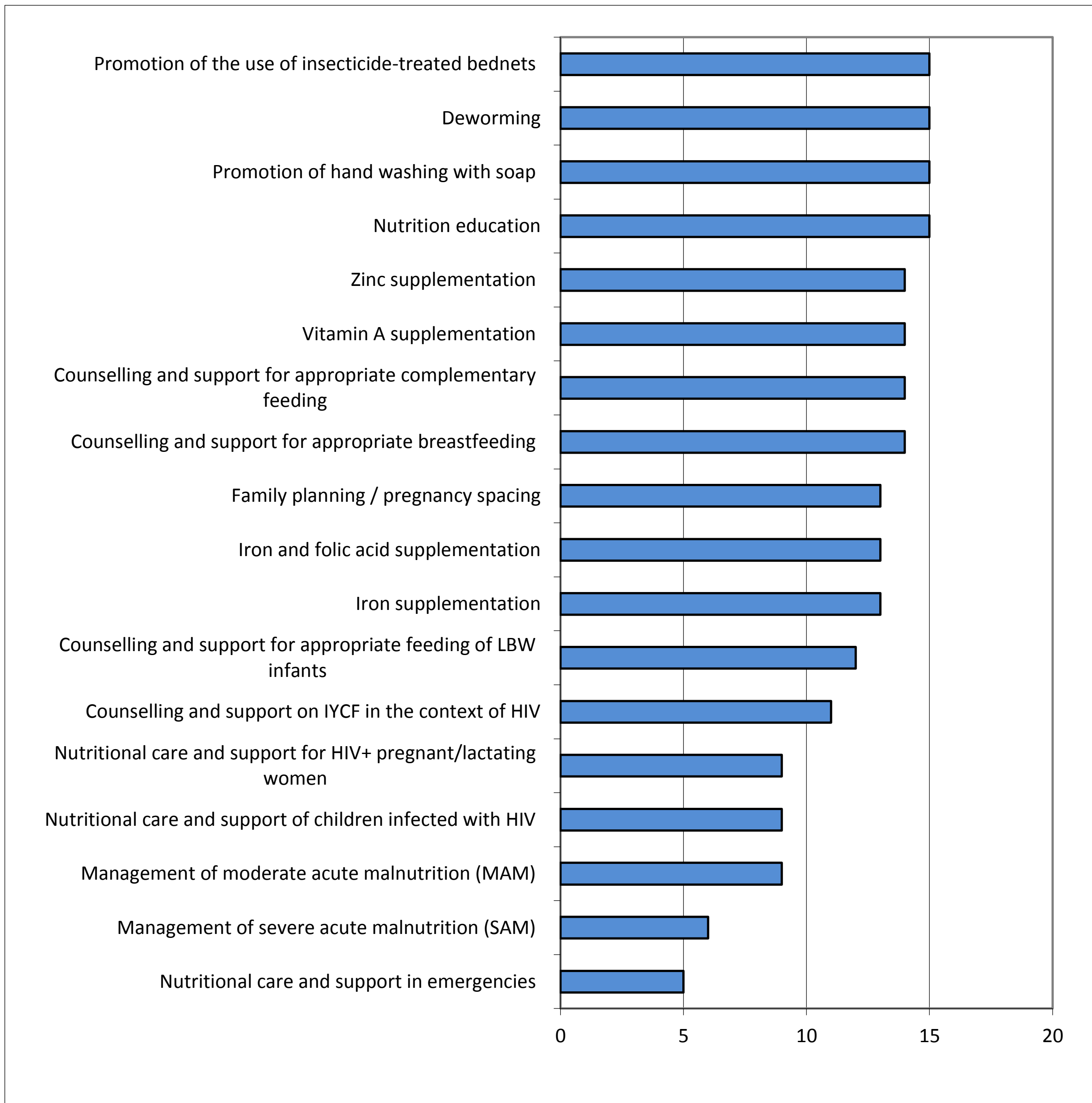



**Figure 15 Interventions implemented at facility level (total 15 facilities)**

## *Capacity to accelerate action in nutrition*

The capacity to accelerate action in nutrition was assessed by looking at indicators such as the number and qualification of nutrition professionals and their distribution in the country at different levels. Other indicators looked at availability, quality and accessibility of supplies used in delivery of nutrition services at all levels. The supplies include guidelines/protocols, IEC materials, equipment, supplements and therapeutic foods.

**Availability of Nutrition Officers/Focal Persons**

All the government departments and ministries interviewed (MoHSW, MAFC, Ministry of Community Development Gender and Children (MoCDGC), PMO and PMO-RALG) reported having a nutrition focal person with relevant qualifications (degree level), however, only the MoHSW, MAFC and MOCDGC have full time staff as per Prime Minister's directives. All the interviewed NGOs and DPs have at least one staff working on nutrition, although some NGOs the respective staff also have other duties.

The PMO has recently directed districts to appoint a focal person or hire an officer to be responsible for nutrition. This has been honoured in the districts assessed and a variety of categories of staff are working on nutrition in different sectors. However, the nutrition focal persons did often not have adequate time because of competing duties and did not have the appropriate background and knowledge. In addition, the terms of reference for the nutrition staff in the districts were not clear and it decided which department to place them. Presently, 97 nutrition officers have been employed in the health sector in the regions and districts. 11 out of 25 regions (44%) and 86 out of 153 councils (56%) have regional or district nutrition officers respectively. Some districts (6) have created more than one position and most of the remaining regions and districts have appointed a focal person for nutrition and confirmed budget allocation for this financial year. However, the process of deploying and employing nutrition officers is underway on most districts. None of the assessed wards and villages were aware of the existence of district level nutrition officers/focal persons, begging the question whether the nutrition officers/focal points are not sufficiently active or under resourced to carry out their duties.

It is clear that more advocacy at all levels is needed to ensure the right working conditions for the Nutrition Officers/Focal Persons and that structured and regularly support and supervision for these is needed. UNICEF in collaboration with TFNC and other partners are developing a training program to be rolled out for all nutrition officers which will hopefully honour this need. Neither the reporting lines within the districts nor how the nutrition focal person/officers are expected to coordinate nutrition amongst all the relevant sectors are clear. Lastly, the support from regional and central level is not yet structured - this needs to be prioritized and systematized in order to effectively use the new cadre. TFNC are currently planning to assign staff to specific regions, a system that previously was in place, but failed to sustain. Commitment (in terms of time and budget line) and structured reporting and response are needed to effectively sustain such a supportive supervision system.

**Capacity building and support**

Improvement of the quality of human resources for nutrition is one of the priorities to be undertaken through improvement of the pre-service and in-service training. Continuing professional development of health service providers and other key stakeholders engaged on nutrition through supervision, coaching,

apprenticeship and monitoring mechanisms is crucial. Since its early years of establishment there have been major efforts in strengthening capacity of TFNC's staff. Currently in 2012, the centre has 137 staff consisting of 57 researchers and 80 other staff (includes programme officers and support staff). Staff training was very strongly prioritised in the early years, but in the past years greatly declined due to reduced government support and the withdrawal of SIDA's support to TFNC and changes in training policies that have led to reduced accessibility of TFNC to scholarships. Besides strengthening the capacity of its staff, the centre collaborates with other institutions to conduct and support in-service nutrition training, curriculum design, development and review. Support has been provided in developing and reviewing training curricula and modules on nutrition for secondary schools, Sokoine University of Agriculture, Muhimbili University of Health Science, Agriculture, Health and Community training institutions. Also, the centre has been conducting a six week course on management of food and nutrition programmes for district level nutrition programme managers since 1995. Other training activities conducted to key actors at District and Community levels offered includes vitamin A, anaemia, Iodine deficiency disorders, salt iodization and postharvest of cereals, roots and tubers. In addition, the centre modifies and adopts WHO/UNICEF training manuals, which have been used in training health service providers.

Available information records a total of 221 and 216 undergraduates from Sokoine University of Agriculture (SUA) since 2005/2006 graduated in nutrition and food science respectively with almost 50 at master's level since 2008. The recent mapping of nutritionists and nutrition officers by TFNC and UNICEF concludes that *…information compiled to date has identified a total of 244 trained nutritionists in 21 regions and all regions reported having at least one nutritionist employed in each of the councils.* These have various educational backgrounds from certificate to masters. Though the recent directive indicates the recruitment and appointment of a nutrition officer in the health sector, the currently employed nutritionists are scattered in all sectors – *32 are Nutrition Officers, 134 Agriculture Officers, 11 Education Officers, 31 Community Development Officers, 6 Health Officers and 13 others.* Of these, *76% indicated that they have specific nutrition activities, 24% had no specific nutrition activities on their job description.* It is evident that a lot of nutritionists are currently employed outside the health sector and not necessarily working on supporting the scaling up evidence-informed nutrition interventions, which are largely in the health sector. It is a lost opportunity not to fully use the capacities available at sub-national level.

**Pre-service training**

Tanzania has a total of 116 public and private health training institutions and 15 agriculture training institutions offering degree and diploma programs. The Human Resources for Health Strategic Plan (2008-2013) states that there are enough training institutions to meet the needs of the health sector and that the government has made strides to increase the total number of students enrolled in existing health training institutes. A total of 23,474 health workers were trained between 1995 and 2005, of which only 16 % were employed in the public sector. Recognizing the need for more trained staff, the MAFC plans to strengthen human capacity for agriculture extension by increasing the number of

students enrolled as well as by strengthening the capacity of the training institutes[16]. However, in the health sector a recent study of the Clinical Officer Training Institutes found that Tanzania's current training capacity is ill-equipped to keep pace with population growth and staff attrition[17]. The major reasons that hampered enrolment in pre-training institutes were number of tutors and staff; classroom capacity and dormitory capacity. The study by ITECH also found that there is lack of motivation for clinical staff to take on academic positions and that the shortage of full-time faculty staff is the most significant barrier to scaling-up enrolment. Some pre-service training institutes receive donor funding, but there are concerns that reliance on these funding sources will affect sustainability. Finally, an increase in the number of private health worker training schools has challenged the capacity of the government to ensure the quality of education delivered across the country.

**In-service training**

The MOHSW is encouraging in-service training in Tanzania and polices and mechanisms for upgrading midlevel cadres exist such as MCH aide to public health nurse, assistant clinical officer to clinical officer, clinical officer to assistant medical officer etc. A considerable side-effect of in-service trainings is that it forces health workers to be absent from their work stations for extended periods of time. As it is often difficult to find temporary replacements, this increases the workload of the staff remaining on site[18]. In addition to the in-service trainings partner NGOs conducts a large number of skill-based trainings. With PEPFAR and Global Fund there has a push to strengthen training and support for health care workers in the care and treatment of individuals with HIV and AIDS. The MOHSW also uses Zonal Training Centres (ZTC) to offer basic and post-basic training in order to upgrade the skill level of all health workers. The ZTCs offer courses to district managers in district planning and budgeting using the Tanzania Essential Health Intervention Program tools. In the agriculture sector, funding exists dedicated to capacity building activities for agriculture extension workers, however the Landscape Analysis did not go in detailed mapping of capacity development and in-service training for this group. Under the Agriculture Sector Development Programme ASDP, there is funding dedicated to capacity building activities.

**Availability of training opportunities and plans**

A range of nutrition training opportunities supported by the government and NGOs are available using standard national training guidelines, but some of the guidelines and training material are not harmonized and some not translated to Kiswahili. Most training lacked follow-up or post training supervision and the impact of trainings conducted is not always measured.

The training opportunities at district and community are limited and not easily accessible due to the lack of available resources. No training plans on nutrition were seen in any of the districts hence training is ad hoc. Health workers assessed had not received comprehensive training on nutrition. Less than a third had received training on IYCF and even less on SAM, MAM and growth monitoring (figure 16). A strong desire to be trained in nutrition at sub-national level was acknowledged by the majority of health workers.

[16] MAFC, 2007-2010
[17] ITECH, 2009
[18] Musau et al., 2010

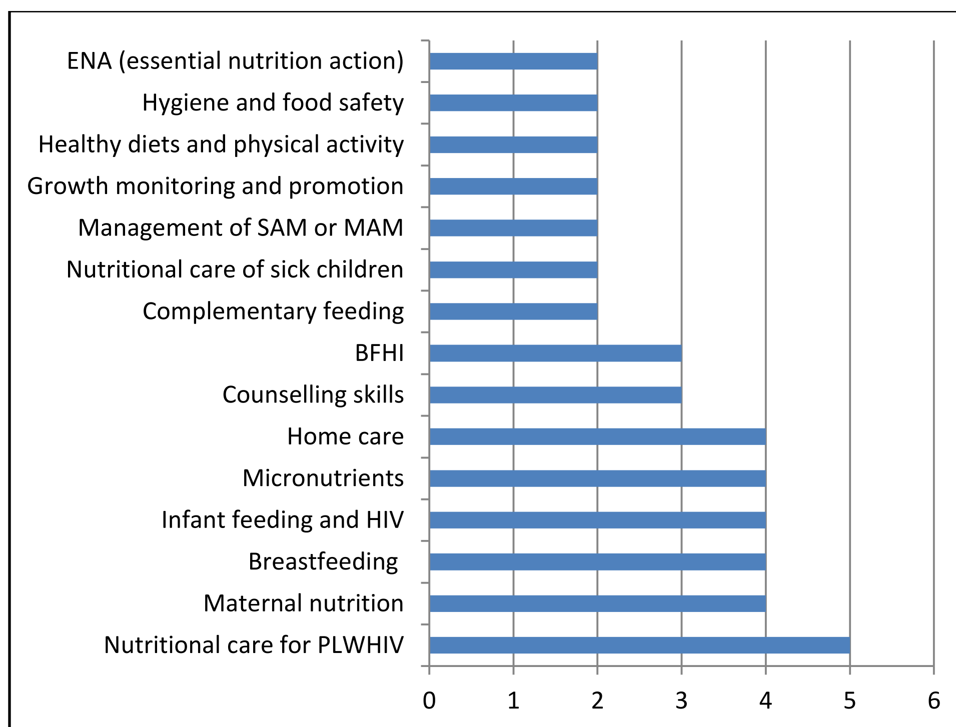



**Figure 16 Training of facility staff (n=13)**

**Health worker confidence, capacity, motivation and support**

The majority of health workers interviewed reported that they were not confident in delivering many of the nutrition services, especially in areas where they were not trained, e.g. healthy eating/NCDs. In the areas where staff had received training, they demonstrated much better confidence When asked to describe concrete counselling situations (e.g. counselling a mother with breastfeeding difficulties), few health workers mentioned clues that would demonstrate good counselling skills e.g. listening and learning skills. Group education and one-to-one counselling was provided in RCH and CTC services, but not in other departments and the time for counselling was seen inadequate especially in health facilities with few staff.

Although health workers complained about lack of technical support and mentoring (especially in private facilities), stakeholders at most levels recognized the existence of the government administrative system for supervision and acknowledged their use of this both from national and regional level to districts and from districts to ward, villages and facilities. However, some stakeholders mentioned that the support and supervision on nutrition was irregular, inadequate and nutrition was poorly integrated into the supervision system. It was not assessed whether this means that the supervision is inadequate because the knowledge of the supervisors is inadequate or if the actual supervision is inadequate.

As mentioned above, the establishment of regional and district focal persons/officers is still in its early stages and a contact list of these staff is being prepared by MOHSW. In some of the assessed districts the sectoral district officers supervise and receive reports from their respective staff, e.g. health or

extension workers. If a comprehensive system on communication and supportive supervision is established from central to regional and district level the nutrition coordination and implementation will without doubt be strengthened.

**Health worker knowledge and confidence**

Most health workers were not confident in implementing nutrition interventions and mentioned that better supervision was needed. Despite the lack of confidence, health workers were often able to answer correctly to the questions assessing their knowledge on nutrition actions. Most of them were aware that HIV positive mothers should exclusively breastfeed for 6 month, but only few knew that HIV positive mothers should continue breastfeeding for up to 12 months (figure 17). This guideline has been introduced to most districts, but training has not been rolled out comprehensively. All health workers knew that healthy diet and lifestyle is relevant in both rich and poor countries and the majority were aware of the zinc protocol for diarrhoea. Health workers did not know that all children have the same potential to grow and it seems they therefore did not see stunting as a mayor problem.

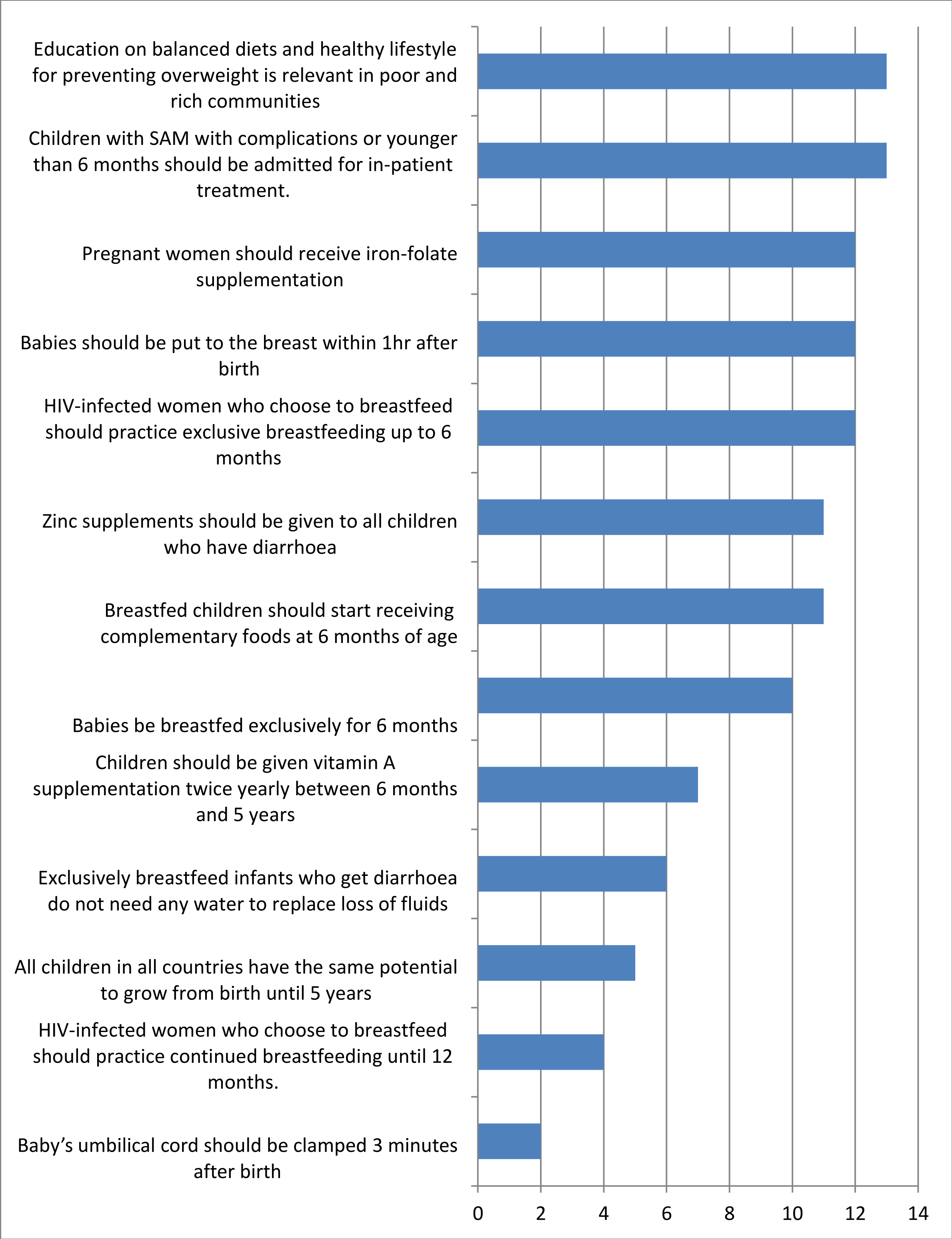



**Figure 17 Health workers' knowledge of basic nutrition actions (n=13)**

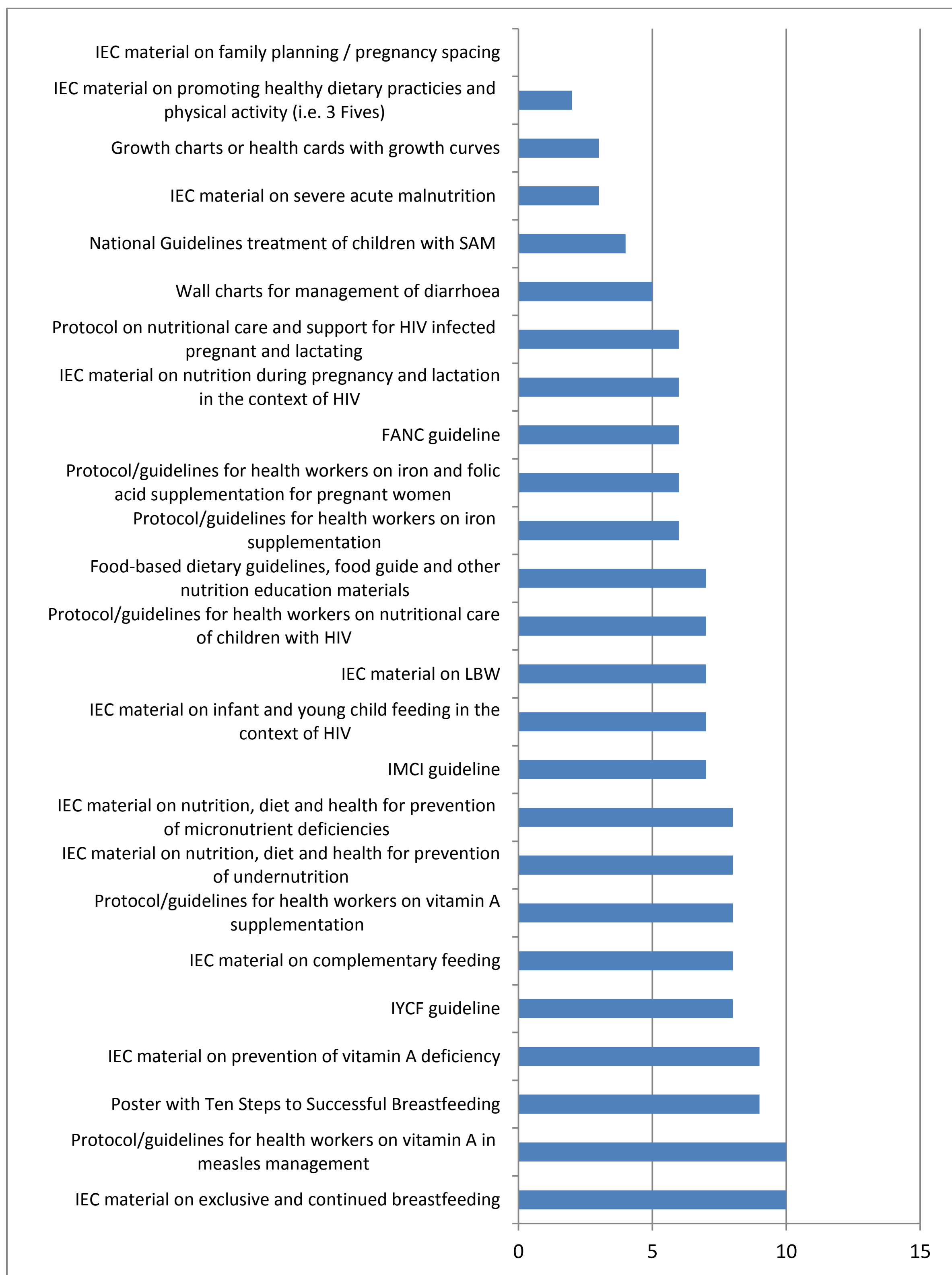



**Figure 18 Availability of nutrition support material (n=15)**

**Protocols, IEC material and supplies**

None of the national IEC material or guidelines were available in more than 2/3 of the facilities and crucial material on key areas such as management of SAM, iron supplementation and growth standards were available in less than half of the facilities assessed (figure 19). Despite interventions such as vitamin A and breastfeeding having been supported throughout the last years, in more than 1/3 of the facilities the full package of materials were was not available. Lack of proper dissemination and orientation was mentioned as the main factor causing difficulty in using guidelines and protocols. It is essential that a harmonized package of material is developed and disseminated throughout the country.

The majority of health facilities visited had a good supply of ORT but had serious shortages of other important supplies that should be available in all facilities. These include height measuring boards, antihelmintics, folic acid, weighing scales and length measuring boards. Disturbingly even Vitamin A was not available in all facilities. It is surprising that only one out of all visited health facilities had equipment to measure height or length – which falls in line with stunting not regarded as a severe problem. The low level of supplies to support SAM and MAM interventions is most likely because this is only implemented at health centers and hospitals. No medications or supplements were found to be past their expiry date.

This situation indicates a serious need for improving supplies and equipment in the health facilities.

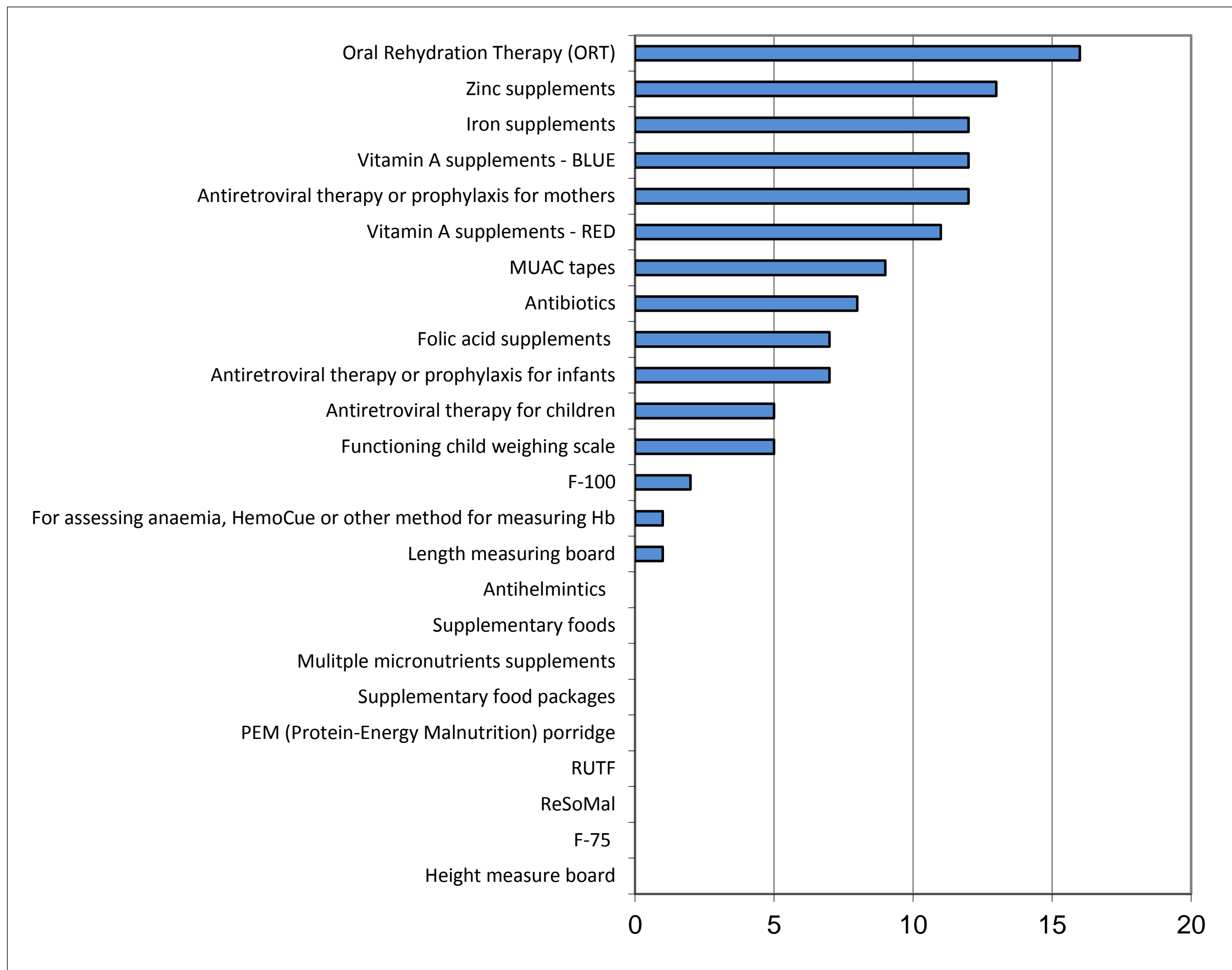



**Figure 19 Equipment, supplements and therapeutic foods in health facilities**

**Nutrition indicators and use of nutrition data**

Key nutrition indicators collected in the existing Health Management Information System (HMIS) are routinely collected by RCH sections in each district. These include growth monitoring, vaccination and supplementation for women and children. Food security, health and care practice indicators are used to analyse the causes of the nutritional problem and assist in finding out why people are malnourished or at risk of malnutrition. The purpose is to generate a household economic profile and or food security and nutrition reports for different livelihood systems on a specific reference period.

Methods for data collection

- Large-scale national surveys or repeated small-scale surveys (Tanzania Demographic and Health Survey, Household Budget Surveys, Agriculture Surveys, Poverty and Human Development - every 5 years)
- Seasonal assessments (Food Security and Nutrition Assessment, Crop forecast - Twice yearly)
- Clinic-based monitoring (continuously)
- Sentinel site surveillance (continuously)
- School census data (periodical)
- Rapid nutrition assessments (Rapid vulnerability assessment – ad hoc)
- Rapid screening based on MUAC measurement (ad hoc)

According to the Statistics Act, 2002 the National Bureau of Statistics is mandated to coordinate statistical services in the country to produce quality statistics that are comparable over time and across subject matter areas. Each sector, including health, is also responsible for collecting; consolidating and reporting findings generated though the existing systems. Some analysis on food security and nutrition situation is done under the coordination of Prime Minister's Office Disaster Management Department in collaboration with MAFC, MOHSW and other stakeholders. Regional level reports are developed on household economic profile and food security and nutrition for different livelihood systems.

Current effort to strengthen the nutrition information system

The importance for providing decision makers with information that is relevant, reliable, timely, clear and concise on food security and nutrition conditions; which explains not only the situation, but translates that into actionable knowledge for policy development and strategic recommendations cannot be over emphasized.

The Government of Tanzania and the UN have throughout the last years been trying to strengthen the nutrition information system and surveillance through several initiatives. The *Mfumo wa Uchambuzi wa Uhakika wa Chakula na Lishe (MUCHALI)* [19] has been established as a strategic framework that builds on a Livelihoods-based Food Security and Nutrition Information Systems (LFSNIS) using the Integrated Food Security Phase Classification (IPC) as analytical and communication tool. As a system, MUCHALI is drawing together information from multiple governmental and international agencies to conduct integrated analysis on food security and nutrition for a wide range of decision makers. The MUCHALI builds from, consolidates, and institutionalizes the Food Security Information Team (FSIT) through the

[19] In English *Tanzanian Food Security and Nutrition Analysis System*

establishment of a National MUCHALI Team and Secretariat and Local Government Authorities (LGA - Councils) MUCHALI Teams. Furthermore, MUCHALI is facilitating establishment of appropriate institutional structures and is devising comprehensive and sustained capacity building strategies at the Regional Administration and Local Government (RALG) levels for food security and nutrition programmes. [20] Concerns has been raised that more nutrition focus is needed in the MUCHALI system.

Recently, a review of systems for nutrition surveillance and information has been conducted recognizing that a *critical part for ensuring scaling-up the nutrition is the need for conducting a thorough review of the existing surveillance system in Tanzania, which will lead to the formulation and operationalization of a National Nutrition Surveillance (or Information) System*. The nutrition surveillance system *will serve local level planning needs and trend monitoring as well as enable decentralized updating of information through coordination and standardized information provision to the district health management teams.*[21]

Some of the preliminary recommendations from the assessment are

- Appoint a dedicated nutritional surveillance officer at central level
- Focus on identifying and using existing data
- Develop a platform for dissemination of the nutritional surveillance system

TFNC in collaboration with other ministries and partners are currently planning the way forward for strengthening the national nutrition information and surveillance system. This will possibly be building on MUCHALI and ensuring that collection of nutrition indicators is strengthened and strongly embedded in the framework.

The systems currently in use (HMIS, TDHS, RVA etc.) collect indicators such as stunting, wasting and underweight. Nutrition data is also collected in specific programs and some stakeholders report that the data collected is indeed used for planning and budgeting. Nevertheless, stakeholders highlighted several weaknesses regarding collection, management and use of nutrition data including limited access, dissemination and sharing of data. Furthermore, the majority of stakeholders, especially at sub-national level, were not aware of existing information systems and which indicators are collected. The existing systems do not include all major nutrition indicators such as optimal infant feeding indicators. In general concerns were raised on poor sharing of nutrition information and limited data transfer/flow from central/regional level to districts possibly because of lack of capacity at regional/national levels.

Analysis and tracking of nutrition data is poor and statisticians and software is not widely available especially at the sub-national level. Secondary analysis from bigger survey, such as TDHS, is rarely being done, partly because it is difficult to get permission to use the data for further analysis for publishing. As mentioned above and evident through this analysis, a first step in scaling up nutrition information and surveillance is to use data already collected in a more coordinated and integrated way. This includes not only the TDHS, but routine data from facilities and food security based surveys.

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[20] *Tanzania Food Security and Nutrition Analysis System,* A Framework, June 2012

[21] Tanzania National Nutrition Surveillance System, draft report, Phillip McKinney and WFP

# Recommendations

The results were shared at a stakeholders' meeting on 6 March 2012 with representation from central ministries, regions, bilateral donors, UN agencies, NGOs and CSOs. In each of the National Nutrition Strategy's strategic objectives a set of recommendations were formulated partly to guide the finalization of the NNS Implementation Plan, but also to guide the actual scale up of nutrition interventions at national level. These recommendations needs to be prioritized by all stakeholders at all levels to effectively scale up nutrition interventions and furthermore, where relevant, needs to be adapted and translated into simple actions at district level.

| Strategic objective | Recommendations |
|---|---|
| **Service delivery** | Evaluate whether a set of essential (and prioritized) nutrition interventions can be recommended to be scaled up in all districts in all relevant sectors in addition to specific nutrition interventions which may be implemented depending on the situation in each district |
| | Integrate nutrition in sector and programme specific routine supervision |
| | Clarify roles and responsibilities for nutrition for staff at all levels and in all relevant sectors |
| | Revitalize the Village Health (and Nutrition) Days and prioritize the delivery of BCC services through these |
| | Strengthen the nutrition component in the Community Health Workers scheme and other extension workers |
| | Ensure capacity building for growth monitoring and the availability of height/length boards, weighing scales, haemoglobin testing equipment, iodine testing kits and other supplies in facilities |

| Strategic objective | Recommendations |
| --- | --- |
| **Behaviour Change Communication** | Ensure multi-sectoral participation in developing the Social Behaviour Change Communication strategy |
| | Ensure harmonization of BCC material package and availability in all districts and facilities in the country |

| | |
| --- | --- |
| **Legislation** | Ensure awareness of the national regulation for breast milk substitutes and related products and other nutrition relevant legislations by stakeholders who have responsibilities in its enforcement and regulation |

| | |
| --- | --- |
| **Policies, plans and programs** | Ensure awareness of the National Nutrition Strategy (NNS) and the finalization of the Implementation Plan |
| | Ensure linkage between sectors is explicit in the NNS Implementation Plan |
| | Ensure that nutrition is adequately reflected in the policies, strategies and plans and is focused on the most vulnerable groups |
| | Support districts in developing district specific plans for rolling out the implementation plan of the NNS Implementation Plan 2012-2016 |

| Strategic objective | Recommendations |
| --- | --- |
| **Capacity building** | Utilize the mapping exercise on human resources for nutrition to advocate for recruitment/re-categorization of nutrition officers |
| | Develop a harmonized in-service training package, linked with follow-up and post-training evaluation, tailored to specific service providers and in line with the agreed essential nutrition interventions |
| | Determine how to deliver in-service training to maximize participation and minimize the disruption of routine services |
| | Review pre-service sector curriculums and strengthen the nutrition component |
| **Advocacy and resource mobilization** | Ensure awareness of the main nutrition problems, its causes and consequences at all levels |
| | Utilize the Child Act to advocate for nutrition |
| | Raise the understanding at district level to broaden funding for nutrition activities at council level through different budget sources e.g. basket funds, block grants and councils own resources |
| | Advocate for ownership at district levels for improving the nutrition situation in their district and fundraising for nutrition |
| | Advocate for increased resources for nutrition within relevant sectors at national level for relevant policies, strategies and plans |
| | Encourage development partners, NGOs and private sector working in relevant sectors to advocate for action and commitment for nutrition |

| Strategic objective | Recommendations |
| --- | --- |
| **Research and M&E** | Strengthen systems for consolidating, compiling, disseminating and utilizing nutrition data from community level through districts and regions to national level |

| | |
| --- | --- |
| **Coordination and partnerships** | Districts to complete stakeholders' activities map as part of a situation analysis for nutrition |
| | Track the process of forming nutrition steering committees at district level, the appointment of nutrition focal persons and their effectiveness |
| | Clarify the horizontal and vertical linkages between coordination groups and rationalize the number of sub working groups |

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Nutrition Policy Mapping in Tanzania

Tanzania Food and Nutrition Centre strategic plan 2005/2006 – 2009/2010

# Annexes

## *Policy mapping*

| Policies | Objectives/ goal | Policy statement relevant to nutrition | Target groups | Responsible actors and partners | Does the policy address MCU and/or underlying causes? |
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| **Title: National Health Policy**<br>**Year: June 2007**<br>**Published by: MOHSW**<br>**Adopted by:** | To improve the health of all citizens especially the vulnerable ones by establishing health a service system that meets the people's needs and increase the life span of Tanzanians | Adequate intake of nutritious food is essential for the promotion and maintenance of p hysical and mental health. A good nutritional state will enable individuals and families to lead socially and economically productive lives. | All Tanzanians | MOHSW from national to district level, MAFSC, Community development gender and children affairs, Development partners, International and national NGOs, CBOs, FBOs, CSOs, | 1. Availability of adequate food in quantity and quality among vulnerable groups (children, pregnant and lactating women) must be promoted.<br>2. Proper infant and young children feeding (breast feeding and complementation) will be encouraged.<br>3. Diet related diseases should be detected or prevented and treated early |

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| **Title: Food and nutrition Policy**<br>**Year: 1992**<br>**Time frame:**<br>**Published by: MOHSW**<br>**Adopted by:** | To improve community nutrition by strengthening food security at household level | All 15 policy statements are relevant to nutrition | All Tanzanians especially the vulnerable including children and women of reproductive age, (pregnant and lactating) the sick, elderly, people living in boarding institution, overweight and obese people | MOHSW, Regional secretariat, Local Government Authorities, the community, private sector, civil society organizations, higher learning institutions, development partners | It has been mentioned under situational analysis and under nutrition development challenges (2) under policy statements (5) |
| **Title: Community Development Policy**<br>**Year: June 1996**<br>**Published by: MCDGC** | To enable Tanzanians as individuals or in their families and/or groups/associations to contribute more to the governments objectives of self reliance and therefore bring about development at all levels and finally the nation as whole | None | Women, children, youth, old people & people with disabilities. | Family/household, local government, central government, parastatal and other institutions, politicians, NGOs, development partners and various religious denominations | No |

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| **Title: Child Development Policy**<br>**Year: October 1996**<br>**Published by: MCDGC** | To promote child development and protect the rights and interests of children. | None | Children | Parents, guardians and community as a whole | The policy address issues of child survival, rights and protection of which nutrition is mentioned |
| **Title: National HIV& AIDS Policy (Draft)**<br>**Year: March 2011**<br>**Time frame: Aug 2008**<br>**Published by: PMO** | To ensure that the transmission of new infections is significantly minimized, those who are infected have access to high quality services and the impact of HIV and AIDs is mitigated | Support women, men, boys and girls living with HIV in need and those affected by HIV and AIDS to improve their livelihoods. | People living with HIV and AIDS | People living with HIV and AIDS, Public, Government,<br>NGOs, development partners and CBO, FBOs and Civil society organizations | No |

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| **Title: National Environmental Policy**<br>**Year: Dec. 1997**<br>**Published by: Vice Presidents Office** | Environmental Policy has no overall objective but a number of objectives. See text below. | None | All Tanzanians | Government institutions, NGOs, Local communities, Formal & informal organizations in society | No |
| **Title : National Livestock Policy**<br>**Year: Dec. 2006**<br>**Published by: Ministry of Livestock Development** | To develop a competitive and more efficient livestock industry that contributes to the improvement of the well being of the people whose principal occupation and livelihood is based on livestock | The policy states its contribution towards national food security through increased production, processing and marketing of livestock products to meet national nutritional requirements | Livestock farmers | Agricultural Sector Lead Ministries, Public sector, Private sector, Development partners. | No |
| **Title: National Population policy**<br>**Year: 2006**<br>**Published by: Ministry of Planning Economy and Empowerment (Ministry of Finance and Economic Affairs)** | To direct development of other policies, strategies and programmes that ensure<br>sustainable development of the people. | None | All the people of Tanzania with more attention to children, the youth, the elderly and people with disabilities and refugees, | All Government ministries, Institutions of Higher Learning, Mass Media, NGOs and Private Sector, Political Parties and Religious Institutions | No |

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| **Title: National Agriculture Policy (Draft)**<br><br>**Year: Aug 2011**<br><br>**Time frame:**<br><br>**Published by: Ministry of Agriculture Food Security and Cooperatives.**<br><br>**Adopted by:** | To develop an efficient, competitive and profitable agricultural industry that contributes to the improvement of the livelihoods of Tanzanians and attainment of broad based economic growth and poverty reduction. | 1.Production of food crops according to agro-ecological zones in order to meet national Food Self- Sufficiency and significant surplus for exports shall be promoted;<br><br>2.Food imports that are consistent with internationally acceptable safety and quality standards shall be regulated;<br><br>3.Production and utilization of crops with high nutrient content in areas experiencing nutritional problems shall be promoted;<br><br>4.Knowledge on good nutrition shall be promoted.<br><br>5.Mechanisms for continuous monitoring and assessment of food security and nutrition at all levels shall be strengthened; and<br><br>6.Measures to ensure food availability, accessibility and utilization shall be promoted. | All Tanzanians | Vice President's Office, Prime Ministers' Office, Agricultural Sector Lead Ministries, Regional secretariats', Local Government Authorities, Public Sector Institutions, Private Sector Institutions, CSOs, Academic and Research Institutions | No |

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| **Title: National Water Policy**<br><br>**Year: July 2002**<br><br>**Published by: Ministry of Water and Livestock Development** | To develop a comprehensive framework for sustainable development and management of the Nation's water resources, in which an effective legal and institutional framework for its implementation will be put in place | 1. Improvement of health through sanitation and hygiene education.<br>2. Use of water for human consumption shall receive first priority.<br>3. Water for food security, energy production and other economic activities is readily available.<br>4.A minimum water requirement is guaranteed to all humans to maintain human health, and sufficient water is guaranteed to restore and maintain the health, services and the functions of ecosystems | All Tanzanians Urban and Rural | Ministry of Water and irrigation, Ministry of Agriculture, Food Security and Cooperatives,<br><br>Ministry of Energy and Minerals,<br><br>Ministry of Health and Social Welfare, Ministry of Natural Resources and Tourism, District Councils, Private Sector, Legal and Regulatory Framework for Urban Water Sanitation and Sewerage, community. | No |

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| **Policy on Early Childhood Development, Tanzania (0 – 8yrs) (Draft)**<br><br>**Time frame: Feb 2010**<br><br>**Published by: Ministry of Community Development, Gender and Children.** | To create a conducive environment to enable all stakeholders from the different sectors to deliver the early childhood development services more collaboratively than it is at present; a comprehensive and reliable coordination, and an alternative in the opposite of most of all the above, which is integrated and multisectoral | The policy recognises that Infant and Young Child feeding is necessary for Early Child Development. The policy also recognise the need for integrated and multi-sectoral programmes aiming at holistic growth development of a child involving and including health, nutrition, security and early stimulation and learning. It is the role of government in collaboration with the community to ensure the accessibility of lunch services to school children. | Children (0 – 8) | PMO-RALG, MOHSW, MOEVT, MOCDGCA, Development Partners, NGOs, CBOs, FBOs, the community, parents/guardian and families. | Under Situational analysis of children in Tanzania, the policy addresses malnutrition and child deaths and the underlying causes which if addressed we can avert a number of these deaths. The policy also emphasise on good nutrition to avoid the risk of mental and intellectual under development |

## *Assessments highly relevant for the joint assessment*

| Assessment | Relevant objectives | Selected recommendations related to nutrition and food security |
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| **TFNC and UNICEF's Women and children in Tanzania, Volume 1 - Mainland** | The report provides in-depth analysis of the situation of children and women in six areas including ***nutrition***. It seeks to provide guidance on what needs to happen to provide an enabling environment in which children can thrive and their potential can be catalyzed for their own benefit and for Tanzania as a whole. It aims to drive evidenced-based advocacy and positive change for children and women in the country, and to serve as a reference tool for Government and non-state actors working towards development outcomes | **Technical:**<br>• ***Focus resources*** on evidence-based nutrition services that have the greatest impact on nutritional status and child survival.<br>• Prioritize nutrition interventions on the ***"1000 days"***<br>• ***Scale up the coverage*** of priority interventions<br>• Protect the nutrition of ***women during pregnancy***<br>• Explore how ***social protection*** interventions can be used as part of a set of interventions<br>• Utilize ***multiple communication channels*** with regard to infant and young child feeding and women's nutritional needs during pregnancy.<br><br>**Institutional:**<br>• Acknowledge the ***health sector's lead responsibility and accountability*** and put nutrition higher on the policy agenda<br>• ***Re-focus TFNC's mandate and strategic plan to: strengthen coordination, generate commitment, strategic direction and leadership, technical support for analytical work, and improve information management.***<br>• Give ***focal persons*** adequate technical guidance and support by relevant structures<br>• LGAs must ***prioritize nutrition activities*** in plans and budgets and health facilities must provide the full set of essential nutrition interventions.<br>• ***Technical supervision and support*** for the delivery of essential nutrition interventions<br>• Allocate adequate ***budgetary resources*** and assure the availability of adequate nutrition ***supplies and equipment***<br><br>**Policy:**<br>• Complete and ensure approval of ***National Food and Nutrition Policy*** and ensure that nutrition is firmly part of ***policies and strategies in all relevant sectors***.<br>• Urgently ***complete and enact legislation, regulations and standards*** needed to create a supportive environment of nutrition, including for the fortification of food. |

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| **Institutional Analysis of Nutrition in Tanzania, Valerie Leach and Blandina Kilama, 2009** | Provides a summary of the situation of nutrition in Tanzania, and an institutional analysis of the principal actors in nutrition nationally and locally.<br>It outlines institutional implications from the strategic plan, and seeks to inform priorities for nutrition work nationally.<br><br>The paper highlights the main areas of action to be taken forward by key actors in nutrition, however, more detailed assessments of specific institutional arrangements will be needed to ensure that the priorities of the strategic plan are fulfilled. | **Priority needs to be given to:**<br>• ***Pregnant and lactating*** women, especially young women and girls<br>• Promotion of and support for ***exclusive breastfeeding and extended breastfeeding***<br>• Deworming of children, rehydration for diarrhea, malaria alleviation, sustaining high rates of immunisation<br>• Work within national strategies – particularly ***MKUKUTA*** and its monitoring system – and in accordance with accepted roles and responsibilities for public service management – ***decentralisation***, JAST principles of national leadership, preference for financing through budget support, and provision of technical assistance according to national demand.<br><br>**TFNC:**<br>• ***Strengthen coordination*** of nutrition actors and interventions<br>• Increase focus on ***analytic work***<br>• Provide technical support for sound ***information systems and communication***<br>• Review ***strategic plan***<br>• Prioritise ***advocacy for nutrition***<br>• Established ***National Committee for nutrition*** in a central ministry, thereby providing priority for child nutrition in national planning and monitoring systems and for oversight of external support for nutrition<br><br>**MOHSW**<br>• Prioritise preventive health services for young children and training with emphasis on promoting effective ***communication skills***<br>• Ensure adequate ***supplies for micronutrient supplementation***<br>• Strengthen assessment, reporting and use of data about ***children's nutrition*** at the time of measles vaccination, as a priority within the ***health management information system***<br><br>**PMO-RALG**<br>• Implement the scheme to provide incentives for ***recruitment of essential staff*** in needy councils<br>• Review the formulae for ***financial allocations to assess the extent they address indicators of child malnutrition***<br><br>**LGA**<br>• Designate member of council staff as a ***nutrition focal point*** |

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| | | • Ensure ***nutrition priorities included in plans and budgets***<br>• Implement promotive and preventive health services for young children and direct outreach and community work to areas most in need<br>• Provide ***monitoring information*** to Ministry of Health, PMO-RALG, TFNC<br>• Train health staff in ***effective communication for early and exclusive breastfeeding*** and sound feeding practices for young children<br><br>**External partners**<br>• Provide ***financial and technical support***<br>**NGO**<br>• ***Support community work*** working with local authorities where support is needed especially with ***innovative nutrition programming***. |
| **District budget allocations for nutrition activities, A Review of Comprehensive Council Health Plans 2010/2011, HKI, March 2011** | The aim of the work was to assess the outcome of VASD advocacy work and set a baseline for scaling up district -led nutrition activities. Determine budget allocation and identify other nutrition related activities included and allocated with funds across CCHPs | • Tracking the ***actual costs of activities*** would help to provide more information on allocation sufficiency.<br>• There is a need for the ***districts to be empowered to follow up and monitor the actual cost*** for implementing VASD.<br>• In areas where costs per child remain high, specific support can be provided to districts where there are hard to reach areas/populations and the combination of efforts can be made to reach the most vulnerable with a number of live saving nutrition interventions. |
| **Strengthening Nutrition within the Ministry of Health and Social Welfare, Proposal for MoHSW Consideration**<br><br>**Charles E. Mambali, Subilaga E. Kazimoto,**<br>**Janneke H. Jorgensen, F. James Levinson, July 2011** | MoHSW has decided to scale up, strengthen and more actively support its nutrition activities in the country, and to do so in a highly participatory fashion actively involving stakeholders at all levels.<br>The paper proposes means by which the Ministry can move toward the achievement of these ends through the creation of a Nutrition Unit at the central level, and through the deployment of | **Responsibilities of the nutritionists within MoHSW structures**<br>• Strengthening and ***active monitoring and evaluation of MoHSW nutrition interventions*** in ways which assure active community participation and involvement.<br>• Systematic and periodic ***review of survey and program-based data***<br>• Training and active supervision<br>• Active ***collaboration with other departments and units in the MoHSW***<br>• Multisectoral collaboration with other nutrition-related programs<br><br>**TOR for the Nutrition Sub-section, MoHSW and recommended responsibilities**<br>• The Nutrition sub-section as a whole will have the responsibility of working in close collaboration with the ***relevant departments and units of the MoHSW*** presently involved in nutrition activity, and assuring the harmonization of their nutrition-related activities<br>• Drafting, revising and updating of ***MoHSW-related nutrition policies, strategies and regulations*** |

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|  | nutritionists to all regional secretariats and district councils.<br><br>It provides TOR for the central unit and suggested reporting responsibilities for this new nutrition cadre. It also addresses the vitally important role for TFNC and the necessity of resolving any potential overlap of responsibilities with a strengthened nutrition role in the MoHSW itself. | and integrating nutrition concerns into other ***health sector guidelines***<br>• Develop ***technical guidelines*** relevant for regional, district and community level<br>• Support the ***regional and district nutritionists*** together with TFNC<br>• Assure that nutrition is adequately covered in the guidelines for the Comprehensive Council Health Plans<br>• Review delivery of ***Essential Nutrition Actions*** at the facility level<br>• Working closely with TFNC and HMIS, ***refine M&E systems*** for MoHSW nutrition-related programs<br>• Recommend a structure for MoHSW annual reports on nutrition<br>• Identify program-driven research priorities<br>• Actively represent the MoHSW in ***multisectoral nutrition coordination*** efforts and meetings<br>• Work closely with international, bilateral and NGO partners involved in nutrition-related activities<br><br>**Recommended Reporting Structure**<br>District nutritionists will be responsible to the District Executive Director (DED), but provide regular reports to the Regional Medical Officer through the District Medical Officer. Technical nutrition reports will be sent to Regional Nutrition Officers. Regional Nutrition Officers will report to the Regional Administrative Secretary (RAS) through the Regional Medical Officer. Technical nutrition reports will be sent to the central Nutrition Sub-section.<br><br>**Resolving Potential Overlap with TFNC**<br>It is suggested that ***discussions be held among senior management*** of the MoHSW to resolve the issues and assign clear responsibilities to TFNC versus the Nutrition Sub-section. |
| **Nutrition at a GLANCE, World Bank** | Brief overview including costs | • ***Increase nutrition capacity within the Ministries of Health and Agriculture***.<br>• ***Improve infant and young child feeding*** through effective education and counseling services.<br>• Take actions to ***reduce anemia through increased deworming*** of young children, and ***iron-folic acid supplementation*** for pregnant women.<br>• Improve dietary diversity through ***promoting home production of a diversity of foods***, and market and infrastructure development.<br>• Achieve universal salt ***iodization, and enrichment of oil and staple foods*** with key micronutrients. |

| Component III: Causes of Malnutrition and Tanzania's nutrition programs past and present, | | **Overview on current programs as well as plans for the future** |
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| **Thoughts for food, an evaluation of the Tanzania Food and Nutrition Centre, SIDA, 1992** | To review the work of TFNC and progress of previous recommendations. Assess relevance of TFNC, ability to influence national policy and appropriateness of its nutritional priorities by program and departmental review. | • Strengthen the Nutrition Education and Training Department<br>• Advocate for the use of the National Food and Nutrition Policy and the conceptional framework – ensure in-house training of the framework<br>• Place more emphasis on PEM as the most important nutritional problem of the country<br>• MoH to appoint a Senior Medical Officer responsible for nutrition<br>• Strengthen the communication and education of the public<br>• Establish a research priority committee<br>• Strengthen and scale of IDD, VAD, anaemia and Infant feeding programs |
| **Capacity Assessment of Mid-Level Human Resource Personnel Working in Nutrition in Tanzania, August 2011, TFNC and HKI et al** | • Numbers and types of mid-level personnel working in nutrition at the district and facility level and describe their distribution<br>• Nutrition worker's current knowledge, training and skills to implement a minimum set of direct nutrition actions and what they are actually 'doing' towards those actions in the field;<br>• Develop an understanding of the basic and additional skills needed<br>• Examine what systems are needed to support the performance of the nutrition workforce and develop a better understanding of the health system barriers that personnel face in scaling up nutrition actions; and | **Workforce Planning and Leadership**<br>• The HR department in the MOHSW should ***fast-track the recruitment of district nutritionists***, ensuring that a candidate with the right training is put in place at the district level.<br>• Consider using mechanisms like the Global Fund to fund nutrition positions at district and regional levels given the shortage of nutritionists.<br>• Provide greater autonomy to local government authorities to ***provide incentives and other motivation to health and agriculture staff*** to reward good performance and increase retention in remote areas.<br>• Sensitize and urge ***District Councils and DED's to submit requests for a district nutritionist*** to the central level.<br>• ***Shift nutrition roles and responsibilities to a focal person at the district level*** to serve as a "stop-gap" measure to address shortages until all districts are equipped with adequate nutrition personnel<br><br>**Workforce Competencies and Training**<br>• Ensure that ***nutrition modules in current curricula promote practice- and problem-based learning***.<br>• ***Sensitive and orient district leaders*** (DMOs, DEDs and DALDOs) on the new global evidence for nutrition and key effective interventions to help in planning and budgeting for nutrition activities.<br>• ***Required competencies for mid-level workers and nutritionists should be outlined***, aligned with national policies and international recommendations for nutrition, and ***appropriate on the job-training package designed***. |

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| | • Explore the perceptions of key stakeholders on the technical knowledge, competencies and skills that the newly created cadre of nutrition officers at the district levels will require to effectively plan, manage and implement nutrition actions, and a framework for the training they should receive. | **Workforce Supporting Factors**<br>• ***Guidelines on which type of nutrition activities can be incorporated in the CCHP at the district should be issued.***<br>• ***Specific nutrition roles, functions, and responsibilities should be outlined in health and agriculture job descriptions.***<br>• Efforts should be made to ***match individual health and agriculture worker's skills with their tasks***.<br>• ***Nutrition teaching aids, information, and other materials should be available to health and agriculture workers*** to motivate them and improve their performance.<br>• ***Supportive supervision***, that includes audit and feedback to improve nutrition planning and performance at health facilities, to health workers should be provided.<br>• ***Performance-related pay and other incentives*** should be introduced at the local government level to improve performance of district nutritionist as well as health and agriculture extension workers. |
| **Studies on income growth, cost-benefit analysis':**<br>*Reducing Child Malnutrition in Tanzania*<br>*Combined Effects of Income Growth and Program Interventions*<br>*Harold Alderman*<br><br>*Long term benefits from childhood nutrition interventions in Tanzania, UNICEF, Maria Cristina Rossi*<br><br>*Escaping poverty in Tanzania: What can we learn from cases of success? Kate Higgins*<br><br>*THE BENEFITS OF MALNUTRITION INTERVENTIONS:* | Selected summarized recommendations and results | • Analysis of reasons for improved well-being reveals that ***agriculture, non-farm business, salaried employment, trading and agricultural inputs and implements*** are the most powerful drivers of upward mobility<br><br>• Parental education and access to health care matter<br>• Stunting is a cumulative process - ensure adequate nutrition from very early childhood onward.<br>• Both income growth and the presence of nutrition programs in the community contribute positively and significantly to the reduction of malnutrition - ***only the combination of income growth at the household level with large scale nutrition interventions is shown to be sufficient to attain the MDG benchmark for nutrition***<br>Nutrition programmes are significantly successful in enhancing health and nutritional status of children by improving current height. An additional programme intervention would thus improve children's health, and this improvement will persist over time, previously taller kids being taller than their siblings ten years later. The effect of programme intervention would thus be the cumulative result of a direct effect and an indirect effect through past (standardised) height.<br><br>The empirical evidences reviewed indicate that on balance, income growth both at the household and at the national level contributes significantly to reduction in malnutrition.<br>The evidences further indicate that reducing malnutrition contributes to economic growth and that such contribution can be substantial. |

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| *EMPIRICAL EVIDENCE AND LESSONS TO TANZANIA, Adolf F. Mkenda Department of Economics University of Dar es Salaam* | | Nutrition is linked to several other welfare outcomes, such as reduced morbidity and mortality, and increasing education attainment. As such, reducing malnutrition is both an implicit and explicit aim of poverty reduction. |

*Stakeholder meeting, 6$^{th}$ March 2012*

World Health
Organization

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