

# NUTRITION GOVERNANCE IN TANZANIA

## LESSONS LEARNT FROM IMPLEMENTING THE NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (NMNAP)



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## SUMMARY

In 2016, Tanzania put in place a nutrition action plan that would seek to go beyond previous action plans and strategies. The Prime Minister's Office took the lead in developing a nutrition action plan that not only had ambitious goals and targets but also explicitly called on other sectors to join the country's fight against malnutrition. Today, the National Multisectoral Nutrition Action Plan (NMNAP) provides Tanzania with a strong system for multisectoral nutrition governance at all levels. NMNAP has successfully helped to make nutrition a priority in the country, even within other government departments. The government's financial commitment to nutrition has increased over time as the result of continued advocacy; nutrition officers are in place at regional and district levels, and NMNAP impact targets are being gradually reached. Accountability for achieving nutrition goals has been strengthened due to the establishment of a National Nutrition Compact between the central government and the regions, and sufficient data is now generated to monitor and evaluate the performance of the NMNAP. As a result, multisectoral coordination and cohesive alignment with national priorities has improved at all levels. Continued engagement of partners from non-nutrition sectors will help strengthen NMNAP implementation to achieve better impact. Operationally, the fact that nutrition-related activities are now under one umbrella has made for more cohesion in planning and implementation. Challenges remain, such as limited human resources capacity to make a broad policy operational at the local level; devising a new way of working across sectors; and the urgent need to increase coverage of both nutrition-specific and -sensitive interventions. However, several key messages from Tanzania's experience are applicable to other countries or regions struggling with similar issues.

### KEY MESSAGES

- The 2016-2021 NMNAP, Tanzania's first plan of its kind to address the country's high levels of malnutrition, aims to accelerate the scaling up of nutrition-specific and nutrition-sensitive interventions throughout the country.
- NMNAP specifically indicates the role each sector should play to contribute to improving nutrition outcomes, identifying specific actions for each sector.
- The NMNAP is monitored using a clear framework, including specific metrics, and assessed via scorecards and periodic reviews, and regular bottleneck analyses.
- The NMNAP has brought about many successes: increased prioritisation of nutrition, a gradual increase in investment of human and financial resources for nutrition, and greater accountability for achieving nutrition goals. A substantial number of NMNAP impact targets were met at mid-term.
- NMNAP challenges include low coverage of key nutrition-specific and -sensitive interventions, and an insufficient budget for nutrition.

## BACKGROUND AND OBJECTIVE

Tanzania faces a double burden of malnutrition: one-third of children under five years of age are stunted,<sup>1</sup> one third of women (aged 15-49 years) are overweight or obese, and one-third of women are anaemic (1, 2). Every year, micronutrient deficiencies cost Tanzania over USD 518 million (2.65% of the country's GDP) and contribute to over 27,000 infant and 1,600 maternal deaths (3). The prevalence of stunting in children under five has gradually been reduced from 50% in 1996 to 42% in 2010, 34% in 2015/16, and 32% in 2018 (4). While this, alongside similar declines in the prevalence of underweight and wasting in children below five, represents a huge improvement, the prevalence of stunting in Tanzania remains above the average seen in many neighbouring countries (2). Moreover, while Tanzania's efforts to address malnutrition are noteworthy, they still fall short of the World Health Assembly Global nutrition targets for 2025 (5).

The coexistence of child undernutrition alongside adult overweight and obesity is linked to dietary practices (including infant feeding), a lack of affordable nutritious foods, and lifestyle shifts characterised by little time for food preparation, among other factors (6). These diverse socio-economic, environmental, and cultural factors have led to a two-fold increase in diet-related non-communicable diseases (e.g., hypertension, type 2 diabetes) over the last 10 years (6).

This working paper is a case study that provides insight into how multi-level nutrition governance and urban governance for nutrition<sup>2</sup> are implemented in practice in one district of Dar es Salaam. The paper examines how Tanzania has decentralised its nutrition policy through the National Multisectoral Nutrition Action Plan (NMNAP) 2016-2021 by creating mandates and supporting implementation at national, regional, district, and community levels. The paper describes what characterised nutrition governance before the implementation of NMNAP and what has changed since then as well as the mechanisms used to implement NMNAP at multiple levels of government. Finally, the paper discusses the various factors that have either enabled or posed challenges to implementation.

## METHODOLOGY

This paper is structured around a qualitative case study of the NMNAP. It was developed based on information collected from English-language interviews conducted remotely using Skype, WhatsApp, or Zoom as well as follow-up email correspondence. Respondents were proposed by the GAIN Senior Project Manager, Urban Governance for Nutrition, Tanzania based on their knowledge of the NMNAP and of the informants who were likely to be the most relevant for the case study. A total of five interviews was carried out between September 2019 and January 2020 with NMNAP key informants from the Dar es Salaam region and the Ilala Municipality as well as the GAIN Senior Project Manager, Urban Governance for Nutrition, Tanzania. Interviews were undertaken using a semi-structured interview tool with variations in questions depending on the role and responsibilities of the

<sup>1</sup> According to the World Health Organization (WHO), children are considered stunted if their height-for-age is more than two standard deviations below the WHO Child Growth Standards median. Stunting is a well-established marker of poor child development, predicting poorer cognitive and educational outcomes in later childhood and adolescence (1).

<sup>2</sup> GAIN's Urban Governance for Nutrition programme defines urban governance for nutrition as 'the process of making and implementing decisions that shape food systems to deliver better nutrition for people in cities' (7).

person interviewed. Detailed notes were taken by the interviewer during the interview, and email follow-up with each interviewee was used to obtain clarifications and pose additional questions after the initial interview.

As background for the case study, a limited review of the relevant English-language scientific and non-scientific literature (e.g., project reports, presentations, legislation, websites) was carried out using a combination of search terms such as 'nutrition,' 'nutrition governance,' 'Tanzania,' 'action plan,' 'governance,' 'multisectoral,' and 'impact.' This was done using internet search engines as well as databases such as PubMed, PLOS, and ResearchGate. Approximately 35 peer-reviewed papers, project reports, and presentations were reviewed and used as sources of information for the case study. All information collected from interviews, the literature review, and web searches was then collated and inserted into a standardised template capturing information on the initiative, such as background context; triggers for the initiative; the programme's aims and objectives; stakeholders involved; local government buy-in; funding; enabling factors; challenges; food environment impact; current state; next steps; key messages; and recommendations.

The methods used have certain limitations in terms of the breadth and depth of the case study, since in-person interviews were not undertaken. Nonetheless, the case study is able to suggest lessons learned from the NMNAP process, which should be helpful to other countries and regions trying to put in place similar initiatives.

## THE NATIONAL MULTISECTORAL NUTRITION ACTION PLAN (NMNAP)

### HISTORY OF NUTRITION POLICY IN TANZANIA

Tanzania has a long history of working to improve nutrition. This began at its independence in 1961, and efforts were increased after the Arusha Declaration of 1967, which articulated the ideological and developmental vision for the country and informed the country's initial five-year development plans (8). In 1973, to demonstrate commitment for nutrition, the government established the Tanzania Food and Nutrition Centre (TFNC) to coordinate nutrition activities in the country (9). Working through the Ministry of Health, Social Development, Gender, Elderly, and Children, the Food and Nutrition Centre became the technical nutrition arm of the government, spearheading the national response to nutrition issues and tasked with ensuring a coordinated, effective, and efficient approach to tackling malnutrition. In the period from 1973 to 1992, the government developed several nutrition-relevant guidelines, standards, and acts. However, there was no specific nutrition policy until 1992, when a Food and Nutrition Policy was adopted (9, 10).

The first National Nutrition Strategy (NNS), for 2011-2016 (11), was developed with the aim of sharpening the focus on malnutrition and creating momentum for improving nutritional status, especially of vulnerable groups. The NNS was the result of a participatory process involving a set of nutrition stakeholders that were able to take nutrition-specific and -sensitive actions<sup>3</sup> at various levels of government. The Strategy emphasised that improved nutrition

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<sup>3</sup> According to Ruel and Alderman (12) nutrition-specific interventions or programmes address the immediate determinants of foetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases. Nutrition-sensitive interventions and programmes address the underlying determinants of

can be achieved through implementation of sound policies and programmes *and* through enhancing partnerships amongst nutrition stakeholders. Implementation principles of the NNS include community participation, integrated delivery of services, universal coverage, appropriate technology, intersectoral collaboration, and working in partnership. The process of developing the NNS also contributed to renewed commitment among the relevant partners to address critical barriers to improving the nutritional status of the population.

## DEVELOPMENT OF NMNAP

The 2016-2021 NMNAP was developed to operationalise the National Nutrition Strategy (NNS) 2011-2016 and was the first plan of its kind to address the country's high levels of malnutrition (6, 11). Prior to the NNS nutrition was embedded in other policies, whereas the NMNAP focused on improved nutrition as its main goal. The NMNAP was deemed necessary since the period for the National Nutrition Strategy (2011 –2016) had ended and was under revision. The NMNAP is anchored within the Tanzanian Government's Five-Year Development Plan II (FYDP II) 2016-2021, which explicitly focuses on nurturing an industrial economy and supporting human development (13). The NMNAP is also informed by and integrates elements of the regional<sup>4</sup> and global<sup>5</sup> nutrition-relevant development agendas.

The NMNAP aims to accelerate the scaling up of nutrition-specific and nutrition-sensitive interventions throughout the country. It also seeks to foster enabling environments for the improvement of nutritional status. As an action plan it sets goals, defines key strategies, states activities, and provides the costs to reach expected results. It is meant to guide the implementation of nutrition activities by Local government Authorities<sup>6</sup> (LGAs), Regional Secretaries, and Ministry Departments and Agencies.

NMNAP's novelty lies in the fact that it specifically indicates the role each sector should play to contribute to improving nutrition outcomes. NMNAP seeks to influence policies in six sectors that can have an impact on nutrition: agriculture, livestock, and fisheries; health and HIV; water, sanitation, and hygiene; education; social protection; and environment. NMNAP identified specific actions for these sectors, only some of these sectors were already implementing nutrition-sensitive activities. Non-nutrition sector stakeholders are key to the action plan's success, since they can have an impact on the underlying causes of malnutrition and have the capacity to strengthen enabling environment interventions (6). Within the NMNAP budget, 32% of funding is allocated to nutrition-specific interventions and 68% to nutrition-sensitive interventions.

While NMNAP considers the entire population, its primary focus is on children under five, adolescent girls (15-19 years), pregnant and lactating women, and women of reproductive

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foetal and child nutrition and development— food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment—and incorporate specific nutrition goals and actions (12).

<sup>4</sup> Including the East African Food and Nutrition Policy, the Southern Africa Development Community (SADC) Food and Nutrition Security, and the African Union (AU) Food and Nutrition Strategy (2015-2025) (6).

<sup>5</sup> The Agenda 2030 on Sustainable Development Goals (SDGs); the World Health Assembly Global Nutrition Targets 2025; the UN Network for Scaling Up Nutrition (SUN) Strategy (2016-2020); the UN Decade (2016-2025) of Action on Nutrition; the second International Conference on Nutrition (ICN2) Plan of Action; the 2011 UN Political Declaration on HIV/AIDS; the 2014 UN Outcome Document on Non-Communicable Diseases (NCDs); and the global voluntary NCDs targets for 2025 (6).

<sup>6</sup> LGAs represent the regional and district levels and other lower government levels, such as wards, villages, and streets (14).

age (15-49 years). The Plan seeks to reduce the prevalence of stunting, wasting, and vitamin A deficiency (children 6-59 months); low birthweight; anaemia among women of reproductive age (age 15-49); urinary iodine in women of reproductive age (15-49 years); and prevalence of diabetes, overweight, and obesity in children 0-59 months as well as in adults (see Annex for NMNAP Key impact and outcome targets by 2020/21) (6). NMNAP has seven Key Result Areas – four are nutrition-specific, one is nutrition-sensitive, and two focus on the creation of enabling environments (2).

The target audience for the NMNAP is policymakers (and their technical staff) at all levels of Tanzania's government (national and sub-national), who are involved in the design of policies for, and allocate resources towards, improving the health and wellbeing of the population. The NMNAP can also be used by donors to provide indications of where support is needed, thus guiding development of their country strategies and investments (6).

The NMNAP has support from the highest levels of Tanzania's government. It is led by the Prime Minister's Office, which coordinates the overall NMNAP and provides oversight to ensure that nutrition is a key government priority. The Prime Minister's Office also chairs a Multisectoral High-Level Steering Committee for Nutrition. The Tanzania Food and Nutrition Centre is the institutional base for the multisectoral nutrition information system for tracking and reporting on NMNAP progress (6). The Food and Nutrition Centre also provides strategic leadership and strengthens multisector coordination and collaboration; advocates for resources for nutrition; promotes harmonisation and alignment of sector financing; and provides guidance, training and technical support on nutrition to implementing agencies. The NMNAP also carried out extensive stakeholder consultations and scientific evidence reviews as part of its development.

## **NMNAP GOVERNANCE: FROM THE PRIME MINISTER'S OFFICE TO THE COMMUNITY LEVEL**

The governance mechanism for nutrition in Tanzania has been improving considerably since the NMNAP was adopted. First, NMNAP's decentralised and interactive structure has made it possible to extend policies and initiatives to the community level (see Fig. 1); previously, these stopped at the district (council) level (to which the Prime Minister's Office was directly linked). Second, before the NMNAP, the ministry in charge of the Regional Administration and Local Government (PO-RALG) was unclear on its role in terms of ensuring local ownership and local government capacity to deliver nutrition services. Now, power is delegated to ministries, departments, and agencies as well as to PO-RALG, encouraging local ownership and local government capacity to deliver nutrition services and interventions. This also makes it possible for PO-RALG to provide the High-Level Steering Committee for Nutrition with input from the Regional and Council Steering Committees on Nutrition (15, 16).

Third, the earlier system supporting interaction amongst LGAs, civil society organisations (CSOs), and the private sector was rather inefficient. This has improved with the NMNAP, and LGAs, CSOs, and the private sector now interact with one another and with the local

communities (15, 16). In addition, the Technical Committee on Agriculture consultative group and the Thematic Working Groups on Food Security and Nutrition previously seemed to have a one-way interaction (from lower to higher levels in their internal hierarchies), and it was unclear how they interacted with the rest of the governance structure. They are now integrated into the governance structure, with links between NMNAP's thematic working groups, development partners, and the Multisectoral Nutrition Technical Working Group (15, 16). Finally, to garner outside support, NMNAP has put in place a Development Partners Group on Nutrition, which includes membership from the UN, donors, CSOs, and the private sector (6).

To encourage local ownership and build the capacity of local governments to deliver nutrition services, nutrition interventions have been decentralised through Regional Administration and Local Government (PO-RALG). Under PO-RALG, Regional and Council Nutrition Steering Committees (RMSCN and CMSCN, established in 2011 by a directive from the Prime Minister's Office), nutrition officers, and annual planning and budgeting cycles provide the administrative basis for the implementation of the NMNAP and service delivery at the community level (Figure 1). This decentralisation means that each region, district, and ward<sup>7</sup> puts in place nutrition interventions that are appropriate for its population's specific needs (see Annex A1 for local level NMNAP governance mechanisms). PO-RALG ensures NMNAP implementation at sub-national levels through the Decentralisation and Devolution (D&D) approach (Box 1) and a signed Nutrition Compact agreement (Box 2) (17).

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<sup>7</sup> Tanzania is divided into 31 regions, each of which is subdivided into districts. 'Council' is the same as district or municipality, which is followed by Divisions and then local Wards. A Ward (Kata) is an administrative structure for a single town or portion of a bigger town (Urban Wards). Urban wards are divided into streets and rural wards consist of several villages.

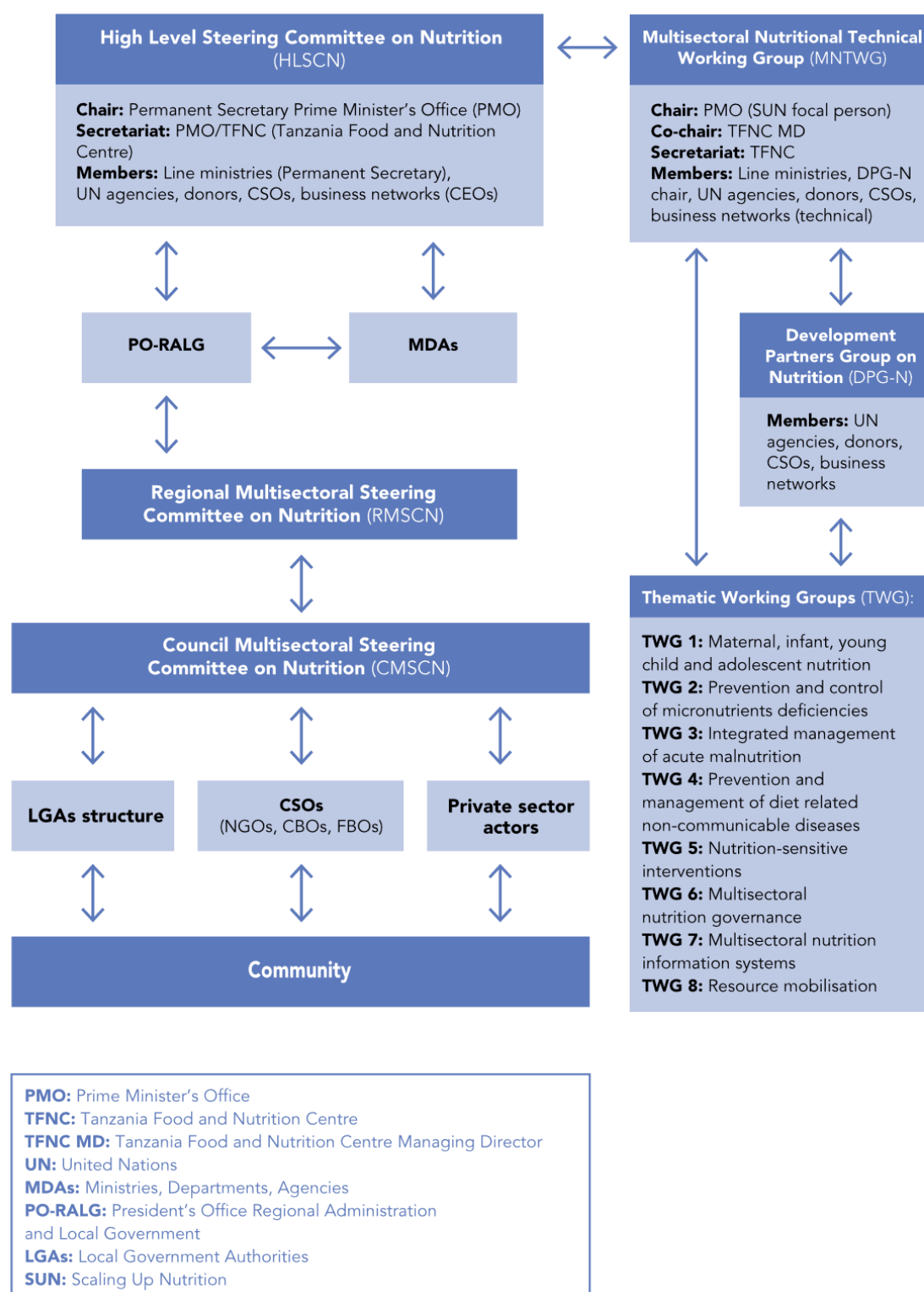


Figure 1. Governance structure for nutrition under the National Multi-sectoral Nutrition Action Plan (NMNAP). Modified from (6)

The Regional and Council Nutrition Steering Committees meet quarterly, and as of 2018, all regions and districts have established Steering Committees. The Steering Committee Terms of Reference outline the main mechanism linking the Multisectoral High-Level Steering Committee for Nutrition to the Regional and Council Nutrition Steering Committees and are

key to operationalising NMNAP at the subnational level (17) (see Annex A1 for local level NMNAP governance mechanisms).

#### BOX 1. THE DECENTRALISATION AND DEVOLUTION (D&D) APPROACH FACILITATES LINKS WITH COMMUNITIES

The D&D approach pays particular attention to the participation of communities and community-based organisations to support social accountability. This means that citizens and/or CSOs participate directly or indirectly in enacting accountability by reminding state and other stakeholders, including the private sector, of the need to meet their obligations to provide quality services. An example of the D&D approach is the 'Nutrition Scorecard' that is produced quarterly at the council level and looks at 11 impact indicators by region and topic (e.g., maternal, infant and young child, and adolescent nutrition; prevention and management of micronutrient deficiencies) and gives a score indicating whether the region is on track, progressing, or not on track. Communities can also participate in the implementation of the NMNAP through a number of activities such as community or village days, which include demonstrations to raise awareness on nutrition (e.g., showing the value of vegetable gardens, how to prepare nutritious foods, and appropriate child feeding practices) (15).

#### BOX 2. THE NUTRITION COMPACT: ACCOUNTABILITY FOR NUTRITION AT REGIONAL AND COUNCIL LEVEL

The Nutrition Compact is a signed agreement between the PO-RALG minister and all regional commissioners to oversee nutrition activities in their respective areas. The compact clearly indicates the roles of regions and councils with regards to achievement of nutrition indicators, such as minimum resource allocation per child for nutrition, recruitment of nutrition officers, multi-sectoral nutrition scorecards, regional and council multisectoral steering committees, nutrition-sensitive interventions across sectors, and regions' strategic plans for nutrition. Through the Compact, which was signed in December 2017, regions are held to account for achievement of nutrition results (stipulated in the NMNAP's Common Results and Accountability Framework (CRAAF)) at regional and district levels.

Progress on the Compact is evaluated twice a year, at which point each region is required to present on the locally relevant set of nutrition indicators. These meetings bring together decision-makers from all 26 regions of mainland Tanzania to share status reports. This process aims to help ensure that resources allocated to councils for nutrition are efficiently and effectively used to accelerate the reduction of malnutrition in their areas of jurisdiction. The Compact will run through 2021, as per the NMNAP timeline (17).

## NMNAP GOVERNANCE IN PRACTICE: THE CASE OF ILALA DISTRICT, DAR ES SALAAM

The functioning of the NMNAP governance mechanism can be illustrated using the case of Ilala District, one of the five districts of Dar es Salaam Region. The District is divided into three divisions and each division into wards (a total of 26). Ilala District is comparable to the rest of Tanzania in that it faces a double burden of malnutrition, including both adult overweight/obesity and child stunting. Data from 2010 show that the prevalence of overweight/obese was higher amongst urban dwellers, women, and those over age 45 years. Furthermore, almost half of women and over half of people above age 54 had type 2 diabetes (18). A large contributor to obesity is high consumption of energy-dense foods; in Tanzania, this includes refined maize flour, potatoes, vegetable oil, and coconut milk, which are consumed most days of the week (19).

In Ilala, the NMNAP is implemented by the CMSCN, overseen by the RMSCN, and works in coordination with the Municipal Council Management Team (MCMT) (Figure 2). The heads of MCMT departments that work on multisectoral nutrition issues are also members of the CMNSC. The CMSCN meets quarterly to discuss and evaluate nutrition issues and the measurement of nutrition indicators in each sector,<sup>8</sup> playing an important role in ensuring accountability, resource mobilisation, and adherence to the planned nutrition budget. The MCMT also makes sure that the nutrition budget is used for its purpose (15), with meetings on a regular basis to discuss various progress reports (20).

The Health Department of the Municipal Council is key to coordinating the implementation of all nutrition-related activities in Ilala. Each Municipal Department prepares a plan and budget, which are submitted to the District Medical Officer (also a member of the MCMT) for clearance. The most active municipal departments engaged in joint nutrition-related activities in Ilala are the Health, Water, Agriculture, Livestock, and Fisheries, and Community and Education Departments.

Both nutrition-specific and -sensitive interventions are implemented based on consideration of the sectoral problems that lead to community nutrition challenges, such as food insecurity, infectious diseases, and unsafe water. NMNAP implementation in Ilala benefits from the support of the government and stakeholders. For example, GAIN has helped municipal leaders prioritise NMNAP implementation by helping ensure that proper planning and budgeting for nutrition are in place (20).

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<sup>8</sup> This includes a discussion on expected results, such as the amount of council budget allocated to and spent on nutrition activities, coverage of nutrition-specific and -sensitive interventions in the community, and how other sectors work on nutrition in the community.

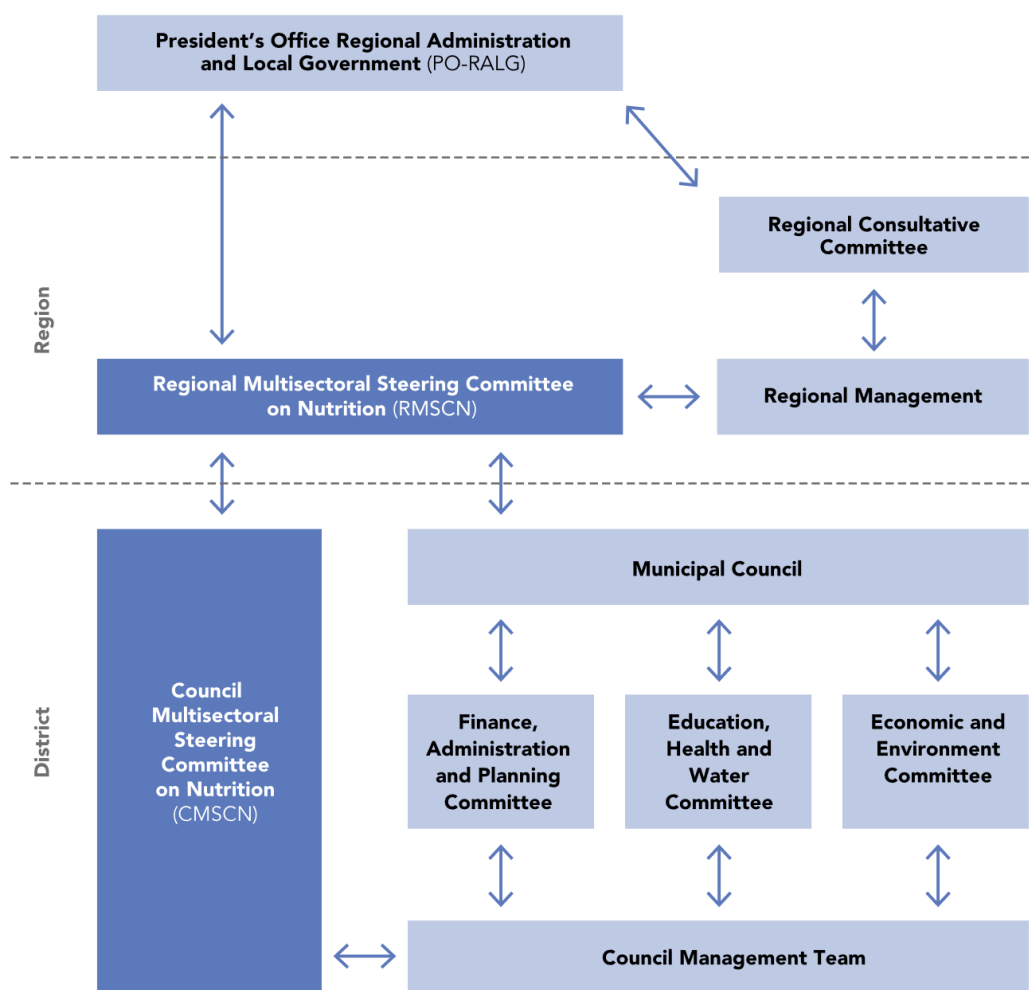


Figure 2. Organisational Chart for the Ilala Council Multisectoral Steering Committee on Nutrition. Modified from (17)

### FUNDING OF NMNAP

Despite these successes, the NMNAP faces some challenges with funding. As per the NMNAP plan for the entire NMNAP period (2016-2021), 30% of the budget was to be mobilised by the government, 60% by external donors, and 10% by the private sector. In reality, the government has only managed to mobilise 3% of the budget, and nutrition interventions remain heavily dependent on donor funding, of which only 50% of the planned budget is available. At the council level, budget execution is still a challenge, with only 7% of councils putting in place the minimum budget allocation for nutrition. Minimum budget allocations have not been increased as planned to reach the recommended \$8 USD per child per year by 2025. Overall expenditure on nutrition-specific interventions by the government is very low, at about TZS 3 billion (approximately \$1.29 million USD per year). Compared to other sectors, nutrition receives less government investment and depends more on development partners' support (2).

## MONITORING OF NMNAP

Progress implementing the NMNAP is measured at national level, with input from the regional and council levels. A 2019 mid-term report provided information on the present status and the midterm review of the NMNAP, which was conducted in the third year of implementation (2018/19) (2). The mid-term review aimed to: assess progress towards planned results; identify drivers of high or low achievement; propose and justify changes in activities, budget, and strategies; and outline some key elements that should be considered in the next NMNAP (2021-2025).

A Common Results, Resources, and Accountability Framework (CRRF) is the NMNAP monitoring and evaluation tool. It is used to monitor annual NMNAP implementation, considering the targets and outputs met and financial commitments made. The NMNAP has developed concrete metrics in order to determine progress and overall programme performance. These include one impact<sup>9</sup> or desired change, seven outcomes or conditions (one outcome for each key result area), and 26 outputs or contributions to change (6). Monitoring and evaluation milestones will be assessed through Annual Joint Multisectoral Nutrition Reviews, the multisectoral Nutrition Scorecard (Box 1), a mid-term review of the NMNAP, and an endline evaluation of the NMNAP based on the results of the 2020/21 Tanzania Demographic and Health Survey (6).

In addition, bottleneck analysis is conducted for selected nutrition-specific interventions every six months to identify points in the flow of planned interventions that need to be adjusted to allow for maximum impact. For each intervention, several relevant indicators are included to measure performance, and barriers to full implementation are identified. Through this process, councils can identify problem areas within the implementation of the selected interventions and propose actions to rectify them, through evidence-based planning and budgeting for nutrition (6).

## RESULTS AND IMPACTS OF THE NMNAP

Since its establishment in 2016, the NMNAP has helped further efforts to improve the nutritional status of Tanzanians. Specifically, The NMNAP brought about increased prioritisation of nutrition. Prior to NMNAP, nutrition was embedded within other programmes, ministries, and sectors (e.g., health). There was no nutrition officer at either regional or district level. Although not all interventions are fully funded to date, the NMNAP has created budgetary placeholders for nutrition, which have become a political priority. Nutrition officers are appointed at the district level, and planning and budget allocation are facilitated (2). The presence of an active CNMSC has made it possible to ensure that nutrition remains on the political and operational agenda.

In addition, the NMNAP has led to a gradual increase in investment of human resources for nutrition. At mid-term, 53% of councils had already employed full-time professional nutrition officers, who had been trained and oriented in planning, budgeting, monitoring, and reporting of nutrition programmes (2). Furthermore, the government has established a cadre of Community Health Workers (CHWs) to deliver a comprehensive package of health services

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<sup>9</sup> NMNAP applies the 'Three Ones' principle: one plan, one coordinating mechanism, and one monitoring and evaluation framework.

to the community. Two full-time CHWs are deployed per village and linked to a nearby dispensary or health centre. Partners are working to support the government in recruitment of CHWs (22). The NMNAP has also increased the government's financial commitment to nutrition as the result of continued advocacy, despite it not meeting planned targets. This is reflected by an increase in the annual budget for nutrition of TZS 4 billion in the 2017/18 period. Most noteworthy is the inclusion of a nutrition cost centre to ensure financial tracking, accountability, and transparency at regional and local levels (22).

The NMNAP has also created accountability for nutrition. Various mechanisms at national and subnational levels have been established and strengthened to ensure the operationalisation and enforcement of legislation. The development of the Nutrition Compact agreement has been a major achievement, as it holds regional commissioners accountable for achievement of the nutrition results stipulated in the NMNAP and its monitoring framework, as well as for execution of the minimum budget allocations for nutrition in each council of mainland Tanzania (22). Indicators now track fund allocation against expenditure, and seven key result areas are monitored under NMNAP implementation. Quarterly Nutrition Steering Committees meet to develop and agree on plans of action and assess their progress. Each region has a regional nutrition strategic plan that lists the expected actions to be taken within a given three-year period. These structures have made it easier to track the progress of MNMAP implementation at the regional and district levels.

Finally, there is improved multisectoral coordination and cohesive alignment with national priorities at all levels of government. The NMNAP has made progress by bringing together national and subnational stakeholders to jointly plan, review, and evaluate priority actions aimed to scale-up nutrition interventions. A High-Level Steering Committee on Nutrition convened the fourth Joint Multisectoral Nutrition Review to assess implementation of the first year of the NMNAP. The percentage of councils holding quarterly meetings of multisectoral steering committees on nutrition has increased from 10% to 85% from 2015/16 to 2018/19 (2). NMNAP has also made it possible for all council plans to be in line with the NMNAP outcomes and outputs, thus facilitating monitoring and evaluation (22).

These positive actions and outcomes have helped to create the nutrition impact. A substantial number of NMNAP impact targets were met at midterm (2). Four indicators achieved or surpassed the midterm target, one was delayed, and four others were not assessed at midterm (Table 1). The midterm review, however, also showed that Tanzania still faces significant challenges in addressing the double burden of malnutrition. Stunting among children under five years of age has fallen but not enough to meet the World Health Assembly (WHA) 2025 targets. Anaemia among women of reproductive age is on track for meeting WHA 2025 targets, as is the prevalence of overweight/obesity among children under five years of age. Overweight and obesity among women of reproductive age, however, has increased (2). The NMNAP is also associated with improved infant and young child feeding practices. Between 2014 and 2018, the prevalence of exclusive breastfeeding and of minimum acceptable diet for infants and young children increased from 40% to 58% and 20% to 30%, respectively. This is likely due to improved coverage of preventive services promoting Maternal, Infant, Young Child, and Adolescent Nutrition, which rose from 5% to 36% at the community level and from 20% to 54% at the facility level (2).

Table 1. NMNAP impact-level indicators: performance versus NMNAP and WHA targets

	NMNAP Impact Indicators	Baseline	NMNAP Target 2018	Progress at MTR 2018	Global WHA Target 2025
1	Prevalence of stunting amongst children under five (CU5)	34.4% (2.7 million CU5)	32%	32% (3 million CU5)	40% reduction in number CU5
2	Prevalence of global acute malnutrition amongst CU5	4.5%	<5%	3.5%	<5%
3	Prevalence of low birthweight	7.0%	<5%	7.0%	30% reduction
4	Percentage of women of reproductive age with anaemia	44.7%	40%	28.7%	50% reduction
5	Prevalence of vitamin A deficiency among children aged 6-59 months	33%	30%	NA	NA
6	Median urinary iodine of women of reproductive age	160 $\mu$ g/L	Between 100 and 299 $\mu$ g/L	NA	NA
7	Prevalence of diabetes amongst adults 25-69 years of age	9.1%	<10%	NA	NA
8	Prevalence of overweight amongst CU5	3.6%	<5%	2.8%	<5%
9	Prevalence of overweight/obesity amongst adults 25-69 years of age	29%	<30%	NA	NA
9a	Proportion of women of reproductive age who are overweight (BMI $\geq$ 25 kg/m <sup>2</sup> )	29%	<30%	31.7%	NA

Notes: Blue shading indicates achievement of NMNAP target 2018; no shading indicates NMNAP 2018 targets were not achieved or data was not available.

Source: (2)

### CHALLENGES IN IMPLEMENTING THE NMNAP

While progress has been achieved, implementing the NMNAP has not been without challenges according to the stakeholders interviewed (15, 16, 20). These include insufficient capacity at all levels to translate the political will and commitment into evidence-based, effective, impactful, and sustainable policies, strategies, and actions that are at scale, multisectoral, well-coordinated, integrated, resourced, and monitored. Documenting and ensuring follow-up of agreed actions also remain key challenges. Second, expediting approval of a revised National Food and Nutrition Policy and strengthening enforcement of legislation are key challenges, requiring increased advocacy and capacity building of regulation enforcers. In addition, it took time for those involved to adapt to a new way of working and get activities off the ground. Since NMNAP governance mechanisms at district level did not previously exist, district officers and others not directly involved in nutrition activities needed time to begin working in a multisectoral way. Those involved in NMNAP implementation have now largely come to understand that the NMNAP does not imply more work but rather better coordinated work towards multisectoral, shared nutrition goals.

In general, there has also been low coverage of key nutrition-specific and -sensitive interventions, and there is a need to ensure the cohesion and engagement of key sectors, the involvement of which is critical for narrowing the implementation gap (21). At district level, a lack of transportation for extension workers, a lack of research (and therefore a lack of data for adequate surveillance), and a lack of basic food supplements for the population (all aspects not included in the NMNAP) pose further challenges to achieving nutritional improvements.

These issues are tied to an insufficient budget for nutrition, which forms a bottleneck to NMNAP implementation at all levels. At present, the NMNAP is only 40% funded, mainly by development partners with a focus on nutrition-specific interventions. Nutrition-sensitive interventions have not been sufficiently funded, and the budget required to reach all NMNAP targets is not available. Policy implementation, impact assessment, and district-level governance are all hindered by the scarcity of funds and their irregular disbursement. Overreliance on donor funds has introduced a large degree of uncertainty in implementing nutrition activities (2). At present, funding gaps are being dealt with by means of advocacy to donors. The introduction of “One thousand shillings for every child” as a new budget guideline for Tanzania requires all councils to set aside 1,000 TZS (approximately USD 0.43) for each child under five years of age. Councils are being urged to actively engage in resource mobilisation for nutrition at the council level and follow up on the use of the budgeted TZS 1,000 (22). There is also a challenge with the actual disbursement of funds for implementation of the planned activities, particularly with government funds, which are often unpredictable and delayed. Only 19% of the planned financial targets were met in fiscal year 2016/2017. A harmonised long-term resource mobilisation and disbursement strategy and strategic advocacy are needed to ensure timely and adequate procurement and disbursement of funds.

## CONCLUSION

This paper has examined the development and implementation of Tanzania’s National Multisectoral Nutrition Action Plan (NMNAP), describing both successes achieved under the plan and challenges remaining with its implementation. Tanzania has seen a shift in policymaking in favour of nutrition strengthened by the NMNAP. The passing of nutrition-focused policies attests to increased awareness amongst policymakers of the importance of improving the population’s nutritional status in order to allow the country to develop to its full extent.

The NMNAP is a strong example of ‘governance for nutrition’ at multiple levels of government—offering lessons that can be applied by other countries and regions. Under NMNAP, the approach to addressing nutrition challenges in Tanzania has shifted from a top-down approach to a multisectoral one, which brings in important non-nutrition stakeholders in an effort to foster an overall enabling environment. The multisectoral mechanism

distributes responsibility among all stakeholders, which facilitates overall implementation of the NMNAP. Further, NMNAP's decentralised mechanism, characterised by a clear distribution of tasks from the national to the district and community levels, has made it possible for activities to reach the local level. Each level of government understands its roles and responsibilities, which are clearly defined, thus making it possible to effectively track progress. In addition, the Nutrition Compact review meeting mechanism has helped stakeholders to understand if and to what extent NMNAP targets are being achieved. Moreover, the needed nutrition personnel are on the ground at the local level.

In addition, the involvement of multiple sectors in implementing nutrition-sensitive programmes provides the opportunity to impact indirect determinants of malnutrition. The multisectoral mechanism distributes responsibility among all these diverse stakeholders, which facilitates overall NMNAP implementation. The engagement of multiple sectors, all of which can make significant contributions to improved nutritional status in the country has now become common practice. Finally, political will from the highest levels has been key to NMNAP implementation. The Prime Minister's Office, being the main coordinator of NMNAP activities, has facilitated its implementation, ensuring clear guidelines and directives.

Going forward, it will be necessary to further strengthen multisectoral coordination and the involvement of non-nutrition sectors at all levels to accelerate NMNAP implementation. Budgetary gaps should also be addressed in a timely manner, and there is a need to ensure efficient disbursement of the funds allocated for NMNAP implementation. However, the country is only halfway through NMNAP implementation. Despite the challenges and given the achievements so far, there is thus sufficient time to make further progress in order to achieve the NMNAP targets.

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## ANNEX – ADDITIONAL INFORMATION ON NMNAP GOVERNANCE

### A1. LOCAL LEVEL NMNAP GOVERNANCE MECHANISMS

The **Regional Multisectoral Steering Committee on Nutrition (RMSCN)** is Tanzania's governing body for the implementation of nutrition activities at the regional level. It supports the Regional Commissioner to ensure that nutrition policies, strategies, guidelines, and government directives on nutrition are translated and implemented at regional and council levels. A key priority of the RMSCN is to translate the NMNAP (2016-2021) into SMART (Specific, Measurable, Achievable, Realistic, and Time-bound) regional strategic action plans that can be used to develop a nutrition compact with the national authorities and ensure that resources allocated for nutrition in regions and councils are efficiently and effectively used to accelerate the reduction of malnutrition (17).

The regional secretariats<sup>10</sup> have the following roles: identify nutrition problems, challenges and solutions in the regions; integrate food and nutrition objectives in Regional Secretariat plans and strategies; interpret policies and guidelines on nutrition for implementation; provide technical guidance and supportive supervision on nutrition to LGAs; coordinate, advise on, monitor, and evaluate the implementation of the NMNAP by different stakeholders at the regional level; and mobilise resources. Furthermore, the Regional Secretariats' Committee may invite any person or stakeholder considered critical (e.g., a 'nutrition champion') to be a member of RMSCN or to provide expert advice in specific meetings (17).

The **Council Multisectoral Steering Committee on Nutrition (CMSCN)** is the governing body for implementation of nutrition activities at the council level. It supports the District Commissioner and Council Executive Director to ensure that nutrition policies, strategies, guidelines, regulations, and government directives on nutrition are translated and implemented at council level. It also serves as a monitoring body for the council on the implementation of the NMNAP. The CMSCN also translates the NMNAP into district-level strategic action plans that can be used to develop a Nutrition Compact.

The **Ward Development Committees (WDC)** are designated to coordinate all development issues at ward and village levels. They can use existing committees to: identify food and nutrition opportunities and challenges at their level; ensure the integration of food, nutrition, and early childhood development issues in local plans and strategies; ensure adequate community sensitisation to increase demand for and uptake of nutrition and early childhood development services; initiate appropriate community-based food, nutrition, and early childhood development interventions and mobilise resources for implementation; and coordinate monitoring and evaluation of nutrition and early childhood development improvement activities at the respective levels in the context of the NMNAP (17).

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<sup>10</sup> Regional Secretariats are within the RMSCN.