

# ZANZIBAR MULTISECTORAL NUTRITION STRATEGIC ACTION PLAN (ZMNSAP)

NUTRITION FOR A HEALTHY AND WEALTHY ZANZIBAR

2020/2021 – 2024/2025

JUNE 2020



The Revolutionary Government  
of Zanzibar

**Recommended citation:**

Revolutionary Government of Zanzibar (2020): The Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP) 2020/2021 – 2024/2025. June 2020.



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# Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP)

**2020/2021 – 2024/2025**

NUTRITION FOR A HEALTHY AND WEALTHY  
ZANZIBAR

FINAL DRAFT



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# LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care/Clinic
ARNS	African Regional Nutrition Strategy
ASR	Adult Survival Rate
AU	African Union
AZASPO	Association of Zanzibar Salt Producers
BMI	Body Mass Index
CBO	Community-Based Organization
CHMT	Council Health Management Teams
CHNM	Community Health and Nutrition Months
CHV	Community Health Volunteers
CHWs	Community Health Workers
CMR	Child Mortality Rate
CMS	Central Medical Stores
CRAF	Common Results and Accountability Framework
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
CVD	Cardiovascular Diseases
DESW	Department of Elders and Social Welfare
DMT	District Management Team
DRNCD	Diet-Related Non-Communicable Diseases
ECD	Early Childhood Development
EBF	Exclusive Breastfeeding
ETR	End-Term Review
FAO	Food and Agricultural Organization
FBO	Faith Based Organization
GDP	Gross Domestic Product
HCI	Human Capital Index
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus

IDA	Iron Deficiency Anaemia
IGN	Iodine Global Network
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IMTC	Intersectoral Management Team Committee
IQ	Intelligent Quotient
ISSC	Intersectoral Steering Committee
IYCF	Infant and Young Child Feeding
JMNR	Joint Multisectoral Nutrition Review
kcal	Kilo calories
KICS	Kavishe International Consultancy Services
KRA	Key Results Area
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MDA	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MEAL	Monitoring, Evaluation, Accountability and Learning
MECNS	Maternal and Early Childhood Nutrition Services
MKUZA	Mkakati wa Kukuza Uchumi Zanzibar
MLEEWC	Ministry of Labour, Empowerment, Elders, Women and Children
MMR	Maternal Mortality Ratio
MMS	Multiple Micronutrient Supplements
MNG	Multisectoral Nutrition Governance
MNIS	Multisectoral Nutrition Information Systems
MNSI	Multisectoral Nutrition-Sensitive Interventions
MoEVT	Ministry of Education and Vocational Training
MoH	Ministry of Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MTR	Mid-Term Review
NCD	Non-Communicable Diseases
NFSND	National Food Security and Nutrition Division
NGO	Non-Government Organization
NI	Nutrition International
NMNAP	National Multisectoral Nutrition Action Plan
NMR	Neonatal Mortality Rate
OCGS	Office of the Chief Government Statistician

PESTLE	Political, Economic, Social, Technological, Legal, Environmental
PO–RALG	President’s Office – Regional Administration and Local Government
PO–RALGSD	President’s Office – Regional Administration, Local Government and Special Departments of the Government of Zanzibar
PPP	Public-Private Partnership
PS	Principal Secretary
RBM	Results-Based Management
RGoZ	Revolutionary Government of Zanzibar
SAM	Severe Acute Malnutrition
SBCC	Social Behavioural Change Communication
SDG	Sustainable Development Goals
STC	Stakeholder Technical Committee
SUN	Scaling Up Nutrition (Movement)
SUN	Scaling Up Nutrition
SWOT	Strengths, Weaknesses, Opportunities, Threats
TASAF	Tanzania Social Action Fund
TDHS	Tanzania Demographic and Health Survey
TDHS-MIS	Tanzania Demographic and Health Survey – Malaria Indicator Survey
TFNC	Tanzania Food and Nutrition Centre
TNNS	Tanzania National Nutrition Survey
U5MR	Under-five Child Mortality Rate
UNICEF	United Nations Children’s Fund
US\$	United States Dollars
USI	Universal Salt Iodization
VPO	Vice President’s Office
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
ZANA	Zanzibar Nurses Association
ZBS	Zanzibar Bureau of Statistics
ZFDA	Zanzibar Food and Drug Agency
ZFSNP	Zanzibar Food Security and Nutrition Policy
ZFSNP-IP	Zanzibar Food Security and Nutrition Policy- Implementation Programme
ZMNSAP	Zanzibar Multisectoral Nutrition Strategic Action Plan
ZMNNS	Zanzibar Multisectoral National Nutrition Strategy
ZSGRP	Zanzibar Strategy for Growth and Reduction of Poverty or MKUZA in Kiswahili

# DEFINITION OF TERMS

Term	Definition
<b>Anaemia</b>	A condition in which a person does not have enough red blood cells or these cells are not able to carry sufficient oxygen to the body's tissues. WHO describes anaemia as the condition in which the concentration of haemoglobin (Hb) in the blood of an individual falls below the established cut-off normal values, which naturally vary according to age, sex, altitude and physiological state (e.g., pregnancy)
<b>Body Mass Index</b>	Body Mass Index (BMI) is calculated as weight (W) in kg divided by the square of the height (H) in metres. Formula: $(W/H^2)$ . A BMI of <18.5 is defined as underweight for women; <20 is underweight for men; 20- <25 is normal for both sexes; 25-<30 is overweight and 30 and above is defined as obese for both sexes
<b>Enabling-environment or cross-cutting interventions</b>	Political actions and policy processes that create and sustain a momentum aimed at reducing undernutrition and malnutrition. They include strategies, plans, legal instruments etc. that provide policy direction, an institutional framework, coordination mechanisms and resources for the purpose.
<b>Low birthweight (LBW)</b>	LBW is defined as a birth weight of 2.5 kg and below. When the birth is not preterm, the cause of LBW may be intrauterine growth retardation caused by maternal malnutrition. Babies born prematurely may also be LBW.
<b>Multisectoral nutrition-sensitive interventions</b>	Activities that address some of the underlying and basic causes of malnutrition by incorporating nutrition goals and actions from a wide range of sectors. They can also serve as delivery platforms for nutrition-specific interventions
<b>Nutrition-specific interventions</b>	Addresses the immediate causes of undernutrition, such as inadequate dietary intake, disease management and some of the underlying causes like feeding and care practices, as well as access to food. They are usually addressed by the Ministry of Health (MoH)

<b>Term</b>	<b>Definition</b>
<b>Overweight and obesity in adults</b>	Excessive weight in relation to height as measured by the BMI. A BMI of 30 and above is defined as obese for both sexes.
<b>Premature or preterm birth</b>	The birth of a baby before 37 weeks of gestation
<b>Stunting</b>	Also called chronic malnutrition, it is low height-for-age (H/A) that is below minus 2 standard deviation (SD) against internationally agreed WHO standards.
<b>Underweight</b>	Low weight-for-age (W/A) that is below minus 2 standard deviation (SD) against internationally agreed WHO standards. It is a combined measure of stunting and wasting.
<b>Wasting</b>	Also called acute malnutrition, it is low weight-for-height (W/H) that is below minus 2 standard deviation (SD) against internationally agreed WHO standards

# FOREWORD

Zanzibar is a part of the United Republic of Tanzania with autonomy over development policy and both recurrent and capital activities. The Union Government is responsible for defence, external affairs, fiscal policies and monetary issues. The Revolutionary Government of Zanzibar (RGoZ) comprises an Executive President, Legislative House of Representatives and Judiciary with an Attorney General and Chief Justice. The Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP) 2020/2021 – 2024/2025 was developed, taking cognizance of the fact that in 2016 Mainland Tanzania developed its own National Multisectoral Nutrition Action Plan (NMNAP) 2016/17–2020/21 in which representatives from had Zanzibar participated.

We are aware that, despite decades of effort, progress towards elimination of malnutrition in Zanzibar has been slow and unacceptably high levels of the condition remain. While the incidence of undernutrition has been declining, problems of diet-related non-communicable diseases (DRNCDs) have been increasing at a fast pace. For example, while stunting declined from a prevalence of 24 per cent in 2014 to 21.5 per cent in 2018, overweight and obesity in women of reproductive age increased from about 30 per cent to 42 per cent during the same period. Currently Zanzibar suffers from the triple burden of malnutrition comprising protein energy deficiency (resulting in stunting, wasting, underweight), micronutrient deficiencies (especially of iron, vitamin A and iodine) and problems of DRNCDs as they manifest themselves in increased weight, obesity, diabetes, high blood pressure, stroke, heart diseases and several types of cancer. This triple burden requires a triple response that is effectively fast-tracked as planned in this ZMNSAP.

We recognize that malnutrition is one of the most serious threats to social and economic growth. It diminishes the ability of children to survive, grow, thrive, learn and become productive adults, and thus reduces their ability to contribute to the economy. Malnutrition retards brain development and lowers performance at school and at work. However, we can and are determined to prevent malnutrition.

This ZMNSAP comes at a time when Zanzibar is gearing its efforts towards industrialization and along with Mainland Tanzania aims to become a middle-income country by 2025. Given that good nutrition is fundamental to the development of the necessary human capital to steer the nation towards these goals, the ZMNSAP must be given the necessary political support, multisectoral push as well as resources to achieve its strategic objectives.

Lastly, let me call upon all sectors and all partners to align their nutrition work with the ZMNSAP and support its implementation. As we build national physical infrastructures (e.g., roads, ports), we must also build “grey matter infrastructure” through improved nutrition, for a healthy and wealthy nation.

**Shaaban Seif Shaaban**

Principal Secretary  
Second Vice President’s Office



# ACKNOWLEDGEMENTS

The steering committee of the Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP), chaired by the Office of the Second Vice President, guided and provided oversight into the development of the ZMNSAP. On behalf of the steering committee, the Ministry of Health (MoH), Zanzibar would like to express its deepest appreciation to all contributors to the ZMNSAP.

**Dr. Festo P. Kavishe**, independent human development consultant and senior Managing Director of Kavishe International Consultancy Services (KICS) was the lead facilitator and synthesizer of the various inputs into this final document. As a senior nutrition expert, he also provided technical oversight and quality assurance to ensure that the ZMNSAP is consistent with the best global practices, experience and latest scientific evidence.

**Dr. Joyceline Kaganda** from the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) was the technical facilitator. She also coordinated the review of the previous Multisectoral National Nutrition Strategy (2013-2018), the development of the ZMNSAP roadmap, the work of the KRA teams, and development of the nutrition-sensitive interventions in the KRA action plan.

The Tanzania food and Nutrition Centre (TFNC) provided facilitators for other KRAs. They were: **Dr Fatma Abdalla** for micronutrients and diet related noncommunicable diseases (DRNCDs); **Mary Kibona** for maternal and early childhood nutrition services and integrated management of malnutrition and **Adam Hancy** for multisectoral nutrition governance, multisectoral nutrition information system (NIS), development of the common results and accountability framework (CRAF) and costing of the ZMNSAP.

Our sincere gratitude also goes to the members of the Zanzibar team who contributed to the development of the document. They included staff from the nutrition unit of the MoH (Asha H. Salmin – as coordinator, Fatma, Ali Said Salama, M. Ashrak, Wanu Haji Ali and Mwanahija K.Mbarouk). Staff from other sectors included: Sheikha M.Ramia (MLEEWC, DESW), Jamila K. Hassan (School of Health and Medical Science), Forogo K. Mtande (Env), Health Unit MoH), Dr. Maryam Juma Bakar (IMCI Coordinator of the MoH), Suleiman S. Hemed (HMIS of the MoH), Salum Mohamed Abdulla (MoEVT), Ali Shauri Ali (PO-RALGSD), and Fatma B.Juma (HSRS MoH). Others who also made valuable contributions include Zuhura Saleh (NCD programme MoH), Ahmed Gharib (Ministry of Agriculture), Abdulla Saleh Omar (MLEEWC, DESW), and Suleiman Atik Suleiman (Feed the Future-Mboga na Matunda). Dr. Juma Salum Mbwana, Director of Curative Services and the Ministry of Health (MoH) Zanzibar, who, chaired the ZMNSAP validation

meeting and Abdalla Hassan Mitawi, Deputy Principal Secretary of the Second Vice-President's Office, who, closed the meeting.

Finally, the MoH would like to thank **UNICEF** for financial and technical support. UNICEF recruited all the facilitators and provided technical and logistical support with the help of the following staff: **Mauro Brero**, Chief of Nutrition at UNICEF; **Joyce Ngegba**, **Nutrition Specialist**; **Abraham Sanga**, **Nutrition Officer** and **Maryam Hemed**, **Health Specialist**.

**Hon. Hamad Rashid Mohamed**  
Minister for Health, Zanzibar

# STATEMENT OF COMMITMENTS

We, the undersigned, support the development and implementation of the Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP) 2020/2021 – 2024/2025 to address all forms of malnutrition in Zanzibar, including the emerging problem of diet-related non-communicable diseases (DRNCDs).

**EMPHASIZING** that the ZMNSAP is a multisectoral document aimed at addressing the unacceptably high levels of the triple burden of malnutrition in Zanzibar, carried mainly by children under the age of 5 and women of reproductive age;

**RECOGNIZING** the health, social and economic benefits of addressing malnutrition in all its forms starting early on in life, especially during the first 1,000 days of life from conception to two years, and the need for adequate nutrition throughout one's life;

**BEING AWARE** of the progress made by the Revolutionary Government of Zanzibar (RGoZ) in reducing the various forms of malnutrition between 1996 and 2015/16, whereby stunting declined from 37 per cent to 24 per cent, wasting from 11 per cent to 7 per cent, underweight from 34 per cent to 14 per cent, anaemia in children under 5 years from 75 per cent to 65 per cent and in women of reproductive age from 63 per cent to 60 per cent, and the progress made towards the elimination of severe forms of vitamin A deficiency and iodine deficiency disorders;

**ACKNOWLEDGING** that despite the progress made, unacceptably high levels of all forms of malnutrition remain and more efforts are required in the following areas:

- creating critical awareness among policymakers and the public at large about the dangers of all forms of malnutrition and the actions they can take;
- improving multisectoral coordination, collaboration and communication on nutrition;
- creating a good environment for nutrition actions by strengthening political support and developing institutional and human resources capacity and thus ensuring equal geographical and professional coverage.
- improving the monitoring and evaluation framework for tracking the progress of the ZMNSAP's implementation process with regard to relevant areas including financing, research and documentation;

**RESTATING** that Zanzibar is a part of the United Republic of Tanzania and thus of the global community. It remains fully committed to the realization of the 2030 Global Sustainable Development Goals (SDGs), the 2025 World Health Assembly (WHA) nutrition targets and those of the African Union (AU) nutrition strategy 2015–2025.

**WE, THEREFORE,** pledge to implement a wide range of specific actions contained in this ZMNSAP that relate to our sectors in the spirit of multisectoral collaboration;

**WE FULLY RECOGNIZE** the mandates of each ministry and other partners and pledge our commitment to mobilizing political, financial and social support to achieve the nutrition objectives and targets laid out in this ZMNSAP.

To indicate our commitment to these pledges,

**WE HEREBY** append our names and signatures hereto.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
Principal Secretary, Second Vice President's Office

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary, Ministry of Agriculture,  
Natural Resources, Livestock and Fisheries

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary, Ministry of Health

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary, Ministry of Finance and  
Planning

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary Ministry of Education and  
Vocational Training

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary, Ministry of Land, Housing,  
Water and Energy

Principal Secretary, Ministry of Trade and  
Industry

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary, Ministry of Labour,  
Investment, Elderly, Women and Children

Principal Secretary, President's Office- Regional  
Administration, Local Government and Special  
Departments of the Revolutionary Government  
of Zanzibar

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Principal Secretary, Ministry of Infrastructure  
Communications and Transport

Principal Secretary, Ministry of Information,  
Tourism and Heritage



# EXECUTIVE SUMMARY

## What is the ZMNSAP about?

The **Zanzibar Multisectoral Nutrition Action Plan (ZMNSAP)**, covering financial years from 2020/2021 to 2024/2025 is a **triple duty evidence-based strategic action plan** that addresses the unacceptably high levels of all forms of malnutrition in Zanzibar. The ZMNSAP targets various audiences including policymakers, planners, programme implementers, various communities and the public at large.

As a strategic plan, the ZMNSAP is intended to be used as a tool for enhancing the impact of the RGoZ's efforts to deliver better health and nutrition results for its population, focusing on children and women. To tear down barriers that previously hindered efforts to address malnutrition, the ZMNSAP strategically promotes:

- improved multisectoral approaches to nutrition interventions, with effective coordination, communication, and monitoring and evaluation frameworks;
- enhancement of the Government's capacity to make better and strategic choices with regard to nutrition by focusing on community capacity development at the Shehia level;
- the alignment of the Government and development partner resources and accountability with common nutrition goals;
- the use of innovation and creativity in nutrition programming;
- the use of digital technology and social media, in addition to the traditional approaches, for creating public awareness on nutrition;
- improved leadership and management role of the Government and strengthening of public-private-partnerships (PPP) at all levels with adequate social accountability; and
- data generation and its use to inform programmes and policy adjustments.

## Objectives of the ZMNSAP

In addition to enhancing the Government's efforts to deliver health and nutrition services to its population, the ZMNSAP was developed in order:

- to render successful the 2013-2018 Zanzibar Multisectoral National Nutrition Strategy (ZMNS) and continue implementing the 2008 Zanzibar Food Security and Nutrition Policy (ZFSNP)

- to use the latest global and national evidence to address the unacceptably high levels of all forms of malnutrition in Zanzibar including emerging problems like the incidence of overweight, obesity and diet-related non-communicable diseases (DRNDs)
- to ensure that all nutrition-sensitive sectors incorporate nutrition considerations into their policies, strategies and plans

## Process used in developing the ZMNSAP

The process was widely consultative, coordinated politically by the Office of the Second Vice-President and technically by the Ministry of Health (MoH), Zanzibar, with facilitative support from UNICEF, the Tanzania Food and Nutrition Centre (TFNC) and the Mainland's Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC).

The process involved the development of a road map, recruitment of lead and technical facilitators, and the formation of four task teams that were given specific tasks based on the agreed key result areas (KRAs). The coordination, consolidation and validation of the drafts of the ZMNSAP documents were done over four workshops chaired by the Second Vice President's Office in coordination with the Secretariat, led by the MoH. The workshops were as follows:

- first – inception workshop- agreed on a roadmap and reviewed the 2013–2018 ZMNNS. The leading facilitator developed draft 1.
- second – drafting workshop– reviewed draft 1, agreed on the document outline, KRAs, work plan and accountability for further drafting. The leading facilitator developed draft 2.
- third – consolidation workshop- reviewed draft 2 and agreed on the common results, targets and work plan for developing draft 3. The leading facilitator developed draft 3.
- fourth – validation workshop – reviewed and validated draft 3, after which the lead facilitator developed the final draft (draft 4).

## The results expected from ZMNSAP

The expected results of the ZMNSAP are divided into three categories:

- the desired change,
- seven key result areas (KRAs), 20 nutrition targets (of which 14 are impact targets and 7 outcome targets) and
- 23 outputs.

The hierarchy of results is predicated on the theory of change whereby the achievement of outputs is expected to result in outcomes, the achievement of outcomes is expected to result in impact and the achievement of impact is expected to lead to the desired change.



The desired change is the establishment of **‘a healthy and prosperous Zanzibar where malnutrition is no longer a problem of public health significance.’**

The seven KRAs chosen are based on the following three categories of the Lancet 2013 framework for addressing malnutrition: (i) nutrition-specific interventions, (ii) nutrition-sensitive interventions and (iii) enabling-environment interventions. The next part discusses the three categories in a more detailed manner:

**(i) Nutrition-specific interventions**

1. **KRA 1:** Delivery of maternal and early childhood nutrition services (MECNS)
2. **KRA 2:** Scaled-up services to address malnutrition among school-age children, adolescents and women, with a focus on micronutrient deficiencies
3. **KRA 3:** Integrated management of acute malnutrition (IMAM)
4. **KRA 4:** Scaled-up services to prevent and manage diet-related non-communicable diseases (DRNCD)

**(ii) Nutrition-sensitive interventions**

5. **KRA 5:** Multi-sectoral Nutrition-Sensitive Interventions (MNSI)

**(iii) Enabling-environment interventions**

6. **KRA 6:** Multisectoral Nutrition Governance (MNG)
7. **KRA 7:** Multisectoral Nutrition Information Systems (MNIS)



## The ZMNSAP 2025 impact nutrition targets

The 14 **ZMNSAP impact nutrition targets** (to be achieved by 2024/2025) are based on the global targets for 2025 of the World Health Assembly and the specific additional factors derived from the Zanzibar situation analysis. The targets can be achieved only through the implementation of the full portfolio of interventions proposed in the ZMNSAP. The targets are as follows:-

**Table 1:** The ZMNSAP impact nutrition targets

1.	Reduce the prevalence of stunting among children under five years (0-59 months) by 25% from 24% in 2015/16 to 18% in 2024/2025.
2.	Reduce and maintain the prevalence of childhood (0-59 months) wasting to less than 5% from the 2018 baseline of 6.1%.
3.	Reduce the prevalence of low birth weight (2.5 kg or less) by 30% from a baseline of 8.3% in 2018 to 5.8% by 2024/2025.
4.	Reduce the prevalence childhood (0-59 months) underweight by 30% from a baseline of 14% in 2015/16 to 9.8% by 2024/2025.
5.	Ensure that there is no increase in the percentage of overweight and obese children (0-59 months) above the 2018 baseline of 2.1%.
6.	Reduce the prevalence of anaemia in women of reproductive age (15-49 years) by 30% from the 2015/16 baseline of 60% to 42% by 2024/2025.
7.	Reduce the prevalence of anaemia among children aged 6-59 months by 30% from the 2015/16 baseline of 65% to 45% by 2024/2025.
8.	Reduce the prevalence of anaemia among pregnant women by 40% or more from the baseline of 80% in 2015/16 to 48% by 2024/2025.
9.	Reduce anaemia among adolescent girls (15-19 years) by 30% from a 2015/16 baseline of 47% to 33% by 2024/2025.
10.	Reduce the prevalence of vitamin A deficiency children aged 0-59 months by 50% from a 2015/16 baseline of 38% to 19% by 2024/2025.
11.	Increase the proportion of women of reproductive age (WRA) with median urinary iodine concentration (MUIC) falling in the range 150- 300ug/L from a 2010 baseline of 25% to 50% by 2024/2025.
12.	Reduce the proportion of the population with raised blood pressure and currently on medication by 25% from a 2012 baseline of 33% to 25% by 2024/2025.
13.	Reduce the proportion of adult population aged 18-69 years with raised blood sugar due to fasting from 3.7% to below 3.7%.
14.	Reduce the percentage of overweight and obese adults aged 18-69 years by 30% from a 2012 baseline prevalence of 39% to 27% by 2024/2025.

## Key strategies

The overarching strategy for the ZMNSAP is a community-centred, multisectoral and well-coordinated approach that focuses on improving the nutrition situation of households and communities.

Supportive cross-cutting strategies include:

- 1) **social and behaviour change communication (SBCC)**
- 2) **advocacy and social mobilization**
- 3) **community-centred capacity development (CCCD)**
- 4) **developing functional human resource capacity**
- 5) **aligning all stakeholders with the ZMNSAP through community-public-private partnerships (C-PPP), effective coordination and collaboration**
- 6) **delivery of quality and timely nutrition services**
- 7) **mainstream equality of gender and coverage into all seven key result areas (KRAs)**
- 8) **developing a resource mobilization strategy**
- 9) **tracking implementation progress using the CRAF and the MEAL framework**
- 10) **effective overall planning and coordination**

## Planned cost of the ZMNSAP

It has been estimated that the ZMNSAP will cost around TSh **30,778.41 million** or **30.78 billion** (US\$ 13.38 million) in the five-year period (2020/2021 – 2024/2025). In terms of proportional contribution to the total budget, **nutrition-specific interventions** (KRA 1 – 4) **comprise 41 per cent of the total budget**, while nutrition-sensitive interventions (KRA 5 – 7) **comprise 59 per cent of the total budget**.

## Organization of the ZMNSAP document

The ZMNSAP document is organized into eight chapters:

**Chapter 1 cites various global and national sources** to discuss the importance of addressing malnutrition in all its forms, delineates the methods used in developing the ZMNSAP, the outcome of the review of the 2014–2018 ZMNS and the target audience for this document.

**Chapter 2 analyses the nutrition situation in Zanzibar** and defines vulnerable groups, common types of malnutrition and their trends. It also discusses the causes of malnutrition, actions that Zanzibar has taken to address the nutrition challenge and the key issues in implementing nutrition interventions in Zanzibar.

**Chapter 3 defines the vision, mission, guiding principles and conceptual frameworks used** for addressing all forms of malnutrition in Zanzibar and for measuring changes in results.

**Chapter 4 articulates the objectives, KRAs, expected results, targets and strategies of the ZMNSAP.** It indicates the guiding principles for planning, implementation and management; defines the desired change and strategic objective; and articulates the KRAs, planned nutrition targets, the expected results per KRA and the key strategies.

**Chapter 5 develops a work plan and budget for each key result area (KRA)** explaining the costing approach used and provides the overall resource requirements for the ZMNSAP.

**Chapter 6 articulates the monitoring, evaluation, accountability and learning (MEAL)** approach used. It defines the CRAF, the MEAL framework, the MEA moments, learning and research. It also defines the frameworks for financial tracking, budget analysis (for nutrition), resource mobilization strategy and institutional arrangements for monitoring and evaluation (M&E).

**Chapter 7 identifies the roles and responsibilities of its different partners, the institutional and legal frameworks for implementation** and results-based management (RBM) of the ZMNSAP; and

**Chapter 8 analyses the risks and mitigation measures in the implementation of the ZMNSAP.** It identifies the possible risks, assesses the likelihood of their occurrence and impact, prioritizes them, and using a combined SWOT and PESTLE analysis, manages risk and suggests mitigation measures.

## Key issues and strategic choices considered by the ZMNSAP

As a strategic evidence-based plan, the ZMNSAP takes a “business unusual” approach, cognizant of the fact that “doing more of the same” will not significantly improve the nutrition situation in Zanzibar. That is why the ZMNSAP emphasizes the following cross-cutting points:

1. political “will and commitment” will need to “walk the talk” by allocating more domestic resources and providing effective leadership in the implementation of the ZMNSAP
2. ensuring synergy and implementation will encourage multisectoral collaboration, coordination and adherence to the **“three ones principle”**: one plan, one coordinating mechanism, and one M&E framework within a CRAF

3. developing institutional and nutrition system capacity, advocacy and communication will result in effective leadership and management of the ZMNSAP
4. creating critical awareness among people about malnutrition will encourage them to take up specific actions individually and collectively to prevent the occurrence of malnutrition

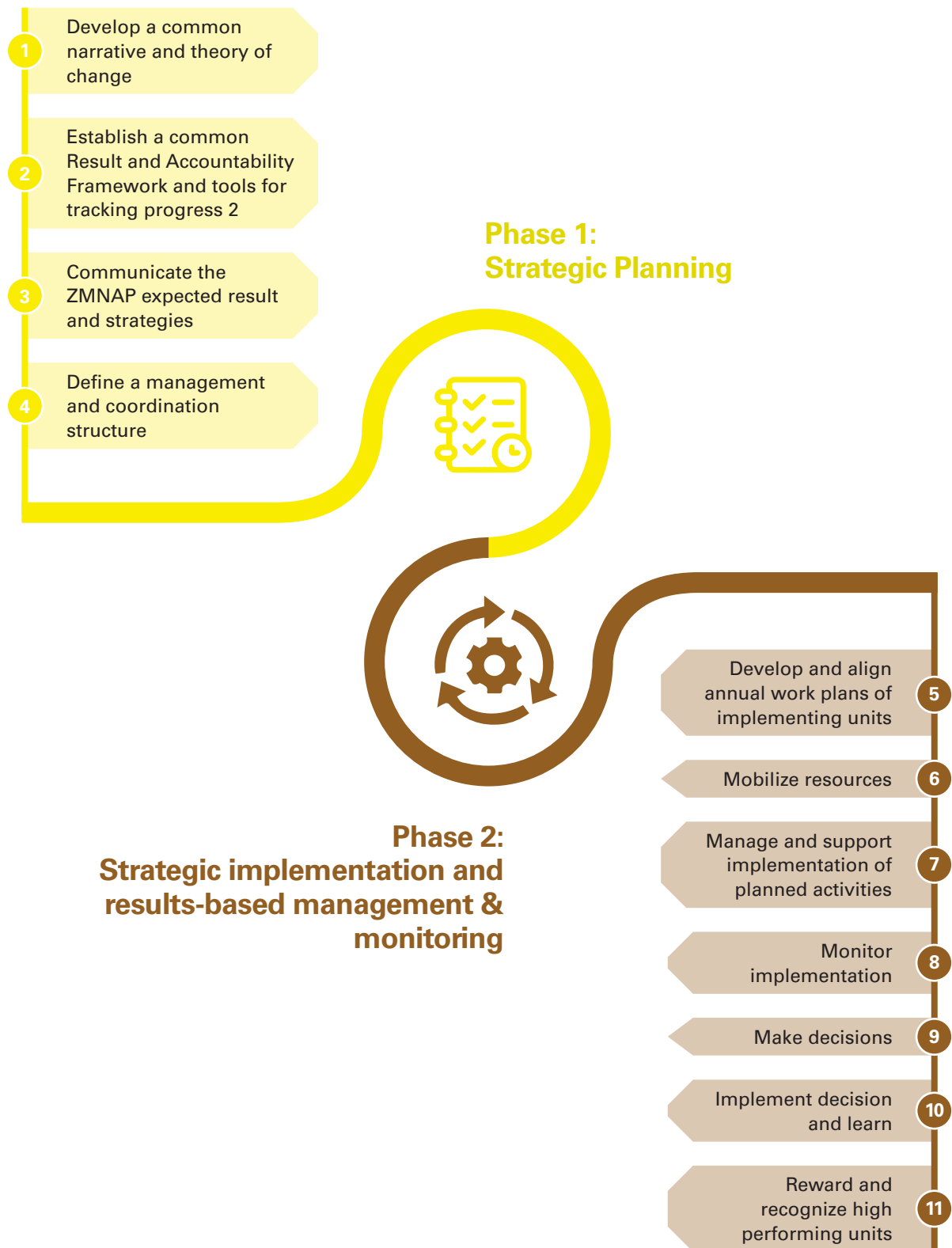
## Key steps for successful implementation of the ZMNSAP

Successful implementation of the ZMNSAP is key to achieving the nutrition targets articulated in it. The ZMNSAP can be considered in two phases (see *Figure 1*). In the first phase, the strategic planning stage, all critical stakeholders developed and reached a **consensus on a common narrative and theory of change**. This phase then established a **CRAF** to measure progress towards ZMNSAP results. Thereafter **the expected results and strategy** of the ZMNSAP were communicated to the key stakeholders, implementing units (ministries, departments and agencies [MDAs], LGAs, CSOs, the private sector) were mobilized and a **management and coordination structure**, clearly defining the roles and responsibilities of all partners, was laid out.

Phase 2 is the implementation phase. Key actions for phase 2 include:

- 1) **ensuring that the annual work plans of the implementing partners (MDAs, LGAs, CSOs, Private Sector)** are aligned with the ZMNSAP's expected results
- 2) **mobilizing resources** from the government, development partners and private sector to fund the interventions defined in the ZMNSAP
- 3) **managing and supporting direct implementation** of planned activities, in accordance with the annual work plans
- 4) **monitoring programme implementation** by quarterly using multisectoral nutrition scorecards and bi-annual bottleneck analysis (BNA), and using this information as part of the annual joint multisectoral nutrition reviews (JMNRs) with the help of the common results and accountability framework (CRAF)
- 5) **making decisions** in steering committee meetings at all levels to **remove identified bottlenecks** using data from process monitoring to improve performances of implementing units
- 6) **implementing decisions and learning how to remove bottlenecks for improved performances of implementing units**
- 7) **rewarding and recognizing high-performing implementing units** (MDAs, LGAs, CSOs, Private Sector)

**Figure 1:** Key steps in the successful implementation of the ZMNSAP



# 1

## BACKGROUND

### 1.1 Introduction

The sustainable development of a nation depends on its children. Therefore, the nation should ensure that the children grow up into healthy, economically productive and prosperous adults, able to live up to their full potential. Only by ensuring that both the mother and child (especially during the first 1,000 days of life from conception to birth to the first two years) receive adequate nutrition, can productive human resources be formed. The first three years of a child's life are crucial because this is when the bodily organs, especially the brain develop the most and need the best nutrition. To reach their full potential, children must first survive, thrive and grow – this requires good nutrition. Children need good nutrition throughout their childhood and adolescence to grow up into productive adults. Adults too need good nutrition to remain in good health, lead life with dignity and avoid premature death. Thus, while good nutrition is critical during the first 1,000 days, it is important for people of all ages.

However, in many countries including Tanzania, the levels of malnourishment among mothers, young children, adolescents and adults, especially women of reproductive age are unacceptably high. Common forms of malnutrition in young children are undernutrition that mainly manifests itself as stunting, wasting, underweight and micronutrient deficiencies, especially iron deficiency (manifested as anaemia); vitamin A deficiency and iodine deficiency disorders (IDD). In adult men and women, especially in women of reproductive age, the incidence of overnutrition, which manifests itself as overweight, obesity and diet-related non-communicable diseases (DRNCDs), is rapidly increasing. The commonest manifestations of DRNCDs include high blood pressure, diabetes, heart problems and various forms of cancer. Often, the same individual can suffer from multiple forms of malnutrition. Most children who are stunted or wasted also suffer from micronutrient deficiencies and people with obesity may also suffer from iron or iodine deficiency.

Globally, at least one in three people suffer from some form of malnutrition. Almost every country in the world is facing a serious challenge with regard to nutrition in the form of undernutrition, micronutrient deficiencies, overnutrition manifesting itself as overweight/obesity and DRNCD, or a triple burden of all the aforementioned forms. In low-income countries like Tanzania, the triple burden of malnutrition remains a “hidden problem” because a majority of the

children, women and men affected are moderately malnourished and identifying malnutrition without regular screenings/assessments is difficult. Mild to moderate micronutrient deficiencies are even more difficult to detect and this has earned micronutrient deficiencies the moniker of “hidden hunger.”

Moreover, policymakers and the community are largely unaware of the existence of all forms of malnutrition and their negative consequences on health, education and socioeconomic development. This is because many forms of malnutrition lack visual markers unlike diseases like malaria, diarrhoea or AIDS.

In Tanzania, including Zanzibar, the global nutrition challenge starkly manifests itself in nutrition transition characterized by high levels of stunting, wasting, anaemia, vitamin A deficiency and iodine deficiency disorders and the high incidence of obesity and DRNCDs. This ZMNSAP not only makes malnutrition visible in all its forms, but also analyses its causes and the broad and specific actions that Zanzibar should take to eliminate malnutrition.

Thus, this five-year **ZMNSAP** (2020/2021 – 2024/2025) is an evidence-informed **triple duty strategic action plan** that aims at addressing all forms of malnutrition in Zanzibar. The ZMNSAP succeeds the ZMNNS implemented during the 2013-2018 period. The ZMNNS was the implementation framework for the 2008 ZFSNP and its five-year (2008-2013) implementation programme (IP). Using a multisectoral community-centred approach, the ZMNSAP (2020/2021 – 2024/2025) scales up interventions that address the unacceptably high rates of malnutrition in Zanzibar. The interventions are divided into three categories: **nutrition-specific interventions, nutrition-sensitive interventions and enabling- environment interventions.**

## 1.2 Why addressing malnutrition in all its forms is important

Good nutrition is a vital building block in the foundation of human health and development. Lifelong access to good nutrition is associated with important short-term and long-term health, educational and economic benefits. Short-term benefits, particularly during the first 1,000 days of life from conception to two years, include good brain development, positive birth outcomes for both the child and the mother; healthy physical, mental and cognitive development; and improved chances of survival, growth and development. In the long term, good nutrition improves educational performance and prepares adolescents for adulthood. Good nutrition also improves the working capacity of adults and their overall quality of life.

In its most recent (2018) strategic direction, the World Bank has pushed for the Human Capital Project (HCP), which seeks global commitment for effective reforms and investments that can transform human capital outcomes for the greater good of both people and economies. To measure progress in the formation of human capital, the World Bank uses the Human Capital Index (HCI) which has three dimensions:



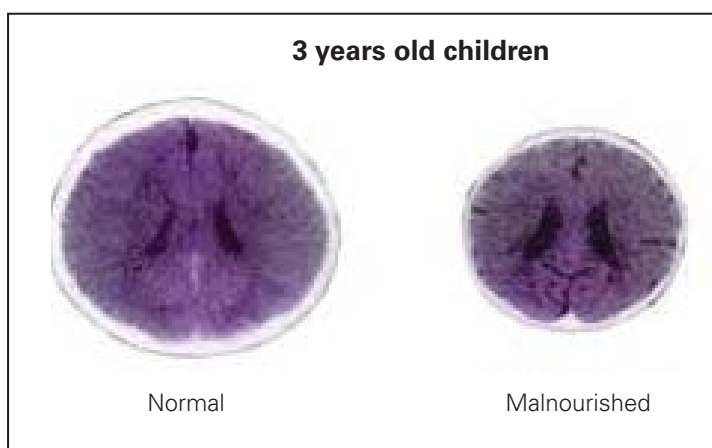
- (i) survival as measured by the under-five mortality rate (U5MR),
- (ii) schooling as measured by duration spent (at least 12 years) and actual learning (quality of education) and
- (iii) health as measured by the prevalence of stunting and adult survival rate (ASR)<sup>1</sup>.

All components of the HCI have nutrition status as a critical element. When the levels of malnutrition go down, it leads to a range of benefits including higher survival rates for both children and adults, higher school completion rates, higher adult wages and faster economic growth. These achievements will help in accelerating our country’s industrial growth and in realizing the national dream of becoming a middle-income country.

Studies<sup>2</sup> show strong relationships between nutrition and health; child survival, life expectancy and mental development, learning capacity, physical work capacity and adult work productivity. Thus, nutrition has a direct impact on a community’s overall social and economic development, an important aspect to consider in the context of Zanzibar’s industrialization drive and Tanzania’s efforts towards becoming a middle-income country by 2025.

Adequate nutrition is necessary for normal brain development. Nutrition is particularly important during pregnancy and infancy, which are crucial periods for the formation of a child’s brain, laying the foundation for cognitive, motor, and socio-emotional development through the life course. The impact of nutrition on brain development is particularly stunning especially during the first 1,000 days of life or the first three years when brain development reaches its peak (Figure 2). Notice the significantly smaller size of the brain of a child due to extreme neglect like severe malnutrition.

**Figure 2: The impact of severe neglect on the brain of a 3-year old child**



UNICEF, WHO and World Bank, 2018

Examples of the impact of nutrition on mental and physical work capacity are as follows:

- stunting may reduce the IQ by 5–11 points
- iodine deficiency reduces the IQ by as much as 10–15 IQ points

<sup>1</sup> Adult Survival Rate (ASR) is the fraction of 15-year-olds who survive to age 60. The ASR measures the survival of the economically productive population.

<sup>2</sup> World Bank’s 2016 paper on “Why Invest in Nutrition?”

- low birth weight (2.5 kilograms and below) may reduce a person’s IQ at a later stage by 5 per cent
- iron deficiency or anaemia reduces performance on mental ability tests (including the IQ) by eight points
- eliminating anaemia can lead up to 5-17 per cent increase in adult productivity
- a 1 per cent loss in adult height due to childhood stunting is associated with 1.4 per cent loss in productivity
- a 1 per cent increase in height is associated with a 4 per cent increase in wages
- body mass index (BMI)<sup>3</sup> falling on either end of the scale, below 18.5 or above 25, is associated with lower productivity

From this data, it can be concluded that improving nutrition is tremendous ‘value for money’ as it reduces the costs related to low/lost productivity and health care. Globally, **it has been estimated that each dollar spent on nutrition delivers something between US\$ 8 and US\$ 138, which is a cost-benefit ratio of around 1:17– similar to that of infrastructure development like roads, railways and electricity** (see Table 2 for cost-benefit ratios of different nutrition intervention programmes). Investing in nutrition is an investment in grey matter infrastructure that develops intelligence. Therefore, the capacity for innovation and creation is crucial for economic growth that directly benefits the poor, reduces inequality, and assists in social mobility through increased employability and productivity. Investing in nutrition extricates individuals, communities and nations at large from the long-term and intergenerational trap of the vicious malnutrition-disease-poverty cycle and accelerates economic growth.

**Table 2:** The cost-benefit of various nutrition intervention programmes

Nutrition intervention programme	Cost (US\$)	Benefit (US\$)	Cost: benefit ratio
Breastfeeding promotion in health facilities	5	67	1:13
Integrated childcare programmes	9	16	1:1.8
Iodine supplementation (women)	15	520	1:35
Vitamin A supplementation (children <6 years)	4	43	1:11
Iron fortification (per capita)	176	200	1:1.4
Iron supplementation (per pregnant woman)	6	14	1:2.3

**Source:** World Bank 2016 –Why invest in nutrition?<sup>4</sup>

<sup>3</sup> BMI is calculated by dividing the person’s weight in kg by the square of the height in metres:  $BMI = W (kg) / H^2 (m)$ . For men normal BMI is 20-<25; overweight is 25-<30; obesity is 30 and above; Women normal BMI is 18.5-<25; overweight 25-<30; and 30 and above is obesity.

<sup>4</sup> World Bank Group (2015): Why invest in nutrition? Sourced from Behrman, Alderman, and Hoddinott (2004). <http://siteresources.worldbank.org/NUTRITION/Resources/281846-1131636806329/NutritionStrategyCh1.pdf>

## 1.3 Global malnutrition and policy frameworks for multisectoral nutrition action plans

The 2017 Global Nutrition Report<sup>5</sup> estimates that globally, around 155 million children under the age of 5 (23 per cent) are stunted; 52 million children (8 per cent) are wasted; two billion people lack key micronutrients like iron, vitamin A and iodine; two billion adults are overweight or obese; and 41 million children are overweight. About 88 per cent of countries, including the United Republic of Tanzania, face a serious burden of either two or all three forms of malnutrition and about 3.4 million people die each year due to health complications related to obesity and overweight. The report has also estimated that the total cost burden of malnutrition is about 3.5 trillion US\$ per year and that the world is far from meeting all the global nutrition targets.

To address the global malnutrition challenge, several steps have been taken globally and regionally to which Tanzania is a party. The global agreements and mechanisms include the 17 Sustainable Development Goals (SDGs), the SUN Movement, the six 2025 nutrition targets of the World Health Assembly (WHA), the UN International Decade on Food and Nutrition and the ICN2 declaration and Plan of Action. The African Union’s (AU) Agenda 2063 and its African Regional Nutrition Strategy (ARNS) 2015–2025 provide the main regional nutrition direction. These frameworks lay down the foundation for addressing the immediate, underlying and basic causes of malnutrition including expanding the political, economic, social and technological space for nutrition actions. Of the 17 SDGs<sup>6</sup>, 112 are directly related to nutrition with SDG 2 being specifically on ending hunger and malnutrition (*Table 3*).

**Table 3:** The 12 SDGs that directly impact nutrition

GOAL NUMBER	SDG NAME	RELATION WITH NUTRITION
01	No Poverty	Poverty limits the ability of individuals, communities and nations to provide food, care and health security.
02	No hunger	
03	Good health	Agriculture and food security are the cornerstones of nutrition.
04	Quality education	Up to 45 per cent of deaths of children under the age of 5 are caused by undernutrition.

(continued)

<sup>5</sup> Development Initiatives, 2017. Global Nutrition Report 2017: Nourishing the SDGs. Bristol, UK: Development Initiatives.

<sup>6</sup> The 17 SDGs by 2030 are: Goal 1 – No poverty; Goal 2 – No hunger; Goal 3- Good health; Goal 4 – Quality education; Goal 5 – Gender equality; Goal 6 – Clean water and sanitation; Goal 7 – Renewable energy; Goal 8 – Good jobs and economic activity; Goal 9 – Innovation and infrastructure; Goal 10 – Reduced inequalities; Goal 11 – Sustainable cities and communities; Goal 12 – Responsible consumption; Goal 13: Climate action; Goal 14 – Life below water; Goal 15 – Life on land; Goal 16: Peace and Justice; Goal 17 – Partnership for the goals.

(continued)

GOAL NUMBER	SDG NAME	RELATION WITH NUTRITION
05	Gender equality	Learning and focusing in school is difficult without an adequate diet. Overall, the health and nutrition of children is better in households with educated parents/caregivers. The higher the education, the better the health and nutrition status.
06	Clean water and sanitation	When women control the family income, children's health and nutrition improve at a greater rate.
08	Good jobs and economic activity	Access to safe water and sanitation is a prerequisite for good nutrition.
12	Responsible consumption	High levels of malnutrition in some countries may result in as much as 11 per cent loss in GDP.
13	Climate action	Tackling resource use and degradation are both critical for sharing resources and improving access to adequate food, health, water and sanitation.
15	Life on land	Climate change may reduce food production, cause water scarcity and increase disease causing vectors.
16	Peace and justice	Soil degradation threaten our ability to grow food.
17	Partnership for the goals	War and conflict are among the major underlying causes of nutrition insecurity.
		Aid allocated to nutrition has high returns: a \$1 investment in nutrition has demonstrated a \$16 return in economic growth.

## 1.4 The Zanzibar policy and legal frameworks for nutrition actions

### High-level multisectoral frameworks

Although the Constitution of Zanzibar does not specifically mention the right to food and nutrition, Article 10. (6) on health, educational and cultural objectives states that the Revolutionary Government of Zanzibar (RGoZ) shall direct its policies towards ensuring that every person has access to adequate health care and equal educational opportunity and that Zanzibar's culture is protected, enhanced and promoted. This policy trajectory has broad implications for nutrition.

More specifically, the ZMNSAP is guided by three overarching policy frameworks:

- a) **Zanzibar Development Vision 2020** reconciles a long-term focus on attaining sustainable human development with a focus on reducing extreme poverty in both rural and urban areas in the short term. The initial Vision 2020 did not specifically address issues of nutrition, but did lay the foundation for that to happen under MKUZA. However, the October 2011 “Revisited Zanzibar Development Vision 2020” working document, clearly spells out the Vision’s long-term policy development for children: full access to quality education, quality health and water services and nutritious food, all of which are crucial for their future health and for ensuring that they lead productive lives.
- b) **Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP or MKUZA in Kiswahili)**, is the second stage of the national development framework to implement Vision 2020. Food security is included in MKUZA II as one of the four cross-cutting issues (alongside gender, HIV/AIDS and environment). MKUZA II elaborates on tackling food security from a cross-sectoral perspective and stresses the symbiotic linkages between poverty reduction, food security and nutrition. It also calls for the development of a framework to tackle these issues. MKUZA III<sup>7</sup> Key Result Area C (4.1.6) focuses on attainment of national and household food security and nutrition for all. It recognizes that “stable national food security and nutrition are fundamental to ensure active participation of citizens in support of Government efforts to eradicate poverty”.
- c) **The 2008 Zanzibar Food Security and Nutrition Policy and Implementation Programme (ZFSNP-IP)** was formulated within the context of Vision 2020 and MKUZA I, both of which guide the development agenda and initiatives of the Government. The ZFSNP-IP was formulated in the context of international commitments, conventions and a series of national policies and strategies in order to establish an enabling environment for sustainable development. The Policy aims at creating an enabling environment in which all Zanzibaris have access at all times to safe, nutritious and adequate food for active and healthy lives. The Policy is based on a number of principles, such as the recognition of the right to adequate food and nutrition and to a standard of living conducive to an active and healthy life, principles of equity and empowerment and a clear focus on resource-poor households and communities.

These principles guide the implementation process and help the Policy in meeting its objectives. Its implementation has resulted in some notable progress being made in raising awareness about malnutrition, laying of the foundation for multisectoral coordination and delivery of nutrition services and being included nutrition in the social and economic policy agenda<sup>8</sup>.

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<sup>7</sup> The Revolutionary Government of Zanzibar, Zanzibar Strategy for Growth and Reduction of Poverty ZSGRP III (MKUZA III), 2016–2020

<sup>8</sup> Susanne Boetkees (2008). Placing Food Security and Nutrition on Zanzibar’s Development Policy Agenda: A Case Study of Successful Policy Development. Maarten IMMINK, December 2008.

**The Zanzibar Multisectoral National Nutrition Strategy (ZMNNS)** for the period 2013–2018<sup>9</sup> succeeded the ZFNSP-IP (2008–2013). *The overall objective of the ZMNNS was to strengthen and increase the capacity of the RGoZ at all levels and across various sectors for scaling up nutrition interventions and services to improve nutritional status.* Since the ZFNSP is still in use, the ZMNNS was developed to support the implementation of the ZFNSP the same way the current ZMNSAP is meant to aid the ZMNNS. While the ZFNSP-IP and ZMNNS were implemented within the context of the **Millennium Development Goals (MDGs)**, its successor, the **ZMNSAP 2020/2021 – 2024/2025**, will be implemented in the context of the **Sustainable Development Goals (SDGs) of Agenda 2030**, the World Health Assembly (WHA) 2025 nutrition targets and the African Union’s Nutrition Strategy (2016–2025) and Agenda 2063 among others. The ZMNNS was also reviewed while developing this ZMNSAP; the outcome of the review is presented later in the document.

## **Sectoral policies, strategies and action plans relevant to nutrition**

### **President’s office – Regional Administration, Local Government and Special Departments (PO–RALGSD)**

Given that the ZMNSAP is multisectoral and community-centred, the PO–RALGSD is crucial for coordination and implementation of policies laid down by the 2014 Zanzibar Local Government Policy (ZLGP) at the sub-national level. This policy is a vehicle for delivering administrative and fiscal responsibilities and services to the people by increasing their ownership and participation in planning, implementing, monitoring and evaluation. The policy guides the governance and administration of local government authorities (LGAs) and addresses those institutional and legal issues and challenges that may affect the efficiency and effectiveness of the local government system in Zanzibar, based on the principle of decentralization by devolution (D & D). Moreover, the policy defines roles and relationships between different stakeholders including key non-state actors and civil society groups in local governance, which will support the ZMNSAP principle of one plan, one coordinating mechanism and one M&E framework.

Other key roles of LGAs that the policy facilitates in implementing the ZMNSAP include:

- i) resource mobilization and allocation to nutrition in accordance with the priorities identified by the ZMNSAP
- ii) routine monitoring of implementation of nutrition-sensitive national policies, strategies, and action plans at the LGA level
- iii) periodic data gathering to provide evidence for reviews of the Zanzibar Food and Nutrition Security Policy(ZFNSP) and the ZMNSAP
- iv) reviewing, evaluation and impact assessment based on the CRAF of the ZMNSAP

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<sup>9</sup> RGoZ (2013): Multi–sectoral National Nutrition Strategy & Costed Implementation Plan (2013–2018). September 2013.

## Health sector

The Health policy of 2011 includes nutrition as an integral part of the Zanzibar Health Sector Strategic Plan III 2013/14–2018/19,<sup>10</sup> with the theme: *“The right to quality health care for better health outcomes.”* The nutrition improvement programme of the Zanzibar Health Strategic Plan III (ZHSSP III) had the broad objective of improving the nutritional status of the Zanzibaris by over 70 per cent by 2018 to contribute to the economic growth of the nation. The key strategies included micronutrient supplementation (vitamin A, iron/folic acid) to the appropriate age groups, promotion of micronutrient food fortification including promotion of salt iodation, improvement in infant and young child feeding (IYCF), management of acute malnutrition and the control and management of DRNCDs. This ZMNSAP reinforces the progress made in these areas.

## Agricultural sector

The **2003 Zanzibar Agriculture Sector Policy** aimed at promoting sustainable development of the agricultural sector for economic, social and environmental benefits. To ensure basic food security at the national, local and household levels, the policy had a specific objective of attaining household and national food security and improving the nutritional status of the people, especially of children and lactating mothers. In 2010, Zanzibar also developed the **“Zanzibar Agricultural Transformation Initiative (ZATI)”** that outlined and prioritized strategic interventions towards agricultural transformation and commercialization aiming to achieve a “Zanzibar Green Revolution,” as articulated in the Zanzibar Development Vision 2020 and the Zanzibar Agricultural Sector Strategic Plan (ZASSP). The key factors identified as necessitating a Zanzibar Green Revolution were: (i) agriculture as a support sector for economic growth and food security, and (ii) agriculture as a source of livelihood.

The 2008 ZFSNP-IP (mentioned earlier) was formulated under the Ministry responsible for agriculture that remains the coordinating Ministry for the policy.

## Ministry responsible for Industry, Trade and Marketing

Since this Ministry has a significant role in food processing and marketing, issues related to salt iodization and overall food fortification will fall under this ministry. Ensuring that the salt produced or imported for human and animal consumption is iodized will address the problem of iodine deficiency disorders. Fortification of maize and wheat flour with essential micronutrients like iron, folic acid, zinc, B vitamins will address the problem of micronutrient deficiencies through a population-based approach.

Moreover, the 2016 National African Growth and Opportunity Act (AGOA) Strategy for the United Republic of Tanzania has an agro-processing component that covers a substantial number of potential subsectors including horticultural products, spices and medicinal herbs, essential oils and nuts. The objective is to enhance the competitiveness of the agro-processing sector

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<sup>10</sup> RGoZ (2013). Zanzibar Health Sector Strategic Plan III 2013/14–2018/19. July 2013

so that it can take full advantage of the 2000 African Growth and Opportunity Act (AGOA) export opportunities to the USA. It is expected that gains from this opportunity will support the importation of diverse types of nutritious foods, given that Zanzibar is dependent on food imports for its food security.

### **Second Vice President's Office (SVPO)**

Having taken the lead in the development of the ZMNSAP, the SVPO, through being chair of the Intersectoral Steering Committee (ISSC) will ensure multisectoral policy implementation and M&E coordination, linkage to the National Development Agenda (MKUZA), and will promote budgetary allocation. The SVPO also coordinates implementation of the 2011 *Zanzibar Disaster Management Policy*, which includes a component on responding to the nutritional impact of food shortages such as that experienced in 2008 due to global economic crisis and erratic rainfall. The SVPO has already acknowledged the negative impact of climate change on food security and will promote policy measures that address environmental and climate change challenges related to nutrition.

### **The Education sector**

The *2006 New Education and Vocational Training Policy* expounds on education as a right and issues like access, quality, gender and geographical equity related to education. Policy recommendations relevant to nutrition include protection through education on HIV and AIDS, universal secondary education up to ordinary level and preschool and early childhood education and development (ECED) as part of basic education. Additionally, the Zanzibar Education Development plan II<sup>11</sup> recommends development of a comprehensive, multisectoral school strategy on student health, nutrition, protection, reproductive health and sanitation and hygiene and extension of a school-feeding programme to all students in need.

## **1.5 Method used in developing the ZMNSAP**

The ZMNSAP formulation process was largely consultative and views were sought from a broad range of stakeholders. As a first step, a lead facilitator<sup>12</sup>, a technical facilitator<sup>13</sup> and four task team facilitators<sup>14</sup> were recruited to support the Zanzibar formulation team on technical issues. The process was based on an agreed roadmap (see *Figure 3*).

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<sup>11</sup> Zanzibar Education Development Plan II 2017/2018–2021/2022

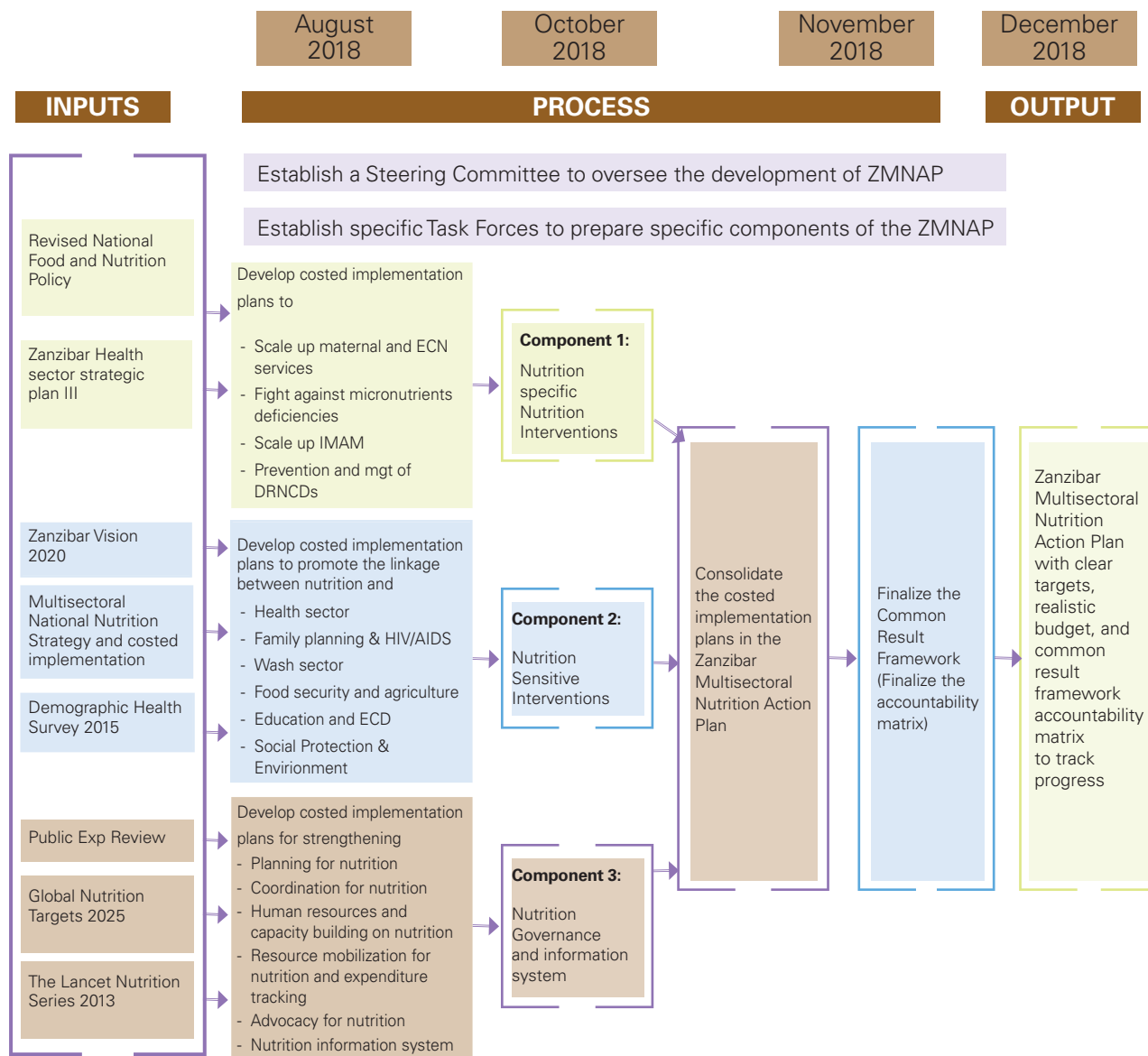
<sup>12</sup> The Lead Facilitator is Dr. Festo Patrick Kavishe. He was also Lead Facilitator for the development of the National Multi-sectoral Nutrition Action Plan (NMNAP) 2016/17–2020/21 for the Tanzania Mainland and also for the Kenya Nutrition Action Plan (ZMNSAP) 2018/19– 2023/24.

<sup>13</sup> The Technical Facilitator is Dr. Joyceline Kaganda who was the TFNC Coordinator of the NMNAP.

<sup>14</sup> Technical key result area facilitators were: Dr. Joyceline Kaganda from MoHCDGEC as lead and the following from TFNC – Dr. Fatma Abdallah, Mary Kibona and Adam Hancy.



**Figure 3: Roadmap for the preparation of the ZMNSAP**



The drafts of the ZMNSAP documents were compared, consolidated and validated over four workshops chaired by the Vice President's Office in coordination with the Secretariat, led by the MoH. The workshops were as follows:-

- First – **inception workshop** – agreed on a roadmap and reviewed the 2013–2018 Zanzibar National Multisectoral Nutrition Strategy (ZNMNS) after which the lead facilitator developed draft 1.
- Second – **drafting workshop** – reviewed draft 1, agreed on the document outline, KRAs, work plan and accountability for further drafting. The lead facilitator then developed draft 2.
- Third – **consolidation workshop** – reviewed draft 2, agreed on the common results, targets and work plan for developing draft 3. The lead facilitator then developed draft 3.
- Fourth – **validation workshop** – opened by the Director of Clinical Services in the MoH and closed by the Deputy Principal Secretary in the Second Vice President's Office (VPO); the workshop reviewed and validated draft 3. After that the lead facilitator developed the final draft (draft 4), it was circulated and the comments received were incorporated into the final document.

The inception workshop held for a large group of national stakeholders in July 2018 was particularly useful in setting the tone and direction of the ZMNSAP. In the inception workshop, the preliminary concept notes of the ZMNSAP were presented and discussed. The workshop also informed key actors about the development of the ZMNSAP and sought their ratification for the process and method.

The key outcomes of the inception workshop were that the stakeholders:

- (i) Agreed to regard the existing Intersectoral Steering Committee (ISC) established under the Food Security and Nutrition Act of July 2011 as the high-level coordination body for the ZMNSAP. The ISC consists of Permanent Secretaries from nutrition-sensitive sectors and is the Second Vice-President's Office. The ISC is supported by a multisectoral technical committee and a secretariat.
- (ii) Proposed that the Deputy Permanent Secretaries (DPS) be made members of the ISC Secretariat to ensure that the ZMNSAP policy-level decisions are effectively implemented.
- (iii) Proposed the establishment a thematic ZMNSAP working group (TWG) chaired by the DPS-MoH and co-chaired by the DFS&N. It was proposed that the ZMNSAP-TWG Secretariat be co-facilitated by both the nutrition section under the MoH and the M&E section of the Food Security and Nutrition Department. Members were to be from the Second Vice President's Office; President's Office – Regional Administration, Local Government and special departments of the RGoZ; Line Ministries (Ministry of Agriculture, Natural Resources, Livestock and Fisheries, Ministry of Health; Ministry of Finance and Planning; Ministry of Education and Vocational Training; Ministry of Land, Housing, Water and Energy; Ministry of

Trade and Industry; Ministry of Labour, Investment, Elderly, Women and Children; Ministry of Infrastructure Communications and Transport; and Ministry of Information, Tourism and Heritage); from development partners, academia, civil society organisations (CSOs) and the private sector.

- (iv) **Established four technical task teams which facilitated the** development of the costed implementation plans for specific components (KRAs) of the ZMNSAP:
- a. the first task team developed action plans on maternal and early childhood nutrition services (MECNS – KRA 1) and integrated management of acute malnutrition (IMAM – KRA 2)
  - b. the second task team developed plans on “nutrition services among school-age children, adolescents and women, with a focus on micronutrient deficiencies (KRA 3) and diet-related non-communicable diseases (DRNCDs – KRA 4)
  - c. the third task team developed components on multisectoral nutrition-sensitive interventions (KRA 5)
  - d. the fourth task team developed action plans on multisectoral nutrition governance (KRA 6) and multisectoral nutrition information systems (KRA 7)

**A technical facilitator from the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) coordinated and guided the technical aspects of the plans of the different KRAs** including the development of a roadmap, governance structure, assigning responsibilities to different stakeholders and guiding their work towards a costed action plan. The technical facilitator also guided task team 3 which developed action plans for multisectoral nutrition-sensitive interventions (KRA 5). **Task team facilitators** from Tanzania Food and Nutrition Centre (TFNC) facilitated the other three teams. The support of the task team facilitators, who were guided by the lead and technical facilitators, included (i) analysis of the current situation and implementing approaches, strategies and gaps related to specific key result areas; (ii) formulation of expected outcomes, outputs, indicators and activities for specific thematic areas; (iii) development and working out of the costing for the detailed work plans; (iv) holding regular sessions to review how far writings on the proposed theme had progressed; and (v) holding validation meetings with other key stakeholders (under various thematic areas).

The **lead facilitator** supported the technical facilitator during key meetings, workshops and events related to the development of the ZMNSAP and especially in the formulation of SMART results. He also wrote the ZMNSAP analytical narrative identifying key issues, their impact and possible actions that could be included in each KRA; consolidated the costed action plans for the seven KRAs and synthesized all inputs into a final ZMNSAP document.

## 1.6 Review of the Zanzibar National Multisectoral Nutrition Strategy (ZNMNS) 2014–2018

Although no formal evaluation of the previous ZNMNS (2014–2018) was done, the inception workshop reviewed the progress made, challenges faced, opportunities and lessons learnt during the development of the new ZMNSAP. As will be seen later, there was good progress in addressing stunting, issues of IYCF, coverage in vitamin A supplementation and deworming and availability of nutrition commodities.

Key challenges to the ZNMNS and lessons learnt during its implementation were:

1. **Inadequate multisectoral coordination and collaboration:** Although multisectoral coordination structures were established at all levels as part of the implementation of the ZFSNP Programme (2010–2014), they did not function as envisaged. As a result, multisectoral collaboration was weak. The new ZMNSAP will revamp the established coordination mechanisms and make them functional, collaborative and effective.
2. **Weak monitoring, evaluation, accountability and learning (MEAL) mechanism:** There was no M&E mechanism and because of weak coordination, it was difficult to know what was happening in the ZNMNS implementation, who was responsible, and what needed to be done to address the situation. Moreover, there was lack of accountability and learning. To address these issues, the ZMNSAP has introduced the CRAF to support results-based management (RBM) to track progress. Moreover, the ZMNSAP has proposed an elaborate monitoring, evaluation, accountability and learning (MEAL) framework with annual, mid-term and end MEAL periods, which will involve all key stakeholders. Additionally, the ZMNSAP has proposed a risk analysis matrix that identifies possible implementation risks and mitigation measures.
3. **Poor advocacy, communication and dissemination of the ZNMNS:** Very few of the inception workshop participants were aware of the existence of the ZNMNS and its coordination structures. The ZMNSAP prioritizes communication and public awareness measures to educate policymakers and the public on nutrition issues. The ZMNSAP also calls for political support in its implementation including resource allocation, coordination, accountability and M&E.

## 1.7 Target audience for the ZMNSAP

Being a national-level action plan, the audience for the ZMNSAP comprises several key players, such as political leaders, policymakers and implementers in nutrition-sensitive sectors at both the national and LGA levels. Development partners, CSOs and relevant private sector actors will find the 2020/2021 – 2024/2025 ZMNSAP useful in their efforts to improve the overall nutritional status in Zanzibar.

# 2

## ZANZIBAR'S NUTRITION SITUATION ANALYSIS

### 2.1 Zanzibar's population and groups most vulnerable to malnutrition

Zanzibar comprises two major islands: Unguja and Pemba. Zanzibar is also known as the "spice islands" because the area is a major producer of spices. The population of Zanzibar was estimated to be 1.3 million during the 2012 census. With an annual population growth rate of 2.8 per cent, it was projected that the population of Zanzibar would reach 1.5 million by 2019. In the past, over 65 per cent of the population was rural and dependent on subsistence fishing and agriculture. However, the urban population has grown rapidly and it was estimated to have declined to 44 per cent in 2019. Urbanization is largely responsible for increase in instances of obesity and overweight. Although much progress has been made in addressing poverty, about 11 per cent of the population still lives below the food poverty line and 30 per cent below the national basic-needs poverty line.

The population groups most affected by undernutrition are children under the age of 5 and women in the reproductive ages, especially pregnant women. Poor and uneducated households are particularly vulnerable to undernutrition. However, in recent years there has been a dramatic increase in the prevalence of overweight, obesity and DRNCDs, which mainly affect women of reproductive age and adult men. In most cases, Pemba has higher levels of undernutrition than Unguja. This ZMNSAP addresses all forms of malnutrition in all population groups, especially focusing on those groups that are the most vulnerable. The section below elaborates on the nutrition situation and trends in Zanzibar.

### 2.2 Triple burden, triple duty action

Like in mainland Tanzania, Zanzibar suffers from the triple burden of malnutrition: (i) protein energy undernutrition manifested in high levels of stunting, wasting and underweight, (ii) micronutrient deficiencies, especially of iron, folic acid, vitamin A and iodine; and (iii) overweight/obesity and DRNCDs. The DRNCDs comprise a group of diseases for which overweight and

obesity are the major risk factors. The group includes cardiovascular diseases (elevated blood pressure, stroke and heart attacks), type 2 diabetes, and several forms of cancer. A triple burden requires a triple duty action that addresses all three forms of malnutrition as this ZMNSAP proposes to do.

## 2.3 Trends in stunting, underweight, wasting and low birthweight among children

According to the 2015/16 TDHS-MIS, the prevalence of **stunting (also called chronic malnutrition)** in Zanzibar (24 per cent) was much lower than in Tanzania mainland (34 per cent), the percentage of the underweight population was the same (14 per cent) in both the regions and the prevalence of wasting in Zanzibar (7 per cent) was higher than in the Mainland (5 per cent) (Table 4). Kaskazini Pemba had the highest rate of stunting (34 per cent), followed by Kusini Unguja (27 per cent), Kusini Pemba (24 per cent), Kaskazini Unguja (23 per cent) and Mjini Magharibi (17 per cent). **Wasting (also known as acute malnutrition)** was higher in Zanzibar (7 per cent) than in the Mainland (4 per cent). High rates of wasting were observed in Kusini Pemba and Kaskazini Pemba (9 per cent each) and Kusini Unguja (8 per cent). Overall, Pemba had a higher rate of stunting (29.5 per cent), wasting (8.9 per cent) and underweight (15.7 per cent) than Unguja where the rate of stunting was 20 per cent, that of wasting was 6 per cent and the rate of underweight was 12.7 per cent (see Table 5).

**Table 4:** The prevalence of nutrition indicators in Tanzania Mainland and Zanzibar

Main sector's indicators for children	Mainland	Zanzibar	Source
Stunting (Children under five years)	34%	24%	DHS 2015/16
Global Acute Malnutrition (GAM), Children < 5 yrs)	5%	7%	DHS 2015/16
Severe Acute Malnutrition (SAM), Children < 5 yrs)	1%	2%	DHS 2015/16
Obesity (women of reproductive age 15-49 years)	10%	20%	DHS 2015/16
Anemia (Children < 5 years)	58%	65%	DHS 2015/16
Anemia (Women of reproductive age 15-49 yrs)	44%	60%	DHS 2015/16
Exclusive breastfeeding (children under six months)	59%	6%	DHS 2015/16
Minimum accepted diet (children 6-23 months)	9%	8%	DHS 2015/16
Iron tablets for 90+ days during last pregnancy	21%	20%	DHS 2015/16
Households with adequately iodized salt	61%	38%	DHS 2015/16
Vitamin A supplementation (children 6-59 months)	72%	61	TNNS (2014)

**Table 5:** Comparing the nutrition status of Unguja and Pemba

Nutrition status	Unguja	Pemba
Stunting	20%	29.5%
Underweight	12.7%	15.7%
Wasting	6%	8.9%

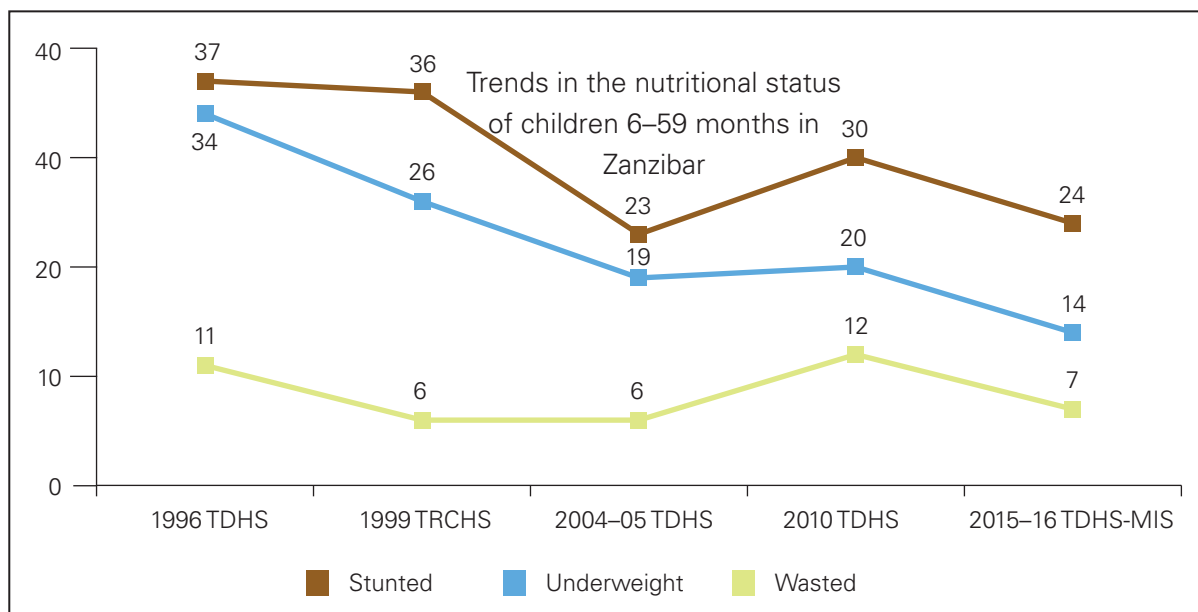
Based on the new prevalence global thresholds<sup>15</sup>, in Zanzibar, the rate of stunting (24 per cent) is categorized as high and the rate of wasting (7 per cent) is categorized as medium in terms of public health significance. Children under the age of 5 comprise 15.6 per cent (234,000) of the total population. Of the 234,000 children under the age of 5, 56,160 (24 per cent of 234,000) children are stunted and 16,380 (7 per cent of 234,000) are wasted.

According to the 2015/16 Tanzania Demographic and Health Survey (TDHS), the prevalence of **low birth weight (LBW)** was 4 per cent. However, the 2018 Tanzania National Nutrition Survey (TNNS) found that the rate of LBW was higher (an average of 8.3 per cent, ranging from 7.4 per cent in Pemba North to 8.5 per cent in Unguja North) than in the Mainland (6 to 7 per cent) between 2010 and 2015. LBW is a birth weight of 2.5 kg or less and is a measure laid out by the public health service delivery and healthcare system. Birth weight is a powerful predictor of newborn survival and growth and is associated with multiple factors. Key ones include maternal nutritional status and conditions like short stature, anaemia, parity, birth interval, multiple pregnancies, adolescent births, hypertension, diabetes and other diseases during pregnancy. Main diseases during pregnancy that can cause LBW in the Tanzanian context include anaemia, malaria and AIDS among others.

Taking 1996 as the baseline, the trends of stunting, underweight and wasting show much improvement, though the levels are still unacceptably high from a public health perspective (see *Figure 4*).

<sup>15</sup> UNICEF (2018): New Prevalence Thresholds for Stunting, Wasting and Overweight in Children. In UNICEF—Working to improve nutrition at scale: Issue 24, 13 December 2018. [https://us14.campaign-archive.com/?e=\[UNIQID\]&u=fb1d9aabd6c823bef179830e9&id=c74c174635](https://us14.campaign-archive.com/?e=[UNIQID]&u=fb1d9aabd6c823bef179830e9&id=c74c174635)

**Figure 4:** Trends in the nutritional status of children 6-59 months in Zanzibar



According to the TDHS 2015/16, the literacy of the mother and family income are the major determinants of stunting, underweight and wasting among children. The indicators improve when a mother’s education level and the wealth quintile of the household go up. A recent (2018) analysis of the past and future drivers of stunting in Tanzania identified multiple factors<sup>16</sup> that led to improvement. Key ones include improvements in birth weight (indicating improved maternal nutrition as reflected in healthy weight gain during pregnancy), improved overall health care (reflected in the negative correlation of stunting to improvements in HIV indicators, health facility assisted births, and ANC blood tests), improvements in prevention and control of malaria (negative correlation of stunting to antimalaria interventions, such as bed nets and intermittent preventive treatment in pregnancy-IPTp), and overall socioeconomic progress due to improved household wealth and education. However, quantitative analysis has not explained many aspects of the drivers and further qualitative studies are needed. Interventions to reduce growth faltering between ages 6–24 months (the period of complementary feeding) could also reduce the prevalence of stunting.

## Underweight among adolescents and women of reproductive age

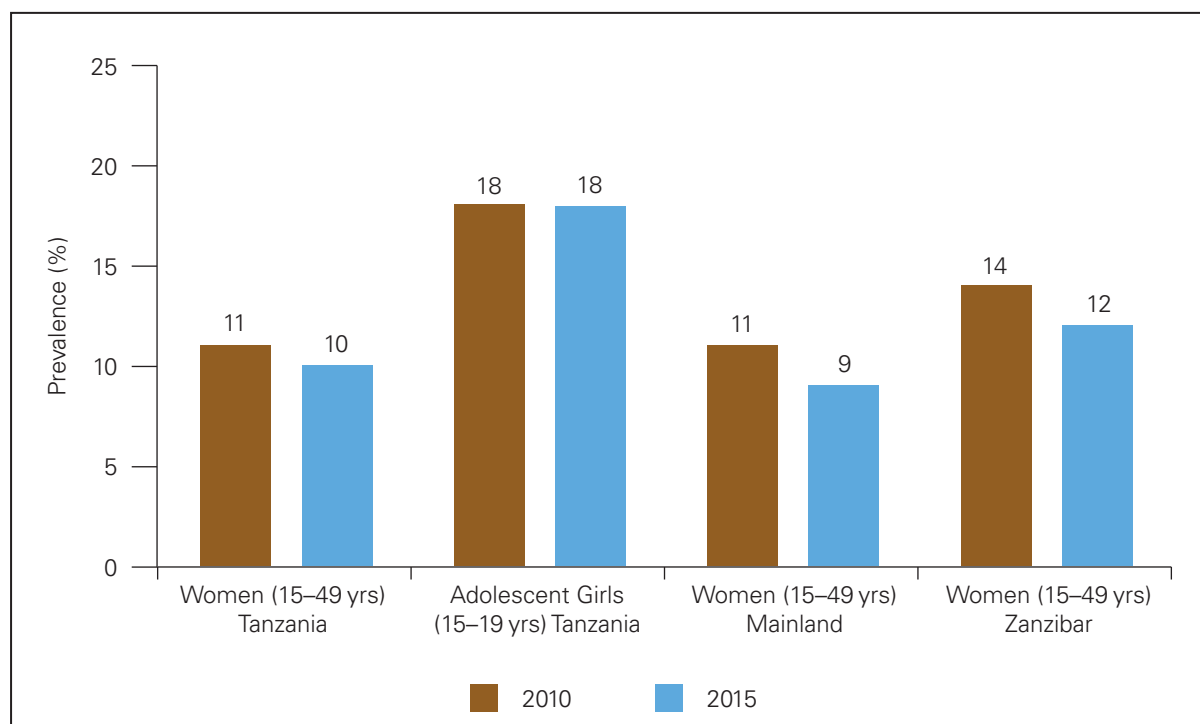
Moreover, according to the TDHS 2015, adolescent girls aged 15–19 years (18 per cent) were worse affected by undernutrition than women aged 20–49 years (7 per cent). With regard to

<sup>16</sup> Derek D. Headey; Jessica Heckert; Anna Folke Larsen; and Dolf te Lintelo (2018). Analysis of the drivers of change in nutrition status of children & women in Tanzania. Findings from a report commissioned by UNICEF. IFPRI



geographic disparities, the prevalence of undernutrition among women aged 15–49 years was higher in Zanzibar (12 per cent) than in the Mainland (9 per cent). The same trend is observed for overweight/obesity: obesity is more prevalent in Zanzibar (39 per cent) than in the Mainland (28 per cent).

**Figure 5:** Trends in prevalence of BMI <18.5 in women in Tanzania 2010-2015



(Source TDHS 2010 & 2015/16)

## 2.4 Micronutrient deficiencies

The micronutrient deficiencies of known public health significance in Zanzibar are of iron and folic acid (resulting in anaemia), vitamin A deficiency and iodine deficiency disorders (IDD). Data does not exist for deficiencies of other micronutrients like zinc, the B-complex vitamins, vitamin D, calcium and others. *Table 6* shows the extent of the common micronutrient deficiency problems in Zanzibar and the Tanzania mainland.

**Table 6: Micronutrient situation in Zanzibar**

Micronutrient indicator	National (Mainland + Zanzibar)	Mainland	Zanzibar	Pemba	Unguja	Source
Anemia in children (6-59 months)	57.7%	57.4%	64.5%	69.1%	61.8%	TDHS 2015/16
Anemia in women of reproductive age (15-49 years)	44.8%	44.3%	60.1%	66.2%	57.8%	TDHS 2015/16
Children dewormed (6-59 months) to address anaemia	37.6%	36.9%	61.6%	64%	60.2%	TDHS 2015/16
Iron tablets for 90+ days during last pregnancy	21.4%	21.4%	20.4%	13.4%	24%	TDHS 2015/16
Households with adequately iodized salt	60.6%	61.2%	37.5%	20.4%	45.9%	TDHS 2015/16
Vitamin A supplementation (Children 6-59 months)	41.2%	40.9%	51.9%	47.1%	54.7%	TDHS 2015/16

In most cases, Zanzibar has higher rates of micronutrient deficiencies than the Mainland and Pemba's situation is worse than Unguja's. As for stunting, wasting and underweight, levels of education and wealth at the individual and household levels determine the prevalence of micronutrient deficiencies.

The commonest micronutrient deficiencies are explained in a more detailed manner below.

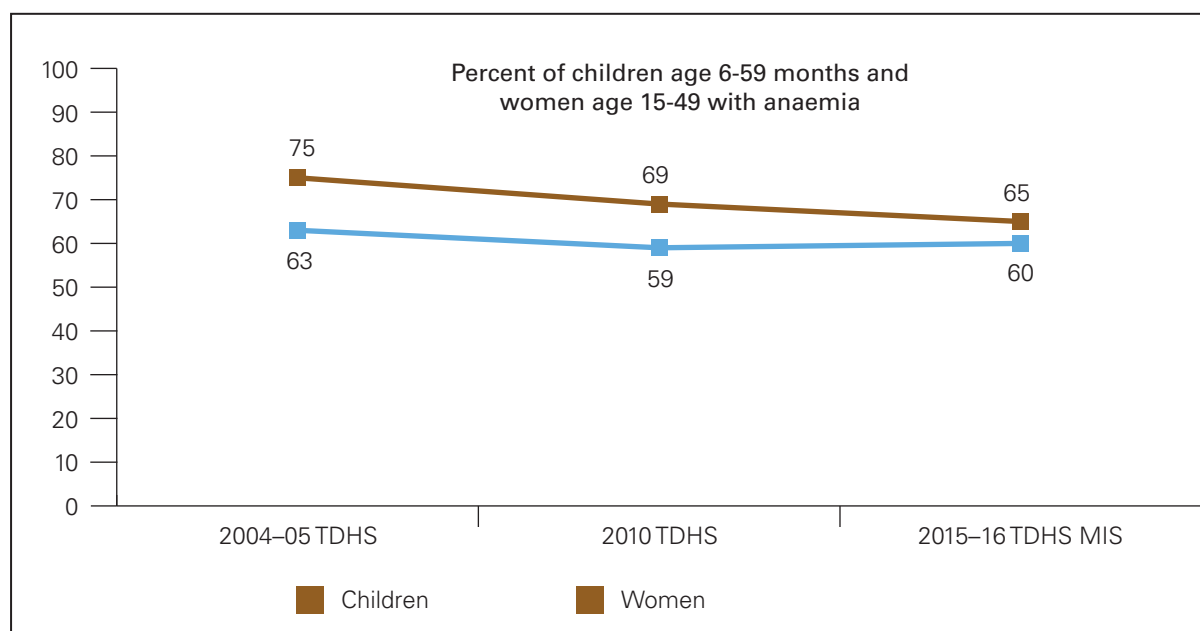
### Anaemia

According to the 2015/16 TDHS-MIS, the indicators of anaemia in Zanzibar are greatly disturbing, especially in children under the age of 5, women of reproductive age and pregnant women and especially so, because the situation has stagnated during the last decade (see *Figure 6*). In the 2015/16 TDHS, the prevalence of anaemia in children aged 6–59 months averaged at about 65 per cent in Zanzibar compared to 58 per cent in the Mainland. Kaskazini Pemba had the highest prevalence (70 per cent) followed by Kusini Pemba (68 per cent), Kaskazini Unguja (65 per cent), Kusini Unguja 62 per cent and lastly Mjini Magharibi at 61 (per cent). For women in the reproductive age group (15–49 years), women in Zanzibar (60 per cent) are more likely to be

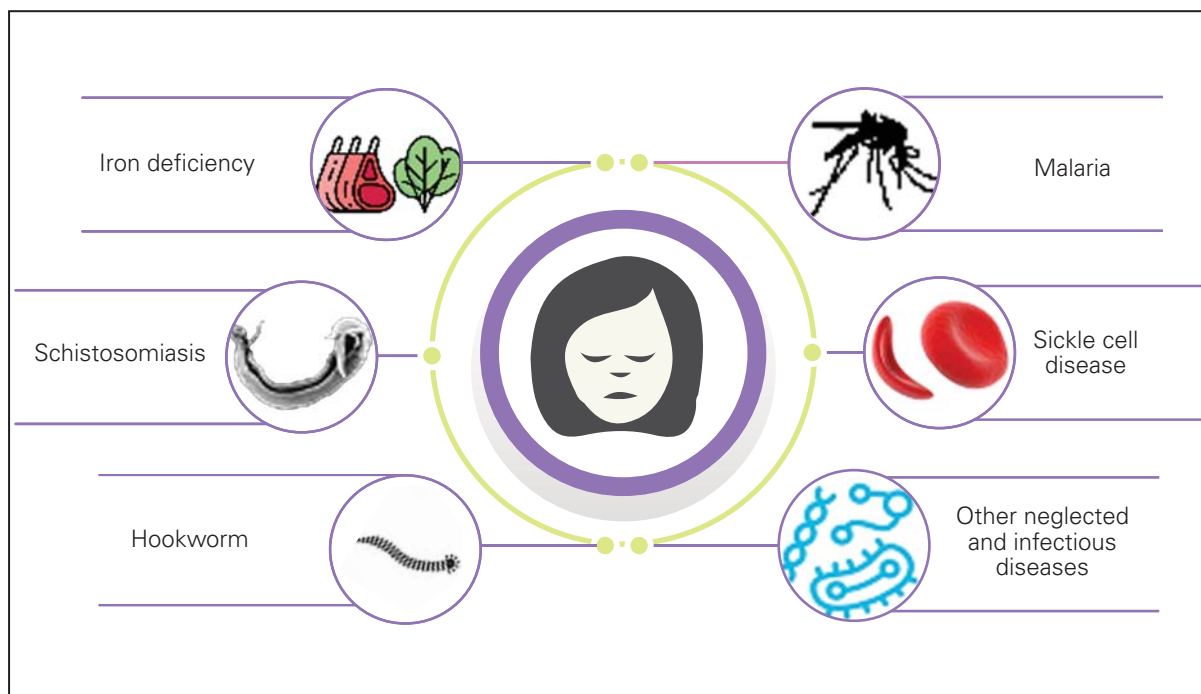
anaemic than women in Tanzania mainland (44 per cent). Very high prevalence rates are found in Kaskazini Pemba (72 per cent), followed by Kusini Pemba (61 per cent), Kaskazini Unguja (60 per cent), Mjini Magharibi (58 per cent) and Kusini Unguja (55 per cent).

Given that Zanzibar has made excellent progress in the control of malaria and deworming, which are high-risk factors for anaemia, the major reason for high anaemia prevalence rates in Zanzibar is likely to be poor dietary quality and diversification. A recent study (2018) done by the International Food Policy Research Institute (IFPRI) and supported by UNICEF, found that the main drivers of anaemia among women in Tanzania were iron deficiency, schistosomiasis, malaria, hookworm, sickle cell disease and other neglected tropical diseases (NTDs) (see *Figure 7*). Other drivers were use of contraceptive hormones and pregnancy

**Figure 6:** Trends in anaemia among children and women n Zanzibar



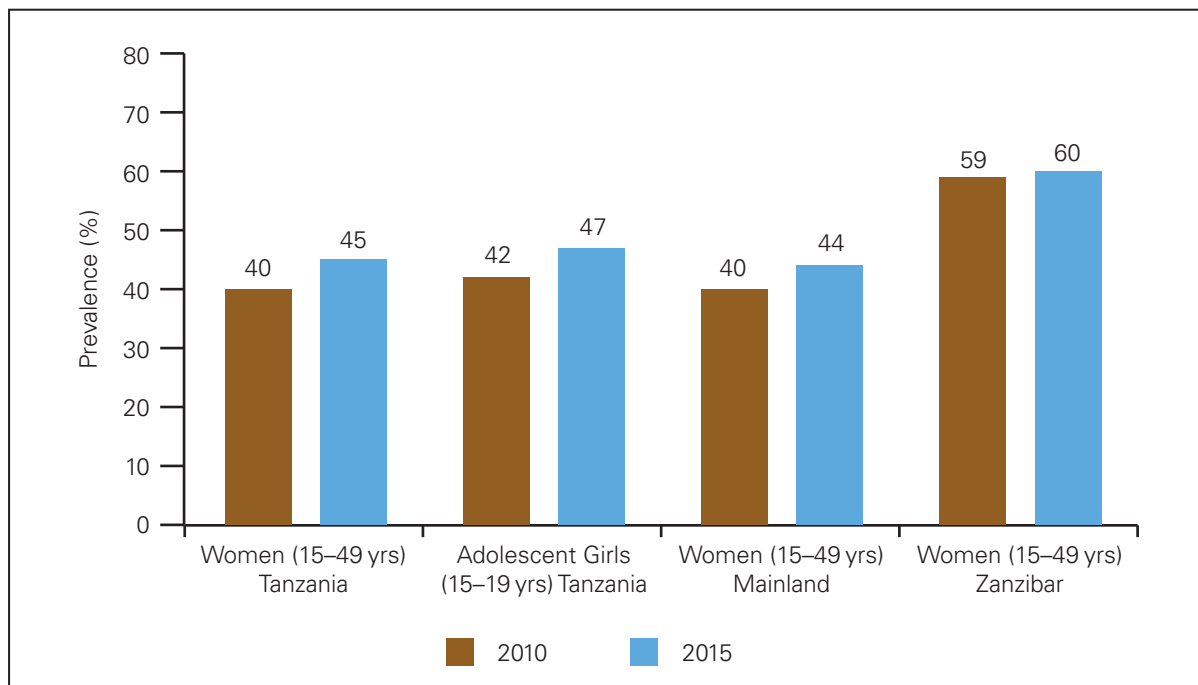
**Figure 7:** Primary drivers of the anaemia situation in Tanzania



Between 2010 and 2015, the prevalence of anaemia and prevalence of overweight/obesity among adolescent girls aged 15–19 years have increased from 42 per cent to 47 per cent and from 9 per cent to 11 per cent respectively, while prevalence of undernutrition has remained unchanged at 18 per cent.

Moreover, according to the TDHS 2015, adolescent girls aged 15–19 years (47 per cent) were worse affected by anaemia compared to women aged 20–49 years (43–45 per cent). With regard to geographic disparities, the prevalence of anaemia among women aged 15–49 years was higher in Zanzibar (60 per cent) than in the Mainland (44 per cent).

**Figure 8:** Trend on prevalence of anaemia among adolescent girls and women of reproductive age 2010–2015 (TDHS 2010&2015/16)



### Vitamin A deficiency (VAD)

The national prevalence of vitamin A deficiency (VAD) in the 2010 TDHS was 33 per cent among children between 6 and 59 months and 36 per cent among women of reproductive age (15–49 years). In Zanzibar, the prevalence of VAD was 38 per cent. Furthermore, the coverage of Vitamin A supplementation among children aged 6–59 months decreased from 46 per cent in 2005 (TDHS) to 41 per cent in 2015/16 TDHS-MIS. However, the coverage of Vitamin A supplementation in Zanzibar was 52 per cent and has improved significantly in recent years.

Based on the recent 2018 TNNS, the coverage of vitamin A supplements and deworming medicine, which are usually given at the same time, was below 90 per cent nationally. The coverage of vitamin A supplementation in the Mainland decreased from 72.2 per cent in 2014 to 63.8 per cent in 2018, while for Zanzibar the coverage increased from 58.2 per cent to 78.9 per cent during the same period. Nationally, the coverage of deworming decreased from 70.6 per cent in 2014 to 59.0 per cent in the Mainland in 2018, while during the same period, deworming in Zanzibar increased from 68.4 per cent to 80.7 per cent with the highest coverage in Pemba North (85 per cent).

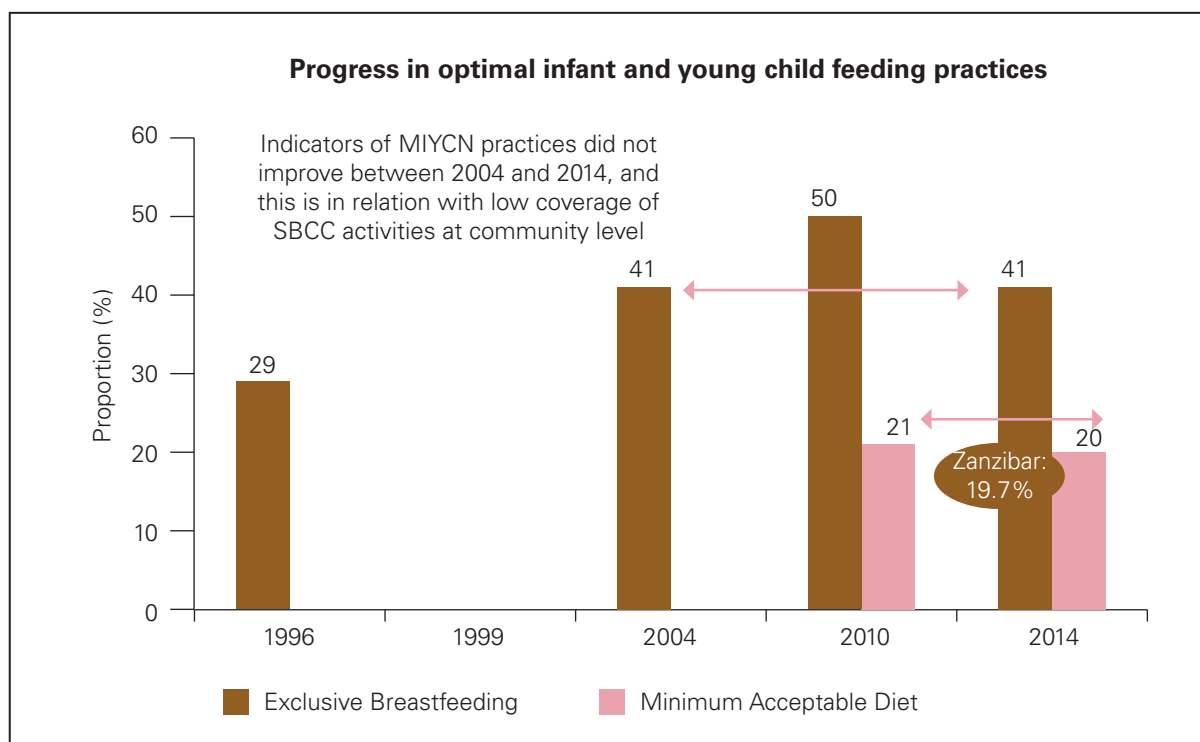
## Iodine deficiency disorders

Laboratory analysis of salt used in households indicated that the proportion of households with iodized salt increased from 90 per cent in the 2010 TDHS to 96 per cent in the 2015 TDHS. Moreover, households with adequately iodized salt (15+ ppm) increased from 47 percent in 2010 to 61 per cent in 2015. In Zanzibar, only 38 per cent of households consumed adequately iodised salt (TDHS, 2015–16) and the data remained almost the same (39 per cent) during the 2018 TNNS. In addition, median urinary iodine concentration for women of reproductive age (15–49 years) increased from 160 µg/L (TDHS 2010) to 180 µg/L (TDHS-MIS 2015–16). For Zanzibar, the median urinary iodine concentration for women of reproductive age was 187 µg/L. The 2018 TNNS did not have biomarkers.

## 2.5 Trends in infant and young child feeding (IYCF) practices

IYCF practices are of concern in Zanzibar given that the proportion of exclusive breastfeeding (EBF) for the first six months of life is extremely low (*Figure 9*). The 2014 TNNS gave an estimate of 20 per cent for Zanzibar and 41 per cent for the Mainland, while the 2015/16 TDHS gave an

**Figure 9:** Trends in IYCF practices in Tanzania



estimate of 6 per cent for Zanzibar and 59 per cent for the Mainland. The most recent 2018 figures for Zanzibar show that EBF has increased from 20 per cent in 2014 to 30 per cent in 2018 (TNNS 2014 & 2018). For purposes of setting targets, we shall use the 2018 TNNS figure of 30 per cent for Zanzibar. The 2025 World Health Assembly global target for EBF is to reach a prevalence rate of 50 per cent or more. As seen in *Table 7*, breast feeding practices are slightly better in Unguja than in Pemba. The main concern in Zanzibar is why EBF is low, while breastfeeding is nearly universal at over 90 per cent, the median duration being 21 months, close to the 23 months recommended by WHO.

**Table 7: Infant and young child feeding (IYCF) practices in Zanzibar: Breastfeeding practice**

Location	% Ever Breastfed	% Initiation within one hour of delivery	% Exclusive breastfeeding (EBF) 0-6 months	Median duration of Breastfeeding (months)
Zanzibar	97.1	46.8	6*	20.6
Unguja	98.7	43.5	6.3*	21.1
Pemba	94.3	52.7	5.6*	18.9

**Source:** Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS 2015-16).

**\*Note:** Prevalence for EBF in Zanzibar in TNNS 2014 was 20%.

In addition, only 12.1 per cent of children, aged 6-23 months, in Zanzibar receive foods from four or more food groups and only 20 per cent receive the minimum acceptable diet which is quite similar to its Mainland counterpart (21 per cent) (TNNS 2014). Overall, indicators of MIYCN practices in Zanzibar did not improve between 2004 and 2014 because of low coverage of social and behaviour communication change activities at the community level (TNNS 2014).

## 2.6 Overweight, obesity and diet-related non-communicable diseases (DRNCDs)

Like other low-income countries, Tanzania has entered that nutrition-transition phase in which unacceptably high levels of undernutrition exist alongside steadily increasing levels of non-communicable diseases (NCDs), most of which are diet-related. Currently, there is a paucity of data regarding the magnitude of DRNCDs in African countries including Tanzania and, therefore, priority, in terms of resources, is being given to those diseases and conditions for which there are more data and which need to be addressed more urgently than DRNCDs. However, this perception is changing, and policymakers and planners are recognizing the existence and consequences of the triple burden of malnutrition and starting to pay close attention to DRNCDs alongside problems of undernutrition.

**Table 8: Risk factors for DRNCDs in Zanzibar**

Main sector's indicators	National	Mainland	Zanzibar	Pemba	Unguja	Source
Total Over weight and Obesity (women 15–49)	28.4%	28.1%	38.9%	31.3%	41.6%	DHS 2015/16
Overweight (women 15–49)	18.4%	18.3%	21.7%	21.5%	21.7%	DHS 2015/16
Obesity (women 15–49)	10%	9.8%	17.2%	9.7%	19.8%	DHS 2015/16
Obesity in under five Children	3.6%	3.7%	2.8%	4%	2.1%	DHS 2015/16
Alcohol consumption	–	29.3%	1.7%	–	–	STEP Survey 2011/12
Members of the community that are physically active	–	83.3%	64.5%	–	–	STEP Survey 2011/12
Hypertension (raised blood pressure)	–	25.9%	33%	–	–	STEP Survey 2011/12
Smoking	–	15.9%	7.3%	–	–	STEP Survey 2011/12
Raised cholesterol	–	26%	24.4%	–	–	STEP Survey 2011/12
Raised blood glucose	–	9.1%	3.7%	–	–	STEP Survey 2011/12

Studies done in Tanzania have shown that the prevalence of DRNCDs and related risk factors, such as hypertension, obesity, diabetes, low physical activity, are especially high in urban areas and in certain high-risk groups. The 2012 Tanzania STEP survey<sup>17</sup> identified relatively higher prevalence levels of selected risk factors associated with NCDs in urban areas and among the wealthy and educated. Diet-related risk factors were: (a) very low intake of fruits and vegetables – only about 2.8 per cent of respondents ate 5 or more servings of fruit and/or vegetables on average per day and as high as 97.2 per cent respondents did not; (b) overweight or obesity (26 per cent); (c) raised cholesterol (26 per cent); and (d) raised triglycerides (33.8 per cent). Other NCD risk factors included tobacco use (15.9 per cent) and alcohol drinking (29.3 per cent). In this survey, the prevalence rates were 9.1 per cent for diabetes and 25.9 per cent for hypertension. *Table 8* summarizes the DRNCDs risk factors from the 2012 Stepwise survey.

<sup>17</sup> Tanzania Steps Survey Report 2012: [https://www.who.int/ncds/surveillance/steps/UR\\_Tanzania\\_2012\\_STEPS\\_Report.pdf](https://www.who.int/ncds/surveillance/steps/UR_Tanzania_2012_STEPS_Report.pdf)



Primary prevention of DRNCDs through targeting the risk factors has been identified as the most cost-effective intervention for controlling the rising burden of NCDs. The World Health Organization STEPS survey is one of the organizations' strategies for combatting NCDs in developing and resource-poor countries..

The same 2018 IFPRI study on drivers of stunting in Tanzania found that *overweight/obesity is rising rapidly especially among the adult female population, and the speed has accelerated in recent years mainly because of improvements in household wealth, TV ownership and fat consumption*. The primary reason for obesity might be changing patterns of work and sedentary lifestyles. Reductions in more arduous employment like firewood and water collection and increase in TV ownership have significantly contributed to the increasingly sedentary way of life. Hence, policies for addressing the obesity epidemic must be holistic and consider both dietary and physical activity issues. Social and behavioural change communication (SBCC) strategies are critical for addressing all forms of malnutrition from childhood to adulthood, integrating information on healthy diets and physical activity. In addition to developing dietary guidelines that target specific populations, TV advertisements and legal restrictions on advertising of unhealthy foods should also be considered.

## 2.7 Causes of malnutrition in Zanzibar

The causes of undernutrition in Zanzibar are multiple and multisectoral– lack of food is not the only reason, as is the popular belief. Children, mostly those under the age of 2, are especially affected by undernutrition because of poor maternal nutrition, unmet physiological needs during the growing years and poor feeding practices for infants and young children. Poor feeding practices include no EBF for the first six months, poor complementary diets and practices in terms of feeding frequency, adequacy and nutrient quality.

In young children, the **immediate causes** are **insufficient dietary intake** and **frequent diseases**. These two causes often occur together and are themselves caused by multiple **underlying factors** including inadequate availability of and access to **nutritious food**, **inadequate care and health services** and an **unhealthy environment**. Other basic causes include poverty, illiteracy, social norms and behaviours.

The main cause of overweight and obesity in both children and adults is an imbalance between calorie intake and expenditure, where intake is high, and expenditure is low. Such an imbalance has resulted from rapid urbanization that has led to an adoption of diets high in sugar, carbohydrates and fats coupled with a sedentary lifestyle and high intake of salt. In addition, poor dietary diversification with low intake of fruits and vegetables, high intake of alcohol, smoking and low physical activity predispose a population to DRNCDs. It should also be noted that stunting during childhood predisposes the child to obesity and other DRNCDs later in life. Individuals with poor dietary habits in their childhood may continue to consume high calorie foods even if the food security situation improves later on in life. Obesity or unnatural weight

gain may also be the result of moving from a high-energy expenditure lifestyle in rural areas to sedentary lifestyles in urban areas.

## 2.8 Malnutrition and childhood and maternal mortality trends

The ultimate manifestation of all forms of malnutrition is increased mortality. **Life expectancy at birth** provides the most useful summary measure of the mortality rate of a country. Estimates based on the 2012 population census<sup>18</sup> showed that overall life expectancy in Tanzania was 61.8 years. It was higher in Tanzania Zanzibar (65.2 years) than in Tanzania mainland (61.7 years). It was also higher among rural populations (62.4 years) compared to urban populations (59.7 years). With regard to sex, there was a difference of approximately four years, with women having higher life expectancy (63.8 years) compared to men (59.8 years), a situation consistent with global trends.

**Childhood mortality reflects** the impact of undernutrition and the inefficacy of public health services. During the last two decades, Tanzania has experienced a substantial reduction in child mortality rates. The infant mortality rate (**IMR**)<sup>19</sup> declined from 89 per 1,000 live births in 2002 to 46 per 1,000 live births in 2012 and under-five child mortality rate (**U5MR**)<sup>20</sup> declined from 141 per 1,000 births to 66 per 1,000 births during the same period (*Figure 10*). The Tanzania TDHS-MIS (2015-16) showed that in Zanzibar the neonatal mortality rate (NMR) was 28 per 1,000 live births, the IMR was 45 per 1,000 live births, child mortality rate (**CMR**)<sup>21</sup> was 11 per 1,000 live births and U5MR was 56 per 1,000 live births. These rates are very similar to those of the Mainland. The same data shows that while neonatal and infant mortality rates per 1,000 births are higher in Unguja (NMR of 33 and IMR of 50) than in Pemba (NMR 19 and IMR of 37), the CMR (7/1,000 live births) in Unguja is lower than in Pemba (18/1,000 live births). In both Unguja and Pemba, the U5MR is very similar: 57 and 54 per 1,000 live births respectively

The reduction in childhood mortality can be attributed to several factors including improved breastfeeding practices, integrated management of childhood illnesses (IMCI), improvements in the control of malaria, diarrhoea and acute respiratory infections. Other factors are high coverage of health services including coverage for immunization and improvements in childhood

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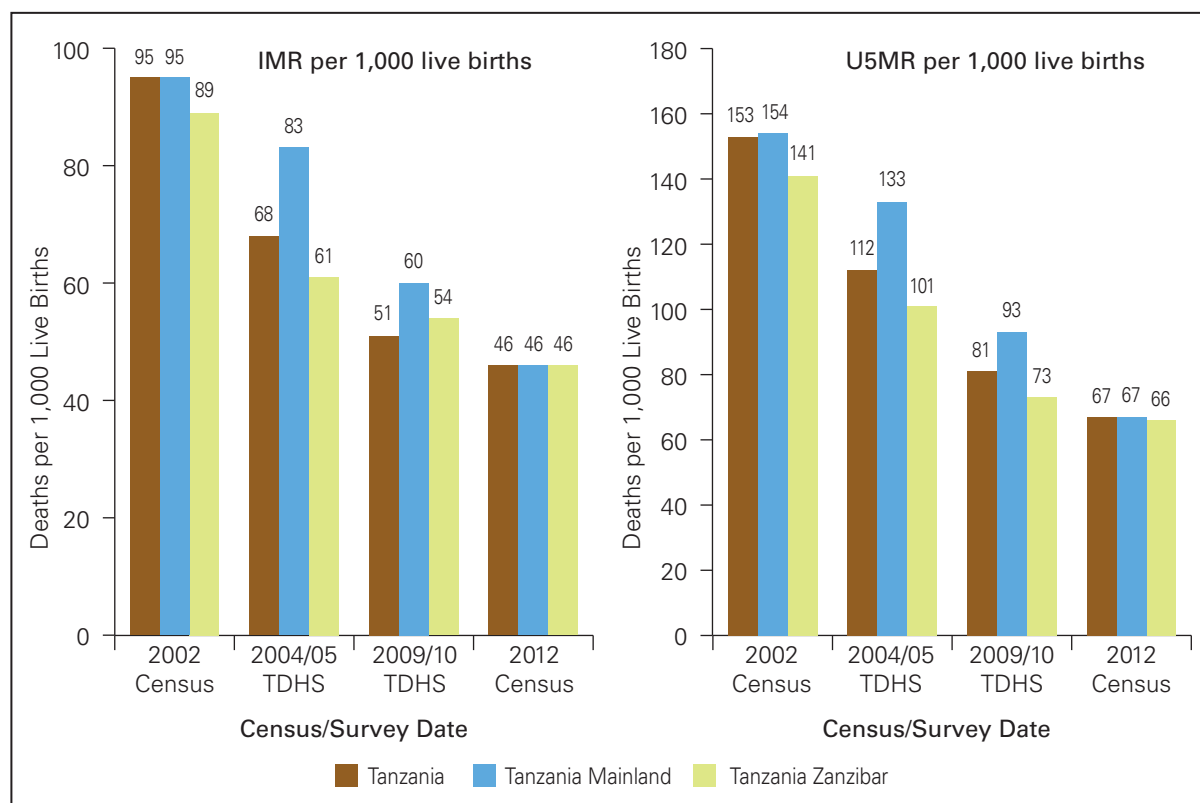
<sup>18</sup> The United Republic of Tanzania (2015): Mortality and Health. National Bureau of Statistics Ministry of Finance Dar es Salaam, and Office of Chief Government Statistician Ministry of State, President Office, State House and Good Governance. July 2015

<sup>19</sup> Infant Mortality Rate (IMR) is defined as the number of deaths of children under one year of age per 1,000 live births.

<sup>20</sup> Under-five Mortality Rate (U5MR) is defined as the probability of dying between birth and age 5, expressed per 1,000 live births.

<sup>21</sup> Child Mortality Rate (CMR) is defined as the number of deaths of children aged 1–4 years per 1,000 live births.

**Figure 10:** Trends in child mortality in Tanzania mainland and Zanzibar



**Source:** Tanzania 2002 and 2012 Population and Housing Censuses and 2004/05 and 2009/10 Tanzania Demographic and Health Surveys

undernutrition among others. However, one in every 15 children still dies before the child’s fifth birthday; and malaria, acute respiratory diseases and diarrhoea persist as the most common childhood illnesses.

**Maternal mortality ratio (MMR)**<sup>22</sup>, on the other hand, has not benefited from these interventions as much as child mortality has. Maternal deaths in Tanzania (with an MMR of 556 per 100,000) constitute 18 per cent of all deaths of women aged 15–49. The main direct causes of maternal deaths are nutrition-related which include haemorrhages, infections, unsafe abortions, hypertensive disorders and obstructed labours. HIV and malaria, the primary causes of fatality in Tanzania, further exacerbate the MMR. The fact that more than half of the births in Tanzania occur at homes also contributes to the elevated maternal mortality rate. Of all pregnant women, only 46 per cent are assisted during childbirth by a doctor, clinical officer, nurse, midwife or maternal and child health aide. Although antenatal care (ANC) coverage is high in Zanzibar (98 per cent of pregnant women make at least one visit to care clinics during their pregnancy) many

<sup>22</sup> Maternal Mortality Ratio (MMR) is defined as the number of maternal deaths per 100,000 live births. A **maternal death** is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

women do not make the recommended four ANC visits. This results in maternal health services remaining underutilized. Major challenges to reducing maternal, newborn and child mortality include limited access to quality health services, a weak referral system and poor health-seeking behaviour among women.

## 2.9 Actions taken to address malnutrition in Zanzibar

The RGoZ has taken many steps to improve the nutrition status for all Zanzibaris with tangible progress in the nutrition situation of children and women.

### **Key nutrition interventions that Zanzibar has implemented include:**

- promotion of better quality infant and young child feeding (IYCF)
- treatment of severe acute malnutrition (SAM)
- routine and biannual nutrition screening of children under the age of 5 during CHNMs
- supplementation of iron and folic acid (IFA) to pregnant women
- vitamin A supplementation to children aged 6–59 months
- mass deworming for children aged 12–59 months
- promotion of universal salt iodization (USI)

### **The main achievements made include:**

- increased coverage of vitamin A and deworming to cover 95 per cent of the target population by December 2018
- increased proportion of households using adequately iodized salt
- availability of nutrition supplies in all health facilities for SAM treatment
- biannual screening for SAM in children under 5. The proportion of children with SAM who were treated in Zanzibar increased from 32 per cent in 2017 to 35 per cent in December 2018
- supporting mentoring staff at health facilities and the community level on nutrition. The proportion of Shehias with community health volunteers (CHVs) capable of providing stunting reduction services in Zanzibar was above 75 per cent by December 2018

## 2.10 Key issues in implementing nutrition programmes in Zanzibar

The review of the ZMNNS (2013–2018), during the inception workshop, revealed that despite decades of high-level political commitment and efforts to address malnutrition in Zanzibar, the prevalence levels of all forms of malnutrition are still unacceptably high. The pace of progress for undernutrition is slow while obesity levels, incidence of overweight and DRNCDs are increasing at an alarming rate. The key programmatic issues and bottlenecks in addressing malnutrition in Zanzibar are shown in *Figure 11* and have been divided into three categories: supply-side issues, demand-side issues and enabling-environment issues.

This ZMNSAP builds on the foundation and lessons learnt during the implementation of the ZMNNS and so addresses all three issues. Cross-cutting challenges identified include inadequate accountability mechanism, low functional capacity of all nutrition-relevant systems and low awareness among policy makers and implementers of the existence of the ZMNNS itself. Key lessons learnt include the importance of political will, the need for promoting and advocating strategies among key stakeholders, the importance of functional multisectoral coordination and community participation, the need for functional M&E to track both programmatic and financial progress, the need to develop human resource capacity and the importance of programmatic and social accountability among others.

**Figure 11:** Key issues in implementation of nutrition programmes in Zanzibar

### Supply Side



- Low human resources capacity to provide services for MIYCN, micronutrient supplementation and fortification
- Inconsistent availability of nutrition supplies, commodities, and equipment
- Low capacity for clinical nutrition and dietetics.

### Demand Side



- Inadequate caregivers' practices on nutrition related behaviors
- Inadequate practical support to nutrition at all levels
- Poor utilization of services provided
- Lack of program and social accountability

### Enabling Environment



- Inadequate planning, multisectoral collaboration and coordination, monitoring, evaluation and learning from nutrition programs
- Low funding for nutrition activities
- Inadequate sectoral and multisectoral nutrition information system
- Low advocacy, communication and social mobilization for nutrition

# 3

## DESIGN FRAMEWORKS FOR THE ZMNSAP

### 3.1 Vision

A Zanzibar free from preventable malnutrition to accelerate human development and socio-economic growth.

### 3.2 Mission

Strengthen capacities of Food, Health, Education and Social protection systems to deliver nutrition interventions at scale.

### 3.3 Guiding principles

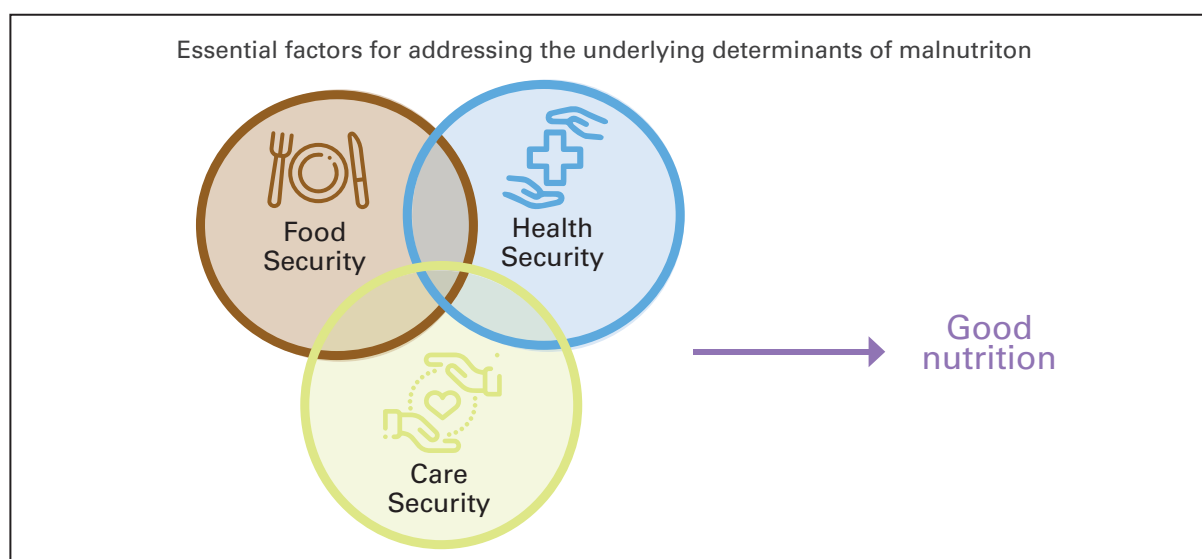
1. **Rights-based approach:** the right to adequate food and nutrition and to a standard of living necessary for an active and healthy life, as stipulated in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child (CRC), the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and other international agreements and re-affirmed in MKUZA
2. **Respect for human dignity and the rule of law**
3. **Need to address issues of inequity:** as they relate to geography, rural/urban conditions, education, wealth, and gender
4. **Ensuring gender equality and the empowerment of women**
5. **Prioritizing vulnerable groups:** children, women, adolescent girls, poor households and communities
6. **Ensuring multisectoral collaboration and coordination** with all relevant sector policies, strategies and action plans

7. **Need for national ownership and for government to be in the driver's seat.** While the RGoZ will provide leadership in its implementation, special efforts will be made to strengthen partnerships including public-private partnerships (PPP). This will achieve common goals and strengthen the capacity of the civil society and private sector to contribute to good nutrition for all Zanzibaris
8. **Non-discrimination** with respect to age, gender, social status and religion
9. **Effective equal participation and empowerment** of all Zanzibaris and/or their representatives in the formulation, implementation and monitoring of policy measures, programmes, projects and other actions
10. **Accountability and transparency** in decision-making, public resource allocation, and use

### 3.4 Conceptual frameworks used for addressing all forms of malnutrition in Zanzibar

The ZMNSAP adopts a conceptual framework that addresses the manifestations and the immediate, underlying and basic determinants of all forms of malnutrition. The ultimate manifestation of all forms of malnutrition is premature death and intergenerational transfer of malnutrition. Malnutrition itself is a manifestation of various social, economic and biological processes. The **immediate determinants are food intake and diseases**, and the **underlying determinants** are the triad of factors: **food security, care security, and health security**. These underlying determinants include availability and access to basic services (health, WASH, Education, shelter and infrastructure), which are important causative factors, but none on its own is a sufficient cause (Figure 12).

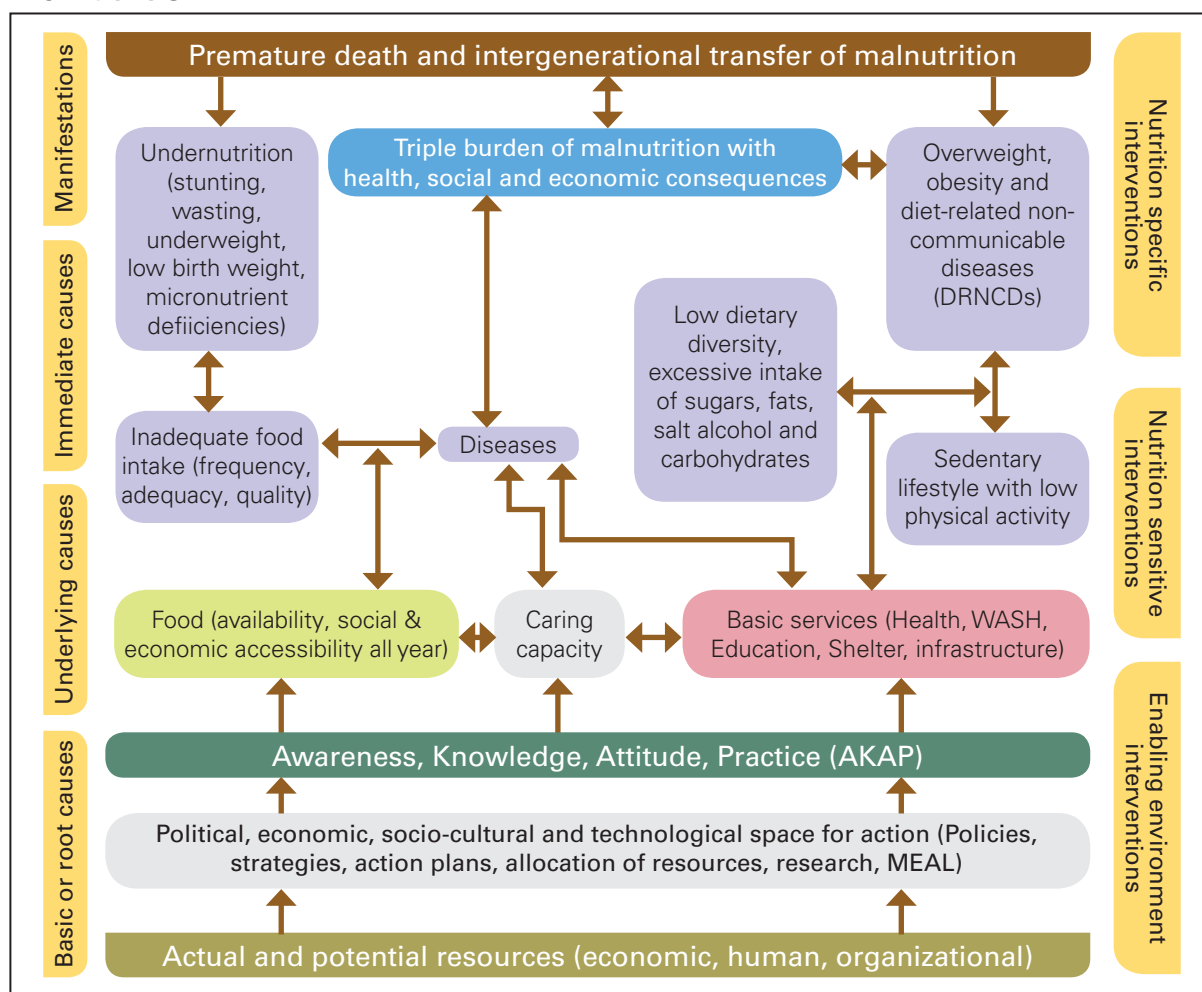
**Figure 12:** The triad of the underlying determinants of malnutrition



The underlying causes of all forms of malnutrition are themselves determined by more **basic or root causes**. **Awareness, attitude, education, knowledge and practices** with regard to nutrition play important roles in determining the nutritional status of a nation. More structural (basic) causes can be categorized as political, economic, social, cultural and technological, and the availability and allocation of actual and potential resources (economic, human and organizational) to nutrition. From this conceptual framework, it is clear that nutrition is not a sector nor a domain of any one ministry or discipline, but is multisectoral and multidisciplinary. A country's nutrition status has many ramifications across the individual, household, community, national and global levels.

In general, nutrition-**specific interventions address the manifestation and immediate causes of malnutrition, nutrition-sensitive interventions address the underlying causes and enabling environment interventions address the basic or root causes of malnutrition**. This ZMNSAP adopts the conceptual framework shown in *Figure 13* in both its planning and proposed interventions.

**Figure 13:** Conceptual framework for the determinants of all forms of malnutrition



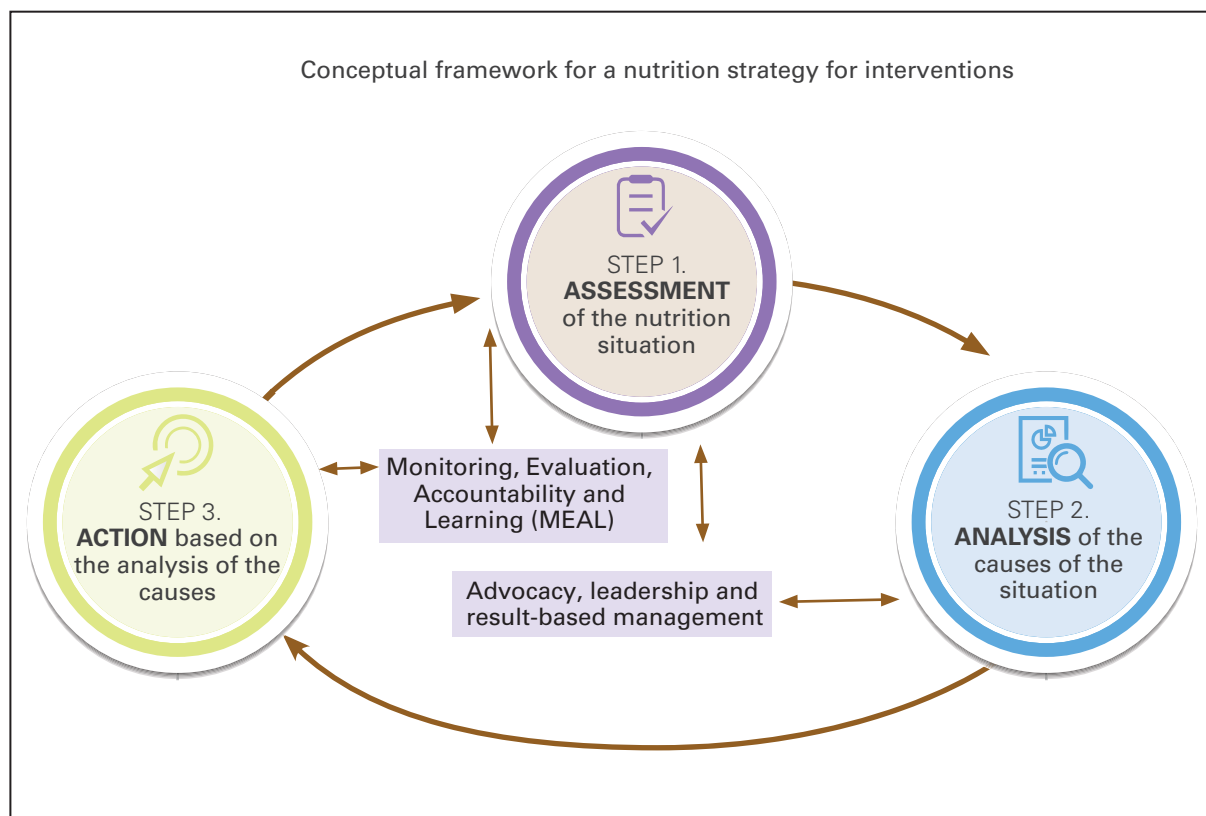
**Source:** Kavishe F.P (2018). Adapted from Kenya Nutrition Action Plan 2018–2023 as part of conceptualization of ZMNSAP 2020/2021–2024/2025



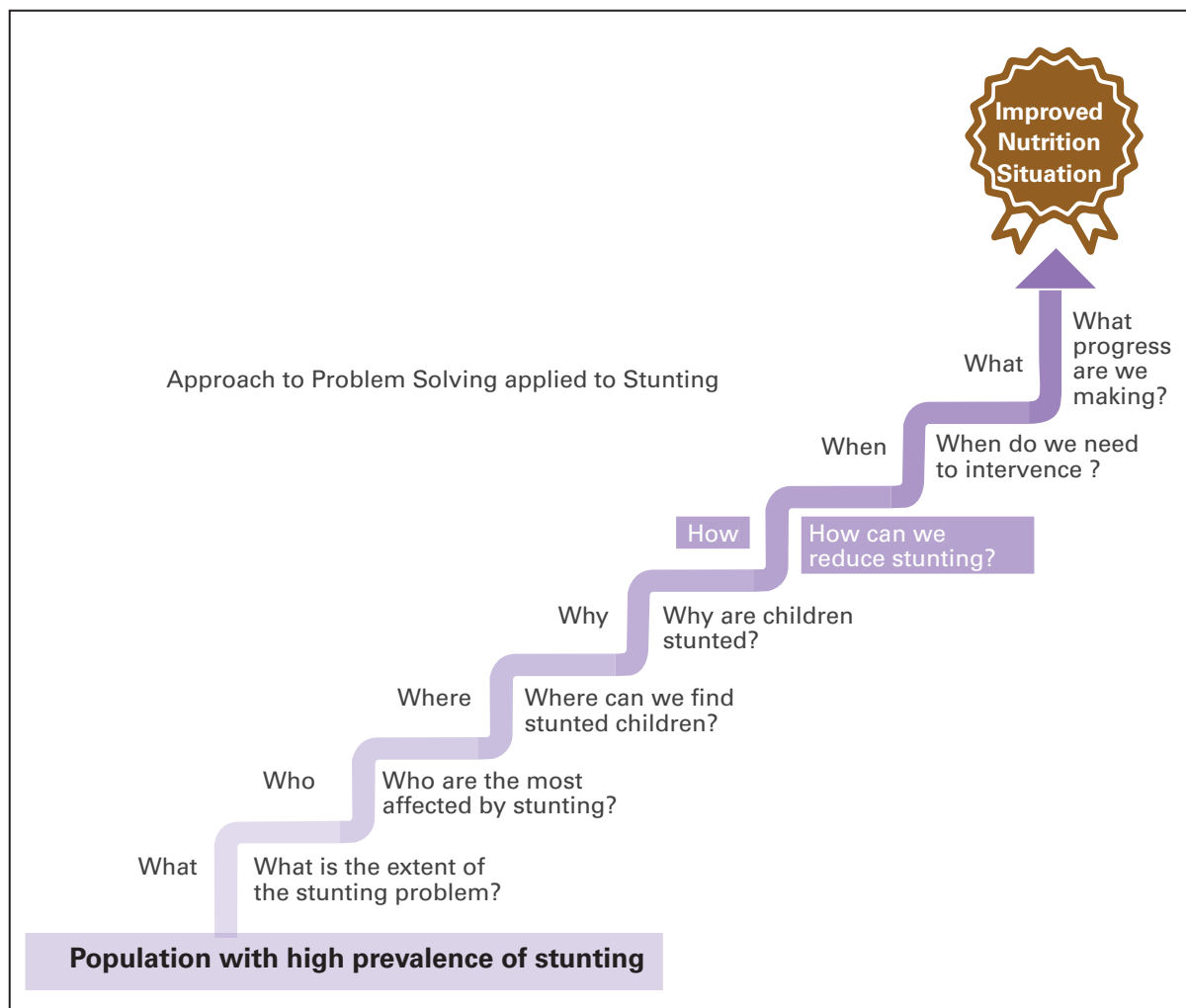
## The ZMNSAP conceptual strategy for nutrition actions

The ZMNSAP also adopts a conceptual strategy to ensure that the extent and nature of the problem of malnutrition are adequately assessed, its causes analysed in terms of their depth and relationships, and possible solutions (actions) suggested/developed. Monitoring and evaluation (M&E) ensures that actions taken are re-assessed and re-analysed and new actions are taken, resulting in a cyclic process called the **“triple A process” of assessment, analysis and action** (see Figure 14). Figure 15 shows typical questions one can ask when addressing malnutrition, using stunting as an example.

**Figure 14:** The “triple A process” of assessment, analysis and action for nutrition action



**Figure 15:** Framework questions for problem solving using stunting as an example



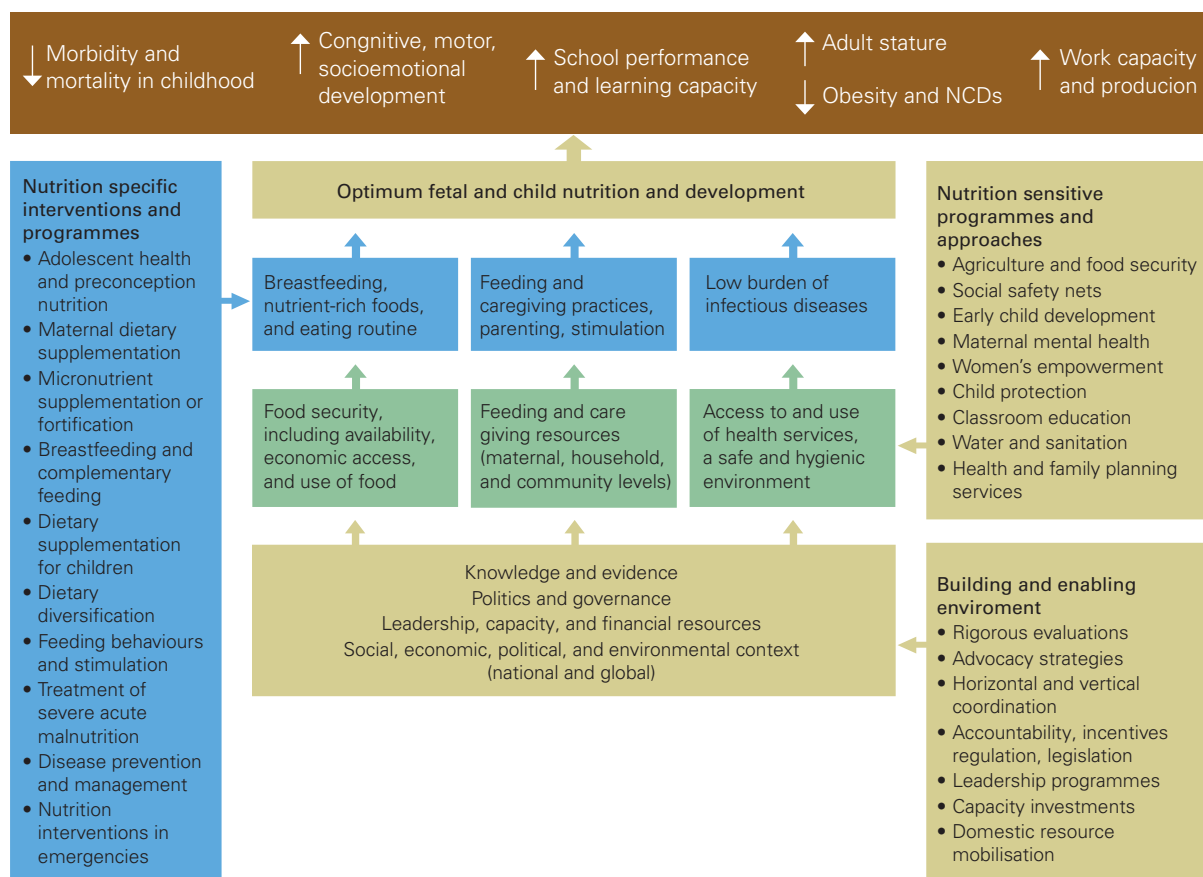
## Conceptual framework of interventions to address malnutrition in the ZMNSAP

After assessing and analysing the extent and nature of malnutrition in Zanzibar, based on the conceptual model for analysis (*Figure 15*), the ZMNSAP uses the conceptual framework shown in *Figure 16* to concretize its plan. The framework is based on the 2013 Lancet Series on “maternal and child malnutrition” to divide interventions into three categories:

- (i) **nutrition-specific interventions**
- (ii) **nutrition-sensitive interventions**
- (iii) **enabling-environment or cross-cutting interventions**

Prioritized interventions in each category are then further developed into KRAs.

**Figure 16:** The conceptual framework of the ZMNSAP interventions

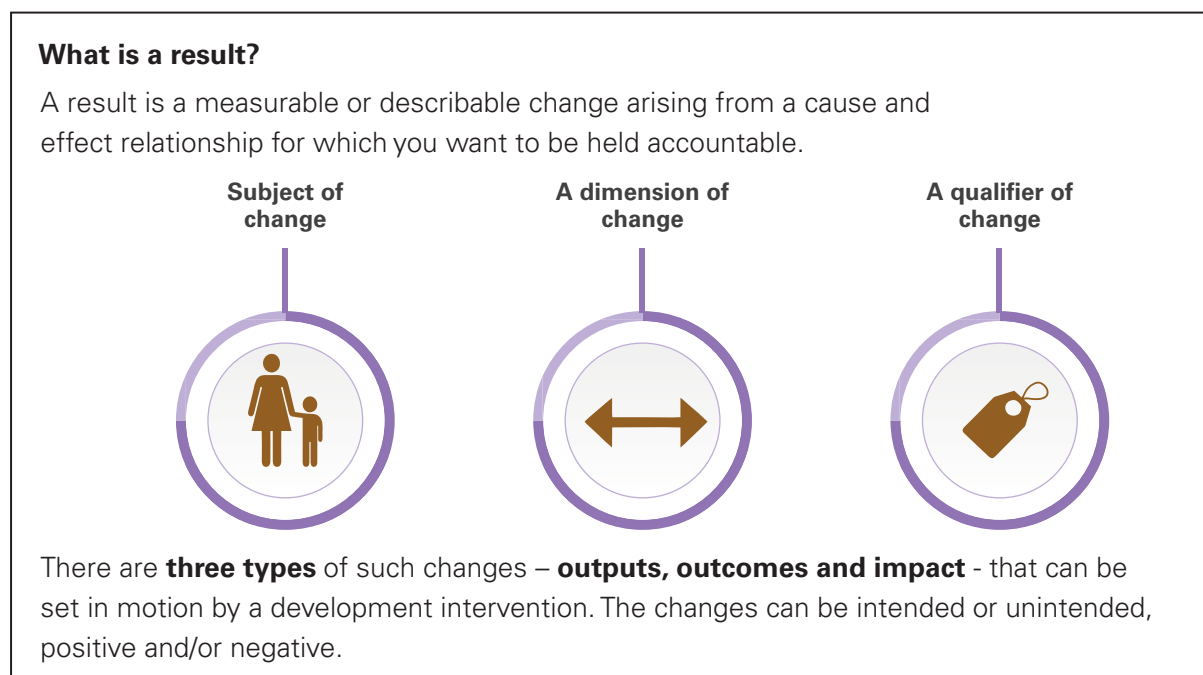


### 3.5 The ZMNSAP theory of change: Conceptual framework for measuring changes in results

A critical component of any plan is to know whether or not the plan is being implemented as envisaged, and whether progress is being made towards the achievement of planned results. **A result is a measurable or describable change arising from a cause and effect relationship for which one will need to be held accountable, and a change that can be described as an output, outcome or impact** (see Figure 17). Thus, in addition to being evidence-based, the ZMNSAP emphasizes on results-based planning, budgeting, implementation, management and monitoring and evaluation (M&E).

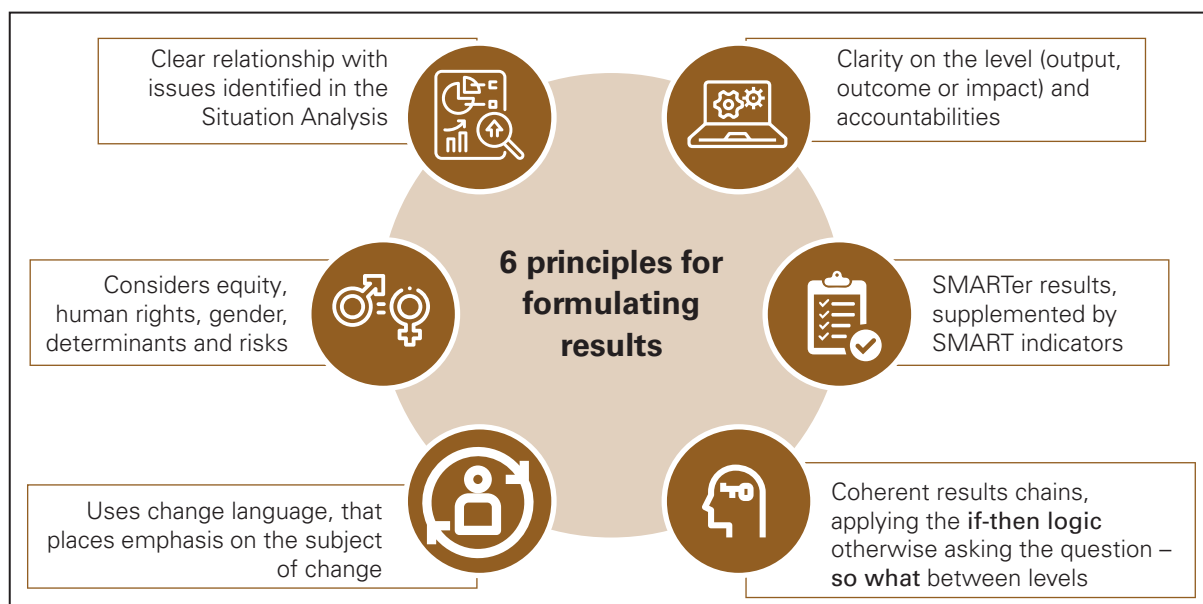
To be able to measure results-oriented progress, the ZMNSAP clearly defines the results to be achieved ensuring that the results' indicators are sensitive to change and can measure both the process and its impact. This enables identification of short-term implementation factors for adjustment (in terms of budget, implementation approaches, stakeholders, etc.) and longer-term factors for strategy adjustment.

**Figure 17:** What is a result as described in the ZMNSAP?



The ZMNSAP has used six principles in formulating results as shown in *Figure 18*.

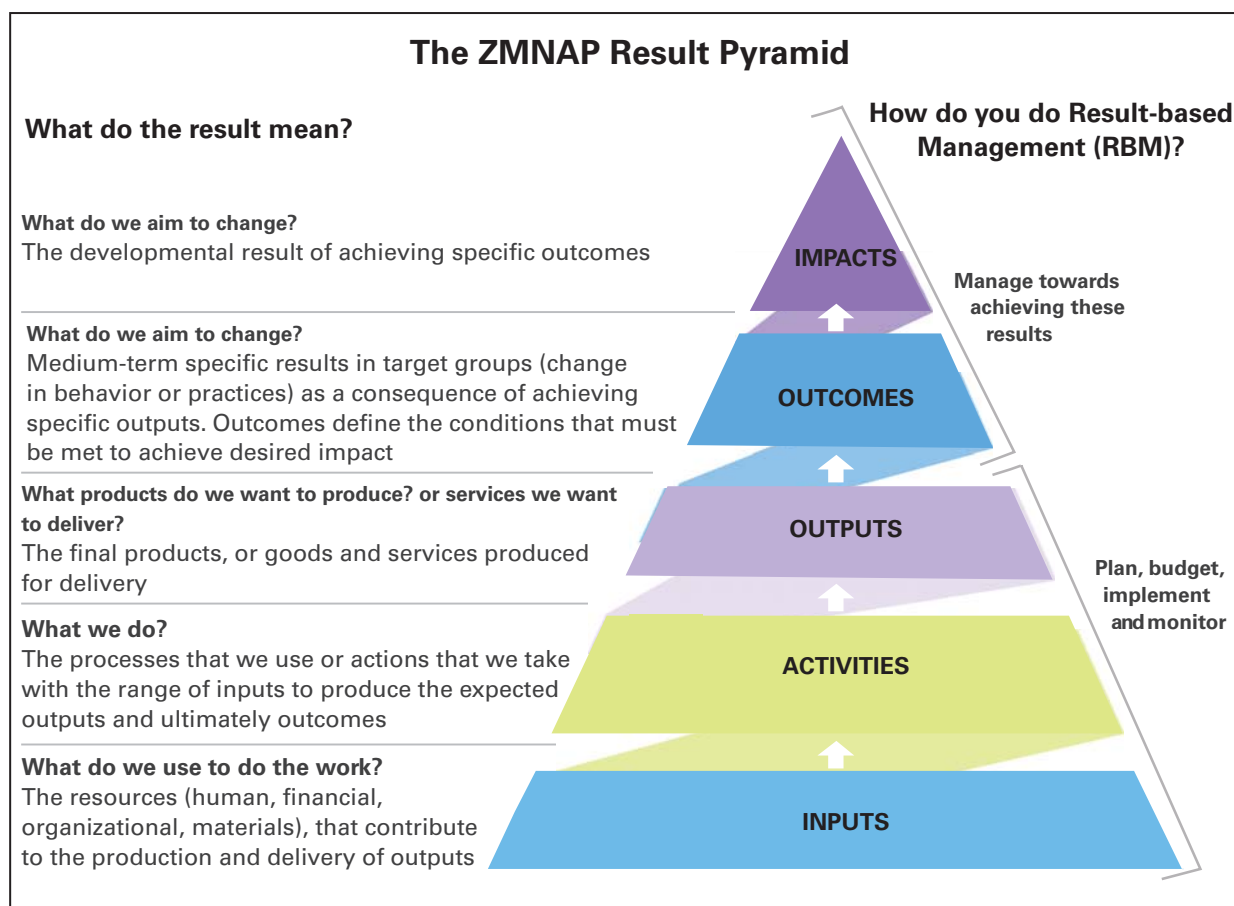
**Figure 18:** The six principles used to formulate the ZMNSAP results



Based on the six principles, the pyramid model adopted (*Figure 19*) uses the logical framework whereby the results are hierarchically defined starting from low-level results (**outputs**) to middle level results (**outcomes**) to higher level results (**impact**). The assumption is that there is a

cause and effect relationship and if outputs are achieved, they will lead to the achievement of outcomes and in turn influence the nutrition situation.

**Figure 19:** Logical framework conceptual model for measuring results



The model recognizes that there are assumptions embedded into the model itself, which if true, will cause the results chain to remain intact. For example, providing information on nutrition will lead to changes in behaviours of the targeted group. Moreover, there may be changes like economic growth or political changes, external to the nutrition system, that may have unforeseen positive or negative effects.

Thus, the ZMNSAP recognizes the importance of using the “theory of change” in measuring progress. The theory of change is essentially a comprehensive description and illustration of how and why a **desired change** (the highest-level result) is expected to occur in a particular context. It does so by first identifying the desired long-term goals (**impacts**) and then working backwards to identify all the conditions (**outcomes**) and outputs that must be in place (and how these relate to one another causally) for the goals to be achieved. Through this approach, the precise link between **activities-inputs-outputs-outcomes** and the achievement of long-term goals (**impact**) are better understood. This leads to better planning in that activities are linked to a

detailed understanding of how change actually occurs. It also leads to better evaluation since the theory makes it possible to measure progress towards the achievement of long-term goals that go beyond the identification of programme outputs. Again, the theory of change provides the basis for reporting successes, setbacks and lessons, and evaluation results.

While a good theory of change is critical for planning and evaluation, it is also a powerful communication tool because you can capture the complexity of your initiative in a form that is understandable to others. Being specific about what made your initiative successful, and how much change, or success can be expected under given conditions are what policymakers need to know in order to apply lessons learnt from one initiative to other problems.

Policymakers also need to identify strategic allies, which in the language of the theory of change are called **'MOVERS'**, the people who support the policies, strategies and action plans towards the achievement of the desired change. These people should be encouraged and motivated to continue with their support. Policymakers should also identify the **'BLOCKERS'**, those people who want to maintain the status quo because of profit or other personal interests or gains. They, for example, will try to prevent interventions that reduce the excessive consumption of alcohol, sugary drinks, salt or prevent the marketing of breast milk-substitutes, or campaigns against smoking. In between are the **'FLOATERS'**, people who can be swayed in either direction. They need to be identified and persuaded into becoming movers.

# 5

## OBJECTIVES, KEY RESULT AREAS, EXPECTED RESULTS, TARGETS AND STRATEGIES

### 4.1 Guiding principles used in planning, implementation and management of the ZMNSAP

**i) proposed actions and investments to meet the following criteria:**

- must be evidence-based
- must be results-oriented: results-based planning (RBP), results-based management (RBM), results-based financing (RBF); and results-based M&E
- must be implemented on a large-scale and with quality
- results, roles, responsibilities and accountabilities to be well defined
- monitoring of progress must be on the basis of the theory of change
- must be empowering, and sustainable with active community participation

**ii) coordination, collaboration and tracking of progress to be guided by the following criteria:**

- the government remains in the driving seat
- must be adherence to the “three ones principle” (one plan; one coordinating mechanism and one monitoring, evaluation and learning framework) to ensure coherence
- must be development of community capacity and reinforcement of effective community-public-private-partnerships

**iii) monitoring and evaluation must be able to demonstrate effective delivery of key activities and must adopt the criteria used in M&E systems for large-scale programmes:**

- appropriate level of results (impact, outcome, output)
- appropriate ratio of outputs per outcome
- appropriate ratio of indicators to output-outcome-impact
- demonstrable quality of results
- the SMART (specific, measurable, attributable, replicable and time-bound) principle
- neutral and specific formulation of indicators
- the soundness of horizontal logic (baseline, milestones, reliable source)

## 4.2 Desired change

A healthy and wealthy Zanzibar where malnutrition is no longer a problem of public health significance.

## 4.3 Strategic objective

To reduce the prevalent levels of all forms of malnutrition in Zanzibar and to achieve the 2025 global and national nutrition targets.

## 4.4 Key result areas (KRAs)

The ZMNSAP prioritizes seven KRAs for interventions as shown in *Table 9* and categorizes them into four nutrition-specific interventions: one multisectoral nutrition-sensitive intervention and two cross-cutting enabling-environment interventions. The prioritized KRAs are based on the situation analysis.



**Table 9:** Key result areas (KRAs) of the ZMNSAP

CATEGORY OF KRAs	THE 7 KEY RESULT AREAS OF THE ZMNSAP
<b>A: NUTRITION-SPECIFIC INTERVENTIONS</b>	<b>KRA 1:</b> Maternal and early childhood nutrition services (MECNS) scaled up
	<b>KRA 2:</b> Scaled-up services to address malnutrition among school-age children, adolescents and women with a focus on micronutrient deficiencies
	<b>KRA 3:</b> Integrated management of acute malnutrition (IMAM) scaled up
	<b>KRA 4:</b> Scaled-up services to prevent and manage diet-related non-communicable diseases (DRNCDs)
<b>B: MULTISECTORAL NUTRITION-SENSITIVE INTERVENTIONS</b>	<b>KRA 5:</b> Scaled-up actions to ensure a multisectoral nutrition response
<b>C: CROSS-CUTTING ENABLING ENVIRONMENT INTERVENTIONS</b>	<b>KRA 6:</b> Improved nutrition governance
	<b>KRA 7:</b> Strengthened multisectoral nutrition information systems for effective decision-making at all levels

## 4.5 Planned nutrition targets for Zanzibar

The planned nutrition targets are articulated only at the highest and middling levels of results: impact and outcome. Impact target results show planned reduction in the nutritional deficiency status for conditions like stunting, wasting, underweight, micronutrient deficiencies (anaemia, iodine deficiency disorders and vitamin A), and obesity. Outcome target results are defined by changes in behaviour and/or practices that reduce the risk factors for undernutrition and DRNCDs. The ZMNSAP nutrition targets have 15 impact targets and 4 outcome targets (*Table 10*), selected from the expected outcome results of the seven KRAs.

**Table 10: ZMNSAP nutrition targets by 2024/2025**

ZMNSAP ADOPTED NUTRITION TARGETS BY 2024					
S/N	ZMNSAP expected results (Global targets used where applicable)	Indicator	Baseline Prevalence (%)	Target (%) 2024/2025	Framework for targets
<b>IMPACT TARGETS<sup>23</sup></b>					
1.	Reduce the prevalence of stunting among children under the age of 5 by 25%	Prevalence of stunting (H/A <2SD) among children aged 0-59 months	21.5 TNNS 2018	16.1	WHA target 1 reduction is by 40%
2.	Reduce and maintain childhood wasting at less than 5%	Prevalence of wasting (W/H <2SD) among children aged 0-59 months	6.1 TNNS 2018	<5	WHA target 6 is to reduce the prevalence to below 5%
3.	Reduce the prevalence of low birth weight by 30%	Prevalence of birth weight of 2.5 kg and below	8.3 TNNS 2018	5.8	WHA target 3 is reduction by 30%
4.	Reduce childhood underweight by 30%	Prevalence of underweight (W/A <2SD) among children aged 0-59 months	14 TNNS 2018	9.8	ZMNSAP target
5.	No increase in childhood overweight/obesity	Prevalence of overweight/obesity (W/A >2SD) among children aged 0-59 months	2.1 TNNS 2018	<2.1	WHA target 4 is "no increase"
6.	Reduce the prevalence of anaemia among women of reproductive age by 30%	Prevalence of anaemia in non-pregnant women of reproductive age (15-49 years)	43.2 TNNS 2018	30.2	WHA target 2 is reduction by 50%
7.	Reduce anaemia among children aged 6-59 months by 30%	Prevalence of anaemia among children aged 6-59 months	65 TDHS 2015/16	45	ZMNSAP target
8.	Reduce anaemia among pregnant women by 40% or more	Prevalence of anaemia among pregnant women	80 TDHS 2015/16	48	ZMNSAP target (prevalence in WRA is 60%)
9.	Reduce anaemia among adolescent girls by 30%	Prevalence of anaemia among girls aged 15-19 years (%)	47 TDHS 2015/16	36	ZMNSAP target (prevalence in WRA is 60%)
10.	Reduce vitamin A deficiency among children by 50%	Prevalence of VAD in children aged 0-59 months (%)	38 TDHS 2010	19	ZMNSAP target

(continued)

<sup>23</sup> Impact targets are those that relate to reductions in the nutrition condition (e.g., stunting, wasting, underweight, obesity, micronutrient deficiency)

(continued)

<b>ZMNSAP ADOPTED NUTRITION TARGETS BY 2024</b>					
<b>S/N</b>	<b>ZMNSAP expected results (Global targets used where applicable)</b>	<b>Indicator</b>	<b>Baseline Prevalence (%)</b>	<b>Target (%) 2024/2025</b>	<b>Framework for targets</b>
11.	Increase proportion of women of reproductive age (WRA) with median urinary iodine concentration (MUIC) falling in the range 150-300ug/L	Proportion (%) of WRA with median urinary iodine concentration in the range of 150-300ug/L	25 TDHS 2010	50	ZMNSAP target
12.	Reduce the proportion of population with raised blood pressure or currently on medication by 25%	Proportion of population with raised blood pressure or currently on medication	33 STEP survey 2012	25	NCD target 6 is a 25% relative reduction or contain prevalence of high blood pressure
13.	Reduce the proportion of population with raised fasting blood sugar	Proportion of adults aged 18-69 years with raised fasting blood sugar (%)	3.7 STEP survey 2012	<3.7	NCD target
14.	Halt and reverse the rise in overweight/obesity among adults aged 18-69 years by 30%	Prevalence of overweight/obesity among adults aged 18-69 years	39 STEP survey 2012	27	NCD target 7 (halt the rise in diabetes and obesity)
<b>OUTCOME TARGETS<sup>24</sup></b>					
15.	Increase the rate of EBF during the first six months by 50% and above	Prevalence of EBF among children aged 0-6 months	30 (TNNS 2018)	40	WHA target 5 is to increase EBF by 50%
16.	Increase the proportion of pregnant women taking iron and folic acid for 90+ days during pregnancy by 60% Framework for targets	Proportion (%) of pregnant women taking iron and folic acid for 90+ days during pregnancy	12.8 (TNNS 2018)	20	ZMNSAP target
17.	Increase the coverage of Vitamin A supplementation among children under the age of 5 by 10%	Coverage (%) of Vitamin A supplementation among children aged 6-59 months	78.9 TNNS 2018	90	ZMNSAP target
18.	Increase the proportion of households using adequately iodized salt by 50%	Proportion (%) of households using adequately iodized salt	39 (TNNS 2018)	78	ZMNSAP target
19.	A 10% relative reduction in the prevalence of insufficient physical activity	Prevalence of insufficient physical activity among adults aged 18-64 years	18	16	NCD target 3 is a 10% relative reduction

(continued)

<sup>24</sup> Outcome targets are those that relate to change in behaviour or practice e.g. breast feeding, physical activity, consumption of salt.

(continued)

ZMNSAP ADOPTED NUTRITION TARGETS BY 2024					
S/N	ZMNSAP expected results (Global targets used where applicable)	Indicator	Baseline Prevalence (%)	Target (%) 2024/2025	Framework for targets
20.	A 30% relative reduction in the mean population intake of salt/sodium	Mean intake of sodium salt (g/day)	7	5	NCD target 4 is a 30% relative reduction
21	Increase budgetary allocation for nutrition	Percentage of nutrition budget as a percentage of the total national health budget	<1.0	>1.0	Financing of nutrition

## 4.6 Expected results per key result area (KRA)

### KRA 1: MATERNAL AND EARLY CHILDHOOD NUTRITION SERVICES (MECNS) SCALED UP

#### Outcome 1

**Outcome KRA 1: Optimal nutrition behaviours being practised by an increased proportion of women of reproductive age, pregnant women, mothers/ caregivers/ service providers of children under the age of 5**

#### Outputs

*Output 1.1: increased coverage and quality of maternal and early childhood nutrition services (MECNS) in different health facilities*

*Output 1.2: increased coverage and quality of MECN services at the community level*

*Output 1.3: increased awareness of MECS in the community*

*Output 1.4: improved law enforcement of MECN-related services*

### KRA 2: SCALED-UP SERVICES TO ADDRESS MALNUTRITION AMONG SCHOOL-AGE CHILDREN, ADOLESCENTS AND WOMEN WITH A FOCUS ON MICRONUTRIENT DEFICIENCIES

#### Outcome 2

**Outcome KRA 2: Adequate micronutrients being consumed by the general population of Zanzibar, in particular women, adolescents and children**

## Outputs

*Output 2.1: improved anaemia prevention and control interventions among women, adolescents and children*

*Output 2.2: strengthened services for prevention and control of Vitamin A deficiency and deworming among children aged 6–59 months*

*Output 2.3: increased availability and supply of adequate quality iodized salt*

*Output 2.4: reduced deficiency of other micronutrients and improved control interventions among women, adolescents and children*

## KRA 3: INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION (IMAM) SCALED UP

### Outcome 3

**Outcome KRA 3: Improved integrated management of acute malnutrition**

## Outputs

*Output 3.1: improved quality of services for management of SAM and MAM in at least 75 per cent of health facilities*

*Output 3.2: at least 75 per cent of children under the age of 5 are reached through screening for SAM and MAM at the community level*

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

## KRA 4: SCALED-UP SERVICES TO PREVENT AND MANAGE DRNCDs

### Outcome 4

**Outcome KRA 4: Zanzibar's population is physically active and eats a healthy diet.**

## Outputs

*Output 4.1: increased access to DRNCD quality services in 55 existing health care facilities from (only 49 health facilities have DRNCD quality services at the moment)*

*Output 4.2: at least 50 per cent of school-age children and adult population are sensitized to risk factors for non-communicable diseases*

*Output 4.3: reviewed policies and legislation to integrate prevention and control of NCDs*

*Output 4.4: steps survey conducted*

*Output 4.5: clinical dieticians trained*

## **KRA 5: SCALED-UP ACTIONS TO ENSURE A MULTISECTORAL NUTRITION RESPONSE**

### **Outcome 5**

**Outcome KRA 5: Nutrition-sensitive interventions scaled up by line sectors, private sector and CSOs to reach out to all communities to improve nutrition**

### **Outputs**

*Output 5.1: increased accessibility of quality nutritional services to vulnerable groups*

*Output 5.2 strengthened nutritional interventions in educational institutions*

*Output 5.3: increased availability and utilization of quality food within households*

*Output 5.4: improved WASH practices including hand washing*

*Output 5.5: communities regularly use quality maternal health services including family planning, NTD prevention and treatment of AIDS and malaria*

*Output 5.6: climate-sensitive multisectoral nutrition interventions are promoted and integrated into actions that address the underlying causes of malnutrition, focusing on food security, care security and health and WASH security.*

## **KRA 6: IMPROVED NUTRITION GOVERNANCE**

### **Outcome 6**

**Outcome KRA 6: Multisectoral nutrition governance strengthened**

### **Outputs**

*Output 6.1: Increased political and financial commitment of the government to nutrition issues*

*Output 6.2: Functional sectoral and multisectoral coordination at all levels*

*Output 6.3: Improved human resources and capacities for nutrition at all levels*

## **KRA 7: STRENGTHENED MULTISECTORAL NUTRITION INFORMATION SYSTEMS FOR EFFECTIVE DECISION-MAKING AT ALL LEVELS**

### **Outcome 7**

**Outcome KRA 7: Strengthened multisectoral nutrition information systems for effective decision-making at all levels**

### **Outputs**

*Output 7.1: Comprehensive multisectoral system for collection, management, analysis, and dissemination of nutrition and related data and information at all levels in place.*

## 4.7 Key strategies

### Overarching strategy

The overarching strategy for the ZMNSAP is the adoption of a community-centred multisectoral and well-coordinated approach that focuses on improving the nutrition situation of households and communities.

### Supportive cross-cutting strategies:

- 1) **Social and behaviour change communication (SBCC) for nutrition** with the use of available local, public and social media.
- 2) **Advocacy and social mobilization** to sustain political will and government commitment to nutrition and to mobilize adequate resources for the ZMNSAP.
- 3) **Community-centred capacity development (CCCD):** The development of human, institutional and organizational capacity is critical in the implementation of the ZMNSAP, especially at the community level. **Community participation** greatly enhances **social accountability**.
- 4) **Developing functional human resource capacity** to implement the ZMNSAP is critical. Efforts will be made to conduct in-service trainings and recruit additional nutrition officers to support the implementation of the ZMNSAP.
- 5) **Aligning all stakeholders with the ZMNSAP through community-public-private partnerships (C-PPP):** Participation of stakeholders and development partners in the implementation and M&E of the ZMNSAP is important in achieving the nutrition targets. The ZMNSAP will serve as a platform where coordination and collaboration can occur using the “three ones principle” of one plan, one coordinating mechanism and one M&E framework.
- 6) **Delivery of quality, timely, and specific nutrition services:** Specific nutrition services, such as supplementation of vitamin A, iron-folic acid (IFA), micronutrient powder (MNP), multiple micronutrient supplements (MMS) and deworming will be delivered and that will require efficiency and adherence to national policies and guidelines.
- 7) **Mainstream equality and sustainability in all the seven key result areas (KRAs) of the ZMNSAP without discrimination, focusing on women, children and adolescent girls:** In this respect, the ZMNSAP must be implemented in ways that are sustainable, gender-sensitive and environment-friendly. The implementation methods must be such as to result in the empowerment of women and reduction of inequality.

- 8) **Development of a resource mobilization strategy to ensure adequate funding** for full and efficient implementation of the ZMNSAP.
- 9) **Tracking progress and operational research and development** using the CRAF of the ZMNSAP will help in measuring progress in terms of results (activity-output-outcome-impact) by tracking financial resources (income versus expenditure) and ensuring that lessons learnt from M&E are used as and when necessary. The annual CRAF reports and nutrition scorecard reports to the annual joint multisectoral reviews will shed light on the progress, issues and challenges to be addressed in the subsequent year.
- 10) **Effective overall planning and coordination:** stakeholders will need to plan, align and coordinate their strategies on nutrition within the ZMNSAP framework.



# 5

## COSTED ACTION PLANS FOR THE KEY RESULT AREAS

### 5.1 Introduction

This chapter summarizes results-based work plans for the seven key results areas (KRAs) of the ZMNSAP with an indicative budget and a list of accountable institutions. The logic being followed is that a group of activities produce certain outputs, those groups of outputs lead to outcomes, and the outcomes from all seven KRAs lead to impact results. It is only when the ZMNSAP is fully implemented that we can expect to have the expected impacts.

### 5.2 Costing approach

An estimation of the resource requirements per annum to achieve the planned results is shown for each KRA and then aggregated to estimate the overall resource requirements of the ZMNSAP. The estimations are based on standard costs used by the RGoZ and synchronized for all KRA costs. The estimation recognizes that the Government will provide resources for recurrent costs like human and organizational resources, infrastructure and platforms for various activities. It is also understood that the ZMNSAP costs refer only to the financial costs of implementing the prioritized activities proposed in each of the KRAs. It is recognized that communities will provide in-kind contributions like adhering to nutrition-positive behaviours, such as breastfeeding, consumption of diversified foods including fortified ones, exercising, avoiding smoking and excessive alcohol intake and others. Since the plan is results-based, the proposed budget is also results-based (results-based budgeting) –right from calculating the cost of the proposed activities and aggregating the costs of specific outputs and outcomes.

## 5.3 Overall resource requirements for the ZMNSAP

Table 11 provides the overall budget for the ZMNSAP disaggregated for each KRA. The overall cost of the ZMNSAP has been estimated to be around TSh **30,778.41 million** (US\$ 13.38 million) from 2020/2021 to 2024/2025. In terms of proportional contribution to the total budget (see Figure 20), the highest-to-lowest costs consist of

- i. KRA 5 on multisectoral nutrition interventions contributing to 39.2 per cent of the budget;
- ii. KRA 2 on nutrition in school-aged children, adolescents and women focusing on micronutrients contributing to 27.2 per cent;
- iii. improved nutrition governance contributing to 12 per cent;
- iv. multisectoral nutrition information systems contributing to 7.7 per cent;
- v. management of acute malnutrition contributing to 6.4 per cent;
- vi. prevention and management of acute malnutrition contributing to 6.3 per cent and lastly
- vii. maternal, infant and early childhood nutrition contributing to 5.7 per cent.

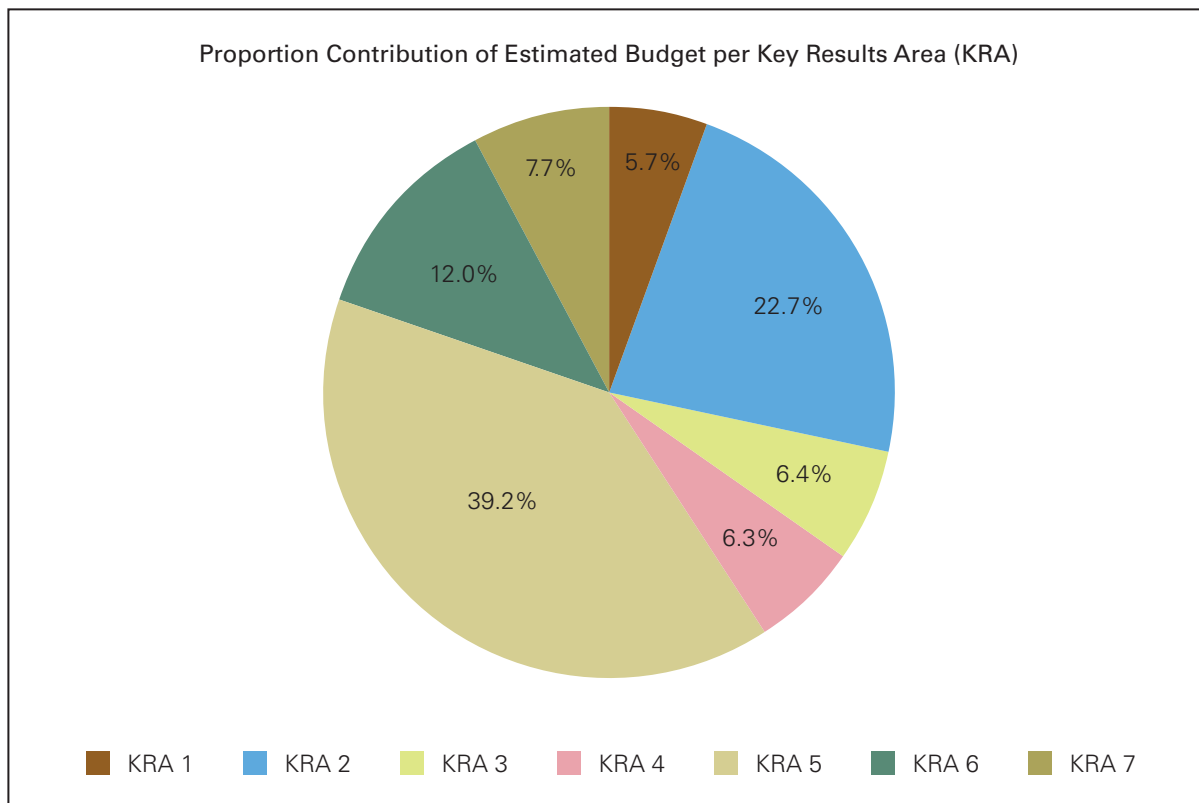
**Nutrition-specific interventions** (KRA 1–4) **comprise 41.1 per cent of the total budget**, while **nutrition-sensitive interventions** (KRA 5–7) **comprise 59.1 per cent of the total budget**.

Table 11 shows that the start-up costs for 2020/2021 for all KRAs will be greater than those of the subsequent years.

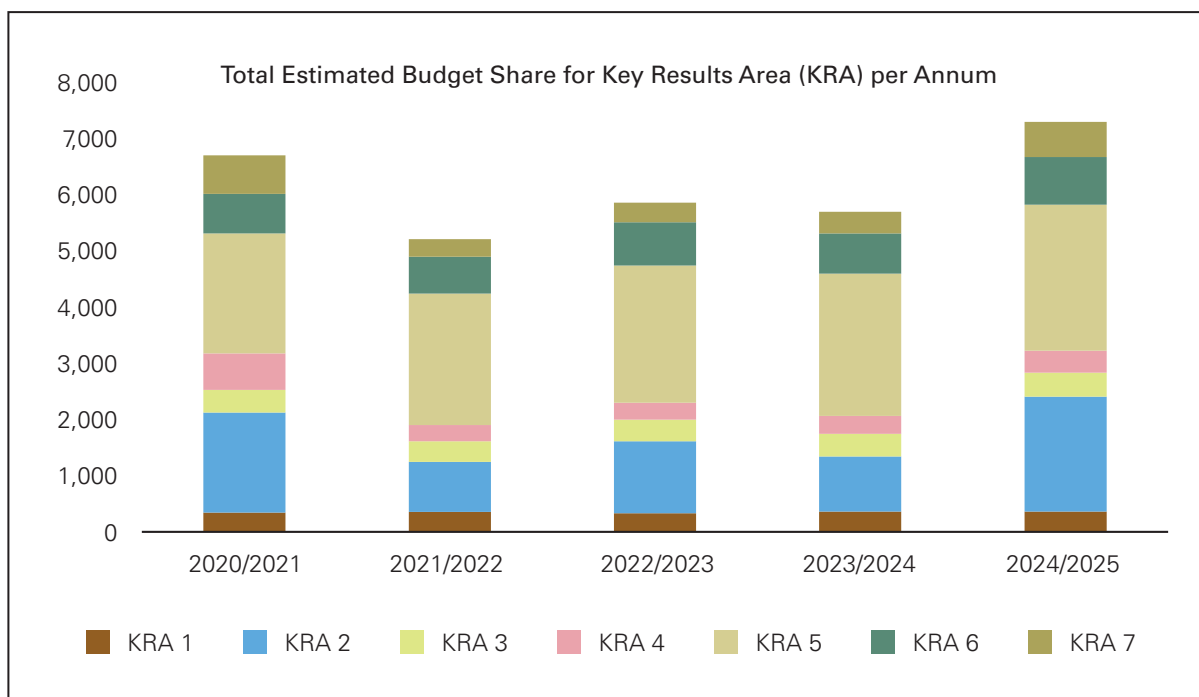
**Table 11: Annual and total financial resource requirements for the ZMNSAP per KRA**

Annual and total financial resource requirements for the ZMNSAP per key result area 2020/2021 – 2024/2025										
KRA	Expected result for KRA	Budget in TSh (Millions)					Total in TSh (Millions)	Total in US\$ Millions	Proportional Contribution (%)	
		2020/2021	2021/2022	2022/2023	2023/2024	2024/2025				
KRA 1	MATERNAL AND EARLY CHILDHOOD NUTRITION SERVICES SCALED UP	341.48	357.32	331.48	363.73	358.76	1,752.77	0.76	5.7%	
KRA 2	SCALED-UP SERVICES TO ADDRESS MALNUTRITION AMONG SCHOOL-AGE CHILDREN, ADOLESCENTS AND WOMEN, WITH A FOCUS ON MICRONUTRIENT DEFICIENCIES	1,783.83	886.97	1,281.51	977.89	2,049.31	6,979.51	3.03	22.7%	
KRA 3	INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION (IMAM) SCALED UP	404.51	366.49	385.17	403.74	424.63	1,984.54	0.86	6.4%	
KRA 4	SCALED-UP SERVICES TO PREVENT AND MANAGE DIET-RELATED NON-COMMUNICABLE DISEASES	646.69	288.76	303.18	318.36	391.08	1,948.07	0.85	6.3%	
KRA 5	SCALED-UP ACTIONS TO ENSURE A MULTISECTORAL NUTRITION RESPONSE	2,138.60	2,345.10	2,437.50	2,530.60	2,599.00	12,050.80	5.24	39.2%	
KRA 6	IMPROVED NUTRITION GOVERNANCE	701.34	652.07	773.23	718.90	852.48	3,698.02	1.61	12.0%	
KRA 7	STRENGTHENED MULTISECTORAL NUTRITION INFORMATION SYSTEMS FOR EFFECTIVE DECISION-MAKING AT ALL LEVELS	688.52	315.17	349.29	387.03	624.70	2,364.70	1.03	7.7%	
<b>TOTAL RESOURCE REQUIREMENTS (KRAs 1–7)</b>		<b>6,704.97</b>	<b>5,211.88</b>	<b>5,861.35</b>	<b>5,700.25</b>	<b>7,299.96</b>	<b>30,778.41</b>	<b>13.38</b>	<b>100.2%</b>	

**Figure 20:** Proportional budget contribution per KRA



**Figure 21:** Estimated budget share per KRA per annum



## 5.4 Work plans and budget for each key result area (KRA)

### 5.4.1 KRA 1: MATERNAL AND EARLY CHILDHOOD NUTRITION SERVICES (MECNS)

#### Expected outcome

Optimal nutrition behaviours being practised by an increased proportion of women of reproductive age, pregnant women and mothers/caregivers/service providers of children under the age of 5.

#### Context

Because of their unique role in reproduction and the provision of care and their constitutions in general, the nutritional status of women from birth to their reproductive ages is closely associated with that of children under the age of 5. Children under the age of 5 and women of reproductive age, especially pregnant and lactating women and adolescent girls are the most affected by undernutrition due to their specific physiological needs. For pregnant women and children, the 1,000-day period, from conception to the time when the child is 2 years, is a good period to implement high priority, evidence-based, cost-effective health and nutrition interventions to reduce death and disease. Adequate nutrition in this critical period in a woman's life and a child's life is widely recognized to have the greatest impact on survival, cognitive and physical development, and mitigation of risks of chronic diseases.

#### Improving infant and young child feeding (IYCF) practices

Adopting optimal nutritional behaviours and practices during the high-risk periods will reduce the probability of developing malnutrition. Appropriate infant and young child feeding practices include early initiation of breastfeeding within the first hour of birth, exclusive breastfeeding in the first six months of an infant's life and continued breastfeeding up to two years and beyond with appropriate complementary feeding. At the age of 6 months, the child is introduced to semi-solid and solid foods gradually and the amount of food and frequency of feeding increases as the child grows older. In addition to addressing nutrition needs of children, early childhood development should include stimulation and learning.

#### Breastfeeding practices

The TDHS 2015/16 revealed that 97.1 per cent of newborns in Zanzibar are ever breastfed with Unguja showing a higher prevalence (98.7 per cent) than Pemba (94.3 per cent). The practice of early initiation of breastfeeding is crucial for both the child and the mother for bonding and the production of colostrum which contains a lot of antibodies for immunity. In Zanzibar, 46.8 per cent of children were breastfed within one hour of birth and the practice was more prevalent in Pemba (52.7 per cent) than in Unguja (43.5 per cent) (TDHS 2015/160).

According to the TDHS 2015/16, the practice of EBF in Zanzibar is alarmingly low (see Table 12). Only 6 per cent of infants are breastfed in the first six months of their lives. The situation is worse in Unguja (5.6 per cent) than in Pemba (6.3 per cent). However, the 2014 TNNS found that only 20 per cent of infants were exclusively breastfed for the first six months in Zanzibar– this is the baseline the ZMNSAP has used to measure progress. The 2015/16 TDHS showed that the average duration of any kind of breastfeeding in Zanzibar was 20.6 months, which is just adequate, compared to the recommended 23 months. Children in Unguja are breastfed for a longer period (21.1 months) than in Pemba (18.9 months).

**Table 12: Breastfeeding practices in Zanzibar**

Region	% Ever Breastfed	% Initiation within one hour of delivery	% Exclusive breastfeeding 0–6 months <sup>25</sup>	Media duration of Breastfeeding (months)
Zanzibar	97.1	46.8	6	20.6
Unguja	98.7	43.5	6.3	21.1
Pemba	94.3	52.7	5.6	18.9

**Source:** Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015–16

### Complementary feeding

Appropriate complementary feeding for children should include a variety of foods to ensure that the nutrient requirements for the growth and development of a child are met. In this regard, it is important that timely complementation starts right after the completion of six months of EBF. The process for the application and promotion of young child feeding (PROPAN) assessment conducted in 2012 in Zanzibar highlighted that the majority of infants (98 per cent) in the study had solids/semi-solids introduced to them at a mean age of 3.9 months (ZNNS 2014). The TDHS 2015/16 showed that as high as 91.9 per cent of children aged 6–8 months and 98.9 per cent of children aged 9–11 months in Tanzania (including Zanzibar) received complementary foods. The same TDHS also showed that about 13.8 per cent of children aged 6–23 months in Zanzibar met the minimum acceptable diet criteria appropriate for their age and the prevalence of minimum acceptable diet is higher in Unguja (18.3 per cent) than in Pemba (3.5 per cent). To meet the minimum acceptable diet, children must be fed at least four times a day – their diet must be diverse and include at least four food groups of complementary feeding.

### Early childhood development (ECD) services

There is inequitable access to preschool education services. Out of the 20,078 children enrolled in pre-schools, only 3,658 (18 per cent) children come from rural areas. Most ECD centres are institutionalized, are located mostly in towns, are privately owned and charge exorbitant

<sup>25</sup> The Tanzania National Nutrition Survey (TNNS) of 2014 showed the prevalence of exclusive breastfeeding in Zanzibar to be 20 per cent and that would be the baseline that will be used to measure progress.

fees. These circumstances bar the majority of children (from poor families) from accessing ECD services. While the number of children accessing pre-primary education has increased from 13,155 (12.7 per cent) in 2001 to 29,732 (33.9 per cent) in 2010 (MoEVT Budget speech 2010/2011), the quality of early stimulation remains a serious challenge and has adverse effects on learning readiness (Foster Kholowa and Lyabwene Mtaha 2013)<sup>26</sup>.

Violence against children, sexual exploitation, and other forms of abuse including leaving them at orphanages and abandonment are some of the major problems that Zanzibar is facing today. These forms of abuse happen in homes, workplaces and in schools. Moreover, support services for victims of violence and abuse are severely limited (Foster Kholowa and Lyabwene Mtaha 2013).

Though several services and initiatives on early childhood development are evident across sectors, particularly in the health and community development and social welfare sectors, Zanzibar faces many challenges in ECD implementation. It is crucial therefore, to identify the existing good practices and prevailing gaps in ECD service delivery across Zanzibar and to integrate them with maternal, infant and young child interventions for programming purposes.

### **Work plan and budget on KRA 1 (MECNS)**

*Table 13* shows the planned results, work plan and budget for KRA 1.

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<sup>26</sup> Foster Kholowa and Lyabwene Mtahabwa (2013): A report on Assessing the current status of Early Childhood Development (ECD) Services in Zanzibar

**Table 13: Work plan and budget for KRA 1: maternal and early childhood nutrition services**

Work plan and budget for KRA 1: maternal and early childhood nutrition services (MECNS)						
Outcome/Outputs /Activities	Budget in TSh (millions)				Total TSh	Total US\$
	2020	2021	2022	2023		
Years of implementation	2020	2021	2022	2023	2024	Millions
<b>Outcome KRA:1 –Increased proportion of women of reproductive age, pregnant women, mothers/caregivers/service providers of children under the age of 5 who practise optimal nutrition behaviours</b>	341.48	357.32	331.48	363.73	358.76	0.76
<b>Output 1.1: Increased coverage and quality of maternal and early childhood nutrition services (MECNS) in different health facilities</b>	<b>208.56</b>	<b>238.41</b>	<b>209.8</b>	<b>240.66</b>	<b>231.29</b>	<b>0.49</b>
1.1.1 Conduct TOT and cascade training on MECNS integrated training to health care providers	79.00	42.31	44.43	46.65	48.98	0.11
1.1.2 Revise and implement supportive supervision and mentorship and coaching tools to integrate MECNS activities into health facilities	108.80	96.78	101.62	106.70	112.03	0.23
1.1.3 Conduct quarterly meetings for the MECNS thematic working group	20.76	21.80	22.89	24.03	25.23	0.05
1.1.4 Revise pre-service curricula of health service providers to integrate nutrition issues	-	18.47	-	20.37	-	0.02
1.1.5 Conduct working session to review BFHI tools and to align them with new WHO and UNICEF recommendations	-	20.13	-	-	-	0.01
1.1.6 Conduct internal and external BFHI quality assurance assessment in regional and district hospitals	-	38.92	40.86	42.91	45.05	0.07
<b>Output 1.2: Increased coverage and quality of MECN services at the community level</b>	<b>101.48</b>	<b>84.26</b>	<b>87.03</b>	<b>86.68</b>	<b>89.27</b>	<b>0.19</b>

(continued)



(continued)

Work plan and budget for KRA 1: maternal and early childhood nutrition services (MECNS)									
Outcome/Outputs /Activities	Budget in TSh (millions)					Total TSh	Total US\$		
	2020	2021	2022	2023	2024				
Years of implementation	2020	2021	2022	2023	2024	Millions	Millions		
1.2.1	12.94	-	-	-	-	12.94	0.01		
1.2.2	47.91	41.54	42.31	39.72	39.97	211.45	0.09		
1.2.3	-	-	-	-	-	-	-		
1.2.4	9.0	9.50	10.43	10.95	11.50	51.38	0.02		
1.2.5	6.87	7.22	7.58	7.96	8.35	37.98	0.02		
1.2.6	24.76	26.00	26.71	28.05	29.45	134.97	0.06		
<b>Output 3: Increased awareness of MECNS in the community</b>	<b>22.01</b>	<b>23.1</b>	<b>24.25</b>	<b>25.47</b>	<b>26.74</b>	<b>121.3</b>	<b>0.05</b>		
1.3.1	18.22	19.13	20.08	21.09	22.14	100.66	0.04		
1.3.2	3.79	3.97	4.17	4.38	4.60	20.91	0.01		
<b>Output 4: Improved law enforcement of MECN-related services</b>	<b>9.43</b>	<b>9.90</b>	<b>10.40</b>	<b>10.92</b>	<b>11.46</b>	<b>52.11</b>	<b>0.02</b>		
1.4.1	9.43	9.90	10.40	10.92	11.46	52.11	0.02		

## 5.4.2 KRA 2: SCALED-UP SERVICES TO ADDRESS MICRONUTRIENT MALNUTRITION AMONG WOMEN, CHILDREN AND ADOLESCENTS.

### Expected outcome

The general population of Zanzibar, especially women, children and adolescents consume adequate micronutrients.

### Context

Micronutrient malnutrition is a serious threat to the health and productivity of more than two billion people worldwide. The major manifestation of micronutrient deficiencies in Zanzibar are iron deficiency anaemia (IDA), iodine deficiency disorders (IDD) and vitamin A deficiency (VAD). Other concerning micronutrient deficiencies are folic acid, zinc and some vitamin B (B12 and niacin) deficiencies, but their extents are not known.

The effects of micronutrient deficiencies are profound: premature death, poor general health, blindness, growth stunting, mental retardation, neuro-tubal defects, learning disabilities, and low work capacity. The groups affected the most severely by micronutrient deficiencies in Tanzania are infants, young children, adolescents and women of reproductive age (15–49 years). Deficiencies of essential vitamins and minerals among children result in poor growth, inadequate cognitive and brain development, poor performance in school and low academic achievements, low future income and hence poverty, early onset of non-communicable diseases, poor immunity, and low life expectancy. In women of reproductive age, micronutrient deficiencies result in a range of complications such as pre-term delivery, intrauterine foetal death, low birth weight and congenital malformations. Micronutrient deficiencies among children, adolescents, and women of reproductive age may derail broad development goals and national economic growth.

Micronutrient malnutrition is the result of a number of factors. The underlying causes include poor dietary intake and high burden of infectious diseases. Many Tanzanian families lack foods that are fortified with essential vitamins and minerals and this results in micronutrient malnutrition as well. Furthermore, limited feeding frequency, consumption of foods that inhibit the absorption and bioavailability of key nutrients, and restrictive feeding practices also result in micronutrient malnutrition.

A high burden of infectious diseases, especially parasitic infections, are also associated with certain micronutrient deficiencies. For example, iron can also be lost in the presence of blood depleting parasites such as intestinal worms or diseases causing haemolysis. Micronutrient deficiency may also result from loss of nutrients due to vomiting, diarrhoea, and loss of appetite.

The other cause of micronutrient deficiency includes household food insecurity. Women of reproductive age, adolescents, and children are the most severely affected by food insecurity

and hunger, and end up consuming foods that are of low nutritional quality. While some regions in Tanzania are food-secure, there are seasonal variations in the availability or lack of certain types of foods. Most micronutrient rich foods such as vegetables and fruits are seasonal with poor storage technology rendering them unavailable for many months of the year. The prices of animal food sources fluctuate throughout the year and this makes the consumption of these critical sources of vitamins, minerals and protein inconsistent, even if available. Finally, poor sanitation and water supply increases the risk of disease transmission through food preparation and contamination. Moreover, household food insecurity and unhealthy environment have adverse nutrition effects on many children, adolescents and women of reproductive age. The basic causes of micronutrient deficiencies are poverty, weak enabling environment, negative sociocultural practices, inadequate access to and control of financial/economic resources and social disadvantages including gender inequalities.

Over the last three decades, the Government of Tanzania, in collaboration with partners, has implemented national programmes to prevent and control micronutrient deficiencies through high-impact interventions, including supplementation, food fortification, food-based dietary diversity and public health strategies. Public health measures have included strategies to reduce the transmission and treatment of infectious diseases like measles, diarrhoea, acute respiratory infections (ARI), worms and malaria that deplete micronutrients. In spite of this progress, the country has yet to ensure optimal intake of these vitamins and minerals by all population groups..

### **Strategies to address Micronutrient Deficiencies**

The most conventional and widely practised strategies used to address micronutrient malnutrition are micronutrient supplementation and food fortification. These strategies however, do not address the primary cause of poor micronutrient status or inadequate dietary intake: food insecurity and these strategies may not be the most acceptable, accessible, or appropriate for rural and/or ultra-poor households. Complementary strategies that support diets tailored to local and diversified needs and agriculture-based interventions are needed along with efforts to improve the capacity and reach of supplementation and fortification. Moreover, to ensure optimal intake, **awareness** is required to be created among policymakers, health care providers, caregivers and the public at large about the importance of micronutrients and strategies that are available.

These strategies need to be coupled with efforts to reduce the transmission and treatment of infectious diseases. Effective methods for overcoming micronutrient malnutrition do exist, but they require concrete, comprehensive and cost-effective efforts by governments to be successful. The unnecessary human suffering and hindrance to economic development caused by micronutrient malnutrition can largely be eliminated by improving the nutritional quality of the food supply and by educating people about good dietary practices.

Challenges in addressing micronutrient deficiencies in risk groups include:

- inadequate funds to support micronutrients interventions
- interventions largely dependent on donors
- resistance of communities to adoption of best practices
- low compliance and irregular enforcement of relevant laws
- low awareness of the consequences of micronutrient deficiencies

This plan (ZMNSAP) adopts strategies that address the identified challenges and aims at interventions that:

- improve anaemia prevention and control among women, adolescents and children
- strengthen services for prevention and control of Vitamin A deficiency and deworming among children aged 6–59 months
- increase availability and supply of adequate quality iodized salt
- improve the levels of other micronutrients among women, adolescents and children

*Table 14* shows the work plan and budget for KRA 2.

**Table 14: Work plan and budget for KRA 2 on scaled-up services to address micronutrient malnutrition among women, children and adolescents**

Work plan and budget for KRA 2: Scaled-up services to address malnutrition among school-age children, adolescents and women, with a focus on micronutrient deficiencies									
Outcome/Outputs/Activities	2020	2021	2022	2023	2024	Total Millions (TSh)	Total Millions (US\$)	Accountable lead institution	
<b>Outcome 2: The general population of Zanzibar, especially women, adolescents and children, consume adequate micronutrients</b>	1783.83	886.97	1281.51	977.89	2049.31	<b>6979.51</b>	3.03	MoH	
<b>Output 2.1: Improved anaemia prevention among and control interventions for women, adolescents and children</b>	<b>792.99</b>	<b>196.72</b>	<b>520.12</b>	<b>216.89</b>	<b>1178.2</b>	<b>2904.92</b>	<b>1.26</b>	<b>MoH</b>	
2.1.1 Adopt and roll out the Mainland National Anaemia Prevention and Control Guidelines, training manuals and job aids including brochures, posters and air radio spots for health service providers	371.71	16.89	331.30	18.62	686.72	<b>1425.24</b>	0.62	MoH	
2.1.2 Conduct comprehensive needs assessment of adolescents' IFA supplementation and establish a system for quarterly IFA supplementation consistent with WHO standards	7.75					<b>7.75</b>	0.003	MoH/MoEVT	
2.1.3 Conduct supportive supervision of, and provide coaching/ mentorship to health facilities and schools to ensure that the IFA supplementation is of good quality	161.09	169.15	177.6	186.49	195.81	<b>890.14</b>	0.39	MoH	
2.1.4 Conduct sensitization meetings with the media and influential people on the importance of prevention and control of anaemia.	19.37	10.68	11.22	11.78	12.37	<b>65.42</b>	0.03	MoH	
2.1.5 Train health workers, teachers, CHVs and other relevant stakeholders in IFA/MMS and WIFA supplementation	233.07				283.3	<b>516.37</b>	0.22	MoH/MoEVT	

(continued)

(continued)

Work plan and budget for KRA 2: Scaled-up services to address malnutrition among school-age children, adolescents and women, with a focus on micronutrient deficiencies									
Outcome/Outputs/Activities	2020	2021	2022	2023	2024	Total Millions (TSh)	Total Millions (US\$)	Accountable lead institution	
<b>Output 2.2: Strengthened services for prevention and control of Vitamin A deficiency among and deworming of children aged 6-59 months</b>	<b>570.68</b>	<b>596.1</b>	<b>625.9</b>	<b>657.2</b>	<b>690.06</b>	<b>3 139.94</b>	<b>1.37</b>	<b>MoH</b>	
2.2.1 Mobilize the community and urge them to send children under the age of 5 to health facilities for routine vitamin A supplementation	25.99	27.29	28.65	30.08	31.59	<b>143.60</b>	0.06	MoH/PORALG	
2.2.2 Train health service providers and CHVs in routine Vitamin A supplementation	7	7.35	7.71	8.1	8.5	<b>38.66</b>	0.02	MoH	
2.2.3 Incorporate activities on the prevention and control of Vitamin A deficiency into the councils' annual plans and budgets	14.64	15.37	16.14	16.95	17.8	<b>80.90</b>	0.04	MoH/PORALG	
2.2.4 Integrate and procure Vitamin A capsules and deworming supplies	523.05	546.09	573.4	602.07	632.17	<b>2876.78</b>	1.25	MoH	
<b>Output 2.3: Increased availability and supply of adequate quality iodized salt</b>	<b>320.48</b>	<b>59.27</b>	<b>62.23</b>	<b>65.34</b>	<b>213.92</b>	<b>721.24</b>	<b>0.31</b>	<b>MoH</b>	
2.3.1 Adopt training packages (guidelines, protocol, monitoring tools and job aids) for salt producers, service providers and CHVs /CORPs	91.31					<b>91.31</b>	0.004	MoH	
2.3.2 Train salt producers, wholesalers, retailers and groups of salt vendors in the importance of iodized salt including quality salt production, iodization, handling, salt regulation and its enforcement	119.55				145.31	<b>264.86</b>	0.12	MoH	
2.3.3 Procure potassium iodate and iodation equipment including monitoring kits for iodized salt	29.4	30.87	32.41	34.03	35.74	<b>162.45</b>	0.07	MoH	

(continued)

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Work plan and budget for KRA 2: Scaled-up services to address malnutrition among school-age children, adolescents and women, with a focus on micronutrient deficiencies									
Outcome/Outputs/Activities	2020	2021	2022	2023	2024	Total Millions (TSh)	Total Millions (US\$)	Accountable lead institution	
2.3.4 Review the current salt regulations and bylaws to facilitate enforcement of salt regulations	10.06					<b>10.06</b>	0.004	ZFDA	
2.3.5 Sensitize the community to the importance of consuming adequate iodized salt, through community social gatherings (that is, religious gatherings and village meetings), locally available radio/TV, IEC materials, road shows, celebrities/artists and phone messages to salt producers, salt traders, health care workers and the community at large	42.07	10.71	11.24	11.8	12.39	<b>88.21</b>	0.04	MoH/PORALG	
2.3.6 Develop an action plan for the consolidation of salt production and iodation	11.24					<b>11.24</b>	0.01	MoH	
2.3.7 Arrange quarterly supervision and inspection by the joint team of producers' sites and storage points for wholesalers and retailers.	11.6	12.18	12.79	13.43	14.1	<b>64.10</b>	0.03	MoH/ZFDA	
2.3.8 Support CHV supervisors in monitoring iodized salt at the farm and community levels	5.25	5.51	5.79	6.08	6.38	<b>29.01</b>	0.01	MoH/PORALG	
<b>Output 2.4: Prevent other micronutrient deficiencies and control interventions among women, adolescents and children</b>	<b>99.68</b>	<b>34.88</b>	<b>36.63</b>	<b>38.46</b>	<b>40.38</b>	<b>250.03</b>	<b>0.11</b>	<b>MoH</b>	
2.4.1 Adopt and roll out the Mainland National Prevention and Control of Micronutrient Deficiency Guidelines, training manuals and job aids, including brochures, posters and air radio spots for health service providers	66.46	-	-	-	-	<b>66.46</b>	0.03	MoH/PORALG	

(continued)

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Work plan and budget for KRA 2: Scaled-up services to address malnutrition among school-age children, adolescents and women, with a focus on micronutrient deficiencies									
Outcome/Outputs/Activities	2020	2021	2022	2023	2024	Total Millions (TSh)	Total Millions (US\$)	Accountable lead institution	
2.4.2 Celebrate child health nutrition month and mobilize the community with the use of media to make people aware of the importance of micronutrients, fortified food, dietary diversification and biofortification, using national and local radio/TV, SBCC materials, road shows, celebrities/artists and phone messaging.	33.22	34.88	36.63	38.46	40.38	183.57	0.08	MoH/PORALG	
<b>Output 2.5 Research on underlying causes of high levels of anaemia and micronutrient deficiencies</b>						532.9	0.23	MoH	
2.5.1 Conduct research on the underlying cause of anaemia among risk groups in Pemba						276.2	0.12	MoH	
2.5.2 Conduct research on micronutrients other than iron						256.7	0.35	MoH	



### 5.4.3 KRA 3: INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION (IMAM)

#### Expected outcome

Improved integrated management of acute malnutrition (IMAM)

#### Context

An estimated 450,000 children in Tanzania are acutely malnourished or wasted, with over 100,000 suffering from severe acute malnutrition (SAM). In Zanzibar, 12 per cent of children under the age of 5 suffer from acute malnutrition and of the 12 per cent, 4.5 per cent of children are severely and acutely malnourished (UNICEF 2014). This means that about 40,000 children under the age of 5 are suffering from acute malnutrition and 21,000 of those children are suffering from SAM. The unacceptably high levels of wasting threaten not only individual lives but also the subsequent generation's social and economic advancement due to poor health, high health expenditures, and lost educational achievements, incomes, and opportunities (Action against Hunger, 2017). Moreover, SAM is associated with increased severity of common infectious diseases and death. Among children with SAM, mortality is almost twice that of normal children.

#### Causes of acute malnutrition (wasting)

The causes of wasting are multiple: maternal undernutrition, acute food shortages, poor infant and young child feeding practices, repeated infectious diseases, and poor sanitation and hygiene. Other factors include low capacity of caregivers and health systems for preventing the advancement of moderate level malnutrition to severe levels. Lack of integration in the management of acute malnutrition and poor outreach capacity to keep track of malnourished children in the community are other important factors. Basic factors include poverty, low investment in nutrition at all levels, poor education, and low public and policy awareness among others.

#### Strategies to address acute malnutrition

Integration of strategies for the prevention and treatment of moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) are critical in addressing the overall problem of acute malnutrition. These strategies include the promotion of appropriate breastfeeding and complementary feeding practices, access to appropriate health care for the prevention and treatment of diseases and improved sanitation and hygiene practices. Disease prevention strategies are important in breaking the infection-malnutrition cycle with regard to the control of malaria, diarrhoea and repeated respiratory infections. Although not mentioned as a problem in Zanzibar, HIV and AIDS should be ruled out among children who are severely malnourished and appropriate measures should be taken.

#### Work plan and budget for IMAM

Table 15 depicts the expected results at the level of outcome, outputs, activities and the annual budget for the IMAM KRA.

**Table 15: Work plan and budget for KRA 3 on integrated management of acute malnutrition**

Outcome/Outputs /Activities	KRA 3: Annual budget in TSh (millions)					Total TSh	Total US\$
	2020	2021	2022	2023	2024	Millions	Millions
<b>Outcome: 3: Improved integrated management of acute malnutrition</b>	404.51	366.49	385.17	403.74	424.63	2 186.48	0.95
<b>Output 3.1: Improved quality of services for the management of SAM and MAM in at least 75 % of health facilities</b>	<b>166.12</b>	<b>174.1</b>	<b>183.15</b>	<b>191.62</b>	<b>201.92</b>	<b>1 118.83</b>	<b>0.05</b>
3.1.1 Conduct quarterly supportive supervision of IMAM activities in 11 districts of Unguja and Pemba (yearly)	92.17	96.78	101.62	106.70	112.03	509.3	0.22
3.1.2 Conduct quarterly meetings for the IMAM thematic working group	49.20	51.66	54.24	56.96	59.80	271.86	0.12
3.1.3 Training facility-based health service providers in the management and treatment of MAM/SAM	24.75	25.99	27.29	28.66	30.09	136.45	0.06
<b>Output 3.2: At least 75% of children under 5 years are reached out to through screenings for SAM and MAM at the community level</b>	<b>139.63</b>	<b>96.54</b>	<b>101.38</b>	<b>106.44</b>	<b>111.77</b>	<b>555.76</b>	<b>0.24</b>
3.2.1 Adopt IMAM training package (guidelines, monitoring tools and job aids) for the community and adapt it as necessary	25.74					25.74	0.01
3.2.2 Conduct IMAM supportive supervision and follow-up of defaulters	32.86	34.50	36.23	38.04	39.94	181.57	0.08
3.2.3 Develop and roll out a comprehensive community IMAM outreach and mobilization package to address negative social norms	34.30	12.98	13.63	14.31	15.03	90.25	0.04
3.2.4 Train CHVs in IMAM community outreach, counselling and mobilization packages	43.20	45.36	47.63	50.01	52.51	238.71	0.10
3.2.5 Advocate funding IMAM by the government and development partners to ensure adequate implementation	3.53	3.70	3.89	4.08	4.29	19.49	0.01

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Outcome/Outputs /Activities	KRA 3: Annual budget in TSh (millions)					Total TSh	Total US\$
	2020	2021	2022	2023	2024	Millions	Millions
<b>Output 3.3: Essential therapeutic nutrition supplies and equipment are available in at least 90 % of health facilities providing services for the management of SAM and MAM</b>	<b>98.76</b>	<b>95.85</b>	<b>100.64</b>	<b>105.68</b>	<b>110.96</b>	<b>511.89</b>	<b>0.22</b>
3.3.1 Procure and distribute ready-to-use therapeutic foods, medicines, anthropometric tools and other materials (cell phones, badges, rain coats and bicycles)	91.29	95.85	100.64	105.68	110.96	504.42	0.22
3.3.2 Review nutrition supplies and integrate them into the central procurement logistics system	7.47					7.47	0.003
<b>Total budget for KRA 3</b>	<b>404.51</b>	<b>366.49</b>	<b>385.17</b>	<b>403.74</b>	<b>424.63</b>	<b>2186.48</b>	<b>0.95</b>

## 5.4.4 KRA 4: SCALED-UP SERVICES TO PREVENT AND MANAGE DIET RELATED NON-COMMUNICABLE DISEASES (DRNCD)

### Expected outcome

Zanzibar's population is physically active and eats a healthy diet.

### Context

Non-communicable diseases (NCDs) refer to chronic diseases that last long, progress slowly and do not pass from one person to another. The four main types of NCDs are cardiovascular diseases (CVD), cancers, chronic respiratory diseases and diabetes. Public health specialists concerned with low-income and middle-income countries have devoted considerable attention to communicable diseases and maternal and child health for quite some time now. Recently, however, their attention has turned to non-communicable diseases due to the recognition that the NCD burden in low- and middle-income countries is not only growing rapidly, but is already astoundingly huge. Cardiovascular diseases (CVD) have become the leading cause of death worldwide in both developing and developed countries.

NCDs are now a growing global problem including in low-income countries like Tanzania. The NCD burden is one of the major challenges to socioeconomic development as it is a big burden to both the economy and the health care system. Tanzanian estimates from 2010 showed that NCDs accounted for about 27 per cent of all deaths of which cardiovascular diseases accounted for 12 per cent, injuries 8 per cent, cancers 3 per cent, respiratory diseases 3 per cent and diabetes 2 per cent, (WHO, 2011).

### Risk factors for NCDs

The main modifiable risk factors for NCDs are behavioural and include unhealthy diets, low levels of physical activity, smoking and excessive consumption of alcohol. In addition to behavioural risk factors, there are biological risk factors, such as obesity, raised blood pressure, raised cholesterol and raised blood glucose. Being overweight or obese increases the risk of NCDs like diabetes, hypertension, CVDs, stroke and several types of cancer, especially those of the oesophagus, pancreas, colon, kidneys, and thyroid gland. The rise in NCDs in Tanzania is mainly due to the social demographic transition from a young population to a relatively older population and rapid urbanization.

The behaviour risk factors are fuelled by globalization and urbanization as they lead to increased consumption of animal-based, energy-dense and refined/processed foods with high sugar, fats, salt content and very little fibre and decreased consumption of whole grains, legumes, nuts, fruits and vegetables, unpolished brown rice, corn and millet. Increased use of technology and motorized transport, sedentary behaviour (including sitting, lying down, working on the computer and watching television) and easy availability of alcohol and tobacco aggravate behavioural risk

factors as well. Urbanization too plays an important role as people who move from rural to urban areas continue consuming high-energy foods, but drastically cut down on physical activities.

People in developing countries, who received poor diets as children, are more likely to get NCDs like diabetes and CVD. Studies have indicated that when a child has suffered from malnutrition at some point or had low birth weight, the chance of his/her getting NCDs later in life is very high. Foetal or early childhood undernutrition (that leads to stunting) increases the risk of individuals getting NCDs even if their nutrition status improves later on in life. Thus, we see that in developing countries, NCDs are more common among younger age groups and among those who are not morbidly overweight or obese than in developed countries.

### **Situation of NCDs and risk factors in Zanzibar**

In 2012, WHO estimated that in Tanzania NCDs accounted for 31 per cent of all deaths (injuries 12 per cent, CVDs accounted 9 per cent, cancers for 5 per cent, chronic respiratory diseases for 1 per cent and other NCDs accounted for 13 per cent) (WHO NCD Country profiles, 2014). Data from the WHO STEPS survey that was conducted in Tanzania in 2012 showed that certain sections of the population were at a higher risk of getting NCDs.

Tobacco users (15.9), alcohol drinkers (29.3 per cent), people who are overweight and obese (26 per cent), people with raised cholesterol (26 per cent) and people with raised triglycerides (33.8 per cent), were amongst the high-risk populations. The study also revealed that the prevalence of diabetes (9.1 per cent) and hypertension (25.9 per cent) was high among these groups. In addition, the risk of developing diabetes or hypertension increased for people who ate less than five servings of fruits and/or vegetables on average per day (97.2 per cent). To understand the current situation, the ZMNSAP proposes to do another STEPS survey.

Even in Zanzibar, the incidence of risk factors for NCDs is very high. The prevalence of overweight increased from 27 per cent (2005 TDHS) to 30 per cent (2010 TDHS) to 38 per cent (2015 TDHS-MIS). In 2015, 2.8 per cent of children under the age of 5 were obese (2015 TDHS-MIS) – this rate meets the WHA target of keeping obesity among children under the age of 5 to below 5 per cent. Overall 7.3 per cent of the population in Zanzibar smoked, with men accounting for 14.6 per cent and women accounting for a meagre 0.7 per cent (STEP survey 2011). Eighteen per cent of the total population was physically inactive and 1.7 per cent consumed alcohol. Thirty-three per cent of the population had hypertension with men accounting for 37.0 per cent and women accounting for 29.4 per cent. The population consumed about 1.7 servings of fruit and/or vegetable per day. 3.7 per cent of the population had diabetes with older people accounting for 8.4 per cent and the younger group accounting for 2.1 per cent (STEP survey 2011). An average of 7 grams of salt was consumed per day- a measure that was way above the WHO recommendation of 4g or less per day {Fortification Assessment Coverage Tool (FACT) Survey in Tanzania-2016}.

## Strategies for addressing NCDs

A majority of non-communicable diseases can be averted through interventions and policies that reduce the major risk factors. Nutrition interventions play a pivotal role in managing and preventing NCDs. However, inadequate capacity of the health care system in providing quality nutrition education and counselling services, limited screening of the population and inadequate knowledge among health care providers and the general population on healthy lifestyles and safe nutrition practices, have rendered current preventive efforts to combat the NCDs ineffective. Training clinical dietitians in nutrition interventions can increase the capacity of the health care system. Moreover, lifestyle changes like giving up smoking or alcohol may not be easy to make and will require support and encouragement through investments in education, changes in food policies, and sometimes, even changes in urban infrastructure.

### Health promotion and lifestyle interventions

Promotion of healthy diets and lifestyles reduce the risk of NCDs. Healthy diets should be promoted across all age groups, especially among women (before and during their pregnancy), adolescent girls and schoolchildren. An optimal diet includes:

- achieving a balance between energy intake from food and energy expenditure through physical activities to maintain a healthy weight
- limiting energy intake from fats and consuming unsaturated fat instead of saturated fat
- limiting sodium consumption from all sources and ensuring that the salt eaten is iodized
- increasing the consumption of fruits, legumes, whole grains and nuts; limiting protein intake from animal sources

It will be useful to encourage people to use the already existing mHealth app (mobile health services) which uses mobile-based technologies to promote healthy behavioural changes. The growing use of mobile phones in the country makes the mHealth a viable public health tool.

The key risk factors – obesity, physical inactivity, and unhealthy diets – for the development of CVD and diabetes require interventions to bring about changes in unhealthy lifestyles. These changes are most likely to occur with the implementation of a coordinated range of interventions meant to encourage individuals to maintain a healthy weight, participate in daily physical activities for at least 30 minutes per day, and adopt a healthy diet.

**Education** is the key to implementing such changes. It appears to be more effective when provided through multiple methods and sites, such as schools, workplaces, mass media, and health centres. Educational messages are also more effective if they are reinforced by action. Schools, for example, could include in their curricula not only the benefits of good nutrition, but also the importance of healthy meals. Worksites could not only inform workers about the

importance of physical activity, but also provide an environment conducive to physical activity (e.g., use of non-motorized transportation like bicycles).

### **Promoting physical activity**

Engaging in physical activity for 30 minutes per day is of the utmost importance. Promotion of physical activity along with healthy diet can be done through mass media. Furthermore, people can be encouraged to increase their physical activities (e.g, walking) and use public and non-motorized transport. Schools should promote physical activities by providing a supportive environment, workplaces should provide space for fitness activities and signs to encourage the use of stairs and community-level campaigns that focus on a common goal (e.g., reduction in the risk of diabetes or CVDs) should be conducted. Furthermore, group-based physical activity programmes should be encouraged.

### **Reducing tobacco use**

Increases in taxes on and prices of tobacco products can significantly reduce tobacco use through lower initiation and increased cessation, especially among young people and the poor. Smoke-free workplaces and public places reduce second-hand smoke and effectively help smokers to cut down on smoking or quit smoking. In addition, tobacco advertising, promotion and sponsorship bans can also reduce tobacco consumption. Tobacco use can also be reduced through regular mass media campaigns and graphic health warnings on tobacco packages.

### **Reduction in excessive use of alcohol**

Public education, mass media campaigns and consumer warning labels and messages may reduce the excessive use of alcohol. Other effective measures include increasing taxes on alcoholic beverages, regulating the availability of alcoholic beverages (e.g., restricting access to retail alcoholic beverages and restricting marketing, comprehensive advertising, and promotion of alcoholic beverages) and sponsorship bans on alcoholic beverages.

### **Challenges to successful health promotion**

The main challenges with regard to NCDs in Zanzibar include:

- low awareness of the consequences of NCDs and ways to prevent them among policymakers, health care providers and the community at large
- lack of clinical dieticians and health staff with adequate skills to treat overweight/obesity and NCDs in general
- lack of dietary guidelines
- inadequate enforcement of dietary regulations

This plan (ZMNSAP) adopts interventions that:

- increase access to NCD quality services in the existing health care facilities
- sensitize school-age children and the adult population to risk factors for NCDs and also methods for prevention
- review policies and legislation to incorporate issues of prevention and control of NCDs into health and nutrition policies, strategies, action plans and programmes

#### **Work plan and budget for KRA 4 on DRNCDs**

*Table 16* depicts the work plan and budget for KRA 4 indicating the expected results (outcome, output, activities) and the annual budget.



**Table 16:** Work plan and budget for KRA 4 on scaled-up services to prevent and manage diet related non-communicable diseases (DRNCDS)

Work plan and Budget for KRA 4: Diet-related non-communicable diseases (DRNCDS)								
Outputs /Activities	Budget in TSh (millions)					Total TSh Millions	Total US\$ Millions	Lead institution
	2020	2021	2022	2023	2024			
<b>Outcome 4: Zanzibar's population is physically active and eats healthy diets.</b>	<b>646.69</b>	<b>288.76</b>	<b>303.18</b>	<b>318.36</b>	<b>391.08</b>	<b>1948.07</b>	<b>0.85</b>	<b>MoH</b>
<b>Output 4.1: Increased access to DRNCD quality services in the existing health care facilities from 49 To 55 health facilities)</b>	<b>235.22</b>	<b>30.5</b>	<b>32.02</b>	<b>33.63</b>	<b>145.94</b>	<b>477.31</b>	<b>0.21</b>	<b>MoH</b>
4.1.1 Review and update the health-training curriculum to include prevention and management of DRNCD even for university curricula	43.55					43.55	0.02	MoH
4.1.2 Train at least two health care workers and CHV per facility in risk factors for DRNCD in Unguja and Pemba	91.02				110.63	201.65	0.09	MoH/PORALG
4.1.3 Procure and distribute equipment and supplies for prevention and management of DRNCDS	71.61					71.61	0.03	MoH
4.1.4 Quarterly supervise prevention and management of DRNCDS and provide mentorship to the staff on prevention and management of DRNCDS	17.93	18.83	19.77	20.76	21.8	99.09	0.04	MoH
4.1.5 Conduct screening programmes/campaigns on DRNCDS risk factors for the community	11.11	11.67	12.25	12.87	13.51	61.41	0.03	MoH
4.1.6 Conduct STEPS survey to update the one that was done in 2012								

(continued)

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Work plan and Budget for KRA 4: Diet-related non-communicable diseases (DRNCDS)							
Outputs /Activities	Budget in TSh (millions)				Total TSh	Total US\$	Lead institution
	2020	2021	2022	2023			
4.1.7	Train a cadre of dieticians to support the nutritional management of DNCDs						
<b>Output 4.2: At least 50 % of school-age children and adult population are sensitized to the risk factors for non-communicable diseases</b>		<b>180.45</b>	<b>91.87</b>	<b>96.46</b>	<b>101.29</b>	<b>52.54</b>	<b>MoH/MOED</b>
4.2.1	Conduct advocacy meetings with key policy and decision makers, the MoH management team and development partners for securing adequate financial resources for DRNCD prevention and control	16.09	16.89	17.73	18.62	19.55	MoH
4.2.2	Develop school education modules on healthy eating and lifestyles and provide DRNCD related training to primary, secondary and institutional teachers in Unguja and Pemba quarterly	92.95					MoH/MOED
4.2.3	Conduct public awareness campaigns to inform food vendors, hoteliers, traditional healers and employees in workplaces, journalists, editors and media owners on healthy eating and lifestyles for all age groups	44.27	46.48	48.81	51.25		MoH
4.2.4	Quarterly develop and air radio and TV spots on DRNCD prevention	27.14	28.50	29.92	31.42	32.99	MoH
<b>Output 4.3: Reviewed policies and legislation to integrate issues of prevention and control of NCDs</b>		<b>231.02</b>	<b>166.39</b>	<b>174.7</b>	<b>183.44</b>	<b>192.6</b>	<b>ZFDA/MoH</b>

(continued)

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Work plan and Budget for KRA 4: Diet-related non-communicable diseases (DRNCDS)							
Outputs /Activities	Budget in TSh (millions)				Total TSh Millions	Total US\$ Millions	Lead institution
	2020	2021	2022	2023			
4.3.1 Advocate development of laws and regulations to curb the advertisement of unhealthy foods	20.29				20.29	0.01	ZFDA/MoH
4.3.2 Advocate initiation/review of policies and legislation that regulate advertisement, promotion and sponsorship of tobacco and alcohol	210.73	166.39	174.7	183.44	92786	0.4	ZFDA/MoH
<b>Output 4.4 STEPS Survey conducted</b>							
4.4.1 Conduct a STEPS survey to update the one done in 2012					1,273.1	0.56	MoH/NBS/Office of Chief Govt. Statistician
<b>Output 4.5 Clinical Dieticians trained</b>							
4.5.1 Train two dieticians per clinic in administering proper nutrition to people with DRNCDS					0.312	0.136	MoH

## 5.4.5 KRA 5: MULTISECTORAL NUTRITION-SENSITIVE INTERVENTIONS

### Expected outcome

Line sectors, private sectors and CSOs will scale up nutrition-sensitive interventions to reach out to all communities in order to improve nutrition.

### Context

Multisectoral nutrition interventions are generally nutrition-sensitive. They can help enhance the reach and impact of nutrition-specific interventions by creating a stimulating environment in which young children can grow and develop to their full potential and adults can become more productive. The ZMNSAP identifies the following main nutrition-sensitive sectors for multisectoral nutrition actions: **social protection; education; agriculture; water, sanitation and hygiene (WASH) and health**. This identification is based on the evidence that scaling up of some interventions in these key nutrition-sensitive sectors has had a strong impact on improving nutrition, especially on nutrition related to stunting.

To make their policies, strategies and programmes more effective in relation to raising nutrition levels, nutrition-sensitive sectors can take various steps. These include strengthening nutrition focused goals, designing new ones and encouraging their integration in the implementation process; improving targeting, timing, and duration of their interventions; using conditions to stimulate the demand for quality nutrition services; and focusing on women's nutrition and empowerment. Women who are well-nourished are also empowered and they enhance their families' capacity for good health, nutrition, learning and economic development.

### Social protection

With regard to **social protection**, the Zanzibar Development Vision's policy focuses on vulnerable and disadvantaged groups and works towards the protection of orphans, and prevention of violence against women and children. The policy objectives include strengthening of the capacity of households and communities in providing health care and schooling to children. These areas, along with nutrition, are precisely those that the Tanzania Social Action Fund (TASAF) programme uses as conditions for their cash transfers to households living in extreme poverty.

For these households, the TASAF makes a modest cash transfer conditional on a family's participation in education and health related services, as well as community sessions on health, nutrition and sanitation. The ZMNSAP will support coordination and linkages between ministries responsible for social protection and communities providing nutritional services to vulnerable groups through social behavioural change strategies and approaches.

## Education

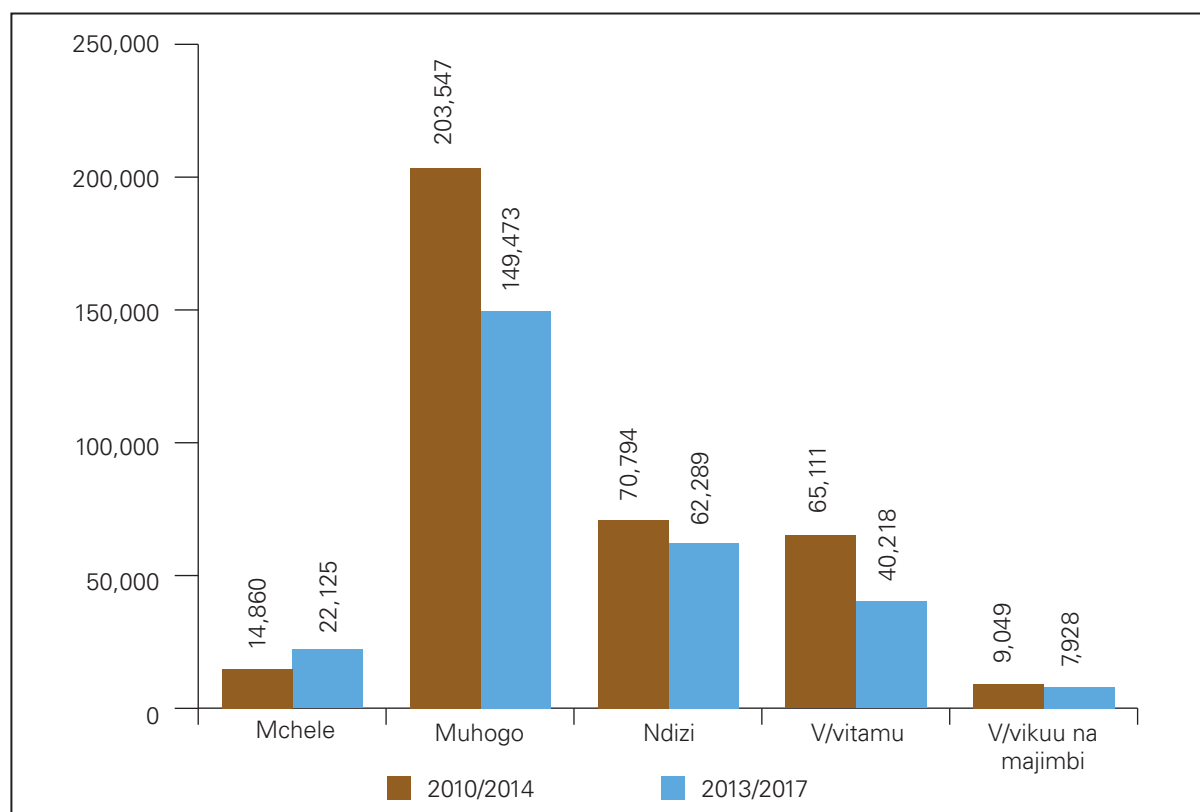
The Zanzibar **education development plan** identifies poor student health and nutrition as one of the core problems of education outcomes in Zanzibar. Apart from revealing the known benefits of school-feeding programmes, the ZMNNS analysis revealed that few primary schools are enlisted in the school-feeding programme. However, at the secondary level, no school-feeding programme exists. The existing school-feeding programme for pre-primary has no school-feeding guidelines.

School-feeding programmes have been used to address specific micronutrient deficiencies, alleviate short-term hunger and improve cognition, motivate parents to enrol their children in schools and improve attendance and promote community participation. The ultimate goal is to improve learning outcomes. The ZMNSAP will strengthen nutritional interventions in educational institutions by focusing on school-feeding programmes as one of the key performance indicators of the Zanzibar Education Development Plan, thus contributing to increased net-enrolment and net-attendance rates.

## Agriculture

Ensuring basic **national and household food security with the agriculture sector's help** is crucial for nutrition improvement. At the national level, Zanzibar achieves food security through

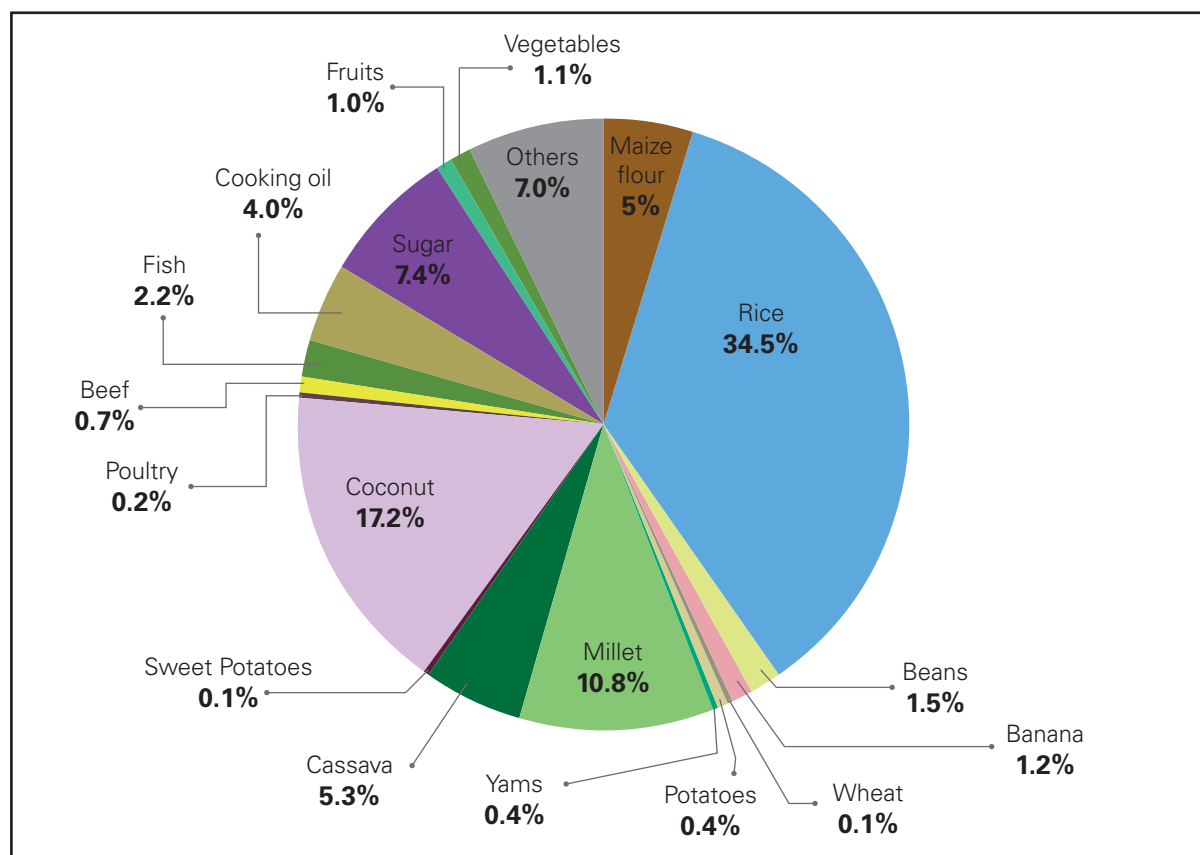
**Figure 22:** Food production in Zanzibar



a combination of food production and importation. Since domestic food production, especially the production of rice (the staple), is inadequate, food importation plays a very important role in achieving both national and household food security. *Figure 22* shows that with the exception of rice, the production of which is increasing, food production in Zanzibar between 2010 and 2017 generally declined or remained stagnant at best. This decline or stagnation might be a result of climate change due to which the sea level is rising and encroaching on productive lands. Seawater makes the lands saline and unsuitable for food production. Climate change has also affected the availability of fish, the major source of protein in Zanzibar.

In 2017/2018, food imports stood at about 220,898 tonnes with rice, maize flour, wheat flour and sugar comprising 79.1 per cent of the total food import (174,806.7 tonnes). Rice made up 38.8 per cent of the imports, wheat flour 23.6 per cent and sugar 16.8 per cent. *Figure 23* derived from the household budget survey (HBS) of 2012 shows that rice, millet and coconut are the major foods being consumed, with very little consumption of fruits, vegetables and protein.

**Figure 23:** Food consumption pattern in Zanzibar



An analysis of the Zanzibar food basket gap shows an unhealthy food consumption pattern: (a) high-energy intake (above 2100 kcal), (b) high intake of fat and carbohydrate, (c) low intake of protein and (d) an imbalance in the intake of micronutrients.

The main challenges in the agriculture sector relate to a number of factors including:

- low level of food production attributed to climate change factors resulting in increases in the prices of meat and fish, fruits and vegetables
- inadequate production of animal-source foods
- high import dependency ratio
- lack of effective pre- and post-harvest handling techniques
- poor market and infrastructure

The RGoZ has taken several measures to address some of these challenges. The long-term objective is to provide access to productive resources, opportunities and progress towards more socially just forms of agriculture by improving standards of nutrition, increasing output and improving the quality of food commodities. Review of the ZMNNS showed that inadequate coordination among sectors, little awareness of nutrition outcomes and poor visibility of nutrition-sensitive interventions in agriculture are among the key challenges in the sector. The ZMNSAP will promote modernization of food crop production using biofortified seeds, intercropping and home gardens and promotion of fruits, vegetables and small-scale animal rearing for meat production to diversify diets.

### **Water, sanitation and hygiene**

**Improved water sanitation and hygiene (WASH)** is among the top things required for Zanzibar to attain high quality livelihoods for its entire population.. For the past five years, the ZMNNS has been focusing on school WASH programmes; however, the coverage was only for a few selected pilot schools due to financial constraints. The ZMNSAP will advocate increasing the budget for school WASH programmes and will promote WASH behaviours among extension workers and in the community at large to install a cleanness culture and behaviours.

### **Health – coordination with other sectors**

In addition to being the main sector for nutrition-specific interventions, **the health sector** is at the top for multisectoral nutrition-sensitive interventions since the issue of health transcends the health sector itself. Nutritional status is both an important determinant and indicator of what course a disease or an infection takes. In the case of HIV/AIDS, deterioration in the nutritional status indicates the disease's progression. Malaria and other infections in undernourished children may further reduce their immunity and lead to preventable deaths. The immunosuppressive effects of undernutrition starts manifesting during a foetus's intrauterine life– thus adequate maternal nutrition is crucial. The Zanzibar Development Vision 2020 aims to raise the health and nutritional standard of the Zanzibar community in general and for women and children in particular. To enhance health and nutritional services, the ZMNSAP will promote coordinated handling of family planning, neglected tropical diseases (NTD), prevention and treatment of

HIV, scaled-up interventions for the prevention of anaemia, control of malaria and treatment of parasitic worms (helminths).

### **Climate change and nutrition security**

According to the Office of the Second Vice President, in the last two decades, Zanzibar has noted the impact of climate change on food and nutrition security and has thus called for the inclusion of a component on climate change and food security in the ZMNSAP. Two key observations have been made. First, sea level seems to be rising and as a result saline seawater has slowly depleted arable land, especially in Pemba, affecting food production. Second, of late, fishermen have been compelled to go deeper into the ocean to catch fish because the amount of fish near the surface and the total amount of fish in general is decreasing. This development is concerning because fish is the major source of protein in Zanzibar.

Recent studies have reinforced the severity of impact of climate change on nutrition, and have proposed certain adaptation and mitigation measures for strategies and action plans, especially with regard to the interactions of the three underlying causes of undernutrition: (1) household food access, (2) maternal and childcare and feeding practices, and (3) environmental health and access to health services. Based on the three underlying causes, a global multi-agency cross-sectoral study analysed the impacts of climate change on nutrition security and recommended mechanisms and policies to address them.<sup>27</sup> It concluded that improved multisectoral coordination and political will are indispensable for incorporating nutrition-sensitive actions into climate-resilient sustainable development efforts.

The authors recommend wider efforts on climate change mitigation and adaptation and climate-resilient development. Recommended measures include a combination of measures that include climate-resilient and nutrition-sensitive agricultural development, social protection, improved maternal and childcare and health, and nutrition-sensitive risk reduction and management. Other recommendations include community development measures, nutrition-smart investments, increased policy coherence, and institutional and cross-sectoral collaboration. Placing human rights and international solidarity at the centre of mitigation and adaptation strategies will advance sustainable development and foster nutrition security. The ZMNSAP will promote implementation of these recommendations and will initiate specific studies on the impact of climate change on food and nutrition security in the Zanzibari context.

### **Work plan and budget for KRA 5**

*Table 17* shows the expected results, work plan and budget for the multisectoral nutrition-sensitive interventions.

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<sup>27</sup> Tirado MC, Crahay P, Mahy L, Zanev C, Neira M, Msangi S, Brown R, Scaramella C, Costa Coitinho D, Müller A. (2013) Climate change and nutrition: creating a climate for nutrition security. *Food Nutr Bull.* 2013 Dec; 34(4):533–47.



**Table 17: Work plan and budget for KRA 5 on multisectoral nutrition interventions**

KRA 5: Multisectoral nutrition-sensitive interventions							
Outputs /Activities	Budget in TSh (millions)				Total Tsh Millions	Total US\$ Millions	
	2020	2021	2022	2023			2024
<b>Outcome 5: Line sectors, private sector and CSOs scale up nutrition-sensitive interventions to reach all communities</b>	<b>2138.6</b>	<b>2345.1</b>	<b>2437.5</b>	<b>2530.6</b>	<b>11552.3</b>	<b>5.682</b>	
<b>Output 5.1: Vulnerable groups have increased access to quality nutritional services</b>	<b>498.9</b>	<b>523.8</b>	<b>550</b>	<b>577.5</b>	<b>2257.6</b>	<b>0.97</b>	
5.1.1 Sensitize TASAF and early education and childhood development (EECD) staff to the importance of providing nutritional services to vulnerable groups.	21.6	22.7	23.8	25.0	97.8	0.04	
5.1.2 Train CHVs from all Shehias in the use of SBCC kits	83.2	87.3	91.7	96.3	376.4	0.16	
5.1.3 Procure SBCC models and roll them out in all districts	394.1	413.8	434.5	456.2	1783.4	0.77	
<b>Output 5.2 Strengthened nutritional interventions in educational institutions</b>	<b>1294.8</b>	<b>1359.5</b>	<b>1427.5</b>	<b>1499</b>	<b>7154.6</b>	<b>3.11</b>	
5.2.1 Develop and disseminate National School-Feeding Guidelines/Manual for pre-primary, primary and secondary school pupils	161.1	169.1	177.6	186.5	890.0	0.38	
5.2.2 Train teachers, school management committees, the MoEVT and LGA officials in the School-Feeding Guidelines/Manual	752.9	790.6	830.2	871.7	3,407.8	1.48	
5.2.3 Review school health and nutrition programmes to incorporate nutrition, WASH and child protection actions	23.3	24.5	25.7	27.0	105.5	0.46	

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KRA 5: Multisectoral nutrition-sensitive interventions							
Outputs /Activities	Budget in TSh (millions)				Total Tsh Millions	Total US\$ Millions	
	2020	2021	2022	2023			2024
5.2.4	305.2	320.4	336.4	353.3	370.9	1,381.1	0.60
5.2.5	52.3	54.9	57.6	60.5	63.5	288.8	0.12
<b>Output 5.3: Increased availability and utilization of quality food within households</b>	<b>156.8</b>	<b>164.5</b>	<b>172.8</b>	<b>181.6</b>	<b>190.4</b>	<b>866.1</b>	<b>1.05</b>
5.3.1	31.5	33.1	34.7	36.5	38.3	174.0	0.76
5.3.2	55.0	57.7	60.6	63.7	66.8	303.9	0.13
5.3.3	46.7	49.0	51.5	54.1	56.7	258.0	0.11
5.3.4	23.6	24.7	26.0	27.3	28.6	130.2	0.05
<b>Output 5.4: Improved WASH practices including hand washing</b>	<b>102.4</b>	<b>107.4</b>	<b>112.8</b>	<b>118.3</b>	<b>124.4</b>	<b>565.6</b>	<b>0.24</b>
5.4.1	56.7	59.5	62.5	65.5	68.9	313.3	0.13
5.4.2	45.7	47.9	50.3	52.8	55.5	252.3	0.11

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KRA 5: Multisectoral nutrition-sensitive interventions							
Outputs /Activities	Budget in TSh (millions)				Total Tsh Millions	Total US\$ Millions	
	2020	2021	2022	2023			2024
<b>Output 5.5: Communities regularly use quality maternal health services including family planning and prevention and treatment of HIV, malaria and neglected tropical diseases (NTD)</b>	<b>85.7</b>	<b>89.9</b>	<b>94.4</b>	<b>99.2</b>	<b>104.1</b>	<b>0.21</b>	
5.5.1 Ensure that family planning, and prevention and treatment of HIV, malaria and NTDs are adequately linked with nutrition outcomes	36.7	38.5	40.4	42.5	44.6	0.09	
5.5.2 Train the key family planning, NTD and prevention and treatment of HIV and malaria staff in linkages between nutrition and these programmes	49.0	51.4	54.0	56.7	59.5	0.12	
<b>Output 5.6: Climate-resilient multisectoral nutrition interventions are promoted and integrated into actions that address the underlying causes of malnutrition, focusing on food security, care security and health and WASH security.</b>	<b>-</b>	<b>100.0</b>	<b>80.0</b>	<b>55.0</b>	<b>-</b>	<b>0.102</b>	
5.6.1 Review policies and strategies of nutrition- sensitive sectors to ensure that they are climate change resilient.	-	50.0	30.0	25.0	-	0.045	
5.6.2 Study the impact of climate change on food and nutrition security in Zanzibar and promote evidence-informed and context-specific adaptation and mitigation measures (Kilimo himilivu).	-	50.0	50.0	30.0	-	0.057	

## 5.4.6 KRA 6: MULTISECTORAL NUTRITION GOVERNANCE

### Expected outcome

Multisectoral nutrition governance strengthened.

### Context

Multisectoral nutrition governance (MNG) is crucial in **enabling** a large-scale coordinated and collaborative response to the nutrition challenge. It not only sustains political will, facilitates development of consensus on the nutrition narrative and provides direction to policies, strategies and implementation; but also makes various stakeholders agree on common results, accountability and monitoring and evaluation. MNG also creates empowering conditions for sustainability (government ownership, financing and human resources), facilitates gender mainstreaming, addresses issues of equity and links community-level actions with meso-level and macro-level policies and strategies.

Key components of an MNG framework include intersectoral cooperation of government and non-government sectors, vertical coordination between various levels of the government, sustainable and well managed funding from government and partners, adequate human resource development, and creative and innovative advocacy and social mobilization of improved nutrition.

To ensure that the framework works, the ZMNSAP provides for:

- (a) the involvement of the executive branch of the government in both the development and implementation of the framework
- (b) the establishment of multisectoral coordination bodies at both the national and subnational levels
- (c) the framing of the ZMNSAP as part of the National Development Agenda
- (d) the development of a single narrative about the severity of the malnutrition problem
- (e) the development of the capacity of the community and local governments to deliver nutrition services
- (f) the encouragement of local ownership of the proposed interventions
- (g) the development of a framework for monitoring, evaluation, accountability, learning (MEAL) and research
- (h) the development of a mechanism that promotes multisectoral leadership and management

### Work plan and budget for KRA 6

Table 18 shows the key results, (outcomes and outputs) activities and their associated annual budgets for KRA 6.

**Table 18: Work plan and budget for KRA 6 on multisectoral nutrition governance (MNG)**

WORK PLAN AND BUDGET FOR KRA 6 on MULTISECTORAL NUTRITION GOVERNANCE (MNG)									
Outcome/Outputs /Activities	Estimated Budget in TSh. (Millions)					Total TSh. (Millions)	Total US\$	Accountable Institutions	
	2020/21	2021/22	2022/23	2023/24	2024/25			Leader	Collaborators
<b>Outcome 6: Multisectoral nutrition governance strengthened</b>	<b>701.34</b>	<b>652.07</b>	<b>773.23</b>	<b>718.90</b>	<b>852.48</b>	<b>3,698.02</b>	<b>1.61</b>		
<b>Output 6.1: Increased political and financial commitment of the government to nutrition</b>	<b>94.97</b>	<b>99.72</b>	<b>104.70</b>	<b>109.94</b>	<b>115.44</b>	<b>524.77</b>	<b>0.23</b>		
6.1.1 Advocate the need for increased commitment of the government and political leaders	26.66	27.99	29.39	30.86	32.41	147.31	0.06	MoH	Sectoral ministries, donors
6.1.2 Conduct annual joint nutrition stakeholder meetings to review the implementation of the ZMNSAP	64.39	67.60	70.98	74.53	78.26	355.77	0.15	MoH	Sectoral ministries, donors
6.1.3 Advocate the establishment of a development partner group (DPG) for nutrition	3.93	4.12	4.33	4.54	4.77	21.69	0.01	MoH	Sectoral ministries, donors, CSOs
<b>Output 6.2: Ensure functional, sectoral and multisectoral coordination at all levels</b>	<b>94.11</b>	<b>98.82</b>	<b>103.76</b>	<b>108.94</b>	<b>114.39</b>	<b>520.02</b>	<b>0.23</b>		
6.2.1 Conduct biannual intersectoral steering committee meetings on food security and nutrition (FSN)	15.43	16.20	17.01	17.86	18.75	85.23	0.04	Inter-sectoral Committees	Office of the Second Vice President
6.2.2 Conduct multisectoral technical coordination meetings for nutrition	15.90	16.69	17.52	18.40	19.32	87.83	0.04	TWGs	MoH
6.2.3 Conduct technical working group meetings on nutrition governance and information system quarterly	17.92	18.82	19.76	20.74	21.78	99.02	0.04	Regions and districts	MoH
6.2.4 Strengthen the capacities of the established multisectoral steering committees for nutrition at subnational levels (region and council)	44.87	47.11	49.47	51.94	54.54	247.94	0.11	Regions and districts	MoH

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WORK PLAN AND BUDGET FOR KRA 6 on MULTISECTORAL NUTRITION GOVERNANCE (MING)									
Outcome/Outputs /Activities	Estimated Budget in TSh. (Millions)					Total TSh. (Millions)	Total US\$	Accountable Institutions	
	2020/21	2021/22	2022/23	2023/24	2024/25			Leader	Collaborators
<b>Output 6.3: Improved human resources and capacities for nutrition at all levels</b>	<b>68.78</b>	<b>72.22</b>	<b>75.83</b>	<b>79.62</b>	<b>83.60</b>	<b>380.05</b>	<b>0.17</b>		
6.3.1 Recruit nutrition officers at the central, regional and council levels	.00	.00	.00	.00	.00	.00	0.00	Regions and Districts	MoH
6.3.2 Provide on-job training to nutrition officers at all levels in Unguja and Pemba	40.51	42.54	44.66	46.90	49.24	223.84	0.10	MoH	Sectoral ministries, donors, CSOs
6.3.3 Support learning visits on nutrition issues within and outside the country	28.27	29.68	31.17	32.73	34.36	156.21	0.07	Office of the Second Vice President	MoH
<b>Output 6.4: Increased communication and public awareness on the ZMNSAP</b>	<b>443.48</b>	<b>381.31</b>	<b>488.94</b>	<b>420.40</b>	<b>539.05</b>	<b>2,273.18</b>	<b>0.99</b>		
6.4.1 Conduct semi-annual meetings for relevant regional and district officers to create synergies and raise awareness on the ZMNSAP	223.94	235.14	246.89	259.24	272.20	1,237.41	0.54	Regions and Districts	MoH
6.4.2 Sensitize the community to the ZMNSAP on village health and nutrition days (VHNDs)	87.33	91.70	96.28	101.10	106.15	482.55	0.21	Regions and Districts	MoH
6.4.3 Develop and disseminate BCC materials for the ZMNSAP	95.69	16.13	105.50	17.79	116.31	351.42	0.15	MoH	Office of the Second Vice President
6.4.4 Disseminate health and nutrition education on the ZMNSAP through mass media	36.52	38.35	40.26	42.28	44.39	201.80	0.09	MoH	Ministry of Information, Tourism and Antiques

## 5.4.7 KRA 7: MULTISECTORAL NUTRITION INFORMATION SYSTEMS (MNIS)

### Expected outcome 7

Strengthened multisectoral nutrition information systems for effective decision-making at all levels

### Context

According to the Scaling Up Nutrition (SUN) Movement, information systems for nutrition should have three main functions:<sup>28</sup> Firstly, measuring **changes** in the nutrition status of vulnerable people, children and women; secondly, tracking **progress** in the implementation of actions; and thirdly, helping to prioritize **response**. Reliable monitoring of progress, evaluation of outcomes and demonstration of results are central to the implementation of the ZMNSAP.

A good multisectoral nutrition information system should facilitate collection, collation, analysis and dissemination of synthesized data from multiple sources in order to inform multisectoral responses with them. Sources include areas such as agriculture, food security, health, education, social protection, WASH, environment and climate change among others. Since Zanzibar lacks such a coordinated framework, the ZMNSAP proposes a framework for a multisectoral nutrition information system (MNIS) as a KRA. Owned by the government, the MNIS will facilitate the tracking of the progress of the ZMNSAP and provide a better understanding of the extent, location, and immediate, underlying and basic determinants of malnutrition that are vital for mounting appropriate responses and adequately allocating resources.

The proposed MNIS covers all administrative levels (from the national level to the community level) and aims to provide quality and timely multisectoral data that can easily be analysed and used at the point of collection. The capacity to undertake such practical and timely analysis and interpretation is extremely important for providing feedback in ways that can improve the design and refine the strategic priorities of the ZMNSAP.

As part of the development of the ZMNSAP, UNICEF rapidly mapped the availability of routine nutrition information in the agricultural, educational and social protection sectors. The mapping included the type of nutrition information collected, frequency of data collection, plans to use/modify nutrition indicators if they did not exist or were not being used adequately at the time of the mapping and details on the system capacity and challenges. The ultimate goal of the exercise was to identify potential nutrition indicators which could be integrated into the ZMNSAP, identify challenges faced by an MDA in the case of routine information systems and suggest measures for improvement.

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<sup>28</sup> Scaling Up Nutrition in Practice (2014): Information Systems for Nutrition. Newsletter, April 2014

The key findings were of the mapping:

- the Ministry of Education, MLEEWC and TASAF have a system in place to collect routine information system
- the Ministry of Agriculture does not have a system in place to collect routine data, but relies on data generated by other institutions or collects information as per need. The MoA is developing its own electronic database which is expected to be ready by the end of 2019
- all visited MDAs have nutrition-related interventions; however, **only MLEEWC records nutrition indicators** in its routine information system although data flow is hampered by lack of accountability of the responsible officers
- all visited MDAs had the potential to include nutrition indicators in their information systems

The recommendations formulated after the mapping exercise were:

- as members of the ZMNSAP, each of these visited sectors should have at least one indicator included in the CRAF to track the ZMNSAP
- the coordination structure under the Second Vice President's Office should establish a mechanism for capacity-building in data collection to aid ZMNSAP members
- where possible, UNICEF and TASAF should decide on *Stawisha Maisha* indicators, based on the ZMNSAP CRAF, to be used for TASAF data collection

### **The MNIS framework for the ZMNSAP**

The proposed MNIS emphasizes the importance of a robust performance framework that includes indicators at the three key levels of results: **output, outcome and impact**. The ZMNSAP has adopted the CRAF as the overall framework to define the indicators that an MNIS should use. The main indicators were defined bearing in mind:

- 1) prospective results for improvement in nutritional status
- 2) the defined populations in which these improvements will be seen
- 3) the interventions necessary to achieve the results and clear indications on the current coverage level and on the goal coverage
- 4) the identification of responsibilities of line ministries and sectors within the government for implementing the interventions
- 5) the roles and responsibilities of non-government partners
- 6) a shared framework for performance M&E

### **Work plan and budget for KRA 7**

Table 19 shows the work plan and budget for KRA 7. This should be read in conjunction with the CRAF shown in appendix 1.



**Table 19: Work plan and budget for KRA 7 on multisectoral NISs**

WORK PLAN AND BUDGET FOR KRA 7 - MULTISECTORAL NUTRITION INFORMATION SYSTEMS (MNIS)									
Outcome/Outputs /Activities	Estimated budget in TSh (Millions)					Total TSh (Millions)	Total US\$	Accountable institutions	
	2020/21	2021/22	2022/23	2023/24	2024/25			Leader	Collaborators
<b>Outcome 7: Strengthened multisectoral nutrition data system, nutrition research and learning for effective evidence-based decisions</b>	<b>688.52</b>	<b>400.71</b>	<b>405.31</b>	<b>426.14</b>	<b>689.93</b>	<b>2,610.61</b>	<b>1.14</b>		
<b>Output 7.1: Strengthened comprehensive multisectoral nutrition and related information systems at all levels</b>	<b>129.44</b>	<b>83.69</b>	<b>142.71</b>	<b>92.26</b>	<b>157.34</b>	<b>605.43</b>	<b>0.26</b>		
7.1.1 Develop and manage a comprehensive system for regular multisectoral data collection, analysis and reporting of nutrition at all levels	23.77	24.96	26.21	27.52	28.89	131.34	0.06	MoH	Sectoral ministries, donors, CSOs
7.1.2 Develop and disseminate annual implementation reports for nutrition	14.51	15.24	16.00	16.80	17.64	80.18	0.03	Office of the Second Vice President	MoH
7.1.3 Conduct annual bottleneck analysis for nutrition and analysis of the implementation of nutrition budgets	24.58	25.80	27.09	28.45	29.87	135.79	0.06	MoH	Sectoral ministries, donors, CSOs
7.1.4 Produce and disseminate multisectoral nutrition scorecards at all levels	16.85	17.69	18.57	19.50	20.48	93.08	0.04	MoH	Sectoral ministries, donors.
7.1.5 Conduct mid- and end-term evaluation of the implementation of the ZMNSAP	49.74	.00	54.84	.00	60.46	165.04	0.07	Office of the Second Vice President	MoH

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WORK PLAN AND BUDGET FOR KRA 7 - MULTISECTORAL NUTRITION INFORMATION SYSTEMS (MNIS)										
Outcome/Outputs /Activities	Estimated budget in TSh (Millions)					Total TSh	Total US\$	Accountable institutions		
	2020/21	2021/22	2022/23	2023/24	2024/25			Leader	Collaborators	
<b>Output 7.2: Multisectoral routine NIS enhanced</b>	<b>286.00</b>	<b>186.97</b>	<b>126.04</b>	<b>190.49</b>	<b>137.63</b>	<b>927.13</b>	<b>0.40</b>			
7.2.1 Conduct annual data quality audits for available sectoral routine data systems (HMIS, EMIS, LMIS, TASAF, agriculture and social Welfare) to ensure that they include nutrition	49.74	52.23	54.84	57.58	60.46	274.84	0.12	MoH	Sectoral ministries, donors.	
7.2.2 Advocate and strengthen the capacity of routine data systems to include nutrition indicators and for nutrition surveillance at all levels	50.79	53.33	.00	58.80	.00	162.92	0.07	MoH	Sectoral ministries, donors, CSOs	
7.2.3 Develop and manage a harmonized system/mechanism for comprehensive management of nutrition-related data and information	111.75	25.96	12.98	12.98	12.98	176.65	0.08	MoH	Sectoral ministries, Donors, CSOs	
7.2.4 Develop and manage a feedback mechanism framework for the ZMNSAP	39.93	19.97	20.97	22.02	23.12	126.01	0.05	MoH	OCGS, sectoral ministries, donors and CSOs	
7.2.5 Sensitize nutrition stakeholders to the importance of evidence-based information at all levels	33.79	35.48	37.25	39.12	41.07	186.71	0.08	MoH	OCGS, sectoral ministries, donors and CSOs	
<b>Output 7.3: Enhanced evidence-based decision-making through nutrition research and studies</b>	<b>273.08</b>	<b>130.06</b>	<b>136.56</b>	<b>143.39</b>	<b>394.96</b>	<b>1,078.05</b>	<b>0.47</b>			

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WORK PLAN AND BUDGET FOR KRA 7 - MULTISECTORAL NUTRITION INFORMATION SYSTEMS (MNIS)										
Outcome/Outputs /Activities	Estimated budget in TSh (Millions)					Total TSh (Millions)	Total US\$	Accountable institutions		
	2020/21	2021/22	2022/23	2023/24	2024/25			Leader	Collaborators	
7.3.1	24.34	80.00	84.00	88.20	92.61	369.15	0.16	MoH	OCGS, sectoral ministries, donors and CSOs	
7.3.2	180.02	.00	.00	.00	218.82	398.84	0.17	MoH	OCGS, sectoral ministries, donors and CSOs	
7.3.3	21.05	.00	.00	.00	25.59	46.64	0.02	MoH	OCGS, sectoral ministries, donors and CSOs	
7.3.4	47.68	50.06	52.56	55.19	57.95	263.43	0.11	MoH	OCGS, sectoral ministries, donors and CSOs	

# 6

## MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)

### 6.1 The common results and accountability framework (CRAF)

In developing the ZMNSAP, a CRAF (depicted in appendix 1) was finalized. The CRAF is based on the criteria proposed by the SUN Movement<sup>29</sup>.

The main advantages of a CRAF are:

- I. Being an agreement around a single-set of nutrition results, the CRAF serves as the basis for aligning the results defined in the different KRAs .
- II. the CRAF enables multiple stakeholders (different ministries and external stakeholders) to work towards common goals (or set of results) for the improvement of nutrition and to agree on how the responsibility for implementation and achievement of results will be shared by different sectors.
- III. the overall cost of the CRAF incorporates the costs of multiple sectors and reflects the overall financial requirements for successfully scaling up nutrition.

The ZMNSAP CRAF uses the following factors to formulate the criteria for evaluation::

1. expected target results for improvement in nutritional status
2. defined populations in which these improvements will be seen
3. interventions necessary to achieve the results and clear indications on the current coverage level and on the goal coverage

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<sup>29</sup> Source: Scaling up Nutrition website ([www.scalingupnutrition.org](http://www.scalingupnutrition.org))

4. the main stakeholders accountable for the achievement of the results (line ministries and sectors within the government)
5. the roles and responsibilities of collaborators including non-government partners
6. a shared framework for performance M&E

## 6.2 The MEAL framework

The CRAF is an important framework tool for MEAL. An effective MEAL framework is important to track progress, make adjustments, discover unplanned effects of interventions, or judge the impacts made. A MEAL system also makes the implementers accountable to the stakeholders because it needs information sharing and development of a complaint or feedback mechanism that can guide implementation. The MEAL framework articulates the strategies to be used to ensure a sound M&E platform that can generate good quality and policy-relevant evidence in a timely manner. It also encourages evidence-based decision-making, planning, resource allocation, continued learning and mutual accountability.

**Table 20:** The MEAL concept explained

The MEAL	What it means
<b>Monitoring</b>	The routine monitoring of project resources, activities and results, and analysis of the information to guide project implementation.
<b>Evaluation</b>	The periodic (mid-term and final) assessment and analysis of an existing strategy/action plan
<b>Accountability</b>	Transparency of all processes: planning, execution and reporting
<b>Learning</b>	The process through which information generated by M&E is reflected upon and is used to continuously improve the ability of an action plan/strategy to achieve desired results.

The ZMNSAP MEAL framework will therefore ensure:

- continued reporting on progress through regular and systematic tracking of the implementation
- alignment with stakeholders' resources and actions to strengthen nutrition interventions
- evidence-based decision-making; through ensuring timely availability of good quality evidence that is effectively disseminated

- enabling constructive evidence-based policy dialogue to facilitate evidence-informed decision-making
- operational research capacity is strengthened so that the evidence generated informs decision making
- documentation of lessons learnt in implementation to promote learning, institutional memory and linking of nutrition programmes with research and training

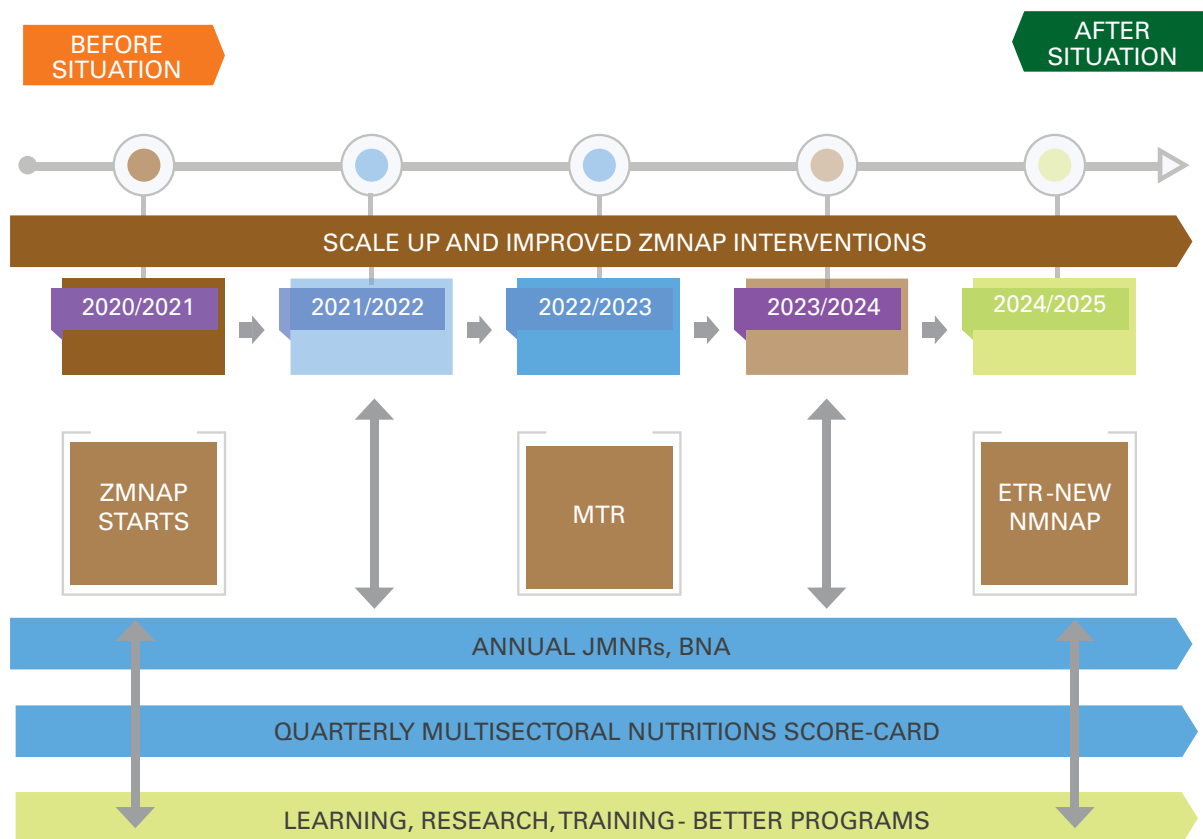
The MEAL system for the ZMNSAP will be linked to the overall M&E of the National Development Agenda and the process will be vested under the Intersectoral Steering Committee of the Food Security and Nutrition Policy (FSNP). Approximately 5–10 per cent of the ZMNSAP budget should be allocated to the MEAL system. However, it is recommended that certain MEAL components, such as assessments, baselines, routine monitoring, ongoing reflection and learning, and periodic evaluations be costed/priced.

## 6.3 The MEAL moments

There will be **four key moments for tracking progress and learning** (see Figure 24), whereby information will be presented, discussed, lessons learnt, and strategic decisions made with respect to adjustments in strategy or activities. The four key moments are:

- (1) the presentation of quarterly and biannual reports on routine data collection, like the HIS, nutrition score card, and feedback from coordinating structures which provide moments for adjustments of activities;
- (2) the establishment of annual joint multisectoral and multi-stakeholder nutrition reviews (**JMNRs**). During these moments, the CRAF and financial tracking tools will be used to show stakeholders the progress made and the challenges faced as well as to decide on future actions and solutions. The JMNRs will make recommendations on how those challenges will be resolved and who will be accountable. Progress on implementation of the recommendations will need to be presented at the next annual review.
- (3) the review of the MEAL system halfway through and the assessment of progress towards the realization of objectives and targets at a **mid-term review (MTR)** session in 2022/2023. The MTR will coincide with the third annual work plan review and its outcome will determine future priorities, strategy and/or targets.
- (4) the evaluation of the overall performance of the ZMNSAP against the set objectives and targets, identification of new information generated and use of the lessons learnt to design the subsequent ZMNSAP at the **end-term review (ETR)** in 2024/2025. The evaluation will look at the effectiveness, efficiency, sustainability and relevance of the ZMNSAP using a combined quantitative and quasi-experimental methodology to represent a **'before and after situation'**.

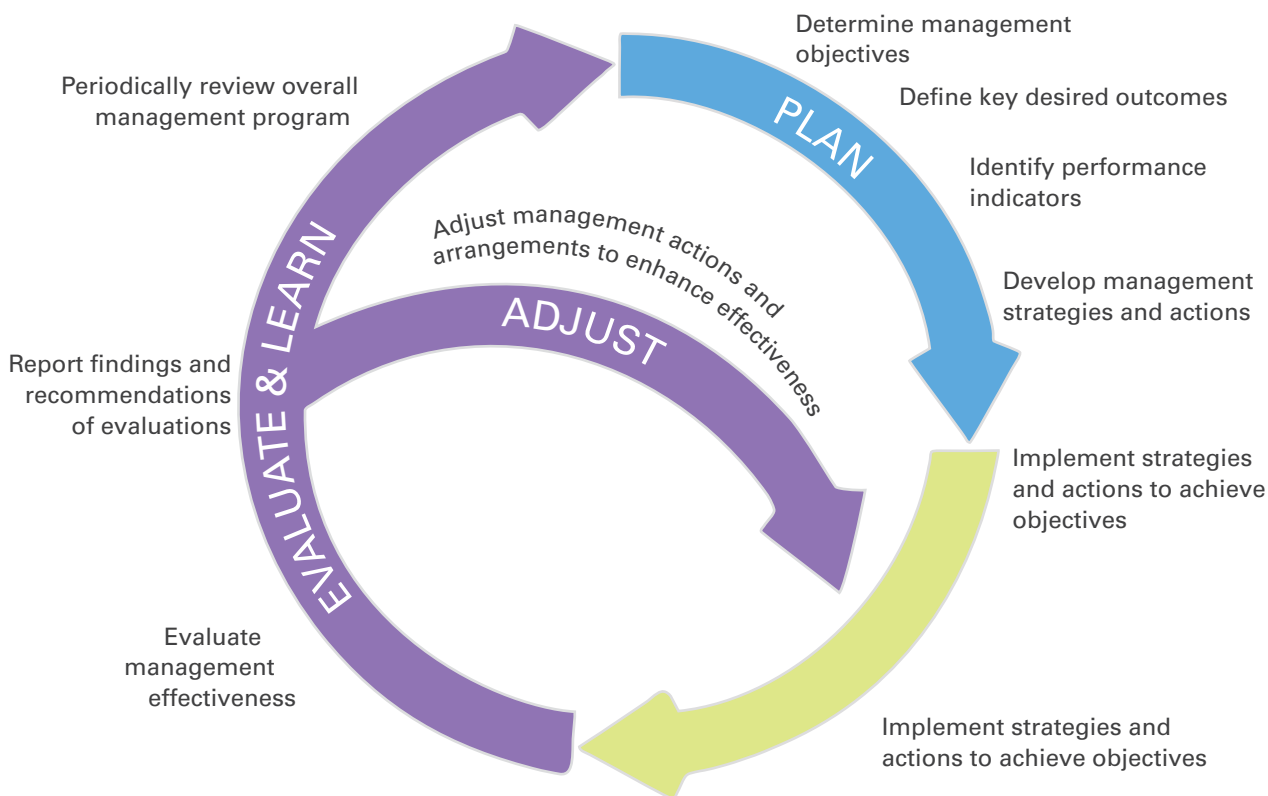
**Figure 24:** The ZMNSAP MEAL moments



## 6.4 Learning

An adaptive management cycle approach will be used in the learning process (see Figure 25). This involves improving outcomes and knowledge through learning. For example, learning can modify the common nutrition narrative, identify new determinants and drivers of the situation, provide evidence for more high-impact strategies and interventions, predict results and design targets. Learning will involve assessing what works well in a particular context, what does not, which aspects have more influence on the achievement of results, and which strategies can be replicated etc.

**Figure 25:** The learning cycle



The following initiatives will guide learning:

- (1) comparing results across time to determine which ones help the most in achieving the mission and desired results
- (2) facilitating learning at both levels – formal and informal and encouraging the sharing of learning experiences (positive and negative) with partners, communities, and other stakeholders. This strengthens accountability and transparency
- (3) documenting processes and reports (paper based, photos, videos etc.) and safely storing MEAL outputs (both electronic and paper formats) in order to keep the knowledge produced within the organization, even if the key staff leave
- (4) mentoring staff with a focus on specific issues or identified needs and allowing individuals to reflect on and question existing practices
- (5) introducing training courses in response to the feedback
- (6) developing innovative tools for MEAL



## 6.5 Research to complement M&E

The learning from M&E will be complemented by operational and implementation research. The objective is to incorporate systematic uptake of research findings and other evidence-based practices into routine practice, and, thereby, improve the quality and effectiveness of chosen interventions. In addition to looking into the factors that determine implementation, research will also determine whether the results are indeed direct results of the interventions. Research can also look into the structure of implementation (e.g., the roles played by the government, non-governmental organizations, development partners, the private sector, and citizens in general). Issues that demand new forms/ kinds of knowledge will also be looked into.

The results of the research will be used at the JMNRs, MTR and ETR to identify significant implementation/ operational challenges and generate new knowledge, both technical and programmatic. New knowledge produced will be disseminated through appropriate programmatic adjustments.

Research questions identified in the situation analysis include:

- 1) Why is the prevalence of EBF (exclusive breastfeeding for the first six months of a child's life) so low in Zanzibar?
- 2) What are the main causes of anaemia in Zanzibar?
- 3) What are the other micronutrients (other than iron) of public health significance in Zanzibar? (e.g., zinc)
- 4) Does consumption of food outside the household affect the nutritional status of the household?
- 5) What are the main climate change factors that affect nutrition and how can they be mitigated?

Some key implementation research questions for the ZMNSAP may include:

- 1) How functional and effective are the coordinating structures at the national and local government levels?
- 2) Have different sectors and development partners aligned their strategies and programmes with the ZMNSAP?
- 3) What is the extent of public awareness on nutrition created by the ZMNSAP?
- 4) Is the leadership and accountability mechanism of the ZMNSAP working as envisaged?
- 5) Is the change in the nutrition situation (at mid-term and end-term stages) a result of the implementation of the ZMNSAP?

## 6.6 Financial tracking and budget analysis for nutrition

As part of the implementation, a mechanism for financial management and tracking of the ZMNSAP will need to be developed. This will require development of a tool to track nutrition resources across relevant sectors at the national and local government levels. The SUN Movement has developed a model nutrition tracking tool which Kenya has uniquely adapted. Implementers of the ZMNSAP can learn from the Kenya experience. With this tool, policymakers will be able to locate sources of funding for nutrition and using this information; will be able to advocate targeted actions for influencing nutrition outcomes. Moreover, financial tracking will ensure both programmatic and social accountability and facilitate resource mobilization.

## 6.7 Resource mobilization strategy for the ZMNSAP

Development of a resource mobilization strategy will be key to the success of the ZMNSAP. The strategy should consider the national financial resource allocation and global aid architecture with a view to incorporating the ZMNSAP into strategy and resource allocation discussions. LGAs will need to consider allocating funds for every child under the age 5. In Tanzania mainland TSh 1,000 (US\$ 0.43) was allocated for each child in 2017/18 with the aim of increasing it to the World Bank's recommendation of TSh 18,391 (US\$ 8.0) by 2030.

## 6.8 Institutional arrangements for M&E

Currently, several institutions collect nutrition-relevant data. To ensure timely collection, quality, multisectoral analysis and dissemination, an institutional base for such an M&E system is necessary. The ZMNSAP proposes that the Zanzibar Office of Chief Government Statistician (OCGS) functions as the institutional base and that it works closely with the Food and Drug Board of the MoH.

# 7

## LEADING AND MANAGING THE ZMNSAP

### 7.1 Introduction

The success of the ZMNSAP is highly dependent on strategic leadership and management. While leadership provides direction mainly at the policy and strategy levels, management is concerned about the “nuts and bolts” of implementation of planned activities. Given the ZMNSAP’s complex and multisectoral nature, the roles of the different actors need to be well defined so that they all can work towards the same goal: the results planned in this ZMNSAP are achieved effectively and efficiently. Thus, this section will define the responsibilities and accountabilities of the different actors, both governmental and non-governmental.

### 7.2 Roles and responsibilities of the different partners

Since the ZMNSAP plans to implement the ZFSNP like its mother policy, its implementation will involve a wide range of actors operating in different sectors and at different levels. The key actors to be involved include government institutions, CSOs (community-based organizations (CBOs) and faith based organizations (FBOs), development partners, the community, the private sector and the media. Individuals, households and the communities are themselves the major implementers since without their active participation the nutrition situation is unlikely to improve. Below we detail the roles and responsibilities of the key actors.

#### (A) GOVERNMENT

Various government institutions have roles to play in creating an enabling environment for the implementation of the ZMNSAP, as the KRAs have identified. This calls for a strong intersectoral collaboration and coordination as a necessary condition for effective and efficient implementation. The following ministries have been identified as the key actors in ZMNSAP implementation in accordance with their roles and mandate areas:

## Second Vice President's Office

The Vice President's Office plays a central role in coordinating different government efforts (including efforts towards achieving adequate nutrition). Moreover, the Office coordinates efforts in response to emergencies and ensures that food reaches beneficiaries on time, as embodied in the FSNP. The Office is also the institutional home of the food security and nutrition information technology (FSNIT). The FSNIT is in charge of collecting and disseminating food security and nutrition information, issuing early warning to stakeholders and establishing links between international and internal agencies in food-aid support and other emergency services.

## Ministry of Health (MoH)

Having taken the lead in the formulation of the ZMNSAP, and as mandated by the ZFSNP, the MoH will lead the implementation of the ZMNSAP. Specific activities that the MoH will undertake mainly fall under the nutrition-specific key results areas (KRAs). The activities include:

- (1) KRA 1 on scaling up maternal and early childhood nutrition services (MECNS)
- (2) KRA 2 on scaling up services in collaboration with the Ministry of Education (MoE) to address malnutrition among school-age children, adolescents and women with a focus on micronutrient deficiencies
- (3) KRA 3 on scaling up integrated management of acute malnutrition (IMAM)
- (4) KRA 4 on scaling up services to prevent and manage DRNCDS

Also, the Ministry has important roles to play as follows:

- (1) KRA 5 on scaling up actions to ensure a multisectoral nutrition response: the MoH will identify nutrient-rich foods for promotion, conduct food analysis and enforce food safety regulations. Other actions will include promotion of hygiene and sanitation, provision of nutritional support, care and treatment of HIV/AIDS as part of social safety nets, capacity development for clinical nutrition and dietetics, support of nutrition education in schools. The MoH will also promote the overall multisectoral response.
- (2) KRA 6 on improving multisectoral nutrition governance: the MoH will ensure effective and efficient multisectoral coordination and collaboration at all levels. To do this well, it will function as the secretariat for various coordinating bodies of the ZMNSAP at all levels.
- (3) KRA 7 on strengthening a multisectoral NIS, nutrition information system, for effective decision-making at all levels: the MoH will work closely with the Office of the Chief Government Statistician (OCGS) to establish and harmonize a multisectoral nutrition information mechanism.

## **Ministry of Agriculture (MoA)**

Since the Ministry is the leading institution in the coordination of the implementation of the ZFSNP, it will work closely with the MoH in the implementation of the ZMNSAP. The current mandatory areas for the MoA with regard to the ZFSNP include looking at issues related to local agricultural production and productivity, and monitoring a regulatory framework for the environment, natural resources and cooperatives. As such, the Ministry will assume a coordinating role on policy- implementation and evaluation and will be working very closely with all key ministries and institutions responsible for the implementation of the ZFSNP.

## **Ministry of Labour, Empowerment, Elderly, Youth, Women and Children (MLEEWC)**

This Ministry supports the most nutritionally vulnerable groups by focusing on poor households. As such, the Ministry will play a very important role in the implementation of the ZMNSAP.

## **Ministry of Education and Vocational Training**

The Ministry is responsible for all technical and vocational training and is entitled to provide appropriate vocational training to address concerns of FSN interventions as outlined in the ZFSNP and in the ZMNSAP. The Ministry is also responsible for providing an enabling environment for implementation of school health, nutrition and WASH interventions and ensuring effective coordination of school-feeding and school gardening activities as part of social safety nets in addressing issues of malnutrition among children. The Ministry should work closely with the MoH and other stakeholders involved in school health, nutrition and WASH programmes for holistic implementation of the ZMNSAP.

## **Ministry of Finance and Planning**

The Ministry of Finance and Planning is responsible for national planning and budgetary issues and is the custodian of overarching national policies such as Vision 2020 and ZSGRP (MKUZA), which contain FSN goals. As the ZFSNP and the ZMNSAP are basically derived from MKUZA, the Ministry assumes important roles in the implementation of the ZMNSAP. Major roles include allocating adequate financial resources for the implementation of the ZMNSAP through the budgetary process and other frameworks. It encourages investments in FSN-relevant micro-enterprises through tax incentives and other related tariffs aimed to improve the business environment in terms of food fortification. Since the Ministry is the coordinating institution for MKUZA, it also provides a monitoring programme for the ZFSNP and the ZMNSAP in line with the MKUZA Monitoring Master Plan.

## **Ministry of State – President’s Office – Regional Administration, Local Government and Special Departments of the Government of Zanzibar**

The ZFSNP and its ZMNSAP implementation framework recognizes the role of districts and Sheias in the implementation of the ZMNSAP and its policies. As such, the Ministry in the President’s Office for Regional Administration, Local Government and Special Departments of the Government of Zanzibar assumes a prominent role in mainstreaming food and nutrition security in the district and Sheia development planning. The Ministry is also responsible for ensuring effective performance of district and community authorities in supervision, monitoring and evaluation of district and community level issues related to the implementation of the ZMNSAP. The main ZMNSAP KRAs that the Ministry will be involved in are:

- KRA 5 on scaling up actions to ensure a multisectoral nutrition response,
- KRA 6 on improving multisectoral nutrition governance to ensure effective multisectoral coordination at the regional and district levels and
- KRA 7 on strengthening a multisectoral NIS for effective decision-making at all levels.

## **Ministry of Land, Water, Energy and Environment**

The ZFSNP recognizes that effective land administration (including the implementation of the Land Use Plan) is a significant contributing factor in addressing both food availability and accessibility as it can improve local agricultural productivity and ensure access to credit facilities. The Ministry is also responsible for facilitating availability of clean and safe water for humans and livestock and regulating energy tariffs for sustainable livelihood development. As such, it contributes towards effective implementation of the ZFSNP and ZMNSAP in promoting livelihoods and ensuring food and water safety.

## **Ministry of Trade, Industries and Marketing**

With regard to FSN, the Ministry is responsible for regulations related to food importation, marketing and consumer protection. The Ministry is also partially responsible for developing a regulatory framework on food marketing, the efficacy of which will play an important role in reducing food insecurity and malnutrition among the most vulnerable producer and consumer groups.

## **Ministry of Infrastructure, Communication and Transport**

The Ministry has a significant and supportive role in accelerating the growth of both urban and rural economies. It is also responsible for the improvement of productive and service sectors by

ensuring efficient transportation and communication infrastructure that foster linkages between production, distribution and marketing centres for food and related inputs. The Ministry also assumes an important role in facilitating trade, especially in exportation and importation of foodstuff and other commodities that are important for ensuring national food security.

## **Ministry of Information, Tourism and Heritage**

This Ministry will help in raising public awareness on good nutrition and will mobilize resources for the implementation of the ZMNSAP.

## **Development Partners**

Zanzibar appreciates the contribution and support of its development partners, particularly multilateral and bilateral donors. These entities will play an important role in providing financial and technical assistance to FSN policies as part of MKUZA implementation.

## **Private Sector**

The policy recognizes the importance of the private sector (NGOs and CSOs) in advocacy, advisory, training and other services with regard to FSN.

## **Media**

The media plays an important role in FSN through advocacy, sensitization, and generation of overall public awareness and the promotion of nutrition.

## **7.3 Institutional and legal frameworks**

The ZMNSAP recognizes the multisectoral nature of the problems of malnutrition and it is set to achieve its objectives through effective sectoral and multisectoral coordination and with the help of various actively participating stakeholders with clearly defined roles and responsibilities. Since the ZMNSAP is an implementation plan of the ZFSNP, it will use the same implementation coordination structures as those defined by the ZFSNP (*see Figure 26*).

Thus, the following institutions will provide the overall implementation framework at all levels:

(1) National level

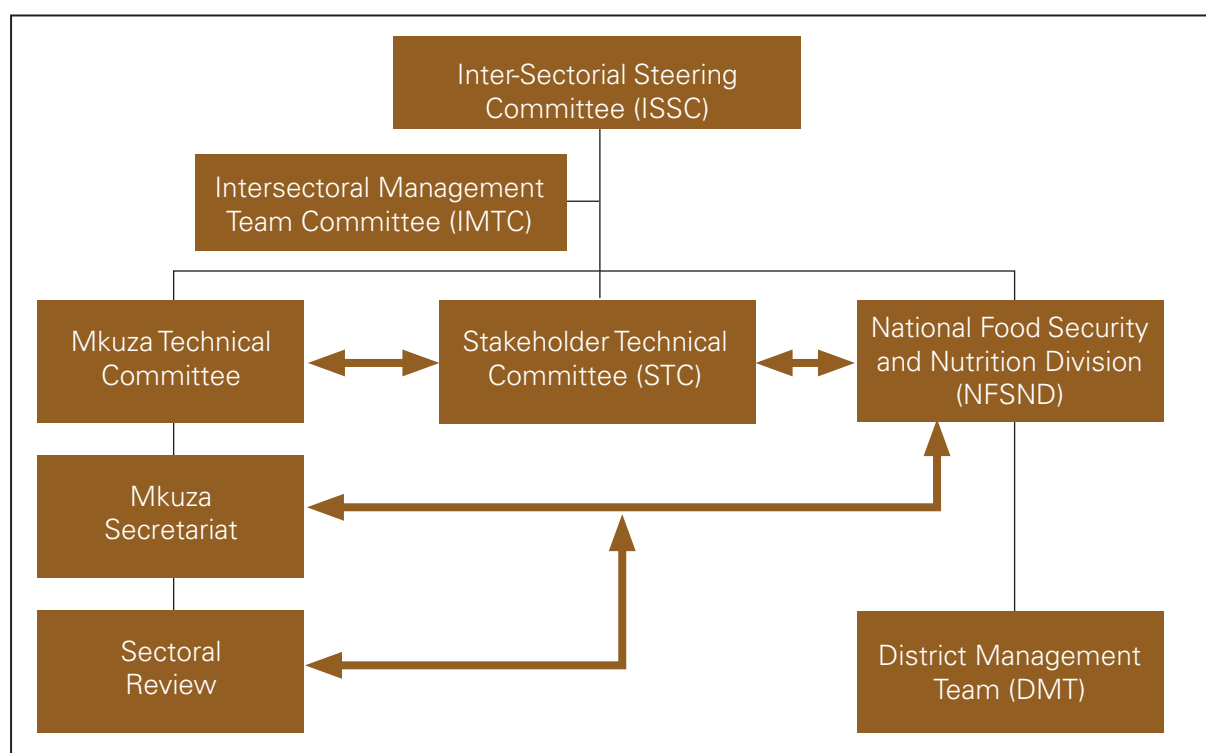
- a. the Intersectoral Steering Committee (ISSC) whose membership consists of high-level representatives of key nutrition-sensitive Ministries (PS level), as well as representatives of the private sector (Chamber of Commerce), and NGOs
- b. Intersectoral Management Team Committee (IMTC) that will support the ISSC

- c. three technical Committees: MKUZA Technical Committee under which there is a MKUZA Secretariat, Stakeholders' Technical Committee (STC) and National Food Security and Nutrition Division (NFSND)

(2) District level – The Council Health Management Team (CHMT)

Below, we define the composition and roles of the various national and district coordination structures with regard to the implementation of the ZMNSAP.

**Figure 26:** Institutional coordination structures of the ZFSNP and ZMNSPP



**The ISSC** comprises the following 12 members:

1. Principal Secretary, Second Vice-President's Office
2. Principal Secretaries of
  - i. Ministry of Agriculture
  - ii. Ministry of Finance and Planning
  - iii. Ministry of Education and Vocational Training
  - iv. Ministry of Health
  - v. Ministry of Land, Water, Energy and Environment



- vi. Ministry of Trade, Industries and Marketing
  - vii. President's Office- Ministry of Regional Administration Local Government and Special Departments
  - viii. Ministry of Labour, Empowerment, Youth, Elderly, Women and Children
  - ix. Ministry of Communication and Transport
3. Executive Director, Zanzibar National Chamber of Commerce, Industries and Agriculture (ZNCCIA)
  4. Secretary General, Association of NGOs in Zanzibar (ANGOZA)

Principal Secretary, MoA is the chair of the ISSC and the National FSN Division (NFSND) performs the secretariat functions of the ISSC. The ISSC is the main decision-making body and is responsible for providing overall guidance to ZFSNP through implementation and operationalization of the ZMNSAP.

The **main roles and responsibilities of the ISSC in relation to the ZMNSAP** will be:

- safeguarding effective intersectoral communication and policy coordination by meeting on a quarterly basis to promote synergy, guiding implementation of various activities and avoiding duplications of interventions
- providing guidance on implementation according to the ZMNSAP defined priorities and strategies
- soliciting technical advice on specific issues related to the ZMNSAP from the Stakeholders' Technical Committee (STC)
- directing the National Food Security and Nutrition Division (NFSND) to prepare relevant reports for consideration by the ISSC (e.g., work and budget plans, monitoring reports, position papers on specific ZMNSAP issues etc.)
- approving budget proposals that promote efficient allocation and utilization of resources for the achievement of the ZMNSAP results and targets and providing guidance on resource mobilization
- monitoring implementation of the ZMNSAP and making adjustments whenever necessary
- reporting to the MKUZA poverty monitoring system (i.e., MKUZA IMTC) about the progress of ZMNSAP implementation

**The Stakeholders' Technical Committee (STC)** will serve as an advisory body to the ISSC to ensure effective and coordinated implementation of the ZMNSAP. The Director for Policy and Planning (Ministry of Agriculture) will be the chair of the STC and will report to the ISSC. The National Food Security and Nutrition Division (NFSND) will perform the secretariat functions. Other STC members will include directors and/or programme coordinators of the key institutions

as mentioned in the ISSC membership list above. Additionally, technical agencies like OCGS, TMA and Chief Government Chemist (CGC) will be invited to STC meetings on an ad hoc basis if need be.

The STC will meet once every three months and will be specifically responsible for:

- safeguarding inter-institutional coordination, guiding implementation of activities, promoting synergies and avoiding duplication
- reviewing budget plans, providing recommendations to the ISSC to ensure ZMNSAP priorities are mainstreamed into every sector-budget plan (MTEF)
- monitoring the FSN situation and evaluating the progress made
- advising the ISSC accordingly on improving programme design and implementation
- interacting with the MKUZA poverty monitoring system (i.e., MKUZA / MKUZA TWGs) as well as with the NFSND
- reporting to the ISSC

**The National Food Security and Nutrition Division (NFSND)** has been mandated by the RGoZ to handle FSN issues and coordinate the day-to-day implementation of the ZFSNP and, therefore, the ZMNSAP. The Division is housed in the Policy and Planning Department of the Ministry of Agriculture and performs under the technical guidance of the STC and the overall supervision of the ISSC. The NFSND undertakes technical work needed for decision-making by the ISSC and assists the STC with its technical deliberations. The NFSND interacts with the STC and reports directly to the ISSC.

The main responsibilities of the NFSND with regard to the implementation of the ZMNSAP will include:

- routinely coordinating ZMNSAP-related matters
- keeping track of new developments/challenges in the area of ZFSNP and ZMNSAP implementation at national and subnational levels
- preparing annual work plans and budgets in line with the ZFSNP and ZMNSAP and mainstreaming nutrition issues as highlighted in the ZFSNP and ZMNSAP into relevant sector-budget plans (MTEF)
- liaising closely with the Council Health Management Teams (CHMT) in coordinating and monitoring district level implementation of the ZFSNP and ZMNSAP

The **CHMT** responsibilities will include:

- mainstreaming of the ZMNSAP into council-level development plans and budgets. This will involve identification of nutrition issues and their adequate integration into council and community (Shehia) development plans and budgets
- providing technical guidance on the implementation of the ZMNSAP at the council and community levels by ensuring alignment and compliance with the ZMNSAP
- identifying capacity development needs at the council and community levels. This includes training, sensitization and other relevant capacity development activities
- receiving and reviewing monitoring reports of the ZMNSAP and preparing quarterly updates on the progress in various districts
- reporting to the PO-RALG&SP through the regional office and liaising closely with the NFSND to ensure inter-institutional coordination

Membership of the CHMT includes:

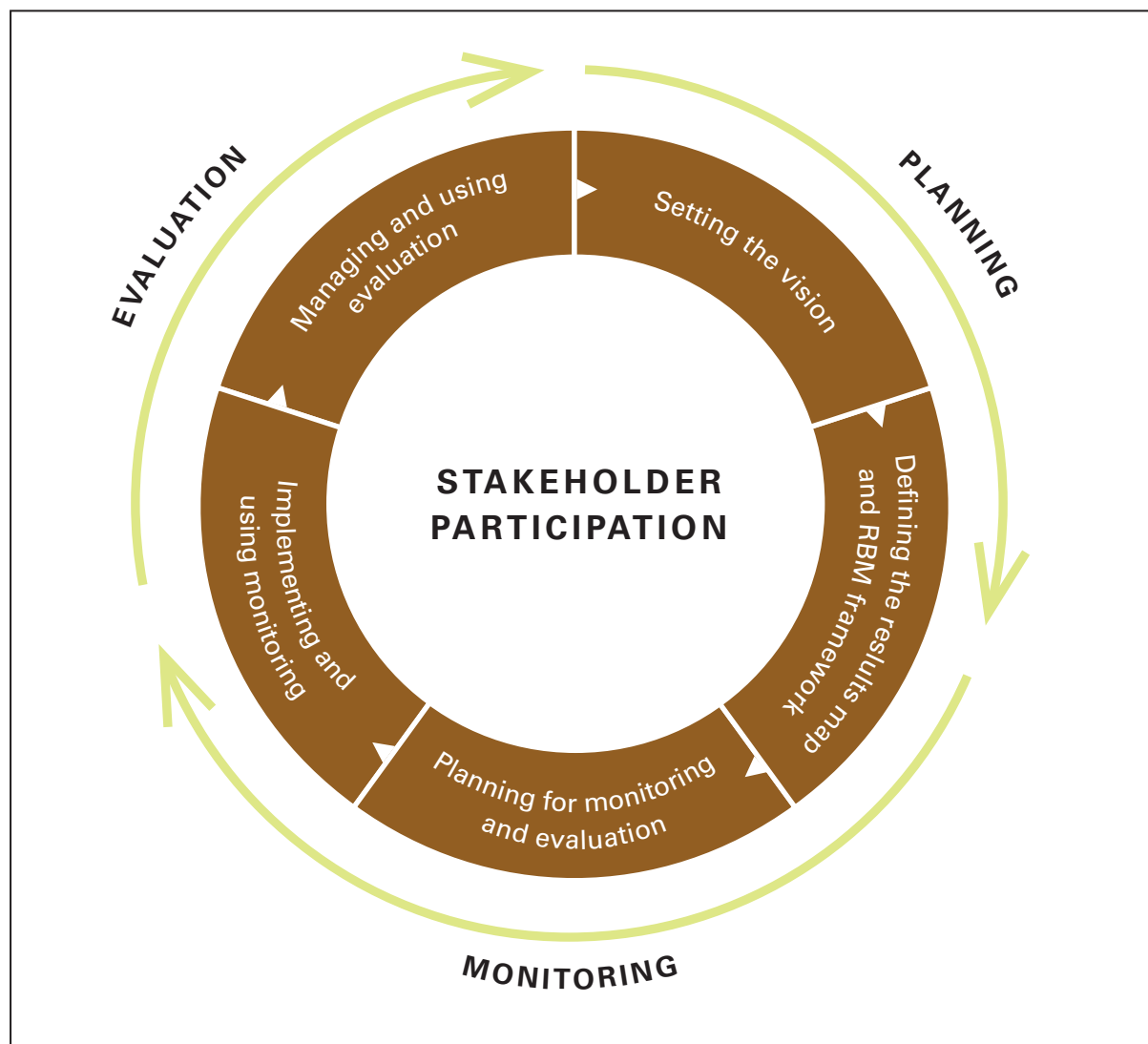
- District Administration Officer (DAO) as the permanent chair, reporting directly to Regional Administration Officer and subsequently to the PO-RALG&SD. For ZMNSAP implementation, this structure shall be strengthened by expanding the current terms with regard to FSN interventions
- heads of sectors
- District Planning Officer (DPO) as a secretary of CHMT meetings will be the liaison officer for ZMNSAP issues at the district level

## 7.4 Results-based management (RBM) of the ZMNSAP

The ZMNSAP will be managed using the results-based management (RBM) approach. RBM is a management strategy according to which all actors, contributing directly or indirectly to achieving a set of results, ensure that their processes, products and services contribute to the achievement of the desired results (**outputs, outcomes and impact**). The actors in turn use information and evidence on actual results to inform decision-making with regard to the design, for resourcing and delivery of programmes and activities as well as for accountability and reporting. The RBM approach ensures linkages between the subject of change, dimension of change and qualifier of change.

The aim of the RBM approach is to improve the effectiveness and accountability of achieving planned results. A solid RBM system rests on what is commonly referred to as a 'life cycle'

**Figure 27:** Results-based management using the “life cycle” approach



**Source:** UNDP, Handbook on Planning, Monitoring and Evaluation for Development Results, 2009.

approach in which ‘results’ are central to planning, implementation, monitoring and evaluation, reporting and ongoing decision-making (see Figure 27). By focusing on ‘results’ rather than ‘activities’, RBM helps to better articulate the plan’s vision and expected results and to better monitor progress using indicators, targets and baselines (see Appendix 1).

Results-based reports also help stakeholders and funders to better understand the impact that a given programme or project is having on the local population.

# 8

## RISK ANALYSIS AND MITIGATION

### 8.1 Risk identification, assessment and prioritization

Risk analysis and management are critical components in the development and implementation of any strategic plan. Risk analysis and mitigation consist of the systematic use of available information to determine the probability of certain events occurring, their magnitude and consequences, and ways to mitigate them. The process helps in developing options and actions to enhance strengths and opportunities and reducing threats and weaknesses to the achievement of planned objectives. It involves:

- 1) **risk identification** – it defines risk events and their relationships.
- 2) **risk impact assessment** – it assesses the probability (likelihood) of their occurrence and their consequences (impact). Consequences may include cost, schedule, technical performance, as well as changes in capability or functionality.
- 3) **risk prioritization analysis:** it identifies risk events in an ascending order: from the most critical to the least critical.
- 4) **risk mitigation:** it reduces the likelihood of a risk event occurring and/or the effect of a risk event if it does occur.

The interpretation of risk is based on the **likelihood of its occurrence** and the level of its consequences/impact as shown in *Table 21*.

**Table 21:** The risk analysis framework

5 levels of likelihood of occurrence	5 levels of consequence/impact				
	5 Catastrophic	4 Critical	3 Marginal	2 Minor	1 Negligible
5 Near certain	5 High	5 High	5 High	3 Medium	1 Low
4 Highly likely	5 High	5 High	4 Medium	2 Medium	1 Low
3 Likely	5 High	4 Medium	3 Medium	1 Low	1 Low
2 Unlikely	4 Medium	3 Medium	2 Low	1 Low	1 Low
1 Remote	3 Low	2 Low	1 Low	1 Low	1 Low

The risk analysis framework can be simplified into a 4x4 risk assessment matrix table, which **categorizes risk as high, medium or low** as in *Table 21*. This framework is used along with the SWOT and PESTLE analyses frameworks to develop the “risk analysis, evaluation and mitigation” matrix for the ZMNSAP (*Table 23*).

**Table 22:** Risk assessment prioritization matrix

Likelihood of occurrence	Consequence/impact		
	High	Medium	Low
High	5	4	3
Medium	4	3	2
Low	3	2	1

## 8.2 The SWOT analysis in managing risk

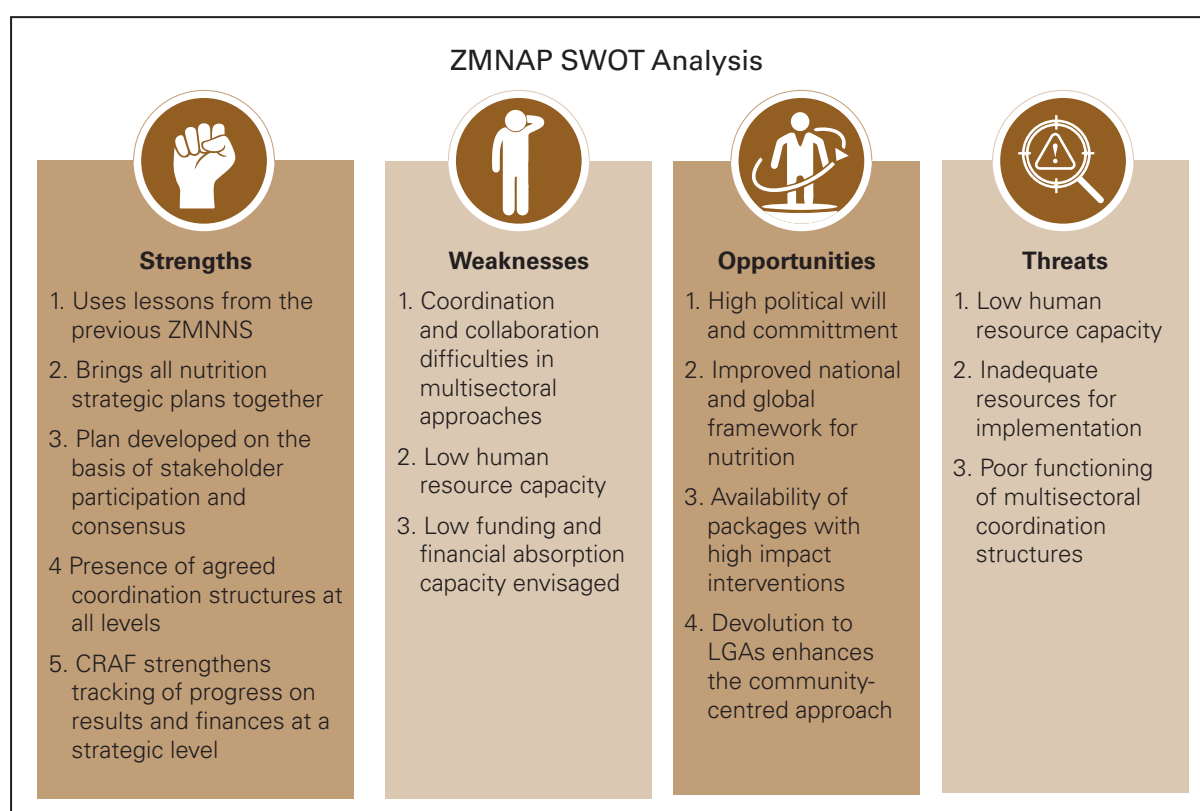
SWOT is an acronym for:

- **strengths** – what advantages does the plan have in addressing malnutrition? How can these plans be effectively used to ensure effective implementation?
- **weaknesses** – are there any internal disadvantages of the plan? What should be done to address them?

- **opportunities** – what are the current external trends which need to be taken advantage of? How should it be done?
- **threats** – what are the external factors which may cause a problem and have a negative impact on the plan?

A SWOT analysis is helpful in identifying internal strengths and weaknesses of the plan, and external opportunities and threats that require mitigation measures, as shown in *Figure 28*.

**Figure 28:** SWOT analysis for the ZMNSAP



## 8.3 PESTLE analysis in managing risk

The acronym **PESTLE** stands for:

- **political** – national and global political issues which may affect the ZMNSAP, either immediately or in the future
- **economic** – GDP growth, financial allocations to nutrition etc.
- **social** – changes in lifestyle and buying trends, media, major events, ethics, advertising and publicity factors

- **technological** – innovations, access to technology, licencing and patents, manufacturing, research funding, global communications
- **legal** – legislation, laws and regulations which have been passed, or proposed and may come into effect and affect smooth implementation of the ZMNSAP
- **environmental** – environmental issues (e.g., climate change) occurring either locally or globally and their impact on nutrition

The PESTLE analysis helps categorize the broad areas where risk analysis can take place. It ensures that the possible broad spaces where risk may exist are covered.

## 8.4 Risk mitigation measures

Risk mitigation handling options include:

- 1) **assuming/accepting:** acknowledge the existence of a particular risk and consciously accept it without trying to control it.
- 2) **avoiding:** adjust programme requirements or impose constraints to eliminate or reduce the risk. This adjustment could be accommodated by a change in funding, schedule, or technical requirements.
- 3) **controlling:** implement actions to minimize the impact or likelihood of the risk.
- 4) **transferring:** reassign organizational accountability, responsibility, and authority to another stakeholder who is willing to accept the risk.
- 5) **watching/monitoring/responding:** monitor the environment for changes that affect the nature and/or impact of the risk and respond accordingly.

## 8.5 Combined SWOT and PESTLE risk analysis, evaluation, prioritization and mitigation

*Table 23* synthesizes the different types of risk analysis frameworks into a single matrix. The PESTLE analysis is used to categorize the types of risks; SWOT weakness and threat components are used to identify the risk events and the risk analysis framework is used to describe the likelihood of their occurrence, consequences/impact and the risk level/priority. Lastly, the matrix uses the strength and opportunities components of SWOT and other information to propose mitigation strategies and identify who will be responsible to implement them.



**Table 23: Risk analysis, mitigation and accountability matrix for the ZMNSAP**

PESTLE categorization of risks	Identified risk event	Risk consequence	Likelihood of occurrence	Risk impact / consequence	Risk priority	Risk mitigation strategy	Responsibility for mitigation
1. Political risks	1. Inadequate political support.	Affects implementation	Low	High	3	<ul style="list-style-type: none"> <li>Adapt to political landscape</li> <li>Advocate maintaining implementation momentum</li> <li>Boost up community implementation</li> </ul>	Intersectoral Steering Committee (ISSC), LGAs, development partners (DPs), NGOs, CSOs and CBOs
	Political challenges during the 2020 elections				3	<ul style="list-style-type: none"> <li>Put the ZMNSAP in election manifestos</li> </ul>	Political parties
2. Economic risks	2. Inadequate funding	<ul style="list-style-type: none"> <li>Some activities slowed down or came to a halt</li> <li>Linkages and relationships disrupted</li> </ul>	High	High	5	<ul style="list-style-type: none"> <li>Develop and implement a robust ZMNSAP resource mobilization strategy</li> <li>Advocate resource allocation by LGAs</li> </ul>	NFSND, ISSC, IMTC, LGAs and development partners
	3. Inadequate mechanisms for financial management and consolidation of financial tracking	<ul style="list-style-type: none"> <li>Implementation disrupted</li> <li>Implementation costs unknown</li> </ul>	High	High	5	<ul style="list-style-type: none"> <li>Enhance accountability and reduce red-tapism</li> <li>Develop a financial tracking tool</li> </ul>	NFNSD, ISSC, DMT, development partners and Ministries of Finance and Regional Administration and Local Government

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PESTLE categorization of risks	Identified risk event	Risk consequence	Likelihood of occurrence	Risk impact / consequence	Risk priority	Risk mitigation strategy	Responsibility for mitigation
	4. Poor adherence to financial pledges and agreements	<ul style="list-style-type: none"><li>• Ineffective and inefficient implementation</li><li>• Lowers credibility and accountability of the ZMNSAP</li></ul>	Low	Medium	3	<ul style="list-style-type: none"><li>• Promote financial accountability and transparency of all stakeholders</li><li>• Use legislative mechanisms to enforce accountability</li><li>• Strengthen M&amp;E mechanisms and ensure feedback between implementers and accounting officers</li></ul>	NFNSD, ISSC, DMT, development partners and Ministries of Finance and Regional Administration and Local Government
	5. Poor resource absorption and responsive capacity management of collaborating partners	<ul style="list-style-type: none"><li>• Resource wastage</li><li>• Reduction in partner support</li><li>• ZMNSAP results unachieved</li></ul>	Low	Medium	3	<ul style="list-style-type: none"><li>• Develop sound and realistic work plans</li><li>• Streamline implementation procedures to reduce bureaucracy</li><li>• Enhance effective M&amp;E at all levels</li></ul>	NFNSD, ISSC, DMT, development partners and Ministries of Finance and Regional Administration and Local Government
3. Social risks	6. Resistance to collaboration by key stakeholders	<ul style="list-style-type: none"><li>• Fragmentation and duplication in implementation</li><li>• Lack of accountability, confusion and mistrust among stakeholders</li></ul>	Low	High	3	<ul style="list-style-type: none"><li>• Ensure stakeholder dialogues at all levels</li><li>• Establish procedures for consultations among stakeholders</li><li>• Let all stakeholders promote and prioritize joint planning</li><li>• Support regular programme reporting and briefings</li></ul>	NFNSD, ISSC, DMT, development partners, Ministries of Finance and Regional Administration and Local Government

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PESTLE categorization of risks	Identified risk event	Risk consequence	Likelihood of occurrence	Risk impact / consequence	Risk priority	Risk mitigation strategy	Responsibility for mitigation
	7. Deterioration in security	<ul style="list-style-type: none"> <li>Implementation disrupted</li> <li>Inability to supervise, M&amp;E</li> </ul>	Low	High	3	<ul style="list-style-type: none"> <li>Monitor for early warning</li> <li>Develop contingency plans</li> </ul>	NFNSD, ISSC, DMT and security organs
	8. Inadequate human resources capacity	<ul style="list-style-type: none"> <li>Low implementation capacity</li> </ul>	Medium	High	4	<ul style="list-style-type: none"> <li>Recruit more nutrition officers</li> <li>Conduct training for the relevant staff</li> </ul>	NFNSD and Ministry of Regional Administration and Local Government
4. Technological risks	11. Low capacity to use ICT for M&E and for advocacy	<ul style="list-style-type: none"> <li>Inefficient mechanism for collecting and analysing data</li> </ul>	High	High	5	<ul style="list-style-type: none"> <li>Conduct training on technology for nutrition (T4N)</li> </ul>	NFNSD and sectoral ministries
5. Legal risks	12. Low enforcement of nutrition-relevant laws (e.g., food fortification, food safety, marketing of BMS, maternity leave)	<ul style="list-style-type: none"> <li>Inadequate implementation</li> </ul>	High	High	4	<ul style="list-style-type: none"> <li>Monitor enforcement</li> </ul>	Enforcement institutions as per relevant acts/regulations
6. Environmental risks	13. Occurrence of disasters (e.g., drought, storms, tsunami and other climate change related events)	<ul style="list-style-type: none"> <li>Disruption in implementation process</li> </ul>	Low	High	3	<ul style="list-style-type: none"> <li>Monitor and develop contingency plans and funding</li> <li>Mainstream sector-wide response</li> </ul>	NFNSD, ISSC, DMT, and development partners

# APPENDICES

## Appendix 1 A: Common results and accountability framework (CRAF) – impact and outcome

Table 24: Common impact and outcome results framework

COMMON IMPACT AND OUTCOME RESULTS ADOPTED AS THE NUTRITION TARGETS BY 2024/2025							
S/N	Expected results	Indicator	Baseline	Target 2024/25	Means of verification	Framework for targets	Accountability
<b>IMPACT TARGETS<sup>30</sup></b>							
22	Reduce the prevalence of stunting among children under the age of 5 years by 25%	Prevalence of stunting (H/A <2SD) among children aged 0-59 months	21.5 TNNS 2018	16.1	TDHS/TNNS	<b>Global targets used where applicable</b> WHA target 1 proposes reduction by 40%	<b>All stakeholders</b> All stakeholders
23	Reduce childhood wasting and maintain it at less than 5%	Prevalence of wasting (W/H <2SD) among children aged 0-59 months	6.1 TNNS 2018	<5	TDHS/TNNS	WHA target 6 is to reduce to the rate below 5%	All stakeholders
24	Reduce the prevalence of low birth weight by 30%	Prevalence of birth weight of 2.5 kg and below	8.3 TNNS 2018	5.8	TDHS/TNNS	WHA target 3 proposes a reduction by 30%	All stakeholders
25	Reduce childhood underweight by 30%	Prevalence of underweight (W/A <2SD) among children aged 0-59 months	14 TNNS 2018	9.8	TDHS/TNNS	ZMNSAP target	All stakeholders
26	No increase in childhood overweight/obesity	Prevalence of overweight/obesity (W/A >2SD) of children 0-59 months	2.1 TNNS 2018	<2.1	TDHS/TNNS	WHA target 4 is "no increase"	All stakeholders
27	Reduce the prevalence of anaemia among women of reproductive age by 30%	Prevalence of anaemia among non-pregnant women aged 15-49 years	43.2 TNNS 2018	30.2	TDHS/TNNS	WHA target 2 proposed 50 % reduction	All stakeholders
28	Reduce anaemia among children aged 6-59 months by 30%	Prevalence of anaemia among children aged 6-59 months	65 TDHS 2015/16	45	TDHS/TNNS	ZMNSAP target	All stakeholders

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<sup>30</sup> Impact targets are those that relate to reductions in the nutrition condition (e.g., stunting, wasting, underweight, obesity and micronutrient deficiency)

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COMMON IMPACT AND OUTCOME RESULTS ADOPTED AS THE NUTRITION TARGETS BY 2024/2025							
S/N	Expected results	Indicator	Baseline	Target 2024/25	Means of verification	Framework for targets	Accountability
29	Reduce anaemia among pregnant women by 40% or more	Prevalence of anaemia among pregnant women	80 TDHS 2015/16	48	TDHS/TNNS	ZMNSAP target (prevalence in WRA is 60%)	All stakeholders
30	Reduce anaemia among adolescent girls by 30%	Prevalence of anaemia among girls aged 15-19 years (%)	47 TDHS 2015/16	36	TDHS/TNNS	ZMNSAP target (prevalence in WRA is 60%)	All stakeholders
31	Reduce vitamin A deficiency among children by 50%	Prevalence of VAD among children aged 0-59 months (%)	38 TDHS 2015/16	19	TDHS/TNNS	ZMNSAP target	All stakeholders
32	Increase the proportion of women of reproductive age (WRA) with median urinary iodine concentration (MUIIC) falling in the range 150- 300ug/L	Proportion (%) of WRA with median urinary iodine concentration in the range of 150- 300ug/L	25 TDHS 2015/16	50	TDHS/TNNS	ZMNSAP target	All stakeholders
33	Reduce the proportion of population with raised blood pressure or currently on medication by 25%	Proportion of population with raised blood pressure or currently on medication	33 STEPWISE survey 2012	25	STEPWISE SURVEY	NCD target 6 proposes a 25% relative reduction in the prevalence of high blood pressure or maintaining it at 25%	All stakeholders
34	Reduce the proportion of population with raised fasting blood sugar	Proportion of adults aged 18-69 years with raised fasting blood sugar (%)	3.7 STEPWISE survey 2012	<3.7	STEPWISE SURVEY	NCD target	All stakeholders
35	Halt and reverse the rise in overweight/obesity in adults aged 18-69 years by 30%	Prevalence of overweight/ obesity in adults aged 18-69 years	39 STEPWISE survey 2012	27	STEPWISE SURVEY	NCD target 7 (Halt the rise in diabetes and obesity)	All stakeholders

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COMMON IMPACT AND OUTCOME RESULTS ADOPTED AS THE NUTRITION TARGETS BY 2024/2025							
S/N	Expected results	Indicator	Baseline	Target 2024/25	Means of verification	Framework for targets	Accountability
<b>OUTCOME TARGETS<sup>31</sup></b>							
36	Increase the rate of exclusive breastfeeding (EBF) in the first six months by 30% or above	Prevalence of EBF in children aged 0-6 months	30 (TNNS 2018)	40	TDHS/TNNS	Global targets used where applicable WHA target 5 is to increase EBF by 50%	MoH/ Breastfeeding mothers
37	Increase the proportion of pregnant women taking Iron and folic acid supplements for 90+ days during pregnancy by 60%	Proportion (%) of pregnant women taking Iron and folic acid supplement for 90+ days during pregnancy	12.8	20	TDHS/TNNS	ZMNSAP target	MoH/ MOTHERS ATTENDING ANC
38	Increase coverage of Vitamin A supplementation among children under the age of 5 to 90% or above	Coverage (%) of Vitamin A supplementation among children aged 6-59 months	78.9 TNNS 2018	90	TDHS/TNNS	ZMNSAP target	MoH
39	Increase the proportion of household using adequately iodized salt by 50%	Proportion (%) of household using adequately iodized salt	39 (TNNS 2018)	78	TDHS/TNNS	ZMNSAP target	SALT PRODUCERS AND OTHER USI STAKEHOLDERS
40	A 10% relative reduction in the prevalence of insufficient physical activity	Prevalence of insufficient physical activity among adults aged 18-64 years	18	16	STEPWISE SURVEY	NCD target 3 proposes a 10% relative reduction	GENERAL POPULATION
41	A 30% relative reduction in the mean intake of salt/sodium (g/day)	Mean intake of sodium salt (g/day)	7	5	STEPWISE SURVEY	NCD target 4 proposes 30% relative reduction	MoH/ GENERAL POPULATION
42	Increase budgetary allocation for nutrition	Percentage of nutrition budget as a percentage of the total national health budget	<1.0	>1.0	BNA/ANNUAL AND FIVE-YEAR BUDGET REPORTS	Financing of nutrition	MINISTRY OF FINANCE AND PLANNING

<sup>31</sup> Outcome targets are those that relate to change in behavior or practice e.g., breast feeding, physical activity, consumption of salt.

## Appendix 1 B: Common results and accountability framework (CRAF) – outputs

Table 25: Common output results and accountability framework

COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP								
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions	
<b>KRA 1: MATERNAL AND EARLY CHILDHOOD NUTRITION SERVICES (MECNS) SCALED UP</b>	<b>Outcome 1</b>	<b>Increased proportion of adolescents, WRA, pregnant women and mothers/caregivers/service providers of children under the age of 5 practising optimal nutrition behaviours</b>						
	Output 1.1	Increased coverage of quality MECN services in different health facilities	Percentage of pregnant women who have received counselling on optimal child feeding from health workers in the last fiscal year	20% (BNA 2015)	65%	BNA Reports	MoH	LGAs, UN, academia, NACTE, TEA and MoE
	Output 1.2	Increased coverage of quality MECN services at the community level	Percentage of mothers or caregivers of children under the age of two receiving counselling on optimal child feeding from CHVs	15% BNA (2015)	65%	BNA Reports	LGA	MoHCDGEC, UN, NGOs and CSOs
	Output 1.3	Improved law enforcement of MECN-related services	Percentage of employers providing minimum maternity benefits	0	50%	Periodic assessment reports (MoH)	MoH	ZFDA, TBS, NGOs, UN and LGA
			Number of staff oriented on different law and regulations supporting MECNS	0	50000	Periodic reports (MoH)		

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP								
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions	
<b>KRA 2: SCALED-UP SERVICES TO ADDRESS MALNUTRITION AMONG SCHOOL-AGE CHILDREN, ADOLESCENTS AND WOMEN WITH A FOCUS ON MICRONUTRIENT DEFICIENCIES</b>	<b>Outcome 2</b>	<b>Scaled-up services to address malnutrition among school-age children, adolescents and women, with a focus on micronutrient deficiencies</b>						
	Output 2.1	Improved anaemia prevention and control interventions among women, adolescent and children	Percentage of pregnant women taking iron and folic acid (IFA) supplements for 90+ days during pregnancy	20.4% (TDHS 2015/16)	45%	HMIS/TDHS/NNS	MoH	UNICEF, NI and WB
			Percentage of adolescent girls receiving IFA supplementation	9.7% (TDHS 2010)	35%	HMIS/TDHS/NNS	MoH	UNICEF, NI and WB
			Percentage of health care providers trained in prevention of anaemia and importance of IFA supplementation (%)	NA	50%	MoH REPORTS	MoH	UNICEF, NI and WB
	Output 2.2	Strengthened services for prevention and control of Vitamin A deficiency and deworming among children aged 6-59 months	Percentage of children under the age of 5 dewormed	62% (TDHS 2015/16)	95%	CHNM REPORTS /HMIS/TDHS/ NNS	MoH	UNICEF, NI and WB
		Percentage of children aged 6-59 months who have received Vitamin A supplementation in the last six months	52% (TDHS 2015/16)	95%	CHNM REPORTS/HMIS/ TDHS/NNS	MoH	UNICEF, NI and WB	
		Percentage of health care providers trained in the importance of Vitamin A supplementation	NA	80%	CHNM/MoH Training Reports	MoH	UNICEF, NI and WB	

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP									
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions		
		Percentage of councils that have integrated Vitamin A prevention and control activities in the councils' annual plans and budgets	NA	80%	CHNM/ MoH REPORTS	MoH	UNICEFNI and WB		
	Output 2.3	Increased availability and supply of adequate quality iodized salt	65%	97%	HMIS/TDHS/NNS	MoH	UNICEFNI, WB and IGN		
		Percentage of cases of Salt Act and Regulation defaulters reported	NA	80%	ZFDA & MoH REPORTS	MoH	UNICEFNI, WB and IGN		
		Percentage of households consuming adequately iodized salt	38% (TDHS 2015/16)	80%	ZFDA & MoH REPORTS/TDHS/ NNS	MoH	UNICEFNI, WB and IGN		
		Number of community sensitization meetings on the importance of consuming adequately iodized salt	NA	220	MoH REPORTS	MoH	UNICEFNI, WB and IGN		
		Number of supportive supervision and inspection conducted in salt production sites and storage points	NA	20	ZFDA & MoH REPORTS	MoH	UNICEFNI, WB and IGN		
		Percentage of salt producers, wholesalers, retailers and groups of salt vendors trained in the importance of iodized salt	NA	70%	MoH REPORTS	MoH	UNICEFNI, WB and IGN		

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP							
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions
<b>KRA 3</b> <b>INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION (IMAM) SCALED UP</b>	Output 2.4	Improved other micronutrient deficiency prevention and control interventions among women, adolescent and children	NA	20	MoH REPORTS	MoH	UNICEF, NI, WB and IGN
	<b>Outcome 3</b>	<b>Improved access and quality management services for integrated management of acute malnutrition</b>					
	Output 3.1	Improved quality of services for management of SAM and MAM in at least 75 % of health facilities	11 % (2018/2019 BNA)	75%	MTUHA, HIMS and health facility reports	MoH	LGAs, UNICEF and WHO
	Output 3.2	At least 75% of children under the age of 5 receive screening for SAM and MAM at the community level	Percentage of health facilities providing inpatient treatment (ITP) of SAM	73 % (2018/2019 BNA)	75%	MTUHA, HIMS and health facility reports	MoH

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP							
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions
	Output 3.3	Essential therapeutic nutrition supplies and equipment are available in at least 90 % of health facilities providing services for the management of SAM and MAM	Percentage of health facilities with no stock-out of RUTF, F100, F 75 lasting more than a month during the last fiscal year	20% (2018/2019 BNA)	90%	MTUHA, HIMS and health facility reports	MoH LGAs, UNICEF and WHO
<b>KRA 4</b>	<b>Outcome 4: Zanzibar population's is physically active and eats healthy diets</b>						
<b>SCALED-UP SERVICES TO PREVENT AND MANAGE DIET-RELATED NON-COMMUNICABLE DISEASES (DRNCDS)</b>	Output 4.1	Increased access of DRNCD quality services in 55 existing health care facilities (only 44 facilities have quality DRNCD services at the moment)	Number of existing PHCU+ from 49 to 55	49%	55	HMIS	MoH WHO
		Sensitize at least 50 % of school-age children and adult population to the risk factors for non-communicable diseases by December 2023	Number of health care providers trained in the risk factors for DRNCD	NA	500	MoH Reports	MoH WHO, UNICEF
	Output 4.2		Number of community screening programmes/campaigns on DRNCDS risk factors conducted	NA	220, TBD	MoH Reports	MoH WHO, UNICEF
			Percentage of school-age children and adults sensitized to the risk factors for non-communicable diseases	NA	50%	MoH Reports	MoH WHO, UNICEF
			Number of school teachers trained in healthy eating and lifestyles	NA	70, TBD	MoH and Ministry of Education reports	MoH and Ministry of Education reports WHO and UNICEF

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP								
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions	
		Number of public awareness campaigns on healthy eating and lifestyles conducted for food vendors, hoteliers, employees in workplaces and media people	NA	70, TBD	MoH reports	MoH	WHO and UNICEF	
	Output 4.3	Reviewed policies and legislation integrated issues of prevention and control of DRNCD	NA	2	MoH reports	MoH	WHO and UNICEF	
		Number of inspection operation conducted on enforcement of regulations on prevention and control of DRNCD	NA	110	ZFDA & MoH reports	MoH	WHO and UNICEF	

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP								
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions	
<b>KRA 5 SCALED-UP ACTIONS TO ENSURE A MULTISECTORAL NUTRITION RESPONSE</b>	<b>Outcome 5: Line sectors, private sector and CSOs scale up nutrition-sensitive interventions to reach all communities to improve nutrition.</b>							
	Output 5.1	Vulnerable groups with increased accessibility to quality nutritional services	Percentage of vulnerable (poor) households served by social protection schemes disaggregated by location	41.7% (2014/15)	45%	Survey	TASAF	LGAs, UNICEF and WHO
	Output 5.2	Strengthened nutritional interventions in educational institutions	The number of children of official school age attending school expressed as a percentage of the total number of school-age children	Kaskazini Unguja = 80.7% Kusini Unguja = 92.6% Mijini Magharibi=91.5% Kaskazini Pemba = 77.2% Kusini Pemba = 79.1% Primary Education (2010)	100%	TDHS	MoEVT	OCGS
	Output 5.3	Increased availability and utilization of quality food within households	Percentage of population below the food poverty line (The population whose household total spending on all items is less than what they need to spend to meet their food needs, expressed as a percentage of the total population)	10.8% (2014/15)	7.2%	HBS, every 5 years	OCGS	MoH, WHO, UNICEF, LGAs and NGOs

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP							
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions
		Percentage of food-secure households (the number of households which have sufficient, safe and nutritious food to maintain a healthy and active life, expressed as a percentage of the total number of households in a particular area)	51.4% (2014/15)	75%	HBS, Every 5 years	OCCS	MoH, WHO, UNICEF, LGAs and NGOs
	Output 5.4	Improved WASH practices including hand washing	Total = 92.6% Urban = 98.4% Rural = 88.3% (2014/15)	100%	HBS	Ministry responsible for water	LGAs
	Output 5.5 (Health)	Communities regularly use quality maternal health services including family planning, neglected tropical diseases (NTD) prevention and treatment of HIV and malaria	47.1	90	HMIS facility-based	MoH	LGAs
		Increased use of modern contraceptives	14% in 2015/2016 (TDHS)	20%	TDHS	MoH	LGAs
		Number of NTDs prevailing in Zanzibar eliminated (lymphatic filariasis, schistosomiasis, trachoma) according to the National NTD strategic plan.	N/A	N/A	N/A	MoH	LGAs

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP									
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions		
		Percentage of NTD cases properly managed (LF)	0.9% 2008	50%	Routine HMIS	MoH	LGAs		
		Percentage by which the Incidence of malaria has reduced	0.6% 2008	10%	ZACP- ANC Surveillance	MoH	LGAs		
		Reduction in HIV prevalence among pregnant women aged 15-24 years		TBD					
	Output 5.6 (Climate change)	Agricultural policies, strategies and plans integrating climate change concerns	N/A	Yes	JMNRS	MANRLF	VPO		
	Climate-resilient multisectoral nutrition interventions are promoted and integrated into actions that address the underlying causes of malnutrition, focusing on food security, care security and health and WASH security	Climate change concerns included in the curricula of primary and secondary schools	N/A	Yes	JMNRS	MANRLF	VPO		
		Health strategic plans reviewed to include climate change concerns	N/A	Yes	JMNRS	MoH	VPO		

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP								
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions	
<b>KRA 6 IMPROVED NUTRITION GOVERNANCE</b>		Number of research projects done on nutrition and climate change	0	At least 1	JMNRs	VPO	Ministries responsible for agriculture, health and education	
		<b>Outcome 6: Multisectoral Nutrition Governance Strengthened</b>						
	Output 6.1	Increased political and financial commitment of the government to nutrition	Percentage of government budget spent on nutrition	1.5% (2016/17) (PER, 2018)	1.80%	MTEF	MoH	Sectoral ministries and Donors
			Execution rate (in %) of the government budget for nutrition	MDAs < 10% Pemba =46% Unguja =36% (PER, 2018)	MDAs=35% Pemba=70% Unguja=60%	MTEF	MoH	Sectoral Ministries and donors
			Annual nutrition stakeholders' meeting conducted (yes/No)	NA	Yes	Meeting report	MoH	Sectoral ministries, donors and CSOs
	Output 6.2	Ensure functional sectoral and multisectoral coordination at all levels	Number of intersectoral steering committee meetings on FSN conducted	NA	2	Annual reports	Intersectoral committees	Office of the Second Vice President
		Number of quarterly technical thematic working group meetings conducted	0	4	TWG meeting reports	TWGs	MoH	
		Percentage of regions and councils conducting multisectoral nutrition coordination meetings (steering committees)	0	100%	Meeting reports	Regions and districts	MoH	

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP									
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions		
	Output 6.3	Improved human resources and capacities for nutrition at all levels							
		Percentage of councils and regions with the required nutrition personnel	TBD	100%	HR reports	Regions and districts	MoH		
		Percentage of nutrition officers at the regional and district levels who have received relevant on-job training	NA	100%	MoH reports	MoH	Sectoral Ministries, Donors, CSOs		
		Number of learning visits on nutrition issues conducted within and outside the country	TBD	2	Annual reports	Office of the Second Vice President	MoH		
	Output 6.4	Increased communication and public awareness on ZMNSAP							
		Percentage of regions and districts that have conducted two awareness creation meetings on the ZMNSAP per year	0%	100%	Annual reports	Regions and districts	MoH		
		Percentage of villages in which community sensitization meetings were conducted	70%	100%	Annual reports	Regions and districts	MoH		
		Number of BCC materials disseminated for the ZMNSAP	0%	At least 5	Annual reports	MoH	Office of the Second Vice President		
		Percentage of local social media, radio and television station airing nutrition messages	0%	80%	Annual reports	MoH	Ministry of Information, Tourism and Antiques		

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP								
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions	
<b>KRA 7</b> <b>STRENGTHENED MULTISECTORAL NUTRITION INFORMATION SYSTEMS FOR EFFECTIVE DECISION-MAKING AT ALL LEVELS</b>	<b>Outcome 7: Strengthened multisectoral nutrition information systems for effective decision-making at all levels</b>							
	Output 7.1	Strengthening a comprehensive multisectoral nutrition and related information system at all levels	A comprehensive multisectoral information system has been developed and is being maintained	NA	System accessible	MoH reports	MoH	Sectoral ministries, donors and CSOs
			Annual implementation reports for nutrition developed and disseminated	NA	1	Annual reports	Office of the Second Vice President	MoH
			Bottleneck analysis (BNA) and analysis of annual work plan conducted	BNA=2 AWP=0	BNA = 2 AWP =2	MoH reports	MoH	Sectoral ministries, donors and CSOs
			Percentage of regions and councils disseminating multisectoral nutrition scorecard	0	100%	Annual reports	MoH	Sectoral ministries and donors.
		Mid-term and end-term evaluation conducted	0	MTR =1 ETR=1	Evaluation reports	Office of the Second Vice President	MoH	
	Output 7.2	Strengthening accessibility and use of nutrition data and information at all levels	Annual data quality audits conducted for the available sectoral data system	NA	1	Annual reports	MoH	Sectoral ministries and donors.
		Percentage of RNUOs and DNUOs capacitated for routine data system and nutrition surveillance	NA	100%	MoH Reports	MoH	Sectoral ministries, donors, CSOs	

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COMMON OUTPUT RESULTS AND ACCOUNTABILITY FRAMEWORK FOR THE ZMNSAP									
KEY RESULT AREA (KRA)	Expected Results	Indicator	Baseline (Year)	Target 2024/25	Means of verification	Lead Institution	Collaborating Institutions		
		Feedback mechanism and learning framework developed and operationalized	NA	Operationalization	MoH Reports	MoH	Sectoral ministries, donors and CSOs		
		Number of sensitization meetings on the use of evidence-based information conducted for nutrition stakeholders	TBD	4	MoH Reports	MoH	OCGS, sectoral ministries, donors and CSOs		
	Output 7.3	Enhanced evidence-based decision-making through nutrition research and studies	NA	100%	MoH Reports	MoH	OCGS, sectoral ministries, donors and CSOs		
		Number of nutrition surveys and studies conducted	2	3	MoH Reports	MoH	OCGS, sectoral ministries, donors and CSOs		
		Number of dissemination meetings conducted for relevant stakeholders	NA	3	MoH Reports	MoH	OCGS, sectoral ministries, donors and CSOs		
		Number of nutrition and other relevant officers trained in nutrition research	TBD	22	MoH Reports	MoH	OCGS, sectoral ministries, donors and CSOs		
		Number of clinical dieticians trained	NA	30	MoH Reports	MoEVT	SUZA		

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## Appendix 2: List of contributors to the development of the ZMNSAP

S/N	Role	Organization	Name
Overall Facilitators			
1.	Lead facilitator and writer of the ZMNSAP	Kavishe International Consultancy Services (KICS) and Iodine Global Network (IGN)	Dr. Festo P. Kavishe
2.	Technical facilitator	TFNC	Dr. Joycelene Kaganda
3.	Partner facilitator	UNICEF Tanzania	Mr. Mauro Brero
TASK TEAMS, FACILITATORS, CHAIRS AND MEMBERS			
<b>TASK TEAM 1</b>		<b>MATERNAL AND EARLY CHILDHOOD NUTRITION SERVICES (KRA 1) AND INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION (KRA 2)</b>	
1.	Facilitator	TFNC	Mary V. Kibona
2.	Chairperson	Ministry of Labor, Empowerment, Women, Elders and Children	Sheikha Ramia
3.	Secretary	Ministry of Health, Nutrition Unit	Fatma A. Said
4.	Member	Ministry of Health, Nutrition Unit	Asha H. Salmin
5.	Member	Ministry of Health, Nutrition Unit	Wanu Haji ALLY
6.	Member	Ministry of Health, Nutrition Unit	Wanu Hilika
7.	Member	Ministry of Health, Nutrition Unit	Mwanahija K. Mbarouk
8.	Member	Ministry of Health, Nutrition Unit	Subira Bakar Ame
9.	Member	TASAF	MR. Makame
10.	Member	State University of Zanzibar (School of Health)	Jamila Kingwaba
11.	Member	D-TREE International	Omar Abdullah
12.	Member	Save The Children	Nyamizi Njile
<b>TASK TEAM 2</b>		<b>PREVENTION OF MICRONUTRIENTS DEFICIENCIES (KRA 3) AND DIET-RELATED NON-COMMUNICABLE DISEASES (KRA 4)</b>	
1.	Team Facilitator	TFNC	Dr. Fatma Abdallah
2.	Chair	MOH – NCD Unit	Zuhura Amour
3.	Member	MoH – Nutrition Unit	Asha S. Salmin
4.	Member	UNICEF	Abraham Sanga
5.	Member	TASAF	Makame Ali Haji

S/N	Role	Organization	Name
<b>TASK TEAM 3</b>		<b>NUTRITION-SENSITIVE INTERVENTIONS (NSI)</b>	
1.	Team Facilitator	TFNC	Dr. Joyceline Kaganda
2.	Chair	Department of Food Security and Nutrition (MoA)	Ahmed Gharib
3.	Member	Department of Preventing Services (MoH)-WASH	Forogo K. Mtande
4.	Member	Department of Primary School (MoE) and School-Feeding Programme- Education	Salum Mohamed Abdulla
5.	Member	Department of Elders and Social Welfare (Ministry of Labour, Empowerment, Elders, Women and Children)- Social Protection	Abdulla Saleh Omar
6.	Member	Ministry of Trade and Industry-Trade and Industry	Mlisho Ali Khamis
7.	Member	UNICEF	Joyce Ngegba
8.	Member	LGAs	Ali Shauri
9.	Member	HMIS Officer	Suleiman Hemed
<b>TASK TEAM 4</b>		<b>MULTISECTORAL NUTRITION GOVERNANCE (KRA 6) AND MULTISECTORAL NIS (KRA 7)</b>	
1.	Team Facilitator	TFNC	Adam Hancy
2.	Chair	Director- Policy, Planning and Research (Ministry of Health)	Fatma Bakari Juma
3.	Secretary	Director- Food Security and Nutrition Department (Ministry of Agriculture)	Ahmed Gharib
4.	Member	UNICEF	Maryam Hemed
5.	Member	Ministry of Health, Nutrition Unit	Salama Ashrak
6.	Member	Director- Local Government (PO–RALGSD)	Zuhura Salum Rashid
7.	Member	Director- Public Administration (Second Vice President's Office)	Mussa Haji Mussa
8.	Member	Planning Policy and Research- MoFP	Mohammed Maulid Mohammed
9.	Member	Monitoring and Evaluation- Ministry of Education	Salum Abdallah
10.	Member	Save the Children	Asma Khamis
11.	Member	D-TREE International	Omari Ally Abdallah
12.	Member	Organization: MoH – Health Promotion Unit	Halima Ali Khamis







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