



MAPPING EXISTING NUTRITION AND EARLY STIMULATION PROGRAMS IN TANZANIA



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1.0 BACKGROUND

Substantial gains in child survival and nutrition status have been reported in Tanzania during the last 15 years.^{1,2} However, stunting remains unacceptably high and affects more than one in three children under five years of age (34 percent). Stunting rates vary dramatically by region and by socio-economic status, with five regions having rates greater than 40 percent.² High levels of undernutrition contribute to high child and maternal mortality, poor educational performance, intergenerational transfer of poverty and inequity, and low economic productivity during adulthood. Hence, there is increasing need to move beyond just surviving to thriving in Tanzania, as well as other low- and middle-income countries (LMICs).³

The Government of Tanzania (GoT) recently launched the National Multisectoral Nutrition Action Plan 2016– 2021 (NMNAP). This plan defines priority areas, costs the action plan, and provides a roadmap towards implementing integrated multisectoral interventions aimed at improving nutrition in Tanzania.⁴ NMNAP taps into the increasing evidence on early childhood care and development (ECCD) investments,⁵ and their potential to have profound long-term impacts on health and adult productivity.^{6, 7} It also emphasizes interventions that target the first 1,000 days⁸ of a child's life. Optimal coverage and access to these high-impact interventions is central to accomplishing the NMNAP.^{9, 10, 11}

Implementation of NMNAP calls for increasing integration of multisectoral responses, partnerships, and nutrition packages focusing on the first 1,000 days. Further, to avoid inadvertent complexity in the delivery of these packages, careful selection, planning, and implementation of cost-effective bundles of nutrition-specific and sensitive interventions is required.

A mapping of existing nutrition and early child stimulation programs in Tanzania was undertaken in 2018. This report presents the findings of this mapping exercise beginning with a brief introduction, mapping objectives, summary of integrated interventions, approaches, and best practices currently implemented by the leading GoT/development partner (DP) nutrition programs. The report then presents lessons learned from programmatic field experiences, particularly focusing on the delivery of nutrition-specific and sensitive interventions targeting women with children within the first 1,000 days of life (i.e., what works, how and for whom, at what level of service delivery, challenges/bottlenecks to accessing and using GoT/DP-implemented

¹ Sato et al., 2017. Decomposition of determinants on child health over years. Draft. World Bank.

² 2015/2016 Tanzania Demographic Health Surveillance (TDHS).

³ Black, M., Walker, S.P, Fernald, L. Andersen, DiGirolamo, C. Lu, C. et al. 2016 Advancing Early Childhood Development: from Science to Scale Early childhood development coming of age: science through the life course. *The Lancet* October 4, 2016 [http://dx.doi.org/10.1016/S0140-6736\(16\)31389-7](http://dx.doi.org/10.1016/S0140-6736(16)31389-7).

⁴ The 7 priority key result areas of the NMNAP: (1) Scaling up Maternal, Infant, Young Child and Adolescent Nutrition; (2) Scaling up Prevention and Management of Micronutrient Deficiencies; (3) Scaling up Integrated Management of Acute Malnutrition; (4) Scaling up Prevention and Management of Diet-Related Non-Communicable Diseases; (5) Scaling up multi-sectoral nutrition sensitive interventions (agriculture and food security, health and HIV, WASH, education, social protection, and environment and climate change); (6) Strengthening multi-sectoral nutrition governance; and (7) Establishing a multi-sectoral nutrition information system.

⁵ ECCD is defined by UNICEF as the provision of health and nutrition, stimulation and care, safety and protection, and education from conception to eight years old. Integrated ECCD services are increasingly being recognised as a key strategy for the realisation of children's rights and poverty reduction.

⁶ Grantham-McGregor et al. 2007. Developmental Potential in the First 5 Years for Children in Developing Countries. *The Lancet* 369 (9555): 60–70.

⁷ Gertler, Paul, James Heckman, Rodrigo Pinto, Arianna Zanolini, Christel Vermeersch, Susan Walker, Susan Chang, and Sally Grantham-McGregor. 2014. "Labor Market Returns to an Early Childhood Stimulation Intervention in Jamaica." *Science* 344 (6187): 998–1001.

⁸ The first 1,000 days refers to the period from conception to two years of age.

⁹ Tanzania Stakeholder and Nutrition Action Mapping FY2015/16: National Results. TFNC, SUN Network, REACH. Shared in Feb 2017.

¹⁰ Nyhus Dhillon et al, Executive Summary for the Micronutrient Powders Consultation: Lessons learned for operational guidance; *Matern Child Nutr.* 2017

¹¹ [Fortification Assessment Coverage Tool \(FACT\) Survey in Tanzania - 2015, National](#) Bureau of Statistics (NBS, Tanzania).

¹² ECD interventions comprise several stages of mental and physical growth as well as a variety of contexts such as homes, schools, and the community. ECD activities range from childcare to nutrition for pregnant mothers and young children to parent education. They are meant to address the health, nutritional, cognitive, linguistic and socio-emotional needs of the child.

interventions). Finally, the report concludes with a series of recommendations to support GoT efforts in designing and implementing high-impact early childhood development programs.

2.0 OBJECTIVES

The broad objective of this mapping exercise is to inform the GoT IEY project design through a review of existing nutrition and early child stimulation programs in Tanzania.

Specifically, this work reviewed the following:

1. Existing nutrition programs and types of interventions implemented (including activities, what works, and how);
2. Delivery platforms for nutrition programs and applicable approaches, including operational strengths, challenges, and opportunities;
3. Bottlenecks related to access and utilization of nutrition-specific, as well as sensitive interventions.

3.0 METHODOLOGY

A desk review was conducted to identify key DP programs currently implemented in Tanzania. Program selection was mainly based on size, coverage in terms of geography, and target population (women and their children within the first 1,000 days). Programs integrating early childhood stimulation interventions were also included in the review. Preliminary information about selected programs was collected through telephone interviews and used to identify locations for field visits.

Table 1 Key Nutrition Programs in Tanzania, by Priority Interventions, by Region

Program/Implementer	Region	MIYCAN	Micronutrient	IMAM	Growth Monitoring	CCD/Early stimulation	Nutrition Sensitive
Next Generation/CUAMM	Simiyu, Ruvuma*	X		X		X	
Scaling up IMAM/CUAMM	Iringa*, Njombe*	X		X		X	
Right to water / CUAMM	Iringa*, Dodoma						WASH
Mwanzo Bora / Africare	Morogoro, Dodoma, Manyara, Iringa*, Mbeya, Songwe, Unguja, Pemba	X	X			X	Agr, Livestock WASH
ASRP / UNICEF, PACT, CRS, CUAMM, COUNSENUH, IRDO	Mbeya, Iringa*, Njombe*, Songwe	X			X	X	WASH Agr.
ASTUTE/ IMA World Health	Geita, Kagera*, Kigoma, Mwanza, Shinyanga	X				X	WASH
Lishe Ruvuma/COUNSENUH	Ruvuma*	X			X	X	Agr. Livestock WASH
Food Security & Nutrition/ Save the Children, WFP	Dodoma, Singida	X		X			Agr.
Tuwekeze Pamoja/ Save the Children	Mbeya	X				X	WASH, Agr GBV
Reproductive MCH / Save the Children	Zanzibar	X		X	X		

*Program field sites visited

4.0 INTERVENTIONS, APPROACHES & BEST PRACTICES

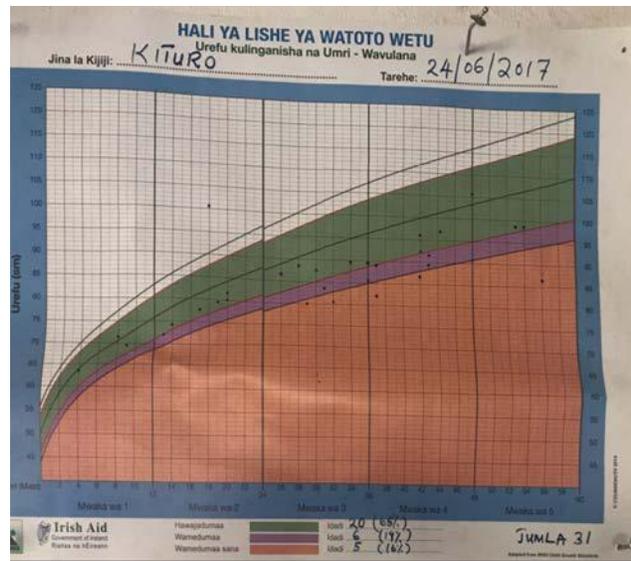
The following selected interventions are being implemented across all programs. Table 2 summarizes details on approaches, tools used, and observations made from operational experiences for the main interventions below, as well as other included interventions.

4.1 Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN): MIYCAN is mainly delivered as part of socio-behavioral change communication (SBCC) for nutrition. Three main approaches are currently implemented in the field to deliver SBCC, as well as other interventions: Home visits, women peer support groups (PSGs), and village health days (VHDs). Components integrated into the SBCC package, such as flip charts (“*Bango Kitita*”), are primarily based on SBCC materials originally developed by the Mwanzo Bora Nutrition Program (MBNP) and approved by the Ministry of Health. All other programs use the same SBCC material, except for ASTUTE, which uses their own flipcharts. The key difference between the two flipcharts is the inclusion of child stimulation messages in the ASTUTE program.

4.2 Growth Monitoring and Promotion (GMP): Standard growth monitoring practices¹³ conducted through primary healthcare facilities continue to be challenging due to a lack of equipment and/or provider training. UNICEF-supported programs implemented by implementation partners (i.e., CUAMM, CRS, and Save the Children) support growth monitoring at the primary care facility level, and provide anthropometric measuring equipment (weighing scales, length boards, and mid-upper arm circumference (MUAC) tapes) as well as training. COUNSENUTH has extended growth-monitoring services to the community level through quarterly VHDs. COUNSENUTH supports GMP only at the community level, and routinely conducts assessments on weight, height, and MUAC measurements.

Best Practice 1: COUNSENUTH-Supported Growth Monitoring at the Community Level

GMP is provided for all children under five years of age at quarterly VHDs, which are conducted by the village dispensary health worker with assistance from community health volunteers (CHVs). Health staff use an aggregate village growth monitoring card and complementary registers with individual identifiers to record data. At the end of the village health days (VHD) aggregated growth monitoring charts (weight for age/height for age) and reports are generated. These summary reports and aggregated charts are then posted at the village health council board. This practice enhances data utilization at the village level, starting with individual feedback to parents/caretakers, and then aggregate feedback to the village council. GMP trends become an integrated part of the village council



agenda and subsequent community actions. This approach for community-level GMP has better coverage (>90 percent) and continuity, with CHVs conducting individual follow-ups of children who had growth faltering or missed VHDs. In comparison to the facility GMP, the VHD records show more GMP assessments and cases identified than facility GMP records. While broader coverage is a positive outcome of the VHD program, monitoring is necessary to ensure quality of care and better linkages to facility GMP data.

¹³WHO Child Growth Standards: Includes length/height-for-age, weight-for-age, weight-for-length, weight-for-height, head circumference-for-age, arm circumference-for-age and body mass index-for-age. <http://www.who.int/childgrowth/standards/en/>

4.3 Integrated Management of Acute Malnutrition (IMAM): IMAM services, especially management of severely acute malnutrition (SAM), are included within UNICEF-supported programs, but largely missing from all other programs. The paucity of SAM inpatient services, largely due to a lack of trained personnel on SAM management protocols and lack of ready-to-use therapeutic foods (RUTFs), has resulted in SAM management that is focused mainly on treating clinical complications. CUAMM supports a strong IMAM program, which links in-patient SAM management with outpatient and/or community-based care. Despite this strong network, the use of SAM services remains low, with a relatively higher caseload during farming season (approximately three to five SAM cases/month per village) . Potential explanations include, missed cases from screening and referrals, high seasonal variations for SAM, high rates of absconding from treatment, or a preference for alternative forms of care (i.e., traditional healers).

Best Practice 2: CUAMM-Supported IMAM Program in Iringa, Njombe, Ruvuma, and Simiyu



This program provides inpatient facility care for SAM cases at the district level and at select health centers (based on the catchment area). The program also includes outpatient follow-up services where subsequent assessments & RUTFs are provided through the village health dispensaries.

To facilitate referrals between health facilities and communities, as well as linkages to IMAM facilities, facilities can use registers for referrals back to the community level with their respective CHVs and for follow-up and provision of RUTFs. In facilities that do not provide IMAM services, training has been conducted to enable health workers to identify and refer patients to existing services where appropriate.

Despite the wide coverage of services, utilization is affected by the passive screening approach (only screening those coming to the health facility) and high rates of absconding from treatments. In addition, there is heavy reliance on program supplies and IMSAM commodities (e.g., growth monitoring tools, RUTFs, foods for cooking demonstration, etc.).

4.4 Micronutrient Powder Supplementation (MNP): Provision of iron and folate (IFA) for pregnant women and vitamin A (VAS) drops to children occurs primarily at the facility level, mostly through maternal and child health (MCH) services. Regular stock-outs interrupt coverage and continuity of these services. Occasionally, the rural districts of local government authorities (LGAs) (e.g., Ruvuma) procure buffer stocks of IFA to cover stock-out periods. COUNSENUth-supported regions have community micronutrient supplementation integrated with the quarterly VHD activities. The primary health care workers review the MCH records, and provide the missed doses/refills. Among all programs included in this mapping exercise, only the Mwanzo Bora-supported regions promoted the distribution of micronutrient sachets through CHVs (introduced by *TUBORESHE chakula*), food fortification through maize millers, and sunflower oil food processors at sub-regional level (in collaboration with NAFKA).

4.5 Early Child Stimulation: Integration of early child stimulation activity with nutrition programs is in its early stages in Tanzania. In the broader context of early childhood development (ECD), programs have adopted (with modifications) the UNICEF-supported CCD guidelines and kits, and incorporated early child stimulation activities into child care and development activities. These programs use PSGs, VHDs, and CHV's home visits to promote age-appropriate toys using locally available materials. CRS has established a total of eight CCD spaces (four facility-based and four at the community level), and CUAMM is working on establishing the same. Design of facility-based CCD spaces involves infrastructure investments (i.e., building/physical space) and CCD trained personnel. Hence, there are higher cost implications for establishing CCD spaces at

the facility level as compared to establishing CCD spaces at the community level. The CCD community model is implemented through monthly PSG meetings for pregnant women and parents/caretakers of children less than two years of age. Save the Children and PCI Tanzania are planning to roll out integrated early child stimulation activities in Mbeya and Mara region respectively using the less structural, low-cost community CCD model.

4.6 Other Integrated Interventions: In addition to the main interventions above, several additional interventions have been integrated across all programs. These multisectoral interventions broadly include the following nutrition-sensitive sectors:

- 4.6.1 **Agriculture/livestock:** Interventions include home gardening and keeping small livestock, with supporting agriculture extension services; provision of seeds, fertilizers; and provision of a few small animals like chicken, rabbit, etc. (Best Practice 4: Mwanzo Bora “Pay It Forward” model). Provision of small animals is guided by local preferences: for example, rabbits are more preferred in Iringa and Njombe, and less preferred in Ruvuma.
- 4.6.2 **Water, sanitation, and hygiene (WASH):** WASH mainly focuses on incorporating SBCC messaging on improved sources of drinking water, water treatment, promoting hand washing using tippy taps, and improved toilets.
- 4.6.3 **Social protection:** Conducted indirectly through linkages with TASAF and provides beneficiary households with conditional financial support.
- 4.6.4 **Multisectoral information system:** Supported district nutrition officers with tools (e.g., laptops in COUNSENUTH-supported regions) and basic training on collecting and aggregating data (UNICEF bottleneck analysis data, nutrition score card, etc.)
- 4.6.5 **Multisectoral governance for nutrition:** Provided more support to multisectoral coordination committees and multisectoral technical teams.

A detailed description of all interventions, approaches, tools, and respective observations from the field are summarized in table 2.

Best Practice 3: CUAMM-Supported Home Vegetable Produce Processing for Extended Shelf Life and Consumption

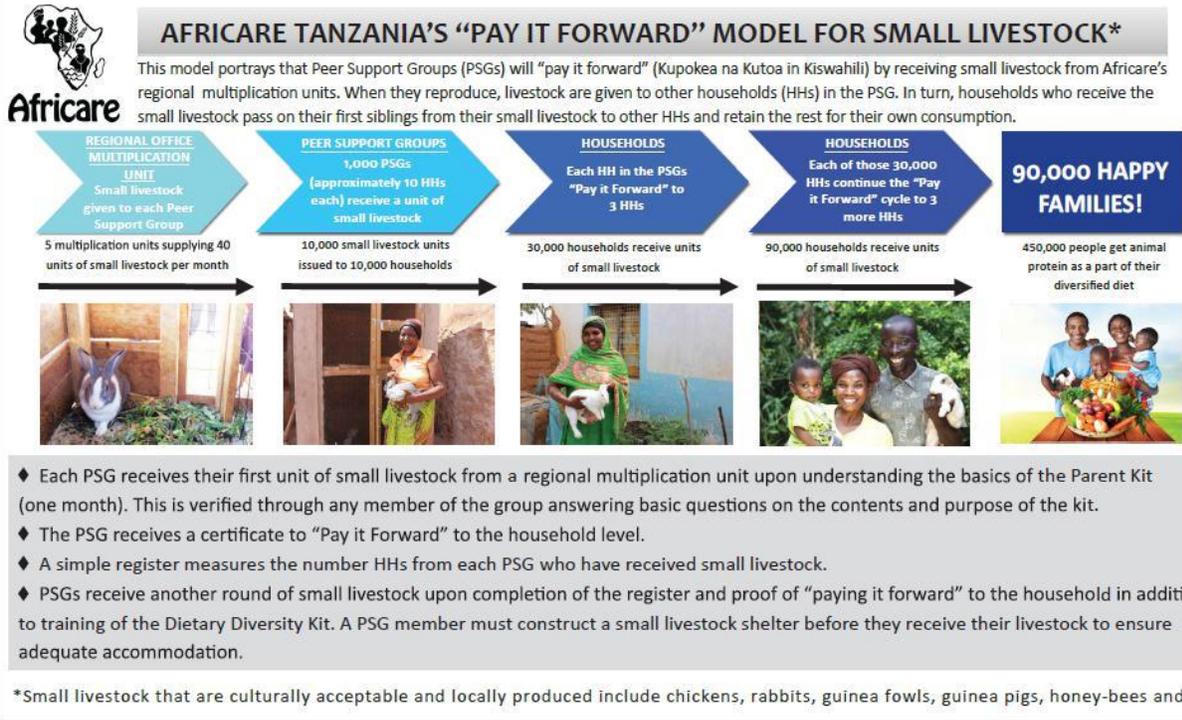
Vegetable production through home gardening has been widely adopted across all programs. However, in most settings, production is highly seasonal due to drought and pests. These seasonal variations lead to suboptimal intake, especially during off-season periods, which account for almost half of the year.

Use of vegetable solar dryers, as demonstrated by the CUAMM-supported nutrition-sensitive agriculture program in Iringa and Njombe PSGs, allows households to process excess harvest and store nutrient-preserved solar-dried vegetables for off-season consumption.

The shelf life of the processed vegetable is extended by three to six months, while still retaining essential nutrients. This approach ensures year-long consumption to meet vegetable consumption and dietary diversity needs.



Best Practice 4: Mwanzo Bora Nutrition Program “Pay it Forward” Model for Small Livestock



Best Practice 5: WASH in COUNSENUTH-Supported Regions - Drinking Water Treatment and Storage

In addition to tippy taps, which are widely adopted across all programs, COUNSENUTH PSGs have mobilized their own resources to obtain water storage buckets for member households. Each bucket costs Tsh 10,000 (approximately US\$4).

Members boil or treat water with water guards, then filter and store the water for drinking at the household level.

This exemplifies the way that PSGs, empowered with SBCC messages and nutrition knowledge, can be used to promote and implement key low-cost interventions at the household level.



Table 2 Interventions, Approaches, and Tools Implemented by Nutrition Programs in Tanzania

Priority Areas / Interventions	Approaches	Tools	Observations
<p>SBCC (mainly MIYCAN)</p>	<p>Three main levels:</p> <p>1. Individual – Home visits by village-level facility health workers (CHVs).</p> <p>2. Group</p> <p>a) Women PSGs – typically a group of eight to 12 women of reproductive age who reside in close proximity and meet at regular intervals (monthly). Establishment of these groups is coordinated by CHVs, and once established, stable groups coordinate themselves with minimal support from CHVs.</p> <p>b) VHDs – typically meet quarterly, with involvement of CHVs, health facility workers, village council, men and women with children < five years.</p> <p>c) Community Outreach and Positive Deviance – SBCC activities are tailored to target groups (e.g., addressing specific needs for MAM/SAM household cases through positive deviance hearth, which is mainly implemented by ASTUTE).</p> <p>3. Mass media</p> <p>a) Feature mainly radio spots, talk shows, information sessions through local stations, etc.</p> <p>b) Pre-recorded radio messages on digital radios for monthly group SBCC sessions (COUNSENUTH).</p> <p>c) Live presentations by CHVs during VHDs using public announcement systems.</p> <p>d) Theatre arTshowcased during village gatherings (e.g. VHDs, village market days, etc.).</p>	<ol style="list-style-type: none"> 1. Standardized, approved materials by MoH: <ol style="list-style-type: none"> a) Flipchart (Bango Kitita) - developed by Mwanzo Bora as part of the first 1,000 days kit. b) Flipchart (Bango kitita) - developed by ASTUTE program. 2. Local radio stations, production of radio spots, talk shows, and information sessions. 3. Digital radios with SBCC nutrition messages recorded in its memory card, based on the content developed for the first 1,000 days kits. ¹⁴ 4. Basic public announcement (PA) systems. 	<ol style="list-style-type: none"> a) Reaching every eligible household with a child in its first 1,000 days through home visits is resource intensive. PSGs have a potential multiplier effect, but adherence varies widely from 65-90 percent. ¹⁵ b) The two flipcharts overlap to a great extent. ASTUTE flipchart contains additional information on early child stimulation messages/module. c) Mwanzo Bora flipchart is widely adopted, with or without the full kit, which also contains user manuals and guides. The cost of a full kit is US\$80, and the aggregate costs of kits for large-scale program appears prohibitory. ¹⁶ d) ASTUTE, in collaboration with Development Media International (DMI), implements the largest mass media campaign. Mass media campaigns are context-sensitive and at present, best delivered through local radio due to the limited coverage of national radio, especially in remote areas.

¹⁴ Digital radio with recorded SBCC messages implemented by COUNSENUTH ensures consistency in delivering standardized SBCC messages, since most CHVs have a low level of literacy and received only a short training. Each digital radio costs around US\$10.

¹⁵ Attendance to women PSGs varies depending on seasonality (low during farming season), time (members fatigue), and level of integrated activities beyond nutrition SBCC (e.g., microfinancing/income generating projects, etc.).

¹⁶ Mwanzo Bora first 1,000 days are produced and supplied locally. However, the cost of kits is reported to be too high for programs to afford.

<p>Prevention and Management of Micronutrient Deficiencies</p> <ul style="list-style-type: none"> - IFA - Vitamin A - Micronutrient sachets - Food fortification - Deworming 	<p>Complementing primary healthcare services (primarily supported by the government) – procurement and supply of buffer stock for IFA to cover facilities during stock-outs (CUAMM).</p> <p>Extension of MCH services to the community – includes provision of vitamin A, IFA supplementation through VHDs and/or community outreach.</p> <p>Promoting use of micronutrient sachets – implemented by <i>Mwanzo Bora (Tuboreshe Chakula)</i> through the women PSGs.</p> <p>Promoting food fortification – through small- and medium-scale millers. Implemented by <i>Mwanzo Bora</i> in collaboration with <i>Nafaka</i>. <i>Tuboreshe Chakula</i> provided support to small- and medium-scale millers to adopt technology (mixer dossiers), provide access to finance, assistance with procurement and marketing, technology support, etc.</p>	<p>5. Supplements (IFA, Vitamin A, deworming pills, micronutrient sachets, and fortifications).</p>	<p>e) IFA stock-outs at facility-level appear to be common. The pattern of stock-outs seems to be uniform across facilities in the same districts. Stock-outs can be attributed to systematic issues (supply chain), especially suboptimal documentation (incomplete registers make accurate planning and supply projections difficult. Lack of logistic information systems between facilities and district medical stores results in manual order processing and time away from facilities to replenish stocks (village dispensary workers physically leave their facilities, and frequently visit the district hospital pharmacists to replenish their IFA stock).</p>
<p>Growth Monitoring, Promotion & Integrated Management of Acute Malnutrition (IMAM)</p> <ul style="list-style-type: none"> - Nutrition Growth Monitoring - IMAM 	<p>Primary healthcare (MCH) services – Although growth monitoring and promotion (GMP) services are expected to occur primarily at the village health facility level, access to services varies due to lack of equipment and training (especially across regions not supported by UNICEF).</p> <p>Community-level GMP through the VHDs – (COUNSENUTH)</p>	<p>6. MoH Growth Monitoring Manual.</p> <p>7. Child health books (blue one for boys and pink one for girls).</p> <p>8. Weighing scales and length boards.</p> <p>9. Village Growth Monitoring cards. ¹⁷</p>	<p>f) Facility-based GMP in regions not covered by UNICEF-supported programs either focus on measuring weight-for-age, or GMP is not conducted at all due to a lack of anthropometric equipment and/or trained health care workers.</p> <p>g) COUNSENUTH community-based GMP has over 90 percent coverage in growth monitoring at the village level.</p> <p>h) In places where both facility and community GMP activities are implemented, data on the number of screened and/or malnourished children (e.g., stunted, underweight, wasted, etc.) are not linked between the two levels. Hence, facility data may be underreporting the number of MAM/SAM cases, data may not be showing up at all in the</p>

¹⁷ Village Growth Monitoring card is a novel village aggregate growth monitoring tool originally developed by COUNSENUTH. It resembles individual child growth monitoring card/chart, and is used to summarize data collected during VHDs, GMP, on numbers of stunted, underweight, wasted, etc.

			facility-level, or there is an actual low provision/utilization of GMP.
	<p>MAM – Managed through nutrition counseling by the village health facility worker and CHVs at the community level.</p> <p>SAM - Select inpatient facilities and demonstration kitchens (CUAMM).</p> <p>Facility and home visits (CHVs) follow-up SAM/MAM services - (CUAMM, Save the Children).</p> <p>Follow-up home visits by CHVs after being released from SAM inpatient facilities – Part of criteria for children need home visits by CHVs.</p> <p>Provision of nutrient-enriched foods – Provision to malnourished, pregnant and lactating women (PLW), and children (Save the Children/WFP).</p>	<p>10. IMAM protocols and trained health workers.</p> <p>11. RUTFs (F-75, F-100, Plumpynut).</p> <p>12. Facility-community referral network for CHVs follow-up services.</p> <p>13. Nutrient-enriched foods (flour) for Save the Children/WFP.</p>	<p>i) Availability of SAM inpatient services possibly due to the level of demand, given fewer numbers of identified cases, and lack of trained primary healthcare facility workers.</p> <p>j) Facility care (inpatient treatment) for SAM faces high rates of absconders. ¹⁸ Parents are required to stay in hospital for three weeks. Co-existence of economic factors and sociocultural beliefs results in many SAM cases self-referred to traditional healers instead.</p>
<p>Multisectoral nutrition-sensitive interventions</p> <ul style="list-style-type: none"> - Agriculture and livestock - WASH - Social Protection 	<p>Agriculture extension & homestead food production for consumption and income (all programs):</p> <ul style="list-style-type: none"> - Homestead vegetable gardens. - Vegetables preservation for off-season consumption (CUAMM Iringa/Njombe). - PSGs small animal keeping projects – includes small animals like chicken, rabbits, etc. (MBNP, COUNSENUTH, CRS). <p>WASH – Mainly involves integrating WASH messages within the SBCC package delivered through PSGs, VHDs and HVs (all programs).</p> <p>Tippy-taps (<i>kibuyu chirizi</i>) at households, schools, common areas like market, etc. – (CUAMM and COUNSENUTH).</p>	<p>14. PSGs farm schools/ champion farmers.</p> <p>15. Agriculture extension services.</p> <p>16. Agriculture inputs – seeds, organic manures, small animal breeding etc.).</p> <p>17. Solar vegetable dryer (One per PSG).</p> <p>18. SBCC using standardized flipcharts approved by MoH Tanzania (<i>Bango Kitita</i>).</p>	<p>k) Integrating NSI through PSGs empowers women and improves adherence to PSG activities. Most of the vegetable production is for consumption rather than income generation (this is more so for vegetables than small animals).</p> <p>l) Vegetable production is challenged by water scarcity and pests, is highly seasonal, and is mostly unable to meet yearlong demands. Use of locally made, low-cost solar dryers ¹⁹ ensures preservation of vegetables during off-season.</p> <p>m) PSGs provide an efficient platform for adoption of best practices in WASH. Empowered with knowledge, PSGs can be a catalyst to drive socio-behavioral change in their households and eventually the community by leveraging their own resources.</p>

¹⁸ Absconding rates for SAM inpatient cases can be as high as 70 percent in CUAMM-supported SAM inpatient facilities.

¹⁹ One locally-made solar vegetable dryer is estimated to cost Tsh 400,000, and one dryer serves 10-15 households.

	<p>Improved household drinking water – Using various water treatment and safe storage methods like tapped buckets (COUNSENUTH).</p> <p>Improved latrines – Mostly involves provision of messages complimentary to the national sanitation campaign (all programs).</p>		
	<p>Social Protection - Reaching the last mile by using TASAF enrolled households ²⁰ to identify vulnerable beneficiaries (all programs).</p>	<p>19. Linkage with TASAF registered households (at risk households), and enrollment of parents/ caretakers to join PSGs (for SBCC and put priority on other interventions).</p>	<p>n) Reaching the last mile: The most vulnerable households can be identified through TASAF. However, nutrition and/or adherence to programmatic activities is not yet part of the TASAF conditionality for co-enrolled households.</p>
Early Child Stimulation	<p>Locally resourced and age appropriate toys for early child stimulation – Promoted as part of an integrated SBCC – CCD component, delivered through the PSGs, quarterly VHDs, and home visits.</p> <p>Men Baraza’s, biweekly or monthly meetings (depending on the season) – Incorporates CCD/ Early Child Stimulation SBCC messages (Save the Children, <i>Tuwekeze Pamoja</i> project). This is in addition to the women PSGs.</p> <p>CCD spaces (facility and community) – This ranges from established corners at the facility level (CUAMM and CRS), to playgrounds (COUNSENUTH), village level crèches (CUAMM), and less structural forms through PSG meetings and CCD mats at the community level (Save the Children).</p>	<p>20. UNICEF CCD kits and accompanying manuals used as prototypes.</p> <p>21. CCD trained facility staff and CHVs</p> <p>22. Actual CCD spaces in facilities as well as at the village level</p>	<p>o) Adoption and implementation of the original UNICEF CCD kits is hindered by the cost²¹ of the kit and perceived context appropriateness.</p> <p>p) Overall, health facility staff are lagging on receiving CCD training, compared to CHVs who have been trained as part of their 3 weeks training.</p> <p>q) “CCD space” varies from less to more infrastructural-intensive forms, with varied costs implication. ²² There is limited consensus on models/ forms for scale up. Save the Children implements a model that is relatively less structural and less resource intensive.</p>

²⁰ Tanzania Social Action Fund (TASAF) III/ Productive Social Safety Net (PSSN) Programme; <http://socialprotection.org/programme/tanzania-social-action-fund-tasaf-iii-productive-social-safety-net-pssn-programme>.

²¹ Estimated cost for one UNICEF CCD kit is US\$1,850.

²² Cost of CCD spaces is estimated at Tsh 600,000 to 4,000,000 depending on the structural inputs.

<p>Multisectoral Governance for Nutrition</p>	<p>Vertical & horizontal partnerships - GoT/ DPs/ NGOs/ LGAs/ CSOs.</p> <p>Coordination/Steering - RNO's, DNO's/multisectoral nutrition committees (regional and district level).</p> <p>District Multisectoral Nutrition Technical Team – Members are selected and take a more hands on approach, with quarterly meetings preceding and reporting to the Multisectoral Nutrition Committee (COUNSENUth-supported regions).</p> <p>Regional planning & budgeting for nutrition – Involves the following members during the planning/budgeting cycles: <u>District members:</u> nutrition officers/focal persons; medical officers; planning officers; health secretaries; Agriculture, Livestock and Fisheries officers. <u>Regional members:</u> nutrition officers/focal persons; administrative secretary; Social Services sector representatives (RMO, assistant administrative secretary – Planning and Coordination section (UNICEF)).</p> <p>Common Results, Resource and Accountability Framework (CRRAF) reviews expected results and financial commitments across the NMNAP thematic groups (1-7) at the joint Multisectoral Nutrition Review meetings (UNICEF).</p> <p>Bottleneck Analysis for Nutrition (BNA) – UNICEF-supported biannual bottleneck analysis, using a district-level tool to identify bottlenecks across determinants for</p> <ul style="list-style-type: none"> a) Supply – Availability of commodities, HR, geographical access, and community outreach b) Demand – utilization and continuity c) Quality. 	<ul style="list-style-type: none"> 23. ToR nutrition officers – regional and district level. 24. ToR multisectoral nutrition committees – regional and district level. 25. Regional and district pre-planning and budgeting for nutrition training (UNICEF) 26. Nutrition officer tool for Planning and Reporting Process (PLANREP) <ul style="list-style-type: none"> 27. District level tools – BNA & nutrition score card. 	<ul style="list-style-type: none"> r) Partnerships between government/DPs/NGOs/LGAs/CSOs are critical. Multisectoral programs (e.g., health, agriculture, WASH) tend to be more vertical on top, and to a large extent remain so at the LGA level. s) Programmatic multisectoral collaborations between implementers, especially at the LGA-level (government/DPs/ NGOs and CSOs), are pivotal in catalyzing rapid scale-up/coverage across the five priority regions, and strengthening capacity and driving innovation in the implementation of nutrition programs at the community level. Experiences from successful programmatic collaborations inform GoT nationwide efforts (e.g., formalization of CHW cadre). t) Rollout and rapid scale-up of integrated nutrition interventions across the five priority regions involves massive operational training, as well as implementation of research needs. u) Due to competing tasks affecting members of the district as well as the regional multisectoral nutrition committees (e.g., frequent changes on appointments, and delegation, etc.), attendance and consistency of the committee's inputs is difficult. v) The BNA tool allows tracking of bottlenecks and improvements around four nutrition-specific areas (IFA, IMAM, IYCF, and VAS).
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Multisectoral Information System for Nutrition

Register for MAM and SAM cases identified at primary health care facilities – TFNC/MoH facility-based IMAM registers are available at the primary healthcare level. At facility level, this data is aggregated and reported through DHIS 2.

National Nutrition Scorecard – National multisectoral scorecard for nutrition indicators.

28. IMAM registers.
29. DHIS 2.

- w) At primary health facility level, DHIS 2 is the information system for nutrition.
- x) Further review of nutrition indicators/data sources and linkages between community/facility data, especially in settings where data is already collected from the community level (e.g., growth data from the VHDs), is needed. Further consideration is required during the M&E plan development.
- y) Utilization of data at the community level remains low, with the exception of COUNSENUTH-supported regions.

5.0 DELIVERY PLATFORMS

- 5.1 Community Health Volunteers (CHVs):²³ Currently, CHVs are the main platform for delivering nutrition program interventions at the community level, and to some extent, supporting health workers at the facility level. Other community cadres (e.g., community/village social welfare workers) are being used for interventions like the implementation of community CCD spaces (e.g., Save the Children, *Tuwekeze Pamoja* Project). The following features are common across interventions:
- 5.1.1 Typically, each village is allocated two resident part-time (six to eight hours/week) CHVs. A group of 15-20 CHVs are supervised by one full-time CHV supervisor. Supervisors typically have form four education (secondary school), and are hired full time by the programs. They may or may not be residents of their respective villages.
 - 5.1.2 CHVs are expected to conduct an average of six household visits per week. Since it is not possible for CHVs to visit every household with a child in its first 1,000 days due to costs, home visits are prioritized. These parameters include households with first-time pregnancies, children aged less than nine months, children aged less than two years with feeding problems, underweight children less than five years (those falling in the gray or red zone on their growth monitoring cards), and very poor families/households registered under the TASAF scheme. The only exception is ASTUTE, which plans home visits for all households with a child within the first 1,000 days, but reduces the number of visits that can be accomplished annually (aiming at one home visit per quarter).
 - 5.1.3 In addition to home visits, CHVs establish and provide support to PSGs. At least four PSG sessions and quarterly VHDs are conducted to deliver SBCC messages for health, as well as nutrition-specific and sensitive interventions.
 - 5.1.4 In programs where IMSAM services are integrated, CHVs play a key role in identification, referrals, and community follow-up of discharged SAM cases.
 - 5.1.5 While CHVs primary care role is restricted mainly to SBCC, often CHVs provide support at the health facility level with other MCH functions (growth monitoring, immunizations, etc.).
 - 5.1.6 Across the programs, CHVs receive an initial three to four weeks of consecutive training and an average one week of additional refresher training per year.
 - 5.1.7 CHVs receive a monthly stipend of Tsh 20,000 with quarterly allowances amounting to Tsh 15,000–20,000 for communication. Supervisors receive a salary at a range of Tsh 100,000–120,000. Financial remuneration is relatively consistent across the various programs, however other incentives exist. For example, some programs provide transportation like bicycles for CHVs and motorcycles for supervisors (Save the Children).
- 5.2 Peer Support Group (PSGs): PSGs have been widely adopted by all programs as a strategy to engage pregnant women and mothers with children less than two years of age, particularly in high risk and hard-to-reach/TASAF households. Common operational features for PSGs across programs are highlighted below.
- 5.2.1 Each group enrolls 10-12 women and meets regularly, one to two times per month, depending on the season and if there is a coinciding VHD.
 - 5.2.2 CHVs attend PSGs and deliver SBCC nutrition-specific and sensitive messages, answer questions, and assess general needs (e.g., linkage with agriculture extension officer, etc.). As time passes, PSGs become self-sustainable and less dependent on support from CHVs. In CUAMM, MBNP, and the COUNSENUETH programs, more established PSGs have become instrumental in supporting the formation of new PSGs, and with sharing skills on microfinance activities and adoption of SBCC messages and practices.
 - 5.2.3 The more widely-adopted SBCC practices include small-scale (household) vegetable production, vegetable preservation using solar dryers for off-season consumption (in CUAMM-supported regions), and raising small animals for home consumption and income generation/poverty alleviation activities.

²³ CHVs are village health volunteers, often with primary school education and selected by the village (based on familiarity with community, acceptance and commitment) to provide linkage between the primary care health facility and the community.

- 5.2.4 PSGs receive additional technical support (mostly coordinated by CHVs) from agriculture extension officers, district nutrition officers, social workers, etc.
- 5.2.5 PSGs have a multiplier effect in intervention coverage, intensity, and fidelity. These include reinforcing SBCC messages/practices promoted through the health facility, during home visits, farm schools, champion farmers, etc. In addition, the groups promote a positive competitive environment for the adoption of best practices for nutrition and health (e.g., improved water and sanitation at the household level).
- 5.2.6 PSGs provide women a platform to negotiate other cross-cutting social-economic issues at the village level (e.g., gender-related matters through the village council, including domestic violence and support to single mothers). For example, in COUNSENUTH and CUAMM-supported regions, PSGs support CCD activities for stay-at-home children during farming season.
- 5.2.7 Empowered PSGs can sustainably use their own resources to support child nutrition and development, as in the case of CUAMM and COUNSENUTH-supported regions. PSG members contribute Tsh 1,000 or an equivalent portion of maize for collective milling and preparation of nutrient -enriched flour for infant feeding. Regardless of the individual member's contribution, all women receive equitable portions of nutrient-rich flour for infant feeding for the next one month.
- 5.2.8 By default, all programs approached formation of PSGs with a special focus on women. Inadvertently, there have been no male PSGs; hence male involvement remains poor across all programs.

5.3 Village Health Day (VHDs): Quarterly VHDs, implemented by most programs (with the exception of ASTUTE), bring together pregnant women, parents/caretakers of children less than five years of age, village government, primary care facility workers, CHVs, and DP-funded program members. It is characterized by the following:

- 5.3.1 VHDs organize a daylong delivery of several MCH services and nutrition-related activities. Among the services delivered are growth monitoring and promotion for children, review of MCH cards, and provision of missed vaccinations and/ or vitamin A drops. Similarly, services for pregnant women include a review of ANC records, hemoglobin measurements (which is not routinely available at village dispensaries, but provided during VHDs), and provision of IFA for those who missed ANC visits or ran out of their prescriptions.
- 5.3.2 Supplies for VHDs are coordinated through the village health facility, with support from the program as necessary in areas like anthropometric equipment and IFA during stock-outs.
- 5.3.3 In COUNSENUTH-supported regions, costs involved in hosting VHDs are met through contributions from the village government (Tsh 18,000) and households (Tsh 500 each). Minimal co-financing from the program supports program participation and transportation of district staff like the district nutrition officer, agriculture extension officer, etc. The total cost involved (excluding commodities for nutrition) is estimated at Tsh 80–100,000, mainly covering logistics and food for children, men, and women in attendance.
- 5.3.4 Women and children identified with health and/or nutrition needs can receive referrals for further care, including counseling and CHV home visit follow-ups.
- 5.3.5 Presence of all PSGs from the village at the VHDs allows CHVs to review SBCC messages for nutrition-specific and sensitive interventions with all PSGs, including cooking demonstrations and promotion of early child stimulation activities.
- 5.3.6 To enhance participation and attendance at VHDs, a number of theatre art performances are incorporated with key health and nutrition-related messages emphasized. Theatre art performance is put on by a mixed group of villagers, including PSGs members and CHVs (talented men and women).
- 5.3.7 At the end of each VHD, the village council receives an actionable summary report to be discussed at the next village council meeting, including application of by-laws for non-compliant parents and caretakers. Non-compliant parents (mostly men/head of households) receive fines not exceeding Tsh 5,000. This is a common practice in Iringa, Njombe, and Ruvuma regions in particular.
- 5.3.8 Absences of pregnant women, parents/caretakers and their children are noted, and followed-up to ensure consistent attendance in the future.

- 5.3.9 The ASTUTE program implements community outreach instead of VHDs, coordinated by CHVs with involvement of the parents. Children identified with SAM and MAM are referred for care, and parents/caretakers are enrolled into a positive deviance program during the positive deviance hearth (PDH) sessions.

Best Practice 6: ASTUTE-Supported Positive Deviance Hearth (PDH) in Kagera, Mwanza, Geita, Kigoma, and Shinyanga



During the outreach services, CHVs and/or village health workers identify malnourished children and refer cases for further care and PDH (where applicable).

PDH, a community-level malnutrition rehabilitation approach adopted from World Vision, connects women with malnourished children to socio-economically similar families with healthy children. This approach promotes good behaviors in a culturally and socio-economically sensitive way.

Specifically, the group sessions involve cooking demonstrations, feeding practices based on locally available foods (to ensure the minimum dietary diversity is achieved), and improved WASH practices, etc. The sessions are hands-on and occur at home (location for nutrition training/rehabilitation).

Parallel nutrition assessments are done at baseline, sixth, and 12th days (graduation based on meeting criteria for weight gain). Assessment continues with growth monitoring as well as growth promotion at first, third, sixth, and 12th month. Data from the ASTUTE program shows that at the 12th day, 55 percent of enrolled children gain weight ranging from (400–1200gm).

5.4 Mass Media: Use of mass media mainly includes radio spots, short programs, and call-in shows that reinforces nutrition SBCC messages and reaches diverse social groups and stakeholders in the community. Mass media programs deliver consistent, persuasive messages that positively influence perceptions and practices around nutrition for women and children. Topics covered are in line with the approved MoH messages on nutrition-specific and sensitive interventions, incorporating (but not limited to) caring for pregnant women, breastfeeding, IYCF, WASH, and CCD. Sustaining mass media campaigns can be costly, and not all programs have the required resources in place. To ensure consistent delivery of positive nutrition messages at low cost, COUNSENUth -supported regions have adopted the use of digital radios with recorded messages on a memory card covering a broad range of SBCC nutrition-specific and sensitive messages. These are played during PSGs, as well as other village meetings and/or organized gatherings like schools, market days, etc. While this approach ensures standardized message delivery, especially where CHVs literacy is not high, it may lack human interaction in delivering key messages. The largest mass media component is run by the ASTUTE program working in collaboration with Development Media International to deliver radio spots, and short programs through local radio stations in five regions: Mwanza, Shinyanga, Geita, Kagera, and Kigoma.

6.0 CHALLENGES/OPERATIONAL BOTTLENECKS

Implementation of high impact nutrition programs requires that the target population be adequately informed of available services, how available services will assist them, and the equally important question of how to access these services. These dynamics need to be supported by the actual delivery of services by

the various stakeholders involved, particularly at the community level. Bottlenecks occur at supply, delivery or demand levels, and affect the whole continuum as well as the theory of change/impact of the nutrition programs.

6.1 Supply-Side Bottlenecks:

Table 3 Supply-side Bottlenecks to Health/Nutrition Service Provision in Tanzania

Bottleneck	Observations
Limited resources/ coverage in terms of geography and integrated interventions	<p>Limited resources impact coverage in terms of geography, approaches, type of package, and intensity of interventions. This is particularly the case in reaching the “last mile” of hard-to-reach and the most at-risk populations. It is important and necessary to obtain the best available information and tailor program content based on the local context.</p> <p>Partners invariably implement integrated interventions, with most partners focusing on MIYCAN and overall delivery of SBCC messages. Due to limited resources and/or other operational challenges that make it difficult to reach 100 percent of the target population, realistic targets and goals are key to a program’s success.</p> <p>The target coverage for UNICEF-supported programs in their respective regions (i.e., CUAMM, CRS, and Save the Children) is set at 75 percent of villages in supported districts. Inclusion criteria for villages were based on the perceived need, concentration of TASAF households, and absence of overlapping nutrition-related programs.</p> <p>The 75 percent target coverage is part of the government-DP agreed plan for scale-up and transition to phase-out DP support. This strategy requires the government to meet the remaining 25 percent target, and scale-up coverage to 50 percent, 75 percent, and 100 percent by year two, three, and four respectively as the DP-funded program coverage downscales. This transition has not materialized as planned, and most DP-funded program areas are still operating at 75 percent coverage at year four. This could be partly explained by the lack of regular monitoring of phase-out plan milestones from the project inception. Only the ASTUTE program covers 100 percent of the councils in their supported regions. The comparative advantage of breadth versus depth on rolling-out the program has not been evaluated.</p>
Systems, especially supply chain	Existing supply chain challenges include: missing therapeutic foods in the essential drugs list and frequent stock-outs of essential commodities like anthropometry equipment, IFA, and Vitamin A. Poor record keeping (e.g., for IFA provision at facility level) affects planning and projections of the stock. Parallel supply chain systems (e.g., for RUTFs by UNICEF-supported programs) have worked well only in specific areas supported by the respective partner.

6.2 Delivery-Side Bottlenecks:

Table 4 Delivery-side Bottlenecks to Health/Nutrition Service Provision in Tanzania

Bottleneck	Observations
Paucity of evidence supporting operational models	There is a lack of evidence (e.g., cost effectiveness) supporting adoptable operational models for scaling-up ECD interventions in the context of limited resources. These knowledge gaps include: 1) Guidelines for where to establish CCD spaces (facility vs. community or both?); 2) Operationalization of CHVs and CHWs,

	how many households should be covered by each CHV, what services they should provide, which HHs to visit and visit frequency; and 3) Growth monitoring and promotion.
Delivery approaches/models and continuity of care	Delivery of integrated interventions requires multiple stakeholders (involvement of local stakeholders, CSOs, and CBOs) to enhance sustainability. Linkages between facility and community (e.g., IMAM facility and community care) are key in preventing high rates of absconding facility treatment.
Human Resource	Most village dispensaries are managed single-handedly, with one nurse attendant at the regional and/or district level, two CHVs per village with limited capacity and scope (standard seven education, three weeks training), and a multitude of competing needs. There is a need to integrate other cadres available at the community level (e.g., CSWs, optimization of CHWs/CHVs transition, and/or hybrid models).
Evolving LGA capacities	Capacities include planning, budgeting, coordination, oversight, supervision, and regulation as well as information management.
Multisectoral complexity with coordinating the implementation of nutrition programs	Every ministry has its own structure going down to the community level. However, the nutrition officers who are designated coordinators for the regional/district multisectoral committee, report to RMO/DMO respectively, hence there is a need to strengthen the governance of multisectoral responses (especially from sectors beyond health), and increase accountability to common LGA plans.
Quality/Efficiency	Limited application of M&E systems and data at the beneficiary level, lack of formative and midterm evaluations, and lack of implementation research/operational feedback presents a missed opportunity to know what works and how to leverage further improvements. Current BNA is limited to four selected nutrition-specific areas. BNA on nutrition-sensitive interventions (e.g., WASH, agriculture, etc.) is still lacking.

6.3 Demand-Side Bottlenecks:

Table 5 Demand-side Bottlenecks to Health/Nutrition Service Provision in Tanzania

Bottleneck	Remarks
Poverty (poor HH)/ Culture/ Beliefs	For hard-to-reach “the last mile” populations, the use of TASAF enhances the reach of PSGs participants by 12 percent (CUAMM program) and promotes competition with alternative forms of care (e.g., traditional healers in cases of SAM).
Limited male involvement	By default, the design of nutrition programs has focused on women. Inherently, male participation has remained limited to VHDs, which also affects HH-level involvement.
Seasonality	Malnutrition trends increase during short and long farming seasons, especially between October and January in Njombe, Iringa, and Ruvuma. This trend may be attributed to poor child care as women spend more time away from home, poor food storage practices, and limited food availability. There is a need to realign resources and approaches to be more sensitive to seasonal changes.

Suboptimal ownership for sustainability	Participation in PSGs, farm schools, etc. has been declining. PSG participation in CUAMM, COUNSENUH, ASTUTE ranges from 60–80 percent depending on the season. There is a need to consider human-centered design approaches (i.e., incorporating viewpoints from the target population) in designing potential solutions to existing problems. This approach will enhance ownership, participation, and sustainability.
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7.0 RECOMMENDATIONS

A number of recommendations are presented below for consideration when designing a high impact nutrition and early child stimulation program.

7.1 General recommendations:

- 7.1.1 Strengthen strategic partnerships particularly at the level of LGAs with CSOs, local NGOs, TASAF, and non-traditional partners like traditional healers. Stakeholders need to be mapped, developed, and aligned to respond to LGA-led nutrition plans.
- 7.1.2 Combine delivery platforms (facility and community) and different approaches (e.g., home visits, PSG meetings, VHDs, and facility). Depending on the local context and needs, additional approaches such as PDH can be considered.
- 7.1.3 Engage both CHVs and CHWs for program sustainability. Mapping the respective tasks and accountability lines of other cadres that exist at the community level might facilitate synergies between the roles of existing community cadres.
- 7.1.4 Maximize and maintain community participation and ownership of the nutrition program. Initial and ongoing community consultation activities are key. For example, community consultations on how to engage men and increase attendance at PSGs, VHDs, etc. can better inform program design and improve the process and outcomes.

7.2 Specific recommendations – coverage, scale-up, and phase out:

- 7.2.1 Prioritize the “last mile”/most at-risk households. Establishing a working relationship with the TASAF program and promoting inclusion of nutrition conditions would enhance the program reach and impact – especially as the proposed project will cover the majority of regions, and other DPs will likely cover the remaining regions.
- 7.2.2 Design a phased approach with a detailed implementation plan to guide scale-up without comprising quality (breadth versus depth). To do so effectively, the best available data should be used to map needs and priorities in selected regions and inform the roll-out and scale-up of the program.

7.3 Specific recommendations – integrated program design and delivery: Design of the integrated package is best informed by experiences from ongoing programs. The following considerations can be made for the priority interventions mapped during this exercise:

- 7.3.1 Review and standardize a main SBCC tool to be used for training, and/or integrate specific areas of interest from existing packages (e.g., Mwanzo Bora, ASTUTE, ECSA, and UNICEF) for training implementers.
- 7.3.2 Strengthen existing interventions provided through health facilities by training and equipping primary health workers to deliver and/or help CHVs/CHWs deliver GMP, SBCC messages for CCD, records keeping, and planning for nutrition commodities supplies like IFA. Experiences from CONNECT Tanzania show improved or enhanced community interventions stimulate/increase demand for health facility services.
- 7.3.3 Incorporate community-based GMP through the quarterly VHDs. Further considerations should include how to ensure quality and linkages between community GMP data to facility records.

- 7.3.4 Take a more preventive approach to SAM. Scaling inpatient IMSAM services can be costly, especially when cases are sporadic and seasonal. Focus on screening and early identification of growth faltering to prevent MAM and SAM.
- 7.3.5 Prioritize careful planning and sufficient piloting when integrating newer interventions like CCD at facility and community levels. For CCD spaces, adopting simple designs (e.g., CCD mats with PSGs from Save the Children Tanzania, supported with evidence from their work in Rwanda²⁴) provides a good starting point.
- 7.3.6 Integrate nutrition-sensitive interventions, particularly WASH, nutrition-sensitive agriculture, and social protection. These programs are key to improving the nutritional status of women and children. Integration will require collaboration with multi-sectoral teams (e.g. WASH and agriculture) at the LGA level. Review of respective sectoral plans and operations at local/ LGA levels is recommended to inform the integration, as well as the necessary synergies at the community level.
- 7.3.7 Build on and leverage existing experiences/efforts and program resources. For example, ASTUTE has a robust media campaign in place, ECSA has already developed training materials, and resource-training structures are already in place. Partnering with existing efforts can be instructive, cost-effective, and broaden the reach of new messaging.

7.4 Specific recommendations - delivery platforms and approaches:

- 7.4.1 Prioritize target groups for each intervention. Visiting all eligible households with children in their first 1,000 days is costly; the criteria for prioritizing households for home visits need to be considered.
- 7.4.2 Engage CHVs/CHWs on a full-time, rather than part-time, basis to increase efficiency. Switching to a full-time position model may also improve retainment rates.
- 7.4.3 Establish a system to track CHV/CHW workloads. This type of data system could be used to inform future scale-up approaches and required investments.

7.5 Specific recommendations - M&E:

- 7.5.1 Design a program evaluation process and incorporate it into a fully developed M&E plan (involving formative, midline, and end-line evaluations) in parallel with the actual program design.
- 7.5.2 Strengthen and integrate existing M&E systems at the national level (e.g., DHIS 2, Nutrition Score card, BNA analysis, and common Results, Resource and Accountability Framework, etc.) to facilitate assessing program progress relative to other ongoing efforts nationally.

7.6 Specific recommendations - institutional capacity:

- 7.6.1 Create a LGA capacity development plan to address the following key areas, particularly at the LGA-level: planning, budgeting, coordination, oversight, supervision, regulation, and information management. Continuous assessment of LGA capacity to identify areas that needs strengthening will be key to the successful implementation of this project.
- 7.6.2 Support district nutrition multisectoral committees in implementing the newly released ToR. Incorporating technical multisectoral committees, as shown in the COUNSENUTH-supported regions, enhances multisectoral coordination at the district level.
- 7.6.3 Strengthen the role of village councils and village development committees as potential oversight platforms at the community level. Potential areas for strengthening include: data utilization, planning, local resource mobilization, enforcement and application of bylaws, local ownership, and fidelity to the program.

²⁴ Save the Children – Experience on implementing CCD spaces in Rwanda: Saving Brains End Line Report – First steps 0-3 program in Rwanda; First steps towards quality early childhood care and development through holistic parenting education.

7.7 Specific recommendations - community ownership, fidelity, and sustainability of the program:

- 7.7.1 Ensure the sustainability of PSGs through relevant socioeconomic empowerment activities (e.g., microfinancing) and poverty alleviation activities that are sensitive to the local context and needs. Empowered PSGs can be self-sustaining, and can be catalysts to support key cross-cutting areas for nutrition (e.g., women empowerment, domestic violence, etc.). It is critical that the scope of PSG activities goes beyond nutrition-specific activities.

7.8 Other areas for consideration:

- 7.8.1 Adopt performance-based systems at the LGA- level based on agreed-upon plans.
- 7.8.2 Incorporate appropriate incentives for participating LGAs to catalyze positive competition, innovation, and sharing of best practices. Experiences from the WASH sector (e.g., district competitions during WASH campaign month) can be replicated for other nutrition-sensitive and specific interventions.
- 7.8.3 Integrate LGA to national-level advocacy efforts for nutrition to support program goals.