The United Republic of Tanzania

GUIDELINE FOR COUNCILS FOR THE PREPARATION OF PLAN AND BUDGET FOR NUTRITION

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Contents

Glossary of nutrition terms

Body mass index	Body mass index is a measure of thinness in adults. It is based on an individual's weight relative to height
Stunting	Stunting is defined as a short height for age of a child. It is also known as chronic malnutrition, and indicates that a child has failed to achieve his or her genetic potential for height. Stunting is the result of long-term nutritional deprivation and often results in delayed mental development, poor school performance and reduced intellectual capacity.
Underweight	Underweight is defined as a low weight for the age of a child. A child may be underweight if he/she is stunted and/or is underweight. Evidence has shown that the mortality risk of children who are even mildly underweight is increased.
Wasting	Wasting is defined as a low weight for the height of the child and is a measure of 'thinness'. It reflects malnutrition of recent origin, and is also known as acute malnutrition. Wasting impairs the functioning of the immune system and can lead to increased risk of serious illness and death.

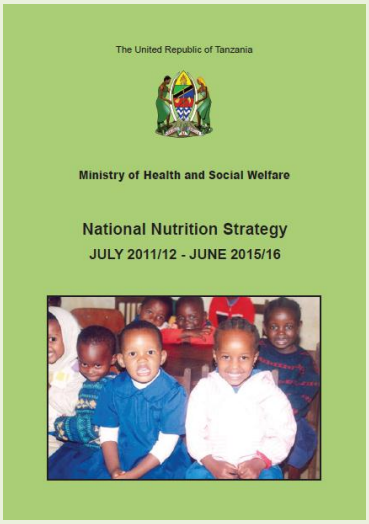
1. Introduction

Malnutrition is one of the most serious problems affecting infants, children and women of reproductive age in Tanzania. Despite progress made, millions of children and women in Tanzania continue to suffer from one or more forms of malnutrition including low birth weight, stunting, underweight, wasting, anaemia, and vitamin and mineral deficiencies. Malnutrition is a threat to the health and survival of children and women, the educational performance of school children and the productivity of the nation.

High level commitments for nutrition

In June 2012, Tanzania signaled its commitment to addressing malnutrition by joining the global Scaling Up Nutrition (SUN) Movement and making several important commitments towards improving nutrition (Box 1).

Box 1: Government commitments to nutrition announced by the Prime Minister in June 2011



- Finalization of the implementation plan for the National Nutrition Strategy
- Integration of nutrition into the Tanzania Agriculture and Food Security Investment Plan
- Establishment of a new High Level National Nutrition Steering Committee
- Establishment of a designated line in the national budget for nutrition effective financial year 2012/13
- Rapid establishment of nutrition focal points at the district level
- Gazetting, finalization and enforcement of the national standards for oil, wheat and maize flour that were set in 2010 so that millers will begin fortifying.

SUN is a multi-stakeholder movement to reduce hunger and undernutrition, with a specific focus on the critical window of opportunity between pregnancy and two years of age. The movement brings organizations together across sectors to support national plans to scale up nutrition by helping to ensure that financial and technical resources are accessible, coordinated, predictable and ready to go to scale. The President is among one of the global leaders that has been appointed by the UN Secretary-General to the SUN Lead Group, which is responsible for strategically guiding the SUN Movement, mobilizing support and strengthening both coordination and accountability within the Movement.

At the country level, the key stakeholder groups that are working together with the government to improve nutrition included development partners, UN agencies[1], civil society organizations, academia and the private sector.

[1] The Renewed Efforts Against Child Hunger (REACH) is the joint United Nations initiative (FAO, UNICEF, WFP and WHO) to support the scaling up of multisectoral nutrition activities at country level.

The High Level Steering Committee on Nutrition (HSCN) was established in July 2012 to guide national efforts in scaling up nutrition, and councils have established similar committees at council level. The Prime Minister launched the National Nutrition Strategy 2011-16 in September, and the following year the Implementation Plan was developed. In addition, a budget line for nutrition was established and introduced, beginning Fiscal Year 2012-13.

Purpose of the guideline

The Guideline has been developed to assist councils throughout the country in identifying key actions to include in their annual plans and budgets to prevent and address malnutrition. It should be used by all those involved in the preparation of the council's plans and budgets, under the overall guidance of the District Planning Officer.

Because malnutrition has multiple causes, actions are needed across multiple sectors to ensure that all the conditions for good nutritional status are met. Therefore suggested actions have been identified for all key sectors, including health, agriculture, community development, education and water as well as the Planning Department.

2. Malnutrition in Tanzania

Magnitude of the problem

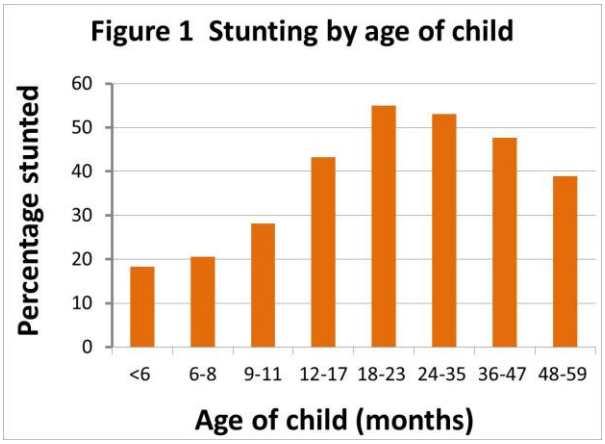
Despite striking improvement in many health indicators over the last decade, there has been poor progress in improving the nutritional status of children and women in Tanzania. Stunting currently affects 42 percent of under five children, and is only a two percentage points lower than it was in 2005[2]. Child underweight (16 percent) also remains at unacceptable levels, and there are pockets of very high acute malnutrition. About one third of children age 6-59 months are iron deficient and vitamin A deficient, 69 percent are anemic, and over 18 million Tanzanians do not consume adequately iodated salt.

Children age less than 5 years	
Stunting[1]	42%
Underweight[1]	16%
Anaemia[2]	69%
Iron deficiency[2]	35%
Vitamin A deficiency[2]	33%

Women age 15-49 years	
Low body mass index	11%
Iodine deficiency	36%
Anaemia	40%
Iron deficiency	30%
Vitamin A deficiency	37%

Source: TDHS 2010; TDHS Micronutrients 2010. [1]Children 0-59 months. [2]Children 6-59 months

The nutrition situation of adolescent girls and women in Tanzania is also alarming. About one third of women age 15-49 years are deficient in iron, vitamin A and iodine, two fifths of women are anemic and one in ten women are undernourished. Malnourished adolescent girls and women are more likely to give birth to low birth weight infants, thus transferring undernutrition from one generation to the next.



The rate of malnutrition increases very rapidly between birth and two years of age (see Figure 1). Beyond two years of age, much of the damage caused by poor nutrition cannot be corrected. It is therefore very important to ensure that interventions to prevent malnutrition pay special attention to the nutrition needs of women during pregnancy and young children up to two years of age.

The high levels of stunting in the country, affecting over 3 million children, constitute a silent emergency. Stunting does not generally receive the same attention as acute malnutrition or underweight because the effects are hidden and the threats to health and survival are not immediate. However, the consequences of stunting are serious and long-lasting. Stunting is a sign that the child has been deprived of essential nutrients not only for growth, but also for

[2] All data in this paragraph are from the 2010 Tanzania Demographic and Health Survey

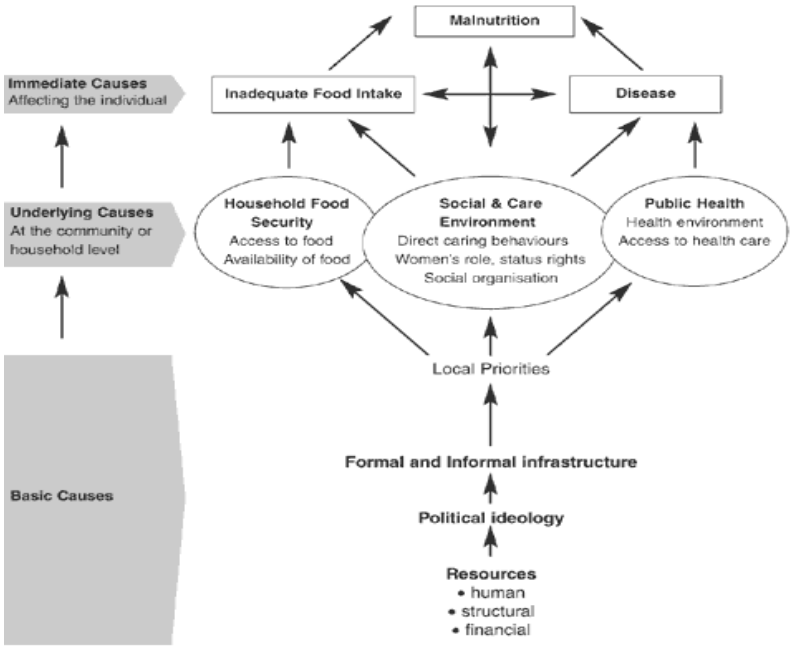
building strong immune systems and for healthy brain development. The World Health Organization regards stunting as 'very high' if it is greater than 40 percent in a population. This threshold is exceeded in fourteen regions of the country.

Inequities in child nutrition continue to persist. Children in poorer households have significantly higher levels of stunting compared with children from households that are wealthier. There is also great variation in nutritional status, feeding and caring practices for young children and access to nutrition services by region. Annex 1, 2 and 3 provide key nutrition statistics for each region.

Causes

There are many causes of stunting and other forms of undernutrition (Figure 2). Most people are aware that children will become malnourished if they do not have enough food to eat. They may also become malnourished if they suffer infectious diseases, such as diarrhea, measles, and HIV and AIDS. These two causes – poor dietary intake and infectious diseases – often occur together and are caused by many underlying factors including poor agricultural production, lack of income to purchase nutritious food, poor health services, poor sanitation and hygiene, unsafe water, and poor caring practices for children and women. Other basic causes include the low literacy of caregivers and the low status of women in society, including their ability to take decisions on common household decisions such as use of household income, what food to buy and cook, when to seek medical care, and the division of household chores.

Figure 2: Conceptual framework of malnutrition[3]



[3] Adapted from UNICEF (1998). *State of the World's Children 1998*. UNICEF: New York.

It is very important to remember that it is not just the *quantity* of food that is important for good nutritional status, but the *quality* too. In Tanzania, most family meals contain a staple - usually maize, banana, cassava or rice - with cooked vegetables, beans and sometimes meat of fish if they are able to afford. Very young children are usually given "uji" (porridge) that often lacks foods rich in vitamins and minerals, which they need to develop strong immune systems and to grow and learn well. The quality of the diet of pregnant and breastfeeding women is also very important because it determines how well the mother can nourish her young child during pregnancy and after childbirth, as well as maintain her own nutrition and health status. Vegetables, fruits, legumes such as beans, and if possible animal foods, need to be part of the diet of all young children from the age of six months, as well as pregnant and breastfeeding women. The frequency of feeding is also important; two-thirds of children aged 1-2 years are not given enough meals each day to meet their growing requirements.

Before the age of six months, children should be exclusively breastfeed, which means they should be given breast milk and no other food or liquid, not even water. Breast milk contains all the nutrients, vitamins, minerals and liquid that a child needs to grow healthily for the first six months, and protects them from infectious diseases such as diarrhea. From six months of age, the child should be given other nutritious foods, and breastfeeding should continue until at least two years of age. In Tanzania, the average duration of exclusive breastfeeding is only 2.4 months, well below the recommended six months.

Consequences

More child and maternal deaths: Malnutrition is responsible for over one third of child deaths every year in Tanzania. In fact, about 130 children die every day in Tanzania from causes related to malnutrition, and it is the single greatest cause of child deaths in the country. Malnutrition is also one of the factors responsible for the high number of maternal deaths. More than 10 million women in Tanzania are anemic due to iron deficiency, and more than 1600 women die each year from complications related to anemia during childbirth.

More sick children: children who are malnourished are more likely to become sick and suffer serious illnesses because they lack essential nutrients for a healthy immune system.

Poor school performance: Iodine, iron and other nutrients are needed for healthy brain development. When the diets of pregnant women and young children lack these nutrients, children are less able to develop well and will perform poorly at school.

Lower work productivity: Malnourished children often become short and weak adults who cannot work as hard, making it very difficult for poor households to escape from poverty. Iron deficiency in adults decreases productivity by up to 17 percent. Malnutrition is particularly damaging for small-scale farmers who do very labour intensive work on a daily basis.

Reduced impact of investments in all key basic services. Resources spent on education, health, and in the treatment of various diseases, including HIV and AIDS, will have less impact unless undernutrition is prevented and treated.

3. Situation analysis for planning and budgeting for nutrition

In addition to this planning and budgeting guideline, it is recognized that a better understanding of the nutrition situation in each district would help local government authorities to plan and budget for nutrition interventions.

The government, in collaboration with partners, has therefore developed a District Nutrition Assessment Tool to build the capacity of district staff to assess the causes of malnutrition in their respective district; to identify the major bottlenecks to scaling up services to improve nutritional status; and to develop "District scale-up plans" in line with the National Nutrition Strategy.

The district tool can be conducted in one week with an external or internal facilitator and includes presentations, guidance and tools to cover the following components:

- Understanding malnutrition and its causes
- Compiling and using nutrition data
- Identifying and prioritizing district-specific nutrition problems
- Using a bottleneck analysis in order to define key actions to address the nutrition problems
- Developing a 3-year "District Scale Up Plan" in line with the National Nutrition Strategy and Implementation Plan.

The district tool will be implemented with technical support from the Tanzania Food and Nutrition Centre and partners and is in line with current tools and guidance from central level such as the sector specific planning and budgeting guidelines and the Opportunities and Obstacles to Development (O&OD) approach. It will include nutrition-specific and nutrition-sensitive interventions delivered through the health, agriculture, community development, water and education sectors. The result of the assessment will be a 3-year "District Scale Up Plan" with prioritized activities that can be transferred in the annual sector plans and budgets.

The tool includes a detailed facilitation guideline, including details on logistical preparations and timelines, so that all districts interested can undertake the exercise.

4. What each sector can do to improve nutrition

The National Nutrition Strategy (NNS) and its Implementation Plan, as well as sector specific strategies and plans, provide the roadmaps for actions to improve nutrition across multiple sectors. In the following pages, the role of each sector in improving nutrition in Tanzania is described, and activities that could be included in the council plans and are suggested. It is important to note that these suggestions are not exhaustive, and the council should follow the standard planning process to identify nutrition priorities and actions needed to address its nutrition challenges.

The following resource documents are also available from the Tanzania Food and Nutrition Centre to assist in the preparation of the plan and budget:

- National Nutrition Strategy 2011-16 and the Implementation Plan, MoHSW
- Essential Package of Nutrition Interventions at District Level, TFNC, 2010

In addition, districts are advised to consult:

- Guidelines issued by the Ministry of Finance, including the "Guidelines for the preparation of the annual plan and budget 2012/13 in the implementation of the five year development plan 2011/12 – 2015/16" (and subsequent fiscal years)
- Relevant guidelines issued by the Prime Minister's Office Regional Administration and Local Government (PMO-RALG)
- Sector-specific planning and budgeting guidelines, such as the Comprehensive Council Health Plan (CCHP) Guidelines

As stipulated in the Ministry of Finance's national planning and budgeting guidelines "councils are instructed to allocate sector-specific Block Grant, General Purpose Grant, Basket Funds, local own source revenues and other relevant development grants to locally prioritized interventions for nutrition, in line with the National Nutritional Strategy".

An item code 221800 (Nutritional Supplies and Services) and Sub-item code 221801 (Nutrition) have been established.

Planning

The Planning Department over sees the implementation of the council's five year Strategic Plan. It provides planning guidance, and ensures plans and budgets are prepared. It also has the ability to convene meetings with all key sectors when issues of common interest, such as nutrition, need to be discussed.

The following essential nutrition interventions are delivered through the Planning Department:

- Conduct quarterly meetings of the multi-sectoral Council Nutrition Steering Committee. Ensure the participation of all key sectors.
- Ensure that there is a standing agenda item on nutrition in both the standing committees and Full Council Meetings.
- Ensure nutrition interventions are included in the plans and budgets of all key departments, that they are prioritized for resource allocation, and that they are monitored and evaluated.

The following activities should be among the activities considered when formulating the district plan and budget:

1. Convene quarterly meetings of the multi-sectoral Council Nutrition Steering Committee

2. Coordinate and undertake monitoring and evaluation of the planned activities

Health

Health service providers have a very important role to play in preventing and treating malnutrition because they have close contact with those at greatest risk of malnutrition and its consequences, including pregnant and breastfeeding women and children aged less than two years.

Many nutrition actions are already integrated into health services, for example, educating pregnant mothers on a healthy diet, promoting exclusive breastfeeding and complementary feeding, and the provision of vitamin and mineral supplements. However, they all require more attention and priority by those responsible for providing and supervising the provision of health services.

The following essential nutrition interventions are delivered through the health sector:

- Vitamin A supplementation of children aged 6-59 months twice a year
- Iron-folate supplementation of women during pregnancy and three months post-partum
- Folic acid supplementation of women before pregnancy
- Deworming of pregnant women from the second trimester of pregnancy and children aged children aged 12-59 months twice a year
- Behavior change communication including
  - Promotion of exclusive breastfeeding, continued breastfeeding and complementary feeding
  - Promotion of appropriate dietary intake and rest during pregnancy
  - Promotion of the consumption fortified foods, including iodated salt
  - Nutrition counselling for wasting, underweight and over-weight
  - Promotion of dietary diversification, healthy eating and exercise for the whole family
- Growth monitoring and promotion, and screening for acute malnutrition
- Treatment of malnutrition (acute malnutrition, anaemia, and other micronutrient deficiencies).
- Nutrition care and support (including nutrition assessment and counseling) for children and pregnant and breastfeeding women, including those with TB, HIV, AIDS and other chronic conductions such as diabetes and hypertension.
- Complementary health interventions including IPT during pregnancy, use of ITNs during pregnancy and for children aged less than five years, PMTCT services, child vaccinations and treatment of childhood illnesses.

The following activities should be among the activities considered when formulating the district plan and budget:

1. Recruit/appoint a full-time Regional/District Nutrition Officer

2. Ensure adequate nutrition supplies and equipment are procured including:
   - Vitamin A supplements
   - Deworming tablets
   - Iron-folate supplements

- Weighing scales, height/length boards and mid-upper arm circumference (MUAC) tapes for children and adults

3. Conduct outreach activities to ensure optimal coverage of nutrition services, particularly in hard-to-reach areas, including twice-yearly distribution of vitamin A supplements to children aged 6-59 months and deworming tablets to children aged 12-59 months twice a year in June and December. Utilize opportunities to link outreach activities with other health and nutrition services for example, promotion of exclusive breastfeeding, complementary feeding and iodated salt, vaccination services, and screening for acute malnutrition using MUAC (mid-upper arm circumference) strips.

4. Training, supervise and monitoring of community and facility based health care providers on the provision of nutrition services. Consider the following training courses, using the national packages:
    - Essential Nutrition Actions (5 day course)
    - Infant and Young Child Feeding (5 day course for health workers in close contact with mothers[4], and 1 day course for all other health workers)
    - Training on management of severe acute malnutrition if the supplies are available (5 day course)

5. Collaborate with Community Development, Agriculture, Livestock and Fisheries, Education, Water and other departments to train community-based workers[5] and conduct outreach activities to improve nutrition behaviours that are a problem in the district (e.g. exclusive breastfeeding, complementary feeding practices, use of iron-folate supplements during pregnancy, care of pregnant women, use of iodated salt, etc).

6. Monitor compliance through health inspection visits with national regulations on fortified foods (iodated salt, fortified wheat flour and fortified oil), and the National Regulations for Marketing of Breast-milk Substitutes and Designated Products to ensure that infant feeding products are not being inappropriately marketed to parents.

7. Promote awareness and compliance with the Maternity Protection legislation concerning maternity and paternity leave and breastfeeding breaks for employed breastfeeding women.

[4] Includes re-vitalization of the Baby Friendly Hospital Initiate in all health facilities providing maternity services.
[5] E.g. Community-owned resource persons, Village Health Workers, etc

Agriculture, Livestock and Fisheries

The agriculture, livestock and fisheries sector in Tanzania has a critical role in improving the access of households to affordable and nutritious food throughout the year. Adequate attention should be given to *nutritious* foods, not simply staple foods that predominantly contain carbohydrate and little in the way of protein, vitamin and minerals. Pulses, vegetables, fruits and animal products are needed to safeguard every Tanzanian from stunted growth, poor health and low productivity in adulthood. Extension workers have close contact with farmers, of which about 80 percent are women, and these contacts should be used to relay information that will help them to improve their production and consumption of nutrient rich foods.

The following essential nutrition interventions are delivered through the agriculture, livestock and fisheries sector:

- Increase the production and marketing of a variety of nutrient rich food crops (including indigenous crops) and support improved livestock and fisheries keeping to improve access to a diverse diet
- Reduce post-harvest losses to maximize food stocks and their availability throughout the year
- Improve food preservation techniques to increase the availability of nutrient rich foods throughout the year
- Ensure processing techniques that increase nutrient value (blending, fortification, fermentation etc)
- Promote good meal preparation techniques and nutritious dietary intake for all the family, especially pregnant and breastfeeding women and children aged less than two years.
- Promote labour saving technologies, particularly among women farmers.
- Promoting income generating activities in agriculture, livestock and fisheries to enhance households' ability to afford a nutritious diet
- Conduct district food security and nutrition assessments, and identify and support the most vulnerable households.

The following activities should be among the activities considered when formulating the district plan and budget.

1. Provide inputs (e.g. seeds, tubers, eggs, fingerlings, fertilizers, vaccines etc) for the production of nutrient rich crops, vegetables, fruits, livestock and fish[6].

2. Promote nutrition friendly agriculture and livestock rearing, including homestead gardens for the supply of vegetables, fruits and small livestock products[7] throughout the year

3. Promote school gardens as a demonstration tool for school children and to support school feeding programs.

[6] E.g. orange-fleshed sweet potato, mchicha and tree spinach.
[7] E.g. groundnuts, oilseed crops, spinach, amaranths, pumpkins, mushrooms, carrots, cassava, tomato, fruits, chicken for eggs and meat, etc

4. Provide in-service training and support to agricultural, livestock and fisheries extension workers on how to provide information and advice to food producing households to increase the production and consumption of nutrition rich foods; promote post-harvest processing and preservation techniques, and other value addition technologies; and increase knowledge on appropriate dietary intake and food safety.

5. Promote private sector participation in food processing (particularly fortification and blending), preservation and food safety.

6. Identify and link stakeholders involved in agriculture and nutrition related interventions.

Community Development

The Community Development Department works in partnership with community members, community groups, civil society organizations (CSOs) and others to assist the community in addressing its identified needs, including nutrition needs. It plays a crucial role in mobilizing the community and in promoting key actions/behaviours that are important for good nutrition. It also addresses the gender dimensions of malnutrition through actions to improve girl's education and women's literacy, the involvement of women in socio-political decision making, and the strengthening of livelihood skills of women.

The following essential nutrition interventions are delivered through the community development sector

- Mobilize community members, CSOs, faith based organizations and other groups to understand their nutrition problems, analyze the causes and take appropriate actions.
- Promote appropriate nutrition actions/behaviours[8] at community level
- Promote community-based nutrition and nutrition-sensitive interventions such as
  - Community-based growth monitoring and promotion
  - Community support groups on breastfeeding and complementary feeding ("Baby friendly" communities)
  - Promotion of home gardening, small livestock keeping, food preservation techniques, and labour saving technologies for women.
  - Income generating activities for households, particularly vulnerable households.

The following activities should be among the activities considered when formulating the district plan and budget:

1. Orient Community Development Workers in order to promote essential nutrition actions/behaviours at community level, and provide appropriate IEC materials.

2. Organize regular nutrition events with community-owned resource persons (CORPs) within wards to promote essential nutrition actions and behaviours, in collaboration with other departments, including health, and agriculture, livestock and fisheries. Provide appropriate IEC materials.

3. Engage existing community groups (e.g. farmer's groups, savings and credit groups, women's groups, village leadership, religious groups, civil society organizations, local cultural and drama groups, youth groups, literacy groups, artists, etc) to promote nutrition and disseminate IEC (information, education and communication) materials.

4. Disseminate information and messages targeting nutrition behavior change through local radio stations and other cultural resources such as drama, performing art and songs through local radio stations

[8] E.g. breastfeeding and complementary feeding practices; dietary intake and rest during pregnancy and breastfeeding; utilization of nutrition and health services available through health facilities such as vitamin A supplementation, deworming, iron-folate supplementation, growth monitoring and promotion, antenatal services, and facility-based deliveries; promotion of food processing and preservation techniques; promotion of iodated salt and other fortified food products; handwashing and sanitation.

Education

Targeting school children with nutrition interventions is important for several reasons. Firstly, school children will be future parents and caregivers, and what they learn at school has an important influence on whether or not they adopt good nutrition behaviours both during their school years and in later life. Secondly, school children can act as powerful advocates on good nutrition actions and behaviours within their families and the community. Thirdly, actions to reduce hunger during the school hours can improve their attendance, concentration and ability to learn, which can lead to better learning outcomes.

The following essential nutrition interventions are delivered through the education sector:

- Use school gardens to educate school children on the cultivation, preservation (e.g. through solar drying) and nutritional value of locally available fruits and vegetables
- Educate school teachers, school children and the members of the community on the importance of good nutrition from infancy to adulthood.
- Promote school feeding as a means to improve school attendance, reduce short-term hunger, improve concentration and improve learning outcomes, and mobilize community members to support the school feeding programme.

The following activities should be among the activities considered when formulating the district plan and budget:

1. Establish school gardens, including small livestock rearing, in liaison with the agricultural and livestock department and CSOs. Use school gardens to educate school children and their communities on importance of homestead food production and on the production, preservation (e.g. through solar drying) and consumption of a diversity of foods.

2. Facilitate the dissemination of IEC (information, education and communication) materials on nutrition to school children, and through school children to their families and community members.

3. Promote community-based school feeding programs and ensure the involvement of parents, school committees, the community and the local government authority

4. Engage school teachers and school children as advocates for nutrition, through school debating clubs, inter-school competitions, and other activities.

Water, Sanitation and Hygiene

Safe and clean water, proper sanitation and good hygiene practices are essential to prevent water and sanitation related diseases that can cause malnutrition, particularly diarrhea. Close access to water is also important as it reduce the time and energy it takes women to collect water so that they can spend more time looking after the health and nutrition needs of young children and other family members. The water sector is taking action to improve the infrastructure for safe and clean water, sanitary and hand-washing facilities. These actions are not considered here, instead, we focus on the actions needed to improve sanitation and hygiene behaviours.

The following essential nutrition interventions are delivered through the water, sanitation and hygiene sector

- Promotion of good sanitation and hygiene practices
- Promotion of appropriate household water treatment practices

The following activities should be among the activities considered when formulating the district plan and budget:

1. Train hygiene promoters and local water technicians to promote behaviour change on hygiene, sanitation and water treatment practices in the community

2. Facilitate the dissemination of information and education promoting good hygiene, proper sanitation and water treatment practices at the community level

3. Collaborate with the Health Department, Community Development Department, Agriculture and Livestock Department and Education Department to sensitive community members on sanitation, hygiene and household water treatment practices.

4. Support water user committees, other groups/communities, CORPs and artisans in advocating with community members on good sanitation and hygiene practices, as part of the council's efforts in improving nutrition

5. Key reference documents

1. National Food and Nutrition Policy (1992)[9,10]
2. National Nutrition Strategy (2011/12 - 2015/16) and Implementation Plan[9]
3. Guidelines on Infant and Young Child Feeding (2004) [9,10]
4. National Guidelines for Nutrition Care and Support for PLHIV (2009) [9]
5. Implementation Guidelines for Vitamin A Supplementation and Deworming (2011)[9]
6. Small scale salt producers Training manual (2004)[9]
7. National Guidelines For Nutrition Surveys In Tanzania (2006) [9]
8. National Guidelines on the Integrated Management of Acute Malnutrition (2008) [9]
9. Guidelines on Community Based Nutrition and Rehabilitation (2004) [9]
10. Guidelines on Community Based Health Care Health[11]
11. Guidelines on the Prevention of Non-Communicable Diseases with Healthy Eating and Lifestyles (2011) [9,11]
12. Healthy eating and lifestyles Booklet (2011)[9]
13. National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Health in Tanzania (2008-2015) [11]
14. National Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of HIV [11]
15. Policy Guideline for Health Promotion in Tanzania[11]

[9] Available from TFNC
[10] Under revision
[11] Available from MoHSW

Annex 1: Nutritional status of children and women by region in Tanzania (TDHS, 2010)

Region	Children aged 0 to 59 months						Women aged 15 to 49 years			
	% stunting	% wasting	% underweight	% anaemia	% iron deficieincy	% vitamin A deficiency	% low body mass index	% anaemia	% iron deficieincy	% vitamin A deficiency
Dodoma	56	5	27	48	29	30	25	29	28	33
Arusha	44	10	28	63	52	30	19	33	45	38
Kilimanjaro	28	5	11	42	45	34	8	18	29	38
Tanga	49	6	24	53	37	32	8	35	39	32
Morogoro	44	5	16	59	32	36	6	45	30	38
Pwani	32	4	12	71	30	45	14	51	22	45
Dar es Salaam	19	7	12	69	45	34	6	56	27	47
Lindi	54	4	24	77	23	31	20	56	16	36
Mtwara	44	3	19	67	13	36	13	39	7	37
Ruvuma	46	5	16	59	19	32	11	33	16	41
Iringa	52	4	18	46	19	35	5	28	15	39
Mbeya	50	1	10	55	30	26	5	32	22	33
Singida	39	9	19	44	50	21	19	29	40	30
Tabora	33	4	11	69	49	33	11	55	50	32
Rukwa	50	4	14	42	22	26	8	22	21	32
Kigoma	48	3	15	62	50	39	14	35	45	34
Shinyanga	43	3	10	75	48	37	13	54	46	39
Kagera	44	5	17	49	25	47	12	29	26	40
Mwanza	39	4	11	63	34	27	10	52	27	28
Mara	31	5	12	47	25	26	14	36	22	34
Manyara	46	7	24	52	45	44	16	27	42	49
Mainland	42	5	16	58	35	33	11	40	30	37
Tanzania	42	5	16	59	35	33	11	40	30	37

Stunting	Z-score height for age <-2 standard deviations
Wasting	Z-score weight for height <-2 standard deviations
Underweight	Z-score weight for age <-2 standard deviations
Anaemia	Haemoglobin concentration <11.5 g/dL for children, <11 g/dL for pregnant women and <12 g/dL for non-pregnant women
Iron deficiency	Serum Transferrin Receptor >8.3 µg/mL
Vit A deficiency	Retinol binding protein <0.825 µmol/L in children and <1.24 µmol/L in women, corrected for infection/inflammation (raised C-reactive protein).
Low body mass index	Body mass index <18.5 kg/m^2

Annex 2: Nutrition practices by region in Tanzania (TDHS, 2010)

Region	% started breastfeeding within 1 hour of birth	Children age 6-35 months		Women age 15-49 years	
		% consumed foods rich in vitamin A in past 24 hours	% consumed foods rich in iron in past 24 hours	% consumed foods rich in vitamin A in past 24 hours	% consumed foods rich in iron in past 24 hours
Dodoma	43	61	12	76	13
Arusha	83	42	21	56	24
Kilimanjaro	55	63	46	77	55
Tanga	42	59	27	69	36
Morogoro	66	52	19	64	26
Pwani	75	67	31	80	30
Dar es Salaam	69	62	44	74	54
Lindi	41	63	20	69	21
Mtwara	65	59	29	74	39
Ruvuma	47	65	25	73	27
Iringa	73	57	24	67	31
Mbeya	38	58	33	73	43
Singida	31	68	15	78	22
Tabora	55	66	25	75	28
Rukwa	18	76	44	83	48
Kigoma	45	49	21	57	29
Shinyanga	36	78	28	86	31
Kagera	52	55	34	66	41
Mwanza	25	55	32	63	38
Mara	22	80	58	87	60
Manyara	93	51	17	62	16
Mainland	49	62	29	72	34
Total	49	62	30	72	35

Annex 3: Coverage of selected nutrition interventions by region in Tanzania (TDHS, 2010)

Region	Children age 6-59 months:						
	% given vitamin A supplement in past 6 months	% given deworming tablet in last 6 months	% given iron supplements in past 7 days	% postpartum vitamin A	% women who took iron supplements for at least 90 days in previous pregnancy	% households consuming iodated salt	% households consuming adequately iodated salt
Dodoma	63	59	1	33	6	85	34
Arusha	70	65	3	22	2	100	97
Kilimanjaro	61	58	1	33	1	89	74
Tanga	58	46	2	30	1	79	36
Morogoro	77	64	3	29	7	92	73
Pwani	58	48	1	22	11	83	76
Dar es Salaam	67	57	6	40	5	99	93
Lindi	57	40	0	37	12	29	6
Mtwara	70	50	2	37	9	58	18
Ruvuma	80	65	1	16	2	61	26
Iringa	82	77	3	28	1	80	57
Mbeya	63	54	0	15	4	85	59
Singida	66	50	0	32	8	54	26
Tabora	28	14	1	21	1	93	59
Rukwa	52	50	0	7	2	86	56
Kigoma	65	46	4	30	1	89	76
Shinyanga	12	15	1	9	1	69	48
Kagera	77	57	0	27	1	88	67
Mwanza	77	55	1	32	1	92	69
Mara	69	49	1	19	2	100	98
Manyara	60	56	1	26	1	60	55
Mainland	60	49	1	25	3	59	82
Total	61	50	1	26	4	59	82