UNITED REPUBLIC OF TANZANIA

MINISTRY OF FINANCE

PUBLIC EXPENDITURE REVIEW OF THE NUTRITION SECTOR

MAIN REPORT

MARCH 2014

INNOVEX

unicef

Irish Aid
An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

CURRENCY EQUIVALENT

2010/11 (AVERAGE)

USD 1 = TZS 1,420
EUR 1 = TZS 1,883
GBP 1 = TZS 2,195

2011/12 (AVERAGE)

USD 1 = TZS 1,563
EUR 1 = TZS 2,176
GBP 1 = TZS 2,507

2012/13 (AVERAGE)

USD 1 = TZS 1,562
EUR 1 = TZS 2,009
GBP 1 = TZS 2,476

MEASURES

METRIC SYSTEM

FISCAL YEAR

1 JULY – 30 JUNE

Acknowledgement:
In addition to consultants from INNNOVEX Development Consulting Ltd, the study was under the Assistant Commissioner of Budget, Ministry of Finance Mr John Mwilima and coordinated by Mr Charles Mwamwaja. The field work to the 15 selected local councils included the Government staff as follow: Mrs Rachel Ntiga (MoF); Mr Emmanuel Matiku (MoF); Mr Martin Tupilike (MoF); Mrs Aneth Nombo (TFNC); and Mr Fred Lwoga (TFNC). The national team also highly appreciated direct and indirect support from many stakeholders and notably the support team documented on Annex B of this report.

TABLE OF CONTENTS

Abbreviations and Acronyms

ASDP	Agriculture Sector Development Programme
ASP	Agriculture Strategic Plan
CAADP	Comprehensive Africa Agriculture Development Programme
DC	District Council
ECAGR	Exponential Cumulative Average Growth Rate
FAO	Food and Agriculture Organization
GDP	Gross Domestic Product
GoT	Government of Tanzania
IDD	Iodine Deficiency
PMO	Prime Minister's Office
LGA	Local Government Authority
MAFC	Ministry of Agriculture, Food Security and Cooperatives
MC	Municipal Council
MCDGC	Ministry of Community Development, Gender and Children
MCH	Maternal and Children Health
MDA	Ministries Departments and Agencies
MDGs	Millennium Development Goals
MKUKUTA	Mkakati wa Kuondoa Umasikini na Kukuza Uchumi Tanzania
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Diseases
NFFA	National Food Fortification Alliance
NNS	National Nutrition Strategy
NPFS	National Programme for Food Security
NTD	Neural-Tube Defect
OC	Other Charge
PE	Personal Emolument
PER	Public Expenditure Review
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PO-PC	President's Office, Planning Commission
RS	Regional Secretariat
SPFS	Special Programme for Food Security
TAFSIP	Tanzania Agriculture and Food Security Implementation Plan
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drugs Authority

TFNC	Tanzania Food and Nutrition Centre
TGEB	Total Government Expenditure Budget
TWG	Technical Working Group
TZS	Tanzania shilling
UNICEF	United Nations Children's Fund
USD	United States dollar
VAD	Vitamin A Deficiency
VAS	Vitamin A Supplementation

Executive Summary

Background

Malnutrition in Tanzania remains a significant development issue, notably public health problem, affecting mostly women of reproductive age and children below 5 years of age. The prevalence of vitamin A deficiency (VAD) is 33% among children below 5 years of age and 30% among women of reproductive age. According to the TDHS 2010, at the national level, 42 percent of children under 5 have low height-for-age or are stunted, 5 percent have low weight-for-height or are wasted, and 16 percent have low weight-for-age, which reflects both chronic and acute undernutrition. The prevalence of vitamin A deficiency (VAD) is 33% among children between 6-59 months and 30% among women of reproductive age. An estimated 53% of pregnant women in Tanzania are anaemic, with only 4% of pregnant women taking iron and folic acid supplements for at least 90 days. Vitamin A supplementation to children aged 6 to 59 months, food fortification and deworming has been identified as the most worthwhile development intervention by the 2008 Copenhagen Consensus. Studies indicate that coverage above 80% in this target population results in an estimated 23% reduction in under-five mortality.

The Government of Tanzania with support of Development Partners (DPs) and other stakeholders are committed to address the nutrition challenges and problems in the country. In order to tackle these challenges and problems the Government and stakeholders require up- to date information on the quantum of resources available, allocated and spent on the nutrition. To address the lack of data on the amount and type of funds allocated and spent on nutrition in Tanzania, the Ministry of Finance in Tanzania, with the technical and financial support of UNICEF and the World Bank, led the implementation of a public expenditure review (PER) for nutrition. INNOVEX Development Consulting Ltd was therefore contracted by UNICEF to carry out the PER in the nutrition sector. The purpose of the PER is to provide baseline information on allocations and expenditures on nutrition, against which to assess progress after the introduction of the budget line on nutrition in Financial Year 2012/13.

Approach and scope

The nutrition sector PER was designed in such way to address three fundamental questions applicable to public expenditure review of any sector taking into account it is the first time it is conducted in the sector. The key questions in any PER process regardless of the sector are as succinctly summarised by Pradhan (1997) as follows:

- Is there a rationale for government intervention in general and public expenditure in particular?
- If there is an underlying market failure, how large is the discrepancy between social and private values this imposes and how much can alternative expenditure allocations improve upon private market?
- What is the impact of alternative expenditure allocations on the poor, marginalized groups, women, and children/young?

The three key issues in any PER process that is fiscal efficiency [level of spending], allocative efficiency [composition of spending] and operational efficiency [efficient public sector spending] are addressed in the first, second and third question above respectively and were necessary when carrying out the nutrition sector PER. The nutrition sector PER methodology was localised on the context of Tanzanian environment and taking stock of numerous past PER undertaken in other sectors notably health, education, agriculture, roads, water. The main basis of conducting this public expenditure review was therefore assessing the extent of fiscal discipline, allocative efficiency and operational efficiency in the nutrition sector in line with defined protocols.

Key Findings

The key findings from this nutrition sector public expenditure review are summarised below:

- **Challenges in Data**: Data collection was a challenging and daunting task during the study. The data sources varied in data management and in preparation of the resources allocation, reporting actual expenditures and monitoring of their activities. Most of the DPs and NGOs data were on aggregate form, hence lower level analysis was not possible. Public sector, including ministries, agencies (e.g. TFNC) and local councils actual expenditures data on activities implemented were not available especially on the Government funding
- **Nutrition funding**: Total nutrition investment at the national level excluding the resources allocated at the local councils amount to TZS 78.6 billion (USD 51.4 million) over a three years period. The annual resources allocations were TZS 17.8 billion (USD 12.5 million), TZS 27.5 billion (USD 17.6 million) and TZS 33.2 billion (USD 21.3 million) between FYs 2010/11 to 2012/13 respectively. The nutrition sector budget allocation compared to the national GDP were 0.05%, 0.06% and 0.06% for the three years. Also in comparison with the Government total expenditure budget, nutrition allocations were 0.15%, 0.20% and 0.22% respectively. This level of resources allocation was inadequate to address the nutrition challenges in the country
- **Funding gap:** While the NNS implementation was estimated to spend TZS 118.9 billion and TZS 145 billion in 2011/12 and 2012/13, the actual resources allocation at national level was only 23.1% and 22.9% respectively. This shows significant funding gap, which ultimately resulting in low level of implementation for the national nutritional strategy implementation plan 2011-2016
- **Target Groups**: Public spending on nutrition interventions were not targeted to the most vulnerable groups including children under two and pregnant women. The total resources allocation at a national level allocated meagre amount to children under two (0.3%) and pregnant women (0.3%). Though public spending for the children under five was significant (24.1%), however the range of age does not assure adequate coverage to children under two who are at higher risk and vulnerable to poor nutrition than age three and above
- **Councils**: Currently, Councils do not have earmarked fund for implementing nutrition interventions. The 15 visited local councils have neither nutrition strategic plans nor the nutrition causes determinant surveys undertaken. Nutrition interventions were incorporated in MTEFs on ad hoc basis and few selective interventions by sectors, and by the end of the day they were not implemented due to lack of fund. The total nutrition resources allocation for 14 councils was **TZS 2.48 billion** for a three-year, with an average of **TZS 59.2 million** (USD 37,000) per council per annum..

Recommendations

Following the analytical work supported by the situational analysis of nutrition public expenditure in Tanzania, it is recommended to:

- **Establish Ring-fenced Nutrition Fund**: Government should create financial mechanisms to protect (earmark) nutrition funding, by allocating required resources to implement NNS through available sources of fund, e.g. basket funds such as Health, Agriculture etc. to ensure that MDAs and LGAs implement nutrition interventions in a purposeful and transparent manner rather than adopting an ad hoc approach as is the practice now. The NNS implementation plan identified interventions which are to be implemented by various stakeholders, which should be featured in MTEFs on an annual basis. The following recommendation are relevant:
    - ✓ **Make nutrition as part of Health Basket Fund**: The Government should discuss with Health Sector Basket Fund (HBF) partners and agree to invite nutrition sector donors into the (HBF) under the Ministry of Health and Social Affairs.
    - ✓ **Formula Allocation:** The Government and Development Partners in nutrition sector should develop a formula for fund allocation in nutrition interventions. The interventions can be

blocked into major specific and high impact interventions that LGAs can implement. The MoHSW in collaboration with MoF and PMO-RALG can oversee funds allocation on an annual basis according to the agreed formula. Key nutrition indicators and sectors' needs can be used in the formula to allocate resources. The allocation will target funds to LGAs

- ✓ **Government should increase its funding of nutrition:** as a first step, the Government should include key nutrition interventions as protected items in the budget guideline and set a minimum amount of Shillings that it would invest in nutrition sector, in line with NNS. The Government should also ensure that nutrition interventions are included in Councils annual budgets
- ✓ **Resource Mobilisation Strategy**: The Government should prepare a resource mobilisation strategy to fund the sector. To start with, the Government should target at initiatives that seeks to encourage donors to fund NNS Implementation Plan with of mobilising at least 80% of the needed resources by 2016.

- **Develop medium-term and long-term capacity building programs for nutrition officers and institutions**: Going by D-by-D, it is important to ensure that local councils have the capacity to deliver nutrition services in their respective areas. PMO-RALG should give high priority to facilitate recruitment of the District Nutrition Officers (DNUOs) in the remaining LGAs and their empowerment. Another areas for capacity building include strengthening TFNC with planning, financial management system, as well as in monitoring and evaluation so that the institution becomes an effective national center on nutrition research and capacity building

- **Enhance coordination and partnership:** Generally, the nutrition sector PER 2013 found out that despite a number of interventions and frameworks on coordination and partnership, implementation is still fragmented and resources allocation were neither coordinated nor directed necessarily towards real problem areas and groups. This calls for the need to clarify roles of the various institutions in the sector in order to strengthen existing mechanisms for coordination at the national and local levels. In particular, the MoHSW nutrition unit should be strengthened to enable it play effectively its coordination roles.

- **Establish monitoring mechanisms in nutrition sector:** establish nutrition tracking system to ensure that sector interventions are monitored on an annual basis. In addition, conduct sector PERs after every two years to inform progress in the sector.

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1 Background and Context

1.1 Introduction

This report is the result of the public expenditure review work undertaken by the INNOVEX Development Consulting Ltd in 2013. UNICEF has contracted INNOVEX to carry out the public expenditure review of the nutrition sector on behalf of the Government of Tanzania through the Ministry of Finance (MoF).This report is submitted to the MoF and UNICEF following completion of the assignment. Section one of the report covers the background of the study, objective, scope, methodology and report structure.

1.2 Background

Undernutrition is one of the World's most serious but least addressed health problems. The consequences of malnutrition include failure to grow, frequent illness, brain damage, cognitive impairment, lower productivity and a greater likelihood of diet-related chronic diseases later in life. The human and economic costs are enormous, falling hardest on the very poor and on women and children. In developing countries, undernutrition interacts with repeated bouts of infectious disease, causing an estimated 3.5 million preventable maternal and child deaths annually. Its economic costs in terms of lost national productivity and economic growth are huge.

Malnutrition in Tanzania remains a significant development issue, notably public health problem, affecting mostly women of reproductive age and children below 5 years of age. According to the TDHS 2010, at the national level, 42 percent of children under 5 have low height-for-age or are stunted, 5 percent have low weight-for-height or are wasted, and 16 percent have low weight-for-age, which reflects both chronic and acute undernutrition. The prevalence of vitamin A deficiency (VAD) is 33% among children between 6-59 months and 30% among women of reproductive age. An estimated 53% of pregnant women in Tanzania are anaemic, with only 4% of pregnant women taking iron and folic acid supplements for at least 90 days. Vitamin A supplementation to children aged 6 to 59 months, food fortification and deworming has been identified as the most worthwhile development intervention by the 2008 Copenhagen Consensus. Studies indicate that coverage above 80% in this target population results in an estimated 23% reduction in under-five mortality.

Efforts to address nutritional problems in Tanzania date back to the late 1920s (Annex F). After independence nutrition activities were implemented through different units such as Tanganyika National Freedom from Hunger Committee, Nutrition Extension Services and Tanzania Nutrition Committee under the Ministry of Health. Tanzania Nutrition Committee developed Tanzania's first comprehensive nutrition plan (1965 – 69) with support from UNICEF, the World Health Organization (WHO) and the Food and Agriculture Organization (FAO). In 1972 the Tanzania Food and Nutrition Centre (TFNC) was created as a Parastatal organization to coordinate the nutrition activities implemented by nutrition units formed in the Ministry of Agriculture (MoA) and the Ministry of Education (MoE) independent of the Ministry of Health (MoH) (Kavishe, 1993). Other efforts were on establishment of National food and nutrition policy in response to national crises for food and social effect of structural adjustment occurred during 1973 – 75 (Kavishe, 1993). Finally, the implementation of Iringa Joint Surveillance project which was undertaken between 1978 and 1982 which resulted in the formulation of the nutrition conceptual framework used during implementation of Iringa Joint Nutrition support programme (1983 – 1988). That program resulted in significant reductions in child underweight and mortality.

Since 1990s, the Government of Tanzania has been setting out its nutrition plans for action. These nutrition goals was hoped to be achieved by the year 2000 and the annual reduction in the level of infant, child and maternal malnutrition that would be required to reach these goals. These targets were based on Tanzania's positive experience of nutrition programming in the 1980s and on the adoption of the goals set by the World Summit for children in 1990 and the International conference on nutrition in 1992 at which global nutrition goal were adopted. The nutrition plan for action was seen as an important step in defining what was to be achieved by all those concerned with nutrition in Tanzania in the 1990s. The goals include:

- Reduction in the prevalence of severe as well as moderate malnutrition among under five children by half of 1990 levels
- Reduction of the prevalence of low birth weight (LBW) (2.5 kg or less) to less than 10%
- Reduction of the prevalence of iron deficiency anaemia in women by one third of the 1990 levels
- Virtual elimination of iodine deficiency disorders
- Virtual elimination of vitamin A deficiency and its consequences including blindness
- Growth promotion and monitoring to be action oriented in all MCH clinics
- Dissemination of knowledge and supporting services to increase food production to ensure household food security.

Data from the TDHS indicate some improvements in nutrition. The prevalence of stunting fell by an absolute on 6% in the 2004/05 survey after a period in the 1990s when there was no change. The percentage of children underweight for age and the percentage wasted has also declined since 1996. The declining rate of stunting among rural children accounts for the recent improvements observed at national level. Between 1999 and 2004, the prevalence of stunting in urban areas increased slightly to 26%. Rural rates, on the other hand, declined from 48% to 41% over the same period. Nonetheless, given the high rates of malnutrition which are prevalent among rural children, it is obvious that Tanzania was not able to reduce stunting among children under five years to 20% in 2010, which was the target set under MKUKUTA. Based on the TDHS 2010, children in the Central and Southern Highlands zones are particularly disadvantaged, at least half are stunted, which reflects long-term undernutrition in the area.

Despite the existence of malnutrition in Tanzania, the Government has already scaled up a number of cost-effective nutrition-related health interventions which resulted to improvement of nutrition status of the under-five and pregnant women (THDS 2010). These interventions include: Vitamin A supplementation of children under five has reached 60%, over 80% of urban salt is Iodized, over 95% of pregnant women received antenatal care, 60% received Iron-folate tablets, 63% of women received intermittent malaria treatment, 75% of children under two years are completely vaccinated, 50% of under-five have received deworming treatment and close to two-third of families have an insecticide treated mosquito net. These efforts have shown impact on under-five mortality which has fallen from 137 in 1996 to 87 in 2010 (DHS 2009/10).

Nutrition is firmly anchored in the National Strategy for Growth and Poverty Reduction (MKUKUTA 2011-2015), the National Nutrition Strategy (2011-2016) which has been launched, and nutrition has been included as a separate investment priority in the Tanzania Agriculture and Food Security Investment Plan (TAFSIP). A High Level Steering Committee on Nutrition has been established under the leadership of the Prime Minister's Office (PMO) to provide guidance on moving the nutrition agenda forward. Multi-sectoral committees are also being established at council level and Nutrition Officers recruited at regional and district level to support efforts in implementing the National Nutrition Strategy.

Furthermore, the government has introduced a budget line for nutrition, effectively from July 2012. In preparation, nutrition has been embedded in the Ministry of Finance (MoF) national planning and budgeting guidelines for fiscal year 2012/13, directives have been issued to all councils to include nutrition in the plans and budgets for fiscal year 2012/13, and guidance has been provided to all councils on identifying key actions to include in their plans and budget for 2012/13. The Government commitment continued thereafter, as nutrition agenda was emphasised also on planning and budgeting guideline for FY 2014/15.

1.3 Study Objective

To address the lack of data on the amount and type of funds allocated and spent on nutrition in Tanzania, the Ministry of Finance in Tanzania, with the technical and financial support of UNICEF and the World Bank, led the implementation of a public expenditure review (PER) for nutrition. The purpose of the PER is to provide baseline information on allocations and expenditures on nutrition, against which to assess progress after the introduction of the budget line on nutrition in Financial Year 2012/13. The PER will also assist in providing inputs into the National Budget Guidelines and other activities aimed at building capacity of the national and local authorities to plan and budget for nutrition. The information will also guide donor priorities for funding allocation in nutrition. The PER study is in full compliance with National Nutrition Strategy, the draft plan for its implementation, as well as UNDAP (United Nations Development Assistance Plan) objectives for Tanzania.

The analytical exercise forms part of annual work conducted by the World Bank in collaboration with the Government and other development partners. The PER used the approved budget and actual spending data for FYs 2010/11, 2011/12, FY 2012/13 and assessed relevance (choice of cost-effective interventions that are appropriate for addressing the nutrition challenges in Tanzania), consistency (with the proposed interventions in the NNS) and effectiveness of budget allocation and expenditure in accordance with the NNS. It is expected that the PER will feature as one of the policy notes of the nutrition sector in Tanzania.

1.4 Study methodology

1.4.1 Approach

The nutrition sector PER was designed in such way to address three fundamental questions applicable to public expenditure review of any sector taking into account it is the first time application within the sector. The key questions in any PER process regardless of the sector are as succinctly summarised by Pradhan (1997) as follows:

- Is there a rationale for government intervention in general and public expenditure in particular?
- If there is an underlying market failure, how large is the discrepancy between social and private values this imposes and how much can alternative expenditure allocations improve upon private market?
- What is the impact of alternative expenditure allocations on the poor, marginalized groups, women, and children/young?

The three key issues in any PER process that is fiscal efficiency [level of spending], allocative efficiency [composition of spending] and operational efficiency [efficient public sector spending] are addressed in the first, second and third question above respectively and were necessary when carrying out the nutrition sector PER. The nutrition sector PER methodology was localised on the context of Tanzanian environment and taking stock of numerous past PER undertaken in other sectors notably health, education, agriculture, roads, and water. The main basis of conducting this public expenditure review therefore was assessing the extent of fiscal discipline, allocative efficiency and operational efficiency in the nutrition sector in line with defined protocols. Specific tasks and activities that the PER team conducted include the following:

- **Project inception**: The project commenced with series of meeting between the consultants, UNICEF, the nutrition sector Technical Committee and the Ministry of Finance. The meetings and consultations during this stage established and defined clearly the scope of the nutrition sector PER in terms of coverage, stakeholders' participation and confirmed the approach. During this stage, the consultants developed a number of data collections tools for national and sub-national levels. The training program for the PER team was reviewed and agreed.
- **Training of Team**: Consulting team with support of the Ministry of Finance conducted a three-day training to the nutrition sector PER team in Morogoro. The training was widened to include the national

team (consultants and selected staffs from TFNC and Ministry of Finance) as well as participants from the 15 local councils. Each local council sent a minimum of four participants from various departments and one regional representative from 11 regions in the country. From the LGAs we had district planning officers, economists, district nutrition focal persons, district community development officers while from the RAS we had regional nutrition coordinators or health coordinators. The training focused on nutrition issues as well as approach on conducting PER with emphasis on data collection at local councils. The training was also attended by representatives of the nutrition sector donors and stakeholders

- **Data collection**: The team embarked on data collection after the training in Morogoro. Nutrition sector PER data was collated from a number of key stakeholders as explained on sub-section 1.4.2 below. During data collection stage, data tools developed during the project inception were used extensively. At LGAs, training participants from the selected LGAs supported the national PER team to collate various data from their respective councils during the field visits. After the data collection exercise in the districts, data collection continued in Dar es Salaam particularly focusing on central government, DPs and NGOs/CSOs.
- **Data analysis**: After completion of the data collection, the consulting team embarked on data entry, cleaning and analysis. The team used extensively Microsoft Excel to compile the national database for the nutrition sector. The data analysis entailed aggregation, comparison, correlation, trends and decomposition of nutrition expenditure by using a number of classifying variables as reported in this document.
- **Report writing**: The PER team embarked on drafting the document after completion of the basic data analysis and synthesising qualitative issues and facts found during the assignment. The report structure is summarised on sub-section 1.5 of this document.

1.4.2 Data Sources

Nutritional public expenditure data were collated from both public and private sectors institutions which undertake nutrition interventions. There were a number of basic data sources used to compile comprehensive database for the assignment at a national level and sub-national level. The data collated were for the nutrition interventions and programs which were implemented in Tanzania between FY 2010/11 and FY 2012/13 for both budget and actual expenditure. The data sources were categorised under the following major areas:

- **Ministries and Agencies**: The nutrition sector PER team collected data from six nutritional sector lead ministries, namely: Ministry of Health and Social Welfare (MoHSW); Ministry of Agriculture Food Security and Cooperatives (MAFC); Ministry of Education and Vocational Training (MoEVT); Ministry of Water (MoW); Ministry of Community Development, Gender and Children (MCDGC) and Ministry of Livestock Development and Fisheries (MLDF). In addition, data was also collected from the Tanzania Food and Nutrition Centre (TFNC) and Ifakara Health Institute. The Government funding for the nutrition sectors were through the annual budget of the respective ministries, department and agencies (MDAs) dealing with the nutrition interventions
- **Donors/DPs:** Development partners (donors/DPs) fund nutrition programs and interventions via two channels, first into the Government system (on-budget) and secondly directly (off-budget) to the implementing institutions. The implementing institutions include the local councils, civil society organisations (CSOs), ministries and agencies such as TFNC. A number of DPs were consulted and data collected. Data from donors were checked against spending done by implementing institutions in order to avoid double-counting, and only budget and expenditure which were directly spent by respective donors were included under the national nutritional database. Data provided by donors were on aggregated at programs and interventions, hence used to determine total national budget and expenditure for the nutrition sector
- **CSOs/NGOs**: Civil Society Organisations (CSOs) and NGOs were mostly the implementers of the nutrition programs and interventions funded by the DPs on various parts of the countries. A number of CSOs/NGOs based on a list agreed were consulted and data collected on budget and actual

expenditure on nutrition interventions. However, similar to DPs, the data from CSOs/NGOs were on aggregated level in terms of programs and interventions, hence detailed analysis at a low level was not possible.

- **Councils/LGAs**: A total of 15 selected LGAs were visited and data collected through structured tools and in-depth interviews. The LGAs institutional data were collected on financial (budget and actual expenditure) and nutrition interventions planning and execution. In addition, a sample of LGAs staff (mostly Head of Departments) were selected randomly to provide opinions and views regarding the nutrition in their respective areas. Data were collected from 164 respondents using a structured survey tool from the 15 selected LGAs. The 15 LGAs were selected on the basis of representative on nutrition status as well as urban and rural councils. The 15 councils are shown on **Table 1.1**below:

Table 1.1: List of 15 visited local councils

	Region	Category	Regional Nutrition Status (stunting %)[1]
Kigoma District Council	Kigoma	Rural	48%
Shinyanga Municipal Council	Shinyanga	Urban	43%
Kishapu District Council	Shinyanga	Rural	43%
Morogoro Municipal Council	Morogoro	Urban	44%
Mpwapwa District Council	Dodoma	Rural	56%
Kongwa District Council	Dodoma	Rural	56%
Babati Town Council	Babati	Urban	46%
Muheza District Council	Tanga	Rural	49%
Pangani District Council	Tanga	Rural	49%
Mtwara Municipal Council	Mtwara	Urban	44%
Lindi District Council	Lindi	Rural	54%
Ruangwa District Council	Lindi	Rural	54%
Mbeya Municipal Council	Mbeya	Urban	50%
Iringa District Council	Iringa	Rural	52%
Makete District Council	Njombe	Rural	52%

1.4.3 Study deliverables

The terms of reference for the nutrition sector PER 2013, specifically identified the following deliverables to be produced during undertaking of the assignment:

- **Main Report:** This is the main deliverable, which comprises detailed findings, conclusion and recommendations of the study. This document is the core deliverable and was prepared and bound separate to other deliverables as described below

[1]Figures based on regional data and not districts. National average was 42%, driven mostly by low stunting level of Dar es Salaam at 19% with large population than other regions

- **Policy Brief:** The purpose of preparing this document is to have a brief and concise policy document that will be used for advocacy and communication on the nutrition sector and expenditure in the country. The policy brief will be prepared from the final Nutrition PER report
- **PER Protocol:** The PER protocol is a document which spells out in detail how the study was undertaken including basic definitions, study approach, sources of data, variables for classifications and analysis and other relevant information.

1.5 Main report structure

The main report for the nutrition sector public expenditure study was prepared in a single volume. Section 1 has been covered in previous sub-sections, therefore, the remaining part of this document has been structured into five other sections as highlighted below:

- **Section 2 – Nutrition Policy and Framework:** This section examines policy and framework in which nutrition interventions are executed in the country at both national and lower levels. The nutrition policy and framework in Tanzania were reviewed on the context of nutrition problems. The national commitment and aspiration on achieving high nutrition status for the population has also been covered in this chapter. Thorough discussion has been undertaken on the fact that nutrition has not been on the policy agenda for many years, the impact of that and how the recent political commitments are refocusing the government priorities and resulting in some changes in the sector
- **Section 3 – Allocations and Alignment of Budget:** This section presents detailed analysis of budgeting for the nutrition interventions at national and sub-national levels. The analytical results is presented on budget data and trend over the three years i.e. FYs 2010/11 to 2012/13. The implications of budget allocations and alignment were measured and compared against the national nutrition priorities and strategies
- **Section 4 – Planning and Execution of Nutrition Interventions:** This section presents analytical and non-analytical results of the study on actual expenditure on nutrition sector. In addition, the section provides results on the planning process and execution of interventions found on the ground at national and lower levels. Other soft issues relating to the nutrition sector in Tanzania were also been addressed on this section as evidenced through interviews and discussions with stakeholders during the course of the study
- **Section 5 – Conclusion and Recommendations:** This section provides study conclusion together with consulting team recommendations to key stakeholders of nutrition sector. The section also includes the plan of action for both national and lower levels in order to improve resource allocation to the nutrition sector
- **Section 6 – Annexes:** This final section is comprised of annexes on the nutrition sector PER. It includes reference lists, detailed financial and non-financial nutrition detailed data, and others.

2 Nutrition Policy and Framework

This section of the report examines policy and framework in which nutrition interventions are executed in the country at both national and local levels. The national commitment and aspiration on achieving high nutrition status for the population has also been covered in this chapter. The thorough discussion has been underlined on the fact that nutrition has not been on the policy agenda for many years, the impact of that and how recent political commitments are resulting in changes in the sector.

2.1 National Level

Several initiatives have been taken by the Government of Tanzania to improve nutrition of its citizens over the years. The initiatives included creation of the Tanzania Food and Nutrition Centre (TFNC) in 1973 and enactment of a national food and nutrition policy in 1992 (currently under review). Followed the country's commitment to scale up nutrition, efforts have been made to include nutrition interventions in a number of national strategies, policies and programs in food and agriculture sector with the aim of improving nutrition (**Table 2.1**). Nutrition is firmly anchored in the National Strategy for Growth and Poverty Reduction (MKUKUTA 2011-2015) and the Health Sector Strategic Plan III. The National Nutrition Strategy (2011-2016) has been launched, and nutrition has been included as a separate investment priority in the Tanzania Agriculture and Food Security Investment Plan (TAFSIP). A high level steering committee on Nutrition has been established under the leadership of the Prime Minister's Office (PMO) to provide guidance on moving the nutrition agenda forward. Multi-sectoral committees are also being established at council level and Nutrition Officers recruited at regional and district level to support efforts in implementing the National Nutrition Strategy.

Table 2.1: Current strategies and policy framework for improving food security and nutrition

	Objectives, main components & Key points
Tanzania Development Vision 2025	Among other goals, Tanzania Vision 2025 states that by 2025, Tanzania should attain a "High quality livelihood." The three principal objectives of the Vision 2025 • achieving quality and good life for all; • good governance and the rule of law; and • building a strong and resilient economy that can effectively withstand global competition These objectives not only deal with economic issues, but also include social issues such as education, health, the environment and increasing involvement of the people in working for their own development. The thrust of these objectives is to attain a sustainable development of the people. Several strategies deal with food security and nutrition: • Food self-sufficiency and food security • Access to quality primary health care for all • Reduction in infant and maternal mortality rates by three-quarters of current levels • Universal access to safe water • Absence of abject poverty
National Strategy for Growth and Reduction of Poverty II (NSGRP II) or MKUKUTA II (Kiswahili)	Provides a framework for focusing policy direction and thrust on economic growth and poverty reduction in various sectors. The two initiatives recognize the importance of food and nutrition security, climate change adaptation and improving survival, health, nutrition and well-being, especially for children, women and vulnerable groups. Cluster II is on improvement in the quality of life and social well-being, where one of the goals is reduction in the prevalence of stunted and underweight children. The agriculture sector is addressed under the Cluster on Growth and Reduction of Income Poverty.

Table 2.1: Current strategies and policy framework for improving food security and nutrition

	Objectives, main components & Key points
Millennium Development Goals (MDGs)- 2000-2015	There are eight international development goals that; All 189 United Nations member states (Tanzania inclusive) have agreed to achieve these goals by the year 2015.The MDG goals related to nutrition are: ✓ MDG 1:Eradicating extreme poverty and hunger ✓ MDG 2:Achieving universal primary education ✓ MDG 4:Reducing child mortality rates ✓ MDG 5:Improving maternal health ✓ MDG 6:Combating HIV/AIDS, malaria, and other diseases MKUKUTA II is a medium term mechanism to achieve the aspiration of Tanzania's Development Vision 2025 (TDV 2025) and the Millennium Development Goals (MDGs) MKUKUTA II translates Vision 2025 aspirations and MDGs into measurable broad outcomes organized under three clusters – Cluster I: Growth for Reduction of Income Poverty; Cluster II: Improvement of Quality of Life and Social Well-being; Cluster III: Governance and Accountability.
Food and Nutrition Policy (currently under review)	The aims of the Food and Nutrition Policy are to: i. Integrate food and nutrition activities undertaken by various sector. ii. Enable each sector to play its part in the elimination of malnutrition problems. iii. Improve the nutritional situation of the Tanzanian community, especially children and women. iv. Strengthen the procedures of obtaining and supplying food within the household, villages and towns by utilizing locally produced foods v. Enable Tanzanians to produce and use food which can adequately meet their nutritional needs. vi. Establish a viable research programs, to facilitate the improvement of food and nutrition in the country. The objectives of the Food and Nutrition Policy are to: i. Prepare a viable system for coordinating, balancing and guiding food and nutrition activities which are being undertaken by various sectors ii. Provide guidelines and techniques to combat food and nutrition problems in the country and to enable each sector to play its role iii. Rectify the state of food availability and formulate proper strategies and techniques to ensure the availability and utilization of food in accordance with nutritional requirements iv. Involve all sectors which deal with issues pertaining to food and nutrition in realizing and strengthening the methods of improving the nutrition situation v. Incorporate food and nutrition considerations in development plans and to allocate available resources towards solving the problem of food and nutrition at all levels vi. Ensure nutrition as one of the indicators in assessing social development achievements of economic and health improvement projects vii. Formulate and develop research which facilitate solving of food and nutrition problems. The important areas of the policy are: • Food Security • Care for Special Groups • Essential Human Services • Food and Nutrition • Roles of various sectors in the implementation of the Food and Nutrition Policy in Tanzania.
National Nutrition Strategy (July 2011/12 – June 2015/16)	The goal of the Strategy is that all Tanzanians attain adequate nutritional status, which is an essential requirement for a healthy and productive nation. This will be achieved through policies, strategies, programs and partnerships that deliver evidence-based and cost-effective interventions to improve nutrition. The Strategy has a set of priority areas that are key to improving nutritional status of the people. The actions under the priority areas address nutritional problems that are of public health significance or are emerging challenges that have the potential for being a significant barrier to human development in the near to medium-term. They are evidence-based, cost-effective and of proven feasibility in Tanzania or similar contexts. The areas are: • Promotion of good infant and young child feeding practices • Prevention and control of vitamin and mineral deficiencies • Improvement of maternal nutrition • Nutrition care and support for PLHIV

Table 2.1: Current strategies and policy framework for improving food security and nutrition

	Objectives, main components & Key points
	• Support for children, women and households in difficult circumstances • Prevention and control of diet-related non-communicable diseases • Improvement of household food security • Conducting nutrition surveillance, surveys and information management
National Food Fortification Programme	The program aims at making enriched foods available and encouraging their consumption through mandatory fortification of staple foods, including wheat flour, maize flour and edible oil. Food fortification is a core component of the NNS and one of the 6 priority actions that the Government committed to at the UN-General Assembly (UNGA) in 2010.
Agricultural Sector Development Programme (ASDP)-(2006-2013)	The ASDP strategic objectivesincluded (i) creating an enabling and favourable environment for improved productivity and profitability in the agricultural sector; and (ii) increasing farm incomes to reduce income poverty and ensure household food security
KILIMO KWANZA (Agriculture First)	*KILIMO KWANZA* is a national resolve to accelerate agricultural transformation. It comprises a holistic set of policy instruments and strategic interventions towards addressing various sectoral challenges and taking advantage of the numerous opportunities to modernize and commercialize agriculture in Tanzania. It acts as a central pillar in achieving the country's Vision 2025 and a force to propel the realisation of the Nation's socio-economic development goals. Agriculture in the context of *KILIMO KWANZA* conforms to the FAO definition which includes crops, livestock, fisheries, forestry and bee-keeping. *KILIMO KWANZA* is a catalyst for the implementation of Agricultural Sector Development Programme (ASDP) and accelerates implementation and achievement of MDGs targets and objectives with a stronger emphasis for pro – poor growth. It takes a holistic approach for the development of agricultural sector which involves all sectors in the economy. *KILIMO KWANZA* provides national coordination of resources, planning and accountability for implementation of agricultural transformation and enhances strong private sector participation as a key agent towards realization of agricultural goals. The implementation of *KILIMO KWANZA* revolves around ten pillars, namely: 1. Political will to push agricultural transformation 2. Enhanced financing for agriculture 3. Institutional reorganization and management of agriculture 4. Paradigm shift to strategic agricultural production 5. Land availability for agriculture 6. Incentives to stimulate investments in agriculture 7. Industrialization for agricultural transformation 8. Science, technology and human resources to support agricultural transformation 9. Infrastructure Development to support agricultural transformation 10. Mobilization of Tanzanians to support and participate in the implementation of *KILIMO KWANZA*.
Agriculture Sector Development Project (ASDP), AF-II	Both ASDP and ASP aim at increasing the growth rate of agricultural GDP. Targets for mainland Tanzania are to increase the agricultural sector annual growth rate from 3.2 percent in 2009 to 6.3 percent in 2015 (MKUKUTA II and MKUZA II), through transformation of the sector from subsistence to commercial agriculture. Besides stimulating agricultural growth, ASDP and ASP target also to achieve food security and reduce rural poverty.
Special Programme for Food Security (SPFS)	The special program for Food Security aims at 1/ Improving the national food security through rapid increases in productivity and food production , 2/ reducing year to year variability in agricultural production, 3/ improving Tanzanian's access to food.The SPFS Phase I was operational in Dodoma and Morogoro regions
Tanzania Five Year Development Plan 2011/12 – 2015/16	The Five-Year Development Plan (FYDP) has taken into account overall national development goals and policy objectives; sectoral initiatives, the National Strategy for Growth and Reduction of Poverty, MKUKUTA II, the key benchmarks of Long Term Perspective Plan (2011/12 - 2025/26), as well as findings of the Review of Vision 2025. The Plan is underpinned by specific strategies to fast-track realization of the Vision 2025 goals and objectives. These include sustainable and effective utilization of existing human and natural capital, and creation of an enabling environment for the private sector to invest and participate in a wide range of business opportunities in the next five years. It is the government's expectation that this Plan will help scale up the country's efforts of promoting socioeconomic development.

Table 2.1: Current strategies and policy framework for improving food security and nutrition

	Objectives, main components & Key points
	The five core priority areas of the FYDP include Infrastructure, Agriculture, Industry and Human capital. Under the fifth priority area of the Plan (Human Capital, which encompasses education and health**), nutrition is placed under health (improving social welfare related to nutrition issue)**

2.2 National Nutrition Strategy

Efforts to scale up nutrition in the country are guided by the National Nutrition Strategy (NNS) which is under the Ministry of Health and Social Welfare (MoHSW). The Strategy, which was developed by TFNC with contributions from a number of key stakeholders provides an opportunity for re-examining critically factors contributing to malnutrition, especially for vulnerable groups based on current scientific knowledge and experience over the years for addressing nutrition problems. The NNS aims at contributing to renewed commitment towards addressing critical issues basic to improving nutrition status of the community.

It focuses on eight priority areas which relate to nutritional problems of public health significance or emerging challenges that have the potential for being a significant barrier to human development in the near to medium-term. They are evidence-based, cost-effective and of proven feasible in Tanzania or similar contexts, and include:

- Infant and young child feeding
- Vitamin and mineral deficiencies
- Maternal and child malnutrition
- Nutrition and HIV and AIDS
- Children, women and households in difficult circumstances
- Diet-related non-communicable diseases.
- Household food security
- Nutrition surveillance, surveys and information management

The strategy is in-line with, and will contribute to, achieving the objectives of the National Development Vision 2025, MKUKUTA, Millennium Development Goals, the African Regional Nutrition Strategy (2005-2015) and all other relevant policies, programmes and strategies by the Government. In the National Strategy, it is ensured that interventions that are mandated for other sectors, such as health, water, agriculture and education, and which are included in their sectoral strategies and action plans are not duplicated.

Apart from the NNS, there are also nutrition specific and nutrition-sensitive policies, plans and strategies that complement the NNS, as shown in **Table 2.2**. Almost all needed nutrition-specific policies, strategies and plans, which address the immediate causes of undernutrition, i.e. inadequate dietary intake and ill health (include treating acute malnutrition, increasing micronutrient intake, and promoting exclusive breastfeeding) are in place. However, Nutrition-sensitive policies strategies and plans which usually address the underlying factors that contribute to malnutrition (including hunger, poverty, gender inequality, and poor access to safe water and health services) are currently not well represented.

The 2010 SUN Road Map identified priority areas in which to mainstream nutrition; they included agriculture, education, social protection, and health (SUN 2010). In Tanzania, agriculture sector has a well-established policy framework for improving food security and nutrition as depicted in Table 2.1. However, other sectors, namely Education, Community Development, and Water do not have nutrition relevant policies, strategies and plans. A 2003 World Bank Economic Review article on child malnutrition concluded that delivery of "indirect" (nutrition-sensitive) actions for income growth through food security and agriculture interventions alone is not enough to reach the Millennium Development Goal of halving the prevalence of underweight children by 2015 (Haddad et al 2003). SUN movement and other stakeholders have tried to explain the importance of these sectors to nutrition, as follows:

- **Education**: Children who are well nourished are able to concentrate and learn better at school. There is convincing evidence for a strong link between the level of a mother's education and her child's nutritional status. Policies that promote strong linkages between nutrition and education can play a key role in advancing overall efforts to improve nutrition outcomes (SUN 2011)
- **Social Protection**: Social protection policies can help tackle both the immediate and underlying causes of malnutrition by reducing vulnerability, protecting productive assets, ensuring basic needs can be met and securing access to a nutritious diet, particularly in times of crisis or instability (SUN 2011)

- **Women's Empowerment**: At the core of all efforts to scale up nutrition, women are empowered to be leaders in their families and communities, leading the way to a healthier, stronger world (SUN 2011)
- **Water, sanitation and hygiene (WASH)**: There is a close link between WASH and undernutrition. WHO ((2008) estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections as a result of unsafe water, inadequate sanitation or insufficient hygiene. Diarrhoea, largely caused by a lack of water, sanitation and hygiene, is a leading cause of death in children under-five globally, and its constant presence in low-income settings may contribute significantly to under-nutrition (Liu et al. 2012). Parasitic infections, such as soil-transmitted helminths (worms), caused by a lack of sanitation and hygiene, infect around 2 billion people globally (Brooker S, Clements A C and Bundy D A,2006), while an estimated 4.5 billion people are at risk of infection Ziegelbauer K et al. 2012). Such infections can lead to anaemia and reduced physical and cognitive development. A lack of safe water close to home has many indirect effects on nutrition. People are often left with no choice but to drink unsafe water from unprotected sources. Where safe water is available to purchase from vendors, limited quantities leave little for good hygiene practices. The time wasted collecting water or suffering from water-related illnesses prevents young people from getting an education, which has a significant impact on their health, wellbeing and economic status.

Table 2.2: Current strategies and policy framework for improving nutrition

Nutrition specific policies, strategies and plans
• National Nutrition Implementation Plan, 2012 • Tanzania National Nutrition Strategy, 2011-2016 • National Guidelines on Infant and Young Child Feeding, 2012 Draft • Guidelines for Community Based Nutrition Rehabilitation, 2012 • Management of Acute Malnutrition Guidelines, 2008 (revised 2011) • Implementation Guidelines for Vitamin A Supplementation and Deworming, 2010 • National Guidelines on Food by Prescription, 2009 • National Policy Guidelines on Infant and Young Child Nutrition, Draft 2007 • Guide on Nutrition Care and Support for People Living with HIV, 2007 • Tanzania National Strategy on Infant and Young Child Nutrition, 2004 • Guidelines for Community Based Nutrition Rehabilitation, 2004 • Policy Guidelines for Micronutrient Supplementation, 1997 (currently under review) • National Food and Nutrition Policy, 1992 (currently under review)
Nutrition-Sensitive policies
• Integrated Early Childhood Development Policy, 2011 • Health Sector Strategic Plan III, 2009-2015 • Health Sector HIV and AIDS Strategy II, 2008-2013 • The National Road Map Strategic Plan to Accelerate Reduction of Maternal, New-born and Child Deaths in Tanzania, 2008-2014 • National Health Policy, 2007 • National HIV and AIDS Policy, 2001 • National Disaster Management, 2004 *(Under review)* • National Livestock Development Policy, 2006 • Agriculture Sector Development Program, 2002 • Agriculture Sector Development Strategy, 2001 • National Fisheries Sector Policy and Strategy Statement, 1997 • Agriculture and Livestock Policy, 1997 (*Under review)* • Education Training Policy, 1995

2.3 Sub-national Level

Tanzania is placing strong emphasis on decentralization to ensure that nutrition is on the agenda with those working closest to affected communities. Advocacy on nutrition issues with Regional Commissioners has been undertaken to ensure they are sensitized on the need to take action on nutrition. According to the National Nutrition Strategy, LGAs are "responsible for integrating Strategy components/activities into their Comprehensive Council Development Plans; ensuring the implementation of policies, strategies and guidelines within their respective districts; mobilizing resources for implementation of nutrition activities; and sensitizing and supporting wards and communities to initiate, implement and monitor nutrition activities at ward and community levels. In addition the LGAs will coordinate, provide technical support and monitor the implementation of the Strategy at ward and village/mtaa levels". It is also expected that the newly established Council Multisectoral Nutrition Steering Committees at district level will coordinate nutrition interventions. However, there have been concerns that guidance on membership, terms of reference and reporting of the Steering Committees is lacking and further support to councils is needed to effectively coordinate nutrition issues. These concerns were evident throughout the LGAs that the PER team visited during the study.

2.4 Scale up nutrition actions

Tanzania like many other Third World countries has adapted the emerging framework of key considerations, principles and priorities for action to address undernutrition. In September 2011, Tanzania joined the Scaling Up Nutrition (SUN) partnership at the High Level Meeting on the United Nations. President Jakaya Kikwete was among the 27 Global Leaders to head worldwide effort to address child malnutrition. The 27 leaders committed to advancing the strength and security of nations by improving maternal and child nutrition. By joining the SUN partnership, Tanzania committed itself to promote good nutrition through nutrition sensitive development in many sectors and nutrition specific, highly cost-effective interventions during 1000 days which is considered a window of opportunity when the child's mental and physical potential is determined.

Since joining the SUN Movement in June 2011, the Government and its implementing partners have steadily taken necessary critical steps for curbing malnutrition:

- High Level Steering Committee (HLSCN) for nutrition was created. The committee, which is convened by the Prime Minister's Office involves representatives of nine key ministries, development partners, UN agencies, civil society, faith based organizations, academia and business
- A Council Multisectoral Steering Committee on Nutrition has also been established at district level chaired by the Executive Director and has full inclusion of all stakeholders, including representatives of relevant departments, civil society organizations, private sector and religious groups. The next step here would be ensuring that the committee functions
- The National Nutrition Strategy was finalized with the support and participation of the HLSCN as well as cross-sectoral technical expertise. The costed implementation plan has also been finalized
- About 109 nutrition officers have so far been recruited and deployed to the districts (against 168 required). The aim is to place a nutritionist in every district in the country, therefore the process is still ongoing. Development of an in-service training programme for the new cadres of regional and district nutrition officers is currently being done by UNICEF in collaboration with the Sokoine University of Agriculture
- The national food fortification standards for oil, wheat and maize flour was finalized and officially launched by the President. It is now compulsory for all food processers in Tanzania to fortify flour and oil. Apart from large scale food fortification, the Government will be working with rural millers to fortify their flour using "special machines" in an effort to combat micronutrient deficiencies at the village level
- The Government has introduced a budget line for nutrition expenditure and has developed budget guidelines to help ministries and local government authorities improve budgeting for nutrition. Capacity development of local government authorities on how to integrate nutrition into their plans and budgets has been done. All LGAs have now been oriented on the guidelines despite the fact that more awareness creation would be needed as evidenced by this study
- Nutrition has been integrated into agriculture activities as outlined in the Tanzania Agriculture and Food Security Investment Plan. Food and Nutrition Security is one of the seven thematic program areas with its own strategic objective and major investment programmes
- The national food fortification standards for oil, wheat and maize flour was finalized and officially launched by the President. It is now compulsory for all food processers in Tanzania to fortify flour and oil. Currently large scale fortification is being done for edible oil and maize and wheat flour. Apart from large scale food fortification, the Government will be working with rural millers to fortify their flour using "special machines" in an effort to combat micronutrient deficiencies at the village level.

2.5 Institutional Framework

The NNS has emphasized the importance of the participation and involvement of stakeholders and has clearly stated their role in its implementation. The implementation of the NNS requires the involvement of multiple stakeholders at all levels from the community level to the national level; Public sectors (sectoral ministries, regional secretariats and local government authorities), higher learning institutions, professional bodies, private sector, development partners, civil society organizations, media and the community. The Strategy has also ensured that interventions that are mandated for other sectors, such as health, water, agriculture and education, and which are included in their sectoral strategies and action plans are not duplicated.

The roles of key players in Nutrition

Players in nutrition sector	Description
Ministry of Health and Social Welfare (MoHSW)	The Ministry is responsible for the delivery of public health services including ANC, RCH services, IMCI, preventive services, outreach, as well as communication and support for public health activities in communities: • It is the parent ministry for TFNC and responsible for TFNC Board, plans and budgets • It is responsible for formulating policies, strategic plans, regulations and legislation, and develops guidelines to facilitate implementation of nutrition interventions. • It oversees preventive services, national and referral hospitals, procurement and distribution of equipment, drugs and supplies, donor coordination, the overall health budget, human resources planning and quality assurance at all levels • The Ministry chairs several consultative committees (listed under the TWG section) • It parents the Medical Stores Department through which drugs and medical supplies are provided, including those needed for control of micronutrient deficiencies and curative services of health facilities.
The sectoral ministries	The sector ministries that have staff deployed up to the community level, have responsibilities of ensuring that nutrition concerns are incorporated into their policies and programs, as related to the sector's needs. The Sectoral ministries that have nutrition concerns include: - Regional administration and local government: The offices of the Regional Administrative Secretaries interpret and adapt national policies to regional realities and monitor their implementation in districts interpret and adapt national policies to regional realities, and monitor their implementation in districts. The local Government Authorities (LGAs) are responsible for the delivery of public services which affect nutritional outcomes. They are responsible for implementation of nutrition services, which start with prioritising, plan and allocation of budget for nutrition interventions in line with NNS. They are also responsible for establishing and ensuring proper function of the Council Multisectoral Nutrition Steering Committee, which is chaired by the District Executive Director and has full inclusion of all stakeholders, including representatives of relevant departments, civil society organizations, private sector and religious groups. LGAs are also responsible to ensure that Regional and district nutrition officers are being recruited and nutrition training is being provided at district level. - Community development, gender and children: plays a crucial role in mobilizing the community and promoting key actions and behaviours that are important for good nutrition. It has responsibility for training community development workers who are subsequently employed by local authorities. The Community Development department works in partnership with community members, community groups, CSOs and other players to assist the community in addressing it's identified needs and therefore provides strong support for community work to prevent malnutrition. The department

Players in nutrition sector	Description
	also addresses the gender dimension of malnutrition through actions to improve girl's education and women's literacy, the involvement of women in socio-political decision making, strengthening of livelihood skills of women and male involvement in maternal and child health. - Education and Vocational Training; which approves the curriculum of primary schools and the certification of teachers has a role to play in ensuring that it has Policies that promote strong linkages between nutrition and education to advance overall efforts to improve nutrition outcomes. It is responsible to ensure that children are well nourished so that they are able to concentrate and learn better at school and improving their attendance. In addition this sector is responsible to ensure that a girl child is well educated, as evidences show that there is a strong link between the level of a mother's education and her child's nutritional status. - Agriculture, livestock, fisheries and food security; has a critical role in improving the accessibility of affordable and nutritious food by households throughout the year. The Ministry has policies and strategies which aim at strengthening agricultural development, improving food security and reduce rural poverty through empowering small farmers to lift families and communities out of poverty It has also responsibility for training agricultural extension staff, which has close contacts with farmers, therefore have responsibility to relay information that will help them to improve their production and consumption of nutrient rich foods. The Ministry also has a Food Security Unit which works closely with the Disaster Preparedness Unit of the Prime Minister's Office and the managers of the Strategic Grain Reserve in times of critical national food shortages. - Water and sanitation; is responsible for the improving the delivery of services which affect nutritional outcomes. Its role is to improve infrastructures for safe and clean water, sanitary and hand-washing facilities which will reduce infections and diseases that will in turn prevent malnutrition. Improving accessibility of water will reduce women time and energy to fetch water and therefore they can spend more time caring for their children and other family members. - Industry and trade; has roles to play in regulating and promoting food fortification with vitamins and minerals, ensuring production of iodized salt and promoting grading and packaging of nutritious food products. - Planning, economy and empowerment: provide planning guidance and ensures plans and budgets are prepared; and ensures that nutrition interventions are included in the plans and budgets
The Tanzania Food and Nutrition Centre (TFNC)	TFNC is the national institution for nutrition established by the Act of Parliament No. 24 of 1973, which was later amended with the Act No 3 of 1995. It is mandated with nutrition policy formulation, planning and initiation of nutrition programmes, advocacy, advising, capacity development, harmonization, coordination, research, monitoring and evaluation of nutrition services in the country. The Centre acts on behalf of the MoHSW.
Private sector	The Private Sector has a strategic role to play in improving the well-being of Tanzanians. While the driving force of the private sector is to make profit its role is mainly focused in fortified and other nutrition-related products, public-private partnerships, social marketing, and, more broadly, in generating growth in food production, income and employment. According to NNS, "The government is committed to enhancing Public-Private Partnership (PPP) in implementing actions including nutrition"
The High Level Steering Committee for Nutrition (HLSCN)	The HLSCN is a multi-stakeholder platform, which was created following the joining of the SUN Movement in June 2011 as a Government commitment to scale up nutrition in the country. The committee is convened by the Prime Minister's Office and involves representatives of nine key ministries, development partners, UN agencies, civil society, faith based organizations,

Players in nutrition sector	Description
	academia and business. The HLSCN operates within and leverages existing government systems and dialogue mechanisms for developing cooperation which promote national ownership and enhance effectiveness. Apart from having an advisory role it is also responsible for policy making coordination, advocacy, and resource mobilization for scaling up nutrition in the country. The Committee is a structured high- level mechanism chaired by the Permanent Secretary in the Prime Minister's office and comprised of Permanent Secretaries from relevant sectors namely: - Ministry of Health and Social Welfare - Ministry of Agriculture Food Security and Cooperatives - Ministry of Education and Vocational Training - Ministry of Industries and Trade - Ministry of Finance - Ministry of Community Development Gender and Children - Ministry of Livestock Development and Fisheries - Ministry of Water - Prime Minister's Office, Regional Administration and Local Governments Other representatives include: - Development partners (USAID, Irish Aid) - United Nations agencies (UNICEF) - Civil society (local CSOs: COUNSENUTH and PANITA) - Faith Based Organizations (Tanzania Episcopal Conference and Christian Council of Tanzania) - University (Sokoine University of Agriculture) - Business (Power Foods and Bakhresa Group)
A Multi-sector Nutrition Technical Working Group	The NTWG supports the HLSCN and is chaired by the Director of the Tanzanian Food and Nutrition Centre (TFNC). The Technical Working Group (TWG) supports the major national nutrition programs in Tanzania and includes senior technical specialists from all nine line Ministries that are involved in the HLSCN. Its role is to provide technical expertise that supports the SUN Movement, including advising on policy, supporting the development of implementation guidelines and resource sourcing. There are a number of nutrition consultative groups presides over all major national nutrition programmes (based at TFNC) that reports to the TWG. The consultative groups are the steering body for the implementation of the respective programmes and play a policy advisory role to the relevant government bodies. The consultative groups are multi-sectoral and membership is institutional. Each consultative group is chaired by the relevant sector Ministry or institution with TFNC acting as the secretariat and the focal point, coordinating the rest of the group members. The consultative groups are on: - National Infant and Young Child Nutrition (IYCN) - Household Food Security - Anaemia - Vitamin A - Management of Acute Malnutrition - Social and Behaviour Change Communication (SBCC) - Nutrition Surveillance - Nutrition and HIV Working Group - Nutrition in Emergencies Working Group - National Council for Control of Iodine Deficiency Disorders - National Food Fortification Alliance
Civil Societies Organizations (CSOs)	The CSOs complement the government's efforts in addressing malnutrition. International NGOs tend to have a national focus and are well equipped technically and financially to support nutrition and related undertakings at various levels, while the local CBOs, NGOs and FBOs work at the grassroots and intermediary levels in implementing nutrition and related activities. CSOs are actively involved in the delivery of nutrition interventions while adhering to

Players in nutrition sector	Description
	national governing policies, guidelines, laws and regulations, and national standards. Their role also includes enhancing good governance and accountability of both the public and private sectors, as well as in service delivery. They play crucial role in influencing national policies to improve nutrition services and in advocating and sustaining political will for government action.
The Development Partners include the UN agencies, and multi-lateral and bilateral organizations	DPs work closely with the Government in addressing the problem of malnutrition by mobilizing resources. They provide financial, technical support in the implementation of nutrition interventions and also facilitate capacity building and support monitoring and evaluation initiatives. The institutional arrangements among the development partners which include The Joint Assistance Strategy for Tanzania (JAST) and the Sector Wide Approaches (SWAp) provide conducive to the mobilization of resources and action for nutrition. Development Partners Group on Nutrition (DPG-nutrition) strengthens development partnerships and effectiveness of development cooperation by working with the government and other stakeholders. It also enhances coordination among development partners and ensuring greater support for nutrition.

2.6 Institutional Issues

Following institutional issues are considered critical in improving function of the nutrition institutions in the country:

- The Government have re-established the Nutrition Section under the Ministry of Health and Social Welfare in 2011. The previous section was later transformed into TFNC. However, due to importance of issues of sectoral coordination, the re-establishment is considered a positive move from the Government. However, since 2011, the Government has been slow in creating a working environment for this important Section. The Section has only three staffs, a single office room with no facilities. Adequate resources are needed to make this Section function as intended. The Section has five key and critical vacant position including an M&E Expert, Regional Liaison Officer, Nutritional Experts (2 for coordination) and Medial Doctor on Nutrition. A final note is that still to create Nutrition Section is a quick and temporary solution, the Government should consider to elevate it to department level
- The Government commitment towards nutrition agenda is at high level, whereby H.E. the President appointed the Presidential Nutrition Advisor. Within his office it was established the Presidential Nutrition Advisory Committee to ensure that the agenda is seriously taken on board. It is up to the existing institutions and organs such as TFNC and HLSCN to work very closely with the Presidential Nutrition Advisory Committee in order to implement specifically on issues of sectors coordination. Nutrition has to be taken seriously with all lead sector ministries including education, industry, water, agriculture and livestock

3 Allocations and Alignment of Budget

Section three covers detail analysis of the budget allocations and alignment for a period of three years, 2010/11 to 2012/13. The section is structured into various sub-sections that addressed the study objectives and outcome expected under the terms of reference. The section include the following sub-sections:

- Budget allocations
- Budget composition
- Budget alignment
- Sources of finance
- Budget target areas.

3.1 Budget Allocations

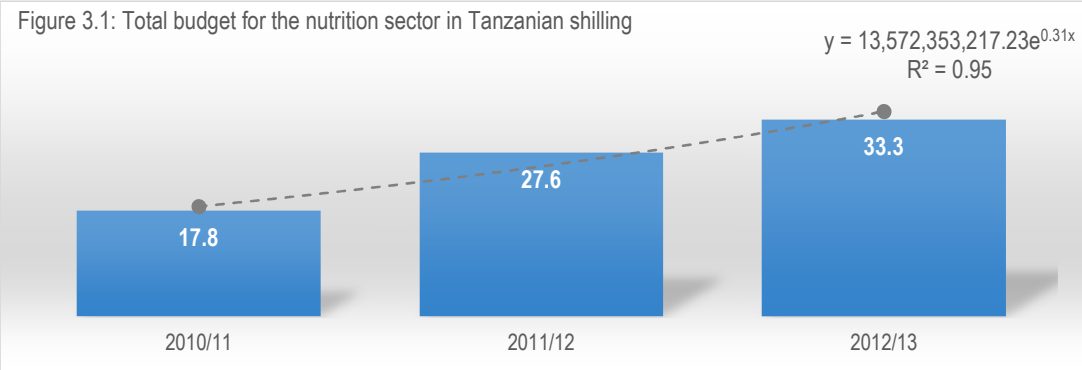
3.1.1 National Level

The national nutrition sector total budget were determined on the basis of data collated at a national level through MDAs, development partners and other organisations that are involved in nutrition programs and interventions. The national aggregate data do not include the sub-national data due to difficulties in collecting nutrition specific budget and expenditure from all the 134 local councils. Therefore, the national data excludes the LGAs data which could not be captured at a national level.

Figure 3.1 below shows the total budget allocation for a three-year period from FY 2010/11 to FY 2012/13.The total budget at a national level for the three years was **TZS 78. 6 billion** (equivalent to **USD 51.4 million**). The annual total budget allocations were TZS 17.8 billion ($ 12.5 million), TZS 27.5 billion ($ 17.6 million) and TZS 33.2billion ($ 21.3 million) in FYs 2010/11 to 2012/13 respectively.

The annual budget allocation for nutrition sector significantly increased during the three years especially after scaling-up efforts through national nutrition strategy and strengthening of the Government nutrition agenda in FY 2011/12, and thereafter. Over a three-year period, the budget allocation grew at a rate[2]of 31% per annum, with a big jump between 2010/11 and 2011/12 (55%), while increase between 2011/12 and 2012/13 was 21% per annum. The Government and international community efforts to improve the nutrition status in the country could be attributed to this increase in the budget allocation.

Figure 3.1: Total budget for the nutrition sector in Tanzanian shilling



[2]Based on exponential cumulative average growth rate (ECAGR)

3.1.2 Sub-national Level

Nutrition data were collated from a sample of 15 selected local government authorities visited by the national nutrition PER team. The budget data were extracted from the councils' annual medium term expenditure frameworks (MTEFs) submitted to the Government. Due to lack of District Nutrition Sector Annual Plans or Strategic Plans, the national nutrition PER team had to review each of the MTEF and extract the nutrition interventions with their respective budget one by one. Some of the LGAs provided their budget estimates in softcopy using PlanRep. At the end of exercise, nutrition interventions were extracted for 14 Councils as reported on **Table 3.1** below[3].

Total nutrition sector budget for the three years for the 14 Councils was **TZS 2.48 billion**, with an average of TZS 59.2 million per council per annum. The Councils nutrition budget data showed fluctuating patterns among the Councils as well as within each Council from one year to the other. Some of the Councils, for example Kigoma District Council, Kishapu District Council, Iringa District Council and Morogoro District Council sets of the budget data for the complete three years could not be obtained. The comparisons of the Councils total nutrition resources allocation into nutrition activities relative to total budget for three years shows a very small proportions among the 14 Councils. The average proportion was 0.3% of the total budget over the three years with six Councils out of 14 were having proportions below the average (**Table 3.1**).

Table 3.1: Comparison of Councils budget and nutrition resources allocation over the three years

	Nutrition	Total Budget	%Total
BABATI TC	190,680,327	39,709,490,084	0.5%
IRINGA DC	79,338,000	95,853,820,963	0.1%
KIGOMA DC	109,656,000	72,894,790,298	0.2%
KISHAPU DC	16,873,480	66,075,504,569	0.0%
KONGWA DC	302,925,642	53,829,358,679	0.6%
LINDI DC	217,121,600	48,352,455,109	0.4%
MAKETE DC	306,873,500	39,296,963,669	0.8%
MBEYA MC	329,518,700	143,130,857,767	0.2%
MOROGORO DC	43,449,016	72,728,601,255	0.1%
MPWAPWA DC	302,675,237	41,620,355,295	0.7%
MTWARA MC	97,429,700	28,286,237,428	0.3%
MUHEZA DC	162,919,835	48,352,001,411	0.3%
PANGANI DC	73,763,000	13,037,373,366	0.6%
RUANGWA DC	254,566,372	32,582,511,579	0.8%
Grand Total	**2,487,790,409**	**795,750,321,472**	**0.3%**

Issues found regarding the budget allocation for the nutrition interventions at councils:

- Nutrition interventions and budget from the Councils showed that the data were independent from the national budget (no double counting), hence aggregate figures from the LGAs could reasonably be added into the national data to obtain the national total budget and expenditure on nutrition sector. However, since the PER study has only covered 15 LGAs, the total budget for nutrition sector intervention in all the LGAs cannot be established
- Patterns of budget allocation showed that the councils were not consistent in identifying and prioritising nutrition interventions in their respective areas during the past three years. Resource

[3]Interventions at councils were those identified and related to nutrition interventions not necessarily those which have direct or immediate impact to the nutrition status of the population targeted. The definition used was that found on the Guideline for Councils for the Preparation of Plan and Budget for Nutrition, Prime Minister's Office (October 2012)

allocation were mainly ad hoc and targeting those which were driven from the centre such as support of Vitamin A and deworming campaigns.

3.1.3 Budget adequacy

Increasing economic growth alone is rarely sufficient to address undernutrition especially if the level of resources allocated to address nutritional problems are inadequate and insufficient. The questions of how much is adequate at national, sub-national or even household level is relative based on expected outcomes, inputs in terms of services and materials needed to address the problem. Nutrition as a "sector" on its own does not have a system that can track all of its resources at a go, hence the PER was used to establish the level of funding at national and sub-national levels. However, the absolute figures of budget allocation or expenditure alone cannot tell whether the resources provided were adequate or not. One of the common approach in determining relativity of the resources in an economy or society is benchmarking. In this nutrition sector PER study, the allocated resources were compared to the national Gross Domestic Product (GDP) and Total Government Expenditure Budget (TGEB) during the three years.

Tanzania continues to do well in maintaining overall macroeconomic stability – which, along with institutional and policy reforms, has been a fundamental factor behind the strong economic growth rates. The GDP grew from TZS 37.5 trillion in FY 2010/11 to TZS 53.2 trillion in FY 2012/13[4]. The growth in GDP measured by ECAGR[5] was 17% per annum during the three years. Nutrition sector budget allocations proportions to the GDP were 0.05% in FY 2010/11, 0.06% in FY 2011/12 and 0.06% in FY 2012/13.

The total government budget and expenditure were also growing at significant rates between 2010/11 and 2012/13. The total Government expenditure budget was TZS 11.6 trillion in 2010/11, TZS 13.5 trillion in 2011/12 and TZS 15.1 trillion in 2012/13. The growth in Total Government Expenditure Budget measured by ECAGR[6] was 13% per annum during the three years. Nutrition sector budget allocations proportions to the TGEB were 0.15% in FY 2010/11, 0.20% in FY 2011/12 and 0.22% in FY 2012/13.

Figure 3.2 below compares the budget allocation on nutrition against the NNS resources estimates for periods 2011/12 and 2012/13. While the NNS implementation was estimated to spend TZS 118.9 billion and TZS 145 billion in 2011/12 and 2012/13, the actual resources allocation at national level was only 23.1% and 22.9% respectively. Clearly this is inadequate funding of the nutrition sector, and low level of implementation for the national nutritional strategy implementation plan 2011-2016.

Figure 3.2: NNS resources estimates and nutrition sector allocation (TZS billion)

[4]Projected based on FY 2011/12 GDP TZS 44.7 trillion and same nominal growth rate of past year at 19%

[5]ECAGR = Exponential Cumulative Average Growth Rate, calculated on nominal money value

[6]ECAGR = Exponential Cumulative Average Growth Rate, calculated on nominal money value

3.2 Budget Composition

3.2.1 Implementing agents

The nutrition sector implementing agents were classified under four categories, namely Ministries, Civil Society Organisations, Agencies and Donors[7]. **Figure 3.3** below summarises the total budget allocation for the three years of each implementing categories. The largest implementing group was Civil Society Organisations (CSOs) which accounted for 44.7% of budget allocation on nutrition interventions for the three years. Agencies, mainly TFNC accounted for about 29.2%, while Ministries 13.3% and DPs 12.8%. DPs reported on budget allocation were those that actually undertook the activities themselves or transferred funds to sub-national implementing units which were not included in the national database. It would also be important to note that most of the funds that CSOs spent largely came from DPs.

Figure 3.3: Budget allocation by implementing agents

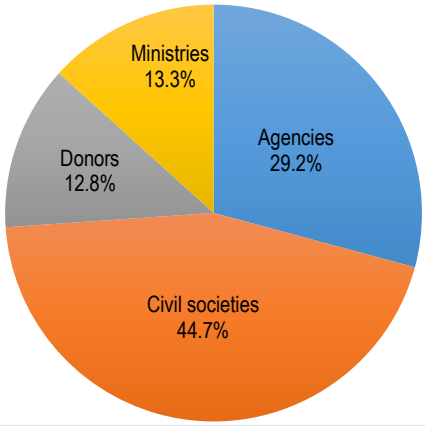


Table 3.2: Proportions of Budget allocation

	Community	National
Agencies	0.0%	100.0%
Civil societies	69.3%	30.7%
Donors/DPs	69.7%	30.3%
Ministries	68.1%	31.9%
Grand Total	**48.9%**	**51.1%**

In terms of coverage, with exception of the agencies, other nutrition implementing organs directed the budget allocations to their preferred community areas and are not for the entire country. Total budget allocation for the community based was 48.9%, while that of the national was 51.1% during a three-year period (**Table 3.2**). It should be noted here agencies are supposed to include all Government independent units such as TFDA, TFNC, TBS, Ifakara Health Research Institute and others in connection to nutrition interventions

The patterns of budget allocation year-to-year was not significantly different to a three-year aggregate shown above, except for the Donors where allocation changed significantly favouring national interventions (80%) compare to community interventions (20%) during the FY 2012/13.

[7] Although donors are under normal circumstances not implementing agents, these are donors that undertook the activities themselves directly or transferred funds to sub-national implementing units and were not included in the national database.

3.2.2 Expenditure Type

Seven components of the nutrition sector PER were developed to analyse the resources allocation and expenditure during the three-year period. Patterns of resources allocation in terms of PER components were similar between national level and sub-national level as shown on **Table 3.3** below.

At national level, 44% of resources were allocated to provide technical capacity of the nutrition institutions and service providers during the three-years. In addition, resources were allocated for equipment and supplies 21.7%, service provision 18.5% and monitoring and evaluation 9.3%. The least allocated components at national level were advocacy (1.6%), coordination (2.2%) and behavioural change communication (2.5%). The budget allocation at the national level showed un-balance resources allocation given the critical importance of components such as public communication for behavioural change and level of equipment and supplies. The large resources allocation into technical capacity and service provision calls for rationalisation of the resources through national coordination and pooling of resources towards national priorities and interventions.

At sub-national level, resources were allocated mostly to service provision (55.8%), equipment and supplies (24.6%) and technical capacity (12.5%). The least allocated components at sub-national level were advocacy (0.2%) and coordination (0.2%).

Table 3.3: Budget allocation by components

	National	Sub-national
Advocacy	1.6%	0.2%
Behaviour change communication	2.5%	3.9%
Coordination	2.2%	0.2%
Equipment and supplies	21.7%	24.6%
Monitoring and evaluation	9.3%	3.0%
Service provision	18.5%	55.8%
Technical capacity for nutrition	44.1%	12.5%
Grand Total	**100.0%**	**100.0%**

Table 3.4 below shows budget allocation by expenditure type on capital (assets acquisition), goods and services, personnel costs and transfers to other implementing units. Ministries have large transfers' fund due to the fact that MoHSW include in its annual budget (MTEFs) aggregate estimates for the TFNC for the Government resources. Agencies showed large personnel costs (66.7%) possibly because TFNC has a full-fledged staff dedicated to address nutrition matters in the country. The figures for the personnel costs under the Ministries and the Councils were mainly representing a number of payroll related allowances including extra duty and sitting allowances. The data analysis showed that there was no funds allocated by the Councils to other lower level implementing units such as wards and wards or cash transfers to household as safety net for nutritious food on most vulnerable groups in their respective areas.

Table 3.4: Composition of budget allocation by type

	Agencies	Ministries	Councils
Capital spending	8.6%	3.6%	20.1%
Goods and services	24.7%	35.2%	65.3%
Personnel Costs	66.7%	2.2%	14.6%
Transfers	0.0%	59.0%	0.0%
Grand Total	**100.0%**	**100.0%**	**100.0%**

The nutrition data which were extracted from the MTEFs provided avenue for detailed lower level analysis to determine which actual resources were allocated for each intervention or activity budgeted. The institutions which provided their annual MTEFs include the Ministries, TFNC and Councils. Summary of the specific budget inputs are provided below:

- **Ministries**: The six ministries included in the nutrition sector had a total budget of TZS 12.6 billion during the three years, out of which 57.6% was the MoHSW transfers to TFNC. The only budget input with significant resource allocation was specific food (diet) for PLHIV which accounted for 23.3%. The rest of the budget inputs were less than 2%. This indicates that there was no adequate resources allocated by the Ministries for the nutrition sector with the exception of the MoHSW. Furthermore, MoHSW have a number of health services interventions which were combined with nutrition interventions and become difficult to disentangle out of the existing MTEFs format
- **TFNC**: Three years budget from MTEFs was TZS 12.6 billion. Decomposition of the TFNC three years budget showed that inputs which were allocated high resources were basic salaries (61.3%), Per Diem (5.4%) and public buildings (7.5%). Therefore, with only three budget inputs, TFNC have allocated more than 74% and left only 26% for other activities including specific nutrition sector interventions. The analysis of TFNC budget clearly shows that the Government resources which were allocated through national budget system were to maintain TFNC's operational capacity and not to provide direct services to the public. There were other funds that were availed to TFNC by a number of donors through nutrition programs which were not captured in MTEFs
- **Councils**: Nutrition budget extracted from 15Councils was total to TZS 2.4 billion over the three years. Decomposition of the Councils three years budget showed that inputs which were allocated highest resources was extra duty allowance (13.3%), Per Diem (12.5%), Livestock (10%) and diesel (8.9%). Among the least resources allocation were on Vitamin A (0.026%) and deworming tablets (0.1%).

3.2.3 Target beneficiaries

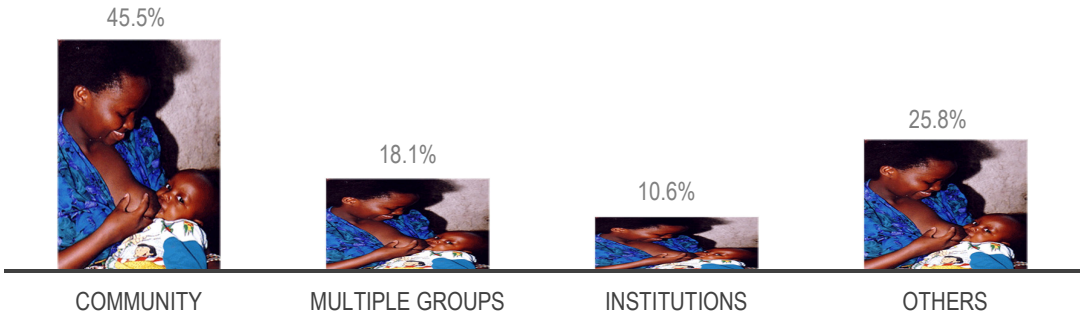
Analysis was carried out on final target beneficiaries to whom the resources allocation were targeting during a three-year period at a national level (**Table 3.5** below). Most of the resources (27.4%) were targeting institutional capacity in term of administration, programs management and capacity building. Other target groups with significant resource allocation (above 10%) were children under five (24.1%), service providers[8] (21.3%) and communities (12.1%). The analysis showed that most critical groups including children under two, pregnant women, women of birth bearing age and children of school age were marginalised on resources allocation.

Table 3.5: National budget allocation by target beneficiaries

	Total Budget	% Total Budget
Children school age	69,464,640	0.1%
Children under 2	259,292,000	0.3%
Children under 5	18,921,961,524	24.1%
Community	9,498,486,537	12.1%
Household	758,594,690	1.0%
Institutions	21,550,216,557	27.4%
Multiple groups	4,203,763,995	5.3%
Other adults	405,964,944	0.5%
Pregnant women	248,804,943	0.3%
Public	5,843,670,255	7.4%
Women 19-45	149,855,000	0.2%
Service Providers	16,718,883,829	21.3%
Grand Total	**78,628,958,914**	**100.0%**

Comparison with sub-national level was done using the local council budget allocation during the three years. The results (**Figure 3.4**) showed that at sub-national level more resources were allocated to communities (45.5%), institutions (10.6%) and multiple groups (18.1%). Similar to national level resources allocation, marginalised groups at local councils were children under two, pregnant women, women of birth bearing age and children of school age. Safety nets and cash transfers to vulnerable groups at household level could not be found in both national and sub-national levels. Safety nets and cash transfers are important interventions for helping poor families afford nutritious meals for their children, pregnant women and others.

Figure 3.4: Sub-national budget allocation by target beneficiaries



[8]Service providers include care providers, service delivery units such as health centres, dispensaries and staff

3.3 Budget Alignment

The budget allocation into nutrition sector programs and interventions were expected to be aligned with the national priorities and strategies as identified and developed into the NNS. The NNS has identified and documented eight priorities which are expected to be followed by implementing agents in their resources allocation and spending. In addition, the NNS propounded the national priorities into eight strategies to implement the NNS. However, it should be noted that the NNS was prepared during the period starting 2011/12, while this PER also covers one year before NNS was launched i.e. FY 2010/11. Therefore, the alignment of resources allocation was based on aggregated data for the three years i.e. FY 2010/11 to FY 2012/12. The paragraphs below summarise the results of data analysis based on resources allocation in relation to specific priorities and strategies of the NNS.

3.3.1 Alignment on Priorities

Table 3.6 below summarise results of data analysis on nutrition sector budget allocation at national and sub-national on the basis of nutritional priorities as established in the NNS. The patters showed different levels of allocations among the priorities between national and sub-national levels (***statistical correlation of -0.16***). While national resources allocation favoured nutrition surveillance (27.1%) and vitamin and mineral deficiencies (26.9%), the subnational allocations favoured household food security (42.2%) and vitamin and mineral deficiencies (18.6%). However, it was observed that at national level significant resources were allocated into interventions which were not classified into either of the eight nutritional priorities. These interventions and programs costs were aggregated into "Non-prioritised interventions". Large allocation into household food security at local councils resulted from inclusion of a large number of interventions under agriculture and livestock sectors which targeted achieving food security.

Table 3.6: Alignment of budget allocation and national priorities

	National	Sub-national
Child, Women and Households in Difficult Circumstances	4.9%	4.7%
Diet-Related Non-Communicable Diseases	0.1%	12.0%
Household Food Security	5.2%	42.2%
Infant and Young Child Feeding	0.6%	3.7%
Maternal and Child Malnutrition	11.7%	9.1%
Non-prioritised Intervention	20.9%	0.0%
Nutrition and HIV/AIDS	2.7%	7.8%
Nutrition Surveillance, Surveys and Information Management	27.1%	1.9%
Vitamin and Mineral Deficiencies	26.9%	18.6%
Grand Total	**100.0%**	**100.0%**

3.3.2 Alignment on strategies

Table 3.7 below summarise results of data analysis on nutrition sector budget allocation at national and sub-national on the basis of strategies documented in the NNS. The budget patterns show similar levels of allocations among the priorities between national and sub-national levels (***statistical correlation of 0.79***). The national resources allocation was significant to accessing quality nutrition services41.9% and 80% for national and sub-national levels. The other significant strategy allocated adequate resources was institutional and technical capacity whereby national level was 37.7%, and sub-national level was 12.1%.

Table 3.7: Alignment of budget allocation and national strategies

	National	Sub-national
Accessing Quality Nutrition Services	41.9%	80.0%
Advocacy and Behaviours Change Communication	3.6%	3.6%
Coordination and Partnerships	5.6%	0.2%
Institutional and Technical Capacity for Nutrition	37.7%	12.1%
Legislation for a Supportive Environment	0.5%	0.0%
Mainstreaming Nutrition into National and Sectoral Policies, Plans and Programs	0.8%	0.0%
Research, Monitoring and Evaluation	9.2%	3.2%
Resource Mobilisation	0.7%	0.9%
Grand Total	**100.0%**	**100.0%**

Table 3.8 below shows the summary of the Tanzania National Nutrition Strategy Implementation Plan (211-2016) with a total nutrition investment cost of TZS 823.9 billion over a five-year period. Comparison of Tables 3.7 and 3.8 showed non alignment of the resources allocation to the national strategies as outlined in the implementation plan 2011-2016. For example, the NNS implementation plan estimated only 3% of resources to be spent on institutional and technical capacity, however it was 37.7% and 12.1% to national and sub-national levels. At national level the first strategy on assessing quality nutritional services was highly and significantly deviated to the implementation plan.i.e.41.9% versus 81%.

Table 3.8: Resources allocation under the NNS Implementation Plan

	Amount (TZS bn)	% Total
Accessing Quality Nutrition Services	666.2	81%
Advocacy and Behaviours Change Communication	29.4	4%
Coordination and Partnerships	36.1	4%
Institutional and Technical Capacity for Nutrition	21.3	3%
Legislation for a Supportive Environment	19.1	2%
Mainstreaming Nutrition into National and Sectoral Policies, Plans and Programs	13.6	2%
Research, Monitoring and Evaluation	23.9	3%
Resource Mobilisation	14.3	2%
Grand Total	**823.9**	**100%**

Comparison was made on resources alignment between NNS implementation plan and the nutrition sector allocation during the two years of implementation i.e. 2011/12 and 2012/13. **Table 3.9** below summarise the common-size comparison by strategies. The results showed significant non-alignment of resources allocation with national strategies during the first two years of implementation of NNS.

Table 3.9: Resources alignment with strategies

	NNS Plan %		Nutrition Allocation %	
Strategies	2011/12	2012/13	2011/12	2012/13
Accessing Quality Nutrition Services	82%	80%	42%	34%
Advocacy and Behaviours Change Communication	4%	4%	3%	4%
Coordination and Partnerships	3%	2%	0%	0%
Institutional and Technical Capacity for Nutrition	1%	1%	0%	2%
Legislation for a Supportive Environment	3%	3%	48%	37%
Mainstreaming Nutrition into National and Sectoral Policies, Plans and Programs	2%	2%	0%	2%
Research, Monitoring and Evaluation	0%	3%	4%	17%
Resource Mobilisation	5%	5%	3%	5%
Grand Total	**100%**	**100%**	**100%**	**100%**

3.4 Sources of Finance

3.4.1 Who funded?

The analysis of nutrition data at national level indicated that there were 35 various sources of funding nutrition during the three-year period; they committed resources of TZS 78.6 billion for the sector. The aggregate budget allocation for the three years were funded 77.7% by the DPs (Donors) and 22.3% GoT (**Figure 3.5**).

Figure 3.5: Proportion of aggregate funding for three years

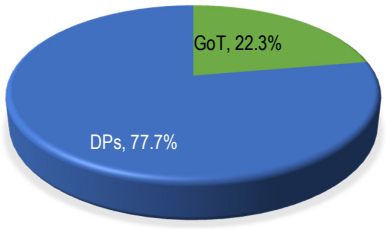
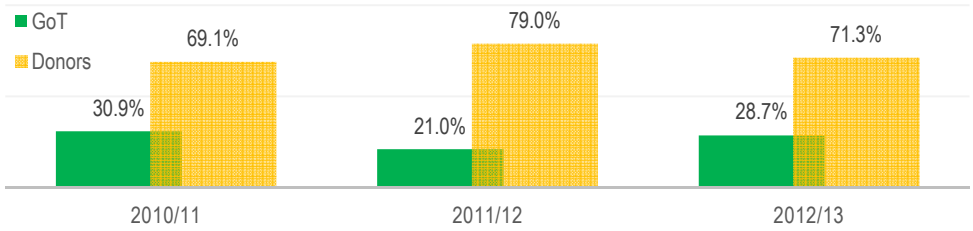


Figure 3.6 below shows the proportions of funds between the Government (GoT) and DPs for each of the three years. There was slight variation on proportions of funding between DPs and GoT in each year, however in all three years DPs proportions were higher than the GoT.

Figure 3.6: Proportions of resources allocation GoT and DPs



3.4.2 Who funded what?

Analysing the budget allocation by national priority and funds committed by the DPs and Government shown on **Table 3.12** below. Donors funded mostly Vitamin and Mineral Deficiencies (34.5%), Nutrition surveillance, survey and information management (33%) and maternal and child nutrition (15.1%). The GoT funded mostly child, women and household in difficulties (21.2%) and household food security (12%). The GoT funded significant resources into interventions that could not be classified under any of the national priorities, hence accounted as non-prioritised intervention (57.6%) compared only to 10.3% by the DPs.

Table 3.12: Proportions of funding sources by national priorities

	DPs	Government
Child, Women and Households in Difficult Circumstances	0.2%	21.2%
Diet-Related Non-Communicable Diseases	0.1%	0.1%
Household Food Security	3.2%	12.0%
Infant and Young Child Feeding	0.7%	0.1%
Maternal and Child Malnutrition	15.1%	0.0%
Non-prioritised Intervention	10.3%	57.6%
Nutrition and HIV/AIDS	2.8%	2.3%
Nutrition Surveillance, Surveys and Information Management	33.0%	6.5%
Vitamin and Mineral Deficiencies	34.5%	0.2%
Grand Total	**100.0%**	**100.0%**

3.4.3 Councils resources

Councils in the country received funds through a number of channels from the Government, Development Partners and also generate finance from their own local sources. Generally, the own local sources accounted for a small proportions of the total funds disposed to the LGAs to function in any particular year. **Table 3.13** below shows the composition of the sources of funds which were used to budget for the nutrition interventions during the three years. Most of the funds were from basket funds which accounted for 62.9%, followed by block grants (recurrent budget on Other Charges) at 28.8%. Among the basket funds which were used to allocate funds for nutrition interventions included Health Sector Basket Fund and Agriculture Sector Development Fund.

Councils' own sources of fund which were allocated for the nutrition interventions was only 1.5%. During the three years, the 15 selected councils own revenue was reported at TZS 69.2 billion, hence the nutrition allocation from it was merely a 0.05%. This indicated that the Councils do not allocate adequate own sources into implementing nutrition interventions in their own areas. Even during interviews with LGA management and Council leaders, nutrition awareness was low and particularly nutrition budgeting using own source was completely not evident or even considered.

Table 3.13: Composition of the sources of funds for nutrition interventions inLGAs

	Total	% Total
Basket Fund	1,563,894,894	62.9%
Block Grant	715,816,515	28.8%
Council Fund	37,481,000	1.5%
Other Fund	170,598,000	6.9%
Grand Total	**2,487,790,409**	**100.0%**

3.4.4 Top Donors

There were 35 Donors who funded the nutrition interventions during the three years either directly or indirectly through implementing agencies. The top five Donors were USAID, ONE UN FUND, Harvard School of Public Health, UNICEF and Irish Aid in that order. However, analysis results were based on linking each activity with a unique Donor and not decomposing resources channelled through basket funds or transferred to a final Donor. For example, the program "Rural Food Fortification Program" was implemented by the Ministry of Health and Social Welfare and other agencies, was funded by the Japanese Social Development Fund (JSDF) through World Bank (IDA Grant), hence it was classified under the World Bank and not JSDF.

Table 3.14: Five Top Donors Funding Nutrition

	% Total Budget	Rank
USAID	22.9%	1
ONE UN FUND	8.9%	2
Harvard School of Public Health	7.7%	3
UNICEF	5.7%	4
Irish Aid	5.2%	5

3.5 Budget Target Areas

There is disparity on the level of nutrition status by regions and districts in Tanzania as reported in a recent TDHS 2010 as well as the previous other studies. Therefore, it is logical to expect that resources allocation will target areas by demand and need of nutrition services in order to address the situation. However, data collected from implementing agencies and donors were mostly in aggregate form in quantum as well as intervention areas. For example, a program just reported that it provided nutrition intervention to two or more regions or district without breaking it down and therefore making it difficult to assess equity in resources distribution by areas. Two examples are presented below to show the high level assessment of equity in resources location at national and sub-national levels.

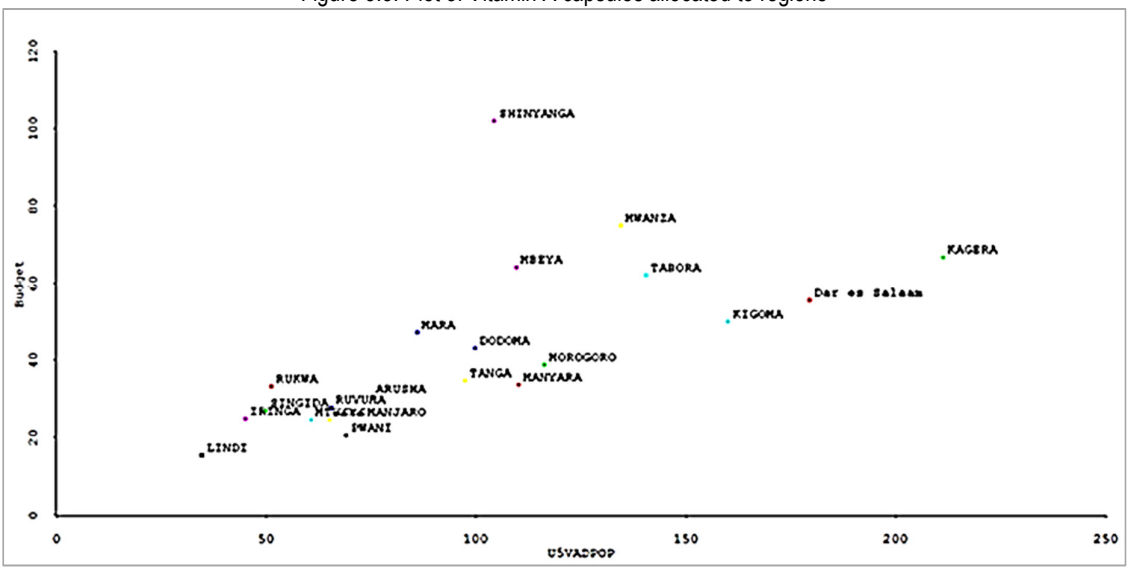
3.5.1 Distribution of Vitamin A

UNICEF fund the purchase and distribution of Vitamin A and deworming tablet to all districts in the country. The data collected from 2010/11 to 2012/13 showed that, UNICEF allocated USD 300,000 to Vitamin A capsules and similar amount to Mebendazole (deworming) tablets every year. Vitamin A capsules were targeting children between 6 to 59 months (Under 5). The amount allocated differed by regions and districts, however, the same level of resources were allocated consistently (fixed) for the three years.

The analysis was undertaken to determine equity distribution of the Vitamin A capsules on the basis of demand as reported by the level of Vitamin A deficiencies in the regions in the country. As the data on VAD was on regional level, the resources per districts were aggregated into their respective regions and correlated by the respective VADs. A high positive correlation (**0.72**) found when the amount of Vitamin A capsules allocated to regions were compared against the children under 5 population. However, when the children under 5 population was deflated by the VAD rate, the correlation went down to **0.66**. The high correlation was also confirmed by the regression analysis which showed that the coefficient of VAD population was significant (**t-value=3.784** and **R^2=0.43**). This clearly confirmed that the formula used by the Ministry of Health and Social Welfare together with UNICEF incorporate variables related to children population.

Figure 3.8 below was used to analyse the distribution of Vitamin A capsules resources allocated to the regions during the three years. Generally the trend showed that there was fair distribution of the Vitamin A capsules to the regions. However, the data showed also marked unequal distribution (outliers) to some few regions, for example Shinyanga was allocated un-proportionately more resources than Mbeya, Morogoro and Manyara. Also Mwanza region resources allocation was un-proportionately more than Kigoma, Dar es Salaam and Kagera.

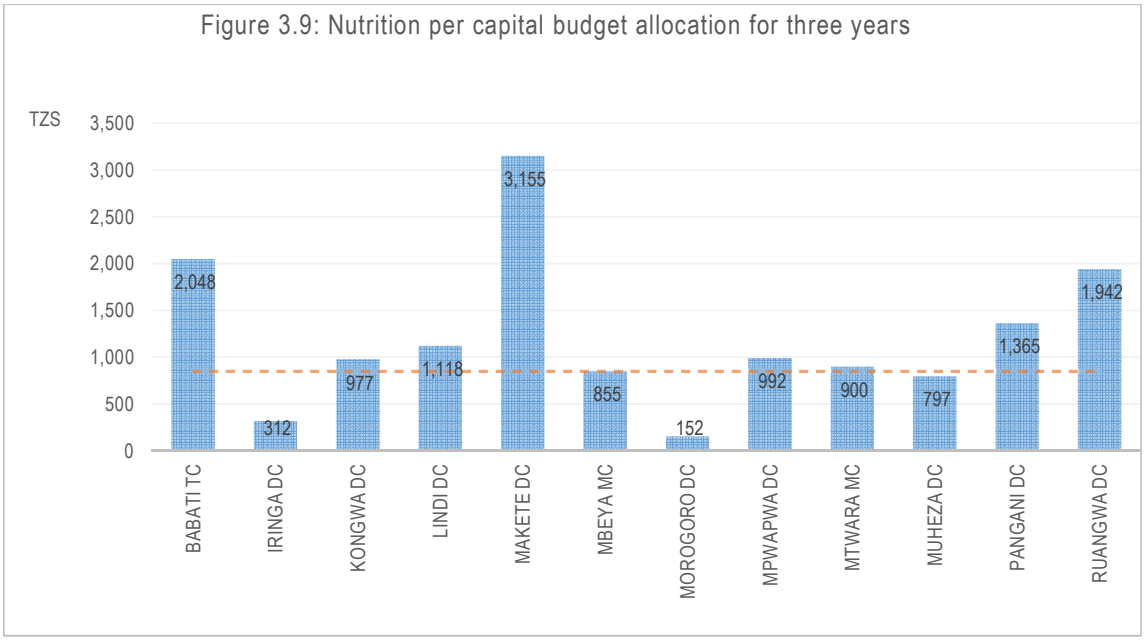
Figure 3.8: Plot of Vitamin A capsules allocated to regions



3.5.2 Disparities in allocation

Analysis was conducted to 12 selected LGA as shown on **Figure 3.9** below in terms of the three years budget allocation relative to total population of the district[9]. The results showed a very high level of variations among the councils, with a very small average of TZS 856 per capita and a high standard deviation of TZS 824, thus leading to a high coefficient of variation of 0.96. The highest per capital budget allocation was that in Makete District Council at TZS 3,155 (**equivalent to USD 1.97**) for a period of three years. Four Councils had per capita budget allocation below the average, these include Iringa District Council, Mbeya Municipal Council, Morogoro District Council and Muheza District Council.

Figure 3.9: Nutrition per capital budget allocation for three years



[9]Population based on censor results of 2012

4 Planning and Execution of Nutrition Interventions

This section covers the review of the planning and execution in relation to the nutrition sector in the country.The Government budget is an important instrument for implementation of policy decisions by the Government to achieve social, economic and political ends. The formulation of the budget requires a series of processes linked to a chain of interventions and legal and regulatory mechanisms that involve a number of players and stakeholders. Since the budget is a public instrument, it is based on a legal framework which gives it the necessary mandate. The budget formulation and process is thus a legalized and formalized work cycle of preparing budget estimates, authorization, implementation, control and accounting.

The section starts with assessing planning and budgeting process at national and sub-national levels as well as implementing agents, including Donors and Civil Society Organisations (CSOs). The section also provides analytical comparison of the budget allocation versus the actual expenditure on nutrition interventions. Finally, the section provides an assessment of practical situation on nutrition planning and execution of the nutrition interventions on the ground through, facts found, views and opinion of various stakeholders consulted during the study. The section is structured under the following sub-sections:

- Planning process
- Budgeting process
- Budget execution
- Situational analysis
- Constraints and challenges

4.1 Planning Process

National planning and budgeting framework is well constituted in legislations, guidelines as well as national Medium Term Expenditure Framework (MTEFs). The planning processes, procedures and guidelines embedded into the MTEFs are well known and applied by MDAs as well as LGAS in the country in a uniform and consistent manner. Nutrition information gathering and assessment was much easily done through the on-budget interventions rather than on off-budget ones in MDAs, LGAs and CSOs. This sub-section presents the planning and budgeting process at both national and sub-national levels.

4.1.1 National Level Planning

Planning matters. It is during the planning process that strategic decisions are made concerning problems to address and means by which service delivery can be improved. This impacts crucially on the day-to-day lives of the average citizen. Given this, there should be a strong focus on consulting with beneficiary groups and ensuring responsiveness to their needs. Taking this into consideration, the planning process in Tanzania contains seven key steps. These include:

- Situation Analysis
- Strategic Plans
- Budgeting
- Action Planning

- Implementation
- Monitoring and Evaluation
- Reporting.

Planning process for the nutrition sector is not different to other sectors, hence guided by the same process, policies and legislations. The Public Finance Act of 2001(as amended in year 2004) is a legal instrument which provides the legal framework for the budget system with regard to revenue, expenditure control and accountability. The planning and budgeting process involves a number of ongoing activities in a circle throughout the year. It starts with macro-economic policies and objectives, setting revenues and expenditure ceilings, approval and its execution. Planning and budgeting at the national level is guided by the Government directives and policies as culminated into the annual budget guidelines issued by the Ministry of Finance (MoF) annually. The budget guidelines are to be used by the Ministries, Departments and Agencies (MDAs), Regional Secretariats (RSs) and Local Government Authorities (LGAs) in preparing well informed medium term plans and budgets.

The Ministry of Finance (MoF) in collaboration with the President's Office, Planning Commission (PO-PC), normally prepares the planning and budgeting guideline in time and disseminate it widely including uploading it into various national websites. **Table 4.1** below highlights the key issues on the national planning and budgeting guidelines issued during the last five years, in relation to the nutrition sector.

Table 4.1: National planning and budgeting guidelines

	Description	Nutrition Directives
2010/11	This planning and budgeting guideline for FY 2010/11 was issued by the Ministry of Finance in February 2010. The timing of the issue was on planning and budgeting calendar which was between March and May and submission to the national Parliament in June each year	There were few mentions on 'nutrition' in the document but with no specific directives on planning and budgeting. Nutrition was mentioned occasionally in the document with reference to the Health Sector and HIV and AIDS agenda.
2011/12	The planning and budgeting guideline for FY 2011/12 was issued by the Ministry of Finance in March 2011. The timing followed the past planning and budgeting timeline	There were few mentions on 'nutrition' in the document but with no specific directives on planning and budgeting. Nutrition was mentioned occasionally in the document with reference to the Health Sector and HIV and AIDS agenda. Basically, in relation to nutrition sector, there was no difference between the 2011/12 and the 2010/11 budget guidelines.
2012/13	The planning budgeting guideline for FY 2012/13 was issued jointly by the Ministry of Finance and the President's Office, Planning Commission in February 2012	This became the first guideline to include nutrition as a priority sector for planning and budgeting. There was detailed instructions to the LGAs on planning and budgeting for nutrition. Pending specific grant for nutrition, LGAs were instructed to allocate sector specific Block Grant, General Purpose Grant, Basket Funds, local own source revenues and other relevant development grants to locally prioritised interventions in line with the NNS. Specifically, LGAs were instructed to: • Ensure Council Multi-Sectoral Nutrition Steering Committee were functional and submit periodic reports to PMO-RALG • Allocate resources for nutrition within all key sectors including health, agriculture, livestock, education and community development • Recruit a Nutrition Officer at district level
2013/14	The planning budgeting guideline for FY 2013/14 was issued jointly by the Ministry of Finance and the President's Office, Planning Commission in December 2012. The Government changed the planning	MDAs, RSs, and LGAs implementing nutrition interventions were instructed to allocate resources in line with National Nutrition Strategy and **submit quarterly performance reports to Prime Minister's Office (PMO)**. On the other hand, LGAs should ensure a functioning Council Multi-Sectoral Nutrition Steering Committee and submit quarterly performance reports to PMO-RALG for consolidation. Furthermore, LGAs in

Table 4.1: National planning and budgeting guidelines

	Description	Nutrition Directives
	and budgeting timeline, hence the guideline was issued early comparing with other years.	collaboration with communities were instructed to prepare and implement a comprehensive nutrition program which will enable provision of school meals to all students in day primary and secondary schools.
2014/15	The planning budgeting guideline for FY 2014/15 was issued jointly by the Ministry of Finance and the President's Office, Planning Commission in October 2013	MDAs, RSs, and LGAs implementing nutrition interventions have been instructed to allocate resources in line with National Nutrition Strategy and submit quarterly performance reports to Prime Minister's Office (PMO). On the other hand, LGAs should ensure a functioning Council Multi-Sectoral Nutrition Steering Committee and submit quarterly performance reports to PMO-RALG for consolidation. Furthermore, LGAs in collaboration with communities were instructed to prepare and implement a comprehensive nutrition programs which will enable provision of school meals to all students in day primary and secondary schools

4.1.2 Sub-national Level Planning

In addition to the national legislations, policies and guidelines, the local councils are also guided by the local framework and legislations. Local Government Finance Act No 9 of 1982 (as amended by Miscellaneous Act No 6 of 1999) stipulates the requirements and procedures to be followed by LGAs in preparing annual estimates of revenues and expenditures. Furthermore, sectors also have separate guidelines to guide on planning and budgeting. For example, in the Health Sector there is Comprehensive Council Health Plan Guidelines (CCHP), which is based on cost centres and types of expenditure.

Along the same spirit of improving capacity of LGAs in planning and budgeting for the nutrition sector, the Prime Minister's Office (PMO) prepared and issued "Guideline for Councils for the Preparation of Plan and Budget for Nutrition" in October 2012 (second edition). The guideline for the nutrition addressed the issue of planning and budgeting in multi-approach hence covered the following sectors and operating units:

- Planning
- Health
- Agriculture (including Livestock and Fisheries)
- Community Development
- Education
- Water, Sanitation and Hygiene.

The guideline was developed to assist councils in the country in identifying key actions to include in their annual plans and budgets to prevent and address malnutrition. The guideline provides a detailed list of nutrition essential interventions[10] by sector, propounded in activities. Review of the 15 selected councils during the FY 2012/13 when the guideline was expected to have taken effect has revealed non-compliance to the requirements of the issued guidelines. However, a few interventions that were noted concentrated within Health and Agriculture sectors.

In addition to the guideline for nutrition planning and budgeting, the Government in collaboration with Development Partners developed a District Nutrition Assessment Tool to build capacity of district staff to assess causes of malnutrition in their respective districts; 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 (NNS). None among the 15 selected District Councils were found to have the plans prepared. Few Councils have reported during the FY 2012/13 they had planned to undertake nutritional status assessment and surveys, for

[10]Essential interventions include both direct and indirect interventions. This is the definition also used in this report

example Muheza District Council. In addition, some of the districts were not aware at all of the assessment tools.

Furthermore, in the third Health Sector Strategic Plan (HSSP III), covering July 2009 to June 2015, there is focus on equitable and high quality health and social welfare services and client satisfaction. The MoHSW adopted strategies with priorities developed according to Essential Health Package (EHP) of Tanzania. Based on EHP there are a total of 11 priority areas listed on Comprehensive Council Health Plan, of which four (4) have some direct activities for nutrition.

4.1.3 Civil societies

Civil society organisations complement the Government's efforts in addressing malnutrition in the country. The CSOs work mostly at grassroots and intermediary levels in implementing nutrition and related activities. Due to decentralisation policy, CSOs work in collaboration with the Councils to ensure that interventions undertaken are in line with the Government policies, within mandate and also community demand. There are CSOs that implement the planned interventions by getting funds from DPs.

Planning process for the CSOs are different to the Government, hence in most cases, CSOs work closely and directly with the DPs. Normally, the CSOs develop the projects or programs on nutrition interventions and solicit the funds from a number of DPs who have similar strategies and objectives along the same sector.

4.2 Budgeting process

The format of MTEFs split the expenditure budget into two main parts of recurrent expenditure and development expenditure. The recurrent expenditure includes Personal Emoluments (PE) and Other Charges (OC). The development expenditure include costs of development programs, projects and other non-operational interventions. DPs mostly focus budget support for the development expenditure through basket funds, bilateral grants and credits. Data gathering process for the study entailed detail review of the annual budgets of a number of agencies in the nutrition sector, this include the six nutritional sectoral ministries, TFNC and 15 LGAs.

The Government of Tanzania through the MoF and PMO-RALG have developed computer tools to assist planning and budgeting process, namely SBAS and PlanRep. The tools are used to link the process of planning and budgeting at both central and local levels to ensure national priorities and strategies are adhere too. After the budget approval by the Parliament, the MoF/PMO-RALG post the budget data into the Epicor (Budget Module) for implementation and accountability. Print-out summaries are later sent to the respective planning department of MDAs and LGAs. Accounts Department can access the budget data on-line from the Epicor.

Nutrition interventions were found on both sides of the budget: recurrent and development expenditures. Ministries and LGAs use the same codes for the cost elements (resources input) i.e. the Government Financial Statistics (GFS) for the recurrent and development inputs. However, agencies including TFNC have adopted different codes (**chart of accounts**) to GFS codes 2001.

The key findings from the review of the nutrition budgets include the following:

- **Budget coherence**: At the national level, TFNC have a major role to coordinate, implement and monitor nutrition sector in the country. However, one of the major weaknesses of the TFNC is lack of capacity to manage planning and budgeting of its activities. Despite the existence of the national framework for planning and budgeting, TFNC plans and budgets are fragmented as the annual budget (MTEFs) submitted to the Government do not include a large number of programs and interventions funded by the Donors. These creates difficult in managing resources at management level as well as lack of information at central point regarding national interventions undertaken by TFNC and supported by the Donors. The reason is delay by Donors to inform TFNC the amount of funds they have committed so that they are included in the MTEF in the same format before the MTEF books are submitted to the Ministry of Finance. During the three years period, TFNC had a total budget of TZS 16.6 billion, out of which 34.4% was funded by Donors. On aggregate, 28.4% (Donors fund) of the TFNC budget allocations were not reflected in the national budget
- **Budget revisions**: Upon submission of the annual budgets (MDAs & LGAs) to the MoF and subsequent to the Parliament, entities do not re-work their MTEF books after revisions and approval. These results into terminologies such as “annual budget”, “approved budget”, and “actual budget” to be used indicating which budget estimates are referred to following number of revisions. It would be proper that revisions of the MTEFs is done following approval of budgets in parliament
- **Appropriate unit costs**: The planning and budget guidelines require the MDAs and LGAs to cost activities using “**appropriate unit costs**” and “**measurement units**” as issued by the Government Procurement Services Agency (GPSA). However, it was noted that same budget entity applied more than two different unit costs for the same cost element, for example Diesel: TZS 1500, TZS 1700 and TZS 2000 in the same period and in the same LGA
- **Interventions not costed:** There were a number of nutrition interventions included in the MTEFs especially for LGAs without resources allocation (not costed). This indicates that the process of reviewing and rationalising budgets would normally end up treating nutrition interventions as being not priorities, hence deleted from final resources requested from the Government
- **Over costed interventions**: There were cases whereby the same cost element is repeated several times in the same activity just using different titles. This practice raise an alarm on seriousness in budgeting process especially to Ministries and Councils. The common cost elements (input resources) used concurrently in the same activities include **“Petrol”, “Diesel”, and “Fuel”**. Similarly, the use of cost elements such as **“Food & Refreshment Expense”** together with **“Entertainment Expense**” were also noted

- **Unclear inputs**: Cases of the inputs used terms which were too general, which are not effective in allocation of resources efficiently. For example it was found out that some of interventions/activities were costed with unclear inputs for example “HIV/AIDS Epidemics” as cost element is not clear what exactly was allocated for or spent on.

4.3 Budget Execution

Budget execution in terms of actual implementation of nutrition interventions was assessed and reviewed on the basis of data received on expenditure for the planned activities. The planning process followed by resources allocation will not result in outcomes and impact expected if actual funding will not be provided in appropriate quantum, also in target expenditure areas as per allocation and in the right time. Even if the level and composition of nutrition expenditures are appropriate, analysis on actual spending patterns and value for money are necessary to determine efficiency and effectiveness.

The study found out that implementing agencies especially ministries, local councils as well as TFNC do not produce budgetary reports with information to compare nutrition budget allocation against actual spending per each activity. This was encountered mostly on the activities funded by the Government through the national budget (MTEFs), whereby data for actual expenditures by activities were not available. It was noted that nutrition interventions funded through off-budget by Donors were reported on both budget and actual expenditures.

4.3.1 National Level

Generally, the budget execution for the funds provided by the Donors to implement nutrition interventions was good as funds were made available as per estimated budget allocations. **Table 4.2** below shows that overall, the resources committed and provided into nutrition interventions was 91.9% of the budget allocation during the three years period.

Table 4.2: Comparison of budget versus actual spending

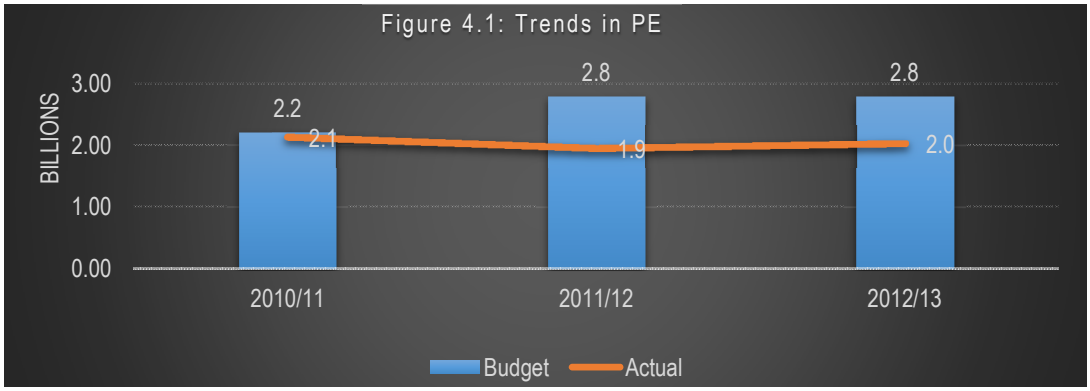
	Total Budget	Total Actual	% Actual/Budget
Agencies	10,281,180,356	10,259,147,101	99.8%
Civil societies	35,149,782,553	33,005,646,504	93.9%
Donors	10,070,469,388	10,070,469,388	100.0%
Ministries	2,939,424,380	379,348,287	12.9%
Grand Total	**58,440,856,676**	**53,714,611,280**	**91.9%**

On the Government funding, data from TFNC recurrent expenditures were obtained at aggregate levels without breakdown by activities. During the three years period, TFNC reported to have received a total of TZS 8.8 billion against the budget of TZS 11.1 billion for operational activities (recurrent expenditures) equivalent to 79% of the budget allocations. During FY 2010/11, TFNC budget turnout was higher (95%) comparing to the two subsequent periods. The actual expenditures in FY 2011/12 declined by 12% from TZS 3.1 billion to TZS 2.7 billion.

Table 4.3: Comparison of budget versus actual spending for recurrent

	Total Budget	Total Actual	% Actual/Budget
2010/11	3,325,203,812	3,169,194,206	95%
2011/12	3,910,616,950	2,780,661,340	71%
2012/13	3,963,037,046	2,872,345,508	72%
Grand Total	**11,198,857,808**	**8,822,201,054**	**79%**

The breakdown of recurrent expenditures for TFNC between personal emoluments (PE) and other charges (OC) showed similar trend in comparison between budget allocations versus actual spending. The levels of PE actual expenditures versus budget allocations were 97%, 70% and 73% for the three years, with an average of 79%. OC trends also showed an average of 79% between actual and budget allocations. In terms of timing of fund release from the Government, it has been consistent on monthly basis for PEs between 2010/11 to 2012/13. The patterns of fund released for OCs was monthly in FY 2010/11 and later was 10 times (2011/12) and eight times in FY 2012/13.



TFNC used manual financial management systems to maintain information on resources received and spent from various sources including the Government and Donors. The data collection process itself at TFNC also took long time as a result of the existing manual financial management system. The manual financial management system for an organisation like TFNC which has huge responsibilities to plan, coordinate, implement and monitor the whole of the nutrition activities in the country lends it to be ineffective and incapacitated to deliver with efficiency.

Furthermore, the information provided by TFNC on off-budget interventions and funds were on aggregated level and could not be useful for either planning or assessment. For example, an analysis of “on budget” was carried out to determine how much fuel did TFNC budget for its operations during the three years and it was found that total fuel could service between 11 and 19 vehicles throughout the year. If similar information would be available from the off-budget programs and interventions, then information on budget rationalisation on expenditure items like fuel would be available. The imbalance in resources allocations occurred due to lack of information and fragmented budgeting process for programs and interventions funded by different sources.

4.3.2 Sub-national Level

Tanzania is committed to decentralisation by devolution (D-by-D) and has an administrative structure in which local government authorities (LGAs) are responsible for the delivery of public services. Limitation on financial resources and human skills capacity has been a challenging for LGAs to spearhead development and services delivery efficiently and effectively.

Tracking actual implementation of nutrition interventions on LGAs periodic reports has been a challenging and daunting task as the actual expenditure reports do not provide information per activity. The LGAs are operating their integrated financial management system (IFMS) using a software called Epicor. The Epicor is a centralised package stationed at PMO-RALG in Dodoma, with LGAs accessing some of the functions using their own workstations from their respective locations. The human skills capacity to operate and manipulate the system to generate reports and strategic information is still a challenge and mostly depends on few accounting staff who were trained. Currently, the software run on version 9.5 which has a module that is able to track actual expenses by cost centre, inputs and activity codes.

The recent Epicor version 9.5 has a function which can produce a report called "**Itemized Commitment and Expenditure Report by Fund Category**", it provides avenue for tracking actual implementation on nutrition interventions at least through inputs (cost elements) and by cost centre codes. Since, activities are not mentioned by title, tracing the codes from cost centres and activity codes prove to be a difficult task and time consuming. Furthermore, out of 15 visited LGAs, only four managed to print the itemized report from their systems. In addition, this version of Epicor started to be used for the FY 2012/13. Therefore, data for analysing budget execution on implementation of nutrition interventions identified in selected LGAs was not available.

Table 4.4: Budget execution and outturn at selected LGAs

	ACTUAL	BUDGET	%Outturn
Babati TC	20,868,711,802	39,709,490,084	53%
Iringa DC	73,733,882,514	95,853,820,963	77%
Kishapu DC	47,773,317,116	66,075,504,569	72%
Kongwa DC	36,564,266,250	53,829,358,679	68%
Lindi DC	42,223,248,259	48,352,455,109	87%
Makete DC	29,434,038,032	39,296,963,669	75%
Mbeya MC	92,485,882,490	143,130,857,767	65%
Morogoro DC	60,554,677,170	72,728,601,255	83%
Mtwara MC	24,595,851,371	28,286,237,428	87%
Muheza DC	53,353,350,492	48,352,001,411	110%
Pangani DC	21,993,665,652	13,037,373,366	169%
Ruangwa DC	23,213,881,332	32,582,511,579	71%
Shinyanga MC	56,616,846,962	47,737,885,791	119%
Grand Total	583,411,619,442	728,973,061,670	80%

Table 4.4 above shows the comparison of the total expenditure budget versus total actual expenditures for the selected LGAs. Overall, the budget out turn was 80% and 7 out of 13 LGAs their budget outturns were below the average. There are a number of reasons, the first being that funds released by the Government were delayed, hence activities were not implemented. Second, commitment by Government and DPs were not honoured fully as provided in the budget allocations.

Box 4.1: Muheza District Council

Muheza District Council have a total population of 204,461 (193,014: 2010) scattered in 113 villages. Total district area is 1,974 square kilometre of which arable land is 85%. Budget allocation for nutrition essential interventions for three years was TZS 162.9 million making it among the councils with a very low level of resources allocation per capita of the 15 visited LGAs. The Council planned to undertake nutrition survey in the District that covers most of the primary health facilities and 35 primary schools. The target groups were women (15-49 years), school children and children (0-59). Total budget for this activity hardly exceed TZS 2.6 million (< USD 1,625). However, given priorities in other services including water, the management of the Muheza District Council struggle to raise this small amount of resources to undertake this important intervention, which will provide useful information to plan for cost-effective

Shortfalls in funding has resulted in a number of planned nutrition interventions not to be pursued. Generally, nutrition interventions were taken to be part of the health services, hence cost austerity always fell on its activities, which normally are said to be considered not priorities.

Furthermore, it was noted that the local councils failed to fund even nutrition activities with very little resources requirement. For example, Muheza District Council could not raise TZS 2.6 million to undertake district nutrition survey which could provide relevant information on determinants of poor nutrition status in the district given high potential in food and fruits production (see **Box 1**). Muheza District in Tanga region is among the areas with the higher stunting rate (49%) than the national average (42%). Tanga is among the regions with good food security and availability of diet products such as fruits and vegetables in the country, hence the real causes of malnutrition have to be known if the interventions have to work to address the problems.

4.4 Situational Analysis

This sub-section provides PER results on assessment and observation during the field work on nutrition actual practice in relation to the organisations implementing the nutrition in Tanzania. In addition, the views and opinion of various stakeholders consulted during the assignment are summarised and presented in tis sub-section.

4.4.1 National Level

Table 4.5 depicts the profile of consulted nutrition stakeholders at the national level. The interviewed organisations include UN agencies, CSOs (International and Local NGOs). The delivery channels for interventions included activities implemented by the partners directly, through local CSOs and activities implemented through the Government system (TFNC, LGAs and ministries).

Table 4.5: Selected CSOs and Donors activity profiles

	Primary focus/ objectives	Delivery channel	Source of funding
FAO	• Help eliminate hunger, food insecurity and malnutrition • Make agriculture, forestry and fisheries more productive and sustainable • Reduce rural poverty • Enable inclusive and efficient agricultural and food systems • Increase the resilience of livelihoods from disasters	Ministry of Agriculture, Ministry of Livestock & Fisheries, International NGO, Private sector	United Nations
Aga Khan Foundation	Provision of community-based MNCH services, capacity building at the primary health care level, strengthening of links with referral services and innovations focusing on health systems improvement through the mentioned four main components The project has four major objectives • Improved quality of and access to MNCH services; • Increased utilisation of MNCH service at primary care level; • Improved MNCH health practices through behaviour change communication and health promotion; • Enhanced knowledge transfer and exchange on MNCH through a strong public private partnership approach.	RHMT/CHMT	Department of Foreign Affairs, Trade and Development (DFATD)- Canada
AXIOS	Increasing access to quality health care in developing countries through innovative approaches, with a particular focus on improving health systems and building local capacity		USAID
Concern Worldwide	To improve livelihood of the poor that range from increasing food and income, access to safe and clean water, improved sanitation and hygiene and address stunting malnutrition and nutrition in 1000 days of a child.	LGAs	Irish Aid through UNICEF; Concern worldwide

Table 4.5: Selected CSOs and Donors activity profiles

	Primary focus/ objectives	Delivery channel	Source of funding
Centre for Counselling, Nutrition and Health Care (COUNSENUTH)	• To promote nutritional care and preventive health services • To promote and facilitate implementation of community health, nutrition and other related programmes. • To build capacity on nutrition for care providers at all levels especially for NGOs & CBOs • To provide technical assistance to implementing partners in nutrition and counselling Major target groups include: • Women, Children, Youths, Adolescents and Families. • Most Vulnerable Groups such as pregnant and lactating women, Orphans, and the sick. • Social/health service providers at all levels	Own channel, local NGOs/CBOs/FBOs	- MWANZO BORA (USAID)- - IRISH AID - GLOBAL FUND Round 6 - consultancies, small projects & membership contributions
ENGENDERHEALTH respond Tanzania project	• Family Planning focusing on LA/PMs, and other Reproductive Health services • Comprehensive Post Abortion Care(cPAC) • Cervical cancer Screening • Basic Emergency Obstetric and New born Care (BEmONC) • Prevention of Mother to Child Transmission of HIV (PMTCT) • Facility based Gender-Based Violence services • RH/HIV integrations services	Own channel, NGOs/CBOs/FBOs (COUNSENUTH)	-
Management and Development for Health (MDH)	Focus on addressing public health priorities through evidence based interventions and partnership	Ministry of Health and Social Welfare; LGAs	PEPFAR/CDC
Africare (Mwanzo Bora nutrition Program)	The main focus of Africare is the implementation of community development programs in the areas of livelihoods, HIV/AIDS, nutrition and resettlement	LGAs, local NGOs/CBO/FBOs	USAID (100%)
SAVE THE CHILDREN	In Tanzania, Save the Children works on specific objectives in four core thematic areas: • Right to Health - All children survive and grow up healthy • Right to Freedom from Hunger - All children grow up properly nourished • Right to Protection - All children are protected from exploitation and abuse • Right to Participation – All children participate in making decisions that concern them	Own channel, local NGO/CBO/FBO	
Tuboreshe Chakula	• Processing and consumption of rice, maize and sunflower oil in the regions of Morogoro, Dodoma, and Manyara	Own channel	USAID (100%)

Table 4.5: Selected CSOs and Donors activity profiles

	Primary focus/ objectives	Delivery channel	Source of funding
	• Processing and consumption improvement		
UNICEF UN)	UNICEF has been on the ground in Tanzania since 1954 as part of its emergency operations, though the office was set up in 1975. Since then, UNICEF's assistance to Tanzania has taken many forms guided by the changing situation of women and children in Tanzania, national and organization priorities. UNICEF assists the government to implement high-impact, cost effective health and nutrition services targeted at hard-to-reach communities	MoHSW- Mainland; TFNC; LGAs; local NGO/CBO/FBOs ; International NGO (Concern)	United Nations
WFP (UN)	WFP supports the government to strengthen community and local institutions to combat food insecurity and deliver hunger solutions	Own channel	- One UN fund Multi-lateral contributions
WHO (UN)	The mission of the World Health Organisation (WHO) remains 'the attainment by all people, of the highest possible level of health' (Article 1 of WHO Constitution). The 11th General Programme of Work 2006-2015, the Medium-Term Strategic Plan 2008-2013, the Biennial Programme and Budget outline the key policy directions for WHO actions. The overall objective of WHO is to provide technical and policy guidance on global health matters, strengthening health systems and providing global orientations for disease prevention and control as well as supporting its Members States to address public health priorities to improve the people's well-being. WHO objectives are fulfilled through its core functions which are: • Providing leadership on matters critical to health and engaging in partnerships where joint action is needed • Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge • Setting norms and standards and promoting and monitoring their implementation • Articulating ethical and evidence-based policy actions • Providing technical support, catalysing change, and building sustainable institutional capacity, and • Monitoring the health situation and assessing health trends	MoHSW, Ministry of Agriculture, TFNC, TFDA, PMO, LGAs. local NGO/CBO/FBOs (PANITA, COUNSENUTH);International NGO (Save the Children, HKI, University Research Co, Africare)	-
Helen Keller International (HKI)	Nutrition and Neglected Tropical Diseases.	TFNC , TFDA, LGAs, local NGOs /CBOs /FBOs (TAHEA-Mwanza)	CIDA (VAS),DFID(FF), GAIN(FF), CIP(OFSP), Irish Aid(EHFP), Bill and Melinda Gates Foundation (ARCH).

Table 4.6 shows the interventions and nutrition programmes that have been implemented between 2008 and 2013 by the stakeholders. The interventions were categorised into nutrition specific and nutrition sensitive. Majority of interventions were direct/ specific nutrition interventions. However, no conclusion can be drawn from this issue, since it provides a quick picture on the types of nutrition interventions being implemented by the interviewed partners. Nutrition sensitive interventions could be implemented by other stakeholders who were not interviewed and whose main area of focus is agriculture, hygiene & sanitation, economic empowerment, education etc.; and not nutrition.

Table 4.6: Reported interventions categorised into nutrition specific and nutrition sensitive

Nutrition specific interventions*	Nutrition sensitive interventions**
• Capacity building in Nutrition Assessment, Counseling and support (NACS) to HF and community care providers • Community health education and promotion through Nutrition Health Camps • Growth and monitoring and promotion • Strengthening health and nutrition education on health facilities • Nutrition support and supplementation and malnutrition management • Distribution of Iron & folic acid supplements(FeFo) to pregnant and breastfeeding mothers • Nutritional care and support to PLHIV and OVC • Improving Nutrition for Women and Children through reducing maternal anemia and childhood stunting • Trainings of service providers and community in preparing nutritious foods • Micronutrient Activities (Vitamin A Supplementation and Salt Iodisation, Deworming) (*2008-2013)* • Integrated Management of Acute Malnutrition (Severe acute malnutrition) (*2008-2013)* • Infant and Young Child Feeding (Breastfeeding and Complementary Feeding) (*2008-2013)* • Other (Supporting planning and budgeting for nutrition at LGA level, Support Health Basket Fund, Advocacy, Capacity Development both LGAs and TFNC) (*2008-2013)* • *Supplementary feeding* • National Food Fortification	• Develop capacity for the national and Regional Administration (RALG) teams for MUCHALI (Tanzania Food Security and Nutrition Analysis Framework) and on improved data management for food and nutrition security assessment, analysis, reporting and communication (using IPC-integrated food security phase classification) • Promotion and production of diverse nutritious food • Promoting micronutrient consumption through enhanced homestead food production

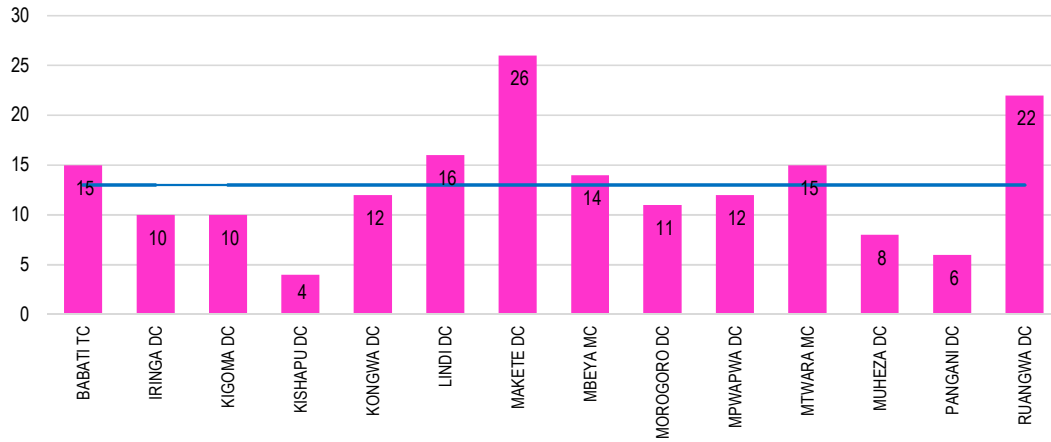
***Nutrition specific interventions:** Evidence for interventions which have a direct impact on the immediate causes of undernutrition (inadequate food intake, poor feeding practices and high burden of disease) such as breastfeeding, complimentary feeding, micronutrient supplementation and home fortification, disease management, treatment of acute malnutrition and nutrition in emergencies.

****Nutrition sensitive interventions:** Nutrition-sensitive interventions address the underlying factors that contribute to malnutrition—including hunger, poverty, gender inequality, and poor access to safe water and health services—by integrating nutrition actions into other sectors.

4.4.2 Sub-national Level

The situation on the ground revealed that nutrition interventions were allocated resources on ad hoc basis and lacked consistency in the number of activities among the councils and within each council (see **Figure 4.2** below). Number of activities allocated resources during the three years is indicated in the figure below. The average number of activities allocated resources was 13, while 50% of the visited LGAs were having the number of activities less than the average. In addition, some of the councils for example Kigoma District Council provided data for one year with a total of 10 activities, same number compared to Iringa District Council which covered three years.

Figure 4.2: Number of nutrition activities planned for three years



Senior management of the 15 selected LGAs were interviewed and asked to respond on a number of issues to capture situational of nutrition sector in their respective areas. The interview was carried out using a structured survey questionnaires that respondents were asked to complete themselves. A total of 164 respondents returned completed survey questionnaires from the 15 LGAs. In addition, the national nutrition PER team undertook ad hoc consultations with other staffs and stakeholders in local councils visited in order to understand the reality and position of the sector at sub-national level.

More than half of the respondents (56%) acknowledged that District Nutrition Officer (DNUO) is responsible for nutrition planning and budgeting, while more than a quarter (32%) thought that DMO is responsible. However, very few (31%) thought that DNuO is an influential person for nutrition planning and budgeting. Other people mentioned to influence nutrition planning and budgeting include DPLO (22%), DED (21%) and DMO (15%).

When asked about the level of responsibilities they thought DNUO have in relation to nutrition sector at council level, majority thought that the major responsibility was providing technical support (74%), develop and submit plans and budget (70%) and advise council director (67%). More than a quarter (39%) mentioned that financial mobilization, initiation and undertaking studies and participation in meetings and forums were minor roles for DNUO. It was noted that, although all the districts visited have appointed staff to be responsible for nutrition but these nutrition officers do not yet know their roles, responsibilities and lines of reporting. The presence of DNUOs in some districts are yet to win relevance as some had not been allocated an office even after being employed for more than six months. In some of the districts, the Council leadership (Mayor/Chairman of relevant committees) did not know that they had nutrition officers in their districts. In order for them to effectively coordinate and ensure scaling up of nutrition interventions DNUOs would need maximum support from the national level, in terms of training and clear and effective reporting lines.

DNUOs who are accountable for coordinating and the delivery of quality nutrition services at council level are not members of council management team due to the fact that they are under DMO, who is already a member. This fact is supported by the responses from the districts, where the majority (83%) supported the idea that nutrition should be an independent unit at the council level if real nutrition is to be given the importance that it deserves. If

nutrition is to be addressed more seriously there has to be a change in the district organisation structure so that this position reports directly to the District Executive Director and becomes a member of council management team. Currently, it is extremely difficult for this position to command attention and resources as well as coordinating the work of staff from other sectors due to being in a particular sector.

Majority of the respondents (86%) recognized that nutrition is a major problem in their councils. However, almost half 49% of the respondents perceived that nutrition is given required priority at the household level, while few mentioned at the national level (29%), and even fewer (21%) at the council level. This indicates lack of the councils to recognise that nutrition is their responsibilities.

Nutrition is part of Goal 3 of the MKUKUTA (Improving Survival, Health, Nutrition and Well Being, Especially for Children, Women and Vulnerable Groups) under cluster II and therefore all the councils are supposed to have specific objectives addressing nutrition. From our results it was found that nutrition was mentioned as component in health and agriculture interventions. However, no specific plans for action were in place to address nutrition in other sectors. Due to its multi-sectoral nature, nutrition has to be recognised and firmly included in plans and strategies of many relevant sectors. This may need advocacy from different actors at national and sub-national level for all key implementers for planning and budgeting at local government to be made aware regularly of nutrition and its importance in the development process, and that it is their responsibility and should ensure that it is part of the regular agenda of their deliberations, planning and budgeting.

Currently, the major constraints in nutrition budget execution cited by many respondents were limited resources (68%) and lack of funding (55%). Improving their understanding in how the different strategies highlighted in council plans might lead to improved nutrition outcomes and , which will also support cluster I of the MKUKUTA (growth and reduction of income poverty), since nutrition has a profound effect on economic development, growth and prosperity and malnutrition is recognized as a key constraint to poverty reduction. In this way, it will encourage them to prioritize nutrition interventions in terms of budgeting and resource allocations. According to Ministry of Finance's national planning and budgeting guidelines "councils are instructed to allocate sectors-specific Block Grant, General Purpose Grant, Basket Funds, local own source revenue and other relevant development grants to locally prioritized interventions for nutrition, in line with the National Nutrition Strategy". Landscape Analysis (2012) reported that most districts were interested in budgeting for nutrition, but actual funding and allocation does not always follow. None of the districts actively raised funds for nutrition and further advocacy is needed to ensure districts prioritize nutrition and innovatively mobilize resources. This PER also notes different funding opportunities which exist at district level including health basket fund, Tanzania Social Action Fund (TASAF), Agriculture Sector Development Programme (ASDP), development partners, NGOs, local government block grant, and own revenue.

More than half of the respondents (52%) recognized that the determinant of the nutrition planning process at the council level is for the community to prioritize nutrition; and few mentioned councils (18%), health department (16%) and others (14%) like government, donors and individual initiatives. Planning for development starts at village level by using Opportunity and Obstacles to Development (O & OD) process, which is a part of decentralization, restructuring and reform of local authorities. It is a process which was initiated by the Government in 2002 to facilitate people in the community to participate in planning, implementing, and owning their community plans with the aim of shifting planning process from top-down to bottom-up. It is recognized as a core process to promote community participation in local development and accountable and transparent local governance. The O & OD process is used at village, Ward up to district level. However, Landscape analysis (2012) found out that nutrition was generally not included in ward and village plans and the few nutrition activities implemented at community level was most commonly led by CSOs. In addition, some districts did not fully follow the recommended planning and budgeting process and hence some wards and villages were not involved in planning for nutrition interventions. There is therefore a need to strengthen this process as well as guidance in prioritizing nutrition interventions at community level. Prioritization is also needed by central government, PMO-RALG, MoHSW and other ministries so that when districts do plan for nutrition interventions the planned activities are actually funded.

5 Conclusion and Recommendations

Section five of the nutrition sector public expenditure review covered final part of the report, which summarises key findings, provide general conclusion and recommendations. Furthermore, a brief outline of the proposed plan of action was included into this Section. The Section draws conclusion and recommendations based on findings and facts documented on the previous sections of the report. For the Government and stakeholders to scale-up nutrition in Tanzania, it would be important that the specific issues raised in the following paragraphs are properly reviewed and adequately addressed. Obviously, some of the issues raised here would need more in-depth studies to understand the best approach to tackle them.

5.1 Key Findings

The key findings from this nutrition sector public expenditure review are summarised below:

- **Challenges in Data**: Data collection was a challenging and daunting task during the study. The data sources varied in data management and in preparation of the resources allocation, reporting actual expenditures and monitoring of their activities. Most of the DPs and NGOs data were on aggregate form, hence lower level analysis was not possible. Public sector, including ministries, agencies (e.g. TFNC) and local councils actual expenditures data on activities implemented were not available especially on the Government funding
- **Nutrition funding**: Total nutrition investment at the national level excluding the resources allocated at the local councils amount to TZS 78.6 billion (USD 51.4 million) over a three years period. The annual resources allocations were TZS 17.8 billion (USD 12.5 million), TZS 27.5 billion (USD 17.6 million) and TZS 33.2 billion (USD 21.3 million) between FYs 2010/11 to 2012/13 respectively. The nutrition sector budget allocation compared to the national GDP were 0.05%, 0.06% and 0.06% for the three years. Also in comparison with the Government total expenditure budget, nutrition allocations were 0.15%, 0.20% and 0.22% respectively. This level of resources allocation is inadequate to address the nutrition challenges in the country in view of the National Nutrition Strategy
- **Funding gap**: While the NNS Implementation Plan estimated to spend TZS 118.9 billion and TZS 145 billion in 2011/12 and 2012/13 respectively, the actual resources allocation at national level was only 23.1% and 22.9% respectively. At this low level of nutrition spending, it would remain a challenge to realise objectives set in the National Nutritional Strategy Implementation Plan 2011-2016
- **Cost-effectiveness:** Most of the resources at the national level were directed towards least cost-effective interventions by both the Government and Donor funds. Overall, the least cost-effective interventions accounted for 73.1% of the total investment on nutrition for the three years. The Government has a high level of nutrition investment into least cost-effective interventions of 99.1%, while DPs have 65.7%
- **Target Groups**: Public spending in nutrition interventions were not targeted to the most vulnerable groups including children under two and pregnant women. The total resources allocation at national level allocated meagre amount to children under two (0.3%) and pregnant women (0.3%). Though public spending for the children under five was significant (24.1%), however the range of age does not assure adequate coverage to children under two who are at higher risk and vulnerable to poor nutrition than age three and above
- **Councils**: Currently, Councils do not have earmarked fund for implementing nutrition interventions. The 15 visited local councils do not have neither nutrition strategic plans nor the "nutrition causes

determinant" surveys. Nutrition interventions were incorporated in MTEFs on an ad hoc basis and few selective interventions by sectors, and by the end of the day they were mostly not implemented due to lack of fund. The total nutrition resources allocation for 14 councils was **TZS 2.48 billion** for a three-year, with an average of **TZS 59.2 million** (USD 37,000) per council per annum.

5.2 Conclusion

The study conclusions from the study are summarised below:

1) **Inadequate Funds**: Firstly, it is evident that the resource level geared towards nutrition sector interventions are inadequate at both central and council levels. Investment in nutrition has favourable returns, hence there is strong economic rationale to increase the allocation of financial resources to improve nutrition in the country. Currently there is no adequate base to allocate resources to implementing institutions including LGAs. Simple formula mechanism can be developed based on targeted interventions and unit cost can be established to support budgeting at all levels

2) **Funding modalities not effective**: Effective funding mechanisms need to encourage policy coordination and implementation through advocacy and awareness creation. The Government and stakeholders should adopt a funding mechanism that channel resources in a coordinated manner from all sources and direct them into implementation of the NNS. Consideration on basket fund or other best funding modalities should be explored, developed and implemented in medium term in order to implement the NNS effectively. The Health Bask Fund model of funding could be considered, particularly by making nutrition interventions part of the Health Basket Fund under the MoHSW.

3) **Targeted interventions not aligned with strategies**: The review found out that the targeted interventions were not aligned to the national strategies in terms of resources allocation and implementation. Government and DPs do not appear to be guided by the NNS when implementing their nutrition activities

4) **Lack of clear point of accountability**: Malnutrition is caused by multiple factors and requires solutions that involve many sectors, including health, food and agriculture, industry, water supply and sanitation, education, community development and others. It has been found that coordination in the sector is generally weak at national level and almost non-existent at lower levels. In the absence of adequate coordination, actors tend to define their own nutrition intervention packages and programs sometimes without any consideration of demand and needs or even the NNS. The result is often fragmented interventions scattered in pre-selected areas with limited or no impact relative to the investment.

5) **Institutions and Human Resources to manage resources need improvement**: Capacity for nutrition sector implementation is low in both human resources and institutions involved. This include low number and motivation of nutrition officers at councils, weak national nutrition institutions in terms of systems and resources. For example, not all councils have appointed District Nutrition Officers (DNUOs), while those appointed are not empowered to undertake their responsibilities effectively. Similarly, the Nutrition Section at the MoHSW despite of the good intention to establish it, lacks resources to effectively function as a coordinating unit in the nutrition sector.

6) **Long-term commitment from the Government is required:** Nutrition programs and interventions need sustainable financial resources to be successful, with long-term commitment and implementation from the Government. Long-term commitment will result when the Government will mobilise and manage own funding sources unto nutrition sector as well as mobilise Development Partners to support its course. Development Partners and other sources of funding are more likely to come in support once high commitment is initiated and significantly implemented by the Government.

5.3 Main Recommendations

Following the analytical work supported by the situational analysis of nutrition public expenditure in Tanzania, it is recommended to:

1) **Establish Ring-fenced Nutrition Fund**: Government should create financial mechanisms to protect (earmark) nutrition funding, by allocating required resources to implement NNS through available sources of fund, e.g. basket funds such as Health, Agriculture etc. to ensure that MDAs and LGAs implement nutrition interventions in a purposeful and transparent manner rather than adopting an ad hoc approach as is the practice now. The NNS implementation plan identified interventions which are to be implemented by various stakeholders, which should be featured in MTEFs on an annual basis. The following recommendation are relevant:

   - **Make nutrition as part of Health Basket Fund**: The Government should discuss with Health Sector Basket Fund (HBF) partners and agree to invite nutrition sector donors into the (HBF) under the Ministry of Health and Social Affairs.
   - **Formula Allocation:** The Government and Development Partners in nutrition sector should develop a formula for fund allocation in nutrition interventions. The interventions can be blocked into major specific and high impact interventions that LGAs can implement. The MoHSW in collaboration with MoF and PMO-RALG can oversee funds allocation on an annual basis according to the agreed formula. Key nutrition indicators and sectors' needs can be used in the formula to allocate resources. The allocation will target funds to LGAs
   - **Government should increase its funding of nutrition:** as a first step, the Government should include key nutrition interventions as protected items in the budget guideline and set a minimum amount of Shillings that it would invest in nutrition sector, in line with NNS. The Government should also ensure that nutrition interventions are included in Councils annual budgets
   - **Resource Mobilisation Strategy**: The Government should prepare a resource mobilisation strategy to fund the sector. To start with, the Government should target at initiatives that seeks to encourage donors to fund NNS Implementation Plan with of mobilising at least 80% of the needed resources by 2016.

2) **Develop medium-term and long-term capacity building programs for nutrition officers and institutions**: Going by D-by-D, it is important to ensure that local councils have the capacity to deliver nutrition services in their respective areas. PMO-RALG should give high priority to facilitate recruitment of the District Nutrition Officers (DNUOs) in the remaining LGAs and their empowerment. Another areas for capacity building include strengthening TFNC with planning, financial management system, as well as in monitoring and evaluation so that the institution becomes an effective national center on nutrition research and capacity building

3) **Enhance coordination and partnership:** Generally, the nutrition sector PER 2013 found out that despite a number of interventions and frameworks on coordination and partnership, implementation is still fragmented and resources allocation were neither coordinated nor directed necessarily towards real problem areas and groups. This calls for the need to clarify roles of the various institutions in the sector in order to strengthen existing mechanisms for coordination at the national and local levels. In particular, the MoHSW nutrition unit should be strengthened to enable it play effectively its coordination roles.

4) **Establish monitoring mechanisms in nutrition sector:** establish nutrition tracking system to ensure that sector interventions are monitored on an annual basis. In addition, conduct sector PERs after every two years to inform progress in the sector.

6 Annexes

LIST OF ANNEXES:

- Annex A: List of Reference
- Annex B: Support Team
- Annex C: Selected Cross-tab Results
- Annex D: Interventions at National
- Annex E:Interventions at Sub-national
- Annex F: Nutrition Milestones

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6.2 Annex B: Support Team

Name	Position	Organisation
Benedict Jeje	Managing Director	Tanzania Food and Nutrition Centre
Bertha Donald	Nutrition District Officer	Muheza District Council
Dorothy Lema	Ag.Regional Nutritional Officer	Tanga Region
Helen Semu	Focal Person Nutrition	Ministry of Health and Social Welfare
Tabitha Owenya	District Social Welfare Officer	Pangani District Council
Yohanamaaria Majua	Nutrition District Officer	Kongwa District Council
Felista Mwigune	Ag Municipal Planning Officer	Mtwara Municipal Council
Baraka Kilagu	Community Development Officer	Mtwara Municipal Council
LIshika	CHRO	Mtwara Municipal Council
Andrea Chezue	District Planning Officer	Lindi District Council
Goodluck Hatibu	District Water and Sanitation Officer	Lindi District Council
Samwel Warioba	Economist	Ruangwa District Council
Soloma	District Planning Officer	Babati Town Council
Amani Mwakipesile	City Nutrition Officer	Mbeya City Council
Lewis Mahembe	Regional Nutritionist	Mbeya Region
Martin Chacha	District Nutrition Officer	Iringa District Council
Daudi Kumburu	Ag. Social Welfare Officer	Njombe Region
Abraham Sanga	District Nutrition Officer	Makete District Council
Evance Gambishi	Regional Nutrition Officer	Morogoro Region
Enock Kasole	District Nutrition Officer	Morogoro District Council
OnesmoMahawanga	Acting District Treasurer	Kigoma District Council
Rasheed Makene	Regional Social Welfare Officer	Kigoma Region
Peter Rutaba	Economist	Kigoma District Council
Alex Butoto	Nutritionist – Agricultural Officer	Kigoma District Council
Mariam Mwita	Regional Nutritional Officer	Shinyanga Region
MwasagaMwambuli	Principal Economist	Shinyanga Municipal Council
Emmanuel Ng'hambi	Municipal Social Welfare Officer	Shinyanga Municipal Council
WemaMashaka	Municipal Community Development Officer	Shinyanga Municipal Council
LoyceNicolao	Acting Municipal Nutrition Officer	Shinyanga Municipal Council
AvelinaKimario	District Nutrition Officer	Kishapu District Council
Andrew Hagamu	Acting District Planning Officer	Kishapu District Council

6.1 Annex C: Selected Cross-Tab Results

Table C1: Priorities vs classification (National Level)	Curative	Operational	Preventive	Grand Total
Child, Women and Households in Difficult Circumstances	20,326,492	3,712,525,000	91,823,732	3,824,675,224
Diet-Related Non-Communicable Diseases		99,636,000		99,636,000
Household Food Security	151,444,001	3,758,569,012	150,657,000	4,060,670,013
Infant and Young Child Feeding	176,506,000	143,796,500	138,089,600	458,392,100
Maternal and Child Malnutrition	8,386,645,666	349,610,002	487,047,929	9,223,303,597
Non-prioritised Intervention	2,552,816,684	13,850,874,345	0	16,403,691,028
Nutrition and HIV/AIDS	1,462,613,040	659,956,344		2,122,569,384
Nutrition Surveillance, Surveys and Information Management	10,960,002	20,524,617,664	768,600,989	21,304,178,655
Vitamin and Mineral Deficiencies	12,087,791,536	736,062,952	8,307,988,425	21,131,842,913
Grand Total	**24,849,103,421**	**43,835,647,819**	**9,944,207,675**	**78,628,958,914**

TableC2: Priorities and funding source (National Level)	Donors		Government	
Row Labels	Total Budget	% Total Budget	Total Budget	% Total Budget
Diet-Related Non-Communicable Diseases	80,766,000	81.1%	18,870,000	18.9%
Household Food Security	1,950,377,213	48.0%	2,110,292,800	52.0%
Infant and Young Child Feeding	441,567,100	96.3%	16,825,000	3.7%
Maternal and Child Malnutrition	9,223,303,597	100.0%		0.0%
Nutrition and HIV/AIDS	1,716,604,440	80.9%	405,964,944	19.1%
Nutrition Surveillance, Surveys and Information Management	20,167,289,530	94.7%	1,136,889,125	5.3%
Vitamin and Mineral Deficiencies	21,101,892,913	99.9%	29,950,000	0.1%
Non-prioritised Intervention	6,317,982,289	38.5%	10,085,708,739	61.5%
Child, Women and Households in Difficult Circumstances	112,150,224	2.9%	3,712,525,000	97.1%
Grand Total	**61,111,933,306**	**77.7%**	**17,517,025,608**	**22.3%**

TableC3: Implementers at National Level	Budget 2010	Budget 2011	Budget 2012	Total
Africare	0	7,815,000,000	7,810,000,000	15,625,000,000
Aga Khan Foundation	0	90,654,000	120,742,600	211,396,600
Aga Khan Health Services Tanzania	0	0	222,310,000	222,310,000
Axios Foundation Tanzania	21,517,000	0	0	21,517,000
Concern Worldwide	0	0	1,220,026,914	1,220,026,914
CONSENUTH	2,570,332,740	924,034,130	157,919,196	3,652,286,066
Engender Health	0	0	109,340,000	109,340,000
Helen Keller International	1,351,840,000	2,930,625,000	6,666,616,000	10,949,081,000
Ifakara Health Institute	3,484,224,152	1,759,042,604	1,094,762,064	6,338,028,820
MAFC	825,480,000	355,012,300	388,276,630	1,568,768,930
MCDGC	31,600,000	30,600,000	4,400,000	66,600,000

TableC3: Implementers at National Level	Budget 2010	Budget 2011	Budget 2012	Total
MLDF	754,620,000	296,660,000	603,120,500	1,654,400,500
MOEVT	100,000,000	15,000,000	24,000,000	139,000,000
MOHSW	1,004,000,000	1,981,257,868	3,978,191,512	6,963,449,380
MOW	24,000,000	2,000,000	28,500,000	54,500,000
Save the Children	183,221,848	514,141,258	940,019,197	1,637,382,303
TFNC	4,230,845,324	6,123,707,045	6,269,406,975	16,623,959,344
UNICEF	852,000,000	937,800,000	937,200,000	2,727,000,000
WFP	1,747,569,860	3,196,056,786	2,071,822,742	7,015,449,388
WORLD VISION	322,624,000	588,496,071	590,322,599	1,501,442,670
WHO	296,780,000	0	31,240,000	328,020,000
Grand Total	**17,800,654,923**	**27,560,087,062**	**33,268,216,929**	**78,628,958,914**

Table C4: Priorities vs classification (Councils Level)	Capacity	Curative	Preventive	Grand Total
Child, Women and Households in Difficult Circumstances	4,676,000	20,000,000	92,340,000	117,016,000
Diet-Related Non-Communicable Diseases	139,130,000	30,935,000	129,279,516	299,344,516
Household Food Security	962,967,386		87,536,055	1,050,503,441
Infant and Young Child Feeding	91,520,000			91,520,000
Maternal and Child Malnutrition	114,242,030	41,035,000	70,911,500	226,188,530
Nutrition and HIV/AIDS	28,895,000	164,127,000	526,000	193,548,000
Nutrition Surveillance, Surveys and Information Management	6,550,000	23,440,000	16,040,000	46,030,000
Vitamin and Mineral Deficiencies		445,816,922	17,823,000	463,639,922
Grand Total	**1,347,980,416**	**725,353,922**	**414,456,071**	**2,487,790,409**

Table C5: Target vs classification (Councils Level)	Capacity	Curative	Preventive	Grand Total
Children school age		4,510,000	51,155,055	55,665,055
Children under 5		129,347,500	33,154,000	162,501,500
Community	860,460,242	78,514,400	192,826,516	1,131,801,158
Farmers	46,549,000			46,549,000
Household	124,953,212			124,953,212
Institution	262,472,000			262,472,000
Lactating women			75,540,000	75,540,000
Multiple groups	51,545,962	345,929,022	53,278,000	450,752,984
Other adults	2,000,000	160,953,000		162,953,000
Pregnant women		6,100,000		6,100,000
Public			3,390,000	3,390,000
Women 19-45			5,112,500	5,112,500
Grand Total	**1,347,980,416**	**725,353,922**	**414,456,071**	**2,487,790,409**

Table C6: Councils vs sources	Basket Fund	Block Grant	Council Fund	Other Fund	Grand Total
BABATI TC	188,955,327		1,725,000		190,680,327
IRINGA DC		79,338,000			79,338,000
KIGOMA DC	39,410,000	35,110,000	35,136,000		109,656,000
KISHAPU DC		16,873,480			16,873,480
KONGWA DC	268,912,642	34,013,000			302,925,642
LINDI DC	211,401,600	5,100,000	620,000		217,121,600
MAKETE DC	18,460,000	134,878,500		153,535,000	306,873,500
MBEYA MC		329,518,700			329,518,700
MOROGORO DC	43,449,016				43,449,016
MPWAPWA DC	302,675,237				302,675,237
MTWARA MC	97,429,700				97,429,700
MUHEZA DC	99,735,000	63,184,835			162,919,835
PANGANI DC	55,963,000	17,800,000			73,763,000
RUANGWA DC	237,503,372			17,063,000	254,566,372
Grand Total	**1,563,894,894**	**715,816,515**	**37,481,000**	**170,598,000**	**2,487,790,409**

6.2 Annex D: National Level Interventions

Implementer / Program / Activity	Grand Total
Africare	15,625,000,000
Mwanzo Bora Program	15,625,000,000
Supportive supervision, mobilization of Peer Support Groups	624,800,000
Training of Health Workers, District Nutrition Technical Facilitators etc.	15,000,200,000
Aga Khan Foundation	211,396,600
Health Improvement Project	211,396,600
Capacity development to health care workers and CORPs	90,654,000
Diet diversities interventions	18,744,000
Early childhood Development	32,489,600
Management of moderate malnourished children	54,670,000
WASH	14,839,000
Aga Khan Health Services Tanzania	222,310,000
Improving Maternal and Child Health in Tanzania	222,310,000
Capacity Building in Nutrition	72,455,000
Nutrition Community Health Camps	149,855,000
Axios Foundation Tanzania	21,517,000
Access to Quality Health Care	21,517,000
Capacity building for volunteers on nutrition assessment and counselling	21,517,000
Concern Worldwide	1,220,026,914
Bringing Nutrition Action to Scale	1,220,026,914
Availability and access to diverse and nutrient-rich foods to household level	150,657,000
Direct programme costs; transport & staff salaries	240,675,200
Evidence and learning from district and community programming	150,000,000
Indirect programme costs	351,146,714
Monitoring and evaluation	48,870,000

Implementer / Program / Activity	Grand Total
Pregnant women and caregivers of children aged less than two years enabled to practice nutrition-relevant behaviours	110,000,000
RALGs effectively plan, budget, coordinate and monitor nutrition services	168,678,000
CONSENUTH	3,652,286,066
69,766,000	
Conduct a Four-day training in nutrition and NCDs for 72 care providers from Mwanza, Shinyanga, Kagera & Mara Regions	10,200,000
Conduct three-day training in nutrition and non-communicable diet related diseases for 50 health care providers and pre-test the manuals.	11,200,000
Edit and print the training package on nutrition and non-communicable diet related diseases	7,412,000
Institutional costs	2,192,000
Prepare nutrition component in the NCD desk guide for health care providers	1,520,000
Prepare training package on nutrition and non-communicable diet related diseases	24,430,000
Project Management	12,812,000
Health Promotion: Prevention & Dietary Management of NCDs (GIZ & NHIF)	26,004,000
Develop a modular curriculum and training materials for health promotion/prevention on NCDs	9,300,000
Develop and print Q&A booklet on priority chronic diseases of lifestyle and their risk factors	16,704,000
Improving nutrition services in reproductive and child health clinics in Manyara and Iringa regions (Engender Health)	112,434,006
Assess services provided at RCH clinics in Iringa and Manyara regions	7,990,001
Conduct an inventory of local foods found in Iringa and Manyara regions	7,990,001
Develop training module for health care providers	4,880,001
Development, pre-testing and printing the data collection tools/ checklist	2,970,001
Institutional costs	18,739,000
Modify the health service providers training package for community training	3,600,001
Train Community care providers in nutrition (Iringa and Manyara)	28,260,000
Train health RCH care providers in nutrition - Iringa	18,695,001
Train health RCH care providers in nutrition - Manyara	19,310,000
Integrating Food and Nutrition Interventions into PMTCT and MVC Services at Community Level in Tanzania (FANTA 2)	112,334,060
Conduct consultative meetings and validation workshops with key partners for review of package	17,663,469
Conduct consultative meetings and validation workshops with key partners for review of package with key partners	28,186,600
Desk review and draft nutrition package for MVC	20,326,492

Implementer / Program / Activity	Grand Total
Desk review and draft nutrition package for PMTCT and infants and young children	24,831,269
Pre-test and editing of materials	8,050,078
Professional editing, design and layout of materials	13,276,152
Mwanzo Bora Nutrition Program	2,379,441,454
Operating costs for the project	2,379,441,454
Nutritional care and support to PLHIV (GFR4)	567,588,350
Conduct quarterly supervision and meetings in 22 districts	36,570,000
Develop, print and distribute IEC materials on nutritional care and support for PLHIV	164,747,350
Orientation of Implementing partners on nutritional care and support of PLHAs	11,395,000
Procure and distribute supplementary food items for identified PLHIV in 22 districts	226,656,000
Program Management	99,200,000
Train home base care providers on nutritional care and support to PLHIV	29,020,000
Nutritional care and support to PLHIV (TUNAJALI)	348,219,000
Conduct an inventory of local foods found in TUNAJALI Program target regions	143,454,000
Conduct supervised transfer training of HBC volunteers on nutritional care and support to PLHIV and OVC	34,695,000
Conduct supportive supervision on nutrition issues to sub grantees	26,835,000
Project Management	34,110,000
Reprinting and distribution of IEC materials on nutrition for volunteers, families and clients	72,825,000
Training of Trainers (TOT) in nutritional care and support to PLHIV and OVC	36,300,000
Scaling up Nutrition Interventions in Ruvuma (Irish Aid)	36,499,196
Conduct baseline survey in Tunduru to benchmark indicators	21,111,992
Development of a comprehensive proposal on scaling up nutrition interventions in Ruvuma Region	0
Increase capacity of LGAs staff to plan, budget and implement nutrition interventions	3,986,224
Meeting to validate Ruvuma report data	4,000,000
Prepare summary documents of Ruvuma report (in English & Kiswahili); Design & print and dissemination them to stakeholder	5,386,000
Rapid, in-depth nutrition assessment and mapping of districts in Ruvuma	0
Strengthen council multi-sectoral nutrition committees and facilitate coordination and meetings of nutrition sectoral plans d and focal persons	2,014,980
Engender Health	109,340,000

Implementer / Program / Activity	Grand Total
Respond Tanzania Project	109,340,000
Training in maternal and child nutrition to healthcare providers from 12 hospitals	109,340,000
Helen Keller International	10,949,081,000
Nutrition and Neglected Tropical Diseases	10,949,081,000
Advocacy for resource investment in OFSP in Tanzania RAC	587,492,000
Assessment and Research in Child Feeding	82,786,000
Creating Homestead Agriculture for Nutrition and Gender (CHANGE)	0
Demand creation for OFSP (SASHA - marando bora)	196,173,000
Improving micronutrient consumption through production and consumption of OFSP - eat orange	177,530,000
National Food Fortification program - follow-up (DFID)	4,061,200,000
National Food Fortification program - start-up (GAIN)	1,093,804,000
National Vitamin A Supplementation	1,923,698,000
Promoting micronutrient consumption through enhanced homestead food production - EHFP	1,652,936,000
Reaching Hard-to-Reach children with VAS	1,173,462,000
Ifakara Health Institute	6,338,028,820
Nutrition Program	6,338,028,820
Malnutrition in Under 2s	176,506,000
Nutrition Monitoring	132,789,340
Trial on Pre-pregnancy Supplementation	138,804,943
Vitamin A	5,889,928,536
MAFC	1,568,768,930
MTEF	1,568,768,930
Develop oil seed strategy and formulate national platform for promotion of production and marketing	15,600,000
Develop strategy and formulate platform for promotion of production and marketing of roots and tuber crops	95,885,000
Disseminate improved technologies on wheat production	64,000,000
Dissemination of improved technologies on cassava	207,300,000
Evaluate and introduce to farmers high value vegetables, fruits and spices materials	91,047,300
Facilitate accessibility to care and support services to SLHA	73,200,000

Implementer / Program / Activity	Grand Total
Identify and support three NGOs providing food and nutrition services for scaling up the support to vulnerable groups	252,000,000
Identify, register and backstop at least 200 nursery operators on production of improved mango and citrus seedling	20,000,000
Multiply and maintain breeder seeds for cereals, grain legumes, oil seeds, root crops and vegetables	231,310,000
Prepare and disseminate guidelines on blending of food crops	18,950,000
Produce mango seedlings	286,256,450
Promote processing and utilization of endangered indigenous foods for food insecurity regions	0
Support rural agro-processing (cassava & oil seeds)	133,650,000
Take into stake and promote/disseminate technologies on production of mangoes, grapes, avocados, fruits etc.	79,570,180
MCDGC	66,600,000
MTEF	66,600,000
Provide nutritious food and materials support to SLHA	66,600,000
MLDF	1,654,400,500
MTEF	1,654,400,500
Construct and operationalise three mariculture seed production	172,921,000
Develop and disseminate technologies to increase beef productivity	183,450,000
Develop and disseminate technologies to increase dairy productivity	196,350,000
Develop and disseminate technologies to increase goats & sheep productivity	78,943,000
Develop and disseminate technologies to increase indigenous chicken productivity	63,000,000
Develop and facilitate implementation of programmes for small stock, dairy, beef production and processing	25,520,000
Develop and promote new technologies in Aquaculture	41,496,500
Promote collection and processing of milk	12,400,000
Provide Nutrition Support to Employees Living with HIV/AIDS	38,400,000
Sensitization of stakeholders on proper use and storage of livestock inputs and increase awareness of food security	126,520,000
Stocking and restocking of man-made and natural water bodies	16,300,000
Strengthen fish farming centres and distribute 3000000 quality fish fingerlings	622,200,000
Support and participate in maziwa week and school milk feeding day	76,900,000
MOEVT	139,000,000
MTEF	139,000,000

Implementer / Program / Activity	Grand Total
Provide care and support to 300 SLHA	139,000,000
MOHSW	6,963,449,380
MTEF	4,024,025,000
Facilitate implementation of National Nutrition Strategy	300,000,000
Provide basic needs to 2000 vulnerable groups in public social welfare institutions	3,712,525,000
Provide care and support to 100 SLHA	11,500,000
Rural Food Fortification Pilot Program	2,939,424,380
Baseline survey for program	189,250,000
Computers procured and supplied to regions and districts	32,000,000
Contingency	98,768,977
Convene task force meeting on food fortification and conduct quarterly national level program supervision	30,490,000
Data on total annual maize flour processed and projected amount of rural fortifiable maize flour in Arusha region established	38,716,000
Data on total annual maize flour production and projected amount of rural fortifiable maize flour in Iringa region established	38,716,000
Develop monitoring and evaluation plan for rural fortification components	28,322,000
Develop social marketing for rural food fortification including social marketing products	500,000,000
Essential Nutrition Actions booklet printed and disseminated	24,000,000
Fortification equipment for rural mills procured	112,500,000
Laboratory equipment procured	167,159,070
Manual on quality assurance and quality control developed and disseminated	8,688,000
Procure fortificants, store and distribute	400,000,000
Program coordination	420,113,333
Project inception in Arusha region	5,498,500
Project inception at district level – in 3 selected districts of Iringa region	10,218,000
Project inception at district level – in 3 selected districts of Arusha region	10,218,000
Project inception in Iringa region	5,498,500
Project presentation to the national food fortification alliance	1,672,500
Provide financial support to 6 identified district councils for implementation	142,920,000
Simplified user friendly guidelines, reader materials, and poster on small scale rural food fortification developed and disseminated	20,248,000

Implementer / Program / Activity	Grand Total
Tender administration	30,000,000
Training and certification of maize flour millers on basic aspects of rural food fortification in Arusha region	149,024,000
Training and certification of maize flour millers on basic aspects of rural food fortification in Iringa region	149,024,000
Training on essential nutrition actions and fortification basics conducted in Arusha region	77,580,000
Training on essential nutrition actions and fortification basics conducted in Iringa region	77,580,000
Training on quality assurance for food inspectors in Arusha zone	21,502,000
Training on quality assurance for food inspectors in Iringa region	21,502,500
Training village health workers in Arusha region	64,107,500
Training village health workers in Iringa region	64,107,500
MOW	54,500,000
MTEF	54,500,000
Kutoa posho maalumu ya chakula kwa watumishi wanaoishi na virusi vya ukimwi	54,500,000
Save the Children	1,637,382,303
Creating Nutrition Partnership in Tanzania	219,097,508
At least 15 members of Parliament become "Nutrition Champions" supporting advocacy work and influencing policy development at national and district level	22,698,475
Development and implementation of advocacy strategy at national level	52,290,000
Media arm of the partnership for Nutrition established to provide critical support to the advocacy work for the partnership	24,052,010
Nutrition Partnership fully formalized and registered	92,657,023
Partnership's capacity to influence Nutrition planning, budgeting and practice at district level is increased	27,400,000
Harnessing Agriculture for Nutrition Outcomes	276,219,419
Document and disseminate project achievements	132,706,504
Increase capacity of local district government and CSOs staff to deliver nutrition-sensitive agriculture programs	56,452,900
Increase food and nutrient intake for infants and young children and women of reproductive age	87,060,015
Tutunzane II Shinyanga OVC Programme	513,194,690
Improve Health and well-being of PLWAs and their families	513,194,690
Working Together for Better Nutrition	628,870,686
Enhance, strengthen and position the PANITA as an independent network	349,574,359
Increase prioritization and implementation of Nutrition in development plans from national to local authority	91,017,877

Implementer / Program / Activity	Grand Total
Raise the public profile of nutrition in Tanzania and inspire action among key population segments	188,278,450
TFNC	16,623,959,344
Cassava Adding Value for Africa	310,246,500
Support development of high quality cassava flour value chain	310,246,500
Cassava Gmarkets	324,139,167
Providing knowledge and technologies on value chains of high quality cassava flour to smallholder farmers	324,139,167
Community Infant and Young Child Feeding - Capacity Development	105,600,000
Promotion of exclusive breastfeeding, optimal complementary feeding and good maternal nutrition	105,600,000
Control of micronutrients deficiencies through food fortification with micronutrients	501,142,425
Food fortification	501,142,425
Control of micronutrients deficiencies through Vitamin A Supplementation (VAS)	11,414,000
Preventing and control Vitamin A deficiency	11,414,000
District Gap analysis for scaling up nutrition	9,320,000
Development of Nutrition Scale Up Plan for Districts	9,320,000
Infant and Young Child Feeding	226,729,500
Assessment of implementation of IYCN	0
Conduct supportive supervision on Infant and Young Child Feeding	3,847,500
Consultative meetings on Infant and Young Child Feeding	3,870,000
Develop Essential Nutrition Action (ENA) Guidelines	9,340,000
Develop National IYCF TOT training package	4,460,000
Development of Infant and Young Child Feeding guidelines	58,739,000
Dissemination of Post intervention results of ENA	19,720,000
External assessment of Baby Friendly Hospital Initiative	39,355,000
Study Tour	2,283,000
Supportive supervision on BFHI	16,700,000
Supportive supervision on Essential Nutrition Action	7,695,000
Training of ENA Supervisors in thee Districts	60,720,000
Integrated Management of Acute Malnutrition	153,653,000

Implementer / Program / Activity	Grand Total
Management of Acute Malnutrition	153,653,000
Landscaping analysis	128,483,972
Landscaping analysis for scaling up nutrition in Tanzania	128,483,972
Limit CBSD	21,391,000
Quantification of the impact of CBSD on food security and on cassava value chains	21,391,000
MTEF	12,680,807,808
Advocate for regions and districts to fill vacant nutrition positions	35,750,000
Air Radio and Televise 6 TV programmes	24,295,000
Assessment on deployment of TFNC staff at regional level	10,030,000
Attend 3 Parliamentary Committee meetings	8,360,000
Basic Salaries and other statutory contributions for 609 TFNC employees	7,770,348,112
Computerization of TFNC Accounts	170,000,000
Conduct 6 stocktaking and 3 Audit exercises and produce 3 reports for MPs	107,114,000
Construction of New Office Building at TFNC Mikocheni	1,050,000,000
Develop and print 250 copies training manual on Nutrition management of Diet Related NCDs	18,870,000
Develop and print national school feeding guidelines	7,800,000
Develop and print second TFNC Strategic Plan	39,458,000
Develop and print training manual on healthy eating and lifestyles	13,190,000
Develop and print training programme for new nutrition officers	28,250,000
Develop TFNC Annual Food and Nutrition Plans and Budget	30,500,000
Develop, review, produce and distribute food and nutrition IEC	19,774,000
Development of ICT at TFNC	46,500,000
Finalize review of TFNC Act	50,940,000
Finalize, print and disseminate National Food and Nutrition Policy	65,000,000
Hold 12 Governing Board, 6 Workers and 3 Master Workers Council Meetings	234,000,000
Hold 3 end of the year all staff meeting, Provide awards, gifts and presents to 10 best workers	86,763,000
Monitor the implementation of TFNC activities and produce reports	17,300,000
Organize four Nutrition in Emergency Working Group meetings	21,500,000

Implementer / Program / Activity	Grand Total
Organize Six Nutrition Coordination Meeting	21,960,000
Organizing press conference to commemorate World Breastfeeding Week	16,825,000
Organizing six Nutrition Multisectoral Technical Working Group meetings	20,150,000
Participate in international conferences and meetings	52,800,000
Participate in Public Service Week, Saba Saba and Nane Nane Exhibitions	82,440,000
Pay Insurance Premiums for 522 employees, 45 vehicles and buildings	66,700,000
Pay other personal emoluments and allowances to 609 TFNC staff	467,848,000
Print 1000 copies of the Implementation Plan of the NNS	11,850,000
Print and Disseminate EPRP and Job Aides	16,620,000
Print and disseminate Essential Nutrition Interventions Package to 138 councils	3,500,000
Print and disseminate IEC materials including NNS Implementation plan	79,950,000
Print and disseminate national guidelines on healthy eating and lifestyles to 138 councils	6,500,000
Print and distribute national guidelines on nutrition care and support for PLHIV to 138 councils	14,979,125
Procure chemicals, reagents and equipment for TFNC laboratory	19,780,171
Procure office furniture, equipment and supplies	48,630,000
Procurement of goods and services	7,042,000
Promote and support operational research in Nutrition	150,000,000
Provide office utilities to TFNC office and Laboratory	257,160,000
Provide technical support on Vitamin A supplementation and de-worming campaign to 138 councils	29,950,000
Provide Technical support to 10 line ministries in planning and budgeting for Nutrition	31,660,000
Provide Technical support to 133 councils in planning and budgeting for Nutrition	246,380,000
Provide Technical support to regional and district nutrition officers	10,660,000
Recruit 12 new staff	25,440,000
Repair 5 units office buildings and furniture, 3 times each	52,585,000
Repair 5 units staff houses buildings, 3 times each	104,550,456
Review and print Planning and Budgeting Guideline for Nutrition at District level	160,000,000
Service, Maintain and Repair 45 vehicles	93,400,000
Service, maintain and repair of 20 computers, 6 photocopiers and 16 Fire ext.	8,340,000

Implementer / Program / Activity	Grand Total
Strengthen Centre's Legal services	59,250,000
Strengthen Food and Nutrition Library and documentation	40,500,000
Strengthen provision of administrative and logistical support in the department of Community Health and Nutrition	66,260,000
Strengthen provision of administrative and logistical support in the department of Food Science and Nutrition	69,960,000
Strengthen provision of administrative and logistical support in the department of Nutrition Education and Training	67,960,000
Strengthen provision of administrative and logistical support in the department of nutrition policy and planning	69,660,000
Support Bi-annual food security and nutrition assessment	57,880,000
Support HIV and AIDS mitigation at workplace	22,764,944
Support local long and short term training to 60 TFNC staff	65,600,000
Support Multisectoral Nutrition Working Group	1,950,000
Support the workers council union (RAAWU)	49,403,000
Train and Orient 21 Regional and 25% of District Nutrition Officers	34,800,000
Train TOT on quality and safety of processed complementary foods in 9 municipalities and towns	14,540,000
Undertake in-service training and educational seminars for TFNC staff	4,380,000
Undertake TFNC program review	18,243,000
Valuation of TFNC Assets	74,215,000
National Nutrition Strategy	41,918,000
Advocacy and Dissemination of the National Nutrition Strategy (NNS) at Regional and District Levels	38,518,000
Development of the NNS Implementation Plan	3,400,000
Nutrition Care and Support for PLHIV	838,985,250
Development and printing service delivery tools (job aids, M&E) educational materials and radio programs	201,793,850
Supportive supervision on management of RUTF	327,704,500
Train health care workers on management of Acute Malnutrition using RUTF in 12 Districts	309,486,900
Nutrition in Emergencies	132,390,000
Bi-annual rapid vulnerability assessment	93,850,000
Meeting to review nutrition in Emergencies and translate job aids	3,980,000
Nutrition in emergencies coordination meetings	4,950,000
Nutrition in emergencies training	29,610,000

Implementer / Program / Activity	Grand Total
Nutrition Multi sectoral Technical Working Group	12,140,000
Support quarterly Multisectoral Nutrition Technical Working Group meetings	12,140,000
Nutrition Research	22,755,000
Study on effects of micronutrients fortified food on biomarkers of iron and zinc in pre-school children with or without Helicobacter pylori infection in Tanzania	22,755,000
Nutrition Survey	14,480,000
Development of Nutrition Survey Guideline	14,480,000
Planning and Budgeting for Nutrition	350,856,700
District planning and assessment workshop	13,305,200
Mapping of Regional and District nutritionists	13,545,000
Zonal level meetings on planning and budgeting for nutrition	324,006,500
Prevention of Iodine Deficiency Disorders	427,769,522
A study on effects of excess iodine intake on thyroid function in school children	24,070,640
National Council for Control of Iodine Deficiency Disorders meetings	20,576,000
Roll quality control protocols in low performing regions	187,093,200
Sensitization of District leaders and Salt Inspectors in low salt iodation performing Districts	22,216,000
Strengthening National IDD control in Tanzania	57,312,255
Technical Supportive supervision in 29 salt producing districts	116,501,427
Small scale cassava processing and vertical integration of the cassava subsector in Southern and East Africa - Phase II	112,700,000
Development and commercialization of good quality and competitive cassava products	112,700,000
Social and Behavioural Change Communication	16,797,500
Task Force and consultative meetings	16,797,500
Sorghum Promotion	51,040,000
Develop new TFNC website and establish zonal communication centres	9,760,000
Promotion of sorghum processing and consumption	41,280,000
Technical Support	129,200,000
Technical support to Nutrition Interventions at District Level	129,200,000
UNICEF	2,727,000,000
Micronutrient Support	2,727,000,000

Implementer / Program / Activity	Grand Total
Mebendazole Tablets to LGAs	1,363,500,000
Vitamin A Capsules to LGAs	1,363,500,000
WFP	7,015,449,388
Blanket supplementary feeding	7,015,449,388
Supplementary feeding for treatment of moderate acute malnutrition and prevention of stunting	7,015,449,388
WHO	328,020,000
Food borne diseases and food hazards prevention and control	176,080,000
Food borne diseases and food hazards prevention and control (TFDA)	176,080,000
Food borne diseases risk assessment and control systems	151,940,000
Food borne diseases risk assessment and control systems (TFDA)	151,940,000
WORLD VISION	1,501,442,670
7+11 Mainstreaming	208,810,000
Contribute to the improved nutrition/health status of under five children, pregnant & lactating mothers	208,810,000
AIM Health Project	279,422,929
Children and mothers are well nourished access essential health services and are protected from infectious diseases	279,422,929
Arusha Rural, Karatu & Same Projects	208,406,960
Mothers and children are well nourished	208,406,960
Bukoba Rural and Karagwe Projects	176,751,981
Mothers and children are well nourished	176,751,981
Kilindi MNeCH Project and Eastern Zone ADP	269,687,732
Improved access and utilisation of MNCH services, adoption of positive nutrition and WASH practice at community level	269,687,732
Nzega, Igunga & Kahama Projects	266,539,336
Mothers and children are well nourished	266,539,336
Sustain MNCH and Sponsorship Programs	91,823,732
Improved knowledge and skills of caregivers to meet nutrition needs	91,823,732
Grand Total	78,628,958,914

6.3 Annex E: Sub-national Level Interventions

COUNCIL / PROGRAM / ACTIVITY	Capacity	Curative	Preventive	Grand Total
BABATI TC	**173,149,327**	**0**	**17,531,000**	**190,680,327**
MTEF	**173,149,327**	**0**	**17,531,000**	**190,680,327**
Construct VIP latrines for demonstration in villages	80,000,000			80,000,000
Establish demonstration gardens for fruits and vegetables	1,725,000			1,725,000
Facilitate groups of women on cultivation and processing of Vitamin A potatoes	1,100,000			1,100,000
Facilitate Vitamin A campaign and control of Diseases for Under 5			10,331,000	10,331,000
Facilitate Vitamin A campaign and control of Diseases for Under 6			2,400,000	2,400,000
Facilitate Vitamin A campaign and control of Diseases for Under 7			4,800,000	4,800,000
Sensitise milk drinking in secondary schools and primary schools	1,000,000			1,000,000
Sensitize mothers to attend clinics	5,112,500			5,112,500
Support community construct milk collection and processing centre	40,000,000			40,000,000
Support disadvantaged groups vulnerable to HIV/AIDS provide dairy goats	2,000,000			2,000,000
Support group of farmers providing dairy cows	10,990,230			10,990,230
Support groups to construct fish ponds and planting fish	7,724,750			7,724,750
Support groups with dairy cows	7,724,800			7,724,800
Support groups with dairy goats	7,724,797			7,724,797
Support groups with maize milling machines	8,047,250			8,047,250
IRINGA DC	**66,708,000**	**0**	**12,630,000**	**79,338,000**
MTEF	**66,708,000**	**0**	**12,630,000**	**79,338,000**
Conduct outreach services to 20 villages located far from Health Centres	17,825,000			17,825,000
Conduct Outreach Services to for RCH activities in Health Centres	13,200,000			13,200,000
Conduct Outreach Services to villages	10,934,000			10,934,000
Conduct training on PMTCT to 10 Hospital Staff (Council Hospital)	5,782,000			5,782,000
Conduct training on PMTCT to 40 Hospital Staff (CHMT/CHSB)	5,942,000			5,942,000

Conduct training to 30 MCH workers on breastfeeding and rampant cases	6,005,000			6,005,000
Conduct Vitamin A Supplementation and Deworming Campaign Twice			12,630,000	12,630,000
Develop IEC materials for awareness creation to the community	4,300,000			4,300,000
Orient 15 Health Facilities staff on PMTCT, VTC, PITC and CTC services	2,720,000			2,720,000
KIGOMA DC	**96,236,000**	**6,820,000**	**6,600,000**	**109,656,000**
MTEF	**96,236,000**	**6,820,000**	**6,600,000**	**109,656,000**
Carry out 91 outreach and 4 mobile services monthly	23,440,000			23,440,000
Conduct deworming to primary schools pupils		6,820,000		6,820,000
Conduct follow-up on PMTCT new guideline to 68 health facilities	2,550,000			2,550,000
Conduct quaterly follow-up on growth monitoring and nutrition assessment			6,600,000	6,600,000
Conduct training on improvement of fish farming system to fish farmers	5,460,000			5,460,000
Mentoring on Essential Nutrition Action (ENA) to Dispensaries	1,650,000			1,650,000
Provide meal allowance to council staff Living with HIV/AIDS	35,136,000			35,136,000
Purchase of modern cereal processing machines in 4 villages	28,000,000			28,000,000
KISHAPU DC	**4,968,480**	**0**	**11,905,000**	**16,873,480**
MTEF	**4,968,480**	**0**	**11,905,000**	**16,873,480**
Conduct Vitamin A and Deworming campaign Two Round			11,705,000	11,705,000
Establish sorghum seed multiplication plot at Mwamala Agriculture Centre	4,968,480			4,968,480
Facilitate treatment of wells in the District			200,000	200,000
KONGWA DC	**273,225,242**	**0**	**29,700,400**	**302,925,642**
MTEF	**273,225,242**	**0**	**29,700,400**	**302,925,642**
Construction of vegetable sheds	20,000,000			20,000,000
Improve poultry productivity and hatching	2,000,000			2,000,000
Improve product and improved sorghum seed	12,074,212			12,074,212
Introduce dairy cattle	15,700,000			15,700,000
Nutrition activities (Dispensaries)	795,000			795,000

Provide food to risk mothers (CHMT/CHSB)	75,540,000			75,540,000
Provide nutritional food nd fare to employees LHIV	14,013,000			14,013,000
Purchase and distribution of 5000 improved chickens and cocks	93,203,000			93,203,000
Purchase of sorghum hauling machine	13,000,000			13,000,000
Special foods to Health Centres	6,900,030			6,900,030
Supplementation of Vitamin A (Health Centres)			29,700,400	29,700,400
Support transport fare and nutrition food for patients attending TCT (CHMT/CHSB)	20,000,000			20,000,000
LINDI DC	**166,666,600**	**0**	**50,455,000**	**217,121,600**
MTEF	**166,666,600**	**0**	**50,455,000**	**217,121,600**
Advice livestock keepers' on improved livestock production in 28 wards	5,100,000			5,100,000
Conduct community awareness and sensitisation based on nutrition health in wards	1,750,000			1,750,000
Conduct measles vaccination campaign to children aged 9 months to 5 years			23,740,000	23,740,000
Conduct national Vitamin A and deworming campaign under 5 years children			25,200,000	25,200,000
Conduct screening for oral care, eye and deworming at primary schools			1,515,000	1,515,000
Conduct sensitization meetings in 3 divisions on importance of latrines use	2,285,000			2,285,000
Conduct supportive food premises inspection	5,895,000			5,895,000
Conduct training to RCH workers in nutrition preparations and feeding	85,395,000			85,395,000
Construct 10 fishing ponds at Sudi and Mchinga	10,000,000			10,000,000
Facilitate improvement of fish and seaweed farming	620,000			620,000
Introduce new varieties of horticulture crops through FFS in villages	4,320,000			4,320,000
Provide support to 320 PLHIAs on medicine and food nutrients	29,475,000			29,475,000
Support availability of horticulture inputs and processing machines	7,500,000			7,500,000
Support availability of sesame inputs, equipment and machinery	4,026,600			4,026,600
Support PLHAs on medicines and food nutrients	5,500,000			5,500,000
Training of farmers to improve husbandry of cassava production	4,800,000			4,800,000
MAKETE DC	**253,795,000**	**2,253,500**	**50,825,000**	**306,873,500**

MTEF	**253,795,000**	**2,253,500**	**50,825,000**	**306,873,500**
CHMT to conduct consultation to identify appropriate interventions that can be linked with bi-annual Vitamin A Supplementation and deworming	4,000,000			4,000,000
Conduct FFS in potatoes, garlic and vegetable production in villages	59,516,000			59,516,000
Conduct follow-up and monitoring in 12 child friendly schools on hand-washing with soap and face washing	4,080,000			4,080,000
Conduct follow-up and monitoring of CORPS trained on PHAST	1,700,000			1,700,000
Conduct hygiene and hand-washing campaign in villages			5,000,000	5,000,000
Conduct monthly outreach mobile RCH services in 24 Health Centres	12,360,000			12,360,000
Conduct orientation to 196 CORPS on screening of children for SAM	20,400,000			20,400,000
Conduct sanitation marketing in villages			25,000,000	25,000,000
Conduct sensitization of District, Division and Wards Leaders on PMTCT	2,640,000			2,640,000
Conduct training to 15 CHMT members on PMTCT	6,690,000			6,690,000
Conduct training to 50 health workers on community based management of SAM	19,200,000			19,200,000
Conduct training to 50 health workers on screening of children for SAM	2,860,000			2,860,000
Construct fish ponds in villages	1,850,000			1,850,000
Coordination meeting with stakeholders supporting PMTCT in the District	1,395,000			1,395,000
Facilitate acquisition of dairy cattle and bulls in villages	15,410,000			15,410,000
Facilitate Bi-Annual Vitamin A Supplementation and Deworming			14,725,000	14,725,000
Facilitate community to develop their plans on water hygienic and sanitation	19,440,000			19,440,000
Facilitate folic acid, ferrous sulphate and Mebendazole to 300 expectant mothers			6,100,000	6,100,000
Facilitate management of macro and micro nutrients deficiency among patients admitted		2,253,500		2,253,500
Increase production of apples in villages	4,463,000			4,463,000
Prepare tools and facilitate training on hygiene and sanitation	1,985,000			1,985,000
Refresher training to Health Workers on PMTCT	10,830,000			10,830,000
Support vulnerable groups with improved chickens in 7 villages	4,676,000			4,676,000
Supportive supervision in 33 HFs on PMTCT and HEID activities	5,340,000			5,340,000
Train 160 CORPS from 16 villages	29,760,000			29,760,000

Train 172 primary school teachers (health coordinators) on water sanitation, hygiene promotion and hand-washing facilities	25,200,000			25,200,000
MBEYA MC	**285,201,200**	**0**	**44,317,500**	**329,518,700**
MTEF	**285,201,200**	**0**	**44,317,500**	**329,518,700**
Conduct monitoring, supervision and evaluation on dairy management and milk processing	45,400,000			45,400,000
Conduct sensitization meeting on establishment of hygienic groups	830,000			830,000
Conduct supervision, monitoring and evaluation on fruit seedling nurseries	5,640,000			5,640,000
Conduct supportive supervision and outreach services to 23 centres	9,170,000			9,170,000
Conduct training to 30 Hospitals and Health Centres Staff on Kangaroo mother care method for pre-mature and low eight babies	6,125,000			6,125,000
Conduct Vitamin A Supplementation and Deworming Campaign Twice			44,317,500	44,317,500
Conduct 160 outreach services to 12 Health Facilities	11,080,000			11,080,000
Facilitate community to establish fish ponds for fingerlings production	2,740,000			2,740,000
Facilitate production of 10,000 seedlings of avocado, mangoes, passion, guava nurseries	125,071,200			125,071,200
Facilitate training on dairy cattle husbandry to 2 dairy groups	6,400,000			6,400,000
Facilitate training on dairy cattle husbandry to dairy groups	35,310,000			35,310,000
Facilitate training on fruit seedlings management and environmental conservation	12,100,000			12,100,000
Facilitate training to 30 fish farmers on modern fish ponds management and fish production	1,335,000			1,335,000
Support acquisition of sets of milk processing storage tools	24,000,000			24,000,000
MOROGORO DC	**34,195,000**	**0**	**9,254,016**	**43,449,016**
MTEF	**34,195,000**	**0**	**9,254,016**	**43,449,016**
Collect water sample for analysis during a year to improve water quality in villages	762,000			762,000
Conduct 20 mobile and 36 outreach services monthly	15,380,000			15,380,000
Conduct environmental health and sanitation competition in villages			3,430,016	3,430,016
Conduct IEC on health issues			2,150,000	2,150,000
Conduct school health programme to 50 primary school teachers	2,000,000			2,000,000
Conduct training to 25 health officers on new regulations and rules regarding public health	4,000,000			4,000,000
Conduct Vitamin A and Deworming campaign Two Round			2,650,000	2,650,000

Conduct Vitamin A Campaign by 7 Cascade at wards			1,024,000	1,024,000
Facilitate 264 village health workers to conduct Vitamin A campaign	5,280,000			5,280,000
Sensitize 147 schools on the establishment of food supply schemes	1,575,000			1,575,000
Train 25 service providers on nutrition status for under 5	5,198,000			5,198,000
MPWAPWA DC	**79,001,987**	**0**	**223,673,250**	**302,675,237**
MTEF	**79,001,987**	**0**	**223,673,250**	**302,675,237**
Community mobilisation on VAS, Deworming and Measles			4,785,000	4,785,000
Establish and manage vegetables and fruit gardens	2,910,000			2,910,000
Facilitate food for assets projects	307,000			307,000
Implement VAS Supplement Exercise (Dispensaries)			127,257,250	127,257,250
Implement VAS Supplement Exercise Campaign (District Hospital)			40,661,000	40,661,000
Implement VAS Supplement Exercise Campaign and Deworming (Health Centres)			50,970,000	50,970,000
Improve local chickens	44,645,932			44,645,932
Initiate nutrition programme to primary schools	11,150,055			11,150,055
Provide nutritional educational materials	3,390,000			3,390,000
Sensitise use of Iodated Salt	1,969,000			1,969,000
Supervision of Iodated Salt Use	6,440,000			6,440,000
Support school feeding program in primary schools	8,190,000			8,190,000
MTWARA MC	**70,289,700**	**0**	**27,140,000**	**97,429,700**
MTEF	**70,289,700**	**0**	**27,140,000**	**97,429,700**
Conduct demonstration sanitation facilities at schools			12,500,000	12,500,000
Conduct sanitation campaign			1,650,000	1,650,000
Facilitate construction of pit latrines utensils, drying racks and garbage pits in household	19,258,000			19,258,000
Facilitate sensitization activities in water sanitation	10,087,000			10,087,000
Increase cassava production per hectare	5,007,000			5,007,000
Increase eggs production and growth rate of local chickens	3,071,200			3,071,200

Increase milk production per cow	17,298,000			17,298,000
Organise monthly competitions on hygiene and sanitation in Mitaa and villages			2,000,000	2,000,000
Procure 15 hybrid dairy cattle	13,195,000			13,195,000
Provide Vitamin A Supplementation to Children under 5			5,990,000	5,990,000
Sensitize communities on hygiene and hand-washing in villages			2,500,000	2,500,000
Sensitize community on early ANC attendance	1,440,000			1,440,000
Train 15 livestock keepers and dairy husbandry	438,500			438,500
Train 50 farmers on cassava production, processing and storage	495,000			495,000
Train and construction of demo pit latrines in villages			2,500,000	2,500,000
MUHEZA DC	**142,464,835**	**0**	**20,455,000**	**162,919,835**
MTEF	**142,464,835**	**0**	**20,455,000**	**162,919,835**
Conduct session of Vitamin A Supplementation			18,750,000	18,750,000
Construct fish pond with community participation	10,000,000			10,000,000
Construction of cassava processing units	25,000,000			25,000,000
Distributing deworming drugs and materials			1,705,000	1,705,000
Improve dairy cattle by provision of calf heifers to vulnerable groups	44,280,000			44,280,000
Provide nutritional support to Employees LHA	8,432,000			8,432,000
Provide nutritious food to PLHA in villages	50,860,000			50,860,000
Support vulnerable groups on poultry husbandry to improve egg laying	3,892,835			3,892,835
PANGANI DC	**64,349,000**	**0**	**9,414,000**	**73,763,000**
MTEF	**64,349,000**	**0**	**9,414,000**	**73,763,000**
Facilitate availability of quality and affordable seeds and fertilizers	6,652,000			6,652,000
Facilitate procurement of 16 dairy cattle	37,547,000			37,547,000
Facilitate Vitamin A Supplementation to Under 5 in two round			9,414,000	9,414,000
Mobilize resources and facilitate provision of needy support students	16,800,000			16,800,000
Provide food support for staff who are affected by HIV/AIDS	1,000,000			1,000,000

Training on production of vegetables	2,350,000			2,350,000
RUANGWA DC	**212,869,100**	**19,115,000**	**22,582,272**	**254,566,372**
MTEF	**212,869,100**	**19,115,000**	**22,582,272**	**254,566,372**
Conduct distribution and administration of albendazole		16,310,000		16,310,000
Conduct distribution and administration of praziquantel to primary schools		2,805,000		2,805,000
Conduct Outreach Services	12,500,000			12,500,000
Conduct residential training to groups of farmers on quality simsim post-harvest practise	6,274,000			6,274,000
Conduct sensitization campaign on construction of pit latrines	1,000,000			1,000,000
Conduct sensitization to women to attend post natal clinics	250,000			250,000
Conduct training on hygiene and sanitation to villages	4,130,000			4,130,000
Conduct Vitamin A and Deworming campaign Two Round			16,882,272	16,882,272
Conduct water quality monitoring to big water supply	1,200,000			1,200,000
Create awareness on cleanness competition at wards and villages	1,912,500			1,912,500
Preparedness of 54 Diarrhoea Kits	5,000,000			5,000,000
Procure Vitamin A and Medical Supply			5,700,000	5,700,000
Provide meal allowance to 30 council staff Living with HIV/AIDS	6,837,000			6,837,000
Provide need support (food) to infected teachers	3,174,000			3,174,000
Provide nutritional food to needy PLHIV Group	9,700,000			9,700,000
Sensitize community on importance of PMTCT and address stigma	526,000			526,000
Support acquisition of 35,660 fisherings	3,156,600			3,156,600
Support acquisition of cassava planting materials	3,390,000			3,390,000
Support acquisition of dairy cattle to groups in villages	88,069,000			88,069,000
Support acquisition of indigenous goats to groups in villages	55,950,000			55,950,000
Support acquisition of maize and sorghum basic seeds	1,190,000			1,190,000
Support community to establish community water supply	8,610,000			8,610,000
Grand Total	**1,923,119,471**	**28,188,500**	**536,482,438**	**2,487,790,409**

6.4 Annex G: Nutrition Milestones in Tanzania

- 1920s, 1st survey concerning nutrition status was conducted in Kilwa, Kilimanjaro and Arusha.
- 1920s and 1930s deliberate effort were made to improve diet in schools, prisons, hospitals, labour camps and military.
- 1937, British Government appointed a committee to report and advice on human nutrition in Tanganyika Territory
- 1947, a Nutrition Unit was established under Ministry of Health
- 1949, Multisectoral Team was sent to Makerere to be trained in nutrition
- 1953/54 famine increased mortality which triggered establishment of Multi-sectoral Central Advisory Committee on nutrition to review and advice on Nutrition
- 1961 during independent celebration, improvement of nutrition status of Tanzanian community was taken up as an issue of a major concern
- In 1967 the Arusha Declaration emphasized the need to enhance food availability, preparation and preservation.
- 1970's Nutrition Units was developed under Ministry of Agriculture and Education
- In 1973, Tanzania Food and Nutrition Centre was established by the Act Number 24 and amended by Act 3 of 1995- Under Prime Minister's Office and later was moved to Ministry of Health.
- In 1992 Food and Nutrition Policy was developed
- In 1992, The Baby Friendly Hospital Initiative was initiated in Tanzania aiming to help parents to make informed decisions about feeding their babies
- In 2005, MKUKUTA was developed but classified as 'weak' in terms of its nutrition content, scoring only 17.5 out of a possible 58 points.
- In line with MKUKUTA, in 2005 Nutrition Strategic Plan 2005-2010 was developed.
- 2010 New MKUKUTA considered more nutrition issues.
- 2010, Hillary Clinton, the USA Foreign Secretary and Irish Foreign Minister Eamon Gilmore, re-affirmed the commitment of their countries to support Tanzania to scale up nutrition activities.
- 2010 Development of National Nutrition strategy
- 2011 Launching the **National Nutrition Strategy** 2011-16.
- 2011 Establishment of a National **High Level Steering Committee** for Nutrition.
- 2011 Recruitment of **Nutrition Officers** and establishment of Nutrition Focal Points at the National, Regional and District level.
- Effective in FY 2012/2013, establishment of a **designated line** in the national budget for nutrition.
- 2012,UN Secretary---General Appoints 27 Global Leaders to Head (including H.E President Dr. Jakaya Kikwete) Worldwide Effort to Address Child Malnutrition as part of the global Scaling Up Nutrition (SUN) Movement. The

27 leaders committed to advancing the strength and security of nations by improving maternal and child nutrition.

- 2012 development of guideline for councils for preparation of plan and budget for nutrition.
- May 2013, the President of Tanzania H.E. Dr. Jakaya Mrisho Kikwete and SUN Lead Group Members, launched a nationwide nutrition sensitization campaign – *the Presidential Call for Action on Nutrition*. All of Tanzania's Regional Commissioners attended the launching and made commitments to advocate for improved nutrition in their respective regions. Development Partners were also present including UNICEF,WFP, WORLD BANK ,UK AID, USAID, HKI, IRISH AID, GAIN and WHO as well as private entrepreneurs; They all stated their continued support for the Presidents call for action.