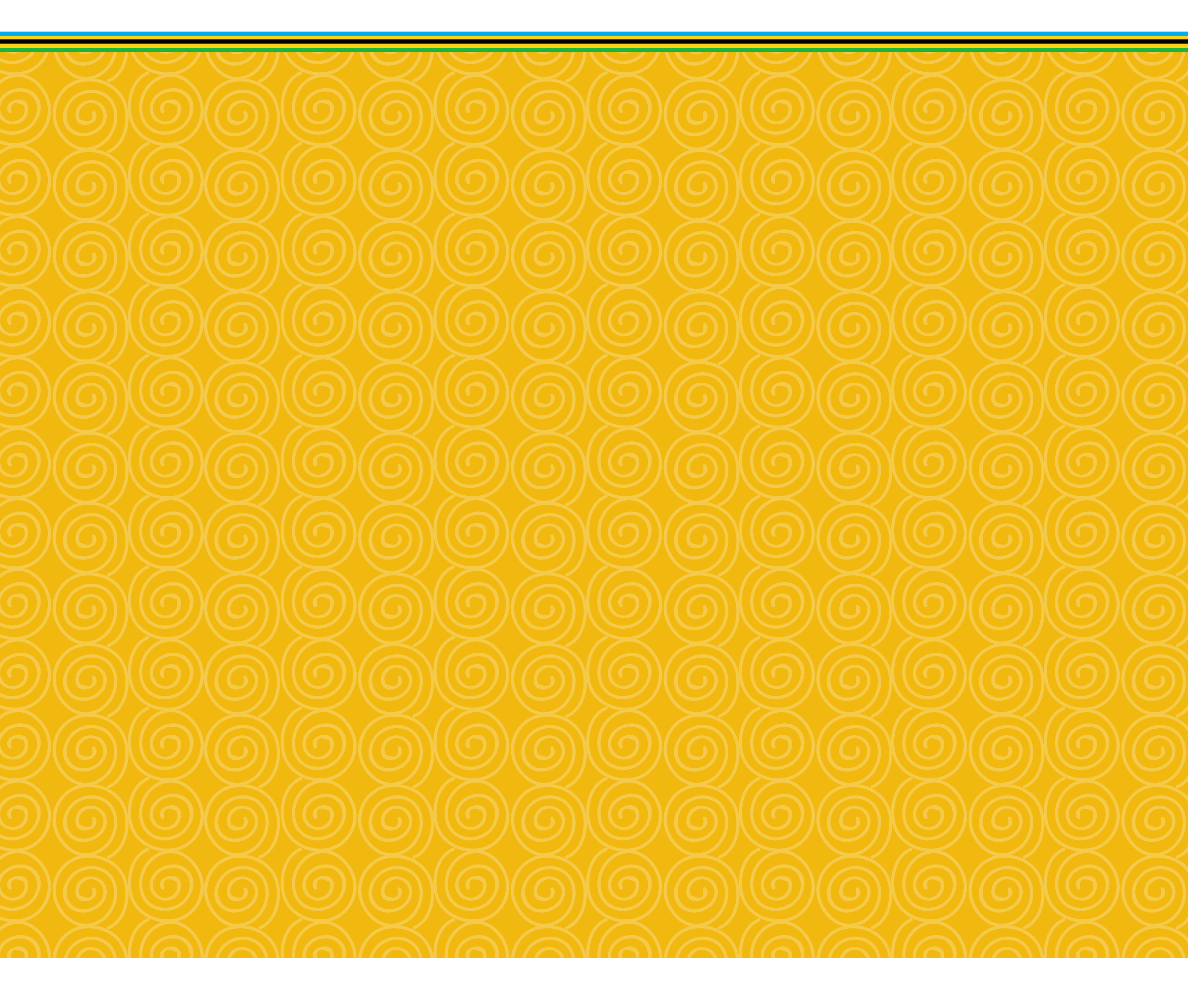
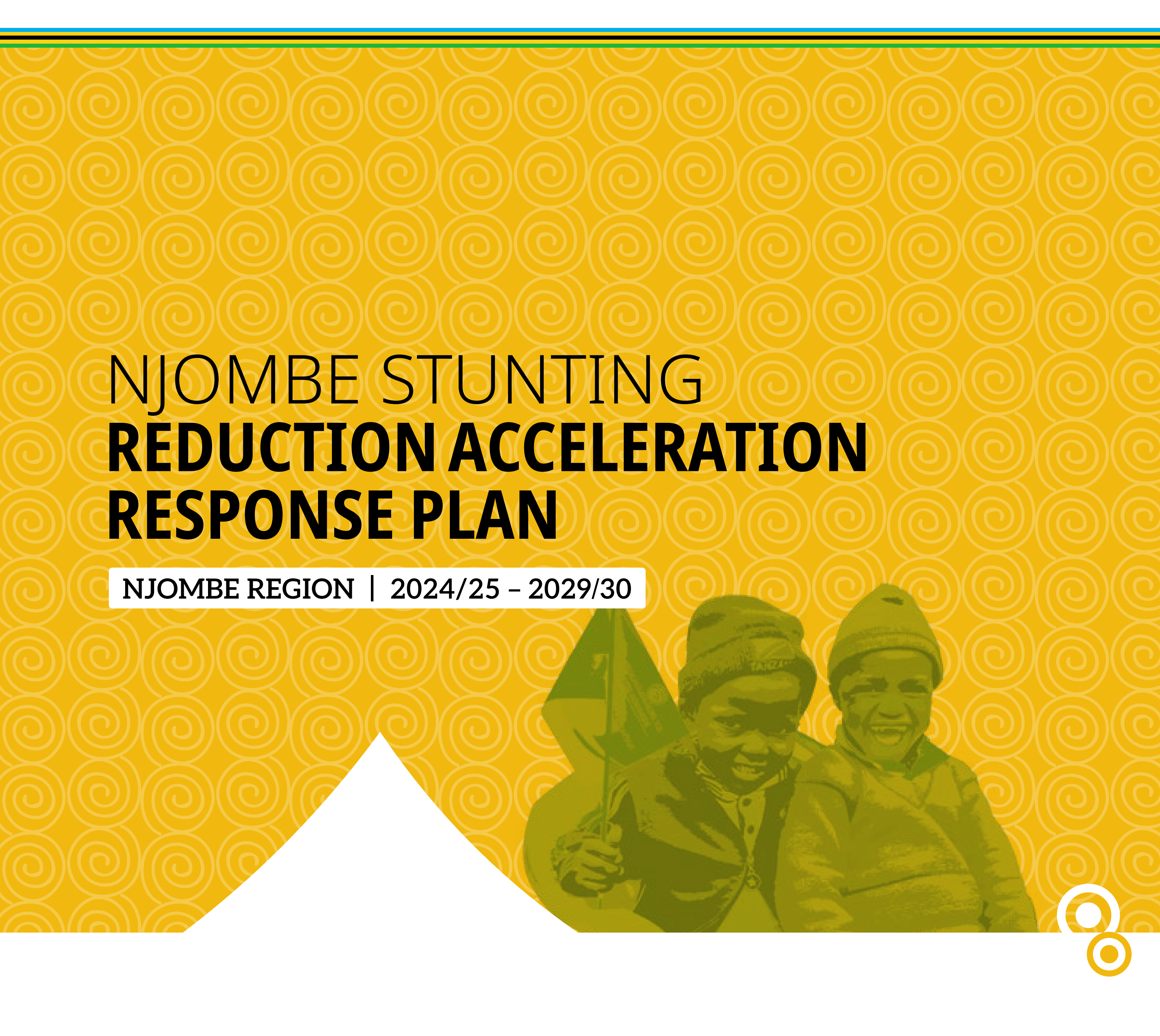
THE UNITED REPUBLIC OF TANZANIA
PRESIDENT'S OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

NJOMBE STUNTING REDUCTION ACCELERATION RESPONSE PLAN

NJOMBE REGION | 2024/25 – 2029/30

unicef
for every child





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NJOMBE REGION | 2024/25 – 2029/30

Keynote Foreword

Ladies and gentlemen, distinguished guests, development partners, community leaders, esteemed colleagues,

It is with immense pride and a deep sense of responsibility that I stand before you today to launch the Njombe Stunting Reduction Acceleration Response Plan (NSRARP) 2024/25 – 2029/30. This moment marks a significant milestone in our collective journey towards eradicating stunting and improving the health and well-being of our children and communities in Njombe region.

Stunting, a severe form of chronic undernutrition, has long-term and irreversible consequences on children's physical and cognitive development. It not only affects their immediate health, but also their future productivity and potential, ultimately impeding our region's socio-economic development. Today, we take a decisive step to address this challenge head-on with the Acceleration Response Plan.

The NSRARP is not just a plan; it is a comprehensive and strategic framework designed to tackle the multifaceted causes of stunting. It addresses immediate, underlying and basic causes of malnutrition through an integrated, evidence-based and multisectoral approach. Our goal is ambitious yet achievable: to reduce the prevalence of stunting among children under 5 years of age in Njombe region from 40 per cent to 25 per cent by 2030. This reduction will signify a brighter and healthier future for our children.

To achieve this, the NSRARP outlines specific interventions that focus on supporting pregnant women, caregivers and children in our region to have increased access to adequate, safe and nutrient-rich foods, to have the ability to perform optimal dietary, responsive caregiving, positive parenting and hygiene practices, and to receive gender-responsive quality-integrated nutrition services from all sectors.

Our approach is holistic and multisectoral, recognizing that stunting cannot be addressed by the health sector alone. We need coordinated multisectoral efforts across agriculture, education, community development and the private sector. This plan emphasizes the importance of strong partnerships with government agencies, non-governmental organizations, development partners and community stakeholders.

I extend my deepest gratitude to all the individuals and organizations that have contributed to the development of this plan. Your dedication, expertise and unwavering commitment have been instrumental in shaping a robust and comprehensive strategy.

Special thanks go to the President's Office Regional administration and Local Government (PO-RALG), Prime Minister's Office (PMO), Ministry of Health, Ministry of Community Development, Gender, Ministry of Agriculture, Ministry of Livestock and Fisheries, the Regional Health Management Team, United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), Management and Development for Health (MDH), Tanzania Food and Nutrition Centre (TFNC) and our private sector partners for their invaluable support. I also commend the efforts of civil society organizations (CSOs), community-based groups and healthcare professionals who have been at the forefront of this work.

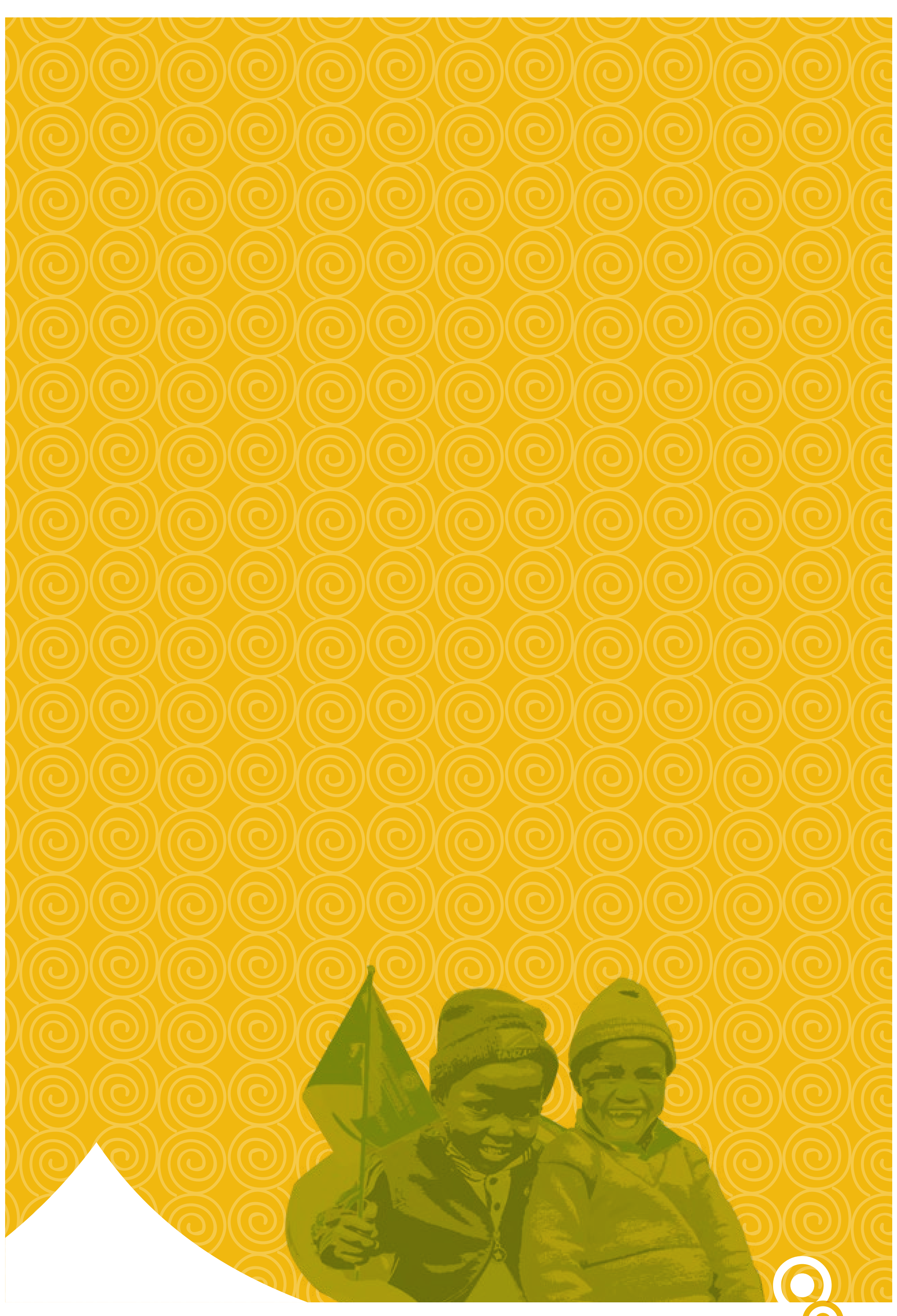
The NSRARP is more than a document; it is a testament to our collective resolve to ensure that every child in Njombe has the same opportunity to reach his or her full development potential. It is a call to action for all of us to work together in solidarity with unwavering commitment. We must mobilize resources, implement innovative solutions and sustain our efforts to achieve the vision of a stunting-free Njombe.

I urge all stakeholders to remain steadfast in their support and engagement. Let us continue to collaborate, innovate and persevere in our shared mission. Together, we can transform the nutritional landscape of Njombe and create a future where our children thrive, our communities prosper and our region flourishes.

Thank you

Anthony John Mtaka

Njombe Regional Commissioner



Statement of Commitment

We, the multisectoral stakeholders involved in the NSRARP, hereby affirm our unwavering commitment to the goals and objectives outlined in this critical initiative. Recognizing the profound impact of stunting on the health, cognitive development and prospects of children in Njombe region, we pledge to collectively prioritize and implement evidence-based interventions.

We acknowledge disparities in prevalence of stunting in the district councils and multifaceted causes, ranging from maternal workload, social and cultural norms to inadequate child feeding and care practices and access to quality health and nutrition services. We also acknowledge the understanding of these challenges and the impact they have not only on the growth and development of our children but also on the overall economic productivity of our community. We believe that it is a time to fully address childhood stunting and other forms of malnutrition in the region to accelerate progress towards ending malnutrition both in our region and across Tanzania.

Our commitment spans across government agencies, development partners, civil society organizations, community leaders, healthcare professionals, educators and private sector representatives. Together, we will harness our collective expertise, resources and networks to effectively address multiple causes and other bottlenecks to bring about positive change.

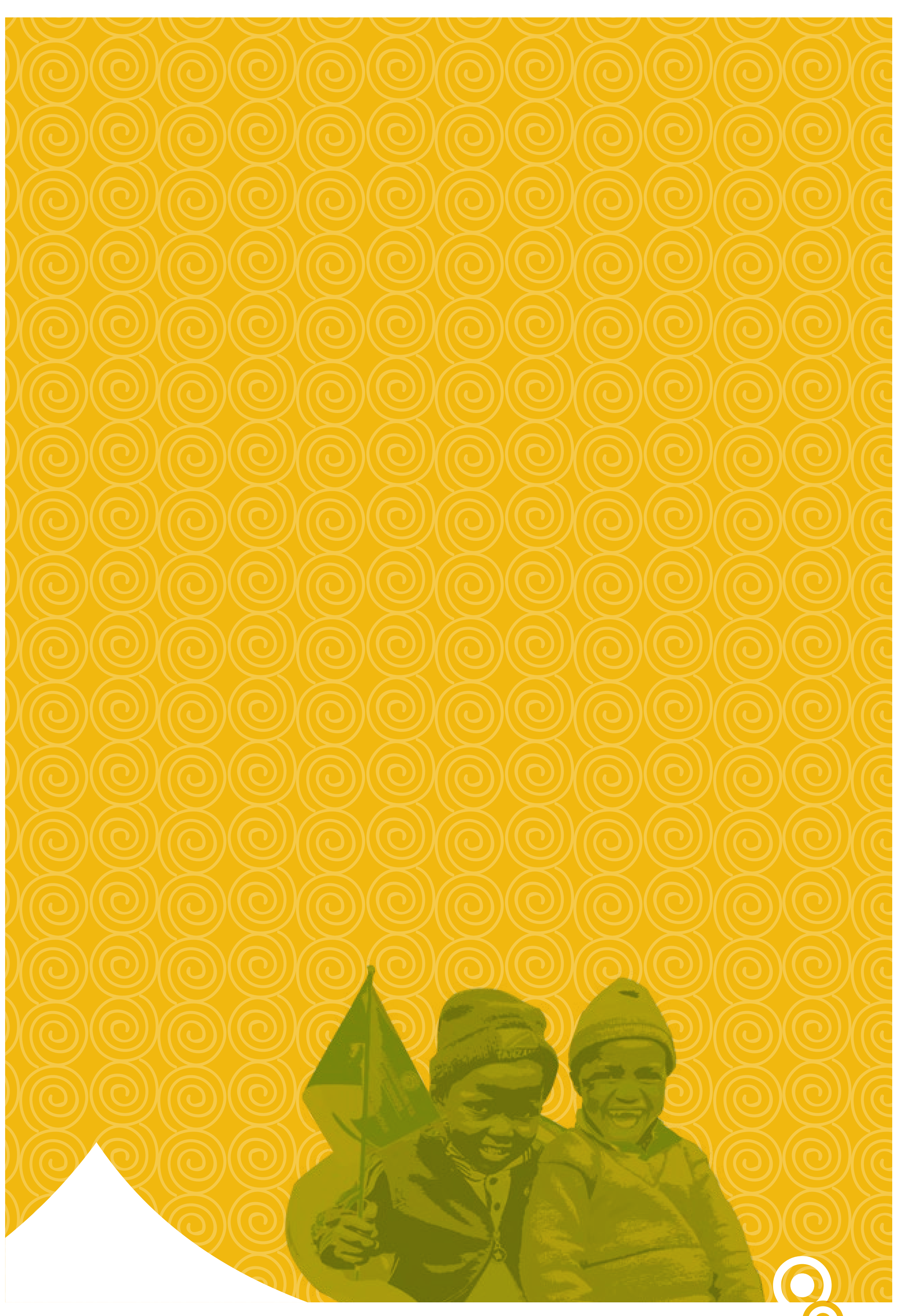
We are dedicated to promoting synergy and collaboration among sectors, including agriculture and food security, livestock and fisheries, health, nutrition, education, Early Childhood Development (ECD), Water, Sanitation and Hygiene (WASH), social protection and community development. By fostering integrated approaches and leveraging our respective strengths, we shall actively participate in the implementation of the NSRARP through Multisectoral Nutrition Steering Committees to achieve sustainable improvements in nutrition outcomes for children, adolescents and women.

Accountability, transparency and inclusivity will guide our actions as we work towards reducing stunting rates, enhancing nutrition practices, strengthening health services and advocating for supportive policies. Through coordinated efforts for continuous monitoring, evaluation and adaptation, we commit to ensuring that our efforts yield measurable impacts and the lasting benefits for the people of Njombe.

In signing this Statement of Commitment, we affirm our shared responsibility and determination to build a healthier, more resilient community where all children can thrive and reach their full potential.

Judica H. Omari

Regional Administrative Secretary



Acknowledgements

The development of the NSRARP has been a collaborative effort that reflects dedication and commitment of numerous individuals and organizations. As the National Nutrition Consultant, it is my privilege to extend heartfelt gratitude to all those who have contributed to this vital initiative. First and foremost, I would like to thank the Regional Commissioner, for his unwavering support and leadership. His vision and commitment have been instrumental in driving this initiative forward. I also thank the Regional Administrative Secretary for her critical contributions to this initiative since the beginning.

I extend my deepest appreciation to the government agencies, particularly the PO-RALG, PMO, Ministry of Health, Ministry of Community Development, Gender, Ministry of Agriculture, Ministry of Livestock and Fisheries, the Regional Health Management Team, UNICEF, USAID, MDH, TFNC and the private sector partners for their invaluable contributions in shaping the strategic direction of the Acceleration Response Plan. Their expertise and insights have been critical in ensuring the plan is comprehensive, and evidence based.

Special thanks to our development partners, especially UNICEF and the Government of Norway, for their valuable and generous technical and financial support. Their global, national and regional experience, and resources have greatly enriched the multisectoral nutrition planning and implementation processes. I am also grateful to the civil society organizations and community-based groups whose grassroots efforts and advocacy have provided essential insights and mobilized the community support.

Special recognition is due to the following individuals from UNICEF: Patrick Codjia, Ophilia Karumuna, Tuzie Edwin Ndekia, Ruth Nkurlu, Mary-Ann Schreiner, D'Arcy Williams, Lusako Sichali, Joyce Ngegba, Ramadhani Mwiru, Abraham Sanga and Jaah Mkupete (consultant). Also Judica H. Omari (RAS), Njombe Regional Task Force members, including Dr Juma Mfanga (RMO), Bertha Nyigu (RNuO) and Mussa Halifa (planner and coordinator of TASAF Njombe), are deeply appreciated for their invaluable contributions. The development of NSRARP would not have been possible without the technical input provided by key partners drove all the way from Dar Es Salaam, Ms. Juliet Itatiro, Nutrition Specialist from MDH and others for providing quality assurance throughout the process.

To the healthcare professionals, planners, nutritionists, agriculture and livestock extension workers, food scientists, community development workers, village and ward executives, village health workers, religious leaders, influential figures, parents, caregivers, educators and social workers on the frontlines, your dedication to improving the lives of children and families in Njombe is truly commendable.

Finally, I would like to acknowledge our competent drivers who drove us to all places in the region to accomplish the field work, the families and community members who have actively participated in the development of this plan. Your voices and experiences have shaped our understanding and approach, ensuring that the NSRARP is responsive to the real needs of the people it aims to serve. Together, we have laid a strong foundation for a healthier future for the children of Njombe. Let us continue to work in solidarity and with unwavering commitment to achieve the vision of a region free from the burden of stunting.

Dr. Rajab M. Rutengwe

National Nutrition Consultant - UNICEF

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Acronyms

ANC	Antenatal Care
AOR	Assessment of Risk
BMI	Body Mass Index
CHWs	Community Health Worker
CLTS	Community-led Total Sanitation
CMR	Child Mortality Rate
CPD	Continuing Professional Development
CSO	Civil Society Organization
DPs	Development Partners
ECD	Early Childhood Development
ESARO	Eastern and Southern Africa Regional Office
FAO	Food and Agriculture Organization
FBO	Faith-Based Organization
GDP	Gross Domestic Product
HLI	Higher Learning Institutions
HSSP	Health Sector Strategic Plan
IFA	Iron and Folic Acid
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
LGA	Local Government Authority
MAM	Moderate Acute Malnutrition
MEAL	Monitoring, Evaluation, Accountability and Learning
MEL	Monitoring, Evaluation and Learning
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Rate
MMS	Multiple Micronutrient Supplementation
MNPs	Micronutrient Powders
MNSC	Multisectoral Nutrition Steering Committee
MoH	Ministry of Health

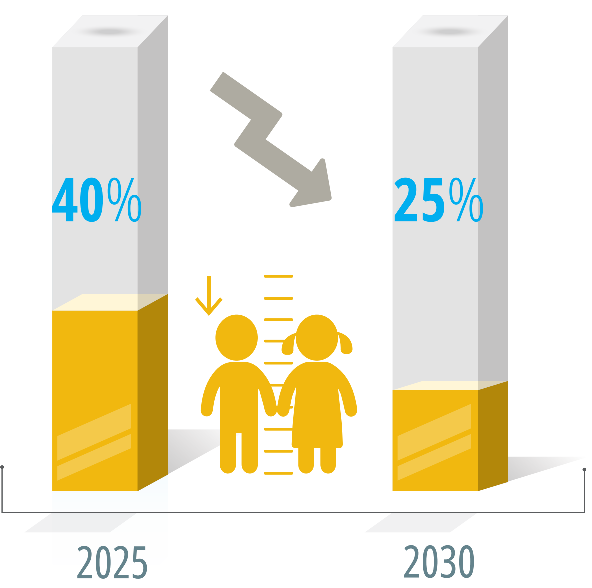
MTEF	Medium Term Expenditure Framework
MUAC	Mid Upper Arm Circumference
NBS	National Bureau of Statistics
NGO	Non-governmental Organization
NMNAP	National Multisectoral Nutrition Action Plan
NSRARP	Njombe Stunting Reduction Acceleration Response Plan
PMELC	Planning, Monitoring, Evaluation and Learning Cycle
RAS	Regional Administrative Secretary
RBM	Results-Based Management
RMO	Regional Medical Officer
SAM	Severe Acute Malnutrition
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SUN	Scaling Up Nutrition
TASAF	Tanzania Social Action Fund
TBD	To Be Determined
TDHS	Tanzania Demographic and Health Survey
TFNC	Tanzania Food and Nutrition Centre
TNNS	Tanzania National Nutrition Survey
ToC	Theory of Change
TZS	Tanzanian Shilling
UNICEF	United Nations Children's Fund
USD	United States Dollar
VAS	Vitamin A Supplementation
VHND	Village Health and Nutrition Day
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive Summary

The Njombe Stunting Reduction Acceleration Response Plan (NSRARP) 2025–2030 is a comprehensive regional initiative designed to drastically reduce stunting rates among children under 5 years in Njombe region by 2030. Recognizing stunting as a critical indicator of chronic undernutrition with profound impacts on health, cognitive development and economic productivity, this plan adopts a multifaceted approach targeting the immediate, underlying and basic causes of malnutrition.

The expected impact of the NSRARP is to reduce the prevalence of stunting among children under 5 years of age in Njombe Region from 40 per cent in 2025 to 25 per cent in 2030. The expected outcomes to lead to this drastic reduction in childhood stunting are that pregnant women and children in Njombe have both good diets, driven by adequate food and dietary practices, and good care, driven by adequate services and practices.

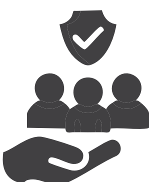
Expected impact to reduce prevalence of stunting among children under 5 years



To achieve these **outcomes** by 2030, the expected output results include:

Pregnant women and children have increased access to adequate, safe and nutrient-rich foods.

Parents, caregivers and children have increased access to counselling and resources to perform optimal dietary, responsive caregiving, positive parenting and hygiene practices.



Pregnant women and children receive gender-responsive quality-integrated nutrition services from the Health, Water, Sanitation and Hygiene (WASH), Early Childhood Development (ECD), Social Protection, Education and Food Systems.

This will be achieved through a holistic package of evidence-based, nutrition-specific and First 1,000 Days. To specifically accelerate stunting reduction, the focus population groups include children under 5 years of age, pregnant and lactating women, and women of reproductive age (15–49 years). The assumption is other critical nutrition programmes that target other population groups should continue to provide high-quality interventions to improve diets, services and practices.

Key stakeholders and partners must mobilize around TZS 7.8 billion (USD 3 million) over 5 years to meet the NSRARP's expected impact, outcomes and output results.

Multisectoral Nutrition Steering Committees and Njombe Stunting Reduction Taskforce will provide strategic guidance on the implementation and monitoring of the NSRARP. To achieve expected results, Medium Term Expenditure Framework (MTEF) planning will be an integral part of the implementation and monitoring processes with engagement of multiple sectors in the region secretariat, local government authorities, partners and stakeholders. The NSRARP will expand and strengthen partnerships with Development Partners, Non-governmental Organizations (NGOs), Faith-Based Organizations (FBOs), civil society organizations (CSOs), the private sector, research institutions and other community groups.

In conclusion, by addressing the immediate, underlying and root causes of stunting through integrated, evidence-based interventions and fostering a supportive environment for sustaining change, the NSRARP will transform the nutrition landscape of Njombe.

1 INTRODUCTION TO THE NSRARP

1.1 Background

The Njombe Stunting Reduction Acceleration Response Plan (NSRARP) is a forward-looking evidence-based initiative to address the unacceptably high stunting prevalence in Njombe, in line with the national commitments to improve nutrition and health outcomes.

Njombe region, as a part of Tanzania's Southern Highlands zone, receives prolonged period of intense rains making it among the top country's food basket regions, producing mainly maize, beans, Irish potatoes and fruits yet facing significant challenges in child nutrition. With the alarming childhood stunting prevalence of 50 per cent reported in Njombe region in 2022 [Tanzania Demographic and Health Survey – Malaria Indicator Survey (TDHS–MIS), 2022], the development of the NSRARP began with the recognition of this challenge and its devastating effects on young child and the nation at large. Stunting or chronic malnutrition often occurs when a child lives with long-term nutritional deprivations in the First 1,000 Days of life. A stunted child has reduced physical and cognitive growth and development affecting their intellectual performance. Later in life, stunting affects economic productivity, increases risk of

The NSRARP 2025–2030 outlines a holistic approach to improving child nutrition and health by emphasizing upon the importance of political commitment, building capacities, scaling-up quality integrated multisectoral interventions and services, enhancing ECD, driving behavioural change and effective multisectoral coordination.

nutrition-related chronic diseases, such as diabetes and heart disease, and perpetuates intergenerational cycle of malnutrition.

In 2023, the Njombe Regional Commissioner organized a stakeholder meeting in response to a call to action from the President of the United Republic of Tanzania, Her Excellency, Dr. Samia Suluhu Hassan, who instructed all the regions with high prevalence of stunting to come up with plans of actions to sustainably reduce the prevalence of stunting. Development of an evidence-based response plan was, therefore, important to increase collaboration with stakeholders to accelerate actions for stunting reduction. The NSRARP 2024/25–2029/30, therefore, outlines a holistic approach to improving child nutrition and health by emphasizing upon the importance of political commitment, building capacities, scaling-up quality integrated multisectoral interventions and services, enhancing ECD, driving behavioural change and effective multisectoral coordination. A task force was established to spearhead the development, implementation and monitoring of the NSRARP.

This NSRARP aligns with the national development priorities, particularly those stated in the Tanzania's National Multisectoral Nutrition Action Plan II (NMNAP II), emphasizing the government's commitment to reduce malnutrition in all its forms and developing strong and quality human capital through scaling-up integrated and multisectoral nutrition actions.

The NSRARP is also harmonized with other national initiatives aimed at improving health and nutrition. These initiatives include the Health Sector Strategic Plan (HSSP), the Tanzania Development Vision 2025, which collectively aim to create a healthier and more prosperous nation, and the Njombe region's strategic development agenda geared towards enhancing food security, improving healthcare services, and leveraging local resources and knowledge to combat malnutrition. The localized approach ensures that interventions are contextually appropriate and culturally sensitive, thereby increasing their effectiveness and sustainability. In addition, by aligning with the Sustainable Development Goals (SDGs), particularly SDG 2 (Zero Hunger) and SDG 3 (Good Health and Well-being), the NSRARP contributes to global efforts to eradicate hunger and promote well-being for all.

The implementation of the NSRARP is expected to yield significant benefits for Njombe region. By focusing on seven nutrition-specific and five First 1,000 Days, the plan is expected to substantially reduce stunting rates through a holistic package of evidence-based activities:

Evidence-based activities to reduce stunting through implementation of the NSRARP

Nutrition-Specific Interventions

1. Promoting optimal infant and young child feeding (IYCF)
2. Delivering comprehensive antenatal care (ANC) services [including iron and folic acid (IFA)/multiple micronutrient supplementation (MMS)] for maternal nutrition
3. Scaling up food fortification and promoting use of fortified foods
4. Promoting optimal use of micronutrient powders (MNPs)
5. Strengthening child growth monitoring and promotion
6. Preventing and managing child diseases
7. Enhancing nutrition in schools

First 1,000 Days

1. Improving food security through agricultural and livestock production of nutritious and diverse foods
2. Supporting integration of ECD (gender-responsive positive parenting and responsive caregiving)
3. Promoting WASH campaigns for improved sanitation and hygiene (e.g., Baby WASH)
4. Expanding nutrition-sensitive social protection programming that targets the poorest households
5. Strengthening nutrition governance, monitoring and information systems

The selected interventions in the NSRARP have been prioritized, based on their likelihood to accelerate childhood stunting within the indicated timeframe. This means that some other interventions across multiple sectors also focused to improve health and nutrition status of women, adolescents and children are not included but should continue to be supported and implemented by specific sectors (e.g., Health, Community Development, Social Welfare, WASH, Social Protection, Education, Agriculture, Livestock and Fisheries).

The region will benefit from strengthened multisectoral and private sector engagement, which will facilitate the mobilization of resources and expertise necessary for sustainable progress. In addition, by addressing harmful cultural and gender norms, the response plan will create an enabling environment to support optimal child growth and development.

1.2 Objectives

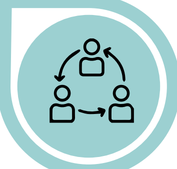
The overall objective of the NSRARP is to guide the efforts to accelerate the reduction of the high prevalence of childhood stunting through engagement of political leaders, actors from multiple sectors, communities and stakeholders.

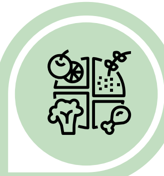
Objectives of the NSRARP

Guiding the prioritization of multisectoral interventions to address stunting

Providing a clear implementation plan with targets, activities and responsible parties to act and track progress

Strengthening collaboration and convergence through coordination at all levels from village to region





Improving coverage of multisectoral nutrition services and accelerating the adoption of positive practices for nutrition

Bolstering monitoring, evaluation and accountability for delivery of multisectoral nutrition services, to address stunting

The NSRARP will cover all villages and streets (“mitaa”) in Njombe region and will include both men and women, boys and girls in implementation and monitoring of the results. Population of focus will be children under 5 years of age, women of reproductive age (15–49 years) and adolescents.

1.3 Guiding Principles

The NSRARP is guided by a set of principles:

- **Leadership and Ownership:** The regional government will maintain a central role, ensuring local ownership and sustainability.
- **Stakeholder Participation:** Engagement and participation of multiple stakeholders in all stages from designing, implementation, monitoring and reporting will contribute to ownership and sustainability of the investment made.
- **Evidence-based Facts:** Data will be used to guide choices of interventions and making necessary adjustments in case some activities do not yield expected results.
- **Strengthening Accountability:** Committed to scalable, evidence-based multisectoral interventions and strengthening implementation of the nutrition compact will ensure monitoring progress in achieving results.
- **Optimizing Community Platforms:** Equitable, accessible and quality integrated nutrition service delivery at community level to ensure that Acceleration Response Plan is delivered in an efficient, effective and sustainable manner.
- **Community and Private Sector Engagement:** Strengthening and leveraging effective partnerships with community members and the private sector to enhance the reach and impact of interventions.
- **The Three “Ones” Principle:** Adhering to the integrated approach of one plan, one coordinating mechanism and one Monitoring, Evaluation, Accountability, and Learning (MEAL) framework to ensure cohesive and unified action.

These guiding principles will ensure that the NSRARP is implemented in a manner that is inclusive, effective and sustainable, ultimately contributing to the significant reduction of stunting in Njombe.

1.4 Conceptual Framework

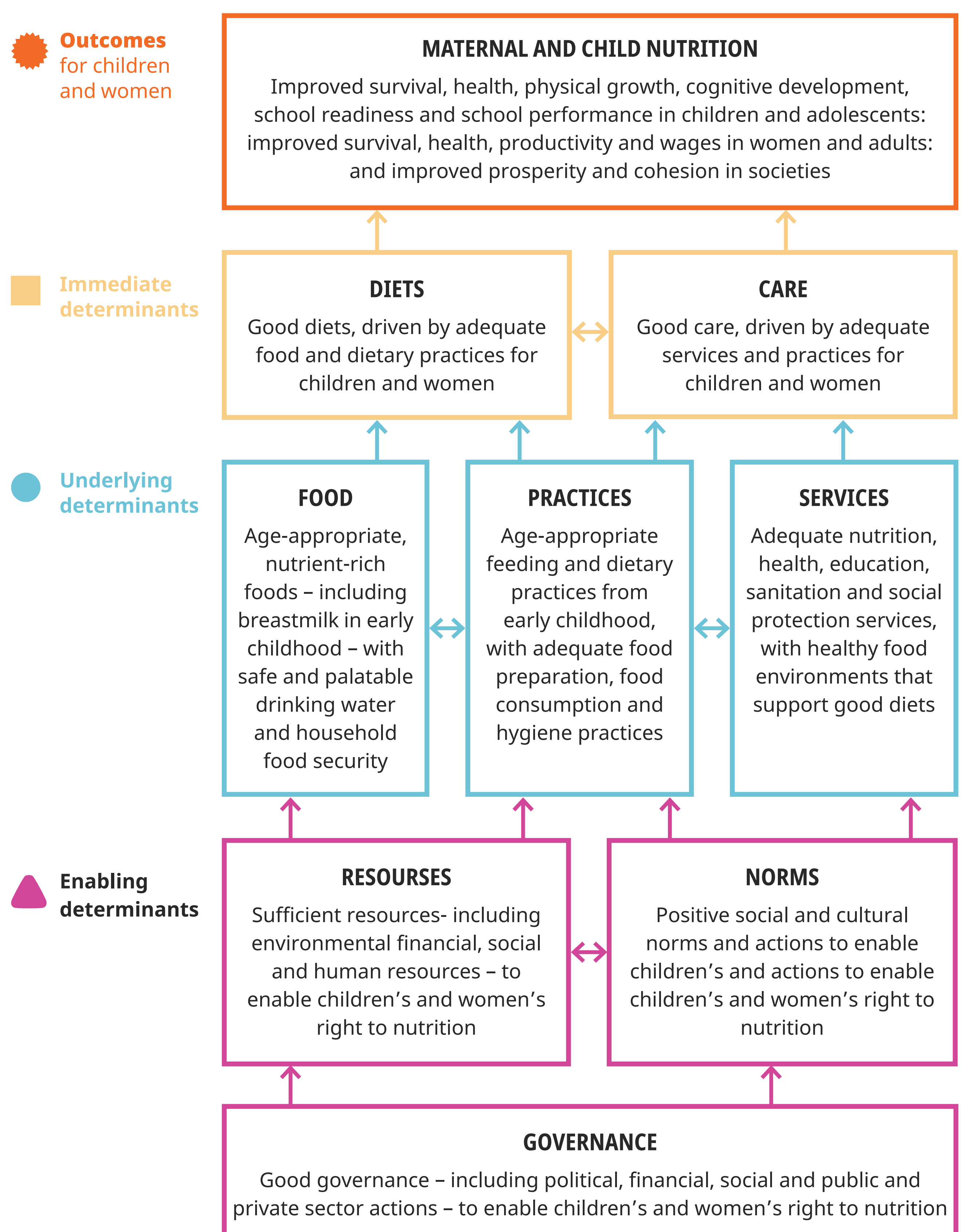


Figure 1 | *UNICEF's Framework on Maternal and Child Nutrition, 2020*

Malnutrition is not simply caused by a poor diet in terms of quantity and/or quality. Other sectors play an important role in the prevention of malnutrition, including care and WASH practices, healthcare, access to food within the household and other contextual factors, such as social and cultural norms, can all contribute to undernutrition.

Figure 1 shows the UNICEF's conceptual framework (2020) on the determinants of maternal and child nutrition outlining the immediate, underlying and enabling determinants to prevent malnutrition in all its forms. The framework has been adopted in developing the NSRARP by highlighting the interconnectedness of the multiple determinants and other drivers, and thus, tailored to address the specific needs from individual care practices to broader social and environmental factors.

The conceptual model promotes a broader understanding of factors that affect nutritional status and encourage looking beyond the immediate needs of people, but considering other factors that affect nutrition at all levels to prioritize needs. As there is no single determinant of under-nutrition it was necessary to consider three levels of determinants (immediate, underlying and enabling) together with context-specific factors to plan for successful intervention strategies for children to survive and thrive.

The framework adopted and developed NSRARP for the interconnectedness of the multiple determinants and other drivers, tailored to address specific needs from individual care practices to broader social and environmental factors.

2

SITUATION ANALYSIS

2.1 Njombe Region Situation Analysis

The Njombe region, located in the southern highlands of Tanzania, is characterized by its fertile lands and significant agricultural productivity. Despite this, Njombe faces a high prevalence of stunting among children under five years of age indicative of the underlying socio-economic challenges affecting the population. The region comprises of six Local Government Authorities (LGAs): Ludewa District Council (DC), Makambako Town Council (TC), Makete DC, Njombe DC, Njombe TC, and Wanging'ombe DC. It has 18 divisions, 107 wards, 381 villages, 82 streets and 1839 hamlets. According to the 2022 Population and Housing Census, the region has an estimated population of 889,946.

Njombe’s socio-economic profile reveals a population that relies heavily on rain-fed agriculture led by small-holder farmers, producing food crops such as maize, Irish and sweet potatoes as well as pulses on subsistence basis. Women are the primary source of agricultural labour force in Njombe region.

However, the agricultural sector is often affected by issues such as limited access to markets, inadequate storage facilities and

climate change, which impact food security due to limited access to diverse nutrient dense foods. Households often rely on staple crops like maize, which lack essential nutrients. In addition, there is a notable disparity in the distribution of resources and services, with rural areas experiencing higher levels of deprivation compared to urban centres.

In May 2024, a Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey and qualitative Social and Behaviour Change (SBC) assessment were conducted in Njombe region to assess the nutritional status of children under the age of 5 years and that of women of reproductive age (15–49 years) and to explore the interplay of social, cultural and economic elements influencing child nutrition in the region. The survey was led by the Tanzania Food and Nutrition Centre (TFNC) with financial support from UNICEF.

While the TDHS (2022) indicated the stunting rate of 50 per cent in Njombe region, higher than the National average of 30 per cent in 2022, the 2024 SMART survey indicates that the prevalence of stunting is 40 per cent, which is lower than the stunting rates found in the previous National Nutrition SMART Surveys conducted in 2014 and 2018 where stunting rates were 52 per cent and 54 per cent respectively. Based on these new findings, while there has been slight historical progress on stunting reduction, it still means that approximately 46,000 children under 5 years of age are stunted in Njombe region in 2024.

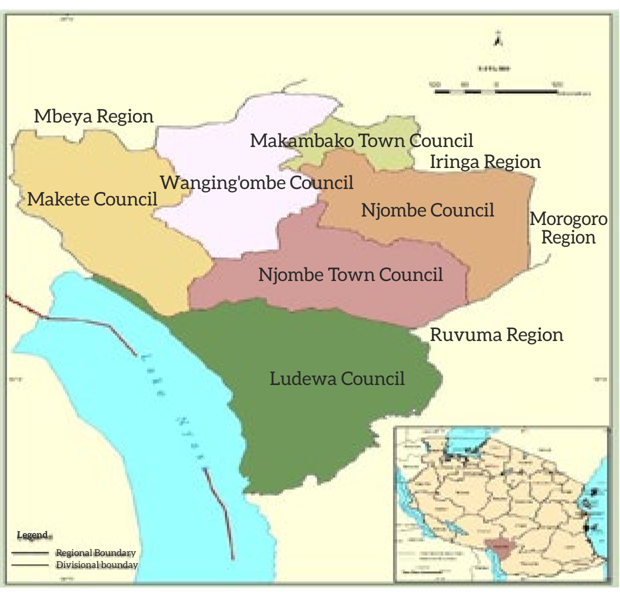


Figure 2 | *Map of Njombe Region (District and Town Councils)*

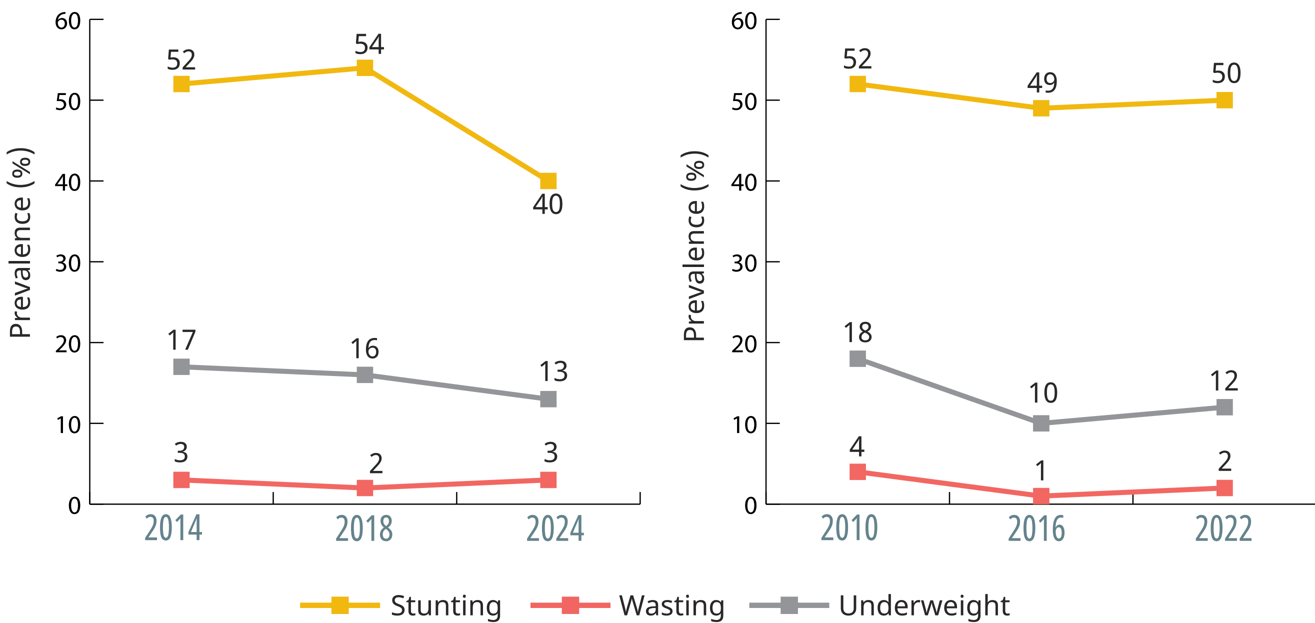


Figure 3 | *Trends in Nutrition among Children under five in Njombe Region, Tanzania National Nutrition Survey (TNNS)*

Figure 4 | *Trends in Nutrition among Children under five in Njombe Region, Tanzania Demographic and Health Survey*
Note: *In 2010, Njombe was part of Iringa region.*

The most affected councils with a prevalence of stunting exceeding 40 per cent were: Makete DC (50 per cent) followed by Njombe DC (45 per cent), Njombe TC (42 per cent) and Makambako TC (41 per cent), Ludewa DC (34 per cent) and Wanging'ombe DC (35 per cent).

Stunting occurs in the 6–23 month window, when children need to consume nutrient-dense foods, including animal-sourced foods such as dairy, dagaa, eggs and meat. Availability of high-quality foods and affordability of nutrient-rich foods, mothers' knowledge and time to prepare appropriate foods for children affect a family's ability to provide a healthy diet and prevent stunting. Suboptimal breastfeeding practices, including timely initiation of breastmilk and exclusive breastfeeding for the first 6 months of foods, contributing to nutritional outcomes.

The SMART survey further showed that only 59 per cent of children from 6 to 8 months had a timely introduction of complementary food. Approximately 67 per cent of the children aged 6–23 months consume minimally diverse diet and 53 per cent of children 6–23 months in Njombe region received a minimum acceptable diet, ranging from 8.2 per cent in Makete DC to 69.2 per cent in Njombe TC. The proportion of children aged 6–23 months who received solid, semi-solid or soft foods the minimum number of times or more was 64 per cent. The survey also revealed only 58 per cent of children under 0–23 months were breastfed within 1 hour of birth and 69 per cent of infants under 6 months of age were exclusively breastfed.

Findings of the qualitative assessment indicated that economic constraints significantly affect the quality and diversity of children's diets post-breastfeeding. Commonly, children older than 6 months are fed a maize flour porridge, with variations in diet largely dependent on familial economic status. The assessment also highlighted a general lack of knowledge about appropriate complementary foods and feeding practices, which are crucial after 6 months of exclusive breastfeeding. Barriers on child feeding and dietary diversification included inadequate time and availability of parents to provide proper feeding practices for their children due to their engagement in livelihood work such as farming or income-generating activities. Fathers are less involved in childcare responsibilities making it difficult to have a positive influence on their children's diet and increase the workload for women.

Promotion of proper child nutrition, especially during the critical first 2 years of life, is deeply influenced by societal and gender roles

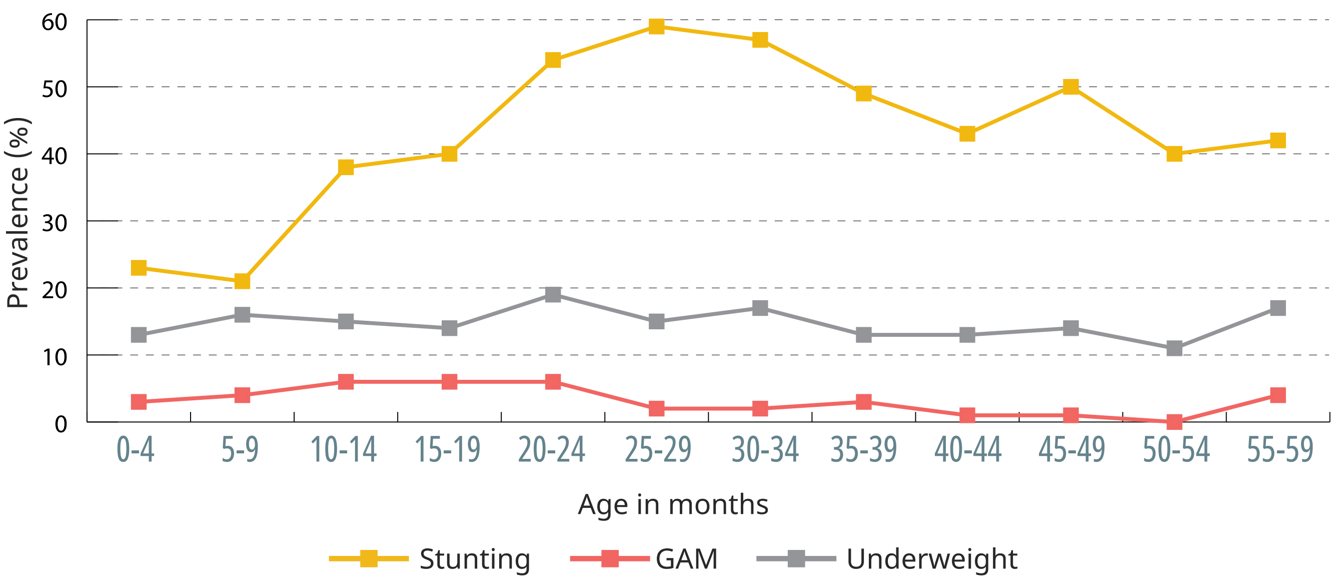


Figure 5 | *Trends in Child Undernutrition in Njombe by Age (in months)*

within the community. Limited support from husband or partner and extended family members, men's limited knowledge and level of involvement in childcare as well as perceived norms such as childcare as women's responsibility, negatively affect nurturing environment for children to thrive.

Poor maternal nutrition during pregnancy and breastfeeding may increase the risk of preterm delivery or low-birth weight (LBW) of the baby and lead to stunted growth of the child. The SMART survey showed that only 49 per cent of pregnant women aged 15–49 years old took iron and folic acid (IFA) for 90 days. The proportion of pregnant women of reproductive age (15–49 years old) who were malnourished was higher among adolescent girls aged 15–19 years than among the older. For non-pregnant women (15–49 years old), the prevalence of underweight was also higher in the age groups of 15–19 years old and 20–24 years old. In addition, the distribution of overweight and/or obesity among pregnant women exceeded 30 per cent in nearly all councils.

Inadequate access to safe water, sanitation and poor hygiene practices increases the burden of infectious pathogens and higher chances for a child to experience diarrhoea, pneumonia, worm infestation and damaged intestinal villi leading to growth retardation. Access to clean water as well as sanitation and hygiene practices still a challenge in Njombe communities. The SMART survey found that only 58 per cent of the households use drinking water from improved sources, 34 per cent use unimproved sources and 7 per cent use surface water. Only 31 per cent of households used soap for handwashing in at least two critical times (including after defecating) in the past 24 hours. In addition, only 48 per cent of the households use improved excreta disposal facilities, only 18 per cent households use shared facilities and 34 per cent of the households use unimproved toilets. Majority of the households (95 per cent) with children under 3 years old were safely disposing children's faeces, while the remaining 5 per cent were not disposing their children's faeces safely.

With regards to other forms of malnutrition in the region, wasting is at 3 per cent, underweight at 13 per cent and 4 per cent of children under 5 years of age are overweight. On an average 12 per cent of the children aged under 5 years in Njombe are born with weight less than 2.5 kg, which is two times more than the national average (6 per cent). Similarly, the SMART survey revealed that there is a higher proportion of under five children with LBW across the councils ranging from 6.6 per cent in Makambako DC to 21 per cent in Njombe DC.

The more deprived populations in these LGAs are often the rural poor, women and children who lack access to essential services such as healthcare, WASH, education, early childhood development, extension services, information and means of production. Cultural norms and gender disparities further exacerbate the situation, with women and children bearing the brunt of stunting.

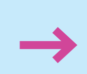
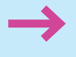
In conclusion, the drivers of childhood stunting in Njombe include limited availability of diverse and affordable nutrient-dense foods, poor community understanding of the term stunting and growth faltering, inadequate knowledge and poor IYCF and care practices, poor knowledge on dietary diversification of children's food, poor male involvement in childcare and feeding practices, inadequate purchasing power, and unhygienic environment and childhood illnesses.

3 THEORY OF CHANGE

The Theory of Change (ToC) for the NSRARP in Figure 5 provides a clear casual pathway for the changes expected to happen in the lives of children, adolescent, women, caregivers and the entire community in Njombe. The NSRARP focuses on two outcomes and three outputs, which are necessary to bring the desired changes of equitable reduction of childhood stunting. This will be achieved through a holistic package of evidence-based nutrition-specific and First 1,000 Days.

3.1 Results Chain

The ToC's results chain uses a simple **"if-then"** logic. For the NSRARP to comprehensively address Njombe's situation of high levels of childhood stunting, the appropriate enabling conditions for change must be in place.

Enabling conditions Activities 	**If…** there are sufficient resources (including application of multisectoral nutrition policies, strong partnership with regional private sector stakeholders, plans for resource mobilization around supplies, commodities, human resources and robust data collection and analysis), positive social and cultural norms (including community leaders engaging in dialogue to foster positive social and gender norms, community-wide awareness and empowerment campaigns on positive norms around nutrition, parenting, childcare, WASH, health, early marriage and pregnancy, motivated frontline workers trained on gender-responsive programming and SBC support), and good governance (including coordination of multisectoral nutrition interventions and partners in line with the NSRARP), **then…** a holistic intervention package of seven nutrition-specific and five nutrition-sensitive activities can be effectively and efficiently implemented.
Activities Outputs	**If…** these seven nutrition-specific activities (including the promotion of optimal breastfeeding, age-appropriate complementary feeding and responsive caregiving, delivery of comprehensive ANC services (including IFA/MMS) for maternal nutrition, strengthening food fortification infrastructure, promotion of MNPs, community growth monitoring and promotion, disease prevention and management, and enhancing nutrition in schools) and five nutrition-sensitive activities (including enhanced food security through agricultural and livestock production of nutritious and diverse foods, early childhood development, improved WASH programming and promotion, nutrition-sensitive social protection targeting poorest households, and improved nutrition governance, monitoring and informational systems) are implemented, **then…** the holistic intervention package would result in the three outputs for pregnant women, parents, caregivers and children in Njombe.
Outputs Outcomes 	**If…** pregnant women and children have increased access to adequate, safe and nutrient-rich foods; parents, caregivers and children have increased access to counselling and resources to perform optimal dietary, responsive caregiving, positive parenting and hygiene practices; and pregnant women and children receive gender-responsive quality integrated nutrition services from the Health, WASH, ECD, Social Protection, Education and Food Systems, **then…** the three outputs would result in the two outcomes for pregnant women and children in Njombe.
Outcomes Impact	**If…** pregnant women and children in Njombe have good diets, driven by adequate food and dietary practices, and good care, driven by adequate services and practices, **then…** Njombe's prevalence of childhood stunting among children under five will reduce from 40% in 2024 to 25% in 2030, which will also contribute to the prevention of other forms of malnutrition including wasting, micronutrient deficiency, overweight and obesity in line with NMNAP II (2021/22–2025/26).

3.2 Assumptions and Risks

The results chain of this ToC is based on a set of assumptions and risks that need to be taken into consideration while implementing the NSRARP:

Assumptions

- Communities in Njombe accept the NSRARP and **positively engage with activities;**
- Stakeholders will **participate in activities** and support coordination mechanisms;
- Parents and caregivers are supported to **provide responsive care** and pro-nutrition practices;
- User-friendly guidelines, tools and resources are available and **accessible to communities;**
- Poor households have access and benefit from PNNS's **integrated nutrition services;**
- Strong community social fabric **available for support;**
- Political will is **continued and sustained** across all levels of government, including public financing;
- National policies exist to **promote holistic food and nutrition** security and
- Laws are enforced to **create enabling environment** for optimal nutrition.

Risks

- Change in political leadership that could **change priorities at all** levels of government;
- Economic shocks, climate disasters, or pandemics;
- Decline in resources for such **a multisectoral response** to nutrition, including public financing;
- Human resource constraints;
- Parents, caregivers and families unable to benefit from NSRARP activities due to **lack of resources or time** and
- Persistence of **deep-rooted** social and cultural norms.

NJOMBE STUNTING REDUCTION ACCELERATION RESPONSE PLAN

Theory of Change

Impact

By 2030, stunting rates among under five children is reduced from 40% to 25% in Njombe region

Outcomes

- Pregnant women and children in Njombe region have **good diets**, driven by adequate food and dietary practices
- Pregnant women and children in Njombe region have **good care**, driven by adequate services and practices

Outputs

- Pregnant women and children have increased access to adequate, safe and nutrient rich **foods**.
- Parents caregivers, and children have increased access to counseling and resources to perform optimal dietary responsive caregiving positive parenting and hygiene **practices**
- Pregnant women and children in Njombe Region have good care, driven by adequate **services** and practices

Activities

Nutrition Specific Activities

1. Promote optimal infant and young child feeding
2. Deliver comprehensive ANC services (including IFA/MMS) for maternal nutrition
3. Scale-up food fortification and promote use of fortified foods
4. Promote optimal use of Micronutrient powders (MNPs)
5. Strengthen child growth monitoring and promotion
6. Prevent and manage child diseases
7. Enhance nutrition in schools

Nutrition Sensitive Activities

1. Improve food security through agricultural and livestock production of nutritious & diverse foods
2. Support integration of ECD (gender -responsive positive parenting and responsive caregiving)
3. Promote WASH campaigns form improved sanitation and hygiene (ex. Baby WASH)
4. Expand nutrition-sensitive social protection programming that targets poorest households
5. Strengthen nutrition governance, monitoring, and information systems

Enabling Conditions

Resources

- Application of multisectoral policies related to nutrition
- Strong partnership with regional stakeholders including private sector.
- Resource mobilization including supplies/ commodities/ human resources for nutrition

Norms

- Community influencers, leaders & community members engage in community dialogue fostering social and gender norms
- Community- wide awareness and empowerment campaigns on positive norms on nutrition, parenting childcare, WASH, health and early marriages/ pregnancies
- Motivated frontline workers trained on gender- responsive and SBC support

Governance

Coordination of multi- sectoral nutrition interventions and partners aligned with the Njombe Stunting Reduction Acceleration Response plan (NSRARP)

Situation

- High prevalence rates of childhood stunting in Njombe region (40%) affecting 46,114 out of 114,711 children under-five years.
- High stunting prevalence in all LGAs: Makete (50%): Njombe DC (45%) Njombe TC (42%): Makambako TC (41%) Wanging ombe (35%): Ludewa(34%)
- Insufficient knowledge about appropriate complementary feeding practices crucial after six months of exclusive breastfeeding, with only 60% of children 6-23 months consuming a diverse diet and 53% of children consume minimum acceptable diet
- Despite fertile land significant agriculture productivity, households rely on nutrient poor staple crops due to limited access to markets, inadequate storage facilities, and climate change, which limits access to the diverse nutrient dense foods produced in the region
- Low levels of father participation and engagement in childcare
- High levels of gender-based violence against women and children
- Inadequate access to safe water and sanitation and poor hygiene practices

Assumptions

- Communities in Njombe accept the proposed plan and positively engage with activities.
- Stakeholders will participate in activities and support coordination mechanisms
- Parents & caregivers are supported to provide responsive care and pro nutrition practices
- User friendly guidelines, tools, and resources are available and accessible to communities
- Poor households have access and benefit from PSSN's integrated nutrition services.
- Strong community social fabric available for support
- Political will is continued and sustained across all levels of government, including public financing
- National policies exist to promote holistic food and nutrition security
- Laws are enforced to create enabling environment for optimal nutrition

Risks

- Change in political leadership that could change priorities at all levels of government;
- Economic shocks, climate disasters, or pandemics;
- Decline in resources for such a multisectoral response to nutrition, including public financing;
- Human resource constraints;
- Parents, caregivers and families unable to benefit from NSRARP activities due to lack of resources or time and
- Persistence of deep-rooted social and cultural norms.

4

IMPLEMENTATION STRATEGY

4.1 Interventions and Activities

The NSRARP leverages a holistic package of evidence-based nutrition-specific and First 1,000 Days to address the complex drivers of stunting in Njombe.

Nutrition-Specific Interventions

These nutrition-specific interventions' activities address the immediate determinants of maternal and child nutrition and development:

- **Promoting optimal IYCF:**
  - Capacity building of 700 healthcare providers in 350 health facilities, and 920 community healthcare workers (CHWs) in 420 communities on breastfeeding, IYCF and responsive caregiving (including tools)
  - Bi-annual council community mobilization campaigns (e.g., media, radio and cooking demos)
  - Capacity building of 100 community groups on processing nutrient-rich flour

- **Delivering comprehensive ANC services (including IFA/MMS) for maternal nutrition:**
    - Capacity building of 700 healthcare providers in 350 health facilities on delivery of quality maternal nutrition services, including adherence to ANC services and IFA/MMS
    - Procurement of IFA/MMS for 150,000 (5 months dose for 30,000 pregnant women each year) pregnant women across 5 years
- **Scaling up food fortification and promote use of fortified foods:**
    - Capacity building of 200 small millers to fortify local flour
    - Procurement of fortificants for 200 small millers across 5 years
    - Promoting optimal use of MNPs:
    - Procurement of MNPs for 9,000 children aged 6–23 months across 5 years
    - Bi-annual council community mobilization campaigns (e.g., media, radio and MNP use)
- **Strengthening child growth monitoring and promotion:**
    - Capacity building of 700 healthcare providers in 350 health facilities and 920 CHWs in 420 communities on growth monitoring and promotion (including tools)
    - Procurement of anthropometric equipment (length boards, mid upper arm circumference (MUAC) tapes, big charts, etc.)
    - Implementation of community-based child growth monitoring through Village Health and Nutrition Day (VHNDs) in 420 communities with support from 920 CHWs

The procurement of iron and folic acid, multiple micronutrient supplements (MMS) has been arranged for 150,000 (5 months dose for 30,000) pregnant women across 5 years.

- **Preventing and managing child diseases:**
    - Capacity building of 100 healthcare providers from 12 hospitals and 46 health centres on management of diarrheal in children and wasting
    - Procurement of therapeutic milks and foods for 1,000 children under five across 5 years
- **Enhancing nutrition in schools:**
    - Capacity building of 1,200 teachers from 600 primary and secondary schools to deliver updated national food and nutrition education curriculum
    - Capacity building of 600 parent associations to provide nutritious and safe school meals, and 600 student health and nutrition clubs to develop nutrition skills and behaviours
    - Establishment of 600 school gardens and/or livestock keeping projects that provide both life skills to learners and ability for schools to supply their own fruits and vegetables

First 1,000 Days

These First 1,000 Days' activities address underlying determinants of maternal and child nutrition and development.

- **Improving food security through agricultural and livestock production of nutritious and diverse foods:**
  - Capacity building of 300 agricultural and livestock extension workers to support the production of nutritious foods for household consumption
  - Bi-annual council community mobilization campaigns (e.g., media, radio and demos)
  - Procurement of agricultural inputs for bio-fortified crops (e.g., orange-flesh sweet potatoes, iron-fortified beans) for 10,000 vulnerable households and 600 schools, including seeds, seedling, fertilizers and small animals
- **Supporting integration of ECD (gender-responsive positive parenting and responsive caregiving):**
  - Capacity building of 700 healthcare providers in 350 health facilities, and 920 CHWs in 420 communities on counselling parents and caregivers to implement responsive caregiving and positive parenting, while establishing female and male caregiver groups
  - Establishment of 36 ECD centres, including a market-based centre of excellence
  - Establishment of male champions initiative to promote positive transformation of social norms in support of maternal and child nutrition in 100 communities

- **Promoting WASH campaigns for improved sanitation and hygiene (e.g., Baby WASH):**
    - Bi-annual council community mobilization campaigns (e.g., media, radio and demos) to promote clean and safe environment for babies including community-led total sanitation (CLTS), physical separation between animals and children, household cleanliness and handwashing
- **Expanding nutrition-sensitive social protection programming that targets the poorest households:**
    - Supporting 10,000 Tanzania Social Action Fund (TASAF) beneficiaries and other vulnerable households with community-based nutrition services including "Stawisha Maisha" initiative, counselling and food-based support (fortified foods, MNPs and seedlings) to support them to produce and consume nutritious foods
- **Strengthening nutrition governance, monitoring and information systems:**
    - Conducting quarterly supportive supervision and monitoring to strengthen quality of nutrition-related services at 250 health facilities
    - Procurement of digital monitoring tools to enhance informational system
    - Conduct bi-annual reflection meetings at council level and annual meetings at regional level

4.2 Change Strategies

These above-mentioned interventions are brought to life by using the following five key change strategies:

1. ADVOCACY:

To effectively drive progress in nutrition and health outcomes, targeted advocacy efforts will be crucial. This strategy involves engaging key stakeholders, including political leaders, government officials, non-government officials, policy makers, community leaders, religious leaders, academicians, researchers and parents to build awareness and support for nutrition initiatives. By leveraging data, success stories and evidence-based practices, advocacy efforts aim to influence positive changes, mobilize resources and promote the prioritization of nutrition and health issues at community levels. Engaging the media and utilizing various channels will also amplify these messages and stimulate public engagement.

2. STRENGTHENING MULTISECTORAL PARTNERSHIPS:

To effectively drive progress in nutrition and health outcomes, targeted advocacy efforts will be crucial. This strategy involves engaging key stakeholders, including political leaders, government officials, non-government officials, policy makers, community leaders, religious leaders, academicians, researchers and parents to build awareness and support for nutrition initiatives. By leveraging data, success stories and evidence-based practices, advocacy efforts aim to influence positive changes, mobilize resources and promote the prioritization of nutrition and health issues at community levels. Engaging the media and utilizing various channels will also amplify these messages and stimulate public engagement.

3. CAPACITY BUILDING:

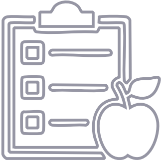
To ensure the successful implementation of nutrition interventions, capacity building focuses on enhancing the skills and knowledge of individuals and institutions involved in the NSRARP. This includes providing training and professional development for healthcare providers, nutritionists and community workers on the best practices in nutrition programme management. In addition, strengthening the institutional capacities by upgrading systems, tools and processes will improve the efficiency and effectiveness of the NSRARP delivery. This strategy aims at building a robust workforce and institutional framework capable of managing and scaling up nutrition initiatives.

4. SOCIAL AND BEHAVIOUR CHANGE:

Effective SBC strategies are essential for transforming community practices and attitudes towards nutrition and health. This involves designing and implementing behaviour change campaigns that address key factors influencing dietary habits and health practices. By utilizing a mixture of educational, community engagement and media activities, this strategy seeks to leverage behavioural insights to promote positive behaviours such as healthy eating and proper hygiene practices. Engaging community leaders and leveraging local traditions and norms will also help in fostering sustainable behavioural changes.

5. NUTRITION SYSTEMS STRENGTHENING:

To achieve lasting improvements in nutritional outcomes, it is critical to strengthen nutrition systems at all levels. This strategy focuses on enhancing the functionality and integration of nutrition-related services within the health system. It includes improving the availability and quality of nutrition data, expanding access to essential nutrition services and ensuring that nutrition initiatives are well-coordinated and effectively implemented. Strengthening these systems will involve improving supply chain management for nutrition-related and fostering collaboration between health facilities and community-based nutrition initiatives. This comprehensive approach aims at building a resilient and responsive nutrition system capable of addressing both immediate and long-term nutritional needs.



4.3 Sustainability Plan

This NSRARP focuses on a series of cost-effective and high impact nutrition interventions during the First 1,000 Days from a woman's pregnancy to the child's second birthday to increase the child's ability to grow, learn and rise out of poverty. These interventions are among the best investments to sustain children nutrition outcomes and sustained financial and human resource support will be required to ensure long term targets are met and sustained well beyond 2030. This sustainability plan outlines the strategies to sustain the investment being made and nutrition results through coordinated actions, community involvement and periodic reviews, feedback and adjustments.

- **Political Commitment and Leadership:** With ongoing political commitment and leadership, Njombe region is positioned to exercise effective oversight in strengthening domestic financing accountability to increase its minimum budget allocation for under five children, throughout.

- **Stakeholder Engagement:** Njombe region will nurture strong partnership with its stakeholders including development partners, community-based organizations, local government authorities, academia, businesses/ private sector partners, schools, media, etc., to form a broad-based partnership dedicated to finance, to promote ownership and supportive actions to reduce stunting in the region.

- **Community Engagement:** The NSRARP has been designed in collaboration with community and so the region will continue to actively engage community members including women, men, adolescent boys and girls, youth and elderly people in empowerment activities, implementation and monitoring of the activities to ensure ownership and see the importance of the investments by making their lives.

- **Community-based Integrated Nutrition Services:** The NSRARP will strengthen microplanning and implementation of VHND, a sustainable community-led practice for promoting community-based-integrated nutrition services (nutrition, health, WASH, child protection, early learning, responsive caregiving) for early childhood nutrition, growth and development.

- **Prioritization of Capacity Building:** The NSRARP prioritizes the capacity strengthening of the region's human resources (frontline workers, local leaders and regional/district subject-matter specialists) to lead, plan, budget, implement and monitor the response plan in a timely and quality manner. The region will also empower community members, especially women, caregivers and parents, to improve nutrition for children and promote continuous community-based solutions.

- **Coordination:** The region through its Multisectoral Nutrition Steering Committee (MNSCs) will regularly review the progress and assess MNSCs to ensure that they are facilitating decisions and actions towards results and continuously implementing community feedback system to improve plans based on local experiences and needs.

- **Resource Mobilization:** In collaboration with partners, the region will develop resource mobilization plan to secure sustainable funding sources from increased domestic and international investment. A clear partner map will benefit the region's efforts to mobilize resources better and strengthen coordination among partners.

5

ROLES AND RESPONSIBILITIES

5.1 Key Actors

The NSRARP involves several key actors, each with specific roles and responsibilities to ensure successful implementation are presented in Table 1.

Table 1 | *Key actors and their responsibilities*

Njombe Regional Secretariat

RESPONSIBILITIES

- Identifying nutrition problems, challenges and solutions in the regions;
- Integrating food and nutrition objectives in the regional secretariat plans and strategies;
- Interpreting policies and policy guidelines on nutrition;
- Maintaining norms and minimum standards;
- Providing technical guidance and supportive supervision to local government authorities on nutrition;
- Coordinating, monitoring and evaluating the implementation of the strategy by different stakeholders at the regional level.

RESPONSIBILITIES

The Njombe Region LGAs

- Strengthening the multisectoral coordination committees at the LGA level on nutrition;
- Integrating the NMNAP II components/activities into their comprehensive council development plans;
- Ensuring the implementation of the policies, strategies and guidelines within the respective districts;
- Mobilizing resources for the implementation of nutrition activities;
- Sensitizing and supporting the wards and communities to initiate, implement and monitor nutrition activities at the ward and community levels;
- Coordinating, providing technical support and monitoring the implementation of the NMNAP II at the ward and village/street levels.

Ward/village Levels

- Identifying food and nutrition opportunities and challenges at the respective levels.

Community/households

- Individuals and families hold the key to maintaining and improving their own health and nutrition conditions, and they are actors in their own development. The community will be responsible for mobilizing resources, initiating, implementing, and monitoring the implementation of nutrition activities in line with regional and LGAs priorities.

CSOs

- Advocating for nutrition as a human development issue;
- Mobilizing resources for the implementation of the NMNAP II;
- Providing technical and financial support to LGAs in the implementation of the NMNAP II;
- Supporting LGAs in the capacity development and management of nutrition activities;
- Incorporate nutrition interventions in community-based programs and ensure effective linkages to the healthcare system and other relevant sectors;
- Advocating for the prioritization of nutrition in national, regional, LGA and community development plans;
- Supporting community mobilization and the implementation of nutrition interventions down to the household level;
- Supporting capacity development for the improvement of food and nutrition at all levels in the LGAs;
- Integrating nutrition issues into CSO programs, projects and activities, which target communities and households;
- Aligning the nutrition plans with the government plans at the respective levels.

Media

- Highlighting the problem of malnutrition in Tanzania, advocate for action and report on the progress, failures and successes of those actions to alleviate malnutrition.

Higher Learning, Training and Research Institutions

- Reviewing and updating preservice, in-service and continuing education;
- Curricula to ensure that nutrition is adequately integrated to increase opportunities for training in nutrition.

Development Partners (DPs)

- Mobilizing and providing technical and funding support for the improved planning, implementation, monitoring and evaluation of nutrition services and interventions, in accordance with the national policies and priorities.

Professional Bodies

- Providing professional guidance, conducting research, setting professional standards and participating in the development of nutrition curricula for preservice, in-service and continuing education, to support nutrition outreach activities in the communities.

Private Sector

- Responsible for supporting government and community actions and efforts geared towards the implementation of the acceleration response plan;
- Investing resources for the implementation of the acceleration response plan in line with the laws, regulations and guidelines;
- Increasing investment in the production, processing, storage, and marketing of high-value nutritious products and in the provision of essential and basic social services (food, health and WASH) for improvement in nutrition;
- Investing in the production and marketing of appropriate low-cost laboursaving technologies that improve food and nutrition status at the community level;
- Integrating nutrition support into the corporate social responsibility plans and activities;
- Making the appropriate technologies available for nutrition improvement, including for advocacy, creating public awareness and tracking progress;
- Initiating and improving workplace nutrition programs for their labour force;
- Ensuring compliance with all national laws, regulations and guidelines;
- International protocols for the protection of consumer rights, health and the environment.

Political Parties

- Incorporating food and nutrition improvement issues in their election manifestos and campaigns;
- Supporting mobilization for improved food and nutrition security in the country;
- Supporting initiatives to improve food and nutrition, especially in vulnerable groups;
- Advocating for the prioritization of nutrition in the national, regional, LGA and community development plans.

5.2 Targeted Audiences

The success of the NSRARP hinges on the active engagement and collaboration of a diverse range of target audiences. By addressing the specific needs and roles of each target group, the NSRARP aims to create a supportive and inclusive environment that fosters sustainable improvements in nutrition and reduces stunting in the Njombe region. The target audiences include children, adolescents (girls and boys), women, men, caregivers, parents, community leaders, healthcare providers, policy makers and various stakeholders from different sectors (Table 2).

Table 2 | *Target Audiences, Focus Areas and Strategic Interventions*

Target audience	Focus areas	Strategic interventions
CHILDREN UNDER 5 YEARS	The primary beneficiaries of the acceleration response plan, as interventions are aimed at reducing stunting and improving the overall health and nutritional status of this age group.	Nutritional supplementation, growth monitoring, vaccination programs and promotion of optimal infant and young child feeding (IYCF) practices.
ADOLESCENTS (GIRLS AND BOYS)	Addressing the nutritional needs and promoting healthy behaviours during adolescence, a critical period for growth and development.	Nutrition education, school-based health programs and initiatives to prevent early pregnancies and promote healthy lifestyles.
WOMEN OF REPRODUCTIVE AGE	Ensuring that women have access to adequate nutrition before, during and after pregnancy to support maternal and child health	Prenatal and postnatal care, micronutrient supplementation and education on maternal nutrition and breastfeeding.
CAREGIVERS AND PARENTS	Empowering both female and male caregivers responsible for the care and nutrition of children to adopt and maintain healthy practices.	Training and support programs on responsive care, positive parenting and nutrition education.

Target Audiences
SECONDARY

COMMUNITY LEADERS AND INFLUENCERS

FOCUS AREAS	STRATEGIC INTERVENTIONS
Mobilizing community support and fostering local ownership of nutrition initiatives.	Community engagement and advocacy programs, training for local leaders and initiatives to change harmful cultural and gender norms.

HEALTHCARE PROVIDERS

FOCUS AREAS	STRATEGIC INTERVENTIONS
Enhancing the capacity of healthcare workers to deliver quality nutrition and health services.	Training activities, provision of resources and tools, and integration of nutrition services into primary healthcare.

POLICY MAKERS AND GOVERNMENT OFFICIALS

FOCUS AREAS	STRATEGIC INTERVENTIONS
Securing political commitment and creating an enabling environment for nutrition interventions.	Advocacy for supportive policies, resource allocation, and governance structures that promote food and nutrition security.

MULTISECTORAL PARTNERS AND STAKEHOLDERS

FOCUS AREAS	STRATEGIC INTERVENTIONS
Coordinating efforts across various sectors to address the multifaceted causes of stunting.	Establishing partnerships with agriculture, education, WASH and private sector entities to leverage resources and expertise.

EDUCATIONAL INSTITUTIONS

FOCUS AREAS	STRATEGIC INTERVENTIONS
Integrating nutrition education into school curricula and promoting healthy eating habits among students.	School feeding programs, health education, and initiatives to improve school health environments.

PRIVATE SECTOR

FOCUS AREAS	STRATEGIC INTERVENTIONS
Engaging businesses and industries to support nutrition initiatives through corporate social responsibility and innovative solutions.	Partnerships for food fortification, investments in local food production, and promotion of nutrient-rich food products.

HLI AND RESEARCH INSTITUTIONS

FOCUS AREAS	STRATEGIC INTERVENTIONS
Applied research	Fostering interdisciplinary research, collaborative projects and partnerships with other institutions, industry and government agencies; identify and pursue external funding opportunities, including grants, partnerships; establish research clusters or centres of excellence to focus on key areas of interest; g to support for pilot projects and innovative research initiatives. Facilitate the dissemination of research findings through publications, conferences, and public engagement activities.

Target Audiences
TERTIARY

NON-GOVERNMENTAL ORGANIZATIONS (NGOS) AND CIVIL SOCIETY

FOCUS AREAS

Leveraging the expertise and resources of NGOs to implement and scale-up nutrition interventions.

STRATEGIC INTERVENTIONS

Collaborations on community-based programs, advocacy efforts and capacity-building initiatives.

INTERNATIONAL DONORS AND DEVELOPMENT PARTNERS

FOCUS AREAS

Securing funding and technical support for the implementation of the acceleration response plan.

STRATEGIC INTERVENTIONS

Grant proposals, partnerships for technical assistance and coordination of donor efforts to align with national priorities.

MEDIA AND COMMUNICATION CHANNELS

FOCUS AREAS

Raising awareness and promoting behaviour change through effective communication strategies.

STRATEGIC INTERVENTIONS

Media campaigns, social and behavioural change (SBC) initiatives, and dissemination of success stories and the best practices.

6

MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING PLAN

6.1 Overview

Monitoring, Evaluation, Accountability and Learning (MEAL) plan is a crucial tool to assess the progress of the NSRARP in achieving its set targets. The MEAL plan – centred around a Results Framework – will be used to track the performance, implementation and outputs, ensuring that all activities align with the overall objectives. Through continuous monitoring, real-time data will be gathered on the NSRARP's implementation. A midterm evaluation will identify any challenges or deviations from the plan to inform necessary adjustments. An endline evaluation will provide a more in-depth analysis of the NSRARP's impact, determining whether the intended outcomes were met and what factors contributed to its success or failure. Accountability will ensure that all stakeholders, including beneficiaries and implementing partners, are held responsible for their roles and commitments, fostering transparency and trust.

The MEAL plan clarifies the process and the interventions that will lead to the desired acceleration response plan outputs. It outlines the specific indicators that will be measured, the methods and tools for data collection, and the timeline for reporting and analysis. By systematically documenting lessons learnt throughout the acceleration response plan, the MEAL plan facilitates continuous learning and improvement. This enables the acceleration response plan teams to adapt strategies and interventions based on evidence and feedback, ultimately enhancing its effectiveness and sustainability. The MEAL approach ensures that the response plan remains focused on its goals, responsive to changing circumstances and accountable to all stakeholders involved.

The MEAL Plan will help the NSRARP track results, resources and ensure accountability. The Planning, Monitoring, Evaluation and Learning Cycle (PMELC) is an integral part of the design, implementation and completion of the NSRARP. It will be implemented at all stages within the NSRARP. It initiated a comprehensive needs assessment to enhance food systems, increase the consumption of nutrient-rich foods and promote appropriate nutrition behaviours across all demographic groups. It emphasized fostering responsive care, positive parenting and optimal WASH practices, while improving health and nutrition services for children, women and adolescents. The NSRARP also aims to strengthen multisectoral and private sector engagement in nutrition and create an enabling environment and supportive policies.

6.2 Results Framework

The Results Framework outlined in Tables 3 to 5 provide key result indicators in terms of impact, outcomes and outputs emphasizing the expected benefits for the communities that the NSRARP will serve and how to measure progress. It communicates the direction of change and expected achievements each year for overall reduction of childhood stunting from 40 per cent in 2024 to 25 per cent in 2030.

Impact, Outcome, and Output Indicators and Targets

Table 3 | *Impact Indicators and Targets*

Impact	Impact indicators	Baseline	Targets						Data source	Responsible	Reporting period
		2024	2025	2026	2027	2028	2029	2030			
By 2030, Njombe Region's stunting rates among under five children is reduced from 40% to 25%	Prevalence of stunting among children 0–59 months	40%	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	Prevalence of low birthweight	12%	11.0%	10.00%	9.0%	8.0%	7.0%	6.0%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	Prevalence of underweight among children 0–59 months	12.9%	12.0%	11.00%	10.0%	9.0%	8.0%	7.0%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years

Table 4 | *Outcome Indicators and Targets*

Outcome	Outcome indicators	Baseline	Targets						Data source	Responsible	Reporting period
		2024	2025	2026	2027	2028	2029	2030			
OUTCOME 1 Pregnant women and children in Njombe Region have good diets, driven by adequate food and dietary practices	% of children born in the last 24 months who were put to the breast within 1 hour of birth	58%	60%	62%	64%	66%	68%	70%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	% of infants 0–5 months of age who were fed exclusively breastfed	69%	70%	71%	72%	73%	74%	75%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	% of children 12–23 months of age who were fed breast milk during the previous day	64%	65%	66%	67%	68%	69%	70%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children 6–23 months of age who consumed foods from at least five out of eight defined food groups during the previous day (**Minimum Dietary Diversity - MDD**)	67%	68%	69%	70%	71%	72%	73%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs

Outcome	Outcome indicators	Baseline	Targets						Data source	Responsible	Reporting period
		2024	2025	2026	2027	2028	2029	2030			
	% of children 6–23 months of age who consumed solid, semi-solid or soft foods (but also including milk feeds for non-breastfed children) at least the minimum number of times during the previous day (**Minimum Meal Frequency – MMF**)	64%	67%	70%	73%	76%	79%	81%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children 6–23 months of age who consumed a **minimum acceptable diet (MAD)** in the previous day	53%	55%	57%	59%	61%	63%	65%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children 6–23 months of age who consumed egg and/or flesh food during the previous day	48%	50%	52%	54%	56%	58%	60%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children 6–23 months of age who consumed zero vegetables or fruits during the previous day	21%	30%	40%	50%	60%	70%	80%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children of children 6–23 months of age consumed fortified foods during the previous day	TBD	15%	20%	30%	40%	50%	60%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children of children 6–23 months of age consumed MNPs during the previous day	TBD	35%	45%	50%	55%	60%	65%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of pregnant women who consumed at least 5 out of the 10 defined food groups **(Minimum Dietary Diversity for Women - MDD-W)**	TBD	40%	45%	50%	55%	60%	65%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years

Outcome	Outcome indicators	Baseline	Targets						Data source	Responsible	Reporting period
		2024	2025	2026	2027	2028	2029	2030			
OUTCOME 2 Pregnant women and children in Njombe Region have good care, driven by adequate services and practices	% of households who report having used soap for handwashing at least at two critical times during past 24 hours (including "after defecating")	31%	35%	40%	45%	50%	55%	60%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children 0–59 months who had diarrhoea in the past 2 weeks	13%	12%	11%	10%	9%	8%	7%	DHIS 2 GOTHOMIS	Regional secretariat and LGAs	Periodically between 2–5 years
	% of pregnant women 15–49 years of age who took IFA/MMS supplements for 90+ days	59%	65%	70%	75%	80%	85%	90%	DHIS 2 GOTHOMIS	Regional secretariat and LGAs	Periodically between 2–5 years
	% pregnant women who had early antenatal booking	35%	40%	45%	50%	55%	60%	65%	DHIS 2 GOTHOMIS	Regional secretariat and LGAs	Periodically between 2–5 years
	% of pregnant women who have conducted 8+ ANC visits	3%	5%	20%	25%	30%	35%	40%	TDHS SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	% of children aged 24–59 months who are developmentally on track in health, learning and psychosocial well-being, by sex (ECDI2030)	65%	70%	75%	80%	85%	90%	95%	TDHS	Regional secretariat and LGAs	Periodically every 5 years
	% of male caregivers of children 0–59 months involved in regular childcare activities, such as feeding, bathing and playing with children	TBD	10%	20%	30%	40%	50%	60%	Regional secretariat and LGAs SMART survey	Periodically between 2–5 years	Regional secretariat and LGAs

Table 5 | *Output Indicators and Targets*

Output	Output indicators	Baseline	Targets						Data source	Responsible	Reporting period
		2024	2025	2026	2027	2028	2029	2030			
OUTPUT 1 Pregnant women and children have increased access to adequate, safe and nutrient-rich foods	# of millers (small and medium scale) fortifying maize/wheat flour	TBD	50	100	150	200	250	300	Regional Food Inspection Report	Regional secretariat and LGAs	Annually
	# of community groups trained on processing nutrient-rich flour	TBD	30	50	70	90	100	100	Project Reports	Regional secretariat and LGAs	Annually
	# of households with children under 5 years of age keeping small animals and/or established kitchen gardens	TBD	35%	40%	45%	50%	55%	60%	Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	% of PSSN beneficiaries with children under 5 years benefitting from MNPs supplementation	0	50%	60%	70%	80%	90%	100%	Project Reports	Regional secretariat and LGAs	Periodically between 2–5 years
	% of schools implementing integrated nutrition interventions	TBD	50%	60%	70%	80%	90%	100%	Project Reports	Regional secretariat and LGAs	Periodically between 2–5 years
OUTPUT 2 Parents, caregivers, and children have increased access to counselling and resources to perform optimal dietary, responsive caregiving, positive parenting and hygiene practices	% of population reached with relevant promotional messages through mass/social media	TBD	30%	50%	60%	70%	80%	90%	Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	% of villages and Mitaa implemented Bi-annual council community mobilization campaigns (e.g., media, radio and cooking demos)	TBD	50%	70%	80%	90%	95%	100%	Regional secretariat and LGAs	Regional secretariat and LGAs	Annually
	% of households using unimproved toilets	34%	32%	30%	28%	26%	24%	22%	Regional secretariat and LGAs	Periodically between 2–5 years	Regional secretariat and LGAs
	% of children 0–59 months who receive early stimulation and responsive care from their parents or caregivers	47%	35%	45%	55%	65%	75%	85%	SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	% of children aged 0–59 months who play with two or more of the following playthings at home: household objects or objects found outside (sticks, rocks, animals, shells, leaves, etc.), books, homemade toys or toys that came from a store	0	35%	45%	55%	65%	75%	85%	SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years

Output	Output indicators	Baseline	Targets						Data source	Responsible	Reporting period
		2024	2025	2026	2027	2028	2029	2030			
	% of parents actively engaging in non-traditional gender roles (e.g., fathers participating in caregiving, mothers involved in decision-making).	0	10%	20%	30%	40%	50%	60%	SMART Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	# male champions identified	0	10	20	30	40	50	60	Project Reports	Regional secretariat and LGAs	Annually
	% of community members engaged through community platforms in community dialogue towards eliminating discriminatory social and gender norms and harmful practices	TBD	30%	50%	60%	70%	80%	90%	Survey	Regional secretariat and LGAs	Periodically between 2–5 years
	# female and male caregiver groups established and functioning	0	10	20	30	40	50	60	Project Reports	Regional secretariat and LGAs	Annually
OUTPUT 3 Pregnant women and children receive gender-responsive quality integrated nutrition services from the Health, WASH, ECD, Social Protection, Education and Food Systems	% of pregnant women, adolescents, parents and caregivers benefiting from integrated nutrition and ECD services in community	TBD	65%	70%	75%	80%	85%	90%	Project reports	Regional secretariat and LGAs	Periodically between 2–5 years
	% of children 6–59 months who received vitamin A supplementation	90%	95%	95%	95%	95%	95%	95%	DHIS 2 GOTHOMIS	Regional secretariat and LGAs	Annually
	% of villages with trained CHWs to deliver quality integrated nutrition and ECD services	TBD	40%	50%	60%	70%	80%	90%	Project Reports	Regional secretariat and LGAs	Annually
	% of facilities with at least one trained staff to deliver quality integrated nutrition and ECD services	TBD	60%	70%	80%	90%	100%	100%	Project reports	Regional secretariat and LGAs	Annually
	% of PSSN beneficiaries with children under 5 years benefitting from community-based integrated services	0	50%	60%	70%	80%	90%	100%	Project reports	Regional secretariat and LGAs	Annually
	% of facilities providing MMS for pregnant women	0	20%	50%	70%	80%	90%	100%	DHIS 2 GOTHOMIS	Regional secretariat and LGAs	Annually
	% parents with children 0–59 months who received any early child development counselling in the last 6 months (disaggregated by sex)	TBD	50%	60%	70%	80%	90%	100%	Project reports	Regional secretariat and LGAs	Annually

6.3 Accountability

Accountability is the principle that every actor in the NSRARP will be responsible for their actions, decisions and performance and must be able to demonstrate and explain them to other stakeholders, including the target beneficiaries, partners and donors. This includes:

- Ensuring ethical, transparent, accountability and participatory NSRARP implementation involving all stakeholders and beneficiaries from the communities including individual, family, household, street, village, ward, district council, regional secretariat and national levels.
- An opportunity to provide feedback, raise concerns and submit complaints related to the NSRARP activities or the MEAL system itself, and adapt as needed.
- Training and capacity building for planners, subject-matter specialists, extension and frontline staff involved in MEAL will be conducted.
- Advocacy and sensitization to political leaders, influential persons, religious leaders and community at large will be implemented.
- An open and transparent communication will be facilitated.
- Putting in place measures to protect the confidentiality of feedback and complaints data, ensuring that individuals who provide information are not at risk.

6.4 Monitoring

Progress monitoring of the NSRARP implementation will be ongoing, incorporating continuously periodic reporting and feedback loops. Performance and progress will be tracked through quarterly and annual reports, joint annual nutrition review meetings, and nutritional and ECD scorecards. At the council level, various tools will be employed to collect, analyse and communicate nutrition indicators. These include the multisectoral nutrition scorecard, the ECD scorecard, bottleneck analysis, COMPACT scorecard and annual council multisectoral nutrition work plans. Regional secretariat and all Njombe region councils will produce quarterly reports detailing the progress of multisectoral nutrition actions implemented within their respective areas of jurisdictions. This structured approach ensures a comprehensive and transparent assessment of the NSRARP's effectiveness across all levels.

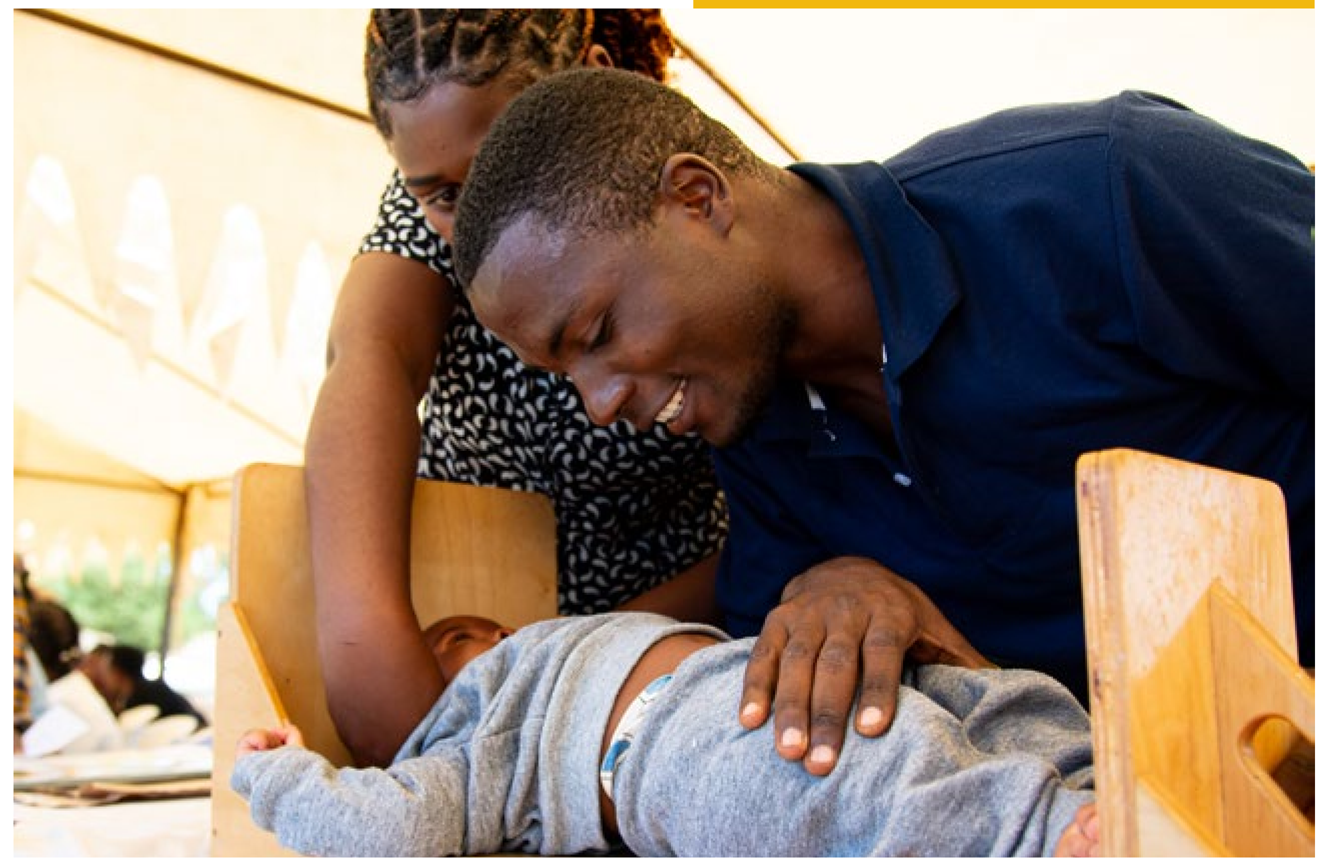
Monitoring progress will occur at output, outcome and impact levels. At the impact and outcome levels, progress will be measured by Tanzania National Nutrition Surveys (TNNS) that are conducted every 2 years. At the output level, progress will be measured through activity reports produced by implementing multisectoral stakeholders including [RS, LGAs, NGOs, CSOs, FBOs, DPs (UNICEF FAO, USAID), TFNC, and SACGOT]. User-friendly Digital Apps such as ODK Collect or Kobo Toolbox will be leverage for smooth MEAL.

6.5 Evaluation

This will comprise of:

- R-MNSC and C-MNSC to implement quarterly multisectoral nutrition comprehensive supportive planning, supervisions and review meetings;
- RMT, RHMT, CMTs and CHMTs, and the compact evaluation meetings are platforms to be involved and integrated in this MEAL framework;
- Annual reviews and adapting MEAL framework are essential for ensuring that it remains relevant, effective, and aligned with the response plan priorities;
- Quarterly, Bi-Annual, Annual, Mid-Term (2027) and End-Term Reviews (2031) that will be conducted in the region and at all councils to assess progress and any necessary changes in activities to ensure attainment of the outcomes;
- Strategic surveys such as TNNS, and TDHS will be conducted covering nutrition delivery systems, namely enabling environment, food, health, education, WASH, social protection, ECD and enabling environment;
- Mid-Term and End-Term Evaluation will be conducted in 2027 and 2031 to assess level of attainment of expected outcomes and impact.

Expenditure for nutrition at LGAs is tracked through the planning and reporting system (PLANREP) to determine the amount of funds allocated for nutrition at decentralized levels.



6.6 Learning Cycle

This will comprise of:

- The NSRARP will have a strong Learning component and will continuously adapting based on feedback and evidence to enhance the response plan design and outcomes.
- The learning will also be generating knowledge and identifying best practices and lessons that can be used to improve implementation.
- There will be an encouragement of a culture of learning and adaptation within the response plan structure.
- There will be establishment of mechanisms for knowledge sharing and learning, both within the RS and LGAs and with external stakeholders and partners through workshops, conferences, learning platforms, or other forums for exchanging information and insights.
- There will be systematic documentation of lessons learnt from the response plan implementation and MEAL processes, and use of gathered information to inform future response plan re-design, implementation and evaluation.

6.7 Financial Tracking and Budget Analysis for Nutrition

According to PO-RALG, the implementation of the NSRARP will abide to NMNAP II (2021/22–2025/26) joint supervision and scrutinization of multisectoral nutrition plans, to ensure that funding for the NSRARP is properly planned and allocated, according to the Mid-Term Expenditure Framework (MTEF). Already, the PO-RALG has created nutrition objectives within the government planning and reporting system, which help to track the nutritional and financial resources of the councils.

Expenditure for nutrition at LGAs is tracked through the planning and reporting system (PLANREP) to determine the amount of funds allocated for nutrition at decentralized levels. Nutrition activities planned at the health facility level are being tracked through the Epicor and FFARS systems, which are also linked to PLANREP. There are government machineries at all levels, which conduct the monitoring and tracking of the financial expenditures for nutrition, e.g., finance committees at the regional and council levels whereby Njombe region is inclusive.

6.8 Applied Research

Applied research is explicitly encouraged to be part-and-parcel of the implementation of the NSRARP. Research will help to identify and test novel discoveries in nutrition and test the feasibility of taking such innovative interventions to scale. Various applied research activities have been identified to support the effective implementation of the NSRARP. Examples of the proposed activities include:

- Undertaking the working sessions for the inclusion of nutrition components such as biomarkers in national surveys (TDHS-MIS, NPS and MUCHALI);
- Undertaking mid-term and end-term reviews for Acceleration Response Plan (action research);
- Developing culturally accepted age and context-specific food recipes and evaluate their efficacy;
- Conducting TNNS and qualitative SBC surveys;
- Adopting and operationalizing national nutrition research roadmaps;
- In cooperation with national institutions, to train relevant nutrition stakeholders on nutrition surveys, nutrition data quality toolkit and data quality assessments.

7

RISK MITIGATION

7.1 Overview

Risk analysis and management is the systematic use of available nutrition information to determine the likelihood of specified diverse events occurring, the magnitude and consequences of the uncertainty of the forecasted cash flow streams and how to mitigate them. It is one of the cornerstones of modern scientific and risk-based approaches to planning, and it refers to the probability of plan's success or failure, hence its inclusion in the NSRARP. Risk analysis allows a balance to be struck between taking risks and reducing them (refer to Table 6–8).

7.2 Risk Analysis Framework

The Risk Analysis Framework shown in Table 6 and Risks and Mitigation Strategies in Table 8, coupled with the Strengths, Opportunities, Weaknesses and Threats (SWOT) analysis approach shown in Table 7, is used in the assessment of risks involved in implementing the NSRARP.

Table 6 | *Risk Analysis Framework*

Likelihood						
	5-Near certain	Low	Medium	High	High	High
	4-High Likely	Low	Medium	Medium	High	High
	3-Likely	Low	Low	Medium	Medium	High
	2-Unlikely	Low	Low	Low	Medium	Medium
	1-Remote	Low	Low	Low	Low	Low
		1-Negligible	2-Minor	3-Marginal	4-Critical	5-Catastrophic
	Consequence/impact level					

Table 7 | *SWOT Analysis for the NSRARP*

Internal

STRENGTHS

- NSRARP uses lessons learnt and best practices from exemplar countries
- Consolidates all nutrition strategic plans/projects together in the region
- NSRARP developed on basis of multisectoral, stakeholder participation and consensus
- Presence of agreed coordination structures from village to regional level
- Common Result, Resource and Accountability Framework strengthens tracking of progress on results and finances at a strategic level

WEAKNESSES

- Low commitment and accountability of government HR to the NSRARP
- Low level of accountability at LGA level
- Coordination challenges in multisectoral approaches
- Low human resource capacity
- Inadequate capacity to produce nutrition food commodities
- Low purchasing power and household income especially in female headed households
- Parents, caregivers, families unable to practice pro nutrition behaviours due to inadequate resources such as income, correct information and support
- Rigid social and gender norms, which affect childcaring and parenting

External

OPPORTUNITIES

- Political good will, leadership, and commitment
- Improved multisectoral and national frameworks for nutrition action
- Existing of evidence based, high impact interventions (nutrition-specific and -sensitive)
- Well established LGAs in Njombe region
- Existence of multisectoral stakeholders and partners in the region

THREATS

- Impact of climate change: seasonal cold weather
- Inadequate resources for implementation
- Changing political climate
- Economic shocks and pandemics

Positive | Negative

7.3 Risk Mitigation

An important component of the NSRARP is to be able to identify and manage risks that may affect its smooth implementation. The process involves:

- **Risk identification:** Defining risk events and their relationship;
- **Risk impact assessment:** Assessing the probability (likelihood) of their occurrence and their consequences (impacts). Consequences may include costs, schedule, technical performance, impacts as well as capability of functionality;
- **Risk prioritization analysis:** Identifying risk events from most to least critical;
- **Risk mitigation:** The ultimate purpose of risk identification and analysis is to prepare for risk mitigation. Mitigation includes a reduction in the likelihood of a risk event occurring and/or a reduction in the effect of a risk event, even if it does occur.

Table 8 | *Risks and Mitigation Measures*

Risks and Mitigation Measures

Risks	Mitigation Measures
Low commitment and accountability of government HR to the Acceleration Response Plan	Continue to advocate and actively coordinate with stakeholders to ensure their policies, strategies and plans on nutrition are aligned with the Acceleration Response Plan
Low level of accountability at LGA level	Well established MEAL framework and strengthened supportive supervision
Coordination and collaboration challenges in multisectoral approaches	Developed capacity of the Acceleration Response Plan multisectoral stakeholders to be able to effectively lead, coordinate and manage implementation of the Acceleration Response Plan
Inadequate financial resources capacity for nutrition implementation	Developed multisectoral resource mobilization framework and collaborate with development partners, private sector, government institutions and CSOs
Inadequate capacity to produce and consume safe, diverse and nutritious food commodities	Improved nutrition-sensitive agriculture through promotion of animal protein, micronutrient rich foods, and bio/fortified maize flour, cassava and orange-fleshed sweet potatoes

Risks	Mitigation Measures
Low purchasing power and household income especially in female headed households	Introduced social safety nets activities through TASAF
Parents, caregivers, families unable to practice pro nutrition behaviours due to inadequate resources such as income, correct information and support	Strengthened nutrition-sensitive agriculture, income-generation activities, value addition of agricultural produce and community awareness and education
Persistence of deep-rooted social and cultural norms that hinder nutritional practices	Transformed communities in social and gender norms to improve gender equity and equality
Low human resources capacity	Government to prioritize human resource capacity development in nutrition and allocate adequate number of skilled staffs to implement the Acceleration Response Plan at all key nutrition-sensitive sectors and community level
Impact of climate change: Seasonal cold weather	Accept and prepare for seasonal cold weather
Changing political climate	The likelihood of occurrence is very low
Economic shocks and pandemics	Monitor closely and adjust plan accordingly

8 COSTING, BUDGET AND TIMELINE

The NSRARP activities are costed at both regional secretariat and council levels. The total cost is estimated at TZS 7,807,234,863 (roughly USD 3 million). Financing the NSRARP will require concerted efforts from the Government of Tanzania, DPs, UN-Agencies, NGOs, CSOs and the private sector. The major investor in these nutrition priorities will be the Government of Tanzania, the private sector and DPs.

8.1 Costing

The NSRARP employs a detailed and systematic costing approach to ensure the effective allocation of resources and to maximize the impact of its interventions. The approach encompasses the following key components (Table 9).

Table 9 | *Costing Approach and Key Budget Components*

Approach	Key components
Activity-based costing	Identification of Activities: All activities necessary for the implementation of the response plan interventions are identified and listed. This includes specific health, nutrition, agriculture, WASH, education and social protection activities. Resource Requirements: For each identified activity, the required resources, including personnel, materials, equipment and infrastructure are meticulously itemized. Cost Estimation: The costs associated with each resource are estimated based on current market prices, historical data and expert consultations. This ensures that the budget reflects realistic and up-to-date financial requirements.
Stakeholder involvement	Collaborative Budgeting: The costing process involves extensive collaboration with various stakeholders, including government departments, non-governmental organizations (NGOs), community leaders and technical experts. This collaborative approach helps to capture diverse perspectives and ensures that all relevant costs are considered. Validation Workshops: Cost estimates are validated through workshops and consultations with stakeholders to ensure accuracy and feasibility. This step helps to identify any overlooked expenses and to adjust cost estimates as necessary.
Multisectoral integration	Cross-Sectoral Budgeting: The response plan's costing approach integrates budgets across different sectors (health, nutrition, ECD, agriculture, WASH, education and social protection) to create a comprehensive financial plan. This integration avoids duplication of costs and ensures that resources are allocated efficiently. Synergy and Efficiency: By coordinating interventions across sectors, the plan leverages synergies and promotes cost-sharing where possible. For example, joint training sessions for health workers and agricultural extension officers can reduce overall training costs.
Phased implementation and costing	Short-Term and Long-Term Phases: The response plan is designed with phased implementation, distinguishing between immediate, short-term actions and longer-term strategies. Each phase is costed separately to facilitate targeted funding and incremental progress. Scalability: The costing approach considers the scalability of interventions, ensuring that costs for scaling up successful pilot interventions are included in the long-term financial plan.

Approach	Key components
Monitoring and adjustment	Ongoing Financial Monitoring: Regular financial monitoring and reporting mechanisms are established to track expenditures against the budget. This ensures that any deviations from the planned budget are identified promptly, and corrective actions are taken. Adaptive Budgeting: The costing approach allows for flexibility and adjustments based on real-time data and changing circumstances. This adaptability is crucial for responding to unexpected challenges and opportunities during the implementation of the response plan.
Sustainability and funding sources	Diversified Funding: The plan identifies and secures funding from multiple sources, including government budgets, donor agencies, international organizations and private sector contributions. This diversified funding approach enhances financial sustainability. Cost-Benefit Analysis: It is partially conducted to demonstrate the long-term economic benefits of stunting reduction, helping to justify investments and secure sustained funding.

8.2 Budget and Timeline

Harnessing the costing framework established by Scaling-Up Nutrition, the NSRARP identifies the costs of seven nutrition-specific and five First 1,000 Days and their activities in Njombe. We refer to this as the full coverage (+90 per cent) scenario and estimate that it would require both annual public financing and development partner funding.

Table 10 | *Budget and timeline for interventions and activities*

Type	Key Intervention	Activities	Budget (TZS)	2025	2026	2027	2028	2029	2030
NUTRITION SPECIFIC INTERVENTIONS	Promote optimal infant and young child feeding	Capacity building (including refresher trainings after every 2 years) of 700 healthcare providers in 350 health facilities IYCF, GMP, responsive caregiving and related (including tools)	427,400,000	253,520,000			173,880,000		
		Capacity building of 900 CHWs in 450 communities on IYCF, GMP, responsive caregiving and related (including tools)	424,800,000	254,700,000			170,100,000		
		Bi-annual council community mobilization campaigns (e.g., mass media/radio, community mobilization events)	503,040,000		125,760,000	125,760,000	125,760,000	125,760,000	
		Capacity building of 90 community groups on processing nutrient-rich flour (legume flour) including procuring appropriate machine	155,400,000	155400000					
		Provision of nutrition care and support by HFWs and CHWs through health facilities and communities (frontline workers' stipend)	810,000,000	162,000,000	162,000,000	162,000,000	162,000,000	162,000,000	
	Deliver comprehensive ANC services (including IFA/ MMS) for maternal nutrition	Capacity building of 700 healthcare providers in 350 health facilities on delivery of quality maternal nutrition services, including adherence to ANC services and IFA/MMS	98,440,000	98,440,000					
		Capacity building of 900 CHWs in 400 communities on delivery of quality maternal nutrition services, including adherence to ANC services and IFA/MMS	99,900,000	99,900,000					
		Procurement of IFA/MMS for 150,000 (5-month dose for 30,000 pregnant women each year) pregnant women across 5 years (in kind donation)	0						

Type	Key Intervention	Activities	Budget (TZS)	2025	2026	2027	2028	2029	2030
	Scale-up food fortification and promote use of fortified foods	Capacity building of 200 small flour millers	78,709,416		38,203,524	40,505,892			
		Procurement of fortificants for 200 small millers across 5 years	309,154,482		73,710,000	73,710,000	78,132,600	83,601,882	
	Promote optimal use of Micronutrient Powders (MNPs)	Procurement of MNPs for 9,000 children aged 6–23 months across 5 years	215,700,038		39,803,400	39,803,400	42,191,604	45,145,016	48,756,617
		Bi-annual council community mobilization campaigns (e.g., mass media, radio, community mobilization events)	656,000,000		164,000,000	164,000,000	164,000,000	164,000,000	
	Strengthen child growth monitoring and promotion	Capacity building of 700 healthcare providers in 250 health facilities on growth monitoring and promotion (including tools)	89,010,000	89,010,000					
		Capacity building of 900 CHWs in 400 communities on growth monitoring and promotion (including tools)	87,600,000	87,600,000					
		Procurement of anthropometric equipment (length boards, MUAC tapes, big charts, etc.)	145,423,673	145,423,673					
		Implementation of community-based child growth monitoring through VHNDs in 420 communities with support from 920 CHWs	216,000,000	72,000,000		72,000,000		72,000,000	
	Prevent and manage child diseases	Capacity building of 100 healthcare providers from 12 hospitals and 42 health centres on management of diarrheal in children and wasting	36,220,000		36,220,000				
		Procurement of therapeutic milks and foods for 9,000 children under five	466,194,354		116,522,522	116,522,522	116,557,152	116,592,099	
	Enhance nutrition in schools	Capacity building of 1,200 teachers from 600 primary and secondary schools to deliver updated national food and nutrition education curriculum	144,960,000			144,960,000			

Type	Key Intervention	Activities	Budget (TZS)	2025	2026	2027	2028	2029	2030
		Capacity building of 600 parent associations to provide nutritious and safe school meals, and 600 student health and nutrition clubs to develop nutrition skills and behaviours	91,920,000			91,920,000			
		Establishment of 600 school gardens and/or livestock keeping projects that provide both life skills to learners and ability for schools to supply their own fruits and vegetables.	176,172,000			58,170,000	58,724,000	59,278,000	
First 1,000 Days	Improve food security through agricultural and livestock production of nutritious and diverse foods	Capacity building of 300 agriculture and livestock extension workers to support production of nutritious foods for household consumption	244,470,000			122,235,000	122,235,000		
		Bi-annual council community mobilization campaigns (e.g., media, radio, demos, village meetings)	118,905,162			26,906,880	28,521,293	30,517,783	32,959,206
		Procurement of agricultural inputs for bio-fortified crops (e.g., orange-flesh sweet potatoes, iron-fortified beans) for 10,000 vulnerable households and 600 schools, including seeds, seedling, fertilizers and small animals	126,562,500			42,187,500	42,187,500	42,187,500	
	Support integration of ECD (gender-responsive positive parenting and responsive caregiving)	Capacity building of 700 healthcare providers in 350 health facilities, on counselling parents and caregivers to implement responsive caregiving and positive parenting, while establish female and male caregiver groups	173,880,000		173,880,000				
		Capacity building of 920 CHWs in 420 communities on counselling parents and caregivers to implement responsive caregiving and positive parenting, while establish female and male caregiver groups	170,100,000		170,100,000				

Type	Key Intervention	Activities	Budget (TZS)	2025	2026	2027	2028	2029	2030
		Establishment of 36 community and market-based ECD centres	298,988,100			73,694,250	74,396,100	75,097,950	75,799,800
		Establishment of male champions initiative to promote positive transformation of social norms in support of maternal and child nutrition in 100 communities	61,863,907			15,459,045	15,463,635	15,468,272	15,472,955
	Promote WASH campaigns for improved sanitation and hygiene (e.g., Baby WASH)	Bi-annual council community mobilization campaigns (e.g., media, radio and demos)	178,357,743			40,360,320	42,781,939	45,776,675	49,438,809
	Expand nutrition-sensitive social protection programming that targets poorest households	Support to 10,000 TASAF beneficiaries and other vulnerable households with community-based nutrition services and food-based support (fortified foods, micronutrient powders and seedlings)	94,050,000			23,175,000	23,400,000	23,625,000	23,850,000
	Strengthen nutrition governance, monitoring, and information systems	Conduct quarterly supportive supervision and monitoring to strengthen quality of nutrition related services at facilities and communities	463,979,301			115,942,838	115,977,266	116,012,039	116,047,159
		Procurement of digital monitoring tools to enhance informational system	103,075,602		51,530,150	51,545,452			
		Conduct bi-annual reflection meetings at council level and annual meetings at regional level	230,958,585			57,713,768	57,730,906	57,748,215	57,765,697
		Baseline and Endline Project Survey	**310,000,000**	**150,000,000**					**160,000,000**
		TOTAL COST (TZS)	**7,807,234,863**	**1,567,993,673**	**1,151,729,626**	**1,658,571,896**	**1,614,038,995**	**1,234,810,430**	**580,090,243**