THE UNITED REPUBLIC OF TANZANIA

PRESIDENT'S OFFICE REGIONAL
ADMINISTRATION AND LOCAL GOVERNMENT

TERMS OF REFERENCE

FOR MULTISECTORAL COMMITTEES ON NUTRITION FOR REGIONAL SECRETARIATS AND LOCAL GOVERNMENT AUTHORITIES

DODOMA MARCH 2018

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LIST OF ABBREVIATIONS

AAS	Assistant Administrative Secretary
CMT	Council Management Team
CSOs	Civil Society Organizations
CDO	Community Development Officer
DACC	District AIDS Control Coordinator
DCC	District Consultative Committee
DED	District Executive Director
DEO	District Education Officer
DHO	District Health Officer
DMO	District Medical Officer
DAICO	District Agriculture, Irrigation and Cooperative Officer
DLFO	District Livestock and Fisheries Officer
DNuO	District Nutrition Officer
DQA	Data Quality Assessment
DRCHCo	District Reproductive and Child Health Coordinator
ECD	Early Childhood Development
FBOs	Faith Based Organizations
IFA	Iron Folic Acid
HLSCN	High-Level Steering Committee on Nutrition
RMSCN	Regional Multisectoral Steering Committee on Nutrition
CMSCN	District/Council Steering Committee on Nutrition
IMAM	Integrated Management of Acute Malnutrition
LGAs	Local Government Authorities

MIYCAN	Maternal Infant Young Child and Adolescent Nutrition
MKUKUTA	Mkakati wa Kupambana na Kupunguza Umaskini Tanzania
MOFP	Ministry of Finance and Planning
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOAFS	Ministry of Agriculture and Food Security
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NMNAP	National Multisectoral Nutrition Action Plan
NSC	Nutrition Steering Committee
PO-RALG	President's Office – Regional Administration and Local Government
PMO	Prime Minister's Office
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RCC	Regional Consultative Committee
RHO	Regional Health Officer
RNuO	Regional Nutrition Officer
RRCHCo	Regional Reproductive and Child Health Coordinator
RS	Regional Secretariat
RIVO	Regional Immunization and Vaccination Officer (RIVO)
RSWO	Regional Social Welfare Officer
RCHWCo	Regional Community Health Workers Coordinator
SBCC	Social Behaviour Change Communication
TASAF	Tanzania Social Action Fund
TDHS	Tanzania Demographic and Health Survey
VASD	Vitamin A Supplementation and Deworming
VDC	Village Development Committee
VIDO	Vaccine and Immunization District Officer
WDC	Ward Development Committee

FOREWORD

The development of these terms of reference (TOR) for the Regional and Council Multisectoral Steering Committees on Nutrition, completes the guidance to the multisectoral coordination structures of the National Multisectoral Nutrition Action Plan (NMNAP) 2016 – 2021 at all levels. The NMNAP was approved by the High-Level Steering Committee on Nutrition (HLSCN) in October 2016, the TOR for the national coordinating structures were completed in August 2017, and the NMNAP was launched by the Prime Minister, Hon. Majaliwa Kassim Majaliwa in Dodoma on 6th September 2017.

Acknowledging that **nutrition is a crosscutting issue that requires the effective contribution of multiple actors, sectors and administrative levels**, the NMNAP adopts a **Community-centred multisectoral approach** consistent with the Government's Decentralization by Devolution (D by D) approach being implemented by the **President's Office - Regional Administration and Local Government (PO-RALG). The D by D strategy emphasizes community action** in addressing developmental issues including for nutrition, through a cyclic process of **assessment, analysis and action (triple A process)**. **For nutrition, the approach has been further enhanced by the Vice-President, H.E Samia Suluhu Hassan, adoption of a nutrition compacts with Regional Commissioners** that requires them to effectively utilize resource for nutrition to bring down the unacceptably high levels of malnutrition in their areas.

The **roles and responsibilities of PO-RALG** in the implementation of the NMNAP include to: -

- ✓ Guide and monitor the integration of nutrition interventions in Regional Secretariats and Local Government Authorities plans and by-laws;
- ✓ Coordinate and facilitate capacity development of Regional Secretariats and Local Government Authorities to plan and implement nutrition improvement programs at the community level; and
- ✓ Coordinate and monitor nutrition interventions by all actors in Regional Secretariats and Local Government Authorities using the principle of the three ones: One Plan, One Coordinating Mechanism and One Monitoring and Evaluation Framework.

While the Regional and Council Multisectoral Steering Committees on Nutrition support PO-RALG to play these roles effectively and facilitate the implementation of the nutrition compact by Regional Commissioners, the TOR define the composition, roles and responsibilities of

these committees and their individual members. Moreover, to ensure accountability, the TOR provide the indicators by which the performance of the committees and the members should be measured. I urge all Members of the committees to play their roles effectively so that we bring down the levels of malnutrition in our communities and eventually the nation at large.

I would like to thank all those who participated in the extensive consultation that developed these terms of reference: PO-RALG led the process with huge support from Nutrition Officers at Regional and District/Town/City Council levels, UNICEF provided financial and technical support and the same Lead NMNAP Facilitator moderated and synthesized the various inputs into this document. Others are Prime Ministers Office, nutrition sensitive MDAs (MOHCDGEC, MOFP, MOA, MoLF, TFNC), Ministry of Health Zanzibar (Nutrition Unit), UN Agencies (UNICEF and WFP), Development Partners (USAID), The World Bank and several nutrition focused NGOs (NI, CUAMM, IMA World Health, Save the Children, Mwanzo Bora, PANITA, ENRICH). Let us continue the support in implementation.

Dr. Zainab A.S. Chaula,
Acting Permanent Secretary,
President's Office-Regional Administration and Local Government

01

INTRODUCTION

1.1 Background and Rationale

Why these terms of reference?

1) This document updates the terms of reference (TOR) of the Regional and Council Multisectoral Steering Committees on Nutrition (R&C-MSCN) established in 2011. The first five years of the functioning of the updated TOR require alignment with the National Multisectoral Nutrition Action Plan (NMNAP) of 2016- 2021. The NMNAP was approved by the High-Level Steering Committee on Nutrition (HLSCN) in October 2016 and launched by the Prime Minister of the United Republic of Tanzania, the Honorable Majaliwa Kasim Majaliwa (MP), on September 6th, 2017.

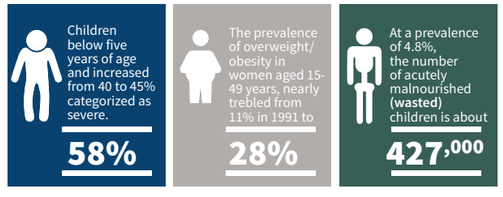
2) The Regional Multisectoral Steering Committee on Nutrition (RMSCN) and Council Multisectoral Steering Committee on Nutrition (CMSCN) were first established in 2011 by a directive from the Prime Minister's Office (PMO) that required Regional Secretariats (RS) and Local Government Authorities (LGAs) to establish them to ensure adequate coordination of nutrition interventions at the Regional and Council levels in alignment with the then National Nutrition Strategy (NNS) of 2011/12-2015/16, which preceded the NMNAP. As of 2018, all RSs and LGAs had established these steering committees. Because the initial TOR had not specified the roles of the committee members, there was little accountability. Moreover, due to lack of funds and commitment, many of these committees were not functioning.

3) The aim of updating the TOR for these committees is to ensure a coordinated, transparent and accountable multisectoral scaled-up response to Tanzania's unacceptably high levels of malnutrition, focusing on community-level actions. The committees put the Government authorities in the driving seat in the fight against malnutrition and define the roles of the different stakeholders to ensue adherence to the THREE ONES NMNAP guiding principles of ONE plan, ONE coordinating mechanism and ONE Monitoring and Evaluation framework, in the spirit of Public-Private-Partnerships (PPP). **Moreover, the Regional**

and Council Committees are critical in supporting Regional Commissioners to implement the "Nutrition Compacts" that the Government will sign with them to ensure that they utilize effectively the nutrition funds that have been provided to LGAs to bring down the unacceptably high levels of malnutrition in their Regions.

1.2 How big is the problem of malnutrition in Tanzania?

4) The status of malnutrition in Tanzania in relation to the six-global nutrition targets that WHO member states have committed to achieve by 2025 is unacceptable with specific reference to stunting and anaemia[1]. Recent data (TDHS 2015/16) shows that although Tanzania has made some good progress in addressing the problem of undernutrition, the pace of improvement, especially for stunting and anaemia has been slow. Between 2010 and 2015/16, stunting in children below five years of age reduced from 42% to 34%, but with no improvements in the prevalence of anaemia which remained at 58% for children below five years of age and increased from 40 to 45% for women in their reproductive ages (15-49 years). Moreover, due to Tanzania's high rate of population growth (2.7% per annum), the absolute numbers of stunted children in Tanzania increased from 2.7 million in 2010 to about 3.0 million in 2015/16 out of an estimated number of 8.9 million children underfive years. At a prevalence of 4.8%, the number of acutely malnourished (wasted) children is about 427,000 of whom half may be severely wasted.



5) Evidence is emerging of a double burden of malnutrition where over-nutrition in adults as manifested by overweight, obesity and diet related non-communicable diseases (DRNCDs)[2] are rising rapidly. The prevalence of overweight/obesity in women aged 15-49 years, nearly trebled from 11% in 1991 to 28% in 2015/16, close to the 34% stunting prevalence in children below five years of age (TDHS 2015/16). This double burden requires "double duty" action as done in the NMNAP, which addresses malnutrition in all its forms.

1.3 Causes of malnutrition

6) The causes of malnutrition are complex, interrelated and multisectoral. The immediate causes are poor dietary intake and diseases; while the underlying causes are food insecurity, inadequate maternal and child care, and inadequate availability and access to basic services like health, education, WASH (water, sanitation and hygiene). This indicates the importance of holistic Early Childhood Development (ECD)[3] interventions to address these challenges. ECD interventions comprise several stages of mental and physical growth as well as a variety of contexts such as homes, schools and the community. ECD activities range from childcare to nutrition for pregnant mothers and young children to parent education and WASH interventions. They are meant to address the health, nutritional, cognitive, linguistic and socio-emotional needs of the child. Basic or root causes of malnutrition relate to poor social-cultural and economic structures of society that do not adequately invest in nutrition, particularly during the early years. Given the complex and multisectoral nature of the nutrition challenge, a coordinated multisectoral approach is essential at all levels, encompassing both nutrition specific and nutrition sensitive interventions. The Regional and Council Multisectoral Steering Committees on nutrition will ensure such a coordinated approach.

1.4 The consequences of malnutrition

1) **The consequences of undernutrition** are multiple, spanning from the individual, household, community and national levels. The worst damages of undernutrition happen during first 1,000 days of life – from conception to two years. Undernourished children have weaker immune systems and are thus more susceptible to infections, illnesses and early deaths than well-nourished children. Long-term effects of insufficient nutrient intake and frequent infections can cause stunting, whose effects, like delayed motor and cognitive development (impaired mental processes of perception, memory, judgement and reasoning) are largely irreversible. Stunted girls are likely to experience obstructed labour during child birth increasing the risk of developing fistulas and even maternal and/or newborn deaths. Stunting also predisposes an individual to overweight, obesity and related consequences such as cardio-vascular heart diseases, hypertension and diabetes in later life stages.

7) Various studies show that chronic malnutrition and lack of early stimulation impact brain development and impair their ability to learn, develop and become productive adults. Moreover, vitamin and mineral deficiencies in the womb and in early childhood can cause nutritional blindness, dwarfism, mental retardation and neural tube defects – all severe handicaps in Tanzania and in any society.

   i. Vitamin A deficiency the commonest cause of preventable blindness and weak body immunity in underfive children, can be easily prevented by exclusive breastfeeding during the first six months, followed by vitamin A fortified complementary foods and supplementation from the age of six months.

   ii. Iodine deficiency, the commonest cause of dwarfism and preventable mental retardation in developing countries including Tanzania is easily preventable by universal salt iodation (USI).

   iii. Folic acid deficiency, easily preventable by ensuring women consume folic acid-rich foods including fortified foods and folic acid tablets before pregnancy, is the commonest causes of neuro-tube defects in the newborn. Neural-tube defects are severe birth defects of the brain (anencephaly – where the baby is born without some parts of the brain and skull) and spina bifida (where the spinal cord at the lower back is open to the outside).

8) However, it should be noted that undernutrition is just part of the story and that there are multiple and overlapping

1 The global nutrition targets **(with Tanzania trend in brackets)** call for a 40 percent reduction in the number of children under-five who are **stunted (number increasing though prevalence decreasing)**; 50 percent reduction of **anaemia in women of reproductive age (increasing)**; 30 percent reduction in **low birth weight (on target)**; no increase in **childhood overweight (on target);** increasing the rate of **exclusive breastfeeding to at least 50 percent (achieved 41%)** and **reducing wasting to less than 5 percent (achieved)**.

2 The trend towards overweight, obesity and DRNCDs in Tanzania is attributed to preventable lifestyle factors related to changes in eating habits and physical activity levels. The key driver is urbanization. People are shifting from traditional diets to consumption of processed foods which are high in carbohydrates, fat, sugar and salt, and low intake of fruits and vegetables. Such lifestyle eventually lead to changes in body composition depicted as overweight and obesity accompanied by elevated levels of blood pressure, lipids and sugar. These are the known risk factors for hypertension, coronary heart disease, stroke, type 2 diabetes and some forms of cancer.

3 Early Childhood Development refers to the cognitive, socio-emotional and physical development of the child. The ECD period spans from pregnancy to 72 months (5years).

factors that contribute to poor brain development and overall social and economic development. Brain development requires also the presence of rich and stimulating environment and responsive caregiving. Chronic malnutrition and lack of early stimulation affects learning abilities, educational achievements, contributing to potentially lower levels of employability and productivity than those well-nourished. This situation leads to an intergenerational transfer of a vicious cycle of undernutrition-poverty-undernutrition.

9) The **most common consequence of overconsumption or 'over-eating' and inactivity in general is overweight and obesity**, characterized by excess weight gain due to the accumulation of excessive body fat. The common major health risks of obesity include: hypertension, heart diseases and heart attacks, chronic liver diseases, diabetes, gallstones, infertility (both female and males) and several diet related cancers (e.g. colon cancer, breast cancer, kidney cancer). These conditions are generally referred to as Diet Related Non-Communicable Diseases (DRNCDs). Other risks of obesity are premature ageing, lack of energy and higher risk of surgical complications. While the major cause of obesity is overeating that exceeds the body's energy needs, stunting during childhood, lifestyle circumstances like inactivity, lack of exercise, excessive consumption of alcohol, fats and sugar; genetics and some medical conditions and/or medications can also be responsible for overweight and obesity. Overweight and obesity reduce physical work efficiency and intellectual articulation due of poor supply of oxygen to the muscles and brain. Consequently an individual feels lazy/sleepy all the time.

1.5 Why is good nutrition critical for industrial growth and sustainable development?

10) The most critical resource in any development endeavour is a physically, emotionally and intellectually strong human resource base, capable of converting available potential resources into value for human and economic development. Good nutrition is central to industrial growth and sustainable human and economic development because it is the foundation of human capital formation. Improved nutrition increases life expectancy and increases the productivity of adults, which are key factors in sustainable development. Good nutrition improves learning ability and capacity to operate creatively and innovatively in a competitive environment important for rapid industrial growth in a middle-income country context. Since most of the impacts of undernutrition on mental development are irreversible and occur during the first 1,000 days of life, **investing in nutrition during the early childhood years is one of the most critical investments a country can make.**

11) The World Bank's 2016 paper on "Why Invest in Nutrition" quotes studies that have shown strong relationships between nutrition, mental development and adult work productivity as follows: -

    i. Stunting may reduce IQ by 5-11 points.

    ii. Iodine deficiency reduces IQ by as much as 10-15 IQ points.

    iii. Low birthweight (2.5 kg and below) may reduce a person's later IQ by 5%.

    iv. Iron deficiency anaemia reduces performance on tests of mental abilities (including IQ) by 8 points.

    v. Eliminating anaemia can lead up to 5-17% increase in adult productivity.

    vi. A 1% loss in adult height due to childhood stunting is associated with a 1.4% loss in productivity.

    vii. A 1% increase in height is associated with a 4% increase in wages.

    viii. Extreme BMI (below 18.5 and above 25) are associated with lower productivity.

12) Thus, there is overwhelming evidence that improving nutrition contributes to economic productivity and development and poverty reduction by improving physical work capacity, mental capacity and school performance. Thus, improved nutrition is tremendous value for money as it reduces the costs related to lost productivity and health care expenditures.

> It is estimated that each dollar spent on nutrition delivers between USD 8 and USD 138, which is a cost-benefit ratio of around 1:20, like that of infrastructure development like roads, railways, electricity etc. (see table 1 for cost-benefit rations of different nutrition intervention programs).

Moreover, **investing in nutrition is an investment in the grey matter infrastructure** and generates growth that directly benefits the poor, reduces inequality and assists in social mobility through increased employability and productivity.

13) Investing in nutrition extricates individual, communities and nations at large from the long-term and intergenerational trappings of the vicious circles of malnutrition-poverty and accelerates economic growth. Estimates show that eliminating malnutrition in Tanzania can contribute up to 2.5% of GDP growth annually. In addition, eliminating malnutrition is one of the best ways to address poverty given that malnutrition is both a cause and consequence of poverty.

Table 1: The cost-benefit of various nutrition programs

Nutrition intervention programs	Cost-benefit (USD)
Breastfeeding promotion in health facilities	5 - 67
Integrated child care programs	9 - 16
Iodine supplementation (women)	15 - 520
Vitamin A supplementation (children <6 years)	4 - 43
Iron fortification (per capita)	176 - 200
Iron supplementation (per pregnant woman)	6 - 14

1.6 Challenges to coordinated multisectoral nutrition response

14) A major challenge for coordinated multisectoral nutrition response in Tanzania has been inadequate capacities at all levels to translate the political will and commitment into evidence-based, effective, impactful and sustainable policies, strategies and actions that are at scale, multisectoral, well-coordinated, integrated, resourced and monitored. To address these challenges, the government strengthened its leadership in nutrition and took several steps which included: launching of the National Nutrition Strategy (NNS) 2011/12-2015/16, development of the NMNAP (2016/17-2020/21), the inclusion of nutrition in national planning and budgeting guidelines, the establishment and recruitment of nutrition officers in all Regions and Councils and the formation of multi-sectoral coordinating structures for nutrition at national, Regional and Council levels.

15) The annual Joint Multisectoral Nutrition Reviews (JMNRs) started since 2014 have showed challenges regarding the functionality and effectiveness of these coordinating structures. The main challenges relate to inadequate terms of reference (TOR) with regards to composition, roles and responsibilities, performance monitoring, and functionality and inadequate funding. Moreover, the NMNAP called for a review/ updating of the TOR of these coordinating committees at all levels to ensue alignment with the implementation of the NMNAP. The TOR for all the national structures were completed in July 2017 and this document completes the TOR for the Regional and Council committees. The diagram below shows the position of the Regional and Council multisectoral steering committees on nutrition within the NMNAP coordination mechanism.

1.7 Objectives of the Regional and Council Multisectoral Steering Committees on Nutrition (R&CMSCN)

16) The main objective of the R&CMSCN is to provide oversight and accountability to Regions and Local Government Authorities (LGAs) to efficiently and effectively deliver timely quality nutrition specific and sensitive interventions to all communities in Tanzania through strengthened nutrition governance.

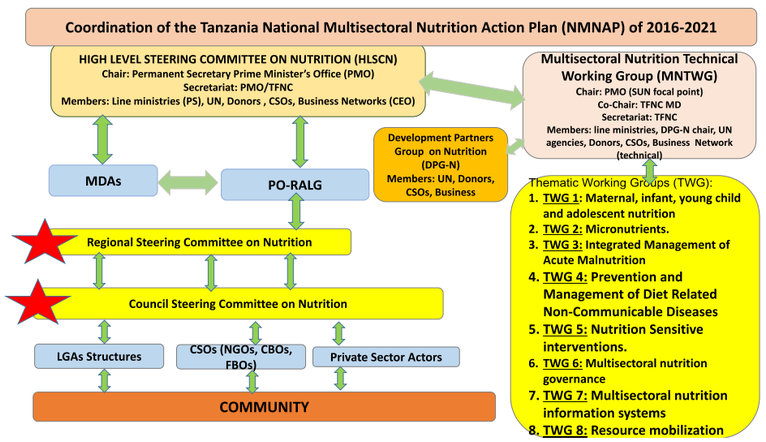


Figure 1: Coordination framework for the NMNAP 2016/17 - 2020/21

1.8 Broad Roles and Responsibilities of the R&CMSCN

17) The key roles and responsibilities include: -

i. Oversee development of costed strategic nutrition action plans that align with the national multisectoral nutrition response, specifically the NMNAP during the 2016/17 – 2020/21 period.

ii. Promote an integrated coordination of the national multisectoral nutrition response at the Regional and Council levels, using the principle of the three ones: One plan, one coordinating mechanism and one monitoring and evaluation mechanism by ensuring participation of all nutrition stakeholders;

iii. Serve as the inter-sectoral monitoring body for nutrition at the Regional and Council levels, ensuring the efficient and effective use of resources for nutrition impact and integration of early stimulation into nutrition interventions.

1.9 Structure of The TOR for the R&CMSCN

18) The updated TOR for the R&C-MSCN: -

- Define the structure and composition of the Regional and Council Multisectoral Steering Committees on Nutrition.
- Identify the roles and responsibilities of the committees at Council, Ward and Village/Mtaa levels.
- Identify the roles and responsibilities of each position held in the committee (chairperson, Secretary and members);
- Define the specific roles of the Nutrition Officers at the Regional and LGA levels;
- Define the performance indicators of the R&CMSCN and those of its core members.

1.10 The process for developing the TOR

19) The process took about four months and involved an extensive multi-stakeholder consultative process organized by PO-RALG, funded by UNICEF and facilitated by the same NMNAP Lead facilitator. Participants included PO-RALG, PMO, MDAs (MoHCDGEC, MoAFS, MoFP, TFNC), Ministry of Health Zanzibar (Nutrition Unit), United Nations Agencies (UNICEF, WFP), CSOs (CUAMM, Mwanzo Bora, NI, IMA World Health, PANITA, Save the Children, ENRICH), donors (USAID), The World Bank and the DPG-N through their review of shared drafts. The initial draft was developed in a workshop held in Morogoro (August 7-9, 2017), followed by a task force workshop held in Dodoma October 30th – November 3rd 2017, which the Lead Facilitator consolidated into a second draft and circulated for comments. The Lead Facilitator incorporated comments received into a third draft, which was validated by a workshop held in Dodoma November 13-15th, 2017 and developed into draft 4. Draft 4 was circulated for final comments, which were incorporated into this final TOR. The TOR has been approved by PO-RALG Management on 15 March 2018. The list of participants for these workshops is shown in appendix 2.

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TERMS OF REFERENCE FOR THE REGIONAL MULTISECTORAL STEERING COMMITTEE ON NUTRITION (RMSCN)

2.1 Introduction

20) The Regional Multisectoral Steering Committee on Nutrition (RMSCN) is the governing body on implementation of nutrition activities at the Regional level. It supports the Regional Commissioner (RC) to ensure that nutrition policies, strategies, guidelines, regulations and government directives on nutrition are translated and implemented at Regional and Council levels.

21) A key priority of the RMSCN is to translate the National Multisectoral Nutrition Action Plan (NMNAP) of 2016/17 – 2020/21 into SMART (Specific, Measurable, Achievable, Realistic, Time-bound) Regional strategic action plans that can be used to develop a nutrition compact with the national authorities, that will ensure resources allocated for nutrition for Regions and Councils are efficiently and effectively used to accelerate the reduction of malnutrition.

2.2 Roles and responsibilities of the RMSCN

22) The NMNAP gave the **Regional Secretariats the following roles: -**

i. Identify nutrition problems, challenges and solutions in the Regions;

ii. Integrate food and nutrition objectives in Regional Secretariat plans and strategies;

iii. Interpret policies and guidelines on nutrition for implementation;

iv. Provide technical guidance and supportive supervision on nutrition to LGAs; and

v. Coordinate, advise, monitor and evaluate the implementation of NMNAP by different stakeholders at Regional level.

vi. Resource mobilization

23) The specific roles and responsibilities of the Regional Multisectoral Steering Committee on Nutrition are, therefore, to: -

I. Coordinate and oversee the scale-up of nutrition interventions in respective Councils within the Region, according to the National Multisectoral Nutrition Action Plan (NMNAP) including to oversee the integration of early childhood development (ECD) into existing nutrition programs. An ECD guideline will need to be developed to ensure this happens.

II. Receive and discuss multisectoral nutrition implementation reports from Councils and development partners and provide feedback.

III. Share innovations and best practices across Councils in accelerating reduction of malnutrition.

IV. Monitor and enforce nutrition relevant legislations and regulations e.g. on salt iodation, food fortification and the code on marketing of breastmilk substitutes and related products[1].

V. Mobilize financial resources for nutrition and ensure those resources are effectively used to improve the nutrition situation in the Region.

VI. Promote collaboration among nutrition stakeholders across sectors for better nutrition outcomes in the Region e.g. through meetings of stakeholders (public, private, non-governmental sectors) to present and discuss nutrition issues.

VII. Conduct Regional Nutrition Situational/Gap Analysis (including early stimulation in the gap analysis) and use it to develop 5-year Multi-sectoral plans on nutrition at Regional level.

VIII. Advocate to RCC, partners, Private Sector and other relevant structures on nutrition issues as critical development priority.

IX. Discuss findings of Nutrition Surveys, nutrition score card, Bottle Neck Analysis (BNA), Joint Multisectoral Nutrition Reviews (JMNR) to inform decision making process and taking appropriate actions.

X. Ensure transparency and accountability on actions agreed by the committee.

XI. Conduct monitoring and evaluation of Nutrition Score Card reports and implementation of the NMNAP

XII. Ensure LGAs and Stakeholder's Nutrition plans are incorporated into the medium-term expenditure framework (MTEF) and monitor Regional and Councils expenditure on nutrition to influence Sustainable Development Goals (SDGs).

XIII. Develop and agree on formal plans regarding how various government departments and non-state actors in the Region and its constituent Council will work together.

XIV. Conduct quarterly nutrition multisectoral comprehensive supportive supervision in LGAs.

1 The Code aims to contribute "to the provision of safe and adequate nutrition for infants, by the protection and promotion of **breastfeeding**, and by ensuring the proper use of **breast-milk substitutes**, when these are necessary, based on adequate information and through appropriate **marketing** and distribution

xv. Advise statutory committees (RCC, KUU) on appropriate strategic nutrition interventions and response actions taken to implement the national multisectoral nutrition response action plans.

2.3 Composition of the RMSCN

24) As shown in table 2, the composition of members of the RMSCN consists of the Regional Administrative Secretary (RAS) as chair, Assistant Administrative Secretary – Health as Secretary while Regional Nutrition Officer forms Secretariat, and key nutrition stakeholders in the Region including heads of nutrition sensitive sectors; nutrition focused Civil, Faith based and other non-governmental organizations (CBO & FBO, NGOs), the media, private sector and where available academic and research institutions. Depending on the agenda, technical staff may be invited to meetings as needed.

Table 2: Composition of the Regional Multisectoral Steering Committee on Nutrition

S/N	Title in RMSCN	Designation	Technical staff who may be invited depending on agenda
1.	Chairperson	Regional Administrative Secretary (RAS)	
2.	Secretary	Assistant Administrative Secretary (AAS) Health Services	• Regional Reproductive and Child Health Coordinator (RRCHCo) • Regional Health Officer (RHO) • Regional Alternative Medicine Coordinator • Regional Community Health Workers Coordinator (RCHWCo) • Regionalw Aids Control Coordinators (RACC) • Regional Social Welfare Officer (RSWO) • Regional Immunization and Vaccination Officer (RIVO)
3.	Member	Assistant Administrative Secretary Education	
4.	Member	Assistant Administrative Secretary Water (AAS-Water)	Given the critical link between nutrition and WASH, the RMSCN should identify a specific person
5.	Member	Assistant Administrative Secretary Planning and Coordination	• Community Development Officer • TASAF Coordinator
6.	Member	Assistant Administrative Secretary Economic and Production	• Fisheries Officer • Livestock officer • Agriculture Officer • Trade Officer
7	Member	Assistant Administrative Secretary - Administration and Human Resource	• Human Resource Officer
8	Member	Regional Chief Accountant	• Accountant
9.	Member	2 representatives from Faith Based Organizations. (1 Christianity & 1 Muslims)	Membership will rotate annually, however the membership can be renewable as can be seen relevant by the FBOs
10.	Member	2 Representatives from umbrella Community-Based Organizations (Nutrition focused)	• For Regions with more than 2 CBOs the membership will rotate on three years' basis • For CBOs to be members of RNSC, it should be working in more than one Council in the Region
11.	Member	2 representatives from Non-Governmental Organizations (NGO's) (Nutrition focused)	For Regions with more than 2 NGOs the RNuO should organize quarterly meetings of nutrition focused development partners and the private sector just before planned RMSCN meetings and report outcome to the RMSCN. This will help facilitate greater communication and engagement of development partners, the Private Sector (PS) and the RS/LGAs.
12.	Member	Information officer	
13.	Member	1 representatives from media	
14	Member	1 representative from nutrition related private sector	Miller, food processors, salt iodation, etc. memberships will rotate on 2 years' basis. The member should be operating in more than one Council in the Region.
15	Secretariat	1. Regional Nutrition Officer 2. Committee Clerk	If there more than one Regional Nutrition Officer, all should be in the Secretariat
16	Committee may invite any person or stakeholder considered critical (e.g. nutrition champion) to be a member of RMSCN or to provide expert advice in specific meetings.		

2.4 Roles of Committee Members

25) The general roles of a chairperson and secretary are shown in appendix 1. This section identifies the roles as they specifically relate to the RMSCN.

26) THE CHAIRPERSON: The roles of the chairperson of the RMSCN are to:

i) Ensure RMSCN meetings are conducted quarterly

ii) Include a calendar of meetings of the RMSCN into the Regional calendar

iii) Ensure line sectors responsible for nutrition (sensitive and specific) at the Regional level present reports on implementation/activities during steering committee meetings.

iv) Present reports to every Regional Management and RCC meetings.

v) Submit reports to Permanent Secretary of relevant Ministries represented in the RMSCN.

vi) Mobilize financial resources and ensure resources are available and allocated for nutrition activities.

vii) Conduct meetings consistent with the general roles shown in appendix 1 include performance indicators of chairperson

27) THE SECRETARY: The role of the Secretary of the RMSCN will be to: -

i) Coordinate the quarterly meetings of the committee in close collaboration with the chairperson adhering to the general roles of a Secretary shown in appendix 1.

ii) Promote the work of the RMSCN in the Region

iii) Follow-up on invitation and regular attendance of key members of the steering committee

28) Regional Nutrition officer (RNuO) as the nutrition technical person will: -

i) Serves as Secretariat to the RMSCN.

ii) Mobilize financial resources and ensure resources are available and allocated to nutrition activities in the Region.

iii) Develop and submit plans, budget and reports for nutrition activities in the RMSCN.

iv) Provide technical support and monitor implementation of the NMNAP at Regional level.

v) Support integration of nutrition in sector policies, strategies and programmes.

vi) Ensures ECD is integrated in the interventions of the relevant sectors (health, education, social welfare, social protection)

vii) Establish, up-to date and maintain a consolidated database on nutrition for the Region.

viii) Initiate and support undertaking of studies to support the RMSCN make evidence-informed decisions.

ix) Advocate for nutrition at all levels/ sectors.

29) Indicators to evaluate the performance of the Regional Nutrition Officer will include: -

i) Proportion of planned nutrition activities integrated into MTEF which are aligned with the NMNAP

ii) Proportion of nutrition interventions in the annual plan that are implemented annually

iii) Proportion of nutrition interventions that include early stimulation implemented annually

iv) Proportion of budget allocated and disbursed to nutrition interventions that has been expended in alignment with the NMNAP.

v) Proportion of nutrition reports submitted per reporting period

vi) Proportion of planned nutrition supportive supervision conducted in the Councils annually.

30) Specific Responsibilities of Head of Sections as members of RMSCN:

AAS – Health: To present the implementation report on the following nutrition issues: -

i) Micronutrients supplementation (IFA, VASD, ZINC) and food fortification -example salt iodation.

ii) Implementation of the outcomes of the Child Health Nutrition Month (CHNM)

iii) Implementation status of MIYCAN

iv) Early Childhood Development (ECD) services/activities

v) IMAM

vi) Sanitation including status of toilets in the respective area of jurisdiction.

vii) Prevention and management of diet related NCD

Performance indicators for AAS – Health,

i) Percentage of planned RMSCN meetings convened annually, minutes shared and action points implemented.

ii) Vaccination Coverage for under 5 years' children

iii) Proportional of facility health workers trained on nutrition issues.

iv) Proportional of community health workers trained on nutrition issues.

v) Proportion of households with hand washing facilities and improved latrine in use.

vi) Number of centers implementing ECD practices2. Specific ECD practices to monitor include health related ECD practices e.g. antenatal care, early stimulation, growth monitoring, sanitation and hygiene, declaration of elimination of open defecation) etc.

AAS – Education: To report on: -

i) Status of school feeding program and supportive supervision on proper food handling practices in schools

ii) Status of inspection of food safety, standards and quality in boarding schools

iii) Establishment of school fruits & vegetable gardening

iv) Nutrition education in schools

v) Gender situation in primary and secondary schools.

Performance indicators:

i) Number of girls enrolled and completed primary and secondary school education

ii) Nutrition and health education sessions conducted in schools quarterly.

iii) Nutrition inspections on food quality and standard in boarding schools done

iv) Proportion of pre-school aged children attending pre-school

v) Proportion of households with preschool children attending nutrition and health education sessions offered by the schools.

vi) Proportion of preschool students who are malnourished (if data is available).

vii) Number of primary and secondary school adolescent girls (in pilot Regions) who receive weekly iron and folic acid supplements.

viii) Proportion of toilets in primary and secondary schools which are functional.

ix) Proportion of girls dropping out of school and main reasons for this

x) Proportion of schools with functional facilities for handwashing with soap.

xi) Proportion of schools participating in the deworming and anti-Schistosoma program

AAS Planning and Coordination: To present report on:

i) Budget for nutritional activities from each department and implementation status of nutritional activities

Performance indicator:

i) Number of stakeholder submitted plans and budgets for nutrition and implementation status

Community Development Officer (CDO): The CDO will ensure: -

i) TASAF beneficiaries with children underfive have their nutrition status measured and the nutrition education

2 Though reported here, ECD practices and investments go beyond health to include promotion of nutrition, early education, water and sanitation, social protection and child protection. The ECD period spans from pregnancy to 72 months (5years).

sessions include education on good ECD practices.

ii) Mobilization community action on nutrition issues

iii) Promote and advocate for gender equality related to nutrition (e.g. dietary diversity during pregnancy, equal participation in nutrition governance etc.)

Performance indicators

i) Number of nutrition education session conducted during TASAF sessions compared to those planned annually.

ii) Number of available community level workers compared to established numbers.

iii) Number of trainings received Vs planned (include those provided under TASAF).

AAS – Economic and Productive Services should report on the following: -

i) Promotion and support of increased production, accessibility and consumption of diverse high nutrient dense food crops

ii) Strategies on post-harvest losses reduction as a method to ensure food security

iii) Promotion of livestock, fishing and poultry farming.

Performance indicators:

i) Proportion of household engaging in homestead food production (horticultural and small animals)

ii) Proportion of household trained on different food storage and preservation methods (malting, fermentation, improved drying etc.)

AAS - Water should report on the following indicator: -

i) Proportion of households with clean and safe water in their respective areas of jurisdiction.

AAS – Administration and Human Resource should report on the following: -

i) Planning and budgeting for human resource for nutrition

ii) Deployment of nutrition professionals

Performance indictors:

i) Proportional of human resource for nutrition

Regional Chief Accountant should report on the following: -

i) Amount of fund being allocated to nutrition and its expenditure

ii) Management responses on the audit queries

Performance indictors:

i) Percentage of funds allocated for nutrition

ii) Percentage of fund utilized for nutrition

iii) Auditors report on nutrition

31) **Roles of NGOs, CBOs, and FBOs: Should**

i) Ensure their plans, including indicative budget, are integrated into Regional plans.

ii) Ensure all implemented nutrition activities for any projects funded/ implemented are reported together within Regional plans by the RNOs as part of Regional activities

iii) Share progress reports on how they have aligned implementation of their programmes with the NMNAP and support provided to the Region/LGAs.

iv) Share their plans and identify areas of collaboration with other stakeholders

v) Share best practices, experiences, lessons learned during implementation of nutrition programs, including examples of where early child stimulation has been integrated.

vi) Report how the program is jointly implemented with the LGAs

vii) Report on their participation of their NGOs in LGA meetings at any level or how their representatives share information from the RSCN &DSCN meetings

viii) Share mid-year and annual reports with the Regions.

2.5 Operational mechanism

32) **Number and frequency of meetings:** meetings should be held every quarter (total of 4 per year)

33) **Venue for meetings:** To be agreed and organized between the Chairperson and Secretary.

34) **Quorum:** Half or more of core members

35) There shall be no DSA or sitting allowance payment to members for the meeting unless supported by Partners or the Chairperson has obtained instructions from relevant Authorities. Lack of DSA should not hinder the meeting to be conducted.

36) **Agenda:** All members should contribute to the agenda items via the Secretary. A standard agenda could be as follows:

i) Opening of meeting

ii) Review of and approval of previous minutes

iii) Matters arising from previous meeting (report on implementation of agreed action points)

iv) Updates on progress towards each Outcome of the NMNAP, provided by nutrition officers and officers from each sector.

v) Results of the quarterly multisectoral nutrition scorecard. This will help facilitate multi-sectoral “accountability”

vi) Outcome of meeting between the RNuO, CSOs and Private Sector

vii) Add other specific agenda items for the day.

viii) Upcoming nutrition events.

ix) Any other business (AOB)

x) Date for next meeting

xi) Close of meeting by chair.

37) **Reporting mechanism:**

i) Each member should provide feedback to their respective sectoral Ministries immediately after the meeting or as soon as possible.

ii) The Secretary should complete the minutes of the meeting within a week and get consent from the Chairperson to circulate to members of the Regional Multisectoral Steering Committee on Nutrition.

iii) Chairperson should present reports to every Regional Management and RCC meetings.

iv) After approval at the next meeting, the chair should share the approved minutes with the PO-RALG, who will then share with the chairs of the MNTWG and HLSCN.

v) The reporting structure has been illustrated in figure 2.

2.6 Performance indicators for the RMSCN

38) **The RMSCN will be evaluated using the following indicators: -**

- ✓ Number of RMSCN meeting conducted per year out of the 4.
- ✓ Presence of Regional multisector strategic plan on nutrition.
- ✓ Proportion of advocacy meetings conducted per year Vs planned
- ✓ Proportion of reports received from different sectors Vs expected
- ✓ Number of nutrition focused stakeholders' whose plans are incorporated into the Regional nutrition work-plans Vs expected
- ✓ Number of scorecard reports discussed Vs expected
- ✓ Proportion of supportive supervision visits conducted to Councils by the Regional supervision team.

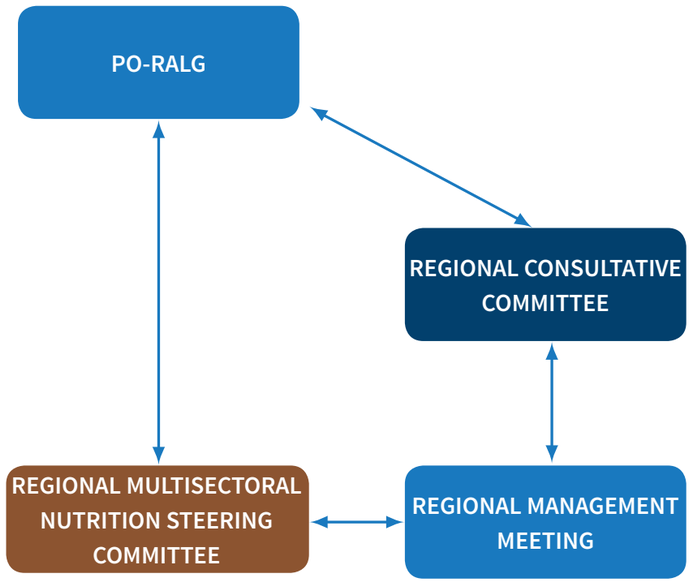


Figure 2. REPORTING STRUCTURE OF RMNSC

03

TERMS OF REFERENCE FOR THE COUNCIL MULTISECTORAL STEERING COMMITTEES ON NUTRITION (CMSCN)

3.1 Introduction

39) The **Council multisectoral steering committee on nutrition** (CMSCN) is the governing body on implementation of nutrition activities at Council level. It supports the District Commissioner and Council Executive Director to ensure that nutrition policies, strategies, guidelines, regulations and government directives on nutrition are translated and implemented at Council levels. It also serves as a monitoring body for the Council on the implementation of the National Multisectoral Nutrition Action Plan (NMNAP).

3.2 Objectives of CMSCN

40) The **main objective** of the CMSCN is to provide oversight and accountability to Council Authorities to efficiently and effectively deliver timely quality nutrition specific and sensitive interventions to all communities in the Council through strengthened nutrition governance. A key priority of the CMSCN is to translate the National Multisectoral Nutrition Action Plan (NMNAP) of 2016/17 – 2020/21 into SMART (Specific, Measurable, Achievable, Realistic, Time-bound) Council strategic action plans that can be used to develop a nutrition compact with the Regional Commissioner, that will ensure resources allocated for nutrition for Councils are efficiently and effectively used to accelerate the reduction of malnutrition in their areas of jurisdiction.

3.3 Roles and responsibilities of the CMSCN

41) In its **implementation, the NMNAP identified the following roles for Local Government Authorities (LGA)**

i) Strengthen Multisectoral Coordination Committee for Nutrition at LGA level.

ii) Establish and facilitate formation of a Nutrition Office in the Council to provide technical support.

iii) Facilitate identification of nutrition problems, challenges and solutions in the LGA.

iv) Integrate nutrition activities into the Comprehensive Council Development Plans.

v) Strengthen community-based activities to fight malnutrition;

vi) Support ward, village/mtaa levels to integrate nutrition into their development plans and implement and monitor nutrition activities at their respective levels;

vii) Identify opportunities to integrate early child stimulation into nutrition interventions and strengthen existing initiatives

viii) Coordinate the implementation, monitoring and evaluation of nutrition interventions in the Council based on the NMNAP

42) The **specific roles and responsibilities of the CMSCN** are, therefore, to: -

i. Coordinate and oversee the scale-up of nutrition interventions in their respective Councils, which align with the National Multisectoral Nutrition Action Plans (NMNAP) including to oversee the integration of early childhood development (ECD) into existing nutrition programs. An ECD guideline will need to be developed at national level to ensure this happens.

ii. Monitor, evaluate and enforce implementation of all policies, strategies, standards, legislations, regulations and guidelines relevant to nutrition e.g. food and nutrition policy, the NMNAP, salt iodation, code on marketing of breastmilk substitutes, guidelines on ECD.

iii. Sensitize and advocate for joint mobilization of resources for implementation of nutrition activities.

iv. Ensure committee member plans and budgets are recognizant of nutrition interventions and align with NMNAP.

v. Monitor Council's and stakeholders' plans and expenditure on nutrition to ensure that they contribute to the achievement of the NMNAP objectives and positively impact on National Development Plans and the National Strategy for Growth and Reduction of Poverty (NSGRP -MKUKUTA).

vi. Receive, review and discuss reports of planned activities from line sectors and stakeholders.

vii. Present milestones of agreed nutrition action plans during quarterly meetings and report to relevant authorities within the Council. Each member should also report to their respective sector.

viii. Monitor and evaluate the implementation of key milestones of the NMNAP and related activities in respective Council using the Nutrition Scorecard (NS) and Bottleneck Analysis (BNA) results.

ix. Promote the coordinated implementation of the NMNAP and related activities across all relevant departments and other stakeholders.

x. Monitor and evaluate the provision of technical support on the implementation of the NMNAP at ward and village/ street levels Including those that have early child stimulation.

xi. Advise CMT and standing committees on appropriate strategic nutrition interventions and response actions taken to implement NMNAP.

xii. Submit a report on the implementation of nutrition interventions and minutes of the meetings of the committee to the RMSCN.

xiii. Conduct comprehensive nutrition supportive supervision at Ward and Village/Mtaa levels.

3.4 Composition of the CMSCN

43) Table 3 shows the **composition of the CMSCN by title, designation** and suggest optional persons who can attend depending on their contribution to the content of the agenda. The composition consists of the District Executive Director or City/Municipal/ Town Director as chair; the Council Medical Officer as Secretariat while Council Nutrition Officer (D/CNuO) as Secretariat, and key nutrition stakeholders in the Council including heads of nutrition sensitive sectors; nutrition focused Civil, Faith based and other non-governmental organizations (CBO & FBO, NGOs), the media, private sector and where available academic and research institutions. Depending on the agenda, technical staff may be invited to meetings as needed.

Table 3: Composition of the Council Multisectoral Steering Committee on Nutrition (CMSCN)

S/N	Tittle in CMSCN	Designation	Technical staff to attend as needed
1.	Chairperson	District /Municipal /Town /City Executive Director	
2.	Secretary	Council Medical Officer	• District Reproductive and Child Health Coordinator (DRCHCo) • District Health Officer (DHO). • District Alternative Medicine Coordinator • District Community Health Workers Coordinator (DCHWCo) • District Aids Control Coordinators (DACC) • District Health Management Information System Coordinator (HMISCo or MTUA) • District Social Welfare Coordinator (DSWOco) • District Immunization and Vaccination Officer (DIVO)
3.	Member	Council Planning Officer	Trade Officer
4.	Member	Council Human Resource Officer	Human Resource Officer
5.	Member	Council Treasurer	Accountant

S/N	Tittle in CMSCN	Designation	Technical staff to attend as needed
6.	Member	Council Education Officer (Primary)	• School health coordinator • ECD Coordinator
7.	Member	Council Education Officer (Secondary)	Enrolment Coordinator
8.	Member	Council Agricultural, Irrigation and Cooperative Officer	Technical staff to attend when needed are: - • Extension Officer • Crop Officer • Cooperative Officer
9.	Member	Council Livestock and Fisheries Officer	Technical staff to attend the meeting when are needed: • Fisheries Officer • Livestock officer
10.	Members	Council Community Development Officer	The following Technical staff are not members, they will attend the meeting when they are needed: • TASAF Coordinator • Council HIV and AIDS Coordinator (CHACC)
11.	Members	District Water Engineer	Given the critical link between nutrition and WASH the CMSCN should identify a specific person to support the Water Engineer.
12.	Members	Two representatives from faith Based Organizations (FBO): one Christian & one Muslim	Membership will rotate annually. However, the membership can be renewable as can be seen relevant by the FBOs
13.	Members	Two Representatives from Community Based Organization(CBO) (Nutrition Based)	• For Councils with more than 2 CBOs the membership will rotate on three-years basis • CBO should be working in more than two wards to be a member of Council Steering Committee on Nutrition
14.	Members	Two representatives from Non-Governmental Organizations (NGO's)	For Councils with less than 2 NGO's all should be members. If the number is more than 2, only 2 can be selected to represent the others. NB: rotation will be considered to the NGO's with high coverage. *The Council Nutrition officer can also organize quarterly meetings between the NGOs/ development partners, the private sector and LGAs and present outcome next CMSCN.*
15.	Member	Council Information officer	
16.	Member	Private Sector:	e.g. millers' associations, producers of fortified food products. Memberships will rotate on 2 years' basis. The member should be operating in more than one Ward in the Council.
17.	Member	One from Academia:	Universities and other institutions of higher learning
18.	Members	Two from media	Local and representatives of national media
19	Secretariat	Council/District Nutrition Officer (CNuO) One Council clerk	If there is more than one NuO at Council Headquarters they should all be included in the secretariat
	The Chairperson can invite any technical staff, experts or other persons that can significantly contribute to the meeting's agenda.		

3.5 Roles of Committee Members

44) **ROLE OF CHAIRPERSON:** The roles of the CMSCN chairperson are to:

i. Ensure CMSCN meetings are conducted quarterly

ii. Mobilize financial, human and organizational resources, and ensure mobilized resources are available and used for nutrition activities.

iii. Ensure line sectors responsible for nutrition at the Council level present reports during steering committee meeting

iv. Ensure presentation of reports from CMSCN members to the CMT and Standing Committees

v. Presents reports to CMT and Standing Committees (Administration and Finance, Health, Water, Education etc.)

vi. Submit nutrition implementation reports to RS quarterly

vii. Presents the meeting agreements to the higher-level committee e.g. DCC and RS.

viii. Perform the general roles of a chairperson as shown in appendix 1

45) **ROLE OF SECRETARY:** The Secretary shall**: -**

i. Coordinate quarterly meetings following directives from chairperson

ii. Liaise with the Secretariat (NuOs and Council Clerk) to prepare reports and minutes of the meeting.

iii. Follow-up on invitation and regular attendance of key members of the steering committee.

iv. Perform the general duties of a Secretary as detailed in appendix 1.

Council Nutrition Officer (CNuO) duties are as follows: -

i. Serves as a Secretariat to the CMSCN.

ii. Mobilize financial resources and ensure resources are available for nutrition activities.

iii. Develop and submit plans, budget and reports for nutrition activities in the steering committee for nutrition.

iv. Provide technical support and monitor implementation of the NMNAP at Council level.

v. Support integration of nutrition in Sector policies, Strategies and Programmes.

vi. Establish and maintain a consolidated and updated database on nutrition including the Scorecard and BNA.

vii. Initiate and support undertaking of studies to generate preliminary evidence based nutrition situation.

viii. Collaborate with the DCDO to ensure complementarity of nutrition interventions by CSOs and NGOs

ix. Organize quarterly meetings between the LGA and development partners, NGOs (CSOs, FBOs, CBOs) and the private sector in Councils where there are more than 2 NGOs and present outcome to the D/CMSCN.

x. Maintain open regular dialogue with other steering committee members during the quarter to ensure that the action points are implemented and critical challenges are being addressed early on.

46) **Indicators to** evaluate the performance of the D/CNuO will include: -

i. Proportion of planned nutrition activities integrated into MTEF which are aligned with the NMNAP

ii. Proportion of nutrition interventions in the annual plan that are implemented annually

iii. Proportion of nutrition interventions that include early stimulation implemented annually

iv. Proportion of budget allocated and disbursed to nutrition interventions that has been expended in alignment with the NMNAP.

v. Proportion of nutrition reports submitted per reporting period Vs planned

vi. Proportion of planned nutrition supportive supervision visits conducted by the Council annually.

3.6 Role of members:

47) All members will perform their roles according to the **general roles of members** detailed in appendix 1.

The specific responsibilities of Heads of Departments as members of CMSCN are as follows: -

48) **Council Medical Officer:** To present implementation report of the following activities: -

i. Micronutrients supplementation (IFA, VASD, Zinc) and monitoring and enforcement of food fortification regulations: e.g. salt iodation, fortification of maize and wheat flour and edible oil.

ii. Implementation status of MIYCAN

iii. Early Childhood Development (ECD) services/activities

iv. Report on the implementation of outcomes of the Child Health and Nutrition Month (CHNM)

v. WASH situation.

vi. IMAM (Availability of supplies/ equipment's and guidelines, trainings etc.)

vii. Prevention and management of diet related non-communicable diseases (DRNCD)

viii. Vaccination Coverage for under 5 years' children

ix. Proportional of health workers trained on nutrition issues.

x. Status, challenges, needs and plans of the reported activities

Performance indicators for Council Medical Officer

i. Percentage of planned CMSCN meetings convened annually and minutes shared.

ii. Vaccination Coverage for under 5 years' children

iii. Proportional of facility health workers trained on nutrition issues.

iv. Proportional of community health workers trained on nutrition issues.

v. Number of age specific established ECD centers.

vi. Proportion of households with hand washing facilities and improved latrine in use.

49) **Council Education Officers:** To present report on: -

i. Status of school feeding programme and supportive supervision on proper food handling practices

ii. Establishment of school fruits & vegetable garden

iii. Hand washing with soap facilities in schools.

iv. Report on deworming including program implementation in schools

Performance indicators for Council Education Officer

i. Nutrition and health education sessions Vs planned.

ii. Number of primary and secondary school adolescent girls (in pilot Councils) receiving weekly iron and folic acid supplements Vs expected.

iii. Number of girls enrolled and completed primary and secondary school education

iv. Nutrition and health education sessions conducted in schools quarterly.

v. Proportion of pre-school aged children attending ECD centres

vi. Proportion of households with preschool children attending nutrition and health education sessions offered by the schools.

vii. Proportion of preschool students who are malnourished (if data is available).

viii. Proportion of toilets in primary and secondary schools which are functional and with handwashing with soap facilities.

ix. Proportion of girls dropping out of school and main reasons for this

x. Proportion of schools participating in the deworming and anti-Schistosoma program

50) **Council Human Resource Officer: T**o present report on: -

i. Planning and budgeting for human resource for nutrition

ii. Deployment of nutrition professionals

Performance indictors:

i. Proportional of human resource for nutrition

51) **Council Treasurer:** To present report on: -

i. Amount of fund being allocated to nutrition and its expenditure

ii. Management responses on the audit queries

Performance indictors:

i. Percentage of funds allocated for nutrition

ii. Percentage of fund utilized for nutrition

iii. Auditors report on nutrition

52) **Council Planning Officer:** To present report on: -

i. Budget set for nutritional activities from each department and implementation status of nutritional activities.

Performance indicators for Planning Officer

ii. Number of stakeholder submitting planning and budget for nutrition Vs expected.

iii. Proportion of activity and financial implementation Vs planned.

53) **Council Agriculture and Irrigation Officer (Council Agriculture, Irrigation and Cooperative Officer):** Should provide report on the following: -

i. Promotion and support of increased production, availability, accessibility and consumption of diverse high nutrient food crops.

ii. Strategies on post-harvest storage to reduce losses and improve food safety.

iii. Report on prices of nutritious diet foods in Council food markets based on Filling the Nutrient Gap (FNG) model.

Performance indicators for DAICO,

i. Proportion of households engaging in horticultural production

ii. Proportion of households trained on different food storage and preservation methods (malting, drying etc.)

iii. Proportion of food secured households based on TFNC household food security model.

54) **Council Livestock and fisheries officer. Should report on: -**

i. Promotion of livestock, fishing and poultry farming (Small animal farming)

ii. Promotion of household level storage, processing, preservation and consumption of animal source foods.

55) **Council Water Engineer: Should provide report on the following: -**

i. Coverage of households with safe and clean water in their respective areas of jurisdiction.

56) **Council Community Development Officer: Should ensure: -**

i. TASAF beneficiaries with children underfive have their nutrition status measured and the nutrition education sessions include education on good ECD practices.

ii. Mobilization community action on nutrition issues

iii. Promote and advocate for gender equality related to nutrition (e.g. dietary diversity during pregnancy, equal participation in nutrition governance etc.)

iv. Collaborate with the D/CNUO to ensure complementarity of nutrition interventions by CBOs and NGOs

Performance indicators

i. Number of nutrition education session conducted during TASAF sessions compared to those planned annually.

ii. Number of available community level workers compared to established numbers.

57) **Roles of NGOs, CBOs, and FBOs:** Should: -

i. Ensure their plans, including indicative budget, are integrated into Council plans.

ii. Ensure all implemented nutrition activities for any projects funded/ implemented are reported together within Council plans by the D/CNuOs as part of Council activities

iii. Share progress reports on how they have aligned implementation of their programmes with the NMNAP and how the program is jointly implemented with the LGAs.

iv. Share their plans and identify areas of collaboration with other stakeholders

v. Share best practices, experiences, lessons learned during implementation of nutrition programs, including examples of where early child stimulation has been integrated.

vi. Share their mid-year and annual reports with the D/CMSCN

3.7 Operational mechanism

58) **Number and frequency of meetings:** Meetings should be held every quarter (total of 4 per year)

59) **Quorum:** Half or more of core members.

60) **Venue for meetings:** To be agreed and organized between the Chairperson and Secretary.

61) **There shall be no DSA or sitting allowance payment** to members for the meeting unless supported by Partners or the Chairperson has obtained instructions from relevant Authorities. Lack of DSA should not hinder the meeting to be conducted.

62) **Agenda:** All members should contribute to the agenda items via the Secretary. A standard agenda could be as follows:

i. Opening of meeting

ii. Review of and approval of previous minutes

iii. Matters arising from previous meeting (report on implementation of agreed action points)

iv. Updates on progress towards each Outcome of the NMNAP (to be provided by nutrition officers and officers from each sector)

v. Results of the quarterly multisectoral nutrition scorecard. This will help facilitate multi-sectoral "accountability"

vi. Outcome of meeting between the D/ CNuO, CSOs and Private Sector

vii. Add other specific agenda items for the day

viii. Any other business (AOB)

ix. Date for next meeting

x. Close of meeting by chair.

63) **Reporting mechanism:**

i. Each member should provide feedback to their supervisors immediately after the meeting or as soon as possible.

ii. The Secretary should work closely with the Council Clerk to complete the minutes of the meeting within a week and get consent from the Chairperson to circulate to members.

More elaborated reporting mechanism is shown in Figure 3.

3.8 Performance Indicators for the CMSCN

64) The CMSCN will be evaluated using the following indicators: -

i. Number of CMSCN meeting conducted per year out of the 4.

i) Presence of Council multisector strategic plan on nutrition

ii) Proportion of advocacy meetings

conducted per year Vs planned

iii) Proportion of nutrition interventions Vs planned

iv) Proportion of nutrition interventions implemented Vs planned

v) Proportion of reports received from different sectors and discussed at Council level Vs expected

vi) Number of stakeholders' whose plans are incorporated into MTEF Vs expected

vii) Number of scorecard reports discussed Vs expected

viii) Proportion of strategic nutrition interventions responded by CMT Vs proposed.

ix) Proportion of supportive supervision visits conducted.

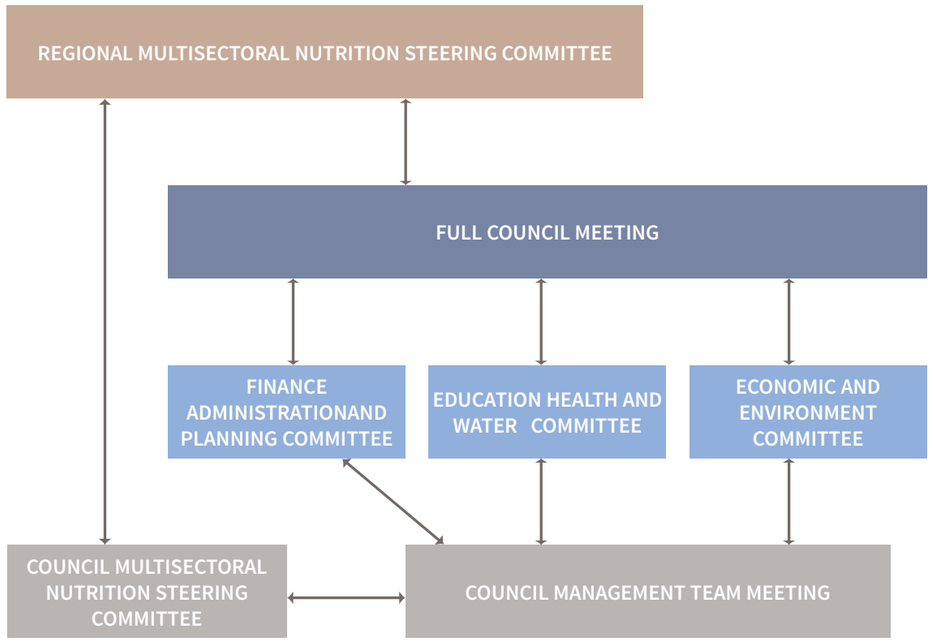


Figure 3. REPORTING STRUCTURE OF CMNSC

04

TERMS OF REFERENCE FOR WARD AND VILLAGE LEVEL COMMITTEES ON NUTRITION GOVERNANCE

4.1 Introduction

65) Although no specific coordinating structure was proposed, the NMNAP identified the following roles for Ward and Village/Mtaa Levels, which can be implemented using existing committees: -

i) Identify food and nutrition opportunities and challenges at the respective level;

ii) Ensure the integration of food, nutrition and early child stimulation issues in ward/village/mtaa plans and strategies;

iii) Ensure adequate community sensitization to increase demand for and uptake of nutrition and early child stimulation services;

iv) Initiate appropriate community-based food, nutrition and early child stimulation interventions and mobilize resources for implementation; and

v) Coordinate monitoring and evaluation of nutrition and early child stimulation improvement activities at the respective levels in the context of the NMNAP.

66) The Ward Development Committees and village Council are statutory within the LGA system and provide the best nutrition governance structures at these levels.

4.2 Roles and responsibilities of the Ward Development Committee (WDC)

67) At ward level, the Ward Development Committee is designated to undertake the role of coordinating all development issues including for nutrition. The specific role and responsibilities of the Ward Development Committee will be to: -

i) Make nutrition a standing agenda in the WDC meetings.

ii) Advocate on identification of food, nutrition and early child stimulation opportunities and challenges at ward level

i) Receive, discuss and act on implementation report from village committee

ii) Ensure the integration of food and nutrition issues in ward plans and strategies

iii) Monitor implementation of the nutritional interventions at the ward level

iv) Ensure nutrition partners working in the area (complete with names, addresses, focus areas, duration, donors etc.) report on their work to the WDC.

4.3 Indicators of performance of the WDC:

i) Number of meetings that include nutrition in their agenda conducted

ii) Proportion of assessment reports submitted

iii) Number of nutrition activities integrated in ward plans

iv) Number of early stimulation activities integrated in ward plans

v) Proportion of children whose nutritional status has been assessed.

vi) WDC has a list of who is working where and doing what in nutrition.

4.4 Operating mechanism of the Ward Development Committee (WDC)

68) The same COUNCIL operating mechanism shall apply at the Ward level, with the same standard agenda. The WDC shall use their normal statutory reporting mechanism to report to the Council authorities.

69) The nutrition technical person at WDC will be the Health Facility Incharge if there is no Nutrition Officer at Ward level.

4.5 Roles and responsibilities of Village/Mtaa Councili (VC)

70) At the village/Mtaa level, the existing Village/ Mtaa Council will be used to discuss issues of nutrition and positive parenting. The roles and responsibilities of the Village/Mtaa Council will be to: -

i) Identify food and nutrition challenges and take corrective measures

ii) Provide report of the nutrition situation to the Ward Development committee (WDC)

iii) Collect relevant community nutrition data

iv) Monitor implementation of the nutritional and early child stimulation interventions at the village level

v) Ensure the integration of food and nutrition issues in village/Mtaa plans and strategies

4.6 Indicators of performance of the Village/Mtaa Council;

i) Number of nutrition opportunities and challenges identified.

ii) Whether the committee has established a nutrition database.

iii) Proportion of children underfive years whose nutrition status has been assessed.

iv) Proportion of children underfive who are well nourished.

v) Number of social behavioural change communication (SBCC) interventions conducted in the area Vs planned.

vi) Number of nutrition activities integrated in Village/Mtaa plans.

4.7 Operating mechanism of the Village Council (VC)

i) The same WDC operating mechanism shall apply at the Village/Mtaa level, with the same standard agenda. The Village/ Mtaa Council shall use their normal statutory reporting mechanism to report to the Ward/Council authorities.

ii) The nutrition technical person at Village Council will be the Health Facility Incharge if there is no Nutrition Officer at Village level.

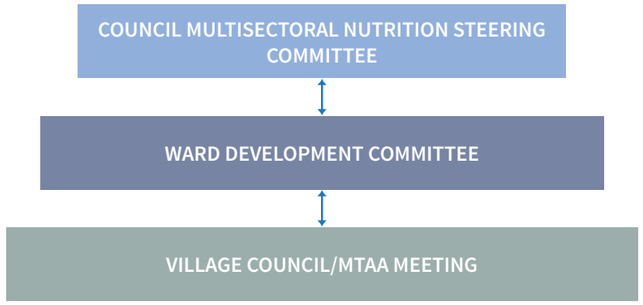


Figure 4. REPORTING MECHANISM OF VILLAGE AND WDC

Appendix 1:

Standard Roles and Responsibilities of Chair, Secretary and Members

The composition of the multisectoral steering committees on nutrition at the Regional and Council levels follow the normal structure of committees: **Chairperson, Secretary** and **Members.** The role of each position is different, and a different person is assigned each role. Recognizing that productive meetings don't just happen, but a lot of 'behind-the-scenes' work must be carried out, it was decided to include a standard "roles and responsibilities" component in all the terms of reference in addition to those specific to each level and member.

As a standard model, effective meetings require that all members of the group go through three stages, which simply put are: (i) prepare before the meeting, (ii) participate effectively during the meeting, and (iii) review your contribution after the meeting to make future meetings more productive. Note that the roles and responsibilities proposed below is just one common model for effective meetings. Successful outcomes can be achieved in different ways with different strategies for different purposes, so adapt as appropriate to specific situations.

Roles and responsibilities of the Chairperson

The roles of a chairperson are to set the agenda, lead the meeting, maintain order at the meeting, ensure the conventions of the meeting are being followed, ensure fairness and equality at the meeting, represent the group to the public and approve the formal minutes of the meeting after they have been done by the Secretary, confirming that they are a correct and truthful representation of the events at the meeting. The chair is the first member of the committee.

Before meetings, the Chairperson: -

i) Schedules the meeting;

ii) Reviews the agenda prepared by the Secretary; and

iii) Clarifies roles and responsibilities.

During the meeting, the Chairperson: -

i) Starts the meeting on time;

ii) Clarifies roles and responsibilities at the first meeting;

iii) Establishes ground rules and guidelines;

iv) Participates as a team leader as well as a member;

v) Follows the agenda and keeps the meeting focused on agenda items;

vi) Retains the power to stop what's happening and change the format;

vii) Pushes for accountability;

viii) Summarises key decisions and actions to enhance understanding of the outcome;

ix) Records recommendations and allocate responsibilities for specific tasks;

x) Makes the most of talent present - asks questions to draw out people with talent and experience;

xi) Allows time to hear experts' (if present) points of view but allocate time with clear directions, for example, "We have five minutes to hear the technical reasons why we should support this";

xii) For important issues when time is limited sets up a sub-committee to collect facts, review the situation, and prepare recommendations to be considered at the next meeting;

xiii) Gets agreement on date and time of the next meeting; and

xiv) Finally closes the meeting on time and on a positive, appreciative and graceful mode.

After the meeting, the chairperson may want to evaluate the meeting a iming to: -

i) Make each meeting better than the previous one by analysing what it achieved;

ii) Get informal, objective feedback from the participants and make a note to correct any inadequacies;

iii) Carry out the "post mortem" when you can still remember details of what happened;

iv) Follow up on agreed commitments - if you want action taken, make sure it is perfectly clear who is responsible to carry out the tasks recommended by the meeting and by when. This should be confirmed in writing and is best done in the minutes (see suggested template below) and again in a follow up reminder to the person who has agreed to take on a task.

Roles and responsibilities of the Secretary

Being also a member of the steering committee, the Secretary's role is to be the guardian of the process of meetings. They make the arrangements for the meetings and keep formal records of the group's process and decisions especially the minutes of the meeting and records of any relevant correspondence and follow up on any actions agreed at the meeting.

Before the Meeting the Secretary needs to discuss with the chairperson to ensure adequate logistical preparations. Key things to consider are: -

Setting the agenda: Each chair will have their own preference, but this is usually the responsibility of the secretary working with the chair. Ask other members if they want to add items to the agenda.

Making sure that the agenda is not overloaded, which may include discussing with the chair and other members what could be postponed to a later meeting, and what could be covered in a written report.

Sending out invitations and documents for the meeting. This will include, but is not limited to, the agenda, the minutes of the last meeting, progress reports, and any papers for discussion or information. Invitations should be sent at least one week before the meeting.

Planning for the meeting, including finding a venue and arranging for suitable refreshments and any audio-visual/IT facilities.

Taking minutes of the meeting. Do they need to be formal minutes that set out who said what, or brief notes that record the agreed actions, who is responsible to implement and by when? (see suggested template below).

Producing and distributing the minutes on time: Some chairs like to authorize distribution of minutes before they are sent further, while others prefer them to be circulated to several key attendees for feedback at the same time. Whatever, process is used, **the minutes should be ready for circulation within a week.**

After being reviewed and approved at the next meeting, they should be signed by the chair and secretary.

If you are new to your role as Secretariat, try to understand the issues which have been raised at previous meetings. This will help you understand what's going on. You can do this by looking at past minutes of meetings, and by asking the chair what is likely to be discussed.

On the day of the meeting, the Secretary will need to:

Make sure that they know who is expected to attend the meeting. If the building has security guards, you may need to provide a list of attendees.

Get to the venue early and check that everything is OK. e.g. make sure that everything is there, the room is laid out correctly, any audio-visual equipment is working, there are enough chairs and any refreshments have arrived.

You may want to give some thought to who sits where, and even mark-out a seating plan, as this makes a huge difference to the way that the meeting runs. You should ensure that the chair is sitting centrally and that you are seated next to the chair to be able to support him/her effectively.

Make sure you have plenty of spare copies of papers for those who haven't brought a copy. If there are a lot of papers it may be appropriate to arrange them in a folder using page/section numbers so that participants can easily find papers related to the current discussion.

If you are using name badges, set them out in alphabetical order on a table by the door, where attendees can pick them up as they arrive.

During the meeting the Secretary can support the chair by:

i) Quietly passing a note to the chair highlighting any issues with the timing of the agenda, or slippage, or when it is health/nutrition break.

ii) Recap and summarise the discussion. This is particularly helpful when people are starting to make the same points again.

iii) Ask for clarification of a point if you don't understand it. The chances are that if you don't understand, others won't either and, anyway, you need to understand it to minute it correctly.

iv) Once an action has been agreed, check who is going to undertake it. It is not uncommon for a meeting to agree that action is necessary, and what that action is, without assigning who is responsible for it. You, as secretary, can ensure that this does not happen.

Roles and responsibilities of Members

Defined as a group of individuals with a variety of skills, talents, and personalities, members are responsible for getting the job done, generate ideas, analyse information, make decisions, and implement actions. While it is the role of the chairperson to run the meeting, the participation of all members is also fundamental to the success of the meeting.

To ensure an effective meeting, all participants at a meeting should:

i) Undertake any necessary preparation prior to the meeting (read documents shared).

ii) Arrive on time (will avoid wasting the time of those who arrived early).

iii) Keep an open mind (you may learn new things. No one is an expert on everything!).

iv) Listen to the opinions of others (even the dumb have something to say!).

v) Participate actively (otherwise, why did you come to the meeting?).

vi) Avoid dominating the proceedings (you are not competing, but contributing).

vii) Avoid conflict situations (look for win-win solutions).

viii) Avoid side conversations which distract others (you will miss the key points).

ix) Ask questions to clarify understanding (There are no wrong questions, only wrong answers!).

x) Note down any action agreed upon (especially those you will need to implement).

xi) After the meeting, undertake any agreed action and brief others as appropriate, especially your boss.

Proposed template on summary minutes of the Regional/Council Multisectoral steering committees on nutrition meetings

Name of Region/Council: _____

Name of Committee: _____

Venue of meeting: _____

Date of meeting: _____

Minute number/ Issues discussed	Decisions/Actions taken	Responsible for implementation	Timeline for implementation	Progress at next meeting
1.				
2.				
3. etc.				

Appendix 2:

List of participants in the development of the Terms of Reference

Table 1: PARTICIPANTS DURING TOR DEVELOPMENT OF TERMS OF REFERENCE (TOR) MOROGORO, AUGUST 7 - 9, 2017

S/N	NAME	POSITIOM	INSTITUTION
1	TUMAINI MIKINDO	ED-Lead Facilitator	PANITA
PO-RALG			
2	STEPHEN J. MOTAMBI	ADNS	PORALG
3	MWITA J.M. WAIBE	NuO	PORALG
4	JEREMIAH MWAMBANGE	NuO	PORALG
5	MARIAM NAKUWA	NuO	PORALG
6	MAGESA JAPHARI	NuO	PORALG
MDAs			
7	PETER KASWAHILI	NuO	MoHCDGEC
8	FRANCIS MODAHA	SRO	TFNC
9	ADAM HANCY	RO-STATISTICS	TFNC
CSOs/NGOs			
10	GODFREY MBARUKU	Project Manager	IMA WORLD HEALTH
11	ELIA MSEGU		AMREF
12	HADIJA HALIDI	NuO - Project Manager	CUAMM
13	ASHA YUSUFU	NuO - Project Manager	SAVE THE CHILDREN
14	NOBERT MASSAY	Project Manager	PACT
15	DEBORA ESSAU	NuO	PANITA
NUTRITION OFFICERS AT REGION AND COUNCIL			
16	PROSPER M. MUSHI	RNuO	RS-ARUSHA
17	EMMACULATHA KALOLO	DNuO	KWIMBA DC
18	BERTHA NYIGU	RNuO	RS-NJOMBE
19	DENNIS MADELEKE	RNuO	RS-SHINYANGA
20	HERIETH KIPUYO	RNuO	RS-MTWARA
21	LEWIS MAHEMBE	RNuO	RS-MBEYA
22	TEDA D. SINDE	RNuO	RS-SINGIDA
23	ALICE C. KIPANGA	RNuO	RS-RUKWA
24	JANET MNZAVA	RNuO	RS-DSM
25	WINFRIDA CHACHA	DNuO	SIMANJIRO DC
26	PAMELA H. MEENA	RNuO	RS-PWANI
27	NAOMI A. RUMENYELA	MNuO	KIGOMA UJIJI MC
28	ESTHER S. PIUS	DNuO	MBOGWE DC
29	MWANAMVUA ZUBERI	RNuO	RS-TANGA
30	ASNATH MREMA	RNuO	RS-KATAVI
31	NEEMA MTEKWA	RNuO	RS-IRINGA
32	DESDERY J. KARUGABA	RNuO	RS-KAGERA
33	HAPPY M. MOSES	RNuO	RS-MOROGORO
34	FRIDA MUHINDI	dNuO	MBOZI DC
35	EUGENIA KOMBEO	RNuO	RS-RUVUMA
36.	REHEMA NAPEGWA	RNuO	RS-TABORA
37	JOSEPHINE SWAI	RNuO	RS-KILIMANJARO
38.	VERONICA BALULA	DNuO	KILWA DC
39	CHACHA MAGIGE	RNuO	RS-SIMIYU

Table 2: PARTICIPANTS AT DRAFT 2 TASK FORCE WORKSHOP HELD MIPANGO HOUSE DODOMA, OCTOBER 30TH – NOVEMBER 3RD 2017.

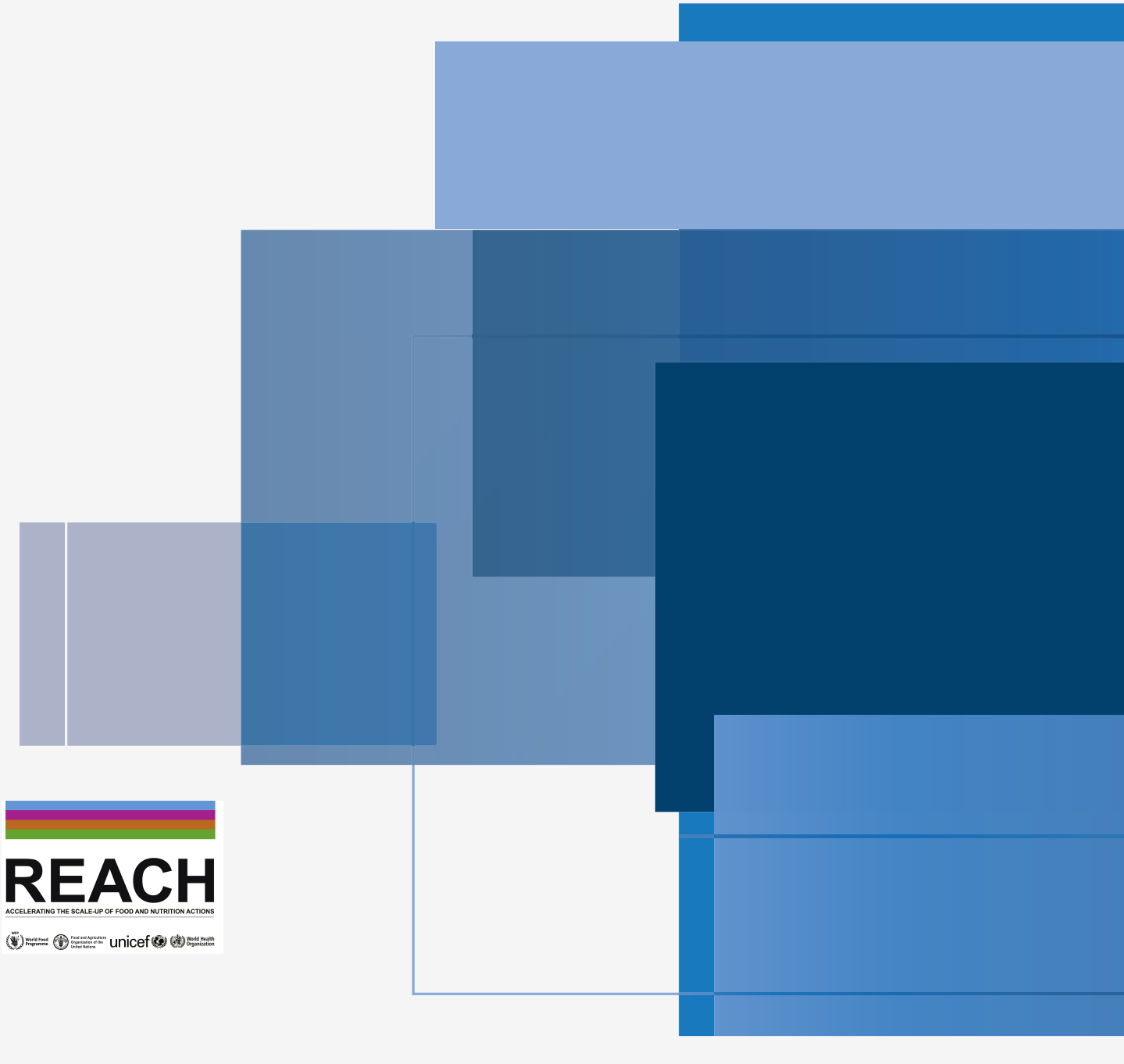
S/N	NAME	POSITION	INSTITUTION
1	DR. FESTO KAVISHE	Lead Facilitator	Consultant/UNICEF
PO-RALG			
2	STEPHEN J. MOTAMBI	ADNS	PO-RALG
3	MARIAM NAKUWA	NuO	PO-RALG
4	FESTO S. TILIA	NuO	PO-RALG
5	MAGESA JAPHARI	NuO	PO-RALG
6	PROSPER M. MUSHI	NuO	PO-RALG
7	MWITA J.M. WAIBE	NuO	PO-RALG
8	JEREMIAH H. MWAMBANGE	NuO	PO-RALG
NUTRITION OFFICERS AT REGIONAL AND COUNCIL LEVELS			
9	NEEMA A. KWEBA	DNuO	MLELE DC
10	TILIZA MBULLA	DNuO	IRINGA DC
11	BETHA NYIGU	RNuO	RS NJOMBE

12	DENNIS MADELEKE	RNuO	RS SHINYANGA
MINISTRIES, DEPARTMENTS AND AGENCIES (MDAs)			
13	ALOYCE H. KWAY	P/Economist	PMO
14	ADAM HANCY	R.O - Statistics	TFNC
15	FRANCIS MODAHA	Snr. R.O	TFNC
16	PETER KASWAHILI	NuO	MOHCDGEC
CSOs/NGOs			
17	JOSEPH L. MUGYABUSO	RNuCo-ASTUTE	IMA World Health
18	TUMAINI MIKINDO	Executive Director	PANITA
19	SYLVESTER NANDI	SPO	NI-TZ
UNITED NATIONS			
20	HELEN WEST	Consultant	WFP/BCG
21	FERGUS HAMILTON	Consultant	WFP

Table 3: PARTICIPANTS AT VALIDATION WORKSHOP, HELD AT MIPANGO HOUSE, DODOMA, 13-15 NOVEMBER 2017 AND THOSE WHO SENT email COMMENTS BUT COULD NOT PARTICIPATE IN MEETING

S/N	Name	Position	INSTITUTION
1	DR. FESTO KAVISHE	LEAD FACILITATOR	INDEPENDENT CONSULTANT
PO-RALG			
2	STEPHEN J. MOTAMBI	ADNS	PORALG
3	MWITA J.M. WAIBE	NuO	PORALG
4	MAGESA JAPHARI	NuO	PORALG
5	MARIAM NKUMBWA	SWO	PORALG
6	FESTO S. TILIA	NuO	PORALG
7	ZAINABU KITEMBE	SWO	PORALG
8	JEREMIAH H. MWAMBANGE	NuO	PORALG
9	PROSPER M. MUSHI	NuO	PORALG
10	ZUHURA H. KARYA	PSWO	PORALG
MINISTRIES, DEPARTMENTS AND AGENCIES (MDAs)			
11	PETER KASWAHILI	NuO	MOHCDGEC
12	FRANCIS MODAHA	SEN. RESEARCH OFFICER	TFNC
13	SAMSON MAPUNDA	ECONOMIST	MoFP
14	ALOYCE H. KWAY	PRINCIPAL ECONOMIST	PMO
15	MARGARET NATAI	NUTRITION FOCAL POINT	MOA
16	DR. JOYCELINE KAGANDA	MANAGING DIRECTOR	TFNC
REGIONAL AND DISTRICT/COUNCIL/TOWN NUTRITION OFFICERS			
17	MARIAM ATHUMANI	RNuO	RS DODOMA
18	MWANAMVUA ZUBERI	RNUO	RS TANGA
19	HAPPY M. MOSES	RNuO	RS MOROGORO
20	HERIETH KIPUYO	RNuO	RS MTWARA
21	THEDA SINDE	RNuO	RS SINGIDA
22	JANET ALLAN MZAVA	RNuO	RS DAR ES SALAAM
23	JOSEPHINE SWAI	RNuO	RS KILIMANJARO
24	REHEMA NAPEGWA	RNuO	RS TABORA
25	CHACHA MAGIGE	RNuO	RS SIMIYU
26	ASNATH MREMA	RNuO	RS KATAVI
27	PAMELA MEENA	RNuO	RS PWANI
28	LEWIS MAHEMBE	RNuO	RS MBEYA
29	PAUL MAKALI	RNuO	RS KAGERA
30	MARY BONAVENTURE	RNuO	RS DODOMA
31	ALICE KIPANGA	RNuO	RS RUKWA
32	ANNA ANDREW	RNuO	RS ARUSHA
33	NEEMA MTEKETA	NuO	IRINGA-RRH
34	EUGENIA KOMBEO	NuO	SONGEA RRH
35	RIZIKI I. MBILINYI	NuO	RS RUKWA
36	WINIFRIDA CHACHA	DNuO	SIMANJIRO DC
37	HAFSA H. PONGWE	DNuO	SONGWE DC
38	CHRISTINA HENJEWELE	TNuO	BARIADI TC
39	IDRISA ABDI	DNuO	MBULU DC
40	EMMA KILIMALI	NuO	MWANZA CC
41	IMACULATE KALOLO	DNuO	KWIMBA DC
42	ESTER SHABO	DNuO	MBOGWE DC
43	VERONICA BALUWA	DNuO	KILWA DC
44	FRIDA MUHINDI	DNuO	MBOZI DC
45	PRISCA SHIRATI	DNuO	BUTIAMA DC

46	NAOMI LUMENYELA	DNuO	KIGOMA UJIJI MC
UNITED NATIONS AGENCIES			
47	JOYCE NGEGBA	NUTRITION SPECIALIST	UNICEF
48	MAURO BRERO	NUTRITION SPECIALIST	UNICEF (by email)
49	NEEMA SHOSHO	NuO	WFP
DEVELOPMENT PARTNERS			
50	TEMINA MKUMBWA	NUTRITION COORDINATOR	USAID TANZANIA (By email)
51	CHIHO SUZUKI	SENIOR HEALTH SPECIALIST	THE WORLD BANK, TANZANIA (By email)
52	YI-KYOUNG LEE	SENIOR HEALTH SPECIALIST, NUTRITION & POPULATION EASTERN & SOUTHERN AFRICA REGION	THE WORLD BANK, WASHINGTON (By email)
53	ELLA VICTORIA HUMPHRY		THE WORLD BANK (By email)
CSO/NGOS			
54	JOSEPH K.L. MUGYABUSO,	REGIONAL NUTRITION COORDINATOR – ASTUTE (MWANZA)	IMA WORLD HEALTH, TANZANIA COUNTRY OFFICE (By email)
55	DR. SYLVESTER NANDI	SENIOR PROJECT OFFICER	NUTRITION INTERNATIONAL (NI) - TANZANIA
56	ASHA YUSUPH	PROJECT OFFICER	SAVE THE CHILDREN
57	PAULINE KISANGA	MANAGING DIRECTOR	COUNSENUTH (By email)
58	LAURETA LUCAS	SENIOR PROJECT OFFICER ENRICH	NI (By email)



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS

World Food Programme · Food and Agriculture Organization of the United Nations · unicef · World Health Organization