

REPORT FROM NUTRITION GROUP
IN 2006 ANNUAL HEALTH SECTOR TECHICAL REVIEW MEETING

Summary Overview of Situation:

Positive Nutritional Changes between 1999 and 2004/5 DHS

Stunting 44 – 38%

Underweight 30 – 22%

Wasting 5 – 3 %

Under 5 Anemia prev 72%

Women 15-48 48%

National coverage of HH level Iodated salt 84%

Vit A deficiency (low serum retinol levels 24% (1997)

Vit A coverage (Annual 2-dose campaign) – 85%

Milestones from 2005 AHSR and Progress Made

Milestone 1 - Establish Regular Nutrition Partnership Forum

- Causality analysis undertaken towards development of National Nutrition Strategic Plan
- Institutional analysis of nutrition initiated
- Nutrition surveillance system currently being re-designed.

Milestone 2 – Establish National Integrated Nutrition Programme linked to Mkukuta and MTEF

National strategy & policy developed for Infant and Young Child Nutrition.

Initial work for implementation of integrated minimum nutrition package begun in two districts (Makete and Kibaha)

Milestone 3 - Build Capacity for Nutrition at District Level

Discussion initiated between TFNC and PMORALG regarding human resources for nutrition.

Capacity Development for Nutritional Care and Support for PLWHAs (National guidelines developed & distributed; TOT of Home Based Care providers conducted in 38 district; PMTCT counselors trained in 3 districts; Advocated incorporation of nutrition and HIV/AIDS in curricula of Educ, Agric.)

RECORD OF GROUP DISCUSSION

Why Health Sector Has Had Inadequate Response on Nutrition

There was in-depth reflection on the long term inertia in the health sector towards nutrition. Lack of commitment and action was attributed to the following factors:

- Fatalism in terms of the long term poor performance on nutritional indicators.
- Perception that nutrition and actions to influence it, largely fall outside the central health mandate.
- Prevalent misconception that nutrition is mostly related to food security and food provision. Since introduction of Mkukuta tendency of Health sector personnel is to relegate nutrition to Cluster 1.
- Lack of clear political and bureaucratic accountability. Nutrition therefore has many parents but no home.
- Lack of understanding, particularly at District level, about what practical interventions can be taken to influence nutritional status.
- Removal of the cadre of district nutrition officer and lack of sufficient staff to focus on nutrition.

Need for Repositioning of Nutrition in the Health Sector

There is need for a major shift in thinking, attitude and action from the highest to lowest levels of the health system in relation to nutrition. This needs to be informed by the following:

- 1) **There have been substantial improvements of nutritional status over past 5 years** and these positive gains will need to be built on in order to achieve further gains in health status.
- 2) **Nutritional outcomes are directly related to the quality of health interventions.** Nutritional status at birth is directly related to the quality of reproductive health measures. Nutritional status is also significantly related to the control of recurrent illness malaria, Accute Respiratory Illnesses (ARI) and diarrhoea. There is also a close connection between prevention of mother to child transmission of HIV/AIDs and breastfeeding. Malnutrition also underlies over 50% of all childhood deaths. Without addressing nutrition, therefore, it will be difficult to make substantial improvements towards the MDGs. Due to its central relevance to the health sector, nutrition should become an integral part of the SWAP.

- 3) **Nutrition is not just about food production and household food security.** The Southern Highlands of Tanzania reflects the lowest rates of malnutrition in the entire country despite having the highest level of food production.
- 4) **The health sector is in the best position to make the most significant change in nutritional status.** This is because the most significant factors affecting malnutrition are health status, health behaviours, infant and young child feeding practices and child care practices. All of these can be addressed by preventive, curative and health promotion interventions.
- 5) **Tangible actions can be taken at District level to make significant changes in nutritional status of children which can be delivered at minimal cost.**

Target Group for Health Sector Nutrition Response

Rather than trying to intensify nutrition response broadly relating to the entire under 5 health programme and school health programme there was agreement that repositioning of health sector response to malnutrition would need to be discrete and focused. It was agreed that in the first instance the **focused target group should be children from birth to two years**. Rationale for this was given as follows:

- This is the target group most greatly affected by malnutrition. Stunting rates in Tanzania show steady increase from birth and then steep decline after 18 months.
- This is the target group within which the effect of malnutrition on mortality is greatest and therefore a focus on this group would relate most directly to achievement of the MDGs.
- The Health sector has most frequent contact with this age group (through antenatal, delivery, post natal, immunization and child health clinics) and therefore would be able to have most influence.

Strategy for Integration of Nutrition Actions

There was strong agreement that strengthening of nutrition action should be integrated into each health/disease-related intervention. However, there was caution about how integration should be approached. Information was shared on the fate of the rural development strategy that had huge workshops with broad cross-section of stakeholders that set lofty goals but then with no follow-up and responsibility for implementing it. Specific entry points will need to be identified and persons informed of and trained for their responsibilities.

Strengthening Information for Nutrition Actions

There are various types of needs for information.

- Evidence to inform advocacy
- Systematic/routine data collection to inform planning

- **Strengthened information/updating of surveys to understand trends**
- **Generation of new knowledge through research to inform approaches**

Evidence to inform advocacy

With the marked spacial concentration of malnutrition across the country, there is need to understand the contributing factors for these special variations. There are also linkages between malnutrition and various determinants such as short birth spacing, young age of mother and duration of exclusive breast feeding.

Analysis of DHS data is currently being undertaken to determine specific factors contributing to variations. The DHS data can also be used to show Districts their relative status in terms of nutrition. All this information needs to be drawn upon in order to design advocacy packages to influence action.

Systematic/routine data collection to inform planning

Weekly reports on nutritional status are collected by MOH, but these are of questionable quality and the data is not used to inform action. While comprehensive nutrition surveillance system is being developed, there is need to identify a “Quick Win” for data strengthening to inform action. Recommendation was given for using the high rate of coverage of the Measles immunization given at 9 months as a critical point for strengthening of data.

Strengthened information/updating of surveys to understand trends

Several surveys are now outdated. There is therefore urgent need to conduct new surveys to update information. Priorities include:

- Survey on retinol levels. The latest survey was conducted in 1997. It is important to have current data on status particularly to determine the impact of the 5 years of high coverage annual two-dose Vitamin A campaigns.
- First national survey of Haemoglobin levels was achieved through 2005/6. Now a Situation analysis is needed on anemia prevalence in order to inform action.

Generation of new knowledge through research to inform approaches

The current initiative in focus districts to design community-driven integrated nutrition interventions should be used to inform approaches that can be scaled-up.

Specific Recommendations for Mobilization and Action

- If stunting could be brought down by 15% this could achieve a 50% drop in under 5 mortality. Rather than advocating that nutrition underlies over 50% of all mortality, which is a global figure that does not have convincing significance for Districts, this formula (based on Pelatiers? Algorithm) to show the risk of malnutrition and the percentage of mortality reduction that can be achieved through reductions in malnutrition.
- Create incentives of block grant to districts that show progress on malnutrition reduction.

- Hold District councils accountable for nutrition “in Nazi style” by demanding improvement on achievement of nutrition indicators while simultaneously providing additional support to improve nutrition.
- Ensure that all existing funds for health interventions include a component to support specific nutrition interventions (eg. President’s Malaria Initiative to support integration of nutrition training during training for change in Malaria treatment; HIV/AIDs training to integrate component on nutrition).
- Assess all on-going health interventions and identify entry points for strengthening of nutrition.
- Use Case Management and the high care-seeking behaviour in Tanzania (eg. for fever and cough) to screen for malnutrition and to undertake nutrition counseling. (Currently the most under-performed area within Facility IMCI is nutrition screening).
- Strengthen Facility management of Severe Malnutrition (70% Case Fatality Rate). Address missed opportunity for preventing repeat episodes by using technical resource of Regional Centre for management of severe malnutrition (ie.MUCHS) to train health workers and proposed nutrition focal points.
- Strengthen the nutrition component of Community IMCI in relation to breast feeding, complementary feeding and food hygiene. This is critical as few children visit clinics and when they do it is because children are already sick.
- Facilitate the establishment of Breast feeding support groups at community level in order for there to be “Baby Friendly Communities” which would have more impact than Baby Friendly Hospitals.
- Improve linkages between MCH clinic nurses and Community Health Workers.
- Reintroduce Ukumta – ie national Deworming. (Deworming is now totally donor dependent).
- An infant and young child feeding strategy was recently been developed but has never been applied in earnest. This should be used in the new proposed thrust.
- Make supplementation support available for pregnant and lactating mothers. *Is this in the food policy?*

Human Resources to Manage and Implement Nutrition Interventions

At national level there was proposal for a senior Nutrition officer to serve as a counterpart to TFNC in terms of coordinating roll out of the proposed nutrition minimum package and ensuring the coordination across relevant ministry programmes related to RCH. Information was shared that the MOH has been considering a post for non-communicable diseases that could possibly serve the function of a senior officer to support the strengthening of nutrition action. This person would serve as counterpart to TFNC working within the machinery of the MOH. It was noted from institutional memory, however, that before the introduction of TFNC in 1973, there was a senior nutrition officer in MOH and that officer was transferred to TFNC. It was also noted that one role of TFNC is to liaise amongst MOH departments. It was agreed that further reflection on this should be informed by findings of the nutrition institutional analysis.

At district level proposal was made for designation of a specific nutrition focal point from existing DHMT. Concern was raised that Districts might consider this a duplication as each district already has a person assigned to nutrition from the Ministry of Agriculture. Clarification was made that the person from MOA is an agriculture extension worker with the functional title “agricultural nutrition subject matter specialist”. This person is more concerned with food production and food security issues. The proposal is to assign a health officer who, through nutrition training, would be able to provide technical support and ensure coordination amongst all MOH programmes in relation to nutrition as well as to ensure linkage with other sectors. Experience was shared by the Director of the National Malaria Programme on how District Malaria focal points were designated. A letter was written from DPS to the Districts directing them to nominate a focal point. Nothing changed in term of the persons substantive title, reporting relationship or formal job description but the workplan was changed and understood and persons were given 12 weeks of training. The point was made by TFNC staff that if Malaria as a single disease needed a specific focal point then Nutrition that is multi-faceted should seriously be considered for such support.

At Community level the role of Community Health Workers was recognized as critical in nutrition monitoring, promotion and malnutrition prevention. Further thought would have to be given for greater systematization, supervision and support for this category of worker

PROPOSED NUTRITION MILESTONES FOR THE ANNUAL HEALTH SECTOR REVIEW

It was agreed that the 2006 Annual Health Sector Review should be used as a turning point opportunity for the Health Sector to take the lead and ownership for nutritional targets and progress for nutrition specifically focused on children from birth to 18 months. It is proposed that this be enacted through the following milestones:

1. Explicit demonstration of senior management commitment to scale-up Health sector response to nutrition. Indicators:

- a) “Quick Wins” for Nutrition included in Central level 2006/7 MTEF including Annual two-dose Vitamin A supplementation and Deworming. Quick Win for Anemia?
- b) Minimum package of interventions/commodities for nutrition defined and incorporated in district budget guidelines.
- c) Directive issued for systematic collection of nutritional status data for children at 6 month immunization visit.

2. Identification of existing post at District level to be designated with full time responsibility for Nutrition with standardized specification of roles.

Ministry of Local Government to issue directive by end May 2006 to be effective by end July.

3. Initiation of rapid response capacity development to increase technical and management capacity for essential nutrition actions.

- a) Intensive initial nutrition training conducted for all newly designated district nutrition coordinators to capacitate them to implement the minimum nutrition package.
- b) Districts capacitated to generate and apply district nutrition analysis to planning and budgeting for nutrition interventions. (To investigate possibility of incorporating use of nutrition profiles as part of exercise to roll-out of Burden of Disease and District Health Accounts tool through the Zonal Training Centres).
- c) All case management training to incorporate training on screening and treatment of malnutrition.