NUTRITION STAKEHOLDER & ACTION MAPPING REPORT

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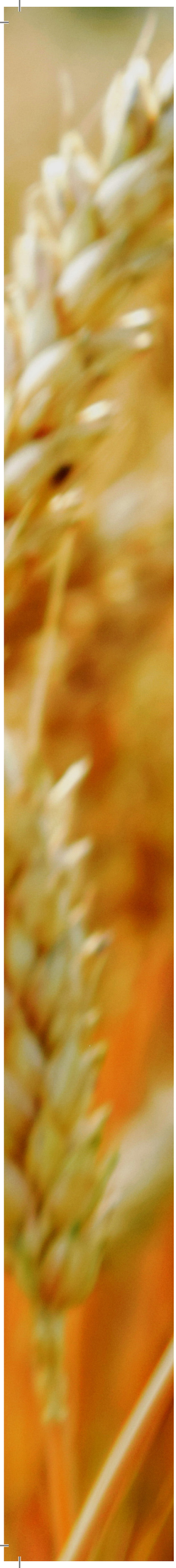

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ACRONYMS

ANC	Ante-Natal Care
CAPMAS	Central Agency for Public Mobilization and Statistics
EGP	Egyptian Pounds
GDP	Gross Domestic Product
M&E	Monitoring & Evaluation
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MNP	Multiple Micronutrient Powder
MoHP	Ministry of Health & Population
NGOs	Non-Governmental Organisations
NNI	National Nutrition Institute
PNC	Post-Natal Care
REACH	Renewed Efforts Against Child Hunger and undernutrition
SAM	Severe Acute Malnutrition
SDGs	Sustainable Development Goals
SUN Movement	Scaling Up Nutrition Movement
SUN-PMT	Scaling Up Nutrition Planning and Monitoring Tool
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation & Hygiene

EXECUTIVE SUMMARY

Although Egypt has made strides in improving rates of malnutrition in the country, the levels of undernutrition, micronutrient deficiencies and more recently, overweight, are still unacceptably high, imposing prohibitive economic and social costs on individuals, communities and the country as a whole. Recognising the need to address this issue with greater urgency, the Ministry of Health and Population (MoHP) has developed a Nutrition Agenda for Action framework document with UNICEF (2017) to serve as a road map to address the nutrition challenges that the country faces. This Nutrition Agenda for Action focuses on ways of improving child and maternal nutrition, in line with recent evidence outlined in the 2008 and 2013 Lancet series on Maternal and Child nutrition and guided by the newly adopted Sustainable Development Goals (SDGs) and Egypt's Vision 2030.

A key recommendation of the Nutrition Agenda for Action is to focus on nutrition actions around the 1,000 days approach. As the MoHP is now starting the process of planning to scale-up the outlined nutrition actions, to assist in this process and specifically to inform strategic and operational planning, it is necessary to know the current status of each nutrition action being implemented in the country in order to establish a baseline as guidance for planning. To provide this information, the decision was taken by the MoHP to carry out Stakeholder and Action Mapping, an approach developed by Renewed Efforts Against Child Hunger and undernutrition, through which data is collected on the nutrition actions being implemented, by whom, where in the country and through which delivery channels, building up a detailed picture of the nutrition landscape. The mapping, successfully carried out under the leadership of the MoHP, covered the nutrition actions in line with the strategic areas currently being focused on in Egypt, namely maternal, child and adolescent nutrition.

The findings of the nutrition mapping set out the current situation around implementation of maternal, child and adolescent nutrition interventions in Egypt, informing the Government and other key stakeholders on what nutrition actions are being implemented in the country as well as who is supporting each action, the extent of coverage and the use of different delivery channels for each action. Critically the exercise also highlights the gaps in implementation. Key findings include:

Stakeholder Support: The number of stakeholders is somewhat limited with the majority of implementers being Government departments. Some stakeholders are working on the same actions in the same Governorates and there is a concentration of stakeholders in Upper Egypt.

Coverage: With the exception of a number of routine actions, there is limited coverage of most nutrition actions for key target groups with a number of high-impact nutrition actions not implemented in Egypt. Based on DHS 2014 stunting rates, there are a number of Governorates which should be considered a priority for scaling up key nutrition actions.

Delivery Channels: As most of the nutrition actions mapped are through the health sector it is not surprising that the focus is on health sector delivery channels. There is potential for scaling up others types of delivery channels including at the community level. There was limited capacity building done in 2015 by either the Government or partners.

The key recommendations, based on the findings of the nutrition mapping and in line with the Agenda for Action are as follows:

Stakeholder Support: A governance structure needs to be put in place that has a clear delegation of roles and responsibilities and mandate to coordinate nutrition activities to ensure all stakeholders are moving towards same goal. The findings of the mapping should be used to help coordinate stakeholders and has to be owned by the MoHP. It is important to ensure that stakeholders are held to account for delivering on nutrition objectives in order to reach a shared goal. Joining the SUN Movement could help to foster greater collaboration and to learn from other countries experiences in terms of developing accountability mechanisms.

Coverage: Greater emphasis should be placed on high-impact, cost effective interventions. The mapping data can be used for more targeted planning to support coordination and implementation with a focus on governorates with higher stunting and lower coverage of actions. To support monitoring of scale-up, the mapping should be carried out on a yearly basis covering all nutrition sensitive areas including WASH and agriculture. The mapping data should also be used to work with current / potential partners to fill known gaps in funding and programming.

Delivery Channels: Stakeholders need to assess and ensure that they are using the most effective channels for each action (standardised approach). Work should be done to maximise synergies, especially for channels used for multiple interventions through stakeholders sharing expertise and carrying out integrated training for each channel. To inform decision-making on the most appropriate delivery channels to scale up, operational research may be required to look into the most effective channels and/or potential bottlenecks within certain channels. Once appropriate channels for particular actions identified, work to improve expertise and scalability within those channels to support efforts to reach a greater number of key target groups with important nutrition actions.

BACKGROUND

Despite the national efforts across the health sector in Egypt, and the relatively strong decline in child mortality, the nutrition situation remains concerning with the country off-course to meet key nutrition-related World Health Assembly targets including under five wasting and overweight, and anaemia among women of reproductive age.

Over the last few decades, emerging socio-economic trends such as rapid population growth and economic shocks have negatively affected Egypt's development potential, which in turn have led to stagnation in food security and nutrition trends with Egypt identified as one of 36 countries that account for 90 per cent of the global burden of malnutrition[1]. The Cost of Hunger report put the economic cost of malnutrition in Egypt at 20.3 billion Egyptian pounds (EGP) in 2009 as a result of child undernutrition due to its strong negative impact on learning, education and future productivity. This figure is equivalent to 1.98 per cent of GDP[2]. As a result, the Government has identified it as a priority area for action.

In this context, the Ministry of Health and Population (MoHP) has recently taken important actions to address this issue, including establishing the Nutrition Unit affiliated to the Maternal Child Health (MCH) General Directorate. It has also developed a Nutrition Agenda for Action framework document with UNICEF to serve as a road map to address the nutrition challenges that the country faces. This Nutrition Agenda for Action focuses on ways of improving child and maternal nutrition, in line with recent evidence outlined in the 2008 and 2013 Lancet series on Maternal and Child Nutrition and guided by the newly adopted Sustainable Development Goals (SDGs) and Egypt's Vision 2030.

Key recommendations from the Nutrition Agenda for Action include building on existing nutrition programming in the shorter term, in order to yield measurable impact in nutrition, including actions that are focused around the 1,000 days approach. The right nutrition during this 1,000 day window has a profound impact on a child's ability to grow, learn and thrive and therefore actions for pregnant & lactating women and young children are crucial. Recommended focus areas to scale up include nutrition actions around Infant & Young Child Feeding, Micronutrients, specific primary health care actions (in line with the Lancet and World Bank recommendations[3]) as well as encouraging nutrition-sensitive programming that links up with wider nutrition programming including in WASH, agriculture and social protection.

The Nutrition Agenda for Action also places importance on strengthening leadership, institutional capacity, and building a governance and coordination structure in the medium to longer terms to build a national nutrition system. The MoHP is now in the process of institutionalizing the key concepts of the Nutrition Agenda for Action and starting the process of planning to scale-up the outlined nutrition actions.

1 Black et al. 2008
2 Cost of Hunger in Egypt: Implications of Child Undernutrition on the Social and Economic Development of Egypt, COHA, June 2013
3 Series on Maternal and Child Nutrition, The Lancet, 2008/2013 & Scaling Up Nutrition: What Will it Cost? Horton et al., 2009

RATIONALE

To assist in this process and specifically to inform strategic and operational planning, it is important to make sure that the right target groups are being reached with the right nutrition actions. At the same time, to be able to identify and plan the extent to which each identified nutrition action needs to be scaled up and where in the coming years, it is necessary to know the current status of each action in the country in order to establish a baseline as guidance for planning.

A Nutrition Landscape Analysis was carried out in 2012, and although this gave a good insight into the nutrition problems and stakeholders' readiness, commitment and capacity to scale up evidence-informed nutrition actions, it did not cover comprehensively what was being done and where by all stakeholders or the number of key target groups reached through each nutrition action. These components are key when looking to plan and scale up Key Nutrition Actions.

Therefore, as the required information to inform planning was not available, the MoHP concluded that a comprehensive nutrition mapping should be carried out to provide an up-to-date picture of the nutrition landscape to inform strategic and operational planning specifically around maternal, child and adolescent nutrition and help key stakeholders make decisions on what actions to scale up and where in order to reduce undernutrition in the country[4]. The decision was taken to limit the scope of the mapping to concentrate on the nutrition strategic areas being focused on in Egypt (see "Methodology and Steps Taken" section).

The methodology chosen by the MoHP to successfully reach these goals was Stakeholder & Action Mapping using the Scaling Up Nutrition Planning and Monitoring Tool (SUN-PMT). This country owned and led approach, developed by Renewed Efforts Against Child Hunger and undernutrition (REACH)[5] and now positioned as a tool available to all Scaling Up Nutrition (SUN) Movement[6] countries, can provide a more complete picture of the nutrition landscape by collecting and analysing information on stakeholders, actions and delivery channels at different geographic levels in order to:

- Inform policy-makers and nutrition stakeholders about the make-up of the nutrition landscape
- Establish which nutrition actions to scale up, how and where for planning
- Monitor nutrition action scale-up, evaluate coverage and for advocacy

In order to gain a comprehensive view of the nutrition landscape focused around maternal, child and adolescent nutrition, all stakeholders involved and actions , currently being carried out to improve the nutritional status of these key groups would be mapped. Stakeholders include Government departments, multilateral and bilateral agencies, NGOs and private organisations.

The results of this nutrition mapping exercise would inform the Government and other key stakeholders about the makeup of the nutrition landscape, specifically for maternal and child interventions. This would establish a baseline from which to accelerate progress towards ending maternal and child malnutrition in Egypt through the development of policies and plans in line with the Nutrition Agenda for Action. The initiative also would enable stakeholders to identify potential partners for future collaboration to work on scaling up nutrition actions and could also be used as an advocacy tool to highlight the areas that need the further support of stakeholders.

4 The scope of the Stakeholder & Action Mapping did not include any private sector providers of the nutrition actions mapped

5 REACH is a country-led approach to scale-up proven and effective interventions addressing child undernutrition through the partnership and coordinated action of UN agencies, civil society, donors, and the private sector, under the leadership of national governments.

6 Scaling Up Nutrition-SUN is a global movement, which unites governments, civil society, businesses and citizens in a worldwide effort to end malnutrition and undernutrition.

OBJECTIVES / AIMS

The Stakeholder & Action Mapping aims to comprehensively review the nutrition landscape in the country in order to:

1. Support the Government's review process of nutrition in the country for the purpose of updating existing policies and programmes.
2. Provide inputs for nutrition strategic and operational/ annual planning so that informed decisions can be made on which nutrition actions to scale-up, how, and where.
3. Provide a basis for nutrition annual review and implementation monitoring.

EXPECTED OUTCOMES

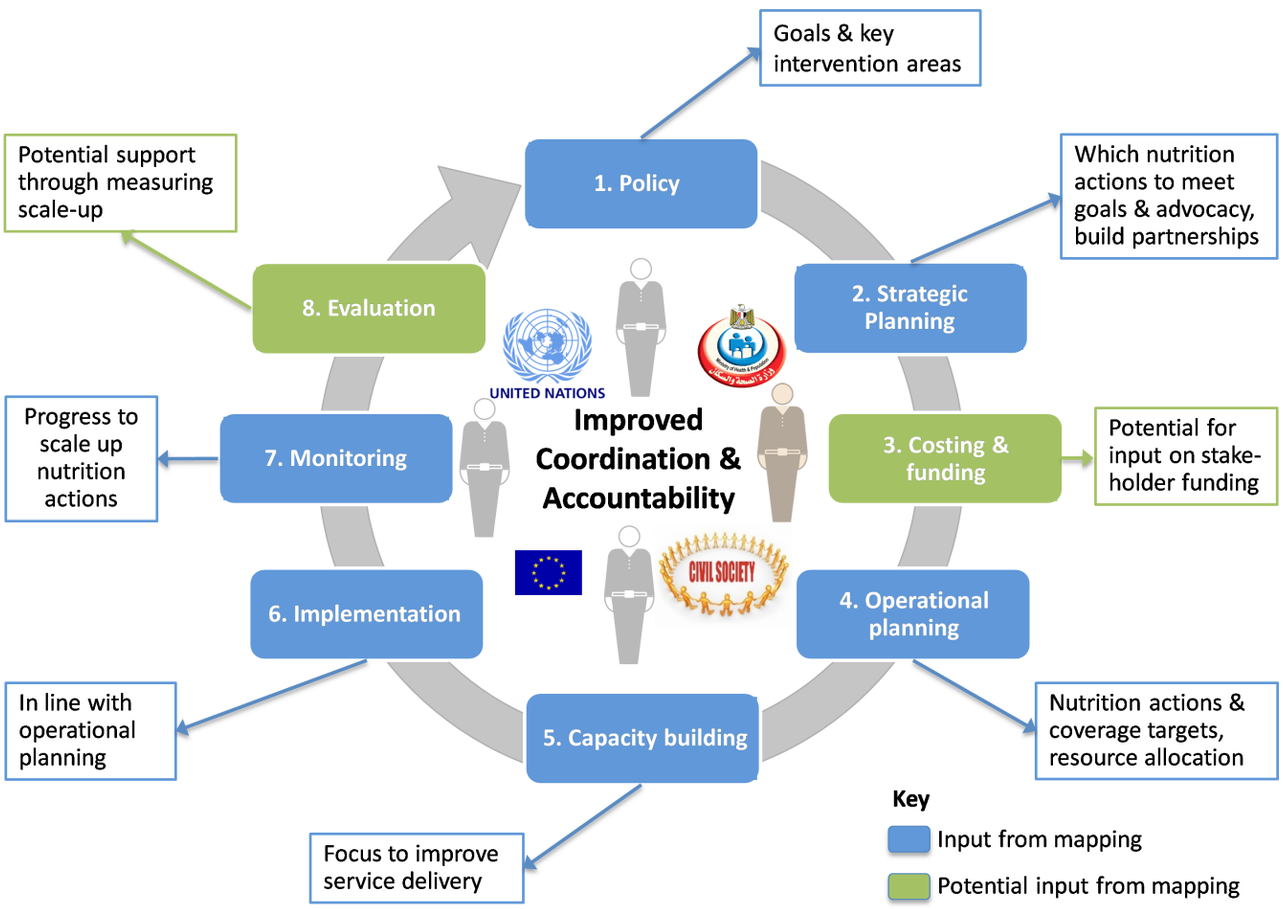
1. The Government and stakeholders have a clear picture of the nutrition landscape and use the mapping data to support updating of policies and programmes.
2. The mapping findings are used to make decisions on identifying and scaling up Key Nutrition Actions as part of the planning process.
3. The Government, with stakeholders, continues to collect mapping data on an annual basis and use it for monitoring progress of scale-up over time.

NUTRITION STAKEHOLDER & ACTION MAPPING AND THE PROGRAMME CYCLE

As the *Expected Outcomes* highlight, Stakeholder & Action Mapping can support at various stages of the programme cycle including decision-making (policy, planning), governance and implementation/monitoring of progress. In terms of policy and planning, by having access to data on roles of organisations, the geographic and beneficiary coverage of Key Nutrition Actions, and the capacity and use of delivery mechanisms, policy experts, planners and programme implementers can understand more fully where resources should be focused and the extent to which they can potentially scale up existing actions in the short to medium term to ensure that Key Nutrition Actions are implemented more effectively and are better targeted at the right beneficiaries.

In terms of implementation/monitoring progress, the mapping data can be used to i) look at the use / capacity gaps of delivery mechanisms for nutrition interventions; ii) look at the alignment of partners with the policy and programmatic directions; and iii) help understand whether putting greater resources (technical and financial) into implementing Key Nutrition Actions can lead to greater coverage of target groups and better outcomes over time. Figure 1 below summarises the key steps in the programming cycle where Stakeholder & Action Mapping can support.

Figure 1: Key Steps in Programme Cycle & Where Stakeholder & Action Mapping Supports



Those steps highlighted above in blue, i.e. those that can be informed by data from the Stakeholder & Action Mapping are explained in more detail below:

1. Policy: By comprehensively assessing the nutrition landscape, the mapping gives a good basis to inform discussions on updating nutrition policy in terms of the current focus areas versus those with the greatest potential impact, based on evidence presented in global literature

2. Strategic Planning: The mapping informs programming discussions on which Key Nutrition Actions could have the greatest impact to improve the nutrition situation of a specific country. It is also a powerful advocacy tool – enabling the Government to work with key partners and attract new ones based on the gaps identified through the strategic planning process and the mapping.

4. Operational Planning: By providing a baseline on the coverage of each action at national level, by governorate and by target group, the mapping provides a base from which to set coverage targets over the coming years.

5. Capacity Building: Looking at the use and potential size of delivery mechanisms to assess which are potentially overstretched or underused as well as assessing the number of key staff being trained by government and partners to implement Key Nutrition Actions in the mapping year.

6. Implementation: By carrying out the mapping on a yearly basis can assess whether Government ministries/ departments and other stakeholders are moving towards focusing on the Key Nutrition Actions identified and planned for.

7. Providing input (with data from two or more years of mapping) to help monitor the progress of scaling up Key Nutrition Actions and whether it is in line with programme targets.

Those steps in the programme cycle highlighted in green/ blue in the above diagram cannot be informed by data from the mapping at the moment. However there is potential for them to do so.

3. Costing & Funding: In some countries the mapping has been extended to include the funding spent on the nutrition actions mapped in the same year and also the available funding for each action moving forward. This can help to show where the gaps are in funding and provoke discussion on where finite funding should be focused. It is particularly useful to carry out once a national/joint nutrition plan or programme has been costed in order to compare available funding with the requirements.

8. Evaluation: If the mapping is carried out over a number of years, trends can start to be looked at to assess progress in scaling up the Key Nutrition Actions. This can be one key source of data to feed into an evaluation of the impact of a nutrition programme/plan for example to see whether scale-up is resulting in a greater impact or not. Therefore it is important to understand and link the nutrition actions mapped with the impact indicators that they can have a positive effect on as this can also support in terms of defining the key nutrition issues in the country and deciding on which nutrition actions priority should be given to.

The mapping can also support the improvement of coordination across the programme cycle by providing data on who is doing what and where. This gives the opportunity to work with all stakeholders to ensure that all are moving towards the same goal in a unified manner and not, for example, duplicating actions in the same geographic areas.

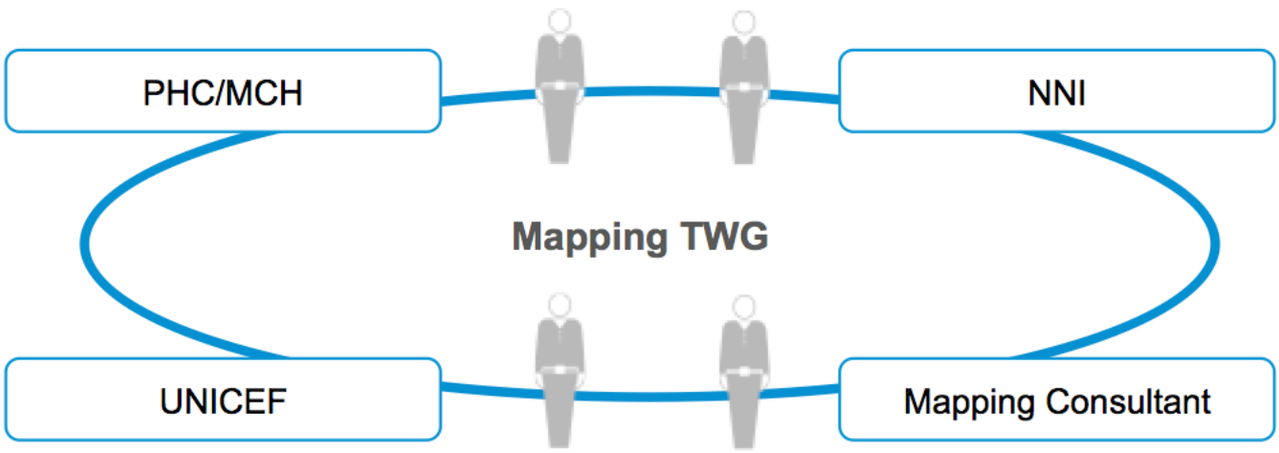
It also supports greater accountability through monitoring scale-up over time and acting as a mechanism to ensure that different stakeholders across Government sectors and beyond can be held to account for delivering on nutrition objectives in order to reach a shared goal. However, in order to take advantage of this potential to use the mapping data to support the improvement of coordination and accountability, the required governance structures need to be in place.

METHODOLOGY AND STEPS TAKEN

a) Coordination and Leadership

The Stakeholder & Action Mapping was carried out under the leadership of the MoHP, specifically the Primary Health Care Sector in close collaboration with the National Nutrition Institute (NNI). A Mapping Technical Working Group (TWG) was set up with the overall objective of taking the lead on implementation of the Nutrition Stakeholder & Action Mapping exercise to ensure it would be implemented in a timely and high quality manner. The TWG, chaired by the MoHP, was comprised of members from key nutrition stakeholders supporting the mapping, including the Maternal & Child Health Department under the Primary Health Care Sector, the National Nutrition Institute, UNICEF and the mapping consultant (hired to give technical support during implementation). A detailed Terms of Reference were developed (see Annex One) outlining clearly the purpose, roles and responsibilities of the TWG to ensure it could carry out its role in full.

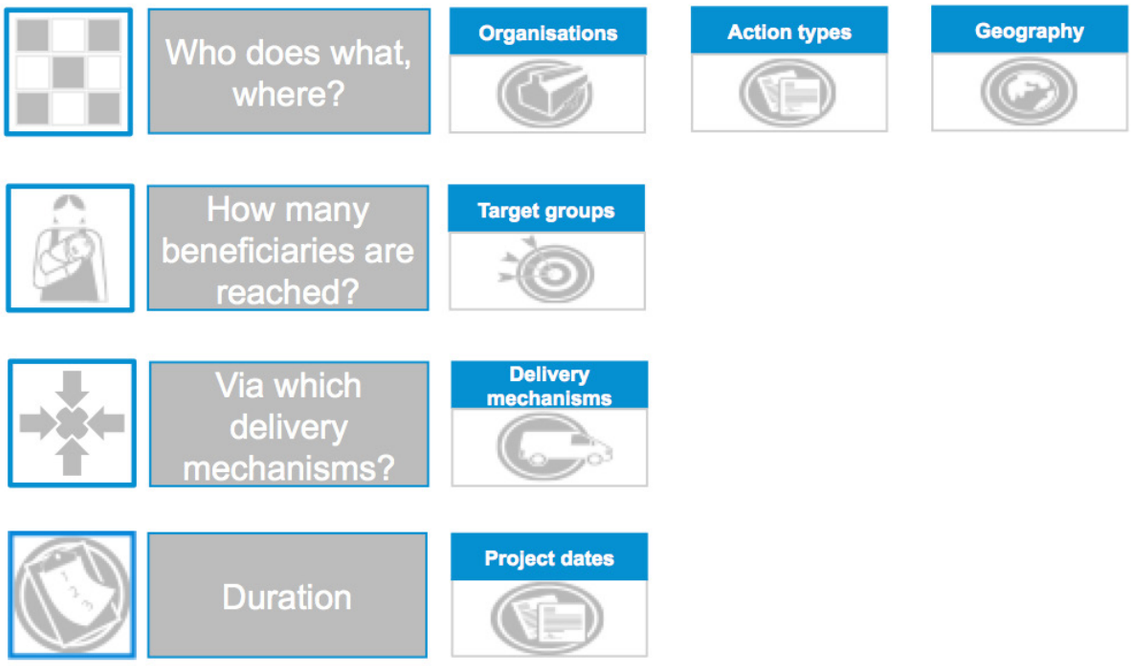
Figure 2: Composition of the Mapping Technical Working Group



b) The Tool

The Stakeholder & Action Mapping is based around the SUN-PMT Tool which provides a basis for carrying out a comprehensive mapping of nutrition stakeholders (including Government sectors) and actions and can be used to collect data at multiple geographic levels including national, regional and district levels. All background data required for data collection (geographic data, nutrition actions, target groups, delivery mechanisms) can be stored in the Tool. Data to be entered directly during interviews through the questionnaire section and this data then goes directly into a database within the Tool. The below graphic outlines the key areas of data collected through the mapping:

Figure 3: Focus of Stakeholder & Action Mapping



From this information, the geographic and beneficiary coverage and gaps at national, governorate and district levels can be assessed and any overlaps and/or complementarity can also be identified. Delivery channels used to implement each action can also be assessed to understand which are being used per action and the intensity of use of each.

From the SUN-PMT Tool key outputs can be directly produced on the following areas:

1. What actions stakeholders are supporting (field implementers, catalysts, donors)
2. The delivery mechanisms being used to implement each action
3. Geographic coverage by governorate / district and by stakeholder
4. Population coverage by governorate / district and by stakeholder

c) Technical Consultations & Planning

Technical meetings were held with the Government and key stakeholders in order to set out the planned framework / roadmap for carrying out the Stakeholder & Action Mapping and to gain buy-in. Key areas of discussion included the following:

- Geographic focus
- Key Nutrition Actions (see Annex Two)
- Key target groups for each identified nutrition action
- Key delivery mechanisms
- List of Government departments and other stakeholders to interview
- Timing of each stage of the mapping

In Egypt, it was agreed to carry out a national level mapping of stakeholders as the main current focus was around national level policy and planning. Data would be collected for the year 2015, as it was the most recent time period for which data was readily available.

A key area of discussion was around the scope of the nutrition actions included in the mapping, and three main approaches were suggested: i) to focus on nutrition actions around the 1,000 days approach /maternal and child nutrition, ii) To map all actions related to nutrition in the health sector, including through ongoing partnerships with other government ministries, iii) To take into account the full multisectoral approach to tackling undernutrition and cover all relevant nutrition-related actions.

As this was the first time to carry out the mapping, the decision was made to make sure the goal was achievable and focused on the nutrition strategic areas being focused on in Egypt. As Egypt is only starting to take tentative steps towards a multisectoral approach, it was also felt that looking at all nutrition actions focused around maternal, child and adolescent nutrition child under the MoHP made the most sense as data was known to be generally available and the different actors known to a greater or lesser extent. This would give a clear picture of everything that was being done and all the partners working in the same areas and would also help to improve coordination within the Ministry itself.

The key decisions made in the initial technical meetings provided the basis from which the TWG could work to finalise the key data required and to plan each identified step to carry out the mapping in Egypt. The planned approach was then presented to all known stakeholders supporting the identified Key Nutrition Actions to be mapped in order to gain their buy-in and participation.

d) Customization of the SUN-PMT Tool

The SUN-PMT Tool is deliberately highly customisable to enable its adaptation to a specific country's situation. Therefore the information gathered through the technical discussions with the Government and key stakeholders as well as through the work of the TWG was vital in adapting the Tool to the Egypt context. Background data collected / agreed on and entered included i) Geographic data, ii) chosen nutrition actions, iii) Key nutrition situation indicators, iv) Target groups for each action, and v) identified delivery mechanisms. Furthermore, the latest available population data by geographic area was acquired from the MoHP and CAPMAS and disaggregated by target group in order to be able to calculate the current target group coverage per Key Nutrition Action based on the data collected.

e) Capacity Building on Tools and Data Collection

Identified staff from the MoHP and NNI were trained (a total of twelve), using a practical approach, on the SUN-PMT Tool to enable participants to collect good quality data in a systematic manner from identified nutrition stakeholders. Training covered: i) Preparing for carrying out Stakeholder & Action Mapping ii) How to set up the SUN-PMT Tool; iii) How to set up and carry out effective interviews to collect relevant data from nutrition stakeholders; iv) Entering and cleaning data; v) Carrying out Stakeholder & Action Mapping round one data collection. To ensure the quality of data, the training included modules focusing on a set methodology to follow for all interviews and ensuring the quality of data collected. The interview teams also pre-tested the Tool in highly supervised interviews with pre-identified organisations. More information on the training can be found in Annex Three.

f) Data Collection

In Egypt, the 28 Key Nutrition Actions mapped included both nutrition specific and nutrition sensitive actions[7] in health, water and sanitation and social protection. The TWG developed and finalised a list of known stakeholders working on these Key Nutrition Actions based on their own knowledge and discussions with colleagues. It was also agreed that if other potential stakeholders were mentioned during an interview, they could also be interviewed if deemed that they were undertaking or supporting any of the Key Nutrition Actions. The final list of stakeholders to be interviewed included Government departments, bilateral and multilateral organisations and NGO's with the number interviewed shown in the below table by type:

Table 1: Stakeholders Interviewed by type

Stakeholders by Type	Number of Stakeholders Interviewed	Number with Relevant Activities in 2015
Government Departments	18	10
UN	3	3
Bilateral / multilateral partners	2	1
NGOs	5	4
Total	28	18

Prior to the interviews, a letter requesting an interview was sent by the MoHP to each stakeholder. The letter also outlined all the types of data that would be required during the interview and included a separate data collection handout with detailed information on the Key Nutrition Actions, the target groups, the delivery mechanisms and a glossary of key mapping terms. The purpose was to ensure that the stakeholders would be prepared with the required information before the interviews took place to minimise the follow-up required by the interview teams. The data collection handout can be found in Annex Four.

Five trained teams, each consisting of two members, carried out the interviews. Each team was allocated a number of the stakeholders to be interviewed. Once it was confirmed that stakeholders had received the request for interview letter, the organisations were contacted by the teams to arrange a suitable time / day for the interview. The interviews took place with specific members of each organisation – namely those with strong knowledge of nutrition related programs such as project officers and M&E officers.

Having teams of two persons allowed for one person to enter the data directly into the SUN-PMT Tool during interviews whilst the other carried out the interview and took handwritten notes to enable comparison and crosschecking of the accuracy of all data entered directly after the interview. The same teams that carried out a specific interview followed up on any remaining issues identified. The types of data collected can be found in Annex Five.

The data collected from stakeholders during the interviews was self-reported and relied on the information available to them from their own reporting mechanisms. Data from organisations that had different roles to implement the same nutrition action (implementer, catalyst, and donor) were crosschecked for consistency. If stakeholders did not have a complete record of the number of the target group reached by a particular action during 2015, an estimate was made based on the information that was available from the stakeholder or from others sources. The mapping did not assess the quality of the action (i.e. whether international guidelines/ protocols were being followed).

g) Supervision

The mapping consultant supervised teams for the first week of interviews with feedback given during and after each interview. After the first week, a member of the TWG, also trained on the Stakeholder & Action Mapping, supported the teams on the ground with the mapping consultant providing remote support. In order to control data inaccuracies and errors, spot-checks during and after interviews were conducted. Amalgamated data from different teams / days of data collection were also cross-checked for potential duplicate entries, accuracy of data from each partner implementing the same project, precision of beneficiary numbers being reached relative to the baseline target population figures, and other potential errors. Feedback was given to each team on data collected and any gaps that needed to be filled.

h) Analysis and Production of Outputs

The SUN-PMT Tool has inbuilt outputs that can be generated to produce results based on the interview data entered, as described above in Section b. - The Tools. Therefore for basic analysis, the SUN-PMT Tool was used. Further analysis was performed using Microsoft Excel to look in more detail at stakeholder support and delivery channels. Finalised outputs were then developed for reporting and presentation to stakeholders.

7 Key findings from The 2013 Lancet Series on Maternal and Child Nutrition show that nutrition-sensitive programmes in agriculture, social welfare, early child development, and schooling can be successful at addressing several underlying determinants of nutrition

LIMITATIONS OF THE MAPPING

a) Data Disaggregation

- Stakeholders were generally unable to provide data on beneficiary numbers at a district level. In almost all cases, available data was aggregated at the governorate level. This does not affect the overall findings but does mean that it is not possible to understand the number of districts covered within a governorate and the extent to which a specific target population is covered for a particular Key Nutrition Action (unless target group coverage is close to one hundred percent), or see the current status of implementation for a specific district.

b) Incomplete View of the Nutrition Landscape

- As planned, the scope of the nutrition actions mapped did not include all sectors such as Water, Sanitation and Hygiene (WASH), agriculture, and social protection. This means that the findings of the mapping do not present a complete picture of the nutrition landscape in Egypt. However, it is likely that efforts will be made to include these sectors in future.

c) Data Availability

- Finally, some departments in the MoHP were unable to provide full data for the mapping so a small amount of data is incomplete. At the same time, data for some actions, particularly related to routine Ante-Natal Care (ANC) or Post-Natal Care (PNC) were expressed by number of visits rather than number of cases. Therefore, estimates had to be made on the number of individual cases for the relevant nutrition actions based on the average number of visits to ANC or PNC per patient.

KEY FINDINGS

This section highlights the major findings from the Stakeholder & Action Mapping. More detailed results are presented in the accompanying PowerPoint presentation.

a) Stakeholder Support

Overall, there are stakeholders, whether Government and/or partners, who are supporting across almost all of the 28 mapped nutrition actions in all parts of the country, through implementation, support of implementation or through funding. Four actions were not implemented during 2015 including provision of routine calcium supplements and deworming tablets, as well as capacity building for planning/coordination and M&E/information systems.

The number and mix of stakeholders (Government, multilateral, bilateral, NGOs) supporting varies by action and by category of action with higher support across Infant and Young Child Feeding and Micronutrient Supplementation. However, this does not necessarily translate into high geographic coverage with some actions having high coverage with a low number of stakeholders supporting, often when it is a routine activity that is institutionalised.

Table 2: Stakeholders Supporting the 28 Key Nutrition Actions

Action Categories	Field Implementers	Catalysts	Donors	Governorates Covered
Infant & Young Child Feeding	8	6	12	16-27
Micronutrient Supplementation	7	10	7	0-27
Disease Prevention/Management	4	3	3	0-27
Maternal, Neonatal & Child Health	5	5	6	1-27
Nutrition Education	4	3	6	5-17
WASH	4	2	7	26
Social Protection	4	2	7	18-27
Nutrition Governance	0	0	0	0

Key: Lowest to highest number of Stakeholders 

This can be seen in the above table where, for example, for Micronutrient Supplementation, the number of stakeholders (Field Implementers, Catalysts, Donors) is relatively high, but not all actions are being implemented (calcium supplementation). Conversely, for the Disease Prevention/Management action category, which includes five actions, there is a low number of stakeholders but some of the actions (such as diarrhoea treatment) cover all twenty-seven governorates. Therefore it is important to look at not only the number of stakeholders supporting an action, but also the geographic coverage and, most critically, the target population coverage.

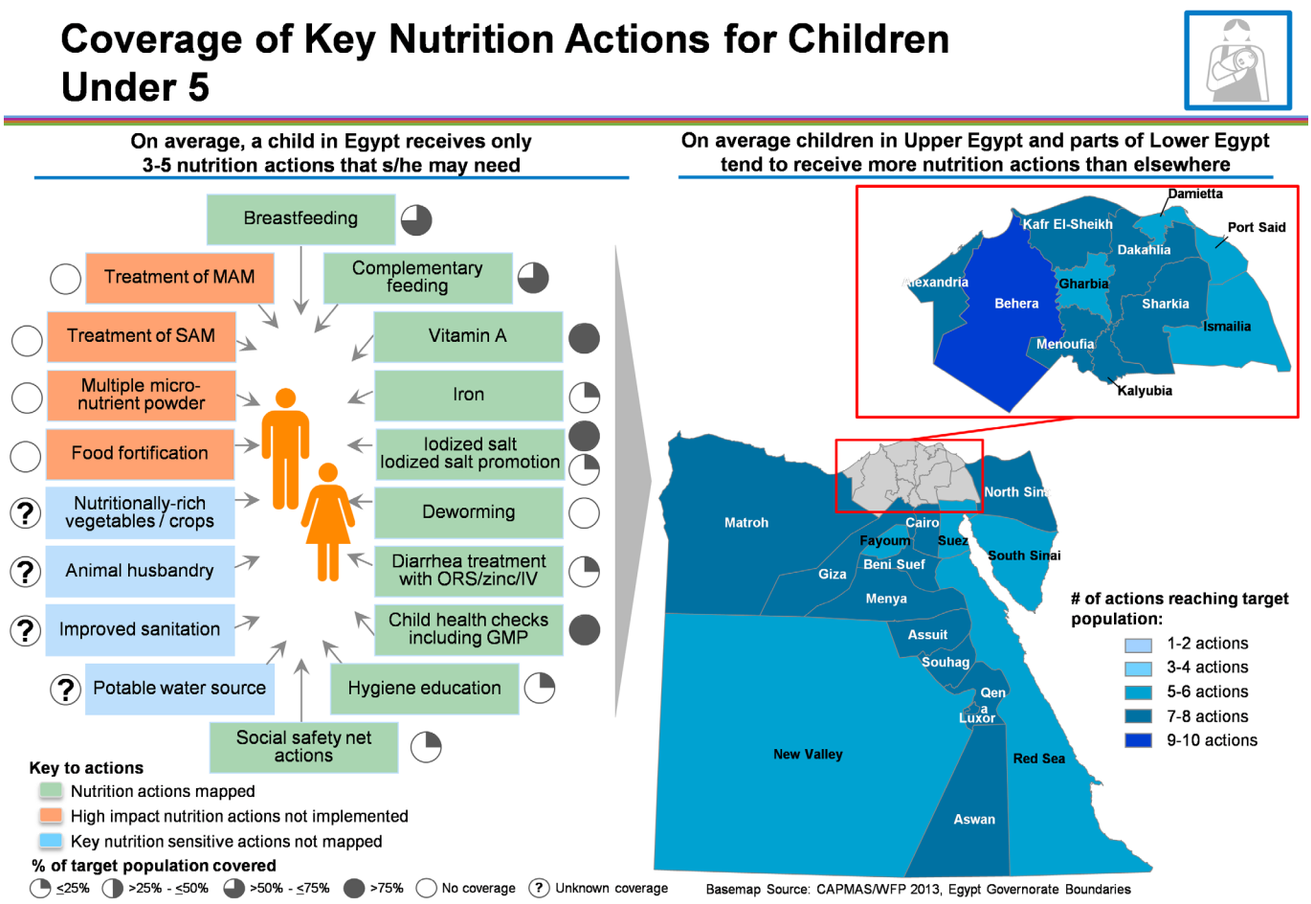
b) Coverage of Key Nutrition Actions for Most Critical Target Groups

The Nutrition Agenda for Action recommends scaling up nutrition actions that can yield measurable impact, including actions that are focused around the 1,000 days approach as well as nutrition-sensitive programming in the longer term. Therefore, data from the Stakeholder & Action Mapping was analysed in terms of how well key target groups for the 1,000 days approach (women of reproductive age and children under two) are being reached with the nutrition actions they require to ensure children have the best possible start in life in terms of their nutritional status. However, as some actions continue for children up to five years old, this age range was taken as the default for analysis.

i) Children Under Five

Figure 4 below shows the number of Key Nutrition Actions important for growth and development that on average a child receives in Egypt (green) out of those mapped. It also shows important actions that were not implemented in 2015 (orange) or were not mapped (blue), giving a total of eighteen actions. Overall the data shows that, although there are a number of Key Nutrition Actions routinely being implemented through the health system such as vitamin A distribution, there is a wide gap between the number of nutrition actions that children under five years old should receive and are actually receiving.

Figure 4: Coverage of Nutrition Actions for Children Under Five



Out of ten Key Nutrition Actions mapped that could impact on a child's nutritional status, the average child receives between three and five of them. A further four actions which could have a positive impact on nutritional status, including treatment of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM), provision of Multiple Micronutrient Powder (MNP) and national level food fortification[8] were not implemented in Egypt in 2015. Furthermore, a number of nutrition-sensitive actions were not mapped including WASH, agriculture and social protection related actions which evidence also shows could improve the nutritional status of children[9]. Therefore, at present and based on the nutrition actions mapped, the average Egyptian child receives on average three to five out of a potential eighteen nutrition actions that can have a positive impact on their nutritional status.

In terms of where children are most likely to receive any of the ten Key Nutrition Actions mapped, analysis shows that children in governorates in Upper Egypt as well as in parts of Lower Egypt have a greater chance of receiving a higher number of the actions. Behera governorate in Lower Egypt has the highest number of actions being implemented with nine, and between seven and eight of the actions are being implemented in almost all governorates in Upper Egypt. However, for almost all actions, all children are not covered in each governorate. Further detailed information on the breakdown by governorate can be found in the mapping database.

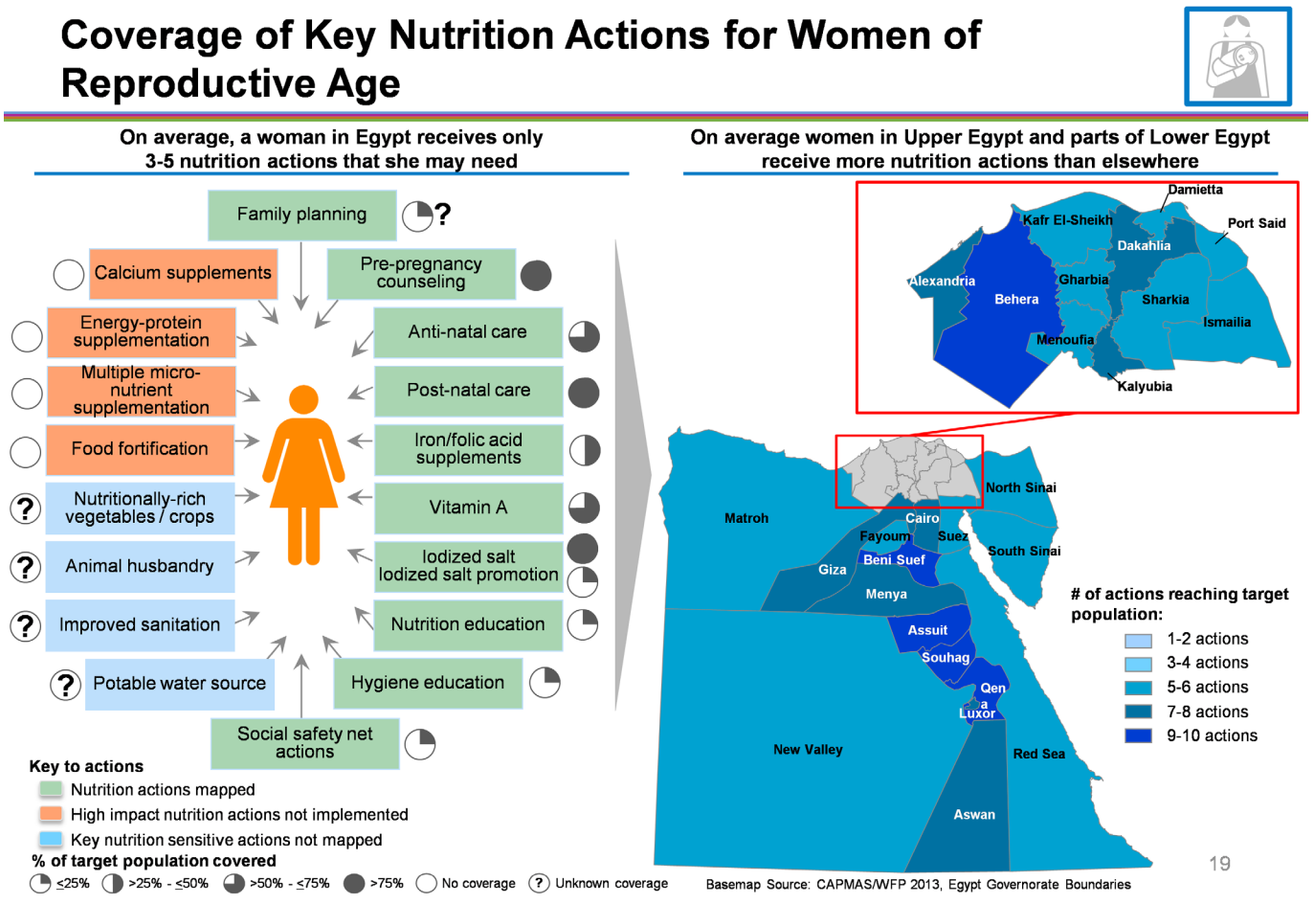
8 It was understood that national level food fortification was implemented in the past and that there are plans to revive that program.
9 Series on Maternal and Child Nutrition, The Lancet, 2008/2013 & Scaling Up Nutrition: What Will it Cost? Horton et al., 2009

ii) Women of Reproductive Age

Figure 5 below shows the number of Key Nutrition Actions from those mapped important for health and wellbeing that on average a woman of reproductive age receives in Egypt (green). It also shows important nutrition actions for women of reproductive age that were not implemented in 2015 (orange) or were not mapped (blue), giving a total of eighteen actions. Overall the data shows that, although there are a number of actions implemented through the health system with wide reach such as ante-natal care, there is a wide gap between the number of Key Nutrition Actions that women of reproductive age should receive and they are actually receiving.

Out of ten Key Nutrition Actions mapped that can have a positive impact on the nutritional status of women of reproductive age, the average woman in Egypt receives between three and five of them. Four other nutrition actions, which could have an impact on a woman's nutritional status are not being implemented in Egypt and include calcium supplements, energy-protein supplements, MNP supplementation and also food fortification. The same nutrition sensitive actions in agriculture and WASH that can improve the nutritional status of children can also positively impact on women of reproductive age[10], however, they were not included in the mapping this time but ideally would be in future. Therefore, at present and based on the nutrition actions mapped, an Egyptian woman receives on average three to five out of a potential eighteen nutrition actions that can have a positive impact on their nutritional status.

Figure 5: Coverage of Key Nutrition Actions for Women of Reproductive Age



10 Series on Maternal and Child Nutrition, The Lancet, 2008/2013 & Scaling Up Nutrition: What Will it Cost? Horton et al., 2009

Looking at the geographic spread by governorate of the ten nutrition actions mapped, which can improve the nutritional status of women of reproductive age the below map shows that, even more so than for children under five, women are most likely to receive a higher number of the actions in Upper Egypt. In this area, four governorates (Beni Suef, Assuit, Souhag and Qena) are implementing nine out of ten of the actions. Within Lower Egypt, the Frontier Governorates (including North and South Sinai) and the Urban Governorates, the number of actions being implemented are most likely to be between five and six (exceptions being Alexandria, Behera and Dakahlia in Lower Egypt where between seven and nine are being implemented). However, as with children under five, for almost all actions, all women of reproductive age are not covered in each governorate. Further detailed information on the breakdown by governorate can be found in the mapping database.

In Summary

Overall, it is fair to say that for the Key Nutrition Actions currently being implemented for children under five and women of reproductive age, the geographic coverage and the target group coverage are currently at a low level and there is wide scope for scaling up existing actions to improve the nutrition situation. This includes iron supplementation, deworming, diarrhoea treatment, hygiene education and social safety net programs targeting children as well as iron/folic acid supplementation for pregnant women, and nutrition education, hygiene education and social safety net programs targeting women of reproductive age.

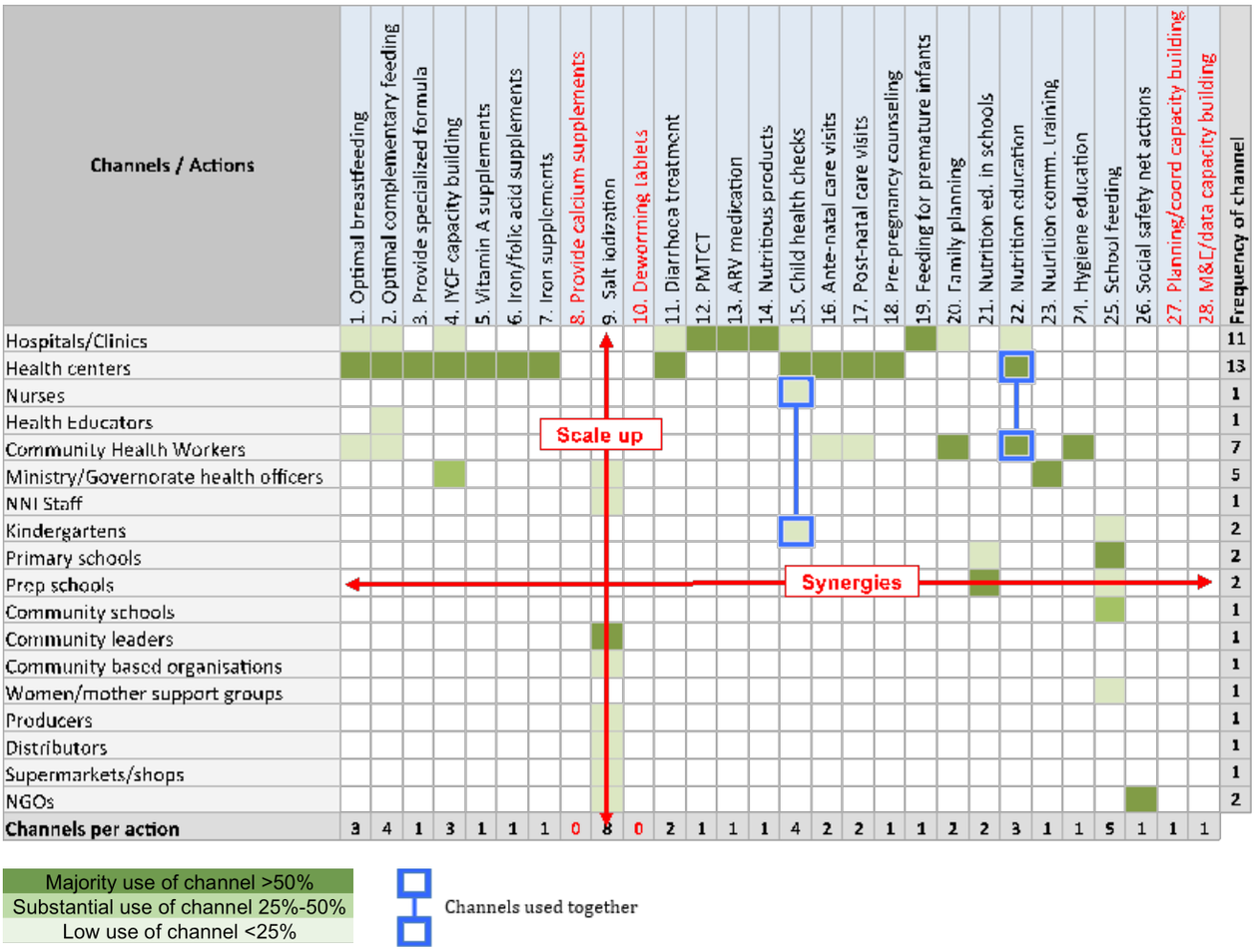
At the same time, there are a number of nutrition actions that are considered important in global literature but are not currently being implemented in Egypt. For children under five these include treatment of moderate and severe acute malnutrition, provision of multiple micronutrient supplementation and food fortification. For women of reproductive age these include calcium supplements, energy-protein supplements, and multiple micronutrient supplements for pregnant women and also food fortification. These should be looked at in terms of when and how they could be implemented in Egypt using an evidence-based approach and in line with the Nutrition Agenda for Action.

c) Delivery channels

Delivery channels refer to the mechanisms used to reach the target groups with each of the Key Nutrition Actions. Delivery channels encompass a wide range of mechanisms across the relevant sectors and can be either the person or entity that has direct contact with the beneficiary. The mapping identified eighteen different delivery channels currently being used to implement all the actions mapped, with each channel involved in delivering between one to thirteen actions and each action using up to eight channels. This is a relatively low number of delivery channels compared to the number of actions mapped, but can be partly explained by the relatively narrow focus of the actions which did not include many WASH and social protection actions implemented outside of the health sector or any agriculture related actions.

As Figure 6 below shows, for Key Nutrition Actions delivered through the health sector, the primary delivery channels are in the health sector (hospitals/clinics, health centres and community health workers). These channels are being used intensively for the most part for implementing each action.

Figure 6: Intensity of Use of the Mapped Delivery Mechanisms



The only exceptions to this are for salt iodization with the private sector and the National Nutrition Institute heavily involved, and also for some training where the Ministry of Health is involved directly. Education sector related actions including school feeding and nutrition education are, not surprisingly, mainly delivered through the education sector and schools in particular and represent the only real deviation away from the health sector.

It is somewhat surprising that community structures and NGOs have little role to play in delivering the nutrition actions, with them only participating in the delivery of salt iodization (communication and awareness), school feeding delivery and social safety nets at community level. In fact there were a number of delivery mechanisms that it was thought were being used but in fact no information was found for the Key Nutrition Actions mapped. This particularly included different forms of media (TV, radio, internet, text messaging etc.) and also other community-based structures such as various community groups and religious centres.

Whether a broad or narrow range of delivery channels are being used to implement each action is not necessarily an issue in itself. The key issue is whether the most effective delivery channels are being used for each nutrition action and whether they are being used efficiently. The findings on delivery mechanisms pose some interesting questions including: i) Whether some delivery mechanisms are in danger of becoming over utilized or exhausted, particularly in the health sector. This in turn raises the issue of whether it is possible to increase capacity of such delivery mechanisms? ii) For delivery mechanisms that are less commonly used, is there potential to strengthen scale up through these delivery mechanisms? iii) For the actions with few delivery mechanisms, is there potential to increase reach by extending delivery of the service through other delivery mechanisms? iv) Are all the different channels being used to implement an action linked to ensure efficient implementation through the creation of synergies. As Egypt is looking towards scaling up Key Nutrition Actions in the country, some of these issues may warrant further investigation to ensure that the delivery mechanisms are in place to support scale-up of service delivery.

KEY RECOMMENDATIONS

a) Stakeholder Support – Strengthening Coordination & Accountability

The Nutrition Agenda for Action recommends the strengthening of leadership and the building of a governance and coordination structure in the medium to longer term in order to support the implementation of national/joint nutrition plans. The Stakeholder & Action Mapping, by bringing together information on stakeholders involved in implementing 28 Key Nutrition Actions provides a starting point to begin implementing such a structure.

i) Coordination

Strengthen coordination to ensure all stakeholders moving towards the same goal: Strengthened coordination goes hand in hand with developing a comprehensive national/ joint nutrition plan and is key in order to ensure there all stakeholders are moving towards the same goal in a unified manner and not, for example, duplicating actions in the same geographic areas. As Egypt is moving towards developing such a nutrition plan, in line with the Nutrition Agenda for Action, it is important that a governance structure is developed and put in place in order to improve coordination. It should have a clear delegation of roles and responsibilities and mandate to coordinate nutrition activities in the country and should include establishing clear lines of communication, decision making and information sharing among all stakeholders.

Such a governance structure should include a high-level ministerial body which is reported to by Inter-Ministry / Inter-Agency level mechanisms whose main role is to coordinate technical aspects of implementing a national/ joint nutrition plan. A nutrition secretariat should be set up to support these mechanisms by playing a coordinating role among these different bodies and coordinating to ensure the smooth implementation of such a nutrition plan. In the longer term it would be important to put in place coordinating structures at the governorate and district levels. The mapping can be a key component in managing and guiding implementation, including supporting coordination and through the comprehensive information it has on all stakeholders and their nutrition activities.

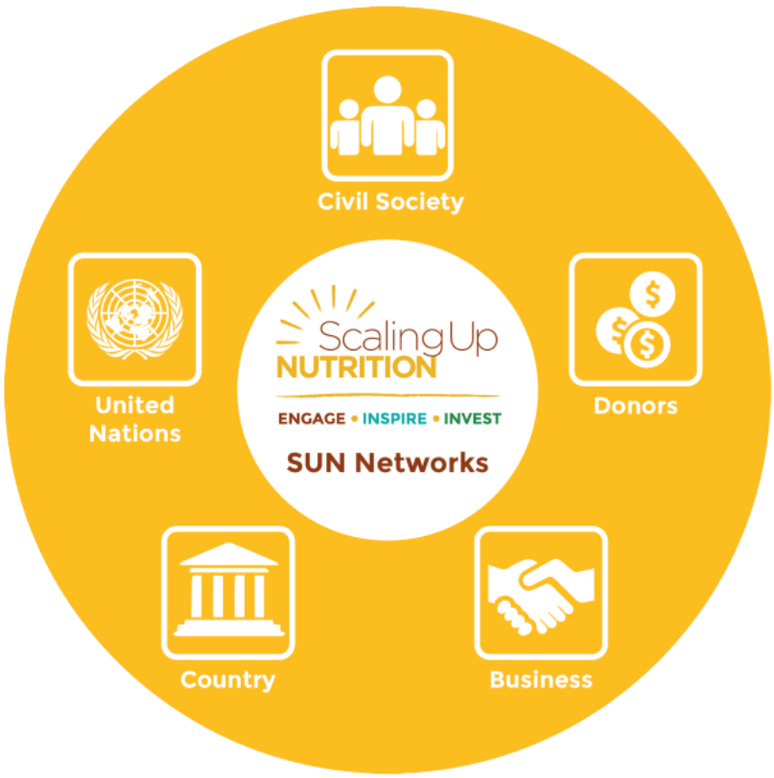
ii) Accountability

Strengthen accountability to improve progress towards nutrition goals: Greater accountability goes hand in hand with greater coordination, and acts as a mechanism to ensure that different stakeholders across Government and beyond can be held to account for delivering on nutrition objectives in order to reach a shared goal. Examples of methods that could be used to pursue greater accountability include common monitoring frameworks and the collecting and sharing of data on nutrition inputs, outputs and outcomes. Stakeholder & Action Mapping can give a good overview of the nutrition landscape and monitor implementation scale-up over time. However, also developing a systematic and comprehensive routine data collection system (i.e. a nutrition information system) would further enhance accountability.

iii) SUN Movement

Join the SUN Movement to foster greater collaboration and learn from other countries experiences: A key mechanism that can support efforts towards greater coordination and accountability is the SUN Movement. This Movement encourages increased coordination and the fostering of greater collaboration among stakeholders for improved nutrition outcomes within a country and also globally. To facilitate this, a number of networks have been created at global and national levels to support a more coherent nutrition agenda as the below diagram shows.

Figure 7: The SUN Networks



As Egypt is now working towards operationalising the Nutrition Agenda for Action, the time could be suitable for joining the SUN Movement. By establishing the different networks in the country, coordination among different stakeholders would be encouraged as well as greater accountability through close collaboration. The SUN Movement at national and international levels also provides a mechanism for peer learning and review through working collaboratively, giving an excellent opportunity for the Government to learn from other countries which have embarked on a similar process.

b) Coverage of Key Nutrition Actions

The Nutrition Agenda for Action recommends scaling up existing nutrition programming in the shorter term, particularly actions that can yield measurable impact, including actions that are focused around the 1,000 days approach (Infant & Young Child Feeding, Micronutrients, specific primary health care actions). It also encourages nutrition-sensitive programming that links up with wider nutrition programming including in WASH, agriculture and social protection in the longer term. Therefore the recommendations around increasing coverage of Key Nutrition Actions focuses on what can be done to achieve this.

i) Policy & Strategic Planning

Use the findings of the mapping to influence the development of policies and strategic planning: The findings of the mapping show that only a small number of the Key Nutrition Actions are currently at scale, particularly for children under five and women of reproductive age. To ensure a much greater positive nutrition impact on the key target groups, it is important to ensure that evidence-based, high impact nutrition actions are available to all potential beneficiaries and that available data from existing nutrition information systems and data monitoring platforms are made available to understand the current status. High impact and cost-effective actions recognized in global literature are outlined in Annex Six and include vitamin and mineral supplementation and promotion of breastfeeding and complementary feeding amongst others. It is recommended that these are focused on first as generally speaking they can be scaled up more rapidly and have a greater impact in a shorter time than other actions.

This is not to say that nutrition sensitive actions should not be focused on at all. However, the potential impact of nutrition sensitive actions has only recently been recognised in the 2008 Lancet series on Maternal and Child Nutrition and since 2010 the SUN Movement has emphasised placing more focus on nutrition-sensitive approaches to improve maternal and child nutrition. So far, efforts to implement at scale are very much in their infancy, with nutrition sensitive approaches lacking a common definition, and little guidance on how to design and implement a multi-sectoral approach to nutrition. Therefore it is recommended that as the evidence base grows and best-practice approaches emerge, they can be implemented more gradually.

ii) Advocacy

Use the findings of the mapping as an advocacy tool: The mapping gives a good overview of the nutrition landscape and creates a good opportunity for the MoHP to create an advocacy tool with partners as it provides a solid evidence base, particularly highlighting the gaps in current nutrition programming. The main aim of developing such a tool would be to enlist greater support from all types of stakeholders, whether current or potential, for scaling-up the Key Nutrition Actions. The specific aims of the advocacy tool would be:

- To inform and further engage relevant Government counterparts and stakeholders around the current nutrition situation and to show what needs to be done in the country as highlighted in the Nutrition Agenda for Action in order to meet the global nutrition targets and align with the Sustainable Development Goals

- To inform all nutrition stakeholders of the Nutrition Agenda for Action and Key Nutrition Actions as well as where the implementation gaps are (geographic, target population coverage, necessary nutrition actions not being implemented, capacity building to improve delivery channels)

- To seek further / new sources of funding and/or technical support from stakeholders based in or outside of Egypt

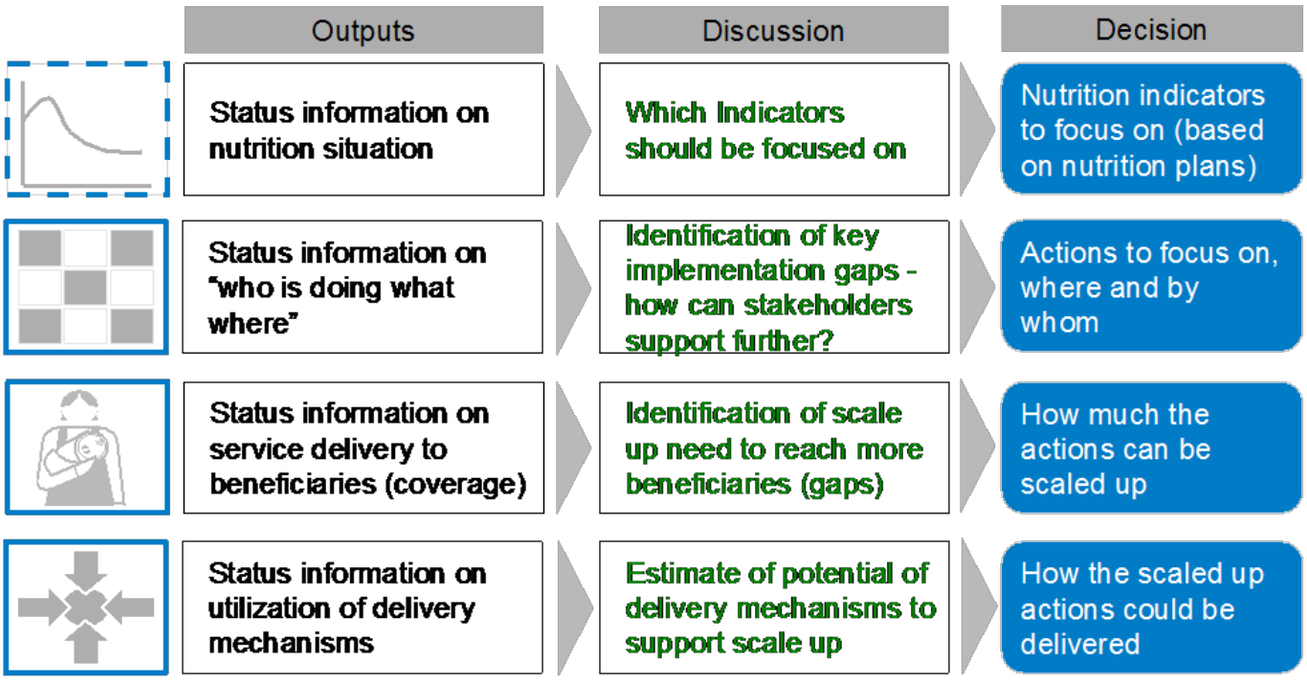
- Equip key actors to be able to advocate for nutrition and put nutrition at the heart of development priorities at all levels

In the short term, with key information readily available in the mapping database, once (potential) partners are looking to support the nutrition agenda in Egypt or looking to expand their activities, the MoHP has the information required to work with the partner and agree on where support is needed the most in line with a national/joint nutrition plan. The same also applies within the Government whereby the Nutrition Unit can work with other departments and ministries as needed to look at filling the gaps that exist and to start working towards common goals.

iii) Operational Planning

Integrate the findings and recommendations to inform the planning process: The outputs of the mapping constitute the first time that such comprehensive data is available on who is doing what and where in nutrition in the country. Even more crucial is the information on the target beneficiary coverage. These data are useful to the Government for developing more targeted planning of nutrition actions at national and governorate levels to support coordination and implementation. The below figure summarises how key data from the mapping can be used to help make planning decisions.

Figure 8: Key information and how it can be used to help make planning decisions



It is recommended that governorates with a combination of higher levels of stunting and lower coverage of Key Nutrition Actions are focused on first. However, in order for the findings to be used effectively, it is important that key stakeholders in relevant sectors as well as planners are sensitized not only on the process but also on the purpose of carrying out the Stakeholder & Action Mapping (i.e. to inform the planning process and for monitoring scale-up progress) and it is demonstrated how the data can be used to support nutrition planning. For this purpose, it is also crucial that a link is created and maintained between the program implementers and planners within each department and sector of the Government.

iv)Implementation & Monitoring of Progress

Integrate as part of the monitoring & evaluation process of the MoHP: Stakeholder & Action Mapping data can provide a good evidence base from which to monitor implementation and track progress. Therefore key data, particularly on beneficiary coverage, should be used to support monitoring of scale-up on a yearly basis and to help evaluate implementation of national/joint nutrition plans based on the Nutrition Agenda for Action. For this, the mapping needs to be carried out on a regular basis over a period of time to track progress in scale up and to be able to see the changes in coverage of nutrition actions in line with targets set in the nutrition plan. Carrying it out on a periodic basis also provides a source of data to help evaluate whether an increase in coverage of Key Nutrition Actions for key target groups is having an associated impact on relevant impact indicators.

It is recommended that to enable comprehensive monitoring of Key Nutrition Action scale-up, the mapping should be carried out on a yearly basis. It would also be important to include all nutrition sensitive actions in WASH, agriculture and social protection in subsequent rounds to ensure that a full picture is built up of activities and stakeholders. This approach would also encourage nutrition sensitive planning and monitoring of relevant actions in each sector and encourage greater collaboration and coordination. To ensure the success of future rounds of the mapping and improve the monitoring of Key Nutrition Action scale-up, it is important to ensure that government departments and ministries as well as other partners refine their programmatic data collection to include the types of data collected in the mapping.

c) Delivery Channels – Improving Capacity to Implement

The Nutrition Agenda for Action also calls for focus to be placed on institutional capacity building. Most of the capacity building required for scaling-up Key Nutrition Actions is in the delivery channels used to provide the services to target groups such as the health system. Therefore, the recommendations around delivery channels are as follows.

Focus on the most appropriate channels and maximise synergies: It is important to ensure that the most appropriate channels are being used to deliver each nutrition action and this requires strong coordination between all stakeholders to work together to assess the current channels being used and other available channels and agree on the best implementation approach. Once the key channels are agreed on, it is critical to maximise synergies, especially for those channels used for multiple actions through stakeholders sharing expertise / learning and doing integrated training. As well as improving expertise and scalability, this approach could also result in more robust and innovative methods and optimal use of resources.

Operational Research into channel use and capacity building: To inform decision-making on the most appropriate delivery channels to scale up, operational research may be required to look into the most effective channels and/or potential bottlenecks within certain channels. Once specific channels are highlighted as the most appropriate, a capacity assessment looking into the training packages and also the workload of staff in the health system is recommended in order to ensure that certain channels are not being over-utilised. If new nutrition actions are to be implemented without obvious delivery mechanisms in place it would be important to pilot chosen channels first and then scale up based on the evidence generated. In this regard it could also be important to look at international examples if available.

LESSONS LEARNED AND OPPORTUNITIES CREATED

a) Ownership & Buy-in

The mapping was given high importance within the MoHP and among key stakeholders as it was felt that the timing was right to gain a good understanding of the nutrition landscape to inform operationalization of the Nutrition Agenda for Action and increase the visibility of the nutrition agenda within and outside of the MoHP. There was discussion around how broad to make the scope of the mapping with it ideally being done across all relevant sectors. However, as it was felt that even within the health sector there were challenges and the move towards a multisectoral approach is in its infancy, the scope of the mapping was limited to the health sector, particularly primary care. Although not the ideal approach, it allowed the mapping to go ahead successfully, and created a platform to work from.

However the mapping provides a good opportunity to raise awareness of the nutrition agenda and to establish/ strengthen links not only among stakeholders directly linked to the MoHP but also with stakeholders in other sectors such as WASH, agriculture and social protection within and outside of the Government. This can be done by sharing / presenting the Nutrition Agenda for Action and the mapping findings to sensitise on their purpose and the important role that the different sectors can play in improving the nutrition situation in Egypt. This can potentially build critical links ahead of potentially expanding the scope of the mapping in 2017.

b) Embedding the mapping as a regular activity of the MoHP

The MoHP carried out the first round of the mapping with technical support from a consultant. This first round included capacity building of MoHP and NNI staff on carrying out the mapping so that they would be able to carry it out again in future to support the monitoring of the scale-up of nutrition actions based on the targets set in national/joint nutrition plans. However, collecting the data is only the start. Being able to work with the data, understand it and manage it is also very important to enable the most to be got out of future rounds of the mapping.

Two approaches can ensure this: i) The mapping focal person in the MoHP (Nutrition Unit) should have the mapping work included in their job description and be a part of their regular work. To support this role, further capacity building may be needed before the next round of the mapping is carried out; ii) It is important to embed the mapping within the regular work plans of the Nutrition Unit and other relevant departments and sectors to ensure it is given enough priority in terms of necessary support and making data available. To support this, it may be prudent to develop a template that can be filled in by each sector / department for the mapping ahead of time. This would also make them aware of the data that is needed so that they can make sure it is available.

As part of the process of embedding the mapping, it is important that the data is housed and managed appropriately within the MoHP to ensure that the data is handled and shared following pre-defined protocols. Ideally, the mapping focal person would look after the data as part of their job description and be able to provide support over the medium to long term for the mapping in terms of coordination and using the results, including sharing information with stakeholders as needed. Data sharing protocols would include, at a minimum: i) All stakeholders being clear on what data would be shared, ii) for what purpose, iii) who would manage the data, iv) who would have access to the data and v) how and when stakeholders would be able to access the data (see annex Seven).

c) Expanding the mapping to include a broader range of Nutrition Sensitive Actions

The mapping focused on nutrition actions under the mandate of the MoHP or those that it worked on with partner ministries, as described above, as it was felt that the vast majority of available data related to nutrition actions could be efficiently collected within these confines. However, although a good picture of a large part of the nutrition landscape was constructed, the MoHP recognised that it was incomplete, especially in terms of WASH, agriculture and social protection related actions.

Although including a much broader range of nutrition sensitive actions would increase the time and effort required to carry out the mapping, as the focus turns more towards a multisectoral approach to nutrition in Egypt, it would make sense to include them. This creates an opportunity for the MoHP to engage more with the different sectors on nutrition through the mapping. In order to successfully map the WASH, agriculture and social protection sectors, it would be important to work with the different sectors to assign focal persons and train sector-specific data collectors also.

It also creates challenges, including on covering the sectors comprehensively and reaching agreement on the types of nutrition sensitive actions to be included in the mapping, as there is often variation among stakeholders about what constitutes a nutrition sensitive action as well as a global discourse on-going on the same topic. Good starting points on this include a briefing note developed by the SUN Movement entitled: "Methodology and Guidance Note to Track Global Investments in Nutrition" which includes a section on defining what constitutes a nutrition sensitive action. A second SUN document entitled: "Guidance for the use of the Common Results Framework (CRF) Planning Tool" describes the types of programmes that fit into each of the nutrition sensitive categories and sub-categories. The definitions used in these documents can be found in Annex Eight. It would also be important to review the current actions in the mapping to assess their level of importance to tackling the nutrition issues in the country. This would also be important to keep the number of nutrition actions to a manageable level once nutrition sensitive actions are included. It is recommended not to map more than 30 nutrition actions.

NEXT STEPS

Based on the recommendations of, and the opportunities created by, the Stakeholder & Action Mapping, discussions should be held between the Government and key stakeholders on the following key issues.

a) Stakeholder Support – Strengthening Coordination & Accountability

Coordination: Look at ways to build on the opportunities created by the mapping to improve coordination of stakeholders and activities in line with the Nutrition Agenda for Action and future national/joint nutrition plans. Also, it is important to ensure that the mapping work is included in the job description of the focal person, including managing the data. A decision should also be taken on where to house the data within the MoHP.

Accountability: Look at ways to embed the mapping into the regular work plans of the MoHP to continue implementing on a regular basis so that mapping can be used to monitor progress against plans as well as support coordination.

SUN Movement: In order to support the embryonic efforts in Egypt to scale-up nutrition programming and particularly around coordination and accountability, the MoHP should start to reach out to key decision makers about joining the fifty-seven countries already collaborating in the SUN Movement. As the Movement supports any country that is developing, updating or implementing policies, strategies and plans of action to scale up nutrition, it would be timely and also enable peer learning from countries that have gone through a similar process that Egypt is now starting.

b) Coverage of Key Nutrition Actions

Policy & Strategic Planning: Continue to move forward with operationalising the Nutrition Agenda for Action. The mapping findings should be used to inform continued development of the approach and take into account the recommendation to focus primarily on high-impact, evidence-based nutrition actions.

Advocacy: Review the mapping findings and look at how they could be further developed into an advocacy strategy. To aid this process, look at setting up a technical taskforce, led by the mapping focal person. In the short-term, the key findings of the mapping could be shared with all stakeholders. This includes presenting the findings and the mapping concept to other key sectors.

Operational Planning: The findings of the mapping should be presented to technical staff and planners within the MoHP to demonstrate how the data can be used for planning and monitoring of scale up. Agreement also needs to be reached on carrying out the mapping on a yearly basis and expanding the scope to include WASH, agriculture and social protection sectors as well as any others carrying out nutrition-related activities.

Implementation and Monitoring of Progress: To enable effective monitoring of progress, it is important that the mapping is carried out on a regular basis. Once basic agreement is reached on this, a key first step would be to ensure that the mapping is included as part of work plans of the Nutrition Unit under the MCH General Directorate for 2017 onwards.

c) Delivery Channels – Improving Capacity to Implement

Current delivery channel use should be further assessed as appropriate based on the mapping findings in terms of those that appear to be over-used, those that may be underused, and potential channels that have not been considered up to now. For channels that are heavily used for implementation such as health centres, a capacity assessment may be required. To investigate other issues such as underused and currently not used channels, operational research should be designed and carried out as appropriate.

CONCLUSION

This Nutrition Stakeholder & Action Mapping was carried out successfully by the MoHP of the Government of the Arab Republic of Egypt to provide an evidence base to support planning to scale-up Key Nutrition Actions to accelerate progress towards ending maternal and child malnutrition in the country in line with the Nutrition Agenda for Action. The findings of this nutrition mapping exercise set out the current situation around implementation of maternal, child and adolescent nutrition interventions, informing the Government and other key stakeholders on what nutrition actions are being implemented in the country as well as who is supporting each action, and the extent of coverage. The mapping also gives some insight into the use of different delivery channels for each action. Critically the exercise also highlights the gaps in implementation, providing some direction on where focus needs to be placed, as well as the gaps in programmatic data currently collected, suggesting that attention should be given to improving data management and use. However, by bringing together information on all stakeholders working on the Key Nutrition Actions mapped, the exercise also provides a base from which to improve coordination and accountability and could also be used as an advocacy tool to highlight the areas that need the further support of stakeholders.

This mapping exercise is only the beginning of the process of scaling up nutrition actions in Egypt. It provides an evidence base from which to move forwards to the planning and implementation phases along with the Nutrition Agenda for Action. Moving forwards, in order to successfully plan for scale-up, it is important to ensure that the framework of the Nutrition Agenda for Action and the findings, recommendations and the next steps highlighted in this report are used to inform the development of national/joint nutrition plans and programmes and to monitor the scale up of Key Nutrition Actions over the coming years.

ANNEXES

Annex One: Terms of Reference for Mapping Technical Working Group

Terms of Reference
Egypt Nutrition Stakeholder & Action Mapping Technical Working Group
Final Version - September 8th, 2016

Purpose

The aim of these terms of reference is to define the role of the Technical Working Group (TWG) for implementation of the Nutrition Stakeholder & Action Mapping exercise in Egypt under the Ministry of Health and Population (MoHP).

Background

The MoHP has decided to carry out Nutrition Stakeholder & Action Mapping in order to inform the current moves towards institutionalizing and scaling up nutrition actions with a focus on maternal and child health, within the context of the newly adopted Sustainable Development Goals (SDGs) and the Strategic National Development Agenda (Egypt's Vision 2030). In order to ensure timely and well-executed implementation, it was agreed to set up a TWG to drive forward and lead on the process.

Overall Objective & Tasks

The overall objective of the TWG is to take the lead on implementation of the Nutrition Stakeholder & Action Mapping exercise; ensuring it is implemented in a timely and high quality manner.

The tasks include to:

1. Carry out all necessary preparation steps including gathering information required for data collection tool setup and identifying data collectors
2. Arrange a meeting with all relevant stakeholders to sensitise them on Nutrition Stakeholder & Action Mapping prior to data collection
3. Take the lead on identifying all relevant stakeholders for interview and communicating with them as necessary
4. Attend relevant capacity building sessions
5. Support data collection teams during the data collection period
6. Support on data compilation, cleaning and production of outputs
7. Take the lead on dissemination of findings
8. Report to primary health sector head of the MoHP on issues discussed / decisions made in the TWG following each meeting
9. To secure necessary approvals to get access to required information

Composition

The members of the TWG shall include the following persons representing the MoHP, the National Nutrition Institute, and UNICEF:

Dr Afaf Tawfik - NNI Director

Dr Khaled El Oteifi - MCH director

Dr Dina Abd El Hady – MCH (Technical working group coordinator)

Dr Kariman Salah El-din Yasser (Technical working group rapporteur)

Dr Alia Hafiz - UNICEF

Mr Matthew Robinson, Stakeholder & Action Mapping Consultant, will technically support the TWG.

Structure

A group coordinator will be agreed on to direct the group. Members will also agree on a secretary from among the members whose primary tasks include liaising with members on scheduled meetings and compiling minutes.

From time to time it may be prudent to invite other persons to become members of the TWG if it is believed they can add value to the work of the group. Inviting a new member to be a part of the TWG must be agreed on by consensus among existing members.

Meetings

Scheduling: TWG meetings will be held on an ad-hoc basis as and when necessary in line with progress in implementation of the Nutrition Stakeholder & Action Mapping. The TWG members will agree on dates for meetings with reminders sent to all members by the secretary.

Format: The secretary should circulate an agenda before each meeting.

Minutes: For each meeting, the secretary will compile minutes to include topics discussed, recommendations and decisions made, action points, and agenda items for future meetings. The minutes will be distributed to TWG members no later than 2 days after the meeting.

Decision Making

Decisions on all issues will be reached by consensus, after ensuring that all members positions on the specific matter have been fully understood and given due consideration. For some decisions, the issues may be referred to a higher level in the MoHP, as necessary.

Communication / Information Sharing

Issues discussed and/or materials developed in TWG meetings or by TWG members must not be circulated to external audiences until all TWG members and/or the MoHP have given their consent.

Documentation will be maintained showing the steps taken throughout the Nutrition Stakeholder & Action Mapping process and it will be ensured that the MoHP endorses key documents.

Amendments to the Terms of Reference

Changes to these Terms of Reference may be made, as needed, with the agreement of all TWG members and the endorsement of the MoHP.

Annex Two: The Key Nutrition Actions

Action category	Action
IYCF	1. Promote optimal breastfeeding practices (e.g. BFHI, BFCI)
IYCF	2. Promote optimal complementary feeding practices including local food-based approaches
IYCF	3. Provide specialized formula for children with special needs
IYCF	4. Support IYCF capacity building and tools
Micronutrient supplementation	5. Provide vitamin A supplements
Micronutrient supplementation	6. Provide iron/folic acid supplements
Micronutrient supplementation	7. Provide iron supplements
Micronutrient supplementation	8. Provide calcium supplements
Micronutrient supplementation	9. Carry out/support salt iodization
Disease prevention/management	10. Provide deworming tablets
Disease prevention/management	11. Provide diarrhoea treatment with ORS, zinc / IV rehydration solution
Disease prevention/management	12. Promote prevention of mother to child transfer of HIV (PMTCT)
Disease prevention/management	13. Provide ARV medication
Disease prevention/management	14. Provide specialized nutritious products in case of disease (Inborn Error of Metabolism – IEM, Coeliac, Autism and others)
Maternal, neonatal & child health	15. Provide child health checks, including growth monitoring & promotion
Maternal, neonatal & child health	16. Promote ante-natal care visits (incl. counselling on optimal maternal nutrition practices)
Maternal, neonatal & child health	17. Promote post-natal care visits
Maternal, neonatal & child health	18. Promote pre-pregnancy counselling
Maternal, neonatal & child health	19. Support feeding for prematurely born infants
Family planning	20. Promote family planning, including optimized inter-pregnancy intervals
Nutrition education	21. Carry out nutrition education as part of school curricula (e.g. school gardens)
Nutrition education	22. Carry out nutrition education (e.g. cooking demonstrations, nutrition counselling, promote healthy dietary/lifestyle choices)
Nutrition education	23. Support training on nutrition communication strategies, tools and channels such as mass media and social media approaches
WASH	24. Carry out hygiene education
Social protection	25. Provide school feeding with adequate micronutrient levels
Social protection	26. Provide conditional social safety net actions (e.g. cash, voucher, food, other)
Nutrition Governance	27. Support capacity building for nutrition planning and coordination (national, provincial, district)
Nutrition Governance	28. Support capacity building on nutrition M&E/information systems

Annex Three: Capacity Building on Stakeholder & Action Mapping

Nutrition Stakeholder & Action Mapping Data Collection Training – Egypt

Participants: Persons who will implement the Nutrition Stakeholder & Action Mapping including:

- Members of the Mapping Technical Working Group (TWG)
- Identified data collectors from the MoHP & NNI

Total Number of Participants: Members of the Mapping TWG and around 6-8 data collectors (dependent on number of nutrition stakeholders to be mapped and the time period for data collection), giving a maximum total of 14 participants.

Training Length: One full day minimum

Proposed Date: Monday, September 19th 2016

Proposed Venue: UNICEF office

Requirements:

- Screen and projector
- Laptops – minimum one between two trainees (to be provided by trainees)
- Flipchart and pens

Aims of the Training

- To train participants to use the Scaling Up Nutrition Planning & Monitoring Tool (SUN-PMT) to be able to carry out the Nutrition Stakeholder & Action Mapping.
- To enable participants to collect good quality data in a systematic manner from stakeholders for the Nutrition Stakeholder & Action Mapping.

Expected Outcomes of the Training

By the end of the training participants should be able to:

- Use the SUN-PMT including setting up the tool, entering data and cleaning data
- Carry out effective interviews to collect relevant data from nutrition stakeholders

Training Key Sessions:

1. Review of aims and process of Nutrition Stakeholder & Action Mapping
2. How to prepare for the Nutrition Stakeholder & Action Mapping – Data required
3. Carrying out the Mapping using the Scaling Up Nutrition Planning & Monitoring Tool (SUN-PMT)
   3a – How to tailor the SUN-PMT to local needs
   3b –How to conduct data collection from stakeholders
   3c - Generating outputs from the SUN-PMT
4. Next Steps & Preparation for Round 1 Data Collection.

Detailed Guide to Sessions

Welcome and Introduction (15 min)

- Participant introductions
- Schedule, aims and objectives, expected outcomes

1. Review of Aims and Process of Nutrition Stakeholder & Action Mapping (30 min)

This section includes an overview of the purpose and aims of the Nutrition Stakeholder & Action Mapping generally, and for Egypt, including a brief look at some of the results / outputs that can be generated from the Mapping to meet the identified aims.

Step-by-step:

i. Overview of the purpose and aims of the Nutrition Stakeholder & Action Mapping in general and specifically for Egypt.

ii. Based on outlined aims, introduction of the kinds of outputs possible and how they link to achieving the aims such as role of stakeholders, who doing what and where, geographic and target population coverage, delivery mechanisms

iii. Expected outputs and the uses / purpose of each

iv. Mapping key steps

v. Discussion / questions

2. How to Prepare for the Nutrition Stakeholder & Action Mapping – Data Required (60 min)

This section includes a quick review of the data required for the Nutrition Stakeholder & Action Mapping before starting and available sources (in the Egypt context).

Step-by-step:

i. Key areas of data required (Situation indicators, nutrition actions, target groups, delivery mechanisms, population data for each target group, types of stakeholders)

ii. Overview of the nutrition actions chosen in Egypt as well as target groups and delivery mechanisms

iii. Overview of the need for population data and potential sources

3. Carrying out the Mapping using the Scaling Up Nutrition Planning & Monitoring Tool (SUN-PMT)

Overview of the SUN-PMT - the types of information that can be captured, how to fill in / use each section, the outputs that can be produced within the SUN-PMT etc.

Each stage of the process to be introduced using dummy data with a participatory approach used: Participants to practice using the SUN-PMT with computers (individually or in pairs) as we go through step-by-step.

Step-by-step:

3a: How to tailor the SUN-PMT to local needs (60 min)

i. Entering data (situation indicators, nutrition actions, target groups, delivery mechanisms)

ii. Linking specific data (Actions-delivery mechanisms, actions-target groups, actions-situation indicators)

iii. Setting situation indicator thresholds and coverage targets

3b: SUN-PMT - How to collect data from external sources including interviewing stakeholders (120 min)

i. Adding and estimating target population groups data

ii. Adding situation indicator data

iii. Process to carry out interviews and who to interview

iv. Getting and storing contact data

v. Interviewing stakeholders – Setting up, required data, using the interview sheet

vi. Interviewing stakeholders – techniques and tips

vii. Calculating number of beneficiaries

viii.Storing and editing data

ix. Interview and data collection issues including potential duplicate data

x. Role plays to practice filling out the SUN-PMT in interview situation (example role play first)

3c: Generating outputs from the SUN-PMT (60 min)

i. Reporting – How to generate reports from the SUN-PMT and what they show (Situation indicator dashboard, who does what, geographic coverage per geography, geographic coverage per stakeholder, population coverage per geography, population coverage per stakeholder, population coverage per project, target realisation)

ii. SUN-PMT tips and tricks

4. Next Steps and Preparation for Round 1 Data Collection (60 min)

Looking at the next steps in the mapping process in order to ensure round 1 goes smoothly

Step-by-step:

i. Typical steps to carry out data collection

ii. Stakeholders and dates of interviews

iii. Reviewing interview process, questions and hand-outs

iv. Setting up for practice / guided interviews

Wrap Up (15 min)

- Review of what done in the workshop and what trainees should now know
- Review of any issues that have come up during the training and any other final questions / comments

Training Schedule:

Monday 19th September 2016

Time	Session
9:00 – 9:15	Welcome and Introduction
9:15 - 9:45	1. Review of aims and process of Nutrition Stakeholder & Action Mapping
9:45 – 10:45	2. How to prepare for the Nutrition Stakeholder & Action Mapping – Data required
10:45 – 11:00	**Break**
11:00 – 12:00	3a. How to tailor the SUN-PMT to local needs
12:00 – 1:00	**Lunch Break**
1:00 – 3:00	3b. How to conduct data collection with stakeholders
3:00 – 3:15	**Break**
3:15 – 4:15	3c. Generating outputs from the SUN-PMT
4:15 – 5:15	4. Next steps and preparation for round 1 data collection
5:15 – 5:30	Wrap up

Annex Four: Data Collection Handout

Y/N	Action Category	Actions	Target Groups
	Infant & Young Child Feeding	1. Promote optimal breastfeeding practices (e.g. BFHI, BFCI)	Pregnant & lactating women, lactating women, adolescent girls 10-19 years
		2. Promote optimal complementary feeding practices including local food-based approaches	Mothers / caregivers
		3. Provide specialized formula for children with special needs	Children with special needs 0-11 months
		4. Support IYCF capacity building and tools	Doctors, nurses, health educators, community health workers, dieticians, pharmacists
	Micronutrients	5. Provide vitamin A supplements	Children 6-23 months, postpartum women
		6. Provide iron/folic acid supplements	Pregnant women
		7. Provide iron supplements	Children 6-23 months
		8. Provide calcium supplements	Pregnant women
		9. Carry out/support salt iodization	Producers, distributers, social marketers
	Disease Prevention & Management	10. Provide deworming tablets	Pregnant women, children 12-59 months, children 5-9 years
		11. Provide diarrhoea treatment with ORS, zinc / IV rehydration solution	Children 0-59 months
		12. Promote prevention of mother to child transfer of HIV (PMTCT)	Pregnant & lactating women 15-49 years with HIV
		13. Provide ARV medication	Pregnant & lactating women 15-49 years with HIV
		14. Provide specialized nutritious products in case of disease (Inborn Error of Metabolism – IEM, Coeliac, Autism and others)	Children 12-59 months with special needs
	Maternal, Neonatal & Child Health	15. Provide child health checks, including growth monitoring & promotion	Children 0-59 months, adolescent girls 10-19
		16. Promote ante-natal care visits (incl. counseling on optimal maternal nutrition practices)	Pregnant women
		17. Promote post-natal care visits	Post partum women
		18. Promote pre-pregnancy counseling	Married women of reproductive age 15-49 years
		19. Support feeding for prematurely born infants	Premature children 0-1 months
	Family Planning	20. Promote family planning, including optimized inter-pregnancy intervals	Married women of reproductive age 15-49 years, men
	Nutrition Education	21. Carry out nutrition education as part of school curricula (e.g. school gardens)	Kindergartens, Primary schools, Prep schools, Secondary schools
		22. Carry out nutrition education (e.g. cooking demonstrations, nutrition counseling, promote healthy dietary/lifestyle choices)	Mothers / caregivers
		23. Support training on nutrition communication strategies, tools and channels such as mass media and social media approaches	Doctors, nurses, health educators, community health workers, teachers, social workers
	WASH	24. Carry out hygiene education	Households
	Social Protection	25. Provide school feeding with adequate micronutrient levels	Kindergartens, primary schools
		26. Provide conditional social safety net actions (e.g. cash, voucher, food, other)	Pregnant women, children 0-59 months
	Nutrition Governance	27. Support capacity building for nutrition planning and coordination (national, provincial, district)	Middle management, first line management
		28. Support capacity building on nutrition M&E/ information systems	Middle management, first line management, statisticians

Delivery Mechanisms

Category	Delivery mechanism
Health system	☐ Hospitals/Clinics ☐ Health centers ☐ Midwives ☐ Health educators ☐ Community Health Workers ☐ Ministry/Governorate health officers ☐
Schools	☐ Kindergartens ☐ Primary schools ☐ Prep schools ☐ Secondary schools ☐
Community	☐ Community leaders ☐ Community based organisations ☐ Community outreach activities/ campaigns ☐ Women/Mother support groups ☐ Youth groups ☐
Mass campaigns	☐ Mass campaigns ☐

Category	Delivery mechanism
Media	☐ Radio ☐ TV ☐ Billboards ☐ Newspaper ☐ Text messages ☐ Internet / Social media ☐
Social services	☐ Social service offices ☐ Community health workers of Ministry of Social Solidarity ☐
Faith based	☐ Religious centers ☐
Private sector	☐ Producers ☐ Distributors ☐
Assistance organisations	☐ Micro-credit organizations ☐ NGOs ☐ UN agencies ☐

Definition of Stakeholder Roles & Key Terminology

Stakeholder Roles: Responsible Ministry / Department: The government organisation leading on the nutrition action

Field Implementer: Implementing the nutrition action, monitoring and evaluation, education, training, capacity building

Catalyst: Coordination/management, sub-contracting, technical support, development of programmes and policies

Donor: Funding of the nutrition action

Key Terminology: Nutrition action - Any specific activity which focuses on improving nutrition outcomes e.g. Vitamin A supplementation; Breastfeeding counseling

Nutrition specific action – address the immediate causes of malnutrition, like inadequate dietary intake and some of the underlying causes like feeding practices and access to food

Nutrition sensitive action - address some of the underlying and basic causes of malnutrition by incorporating nutrition goals and actions from a wide range of sectors such as WASH and social security

Target group / beneficiary – The persons that a specific nutrition action is aimed at

Delivery mechanisms – The way that the nutrition action is given to the target group e.g. Health workers; Hospital

Stakeholder – All organisations involved in implementing or supporting a nutrition action e.g. Government departments, bilateral/multilateral agencies, civil society, private sector

SUN-PMT – Scaling Up Nutrition Planning & Monitoring Tool – excel based tool used for data collection

REACH – Renewed Efforts Against Child Hunger (Developed the Nutrition Stakeholder & Action Mapping approach)

Annex Five: The Types of Data Collected for Stakeholder & Action Mapping

1. The actions being implemented / supported by the organisation
2. The start and end date of each action
3. The governorates/districts the actions are being implemented in
4. The target groups(s) that are being focused on
5. The number of the target group being reached in total during 2015 by governorate/district
6. The delivery channels being used to provide the action to the target group
7. The role/s of the organisation and other organisations involved

Annex Six: High Impact Evidence-based Direct Nutrition Interventions

World Bank, Scaling Up Nutrition: What will it Cost? Horton et.al. 2009

TABLE 1 Evidence Based Direct Interventions to Prevent and Treat Undernutrition

Promoting good nutritional practices ($2.9 billion):

- ❑ breastfeeding
- ❑ complementary feeding for infants after the age of six months
- ❑ improved hygiene practices including handwashing

Increasing intake of vitamins and minerals ($1.5 billion)

Provision of micronutrients for young children and their mothers:

- ❑ periodic Vitamin A supplements
- ❑ therapeutic zinc supplements for diarrhoea management
- ❑ multiple micronutrient powders
- ❑ de-worming drugs for children (to reduce losses of nutrients)
- ❑ iron-folic acid supplements for pregnant women to prevent and treat anaemia
- ❑ iodized oil capsules where iodized salt is unavailable

Provision of micronutrients through food fortification for all:

- ❑ salt iodization
- ❑ iron fortification of staple foods

Therapeutic feeding for malnourished children with special foods ($6.2 billion):

- ❑ prevention or treatment for moderate undernutrition
- ❑ treatment of severe undernutrition ("severe acute malnutrition") with ready-to-use therapeutic foods (RUTF).

Reference: Scaling Up Nutrition: What Will it Cost? Horton, et.al. 2009

The Lancet, Maternal & Child Nutrition 2, Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Bhutta et.al. 2013

	Cost
Salt iodisation	$68
Multiple micronutrient supplementation in pregnancy (includes iron-folate)	$472
Calcium supplementation in pregnancy	$1914
Energy-protein supplementation in pregnancy	$972
Vitamin A supplementation in childhood	$106
Zinc supplementation in childhood	$1182
Breastfeeding promotion	$653
Complementary feeding education	$269
Complementary food supplementation	$1359
SAM management	$2563
Total	$9559

Data are 2010 international dollars, millions.

Table 6: **Total additional annual cost of achieving 90% coverage with nutrition interventions, in 34 countries with more than 90% of the burden**

Annex Seven: Carrying Out the Stakeholder & Action Mapping on a Yearly Basis and Maintaining the Database

Key steps in carrying out the Stakeholder & Action Mapping on a yearly basis:
(Reference – REACH Stakeholder & Action Mapping Tool Training Guide)

Setting Up

a) Stakeholder & Action Mapping exercise team leader appointed:

1. Key roles include leading the process including supervising the data collection and taking the lead on data analysis and production of outputs

b) Reviewing and/or updating the key data required:

1. Key Nutrition Actions and related nutrition situation indicators
2. Key target groups for each nutrition action
3. Key delivery mechanisms
4. List of stakeholders and contact persons to interview
5. Population data for each target group

c) Setting the timeline:

A guide to the time needed to carry out each stage of the Stakeholder & Action Mapping

1. Setting up	1 – 2 weeks
2. Data collection	3 – 4 weeks
3. Data cleaning	1 – 2 weeks
4. Data analysis and production of outputs	1 – 2 weeks

Data Collection

a) Preparation for data collection

1. Selection and training of data collectors (2 – 4 teams of 2 persons) – ideally Government staff from each key ministry
2. Preparation of official letter to be sent to each identified stakeholder
3. Confirming of interview dates with each stakeholder

b) Carrying out data collection

1. Identified stakeholders interviewed by interview teams (laptops required)
2. Any required follow-up done by same teams for each interviewed stakeholder

c) Data cleaning

1. Collected data should be crosschecked for potential duplicate entries, specifically in terms of beneficiary numbers as well as other potential errors (number of beneficiaries covered, spelling issues, etc.).
2. Data should be amalgamated into a master version of the tool on a regular basis and rechecked – particularly for conflicting data

d) Data Analysis and production of outputs:

Basic data analysis can be mostly done using the available tool functions and focuses on the following areas:

1. Who does what and where
2. Geographic coverage of Key Nutrition Actions and stakeholders
3. Beneficiary coverage of Key Nutrition Actions and stakeholders
4. Delivery mechanisms used

Maintaining the Database:

Data Administrator

The Stakeholder & Action Mapping exercise team leader should also look after the database. One person should be in charge of the database in order to ensure data consistency. Ideally a second person would be available who understands the tool and the data it contains.

Data Handling

Data protection The data should be password protected and stored on a computer that is also password protected
Data retention: The data should be backed up on a regular basis when changes are made, using an external hard disk
Data access: Access to the data should be restricted to the team leader in normal circumstances. Protocols should be developed for sharing of the data when needed.

Data Requests

Between the yearly mappings, the database will require little attention except for when requests for data are received from stakeholders. Requests should be received by the team leader and processed by him/her.

Example requests from stakeholders are likely to be around the following:

1. Stakeholders currently working on a given Key Nutrition Action in a particular district or governorate
2. Information around a particular Key Nutrition Action in terms of current gaps

Such requests can be handled by producing set outputs using the available tool functions in the SUN-PMT Tool

Stakeholder & Action Mapping Key Considerations:

1. Each year, data collected should be added to the existing database – ideally data would be collected at the beginning of a year (to collect data for the year just ended)
2. The number of actions mapped should be kept to a minimum in order to ensure data is collected in a timely manner
3. Need to ensure the availability of mobile IT equipment for data collection
4. In the medium term, support is needed to build the capacity of the NNC Secretariat to oversee the Stakeholder & Action Mapping as well as provide technical support during the data collection
5. It is highly likely that a new web-based SUN-PMT will be available before the next round of mapping takes place which may require capacity building

Annex Eight: Definitions of Nutrition Sensitive Interventions

Document: SUN DONOR NETWORK - Methodology and Guidance Note to Track Global Investments in Nutrition (December 2013)

To be nutrition sensitive, the interventions must fulfil ALL the following criteria:
1. Aimed at Individuals: the actions must intend to improve nutrition for women or adolescent girls or children; AND
2. The project has a significant nutrition objective OR nutrition indicator(s); AND
3. The project must contribute to nutrition-sensitive outcomes, which are explicit in the project design through activities, indicators and specifically the expected results themselves.

Document: Guidance for the use of the Common Results Framework (CRF) Planning Tool (June 2015)

Types of nutrition sensitive interventions (more details provided in the document):
1. Food Security: availability; accessibility and supplementary feeding (resilience).
2. Care environment: Activities that improve the care environment for children as well as carers ability to adequately look after their children.
3. Health & WASH: This category has been split into four sub-categories: health; reproductive health; sanitation/hygiene, and water

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