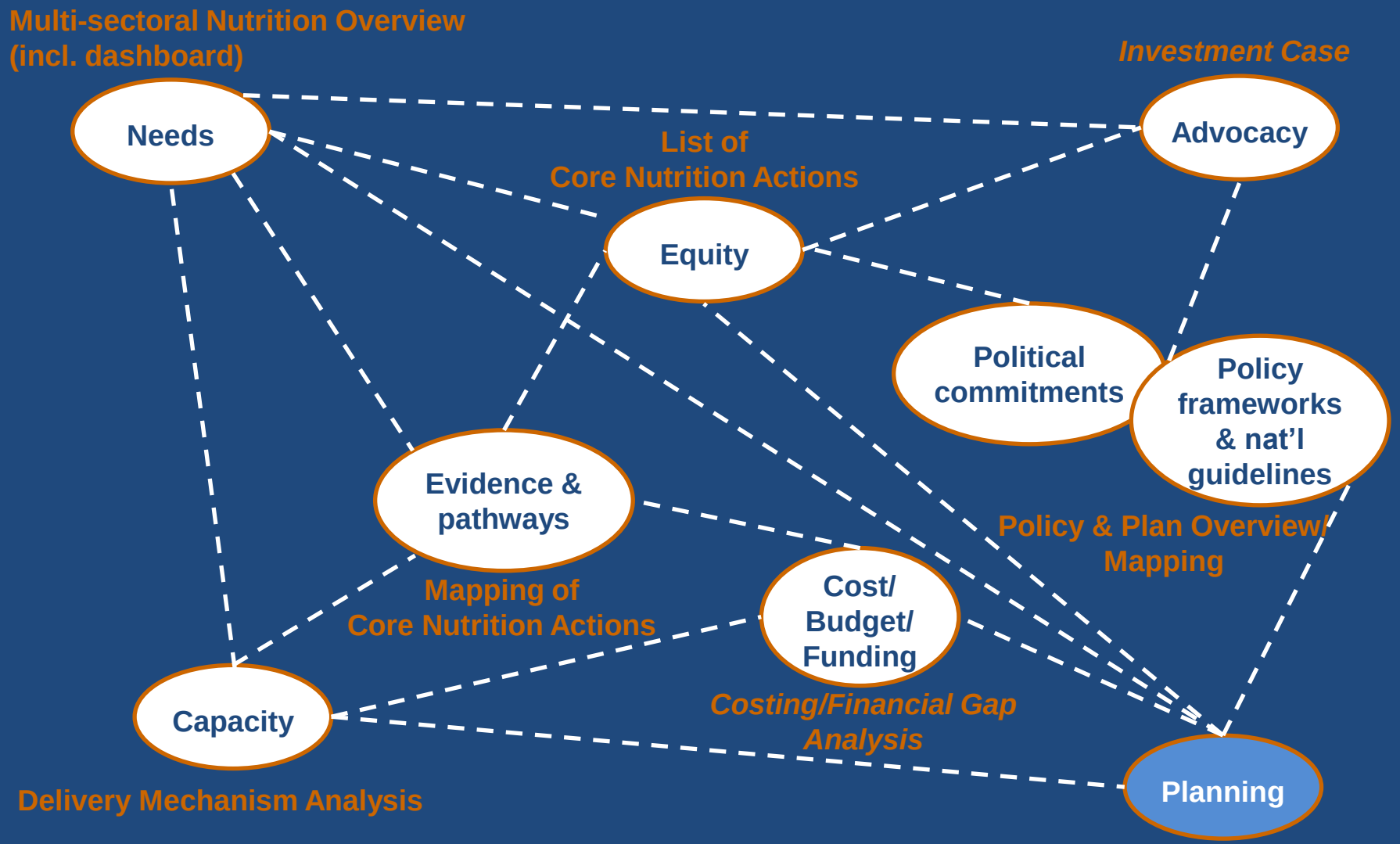
Connecting the dots: Key inputs for facilitating coherent and comprehensive nutrition planning

Insights from selected countries

October 2015

UN Nutrition

Connecting the dots…



Influencing factors for planning

REACH deliverables listed in orange text = inputs for planning

Other planning inputs listed in *orange italic* text

PREFACE

Many of the highlights included in this booklet
are emerging materials that have yet to be validated in-country.
They are profiled here in an effort to foster knowledge-sharing
about nutrition planning, an area of increasing interest
to countries and the wider nutrition community.

The process of establishing consensus among partners
is equally important as the outputs of the
analytical exercises featured in this booklet.

REACH[1] is an inter-agency partnership that promotes a country-led, multi-sectoral approach to addressing undernutrition

WHO?

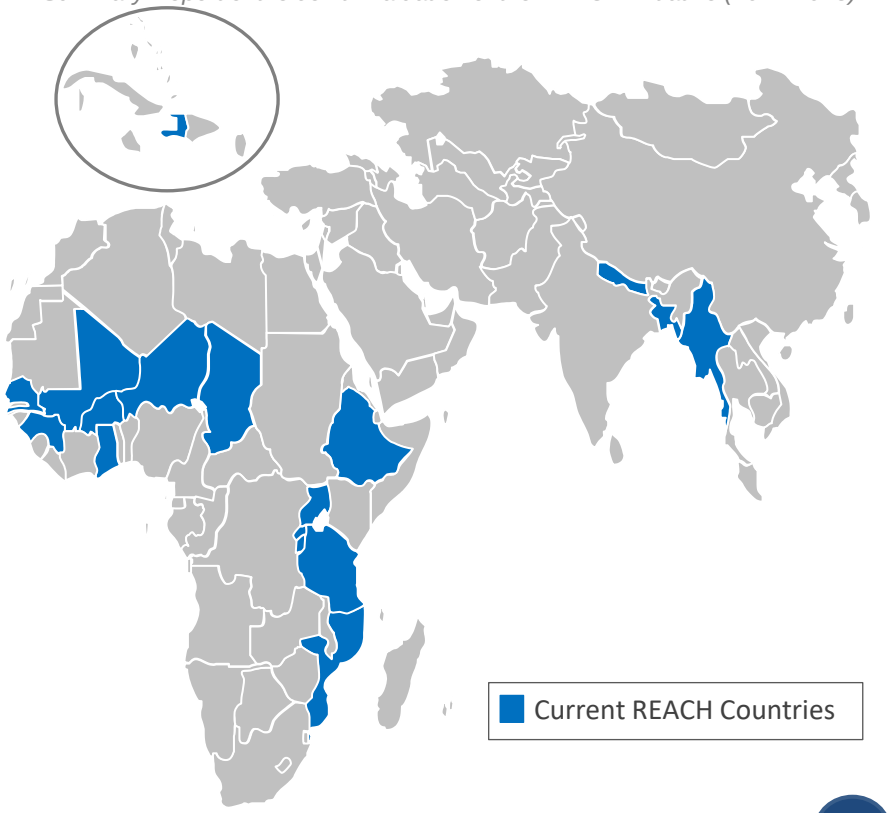
- Initiated by **FAO, WHO, UNICEF, WFP (plus IFAD)**
- **Collaborates** with UN agencies, NGOs, academia, private sector and donors
- **Supports SUN at country level** and is part of the UN Network for SUN
- Facilitates inter-agency collaboration and SUN processes at country level through **international + national facilitators**, who are…
- Supported by the REACH **Secretariat** in Rome

WHAT?

- A **country-led coordinated process** designed to improve **nutrition governance**
- A **multi-stakeholder, multi-sectoral approach** to tackling under-nutrition
- A **lever** for **management, capacity building and analytical excellence** to support inclusive country dialogue on nutrition
- Not an implementing agency!
- *Efforts are underway to develop a 5-year **strategy for REACH 2.0 (2016-2020)***

"a unique facilitating and catalytic function at the country level as a result of its neutrality, flexibility, quality of technical tools, links with national planning and priorities, and – in the opinion of many national stakeholders – its competent staff."

– Summary Report of the Joint Evaluation of the REACH Initiative (2011-2015)[2]



[1]REACH was absorbed by UN-Nutrition in 2021 in light of the new institutional arrangements for UN coordination on nutrition.
[2] WFP/EB.2/2015/6-C (2015)

Three levels of planning are undertaken for three different types of nutrition actions, including governance

Illustrative

3 Levels of Planning

- Formulation/updating of **national**, *multi-sectoral* nutrition action plan
- Integration of nutrition into relevant *sector* & sub-sector plans at **national** level
- Integration of nutrition into **sub-national**, *multi-sectoral* development plans (e.g. provincial, regional, district)

! Sometimes, planning processes are undertaken in parallel but not connected, hindering integrated approaches to nutrition.

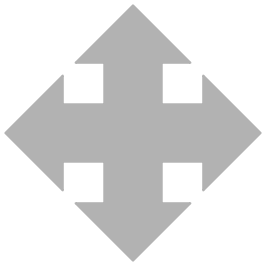
3 Levels of Nutrition Actions

- Nutrition-specific actions
- Nutrition-sensitive actions
- Nutrition governance actions (e.g. enabling political environment)

Facilitation support which links national and sub-national planning streams is key to fostering coherent and joint action

Illustrative

National planning efforts	Sub-national planning efforts
National Multi-sectoral Nutrition Plan	Provincial/Regional multi-sectoral, development plans
National sector plans related to nutrition	Department multi-sectoral development plans
National sub-sector plans related to nutrition	Community multi-sector development plans



Multi-sectoral plans

Sector or sub-sector plans

A number of actors and institutions engage in nutrition planning, including the Ministries of Finance and Planning, where possible

Illustrative

Actor	Role	Examples
Decision / Policy-makers	• To provide high-level political support • To serve as nutrition champions • To help generate commitment from mid-level officials, decision-makers & implementers at sub-national levels	• *Rwanda*: District managers signed a performance contract with the **President** that will meet targets stipulated by the district plans • *Ghana*: Ministers of Finance & Planning
Technical specialists	• To sensitize decision-makers & local politicians to ensure nutrition is a priority • To provide technical guidance & leverage evidence • To provide insight on delivery capacity • To collect & track programing data • To track financial data	• *Mali*: **Gov't officials** from 6 **ministries** & 29 **governmental technical services** participated in planning workshops that informed the development of the Multisectoral Action Plan • *Tanzania*: Gov't officials at Tanzania Food & Nutrition Centre • *Ghana*: **National Statistical Service** • *Ghana*: **Cross-sectoral planning groups** • *Generic:* **Government Budget Officers**
Collaboration Platforms	• To shape policy/provide strategic direction • To support multi-sectoral coordination • To support implementation & advise high-level platforms	• *Multiple countries:* **High-level collaboration platforms** • *Mozambique & Nepal:* **Nutrition Secretariats** • *Multiple countries:* **Working/Technical level**
Sub-national authorities / Development Committees	• To reconcile local development plans/priorities with national plans/priorities	• *Ghana*: **Regional/Provincial Managers & Regional Planning & Coordination Units** • *Mozambique*: **District Development Committees** • *Generic:* **Area councils & communities**
Local stakeholders	• To share their perceptions of nutrition problems & local priorities • To participate in joint-assessments • To demand support for nutrition actions	• *Ghana*: **Women's groups** • *Generic:* **Civil society** • *Generic:* **Community groups**

While there are milestones for nutrition planning, the process is often iterative so as to ensure relevance

Illustrative

Main steps for nutrition planning

1. **Sensitize actors about the need to invest in nutrition**
   - Communicate the consequences – social & economic – associated with malnutrition
1. **Identify the objectives (generic & specific)**
   - Refresh understanding of the main nutrition problems in the area
2. **Identify and prioritize the planned actions & activities**
   - Severity of the problem (prevalence, absolute numbers, etc.)
   - Recent trends (improvement, deterioration, status quo)
   - Coverage (which actions have low coverage?)
3. **Identify implementation strategies for providing those actions & activities**
   - Identify target groups (primary & secondary target groups)
   - Identify delivery mechanisms through which actions & activities will be provided
4. **Assign responsibilities (develop responsibility/action matrix)**
   - Determine which stakeholders will conduct the identified actions & activities, through which delivery mechanisms
   - Identify the role of each stakeholder involved by action (e.g. lead, technical support, coordinator, M&E including at the local level)
5. **Identify indicators & coverage targets**
   - Outcome indicators
   - Output indicators
   - Coverage (current & time-specific targets)
6. **Determine budgetary allocations of nutrition actions & activities**
   - Quantify resources[1] needed to implement actions & activities
   - Solicit &/or advocate for the creation of nutrition budgetary codes
   - Identify the financial source (internal/external) of actions & activities
7. **Identify timeframe (timing & duration) of planned nutrition actions & activities**
   - Identify the duration of planned nutrition actions & activities
   - Determine the timing & sequencing of planned nutrition actions & activities

Leverage learning opportunities from planning exercises & refine related guidance, national policy, sector planning, etc.

[1]Refer to MQ-SUN costing data, WHO's ONE Health tool or other costing methodologies, as needed.

Making the investment case can enrich planning and help mobilize actors; Malnutrition is preventable, and yet it continues to hinder development and claim human lives

Some adverse effects on human health & well-being are irreversible

	Social costs	Uganda	Global or other countries
1	Child mortality in terms of add'l cases due to underweight	15%[1]	n.a.
2	Disability-adjusted life years (DALYs) for under5s	n.a.	21%[3]
3	Reduced IQ (breastfeeding can raise IQ)	n.a.	3 pts[2]
4	Congenital abnormalities e.g. cretinsim	n.a.	n.a.
5	Increased risk of degenerative diseases (e.g. Diabetes)[4,5]	n.a.	n.a.
6	Lower educational outcomes than non-stunted children	1.2 yrs. less schooling[1]	0.2-1.2 yrs. less schooling[1]
7	Repetitions in school due to stunting	7.3%[1]	7-16%[1]

Economic consequences are incurred at individual, household & society levels

	Economic costs	Uganda	Global or other countries
1	Annual losses in million of USD due to child undernutrition	USD 899[1]	n.a.[2]
2	% of GNP lost annually due to child undernutrition	5.6%[1]	1.9-16.5%[1]
3	Reduced productivity due to a 1% loss in adult height due to stunting	n.a.	1.4%[7]
4	Reduced hourly adult wages due to child stunting[6]	n.a.	20% less[7]
5	Income increases associated with breastfeeding >12 mo.	n.a.	33%[8]
6	Other?	?	?

n.a. = not available

DRAFT

Nutrition is a human right[9] and is central to sustainable development

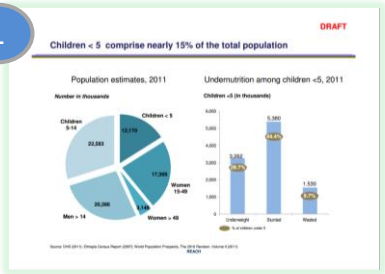
[1]AU Commission, NEPAD Planning & Coordinating Agency, UN Economic Commission for Africa & WFP (2013) / [2]Black et al. (2013) / [3]Black et al. (2008) / [4]UNICEF (2013) / [5]Horta el al. (2013) / [6]Hoddinott et al. (2013) / [7]World Bank (2006) / [8]Victora et al. (2015) / [9]Convention on the Rights of the Child Art. 27(3)

REACH analytical tools and knowledge-sharing resources are used to inform planning processes and scale up discussions

Illustrative

Multi-sectoral Nutrition Overview (MNO)

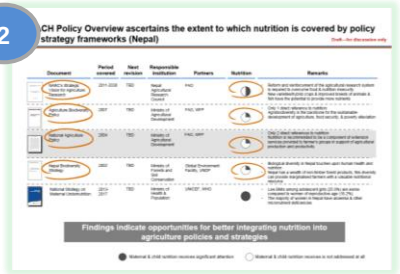
1



- Identification of nutrition problems at nat'l & sub-nat'l levels
- Identification of nutrition trends over time
- Identification of vulnerable groups

Policy & Plan Overview[1] PPO

2



- Overview of political priorities
- Overview of extent to which nutrition is reflected in policies/strategies/plans
- Identification of opportunities for multi-sector coordination

Stakeholder & Nutrition Action Mapping[1]

3

- View of implementation of key nutrition actions
- Identification of gaps in coverage
- Understanding of delivery mechanisms

4 Compendium of Actions for Nutrition (CAN)

Planning processes & scale up discussions

[1]The selection of the Core Nutrition Actions is another REACH deliverable and is a prerequisite for both the Policy & Plan Overview and the Nutrition Stakeholders & Action Mapping.

Recap on the nutrition situation in the two regions of Uganda, where REACH and WHO (ANI project) are working together

Excerpt from the Uganda Situation Analysis Dashboards

		Indicator	Status National	Trend	Sev-erity	Target 2016	Status Western	Status Eastern
Nutritional Impact	**Stunting**	Prevalence of stunting among children <5 years old	**33%**	↗	🔴	32%	44%	25%
	Wasting	Prevalence of wasting among children <5 years old	**5%**	↗	🟡	N/A	3%	5%
	Underweight	Prevalence of underweight among children <5 years old	**14%**	↗		10%	16%	10%
		Prevalence of underweight among non-pregnant women 15-49 years old (with BMI < 18.5 kg/m2)	**12%**	↗		8%	8%	20%
	Iron deficiency	Prevalence of anaemia among children <5 years old	**49%**	↗	🔴	50%	39%	55%
		Prevalence of anaemia among women 15-49 years old	**23%**	↗	🟡	30%	17%	28%
Underlying Causes	**Food Security**	Percentage of households with poor or borderline food consumption	**20%**	↗		N/A	18%	24%
	Health	Percentage of newborns weighing <2.5 kg at birth	**10%**	↗		9%	8%	7%
	Care	Percentage of infants exclusively breastfed to age 6 months	**63%**	↗		75%	???	???
		Prevalence of diarrhoea among children 6-59 months old	**23%**	↗		N/A	19%	33%
Basic Causes	**Education**	Female literacy rate	**64%**	↗		N/A	63%	49%
	Gender	Women's intra-household decision-making power	**37%**	N/A		N/A	37%	26%

Note: Statistics presented in red are above the established targets, whereas those presented in green are below such targets.
Sources: DHS (2011 & 2006) / CFSVA (2013 & 2009)

Situation Analysis Dashboard – National level
Gender-sensitive view highlights data gaps

Excerpt from the Rwanda MNO Dashboards

Severity: Low · Medium · High

Trend: Improvement · No change · Worsening

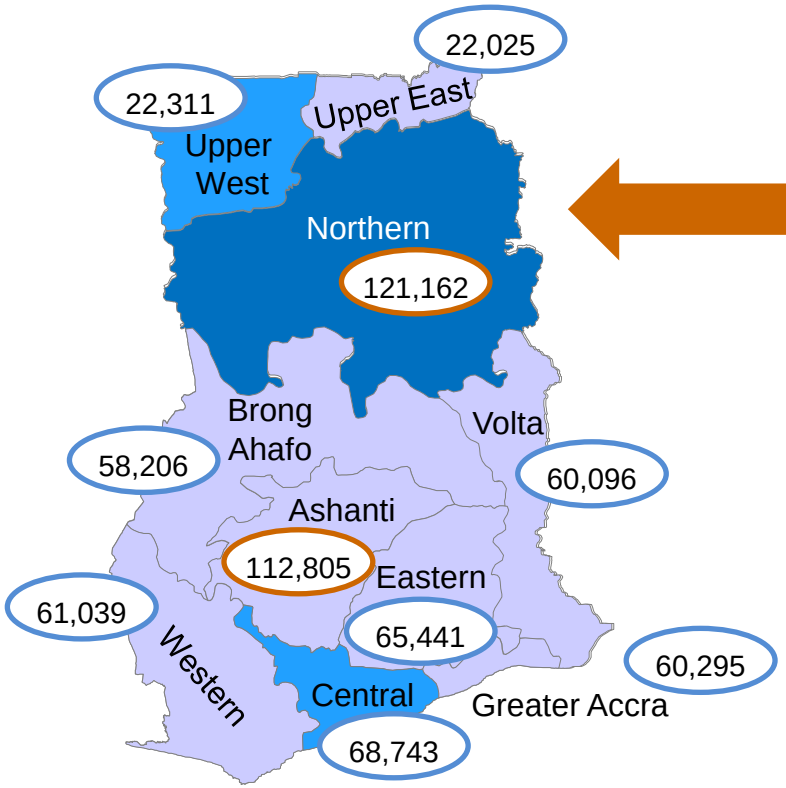
		Indicator	Status	Female	Severity	Trend	Male	Severity	Trend
Nutritional impact	Stunting	Stunting prevalence among children 0-59 mo. old[1]	37.9%	32.9%	high	↗ 41.1%	42.7%	high	↗ 47.4%
	Wasting	GAM prevalence among children 0-59 mo. old[1]	2.2%	2.0%	low	↗ 2.4%	2.4%	low	↗ 3.3%
		SAM prevalence among children 0-59 mo. old[1]	0.6%	0.3%	medium	↗ 0.6%	0.9%	medium	↗ 1.0%
	Underweight	Underweight prevalence among children 0-59 mo. old[1]	9.3%	9.3%	low	↗ 10.2%	9.3%	low	↗ 12.7%
	Iron deficiency	Anemia among children 6-59 mo. old (any anemia) [1]	36.5%	35.8%	medium	↘ 35.0%	37.3%	medium	↗ 41.2%
		Anemia among women 15-49 yrs old (any anemia) [1]	19.2%	19.2%	medium	↘ 17.3%			
	Vit A deficiency	Vitamin A deficiency among children 0-59 mo. old	N/A						
	Iodine deficiency	Iodine deficiency among children 6-12 years old	N/A						
Underlying causes	Food security	Households with poor & borderline food cons. score[2] Global Hunger Index rating[3]	21.1% 15.6						
	Health & Sanitation	Under 5 mortality rate (deaths per 1,000 live births) [1] Low birthweight prevalence (<2,500g) [1] Women 15-49 yrs w/ problems accessing health care[1] Household access to improved water source[4] Household access to improved sanitation facilities[4]	50 X.x% Xx.x% 84.8% 83.4%	XX	high na	97 61.4%	XX	high na	107
	Care	Households with handwashing facility, soap & water*	Xx.x%						
		Infants 0–5 mo. exclusively breastfed[1] Timely initiation of solid or semi-solid foods (6-8 mo.) [1]	87.3% 55.8%						
		Children 6-23 mo. old w/ min acceptable diet (MAD) [1]	17.8%	Xx.x%	na	16.6%	Xx.x%	na	17.1%
Basic causes	Education	Individuals that completed primary school or higher[1] Literacy rate 15 years or more[4]	Xx.x% 72.1%	Xx.x% 67.6%	na na	30.1% ↗ 64.5%	Xx.x% 77.3%	na na	33.4% ↗ 75.7%
	Population	Total fertility rate[1] Percentage with unmet need for family planning[1]	4.2 18.9%	4.2	na	↗ 4.6			
	Gender	Teenage pregnancy: women 15-19 with a live birth[1] Women who participate in major household decisions[1] Global Gender Gap ranking[5]	5.5% Xx.x% 7 / 142	5.5% Xx.x%	na na	↘ 4.7% 58.7%			
	Poverty	Population living under national poverty line[4] Population living in extreme poverty (national line)[4]	39.1% 16.3%						

[1]DHS (2014/15 & 2010) / [2]CFSVA (2012) / [3]GHI (2014) / [4]EICV (2013/14 & 2010/11) / [5]GGGI (2014)

Note: Missing information to be updated as soon as the full Rwanda DHS 2014/15 is released. Data reported in the trends column refers to the previous data for the given indicator.

Emphasizing the need to consider both prevalence and absolute numbers, by region, to inform planning and prioritization exercises

Excerpt from the Ghana MNO



Stunting prevalence among <5s

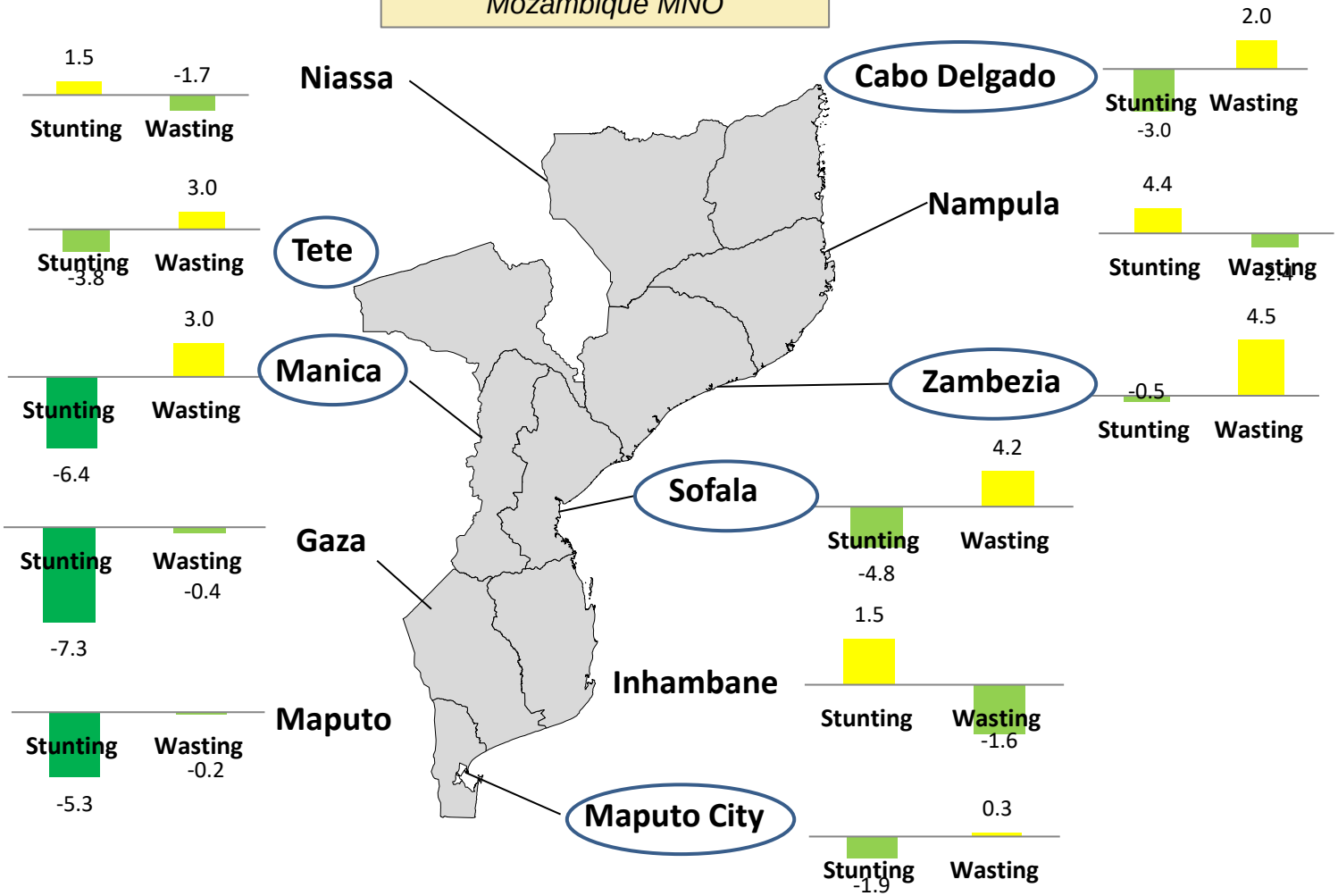
- ≥ 40%
- 30-39.9%
- 20-29.9%
- < 20%
- xx,xxx Absolute number of stunted children

- The Northern region is most adversely affected by stunting, with the highest prevalence (33.1%) & absolute numbers of stunted children
- A large number of stunted children also reside in the Ashanti region, where the prevalence of stunting is low
- The other 2 regions with an elevated prevalence of stunting - Central (22.0%) & Upper West (22.2%) do not have high numbers of stunted children

Source: DHS (2014) / 2010 Population and Housing Census (Ghana Statistical Service, May 2013)

Comparing changes in stunting and wasting prevalences to identify converging/diverging trends to ensure appropriate action is planned

Excerpt from the Mozambique MNO



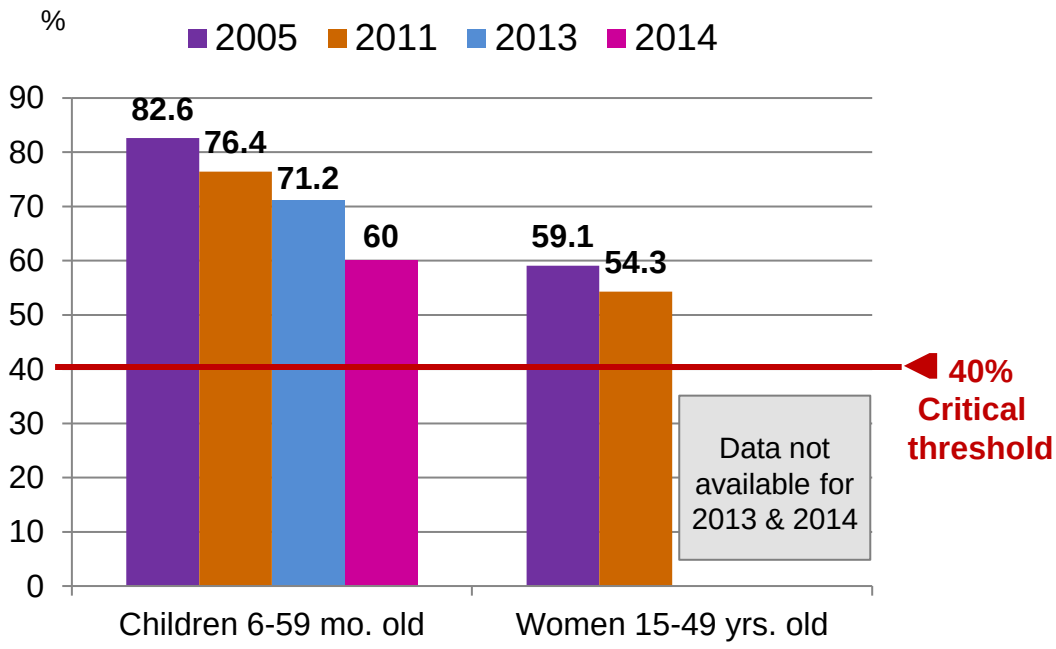
Provinces where stunting has declined but wasting has increased

Source: MICS (2008) / DHS (2011)

Anaemia among both women and children remains a public health problem despite the continuous declines observed from 2005 to 2014, warranting further action

Excerpt from the Senegal MNO

The vast majority of children ages 6-59 months are anaemic



Consequences:

- Reduced immunity
- Increased risk of maternal and perinatal mortality
- Intrauterine growth retardation
- Premature births
- Reduced cognitive and psychomotor development
- Reduced ability to concentrate/ scholastic performance
- Fatigue, reduced physical capacity/ activity levels

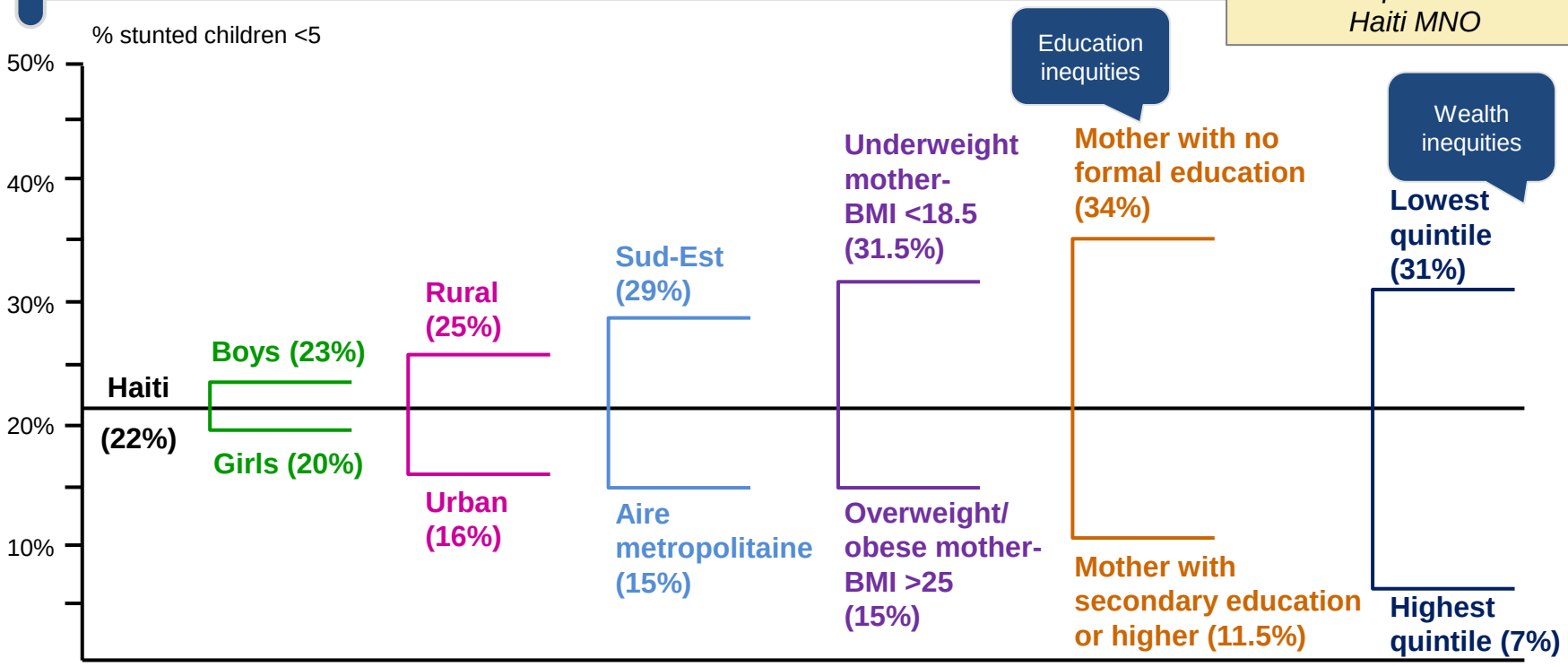
Assessment:

- Anaemia is a proxy for iron deficiency
- Measuring *haemoglobin levels in the blood* is the most common biochemical indicator with different cut-offs established for different sub-groups and environmental factors (e.g. altitude)

Source: EDS (2005, 2011 & 2013)

Maternal education and household wealth are the main factors driving inequities for chronic malnutrition in Haiti

Excerpt from the Haiti MNO

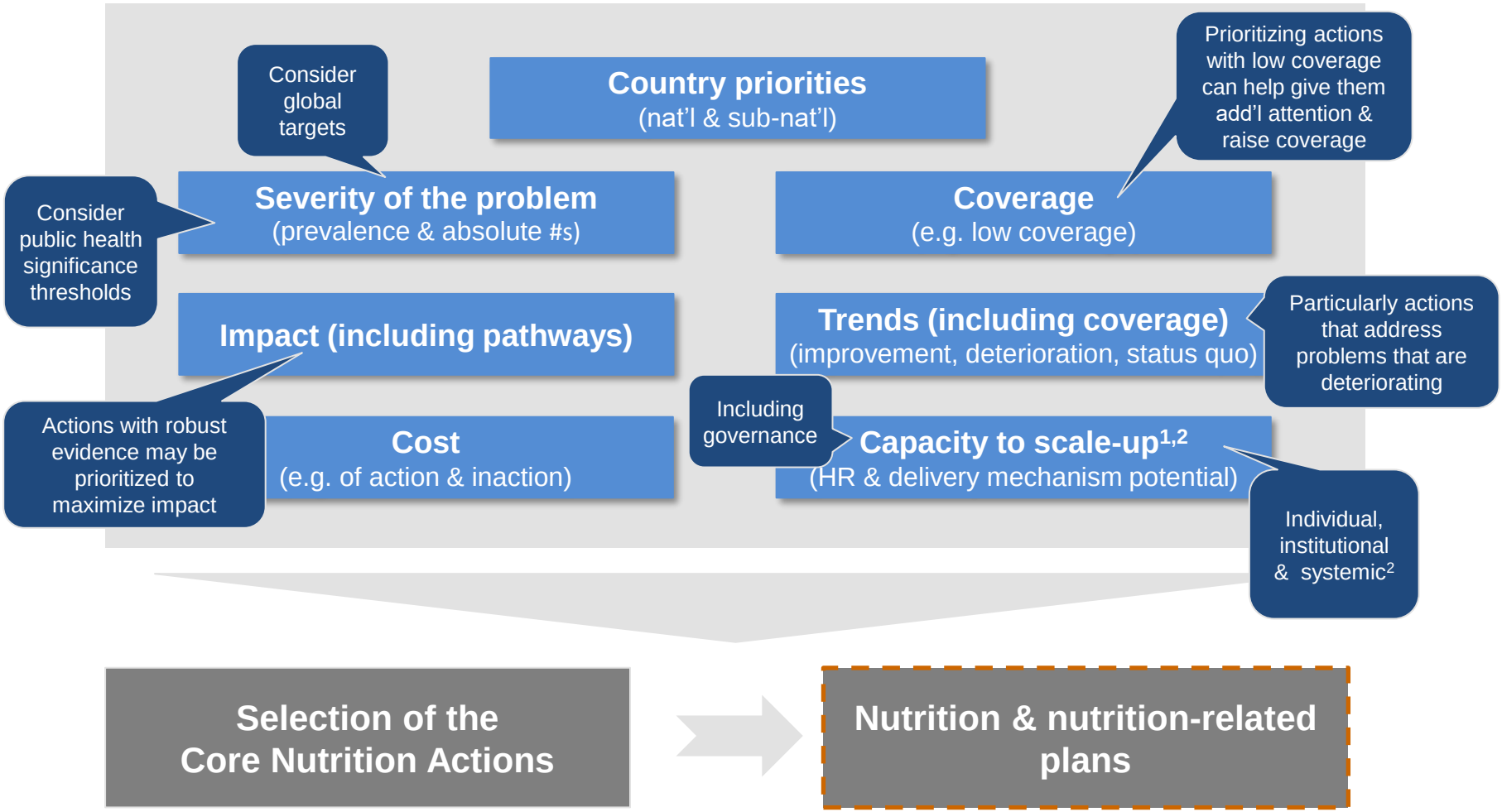


Source: EMMUS V (DHS 2012)

- A child whose parents belong to the lowest wealth quintile is **4.4 times more likely** to be stunted than a child whose parents are in the highest wealth quintile.
- A child whose mother has not received any formal education is **nearly 3 times more likely** to be stunted than a child whose mother received a secondary education or higher.
- Other factors that significantly impact the inequities of stunting are mother's weight and the geographical location. Gender and urban/rural divides have a much lower impact.

The selection of core nutrition actions is context-specific and is driven by a series of factors, leveraging technical expertise

Illustrative



[1]Adapted from REACH Ghana (2014)
[2]Gillespie S., Menon P. & Kennedy A. (2015)

Highlighting how nutrition is reflected in related national policy/strategy frameworks when formulating nutrition plans, including at sub-national levels, to support scale-up

Excerpt from the Mozambique PPO

Document	Period covered	Next revision	Responsible institution	Partners	Nutrition	Remarks
 AGENDA 2025	2003-25	2025	National Council	UNDP, African Futures, Universities		• Recognizes malnutrition as a threat to development • Recognizes the need for human resources trained in nutrition • Emphasizes the need to improve food security
 National Development Strategy (NDS)	2015-35	2035	Ministry of Econ. & Finance	None		• Chronic malnutrition said to be high • Recognizes nutrition as key for improving health • Food security is prioritized in agricultural actions • Promotes fisheries & aquaculture • Promotes investments in infrastructure & sanitation
 Food & Nutrition Security Strategy (FNSS)	2008-15	**2015**	Ministry of Agriculture & Food Security	UNICEF, WFP		• Chronic malnutrition mentioned as a threat, reducing the country's productivity by 2-3% of GDP • Strategic pillars of the strategy: food production (availability), access, utilization, adequacy (incl. quality) & stability • Mentions the need for a multi-sectoral approach
 Agricultural Sector Development Strategy (ASDSP)[1]	2011-20	2020	Ministry of Agriculture & Food Security	None		• Malnutrition is *not* clearly recognized as problem • Mentions agriculture as essential for food & nutrition security
 Family Planning & Contraception Strategy (FPCS)	2010-20	**2020**	Ministry of Health	UNFPA		• Malnutrition is *not* explicitly recognized as a problem • Family planning is recognized to have a vital role in child nutrition & in combating the development of infectious diseases

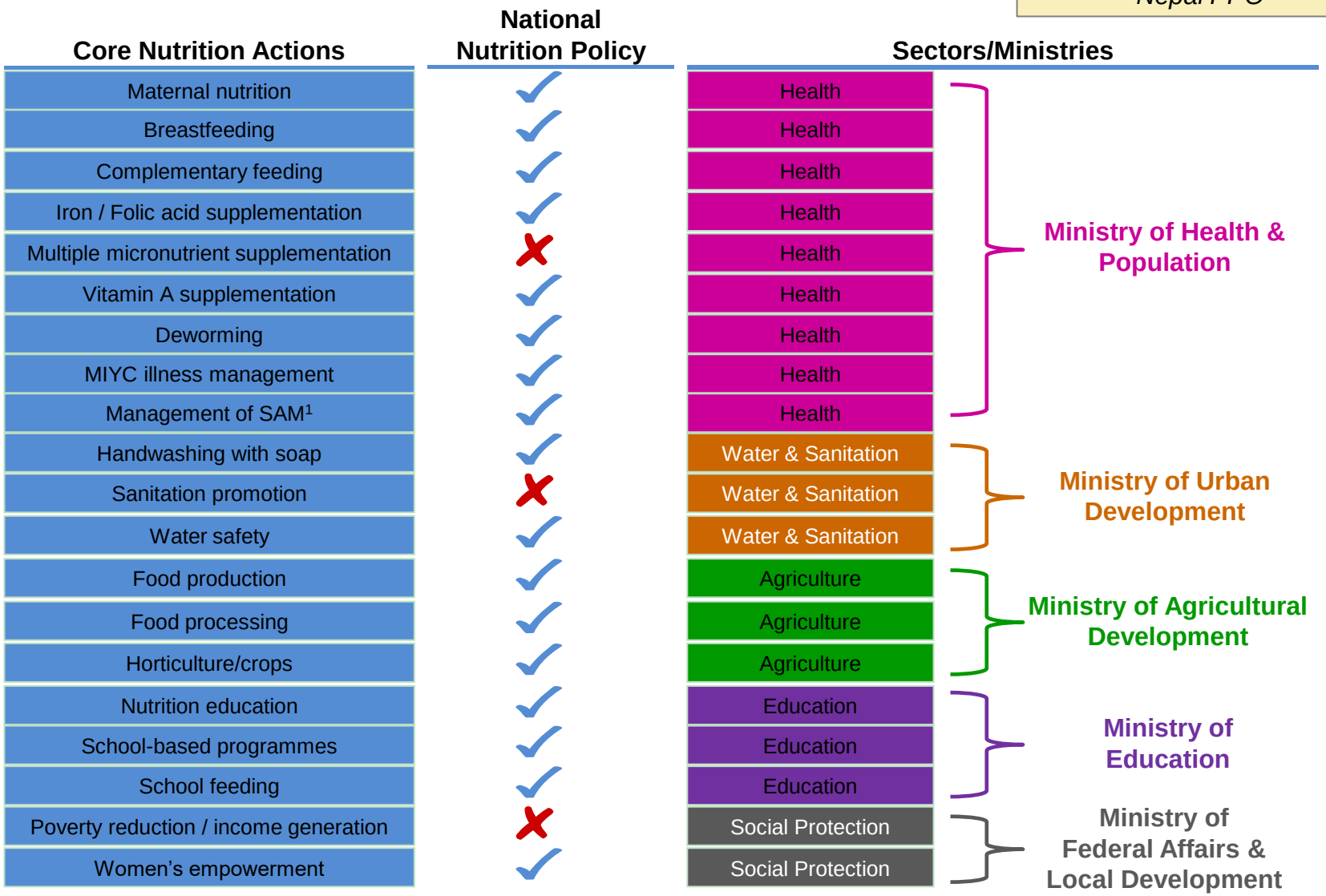
Understanding how nutrition supports wider development can help sensitize actors about how nutrition is relevant to multi-sectoral, sector/sub-sector & sub-national planning

● Maternal & child nutrition receives significant attention ○ Maternal & child nutrition is not addressed at all

[1]While this document is called a strategic plan, country actors consider it to serve as a strategy, and thus it is classified with the strategies on this slide.

Efforts taken to ensure that core nutrition actions omitted from the national nutrition policy/strategy are included in nutrition-related plans, including the national nutrition plan

Excerpt from the Nepal PPO

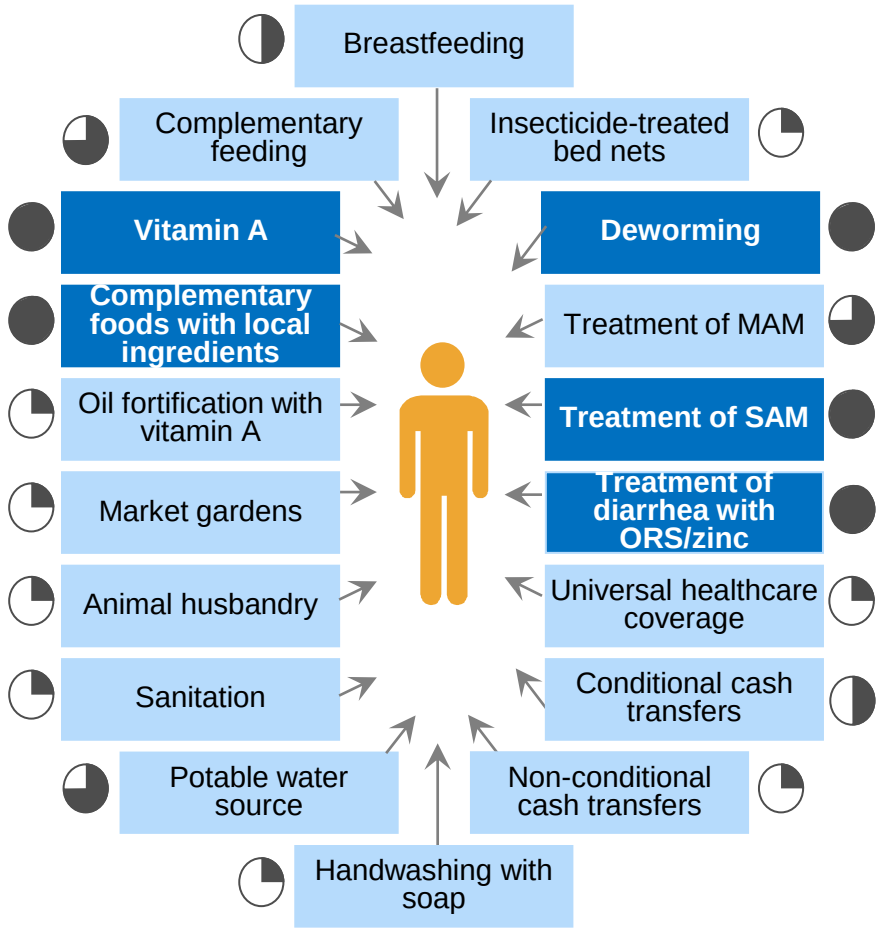


[1]SAM = Severe acute malnutrition

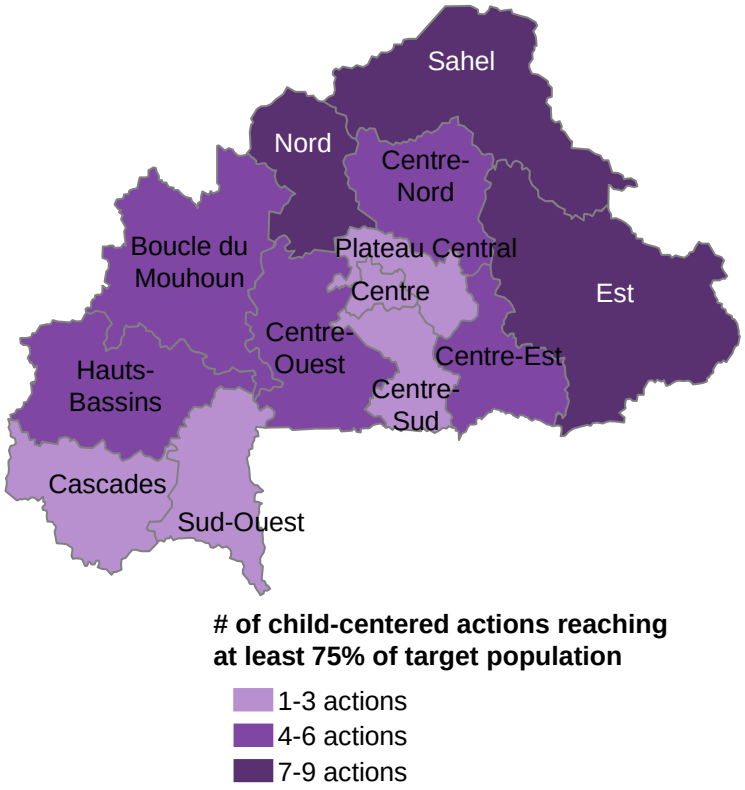
Planning can take into account mapping data, which indicated that most actions are implemented in all regions of Burkina Faso, though many actions only reach a few children

Excerpt from the Burkina Faso Nutrition Stakeholder & Action Mapping

A typical child in Burkina Faso received only ~5 nutrition actions[1] that he/she may need



On average children in the Nord, Sahel and Est regions received more nutrition interventions than elsewhere



[1]The nutrition actions depicted on this page refer to a subset of the core nutrition actions in Burkina Faso.

Framing the main nutrition problems according to their consequences and the applicable objectives of the National Nutrition Plan can help define the vision/goal of sub-national nutrition planning

Adapted from the work-in-progress Myanmar MNO

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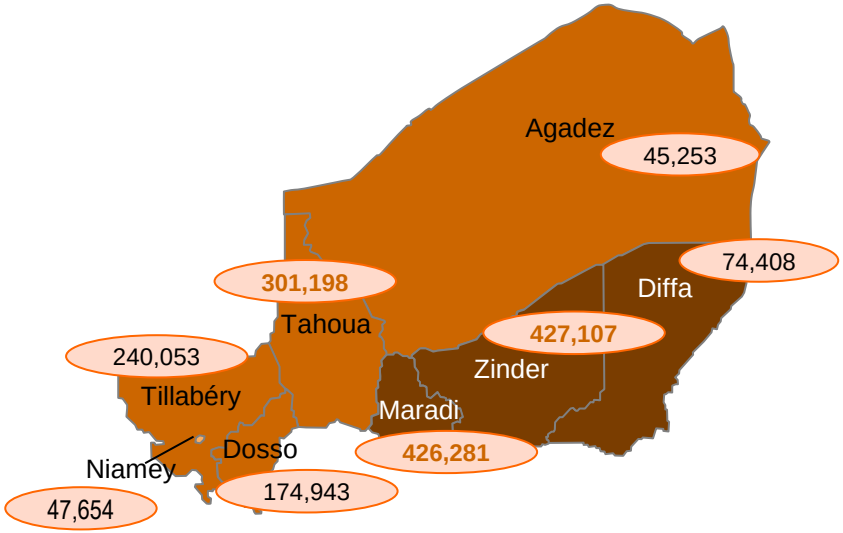
	Main nutrition / nutrition-related problems	Consequences	Alignment to nat'l nutrition plan	Status
Nutritional impact	**Chronic malnutrition (stunting)** (% children under 5 years old)	Reduced cognitive & physical development[1]; years of schooling[2], hourly wages[3] & productivity[4]; increased risk of NCDs[5]; GDP losses[2,4], etc.	All Strategic Objectives (SOs)	47.8%[10]
Nutritional impact	**Acute malnutrition (wasting)** (% children under 5 years old)	Increased risk for morbidity (illness & disease), child mortality[6,7], etc.	All Strategic Objectives (SOs)	10.0%[10]
Underlying causes	**Food insecurity** (% households with poor or borderline food consumption)	Increased risk of acute & chronic malnutrition; increased risk of micronutrient deficiencies which can impair immunity; sale of productive assets/resources; destitution; etc.	SO 1.1; SOs 2.3-2.6	Not available
Underlying causes	**Sub-optimal care practices** (% infants 0-5 months that are exclusively breastfed)	Increased risk of stunting[6,8], child morbidity & mortality[1,6], adulthood obesity & selected NCDs[9] & transmission of HIV[6]; reduced immunity & IQ[1], etc.	SO 2.5	23.6%[10]
Underlying causes	**Limited access to health services & poor health environment** (Under-five mortality rate)	Loss of life during childhood; reduced workforce, etc.	SO 1.2	46.1/ 1000[10]
Basic causes	**Basic causes** (Population living under the poverty line)	Increased vulnerability to food insecurity; limited access to health services; increased risk of dropping out of school; etc.	SO 4,6 & 10	26%[11]

[1]Black et al. (2013) / [2]AU Commission, NEPAD Planning & Coordinating Agency, UN Economic Commission for Africa & WFP (2013) / [3]Hoddinott et al. (2013) / [4]World Bank (2006) / [5]UNICEF (2013) / [6]WHO (2013) / [7]WFP (2012) / [8]Bhutta et al. (2013) / [9]Horta el al. (2013) / [10]MICS3 (2009-10) / [11]Integrated Household Living Conditions Assessment (2011)

REACH analytical support can help ensure that the regions most adversely affected by stunting and low coverage are prioritized through planning exercises

Excerpt from the Niger MNO & Nutrition Stakeholder & Action Mapping

Prevalence of stunting is highest in the Zinder, Maradi and Diffa regions, however the absolute number of children affected is relatively lower in Diffa



% of stunting among children 0-59 months[1]

- 20% - 29%
- 30% - 39%
- ≥40%
- Absolute number of stunted children[2]

Very few core nutrition actions are reaching 75% or more of the target populations, with scope to scale-up further

# of actions reaching at least 75% of target population

- 2 actions
- 3 actions
- 4 actions et plus

Planning efforts should pay particular attention to Maradi where stunting is highly prevalent & coverage very low

[1]DHS (2012) / [2]DHS (2012), INS

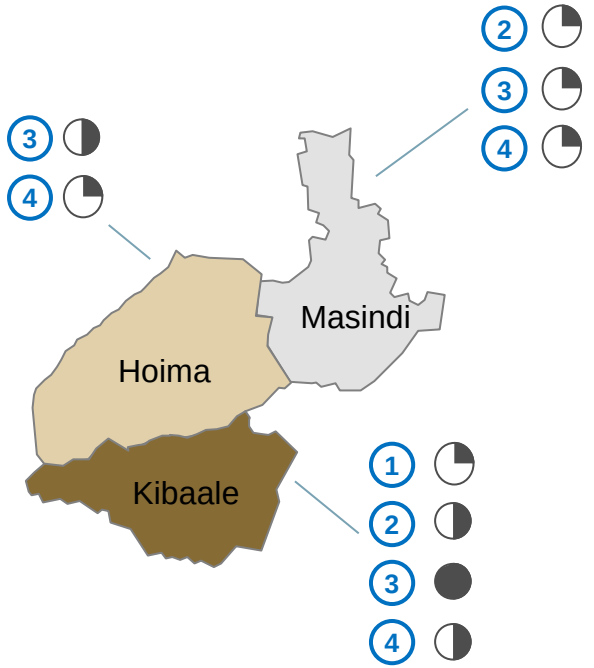
Knowledge about coverage shortfalls can enrich planning discussions: How are the 3 ANI Project districts in the Western region of Uganda performing on actions addressing anaemia among children?

Excerpt from the Uganda Nutrition Stakeholder & Action Mapping

4 actions addressing child[1] anaemia
Regional level of child anemia at 39%

	Related country relevant actions	Target groups	% Population coverage		
			Hoima	Kibaale	Masindi
1	**Provide insecticide treated bed nets**	Children 0-59 months	N/A	**9%**	N/A
2	**Provide deworming tablets**	Children 6-59 months	N/A	**31%**	**<1%**
3	**Provide materials for small-scale horticulture / crop diversification**	Smallholder farmer households	**40%**	**86%**	**4%**
4	**Provide livestock, poultry or fish for small-scale animal husbandry or aquaculture**	Smallholder farmer households	**11%**	**34%**	**1%**

There is limited population coverage of actions addressing anaemia among children
particularly in Hoima and Masindi



Number of actions reaching at least 30% of target population

0 actions | 1 action | 2 actions | 3 actions | 4 actions

% of target group covered

≤25% | >25% to 50% | >50% to 75% | >75%

[1]Children 0-59 months old

The pervasive low coverage of interventions supporting household food security requires close attention in nutrition planning exercises

Excerpt from the Senegal Nutrition Stakeholder & Action Mapping

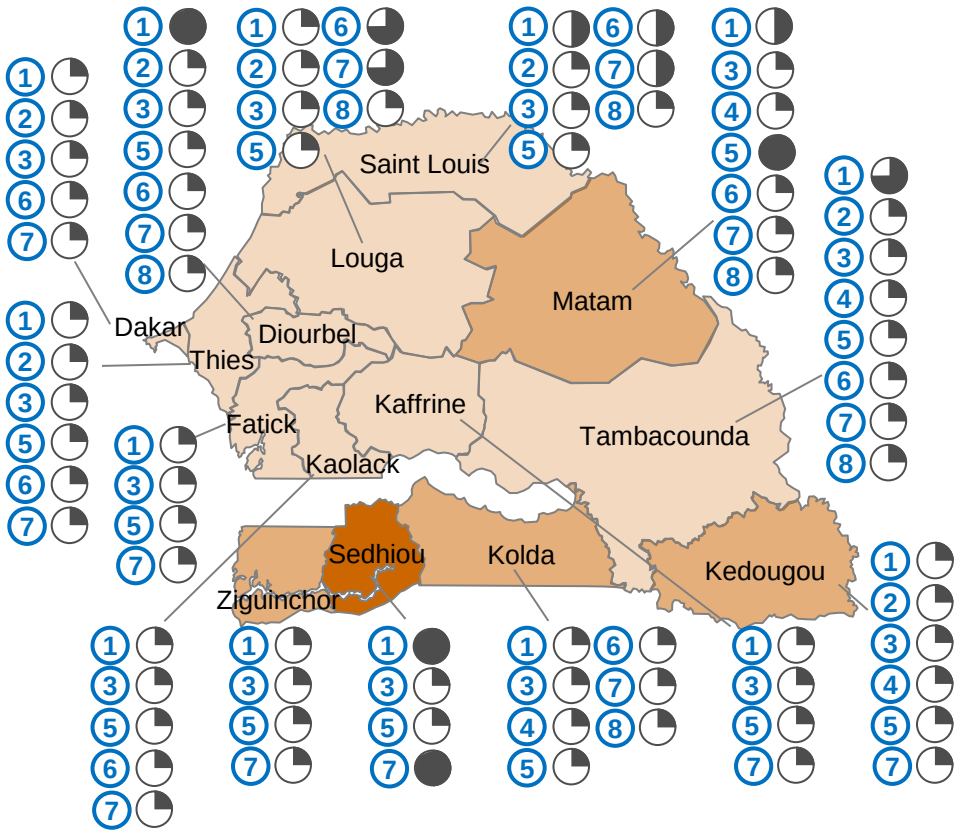
8 actions mapped support the prevention of food insecurity

	Core Nutrition Actions	Target Groups (TG)	% of TG covered
1	Household food fortification	Children 6-23 months	
2	Small-scale food fortification	Children 6-59 months	
3	Development of small-scale farming	Households	
4	Biofortification	Households	
5	Social safety net program	Households	
6	Nutrition education	Mothers & guardians	
7	Key behaviours conducive to good nutrition	Mothers & guardians	
8	Functional Literacy Program	Women 15-49 years	

% of target group covered

≤25% >25% to 50% >50% to 75% >75%

Despite the implementation of actions in many regions, only a small percent of the target groups are reached



% of households who have moderate or severe food insecurity[1]

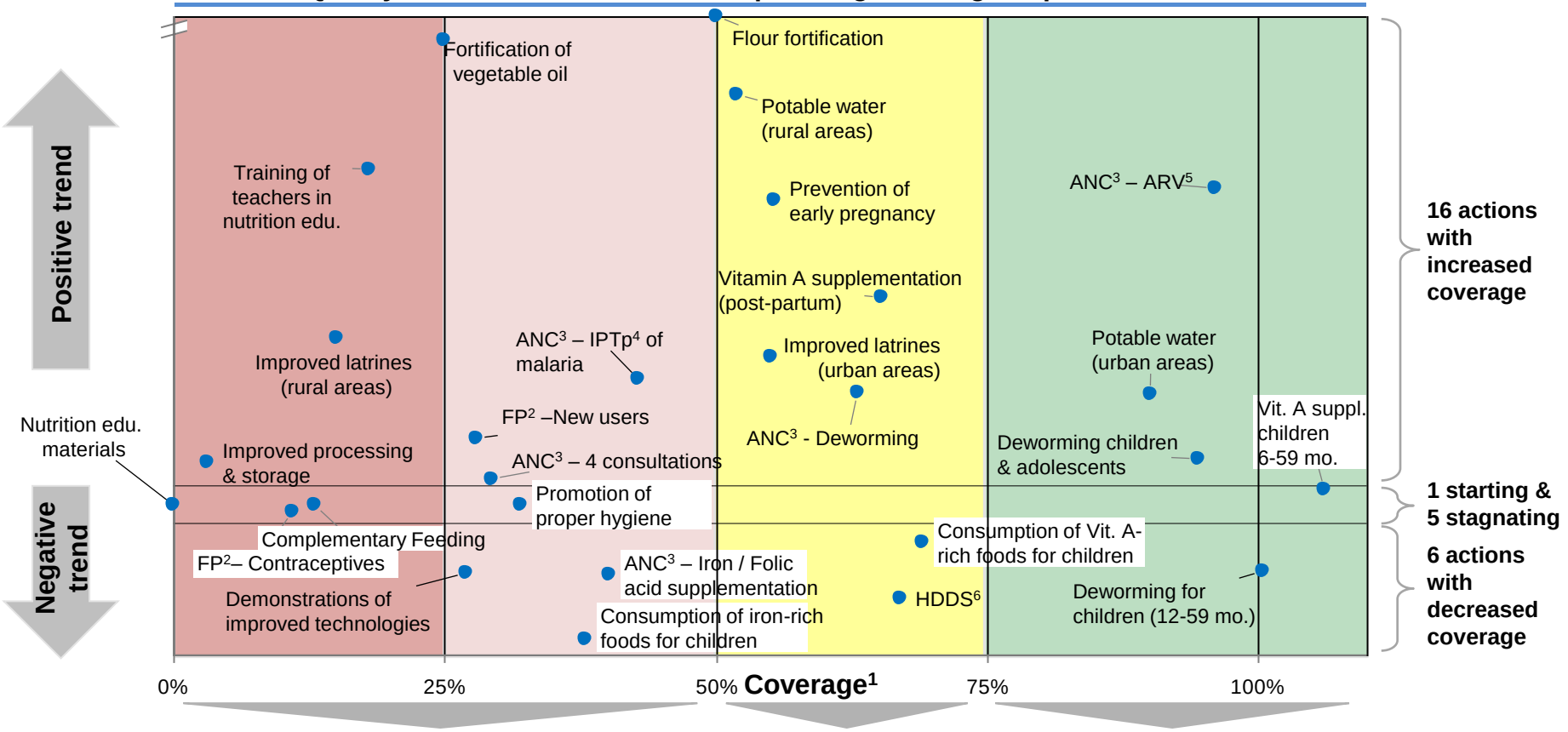
<25% 25% to <50% 50% to 75% >75%

[1]CFSVA (2014)

Consideration may be given to whether population coverage of nutrition actions is improving over time, with implications for planning

Excerpt from the Mozambique Nutrition Stakeholder & Action Mapping

Is further investment needed in capacity development?
Are new delivery mechanisms needed? Is increased political support needed?
Quality of actions? Are the scale-up strategies being adopted effective?



Source: Sector information, surveys, REACH analysis

[1]Only coverage indicators included, 2. 2014 vs. Baseline (2012 or 2011)

[2]FP = Family Planning / [3]ANC = Antenatal care / [4]IPTp = intermittent preventive treatment during pregnancy / [5]ARV = antiretroviral / [6]HDDS = Household dietary diversity support

Seize opportunities to leverage global expertise for target setting at the country level, including decentralized levels

Illustrative

Global nutrition targets for 2025

40% reduction in the number of children under-5 who are stunted

50% reduction of anaemia in women of reproductive age

30% reduction in low birth weight

no increase in childhood overweight

increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%

reduce and maintain childhood wasting to less than 5%

Current Status	2025 targets
XX%	XX%
XX%	XX%
XX%	XX%
XX%	XX%
XX%	XX%
XX%	XX%

To be populated with data from the geographic area

To be calculated with the data national &/or sub-national level

The Sustainable Development Goals (SDGs) of the 2030 Agenda are another key reference

Source: Available at http://www.who.int/nutrition/topics/nutrition_globaltargets2025/en/

Facilitation instruments for setting targets for national and sub-national plans and performance-based budgeting

Illustrative – to be populated with country data

Nutrition actions[1]
Decentralized level (e.g. xx%)

Set annual targets
Decentralized level (e.g. xx%)

	Nutrition-related actions	Target groups	Summary coverage (baseline)	% coverage (baseline)	Source	% Pop.[2] coverage (2016)	% Pop.[2] coverage (2017)	% Pop.[2] coverage (2018)	% Pop.[2] coverage (2019)	% Pop.[2] coverage (2020)
1	**Provide iron-folic acid / iron supplements**	Pregnant women 15-49 years		XX%	ABC				XX%	XX%
2	**Provide multiple micro-nutrient supplements**	Pregnant women 15-49 years								XX%
3	**Provide insecticide treated bednets**	Pregnant wom 15-49 years								XX%
4	**Provide insecticide treated bednets**	Post-partum wor 15-49 years				XX%	XX%	XX%		XX%
5	**Provide deworming tablets**	Pregnant women 15-49 years		XX%	ABC					
6	**Carry out insecticide spraying**	Households		XX%	ABC					
7	**Promote small-scale horticulture / crop div.**	Households		XX%	ABC					
8	**Promote small-scale animal husbandry**	Households		XX%	ABC					
9	**Etc.**	XYZ		XX%	ABC	XX%	XX%	XX%	XX%	XX%

Refer to coverage estimates for CNA[3] from the Stakeholder & Nutrition Action Mapping

Other estimates may come from secondary sources

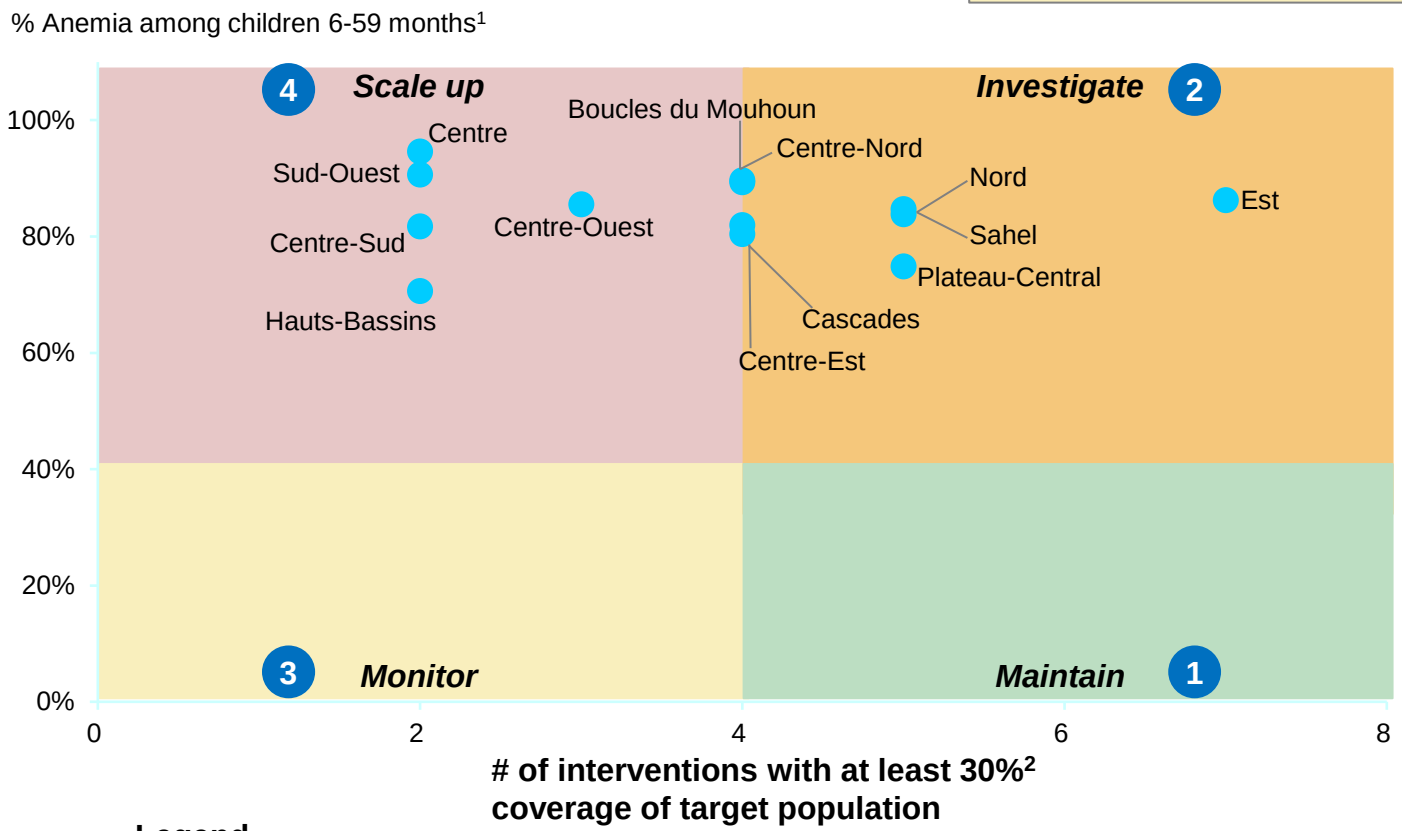
Helpful sources:
(1) Targets stipulated in National Nutrition Plan (or other gov't frameworks)
(2) Global targets

Other considerations:
(1) Delivery mechanism capacity to scale-up (Refer to Delivery Mechanism Analysis)
(2) Feasibility of introducing performance-based targets
(3) Other drivers or incentives for increasing coverage (e.g. champions, peer recognition, status[4], innovation & learning everaged[5], leadership[5])
(4) Barriers[4] to increasing coverage (e.g. lack of sub-nat'l data available, lack of funding)
(5) Scaling up strategy, processes & pathways[4]

[1]For women 15-49 years
[2]Pop. = Population
[3]CNA = Core nutrition actions
[4]Gillespie S., Menon P. & Kennedy A. (2015)
[5]Cooley L. & Linn J. F. (2014)

Using data to facilitate discussions about which regions are not adequately addressing child anaemia for sound planning

Excerpt from the Burkina Faso Nutrition Stakeholder & Action Mapping



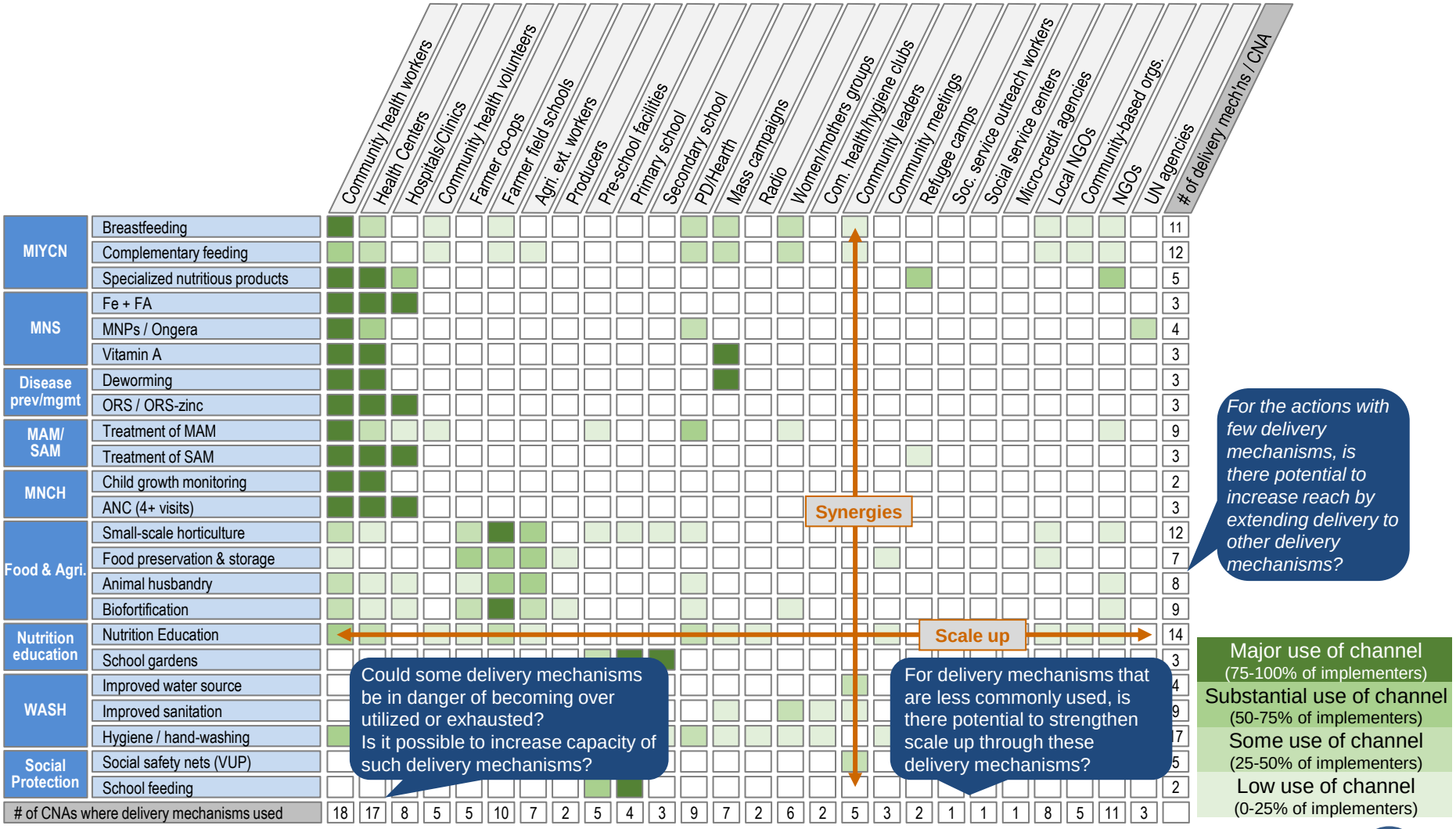
Legend

1	2	3	4
Maintain Nutrition situation is not critical and there is adequate coverage of actions	**Investigate** Nutrition situation is critical and there is adequate coverage of actions	**Monitor** Nutrition situation is not critical and there is not adequate coverage of actions	**Scale up** Nutrition situation is critical and there is not adequate coverage of actions

[1]ENIAB (2014)
[2]This number is a country-defined level based on the results of the stakeholder mapping to highlight disparities in action coverage.

Leverage findings on delivery mechanisms to identify opportunities for both scale up and synergies concerning the core nutrition actions

Excerpt from the Rwanda Nutrition Stakeholder & Action Mapping



Costing data can guide planning discussions on how to maximize impact while minimizing the cost of implementing national nutrition plans

Some actions are more economical than others

Interventions	Cost per DALY saved		Cost per life saved	Cost per case of stunting averted
	Mali	Global		
Community-based behavior change nutrition programs	$14.1	$53-$153	$1,369.1	$179.6
Vitamin A supplementation	$0.8	$3-$16	$712	$14.1
Therapeutic zinc supplementation	$13.9	$73	$2,773	-
Multiple micronutrient powders	$4.3	$12.2	n/a	n/a
Deworming	n/a	n/a	n/a	n/a
Iron/folic acid supplementation for pregnant women	$23.2	$66-$115	$116	$214
Iron fortification of staple foods	n/a	n/a	n/a	n/a
Salt iodization	n/a	n/a	n/a	n/a
Procurement of complementary foods for the prevention of moderate malnutrition	$659	$500-$1000	$2,171	-
Management of severe acute malnutrition	$193.4	$41	$2,384	-
TOTAL	**$110.1**	**n/a**	**$5,912.9**	**$1,487.8**

Source: World Bank (2014 & 2010)

Exploring scenarios for implementing national nutrition plans that maximize impact and minimize costs

Scale-up planning driven by the cost of nutrition interventions &/or the regions with the greatest need to maximize the allocation of limited resources

Proposed scenarios	Annual public investment (USD in millions)	Annual benefits			Unit cost by type of benefit (USD in millions)		
		DALYs saved	Lives saved	Cases of stunting averted	DALYs saved	Lives saved	Cases of stunting averted
National coverage	$85	1,172,742	14,738	58,572	$110.1	$5,912.9	$1,487.8
Scenario 1: Prioritization by region	$58.4	644,726	8,794	31,429	$90.6	$6,640	$1,857.9
Scenario 2: Prioritization by intervention	$45.3	1,070,822	12,567	58,572	$42.3	$3,602.3	$772.9
Scenario 3: By region & intervention	$38.7	768,068	9,130	35,254	$50.4	$4,238	$1,097.7

Scenarios 2 & 3 are the most economical

Source: World Bank (2014 & 2010)

Understanding who are the key stakeholders and their respective roles is a critical input for nutrition planning, particularly the articulation of a CRF[1]

Excerpt from the Tanzania Nutrition Stakeholder & Action Mapping

	Country relevant actions	Responsible Ministries	Catalysts	Field implementers	Donors
Food & Agriculture	**Provide materials and training for small-scale horticulture**	MAFC, MLFD, MoHSW	CRS, Fintrac, NAFAKA, HKI, IITA, ICRISAT, Sokoine University, University of Alberta, International Livestock Research Institute, PWRDF	ACT MASASI, Global Service Corps, HACOCA, CBO, Iringa Mercy Organization, Rungwe Small Tea Grower's Association, Njombe Agriculture Development Organization, Zapha+, RUDI, MVIWATA, FIPs, IFDC, DANIA, CRS, ARVDC	IDRC, USAID, DFATD, Irish Aid, BMGF
	Promote food preservation and storage	MAFC, MoHSW	WFP, Save the Children, COUNSENUTH, IITA, ICRISAT, PWRDF	ACT – MASASI, RUDI, Faida MaLi, PEMWA, ROPA, TFNC, Lukoveg, ARVDC	AGRA, Irish Aid, DFATD, USAID
	Promote universal salt iodization	MoHSW	Save the Children, COUNSENUTH, TSPA, PWRDF	ACT MASASI, TFNC, PEMWA, ROPA	UNICEF, Irish Aid, DFATD
	Carry out / support food fortification	MoHSW	HKI, NFFA, TFNC, TFDA	Private Sector, HKI	DFID
Nut. Edu.	**Carry out nutrition education**	MAFC, MoHSW, PMO-RALG	Plan, GAIN, CRS, Save the Children, AMREF, COUNSENUTH, Jhpiego, Africare, Sokoine University, University of Alberta, International Livestock Research Institute, PWRDF	Aga Khan Foundation, ACT MASASI, private sector, PASADIT, MOCSO, Dioceses of Geita, PEMWA, ROPA, RHMT, CHMT, TFNC	IDRC, DFATD, USAID, Hilton Foundation, Reckit Benkiser, UNICEF, Irish Aid
WASH	**Provide materials for improved water sources**	Ministry of Water, MoHSW	CRS, COUNSENUTH, PWRDF	ACT MASASI, Dioceses of Ifakara - Kilombero, Dioces of Arusha, TFNC	Global Sanitation Funds, DFATD, Irish Aid
Social Prot.	**Provide conditional cash tranfers**	MAFC, MLFD, MoHSW	COUNSENUTH, PMO-Disaster Dept, TFNC, UNICEF, Sokoine University	TFNC, UNICEF, MLFD, Sokoine University	Irish Aid

Consider whether there is scope to build alliances among stakeholders in pursuit of implementation efficiencies

[1]CRF = Common Results Framework

Support with collating various planning inputs to guide the development of a Common Results Framework

Illustrative – to be populated with country data

Summary Planning Matrix Template

Nutrition action & supporting activities	Location	Delivery mechanism	Timeline				Budget	Source of funding		Implementing agency		Indicator	Targets (Pop. Coverage)
			Q 1	Q 2	Q 3	Q 4		Gov't	Other	Lead	Collabn.		
1. Action A													
1.1 Activity A1													
1.2 Activity A2													
2. Action B													
2.1 Activity B1													
2.2 Activity B2													
2.3 Activity B3													
3. Action C													
3.1 Activity C1													
3.2 Activity C2													
3.3 Activity C3													
Etc.													

Identify the lead actor, coordinator as well as actors that provide technical & M&E support

Leverage data from Stakeholder & Nutrition Action Mapping for the core nutrition actions, replicating &/or expanding for other actions, as needed.

To be tailored to the context

May be adapted to national & sub-nat'l planning

A glimpse at the countries where REACH has supported or is actively supporting nutrition planning efforts, including at sub-national levels

National Planning

REACH engaged in national planning in 17 countries

- Bang-ladesh
- Burkina Faso
- Burundi
- Chad
- Ethiopia
- Ghana
- Haiti
- Guinea
- Mali
- Mozam-bique
- Myanmar
- Nepal
- Niger
- Rwanda
- Senegal
- Tanzania
- Uganda

Sub-national Planning

REACH engaged in sub-nat'l planning in 7 countries

- Ghana
- Mozam-bique
- Nepal
- Niger
- Rwanda
- Tanzania
- Uganda