MULTI-SECTORAL NUTRITION IMPLEMENTATION PLAN, RESULTS FRAMEWORK & DASHBOARD OF INDICATORS

NAMIBIA (2012/13-2015/16)

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NAFIN

Namibia Alliance for Improved Nutrition

PREFACE

The Ministry of Health and Social Services (MoHSS) recognizes the contribution of good nutrition to the socio-economic development of the nation. In recognition of this fact, and as a sign of Namibia's commitments to the Scaling Up Nutrition Global Movement (SUN), the Ministry of Health and Social Services, as the lead ministry of the Namibian Alliance for Improved Nutrition (NAFIN) has developed a Country Implementation Plan to scale up nutrition interventions that are evidence based and proven to reverse the trend of increasing malnutrition being experienced in Namibia.

The SUN Country Implementation Plan will address various maternal, infant, and young child nutrition problems in the country. It has been developed based on existing policy and strategy documents such as the National Nutrition Strategic Plan 2011-2015 and was heavily informed by findings from the WHO Nutrition Landscape Analysis Report; 2012. The SUN Country Implementation Plan has been developed to bring together all of the relevant sectors; health, education, water and sanitation, agriculture and social welfare, in order that the underlying determinants of malnutrition are addressed.

This SUN Country Implementation Plan marks a major achievement in the history of the Ministry of Health and Social Services at a time when food and nutrition interventions require the commitment of many sectors, from community to national level, in government and among development partners, that are tasked with working together for the successful scaling up of nutrition actions in Namibia.

The SUN Country Implementation Plan focuses on the identification of nutrition specific and nutrition sensitive activities that cross sectors but that also require sectors to work together collaboratively and effectively if the underlying causes of malnutrition are to be adequately addressed.

This report describes the methodologies used for assessing and classifying commitments to evidence based nutrition interventions that if scaled up have the potential to make malnutrition history in Namibia.

The SUN Country Implementation Plan contains a common results framework that will be used to track progress toward the goal of ending malnutrition in Namibia. The activities within this plan reflect direct interventions in areas such as health service delivery for integrating nutrition into maternal and infant and child health programmes, small scale agriculture, community mobilization for improved sanitation and health and hygiene practices and a range of activities considered enabling activities such as capacity building and training.

I fervently hope that this SUN Country Implementation Plan will be beneficial to the future policymakers in their efforts to reduce and prevent negative nutrition-related health impacts, and will thus contribute to sustainable social and economic development in Namibia.

……………………………………………..

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MINISTER OF HEALTH AND SOCIAL SERVICES

ACKNOWLEDGEMENT

During the month of August 2012, the multi-sectoral implementation strategy was developed and the main objective was to ensure integration of multi-sectoral approaches for a reduction in stunting prevalence amongst children under 5. At 29 per cent, the prevalence of stunting in Namibia is not only a critical health issue but is also a significant development issue. The multi-sectoral implementation plan has therefore been developed in response to the urgent need to scale up nutrition interventions and improve nutrition outcomes in the country, in the next five years and beyond.

This implementation plan was undertaken through concerted efforts with technical oversight by UNICEF under the auspices of the Namibian Alliance for Improved Nutrition (NAFIN). The implementation process was guided by extensive consultations with stakeholders, especially NAFIN members at the national level. The technical views and opinions were generated from many national organizations and institutions, government line ministries, UN agencies, and NGOs.

We would therefore like to express our deep sense of gratitude to all who contributed their time, technical ideas, inputs and opinions that helped identify gaps, constraints and opportunities for multi-sectoral responses for nutrition. We appreciate and highly acknowledge the contributions of Hon. Nahas Angula, who at the time of consultations was in the position as Rt. Hon Prime Minister. We acknowledge and appreciate the unreserved passion and commitment Hon. Nahas Angula has made to improve the nutritional status in Namibia, through chairing NAFINs monthly meetings and being a champion for nutrition.

We also want to extend our gratitude to all the government line ministries (education, gender, water and sanitation, agriculture, defense, communications and technology, and health) who were able to give useful contributions with regard to how multi-sectoral approaches would work in Namibia, including potential areas of integration. We cannot fail to recognize the contributions of the UN Agencies, notably, WHO and UNICEF. Their views were extremely useful in shaping the final outlook of this document. Our gratitude and acknowledgement also goes to the World Bank, for their assistance in developing the costed implementation plan. We also recognize the contributions of the NGOs who took part in this activity, e.g. Synergos, iTECH and FANTA. Lastly we would like to thank the nutrition International Consultant, Dr Margaret Wagah who offered technical guidance to the development of the implementation plan and the implementation tools. We have confidence that the information contained in this implementation plan will significantly contribute to the improvements of nutritional status of the vulnerable population groups in Namibia over the next five years and beyond.

EXECUTIVE SUMMARY

Background and situation analysis

Although the government has made strong commitments through significant investments in social sectors in the past decade, these have not translated into major improvements in development outcomes for children, women and families including their nutrition status. Children in Namibia are becoming increasingly vulnerable to chronic malnutrition due to a range of factors, namely environmental disasters such as floods and drought, repeated cycles of illness, intergenerational malnutrition, food insecurity, poor infant and young child feeding and care practices, education attainment of women, unemployment and poverty. One third or 29 per cent of Namibian children under-five are stunted, making them more vulnerable to illnesses, compromising their physical and cognitive development and placing them at a higher risk of death. Children who are stunted become less productive adults and with lower earning capacity over their lifetime than children who are not stunted.

Hidden hunger (micronutrient deficiency) is also a challenge in Namibia as indicated by high rates of anemia surpassing the WHO thresholds of ‘no public health problem’. According to Namibian Demographic and Health Survey (NDHS) 2006/07, only 60 per cent of salt for human consumption is fortified, which is below the WHO recommendation of 90 per cent, and more than a quarter of pre-

school children were identified vitamin A deficient and thus 20 times more likely to die from common childhood diseases. Overweight, obesity and other diet related illness are emerging rapidly with the evidence of these challenges beginning at childhood and deaths in adults due to these illnesses contributing to close to 40 per cent of all deaths. The role of nutrition care for those with communicable diseases such as TB and HIV is also emerging as a key consideration in Namibia to reduce morbidity and mortality.

It is apparent that many hurdles are still to be overcome in Namibia if the current malnutrition trends are to be reversed. What is known about the barriers to scaling up nutrition has been largely informed by the joint led Ministry of Health and Social Services (MoHSS) and WHO, Nutrition Landscape Analysis (NLSA), which commenced in 2011 and was recently finalised in mid 2013. The NLSA has provided the information about national commitment, human and financial resource allocations, technical capacity, willingness and readiness to act that has shaped the priority result areas focused on in the Country Implementation Plan (CIP). Coupled with the NLSA findings and recommendations made, and based on the three principles for the SUN Movement; the CIP reflects not only the nutrition specific interventions that need to be scaled up but it also reflects nutrition sensitive interventions in areas such as water, sanitation and hygiene promotion, social welfare, disaster risk management, education and agriculture.

Multi-Sectoral plan

Improving nutritional status of vulnerable population groups during the period 2012/13-2015/16 will be supported by the implementation of a multi-Sectoral plan for nutrition, consisting of nutrition specific and sensitive interventions. This implementation plan therefore presents a synopsis of the key areas of attention required to address nutrition problems in Namibia. The multi-Sectoral country implementation plan is informed by the Strategic Priorities outlined in the Strategic Plan for Nutrition 2011-2015, which are;

1. Optimal maternal, infant and young child nutrition status
2. Improved access to and consumption of diversified diet
3. Improved resiliency to shocks that impact on nutrition status
4. Strengthened policy, legal and institutional framework for nutrition.
5. Increased awareness of and commitment to addressing nutrition issues
6. An effective and functional nutrition Monitoring and Evaluation system

Multi-Sectoral Framework and Coordination

In order to implement the activities under the Multi-sectoral country implementation plan, coordination at national, regional and constituency level is necessary. It is recommended that existing coordination platforms such as NAFIN at national level, Regional Development Coordinating Committees (RDCC) and Constituency Development Committees (CDC) be utilized. It is envisaged that NAFIN will lead the nutrition response by monitoring implementation of strategies and activities by the respective line ministries and sectors. NAFIN is the platform for bringing together stakeholders from government, private sector, civil society organizations', and association of churches, development partners and UN

agencies. Together the members of NAFIN will oversee and monitor progress against the objectives set out in the country implementation plan and common results matrix. Accountability for implementing the nutrition specific and sensitive activities will lie with the respective sectors and these sectors will report via the technical working groups to the NAFIN Chairperson.

Implementing the activities also requires coordination and local level monitoring at regional and constituency level. The recommendation to use existing platforms is based on the need to build capacity of regional development coordinating committees and constituency development committees to monitor and track the implementation of nutrition activities by implementing agencies, government ministries and civil society organizations. Regional and constituency level committees will develop local level indicators (process and outcome) based on the common results framework, which will provide them with the necessary tools to monitor progress against the target results.

Results Framework and Dashboard of Indicators

The result areas and indicators in the results matrix are linked to the intervention activities and reflect input, output and outcome indicators. The results matrix is a tool for tracking the progress of implementation and intermediate outcomes. Some of the activities however are steps required in order to build capacity for nutrition interventions to eventually be implemented. For example, there are a number of training activities and it is acknowledged that training does not mean implementation or desired behaviour change; however it is a required step. Due to the substantial limitation in human resource capacity in Namibia, the first year of the CIP will have a stronger emphasis on training and supervision of knowledge transfer in practice. The results matrix will track progress against 5 key areas; 1) improvement in maternal, infant and young child nutrition status; 2) reduced burden of non-communicable disease; 3) improved resiliency to shocks that impact on nutritional status; 4) improved awareness of and commitment to national nutrition priorities; and 5) a functioning and effective monitoring and evaluation system.

Conclusions

The SUN CIP aims to complement the existing *Namibian Strategic Plan for Nutrition 2011-2015*, by going beyond nutrition specific interventions and including the roles, responsibilities and activities undertaken by other ministries and sectors that have indirect impact on nutritional status of women and children. The SUNCIP reflects a shift in focus from considering only the immediate causes of malnutrition to also consider the root causes or basic causes of malnutrition. To achieve the stated nutrition targets depends however, on some important assumptions including the willingness of all relevant government line ministries and other partners that have contributed to developing the SUN CIP to commit to actively participate in NAFIN meetings and the technical working groups tasked with overseeing the implementation of activities from the plan.

Achieving the long term goal of making malnutrition history is also dependent on building a strong skilled workforce and developing the institutional arrangements necessary for scaling up and sustaining quality nutrition interventions. Tracking progress against the indicators set out in the plan will require an investment in strengthening information management systems. This will facilitate effective monitoring of progress towards the achievement of set targets and inform future evidence based programming for nutrition.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Virus
ANC	Antenatal Care
BMI	Body Mass Index
BFHI	Baby Friendly Hospital Initiative
CBOs	Community-based Organisations
CIP	Country Implementation Plan
C-IYCF	Community Infant and young child feeding
CDC	Constituency Development Committees
CSOs	Civil Society Organizations
DDRM	Directorate Disaster Risk Management
DHS	Demographic Health Survey
DP	Development Partners
ECD	Early Childhood Development
eMTCT	Elimination of mother to child transmission
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agricultural Organisation
FBO	Faith Based Organisations
GDZ	German Development Services
HIV	Human Immuno-deficiency Virus
HMIS	Health Management and Information System
IFA	Iron Folic Acid
IYCF	Infant and Young Child Feeding
LAC	Local Authorities Committees
MCHD	Maternal Child Health Days
M&E	Monitoring and Evaluation
MAWF	Ministry of Agriculture, Water and Forestry
MGECW:	Ministry of Gender, Equality and Child Welfare
MNP	Micronutrient Powder
MOD	Ministry of Defense
MOE	Ministry of Education
MOHSS	Ministry of Health and Social Services
MOICT	Ministry of Information and Communication Technology
MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MUAC	Mid upper arm circumference
NACS	Nutrition Assessment Counseling and Support
NAFIN	Namibia Alliance for Improved Nutrition
NDHS	Namibian Demographic Health Survey
NDP4	Namibia Development Plan 4
NGOs	Non-Governmental Organizations
NMF	Nutrition Multi-stakeholder Forum
NPC	National Planning Commission
NPNL	Non-Pregnant, Non-Lactating
OPM	Office of the Prime Minister
PS	Private Sector
PMTCT	Prevention of mother to child transmission

RDCC	Regional Development Coordinating Committee
RUTF	Ready to use therapeutic food
SD	Standard deviation
SUN	Scaling Up Nutrition
TB	Tuberculosis
TOT	Trainer of Trainers
UN	United Nations
UNAM	University of Namibia
UNDP	United Nations Development Program
UNICEF	United Nations' Children's Fund
WATSAN	Water and Sanitation
WFP	World Food Program
WHO	World Health Organization

1 INTRODUCTION

1.1 Background

Namibia is a relatively young nation, having gained independence in 1990 following nearly a century of German and South African rule. Namibia has been classified as an upper middle income country, ranking 112 out of 209 countries. Although the government of Namibia has made tremendous commitments through significant investments in social sectors in the past decade, these have not translated into major improvements in nutritional outcomes for children, women and families. While Namibia is on track to achieve the Millennium Development Goals (MDGs) on education, environment and gender, the severity of the HIV&AIDS epidemic is frustrating efforts to achieve Millennium Development Goals 4, 5, and 6.[1] In this regard, in 2008, the Namibia National Planning Commission (NPC) reported that Namibia is not making adequate progress on the issues of maternal health and child mortality including malnutrition. Clearly, one area in which Namibia has not made any significant improvements is on maternal, child and the general population's nutritional status. With this scenario, the MDG target of 31% set for reducing under nutrition by 2015 is unlikely to be achieved unless drastic, radical and decisive actions to address malnutrition are put in place by the government of the Republic of Namibia

[1] Word Bank, 2011. Namibia Country Profile.http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/NAMIBIAEXTN/0,,menuPK:382303~pagePK:141132~piPK:141107~theSitePK:382293,00.html [Accessed 14th August 2012]

It is apparent that many hurdles are still to be overcome if the current malnutrition trends are to be reversed. These include among others, improving the nutrition workforce/capacity building, adopting the Scaling-Up of Nutrition (SUN) recommendations, adopting a multi-stakeholder approach in planning, implementing multi-sectoral nutrition interventions and strengthening nutrition coordination, leadership, governance, advocacy and resource mobilization.

1.2 Rationale for multi-sectoral plan

In order therefore to respond to the malnutrition situation in Namibia, the Rt. Hon Prime Minister of the Government of the Republic of Namibia in 2009 initiated the “Namibia Alliance for Improved Nutrition” (NAFIN), a multi-sectoral private-public partnership nutrition forum that brings together different government line ministries, UN agencies, the private sector, NGOs and development partners involved in nutrition and food security. To date, NAFIN serves as the central coordination body tasked with identifying what needs to be done with regard to addressing the high levels of malnutrition in Namibia.

Under the leadership of the Rt. Hon Prime Minister, Namibia became a member of the Scaling Up Nutrition (SUN) movement in November 2011. Subsequently in 2012, UN Secretary General Ban Ki-Moon appointed 27 world influential leaders, including the Rt. Hon Prime Minister of the Government of the Republic of Namibia, as SUN Lead Group members to advance the strength and security of nations by improving maternal and child nutrition. This influential group, has served in their respective capacities to offer strategic guidance for the SUN global Movement and within their respective countries.

With Namibia being one of the newer members of SUN movement, NAFIN is now working closely with REACH and the SUN secretariat to facilitate the development of a multi-sectoral implementation plan, results matrix and a dashboard of nutrition indicators. Under NAFINs framework, different stakeholders with focused and well planned efforts work together in a coordinated manner to draw on and contribute their respective strengths; complementarities to create synergies in achieving the target results while at the same time avoid duplication of activities. To get this process started, an international consultant was sub-contracted by UNICEF to spearhead this activity and hence an initial draft of the country implementation plan, results matrix and indicator dashboard were developed and have since been refined based on sectoral discussions and inputs.

2 NAMIBIA NUTRITION SITUATION ANALYSIS

2.1 Trends and current nutrition situation

2.1.1 Child malnutrition

Children in Namibia are increasingly becoming vulnerable to malnutrition. Low birth weight has been on the increase between 2000 and 2006 (from 8% to 14%). It has been consistently shown that small babies grow up to be small children and in turn tend to be smaller and less productive adults. While the percentage of underweight children (too thin for age) has declined in the last two decades, stunting levels i.e. (too short for age) and wasting (too thin for height) have increased as shown in Figure 1. The current rate of stunting (29%) is on the border line of the

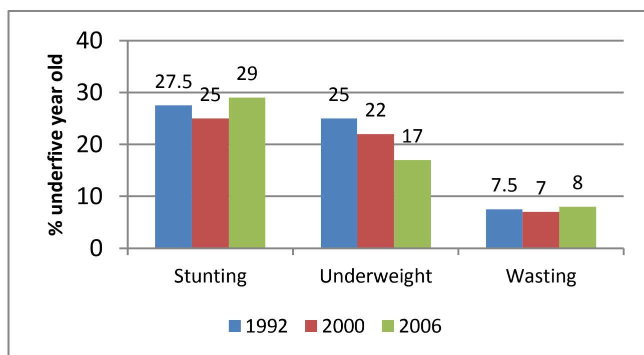


Figure 1: Trends in malnutrition rates (1992-2006)[1]

WHO[2] cut off thresholds of high prevalence category (30%). Underweight (17%) and wasting rates are all in the medium category. With one out of every three children under 5 years of age stunted, Namibia has almost twice the percentage of moderately stunted children and three times the percentage of severely stunted children than what is expected for a country with its level of economic development. This national data apparently masks significant regional, age and gender disparities. Almost one out of every three Namibian children under the age of 5 is malnourished.

In addition, Namibia is presently facing challenges of micronutrient malnutrition (hidden hunger) which leads to chronic malnutrition (stunting). Pre-school children are the group most affected by anemia. As shown in Figure 2, the proportion of anemic pre-school children is above the WHO[3] threshold of severe public health problem while the prevalence rates for pregnant women and Non-Pregnant, Non-Lactating (NPNL) women are of moderate threshold levels according to WHO classification. Efforts therefore need to be put in place to reduce anemia rates.

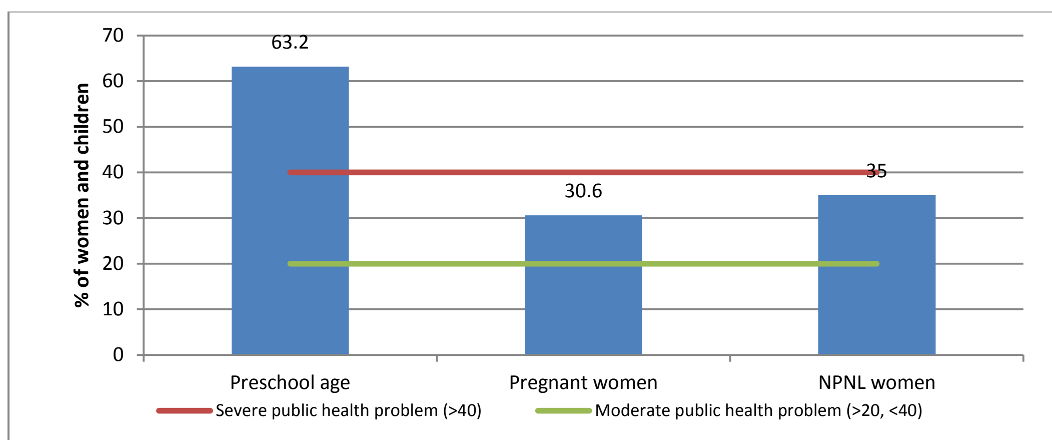


Figure 2: Prevalence of anemia in Namibia[4]

Iodine in salt is the most reliable source of iodine for the vast majority of the population in Namibia. The percentage of households consuming adequately iodized salt is 60%, which is significantly below the WHO target of>90%. Iodine deficiency is the single most preventable cause of mental retardation, but an important public-health problem in some pockets of Namibia such as Kavango region with iodine deficiency as high as 70% (>50% WHO cut off). In addition, over 23% of pre-school children in Namibia are currently suffering from Vitamin A deficiency. Children who are deficient in vitamin A are 20 times more likely to die from common childhood diseases.

[2]WHO, 2012.Global database on child growth and malnutrition.http://www.who.int/nutgrowthdb/about/introduction/en/index5.html (Accesses 8th August 2012)
[3]WHO 2008. Worldwide prevalence of anemia 1993–2005 : WHO global database on anaemia. Geneva, World Health Organization. http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf (Accessed 8th August 2012)
[4]MOH 2008. For preschool and pregnant women, the cut of is HB<110g/L and for the NPNL is HB<120110g/L

2.1.2 Maternal nutrition

In Namibia, women are at an increased nutritional risk due to their maternal physiological functions. Thus maternal nutrition is an area of nutritional challenge. According to the NDHS 2006/7, stunting prevalence in children born to underweight mothers is of alarming proportions and falls within the very high burden category according to WHO guidelines. In Namibia, children born to mothers who are underweight are three times more likely to suffer from severe forms of stunting than children born to normal or overweight women. These findings are significant when we take into consideration that 15% of mothers are estimated to be underweight, with the prevalence higher in the rural areas compared to the urban areas. Just fewer than 60% of mothers are of normal weight.

It has been reported that antenatal maternal night blindness is prevalent in Namibia[5]. This is indicative of severe vitamin A deficiency among pregnant women and thus puts them at an increased risk of poor birth outcomes such as low birth weight. If intake and coverage of vitamin A is not urgently increased through supplementation, fortification or dietary diversity, then the unborn infant is at risk of stunting.

2.1.3 Diet related disorders and diseases

Overweight and obesity are emerging as serious problems in developing and middle income countries. Currently, 4.3% of Namibian children are classified as overweight (WH+2SD) and 28% of women are overweight, with a BMI of greater than 25kg/m2 while 11.7% of women are severely obese with a BMI greater than 30 kg/m2. Observations of overweight according to age cohorts showed that the highest prevalence of overweight babies was between the 4-6 month age group and decreased with increasing age after the first year of life. The prevalence of overweight (WH+2SD) among children in the urban areas under the age of five was twice as high as overweight prevalence among rural children[6].

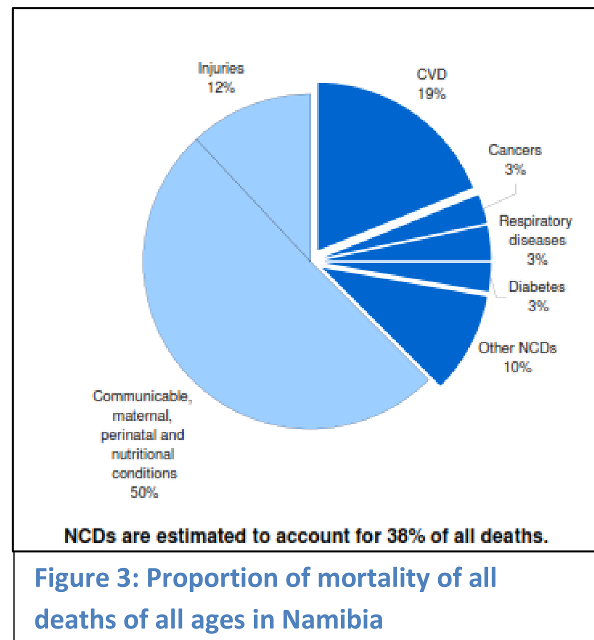


Figure 3: Proportion of mortality of all deaths of all ages in Namibia

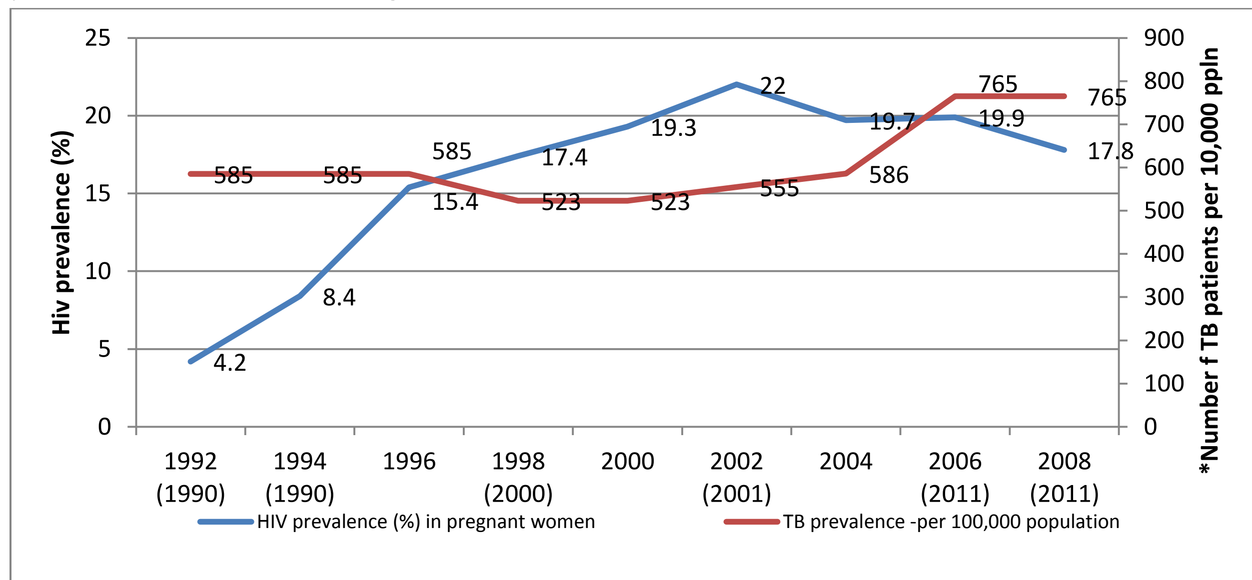
It's now well established that obesity is a risk factor for many diet related disorders (non-communicable diseases) which accounts for significant deaths (38%) in Namibia as shown in Figure 3[7]. Out of these diseases, cardiovascular diseases account for half

[5] NAFIN, 2010.Malnutrition in Namibia. Time to action Now. Government of Namibia. Windhoek.
[6] NAFIN, 2010.Malnutrition in Namibia. Time to action Now. Government of Namibia. Windhoek.

of the number. Other non-communicable diseases include diabetes and cancers. Nutrition thus plays a major role in prevention and management of these diseases and can further go a long way in preventing them.

2.1.4 Communicable diseases

In a country which is affected by two critical communicable diseases namely; HIV and TB, nutrition status of the population is bound to be affected by these diseases. HIV prevalence in Namibia is among the highest in the world. Routine antenatal surveillance estimated that 1 in 5 pregnant women were infected with HIV in 2006[8]. The epidemic has cut across all sectors of society and is severely affecting the population. Despite a decline in HIV prevalence rates, which have fallen from 22 percent in 2002 to 17.8 percent in 2008 (as shown in Figure 4), new HIV infections remain a serious issue of national concern.



* Years shown in bracket are corresponding years for the TB rates

Figure 4: HIV and TB prevalence rate[9][10]

Namibia has one of the highest tuberculosis prevalence rates in the world at 765 per 100,000, with some regions reporting tuberculosis rates as high as 1,000 per 100,000[11]. HIV and TB are related. As shown in

[7]WHO, 2010. Non-Communicable Diseases profile of Namibia. http://www.who.int/nmh/countries/nam_en.pdf [Accessed 13th August 2012]

[88]NAFIN, 2010.Malnutrition in Namibia. Time to action Now. Government of Namibia. Windhoek.

[9] Various source of data: MOHSS, 2008. HIV/AIDs in Namibia: Behavioral and Contextual Factors Driving the Epidemic; Index Mundi 2012. http://www.indexmundi.com/namibia/tuberculosis-prevalence-rate-per-100,000-population.html [Accessed 14th August 2012]

[10] Years shown in bracket are corresponding years for the TB rates

[11] Word Bank, 2011. Namibia Country Profile.http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/NAMIBIAEXTN/0,,menuPK:382303~pagePK:141132~piPK:141107~theSitePK:382293,00.html [Accessed 14th August 2012]

Figure 4, the prevalence rates of HIV and TB follow almost similar patterns. About 67 percent of newly registered TB patients are HIV positive[12].

Infections lead to increased nutritional needs required for the infected to stay healthy and live longer. Energy requirements for people with HIV and AIDS increase by between 10% - 100%, depending on the phase of the disease. Nutrition can play a key role in the management of TB and HIV and thus should be part and parcel of policy and programs on nutrition, HIV, TB and other communicable diseases.

2.2 Causes of malnutrition in Namibia

The malnutrition challenge has been analyzed and is well documented in various policy and program documents. The potential to impact positively on malnutrition requires a series of well coordinated implementation of evidence based interventions. Critical to addressing the underlying and basic causes of malnutrition is a multi-sectoral approach. NAFIN[13] has articulated the broad causes of malnutrition in Namibia and what needs to be done. This is summarized in Table 1.

Table 1: Causes of malnutrition and what needs to be done in Namibia per respective cause

#	Causes of malnutrition	What needs to be done
1	**Immediate causes**	
a	Poor access to micronutrient rich foods (Vitamin A, iron, folic acid, zinc and iodine)	• Scale-up the coverage of vitamin A and iron/folic acid supplementation • Fortification of maize, wheat flour and other centrally processed staple foods with iron, folic acid, vitamin A and zinc among national and small scale millers • Encourage the production and consumption of micronutrient rich foods • Strengthen and enforce legislation on salt fortification • Social mobilization and promotion of importance of consuming fortified foods
b	High disease prevalence including for HIV and TB	• Targeted food distribution to chronically ill patients • Integrate nutrition into HIV, TB and other communicable diseases programs and policies • Household food security initiatives such as homestead gardening
2	**Underlying causes**	
a	Inequitable access to water, sanitation and hygiene	• Nationwide WASH communications strategy • Increased access to, and use of improved latrine facilities • De-worming twice yearly for all children aged one year and above
b	Insufficient access to food	• Community awareness campaigns on nutrition and household food security programs • Vegetable garden establishment • Targeted food distribution to highly vulnerable households

[12]USAID 2008.Namibia Tuberculosis Profile.http://transition.usaid.gov/our_work/global_health/id/tuberculosis/countries/africa/namibia.pdf [Accessed 14th August 2012]

[13]NAFIN, 2010.Malnutrition in Namibia. Time to action Now. Government of Namibia. Windhoek.

		and schools in food insecure areas • Establishment of local markets for sale of locally grown foods
c	Inadequate maternal, infant and child care including poor infant feeding practices, Teenage pregnancies and small stature and poor health care delivery of micronutrient supplements	• Exclusive breastfeeding up to 6 months, followed by complementary feeding up to 2 years • Improved nutrition and health care for pregnant women • Greater access to low cost fortified complementary foods for young children (6 to 24months) • Twice yearly Vitamin A supplementation for all children under-five • Access to Micronutrient Powder for all children under-five • Availability of ready to use fortified therapeutic food for moderate and severely malnourished children • Community-based growth monitoring systems that are linked to services such as health facilities and social workers
3	**Basic causes**	
a	Socioeconomic and regional disparity in health care provision, wealth distribution, education	Increased investments in poverty eradication, healthcare provision and education for the vulnerable areas
b	Limited inclusion of nutrition in policies in existing policy documents	Incorporate nutrition and nutrition-related policies in existing policy frameworks and development of new policies with relevance to nutrition Intensified multi-sectoral responses with impacts on nutrition Capacity development in basic education, secondary and tertiary levels to develop nutrition human resource capacity

Some of the actions to be done are not suggestions from NAFIN 2010, but expert suggestions based on consultative meetings with key stakeholders.

2.3 Namibia Policy Environment

Namibia has made commendable efforts in integrating nutrition into key policies. Apart from the National Strategic Plan for Nutrition, which defines the nutrition direction for the country up till 2015, a number of policy frameworks reflect the commitment and intent to reverse the poor nutrition trends. Namibia's Agricultural Policy aims to ensure food security and improve nutritional status and create and sustain viable livelihoods. It also aims to create employment opportunities in rural areas and improve the living standards of farmers and their families as well as farm workers. The Fisheries White Paper reflects the importance of developing marine fisheries sustainably and therefore promoting fish and seafood as a source of protein and micronutrients for the population. The Social Welfare policy on the other hand, has pledged that all people over sixty years of age in Namibia are eligible to receive an old age pension, thereby putting into place a social safety net program. This also indicates that these families have access to a source of income which may reduce their vulnerabilities to malnutrition. In addition, Namibian Health Policy reflects the commitment of achieving health for all populations, which potentially contributes to tackling both the immediate and underlying causes of malnutrition.

The Education Policy aims at improving access to education and improving the quality of education respectively. It's now clear that lack of education, especially amongst women has been linked to poor nutritional status and reduced ability to adequately provide the family basic needs. Meanwhile, the Water supply and Sanitation Policy pledges to ensure availability of essential water supply and

sanitation services to all Namibians at an affordable cost while the Environmental Policy seeks to achieve sustainable food security and good nutritional status through environmental protection and appropriate management of water resources, wetland conservation, use of wildlife and the exploitation of indigenous plant life, which endeavors to establish sustainable systems for the benefit of both local communities and the country as a whole.

As articulated by NAFIN, to place nutrition squarely at the centre of Namibia's development agenda, strategies and goals reflecting commitment of nutrition strategies need to be included in Namibia's poverty reduction strategy (PRSP). The PRSP is encompassed in the country's National Development Plan (NDP4), of which reduction in stunting is a key priority and reflects the level of the Government's commitment to nutrition.

2.4 Namibia stakeholder analysis

Multi-sectoral approaches to tackling malnutrition in Namibia implies that various key actors in nutrition specific and nutrition sensitive areas need to willingly come together and contribute to developing strategic actions required for achieving Namibia's nutrition targets. To date, different types of relevant stakeholders have been identified in Namibia and can be categorized as follows:

1. Donors: Those providing financial support to the government and NGOs to implement nutrition and/or nutrition related interventions. They include USAID, among others.
2. Technical support: Stakeholders who in addition to providing other types of support, provide practical guidance on how nutrition targets can be achieved and directly or indirectly participates in the implementation of the guidance provided. They include UNICEF, WHO, WFP, FANTA, CDC, Synergos, among others.
3. Policy support: Those providing advice on nutrition and related policy direction of the country. These are the various arms of the government of Namibia dealing with policy.
4. Government implementers: Government ministries charged with specific responsibility on behalf of Namibian government and for all Namibians. These are the ministries of health, education, agriculture, gender, environment and tourism and DDRM.
5. Non-government implementers and Faith based organisations: Any organization which either supports the government directly or indirectly to implement activities or in itself has an operation system to implement activities. Most of these in Namibia are NGOs and FBOs.
6. Private sector: These are profit oriented organizations that link to nutrition activities. They include Namib Mills, among others.
7. Logistics (delivery channel): Organizations providing support to ensure that nutrition or related products reach or are close to final beneficiaries.

A general overview of these stakeholders is summarized in Table 2, which shows that some partners can fall into more than one category of stakeholder. The partners/types of stakeholders have broadly been categorized into those providing support for preventive and treatment services. The varying efforts of all these partners need to be focused and well-coordinated to create positive significant change in maternal, child and the general population's nutritional status.

Table 2: Stakeholder analysis against the critical focus areas (SUN and additional areas)

	Partners type	Preventive interventions									Treatment interventions		
SUN		Breast feeding	Complementary feeding practices	Hygiene practices including hand washing	Vitamin A and iron supplementation and deworming	Salt iodization	fortification of staples	Growing and consumption of variety foods	Prevention and management of diet-related illnesses	Management of communicable diseases	Therapeutic feeding	Supplementary feeding	Zinc supplementation
Stakeholders	**Donor support**	World Bank, USAID, CDC, PEPFAR (USA), Global Fund,											
	Technical support	UNICEF, WHO, WFP, UNDP, FANTA 3, iTech, Synergos, CDC, Global Fund						FAO	**WHO**	**WHO, UNICEF**	FANTA, iTech, UNICEF, GF, WFP		
		Educational institutions (NHTC, UNAM, Polytech)											
	Policy support	National Planning commission (NPC), Government ministries (MOHSS, MAWF, MRLGHRD, MOE, MGECW, DDRM, MICT)											
	Government implementer	MOHSS,						MAWF	MOHSS		MOHSS		
		MAWF							MOE				
	Non-government implementers	NRCS, CAA, CHS, FBO, among others								NANGOF, NANASO	NRCS, CAA, CHS among other NGOs		
	Private sector					Namibian grain producers, Bokomo, Namib Mills and Southern Choice Mills, Salt manufactures							
	Logistics (delivery channel)	MOHSS		DWSSC & Local Gov. authorities	MOHSS	Private sector as above		MAWF	**MOHSS**	**MOHSS**	MOHSS, UNICEF ,WFP		

Key (color codes) for sectors

- Varied sectors
- Health sectors
- Agriculture
- Water
- Education
- Private sector
- Agriculture and water
- Policy
- Food

3 MULTI-STAKEHOLDER PLAN

3.1 Multi-stakeholder plan overview

Improving nutritional status of vulnerable population groups during the period 2012/13-2015/16 will be supported by the implementation of a multi-sectoral action plan for nutrition. Core to the implementation process will be the engagement of a number of multiple players either involved in implementation of nutrition specific activities or nutrition sensitive activities. In lieu of a SUN Country Focal Person, the action plan will be spearheaded by the Food and Nutrition Sub-Division of the Health and Family Welfare Division under the Directorate of Primary Health Care of the Ministry of Health and Social Services (MoHSS). The Food and Nutrition Sub-Division with support from development partners will provide the overall coordination and oversight of nutrition matters. They will facilitate where appropriate, engagement with other relevant line ministries in order to operationalize a truly multi-sectoral approach. Inter-ministerial and sectoral partnerships e.g. MAWF, MOE, MGECW, MOHSS, DDRM, & NPC, whereby nutrition specific and sensitive activities are jointly planned and implemented are the goal. Other partners include; UN agencies, CSOs, Private Sector Organizations and FBOs involved in nutrition service delivery, policies and programming.

3.2 Critical assumptions of the implementation plan

Effective implementation of this multi-sectoral plan will depend on the following assumptions i.e;

a) The government line ministries and other partners willingness to participate in the multi-sectoral response to nutrition
b) Resource availability and allocation by donors and the government of Namibia to ensure successful implementation of the multi-sectoral approaches
c) Multi-sectoral responses are never easy to implement due to institutional mandates and lack of shared visions between any two partners
d) Accountability requirements and expectations by all involved partners
e) Establishment of clear roles and responsibilities
f) Bringing together more than one partner to build consensus around a common problem and its solutions can be difficult

3.3 The process of developing the implementation plan

The process of developing this multi-sectoral implementation plan was initiated back in 2009 when the Rt. Hon Prime Minister of the Government of the Republic of Namibia in 2009 instituted the formation of the "*Namibia Alliance for Improved Nutrition*" (NAFIN), i.e. a multi-sectoral private-public partnership nutrition forum comprising of different government line ministries, the private sectors, NGOs and Development Partners involved in nutrition and food security interventions. The objective of NAFIN has been to envision how nutrition improvement can be realized using a multi-sectoral approach.

The development of the nutrition implementation plan involved a series of steps.

- First and foremost, an international consultant was hired by UNICEF to provide technical guidance and oversight on the development of a draft implementation plan. An inception workshop was subsequently organized by NAFIN. The consultant shared the expected process including; the implementation plan, results matrix and the dashboard of nutrition indicators. The feedback from the deliberations of the inception workshop was instrumental in the development of the draft report.
- The inception workshop was followed by a number of highly consultative meetings among relevant stakeholders on nutrition relevant areas to identify gaps, constraints and opportunities for multi-sectoral responses for nutrition programming. During these technical meetings, the consultant was able to hold interviews with the former Rt. Hon Prime Minister who has unreservedly shown passionate commitment to improving nutritional status in Namibia through chairing NAFIN monthly meetings.
- The process of developing the implementation plan also included a review of all relevant literature including policy documents, guidelines and in-country nutrition relevant materials to understand the nutrition landscape. The WHO led Nutrition Landscape Analysis (NLSA) informed the multi-sectoral plan by providing considerable insights to the barriers for implementation and scale up of nutrition interventions. The NLSA has been a critical piece of work that has led to a greater understanding of the government's readiness, commitment and capacity to act with regard to scaling up nutrition. It has unpacked information about where are the capacity gaps; technical, financial and human resource gaps and areas that require concerted effort if the

nutrition situation is to improve. These key national documents and assessment processes led to the development of the draft multi-sectoral country implementation plan.

- The draft implementation plan and tools were validated at a high-level NAFIN workshop, chaired by the Rt. Hon Prime Minister and the feedback from the validation workshop has been incorporated into the revision of this final document, and has been presented during a SUN Global meeting in New York during the UN General Assembly.

3.4 Description of the plan

Sustained improvements in nutritional outcomes in Namibia will require the implementation of evidence based, high impact, cost effective nutrition interventions as well as the integration of nutrition into health, agriculture, education, employment, social welfare and development programs that have indirect impacts on nutritional status. The multi-sectoral implementation plan aims to put in place measures to alleviate the double burden of malnutrition in children and women by paying special attention to the period from conception to two years of a child's life, even though a life-circle approach will be equally considered. These actions are necessary if optimal nutritional status is to be achieved and future manifestations of diet related lifestyle diseases and non-communicable diseases are to be prevented.

The implementation plan recognizes that guaranteeing multi-sectoral approaches is not an easy task. This is due to the fact that for too long nutrition has been seen as a health issue and therefore the sole responsibility of the health sector. More is understood about the multiple causes of malnutrition, especially the underlying and basic causes, which incidentally sit not with a range of non-health sectors such as education, agriculture, water and sanitation, social welfare, etc. To achieve the elimination of malnutrition in Namibia all relevant sectors must be actively engaged and involved in every step from planning to evaluating impact on nutritional status.

For instance, while agriculture has made widespread advances in making food available, linkages with improving nutrition outcomes are still limited in the country. How agriculture will therefore tackle persistent problems of under-nutrition will be an important consideration under this multi-sectoral implementation plan.

But for these synergies to be realized, implementation processes will need to be well coordinated among various actors. Presently, it is clear that coordination and administration of nutrition programs have literally no linkages with sector ministries such as education, agriculture, water and sanitation, gender and social welfare, etc. Developing these linkages are now deemed as particularly instrumental in addressing the problem of under-nutrition in Namibia. The activities carried out by each sector may be specific to their sector and mandate however the potential contribution that these activities can make toward improving nutritional status of the population is considerable. The mandates and subsequent actions may differ but the goal is singular; to achieve improvement in nutrition indicators for Namibia.

The over-arching goal of this implementation plan is to put in place evidence based actions that are proven to reduce the burden of malnutrition. The Lancet nutrition series (2008) identified 13 evidence-based high-impact nutrition interventions. Five interventions are strongly linked to child mortality and are therefore considered lifesaving. These thirteen direct nutrition interventions can be delivered most

easily through existing health structures, systems, and platforms, but are dependent on the country's context and capacity.

The Health Sector's 13 evidence based actions

Five Lifesaving Nutrition Interventions

1. Breastfeeding promotion and support
2. Vitamin A supplementation
3. Therapeutic zinc supplements
4. Iron folic-acid supplementation for pregnant women
5. Treatment of severe acute malnutrition

High Priority Nutrition Interventions

6. Complementary feeding promotion
7. Hand washing and hygiene promotion
8. Provision of multiple micronutrient powders
9. Iron fortification of staple foods
10. Salt iodization
11. Iodine supplements
12. Prevention and treatment of moderate malnutrition in children 6-23 months
13. Deworming

To achieve this broad goal, a multi-sectoral nutrition country implementation plan, results matrix and dashboard of indicators and targets has been developed and will constitute the framework by which NAFIN will regularly monitor progress towards improving nutritional status in Namibia. In doing so the aim is also to build a body of evidence for the role of nutrition sensitive activities and interventions for reducing malnutrition. Namibia is in a position to contribute to the global evidence base regarding the impact of nutrition sensitive interventions on nutritional status. This implementation plan has therefore been constructed in a way that outlines the outcome areas, outputs, indicators and targets as detailed below.

3.5 Strategic areas of focus, key outcomes, outputs, indicators and targets

This plan has proposed a series of six high-priority actions and outputs that have impact on nutrition programs as well as indicators for monitoring the implementation of the plan. They include;

1. Supporting effective implementation of both nutrition specific and nutrition sensitive actions using multi-sectoral strategies
2. The establishment of multi-sectoral coordination and planning mechanisms at national, regional and community levels as well as at policy and technical levels
3. Establishment of strong institutional arrangements for effective coordination of nutrition activities

4. Capacity development of all cadre of health care workers (nurses, community health volunteers), agriculture extension, water and sanitation extension workers and family promoters with basic nutrition knowledge and skills
5. Strengthened monitoring and evaluation systems that capture cross-sectoral activities and high impact nutrition interventions
6. Sustained momentum on high level advocacy and resource mobilization to address problem indicators

Implementation of the multi-sectoral plan summarized in Appendix 1 is guided by five broad results areas, which are described in detail below;

3.6 The multi-sectoral implementation planning matrix

3.6.1 Result Area 1: Maternal, Infant and young child nutrition improve as a result of increased coverage of essential nutrition actions at health facilities and community level

The Issue: This plan recognizes that provision of good nutritional practices must be accompanied by awareness creation in the 4 priority areas as outlined in the Strategic Plan for Nutrition i.e. (maternal and child nutrition; micronutrient deficiencies; diet related diseases and lifestyles; and nutritional management of communicable diseases). Malnutrition in Namibia is presently caused by a number of complex factors, which the implementation plan will address.

Reductions in stunting and micronutrient deficiencies must top the agenda of this implementation plan. But most importantly, greater attention will be paid to the double burden of malnutrition by focusing not only in the earlier years of development (i.e. the period from conception to a child's second birthday) but will also take a life cycle approach capturing issues such as diet related lifestyle and non-communicable diseases, which are presently emerging health and nutrition challenges in Namibia.

Good maternal nutrition is a predictor of good nutrition, health and well-being of children. As depicted by low body mass index (BMI) and micronutrient deficiencies of mothers as well as precarious child nutrition situation, there is an urgent need to improve maternal nutrition through concerted actions. Ensuring maternal nutrition is the first step to guaranteeing sound nutrition and health status of the mother and the baby, especially during the first 1000 days from conception to two years of birth.

Whereas it's important to note that there have been a number of nutrition interventions carried out in the country, such as Vitamin A supplementation for children 9-60m and iron folic acid supplementation for pregnant and lactating women, the implementation of these interventions has been limited in scope and coverage to effectively address maternal and child health, micronutrient control, NCDs and diet related and lifestyle diseases. These nutrition interventions are not presently producing the desired impacts due to limited human resources and technical capacity within the health system.

Added attention will be paid to scaling up knowledge and practices from national, regional, constituency and household levels. Complete elimination of under-nutrition will however require long term multi-sectoral approaches. To increase knowledge and practices on the magnitude of under-nutrition, a number of tangible activities are crucial and include;

Objective 1.1	**More than 80 percent of children under 5, and pregnant and lactating women have access to low cost high impact maternal and child health interventions in regions with the highest burden of malnutrition**
Activities	1.1.1 Train health workers on nutrition counseling for women of reproductive age attending family planning services and pregnant women attending ANC or PMTCT services 1.1.2 Conduct social mobilisation activities as per the Nutrition Communications strategy for maternal nutrition 1.1.3 Job aids on Maternal Nutrition for ANC and PMTCT health workers 1.1.4 Conduct social mobilisation activities as per the Nutrition Communications Strategy for IYCF 1.1.5 Implement communication activities for the promotion of diversified dietary intake for prevention of micronutrient deficiency at national, regional and constituency levels 1.1.6 Train Health Workers and Implement the minimum 7 steps of the BFHI at selected health facilities/maternity wards 1.1.7 Train health workers and volunteers on IYCF and C-IYCF counseling 1.1.8 Supportive supervision for health workers and volunteers for IYCF and C-IYCF counseling 1.1.9 Supportive supervision for ANC and PMTCT health care workers 1.1.10 Implement activities under the eMTCT strategy relevant to HIV and infant feeding 1.1.11 Develop sanitation infrastructure with improved sanitation facilities in poor rural areas 1.1.12 Develop and implement WASH communications strategy 1.1.13 Develop a set of ECD centre operating guidelines for IYCF and nutrition 1.1.14 Train ECD centre workers in IYCF and nutrition practices 1.1.15 Pilot implementation of IYCF program in selected ECD centres (2 centres in 3 high stunting burden areas)
Indicator(s)	# of health workers trained # of social mobilisation activities conducted Job aids developed Number of health facilities implementing the 7 steps of BFHI # supportive supervision visits % of HH with improved sanitation facilities (Rural)

	WASH strategy launched # of TWG meetings held # ECD centre workers trained # ECD centres implementing and meeting the IYCF standards
Objective 1.2	**To reduce the prevalence of micronutrient deficiencies among infants, young children and women of reproductive age**
	1.2.1 Develop and/or revise micronutrient policy and implementation guidelines for supplementation programmes [vitamin A, iron (including deworming), iodine, zinc and calcium] 1.2.2 Train Health workers in routine vitamin A, Zinc, IFA supplementation for women and young children 6-59m 1.2.3 Implement Maternal and Child Health Days (MCHD) as key delivery platform in high burden regions for critical low cost high impact maternal and child health interventions 1.2.4 Pilot MNP in x districts in 2 selected regions (Hardap and Ohangwena) 1.2.5 Scale up MNP in regions with highest burden of malnutrition (dependent on Pilot study outcomes) 1.2.6 Develop national mandatory food fortification programme including National Food Standards and regulations
Indicator(s)	Policy guidelines developed and implemented # health workers trained # of sites where MCHDs conducted Food fortification Legislation adopted
Objective 1.3	**By end of 2015/2016 increase coverage of NACS programme to match all ART sites**
	1.3.1 Scale-up NACS to sites selected as part of expansion plan (train remaining health facilities in NACS service delivery) 1.3.2 Provide nutrition assessment equipment to scale-up NACS 1.3.3 Develop a Community Nutrition Promoter service delivery model in partnership with NGOs / CSOs and FBOs 1.3.4 Conduct quarterly supportive supervision and mentoring visits for health facility workers delivering NACS services 1.3.5 Strengthen current supply management system for nutrition, maternal and child health commodities, and ensure end-user monitoring for effective delivery of services
Indicator(s)	Number of health facilities out of the total, which are providing NACS services Number of NACS sites fully equipped % of defaulters followed up within the reporting quarter Number of supportive supervision visits conducted over 12 months End-user monitoring reports
Objective 1.4	**Strengthen the legal, policy and institutional frameworks for planning, implementing, coordinating and monitoring nutrition programmes**
	1.4.1 Develop MoHSS Circular relevant to the Code of Marketing of Breast milk

	Substitutes as interim measure while waiting for Public Health Bill to be promulgated by Cabinet 1.4.2 Advocate for Public Health Bill promulgation by Cabinet 1.4.3 Develop regulations for the Code for Marketing of Breast Milk Substitutes 1.4.4 Train health inspectors in the Code adherence monitoring 1.4.5 Implement Code monitoring and reporting mechanisms
Indicator(s)	Circular for Code of marketing for BMS produced Number of Advocacy documents produced Number of Code Regulation violations # health inspectors trained
Objective 1.5	**By end 2015/16 increase national capacity to produce, support and manage a skilled nutrition workforce**
Activities	1.5.1 Incorporate nutrition modules into pre-service training courses for nursing, medicine, paramedics and master of public health 1.5.2 Develop a Diploma in Nutrition Programme at UNAM 1.5.3 Develop and implement nutrition research / Thesis topics for Master of Public Health programme 1.5.4 Conduct capacity building activities for NHTC to deliver nutrition modules in the in-service healthcare provider professional development programme; IYCF, C-IYCF, GMP, NACS, Maternal nutrition 1.5.5 Develop nutrition modules and training materials for extension officers from MAWF, MGECW, MoE, DDRM
Indicator(s)	# of modules developed and incorporated into academic pre-service courses Diploma program offered at UNAM in 2015 5 key research areas identified and reflected in the MPH Thesis curriculum # of TOTs # of NHTC/RHTC staff trained as trainers

3.6.2 Result Area 2: Reduced burden of non-communicable disease

Namibia is facing the double burden of malnutrition in that under-nutrition and over-nutrition are both serious threats to health, well-being and national development. Non-communicable diseases caused by overweight and obesity are increasingly contributing to adult morbidity and mortality. According the 2006 Demographic and Health Survey, 27 per cent of women of reproductive age (15-49years) has a Body Mass Index (BMI) above 25. The implications of increasing prevalence of obesity related NCDs are yet to be fully understood in the context of Namibia, however what is evident from health system analyses, such as the Nutrition Landscape Analysis, is there is limited capacity within the current health system to prevent, manage and or treat NCDs.	
Objective 2.1	**Reduce the prevalence of women of reproductive age (15-49y) with BMI 25 or above**

Activities	2.1.1 Assess prevalence and causes of obesity and associated NCCD in school aged children 13-17 2.1.2 Develop and disseminate guidelines for nutritional prevention and treatment of NCD 2.1.3 Train healthcare providers on dietary management of NCDs 2.1.4 Conduct social marketing campaign for the prevention of obesity and associated NCDs 2.1.5 Assess prevalence of overweight and obesity among women of reproductive age
Indicator(s)	Availability of results in all concerned agencies NCD guidelines endorsed, # health facilities oriented on NCD guidelines # of healthcare providers trained # of social marketing activities conducted in 12 months # of women (15-49 years) with BMI greater than 25

3.6.3 Results Area 3: Improved community and household food and livelihood security

The Issue: The manner in which households withstand shocks to food and nutrition security will be explored and measures put in place to address them. In Namibia, it's now clear that there are a number of shocks and crisis to food and nutrition security and these are now noted to result from complex interactions between economic, social and environmental factors. Issues like droughts and delayed rainfall constantly pose stress on the already chronically vulnerable population groups. In a cattle rearing economy, disasters such as droughts have the capacity to potentially destroy livestock, assets and peoples production capacity, thereby creating a poverty trap and potentially contributing to increased food prices, decreasing food consumption and dietary diversity, respectively. Building vulnerable communities' resilience so they can respond to these shocks are important considerations that have been built into this implementation plan. Efforts to address these food security shocks and complexities will call for multi-Sectoral responses; hence strategies that address shocks to food insecurity must include immediate, mid-term and long term responses.	
Objective 3.1	**To improve backyard and community gardening management and production techniques for the production of nutritious foods for home consumption and sale**
Activities	3.1.1 Scale up the urban and peri-urban horticulture program under the MAWF 3.1.2 Develop and implement nutrition module/training component to include in the horticulture program run by the MAWF 3.1.3 Provide technical and supply inputs to households and small scale farmers to grow vitamin A rich vegetables (orange flesh sweet potato) 3.1.4 Train individuals and community groups in post-harvest handling and storage techniques/technologies 3.1.5 Build school gardens in schools operating the School Feeding Program 3.1.6 Revise and update the hostel feeding programme (menu review) 3.1.7 Develop and monitor set of nutrition indicators for WATSAN interventions in two regions implementing water re-use projects
Indicators	Increase in number of households enrolled in horticulture programme Increase in number of households reporting consumption of home grown vegetables Increased dietary intake amongst hostel residence
Objective 3.2	**Increase household and community resilience to shocks and threats that affect nutrition status**

	3.2.1 Implement E-IYCF and food relief strategies during emergencies 3.2.2 Conduct community mobilization and sensitization activities on prevention, mitigation and recovery strategies relevant to emergency situations 3.2.3 Train health workers and community based providers/volunteers to identify households with children who qualify for Child Grants and to refer them to appropriate services
Indicators	Number of community mobilization activities conducted Number of health workers trained to identify households at risk or eligible for social welfare grants
Objective 3.3	**To increase awareness of and enrolment in social protection interventions for improved nutrition**
	3.3.1 School Feeding Programme Implement the recommendations made from the School Feeding Programme review; 3.3.2 Conduct a regional and constituency level mapping exercise to identify nutrition sensitive interventions for livelihood strengthening 3.3.3 Develop and implement a bi-directional referral system between nutrition services and nutrition sensitive interventions
Indicators	Deliverables of SFP review met Increase in number of referrals to FSL programmes

3.6.4 Results Area 4: Improved awareness of and commitment to national nutrition priorities

The Issue:

Policies and programs that are sensitive to nutrition are required to reduce the double burden of under-nutrition, diet and lifestyle related diseases and communicable diseases. In this regard, to ensure successful realization of nutrition outcomes, nutrition actions will need to be well reflected in policies and programs of all sectors that impact on nutrition. Relevant line ministries will incorporate nutrition objectives into sectoral policies and plans while key nutrition indicators will need to be reflected in the national policies and action plans e.g. PRSP national development plans and vision 2030.

Policy-wise, the need to decentralize the structures from national to regional and community levels for implementation of nutrition programs is now urgent. While it's clear that there is ample political good will at the national level, these must be accompanied by commensurate structures at the regional, constituency and community levels. At the regional level and in policy discussions, a better understanding of the nutrition situation coupled with the importance of nutrition for socio economic development will be developed and close cooperation established between the different departments in each of the 13 regions, including involving the regional development coordinating committees in the planning and implementation of the nutrition programs. A clear structural arrangement for coordinating nutrition activities will be established at the regional level and nutrition activities reflected in the annual regional work-plans to ensure nutrition's visibility all the way to the community level.

To guarantee incorporation of nutrition objectives into the regional work plans, consultative and review meetings will be organized at each of these regional and sub-regional levels to develop the functional plans and programs with clear nutrition indicators. It will also be important that capacity of nutrition human resource is strengthened at each of these levels to ensure effective delivery of

nutrition services. Memorandum of agreement will be developed between nutrition department of the Ministry of Health and the regional entities on the execution of the activities including resource allocation.

In the long term, there will also be need to hire nutrition focal points in each of the 13 regions

Note that nutrition plans will be developed at all these policy levels (national and regional) with clearly defined key results, activities, budget and implementing partners. Annual joint plans will be signed by all partners to confirm their commitment to carry out the activities outlined in the implementation plan. The Memorandum of Agreements will also contain commitments to provide funding and technical support.

Objective 4.1	**Increase awareness of national nutrition situation among policy makers, planners and external funders**
Activities	4.1.1 Implement the Nutrition Communication strategy activities related to advocacy (refer to Nutrition Communications Strategy for details) 4.1.2 Produce reports based on national and local level situation analyses 4.2.2 Develop a financial tracking system for specific nutrition interventions
Indicator(s)	Refer to Communications strategy for details # of reports on nutrition situation at national and or local level
Objective 4.2	**Increase financial and human resource commitment to nutrition programming**
Activities	4.2.1 Develop an investment case/costed plan for nutrition specific and sensitive interventions 4.2.2 Develop a financial tracking system for specific nutrition interventions 4.2.3 Develop an advocacy plan for increasing human resources for nutrition at national, regional and district levels 4.2.4 Develop nutrition posts within the health system at national, regional and district levels (need to specify number of posts)
Indicator(s)	Number of nutrition posts within the health system Completion of an advocacy plan for increasing human resources for nutrition

3.6.5 Results Area 5: Functioning and effective, surveillance, monitoring and evaluation system for nutrition

The Issue:
The implementation plan will need to be monitored and evaluated against set targets and indicators. The objective of Monitoring and Evaluation (M&E) will be to inform decision making in ensuring that planned activities are implemented and targets set are met within the given time-frame.

Presently, the M&E system for nutrition in the country is weak with almost no indicator being collected for nutrition in routine health services. Such indicators as; growth monitoring; underweight; vitamin A supplementation and deworming will need to be collected regularly. Data on IYCF indicators such as breastfeeding and other micronutrient deficiencies such as Iron folic acid supplementation have not been incorporated into the Health Management and Information System (HMIS). In addition, there are no nutrition surveys apart from the Demographic and Health Surveys conducted every five years, a very long time to wait for nutrition information. Similarly, there is no

clear mechanism of validating nutrition survey methodologies to ensure that data collected is standardized across the country.

In order therefore to monitor and evaluate nutrition activities, sources of nutrition data for M&E will include; HMIS to provide routine nutrition data; DHS to provide data after every five years; *Ad-hoc* nutrition surveys that will be conducted from time to time (e.g. regional nutrition surveys, MICS surveys, among others) and Nutrition program documents. In addition, NAFIN working group coordination minutes and other reports for depicting process indicators will constitute monitoring tools.

To collect M&E data, it's important that data collection plan is instituted. To do this, a HMIS 'nutrition focal person', with brief training on nutrition will be hired to be responsible for collecting and reporting all nutrition data on quarterly basis from the sources mentioned above. The data collected will be validated and disseminated to NAFIN for decision making. Recommendations from NAFIN indicating action points with clear descriptions on who is responsible for the follow-up will be submitted to partners. M&E reports will be published in the Namibia Quarterly Nutrition Bulletin to be developed by the nutrition M&E working group under NAFIN. In order to improve the M&E for nutrition programming, the following efforts will be required:

Objective 5.1	**Increase capacity to monitor nutrition indicators at national, regional and constituency levels**
Activities	5.1.1 Develop a set of nutrition indicators for HMIS 5.1.2 Develop and pilot a national nutrition surveillance system; beginning in 2 regions and scaling up to all 13 over 3 years 5.1.3 Develop a set of nutrition indicators to monitor impact of nutrition sensitive interventions on malnutrition amongst children under 5 5.1.4 Pilot multi-sectoral coordination mechanism at regional level in two regions (Hardap and Omaheke) 5.1.5 Pilot nutrition indicator monitoring system in two regions (Hardap and Omaheke)
Indicator(s)	Routine nutrition data collected and reported to national level quarterly Nutrition indicators for 'nutrition sensitive' interventions collected and reported on quarterly Local level nutrition indicator monitoring tool implemented in two selected regions
Objective 5.2	**Increase human resource capacity to assess nutrition situation at national, regional and constituency levels**
	5.2.1 Train national Food and Nutrition Unit staff, UNAM and other relevant stakeholders in nutrition survey methodologies, data analysis and reporting 5.2.2 Conduct periodic nutrition surveys (National; NDHS, regional and district level)
Indicator(s)	Number of staff trained in survey methodologies, data analysis and reporting Number of nutrition surveys conducted

4. FRAMEWORK FOR IMPLEMENTATION OF THE MULTISECTORAL PLAN

The multi-sectoral plan needs a framework for implementation, which describes the structure of the institutional arrangements required to implement the interventions. The framework should also depict how the various sectors will coordinate activities and efforts. There are a number of actions required to create an enabling environment for the successful implementation of nutrition specific and sensitive interventions. Underpinning all interventions is the need for multi-sectoral planning, coordination and joint monitoring.

4.1 Multi-sectoral coordination platform

The proposed multi-sectoral platform is schematically depicted in Figure 5. At the apex is NAFIN, which is housed within the Prime Minister's office representing high level political commitment and coordination amongst the different line ministries and sectors. The national level technical working groups under NAFIN represent the key focus areas and each TWG has responsibility for oversight and implementation of the CIP activities. The working groups are comprised of various relevant stakeholders from government, non-government organisations, educational institutions, UN agencies, development partners and the private sector. At the time of writing this report Namibia had yet to

appoint a SUN Focal Person. The role of the SUN Focal person is to oversee the overall implementation of the SUN CIP and to facilitate coordination between the respective line ministries and sectors

At present there is no regional or constituency level platform specifically set up to coordinate implementation of nutrition activities. Due to competing demands of regional and constituency level authorities it is therefore suggested that existing forums or groups be identified that could assume the role of local level coordination for nutrition. Already in place administratively is the Regional Development Coordinating Committees (RDCC) and other Local Authorities Committees, which are supposed to be representative of the various sectors. RDCCs and Constituency Development Committees could therefore be ideal local level coordination mechanisms for overseeing and monitoring the implementation of nutrition activities on the 'ground'. Mapping of functioning RDCCs and CDCs and identifying any other forums that exist, is needed in order to understand what the capacity at local level is.

With respect to building national capacity to produce, support and manage a skilled nutrition workforce, it is proposed that a long term plan be developed whereby the current Nutrition Sub-Division within the Family Health Division of the Directorate of Primary Health Care, be elevated to a Directorate of Nutrition and Dietetics and be expanded to include both a Clinical Dietetics unit and a Public Health Nutrition unit. This should be considered as part of the current Ministry of Health restructuring process.

Figure 5: Proposed nutrition multi-sectoral structure

NAFIN (PM, Government PSs, Heads of agencies (UN, DPs and NGOs)

SUN Nutrition focal point

Maternal, Infant and Young Child Nutrition Working group

1. Adolescent nutrition/school feeding
2. Non-communicable diseases
3. Nutrition surveillance and growth monitoring
4. HIV and Nutrition

Food Security & Livelihoods Working Group

Food Fortification Working Group

Water and Sanitation Working Group

Regional Level

RDCCs

Health Facility Committees

Ministerial Committees

Sectoral Forums at Regional level (eg WATSAN)

All NGOs, CBOs, FBOs, private sector

Village/Constituency Level

Health Clubs

CDCs, Village Committees

Health clinics

Sectoral Forums at constituency/village

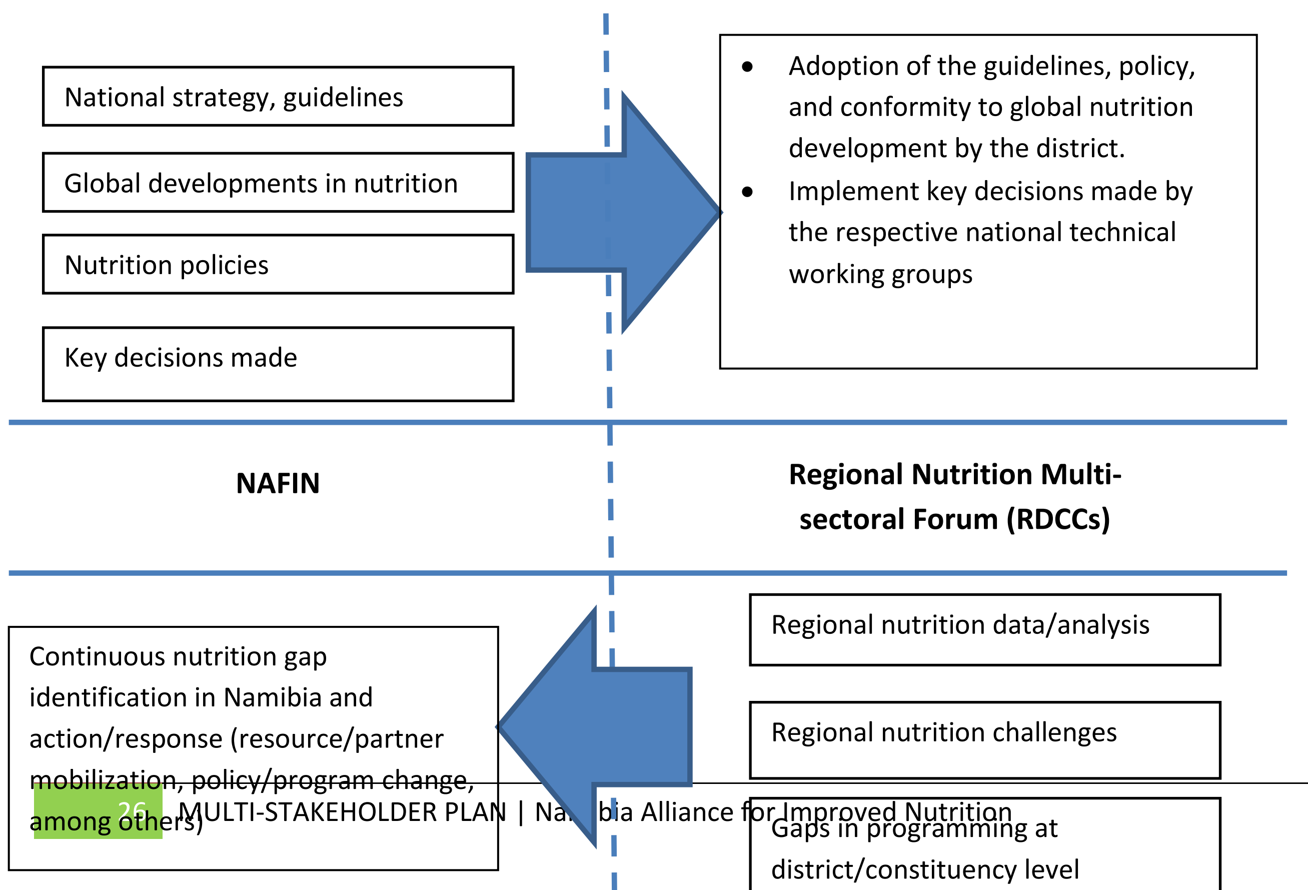
All NGOs, CBOs, FBOs & private sector

There will be close linkage between the national, regional and constituency coordination mechanisms. At the national level, NAFIN will provide strategic direction and guidance and make policy and programming decisions based on regular situation analyses and implementation reports provided from regional forums. The national level TWGs will report at quarterly NAFIN meetings the progress against their respective work plans and CIP indicators. At a regional and constituency level, updates on implementation challenges and progress will be captured in monthly or routine meeting minutes and reported to NAFIN via the respective Chairpersons of the TWGs. Defined ToR for each level; NAFIN, regional and constituency is thus required but currently does not exist.

The TOR guiding coordination at different levels will include (and not limited to) the following:

1. Nutrition targets (derived from national targets)
2. The method of selecting the Chair and Secretariat of the coordination meetings,
3. The coordination meeting frequency
4. Who should attend or be represented, quorum for meetings, e.t.c.
5. How the deliberations should be recorded including:
    a. Challenges experienced
    b. Action points, by who and when

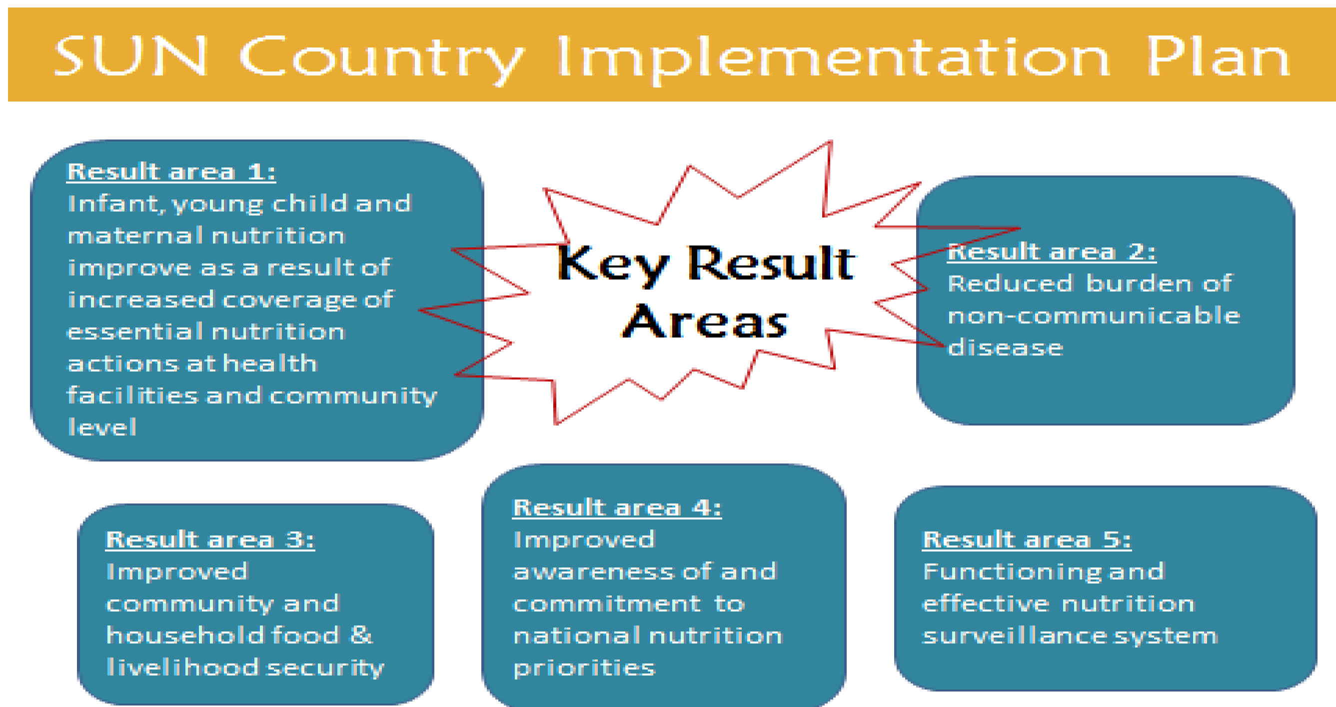
Figure 6: Linkage between national and regional coordination structure



4.2 RESULT MATRIX AND INDICATOR DASHBOARD

Namibia's Common Results Matrix

The Country Implementation Plan spanning 2012/13 until 2015/16 will be measured against a set of agreed result areas and indicators. There are five key result areas;



The Result areas have been largely informed by the findings from the Nutrition Landscape Analysis conducted in 2011/12. Indicators for tracking progress towards the achievement of these results include a range of process, input and outcome indicators. Each of the activities listed in the CIP were selected based on evidence based principles and existing capacity within country. The cost estimate to achieve the results has been calculated using a mix of internationally agreed costs and local costs.

Indicator dashboard

The Namibia nutrition indicator dashboard will at any given point, indicate the status of progress towards achieving the set targets for each result area. The dashboard is shown in Table 4 depicting baseline and targets for each indicator. Some of the indicators are high level impact indicators such as stunting prevalence, while others are process or outcome indicators.

Table 4: Namibia Costing Table by Target Population (DASHBOARD) and Programmatic Outcomes (RESULTS MATRIX)

KEY PERFORMANCE INDICATORS (KPIs)	Namibia's Multi-Sectoral Nutrition Implementation Plan (2013-2015)							
	Costing Table Aggregated by Target Population (Dashboard) and Programmatic Outcomes (Result Matrix)							
	Results area	Interventions	Indicator	Target Population or Quantity - 2015			Delivery Platforms	Total Cost by Result Area
		(From Dashboard)	(% or Quantities)	Target	BASELINE 2012	GOAL END of Y3		TOTAL
KPI-1	OVERARCHING RESULT maternal and child nutrition interventions	TOTAL OUCOME RESULTANT FROM AGGREGATED INTERVENTIONS RESULTS 1 TO 5	% of children under 5 stunted	Percentage	29.0%	20.0%	Proportion of children < 5 and their mothers receiving maternal and child nutrition interventions	TOTAL RESULT 1 to 5
				Number of children < 5 stunted	88,871	16,977		TOTAL NAD 496,310,980
KPI-2	Result area 1 Infant, young child and maternal nutrition improve as a result of increased coverage of essential nutrition actions at health facilities and community level	Exclusive breastfeeding interventions (policy, programme, social mobilization) (Behavioural Change)	% 0-6 m old exclusively breastfeeding	Percentage	24%	50%	Proportion of women receiving nutrition counselling, care and support at ANC and PNC (e.g., 80% of target population)	
				Number of Pregnant women and mothers of infants under six months of age receiving nutrition	52,529	115,424		NAD 6,467,244
KPI-3	Result area 1	Implementation of BMFHI	% of infants initiating breastfeeding within the first 30-60 min after delivery	Percentage	71%	80%	Proportion of infants initiating breastfeeding within 30-60min after delivery	
				Proportion of infants initiating breastfeeding within the first 30-60 min after delivery	49,618	58,289		NAD 1,581,706
KPI-4	Result area 1	WASH interventions	% population practicing open defecation	Percentage	50%	20%	Proportion of rural households with access to improved sanitation	
				Proportion of population practicing open defecation	1,094,477	458,367		NAD 410,595,750
KPI-5	Result area 1	Complementary feeding for infants after the age of six months	% children 6-23 m old who are receiving MAD and still breastfeeding	Percentage	42%	50%	Estimated % mothers who have received CF education	
				Proportion of mothers who have received CF Education	39,960	62,299		NAD 3,898,991
KPI-6	Result area 1	Maternal infant (1<) and young	Percentage of pregnant women	Percentage	34.2%	50.0%	Proportion of	

KEY PERFORMANCE INDICATORS (KPIs)	Namibia's Multi-Sectoral Nutrition Implementation Plan (2013-2015)							
	Costing Table Aggregated by Target Population (Dashboard) and Programmatic Outcomes (Result Matrix)							
	Results area	Interventions	Indicator	Target Population or Quantity - 2015			Delivery Platforms	Total Cost by Result Area
		(From Dashboard)	(% or Quantities)	Target	BASELINE 2012	GOAL END of Y3		TOTAL
		child (1>) nutrition programs	with Hb below 10g/dl (34.2%)	Proportion of pregnant women receiving 90+ of iron and folic acid supplementation	41,650	63,753	pregnant women receiving 90+ of iron and folic acid supplementation	NAD 3,192,909
KPI-7	Result area 1	Periodic Vitamin A supplements	% pre-school (6 - 59m) children with vitamin A deficiency (NDHS 23%)	Percentage	51.5%	80.0%	% children 6-59m supplemented with vitamin A in the last 6 months	
				% children 6-59m supplemented with vitamin A in the last 6 months	168,799	273,474		NAD 8,002,114
KPI-8	Result area 1	Nutrition Assessment Care and Support (NAC)	% of women of reproductive age underweight	Percentage	16.0%	10.0%	Number of pregnant woman measured using MUAC at AN+C	
				Proportion of pregnant women measured using MUAC at ANC	19,485	12,751		NAD 209,912
KPI-9	Result area 1	Prevention and treatment for moderate acute malnutrition (MAM)	% 6-59m MAM (wasting) Outcome: % of MAM cured % of defaulters	Percentage	5.6%	2.0%	Number of wasted chidren covered by supplementary food aid assistance	
				Proportion of children 6-59 m MAM (wasted)	18,355	6,837		NAD 15,467,136
KPI-10	Result area 1	Treatment of severe under nutrition ("severe acute malnutrition - SAM") with ready-to-use therapeutic foods (RUTF)	% 6-59 m severely malnourished (wasting)	Percentage	1.9%	1.5%	Number of severely malnourished children (6-59m) who have received treatment	
				% of severely malnourished who have received treatment	6,228	5,128		NAD 31,385,706
KPI-11	Result 2	Education on prevention and management of diet-related NCDs	% of low birth weight infants	Percentage	27.0%	22.0%	Proportion of women receiving nutrition counselling, care and support at ANC and PNC (e.g., 80% of target population)	
	Reduced burden of non-communicable disease			% of women of reproductive age (15-49 Y) with BMI 25 or above	153,904	104,860		NAD 7,435,521
KPI-	Result 3	Food security initiatives	% of food insecure households	Percentage	0%	5%		

KEY PERFORMANCE INDICATORS (KPIs)	Namibia's Multi-Sectoral Nutrition Implementation Plan (2013-2015)							
	Costing Table Aggregated by Target Population (Dashboard) and Programmatic Outcomes (Result Matrix)							
	Results area	Interventions	Indicator	Target Population or Quantity - 2015			Delivery Platforms	Total Cost by Result Area
		(From Dashboard)	(% or Quantities)	Target	BASELINE 2012	GOAL END of Y3		TOTAL
12	Improved community and household food & livelihood security			% of rural households supported in local homestead food production -	-	12,000		NAD 2,620,207
KPI-13	Result area 4	MoHSS/ Food and Nutrition Sub-division (staffing only) budgetary resource allocation to support national nutrition priorities	Number of staff assigned to F&N Sub-division as proportion of resources allocated to support national nutrition priorities	Percentage	23.5%	100.0%		
	Improved awareness of and commitment to national nutrition priorities			Increased budgetary staff allocation (4 HQ + 13 Regions)	4	17		NAD 5,353,784
KPI-14	Result 5 Functioning and effective monitoring and evaluation system	Develop and implement a food and nutrition surveillance system for M&E and policy decision making support	National Nutrition surveillance information system developed and implemented	Percentage	0%	100%		
				Online access to monthly data on MAM and SAM being used for M&E and policy decision making				NAD 100,000

The total cost to achieve the high level target results within the timeframe of the CIP; 2012/13 – 2015/16 is approximately $496,310,980 Namibian dollars or $49,631,098 million US Dollars.

5. CONCLUSIONS

The Country Implementation Plan is the first attempt by NAFIN to represent a multi-sectoral approach to reduce stunting. Nutrition has been seen mostly as a health issue in the past. This plan and the consultative process used to develop it, is hopefully the first step to greater engagement and representation at NAFIN by the respective line ministries and sectors. Accountability to implement, monitor and evaluate the activities is essential to meet the target to reduce stunting to below 20 per cent by 2015/2016. Coordination, information sharing and joint monitoring within and across sectors are critical. Existing coordination mechanisms or platforms such as NAFIN need to be strengthened to ensure participation by all ministries whose core activities are reflected in this plan. Coordination mechanisms at regional, constituency and village level need to be identified and supported and reporting channels established so information can flow from ground up and vise versa.

Progress of implementation will be measured by monitoring and tracking process indicators throughout the life of the plan, while outcomes and results will be measured only at the end of the life of the plan; 2015/16.

The achievements of the nutrition targets depend on the willingness of government line ministries and other partners to actively participate in NAFIN meetings and the technical working group meetings.

Way forward

- It's important that this developed implementation plan is functional. Hence, piloting it starting with one region, for a period of 6 months and later rolling it out to other regions coupled with technical guidance will provide ample information on how it works, and for scaling up to other regions.
- The multi-sectoral implementation plan, results matrix and dashboard of indicators must be disseminated in a series of workshops among government line ministries and stakeholders involved in nutrition activities in the country. The dissemination will take form of both national and regional workshops for further refinement and buy-in and ownership by all involved parties.
- As a follow up activity to this implementation plan, the development of a line by line budget tracking system for all the activity items in the implementation plan. This will assist NAFIN to understand the actual cost to implement the range of nutrition specific and sensitive activities and to subsequently identify funding gaps.
- It's also critical that as the implementation process commences a detailed M&E plan for activities in the implementation matrix is developed.

SUN Country Implementation Plan – 2012/13 – 2015/16

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
Result 1 & 5 KPIs: 2-10	**Objective 1.1 More than 80 per cent of under 5 children, and pregnant & lactating women have access to low cost high impact maternal and child health interventions in regions with highest burden of malnutrition**	1.1.1 Train health workers on nutrition counseling for women of reproductive age attending family planning services and pregnant women attending ANC or PMTCT services	# of health workers trained	**MoHSS PHC**		**UNICEF, WHO,**	**x**	**x**	**x**
		1.1.2 Conduct social mobilisation activities as per the Nutrition Communications strategy for maternal and infant nutrition	# of social mobilisation activities conducted	**MoHSS PCH**	**MICT**	**UNICEF, WHO, FANTA, iTECH**		**x**	
		1.1.3 Job aids on Mat Nut for ANC and PMTCT health workers	Job aids developed	**MoHSS PHC**		**UNICEF, WHO, iTECH**	**x**		
		1.1.4 Implement communication activities for the promotion of diversified dietary intake for prevention of micronutrient deficiency at national, regional and constituency levels	# of communication activities	**MoHSS PHC**	**MICT**	**Food Fortification Technical Working group**		**x**	**x**
		1.1.5 Train Health Workers and Implement the minimum 7 steps of the BFHI at selected health facilities/maternity wards	Number of health facilities implementing the 7 steps of BFHI	**MoHSS**	**NHTC**	**UNICEF, WHO, iTECH**	**x**	**x**	**x**
		1.1.6 Train health workers and volunteers on IYCF and C-IYCF counseling	# people trained	**MoHSS**	**NHTC**	**UNICEF, WHO, NRCS, iTECH, FANTA**	**x**	**x**	**x**
		1.1.7 Conduct supportive supervision visits with health workers and volunteers for IYCF and C-IYCF counseling	# supportive supervision visits	**MoHSS**	**CHBC**	**UNICEF, WHO, NRCS, iTECH, FANTA, CAA**	**x**	**x**	**x**

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
		1.1.8 Conduct supportive supervision visits for ANC and PMTCT health care workers	# supportive supervision visits	**MoHSS**	**DSP**	**UNICEF, WHO, NRCS, iTECH, FANTA**	**x**	**x**	**x**
		1.1.9 Implement activities under the eMTCT strategy relevant to HIV and infant feeding	# of activities implemented	**MoHSS PHC Directorate**	**DSP**	**UNICEF, WHO, NRCS, iTECH, FANTA**	**x**	**x**	
		1.1.10 Develop sanitation infrastructure with improved sanitation facilities in poor rural areas	% of HH with improved sanitation facilities (Rural)	**MAWF DWSSC**	**MRLGHRD**	**UNICEF, WASH Health Task Force**		**x**	**x**
		1.1.11 Develop and implement WASH communications strategy	WASH strategy launched	**MAWF DWSSC**	**MoHSS MoE MICT**	**UNICEF, WHO, WASH Health Task Force**	**x**	**x**	**x**
		1.1.12 Develop a set of ECD centre operating guidelines for IYCF and nutrition	# of TWG meetings held	**MGECW**	**MoHSS**	**UNICEF, WHO**		**x**	
		1.1.13 Train ECD centre workers in IYCF and nutrition practices	# ECD centre workers trained	**MGECW**	**MoHSS**	**UNICEF, WHO, NHTC**		**x**	**x**
		1.1.14 Pilot implementation of IYCF program in selected ECD centres (2 centres in 3 high stunting burden areas)	# ECD centres implementing and meeting the standards	**MGECW**	**MoHSS**	**UNICEF, WHO, NHTC**		**x**	**x**
	Objective 1.2 To reduce the prevalence of micronutrient deficiencies	1.2.1 Develop and/or revise micronutrient policy and implementation guidelines for supplementation programmes [vitamin A, iron (including deworming), iodine, zinc and calcium]	Policy guidelines developed and implemented	**MoHSS**		**UNICEF, WHO, iTECH, FANTA**	**x**	**x**	

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
	among infants, young children and women of reproductive age	1.2.2 Train Health workers in routine vitamin A, Zinc, IFA supplementation for women and young children 6-59m	# health workers trained	**MoHSS**		**UNICEF, WHO, iTECH, FANTA**		**x**	
		1.2.3 Implement Maternal and Child Health Days (MCHD) as key delivery platform in high burden regions for critical low cost high impact maternal and child health interventions	# of sites where MCHDs conducted	**MoHSS**		**UNICEF, WHO**	**x**	**x**	**x**
		1.2.4 Pilot MNP in x districts in 2 selected regions (Hardap and Ohangwena)	# of mothers enrolled in MNP pilot project	**MoHSS**		**GAIN, UNICEF, WHO**	**x**	**x**	
		1.2.5 Scale up MNP in regions with highest burden of malnutrition (dependent on Pilot study outcomes)	Dependent on outcome of Pilot Study	**MoHSS**		**GAIN, UNICEF, WHO**		**x**	**x**
		1.2.6 Develop national mandatory food fortification programme including National Food Standards and regulations	Legislation adopted	**MoHSS**	**National Standards Institute**	**Food Fortification TWG**		**x**	
	Objective 1.3 By end of 2015 increase coverage of NACS program to match all ART sites	1.3.1 Scale-up NACS to sites selected as part of expansion plan (train remaining health facilities in NACS service delivery)	Number of NACS sites	**MoHSS**		**iTECH, FANTA**	**x**	**x**	**x**
		1.3.2 Provide nutrition assessment equipment to scale-up NACS	Number of NACS sites fully equiped	**MoHSS**		**CDC, UNICEF, WHO**	**x**	**x**	
		1.3.3 Develop a Community Nutrition service delivery model in partnership with NGOs / CSOs and FBOs	% of defaulters followed up within the reporting quarter	**MoHSS**		**UNICEF, WHO, NRCS, CAA, DAPP, iTECH, FANTA**	**x**	**x**	

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
		1.3.4 Conduct quarterly supportive supervision and mentoring visits for health facility workers delivering NACS services	Number of supportive supervision visits conducted over 12 months	**MoHSS**		**iTECH, FANTA**	**x**	**x**	**x**
		1.3.5 Strengthen current supply management system for nutrition, maternal and child health commodities, and ensure end-user monitoring for effective delivery of services	End-user monitoring reports	**MoHSS**		**FANTA, iTECH**	**x**	**x**	**x**
	Objective 1.4 Strengthen the legal, policy and institutional frameworks for planning, implementing, coordinating and monitoring nutrition programmes	1.4.1 Develop MoHSS Circular relevant to the Code of Marketing of Breast milk Substitutes as interim measure while waiting for Public Health Bill to be promulgated by Cabinet	Circular produced	**MoHSS**		**UNICEF, WHO, iTECH, FANTA, CDC**	**x**		
		1.4.2 Advocate for Public Health Bill promulgation by Cabinet	Advocacy documents	**MoHSS**	**National Standards Institute**	**UNICEF, WHO, iTECH, FANTA, CDC**	**x**	**x**	
		1.4.3 Develop regulations for the Code for Marketing of Breast Milk Substitutes	Code Regulations	**MoHSS**	**National Standards Institute**	**UNICEF, WHO, iTECH, FANTA, CDC**		**x**	
		1.4.4 Train health inspectors in the Code adherence monitoring	# health inspectors trained	**MoHSS**	**National Standards Institute, NHTC**	**UNICEF, WHO, iTECH, FANTA, CDC**		**x**	**x**
		1.4.5 Implement Code monitoring and reporting mechanisms	Monitoring reports	**MoHSS**		**UNICEF, WHO, iTECH, FANTA, CDC**		**x**	**x**

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
	Objective 1.5 By end 2015 increase national capacity to produce, support and manage a skilled nutrition workforce	1.5.1 Incorporate nutrition modules into pre-service training courses for nursing, medicine, paramedics and master of public health	# of modules developed and incorporated into academic pre-service courses	**MoHSS/ UNAM**	**MoE**	**UNICEF, WHO, iTECH, UNAM**		**x**	**x**
		1.5.2 Develop a Diploma in Nutrition Programme at UNAM	Diploma program offered at UNAM in 2015	**UNAM**	**MoE**	**UNICEF, WHO, iTECH, UNAM**		**x**	**x**
		1.5.3 Develop and implement nutrition research / Thesis topics for Master of Public Health programme	5 key research areas identified and reflected in the MPH Thesis curriculum	**UNAM**	**MoE**	**UNAM, UNICEF, WHO, iTECH**		**x**	**x**
		1.5.4 Conduct capacity building activities for NHTC to deliver nutrition modules in the in-service healthcare provider professional development programme; IYCF, C-IYCF, GMP, NACS, Maternal nutrition,	# of TOTs	**NHTC & MoHSS**		**UNAM, UNICEF, WHO, iTECH**	**x**	**x**	**x**
		1.5.5 Develop nutrition modules and training materials for extension officers from MAWF, MGECW, MoE, DDRM	# of NHTC/RHTC staff trained as trainers	**MoHSS**	**MAWF MGECW MoE DDRM**	**UNICEF, WHO, iTECH**	**x**	**x**	**x**
Result 2 KPI 11	**Objective 2.1 Reduce the prevalence of women of reproductive age (15-49y) with BMI 25 or above**	2.1.1 Assess prevalence and causes of obesity and associated NCCD in school aged children 13-17	Availability of results in all concerned agencies	**MoHSS**		**WHO**		**x**	
		2.1.2 Develop and disseminate guidelines for nutritional prevention and treatment of NCD	NCD guidelines endorsed, # health facilities oriented on NCD guidelines	**MoHSS**		**WHO**	**x**	**x**	
		2.1.3 Train healthcare providers on dietary management of NCDs	# of healthcare providers trained	**MoHSS**		**WHO**		**x**	**x**

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
		2.1.4 Conduct social marketing campaign for the prevention of obesity and associated NCDs	# of social marketing activities conducted in 12 months	**MoHSS**		**WHO**		**x**	**x**
		2.1.5 Assess prevalence of overweight and obesity among women of reproductive age	# of women (15-49 years) with BMI greater than 25	**MoHSS**		**WHO**		**x**	**x**
Result 3 KPI 12	**Objective 3.1 To improve backyard and community gardening management and production techniques for the production of nutritious foods for home consumption and sale**	3.1.1 Scale up the urban and peri-urban horticulture program under the MAWF	# of participants/communities enrolled in the horticulture	**MAWF - DEES**			**x**	**x**	**x**
		3.1.2 Develop and implement nutrition module/training component to include in the horticulture program run by the MAWF	# of extension officers trained using the nutrition module	**MAWF**	**MoHSS**	**FAO, UNICEF, iTECH**	**x**	**x**	
		3.1.3 Provide technical and supply inputs to households and small scale farmers to grow vitamin A rich vegetables (orange flesh sweet potato)	# of households and/or small farmers growing vit A rich vegetables	**MAWF**	**UNAM**	**FAO, UNAM, UNICEF**		**x**	**x**
		3.1.4 Train individuals and community groups in post-harvest handling and storage techniques/technologies	# of households /individuals trained in post-harvest techniques	**MAWF**		**FAO**	**x**	**x**	**x**
		3.1.5 Build school gardens in schools operating the School Feeding Program	# of school gardens producing food to supplement SFP meal	**MAWF & MoE**	**MoE**	**WFP**	**x**	**x**	**x**
		3.1.6 Revise and update the hostel feeding programme (menu review)	# of Hostels implementing the new menu	**MoE**	**MoHSS**	**WFP**		**x**	
		3.1.7 Develop and monitor set of nutrition indicators for WATSAN interventions in two regions implementing water re-use projects	Indicators routinely collected and reported	**MAWF / DWSSC**	**MoHSS**	**UNICEF, Wash Health Task Force**	**x**	**x**	**x**

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
	Objective 3.2 Increase household and community resilience to shocks and threats that affect nutrition status	3.2.1 Implement E-IYCF and food relief strategies during emergencies	# of interventions implemented	**DDRM MoHSS**		**WFP, UNICEF, WHO**	**x**	**x**	**x**
		3.2.2 Conduct community mobilization and sensitization activities on prevention, mitigation and recovery strategies relevant to emergency situations	# of community mobilization activities conducted	**DDRM**	**MoHSS, MAWF**	**WFP, UNICEF, IOM, WHO**	**x**	**x**	**x**
		3.2.3 Train health workers and community based providers/volunteers to identify households with children who qualify for Child Grants and to refer them to appropriate services	# of health workers trained # referrals of eligible children to grants programmes by health workers	**MGECW**	**MoHSS MoF NPC**	**UNICEF, UNFPA,**	**x**	**x**	**x**
	Objective 3.3 To increase awareness of and enrolment in social protection interventions for improved nutrition	3.3.1 School Feeding Programme - Implement the recommendations made from the School Feeding Programme review	Deliverables of SFP review met	**MoE**	**MoHSS**	**WFP**	**x**	**x**	**x**
		3.3.2 Conduct a regional and constituency level mapping exercise to identify nutrition sensitive interventions for livelihood strengthening	Nutrition sensitive initiatives mapped in selected regions/districts	**MLGRHD**	**RDCC**	**USAID – LIFT, WFP, UNICEF**	**x**	**x**	
		3.3.3 Develop a bi-directional referral system between nutrition services and nutrition sensitive interventions	Number of referrals from NACS sites to nutrition sensitive initiatives	**MoHSS MLGRHD**	**RDCC**	**USAID – LIFT, WFP, UNICEF**		**x**	**x**
Result 4 KPI 13	**Objective 4.1 Increase awareness of national nutrition situation among policy makers, planners and**	4.1.1 Implement the Nutrition Communication strategy activities related to advocacy (refer to Nutrition Communications Strategy for details)	Refer to Communications strategy for details	**MoHSS**	**MICT**	**WHO, UNICEF, FANTA, iTECH, Synergos**	**x**	**x**	**x**
		4.1.2 Produce reports based on national and local level situation analyses	# of reports on nutrition situation at national and or local level	**MoHSS**	**MICT**	**WHO, UNICEF, FANTA, iTECH,**	**x**	**x**	**x**

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
	external funders					**Synergos**			
	Objective 4.2 Increase financial and human resource commitment to nutrition programming	4.2.1 Develop an investment case/costed plan for nutrition specific and sensitive interventions	Costed plan finalised, number of activities with funding gaps	**MoHSS**	**NPC**	**World Bank, UNICEF, WHO**	**x**	**x**	
		4.2.2 Develop a financial tracking system for specific nutrition interventions	# of line items related to nutrition with allocated budget	**MoHSS**	**NPC**	**World Bank, UNICEF, WHO**		**x**	**x**
		4.2.3 Develop an advocacy plan for increasing human resources for nutrition at national, regional and district levels	Advocacy plan presented to Cabinet	**MoHSS**	**NPC**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
		4.2.4 Develop nutrition posts within the health system at national, regional and district levels (need to specify number of posts)	# of nutrition posts within the health system	**MoHSS**	**MoF**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
Result 5 KPI 14	**Objective 5.1 Increase capacity to monitor nutrition indicators at national, regional and constituency**	5.1.1 Develop a set of nutrition indicators for HMIS	Indicators incorporated into HMIS and monthly reports produced	**MoHSS**	**NPC NSA**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
		5.1.2 Develop and pilot a national nutrition surveillance system	Surveillance system operating	**MoHSS**	**NSA**	**WHO, WFP UNICEF, FANTA, iTECH, CDC**	**x**	**x**	**x**

Results Area	Objective	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
	levels	5.1.3 Develop a set of nutrition indicators to monitor impact of nutrition sensitive interventions on malnutrition amongst children under 5	Nutrition indicators incorporated into agriculture and WASH interventions	**MoHSS**	**MAWF**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
		5.1.4 Pilot multi-sectoral coordination mechanism at regional level in selected regions	Nutrition specific and sensitive interventions monitored at regional level through regional development coordinating committees	**MoHSS**	**RDCC**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC, Synergos, Geneva Global**	**x**	**x**	
	Objective 5.2 Increase human resource capacity to assess nutrition situation at national, regional and district levels	5.2.1 Train national Food and Nutrition Unit staff, UNAM and other relevant stakeholders in nutrition survey methodologies, data analysis and reporting	Number of people trained	**MoHSS**	**NSA**	**UNICEF, WHO, UNAM**	**x**	**x**	**x**
		5.2.2 Conduct periodic nutrition surveys (National; NDHS, regional and district level)	Number of surveys conducted	**NPC**	**MoHSS**	**UNICEF, WHO, WFP, UNAM**	**x**	**x**	**x**

Activity Plan by Sector 2012/13 – 2015/16

Sector	Activity	Indicator	Lead Ministry / Directorate	Other ministries/ Directorates	Partners	2013/14	2014/15	2015/16
Health Sector	1.1.1 Train health workers on nutrition counseling for women of reproductive age attending family planning services and pregnant women attending ANC or PMTCT services	# of health workers trained	**MoHSS PHC**		**UNICEF, WHO,**	**x**	**x**	**x**
	1.1.2 Conduct social mobilization activities as per the Nutrition Communications strategy for maternal and infant nutrition	# of social mobilization activities conducted	**MoHSS PCH**	**MICT**	**UNICEF, WHO, FANTA, iTECH**		**x**	
	1.1.3 Job aids on Mat Nut for ANC and PMTCT health workers	Job aids developed	**MoHSS PHC**		**UNICEF, WHO, iTECH**	**x**		
	1.1.4 Implement communication activities for the promotion of diversified dietary intake for prevention of micronutrient deficiency at national, regional and constituency levels	# of communication activities	**MoHSS PHC**	**MICT**	**Food Fortification Technical Working group**		**x**	**x**
	1.1.5 Train Health Workers and Implement the minimum 7 steps of the BFHI at selected health facilities/maternity wards	Number of health facilities implementing the 7 steps of BFHI	**MoHSS**	**NHTC**	**UNICEF, WHO, iTECH**	**x**	**x**	**x**
	1.1.6 Train health workers and volunteers on IYCF and C-IYCF counseling	# people trained	**MoHSS**	**NHTC**	**UNICEF, WHO, NRCS, iTECH, FANTA**	**x**	**x**	**x**
	1.1.7 Conduct supportive supervision visits with health workers and volunteers for IYCF and C-IYCF counseling	# supportive supervision visits	**MoHSS**	**CHBC**	**UNICEF, WHO, NRCS, iTECH, FANTA, CAA**	**x**	**x**	**x**

	1.1.8 Conduct supportive supervision visits for ANC and PMTCT health care workers	# supportive supervision visits	**MoHSS**	**DSP**	**UNICEF, WHO, NRCS, iTECH, FANTA**	**x**	**x**	**x**
	1.1.9 Implement activities under the eMTCT strategy relevant to HIV and infant feeding	# of activities implemented	**MoHSS PHC Directorate**	**DSP**	**UNICEF, WHO, NRCS, iTECH, FANTA**	**x**	**x**	
	1.2.1 Develop and/or revise micronutrient policy and implementation guidelines for supplementation programmes [vitamin A, iron (including deworming), iodine, zinc and calcium]	Policy guidelines developed and implemented	**MoHSS**		**UNICEF, WHO, iTECH, FANTA**	**x**	**x**	
	1.2.2 Train Health workers in routine vitamin A, Zinc, IFA supplementation for women and young children 6-59m	# health workers trained	**MoHSS**		**UNICEF, WHO, iTECH, FANTA**		**x**	
	1.2.3 Implement Maternal and Child Health Days (MCHD) as key delivery platform in high burden regions for critical low cost high impact maternal and child health interventions	# of sites where MCHDs conducted	**MoHSS**		**UNICEF, WHO**	**x**	**x**	**x**
	1.2.4 Pilot MNP in x districts in 2 selected regions (Hardap and Ohangwena)	# of mothers enrolled in MNP pilot project	**MoHSS**		**GAIN, UNICEF, WHO**	**x**	**x**	
	1.2.5 Scale up MNP in regions with highest burden of malnutrition (dependent on Pilot study outcomes)	Dependent on outcome of Pilot Study	**MoHSS**		**GAIN, UNICEF, WHO**		**x**	**x**
	1.2.6 Develop national mandatory food fortification programme including National Food Standards and regulations	Legislation adopted	**MoHSS**	**National Standards Institute**	**Food Fortification TWG**		**x**	
	1.3.1 Scale-up NACS to sites selected as part of expansion plan (train remaining health facilities in NACS service delivery)	Number of NACS sites	**MoHSS**		**iTECH, FANTA**	**x**	**x**	**x**

	1.3.2 Provide nutrition assessment equipment to scale-up NACS	Number of NACS sites fully equiped	**MoHSS**		**CDC, UNICEF, WHO**	**x**	**x**	
	1.3.3 Develop a Community Nutrition service delivery model in partnership with NGOs / CSOs and FBOs	% of defaulters followed up within the reporting quarter	**MoHSS**		**UNICEF, WHO, NRCS, CAA, DAPP, iTECH, FANTA**	**x**	**x**	
	1.3.4 Conduct quarterly supportive supervision and mentoring visits for health facility workers delivering NACS services	Number of supportive supervision visits conducted over 12 months	**MoHSS**		**iTECH, FANTA**	**x**	**x**	**x**
	1.3.5 Strengthen current supply management system for nutrition, maternal and child health commodities, and ensure end-user monitoring for effective delivery of services	End-user monitoring reports	**MoHSS**		**FANTA, iTECH**	**x**	**x**	**x**
	1.4.1 Develop MoHSS Circular relevant to the Code of Marketing of Breast milk Substitutes as interim measure while waiting for Public Health Bill to be promulgated by Cabinet	Circular produced	**MoHSS**		**UNICEF, WHO, iTECH, FANTA, CDC**	**x**		
	1.4.2 Advocate for Public Health Bill promulgation by Cabinet	Advocacy documents	**MoHSS**	**National Standards Institute**	**UNICEF, WHO, iTECH, FANTA, CDC**	**x**	**x**	
	1.4.3 Develop regulations for the Code for Marketing of Breast Milk Substitutes	Code Regulations	**MoHSS**	**National Standards Institute**	**UNICEF, WHO, iTECH, FANTA, CDC**		**x**	
	1.4.4 Train health inspectors in the Code adherence monitoring	# health inspectors trained	**MoHSS**	**National Standards Institute, NHTC**	**UNICEF, WHO, iTECH, FANTA, CDC**		**x**	**x**
	1.4.5 Implement Code monitoring and reporting mechanisms	Monitoring reports	**MoHSS**		**UNICEF, WHO, iTECH, FANTA, CDC**		**x**	**x**

	1.5.1 Incorporate nutrition modules into pre-service training courses for nursing, medicine, paramedics and master of public health	# of modules developed and incorporated into academic pre-service courses	**MoHSS/ UNAM**	**MoE**	**UNICEF, WHO, iTECH, UNAM**		**x**	**x**
	1.5.2 Develop a Diploma in Nutrition Programme at UNAM	Diploma program offered at UNAM in 2015	**UNAM**	**MoE**	**UNICEF, WHO, iTECH, UNAM**		**x**	**x**
	1.5.3 Develop and implement nutrition research / Thesis topics for Master of Public Health programme	5 key research areas identified and reflected in the MPH Thesis curriculum	**MoHSS & UNAM**	**MoE**	**UNAM, UNICEF, WHO, iTECH**		**x**	**x**
	1.5.4 Conduct capacity building activities for NHTC to deliver nutrition modules in the in-service healthcare provider professional development programme; IYCF, C-IYCF, GMP, NACS, Maternal nutrition,	# of TOTs	**NHTC & MoHSS**		**UNAM, UNICEF, WHO, iTECH**	**x**	**x**	**x**
	1.5.5 Develop nutrition modules and training materials for extension officers from MAWF, MGECW, MoE, DDRM	# of NHTC/RHTC staff trained as trainers	**MoHSS**	**MAWF MGECW MoE DDRM**	**UNICEF, WHO, iTECH**	**x**	**x**	**x**
	2.1.1 Assess prevalence and causes of obesity and associated NCCD in school aged children 13-17	Availability of results in all concerned agencies	**MoHSS**		**WHO**		**x**	
	2.1.2 Develop and disseminate guidelines for nutritional prevention and treatment of NCD	NCD guidelines endorsed, # health facilities oriented on NCD guidelines	**MoHSS**		**WHO**	**x**	**x**	
	2.1.3 Train healthcare providers on dietary management of NCDs	# of healthcare providers trained	**MoHSS**		**WHO**		**x**	**x**
	2.1.4 Conduct social marketing campaign for the prevention of obesity and associated NCDs	# of social marketing activities conducted in 12 months	**MoHSS**		**WHO**		**x**	**x**
	2.1.5 Assess prevalence of overweight and obesity among women of reproductive age	# of women (15-49 years) with BMI greater than 25	**MoHSS**		**WHO**		**x**	**x**

	3.3.3 Develop a bi-directional referral system between nutrition services and nutrition sensitive interventions	Number of referrals from NACS sites to nutrition sensitive initiatives	**MoHSS MLGRHD**	**RDCC**	**USAID – LIFT, WFP, UNICEF**		**x**	**x**
	4.1.1 Implement the Nutrition Communication strategy activities related to advocacy (refer to Nutrition Communications Strategy for details)	Refer to Communications strategy for details	**MoHSS**	**MICT**	**WHO, UNICEF, FANTA, iTECH, Synergos**	**x**	**x**	**x**
	4.1.2 Produce reports based on national and local level situation analyses	# of reports on nutrition situation at national and or local level	**MoHSS**	**MICT**	**WHO, UNICEF, FANTA, iTECH, Synergos**	**x**	**x**	**x**
	4.2.1 Develop an investment case/costed plan for nutrition specific and sensitive interventions	Costed plan finalised, number of activities with funding gaps	**MoHSS**	**NPC**	**World Bank, UNICEF, WHO**	**x**	**x**	
	4.2.2 Develop a financial tracking system for specific nutrition interventions	# of line items related to nutrition with allocated budget	**MoHSS**	**NPC**	**World Bank, UNICEF, WHO**		**x**	**x**
	4.2.3 Develop an advocacy plan for increasing human resources for nutrition at national, regional and district levels	Advocacy plan presented to Cabinet	**MoHSS**	**NPC**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
	4.2.4 Develop nutrition posts within the health system at national, regional and district levels (need to specify number of posts)	# of nutrition posts within the health system	**MoHSS**	**MoF**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
	5.1.1 Develop a set of nutrition indicators for HMIS	Indicators incorporated into HMIS and monthly reports produced	**MoHSS**	**NPC NSA**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	**x**	**x**	**x**
	5.1.2 Develop and pilot a national nutrition surveillance system	Surveillance system operating	**MoHSS**	**NSA**	**WHO, WFP UNICEF, FANTA, iTECH, CDC**	**x**	**x**	**x**

	5.1.3 Develop a set of nutrition indicators to monitor impact of nutrition sensitive interventions on malnutrition amongst children under 5	Nutrition indicators incorporated into agriculture and WASH interventions	**MoHSS**	**MAWF**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC**	x	x	x
	5.1.4 Pilot multi-sectoral coordination mechanism at regional level in selected regions	Nutrition specific and sensitive interventions monitored at regional level through regional development coordinating committees	**MoHSS**	**RDCC**	**WHO, UNICEF, WFP, FANTA, iTECH, CDC, Synergos, Geneva Global**	x	x	
	5.2.1 Train national Food and Nutrition Unit staff, UNAM and other relevant stakeholders in nutrition survey methodologies, data analysis and reporting	Number of people trained	**MoHSS**	**NSA**	**UNICEF, WHO, UNAM**	x	x	x
Agriculture and WASH	3.1.1 Scale up the urban and peri-urban horticulture program under the MAWF	# of participants/communities enrolled in the horticulture	**MAWF - DEES**			x	x	x
	3.1.2 Develop and implement nutrition module/training component to include in the horticulture program run by the MAWF	# of extension officers trained using the nutrition module	**MAWF**	**MoHSS**	**FAO, UNICEF, iTECH**	x	x	
	3.1.3 Provide technical and supply inputs to households and small scale farmers to grow vitamin A rich vegetables (orange flesh sweet potato)	# of households and/or small farmers growing vit A rich vegetables	**MAWF**	**UNAM**	**FAO, UNAM, UNICEF**		x	x
	3.1.4 Train individuals and community groups in post-harvest handling and storage techniques/technologies	# of households /individuals trained in post-harvest techniques	**MAWF**		**FAO**	x	x	x
	3.1.5 Build school gardens in schools operating the School Feeding Program	# of school gardens producing food to supplement SFP meal	**MAWF & MoE**	**MoE**	**WFP**	x	x	x
	1.1.10 Develop sanitation infrastructure with improved sanitation facilities in poor rural areas	% of HH with improved sanitation facilities (Rural)	**MAWF DWSSC**	**MRLGHRD**	**UNICEF, WASH Health Task Force**		x	x

	1.1.11 Develop and implement WASH communications strategy	WASH strategy launched	**MAWF DWSSC**	**MoHSS MoE MICT**	**UNICEF, WHO, WASH Health Task Force**	**x**	**x**	**x**
	3.1.7 Develop and monitor set of nutrition indicators for WATSAN interventions in two regions implementing water re-use projects	Indicators routinely collected and reported	**MAWF / DWSSC**	**MoHSS**	**UNICEF, Wash Health Task Force**	**x**	**x**	**x**
Education	3.1.6 Revise and update the hostel feeding programme (menu review)	# of Hostels implementing the new menu	**MoE**	**MoHSS**	**WFP**		**x**	
	3.3.1 School Feeding Programme - Implement the recommendations made from the School Feeding Programme review	Deliverables of SFP review met	**MoE**	**MoHSS**	**WFP**	**x**	**x**	**x**
Disaster Risk Reduction	3.2.1 Implement E-IYCF and food relief strategies during emergencies	# of interventions implemented	**DDRM MoHSS**		**WFP, UNICEF, WHO**	**x**	**x**	**x**
	3.2.2 Conduct community mobilization and sensitization activities on prevention, mitigation and recovery strategies relevant to emergency situations	# of community mobilization activities conducted	**DDRM**	**MoHSS, MAWF**	**WFP, UNICEF, IOM, WHO**	**x**	**x**	**x**
Develop	3.2.3 Train health workers and community based providers/volunteers to identify households with children who qualify for Child Grants and to refer them to appropriate services	# of health workers trained # referrals of eligible children to grants programmes by health workers	**MGECW**	**MoHSS MoF NPC**	**UNICEF, UNFPA,**	**x**	**x**	**x**

	1.1.12 Develop a set of ECD centre operating guidelines for IYCF and nutrition	# of TWG meetings held	**MGECW**	**MoHSS**	**UNICEF, WHO**		**x**	
	1.1.13 Train ECD centre workers in IYCF and nutrition practices	# ECD centre workers trained	**MGECW**	**MoHSS**	**UNICEF, WHO, NHTC**		**x**	**x**
	1.1.14 Pilot implementation of IYCF program in selected ECD centres (2 centres in 3 high stunting burden areas)	# ECD centres implementing and meeting the standards	**MGECW**	**MoHSS**	**UNICEF, WHO, NHTC**		**x**	**x**
Local Govt	3.3.2 Conduct a regional and constituency level mapping exercise to identify nutrition sensitive interventions for livelihood strengthening	Nutrition sensitive initiatives mapped in selected regions/districts	**MLGRHD**	**RDCC**	**USAID – LIFT, WFP, UNICEF**	**x**	**x**	
NPC	5.2.2 Conduct periodic nutrition surveys (National; NDHS, regional and district level)	Number of surveys conducted	**NPC**	**MoHSS**	**UNICEF, WHO, WFP, UNAM**	**x**	**x**	**x**

SUN Dashboard of Indicators

Result Area	Interventions	Indicator	Status			Process/coverage indicator	Status		
			Baseline	Status	Target		BL		Target
Result area 1: Infant, young child and maternal nutrition improve as a result of increased coverage of essential nutrition actions at health facilities and community based activities	All maternal and child nutrition interventions	% of children under 5 stunted	29.0%		<20%				
	Exclusive breastfeeding interventions (policy, programme, social mobilization)	% 0-6 m old exclusively breastfeeding	23.9%		30%	Number of health facilities with nutrition integrated into SRH services	-		
	Implementation of BMFHI	% of infants initiating breastfeeding within the first 30-60 min after delivery	71%		85%	Proportion of infants delivered in health facilities initiating breastfeeding within 30-60min	-		
	Complementary feeding for infants after the age of six months	% children 0-23 m old who are still breastfeeding with appropriate complementary foods	34%		50%	Estimated % mothers who have received CF education	-		
	WASH interventions	% population practicing open defecation	52%		25%	Proportion of households with access to improved sanitation			
	Establish BMFHI within health facilities	Percentage of maternity wards reaching all criteria for BMFHI	0		90%	Percentage of maternity wards reaching all criteria for BMFHI			
	Maternal nutrition programs	Proportion of pregnant women with Hb below 10g/dl	34%		30%	Proportion of pregnant women receiving 90+ of iron and folic acid supplementation	30.0%		
		% of women of reproductive age underweight	16%		8%	Number of pregnant woman measured using MUAC at ANC			
	Periodic Vitamin A supplements	% **pre-school** children with vitamin A deficiency	23.0%		15%	% children 6-59m supplemented with vitamin A in the last 6 months	51.5%		
	De-worming	% <2 years old with iron deficiency	-			Estimated % children 6-59 m dewormed in the last 6 m	9.1%		
	Prevention and treatment for moderate acute malnutrition	% 6-59m MAM (wasting)	5.6%		2%	% of MAM cured % of defaulters			

	Treatment of severe under nutrition ("severe acute malnutrition") with ready-to-use therapeutic foods (RUTF)	% 6-59 m severely malnourished (wasting)	1.9%		1%	% of severely malnourished who have received treatment	-		
Result 2: Reduced burden of non-communicable disease	Education on prevention and management of diet-related NCDs	Prevalence of low birth weight infants	14%		8%	Number of health facilities with trained health workers to deliver NCD counselling	-		
Result 3: Improved community and household food & livelihood security	Food security initiatives	% of food insecure rural households				Proportion of rural households supported in local homestead food production			
Result area 4: Improved awareness of and commitment to national nutrition priorities	Communications and advocacy interventions	% of MoH budget allocated to nutrition specific interventions	0		5%	Number of communications activities conducted in a 12 month period			
	Capacity building initiatives	Number of staff with nutrition skills at each level of service delivery (National – District)	4		17	Coverage of skilled human resources			
Result area 5: Functioning and effective nutrition monitoring and evaluation system	Nutrition data collection & surveillance interventions	National nutrition surveillance info system developed and implemented	0		Functioning	Number and frequency of nutrition surveillance reports produced in a 12 month period	-		

Good progress

Some progress

No progress

No Data