A multi-sectoral perspective to nutrition: From analysis to action

A compilation of materials from selected countries

*SUN Annual Gathering, New York*

September 2013
Telling the ‘nutrition story’

The complete (multi-sectoral) story –
in a way that connects the dots,
captures the attention of decision-makers,
appeals to technical practitioners,
fosters consensus among diverse stakeholders
on the nutrition issues of the country
and nutrition governance situation,
and ultimately, prompts action.
PREFACE

The booklet provides an overview of REACH and illustrates the methodology of the Nutrition Analysis, which reviews the major nutrition problems and contributing factors with a view to defining the ‘nutrition story’ of a given country. These findings are typically used to inform advocacy, planning, planning efforts, among other applications.

The booklet also reports progress on nutrition governance comparing REACH baseline assessment data to the current status.

Many of the highlights included in this booklet are emerging materials that have yet to be discussed in-depth and validated by the country. The process of establishing consensus among partners is equally important as the outputs of the REACH stock-taking exercises.
Introduction: REACH IN 5 MINUTES
Who, what, where, how and theory
The REACH inter-agency partnership was initiated in 2008 by FAO, WHO, UNICEF, WFP and later engaged IFAD. It stemmed from ECHUI, and was first piloted in Lao PDR and Mauritania with the support of the Boston Consulting Group. The approach was later refined and expanded to other countries. It quickly became an active part of the SUN Movement and the UN network which it co-facilitates with the UNSCN. REACH works also with academic institutions such as Columbia University. REACH is not an implementing agency, but a catalyst for building national capacity for multi-sectoral nutrition governance and opens the doors for partners to implement nutrition-related actions at scale.

Various forms of support are available to interested countries though country facilitators generally facilitate inter-agency collaboration and SUN processes. REACH support models include:

- **Intense support** currently being implemented in Bangladesh, Ethiopia, Ghana, Mali, Mozambique, Nepal, Niger, Rwanda, Tanzania and Uganda;
- **Moderate support** in Chad and Burundi
- **Remote support** to countries with sustained commitment, including Mauritania, Sierra Leone (and Lao PDR).

Other countries such as Malawi, Guinea, The Gambia, Republic of Congo, and others have voiced interest in implementing REACH.

Facilitators are supported by the REACH Secretariat, hosted by WFP Rome.
If we address these issues...

Little consensus on the causal problems of undernutrition

Limited political commitment

Weak coordination of gov'ts with UN agencies and other stakeholders

Nutrition is not seen as a multi-sectoral issue

Poor capacity development

Accountability and responsibility is undervalued

with these strategies to improve governance...

REACH outcomes

1. Increased awareness and consensus of stakeholders

2. Strengthened national policies and programmes

3. Increased human and institutional capacity

4. Increased effectiveness and accountability

then we can achieve...

Political support to fund programs and coordinated nutrition efforts

this impact

Nutritional impact and coverage

Improved nutrition for women and children

Action spans beyond 2015 as hunger remains a problem, and nutrition issues gain a stronger emphasis in the post-2015 agenda

Source: REACH Secretariat
... by facilitating improved multi-sectoral nutrition governance and action

... in order to implement change and achieve the 4 REACH outcomes

1. Leadership and Commitment
   Enabling environment and agenda setting for advocacy

2. National nutrition policy
   National nutrition action plan
   Comprehensive, multi-sectoral, government owned, funded and operational

3. Capacity development
   Human, institutional and organizational capacity

4. Monitor and evaluate
   Tracks targets, identifies gaps, and promotes accountability

Nutritional impact and coverage

Source: REACH Secretariat
... and building on a widely-accepted conceptual framework for analysing the causes of malnutrition

Outcomes

Malnutrition, death & disability

Immediate causes

Inadequate dietary intake

Disease

Underlying causes at household/family level

Insufficient access to FOOD

Inadequate maternal & child CARE practices

Poor water, sanitation & inadequate HEALTH services

Basic causes at societal level

Quantity and quality of actual resources – human, economic & organisational - and the way they are controlled

Potential resources: environment, technology, people

Source: Adapted from UNICEF
1: BASIC NUTRITION TRENDS
Stunting, wasting, underweight & micronutrient deficiency disorders

- Understand/quantify main target groups in relation to the greater population
- Summarize trends in nutrition impact data (both anthropometric and micronutrient deficiencies) over time
- Compare relative levels (prevalence) to absolute numbers of nutrition impact indicators
- Depict data on the nutrition situation at regional/district/provincial levels
- Identify converging and diverging trends between stunting and wasting
Looking at demographics through the nutrition lens to quantify the main nutrition problems (Bangladesh)

Demographic breakdown

Bangladesh population (million)

- Total population: 150 m
- Men (+15): 51.9 m
- Women (+15): 49.7 m
- Children 5–14: 30.8 m
- Children < 5: 17.2 m

Types of undernutrition in children 6-59 months

- Underweight: 4.6 m (48.6%) moderate, 2.0 m (2.2%) severe
- Stunted: 3.2 m (13.5%) moderate, 0 m (0%) severe
- Wasted: 1.6 m (13.5%) moderate, 0 m (0%) severe

1. BBS Population Census 2001, BBS (Nationwide projection) 2010
2. HFSNA 2009 (WHO standard 2006); 3. Approximately 8 million children (<5 y) are underweight according to NCHS/CDC/WHP 1977
3. Prevalence of under-nutrition is higher among the children of 6–23 months due to poor quantity & quality of feeding practices, 10.8% of total population are the children of 6-59 months age group (HFSNA 2009)
Summarising anthropometric trends over time, and measuring against MDG1 target 2 & ‘critical’ population thresholds (Ethiopia)

**Underweight children <5**

<table>
<thead>
<tr>
<th>Year</th>
<th>Other NS</th>
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**Stunted children <5**

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**Wasted children <5**

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*Note: Prevalence recalculated using 2006 WHO growth standards

Source: DHS (2011); DHS (2005); DHS (2000); Other NS (1992); WHO Conversion tool from NCHS reference into estimates based on the WHO Child Growth Standards
Anaemia decreasing in under5s & women of child-bearing age

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

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

Source: DHS (2011); Health Sector Development Programme (HSDP) IV Mid-Term Review presentation, Addis Ababa, 17 May 2013
Emphasizing the need to consider both prevalence and absolute numbers, by region, to inform prioritisation exercises (Nepal)

Wasting among children <5

Source: Census 2011 population projection, Estimated Target Population (2011-12), DoHS, Kathmandu
Determining whether areas with the greatest burden of stunted and wasted children overlap (Ethiopia)

**Stunted children <5 in 2011**

- ~ 4.6 million children

**Wasted children <5 in 2011**

- ~ 950,000 children

Comparing changes in stunting and wasting prevalences to identify converging/diverging trends (Mozambique)

Source: MICS 2008, DHS 2011
2: CAUSES OF MALNUTRITION

Underlying & basic causes

• Unpack the main determinants of malnutrition across sectors as per the causal framework

• Summarize trends in data on food security, care practices, health services and environment over time

• Highlight disparities by geographic region, urban/rural areas, gender, livelihood groups, wealth quintile, etc.

• Explore linkages between nutrition levels (e.g. stunting, wasting, etc.) and underlying causes (food insecurity, poor care practices, poor health services and environment) and basic causes (e.g. poverty, gender, etc.)
Underlying Causes: Food Security
Dietary diversification, food preservation, fortification and livelihoods

• Consider the four pillars of food security: food availability, food access, food utilisation and food stability

• Highlight geographic areas most affected by food insecurity and compare to stunting data

• Consider how food insecurity influences local dietary trends both in terms of quantity and types of foods consumed

• Acknowledge food fortification (including salt iodisation) as a means to enhancing food quality

• Explore linkages between livelihood groups, gender, etc. and nutrition levels (e.g. stunting, wasting)
Identifying associations between food insecurity and stunting (Nepal)

Source: NDHS (2011); Coates et al. (2007)
Highlighting where regional levels of food insecurity and stunting are not always aligned (Sierra Leone)

Food insecurity highest in Northern and parts of Southern, but Eastern relatively food secure

High rates of stunting in Southern and Eastern regions

Stunting prevalence, children 6-59 months (2010)

- 40+%%
- 30-39.9%
- 20-29.9%

**Basic food basket per month per person**

- Considering quantity and dietary diversity

- 3 kg rice
- 9.1 kg maize flour
- 2.0 kg dry beans
- 0.5 kg groundnuts
- 3.5 kg dry fish
- 0.5 L cooking oil
- 1.2 kg sugar
- 0.1 kg salt
- 3.4 kg fresh vegetables
- 3.6 kg fruits

**Average cost* of a basic food basket for a household with 5 members**

- **6.380,00 meticais/month**
  - Households who buy industrially processed maize and flour

- **5.556,00 meticais/month**
  - Households who consume maize grain from their own production or buy maize grain on the market and take it to small mills.

**Household income**

- 55% of the households live under the national poverty line of 18.4 meticais (USD 0.50) per day

- Estimated *daily* income for a household of five living below the national poverty line is 92.0 meticais

- Estimated *monthly* income for the population living under the national poverty line is **2,760 meticais**

  *The price of the basic food basket for a household is nearly double their total monthly income, calling for social protection measures*

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Household use of iodized salt is on the rise, but on average, only 35% of Ghanaian households consume adequately iodised salt (>15ppm).

Northern, Volta and Upper East regions with greatest room for improvement.
Considering how income levels and livelihoods affect household food security and nutritional status (Sierra Leone)

**Links between food security and income**

<table>
<thead>
<tr>
<th>Food consumption score</th>
<th>Annual household income</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td></td>
<td>3,486,731</td>
<td>2,200,000</td>
</tr>
<tr>
<td>Borderline</td>
<td></td>
<td>4,082,511</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Acceptable</td>
<td></td>
<td>7,434,464</td>
<td>4,100,000</td>
</tr>
</tbody>
</table>

Source: CFSVA, 2011

**Links between nutritional status and livelihood**

- other: 1.2%
- livestock: 2.2%
- handicrafts: 4.6%
- salary and skilled labor: 4.7%
- fishing: 4.9%
- remittances and gift: 5.1%
- cash crops: 5.2%
- trading, commercial: 5.2%
- food crops: 6.4%
- petty trade: 8.9%
- mining: 9.4%
- unskilled labor: 12.4%

malnourished children (muac < 12.5)
Women involved in farming systems but face many challenges to access resources

**Time constraints:**
- Main reason women do not join farmers organisation due to lack of time
- Insufficient time for activities such as weeding affects productivity and yields
- Time-consuming manual post-harvest handling and processing activities but limited access to labour-saving technologies

**Low levels of education and limited financial literacy** inhibit women from engaging in marketing activities, accessing credit

**Women often have to go through men** to access land, negotiate prices and deals, or technology/inputs

**Limited influence or control of household resources:**
- Women have little control over income, particularly for high-value crops
- Many women find additional income generating activities or sell unprocessed rice or other products at low prices to generate ‘fast cash’ to meet daily needs

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Consider gender issues also in relation to ‘care’, ‘health’ and basic causes

Underlying Causes: Care Practices
Exclusive breastfeeding, adequate complementary feeding & personal hygiene

• Compare infant and young child feeding (IYCF) practices to nutritional status
• Review infant feeding data, particularly early initiation of and exclusive breastfeeding, in view of the multiple benefits of proper breastfeeding
• Highlight infant feeding trends over time and prompt further inquiry on barriers to breastfeeding
• Understand complementary feeding data in relation to international guidelines
Analysing infant and young child feeding behaviours against nutritional status, particularly stunting (Nepal)

IYCF: Infant and young child feeding
Source: Census 2011 population projection, Estimated Target Population (2011-12), DoHS, Kathmandu
Despite initial improvement in early initiation and exclusive breastfeeding (EBF), rates remain low with a sharp decline in EBF from 2006 to 2010. In 2010, just 6.5% were EBF at 4-5 months old, with many also receiving other substances, increasing the risk of illness due to contamination.

IYCN: Infant and young child nutrition
Source: DHS (2001); DHS (2006); MICS (2010).
Understanding data on the timely introduction of complementary foods within the context of international guidelines (Ethiopia)

Complementary feeding practices among children 6-23 months (2011)

- International guidelines promote complementary foods to be introduced at 6 months of age but most children in Ethiopia receive them either too early or late.
  - Nearly 20% of children receive complementary foods earlier
  - Nearly 50% of children start eating complementary foods later

Source: DHS (2011)
Reviewing personal hygiene practices, particularly among care-takers, as key determinants of undernutrition (Niger)

Low adoption of hand-washing with soap practices though higher uptake in urban areas

% Mothers who complied with 5 key hand-washing behaviours*

<table>
<thead>
<tr>
<th>Location</th>
<th>% Complied</th>
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<tbody>
<tr>
<td>Niamey</td>
<td>25</td>
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<tr>
<td>Dosso</td>
<td>18</td>
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<tr>
<td>Maradi</td>
<td>16</td>
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<td>Agadez urbain</td>
<td>12</td>
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<td>Tillabéri</td>
<td>11</td>
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% Population that washes hands with soap

- Water + soap
- Water + ash
- Water only

Niamey

- Water + soap: 32%
- Water + ash: 3%
- Water only: 65%

Urban Areas

- Water + soap: 40%
- Water + ash: 3%
- Water only: 57%

Rural

- Water + soap: 36%
- Water + ash: 4%
- Water only: 60%

*Note: The 5 hand-washing behaviours were identified as part of the ‘essential family practices’ which are specific to Niger in 2013. The HW behaviours include: (1) prior to preparing food; (2) prior to preparing meals for infants and children; (3) prior to feeding infants and children; (4) after using the toilet (defecation); and (5) after cleaning a child who has defecated.

Source: National nutrition and morbidity survey among children 0 to 59 months, Niger, National Health Institute INS (2010)
Underlying Causes: Health Services & Environment
Healthcare, micronutrient supplementation, water and sanitation

• Explore associations between nutritional status and health status in view of substantial proportion of undernutrition-related child deaths globally

• Compare stunting levels with access to proper sanitation facilities/clean water, given linkages between faecal contamination/stunting and contaminated water/diarrhoea/wasting

• Highlight key sanitation, water and health services trends over time, by geographic or urban/rural areas

• Consider access to, quality of and uptake of maternal health services (antenatal and post-partum), recognising the importance of the first 1000 days of life
Acknowledging that some infectious diseases can impede nutrient absorption and lead to and/or exacerbate forms of undernutrition (Niger)

Diarrhoea is a major risk factor
(% among children <5 yrs. old with wasting by diarrhoea profile)

- w/o diarrhoea: 12%
- Treat diarrhoea: 19%
- Untreated diarrhoea: 24%

Malaria can also contribute to acute malnutrition
(% among children <5 yrs. old with wasting by malaria profile)

- No malaria: 12.6%
- Treated malaria: 17%
- Untreated malaria: 18%

Source: Extracted from the causal analysis of malnutrition based on two surveys MICS (2000) and MICS (2006)
Comparing stunting levels to limited access to proper sanitation facilities by geographic area to identify relevant associations (Ghana)

Northern regions widely practice open defecation and have the highest rates of stunting.

Source: MICS (2011)
Including sanitation trends over time and identifying urban-rural divides (Uganda)

Slowing decline in proportion of households with no facility

Vast majority of rural households use non-improved toilet facilities

Source: UDHS 2011, 2006
Recognising access to clean water as an important component of addressing undernutrition and portraying related trends (Sierra Leone)

Use of an improved drinking water source has gradually improved over the last 6 years

But rural populations still lack access to safe water – Almost no use of HH water treatment methods (2008)

Recognising importance of antenatal care in relation to the first 1000 days (Uganda)

- Uptake same in urban and rural areas
- Most antenatal care provided by skilled provider
- Less than 25% of women seek antenatal care in the first trimester of pregnancy
- About half of women have 4 or more ANC visits, with uptake higher in urban settings

Source: DHS (2011)
Uneven progress e.g. substantial increase for Greater Accra and nominal increases in Eastern and Upper West Regions.

In 2011, 74% of Ghanaian children age 6-59 months received Vitamin A supplement.

Three regions approaching or have achieved scale in 2011, with Upper East Region and Brong Ahafo reaching 90%.
Basic Causes
Poverty, Education and Gender

• Consider relationships between poverty and child undernutrition
• Review statistics on child marriage, where relevant, in view of emerging linkages between teenage pregnancy and stunting
• Consider gender disparities (e.g. completion of primary education among girls, access to credit among women, etc.) which may contribute to maternal and child undernutrition
Noting if poorest households tend to have higher prevalence of children who are stunted and/or underweight (Bangladesh)

Addressing poverty alone is insufficient for improving child undernutrition

Source: BDHS (2011) using WHO Child Growth Standards
Calling attention to early marriage in view of emerging linkages between teenage pregnancy and stunting (Mozambique)

- Marriage before the age of 18+ is prohibited by law.
- = violation of children’s rights and of the Convention of Elimination of all forms of Discrimination Against Women.
- Early marriage remains high, particularly in rural areas, though levels have been decreasing
- Over half of women in rural areas are married before their 18th birthday

Source: DHS 2003, MICS 2008, DHS 2011, PAMRDC

+ Increased in 2004 from 16 to 18 years
*MICS 2008 for marriages under 15 includes women age 15-49
REACH Nutrition Analysis and Indicator Dashboards can catalyse change and/or prompt action in nutrition policy, planning as well as the implementation of nutrition interventions. For example, they may help to:

- Gain consensus on main nutrition problems and priority interventions
- Advocate for continued action/momentum for addressing child and maternal undernutrition in spite of recent progress
- Inquire further on why some provinces experienced decreases in stunting, yet increases in wasting, during the same period so that appropriate action can be taken
- Suggest conducting refresher trainings for health professionals on proper IYCF practices, where lowest proportions of children ages 6-23 months receive proper IYCF and stunting is highest
- Intensify construction and/or rehabilitation of safe water points and prioritise areas for household water treatment interventions where access to safe water is most constrained
- Underscore regional, urban-rural, gender, etc. disparities with quantitative data to promote increased equity
- Promote common messages regarding the nutrition situation of the country
Drawing upon findings of Nutrition Analysis to determine possible action, including nutrition-sensitive approaches. For example:

**Food, agriculture & diets**
- Consumption
  - Consumer subsidies
  - Improvement of local recipes & food preparation methods
  - Food-based dietary guidelines
- Horticulture/crops
  - Diversification & locally adapted varieties
  - Biofortification
- Livestock & Fisheries/aquaculture
  - Small-scale animal husbandry
  - Animal health services
- Food processing and storage
  - Fortification
  - Food preservation (including complementary foods)
  - Food storage

**Health-based**
- Treatment of acute malnutrition
- Treatment of severe acute malnutrition
- Treatment of moderate acute malnutrition
- Prevention &/or treatment of soil, waterborne & endemic diseases
  - Deworming
  - ORT
  - Vaccinations (polio, measles, etc.)
  - IPTp (anti-malaria)
  - PMTCT of HIV
  - DOTs for TB
  - Antibiotics for pneumonia
- Micronutrient supplementation
  - Iron and folic acid/Iron supplementation
  - Vitamin A/D/E/zinc supplementation
  - Multiple micronutrient supplements (powders & capsules)
- Water, Sanitation & Hygiene
  - Construction of safe water points
  - Household water treatment
  - Latrine construction

**Social protection**
- Cash & vouchers
  - Cash/Vouchers-for-work
  - Cash/Vouchers-for-training
  - Conditional cash transfers
- In kind transfers
  - General food distribution
  - Blanket Supplementary Feeding
  - School feeding
- Other safety nets
  - Public works
  - Food-for-assets
  - Food-for-training

**CARE**
- Breastfeeding promotion & support
- Complementary feeding promotion & support
  - Food preparation/hygiene promotion
  - Childcare support/care-giver workload
  - Health-seeking behaviour
  - ITN bednets (anti-malaria)
  - Personal hygiene promotion

**Context assessment**
- Do no harm
- Equity
- Women’s empowerment
- Multi-sectoral collaboration
- M&E (explicit nutrition outcomes & indicators)
3: MEASURING PROGRESS

Findings from REACH baseline assessments against current status

Outcome 1: Increased awareness and consensus of stakeholders
Outcome 2: Strengthened national policies, plans and programmes
Outcome 3: Increased human and institutional capacity
Outcome 4: Increased effectiveness and accountability
Outcome 1: Since the initial situation, 70% of countries have reported overall improvement in stakeholder awareness level of nutrition issues.

Notes:
- All countries joined REACH in 2011 except for Bangladesh (joined in Dec 2010) and Niger (Feb 2012)
- Stakeholders: Top 5 nutrition-relevant Government Ministries, UN Agencies, NGOs and Donors
Outcome 2: Since baseline, 80% of countries have been revising or have completed their nutrition policies

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<th>Baseline</th>
<th>Current Status</th>
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<td>Ghana &amp; Mali</td>
<td>Uganda, Tanzania, Mozambique, Bangladesh</td>
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<td>Niger</td>
<td>Endorsed: Nepal &amp; Rwanda</td>
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<tr>
<td>Developed (not endorsed)</td>
<td>Endorsed: Ethiopia, Ghana, Mali, Mozambique (being revised)</td>
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<tr>
<td>Completed, outdated (endorsed)</td>
<td>Endorsed: Nepal &amp; Rwanda (being revised)</td>
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<tr>
<td>Completed, up-to-date (endorsed/ being endorsed)</td>
<td>Being endorsed: Niger</td>
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Outcome 2: Compared to the previous 30% of countries, 70% have now completed a multi-sectoral nutrition action plan

- **Baseline**
  - Bangladesh
  - Ghana
  - Mali
  - Tanzania

- **Plan in development (not endorsed)**
  - Nepal
  - Niger
  - Uganda

- **Plan completed (endorsed)**
  - Rwanda
  - Ethiopia
  - Mozambique

**Current Status**
- **Bangladesh**
- **Ghana**
- **Mali**
  - **Nepal**, **Niger**, **Uganda**
  - **Rwanda**, **Ethiopia**, **Mozambique**

- Ethiopia has completed updating its national plan, which was launched in June 2013
- Bangladesh has an outdated action plan from 1997, a new one will be developed after the nutrition policy (which is being revised) has been approved
- Rwanda and Mozambique have started revising their plans
Outcome 3: While initially 20% of countries had started establishing high level governance/management coordination structures, 60% now have one.

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<tr>
<th>Countries</th>
<th>NCM in the process of being established</th>
<th>NCM formally established in government</th>
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<td>Tanzania</td>
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<td>✓</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>--</td>
<td>✓</td>
</tr>
<tr>
<td>Niger</td>
<td>--</td>
<td>✓</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Ghana</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Mali</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Mozambique</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Initially, **only 20%** of countries had started the process of establishing a high level nutrition coordination mechanism (NCM).

Currently, **60%** of the countries have formally established a high level NCM.
Indicator Dashboard is one of the REACH’s flagship tools and can be used to track progress. Different views of the dashboard can be developed to:

- Summarize the nutrition situation of a country in one page
- Highlight disparities (e.g. rural/urban, gender)
- Describe the situation at sub-national levels

Outcome 4: While initially one country (10%) had a dashboard, now 90% of countries are developing a dashboard or completed it.

Next step: Countries to integrate dashboards into national information systems so that they are government-owned and are utilized to systematically track impact and implementation.
### Summarising the nutrition situation in one page

**Indicator Dashboard (Bangladesh Example)**

<table>
<thead>
<tr>
<th>Key problems</th>
<th>Problem indicator</th>
<th>Status</th>
<th>Interventions</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEHAVIOR/ CARE</strong></td>
<td>% of children breastfed within 1 hr of birth</td>
<td>36 %</td>
<td>Early initiation of breastfeeding promotion</td>
<td></td>
</tr>
<tr>
<td>Poor IYCF Practices</td>
<td>% of infants 0-6 months of age who are exclusively breastfed</td>
<td>48.7 %</td>
<td>Exclusive breastfeeding promotion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of infants 6-8 months of age who receive solid, semi-solid or soft foods along with breast milk</td>
<td>57.6 %</td>
<td>Complementary feeding promotion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% households using HWT methods</td>
<td>6.7%</td>
<td>Household water treatment education and equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% households with access to improved water sources</td>
<td>97.1%</td>
<td>Hand washing with soap</td>
<td></td>
</tr>
<tr>
<td>Soil, water borne &amp; endemic diseases</td>
<td>% Population washing hands before eating</td>
<td>58.8%</td>
<td>Insecticide treated nets (ITN)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diarrhea prevalence children &lt; 5</td>
<td>9.8%</td>
<td>IPTp</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% &lt; 5s slept under ITN last night</td>
<td>0.5%</td>
<td>De-worming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% malaria prevalence children &lt; 5</td>
<td>4.0%</td>
<td>Latrine provision and usage promotion</td>
<td></td>
</tr>
<tr>
<td>High prevalence of acute malnutrition</td>
<td>% pregnant women at risk of getting malaria</td>
<td>1.9%</td>
<td>Zinc for diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>STH % &lt; 5 infected</td>
<td>44.6%</td>
<td>Therapeutic feeding for SAM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of households without access to hygienic latrines</td>
<td>74.7%</td>
<td>Supplementary feeding for SAM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% &lt; 5 with diarrhea</td>
<td>9.8%</td>
<td>Vitamin A supplementation for children</td>
<td></td>
</tr>
<tr>
<td>Insufficient macro and micronutrient intake</td>
<td>% children &lt; 5 SAM</td>
<td>3.0%</td>
<td>Vitamin A supplement for post partum women</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MAM prevalence for children &lt; 5 (not including SAM)</td>
<td>14.0%</td>
<td>Iron/ folic acid suppl./ fort. MNP/ Sprinkles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of &lt; 5 / P women with low serum retinol</td>
<td>6.5%</td>
<td>Nutrition education for dietary diversity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of &lt; 5 with low serum retinol</td>
<td>28.7%</td>
<td>Conditional cash transfers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt; 5 mortality rate per 1000 live births</td>
<td>54%</td>
<td>Local homestead food production</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% &lt; 5 with iron deficiency anemia (IDA)</td>
<td>67.9%</td>
<td>Conditional cash transfers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iron deficiency anemia in pregnant women</td>
<td>38.8%</td>
<td>Conditional cash transfers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Households with poor or borderline FCS scores</td>
<td>25.0%</td>
<td>Conditional cash transfers</td>
<td></td>
</tr>
<tr>
<td>Insufficient access to food</td>
<td>Household food insecurity - % of population undernourished</td>
<td>26.0%</td>
<td>Conditional cash transfers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% pop. living under national poverty line</td>
<td>40.0%</td>
<td>Conditional cash transfers</td>
<td></td>
</tr>
</tbody>
</table>

1. Equals ~ 37,000 of under-five deaths, according to Unicef 2009 2. 19/1000 estimated malaria cases all ages in Bangladesh 3. Data for rural Bangladesh only 4. Before 21.7% according to WHO VMNS/HKI 1997/1998 5. Tissue concentrations of vitamin A which are low enough to have adverse health consequences 6. Operational coverage of any net per 2 persons at risk in 2007 IRS/ITN, Global Malaria Report 2008 7. Due to country-specific Issues like differing applications of the methodology, different thresholds (cut off points), cross country comparisons are not made 8. Food Consumption Score (FCS) is a benchmark for WFP (<42 SCORE), HFSNA 2009, P-66 9. HFSNA 2009; 10. MICS 2006
<table>
<thead>
<tr>
<th>Indicator</th>
<th>URBAN</th>
<th>RURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting</td>
<td>35.0%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Wasting</td>
<td>3.8%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Vitamin A deficiency</td>
<td>63.3%</td>
<td>73.1%</td>
</tr>
<tr>
<td>Iron deficiency</td>
<td>59.7%</td>
<td>72.0%</td>
</tr>
<tr>
<td>IDD</td>
<td>89.6 µg/L</td>
<td>59.2 µg/L</td>
</tr>
<tr>
<td>Food Security</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Health and Sanitation</td>
<td>100</td>
<td>111</td>
</tr>
<tr>
<td>Care</td>
<td>75.0%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Education</td>
<td>49.0%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Population</td>
<td>4.5</td>
<td>6.6</td>
</tr>
<tr>
<td>Gender</td>
<td>42.4%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Poverty</td>
<td>49.6%</td>
<td>56.9%</td>
</tr>
</tbody>
</table>

**Nutritional Impact**

- **Stunting**: Prevalence of stunting among children 6-59 mo. old
- **Wasting**: GAM prevalence among children 6-59 mo. old
- **SAM prevalence among children 6-59 mo. old**
- **Vitamin A deficiency**: Children <5 with Vitamin A deficiency
- **Iron deficiency**: Children 6-59 mo. old with anemia
- **Women 15-49 yrs. old with anemia**
- **Vitamin A deficiency**: Children <5 with Vitamin A deficiency
- **Iron deficiency**: Children 6-59 mo. old with anemia
- **Women 15-49 yrs. old with anemia**
- **IDD**: Median urinary iodine level for school-aged children

**Underlying Causes**

- **Food Security**: Households with poor or borderline food consumption
- **Global Hunger Index Score**
- **Health and Sanitation**: Under 5 mortality rate
- **Proportion of institutional deliveries**
- **Households with access to improved water sources**
- **Households with access to improved sanitation facilities**
- **Care**: Timely initiation of breastfeeding
- **Infants 0-5 mo. old exclusively breastfed**
- **Children 6-23 mo. old receiving an acceptable diet**
- **Households with a washing station equipped with water and soap/cleansing material**
- **Households taking 30+ minutes to fetch water**

**Basic Causes**

- **Education**: Females that completed primary school or higher
- **Females 15-49 yrs. who are literate**
- **Total fertility rate**
- **Women who were married before 18 yrs.**
- **Women ages 15-19 who already had a child or are currently pregnant**
- **Population living under national poverty line**
- **GINI Index**

**Severity and Trends**

- **Severity**: Not currently a serious problem, Urgent Problem requiring urgent action, Not applicable
- **Trends**: Improving, Deteriorating, No Change
### Understanding sub-national nutrition situation

Situation Analysis Dashboard, Iringa Region (Tanzania)

#### Nutritional Impact

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Status</th>
<th>Severity</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting</td>
<td>51.9%</td>
<td>Poor</td>
<td>Improving</td>
</tr>
<tr>
<td>Wasting</td>
<td>3.5%</td>
<td>Good</td>
<td>Improving</td>
</tr>
<tr>
<td>SAM prevalence among children 0-59 mo</td>
<td>0.8%</td>
<td>Poor</td>
<td>No change</td>
</tr>
<tr>
<td>Underweight</td>
<td>18.2%</td>
<td>Poor</td>
<td>Improving</td>
</tr>
<tr>
<td>Vitamin A Deficiency</td>
<td>35.1%</td>
<td>Poor</td>
<td>N.A.</td>
</tr>
<tr>
<td>Iron Deficiency</td>
<td>45.6%</td>
<td>Poor</td>
<td>No change</td>
</tr>
<tr>
<td>Iodine Deficiency Disorders</td>
<td>24.7%</td>
<td>Poor</td>
<td>N.A.</td>
</tr>
</tbody>
</table>

#### Underlying Causes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Status</th>
<th>Severity</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Security</td>
<td>14.5%</td>
<td>Poor</td>
<td>N.A.</td>
</tr>
<tr>
<td>Health &amp; Sanitation</td>
<td>28.0%</td>
<td>Good</td>
<td>Improving</td>
</tr>
<tr>
<td>Household access to improved water source</td>
<td>68.1%</td>
<td>Good</td>
<td>N.A.</td>
</tr>
<tr>
<td>Care</td>
<td>73.0%</td>
<td>Good</td>
<td>Improving</td>
</tr>
<tr>
<td>Mothers who washed hands after using toilet</td>
<td>90.2%</td>
<td>Good</td>
<td>Improving</td>
</tr>
</tbody>
</table>

#### Basic Causes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Status</th>
<th>Severity</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>45.8%</td>
<td>Good</td>
<td>Improving</td>
</tr>
<tr>
<td>Population</td>
<td>5.4</td>
<td>Good</td>
<td>Improving</td>
</tr>
<tr>
<td>Gender</td>
<td>20.9%</td>
<td>Poor</td>
<td>Worsening</td>
</tr>
</tbody>
</table>

*Signs: ◊ indicates additional index or measure; † indicates further description is required.
Unlike a story book, this is not ‘THE END’

*It is just the beginning and/or a basis upon which:*

- Country priority interventions are selected,
- Stakeholders and activities are mapped
- Institutional arrangements are analysed,
- Delivery mechanisms are analysed
- Coverage is mapped
- Policy formulation and reform is supported
- Multi-sectoral planning and budgeting is supported
- Coordination capacity is supported and enhanced
- Efficiency and effectiveness are improved.
RENEWED EFFORTS AGAINST CHILD HUNGER AND UNDERNUTRITION

Visit http://www.reachpartnership.org/home for further information