Government of Malawi
Department of Nutrition, HIV and AIDS

National Multi-Sector Nutrition Policy 2018–2022

April 2018

Foreword

The Government of Malawi recognises that adequate nutrition is a prerequisite for human growth and development, as it plays an important role in one's physical and intellectual development, and consequentially work productivity. Nutrition is fundamental for the socio-economic growth and development of this country, thus, Government has placed nutrition high on the national development agenda.

In 2007, Malawi developed the first edition of National Nutrition Policy and Strategic Plan that guided the implementation of a multi-sectoral nutrition response. The goal of the Policy and Strategic Plan was to facilitate the improvement of the nutrition status of all Malawians with emphasis on children under five years, pregnant and lactating women, school aged children and other vulnerable groups such as people living with HIV, and people affected by emergencies.

The Government of Malawi has renewed its commitment and strategic response to nutrition-related issues by reviewing the National Nutrition Policy, which is multi-sectoral and covers both nutrition-specific and nutrition-sensitive interventions. The National Multi-Sector Nutrition Policy 2018–2022 serves to redirect the national focus on nutrition programming and to realign the national nutrition priorities with the national development agenda.

The Government of Malawi understands that the causes of malnutrition are multi-faceted, which require multi-sectoral approach, coordination, and implementation platforms with clear terms of reference at all levels. In this regard, the Government established the Department of Nutrition, HIV and AIDS in 2004 to provide oversight and coordination of the national nutrition response. Understanding that operationalisation of this Policy falls in the hands of a number of sectors, each sector is expected to commit itself to fulfil its mandate.

The Government is committed to continue placing nutrition high on the national development agenda. I therefore call upon all line ministries and other stakeholders to join hands in the successful implementation of this Policy.

Honourable, Atupele Austin Muluzi, M.P

MINISTER OF HEALTH AND POPULATION

Preface

The National Multi-Sector Nutrition Policy 2018–2022 has been developed following the review of the National Nutrition Policy and Strategic Plan 2007–2012. The Policy was reviewed through a consultative process that involved a range of stakeholders including the local leaders and communities, line ministries, civil society, development partners, and the private sectors. The process has taken into consideration the lessons learnt, gaps identified and emerging issues.

This new Policy aims at ensuring that evidence-based, high-impact nutrition interventions are developed and implemented at scale. The Policy will be implemented in line with the overarching National Development Strategy, which considers nutrition as one of the priority area under the social development thematic area.

The Policy is aligned with the Scaling Up Nutrition movement, global declarations and commitments, which Malawi is signatory such as the Sustainable Development Goals and the World Health Assembly targets. The Government of Malawi is indebted to all the people and institutions that were involved in reviewing the Policy. Special appreciation goes to the World Bank, Canadian International Development Agency, United States Agency for International Development – through the Food and Nutrition Technical Assistance III Project, and the United Nations organisations for their financial and technical support.

Dr. Dan Namarika
SECRETARY RESPONSIBLE FOR NUTRITION, HIV AND AIDS

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ADC	Area Development Committee
AEC	Area Executive Committee
ANCC	Area Nutrition Coordination Committees
BFHI	Baby Friendly Hospital Initiative
CHD	Child Health Day
CMAM	Community-based Management of Acute Malnutrition
CBO	Community Based Organisations
CSO	Civil Society Organisations
DAES	District Agriculture Extension Services
DC	District Commissioner
DMECC	District M&E Coordination Committees
DNCC	District Nutrition Coordination Committees
DNHA	Department of Nutrition, HIV, and AIDS
DHS	Demographic and Health Survey
HSA	Health Surveillance Assistant
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
IPs	Implementing Partners
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition

M&E	Monitoring and Evaluation
MGDS	Malawi Growth and Development Strategy
MICS	Multi Indicator Cluster Survey
MNS	Micronutrient Survey
MoAIWD	Ministry of Agriculture, Irrigation and Water Development
MoEST	Ministry of Education Science and Technology
MoFEPD	Ministry of Finance Economic Planning and Development
MoH	Ministry of Health
MoIT	Ministry of Industry and Trade
MoJCA	Ministry of Justice and Constitutional Affairs
MoLGRD	Ministry of Local Government and Rural Development
MUAC	Mid-Upper Arm Circumference
MVAC	Malawi Vulnerability Assessment Committee
NCDs	Non-Communicable Diseases
NCST	Nutrition Care Support and Treatment
NMNP	National Multi-Sector Nutrition Policy
NRU	Nutrition Rehabilitation Unit
ORS	Oral Rehydration Salts
OTP	Outpatient Therapeutic Programme
PLHIV	People Living with HIV
PPP	Public –Private Partnership

SAM	Severe Acute Malnutrition
SFP	Supplementary Feeding Program
SUN	Scaling Up Nutrition
TB	Tuberculosis
VNCC	Village Nutrition Coordination Committees
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organisation

Glossary

Acute Malnutrition is caused by a decrease in food consumption and/or illness resulting in bilateral pitting oedema or sudden weight loss. They are two forms of acute malnutrition; Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM).

- **SAM** is very low weight-for-height below -3 z-scores of the median WHO growth standards, visible severe wasting, MUAC less than 11.5 cm in children 6–60 months old or presence of bilateral pitting oedema.

- **MAM** is defined as a weight-for-height between -3 and -2 z-scores of the median World Health Organisation (WHO) child growth standards, wasting, and mid-upper arm circumference (MUAC) between 11.5 and 12.5 cm in children 6–60 months old.

Adequate Nutrition refers to the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, combined with regular physical activity.

Food Security is defined as including both physical and economic access to food that meets people's dietary needs and food preferences for a productive and healthy life. Food security has four components: food availability, food access, food utilisation, and stability of the first three components

Nutrition is the intake of food, considered in relation to the body's dietary needs. It is the science that interprets the interaction of nutrients and other substances in food in relation to maintenance, growth, reproduction, health, and disease of an organism.

Nutrition Security is achieved when secure access to an appropriately nutritious diet is coupled with a sanitary environment, adequate health services and care to ensure a healthy and active life for all household members.

Nutrition Sensitive Interventions address the underlying causes of foetal and child nutrition and development— food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment.

Nutrition Specific Interventions address the immediate causes of foetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases

Nutrition Surveillance refers to monitoring the state of health, nutrition, eating behaviour, and nutrition knowledge of the population for the purpose of planning and evaluating nutrition policy. Especially in low-income countries, monitoring may include factors that may give early warning of nutritional emergencies.

Overnutrition is a result of excessive intake of energy, leading to overweight and obesity.

Overweight and Obesity is defined as abnormal or excessive fat accumulation that may impair health. Overweight and obesity is measured by a body mass index greater than 25.

Stunting reflects retarded growth, defined as height-for-age below -2 z-scores of the median WHO growth standards.

Undernutrition is a lack of nutrients caused by inadequate dietary intake. It encompasses a range of conditions including acute undernutrition, chronic undernutrition, and micronutrient deficiency.

Underweight is weight-for-age below -2 z-scores of the median WHO growth standards.

1.0. Introduction

Nutrition is a pre-requisite for human growth and development and an integral element for the social and economic development of a country. Adequate nutrition is critical for physical and intellectual development of an individual and is a major determinant of one's intellectual performance, academic and professional achievement, and overall work productivity at later stages in life. This directly and indirectly influence potential future gains and economic contribution of the individual to the nation.

The National Multi-Sector Nutrition Policy (NMNP) 2018–2022 is intended to provide a guiding framework for the successful implementation of the national nutrition response; address the existing and emerging national and global issues; and consequently, uphold the Government's commitment towards eliminating all forms of malnutrition. The Policy shall be operationalised through the National Nutrition Strategic Plan 2018–2022. Additional supporting operational strategies and guidelines shall be developed to further translate the aspiration into tangible actions. These shall include the following strategies and guidelines: National Nutrition Education and Communication; infant and young child feeding (IYCF); Micronutrient; Adolescent Nutrition; School Health and Nutrition; Early Childhood Development; Community-based Management of Acute Malnutrition (CMAM); Nutrition Care Support and Treatment (NCST); and prevention and treatment of nutrition-related Non-Communicable Diseases (NCDs).

The Policy has identified eight priority areas which include: i) Prevention of undernutrition; ii) Gender equality, equity, protection, participation and empowerment for improved nutrition; iii) Treatment and control of acute malnutrition; iv) Prevention and management of overweight and nutrition-related NCDs; v) Nutrition education, social mobilisation, and positive behaviour change; vi) Nutrition during emergency situations; vii) Creating an enabling environment for nutrition; and viii) Nutrition monitoring, evaluation, research and surveillance. The Policy also contains an implementation plan, monitoring and evaluation framework presented in annexure I and II respectively.

1.1. Background

The Government of Malawi developed the first National Nutrition Policy in 2007 whose overall goal was to have a well-nourished nation with sound human resource that effectively contributes to the economic growth and prosperity. The first Policy recognized malnutrition as a disorder with social, cultural, economic, development, political, and biomedical dimensions. The Policy was expected to facilitate achievement of the following objectives:

i. Prevention and control of the most common nutrition disorders among women, men, boys, and girls in Malawi by 2011 with emphasis on vulnerable groups.

ii. Increased access to timely and effective management of the most common nutrition disorders among women, men, boys, and girls in Malawi by 2011 with emphasis on vulnerable groups.

iii. Creation of an enabling environment for the effective implementation of nutrition services and programmes between 2007 and 2011.

The first edition of the Policy was implemented for a period of five years, 2007 to 2011 and operationalized through the National Strategic Plan. The Policy was aligned to the Malawi Growth and Development Strategy (MGDS) I and the Millennium Development Goal.

Malawi has registered significant progress in the prevention, treatment, care, and support of malnutrition which include:

i. Strengthened Government stewardship, championship and multi-sector coordination of nutrition interventions and programmes through the National Nutrition Committee, Nutrition Technical Working Groups, and District Nutrition Coordination Committees (DNCC).

ii. Development of the Food and Nutrition Security Bill, strategic documents, and guidelines.

iii. Improved nutritional status of the Malawian population. This has been marked by a reduction in the following nutrition indicators:

- Percentage of children under five years of age who are stunted from 47.1 in 2010 to 37.1 in 2015-16, (Demographic Health Survey [DHS])
- Percentage of children under five years of age who are underweight from 12.8 in 2010 to 11.7 in 2015-16, (DHS)
- Percentage of children under five years of age who are wasted from 4.0 in 2010 to 2.7 in 2015-16, (DHS)

Despite the improvement in the nutrition indicators, the prevalence of malnutrition remains high according to global standards. This calls for a re-definition of the strategies based on emerging issues, lessons learnt, and best practices.

1.2. Nutrition Situation

Undernutrition

Over the past two decades, Malawi has experienced a decline in the rates of undernutrition, an indication that investments in nutrition are paying off. The percentage of children under five years of age who are stunted has decreased from 47.1 to 37.1, underweight from 12.8 to 11.7 and wasting from 4.0 to 2.7 (DHS 2010 and DHS 2015-16 respectively). Similarly, the prevalence of micronutrient deficiencies decreased, anaemia decreased from 55 percent to 28 percent and Vitamin A from 59 percent to 4 percent (MNS 2009 and MNS 2015 – 16 respectively). Even with the noted decline in undernutrition, continued efforts are needed to address micronutrient deficiencies and the high rates of stunting. Additionally, Zinc deficiency is an emerging public health concern affecting over 60 percent of the population including children under the age of five and women of reproductive age group (MNS 2015).

The prevalence of undernutrition is high among adolescent girls (15.6 percent); similarly, the IYCF practices need to be improved as the proportion of infants 0–6 months old who are exclusively breastfed declined from 71.4 percent in 2010 to 61.2 percent in 2015-16; and only 7.8 percent of children aged 6–23 months consumed foods that met the minimum acceptable diet.

The causes of undernutrition are manifold: repeated infections including acute respiratory infections, diarrhoea, and malaria; suboptimal breastfeeding and infant feeding practices resulting in inadequate dietary intake are the immediate causes of malnutrition. The underlying causes include food insecurity; gender inequality; poor hygiene practices and lack of safe water and sanitation. As such, malnutrition is a complex problem that persists due to multiple causes rooted in various sectors. In addition to nutrition-specific interventions, nutrition-sensitive interventions that are multi-sectoral are essential in reducing and eradicating malnutrition in Malawi.

Overnutrition

In addition to a high prevalence of undernutrition, the WHO in 2014 estimated that nine percent of children under five are overweight. In Malawi, adults between 15 and 49 years of age, 21 percent are overweight while five percent are obese. The prevalence of overweight and obesity is higher in women (24 percent are overweight and 6 percent are obese) than men (17 percent are overweight and 3 percent are obese).

The prevalence of cardiovascular diseases (e.g., heart disease and stroke), cancer, respiratory diseases, and diabetes mellitus are increasingly becoming significant causes of morbidity and mortality in Malawi. As overweight, and more so obesity increase, the risk of nutrition-related NCDs also increases. These statistics demonstrate the need to address all forms of malnutrition including overweight and obesity.

1.3. Current Nutrition Interventions and Strategies

Through the implementation of the National Nutrition Policy and Strategic Plan 2007–2011, significant progress was made in addressing some of the aforementioned nutrition challenges. Notable positive achievements include establishment of a multi-sectoral coordinating institution; increasing access to services by expanding coverage of evidence-based, high-impact interventions; providing a framework for standardisation and improvement of nutrition service delivery; and positioning nutrition high on the National Development Agenda.

The National Nutrition Response was and is partially consistent with the conceptual framework on actions to achieve optimum foetal and child nutrition and development. A comprehensive multi-sectoral nutrition programme therefore needs to build an enabling environment for nutrition, while also implementing high-impact, nutrition-specific and nutrition-sensitive interventions.

1.4. Linkages with Other Relevant Key Policies and Legislation

The Policy will operate in line with the existing legal and policy frameworks at national and global levels as indicated in the following section.

The Constitution

The NMNP 2018-2022 is aligned with the Constitution under Chapters III and IV, which provide for the Principles of National Policy and Human Rights, respectively. In section 13 (b), the Constitution provides that: 'The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals: (b) Nutrition – To achieve adequate nutrition for all in order to promote good health and self-sufficiency'.

Malawi Growth and Development Strategy

The MGDS, as an overarching policy document, identifies Nutrition as one of the national priorities. The NMNP shall thrive to uphold the vision to have 'a well-nourished Malawian population that effectively contributes to the social and economic growth and prosperity of the country'.

Linkages with Legislations

The Policy shall operate in an environment, which has other legislation that touches on nutrition-related issues such as: The Consumer Protection Act; The Pharmacy Medicines and Poisons Act; The Malawi Bureau of Standards Act; The Public Health Act; Health and Welfare Act; The Prevention of Domestic Violence Act; The Child Care Justice and Protection Act; The Persons with Disabilities Act; and The Local Government Act.

National Agriculture Policy

The Agriculture Policy promotes nutrition-sensitive food and agriculture-based approaches including production of diversified foods, and dietary diversification. It also promotes integrated homestead farming, production and consumption of high nutritive-value foods, more capital-intensive forms of agriculture (cash crops, livestock, and aquaculture), market access, and ensuring sustainable food and nutrition security for all Malawians.

National Health Policy

The Health Policy promotes several nutrition-specific interventions at the health facility and community level. These interventions include promoting dietary diversity; optimal IYCF and caring practices; treatment of acute malnutrition; nutrition care support and treatment for people living with HIV (PLHIV) and tuberculosis (TB) patients; and micronutrient supplementation. In addition, the Health Policy also promotes, growth monitoring and promotion, provision of insecticide-treated bed nets, and de-worming.

National Education Policy

The National Education Policy advocates for the promotion of the school feeding programme; school health and water sanitation, and hygiene (WASH); HIV and AIDS; gender; and education interventions. The Policy is also mainstreaming nutrition within the school curricula and implementing nutrition-sensitive interventions that improve classroom education and keeping adolescent girls and young women in schools.

National Gender Policy

The Gender Policy seeks to mainstream gender in the national development process in order to enhance participation of women and men, girls, and boys at individual, household, and community levels for sustainable and equitable development. It also promotes a holistic approach to gender equality and social protection, poverty reduction through microfinance, and sustaining livelihoods of ultra-poor households using cash transfers.

Decentralization Policy

The Decentralization Policy seeks to create a democratic environment and institutions for governance and development at the local level that facilitate grassroots participation in decision making. It supports the roll out of nutrition interventions, and promotes district- and community-level operationalisation of nutrition policies and strategic plans.

Nutrition has also strong linkages with other social and sectoral policies as a cross-cutting issue as follows: National Social Support Policy; National Population Policy; National Youth Policy; and National HIV and AIDS Policy.

Linkages with International Instruments

The Policy is guided by international human rights and other instruments, which Malawi is party to at the regional and global levels, such as: the Convention on Human Rights; the International Covenant on Economic, Social, and Cultural Rights; the Convention on the Elimination of all Forms of Discrimination Against Women; the Convention on the Rights of the Child; the African Charter on Human and People's Rights and its relevant protocols; the Southern African Development Community Protocol on Gender and Development; the Declaration of Commitment on HIV and AIDS Action; the Maputo Declaration on Tuberculosis, HIV and AIDS, Malaria and other related infections; the World Health Assembly Targets; the Sustainable Development Goals; and Scaling up Nutrition (SUN) movement.

The instruments collectively enshrine the respect, protection, and fulfilment of the rights of all individuals, especially those with nutrition disorders and other vulnerable populations. The Policy will also be guided by the 'Malawi Commitments on Nutrition' espoused in 2013 in the London Compact 'Nutrition for Growth: Beating Hunger through Business and Science'.

1.5. Purpose of the Policy

This NMNP 2018–2022 serves as a guiding document for national nutrition stakeholders, including government, civil society, faith-based organisations, academia, the private sector, and development partners to promote:

- Evidence-based programming and strengthening of the national nutrition response.
- Scale up of evidence-based innovative interventions.
- Re-alignment of nutrition interventions to the current national development strategy, the SUN movement, World Health Assembly targets, the Sustainable Development Goals, and other new global declarations, which the government has signed.

The Policy provides the framework and context within which sectoral and other strategic plans and budgets should be coordinated, formulated, implemented and monitored.

2.0. Broad Policy Direction

2.1. Policy Goal

A well-nourished Malawian population that effectively contributes to the economic growth and prosperity of the country.

2.2. Policy Outcomes

The expected outcomes of this Policy are:

i. Improved adolescent, maternal, and child nutrition, and health.

ii. Reduced prevalence of overweight and nutrition-related NCDs among the general population.

iii. Reduced nutrition-related mortality among children under the age of five years, and the general population.

iv. Improved enabling environment for effective coordination and implementation of nutrition-sensitive and specific interventions.

2.3. Policy Objectives

The objectives of the policy are to:

i. Prevent undernutrition with emphasis on children under five, adolescent girls, school-going children, pregnant and lactating women, PLHIV, and other vulnerable groups.

ii. Enhance gender equality, equity, protection, participation, and empowerment of adolescent, women, and children for improved nutrition.

iii. Treat and control acute malnutrition among children under five, adolescents, pregnant and lactating women, PLHIV, and other vulnerable groups.

iv. Prevent and manage overweight and nutrition related NCDs.

v. Enhance nutrition education, social mobilisation, and positive behaviour change.

vi. Improve delivery of nutrition interventions during emergencies.

vii. Create an enabling environment for effective implementation of nutrition interventions.

viii. Enhance evidence-based programming through nutrition monitoring, evaluation research, and surveillance.

2.4. Guiding Principles

The successful implementation of the Policy will be guided by the following principles.

Right to optimum nutrition: Every Malawian has a right to access safe and nutritious food at all times, even during emergency situations.

Multi-sectoral approach: Nutrition issues are multi-faceted in nature and implemented by different sectors that need effective partnerships and coordination.

Gender Equality and Equity: Eliminating gender and other inequalities will help address some of the underlying causes of malnutrition and accelerate nutrition improvement for all.

Decentralization: Effective implementation of nutrition activities through a well-governed decentralized system will yield greater beneficial outcomes for households and communities.

Community empowerment and participation: Partnering with and empowering communities in the delivery of nutritional knowledge, skills, and resources is likely to yield better outcomes and engender community acceptance and ownership.

Evidenced-based interventions: Evidence-based, proven strategies and best practices have potential for greater impact on improving nutrition. The NMNP will promote evaluation and learning, documentation of implementation successes, best practices, and application of lessons learnt in programming.

3.0. Policy Priority Areas

The Policy has identified eight priority areas that consolidate aspirations contained in the goal and the policy objectives.

The priority areas are:

i. Prevention of undernutrition

ii. Gender equality, equity, protection, participation, and empowerment for improved nutrition

iii. Treatment and control of acute malnutrition

iv. Prevention and management of overweight and nutrition-related NCDs

v. Nutrition education, social mobilisation, and positive behaviour change

vi. Nutrition during emergency situations

vii. Creating an enabling environment for nutrition

viii. Nutrition monitoring, evaluation, research, and surveillance

3.1. Policy Priority Area 1: Prevention of Undernutrition

Prevention of undernutrition involves adequate dietary intake and control of acute diseases throughout the life cycle of human growth and development. In Malawi, prevention of undernutrition has been a challenge due to inadequate availability and access to diverse nutritious foods; poor health-seeking behaviours; WASH; weak access to quality health care; low education levels among caregivers; and insufficient household incomes. In this regard, prevention of undernutrition, therefore, requires a multi-sectoral approach in delivering nutrition interventions to reach sustainable change.

Policy Statements

The Policy will ensure that:

I. High-impact, cost-effective nutrition interventions are scaled up to all communities.

Strategies:

- Promote optimal nutrition in the general population.
- Promote women's nutrition before, during, and after pregnancy.
- Intensify prevention and control of micronutrient malnutrition.
- Promote optimal breast feeding practices for children 0-6 months at facility, community, and household levels.

- Promote continued breastfeeding and appropriate complementary feeding of children aged 6–24 months and beyond.
- Strengthen optimal feeding of children during and after illness.
- Promote improved WASH practices at community and household level

II. High-impact, nutrition-specific, and nutrition-sensitive interventions in the relevant core sector policies, strategies, implementation plans, and budgets are integrated.

Strategies:

- Promote implementation of nutrition-sensitive and nutrition-specific interventions in the core relevant sectors.
- Promote school feeding and school health and nutrition programmes.

III. Private sector engagement in the production, processing and consumption of high-quality nutritious foods is enhanced.

Strategies:

- Promote Public-Private Partnerships in food production, processing, fortification, and consumption.
- Promote fortification and standardisation of centrally-processed food for improved nutrition.

3.2. Policy Priority Area 2: Gender Equality, Equity, Protection, Participation, and Empowerment for Improved Nutrition

Gender equality and equity is a fundamental human right. Advancing gender equality and equity is critical in promoting healthy and prosperous nation. Gender equality and equity are achieved when women, men, boys and girls enjoy the same rights and opportunities in economic empowerment, participation in socio-economic activities and decision making across all sectors. Gender inequality is high in Malawi and adversely impacts nutrition status of women, children and other vulnerable groups.

As girls move into adolescence, gender disparities widen. Early marriages and teenage pregnancies affect girls far more than boys with higher risk for nutrition and health disorders. Women's participation, particularly those of child bearing age, in decision-making at household level is low.

Therefore, it is necessary for male involvement at household, and community level to achieve gender equality, equity, protection and empowerment.

Policy Statements

The Policy will ensure that:

I. Optimum nutrition service delivery to adolescents is promoted.

Strategy:

- Promote improved nutrition for adolescents.

- Promote iron-folate supplementation for women of reproductive age,

II. Men's shared responsibility for child care and household duties to enable women participation in social and economic activities is increased.

Strategy:

- Promote male involvement in maternal nutrition, child care, and household duties.

III. Approaches to improve women's decision-making power for access to optimum nutrition are integrated and leveraged.

Strategy:

- Address gender and socio-cultural issues that affect adolescent, maternal, infant, and young child nutrition.

IV. Livelihood for women- and child-headed households to increase access and control of resources for improved nutrition status is sustained.

Strategy:

- Promote sustainable livelihoods interventions for women- and child-headed households.

3.3. Policy Priority Area 3: Treatment and Control of Acute Malnutrition

Treatment and control of acute malnutrition focuses primarily on timely identification, treatment, and follow-up of acutely malnourished children through a community- and facility-based approach. In addition, the Government established nutrition care support and treatment (NCST) interventions, which aims at addressing malnutrition among adolescent and adults with chronic illness such as TB, HIV and AIDS.

However, treatment and control of acute malnutrition has faced several challenges, including: inadequate coverage; weak linkages between facilities and communities; low capacity and participation of clinicians in the management of acute malnutrition; insufficient community outreach and mobilisation; weak supply chain management; and overall low quality of service delivery.

Policy Statements

The Policy will ensure that:

I. Interventions on the management of acute malnutrition are owned and financed by the Government.

Strategy:

- Strengthen the implementation of CMAM and NCST through lifecycle approach targeting adolescents, adults and children.

II. Nutrition assessment, counselling, and support services and linkage with livelihood interventions targeting adolescents, adults, and children recovering from various forms of ailments including TB, HIV and AIDS are scaled up to ensure a continuum of care.

Strategy:

- Promote scaling up of nutrition treatment, care, and support for TB patients, PLHIV, and other chronically ill persons in all public and private health facilities.

III. Enabling environment for CMAM and NCST service delivery, and M&E system at all levels is strengthened.

Strategy:

- Promote governance, coordination, monitoring and evaluation of CMAM and NCST service delivery.

3.4. Policy Priority Area 4: Prevention and Management of Overweight and Nutrition-related NCDs

Prevention and management of overweight and nutrition-related NCDs focuses on prevention, early identification, and treatment of overweight, obesity, and nutrition-related NCDs such as cardiovascular diseases, diabetes, cancers, and chronic respiratory (lung) conditions. Overweight and obesity can be a result of overnutrition, random genetic abnormalities, heredity, and lifestyle including environmental causes.

Overweight and obesity are on the rise and contribute to nutrition-related NCDs, which are significant causes of morbidity and mortality in the country. In addition to that, urbanisation, changing lifestyles such as tobacco smoking, excessive alcohol consumption, physical inactivity, and low fruit and vegetable intake are well known shared risk factors for development of nutrition-related NCDs. However, identification and management of nutrition-related NCDs are not regularly done and the preventive measures for overweight and obesity are also not adequately met at the community and facility level.

Policy Statements

The Policy will ensure that:

I. Overweight and nutrition-related NCDs by all nutrition service providers is detected and managed early.

Strategy:

- Increase access to services for prevention, early detection, and management of nutrition-related NCDs.

II. Service providers' capacity to provide nutrition and lifestyle counselling services for those who are overweight and obese is enhanced.

Strategy:

- Strengthen capacity of service providers' to provide nutrition and lifestyle counselling services at the facility and community level.

III. Nutrition-related NCDs are prevented through behaviour change communication focused on consumption of appropriate diet, promotion of healthy lifestyles, and physical activity.

Strategy:

- Promote awareness campaigns and behaviour change communication on prevention of nutrition-related NCDs.

3.5. Policy Priority Area 5: Nutrition Education, Social Mobilisation and Positive Behaviour Change

Nutrition education focuses on increasing the nutrition knowledge and awareness to the public and promoting desirable behaviours and practices in food production, processing, storage, and consumption for optimum nutrition. It is a combination of education strategies that enhances multi-sectoral response by mobilising and building strong movement and commitment for improvement in nutritional status at the individual, household, and community levels.

The key challenges in nutrition education, social mobilisation, and positive behaviour change are cultural beliefs, practices, and taboos that prevent access and utilisation to nutritious foods. Such changes are often difficult and require more than providing correct information about prevention of undernutrition or overnutrition. Therefore, well-designed social and positive behaviour change interventions are critical for improvement in nutrition practices.

Policy Statements

The Policy will ensure that:

I. Nutrition education, behaviour change communication, and social mobilisation interventions are scaled up.

Strategies:

- Promote behavioural change for collective action, community ownership, and improved nutrition knowledge, attitudes, and practices.
- Advocate for stakeholders' participation in nutrition education programming at all levels.
- Promote social mobilisation through mass media and other communication channels.

II. Capacity of the core sectors to formulate and implement nutrition social mobilisation and behaviour change communication interventions is enhanced.

Strategy:

- Strengthen the capacity of all sectors at national and district level to review and implement nutrition education and communication strategy.

3.6. Policy Priority Area 6: Nutrition during Emergency Situations

Emergency situations occur when there is an exceptional and widespread threat to life, health, and basic subsistence that is beyond the coping capacity of individuals and communities. Malawi is prone to disasters, predominantly droughts and floods, which are further exacerbated by climate change. The affected population are sometimes displaced from their homes, lose their livelihoods, and have little access to resources or services and become vulnerable to infectious diseases and malnutrition. The impact of these disasters on the population are particularly devastating due to the high dependence on subsistence farming, over-reliance on rain-fed agriculture, poverty, limited crop diversity, and a lack of disaster-risk management infrastructure and systems.

The key challenges during emergency situations are food insecurity, poor livelihoods, inadequate coping mechanisms resulting in limited availability, and access to food and nutrition that compromises the nutritional status of individuals, especially vulnerable groups.

Policy Statement

I. The Policy will ensure that food and nutrition response to the affected population including vulnerable groups during emergency situations is done timely and effectively.

Strategies:

- Promote timely detection, management, and treatment of malnutrition.

- Promote nutrition education on maternal and child nutrition.
- Promote resilient programmes aimed at improving maternal and child nutrition.
- Strengthen coordination measures of nutrition emergency response at all levels.

3.7. Policy Priority Area 7: Creating an Enabling Environment for Nutrition

An enabling environment is a set of interrelated conditions such as legal, organisational, fiscal, informational, political, and cultural that impact the capacity of stakeholders to engage in nutrition interventions in a sustained and effective manner. Creating enabling environment involves ensuring that there is effective coordination, advocacy, regulations, governance, accountability, capacity building, and resource mobilisation. In 2004, the Government established the DNHA to provide policy guidance, oversight, and M&E for all sectors implementing nutrition interventions. Through the DNHA, several governance structures have been established at the national, district, and community levels.

Challenges for the enabling environment include insufficient capacity (human and financial), unavailability of legal instruments for nutrition, and weak coordination and governance of structures at all levels.

Policy Statements

The policy will ensure that:

I. Multi-sector and intra-sector coordination of nutrition interventions at national, district, and community levels is enhanced.

Strategy:

- Strengthen nutrition coordination at all levels.

II. Nutrition advocacy measures are well coordinated to increase resources, and social and political commitment.

Strategy:

- Advocate for increased financial resource allocations for nutrition programming by government and development partners.

III. Allocation of human resources by government for the implementation of nutrition interventions is increased.

Strategy:

- Strengthen human capacity for effective programming and delivery of nutrition services at all levels.

IV. Legal mechanisms that establish food safety standards and protect consumers is developed.

Strategy:

- Enforce legal instruments to guide implementation of nutrition services and programmes.

V. Investment in delivery of high-impact nutrition interventions is increased across the sectors.

Strategy:

- Promote public-private partnership in implementation of nutrition programmes.

3.8. Policy Priority Area 8: Nutrition Monitoring, Evaluation, Research and Surveillance

Nutrition monitoring, evaluation, research, and surveillance aim to measure achievements, progress and gaps, and to trigger corrective actions for nutrition planning and programming. Nutrition M&E is primarily designed to provide stakeholders with relevant information on the implementation progress of nutrition services. It further helps in evidence-based decision making.

Nutrition research generates new information and provides evidence on improving programming and practice. Although research has been key in building some of the national programmes such as the CMAM and sugar fortification, it has not been adequate in supporting evidence-based programming around national policy priorities. The Nutrition Research Strategy was not adequately disseminated to partners including academia, private sector, and non-governmental institutions. There are inadequate financial and human resources to support national nutrition research capacity.

Surveillance provides routine information about the population's nutritional status, identifies at-risk groups, and enables timely interventions to address a problem. While the intervention was successful, it has limited coverage and focuses on limited nutrition interventions.

Policy Statements

The Policy will ensure that:

I. Collaboration and coordination of nutrition research activities is strengthened.

Strategy:

- Promote coordination and collaboration of nutrition researchers in line with the national nutrition research strategy and other existing actions in the research institutions.

II. Nutrition Research, routine information, dissemination, utilization, and feedback at national and district levels to enhance evidence-based decision making.

Strategies:

- Promote research and use of information for evidence-based decision making at all levels.
- Strengthen monitoring, evaluation and surveillance systems for routine information sharing and data utilisation at all levels.

4.0. Implementation Arrangements

Outlined in this chapter is how the policy will be implemented, including institutional arrangements, resource mobilisation, sustainable financing, and monitoring and evaluation.

4.1. Institutional Arrangements

The Government recognises the importance of stakeholders and partnership in implementation of this policy. The stakeholders include ministries, departments, agencies, development partners, academic and research institutions, the public sector, the private sector, civil society organisations (CSOs), non-governmental organisations, faith-based organisations, and the communities which are as follows:

The Department of Nutrition, HIV and AIDS (DNHA)

The Department will be responsible for provision of oversight, strategic leadership, policy direction, coordination, resource mobilisation, capacity building, quality control and monitoring and evaluation of the national nutrition response. The department will also be responsible for 1) high level advocacy; 2) spearheading the mainstreaming and integration of nutrition in the national development agenda, sectorial policies, programs, and outreach services; 3) ensuring the implementation of the Policy by sectors and other stakeholders on the basis of the defined mandates; 4) tracking sector performance and ensuring accountability; and 5) resource tracking.

Ministry responsible for Agriculture, Irrigation and Water Development (MoAIWD)

The Ministry will be responsible for food and nutrition security and mainstreaming nutrition as a core priority area by focusing on improving food access and promoting diversified diets. The Ministry will support production of diverse nutritious crops and livestock. Ministry will promote consumption and utilization of diverse diet from the six food groups including bio-fortified foods, and strengthen value chains to improve production, availability, distribution, and access to high-quality and safe nutritious foods. Ministry will also promote Water, Sanitation and Hygiene (WASH) interventions.

Ministry responsible for Health

The Ministry will be responsible for provision of leadership and technical direction in programming and delivery of the quality and cost-effective clinical and biomedical nutrition services in partnerships with stakeholders.

Ministry responsible for Gender, Children, Disability and Social Welfare

The Ministry will be responsible for provision of leadership and technical direction in programming gender and mainstreaming nutrition interventions. The Ministry will promote women's and adolescent's empowerment, integration of nutrition in income generating activities, social protection and welfare programmes, and community mobilisation in support of nutrition. Ministry will also promote the early stimulation, care, protection, and development amongst children.

Ministry responsible for Education, Science and Technology (MoEST)

The Ministry will be responsible for implementation of the school health and nutrition programmes, including school feeding. It will also be responsible for inclusion of nutrition education in school curricula at all levels of the education system.

Ministry responsible for Local Government and Rural Development (MoLGRD)

The Ministry will be responsible for implementation of nutrition interventions at the council and community levels. It will ensure the replication of the multi-sectoral approach to nutrition at the district, municipal and city council levels. It will also establish district and community-level nutrition committees.

Ministry responsible for Finance, Economic Planning and Development

The Ministry will be responsible for mobilisation of resources from government and development partners, and private sectors for nutrition interventions.

Ministry responsible for Information and Civic Education

The Ministry will be responsible for dissemination of nutrition information and public awareness using different communication channels.

Ministry responsible for Industry and Trade

The Ministry will be responsible for enforcement of trade-related sections of legislation that have impact on food, nutrition, counterfeit law, Salt Iodisation Act, food standards as defined and protected by the Malawi Bureau of Standards, and the National Code of Marketing of Breast Milk Substitutes.

Ministry responsible for Youth Development

The Ministry will be responsible for provision of leadership and coordination in the delivery of high quality, culturally appropriate, and contextually relevant nutrition information and services to the youth.

Ministry responsible for Justice and Constitutional Affairs

The Ministry will be responsible for drafting and interpreting legislations that support food, nutrition, and the wellbeing of Malawians.

Ministry responsible for Climate Change

The Ministry will be responsible for coordinating integration and mainstreaming of nutrition in environmental and social impact assessment and management plans in view of challenges due to climate change.

Academic and Research Institutions

Academic and research institutions will be responsible for conducting nutrition research and disseminating findings to inform policy and programming. The academic institutions will also play an important role in ensuring that pre-service education addresses up-to-date nutrition policy, interventions, and standards that are relevant to the Malawi context.

Development Partners

Development partners will align their nutrition interventions, programmes and financial support with the Policy and nutrition strategy. The development partners will continue to undertake high-level advocacy for nutrition among policy and decision makers; provide technical support including policy analysis and implementation; and assist Government sectors in mobilizing resources for implementation of nutrition programs.

Private Sector Agencies

Private sector agencies will ensure that the standards in the production and marketing of high nutritive-value foods are upheld; follow mandatory fortification requirements and adhere to recommended fortification standards in all the centrally-processed foods; ensure that the provisions of the Nutrition and the Right to Food and Food Safety Acts are adhered to; meet their social corporate obligation in promoting good nutrition for their employees and the nation.

Civil Society Organisations

At the national level, the Civil Society Organizations (CSOs) will collaborate with the government to advocate for and implement nutrition-specific and nutrition-sensitive interventions, ensuring mutual accountability. CSOs in Malawi, will play a crucial role to ensuring that the concerns of various stakeholders in nutrition are heard and that government is held accountable to its commitments to the citizens of Malawi on matters of nutrition security.

Principal Secretaries' Committee on Nutrition, HIV, and AIDS

The Principal Secretaries' Committee on Nutrition, HIV, and AIDS will be responsible for ensuring that nutrition interventions are implemented according to each sector's mandate, roles, and responsibilities. As controlling officers at the sector level, the Principal Secretaries, through this committee, will be accountable for operationalisation of the strategic interventions assigned to their sectors. This responsibility includes ensuring that their respective sectors have been assigned adequate financial and human resources for nutrition, develop action plans for implementation, establish clear objectives and targets, and adhere to reporting and review mechanisms for nutrition interventions.

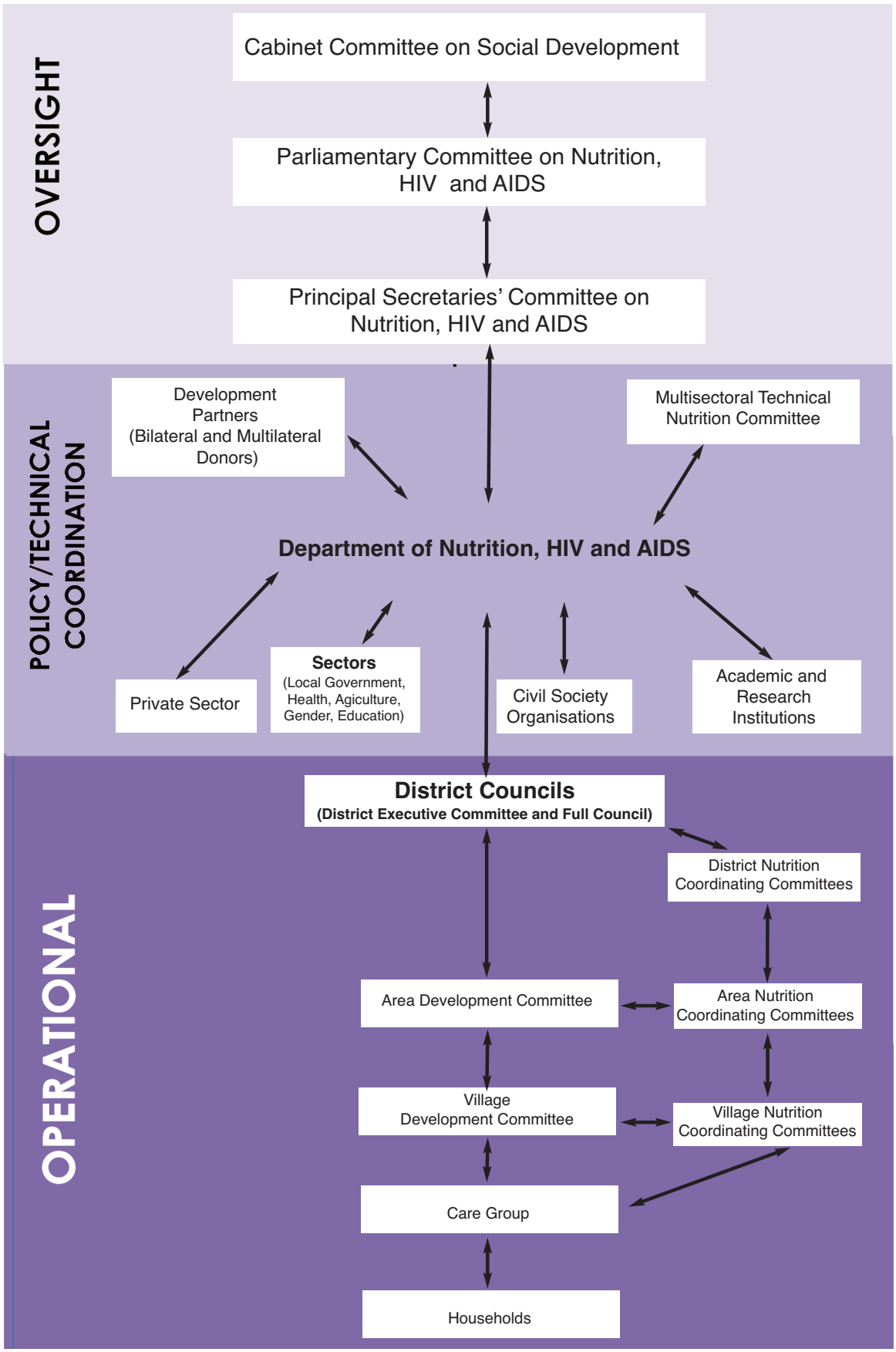
Multi-Sectoral Technical Nutrition Committee

The Multi-Sectoral Technical Nutrition Committee will provide technical oversight in the implementation of the policy within each sector, receive reports from technical working groups and provide technical advise to TWGs.

District Nutrition Coordination Committees

District Committees will work closely with all the district level structures including the Area and Village Development Committees. The Committees will be responsible for providing nutrition technical guidance to stakeholders, coordinating, monitoring, and evaluation of interventions at the district and community levels.

Figure 1: NMNP 2018 - 2022 Institutional Arrangements



4.2. Implementation Plan

This Policy will guide implementation of nutrition interventions and programmes by the defined line-ministries and sectors, under the coordination of DNHA guided by the strategic focus and interventions contained in Annexure I.

4.3. Monitoring and Evaluation

The monitoring and evaluation will be guided by the National Monitoring and Evaluation Framework as presented in Annexure II.

This Policy will be reviewed after five years.

Annexure I: Implementation Plan

Priority Area 1: Prevention of Undernutrition		
Objective: Prevent undernutrition with emphasis on children under 5, adolescent, school-going children, pregnant and lactating women, PLHIV, and other vulnerable groups		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: High-impact, cost-effective nutrition interventions are scaled up to all communities		
1.1. Promote optimal nutrition in the general population	MoAIWD, MoH	2018–2022
1.2. Promote women nutrition before, during and after pregnancy	MoAIWD, MoH	2018–2022
1.3. Intensify prevention and control of micronutrient malnutrition	MoAIWD, MoH	2018–2022
1.4. Promote optimal breast feeding practices for children 0–6 months at facility, community, and household level	MoAIWD, MoH	2018–2022
1.5. Promote continued breastfeeding and appropriate complementary feeding of children aged 6–24 months and beyond	MoH	2018–2022
1.6. Strengthen optimal feeding of children during and after illness	MoH MoAIWD	2018–2022
1.7. Promote improved WASH practises at community and household levels	MoAIWD, MoH, MoGCWS	2018–2022

Policy Statement 2: High-impact nutrition-sensitive and nutrition-specific interventions in the relevant core sector policies, strategies, implementation plans, and budgets are integrated		
1.8. Promote implementation of nutrition sensitive and nutrition-specific interventions in the relevant core sectors	MoAIWD, MoH, MoGCWS	2018–2022
1.9. Promote school feeding and school health and nutrition programmes	MoEST, MoAIWD, MoH, MoGCWS	2018–2022
Policy Statement 3: Private sector engagement in the production, processing, and consumption of high-quality nutrition foods		
1.10. Promote Public-Private Partnerships in food production, processing, fortification and consumption.	PPP commission, DNHA	2018–2022
1.11. Promote fortification and standardisation of centrally processed food for improved nutrition	MoIT, DNHA	2018–2022

Policy Priority Area 2: Gender Equality, Equity, Protection, Participation and Empowerment		
Objective: Enhance gender equality, protection, participation, and empowerment of adolescent girls, women, and children for improved nutrition		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: Promote optimum nutrition service delivery to adolescents		
2.1. Promote improved nutrition for adolescent	MoGCWS, DNHA	2018–2022
2.2. Promote iron-folate supplementation for women of reproductive age	MoEST, MoH, MoGCWS	2018-2022
Policy Statement 2: An increase in men's shared responsibility for child care and household duties to enable women participation in social and economic activities		
2.3. Promote male involvement in maternal nutrition, child care and household duties	MoGCWS, DNHA	2018–2022
Policy Statement 3: Integration and leverage approaches to improve women's decision-making power for access to improved nutrition		
2.4. Address gender and socio-cultural issues that affect adolescent, maternal, infant, and young child nutrition	MoGCWS	2018–2022
Policy Statement 4: Sustained livelihoods for women and child headed households to increase access and control of resources for improved nutrition status		
2.5. Promote sustainable livelihoods interventions for women and child headed households	MoGCWS	2018–2022

Policy Priority Area 3: Treatment and Control of Acute Malnutrition		
Objective: Treat and control acute malnutrition among children under 5, pregnant and lactating women, PLHIV, and other vulnerable groups		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: Government ownership and financing of interventions on the management of acute malnutrition		
3.1. Strengthen the implementation of CMAM and NCST through lifecycle approach targeting adolescents, adults and children	MoH	2018–2022
Policy Statement 2: Scale up of nutrition assessment, counselling, and support services and linkage with livelihood interventions targeting adolescents, adults and children recovering from various forms of ailments including HIV and AIDS and TB to ensure a continuum of care		
3.2. Promote scaling up of nutrition treatment, care and support of TB patients, PLHIV and other chronically ill persons in all public and private health facilities	MoH	2018–2022
Policy Statement 3: Strengthen enabling environment for CMAM and NCST service delivery and M&E System at all levels		
3.3. Promote governance, coordination, monitoring and evaluation of CMAM and NCST service delivery	MoH, DNHA	2018–2022

Policy Priority Area 4. Prevention and Management of Overweight and Nutrition-related NCDs		
Objective: Prevent and manage overweight and nutrition-related NCDs		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: Early detection and management of overweight and nutrition-related NCDs by all nutrition service providers		
4.1 Increase access to services for prevention, early detection and management of nutrition related NCDs	MoH, DNHA, Media	2018–2022
Policy Statement 2: Enhancement of service providers' capacity to provide nutrition and lifestyle counselling services for those who are overweight and obese		
4.2 Strengthen capacity of service providers' to provide nutrition and lifestyle counselling services at the facility and community levels	MoH, DNHA, Media	2018–2022
Policy Statement 3: Prevention of nutrition-related NCDs through behaviour change communication focused on consumption of appropriate diets, promotion of healthy lifestyles, and physical activity		
4.3 Promote awareness campaigns and behaviour change communication on prevention of nutrition-related NCDs	MoH, DNHA, Media	2018–2022

Policy Priority Area 5: Nutrition Education, Social Mobilisation and Positive Behaviour Change		
Objective: Enhance social mobilisation & positive behaviour change communication for nutrition		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: Scale up of nutrition education, behaviour change communication and social mobilisation interventions		
5.1. Promote behavioural change for collective action, community ownership and improved nutrition knowledge, attitudes, and practices	MoEST	2018–2022
5.2. Advocate for stakeholders participation in nutrition education programming at all levels	DNHA, MoLGRD	2018–2022
5.3 Promote social mobilisation through mass media and other communication channels	Ministry of Information	2018–2022
Policy Statement 2: Enhanced capacity of the core sectors to formulate and implement nutrition social mobilisation and behaviour change communication interventions		
5.4. Strengthen the capacity of all sectors at national and district level to review and implement nutrition education and communication strategy	MoEST, DNHA	2018–2022

Policy Priority Area 6: Nutrition during Emergency Situations		
Objective: Enhance delivery of nutrition interventions during emergencies		
Policy Statement	**Responsibility**	**Timeframe**
Policy Statement 1: Timely and effective food and nutrition response to the affected population including vulnerable groups during emergency situations		
6.1. Promote timely detection, management and treatment of malnutrition.	MoH, DNHA	2018–2022
6.2. Promote nutrition education on maternal and child nutrition.	MoEST, DNHA	2018–2022
6.3. Promote resilient programmes aimed at improving maternal and child nutrition	MoH, DNHA	2018–2022
6.4. Strengthen coordination measures of nutrition emergency response at all levels.	DNHA, MoLGRD	2018–2022

Policy Priority Area 7: Creating an Enabling Environment for Nutrition		
Objective: Create an enabling environment for effective implementation of nutrition interventions		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: Enhanced multi-sector and intra-sector coordination of nutrition interventions at national, district, and community levels		
7.1. Strengthen nutrition coordination at all levels	DNHA, MoLGRD, MoFEPD	2018–2022
Policy Statement 2: Nutrition advocacy measures to increase resources, social and political commitment		
7.2. Advocate for increased financial resource allocations for nutrition programming by government and development partners	MoH, DNHA	2018–2022
Policy Statement 3: Increased allocation of human resources by government for the implementation of nutrition interventions		
7.3. Strengthen human capacity for effective programming and delivery of nutrition services at all levels	DNHA, MoLGRD	2018–2022
Policy Statement 4: Development of legal mechanisms that establish food safety standards and protect consumers		
7.4. Enforce legal instruments to guide implementation of nutrition services and programmes	DNHA, MoJCA	2018–2022
Policy Statement 5: Increased investment in delivery of high-impact nutrition interventions across the sectors		
7.5. Promote public private partnership in implementation of nutrition programmes	DNHA, PPPC	2018–2022

Policy Priority Area 8: Nutrition Monitoring, Evaluation, Research and Surveillance		
Objective: Enhance evidence-based programming through nutrition research and surveillance		
Policy Statements	**Responsibility**	**Timeframe**
Policy Statement 1: Strengthened collaboration and coordination of nutrition research activities		
8.1. Promote coordination and collaboration of nutrition researchers in line with the nutrition research strategy and other existing actions in the research institutions	DNHA, Academia	2018–2022
Policy Statement 2: Routine information, dissemination, utilization and feedback at national and district levels for evidence-based decision making		
8.2 Promote research and use of information for evidence-based decision making at all levels	DNHA, Academia	2018–2022
8.3. Strengthen monitoring, evaluation and surveillance systems for routine information sharing and data utilization at all levels	DNHA, Academia	2018–2022

Annexure II: Monitoring and Evaluation Plan

Priority Area 1: Prevention of Undernutrition								
Outcome: Improved nutrition status of Children under 5, women of reproductive age group and other vulnerable groups								
Objective: Prevent under-nutrition with emphasis on children under 5, adolescent girls, pregnant and lactating women, people living with HIV (PLHIV), and other vulnerable groups								
Output 1: Improved nutrition status of children under 5								
Performance Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Percentage of children under five years of age who are stunted	36%	34%	33%	31%	30%	37%	DHS / MICS	Relevant sectors continue to implement planned nutrition related programme
Proportion of children 6–59 months received vitamin A supplement doses	88%	90%	92%	94%	96%	86%	CHD reports	Micronutrients supplementation programme will be scaled up by IPs
Proportion of children 6–59 months received deworming medication	71%	73%	75%	77%	79%	69%	CHD reports	Micronutrients supplementation programme will be scaled up by IPs
Percentage of children age 20–23 months who received breast milk during the previous day	77%	79%	81%	83%	85%	75%	DHS / MICS	Relevant sectors continue to implement planned nutrition related programme
Percentage of children 6–23 months of age who received a minimum acceptable diet	13%	18%	22%	27%	32%	8%	DHS/ Surveillance	Increased crop and dietary diversity
Percentage of children 6–23 months of age who consumed iron-rich foods during the previous day	47%	49%	51%	53%	55%	45%	DHS	Relevant sectors continue to implement planned nutrition related programme

Percentage of low birth weight babies	12%	11%	10%	9%	8%	13%	DHS / MICS	Relevant sectors continue to implement planned nutrition related programme
Percentage of children under five years of age who are underweight	11%	10%	9%	7%	6%	12%	HMIS/ DHS / MICS	Relevant sectors continue to implement planned nutrition related programme
Percentage of children 6–23 months received micronutrient powders 30 sachets	TBD	TBD	TBD	TBD	TBD	TBD	Care group register	Micronutrients supplementation programme will be scaled up by IPs
Percentage of new-borns breastfed within 30 minutes of birth	78%	80%	82%	84%	86%	76%	HMIS	Relevant sectors continue to implement planned nutrition related programme
Percentage of children age 6–23 months who received foods from 4 or more food groups during the previous day	30%	35%	40%	45%	50%	25%	Care group register/ DHS/ MICS	Increased crop and dietary diversity
Percentage of children age 6-23 months who received minimum meal frequency	34%	39%	44%	49%	54%	29%	DHS	Increased crop and dietary diversity
Percentage of children age 6–59 months with anaemia	61%	59%	57%	55%	53%	63%	DHS	Relevant sectors continue to implement planned nutrition related programme

Output 2: Improved nutrition status of women of reproductive age group								
Performance Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Percentage women of reproductive age 15–49 years who are thin	6%	5%	4%	3%	2%	7%	DHS	Relevant sectors continue to implement planned nutrition related programme
Percentage women of reproductive age 15–49 years consuming 4 or more food groups	29%	31%	33%	35%	37%	27%	Surveillance	Increased crop and dietary diversity
Proportion of households consuming adequately iodised salt	>90%	>90%	>90%	>90%	>90%	90%	DHS / MICS	Micronutrients supplementation programme will be scaled up by IPs
Percentage of pregnant women received 120+ iron folate (FeFo) tablets	28%	33%	38%	43%	48%	23%	HMIS	Availability of iron/folate supplements
Percentage of pregnant women age 15–49 years with anaemia	32%	31%	30%	28%	27%	33%	DHS	Relevant sectors continue to implement planned nutrition related programme
Percentage of clients received nutrition assessment	15%	25%	35%	45%	55%	5%	HMIS	Relevant sectors continue to implement planned nutrition related programme

Policy Priority Area 2: Gender Equality, Equity, Protection, Participation and Empowerment								
Outcome: Improved gender quality, protection, participation and empowerment at household and community level								
Objective: Enhance gender equality, protection, participation, and empowerment of adolescent girls, women, and children for improved nutrition								
Output 1: Improved access to children, youth and women for gender equality, protection, participation and empowerment								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Percentage of ECD centers providing nutrition support	35%	40%	45%	50%	55%	30%	Social welfare reports	Relevant sectors continue to implement planned nutrition related programme
Percentage of Households benefiting from social cash transfers	62%	64%	66%	68%	70%	60%	Social welfare Reports	Relevant sectors continue to implement planned nutrition related programme
Output 2: Increased access to school health and nutrition								
Percentage of primary schools operating school meals	48%	50%	52%	54%	56%	46%	SHN reports	School Meals Program will be scaled up by partners
Percentage of primary schools implementing complete SHN package	TBD	TBD	TBD	TBD	TBD	TBD	SHN reports	School Meals Program will be scaled up by partners

Policy Priority Area 3: Treatment and Control of Acute Malnutrition								
Outcome: Reduced prevalence of acute malnutrition among children under 5, pregnant and lactating women, PLHIV, and other vulnerable groups								
Objective: Treat and control acute malnutrition among children under 5, pregnant and lactating women, PLHIV, and other vulnerable groups								
Output 1: Reduced wasting among children under five years, pregnant and lactating women, PLHIV and other vulnerable groups								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Percentage of children under five years of age who are wasted	2.5%	2.2%	2.0%	1.7%	1.5%	2.7%	DHS / MICS/ Surveillance	Relevant sectors continue to implement planned nutrition related programme
Proportion of children who have discharged as recovered in CMAM program (1. NRUs 2. OTPs 3. SFPs)	85%, 90%, 85%	86%, 91%, 86%	87%, 92%, 87%	88%, 93%, 88%	89%, 94%, 89%	84%, 89%, 84%	CMAM reports	Relevant sectors continue to implement planned nutrition related programme
Proportion of children who have defaulted in the course of program (1. NRUs 2. OTPs 3. SFPs)	< 5%, <5%, <10%	< 5%, <5%, <10%	< 5%, <5%, <10%	< 5%, <5%, <10%	< 5%, <5%, <10%	3%, 8%, 13%	CMAM reports	Relevant sectors continue to implement planned nutrition related programme
Proportion of children 6–59 months of age admitted for treatment in CMAM	37%	39%	41%	43%	45%	35%	CMAM reports	Relevant sectors continue to implement planned nutrition related programme
Proportion of adolescent and adults in HIV and TB care and treatment who receive nutrition assessment	50%	60%	75%	85%	85%	<50%	NCST reports	Relevant sectors continue to implement planned nutrition related programme
Proportion of adolescents and adults in HIV and TB care and treatment whose nutritional status is assessed & classified as moderate and severe undernutrition	<10%	<8%	<5%	<5%	<5%	12%	NCST reports	Relevant sectors continue to implement planned nutrition related programme
Output 2: Reduced number of deaths of children under five years due to wasting								
Proportion of children who have died in the course of program (1. NRUs 2. OTPs 3. SFPs)	<5%, <1%, <1%	<5%, <1%, <1%	<5%, <1%, <1%	<5%, <1%, <1%	<5%, <1%, <1%	10%, 1%, 0%	CMAM reports	Relevant sectors continue to implement planned nutrition related programme

Policy Priority Area 4. Prevention and Management of Overweight and Nutrition- related NCDs								
Outcome: Reduced prevalence of overweight/ obese among children under 5 and women of reproductive age group								
Objective: Prevent and manage overweight and nutrition-related NCDs								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Output 1: Reduced number of children under 5 who are overweight								
Percentage of children under five years of age who are overweight	4.7%	4.4%	4.1%	3.8%	3.5%	5%	DHS/MICS	Relevant sectors continue to implement planned nutrition related programme
Output 2: Reduced number of women who are overweight or obese								
Percentage women of reproductive age 15–49 years who are obese or overweight	20%	19%	18%	17%	16%	21%	DHS	Relevant sectors continue to implement planned nutrition related programme

Policy Priority Area 5: Nutrition Education, Social Mobilisation and Positive Behaviour Change								
Outcome: Improved positive behaviour change among targeted population to achieve optimum nutrition								
Objective: Enhance social mobilisation and positive behaviour change communication for nutrition								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Output 1: Improved breastfeeding practices								
Proportion of children 0–5 months of age who are exclusively breastfed	63%	65%	67%	69%	71%	61%	DHS/ Surveillance	Nutrition education programme will be scaled up by implementing partners
Output 2: Improved care seeking behaviour among the community								
Percentage of children under five years of age from households with ITN, who slept under an ITN last night	71%	73%	75%	77%	79%	69%	DHS	Availability and accessibility of insecticide treated nets
Percentage of children under age 5 with diarrhoea in the last 2 weeks who received ORT and continued feeding during the episode of diarrhoea	54%	59%	64%	69%	74%	49%	DHS / MICS	Availability of ORS and knowledge of mothers on homemade fluids for management of diarrhoea
Percentage of children under 5 with diarrhoea in the last 2 weeks who received zinc	33%	38%	43%	48%	53%	28%	DHS	Availability of Zinc and knowledge of mothers on management of diarrhoea
Percentage of pregnant women received antenatal care (ANC) in first trimester	17%	22%	27%	32%	37%	12%	DHS/ MICS	Awareness about ANC among pregnant women

Output 3: Improved positive behaviour change through agriculture nutrition-sensitive interventions for optimum nutrition								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Percentage of care groups established	69%	71%	73%	75%	77%	67%	Care group register	Nutrition education programme will be scaled up by implementing partners
Percentage of care groups trained	82%	84%	86%	88%	90%	80%	Care group register	Nutrition education programme will be scaled up by implementing partners
Percentage of care groups functioning	82%	84%	86%	88%	90%	80%	Care group register	Nutrition education programme will be scaled up by implementing partners
Percentage of backyard gardens established	27%	32%	37%	42%	47%	22%	Care group register	Nutrition education programme will be scaled up by implementing partners
Percentage of households practising integrated household farming (at least 3)	41%	43%	45%	47%	49%	39%	DAES monthly report	Nutrition education programme will be scaled up by implementing partners
Percentage of women reported 4 or more ANC visits during pregnancy for their most recent birth	53%	55%	57%	59%	61%	51%	DHS	Nutrition education programme will be scaled up by implementing partners
Percentage of households with children under age two benefiting from monthly care group services in intervention districts	76%	78%	80%	82%	84%	74%	Care group register	Relevant sectors continue to implement planned nutrition related programme

Percentage of cluster leaders conducting home visits to counsel the caregivers	67%	69%	71%	73%	75%	65%	Care group register	Relevant sectors continue to implement planned nutrition related programme
Output 4: Improved beneficiaries participation in growth monitoring sessions								
Percentage of children 2–5 years participating in growth monitoring and promotion sessions	77%	79%	81%	83%	85%	75%	Care group register	Nutrition education programme will be scaled up by implementing partners
Output 5: Improved access to safe drinking water and improved sanitation facilities								
Percentage of population using improved sources of drinking water	89%	91%	93%	95%	97%	87%	DHS/ MICS	Government commitment to provide safe drinking water
Percentage of population using improved sanitation facilities	56%	57%	58%	59%	60%	55%	DHS/ MICS	Sanitation will be scaled by IPs

Policy Priority Area 6: Nutrition during Emergency Situations								
Outcome: Improved food and nutrition response during emergency situations								
Objective: Enhance delivery of nutrition interventions during emergencies								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Output 1: Reduced number of persons who are risk of food insecurity and livelihoods								
Percentage of population at risk of food and livelihoods insecurity	16%	15%	14%	13%	12%	17%	MVAC/ Surveillance	Relevant sectors continue to implement planned nutrition related programme
Output 2: Improved community screening and response for acute malnutrition								
Percentage of children 6–59 months screened for acute malnutrition	49%	51%	53%	55%	57%	47%	Nutrition Emergency Reports	Relevant sectors continue to implement planned nutrition related programme
Percentage of children 6–59 months identified as MAM	>2%	>2%	>2%	>2%	>2%	4.4%	Nutrition Emergency Reports	Relevant sectors continue to implement planned nutrition related programme
Percentage of children 6–59 months identified as SAM	>1%	>1%	>1%	>1%	>1%	1.6%	Nutrition Emergency Reports	Relevant sectors continue to implement planned nutrition related programme
Percentage of households with acute malnourished children covered under MVAC response	TBD	TBD	TBD	TBD	TBD	TBD	Nutrition Emergency Reports	Relevant sectors continue to implement planned nutrition related programme

Policy Priority Area 7: Creating an Enabling Environment for Nutrition								
Outcome: Improved multi-sectoral programming and coordination of nutrition interventions								
Objective: Create an enabling environment for effective implementation of nutrition interventions								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Output 1: Increased monitoring visits for quality assurance								
No. of monitoring visits conducted for Implementation of International Code of Marketing of Breast-milk Substitutes at district level	2	2	2	2	2	0	DNCC reports	Relevant sectors continue to implement planned nutrition related programme
No. of monitoring visits conducted for fortification	4	4	4	4	4	4	Fortification reports	Relevant sectors continue to implement planned nutrition related programme
Output 2: Improved performance of HSAs for CMAM								
Percentage of HSAs trained in CMAM	57%	59%	61%	63%	65%	55%	HMIS	Relevant sectors continue to implement planned nutrition related programme
Output 3: Increased budgetary allocation for nutrition by government								
Percentage of budgetary allocation for nutrition programs	0.04%	0.04%	0.04%	0.05%	0.05%	0.03%	DNCC reports	Relevant sectors continue to implement planned nutrition related programme

Output 4: Increased access to baby friendly hospitals								
Percentage of district/ community hospitals certified as baby-friendly	7%	9%	11%	13%	15%	5%	HMIS	More health facilities adopt Baby Friendly Health (BFHI) initiatives
Output 5: Improved coordination at district and community level								
Is the District Nutrition Coordination Committee (DNCC) functional in the district?	28	28	28	28	28	26	DNCC reports	District stakeholders' commitment and willingness
Number of Area Nutrition Coordination Committees (ANCC) functioning in the district	120	135	150	175	190	105	DNCC reports	District stakeholders' commitment and willingness
Percentage of Village Nutrition Coordination Committees (VNCC) functioning in the district	52%	54%	56%	58%	60%	50%	DNCC reports	District stakeholders' commitment and willingness

Policy Priority Area 8: Nutrition Monitoring, Evaluation, Research and Surveillance								
Outcome: Strengthened real time information system for evidence based decision making at all levels								
Objective: Enhance evidence based programming through nutrition research and surveillance								
Indicator	**Target 2018**	**Target 2019**	**Target 2020**	**Target 2021**	**Target 2022**	**Baseline**	**Source of Verification**	**Assumptions/ Risks**
Output 1: Improved evidence based action								
Number of review meetings conducted	4	4	4	4	4	2	DNHA Reports	Integrated information system will be implemented by DNHA
Number of districts using harmonized reporting system	10	15	20	25	28	5	DNHA Reports	Integrated information system will be implemented by DNHA
Number of research dissemination conferences conducted	1	0	1	0	1	1	DNHA Reports	Research TWG and Task force active
Output 2: Improved coordination for M&E at district level								
Is the District M & E Coordination Committee (DMECC) functional in the district?	20	22	24	26	28	18	DNCC reports	District stakeholders commitment and willingness

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