Republic of Zambia

Programme Impact Pathways for Nutrition Interventions For use by programme officers

Produced by:
Public Health and Community Nutrition Unit of the National Food and Nutrition Commission

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About the NFNC

The National Food and Nutrition Commission (NFNC) is a statutory body that was established in 1967 by an Act of Parliament, Chapter 308, No. 41 under the Ministry of Health as an advisory body to the Government on matters concerning food and nutrition. Its broad objective is to promote and oversee nutrition activities in the country, primarily focusing on vulnerable groups such as children and women. In pursuance of this mandate, the NFNC has, since inception undertaken several activities aimed at nutritional improvement with varying degrees of success. Many of these have been done through collaborative effort with both local and international stakeholders.

Vision: To be Zambia's centre of excellence in leading food and nutrition action for optimal nutrition

Core Values: Creativity, Empowerment, Teamwork and Trust

Mission Statement: To provide efficient and effective leadership for coordinated food and nutrition action in Zambia

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The National Food and Nutrition Commission
Public Health and Community Nutrition Unit
Lumumba Rd
Plot 1150
Box 32669,
Lusaka
https://www.nfnc.org.zm/

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Preface

Building on the gains made during the MCDP I implementation period, the goal of MCDP II is to facilitate distinctive reduction in stunting among children less than two years of age through implementing multisectoral interventions that have shown evidence of preventing stunting during the critical First 1000 days of human life**.** The nutrition impact pathways, therefore, guides the ways in which various sector activities could improve nutrition. Programme officers have had challenges in understanding the link between nutrition outcome and other sectors' input/activities. Previously, the thinking was that agriculture ended with food production, WASH in improved sanitation and water, and social protection in helping the vulnerable; with little effort to see these as nutrition determinants. For example, agriculture production (crop, livestock and fish) as key to dietary diversity, food safety and adequacy of the diet for improved nutrition outcomes, or WASH for prevention of diseases to support adequate child growth and development. The MCDP II Impact Pathways for Nutrition Interventions, therefore, acts as a guide for programme officers involved in nutrition actions to help them understand the links between various sector activities and to support the design of nutrition-sensitive and specific interventions that have a nutrition lens.

"I imagine what it would be like working with a community which understands that [1] agriculture through crop diversity, livestock and fisheries can change the quality of unwholesome diets to the healthy diets; [2] the importance of WASH in preventing disease so that their children's growth is not stalled, at any one time, due to illness and recovery period; and [3] prompt health-seeking behaviour can save life and shorten period of illness to allow timely catch-up growth. I hope that accumulating such knowledge on the link of various sectors' interventions on nutrition will change lifestyles and result in a population with well-nourished gigantic individuals as it was at creation. Such achievements require carefully designed interventions, and Nutrition Impact Pathways serves this purpose."

The development of the MCDP II Impact Pathways for Nutrition Interventions demonstrates Government's continued commitment to scale up high impact nutrition-specific and nutrition-sensitive interventions to prevent and reduce undernutrition in the country while emphasizing their link to nutrition. This document has been informed by lessons learnt from MCDP I, the global priorities and policy frameworks for action to reduce undernutrition, as well as the cumulative impetus among stakeholders to improve nutrition in Zambia.

The MCDP II Impact Pathways are categorized in tandem with the priority interventions indicated in the Intervention Pyramid for Scaling up of Minimum Package of Interventions for the First 1000 Most Critical Days and spin on the following critical areas of nutrition: Response to critical situations, Agriculture, livestock and fisheries, Health and Nutrition, Economic dimension, WASH, Nutrition governance, Social and behaviour change and gender equality.

We hope that the Programme Impact Pathways for Nutrition Interventions will help key line ministries, partners and stakeholders involved in nutrition actions understand how well nutrition-specific and nutrition-sensitive interventions are delivered, and that they will help create greater impact in reducing undernutrition among vulnerable populations such as young children, pregnant and breastfeeding mothers.

Musonda Mofu
Acting Executive Director
National Food and Nutrition Commission

Abbreviation

CBV	Community Based Volunteer
CLT	Community Led Total
CMAIYCN	Community Maternal Adolescent Infant and Young Child Nutrition
DHO	District Health Office
DMMU	Disaster Management and Mitigation Unit
DNCC	District Nutrition Coordinating Committee
ECD	Early Childhood Development
EED	Environmental Enteric Disfunction
EMIS	Education Management Information System
GMP	Growth Monitoring and Promotion
HMIS	Health Management Information System
IEC	Information Education and communication
IMAMA	Integrated Management of Acute Malnutrition
ITP	Inpatient Therapeutic Care
IYCF	Infant and Young Child Feeding
MAIYCN	Maternal Adolescent Infant and Young Child
MAM	Moderate Acute Malnutrition
MCDP	Most Critical Days Programme
MCDSS	Ministry of Community Development and Social Services
MFL	Ministry of Fisheries and Livestock
MLG	Ministry of Local Government
MOA	Ministry of Agriculture
MOH	Ministry of Health
NFNC	National Food and Nutrition Commission
NHC	Neighbourhood Health Committee
NSG	Nutrition Support Group

OTP	Outpatient Therapeutic Programme
PHO	Provincial Health Office
PIP	Programme Impact Pathways
PNCC	Provincial Nutrition Coordinating Committee
RUTF	Ready to Use Therapeutic Feeds
SAM	Severe Acute Malnutrition
SBCC	Social Behaviour Change Communication
TWG	Technical Working Group
WASH	Water Sanitation and Hygiene
WNCC	Ward Nutrition Coordinating Committee
ZamNIS	Zambia Nutrition Information System
ZVAC	Zambia Vulnerability Assessment Committee

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1. Introduction

Zambia has a burden of undernutrition. The Government of the Republic of Zambia having realised this burden, has prioritised nutrition in the past two 5th, 6th and the current 7th National Development Plan. The Zambia Demographic and Health Survey for 2018 (Figure 1) indicated that the key finding pertaining to the nutrition of under-five children show that 35% were stunted, 4% were wasted, 12% were underweight and 5% were overweight (ZamStat; MoH; UTH Virology Laboratory; ICF., 2018). According to WHO, the stunting (35%) and underweight (12%) prevalence are considered high while wasting (4%) and overweight (5%) are low (WHO Expert Committee, 1995). The statistics highlighted above show that the undernutrition situation in Zambia is alarming ZamStat; MoH; UTH Virology Laboratory; ICF., 2018; WHO Expert Committee, 1995; de Onis, et al., 2019). Even with this gloomy revelation it should be noted that there has been a steady, but slow reduction in all the under-nutrition indicators in the five year period (Figure 1).

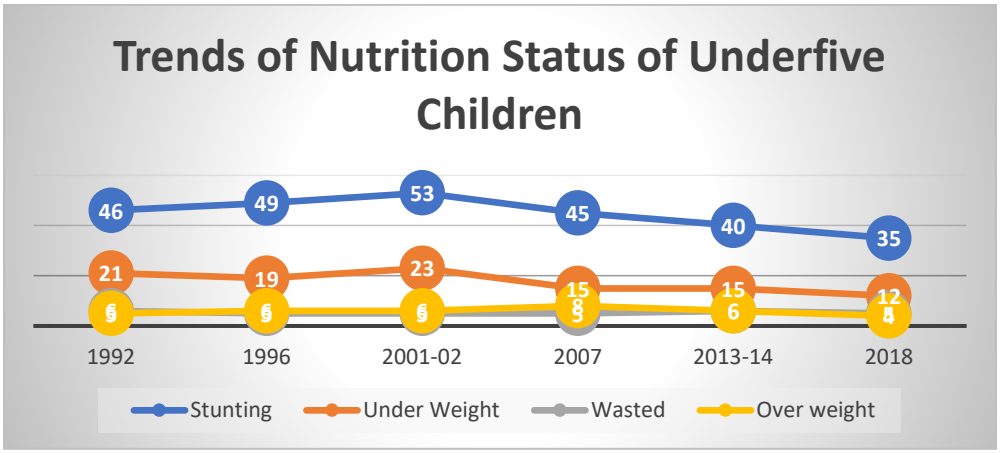


Figure 1: Nutrition Status Trends as presented by 2018 ZDHS

Stunting is a sign of chronic undernutrition that is usually caused by an inadequate intake of food or failure of the body to use nutrients from food consumed over a long period and/or recurring or prolonged infections such as diarrhoeal diseases (Hambidge & Krebs, 2018). The period of prolonged inadequate food intake and disease limits the supply of the needed nutrients leading to slowed linear growth of the child compared to their age so that the child is shorter than they are expected to be. In addition, chronic undernutrition affects brain development resulting in poor cognitive development and poor performance in school (Maternal and Child Nutrition Study Group, 2015). When these stunted children grow to be adults, they may attract low wage jobs, therefore, have less economic productivity (Victora, et al., 2008). Stunting therefore has serious implications on economic development of individuals, families and nations. Stunted women tend to have low birth weight offspring (Maternal and Child Nutrition Study Group, 2015). Similarly, underweight (Table 1) occurs, because of inadequate food intake and disease, but in this case, the child moves from being healthy to underweight in a short space of time (WHO Expert

Committee, 1995). Children who suffer from acute under-nutrition in the first 2 years of life and experience rapid weight gain later in childhood or adult life are at high risk of nutrition-related chronic diseases. (Victora, et al., 2008).

Table 1: different forms of malnutrition as defined by WHO that occur among children

Sr #	Form of malnutrition	Definition
1	Stunting (Low height-for-age):	Stunted growth reflects a process of failure to reach linear growth potential as a result of suboptimal health and/or nutritional conditions and is associated with poor socioeconomic conditions and increased risk of frequent and early exposure to adverse conditions such as illness and/or inappropriate feeding practices. prevalence of stunting starts to rise at the age of about three months and slows down at around three years of age.
2	Underweight Low weight-for-age:	Weight-for-age reflects body mass relative to chronological age. It is influenced by both the height of the child (height-for-age) and his or her weight (weight-for-height), and its composite nature makes interpretation complex.
3	Wasting (Low weight-for-height)	Wasting or thinness compared to one's height indicates in most cases a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease and may also be the result of a chronic unfavourable conditions. Typically, the prevalence of low weight-for-height shows a peak in the second year of life. ??
	High weight-for-height: (Overweight)	Overweight describs high weight-for-height. Even though there is a strong correlation between high weight-for-height and obesity as measured by adiposity, greater lean body mass can also contribute to high weight-for-height.
Source: (de Onis *et al.*, 2019)		

Globally, undernutrition, has been identified as a hindrance to economic progress of nations. This is what was realised during the 2010 UN General Assembly and led to a side line meeting coming up with a movement to scale up nutrition, to help the affected LMICs. Zambia was among the early risers that quickly joined this movement to improve the nutrition of its people. In an effort to address nutrition challenges within the SUN movement principles, that had identified child undernutrition, and especially stunting as the biggest challenge, the Government of the Republic of Zambia adopted the First 1000 Most Critical Days Program (MCDP) with the main objective of reducing undernutrition due to chronic malnutrition {stunting}.

The first 1000 days of a child's life is a critical period when the foundation of growth and development of a child is laid. This is when the foundations of health, growth and neurodevelopment across the lifespan are established (Horton, 2008). Hence, it is the appropriate time to intervene towards a good foundation. This period has been termed a window of opportunity for correct interventions towards healthy growth and development.

The MCDP is designed in a manner that enhances the growth and development that takes place in the first 1000 days of human life. The first 1000 MCDP addresses undernutrition particularly stunting through addressing the nutrition needs of pregnant and lactating women and children from conception up to 24 months of a child. The interventions should be cross cutting involving

both nutrition specific and nutrition sensitive interventions. Nutrition specific interventions address actions on the immediate determinants of foetal and child nutrition and development such as appropriate feeding practices, dietary diversity, vitamin and mineral supplementation and food fortification while the nutrition sensitive interventions address the underlying determinants of nutrition such as wash, agriculture, social safety nets and women's empowerment and can make a substantial contribute to reduction of stunting (Khalid, Gill and Fox, 2019). The underlying determinants of malnutrition include household food insecurity; inadequate care and feeding practice; and unhealthy household environment and inadequate health services (UNICEF, 2013).

Six high impact priority nutrition interventions are commonly implemented in the country namely: Promotion of Gender Equality and women's empowerment, Social and behaviour change and communication campaign to reduce stunting, promotion of improved infant and young child feeding and care practices, promotion of maternal nutrition, dietary diversity through nutrition-sensitive agriculture and promotion of safe water, hygiene and sanitation (National Food Nutrition Commission, 2017).

Zambia implemented phase I of the MCDP over the period 2013 to 2017. The second phase was set to start from 2018 to 2021. The goal of MCDP II is to facilitate a distinctive reduction in stunting among children less than two years of age to 25% in the targeted districts by 2022. This will be achieved through the implementation of high-impact interventions that have shown evidence of reducing stunting during the critical first 1000 days of human life as highlighted above (National Food Nutrition Commission, 2017).

In order to ensure that the needed impact (reduction in stunting) is achieved, the Programme Impact Pathway framework has been adapted to guide implementation of interventions. The Program Impact Pathway (PIP) is an approach used to determine the required resources to achieve the envisioned impact of reducing stunting ultimately contributing to socio-economic development. Just like MCDP I, MCDP II PIP framework is composed of inputs (resources), process (activities and methods of work), outputs (what is produced), outcomes (level of achievement in terms of what change is brought as a result of the intervention) and impact (long term and irreversible change) . The MCDP II PIPs have been categorized following the priority interventions indicated in the Intervention Pyramid for Scaling Up of Minimum package of Interventions for the First 1000 Most Critical Days (Figure 2). The impact pathways are grouped as follows:

- Response to critical situations
- Agriculture, livestock and fisheries??
- Health and Nutrition
- Economic dimension
- WASH
- Nutrition governance
- Social and behaviour change and gender equality.

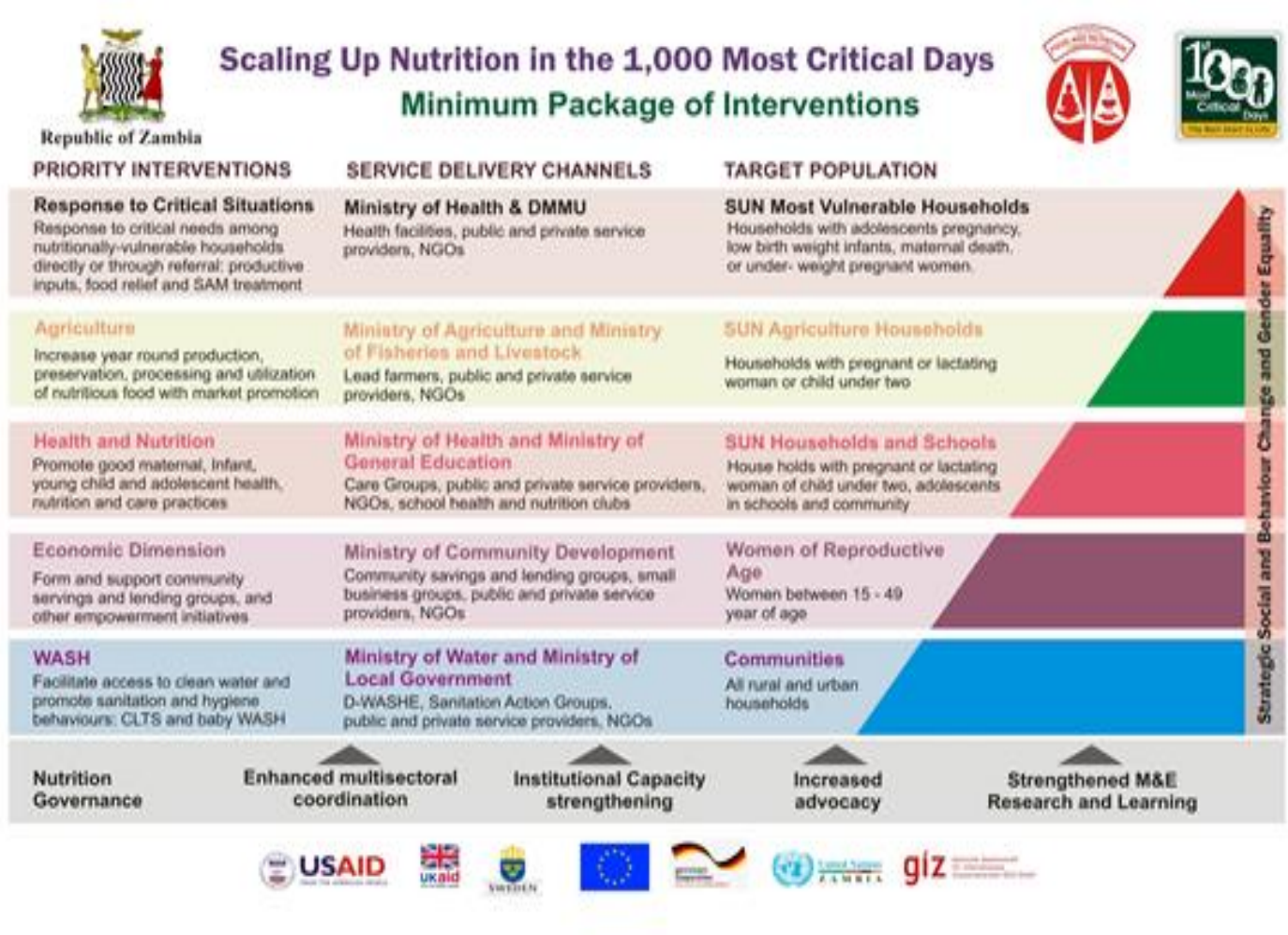


Figure 2: Intervention Pyramid for Scaling Up of Minimum Package on Intervention for 1000 Most Critical Days (source: (National Food Nutrition Commission, 2017).

2. The Impact Pathways

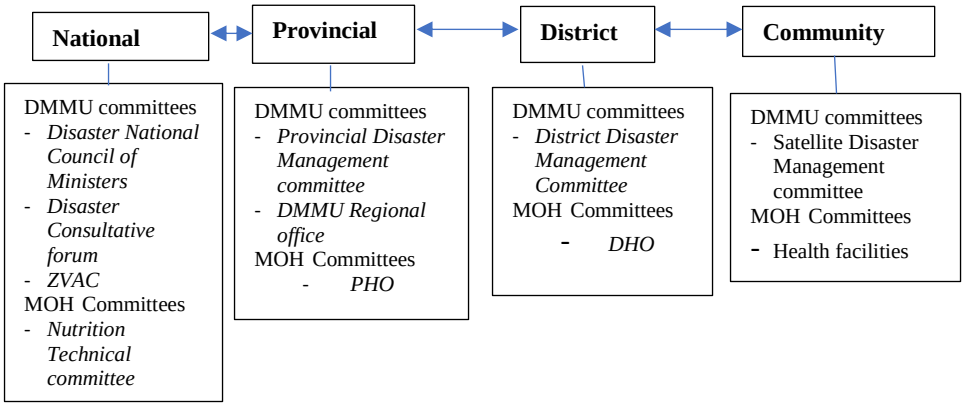
2.1. Response to Critical Situations

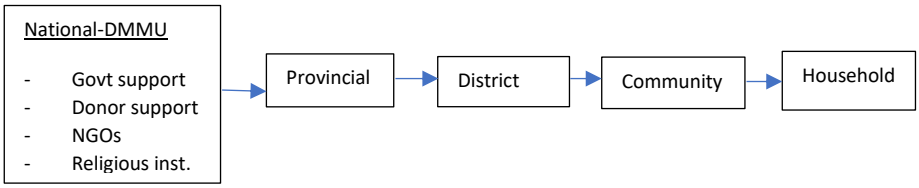
It is common that during an emergency, access to adequate and safe food and water is limited. People in crises situation (drought, flood and in some instances pandemic,) may experience "one or more of the following adverse consequences: direct exposure to violence, witnessing violence, loss of family members, displacement, food scarcity, increased exposure to communicable diseases, reduced access to health services, plus a range of other socioeconomic setbacks" (Hill, 2004). As a result, the affected population particularly children, pregnant lactating women, pregnant adolescents, underweight women and low birth weight babies become prone to food insecurity increasing the risk of undernutrition. In addition, infant feeding practices particularly breastfeeding is threatened as a result of maternal malnutrition; increased availability of breastmilk substitutes that may be distributed without adequate instruction and sometimes in incorrect quantities; and inadequate services to maintain good practices especially the hygiene practices (FAO, 2005). Due to unsafe water, inadequate materials to maintain hygiene and overcrowding, the population is also at risk of diseases such as diarrhoea, respiratory infections, skin and eye disease and intestinal infestations. Recurrent diseases are known to affect the growth and development of children and economic production in adults (Stephensen, 1999; Abegunde and Stanciole, 2006; Dewey and Mayers, 2011; Laxminarayan and Malani, 2011). As a result, action to promote nutrition interventions is key in reducing morbidity and mortality and generally maintain decency in the population (PHAST, 2008).

In Zambia, the most common critical conditions are the extreme weather conditions such as the floods and droughts. The northern half of the country is usually affected by flooding while the southern and Western provinces tend to experience prolonged dry spells. Both conditions affect the agricultural production and productivity in the areas (DMMU, 2020). Of late, just like other parts of the world, the country has experienced a COVID 19 pandemic that may impact negatively on nutrition and provision of services. such pandemic threaten food security and nutrition particularly among people who are already undernourished (Reliefweb, 2020) by disrupting mostly the financial (affordability) and physical access to food (European Commission, 2021).

Furthermore, pests and diseases tend to damage crops in community where they may manifest affecting agricultural production in terms of food availability and access. poor availability of food may also lead to increase in food prices resulting in a devastating impact on food security and livelihoods (FAO, 2017). Outbreak of animal diseases tend to reduce the numbers of and sometimes almost wiping out animals in affected areas. African Migratory Locust has also affected agriculture in Zambia at times Demolishing crops and livestock pasture in a matter of hours (FAO, 2020a, 2020b).

Table 2: Impact Pathway for Response to Critical Situations

Priority Interv.	**Response to critical needs among the nutritionally-vulnerable households directly or through referral; productive inputs, food relief and SAM treatment**
Ministry	Ministry of Health and DMMU
Inputs	1. Structures in place to identify and mitigate emergencies in DMMU and MoH, and other key ministries or institutions at different levels  2. Financing of emergency mitigation by Ministry of Finance through MoH DMMU and Cooperating partners 3. Availability of protocols and guides (food distribution, IMAM, Emergency declaration, etc) 4. Planning for an emergency – (MoH and DMMU) 5. Availability of relief supplies (therapeutic supplies, general food rations, hygiene supplies) for mitigation of undernutrition by MoH and DMMU 6. Monitoring systems in place i.e. HMIS, ZAMNIS, crop forecast survey, ZVAC, smart survey

Process	1. Procurement and distribution of relief supplies (therapeutic supplies (F75, F100, RUTF, Resomal) food for the affected population and hygiene supplies) for mitigation of undernutrition by MoH and DMMU, with support of partners . Management and distribution of therapeutic supplies and relief supplies – ***Procurement (food relief)***  *Procurement of therapeutic supplies*: Medical stores central /regional hubs → PHO → DHO →Health facility. →community (Beneficiaries). 2. Review of protocols and guidelines 3. Training at different levels on the protocols and guidelines related to maintenance or correction of nutrition status and provision of relief food to the affected population and provision of habitable hygienic living conditions under DMMU. 4. This is done under Ministry of Health, *MoH HQ & DMMU (ToTs) → Provincial levels →District →community → Household* 5. Conduct community sensitisation and mobilisation. 6. Conduct active case finding at community level and referral of SAM /MAM children.

Outputs	**For MoH:** 1. IMAM protocols and guidelines disseminated. 2. Staff and CBVs trained on IMAM protocols in emergency mode or non emergency approaches. . 3. Availability therapeutic supplies (F75, F100, RUTF, Resmal CMV), 4. Rapid Nutrition assessments conducted 5. Medical and Nutrition supplies provided to health facility and community repeated captured in 1 above 6. Number of identified SAM and MAM children (GAM rate) established and reported 7. Conduct sensitization and report on number of sensitisation activities conducted and the impact 8. Reports on number of children aged 6-59 months screened and referred for treatment	**For DMMU:** 1. Resource mobilisation and coordination of emergency situations 2. Nutrition Standards for the distribution of relief food disseminated 3. Relief food to the affected households distributed 4. Capacity built in Resilience. 5.
Outcomes	1. Greater understanding of MAM/ SAM management by staff 2. Reduced stock outs of supplies for management of SAM/MAM 3. Increased coverage of MAM/ SAM case findings 4. Increased use of MAM/SAM facilities by households or families (increased attendance) 5. Increased survival rate for SAM children, (cure rate,) 6. Decreased defaulter rate and mortality rate 7. Improved health among under-five children,	1. Amount of relief food distributed
Impact	1. Improved health of children under five with focus on the under two 2. Reduced under nutrition with a focus on wasting in children under two years. 3. Improved KAP of health and nutrition among households	

Assumptions	1. Availability of supplies and equipment – no stockouts of RUTF 2. Established IMAM sites with space, trained staff, equipment to provide OTP or ITP services 3. Availability of adequate motivated and trained staff 4. Availability of community volunteers to provide the services 5. No intra-household RUTF Sharing 6. Availability of protocols and guidelines to guide the process 7. Reduced abuse/misuse of RUTF by health workers and volunteers 8. Availability of robust emergency plans
Gender barriers	1. Gender roles - Longer stay in the hospital for severe cases reducing care for children left at home, making the stay of mothers in the hospital (malnutrition ward) difficult due to stalled responsibilities at home such as taking care of other children and husband, and looking for income (leads to defaulting). 2. Infrastructure - Longer distances to the health facilities reducing access and increasing the default rate for OTP cases and increasing run away from malnutrition wards before treatment is completed 3. Decision making - Low-level decision-making powers for women in the household compared to men and men's control of income and expenditures and all other household assets- hampering access to facilities
Gender responses	1. Gender awareness through communication and advocacy at all levels 2. On-going sensitization campaigns at all levels (provincial-district-sub-district-community) 3. Motivations for male involvement (preferential service for couples)

2.2. Agriculture, Livestock and Fisheries???

The link between nutrition and agriculture is depicted by the widely known UNICEF Conceptual Framework for malnutrition which indicates that the immediate causes of undernutrition are inadequate dietary intake and disease (UNICEF, 1998). The agricultural sector activities are responsible for food production and can determine the dietary diversity at household level (Herforth and Harris, 2014). Not having adequate food (considering both quality and amount) for a longer period results in nutritional deficiencies thus compromises growth in children. In addition, nutritional deficiencies are linked to compromised immune system leaving the body more susceptible to disease. Longer duration and repeated diseases similarly, slows child growth and development. Nutrition sensitive programmes have shown improvements in micronutrient status in both women and children and some impact on anthropometric status in children (Sharma *et al.*, 2020).

As a result of such evidence, addressing agriculture interventions to support nutrition has evolved from promoting crop diversity, animal and aquaculture production to improve food consumption. Over the years, other elements such as biofortification of food crops such as the orange fleshed sweet potatoes and maize and iron-rich beans (mbereshi) to increase micronutrient levels in food being consumed by population to meet the needs have been included. Food production (particularly diverse production) is a direct way in which food is made available to households with the diversity required thus making them food secure (Food, no date)(World Bank, 2007). It has also included a focus on gender and intrahousehold resource control and food safety (Webb, 2013). Women empowerment allows for decision-making power related to income, time, labour, assets and resource allocation (Food, no date; Sharma *et al.*, 2020). Food safety is important in the agriculture cycles to reduce the incidence of food-borne diseases such as diarrhoea that have an impact on health by limiting growth and development in children and productivity in adults (World Bank, 2007). Agriculture is also a source of income that is used to buy food and non-food items to improve the welfare of the household particularly if earned or controlled by women. Income yielded from the sale of agricultural products can be used by the household to purchase foods they are not able to grow on their own and pay other fees (World Bank, 2007; Dury, Alpha and Bichard, 2015; Sharma *et al.*, 2020). food prices also affect the demand and supply for food items determining what is available and accessible on the market for the households (Ruel, Quisumbing and Balagamwala, 2018).

Following the discussions highlighted above, Zambia will carry out the nutrition-sensitive intervention in agriculture in the following areas: 1) diversified food production to increase dietary diversity and household own consumption, 2) food production for increased household income, and 3) women's empowerment measured by control over resources and decision-making related to agriculture and household food expenditures. Both male and female family members will be reached by agriculture-sensitive interventions to ensure that men support better nutrition for the entire family (National Food and Nutrition Commission, 2017).

Table 3: Impact Pathway for Agriculture

Priority Interventions	**Increase year-round production, preservation ,processing and utilization of nutritious foods with market promotion [2]**
Ministry	Ministry of Agriculture (MoA) and Ministry of Fisheries and Livestock (MFL)
Inputs	1. MoA and MFL receive finances 2. Availability of coordinating structures, technical (planning guidelines, material development,) and material support 3. M&E and data collecting system 4. Availability of protocols, guidelines and training materials for production, processing and marketing of diverse, nutritious foods in crops, small livestock, fish, processing, preservation and storage 5. Availability of agricultural production inputs for the community (eg fish fingerlings, seed, seedlings, fruit tree, equipment, fertiliser) 6. Extension services to support increased knowledge in agricultural production
Process	1. Training at different levels ensuring gender sensitivity. 2. Supply of agriculture inputs such as fish fingerlings, seed, seedlings, fruit tree, equipment (irrigation, processing and land preparation). 3. linking beneficiaries to private sector input suppliers and produce buyers 4. Women groups establish agriculture production. 5. Women groups access markets for their products. 6. Consumption of neglected/ underutilised foods promoted 7. Demonstration sites/ field days established for crops, livestock, fish and vegetable production and storage 8. Nurseries established (fruits trees, seed multiplication 9. Training of camp extension officers focusing on nutrition sensitive agricultural production 10. Identification and training of lead farmers 11. Training beneficiaries in food production, processing, storage and utilisation Climate Smart Agriculture 12. Partnership with Ministry of Community Development and Social Services 7. Provide the protocols and guidelines and training materials to be used for production, processing and marketing of diverse, nutritious foods in crops, small livestock, fish, processing, preservation and storage 13. Establishment of home/ keyhole gardens around dwelling places by women groups 14. Establishment of fruit trees at household level 15. Development of fish ponds by community 16. Development of other community activities (peanut butter processing, preservation of foods)

Outputs	1. Women trained in nutrition sensitive agriculture practices 2. Agricultural inputs supplied 3. vegetable and fruit Nurseries established by women 4. Protocols were provided to supportive staff 5. Fish ponds established in communities 6. Farmers trained 7. Women clubs formed 8. Model gardens established 9. Small livestock reared 10. Market linkages developed for both input and output marketing
Outcomes	1. Increased production and consumption of dietary-diverse nutrient-dense foods. 2. Improved small livestock farming 3. Improved fish farming 4. Improved home gardening 5. Improved dietary diversification 6. Consumption of neglected/ underutilised high nutritional value foods including edible insects and caterpillars promoted. 7. Greater understanding of dietary diversity in the community 8. Increased knowledge in nutrition sensitive agriculture production
Impact	1. Improved health of children under five with focus on the under two 2. Reduction of stunting in under five children with focus on the under two
Assumptions	1. Favourable weather to support agricultural production 2. Availability of extension services for crops, fisheries and small livestock 3. Commitment of community groups to the programme. 4. Availability of protocols and guidelines 5. Availability and access to inputs for farmers 6. Capacity provided to increase food production 7. Assured ready markets for diversified seeds 8. Availability of funds 9. Mass sensitization on the importance of neglected foods to health improvement
Gender barriers	1. Limited access to land by women 2. Availability of female extension officers to assist the women groups (culture of men not expected to deal with other men's wives directly) 3. Limited time available due to competing activities 4. Male control overall assets in the household 5. Lack of labour to do hard farm work like cutting trees and fish farming. 6. Access to markets (distance, time, financial resources)
Gender responses	1. Sensitise the traditional leader on the importance of land access to women. 2. Involve husbands in gender training. 3. Gender awareness through communication and advocacy at all levels 4. Information provision particularly of women

2.3. Health and Nutrition

Infant and young child feeding practices are key in promoting growth and development in children. For instance, early initiation of breastfeeding promotes exclusive breastfeeding which is critical in reducing child morbidity and mortality by protecting children from diarrhoea and common childhood illnesses such as pneumonia (WHO, 2010)(WHO, 2019). Exclusive and continued breastfeeding could help prevent 13% of deaths among children under five years old (WHO, 2020a) while Complementary feeding can prevent 6%, Zinc 5%, and Vitamin A 2% of death (Gareth Jones *et al.*, 2003). The benefits are high when multiple interventions are implemented particularly if the coverage is very high. In addition to the prevention interventions, the sectors provide treatments for certain conditions to reduce child mortality. IMAM aims at preventing further deterioration to a child who is already suffering from moderate acute malnutrition. Deworming gets rid of intestinal infestations, while treatment of diarrhoea reduces the period spent in illness and child death. All the interventions aim at facilitating growth and development in children (Checkley *et al.*, 2008; Nel, 2010; Blouin *et al.*, 2018; Brander *et al.*, 2019; WHO, 2020b). Maternal nutritional status can impact pregnancy outcomes. Micro-nutrient and energy deficiencies during pregnancy may result in low birth weight or preterm delivery and the condition of poor nutrition in the new born baby may continue later after birth particularly with poor child care practices (Thame *et al.*, 1997; Bhombal and Benitz, 2017). Poor nourished children are likely to become poorly nourished adults who may also produce poorly nourished children, the cycle which become intergenerational if not addressed (UNSCN, no date; WHO, 2008).Preterm delivery is responsible for about 59% of the under-5 deaths (Gareth Jones *et al.*, 2003).

Table 4: Impact Pathway for Nutrition Specific Interventions

Priority Intervs.	**Promote good maternal, infant, young child and adolescent health, nutrition and care practices**
Ministry	Ministry of Health and Ministry of General Education

Inputs	1. Availability of finances and human resource 2. Forecasting, planning and ordering 3. Monitoring and Evaluation system available in the health and education systems (HMIS, ZAMNIS) 4. Availability of protocols, guidelines and training materials necessary to ensure target beneficiaries are reached 5. Availability of take-home reading /IEC materials for adolescents and parents 6. National procurement of supplies including Iron & folic acid supplementation, Vitamin A supplementation, deworming tablets/ SAM medication, zinc tablets for diarrhoea treatment, RUTF and Growth monitoring kits 7. School feeding and deworming commodities
Process	1. Strengthen the M&E system at community and facility level 2. At service delivery point i. Establish and empower various community support groups such as Nutrition Support Groups and Mother Support Groups; ii. Establish/revamp BFHI approach in health facilities; iii. Strengthen MAIYCN counselling; iv. Strengthen community outreach – ensure nutrition package for outreach ; v. Promote micronutrient supplementation for pregnant and lactating women, children under five years and in some instances adolescent girls. vi. Scale up case finding and management of IMAM cases 3. Conduct community mobilization/community sensitization and awareness creation /specific counselling 4. Establish adolescent clubs in schools and include a nutrition package 5. Establish adolescent corners in health facilities, include a nutrition package 6. Review the MAIYCN training package. 7. Train health workers on MAIYCN 8. Equipment supplied (anthropometric tools) 9. Promote convergence of activities at community and household levels to ensure all concerns are addressed

Outputs	1. Medical and nutritional supplies procured and supplied to district, health facilities and community-based volunteers 2. Service providers and community volunteers trained in various packages 3. Protocols and guidelines are developed, disseminated and shared as needed 4. Adolescents School clubs established, and nutrition package provided to guide delivery of nutrition interventions 5. Strengthened and empowered NSGs and other Community groups for delivery of nutrition messages 6. Functioning BFHI initiative in health facilities 7. Youth friendly corners in health facilities formed and equipped with a Nutrition package material 8. Improved early and timely identification of SAM/MAM
Outcomes	1. Increased coverage of nutrition interventions among the MAIYC targeted groups 2. Improved capacity in MAIYCN and child caring service delivery 3. Improved linkages between nutrition and early childhood development (ECD) to enhance positive practices that promote holistic Child Development 4. Improved promotion of maternal nutrition assessment and counselling 5. Increased coverage for Sam/MAM cases 6. Improved community knowledge of nutrition interventions such as maternal and adolescent nutrition 7. Increased number of mothers' breastfeeding according to recommended guidelines and practices 8. Increased attendance (coverage) of pregnant and lactating mothers at health facilities so that these can be provided with nutrition
Impact	1. Improved maternal and child health nutritional outcomes 2. Increased number of individuals practicing the promoted nutritional behaviour in communities and households 3. Contribution to reduced prevalence of stunting among the children less than 2 years.

Assumptions	1. MoH passes policy for every health facility to be baby-friendly. 2. Availability of resources and trained facilitators on CMAIYCN 3. MoH reinforcing policies on integration of ECD in child health and nutrition programmes. 4. Commitment of implementing partner (IP) to integrate diet diversity promotion in their programmes. 5. School authorities supportive of nutrition clubs to undertake the task. 6. Willingness of adolescent girls to visit youth-friendly corners in health facilities. 7. Availability of equipment such as anthropometric measurements 8. Capacity to forecast and plan and procure 9. Capacity to monitor at health facility and community level 10. Ability to collect quality anthropometric measurements 11. Availability of M & E data 17. Availability of protocols 18. Women take the folic acid and iron supplementation 19. Functioning supply chain from national to facility 20. Availability of convergence of activities at community and household levels
Gender barriers	1. A cultural norm where a women's voice is subdued in the presence of men 2. Misconceptions around breastfeeding 3. Low literacy levels 4. Competing demands on women's time 5. Distance to health facilities 6. Inadequate resources (financial) for transport and food for subsistence at facility 7. Large number of children under 5 requiring service exacerbated by time constraints 8. High demand against low staff capacity in health facilities 9. Lack of male involvement and support to attend health facilities 10. Cultural barriers
Gender responses	1. Formation of literacy clubs with support from MCDSS 2. Strengthen the nutrition education messages 3. Harmonise messaging across sectors 4. Clear targeting of men and women the implementing of interventions 5. Support and strengthen implementation of outreach services from health facilities and nutrition support groups in communities 6. Provide transport for sub-district staff and community agents (bicycles, motorbikes) 7. Gender awareness through communication and advocacy at all levels\ 8. On-going sensitisation campaigns at all levels (provincial-district-sub-district-community) 9. Incentives for male involvement (preferential service for couples)

2.4. Economic Dimension

In the economic dimension of interventions, the MCDP aims to improve food and nutrition security, diet quality and empower women through improved targeted agriculture and social safety nets. interventions in this category aims to improve year-round income and cash flow that can be used to acquire food not grown by the household to support a healthy diet and non-food items such as supporting education, accessing health care services to improve quality of life (Herforth Anna and Harris, 2014). Among other factors, women empowerment includes decision making related to income, assets and labour (Herforth Anna and Harris, 2014). In rural areas, women are responsible to supply food for families compared to men, therefore, when decisions concerning use of income are made by women, the income is more likely to be used to purchase basic needs such as food and health services (FAO, no date; Quisumbing *et al.*, 1995). for this reason, interventions to improve stunting should include empowering women economically through community-based savings groups that help members save money, access credit, and invest in income-generating activities, improve their ability to have access to and control over productive resources and to have meaningful participation in economic decision-making (PCI, 2021; UN Women, 2021). Behaviour change strategies need to be strengthened and the focus should be gender equity (The Lancet, 2015). In MCDP II, activities relating to improving food security, diet quality, women empowerment and behaviour change strategies have been included to help reduce stunting.

Table 5: Impact pathways for Economic Dimension

Priority Intervs.	**Form and support community services and lending groups, and other empowerment initiatives**
Ministry	Ministry of Community Development and Social Services
Inputs	1. MoA and MCDSS receive finances for safety nets and women empowerment 2. Protocols, guidelines and training packages in agriculture and social safety nets 3. Linkages between Agriculture and Community Development ministries 4. Supplies such as seed and other inputs. 5. Robust selection criteria for vulnerable target households 6. State of art nutrition curriculum for community development colleges 7. Package of nutrition messages to support safety nets programmes 8. M&E and data collecting system available

Process	MCDSS Activities: 1. Establishment of district gender development committee. 2. Gender training for men, women and traditional leaders. 3. Establish women groups4. Establish, train and support saving groups Agricultural activities: 1. Formation of women groups/cooperatives 2. Training of women in animal husbandry, crop production and food processing. 3. Link the women to markets for their produce 4. Encourage consumption of diverse homestead production. 5. Provide input (seed, small livestock, etc) 6. Adequate targeting of vulnerable households 7. Develop key nutrition messages for the safety nets
Outputs	1. Men and women trained in gender 2. Women trained in animal husbandry, crop production and food processing. 3. Women accessing markets for their produce 4. Amount of agricultural produce from vulnerable households 5. Understanding of the link between nutrition and safety nets in communities and households established 6. Number of vulnerable households consuming local food from homestead gardens or produce 7. Key nutrition messages developed for safety nets 8. Increased income, ability to borrow money, joint decision making by men and women, women's access and control of income
Outcomes	1. Improved community mobilisation and participation of women and men from vulnerable households. 2. increased women's access to empowerment programmes and services including agriculture inputs; agricultural extension services and markets; entrepreneurship skills and access to loans. 3. Improved dietary diversity in households 4. Increased agricultural production to vulnerable households 5. Increased understanding of the link between nutrition and safety nets in communities and households 6. Increased consumption of local food from homestead gardens or production among vulnerable households 7. Key nutrition messages developed for safety nets
Impact	1. Improved health and nutrition status of children under five adolescents and women (pregnant and lactating) 2. Reduction of stunting among children under five years of age.

Assumptions	1. Availability of ed 2. Availability of suitable agricultural inputs 3. Functioning monitoring and evaluation system 4. Availability of community agents 5. Ability to motivate community agents 6. Availability of protocols and guidelines 7. Transparency and flexibility among implementing partner to accommodate due diligence assessors 8. Availability of objective risk assessors
Gender barriers	1. Women's low status: A cultural norm where a women's voice is subdued in the presence of men 2. Limited decision making among women compared to men 3. Low literacy levels 4. Male control overall assets in the household
Gender responses	1. Sensitise the traditional leader on the importance of land access to women. 2. Involve husbands in gender training. 3. Gender awareness through communication and advocacy at all levels

2.5. Water, Sanitation and Hygiene (WASH)

Improving the nutrition of the children without addressing diseases may not yield adequate growth (United Nations – ACC/SCN, 1991; Pelletier and Frongillo, 2003; Mason *et al.*, 2006). Evidence has shown that there is a strong association between stunting and the environmental conditions children are subjected to. Exposure to poor water, sanitation and hygiene (WASH) environments increase the risk of suffering from infectious diseases such as diarrheal diseases, helminth infection and environmental enteric dysfunction (EED) that have a negative impact on growth (Gyorkos *et al.*, 2011; Guerrant *et al.*, 2013; Budge *et al.*, 2019). Further, recurring infections of diarrhoea and EED result in undernutrition (The Lancet, 2015; Dominguez, 2017). Water, sanitation, hygiene interventions could reduce child death by about 63% (Gareth Jones *et al.*, 2003) while effective and integrated case management of childhood infections (diarrhoea and dysentery, pneumonia, malaria, and neonatal sepsis) could save 33% of total child deaths each year (Gareth Jones *et al.*, 2003).

The activities under WASH are meant to reduce the occurrence of infectious diseases. The activities included are in the area of provision of clean water, and provision of latrines.

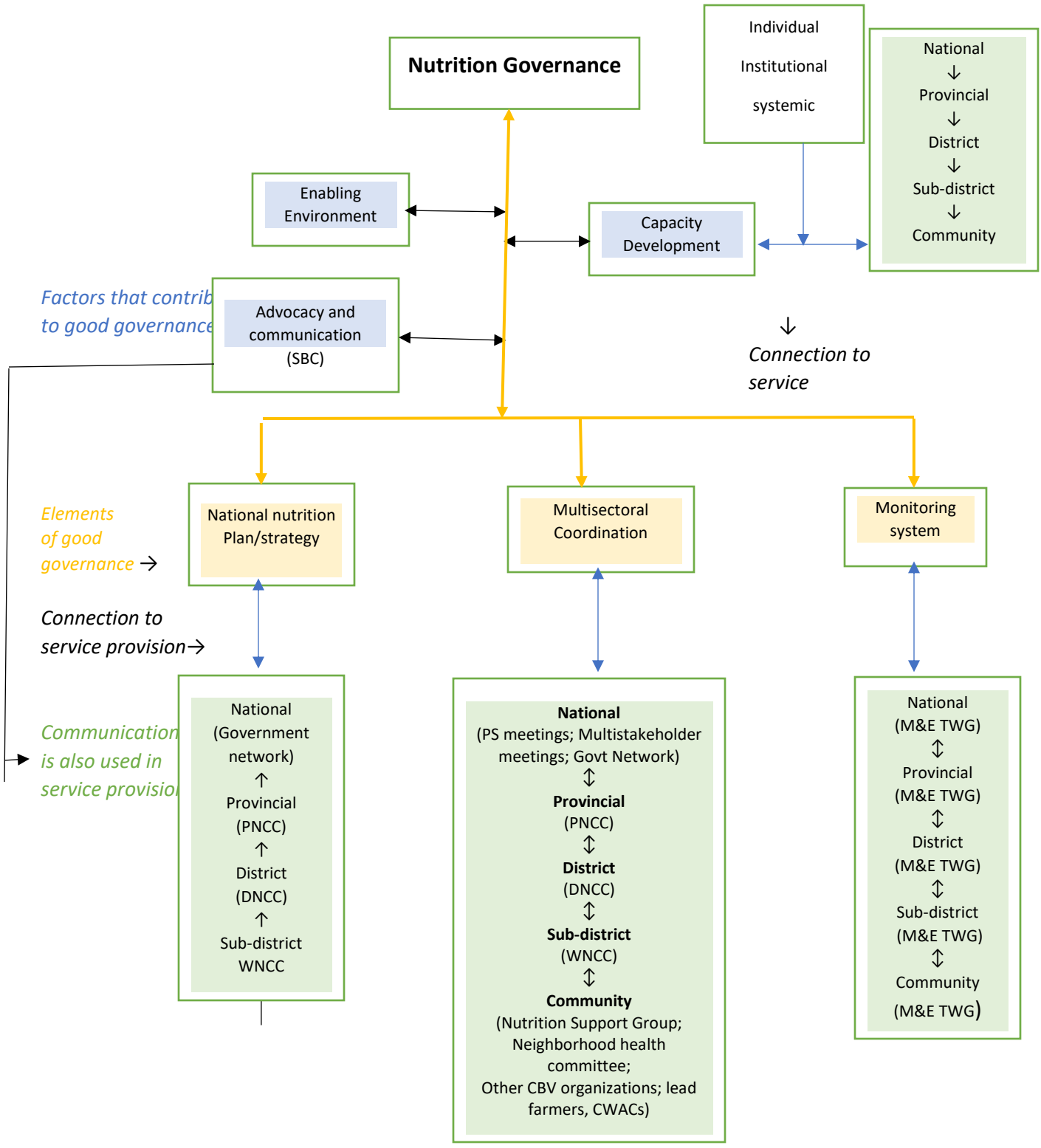
Table 6: Impact Pathway for WASH

Priority Intervs.	**Facilitate access to clean water and promote sanitation and hygiene behaviours: CLTS and baby WASH**
Ministry	Ministry of Water Development, Sanitation and Environmental Protection and Ministry of Local Government
Inputs	Integrated district plan for the provision of water points and latrines Monitoring system available Finances available at MLG
Process	District councils' Activities 1. drilling and rehabilitation of water points; est. water points in the community 2. Construct latrines 3. Area pump minders (APM) and V WASHE training 4. Pieces of training and establish WASH groups 5. Indicator development; 6. Monitoring
Outputs	Enhanced provision of complementary activities to community lead total sanitation (CLTS) for use of improved sanitation Enhanced delivery of complementary services on provision of safe and clean water Enhanced promotion of a safe environment for young children

Outcomes	Improved Access to and Use of Safe Water, Hygiene and Sanitation
Impact	reduced incidence of diarrhoea and other environmental related infections Improved nutrition status of children under five
Assumptions	Sustained support to community masons Sustained support to community champions Sustained support to Area pump minders /WASHE committee Community ownership and accountability of the service Availability of service providers with appropriate water treatment technologies Well sensitised communities with support from traditional leadership. Local Authorities and Traditional leadership enforcing by-laws on sanitation
Gender barriers	Poor access to soap for handwashing. Emphasis on men in WASH activities – impacts positioning of water points, gender-sensitive issues Women and girls time and energy burden in water collection /transportation
Gender responses	Include women in WASH groups Increase promotional activities that involve accessible cleaning material Clear targeting of men and women Gender awareness through communication and advocacy

2.6. Nutrition Governance

A GRAPHICAL REPRESENTATION OF THE ELEMENTS AND FACTORS OF GOOD GOVERNANCE (Kennedy & Fekadu, 2016).



The SUN Movement (the United Nations (UN) initiative) has provided a framework for assessing nutrition governance. The assessment framework illustrates three characteristics of good nutrition governance. These are the existence of a national nutrition plan, a multi-sectoral mechanism for nutrition, and the existence of a national nutrition monitoring system (Kennedy and Fekadu, 2016). Since nutrition is cross-cutting, the multi-sectoral mechanism is very necessary for the national fight against undernutrition and in the maintenance of momentum for the fight (Kennedy and Fekadu, 2016). It has already been established that stunting can best be tackled with the contribution of the key sectors, namely health, agriculture, education, WASH, social protection and communication; each playing their role in the execution of either the nutrition-sensitive or nutrition-specific interventions (Kennedy and Fekadu, 2016). It has also been established that the nutrition-specific interventions contribute 20% in the reduction of stunting, while nutrition-sensitive intervention contributes 80% (The Lancet, 2015). This evidence makes it necessary to coordinate action with a common goal especially that the beneficiary of the action is the same for all the sectors. Nutrition governance is more successful when there is an enabling environment, coupled with availability of the different capacities needed in the different institutions at all levels (Kennedy and Fekadu, 2016). The enabling environment can be looked at as the inputs required for an activity/intervention to take place effectively when considered in PIP terms.

The diagram below illustrates how the governance correlates with the MCDP II PIPs

Table 7: Impact Pathway for Nutrition Governance – Multisectoral coordination

Priority Interventions	**Enhance multisectoral coordination**
Ministry	NFNC and all key ministries
Inputs	1. Coordination structures at every level (National, provincial, district and sub-district) 2. Coordination guidelines 3. Develop Stakeholder management strategy 4. Financing 5. A system for compliance to coordination guidelines

Process	1. Establish coordination structures (at all levels) 2. Develop coordination guidelines o Printing coordination guidelines o Orientation on coordination guidelines at all levels 3. Develop stakeholder management strategy o Develop stakeholder management and communication plan o Printing coordination guidelines document o Disseminate stakeholder Management and communication plan 4. Develop a quality assurance document to monitor compliance of all components in the programme implementation 5. Train coordination structures at all levels on quality assurance
Outputs	1. Coordination structures established at all levels 2. Coordination guidelines developed 3. Stakeholder management strategy developed 4. Quality assurance document to monitor compliance of all components (eg coordination advocacy, health and nutrition, etc.) in the programme implementation developed 5. Coordination structures at all levels trained on quality assurance
Outcomes	-Strengthened Multisectoral coordination at all levels
Impact	-Improved Health and nutrition status of children under five years of age and women of childbearing age -Reduce stunting
Assumptions	1. High-level political commitment 2. Commitment by stakeholders to participate in all processes (eg establish structures, develop guidelines, develop quality assurance document, etc) 3. Commitment by lead a institution to spearhead all the processes 4. availability of necessary competence to lead all the process 5. Availability of finances

For effective implementation the MCDP II capacity development is important. For effective capacity development, three levels need to be addressed simultaneously. The three levels are individual, institutional and systemic (Kennedy & Fekadu, 2016).

Table 8: Impact Pathway for Nutrition Governance – Institutional Capacity Strengthening

Priority Interventions	**Institutional Capacity Strengthening**
Ministry	NFNC and all key ministries
Inputs	1. Nutrition workforce plan in place 2. Leadership and management training package available 3. Internship programme in place 4. Pre and In-service training plan in MCDP II 5. Pre and in-service training guideline for MCDP II in place 6. Financing
Process	1. Develop MCDP II nutrition workforce plan 2. Develop Leadership and management training package for the nutrition support coordinator 3. Develop internship programme across selected line ministries (ie. MoA MFL, MoH, MCDSS) 4. Develop pre and In-service training plan for MCDP II 5. Develop Pre and in-service training guideline for MCDP II 6. Hold consultative meetings in all the processes
Outputs	1. Nutrition workforce plan developed 2. Leadership and management training package developed 3. Internship programme across all line ministries in place 4. Pre and In-service training plan for MCDP II Developed 5. Pre and in-service training guidelines for MCDP II Developed 6. Improved nutrition service delivery
Outcome	- Institutional Capacity Strengthened in nutrition service delivery
Impact	-Reduced stunting and other forms of malnutrition
Assumptions	1. High-level political commitment 2. Commitment by stakeholders to participate 3. Commitment by a lead institution to spearhead all the processes 4. Availability of necessary competence to lead all the process 5. Availability of finances 6. Availability of interns to participate in the programme

Table 9: Impact Pathway for Nutrition Governance - Advocacy

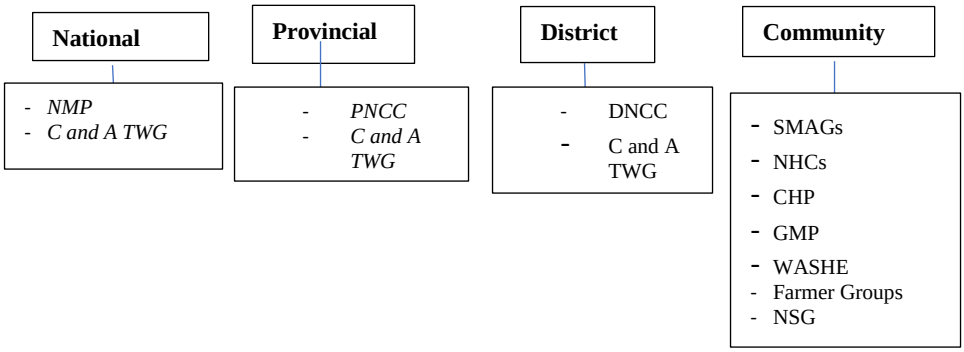
<table>
<tr><td>Priority Interventions</td><td colspan="3">Increased Advocacy</td></tr>
<tr><td>Ministry</td><td colspan="3">All key ministries</td></tr>
<tr><td>Inputs</td><td colspan="3">Formative research on SBCC
Desk review of existing communication, advocacy & SBCC materials
Development of MCDP II communication and advocacy and SBCC strategy and guidelines
↓
Development of sector-specific messages
Identification of channels of communication and audiences</td></tr>
<tr><td>Process</td><td colspan="3">Meetings and consultations on the development of the guiding documents
↓
Trainings at different levels</td></tr>
<tr><td rowspan="4">Outputs</td><td>Sustained coordination mechanism at all levels</td><td>Enhance capacity for all implementing partners in financial management and accountability</td><td rowspan="4">Leveraged public-private partnerships in MCDP II interventions</td></tr>
<tr><td>Enhance the capacity of the nutrition implementation technical group (IPG) to lead the planning and implementation of the MCDP II</td><td>Improved expenditure tracking for MCDP II</td></tr>
<tr><td></td><td>Improved government allocation of finances to MCDP II</td></tr>
<tr><td>Improve learning, documentation and sharing of MCDP experiences, best practices to facilitate rolling out countrywide</td><td>Enhance internal and external audits</td></tr>
</table>

Outcomes	Strengthen multisectoral policy and coordination at all levels	Strengthen financing and accountability at all levels	Enhanced partnerships and alliances of MCDP II
Impact	Improved health and nutrition status of children under five		
Assumptions	6. Enhanced nutrition governance at all levels 7. High-level political commitment 8. Commitment by members to participate in these meetings 9. Structures are aligned with the decentralization policy 10. Clearly defined roles and responsibilities of nutrition technical working group 11. A clear link to the national multi-stakeholder platform 12. Commitment by partners to the technical working group 13. Guidelines are user friendly 14. The willingness of multiple partners to participate in the reviews 15. Availability of necessary competence to generate success stories 16. Availability of financial resources		

2.7. Strategic Social and Behaviour Change

According to AIR report, increased nutrition knowledge did not result or translate in to improved nutrition practices as was observed in MCDP I (Andrew *et al.*, 2018). In MCDP II SBCC which will involve multiple approaches at community level will be upscaled.

Table 10: Impact Pathway for Social and Behaviour Change– cross cutting

<table>
<tr><th>Priority Intervs.</th><th>Social Behaviour Change</th></tr>
<tr><td>Lead Instit.</td><td>NFNC</td></tr>
<tr><td>Inputs</td><td>
1. Structures in place to implement or facilitate implementation of SBC activities


2. Financing of SBC and General Education activities
3. Availability of communication strategy, tools and implementation plan
4. Planning for SBC and General Education – All SUN Districts
5. Availability of protocols, guidelines, supplies, training materials, inputs for all ministries
6. Information systems in place i.e. HMIS, ZAMNIS, crop forecast survey, ZVAC, smart survey, EMIS
7. Availability of Communication channels
</td></tr>
</table>

Process	1. Develop of the SBC and communication products (strategy, tools, training materials, implementation plan) 2. Use different communication channels Interpersonal, multiple media (mass media, radio, posters, flyers, dance, drama, song) and social media (Facebook, Twitter) 3. Develop gender responsive materials 4. Train TWGs and various implementation structures in SBC and communication 5. Procure and distribute supplies, materials, input 6. Review protocols and guidelines 7. Promote: i. Production of diversified and consumption of diversified foods among pregnant and lactating women ii. Adoption of stunting reduction behaviours (IYCF, WASH, Food and Dietary Diversity; Maternal and Adolescent nutrition)
Outputs	1. Communication products developed 2. Public support.
Outcomes	1. Increased knowledge about nutrition 2. Behavioural change at community level (including IYCF, feeding practices, etc.) 3. Increased demand for nutrition interventions 4. Increased supply of nutrition interventions 5. Increased Public awareness on 1st 1000 MCDP (including "deliverers" and "recipients" of nutrition interventions) 6. Increased print and electronic media coverage on 1st 1000 MCDP 7. Increased electronic media coverage on 1st 1000 MCDP 8. Improved nutrition knowledge – including nutrition specific interventions and nutrition sensitive interventions
Impact	4. Improved health of children under five with focus on the under two 5. Reduced stunting in under five children with focus on the under two
Assumptions	1. Availability of funds for 2. Nutrition knowledge will diffuse through print and electronic media 3. Nutrition messages will invoke change in target groups
Gender barriers	1. Women in rural areas denied access to information technology (radios controlled by men) 2. Women time constraints (limiting exposure to media) 3. Illiteracy and inappropriate language limit understanding

Gender responses	1. Broadcasting and transmission at times when women able to access media 2. Formation of listening groups which include women 3. Provide access to radio – wind up radios 4. Provide multiple channels of media

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5. Appendices

5.0 Appendix 1: Check List for the Joint Supportive Visits

1.0 Policy and Coordination

1.1. Check for existence of minutes for the DNCC meetings (*check minutes for the following*)

- Any issues (challenges) arising in the meetings
- How the issues (challenges) were dealt with
- Was national/provincial level support needed?
- What support did that level give and was the situation resolved?
- Did the support requested for provided on time?

1.2. Check for reports on any orientation that was proposed to be done, be it of the DDCC, Heads of Departments or Wards that were formed.

- Has it been done?
- Who was oriented? (ask for Attendance lists and check to see if there was a mix of sectors in the training that would show convergence.)
- Any issues from the orientation
- Was national/provincial level support needed?
- Did national/provincial level provide the support
- What support did that level give and was the situation resolved?
- Visit one of the oriented DDCC member or Head of Department and have a discussion with them to assess their understanding of the 1st 1000 MCDP
- Visit one of the WNCC that was oriented and assess their understanding of the 1st 1000 MCDP

1.3. Check for reports (from the DNCC and WNCC) on the formation and functionality of the ward nutrition coordinating committees and respond to the following areas of concern:

- Has it been done?
- Who are the members? (ask for Attendance lists and check to see if there was a mix of sectors in the training that would show convergence.)
- Was gender considered during the formation of the WNCC?
- Any issues arising from the formation of the WNCC
- Was national/provincial/district level support needed?
- Did national/provincial/district level provide the support
- What support did this level give and was the situation resolved?
- Is the WNCC functional? (ask for minutes to verify)

- Check the WNCC work schedule to see if the planned activities cover all key sectors?

2. Priority Interventions

2.1. <u>Visit to the District HEALTH DIRECTOR</u>

- Have there been any challenges in implementing of the Health Priority Interventions?
- Are there any lessons which can be applied to other districts?
- Is the district and community aware of the 1000 MCD programme?
    - *(**Further action**: the support supervising team is expected to also meet some of the target recipients of the services in one of the areas to check awareness of the programme)*
- Is there communication and coordination of the MCDP issues between the:
    - National and district level?
    - National and Province?
    - Province and District?
    - District level and ward level?
    - Ward level and community?
- Have the relevant service providers been trained or oriented in implementing 1000 MCDP II?
    - District level staff
    - Sub-district level staff
    - Community-based agents trained
        - Nutrition Support groups
        - Growth monitors/ promoters
        - SMAGs
        - CHAs
        - CBOs
        - V-WASH
- How many service providers have been trained in the following and are practising?
    - IYCF (CIYCF)
    - GMP (CBGMP)
    - IMAM (CMAM)
    - V-WASHE
    - PMTMCT
    - IMCI (CMICI)

- Have the service providers been supported in implementing the 1st 1000 MCDP priority interventions? (Materials (guidelines, training packages, job aids), stationary, equipment, transportation, mentoring and supervision)
- Have the target communities been oriented about the 1st 1000 MCDP?
- Have relevant community leaders been involved in any way in delivering the priority interventions service? (*Visit any one and hold discussion to asses understanding of 1st 1000 MCDP*)
    - Chiefs
    - Headmen
    - Church leaders
- Has the district health office planned for adequate supplies for priority interventions? And are these available?
    - Iron & folic acid supplementation
    - Vitamin A supplementation
    - De-worming tablets/ medication
    - Zinc Tablets (diarrhoea)
    - ORS
    - Growth monitoring kits
    - RUTF
    - Protocols/guidelines
    - Training manuals – IMAM, GMP, MAIYCN (IYCF)
- Have the necessary supplies reached the target health facilities?
    - Iron & folic acid supplementation
    - Vitamin A supplementation
    - De-worming tablets/ medication
    - Zinc Tablets (diarrhoea)
    - ORS
    - Growth monitoring kits
    - RUTF
    - Protocols/guidelines
    - Training manuals – IMAM, GMP, MAIYCN (IYCF)
- Have the necessary supplies reached the target groups?
    - Iron & folic acid supplementation
    - Vitamin A supplementation
    - De-worming tablets/ medication
    - Zinc Tablets (diarrhoea)

- ORS
- RUTF
- GMP sessions

- Have you facilitated establishment of various community-support groups to support implementation of priority interventions?
    - E.g. Nutrition support groups
- Are there facilities implementing the Baby Friendly Hospital / Health facility Initiative?
- How does the health sector collaborate with other ministries at community level where interventions are being delivered/implemented to ensure that there is convergence in the implementation of interventions?

2.2 Visit the District Council Office

- What are the challenges in implementing promotion of water, hygiene and sanitation activities in the District?
- Are there any lessons which can be applied to other districts?
- Have communities been sensitised on water, sanitation and hygiene (WASH)?
- Have the necessary supplies for District WASH activities been acquired and distributed to the target communities?
    - Chlorine
    - Borehole spare parts
    - Testing kits
    - Building materials for latrines
    - Orientation materials
- Have trainings or orientations in D-WASH been conducted for different target groups
    - Training of EHTs
    - orientation of CHVs
    - Areas Pump Minders/V-Washe Training
    - Orientation of mother
    - Availability of Training materials
    - Training in sanitation, latrine construction and maintenance
- Has there been construction of latrines and how many in;
    - communities,
    - schools,
    - clinics
    - other delivery points

- Has there been establishment of WASH groups in the communities?

- How many water points have been established and maintained in the following?
    - communities,
    - schools,
    - clinics
    - other delivery points
- Have the community champions been identified?
- Are the community champions participating in the implementation of MCDP II?
- How does the council collaborate with other ministries at community level where interventions are being delivered/implemented to ensure that there is convergence in the implementation of interventions?

2.3 Visit to the DACO's office

NOTE: A visit to one of the sites for field check and interviewing some beneficiaries.

- Have there been challenges in implementing activities to promote increased availability of diverse locally available and processed foods (with focus on women's empowerment)?
- Have communities been sensitized on promotion of increased availability and consumption of diverse locally available and processed foods (with focus on women's empowerment)
- Have the supplies for the implementation of the activities been procured and delivered to the target communities?
    - Agricultural inputs
        - fertilizers
        - tools and equipment
        - seeds
        - IEC
    - Fish stock
    - Small livestock
    - Fruit tree nurseries
    - Orange fleshed sweet potato vines
    - Orange maize
- Have demonstration sites (visit some field) been established for
    - crops,
    - livestock,

- fish
- vegetable production and storage
- Fruit trees

- Have seed multiplication fields been established
    - How many communities have these?
- How many female Lead Farmers, Model Farms/ plots have been established in the community?
- How many female Lead Farmers are delivering messages to groups of women with children less than 2 years
- How many women groups have been establishment?
- How many gender trainings have been held for men, women and traditional leaders?
- Has the district Gender Development Committee been formed?
    - Have they been meeting and are there minutes?
    - Have there been issues raised and have these issues been resolved?
- How many women have been trained in locally diverse and processed food?

    (The issues below can be verified during the field visits through observation. A transect walk may be required to observe the issues below).

    - Have the women established gardens
    - Have the women been producing and processing diverse foods?
    - Have Fish ponds been established and are they functioning?
    - Are small livestock being reared and are they being utilized?
- Ask the households if they receive other interventions other than agriculture intervention? (WASH, cash transfer, village banking, food security pack, health education concerning breast feeding and complementary)

2.4 Visit to DEBS office

- How many schools have established school gardens, orchards and nutrition clubs in your district?
- Have there been challenges in orienting schools on the MCDP II and on establishing school gardens, orchard, nutrition clubs?
- Has there been orientation on nutrition sensitive messages at the following levels?
    - DEBS
    - Schools

- Parent-Teacher Associations
- Nutrition Clubs

- Have the necessary supplies and equipment been delivered to the target schools and communities? (*Visit at least one school to verify the issues below*)
    - IEC materials
    - Training materials
    - Production inputs –seeds and seedlings, chemicals, tools
- Has there been orientation of the following in production unit skills (vegetables, fruit, fish and animal production)? (*Interview at least two individuals from any two categories listed below to verify*.)
    - Schools (teachers and pupils)
    - Parent-Teacher Associations
    - Nutrition Clubs
- Have there been events held in the community through which nutrition sensitive messages have been delivered?
- Are there any school nutrition clubs undertaking promotional activities of the 1st 1000 MCDP in schools and surrounding communities?
- Are there teachers who part of the DNCC and WNCC?

2.6 Visit to Ministry of Community Development

- Have there been challenges in sensitizing communities on the MCDP?,
- Have adequate IEC supplies been available and delivered to target communities?
- Have there been sensitization meetings for beneficiaries of the Food Security Pack, Social Cash Transfer, Women's Empowerment Programme, Farmer Input Support Programme on key nutrition sensitive messages?
- How are your programme integrated in the MCDP?

3.0 Institutional and capacity building

Ask the following questions within the coordination office;

- Have there been any challenges in implementing activities under this strategic area?
- Have the necessary logistics and supplies been acquired and distributed?
    - Vehicles
    - Motorbikes
    - Bicycles
    - Office equipment e.g.

- desk top computer
- laptop
- printer
- copier
- LCD projector
- Generator
- Projector Stand
- Flip chat stand
- scanner
- digital camera
- Mega phone
- internet modem)

- Has there been training or orientation to enhance the management of the 1st 1000 MCDP:
    - Training in management information system (MIS) for DNCC members
    - Training in programme management and Team Building for DNCC Committee members
    - Training in programme management and Team Building for the WNCC members
    - Orientation workshops in leadership, gender and team building for community structures to support 1st 1000 MCD programme activities.
- Have these orientations been helpful?
- Did the orientations involve all the sectors?

4.0 Communication and advocacy

- Have you had any challenges in implementing activities under this strategic area?
- Has the district ordered and distributed various IEC materials for the 1st 1000 MCDP to service delivery points
- Has there been advocacy meetings held for all the local leaders on 1st 1000 MCDP?
- Have there been sensitization meetings by local leaders to promote 1st 1000 MCDP in their respective communities
- Has the district participated in the commemoration of various events in the district where 1st 1000 MCDP was promoted?

    e.g.
    - World Breast Feeding Week
    - World Food Day

        - Agric. Show
        - WASHE
    - Have nutrition campions been identified and oriented in your district?
    - Have you conducted any Nutrition campaigns in your district?
    - Has the social behaviour change training been implemented in the district?
    - Does the district have a communication and advocacy strategy in place?
    - Is the communication and advocacy technical working in place and functional? (*if yes, ask for the minutes*)
    - Is the district running community radio programmes about the 1000 MCDP?

5.0 Monitoring, Evaluation and Research

- Have you had any challenges in implementing M&E activities?
- Have you been oriented in M&E at District, sub-district and community levels?
- Are tools available for data collection at all levels?
- Is the M&E data base in place and functional?
- Is the monitoring and evaluation technical working in place and functional? (*if yes, ask for the minutes*)