



## Scaling up Nutrition in the African Region

A Consultation in response to the WHA  
Resolution (WHA 63.23)

Harare, 3-5 May 2011



## Contents

	<i>Page</i>
<b>ABBREVIATIONS</b> .....	<b>1</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>2</b>
<b>INTRODUCTION</b> .....	<b>4</b>
<b>OPENING OF THE MEETING</b> .....	<b>4</b>
<b>OBJECTIVE 1: TO PRESENT COUNTRY PROGRESS, NEEDS AND COMMITMENTS TO SCALE UP</b> .....	<b>5</b>
GLOBAL NUTRITION SITUATION: BURDEN AND POLICY RESPONSE – FRANCESCO BRANCA, DIRECTOR OF THE DEPARTMENT OF NUTRITION FOR HEALTH AND DEVELOPMENT, WHO GENEVA .....	5
NUTRITION CHALLENGES IN THE AFRICAN REGION – CHARLES SAGOE-MOSES, REGIONAL ADVISOR FOR INFANT AND YOUNG CHILD FEEDING, WHO AFRO .....	6
PROGRESS WITH SCALING UP NUTRITION – SUN FRAMEWORK – DAVID NABARRO, UNITED NATIONS SECRETARY-GENERAL’S SPECIAL REPRESENTATIVE FOR FOOD SECURITY AND NUTRITION.....	7
JOINT FAO/WHO INTERNATIONAL CONFERENCE ON NUTRITION 20 YEARS LATER (ICN+20) – BRIAN THOMPSON, NUTRITION AND CONSUMER PROTECTION DIVISION, FAO .....	8
COUNTRY PRESENTATIONS.....	9
PLENARY DISCUSSION ON CROSS CUTTING ISSUES: POLICY DEVELOPMENT AND CHALLENGES OF SCALING UP .....	10
<b>OBJECTIVE 2: TO COLLECT COUNTRY CONTRIBUTIONS AND PERSPECTIVES ON THE COMPREHENSIVE IMPLEMENTATION PLAN</b> .....	<b>11</b>
EAST CENTRAL AND SOUTHERN AFRICA HEALTH COMMUNITY (ECSA-HC) – DOROTHY NAMUCHIMBA, MANAGER FOR FOOD SECURITY AND NUTRITION .....	11
OVERVIEW OF THE COMPREHENSIVE IMPLEMENTATION PLAN ON MATERNAL, INFANT AND YOUNG CHILD NUTRITION – FRANCESCO BRANCA, DIRECTOR OF THE DEPARTMENT OF NUTRITION FOR HEALTH AND DEVELOPMENT, WHO GENEVA .....	12
DISCUSSION ON THE COMPREHENSIVE IMPLEMENTATION PLAN.....	12
COUNTRY SUCCESS STORIES .....	16
NUTRITION-SENSITIVE FOOD AND AGRICULTURE-BASED APPROACHES – LESLIE AMOROSO, NUTRITION AND CONSUMER PROTECTION DIVISION (AGN), FAO.....	18
EDUCATION TRIALS OF IMPROVED PRACTICES (TIPS) FOR COMPLEMENTARY FEEDING – CHARITY DIROIMWE, NUTRITION CONSULTANT FOR FAO.....	19
COMMUNITY PROGRAMMES LINKING NUTRITION AND FOOD SECURITY – EVIDENCE BASED INTERVENTIONS IN FAO PROJECTS IN LESOTHO AND MALAWI – BRIAN THOMPSON, FAO .....	20
<b>OBJECTIVE 3: TO EXPLORE THE COMMITMENT TO SUPPORTING IMPLEMENTATION OF PROPOSED ACTIONS</b> .....	<b>21</b>
WORKING GROUPS ON EFFECTIVE INTERVENTIONS.....	21
IMPLEMENTATION MECHANISMS AND TOOLS.....	24
<i>Scaling Up Nutrition: the role of civil society - Nathalie Ernault, Policy Advisor for MSF Access Campaign</i> .....	24
<i>Country process: Policy briefs for Country Scale up plans – Chizuru Nishida, Coordinator for Nutrition Policy and Scientific Advise, WHO Department for Nutrition</i> .....	24
<i>REACH –joint approach to ending child hunger – Ferima Coulibaly-Zerbo, Technical officer for nutrition for West Africa, WHO</i> .....	25
<i>Global nutrition governance – United Nations Standing Committee on Nutrition (UNSCN), Lina Mahy, UNSCN</i> .....	26

<i>Capacity building – Anu Narayan, Deputy Regional Director- East and Southern Africa for Hellen Keller International .....</i>	<i>26</i>
<i>Costing nutrition interventions with the One Health Tool – Ursula Trubswasser, Technical focal point for nutrition for Eastern and Southern Africa, WHO.....</i>	<i>27</i>
<i>e-Library of Evidence for Nutrition Actions (eLENA) and Global Information System on Implementation of Nutrition Actions and Policies (GISNAP) - Chizuru Nishida, Coordinator for Nutrition Policy and Scientific Advice, Department of Nutrition, WHO .....</i>	<i>28</i>
<b>CONCLUSIONS.....</b>	<b>30</b>
<b>CLOSURE OF THE MEETING .....</b>	<b>31</b>
<b>ANNEX 1 - PROGRAMME .....</b>	<b>32</b>
<b>ANNEX 2 - PARTICIPANTS.....</b>	<b>35</b>
<b>REFERENCES .....</b>	<b>43</b>

## **Abbreviations**

BFHI	Baby Friendly Hospital Initiative
CAADP	Comprehensive African Agriculture Development Programme
CTC	Community-based Therapeutic Care
DFID	United Kingdom Department of Foreign International Development
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization
ICN	International Conference of Nutrition
IDSR	Integrated Disease Surveillance and Response
IYCN/F	Infant and Young Child Feeding/Nutrition
MSF	Medcins sans frontiere
NCD	Noncommunicable Diseases
OTP	Outpatient Therapeutic Programme
REACH	Ending Child Hunger and Undernutrition Partnership
RUTF	Ready to Use Therapeutic Food
SCN	Standing Committee on Nutrition
SUN	Scaling Up Nutrition
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

## Executive summary

The World Health Assembly (WHA) was made aware that worldwide malnutrition accounts for 11% of the global burden of disease, which leads to long-term poor health and disability and poor educational and developmental outcomes. The WHA further learned that worldwide 186 million children are stunted and 20 million suffer from the most deadly form of severe acute malnutrition each year.

In response to these challenges, the 63<sup>rd</sup> WHA has approved resolution 63.23, urging Member States to increase the political commitment to prevent and reduce malnutrition in all its forms, to strengthen and expedite the sustainable implementation of the global strategy for infant and young child feeding, to develop or review current policy frameworks addressing the double burden of malnutrition, to scale up interventions that improve infant and young child nutrition and to strengthen nutrition surveillance.

The overall objective of the Consultation on the WHA resolution was to update partners on the nutrition situation in Africa and to advocate to governments and partners for the implementation of the WHA resolution and discuss the preparation for the proposed International Conference on Nutrition 20 years since the first ICN was held in 1992 (ICN +20).

Nineteen countries came to the meeting, representing the health, agriculture and education sectors. Donors, UN agencies, regional organizations and NGOs were also represented.

The meeting was an opportunity to stock take on the current state of implementation of policies and programmes in nutrition, to present and discuss the outline of the Comprehensive Implementation Plan on maternal, infant and young child nutrition to be discussed at the 64<sup>th</sup> World Health Assembly in May 2011, at a time of increased interest and political commitment to nutrition as also documented by the success of the Scaling Up Nutrition movement. The meeting also allowed establishing a dialogue on nutrition policies and programmes involving the health and agricultural sectors.

Countries reported challenges as well as achievements and successes:

- Multisectoral policies and strategies exist, but nutrition is not always mainstreamed in development plans; while nutrition policies, strategies and plans of action have been developed in many countries there is seldom adequate investment for their implementation
- While a number of countries have made little or no progress in achieving the MDG 1 for reducing poverty, hunger and malnutrition, others have had significant success
- Key factors for success include high level political commitment, public awareness, good coordination between actors and the presence of high level multisectoral coordination mechanisms
- Some successes have been documented in promoting breastfeeding rates, in addressing severe acute malnutrition and in improving coverage of micronutrient interventions
- Challenges include insufficient capacity of decentralised cadres who provide services to implement all the nutrition interventions at scale, the need to have a harmonized intervention package, and the sustainability of financial resources.

Participants provided useful feedback on WHO's Comprehensive Implementation Plan on maternal, infant and young child nutrition:

- The CIP is a useful tool to commit governments for nutrition, particularly through the discussion at the World Health Assembly
- The CIP should make closer link to existing initiatives, like SUN and focus on the effective interventions, but give a greater attention to interventions addressing the double burden
- The CIP should focus on the response to the challenges of implementation and scaling up and should take stock of documented success in implementation modalities
- The CIP should ensure the involvement of other sectors for interventions beyond the health sector but leave to the other sectors the detailed definition to the relevant policies
- General targets should be proposed, but specific targets should be established at country level
- The CIP should stimulate the commitment of health ministers to allocate a budget for nutrition and to identify financing mechanisms in countries

- The CIP should also advocate for the establishment of a clear mechanisms for accountability and transparent use for resources.

On the development and implementation of scale up plans, participants highlighted:

- The need for comprehensive country scale up plans for the different interventions
- The need of adequate costing tools for development of policies and programmes
- The need for harmonized and agreed indicators.

The linkages between food security, agriculture, nutrition and health were articulated and FAO was asked to continue to provide its assistance to countries in the implementation of nutrition-sensitive food and agriculture-based approaches for improving nutrition for all, including for mothers, infants and young children, at policy, strategy and programme level, as these were acknowledged as been effective, viable and sustainable long-term solutions for improving diets and raising levels of nutrition.

## Introduction

The World Health Assembly (WHA) was made aware that worldwide malnutrition accounts for 11% of the global burden of disease, which leads to long-term poor health and disability and poor educational and developmental outcomes. The WHA further learned that worldwide 186 million children are stunted and 20 million suffer from the most deadly form of severe acute malnutrition each year.

Globally, maternal and child under nutrition contributes to 35% of the disease burden in children younger than 5 years and is the underlying cause of 3.5 million deaths. Twenty three out of the 40 countries with child stunting prevalence of 40% or more are in Africa.

Around 1 in 7 infants (15%) weigh less than 2,500 grams at birth in Africa, affecting 5 million newborns every year. Most of the countries have more than 10% of prevalence from medium high (11 to 15%) to high (16-20%) and very high (>20%).

Only 31% of infants in Africa are exclusively breastfed during the first six months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate and unsafe. Under-nutrition amongst displaced persons, including refugees, due to recurrent droughts, wars and civil strife, is high in the Region, as it is among people living with HIV/AIDS. Diet-related chronic conditions, such as obesity, diabetes, cardiovascular disease and certain cancers are increasing in Africa.

In response to these challenges, the 63<sup>rd</sup> WHA has approved resolution 63.23, urging Member States to increase the political commitment to prevent and reduce malnutrition in all its forms, to strengthen and expedite the sustainable implementation of the global strategy for infant and young child feeding, to develop or review current policy frameworks addressing the double burden of malnutrition, to scale up interventions that improve infant and young child nutrition and to strengthen nutrition surveillance.

Resolution 63.23 also calls for stronger measures to implement the International Code of Marketing of Breast-milk Substitutes and to end inappropriate promotion of food for infants and young children. Resolution 63.23 requests the Director General (DG) of WHO to strengthen the evidence base on effective and safe nutrition actions, to mainstream nutrition in all WHO's health policies and strategies, to support Member States in expanding their nutritional interventions and to develop a comprehensive implementation plan on infant and young child nutrition as a critical component of a global multisectoral nutrition framework.

An outline of the comprehensive implementation plan has been prepared for country and regional consultations and for discussion at the 64<sup>th</sup> WHA. The outline is supported by four background papers that provide (1) an analysis of the implementation of nutrition policies globally; (2) a review of effective nutrition interventions; (3) a description of country processes to scale up nutrition interventions; and (4) a framework for monitoring the implementation of the implementation plan.

Public comments have been sought on the plan outline and on the background papers. Country consultations will be held whenever possible, but regional consultations will be the main opportunity for discussion.

## Opening of the meeting

In welcoming the participants, Custodia Mandlhate, WHO Country Representative for Zimbabwe, **x, FAO Deputy Regional Director for Eastern and Southern Africa**, Oladapo Walker, WHO IST Coordinator for Eastern and Southern Africa, and Dr Gibson Mhlanga, Principal Director for Preventive Services in the Ministry of Health and Child Welfare for Zimbabwe, stressed the importance of the meeting and the impact it could have on improving nutrition in the African Region.

The need for collaboration between different sectors in order to scale up nutrition was stressed by all speakers. They agreed that the meeting represented an important step towards bringing the nutrition and agriculture closer together and addressing malnutrition within a multisectoral approach.

The overall objective of the Consultation regarding the WHA resolution was to update partners on the nutrition situation in Africa and to advocate to governments and partners for the implementation of the WHA resolution.

The specific objectives were:

- (a) to present country progress, needs and commitments to scale up nutrition;
- (b) to collect country contributions and perspectives on the comprehensive implementation plan;  
and
- (c) to explore the commitment to supporting implementation of proposed actions.

Nineteen countries attended the meeting, representing the health, agriculture and education sectors; donors, UN agencies, regional organizations and NGOs were also represented.

Jenny Amery from DFID, emphasized the donor interest in the Scaling up Nutrition Initiative. DFID has a strong interest in nutrition, focuses on high burden countries and the window of opportunity (from conception to the first two years of life). DFID aims to integrate a range of different sectors, with a strong focus on gender.

## **Objective 1: To present country progress, needs and commitments to scale up**

### **Global nutrition situation: burden and policy response – Francesco Branca, Director of the Department of Nutrition for Health and Development, WHO Geneva**

Worldwide 186 million children are stunted. While stunting trends in Asia and Latin America have been declining over the last 20 years, rates in Africa have remained the same, around 40 per cent. For wasting, the African Region shows an increasing rate from 8 to 10 per cent, while in Asia, where highest rates are found, wasting has slightly decreased, from 12 to 11 per cent. Forty-three million children worldwide are overweight and rates in all regions are increasing, with the highest increase in Africa, from 4 to 8.5 % since 1990.<sup>1</sup>

Research suggests that early stunting and adolescent obesity may co-exist in the same socio-geographic population.<sup>2</sup>

While exclusive breastfeeding rates are the highest in South East Asia, rates in the African Region have been increasing steadily since the 1980s, from 12 to 30%.

The health and nutritional status of people in the developing world is influenced by changes in lifestyle and in food systems. Food systems are being transformed as a result of global economic and social change. Urbanization, foreign direct investment in the markets of developing countries and increasing incomes are prime facilitators of the observed changes, while social changes, such as the increased number of women in the workforce and rural to urban migration, provided an added stimulus. Changes are also facilitated by food production based on intensive agriculture, new food processing and storage technologies, longer product shelf-life, the emergence of food retailers and the intensification of advertising and marketing of certain products.<sup>3</sup>

Global dietary trends show an increase in refined sugars, fat, meat consumption and milk productions. At the same time, fruit and vegetable production has not been growing sufficiently, particularly in Africa.

The Global Nutrition Policy Review showed that all countries have policies or strategies to address nutrition, but often these policies are not officially adopted and do not address the existing nutrition challenges. It was also shown that programmes are seldom implemented on national scale, that food and agriculture strategies and development plans rarely include nutrition goals and that the focus on gender and vulnerable groups appears insufficient.<sup>4</sup>

The main policy gaps relate to maternal and infant nutrition, obesity and noncommunicable diseases and micronutrients.

The Policy Review also showed that a number of sectors are involved in nutrition coordination. While the Ministry of Health remains, in most countries, the main coordination institution for nutrition, a few countries position nutrition as part of a high-level policy making body, like the Office of the Prime Minister, the President or the Planning Commission.

The passage of WHA resolution 63.23 was an important milestone, as it urges Member States to increase their political commitment to nutrition in order to prevent and reduce malnutrition in all its forms, to strengthen and expedite the sustainable implementation of the global strategy for infant and young child feeding, to develop or review current policy frameworks addressing the double burden of malnutrition, to scale up interventions to improve infant and young child nutrition and strengthen nutrition surveillance.

### **Nutrition challenges in the African Region – Charles Sagoe-Moses, Regional Advisor for Infant and Young Child Feeding, WHO AFRO**

Presently, 14 countries in Sub-Saharan Africa are on track to reach the MDG1 target of cutting hunger and malnutrition by half by 2015. While having underweight populations affects relatively few African countries, chronic malnutrition is becoming an increasing problem in Africa, which has the greatest number of countries globally with critical stunting levels of above 40%.

Simultaneously, the risk of being overweight is increasing in Africa. The concurrent prevalence of maternal underweight and overweight in the same country suggests the beginnings of the double burden of malnutrition in many parts of Africa.

The work of nutrition is guided by various global and regional strategic frameworks including: the Comprehensive African Agricultural Development Programme (CAADP); the Africa Regional Nutrition Strategy (ARNS for 1993 to 2003 and for 2005 to 2015); the WHO/UNICEF Global Strategy on infant and young child feeding, 2003; Food Safety and Health: A Strategy for the WHO African Region; The WHO Global Strategy on Diet, Physical Activity and Health, 2004; and the Strategic Directions 6 on Achieving Sustainable Health Development in the African Region, 2010-15.

The window of opportunity to prevent chronic malnutrition is very short, but there is strong evidence to recommend a number of interventions:

- Pre-natal (-9 months to birth):
  - Improved maternal nutrition, health and caring practices.
- Post-natal (0-24 months):
  - Protection, promotion and support of optimal breastfeeding;
  - Adequate complementary feeding (timing, amount, animal source foods, fortified foods);
  - Micronutrient Deficiency Control ;
  - Appropriate nutritional management of infections *and* malnutrition; and
  - Integration for sustainable elimination of malnutrition: Food Security, Health, Water and sanitation, Social Protection & Education.

Implementation of some of these interventions in Africa is not at scale, however. For example, early initiation of breastfeeding is only practiced by 49% of mothers, exclusive breastfeeding at 6 months: 33%, and introduction of complementary feeding at 6 months: 70%. Vitamin A supplementation coverage shows overall high implementation rates of 81% and consumption of iodized salt is estimated to be at 61%.

The main challenges of implementation are the effects of the high burden of diseases (especially communicable diseases such as HIV, Tuberculosis and Malaria) on food production, inadequate dietary

intake, increasing household food insecurity, inadequate health services, poor water supply and sanitation; and inappropriate practices for maternal or child care.

In addition, mainstreaming nutrition into national development action plans remains a big challenge resulting in inadequate financial investment in the area.

As a way forward, the speaker proposed the development of multisectoral food and nutrition policies and comprehensive communication strategies, promotion of behaviour change; government leadership; support for operational research; capacity building; and advocacy for strengthened partnerships and resource mobilization.

### **Progress with Scaling Up Nutrition – SUN Framework – David Nabarro, United Nations Secretary-General’s Special Representative for Food Security and Nutrition**

The Scaling Up Nutrition (SUN) Framework has been endorsed by more than 100 entities from national governments, the United Nations system, civil society organizations, development agencies, academia, philanthropic bodies and the private sector. They are committed to supporting its implementation in ways that respond to the needs of people within countries affected by under-nutrition.

The reasons for the need to act are three-fold:

- There is renewed international focus on human rights as a basis for economic, social and human development and to address food and nutrition security;
- There is abundant evidence on the impact of under-nutrition on infant and young child mortality and its largely irreversible long-term effects on intellectual, physical and social development as well as on health; and
- There is widespread recognition that a series of well-tested and low-cost interventions can protect the nutrition of vulnerable individuals if incorporated into agriculture, social protection, health and educational programmes.

Successful strategies to improve the nutrition of communities are therefore based on two elements.

First is nutrition-sensitive development across sectors – a consistent focus on nutritional outcomes and indicators within local and national initiatives to end hunger and improve food and nutrition security, to improve living conditions and to ensure social protection - among both rural and urban populations.

Second is particular attention to the challenges faced by those most affected by under-nutrition – young children and women – through nutrition-specific interventions.

National authorities will be supported in realizing their commitments and obligations through the SUN Framework by multi-stakeholder groups, requiring efforts on all levels: country level, capacity development, global support functions, financing pathways and governance.

The steps for country engagement include the following:

- Request from national authorities
- Active “champion” to convene development partners
- In-country consultations via multi-stakeholder platform and process
- Nutrition policy in place and being pursued
- Stock-taking of actions and intentions
- Action plan with results framework
- Joint validation
- Implementation with coordinated support from government and partners

In the African Region, there are currently 13 so called SUN “Early Risers” (Benin, Ethiopia, Ghana, Malawi, Mali, Mozambique, Niger, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, and Zambia). An Early Riser country reference group is currently being established to reflect the interests of national focal points.

There are six global taskforces engaged on different subjects: country support, development partners, monitoring and reporting, civil society, private sector and communications.

It is envisaged that by end of 2011, there will be progress in at least 12 Early Riser countries and an agreed results framework in five other countries. Furthermore, critical resource gaps will be identified and agreements with development partners to help meet the gaps.

**Joint FAO/WHO International Conference on Nutrition 20 years later (ICN+20) – Brian Thompson, Nutrition and Consumer Protection Division, FAO**

The Joint FAO/WHO International Conference on Nutrition (ICN) in 1992 adopted the World Declaration and Plan of Action for Nutrition. One hundred and fifty-nine countries participated in the ICN and pledged to reduce starvation, chronic hunger, under-nutrition, micronutrient deficiencies, diet related communicable and non-communicable diseases, impediments to optimal breastfeeding, and inadequate sanitation and hygiene.

The outstanding result of the ICN 1992 was that countries prepared National Plans of Action to alleviate hunger and malnutrition.

Despite the achievements in the two decades following the ICN, the progress in reducing hunger and malnutrition has been unacceptably slow.

It is well known that malnutrition acts as a brake on development and places an intolerable burden on national health systems and on the entire culture, social and economic structures of nations.

Investing in nutrition is, therefore, not only a moral imperative, but it improves productivity and economic growth and reduces health care costs as well as promoting education, intellectual capacity and social development.

ICN+20 aims to revitalize the role of nutrition at international level and strengthen governance for nutrition by supporting other initiatives, like SUN and REACH.

The purpose of ICN+20 is to mobilize the political will and resources for improving nutrition and for reaching a consensus on a World Declaration on Nutrition that will lay the basis for achieving better nutrition for all. ICN+20 should further achieve a consensus around a global multisectoral nutrition framework indicating concrete steps to improve nutritional status.

The ICN+20 conference will be a high-level political event lasting for three days. In preparation for the conference, seven regional preparatory meetings, as well as expert meetings and stakeholder consultations, will be held throughout 2011 and 2012. The purpose of the regional meetings will be to involve countries, to facilitate exchange and to provide frameworks for the preparation of the country papers. Following the regional consultations, a regional synthesis paper will be prepared drawing on the country papers to help inform the debate at the ICN+20.

## **Discussion**

The issue of *accountability* was raised during the discussion. Speakers emphasized the importance to define clear indicators, benchmarks and goals. There is a need to have goals at country, regional and global levels. Countries, donors and international organizations have to be accountable for their actions. It was stressed that there is a wealth of nutrition indicators as well as good frameworks to assess implementation status. It will be crucial to have an agreement on a set of core indicators that do not add extra burden on countries.

It was also stressed that there should be multisectoral accountability within the UN. The UN Standing Committee on Nutrition has been established in 1977 with the purpose to have a multisectoral approach, but it have apparently faced significant challenges in pulling all sectors together. As the work of the SCN is being taken forward, the individual UN agencies have to be clearer and more transparent about their own multisectoral responsibilities. The REACH Initiative was mentioned as a very good example of UN agencies working towards this direction.

Participants expressed concern about *ICN+20*. There have been several conferences and global agreements regarding nutrition already. It was considered more important to focus on implementation

than putting additional effort on the policy level. Presenters explained that while country implementation processes need to go on, the ICN+20 will be a “one-point-in-time” event to refocus global attention on nutrition and ensure commitment at high levels. This will help mainstream nutrition in countries and in different sectors, as well as in UN agencies. Furthermore, the ICN+20 will be a good forum to discuss nutrition policies outside the health sector, since there is a great deal of evidence regarding nutrition from outside the health sector. Countries will be invited to contribute to the finalization of the plan for the conference.

It was stressed that despite all the meetings, available tools and frameworks, little impact has been made in nutrition. Resource mobilization and priorities of donors were mentioned as some of the challenges to scaling up nutrition interventions. Priorities of donors do not always match the objectives and plans of governments. Additionally, resources for nutrition seem to be scattered and it is difficult for governments to identify all available funding options.

With regard to the SUN Framework, it was emphasized that SUN is not an initiative or a programme, but builds on existing actions. Donors appear very committed to raising funds for nutrition within the SUN Framework. If countries have comprehensive multisectoral plans, in which achievements are tracked, donors will be more supportive to countries. Countries should also encourage donors to realize the linkages, for instance between nutrition and maternal and child health. Governments should further take the lead and clearly determine their gaps and needs, so that donors can demonstrate their support.

## **Country presentations**

Countries gave presentations in parallel sessions and reported synthesis reports back to the plenary. The main cross-cutting issues, challenges and success of countries were:

### Nutrition situation:

Under-nutrition in countries is still very high and there has only been slow progress in reducing it. Stunting remains high in all countries with levels between 20 and 42%. Exclusive breastfeeding is low in most countries.

Infectious diseases like HIV and Malaria; cultural feeding practices; food insecurity; poverty; climate changes; lack of political commitment; and brain drain were mentioned among the main causes for nutritional challenges.

### Policy framework and implementation of interventions:

Botswana, Ghana, Lesotho and Mozambique stressed that strong political commitment exists at high levels. Only few countries have nutrition in their poverty reduction and development plans. Nutrition policies are in place or being developed or improved in all countries. With regard to health and agriculture, national health sector plans as well as food and nutrition policies typically exist. Multisectoral mechanisms are in place, but are sometimes too weak to be effective. Sierra Leone emphasized the existence of a strong coordination platform through REACH.

With regards to interventions, most of the effective interventions are included in national plans and implemented with various degrees of success. Nutrition interventions are furthermore integrated in mother and child health, HIV and other programmes. Some interventions, like school feeding in Kenya and Liberia, have achieved improved coverage. Agriculture interventions seem to focus mainly on crops. With regard to non-health interventions, Lesotho conducted successful trainings of extension workers on food security and Sudan utilized women’s association for crop introduction.

### Success factors:

- Increased awareness of the multisectoral approach
- Existence of political documents and guidelines

- Good community capacity development
- University nutrition trainings as well as public health trainings for nutritionists available
- Health sector leadership in most coordination platforms

#### Challenges:

High level political commitment and funding is lacking in a number of countries. It appears, however, that nutrition in the context of HIV is well-funded in some countries. Financial support from governments is limited in most countries. Nutrition funds that are available are often scattered among different programmes. Weak inter-sectoral collaboration, particularly the poor links between food security and nutrition sectors, has been mentioned by some countries. Furthermore, lack of capacity and absence of accurate data appear to be challenges. Malawi also stressed the need to harmonize intervention packages at community level.

With regards to programmes, the lack of adequate legislation, for instance regarding food fortification, was mentioned.

What is needed to scale up nutrition?

- Nutrition needs to be prioritized as a national development issue
- Advocacy for more effective commitment for implementation
- Nutrition indicators need to be integrated into Health Information Systems
- Coordination and funding mechanisms at different levels need to be defined
- Better research, monitoring and evaluation and nutrition surveillance
- Nutrition and food security interventions need to be integrated into one programme
- Linkages between programmes should be strengthened, especially with regard to HIV and mother and child health
- Curricula need to be developed for agriculture and nutrition
- Stakeholder involvement needs to be strengthened
- Community-level interventions should be improved and harmonized
- Nutrition should be a separate department within the Ministry of Agriculture
- Human resources need to be strengthened

### **Plenary discussion on cross cutting issues: policy development and challenges of scaling up**

#### Strengthening capacity:

All countries stressed the issue of limited nutrition capacity. In order to implement and scale up nutrition interventions, more staff will be needed at community level. While more and more countries have trained nutritionists, they might be overqualified for work at community level. Furthermore, salaries are usually not enough to pay skilled nutritionists. Therefore, nutrition skills of low cadres, like nurses, midwives, community health promoters need to be strengthened, particularly in the area of counselling for infant and young child feeding. It was also mentioned that not only in the health sector, but also within agriculture ministries, there is a need for nutritionists.

#### Getting commitment for nutrition:

Kenya gave the example of the adaptation from a specific vaccine for children under five and that the World Health Assembly motivated the Minister of Health to make the change, since the WHA is an important forum to bring issues on the agenda of ministers.

#### Private sector involvement:

In Uganda, the private sector (both local industries as well as food processing industry) was involved in food fortification and has contributed significantly to making fortification mandatory.

Zambia stressed that manufacturers of baby foods are coming into countries and promoting their products through promotional materials during child health weeks.

While IBFAN emphasized the importance of Public Private Partnerships, the challenge of potential conflict of interest remains. Since legal systems in Africa are weak, enforcement is difficult. It was also mentioned that at national level, government and civil society can ensure appropriate involvement of the private sector; it is difficult to monitor activities of the private sector at local levels. Kenya highlighted that, for both NGOs and industries, it is crucial that the government is well organized, has standards and monitors activities of the industry. Also, NGOs need to align their activities with government objectives and guidelines.

Also, GAIN stressed that if rules of fortification are well set out, it will be easier to engage with the private sector.

It was concluded that the WHA needs to be engaged to clarify the issue of Public-Private Partnerships.

#### Perspective from non-health on who should coordinate nutrition:

The National Planning Authority (NPA) in Uganda took the initiative and identified a gap that all the different sectors had vertical interventions. The NPA then identified nutrition as a key issue. It started as a forum and then developed a plan with all different sectors, like trade, gender, agriculture and health. The Ugandan NPA is a neutral body, which is important when it comes to handling multisectoral coordination. If nutrition coordination is left to one ministry, it might only consider its own priorities.

Tanzania highlighted the need for education, especially with regard to politicians. The definitions and complexity of nutrition and food security does not seem to be well understood by political leaders. Engaging politicians will, therefore, be crucial.

The participant from Southern Sudan suggested that the main causes of malnutrition are poverty and lack of knowledge. While enough food is produced, farmers often sell nutrient-rich foods instead of feeding them to their children.

Eritrea shared the information on their food programme, where crops and livestock are given to households, which generates income and food production at the household level.

## **Objective 2: To collect country contributions and perspectives on the comprehensive implementation plan**

### **East Central and Southern Africa Health Community (ECSA-HC) – Dorothy Namuchimba, Manager for Food security and nutrition**

The East Central and Southern Africa Health Community (ECSA-HC) a regional inter-governmental health organization, operates in ten countries: Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. ECSA-HC was founded under the Commonwealth Secretariat in 1974 and became autonomous in 1980 under direct control of Member governments. In 2002, it was officially re-named the ECSA Health Community.

The ECSA-HC promotes and encourages efficiency and relevance in the provision of health services in the region and fosters regional cooperation and capacity to address the health needs of member states. ECSA further represents a strong voice and policy advocate for sustainable access to and better health care by every person. It also is a center of learning and excellence to share best practices and to provide advice and expertise.

Food and Nutrition Security is one of the six technical programmes of ECSA-HC. With its mandate to undertake activities and contribute to reduction of malnutrition in the region, ECSA contributes to improvement of nutrition, food safety and security and strengthens capacity of Member States for prevention and control of communicable and non-communicable diseases.

Main achievements of ECSA-HC include: technical support in food fortification; development of manuals on food control; upgrading laboratories through the ECSA Laboratory Proficiency Network; training of country teams in ENA; and providing a database of nutrition professionals. With regard to food fortification, ECSA-HC is supporting countries to expand their programmes. ECSA-HC is also advocating for policies to support production and consumption of indigenous foods and to create local demand for bio-fortification.

### **Overview of the comprehensive implementation plan on maternal, infant and young child nutrition – Francesco Branca, Director of the Department of Nutrition for Health and Development, WHO Geneva**

The purpose of the comprehensive implementation plan on maternal, infant and young child nutrition (the Plan) is to increase political commitment to preventing and reducing malnutrition in all its forms, to expedite implementation of the global strategy on infant and young child feeding, and to expand interventions.

The Plan is aimed at Member States, international partners and WHO, which also acts as the Secretariat. It is proposed that national and regional consultations involve a broad range of stakeholders including representatives of different government sectors, organizations in the United Nations system, development banks, donors, civil society and the private sector.

The Plan comprises four main sections:

- Challenges: child under-nutrition (wasting and stunting), low birth weight, micronutrient deficiencies, child overweight, maternal under-nutrition, maternal anemia, maternal overweight, inequities.
- Implementation of policies and programmes to reduce the double burden of malnutrition: Although all Member States have nutrition policies and programmes, they have not always been officially adopted, do not comprehensively address all the nutrition challenges and do not articulate operational plans and programmes of work.
- Objectives, targets and timeframe: global targets will be defined for the identified challenges and specific quantitative targets will be defined at country level. The overall time frame for the plan is ten years. After five years, short-term outcomes will be assessed.
- Actions are split into five different categories:
  1. To create a supportive environment for the implementation of comprehensive food and nutrition policies
  2. To include all required effective health interventions with an impact on nutrition in plans for scaling up
  3. To stimulate the implementation of non-health interventions with an impact on nutrition
  4. To provide adequate human and financial resources for the implementation of health interventions with an impact on nutrition
  5. To monitor and evaluate the implementation of policies and programmes

The full text of the Plan is available at: [www.who.int/nutrition/EB128](http://www.who.int/nutrition/EB128)

### **Discussion on the Comprehensive Implementation Plan**

The presentation was followed by a discussion on a number of questions and participants provided the following feedback on the comprehensive implementation plan (CIP or the Plan):

#### **Does it serve the general purpose?**

South Africa: There is poor understanding of what nutrition is, which could be the reason for not getting enough attention on nutrition from politicians. There is a need to advocate and educate for nutrition. For those who do not have a good understanding of nutrition, the CIP might not fulfil its purpose.

Uganda: The CIP should include a basic definition of nutrition, so that other relevant sectors understand what we talk about. Also, the consequences of malnutrition on school performance, national development and the like should be highlighted in the plan.

Namibia: Nutrition is not only a health issue, but since this plan will be presented at the WHA, it will only involve the health sector. We need to make sure that other sectors are part of this process from the inception of this document.

Zambia: It would be useful to stress the importance of repositioning nutrition in the center of development. It would be important to explain the role that nutrition has to improve development.

HKI: There is a concern regarding the link of CIP to SUN. Since SUN has been widely endorsed, it might be a problem to have another document, like CIP, that is not clearly linked to the SUN Framework. The specific actions are very much related to the 1,000 days initiative. While the actions related to the health sector are the strength of WHO, actions outside the health sector are defined very broadly in the plan and should be left to other sectors to elaborate.

**Are the challenges too broad? Is there a need for regional specificities?**

IBFAN: The CIP is very ambitious and tries to cover too many issues. The Lancet series of 2008 came up with a set of high impact interventions. However, in the Plan, a number of additional interventions are included, which might overburden countries. It is important to focus on the main critical interventions. For the African context, we need to be very specific and agree on what we can do immediately.

Uganda: The challenges that are mentioned in the Plan are mainly related to nutrition outcomes. There are a number of challenges with regard to the specific interventions. The challenges in the CIP should also address the systematic issues on how to implement and scale up interventions. Countries require global guidance on that. Furthermore, the issue of behaviour change needs to be stressed more in the Plan.

PATH: The CIP needs to be aligned with the SUN framework to make sure that we don't come up with something different from what is known and recognized by countries and donors already.

WHO responded to the concerns raised by HKI and PATH by explaining that when the Global Action Plan for Nutrition was developed, countries had asked about legitimacy of the Plan. The Secretariat brought this up in a report and asked for a more legitimate document. WHO, as the Secretariat, makes sure that all developments related to the SUN movement are regularly brought to the discussion at the WHA. It will be important to have full legitimacy and for countries to have ownership through the WHA, which is run by the Member States. It was also emphasized that CIP is not an initiative but is being aligned with SUN.

WFP: The challenges of implementation should be stressed in the CIP. The implementation modalities for scaling up need to be explained.

Zambia: It needs to come out very clearly in the Plan that it focuses on Infant and Young Child Nutrition. However, there should be mention of water and sanitation as well as the environment in the Plan.

**Are the objectives, targets and time frame adequate and specific enough?**

Uganda: It would be important to have exact timelines for the actions in the Plan. If the Plan is covering ten years, for instance, guidelines for implementation should be developed by WHO in the beginning rather than towards the end of the timeframe of the Plan.  
There is also a need for a general target, similar to the MDGs. Countries will then be able to measure their achievements against this target.

South Africa: Setting timeframes will be difficult if we don't know how to address the current challenges.

**For policies and programmes, should there be a full menu of interventions or a prioritisation of interventions? Are all challenges adequately addressed through the interventions?**

Sierra Leone: It will be important that countries define their priorities from this Plan.

Zambia: The interventions in the Plan are detailed with regard to under-nutrition, but for overweight and NCDs, the interventions are not as specific.

HKI: The prioritization of interventions outside the health sector will be more difficult, because the evidence is not as strong. With regard to overweight and obesity, while it is still 8% among children in Africa and we need to include it, the focus of the plan should be on underweight.

IBFAN: The major focus of the WHA resolution was on the code and on scaling up the Global WHO/UNICEF infant and young child feeding strategy. It will be important to focus on the WHA resolution and not cover too many issues in the Plan.

MSF: It will be important to have all effective interventions in the Plan, but when it comes to the implementation in country, a country-specific strategy should be designed.

Micronutrient Initiative: While the evidence for the effectiveness of the interventions mentioned in the SUN Framework is available, we need to encourage studies that assess the delivery mechanisms and the operational issues.

WHO: There is currently a big gap and WHO is working together with many partners, such as MI, to develop a decision tree on the implementation of the different interventions.

Zambia: It will be important that this Plan highlights the linkages between health and agriculture, particularly at the community level, where, for instance, food security programmes will be essential to sustain the positive outcome of a child treated from severe acute malnutrition.

ECSA-HC: There is a lot that countries can learn from each other. There are many good practice examples, but it seems they are not being shared adequately. It appears that we keep doing the same things, but don't realize what has been done already.

WHO: There is a global database on implementation of good practices, which we want to make available and share the experiences of country programmes as well as of NGOs.

**Finances – should there be more on costing or finance mechanisms?**

Kenya: Since the creation of the Global Fund, Kenya has made significant achievements in the fight against Tuberculosis and Malaria.

Sierra Leone: It might be useful if the WHA could commit ministries of health to allocate a certain percentage of their budget to nutrition.

Sudan: There are a number of forums in which nutrition is neglected and which we could use to discover new sources of funding.

Tanzania: The health ministry is the most sympathetic for nutrition, and moving nutrition concerns to the Prime Minister's office or to the agriculture ministry has not worked in Tanzania. There is a need for an advocacy tool since approximately 50% of child deaths are attributable to malnutrition. We need to better explain these relevant facts to our health ministries.

WFP: Even if we get a "Global Fund for Nutrition" in the future, we need to ensure the rationalization presently available funding for nutrition programming. We need to find a way to share funds and burdens among ministries and community health workers.

Uganda: While it would be a positive step to have a "Global Fund for Nutrition", we nevertheless have to address systemic issues of implementation and scaling up.

Liberia: The Plan contains a list of different interventions, among which the countries need to prioritize. It would be important to have costing for these different interventions to facilitate this prioritization process. Regardless of whether there will be a "Global Fund for Nutrition", we need to integrate nutrition into HIV, TB and/or malaria proposals.

### **Monitoring – proposal for accountability mechanisms?**

Ghana: Monitoring and evaluation, as well as data management, is very weak for nutrition programming. It would be useful to have a set of agreed indicators on which we should report. WHO has done a lot of work on surveillance and integration of nutrition into Integrated Disease Surveillance and Response (IDSR, but only a few countries have achieved such integration thus far.

IBFAN: We need agreed definitions for indicators, such as exclusive breast feeding. Definitions in different countries vary; furthermore, surveys are not done regularly or in a consistent manner. It is important that we have comparable data to share.

Namibia: There is a lack of funding to do agricultural evaluations, and while FAO has a set of indicators, these need to be shared with the countries.

### **Roles and responsibilities?**

Sierra Leone: It would be important to have clear Terms of Reference (ToR) of partners in the plan

Uganda: This document should also be taken forward by FAO or The Committee on World Food Security through their governing mechanisms to ensure that the agricultural sector is part of this plan.

MSF: It needs to be clarified who should be part of the policy design. Particularly with respect to the private sector, the involvement of different entities has to be clearly specified. It is also important to draw a line between policy development and policy implementation as well as to set forth who should be involved at which level.

GAIN: The private sector is very innovative in reaching consumers and we need to engage with them.

### **Overall reporting on plan implementation? What should go in reports? Who should be the recipients?**

Kenya: Reports should have different content for different actors. For instance, nutritionists might be more interested in the technical part of a report.

The indicator list is changing and is based on different criteria and the need to monitor from input to outcome. We need to set indicators, where we have the possibility to collect data. It will be important to have agreement on the indicators, which we can use for global comparison and country level accountability.

## **Country success stories**

### **Salt iodization and Vitamin A supplementation in Tanzania**

*Salt iodization* was formally launched in 1994. At this time, there was already iodized salt on the market, but the challenge was to iodize salt from small scale salt producers (SSSP). To initiate a specific programme, an inventory of SSSP was conducted.

The objectives were to map the SSSPs, establish their production scales, assess their capacities for salt iodization and define gaps and needs with regard to production.

A total of around 6,500 SSSPs were identified, and they used different methods for salt iodization: spraying (57%), dripping (28%) and mixers (6%). The majority of producers had very small production levels of 0-100 metric tons per year.

Prior to the inventory, almost none of the SSSPs had iodized salt. The reasons given for not iodizing salt were limited access to potassium iodate, lack of equipment, no demand from consumers, high costs of iodization and lack of training.

As part of the recommendations of this inventory, awareness was raised, and SSSPs were trained on iodization and quality control. Furthermore, equipment and supplies were provided as well as monitoring and supportive supervision.

As an outcome of combined efforts to raise public awareness on salt iodization, demand for iodized salt went up and policy makers and salt dealers were sensitized.

The impact was measured through the Tanzania Demographic Health Survey in 2010, which showed that almost 90% of households are now consuming iodized salt, of which 47% have salt with adequate iodine levels.

The supportive supervision to SSSPs is ongoing and the salt regulations are being enforced through inspections and legal action. It is also currently being negotiated to include potassium iodate in the list of National Essential Drugs.

The main activities of the *Vitamin A supplementation programme* include half-yearly Child Health Days, integrated with deworming and guidelines for Vitamin A supplementation. Tools are available for supervision, data collection and budgeting. All districts have been trained on Vitamin A supplementation and budgeting. Furthermore, advocacy work is ongoing to sensitize politicians and officials at national and regional levels, especially in low performing districts, as well as to sensitize development partners. Monitoring and evaluation of the programme is done through budget tracking, coverage tracking and post-event coverage surveys.

The main constraints of the programme are that the degree of institutionalization is uncertain and food-based approaches have been neglected. There is a need to revive efforts for food-based approaches.

Since there is also a threat of donors pulling out, it will be crucial to ensure government commitment to fully take over the programme.

### **Flour fortification in Uganda**

Micronutrient deficiencies in Uganda are high with 20% of children and 19% of women being Vitamin A deficient. Further, Iron deficiency affects 73% of children and 49% of women.

In response to the micronutrient challenges, the government has introduced the Universal Salt Iodization programme in 1994, which made salt iodization mandatory. In 2000, fortification was expanded to other food products commonly consumed, like maize flour, wheat and oil.

Currently, with support from the Global Alliance for Improved Nutrition (GAIN), four wheat producers and four oil producers are fortifying. Through WFP, three producers are being supported to fortify maize. Fortification of sugar is under discussion.

The strong coordination and collaboration in this effort has led to involvement of more development partners (USAID, UNICEF and WFP) with the public, private and civil society. Political commitment led to including food fortification as a strategy for elimination of micronutrient deficiencies in the National Food and Nutrition Policy. Furthermore, the government has exempted taxes on fortificants. Costs for fortification are being shared between the Ministry of Health, donors and industries. The successes of the fortification programmes have resulted in 98% households consuming iodized salt and 85% of oil being fortified with Vitamin A. Main challenges include limited capacity to regulate and monitor standards and the lack of laboratories to test. Industries are partly lacking the ability to conform to standards and technology. There are still many small producers that are not fortifying.

### **Infant and young child feeding in Ghana**

The National Plan of Action for Nutrition in 2000 included infant and young child feeding (IYCF) as a priority. The year 2002 saw an IYCF assessment and the appointment of a National IYCF coordinator in addition to a coordinator for the Baby Friendly Hospital Initiative (BFHI). Ghana has a breast feeding policy, as well as an IYCF strategy, in addition to guidelines on HIV and infant feeding. Twenty-seven percent of facilities are certified as “baby friendly”, as part of the BFHI.

There is also legislation for breastfeeding promotion in place.

Breastfeeding counseling has been integrated in antenatal services and trainings on BFHI and IYCF are being conducted for pre- and in-service.

The IYCF programme includes a strong community outreach and support through mother-to-mother as well as father- and grandmother-support groups. Community implementation of the programme also includes malaria control, annual Maternal and Child Health Weeks as well as community-based milling and fortification. At the community level, NGOs are supporting the implementation. The LINKAGES project was helping the preparation of counseling cards for mothers, grandmother and fathers groups. As part of the programme, curricula of health training institutions were reviewed. There is also strong support from partners, like UNICEF and WHO, and collaboration with the Ministry of Finance for this programme.

The main challenges of the programme are that the International Labour Organization Maternity Protection Convention has not been ratified. Funding for BFHI is limited and monitoring of certified facilities is lacking. There is also high staff turnover in institutions and refresher training is often inadequate. The challenge of harmonizing information and education materials was also stressed, as well as the lack of research for IYCF.

### **Malnutrition: integrated community programmes in Malawi and Nigeria**

#### **Malawi**

The Community based therapeutic care (CTC) programme was introduced in 2002 in one district and was consequently expanded to other districts. In 2006, it was adopted as a national strategy.

The reasons for adopting CTC in Malawi were the limited access to services for most children in need for care, as well as increased case load, with which the health care system could not cope.

Prevention and management of malnutrition is part of the National Development Agenda and acute malnutrition is recognized as a threat to child survival by the Malawian government, which shows a strong leadership in the programme. This enabling environment is further supported by partners' contribution to the programme, in terms of both supplies and technical support.

CTC has been institutionalized in Malawi through inclusion of malnutrition prevention and management in national development strategies and through the setting up a multi-stakeholder CTC Advisory Committee. Standardization of services is ensured through guidelines and trainings, facilitated by a pool of trainers at national and district level. The treatment and management of acute malnutrition is also integrated into other programmes, like Integrated Management of Childhood Illnesses and Infant and Young Child Feeding.

Local production of Ready-to-use-therapeutic foods (RUTF) is currently being accredited and scaled up.

As of December 2010, all 28 districts are reached with Nutrition Rehabilitation Units (NRU), Supplementary Feeding Programmes as well as Out-Patient Programmes (OTP). OTP sites have increased from 32 in 2004 to 418 in 2010.

Cure rates of the programme are above 80% and death rates below 10%.

The CTC programme also serves as a good entry point for HIV services, since 28% of patients at NRUs are HIV infected.

Main challenges of the programme are the need for resources, retention of community volunteers and weak monitoring and reporting.

The government will continue to advocate for CTC; strengthen the domestic resource allocation through District Implementation Plans and budgets; and strengthen district and community systems through Community Nutrition and HIV workers.

### **Nigeria**

The Community-based Management of Acute Malnutrition (CMAM) programme in Northern Nigeria is a good example from moving from a model programme to expansion. The programme has been implemented in the eight Sahel states and over 50,000 children have been admitted to the programme by March 2011. An evaluation of access and coverage showed that the programme had a 45% defaulter rate and a 52% cure rate. An assessment of possible reason for the high defaulter rates showed that defaults took place after the first visit. Most defaulters were within 30 minutes walking distance from the OTP site. However, there was a weak link between volunteers and health workers, which affected the follow up.

Among the lessons learnt, it was shown that the CMAM programme in Northern Nigeria increased the utilization of Primary Health Care facilities, an uptake of antenatal care, routine immunization and other services. It was also demonstrated that partnerships can lead to leverage of huge financial and human resource capacity to scale up the programme.

The plans for the future are to expand CMAM to over 400 sites by the end of 2011 and reach 150,000 severely malnourished children and to integrate IYCF counseling in CMAM sites to ensure prevention.

### **Nutrition-sensitive food and agriculture-based approaches – Leslie Amoroso, Nutrition and Consumer Protection Division (AGN), FAO**

Nutrition makes an important contribution to the achievement of each of the MDGs. FAO works with its Member States and the international community to achieve the MDGs.

Agriculture has three purposes: to produce foods for consumption; to support livelihoods, provide employment opportunities and generate incomes; and to protect and safeguard the environment for future generations in terms of land, soil and water and the flora and fauna.

FAO is working to better integrate nutrition into agriculture, food security and vulnerability policy frameworks. The terminology of “food and nutrition security” best describes the integration of nutrition into food security. Including nutrition underscores the need to not only look at the quantity of food but also the quality in terms of variety, diversity and nutrient content and care.

Food and agriculture-based strategies focus on food as the primary tool for improving the quality of the diet and for addressing and preventing malnutrition and nutritional deficiencies.

Poor, monotonous diets low in quantity and quality lead to hunger and malnutrition. Food and agriculture-based approaches address this problem by making more food available and accessible and by providing nutrition education and dietary counselling.

There is a need to increase access to and consumption of rich and diverse diets. Simple technologies that can help improve consumption patterns include: diversified production of fruits and vegetables with micronutrient rich varieties; production of animal source foods; investment in sustainable forest and pasture management; protection of biodiversity; selection of crops based on nutritional content in

addition to yields and market value; increasing availability of and access to fertilizers; reducing post-harvest losses; and training extension staff and households in basic nutrition and food preparation skills. FAO held an *International Symposium on Food and Nutrition Security: Food based approaches for improving diets and raising levels of nutrition* to collect and better document evidence that demonstrates the impact and effectiveness of nutrition-sensitive, food-based approaches.

FAO's policy response to improving food and nutrition security includes technical assistance; promotion of nutrition-sensitive agriculture policies and programmes; capacity building; nutrition education strategies; promotion of improved family feeding practices and complementary feeding; conducting baseline surveys; promoting small-scale food processing and preservation techniques; and improving water harvesting and irrigation systems.

### **Education Trials of Improved Practices (TIPs) for complementary feeding – Charity Diroimwe, Nutrition consultant for FAO**

FAO has been promoting improved complementary feeding in a number of countries through comprehensive food-based approaches, promoting a variety of nutritious, safe and culturally acceptable diets.

Feeding recommendations and complementary feeding recipes have been developed and tested through formative research process called "Trials of Improved Practices" (TIPs). TIPs has been first used in nutrition programming in the 1980s and is based on a process of formative research that uses quick, interactive information-gathering methods with mothers and other key people. During consultative research, nutrition related information on nutrient content of locally available foods and key cultural and personal concerns are examined. Changes in behaviour and feeding practices are discussed and negotiated with the family who then agree to try one or two new practices.

FAO has been using the TIPs approach since 2002 in Zambia, Afghanistan, Laos and Cambodia. In all the four countries intersectoral teams have been set up, consisting of health, agriculture and education ministry as well as women's unions, and community workers.

TIPs is a very consultative process and in the four countries, dialogues have been held between community and service providers and TIPs facilitating teams documented the acceptability and feasibility. Furthermore, seasonal food availability calendars have been developed in a participatory manner. The calendars have been excellent tools to strengthen food production and utilization by raising awareness of available foods and by facilitating effective planning of food security interventions to fill gaps.

As an outcome of the projects, feeding recommendations and seasonal specific complementary feeding recipes have been developed and tested. Examples were given for recipes for the different age groups (6-8, 9-11 and 12-24 months), specifying the amounts per raw ingredients and per final cooked meal. Based on the seven food groups recommended by WHO for complementary feeding, minimum dietary diversity was defined.

The project findings showed that dietary diversity was possible using local foods. An example from Cambodia was given where the inclusion of leafy vegetables, fish, eggs, meat to the diet of children between 6 and 24 months was successful after introduction of TIPs.

Families were very interested to learn about child feeding and about 70% of families managed to prepare and feed nutritionally improved porridges 3-5 days a week. It was also shown that mothers shared their skills with others and continued feeding improved complementary foods even after TIPs was completed.

The main challenges of the projects were seasonal food availability; time constraints during planting season; affordability of micronutrient-rich foods; meeting iron and zinc requirements; and scaling the project up to national level.

It would be important to support appropriate food processing and preservation to extend the availability of nutrient-rich foods throughout the year and to continue Vitamin A supplementation, iron fortification and explore the use of micronutrient powders to fill micronutrient gaps.

### **Community programmes linking nutrition and food security – Evidence based interventions in FAO projects in Lesotho and Malawi – Brian Thompson, FAO**

Malnutrition impacts agricultural in different ways: reduced ability to do work; loss of earnings; loss of knowledge and skills; increased expenditures; and impoverishment of households. Malnutrition also impacts food security through increased fatigue, absenteeism, and decline in productive family members. Research from Tanzania has shown that per capita food consumption in the poorest households decreased by 15%.

Nutrition is a cross-cutting issue in which all sectors should be involved, not just the health sector. With most people in Africa dependent on the primary sector for their livelihood, agriculture plays a key role. There are a number of lessons to be learned from an inter-agency project on protecting and improving food and nutrition security of orphans and HIV/AIDS affected children in Lesotho and Malawi. Target beneficiaries in this project were community-based, district, and national level institutions, active in this area, as well as orphans and children affected by HIV/AIDS and/or food insecurity. Activities of this programme included nutrition/health care and support; food security and livelihoods support; and institutional capacity building for delivery of support services.

To improve food and nutrition security, production of crops and vegetables were promoted as well as post-harvest initiative, diversification, and bio-intensive agricultural techniques. For income generation, beneficiaries received food security and nutrition education, fuel saving stoves were introduced, as were income-generating activities.

Training and education activities included promotion of school enrolment and retention as well as early childhood care and development. The project also had a social welfare component and aimed to improve access to health services.

Through participation in different fora at grassroot, national and international levels, innovations and good practices generated by the project have been published locally and internationally.

The project showed very positive impacts on risk behaviours, slowed spread of HIV, extended and improved quality of life; and reduced vulnerability.

However there is a need for better monitoring and evaluation tools to assess the impact of policies and programmes and effective models of integrated nutrition-sensitive agriculture programmes.

Furthermore, programmes need to go beyond simply improving access to food, they must also influence food utilization.

For the future, it will be important to document and apply the lessons learnt in community-based, interagency multi-sectoral actions and ensure greater collaboration between donors, UN agencies, national stakeholders and local communities. It will also be crucial to have active participation in the preparations at national and regional levels for the ICN+20.

### **Discussion on agriculture and other non-health interventions**

Sierra Leone emphasize that the extension systems are very weak, since it is difficult to motivate people to work for unattractive salaries. It might be practical to use farmers as extension workers to fill the gap.

Following the question on which crops should be grown, it was suggested that this would depend on the nutritional gaps observed in the respective communities. A TIPs approach can help close nutrition gaps at the community level. At the same time, particularly for other age groups, it would be crucial to look at the extent of the lean season. It needs to be assessed if production should be improved or for instance storage capacities or post-harvest losses. The type of soil and availability of agricultural land is another

thing that should be looked into. In terms of animal sources food, the possibilities of small animal production should be explored to avoid the environmental impact of bigger animal production. Rabbit production was mentioned as an example, since the feed for rabbits does not compete with food for human use.

There are certain crops that give good results and have high nutrient values. For instance fruit trees, like papayas.

It was stressed that introducing animal source foods to the diet of children between 6 and 24 months, remains a major challenge. However using animal source foods 1-2 times per week, would already be a major achievement.

### **Objective 3: To explore the commitment to supporting implementation of proposed actions**

#### **Working groups on effective interventions**

##### **Behavioural interventions and education**

The main policy challenges include weak consultation on new policies at all levels as well as weak structures at lower levels to implement policies. Policies related to HIV and infant feeding are normally formulated and implemented at varying levels with the IYCF policies, but integration at policy formulation is weak. It was also mentioned that completion of policy and guideline formulation takes long from the time from when they are formulated at WHO level. Dissemination of new policies also does not always reach the lower levels.

Under challenges related to advocacy the group mentioned the need for good quality data, clear and simple messages, good evidence, findings from similar good practice programs, identification of champions at political level, alignment of policies, follow up or implementation plans.

The lack of capacity to implement and to manage policies as well as weak monitoring and evaluation was highlighted as the main challenges of implementation.

As solutions, Liberia suggested to strengthen community ownership through integration at community level by getting them involved and training them. South Africa stressed the importance of involving the media and ensuring that nutrition messages and plans are understood.

Proposed interventions include engaging in dialogue at all levels; involving and empowering men; communicating the importance of breastfeeding; and strengthening in- and pre-service curricula of health workers. At policy level, it will be crucial to have advocacy tools and identify a champion. Having simple monitoring and evaluation tools in place will help getting reliable data for which indicators need to be harmonized and simplified. It has also been shown that mother-to-mother support groups at the community level can be very useful, as well as involving traditional birth attendants to promote breastfeeding. Before programmes are being implemented at community level, plans have to be communicated well with health workers and there needs to be follow up to trainings and supervision for health workers.

Support for implementation and scaling up will require that donors put more focus on nutrition and nutrition priorities are adequately advocated during meetings with ministers. It was also stressed that partners should follow up on implementation and that delivery mechanisms should be well specified when new guidelines are developed. Liberia mentioned the importance of taskshifting by empowering others to take over responsibilities. For instance nurses should be trained in clinical nutrition and doctors in their role as decision makers might play important roles in shifting more focus on nutrition in funding of health interventions. The group furthermore stressed the importance of country ownership and leadership by having a mechanism in place to monitor activities and funds and by building local capacity instead of involvement of external consultants.

In the discussion it was suggested that local media, like radios can play an important role in changing behaviour. Training local journalists can help to ensure consistency of messages. The need for country specific behaviour change communication strategies was also stressed. With regard to the private sector, South Africa explained that they are trying to ban adverts addressed to children.

### **Malnutrition, targeted interventions and other health interventions**

Policies are in place for the interventions related to severe acute malnutrition. Nutrition support for patients with Tuberculosis is not reflected in all policies of countries. Supplementation for women with low body mass index is also rarely part of national policies. Supplementation is mainly related to pregnant and lactating women. In South-Africa for instance, HIV and TB are placed in social protection or education policies. Liberia and Sierra Leone mentioned that pregnant and lactating women are also integrated under agriculture and under small holder commercialization programmes.

The main challenges for implementation and scaling up are that nutrition is not visible within the health system as well as the lack of human resources, particularly at facility level to implement activities. The lack of main indicators to follow up as well as financial, supply and logistic constraints were also mentioned as challenges of implementation.

As solutions to overcome these challenges, the group suggested to increase awareness of nutrition at the highest political level; to develop multi-sectoral plans; to improve surveillance and data to advocate for resource; to use regional Member States institutions for advocacy; to use champions for advocacy; and to strengthen coordination among different actors.

The support needed to scale up includes technical, financial and logistic support, as well as support to strengthen monitoring and evaluation; capacity of health staff; to set up a platform for coordination and integration of interventions; and to share best practices.

With regard to other health interventions, interventions such as deworming of children and pregnant women, prevention of mother to child transmission of HIV, and hand washing are included in all national nutrition policies. Reduction of indoor air pollution and the prevention and control of occupational risks in pregnancy are not included in the policies of Liberia, Uganda, Ghana, Sierra- Leone, Tanzania, Malawi, Zambia, Kenya and Botswana.

In South Africa, all relevant other health interventions, mentioned in the Comprehensive Implementation Plan are reflected in policy documents.

The group suggested that interventions related to EPI, Integrated Management of Childhood illnesses and NCDs should be included in the Comprehensive Implementation Plan under “other health interventions”.

To support the implementation and scale up of these other health interventions, there is a need to strengthen the link between nutrition and other health interventions, as well as to ensure integration and mainstreaming of nutrition into other health interventions.

### **Micronutrient interventions**

The group highlighted that there is need to have a policy on the supplementation of iron in malaria endemic areas. It was also noted that delivery mechanisms for Vitamin A and iron vary from country to country (routine, campaigns, early childhood centres or schools). There is currently no policy on duration, and compliance related to iron supplementation for adolescent girls in schools.

The group further stressed the need for human resources and involvement of community health workers to give vitamin A. Other issues that were raised included the distribution of Zinc with ORS in the community; the need for resources in campaigns and child health days; and the need to include supplementation in school health policies.

The main challenges for micronutrient interventions are lack of human resource, in particular health workers and community volunteers; sensitization and monitoring mechanisms for home fortification; monitoring of food fortification; and logistics for instance for distribution of iron supplements to schools.

Suggestions were made to overcome these challenges through trainings: in-service, as well as staff from other sectors and community volunteers. Furthermore there is a need for advocacy to achieve policy change. The integration of Behaviour Change Communication and TIPs and other services into micronutrient programmes, as well as the development of guidelines were also suggested as a solution.

In the discussion it was mentioned that guidelines on iron in malaria affected areas are currently being revised and will be published soon. Weekly iron/folate supplementation is being recommended now to help increase compliance. It is also important to note for countries when implementing supplementation programmes, that when Vitamin A supplementation is for instance moved from child health days to more sustainable integrated approaches, the coverage is expected to go down. A concern was raised related to Vitamin A supplementation at community level. Since doctors appear to be concerned about Vitamin A overdoses, there is resistance to use community health workers for supplementation programmes.

It was also stressed by participants that food-based approaches are crucial in preventing micronutrient deficiencies and need to be included in the list of interventions in the Comprehensive Implementation Plan.

### **Nutrition-sensitive food and agriculture-based approaches**

Gender is a key issue to consider in such interventions given that the majority of farmers are female and women are also key in infant and young child nutrition. The group further highlighted the need to consider the social and cultural practices that surround women.

With regard to the farm to table approach, it would be crucial to consider breeding of high nutrient crops, as well as research on nutrition specific problems and gender sensitive technologies. Furthermore the need to improve traits for nutritious and local foods as well as to breed varieties tolerant to climate change was mentioned in the discussions.

In terms of production, small scale production of nutrient rich foods and small scale production should be increased.

It was also mentioned that gender sensitive and labour saving technologies need to be promoted as well as the production and consumption of healthy foods through education. Education will also be important with regards to preparation, processing, budgeting, preservation and storage for better retention of nutrients and reduction of post-harvest losses.

In the discussion it was mentioned that a lot of focus has been put on small scale farmers. The group justified that by the fact that in Africa most farmers are small scale farmers and interventions addressing household farmers have been shown to improve household food security.

It was also mentioned that there is a need for indicators in agriculture to measure process.

### **Social protection**

Current social protection programmes in countries include school feeding, cash transfers, food for work, supplementary feeding, social grants, and food for prescription.

Target groups are usually elderly people, vulnerable groups (including HIV+), Orphans or Vulnerable Children (OVCs) and pregnant teen-agers.

For some programmes, for instance in Ghana and South Africa, the implementation is nation-wide. Most often though it appears scattered or only focused on specific areas.

Programmes use different mechanisms or tools, like voucher, bank payments, electronic transfers, through communities or through the private sector.

The main challenges of social protection programmes highlighted by the group are sustainability, accountability and transparency.

The group suggested a number of success factors, like creating linkages to the broader social issues, ensuring community ownership, strong commitment of government, collaboration within the communities and efforts to switch to more sustainable activities.

The main challenges of social protection programmes appear to be lack of government commitment, lack of funds, sustainability, intersectoral linkages, capacity, overdependence on donors and not reaching the right target.

The group emphasized the need for broader integration with other social programs and to tailor social protection programs in a way to make an impact on nutrition.

It was concluded, that existing social protection programs have the potential to address the nutritional needs of the most vulnerable. To increase their potential less financial dependency will be crucial, as well as improved accountability, sustainability and transparency.

## **Implementation mechanisms and tools**

### ***Scaling Up Nutrition: the role of civil society - Nathalie Ernoult, Policy Advisor for MSF Access Campaign***

MSF is an international medical humanitarian organization, providing aid in about 60 countries to people whose survival is threatened by conflict, epidemics, malnutrition or natural disasters. MSF strives to provide high quality care to patients and ensures access to existing medical tools. The yearly funding of MSF is on average 40 Million US Dollars.

The experiences of MSF contributed to discussions on models of care on for instance decentralized treatment of acute malnutrition and early intervention on children under 2 years of age.

The main challenges are that these interventions are usually implemented by INGOs in humanitarian context. There is therefore a need to integrate them as part of the health package for the long run.

To ensure this integration, participation of Civil Society Organizations (CSO) is key.

Malnutrition is currently moving from the humanitarian to the development agenda with the need of sustained commitment of all actors, in particular of CSOs. Furthermore a range of CSOs have good records in the health and non-health sector, which can be mobilized.

Civil Society Organizations are on the ground at the contact with the people in need, even in the most remote places. CSOs already play a key role in supporting decentralization of the health structures at district and local level. They can furthermore support, train and reinforce the health system in human resources.

CSOs are therefore key actors to scaling up nutrition activities by contributing to policy decisions and pushing for funding commitments for countries, generating nutrition awareness, and participating in Research and Development for improved programme delivery.

### ***Country process: Policy briefs for Country Scale up plans – Chizuru Nishida, Coordinator for Nutrition Policy and Scientific Advise, WHO Department for Nutrition***

One of the background papers for the implementation of the WHA resolution on IYCN described the proposed process for developing country scale-up plans.

The proposed process includes five steps:

- Step 1 is a context mapping and assessment of implementation challenges in countries, which can include a Landscape Analysis Country Assessment, a participatory assessment and analysis of readiness to scale-up nutrition action. Tools are available for national provincial, district, facility level and NGOs. Currently 13 countries have conducted the Landscape Analysis country assessment. Other assessment tools, like the REACH assessment could be used for this stage.
- Step 2 includes a country stakeholder s workshop to discuss and identify existing challenges for implementing scale-up plans. This should be a 1-2 day meeting with a wide range of technical level stakeholders. In-depth technical discussions should be held on priority problems, possible interventions, delivery channels, financing options, potential coverage, as well as available evidence for what works in practice in the concerned country context.

- Step 3 is an analysis of programme delivery options and preparation of policy briefs, where the country team supported by local experts and researchers prepares strategic operational plans. Policy briefs will include operational requirements, expected coverage, as well as decision trees for the interventions.
- Step 4 will include deliberative dialogues in a 1-2 days stakeholder meeting of high level policy makers and interested donors to discuss and validate the evidence-base and contextual issues related to the prepared policy briefs. The appropriate policy options will then be collectively selected. This meeting should further ensure political commitment of the national government and identify and secure required funds for the implementation and monitoring and evaluation.
- Step 5 will be the preparation of scale-up plan, which should be based on collectively selected and agreed evidence-informed policy options, including targets, programme areas to be covered, delivery options, responsibilities of stakeholders, capacity needs, financial investment, monitoring and evaluation mechanism and plans on how to implement social mobilization. Scale-up plans will need to be aligned with overall plans of concerned sectors as well as the broader development agenda and strategies.

***REACH –joint approach to ending child hunger – Ferima Coulibaly-Zerbo, Technical officer for nutrition for West Africa, WHO***

REACH: Ending Child Hunger and Undernutrition Partnership was jointly established by the United Nations Food and Agriculture Organization (FAO), World Health Organization (WHO), United Nations Children’s Fund (UNICEF) and the World Food Programme (WFP). In addition to the contribution of the founding UN partner agencies, REACH draws on the support of NGOs, academic institutions and private sector actors.

The REACH process builds consensus on the magnitude of nutritional challenges and the need for new approaches to scaling-up coverage for the most disadvantaged. Food security, child and maternal health, and care must all be taken into account when analyzing the causes of hunger and malnutrition, as well as when formulating and delivering responses. REACH specifically engages stakeholders to improve: 1) infant and young child feeding; 2) hygiene and sanitation; 3) micronutrient intake; 4) parasite control; 5) treatment of acute malnutrition; and 6) household food security. This coordinated approach to good governance and institutional capacity building ensures more effective and coherent food and nutrition actions.

Essential conditions for scaling up nutrition actions include motivation, commitment, responsibility and moral imperative in the leadership and capacity in terms of human resources, institutional strengthening and an enabling policy and socioeconomic environment.

Functional capacities necessary to enable the sustainable development of technical capacities entail policy and action planning, coordination, implementation, knowledge sharing, financing and communication.

Capacity development builds upon existing capacities at the individual, the organization and the policy level.

REACH employs a phased approach with a view to mainstreaming REACH into regular government work and activity.

At present, REACH is supporting nutrition and food security activities in Bangladesh, Lao PDR, Mauritania, and Sierra Leone. In Sierra Leone for instance REACH is aiming to link the National Food and Nutrition Policy with the CAADP investment plan.

The approach is predicated on expert facilitation and a participative process, spearheaded by two REACH facilitators (one international and one national) who work closely with government counterparts and other stakeholders. REACH further provides a platform for joint advocacy to elevate nutrition on

national agendas and identifies clear synergies. Another important feature of REACH is that it maximizes the impact of existing investments and systematically mobilizes additional resources for scaling up.

***Global nutrition governance – United Nations Standing Committee on Nutrition (UNSCN), Lina Mahy, UNSCN***

The UNSCN was established in 1977 as a point of convergence in the area of food and nutrition ensuring that the system wide response is greater than the sum of individual efforts. The UNSCN is also an inclusive platform to support country-led action with the ultimate goal of tackling the double burden of malnutrition and reaching food and nutrition security for all.

The UNSCN is a UN entity mandated to be a point of convergence in harmonizing nutrition policies and activities and providing initiative in the development and harmonization of concepts, policies, strategies and programmes in response to nutritional needs of countries.

Senior Executives of FAO, WHO, UNICEF and WFP are currently considering how the working process of the UNSCN can be improved through its reform.

The functions of a reformed UNSCN would include the provision of a global strategic leadership and advocacy in nutrition; enhancement of dialogues and linkages; harmonization of concepts, methodologies and guidelines; promotion of exchange of practices and tools; reporting on global trends, progress and result; and engagement and facilitation of dialogue with other stakeholders across health, food security and social protection.

The Global Nutrition Forum provides a space for all key nutrition stakeholders; transparent and inclusive discussions on nutrition solutions; and proposes innovations. The next Global Nutrition Forum is planned on 4-7 October 2011 in Maputo.

The UNSCN produces regular SCN news, reports on the World Nutrition Situation, SCN Nutrition Policy papers. The website of UNSCN also provides a forum for e-groups on moderate malnutrition as well as nutrition and climate change.

The development of the SUN Road Map was also supported by the UNSCN. It provides technical and administrative support to the SUN Transition Team and its six interlinked Task Forces and facilitates access to and exchange of knowledge, practices, tools, standards and harmonized policies. Furthermore, the UNSCN catalyzes and facilitates networking, coordination and communication by linking to the Thousand Day Movement and other global processes.

***Capacity building – Anu Narayan, Deputy Regional Director- East and Southern Africa for Hellen Keller International***

Currently only little is known about knowledge, training and capacity of nutrition personnel in East and Southern Africa. Furthermore, nutrition knowledge and skills do not always trickle down to intended target groups. Overall, there is a critical shortage of nutritionists in most countries, which implies that health and agriculture workers perform the bulk of nutrition activities at health facilities and community levels.

It is estimated that globally 57 countries, have a critical shortage of health workers, of which 36 are in Africa. Studies conducted in East and Southern Africa, as well as West Africa were undertaken to estimate the number of university graduates trained annually. It was shown that there are about 480 Bachelors in the ECSA region and 280 in West Africa, which is both woefully inadequate. The estimated annual need per country is 100-500 implementers, 10-15 planners, and 1-5 policy makers.

HKI jointly with World Bank is currently conducting a Capacity Assessment of the Nutrition Workforce. It was originally planned in four countries: Kenya, Tanzania, Uganda and Zimbabwe. The study is partly co-funded in by UNICEF and FANTA-2/USAID.

The objectives of the research are to collect background information on the numbers and types of personnel working in nutrition at district, facility and community level. The workers' knowledge, training and skills to implement a minimum set of direct nutrition actions will also be assessed. The study is

further aiming to develop an understanding of additional required skills and the type of supporting systems that are needed for better performance of the nutrition workforce.

The research will include a document review, analyses of nutrition curricula, job and task analysis of mid-level workers, focus group discussion with health and agriculture workers and a workshop with key stakeholders.

The analysis of the study will be used to inform national nutrition plans and human resource strategies as countries scale up nutrition actions. The findings will further add evidence to the global discussion on core competencies that the national nutrition workforce should possess. The study will also provide recommendations on the types of cadres to be trained for community-based nutrition activities.

**Monitoring and evaluation – Chizuru Nishida, Coordinator for Nutrition Policy and Scientific Advice, Department of Nutrition, WHO**

One of the background papers for the implementation of the WHA resolution on IYCN described the framework for monitoring implementation and accounting for results and resources. This framework relates to the fifth action of the Comprehensive Implementation Plan (CIP) to monitor and evaluate the implementation of policies and programmes. This will require a well defined monitoring framework to assess progress made towards the objectives of the CIP. The framework also has to provide accountability for the actions implemented, as well as resources made available and results.

The work on monitoring evaluation as part of the CIP is used for the SUN Task Force F on “Supporting Monitoring and Reporting” of the implementation of the Scaling Up Nutrition Framework at country level.

A first draft of the framework has been prepared in August 2010 with a subset of indicators from the SUN roadmap. This has been submitted to the WHO Executive Board 128 in January 2011 and discussed and harmonized in the SUN Task Force F. The framework is now under final revisions with the Task Force.

The main criteria for core indicators were the ability to be measured in a common way across countries; ability to measure changes so to influence national policy-makers to further invest in nutrition; availability and easy collection of data; and balance of input, output/outcome and impact indicators. Data should further be possible to disaggregate to reflect equity and gender issues.

Currently seven output/outcome indicators have been defined and twelve impact indicators.

As part of the next steps, data sources for different indicators will be mapped and existing data collection systems in countries will be assessed. A mapping will also be done of potential data collection capacities. Countries and different actors will be requested to provide information and follow-up.

Periodic reports will be prepared with country profiles and baselines.

***Costing nutrition interventions with the One Health Tool – Ursula Trubswasser, Technical focal point for nutrition for Eastern and Southern Africa, WHO***

Costing analysis may be done at different levels for different purposes. For instance at health center or hospital level, cost analysis could be used to set user fees or plan facility resources. At sub-national or national level, costing might be done for a national strategy, advocacy or resource mobilization. Cost analysis tools also can have a different scope, from only a specific nutrition programme scope to an overall health sector scope. There are different questions that costing tools can address, like the resources currently used, the resources needed to make services more efficient or the resources needed for planned activities in the future.

Nutrition managers need to assess costing tools well to ensure their needs are met, since one tool cannot do everything.

In 2008, an Inter-Agency Working Group on Costing was established, consisting of WHO, UNICEF, World Bank, UNAIDS, UNFPA and UNDP) to support standardized methods and tools. The group reviewed 13 commonly used costing tools. The review showed that there are many tools with different frameworks,

terminology and software, of which few can do a health impact analysis to inform strategic planning. A technical consultation was held in 2008, where countries requested the UN agencies to harmonize tools. In response to the country request, the Inter-Agency Working group started developing the “One Health Tool”. The United Nations “One Health Model” is a new software tool designed to strengthen health system analysis, costing and financing scenarios at the country level. Its primary purpose is to assess public health investment needs in low and middle income countries. For the first time, planners have a single framework for planning, costing, impact analysis, budgeting and financing of strategies for all major diseases and health system components.

The tool is designed for use by experts involved in national health planning, including government health planners, UN agencies, non-governmental organizations, donors, researchers and consultants. It can be used to support the development of a national health strategic plan, a medium-term expenditure framework, or a needs assessment for the Millennium Development Goals.

The model takes a comprehensive approach to health systems. It incorporates planning and costing of all the health systems building blocks: human resources, facilities, equipment and transportation, medicines and supply chains, health management information systems, monitoring and evaluation, governance activities such as policy and advocacy, and activities related to financing and administration. The model can also be used for programme-specific costing. The user can set up and define a national nutrition programmes to match the country context, and then estimate the cost for a specific programme, including an analysis of the broader health system implications. The format for programme planning is streamlined so that a consistent approach is used across programmes.

A group of health planning experts (known as the Country Reference Group) in low- and middle-income countries ensures that inputs from ministries of health are incorporated into the tool. The group has been attending inter-agency working group meetings, participating in technical discussions and engaging in the tool design and planning for its roll-out.

The tool will be made public in mid-2011, following pilot testing in selected countries. Mechanisms for training, such as web-based courses, are currently being explored.

***e-Library of Evidence for Nutrition Actions (eLENA) and Global Information System on Implementation of Nutrition Actions and Policies (GISNAP) - Chizuru Nishida, Coordinator for Nutrition Policy and Scientific Advice, Department of Nutrition, WHO***

The Department of Nutrition for Health and Development (NHD) in collaboration with internal and external partners initiated the development of an electronic Library of Evidence for Nutrition Actions (eLENA) in 2009. eLENA is being designed as an on-line web portal that will contain the most current and relevant information related to nutrition actions interventions across a broad spectrum of topics. The aim of eLENA is to guide Member States and partners to develop and implement effective policies and intervention programmes to scale up nutrition. eLENA will compile and centralize this information to facilitate the adoption and adaptation of evidence-informed guidelines so that safe and effective interventions can be scaled up globally. It will further be a single point of reference for the latest WHO nutrition guidelines and recommendations and related information.

A single intervention title within eLENA will contain the biological, behavioural and contextual rationales for the nutrition action, along with current evidence, existing guidelines, and other resources that are available on the subject. eLENA will also be used as a forum to share commentaries, or expert opinion on each of the nutrition actions.

An email campaign aimed at potential users will take place between June and August 2011 to raise awareness and promote its use. The expected launch is the 10 August 2011 with an initial forty titles that will continue to be added to throughout the coming years.

GISNAP, the global information system is building on existing work in WHO to monitor nutrition policy and action since the 1992 ICN. It is being designed as an online interactive database of nutrition action and policies. The launch of GISNAP is planned for 2012. The information on actions will be fed by interested parties, i.e. UN, NGOs, governments, research and interest groups using an online template.

Policy data will initially come from the recent Global Nutrition Policy Review and the existing WHO Global Database on National Nutrition Policies and Programmes, though additional policy documents can be added through a similar online template.

The information system will assist in monitoring the implementation of nutrition policies in countries and could therefore constitute an important tool for accountability. It could also serve a range of specific tasks such as monitoring the implementation of the SUN-actions as well as many other nutrition-related actions which are recommended by WHO.

GISNAP will include policy factsheets, action fact sheets, country policy and action data and interactive, multilayer maps.

eLENA and GISNAP will be interconnected also with the Nutrition Landscape Information System (NLIS) NLIS bring together all existing WHO Global Nutrition Databases dynamically, as well as other existing food and nutrition-related data from partner agencies, like UNICEF, UN Statistics Division, UNDP, FAO, DHS, the World Bank, the International Food Policy Research Institute and the International Labour Organization. NLIS is online accessible through the following link:

<http://www.who.int/nutrition/nlis/en/index.html>

### **Discussion on implementation mechanisms and tools**

During the discussion it was stressed that at community level there are often no nutritionists. It will be important to define at which level we need nutritionists and what profiles and nutrition skills are needed at different levels. A lot of focus has been put on university degrees in nutrition, but university graduates will be overqualified for implementation. There might be a need to advocate for mid-level nutrition staff.

Ghana for instance has technical nutrition officers that are not graduates, but have done a three-year course. It will not be feasible to have “nutritionists” on all levels up to the community level. WHO is currently working on a paper defining the competencies needed at different levels.

Countries also raised a concern about the numerous *global and regional initiatives*, which all create an extra burden to countries, needing to create different mechanisms and reporting systems for different initiatives. It was highlighted that countries need to be in the driving seat, deciding what could work for them and pick components of different initiatives for their country setting.

With regard to the WHO tool to develop *country scale up plans*, countries expressed interest in learning from countries which have gone through the first steps of this approach and have conducted the Landscape Analysis Country Assessment. The methodology of developing scale up plans has been developed in line with SUN, but it was also emphasized that SUN is a movement, which will be able to assist countries once country scale up plans are in place.

The importance of *civil societies* in accountability was also stressed. Consumer groups can play a strong role in driving government policies and in ensuring a balance in involving the private sector. Experiences from NGOs can be very valuable and it would be crucial to share these good practices experience. Countries also raised the concern that some NGOs are implementing programmes without building local capacity and ensuring sustainability or addressing actual country needs. It was also mentioned that guidelines of NGOs do not always reflect government guidelines.

With regard to costing tools for nutrition, it was stressed that it will be crucial to have one comprehensive tool for all interventions and levels. The advantage of using costing tools was emphasized in order to have transparency of funds and costed activities, which might help raise donors' interest in national nutrition plans.

It was suggested that indicators 19, 20 and 21 in the *indicator table* are composite indicators, which are affected by many factors and could be omitted from the list.

Indicator 3 was considered as too vague. Instead of only saying “adoption”, the indicator should indicate the existence of a law. In the definition of the indicator, the code documentation center should be indicated as a source. With regard to indicators 12-14 on nutritional status, it was stressed that underweight has been left out and since it is part of the MDGs, it would be important to ensure consistency. The monitoring framework should specify the frequency of reporting on the indicators. It was also stressed that an indicator on overweight/obesity should be included in the list of indicators.

## Conclusions

The discussions of the meeting were very fruitful and promising activities had been proposed. The meeting was an opportunity to stock take on the current state of implementation of policies and programmes in nutrition, to present and discuss the outline of the Comprehensive Implementation Plan on maternal, infant and young child nutrition to be discussed at the 64<sup>th</sup> World Health Assembly in May 2011, at a time of increased interest and political commitment to nutrition as also documented by the success of the Scaling Up Nutrition movement. The meeting also allowed to establish a dialogue on nutrition policies and programmes involving the health and agricultural sectors, in preparation for the proposed International Conference on Nutrition 20 years since the first ICN was held in 1992 (ICN+20).

Countries reported challenges as well as achievements and successes:

- Multisectoral policies and strategies exist, but nutrition is not always mainstreamed in development plans; while nutrition policies, strategies and plans of action have been developed in many countries there is seldom adequate investment for their implementation
- While a number of countries have made little or no progress in achieving the MDG 1 for reducing poverty, hunger and malnutrition, others have had significant success
- Key factors for success include high level political commitment, public awareness, good coordination between actors and the presence of high level multisectoral coordination mechanisms
- Some successes have been documented in promoting breastfeeding rates, in addressing severe acute malnutrition and in improving coverage of micronutrient interventions
- Challenges include insufficient capacity of decentralised cadres who provide services to implement all the nutrition interventions at scale, the need to have a harmonized intervention package, and the sustainability of financial resources

On the development and implementation of scale up plans, participants highlighted:

- The need for comprehensive country scale up plans for the different interventions
- The need of adequate costing tools for development of policies and programmes
- The need for harmonized and agreed indicators

The linkages between food security, agriculture, nutrition and health were articulated and FAO was asked to continue to provide its assistance to countries in the implementation of nutrition-sensitive food and agriculture-based approaches for improving nutrition for all, including for mothers, infants and young children, at policy, strategy and programme level, as these were acknowledged as being effective, viable and sustainable long-term solutions for improving diets and raising levels of nutrition.

Next steps:

- WHO will use to the inputs from countries to further develop the Comprehensive Implementation Plan, which will be presented at the next WHA
- FAO and WHO will jointly work with countries on further developing their country nutrition papers and on preparations for the ICN+20

## **Closure of the meeting**

In the closing remarks, FAO, USAID, UNICEF, WFP and WHO stressed the importance of this meeting and the need to further work on scaling up nutrition in the African Region. The joint nature of the meeting with health and agriculture representatives was highlighted as a major achievement. Concerns of countries have been raised and the regional agencies will assist countries in finding the right way to different nutrition initiatives. It was suggested that for future meetings, the link to CAADP as well as food safety should be made more strongly. The organizers expressed warm thanks to the Zimbabwean Government for hosting the meeting and to the participants for their valuable contributions.

# Annex 1 - Programme

## Scaling up Nutrition in the African Region

A consultation in response to the World Health Assembly Resolution (WHA 63.23)

### 3-5 May 2011, Harare, Zimbabwe

**Tuesday, 3 May 2011**

**Chair:** Patience Mensah, WHO

**8.30 – 9.30 Introduction and Objectives.**

Welcome address: WHO (WR) and FAO (Subregional office)

Key note address WHO (IST / ESA)

Opening address: MoH Zimbabwe

Introduction and objectives of the meeting

Administrative briefing

**Objective of day 1: To present country progress, needs and commitments to scale up nutrition**

**9.30 – 10.30 Global and regional nutrition situation and policy responses**

Global nutrition situation: burden and policy response – WHO, Francesco Branca

Nutrition challenges in the African Region – WHO, Charles Sagoe-Moses

SUN Framework – global initiative to scale up nutrition interventions – David Nabarro

Multisectoral policy responses: roadmap to a International Conference of Nutrition – twenty years later (ICN+20) - FAO, Brian Thompson

Donors perspectives on scaling up - Dfid, Jenny Amery

**10.30 -11.00 Discussion**

11.00 -11.15 Coffee/Tea break

**11.15 – 13.00 Country presentations and discussion (two separate groups)**

**Group 1:** Botswana, Djibouti, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mozambique, (Chair: Ghana, Rapporteur: Luca Passerini)

**Group 2:** Namibia, Nigeria, Rwanda, Sierra Leone, Tanzania, Uganda, South Africa, Sudan, Zambia, Zimbabwe (Chair: Zimbabwe, Rapporteur: Ferima Coulibaly-Zerbo)

13.00 – 14.00 Lunch

14.00 – 15.00 **Country presentations and discussion (follows from previous session)**

15.00 – 15.30 Coffee/Tea break

15.30 – 16.00 **Summary of country presentations and discussions.**

16.00 – 17.30 **Plenary discussion on cross cutting issues: policy development and challenges of scaling up**

Facilitators: Francesco Branca, WHO and Brian Thompson, FAO

### **Wednesday, 4 May 2011**

**Objective of day 2: To collect country contributions and perspectives on the comprehensive implementation plan**

**Chair:** South Africa

8.30 – 10.30 Nutrition actions of ECSA – Dorothy Namuchimba

**Effective interventions in the health sector.**

Overview of the comprehensive implementation plan–WHO, Francesco Branca

1. Behavioral interventions
2. Malnutrition
3. Targeted nutritional support
4. Other health interventions
5. NCD

10.30 -11.00: Coffee/Tea break

11.00 - 13.00 **Country success stories**

1. Breastfeeding/infant and young child feeding- Ghana
2. Micronutrient supplementation and salt iodization - Tanzania
3. Flour fortification – Uganda
4. Malnutrition: Integrated community programmes – Malawi and Nigeria

**Discussion**

13.00 – 14.00 Lunch

**Chair:** Zambia

14.00 – 15.00 **Effective interventions and country success stories in agriculture and other non-health sectors**

1. Nutrition-sensitive food and agriculture-based approaches – FAO, Leslie Amoroso
2. Education Trials of Improved Practices (TIPs) for complementary feeding – FAO, Charity Diroimwe
3. Community programmes linking nutrition and food security – Evidence based interventions in FAO projects in Lesotho and Malawi – FAO, Brian Thompson

15.00 – 15.30 Coffee/Tea break

15.30 – 17.30 **Group works**

5 working groups:

1. Behavioural interventions and education
2. Malnutrition, targeted interventions and other health interventions
3. Micronutrient interventions
4. Nutrition-sensitive food and agriculture-based approaches
5. Social protection

19.00 **Cocktail**

**Thursday, 5 May 2011**

**Chair:** Tanzania

**Objective of day 3: To explore the commitment to supporting implementation of proposed actions.**

8.30 – 10.00 **Report back from working groups (5)**

10.00 – 10.30 Coffee/Tea break

10.30 – 12.30 **Implementation**

1. Role of civil society - MSF, Nathalie Ernoult
2. Country process: Policy briefs for Country Scale up plans – WHO, Chizuru Nishida
3. REACH –joint approach to ending child hunger – WHO, Ferima Coulibaly-Zerbo
4. Global nutrition governance - SCN, Lina Mahy
5. Capacity building –HKL, Anu Narayan

12.30 – 13.30 Lunch

**Chair:** Botswana

13.30 -15.00 **Implementation tools**

1. Monitoring and evaluation – WHO, Chizuru Nishida
2. Costing nutrition interventions with the One Health Tool – WHO, Ursula Trubswasser
3. eLENA, GISNA - WHO, Chizuru Nishida

15.00 - 15.30 **Closing ceremony**

WHO and FAO

## Annex 2 - Participants

Country	Name	Title	Organization	Address	Telephone/ Mobile	Email
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<sup>1</sup> WHO. World Health Statistics 2010.

<sup>2</sup> Kimani-Murage et al, The prevalence of stunting, overweight and obesity, and metabolic disease risk in rural South African children, BMC Public Health, 2010, 10: 158.

<sup>3</sup> Globalization of food systems in developing countries: impact on food security and nutrition, FAO, 2004.

<sup>4</sup> Global Nutrition Policy Review, WHO, 2010.