

**Burundi and Myanmar:  
Mapping multi-sector actions**

**Championing  
nutrition in Gabon**

**Emergency nutrition preparedness  
in Latin America and the Caribbean**

# NUTRITION EXCHANGE

ENN



**Rajasthan's new  
partnership for  
community health**

**A second national nutrition  
plan for Bangladesh**

**Programming at district  
level in Balochistan**

10<sup>th</sup>  
ISSUE

English

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**Front cover:** Bangladesh; WFP/Saikat Mojumder

**Back cover:** India; WFP/James Giambrone



HKI Niger

## What is Nutrition Exchange?

*Nutrition Exchange* is an ENN publication that contains short, easy-to-read articles on nutrition programme experiences and learning from countries with a high burden of malnutrition and those that are prone to crisis. Articles written by national actors are prioritised for publication. It also provides information on guidance, tools and upcoming trainings. NEX is available in English, French, Arabic and Spanish.

## How often is it produced?

*Nutrition Exchange* is a free, bi-annual publication available in hard copy in English and French, and electronically in English, French, Arabic and Spanish.

## How to subscribe or submit an article

To subscribe to *Nutrition Exchange*, visit <http://www.ennonline.net/nex>

Many people underestimate the value of their individual experiences and how sharing them can benefit others working in similar situations. ENN aims to broaden the range of individuals, agencies and governments that contribute material for publication in *Nutrition Exchange*.

Often the articles you see in *Nutrition Exchange* begin as a few bullet points that authors share with us. The editorial team will help support you in writing up your ideas into an article for publication.

To get started, just email Carmel and Judith ([carmel@ennonline.net](mailto:carmel@ennonline.net) and [Judith.Hodge@ennonline.net](mailto:Judith.Hodge@ennonline.net)) with your ideas. We are now looking for articles for NEX Issue 11 so please be in touch.

This edition of *Nutrition Exchange* was funded by UK aid from the UK Government and Irish Aid. The ideas, opinions and comments therein are entirely the responsibility of its author(s) and do not necessarily represent or reflect UK Government or Irish Aid policy.



# Editorial

We're proud to introduce this tenth issue of *Nutrition Exchange*! The publication has grown from a digested version of *Field Exchange*, first published in 2011, to a fully-fledged publication in its own right, designed to meet the needs of national and sub-national actors for easy-to-access information on nutrition programming. NEX has gone from strength to strength and now showcases original articles by government staff, development and humanitarian partners working across sectors to address malnutrition.

In 2016 the publication became biannual and available in four languages (English, French, Arabic and Spanish) and also included a focus on capturing experiences from SUN Movement countries. We believe this resource is helping national actors to understand more about nutrition, why it is important and how they and their peers in other countries are making progress to address malnutrition, while facing and overcoming unique implementation challenges.

Articles in this issue cover a wide breadth and depth of such experiences. But a general theme that emerges is of the progress that can be achieved when forces combine to work for common nutrition goals. Multi-sectorality is often reported on at national level; but a story from **Rajasthan** in India illustrates how steps to achieve effective coordination can often lie in actions sub-nationally. The article describes how a successful 'tripartite' partnership was formed between three different groups of health and nutrition workers to coordinate their efforts towards a common goal – that of detecting and treating child undernutrition. In **Somalia's** Gedo province, where there is an absence of government structures, community members are trained for a similar role in a community-based surveillance system that leads to identifying programme improvements. In **Balochistan**, Pakistan's poorest province, a local NGO steps in to implement a provincial-level nutrition programme for those districts left without coverage.

Sometimes, emergencies are a catalyst for creative thinking around nutrition interventions. In post-earthquake **Nepal**, government and UN agencies have collaborated on the use of hospitals in urban settings, an under-utilised platform for nutrition interventions. In **Latin America and the Caribbean region**, countries are also facing increasing frequency of natural disasters: a new platform provides guidance and support for nutrition preparedness to be included in national nutrition plans.

Bangladesh's national plan has been praised for its inclusion of nutrition-specific and nutrition-sensitive interventions in

the country's second National Plan of Action, requiring a range of sectors to work together. In **Gabon**, an agriculture minister and nutrition champion did much to catalyse the country's multi-sector platform and prepare its national plan. Mapping tools can help actors from different sectors see the wider nutrition picture: that was certainly the experience of those stakeholders who came together to map nutrition interventions in **Burkina Faso** and **Myanmar**.

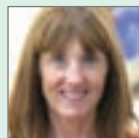
The **Eastern Mediterranean** region contains a wide diversity of countries and states, most often in the news for ongoing conflicts. An article in this issue focuses on the measures being taken by countries in the region to tackle overweight and obesity. Finally, an article from the **West Africa** region reports on collaborations with local producers to deliver fortified, blended food products – ensuring they are part of the solution for combatting the double burden of malnutrition.

Through active support to authors in the writing process, NEX provides a unique opportunity for those working on the ground to share their stories and lessons learnt with a wider audience. Thanks to all NEX readers and authors for the last ten issues – it's been our privilege to work with you and on your behalf. And we look forward to working with more national and sub-national actors and to sharing this resource as widely as possible through the next ten issues of *Nutrition Exchange*.

Happy reading,

Carmel Dolan, Co-editor, NEX ([carmel@enonline.net](mailto:carmel@enonline.net))

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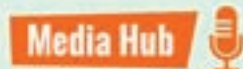


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Listen to an interview with the editors on the ENN podcast channel:

[www.enonline.net/mediahub/podcast/nex10editorial?version=current](http://www.enonline.net/mediahub/podcast/nex10editorial?version=current)

## About ENN

ENN enables nutrition networking and learning to build the evidence base for nutrition programming.

Our focus is on communities in crisis and where undernutrition is a chronic problem.

Our work is guided by what practitioners need to work effectively.

- We capture and exchange experiences of practitioners through our publications and online forum en-net.
- We undertake research and reviews where evidence is weak.
- We broker technical discussion where agreement is lacking.
- We support global-level leadership and stewardship in nutrition.

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# Improving adolescent nutrition

There is growing recognition that addressing the nutritional needs of teenagers (ages 10-19 years) brings triple dividends: better health for adolescents now, for their future adult life and for their children. Often referred to as the ‘additional window of opportunity’ for growth and development, the second



decade of life is a time of rapid physical, cognitive and social transformation. New guidelines from the World Health Organization (WHO) set out the potential of healthy eating practices during adolescence to limit nutrient deficits and growth faltering from the first decade of life and harmful behaviours that contribute to diet-related, non-communicable diseases in adulthood.

The publication highlights evidence-based actions to address malnutrition during adolescence to support country implementation. Creating optimal nutrition among teenagers – as with other groups – requires coordinated actions involving multiple sectors; the guidance is intended for use by a range of stakeholders in many sectors. Recommended interventions include providing micronutrients through fortification and targeted supplementation; managing acute malnutrition in adolescents; and preventing adolescent pregnancy/promoting antenatal nutrition.

[www.who.int/nutrition/publications/guidelines/effective-actions-improving-adolescent/en/](http://www.who.int/nutrition/publications/guidelines/effective-actions-improving-adolescent/en/)



Adolescents in a school feeding programme in Phnom Penh, Cambodia

WFP/Heather Hill

## The ‘urban agenda’ – Meeting the food and nutrition security needs of the urban poor

The combined global impact of conflicts, climate change and food security has led to a large increase in people migrating to cities to seek safety and services. It is estimated that 66 per cent of the world’s population will live in urban areas by 2050, an increase from 54 per cent in 2014, putting significant pressure on food systems.

This paper by Dutch non-profit organisation SNV explores current understanding of food and nutrition security challenges faced by the urban poor, drawing on evidence from Africa, Latin America and Asia. Data from Kenya, Ecuador, Brazil, Haiti and the Philippines show higher infant and neonatal mortality in slums when compared to rural areas.

According to a study published in *The Lancet*, children are especially vulnerable in slums because of low breastfeeding rates and poor sanitation, which predispose them to chronic diarrhoea and stunting. Poor urban households face constraints related to access to food, health and public services, made worse by poor sanitation and limited income. The report proposes four closely-related pillars for an ‘urban agenda’ to improve the health and wellbeing of those living in cities:

- *Governance* – city planners should consider informal settlements as part of the permanent urban landscape and nutrition coordination committees could be replicated in an urban context;
- *The food environment* – authorities should address the food needs of the urban consumer and seller alike, taking into account the cost of safe and nutritious food and health and safety risks from poor sanitation and lack of cooking facilities; and
- *Social and behaviour change* – poor urban residents must be supported to make healthy food choices, within the constraints of their budgets, and working conditions must be improved for informal vendors, particularly women, with consideration to their role as caregivers and mothers.

For more information, visit [www.snv.org/public/cms/sites/default/files/explore/download/paper\\_-\\_the\\_urban\\_agenda\\_0.pdf](http://www.snv.org/public/cms/sites/default/files/explore/download/paper_-_the_urban_agenda_0.pdf)



A group discussion with informal food market vendors, Khulna, Bangladesh

WHO

<sup>1</sup> Ezeh, A. et al. 2016. The history, geography, and sociology of slums and the health problems of people who live in slums. *The Lancet*, 10068: 547-558.



Ubirajara Machado

# Schools as a system to improve nutrition

Children in low-income populations may start school already stunted and/or suffering from micronutrient deficiencies or (increasingly) affected by excessive weight. School-based measures can help prevent and manage all forms of malnutrition while improving education outcomes. A discussion paper from the UN Standing Committee on Nutrition (UNSCN) shows that schools offer a unique opportunity to improve nutrition using a multi-sector approach. Providing school meals is the most widely known, school-based food and nutrition intervention, but schools offer other opportunities to improve nutrition, such as promoting handwashing with soap before meals, deworming treatments, nutrition education, agricultural diversification, improved water and sanitation facilities and micronutrient supplementation.

The influence of schools can extend beyond the pupils themselves, with the involvement of teachers, parents and other community members in capacity-building on healthy diets and education. Interventions can catalyse community development, including influencing agricultural production systems to deliver diverse and nutritious foods (through farmer production), promote lifelong healthy-eating habits, and tackle basic health, hygiene and sanitation issues. By providing a better health and living environment in their own right, schools have the potential not only to support education, but also to underpin mainstream nutrition activities in communities.

For more information, visit [www.unscn.org/uploads/web/news/document/School-Paper-EN-WEB-nov2017.pdf](http://www.unscn.org/uploads/web/news/document/School-Paper-EN-WEB-nov2017.pdf)

## Mapping NCD alliances

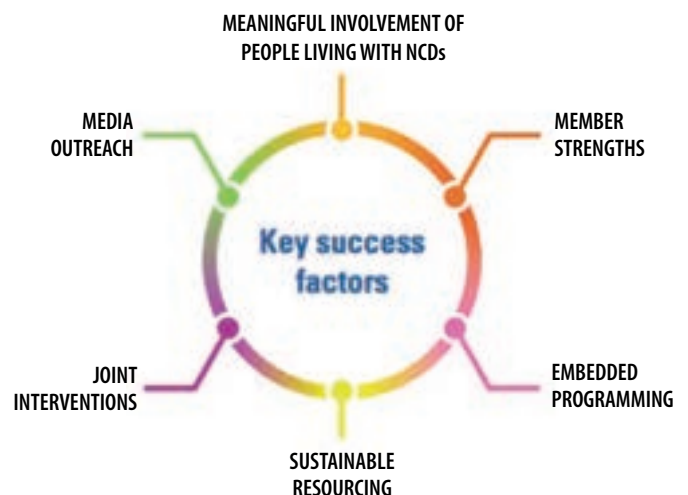
Non-communicable diseases (NCDs) – which include cancer, diabetes, chronic obstructive pulmonary disease, cardiovascular disease and mental health conditions – are the leading cause of death worldwide and affect developing countries disproportionately. Since the start of the decade, NCDs have been elevated onto national and global health and development agendas through a series of political commitments, including the WHO 2025 Global NCD Targets and Action Plan (2013-2020). They were also included in the 2030 Sustainable Development Goals (SDGs). However, progress in NCD prevention and control has been slow and NCDs are often under-represented in the national health plans of developing countries. For example, NCDs cause 30 times more deaths but receive 17 times less funding than HIV/Aids.

The *NCD Alliance Atlas* shares 38 case studies of good practice to act as an advocacy tool to promote action on all NCDs, including addressing diet-related NCDs. Lessons from other global health and development movements, notably HIV/Aids, have demonstrated the importance of strong civil society organisations (CSOs) and community-based efforts in accelerating action. The Atlas provides a snapshot of the current state of global NCD CSO alliances. Success stories on nutrition-related NCDs include:

- **South Africa's** efforts in an advocacy agenda to support a tax on sugar-sweetened beverages;

- **Zanzibar's** collaboration to improve healthy eating opportunities via greater involvement of district-level policymakers in NCD discussions and media campaigns to promote awareness; and
- **Bangladesh's** focus on expanding access to nutritious food and health services, including accessible food package labelling and branding local community shops as health shops, among urban communities.

For more information, visit <https://tinyurl.com/ybbcusr>



# Nutrition financing – a paradigm shift?

The World Bank's *Investment Framework for Nutrition*, launched in 2017, was the first initiative to put a 'price tag' on nutrition, stipulating that a spend of a further US\$7 billion (on top of current spending) is needed by 2025 to achieve the World Health Assembly targets on stunting, wasting, anaemia and exclusive breastfeeding through nutrition-specific interventions. The World Bank confirms that the framework has brought forth new financiers and domestic governments have risen to the challenge – although investment still falls short of the recommended target.

New calculations from Save the Children conclude that a further US\$23 billion is needed each year to achieve Sustainable Development Goal (SDG) 2 to achieve zero hunger by 2030 – three times more than the World Bank estimate. Realising this financial target would be to recognise "a paradigm shift in nutrition financing" since it includes funding multi-sector programmes.

The *Nutrition Boost* position paper suggests addressing the funding gap by: mobilising domestic resources through

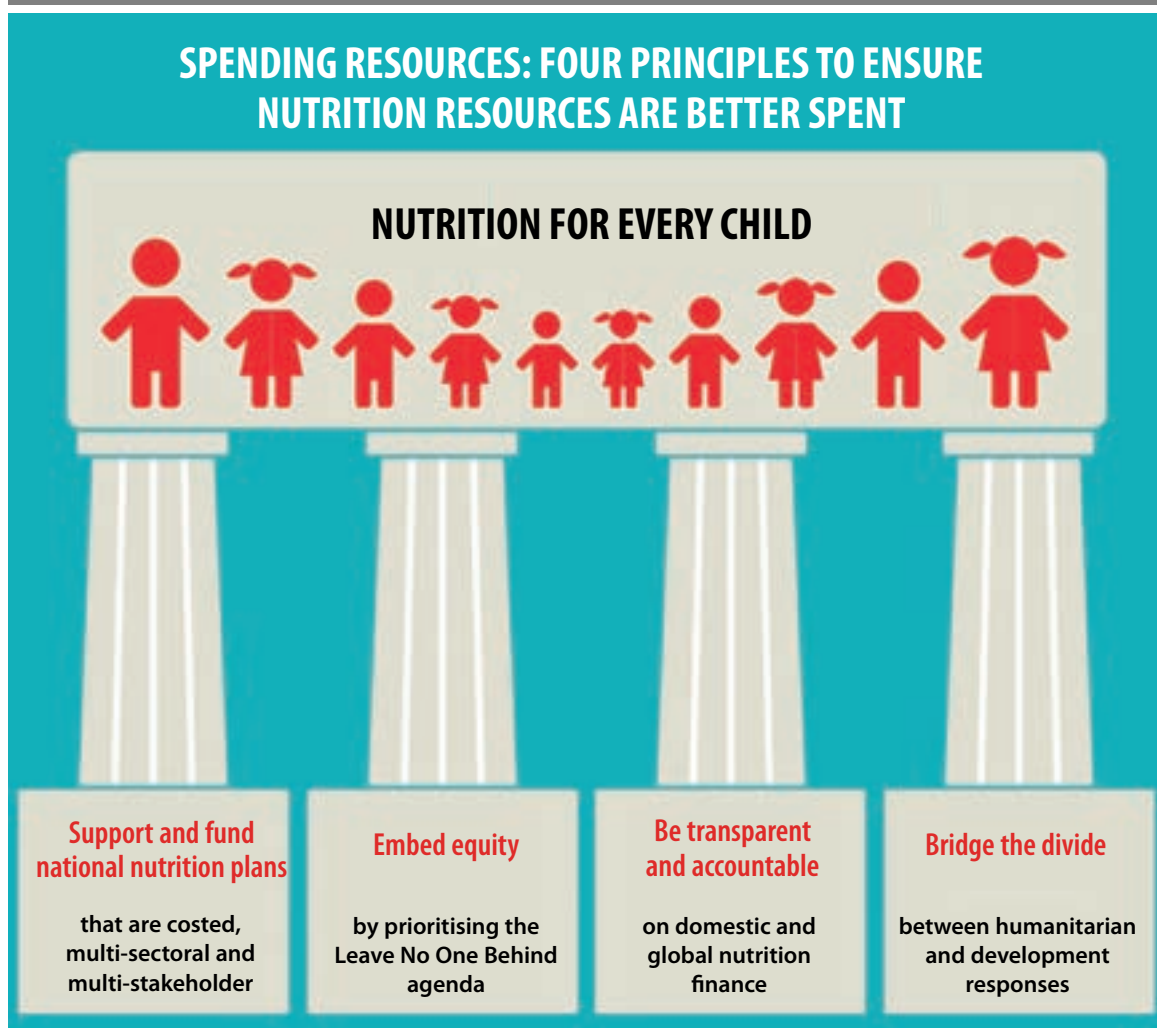
progressive tax reform; scaling up innovative financing mechanisms such as the Global Financing Facility and Power of Nutrition; and improving official development assistance so that it focuses on the most excluded and catalyses domestic resources.

But no matter how much finance is available, four pillars are key (see Figure 1):

- **Supporting and funding national nutrition plans** – the key to country-driven change, providing costs on a country level and identifying funding gaps across the range of nutrition interventions;
- **Equity** – Leave No One Behind;
- **Transparency and accountability** – of all nutrition financing, both domestically and globally; and
- **Bridging the humanitarian-development divide** – investment in shock responsive development work with post-humanitarian response funding to protect developmental gains.

For more information, visit [www.savethechildren.org.uk/](http://www.savethechildren.org.uk/)

Figure 1





## What's new at ENN?

### Nutrition Exchange hits double issue figures!

NEX has come a long way since it started life as a digested version of *Field Exchange* in 2011. The first issues of NEX (known then as *FEX Digest*) focused on translating the more technical content of FEX for the benefit of national and sub-national readers who may not be technical nutritionists but still have a key role to play in addressing malnutrition in their country. This quickly evolved into its own publication, showcasing original articles from national and sub-national actors and adopting its new name.

Since then, NEX has evolved into a biannual publication available in four main languages, Arabic, French, Spanish and English. In just seven years, its readership has grown substantially and it is now sent to 98 countries. NEX has become a key publication written by and for national actors. It helps to capture lessons learnt from all sectors involved in fighting malnutrition in countries across Asia, Africa, Latin America, the Caribbean and the Middle East. It also plays a key role in capturing learning across SUN Movement as part of ENN's Knowledge Management work under the DFID funded TAN Project and enjoys the generous support of the UNICEF regional offices for the Arabic and Spanish translations.



### Wasting prevention

'Adopting a Strategic, Evidence-based Approach to Wasting Prevention' is a multi-phase scope of work by ENN commissioned by the Department for International Development (DFID) through the Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+) programme. The first phase has provided a summary of the aetiology of wasting (see

[www.enonline.net/attachments/2796/030B\\_Aetiology-of-wasting\\_FINAL\\_9May2018.pdf](http://www.enonline.net/attachments/2796/030B_Aetiology-of-wasting_FINAL_9May2018.pdf)) and a literature review of the evidence of what works to prevent wasting. Interviews with the key actors involved in this area will shortly be available on our website.



### Wasting and stunting

ENN continues to coordinate the Wasting-Stunting (WaSt) Technical Interest Group (TIG) – (see [www.enonline.net/ourwork/reviews/wastingstunting](http://www.enonline.net/ourwork/reviews/wastingstunting)). In January 2018, the TIG met in Oxford to discuss the work undertaken in the previous two years and to plan the next phase of work. A short briefing note on WaSt for policy

makers and programme implementors has been published by ENN on behalf of the WaSt TIG in June 2018. It is available now in English, with a forthcoming French version. [www.enonline.net/resources/timetoovercometheseparation](http://www.enonline.net/resources/timetoovercometheseparation).

### Management of At-risk Mothers and Infants (MAMI) meeting

A one-day meeting of the MAMI<sup>1</sup> Special Interest Group (SIG) took place in London in early 2018. The meeting was hosted by ENN in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM) and Save the Children and funded by ENN (with Irish Aid funding) and Save the Children. The meeting aimed to identify synergies, opportunities, priorities and next steps to help develop the evidence base on MAMI, building on a previous meeting ([www.enonline.net/mamimeetingreport](http://www.enonline.net/mamimeetingreport)) and informed by the proceedings of a one-day meeting with the ENN-led Wasting & Stunting Technical Interest Group (WaSt TIG). Presentations on priority areas worked on since 2016 led into four working groups on (1) anthropometric indicators for the identification of nutritionally vulnerable infants, (2) gaps in MAMI programming, (3) questions, interventions and outcomes to assess MAMI and (4) recommendations on non-feeding interventions for this age group.

Next steps were identified, themed around the further examination of existing datasets to provide more evidence; next steps for the community-based management of at-risk mothers and infants (C-MAMI) tool<sup>2</sup>; advocacy; and opportunities for joint analysis with the WaSt TIG. The full meeting report can be downloaded here:

[www.enonline.net/mamimeetingreport2018](http://www.enonline.net/mamimeetingreport2018)

The meeting report for the MAMI-WaSt meeting can be found here: [www.enonline.net/mamiwastmeetingjanuary2018](http://www.enonline.net/mamiwastmeetingjanuary2018)

### Multi-sector programmes

ENN's final synthesis report on multi-sector nutrition programmes (MSPs) at sub-national level in Kenya, Senegal and Nepal documents how these MSPs are operating on the ground. This provides important evidence for policymakers and practitioners on how such nutrition-sensitive programmes are being operationalised and interacting with existing institutions. The case studies look at both government-led implementation (Nepal) and where government acted in a support role (Kenya and Senegal). See [www.enonline.net/exploringmsspsubnationallevel](http://www.enonline.net/exploringmsspsubnationallevel) There is a new discussion theme on en-net in support of this work, dedicated to information-sharing on all aspects of multi-sector nutrition programming. See [www.en-net.org/forum/28.aspx](http://www.en-net.org/forum/28.aspx)



<sup>1</sup> Formerly "management of acute malnutrition in infants under 6 months", the term "MAMI" has been updated to reflect evolution in thinking and scope of the initiative.

<sup>2</sup> [www.enonline.net/c-mami](http://www.enonline.net/c-mami). Version 2 is now available.

**Humanitarian-development nexus**

ENN, with funding from DFID and Irish Aid, is carrying out a series of country studies on nutrition-specific and nutrition-sensitive programming in chronic and acute emergency contexts to determine the extent to which humanitarian and development nutrition-relevant programming is linked. These linkages are often referred to as the humanitarian and development nexus (HDN). At a global level, the impetus for focusing on HDN has arisen through the realisation that an increasing proportion of humanitarian aid is administered in contexts where emergencies are the norm. This means that humanitarian programming continues unabated, with little effort to build resilience and longer-term systems. One of the key recommendations emerging from the 2016 World

Humanitarian Summit was the need to strengthen HDN and there is now a great deal of activity at global and national level to devise policy and programming frameworks to achieve this goal. ENN aims to examine this nexus in a number of contexts using a nutrition-programming lens. The aim of the work will be to determine how HDN is playing out on the ground and where there may be further opportunities for strengthening programmatic linkages for nutrition.

Findings from the first country case study in Kenya are found in an article in Field Exchange 57 (see [www.ennonline.net/fex/57/nexusnutpolicykenya](http://www.ennonline.net/fex/57/nexusnutpolicykenya)). Further case studies include Somalia (expected by October 2018), South Sudan and northern Nigeria. A steering advisory group comprising, donors, UN agencies and INGOs is helping ENN frame the work and contributing to the analysis.

# Emerging face of malnutrition

**N**ew figures from the inter-agency team (UNICEF, WHO and the World Bank Group) on malnutrition show that stunting prevalence in children under five (CU5) has decreased by 5 million since 2016. However, 151 million children were still

affected around the world in 2017. At least one in every four CU5 are stunted in seven sub-regions, although Africa is the only region where the number of stunted children has risen.

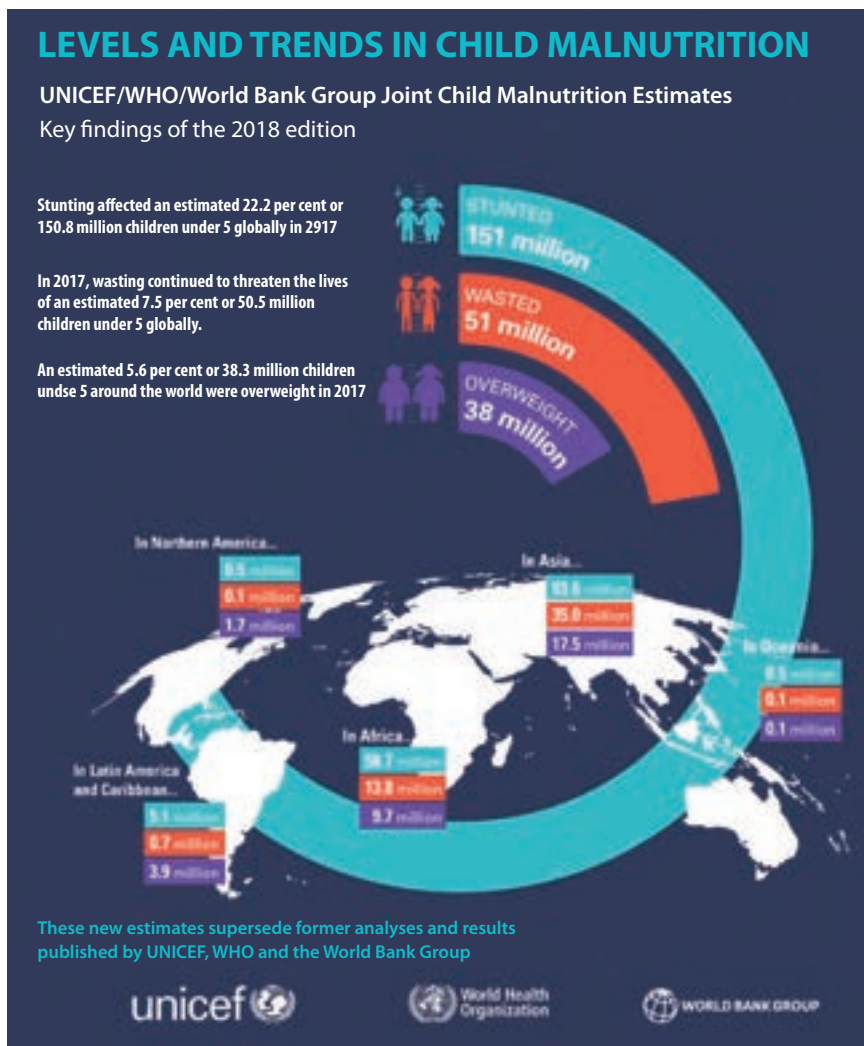
Wasting levels have increased by one million since 2016; 51 million CU5 were wasted and 16 million were severely wasted in 2017. In Southern Asia, 15.3 per cent of children are wasted, constituting a critical public health emergency (global prevalence is 7.5 per cent).

Child overweight and obesity stands at nearly 38 million globally. The new estimates confirm that there has been no progress to stem the rise in overweight for 15 years. Prevention for all forms of malnutrition is the same: adequate maternal nutrition, optimal infant and young child feeding, a healthy environment (including access to health services and clean water and sanitation) and physical activity.

Although children are known to suffer from more than one form of malnutrition, such as stunting and overweight or stunting and wasting, these combined conditions (known as 'concurrency') are not yet available in joint global or regional estimates.

The latest joint estimates show that stunting, wasting and overweight/obesity rates are declining too slowly to meet either World Health Assembly (WHA) targets for 2025 or the 2030 Sustainable Development Goals.

To find out more, visit [www.who.int/nutgrowthdb/2018-jme-brochure.pdf?ua=1](http://www.who.int/nutgrowthdb/2018-jme-brochure.pdf?ua=1)





# Mapping multi-sector actions in Burundi and Myanmar: Towards more effective coordination



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**Dr Sansan Myint** is the national REACH<sup>1</sup> facilitator in Myanmar.

## Background

Multi-stakeholder mapping is intended to provide an overview of actions being implemented to address malnutrition. The mapping exercise aims to identify who is doing what, where and how to provide a comprehensive picture of interventions in terms of geographic and population coverage. Such information places national governments in a better position to lead data-driven, multi-sector, multi-stakeholder discussions to accelerate progress towards national nutrition targets.

REACH (Renewed Efforts against Child Hunger and Undernutrition)<sup>1</sup> has been working since 2008 to use effective tools, such as the *Stakeholder and Nutrition Action Mapping Tool*<sup>2</sup>, to support a range of actors across multiple sectors to engage with nutrition. In 2017 the tool was put into a web platform, making it more compatible with information systems such as District Health Information Systems (DHIS, Version 2). To date, the mapping exercise has been conducted in 15 countries and is currently underway in a further six.

This article describes the use of this tool in two very different contexts: Burundi in East Africa and Myanmar in south-east Asia.

## Burundi

Burundi is a small, landlocked country in East Africa with just over 10.5 million inhabitants. It has high levels of malnutrition, including stunting prevalence of 58 per cent

and wasting prevalence of 6 per cent<sup>3</sup> in children under five years of age (CU5).

The Government of Burundi (GoB), through its SUN Secretariat managed by the SUN Focal Point, expressed interest in conducting the mapping exercise to gain a better understanding of the country's nutrition landscape. Launched in January 2018 with the support of the UN Network Secretariat, the multi-sector mapping is enabling the GoB to gather valuable coverage data, by stakeholder and programme coverage.



A child being weighed at a clinic in Burundi

WFP/Hugh Rutherford

<sup>1</sup> REACH is a country support mechanism under the UN Network, which plays a catalytic role in the Scaling Up Nutrition (SUN) Movement in selected SUN countries.

<sup>2</sup> For an overview of the nutrition mapping tool, visit [www.securenutrition.org/resource/multisectoral-mapping-nutrition-la-cartographie-multisectorielle-des-actions-de-nutrition](http://www.securenutrition.org/resource/multisectoral-mapping-nutrition-la-cartographie-multisectorielle-des-actions-de-nutrition)

<sup>3</sup> GNR 2017. *Global Nutrition Report Nutrition Country Profiles: Burundi*. Bristol, UK: Development Initiatives.

This, in turn, enables the GoB to identify gaps, duplication and opportunities to coordinate nutrition actions across sectors and stakeholders more effectively. Where there is duplication, the mapping exercise will enable the government (and those supporting it) to reallocate scarce resources to other localities with a high malnutrition burden but which are receiving less attention. The GoB also hopes to attract increased investment for nutrition by pursuing this more efficient approach to scale-up.

**Engaging different sectors**

The mapping exercise has also provided an entry point for engaging a notable number of sectors, including staff from seven ministries: Health; Agriculture; Trade and Industry; Planning and Finance; Environment; Local Development; and Social Security and Human Rights. Such wide-ranging engagement and government support has given rise to a dynamic mapping process in Burundi, which is being championed by the SUN Focal Point. The efforts are being coordinated by the Office of the Second Vice President, where the SUN Focal Point is based, and supported by a national mapping team. To date, more than 30 stakeholders have submitted data.

The mapping exercise can also contribute to creating a demand for multi-sector collaboration and instil this new way of working among sector-specific actors. Some actors reportedly do not see how their ‘regular’ work is related to nutrition or how it can be made more nutrition-sensitive. Others are preoccupied with their ‘regular’ sector work and struggle to devote time to multi-sector processes. Such challenges also include extending a multi-sector process to the provincial level<sup>4</sup>. The formulation of the new *National*

*Strategic Plan on Nutrition and Food Security (2019-2023)* offers another opportunity to reinforce a multi-sector approach to nutrition. Key findings from the mapping process have been timed to feed into the review of the GoB’s strategic plan.

For example, a new multi-sector approach to implementing nutrition interventions is being implemented in two southern provinces, Makamba and Rutana. This combines the efforts of public administrative actors, NGOs, local civil society and religious authorities, grouping these stakeholders into a Steering Committee and Technical Committee. The Steering Committee, chaired by the SUN Focal Point, is responsible for monitoring the implementation of nutrition interventions and for better mobilisation of the various actors.

**Remaining challenges**

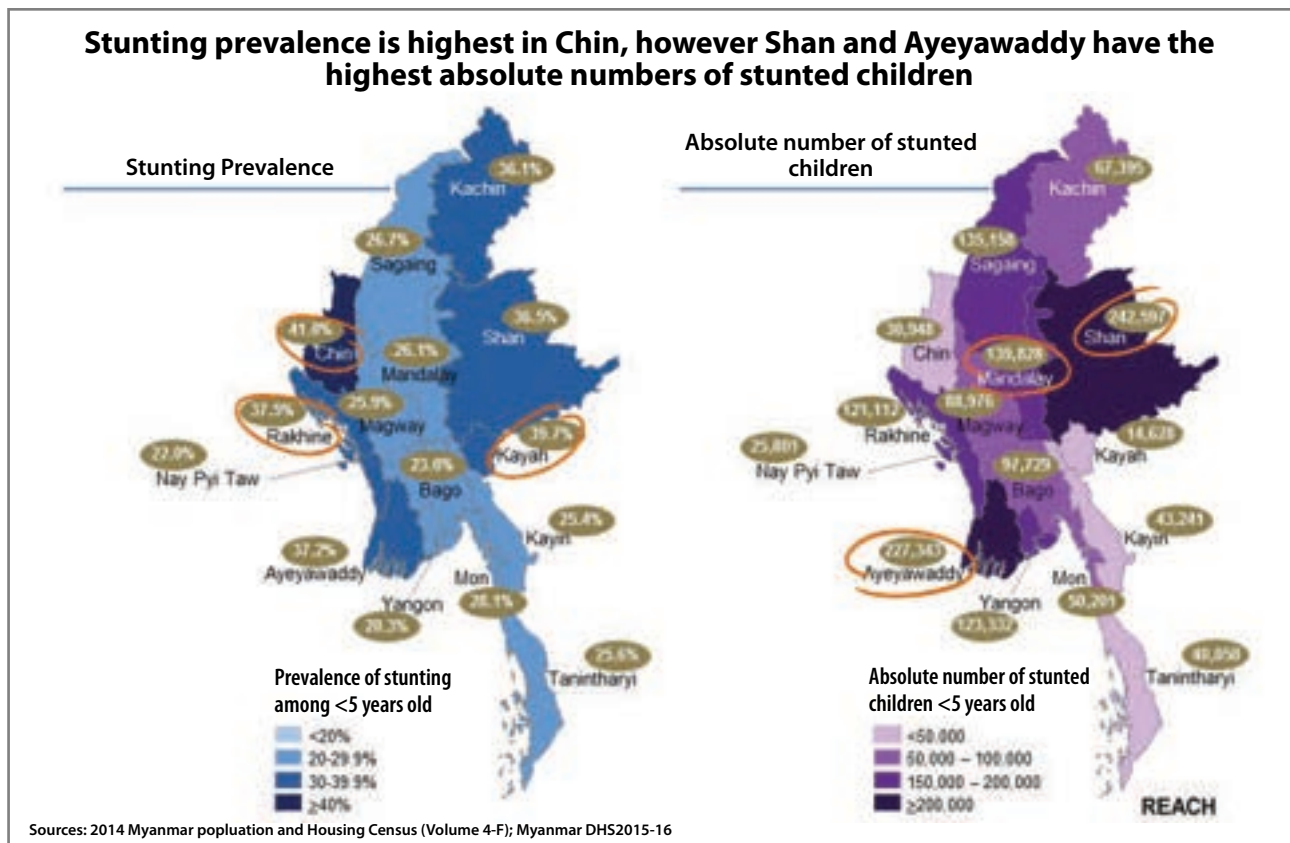
It was important to emphasise the purpose of mapping when collecting data to overcome problems with sharing data, since some actors initially perceived the exercise as a means to control their work. The exercise also highlighted the need to better account for the coverage of interventions that are delivered through varying approaches (e.g. one-off campaigns versus routine services).

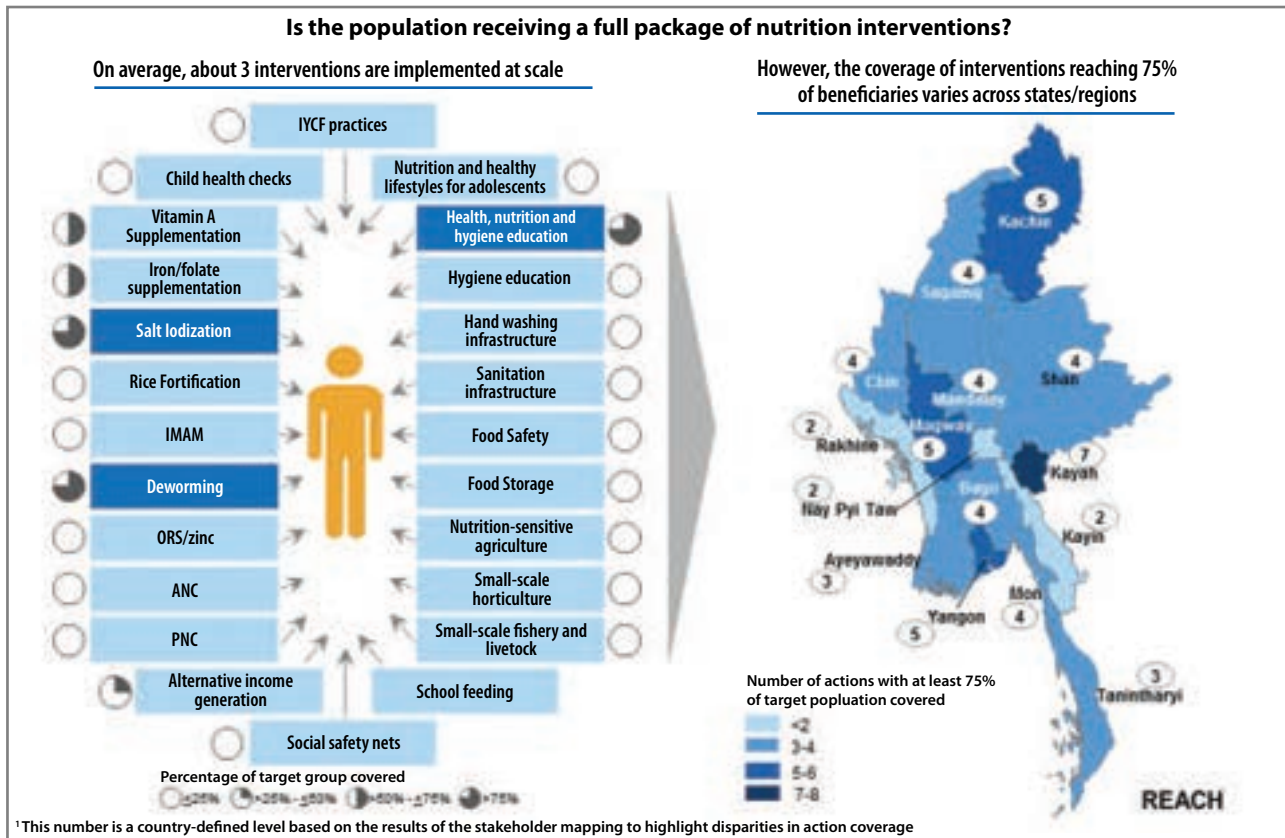
**Myanmar**

Like Burundi, the mapping exercise was government-led and used the same tool adapted to the Myanmar context. The Republic of the Union of Myanmar is home to approximately

<sup>4</sup> To date, two provinces have established decentralised platforms, under the chairmanship of the governor of the province, and are developing Provincial Strategic Food Security and Nutrition Plans, inspired by the Provincial Community Development Plans.

**Figure 1** Excerpt from the Stakeholder & Nutrition Action Mapping (Myanmar)



**Figure 2** Excerpt from Myanmar's multi-sector overview

54 million Burmese, with 135 recognised ethnic groups. The prevalence of stunting in CU5 is 29 per cent and 7 per cent are wasted<sup>5</sup>. However, these figures mask stark regional disparities, with some states and regions reporting wasting prevalence as high as 13.9 per cent and stunting of 41 per cent<sup>6</sup>.

The mapping exercise in Myanmar was successfully completed in 2017, with support from REACH facilitators. Mapping provided an entry point for mobilising a greater number of sectors to engage in nutrition (i.e. those beyond the health sector), including the four key ministries: Agriculture, Livestock and Irrigation; Social Welfare, Relief and Resettlement; Health and Sports; and Education. In addition, the head of the National Nutrition Centre (NNC) and her team, who provide technical support to the SUN Government Focal Point, were actively engaged throughout the process, coordinating and engaging other stakeholders. The Ministry of Health (MoH) houses both the Focal Point (who is the MoH Director General) and the NNC.

The mapping tool is enabling the government and development partners to identify both geographic regions and interventions in need of intensified action, thereby guiding prioritisation. It is also helping to highlight areas with resource gaps. Furthermore, the mapping has been instrumental in strengthening the UN Network and developing more effective working between the SUN networks (UN, government, donor and civil society) with a view to achieving greater impact.

The mapping exercise has also underscored the importance of strengthening data collection and reporting systems within the four ministries involved and has helped identify

specific weaknesses, such as the need for a common results framework. It has raised awareness among country actors about the role of data in evidence-generation.

### Remaining challenges

Each sector and agency has its own organisational mandate and existing plan. It was sometimes difficult to motivate staff to become more transparent and share information on existing sector/agency-specific programmes and budgets. This is in part due to the decision-making processes of individual institutions, which are not always conducive to accommodating joint activities. The mapping opened the door for such sharing and has led to the establishment and functioning of technical teams in the four participating ministries. While much progress has been made towards collective action, continued efforts are needed to consolidate these gains.

### Next steps

Staff from the NNC and the Central Statistics Bureau were trained on the mapping tool and methodology, helping to institutionalise the mapping function within the government so that it can be replicated in the future. The tool will be included in the M&E framework for the new *Multi-sector National Plan of Action for Nutrition (2017-2022)*. Country actors are also exploring the possibility of using future mapping data to track the implementation status of the new plan, as proposed in Tanzania and being implemented in Senegal.

<sup>5</sup> GNR 2017. Global Nutrition Report Nutrition Country Profiles: Myanmar. Bristol, UK: Development Initiatives.

<sup>6</sup> DHS 2015-16.



# Providing district-level coverage for nutrition programming in Balochistan, Pakistan



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## Introduction

Balochistan is the most under-developed of Pakistan's four provinces, with a high proportion of children under five years of age (CU5) who are stunted (52 per cent)<sup>1</sup> and 16 per cent of CU5 who are wasted. Moreover, the prevalence of anaemia among children in this age group is 57 per cent and nearly 49 per cent among women of childbearing age. Numerous factors are thought to contribute to child undernutrition in Balochistan, including: sub-optimal infant and young child feeding (IYCF) practices; frequent child infections (especially diarrhoeal diseases and measles); maternal nutritional deficiencies and/or illness and death; absence/inadequacy of micronutrient supplementation; and household food insecurity and gender inequity.<sup>2</sup>

## A district-level focus on nutrition

In response to the challenging nutrition situation in the province, the Balochistan Department of Health (DoH) launched the Nutrition Programme for Mothers and Children (BNPMC) in 2016 through the new provincial-level Nutrition Cell located in the DoH. The BNPMC implements proven nutrition activities (see list below) among the rural and urban population of seven selected districts, with a focus on economically and socially disadvantaged populations. The total population of these districts is 1,654,613, of which estimated target populations include 132,369 pregnant and lactating women (PLW) and 254,615 CU5. The process for developing the BNPMC involved consultation to agree roles and responsibilities with all stakeholders. These included the DoH, district government, Peoples Primary Health Initiative (PPHI) (the Government's public-private partnership programme providing health services at Basic Health Units in the districts) and local NGOs.

The Nutrition Cell's main role is to set policy at both national and provincial level (the latter is used for implementation). It also provides oversight and leadership for effective programming at both the provincial and district level, establishes standards and technical guidelines (including how to reach the target population), provides technical assistance, carries out monitoring and evaluation, oversees

operations research, and plays an advocacy role with other sectors, such as agriculture and livestock.

Programme implementation, especially service delivery, remains in the domain of the districts, where activities are carried out through partnerships with other public and private sectors. The major partnerships are with the National Programme for Family Planning and Primary Health Care (via the Lady Health Worker Programme, a cadre of community-level health workers providing primary healthcare services), the PPHI and NGOs and community-based organisations (CBOs).

The BNPMC has five components:

- 1. Addressing undernutrition among children** via increased access and availability of IYCF support and Community Management of Acute Malnutrition (CMAM) services across the targeted districts and **pregnant and lactating women**, via behaviour change communication sessions on nutrition, health and hygiene;
- 2. Addressing micronutrient malnutrition**, including vitamin A supplementation of children aged 6 to 59 months and expansion of salt iodisation and wheat flour fortification, etc.;
- 3. Behaviour change communication** – coordinating with communication channels for behaviour changes in nutrition and socio-cultural practices that can lead to undernutrition via advocacy such as development and dissemination of materials, radio programmes, community theatre, etc.;
- 4. Strengthening institutional arrangements** – the BNPMC plans to identify roles and responsibilities, build capacity and strengthen institutional mechanisms since there are currently no clearly defined mechanisms for coordinating sectors (while the public sector does support one position of Deputy Director of Nutrition at the provincial level, district-level activities are supported entirely through positions funded by development partners); and

<sup>1</sup> National Nutrition Survey (NNS, 2011).

<sup>2</sup> Combined findings from NNS 2011 and local level reports and monitoring.

**5. Strengthening monitoring and evaluation systems** – an M&E unit has been established within the Nutrition Cell in the DoH to coordinate monitoring activities throughout the province.

The total cost of the BNPMC is 1,492.62 million PKR (US\$14.21 million), of which 80 per cent has been provided by the World Bank (through the Partnership for Improved Nutrition Trust Fund) and 20 per cent by the Government of Balochistan. The majority of the funding has been allocated to strengthening institutional arrangements (41.3 per cent), which includes programme staffing, technical assistance for capacity building, strengthening coordination mechanisms, etc., addressing malnutrition among children and PLW (37 per cent) and addressing micronutrient malnutrition (13.6 per cent). SCAP Balochistan has received 48 million PKR (US\$0.45 million) of funding for the programme, via the DoH.

### Partnering with a local NGO

A DoH mapping exercise identified that more than half of the areas in each district were not being covered by the BNPMC. A local NGO, the Society for Community Action Process (SCAP-Balochistan), was selected as a partner to implement nutritional services in two poorly serviced districts, Nushki and Kharan, from January 2017 to June 2018. SCAP trained a new cadre of 70 community service providers, including Community Nutrition Workers and project staff, on BNPMC objectives and activities in both districts.

As well as CMAM and supplementary feeding for PLW, the programme focuses on prevention activities. For example, 31,928 women of child-bearing age are being supported on improved IYCF practices, health and hygiene, and the importance of female education and health interventions, such as immunisation. To prevent anaemia, iron and folic acid (IFA) tablets will be provided to 2,554 women in non-covered areas, along with other strategies such as deworming and promoting food diversity and quality. A total of 250 community support groups (Mothers and Fathers Support Groups) have been formed and mobilised, with each group consisting of approximately 20 households. The groups have identified their community resource person, who has undergone capacity-building training in order to conduct group sessions as directed by SCAP using information, education and communication (IEC) materials.

The nutritional services being implemented by SCAP Balochistan will monitor a number of targets. These include: exclusive breastfeeding among infants aged 0-6 months (increase from 40 per cent to 50 per cent); minimum acceptable diet in children aged 6-24 months (increase by 15 per cent from baseline); and an increase by 50 per cent of pregnant women who receive and show compliance in consuming IFA tablets, among other targets. The programme has already achieved 89 per cent coverage of targeted beneficiaries with its first round of community screening and outreach services, including a total of 238,468 CU5 and 120,778 PLW reached/screened.

A number of aspects of the programme are working well in districts:

- NGO has trained human resources with logistics services to ensure nutritional services at fixed OTP sites;
- District Coordination Council (DCC) meetings are being held regularly to ensure the involvement of other



Mothers learn about nutrition from trained Community Nutrition Workers

- stakeholders/departments and policymakers; and
- Few challenges are being experienced with coordination at district level, mainly because the District Health Department is fully involved in programme implementation and providing support for nutritional services.

### Challenges and lessons learned

There are always numerous challenges in working in rural areas where services are poor and health facilities are ill-equipped and difficult to access. About 65 per cent of the districts covered by SCAP lacked any kind of services. Other barriers to be overcome include community misconceptions about different interventions, especially the provision of IFA supplementation and ready-to-use therapeutic food for children with SAM due to lack of education and awareness.

SCAP has engaged in extensive community empowerment to increase people's involvement and participation, although this is hampered by the lack of services. Team building within SCAP has been another crucial factor in ensuring successful programme implementation. The NGO has involved different cadres in this and trained its own staff to ensure quality of services by following global guidelines while working at the district level. SCAP plans to do extensive advocacy for the wider replication of this model and scale-up to reach vulnerable populations in other parts of Balochistan.



Community engagement is an essential feature of district-level programming



# Developing the second National Plan of Action for Nutrition in Bangladesh



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*The views expressed in this article are solely the views of the author and do not reflect the views of the United States Agency for International Development or the United States Government.*

## Introduction

Bangladesh, the most densely populated country in the world with an estimated 162 million people living in a land area of 148,000 square kilometers, has shown remarkable improvement in human development in the past decades, with a significant reduction in poverty. Despite progress, child and maternal malnutrition remains as a major challenge for the country to reach the 2030 Sustainable Development Goals and graduate from its categorisation among the least-developed countries.

The 2014 Bangladesh Demographic and Health Survey shows that overall indicators of economic growth and greater household wealth are strongly related to nutrition. For example, children whose mothers are in the lowest wealth quintile are almost two and a half times more likely to be stunted (50 per cent) than children whose mothers are in the highest wealth quintile (21 per cent). More than one in three (36 per cent) children under five (CU5) are stunted and 14 per cent are wasted. However, even in the highest household wealth quintile, stunting is quite high at 21 per cent; wasting is also high at 12.8 per cent, which clearly highlights that undernutrition is a cross-cutting problem for all Bangladeshis, although it is more pronounced in lower wealth quintiles (NIPOPT, 2016). This situation reflects the underlying causes of undernutrition in the country, which include lack of maternal education; child marriage and early first birth; sanitation and handwashing practices; access to food and healthcare; infant and young child feeding practices; and the status of girls and women in the family and in society.

Losses in economic productivity due to undernutrition are reported to amount to an estimated US\$1 billion of revenue per year (Howlader et al, 2012). Realising the importance of improving nutrition in the overall development agenda, the Government of Bangladesh (GoB) has been focusing on nutrition policies, strategies and programming and on developing a second National Plan of Action for Nutrition (NPAN2).

Bangladesh was an 'early-riser' country, joining the Scaling up Nutrition (SUN) Movement in 2011 and establishing a SUN multi-stakeholder platform (MSP) at the national level in 2012. Led by the GoB, members from the different SUN MSP networks (such as UN, donor and civil society) have actively participated in the NPAN2 formulation process as members of different committees and by providing financial, consultancy and temporary secretariat support for smaller sector committees and mobilising their respective GoB counterparts.

## Building a multi-sector narrative

In 2014 the key development partners in nutrition published a common narrative<sup>1</sup>. While there was a renewed promise to work together, stakeholders identified the need for a multi-sector nutrition policy. The recent National Nutrition Policy 2015 (NNP-2015) clearly articulates multi-sector programming and inter-sector coordination as objectives and places an emphasis on both nutrition-specific and nutrition-sensitive interventions.

National commitment to combat malnutrition is in line with the country's Vision 2021 and the seventh Five-Year Plan (2016-2020). Other factors such as the revitalisation of the Bangladesh National Nutrition Council (BNNC), with the Prime Minister as chair, have also catalysed the development of an action plan to operationalise the NNP-2015.

A national technical committee was created in January 2016 to guide the overall development of NPAN2 (2016-2025). This was further sub-divided into four different sector committees: Health, Urban Health and WASH; Food, Agriculture, Fisheries and Livestock; Women Empowerment, Education, Social Safety Net, Information; and Institutionalisation of NPAN2: Finance, Planning, Budget. The committees all had high-level representation from relevant government ministries, along

<sup>1</sup> Undernutrition in Bangladesh – A Common Narrative ([http://docs.scalingupnutrition.org/wp-content/uploads/2014/06/Common-Narrative\\_BANGLADESH-Final.pdf](http://docs.scalingupnutrition.org/wp-content/uploads/2014/06/Common-Narrative_BANGLADESH-Final.pdf))

with members from UN agencies, NGOs, donors and academia. Each committee developed an action plan for its respective sectors following a common format and highlighted cross-cutting areas, which were harmonised later in the process. Experts from Bangladesh and international consultants were engaged to ensure that each section of the action plan is not only technically sound but also feasible in terms of overall capacity, utilising global learning from different sectors. A costing exercise was involved, which is included in the NPAN2 to help in advocacy for resource mobilisation and financial planning.

A core group was formed during the final step of the exercise to merge the different parts and produce the final document, in which cross-cutting areas were harmonised. The draft NPAN2 went through several rounds of revisions as stakeholder comments were incorporated. The plan addresses the current and emerging nutrition problems of all citizens, especially CU5 (with particular focus on the first 1,000 days), women of child-bearing age (including pregnant and lactating mothers) and adolescent girls. Target indicators for 2025 include reducing CU5 stunting to 25 per cent and wasting to eight per cent, and increasing the rate of exclusive breastfeeding to 70 per cent in infants under six months of age.

### Making key nutrition actions operational

The NPAN2 specifies priority key action areas and major activities under three thematic areas:

1. Comprehensive and integrated social behaviour change communication agenda;
2. Research to generate evidence to inform policy and programming; and
3. Capacity-building, which targets all relevant sectors at different administrative levels.

The plan identifies the ministries and collaborating partners responsible for tracking progress and achievements of indicators, timeframes and costs involved in implementing the agreed priority interventions. It builds on existing platforms and delivery mechanisms that have proven to be effective, such as the agriculture extension network and frontline community workers. The plan includes a common results matrix for different sectors to work together and seeks coordinated financing of key sectors as well as tracking of investments.

A total of 17 ministries will be involved along with other stakeholders and partners. The costing exercise has estimated that a total of approximately US\$1.6 billion is required for the NPAN2 (2016–2025) to carry out the priority activities, institutional development and capacity-building, as well as monitoring and evaluation (M&E) over the next ten years. This M&E will not only track progress made in the implementation of NPAN2 and investments in nutrition, but will also serve as the basis for the annual reports to be submitted to the Prime Minister through the BNNC office, which will be responsible for monitoring NPAN2's progress. The plan provides a breakdown of nutrition-specific and nutrition-sensitive interventions, with the highest budget allocation (and priority) on women's empowerment, education and social safety net (US\$820,577,795); followed by health and urban health (US\$675,721,493). Strategic budgeting and funding will take place within each sector or ministry in alignment with NPAN2. Sub-national dissemination of the plan is underway through division/

Nursing mothers and pregnant women are trained in a community nutrition and health education project in Sadar district, Bangladesh



WFP/Rein Skullenud

district-level events (although GoB is a centralised government system, so each ministry takes the lead for programme design, in consultation with sub-national-level personnel).

### Lessons learned and next steps

Developing NPAN2 has been a great journey that brought highly motivated people on board to improve nutrition. However, bringing key actors under one plan is quite challenging due to the large number of different types of nutrition programming in various sectors, many of which are applying a nutrition lens to programme design. For example, nutrition messaging is now part of the work of agriculture extension workers; safety-net programmes now target pregnant and lactating women; and education has updated the school curriculum with basic nutrition information at the primary level, with plans to update it further.

Leadership and political commitment were key to success: the Ministry of Health and Family Welfare has played a strong leadership role in convening different sectors/stakeholders and development partners have worked with their respective GoB counterparts to ensure their involvement. Dividing into four sector committees and giving leadership of each committee to its respective GoB sector and development partners was another effective strategy.

Next steps are to ensure that the BNNC is fully functional and working with all relevant sectors to make certain that implementation is on track and ensure wider dissemination of the action plan, advocacy and resource mobilisation.



Listen to an interview with the authors on the ENN podcast channel:

[www.ennonline.net/mediahub/podcast/bangladeshnutritionplan?version=current](http://www.ennonline.net/mediahub/podcast/bangladeshnutritionplan?version=current)

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# Regional nutrition strategies to address the double burden in the Eastern Mediterranean



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## Introduction

The burden of disease associated with inadequate nutrition continues to grow in countries of the Eastern Mediterranean Region (EMR), comprising 22 countries and territories in the Middle East, North Africa, the Horn of Africa and Central Asia. Similar to many developing countries, the region suffers from problems of both undernutrition and overweight, obesity and diet-related non-communicable diseases (NCDs), which are all increasing. This 'double burden' of malnutrition negatively impacts EMR health systems. Several micronutrient deficiencies are still being reported from many countries in the region, particularly iron, iodine and vitamin A.

In response to these challenges, the World Health Organization (WHO) Regional Office in the EMR developed the first regional Nutrition Strategy (2010-2019) and Action Plan in coordination with other UN agencies and stakeholders to scale up nutrition<sup>1</sup>. The overall goals of the regional strategy are to encourage countries to reposition nutrition as central to their development agenda; support them in establishing and implementing action on nutrition according to their national situation and resources; and provide a framework for prioritising nutrition actions in each country context. The plan has been updated to include recent initiatives such as the World Health Authority (WHA) global targets 2025 to improve maternal, infant and young child nutrition and the Sustainable Development Goals (SDGs)<sup>2</sup>; most states within the EMR have now developed or reviewed national action plans in line with these.

## Nutrition situation for key indicators

According to the most recent estimates<sup>3</sup>, rates of stunting, wasting and underweight in children under five years of age (CU5) in the region are 28 per cent, 8.69 per cent and 18 per cent, respectively. Yemen, Pakistan, Afghanistan, Sudan and Djibouti have the highest burden of stunting (>30 per cent). Due to political unrest and food insecurity in these countries, as well as in Syria, Iraq and Libya, the total number of wasted CU5 is estimated at 9.1 million (7.3 per cent); out of which nearly half (3.1 million or 3.8 per cent) are severely wasted. Over half of pregnant women have anaemia in the Sudan (58.4 per cent), the Syrian Arab Republic (57.3 per cent) and Pakistan (51 per cent).

Of particular concern is the increasing trend in overweight and obesity among adults and children. Average prevalence of overweight and obesity in the region is 27 per cent and 24 per cent in adults and 16.5 per cent and 4.8 per cent in school-aged children respectively<sup>3</sup>. The highest levels of obesity were reported in Kuwait, Qatar, Bahrain and the



Bakers use fortified flour to make bread in a programme in Afghanistan

WFP/Wahidullah Amami

<sup>1</sup> [www.emro.who.int/nutrition/strategy/](http://www.emro.who.int/nutrition/strategy/)

<sup>2</sup> [www.emro.who.int/nutrition/nutrition-events/scalingup-nutrition-consultation.html](http://www.emro.who.int/nutrition/nutrition-events/scalingup-nutrition-consultation.html)

<sup>3</sup> Lara Nasreddine, Jennifer J. Ayoub and Ayoub Al Jawaldeh, Review of the nutrition situation in the Eastern Mediterranean Region, Eastern Mediterranean Health Journal, Volume 24, issue 1, 2018. [www.emro.who.int/emhj-volume-24-2018/volume-24-issue-1/review-of-the-nutrition-situation-in-the-eastern-mediterranean-region.html](http://www.emro.who.int/emhj-volume-24-2018/volume-24-issue-1/review-of-the-nutrition-situation-in-the-eastern-mediterranean-region.html)



United Arab Emirates (UAE). In 2016, an estimated 5.4 million CU5 (6.7 per cent) in EMR were overweight, an increase from 3.5 million in 1990. Half the region's adult women and more than two out of five men are overweight or obese.

As in other regions, high rates of overweight and obesity are closely linked to physical inactivity and unhealthy diets. The EMR has the highest global prevalence of physical inactivity in adults (approximately one third), with data consistently showing higher levels of inactivity in women than men (compared with an overall global prevalence for both sexes of 23 per cent<sup>4</sup>). There have also been marked changes in the region's dietary patterns consistent with global food consumption, shifting towards higher-energy diets dominated by increased intakes of fats and sugar.

### Key priorities

The following key actions are taking place to support strategic priorities:

1. *Maternal, infant and young child nutrition*: interventions including infant and young child feeding (promotion of breastfeeding and complimentary feeding), food fortification and supplementation programmes, growth monitoring and nutrition surveillance and treatment of severe acute malnutrition (SAM).
2. *NCD-diet related risk factors*: promoting healthy diet through cost-effective interventions identified within the Regional Framework for Action to address NCDs, including: promoting breastfeeding and implementing the International Code of Marketing of Breast-milk Substitutes ('the Code'); reducing salt intake at population level; developing food-based dietary guidelines; food labelling; product reformulation, including replacing trans fats with polyunsaturated fats and sugar reduction; and restricting marketing of unhealthy food to children.
3. *Emergency nutrition*: screening cases for SAM.

### Progress and achievements to date

More than 17 countries have developed full or partial legal documents relating to the Code, but implementation remains a challenge. In 2017, development of food-based dietary guidelines was expanded in the region to include Afghanistan, Egypt, Islamic Republic of Iran, Lebanon, Oman, Qatar and Saudi Arabia. Salt reduction in bread is also progressing in Kuwait, Qatar, Oman, Iran, Bahrain, Morocco, Tunisia and Jordan. Elimination of trans fats is a priority for action in Iran, Saudi Arabia and Tunisia. Adding taxes to sugar-sweetened beverages to reduce sugar consumption is being implemented in Saudi Arabia, United Arab Emirates, Iran and Jordan. Afghanistan, Pakistan, Somalia, Sudan and Yemen have all become members of the Scaling Up Nutrition (SUN) Movement, providing a great opportunity to galvanise action to ensure country progress in efforts to reach SDG targets.

### Challenges in implementation

The EMR is a very complex region and countries have different nutrition problems and challenges with different socioeconomic profiles. There is a double burden of malnutrition and at least 16 countries are experiencing internal conflicts and political instability, making the most

vulnerable inaccessible to nutrition services that are in high demand. Many countries still face challenges in the formulation and implementation of nutrition strategies and action plans that are holistic in their approach to addressing nutrition issues, including Pakistan, Yemen, Sudan, Djibouti and Somalia.

Other challenges in the region include:

1. Weakness of clear political commitment to nutrition action and/or failure to turn the political commitment towards nutritional problems into tangible action;
2. The absence of a policy framework and institutional capacity to plan, implement and monitor nutrition programmes that respond to the multi-sector dimensions of nutrition problems;
3. Recurrent conflicts and natural disasters;
4. The disproportionate allocation of health budgets, often at the expense of preventive strategies such as nutrition;
5. The abandonment of traditional diets, which are often more nutritious, in favour of western diets that feature more refined foods, resulting in the reduction of dietary diversity; and
6. The absence of nutrition expertise in related sectors and inter-sector coordination.

The Regional Strategy has helped countries to set strategic priorities of key activities with clear outcomes and measurable deliverables and enabled states within the EMR to monitor progress towards meeting achievable global targets. Close follow-up and technical support from UN/NGOs is helping to scale up nutrition programmes and focus on cost-effective interventions

A family in Yemen live on fishing and bread baked using food rations



WFP/Fares Khoalid

<sup>4</sup> World Health Organization. Global status report on noncommunicable diseases 2014. Geneva: World Health Organization.



## Championing nutrition in Gabon



An interview with **Yves Fernand Manfoumbi**, Gabon's Minister of Agriculture, Livestock and the GRAINE Programme<sup>1</sup> from October 2016 to February 2017.

As Minister, Manfoumbi recognised that malnutrition was a considerable barrier to the socio-economic and environmental development of the country and sent a request for Gabon to join the Scaling Up Nutrition (SUN Movement) on 21 December 2016. He was elected as a SUN global Nutrition Champion in 2017 and is the honorary president of Gabon's SUN multi-sector nutrition platform in his capacity as champion, participating in meetings and acting as a catalyst and advocate for nutrition on the ground.

### 1. When did you first become aware of nutrition and its importance to your country's development?

After my appointment as Minister of Agriculture, Livestock and the GRAINE Programme (MAEPG), I naturally got in contact with all partners, including FAO [the Food and Agriculture Organization of the United Nations], who briefed me on the Second International Conference on Nutrition (ICN2), the forum devoted to worldwide nutrition problems in the 21st century. At the end of this conference, an assembly of 187 nations approved the final two documents, the Rome Declaration on Nutrition<sup>2</sup>, which engages countries in eradicating hunger and in preventing all forms of malnutrition, and the Framework for Action<sup>3</sup>, the technical guide that aims to facilitate its implementation by defining clear and specific strategies for carrying out these commitments. As a financial economist, I was very aware of the impact of nutrition on GDP and that one dollar invested in nutrition can yield a return of 16 more dollars<sup>4</sup>. This really triggered a 'eureka' or 'light-bulb' moment for me.

### 2. What do you consider to be the main nutritional problems in Gabon?

Gabon is one of those countries that is 'off-course' in terms of progress towards four of the six indicators adopted during the 65th World Health Assembly (WHA) in 2012; this relates to progress towards goals concerning stunting, which affects 18 per cent of children under five years old [CU5] and wasting among CU5 of 3 per cent; anaemia, which affects over half of women of child-bearing age; a prevalence of 8 per cent overweight in CU5, and a particularly low rate of 6 per cent prevalence of exclusive breastfeeding.<sup>5</sup> Micronutrient deficiencies in women and children are also major challenges in terms of public health.

### 3. What prompted your country to join the SUN Movement in 2016?

Gabon became a member of the Scaling Up Nutrition (SUN) Movement in January 2017 through its endorsement, at the highest level, by the President of the Republic by delegation to the Prime Minister, following a request that we submitted in

December 2016. We did this so that Gabon could take part in the dialogue allowing us to interact with other SUN countries and the SUN Movement's assistance system, refine our skills, improve our understanding of the main issues and come to an agreement on priority actions, all in the aim of making sure that we are on the right track for producing results.

### 4. How has being a member of the SUN Movement helped Gabon?

Membership of the SUN Movement has the advantage of helping countries celebrate the progress made by other SUN countries in implementing their national plans for nutrition, in providing a better understanding of the issues and in identifying together the solutions under consideration.

### 5. From your experience as Minister of Agriculture, how does the SUN multi-sector platform work in Gabon and how are the sectors collaborating in targeting malnutrition?

The multi-sector platform brings together various ministries, civil society, technical and financial partners, and was set up under the leadership of the Ministry of Agriculture, Livestock and the GRAINE Programme. Currently nine ministries are involved (including Health, Agriculture, Trade, Infrastructure, Education and Social Protection) and five networks (government, UN, donor, civil society and private sector). The platform meets regularly (at least once a month – more if there are specific activities) and discusses nutrition issues, the National Policy on Food and Nutrition Security (PNSAN), SUN's roadmap strategy, the policy's action plan, etc. The capabilities of members of the multi-sector platform are

<sup>1</sup> The GRAINE (Gabonaise des Réalisations Agricoles et des Initiatives des Nationaux) programme is a key government priority that aims to limit imports of agricultural products, improve food security, create sustainable jobs and promote economic development.

<sup>2</sup> [www.fao.org/resources/infographics/infographics-details/en/c/266118/](http://www.fao.org/resources/infographics/infographics-details/en/c/266118/)

<sup>3</sup> [www.fao.org/3/a-mm215e.pdf](http://www.fao.org/3/a-mm215e.pdf)

<sup>4</sup> International Food Policy Research Institute. 2014. *Global Nutrition Report 2014: Actions and Accountability to Accelerate the World's Progress on Nutrition*. Washington, DC.

<sup>5</sup> GNR 2017. *Global Nutrition Report (2017) Nutrition Country Profiles: Gabon*. Bristol, UK: Development Initiatives.



Green Classes at Okala school in Libreville

FAO, Gabon

pooled so that everyone understands the role they have to play in resolving food and nutrition security problems in Gabon. One example of sectors working together are 'green classes', an agriculture project to produce nutritious food in schools through school gardens. Nutrition training in schools is to be implemented in a collaboration between the Ministries of Education and Health.

**6. Tell us about the new National Policy on Food and Nutrition Security (PNSAN) (2018-2025). How has this been developed?**

As Minister, since my appointment in October 2016, I have been working towards Gabon obtaining a National Policy on Food and Nutrition Security (PNSAN) document. This meets one of the recommendations of ICN2.

Training on the multi-sector nature of nutrition and the role of each sector was organised with the technical support of FAO, UNICEF and WHO [World Health Organisation] to encourage platform members to improve their contribution in drafting the PNSAN document. Each sector has provided support in drafting the document and I have monitored the various stages of the process and brought them to the highest level.

In March 2017, I recommended organising a workshop to approve the PNSAN document and in July 2017 the Ministerial Council ratified the approved document – so nine months after my appointment, Gabon had a strategic reference and policy framework for all the sectors and stakeholders involved in nutrition.

Financial resources are to be mobilised by the Government with the support of partners. REACH will provide technical

support for the development of a coordination framework between the Government and the UN system and MQSUN+ will assist in the development of a costed action plan for PNSAN.

**7. Does PNSAN include interventions to address the prevalence of overweight, obesity and malnutrition?**

PNSAN is taking into account all interventions to fight hunger and malnutrition; that is why it integrates not only nutrition-sensitive interventions, but also nutrition-specific interventions, taking all forms of malnutrition into account. In collaboration with FAO, the Government has initiated a project on developing national dietary recommendations and a food guide for Gabon, to raise awareness of healthy eating.

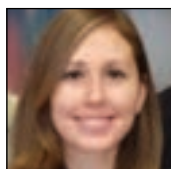
**8. What role do you see for the private sector in terms of malnutrition?**

The private sector has a role of social responsibility to play in the fight against malnutrition and this is why strong advocacy is needed to enable it to finance interventions on the ground. One initiative currently being discussed with agri-business is fortification of cooking oil with vitamin A.

**9. What advice would you give on tackling malnutrition to other countries that are facing similar problems to those in Gabon?**

Other countries must ensure that they have a legal policy framework which takes the issue in its entirety into account; since nutrition is multi-sectoral, its causes must be identified in order to propose solutions and identify the role that each of us must play by involving beneficiaries in sustainable interventions.

# Improving emergency nutrition preparedness and response in Latin America and the Caribbean



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## Introduction

Latin America and the Caribbean (LAC) is one of the most disaster-prone regions in the world and increasingly vulnerable to a range of hazards, including droughts, storms and floods, which have increased in frequency, intensity and unpredictability in recent years<sup>1</sup>. After Asia, LAC has the second highest number of natural disasters, predominantly occurring during the hurricane season between May and November. Almost half (16) of the 33 countries in LAC experience a high or very high level of exposure and vulnerability to natural disasters and human conflicts. The other half (17) experience a moderate or low level of the same risk<sup>2</sup>.

Natural disasters and other man-made crises impact on a range of factors that can increase the risk of undernutrition, illness and death: livelihoods and food crops are lost; food

supplies are interrupted; infectious diseases increase in frequency and severity; and feeding practices are threatened and possibly impeded, leading to an increased risk of acute malnutrition and micronutrient deficiencies. It is therefore crucial to support the protection of vulnerable groups like children, adolescents and women who are particularly affected by emergencies. There is a growing recognition by national authorities in the LAC region of the importance of incorporating risk-informed programming and 'resilience-building into national development policies and plans. However, awareness of factors that affect nutritional status in emergency situations and the preparedness and response capacity for nutrition in emergencies (NiE) is generally low.

## A regional support group for NiE

Since 2013, UNICEF's LAC Regional Office has been supporting a regional group for nutrition resilience (Grupo de Resiliencia Integrada de Nutrición) (GRIN-LAC). Its aim is to increase awareness and understanding of issues related to NiE and to support the strengthening of national capacities to prepare for and respond to those issues.

GRIN-LAC is a network of key stakeholders at regional and national levels in all countries in the region. The group aims to identify, engage and support the national Nutrition Focal Points (NFPs) and other government officials (usually the nutritionists working at the Ministry of Health) responsible for coordinating nutrition-specific issues at times of emergencies and who make up half of the group's 150 members. Other members of GRIN-LAC include people working on nutrition, disaster risk reduction and/or emergency response, such as NGOs, UN agencies and aid agencies, based at regional and national level. GRIN-LAC supports its members to engage with development-focused actors at the national level to strengthen the nexus between humanitarian and development actions and balance immediate short-term responses with lasting and



A nurse reviews with a mother how best to breastfeed her daughter in a baby-friendly tent in Haiti

© UNICEF/UNI/9187/Noorani

<sup>1</sup> The World Bank, Preventative Resettlement of Populations at Risk of Disaster: Experiences from Latin America, The World Bank and Global Facility for Disaster Reduction and Recovery, International Bank for Reconstruction and Development, Washington, DC, September 2011.

<sup>2</sup> Inter-Agency Standing Committee Reference Group on Risk, Early Warning and Preparedness, European Commission. InfoRM - Index for Risk Management, Latin America and the Caribbean. February 2017. Available at: [www.inform-index.org/Subnational/LAC](http://www.inform-index.org/Subnational/LAC)

**“Generation of evidence at national level about capacity gaps and vulnerabilities in emergencies and its dissemination to decision-makers in each country are fundamental to create awareness of risks, encourage reflection and promote concrete actions.”**

Maria Delia Espinoza, a Health Officer  
with UNICEF Nicaragua

sustainable interventions that aim at reaching results in the long term.

### Supporting countries to improve preparedness and response

GRIN-LAC has enabled countries to institutionalise NiE by providing support in three main areas: evidence generation, knowledge management and capacity development. These contribute to strengthening nutrition resilience by building capacities of individuals and institutions to better manage underlying risks that can affect the nutritional status of women and children in emergencies.

### Evidence generation

GRIN-LAC supports the NiE risk assessment, a model that has been developed to help identify gaps in nutrition preparedness on the basis of an analysis of risks, capacities and vulnerabilities of each country in the region, resulting in a risk profile for each country. This has been used to raise awareness of nutrition capacity gaps and vulnerabilities, strategies to mitigate these risks and guide prioritisation of support.

**Nicaragua case study:** In 2016 GRIN-LAC, together with UNICEF Nicaragua, supported the Nicaraguan Government to carry out the NiE risk assessment. Results were presented to the Health Commission of the National System for Disaster Prevention, Mitigation and Attention, who subsequently agreed that guidelines for NiE needed to be produced for individuals and institutions working in emergency preparedness and response. An operations manual was produced for the Emergencies Committee by the Ministry of Health (MoH) with UNICEF and in collaboration with other actors at national and local level. This helped to ensure broad ownership and application by other relevant governmental bodies and organisations.

### Knowledge management

It is crucial to ensure that country experiences are documented and shared so that evidence of what works well or otherwise contribute to learning. GRIN-LAC supports countries to document experiences and lessons learnt related to NiE and share them through quarterly, sub-regional webinars.

**Antigua and Barbuda case study:** The NFP from the Antigua and Barbuda MoH reviewed the experience of the emergency nutrition response to hurricane Irma (2017) and documented lessons learnt, challenges and support needs, with support from GRIN-LAC. This experience was presented to the GRIN-LAC webinars and triggered reflection about gaps in the emergency nutrition response and the lack of frameworks around NiE. The NFP is now in contact with the National Office for Disaster

Services to include nutrition considerations and is planning to develop an infant and young child feeding policy in 2018 that would take NiE considerations into account.

### Capacity development

GRIN-LAC also provides remote strategic guidance and technical support to NFPs on a one-to-one basis on request, for further discussion, guidance and/or clarification.

**Guyana case study:** Remote technical support was provided to the Guyana MoH on emergency nutrition preparedness. As a result the MoH is planning to host a one-day stakeholder meeting in 2018 to chart the way forward for the establishment of the nutrition coordinating body, beginning by clarifying roles and responsibilities of various agencies.

### Next steps

In a survey conducted by GRIN-LAC members in 2017, the challenges to strengthening NiE at national level most cited were lack of trained human resources and lack of country NiE frameworks. This highlighted the need to strengthen training/capacity development for NiE and the need to advocate for the inclusion of NiE in national policies and programmes. To support this, GRIN-LAC plans to:

- Develop and disseminate an NiE toolkit to provide countries with practical tools on key aspects of emergency nutrition preparedness and response and checklists and briefing notes on NiE topics; and
- Launch a report on the state of NiE preparedness in LAC countries to increase evidence-based advocacy efforts on the importance of emergency nutrition preparedness and response in order to increase political commitment on NiE.

For more information on GRIN-LAC or to join the network, visit the online community ([www.facebook.com/groups/GRIN.LAC/](https://www.facebook.com/groups/GRIN.LAC/)) and document repository [/redhum.org/sector/4](https://redhum.org/sector/4) or contact the GRIN-LAC coordinator at [yfautsch@unicef.org](mailto:yfautsch@unicef.org)



A mother breastfeeds her baby in Cobán, Guatemala

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# Post-earthquake recovery in urban Nepal: Using hospitals to detect and treat child and maternal malnutrition



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## Background

Nepal was rocked by a 7.4 magnitude earthquake in April 2015 and aftershocks in the following months. The Government of Nepal (GoN) declared 14 out of 75 districts in the country to be severely affected, three of which (Kathmandu, Lalitpur and Bhaktapur) are in the Kathmandu valley. A comprehensive nutrition in emergency (NIE) response and recovery programme was implemented in all severely affected areas. Integrated Management of Acute Malnutrition (IMAM) was a key component of this response

and included the treatment of severe acute malnutrition (SAM) (between June to December 2017) and moderate acute malnutrition (MAM), as well as a focus on pregnant and lactating women (PLW) (from June 2016 to July 2017).

The target population in Kathmandu Valley was spread over urban areas, including slums, peri-urban and outlying rural areas. A common implementation strategy for the IMAM was initially planned across all 14 earthquake-affected districts and involved community-level screening based on mid upper arm circumference (MUAC), which was measured by Female Community Health Volunteers (FCHVs.) However, the implementation of the approach could not ensure that children with acute malnutrition or PLW were adequately detected for referral. The challenge called for innovative and complementary approaches for maximising programme coverage and reaching out to vulnerable target groups.

## A new strategy for urban areas

The barriers faced in identifying acute malnutrition cases were raised in District Nutrition Cluster (DNC) meetings. These were sub-national clusters set up in affected districts following activation of the National Nutrition Cluster. DNC members included not only the regular nutrition community but also representatives from hospitals in the districts. Cluster members agreed that the approach of mobilising only FCHVs was clearly inadequate in the urban areas. A number of factors were affecting regular MUAC screening by the FCHVs at community level: the disproportionate ratio of FCHVs compared to the dense population in their given catchment area; time constraints on urban FCHVs, who are often

Villagers gather at a food distribution centre in Kartike, Nepal after the 2015 earthquake



WFP/Samir Jung Thapa

engaged in other education or income-generating activities; the difficulties posed by a mobile and migrant population; and the unwelcome reception of FCHVs in some urban households where they are not given access due to lack of familiarity with the service compared to rural areas.

The DNC realised that hospitals offer a largely under-utilised platform for the urban context and the intended target population. While they provide opportunities to conduct screening for acute malnutrition among children brought for routine immunisations and other paediatric services, they did not proactively screen all at-risk children. In other words, nutrition interventions in urban areas had not hitherto been implemented through the hospitals in a systematic and comprehensive way for IMAM.

Concerned stakeholders, including the Child Health Division, District Public Health Offices (DPHO), UNICEF and partner NGO (the Social Development and Promotion Centre (SDPC)), decided to conduct a few rounds of MUAC screenings in Kanti Children's Hospital, a tertiary-level paediatric referral hospital. This process identified a significant number of children with acute malnutrition; as a result, Outpatient Therapeutic Centres (OTCs) and Targeted Supplementary Feeding Centres (TFSCs) were established in six key public hospitals in Kathmandu valley.

### Hospitals come on board

Training on NIE (including IMAM) was organised in Kathmandu, Lalitpur and Bhaktapur districts for hospital management, paediatricians, matrons, nurses and dieticians. Necessary supplies and technical support were provided by UNICEF, while the partner NGO supported the running of the OTCs. The NGO workers measured MUAC of children visiting the hospitals; those identified with acute malnutrition were immediately enrolled in the treatment programme as per international protocols. Nutrition corners were also set up to provide nutrition education and counselling on infant and young child feeding. Gradually, the hospital management allocated better location and space for the OTCs/TFSCs, and paediatricians also started to refer children for MUAC screening, ready-to-use therapeutic food/ready-to-use supplementary food (RUTF/RUSF) provision and nutrition counselling. For PLW, those with a MUAC <23 cm were referred for treatment with supplementary foods.

The new approach started to show results straightaway as the number of identified cases began to increase. Between June 2015 and December 2017, a total of 3,868 cases of children with SAM were identified and treated in the three districts of Kathmandu Valley; 66 per cent of these (2,569 cases) were reached through the hospitals. The data for Kathmandu (the most populous district) showed that 84 per cent of cases were identified from hospital settings. In addition, over 13,000 cases of MAM and over 12,000 PLW were treated.

### Challenges and lessons learned

Initially, all IMAM data from the hospitals, including case identification and management, were being vertically reported by the NGO partner. After discussion among the DPHOs and hospital management, it was found that medical recorders in the hospitals would be able to enter data into the Ministry of Health (MoH) Health Management Information System; this has now been included as part of routine reporting in the hospital.

Another challenge involved the human resource capacity needed for regular follow-up of those treated to ensure that they did not default. The number of cases identified and admitted in the hospital-based OTCs was much higher compared to community-based settings, and included cases from other parts of the country, adding further challenges for follow-up.

The MoH has allocated budget to local government to continue core activities such as logistics supply (including purchase of RUTF); periodic programme reviews at local level; and monitoring and supervision (the total amount budgeted is being finalised through the annual work plan). The MoH is committed to providing programme support in those districts for continuation of the services provided during the earthquake recovery.

### Complementing community level efforts

Hospitals have been identified as an important platform in urban areas through which to identify acute malnutrition cases, offer treatment and provide nutrition counselling. This approach complements the community-level efforts, especially as it was learned that reliance on the FCHVs alone is inadequate in an urban setting. There was a need to engage with the hospitals on a strategic level. The leadership of the DPHOs and MoH played a key role in initiating the intervention, as well as the progress made in the hospital settings. Overall, this approach significantly contributed towards achieving the results for IMAM outlined in the nutrition component of the GoN's Post-Disaster Recovery Framework 2016-2020.

Urbanisation is an evolving area of importance for all nutrition interventions and Nepal is among the top ten fastest urbanising countries in the world. Hospitals can also offer a valuable platform for urban nutrition programming, including the management of acute malnutrition during and outside periods of crisis. They can also be utilised for broader activities to improve maternal infant and young child nutrition, as well as to address the rising burden of overweight/obesity and non-communicable diseases in these populations.

*Acknowledgements: Partner NGO Social Development and Promotion Centre (SDPC) and concerned hospital managements.*



Use of mid upper arm circumference (MUAC) screening at Patan Hospital, Lalitpur

# A partnership between female community health and nutrition workers in Rajasthan, India



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## Background

With over 68 million citizens, Rajasthan is one of the eight states in India that are known as 'Empowered Action Group' (EAG) states; i.e. they have high levels of deprivation. Rajasthan's child health and nutrition data<sup>1</sup> shows that 23 per cent of children under five years old (CU5) are wasted and 39 per cent are stunted and over 70,000 children under one year of age are estimated to die each year. The state authorities have acknowledged the issue and aim to become a beacon for health and nutrition services. To this end, the Akshada Programme, a partnership between the state government, philanthropic organisation Tata Trusts and the non-profit Antara Foundation, aims to scale up improvements rapidly in maternal and child health and nutrition (MCHN) in Rajasthan.

## Village services

Three different groups of female workers – Accredited Social Health Activist (ASHA), Anganwadi Worker (AWW) and

Auxiliary Nurse Midwife (ANM) – are responsible for driving health and nutrition service delivery in India's villages. While ASHAs and AWWs typically cater for 1,000 people each, the ANMs serve 5,000 people across several villages. Each of the female worker categories has a distinct role:

- ASHAs are the first point of contact for the community. They counsel the community via home visits and mobilise attendance at events like village health and nutrition days;
- AWWs run Anganwadi Centres (AWCs), through which they provide nutrition services to pregnant and lactating women (PLW) and young children, including mid-day meals for children aged 3-6 years old; take-home rations for children aged six months to three years and PLWs; and nutrition counselling on Infant and Young Child Feeding (IYCF) to pregnant women and mothers; and
- ANMs provide basic diagnosis, treatment and referral to health centres for pregnant women.

Although they should serve the same beneficiaries and their roles should be complementary, coordination is often lacking between the three cadres of staff. This is mainly because they work for different government ministries: AWWs and ANMs are employed by the Women and Child Development (WCD) and Health Ministries, respectively. In Rajasthan, the WCD Ministry pays ASHAs a fixed payment, while the Health Ministry pays them a performance-based incentive (for referrals to reproductive and child health services, etc.). Different record-keeping formats and methods make it difficult for them to speak a common language, which is essential for coordination; thus they often differ in identification of beneficiaries.

## Triple A: A shared platform

A practical solution was to bring the three frontline workers together under one platform, known as triple A or 'AAA' (a combination of ASHA, AWW and ANM). In 2016-17, AAA was established in 2700 villages in Rajasthan's Jhalawar and Baran districts over a six-month period. This massive effort was driven by the workers themselves, aided by a 13-member

## The case of Radha

Radha (not her real name) is an 18-month old child with severe acute malnutrition (SAM) in a village in northern India. When she visited the local Anganwadi Centre, the AWW discovered that Radha was underweight. There are two issues. Firstly, the AWW cannot validate whether Radha is malnourished without measuring her mid-upper arm circumference (MUAC) to confirm SAM, which only the ASHA is equipped to do. However, the ASHA would only reach Radha's house after several days, following the prescribed linear visit plan (houses 1-10 on day one, houses 11-20 on day two, and so on). The AWW also lacks the technical knowledge to determine whether Radha should be referred for treatment of SAM. The ANM, a trained nurse, is best suited for this but, in the absence of a clear information flow between the three, there is a risk of children like Radha slipping through the net.

<sup>1</sup> Health and nutrition data from National Family Health Survey 4, 2015-16; Population data from Union Census, 2011.



Meeting of all three community health and nutrition workers in Khandi village, Rajasthan, with village map in background



Video:HI

Akshada team, and made possible by working closely with the government system. A joint order was issued by the state's health and integrated child services departments calling for AAA workers to coordinate efforts on MCHN through sharing records, coordinating use of village maps and household visits, regular joint meetings and better planning and surveillance.

The first step was establishing a common database and a focus on high-risk cases. Previously, each group had a different method of record keeping: AWWs organise people by families; ASHAs use households; and ANMs work on a record of fertile, married couples (where the wife is of reproductive age). Under AAA, groups worked together to create a joint village map of household and family coverage. On these maps they numbered houses and affixed 'bindis'<sup>2</sup> to denote various categories of beneficiaries and track them, prioritising those at highest risk – red for high-risk pregnancies, yellow for children with MAM and yellow with a red dot for SAM. Through this system the data is visually represented. AAA also enlisted members of local government, teachers and other influencers to validate their maps. This enabled the community to better appreciate the AAA's work and raise their standing in the villages.

### Coordinating actions

With some guidance from Akshada programme officers, the AAAs realised that maps could be used to plan their work. Using an algorithm, they scheduled visits based on community needs. Home Based Newborn Care (HBNC) visits, children released from Sick Newborn Care Units (SNCUs) and Malnutrition Treatment Centres (MTCs) were prioritised. Thus, the ASHA is present when and where she is most needed.

Importantly, the AAAs meet every month, following the village health and nutrition day, to review each other's work and data, plan for the next month and conclude with a peer learning session. Their new bond has also enabled them to undertake joint visits to difficult households like Radha's.

In the post-AAA world, Radha's nutritional status is confirmed by the ASHA and AWW since they share information. They alert the ANM, who offers medical advice during a joint visit, which is taken seriously by families. The AAA marks Radha's house with a yellow and red 'bindi' on the village map. The ASHA also factors this into her household visit calendar and visits Radha's house more frequently.

### Measuring impact

Impact is being measured via the active monitoring and evaluation of indicators (e.g. household visit calendars showing priority given to high-risk beneficiaries; care indicators, such as antenatal care registrations and visits; process indicators, including AAA meetings conducted by programme officers) and health system strengthening (adoption by the state). Limited monitoring data (from March to April 2018 for Anganwadi centres, covering ten per cent of the population of Jhalawar district) has shown that SAM identification against estimates increased from 1.1 per cent in March to 2.6 per cent in April alone; the percentage of children whose MUAC was measured increased from 52 per cent in March to 62 per cent in April; and MAM identification against estimates increased from 4.7 per cent to 10.6 per cent in the same period.

AAA is benefitting the community in that beneficiaries are no longer left literally 'off the map' and team accountability ensures every household is covered. Care is delivered to those who need it most and in a timely manner. Village mapping and curiosity about 'their bindi' has helped transform the community into empowered consumers of health and nutrition services. Tools like the village map also have wider potential in local governance.

### Next steps and key learnings

In December 2017, the AAA platform was adopted by the state government for scale-up. Over 100,000 ASHAs, ANMs and AWWs across the state are being trained via video-conferencing: the next challenge is how to provide maximum support for this massive endeavour. Moreover, an exciting technology to enable real-time data sharing between the three women is also being implemented in certain areas.

The AAA process has provided a number of lessons, such as the fact that the true value of data in aiding village health and nutrition workers is only realised when it is shared. Furthermore, co-opting the community determines the ultimate success of an intervention; and partnering with government is imperative for interventions to be scalable and sustainable. The common thread is that three female cadres working together can improve nutrition outcomes at the village level.

<sup>2</sup> Coloured dots worn on the forehead by women from some Indian communities.

# Developing a community-based nutrition surveillance system in Somalia



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## Introduction

Somalia's Gedo region is situated along its south-west border with Kenya and Ethiopia and comprises six districts (Belet Hawa, Dollow, Luuq, Baardheere, El Wak and Garbahareey). The population is largely pastoral and agro-pastoral; their livelihoods are often affected by cyclical droughts, which are common and increasing in severity. The region is home to over 734,126 people, including 168,000 internally displaced people (IDPs). Trócaire, an Irish NGO, operates in four of the seven districts, reaching approximately 225,000 people annually with interventions in health, nutrition, education and water, sanitation and hygiene (WASH), targeting IDPs as well as vulnerable and marginalised riverine and rural communities.

The need for humanitarian assistance in Gedo is clear: acute malnutrition is 13-15 per cent, above the emergency threshold for the region and an estimated 13,260 children need ongoing and urgent treatment<sup>1</sup>.

### Summary of features of the CBNS methodology

| Features                   | Sentinel site  |
|----------------------------|--|
| General objective          | Early warning/inform policy &/or programme               |
| Specific objectives        | Monitor trends   |
| Design type                | Longitudinal   |
| Sampling                   | Random   |
| Representativeness         | Representative   |
| Indicators                 | Nutrition, morbidity, immunisation and food security     |
| Analysis assessment design | Descriptive cross-sectional and inferential <sup>2</sup> |
| Data collection            | Periodic – every three months                            |
| Resources                  | Low to medium  |

## Capturing data for effective programming

In conjunction with other partners, including government officials, Trócaire identified the need for a nutrition surveillance system that acts as an early warning system for early case detection and for identifying populations at risk of acute malnutrition. This led to the development of a simplified community-based nutrition surveillance system (CBNSS) to provide continuous trend monitoring of the nutrition situation rather than one-off surveys that only show prevalence levels at a particular point in time.

The CBNSS involves a random selection of villages (referred to as sentinel sites) that represent the catchment population and is using 30 such villages to monitor key trends in the following indicators:

- Global Acute Malnutrition or GAM (SAM+MAM) by mid-upper arm circumference (MUAC) and/or oedema;
- Diarrhoea, acute respiratory infections and fevers;
- Vitamin A and measles immunisation; and
- Household hunger scale.

Data collection is carried out every three months by trained community nutrition workers (CNWs), who are local residents. Prior to the data collection, the CNWs undergo a refresher training on data collection. Current spend on the CBNSS is US\$5,000 per cycle, covering the need for CNW refresher trainings each quarter before data collection. This is expected to decrease to approximately US\$4,000 per cycle.

## Changes to programme design

The 2017 CBNSS assessment had two main results, both of which called for a programme redesign: firstly, it revealed high levels of household food insecurity in all three districts;

<sup>1</sup> FSNAU-FEWS-NET-2017-Post-Deyr-Technical-Release-29-January-2018.

<sup>2</sup> Use of a random sample of data taken from a population to describe and make inferences about the population.

secondly, it identified the need for support in areas not previously targeted.

Food baskets were subsequently included in emergency interventions. The initial food basket contained rice, beans, oil and sugar. However, through community feedback, there was a request to include flour and to divide the 50 kgs of rice into 25kgs of rice and 25kgs of wheat flour; these recommendations were undertaken.

The response initially focused on IDPs in Luuq and Dollow. However, results from the CBNSS led to a retargeting and inclusion of beneficiaries in Belet Hawa, where little response had previously taken place, as well as increasing support for riverine communities in Dollow and Luuq. Trócaire has since secured funding to support this initiative.

### Working with communities

The key implementing partners in all four districts include the community-appointed District Health Boards (DHBs) and Community Education Committees (local structures comprising of respected members of different clans within the district), and the Ministry of Health (MoH) District Health Officers. These structures are an effective, sustainable model for provision of services, particularly in a context where insecurity remains a challenge<sup>3</sup>.

The DHBs supported compilation of population data, mapping accessible/inaccessible areas and arranging community mobilisations (informing/gathering community members when surveillance was due). The MoH District Records Officers were trained as trainers of trainers (ToTs) and participated in the training of the CNWs for data collection and supervision. A technical team oversaw the process and disseminated the data to the programme team, community members, Nutrition Cluster partners in Gedo and other stakeholders. The focus is on a phased plan for establishing structures that provide direct

oversight for health services with ongoing training to build capacity of local government officials.

### Lessons learned

A number of aspects of the programme are working well, including buy-in from staff, government and the community, enabling implementation and the use of the data for decision-making and resource mobilisation. In addition, female CNWs have gone beyond the CBNSS, training women on MUAC screening in their own villages. More mothers are now aware of malnutrition, resulting in a notable increase in self-referrals (270 children over a six-month period).

CNW recruitment has been a challenge, partly due to literacy levels, although a translation of the tools into Somali, refresher trainings and supervision have improved capacity. Community expectations are high; some people feel left out due to the highly targeted nature of interventions and this requires continuous community sensitisation.

Experiences and lessons learned will be shared with stakeholders now that the one-year/four rounds of data collection are complete. Initial findings show that the system can be used to identify hotspots for malnutrition at a lower unit level (i.e. village level) than the FSNAU assessments can identify, as these are more general and less frequent (six-monthly compared to every three months). There are plans to advocate for CBNSS scale-up and integration into community nutrition programming (for example, livelihood and food security interventions) in light of the high GAM rates in South Central Somalia, including Gedo.

<sup>3</sup> The Gedo region was operating without any government structures until 2015. Trócaire, in partnership with the DHBs, has been in charge of health service delivery in the bigger part of Gedo. With the new government in place, Trócaire is slowly shifting some responsibilities to the regional and district government offices in health and education with the aim of handing over fully to the government by 2021.



Trócaire

# Delivering high-quality, locally produced and fortified, blended food products in West Africa



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One of the obstacles to ensuring access to affordable, fortified blended food products (FBFs) in Africa is the lack of companies with the capabilities, technology and know-how (including quality control mechanisms and tests) for production. Therapeutic and supplementary food products such as Plumpy'Nut and super cereals largely depend on imports. To overcome this constraint, the Global Alliance for Improved Nutrition (GAIN) and the World Food Programme (WFP) started a multi-million dollar project in 2015 called ALTAAQ (Achats Locaux, Transformation Alimentaire et

Amélioration de la Qualité). This project recognises the strong links between agriculture, food production companies and nutrition. The project works with farmers, food companies and food-testing facilities to develop locally produced FBFs targeted mainly at infants and children aged 6-59 months (super cereal type of porridge); older children above five years of age (peanut butter paste); and pregnant women. The project's focus is on three francophone countries in West Africa: Senegal, Mali and Burkina Faso. In each, a collaboration with relevant government sectors, including the Ministries of Commerce, Agriculture and Health, is undertaken.

The FBFs include a lipid-based spreadable paste as well as fortified flours and cereals that can be eaten both in stable situations and where there are emergencies. Fortification is done with micronutrients adapted to the nutritional deficiencies directly affecting the local population. The products will be sold commercially on the local market and may also be purchased and distributed by WFP and other partners as part of their humanitarian work.

The project is supporting factory improvements, capacity-building and machinery as well as technical assistance. Because the companies will be able to use local ingredients, the cost of producing the products will allow the companies to sell them at a lower price and will potentially be sustainable. Though the market cost of the products is not yet decided, work is underway to set prices below the current market cost for similar products. (It should also be pointed out that the products developed under the project will not be targeted to infants under six months of age and are not expected to act as replacements of other local, complementary foods but as a supplement to them.)

The four-year project is scheduled to end in late 2019. A unique feature is that it is focused on three integrated parts of the value chain: farmers who are growing the ingredients; the local food companies processing them into finished products; and the laboratories who ensure that they meet nutritional needs and stringent quality standards.



Mothers feed their children fortified food in Matam, Senegal

WFP/Judith Schuler



Laboratories have been upgraded with new equipment and staff training

GAIN

*“The project is contributing to an increased functionality of the national food safety system, which is essential for protecting the health of consumers. The support in improving the quality control and maintenance of the laboratories’ accreditations has had a very positive impact.”*

Ndèye Yacine Ndiaye Diallo, Industrial Quality Advisor,  
Institute of Food Technology (ITA), Senegal

### Working with farmers to improve the quality of raw materials

The ‘farm-to-fork’ supply chain starts in the field. The project has provided farmers with equipment (such as machines for drying and storing the produce) as well as trainings to promote knowledge transfer. (For example, provision of a ‘train-the-trainers’ session in Senegal enabled local farmers to be coached by local trainers who are familiar with their context and practices.) Trainers were also able to meet the quality managers and food technologists in the factories to understand the needs and standards for high-quality raw material.

### Supporting companies to produce the products

First, it was essential to select products made from local ingredients that were regularly consumed. Flours (for porridges) and food pastes (like peanut butter) were identified as the best vehicles as these are already well known to the local population. The sugar content in the peanut-based pastes has been reduced by 40 per cent compared to the non-fortified traditional peanut butter spreads consumed in these countries to support efforts towards a healthier diet.

Three businesses were chosen to help develop the products, one in each country. These are medium-sized companies that already produced food products in which the nutrient

content could be boosted to help to meet the needs of women and children.

Next, the product formula was adapted to the local ingredients and eating habits. Most progress has been made to date in Burkina Faso, where GAIN has collaborated with a team of experts from a French international NGO to reformulate the fortified blended flour in order to comply with both the national standards and the specifications of the product distributed in emergencies.

The project has conducted a detailed evaluation of the needs of each company to assess gaps in production. For example, a mini-lab has been installed so that routine analyses can be conducted on the raw materials and finished products. Furthermore, the regular quality management is assured and staff have been trained on hygiene practices.

Finally, recipes are being developed and equipment needs in Senegal, Burkina Faso and Mali are being assessed, together with acceptability studies which will play an essential role in matching the products’ presentation and taste to consumer preferences. An affordability study will be done through the development of a comprehensive business plan to ensure that products are priced appropriately.

### Lessons learned

There have been some challenges to get the project started and to deliver on some of the goals. It took longer than expected to find the right factories and laboratories that were willing to work with the project to upgrade the quality of production and analyses. From this, the team learned that it was important to partner with actors that already had high-quality production processes and saw the value in expanding their services. Another challenge involved the work with farmers and convincing them to change some of their practices. Working with local ‘trainers of trainers’ who are familiar with farming practices and are trusted by farmers when proposing new ways of working has helped overcome this barrier. Overall, the project has found very capable partners in each country and the team is confident that the launch of the products will lead to sustained consumption of more nutritious foods.



GAIN

Processing peanuts to make fortified peanut-based pastes



Phil Hatcher-Moore/ UNICEF

A counsellor advises mothers on IYCF at a health centre in South Sudan



WFP/ Rose Ogola

A woman collects grain from sorghum plants in Turkana, Kenya

# Online tools

## Nutrition Champions’ toolkit

A toolkit – *Identifying, Engaging and Sustaining Champions for Nutrition* – from Transform Nutrition and the SUN Movement Secretariat shares the experiences of more than 30 countries on fostering support at all levels, including high-level political and popular champions, ministers, MPs and heads of organisations and, at the grassroots level, including health, agriculture and nutrition extension workers and religious leaders. Champions should be relevant for the context and specific purpose, and the tool includes a champion engagement plan to ensure strategic long-term engagement.

[docs.scalingupnutrition.org/wp-content/uploads/2017/12/SUN-Engaging-and-sustaining-champions-for-nutrition-ENG.pdf](https://docs.scalingupnutrition.org/wp-content/uploads/2017/12/SUN-Engaging-and-sustaining-champions-for-nutrition-ENG.pdf)



## Monitoring tool for ‘the Code’

To support implementation of the International Code of Marketing of Breast-milk Substitutes (the Code), WHO, UNICEF and partners have developed the NetCode toolkit. This contains guidance and tools for establishing a national monitoring system; detecting, investigating and acting on alleged violations of existing national measures and the Code; and conducting periodic assessments to verify the level of adherence to national measures. Chile, Ecuador and Mexico conducted an in-depth survey on inappropriate marketing practices based on the protocol, while Cambodia and Kenya adapted the protocol in preparing an implementation and monitoring framework for enforcement of their national laws governing the Code.

[www.who.int/nutrition/publications/infantfeeding/netcode-toolkit-monitoring-systems/en](http://www.who.int/nutrition/publications/infantfeeding/netcode-toolkit-monitoring-systems/en)



## Online platforms

*Malnutrition Deeply* takes a fresh look at critical topics such as stunting, maternal health and food and nutrition security. The platform covers stories on the ground, current debates and how innovations are transforming the nutrition community.

[www.newsdeeply.com/malnutrition/about](http://www.newsdeeply.com/malnutrition/about)

SDG 2 advocacy hub is an initiative bringing together nutrition, food and agriculture organisations to work strategically towards zero hunger in order to meet Sustainable Development Goal 2. Members can network and access content, advocacy tools and campaign guidance via the online platform.

[www.sdg2advocacyhub.org/index.php/](http://www.sdg2advocacyhub.org/index.php/)



## Tools on gender

The Project-Level Women’s Empowerment in Agriculture Index (pro-WEAI) helps agricultural developmental projects assess women’s empowerment in a project setting, diagnose areas of women’s disempowerment, design strategies to address deficiencies and monitor project outcomes.

[weai.ifpri.info/2018/04/27/introducing-pro-weai-a-tool-for-measuring-womens-empowerment-in-agricultural-development-projects/](http://weai.ifpri.info/2018/04/27/introducing-pro-weai-a-tool-for-measuring-womens-empowerment-in-agricultural-development-projects/)

Developed for World Food Programme (WFP) but adaptable for other organisations, the *Gender Toolkit* is a set of resources for integrating gender into the work and activities of WFP to support achievement of gender-equality outcomes in food security and nutrition.

[gender.manuals.wfp.org/en/gender-toolkit/](http://gender.manuals.wfp.org/en/gender-toolkit/)



# SUN Movement update: Making a MEAL of it



Earlier this year, the 60 countries and three Indian States in the SUN Movement held their 2018 **SUN Joint Annual Assessment (JAA)**. 2018 is the fifth year that SUN Countries have undertaken the process allowing for collaboration, consensus-building and priority-setting for the year ahead.

In collaboration with ENN and Secure Nutrition, the SUN Movement Secretariat held a series of webinars to assist countries in preparing for the JAA and make use of country dashboards that highlight areas of focus for scale-up in each country. The dashboards form the basis of the SUN Movement’s **Monitoring, Evaluation, Accountability and Learning (MEAL)** system, which measures the extent to which the SUN Movement is achieving results and impact.

MEAL indicators align with globally-agreed monitoring frameworks and utilise data that is already available and has

been reviewed for quality (e.g. UNICEF Global Databases, WHO Global Health Observatory). This is combined with the yearly reported results from the JAA as well as finance data from national budget analyses and donor spending reviews. The 2016 MEAL Baseline report provides a detailed analysis of each indicator across eight domains (figure 1) to assess how SUN countries are progressing. The MEAL system enables new member countries to benefit from learning opportunities with long-time members and technical assistance in order to strengthen both political and financial enabling environments. It also demonstrates the need to focus further on countries with a high humanitarian risk, as well as countries in West and Central Africa, through greater access to country-to-country learning.

A representative from the SUN Civil Society Network said during the webinars: “The MEAL can be used to look at available data across the different domains and stimulate discussions on gaps, challenges and whether ongoing work is aligned or not.” This was echoed by the UN SUN Network: “It is a very useful tool to bring together different networks at country-level. It can be used for reflection to see where a country is and where it wants to go.” An academic and SUN Executive Committee member from Nepal confirmed that the dashboard is being used for advocacy on programming and investments at both the national and sub-national level. In Kenya, the dashboard’s potential utility for sub-national planning and identifying data gaps was noted by the country’s SUN Government Focal Point.

As SUN Countries undertake the JAA, the MEAL is helping to guide priority-setting and areas for increased focus. For example, the tool demonstrates that the majority of SUN countries need to include targets for diet-related non-communicable diseases in their nutrition plans, national development plans and economic growth strategies. It also shows that greater focus needs to be given to the critical first 1,000 days window of opportunity, as most SUN countries have insufficient funding allocated to scale up nutrition-specific interventions effectively. It also clearly illustrates the need to put women and adolescent girls at the centre of efforts.

A member of the SUN Executive Committee said: “As the excellent SUN Country Dashboard for Nigeria notes, the country does well on enabling environment and on legislation but it does less well on scaling of interventions and quality of food supply and on the SDG [Sustainable Development Goal] drivers of nutrition (such as WASH [Water, Sanitation and Hygiene], women’s empowerment and age of marriage)”. The MEAL therefore demonstrates the importance of SUN countries optimising the delivery of high-impact nutrition actions through a range of platforms and sectors that go beyond health.

Further information is available from the MEAL webpage: [www.scalingupnutrition.org/progress-impact/monitoring-evaluation-accountability-learning-meal/](http://www.scalingupnutrition.org/progress-impact/monitoring-evaluation-accountability-learning-meal/)





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