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Note: The Gambia and Ethiopia are SUN countries but country fiches have not been included in this report.

Preface

One year ago, I joined a group of leaders in pledging to do more to address the global burden of under-nutrition. We set ourselves the ambitious target of substantially reducing under-nutrition during the most vulnerable 1,000-day period of a child's life, from pregnancy to the age of two.

The need for such an initiative is abundantly clear. The food insecurity being faced by millions of people following prolonged drought in the Horn of Africa underscores the need to provide nutritional care and to support national authorities as they help vulnerable families realize their right to food, enjoy food and nutrition security, and resist the impact of climatic and other shocks. Under-nutrition in early in life can also lead to obesity, diabetes and heart disease in later life, making this year's High-level Meeting of the General Assembly on Non-Communicable Diseases especially timely.

Nineteen countries have joined the Movement for Scaling Up Nutrition (SUN), with others soon to follow. Hundreds of local, national and international stakeholders have come together to support them. The initiative is off to a good start.

I welcome SUN's intent to focus on interventions that directly empower women and their households, and to encourage government policies – in particular those for agriculture, health, education, employment and social protection – to be sensitive to nutritional needs.

The UN system is committed to the SUN Movement and our shared work to support national efforts, promote multi-stakeholder action, help integrate the policies of different sectors, and advocate for nutrition internationally. Nutrition is strongly embedded in the work of my High Level Task Force for Food Security and the efforts of the Every Woman Every Child effort.

This report shows the value of having stakeholders agree on policies, frameworks for action, road maps, operational plans, financing mechanisms, systems for monitoring progress and procedures for accountability. This type of groundwork will be even more necessary as the Movement goes beyond engaging partners to realizing results.

Many individuals, networks, governments, organizations, businesses and international bodies have worked hard to ensure the necessary synergy for the Movement to work, and I applaud those individual and collective contributions. For my part, I will continue to stay closely engaged in the SUN Movement and look forward to the impact it will have on our quest to achieve the Millennium Development Goals and truly sustainable development.

BAN Ki-moon, United Nations Secretary-General

Introduction

This compendium of country fiches has been prepared for the High Level Meeting on Nutrition hosted by the United Nations (UN) Secretary-General at the UN General Assembly on September 20th 2011 and the follow-up workshop for the Scale-Up Nutrition (SUN) Movement on September 21st. It accompanies the SUN progress report that is a global overview of progress one year after the launch of the Movement. The country fiches prepared by SUN countries and their partners provide information on progress in individual countries. The report and compendium have been compiled by the Special Representative of the UN Secretary General for Food Security and Nutrition as draft documents for the September meetings. They are not official UN documents. They will be finalized after these meetings and made available to participants. Please address all questions or comments to nabarro@un.org.

1) Food and nutrition security is increasingly recognized as a human right and the basis for economic, social and human development. Yet, ensuring adequate nutrition is an under-recognized global challenge. Today, 925 million people suffer from long-term hunger – or the inability to access enough nutritious food for a healthy life – while one-third of young children, 171 million, are chronically under-nourished and 55 million are wasted. Every year, under-nutrition contributes to 3.5 million preventable deaths of children under the age of five years. Under-nutrition impairs intellectual and physical development and increases the risk that illnesses become fatal. It is also now known to contribute to non-communicable diseases in later life - diseases like diabetes, cardiovascular diseases and cancers.

2) The last decade has witnessed many development successes – including worldwide reductions in child and maternal mortality, increased vaccination rates and literacy in women. Levels of under-nutrition have remained stubbornly high, however, especially in Africa and South Asia. Investing in better nutrition creates life-long, valuable returns. Good nutrition during the 1,000 days between pregnancy and age two contributes to good health, educational achievement, and future income earning potential. It increases a nation's gross domestic product by at least two to three per cent annually. Investment in nutrition is vital to achieving many of the United Nations Millennium Development Goals (MDGs), including eradicating poverty and hunger, reducing child mortality, improving maternal health, combatting disease, empowering women, and achieving universal primary education.

3) The causes of under-nutrition – immediate, underlying and basic - are well recognized. In the long-term these can be addressed by implementing development strategies that are sensitive to people's nutritional needs, together with specific interventions that lead to improved nutritional outcomes among children under two years of age and pregnant and breastfeeding women. Nutrition-sensitive development demands that nutritional outcomes become key goals of national development policies. This involves:
   - Ensuring optimal nutritional impact of all agriculture and food security programmes through research, action, and close monitoring;
   - Ensuring optimal nutritional impact of social protection programmes and targeting of safety nets for vulnerable communities;
   - Ensuring appropriate nutritonal focus within maternal, new-born and child health programmes;
   - Incorporating nutritional considerations within child and adult education;
   - Enhancing the nutritional impact of poverty reduction, employment generation, rural development, water and sanitation and emergency response programmes.

4) The above strategies, combined with specific cost-effective nutrition interventions, will significantly reduce under-nutrition, if they are delivered using efficient mechanisms for implementation - systems for finance, procurement, training and accountability. Effectiveness also depends on a sound understanding of progress made, challenges faced and options for improvement, particularly within communities at risk of under-nutrition. This calls for investment in data systems, monitoring, evaluation, and research.

5) **Vision:** The Scaling-Up Nutrition (SUN) Movement brings together the authorities of countries burdened by under-nutrition, a broad range of stakeholders from multiple sectors in-country, and a global coalition of partners. They have committed to working together to create conditions in which household members – especially women – are enabled to improve their own and their children's nutrition. By implementing a set of specific nutrition interventions, expanding the pool of resources for this effort, and integrating nutrition into health, agriculture, education, employment, social welfare and development programmes, participants in the Movement can together contribute to significant and sustained reductions in under-nutrition and significantly improve the health and prosperity of future generations.

6) **Mission:** Through a coordinated effort that includes technical support, high-level advocacy and innovative partnerships, participants in the SUN Movement will improve people's nutrition and so strengthen health and development. The SUN Movement is not a new initiative, institution or fund: instead it increases the effectiveness of existing initiatives and programmes by supporting national leadership for nutrition; encouraging focus and alignment of this support; and enabling the participation of a wide range of stakeholders to ensure broad ownership and shared responsibility for results.

7) The role and scope of work of the SUN Movement are set out in two documents prepared in 2010: the SUN Framework and the SUN Road Map. These documents outline the approach to implementation and ways of working together within the SUN Movement.

Figure 1: The SUN Framework and SUN Road Map

The ***SUN Framework*** sets out the approaches to tackling high levels of under-nutrition focusing on the 1,000 day window of opportunity. It recognizes that social and economic policies that encourage freedom from hunger, the right to adequate food and nutrition, and the highest attainable levels of health will, if implemented properly, lead to improvements in nutrition. It spells out what needs to be done to improve nutrition outcomes, what investments are required to scale up effective nutrition actions, and the key working principles to move this forward. It is not a prescriptive plan, but an outline of core elements and actions on which national plans can be built and tailored.

The ***SUN Road Map***, developed by a multi-stakeholder task team, provides the principles and direction for increased action and support for countries as they scale up efforts to tackle under-nutrition across a range of sectors. It reflects the principles of food security approved by delegates at the November 2009 Food and Agriculture Organisation World Summit on Food Security and the 2010 World Health Assembly resolution 62.23 on maternal, infant and young child nutrition and is anchored in the United Nations Standing Committee on Nutrition's guiding principles developed in 2009. The Road Map encourages a coherent approach amongst leaders and other nutrition stakeholders to promote coordinated actions to increase the effectiveness of efforts.

Bangladesh

Country context

In the past two decades, Bangladesh has made considerable progress in development, sustaining high rates of economic growth and reducing poverty rates by 8 per cent between 2005 and 2010. In 2010, Bangladesh received the Millennium Development Goal (MDG) award for remarkable achievement in reducing child mortality (MDG 4). Bangladesh is also currently on track to meet MDG 5, for which it is out-performing other countries in the region. The current population of Bangladesh is around 162 million. The per capita Gross National Income is US$ 818 and the net Overseas Development Assistance received per capita was US$ 7.6.

In 2005, 40 per cent of the population, which translates into 56 million people, failed to meet the minimum caloric needs (defined as 2122 Kcal per person per day). Although there has been a reduction in child and maternal under-nutrition in Bangladesh, the prevalence of underweight among under-five children is still high at 41 per cent. The underweight rates for children have stabilized after declining significantly from about 66 per cent in 1990 to 51 per cent in 2000. More than 40 per cent of under-five children are stunted and 18 per cent wasted. Nearly one-third of women are undernourished. The prevalence of anaemia among young infants, adolescent girls and pregnant women is still high. Despite some success in specific programmes, such as the expanded programme on immunization and vitamin A supplementation, nutrition interventions have yet to be implemented at a scale to reach the entire population.

Government response

a) Overall vision for scaling up nutrition

The Government of Bangladesh has closed down its vertical nutrition programme in favour of supporting a multi-sectoral approach to addressing nutrition. The country's alignment with the SUN Movement is ahead of many other countries. This is due to the renewed emphasis of the Government on improving public health and nutrition. The Government is planning to send a letter to the Office of the United Nations Secretary-General's Special Representative for Food Security and Nutrition and Chair of the Scaling Up Nutrition (SUN) Movement Transition Team to signal its intent to scale up nutrition and join the SUN Movement.

b) Commitment to scaling up nutrition

Within the last year the Government has established institutional arrangement for nutrition actions delivered through the Ministry of Health and Family Welfare (MoHFW) by forming the National Nutrition Service (NNS) which is integrated into health and family planning services. The NNS will be guided by the following principles:

- The NNS will oversee implementation of nutrition interventions and coordinate with key sectors (for example, Ministries of Agriculture, Food and Disaster Management, business, non-governmental organisations, academia)
- The NNS will seek to intervene at different stages of the lifecycle with a strong focus on the "window of opportunity from pregnancy through the first two years of life.

The Government is scaling up its infant and young child feeding programmes throughout the country and remains committed to providing community nutrition interventions provided through the community clinics.

The Ministry of Industries is leading the work on fortification of edible oil and salt iodization with active support from the MoHFW. The Ministry of Local Government and Rural Development is leading an innovative programme based on 'one house, one farm'. A total of 578,400 farms will be set up for as many households in the rural area to cut poverty by creating jobs and ensure overall rural development. The Ministry of Information is playing an important role in creating awareness on nutrition issues.

c) National nutrition plans

Updating the National Plan of Action on Nutrition, that was developed in 1997, has been one of the priority actions of the Government. In addition, the formulation of the Agriculture, Food Security and Nutrition Country Investment Plan by the Ministry of Food & Disaster Management (MoFDM) in 2011 was undertaken through a coordinated mechanism between the MoFDM and other Ministries including MoHFW. In 2009 the government launched a plan of action on food policy which aims to ensure sustainable food security including availability, access, and nutrition by 2015.

d) Multi-stakeholder platforms

The Government has established a multi stakeholder platform, the Nutrition Task Group, to oversee nutrition programme planning. The group, however, has not been active in the last year. It has been proposed that a multi-sectoral steering committee is established as part of the national Bangladesh Health, Population and Nutrition Sector Development Programme (HPNSDP). This steering committee would oversee and coordinate nutrition services. Recently, the Government has decided that the National Health Council should serve as the high level coordination committee and involve different ministries in health and nutrition interventions. The National Health Council will coordinate between the relevant ministries, development partners and other stakeholders on health and nutrition issues.

e) Stock-taking and gap analysis

Nutrition stock-taking and gap analysis has not yet been carried out in Bangladesh.

f) Engagement of non-governmental agencies

Preliminary consultations between development partners and MoHFW have already taken place. Development partners are well-aligned and committed in their support of the Government's plans on nutrition interventions. Preliminary consultations on SUN among donors, United Nations (UN) and civil society organizations (CSOs) have been taking place on a regular basis in Bangladesh. A SUN Core Working Group has been established since April 2011. The UN REACH initiative together with the World Bank is currently designing mechanisms at district level to ensure multi-sectoral interventions.

g) Next steps

The major challenges to scaling up nutrition in Bangladesh are:

1. Low level of knowledge and awareness among the policy makers and service providers about the long term effects of under-nutrition
2. Lack of capacity of nutrition service providers and programme managers
3. Weak monitoring and supervision mechanism of nutrition interventions
4. Weak intra and inter-sectoral linkages and coordination

There is an urgent need for a dedicated multi-sectoral governance structure at the highest political and decision-making level that will manage and monitor the scale-up nutrition process and ensure that nutrition remains a national developmental priority. This structure will also ensure that the various national initiatives with potential impact on nutrition are better harmonized and coordinated.

Special attention should be paid to the following:

1. Operationalizing the NNS to ensure coordination in nutrition interventions
2. Human resources development : capacity building of existing workforce in the health sector
3. Ensuring multi-sectoral coordination and establishing intra and inter-ministerial linkages on nutrition interventions
4. Conducting a stock taking and a costing exercise as soon as possible.

Scaling up financial commitments

Development partners have expressed commitment to support the Government of Bangladesh's nutrition strategy and interventions. Several development partners already agreed to pool funds to support the HPNSDP, which comprises substantial investment for nutrition interventions. The Ministry of Finance and development partners are committed to allocating budgetary resources, grants and loans to the agriculture sector to attain food security and nutrition, according to the Finance Minister AMA Muhith at the National Forum on "*Improving the Bangladesh Country Investment Plan*" in March 2011.

Case studies

Although there is a huge need to scale up nutrition interventions in the country, Bangladesh has made significant gains in recent years. All the nutrition interventions targeted for scaling up are among those that have been recommended by the Lancet series on maternal and child under-nutrition. Two such interventions deserve special mention: vitamin A supplementation and zinc as an adjunct to treatment of childhood diarrhoea. The current coverage of vitamin A capsule supplementation in Bangladesh is around 90%, one of the highest in the region. The coverage of zinc treatment for diarrhoea is 20% which is the highest among countries with high burdens of under-nutrition. The Government's decision to mainstream nutrition within the existing health system will improve access to nutrition interventions for those living in hard to reach areas and the poorest segment of the population.

Vitamin A supplementation

The prevalence of night blindness in Bangladesh has been drastically reduced from 3.7% to 0.04% over a period of two decades. Night blindness is no longer a significant public health problem in this country. Change has resulted from a nationwide vitamin A campaign, which covers over 90% of children, and implemented by the MoHFW with active participation of other stakeholders including other ministries, non-government organizations and development partners. De-worming has been added to the vitamin A campaign to nationwide scale up of nutrition services. The campaign invests substantial resources in demand creation, public awareness building and community mobilization.

The REACH initiative in Satkhira

In Satkhira district, the REACH partnership proposes a joint commitment by all stakeholders working together at district levels to ensure that a set of effective nutrition interventions are delivered at scale. Recently REACH started to provide support to the Government to facilitate both nutrition governance and the critical nutrition actions to ensure complementarity among the key ministries and sectors, as well as with development partners. The results of a situation analysis, including surveys and stakeholders mapping exercise, will enrich the Government of Bangladesh and development partners' plans of action for strengthening nutrition interventions. Furthermore, the World Bank and the REACH Initiative are currently jointly developing a Multi-Sectoral Simulation Tool to help the Government identify and then implement cost-effective interventions that would generate a significant improvement in nutritional outcomes. Evidence gained from this tool will support the effective scaling up of nutrition interventions in further districts.

Bangladesh basic indicators

Total population	162,221,000
Population below $1 (PPP) per day, percentage (2005)	49.6
Life expectancy at birth m/f (years)	64/66
Total expenditure on health per capita (Intl $)	48
Adult literacy rate 2005-08 m/f (%)	60/50

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	43% (2007)
Wasting (weight-for-height < –2 SD of WHO standards)	18% (2007)
Birth weight (< 2500 grams)	22% (2006)
Adult thinness (Body-Mass Index <18.5 in women of reproductive age)	30% (2007)
Anaemia in children 6-59 months (Hb < 11 g/dL)	68% (2004)
Anaemia in pregnant women (Hb < 11 g/dL)	36% (2004)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year)	97% (2008)
Iodine supplements (households consuming iodized salt)	84% (2006)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	20% (2007)
Exclusive breastfeeding (infants 0–5 months)	43% (2007)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	11% (2007)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	0.33 (2007)
Access to water (improved drinking-water sources)	80% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	44, 39, 41
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	53, 51, 52
Maternal mortality rate (annual number of female deaths per 100,000 live births)	340 (170-660)
Nutrition governance score	Strong

NA= Not Available

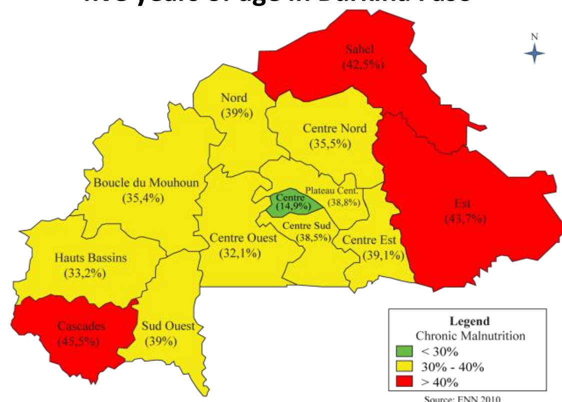
Burkina Faso

Country context

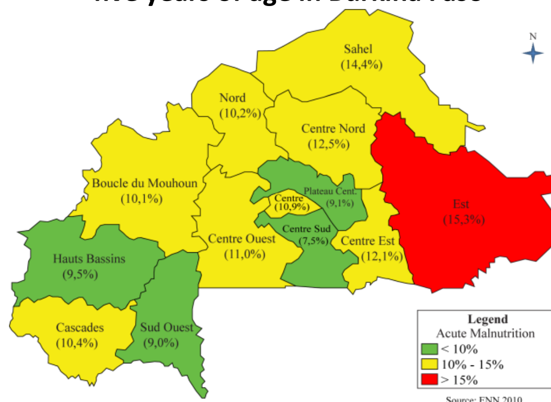
Land-locked in the heart of West Africa, Burkina Faso borders on the Sahara desert and is in the Sahel belt. With 16 million inhabitants, the country is characterized by high rates of population growth. About 44 per cent of the population lives below the poverty line. Burkina Faso was ranked 161st out of 169 countries in the 2010 Human Development Report and faces a number of challenges including high illiteracy and child mortality rates.

Burkina Faso has made important progress in economic growth, which has increased from 3.2 per cent in 2009 to 7.9 per cent in 2010. This is largely a result of growth in the mining and agricultural sectors. Global factors including rising food prices, the financial crisis and the consequences of climate change (drought and floods) are having a negative impact on food diversity and contribute to the persistence of under-nutrition among children under five. Though stunting affects more than one third of young children, rates are declining overall.

Map. 1 : Country map with prevalence of stunting by province in children under five years of age in Burkina Faso



Map. 2 : Country map with prevalence of wasting by province in children under five years of age in Burkina Faso



Source: National Nutrition Survey 2010

Government response

a) Overall vision for scaling up nutrition

Following a deterioration of the nutritional status observed in the 1990s, the Government of Burkina Faso has undertaken significant efforts to better organize and revitalize nutrition interventions. The national nutrition policy adopted in 2007 outlined a clear vision for nutrition development in the country. This vision for nutrition was based on the broader goal for health which was to ensure the best health status for the entire population through provision of a functioning national health care system.

b) Commitment to scaling up nutrition

The Government's political will to make the fight against under-nutrition a national development priority was demonstrated in 2002 through the creation of the National Directorate of Nutrition within the Ministry of Health and through putting in place the elements of the "Three-ones" as follows:

- One national nutrition policy adopted in 2007 which outlined a clear vision for nutrition development for the country;
- One unique multi-sectoral coordination structure, through the creation of a national consultative council for nutrition (CNCN) in 2008;
- One monitoring and evaluation system through the organization of a national nutrition survey every year since 2009, surveys on food vulnerability in urban areas since 2007 and the integration of nutrition indicators in the national health information system.

Since the creation of the Directorate of Nutrition, the government has increased the number of nutrition specialists from 9 to 22 and a nutrition focal point has been designated in each of the 13 regional health directorates. In addition, more than ten thousand health and community workers have been trained in the promotion of infant and young child feeding practices and treatment of acute malnutrition. The provision of logistical materials also strengthened the supervision of specific nutrition activities throughout the health system.

c) National nutrition plans

The national strategic nutrition plan was developed in 2009 with an action plan and a multi-year budget for 2010-2015. In addition, nutrition is incorporated within the Strategy for Accelerated Growth and Sustainable Development (SCADD 2011-2015), in the National Health Development Plan (PNDS 2011-2020), in the Strategic Development of Basic Education Plan (PDSEB 2011-2020), and in the action plan for the information system on food security developed in 2004.

d) Multi-stakeholder platforms

In 2008, the National Nutrition Consultative Council (CNCN) was established by the government. It's a multi-sectoral coordination structure headed by the Minister of health with representatives from other Ministries (agriculture, education, social development, economy and finances) and development partners (UNICEF, WHO, WFP, FAO, World Bank, EU, NGOs). Thematic working groups were also created and in each of the 13 regions, a regional nutrition council was established and headed by the Regional Governors.

e) Stock-taking and gap analysis

In order to assess existing gaps/constraints and identify opportunities to integrate and scale-up nutrition-related actions, a landscape analysis was conducted in Burkina Faso in 2008 with the support of partners. This exercise has helped to identify the strengths and the weaknesses of the country in terms of willingness and capacity to act. The main gaps were identified and recommendations were formulated. Following this exercise, the national strategic action plan for nutrition was developed, the nutrition monitoring and evaluation system was strengthened, and nutrition focal points at regional levels were designated. A capacity building plan for nutrition is still needed, however, as well as strengthening of community-based approaches across the country. The landscape analysis was a good opportunity to lay the foundation for scaling up effective nutrition action in Burkina Faso.

f) Engagement of non-governmental agencies

In order to strengthen the strategic partnership with civil society in 2009, the Ministry of Health began contracting-out with civil society organizations which has allowed the financing of the activities of a network of 150 Executing Community Based Organizations. They implement health and nutrition interventions that have reached around 30 per cent of the population under the guidance of 15 capacity building non-governmental organisations, and the supervision of the health districts and regional governors.

g) Next steps

To continue building upon the initial improvements, the scaling up of nutrition interventions will require:

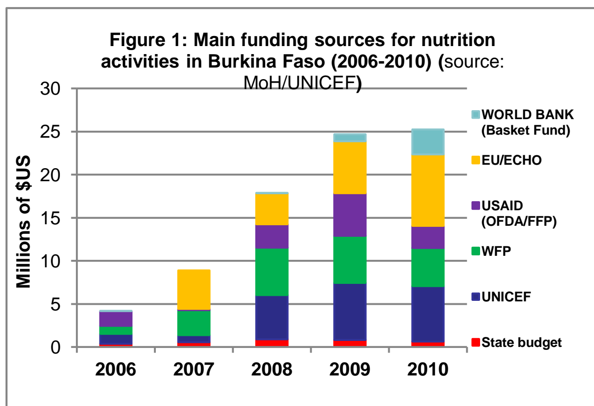
- Capacity strengthening of human resources at all levels;
- Strengthening of partnerships with civil society;
- Pro-active multi-sectoral approach;
- Mobilisation of adequate resources from the state budget and international partners;
- Increased predictability of aid through the gradual shift from emergency funding to development funds

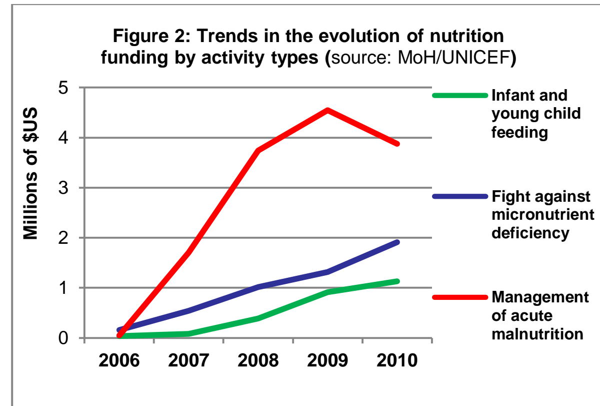
h) Scaling up financial commitments

Bilateral and multilateral organisations, and non-governmental organisations support the Government in pursuing the objectives of the national nutrition policy. Partners' actions have consisted primarily of supporting the scale-up of nutrition interventions through evidence-based advocacy, policy dialogue, capacity building at all levels and increased funding. As a result, the annual funding for nutrition activities increased from less than $5 million to more than $25 million between 2006 and 2010 excluding salaries.

However, most of these funds are emergency funds, which are unpredictable, and intended mainly to support curative actions for acute malnutrition. Preventative interventions, such as the promotion of breastfeeding and complementary infant feeding, receive very little funding.

Development partners plan to invest more than $100 million to support nutrition interventions in 2011-2015, but most of these funds have not been secured and are intended for curative interventions.





Case study

The measures taken by the government, with support from development partners, has allowed for the implementation of the following essential nutrition interventions:

- Promotion of breastfeeding and complementary feeding practices through the network of 150 community-based organisations;
- Vitamin A supplementation for children aged 6-59 months twice a year in the 63 health districts throughout the country, with operational cost secure from the Ministry of Health's common basket fund;
- Fortification of produced oil with vitamin A and wheat flour with iron, vitamins B and zinc;
- Strengthening the control system of iodized salt at borders and in markets;
- Management of severe acute malnutrition in all 13 regions and moderate acute malnutrition in 3 regions.

Burkina Faso has made significant progress in improving the coverage of nutrition interventions (see **figure 3**) and the nutritional situation (see **figure 4**) which has may have contributed to reducing the mortality rate of under-fives and the rates of under-nutrition, though rates remain high.

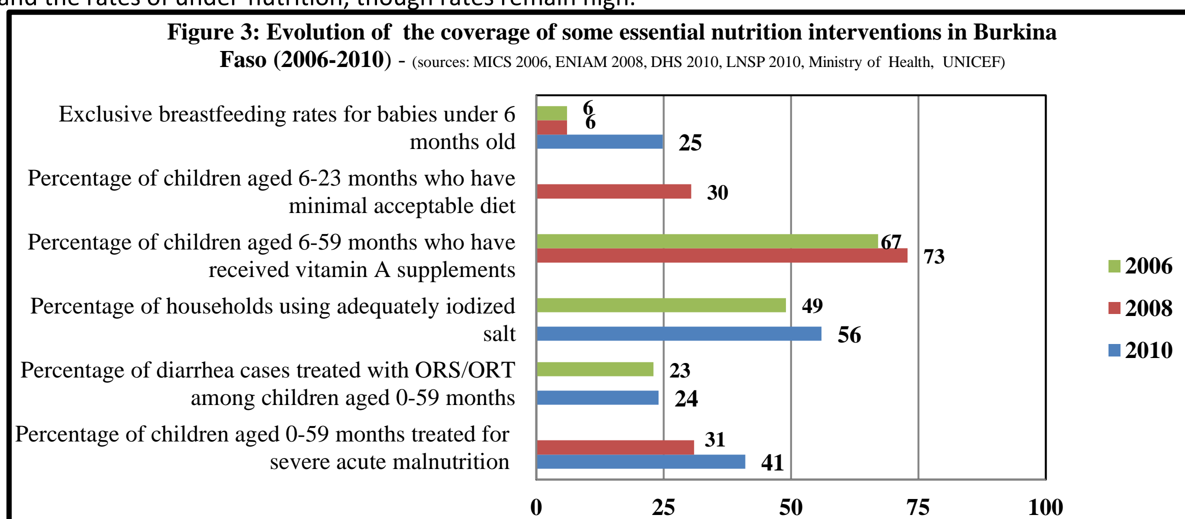
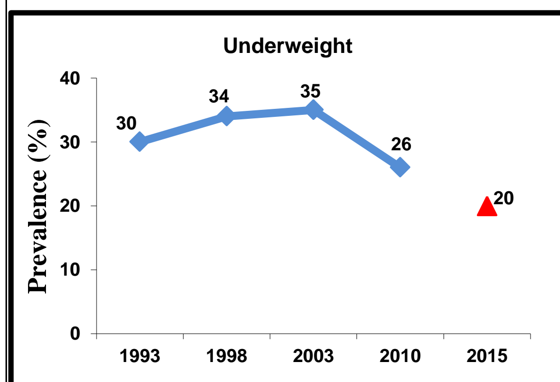
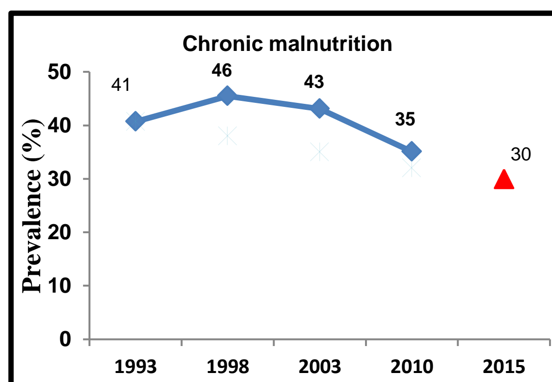


Figure 4: Evolution of malnutrition prevalence among children under five in Burkina Faso





Burkina Faso basic indicators

Total population	15,757,000
Population below $1 (PPP) per day, percentage (2005)	56.5
Life expectancy at birth m/f (years)	49/56
Total expenditure on health per capita (Intl $)	88
Adult literacy rate 2005-08 m/f (%)	37/22

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	35% (2010)
Wasting (weight-for-height < –2 SD of WHO standards)	11% (2010)
Birth weight (< 2500 grams)	12% (2008)
Adult thinness (Body-Mass Index <18.5 in women of reproductive age)	18% (2008)
Anaemia in children 6-59 months (Hb< 11 g/dL)	88% (2010)
Anaemia in pregnant women (Hb< 11 g/dL)	68% (2003)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	73% (2008)
Iodine supplements (households consuming iodized salt)	56% (2009)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	25% (2010)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	30% (2008)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes (1993)
Access to health care (community and traditional health workers / 1000 population)	1.04 (2011)
Access to water (improved drinking-water sources)	76% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - both sexes)	65 (2010)
Under 5 mortality rate (death before age 5 years per 1000 live births - both sexes)	129 (2010)
Maternal mortality rate (annual number of female deaths per 100,000 live births)	560 (330-950)
Nutrition governance score	Strong

NA= Not Available

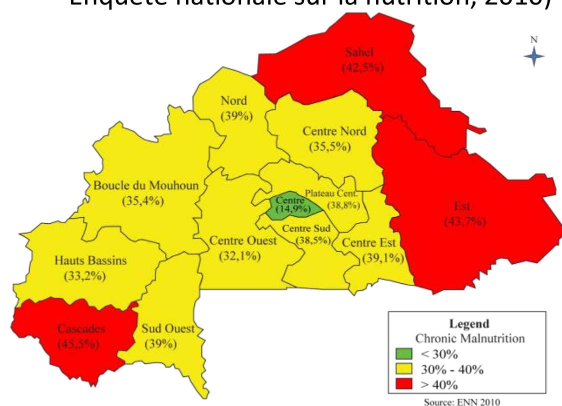
Burkina Faso (version française)

Situation du pays

Enclavé au cœur de l'Afrique de l'Ouest, dans la ceinture du Sahel, le Burkina Faso jouxte le désert du Sahara. Le pays, qui compte 16 millions d'habitants, est caractérisé par une croissance démographique relativement élevée, et près de 44 pour cent de la population vit en dessous du seuil de pauvreté. Classé 161 sur 169 dans le Rapport sur le développement humain 2010, le Burkina Faso est confronté à un certain nombre de défis, parmi lesquels des taux d'analphabétisme et de mortalité infantile relativement élevés.

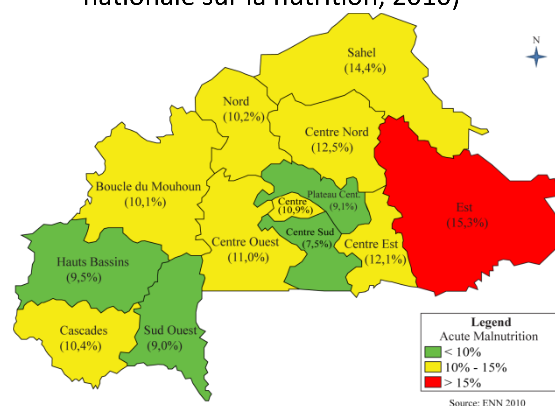
Le Burkina Faso a réalisé des progrès majeurs en parvenant à dynamiser sa croissance économique (7,9 pour cent en 2010 contre 3,2 pour cent en 2009), grâce notamment au développement des secteurs miniers et agricoles. Cependant, des facteurs de portée internationale, à savoir la hausse des prix des denrées alimentaires, la crise financière et les conséquences du changement climatique (sécheresse et inondations), affectent la diversité alimentaire, en plus de contribuer à une sous-alimentation persistante chez les enfants de moins de 5 ans. Bien que plus d'un tiers des jeunes enfants soient touchés par un retard de croissance, on assiste à une baisse globale de ces chiffres.

Carte 1 : prévalence du retard de croissance par province chez les enfants de moins de 5 ans au Burkina Faso (source **:** Enquête nationale sur la nutrition, 2010)



Légende
Malnutrition chronique

Carte 2 : prévalence d'émaciation par province chez les enfants de moins de 5 ans au Burkina Faso (source **:** Enquête nationale sur la nutrition, 2010)



Légende
Malnutrition aiguë

Actions du gouvernement

a) Vision globale pour le renforcement de la nutrition

Face à de la détérioration de la situation en termes de nutrition observée dans les années 1990, le gouvernement du Burkina Faso a décidé de se consacrer largement à une meilleure organisation et au renforcement des interventions nutritionnelles. La politique nutritionnelle nationale adoptée en 2007 esquisse une vision claire en termes de développement de la nutrition dans le pays. Cette vision repose sur l'objectif sanitaire plus large consistant à garantir la meilleure santé possible à toute la population à travers un système national de soins opérationnel.

b) Engagement pour le renforcement de la nutrition
La volonté politique de faire de la lutte contre la sous-alimentation une priorité nationale se traduit en 2002 par la création de la Direction nationale de la nutrition au sein du ministère de la Santé, et par la mise en place des « Trois Uns », à savoir :

- Une politique nutritionnelle nationale adoptée en 2007 qui expose une vision claire en termes de développement de la nutrition dans le pays ;
- Un organe de coordination multisectorielle unique, avec la création en 2008 d'un conseil consultatif national sur la nutrition ; et
- Un système de surveillance et d'évaluation, avec l'organisation d'une enquête nationale annuelle sur la nutrition (2009), d'enquêtes sur la vulnérabilité alimentaire en zone urbaine (2007) et l'intégration d'indicateurs nutritionnels dans le système national d'information sanitaire.

Depuis la création de la Direction de la nutrition, non seulement le gouvernement a augmenté le nombre de nutritionnistes, passant de 9 à 22, mais un point focal nutrition a également été nommé dans les 13 directions régionales de la santé. Par ailleurs, plus de 10 000 soignants et agents communautaires ont suivi une formation axée sur les pratiques alimentaires des jeunes enfants et des nourrissons et sur le traitement de la malnutrition aiguë. Et grâce à la fourniture d'équipements logistiques, la supervision des actions nutritionnelles a pu être renforcée à travers le système de santé.

c) Plans nationaux de nutrition
Un plan stratégique national en faveur de la nutrition est établi en 2009, conjointement avec un plan d'action et un budget pluriannuel pour 2010-2015. De plus, la question de la nutrition est intégrée dans la Stratégie de croissance accélérée et de développement durable (SCADD 2011-2015), le Plan national de développement sanitaire (PNDS 2011-2020), le Plan de développement stratégique de l'éducation de base (PDSEB 2011-2020) et le plan d'action en faveur du système d'information de sécurité alimentaire élaboré en 2004.

d) Plateformes multipartites
En 2008, le gouvernement met en place le Conseil consultatif national sur la nutrition, un organe de coordination multisectorielle dirigé par le ministère de la Santé qui réunit représentants d'autres ministères (Agriculture, Éducation, Développement social, Économie et Finances) et partenaires du développement (UNICEF, OMS, PAM, FAO, Banque mondiale, UE, ONG). En outre, des groupes de travail thématiques sont créés, et un conseil régional de la nutrition est implanté dans chacune des 13 régions, sous la direction des gouverneurs régionaux.

e) Analyse des écarts et bilan
Afin d'évaluer les contraintes / les écarts actuels et de déterminer les possibilités d'intégrer, voire d'élargir des actions nutritionnelles, une analyse globale est réalisée au Burkina Faso en 2008 avec l'aide de divers partenaires. Cette analyse a met en avant les atouts et les faiblesses du pays en termes d'engagement et de capacité d'action. À partir des principaux écarts relevés, des recommandations sont formulées. Suite à cette analyse, un plan d'action stratégique national en faveur de la nutrition est élaboré, le système de surveillance et d'évaluation est renforcé et des points focaux nutrition sont établis au niveau régional. Néanmoins, l'élaboration d'un plan de développement du potentiel demeure nécessaire, tout comme le renforcement à l'échelle nationale d'approches communautaires. L'analyse globale permet de poser les bases pour le développement d'interventions nutritionnelles efficaces au Burkina Faso.

f) Engagement d'organisations non gouvernementales

Afin de consolider son partenariat stratégique avec les acteurs de la société civile en 2009, le ministère de la Santé commence à faire appel à ces acteurs, contribuant ainsi au financement des activités d'un réseau de 150 organisations communautaires d'exécution. Ces dernières réalisent des interventions sanitaires et nutritionnelles en faveur de près de 30 pour cent de la population, sous les conseils de 15 organisations non gouvernementales de développement du potentiel et la supervision des districts sanitaires et des gouverneurs régionaux.

g) Prochaines étapes

Afin de tirer parti des améliorations déjà initiées, l'élargissement des interventions nutritionnelles doit impliquer à l'avenir :

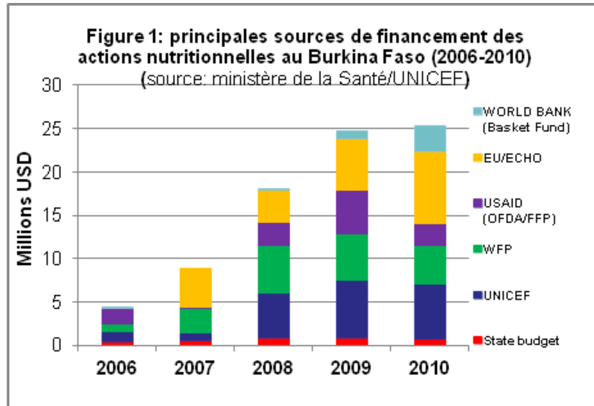
- Le renforcement du potentiel des ressources humaines à tous les échelons ;
- La consolidation des partenariats avec les acteurs de la société civile ;
- L'adoption d'une approche multisectorielle proactive ;
- La levée de ressources adéquates dans le cadre du budget de l'État et auprès des partenaires internationaux ;
- Une meilleure prévisibilité de l'aide en passant progressivement d'un financement d'urgence au financement du développement.

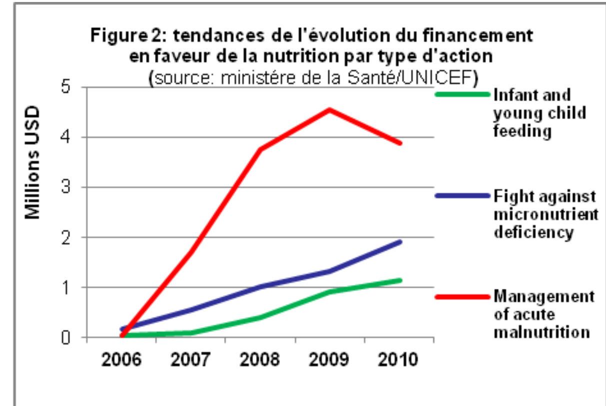
h) Renforcement des engagements financiers

Organisations bilatérales, multilatérales et ONG soutiennent les actions gouvernementales visant à réaliser les objectifs fixés dans la politique nutritionnelle nationale. Les partenaires participent notamment à l'élargissement d'interventions nutritionnelles à travers des campagnes de sensibilisation fondées sur des données factuelles, le dialogue politique, le développement du potentiel à tous les niveaux et un financement accru. Ces actions concourent ainsi à une levée de fonds annuels supplémentaires en faveur de la nutrition, passant de moins de 5 millions USD à plus de 25 millions USD entre 2006 et 2010 (à l'exclusion des salaires).

Cependant, il s'agit généralement de fonds d'urgence, qui sont d'une nature imprévisible et principalement dédiés à des actions curatives contre la malnutrition aiguë. Les interventions préventives, telles que la promotion de l'allaitement et de l'alimentation complémentaire des nourrissons, sont quant à elles bien souvent négligées.

Les partenaires du développement envisagent d'investir plus de 100 millions USD dans des interventions nutritionnelles entre 2011 et 2015. Néanmoins, la plupart de ces apports, non encore mobilisés, sont destinés à financer des interventions curatives.





Banque mondiale (fonds commun)
UE / ECHO
USAID (OFDA / FFP)
PAM
UNICEF
Budget de l'État

Alimentation des nourrissons et des jeunes enfants
Lutte contre les carences en micronutriments
Prise en charge de la malnutrition aiguë

Étude de cas

Les mesures prises par le gouvernement, avec le soutien de partenaires de développement, ont permis la mise en œuvre des interventions nutritionnelles essentielles présentées ci-dessous :

- Promotion de l'allaitement et de l'alimentation complémentaire à travers le réseau de 150 organisations communautaires ;
- Supplémentation en vitamine A chez les enfants âgés entre 6 et 59 mois deux fois par an dans les 63 districts sanitaires nationaux, et prise en charge du coût de cette action par le fonds commun du ministère de la Santé ;
- Enrichissement des huiles produites en vitamine A, et enrichissement de la farine de blé en fer, en vitamines B et en zinc ;
- Renforcement du système de contrôle du sel iodé aux frontières et sur les marchés ;
- Prise en charge de la malnutrition aiguë sévère dans l'ensemble des 13 régions et de la malnutrition aiguë modérée dans 3 régions.

Le Burkina Faso a réalisé d'énormes progrès grâce à une meilleure couverture des interventions nutritionnelles (cf. **figure 3**) et de la situation nutritionnelle (cf. **figure 4**). Le pays a ainsi réduit son taux de mortalité chez les enfants de moins de 5 ans et son taux de sous-alimentation, malgré des chiffres encore élevés.

Figure 3 : évolution de la couverture de certaines interventions nutritionnelles essentielles au Burkina Faso (2006-2010) - (sources : MICS 2006, ENIAM 2008, EDS 2010, LNSP 2010, ministère de la Santé, UNICEF)

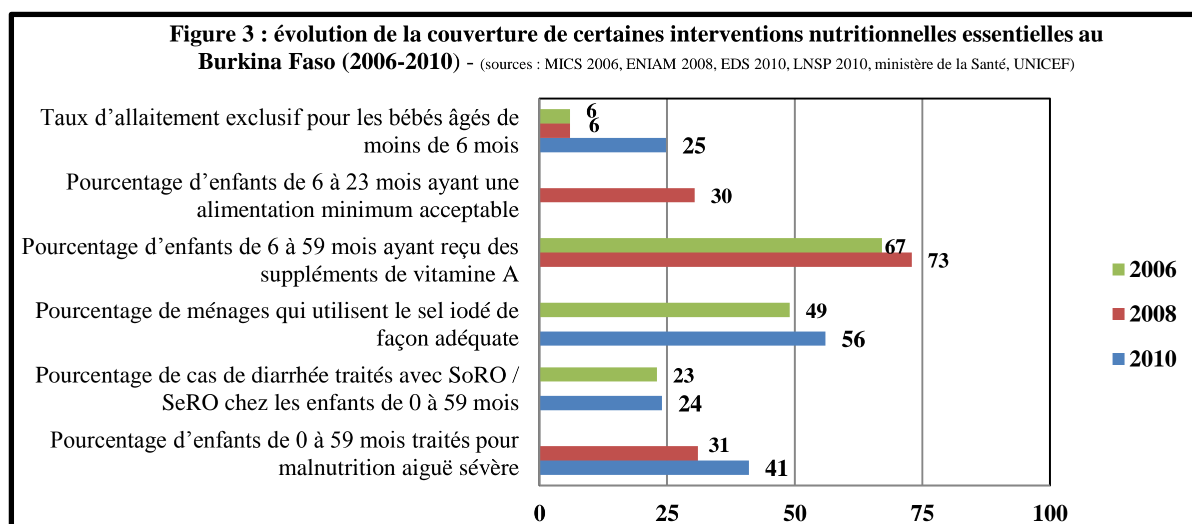
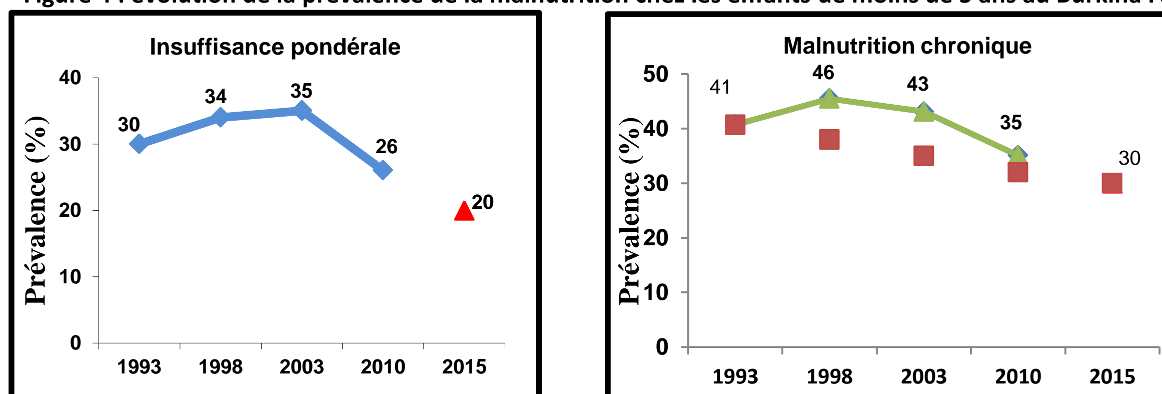


Figure 4 : évolution de la prévalence de la malnutrition chez les enfants de moins de 5 ans au Burkina Faso



Burkina Faso indicateurs de base

Population totale	15 757 000
Population vivant avec moins d'1 dollar par jour (PPA), pourcentage (2005)	56,5
Espérance de vie à la naissance h/f (années)	49/56
Dépenses totales consacrées à la santé par habitant ($ int.)	88
Taux d'alphabétisation des adultes, 2005 – 2008, h/f (%)	37/22

Chiffres donnés pour 2009 sauf mention contraire.

Indicateurs nutritionnels clés

Retard de croissance (rapport taille/âge < -2 ET selon les normes OMS)	35 % (2010)
Émaciation (rapport poids/âge < -2 ET selon les normes OMS)	11 % (2010)
Poids à la naissance (< 2 500 grammes)	12 % (2008)
Maigreur adulte (indice de masse corporelle < 18,5 chez les femmes en âge de procréer)	18 % (2008)
Anémie chez les enfants de 6 à 59 mois (Hb< 11 g/dL)	88 % (2010)
Anémie chez les femmes enceintes (Hb< 11 g/dL)	68 % (2003)
Supplémentation en fer et en acide folique (administrée quotidiennement aux femmes enceintes ≥ 6 mois)	ND
Supplémentation en vitamine A (enfants de 6 à 59 mois ayant reçu 2 doses élevées l'an dernier)	73 % (2008)
Supplémentation en iode (ménages consommant du sel iodé)	56 % (2009)
Supplémentation en zinc et thérapie par réhydratation orale (enfants de 0 à 59 mois souffrant de diarrhées)	ND
Allaitement exclusif (nourrissons de 0 à 5 mois)	25 % (2010)
Alimentation complémentaire (enfants allaités de 6 - 23 mois avec une alimentation minimum acceptable)	30 % (2008)
Code international de commercialisation des substituts de lait maternel (adopté)	Oui (1993)
Accès aux soins de santé (soignants et agents communautaires / 1 000 habitants)	1,04 (2011)
Accès à l'eau (meilleures sources d'eau potable)	76 % (2008)
Sécurité alimentaire (résultat relatif à la consommation alimentaire des enfants de 6 à 59 mois)	ND
Taux de mortalité infantile (décès avant l'âge d'1 an pour 1 000 naissances vivantes - les deux sexes)	65 (2010)
Taux de mortalité avant 5 ans (décès avant l'âge de 5 ans pour 1 000 naissances vivantes - les deux sexes)	129 (2010)
Taux de mortalité maternelle (nombre annuel de décès de femmes pour 100 000 naissances vivantes)	560 (330-950)
Résultat relatif à la gouvernance nutrition	Élevé

ND = Non Disponible

Ghana

Country context

Ghana is located in the middle of West Africa, along the coast and is home to an estimated 24 million inhabitants, with over half (53 per cent) of the labour force involved in the agriculture sector. Ghana is recognized as a lower middle income country. Strong economic growth, stable democratic governance, and steady increases in per capita income since 2000 have put Ghana on track to meet Millennium Development Goal 1 (MDG1). However, food security remains a challenge especially in the deprived three northern regions. One million and two hundred thousand people are food insecure and another two million are vulnerable to food insecurity (WFP Comprehensive Food Security and Vulnerability Assessment 2009).

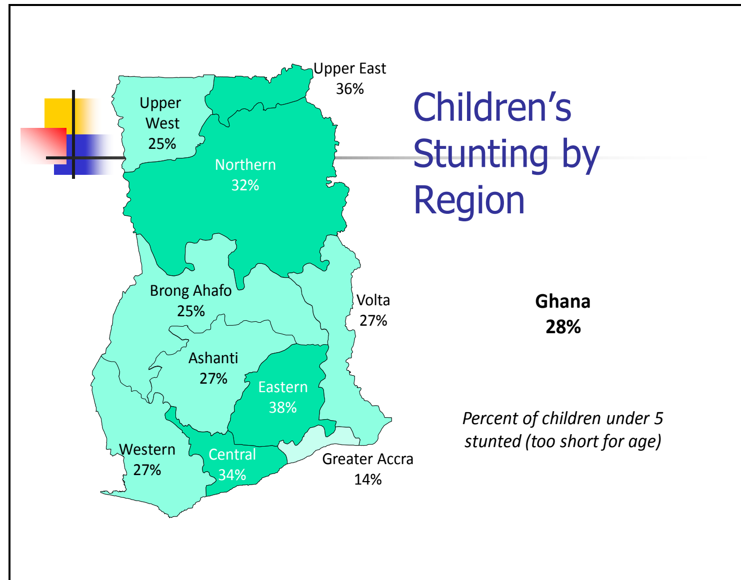
Chart 1: Food insecurity in Ghana

Regions	Food Insecure		Vulnerable to food insecurity	
	No. of people	% pop	No. of people	% pop
Western Rural	12.000	1%	93.000	6%
Central Rural	39.000	3%	56.000	5%
Greater Accra Rural	7.000	1%	14.000	3%
Volta Rural	44.000	3%	88.000	7%
Eastern Rural	58.000	4%	116.000	8%
Ashanti Rural	162.000	7%	218.000	10%
Brong Ahafo Rural	47.000	3%	152.000	11%
Northern Rural	152.000	10%	275.000	17%
Upper East Rural	126.000	15%	163.000	20%
Upper West Rural	175.000	34%	69.000	13%
Urban (Accra)	69.000	2%	158.000	4%
Urban (Other)	297.000	4%	572.000	8%
Total	1.200.000	5%	2.007.000	9%

Source: WFP Comprehensive Food Security and Vulnerability Assessment - 2009

The prevalence of underweight, wasting, and stunting among young children is significantly lower in Ghana than most West African countries. With the exception of underweight, however, child growth has not improved substantially over the past decade. There are substantial disparities within the country. Eastern, Central, Northern and Upper East regions have high rates of stunting which are linked closely to food insecurity, household poverty levels, disease burden (malaria, HIV/AIDS, intestinal worms), inadequate sanitation facilities, and infant and young child feeding practices.

Figure 1: Stunting levels in Ghana



The country has developed and implemented a number of strategies to tackle under-nutrition. Some progress has been made but major challenges remain. Ghana increased its exclusive breastfeeding rates from 53 per cent (Demographic and Health Survey 2003) to 63 per cent (Demographic and Health Survey 2008) but limited progress has been made on improving stunting (chronic malnutrition). Ghana is among the 36 countries with a stunting prevalence in excess of 20 per cent. Levels of wasting have remained relatively constant whilst over-weight among children appears to be on the rise, with 5 per cent overweight in 2008. The prevalence of micronutrient deficiencies such as anaemia is high; with little improvement over the past decade.

Government response

a) Overall vision for scaling up nutrition

The Ghana Shared Growth and Development Agenda (GSGDA) sets the following policy objectives to address the issues relating to nutrition and food security:

- Promote the production and consumption of locally available high quality maize, orange-flesh sweet potato and dark green leafy vegetables.
- Educate and train consumers on appropriate food combination of available foods to improve nutrition.
- Promote the production and consumption of micronutrient-rich foods (eggs, meat/fish and leafy vegetables) by children and women of reproductive age especially in rural areas.
- Enhance nutrition through coordination of programmes and institutions for food security, dissemination of nutrition and health information, and advocacy for food fortification.
- Advocate for increased food security and social protection for vulnerable households including smallholder farmer households.

b) Commitment to scaling up nutrition

On behalf of the Government of Ghana, the Ministry of Health (MoH) of Ghana expressed its interest in being a SUN Country and joined the SUN Movement in 2011. A national planning committee coordinated by the National Development Planning Commission (NDPC) and including members of the MoH, Ghana Health Service (GHS), Ministry of Food and Agriculture (MoFA), civil society organisations and development partners has been established. A launch of the Scaling up Nutrition in Ghana is planned for November 2011.

The Ghana Medium Term National Development (MTND) policy framework 2010-2013 and the Ghana Shared Growth and Development Agenda (GSGDA) identify nutrition and food security as critical and cross-cutting issues in addressing overall human resource development. The GSGDA sets out policy objectives to address the issues relating to nutrition and food security. Both aforementioned documents express particular concern regarding the persistent and high under-nutrition rates among children, especially male children in rural areas and in northern Ghana.

c) National nutrition plans

Prior to the development of the national nutrition policy, a strategic document; *"Imagine Ghana free of Malnutrition"* was developed by multi-sectoral group of stakeholders. The document set out strategic nutrition objectives and provided costing for implementing nutrition interventions to meet set objectives. This document is currently being used as a base for developing the nutrition policy, updating and aligning Ghana's nutrition priorities to address under-nutrition using evidence based nutrition interventions. The World Bank is also working with the Government of Ghana to develop a nutrition advocacy strategy.

In addition, the MoFA has formulated the Food and Agricultural Sector Development Policy (FASDEP) as well as an accompanying investment plan (entitled METASIP) for implementing policy's programmes in the medium term (2011-2015). The Health Sector Medium Term Strategy (HSMTDP) also includes nutrition activities, as does the updated nutrition policy, which is undergoing the final stages of review.

d) Multi-stakeholder platforms

A SUN focal point has been identified and assigned for national action. The Deputy Director General of the GHS is currently leading the SUN Movement in Ghana with technical support from the Nutrition Department of the GHS and development partners, civil society organisations and ministries, departments and agencies. The focal point for coordination is the National Development Planning Commission (NDPC) with support from the Nutrition Department of the GHS.

A multi-sectoral stakeholder's platform that has recently been established is the National Nutrition Partners' Coordination Committee (NaNuPaCC). This group is functional and meets on a quarterly basis. The committee is chaired by the GHS and has representation from the MoFA, academic Institutions, United Nations (UN) agencies, development partners and civil society organizations. NaNuPaCC is responsible for coordinating and harmonizing stakeholders' efforts in nutrition programming, sharing, and accountability, strategic planning and improving technical capacity in nutrition.

The implementation of the scale up plan will be carried out by all the relevant stakeholders under the coordination of the NNDPC and GHS. The United Nations Renewed Efforts Against Child Hunger (REACH) initiated in Ghana have proposed to support Ghana in the preparation of an country implementation plan. REACH is a facilitation and coordination mechanism for nutrition and part of the SUN Movement.

e) Stock-taking and gap analysis

Preliminary analysis about the needs for nutrition action in Ghana has been conducted. An institutional assessment of nutrition has been conducted with the support of the World Bank. The Landscape Analysis on Countries' readiness to accelerate action in nutrition was conducted in 2008. The Analysis identified the nature and extent of nutrition problems and contextual factors as well as the commitment and capacity to act at scale.

f) Engagement of non-governmental agencies

The SUN donor convener is yet to be agreed by the Government of Ghana and the stakeholders. The United States and other development partners, such as Canada and the United Nations Children's Fund (UNICEF), World Health Organisation (WHO), the Food and Agriculture Organisation of the United Nations (FAO), and World Food Programme (WFP), will work in close collaboration with the Government of Ghana in the planning and implementation of SUN.

Development partners provide support to various ministries, departments and agencies to support nutrition improvements. For example, Canada is currently providing $ 110 million over five years to the MoFA in support of their Food and Agriculture Sector Development Policy (FASDEP). The United States has identified Ghana as one of the premier Feed the Future countries and will contribute over $285 million over the next five years.

The United Nations Development Action Framework (UNDAF) 2012-2016 for Ghana has identified Food Security and Nutrition as a specific thematic area for UN support aligned to the priorities of the GSGDA. Relevant UN agencies through REACH will also support facilitation and coordination for developing and implementing the country's action plan on nutrition. UNICEF also supports community management of acute malnutrition (CMAM) and other key nutrition implementation activities and is an active partner at all levels of Government. Other partners, such as the World Bank, the WFP and FAO, are also providing support to improve nutritional outcomes. WFP works to improve food and nutrition security at household level as well as reach the most vulnerable populations through various intervention programmes to serve the purpose of boosting food production of smallholder farmer; preventing severe malnutrition among children and pregnant and lactating mothers; meeting nutritional needs of people living with HIV; and improving income for the rural poor women through nutritional income generating activities.

Civil society organisations play a critical role in SUN in Ghana. Civil society has provided leadership to SUN and also collaborated closely with other stakeholders to finalize the national framework to scale up nutrition. A broad section of international and national civil society organisations are active in the nutrition sector.

GAIN has also provided technical and financial support to the Food Fortification Programme in Ghana. Wheat flour and vegetable oil are fortified with a variety of micronutrients including vitamin A, iron and folic acid.

g) *Next steps*

Based on the results of the stocktaking exercise the gaps and recommendations:

1. Need for nutrition advocacy (e.g. use of PROFILES - computer-based models. consisting of a set of spreadsheet models that are based on recently published scientific research relating under-nutrition to functional consequences in terms of death, sickness, mental capacity and economic productivity) and comprehensive communication
2. Launching of SUN in November 2011
3. Placing nutrition on the agenda of District Assemblies.
4. Finalising the National Nutrition Policy to provide the legal and institutional framework for all stakeholders in nutrition by end of 2012
5. Conducting in-service/refresher training frequently with a more integrated approach also targeting non-nutritionists and curative care officers.

Next Steps

1. Develop costed work plan of priorities for action (involving all stakeholders)
2. Strengthen the strategic capacity of the Nutrition Department for moving all the processes forward
3. Advocate for making nutrition a priority on a sustainable basis for national development.

h) *Scaling up financial commitments*

Information on funding for nutrition is rather limited. The Government of Ghana and the health sector specifically benefit greatly from the support of the governments of the United Kingdom, Denmark, and the Netherlands, all of which provide sector budget support.

Case studies

The nutrition and malaria control for child survival project

Two major causes of the persistent poor nutritional status of children under five years in Ghana are poor infant and child feeding and care. The Community Based Nutrition and Food Security Project (CBNFSP) piloted by the Nutrition Department in four districts between 2003 and 2005, illustrates one holistic policy approach underway that addresses poor nutrition, focusing on children under two years of age and women of reproductive age.

The CBNFSP was a Learning and Innovation Loan (LIL) facility designed to assess modules developed to address the problem of child feeding and care. The CBNFSP was also a component of the Community-based Poverty Reduction Project (CPRP), under the coordination of the National Development Planning Commission and with funding support from the World Bank. Successful implementation of the CBNFSP led to its expansion and the creation of the "Nutrition and Malaria Control for Child Survival Project" (NMCCSP). The NMCCSP is running from 2008-2013 and will cover 300,000 children under the age of two years and 65,000 pregnant women in 77 districts.

The NMCCSP seeks to contribute to reduction of infant and child deaths (MDG4) through improving coordination, collaboration and institutional strengthening for health outcomes, improving demand for community based nutrition and health services and reducing disease burden from malaria. Implementation is on-going in 55 districts whilst 22 are being prepared to join. Key indicators include: exclusive breastfeeding, timely complementary feeding, use of oral rehydration solution, ante-natal care attendance by mothers, and sleeping under insecticide treated bed nets.

Some immediate benefits include increased immunisation and vitamin A coverage, increased antenatal attendance and improved caring practices for children. Major challenges are low level of commitment in some districts and delayed reporting.

Case studies (cont.)

Integration and scale-up of community-based management of moderate and severe acute malnutrition in Ghana
Community-based management of acute malnutrition (CMAM) was first introduced to Ghana in June 2007. This initial effort was led by the GHS in collaboration with UNICEF, WHO, and USAID. Ten learning sites were established in two districts, Ashiedu-Keteke sub-metropolitan area (Greater Accra region) and Agona District (Central region), to refine strategies for scaling up the management of severe acute malnutrition (SAM) in the country.

Interventions for the management of SAM in Ghana are designed to offer case management at decentralized sites that provide ready-to-use therapeutic foods (RUTF) and medication for outpatient management of SAM without medical complications. The few complicated cases of SAM that require immediate medical attention receive care in hospitals until medical complications stabilise and then cases are referred to outpatient care. An important component of care involves the community. Volunteers identify children with SAM within their own communities and refer them to the nearest health facility. The approach has resulted in increased coverage and access to treatment.

The Nutrition Department of the Family Health Division/GHS manages CMAM activities in the country. A national level technical committee comprising technical managers from child health, institutional care, policy, planning, monitoring, and the evaluation division and nutrition departments of GHS, academic institutions, UNICEF, WHO and USAID provide technical guidance in the development of national treatment guidelines, training materials for in-service and pre-service and strategy for national scale-up and implementation of the management of SAM. At the regional level, support teams comprising regional managers in nutrition, public health, disease control and paediatrics oversee technical aspects and scale-up. The support teams are managed by the Regional Director of Health services.

The GHS and its collaborating partners have also initiated a two-phased scale-up for the management of SAM in 2010. The first phase targets five regions and is currently underway. To-date, the GHS has scaled up management of SAM to over 300 health facilities within 27 districts, developed national guidelines for the management of SAM and trained 1,700 health care providers in the management of SAM. Review of the initial learning sites and lessons learned are continuously used to inform the scale up process.

The GHS, in collaboration with partners, is currently in the process of developing a long term five-year scale up strategy and GHS initiated discussions to include the management of moderate and severe acute malnutrition in the curriculum of medical, nursing, nutrition and dietetics students.

Finally, the GHS in collaboration with WFP is also implementing a supplementary feeding programme in 26 districts for 50,000 children under five years in the three northern regions. The mothers of these children in addition to receiving nutrition supplements at the Community Nutrition Education Centres also receive intensive health and nutrition education messages so as to improve their knowledge, attitude and practice in child feeding practices at the household level. These beneficiary children also receive regular growth monitoring and other public health services at these outreach points.

Ghana basic indicators

Total population	23,837,000
Population below $1 (PPP) per day, percentage (2005)	30
Life expectancy at birth m/f (years)	57/64
Total expenditure on health per capita (Intl $)	122
Adult literacy rate 2005-08 m/f (%)	72/59

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	29% (2008)
Wasting (weight-for-height < –2 SD of WHO standards)	9% (2008)
Birth weight (< 2500 grams)	9% (2006)
Adult thinness (Body-Mass Index <18.5 in women of reproductive age)	9% (2008)
Anaemia in children 6-59 months (Hb < 11 g/dL)	76% (2003)
Anaemia in pregnant women (Hb < 11 g/dL)	70% (2008)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	24% (2008)
Iodine supplements (households consuming iodized salt)	32% (2006)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	67% any ORT - zinc 1.8% (2008)
Exclusive breastfeeding (infants 0–5 months)	63% (2008)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	27% (2008)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	0.19 (2008
Access to water (improved drinking-water sources)	82% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	50, 43, 47
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	75, 61, 69
Maternal mortality rate (annual number of female deaths per 100,000 live births)	350 (210-600)
Nutrition governance score	Weak

NA= Not Available

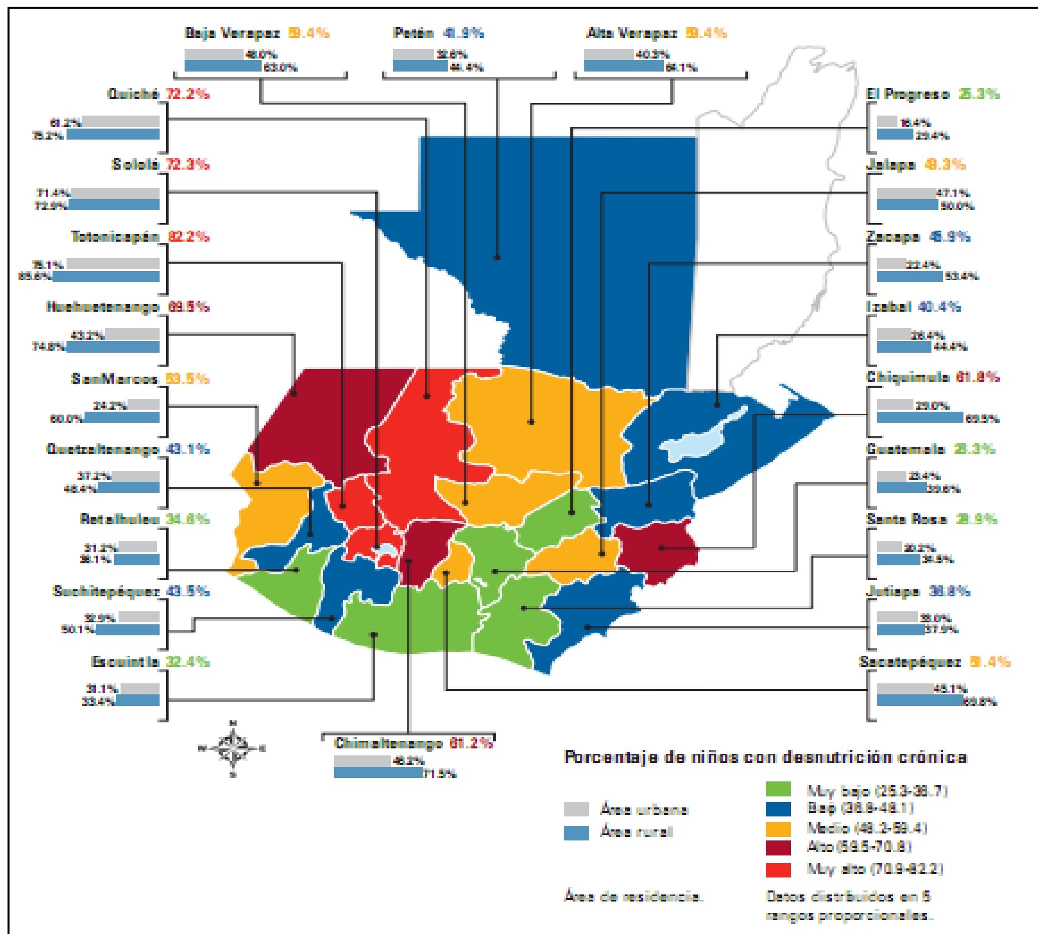
Guatemala

Country context

Guatemala is a low-middle income country of the Central American Region. The total population is around 14 million. Nearly half of the population (46 per cent) live in urban areas where 38 per cent of households are landless. The Gross Domestic Product per capita is $ 5,200. Guatemala's Human Development Index in 2010 ranked 118 among 169 countries, and its Gini Coeficient is 55 placing Guatemala among the countries with the greatest inequalities of wealth.

It is estimated that 51 per cent of Guatemalans live in poverty (15 per cent in extreme poverty) and that 75 per cent of the indigenous population is poor (Encuesta de Condiciones de Vida). Poverty is concentrated in the south western and north western regions of the country and the majority (72 per cent) of the poor live in the rural areas.

Figure 1: Stunting levels in Guatemala



Source: Ministry of Health and Social Protection. V Maternal and Child Health Survey (ENSMI) 2008-2009. Guatemala, 2010.

The Food and Agriculture Organisation (FAO) places Guatemala among the Latin American and Caribbean countries with a high vulnerability to food and nutrition insecurity, based on the levels of extreme poverty, under-nutrition and external dependence. Guatemala's undernourished population has grown from 2.5 million people (2000-2002) to 2.7 million (2005-2007), affecting 21 per cent of the population (Estadísticas del hambre). Guatemala's Global Hunger Index in 2010 was 12 (defined as serious hunger), the highest of Central America (Índice Global del Hambre. El desafío del hambre: énfasis en la crisis de la subnutrición infantil 2010).

Guatemala is the Latin-American and Caribbean country with the highest prevalence of stunting among under-fives and ranks fourth globally. Indigenous and those from the north western and south western regions of Guatemala are most affected.

The Economic Commission for Latin America and the Caribbean and the World Food Programme (WFP) estimated, for the year 2004, that child under-nutrition cost Guatemala approximately US$ 3 billion or 11.4 per cent of Guatemala's Gross Domestic Product. At the same time over-nutrition in adults, school age children and under-fives is on the rise in a country where stunting is still a major public health and development concern.

Government response

a) Overall vision for scaling up nutrition

The approach adopted by the Government of Guatemala is to integrate sectoral policies into an inter-sectoral nutrition strategic plan that is sustainable, rights-based, gender-sensitive and that takes into account the multicultural nature of Guatemalan society and the local circumstances. An inter-sectoral national system for food and nutrition security will be established which will include coordination mechanisms for policy, for programming and for financing, and for attaining the objectives of the nutrition strategic plan nationally and locally. The nutrition strategic plan will also cover risk management and ways to enhance resilience at household, community and local levels.

b) Commitment to scaling up nutrition

The Government of Guatemala signalled its intent to scale up nutrition and join the SUN Movement in December 2010. It has put a number of plans in place which incorporate nutrition.

c) National nutrition plans

SESAN has developed the Strategic Plan for Food and Nutrition Security (PESAN) 2009-2012, that establishes binding commitments between the various institutions that are members of the National Council for Food and Nutrition Security.

Food and Nutrition Security Action Plan for the Western part of Guatemala (PLANOCC)

This plan focuses on the poorer areas in the Western region of Guatemala and is being developed with the financial support of the United States (US). It aims to develop human capital and household resilience through reducing vulnerability and addressing food and nutrition insecurity and stunting, targeting, in particular, women and children.

National Strategy for Stunting Reduction (ENRDC)

This strategy includes direct nutrition interventions (breastfeeding and complementary feeding promotion, micronutrient supplementation and nutrition education) and nutrition-sensitive components to ensure sustainability (water and sanitation, healthcare services, household income generation

strategies, community organization and strengthening). The United Nations (UN) system in Guatemala is providing support for the development and implementation of ENRDC, through the UN inter-sectoral group for food and nutrition security which includes a number of UN agencies. A mid-term analysis of ENRDC was carried out in 2011, showing promising results.

Joint Programme on Children, Food and Nutrition Security

This programme is part of the National Strategy for Stunting Reduction (ENRDC) supported by the joint UN strategy for addressing food and nutrition security and financed by Spain. It was formulated in the context of achieving the MDGs, in particular MDG 1 (poverty and hunger), MDG 4 (infant mortality) and MDG 5 (maternal mortality and is being implemented in the sub-region of Totonicapán, one of the poorest areas of Guatemala.

Scaling Up Nutrition (SUN): global consensus for addressing the first 1000 days

With the technical and financial support from the World Food Programme, a national project for strengthening national capacities to address nutritional challenges of the most vulnerable women and children during the window of opportunity of the first 1000 days is being formulated. This is part of a larger Centro American region initiative that builds upon existing national efforts and aims to strengthen and support them. The following components are included:

- Advocacy and partnership building, including public-private partnerships.
- Multi-micronutrient powder distribution targeting children 6-24 months and pregnant and lactating women.
- Distribution of fortified supplementary foods.
- Environmental protection.
- Social communication, education, information sharing and nutrition counseling.
- Complementary public health actions (deworming, early umbilical cord clamping, among others).
- Nutrition surveillance, monitoring and evaluation.

d) Multi-stakeholder platforms

The Secretariat for Food and Nutrition Security (Secretaría de Seguridad Alimentaria y Nutricional) or SESAN is the institutional mechanism with responsibility for food and nutrition security. It is the national coordinating body to ensure actions addressing food insecurity and under-nutrition are integrated into the plans, programmes and projects of line Ministries. SESAN is not an operational agency. Nutrition-related interventions are implemented by a range of Government institutions and line Ministries including the Ministry of Public Health and Social Assistance, Ministry of Agriculture, Livestock and Food, Ministry of Education, Ministry of Labour, Ministry of Finance and Economy, Ministry of Environment and Natural Resources, among others. Inter-sectoral collaboration is still a challenge as traditionally child under-nutrition has been seen as the responsibility of the Ministry of Health and Social Assistance.

e) Stock-taking and gap analysis

Stock taking and gap analysis of ongoing interventions is in process, with the support of experts in maternal and child nutrition. In a national expert workshop (22 July 2011) the following was initiated:

- Based on a list of proven cost-effective interventions, a qualitative and quantitative analysis of gaps and opportunities was undertaken.
- Feasibility study to address gaps in the short and mid-term.
- Recommendations for an actionable and costed national plan of action to improve nutrition within the first 1000 days of life from pregnancy to two years of age.

Guatemala basic indicators

Indicator	Value
Total population	14,027,000
Population below $1 (PPP) per day, percentage (2005)	16.9
Life expectancy at birth m/f (years)	66/73
Total expenditure on health per capita (Intl $)	337
Adult literacy rate 2005-08 m/f (%)	80/69

Figures are for 2009 unless indicated.

Core nutrition indicators

Indicator	Value
Stunting (height-for-age < –2 SD of WHO standards)	48% (2008-09)
Wasting (weight-for-height < –2 SD of WHO standards)	1% (2008-09)
Birth weight (< 2500 grams)	12% (2002)
Adult thinness (Body-Mass Index <18.5 in women of reproductive age)	2% (2008-09)
Anaemia in children 6-59 months (Hb < 11 g/dL)	NA
Anaemia in pregnant women (Hb < 11 g/dL)	29% (2008-09)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	20% (2008)
Iodine supplements (households consuming iodized salt)	76% (2007)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	50% (2008-09)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	NA
International Code of Marketing of Breast-milk Substitutes (adopted)	Partially
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	94% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	33, 32, 33
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	39, 40, 40
Maternal mortality rate (annual number of female deaths per 100,000 live births)	110 (56-190)
Nutrition governance score	Medium

NA= Not Available

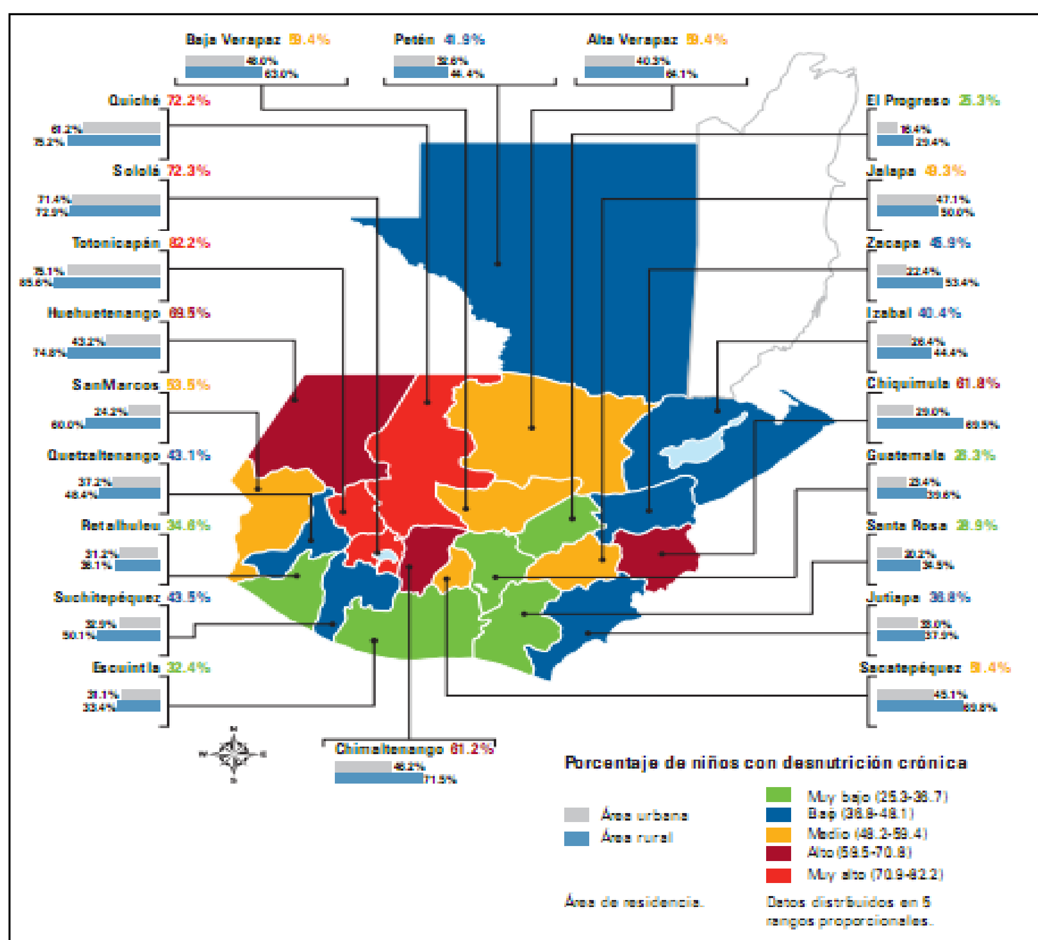
Guatemala (edición española)

Contexto nacional

Guatemala es un país de medianos y bajos ingresos de la región de Centroamérica. La población total es de aproximadamente 14 millones. Prácticamente la mitad de la población (46%) vive en áreas urbanas, en donde el 38% de los hogares no poseen tierras. El Producto Interno Bruto per cápita es de $5,200.00 dólares estadounidenses. El Índice de Desarrollo Humano de Guatemala en el año 2010 se encontraba en el puesto 118 de 169 países, y su Coeficiente de Gini es de 55, lo que sitúa a Guatemala entre los países con mayor desigualdad de la riqueza.

Se calcula que el 51% de los guatemaltecos viven en la pobreza (15% en extrema pobreza) y que el 75% de la población indígena es pobre (Encuesta de Condiciones de Vida - ENCOVI). La pobreza se concentra en las regiones del suroeste y noroeste del país, y la mayoría (72%) de los pobres viven en las zonas rurales.

Figura 1: Niveles de retraso en el crecimiento en Guatemala



Fuente: Ministerio de Salud Pública y Asistencia Social. V Encuesta Nacional de Salud Materno Infantil (ENSMI) 2008-2009. Guatemala, 2010.

La Organización de las Naciones Unidas para la Alimentación y la Agricultura (FAO, por sus siglas en inglés) sitúa a Guatemala entre los países latinoamericanos y del Caribe con mayor vulnerabilidad en cuanto a la inseguridad alimentaria y nutricional, a partir de los niveles de extrema pobreza, desnutrición y dependencia del exterior. La población desnutrida de Guatemala ha aumentado de 2,5 millones (2000-2002) a 2,7 millones (2005-2007), lo que afecta al 21% de la población (Estadísticas del hambre). El Índice Global del Hambre de Guatemala en el año 2010 se encontraba en el puesto 12 (clasificado como problema de hambre grave), el más elevado de Centroamérica (Índice Global del Hambre. El desafío del hambre: énfasis en la crisis de la desnutrición infantil 2010).

Guatemala es el país latinoamericano y del Caribe con la mayor prevalencia de retraso en el crecimiento entre los niños menores de 5 años, y se sitúa en el cuarto puesto a nivel mundial. Los más afectados son los indígenas y los habitantes de las regiones del noroeste y suroeste de Guatemala.

La Comisión Económica para América Latina y el Caribe y el Programa Mundial de Alimentos (WFP, por sus siglas en inglés) calcularon que en el año 2004 la desnutrición infantil le costó a Guatemala aproximadamente $3,000.00 millones de dólares estadounidenses u 11,4% de su Producto Interno Bruto. A la vez, la sobrealimentación en los adultos, niños en edad escolar y menores de 5 años está aumentando en un país en el que el retraso en el crecimiento continúa siendo un problema grave de salud pública y desarrollo.

Respuesta del Gobierno

a) Visión global para fomentar la nutrición

El enfoque adoptado por el gobierno de Guatemala es integrar las políticas sectoriales en un plan estratégico nutricional intersectorial, sustentable, basado en los derechos y sensible a las cuestiones de género y que tenga en cuenta la naturaleza multicultural de la sociedad guatemalteca y las circunstancias locales. Se establecerá un sistema nacional intersectorial de seguridad alimentaria y nutricional que incluirá mecanismos de coordinación para generar políticas, programar, financiar y para alcanzar los objetivos del plan estratégico nutricional, a nivel nacional y local. El plan estratégico nutricional también abarca la gestión de riesgos y formas de fomentar la resistencia a nivel doméstico, comunitario y local.

b) Compromiso para aumentar la nutrición

El gobierno de Guatemala comunicó su intención de aumentar la nutrición y participar del movimiento para el fomento de la nutrición (SUN, por sus siglas en inglés) en diciembre de 2010. Puso en práctica algunos planes que comprenden la nutrición.

c) Plan nacional de nutrición

La Secretaría de Seguridad Alimentaria y Nutricional, SESAN, ha desarrollado el Plan Estratégico de Seguridad Alimentaria y Nutricional (PESAN) 2009-2012, que establece compromisos vinculantes entre las distintas instituciones que pertenecen al Consejo Nacional de Seguridad Alimentaria y Nutricional.

Plan de Acción de Seguridad Alimentaria y Nutricional para el Occidente de Guatemala (PLANOCC)

El plan se centra en las zonas más pobres de la región occidental de Guatemala y es desarrollado con el apoyo económico de Estados Unidos (EUA). El objetivo del plan es desarrollar el capital humano y la resistencia doméstica mediante la reducción de la vulnerabilidad y el abordaje de la inseguridad alimentaria y nutricional, y el retraso en el crecimiento, dirigiéndose especialmente a las mujeres y los niños.

Estrategia Nacional para la Reducción de la Desnutrición Crónica (ENRDC)
Esta estrategia incluye intervenciones nutricionales directas (fomento de la lactancia materna y la alimentación complementaria, suministro de micronutrientes y educación nutricional) y componentes sensibles a las cuestiones nutricionales para garantizar la sustentabilidad (agua y saneamiento, servicios de atención sanitaria, estrategias de generación de ingresos al hogar, organización y fortalecimiento de la comunidad). El sistema de las Naciones Unidas (SNU) en Guatemala brinda apoyo al desarrollo e implementación de la ENRDC, mediante el grupo intersectorial de seguridad alimentaria y nutricional de Naciones Unidas, que incluye algunos de sus organismos. En el 2011 se realizó un análisis semestral de la ENRDC, que mostró resultados prometedores.

Programa Conjunto sobre seguridad infantil, alimentaria y nutricional
Este programa pertenece a la Estrategia Nacional para la Reducción de la Desnutrición Crónica (ENRDC), apoyado por la estrategia conjunta de Naciones Unidas para abordar la seguridad alimentaria y nutricional y es financiado por la Agencia Española de Cooperación Internacional. Se formuló en el contexto de alcanzar los Objetivos de Desarrollo del Milenio, en especial el ODM 1 (pobreza y hambre), el ODM 4 (mortalidad infantil) y el ODM 5 (mortalidad materna) y se está implementando en la subregión de Totonicapán, una de las zonas más pobres de Guatemala.

Aumentar la nutrición (SUN): consenso global para abordar los primeros 1000 días
Con el apoyo técnico y económico del Programa Mundial de Alimentos, se está formulando un proyecto nacional para fortalecer la capacidad nacional para afrontar los desafíos nutricionales de las mujeres y los niños más vulnerables durante el momento oportuno de los primeros 1000 días. Este proyecto está incluido en una iniciativa mayor de la región centroamericana, que parte de los esfuerzos nacionales existentes y tiene como objetivo el fortalecimiento y apoyo de estos. Está integrado por lo siguiente:

- Sensibilización y formación de alianzas, entre otras, alianzas público-privadas.
- Distribución de micronutrientes múltiples en polvo, especialmente a niños de 6 a 24 meses y a mujeres gestantes y en período de lactancia.
- Distribución de alimentos complementarios fortificados.
- Protección ambiental.
- Comunicación social, educación, intercambio de información y asesoramiento nutricional.
- Acciones complementarias de salud pública (tratamiento antiparasitario, pinzamiento precoz del cordón umbilical, entre otras).
- Vigilancia, control y evaluación nutricional.

d) Plataformas de múltiples actores
La Secretaría de Seguridad Alimentaria y Nutricional (SESAN) es el mecanismo institucional responsable de la seguridad alimentaria y nutricional. Es el organismo de coordinación nacional que garantiza que las acciones para abordar la inseguridad alimentaria y la desnutrición se integren en planes, programas y proyectos de los ministerios pertinentes. SESAN no es un organismo operativo. Las intervenciones relacionadas con la nutrición son implementadas por una variedad de instituciones gubernamentales y ministerios pertinentes, entre otros, el Ministerio de Salud Pública y Asistencia Social, el Ministerio de Agricultura, Ganadería y Alimentación, el Ministerio de Educación, el Ministerio de Trabajo, el Ministerio de Economía y Finanzas, el Ministerio de Ambiente y Recursos Naturales, entre otros. La colaboración intersectorial continúa siendo un desafío, ya que la desnutrición infantil tradicionalmente se ha visto como responsabilidad del Ministerio de Salud Pública y Asistencia Social.

e) Análisis de situación y de deficiencias

En este momento se está llevando a cabo el análisis de situación y de deficiencias de la intervención existente, con el apoyo de expertos en nutrición materno-infantil. En un taller de expertos a nivel nacional (22 de julio de 2011), se dio comienzo a:

- Un análisis cualitativo y cuantitativo de las deficiencias y las oportunidades a partir de una lista de intervenciones rentables comprobadas.
- Estudio de viabilidad para abordar las deficiencias a corto y mediano plazo.
- Recomendaciones para un plan nacional de acción viable, con indicación de costos, para mejorar la nutrición en los primeros 1000 días de vida (desde el embarazo hasta los dos años de edad).

Guatemala indicadores básicos

Población total	14.027.000
Población por debajo de $1 (PPA) diario, porcentaje (2005)	16,9
Esperanza de vida al nacer h/m (años)	66/73
Gasto total en salud per cápita (Internacional $)	337
Tasa de alfabetización en adultos 2005-08 h/m (%)	80/69

Las cifras corresponden al año 2009, a menos que se indique de otro modo.

Principales indicadores de nutrición

Retraso del crecimiento (talla para la edad ≤2 DE según los patrones de la OMS)	48% (2008-09)
Emaciación (peso para la talla ≤2 DE según los patrones de la OMS)	1% (2008-09)
Peso al nacer (< 2500 gramos)	12% (2002)
Delgadez en adultos (índice de masa corporal <18,5 para mujeres en edad reproductiva)	2% (2008-09)
Anemia en niños de 6 a 59 meses (Hb < 11 g/dL)	ND
Anemia en gestantes (Hb < 11 g/dL)	29% (2008-09)
Suplementos de hierro y ácido fólico (cantidad diaria recibida por las madres durante 6 meses o más de embarazo)	ND
Suplementos de vitamina A (niños de 6 a 59 meses que recibieron 2 dosis altas el año pasado)	20% (2008)
Suplementos de yodo (hogares que consumen sal yodada)	76% (2007)
Suplementos de zinc y terapia de rehidratación oral (niños de 0 a 59 meses con diarrea)	ND
Lactancia materna exclusiva (niños de 0 a 5 meses)	50% (2008-09)
Alimentación complementaria (niños de 6 a 23 meses alimentados con leche materna, con dieta mínima aceptable)	ND
Código Internacional de Comercialización de Sucedáneos de la Leche Materna (adoptado)	Parcialmente
Acceso a la atención sanitaria (funcionarios de la salud comunitarios y tradicionales/1000 habitantes)	ND
Acceso al agua (fuentes mejoradas de agua potable)	94% (2008)
Seguridad alimentaria (puntaje de consumo de alimentos para niños de 6 a 59 meses)	ND
Tasa de mortalidad infantil (muerte antes de 1 año de vida cada 1000 nacidos vivos – h, m, ambos)	33, 32, 33
Tasa de mortalidad de menores de 5 años (muerte antes de los 5 años de vida cada 1000 nacidos vivos – h, m, ambos)	39, 40, 40
Tasa de mortalidad materna (cifra anual de muertes de mujeres cada 100.000 nacidos vivos)	110 (56-190)
Puntaje de gobernanza sobre nutrición	Medio

ND= No Disponible

Lao Peoples Democratic Republic (PDR)

"The vision for the Government of Lao PDR is to have a prosperous country free from malnutrition, food insecurity and poverty." National Nutrition Strategy for Lao PDR, November 2009

Country context

Lao PDR is a South-East Asian country with a population of approximately 6.3 million people. The Gross National Income per capita is $1,096 (FY 2009-10). Lao PDR has shown impressive economic growth in the past decade but under-nutrition rates remain unchanged making it one of the highest burden countries in the region.

In general, under-nutrition affects both children under five and women of reproductive age. Among under-fives, under-nutrition gradually increases from six months of age and peaks at 24 months. Stunting is the most serious nutritional problem affecting the country with approximately 40 per cent of all children under five classified as stunted. These rates are much higher in remote areas and within ethnic communities. Wasting, although not so high, can reach critical levels in post disaster situations. A significant percentage (more than 30 per cent[1]) of pregnant and lactating women suffer from mild to severe thinness, as measured by body mass index. Various forms of micronutrient deficiencies are prevalent among children under five and women of reproductive age and continue to be a public health concern. Iron deficiency anaemia is also alarmingly high in children, especially under two year of age.

Based on the Lao Expenditure and Consumption Survey (LECS III 2002-2003) a substantial portion of the population suffered from food deprivation, based on a daily minimum energy requirement of 2,100 kcal. An analysis of the underlying causes of under-nutrition identified inadequate nutrient intake as the major cause, due to low intakes of protein, fat and micronutrients in the diet. Lack of dietary diversity is further aggravated by the presence of vector borne and infectious diseases. Other underlying causes for under-nutrition include food non-availability and inaccessibility coupled with poor mother and child care practices (such as poor infant and young child feeding practices, late initiation of breastfeeding, low rates of exclusive breastfeeding, and food taboos). These problems are compounded by poor environmental health and limited access to health services. The absence of nutrition objectives in national development policies and plans has resulted in low investments in nutrition programmes.

Government response

a) Overall vision for scaling up nutrition

The target for 2015 is a reduction in the prevalence of stunting among children under five from the baseline level of 40 per cent in 2006 to 34 per cent and a reduction in wasting from 6 per cent to 4 per cent. The Government plans to include nutrition objectives within broader policy frameworks, to improve multi-sectoral coordination and to improve capacity-building across relevant key sectors.

[1] Ministry of Health (2009) Strategy and Planning Framework for the Integrated package of Maternal Neonatal and Child Health Services 2009-2010, Lao PDR.

b) Commitment to scaling up nutrition

An outstanding achievement of the Government of Lao PDR was the incorporation of nutrition objectives in the 7th National Socio-Economic Development Plan 2011-2015 (NSEDP). Last year, there were also initiatives to mainstream nutrition in sectoral plans including agriculture and education.

In April 2011, the Minister of Health indicated Lao PDR's intent to become a SUN country and join the SUN Movement. Lao PDR has been supported through the United Nations (UN) REACH process to facilitate stronger, inclusive governance and management of multi-sector nutrition programmes. The country is now poised for transition from REACH to SUN. The Government plans to build on the gains of REACH, which included a stock-taking analysis, target setting, prioritization of intervention bundles as well as costing and stakeholder mapping.

c) National nutrition plans

Three key nutrition documents set out Lao PDR's approach to tackling nutrition problems. The National Nutrition Policy (NNP) was endorsed by the Prime Minister in December 2008. The National Nutrition Strategy (NNS) and Plan of Action for Nutrition (NPAN) were endorsed by the Minister of Health in November 2009.

The NNP/NNS/NPAN recognize the multi-factorial nature of under-nutrition and have promoted a mixture of strategies and interventions that consist of cost-effective direct nutrition interventions plus a development approach which engages other key sectors such as the agriculture and education as well as international non-governmental organisations, local civil society organizations and academia in the overall solution to malnutrition. All these processes are carried out in a multi-stakeholder manner and facilitated by REACH, in close partnership with relevant Ministries.

The NNS/NPAN will be reviewed in terms of its targets to bring it in line with the SUN Framework. In the initial analysis done during the formulation of the NPAN, it was estimated that if fully implemented, 80 per cent of target coverage would result in a 50 per cent decrease in the overall burden of disease.

The country, under the leadership of the Ministry of Health and the Food and Agriculture Organisation (FAO), has formulated a national multi-sectoral capacity-building framework plan. Both the current food and nutrition situation as well as capacity gaps identified across relevant sectors and at various operational levels served as the drivers for this road map until 2020. This framework needs to be further integrated as part of the government and other SUN stakeholders fundraising and assistance strategies.

d) Multi-stakeholder platforms

There is on-going discussion, currently led by the Ministry of Planning and Investment, about mechanisms for ensuring high level support and leadership for nutrition. The Ministry of Health has submitted a proposal to establish a Nutrition Centre which will promote a multi-stakeholder platform and provide leadership and coordination in nutrition. The proposal is awaiting approval.

Lao PDR has also developed a food insecurity and vulnerability information mapping system that creates opportunities for multi-sectoral sharing and collaboration. It is important to note that funding constraints have temporarily prevented development and use of the System.

e) Stock-taking and gap analysis

In 2008-9, REACH undertook a comprehensive stock-taking analysis which provided an overview of the situation of nutrition and food security in Lao PDR. Further, it provided information on the main

stakeholders and their activities in the field of the REACH-promoted nutrition and food security interventions. This exercise not only provided a plan for subsequent action, it was also supported by a national policy of inclusiveness in nutritional programming.

As part of the stock-taking exercise, data was collected on trends, recent food and nutrition indicators, causal factors of under-nutrition, types of nutrition interventions being implemented particularly those along REACH promoted interventions, geographical coverage and number and types of beneficiaries, delivery channels, engagement of various actors from government, UN agencies and other development partners and international non-governmental organisations and their profiles.

The results of the stock-taking were used for systematic situational analysis leading to joint planning that facilitated the process for the formulation of the NNS/NPAN including costing of the entire NPAN. It is hoped that this will also serve as basis for preparing the nutrition scale up plan. The outputs were later on also used to advocate for prioritizing nutrition, muti-sectoral collaboration and fund mobilization.

There were a number of challenges met like limited technical capacity of government staff in conducting a good status analysis, formulation of NNS/NPAN and estimation of budget. Likewise, there was limited participation of local civil society organisations. Funding was also a constraint and importantly, there was a dearth of information that could support a good stock-taking analysis and generate information for evidence-based planning

f) Engagement of non-governmental agencies

Under the One UN framework, UNICEF, FAO, WHO and WFP have all contributed to a common resource pool which was used to hire an international REACH facilitator and now a nutrition coordinator. An interagency technical working group on food and nutrition security, composed of technical staff from various UN agencies, has long been established in Lao PDR and later on served as a platform for sharing information and collaboration. To date, a pilot-testing of the Community management of acute malnutrition (CMAM) is being conducted in three provinces in the southern part of Lao PDR with UNICEF, WFP and WHO coming together as partners with the Ministry of Health.

International non-governmental organisations, including CARE International, Save the Children, World Vision, Health Poverty Action and Burnet Institute, are contributing to delivering nutrition and related interventions at the grass-roots level. Their wealth of experiences as well as technical expertise are tapped by both government and UN development partners. They were actively engaged in the stock-taking analysis as well as in the NNS/NPAN formulation.

Local civil society organizations are fairly new in Lao PDR. It was only in 2009 when a decree formally recognizing their existence was passed. Notwithstanding, they have been actively involved in a number of Government projects mostly in agriculture and poverty reduction. Although health and nutrition are considered important by these organisations, it is only recently that they were mainstreamed through a FAO project. There is now increasing awareness on their existence and potential role in mobilizing communities and innovative capacity-building approaches for addressing food and nutrition security problems.

g) Next steps

The SUN process is facing a number of on-going challenges, including:

1. Updating the stock-taking analysis
2. Realignment of NNS/NPAN to SUN framework
3. Approval and adoption of the national multi-sectoral capacity-building framework plan up to year 2020
4. Establishment of a unified tracking system for SUN promoted interventions with the possible inclusion of the indicators in the United Nations Development Assistance Framework
5. Development of a comprehensive implementation plan with costing and high level multi-sectoral coordination mechanism
6. Advocacy and fund mobilization to ensure coordinated support is provided to the stakeholders and Government through a SUN Coordinator
7. Establishment of authoritative leadership from Government, development partners and donors

There is still a wide gap in institutional as well as individual technical as well as management capacity for food and nutrition security. Staff at the provincial and district levels do not have many opportunities for capacity development for various reasons including language barriers. Lao PDR has identified challenges that require continued support, such as:

1. Leadership, accountability and responsibility in the relevant sectors need to be articulated and agreed upon
2. Fast-tracked establishment of a multi-stakeholder platform
3. The stocktaking of best practices for scaling up and promotion of inter-sectoral convergence
4. Financial support for the priority interventions needs to be mobilized

Lao PDR basic indicators

Total population	6,320,000
Population below $1 (PPP) per day, percentage (2005)	33.9
Life expectancy at birth m/f (years)	62/64
Total expenditure on health per capita (Intl $)	86
Adult literacy rate 2005-08 m/f (%)	82/63

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	40~~8~~% (2006)
Wasting (weight-for-height < –2 SD of WHO standards)	7% (2006)
Birth weight (< 2500 grams)	11% (2006)
Adult thinness (Body-Mass Index <18.5 in women of reproductive age)	NA
Anaemia in children 6-59 months (Hb < 11 g/dL)	41% (2006)
Anaemia in pregnant women (Hb < 11 g/dL)	NA
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	91% (2010)
Iodine supplements (households consuming iodized salt)	84% (2006)
Zinc supplements & oral rehydration (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	26% (2006)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	NA
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	57% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	52, 40, 46
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	62, 55, 59
Maternal mortality rate (annual number of female deaths per 100,000 live births)	405 (2005)
Nutrition governance score	NA

NA= not available.

Malawi

Country context

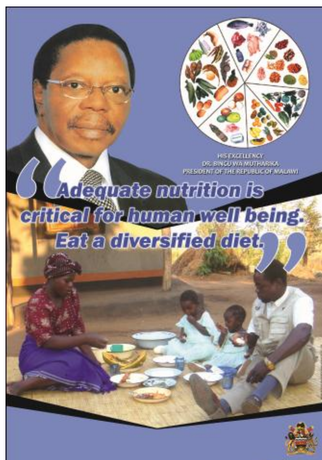
Malawi is a Southern African country with a population estimated at around 15.8 million in 2011. The GNI in Malawi is $290.[2] The agriculture sector is the predominant sector with 80% of the population working in agriculture. Economic growth is at an average rate of 7.5 % and there has been a decrease in the number of people living below the poverty line from 65% in 2004 to about 39% in 2010.

The national food security situation and the overall kilocalorie (Kcal) intake have improved in the last six years though under-nutrition has been a long-standing public health problem in Malawi. A significant percentage of children under-five are moderately or severely underweight. Further, more than half of the children under-five suffer from moderate or severe stunting.

Government response

a) Overall vision for scaling up nutrition

His Excellence Ngwazi Professor Bingu wa Mutharika President of the Republic of Malawi is committed towards ending hunger and malnutrition in Malawi. The Government recognises that nutrition is a crosscutting issue with economic, socio-cultural, developmental, political and biomedical dimensions which require multisectoral approach. Additionally the Government of Malawi continues to provide an agriculture input subsidy and green belt irrigation programmes that will contribute to improving the nutritional status of Malawians.



b) Commitment to scaling up nutrition

Her Excellency Madame Callista Mutharika, the First Lady of the Republic of Malawi has been appointed the coordinator of Nutrition, Safe Motherhood, PMTCT, HIV and AIDS. Her appointment has strengthened the linkages between the services. The First Lady is strongly advocating for Scaling Up Nutrition and the 1000 special days movement. She has also promoted infant and young child feeding including breastfeeding and she has signed the call to action for Scaling Up Nutrition and the 1000 days Declaration. She also launched the SUN-1000 Special Days Movement Campaign in Malawi on 28th July 2011.

Malawi has demonstrated political commitment to the Scaling Up Nutrition Movement and the 1,000 Special Days Movement during the past year. The country has developed a National Nutrition Education and Communication strategy as an advocacy tool. Most visibly, the launch of the SUN-1000 Special Days Movement took place in July 2011.

[2] Pasricha, Sant-Rayn & Biggs, Beverley-Ann, "Undernutrition among children in South and South-East Asia," J. of Paediatrics and Child Health, Vol. 46, Iss. 9., pp. 497-503 (Sept. 2010).

Pre-launch activities included activities to popularise the SUN at different levels through orientation meetings with various groups such as 250 comprising Principal Secretaries, Directors and 32 Deputy Directors and District Commissioners as Policy makers; 40 Media personnel, 50 local leaders, 35 faith community and 64 district level technical officers. Also before the launch date, a press briefing occurred to announce the launch and media programmes and field visits to popularise the SUN-1000 Special Days which reached 6 million people using various multi-media channels.

The launch programme included: Displays, presentations on the SUN-1000 Special Days Initiative; Speeches , Reading of declarations of commitments to support SUN movement in Malawi by various key stakeholders which included the following: Traditional Leaders; Local Councils; Government; Private Sector; Media; Medical Council; Teachers Union; and Development Partners. The event was patronised by over 3000 people that included 30 Cabinet and Deputy Ministers, the Chief Secretary for the Government Civil Service, Principal Secretaries, Directors and other Senior Government Officials, Public Sector Employees, NGOs, Development Partners, Members of Parliament, District Commissioners, Paramount Chiefs and the General Public. All proceedings were aired live on Malawi Television and also received substantial coverage in all the other radio stations and the local papers.

c) National nutrition plans

Nutrition was included as a priority area in the Malawi Growth and Development Strategy (MGDS) I and its successor MGDS II, which is operationalised by the National Nutrition Policy and Strategic Plan (NNPSP). The NNPSP uses the Nutrition Education and Communication Strategy (NECS) as the implementation tool for the SUN-1000 Days Movement. Further, nutrition has been integrated in sector wide approaches (SWAps) of Ministries of Agriculture, Gender and Youth, Health, Education, Information, Water and Irrigation, Natural Resources; and Local Government.

d) Multi-stakeholder platforms

During the past year, the government of Malawi has worked to establish SUN taskforce committees whose composition include public sector (Office of the President and Cabinet: Department of Nutrition, HIV and AIDS, Health, Agriculture, Education, Trade and Industry, Gender, Child and Community Development, Local government), Development Partners, UN Agencies, Academia and Civil Society. The responsibility of the task team is to act as a platform for the coordination of planning and implementation of the SUN-1000 Special Days Launch and follow up activities. The taskforce meets monthly.

The government has also established the SUN Core team with multi-sectoral representation at the national and district levels which comprise of public and private sectors and the civil society. The mandate of the coordination team is to steer the district roll out and ensure that there is multi-sectoral participation in the SUN implementation.

e) Stock-taking and gap analysis

The government of Malawi commissioned a gap analysis study to take stock of the national nutrition situation, existing strategies, institutions, actors and programmes and to identify opportunities and priorities in Scaling Up Nutrition in Malawi. Consensus was reached on the priority areas for the SUN based on the gap analysis and the TIPS study on Infant and Young Child Feeding (2009).

f) Engagement of non-governmental agencies

The government of Malawi has undertaken several actions to engage non-governmental agencies in operationalizing nutrition policy. For example, the government set up the Civil Society network on SUN led by Concern World wide. It also set up a Private Sector network led by Valid International.

g) Next steps

1. District launches in all 28 districts and 6 city and municipal assemblies by 2013
2. Production of training materials for the district and community level
3. Training of 14, 000 staff by 2014
4. Orientation of local leaders 28,197 by 2014
5. Train 80,000 Community Leaders
6. Scale Up Nutrition education and communication through different channels to reach 90 per cent of 450,000 pregnant women 90 per cent of 1.1 million lactating women and 90 per cent of 2.2 million parents of less than 2 years children.
7. Training media all media houses personnel in nutrition
8. Recruit, train and deploy 8,000 community workers by 2016
9. Place nutrition officers at the district council coordinate nutrition (SUN-1000 Special Days) 2013
10. Sustain advocacy on SUN-1000 Special Days

h) Scaling up financial commitments

The government of Malawi has allocated $ 2 million for nutrition.

Malawi basic indicators

Indicator	Value
Total population	15,800,000
Population below $1 (PPP) per day, percentage (2004)	73.9
Life expectancy at birth m/f (years)	44/51
Total expenditure on health per capita (Intl $)	50
Adult literacy rate 2005-08 m/f (%)	80/66

Figures are for 2009 unless indicated.

Core nutrition indicators

Indicator	Value
Stunting (height-for-age < –2 SD of WHO standards)	47% (2010)
Wasting (weight-for-height < –2 SD of WHO standards	4% (2010)
Birth weight (< 2500 grams)	17% (2006)
Adult thinness (Body-Mass Index <18.5)	5% (2010)
Anaemia in children 6-59 months (Hb < 11 g/dL)	55% (2010)
Anaemia in pregnant women (Hb < 11 g/dL)	13% (2010)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	95% (2008)
Iodine supplements (households consuming iodized salt)	87% (2010)
Zinc supplements & oral rehydration (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	72% (2010)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	22% (2004)
International Code of Marketing of Breast-milk Substitutes (adopted)	yes
Access to health care (community and traditional health workers / 1000 population)	0.73 (2008)
Access to water (improved drinking-water sources)	80% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	72, 65, 69
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	116, 104, 110
Maternal mortality rate (annual number of female deaths per 100,000 live births)	510 (300-760)
Nutrition governance score	Strong

NA= not available. Definitions and References for each estimate in Annex 6.

Mali

Country context

Mali is a West African country with a population of over 13 million. The Gross Domestic Product per inhabitant is $1,200 and 36 per cent of the population is estimated to be living under the poverty line (Central Intelligence Agency World Factbook Version 2011). Nearly one third (27 per cent) of the population is believed to be food insecure (Basic survey on food security and nutrition 2007-2008).

Acute and chronic under-nutrition or stunting affects a significant portion of children in Mali, with children living in rural areas generally worse affected than children living in urban areas. Under-nutrition is almost always associated with micronutrient (vitamin and mineral) deficiencies. Anaemia, mainly due to a reduced intake and/or a low bioavailability of iron in food, affects most children between 6-59 months and more than half of pregnant women (Multiple Indicator Cluster Survey 2010). In 2005, a national survey on the prevalence of disorders caused by iodine deficiency in Mali found a slight iodine deficiency in the population of the country (National survey on iodine deficiency disorders 2005). In 2010, iodine consumption in most households is reported to be adequate. The North and Kayes regions have the lowest consumption levels of iodized salt.

Mali suffers from the double burden of malnutrition. In some States, under-nutrition and over-nutrition with increased risks of chronic non-communicable diseases including hypertension, diabetes, cancer and cardiovascular diseases, co-exist in a single household. Although there is limited data on the prevalence of chronic non-communicable diseases, they are likely to be on the increase given the increase in over-nutrition in some areas.

Government response

a) Overall vision for scaling up nutrition

The National Policy on Nutrition Development (PNDN) includes the following goals: (i) reduce the prevalence of acute malnutrition in children between 0-5 years and school aged by half; (ii) reduce the prevalence of chronic malnutrition in children between 0-5 years and school aged by two thirds; (iii) achieve sustainable elimination of disorders associated with micronutrient deficiencies ; (iv) reduce the prevalence of anaemia in children between 0-5 years, school aged and women of childbearing age by one third; (v) improve the nutritional support to pregnant and postpartum women; (vii) improve the support of chronic diseases related to food and nutrition; (viii) ensure sustainable access to adequate food for the entire population, especially for the people who live in the areas of food and nutrition insecurity and the groups at risk (those who live with HIV/AIDS, tuberculosis, older people, etc.). The PNDN is in the final stages of approval and no lead organization has yet been identified.

b) Commitment to scaling up nutrition

In order to mainstream nutrition within the broader poverty reduction policy, the Government of Mali through the Ministry of Health embarked on a large-scale national consultation process. The aim was to tap community networks and other local actors working on nutrition and design strategic guidelines for the country. Several technical workshops and forums were organised in the district of Bamako. More than 1,500 participants took part from local communities. The results of these forums then guided the organisation of the first National Forum on Nutrition in June 2010. The National Forum on Nutrition also engaged officials from several sectors of government including inter-ministerial local, regional, and

national officials around the problem of malnutrition. The Forum has made some specific recommendations, several of which are being implemented now.

c) *National nutrition plans*

Nutrition policy is coordinated by the Nutrition Division of the National Directorate of Health. The Nutrition Committee has prepared the PNDN which outlines specific goals for nutrition improvement. This document is currently being approved by the Government. Once the PNDN is adopted, an inter-sectoral action plan will be developed.

d) *Multi-stakeholder platforms*

One of the outcomes of the National Forum on Nutrition was to hire a Consultant located in the Ministry of Health, to implement the recommendations of the Forum and act as the nutrition focal point. The Consultant is supported by a small multi-sectoral committee that includes representatives from the Ministries of Education, Agriculture, Industrial Development, Health and the Commissioner for Food Security. In addition to this multisectoral Nutrition Committee, nutrition issues are regularly discussed during the meetings of the Health Group as well as of the Food Security Group of the Technical and Financial Partners. The National Forum on Nutrition has been successful in attracting interest in nutrition programming by other sectors.

e) *Next steps*

Planned next steps include:

1. Accelerate the Government approval for the National Policy on Nutrition Development
2. Set up a coordination framework to support nutrition (and the National Council for the Development of Nutrition) with the participation of all stakeholders (Government, United Nations, bilateral partners, donors, non-governmental organisation, business, researchers)
3. Nominate a facilitator/focal point for SUN within the government
4. Identify a facilitator among the technical and financial partners who will secure international support consistent with the implementation of the policy, the future Inter-sectoral action plans, and the institutional set up, and
5. Finalize the inter-sectoral action plan.

f) *Scaling up financial commitments*

Some international partners have already demonstrated strong financial commitment for nutrition programmes. The European Union (EU) for example has allocated over Euro 42 million since 2006 with the aim of preventing malnutrition in Mali. Between 2005 and 2009, the humanitarian arm of the EU has contributed more than Euro 8 million. The United Nations Children's Fund, a technical and financial partner, has also increased its financial resources for nutrition in the last two to three years.

Other donor countries have also contributed to nutrition interventions in Mali including Canada, France, Japan, Spain the United Kingdom, and the United States. Canada has agreed to support the nutrition sector through the REACH initiative.

Mali basic indicators

Indicator	Value
Total population	13,010,000
Population below $1 (PPP) per day, percentage (2004)	51.4
Life expectancy at birth m/f (years)	50/56
Total expenditure on health per capita (Intl $)	66
Adult literacy rate 2005-08 m/f (%)	35/18

Figures are for 2009 unless indicated.

Core nutrition indicators

Indicator	Value
Stunting (height-for-age < –2 SD of WHO standards)	28% (2010)
Wasting (weight-for-height < –2 SD of WHO standards	9% (2010)
Birth weight (< 2500 grams)	19% (2006)
Adult thinness (Body-Mass Index <18.5)	14% (2006)
Anaemia in children 6-59 months (Hb < 11 g/dL)	5% (2010)
Anaemia in pregnant women (Hb < 11 g/dL)	76% (2006)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	97% (2008)
Iodine supplements (households consuming iodized salt)	79% (2006)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	34% (2007)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	7% (2006)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	0.08 (2007)
Access to water (improved drinking-water sources)	56% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	107, 94, 101
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	198, 184, 191
Maternal mortality rate (annual number of female deaths per 100,000 live births)	830 (520-1400)
Nutrition governance score	Weak

NA= Not Available

Mali (version française)

Situation du pays

Situé en Afrique de l'Ouest, le Mali compte 13 millions d'habitants et affiche un produit intérieur brut par habitant de 1 200 USD. Selon diverses estimations, 36 pour cent de la population vit sous le seuil de pauvreté (Central Intelligence Agency World Factbook Version 2011) et près d'un tiers (soit 27 pour cent) de la population souffrirait d'insécurité alimentaire (enquête de base sur la sécurité alimentaire et la nutrition 2007-2008).

Retard de croissance, sous-alimentation aiguë et chronique affectent une part importante d'enfants, les ruraux étant plus durement touchés que les citadins. La sous-alimentation est presque systématiquement liée à des carences en micronutriments (vitamines et minéraux). Quant à l'anémie, généralement inhérente à un apport limité et/ou à une faible biodisponibilité du fer dans les aliments, elle concerne principalement les enfants entre 6 et 59 mois et plus de la moitié des femmes enceintes (Enquête en grappes à indicateurs multiples, 2010). En 2005, une enquête nationale révèle une légère carence en iode chez la population malienne (enquête nationale sur les troubles dus à une carence en iode, 2005). En 2010, la consommation d'iode de la plupart des ménages semble adéquate. Le Nord et la région de Kayes font figurent de bons élèves avec une consommation de sel iodé la plus basse qui soit.

Le Mali est confronté au double fardeau de la malnutrition. En effet, dans certains États, sous-alimentation, suralimentation et risques croissants de maladies non transmissibles chroniques (hypertension, diabète, cancer et maladies cardio-vasculaires) coexistent au sein d'un même foyer. Bien que l'on dispose de peu de données sur la prévalence des maladies non-transmissibles chroniques, ces dernières pourraient bien s'amplifier compte tenu des problèmes croissants de suralimentation rencontrés dans certaines régions.

Actions du gouvernement

a) Vision globale pour le renforcement de la nutrition

La politique nationale de développement de la nutrition (PNDN) fixe les objectifs suivants : (i) réduire de moitié la prévalence de la malnutrition aiguë chez les enfants de 0 à 5 ans et en âge d'être scolarisés ; (ii) réduire de deux tiers la prévalence de la malnutrition chronique chez les enfants de 0 à 5 ans et en âge d'être scolarisés ; (iii) œuvrer à l'élimination durable de troubles liés à des carences en micronutriments ; (iv) réduire d'un tiers la prévalence de l'anémie chez les enfants de 0 à 5 ans en âge d'être scolarisés et chez les femmes en âge de procréer ; (v) renforcer le soutien nutritionnel auprès des femmes enceintes ou venant d'accoucher ; (vii) renforcer le soutien pour les maladies chroniques alimentaires et nutritionnelles ; (viii) garantir un accès durable à une alimentation adéquate pour l'ensemble de la population, notamment pour les personnes vivant dans des régions touchées par l'insécurité alimentaire et nutritionnelle et les groupes à risque (personnes atteintes du VIH/SIDA, de la tuberculose, personnes âgées, etc.). La PNDN est sur le point d'être approuvée. Pourtant, aucune organisation chef de file n'a encore été identifiée.

b) Engagement pour le renforcement de la nutrition

Afin de placer la nutrition au cœur de la politique de réduction de la pauvreté, le gouvernement malien, à travers le ministère de la Santé, a initié un processus de consultation nationale à grande échelle. Il s'agissait de faire appel aux réseaux communautaires et autres acteurs nutritionnels locaux de manière

à élaborer des directives stratégiques applicables au pays. Plusieurs forums et ateliers techniques ont été organisés dans le district de Bamako, auxquels plus de 1 500 personnes issues de communautés locales ont participé. Les résultats des travaux de ces forums ont conduit à l'organisation en juin 2010 du tout premier Forum national sur la nutrition. À cette occasion, les responsables de divers secteurs administratifs, notamment des représentants interministériels locaux, régionaux et nationaux se sont réunis autour de la question de la malnutrition. Le Forum a émis un certain nombre de recommandations spécifiques, dont certaines sont sur le point d'être mises en œuvre.

c) Plans nationaux de nutrition

La division Nutrition de la Direction nationale de la santé est en charge de la politique nutritionnelle du pays. Le Comité nutritionnel a élaboré la PNDN, une politique qui fixe des objectifs spécifiques visant à améliorer la situation nutritionnelle. Ce document est actuellement en phase d'approbation par le gouvernement, après quoi un plan d'action intersectorielle verra le jour.

d) Plateformes multipartites

Suite au Forum national sur la nutrition, un consultant a été nommé au sein du ministère de la Santé afin de mettre en œuvre les recommandations du Forum et d'agir en tant que point focal nutrition. Ce consultant bénéficie de l'appui d'un petit comité multisectoriel composé de représentants des ministères de l'Éducation, de l'Agriculture, du Développement industriel, de la Santé ainsi que du Commissariat à la sécurité alimentaire. Outre ce comité, les questions nutritionnelles font régulièrement l'objet de discussions à l'occasion de réunions organisées par le Groupe Santé et le Groupe Sécurité alimentaire (partenaires techniques et financiers). Le Forum national sur la nutrition s'est révélé fructueux dans la mesure où d'autres secteurs s'intéressent désormais aux programmes nutritionnels.

e) Prochaines étapes

Les prochaines étapes planifiées viseront à :

1. Accélérer l'approbation par le gouvernement de la Politique nationale de développement de la nutrition ;
2. Mettre en place un cadre coordonnateur en faveur de la nutrition (et le Conseil national du développement de la nutrition) impliquant l'ensemble des parties prenantes (gouvernement, Organisation des Nations Unies, partenaires bilatéraux, donneurs, organisations non gouvernementales, entreprises, chercheurs) ;
3. Nommer un facilitateur/point focal SUN au sein du gouvernement ;
4. Définir un facilitateur au sein des partenaires techniques et financiers capable de mobiliser un soutien international qui soit cohérent avec la politique mise en œuvre, les futurs plans d'action intersectorielle et le cadre institutionnel ; et
5. Finaliser le plan d'action intersectoriel.

f) Renforcement des engagements financiers

Certains partenaires internationaux ont déjà démontré un engagement financier très fort en faveur des programmes nutritionnels. L'Union européenne (UE), par exemple, alloue depuis 2006 42 millions d'euros à la prévention de la malnutrition au Mali. Entre 2005 et 2009, l'Office humanitaire de l'UE a apporté plus de 8 millions d'euros. Le Fonds des Nations Unies pour l'enfance, un partenaire technique et financier, a également augmenté les sommes dédiées à la nutrition au cours de ces deux à trois dernières années. D'autres pays donateurs soutiennent des interventions nutritionnelles au Mali, à l'instar du Canada, de la France, du Japon, de l'Espagne, du Royaume-Uni et des États-Unis. Le Canada a notamment accepté de venir en aide à ce secteur à travers l'Initiative REACH.

Mali indicateurs de base

Population totale	13 010 000
Population vivant avec moins d'1 dollar par jour (PPA), pourcentage (2004)	51,4
Espérance de vie à la naissance h/f (années)	50/56
Dépenses totales consacrées à la santé par habitant ($ int.)	66
Taux d'alphabétisation des adultes, 2005 - 2008, h/f (%)	35/18

Chiffres donnés pour 2009 sauf mention contraire.

Indicateurs nutritionnels clés

Retard de croissance (rapport taille/âge < -2 ET selon les normes OMS)	28 % (2010)
Émaciation (rapport poids/âge < -2 ET selon les normes OMS)	9 % (2010)
Poids à la naissance (< 2 500 grammes)	19 % (2006)
Maigreur adulte (indice de masse corporelle < 18,5)	14 % (2006)
Anémie chez les enfants de 6 à 59 mois (Hb< 11 g/dL)	5 % (2010)
Anémie chez les femmes enceintes (Hb< 11 g/dL)	76 % (2006)
Supplémentation en fer et en acide folique (administrée quotidiennement aux femmes enceintes ≥ 6 mois)	ND
Supplémentation en vitamine A (enfants de 6 à 59 mois ayant reçu 2 doses élevées l'an dernier)	97 % (2008)
Supplémentation en iode (ménages consommant du sel iodé)	79 % (2006)
Supplémentation en zinc et thérapie par réhydratation orale (enfants de 0 à 59 mois souffrant de diarrhées)	ND
Allaitement exclusif (nourrissons de 0 à 5 mois)	34 % (2007)
Alimentation complémentaire (enfants allaités de 6 - 23 mois avec une alimentation minimum acceptable)	7 % (2006)
Code international de commercialisation des substituts de lait maternel (adopté)	Oui
Accès aux soins de santé (soignants et agents communautaires / 1 000 habitants)	0,08 (2007)
Accès à l'eau (meilleures sources d'eau potable)	56 % (2008)
Sécurité alimentaire (résultat relatif à la consommation alimentaire des enfants de 6 à 59 mois)	ND
Taux de mortalité infantile (décès avant l'âge d'1 an pour 1 000 naissances vivantes - h/f, les deux sexes)	107, 94, 101
Taux de mortalité avant 5 ans (décès avant l'âge de 5 ans pour 1 000 naissances vivantes - h/f, les deux sexes)	198, 184, 191
Taux de mortalité maternelle (nombre annuel de décès de femmes pour 100 000 naissances vivantes)	830 (520-1400)
Résultat relatif à la gouvernance nutrition	Faible

ND = Non Disponible

Mauritania

"The strategic vision of my department as regards nutrition is focused on respect for the right to a good nutrition as a fundamental right for every Mauritanian"

Mrs. Moulaty Mint Moctar, Minister of Social Affairs, Children and Families, 2009

Country context

Mauritania is 80 per cent desert with a low proportion of farmland and low population density of 2.9 inhabitants per km^2 (3.3 million of inhabitants). Over the last few decades, the country has undergone a rapid transformation from a traditionally nomadic society to a more sedentary population.

The economy is very vulnerable to economic and other shocks including climate change, raw material export prices, and the prices of imports. The Gross National Product per capita is US$ 1,078 and 42 per cent of the population lives below the poverty line (Continuous Household Survey 2008). Approximately 12 per cent of funding for basic social services is provided by the government while 16.9 per cent corresponds to Official Development Assistance (ODA, 2001-2006).

The country is dependent on food imports, as it produces only 30 per cent of its food requirements. Food security surveys show that the coping strategies adopted by households and communities during lean periods or crises, directly affect the quantity and quality of food through (1) reduced food quantity, (2) reduced food quality (3) borrowing of money, and other survival strategies.

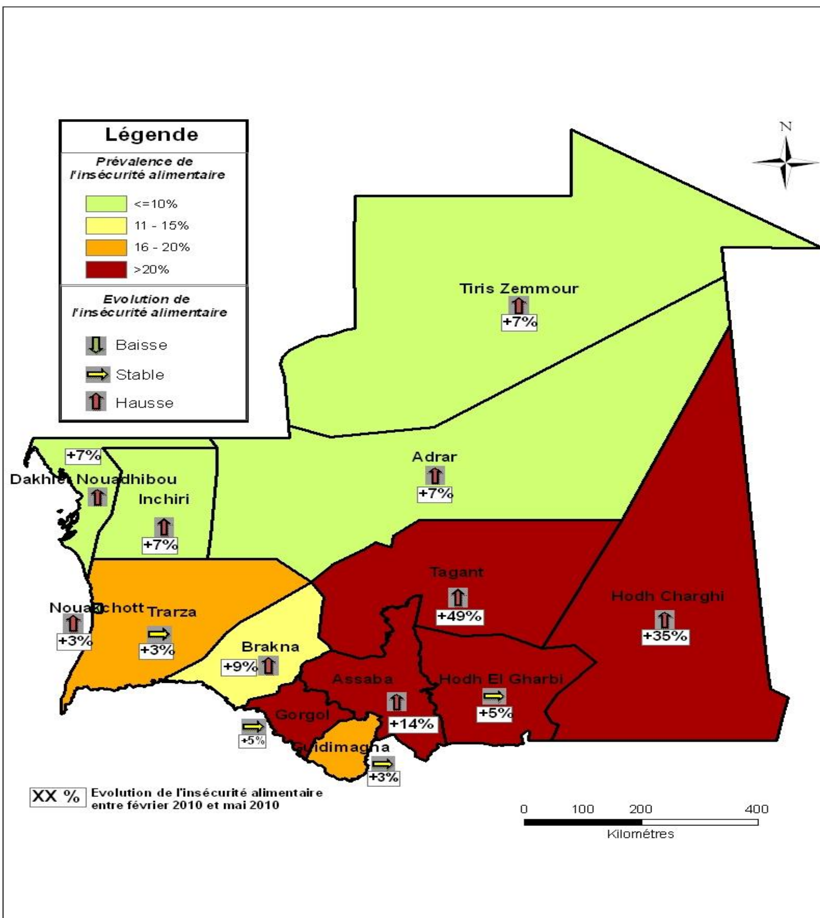
According to the food security survey (Food Security Monitoring System-May 2010), 25 per cent of households were food insecure, including 10 per cent who were severely food insecure.

A recent national nutrition survey (SMART July 2011) found significant rates of wasting, stunting and underweight in children 6-59 months of age. The SMART survey conducted in December 2010 found that most newborn babies were early breastfed, nearly half of children under six months of age were exclusively breastfed and about one in five children between 6 and 23 months have a minimum acceptable complementary diet.

There have been significant improvements in the practices of infant and young child feeding in recent years, however, while the consumption of iodized salt has increased and there has been a declining trend in rates of stunting.

Mauritania has developed a National Policy for Development of Nutrition (2006-2015). In 2010, a Government decree established a National Council for the Development of Nutrition, under the leadership of the Prime Minister, and supported by a Permanent Technical Committee and Regional Coordinating Committees.

Figure 1: Map of food insecurity



Government response

a) Overall vision for scaling up nutrition

The Mauritanian government has made a new commitment to fight against under-nutrition and food insecurity which recognizes the multi-sectoral and multi-causal nature of nutrition. An Inter-sectoral Plan of Action for Nutrition (IPAN 2011-2015) has been developed that sets indicators and targets for 2015 for 17 priority nutrition interventions. It includes an operational plan for building capacity to scale up nutrition and accelerate progress towards achieving Millennium Development Goal 1, aimed at reducing by 50 per cent the proportion of underweight children under five years of age.

b) Commitment to scaling up nutrition

The Government of Mauritania committed to scaling up nutrition and joined the SUN Movement in May 2011. In addition, the Mauritanian government has committed, with the support of partners, to develop a national strategy for food security which is now underway and includes a prioritized action plan and investment programme up to 2015. It aims to boost food production, as well as addressing the various facets of food security: (i) availability of food in sufficient quality and quantity, (ii) access of food for all, (iii) use and quality of food products, and (iv) stability of the food supply. A national strategy for social protection is also being developed that will contribute to strengthening the ability of vulnerable

communities to cope in times of stress. This strategy will promote long term sustainable approaches, ensure greater efficiency in their implementation, and prioritize equitable outcomes.

Several programmatic and institutional achievements were recorded in 2010 (i) the adoption of the decree for food fortification (oil and wheat flour approved in 2010), (ii) the development of a national strategy for food security, (iii) the analysis and review of nutrition curricula at the national university and health schools, (iv) the preparation for the scaling up of several priority interventions such as the promotion of infant and young child feeding, and (v) the introduction of new interventions such as providing children with ready to use nutritional supplements during the lean period and monitoring money transfer interventions to the poorest populations.

c) National nutrition plans

The IPAN has been developed within the framework of the United Nations REACH initiative in Mauritania. Based on an analysis of the nutrition situation assessment of the coverage of interventions conducted by the REACH inter-sectoral technical group, it focuses on five priority areas:

- Improve breastfeeding and complementary feeding;
- Increase micronutrient intake;
- Improve diarrhea treatment and parasite control;
- Improve the treatment of moderate and severe acute malnutrition;
- Improve food security among households;

The selection of areas was guided by six criteria: (i) proven impact, (ii) cost effectiveness, (iii) delivery at the household level, (iv) suitability for scaling up, (v) rapid impact, (vi) sustainability. The IPAN also includes a preliminary budget.

d) Multi-stakeholder platforms

The National Council for the Development of Nutrition is the coordinating body for nutrition which was established and approved in 2010. The council consists of 19 state structures including representatives of mayors' associations, the agri-food sector, and civil society associations. The key structures are the Ministry of Health, the Ministry of Social Affairs, of Children and Families, the Ministry of Rural Development, the Ministry of Industry and the Commissioner for Food Security. The Ministry of Health has leadership for nutrition. No budget lines specified for nutrition exists in Ministry budgets. The Permanent Technical Committee consists of representatives from all the ministries participating in the National Council, as well as development partners.

The REACH inter-sectoral technical group, active since 2008, forms the basis of the Permanent Technical Committee. This working group and at least four regional coordinating committees and are composed of about twenty nutrition actors; focal points from the Ministries of Health, Economic Affairs, Industry and Commerce, Social Affairs, Rural Development and the Commissioner for Food Security, the focal points of SUN United Nations (UN) agencies (FAO, WFP, WHO, UNICEF), international non-governmental organisations, and the University of Nouakchott. The group holds monthly and quarterly meetings to promote coordination and collaboration. These multi-stakeholder platforms have (i) improved joint targeting of the emergency programme beneficiaries in 2009 and 2010, (ii) established operational inter-sectoral synergies and (iii) leveraged economies of scale.

e) Stock-taking and gap analysis

REACH Mauritania supported national government working groups to develop national nutrition plans to bring nutrition interventions to scale by capturing lessons learned and identifying best practices for health-based interventions and food-based solutions. This collaborative approach led to consensus

among multiple stakeholders about the magnitude of nutritional challenges in the country, their causes, and the need for new approaches to scaling-up nutrition interventions.

A country "pre-study" was carried out in 2007 to serve as a baseline for planning purposes. The study was carried out by a local team supervised by the UN agencies with support from the REACH global inter-agency team and of the Boston Consulting Group (BCG). Exchanges followed with key stakeholders in government, United Nations experts and other development partners helped streamline and establish suitable institutional coordination mechanisms. The ensuing analysis helped to raise awareness about the nutritional challenges and emphasised the need for joint and intensified actions. A core team of agency focal points was the core driver of the process that closely worked with the technical committee that included technical experts from key government ministries and from other partners.

A detailed mapping of stakeholders streamlined the REACH national effort by identifying gaps and overlaps in certain areas and accordingly defined the responsibilities and roles of each partner. Joint planning forced actors to reflect more on their comparative advantages and on the direction their expansion should take - geographically and technically. Joint planning led to a harmonised leveraging of funds from donors in support of agreed nutritional interventions that was manifested by the Spanish MDG and the UN Central Emergency Response Fund (CERF) funding to Mauritania.

The stakeholder mapping interviews yielded preliminary information to prepare for the later exercises of coverage and funding assessments.

f) Engagement of non-governmental agencies

Mauritania's partners play a key role in supporting Government efforts in nutrition, in accordance with the Poverty Strategy Reduction Paper (PSRP) and sectoral policies and strategies. Donors such as the Humanitarian Aid department of the **European** Commission, the Office of United States Foreign Disaster Assistance, the United Nations **Office for the Coordination of Humanitarian Affairs** and the Japanese Government are committed to providing emergency nutrition interventions. The European Union, the United States Agency for International Development the Agencia Española de Cooperación Internacional para el Desarrollo, and the MDG Achievement Fund, among others are contributing to improving nutrition in Mauritania in the longer term. Since 2007, the number of nutrition actors, especially international non-governmental organisations, has increased, and the involvement and response of civil society, UN agencies has been sustained. The role of the business sector has been minimal.

g) Next steps

The problem of lack of trained and skilled human resources in nutrition appears to be the major factor blocking progress implementing policies and strategies for scale up. Training needs have been identified and in-service training of staff has been retained as fundamental for system set-up. Approaches and tools were recently updated (strengthening of national Schools of Public Health curricula, establishment of courses related to nutrition in the Department of Science and Technology and Medicine of Nouakchott University). Budget allocations for nutrition and the creation of positions for trained human resources must now be provided by Government departments.

h) Scaling up financial commitments

A preliminary estimate of the IPAN budget was developed in 2009. Supported by its partners in 2011, the Government is developing an investment case for nutrition using the REACH toolkit for the scaling up nutrition interventions in Mauritania. This will start by costing the implementation budget of the

IPAN 2012-2016, and will estimate the potential benefits for the population and the country of its implementation, and apply an equity lens to the analysis to ensure that marginalized, vulnerable or other groups with low access to services are adequately targeted.

The Government-led PRSP (2011-2015) dedicates a whole section to nutrition and promotes its inter-sectoral aspects. Each sector is planning nutrition activities in its budget, but no specific sections or line items appear in Government Ministry budgets.

Figure 2: Table of key indicators for 2010 as a baseline for SUN

Intervention	Indicator	Source (Periodicity)	National
Exclusive and continuous	% children < 6-months with exclusive	Rapid Nut Survey	46%*
	% children 18-23 months with continuous	Rapid Nut Survey	65%
Complementary feeding	% children 6-23 months receiving CF, minimum	Rapid Nut Survey	35%
	% children 6-23 months with a minimum freq	Rapid Nut Survey	36,2
Vitamin A Suppl &	% < 5 years with Vitamin A deficiency	n/d	0%
Iron suppl & Fortification	% 6-59 children with severe/moderate anemia	Rapid Nut Survey April	0%
	% pregnant women with severe/moderate	n/d	0%
Zinc Suppl. & Fortification	% < 5 years with zinc deficiency	n/d	0%
	% < 5 years with diarrhea	Rapid Nut Survey	19,9%
Iodine suppl &	% < 5 years with iodine deficiency	WHO 1995	0%
Ready to use	% < 5 years suffering from global acute	Rapid Nut Survey	12,5%
Domestic water treatment	% households with access to drinkable water	MICS 2007	0%
	% households using water treatment system	MICS 2007	0%
Soap hand washing	% population washing their hands before	Rapid Nut Survey April	0%
	% population washing their hands after using	Rapid Nut Survey April	
Impregnated mosquito nets	% < 5 years sleeping under an impregnated	Rapid Nut Survey	27,6
	Prevalence of malaria among < 5 years	MICS 2007	0%
	% of pregnant women sleeping under an	Survey on malaria	0%
Intermittent preventive treatment	Prevalence of malaria among pregnant women	Survey on malaria	0%
	% of pregnant women exposed to malaria	FAR Endemic Zone(WHO	0%
Deworming	Prevalence of STH & schistosomiasis < 5 years	n/d	0%
Therapeutic feeding	% of < 5 suffering from SAM (lean period)	Rapid Nut Survey 2008/2009/2010 Jun-July	0,9%
Supplementary feeding	% of < 5 suffering from MAM (lean period)	Rapid Nut Survey	11,6%
Conditional cash	% Population living below the national poverty	World Bank 2004	0,0%
Small scale agricultural	% Food insecure population (lean period)	ESAM/FSMS 2008-2009-	25,0%

Mauritania basic indicators

Total population	3,291,000
Population below $1 (PPP) per day, percentage (2004)	21.2
Life expectancy at birth m/f (years)	57/60
Total expenditure on health per capita (Intl $)	47
Adult literacy rate 2005-08 m/f (%)	64/50

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	23% (2008)
Wasting (weight-for-height < –2 SD of WHO standards	8% (2008)
Birth weight (< 2500 grams)	34% (2007)
Adult thinness (Body-Mass Index <18.5)	13% (2001)
Anaemia in children 6-59 months (Hb < 11 g/dL)	NA
Anaemia in pregnant women (Hb < 11 g/dL)	NA
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	87% (2008)
Iodine supplements (households consuming iodized salt)	2% (2007)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	19% (2008)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	NA
International Code of Marketing of Breast-milk Substitutes (adopted)	No
Access to health care (community and traditional health workers / 1000 population)	0.28 (2009)
Access to water (improved drinking-water sources)	49% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	79, 69, 74
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	123, 111, 117
Maternal mortality rate (annual number of female deaths per 100,000 live births)	550 (300-980)
Nutrition governance score	NA

NA= Not Available

Mauritanie (version française)

« La vision stratégique de la nutrition telle que la voit mon cabinet est axée sur le respect du droit à une bonne nutrition, un droit fondamental pour chaque Mauritanien ».

Mme Moulaty Mint Moctar, ministre des Affaires sociales, des Enfants et de la Famille, 2009

Situation du pays

La Mauritanie se compose à 80 pour cent d'une surface désertique avec très peu de terres agricoles et une faible densité de la population de 2,9 habitants/km² (3,3 millions d'habitants). Au cours de ces dernières décennies, le pays a opéré un rapide changement de son mode de vie qui tend à se sédentariser.

L'économie du pays est relativement vulnérable aux crises économiques et autres bouleversements liés notamment au changement climatique, aux prix à l'exportation des matières premières et aux prix à l'importation. Le produit intérieur brut par habitant est de 1 078 USD, et 42 pour cent de la population vit sous le seuil de la pauvreté (Enquête permanente auprès des ménages, 2008). Près de 12 pour cent des fonds dédiés aux services sociaux de base sont distribués par le gouvernement, tandis que 16,9 consistent en une aide publique au développement (aide publique au développement, 2001-2006).

Le pays dépend des importations alimentaires, dans la mesure il ne produit que 30 pour cent de ses besoins. Selon des enquêtes menées sur la sécurité alimentaire, les stratégies d'adaptation adoptées par les ménages et les communautés lors des périodes difficiles ou de crises influent directement sur les aspects quantitatifs et qualitatifs de l'alimentation : (1) réduction de la quantité des denrées alimentaires, (2) réduction de la qualité des aliments et (3) emprunt financier et autres stratégies de survie.

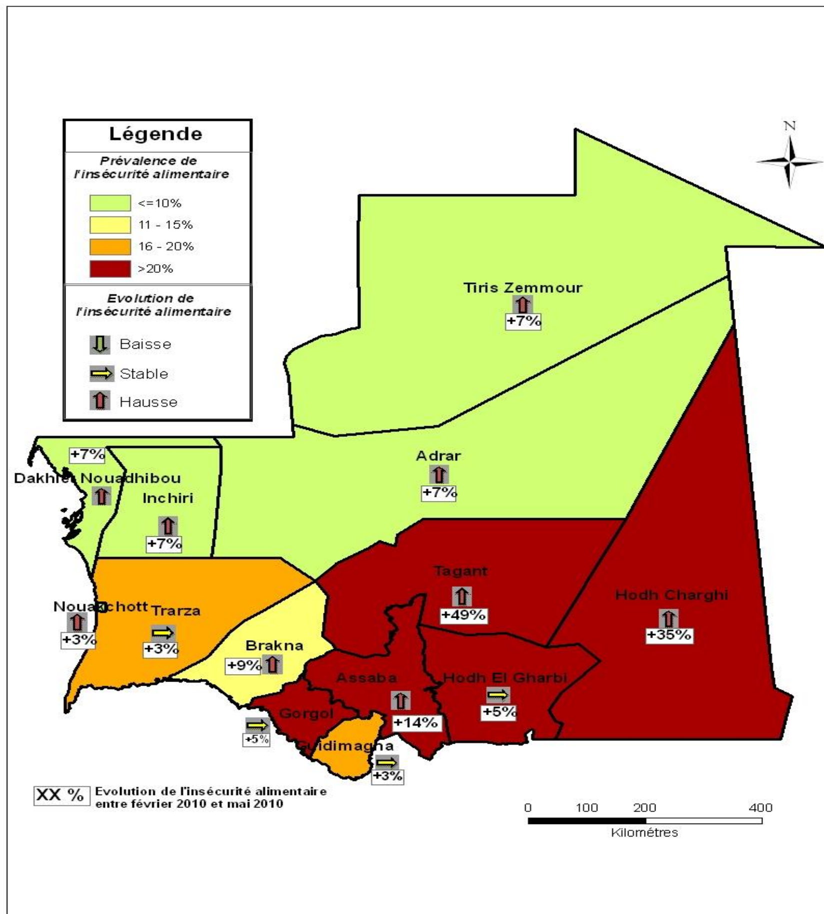
Selon l'enquête sur la sécurité alimentaire (Système de surveillance de la sécurité alimentaire, mai 2010), 25 pour cent des ménages souffrent d'insécurité alimentaire, dont 10 pour cent d'insécurité alimentaire sévère.

Une enquête nationale récente sur la nutrition (SMART, juillet 2011) a révélé des taux élevés d'émaciation, de retard de croissance et d'insuffisance pondérale chez les enfants âgés de 6 à 59 mois. En décembre 2010, cette enquête avait souligné le fait que la plupart des nouveau-nés étaient allaités très tôt, que près de la moitié des enfants de moins de 6 mois étaient exclusivement allaités et qu'environ 1 enfant sur 5 âgé de 6 à 23 mois avait une alimentation minimum acceptable.

Les pratiques alimentaires des nourrissons et des jeunes enfants se sont nettement améliorées ces dernières années, malgré la hausse, dans le même temps, de la consommation de sel iodé s'est accrue, et on assiste à une tendance à la baisse des taux de retard de croissance.

La Mauritanie a élaboré une Politique nationale de développement de la nutrition (2006-2015). En 2010, un Conseil national pour le développement de la nutrition a été établi par décret gouvernemental. Ce Conseil opèrera sous la responsabilité du Premier ministre, avec le soutien d'un Comité technique permanent et des Comités de coordination régionaux.

Figure 1 : carte de la prévalence de l'insécurité alimentaire



Actions du gouvernement

a) Vision globale pour le renforcement de la nutrition

Le gouvernement mauritanien s'est engagé à lutter contre la sous-alimentation et l'insécurité alimentaire, en tenant compte du caractère multisectoriel et multicausal de la nutrition. En ce sens, un plan d'action intersectorielle pour la nutrition (2011-2015) a été défini avec des indicateurs et des objectifs à atteindre pour 2015 pour 17 interventions nutritionnelles prioritaires. Il consiste en un plan opérationnel de développement de potentiel visant à élargir les interventions nutritionnelles et à accélérer la réalisation de l'objectif du millénaire pour le développement 1, de manière à réduire de 50 pour cent la part des enfants âgés de moins de 5 ans sous-alimentés.

b) Engagement pour le renforcement de la nutrition

Soucieux d'élargir les interventions nutritionnelles, le gouvernement mauritanien à rejoint le Mouvement SUN en mai 2011. Par ailleurs, le gouvernement a initié, avec l'aide de divers partenaires, le développement d'une stratégie nationale pour la sécurité alimentaire, en cours d'application, reposant sur un plan d'action priorisé et en un programme d'investissement ouvert jusqu'en 2015. Cette stratégie vise à stimuler la production alimentaire tout en tenant compte des différents aspects de la sécurité alimentaire : (i) disponibilité de la nourriture de qualité et en quantité suffisantes, (ii) accès aux denrées alimentaires pour tous, (iii) usage et qualité des produits alimentaires et (iv) stabilité

de la chaîne alimentaire. Une stratégie nationale de protection sociale va également être définie afin de renforcer la capacité des populations vulnérables à faire face aux périodes difficiles. Cette stratégie soutiendra des approches durables sur le long terme tout en garantissant une plus grande efficacité de mise en œuvre et l'obtention de résultats équitables.

À noter plusieurs réalisations institutionnelles et programmes fructueux au cours de 2010, à savoir (i) l'adoption d'un décret concernant l'enrichissement de denrées alimentaires (huile et farine de blé approuvées en 2010), (ii) le développement d'une stratégie nationale pour la sécurité alimentaire, (iii) l'analyse et la revue des programmes nutritionnels de l'université nationale et des écoles de médecine, (iv) la préparation de l'élargissement de plusieurs interventions prioritaires (par exemple promotion de l'alimentation des nourrissons et des jeunes enfants), et (v) la mise en œuvre de nouvelles interventions telles que l'administration aux enfants de compléments alimentaires prêts à l'emploi pendant la période de soudure et le contrôle des transferts de fonds aux populations les plus pauvres.

c) Plans nationaux de nutrition

Le plan d'action intersectorielle pour la nutrition a été élaboré dans le cadre de REACH, une initiative de l'Organisation des Nations Unies lancée en Mauritanie qui s'appuie sur l'évaluation de la couverture des interventions nutritionnelles menée par le groupe technique intersectoriel REACH. Cette initiative s'articule autour de 5 axes prioritaires :

- Promouvoir l'allaitement et l'alimentation complémentaire ;
- Accroître la prise de micronutriments ;
- Renforcer le traitement de la diarrhée et la lutte contre les maladies parasitaires ;
- Améliorer le traitement de la malnutrition aiguë sévère et modérée ;
- Favoriser une meilleure sécurité alimentaire chez les ménages.

Cette sélection d'axes d'intervention repose sur 6 critères : (i) impact démontré, (ii) rentabilité, (iii) prestation aux ménages, (iv) élargissement durable, (v) impact rapide et (vi) durabilité. Le plan d'action établit également un budget préliminaire.

d) Plateformes multipartites

Le Conseil national de développement de la nutrition a été fondé et approuvé en 2010. Cet organe de coordination réunit 19 structures étatiques, notamment des représentants des associations de maires, du secteur agro-alimentaire et des acteurs de la société civile. Les principales structures englobent le ministère de la Santé, le ministère des Affaires sociales, des Enfants et de la Famille, le ministère du Développement rural, le Ministère de l'Industrie et le Commissariat à la sécurité alimentaire, le ministère de la Santé étant responsable des questions nutritionnelles. Les budgets de ces instances ministérielles ne prévoient aucun poste pour la nutrition. Le Comité technique permanent comprend des représentants de l'ensemble des ministères faisant partie du Conseil national, ainsi que des partenaires du développement.

Le groupe technique intersectoriel REACH, opérationnel depuis 2008, constitue le pilier du Comité technique permanent. Ce groupe de travail, doté d'au moins 4 comités de coordination régionale, se compose d'une vingtaine d'acteurs nutritionnels, de points focaux issus des ministères de la Santé, des Affaires économiques, de l'Industrie et du Commerce, des Affaires sociales, du Développement rural et du Commissariat à la sécurité alimentaire, d'agences de l'Organisation des Nations Unies SUN (FAO, PAM, OMS, UNICEF), d'organisations non gouvernementales internationales et de l'Université de Nouakchott. Le groupe organise des réunions mensuelles et trimestrielles placées sous le signe de la coordination et de la collaboration. Ces instances multipartites ont permis (i) un meilleur ciblage

conjoint des bénéficiaires du programme d'urgence en 2009 et en 2010, (ii) la mise en place de synergies intersectorielles opérationnelles et (iii) des économies d'échelle accrues.

e) Analyse des écarts et bilan

L'Initiative REACH a aidé les groupes de travail du gouvernement mauritanien à développer des plans nutritionnels nationaux capables d'élargir l'échelle d'intervention en s'appuyant sur les enseignements tirés et les meilleures pratiques observées dans les domaines sanitaires et alimentaires. Cette approche concertée a fait naître un consensus parmi diverses parties prenantes quant à l'ampleur des enjeux nutritionnels dans le pays, quant à leurs causes et quant à la nécessité de définir de nouvelles approches d'élargissement des interventions nutritionnelles.

Une étude préliminaire nationale a été réalisée en 2007 afin de servir de base à l'élaboration de projets. L'étude a été menée par un groupe local sous la supervision des agences de l'ONU, avec le soutien du groupe interinstitutionnel global REACH et du cabinet de conseil Boston Consulting Group (BCG). Les échanges qui s'en sont suivis entre les principaux acteurs du gouvernement, les experts de l'Organisation des Nations Unies et d'autres partenaires du développement se sont traduits par la rationalisation et l'établissement de mécanismes de coordination institutionnelle adaptés. L'analyse réalisée par la suite a apporté un éclairage sur les enjeux nutritionnels, en pointant la nécessité de mener des actions communes et plus intenses. Une équipe de base regroupant les points focaux institutionnels s'est imposée comme le moteur du processus à travers une collaboration étroite avec le comité technique, impliquant des experts techniques issus des principaux ministères et d'autres partenaires.

Une cartographie détaillée des parties prenantes a contribué à la rationalisation des efforts nationaux de REACH, grâce à l'identification de lacunes et de chevauchements dans certains domaines et à la définition adéquate des rôles et des responsabilités de chacun. La planification commune a poussé les acteurs à plus se concentrer sur leurs avantages comparatifs et sur la direction à suivre en termes d'élargissement d'un point de vue géographique et technique. Cette planification a favorisé une collecte de fonds mieux organisée auprès des donneurs dédiés à des interventions nutritionnelles approuvées, sous forme d'un financement opéré en Mauritanie à travers l'OMD espagnol et le Fonds central pour les interventions d'urgence de l'ONU.

Les entretiens réalisés dans le cadre de la cartographie des parties prenantes ont permis d'obtenir des informations préliminaires qui serviront à analyser couverture et financement.

f) Engagement d'organisations non gouvernementales

Les partenaires de la Mauritanie jouent un rôle central dans les interventions nutritionnelles gouvernementales menées, conformément au document stratégique de réduction de la pauvreté et aux politiques sectorielles. Le service d'Aide humanitaire de la Commission européenne, l'Office of United States Foreign Disaster Assistance, le Bureau de coordination des affaires humanitaires de l'ONU et le gouvernement japonais, tous donneurs, œuvrent en faveur d'interventions nutritionnelles d'urgence. L'Union européenne, l'Agence américaine pour le développement international, l'Agence espagnole de coopération internationale pour le développement et le Fond pour la réalisation des OMD, notamment, apportent leur contribution pour une meilleure nutrition à long terme en Mauritanie. Depuis 2007, le nombre d'acteurs nutritionnels, particulièrement des organisations non gouvernementales, s'est accru, et la société civile ainsi que les organisations de l'ONU poursuivent leurs efforts. En revanche, la participation du monde des affaires est restée minimaliste.

g) Prochaines étapes

Le manque d'individus formés et qualifiés dans le domaine de la nutrition se pose comme un obstacle majeur à la mise en œuvre des politiques et des stratégies d'élargissement. Suite à la détermination de besoins dans ce domaine, la formation en cours d'emploi est le système qui a été retenu. Plusieurs outils et approches ont été récemment mis à jour (renforcement du programme des écoles nationales de santé publique, mise en place de cours en lien avec la nutrition au département de Science, de Technologie et de Médecine de l'Université de Nouakchott). Désormais, les ministères doivent prévoir un budget pour la nutrition et la création de postes pour du personnel formé.

h) Renforcement des engagements financiers

Une estimation préliminaire du budget du Plan d'action intersectoriel pour la nutrition a été réalisée en 2009. Actuellement en 2011, le gouvernement, soutenu par ses partenaires, élabore un dossier d'investissement à l'aide d'une panoplie d'instruments REACH, dans le but d'élargir les interventions nutritionnelles en Mauritanie. Il s'agira, dans un premier temps, d'évaluer le budget de mise en œuvre du Plan d'action pour 2012-2016, puis d'estimer les avantages potentiels pour la population et le pays et, enfin, de procéder à l'analyse dans une optique d'équité, de sorte que les groupes marginaux, vulnérables et autres jouissant d'un faible accès aux services soient parfaitement ciblés.

Le document stratégique sur la réduction de la pauvreté (2011-2015) émis par le gouvernement consacre toute une partie à la nutrition, en mettant l'accent sur les aspects intersectoriels. Même si chaque secteur prévoit des actions nutritionnelles dans leur budget, aucun poste ni aucune section spécifique ne figure dans les budgets ministériels.

Figure 2 Tableau des indicateurs clés de référence pour SUN (2010)

Intervention	Indicateur	Source (Fréquence)	National 2010
Allaitement exclusif et continu	% enfants < 6 mois exclusivement allaités	Enquête rapide sur la nut., déc. 2008/2009/2010	46 %*
	% enfants < 18-23 mois allaités en continu	Enquête rapide sur la nut., déc. 2008/2009/2010	65 %
Alimentation complémentaire	% enfants 6-23 mois recevant une alimentation de complément, diversité alimentaire minimum	Enquête rapide sur la nut., déc. 2008/2009/2010	35 %
	% enfants 6-23 mois avec fréq. minimum des repas/jour	Enquête rapide sur la nut., déc. 2008/2009/2010	36,2
Enrichissement et supplémentation en vitamine A	% < 5 ans présentant une carence en vitamine A	n/d	0 %
Enrichissement et supplémentation en fer	% enfants 6-59 mois souffrant d'anémie sévère/modérée	Enquête rapide sur la nut., avril 2008	0 %
	% femmes enceintes souffrant d'anémie sévère/modérée	n/d	0 %

Enrichissement et supplémentation en zinc	% < 5 ans souffrant de carence en zinc	n/d	0 %
	% < 5 ans souffrant de diarrhées	Enquête rapide sur la nut., déc. 2008/2009/2010	19,9 %
Enrichissement et supplémentation en iode	% < 5 ans souffrant de carence en iode	OMS, 1995	0 %
Compléments alimentaires prêts à l'emploi	% < 5 ans souffrant de malnutrition aiguë globale (période de soudure)	Enquête rapide sur la nut., juin/juil. 2008/2009/2010	12,5 %
Traitement des eaux ménagères	% ménages ayant accès à l'eau potable	MICS, 2007	0 %
	% ménages utilisant un système de traitement de l'eau	MICS, 2007	0 %
Nettoyage des mains au savon	% population se lavant les mains avant les repas	Enquête rapide sur la nut., avril 2008	0 %
	% population se lavant les mains après avoir été aux toilettes	Enquête rapide sur la nut., avril 2008	
Moustiquaires imprégnées d'insecticides	% < 5 ans dormant sous une moustiquaire imprégnée d'insecticides	Enquête rapide sur la nut., déc. 2008/2009/2010	27,6
	Prévalence du paludisme chez < 5 ans (symptômes)	MICS, 2007	0 %
	% de femmes enceintes dormant sous une moustiquaire imprégnée d'insecticides	Étude sur le paludisme	0 %
Traitement préventif intermittent contre le paludisme	Prévalence du paludisme chez les femmes enceintes	Étude sur le paludisme	0 %
	% de femmes enceintes exposées au paludisme	Zone endémique FAR (estim. OMS)	0 %
Déparasitage	Prévalence de HTS et de schistosomiases < 5 ans	n/d	0 %
Alimentation thérapeutique	% < 5 ans souffrant de MAS (période de soudure)	Enquête rapide sur la nut., juin/juil. 2008/2009/2010	0,9 %
Alimentation de complément	% < 5 ans souffrant de MAM (période de soudure)	Enquête rapide sur la nut., juin/juil. 2008/2009/2010	11,6 %
Transfert d'argent conditionnel	% population vivant en dessous du seuil de pauvreté national	Banque mondiale, 2004	0,0 %
Élevage et production agricole à petite échelle	% population souffrant d'insécurité alimentaire (période de soudure)	ESAM/SMSDA, 2008-2009-2010 (soudure)	25,0 %

Mauritanie indicateurs de base

Population totale	3 291 000
Population vivant avec moins d'1 dollar par jour (PPA), pourcentage (2004)	21,2
Espérance de vie à la naissance h/f (années)	57/60
Dépenses totales consacrées à la santé par habitant ($ int.)	47
Taux d'alphabétisation des adultes, 2005 - 2008, h/f (%)	64/50

Chiffres donnés pour 2009 sauf mention contraire.

Indicateurs nutritionnels clés

Retard de croissance (rapport taille/âge < -2 ET selon les normes OMS)	23 % (2008)
Émaciation (rapport poids/âge < -2 ET selon les normes OMS)	8 % (2008)
Poids à la naissance (< 2 500 grammes)	34 % (2007)
Maigreur adulte (indice de masse corporelle < 18,5)	13 % (2001)
Anémie chez les enfants de 6 à 59 mois (Hb< 11 g/dL)	ND
Anémie chez les femmes enceintes (Hb< 11 g/dL)	ND
Supplémentation en fer et en acide folique (administrée quotidiennement aux femmes enceintes ≥ 6 mois)	ND
Supplémentation en vitamine A (enfants de 6 à 59 mois ayant reçu 2 doses élevées l'an dernier)	87 % (2008)
Supplémentation en iode (ménages consommant du sel iodé)	2 % (2007)
Supplémentation en zinc et thérapie par réhydratation orale (enfants de 0 à 59 mois souffrant de diarrhées)	ND
Allaitement exclusif (nourrissons de 0 à 5 mois)	19 % (2008)
Alimentation complémentaire (enfants allaités de 6 - 23 mois avec une alimentation minimum acceptable)	ND
Code international de commercialisation des substituts de lait maternel (adopté)	Non
Accès aux soins de santé (soignants et agents communautaires / 1 000 habitants)	0,28 (2009)
Accès à l'eau (meilleures sources d'eau potable)	49 % (2008)
Sécurité alimentaire (résultat relatif à la consommation alimentaire des enfants de 6 à 59 mois)	ND
Taux de mortalité infantile (décès avant l'âge d'1 an pour 1 000 naissances vivantes - h/f, les deux sexes)	79, 69, 74
Taux de mortalité avant 5 ans (décès avant l'âge de 5 ans pour 1 000 naissances vivantes - h/f, les deux sexes)	123, 111, 117
Taux de mortalité maternelle (nombre annuel de décès de femmes pour 100 000 naissances vivantes)	550 (300-980)
Résultat relatif à la gouvernance nutrition	ND

ND = Non Disponible

Mozambique

Country context

Mozambique is a country in sub-Saharan Africa that has a population of around 23 million people. The country has undergone slow growth and is recognized as low-income, with approximately 55 per cent of people living in poverty (National Institute for Statistics, 2010). The Gross Domestic Product is $ 423 and Mozambique's Human Development Index ranked 165 out of 169 in 2010. An estimated 35 per cent of households are food insecure.

Mozambique has seen modest gains in child and infant mortality in recent years and may be on track to meet the Millennium Development Goal target 1 on eradicating extreme poverty and hunger as underweight in children under five has declined. It is estimated, however, that under-nutrition is a contributing factor to 36 per cent of remaining child deaths (USAID 2006, Nutrition of young children and mothers in Mozambique). The costs of not addressing this problem were estimated at $ 110 million per year in 2004 in terms of productivity losses alone (Kahn S, et al 2004. Moçambique: Investir nanutrição é reduzir a pobreza. Maputo, MoH/HKI)

The Nutrition Department in the Ministry of Health (National Directorate of Public Health) is primarily responsible for nutrition policy and protocol development as well as the planning and oversight of nutrition activities. The responsibilities of the Nutrition Department are divided into four main areas: 1) nutritional surveillance; 2) nutrition education; 3) prevention and control of under-nutrition (in all its forms) and micronutrient deficiencies; 3) nutrition and HIV and tuberculosis and 4) nutrition and non-communicable diseases. Another Nutrition Unit, specifically for hospital diets, is managed by the Directorate of Medical Assistance.

Government response

a) Overall vision for scaling up nutrition

The Government's Five Year Plan (2010-2014) establishes food and nutrition security as one of the key objectives in the fight against poverty, the improvement of the wellbeing of the population and the promotion of the socio-economic development of the country. The reduction of chronic under-nutrition (stunting) is a strategic objective in various Government planning documents including the Five Year Plan (2010-2014) and the Poverty Reduction Strategy (2011-2014).

The Government endorsed a multi-sectoral Nutrition Action Plan for the reduction of chronic under-nutrition with the goal to reduce stunting in under-fives from 44 per cent in 2008 to 30 per cent in 2015, and 20 per cent in 2020.

Other objectives of the Nutrition Action Plan are:

- Reduce anaemia in adolescents from an estimated 40 per cent in 2010 to 20 per cent in 2015 and 10 per cent in 2020
- Reduce anaemia in pregnant women from 53 per cent in 2002 to 30 per cent in 2015 and 15 per cent in 2020
- Increase the percentage of women who gain more than 5 kg during pregnancy by 30 percentage points
- Reduce iodine deficiency in pregnant women from 68 per cent in 2004 to 35 per cent in 2015 and 15 per cent in 2020

- Increase the coverage of vitamin A supplementation of postpartum women from 60 per cent in 2010 to 70 per cent in 2015 and 90 per cent in 2020
- Reduce anaemia in women of reproductive age from 56 per cent in 2010 to 30 per cent in 2015 and 15 per cent in 2020
- Reduce low birth weight from 15 per cent in 2008 to 10 per cent in 2015 and 5 per cent in 2020
- Reduce stunting in children under two years of age from 37 per cent in 2008 to 27 per cent in 2015 and 17 per cent in 2020
- Increase exclusive breastfeeding rates in children under six months of age from 37 per cent in 2008 to 60 per cent in 2015 and 70 per cent in 2020
- Reduce anaemia in children from 74 per cent in 2002 to 30 per cent in 2015 and 15 per cent in 2020

b) Commitment to scaling up nutrition

Over the past decade, nutrition has gained importance in Government policy. During the 1996 World Food Summit, Mozambique promised to reduce food insecurity and nutrition by half by 2015. In response, the Council of Ministers approved the Food and Nutrition Security Strategy (ESAN) in 1998, which was revised in 2007 and translated into ESAN II (200-2015). ESAN II prioritizes chronic under-nutrition. In 2008, the Ministry of Health highlighted the urgent need to reduce chronic under-nutrition rates and promoted the Nutrition Section to the level of Department. And in 2010, the Government committed itself again to reducing chronic under-nutrition by including it as a strategic objective in the Five Year Plan. The Plan includes the development of the Law on the Human Right to Adequate Food, which supports the State in the formulation and adoption of policies, plans, monitoring and evaluation and prioritisation of the food and nutrition security interventions in a holistic manner. The draft legal framework on the Human Right to Adequate Food is currently being finalised and will be approved by the National Assembly.

c) National nutrition plans

A multi-sectoral Nutrition Action Plan for the Reduction of Chronic Undernutrition 2011-2015 (with PAMRDC as its Portuguese acronym) was developed in 2010 by a group of stakeholders including Government Ministries, non-governmental organisations, donors and development partners. The plan was approved by the Council of Ministers in September of the same year.

The plan is for national coverage of programmes and addresses the capacity gaps in government institutions responsible for its implementation. Priority interventions are identified, which will complement other relevant plans and strategies such as the Food and Nutrition Security Strategy (ESAN II) and the Plan for the Achievement of MDGs 4 and 5, the implementation of which is on-going.

The Nutrition Action Plan consists of seven strategic objectives, each with specific expected results and activities:

Objective 1: Strengthen activities with impact on the nutritional status of adolescents. The proposed activities include micronutrient supplementation, de-worming, education and social mobilisation to reduce early pregnancies and nutrition education.

Objective 2: Strengthen activities with impact on the health and nutrition of women of reproductive age before and during pregnancy and lactation. Activities include micronutrient supplementation, family planning (child spacing), de-worming, prevention and treatment of malaria, sexually transmitted infections, HIV and other infections, weight gain check ups during pregnancy and nutritional supplementation for selected groups.

Objective 3: Strengthen nutrition activities for children under two years of age. The activities include promotion and support of breastfeeding, monitoring compliance with the National Code for the Marketing of Breastmilk Substitutes, counselling for adequate complementary feeding, vitamin A supplementation, deworming and nutritional supplementation for selected groups.

Objective 4: Strengthen household oriented activities that impact on the access and utilisation of foods with a high nutritional value. Activities include studies on nutrient dense local foods, support for the cultivation of nutrient dense foods (vegetable and animal), nutrition education and food preparation demonstrations, education about improved food storage, support for school gardens, social protection for vulnerable households, strengthened law enforcement for iodised salt, initiation of staple food fortification, hygiene education and support for the establishment and use of improved sanitation facilities.

Objective 5: Strengthen the human resource capacity for nutrition. Activities include the development of job descriptions, curricula and training materials for pre-service and in-service training of nutrition professionals, and the development of manuals and training sessions on nutrition for professionals from other sectors like education, social action and agriculture.

Objective 6: Strengthen the national capacity to advocate, coordinate and manage the progressive implementation of the Plan. Activities include the formal establishment of multisectoral groups at central, provincial and district level for the coordination, management, monitoring and evaluation and advocacy and social mobilisation, of the Multi-sectoral Nutrition Action Plan, and the implementation of relevant activities of these groups.

Objective 7: Strengthen the food and nutrition surveillance systems. Activities include the strengthening of the management of the existing food and nutrition surveillance, and support for the timely dissemination of quality, disaggregated information about food and nutrition security.

d) Multi-stakeholder platforms

The Secretariat for Food and Nutrition Security (SETSAN) in the Ministry of Agriculture, has the mandate to coordinate the Food and Nutrition Policies and Strategies, particularly the National Strategy for Food and Nutrition Security 2008-2015 (ESAN II). Historically, SETSAN focused its efforts on food security, distinct from nutrition policy. Now, SETSAN is transitioning to coordinate Food and Nutrition policies and programmes among different sectors. SETSAN answers directly to the Ministry of Agriculture.

To improve the coordination of partners' support to the Government, a Nutrition Partners Forum was established in May 2011 with the United Nations Children's Fund (UNICEF) as the chair and The Government of Denmark as the Vice Chair. There is participation from donors, civil society and UN agencies. The main purpose of the Forum is to harmonise and coordinate the support for implementation of the Nutrition Action Plan and thereby reduce transaction costs.

Additionally, a first meeting of civil society representatives was held in August 2011 to define a platform for civil society support to nutrition and to advocate for the implementation of the Plan. The Nutrition and Food Security Association (ANSA) was elected as the focal point for this group. Both these groups will be integrated into the broader multi-sectoral working group ("GT-PAMRDC") that will include development partners.

In addition, with the objective to mobilise funds, a technical working group on nutrition comprising senior level Ministry of Health officials and their direct cooperation partners, is developing an operational plan for interventions in the Health Sector over a three year period. So far, one province has drafted its own Nutrition Action Plan based on the national Multi-sectoral Nutrition Action Plan. Other provinces are expected to develop similar plans in the near future.

e) Engagement of non-governmental agencies

Since the approval of the Nutrition Action Plan, several meetings have been held for the preparation of its implementation, between the Government led by the Ministry of Health and SETSAN, and the main development partners involved to develop the operational plan and to define the coordination and financing mechanisms of the plan among sectors. At this moment, a draft operational plan and the terms of reference for the multi-sectoral working group ("GT-PAMRDC") for the coordination of the plan are being finalised.

f) Next steps

Donors and development partners have been closely involved in the drafting of the Multi-Sectoral Nutrition Action Plan and the costing of the plan. While the current donors and partners (including non-governmental organisations like Helen Keller International, PSI, Save the Children, FANTA-2 and national non-governmental organisations like ANSA and IBFAN Mozambique, the UN agencies and bilaterals like USAID), will remain closely involved in supporting the implementation of the Plan, several additional donors (including the European Union, DANIDA and the World Bank) have shown an interest in supporting the implementation of the Plan and are finalising their plans for support. In addition, several other large donors (Canada for example) support interventions related to maternal and child health which also include large elements of the Plan. REACH, the UN interagency initiative to end child hunger is going to establish a presence in Mozambique in the course of 2011 to support the coordination and implementation of the Plan.

g) *Scaling up financial commitments*

The costing of the Nutrition Action Plan was done using World Bank methodologies. After taking into account planned contributions, it is estimated that a total additional amount of 5,165.8 million Meticais will be required (US$ 143 million). In addition, the Ministry of Health in collaboration with the World Bank estimated the annual cost of delivering priority nutrition interventions through the health sector in Mozambique at US$ 60 million per year.

Basic indicators

Indicator	Value
Total population	22,894,000
Population below $1 (PPP) per day, percentage (2004)	60
Life expectancy at birth m/f (years)	47/51
Total expenditure on health per capita (Intl $)	50
Adult literacy rate 2005-08 m/f (per cent)	70/40

Figures are for 2009 unless indicated.

Core nutrition indicators

Indicator	Value
Stunting (height-for-age < –2 SD of WHO standards)	44per cent (2008)
Wasting (weight-for-height < –2 SD of WHO standards	4per cent (2008)
Birth weight (< 2500 grams)	15per cent (2008)
Adult thinness (Body-Mass Index <18.5)	9per cent (2003)
Anaemia in children 6-59 months (Hb < 11 g/dL)	74.7per cent (2001-02)
Anaemia in pregnant women (Hb < 11 g/dL)	NA
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	83per cent (2008)
Iodine supplements (households consuming iodized salt)	25per cent (2008)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	37per cent (2008)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	9per cent (2003)
International Code of Marketing of Breast-milk Substitutes (adopted)	Partially
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	47per cent (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	99, 93, 96
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	144, 140, 142
Maternal mortality rate (annual number of female deaths per 100,000 live births)	550 (310-870)
Nutrition governance score	Weak

NA= Not Available

Nepal

Country context

Nepal is a country of approximately 30 million people. With a Gross Domestic Product (GDP) per capita of $470, Nepal is the 13th poorest country in the world and the poorest country in South Asia. Approximately 55 per cent of Nepalese live below the international poverty line of $1.25 per day. Severe and partial food deficit is found in 49 out of 75 districts in Nepal (Nutrition Assessment and Gap Analysis 2009) and 23 districts suffer from chronic food insecurity. Nepal has one of the highest stunting rates in the world, at a cost to the economy of at least 2-3 per cent of GDP annually, in addition to lives lost. Recent declining agricultural production has depressed rural economies and increased widespread hunger and urban migration in Nepal. This situation is compounded by a population growth rate of over 2 per cent per year and one of the highest ratios of population to arable land in the world.

In recent years, Nepal has made considerable progress in reducing child and maternal mortality. Similarly, significant progress has been seen in reducing micronutrient deficiency over the past decade, and Nepal is one of the very few countries in the world that is on track to meet the micronutrient related goals for the World Fit for Children. Sustained and consistent semi-annual vitamin A supplementation to preschoolers covers more than 90 per cent of children and vitamin A deficiency is no longer a public health problem. Similarly, the household consumption of adequately iodized salt has risen to almost 80 per cent in 2011 (preliminary findings from the National Demographic and Health Survey for Nepal 2011).

Yet, there is a huge and widening disparity in the prevalence of under-nutrition across socio-economic groups. Prevalence of stunting among children aged 6-59 months from household in the poorest quintile was double (62 per cent) that in the wealthiest quintile (31 per cent) (National Demographic and Health Survey for Nepal 2006). In households in the poorest quintile, more than half of children below five years (54 per cent) were under-weight. Stunting is almost double in Mid Western Mountains (67 per cent) as compared to Eastern Plain Area (37 per cent). Meanwhile, poor dietary habits of consuming instant high calorie junk foods, lack of physical activity and unplanned rapid urbanization, are on the rise, leading to an increasing prevalence of obesity and associated nutrition related non-communicable disease. Nepal is now facing a double burden of under-nutrition and obesity.

Government response

a) Overall vision for scaling up nutrition

Currently, the Ministry of Health and Population (MoHP), in cooperation with other Ministries, is designing programmes to address nutritional issues. The Nepal Health Sector Programme-II (NHSP-II) also recognizes the need for a more comprehensive response to under-nutrition in women and children. As part of a broader multi-sectoral approach, the partners to NHSP-II have agreed to support the Government of Nepal in its efforts to improve its response to nutrition challenges. This response includes a combination of scaling-up nutrition interventions and studies/pilots to test innovative approaches. Currently, several interventions relevant to SUN recommended interventions are on-going in Nepal.

b) Commitment to scaling up nutrition

In 2009, the Government of Nepal carried out the Nutrition Assessment and Gap Analysis (NAGA). Establishing multi-sectoral architecture and multi-sectoral nutrition action plans, improving human recourse capacity, improving food security and food and care related behaviours are its major recommendations.

Since 2010, the government has worked to respond to the Nutrition Assessment and Gap Analysis (NAGA) recommendations. The National Planning Commission re-constituted the National Nutrition Steering Committee and identified Nutrition Focal Officers (NFOs) within health and non-health sectors that would be responsible for implementing nutrition-related activities. In 2010, the National Health Sector Plan-II (2010-2015) (NHSP) indicated a special priority for nutrition, and highlighted a range of nutrition related services including promotion of locally available food; Maternal, Infant and Young Child Nutrition with growth monitoring promotion; multiple micronutrients and fortified food supplementation; and, behaviour change interventions to improve child survival and development.

In 2011, a review was undertaken of the nutrition components of the NHSP-II, based on global evidence for 'what works' in maternal and child nutrition, Nepali experience with "effective interventions" in the context of the causes of under-nutrition in Nepal. The review concluded that essential nutrition interventions should be (i) maintained/strengthened, (ii) expanded or scaled up, and (iii) piloted and evaluated further. Since May 2011, development of a multi-sectoral nutrition plan for reducing chronic under-nutrition is on-going and will be started in few areas. This will also help to identify evidence based nutrition sensitive interventions in each sectors: agriculture, education, water, sanitation and hygiene, and local development, in addition to the health sector, with a focus on reducing stunting and targeting the 'critical window period of pregnancy to 24 months'

c) National nutrition plans

Nepal has dedicated policy and strategic initiatives to addressing under-nutrition in Nepal for several years. The Nutrition Policy and Strategy was formulated and approved in 2004. In 2006, realizing that the MDG1 would not be met unless a special effort has been made, the National Planning Commission (NPC) constituted a Technical Working Group which resulted in the drafting of the 2007 National Plan of Action on Nutrition. The major programmes and strategic approaches to address nutrition related problems in Nepal are:

- Control of Protein Energy Malnutrition
- Control of Iodine Deficiency Disorders
- Control of Vitamin a Deficiency Disorders
- Control of Iron Deficiency Anaemia
- Improve Maternal Nutrition with low birth weight
- Protection and Promotion of Infant and Young Child Feeding
- Control of Parasitic Infestation by Deworming

d) Multi-stakeholder platforms

National Planning Commission as the "National Nutrition Architect"

The National Planning Commission (NPC) has initiated and consolidated separate sectoral reviews to feed into an evidence based package of national multi-sectoral nutrition plans (MSNP) that aims to reduce stunting and low birth weight through focusing on the 'critical window of opportunity- the first 1000 days'.

The Ministry of Health and Population will concentrate its efforts on delivering nutrition specific interventions aimed at improving the nutritional status of mothers, infants and young children. The Ministry of Education will aim to improve the education, life skills and nutritional status of adolescents. The Ministry of Physical Planning and Works will aim to reduce episodes of diarrhoea among mothers, infants and young children through improved water supply and sanitation facilities. The Ministry of Agriculture and Cooperatives will aim to improve access and availability to nutrition enriched agricultural products and animal foods among mothers and young children in the poorer segments of society. The Ministry of Local Development will aim to increasingly mobilize local resources, and improve local coordination between sectors, as well as to direct social protection measures towards accelerating stunting reduction.

The overall coordination of the multi-sectoral plan at the national level lies with the National Planning Commission, under the stewardship of the National Nutrition Steering Committee and National Food and Nutrition Security Steering Committee. A Food and Nutrition Security Steering Committee to oversee the implementation of the plan at the National and District level was recently approved. The plan will be implemented in 10-12 districts initially and gradual scaled up to cover all the 75 districts within 3-4 years. In each district at least half of the villages will be covered, and these will be the most disadvantaged villages.

Nutrition through Ministry of Agriculture and Cooperatives

The Ministry of Agriculture and Co-operatives (MoAC) is engaged in nutrition promotion through interventions targeted at increasing food production and enhancing food safety. The Government of Nepal has a long-term vision outlined in the Agriculture Perspective Plan and National Agriculture Policy. MoAC has launched programmes on agronomy, horticulture, pisciculture, animal husbandry, poultry and apiculture. Recent activities include nutrition training for kitchen garden, information/education activities, agriculture extension services, integrated pest management, promotion of organic farming, development of low cost nutritious foods etc. The Department of Food Technology and Quality Control under MoAC has three major programme areas - Food Safety and Quality Control; research and development activities (including analysis of food and food ingredients); and development of food composition tables (including food and nutritional surveys, research on nutrient composition of Nepali foods, publication of updated food composition tables and related information, education and communication materials).

Nutrition through Ministry of Education

The Ministry of Education (MoE) with the Ministry of Health has jointly developed School Health and Nutrition Strategy with an objective to improve use of School Health and Nutrition services at schools; to improve healthful school environment. School hygiene and sanitation, mass deworming, iron-folate distribution, nutritional assessment of children at school, and nutrition friendly school policy and environments are the major interventions suggested.

Nutrition through Ministry of Local Development

The Ministry of Local Development (MoLD) encompasses decentralized local governance, social protection and local development activities and hence is one of the important sectors for nutrition sensitive interventions. District Development Committees that fall under this Ministry are the key authorities coordinating sector activity at district levels. MoLD oversees a range of nutrition actions that have the objective of improving child nutrition. These interventions include the child protection grant for families living in poverty or in remote areas; a public works programme implemented in 21 chronically food insecure districts that distributes food baskets and multi-micronutrient powders;

decentralized action for children and women programme that is implemented in 23 districts; a framework for child friendly local governance that reflects child and maternal nutrition in district level planning and resource allocation; a health and nutrition pilot currently underway in three to four districts to target nutrition in the first 1000 days of life; and contribution of local bodies (e.g., District Development Commitees, Municipalities, and Village Development Committees), which is a directive from the Government of Nepal to local bodies for women and children nutrition.

e) Stock-taking and gap analysis

A comprehensive review of health sector interventions to accelerate the progress towards reducing maternal and child under nutrition in Nepal was recently conducted and there is consensus amongst all partners on the interventions that need to be "Maintained and Sustained", "Scaled-up and Expansion", or those that need "Further Evaluation."

f) Next steps

Anticipated major areas for future support and action are:

1. Strengthen institutional capacity through human resources development in relevant sectors
2. Obtain financial and technical resources to scale-up nutrition-specific and nutrition- sensitive interventions
3. Develop integrated household-level data generation and analysis system on food and nutrition and surveillance
4. Implement the multi-sectoral nutrition plan of action.

g) Scaling up financial commitments

Significant resources have been mobilized for Technical Assistance from various sources (AusAID, DfID and EU, among others) for the Food and Nutrition Security agenda, including for studies and analyses to strengthen the evidence base. Also, the World Bank has reserved additional funding for nutrition through the First Thousand Days Project ($ 30 million).

Nepal basic indicators

Total population	29,331,000
Population below $1 (PPP) per day, percentage (2004)	55.1
Life expectancy at birth m/f (years)	65/69
Total expenditure on health per capita (Intl $)	69
Adult literacy rate 2005-08 m/f (%)	71/45

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	49% (2006)
Wasting (weight-for-height < –2 SD of WHO standards	13% (2006)
Birth weight (< 2500 grams)	21% (2006)
Adult thinness (Body-Mass Index <18.5)	24% (2006)
Anaemia in children 6-59 months (Hb < 11 g/dL)	48% (2006)
Anaemia in pregnant women (Hb < 11 g/dL)	42% (2006)
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	93% (2008)
Iodine supplements (households consuming iodized salt)	63% (2000)
Zinc supplements & oral rehydration (children 0-59 months with diarrhoea)	41% any ORT - 0.4% zinc (2006)
Exclusive breastfeeding (infants 0–5 months)	53% (2006)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	29% (2006)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	0.63 (2004)
Access to water (improved drinking-water sources)	88% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	38, 39, 39
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	49, 48, 48
Maternal mortality rate (annual number of female deaths per 100,000 live births)	380 (210-650)
Nutrition governance score	Medium

NA= not available.

Niger

Country context

Niger is a landlocked country in the Sahel with a population of around 15 million. Progress in reducing poverty and hunger has been relatively slow with a decline in the poverty rate from 63 per cent in 1998 to 60 per cent in 2008. Niger consistently has one of the lowest ranks of the United Nations Human Development Index, currently 167th of 169 countries.

The population is concentrated in a narrow band of arable land along the southern border and are involved in subsistence farming and traditional livestock raising. This is insufficient to meet the food needs of the population. The country experiences chronic food insecurity and frequent natural disasters including droughts, floods and locust invasions, when under-nutrition rates spiral. Periodic household surveys estimate that the prevalence of under-nutrition is high. Stunting affects over half of all children under five years of age while over 80 per cent are anaemic. Low birth weight and adult under-nutrition are significant problems and iodine deficiency persists among the general population.

Government response

a) Overall vision for scaling up nutrition

The overall vision of the Government of Niger is to ensure that the population, in particular the vulnerable population, has a nutritional status compatible with a healthy and productive life and to contribute optimally to reduce morbidity and infant and maternal mortality.
The following specific objectives and targets have been set for 2021:

1. Reduction by at least 30 per cent of acute malnutrition (wasting) in children under five;
2. Reduction by at least 30 per cent of chronic malnutrition (stunting) in children under five;
3. Reduction by at least 30 per cent of the rate of low birth weight;
4. Reduction by one third of the prevalence of anaemia among children under five and pregnant and lactating women;
5. Elimination of vitamin A deficiency, including night blindness among children under five and women post partum;
6. Elimination of iodine deficiency through Universal Salt Iodisation;
7. Expansion of the use of zinc in the prevention and treatment of diarrhoea in children under five in all health facilities;
8. Increase from 26.9 to 75 per cent in exclusive breastfeeding among children under six months;
9. Increase from 52 to 95 per cent in the proportion of mothers introducing complementary foods from six months as recommended by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF);
10. Ensure adequate nutritional care of 100 per cent of people living with HIV and tuberculosis.

b) Commitment to scaling up nutrition

Niger is committed to scaling up nutrition and signalled its intention to join the SUN Movement in February 2011. Since then, the European Union has been nominated as the SUN donor convenor and nutrition focal points have been identified in the regions and departments responsible for multi-stakeholder coordination. Furthermore, a budget line for nutrition in the State budget for the year 2012, has been included and approved.

In March 2011, an international symposium was held with the backing of the President, on food and nutrition security in Niger (Sécurité Alimentaire et Nutritionnelle au Niger - SISAN).

Major commitments / recommendations that came out of this meeting are as follows:

- Address nutrition, which is recognized as a national priority, using a multi-sectoral approach;
- Strengthen the political, legal, strategic and programmatic framework for nutrition;
- Strengthen the institutional capacities for nutrition at all levels, including human resources for nutrition (central, regional and district level);
- Ensure adequate and predictable resources for nutrition (internal and external funding);
- Scale up interventions to reduce incidence of new cases of all forms of malnutrition;
- Leverage opportunities provided by initiatives such as SUN and REACH to accelerate progress toward achieving nutrition security for all in Niger.

c) National nutrition plans

A national nutrition strategic plan for 2011-2015 has been drafted and a multi-sectoral committee was recently convened to review and amend it. The document is currently being finalized and sets specific objectives and targets for 2021 that are set out in section a) above.

A nutrition monitoring and evaluation plan has been developed, which falls within the general framework for monitoring and evaluating in the health development plan 2010-2015 under the Ministry of Public Health. A communications plan is in the process of being developed with support from UNICEF.

d) Multi-stakeholder platforms

The Government of Niger has revitalized an inter-ministerial committee of nutrition within the Prime Minister's office which is composed of members from the Office of the President, the Prime Minister's Office, the Ministry of Health, Ministry of Agriculture, Ministry of Livestock, Ministry for Water and the Environment, Ministry for Population, Promotion of Women and Child Protection, Ministry of Higher Education and Scientific Research, Ministry of Education and Literacy, Ministry of Communication and New Information Technologies.

A multi-stakeholder platform that brings together all stakeholders in nutrition (Government Ministries, the United Nations system, non-governmental organisations, civil society, business and religious bodies) is being set up. Leadership is provided by the Nutrition Division within the Ministry of Health with support from UNICEF. Civil society has initiated a process to set up its own platform. Statutory documents for this platform are being developed.

e) Stock-taking and gap analysis

Stock-taking and gap analysis of nutrition programmes and institutions, and of the costs necessary to provide quality services for prevention and treatment of under-nutrition in Niger is underway.

f) Engagement of non-governmental agencies

There is a vibrant civil society in Niger, making significant contributions to nutrition interventions. Niger has one of most extended management of acute malnutrition system in West Africa Region with more than 800 centres for treatment of severe acute malnutrition and about 1,000 treatment sites for moderate acute malnutrition. Contribution of the civil society includes identification and referral of cases of acute malnutrition, bringing technical know-how to improve quality of care, promote adequate nutrition practices at grassroots level, mobilize resources for nutrition and contribute to raising awareness and advocating for nutrition as a national priority.

g) Next steps
Strategies and plans to address gaps in nutrition in Niger's are underway. Large scale implementation will start soon and persisting gaps shall be identified and corrected in the coming year. Once policy and strategy documents are finalised, the required structures will be put in place and advocacy activities implemented. A conference for donors will be organized by the end of this year, as this was one of the recommendations of the International Symposium on Food and Nutrition Security (SISAN - March 2011).

h) Scaling up financial commitments
To strengthen the financial commitments in Niger, several mechanisms have been set up in the Ministry of Public Health such as a monthly meetings between Ministry staff and technical and financial partners; signing of an agreement between the Ministry and donors; and the opening of a donor pool to reflect the priorities of the country and the different procedures of each donor. About USD 1 million (500 million FCFA) is secured for nutrition within the Ministry of Health Budget for 2012.

Case Study

Niger is currently working on a new strategic plan for nutrition which is based on a multi-sectoral approach to bring a holistic solution to various forms of malnutrition in the country. A clear share of planned interventions is based on the Public Private Partnership (PPP). To reduce the incidence of malnutrition and to treat cases of acute malnutrition at an early stage, there is a community based approach in which government, UN agencies, NGO and community based organisation are involved. The approach includes promotion of adequate nutrition practices, screening young children for acute malnutrition, treating cases of moderate acute malnutrition using a community based approach and cases of severe acute malnutrition using an integrated model in which cases without medical complication are handled as outpatient and cases with oedema and/or other medical conditions are treated as inpatient. This approach has resulted in a high proportion of cases of severe acute malnutrition being treated (86% in 2010), greater adoption of adequate nutrition practices (exclusive breast feeding in the first 6 months improved from 9% to 27% between 2009 and 2010) and high coverage for supplementation of vitamin A (95% in 2010) was achieved. This model needs to be documented, costed and scaled up.

Niger basic indicators

Indicator	Value
Total population	15,290,000
Population below $1 (PPP) per day, percentage (2004)	43.1
Life expectancy at birth m/f (years)	57/58
Total expenditure on health per capita (Intl $)	40
Adult literacy rate 2005-08 m/f (%)	43/15

Figures are for 2009 unless indicated.

Core nutrition indicators

Indicator	Value
Stunting (height-for-age < –2 SD of WHO standards)	55% (2006)
Wasting (weight-for-height < –2 SD of WHO standards	12% (2006)
Birth weight (< 2500 grams)	27% (2006)
Adult thinness (Body-Mass Index <18.5)	19% (2006)
Anaemia in children 6-59 months (Hb < 11 g/dL)	84% (2006)
Anaemia in pregnant women (Hb < 11 g/dL)	61% (2006)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	92% (2008)
Iodine supplements (households consuming iodized salt)	46% (2006)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	10% (2009)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	3% (2006)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	48% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	78, 73, 76
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	163, 158, 160
Maternal mortality rate (annual number of female deaths per 100,000 live births)	820 (470-1400)
Nutrition governance score	Medium

NA= Not Available

Niger (version française)

Situation du pays

Le Niger est un pays enclavé dans le Sahel avec une population estimée à environ 15 millions d'habitants. Les progrès en matière de réduction de la pauvreté et de la faim sont relativement lents avec une baisse du taux de pauvreté de 63 % en 1998 à 60 % en 2008. Le Niger a toujours eu l'un des plus faibles indicateurs de développement humain des Nations Unies et il se classe actuellement à la 167e position parmi les 169 pays.

La population se concentre dans une bande étroite de terres arables le long de la frontière sud du pays, où l'on pratique l'agriculture de subsistance et l'élevage de bétail traditionnel. Ces activités ne suffisent toutefois pas à couvrir les besoins alimentaires de la population. Le pays, qui souffre d'insécurité alimentaire chronique, est aussi régulièrement frappé par des catastrophes naturelles (périodes de sécheresse et d'inondations, invasion de criquets pèlerins), et se retrouve pris dans la spirale de la dénutrition. Les enquêtes périodiques réalisées auprès des ménages indiquent une forte prévalence de la sous-nutrition. Plus de la moitié des enfants âgés de moins de cinq ans présentent un retard de croissance tandis que plus de 80 % sont anémiés. L'insuffisance pondérale à la naissance et la sous-nutrition chez l'adulte constituent des problèmes majeurs et la carence en iode continue de toucher l'ensemble de la population.

Actions du gouvernement

a) Vision globale pour le renforcement de la nutrition

La vision globale du gouvernement du Niger consiste à s'assurer que la situation nutritionnelle de la population, en particulier la population vulnérable, s'accorde avec une vie saine et productive, et à contribuer de manière optimale à réduire la morbidité ainsi que la mortalité infantile et maternelle. Les objectifs et cibles spécifiques indiqués ci-dessous ont été définis pour 2021 :

1. Réduction d'au moins 30 % des cas de malnutrition aiguë (émaciation) chez les enfants âgés de moins de 5 ans ;
2. Réduction d'au moins 30 % des cas de malnutrition chronique (retard de croissance) chez les enfants âgés de moins de 5 ans ;
3. Réduction d'au moins 30 % du taux d'insuffisance pondérale à la naissance ;
4. Réduction d'un tiers de la prévalence d'anémie chez les enfants de moins de 5 ans et chez les femmes enceintes et allaitant ;
5. Élimination de la carence en vitamine A, y compris la cécité nocturne chez les enfants de moins de cinq ans et chez les femmes venant d'accoucher ;
6. Suppression de la carence en iode grâce à l'iodation universelle du sel ;
7. Utilisation accrue du zinc pour prévenir et traiter la diarrhée chez les enfants de moins de cinq dans tous les établissements de santé ;
8. Augmentation de 26,9 à 75 % de l'allaitement exclusif pour les nourrissons de moins de six mois ;
9. Augmentation de 52 à 95 % de la proportion des mères à introduire des aliments complémentaires à partir de six mois comme recommandé par l'Organisation Mondiale de la Santé (OMS) et le Fonds des Nations Unies pour l'enfance (UNICEF) ;
10. Assurer un soutien nutritionnel à l'ensemble des personnes atteintes du VIH et de la tuberculose.

b) Engagement pour le renforcement de la nutrition

Le Niger s'engage à augmenter ses interventions nutritionnelles et a signalé en février 2011 son intention de rejoindre le mouvement SUN (Scaling Up Nutrition = Renforcer la nutrition). Depuis lors, l'Union Européenne a été nommée responsable des donateurs du SUN, et les principaux points en matière de nutrition ont été identifiés dans les régions et départements chargés de la coordination entre les diverses parties intéressées. En outre, une ligne budgétaire pour la nutrition a été incluse au budget de l'État pour l'année 2012 et approuvée. En mars 2011, un Symposium International sur la Sécurité Alimentaire et Nutritionnelle au Niger (SISAN) a été tenu avec l'appui du Président.

Cette réunion a débouché sur les recommandations et engagements majeurs suivants :

- Traiter la question de la nutrition, qui est reconnue comme une priorité nationale, en adoptant une approche multisectorielle ;
- Renforcer les lois, les politiques, les stratégies et les programmes pour la nutrition ;
- Consolider les capacités institutionnelles pour la nutrition à tous les niveaux, y compris les ressources humaines (au niveau central, régional et des districts) ;
- Garantir des ressources appropriées et prévisibles pour la nutrition (financement interne et externe) ;
- Multiplier les interventions visant à réduire l'incidence des nouveaux cas de malnutrition, indépendamment de la forme sous laquelle ils se manifestent ;
- Saisir les opportunités offertes par des initiatives telles que SUN et REACH afin d'atteindre plus rapidement l'objectif de la sécurité nutritionnelle pour tous au Niger.

c) Plans nationaux de nutrition

Un plan stratégique national de nutrition pour 2011-2015 a été rédigé ; un comité plurisectoriel s'est récemment réuni afin de l'étudier et de l'amender. Le document, en cours de finalisation, définit les objectifs et cibles spécifiques pour 2021 qui sont mentionnés à la section a) ci-dessus.

Un plan de surveillance et d'évaluation de la nutrition a été développé dans le cadre général de la surveillance et de l'évaluation du plan de développement sanitaire 2010-2015 sous l'égide du Ministère de la Santé publique. Un plan de communication est actuellement mis au point avec le soutien de l'UNICEF.

d) Plateformes multipartites

Le gouvernement du Niger a mis sur pied un comité interministériel de la nutrition au sein du cabinet du premier ministre : il se compose de membres du cabinet du président, du cabinet du premier ministre, du ministère de la Santé, du ministère de l'Agriculture, du ministère de l'Élevage, du ministère de l'Environnement et de l'Eau, du ministère de la Population, de la Promotion de la Protection des Femmes et des Enfants, du ministère de l'Enseignement Supérieur et de la Recherche Scientifique, du ministère de l'Enseignement et de l'Alphabétisation, du ministère de la Communication et des Nouvelles technologies de l'Information.

Une plateforme regroupant l'ensemble des parties intéressées par la question de la nutrition (ministères gouvernementaux, Système des Nations Unies, organisations non gouvernementales, société civile, organismes commerciaux et religieux) est en construction. Soutenue par l'UNICEF, la division Nutrition du ministère de la Santé sera à la tête de cette plateforme. La société civile a initié un processus afin de créer sa propre plateforme. Les documents légaux pour cette plateforme sont en cours d'élaboration.

e) Analyse des écarts et bilan

Un inventaire et une analyse des lacunes des institutions et des programmes pour la nutrition, ainsi que des coûts nécessaires à la prestation de services de qualité pour la prévention et le traitement de la sous-nutrition au Niger sont en cours.

f) Engagement d'organisations non gouvernementales

La société civile nigérienne est particulièrement dynamique et participe activement aux interventions en faveur de la nutrition. Le Niger bénéficie de l'une des gestions les plus développées du système de traitement de la malnutrition aiguë en Afrique de l'Ouest avec plus de 800 centres de traitement de la malnutrition aiguë sévère et près de 1 000 sites de traitement de la malnutrition aiguë modérée. La contribution de la société civile inclut l'identification et l'aiguillage des cas de malnutrition aiguë et fournit les connaissances techniques requises afin d'améliorer la qualité des soins, de promouvoir les pratiques nutritionnelles adéquates à la base, de mobiliser les ressources pour la nutrition et de contribuer à améliorer la prise de conscience et la défense de la question de la nutrition en tant que priorité nationale.

g) Prochaines étapes

Des stratégies et des plans destinés à combler les lacunes en matière de nutrition au Niger sont en cours d'élaboration. Une mise en œuvre à grande échelle débutera prochainement et les lacunes persistantes seront identifiées et comblées l'année prochaine. Après finalisation des documents liés à la politique et à la stratégie, les structures requises seront créées et les activités de défense seront mises en œuvre. Conformément aux recommandations du Symposium International sur la Sécurité Alimentaire et Nutritionnelle (SISAN – mars 2011), une conférence pour les donateurs aura lieu d'ici la fin de l'année.

h) Renforcement des engagements financiers

Afin de renforcer les engagements financiers au Niger, plusieurs mécanismes ont été mis sur pied au sein du ministère de la Santé publique, comme des réunions mensuelles entre le personnel ministériel et les partenaires techniques et financiers, la signature d'un accord entre le ministère et les donateurs, et l'ouverture d'une communauté de donateurs visant à refléter les priorités du pays et les différentes procédures de chaque donateur. Près de 1 million d'USD (500 millions de FCFA) du budget du ministère de la Santé pour 2012 sera consacré à la nutrition.

Étude de cas

Le Niger travaille actuellement à l'élaboration d'un nouveau plan stratégique pour la nutrition reposant sur une approche multisectorielle, ce afin d'apporter une solution holistique à diverses formes de malnutrition dans le pays. Une répartition claire des interventions prévues est basée sur le Partenariat Public-Privé (PPP).
Afin de réduire l'incidence de la malnutrition et de traiter les cas de malnutrition aiguë à un stade précoce, il existe une approche basée sur la communauté et dans laquelle le gouvernement, les agences des Nations Unies, les ONG et les organisations communautaires sont impliquées. L'approche comprend la promotion des pratiques nutritionnelles adéquates, le dépistage de la malnutrition aiguë auprès des jeunes enfants, le traitement des cas de malnutrition aiguë modérée par le biais d'une approche basée sur la communauté et le traitement des cas de malnutrition aiguë sévère à l'aide d'un modèle intégré selon lequel les cas sans complication médicale sont traités en externe et les cas avec un œdème et/ou autres affections médicales sont traités en interne. Cette approche a débouché sur le traitement d'un large pourcentage de cas de malnutrition aiguë sévère (86 % en 2010), une adoption accrue des pratiques nutritionnelles adéquates (augmentation de l'allaitement exclusif au cours des 6 premiers mois avec une évolution de 9 % à 27 % entre 2009 et 2010) et une large couverture de supplémentation en vitamine A (95 % en 2010) a été atteinte. Ce modèle doit être documenté, chiffré et développé.

Niger indicateurs de base

Population totale	15 290 000
Population vivant avec moins d'1 dollar par jour (PPA), pourcentage (2004)	43,1
Espérance de vie à la naissance h/f (années)	57/58
Dépenses totales consacrées à la santé par habitant ($ int.)	40
Taux d'alphabétisation des adultes 2005-08 h/f (%)	43/15

Chiffres donnés pour 2009 sauf mention contraire.

Indicateurs nutritionnels clés

Retard de croissance (rapport taille/âge < -2 ET selon les normes OMS)	55 % (2006)
Émaciation (rapport poids/âge < -2 ET selon les normes OMS)	12 % (2006)
Poids à la naissance (< 2 500 grammes)	27 % (2006)
Maigreur adulte (indice de masse corporelle < 18,5 chez les femmes en âge de procréer)	19 % (2006)
Anémie chez les enfants de 6 à 59 mois (Hb< 11 g/dL)	84 % (2006)
Anémie chez les femmes enceintes (Hb< 11 g/dL)	61 % (2006)
Supplémentation en fer et en acide folique (administrée quotidiennement aux femmes enceintes ≥ 6 mois)	N.D.
Supplémentation en vitamine A (enfants de 6 à 59 mois ayant reçu 2 doses élevées l'an dernier)	92 % (2008)
Supplémentation en iode (ménages consommant du sel iodé)	46 % (2006)
Supplémentation en zinc et thérapie par réhydratation orale (enfants de 0 à 59 mois souffrant de diarrhées)	N.D.
Allaitement exclusif (nourrissons de 0 à 5 mois)	10 % (2009)
Alimentation complémentaire (enfants allaités de 6 - 23 mois avec une alimentation minimum acceptable)	3 % (2006)
Code international de commercialisation des substituts de lait maternel (adopté)	Oui
Accès aux soins de santé (soignants et agents communautaires / 1 000 habitants)	N.D.
Accès à l'eau (meilleures sources d'eau potable)	48 % (2008)
Sécurité alimentaire (résultat relatif à la consommation alimentaire des enfants de 6 à 59 mois)	N.D.
Taux de mortalité infantile (décès avant 1 an pour 1 000 naissances vivantes - h, f, les deux sexes)	78, 73, 76
Taux de mortalité des moins de 5 ans (décès avant 5 ans pour 1 000 naissances vivantes - h, f, les deux sexes)	163, 158, 160
Taux de mortalité maternelle (nombre annuel de décès de femmes pour 100 000 naissances vivantes)	820 (470-1400)
Résultat relatif à la gouvernance nutrition	Moyen

N.D. = Non Disponible

Peru

Country Context

Peru is experiencing a period of sustained growth and falling fiscal deficits as well as a clear improvement in indicators of poverty and under-nutrition among children. The rate of chronic child under-nutrition has fallen from 24.5 per cent in 2006 to 16.5 per cent in 2011. However, anaemia persists among 60-75 per cent of children under 18 months though has reduced from 31.6 per cent to 21 per cent among women of childbearing age between 2000 and 2009 (Instituto Nacional de Estadística e Informática, INEI- ENDES 2009). At the same time, the situation regarding under-nutrition at a sub-national level reveals a wide disparity in rates with some parts of the country still experiencing child under-nutrition as high as 44 per cent while in other areas the rate is 2.4 per cent. On the other hand, the level of food insecurity, which is estimated on the basis of a percentage of the households with a caloric deficit, is around 42 per cent in rural areas and 16.4 per cent in urban areas (E. Zegarra and J. Tuesta 2009. Documento de Trabajo 55. Shock de precios y vulnerabilidad alimentaria de los hogares peruanos GRADE – FAO. Lima, Perú [Working Document 55: Price shock and food vulnerability of Peruvian households].

Government Response

a) Overall vision for scaling up nutrition

The Government has set goals of reducing chronic under-nutrition to 9.5 per cent by 2016 and lowering the infant mortality rate from 18 to 12 per 1000 live births.

Since 2006 there has been a strong political commitment on the part of the President and Ministers to tackle chronic child under-nutrition. Given that one of the major consequences of poverty is chronic child under-nutrition, it has promoted inter-institutional and sector-based co-ordination to implement measures aimed at tackling child under-nutrition, particularly in relation to assistance strategies for distributing food. This, however, has not taken into account the various other aspects such as health awareness, education for mothers and access to basic services as documented by IFPRI ([1] Smith L. and Haddad L. 2000. Overcoming Child Malnutrition in Developing Countries: Past Achievements and Future Choices. Discussion Paper 30. International Food Policy Research Institute. Washington, DC, February).

b) Commitment to scaling up nutrition

In 2007 the government approved a national strategy entitled *CRECER*, which co-ordinates all of the programmes working for children in accordance with Supreme Decree Nº 055 – PCM by the President of the Council of Ministers. This strategy, whose name in Spanish means “grow”, sets out various activities by Government agencies on a national, regional and local level as well as by private organisations, international co-operation and society in general for the purpose of creating an integrated and synergistic approach to reducing poverty and chronic child under-nutrition.

This strategy appears to confirm the low levels of efficiency among social programmes aimed at reducing chronic child under-nutrition despite the strong investment by the State in recent years. It is recognised that chronic under-nutrition is a multisectoral problem and caused by a number of factors and that it requires processes developed in participation with all of the social partners involved, including the beneficiaries themselves, the authorities, public bodies and international technical co-operation agencies. In 2007 a public sector budget law was approved (Ley 28927-*Ley del Presupuesto del*

Sector Público) with the aim of ensuring that the budgeting process promoted and developed results-based management, establishing the Nutrition Strategic Programme in 2008. This programme emerged as a way of reducing chronic undernutrition by means of strategic interventions[3] in line with and under the control of various organisations based on integrated planning and budgeting.

Drawing on scientific evidence published in a special series of *The* Lancet, the Nutrition Strategic Plan prioritises interventions during two key stages of life: during pregnancy and in the time from birth to 36 months. The Plan includes a prioritised list of guaranteed health interventions for reducing chronic undernutrition and promoting perinatal maternal health (DS 003-2008-SA) with comprehensive care for pregnant women, newborns and children among others. The Plan provides an optimum combination of interventions aimed at reducing infant undernutrition for citizens. This approach introduces the concepts of *results* and *product* into the public planning and budgeting process where the budget chain is the same for all organisations associated with this nutrition programme at a national, regional or local level. By 2010-2011 there was an increase in the public budget of some 52 per cent aimed at reducing chronic undernutrition and 25 per cent for the care of pregnant women.

Budget (million sol - S/.)			
Strategic programmes	2009	2010	Variation
01 Articulated Nutrition	1052	1594	52%
02 Maternal-Neonatal Health	359	447	25%

Source: L. Cordero MEF 2011

With regard to interventions aimed at reducing chronic undernutrition, the public budget increased significantly in two effective interventions: monitoring of growth and development, and vaccines.

Intervention (Product)	**2009**	**2010**	**Variation**
33254 children with full vaccinations for age	165m	420m	+254%
Introduction of new vaccinations to prevent acute respiratory infections and diarrhoea in infants under 24 months			
33255 children with CRED complete protection	20m	86m	+432%
Substantially increase the monitoring and development of children to promote the three key practices of care and feeding for children under 36 months, exclusive breastfeeding and appropriate food for children.			

Source: L. Cordero MEF 2011

c) National nutrition plans

Although the country does not have a national nutrition plan, the CRECER strategy promoted by the Presidency of the Council of Ministers sets out interventions from the different sectors and levels of government. Moreover, the Ministry of Finance continues to focus on the "budgeting for results" strategy and includes principle goals of reducing chronic undernutrition within the lifetime of the government which came into being in July 2011. There also exists at national government level a commitment with a series of guidelines for regular budgetary support by means of the Nutrition Strategic Plan on the basis of scientific evidence for the design of the programme's strategy and interventions.

[3] The other four are: Maternal-Neonatal Health Programme, Learning Programme at the End of Cycle III, Programme for Public Access to Identity and the Social Service and Market Opportunities Access Programme

d) Multi-stakeholder platforms

From a public sector perspective the Nutrition Strategic Plan represents a set of interventions which fall under the remit of the following agencies: Ministry of Finance, Ministry of Health, Ministry of Women and Social Development, Integral Health Insurance Plan, JUNTOS programme for conditional cash transfers, and regional governments. These interventions form part of the CRECER national strategy.

The following outcomes are expected as a result of this national strategy:
• Improved nutritional practices on the basis of regional products.
• Provide the target population with access to the Identity programme.
• Promote communities and municipalities (e.g. improved stoves, implementation and correct use of latrines, etc.).
• Increase the number of literate mothers.
• Increase the number of children and under the age of 5 years and pregnant mothers with comprehensive care in relation to health, food and nutrition.
• Increase the number of children with normal growth.
• Expand water and sanitation services.

In the non-governmental sector, the Roundtable for the Fight Against Poverty[4], which was established in 2001, represents a forum for participation by state institutions and non-governmental bodies to adopt agreements and co-ordinate activities for effectively tackling poverty in each region, administrative division, province and district of Peru and has local subcommittees at each subnational level. It is responsible for regularly monitoring the nutrition indicators of the Nutrition Strategic Programme. Moreover, in 2006 it established the initiative against infant undernutrition with the aim of raising awareness among the authorities and to push for reductions in chronic undernutrition[5].

In the private sector, Peru has signed an agreement through the *Solidarity with the People Mining Programme* with mining companies to create a voluntary fund aimed at financing social investment in key areas for miners to support efforts to reduce poverty and infant undernutrition.

In the field of research, 2006 saw the start of efforts by the National Council of Science and Technology (CONCYTEC) to promote the creation of a food and nutrition research consortium by the principal public and private research bodies, universities and research centres. One of its members, the Food and Nutrition National Center defined priorities for research on nutritional topics in 2010.

e) Structures/Leadership for Nutrition

The Ministry of Health working together with the Ministry of Finance, MIMDES and the JUNTOS programme took part in the design of the Nutrition Strategic Plan. The Ministry of Health subsequently produced the definitions and cost structure. The CRECER strategy addresses the following interventions:

The JUNTOS Programme - Conditional Cash Transfers: direct support for the poorest families in both rural and urban areas by providing cash conditional on meeting certain commitments to participate in the citizens' health, nutrition, education and development programme (identity).

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[4] http://www.mesadeconcertacion.org.pe/

[5] The initiative represents institutions working in development and implements food security programmes. It has more than 20 years' experience in the country (ADRA Perú, CARE Perú, CÁRITAS del Perú, PRISMA) and has been strengthened by the incorporation of the Roundtable for the Fight Against Poverty (MCLCP), the Pan American Health Organization (OPS/PAHO), the UN World Food Programme (WFP), UNICEF, and other NGOs

National Identification and Civil Status Registry (RENIEC) – Public Access to the Identity Programme: ensures the issue of national identity document (DNI) and the unique identification code (CUI) to provide children with access to public programmes.

Comprehensive Health Insurance: the affiliation guarantees free access to major health programmes for children at health service facilities, this includes vaccinations, growth and development monitoring and care for sick children among others.

Budgeting for Results: a new approach to public budgets in which resources are scheduled, assigned, executed and evaluated with an emphasis on managing for results relating to the welfare of the population. Five strategic programmes have been initiated which set out to provide interventions from the time of pregnancy until children are eight years of age.

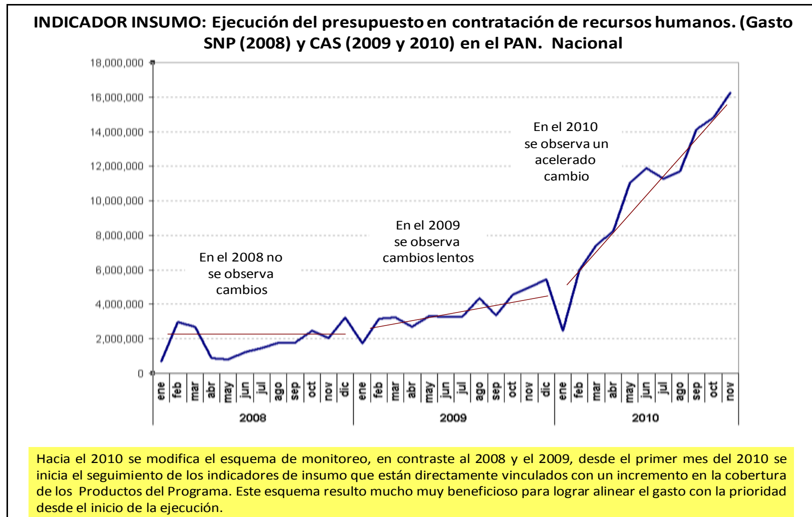
One of these programmes is the **Maternal-Neonatal Programme** whose goal it is to improve the health of mothers, ensuring childbirth is supervised by qualified personnel and to ensure proper care for newborns. The **Nutrition Strategic Plan** aims to reduce chronic infant undernutrition and seeks to safeguard access to basic services for children under the age of 36 months. These resources include growth and development monitoring, vaccinations, health promotion courses for mothers and care for common illnesses among others. However, the most significant advances are to be found in the health sector under the leadership of the Presidency of the Council of Ministers, which seeks to formulate a multi-sector plan to tackle undernutrition. The following table illustrates an important increase in public funding for the principal sectors involved in the strategic programme. This is particularly true of the health sector where resources have been doubled between 2009 and 2011.

Initial Public Budget by Sector 2009-2012

		PIA2009	**PIA2010**	**PIA2011**	**PIA2012**
1 National Government	01 PRESIDENCY - COUNCIL MINISTERS	433,027,586	582,430,671	171,367,904	n/d
	11 HEALTH	280,225,979	549,346,700	576,931,403	560,923,775
	39 WOMEN & SOCIAL DEVELOPMENT	213,195,235	266,602,691	281,495,048	329,059,340
	TOTAL	**926,448,800**	**1,398,380,062**	**1,029,794,355**	**889,983,115**
2 Regional Government	99 REGIONAL GOVERNMENTS	126,505,321	196,094,812	354,807,244	479,637,444
	TOTAL	**126,505,321**	**196,094,812**	**354,807,244**	**479,637,444**
SECTOR	01 PRESIDENCY - COUNCIL MINISTERS	433,027,586	582,430,671	171,367,904	n/d
	11 HEALTH	280,225,979	549,346,700	576,931,403	560,923,775
	39 WOMEN & SOCIAL DEVELOPMENT	213,195,235	266,602,691	281,495,048	329,059,340
	99 REGIONAL GOVERNMENTS	126,505,321	196,094,812	354,807,244	479,637,444
	TOTAL	**1,052,954,121**	**1,594,474,874**	**1,384,601,599**	**1,369,620,559**

Implementation of the budget allowed a more targeted allocation of strategic health, nutrition and education programmes. It also allowed the setting of goals and measurable parameters for combatting poverty with interventions which were carried out at all levels of government (central, regional and municipal).

At the same time, this increase in budgets has facilitated in important expansion of human resources allocated to strengthening the technical capabilities of the health services through the recruitment of staff such as nurses at a national level as shown in the following figure.

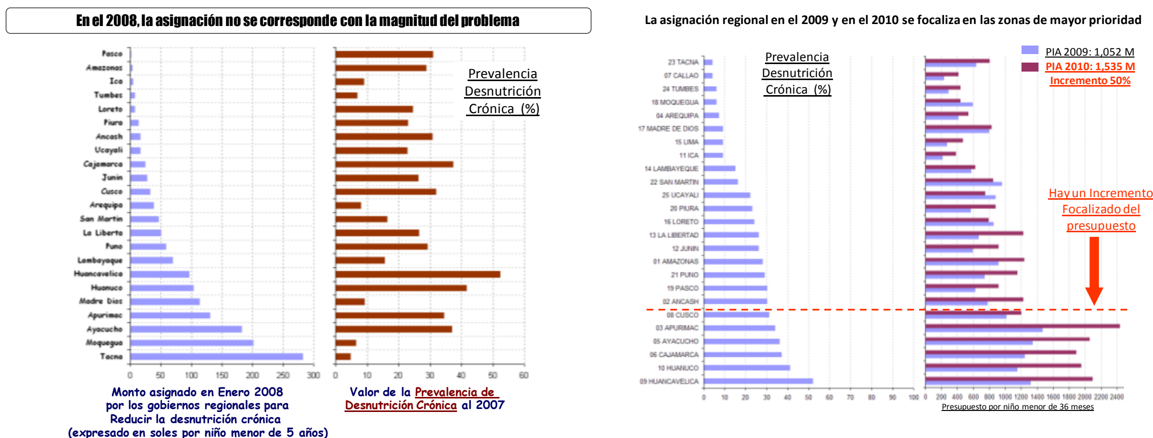


Source: L. Cordero MEF 2011

Former minister Carranza explained that if we can increase the availability of growth and development monitoring from the current 50% to 95%, it would be possible to reduce chronic infant malnutrition in Peru to 6%. This expansion in availability would, he claims, only cost the state an additional S/.400 million." (*El Comercio*, 21 August 2011)

f) Next steps

It is clear that nutrition activities in the country have been expanded in those regions with the most serious problems. This is illustrated in the following diagrams.



Source: L. Cordero MEF 2011

Likewise, results are also being achieved with regard to the availability of growth and development monitoring in targeted areas such as rural regions where CRED availability has increased from 20% to 44% between 2005 and 2010. There are, however, a number of gaps which are yet to be filled.

Product indicator

% of children under 36 months who have completed appropriate CRED for their age

	2005	2007	2008	2009	2010	Variation
National	**25.0**	**24.0**	**21.6**	**27.7**	**39.9**	**12.2**
Residence Area						
Urban	27.8	23.9	22.4	27.3	37.6	10.3
Rural	20.9	24.0	20.3	28.5	44.1	15.6

Source: L. Cordero MEF 2011

Estimates of food vulnerability indicate that the number of families facing the prospect of food shortages has risen to 1.73 million, a figure which represents some 25% of the total number of families in Peru. Of this figure, some 67% are located in the mountains of Peru (1.16 million). Approximately 280,000 vulnerable families are located in jungle areas and another 280,000 are to be found on the coast (including 95,000 in the Lima metropolitan area)[6].

Much greater improvement of the quality of interventions is still needed, particularly with regard to synergies between basic sanitation and access to health services in order to achieve the desired results. The challenge is to ensure that the 158 executive units and the 7,300 health facilities continue their programme of work with a focus on activities falling under the remit of the Nutrition Strategic Plan. Taking into account the need to create a favourable context and environment for child development, plans are being made to improve the infrastructure for basic services such as water, electricity and roads.

h) Scaling up financial commitments

In the period from 2006-2011 it has been possible to mobilize a number of significant resources in the health sector from international co-operation programmes and financial organisations such as EUROPAN, Japan Social Development Fund, USAID, the United Nations (PAHO, PMA, UNICEF, FAO, UNODC), the World Bank and BID. There has been an important harmonisation of donors with regard to the goal of reducing malnutrition. The following table provides an overview of resources originating from international co-operation and finance sources.

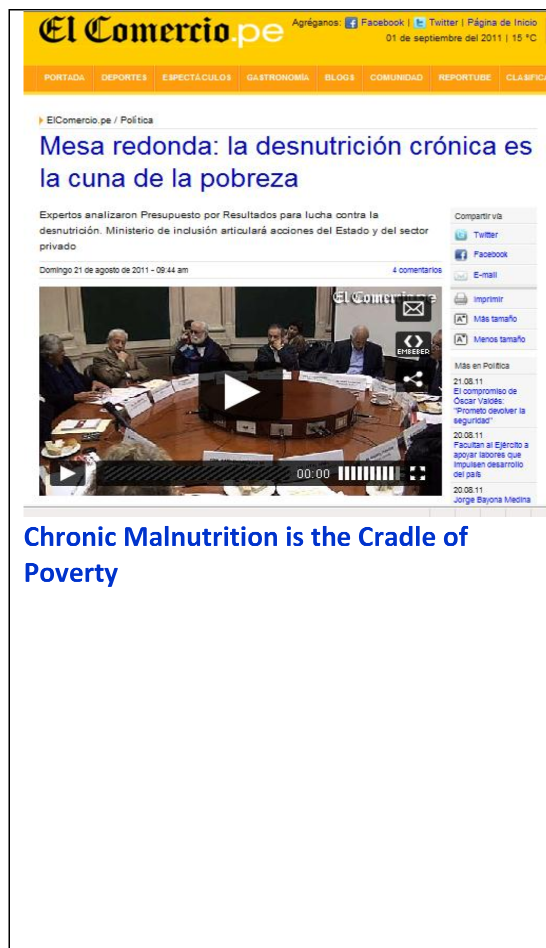
[6] Zegarra E. and Tuesta J. 2009 Op Cit.

Source	Amount (US $)	Type of Resource
MEF – PAN	480 M (S/.1,300 M - 2011)	Public
VOLUNTARY MINING CONTRIBUTION[7]	182 M (S/. 494 M 2010)	Private
EUROPAN	60 M Euros (2009-2013)	International Co-operation
JSDF (Japan Social Development Fund - BM)	2 M (2011-2012)	International Co-operation
USAID	11 M (2010)	International Co-operation
Juntos Results for Nutrition SWAP (BM)	25 M (2011-2015)	Borrowing
PAR SALUD (BM, BID)	100M (2009-2013)	Borrowing
UN System (OPS – FAO – UNICEF – PMA -ONUDD)	6 M (2009-2012)	International Co-operation

Produced by author. TC S/. 2.7 / US $

The media is also becoming involved supporting the continuation of important work already underway. Particular emphasis is being placed on the need to continue using the Budgeting for Results initiative as a tool. One newspaper, *El Comercio* also organised a roundtable meeting in August 2011 which was attended by various experts in the field. In addition to the benefits of the Budgeting for Results initiative, the group of experts also discussed matters of social policy which are applicable to the new government as well as the role the new ministry needs to take with regard to social development and inclusion.

[7] http://www.snmpe.org.pe/pdfs/Informe-Quincenal/Mineria/Informe-Quincenal-Mineria-Programa-minero-de-solidaridad-con-el-pueblo-aporte-voluntario.pdf. 31 ago 2011 Not all resources are for nutrition, some also include infrastructure projects.



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Mesa redonda: la desnutrición crónica es la cuna de la pobreza

Expertos analizaron Presupuesto por Resultados para lucha contra la desnutrición. Ministerio de inclusión articulará acciones del Estado y del sector privado

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Chronic Malnutrition is the Cradle of Poverty

The meeting of the expert roundtable was attended by Dr Francisco Miró Quesada Rada, Director of *El Comercio* and was moderated by Juan Paredes Castro, politics editor. Discussions began with a presentation from former minister of finance Dr Luis Carranza.

It was noted that chronic malnutrition is a problem which has irreversible consequences for the physical and mental development of a person. "A child suffering from chronic malnutrition will experience problems learning at school and this will affect their future income. Moreover, it has been found that the probability of children whose parents did not finish primary education proceeding to university is less than 1%". Luis Cordero, former MEF coach said that the budget allocated to combat chronic malnutrition has increased from S/.1,050 million in 2009 to S/.1,535 million in 2010. During this period key interventions were realised in relation to vaccinations against pneumonia and respiratory infections in children.

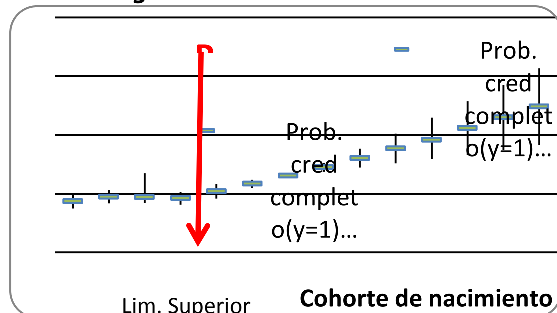
The previous government increased the budget for vaccines from S/.165 million in 2009 to S/.420 million in 2010. With regard to the growth and development monitoring programme (CRED), the budget was quadrupled from S/.20 million in 2009 to S/.86 million in 2010. CRED is a programme which helps mothers to better care for their young infants with regard to hygiene, recognising illnesses and methods for preventing them. This helped to reduce the incidence of chronic childhood malnutrition.

Principal Indicators

The principal indicators are monitored by ENDES.

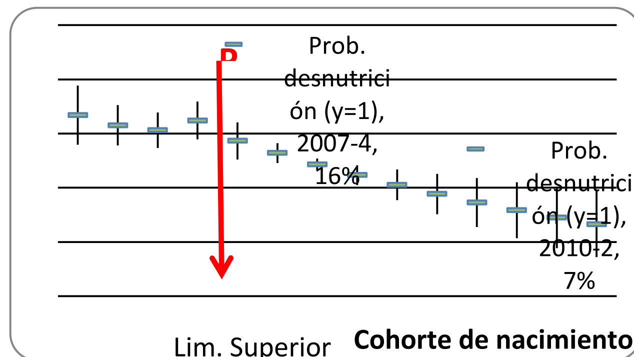
Evaluation of Impact:

Interim Result 1: *Growth and Development Monitoring*



Lim. Superior: Upper Limit
Lim. Inferior: Lower Limit
Cohorte de nacimiento: Birth Group
Prob. cred completo: Probable complete CRED

Final Result: *Undernutrition*



Source: L. Cordero MEF 2011

The likelihood of a child to have full growth for its age increased significantly for children born after 2008. Controlling for other characteristics of the child, the household, the community, interventions such as JUNTOS and SIS as well as the growth rate in the relevant administrative division, the reduced likelihood for children born in 2010-2012 is 100% compared with children born in 2007-4.

The likelihood of a child suffering from chronic undernutrition decreases significantly in children born after 2008. Controlling for other characteristics of the child, the household, the community, interventions such as JUNTOS and SIS as well as the growth rate in the relevant administrative division, the reduced likelihood of suffering undernutrition for children born in 2010-2012 is 60% compared to children born in 2004-2007.

No.	INDICATOR	**2000**	**2007**	**2009**	**2010**
1	Prevalence of undernutrition in children under 5 years – NCHS (OMS)	25.4	22.6 (28.5)	18.3 (23.8)	17.9 (23.2)
2	Prevalence of anaemia in children aged 6-36 months	60.9	56.8	50.4	50.3
3	Incidence of low birth weight	8.5	8.4	7.1	8.0
4	Children aged less than 6 months who are exclusively breastfed	67.2	68.7	68.5	68.3
5	Incidence of acute respiratory infection in children aged less than 36 months	21.3	24.0	17.2	18.3
6	Prevalence of acute diarrhoeal disease in children aged 36 months	19.8	17.4	18	18.9
7	Households with access to treated water	84.4	92.9	91.1	91.5
8	Households with basic sanitation	75.9	81.8	83.3	85.3
9	Rural households with basic sanitation	48.6	61.0	64.7	67.8
10	Pregnant women who received iron supplements	60.2	74.9	80.1	86.1

Source: ENDES

Peru basic indicators

Total population	29,165,000
Population below $1 (PPP) per day, percentage (2004)	5.9
Life expectancy at birth m/f (years)	74/77
Total expenditure on health per capita (Intl $)	400
Adult literacy rate 2005-08 m/f (%)	95/85

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	24% (2009)
Wasting (weight-for-height < –2 SD of WHO standards	1% (2009)
Birth weight (< 2500 grams)	8% (2007)
Adult thinness (Body-Mass Index <18.5)	1% (2009)
Anaemia in children 6-59 months (Hb < 11 g/dL)	37% (2009)
Anaemia in pregnant women (Hb < 11 g/dL)	27% (2009)
Iron & folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	2% (2001)
Iodine supplements (households consuming iodized salt)	91% (2004)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	70% (2009)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	66% (2004-06)
International Code of Marketing of Breast-milk Substitutes (adopted)	Partially
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	82% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	22, 17, 19
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	24, 19. 21
Maternal mortality rate (annual number of female deaths per 100,000 live births)	98 (62-160)
Nutrition governance score	Strong

NA= Not Available

Perú (edición española)

Contexto nacional

Perú goza de un período de crecimiento sostenido y déficits fiscales decrecientes, con una mejora en los indicadores de pobreza y de desnutrición infantil. La tasa de desnutrición crónica infantil se ha reducido de 24,5% en el 2006 a 16,5% en el 2011; sin embargo la anemia persiste en el orden del 60 al 75% en los menores de 18 meses y se redujo del 31,6% al 21% en mujeres en edad fértil entre el 2000 y 2009 (Instituto Nacional de Estadística e Informática, INEI- ENDES 2009). Al mismo tiempo, la situación de la desnutrición a nivel subnacional pone de manifiesto una gran disparidad en las tasas, existiendo aún áreas del país con tasas de desnutrición infantil del orden del 44% y otras con 2,4%. Por otro lado, el nivel de inseguridad alimentaria estimado a partir del porcentaje de hogares con déficit calórico es del orden del 42% en el ámbito rural y 16,4% en el ámbito urbano (E. Zegarra and J. Tuesta 2009. Documento de Trabajo 55. Shock de precios y vulnerabilidad alimentaria de los hogares peruanos GRADE – FAO. Lima, Perú [Working Document 55: Price shock and food vulnerability of Peruvian households]).

Respuesta del Gobierno

a) Visión global para fomentar la nutrición

El Gobierno se ha propuesto la meta de reducir la desnutrición crónica a 9,5% en el 2016 y disminuir la tasa de mortalidad infantil de 18 a 12 por 1000 nacidos vivos.

Desde el 2006 existe un compromiso político fuerte por parte del presidente y a nivel interministerial de reducir la desnutrición crónica infantil. Teniendo en cuenta que una de las principales consecuencias de la pobreza es la desnutrición crónica infantil, se ha promovido la coordinación interinstitucional y sectorial para implementar medidas para enfrentar la desnutrición infantil, especialmente para desterrar estrategias asistencialistas de distribución de alimentos. Sin embargo, no se han tenido en cuenta otros aspectos como la atención en salud, la educación de la mujer y el acceso a servicios básicos documentado por IFPRI ([1] Smith L. and Haddad L. 2000. Overcoming Child Malnutrition in Developing Countries: Past Achievements and Future Choices. Discussion Paper 30. International Food Policy Research Institute. Washington, DC, February).

b) Compromiso para aumentar la nutrición

En el 2007, el Gobierno aprobó la Estrategia Nacional CRECER, que articula todos los programas que trabajan a favor de la infancia, de conformidad con el Decreto Supremo Nº 055 – PCM de la Presidencia del Consejo de Ministros. Esta estrategia articula intervenciones de entidades del gobierno nacional, regional y local, de las entidades privadas, la cooperación internacional y la sociedad civil en general; con la finalidad de lograr integralidad y sinergia, para reducir la pobreza y la desnutrición crónica infantil.

Esta estrategia parece constatar la escasa eficiencia de los programas sociales para la reducción de la desnutrición crónica infantil, a pesar de la fuerte inversión efectuada por el Estado en los últimos años. Se reconoce que la desnutrición crónica es multisectorial y generada por múltiples causas y plantea procesos articulados con la participación de todos los actores sociales involucrados, lo cual incluye a los propios beneficiarios, las autoridades, las entidades públicas y el aporte de la Cooperación Técnica Internacional. En el 2007 se aprobó el “Presupuesto por Resultados” (Ley 28927-Ley del Presupuesto del Sector Público), con el fin de lograr que el proceso presupuestario impulse y desarrolle una gestión

basada en resultados, estableciéndose el Programa Estratégico Articulado Nutricional iniciado en el 2008. Este Programa Estratégico planteó como fin reducir la desnutrición crónica a través de intervenciones estratégicas[8] alineadas y bajo responsabilidad de diversos actores, partiendo de una visión integrada de planificación y presupuesto.

Basándose en las pruebas científicas publicadas por la Serie The Lancet, el Programa Articulado Nutricional (PAN) prioriza las intervenciones en dos momentos fundamentales del ciclo de la vida: durante la gestación y desde el nacimiento hasta los 36 meses. El PAN incluye un listado priorizado de intervenciones sanitarias garantizadas para la reducción de la desnutrición crónica y la estimulación de la salud materna y perinatal (DS 003-2008-SA) con atenciones integrales para gestantes, recién nacidos y niños, entre otros. El Programa, plantea una óptima combinación de intervenciones para lograr reducir la desnutrición infantil de los ciudadanos. Este enfoque introduce los conceptos de *resultados* y *producto* en la planificación y el presupuesto público, donde la cadena presupuestal es la misma para todas las entidades vinculadas a este programa articulado nutricional, ya sea a nivel nacional, regional o local. Al 2010-2011 se incrementó el presupuesto público al 52% para reducir la desnutrición crónica y al 25% para la atención de las gestantes.

Presupuesto (millones soles - S/.)				
Programas estratégicos		2009	2010	Variación
01 Articulado nutricional	1052	1594	52%	
02 Salud materno neonatal		359	447	25%

Fuente: L. Cordero MEF 2011

Respecto a las intervenciones para reducir la desnutrición crónica, el presupuesto público aumentó significativamente en dos intervenciones eficaces: control de crecimiento y desarrollo y vacunas.

Intervención (Producto)	**2009**	**2010**	**Variación**
33254 niños con vacuna completa para su edad	165M	420M	+254%
Introducción de nuevas vacunas para prevenir las infecciones respiratorias agudas y las diarreas en menores de 24 meses			
33255 niños con CRED completo según edad	20M	86M	+432%
Incrementar sustancialmente la cobertura del control de crecimiento y desarrollo de los niños para promover las tres prácticas claves de cuidado y alimentación del menor de 36 meses: lavado de manos, lactancia materna exclusiva y adecuada alimentación del menor.			

Fuente: L. Cordero MEF 2011

c) Plan nacional de nutrición

Si bien el país no cuenta con un plan nacional de nutrición, la estrategia CRECER promovida desde la Presidencia del Consejo de Ministros articula las intervenciones desde los diferentes sectores y niveles de gobierno. Además, el Ministerio de Economía y Finanzas continúa con el enfoque de “Presupuesto por Resultados” y se incluyen metas principales de reducción de la desnutrición crónica en el Gobierno iniciado en julio del 2011. A nivel del Gobierno nacional, hay un compromiso asumido con una serie de lineamientos de apoyo presupuestario regular a través del Programa Articulado Nutricional sobre la base de pruebas científicas, para diseñar la estrategia y las intervenciones del Programa.

[8] Los otros cuatro son Programa Salud Materno Neonatal, Programa de Logros de Aprendizaje al finalizar el III ciclo, Programa de Acceso de la Población a la Identidad y Programa de Acceso a Servicios Sociales y Oportunidades de Mercado.

d) Plataformas de múltiples actores

Desde el sector público, el Programa Articulado Nutricional plantea un conjunto de intervenciones que competen a los siguientes actores: Ministerio de Economía y Finanzas, Ministerio de Salud, Ministerio de la Mujer y Desarrollo Social, Seguro Integral de Salud, Programa JUNTOS de Transferencias Monetarias Condicionadas, Gobiernos Regionales. Estas intervenciones se enmarcan en la estrategia nacional CRECER.

En el marco de esta estrategia nacional, los resultados esperados son los siguientes:
Mejorar las prácticas nutricionales en base a los productos regionales.
Lograr el acceso a la identidad de la población objetivo.
Promover comunidades y municipios saludables (Ej.: cocinas mejoradas, implementación y uso correcto de letrinas, etc.).
Incrementar el número de madres alfabetizadas.
Incrementar el número de niños y niñas menores de cinco años de edad y de madres gestantes con atención integral en salud, alimentación y nutrición.
Incrementar el número de niñas y niños con crecimiento normal.
Ampliar la cobertura del servicio de agua y saneamiento.

Desde la sociedad civil, la Mesa de Concertación para la Lucha contra la Pobreza[9], instancia establecida en el año 2001 es un espacio en el que participan instituciones estatales y la sociedad civil para adoptar acuerdos y coordinar acciones que permitan luchar eficazmente contra la pobreza en cada región, departamento, provincia y distrito del Perú y cuenta con mesas en cada nivel subnacional. Se encarga de hacer el seguimiento periódico a los indicadores nutricionales del Programa Estratégico Articulado Nutricional. Además, en el 2006 se instala la Iniciativa contra la desnutrición infantil con el fin de sensibilizar a las autoridades y abogar por la reducción de la desnutrición crónica[10].

Desde el sector privado, a través del Programa Minero Solidaridad con el Pueblo, el Perú firma un acuerdo con las empresas mineras para crear un fondo voluntario, destinado a obras de inversión social en las zonas de influencia de las mineras para apoyar iniciativas de reducción de la pobreza y la desnutrición infantil.

En el campo de la investigación, se iniciaron esfuerzos en el 2006 desde el Consejo Nacional de Ciencia y Tecnología (CONCYTEC) para promover la constitución de un Consorcio de Investigación en Alimentación y Nutrición, desde las principales entidades públicas y privadas de investigación, universidades y centros de investigación. A partir de uno de sus miembros, el Centro Nacional de Alimentación y Nutrición ha definido prioridades de investigación en temas nutricionales en el 2010.

e) Estructuras/liderazgo para la nutrición

El Ministerio de Salud en coordinación con el Ministerio de Economía y Finanzas, el MIMDES y el Programa JUNTOS ha participado en el diseño del Programa Articulado Nutricional, luego el Ministerio de Salud ha diseñado las definiciones operacionales y la estructura de costos. La Estrategia CRECER aborda las siguientes intervenciones:

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[9] http://www.mesadeconcertacion.org.pe/

[10] La Iniciativa representa instituciones que trabajan para el desarrollo, implementando programas de seguridad alimentaria y que cuentan con mas de 20 anos en el país (ADRA Perú, CARE Perú, CÁRITAS del Perú, PRISMA) que se ha fortalecido con la incorporación de la Mesa de Concertación para la Lucha contra la Pobreza (MCLCP), la Organización Panamericana de la Salud (OPS/OMS), el Programa Mundial de Alimentos (PMA), UNICEF, y otras ONG

El Programa JUNTOS - Transferencias monetarias condicionadas: apoyo directo a las familias más pobres de las zonas rurales y urbanas, mediante la entrega de dinero en efectivo condicionado al cumplimiento de compromisos de participación en el programa de salud, nutrición, educación y desarrollo de la ciudadanía (Identidad).

Registro Nacional de Identificación y Estado Civil (RENIEC) – Programa de acceso público a la Identidad: asegura la expedición del Documento Nacional de Identidad (DNI) y del Código Único de Identificación (CUI) para permitir el acceso a los niños y niñas a los programas públicos.

Seguro Integral de Salud: la afiliación garantiza la atención gratuita para las principales prestaciones de salud dirigidas a los niños y niñas en los servicios de salud, tales como vacunas, el control de crecimiento y desarrollo, atenciones de niños enfermos, entre otras.

El Presupuesto por Resultados: Es un nuevo enfoque de elaboración del presupuesto público, en el que los recursos se programan, asignan, ejecutan y evalúan con un enfoque de gestión por resultados orientados al bienestar de las personas. Se inician cinco programas estratégicos que definen intervenciones a realizarse desde el embarazo, hasta los 8 años de edad de los niños y las niñas.

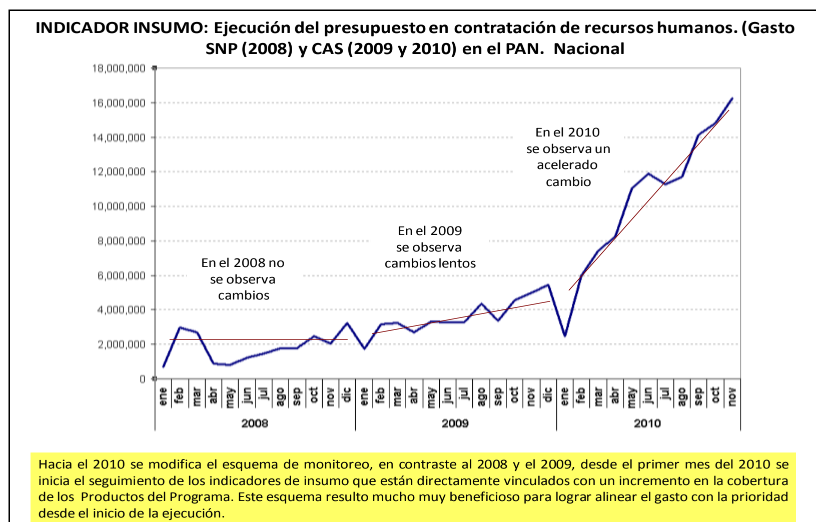
Uno de estos programas es el **Programa Materno Neonatal** cuyo fin es mejorar la salud materna, asegurar un parto atendido por personal calificado y asegurar una buena atención del recién nacido. El **Programa Articulado Nutricional** plantea la reducción de la desnutrición crónica infantil y está dirigido a asegurar a los niños menores de 36 meses el acceso a servicios básicos como, control de crecimiento y desarrollo, vacunación, educación a la madre en prácticas saludables, atención de las enfermedades prevalentes de la infancia, entre otros. Sin embargo, los mayores avances se encuentran en el sector salud, siempre bajo el liderazgo de la Presidencia del Consejo de Ministros, instancia que busca la articulación multisectorial para la reducción de la desnutrición. El siguiente cuadro muestra el importante aumento en el presupuesto público en los principales sectores involucrados en el Programa Articulado Nutricional, principalmente en el sector salud, duplicando los recursos entre el 2009 y el 2011.

La aplicación del Presupuesto por Resultados permitió una asignación más focalizada en programas estratégicos de salud, nutrición y educación, así como trazar metas e implementar parámetros medibles para combatir la pobreza con intervenciones que se realizaron en todos los niveles del gobierno (central, regional y municipal).

Presupuesto Público Inicial 2009-2012 por sector

		PIA2009	PIA2010	PIA2011	PIA2012
1 Gobierno nacional	01 PRESIDENCIA – CONSEJO DE MINISTROS	433.027.586	582.430.671	171.367.904	n/d
	11 SALUD	280.225.979	549.346.700	576.931.403	560.923.775
	39 MUJER Y DESARROLLO SOCIAL	213.195.235	266.602.691	281.495.048	329.059.340
	TOTAL	**926.448.800**	**1.398.380.062**	**1.029.794.355**	**889.983.115**
2 Gobierno regional	99 GOBIERNOS REGIONALES	126.505.321	196.094.812	354.807.244	479.637.444
	TOTAL	**126.505.321**	**196.094.812**	**354.807.244**	**479.637.444**
SECTOR	01 PRESIDENCIA – CONSEJO DE MINISTROS	433.027.586	582.430.671	171.367.904	n/d
	11 SALUD	280.225.979	549.346.700	576.931.403	560.923.775
	39 MUJER Y DESARROLLO SOCIAL	213.195.235	266.602.691	281.495.048	329.059.340
	99 GOBIERNOS REGIONALES	126.505.321	196.094.812	354.807.244	479.637.444
	TOTAL	**1.052.954.121**	**1.594.474.874**	**1.384.601.599**	**1.369.620.559**

Paralelamente, este aumento presupuestario ha permitido un aumento importante en los recursos humanos, asignados para fortalecer la capacidad técnica de los servicios de salud a través de la contratación de personal, como enfermeros a nivel nacional según se muestra en el siguiente cuadro.

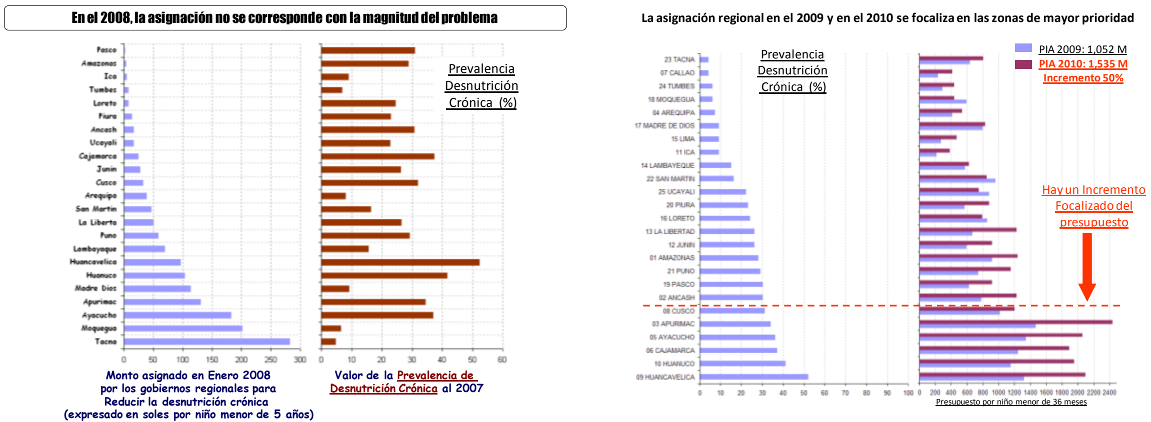


Source: L. Cordero MEF 2011

El ex Ministro Carranza precisó que si se logra elevar la cobertura del control de crecimiento y desarrollo del actual 50% a 95%, se podría reducir la desnutrición crónica infantil en el Perú a 6%. Esta ampliación de cobertura “costaría al Estado solo S/.400 millones adicionales.” (El *Comercio* 21 agosto 2011)

f) Pasos siguientes

Es claro que las intervenciones en nutrición en el país se han ampliado en aquellas regiones con los problemas más graves, como lo muestran los cuadros adjuntos.



Fuente: L. Cordero MEF 2011

Asimismo, se ven resultados en los niveles de cobertura de control de crecimiento y desarrollo alcanzados en zonas focalizadas, como las rurales, que pasan del 20% al 44% de cobertura CRED entre el 2005 y el 2010. Sin embargo, aún hay brechas que cerrar.

INDICADOR DE PRODUCTO

% de niños/as menores de 36 meses con CRED completo para su edad

	2005	2007	2008	2009	2010	Variación
Nacional	**25,0**	**24,0**	**21,6**	**27,7**	**39,9**	**12,2**
Área de residencia						
Urbana	27,8	23,9	22,4	27,3	37,6	10,3
Rural	20,9	24,0	20,3	28,5	44,1	15,6

Fuente: L. Cordero MEF 2011

Según los cálculos de vulnerabilidad alimentaria, la cantidad de familias en situación de vulnerabilidad alimentaria asciende a 1,73 millones, que representan el 25% del total de familias peruanas, de las cuales 67% se encuentran ubicadas en la sierra peruana (1,16 millones). Unas 280.000 familias vulnerables se encuentran en la selva y otras 280.000 en la costa (incluidas 95 mil en Lima Metropolitana)[11].

Aún es necesario un mayor alineamiento entre las intervenciones y la calidad de las mismas, especialmente en sinergia con las de saneamiento básico y acceso a los servicios de salud para alcanzar los resultados esperados. El reto es asegurar que las 158 unidades ejecutoras y los 7.300 establecimientos de salud continúen su programación enfocándose en las intervenciones que competen al Programa Articulado Nutricional. Teniendo en cuenta que es necesario generar un contexto y entornos favorables para el desarrollo infantil, se plantea mejorar también la infraestructura de los servicios básicos: agua, energía eléctrica y carreteras.

[11] Zegarra E. y Tuesta J. 2009 Op Cit.

h) Aumento de compromisos financieros

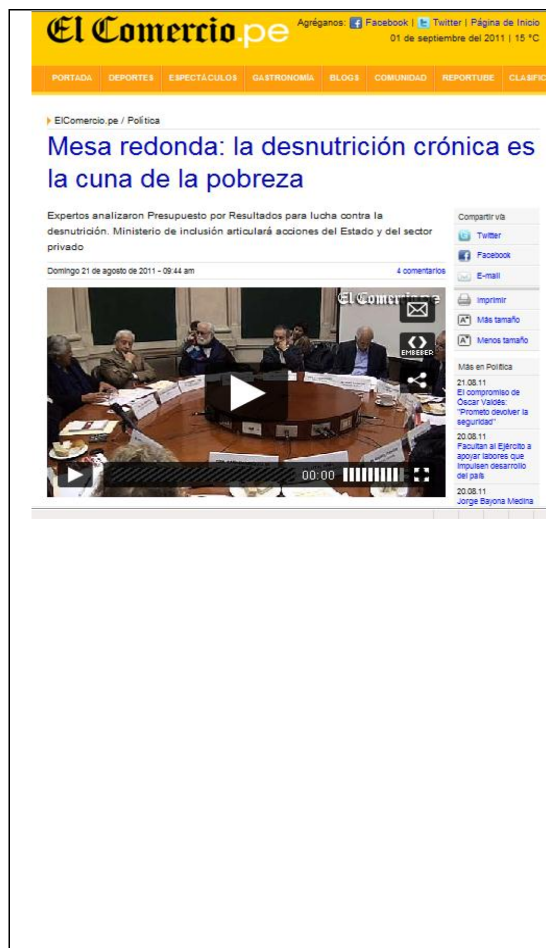
En el período 2006-2011, se han movilizado importantes recursos de programas de Cooperación Internacional y entidades financieras, especialmente en el sector salud, tales como EUROPAN, Japan Social Development Fund, USAID, Naciones Unidas (OPS, PMA, UNICEF, FAO, ONUDD) Banco Mundial y BID. Se ha manifestado un alineamiento importante de los donantes en torno a la meta de reducción de la desnutrición. Los recursos procedentes de fuentes de cooperación internacional y financiamiento se presentan en el siguiente cuadro.

Fuente	Monto (US $)	Tipo de recursos
MEF - PAN	480 M (S/.1.300 M - 2011)	Público
APORTE VOLUNTARIO MINERO[12]	182 M (S/. 494 M 2010)	Privado
EUROPAN	60 M Euros (2009-2013)	Cooperación Internacional
JSDF (Japan Social Development Fund - BM)	2 M (2011-2012)	Cooperación Internacional
USAID	11 M (2010)	Cooperación Internacional
JUNTOS Results for Nutrition SWAP (BM)	25 M (2011-2015)	Préstamo
PAR SALUD (BM, BID)	100M (2009-2013)	Préstamo
UN System (OPS – FAO – UNICEF – PMA -ONUDD)	6 M (2009-2012)	Cooperación internacional

Elaboración propia. TC S/. 2,7 / US $

Los medios también vienen involucrándose para propiciar la continuidad de los importantes esfuerzos iniciados, haciendo énfasis en la necesidad de continuar con el uso de la herramienta de Presupuesto por Resultados, reuniendo a importantes expertos en una mesa redonda convocada por el diario El Comercio, en agosto de 2011. El grupo de expertos dialogó acerca de las políticas sociales que aplicarán el nuevo gobierno y el rol que deberá cumplir el nuevo Ministerio de Desarrollo e Inclusión Social y los beneficios de la herramienta Presupuesto por Resultados.

[12] http://www.snmpe.org.pe/pdfs/Informe-Quincenal/Mineria/Informe-Quincenal-Mineria-Programa-minero-de-solidaridad-con-el-pueblo-aporte-voluntario.pdf. 31 ago 2011 No todos los recursos son para nutrición, también incluyen obras de infraestructura.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PORTADA DEPORTES ESPECTÁCULOS GASTRONOMÍA BLOGS COMUNIDAD REPORTUBE CLASIFICA

ElComercio.pe / Política

Mesa redonda: la desnutrición crónica es la cuna de la pobreza

Expertos analizaron Presupuesto por Resultados para lucha contra la desnutrición. Ministerio de inclusión articulará acciones del Estado y del sector privado

Domingo 21 de agosto de 2011 - 09:44 am

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20.08.11 Jorge Bayona Medina

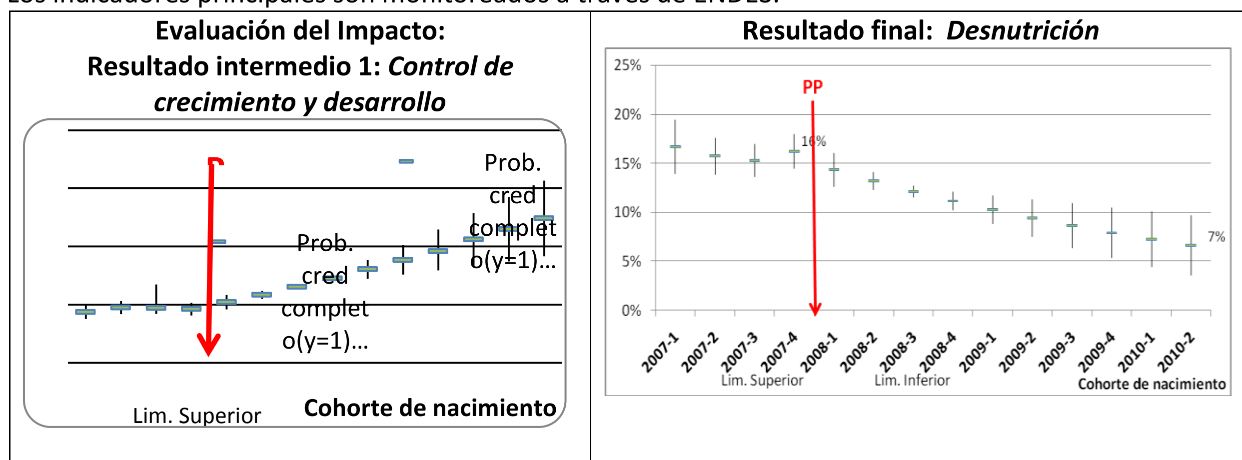
La mesa contó con la participación del Dr. Francisco Miró Quesada Rada, director de El Comercio; fue moderada por Juan Paredes Castro, editor central de Política; y se inició con una exposición del ex Ministro de Economía del pasado gobierno, doctor Luis Carranza.

Se mencionó que la desnutrición crónica es un problema que tiene consecuencias irreversibles en el desarrollo físico y mental de las personas. "Un niño con desnutrición crónica tendrá problemas para aprender en la escuela y eso repercutirá en sus ingresos a futuro. Además, está comprobado que es menor al 1% la probabilidad de que un niño cuyos padres no terminaron la primaria acuda a la universidad". Luis Cordero, ex técnico del MEF, mencionó que el presupuesto destinado a combatir la desnutrición crónica se elevó de S/.1.050 millones en el 2009 a S/.1.535 millones en el 2010. En ese período, también se lograron intervenciones claves en la aplicación de vacunas contra la neumonía e infecciones respiratorias en los niños.

El régimen anterior elevó el presupuesto para vacunas de S/.165 millones en el 2009 a S/.420 millones en el 2010. Y en el caso del programa Control de Crecimiento y Desarrollo (CRED), se cuadruplicó el presupuesto, de S/.20 millones en el 2009 a S/.86 millones en el 2010. CRED es un programa que capacita a las madres en el cuidado de sus hijos en la primera infancia, en temas de higiene, reconocimiento de enfermedades y medidas de prevención. Todo ello permitió disminuir la incidencia de la desnutrición crónica infantil.

Principales indicadores

Los indicadores principales son monitoreados a través de ENDES.



Fuente: L. Cordero MEF 2011

La probabilidad de un niño promedio de alcanzar el crecimiento completo para su edad aumentó significativamente para los niños que nacieron a partir del 2008. Teniendo en cuenta otras características del niño, del hogar, de la comunidad, de intervenciones como JUNTOS y SIS, así como el

crecimiento departamental correspondiente, el incremento de la probabilidad de los niños que nacieron en 2010-2 respecto a los que nacieron en 2007-4 es del 100%.

La probabilidad de un niño promedio de sufrir de desnutrición crónica disminuye significativamente para los niños que nacieron a partir del 2008. Teniendo en cuenta otras características del niño, del hogar, de la comunidad, de intervenciones como JUNTOS y SIS, así como de la tasa de crecimiento departamental correspondiente, la reducción de la probabilidad de sufrir de desnutrición de los niños que nacieron en 2010-2 respecto a los que nacieron en 2007-4 es del 60%.

Nº	INDICADOR	**2000**	**2007**	**2009**	**2010**
1	Prevalencia de desnutrición en niños menores de 5 años – NCHS (OMS)	25,4	22,6 (28,5)	18,3 (23,8)	17,9 (23,2)
2	Prevalencia de anemia en niños de 6 – 36 meses	60,9	56,8	50,4	50,3
3	Incidencia de bajo peso al nacer	8,5	8,4	7,1	8,0
4	Niños menores de 6 meses con lactancia materna exclusiva	67,2	68,7	68,5	68,3
5	Incidencia de infección respiratoria aguda (IRA) en niños menores de 36 meses	21,3	24,0	17,2	18,3
6	Prevalencia de enfermedad diarreica aguda (EDA) en niños de 36 meses	19,8	17,4	18	18,9
7	Hogares con acceso a agua tratada	84,4	92,9	91,1	91,5
8	Hogares con saneamiento básico	75,9	81,8	83,3	85,3
9	Hogares rurales con saneamiento básico	48,6	61,0	64,7	67,8
10	Mujeres gestantes que recibieron suplemento de hierro	60,2	74,9	80,1	86,1

Fuente: ENDES

Perú indicadores básicos

Población total	29.165.000
Población por debajo de $1 (PPA) diario, porcentaje (2004)	5,9
Esperanza de vida al nacer h/m (años)	74/77
Gasto total en salud per cápita (Internacional $)	400
Tasa de alfabetización en adultos 2005-08 h/m (%)	95/85

Las cifras corresponden al año 2009, a menos que se indique de otro modo.

Principales indicadores de nutrición

Retraso del crecimiento (talla para la edad ≤2 DE según los patrones de la OMS)	24% (2009)
Emaciación (peso para la talla ≤2 DE según los patrones de la OMS)	1% (2009)
Peso al nacer (< 2500 gramos)	8% (2007)
Delgadez en adultos (índice de masa corporal <18,5)	1% (2009)
Anemia en niños de 6-59 meses (Hb < 11 g/dL)	37% (2009)
Anemia en gestantes (Hb < 11 g/dL)	27% (2009)
Suplementos de hierro y ácido fólico (cantidad diaria recibida por las madres durante 6 meses o más de embarazo)	ND
Suplementos de vitamina A (niños de 6-59 meses que recibieron 2 dosis altas el año pasado)	2% (2001)
Suplementos de yodo (hogares que consumen sal yodada)	91% (2004)
Suplementos de zinc y terapia de rehidratación oral (niños de 0-59 meses con diarrea)	ND
Lactancia materna exclusiva (niños de 0-5 meses)	70% (2009)
Alimentación complementaria (niños de 6-23 meses alimentados con leche materna, con dieta mínima aceptable)	66% (2004-06)
Código Internacional de Comercialización de Sucedáneos de la Leche Materna (adoptado)	Parcialmente
Acceso a la atención sanitaria (funcionarios de la salud comunitarios y tradicionales/1000 habitantes)	ND
Acceso al agua (fuentes mejoradas de agua potable)	82% (2008)
Seguridad alimentaria (puntaje de consumo de alimentos de niños de 6-59 meses)	ND
Tasa de mortalidad infantil (muerte antes de 1 año de vida cada 1000 nacidos vivos – h, m, ambos)	22, 17, 19
Tasa de mortalidad de menores de 5 años (muerte antes de los 5 años de vida cada 1000 nacidos vivos – h, m, ambos)	24, 19. 21
Tasa de mortalidad materna (cifra anual de muertes de mujeres cada 100.000 nacidos vivos)	98 (62-160)
Puntaje de gobernanza sobre nutrición	Alto

ND= No Disponible.

Senegal

Country context

Senegal is a country in the Sahel, situated in western Africa with a population of around 12.5 million inhabitants. The Senegalese economy is relatively stable with a growth in Gross Domestic Product of 4.2 per cent in 2010 compared to 2.2 per cent in 2009 (Document de Politique Economique et Sociale, August 2010). Despite this, there are insufficient resources available to fight poverty. According to the results of an analysis of vulnerability, food security and nutrition (World Food Programme 2009-2010), 15.6 per cent of Senegalese households are food insecure. The situation is most pronounced in the south east part of the country. Data from the Demographic and Health Surveys between 1992 and 2005 have shown an improvement in the nutritional situation with decreasing prevalences of stunting, wasting and underweight in children under five years of age.

Government response

a) Overall vision for scaling up nutrition

Senegal has adopted the final resolution of the 2005 United Nations General Assembly and thus renewed its commitment to improve the living conditions of its people and in particular to achieve the Millennium Development Goals (MDGs) by 2015. Nutrition plays an essential role in achieving the MDGs, especially MDG1: reduction of extreme poverty and hunger. Thus, the fight against under-nutrition has become a major challenge for Senegal.

To address this challenge, in 2006, Senegal updated its national policy on nutrition which is based on the MDGs and poverty reduction and social protection policies. All stakeholders contributed to the updating process. In its present version, the national policy on health aims to *"reduce the number of persons suffering by hunger by half and reduce mortality of children under five years of age by one third".* The following targets have been set: (i) reduce the prevalence of under-nutrition in 0-5 year old children by half; (ii) eliminate in a sustainable manner disorders associated with iodine deficiency and vitamin A deficiency; (iii) reduce anaemia prevalence, especially iron deficiency anaemia by one third; (iv) ensure a sustained availability and access to food in sufficient quantity and quality for the whole population, particularly for vulnerable persons or persons living with the HIV/AIDS.

b) Commitment to scaling up nutrition

In 2000, the Government of Senegal adopted a new strategic approach to reducing poverty with a view to meeting the MDGs. It has implemented a set of initiatives in priority sectors (e.g. infrastructure, agriculture) to support economic growth and accelerate the development process. Nutrition is one of the Government's priority areas and is viewed as critical for achievement of most of the MDGs. Senegal is one of the countries in West Africa that is most likely to reach the MDG nutrition goals set for 2015.

c) National nutrition plans

Following the adoption of the policy letter of nutrition development, the Senegalese Government elaborated a strategic plan (2007-2011) to address under-nutrition among children under five. Under-nutrition is also a key point in the child survival strategic plan (2007-2015) of the Ministry of Health. In addition, two strategic plans are being implemented to address micronutrient deficiencies: salt iodization and food fortification with iron and vitamin A.

d) Multi-stakeholder platforms

The Government of Senegal is committed to scaling up nutrition and has a Unit for the Fight against Malnutrition (Cellule de Lutte contre la Malnutrition - CLM) that is under the guidance of the highest level, at the Primature, and benefits from State funding. The CLM is a coordination body with representatives from all the key ministries that are involved in nutrition (health, agriculture, education, etc.), thus encouraging the development of a multi-sectoral approach.

The CLM holds regular meetings in order to assess the progress of actions which take place within the framework of the national policy for nutrition in the country. It also has some decentralized structures, named CRS (Comités Régionaux de Suivi: Regional Committees for Monitoring) which, with the Regional Governor, coordinates the decentralized departments of the ministries involved in addressing under-nutrition. The CRS organize regular meetings and field visits to follow up on nutrition actions.

e) Stock-taking and gap analysis

A nutrition situation analysis and a needs assessment are priorities in the next strategic plan (2012-2017). This will involve mapping of nutritional priorities, gaps and needs within the health districts. A review of the national nutrition programme was conducted in 2006 as part of the process to prepare for the second phase implementation plan.

f) Engagement of non-governmental agencies

As a result of the Government's policy for decentralization and local development, the national nutrition programme has transferred community nutrition intervention management to local authorities. Civil society organizations are engaged in scaling up nutrition as local authorities sub-contract non-governmental organizations or associations to implement community based nutrition interventions.

The private sector is becoming more aware of its social responsibility and consequently invests more and more in social development activities. There are private sector members on the Senegalese Committee for Food Fortification (SCFF) that is the main body for the fortification of staple foods such as cooking oil and flour. In addition, the iodization of salt by small and medium producers is being strengthened.

g) Next steps

Senegal is developing a new nutrition strategic plan for 2012-2017. In addition to the expansion of direct nutrition interventions, the plan will include a nutrition situation and causal analysis. This analysis will contribute to the identification of specific interventions required to address the different facets of under-nutrition in Senegal. The contribution of the different sectors such as health, agriculture, education will be determined.

h) Scaling up financial commitments

Nutrition is included in the State budget and the amount allocated to nutrition is being increased on an annual basis. It rose from US $ 0.4 million (172 million CFA) in 2002 to$ 2.4 billion (1,172 billion CFA) in 2007, and there are planned increases up until 2016. This financial contribution from the Government will help to ensure that nutrition programmes are sustainable.

The allocation of the budget to nutrition in the context of competing requirements from other sectors, illustrates the political commitment to nutrition of the Government.

Senegal basic indicators

Total population	12,534,000
Population below $1 (PPP) per day, percentage (2004)	33.5
Life expectancy at birth m/f (years)	60/63
Total expenditure on health per capita (Intl $)	102
Adult literacy rate 2005-08 m/f (%)	52/33

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	20% (2005)
Wasting (weight-for-height < –2 SD of WHO standards	9% (2005)
Birth weight (< 2500 grams)	19% (2005)
Adult thinness (Body-Mass Index <18.5)	18% (2005)
Anaemia in children 6-59 months (Hb< 11 g/dL)	83% (2005)
Anaemia in pregnant women (Hb< 11 g/dL)	71% (2005)
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	90% (2008)
Iodine supplements (households consuming iodized salt)	41% (2005)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	34% (2005)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	22% (2005)
International Code of Marketing of Breast-milk Substitutes (adopted)	NA
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	69% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	55, 46, 51
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	99, 86, 93
Maternal mortality rate (annual number of female deaths per 100,000 live births)	410 (240-680)
Nutrition governance score	NA

NA= Not Available

Sénégal (version française)

Situation du pays

Le Sénégal est un pays du Sahel, situé à l'extrémité ouest du continent africain et dont la population s'élève à environ 12,5 millions d'habitants. L'économie sénégalaise est relativement stable avec une croissance du Produit Intérieur Brut de 4,2 % en 2010 contre 2,2 % en 2009 (Document de Politique Économique et Sociale, août 2010). Malgré tout, les ressources disponibles ne suffisent pas à lutter contre la pauvreté. D'après les résultats d'une analyse sur la vulnérabilité, la sécurité alimentaire et la nutrition (Programme alimentaire mondial 2009-2010), 15,6 % des ménages sénégalais souffrent de l'insécurité alimentaire, un phénomène qui est encore plus marqué dans le Sud-est du pays. Les données issues des Enquêtes Démographiques et de Santé réalisées entre 1992 et 2005 démontrent une amélioration de la situation nutritionnelle avec une baisse des prévalences au niveau du retard de croissance, de l'émaciation et de l'insuffisance pondérale chez les enfants de moins de cinq ans.

Actions du gouvernement

a) Vision globale pour le renforcement de la nutrition

En adoptant la résolution finale de l'Assemblée Générale des Nations Unies de 2005, le Sénégal a renouvelé son engagement visant à améliorer les conditions de vie de ses habitants et en particulier à atteindre les objectifs du Millénaire pour le développement (OMD) d'ici 2015. La nutrition joue un rôle essentiel dans l'atteinte des OMD, et notamment l'OMD 1 : réduire l'extrême pauvreté et la faim. Ainsi, la lutte contre la sous-nutrition est devenue un défi majeur pour le Sénégal.

Afin de relever ce défi, en 2006, le Sénégal a actualisé sa lettre de politique de développement de la nutrition, basée sur les OMD et les politiques de protection sociale et de réduction de la pauvreté. Toutes les parties intéressées ont participé au processus d'actualisation. Dans sa version actuelle, la lettre de politique de développement de la santé doit permettre de *« réduire de moitié le nombre de personnes souffrant de la famine et de diminuer d'un tiers la mortalité chez les enfants âgés de moins de cinq ans ».* Les objectifs suivants ont été définis : (i) réduire de moitié la prévalence de la sous-nutrition chez les enfants de 0 à 5 ans ; (ii) éradiquer les troubles associés aux carences en iode et en vitamine A ; (iii) réduire d'un tiers la prévalence de l'anémie, notamment l'anémie ferriprive ; (iv) garantir la disponibilité et l'accès constants à une nourriture de qualité dans une quantité suffisante pour l'ensemble de la population, notamment les personnes les plus vulnérables et les personnes atteintes du VIH / SIDA.

b) Engagement pour le renforcement de la nutrition

En 2000, le gouvernement du Sénégal a adopté une nouvelle approche stratégique de réduction de la pauvreté en vue d'atteindre les OMD. Un ensemble d'initiatives a ainsi été mis en œuvre dans des secteurs prioritaires (infrastructure et agriculture, par exemple) afin de soutenir la croissance économique et d'accélérer le processus de développement. La nutrition fait partie des domaines prioritaires du gouvernement et est considérée comme essentielle pour l'atteinte de la plupart des OMD. Le Sénégal figure parmi les pays d'Afrique occidentale les plus à même d'atteindre les objectifs nutritionnels OMD pour 2015***.***

c) Plans nationaux de nutrition
Suite à l'adoption de la lettre de politique de développement de la nutrition, le gouvernement sénégalais a élaboré un plan stratégique (2007-2011) pour traiter la sous-nutrition chez les enfants de moins de cinq ans. La sous-nutrition constitue également un point clé dans le plan stratégique pour la survie de l'enfant (2007-2015) du ministère de la Santé. De plus, deux plans stratégiques sont actuellement mis en œuvre afin de traiter les problèmes de carences en micronutriments : iodation du sel et enrichissement alimentaire en fer et vitamine A.

d) Plateformes multipartites
Le gouvernement du Sénégal s'engage à multiplier ses interventions nutritionnelles et dispose d'une Cellule de Lutte contre la Malnutrition (CLM) qui opère sous l'égide de la plus haute autorité gouvernementale, la Primature, et bénéficie de financements de l'État. La CLM est un organe de coordination composé de représentants issus de tous les ministères clés impliqués dans la nutrition (santé, agriculture, éducation, etc.), encourageant ainsi le développement d'une approche multisectorielle.

La CLM tient régulièrement des réunions afin d'évaluer la progression des actions menées dans le cadre de la politique nationale pour la nutrition dans le pays. Elle comporte également des structures décentralisées, appelées CRS (Comités Régionaux de Suivi) qui, en collaboration avec le gouverneur régional, coordonnent les départements décentralisés des ministères impliqués dans la lutte contre la sous-nutrition. Les CRS organisent des réunions régulières et des visites sur place pour assurer le suivi des actions de nutrition.

e) Analyse des écarts et bilan
Une analyse de la situation nutritionnelle et une évaluation des besoins constituent les éléments prioritaires du prochain plan stratégique (2012-2017). À ces fins, il faudra dresser la liste des priorités, des lacunes et des besoins de nutrition dans les districts de santé. Le programme national de nutrition a été révisé en 2006 dans le cadre du processus de préparation du plan de mise en œuvre de la seconde phase.

f) Engagement d'organisations non gouvernementales
Suite à la politique du gouvernement pour la décentralisation et le développement local, le programme national de nutrition a transféré la gestion des interventions nutritionnelles de la communauté aux autorités locales. Les organisations de la société civile sont impliquées dans le renforcement de la nutrition, les autorités locales ayant recours à des associations ou à des organisations non gouvernementales pour mettre en œuvre les interventions nutritionnelles communautaires.

Le secteur privé devient de plus en plus conscient de sa responsabilité sociale et, par conséquent, il investit toujours davantage dans les activités de développement social. On trouve d'ailleurs des membres du secteur privé au sein du Comité Sénégalais pour la Fortification des Aliments (COSFAM). En ce qui concerne la nutrition, il s'agit du mécanisme principal d'enrichissement des aliments de base comme l'huile de cuisson et la farine. En outre, l'iodation du sel par des petits et moyens producteurs a été renforcée.

g) Prochaines étapes
Le Sénégal développe un nouveau plan stratégique de nutrition pour 2012-2017. Outre la multiplication des interventions nutritionnelles directes, le plan comprendra une analyse de la situation nutritionnelle et des causes. Cette analyse contribuera à identifier les interventions spécifiques requises pour aborder

les différentes facettes de la sous-nutrition au Sénégal. La participation des divers secteurs tels que la santé, l'agriculture et l'éducation sera déterminée.

h) Renforcement des engagements financiers

La nutrition figure dans le budget de l'État et le montant alloué à ce poste augmente chaque année. Il est passé de 0,4 million d'USD (172 millions de CFA) en 2002 à 2,4 milliards (1 172 milliards de CFA) en 2007, et des hausses sont prévues jusqu'en 2016. Cette contribution financière du gouvernement permettra de garantir la viabilité des programmes nutritionnels.

L'allocation du budget à la nutrition dans le contexte des exigences concurrentes des autres secteurs, démontre l'engagement politique du gouvernement en faveur de la nutrition.

Sénégal indicateurs de base

Population totale	12 534 000
Population vivant avec moins d'1 dollar par jour (PPA), pourcentage (2004)	33,5
Espérance de vie à la naissance h/f (années)	60/63
Dépenses totales consacrées à la santé par habitant ($ int.)	102
Taux d'alphabétisation des adultes 2005-08 h/f (%)	52/33

Chiffres donnés pour 2009 sauf mention contraire.

Indicateurs nutritionnels clés

Retard de croissance (rapport taille/âge < -2 ET selon les normes OMS)	20 % (2005)
Émaciation (rapport poids/âge < -2 ET selon les normes OMS)	9 % (2005)
Poids à la naissance (< 2 500 grammes)	19 % (2005)
Maigreur adulte (indice de masse corporelle < 18,5 chez les femmes en âge de procréer)	18 % (2005)
Anémie chez les enfants de 6 à 59 mois (Hb< 11 g/dL)	83 % (2005)
Anémie chez les femmes enceintes (Hb< 11 g/dL)	71 % (2005)
Supplémentation en fer et en acide folique (administrée quotidiennement aux femmes enceintes ≥ 6 mois)	N.D.
Supplémentation en vitamine A (enfants de 6 à 59 mois ayant reçu 2 doses élevées l'an dernier)	90 % (2008)
Supplémentation en iode (ménages consommant du sel iodé)	41 % (2005)
Supplémentation en zinc et thérapie par réhydratation orale (enfants de 0 à 59 mois souffrant de diarrhées)	N.D.
Allaitement exclusif (nourrissons de 0 à 5 mois)	34 % (2005)
Alimentation complémentaire (enfants allaités de 6 - 23 mois avec une alimentation minimum acceptable)	22 % (2005)
Code international de commercialisation des substituts de lait maternel (adopté)	N.D.
Accès aux soins de santé (soignants et agents communautaires / 1 000 habitants)	N.D.
Accès à l'eau (meilleures sources d'eau potable)	69 % (2008)
Sécurité alimentaire (résultat relatif à la consommation alimentaire des enfants de 6 à 59 mois)	N.D.
Taux de mortalité infantile (décès avant 1 an pour 1 000 naissances vivantes - h, f, les deux sexes)	55, 46, 51
Taux de mortalité des moins de 5 ans (décès avant 5 ans pour 1 000 naissances vivantes - h, f, les deux sexes)	99, 86, 93
Taux de mortalité maternelle (nombre annuel de décès de femmes pour 100 000 naissances vivantes)	410 (240-680)
Résultat relatif à la gouvernance nutrition	N.D.

N.D. = Non Disponible

Tanzania

"The Government of the United Public of Tanzania is …. committed to the successful implementation of the SUN initiative. Let me reiterate that the government will work day and night with all partners involved to attain the noble objectives and goals and triumph in the SUN… I'm optimistic that with the Scale-Up Nutrition initiative, Tanzania will reduce drastically the number of undernourished Tanzanians and hence avoiding unnecessary death. Together we can."

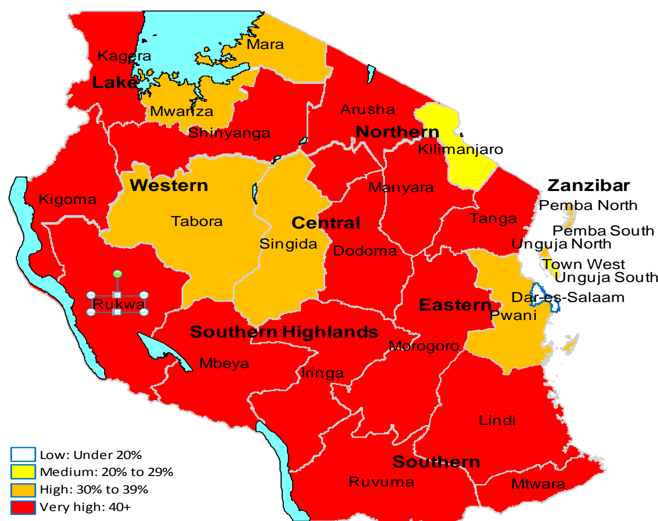
Prime Minister Pinda, June 2011

Country context

Tanzania is an Eastern African country with an estimated population of 43 million people. It is one of the poorest countries in the world in terms of per capita income. The majority (80 per cent) of the labour force work in the agriculture sector and agriculture accounts for 45 per cent of the national Gross Domestic Product. The Gross National Income per capita is US$ 490.

High levels of under-nutrition undermine the country's growth. More than a third of children under five are affected by chronic malnutrition (stunting) and the prevalence is higher in the Southern zone. The diet is based largely on cereals, starches, and pulses (e.g. beans). Lack of dietary diversity contributes to the burden of nutrition-related disease. Anaemia, for example, continues to be a major public health problem.

Figure 1: Stunting levels in Tanzania



Government response

a) Overall vision for scaling up nutrition

The targets for 2015 included in the National Nutrition Strategy include:

1. Reduce the prevalence of stunting in children aged 0-59 months (height-for-age z-score <-2 SD) from 35 per cent in 2010 to 22 per cent.

2. Increase exclusive breastfeeding in children below six months of age from 50 per cent in 2010 to 60 per cent.
3. Reduce the prevalence of vitamin A deficiency among children aged 6-59 months (serum retinol levels <20 µg/dL) from 24 per cent in 1997 to <15 per cent.
4. Reduce the prevalence of anaemia among children aged 6-59 months of age (haemoglobin concentration <11 g/dl) from 71.8 per cent in 2004/5 to 55 per cent.
5. Maintain the prevalence of iodine deficiency among children aged 6-12 years (urinary iodine concentrations <100 µg/l) below 50 per cent.
6. Increase the proportion of mothers who take iron supplementation for more than 90 days during pregnancy and the post-partum period from 10 per cent to 30 per cent.
7. Increase the coverage of adequately iodized salt from 43 per cent to 90 per cent.

b) Commitment to scaling up nutrition

Prime Minister Pinda has fully endorsed Tanzania's support for scaling up nutrition and brought together representatives from government ministries, development partners and civil society for a High Level Meeting on Scaling Up Nutrition in Dar es Salaam in June 2011. This meeting, co-convened by Prime Minister Pinda with the Foreign Ministers of Ireland and the United States, emphasized the importance of the 1,000 Days window of opportunity, and sought to provide a platform to advance the multi-sectoral approach in advancing the National Nutrition Strategy (2010-2015) and Tanzania Agricultural and Food Security Investment Plan.

At the June 2011 meeting, Prime Minister Pinda announced six steps that will be undertaken by the Government of Tanzania to address the nutrition situation and make progress towards achieving the Millennium Development Goals. The steps included:

1. Finalise the implementation plan for the National Nutrition Strategy, which will include clear responsibilities for Government Ministries, development partners, the private sector and civil society;
2. Establish a new High Level National Nutrition Steering Committee led by Government with participation from selected development partners and civil society organizations;
3. Establish a designated line in the national budget for nutrition (effective from the financial year 2012/2013);
4. Integrate nutrition more strongly into agriculture activities as outlined in the Tanzania Agriculture and Food Security Investment Plan;
5. Rapidly establish nutrition focal points at the district level;
6. Gazette, finalise and enforce national standards for micronutrient fortification of oil, wheat and maize flour that were set in 2010.

c) National nutrition plans

The Government of Tanzania has recently developed a draft implementation plan for its National Nutrition Strategy (NNS) (2009-2015). Tanzania's NSS was developed by a range of stakeholders and will be presented to Cabinet for approval in September 2011. The strategy is in-line with, and will contribute to, the National Development Vision 2025, National Strategy for Growth and Reduction of Poverty, the Africa Regional Nutrition Strategy (2005-2015). Nutrition is also included in the Comprehensive Africa Agriculture Development Programme (CAADP). The NSS identifies a set of services that several sectors and agencies need to provide in a harmonized manner in order to establish the conditions under which all Tanzanians can be properly nourished. While it seeks to ensure the nutritional status of all citizens of Tanzania, the major focus is on women of reproductive age and infants aged less than two years since this is the most vulnerable period when under-nutrition can cause lasting damage.

The NSS identifies a set of priority areas which are linked to interventions which have proven feasibility in Tanzania or similar contexts including: (i) infant and young child feeding; (ii) vitamin and mineral deficiencies; (iii) maternal and child under-nutrition; (iv) nutrition and HIV and AIDS; (v) household food security; (vi) nutrition surveillance, surveys and information management. The strategy also identifies a set of eight elements required to ensure the success of nutrition actions including (i) accessing quality nutrition services; (ii) advocacy and behaviour change communication; (iii) legislation for a supportive environment; (iv) mainstreaming nutrition into national and sectoral policies, plans and programmes; (v) institutional and technical capacity for nutrition; (vi) resource mobilization; (vii) research, monitoring and evaluation; (viii) coordination and partnership.

The United States is supporting Tanzania with technical assistance to consolidate, quantify, prioritize and cost the proposed nutrition activities. This will result in a final costed national nutrition implementation plan that will be ready for implementation.

d) Multi-stakeholder platforms

A multi-stakeholder platform is being set up in Tanzania. It consists of the National Nutrition Steering Committee and the Technical Working Group for Nutrition. The National Nutrition Steering Committee is a structured high- level mechanism comprising Permanent Secretaries from relevant sectors (health, agriculture, education, industry, finance, community development, livestock and fisheries, local government, planning) and representatives from development partners, United Nations agencies, civil society, university and business. It is chaired by the Permanent Secretary in the Prime Minister's office. Roles include policy making, coordination, advocacy, advisory role and resource mobilization.

The advantages of the multi-stakeholder platform in Tanzania are that the group is 'multi-sectoral' and 'high level'. It is being formed at a time when nutrition is high up on the national agenda. The National Nutrition Steering Committee is being presided over by the office of the Prime Minister, a strategic position for rallying together sectors and ministries for nutrition action. The multi-stakeholder platform aims to: 1) be a strong voice in advocating for nutrition as prerequisite for national development 2) facilitate the mainstreaming of nutrition in the different sectors, ministries and organizations and 3) bring out issues of concern from the perspectives of the different sectors.

There are other mechanisms of interagency collaboration on nutrition actions. For example, the Tanzania Food and Nutrition Centre (TFNC) is a Government institution established by Act of Parliament in 1973 and mandated to guide, coordinate and catalyze nutrition work in the country. The TFNC is part of the national consultative groups that support the major national nutrition programmes in Tanzania. Each group is chaired by the relevant sector Ministry or institution with TFNC as the secretariat. At present the following consultative groups exist:

- National Consultative Group for Infant and Young Child Nutrition
- National Consultative for Control of Anaemia
- National Council for Control of Iodine Deficiency Disorders
- National Consultative Group for Control of Vitamin A Deficiency
- National Consultative Group for Management of Acute Malnutrition
- National Food Fortification Alliance.

The group advises on policy, implementation guidelines and resource sourcing.

e) Stock-taking and gap analysis

Tanzania is currently planning a joint nutrition assessment to identify the gaps, constraints and opportunities for integrating new and existing effective nutrition actions, using the WHO Landscape Analysis methodology as well as additional methodologies from REACH, including stakeholder and programme mapping tools. This assessment will include an analysis of existing capacities and resources available in the country and identify the promising actions for scaling up through operationalization of the NNS. Additionally, TFNC, supported by the United Nations Children's Fund, is conducting a mapping exercise to assess the current human resource capacity for nutrition at local government level.

f) Engagement of non-governmental agencies

Since September 2010, UNICEF has supported Save the Children to facilitate efforts to create a civil society led partnership for Nutrition in Tanzania (PANITA). Currently, PANITA has a total of 93 civil societies working in nutrition and nutrition sensitive interventions. The partnership was launched by the Minister for Agriculture, Food and Cooperatives on behalf of the Prime Minister, in the presence of representatives of key ministries, development partners, UN agencies and civil society organizations (CSOs). The mission of the Partnership is to advance advocacy efforts, improve coordination and reduce malnutrition by strengthening the capacity of and increased mobilization and coordination of CSOs and other development partners to facilitate a more effective national and local response to addressing malnutrition.

Work done by PANITA in the first year included developing a two year (2011-2013) strategy for the partnership, establishing communication mechanisms to facilitate sharing information and fostering a dialogue among members on strategic nutrition issues, and agreeing on interim and long term governance structure of the partnership. The way forward for PANITA in the next two years will be to participate in the forthcoming policy discussions at national and sub-national level, advocating for implementation of the National Nutrition Strategy and other policies, mobilizing more potential members and influential persons to act as advocate champions on prioritizing nutrition in development plans at all levels, creating awareness to communities on nutrition issues through increased media engagement, and strengthening CSOs at national and sub-national levels to participate in policy, planning, and budgeting for nutrition,

Tanzania basic indicators

Total population	43,739,000
Population below $1 (PPP) per day, percentage (2004)	67.9
Life expectancy at birth m/f (years)	53/58
Total expenditure on health per capita (Intl $)	68
Adult literacy rate 2005-08 m/f (%)	79/66

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	43% (2009-10)
Wasting (weight-for-height < –2 SD of WHO standards	5% (2009-10)
Birth weight (< 2500 grams)	10% (2004-05)
Adult thinness (Body-Mass Index <18.5)	11% (2009-10)
Anaemia in children 6-59 months (Hb < 11 g/dL)	59% (2009-10)
Anaemia in pregnant women (Hb < 11 g/dL)	53% (2009-10)
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	93% (2008)
Iodine supplements (households consuming iodized salt)	59% (2009-105)
Zinc supplements & oral rehydration (children 0-59 months with diarrhoea)	44% (2009-10)
Exclusive breastfeeding (infants 0–5 months)	50% (2010)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	18% (2004-05)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	54% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	70, 66, 68
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	107, 109, 108
Maternal mortality rate (annual number of female deaths per 100,000 live births)	790 (470-1300)
Nutrition governance score	Weak

NA = Not Available.

Uganda

Country context

Uganda's population is estimated at 32 million and is growing at a fast rate of 3.2 per cent per annum. Uganda is classified as one of the least developed countries with a Gross National Income of US$ 38.8 billion and a Gross Domestic Product per capita of US$ 466. Although there have been dramatic successes in poverty reduction efforts in recent years, a quarter of the population continues to live below the poverty line and 31 per cent are classified as food insecure. The country has a high under-nutrition burden, with significant numbers of children under-five years of age stunted, underweight or wasted. A significant percentage of women of reproductive age were also found to be underweight with a body mass index of less than 18.5.

Uganda developed a Uganda Food and Nutrition Policy (UFNP) in 2003, followed by a Food and Nutrition Strategy. In 2008, a Food and Nutrition Bill was drafted to operationalize the UFNP. It established the Food and Nutrition Council and a Secretariat to coordinate implementation of all nutrition interventions. The bill has yet to be enacted into law and new discussions about revising the bill are currently underway.

Government response

a) Overall vision for scaling up nutrition

Uganda's overall vision for scaling up nutrition up until 2015 is to establish a long-term policy to completely end under-nutrition. The main strategy adopted by the Government is targeting under-nutrition among women of reproductive age, infants and young children up to two years of age. This vision and strategy is articulated in the Uganda Nutrition Action Plan (UNAP), which serves as the primary guiding document for the country's response to under-nutrition problems from 2011 to 2016. The UNAP is expected to be launched on 15th September, 2011 by The President of Uganda. Targets for key nutrition indicators have been set for 2015 for children under five and women. These include stunting, underweight, iron deficiency anaemia, low birth weight, exclusive breastfeeding to six months, dietary diversification index, and calorie consumption.

Key Nutrition Outcome Indicators

Outcome indicator	Baseline (UDHS, 2006) %	UNAP target 2015 %
Stunting – % in under-fives	38	32
Underweight – % in under-fives	16	10
Underweight women – non-pregnant women 15-49 years with BMI less than 18.5 kg/m^2	12	8
Iron deficiency anaemia – % in under-fives	73	50
Iron deficiency anaemia - % among women aged 15-49 years	49	30
Vitamin A deficiency – % in under-fives	19	13
Vitamin A deficiency – % among women aged 15-49 years	20	12
Low birth weight - newborns less than 2.5 kg	11	9
Exclusive breastfeeding to 6 months, percent of infants	60	75
Dietary diversification index, percent calories consumed from foods other than cereals & starchy roots	57	75
Calorie consumption (avg. daily energy intake per capita)	2,220 Kcal	2,500 Kcal

b) *Commitment to scaling up nutrition*

The Government of Uganda and development partners are committed to scaling up nutrition. While the finalization of the UNAP is pending, programmes aiming to meet UNAP objectives are already underway.

- The United Kingdom (UK) has supported the Ministry of Health to integrate with SUN.
- Ireland and the World Food Programme (WFP) have initiated cash transfers to Karamoja, the district worst affected by child under-nutrition.
- The United Nations Children's Fund (UNICEF) is supporting the infant and young child nutrition and national level nutrition surveillance for vulnerable communities.
- The National Planning Authority (NPA) and WFP coordinating the Cost of Hunger study under the African Union. Those results will provide an evidence base for nutrition advocacy.
- The United States (US) financed a Cost of Hunger study under the African Union. Those results will provide policymakers and advocates with baseline evidence. The US has also supported Community Link Nutrition programmes that work to integrate Health, Agriculture, Food and Nutrition security and livelihood to enable effective inclusion of child under-nutrition on policy agendas.
- The World Health Organisations (WHO) supported the Ministry of Health to promote breast feeding, initiation of early weaning, growth monitoring, and revised child health cards with new growth standards. WHO also provides management support for acute malnutrition programmes.
- The Food and Agriculture Organisation (FAO) is supporting farmers in seven districts in Uganda in food security, school feeding programmes, household income, nutrition and health in order to prevent child under-nutrition.
- WFP is carrying out Community Based Supplementary Feeding Programmes, School Feeding, De-worming of children in schools, Maternal Child and Health Nutrition Programmes and nutrition awareness and sensitization programmes.

c) *National nutrition plans*

The implementation of the Nutrition Action Plan (UNAP) is set begin in the 2011 fiscal year. The Plan sets out different interventions to be implemented during this period as well as roles and responsibilities for stakeholder organizations. The Plan has been costed and shared with various donors.

d) *Multi-stakeholder platforms*

In 2010, the Government set up a Nutrition Forum to bring together different Government sectors involved in nutrition planning, namely the Ministries of Agriculture, Animal Industry and Fisheries; Health; Education; Local Government; Gender, Labour and Social Development and Trade, Industry and Cooperatives. The Forum also includes civil society organizations as well as the private sector and donor representatives. This Forum is temporary until the Food and Nutrition Law is enacted and the Food and Nutrition Council and Secretariat are established under the Prime Minister's Office.

e) *Stock-taking and gap analysis*

During the last year, the main activity of the Nutrition Forum has been nutrition planning, gathering relevant data on the nutrition conditions of different population sub-groups and charting effective ways to tackle these conditions. This preliminary planning process was spearheaded by the National Planning Authority and culminated in the production of the UNAP (2011 – 2016).

The College of Agriculture Sciences and Nutrition in collaboration with TUFTS University and the US FANTA, organized a collaborative research workshop that helped to identify gaps in the implementation of interventions to improve infant and young child feeding practices. Discussions focused on how research can be used for gap analysis in fighting food and nutrition security and to identify capacity needs for integrated community based nutrition programmes.

f) Next steps

Several donors, including the Governments of the US, UK, Ireland, Canada in addition to the World Bank and other UN organizations, have agreed to help fund UNAP interventions.

The Nutrition Forum is about to undertake two projects: mapping nutrition actors in the whole country and analyzing the action plan against national budget allocation and donor pledges to determine the funding gaps.

United Nations partners, such as WHO, UNICEF, WFP and FAO, have initiated capacity building programmes for implementation of national, district and community level through the UN REACH (Renewed Efforts Against Child Hunger) inter-agency initiative on ending child hunger. The global REACH coordinator visited Uganda and met the chairperson of the NPA and Ministers from key sectors implementing SUN (e.g., Health**,** Agriculture and others like Education and Finance). Currently, a proposal to recruit two technical advisers under the REACH initiative is being reviewed. These advisers would support the coordination of SUN while the process to establish a permanent secretariat for nutrition in the Office of the Prime Minister us underway. NPA also has approved the national focal institution for REACH in Uganda.

g) *Scaling up financial commitments*

Since UNAP was finalized after the reading of the national budget, the Government could only make small commitments in 2011/2012 to scaling up nutrition. However, the Government has promised greater commitment in the next few years. The percentage of the budget going to health is still only 4 per cent and only about 2 per cent of that allocation is assigned to scale up nutrition.

Development partners have also, both individually and under the Joint Nutrition Donor forum, expressed interest in supporting the scaling up initiative. However, no definite commitments have been for UNAP implementation.

Uganda basic indicators

Total population	32,710,000
Population below $1 (PPP) per day, percentage (2004)	28.7
Life expectancy at birth m/f (years)	48/57
Total expenditure on health per capita (Intl $)	115
Adult literacy rate 2005-08 m/f (%)	82/67

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	39% (2006)
Wasting (weight-for-height < –2 SD of WHO standards	6% (2006)
Birth weight (< 2500 grams)	14% (2006)
Adult thinness (Body-Mass Index <18.5)	12% (2006)
Anaemia in children 6-59 months (Hb < 11 g/dL)	73% (2006)
Anaemia in pregnant women (Hb < 11 g/dL)	64% (2006)
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	67% (2008)
Iodine supplements (households consuming iodized salt)	96% (2006)
Zinc supplements & oral rehydration (children 0-59 months with diarrhoea)	54% any ORT - zinc 0.9% (2006)
Exclusive breastfeeding (infants 0–5 months)	60% (2006)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	11% (2006)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	0.19 (2005)
Access to water (improved drinking-water sources)	67% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	89, 69, 79
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	140, 114, 128
Maternal mortality rate (annual number of female deaths per 100,000 live births)	430 (240-670)
Nutrition governance score	Strong

NA= Not Available.

Zambia

"My Government is convinced that investing in high-impact nutrition interventions produces exceptional pay-offs in terms of reduced morbidity, mortality and improved physical and mental growth and that through these interventions Zambia can meet the MDG's and the national vision of becoming a prosperous middle-income country by the year 2030"

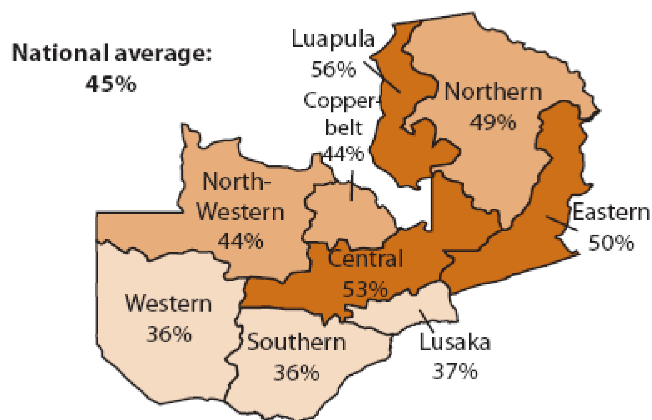
His Excellency Mr. Rupiah Bwezani Banda, President of the Republic of Zambia, at high-level National Nutrition Consultative Forum, February 2011

Country context

Zambia is a landlocked nation located in Southern Africa with a population of approximately 13 million. [13] The economy has experienced strong growth in recent years, with real GDP growth in 2005-2008 of about 6 per cent per year. According to the annual World Bank assessment (July, 2011), Zambia is now classified as a low middle income country. Gross national income per capita is currently estimated to be in the in range of $ 1,006 - 3,975. Despite these economic gains, poverty, food and nutrition insecurity, HIV and AIDS, as well as under-nutrition have remained widespread and chronic challenges to achieving sustainable food and nutrition security in Zambia. The Gini Coefficient of 0.57 (2010)illustrates unequal distribution of income in the country.[14] In fact, 70 per cent of the population cannot afford a minimum cost diet (Cost of Diet Study, World Food Programme 2011).

Chronic under-nutrition (stunting) remains a fundamental threat to the sustainable economic development of Zambia and rates are among the highest in the world. In addition, vitamin A and iron deficiency anaemia affects over half of all Zambian children. More than one in 10 babies are born with low birth weight indicating poor maternal nutrition.

Map 1: Country map highlighting prevalence of stunting by province in children under-five years of age in Zambia



The Zambian Government established the National Food and Nutrition Commission (NFNC), through an Act of Parliament in 1967 and launched a national food and nutrition policy in 2008. Food and nutrition has been one of the priorities on the national agenda in the Fifth and the Sixth National Development Plans.

Government response

a) Overall vision for scaling up nutrition

Zambia's overall vision for scaling up nutrition from 2011 – 2015 is to achieve optimum maternal and child nutritional status during the first 1000 critical days of life. In the long term, the country aims to achieve sustainable food and nutrition security and to eliminate all forms of malnutrition. These goals

13 Central Statistics Office, 2010

[14] UNDPWorld Bank, 201007

are critical for having a well-nourished and healthy population that can contribute optimally to national economic development. The Sixth National Development Plan 2011-2015 aims to reduce stunting in children under five to 30 per cent by 2015.

b) Commitment to scaling up nutrition

In December 2010, Zambia indicated its intent to become a SUN country and join the SUN Movement. A high level National Nutrition Consultative Forum on *Acceleration of Nutrition Actions* was held in Zambia in February 2011 and officially opened by His Excellency, Mr. Rupiah Bwezani Banda, President of the Republic of Zambia. In his official address, the President committed to speeding up nutrition actions over the next five years (2011 – 2015).

The Government's commitment to increasing food and nutrition self-sufficiency was demonstrated by the signing of the Compact for the Comprehensive Africa Agriculture Development Programme (CAADP) in January 2011.

c) National nutrition plans

The Zambian National Food and Nutrition Strategy (NFNS) for the period 2011 to 2015 is currently being finalised. The strategy was developed through a wide consultative process. It sets out clear linkages with other sectors including agriculture, community development and social services, water and sanitation, health and education. However, the NFNS still requires budgeting. The food and nutrition activities in the Sixth National Development Plan have been budgeted under different sectors (health, agriculture, community development and social services and education), but allocations for nutrition activities are generally inadequate. To address this, Zambia has developed a communication and advocacy plan aligned to the NFNS to advocate for increased resources in support of the national nutrition response.

d) Multi-stakeholder platforms

The Government has identified the NFNC as the focal institution to coordinate the support from the donor community and other stakeholders in Zambia.

Multisectoral platforms exist in some programmatic areas such as the National Fortification Alliance, Interagency Coordinating Committee for Maternal Newborn and Child Health, Agricultural Consultative Forum, Vulnerability Assessment Committee, School Health and Nutrition Steering Committee and the Sectoral Advisory Groups (health, social protection, agriculture, water and sanitation, education, and gender and development). These platforms offer an opportunity for integration and mainstreaming of nutrition into sectoral programmes, but effective mechanisms for collaboration, harmonization and synergetic actions on food and nutrition require expanding, strengthening, and supporting.

To improve collaboration on food and nutrition actions, the Zambian Government has proposed a National Food and Nutrition Steering Committee at Cabinet level to spear-head the implementation of SUN activities as part of the National Food and Nutrition Strategic Framework. This will mainly involve decision makers such as Permanent Secretaries from key ministries with a stake in food and nutrition. The National Food and Nutrition Multi-stakeholder Committee will oversee the technical and implementation levels. The Committee's Secretariat is the NFNC and will include participation of key government line ministries, cooperating partners, civil society, and the private sector. For speedy execution of the recommendations from the National Multi-stakeholders committee, the NFNC will operate through the existing or new technical working groups/taskforces as need arises as well as the SUN platforms for cooperating partners, civil society and the private sector. Terms of reference for a

multi-stakeholder forum are being developed and are expected to be finalized at the first multi-stakeholder meeting to be held in September 2011.

e) Stock-taking and gap analysis

A concept note on mapping and gap analysis for the SUN in Zambia has been developed and is under review by the NFNC. The NFNC, as the SUN focal institution, has approached DFID for Technical Assistance for a local and /or international consultant to undertake this task.

f) Engagement of non-governmental agencies

A Nutrition Cooperating Partners (CP) group was created in 2010 and formalized when Zambia became a SUN country in February 2011. It consists of donor agencies from the United Kingdom (UK), Ireland and the United States and includes UN agencies (UNICEF, WFP, and the World Bank). UNICEF and the UK have been designated as co-convening lead agencies. The CP group meets on a monthly basis and are in regular liaison with the NFNC to mobilize support and track progress.

Members of the CP group are already co-funding nutrition activities such as the food consumption and micronutrient assessment and the group is discussing setting up a Pooled SUN Partnership Fund to contribute to financing the NFNS. This fund would allow willing donors to pool their funding and encourage funders to fund collectively agreed activities through their own funding mechanisms.

A SUN Civil Society Organization forum is being created. Participating members have started aligning their efforts to the SUN Roadmap. They are developing a concept note to mobilize resources for advocacy on the SUN/1000 days campaign.

g) Next steps

The SUN process is facing a number of on-going challenges, including:

- Limited involvement of the media and/or insensitive media to nutrition including the private sector;
- Limited, erratic and non-coordinated funding for nutrition from government and partners;
- Delay in carrying out the mapping and gap analysis;
- Delay in launching SUN because of the general elections;
- Limitated multi-sector coordination;
- Non availability or limited number of civil society organizations to directly champion nutrition issues;
- Limited and fragmented interventions by local and international NGOs (though there is an increasing number of them);
- Lack of established or formalised private sector forum in the context of the SUN movement.

To expedite the SUN processes, in the coming few months the NFNC and Nutrition CPs will step up efforts to:

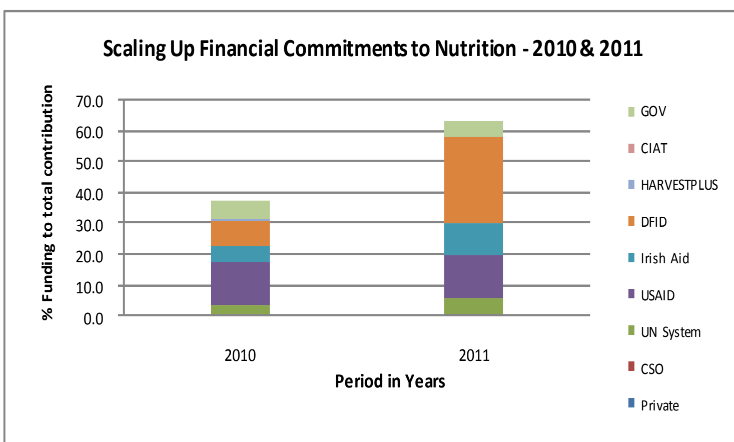
1. Solicit technical assistance for the nutrition interventions mapping /gap analysis as well as the costing of the NFNSP. This will inform the development and costing of the 1000 days programme as part of the NFNSP which should be ready for implementation by early 2012 and
2. Hold the first multi-stakeholder meeting in September 2011, where it is expected that stakeholders and partners will agree on priorities for the next four months.

Special attention will be paid to the following:

1. Drawing up investment portfolios for the strategy to guide the mobilization of resources from government, donor communities, civil society, private sector, and stakeholders for its implementation;
2. Technical assistance from CPs and SUN Taskforces to build in-country capacity for accelerated action;
3. Mobilization of national civil society organizations to champion nutrition issues including high level in-country advocacy to lobby for increased budgetary allocation from the national treasury to match resources with the existing high burden of malnutrition.. This extends to advocating for increased financial support to accelerate the implementation of the strategy. that includes high impact nutrition interventions;
4. Establishing a functional Monitoring and Evaluation (M&E) system to track progress and impact on reducing under nutrition in Zambia;
5. Mobilize the private sector to establish the private sector forum to feed into the MSP; and
6. Strengthening stakeholder coordination at all levels.

h) Scaling up financial commitments

The total combined financial commitment to nutrition from different sources has steadily increased from almost 37 per cent in 2010 to 63 per cent in 2011. As illustrated in the figure below, substantial increase in the financial commitment was from DFID whose financial envelope commitment expanded by more than 50 per cent.



Notes:

a) The United Nations (UN) System financial commitment includes contribution only from the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization (FAO), the World Food Program (WFP). WFP funding only refers to funding directly disbursed to the National Food and Nutrition Commission (NFNC) through an agreement. FAO contribution reflected is for 2010 only.

b) Government (Gov) commitment reflects financial allocation to the NFNC, Food & Nutrition Section under the Ministry of Agriculture, and Nutrition section of the Ministry of Health. Other sources of commitment from other Gov line ministries such as community development and social services, water, sanitation, health and education were not available at the time of reporting.

c) Other funding tracked includes projects financed by the International Centre for Tropical Agriculture (CIAT) and Harvest Plus though signed agreement with the NFNC.

d) The financial commitment from the Department for International Development (DFID) also includes projected finance subject to approval by DFID.
e) United States Agency for International Development. Financial commitment includes financing through USAID projects
f) Exchange rates used are 1 USD to ZMK 4,930; 1 Euro to ZMK 7, 120; and 1British Sterling to ZMK 8,149.
g) Financial contribution from Civil Society Organizations (CSOs) includes CARE, Concern Worldwide, and Heifer International.

Case Study

A social cash transfer (SCT) to poor households in Zambia has been implemented on a pilot basis in three districts namely Chipata (urban), Kalomo (peri-urban) and Kazungula (rural remote) focussing on households with high dependency ratios, high incidences of households heads who are elderly, orphaned, female or widowed. These are the mostly labour constrained of the ultra-poor. A fundamental objective of all SCTs is to reduce hunger in poor households, by enhancing their access to food and other basic needs. Associated with the SCTs is the child grant scheme which has a direct link to scaling up nutrition/1000 critical days campaign.

Results from the pilot indicated increased expenditure on food consumption in the two rural districts (Kazungula and Kalomo). An evaluation report revealed increased food consumption by beneficiaries as a consequence of the incremental purchasing power provided by SCTs (Tembo and Freeland, 2008). Furthermore it was found that reported hunger decreased, while meals per day and dietary diversity both increased, as a direct result of receiving cash transfers. On the contrary in the urban district (Chipata) SCTs resulted in raising non-food consumption expenditure.

Zambia basic indicators

Total population	13,046,508
Population below $1 (PPP) per day, percentage (2004)	64.3
Life expectancy at birth m/f (years)	46/50
Total expenditure on health per capita (Intl $)	68
Adult literacy rate 2005-08 m/f (%)	81/61

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	45% (2007)
Wasting (weight-for-height < –2 SD of WHO standards	6% (2007)
Birth weight (< 2500 grams)	10% (2007)
Adult thinness (Body-Mass Index <18.5)	10% (2007)
Anaemia in children 6-59 months (Hb < 11 g/dL)	53% (2003)
Anaemia in pregnant women (Hb < 11 g/dL)	47% (1998)
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	92% (2009)
Iodine supplements (households consuming iodized salt)	94% (2002)
Zinc supplements & oral rehydration (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	61% (2007)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	25% (2007)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	NA
Access to water (improved drinking-water sources)	60% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	70 (2007)
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	119 (2007)
Maternal mortality rate (annual number of female deaths per 100,000 live births)	591 (2007)
Nutrition governance score	Medium

NA= not available.

Zimbabwe

Country context

Zimbabwe is a Sub-Saharan African country with an estimated population of 12.5 million. While the Gross National Income for Zimbabwe is not available, the country has experienced growth despite recent unrest. In spite of this, more than half of the population in Zimbabwe continues to live in poverty. In 2003, 53 per cent of the urban population and 63 per cent of the rural population was estimated to be living below the food poverty line (Poverty Assessment Study Survey 2003).

The food security situation in Zimbabwe is fragile. While food availability in the country continues to improve, the country still faces a national food availability deficit (Zimbabwe Vulnerability Assessment Committee - ZIMVAC 2010). Access to sufficient, diverse and good quality food is a persistent and significant problem for the majority of Zimbabweans (National nutrition Survey 2010; Rural Livelihoods Assessment 2010). Post harvest management of food has been identified as a major factor affecting food safety and food losses. Under-nutrition in Zimbabwe has increased steadily over the past two decades. Between 1994 and 2010 alone, rates of stunting have increased by nearly 40 per cent (UNICEF A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005-2010). Approximately one in three children under five years of age is currently stunted in Zimbabwe.

In Zimbabwe, gains are vulnerable due to the decline in the percentage of the population with access to improved water, between 2006 and 2009. This is also exacerbated by a decline in nutrition and hygiene education services. Currently the water sector faces many challenges and the recent economic decline has led to a dramatic deterioration in the quality and reliability of water services.

Government response

a) Overall vision for scaling up nutrition

Zimbabwe's Food and Nutrition Council (FNC) has recently led a process, in collaboration with multiple sectors and stakeholders to develop a national Food and Nutrition Security Policy for Zimbabwe. The policy provides a strategic and practical way forward for addressing existing legal frameworks as well as national commitments and planning documents such as the Millennium Development Goals, and the Medium Term Plan (2011-15).

b) Commitment to scaling up nutrition

While Zimbabwe has a long commitment to addressing food and nutrition security through multi-sectoral action, it has only recently officially joined the SUN Movement in July 2011. The FNC, situated in the Office of the President, is mandated as the lead Government institution to "*promote a cohesive national response to the prevailing household food and nutrition insecurity through co-ordinated multi-sectoral action".* At the request of the Government, the Swiss Government has been identified as the convening donor for the SUN.

The Government, through the FNC, is in the process of strengthening a number of multi-stakeholder platforms. For example, FNC and partner Ministries are strengthening Food and Nutrition Security Committees which will play a critical role in convening multi-sectoral assessments, programmes, policy implementation at the sub-national level.

c) National nutrition plans

This year, the FNC has undergone a strategic planning process and developed a FNC Strategy (2011 – 13): Promoting Food and Nutrition Security in the Context of Economic Growth. Some financial resources (Government and non-Government) have already been secured to meet key outputs. The FNC has also begun a process to "Strengthen Food and Nutrition Security Analysis in Zimbabwe" (May 2010). As part of this overall system, a conceptual framework, a defined technical tool box of instruments and defined institutional accountabilities, which underpin and are necessary for a coherent food and nutrition security information system in Zimbabwe.

d) Multi-stakeholder platforms

The FNC and its associated co-ordination mechanisms have long provided an important platform for multi-sectoral collaboration. FNC continues to coordinate nutrition work by several Ministries (including labour and social services, agriculture, health, local government, women, water, education), the United Nations (UN) agencies and non-governmental organisations (NGOs), particularly in assessments, multi-sectoral programming and policy development.

While the nutrition sector itself has been underfunded in Zimbabwe, a number of development partners continue to provide substantive support for indirect interventions addressing food and nutrition security in the country, including most significantly through the food and agricultural sector, the water and sanitation sector, the health sector and the social protection sector.

- **Co-ordination structures:** Supported and led by the UN and co-chaired by the Government, the Nutrition Cluster, the Agriculture Cluster, the WASH cluster and Food Aid Working group have provided important interim coordination capacity for the relevant nutrition sectors in Zimbabwe. Rather than creating an inter-cluster mechanism, the UN is supporting the FNC to provide a multi-sectoral coordination function.
- **Funding and programme planning mechanisms that impact directly and indirectly impact on nutrition:** A number of important mechanisms are established and evolving. For example, in strengthening livelihoods, agriculture and food security, a number of donors, are supporting twenty NGOs though the Protracted Relief Programme while the US is supporting a consortium of NGOs under their 'PRIZE' programme. In the health sector, a Health Transition Fund (HTF) is being established to support Government priorities including support for the scale up of high impact nutrition interventions. In the social protection sector, the donors are supporting a Government-led National Action Plan II (2011 – 15) through the United Nations Children's Fund that will aim to provide cash transfers to extremely poor households.

e) Stock-taking and gap analysis

Important baselines studies, such as the National Nutrition Survey (July 2010), ZIMVAC rural and urban livelihood assessments have been conducted. These have been used in Government budget and planning processes as well as to advocate for resources.

Donor, UN and NGO contributions (in terms of technical, logistical and financial contributions) are supporting further national assessments led by Government. In particular, the ZIMVAC rural and urban assessments, the national nutrition survey and the famine early warning system as well as the Household Food Economy baseline studies have proved to be important instruments for national planning. An efficacy study, led by a coalition of development partners is exploring the contribution that water, sanitation and hygiene practices play towards growth faltering in Zimbabwe. This research will have important implications for prioritizing programmes and strategy including in the water and sanitation sector, to addressing the increasing prevalence of stunting in the country.

f) Next steps

A comprehensive financial tracking system for food and nutrition security (through multi-sectoral action) for Zimbabwe has not yet been established. Despite the well-recognized challenges to do a multi-sectoral analysis, this will be priority for the FNC to complete in 2011 in collaboration with relevant Ministries and partners.

g) *Scaling up financial commitments*

Existing analysis of available information suggests that the nutrition sector is underfunded. For example, only 14 per cent (US$ 2 million) of the requested funding for nutrition under the Consolidated Appeal Process 2011 (total of US$ 14 million) has been received. Including additional sources such as CERF (supplementary funding) as well as funding that is available through development funding channels, the current financial commitment for nutrition is an estimated $US 6 million. This does not include commitments in other sectors such as agriculture and food security, WASH, health, social protection and education sectors that aim to address the underlying causes of under-nutrition. Nor does this analysis include the contributions of the Government and business. Further analysis will be necessary to do a more comprehensive and accurate analysis.

An estimated 60-70 per cent of the total funding for nutrition that is available is through emergency funding mechanisms that have focused on acute under-nutrition. As the country moves towards an increasingly development agenda, it will be important to secure longer-term funding for nutrition programming.

Case Study

Development of a Food and Nutrition Security Policy: Ensuring national ownership among multiple sectors

The process for developing the Food and Nutrition Security Policy in Zimbabwe has been led by the FNC under the oversight of a Government-mandated multi-stakeholder and multi-sector Task Force. From the outset of the process, a road-map was agreed that informed an extensive consultative process which engaged nation-wide representatives in multiple sectors. As defined in the road-map, there were four phases in the policy development process. In Phase 1 (*Preparation Phase*) national structures, capacities, experts, resources and mechanisms, including a National Steering Committee (NSC), were put in place to support a multi-sectoral approach to the policy development process. Extensive advocacy on the need and ownership of a policy was undertaken with senior Government representatives in different Ministries. A literature review*, Situational Analysis* of the relevant sectors associated with food and nutrition security, including a trend analysis and review of different sector mandates, policies and strategies was undertaken to inform the process. In Phase 2 (*Consultation Phase*) an integrated (multi-sectoral) food and nutrition security framework of analysis was developed with the NSC which informed the development of instruments for consultation and analysis. Representatives from multiple sectors in Government, UN, NGOs, private sector and civil society in all Provinces and most Districts were consulted through semi-structured interviews and focus group discussions. These consultations were facilitated by both Provincial and National Consulting Teams led by representatives from Government Ministries in agriculture, health and labour and social services. At national level, Government-led consultations were held with the relevant technical sectors including in economics, nutrition, food safety and standards, agriculture and social protection. Phase 3 (*Consolidation Phase*) provided an opportunity to reflect on outcomes and findings from the participatory consultations at sub-national level, technical meetings at national level and the *Situation Analysis*, the NSC drafted a set of Commitments and associated Strategic Objectives. This formed the basis for drafting of the Policy which was shared with Government and partners.

Zimbabwe basic indicators

Total population	12,523,000
Population below $1 (PPP) per day, percentage (2004)	NA
Life expectancy at birth m/f (years)	47/50
Total expenditure on health per capita (Intl $)	56
Adult literacy rate 2005-08 m/f (%)	94/89

Figures are for 2009 unless indicated.

Core nutrition indicators

Stunting (height-for-age < –2 SD of WHO standards)	32% (2010)
Wasting (weight-for-height < –2 SD of WHO standards	3% (2010)
Birth weight (< 2500 grams)	11% (2005-06)
Adult thinness (Body-Mass Index <18.5)	9% (2005-06)
Anaemia in children 6-59 months (Hb < 11 g/dL)	58% (2005-06)
Anaemia in pregnant women (Hb < 11 g/dL)	47% (2005-06)
Iron& folic acid supplements (mothers received daily for ≥ 6 months of pregnancy)	NA
Vitamin A supplements (children 6–59 months who received 2 high doses in last year	20% (2008)
Iodine supplements (households consuming iodized salt)	91% (2007)
Zinc supplements & oral rehydration therapy (children 0-59 months with diarrhoea)	NA
Exclusive breastfeeding (infants 0–5 months)	32% (2010)
Complementary feeding (breastfed children 6–23 months with minimum acceptable diet)	13% (2005-06)
International Code of Marketing of Breast-milk Substitutes (adopted)	Yes
Access to health care (community and traditional health workers / 1000 population)	0.04 (2004)
Access to water (improved drinking-water sources)	82% (2008)
Food security (food consumption score for children 6-59 months)	NA
Infant mortality rate (death before age 1 year per 1000 live births - m, f, both)	59, 54, 56
Under 5 mortality rate (death before age 5 years per 1000 live births - m, f, both)	93, 86, 89
Maternal mortality rate (annual number of female deaths per 100,000 live births)	790 (410-1200)
Nutrition governance score	NA

NA= Not Available

Annex 1: Indicators and Definitions

Nutrition indicators	Definition of indicator
Proportion of stunted children < 5 years[0]	Height-for-age < –2 standard deviations of the WHO Child Growth Standards median
Proportion of wasted children < 5 years [0]	Weight-for-height < –2 standard deviations of the WHO Child Growth Standards median
Proportion of babies born with low birth weight[1]	Weight at birth of < 2500 grams (5.5 pounds)
Proportion of thin women of reproductive age[2]	Degree of thinness based on Body-mass Index (BMI)
	BMI 17.0 - 18.49 = mild thinness
	BMI 16.0 - 16.99 = moderate thinness
	BMI <16.0 = severe thinness
Proportion of children < 5 years with Hb[8] concentration of < 11 g/dL[3]	Children 6-59 months with Hb[8] < 11 g/dL at sea level
Proportion of women of reproductive age (15-49 years)[3]	Pregnant women with Hb < 11 g/dL at sea level
	Non-pregnant women with Hb < 12 g/dL at sea level
	Breastfeeding women with Hb < 12 g/dL at sea level
Proportion of pregnant women receiving iron & folic acid supplements[4]	Women who received daily iron & folic acid supplements for at least 6 months of pregnancy
Proportion of children under < 5 years who have received two doses of vitamin A supplements[5]	Children 6–59 months who received two high doses of vitamin A supplements within the last year.
Proportion of households consuming iodized salt[6]	Households consuming iodized salt.
Proportion of children (0 – 59 months) with diarrhoea who received oral rehydration therapy and therapeutic zinc supplements[4]	Children 0 – 59 months who had diarrhoea and were treated with oral rehydration salts or an appropriate household solution and were given zinc as part of the treatment for acute diarrhoea.
Median urinary iodine concentration (µg/L) in children 6-12 years[3]	Median urinary iodine concentration in children 6-12 years (< 100 µg/l indicates that the iodine intake is insufficient).
Proprotion of children < 6 months who are exclusively breastfed[7]	Infants 0–5 months exclusively breast fed.
Proportion of children receiving a minimum acceptable diet at 6-23 months[8]	Composite indicator: Breastfed children 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day and, non-breastfed children 6–23 months who received at least two milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day.

Legal frameworks	Definition
Adoption and effective implementation of International Code of Marketing of Breast-milk Substitutes[9]	This indicator is defined on the basis of whether a government has adopted legislation for effective national implementation and monitoring of the International Code of Marketing of Breast-milk Substitutes.
Human resources	**Definition**
Ratio of community health workers to total population:[10]	Community and traditional health workers / 1000 population
Water and sanitation	**Definition**
Proportion of population with sustainable access to an improved water source[11]	Improved drinking-water sources are defined in terms of the types of technology and levels of services that are likely to provide safe water.
Food security	**Definition**
Individual Food Consumption Score (FCS) of children < 5 years[12]	Proxy indicator that represents the dietary diversity, energy and macro and micro (content) value of the food that people eat. It is based on dietary diversity – the number of food groups a household consumed in the last 7 days; food frequency – the number of days on which a particular food group is consumed in the last 7 days; and the relative nutritional importance of different food groups.
Mortality	**Definition**
Infant mortality rate (year 2009, source WHS 2011): male, female, sexes combined[13]	Probability of dying between birth and 1 year per 1000 live births.
Under five mortality rate (/ 10000/day), (year 2009, source WHS 2011): male, female, sexes combined[13]	Probability of dying between birth and 5 years per 1000 live births.
Maternal mortality ratio (per 100,000 live births); year 2008, source WHS 2011[14]	Annual number of female deaths from any cause related to or aggravated by pregnancy and childbirth or within 42 days of termination of pregnancy, per 100,000 live births.
Nutrition governance	**Definition**
Governance score[15]	1. Existence of an intersectoral mechanism to address nutrition;
	2. Existence of a national nutrition plan / strategy,
	3. Adoption of a national nutrition plan/strategy?
	4. Nutrition included in the national development plan?
	5. Existence of a national nutrition policy;
	6. Adoption of a national nutrition policy?
	7. Allocation of budget for implementation of the national nutrition plan, strategy or policy;
	8. Regular nutrition monitoring and surveillance;
	9. Existence of a line for nutrition in the health budget
	10. Existence of a line for nutrition in the agricultural budget
	11. Existence of a line for nutrition in the social development budget

Footnotes to tables of indicators

[0] WHO Global Database on Child Growth and Malnutrition; and preliminary DHS Burkina Faso, Malawi and Zimbabwe
[1] http://www.childinfo.org/low_birthweight_table.php
[2] NLiS and new data
[3] NLiS and VMNIS
[4] DHS
[5] UNICEF database
[6] NLiS/UNICEF and new DHS Tanzania
[7] WHS 2011 and preliminary DHS Burkina Faso, Malawi and Zimbabwe
[8] Re-analyses of DHS data and new surveys
[9] GPR 2010
[10] Global Atlas of Health Workforce (accessed 21/07/11); and Mozambique MoH
[11] www.wssinfo.org - 2008 estimates; identical to WHS Table 5
[12] WFP
[13] WHS 2011, Table 1; male female, sexes combined
[14] WHS 2011, Table 2
[15] WHO Global Nutrition Policy Review 2010,
WHO Global Database on Nutrition Policies and Programmes 2011
Various Landscape Analysis country assessment
Country papers presented at the Regional consultations on Scaling up Nutrition in the Africa Region (for Anglophone countries in Harare, Zimbabwe, 3 - 5 May 2011 and for Francophone countries in Ouagadougou, Burkina Faso, 4 - 6 July 2011)