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2004

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Integrating SODIS into the community: the experience of Mekomba, Cameroon

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How to cite

MOTAMED, Sandrine, STOLL, Beat. Integrating SODIS into the community: the experience of Mekomba, Cameroon. In: SCN News, 2004, n° 28, p. 78–80.

This publication URL: <https://archive-ouverte.unige.ch/unige:125188>

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UNITED NATIONS SYSTEM

Number 28, July 2004
ISSN 1564-3743

STANDING COMMITTEE ON NUTRITION

Nutrition and the Millennium Development Goals



SCN NEWS

A PERIODIC REVIEW OF DEVELOPMENTS IN INTERNATIONAL NUTRITION

SCN NEWS provides information on issues of importance and sharing of experiences in the field of international nutrition. All manuscripts submitted for consideration are peer-reviewed, although publication is not guaranteed. Overall editorial control is retained by the SCN Secretariat. Every effort is made to ascertain the validity of the information contained in SCN publications. Contributing authors are responsible for the accuracy of references. Manuscript guidelines are available at www.unsystem.org/scn. Items published by the SCN Secretariat do not imply endorsement of views given, nor necessarily the official positions taken by the SCN and its member agencies. The status of quotes and other material is generally indicated in the text and/or sources.

SCN NEWS is issued in July and December each year by the United Nations System Standing Committee on Nutrition. Your contributions to future issues are most welcome; please send these to scn@who.int

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This issue of **SCN NEWS** was edited by Andrea D Moreira, MPS ID. Cover illustration by Lindsay Guillespie.

SCN NEWS
is printed by the
Lavenham Press
United Kingdom

ISSN 1564-3743



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**WE GRATEFULLY ACKNOWLEDGE FUNDING ASSISTANCE FROM
THE GOVERNMENT OF THE NETHER LANDS , FANTA AND USAID*
FOR THE PREPARATION AND PRINTING OF THIS ISSUE OF SCN NEWS**

*THIS PUBLICATION WAS MADE POSSIBLE THROUGH THE SUPPORT PROVIDED TO THE FOOD AND NUTRITION TECHNICAL ASSISTANCE (FANTA) PROJECT BY THE OFFICE OF HEALTH, INFECTIOUS DISEASES, AND NUTRITION OF THE BUREAU FOR GLOBAL HEALTH AT THE US AGENCY FOR INTERNATIONAL DEVELOPMENT, UNDER THE TERMS OF COOPERATIVE AGREEMENT No. HRN-A-00-98-00046-00 AWARDED TO THE ACADEMY FOR EDUCATIONAL DEVELOPMENT (AED). THE OPINIONS EXPRESSED HEREIN ARE THOSE OF THE AUTHOR(S) AND DO NOT NECESSARILY REFLECT THE VIEWS OF THE US AGENCY FOR INTERNATIONAL DEVELOPMENT.

CHAIR'S ROUND UP

July heralded the arrival in Geneva of Dr Roger Shrimpton to take up the position of SCN Secretary. Dr Shrimpton brings to the SCN over 30 years of experience in international nutrition and development, having spent considerable time working in Brazil and Indonesia. Most recently he was an independent consultant, and prior to that Chief of Nutrition at UNICEF Headquarters in New York. On behalf of the SCN family and *SCN News* readers I am delighted to extend a very warm welcome to Roger, I look forward to working with him.

This issue of *SCN News* reports on the proceedings of the 31st Session Symposium and meetings of the SCN Working Groups during the week of 22 March 2004 at the UN Headquarters, New York. The focus of the week was *Nutrition and the MDGs*. A special thanks to Dr Eileen Kennedy and Dr Rainer Gross for their tireless effort in making the Symposium a success. Dr Gross also provides an introduction to the Symposium proceedings. A copy of the 31st Session Report in its entirety can be downloaded from the SCN website www.unsystem.org/scn/

Next year's Session will be hosted by the Government of Brazil, in Brasilia, from 14 to 18 March 2005. The session will again focus on *Nutrition and the MDGs*, but in the context of the right to food and nutrition. A series country case studies are being developed, looking at how nutrition has been incorporated into National Development Plans and poverty reduction strategies. The programme, along with details about how to register for the Session, will be posted on the SCN website in late autumn.

This issue of *SCN News* continues the special series of interviews with former SCN Chairs. Sir Richard Jolly (SCN Chair 1995-2000) talks about memorable SCN achievements during his time as Chair and the contributions the United Nations and its agencies have made to human development, especially health and nutrition, over the last 60 years. Sir Richard leaves us with a call to action to embrace new opportunities and tackle challenges.

I am also pleased to announce a call for proposals for the 9th Dr Abraham Horwitz Lecture (see inside back cover). This lecture series is an important aspect of SCN Symposia providing young students and professionals an opportunity to share their creative ideas towards combating malnutrition. Warm congratulations to Susan Keino from Kenya, for having delivered such an excellent and richly illustrated lecture at this year's Symposium in New York. Her lecture is published in this issue.

July 2004 saw several other key appointments within the SCN network. Congratulations to Dr Denise Costa Coitinho (formerly Senior Lecturer and Coordinator of the Food Security and Nutrition Policies Observatory, Public Policies Research Unit, University of Brasilia) who joined WHO as Director, Nutrition for Health and Development; to Dr Lawrence Haddad (formerly Director, Food Consumption and Nutrition Division, IFPRI) who became the Director, Institute of Development Studies, Sussex; and to Dr Eileen Kennedy (formerly Columbia University) who joined Tufts University as Dean, Friedman School of Nutrition Science and Policy. We also said farewell to Dr Venkatesh Iyengar, IAEA, who valiantly served on the SCN Steering Committee for several years—we wish you the very best in your retirement.

Lastly, I am very pleased to share with you the latest edition of the *Food and Nutrition Library* (3.0) included with this issue of *SCN News*. This extremely valuable reference tool was produced by Dr Michel Loots and his team at the Human Info NGO. The updated CD-ROM contains over 900 publications from UN and bilateral agencies and NGOs. Please contact the SCN Secretariat if you would like to receive more copies.

Catherine Bertini

Chair
Under-Secretary General, UN

SCN SPOTLIGHT

In June 2004, Sir Richard Jolly provided the following interview to SCN News. Sir Richard is currently based at the Institute for Development Studies, Sussex and is documenting the United Nations' role in economic and social progress over the last 55 years. The SCN benefited greatly from Sir Richard's leadership during his time as Chair. We are delighted that Sir Richard remains a supporter of the SCN and has recently stopped by the Secretariat to welcome the new Secretary, Dr Roger Shrimpton.

SIR RICHARD, YOU WERE SCN CHAIR FROM 1995 TO 2000. WHAT STANDS OUT AS THE SCN'S MOST IMPORTANT AND MEMORABLE ACHIEVEMENT DURING THIS TIME?

Without a doubt, the preparation of the three interrelated major SCN documents: the final report to the SCN by the Commission on the Nutrition Challenges of the 21st Century (January 2000), the *4th Report on the World Nutrition Situation* (February 2000), and the SCN's Strategic Plan (April 2000). My experience in the UN has long convinced me that UN bodies like the SCN have a major role in setting future goals and objectives and the Commission Report made a major contribution to this end. The *Fourth Report* provided the data base on which such future plans could be built on—and against which future progress could be assessed, region by region and country by country. The Strategic Plan showed how collaboration could be most productive if focused on and built around the pursuit of common goals and objectives.

But there were many other important achievements in the assessment and mobilization of further progress in key areas of nutrition—for example, guiding and mobilizing action to tackle the “hidden hunger” of micronutrients, developing guidelines in the difficult area of breastfeeding and HIV/AIDS, strengthening links with the Asian Regional Development Bank and issuing technical reports and papers, especially those that emerged from *SCN News*.

The SCN is one of the few UN collaborative groups that has had a major positive impact over its history. If you look back over the first 21 years of the SCN as documented by George H Beaton, you will see that the SCN has played a very important role in promoting nutrition internationally and nationally. Long ago the SCN moved beyond the “show-and-tell” of many other collaborative groups and helped identified priority needs in nutrition on a worldwide scale and priority opportunities based on the latest nutritional science. This means that the SCN has done and still, I hope, does much more than just co-ordinate—it identifies challenges and encourages and organizes responsive action among the UN agencies and related bodies. This underlines another strength of the SCN: it has involved donors and other government and non-government organizations, not just UN agencies. It has not been the only UN collaborative group to do this and take real initiatives, but it is one of the few. The SCN thus offers a challenge to others involved in UN coordination to be leaders and encourage action by the UN in partnership with others.

YOU WERE ALSO CHAIR OF THE WATER SUPPLY AND SANITATION COLLABORATIVE COUNCIL (WSSCC) FROM 1997 TO 2003. WHAT LINKS DO YOU SEE BETWEEN THE SCN AND THE WSSCC?

There are important parallels between the work of the SCN and that of the WSSCC. In some respects, the WSSCC was rather more successful in preparing and promoting *Vision 21*—its report published in 2000 which elaborated goals and supportive actions for water, sanitation and hygiene towards targets for 2015 and 2025. *Vision 21* had strong support throughout the WSSCC and was not hampered by some of the challenges faced by the SCN at the time. In particular, FAO believed that the SCN should not be preparing a report on nutrition goals and objectives (see the Commission Report *Ending Malnutrition by 2020: an Agenda for Change in the Millennium*) and that technical work should be left to the specialized agencies. These internal challenges to the work of the SCN curtailed some of its impact and meant that the WSSCC has probably had more of an impact on action.

Another point of similarity between the SCN and the WSSCC is the important, indeed vital role, played by the technical or executive secretaries. It is said about the Secretary General of the UN, that member governments cannot make up their minds whether they want a secretary or a general. In a lesser way, some members of the SCN cannot decide whether they want a note taker or a technical or executive secretary. I have no doubt in my mind that all effective coordinating bodies of the UN need

someone in this position who is able and willing to take initiatives and provide strong professional leadership. The SCN has been blessed over the years with such persons—John Mason, initially, then Sonya Rabeneck, backed up and supported by efficient organizers like Jane Hedley.

YOU ARE CURRENTLY INVOLVED IN DOCUMENTING THE UN'S ROLE IN ECONOMIC AND SOCIAL PROGRESS OVER THE LAST 55 YEARS. WHAT ARE SOME OF THE HIGHLIGHTS THAT YOU HAVE COME ACROSS IN YOUR RESEARCH, WHICH YOU BELIEVE, HAVE HAD THE MOST IMPACT ON HEALTH AND NUTRITION TODAY?

It will be the UN's 60th anniversary next year. The UN Intellectual History Project (an independent project based in the City University of New York—www.unhistory.org) is beginning to show how the UN, over the whole period of its existence, has made many contributions in the economic and social arena, frequently with more success than it has managed to achieve in political and humanitarian matters. Health and nutrition have been part of the UN's work and sometimes an important part of its success—not alone, of course, but working with countries and in setting global norms and standards. Some of the success is shown by the significant reductions in the proportion of children underweight and stunted, as well as by the impressive increases in life expectancy and the dramatic reduction in child mortality. For all the problems remaining, almost all the improvements have exceeded what was expected in the early years of the UN. WHO, UNICEF, WFP, UNFPA, UNDP and most of the UN agencies have had some part in all of these successes—by specific focused actions and by encouraging countries to adopt approaches to development directed at poverty reduction, human rights, and human needs, with particular attention to children and women. Unlike the World Bank and the IMF, the UN from the beginning has followed a multi-disciplinary approach, with the UN bodies like UNICEF, UNDP, WFP, UNFPA and UNHCR having a high proportion of their staff living and working in developing countries. But let me add that over the last five or ten years, partly in response to the leadership of the present Secretary General, the World Bank and the IMF have been working more closely with the rest of the UN—most recently in support of the Millennium Development Goals (MDGs). This has strengthened our collaboration.

YOU WERE ALSO THE ARCHITECT OF UNDP'S HUMAN DEVELOPMENT REPORT (HDR) FROM 1996-2000. LAST YEAR'S REPORT WAS ON THE MDGs: A COMPACT AMONG NATIONS TO END HUMAN POVERTY. HOW DO YOU THINK THIS LATEST UN COMMITMENT WILL AFFECT ECONOMIC AND SOCIAL DEVELOPMENT?

As indicated above, I see the MDGs as the culmination of several decades of UN experience in setting global objectives and mobilizing action towards them. These goals have had a bigger impact on country performance and development achievement than many people seem to realize (see page 40 of HDR 2002 for a summary of the evidence). But whether the MDGs will achieve similar impact is not evident but will reflect the commitments and efforts of people, communities and governments the world over. Things started well, but war and conflict, especially the Iraq war, have caused major setbacks—destabilizing societies, consuming resources, and distracting leaders from the concentrated efforts that poverty reduction on a global scale will require. The problems of Sub-Saharan Africa are the most serious—and international action and support are vital, on a much bigger scale than at present. But the polarization between the West and the rest, especially the hundreds of millions in the Islamic world, has added other complications, which desperately need attention.

DURING YOUR TIME AS CHAIR, THE 3RD AND 4TH REPORTS ON THE WORLD NUTRITION SITUATION WERE RELEASED BY THE SCN SECRETARIAT. THE 3RD REPORT PROVIDED IMPORTANT MATERIAL FOR IDENTIFYING THE NEW POSSIBILITIES AND CHALLENGES FACING NUTRITION. THE 4TH REPORT STRESSED THE NEED TO MOVE AHEAD IN CREATIVE PARTNERSHIPS TO ADDRESS NUTRITION CHALLENGES THROUGHOUT THE LIFE CYCLE. THE RECENTLY RELEASED 5TH REPORT ASKS HOW A NUTRITION PERSPECTIVE CAN ACCELERATE THE ATTAINMENT OF A COMPREHENSIVE SET OF DEVELOPMENT GOALS. WHAT STRATEGIES DO YOU RECOMMEND TO THE SCN TO ENSURE THAT NUTRITION IS AT THE FOREFRONT OF THE DEVELOPMENT AGENDA?

This is for the present members of the SCN to work out. But I would encourage the effort with three thoughts. First, remember that progress always depends on expressing goals and opportunities in ways that can inspire ordinary people to think in new ways and take action themselves. Second, we must seek ways to draw on the best of nutritional science and promote priority messages through the media. The media has a major role in highlighting nutrition priorities, as currently seen in its focus on obesity in industrialized countries. It is also quite important with respect to micronutrients and promoting

healthier diets in developing countries. Finally, remember our responsibility to be part of the solution, not adding to the problem.

DO YOU HAVE ANY MESSAGES FOR THE CURRENT CHAIR, MS CATHERINE BERTINI, AND THE NEW SECRETARY, DR ROGER SHRIMPTON, ON LEADING THE SCN FORWARD?

These are two highly experienced people—Catherine successfully led the World Food Program for many years and now is Under-Secretary General for Management. Roger was for many years a leading nutritionist in UNICEF and in the university world, with rich field experience. Between them you have two interesting and complementary people, both with experience in taking initiatives forward. The opportunity now presented to them is to reach out and provide leadership with and among the SCN's member agencies.

IN A 1995 INTERVIEW WITH DR HORWITZ, SCN CHAIR FROM 1986-1995, HIS ADVICE TO ALL OF US WAS TO, "KEEP THE FAITH THAT YOU ARE COMMITTED TO A MOST NOBLE CAUSE...." WHAT ADVICE DO YOU HAVE FOR US?

I can do no better than to repeat Dr Horowitz's inspiring words. People do not want advice; but all of us do well to be reminded of great opportunities and lessons of the past, and be ready to be stirred to action today, when faced with the new opportunities and the challenges which face us. Let us keep the faith—and respond to the challenges.

Sir Richard Jolly can be contacted c/o the SCN Secretariat, scn@who.int

Food Security and HIV/Nutrition Specialists

The Food and Nutrition Technical Assistance (FANTA) project is a ten-year Cooperative Agreement managed by the Academy for Educational Development and funded by USAID. FANTA supports integrated food security and nutrition programming to improve the health and well being of women and children in developing countries and is seeking candidates for two positions based in Washington, DC.

Senior HIV/AIDS Advisor- #CS4033EC

The Advisor will develop and implement FANTA's global strategy for providing technical assistance to USAID and partners on issues of HIV/AIDS and nutrition. The Advisor will be responsible for providing technical and programmatic guidance on state-of-the-art on HIV/AIDS and nutrition, including the nutritional implications of antiretroviral therapy, developing and reviewing technical materials, and coordinating with other FANTA staff and USAID to plan and implement technical assistance. Technical assistance activities may include review of proposals and results reports, strategic planning, and strengthening of programme design, implementation, and monitoring and evaluation. The Advisor will supervise FANTA's field operations in eastern and southern Africa.

Qualifications: PhD in nutrition or related public health discipline preferred with a minimum of seven years technical and programming experience in international nutrition, HIV/AIDS, or other health-related work is required and experience with USAID desirable. Excellent written and spoken English required; international travel required for up to 50% time.

Food Security/Sustainable Livelihoods and HIV Mitigation Specialist - #CS4223EC

The Specialist will provide technical leadership in food security, sustainable and resilient livelihoods and the mitigation of the impact of shocks, including HIV, on livelihoods and the availability of, access to, and consumption of food. The Specialist will develop and review technical materials on food security, risk and resilience, food consumption, nutrition and the impacts of HIV/AIDS; and provide technical assistance in food security and nutrition, including Title II food aid programmes to USAID and partners. Technical assistance activities may include review of proposals and results reports, strategic planning, and strengthening of programme design, implementation, and monitoring and evaluation.

Qualifications: PhD in economics or related social science field preferred with at least 7 years of experience; work with USAID, PVO and/or food security/food aid programmes; knowledge of health and nutrition and fluency in French, Spanish, and/or Portuguese highly desirable. Excellent written and spoken English required; international travel required for up to 40% time.

For additional information, visit www.aed.org and www.fantaproject.org. Salary commensurate with experience. Candidates should send resume, and cover letter and US visa status referencing position number to: employ@aed.org, fax: +1 (202) 884-8413 or: AED/HR, 1825 Connecticut Ave NW, Washington DC 20009-5721. Only short listed candidates will be contacted. M/F/D/V EOE/AA.



Nutrition as Key to Achieving the Millennium Development Goals

Proceedings of the SCN Symposium

Introduction by Rainer Gross

On 22 March 2004, international development practitioners and nutrition technocrats and scientists met at the United Nations in New York for the SCN Symposium on *Nutrition as the key to achieving the Millennium Development Goals (MDGs)*. The Symposium focused on nutrition's role in accelerating improvements in poverty reduction, sustainable development and health, particularly in women and children. The outcome of the Symposium reaffirmed nutrition's role in strengthening the mechanisms needed to improve human development and well being.

The SCN is most grateful to our Chair, Ms Catherine Bertini, for hosting such an opportune Symposium and 31st SCN Session. The Symposium would not have been possible without the support of Dr Eileen Kennedy who, along with the Symposium Task Force, assisted in assembling such an impressive programme. Thanks also to UNICEF who assisted in the preparation and implementation of the session. Ms Bertini used the Symposium as an opportunity to launch the *5th Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes*. Many of the Report's messages on linking nutrition to non-nutrition development objectives were echoed throughout the day in presenters' speeches.

This issue of *SCN News* features key Symposium presentations delivered by some of the most influential leaders in development today. Director of the UN Millennium Project, Professor Jeffrey Sachs, opened the Symposium with a clear challenge to the SCN: to provide evidence-based recommendations concerning nutrition interventions, which should be incorporated into the Hunger Task Force's business plan to combat poverty and hunger (see Professor Pedro Sanchez' remarks, p 25). Other presenters encouraged participants to think beyond the nutrition sphere. Ian Johnson, Vice President of the World Bank, noted that food security depends on including a nutrition perspective in a long term sustainable development plan, extending well beyond the year 2015.

Mr Frederick Schieck, USAID Deputy Administrator, provided examples of effective multisectoral and multipartner efforts in combating hunger and famine, which his agency promotes. UNFPA Executive Director, Dr Thoraya Obaid, reminded us that nutrition interventions must be focused on the most vulnerable members of society—women, children and adolescent girls—in order to break the cyclical process of poverty, ill health and malnutrition.

This year Dr Nevin Scrimshaw was honoured with a lifetime achievement award for his invaluable contribution to the field of nutrition. In his keynote address, Dr Scrimshaw outlines key actions the SCN should undertake in respect to the MDGs. Although the SCN community has prided itself on developing inclusive partnerships to tackle nutrition challenges, Dr Scrimshaw stressed that the SCN needs to remain open to new opportunities to meet the millennium challenge.

An enormous challenge awaits the SCN. With José's family's fate in mind, how can the SCN play a role in accelerating progress towards the MDGs? The huge discrepancy between the international affirmation about José's future and his real life situation is clear. Furthermore, why are so many families like José's still without hope of overcoming the vicious circle of poverty? As Jeffrey Sachs states, one of the reasons is the lack of delivering commitment resources. Current international events have shown that independent of political or economic system, whether rich or poor, it is easier to provide financial resources for war rather than peace. However, even in cases where financial resources are made available and translated into successful programmes, why are efforts so often unsustainable?

At the same time as the SCN held its annual meeting, José, a daily labourer who lives with Marinha and their six children in a small village in the Federal State of Pará, northeast Brazil, is struggling against poverty. José has never heard of the Millennium Development Declaration, which has been signed by all nations to improve the harsh living conditions endured by his family. He owns no land and gains his modest earnings from occasional work on a large farm close to his village. This year he was lucky to be employed frequently in the sugarcane harvest. Nevertheless, the prospect of getting out of the vicious circle of poverty is slim. His wife is pregnant again after having a stillbirth last year, and the painful loss of his mother, which required all of his savings from his modest salary, has left him in debt.

As Dr Obaid fervently stressed in her address, the nutrition situation of an individual does not only depend directly on his or her adequate intake of food but also on health status, particularly that of mothers. Furthermore, a child with repeated diarrhoea or malaria will become rapidly malnourished. As described in the UNICEF conceptual framework, adequate access to food at the household level,



proper health services, and adequate sanitation and care at the community level are essential underlying causes for securing adequate nutrition in the family.

Like public health, public nutrition is an ecological science, which deals with nonlinear cause-and-effect relationships of complex systems. Once the system has been severely damaged, the result can be irreversible. This is best illustrated by the example of a spider's web in which each thread represents a different cause-and-effect relationship. If one or even a few threads are damaged, the firmness of the spider's web is still intact. Increasing the number of damaged threads threatens the strength of the spider's web, until suddenly the web collapses. If we want to repair a not yet collapsed but seriously damaged spider's web, we do not need to replace all the threads, but rather identify the most important threads to replace. The replacement threads have to be positioned strategically and they have to be strong.

If the spider's web corresponds to public nutrition, the replacement or repair of the threads represents nutrition interventions. Using the UNICEF Triple-A approach (assessment, analysis, and action), these interventions can be positioned strategically, according to the damage in the system. Once key interventions have been identified, strategies must be developed taking into account socioeconomic conditions, age-groups targeted, and the continuous monitoring of results.

The complexity of ecological systems can easily tempt us to overburden the system with high diversity and fragmentation. Instead, limited resources should be used to focus on a reduced number of interventions. In other words, a greater number and diversity of interventions should be replaced with more consistency to achieve sustainable improvements in the nutrition situations.

We know what nutrition interventions are needed to control the damage to the delicate nutrition web. We also know how to use these interventions intelligently and focus our efforts effectively through assessment, analysis and action. Still, adequate nutrition strategies require: (1) the courage to focus; (2) the perseverance for consistent action; and (3) the ability to secure sufficient resources for these actions.

As seen at this year's Symposium, the MDGs provide a unique opportunity for focusing nutrition interventions and highlighting its importance as an input to improved development outcomes. The SCN has the unique responsibility to encourage all partners to participate in a coordinated response to meet the millennium challenge. Preparations for the 32nd SCN Session in Brasilia, Brazil in March 2005, are well underway. The case studies to be presented during next year's Symposium will draw on lessons-learned in incorporating nutrition into national development plans, with a focus on the right to food and nutrition.

The litmus test for the SCN will be whether its combined efforts will be able to foster the international support needed to allow the José's family and the millions of other families in the world to satisfy their basic needs, and more importantly, fulfil their human right for adequate nutrition, not only today but also tomorrow.

Contact: Rainer Gross, rgross@unicef.org

Correction

In the features article by Dr Chessa Lutter, *SCN News* #27 (December 2003), p 9, an error was made in the list of references. The citation for references 13 and 14 should read as follows:

13. Lutter CK, et al. Nutritional supplementation: effect on child stunting because of diarrhoea. *American Journal of Clinical Nutrition*, 1989, 50:1-8.
14. Pelletier DL, Frongillo EA. Changes in child survival are strongly associated with changes in malnutrition in developing countries. *Journal of Nutrition*, 2003, 133:107-119.

ECONOMICS AND NUTRITION: HOW DO THEY INTERSECT?*

JEFFREY D SACHS

DIRECTOR, UN MILLENNIUM PROJECT

DIRECTOR, THE EARTH INSTITUTE AT COLUMBIA UNIVERSITY

It is an honour to serve as special adviser to Secretary General Kofi Annan on the Millennium Development Goals (MDGs), and to direct an advisory project for the Secretary General called the UN Millennium Project. The MDGs are the world's commitment to making a drastic cut in extreme poverty, hunger and disease by 2015. These goals were adopted by 189 countries at the Millennium Assembly in 2000, and have been reconfirmed many times over, but some of the poorest countries are far off course from actually meeting these goals. If business continues as usual, there will be increased suffering, premature death, chronic extreme poverty and hardship that will not be alleviated despite all the words uttered in defence of economic and social progress. Change is needed if the MDGs are to be achieved.

The UN Millennium Project sets out to understand what is blocking progress toward these goals and what can be done to achieve them, because although they are still achievable in all countries, time is running out. The window of opportunity is shrinking rapidly. The world is less secure if poverty continues to expand and if disillusionment continues to grow.

The purpose of the UN Millennium Project is to make specific recommendations to the Secretary General and the international community by the end of 2004. I would like to ask the SCN to make recommendations on specific aspects of the agenda, particularly on how nutrition can be enhanced and which modalities are needed for improving nutrition worldwide. Strategies should address the goal of poverty and hunger, but other goals related to disease as well.

Nutrition and the MDGs

The first goal addresses extreme poverty and chronic hunger. In both situations progress has been made, but sadly there are dozens of countries worldwide where there is not only insufficient progress, but where there has been significant regress since the adoption of these goals. Chronic hunger and poverty are rising in large parts of Sub-Saharan Africa and South Asia, and are not improving fast enough in parts of Central America, the Andean region, Central Asia, and East Asia.

Besides being a goal itself, nutrition is critical to achieving the other MDGs. Undernutrition contributes to dysfunctional societies with individuals too weak, too vulnerable to disease, and too lacking in physical energy to carry out the extraordinarily laborious tasks of escaping the poverty trap. Malnutrition and hunger feed directly into ill health and poverty. Lack of nutrition means children cannot concentrate adequately in schools, compromising the efforts to achieve universal education.

The poverty trap

Poverty traps are repeatedly observed in societies too impoverished to generate an economic surplus that can be reinvested to break out of the trap. When societies have no income beyond what is needed for subsistence, infrastructure cannot be built, schools and clinics are insufficient and understaffed, and savings to go towards private enterprise is almost entirely absent. Without a surplus that can be used for investment in the health and education of children, poverty is passed on to the next generation—this is what is meant by a poverty trap. The poverty trap is made worse by rapid rural population growth, which puts added stress on the physical environment through deforestation, and depletion of water sources and soil nutrients.

Overcoming poverty requires greater aid from high-income countries to the poor countries (particularly to the well-governed ones). This has been repeatedly promised but has not been realized. In the Monterrey Consensus and several times since then, high-income countries committed to giving 0.7% of their gross national product in official development assistance. What is actually delivered today is around 0.25%, or roughly USD 110 billion per year short of what high-income countries promised. A full commitment to development assistance would make a difference for millions of children that die every year, or that are not in school, or that grow up stunted because of undernutrition and have no chance at a fully productive life.

The inability to address these problems at local levels is due essentially to financial constraints which make it impossible even for well-governed poor countries to take on these challenges adequately.

*Extracted from the transcription of Professor Sachs' presentation.



Therefore avoiding the poverty trap requires a change in the scale of effort by high-income countries in breaking this vicious cycle. We are not asking high-income countries to make new promises, but only to fulfil the commitments they have already made. The fulfilment should be based on rigorous plans of implementation, detailed costing, and mechanisms to account for how resources are to be used.

The Hunger Task Force

The Hunger Task Force, one of the Task Forces of the UN Millennium Project, is chaired by Dr MS Swaminathan and Dr Pedro Sanchez, two leading scientists greatly experienced in problems of agricultural productivity, nutrition and rural development. The Task Force is made up of leading practitioners from around the world in the areas of food production and nutrition, from international agencies, academia, and the private sector. They have identified several strategic areas where increased donor assistance could lead to a reduction of hunger based on reliable scientific evidence:

- *Raising food productivity, meaning the ability of small farm holders to produce more food per hectare.* The biggest problem in Sub-Saharan Africa is a lack of adequate soil nutrients, which have been depleted over decades due to a lack of access to fertilizers or biological alternatives.
- *Improving diets in local communities through a better mixture of crops.* Research has been done to understand how agronomic and nutritional requirements can be better matched at the local level in nutrient-stressed regions of the world. Changes in the choices made in farm systems and practices could enhance local nutrition.
- *Micronutrient supplementation and fortification.* Despite decades of progress in iodized salt and vitamin A supplementation, micronutrient deficiencies remain a huge crisis in many parts of the world. Micronutrient supplementation and fortification require financial resources and science-based strategies.
- *Strategies for the vulnerable population groups, such as mothers, pregnant women, young children, and school-aged children.* School meals should be an entry point for improved nutrition and education. Improved health services along with better nutrition are also needed so that nutrients can be absorbed rather than simply passed through the systems of children suffering from chronic parasitaemia and other infectious diseases.
- *Adequate delivery of emergency relief.* Reliable financing of effective surveillance systems, emergency relief and long-term enhancements in food productivity are all needed. Existing interventions must continue and be scaled up, together with higher levels of scientific research into increased productivity. This calls for properly funded international research efforts, something which unfortunately does not exist today.

Conclusion

In conclusion, over the last two years of the UN Millennium Project it has become apparent that poverty reduction strategies need resources if they are to help the world's poorest break out of the poverty trap. Current levels of donor resources are insufficient for the development of sound medium term strategies for overcoming poverty, which require scaling up investments in public health, education, and infrastructure. The UN Millennium Project is working with the UN Country Teams, the World Bank, the International Monetary Fund, governments, and civil society to create accurate needs assessments at the country level and identify priority areas. Several countries are extremely eager to work closely with us on this, and work has already begun in Senegal, Ghana, Kenya, and Ethiopia, and will soon start in Cambodia, the Dominican Republic, Madagascar, Tajikistan and Yemen to scale up the ambition of the poverty reduction strategies so that they are compatible for meeting the MDGs and clearly define the financial needs to address those challenges.

The UN Millennium Project would appreciate inputs from the SCN about specific nutrition interventions that should become part of these enhanced strategies. Recommendations from the SCN, based on rigorous scientific evidence, could contribute directly to achieving the MDGs. We look forward to learning from your expertise. Thank you very much for the opportunity to share these ideas with you.

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ENVIRONMENT, SUSTAINABLE DEVELOPMENT AND NUTRITION*

IAN JOHNSON

VICE PRESIDENT, WORLD BANK

Today there are 6 billion people earning a gross domestic product of around USD 37 trillion. Yet, there are about 800 million people who are under- or malnourished despite agricultural productivity gains over the last 30 years. Food commodity prices are also at their lowest in 50 to 100 years. Clearly the aggregate global food supply is badly distributed. As Professor Sachs has pointed out, achieving the MDGs needs targeted interventions, better service delivery, increased incomes for the poor, and increased productivity gains, particularly for small farmers. My speech will focus on the trajectory through 2015 and beyond because strategies implemented today will greatly impact our children's future.

The MDGs are achievable due to some of the most important non-depletable resources we have: human ingenuity and technological progress. The MDGs have set the goal of elevating 29% of the world's population out of poverty. This is roughly a 3% per capita increase in income in developing countries. By the middle of the century, we are likely to move to a global economy of USD 140 trillion. How these economic benefits are shared will largely depend on decisions taken now.

While today there is an imbalance in food distribution around the world—800 million people who have too little and others who have too much—by the middle of the century, food demand will double. It will be partly driven by population growth—an additional 2 billion people on earth—but also by dietary changes, particularly in moving to higher-value foods. Livestock and aquaculture fisheries will have to be managed with great care if they are to meet the needs and demands placed upon them over the next 30 to 40 years. These demands have ecological, environmental, social and public health implications, as well as nutritional. We need to envisage a global agricultural system which is both driven by productivity changes and environmental responsibility.

Agricultural productivity and nutrition

In the future, agriculture will remain a key economic sector for developing countries. It is clear that agricultural productivity has to increase dramatically, but it will take a multifaceted approach to accomplish this. Globally, current trading regimes and systems are grossly inequitable and in need of adjustment. The Doha Round hopes to make some inroads into major obstacles preventing developing countries from trading on an equal footing with richer countries. But USD 360 billion in subsidies per year in the north is a major deterrent to agricultural production in the south.

Agricultural systems also need to reflect increasing environmental concerns, such as climate change and bio-diversity loss. The UN and the Intergovernmental Panel on Climate Change have made stark projections under business as usual scenarios in terms of the impact climate change will have on agricultural and food systems in Sub-Saharan Africa and across much of Asia.

We need increased donor commitment to agricultural and food production. The World Bank is increasing its lending for agricultural research, which will triple over the next two years. We are working with bilateral and multilateral partners to make the case that agriculture is central to sustainable development, poverty reduction, and improved nutrition. In Africa, a farmer produces between a third and a quarter of his counterpart in Asia for the same crop. African agriculture must be one of our highest priorities for nutritional, economic and ecological reasons. Further, new institutions must be established that not only can deliver goods farmers need but get farmers' goods to local, regional and global markets. This means greater investment in rural infrastructure, particularly in Africa.

Technology and nutrition

Science and technology can play a pivotal role in transforming societies. Thirty-five to 40 years ago the Green Revolution transformed Asian agriculture by increasing economic productivity and growth. A new science revolution would increase productivity, and improve crop resistance to pests, climate and water shocks. The World Bank has increased its funding to the Consultative Group on International Agriculture Research from 30% to about 42% (USD 410 million per year). It has also invested in work on micronutrients under HarvestPlus. Further, we are developing multistakeholder and multidonor programmes to meet some of the great challenges of today and tomorrow, all of which have a nutri-

*Extracted from the transcription of Mr Ian Johnson's presentation.



tional dimension. However, increasing agricultural productivity must be done in an environmentally and socially responsible manner.

Environment and nutrition

Finally, I would like to emphasize the links between health, nutrition and the environment. Environmental factors play a role in nutrition planning and vice-versa. Key environmental factors have a profound effect on health; they also make nutritional problems worse. A child who is well fed but drinks dirty water and lives in a polluted environment will not grow up healthy. New alliances between the nutrition and environment communities must be formed. Dirty water, poor sanitation—particularly in urban areas—and indoor and outdoor air pollution account for about half of all infant mortality in low-income countries. Working together will help make the case that the underlying causes are every bit as important as service delivery.

Key environmental factors have a profound effect on health; they also make nutritional problems worse.

Conclusion

Let me conclude by making a plea for not only thinking about the short term, such as immediate emergencies as mentioned by Professor Sachs, but to think about the medium term to 2015, and the longer term beyond that. Let us think about promoting positive synergies between nutrition and other sectors, how science and technology can be responsibly applied, and how investment in research for the public good can make a substantial difference. Finally, let us think about the real underlying causes of malnutrition and underdevelopment, not just approximate ones. The World Bank is working on sustainable development, agriculture and the environment—we are your close allies and partners.

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MULTISECTORAL APPROACHES TO HUNGER AND POVERTY MEETING THE CHALLENGE OF THE MILLENNIUM DECLARATION

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I would like to thank Catherine Bertini and the SCN for this invitation to share with you what the United States Agency for International Development (USAID) is doing to ensure that good nutrition is not only an outcome of the development process but a critical input as well. I want to illustrate USAID's commitment to internationally agreed development goals, including those contained in the Millennium Declaration, by providing some specific examples of our work in the areas of: development of new crop varieties, integrated community programmes, and famine mitigation. We believe these are promising means for reducing poverty and hunger.

USAID is embracing new approaches designed outside of single sector "stove pipes," that is to say, they are integrated approaches that cross traditional sector boundaries to address nutrition goals. This means making agriculture both more productive and sustainable, but also fortifying crops nutritionally. We also approach nutritional goals at different levels of society, by inducing behavioural change at community and family levels, as well as at national levels in matters of economic policy and political governance.

The first example is an exciting approach which holds great promise in improving the quality of food in diet-poor populations. Through agricultural research and application of the latest developments in agricultural technology, indigenous foods can be transformed to meet specific dietary needs. The second example comes from the much misunderstood contribution of food aid to transformational development. Initiatives that USAID is sponsoring show how food aid can be programmed at the community level to change food consciousness and health behaviour leading to better young child nutrition. Finally, I want to describe the new and more comprehensive approach we are taking to address the problem of famine. A good illustration is the measures we are supporting in Ethiopia to end its chronic dependence on emergency food assistance and break the cycle of poverty and hunger it is caught up in.

As the SCN knows, hunger has many faces. The *5th Report* tells us that undernutrition contributes to over half of all early childhood deaths. Even mild malnutrition can lead to tragic increases in mortality and morbidity.

Malnutrition also has less visible repercussions. It diminishes individual lives and reduces their productivity. Adults do not reach their full potential because of inadequate nutrition as children. Nutritionists have also made us aware of "hidden hunger" which has devastating effects, particularly on the lives of women and children. I am speaking about widespread micronutrient malnutrition that affects billions of people in the developing world. Ironically, many of these people live and work on farms and in communities where agriculture is the predominant way of life.

Agriculture's contribution to a nutritious diet

Over the past twenty years or so, the development community has failed to build on the accomplishments of the Green Revolution. Agriculture has been neglected, but it offers crucial opportunities for improving the basic nutrition of the smallhold farmers in the developing world, while enhancing their means of livelihood. It brings benefits that are short and long term for both health and economic well being.

To this end, we have recommitted our Agency to programmes designed to promote sustainable agricultural productivity while enhancing the nutritional component of agricultural produce in ways that provide real, measurable improvements in health. Through the Consultative Group for International Agricultural Research (CG Centres) and the HarvestPlus Challenge Programme, we are promoting cutting-edge research that draws upon the latest developments in genetic and nutritional sciences. We are looking for breakthroughs that can be readily adapted and sustained, and which promise immediate and substantial benefits.

USAID has been one of the pioneers in biofortification. In collaboration with the International Food Policy Research Institute and the Danish International Development Agency, we have begun to address the problem of micronutrient deficiency. We are looking at what agricultural science can do to improve the content of key micronutrients: iron, vitamin A, zinc and others. The *5th Report* says that 140 million



preschoolers suffer from vitamin A deficiency. Successful work on micronutrients will bring immediate health benefits to the families of some of the planet's poorest and most marginalized people. Indigenous crops can be the vehicle if micronutrients are introduced in cost effective ways without affecting local tastes and traditional farming practices.

The Bill and Melinda Gates Foundation recently pledged USD 25 million to back the use of science and plant breeding in developing highly nutritious staple foods. USAID will be an important partner in this new alliance. We are joining other donors to provide USD 3 million a year in support of biofortification efforts.

This partnership is important for several reasons. It is illustrative of a new paradigm in foreign aid. If we are to effectively meet the development challenges of the new century, we must pool our resources and work in coordinated ways with the whole range of aid agencies and resources—international, national, nongovernmental, and private.

Plant breeding has yielded fortified foods that are already making a difference. In southern Africa, the common variety of “sweet potato” was a starchy one, lacking the nutritional value of the orange-fleshed, high-beta carotene varieties. USAID-sponsored research in South Africa showed that when children are fed these orange-flesh sweet potatoes, their serum vitamin A levels rise substantially. The research also found that children in South Africa, Mozambique, and Tanzania love the new variety of sweet potatoes—a “sweeter” sweet potato than the traditional starchy one. The CG Centres have worked with an array of national and NGO partners to introduce the orange sweet potatoes. The International Institute for Tropical Agriculture—the CG's tropical Africa centre in Mozambique—has delivered these new, improved varieties to hundreds of thousands of families. Schools and stores are participating in a social marketing nutrition education programme that is transforming agriculture.

A number of lessons can be drawn from this. It shows how food-based approaches can be critically important to improving nutrition. It also demonstrates how even relatively low-budget interventions can have high-impact results when innovatively conceived, and it shows how thinking is evolving. If agriculture is to enhance nutrition, nutrition must also lead the way in transforming agriculture.

The sweet potato success story is rather straightforward. There are other examples of how biotechnology can be utilized to improve the nutritional content of foods which can save lives. USAID is working toward this end with partners in developing countries in both the public and private sectors. Here are several examples.

In India, Michigan State University and the Tata Energy Research Institute are working with Monsanto to develop mustard oil with beta-carotene levels higher than that in red palm oil. Monsanto is donating the technology originally developed in canola research. Mustard oil is the preferred oil in North India where micronutrient deficiency affects people at all economic levels, the poor most especially. Indian nutritional institutes see great potential for helping to alleviate vitamin A deficiency through such programmes.

USAID is also working with partners in the public and private sector in the Philippines to develop Golden Rice. Researchers are making marked progress in enhancing the beta-carotene content of this rice. The International Rice Research Institute, universities in Europe and the US, and the Syngenta Corporation are collaborating on research to ensure that this product moves forward into nutritional and food safety testing as soon as possible.

In Bangladesh, USAID is supporting the introduction of improved methods for fish farming in rural villages where mineral deficiencies are prevalent. As a result, families are managing their ponds more effectively, greatly increasing the yield of marketable fish. The population of smaller fish has also increased, which promotes more home consumption leading to real improvements in the nutrition and well-being of families. Iron levels, especially among women and children, have improved.

It is important to note here that gender has an important role to play in bringing agriculture and nutrition goals together. Our work has shown that when women have a substantial involvement in an agricultural enterprise that provides good income, they make sure that children benefit. In the fish pond example above, women typically manage the ponds. This places them in a position to ensure that increased food and income go to important household needs.

In East Africa, the International Livestock Research Institute has supported women-managed, small-holder dairy technology with astonishing results. In families that adopted the improved technologies, incomes rose and incidence of stunting and wasting in children fell sharply. The key here is combining productivity increases and the income they generate with a commitment to meeting the family's nutritional and health care needs. Increased income allows poor people to purchase more expensive fruits,

vegetables, and livestock products, which helps to diversify diets and nutritional intake.

Integrated community nutrition programmes

Researchers and practitioners have recognized for years that poverty is a key cause of hunger and malnutrition. They have also recognized that an exclusive focus on increasing incomes is not sufficient to reduce the number of hungry and undernourished people, particularly in the short- to medium-term. In rural areas where most of the world's poverty and undernutrition are still concentrated, programmes aimed at increasing agricultural incomes and crop varieties must be complemented with health, sanitation and nutritional education to achieve durable reductions in malnutrition.

It has also long been recognized that interventions need to get down to the community-level to be successful in improving health and nutrition, especially because changing behaviours is so central to achieving sustainable improvements in the well being of the most vulnerable groups, particularly pre-school children. And, because changing behaviours takes time, programmes need reliable, multi-year funding to achieve results.

Our Title II food aid programme is the largest component of US assistance programmes aimed at reducing food insecurity, hunger, and malnutrition at the community level. One third of this programme, more than USD 380 million in 2003, is used to implement multi-year community-based development programmes in 28 of the world's poorest countries. These programmes are carried out in cooperation with 16 international NGO partners.

The majority of the programmes include maternal and child health and nutrition activities with a goal of reducing the underweight and stunting of children. Mother and child activities are integrated with activities aimed at increasing agricultural productivity, thereby creating linkages among health and nutrition and agriculture so that improvements in agricultural productivity and income may translate into better nutrition in households.

A USAID-funded CARE programme in Mozambique, for example, links training in home-enrichment of complementary foods with a crop diversification activity. As a result, 87% of the women in the programme are now using crops such as groundnuts, sesame and sunflower to enrich their young children's food, up from 11% at the beginning of the programme.

Over the past six to eight years, these mother and child health and nutrition programmes have evolved from predominantly facility-based food distribution programmes to integrated community-based development programmes with long-term health and sustainability objectives. The programmes have had proven successes in reducing undernutrition among young children in the target population.

The mother and child health and nutrition programmes build upon the latest research and promote interventions of proven worth in reducing maternal and child death, as well as combating disease and undernutrition. This includes promotion of exclusive breastfeeding, instruction on appropriate complementary feeding, care and support for the HIV/AIDS infected, and the prevention and treatment of preventable childhood diseases. It raises consciousness as to the importance of micronutrient consumption and advises on easily adapted improvements in antenatal care.

The programmes predominantly target children under the age of two and their mothers because we know that children under that age are at the greatest risk of becoming undernourished and also receive the greatest benefit from preventative interventions.

A recent analysis of these programmes has shown that, on average, they reduced the prevalence of stunting by 2.4% per year and underweight by 1.9% per year to the benefit of 6.6 million children. These children will be more educable and productive, less vulnerable to chronic disease later in life.

Our challenge is to build on the experience of these programmes and to bring them to scale so that more families and communities can benefit. While these results are promising, to achieve the goal of halving undernutrition by 2015 will require a concerted effort by the international community in many sectors to achieve measurable and sustainable results.

New thinking on famine prevention

We should not forget that the most prominent development failures and highest levels of undernutrition are found in the most fragile, disaster prone countries. Much of the work and resources of the world community are focused on disaster situations that threaten whole countries with famine. And much of the credit for taking on the responsibility to feed people and save lives in often insecure and intractable situations belongs to agencies and individuals present at this symposium.

Two years ago the SCN symposium addressed nutrition in complex emergencies. While one might



think we can now move on to nutrition in development contexts, underdevelopment and emergencies are intimately interrelated. Poverty, low agricultural productivity, and frequent disasters create a mutually reinforcing cycle of failed development and rising risk of famine.

Nowhere have the dimensions and dynamics of famine been more clearly demonstrated than in Ethiopia. In 2003, the international community provided USD 1.7 billion in relief resources. The US alone provided over USD 530 million in food and non-food assistance. Our combined efforts enabled Ethiopia to pull back from the brink of famine, but not without unacceptably high levels of child malnutrition and mortality.

The Tufts University Famine Center analysis of the situation in Ethiopia is instructive. Famine and famine response there fell into an all too familiar pattern. The world community has treated recurring famines in Ethiopia as discrete episodes to be addressed largely by external food assistance. Non-food responses and development processes, such as agricultural production, livelihood erosion, and chronic nutrition deficits were largely unaddressed.

The necessity for multisectoral approaches to food insecurity and famine is a lesson that development practitioners are beginning to implement. We see that the most serious food and nutrition emergencies arise at the end of a chain of failed development processes across sectors, with basic causes grounded in economic injustice and poor governance. Drought and climatic change may push a country into famine. But we must not mistake the immediate cause of famine for more fundamental ones.

It has become clear to the Government of Ethiopia and the international donor community that business as usual is no longer possible if the cycle of famine is to be broken in that country. A little over a year ago, USAID commissioned a team to work on a Famine Prevention Framework. At the same time, the office in Ethiopia worked with a new National Security Coalition, which assembled key government ministries, civil society groups, and the international donor community, to rethink food security and food assistance for Ethiopia.

Working in conjunction with the Coalition, USAID is now implementing a new multisectoral strategy which is aimed at reducing famine vulnerability, hunger and poverty in Ethiopia over the next five years. The central tenant of the new approach is precisely that economic, social, and governance strategies must be designed to build resilience to inevitable future shocks at the national, local, and household levels. The goal is to break the cycle of destructive famines in Ethiopia by bringing comprehensive changes necessary for reducing her vulnerability to hunger and poverty.

Key component of the strategy include a coordinated effort by the international community to assist the Government of Ethiopia to implement comprehensive economic and governmental reforms needed to exit from the cycle of famine. Smallholder agricultural commercialization will be promoted through policy and institutional changes with the goal of increasing growth rates by 6% by 2006. Economic reforms are important here as is the establishment of a financial infrastructure that can stimulate trade and provide outlets for farm production. An integral programme is the coordination of health, nutrition, agriculture, and HIV/AIDS programmes to mitigate the devastation that this disease brings to Ethiopian society.

If these measures, along with others involving the design of innovative relief models using food aid resources, are successful, the number of food insecure people could be halved in 10 years, per capita incomes could grow by 50%, and the projected rise of malnutrition over the next 15 years could be reversed.

Conclusion

The hope for making hunger and poverty a thing of the past challenges us to work together. Together, we can develop new and nutritious crops that will address the persistent and debilitating micronutrient deficiencies still sapping the potential of billions. In countries such as Ethiopia, we can reduce famine vulnerability with coalitions of government ministries, donors and civil society finding new and creative synergies. In our food aid programmes, we have demonstrated what nutritionists have known for decades, and what is a key conclusion of the *5th Report*, that the integration of health, agriculture, and education in a community is key to nutritional improvement. Only by integrating our know-how and resources can our challenges be met.

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HEALTH AND THE LINKS TO NUTRITION

MATERNAL HEALTH IS KEY

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At this second, a baby girl is being born somewhere in the world. She is being born to a mother who is undernourished and young, 18 years old. It is likely that the baby is stunted in length and low in weight, even though she was born at full term. If she survives, her growth will be more likely to falter. Her ability to learn will be irreversibly damaged, as will her ability to develop other skills needed for the labour market, home and community. She will also be more susceptible to infectious diseases.

Later in life, she will be more likely to suffer from the so-called diseases of affluence such as diabetes, coronary heart disease and diet-related cancer. Throughout her life, her options—and her power to make choices about those options—will be as stunted as her growth. During her childbearing years, she will bear low birthweight babies of her own, continuing the cycle of poverty and ill-health from one generation to the next. And society will be worse off, both socially and economically.

The scenario just described is the fate of one in three infants in the developing world. The food security and nutritional status of an infant reveals much about her history and tells us much about her forward trajectory through life. And this status is determined in large part by the health and nutritional status of her mother. And the health and nutritional status of the mother is determined in part by the status of women in society.

My speech stresses three major points:

- 1) to improve nutrition and health, we must improve the status of women
- 2) nutrition interventions must target three groups: pregnant and breastfeeding women, infants up to the age of two, and adolescents, particularly adolescent girls
- 3) better nutrition is needed to combat HIV/AIDS and malaria.

By doing these three things we will build a foundation for achieving the Millennium Development Goals (MDGs). Nutrition is a fundamental human right and it plays a key role in health. Eradication of hunger ranks high among international goals because good nutrition is essential for the health and human capacity needed to achieve so many of the other MDGs. Freedom from hunger is a sound foundation for economic growth in the world's most impoverished nations. Well-nourished people learn better, produce more, and can more effectively fight off disease. They can also provide better care for their children and the environment.

Today, the high economic costs of hunger and the economic benefits of good nutrition are increasingly obvious. We have a greater understanding of the causes of hunger. We know that the main causes of malnutrition include inadequate access to food and nutrients, inadequate care of mothers and children, inadequate health services and unhealthy environments. We also know that hunger and poverty are perpetuated by lack of access to assets, democratic institutions, and by vulnerability.

Promoting gender equality and empowering women

It is well documented that women's low status in the household and in society is an important cause of poor nutrition. Women's lack of decision-making power and control over income have a significant adverse effect on health-seeking behaviours as well as child health and nutrition. According to Joan Holmes, President of the Hunger Project, chronic hunger occurs, "when people lack the opportunity, or are systematically denied the opportunity, to earn enough money, to produce enough food, to be educated, to learn the skills to meet their basic needs, and to have a voice in the decisions that affect their lives". There is growing international recognition that discrimination against women is a major cause of hunger and malnutrition. For when we speak of hungry people, we are most likely talking about women and children.

It is also true that women have significant productive roles in developing countries. Rural women are responsible for half of the world's food production and produce 60 to 80% of the food in most developing countries. This is particularly true in South Asia and Africa. Women farmers produce 80% of Africa's food, and do the vast majority of the work to process, transport and market this food. Yet, they own only 1% of the land, and receive less than 10% of the credit provided to small-scale farmers.



Sub-Saharan Africa is the only region in the world where the average food production per person has been declining during the past 40 years. In much of rural Sub-Saharan Africa, women are subsistence farmers. Yet, they are often given small and marginalized plots of land. They have less access to credit, extension services and technological inputs than do men, which puts them at a clear disadvantage.

There is a great deal of research showing that the greater the share of household income earned by women, the greater the food security of the household. Studies show that women use more of their earnings than men for the health and welfare of the family and children. Yet, low wages and poor work conditions leave women with few adequate child care options, and studies show that malnutrition is significantly more common among young children when their mothers have to work under such conditions. This is the vicious circle—on the one hand, the mother is working and contributing her earnings to her family, yet she is barely able to survive and her children are more likely to suffer from malnutrition.

The poor nutritional status of infants and women has implications for overall development in terms of productivity losses throughout the life cycle of both boys and girls. Hence, not only are improvements in the status of women needed to improve nutrition, but better nutrition for girls and women can also help develop policies and interventions that can reduce gender inequality. This can be done by both promoting a more level playing field and affirmative action programmes to improve women's status. Such policies would benefit women, their children, and spur overall economic development.

Improving maternal and infant health

Malnutrition often begins at conception. When a pregnant woman has an inadequate diet, has an excessive workload, or is frequently ill, she will give birth to smaller babies with a variety of health problems. For this reason, pregnant and breastfeeding women, and children under two years of age should be priority target groups for nutrition interventions. Other critical groups include pre-adolescents and adolescents, particularly girls. Let's face it: healthy mothers have healthy infants.

All over the world, child malnutrition is linked to poverty, low levels of education, and poor access to health services, including reproductive health and family planning. It is widely known, for instance, that having babies too closely together increases the chance of poor nutrition in both the mother and child. Studies show that waiting at least two to three years between births allows the mother to replenish nutritional reserves. We must also remember that health services during pregnancy and childbirth provide vital entry points for nutrition interventions. It is also true that adequate health services, especially emergency obstetric care, are needed during childbirth to ensure a healthy outcome for both mother and child. Studies show that the death of a mother reduces the chances of a healthy life for children who are left orphaned. So, clearly, all of these interventions reinforce each other.

Maternal malnutrition does not only cause malnutrition in a developing foetus, it is also directly associated with the ill-health, and possibly, the death of the mother. Poor nutrition may lead to maternal mortality in various ways. For one thing, if the mother is malnourished, she may have experienced stunted growth resulting in a small pelvis, which can cause obstructed labour, one of the main causes of maternal mortality.

Other causes of death during childbirth are associated with micronutrient deficiencies. Over 100,000 pregnant women die each year from severe iron-deficiency anaemia. This represents one fifth of all annual maternal deaths. Iron deficiency during pregnancy is also associated with multiple adverse outcomes for both mother and infant, including an increased risk of haemorrhage, sepsis, low birth weight and infant mortality. Serious iodine deficiency during pregnancy may result in stillbirths, miscarriages and congenital abnormalities. Iodine deficiency disorders jeopardize children's mental health and often their very lives. Childhood anaemia can begin when mothers have the ailment before or during pregnancy, and the infant is born with low iron stores.

Deficiency in vitamin A is also a major threat to health. In pregnant women, vitamin A deficiency increases maternal mortality and causes night blindness. Infants born to women who consume too little vitamin A have low stores at birth. The breastmilk of those women is also low in vitamin A. Although severe vitamin A deficiency is declining, sub-clinical deficiency still affects up to 250 million pre-school children, contributing significantly to raised morbidity and mortality in high-risk populations. Vitamin A deficiency is the leading cause of preventable blindness in children and raises the risk of disease and death from severe infections. Between 100 million and 140 million children are vitamin A-deficient and an estimated 250,000 to 500,000 vitamin A-deficient children become blind every year, half of them dying within 12 months of losing their sight.

Since breastmilk is a natural source of vitamin A, promoting breastfeeding is the best way to protect



babies from vitamin A deficiency. However, if the mother is deficient, supplements are needed for both mother and child. In a recent trial in Nepal, low-dose vitamin A supplementation reduced maternal mortality by 44%. For deficient children, the periodic supply of high-dose vitamin A in low-cost, high-benefit interventions has produced remarkable results, reducing mortality by 23% overall and by up to 50% for acute measles sufferers.

Zinc deficiency presents another threat to pregnant women and babies. It is associated with long labour, which increases the risk of maternal and infant death, especially in areas where there is limited access to health services. Another deficiency that threatens pregnant women is folate deficiency, which is associated with a high risk of preterm delivery and low birthweight. Folate deficiency also contributes to anaemia, especially in pregnant and lactating women, and may increase risk of maternal morbidity.

Adolescent nutrition: a neglected dimension

Today, there are about 1.2 billion adolescents in the world—that is one in five persons. These 10- to 19-year-olds face serious nutritional challenges, which affect not only their growth and development, but also their livelihood as adults. Yet, adolescents remain a largely neglected, difficult-to-measure and hard-to-reach population, whose needs are ignored, particularly those of adolescent girls.

Adolescence is a unique period in life because it is a time of intense physical, psychosocial and cognitive development. Caloric and protein requirements are maximal. Increased physical activity, combined with poor eating habits, and other factors such as the onset of menstruation and pregnancy, compounds the impact of poor nutrition for adolescents.

Studies show that community-based approaches are needed to ensure sustainable food security for the household with emphasis on the nutritional needs of adolescent girls. Information and awareness raising programmes are needed to alert governments and communities to the importance of health and nutrition for adolescent girls, and in particular, of the urgent need for adequate intake of iodine. This is equally valid for women of child bearing age.

Combatting HIV/AIDS, malaria and other diseases

The magnitude and depth of the impact of HIV/AIDS in Sub-Saharan Africa is staggering. Livelihoods are being devastated and the food and nutrition security of millions of households seriously undermined. In fact, inadequate access to food is one of the first signs of distress in a HIV/AIDS-affected household. Malnutrition, in turn, increases both the susceptibility to HIV infection and vulnerability to its consequences. Malnutrition has an equally strong negative impact on those suffering from malaria. Nearly 57% of malaria deaths are attributable to malnutrition. Nutrition, therefore, plays a critical role in all four of the main strategies for combating HIV/AIDS—prevention, care, treatment and mitigation—and in combating malaria.

At an individual level, HIV infection accelerates the vicious circle of inadequate dietary intake and disease that leads to malnutrition, while malnutrition increases the risk of HIV transmission from mothers to babies and the progression of HIV infection.

Mother-to-child transmission of HIV has nutritional implications. According to a recent study, exclusive breastfeeding confers a significantly lower risk of HIV transmission than partial breastfeeding. Infants of mothers who have an adequate vitamin A status might have a reduced risk of vertical transmission. There is a need for more studies on these issues.

The nutritional status of those infected and affected plays an important role in determining an individual's current welfare and ability to ensure his or her livelihood through activities that help mitigate the impacts and spread of HIV/AIDS. With regard to nutrition, HIV/AIDS accelerates the vicious circle of inadequate dietary intake and disease by diminishing the capacity to ensure the necessary food, health and care preconditions to good nutrition. It is also clear that when farmers fall sick, they cannot tend to their crops.

The losses caused by HIV/AIDS affect every determinant of food security, including health status, income, capacity to care for children, ability to participate in governance, ability to work on farms or other productive activities, as well as to participate in social networks.

The good news is that nutritional support has the potential to significantly postpone HIV/AIDS-related illness and prolong life. Food aid has significant potential for improving the situation of HIV/AIDS-affected households and communities, and of reducing early death from malaria.

Yet, adolescents remain a largely neglected, difficult-to-measure and hard-to-reach population, whose needs are ignored, particularly those of adolescent girls.



Conclusion

I would like to conclude by charting a way forward. The International Conference on Nutrition's (ICN) framework for nutrition identifies household food security, health services and a healthy environment, as well as care for women and young children, as the underlying determinants of malnutrition. It is necessary to address all these to improve nutrition outcomes. Therefore, one of the key policy priorities is to empower women and invest in girls. The Hunger Task Force, in its recommendations, also says that the empowerment of women is a key part of an overall strategy to achieve the hunger MDG. It also emphasizes that increased investments are needed to raise agricultural productivity, improve how the market functions for poor producers and consumers, and increase the nutritional status of adolescent girls and women.

Given the rise in world wealth, and its growing unequal distribution, and the call for a widespread application of human rights principles, the case for making these investments has never been stronger.

Given the rise in world wealth, and its growing unequal distribution, and the call for a widespread application of human rights principles, the case for making these investments has never been stronger. The many failures to achieve the global promise of hunger reduction can be attributed to a lack of political will. The world can achieve the hunger MDG if it chooses to do so. Such a choice is political, and political choices can be influenced by targeted and sustained advocacy.

For actions to improve the nutrition of mothers and children and empower women, a supportive policy framework is essential. In essence, this means that political decision-making must support the principle of improving the status of women. Women who have no access to information, education, assets nor the time necessary to improve their nutrition and that of their children will be unable to influence decisions that affect their lives.

We must also realize that, in improving the nutrition of mothers and children and empowering women, the role of men is crucial. If these actions are to be framed solely as actions for women, lobbied for by women, and enacted by women, they will be doomed to failure. Without men's participation in initiatives to create options for women, any action promoted solely by women would be counterproductive.

I would also like to stress, as does the Hunger Task Force, that the private sector has to be a part of the solution. The nutrition community has historically avoided partnership with the private sector, largely due to the negative experiences related to exclusive breastfeeding. However, there may be some roles, responsibilities and situations in which the private sector has a comparative advantage. For example, private industry has been a key player in the fortification of food with micronutrients. One fortification success story, still unfolding, is the massive reduction in iodine deficiency through salt iodization.

Finally, I would like to endorse the findings of the SCN's 5th *Report on the World Nutrition Situation*. The report stresses that nutritional status has much to offer those who seek to strengthen governance, reduce poverty and make trade liberalization and health-sector reform work for the poor. For health-sector reform, the huge and largely unappreciated role that malnutrition plays in the global burden of disease, together with the existence of a range of cost-effective health-sector interventions available to improve nutrition, places nutrition activities among the best options to improve the efficiency and quality of health services. And, since malnutrition affects mostly the poor and vulnerable (women and children), addressing malnutrition also addresses inequities in health.

The potential of the nutrition community to accelerate broad development goals is clear. The potential of the development community to mobilize resources for malnutrition reduction is equally obvious. For this "win-win" situation to materialize, the nutrition community needs to recast itself. It must see itself as a component of the development community concerned with nutrition. It must forge new connections across unfamiliar divides. If it does not, nutrition might be relegated to simply being an indicator of the attainment of the MDGs, rather than an essential foundation for their attainment.

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THE SCN AND THE MILLENNIUM DEVELOPMENT GOALS

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Last October in Des Moines, Iowa, our chair, Catherine Bertini, received the 2003 World Food Prize for her remarkable leadership in making the World Food Program the largest and most efficient feeding programme in history. UN Secretary General, Kofi Annan sent a strong message of congratulations to her and added an additional comment that equally applies to this SCN session and my theme today:

I am also very pleased that you are reviewing the United Nations Millennium Development Goals. At a time when many difficult issues divide the international community, these Goals are a shining example of consensus among all nations on what is needed to build a better world. Let's all work together to achieve them – and especially to half world hunger by 2015.

History of the SCN

In 1956, UNICEF, recognizing the importance of timely and appropriate complementary feeding of infants and young children, proposed an initiative to develop and make available low cost protein-rich foods for use in developing countries. At that time UNICEF was expected to receive its technical advice from WHO and FAO. However, neither agency had the necessary technical competence to do so. Dr Marcellino Candau, then Director of WHO, agreed to establish a technical advisory committee on this issue, leading to the creation of the Protein Advisory Group (PAG) in 1956. FAO and UNICEF supported the PAG from the beginning, with major bilateral and international agency support following. The PAG developed standards for a variety of protein sources, guidelines for animal and human testing of new weaning foods, specifications for nutritional content of weaning foods, instructions for effectiveness trials, appropriate complementary feeding and much more.

However, by the 70s the international agencies felt that the original purpose of the PAG was fulfilled. The bilateral agencies, who had become major participants in PAG meetings protested against terminating it, stating that no other mechanism existed for bringing together the international and bilateral agencies involved in nutrition to define, discuss and harmonize their programmes.

Largely due to the insistence of the bilateral agencies, the Agency Committee on Coordination (ACC), on the recommendation of the Economic and Social Council (ECOSOC), established the Sub-Committee on Nutrition (SCN), “to provide initiative in the development and harmonization of policies, concepts, strategies and programmes in the United Nations System in response to the nutritional needs of countries,” with the, “major objective of serving as a point of convergence in harmonizing the policies and activities of the United Nations agencies and hence the United Nations System.”

The PAG held its last meeting in May 1977 and the ACC/SCN met for the first time in September 1977 in Rome. At the same time, to supplement the still limited nutrition expertise available within the agencies, the ACC approved an Advisory Group on Nutrition (AGN) that for many years served the valuable purpose of reviewing agency programmes and identifying new issues and priorities for the SCN.

It is noteworthy that throughout most of its history the SCN did not welcome non-governmental organizations (NGOs). Today NGOs provide important expertise and leadership within the SCN and form a third grouping alongside bilateral and UN agencies. The number of nutrition experts at SCN meetings from the international and multilateral agencies has steadily increased, particularly through the participation of the regional nutrition advisors from FAO, WHO, and UNU. By 2001, the number of highly qualified and experienced nutritionists within the agencies, and later within participating NGOs, significantly outnumbered the very small AGN; it was clear that the AGN was no longer essential. Today there are more than 100 qualified nutrition scientists registered at this 31st Annual Session.

Over the years, it has been to the SCN's advantage to be inclusive rather than exclusive at its annual meetings and other activities. However, the lack of trust that once blocked the participation of the



NGOs is now directed towards major private sector participation. Nevertheless, the camel's head (not just the nose) is already in the tent. It would be to the SCN's advantage to invite private sector leaders to form a fourth grouping within the SCN structure. Since academics are, in current parlance, embedded in each of the four groups, a fifth grouping for them is not needed.

This brief history highlights how the SCN has evolved into a uniquely valuable organization that has much more expertise and influence today than at any time in its history. The global experience and competence represented at this current meeting indicates what an extraordinary institution the SCN has become. Now the challenge is for the SCN and its member institutions to make the critically important contributions necessary if the international system is to achieve the Millennium Development Goals (MDGs).

The SCN and the Millennium Development Goals

The mandate of the SCN is

...to serve as the UN focal point for promoting harmonized nutrition policies and strategies throughout the UN system, and to strengthen collaboration with other partners for accelerated and more effective action against malnutrition.

Its aim is

...to raise awareness and concern for nutrition problems of global, regional and national levels; to refine the direction, increase the scale and strengthen the coherence and impact of actions against malnutrition worldwide and to promote cooperation of UN agencies and partner organizations.

I will provide an overview of the role nutrition plays in achieving the MDGs and suggest how the SCN can play a vital role in this process. The mechanisms available to the SCN are multiple:

- discussions and resolutions at annual meeting
- discussions, reports and recommendations of working groups
- follow up activities by the Secretariat
- commissioned papers and reviews
- *SCN News* and other publications
- coordination meetings on special topics
- actions of the Steering Committee.

Working groups, along with ad hoc task forces, should be the principal means of maintaining SCN's influence and momentum between meetings. Their effectiveness is now limited by short sessions at annual meetings that are usually clogged with reports. These groups must also have a single strong chair with available time to dedicated to the subject.

To be more effective, the SCN must make much greater use of its additional implementation mechanisms.

- Assigning responsibility for specific activities to working groups between annual meetings and creating new working groups or task forces for such purposes. Some working groups should have their own secretariat for continuing actions between, and in preparation for, SCN meetings.
- Through advocacy, influencing private sector organizations, including both global and local food companies, to adopt nutritionally sound practices (eg, fortification and enrichment with appropriate micronutrients, affordable and nutritionally sound complementary foods for infants and young children).
- Adopting strategies and mechanisms for much broader and strategic communication of SCN analyses and recommendations, including strategically placed reviews and advocacy pieces, television programmes, resources for science and policy writers, and prominent lectures.
- Persuading internationally recognized leaders (Nobel and World Food Prize laureates, former UN agency directors, etc) to serve as advocates for specific nutrition programmes during international and regional UN meetings and national visits.

Two additional points: the Secretariat should see its role as promoting and facilitating the strategies that the members implement towards the MDGs; and as a contribution to developing future leaders in nutrition, young nutrition scientists, particularly from the country or region in which the SCN meets,



should continue to be invited to participate.

Nutrition and the Millennium Development Goals

Below are specific actions the SCN should undertake in respect to the MDGs:

Goal 1 – Eradicate extreme poverty and hunger

It is the mission of the SCN and its agency partners to do everything possible to reduce hunger. The SCN should commission and distribute authoritative and compelling reviews of the relationship between poverty and hunger. It should also support proven measures to reduce poverty such as micro-credit and policies to support peasant agriculture (eg, agricultural extension, subsidized inputs, and guaranteed minimum prices).

Goal 2 – Achieve universal primary education

The effectiveness of universal primary education is in part dependent on avoiding the cognitive damage associated with iodine deficiency in pregnancy, iron deficiency in infancy and protein-calorie malnutrition in preschool children. The SCN should demonstrate to government planners that education is less cost-effective if iodine deficiency in pregnancy and infancy and protein-calorie malnutrition in pre-school years are not corrected. It should also disseminate evidence on the strong link between nutrition, education and achieving the other MDGs.

Goal 3 – Promote gender equality and empower women

Gender equality and empowerment of women has long been an initiative of the SCN and its agency partners. The SCN has already widely distributed “The Asian Paradox,” an article attributing the higher rate of stunting in Asia to the chronic under-nutrition of Indian women and the strong gender bias that robs them of control of their lives. The SCN should continue to publicize, in ways that influence policy-makers, the connection between the empowerment of women and the achievement of the other MDGs. It should also identify and promote specific measures that will improve the status of women in a society.

Goal 4 – Reduce child mortality and Goal 5 – Improve Maternal Health

Goals 4 and 5 can be achieved only with the kind of initiatives and actions that the SCN has been promoting. The SCN and its members are already playing a major role in the elimination of micronutrient deficiencies, such as iodine, vitamin A, folic acid, iron and zinc, as public health problems, but there are serious gaps in its efforts. Continuing to promote early exclusive breastfeeding and supporting better prenatal care will also help.

Goal 6 – Combat HIV/AIDS, malaria, and other diseases

Infectious diseases and malnutrition are synergistic which should be viewed as a part of the SCN's mandate for action. The SCN should aim to influence national and international policies and programmes to promote research and disseminate information about the role nutrition plays in the severity and outcome of infectious diseases and on the effect of infections in precipitating nutritional deficiencies and stunting.

Goal 7 – Ensure environmental sustainability

Nutrition is dependent on food, but food security requires sound cropping practices, water management, and sustainable animal and fisheries production. The SCN should take into account the need for environmental sustainability in research, policy, planning and implementation. It should also work with agencies and organizations promoting environmentally sustainable food production.

Goal 8 – Develop a global partnership for development

Because of the link between malnutrition and poverty the SCN should promote global partnerships for development. The SCN's members are already involved in such partnerships, this should be recognized and strongly encouraged.

The effectiveness of the SCN on various food and nutrition issues has varied over time but has always been positive. Progress has been made in:

- controlling vitamin A and iodine deficiencies
- the promotion of breastfeeding and baby friendly hospitals
- the inclusion of folic acid in iron and multivitamin supplementation and fortification programmes



Table 1

Prevalence of iron deficiency		
Region	Prevalence	%
Africa	293,000,000	46
Americas	142,000,000	19
Eastern Mediterranean	184,000,000	45
Europe	86,000,000	10
South East Asia	778,000,000	57
Western Pacific	598,000,000	38
Total	2,032,000,000	37

- the fortification of rations for refugees
- the promotion of a human rights approach to nutrition.

However, the SCN has not been effective in two areas of importance. One is timely and appropriate complementary feeding. Last December, *SCN News* featured articles on, “Meeting the Challenge to Improve Complementary Feeding.” The SCN needs to respond with actions to address the serious problems identified in this report. For the first time this year, complementary feeding is a major component of the working group’s agenda.

The response of the SCN is addressing iron deficiency, which is closely related to complementary feeding, has also been disappointing. This is an important neglected area of nutrition for which there are specific, urgent and effective responses that could make an important contribution towards achieving the MDGs.

At last year’s meeting in Chennai, India, Betsy Lozoff and I presented evidence and called for actions to prevent the extremely widespread and serious cognitive damage of children in developing countries caused by iron deficiency in infancy. With few exceptions, the SCN and its members have done little on this issue or the other consequences of early iron deficiency across the life cycle. In fact, the working group on iron has been incorporated into a single working group dealing with all micronutrients.

The UN Special Session on Children called for a population-wide 30% reduction in anaemia, including iron deficiency, by 2010. Concerted effort toward achieving this target could become an example of how the new SCN can tackle a major, relatively neglected problem, vigorously and effectively. Reducing iron deficiency would have a major impact on nearly all of the MDGs.

Table 1 leaves no doubt that iron deficiency is a massive global health problem. As this tabulation shows, the global prevalence rates are staggeringly high with over two billion iron deficient persons.

In addition:

- prevalence rates in women and children in most developing countries are 40% to 60%
- generally, anaemia prevalence rates for pregnant women in developing countries exceed 50% to 60%
- at up to 100% the prevalence of functional iron deficiency is double that of anaemia.

Even full term, exclusively breastfed infants need either supplementary iron or iron fortified complementary foods from six months of age. For low birth weight babies, additional iron is needed from two months of age. Under one year of age, the required iron cannot be supplied from unfortified food in any society. Iron deficiency is unique in the extent of its adverse impact on health and its economic and social costs at any age or stage in the life cycle including:

- high risk of lasting cognitive damage in infancy
- poorer pregnancy outcomes and lower iron stores in infants
- impaired learning in school, reduced growth, and increased rate of infections in children and adolescents
- high risk of moderate to severe anaemia in pregnancy



- fatigue, lower physical capacity, lower immunity and increased rate of infection, and reversible cognitive deficits in adults and the elderly.

The SCN and its members should have attacked the problem more vigorously long ago. Sufficient knowledge of the needed interventions has been available for some time and experience is steadily growing in how to integrate and apply them effectively. I hope that the SCN will make severe iron deficiency reduction a high priority as part of its contributions to achieving the MDGs.

To be effective in reducing iron deficiency, the SCN should:

- develop a strategic plan which assures that the prevalence and consequences of iron deficiency are understood by governments, agencies and organizations that can contribute to its elimination
- support the universal fortification of flour with B vitamins, including folate and iron
- ensure the provision of preventive weekly iron supplementation for women of childbearing age and pregnant women
- strengthen and expand the current recommendations of the temporary subgroup on the elimination of iron deficiency in children under two years of age through a taskforce with a mandate for action
- promote new efforts and strategies, including those by the food industry, to increase the availability and affordability of iron fortified complementary foods and new “in-home” fortification
- link efforts to reduce iron deficiency with interventions to reduce the prevalence of malaria, prevent and control intestinal parasites, as well as with policies and efforts to improve the nutrition of those living with and affected by HIV/AIDS
- encourage operational and basic research related to iron deficiency and disseminate results and programme outcomes
- promote the effectiveness of *SCN News* in communicating information on iron; a review of recent issues indicates that the topic has been neglected.

Effective information dissemination and advocacy for the prevention of iron deficiency should be a priority for SCN. In addition to reports from the annual meeting, there should be articles related to iron deficiency in *SCN News*, the organization of symposia at scientific meetings, and a specific web-site on the topic. The SCN also needs to follow the successful example of the International Council for Control of Iodine Deficiency Disorders which initiated high level visits to government ministers of health and education to promote legislation and programmes for the prevention of iodine deficiency.

With the support of the Micronutrient Initiative, the United Nations University will continue hosting the iron secretariat for the Working Group on Micronutrients through the International Nutrition Foundation's Iron Deficiency Project Advisory Service project. It will also continue to make available electronically and through CD-ROM the latest information needed by programme implementers for the prevention of iron deficiency.

Summary

This is a new SCN, with a new Chair and Secretary, and a record number of institutional members in three main categories: UN agencies, bilateral agencies, and NGOs. A fourth group, made up of leader from the private sector, would add further strength to the SCN.

The SCN has a new mandate—to help the global system reach the MDGs. The SCN can make a significant start by agreeing on specific issues and actions that will contribute to reaching the MDGs as defined by the UN system. The SCN and its members already have a head start; two closely related and neglected global issues have been identified and should be given priority: timely and appropriate complementary feeding and the high prevalence of iron deficiency.

The working groups and task forces will need to be active between SCN meetings and establish their own secretariats. In addition, the SCN should develop a strong communication and advocacy strategy and promote key SCN messages through outstanding public figures.

Although the SCN and its members have effectively focused on some of the MDGs, it should now be making contributions to achieving all of them. I am confident that the new SCN and its Secretariat will implement the multiple mechanisms available to help the UN system and its partners meet this global challenge.

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MILLENNIUM PROJECT HUNGER TASK FORCE

PEDRO SANCHEZ

CO-CHAIR, HUNGER TASK FORCE

Across the world, 840 million people suffer from hunger. Only 8% of these people are victims of famine or other extreme events. This leaves 92% of those 840 million people suffering from chronic, multi-generational hunger. Unfortunately, it is all too easy to show that donor countries prioritize their funding toward the 8% and not the 92%. In Ethiopia for example, USAID spends \$400 million on help to famine victims but only \$5 million to help victims of chronic hunger. As the chronically hungry continually lose their aid to victims of extreme events, they become more vulnerable to the kinds of shocks that cause extreme events. These funding priorities will not lead to the end of hunger.

Chronically hungry people are made up of several different demographic groups. Fifty percent are smallholder and subsistence farmers who farm their own land; 22% live in rural areas but own no land; 20% live in urban areas; and 8% are pastoralists, forest dwellers, and fisher folk.

The Millennium Project Hunger Task Force has been brought together by Jeffrey Sachs, Special Advisor to the UN Secretary General and head of the Millennium Project. We have been charged with designing a business plan to cut the number of hungry people by half by the year 2015. We will deliver this business plan to the Secretary General in 2005. The Task Force members are a wide variety of experts from science, policy, academia, African governments, NGOs, UN agencies, and the private sector.

We have an especially strong group of nutritionists on the Task Force: Abenaa Akuamo-Boateng from the Ghana Ministry of Health, Patrick Webb of the World Food Program, Meera Shekar of the World Bank, Graeme Clugston of the World Health Organization, and Hans Eenhoorn of Yara International, a division of Unilever.

Working with these nutritionists as well as a group of demographers from the Centre for International Earth Science Information Network, the Hunger Task Force has mapped two major factors by region in Africa: percentage of underweight children underfive by subnational unit and population of underweight children underfive by subnational unit.

We combined these two factors to identify 75 hotspots with greater than 100,000 underweight children underfive as well as a percentage of underweight children underfive that is more than 20%. Of those, eight clusters have been selected for further analysis. Similar research is under way for Asia and Latin America. The final analysis will be released in the Hunger Task Forces' final report.

On the policy level, we have divided our recommendations into three realms of action. Internationally, the whole world must commit to ending hunger. Nationally, developing nations must adopt enabling policy reforms, while wealthy countries must be willing to make trade more fair and aid more available. On the local level, we are advocating synergistic interventions, particularly in the hotspots, to increase the productivity of food insecure farmers, enhance market access to generate income, restore natural assets, and improve the nutrition of the vulnerable.

In order to increase agricultural productivity for food insecure farmers, we must invest in soil health, small-scale water management, seed delivery systems, and reinvent extension. Soil health will require agroforestry techniques, cover crops, and fertilizer subsidies. In Eastern and Southern Africa, 250,000 farm families are already using agroforestry to ensure the productivity of their soil.

In order to improve the nutrition of vulnerable groups, we advocate for programmes using locally produced food that target pregnant and lactating women, children under two, pre-school and school-age children, as well as those suffering from HIV/AIDS and other conditions. We also specifically advocate fortified food supplementation as well as emergency food aid.

For dealing with acute hunger, the Hunger Task Force recommends multilateral, undirected contributions to the World Food Program. Cash donations should be made a priority because they provide more flexibility than commodity donations. Donated food should be used primarily for emergencies when local or regional purchase is not an option. Cash should be used to purchase food locally as much as possible.

In order to enhance market access and income generation, the Hunger Task Force recommends diversification, micro-enterprise, and food-for-work programmes. In addition, governments must invest in



rural infrastructure to make transportation and communication more available to foster market development. In addition, in order to restore natural assets, local communities must restore their degraded lands and governments must invest in slash-and-burn alternatives as well as in green enterprise development.

Though the Hunger Task Force has only been in existence since 2002, we already have encouraging results to report from early village-level actions that were influenced by our recommendations. In the Sekyedomase District in Ashanti, Ghana, Task Force Member Abenaa Akuamo-Boateng of the Ministry of Health instituted supplementation of 422 infants with quality protein maize and barley malt. The supplementation doubled weight gains in seven months and reduced stunting and infant mortality rates.

In the Barsauri Primary School of Nyanza Province, Kenya, Task Force Member Bashir Jama of the World Agroforestry Centre reports that locally produced school lunches resulted in 100% passing of Standard 8 exams. Fifty percent of the children who passed are HIV-AIDS orphans.

According to Task Force Associate Fidelis Wainaina of the Maseno Interchristian Child Self-help Group, Inungo Village in Western Kenya showed a decline of malnourished children under five from 87% to 13% in five years thanks to agroforestry, crop diversification, and malaria control. The village has a high prevalence of HIV-AIDS widows and orphans.

I spoke earlier about reforming national policies. I would like to go into a few more specifics now about what policies are necessary. First and foremost, developing countries and donors must give budget priority to agriculture. In the past, agricultural investment has favoured cash crops that are largely cultivated by men. Even though 80% of farmers in Africa are women, women receive only 7% of extension services. When governments and donors prioritize agriculture, they must prioritize investment in women as farmers and as citizens. Women need inheritance and property rights as well as access to water, fuel wood, conservation tillage, credit and education.

Governments also need to invest in rural areas: roads, education, health, energy, and communications. They must support the self-organization of the poor. We will never achieve the MDGs unless we invest in human capacity. That means education and training for all. In addition, all governments, rich and poor, must eliminate perverse trade subsidies.

In the Millennium Declaration, developing nations pledged to transparency and effective governance in exchange for advice on best practices and smart ways to invest in their citizens. In that same document, wealthy countries committed to increasing sustained investment over the next ten years and longer to help solve the problems. All countries must work together to make development assistance much more effective.

The Hunger Task Force has already begun a variety of work to bring countries together and advise them on best practices. On July 4, 2004, the Task Force and the Government of Ethiopia will co-host a Presidential Level Seminar entitled "Innovative Approaches to Meeting the Hunger MDG in Africa". In addition, the Hunger Task Force is involved in a variety of country advising projects in several African countries. The Earth Institute at Columbia University has also joined the effort by opening the MDG Technical Support Centre in Nairobi, Kenya to provide solutions to development problems.

I would like to leave you with an important message that we all need to hear. Halving hunger by 2015 is possible. The resources and knowledge to do it exist. It is no longer an impossible dream. It is now a political choice that requires a global commitment. We must make that commitment.

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Halving hunger by 2015 is possible. The resources and knowledge to do it exist...It is now a political choice that requires a global commitment. We must make that commitment.



NUTRITION AND THE MILLENNIUM DEVELOPMENT GOALS

A KENYAN PERSPECTIVE ON THE ERADICATION OF EXTREME POVERTY AND HUNGER

SUSAN J KEINO

8TH DR ABRAHAM HORWITZ LECTURE

Poverty and food insecurity are the twin challenges of the 21st century, alongside issues such as HIV/AIDS, conflicts, and natural disasters. Although many countries have had different strategies to tackle these challenges, the United Nation's Millennium Development Goals (MDGs) provide a united front where eight universal goals must be achieved by the year 2015.

The first part of this paper focuses on the MDGs, what they mean for developing countries and progress in achieving them. The paper goes on to discuss why some countries have made progress, especially in alleviating poverty, and why others have not. The second and third parts of the paper address Kenya's progress in achieving the MDGs, policy implications since independence and achievements since the country endorsed the Millennium Declaration at the Millennium Summit in September 2000. The fourth part provides policy recommendations which Kenya should make a priority to alleviate extreme poverty and hunger and most importantly, towards improved nutrition as a key development input.

What the Millennium Development Goals mean for developing countries

In November 1996, the World Food Summit (WFS) recognized access to and availability of food as a human right, yet hunger has continued to plague the developing world, especially South Asia and Sub-Saharan Africa¹. The Copenhagen Declaration on Social Development indicates that more than one billion people in the world live in abject poverty and most go hungry every day². There has been a variety of efforts to eradicate poverty in developing countries, however, only some countries have improved their living standards. In Sub-Saharan Africa, progress has been slow³.

Firstly, through various poverty reduction strategies, many developing countries have experienced an improved growth in gross domestic product (GDP), increased food production, improved school enrollment, gains in the status of women, improved access to primary health care and clean water, and an enhanced respect for human rights. Yet, Sub-Saharan Africa has not followed these trends. Instead, over the recent decades, several factors such as poverty, civil strife, droughts, diseases such as HIV/AIDS, high population growth, decreasing food production, and, sadly, greed, corruption and indifference amongst leaders have exacerbated the food and nutrition situation in many African countries. In addition, as the SCN reports, Sub-Saharan Africa is the only region in the world where the number and percentages of malnourished children is expected to rise over the next twenty years⁴.

Secondly, in developing countries, and in particular Africa, there is a lack of sustained political commitment as seen by the low per capital spending on nutrition. Thirdly, poverty alleviation strategies have not incorporated nutrition programmes, which reduce hunger faster than poverty alleviation strategies alone⁴.

The WFS acknowledged that the solution to problems of poverty and malnutrition in Africa lies in the empowerment of rural communities through assisting them in identifying and overcoming constraints of participation in developmental processes leading to improved living standards and quality of life¹. The empowerment of rural communities to address the MDGs is the responsibility of concerned governments and communities themselves. Governments, because they have a responsibility in meeting the food and nutrient needs of their people; communities, because they have the power to bring about change in living standards through community-based projects. The community is the key stakeholder in any developmental process. It is disappointing that the majority of people living in poor communities, whose needs the goals are addressing, have no knowledge of the existence of the MDGs. This calls for awareness raising within these countries to enlighten people on the existence of fundamental goals which realize their basic needs.

The potential to achieve the MDGs in developing countries is within reach, however, guidance is needed from international organizations and donor agencies on how to accomplish this as well as support in the ongoing process. Most developing countries are endowed with resources that can be chan-



nelled towards the achievement of the MDGs. The first goal on the eradication of extreme poverty and hunger may be the sole goal that will steer the wheel towards the realization of other equally significant goals. However, successful poverty alleviation strategies cannot be designed without an appropriate understanding of poverty and hunger and the relationship that exists between the two. The vicious circle of poverty breeding malnutrition and in turn malnutrition increasing poverty, is further compounded by the distances women have to travel to access markets, health facilities, water, and firewood; the high numbers of unemployed; and the low education levels and high school drop-out rates.

The introduction of MDGs, therefore, has given developing countries a renewed sense of urgency and has emphasized the importance of poverty eradication and of improving livelihoods; it has also provided a united front whereby countries have come together to achieve common goals as well as a time-frame which is the year 2015.

Poverty and hunger in Kenya: post independence policy implications

Since independence, the Kenyan Government has undergone a transition of policies under government control (1963-1979) to liberalized markets (1980 to date)⁷. The control era was marked by government control and participation in agricultural production, marketing and investment activities. The government emphasized self-sufficiency in domestic production of the main food commodities, namely maize, wheat, rice and milk as a means of achieving food security. On the other hand the era of liberalized economy has emphasized the role of market forces in guiding production and marketing of agricultural commodities, with increased private sector involvement and reduced government participation. The mounting debt crisis resulting from the control era triggered the World Bank and International Monetary Fund to push for new policies that limited the state's role by creating enabling environments for individuals and associations to pursue their economic and social objectives⁷.

This shift by Kenya from an era of control to a liberalized economy saw the country move from a food secure to a food insecure nation. Until the late 70s, food security was achieved through domestic production and facilitated by specific policy actions including:

- major land distribution by government to small-scale farmers
- government supported agricultural research that resulted in the release of new high yielding varieties for maize and wheat
- expanded agricultural extension services both in quality and quantity—individual and group farm visits, field demonstrations and whole farm integrated project management (it became expensive in the long-run and targeted only a small group of wealthy farmers)
- increased use of subsidized farm inputs at government-controlled prices
- credit to farmers was made available through the Agricultural Finance Corporation
- producer prices received by farmers were controlled by the government and later deliberately increased as an incentive for farmers to achieve food self-sufficiency
- the marketing of commodities, coordinated by a number of statutory marketing boards, was a booster to agricultural development through the provision of readily accessible markets. Nonetheless, unofficial parallel market outlets for cereals and livestock products existed.

It is worth noting that the above-mentioned policies were centred mainly on agriculture, which was then, and still is today, considered the backbone of the economy. Despite the success of policies in achieving food security in the 60s and 70s (the era of controls), in the 80s, the country was confronted with food shortages and was forced to import maize, wheat and milk in substantial quantities to meet the shortfall⁷.

The food shortfall was attributed to some of the following factors:

- a decline in production due to reduced land available for food crops, resulting from competition by other more profitable commodities
- pricing and marketing inefficiencies
- drought conditions in 1979, 1980 and 1984
- low credit availability and accessibility
- little emphasis and support from the government on traditional, drought resistant food crops such as cassava, sorghum and millet
- concentration of wealth by politically influential individuals, including stretches of under-utilized land



- onset of corruption and mismanagement in public offices
- mismanagement and eventual collapse of food processing and marketing industries such as the Kenya Meat Commission, the Kenya Cooperative Creameries and National Cereals and Produce Board
- the wake of the HIV/AIDS pandemic leading to socio-economic conditions that have affected food production and caused financial instability in the households
- high cost of education and health care leading to low expenditure on food production and purchasing.

With a trend of poor performance in the policy sector for the past decades, there are new efforts to revive the economy, improve food security and eradicate poverty.

The Millennium Development Goals in Kenya

The Kenyan Government endorsed the Millennium Declaration at the Millennium Summit in September 2000. The goals, targets and indicators highlighted in the Summit have given the on-going national frameworks, initiatives and processes a new sense of direction and time frame—the year 2015¹¹.

With a new government in place, Kenya has made progress towards improved governance and renewed donor confidence; however, the challenges facing the nation are still enormous. Poverty remains a constraining factor, and poor health and malnutrition have continued to hinder efforts towards poverty reduction through low productivity and high morbidity and mortality rates. The government has in place various poverty reduction policies and programmes that are designed with the participation of the poor and other stakeholders. At the macro level, these include the National Poverty Eradication Plan (NPEP), the Poverty Reduction Strategy Paper (PRPS), and the Medium Term Expenditure Framework (MTEF). While at micro level, there are specific programmes that address the needs of local communities in various parts of Kenya. With this approach the government expects to reverse the current poverty situation.

While looking at the progress in achieving the MDGs it is important to highlight the strategies the Kenyan Government has adopted to improve human development by 2015 and where nutrition can be incorporated as an input, not just as an outcome.

Goal 1: Eradication of extreme poverty and hunger

NATIONAL POVERTY ERADICATION PLAN AND POVERTY ALLEVIATION

Kenya's population is about 29 million people according to the 1999 census and is projected to grow to 31 million in 2002¹¹. About 56% of the population (that is approximately 16 million people), live below the absolute poverty line, meaning that they are not able to meet their daily basic needs in food, shelter, health, education and related social needs⁸. The NPEP, mentioned above, lists as its main objectives: the reduction of poverty in both rural and urban areas by 50% by 2015; the reduction of gender and geographic disparities, and a healthier, better educated and more productive population. The report on the *Perspectives of the Poor on Anti-Poverty Policies* further reiterates that women and children in general suffer more from intra-household elements of poverty than men, while specific groups such as orphans, single mothers, widows and people with disabilities also suffer disproportionately. The report on the *Geographic Dimensions of Well-being in Kenya*, where poverty mapping has been conducted from district to local levels, clearly documents where the poor are concentrated and the causes of poverty in these regions⁵.

Through the NPEP and the PRSP, the government has put in place the Economic Recovery Strategy for Wealth and Employment Creation (2003-2007)¹⁵ to revive the ailing economy as well as create jobs. Some of the specific objectives include creating 500,000 jobs annually, reducing the poverty level by at least 5% from the current 56.8% level, achieving a high GDP growth rate (rising from an estimated 1.1% in 2002 to 7% in 2006), containing the average annual inflation rate to below 5% and increasing domestic savings to enable higher levels of investment for sustainable development.

NATIONAL FOOD POLICY AND FOOD SECURITY

A selected policy area identified by the report on the *Perspectives of the Poor on Anti-Poverty Policies* is food security. The picture that emerges in the study is one of declining food security and changing consumption patterns, limited extension services, low quality farm inputs and high cost of foodstuffs. However, as stated in the National Food Policy, food security should have top priority since no meaningful development in the economic, social or cultural spheres is possible without it⁹. Food insecurity reduces the quality of life through malnutrition and poor health as a result of infections; infections lead



INDICATOR (children underfive)	Year		
	1990	2000	2015
Prevalence of underweight (weight-for-age)	32.52	33.12	16.26
Prevalence of stunting (height-for-age)	6.17	6.6	3.09
Prevalence of wasting (weight-for-age)	22.5	22.1	11.05

Table 1

Source: Millennium Development Goals Progress Report for Kenya, 2003

to low productivity and low income, thus reducing expenditures for medical services and education. This is evident in the latest report by Kenya Demographic Health Survey (KDHS), which indicates that the steady rise in the death of children is one of the clearest indicators of a drop in the quality of life in Kenya over the past 20 years¹⁰. KDHS indicates that between 1989 and 2003 the infant mortality rate increased by 30%. This is a rise from 60 deaths per 1000 live births in 1989 to 78 deaths per 1000 births in 2003. The child mortality for the same period also increased by 30% from 89 deaths per 1000 births in 1989 to 114 deaths per 1000 births in 2003. Causes of death have been identified to be malnutrition, morbidity, and impaired mental and physical development.

In Kenya, malnutrition remains high according to the *Millennium Development Goals Progress Report for Kenya*¹¹. Table 1 below gives the current prevalence of protein-energy malnutrition among children underfive, based on the 1998 KDHS survey. By 2015, it is projected that there will be a decrease in the prevalence of malnutrition due to the efforts in place to improve food security.

Agriculture, livestock and fishing are major productive sectors identified for investment towards economic recovery as well as provision of food, both in the productive and marginal lands (arid and semi-arid areas). The government has also proposed to eliminate vitamin A deficiency in underfive year olds by 2005 through the production and consumption of nutritious foods, especially those locally produced.

GOOD GOVERNANCE AND DEMOCRACY

The year 2003 can be termed as the year of rebirth for Kenya. The new coalition government has put in place new policies to rejuvenate the ailing economy and improve livelihoods, thus signaling political will. This, together with the new policies will go a long way in achieving the MDGs. What we hope for is continued transparent and accountable governance. Further, the *Millennium Development Goals Progress Report for Kenya*¹¹ indicates that the current government has demonstrated renewed commitment to reducing the high levels of poverty and hunger through the existing initiatives mentioned above and the Economic Recovery Strategy for Wealth and Employment Creation for 2003-2007, as well as its commitment to the New Partnership for Africa's Development (NEPAD) principles which is linked to national planning, poverty reduction and economic recovery.

Goals 2 and 3: Achieving universal primary education and the promotion of gender equality and the empowerment of women

Education is a key determinant of earnings and an important exit strategy from poverty. It improves people's ability to take advantage of the opportunities that can improve their well being and to participate more in the community and markets. The education level of mothers significantly affects the health and nutritional status of household members. On the other hand, poverty and lack of food tend to hamper efforts to provide education. Children from poor families drop out of school in search of employment to contribute to the family income, while those who opt to stay in school have low levels of concentration due to hunger pangs and poor performance. Maternal malnutrition leads to impaired infant growth due to poor nutrition during foetal life, whereas foetal and infant undernutrition affects children's school enrollment, educational attainment, cognitive ability and lifetime earnings. Micronutrient deficiency, especially iodine deficiency, has a spectrum of effects on growth and development, particularly mental. Prevention will therefore result in improved quality of life, productivity, and educability of children and adults.

To achieve the goal of universal primary education, the government has in place the policy of free primary education. This is aimed at reversing the trends of low enrollment and high drop-out rates. Table 2 indicates that the government aims to achieve 100% enrollment by the year 2015.

According to the *Millennium Development Progress Report for Kenya*¹¹ the government's policy of free primary education will substantially contribute towards attaining the second MDG of universal access to primary education by the year 2015. The current and recent unsatisfactory performances of the pri-

**Table 2**

INDICATOR	YEAR		
	1990	2000	2015
Net enrollment rate in primary education	80.0	73.7	100
Proportion of pupils starting grade 1 who reach grade 5	63	81	100

Source: MDG Progress Report for Kenya 2003

mary school system are often linked to Kenya's previous cost-sharing policy and differential geographic access to educational facilities, staffing problems and mismanagement of education resources. The major challenges facing the universal primary education initiative include:

financing the infrastructure expansion and human resource

regional disparities in access whereby low enrollment in some areas is closely linked to the nomadic lifestyle of is local population

high wastage rates, repetition and drop-out rates, and low transition are exacerbated by poverty and HIV/AIDS pandemic

reducing child labour which has been identified as one of the factors explaining declining enrollment rates in primary school in Kenya.

In an effort to close educational achievement gaps between regions and economic classes, the government has invested in four key programmes/activities. These include the children's bill, which provides the framework for enforcing universal primary education in the country and became an Act of Parliament in 2002; the school feeding programme that targets the arid and semi-arid lands; the textbook fund; and the bursary fund to enable the poor to further their education.

The third MDG promotes gender equality and empowerment of women. The goal targets the elimination of gender disparity in primary and secondary education preferably by 2005, and at all levels of education, no later than 2015. *Kenya's Millennium Development Goals Progress Report* indicates that although female to male ratio in primary and secondary school is almost equal, there is a major gap in enrollment in tertiary institutions. However, the enrollment ratio in mid-level tertiary institutions increased from 22.5% in 1998/1999 to 44.2% in 2001/2002. Factors such as premarital pregnancy and early marriage may determine the low progression of women from secondary to tertiary institutions; however, the choice of school subjects and females' poor performance at the end of their secondary schooling influences their engagement in the job market. Results of final secondary school examinations show that girls perform better than boys in languages, while boys consistently perform better than girls in all science subjects.

To promote gender equality, there is a national gender and development policy that has been approved but needs implementation. Other than attaining education, women need to take up leadership positions to influence decisions affecting household accessibility to basic needs such as water, food and shelter. This is also supported by the gender dimensions of the New Partnership for Africa's Development (NEPAD)¹⁴, which emphasize women's participation in macro-economic debates as well as those taking up political positions. Kenya continues to perform dismally in the participation of women in politics. There has been an increase in the number of women members of parliament from a mere five in 1990 to 18 in 2002/2003 (8% of the total parliamentary membership). In terms of leadership positions only seven women serve as Government Ministers as compared to 44 positions held by men.

The involvement of women in non-agricultural wage employment is quite low. The annual economic survey data on wage employment in the modern sector for 1999-2001 reports women's participation around 30%. A review of data on civil service employees shows that women made up 24.3% in September 2002, with a majority concentrated in the lower level job groups, whereas few occupied decision-making positions in the civil service.

The MDGs Progress Report reiterates that the government has committed itself to mainstreaming gender issues in its legislations, policies and programmes. It is also a signatory to international conventions and treaties on women's rights and empowerment.

Goals 4 and 5: reduce child mortality and improve maternal health

Maternal malnutrition causes intrauterine growth retardation (IUGR), and low birth weight. Due to

**Table 3**

INDICATOR	YEAR		
	1990	2000	2015
Underfive mortality rate	98.9	111.5	33.0
Infant mortality rate	67.7	73.7	24.0
Measles	48	76.1	100

Source: MDG Progress Report for Kenya 2003

this, children have a higher risk of dying in infancy. Survivors of IUGR are unlikely to catch up significantly on this lost growth and more likely to experience developmental deficits. Underweight children tend to have severe illnesses (eg, diarrhoea and pneumonia) due to compromised immune systems. Therefore, nutrition is an important component in ensuring a healthy population through proper maternal and child nutrition.

There was a reduction in infant and child mortality in Kenya during the 1960-1990 period. From more than 190 deaths per 1,000 live births in the 60s, the underfive mortality rate decreased to less than 100 deaths per 1,000 live births in the 90s. It is reported that this substantial reduction was, to a large extent, made possible through the control of malaria, tuberculosis, measles, cholera and other highly communicable diseases. For the last decade, Kenya has experienced an increase in infant and child mortality. KDHS reports that today at least 12% of children born alive do not reach age five. This is attributed to a high incidence of child malnutrition, poverty, the HIV/AIDS pandemic, acute respiratory infections, malaria and diarrhoea, and the low quality of health facilities and services.

Similarly, the infant mortality rate decreased in the period 1960-1990 from 100 deaths per 1,000 live births to about 60 deaths per 1,000 live births. In the last decade it has increased to 73 in 2000 (Table 3). It is worth noting that although tremendous progress had been made in the reduction of infant and child morbidity and mortality, which is mostly attributed to the significant improvement in the general immunization status of children, the gains made in child health have in recent years been adversely affected by the HIV/AIDS pandemic.

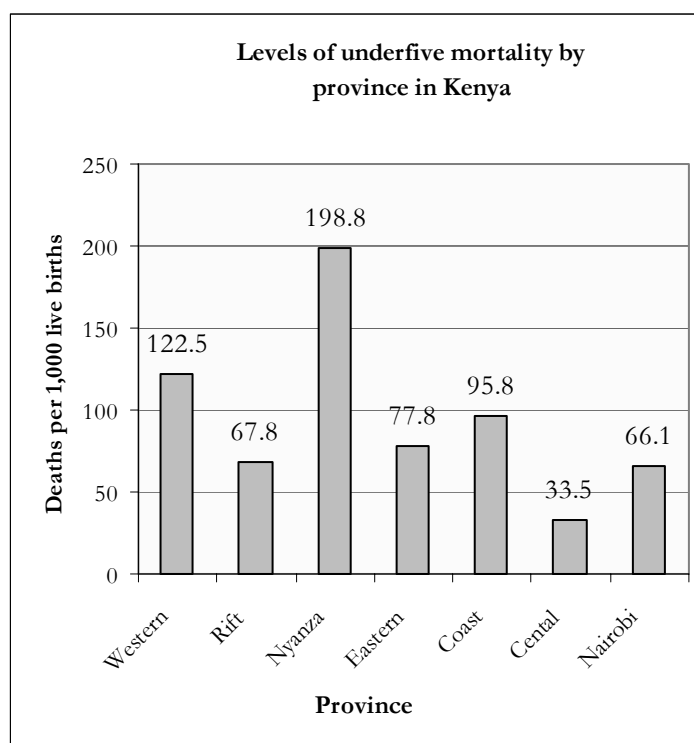
Referring to Figure 1 (next page), it is worth noting that there is a wide geographic disparity of under-five mortality across the regions due to social and economic factors. Although current and reliable sources of data are still lacking on regional differentials in maternal mortality, the KDHS 1998 estimates the maternal mortality ratio at 590 maternal deaths per 100,000 live births. The fifth MDG, which aims at reducing the maternal mortality ratio by three-quarters, between 1990 and 2015, remains a challenge for Kenya. Direct obstetric causes that need to be addressed have been identified such as haemorrhage, sepsis, complications arising from unsafe/induced abortions, eclampsia, and obstructed labour. Other causes include malaria, TB, anaemia, and HIV/AIDS. On a positive note, Kenya has experienced a dramatic decline on total fertility rate from 5.4 in 1993 to 4.4 in 1998¹¹.

Besides the disease burden affecting child and maternal morbidity and mortality, the poor performance of the economy together with demographic pressures have affected the overall delivery of health services in Kenya. However, in an effort to improve the health status of Kenyans, the government, through the Ministry of Health, has set up several programmes that are currently supporting components of reproductive health. These include Kenya's expanded programme on immunization, control of diarrhoeal diseases and acute respiratory infections, nutrition, sexually transmitted infections and HIV/AIDS. There is also the Safe Motherhood Initiative, whose key components include family planning, antenatal care, safe delivery and essential obstetric care.

Goal 6: Combating HIV/AIDS, malaria and other diseases

HIV/AIDS has become one of the major public health challenges facing Kenya today and has been declared a national disaster. In the wake of HIV/AIDS, mortality and morbidity rates have increased, with a wide gender disparity in prevalences (women are more likely to be HIV positive than men)¹⁰. The disease is characterized by wasting, diarrhoea and other opportunistic infections. Nutrition is particularly important in the management of the disease, especially in prolonging life and delaying the progression to full-blown AIDS. Nutrition management centres provide personal individual nutrition support to counteract the severe wasting and malnutrition characteristic of the disease. On the other hand, pregnant women are particularly prone to severe complicated forms of malaria due to their reduced immunity levels. Moreover, malaria in pregnancy is a major cause of anaemia and low birth weight.

Malaria, HIV/AIDS and tuberculosis are at the top of the development agenda for Kenya, and there

Figure 1


Source: KDHS 1998

has been increased political and resource commitment by the government combined with an increase in donor support to fight these diseases. There has also been a steady rise in the number of people infected by the HIV virus. The *MDGs Progress Report for Kenya* indicates that the national HIV prevalence rate doubled from 5.1% to 10.4% between 1990 and 1995 and peaked at 13.4% in 2000 before declining to 10.6% in 2002. Urban areas are more devastated by AIDS than rural areas, although prevalence rates in rural areas are growing more rapidly than in the urban areas. In 2002, prevalence rates were 12.9% in urban areas and 7.7% in rural areas. Younger women in particular are more vulnerable than men. For instance, among 20-24 year olds, about 40% and 15% of women and men, respectively, were infected.

The major HIV/AIDS challenges facing the government are the provision of free or cheap anti-retroviral drugs (ARVs); controlling the spread of the disease by reducing the number of people newly infected; provision of voluntary counselling and testing in the rural areas; behaviour and attitude change; and tackling the problem of rising numbers of children orphaned by the disease as well as the promotion of home-based care and support for people living with HIV/AIDS.

On the other hand, 70% of the total population is at risk of malarial infection. The *MDGs Progress Report for Kenya* indicates that every year, about 34,000 children underfive years of age are estimated to die of illnesses related to malaria, roughly 93 per day. Throughout the country, malaria accounts for about one-third of outpatient clinic visits. The case fatalities in the country are attributed to highland malaria. In response to the huge disease burden and renewed international efforts of Roll Back Malaria, the government has developed a National Malaria Strategy with a main objective of reducing the level of malaria illness and death in Kenya by 30% by the year 2006 and maintain the level of improved control to 2010. Key interventions in place to tackle malaria include providing malaria prevention and treatment to pregnant women, promoting the use of insecticide treated nets and other vector control measures, and improving malaria epidemic preparedness and response.

Policy recommendations

Besides highlighting Kenya's progress in achieving the MDGs, it is important to remember that much more has to be done before Kenya can break out of the poverty trap. In as much as efforts put in place by the Kenyan Government are bearing fruit, as seen in the high enrollment in primary school and recarpeting of major roads, there is a need to concentrate on other services that are crucial to improving livelihoods, such as water and sanitation, as well as direct nutrition interventions and capacity building. These have been incorporated into community-based programmes, which already exist in most parts of the country but need scaling up. Women groups run most of the community-based projects, such as the income generating activities. Since in most cases women do not own land and there-

Table 4

Democracy and good governance Political will and commitment Anti-corruption strategies (transparency and accountability)	
Major policy sectors	
Existing policies	Proposed new policies centred on nutrition as a foundation for development
Health • more clinics and dispensaries opened • free drugs in government hospitals • more VCT centres opened	• private and mission hospitals to offer free ARVs for HIV/AIDS patients • nutrient supplements for HIV/AIDS patients • families affected by HIV/AIDS to be put under a welfare scheme, especially given food provision • promote consumption of indigenous foods for health maintenance
Education • free primary education	• free adult education (targeting women) • reduce cost of secondary and tertiary education to allow more money allocated for food in households • expand school feeding in arid regions
Agriculture • food policy-advocates for increased production and distribution of food • liberalized markets	• rehabilitation of marginal lands • afforestation of deforested lands • adopt of low-cost food policy for arid regions • promote production and consumption of indigenous foods
Land reforms • reclaiming public land that had been grabbed by individuals	• prevent further subdivision of land to small, low yielding pieces • government land that is not being utilized to be leased out to farmers
Infrastructure • road reconstruction and building of bypasses	• construction of rural access roads throughout the country to facilitate accessibility and availability of food to households • construction of more silos to boost food storage capacity

fore cannot use it as collateral to obtain loans, the government needs to intervene by setting aside funds to support these projects that compliment the household income and eventually translate into increased food purchases and meeting the health, nutritional and educational needs of the children.

The new policies ought to be centred on the fact that nutrition is a key component of development (Table 4). The government should take a leading role in planning for the future food and nutritional needs of its people.

- Since food production has not matched population increase and dietary requirements, unproductive land should be rehabilitated and underutilized productive land should be maximised through irrigation, land conservation and afforestation.
- New land policies should favour land consolidation rather than further land division by parents into small portions for their children resulting in limited productivity. Optimization of available resources is vital, and the government needs to ensure water availability in the dry lands for irrigation, livestock as well as domestic use.
- Incentives, such as farm subsidies, may have to be provided to farmers whose productivity levels have declined.
- Cooperatives need to be created by farmers, to serve as channels through which the governments can reach the farmer.



- The government needs to take full control of the demand and supply of food, right from farm production to marketing of the food (going back to the era of controls).
- By adopting a low cost-food policy, the government will ensure that food is not only available but also affordable for the poor and those on marginal lands.

If food production targets population needs and individual dietary requirements, household food security will improve as the nutritional status improves, people's health will also improve, and child mortality rates will decrease with improvements in maternal health. Other policies are equally as important.

- Policies are needed that recognize and strengthen the role of women in food production and procurement through financial support and the improvement of working conditions.
- Education policies in developing countries need to embrace the principle of basic education for all. A policy of free primary education has been adopted in Kenya, however the government must allocate resources to also fund adult education, especially that of women.
- Women are key to household food security and educating them empowers them to influence decisions affecting food availability and accessibility to all household members.
- The high cost of education at the secondary and tertiary levels still constraints households' budgets and reduces available expenditure for food and other needs. Education policy and adequate remuneration of all stakeholders in the educational system needs to be examined.

Community-based projects should be supported as instruments of poverty reduction, especially income generation as well as the nutrition intervention strategies such as school feeding programmes. Renewed political commitment translated into funding and the provision of essential services provides support mechanisms to ensure the success of these community projects. David Beckmann, President of Bread for the World, sums it up well when he says that nutrition programmes reduce hunger faster than poverty alleviation programmes in general⁴.

Because the central role of agriculture in generating employment and income, policies aimed at increasing agricultural production and productivity are essential for improving household food security and nutrition⁶. However, it is necessary, but not sufficient, in halving the numbers of the poor and hungry by 2015. Therefore, it is important to look at policies that will ensure affordable and accessible education and health as well as promote new technologies such as biotechnology that may in the long-run provide the ultimate answer to food insecurity in the region.

Conclusion

Nutrition is an excellent investment. Improved nutrition empowers individuals as well as communities. In doing so it fuels the development process that leads to poverty reduction¹³. The UN has provided leadership through the MDGs, other intergovernmental organizations have the responsibility of following this lead by providing a framework for the process, while states and governments must provide a stable political environment, the will and the commitment to achieve them. Democracy and good governance build the bridge leading to the realization of the MDGs. Good governance and democracy open up channels for dialogue, peace, transparency, accountability, donor support, policy reforms and more respect for human rights. As for civil society organizations, they have an important role to play by putting in place checks and balance to ensure that the MDGs are achieved.

However, let us take nutrition seriously as an input and foundation for development rather than just an outcome, by adopting policies and strategies that integrate it into agriculture, health, infrastructure, education and other major sectors, and by supporting community-based projects that have achieving better health and nutrition as a core objective.

Acknowledgements

As I pay tribute to Dr Abraham Horwitz for his tremendous work in the field of nutrition, I wish to thank SCN for this initiative that has allowed his legacy to live on. I am proud to be associated with the SCN and I am grateful for the opportunity to participate in this important forum. I would like to thank the following people who provided support during the writing of this paper, for their contribution through constructive comments and encouragement: Professor AJ Sigot, Dr M Walingo, Ms J Kwamboka, Dr CK Serrem, Mr Joe Mutuku and last but not least Ms A Moreira.



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IN MEMORIAM

VERNON R YOUNG

1937-2004

Vernon R Young, the world's leading expert on protein and amino acid requirements and metabolism died of complications of renal cancer on March 30 at the age of 66. His innovative use of stable isotopes showed that the estimated essential amino acid requirement levels that had been universally accepted since the 1940s were much too low. These erroneous values had been endorsed by a series of FAO/WHO meetings, including one in 1985. With confirmation from his collaboration with Anura Kurpad in Bangalore, he proposed a new "MIT" pattern that was adopted, with minor changes, by the 2003 FAO/WHO/UNU Joint Expert Consultation. It recognized that adult essential amino acid requirements per gram of protein needed to be increased by a factor of two to three. He reported this work and many other ground-breaking protein and amino acid research results in over 600 scientific publications.

Vernon R Young was born in Rhyl, North Wales in 1937 and obtained his BSc from the University of Reading in 1959 and a Post Graduate Diploma from Cambridge University in 1960. He moved to the University of California, Davis, in 1960 where he obtained his PhD in 1965 for a thesis on calcium and phosphorus homeostasis. In the same year he arrived at the Department of Nutrition and Food Science of the Massachusetts Institute of Technology as a post doctoral fellow and rose rapidly to become a full professor in 1977.

A long series of papers written in collaboration with Nevin Scrimshaw and many graduate students described the nature and variations in obligatory nitrogen losses and nitrogen utilization that established the basis for accurately determining protein requirements. The PhD research of Cutberto Garza, with Young and Scrimshaw confirmed that in long term balance studies MIT students consuming the recommended protein allowance adopted by an ad hoc FAO/WHO Joint Expert Committee in 1973 experienced a loss of lean body mass, negative N balance and other adverse metabolic changes.

Their short and long term nitrogen balance approaches were adopted for the United Nations University-sponsored uniform trials in 15 countries in the 70s. The resulting data indicated that the 1973 FAO/WHO/UNU recommended allowances for dietary protein needed to be increased by one-third. These higher values were adopted by the 1985 FAO/WHO/UNU Expert Consultation on Protein-Energy requirements with a profound effect on estimates of protein deficiency in developing countries and on agricultural and health policy.

Another extended series of studies explored protein absorption and quality of protein and yielded improved procedures for the assessment of the quality of proteins of both vegetable and animal origin. The qualitative importance of both protein synthesis and breakdown in premature infants was first demonstrated in his studies with ^{15}N as a tracer. Using this tracer in adults, he demonstrated a re-distribution in the pattern of whole protein metabolism with advancing age. He extended this to show enhanced rates of protein synthesis and breakdown in children suffering from burns. This provided a metabolic explanation for the greatly increased protein requirement of burn patients.

In a very productive long-term collaboration with Denis Bier, Young showed that whole body amino acid flux, protein synthesis, breakdown and amino acid oxidation in humans respond to the integration of meals and that these responses are modulated by the protein, amino acid and energy components of the diet. These studies led to new approaches, based on amino acid kinetics using stable isotope probes, for determining the quantitative need for the specific indispensable amino acids.

Using stable isotopes he has also explored the metabolism of dispensable amino acids, and developed an approach for quantifying the whole body synthesis rate of alanine, glycine, proline and arginine. This novel method involved a simultaneous administration of two amino acid tracers labeled with stable isotopes, using a nutritionally indispensable amino acid. He also developed a stable isotope method using ^{15}N glycine tracers to explore changes in albumin synthesis with advancing age. The findings indicated that albumin synthesis was regulated by amino acid intake at a lower set-point in the elderly than in young adults.

Young was elected to the National Academy of Science in 1990 and the Institute of Medicine in 1993. Among the more important of his many honors are: the Rank Prize in Nutrition (UK); the Bristol-Myers Squibb Award (USA); the Danone International Prize for Nutrition (France); the WO Atwater Award (USA), Gopalan Gold Medal (India); International Award for Modern Nutrition (Switzerland) and Doctor of Medicine *honoris causa*, Uppsala University (Sweden). He served as President of the American Institute of Nutrition from 1991-92. From 1996-1998 he served as the first Chairman of the Food and Nutrition Board Committee responsible for the new and greatly expanded Recommended Dietary Allowances (RDAs) and guided the group to a consensus.

Words can capture his scientific achievements and his international nutrition reputation but not his ebullient Welsh personality, humour and unusual charisma. Vernon Young's life was dedicated to his research but he was also devoted to his wife, Janice, his four sons Christopher, Andrew, Richard, and Michael, and his daughter Patricia. There are few persons who have been so universally liked throughout the world and who have contributed as much to the science of nutrition.

Nevin Scrimshaw

WORKING GROUPS

IN ORDER TO ACHIEVE MAXIMUM INPUT ON HOW ALL ASPECTS OF NUTRITION CAN HELP ACHIEVE THE MDGs, ALL NINE CURRENT WORKING GROUPS HELD MEETINGS DURING THE 31ST SESSION. FULL REPORTS ARE AVAILABLE ON THE SCN WEBPAGE: WWW.UNSYSTEM.ORG/SCN/PUBLICATIONS/ANNUALMEETING/WORKING_GROUPS.HTM OR UPON REQUEST FROM THE SECRETARIAT, SCN@WHO.INT

BREASTFEEDING AND COMPLEMENTARY FEEDING

Chaired by Miriam Labbok (UNICEF) and Randa Saadeh (WHO)

Over the past year the Working Group followed-up on the matrix *Contribution of Breastfeeding, Complementary Feeding, and Related Maternal Nutrition to the Millennium Development Goals* drafted in Chennai. However, since the protection, promotion and support of optimal infant and young child feeding as described in the *Global Strategy for Infant and Young Child Feeding* addresses each of the eight goals, it was arbitrary to distribute any one specific BF/CF activity against any individual goal. The Working Group therefore fine-tuned the content of the contribution of BF/CF to the goals, rather than report activities against any one goal. A review of the preliminary document addressing planned MDG country assessments found only two infant and young child feeding interventions (interventions based on food supplementation for infants [0-2 years] and interventions for children aged 5-12 years, which focus on supplementation programmes through school meals). Since neither of these address the interventions and indicators of the Global Strategy or of the Working Group, members were asked to provide additional intervention areas and indicators for the SCN to suggest to the MDG country assessment team for inclusion in all country assessments.

The Working Group had four objectives:

- to reach consensus and produce improved definition on the role of BF/CF in support of specific MDGs
- to discuss the inclusion of BF and CF in economic analyses and major planning and funding instruments
- to offer interventions and measures ('how' and 'how to assess') for infant and young child feeding to be included in the MDG country analyses
- to discuss a Goal for 2015.

The following objectives were proposed in support of the MDGs:

- At least 60% of children < 6 months of age exclusively breastfed
 1. development of a statement of rationale
 2. discussion as to whether this is too low or too high
 3. clarity as to the measurement, e.g. cross sectional survey of last 24 hours
 4. alternative suggested: reduce percent of children not exclusively breastfed by half
 5. in general there was agreement with the usefulness of setting an objective.
- At least 60% of children 12-15 months of age are still breastfed with appropriate complementary feeding
 1. discussion as to whether this goal is too low or too high, however, since baseline for this age group is not available, it is difficult to judge
 2. need to separate the 'continued breastfeeding' objective from the complementary feeding objective, and if so it would be too low for 'still breastfeeding'
 3. need to include the concept that breastfeeding is a contribution to household food security
 4. need to consider an additional objective that would increase attention to the related nutritional status and care of the mother, as well as to her role in achieving any BF or CF objective.

Private Sector involvement of SCN There was consensus on the viewpoint that the commercial sector holds different interests which are not consistent with those of the SCN, and therefore should not be part of policy development within SCN. However, recognizing that there will be a process to discuss this issue, the Working Group notes that, given its unique experience in addressing the issue of the private sector,



there should be representation by this Working Group and full acknowledgement of the issues addressed in the International Code of Marketing of Breastmilk Substitutes.

Action Plan for BF/CF Working Group for 2004: In the light of this year's discussion should the BF/CF Working Group have Task Forces? Three potential Task Forces were discussed: a) a TF to follow-up on country-level implementation of the *Global Strategy for Infant and Young Child Feeding*; b) a TF to provide input about SCN Working Group on issues related to infant feeding to the UN MDG Millennium Task Force; and c) a TF to deal with the name of the Working Group and terminology relating to infant and young child feeding. All interested task forces are requested to submit a statement of objective, membership and suggestion of which working group chair might serve as liaison as soon as possible to Miriam Labbok (mlabbok@unicef.org). Those interested in working on any specific task should contact the SCN Secretariat.

The current Working Group Chair and Co-Chairs have served for at least two years. While they are willing to continue if called upon, there has not been an NGO/CSO among them since the current Chair changed status. Participants were invited to send nominations to the Steering Committee.

The group encourages the Steering Committee to give special attention to the topic of the *Global Strategy for Infant and Young Child Feeding* during next year's meeting as the host, the Government of Brazil, has been highly active in addressing infant and young child feeding within its own borders, and has served as a model to other nations.

CAPACITY DEVELOPMENT IN FOOD AND NUTRITION

Chaired by Cutberto Garza (UNU) David Sanders (University of the Western Cape) and Hans Schoeneberger (GTZ)

Regional activities over the last year included:

- *Implementation of the Asian Plan of Action* presented at the 30th Session of the SCN The Asian Task Force conducted a survey to assess the capacities of Asian institutions in five key areas: Maternal and Child Nutrition—CR Yajnik (Japan); School Children and Adolescent Nutrition—C Khan (Vietnam); Adults and Elderly Nutrition—Widjaja Lukito (Indonesia); Food and (Sustainable) Nutrition Security—Khor Geok Lin (Malaysia); and Food Safety—V Prakash (India). Plans are being made to establish partnership training and trainee institutions in each of these core areas to enhance individual, institutional, and organizational capacities. Prof Khor Geok Lin (Malaysia) has assumed responsibility for planning a leadership training programme for mid-career professionals with primary and related nutrition responsibilities throughout the region.
- *Implementation of the African Plan of Action* Regional meetings were held in 2003 to update the plans presented at the 28th SCN Session in Nairobi. Major activities have focused on building capacity in the area of HIV and Nutrition. Drs Robert Mwadime (East Africa) and Pauline Kuzwayo (Southern Africa) have taken primary responsibility for collaborative activities within both regions. Kinday Ndure Samba led an effort to enhance advocacy skills in West and Central Africa. Each also serve as focal point for updating regional action plans. A review of regional action plans by each of the African task forces is planned for 2004 to identify and act on common priorities. An African Network of Graduate Students has been organized and launched under the initial auspices of UNU (C Garza).
- *Implementation of the Latin American Plan of Action* The region has focused on the implementation of a region-wide project sponsored by the Global Forum for Health Research: Challenges for Childhood Health and Nutrition Research in Latin America. This effort is led by Prof R Uauy (INTA, Chile) and Prof Juan Rivera (INSP, Mexico). The group also organized a Leadership Training Workshop for young Latin American professionals working in the area of food and nutrition (J Rivera, Mexico).
- *Completion of Formation of Regional Task Forces for Enhancing Capacity in the Area of Food and Nutrition* An initial meeting is planned for July 2004 for a Middle Eastern counterpart of the other regional task forces. This is being done in close collaboration with IUNS (O Galal, Secretary General) and Dr A Gohar (National Nutrition Institute, Cairo). Dr Fre Pepping (Wageningen University) has initiated organizational plans for naming and organizing a similar group for Eastern Europe. Thus by the end of 2004 groups should be operational in Africa, Asia, Eastern Europe, Latin America, and the Middle East, as planned at the 30th SCN session.

Formal recommendations for moving forward were not reviewed by the group beyond those suggested during the rich discussions that followed presentations by the African Graduate Student Network (AGS-NET) and the Asian Capacity Development Task Force (CASNA, Prof E Wasantwisut, Thai-

land). Key recommendations were:

- AGS-NET promise to enhance present and future networks in Africa. The group's presentation underscored the importance that capacity development will play in achieving and sustaining the MDGs. Thus, the Working Group recommended that efforts be made to ensure the active participation of AGS-NET members at the upcoming 2005 Durban meeting; to assist them in linking with under- and postgraduate students of nutrition in Africa and the diaspora; to enhance access to primary research literature, and to continue close working relationships so that the Working Group may assist AGS-NET with other priority areas identified by student group.
- Progress made by the regional task forces and in establishing groups in the Middle East and Eastern Europe was applauded by the Working Group. If these initial efforts are to succeed, the Working Group must intensify its efforts to associate these groups to other broader capacity development efforts. Thus, the group recommended that efforts be made to link regional task forces to coalitions such as those being built by the Rockefeller Foundation in their Joint Learning Initiative for enhancing health professional resources. Particular emphasis was given to linking the African Regional Task Forces with the Rockefeller initiative Working Group on Disease Programmes. The SCN Working Group also urged regional task forces to broaden their base beyond academia, to improve networking and multisectorial approaches to building capacity and to work more closely with regional development efforts such as those soon to be undertaken by the ASEAN region to fulfill MDG objectives.
- The working group's major challenge remains the cooperation, coordination, and harmonization among capacity development activities undertaken by the SCN tripartite members: the UN agencies, bilateral organizations, and nongovernmental organizations. The discussion reaffirmed the group's commitment to empowering regions by supporting their efforts to enhance long-term capacity development plans that are closely integrated with specific problem solving activities. Among this commitment's principal goals is the increasing and strengthening of a regional professional base for tackling today's and tomorrow's food and nutrition challenges. Realization of these aspirations requires matching actions with rhetoric. This principal challenge remains unchanged and is growing in urgency. Thus, the Working Group discussion urged exploration of concrete actions for improved collaboration among the tripartite SCN members. One example is re-consideration of the approach proposed at the Berlin meeting for an SCN-based fund to support capacity building efforts. The suggested mechanism was the imposition of a 'levy' on ourselves for training, e.g. allocate the equivalent of 2% of funds spent by UN, bilateral agencies and NGO's in sending 'expatriates' to developing countries and/or the equivalent of 2% of the salaries paid by such agencies to professionals from developing countries when such professionals are hired to work outside their country of origin. The Working Group recognizes that such suggestions have a downside (e.g. making nutrition activities 'more expensive'), however, the upside (e.g. contributing to a sustainable work force) may compensate amply for shortcomings.

The present co-chairs are prepared to continue in their respective capacities and to seek input regarding changes in the group's organization through its biannual Newsletter (past copies can be found on SCN webpage: www.unsystem.org/scn/Publications/AnnualMeeting/capacity_development.htm)

HOUSEHOLD FOOD SECURITY

Chaired by Kraissid Tontisirin (FAO) Lawrence Haddad (IFPRI) and Shakuntala Thilsted (Denmark)

The co-chairing system adopted in the summer of 2002 for the Working Group on Household Food Security was maintained and there was close communication Email throughout the year. The recommended workshop on sharing experiences on household food security for better nutrition did not materialize due to conflicting workload and constraints in resources of key actors.

Particular attention was given to the MDG process, with special focus on the work of the Hunger Task Force. A background paper *Achieving MDGs: How can the SCN Working Group on Household Food Security contribute?* was prepared by the Working Group Secretariat for the 31st Session. The session was chaired by Lawrence Haddad, IFPRI, who briefly introduced the topic, linking it to the findings of the *5th Report on the World Nutrition Situation*. This was followed by a general presentation by Kraissid Tontisirin and Florence Egal, FAO, on the contribution of the Working Group to the achievement of the MDGs. Sean Kennedy and Patrick Webb reported on recent work by IFAD and WFP on Result and Impact-Based Management for Household Food Security. Joergen Georg Jensen, Senior Techni-



cal Adviser (Agriculture and Nutrition), Ministry of Foreign Affairs, Denmark, shared his experience and concerns regarding the incorporation of food and nutrition security within the agricultural sector programme of the Danish International Development Assistance (DANIDA). Rosanna Agble, Head of Nutrition, Ghana Health Service, presented her perspective regarding the challenges facing governmental institutions in addressing the multisectoral issues of household food security and attaining the Millennium Development Goals.

Shakuntala Thilsted, co-chair, opened the general discussion. Participants agreed that specific attention should be given to sustainable (and in particular affordable and culturally appropriate) solutions at local level. Progress in improving household food security do not depend so much on new technical interventions *per se*, but on processes. In particular, communication and collaboration at all levels^{3/4}local, national, regional, global^{3/4}within and between institutions (government, academic centres, NGOs, CSOs); and funding and planning modalities are the main challenge. The need for, and difficulties in achieving, collaboration between the health and agriculture sectors was cited as an example. Stakeholders need to adopt a people-centred approach and focus on simple common principles as a basis for concrete, creative and effective dialogue between partners. Local organizations have a key role to play and should not only be considered as recipients. Exchange of information and lessons learnt is essential to enhance the local process.

Recommendations for SCN action in the coming year The group concluded that it should concentrate on the following activities in the coming months:

- provide collated contributions to the Hunger Task Force and global MDG plan (with specific attention to concrete innovations that have a positive impact on HFS and nutrition)

Participants agreed that since nutrition is key to most MDG goals, the MDG process is bound to increase attention and support for nutrition at global and country level. The SCN, and in particular the Working Group, should play a key role in the process, by harnessing the experience and lessons learnt by UN agencies, bilaterals and NGO/CSOs in promoting household food security and nutrition in the last decades:

- strengthen and develop indicators (with particular attention to dietary diversity and process)
- set-up and support in selected countries a network of working group members with a view to mainstreaming HFS and nutrition in relevant policies, programmes and projects.

Given the limited time available, participants did not discuss the modalities for implementation of these recommendations. This will be done by email or by telephone in the coming weeks.

NUTRITION AND HIV/AIDS

Chaired by Andrew Tomkins (Institute of Child Health, London)

Working Group Co-Chair Andrew Tomkins thanked USAID and FANTA for supporting the attendance of Moses Sinkala and Lackson Kasonka, UNU for supporting the attendance of Robert Mwadime, and the SCN Secretariat for their administrative help.

The role of the SCN Working Group on Nutrition and HIV/AIDS—identifying interventions needed to achieve the Millennium Development Goals (MDGs) (Andrew Tomkins) There is now greater commitment to expanding the provision of antiretroviral drugs to more people. The WHO 3x5 initiative and increased funding for RVs from the Global Fund are examples. Several nutritional factors will need to be included within ARV programmes for them to be effective; this requires the development of guidelines and improved skills and capacity of medical and nursing staff. Societal change to reduce the scale of stigma, which often prevents people from accepting Voluntary Counseling and Testing (VCT), is vital.

It is suggested that the following interventions are needed to achieve MDG 1:

- antiretroviral drugs and nutritional guidelines to promote their efficacy and safety
- focused nutrition interventions
- agricultural technology and policies to increase food production and security for sick/affected adults
- food assistance to families lacking food security, are malnourished and affected by HIV.

School attendance is decreasing in many HIV-affected communities which are also poor and food insecure. Several factors contribute to this: the need to care for sick parents, to farm, seek food or employment together with the declining quality of schools and the absence of teachers because of

illness or funerals. In addition the health and nutrition of school children is compromised by factors considered by the Working Group such as micronutrient deficiency and infections.

It is suggested that the following interventions are needed to achieve MDG 2:

- the provision of school meals, parasite control and improved micronutrient status
- improve food security in HIV-affected families so that children can attend school rather than farm/do paid work
- the provision of food aid in return for school attendance.

Several factors affect children's lives which in turn influence their susceptibility to HIV and its associated malnutrition. Lack of confidence in negotiating sex, stigma about discussing HIV or obtaining VCT or treatment, all contribute to increased susceptibility. The lack of awareness of the relationship between HIV and nutrition and the low level of parenting skills among boys are major problems and reflect inadequate discussion within the schools and community groups.

It is suggested that the following are necessary to achieve MDG 3:

- reduction of stigma by community-based societal interventions
- improvement of parenting skills for boys and girls
- increased responsiveness by family members to the nutrition and care needs of women.

Infant and young child mortality rates are increasing among communities with a high prevalence of HIV/AIDS. It is estimated that there are around 700,000 new cases of paediatric HIV globally each year as a result of MTCT. The rates of child mortality are especially high if the mother is dead, seriously ill, absent or is an adolescent. A current emerging concern is that infants who are born to an HIV infected mother may be at immunological risk even though they remain HIV free (uninfected/exposed). There is increasing evidence that micronutrient interventions improve pregnancy outcome of HIV infected mothers and they may improve infant health.

It is suggested that the following are necessary to achieve MDG 4:

- appropriate infant feeding regimes to prevent MTCT
- improving nutrition/health/survival of HIV infected mothers
- improving child health/care/nutrition to prevent opportunistic infection
- improving nutrition of infected and affected children
- preventing adolescent pregnancy
- providing ARVs to mothers and children.

Maternal mortality rates are increasing in many HIV/AIDS affected communities. Whereas there is clear data from a single study in Asia that regular prepregnancy and intrapregnancy supplementation with beta carotene or vitamin A leads to reduced maternal mortality, there is no data on the effect of nutritional supplementation on HIV infected women. There is however increasing evidence that HIV infected women have a higher prevalence of infections which cause mortality. HIV infected women also have worse nutritional status.

It is suggested that the following is necessary to achieve MDG 5:

- provision of ARVs to pregnant and lactating women
- nutrition interventions based on evidence from randomized controlled clinical trials.

HIV has harmful effects on pregnancy outcomes, leading to prematurity and low birthweight in women with malnutrition. It is also known that malaria hastens the progression of HIV/AIDS. Thus the combination of HIV and malaria on foetal and maternal health is of particular concern. Among the opportunistic infections affecting HIV infected individuals, TB is common. There is some evidence that nutritional interventions decrease susceptibility and improve rate of recovery from TB. It is increasingly recognized that ARVs have short and long-term side effects.

It is suggested that the following is necessary to achieve MDG 6:

- prevention of malaria—especially in pregnancy
- evidence-based nutrition interventions in individuals with HIV associated TB and diarrhoea
- improved nutritional management to increase efficacy/safety of ARVs
- improved nutrition/health of HIV-infected individuals not yet on ARVs
- improved nutritional management of opportunistic infections.



HIV infected individuals are especially likely to acquire opportunistic infection such as intestinal infection (from water and food) and respiratory infection (often found in communities with overcrowding and poor housing). There is increasing evidence that community programmes have more sustainable effects on the environment.

It is suggested that the following is necessary in order to achieve MDG 7:

- improve water supplies/sanitation for avoiding diarrhoea
- ensure adequate housing to prevent respiratory infections (ARI/TB)
- develop community-based approaches to ensure environmentally sustainable food production and improved nutrition.

Whilst there are many activities in the area of nutrition and HIV/AIDS, the results are not widely known or appreciated. The importance of developing guidelines to assist national governments and agencies was recognized.

It is suggested that the following is necessary in order to achieve MDG 8:

- share information on what works in controlled situations (efficacy studies)
- share information on the impact of interventions within established services/community systems to assess their effectiveness
- identify knowledge gaps
- improve advocacy to obtain resources for nutrition and HIV interventions in HIV infected/affected communities
- ensure that UN agencies are aware of each others' activities and policies in order to produce a joint coherent policy^{3/4}this would contribute to national capacity building.

WHO activities on Nutrition and HIV/AIDS (Randa Saadeh) WHO seeks to alleviate the overall burden of malnutrition by reducing the severity and complexity of the impact that HIV/AIDS and nutrition have on each other through the development of a comprehensive strategic response derived from evidence-based guidance. To do this WHO has established an Inter-Agency Working Group on Nutrition and HIV/AIDS to share information and coordinate activities. A WHO Technical Advisory Group on Nutrition and HIV/AIDS has also been set up as principal international advisory body for making recommendations to the Director-General. A technical consultation on nutrient requirement for people living with HIV/AIDS was held in May 2003, the report has been published.

HIV/Nutrition and Pregnancy Outcome—a case study from Lusaka, Zambia (Lackson Kasonka) In Zambia, maternal mortality rates have increased from 560/100,000 live births in 1990 to 729 in 2002. Due to a lack of community-based studies available on maternal health, nutrition or pregnancy outcomes, the Breast Feeding and Postpartum Health Project was established in an urban community in Lusaka. Despite the availability of skilled, trained and dedicated staff, stigma within the community prevents widespread uptake of counseling and testing for HIV^{3/4}only 36% of antenatal women agree to have an HIV test. Of these 32% are HIV infected. The significance of these findings in women in relation to pregnancy outcome, and required dosage for antiretrovirals, is not known in these resource poor settings. However the association of nutritional deficiencies with poor pregnancy outcomes infers that there be a causal relationship and studies on nutritional interventions are needed.

Infant feeding, HIV transmission and infant growth (Moses Sinkala) In the light of the study showing the benefits of exclusive breastfeeding (EBF) on post natal transmission of HIV there have been considerable activities to promote EBF among HIV infected populations. However, there has been rather little appreciation of the nutritional problems faced by infants of infected mothers and of the difficulty facing mothers as their children can no longer be supported by breastfeeding alone. In the Breast Feeding and Post Partum Health Project, several aspects of infant and maternal health and nutrition have been highlighted, it is now recognized that several factors increase the chance of a mother transmitting HIV in her breastmilk. Infants of HIV infected mothers may be of lower birth-weight in poorly nourished communities; indeed, the children of infected mothers in the Zambian BFPH study were 60g lighter than those of uninfected mothers. Furthermore, these infants of infected mothers failed to catch up and remained lighter and shorter by age four months. Several reasons for this appear possible—some infants are HIV infected, some were exposed but uninfected, some were premature or had intrauterine growth retardation, maternal milk may be of inadequate volume in HIV infected mothers, and maternal milk may have a high Na level or maternal morbidity (physical/mental) led to poor care. The relative importance of each of these factors is currently unknown.

Nutrition, Food Security and HIV in Southern Africa—UNICEF Southern Africa Nutrition Analysis Project—preliminary analysis (John Mason) Child underweight is highest in high HIV areas (urban/peri-urban probably), with IMR/HIV showing the same relation. Child underweight deteriorates more in high HIV areas, and much more in high HIV drought affected areas. Child malnutrition (underweight or stunting) has recovered somewhat, in some areas, after the drought, but not to 2001 levels. Greatest recovery has been seen in Zimbabwe. Changes in child nutrition is most clearly (and significantly) associated with HIV level by area. It is plausible that food aid mitigated the effect of drought and food insecurity on child nutrition in other countries. Recommendations for policies and programmes are:

- focus more resources to protect child nutrition, health, and development in areas traditionally better off, but which have high HIV/AIDS (urban/peri-urban)
- address destitution through the creation of a safety net
- develop integrated response of nutritional support with treatment
- establish contingency plans and streamlined emergency and development assistance during times of drought
- develop better ways of improving child caring practices and protecting orphans
- ensure that surveys lead to a surveillance system (e.g. combining periodic sample surveys with community based programmes including growth monitoring)
- promote better understanding of effects of assistance (food aid, ARVs) and determinants of malnutrition, which means moving from current ecological to disaggregated analyses.

Information Systems for Exchange of Information on Programmes on Nutrition and HIV (Robert Mwadime) A clearer understanding of the interaction between nutrition and HIV is evolving and the right information needs to get to the right user at the right time. There are various information types:

- list-serves: ProNut-HIV (<http://www.pronutrition.org>); NutritionNET (<http://www.nutritionnet.net>); AF-AIDS Forum (www.archives.healthdev.net/af-aids); INTAIDS-forum (www.listshealthlink.org); PWA-Net (<http://www.health.net/pwha-net>); Source (www.asksources.info)
- electronic or printed materials (newsletters, brochures, reports and articles, data sheets): IFPRI library (<http://www.ifpri.cgiar.org/training/newsletter/>); New and Note-worthy in Nutrition (M.Aspillera@ifpri.org); NICUS (<http://webhost.sun.ac.za/nicus>) run by Stellenbosch University, S Africa; AEGIS (<http://www.aegis.com>); other global websites include: WHO, FAO, WFP, UNICEF, UNAIDS, WB, USAID, others.

Key Recommendations:

- Develop effective nutrition and infection control interventions for prevention and improved management of HIV; associated malnutrition should be incorporated within existing policies and programmes aimed at achieving each of the MDGs; new knowledge is needed to increase the number and efficacy of evidence-based interventions.
- Develop focused guidelines for the inclusion of nutrition interventions to enhance the efficacy and safety of antiretrovirals and to slow down the rate of disease progression for infected individuals not on antiretrovirals.
- The SCN should produce a framework for action document on nutrition and HIV interventions to assist the development of specific policies and programmes by governments, agencies and NGOs with a particular focus on improving food security, health, survival and child development in which organizational responsibilities and resource/benefit implications should be outlined.

NUTRITION IN EMERGENCIES

Chaired by Saskia van der Kam (MSF Holland)

The working group is guided by the UNICEF *Conceptual Framework*. The Working Group reviewed achievements over the past year and focused on:

Treatment of severe malnutrition Although the management and treatment of severe malnutrition has improved considerably in the last decade there is still need for improvement in the efficiency of community-based models and in the treatment of severely malnourished 'forgotten' groups such as adolescents, adults and infants.



Adult malnutrition In 2001 the Working Group recommended the development of methods to measure the prevalence of adult malnutrition in populations and to identify adults who are at risk, for enrolment in feeding programmes—in July 2000 the SCN had published two reviews on assessment of adult and adolescent malnutrition which indicated that in depth research is required in order to define anthropometric and contextual indicators and the cut off points (www.unsystem.org/scn/Publications/html/rnis.html). New research will be jointly conducted by the University of Aberdeen, supported by Partners Research Emergency Nutrition (PREN), Humanitarian Scientific Advisory Group (includes Emergency Nutrition Network; CDC; Epicentre) and the NGO Support Group. The aim is to explore and develop a model to increase the robustness of current indicators of severe adult malnutrition during complex emergencies through a literature review (published and unpublished) and the analysis of data (including context). Agencies are requested to forward any related information including reports, raw data, patient cards, surveys and articles; the adult theme group will send out a data request information package including information on strict data security and confidentiality. Further information can be obtained from pren@abdn.ac.uk

Recommendation: Develop methods to assess adult malnutrition (*Responsible: Jane Knight, University of Aberdeen*)

Community based therapeutic treatment (CTC) Last year the Working Group learnt about community based therapeutic treatment (CTC), a new way of managing severe malnutrition, and will closely follow developments until the CTC (and alternatives) are well developed and consolidated. It has been observed that uncomplicated severe acute malnutrition is relatively manageable: the improvement of the child is rapid and evident when using CTC. CTC motivates care givers (mothers, fathers, health care workers) and lends credibility to health care systems. Experience in 2002-2003 shows outcome indicators below or close to Sphere minimum standards.

Recommendation: Consolidate community treatment of severe malnutrition, including the development of an intervention framework and a position on severely malnourished infants. (*Responsible: Valid International*)

Food security Food security entails the availability and accessibility of adequate quality and quantity of food at household level. The Working Group highlighted the issue of quality.

WFP's goals on food aid in emergencies: In the coming three years WFP will prioritize saving lives in crisis situation; protect livelihoods/enhance resilience to shocks and support improved nutrition and health of vulnerable people. Among the ways to attain these are strengthening of partnership, results-based management, supporting education and reducing gender disparity. To improve quality, WFP is studying the effectiveness of in-country fortification of food aid.

Evidence indicates that micronutrient deficiencies continue to affect populations living in acute and protracted crisis situations. UNHCR recognized that failure to address micronutrient malnutrition in long-term African refugee programmes suggests the need to review policy and practice of agencies involved in refugee health and nutrition programmes. UNHCR is investigating micronutrient deficiency assessment methods, effective supplementation, including the use of iron cooking pots to increase iron consumption, and the development of nutrient analysis software. In addition several NGOs are looking at ways of fortifying food of displaced, refugees and PLWHA.

Recommendations:

- develop and integrate simple and robust methods into routine activities and operations to permit monitoring and surveillance of the micronutrient content of rations and the incidence of micronutrient deficiencies.
- develop ways of supplementation adapted to specific situations, such as in-country improvement of food aid, distribution of supplements to vulnerable groups, fortification of the family pot. (*Responsible : theme group micronutrients in emergencies*)

Care practices Despite being part of the *Conceptual Framework* for years, the sector of care practices is underdeveloped in the agencies working in emergencies. Many agencies are addressing issues of care practices affecting the nutritional status of young children and their care takers, but mainly in the context of development. Not only are the practices themselves critical to children's survival, growth and development, but also are the way in which they are performed (with affection and responsiveness to children).

Mental and social issues in caring practices ACF investigated the psychoaffective/emotional relationship between caregiver-child. Outcomes from research in Sudan made clear that people from the same background can have divergent perceptions of the same context. In a chronic crisis, both displaced

and resident populations are vulnerable. Also highlighted is the relationship between alcoholism, family conflict and relapses. In Afghanistan (Kabul), a study of the causes of severe acute malnutrition of infants under six months showed that, in addition to knowledge, beliefs and cultural practices on infant feeding, depression and anxiety are important causal factors in a society with strict rules about marriage and gender roles.

Recommendations:

- compile details of mental/social support provided by agencies in nutritional programmes to direct future activities in this area
- investigate these interventions in order to recommend the most effective, efficient and locally adapted ways to address care in emergencies. (*Responsible: Action Contre le Faim France*)

Infant and young child feeding in emergencies The previous year theme groups reported on the preparation of training modules for infant feeding in emergencies. Training Module 1 *Infant Feeding in Emergencies, for relief staff* is widely used by health staff and individuals, as well as in training. Access is mainly through the ENN website, other venues will be explored. Module 2, containing technical information for health workers is being finalized: new sections cover managing malnourished infants under six months, the management of artificial feeding in emergencies, and complementary feeding. *Recommendation:* identify gaps in evidence specifically for infant feeding issues (e.g. treatment of severe malnutrition in infants) (*Responsible: Marie McGrath*)

Nutrition and disease (HIV/AIDS) The Working Group continues to support common practice in public health to improve general health status, such as preventative and curative interventions and water and sanitation interventions. The Group has no specific theme group on diseases related to nutrition, although many organizations intervene in this sector. There are many new initiatives related to nutrition and people living with HIV/AIDS on the issue of food security and family support, as well as patient care. The SCN Working Group on Nutrition and HIV/AIDS has provided solid knowledge which is used in various nutrition interventions at the field level. The Nutrition in Emergencies Working Group would like to work with the Working Group Nutrition and HIV/AIDS to share some of the unique experiences and lessons learned during interventions addressing certain aspects of HIV/AIDS in emergency contexts. In this way the Emergency Working Group can fully profit from the valuable knowledge of the Nutrition and HIV/AIDS Working Group, and vice versa. *Recommendation:* a representative of the Working Group on Nutrition in Emergencies should join the Working Group on Nutrition and HIV/AIDS to ensure a physical and sustainable link between the two working groups. (*Responsible: Saskia van der Kam (MSF)*)

Capacity development for nutrition in emergencies Capacity development for nutrition in emergencies' is defined as a process of change which is enabled through relevant and related changes in structures, processes, skills, attitudes and knowledge, that allow individuals and organizations to respond more effectively to the problem of malnutrition in emergencies. The methods used are the development of relevant policies, strategies, best-practice guidelines, curricula and training courses, preferably developed in partnership with national structures and institutions in crisis-affected countries and which aim to improve national capacity. A list of available courses on emergency nutrition is available on NutritionNet (www.nutritonnet.org). The list includes university, agency and NGO courses. The list will be updated next in June 2004. Various training workshops have been conducted in partnership with UN agencies (FAO, WHO, UNICEF, WFP), governments (Ethiopia, Afghanistan) and institutes (Tufts, CDC, Colombia, Univ. of Nairobi, Kenyatta Univ.). In addition to these training activities, there are several other capacity building and collective memory building initiatives: the second edition of the Sphere manual is published, training is ongoing, the SMART project is continuing.

Working Group activities are organized by category based on the UNICEF Causal Framework, where many sectors in nutrition are related; however, for clarity, only activities that directly contribute to the MDG's are listed here:

- *Eradicate extreme poverty and hunger* Activities that are covered in the food security sector contribute directly to this MDG. This year the focus is on the availability and accessibility of micronutrients for populations in emergencies. Nevertheless food availability and accessibility remains a point of interest for many agencies.
- *Achieve universal primary education* Work on caring practices and capacity building contributes to this goal directly. This year the focus is on the caregiver and caretaker. One of the caring aspects in a household is to ensure proper schooling for its members. Food security is an important precondition for proper schooling; in food insecure situations children are often working in the fields or on the street instead of attending school.



- *Promote gender equality and empower women* Capacity building, community-based treatment of severe malnutrition, improvement of care practices, including intervention to improve the mental health of caregivers, contribute directly to this MDG.
- *Reduce child mortality* Efforts to improve treatment of severe malnutrition in new strategies (community treatment of severe malnutrition) and for special groups (infants, adults), contribute directly to this goal. Improving the care given to children is also an important contribution.
- *Improve maternal health* Treatment of severe adult malnutrition and improved care contribute directly to this goal.
- *Combat HIV/AIDS, malaria, and other diseases* Identification and compilation of lessons learned from nutrition interventions in AIDS programmes, and strategies in nutritional programmes to combat HIV/AIDS directly contribute to this goal.
- *Ensure environmental sustainability* The Working Group promotes local production of therapeutic foods and local fortification activities.
- *Development of global partnerships* The capacity development theme group contributes directly to this goal. In addition many strategies promoted by the Working Group envisage partnership with local communities (community treatment of severe malnutrition) and context specific interventions (adult malnutrition, HIV/AIDS).

The current chairs and secretariat are stepping down, henceforth the Working Group Nutrition and Emergencies will be chaired by: Fathia Abdallah (UNHCR) abdallaf@unhcr.ch and Caroline Wilkinson (ACF France) cwilkinson@actioncontrelafaim.org. The Working Group is organized by theme group, each group has a focal point:

- *Micronutrients* Andrew Seal (ICH) a.seal@ich.ucl.ac.uk Fathia Abdallah (UNHCR) abdallaf@unhcr.ch
- *CTC* Paul Rees Thomas (CONCERN) paul-rees.thomas@concern.net Steve Collins (Valid International) steve@validinternational.org
- *Adult malnutrition* Bradley Woodruff (CDC) baw4@cdc.gov
- *Infant feeding in emergencies* Marie McGrath (ENN) marie@enonline.net
- *Mental health and care in emergencies* Cecile Bizouerne (ACF) cbizouerne@actioncontrelafaim.org
- *Capacity building* Annalies Borrel (TUFTS) Annalies.Borrel@tufts.edu

The theme groups propose to plan a longer meeting in 2005, before the SCN annual meeting.

NUTRITION, ETHICS AND HUMAN RIGHTS

Chaired by Urban Jonsson (UNICEF), Wenche Barth Eide and Uwe Kracht (WANAHR)

Developments since the 30th SCN Session include:

- *The Common Understanding* The Second Interagency Workshop on Implementing a Human Rights Based Approach in the Context of UN Reform was held in Stamford, USA, in May 2003. The workshop sought to move forward the agenda of interagency cooperation around human rights mainstreaming, focusing on the CCA/UNDAF processes, as called for in the UN Secretary-General's Agenda for Further Change of September 2002. It also examined examples of how United Nations Country Teams (UNCTs) are dealing with human rights in the context of PRSP and MDG processes. A key result is a Statement of Common Understanding which specifically refers to a human rights based approach to development cooperation and development programming by UN agencies, which was later endorsed by the United Nations Development Group. The three pillars of the Common Understanding are:
 1. all programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the *Universal Declaration of Human Rights* and other international human rights instruments
 2. human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process
 3. development cooperation contributes to the development of capacities of 'duty-bearers' to meet their obligations and/or 'rights-holders' to claim their rights

The SCN Steering Committee's call for mainstreaming human rights in all SCN activities, made at its Tivoli retreat in January 2004, is a first step in this direction.

- *Principles for the respect of human rights by Transnational Corporations (TNCs) and other enterprises* The

SCN is regularly invited as an observer to the UN Sub-Commission on the Promotion and Protection of Human Rights. The 2003 session finalized work on draft 'Norms on responsibilities of transnational corporations and other enterprises with regard to human rights', to be submitted to the 60th session of the Commission on Human Rights meeting in March-April 2004 in Geneva (Doc. E/CN.4/Sub.2/2003/12/Rev.2 (2003)). Specific reference to the respect by transnational corporations and other business enterprises for and contribution to the realization of the rights to adequate food and drinking water and to the highest attainable standard of physical and mental health, warrants the involvement of the SCN.

- *Advancing dialogue at the country level* Members of the SCN, and the Working Group on NEHR in particular, have been especially conscious of the need for national dialogue concerning the implications of applying the right to adequate food and corresponding state obligations, under specific economic, social and cultural conditions prevailing in a given country. They were directly involved in catalyzing two additional national seminars on the right to food in Uganda and Mali, funded by NORAD, and more indirectly in a third in Sierra Leone, funded by Germany through FAO. The seminars drew inspiration from the normative basis established by General Comment No.12 on the right to food and principles derived for implementation by state and non-state actors. It is hoped that the experience from the seminars can inspire similar initiatives elsewhere with funding from other sources, eventually leading to an 'adaptive model' for advancing national dialogue on the right to food and related rights in other interested Member States.

Follow-up action to last year's recommendations:

- *Intergovernmental Working Group on voluntary guidelines for the progressive realization of the right to adequate food* Working Group members participated in the IGWG-RTF established by the FAO Council in response to a recommendation of the *World Food Summit: five years later*. The SCN statement 'On the nutritional dimension of the right to adequate food', drafted by a NEHR task force at the Chennai session was circulated to IGWG participants. In support of the voluntary guidelines process, FAO organized a series of country case studies on the right to adequate food. NEHR Co-chair Uwe Kracht acted as lead consultant for the Uganda study and presented preliminary results from all studies to a group of Government representatives to FAO and FAO staff in February 2004. A full report on the studies will be published shortly by FAO.
- *Sharing of experience on human rights based approaches to development programming* The UNICEF-sponsored book on *Human Rights Approach to Development Programming*, authored by the NEHR Chair, has been widely circulated since its publication in mid-2003. The book on *Adequate Food as a Human Right – Its Meaning and Application in Development*, edited by the two NEHR Co-chairs, as well as NEHR member George Kent's book on *The Human Right to Adequate Food*, both to be published in mid-2004, will further contribute to dialogue and the sharing of experience within the Working Group and beyond.
- *Rights-based monitoring and evaluation* UNICEF has sought to further develop the application of the concepts and proposals contained in the NEHR document on *Monitoring the realization of the rights to adequate food, health and care for nutritional well-being* presented to the 28th SCN session. One outcome is the 2004 discussion paper *The Human Rights Based Approach to Programming at UNICEF and its Implication for Evaluation*.
- *Other NEHR recommendations from Chennai* On human rights in emergencies, the work of the Interagency Standing Committee on Emergencies within the Executive Committee on Humanitarian Affairs demonstrates that it is now generally accepted that human rights apply in both peace and war, with international humanitarian law complementing human rights law in complex emergency situations. Issues concerning the need for human rights training were further addressed at the current NEHR meeting, including aspects of training of UNCTs in mainstreaming human rights in CCA/UNDAFs within the framework of the Common Understanding.

The Working Group recommends:

- that the SCN reformulate its mandate so as to reflect that it will facilitate the ending of malnutrition in all forms through the realization of the rights to adequate food, health and care throughout the world
- that the SCN request all Working Groups now to take steps to mainstream human rights principles in their respective domains



- that the SCN appoint a task force to provide inputs to the Millennium Project Hunger Task Force to reflect human rights principles and standards in its final report.

The NEHR meeting had before it an initial list of selected issues where SCN could contribute to strengthening the human rights dimension in the work of the Hunger Task Force and the Millennium Project more generally—it focused on a brief discussion of two issues: (i) human rights related training and (ii) the further advancement of codes of conduct for the food-related industry, building on recent work by the UN Sub-Commission on the Promotion and Protection of Human Rights on 'Norms on responsibilities of transnational corporations and other enterprises with regard to human rights'. It is intended to continue the discussion early on in the intersessional period, keeping in mind the Hunger Task Force timeframe for finalizing its report by December 2004.

NEHR intends to follow-up the call at the current SCN session for more effective continuation of all the Working Groups' work between sessions. As a first step, the Chair/Co-chairs will contact SCN members to ascertain their willingness to participate in intersessional NEHR activities related to the above recommendations as active NEHR members or to be at least regularly informed as passive members.

MICRONUTRIENTS

Chaired by Frances Davidson (USAID), Bruno de Benoist (WHO) and Ian Darnton-Hill (UNICEF)

The Micronutrient Working Group began with presentations from three managers of micronutrient country programmes that have demonstrated success: Dr. Josefina Bonilla, 'Supplements and Fortified Foods in Nicaragua' (vitamin A, iron and iodine); Ms. Rosanna Agble, 'Micronutrient deficiencies in relation to MDGs^{3/4}The Ghana Experience' (vitamin A, iron deficiency, iodine); and Mr. Ram Shrestha, 'Nepal National Vitamin A Program.' Participation of these presenters was organized by MOST, the USAID Micronutrient Program. In all three programmes, supplementation, particularly vitamin A supplementation, is the most mature intervention. Food fortification is well developed in Nicaragua, starting in Ghana and only in preliminary stages in Nepal. The degree of development of other food-based strategies is variable, although nutrition communication is a component of all programmes.

Key points from the presentations and the subsequent discussions include:

- Recognition that vitamin A supplementation (VAS) can no longer be considered as a short-term intervention. Strategies for sustaining VAS for the long-term are important. Phasing out of VAS has to be done with great prudence and with a strong evidence base. None of the three countries has chosen to phase out VAS, even Nicaragua despite advances in other strategies. Post-partum VAS is less well developed than VAS for children 6-59 months.
- In all cases, strong partnerships bringing together all stakeholders are key elements in the success of micronutrient programmes. These partnerships have leveraged implementation resources beyond the health sector (communities, local governments, media, schools, industry, etc.). Micronutrient programme infrastructure has been leveraged to implement other public health programmes (Nepal) and conversely, existing public health campaigns have been leveraged to include micronutrient programmes (Nicaragua).
- Micronutrient nutrition of the young child (under 2 years of age) remains a great concern, with anaemia levels of young children of particular concern. Improved knowledge of young children's micronutrient intake, technologies for enriching their diets and improving complementary feeding is needed. It was reiterated that breastfeeding promotion and support are key elements in the control of micronutrient malnutrition.
- All successful programmes have included strong communication strategies, including a combination of approaches (community radios, television, interpersonal communications, schools, etc.). Development of very specific, compelling messages that resonate with the target populations is important.
- All successful programmes have included strong training components that reach beyond health workers.
- Food fortification requires understanding of the private sector's needs and should move towards fortifying an array of food products, including those that can reach young children. Specific concerns were raised concerning the use of sugar as a vehicle for vitamin A. Communication has focused on having consumers choose VA-fortified sugar over non-fortified sugar, and to consume only the levels they are used to consuming.

- In all cases, the micronutrient deficiency control programmes are making major contributions to several Millennium Development Goals (MDGs).
- Promotion of production and consumption of micronutrient-rich foods is included to a greater or lesser extent in all three programmes. There is a need for a more systematic identification of potential for food-based strategies and the evaluation of their impact beyond knowledge of micronutrient-rich foods.
- In all three programmes, including the most mature (Nicaragua), it is recognized that external technical and financial resources continue to be necessary. Mobilizing increasing levels of national resources to maintain and expand micronutrient deficiency control remains a challenge. The level of national resources committed for micronutrient programmes is a critical indicator of success.
- In plenary, a brief presentation showed that micronutrient interventions contribute to all MDGs and that successful control of micronutrient malnutrition will be essential for their achievement. Two key recommendations for action reported back to the plenary were:
 1. Improved knowledge of young children's micronutrient intake, technologies for enriching their diets and improving complementary feeding are greatly needed. Food fortification should move towards fortifying an array of food products, including those that can reach young children. Efforts to mobilize national investments in micronutrient programmes must be enhanced. Level of national resources committed for micronutrient programmes is a critical indicator of success.
 2. Ongoing or planned activities should be reported by working group participants and collated by an informal secretariat (UNICEF, USAID, WHO, HKI). This will constitute the Working Group's work plan and will be reported on in a year's time at the next SCN Session.

NUTRITION OF SCHOOL-AGE CHILDREN

Chaired by Arlene Mitchell (WFP)

The Working Group on the Nutrition of School-Age Children has primarily taken advantage of the SCN's annual session as an opportunity to bring attention to the important nutrition issues among the school-age population. Although the Working Group was unsuccessful in convening meetings or holding other events during the year 2003, the promotion of this work through the SCN contributes to the expansion of activities in this area. During the previous year:

- The Alliance for Action on School Feeding, Health and Basic Education for the Sahel was launched in September of 2003. A similar multi-country approach was initiated for the countries of Southern Africa also in 2003. In March 2004, the Latin America School Feeding Network was launched in Santiago, Chile. All of these efforts have involved a wide variety of partners including national governments and local and international health, nutrition and education institutions.
- The WFP Working Group Co-Chair participated actively in the Millennium Development Goal (MDG) Task Force on Education and Gender and coordinated closely with the Hunger Task Force. The work included meetings in New York, Washington, DC, and Bangalore as well as a Millennium Project team mission to Ethiopia. One key recommendation from the Ethiopia visit was to substantially increase school feeding activities there.
- Work has been undertaken on the issue of the sustainability of school feeding operations, by the World Food Programme, the US Department of Agriculture, and Catholic Relief Services.
- UNICEF has announced its support of school feeding and the minimum package approach as described in the 2003 Working Group discussion. The agency has expanded its cooperation with school feeding programmes worldwide.
- Deworming linked to school feeding has expanded significantly over the past year, and gained support from a wider variety of donors and governments.
- Several studies and large-scale initiatives have been undertaken related to nutrition, food, and school-based interventions for children affected by HIV/AIDS. In December, WFP implemented an all-Africa HIV/AIDS and School Feeding workshop with representatives from UNAIDS, UNICEF, FAO, to share lessons learned and to encourage more attention and action on these issues in Africa.

The Working Group discussed the most important linkages between the MDGs and this group's work, and presented recent programme and intervention results and experiences related to scaling up key nutrition interventions for this age group.

- *Linkages between the MDGs and school nutrition* The link between nutrition, children's ability to learn and their education achievement means that adequate nutrition is essential for achieving MDG 2—*Achieving Universal Primary Education*. Since 'school-age children' encompasses adolescents, the health and nutrition of this age group is essential for achieving MDG 5—*Improving maternal health*. Adequate nutrition is essential for a healthy immune system and can reduce the severity of HIV infection. School can also provide a forum for health and nutrition education, including HIV/AIDS prevention education, and for caring for orphans and vulnerable children. This links with MDG 6—*Combating HIV/AIDS, malaria and other diseases*.
- *Scaling up programmes to achieve the MDGs* Presentations focused on recent success stories in nutrition programming for school-age children, highlights are:
 1. *Deworming* Results from a national deworming programme in Nepal which should achieve full national coverage by April 2004 were shared. This study, together with others, has confirmed that deworming is extremely cost effective (in Nepal, 2 cents per child per year) and can have enormous benefits for children, with a reduction in worm load and subsequent improvement in iron status leading to reduced morbidity, improved growth and development.
 2. *Integrated school-based interventions* The experience of the Zambian Government programme implementing a series of interventions, including: deworming, iron supplementation and vitamin A supplementation, and skills-based health education (including for HIV/AIDS prevention and malaria prevention and treatment) was shared. A three year longitudinal study demonstrated a significant reduction in the prevalence of both hookworm and urinary schistosomiasis, after two annual rounds of deworming (e.g. from 60% to 1% for schistosomiasis). The programme has been successful in building capacity in the areas of policy, training and training materials, targeting and delivery, partnerships, monitoring and evaluation. The Zambian Ministry of Education have now committed funds to extend the programme to a further four provinces by 2005, with the aim of full national coverage by 2008.

The Working Group has two specific recommendations regarding scaling up effective nutrition programming for school-age children in order to maximize its contribution to achieving the MDGs:

- school feeding programmes have been around for decades and continue to be one of the mainstay interventions aimed at school-age children. The integration of other interventions into feeding programmes improved efficiency in delivery. It is recommended that every possible effort be made to design and implement school feeding programmes as food plus other school-age health and nutrition interventions
- deworming has proven itself many times over to be one of the least costly and most effective interventions available for addressing both health and nutrition needs of school-age children. It is recommended that every possible opportunity be identified for providing deworming services to school-age children.

A third recommendation pertains to actions that the Working Group should undertake over the next year. Notwithstanding the first recommendation regarding 'school feeding plus,' there appears to be a lack of awareness in the international development community of the current state-of-the-art in school feeding as well as a reoccurring set of questions related to a school feeding that never seem to get answered. To address this gap it is recommended that the SCN support and facilitate the Working Group on the Nutrition of School Age Children to produce a 'state of school feeding' paper. The specific content of this document remains to be elaborated, but it is anticipated that it would be a combination review and meta-analysis drawing on current practice and research in school feeding and school nutrition over the last decade. The recommended approach toward producing this paper would be to draw on experts across a number of institutions involved in school feeding and school nutrition.

The working group is currently chaired by three members (two co-chairs, and a secretary). These three members represent a UN Agency/WFP, an NGO/Save the Children and an academic institution/Imperial College closely associated with the World Bank. These members have served for the past two years. They could conceivably continue to lead this working group, however the future organization of the working group was not discussed due to lack of time and the absence of one of the co-chairs.

NUTRITION THROUGHOUT THE LIFE CYCLE

Chaired by Ricardo Uauy (LSHTM, UK and INTA, Chile) and Ted Greiner (Sweden)

Key recommendations from the Working Group relating to the MDGs

- Promote nutrition, health, care and education of adolescent women, including fulfillment of their reproductive rights (MDGs–1,2,3,4,5,6,8)

The Working Group prioritized the nutrition and health of adolescent women in order to effectively break the intergenerational cycle of poor maternal nutrition, foetal growth restriction and post-natal malnutrition/stunting. There is ample evidence that the nutritional status of women before they become pregnant is more influential on pregnancy outcomes than any nutritional supplements provided during pregnancy. Efforts at improving micronutrient intakes and achieving a healthy weight should thus be undertaken before conception, with emphasis on the adolescent period. The prevention of unwanted pregnancies, especially at the time young girls are still growing, requires information, education and access to reproductive health, including contraception. This is presently an unfulfilled right in many parts of the world. The Working Group considers that efforts to promote women's reproductive rights should go in tandem with efforts to improve nutrition, health, care and education of adolescent women for maximal impact to protect maternal health and child growth and development and to obtain optimal pregnancy outcomes—important to both women and men.

- Achieve the goals of reducing child mortality by including optimal nutrition as embodied in the global strategy on infant and young child feeding (MDGs–1,3,4,6,7)

The Working Group noted with extreme concern the latest figure of 10 million deaths of children under five, close to 30% of these are preventable by simple nutrition and care practices. Exclusive breastfeeding to 6 months, followed by appropriate complementary feeding could alone save close to two million children from death. Additional measures such as clean water and sanitation, micronutrient rich foods and/or food fortification could contribute to preventing another one million deaths. These interventions are presently well formulated and approaches for their effective implementation are presented in the *WHO/UNICEF Global Strategy for Infant and Young Child Feeding*.

- Fulfilment of MDG goals requires integration of the global strategy on NCD prevention (diet, physical activity, and health) (MDGs–1,3,4,5,7,8)

The Working Group examined the double burden of disease affecting most developing and transitional societies around the world. It is no longer a question of focusing on children's health and nutrition or on prevention of adult chronic disease. The evidence presented and discussed indicates that nutrition-related chronic disease NRCs (cardiovascular disease, obesity and diabetes, and some forms of cancer) account for a major proportion of death and of DALYs lost on a global basis, including amongst the low-income groups in developing countries as they experience the epidemiological-nutrition transition. There was consensus within the Working Group that this issue was central to the achievement of the MDGs, since prevention of these conditions must start in early life (from the moment of conception). Moreover, early nutrition is a key factor in determining risks for NRCs. In developing countries these conditions affect adults in their productive years who often succumb before they reach old age. Already strained health resources become progressively limited with the burden of NRCs, especially related to rapidly growing epidemic of diabetes striking at increasingly younger age groups and consuming, for example, 8% of the Ministry of Health budget in Tanzania.

Plan of action for 2004/05:

- Continue work (WHO/UNICEF/IAEA) on cost effective ways of prevention and control of malnutrition in young children. Continue implementing the Global Strategy on Infant and Young Child Feeding.
- Develop a plan of action and global strategy for improvement of foetal growth and prevention of low birthweight. Prioritize adolescent girls in order to break the intergenerational cycle. (WHO/UNICEF/IAEA).
- Support the implementation of the global strategy on NCD prevention considering the special challenges facing developing countries, namely how to address the double burden of disease. Consider addressing this topic in Brazil as a prime example of a country undergoing a rapid nutritional transition.

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PROGRAMME NEWS

ICRW-IFPRI

INTERAGENCY

The Agriculture-Nutrition Advantage Project: seeing some success

The *Agriculture-Nutrition Advantage Project* aims to reduce hunger and malnutrition in Sub-Saharan Africa by promoting policies and programs that integrate agriculture, nutrition and gender. The multi-country project is led by the International Center for Research on Women (ICRW) and the International Food Policy Research Institute (IFPRI), working with colleagues in Ghana, Kenya, Mozambique, Nigeria, and Uganda.

By the end of the project's third year, the five-country teams and the ICRW/IFPRI team are seeing results. Some of the most meaningful changes have occurred at the level of policy-making, training and educational institutions. Changes such as these create an environment for enhancing long-term use of gender and the integration of agriculture and nutrition in development planning and implementation.

For example, the Ghana team organized representatives from 18 public sector agencies, nongovernmental organizations and donors to increase the use of food-based strategies to reduce micronutrient deficiencies; supported the development of Plans of Action in nine districts to serve as pilot sites for planning and implementing community-based actions to support food-based strategies, with support from the World Bank and UNICEF for five of the nine district plans; and worked closely with the Ministry of Agriculture to integrate nutrition into agricultural training institutions' curricula, and gender into health institutions such as medical and nursing schools.

In Mozambique and Uganda, the national agricultural research institutions have incorporated nutrition into their research agendas, and the Uganda team has taken advantage of opportunities to integrate nutrition into the new Poverty Eradication Action Plan (PEAP). In Nigeria, the team supported the launch of the National Policy on Food and Nutrition, the development of a plan of action for implementing that policy, and the decision to second a nutritionist to work in the National Committee on Food and Nutrition. At the community level, the Uganda team has worked with communities to submit proposals requesting support from the National Agricultural Advisory Services (NAADS) for nutrition-specific services.

Findings from the IFPRI/ICRW study of institutional barriers to and opportunities for strengthening links between agriculture and nutrition, particularly as they are informed by gender, in four of the five project countries were used by the country teams to identify key audiences and messages for their advocacy strategies. Project staff served on the Steering Committee for the World Bank's assessment of agricultural science and technologies contributions to poverty and hunger reduction, and successfully integrated language to ensure attention to gender in the final report.

A final report with lessons from this multi-country project will be published later this year. For more information on the project, see previous issues of *SCN News* and www.agnutritionadvantage.org

UNHCHR

The right to adequate food: progress on voluntary guidelines

The Inter-Governmental Working Group (IGWG) established within FAO to elaborate a set of Voluntary Guidelines to support Member States' efforts to achieve the progressive realisation of the right to adequate food in the context of national food security is entering the last stage of its mandate, where crucial decisions have to be taken to conclude the negotiations^a. The following provides an update.

The IGWG was established upon the invitation of the World Food Summit: *five years later*, and its membership is comprised of FAO Member States, UN Members and stakeholders such as international organizations, NGOs, academic and research institutions. The decision to establish the IGWG emphasises its need to ensure contributions from human rights bodies, in particular the Office of the High Commissioner for Human Rights, the Committee on Economic, Social and Cultural Rights and

^aWenche Bart-Eide, Uwe Kracht Towards International Voluntary guidelines for the implementation of the human rights to adequate food. *SCN News* # 25, December 2002, p 60.



the Special Rapporteur on the Right to Food. All three bodies have participated actively in the process. The IGWG has held two sessions and one inter-sessional meeting in the form of an open-ended Working Group. The first session took place in Rome on 24-26 March 2003 and was devoted to the presentation of views and proposals on the elements and structure of the voluntary guidelines. A report prepared by the Secretariat synthesising submissions received, provided the basis for the deliberations. The session concluded by requesting the IGWG Bureau to produce a first draft of the Voluntary Guidelines for consideration at the second session.

The second session of the IGWG was held in Rome from 27 to 29 October 2003 and was devoted to a general debate and presentation of views about the draft voluntary guidelines prepared by the Bureau. The IGWG adopted the draft as a basis for negotiations that were to take place at an open-ended working group of the IGWG in February 2004. However, as delegations used this open-ended working group to make proposals for amendments and insertion/deletion to the draft, negotiation of the guidelines were left to the third, and last, session of the IGWG from 4 to 9 July 2004. The IGWG should report to the FAO Committee on World Food Security by September of 2004.

In April the IGWG Bureau prepared a second draft of the voluntary guidelines taking into account and trying to consolidate, where possible, the proposals made by delegations. The Bureau and the IGWG in general have to face a number of challenges in accomplishing their task.

There are differences among delegations as to the legal status of the right to adequate food, its content and components, as well as to the possibility of judicial remedies to counter instances of non-compliance. There are also differences about the extent to which international factors affecting the right to adequate food at national level should be taken into account. Nevertheless, there is also substantial consensus on a wide range of issues relating to the implementation of the right to food in the areas of nutrition, education and awareness-raising, access to assets and resources and the provision of safety nets in emergency situations. The last session of the IGWG is tasked to adopt a final text of the voluntary guidelines whose elaboration has already served to advance thinking about the implementation of the right to adequate food.

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WHO AND UNICEF

Meeting on BFHI

WHO and UNICEF jointly organized a third international meeting on the Baby Friendly Hospital Initiative (BFHI) with participants primarily from industrialized countries (Barcelona, 31 March-2 April 2004). Hosted by the UK Committee for UNICEF and IHAN España with the support of Generalitat de Catalunya, WHO Geneva and Copenhagen, and UNICEF New York¹.

The meeting's main objectives were to reiterate the commitment to BFHI and its sustainability as one of the operational goals of the *Global Strategy for Infant and Young Child Feeding*, provide a forum for BFHI coordinators to exchange experiences and knowledge, identify obstacles and solutions, and discuss how best to move forward to maintain BFHI as a crucial activity on the international health agenda.

Following the welcome remarks by Victor Soler-Sala, President, BFHI Cataluña, and Andrew Radford, UK Committee for UNICEF, a series of plenary presentations, group work and brainstorming resulted in an exchange of considerable information and in a consensus on recommendations on networking, sustainability, and quality assurance to take BFHI forward.

Highlights of the meeting included:

- emphasis on the urgency and new areas offered in the *Global Strategy for Infant and Young Child Feeding*. WHO and UNICEF were encouraged to be more active in disseminating the Global Strategy and offering model approaches for each action area
- the sharing of materials and updated country records on numbers of baby-friendly hospitals (see Table 1)
- an average increase in the number of countries with baby-friendly facilities of more than 85%,

¹Participants came from: Australia, Austria, Belarus, Belgium, Bulgaria, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Korea, Latvia, Lithuania, Luxembourg, Macedonia, Malta, Netherlands, New Zealand, Norway, Russian Federation, Spain, Sweden, Turkey, United Kingdom of Great Britain and Northern Ireland, United States of America, EU Promotion of Breastfeeding in Europe Project, UNICEF, World Health Organization. Apologies were sent from Hungary, Israel, Japan, Portugal and Switzerland.

and those countries with none in 2000 had added 57 new designations

- excitement around the EU Blueprint for Action on Breastfeeding made available in June
- reconfirmation of the importance of UNICEF national committee support for BFHI
- a suggestion to use the acronym LACH to help English-speakers remember the Global Strategy's main components: Legislation (Code and maternity protection), Authority (national oversight authority), Community (Step Ten of *The ten steps to successful breastfeeding* and other community support), and Health system improvements (baby-friendly hospitals as both a central issue, as well as in the context of pre-service curriculum and health information systems)
- brainstorming on sustainability and quality assurance offered many alternative approaches for cost-savings and increased quality, including the establishment of credentials by a national authority, increased use of self-assessment tools and annual reporting, improved instructions and reduced numbers of assessors
- support for updating assessment tools and training materials/courses, especially in the light of HIV and other new infant-feeding issues
- discussion of a 15 years later meeting to assess progress since Innocenti and to reaffirm the *Global Strategy*

BFHI 2004 Barcelona meeting participants' update	Total hospitals/ maternities reported in 2004	Baby- friendly facilities 2000*	Baby- friendly facili- ties 2004	% in- crease in number of facilities	% of all facilities design. BF
Albania	-	0	2	-	-
Australia	338	17	45	165	13
Austria	110	8	14	75	13
Belarus	140	4	16	300	11
Belgium	108	0	0	-	0
Bulgaria	110	1	5	400	5
Canada	-	1	2	100	-
Denmark	35	8	11	38	31
Finland	33	2	4	100	12
France	800	1	3	200	0
Germany	1000	11	18	64	2
Iceland	10	0	0	-	0
Ireland	22	0	2	-	9
Italy	700	0	7	-	1
Korea (Republic of)	452	11	29	164	6
Latvia	32	0	7	-	22
Lithuania	52	0	4	-	8
Luxembourg	6	1	2	100	33
Macedonia	29	0	28	-	97
Malta	5	0	0	-	0
Netherlands	191	13	22	69	12
New Zealand	86	0	7	-	8
Norway	56	35	36	3	64
Russian Federation	3000	12	162	1250	5
Spain	909	4	9	125	1
Sweden	66	64	64	0	97
Turkey	395	83	206	148	52
United Kingdom	300	32	48	50	16
United States of America	3154	27	42	56	1
AVERAGES, based on number of countries for which data are available	420	11.6	27.4	85.9	18

Table 1
**Number of baby-
friendly facilities,
and proportion of
all facilities, as
reported by
Barcelona meeting
participants
(March-April 2004)**

* from UNICEF records



- the sharing by participants from CEE/CIS countries, of the impact of new initiatives in their countries, and
- agreement that BFHI should be advocated as a vital component of the *Global Strategy*.

The meeting concluded with comments and wrap-up by Andrew Radford of the UK Committee for UNICEF who emphasised the need to maintain focus on increasing the number of Baby-friendly facilities not only because of their direct impact but also because of the influence on hospital outreach, general knowledge, and health worker training. There was resounding agreement to continue the network and to meet once again.

Contact: Andrew Radford (unicef13@dircon.co.uk), Randa Saadeh (saadebr@who.int), and Miriam H Labbok (mlabbok@unicef.org)

FANTA

Meeting the Challenges of Famine in the 21st Century

In recognition of the changing global context for US foreign assistance, development has been elevated as the third pillar of US national security, along with defence and diplomacy. To meet the challenges of this new global context, development assistance must be more effective and be harmonized with the broader US foreign policy objectives.

Famine-prone countries fall into the category of fragile states. Fragile states pose growing problems to U.S. national security interests, impede progress towards further globalization, and consume a disproportionate amount of foreign assistance during humanitarian crises. The United States Agency for International Development (USAID), in response to the critical need to make development more effective and development policy more coherent, is seeking ways to move from famine response to famine prevention in famine-prone countries.

Insufficient funding flexibility and limited levels of development and humanitarian assistance coupled with the need for greater programming synergy has constrained the ability of USAID to address the unique challenges posed by famine-prone countries. The direction of the White Paper implies that “winning and progressing nations” are a better investment for conventional development assistance and “fragile (failing, failed and recovering) states” are targeted with limited humanitarian assistance—food aid in particular—resulting in a focus on consumption-oriented approaches to relief without reducing vulnerabilities.

Famine-prone countries are a unique sub-set of fragile states that require special focus. In response to the need to better deploy resources to meet the challenge of famine in fragile states, the Office of Food for Peace (FFP) and the Office of US Foreign Disaster Assistance (OFDA), with technical assistance from the Academy for Educational Development’s (AED) Food and Nutrition Technical Assistance Project (FANTA), organized a Famine Forum March 24-25, 2004 in Washington, DC.

The objectives of the forum were to:

- recognize that a sub-set of fragile, failing and failed states represents the most ‘famine-prone countries’ and requires that USAID “do business differently” to address the underlying causes through a developmental relief approach
- redefine USAID’s definition of famine and policy toward the application of resource to prevent and respond to the threat of famine
- use the newly identified “famine scales” to lower the present threshold of famine
- identify alternative responses necessary for success beyond the “nuts and bolts” of food and non-food programming, including livelihood and market interventions, responses to health system inadequacies, as well as short- and longer-term policy and governance constraints
- develop approaches that assist in better engagement of other donors to assist in reducing the threat of famine.

Participation in the forum included a broad representation of USAID practitioners, senior-level USAID management and representatives from FEWSNet, the International Food Policy Research Institute (IFPRI) and the AED’s FANTA project. International famine experts Sue Lautze, (Feinstein International Famine Centre at Tufts University) and Stephen Devereux and Paul Howe, Institute of Development Studies made significant contributions to the discussion with some of the state-of-the-art thinking on the challenges of addressing famine in the 21st century.

A synthesis report on the Famine Forum will be available on FANTA’s website at www.fantaproject.org

The impact of Title II maternal and child health and nutrition programmes on the nutritional status of children

FANTA and USAID have released a review of the impact on nutritional status of food assisted Maternal and Child Health and Nutrition (MCHN) programmes that use Title II food aid. Over the past seven years, Title II MCHN activities have evolved from predominantly facility-based food distribution programmes targeted at undernourished children and their mothers, combined with some growth monitoring, to integrated community-based development programmes with long-term health and sustainability objectives. The result of this shift has been a significant improvement in the nutritional status of children benefiting from these programmes. This paper presents the results of a recent review of the impact of Title II MCHN programmes on the prevalence of stunting and underweight in their target populations.

Information on the impact of the Title II MCHN programme on child nutritional status was available for 29 programmes. The review focused on Title II MCHN programmes that ended in 2000 and 2001, for which final evaluation or annual results reports with data on anthropometry were available. Of the 35 Title II MCHN programmes with end dates prior to 2002, evaluations with information on programme impacts on child nutritional status were available for 25 (71%). In addition, final evaluation reports were available for four programmes with end dates in 2002 (all in Ethiopia) and for a joint evaluation of all the Ethiopia programmes.

The review of evaluations shows that the Title II MCHN programmes have been successful in improving the nutritional status (as measured by stunting and/or underweight) of children in their target populations. Copies of the paper, the 4th in the Occasional Paper series can be downloaded from www.fantaproject.org/downloads/pdfs/ffpOP4.pdf

Community Therapeutic Care Workshop in Dublin, October 2003

The USAID-funded FANTA Project collaborated with partner organizations Concern Worldwide and Valid International to coordinate a workshop in Dublin, Ireland, 8-10 October, focusing on the Community Therapeutic Care (CTC) approach (see *SCN News* #27, p 55). CTC is a community-based approach for treating acutely malnourished people in times of stress by providing fast, effective, low-cost assistance. FANTA provides technical assistance and supports monitoring of the programme in Ethiopia, Sudan, and Malawi with funds from the Office of Foreign Disaster Assistance (OFDA) of USAID's Bureau for Democracy, Conflict and Humanitarian Assistance, and the Office of Health, Infectious Disease and Nutrition (HIDN) of USAID's Bureau for Global Health. The workshop brought together approximately 70 key players in severe malnutrition management, including programme implementers, technical advisors, academics, bilateral donors and multilateral agencies such as the United Nations Children's Fund (UNICEF) and the United Nations World Food Program (WFP). For workshop proceedings and presentations, go to: www.fantaproject.org/ctc/workshop2003.shtml

Contact: Bruce Cogill, bcogill@smtp.aed.org

A global advocacy effort on vitamin and mineral deficiency

UNICEF and the Micronutrient Initiative (MI) launched a new global advocacy initiative aimed at re-energizing global efforts to eliminate vitamin and mineral deficiency. *Vitamin and Mineral Deficiency: A Global Progress Report* was released in New York on March 24 2004. As a first step in this effort. The Report presents a global overview of the extent of public health damage and economic loss caused by vitamin and mineral deficiencies. It outlines the progress made to date toward their control and the challenges that lie ahead for their elimination.

The severe effects of vitamin and mineral deficiencies, such as anaemia, cretinism and blindness, have long been known. The report sheds new light on other problems caused by less extreme deficiencies. For example:

- iron deficiency impairs intellectual development in young children and lower national IQs
- vitamin A deficiency compromises the immune systems of approximately 40% of children under five in the developing world, leading to the deaths of one million youngsters each year
- iodine deficiency in pregnancy is causing as many as 20 million babies a year to be born mentally impaired
- some nations lose up to 3% of their GDP annually as a result of lost productivity due to vitamin and mineral deficiencies.

In addition to the global progress report, this initiative takes advantage of *Vitamin and Mineral Deficiency Damage Assessment Reports* that have been prepared by MI and UNICEF for eighty countries, home to about 80% of the world's population. These reports will be used nationally as bases for national level

Micronutrient
Initiative



multi-sectorial discussions aimed at integrating vitamin and mineral deficiency issues into development and investments strategies.

More information can be found at www.micronutrient.org or contact: Ibrahim Daibes, idaibes@micronutrient.org

UNSRDFS

The UN System Network on Rural Development and Food Security: a sister network of the SCN Network

Halving the number of undernourished people by 2015 is one of the first steps towards achieving the first UN Millennium Development Goal of eradicating extreme poverty and hunger. During the World Food Summit (WFS) held in 1996, world leaders pledged their political will and commitment to reach this goal in the Rome Declaration and Plan of Action, where sustainable food security is considered a central aspect.

In this spirit, the UN System Network on Rural Development and Food Security brings together key actors for the achievement of the shared goals of "food for all" and rural poverty reduction. The UN System Network on Rural Development and Food Security is an ex-Administrative Coordinating Committee and sister network of the SCN.

This inter-agency mechanism for follow-up to the WFS (1996) and WFS: *five years later* (2002) uses a global partnership approach that aims to:

- support efforts by governments and their partners to implement the WFS Plan of Action and rural development and food security programmes
- strengthen ties between UN System organizations and other stakeholders, notably NGOs and civil society
- foster synergies between Network members
- exchange and disseminate information, experiences and best practices.

The Network is comprised of an informal two-tiered mechanism: at the country level, some 70 national thematic groups work on rural development and food security issues and at the international level, a network of 20 UN System partners to support these thematic groups. FAO provides the Network Secretariat in collaboration with the International Fund for Agricultural Development and the World Food Program.

To disseminate information, the Network provides a regularly updated website providing information in Arabic, English, French and Spanish on worldwide broad-partnership and multi-stakeholder initiatives for rural development and food security, both at regional and international levels (www.rdfs.net).

The UN System Network is currently carrying out an evaluation that will provide helpful indications for future programme of work, priorities and operational links with the International Alliance Against Hunger launched after the WFS: *five years later*.

To read more about the UN System Network on Rural Development and Food Security visit our website at www.rdfs.net. To be part of the Network's email list and receive information on rural development and food security issues or to provide your comments for the evaluation, please send an e-mail to rdfs@fao.org.

Contact: Stéphane Jost, Stephane.jost@fao.org

NUTRITION: A FOUNDATION FOR DEVELOPMENT

A SUMMARY OF THE READERSHIP SURVEY ANALYSIS

Objective of the survey

In August 2003, a readership survey was conducted to evaluate the publication *Nutrition: A Foundation for Development*. The objective of the survey was to determine by whom and how the briefs have been utilized and how their presentation and content could be further improved.

Launched in 2002 at the SCN 29th session in Berlin, *Nutrition: A Foundation for Development* is a set of 12 briefs on the latest research findings in nutrition as they relate to other development sectors. The briefs are designed to facilitate dialogue between nutrition and other development professionals as well as advocate for integrating nutrition into development strategies. The following is a summary of the readership survey results.

Survey methods used

In order to increase the survey's response rate the questionnaire was sent to all *SCN News* subscribers (6500 questionnaires) along with *SCN News* #26 (July 2003). The SCN Secretariat also sent electronic versions of the survey to 650 of its most contacted members. In addition, the survey was made available online on the SCN's website. This mass-mailing approach was used to increase awareness of the briefs amongst SCN members by encouraging them to request their own copy.

The following survey analysis is based on the 144 questionnaires that were returned (47 by email, 97 by mail).

Respondents profile

Since one of the main aims of this survey was to find out by whom the briefs were being used, the readers were asked about their professional background, the position they hold, the type of organization they work in, as well as their area of work.

In terms of professional background, the majority of the respondents said that they had a nutritional (40%) or a medical (16%) background. The remaining respondents had professional backgrounds in agriculture (8%), other natural sciences (8%), teaching/academic research (7%), economics (6%), politics (4%) or law (1%). Since the respondents were allowed to tick as many answers as applicable, 10% stated that they had a professional background that is a combination of the abovementioned.

Concerning positions held, 13% work as technical officers and professors respectively, 11% as consultants, 8% as directors, 7% as researchers, and 6% were students. The remaining 42% occupied more than two of the already mentioned positions. In absolute terms (see figure 1 below), the majority of the respondents were professors, followed by consultants, researchers, technical officers, directors and students.

When asked about the type of organisation they work in, the respondents replied as follows:

- both university and research institute respectively: 16%

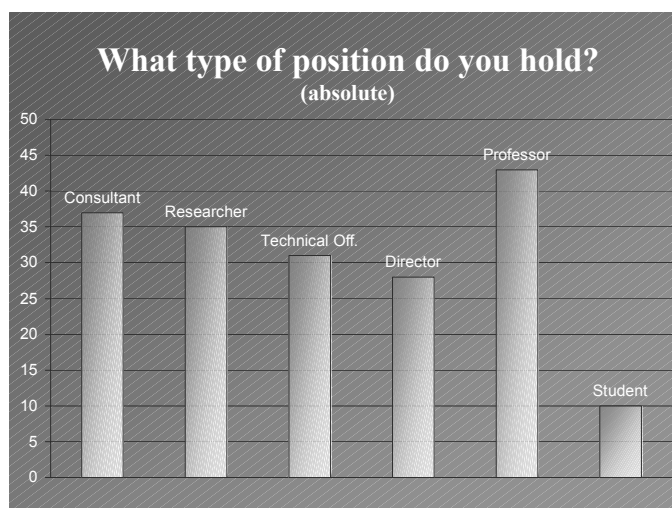


Figure 1

- governmental: 15%
- NGO: 14%
- UN: 6%
- private company: 6%

Among the above, 7% worked both for the government and a university and 4% worked both for an NGO and a university simultaneously.

The remaining respondents (27%) worked in more than two of the abovementioned organizations. Expressed in absolute terms, university work as well as government topped the list.

In terms of area of work, both nutrition and health were high on the list, followed by community development, education, training programmes, agriculture, policymaking, communications, environment and political science (see figure 2 below).

Moreover, the majority of the respondents were either Africa-based (44%) or Asia-based (24%). Thirteen percent were from Europe, 16% from North and South America, and 3% from the Middle East. When asked where the respondents worked, 53% responded in Africa, 25% in Asia and 8% in Europe.

Reading and use of briefs

When asked to what extent the readers had read through the briefs, the majority of the respondents (47%) stated that they have read certain briefs only, 42% said they have read through all the briefs and 7% that they have only browsed the briefs (4% of the respondents left this question unanswered).

As previously mentioned, one of the main objectives of this survey was to determine how the briefs have been utilized. The majority of the respondents (73%) said that they use the briefs as a source of information for teaching/training purposes. Sixty-four percent use it as reference material for written documents or for their own personal interest (also 64%). Fifty-four percent said they use them as a source of arguments for integrating nutrition into other development sectors and as a source of arguments for investing in nutrition in general (47%).

Rating of the briefs and general recommendations

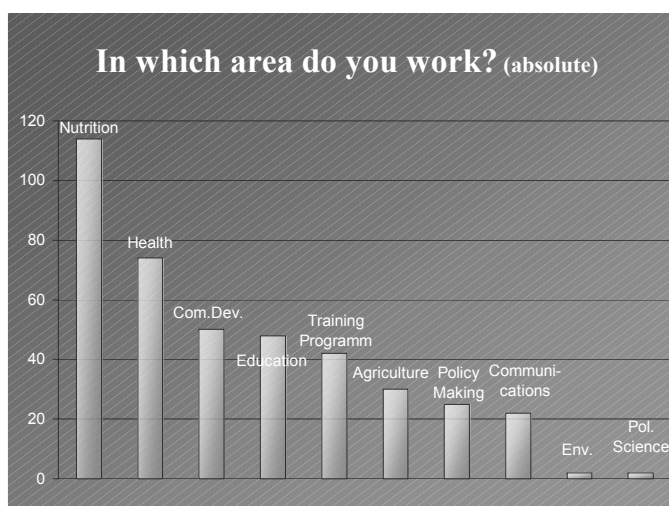
Since the readership survey also aimed at finding out how the content of the briefs could be further improved, the readers were asked to rate the usefulness, the clarity, the technical quality, the presentation as well as the length of the briefs. The results were as follows:

- usefulness: excellent (46%), good (45%), fair (3%), no answer (6%)
- clarity: excellent (43%), good (46%), fair (3%), no answer (8%)
- technical quality: excellent (32%), good (54%), fair (5%), poor (1%), no answer (8%)
- presentation: excellent (30%), good (56%), fair (6%), no answer (8%)
- length of briefs: too long (3%), about right (83%), too short (7%), no answer (7%)

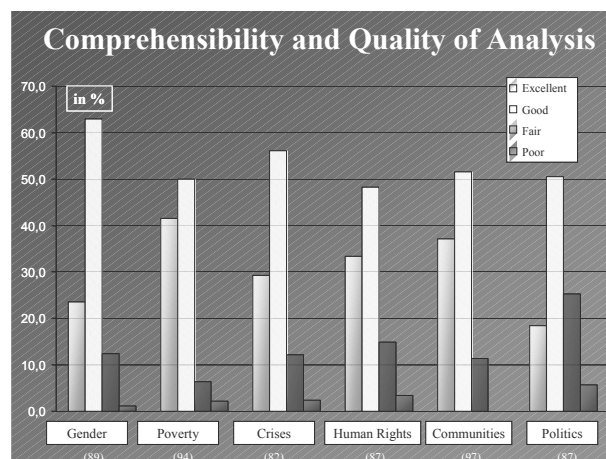
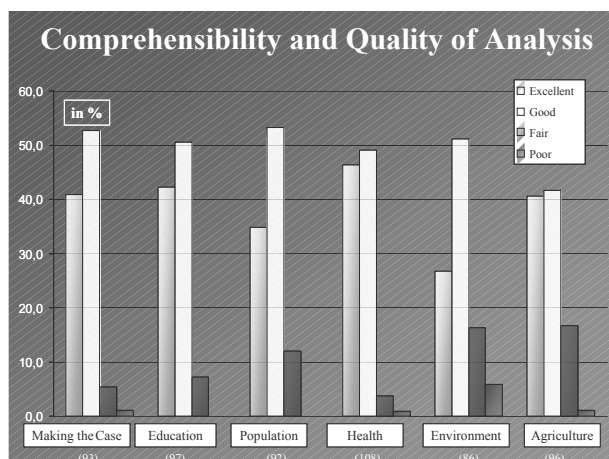
In addition, the readers were asked to rate the individual briefs based on:

- their comprehensibility and quality of analysis and
- the recommendations given in the briefs.

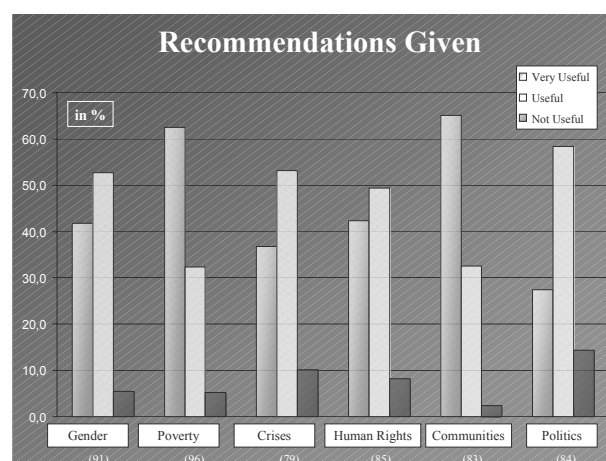
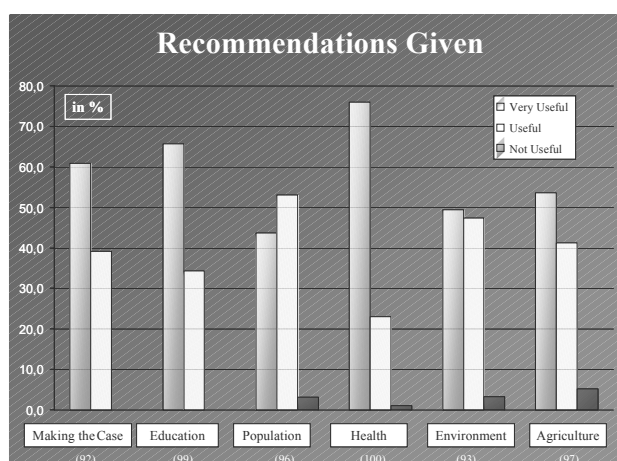
Figure 2



Figures 3a & 3b



Figures 3c & 3d



Note: the numbers in parentheses refer to the number of respondents who had actually answered the question.

The results are summarized in the figures 3a thru 3d.

The overall evaluation of the comprehensibility and quality of analysis of the briefs is presented in the chart below as follows: 35% rated the briefs as excellent, 51% as good, 12% as fair and 2% as poor (see figure 4, next page).

On average, 52% of the respondents considered the recommendations given in the briefs to be very useful, 43% rated them as useful and 5% as not useful (see figure 5, next page).

In addition, the readers were asked to make suggestions for new topics. Among the many suggestions that were made, the following were the most frequent:

- nutrition and biotechnology
- nutrition and globalization
- nutrition and trade
- nutrition and information technology

In general, the briefs were found to be a very helpful publication by the majority of the readers. Moreover, many readers expressed their interest in receiving a revised edition.

However, there has also been expression of concern about how practical the recommendations given in the briefs actually were. Several respondents emphasized the fact that the briefs do not give sufficient practical guidance on how to go about implementing the recommendations given—especially for those not working in the field of nutrition. In addition, some of the readers thought that less space should be used for the Suggested Reading section at the end of each brief and more for new figures or additional information on the topic in question.

Taking the results of this survey into account, the SCN will collaborate with GTZ in the revision of *Nu-*

Figure 4

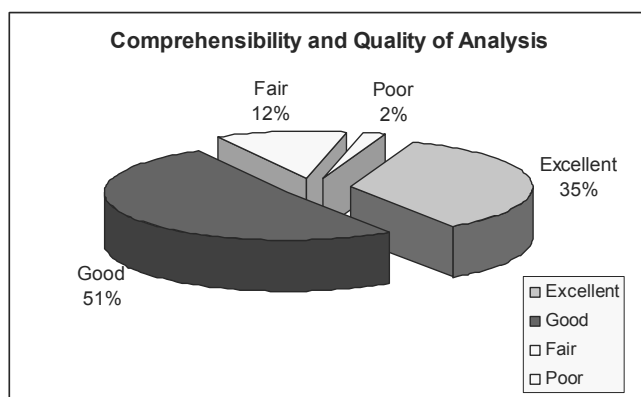
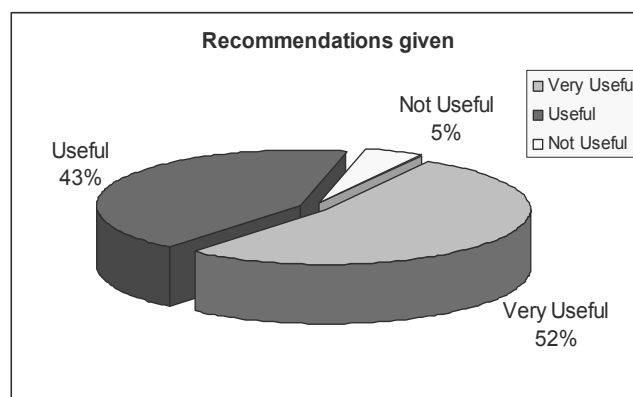


Figure 5



trition: A Foundation for Development. In order to increase the scope of this publication, new topics will be included either in the form of separate briefs or added on to existing briefs. Moreover, increased attention will be given to making recommendations more practical for the readers. The SCN would like to thank the respondents for their very useful feedback and is hopeful that the results of this survey will help improve future editions of *Nutrition: A Foundation for Development*.

The SCN Secretariat would like to thank Ms Ghada Khalil for her work on this survey and GTZ for its support. Contact the SCN Secretariat for copies of Nutrition: A Foundation for Development, scn@who.int

SPEAKERS' CORNER

A NEW THEORY: BREASTMILK DISPLACEMENT MAY BE THE MAJOR CAUSE OF NUTRITIONAL STUNTING

Ted Greiner

Associate Professor, Women's and Children's Health Uppsala University, Sweden*

Congratulations to the SCN Secretariat and Chessa Lutter for the excellent set of articles on complementary feeding in the December 2003 issue of *SCN News*. I would like to add a point or two regarding the interplay between breastfeeding and complementary feeding which I feel received too little attention in the various articles and to finish by postulating a new theory on the cause of nutritional stunting.

Intake of foods and fluids by young infants displaces breastmilk. Before six months of age, this displacement may be close to complete¹. For infants 6-12 months, a simulation by Dewey and Brown concludes that, at an estimated 43% displacement, the typical complementary foods given in Bangladesh lead to an increase in energy and protein (57% and 20% of the amounts given, respectively), but to very little, if any, increase in micronutrient intake. To the contrary, given their usually higher rates of absorption from breastmilk, the net effect is likely to be a decline in infant micronutrient status.

They also review one study relevant to each of the three aspects that need to be taken into account in finding ways to increase complementary food intake while minimizing breastmilk displacement. From this small evidence base one might conclude that promoting increased frequency of feeding is more likely to lead to high levels of breastmilk displacement than promoting increased energy density. The single study that has examined order of presentation (breastmilk first and then complementary foods or vice versa) found no effect.

That they have generally ignored breastmilk displacement effects may explain why so few randomized trials or other well-controlled complementary feeding trials have led to any improvement in linear growth. I am not aware of any published since Dewey summarized outcomes from ten efficacy trials in 2001, finding that linear growth was improved in only three of them². It makes sense that increasing energy and protein intakes, though they lead to increases in weight, will alone not be able to provide all the substrates needed for linear growth.

I believe that this may also be the explanation for a finding illustrated in Figure 1a on page 5 of Lutter's introductory article. It is clear that in low-income settings the average height is normal at birth but begins immediately a rapid and relatively even rate of decline up to about 15 months of age, after which no further damage occurs; average weight-for-height remains then about constant up to 60 months of age.

This decline in the rate of linear growth is not chronic malnutrition and, in young infants, is not yet nutritional stunting. They are undergoing the process of becoming stunted but not through the commonly postulated process of repeated disturbance in weight or cumulated insult from losses in weight due to infection. During the first few months of life, weight-for-age is stable (as illustrated in Lutter's Figure 1b) and weight-for-height is actually higher than the NCHS standard. (This is shown in other figures in the Shrimpton et al article from which Lutter's figures came³.)

Part of the explanation for these seeming anomalies is the different pattern of growth we see in breast-fed infants compared to the largely artificially-fed infants included in the NCHS standards recommended by WHO for international use. (WHO will soon be issuing new growth standards for breastfed infants.) But it is most likely due to the process (discussed above) that happens once complementary foods are added to the diet: breastmilk displacement.

In the early months of life, the infant receives adequate energy, puts on weight, but is unable to mobilize all the substrates required to grow normally in length. The mechanism most likely responsible in the early months is displacement of breastmilk, not by solid foods usually, but by sweetened water, teas and thin gruels of various kinds. This pattern of so-called "predominant breastfeeding" through the early months of life is nearly universal in the developing countries⁴. True exclusive breastfeeding is also lacking in most industrialized countries, but the typically milk-based and fortified supplements provided in

*As of August 2004, Senior Nutritionist, PATH, Washington DC, USA



higher-income circumstances probably do provide enough nutrients to compensate for the displaced breastmilk.

This theory that breastmilk displacement is responsible for the majority of stunting in the developing world, suggests the need for a new research agenda if the important nutritional components underlying many of the Millennium Development Goals are to be met.

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Welcome to new IVACG and INACG Steering Committee members!

The International Vitamin A Consultative Group (IVACG) is pleased to welcome two new members to the IVACG Steering Committee: Dr Chewe Luo, Regional PMTCT Advisor, UNICEF ESARO, and Dr Zulfiqar Bhutta, Professor of Paediatrics, The Aga Khan University.

The International Nutritional Anemia Consultative Group (INACG) is pleased to welcome two new members to the INACG Steering Committee: Mrs Rosanna Agble, Chief Nutrition Officer, Ghana Health Service, and Dr HPS Sachdev, Professor, Maulana Azad Medical College.



STRATEGIZING THE END OF GLOBAL MALNUTRITION

George Kent, University of Hawai'i

International agencies have taken to putting out “strategies” to achieve many lofty goals. Examples include the World Health Organization’s *Global Strategy on Infant and Young Child Feeding*, the Food and Agriculture Organization of the United Nations’ *Strategy to Enhance Food Security in Africa*, and the World Health Organization’s *Global Strategy on Diet, Physical Activity and Health*. Despite the fanfare, examination of the resulting documents generally reveals vague goals, little commitment, uncertain time frames, and soft recommendations. Serious strategies should lead to serious expectation that specific goals will be achieved in a well-defined time frame. Vague guidelines do not constitute strategy.

The objective of the Millennium Project in relation to hunger is clear:

The mandate of the Millennium Project’s Hunger Task Force is to produce a plan—what it takes—for humanity to reduce the proportion of hungry and malnourished people in half by the year 2015 (Millennium Project Hunger Task Force 2003, 9).

The Task Force offered a “Review of Ongoing Strategies” for ending hunger, beginning with the Plan of Action that came out of the World Food Summit of 1996. The group could have gone more deeply into past failures to implement previous agendas addressing malnutrition on a global scale, such as:

- the *Manifesto* of the Special Assembly on Man’s Right to Freedom from Hunger, held in Rome in March 1963.
- the *International Undertaking on World Food Security* and the *Universal Declaration on the Eradication of Hunger and Malnutrition*, issued by the World Food Conference held in Rome in 1974,
- the *Plan of Action on World Food Security* of 1979,
- the *Agenda for Consultations and Possible Action to deal with Acute and Large-scale Food Shortages* of 1981,
- the *World Food Security Compact* of 1985,
- the *Plan of Action for Implementing the World Declaration on the Survival, Protection, and Development of Children*, issued by the World Summit for Children held at the United Nations in New York in September 1990, which included a major section on reducing children’s malnutrition,
- the *World Declaration and Plan of Action on Nutrition* of the International Conference on Nutrition held in Rome in December 1992.

There is much to be learned from all these experiences. How is the current effort different?

One common thread in all these past efforts is that they focus on country-level planning and action. What are the responsibilities of the international community? What is the programme of action that the richer countries of the world and all the intergovernmental agencies are to undertake? In placing such heavy expectations on the poor people and the poor countries of the world, are we in effect blaming the victim?

The Task Force summarized its proposed strategy as follows:

1. Mobilize political action to end hunger—on a global scale as well as on national and local scales, in rich and poor countries.
2. Align national policies that restore budgetary priority to agriculture as the engine of economic growth, build rural infrastructure, empower women, and build human capacity in all sectors involved in hunger-reduction actions.
3. Implement and scale-up proven actions that improve the nutrition of vulnerable groups, raise agricultural productivity in smallholder farms and improve market functions—in ways that create synergies and result in positive transformations.

This points in good directions, but does it qualify as a strategy?

The Hunger Task Force’s approach was to make a list of the many different types of action that could be considered, and then offer “Guidelines for Selecting Among Candidate Actions”. It is not always clear who is to take the selected actions, what is to motivate those who are required to take action, and what agency is to coordinate the separate actions so that they come together to form a cogent programme.

The Task Force’s approach hints at some of the resources that might be used, but it does not tell us how they are to be pulled together. If ending hunger in the long term is a serious objective, and if reducing the proportion of hungry people by half by 2015 is to be taken as a serious intermediate target, then



there is a need to prepare a detailed plan, something like the plan one would need to build a bridge across a river. We would need to establish a clear vision of the thing we intend to build, we would need a commitment of resources of many different kinds, and we would need to formulate a detailed work-plan, a series of steps that would transform piles of resources into that bridge.

That plan could not take the form of a simple list: do A, then B, then C, etc. There would have to be a primary contractor, and several subcontractors. The various contracts would have to anticipate that some subcontractors might not perform up to expectations, materials would sometimes arrive late, and some workers would call in sick or go out on strike. Nevertheless, the task is not to deliver excuses, but to get the job done, no matter what. We know that we could not simply launch the plan and go away. We would have to stay on it, constantly steering the job toward its completion.

Of course, the task of ending hunger and malnutrition is not like building a bridge. While our proposed bridge might be new and unique in many ways, the fact is that many other bridges have been built in the past, and there is a lot that can be learned from past successes, and also past failures. Ending malnutrition, however, is an entirely new sort of challenge, one that requires tools and approaches that have never before been imagined. In some respects the challenge is comparable to President John Kennedy's call in the early 60s to send men to the moon. He had no idea how the job would get done, but he was able to provide the vision.

While the challenge of ending hunger and malnutrition is unique, like the call to send men to the moon, there are important differences. President Kennedy was able to supply not only the vision, but also the resources. And he was able to provide an authority structure through which contractors and subcontractors could be hired and paid and asked to do the bidding of the United States government. The task of ending hunger in the world is far more difficult. The vision has to be so compelling and so complete that it must include finding ways to muster the required resources, and it must include the creation of an organizational structure adequate to meet the requirements of the job.

The major missing piece in the Hunger Task Force's report is the vision. If we are to end malnutrition in the world, we need to sketch out how that world would work. How should social and economic forces be reconfigured so that the world no longer reproduces poverty and hunger? We need a mental picture of that world if we are ever going to build it.

There is a need to formulate a vision together with a plan that we confidently believe will get the job done. It must be articulated with enough clarity to inspire commitment and action, just as the early visions of the great cathedrals inspired generations of people to commit themselves to the fulfillment of the original vision.

If we were serious about ending malnutrition in the world, we would need many things, such as:

- a clear vision of what is to be created
- some way to know when the job is done
- a workplan that would take us to completion
- a series of steps to assure the completion of each part of the plan
- clarity about who needs to do what to get the job done
- clarity about the incentives that would induce the people who need to act to take the actions required of them; and
- contingency plans and a system of mid-course corrections to deal with every sort of obstacle.

Bridges don't get built through wishful thinking, and neither will the ending of hunger. Any serious plan to end hunger should include elements such as these. If it is to fulfill its mandate, the Millennium Task Force on Hunger should give us a picture of what is to be built, and a detailed programme of specific actions that would lead us to confidently expect that hunger will in fact be reduced by half by 2015.

The most discouraging thing about the Task Force is not in the content of its documents, but in the fact that the Task Force itself will be disbanded soon after it submits its final report. What will happen then? Who will be in charge? Who will see this project through to completion? Will we have here a situation in which the architects drop their blueprints on the table, and then they and everyone else goes home?

We need to take the concept of strategy much more seriously, and work out the means for getting to the goal. If the task of strategizing is not taken more seriously, the Millennium Project Hunger Task Force could simply elevate the level of disappointment and disillusionment for the poor and hungry of the world. Perhaps the work of the Hunger Task Force so far should be understood as a prelude, only the beginning of the work that needs to be done to formulate the vision and the commitment and the



planning that are required if the project of ending hunger and malnutrition is to succeed. Who will carry that work forward?

Reference

Millennium Project Hunger Task Force *Halving Hunger by 2015: A Framework for Action, Interim Report of the Millennium Project Hunger Task Force*. New York: Millennium Project, 2003. www.earthinstitute.Columbia.edu/tropag/documents/Hunger_InterimReport020204.pdf

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AJFAND's Electronic Journey

Anne Wangalachi, for AJFAND

Today, information technology has greatly revolutionized the publishing industry, in the past decade or so, with up to 75 % of all journals being published online. The *African Journal of Food, Agriculture, Nutrition and Development* (AJFAND), is an internationally renowned peer reviewed journal. It was launched in August 2001, as the *African Journal of Food and Nutritional Sciences* (AJFNS), so as to provide a platform, through which issues and scientific information concerning Africa, and its unique problems could be effectively addressed and shared. AJFAND has grown from strength to strength as evidenced by the diversity and calibre of submissions received, particularly for the Student Section.

The maiden issue was the conventional print version. AJFAND is an open access journal, currently available at www.ajfand.net having first been available at www.ajfns.net from March 2002. AJFAND's electronic journey has been exciting, challenging and rewarding. The benefits that have been reaped by going online include: shorter production cycles, increased visibility and recognition, more efficient quality control through electronic peer review, greater versatility in the design of the electronic files and an opportunity to build capacity in this exciting field. The November 2003 issue of the Journal, which is an entirely online issue, was very well received. Indeed the sheer numbers of unsolicited manuscripts that we continue to receive are directly attributable to AJFAND's online presence.

Recently, several articles previously published in AJFAND were included in "Bibliografica"—a CD-ROM featuring a state-of-the art reading list comprising leading publications on food and nutrition security in Africa. This CD-ROM was distributed to the participants of the all-Africa Conference on "Assuring Food and Nutrition Security in Africa by 2020: Prioritizing Action, Strengthening Actors, and Facilitating Partnerships," held in Kampala, Uganda on April 1-3, 2004, hosted by the Government of Uganda and sponsored by the International Food Policy Research Institute (IFPRI). This provided a unique marketing opportunity for the Journal.

This electronic voyage has not been without its problems. The challenges faced include: lack of electronic archiving space for past issues of the Journal due to financial constraints; loss of characters upon conversion of the files and delays in the production cycle due to inadequacy of the requisite ICT facilities and skills among some of its reviewers. Furthermore, lack of funding is forcing us to stay fully online.

AJFAND has not been alone in this: it has enjoyed tremendous technical support from various organizations among them the International Network for the Availability of Scientific Publications (INASP), the Association of Learned and Professional Society Publishers (ALPSP), and IFPRI among others. The websites we are linked to include: www.fao.org, www.iufost.org and www.unsystem.org/scn. We wish to thank all our authors, reviewers and donors. Our donors include: FAO, GTZ, and MONSANTO among others.



LETTER TO THE EDITOR

A CRITIQUE OF THE 5TH REPORT ON THE WORLD NUTRITION SITUATION

Dear SCN,

After going through the informative *5th Report on the World Nutrition Situation*, I was left with the same aftertaste as the one I had when I read the SCN's "Ending Malnutrition by 2020" Report (*Food and Nutrition Bulletin* 21:3, Sept 2000). In many of its assertions, the *5th Report* is still, at best, ambiguous about the need for nutritionists to engage in tackling the real basic causes behind the poverty syndrome that perpetuates ensuing cycles of malnutrition. Let me elaborate.

On nutrition, MDGs and overall development (pp iii and iv of the 5th Report)

Here we are told that we are all to do our best to have nutrition increasingly contribute to achieving the MDGs. But then, I ask, what if, day-in-day-out, the prevailing economic system continues to work against achieving these goals? Is nutrition a powerful enough tool to counter the forces behind that economic system? Are we not then working at counter-purpose and being pawns rather than rooks in this chess game? (See *SCN News* #22, 2001 on "Nutrition Goals and Targets," where these same points were already made.)

I am afraid that what the *5th Report's* Highlights Section says for Sub-Saharan Africa (p iii), namely that "child malnutrition, household food insecurity and poverty are all moving in the wrong direction" is true beyond Africa. In numerous countries, the right to nutrition is being denied due to a combination of powerful basic causes.

I can agree with the statement that "it is crucial to move beyond...nutrition and MDGs" (p iv): I commend the authors on this. But this just illustrates the ambiguity I sense throughout the Report. (Ambiguity, I am afraid, does not lead us to redirect our actions and to put in place the right strategies to eradicate malnutrition at its roots). Achieving the MDGs, let us be reminded, will still leave us with sizeable malnutrition and poverty problems to deal with after 2015....

On nutrition and governance (p iv)

What we read here leads me to ask: Has "the nutrition community" really "been at the forefront of community-driven and rights-based development?" (as the Report claims), or is it an exception rather than the rule—and perhaps even wishful thinking? (After all, *SCN News* and *The Lancet*, have already written about how, in the last 10 to 15 years, nutritionists have leaned towards work in micronutrients and away from protein-energy malnutrition, because they find work in the latter so 'un-rewarding' and 'painfully slow', as well as feeling so un-prepared professionally to deal with 'the politics of it all').

In this context, I further ask, is "generating insights...on nutrition and governance" (as the Report calls for at the bottom of p iv) enough? Isn't it perhaps time to act more decisively, beyond insights?

On nutrition and health sector reform (p v)

The Report says that, "addressing malnutrition also addresses inequities in health," (top of p v) and then lists, "practical ways to engage nutrition," ie, 'integrating nutrition in health policy using nutritional tools and models' and 'increasing capacity in nutrition'. Does this imply that for nutritionists to engage in the political aspects and the reversal of the poverty-perpetuating-processes aspects at the base of malnutrition is not 'practical'?

On nutrition and poverty reduction (p v)

The Report implies that an improved nutritional status of women and infants will, "...weaken the inter-generational cycle of poverty". But, what does this improvement do to the basic causes of poverty? Does being able to make \$3/day instead of \$1 in any way weaken the poverty cycle? Is there anything automatic here that I have missed?

Moreover, what the Report euphemistically calls the "socially disadvantaged and especially vulnerable to risk groups", let's be straight-forward, are really the result or outcome of a system that breeds and maintains injustice and inequity. That is why, two sentences later, the Report is right when it points out that nutrition indicators are good indicators of poverty reduction...the ambiguity showing up here again.

On moving forward (p v)

I take exception with the notion advanced in the Report that nutrition is "a driver of development". It rather is an important entry point—as are many others—to get to the basic, structural (national and international) causes of malnutrition and underdevelopment. So, I cannot agree with the statement that "the strategic incorporation of nutrition (into development activities) will increase resources and capacity for malnutrition reduction and for accelerating progress"; certainly not automatically. "Incorporating



nutrition will be challenging"; that is for sure. But primarily it will be challenging for all the political reasons (only brushed upon in the *5th Report*) that have kept this global problem unsolved now (and I dare say by 2015).

In short, I simply cannot understand how the Highlights Section of the *5th Report* can close by saying that the nutrition community needs to be "the custodian of technical knowledge and practical experiences in nutrition to realize the shared goals of a world free of hunger, malnutrition and poverty". I let the reader be the judge.

Reading beyond the Highlights Section (and after finding much rich factual information in the Report), on p 35, under Equity, to my disappointment, I find the authors victimize the malnourished and, therefore, continue to propose 'targeting' them: "Public support for nutrition interventions will benefit the poor more than the rich...", and in the next paragraph, "If targeted preferentially to those in greatest need, nutrition interventions can be even more effective in reducing health inequities"; and at the end of that paragraph—speaking about breastfeeding promotion and micronutrient supplementation—it states: "few interventions are as 'levelling' as these in terms of addressing health inequities." Does this imply that if we go for more of these interventions inequities brought about by a system that reproduces poverty and marginalisation every day will be lessened?

To me, clearly, the message given is: take care of the malnourished and inequities will decrease....but what about the system (and processes) that produces more malnourished every day? Little is said about this, or only very ambiguously. The Report does not recommend nutritionists engage more directly in the struggle to eradicate the roots of poverty.

On p 44, we read that, "The Poverty Reduction Strategy (of the World Bank I assume) has had the desirable effect of moving the poverty debate forward...." But only moving the debate forward is actually having very little to show for—wouldn't the reader agree with me?

The Report further tells us that, "Reducing infant malnutrition...weakens one of the strongest links in the intergenerational transmission of poverty" (p 42). Should we interpret this as meaning that, if we put most of our efforts in treating/preventing malnutrition, poverty will go away by the next generation? Am I, again, missing something?

But the winner statement of all my critique is found under 'Market Failure', on p 35, "In the health sector, fees have been introduced...because sick people are highly motivated to pay for treatment." Really? No comment.

But wait! Way down at the bottom of the list of objections to/criticisms of the PRSPs process, I found what I was looking for (p 45) in the form of a quote from Asbjorn Eide, namely "the need (is) to prevent people from becoming poor and not just how to get people out of poverty". The Report does neither pick up on this nor does it openly endorse it.

In sum, I feel the intentions at interpreting the world nutrition situation in the *5th Report* are overall good, don't take me wrong. But the political oversimplification (or selective blind spot? or naïveté?) is big. Let me justify why I say this: on p 39, the Report says, "A focus on nutrition will lead poverty-reducing strategies to focus on groups that are biologically vulnerable...and vulnerable due to social processes"; this is a step in the right direction. But little is said on the need to focus on the latter processes (which I assume include political processes). What is said further on (bottom of p 43), is that the challenge is "creating a sustainable emergence from poverty and generating political sustainability." I agree. But not so with the sentence immediately after, "Initial indications are positive...in this front". In my modest opinion, they are NOT.

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NB: On page 3, the Report highlights in italics the statement, "*Food and nutrition are human rights precisely because they are necessary inputs for human development*". This statement calls for an important correction: food and nutrition are human rights, which everyone is born with as a given entitlement. Human rights need no justification; 'precisely because' is a utilitarian clause and is, therefore, not acceptable.



LETTER TO THE EDITOR

Dear SCN,

On 1954 May 1954, the United States Supreme Court decided that the racially divisive “separate but equal” doctrine had no place in the field of public education. It has no place in the field of public nutrition, either. This court case, “Brown v Board of Education”, was a hallmark of the US civil rights movement in desegregating public schools and increasing resources to the African American community; it has formed the basis for a number of similar actions worldwide to improve racial equality in various spheres of public life.

It has been fifty years since that case, and equal opportunity for African Americans in the US continues to be a dream, but many are mobilized towards it, and the government structures have made a formal commitment to it. At the SCN conference this year in New York City, it became clear that Africa is the region where we need to redouble our efforts in nutrition. It was the one region singled out in the SCN's *5th Report* where rates of malnutrition are on the rise. Yet, ironically, a number of comments by non-Africans were heard publicly about how the capacity building of Africans is a poor investment. Why does this sound remarkably similar to Brown v Board of Education...? Are Africans qualitatively, as human beings, any different than Europeans? Than (US) Americans? The answer is no.

Clearly, there is a brain drain of local talent when investment is made in strengthening the professional capacities of those from developing countries. Many such individuals do leave their home countries to work in more developed country settings, motivated by improved resources for research and education, salaries, benefits, lifestyle and/or freedom to work as a female. However, the Africans I have met in the field of international nutrition are as committed to their home countries and the African continent as a whole, as ever. Even if such talent leaves for a time, these students and professionals often dedicate their professional work to African issues. Some have also confided in me that if good opportunities were available in their home countries, they would be very interested in returning. And let us not ignore the many who do return to work in Africa.

Why are some in the developed world judging Africans as unworthy of capacity building? It is an unacceptable approach and I hope that we, as a professional community, can step back and examine ourselves to consider the implications of that perspective. Failure to invest in the capacity of Africans will result in long term dependency on foreign technical expertise and staff, which is more expensive and less culturally adept than local staff. If investing more in the capacity of our African colleagues (and others from developing countries) takes longer than our short-term grant cycles require for “results”, then we need to devise more mechanisms that allow for the development of long-term solutions. With micronutrients, we know that short-term solutions are required, but food-based strategies are also in the works for long term sustainability. If we are wrong that investment in our African colleagues might threaten the job security of those of us who are from developed countries, then we should be ashamed. In such a humanitarian field as international public nutrition, I would hope that we can look to the good of our African colleagues—so that in the future Africa will take the leadership in nutrition to design good research, programmes and policies that will reverse the proliferation of malnutrition.

I know that my colleagues who formed the African Graduate Nutrition Students Network (AGSNet) agree. Those who presented at the SCN conference inspired many to support their efforts in linking young African professionals around the globe with human and material resources in nutrition. The United Nations University has given AGSNet a website: (www.unu.edu/capacitybuilding/foodnutrition/ags-net/). Other groups stepped forward at the SCN Session and promised free subscriptions to professional journals and sponsorship to international conferences.

Let us all be similarly committed to building the capacity of Africans in nutrition. As Urban Jonsson so forcefully urges us—Let us not forget the human rights approach! An attitude, albeit a minority one, of “Africans are not as capable or committed” has no place in the SCN.

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PUBLICATIONS

Health and Nutrition Surveillance for Development

Martin Bloem, Regina Moench-Pfanner and Dora Panagides, editors

Hellen Keller Worldwide

2003, 255 pp

Increasingly, international focus is being drawn toward realization of minimum basic needs for all individuals of society. Adoption of the Millennium Development Goals (MDGs) by 189 nations solidified commitment toward a multi-disciplinary effort to achieve a set of eight goals. These encompass reducing poverty and hunger, improving health, education and gender equity and ensuring environmental sustainability.

Large scale national surveys such as the Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and Living Standards Measurement Studies (LSMS) are being used to track global progress toward these goals.

This book highlights the added value of long term surveillance systems at the national level. Comprehensive data collection systems, such as the Nutritional Surveillance Project (NSP) described in this book are recognized as vital information-generating and decision-making tools. Such systems are advocated by many, including the Inter-Agency Working Group on Food Insecurity and Vulnerability Information and Mapping Systems (FIVIMS), as one of the key components of an integrated multisectoral information system to help guide action to address the fundamental causes of poverty and food insecurity at national and sub-national levels. Other elements include early warning information systems and poverty monitoring or vulnerable groups monitoring systems.

This book presents the results of decade of experience in Bangladesh, focussing on the usefulness of health and nutrition surveillance systems for monitoring and evaluating progress toward the achievement of the MDGs. The authors display results of the surveillance system from different perspectives; including monitoring trends in the impact of urbanization and natural disasters on the health and nutritional status of poor households. The multiple advantages of a systematic surveillance system are evident. For example, chapter one demonstrates long term trends in the prevalence of chronic malnutrition among rural and urban (slum) children. Using time series data from 1990 to 1999, a declining trend in the prevalence of chronic malnutrition for both urban and rural populations is noted, however, the gap between urban slum children and rural children is widening, indicating a relative worsening of the conditions in urban slum areas. This information can be used to guide policies, programmes and services to address the problems.

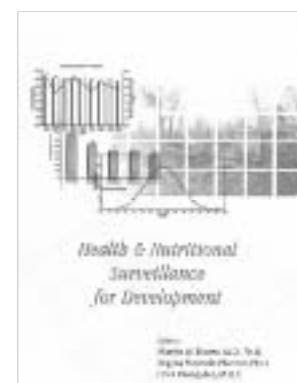
Illustration of the utility of bi-monthly data collection is presented in chapters two to four. The impact of seasonality and natural disasters on household coping strategies are convincingly displayed through analysis of data collected before, during and after natural disasters. The supplemental chapters provide examples of the flexibility of health and nutrition surveillance systems. Key information on the national prevalence of anaemia in Bangladesh was needed to monitor progress toward World Summit for Children goals established in 1990. A special supplementary module was inserted into the NSP in 1997 to measure the prevalence of anaemia in women and children. The results from these additional questions established the baseline, against which progress in reducing the prevalence of anaemia can be monitored and changes in causal factors measured.

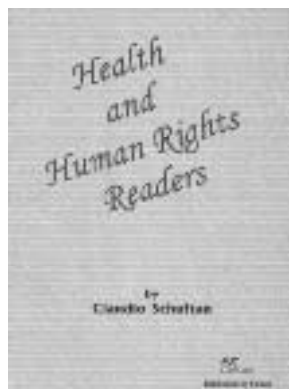
A strong argument is made for establishing surveillance systems. The book demonstrates how surveillance systems can be useful tools for monitoring, evaluation and aid in the development of context-specific, appropriate strategies for achieving the MDGs. Surveillance systems generate useful time series information which, when integrated into the overall programme planning, monitoring and evaluation cycle, can enhance the effectiveness of programme interventions.

The combination of analytical and programmatic applications in the chapters and supplements and methodological information provided in the appendices offers something of interest to a wide range of readers. This book also provides useful information for project managers, government and non-government personnel involved in policy decisions and those interested in monitoring and evaluation systems.

Copies of the book can be obtained by contacting Martin Bloem or Regina Moench-Pfanner (remoench@singnet.com.sg). The book is also available at the following website www.hkiasiapacific.org.

Reviewed by Gina Kennedy, Consultant Nutrition Planning, Assessment and Evaluation Service, FAO and Jenny Riches and Maarten Immink, Secretariat of the Inter-Agency Working Group on Food Insecurity and Vulnerability Information and Mapping Systems (FIVIMS).





Health and Human Rights Readers

Claudio Schuftan

Published by the Centre for Equity into Health and Allied Themes (CEHAT)

2003, 111 pp

This compilation of excerpts and full essays from a variety of sources makes a powerful demonstration of the benefits of a “human rights approach” to development and health. It should be required reading for all local and national practitioners, for states and international “experts.” Fittingly, it was published on the 25th anniversary of the *Alma Ata* “Health for All” conference.

Claudio Schuftan has fully succeeded in his stated objective, “to bring to a practical and understandable level the sometime not so easy concepts of the human rights-based approach to development and to health”. And he has done so in an innovative way guaranteed to hold the reader’s interest to its very end.

The document begins with a brief review of the human rights concerned, presented in five main groupings: economic rights; social rights; cultural rights; civil rights and political rights. These groupings may not always be consistent with the more legalistic UN listings, but they are convenient and make sense.

Directly or indirectly, from childhood through old age, these essays examine today’s main challenges through a keen human rights lens: poverty alleviation; politics and development ethics; the role of the state, the UN and civil society; donors and financing; greed, power and corruption; and privatization, community empowerment and capacity building.

Some excerpts are pearls of wisdom from anonymous sources; others are quotes from the such diverse personalities as Kofi Annan, Amartya Sen or Martin Luther King, Isabel Allende, and Graham Greene, among a vast sprinkling of assorted jurists, medical or other professionals from a broad disciplinary cross section.

This compilation is particularly timely for we face global challenges in the health sector where many states are abdicating their responsibility to provide for the best attainable standard of health for all. The private health sector is growing exponentially and public health investment is declining to a point where, in many countries, they are not even adequate enough to maintain existing infrastructures. In this context, the implementation of the right to health for all is meeting increasing resistance. And yet, a human rights-based approach to development is now the stated policy of the entire United Nations system and is legally backed by international law; under the circumstances, it should offer the best option and is particularly relevant with the approaching five year review of the Millennium Development Goals.

According to the author, the bottlenecks to development are foremost of a political nature and with this in mind, his own words provide the best conclusion:

...the human rights approach to development politicizes the discourse and puts rights/claims holders in the driver’s seat of the development process. It also faces duty bearers with obligations they can no longer dodge. This, particularly because their obligations in this field are anchored in international law and draw their power from the official ratification of the Human Rights covenants by most countries in the world. This is an important and powerful step forward.

For more information, visit www.cehat.org for copies of the *Health and Human Rights Readers* write to cehat@vsnl.com

Reviewed by Hélène Sackstein, European Commission DAPHANE Programme, hsack@free.fr

Corrections

Please note the following corrections to the Publications section of *SCN News* #27 (December 2003):

- *Caring for severely malnourished children* (p 75): the University of Western Cape, South Africa, did not, as stated, help to prepare the book (but was a partner with the London School of Hygiene and Tropical Medicine in producing training modules for nurses), and the main distributor of the book (and CD-ROM) is TALC (PO Box 49, St Albans, AL1 5TX, UK, talca@talcauk.org) which is selling the book for UK£3.15 and the book plus CD-ROM at UK£4.50 (both plus postage). The book can also be purchased from Macmillan (a.cannon@macmillan.com). The Food and Nutrition Technical Assistance Project of the Academy for Educational Development funded this book.
- *The Maternity Protection at Work: A Breastfeeding Perspective* action kit (p 77) was incorrectly listed as an International Labour Organization publication. The correct publisher is the Maternity Protection Coalition. Members of the Maternity Protection Coalition include: IBFAN-GIFA (Switzerland) Elaine.cote@gifa.org; ILCA (USA) chrismulfo@comcast.net; IMCH (Sweden) Amal.Omer-Salim@ich.uu.se; WABA (Malaysia) secc@waba.po.my

HIV and Infant Feeding

Breastfeeding is normally the best way to feed an infant. A woman infected with HIV, however, can transmit the virus to her child during pregnancy, labour or delivery, or through breastfeeding. It is a public health responsibility to prevent HIV infection in infants and young children—especially in countries with high rates of HIV infection among pregnant women, and it is also a public health responsibility to support optimal breastfeeding to prevent mortality and illness due to diarrhoea and respiratory infections. Given the need to reduce the risk of HIV transmission to infants while minimizing the risk of other causes of morbidity and mortality, UN guidance states that "when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life." This guidance was issued at a Technical Consultation on new data on the prevention of mother to child transmission (MTCT) and their policy implications which was convened in October 2000. In order to put this guidance into practice in countries, WHO and UN partners have recently developed or revised the following documents:



HIV AND INFANT FEEDING: FRAMEWORK FOR PRIORITY ACTION

2003, 8 pp

The HIV and Infant Feeding Framework for Priority Action was developed within the context of the *Global Strategy for Infant and Young Child Feeding*, and endorsed by nine UN agencies. The purpose is to recommend to governments key priority actions, related to infant and young child feeding, that cover the special circumstances associated with HIV/AIDS. The aim should be to create and sustain an environment that encourages appropriate feeding practices for all infants, while scaling-up interventions to reduce HIV transmission. (This document is also available in French.)

HIV AND INFANT FEEDING: GUIDELINES FOR DECISION-MAKERS

2003, 75 pp

In order to assist in putting general guidance on HIV and infant feeding into practice in countries, WHO and UN partners (with valuable inputs from NGOs, researchers and government officials) revised *HIV and Infant Feeding: Guidelines for Decision-makers*. The purpose of this publication is to provide information on issues that need to be considered in relation to infant and young child feeding in the context of HIV, and to highlight areas of special concern on which policy decisions need to be made. The guidelines contain an overview of international policy, goals and guidelines; background on HIV and infant feeding; current recommendations for HIV-positive women and considerations relating to different feeding options; an overview of the process of developing or revising a national policy on infant and young child feeding incorporating HIV concerns; considerations for countries considering the provision of free or low-cost infant formula; suggestions for protecting, promoting and supporting appropriate infant feeding in the general population; key issues in supporting HIV-positive women in their infant feeding decisions; and considerations on monitoring and evaluation.

HIV AND INFANT FEEDING: A GUIDE FOR HEALTH-CARE MANAGERS AND SUPERVISORS

2003, 78 pp

This publication is aimed at helping mid-level managers understand issues and organize services to support all women, and especially HIV-infected women, on infant feeding. The document contains a list of key steps, background information, key resources and references, and extensive annexes.

HIV TRANSMISSION THROUGH BREASTFEEDING: REVIEW OF AVAILABLE EVIDENCE

2003, 25 pp

This document presents a summary of the available scientific evidence on the transmission of HIV infection through breastfeeding. It briefly describes the benefits of breastfeeding for both mothers and infants; and summarizes evidence on the relative risk of mother-to-child transmission of HIV-1 infection during pregnancy, delivery, and breastfeeding. The review then focuses on HIV-transmission through breastfeeding: rates, mechanisms, timing, risk factors and approaches for its prevention.

WHAT ARE THE OPTIONS? USING FORMATIVE RESEARCH TO ADAPT GLOBAL RECOMMENDATIONS ON HIV AND INFANT FEEDING TO THE LOCAL CONTEXT

2004, 40 pp

The purpose of this manual is to provide programme managers, researchers, and policy makers with basic guidance on how to conduct local assessments to establish the range of replacement feeding options and breast-milk feeding options that may be acceptable, feasible, affordable, sustainable and safe (AFASS) in different contexts. Findings from local assessments may also be used to develop national policies, guidelines for health workers, materials for training of counsellors and behaviour change communications strategies to support safe infant feeding in programmes to prevent HIV infection in infants and young children.

For further details, please consult the WHO Child and Adolescent Health and Development Department web site, www.who.int/child-adolescent-health/NUTRITION/infant.htm, or write to Dr Peggy Henderson (hendersomp@who.int) or Dr Constanza Vallenaz (vallenaz@who.int) in the Department of Child and Adolescent Health and Development, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

Global Strategy on Infant and Young Child Feeding



GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING WHO, 2003, 30 pp

Recognizing the major burden of childhood malnutrition on child health and development, the WHO Executive Board, at its 101st session in January 1998, called for a revitalization of the global commitment to appropriate infant and young child nutrition, and in particular breastfeeding and complementary feeding. Subsequently, in close collaboration with UNICEF, WHO organized a consultation (Geneva, 13-17 March 2000) to assess infant and young child feeding policies, review key interventions and formulate a comprehensive strategy for the next decade. In May 2002, the 56th World Health Assembly unanimously endorsed the *Global Strategy for Infant and Young Child Feeding*, developed during a two-year participatory process involving well over 100 Member States and international, intergovernmental and non-governmental organizations. This publication contains the Strategy which is intended to act as a guide for action; it identifies interventions with a proven positive impact, and it explicitly defines the obligations and responsibilities in this regard of governments, international organizations and other concerned parties.

IMPLEMENTING THE GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING WHO, 2003, 50 pp

To facilitate the implementation of the Strategy, and assist governments in translating global recommendations into country-specific actions, WHO convened a technical meeting from 3-5 February 2003 in Geneva. This meeting brought together more than 45 participants representing governments, nongovernmental organizations, academic institutions and international organizations. The report summarizes the conclusions and recommendations of the meeting including appropriate ways for achieving progress in the operational areas defined in the *Global Strategy* and steps for a planning framework to facilitate the implementation of the strategy at country level.

INFANT AND YOUNG CHILD FEEDING A TOOL FOR ASSESSING NATIONAL PRACTICES, POLICIES AND PROGRAMMES WHO, 2003, 140 pp

Infant and Young Child Feeding: A Tool for Assessing National Practices, Policies, and Programmes is designed to assist planners and decision-makers at various levels in identifying the strengths and weaknesses of their current policies and programmes. A team made up of representatives from the national government, NGOs, donor agencies, and advocacy groups can use the tool to assess progress toward achieving the targets of the WHO/UNICEF *Global Strategy for Infant and Young Child Feeding*. The tool was field-tested by assessment teams from nine countries.



COMMUNITY-BASED STRATEGIES FOR THE PROMOTION OF BREASTFEEDING IN DEVELOPING COUNTRIES WHO, 2003, 30 pp

The present review examines the evidence for the contribution that community-based interventions can make to improve infant and young child feeding, and identifies factors that are important to ensure that interventions are successful and sustainable. The findings show that families and communities are more than simple beneficiaries of interventions; they are also resources to shape the interventions and extend coverage close to where mothers, other caregivers and young children live. It is intended that the experiences presented will help policy makers, programme planners, and health professionals in the essential and challenging task of translating the *Global Strategy for Infant and Young Child Feeding* into action at all levels: the health system, the community and civil society at large.

Copies of these publications can be ordered from bookorders@who.int

BREAKING THE RULES STRETCHING THE RULES

IBFAN, 2004, 94 pp

Every three years, IBFAN publishes a report on compliance with the International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly Resolutions. The 2004 report, based on evidence collected from January 2002 to April 2004, is organized by company in alphabetical order and follows different Code themes within the write-up of each company. This report is the first major outcome of the Standard IBFAN Monitoring (SIM) tool which aims to popularize monitoring, yet maintaining standard questionnaires so that groups and individuals use the same protocol to report evidence from wherever they are. SIM is not designed to obtain statistical information nor is it meant to provide full information on any one company or any one region. In order to provide continuity and the possibility of assessing progress, the report continues with the same list of the 16 largest companies in the previous reports. Each company's review illustrates their violations according to the Code's rules (eg, provision of clear information, no promotion to the public, no free samples or supplies, etc). Copies of this report can be ordered from

ibfanpg@tm.net.my



COMBATING MALNUTRITION TIME TO ACT

Stuart Gillespie, Milla McLachlan, and
Roger Shrimpton, editors
The World Bank and UNICEF
2003, 165 pp

UNICEF-World Bank have joined forces to provide a fresh perspective on the global effort to address malnutrition, and to evaluate how the two agencies can contribute to reducing malnutrition. The book analyzes the evolution of key policy narratives, country case studies, and workshops in an attempt to understand how policy change in nutrition happened, what influences these processes and what lessons can be learned. Country case studies cover India, Madagascar, The Philippines and Tanzania. Copies of the book can be ordered from www.worldbank.org



COMMUNITY-BASED FOOD AND NUTRITION PROGRAMMES WHAT MAKES THEM SUCCESSFUL A REVIEW AND ANALYSIS OF EXPERIENCE FAO, 2003, 281pp

FAO started a process aimed at developing a methodology that allows countries to carry out in-depth assessments of their community-based food and nutrition programmes. There are now a number of successful programmes and a close examination and analysis of these can help us to understand the process of achieving success. Much can be learned from the experience accumulated with community-based nutrition programmes in developing countries. The purpose is to understand what works, what does not work, why, and how such programmes can be expanded, strengthened and redesigned, if needed. Understanding these relationships require new approaches, new ways of thinking about familiar issues.

The report is divided into five sections (A-E), plus annexes. Section A provides the background and rationale for FAO's decision to undertake this exercise and describes the steps followed. Section B presents criteria for selecting countries and three programmes per region for in-depth case studies. Summaries of desk reviews and full case studies are provided in Annexes 1 – 4. Section C analyses the main findings of the in-depth case studies and desk reviews by drawing out the main lessons learned from the experiences of the programmes, under four headings: macrocontextual factors, community-level factors, programme design features and sustainability. Section D uses the findings of Sections B and C to suggest ways in which community-based nutrition programmes can be improved so as to become more sustainable and have a greater positive impact on nutritional status and food and nutrition security. Section E concludes the report by advising the reader that many of the conclusions are inevitably based on judgement and assessment.

Nutrition planners are advised that the challenge for them is to take from this report what is appropriate in their country context and to use it to improve their existing programmes or to design better programmes. To help in this process, FAO has produced the companion volume: *Improving Nutrition Programmes: An Assessment Tool for Action (AT)* reviewed in *SCN News* # 27, December 2003, pp 76-77. A AT Users Training Manual has been developed by the University of the Western Cape's School of Public Health, South Africa in close collaboration with the Food and Nutrition Division of FAO, with support from the FAO-Netherlands Partnership Programme.

The Report is available in English and Spanish. The AT Users Training Manual is available in English. Printed versions of both publications can be requested to FAO. They can also be downloaded from the FAO website, www.fao.org For further information contact:

guy.nantel@fao.org or irela.mazar@fao.org



EVALUATING CAPACITY DEVELOPMENT EXPERIENCES FROM RESEARCH AND DEVELOPMENT ORGANIZATIONS AROUND THE WORLD ISNAR, CTA, and IDRC 2003, 170 pp

The international community is placing a growing emphasis on developing local capacity as the key to alleviating poverty and hunger in the developing world. This book explains how the International Service for National Agricultural Research's (ISNAR) 'Evaluating Capacity Development Project' used an action-learning approach, bringing together people from various countries and different types of organizations. The authors use examples and lessons drawn from the evaluation studies as a basis for making more general conclusions regarding how capacity development efforts and evaluation can help organizations to achieve their missions. The contributors have taken on board the concept that every evaluation of capacity development effort should



itself contribute to the capacity development effort and to the organization's performance. Copies of this book can be ordered from www.earthprint.com



**HUMAN DEVELOPMENT REPORT
CULTURAL LIBERTY IN TODAY'S
DIVERSE WORLD**
UNDP, 2004, 285 pp

The Human Development Report 2004, argues that states must actively devise multicultural policies to prevent discrimination on cultural grounds—religious, ethnic and linguistic. The expansion of cultural freedoms, not suppression, is the only sustainable option to promote stability, democracy and human development within and across societies. The Report debunks the myths that have been used to deny expansions of cultural freedoms, showing that diversity is not a threat to state unity, not the source of inevitable “clashes”, not an obstacle to development. Instead, it is at the core of human development—the ability of people to choose who they are. The Report presents a path-breaking framework to examine issues of migration, predatory extremism, customary law and cultural diversity. It includes amongst other important topics: an analysis of the vital links between human development and cultural liberty by Nobel Laureate Amartya Sen; analyzes the rise of coercive movements for cultural domination and their challenges to democracies; and examines key areas of policy for cultural diversity and globalization, including traditional knowledge, trade in cultural goods and migration. The Report can be ordered from the Oxford University Press, www.oup.co.uk



LISTENING
Water Supply and Sanitation
Collaborative Council
2004, 80 pp

The traditional top-down methods for providing water and sanitation services in poor communities of the developing world have not been successful in reaching out to all. *Listening* is about a new approach learnt from the failures of the past and begun to achieve well-documented successes of its own—decentralization and empowerment of people and communities to take more control of their own lives and to support them in achieving their own development goals. The report begins with an introduction that draws together some of the most commonly held and strongly felt views of the many contributors to this publication who have helped to pioneer this new approach. The rest of this report contains interviews with individuals working on water and sanitation issues from Asia, Latin America and Africa. There is also a section on statistics on population density, water, sanitation, and hygiene for 100 countries. Copies can be ordered by visit-

**NUTRITIONAL CARE AND
SUPPORT FOR PEOPLE LIVING
WITH HIV/AIDS IN UGANDA**
FANTA, 74 pp

As part of FANTA's efforts to strengthen implementation of nutritional care and support for people living with HIV/AIDS, FANTA technically and financially supports the development and application of national guidelines on nutrition and HIV/AIDS. With support from the USAID Mission in Uganda, FANTA assisted regional and national groups to develop national guidelines in Uganda, *Nutritional Care and Support for People Living with HIV/AIDS in Uganda: Guidelines for Service Providers*. These nationally adopted guidelines provide recommendations on the nutritional needs of PLWHA and on steps that service providers can take to

help PLWHA manage symptoms and improve functioning through nutrition actions. With support from FANTA and the Regional Centre for Quality of Health Care, the guidelines were produced by the Uganda Ministry of Health STD/AIDS Control Programme and the Uganda Action for Nutrition, a national nutrition coalition. Accompanying the national guidelines is a booklet of key messages and recipes for PLWHA and caregivers. This publication is available on FANTA's website at www.fantaproject.org

**NUTRITION AND HIV/AIDS
A TRAINING MANUAL**
FANTA, 2003, 286 pp

The Republic of South Africa has adopted the United States Agency for International Development (USAID) supported *Nutrition and HIV/AIDS: A Training Manual* to train doctors, nurses, pharmacists, and dieticians in nutrition and HIV/AIDS. Nutritional interventions play an integral role in HIV/AIDS care and support by helping PLWHA manage symptoms, reduce susceptibility to opportunistic infections, promote response to medical treatment including ARVs, and improve overall quality of life.

The training manual was developed by the Regional Centre for Quality of Health Care in Kampala, the FANTA (Food and Nutrition Technical Assistance) Project, and the LINKAGES Project with support from USAID Regional Office in Nairobi and the United Nations University. A comprehensive training resource in nutrition and HIV/AIDS, the manual has been disseminated to educational institutions in the east and southern Africa region for use in training health professionals. By strengthening the capacity of health care workers to scale up nutritional care and support, the manual helps meet the recently launched President's Emergency Plan for AIDS Relief objective to provide care to 10 million people infected and affected by HIV/AIDS by 2008.

The manual includes technical information and training materials on: basics of HIV/AIDS; links between nutrition and HIV/AIDS; key nutrition actions for people living with HIV/AIDS; food security components in nutritional care and support; nutritional management of HIV/AIDS-related symptoms; nutritional care for HIV-infected pregnant and lactating women and adolescent

girls; infant feeding and PMTCT; nutritional care for children born to HIV-infected women; and management of drug-food interactions.

This publication is available on FANTA's website at www.fantaproject.org



THE 10/90 REPORT ON HEALTH RESEARCH 2003-2004

Global Forum for Health Research
2004, 282 pp

This is the fourth report of the Global Forum since its creation in 1998 which tracks the global progress made to correct the 10/90 gap in health research. The Report identifies key areas where governments need to act in order to reach the Millennium Development Goals by 2015. First is for governments to measure their investment in health research and bring these into line with their country's burden of disease. The second area of action is for all countries to ensure that research addresses all key obstacles explaining why the burden of disease is and remains so high for a large portion of humanity. Third, is that of research capacity strengthening in low-income countries. Fourth, ensure that public-private partnerships remain viable, efficient in their delivery of health products, and strong positive synergies with the national health and health research system. And finally, a systematic integration of gender issues in all the actions mentioned above and all aspects of the work on the correction of the 10/90 gap. Copies of this report can be ordered from

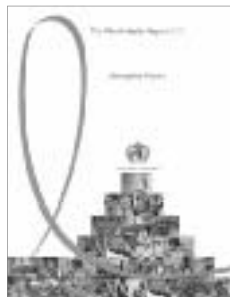
www.globalforumhealth.org



STRUCTURAL ADJUSTMENT THE SAPRI REPORT

Zed Books, 2004, 242 pp

This is a report on a joint participatory investigation by civil society and the World Bank on the impact of structural adjustment policies. The report is a comprehensive, real-life assessment of the actual impacts of the liberalization, deregulation, privatization and austerity policies that constitute structural adjustment policies. There is a chapter on the impact of agricultural sector adjustment policies on small farmers and food security. The Report looks at examples from five countries: Bangladesh, Mexico, the Philippines, Uganda and Zimbabwe. This book can be ordered from www.zedbooks.co.uk



THE WORLD HEALTH REPORT CHANGING HISTORY

WHO, 2004, 169 pp

The 2004 Report calls for a comprehensive HIV/AIDS strategy that links prevention, treatment, care and long-term support. Until now, treatment has been the most neglected element in most developing countries: almost 6 million people in these countries will die in the near future if they do not receive treatment—but only about 400,000 of them were receiving it in 2003. WHO and its partners have declared the treatment gap a global emergency and have launched a drive to provide 3 million people in developing countries with antiretroviral therapy by the end of 2005—on of the most ambitious public health projects ever conceived. This report shows how it can be done. It also looks be-

yond 2005 to explain how international organizations, national governments, the private sector and communities can combine their strengths and simultaneously fortify health systems for the enduring benefit of all. Available in Arabic, Chinese, English, French, Russian and Spanish. Copies of the Report can be downloaded from the WHO site, www.who.int or ordered from bookorders@who.int

OTHER PUBLICATIONS RECEIVED BY THE SCN SECRETARIAT OVER THE PAST SIX MONTHS

Community Based Approaches to Managing Severe Malnutrition. ENN Report on the Proceeding of an Inter-Agency Workshop, Dublin 8-10 October 2003. www.ennonline.net

De Viandas, Sancochos, y Amasijos. María Dikanka Quebecor World Bogotá, 2003.

Efficacy and Effectiveness of Interventions to Control Iron Deficiency and Iron Deficiency Anemia. INACG, 2004. <http://bni.ilsa.org/publications/> to download the publication.

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Getting to Grips with Globalizations: the OECD in a Changing World. OECD, 2004. www.oecd.org

International Negotiations and Decision Making at the United Nations: A Guide. UN Non-Governmental Liaison Service with Gretchen Sidhu. Geneva, UN, 2004.

A Procedure to Estimate the Accuracy and Reliability of HemoCue™ Measurements of Survey Workers. Susan Burger and June Pierre-Louis. Micronutrient Global Leadership, 2003. <http://bni.ilsa.org>

Public Health Nutrition. Special issue on Diet, Nutrition and the Prevention of Chronic Diseases. 7:1(A), 2004.

The Use of Genetically Modified Crops in Developing Countries. Nuffield Council on Bioethics, 2004. www.nuffieldbioethics.org

INTEGRATING SODIS INTO THE COMMUNITY THE EXPERIENCE OF MEKOMBA, CAMEROON

SANDRINE MOTAMED AND BEAT STOLL

INSTITUTE OF SOCIAL AND PREVENTATIVE MEDICINE, FACULTY OF MEDICINE, UNIVERSITY OF GENEVA

SODIS is a water treatment method which eliminates the majority of pathogens that cause diarrhoeal diseases. It is a technique particularly adapted for drinking water in small communities. SODIS relies only on solar energy, the recovery of polyethylene terephthalate (PET) bottles and some black paint¹. Disinfecting chemicals are not needed, nor additional sources of energy. In 1998, SODIS was introduced to villagers in Mekomba, Grande Mefou, Cameroon³. Six voluntary heads of households were trained within a few hours on the use of SODIS and were given pre-painted PET bottles. In the 48 hours that followed, participants were observed on their handling of the bottles and a bacteriological analysis was conducted to ensure the effectiveness of the technique in local conditions.

Six months later, with no new intervention from the trainers, the heads of households were still using SODIS on a regular basis. More than four years later, what has become of the SODIS experience in the village of Mekomba? Regular use of SODIS was established at six months post-intervention—was this enough time to modify behaviour and institutionalize the use of SODIS?

What is SODIS?

SODIS is very simple to implement: dirty water is exposed to the sun in transparent bottles, ideally made of PET. UV-A rays cross the wall of the plastic bottle and, by painting half of the surface of the bottle black, heat builds up in the water². This synergy between the UV-A rays and the increased temperature of the water allows for water purification. On sunny days, it is recommended that bottles be exposed to the sun for six hours before consumption. If the temperature reaches 50° C, only one hour of exposure is enough to kill pathogens in the water. On the other hand, in the event of cloudy weather, water will have to be exposed for two continuous days to ensure purification. The turbidity (ie, the quantity of suspended particles which makes the water opaque) of the water is an important limiting factor. Water having a turbidity higher than 30 NTU will have to be prefiltered. If newspaper headlines (approximate letter size 1.5 cm) can be read through the bottle, turbidity is estimated at roughly less than 30 NTU.

If used daily, the same bottle can be reused for six months to one year. SODIS does not change the taste of the water. No disinfecting chemicals are needed—which protects the environment—therefore reducing user costs and avoiding potential accidents in the home as a result of handling corrosive or toxic substances. In certain areas, boiling water as a means of purification requires searching for firewood and increases deforestation. SODIS uses no other energy source other than free and renewable solar energy. One plastic PET bottle can produce one litre of drinking water per day for up to a year. Since contamination of drinking water often takes place during its handling, SODIS avoids this risk since water can be drunk directly from the bottle.

Mekomba is a village located in the wet, tropical zone in the centre of Cameroon (Grande Mefou). Most people are farmers and live in houses made of wood, mud, and straw. Drinking water is drawn from sources from the periphery of the village approximately 1km away. The untreated water is transported back in buckets and stored in uncovered plastic basins in the home. A cup is usually used to draw the water for drinking⁴. As mentioned above, volunteer heads of households were trained using SODIS, as well as a general introduction given to the entire village. Six months later, during an impromptu visit to the Mekomba, the use of SODIS was still evident. In November 2003, more than four years after the introduction of SODIS to the village, two of the four heads of households were found for follow-up on their use of SODIS.

SODIS four years later

More than four years after its introduction, SODIS was no longer used in Mekomba. Bottles were in fact used by the villagers until they broke, approximately six months to a year later. Years after the villagers were still able to explain the methodology behind SODIS very well. They also mentioned that they observed a reduction in stomach ailments and diarrhoea during the period they utilized SODIS.

No one, however, ever repainted a bottle, either to make greater quantities of water for the family, or to replace a broken bottle. They also did not share the technique with others. Moreover, the village health agent had not continued to teach SODIS to this or any other village. Villagers explained that they would have preferred to see the original instructors return regularly and hand out new bottles.

Discussion

The use of SODIS in the village of Mekomba did not last longer than the lifespan of the bottles. Only two of the six heads of households and the health agent were found, but it was clear that the method was abandoned by the villagers. Why had this happened? The use of SODIS seems relatively simple and villagers testified to its benefits. The technology is inexpensive, even for this village. However, the relative effort to seek an empty bottle and to paint it was not made. The access to empty bottles requires some searching, but should not be a limiting factor in Mekomba. To test this, a primary school teacher asked each of his pupils to get an empty bottle for the following day; the students did this without any problem. On the other hand, it is possible that access to paint is more complicated because it requires community participation to purchase paint—a more important cost for a single user. But this step can be avoided if the bottles are placed on a reflective surface.

But there seems to be an aspect which was not considered when SODIS was first introduced to the village of Mekomba. Did the villagers use SODIS only because they had external motivation, such as visits by trainers? Was there another essential motivating factor, other than medical, that was overlooked?

Successful SODIS implementation requires behavioural change. It is not sufficient to propose a simple and inexpensive method

Continued on p 80...

Conferences

Food Safety Under Extreme Conditions

6-8 September 2004

Jaén, Spain

This conference will address different topics related to traditional fermented foods, especially those from Mediterranean countries and Sub-Saharan African countries. The scientific programme and other information can be found at: www.ujaen.es/buesped/foodsafe/

9th ECOWAS Nutrition Forum

20-24 September 2004

Cotonou, Benin

The technical theme for this meeting is nutrition and HIV. The main objectives are to develop common, pertinent and appropriate strategies for preventing nutritional problems in the ECOWAS subregion and to promote the information and experience exchange amongst nutrition actors. More information can be found at www.ecowasn nutrition.org



Would you like to post a notice on this board?

The next issue of *SCN News* will be published in December 2004. Please send your contributions to scn@who.int

European Health Forum Gastein

6-9 October 2004

Salzburg, Austria

This is a high level discussion platform for leading actors in European health policy offering excellent opportunities for exchange of experience and networking. Registration is available online at: www.ehfg.org

African Nutrition Leadership Programme

5-13 October 2004

South Africa

The aim of this programme is to assist the development of future leaders in the field of human nutrition in Africa. Emphasis will be given to understanding the qualities and skills of leaders, team building and the role of nutrition science. More information can be found at: www.africannutritionleadership.org/

4th European Congress on Nutrition and Health in the Elderly

4-5 November 2004

Toulouse, France

Topics to be covered include nutrition and successful aging, cognitive and physical functioning, body composition and aging amongst others. More information can be obtained by contacting: europa@europa-organisation.com

XXII IVACG Meeting Vitamin A and the Common Agenda for Micronutrients

15-17 November 2004

Lima, Peru

More information available at <http://ivacg.ilsa.org>

2004 INACG Symposium

18 November 2004

Lima, Peru

More information available at: <http://inacg.ilsa.org>

IZiNCG Symposium Moving Zinc into the Micronutrient Programme Agenda

19 November 2004

Lima, Peru

Programme and registration information available at: <http://izincg.ucdavis.edu>

2nd Africa Nutritional Epidemiology Conference

14-18 February 2005

Vanderbijlpark,

South Africa

The theme for this conference is new challenges and innovative tracts in nutrition, public health and human development. There are also various workshops preceding the conference in community diagnosis and nutritional assessment, study design in nutritional epidemiology, project monitoring and evaluation and many more. More information can be found at: www.wmin.ac.uk/idcfnph/conference.htm

Kenya Coalition for Action in Nutrition's Inaugural National Nutrition Congress

21-23 February 2005

Nairobi, Kenya

The theme of the Congress will be food and nutrition security for health and development. Abstracts are accepted until 31 August 2004. More information available at: www.k-can.or.ke/html/congress.htm

14th World Conference on Disaster and Emergency Medicine

16-20 May 2005

Edinburgh, Scotland

The main themes of the conference include: psychosocial aspects of disasters, emergency medical services planning, public health, and infectious diseases and much more. For more information on registration and programme visit: www.wcdem2005.org

Save the Date! Bioavailability 2005

11-14 October 2005

Chiang Mai, Thailand

The aim of this conference is to discuss results of recent scientific results on bioavailability and its role in contributing to better health among people living in developing countries. For more information contact: directnu@mahidol.ac.th

New Resources

The **Nutrition Society** has updated the following information sheets which can now be found on its website www.nutrition-society.org/careers/studentsinfo

Sheet 1: low-cost newsletters and journals for nutritionists; Sheet 2: sources of print materials for nutritionists in developing countries; Sheet 3: sources of CD-ROMs for nutritionists in developing countries. Please send additions or corrections to: office@nutsoc.org.uk

A trainers' guide for a **Four day course on the Essential Nutrition Actions (ENA) approach to improve the nutrition of infants, young children and women**, is now available for downloading from the Academy for Educational Development's LINKAGES project website www.linkagesproject.org. The ENA approach aims to extend the coverage of evidenced-based nutrition support to reach more infants, young children and women through the promotion of seven nutrition actions at six key contact points during the life cycle. The ENA approach integrates the seven actions to avoid the vertical approaches of the past, as well as aims to maximize the opportunities for providing nutrition support to reach as many of the target group as possible. For more information, contact Dr Victoria Quinn at vquinn@aed.org

Courses

Lives and Livelihoods

22 August-

4 September 2004

Montreal, Canada

This is the 4th yearly series of training opportunities that the Feinstein International Famine Center has organized. This workshop is designed for midlevel managers of international humanitarian and donor organizations who work in crisis situations. The workshop will cover key issues in dealing with complex emergencies, including humanitarian and human rights, as well as topics in public health, nutrition and livelihoods. Visit www.famine.tufts.edu for more information.

22nd Leeds Course in Clinical Nutrition

7-10 September 2004

Leeds, UK

Courses to be given in managing clinical nutrition, diabetes and obesity, and eating disorders. For more information and registration, contact: c.would@leeds.ac.uk

The University of Oslo and Akershus University College

conduct a post-graduate course programme on the global dimensions of nutrition. The series consist of: the world nutrition situation; nutrition, globalisation and governance; and nutrition and human rights. Courses begin in January 2005. For more information contact: globalnutcourses@basalmed.uio.no

8th ICDC Annual Training Course on Implementing the International Code of Marketing of Breast-milk Substitutes

20-28 September 2004

Penang, Malaysia

Government officers can learn first-hand drafting of legislation based on the International Code. Course sessions are interactive and consist of lectures, plenary discussions, workshops, role-playing, panel discussions, videos and other audio visual materials. Email ibfanpg@tm.net.my for more information.

11th Seminar of the European Nutrition Leadership Programme

9-17 March 2005

Luxembourg

The aim of the programme is to assist in the development of future leaders in the field of human nutrition in Europe. The programme is designed for final year PhD students and postdoctoral fellows in human nutrition science in Europe. Application deadline 15 November 2004. More information can be found at: www.enlp.eu.com

Division of Human Nutrition at **Wageningen University** has training and research programmes available at the PhD and BSc-MSc level. Core areas of study include nutrition and health, nutrition and epidemiology, and nutrition, metabolism and genomics. For further information please visit: www.fhns.wau.nl/nutepi/uk

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to address an important public health problem. For example, the use of condoms, although proven effective in protecting against the spread of sexually transmitted diseases such as HIV/AIDS, is not more easily integrated into Western societies than in other areas. A public health message is seldom effective in creating behavioural change without formative research into socio-cultural aspects. This is an important first step in evaluating the acceptability of the purposed intervention and to modify certain aspects of the public health message in order to adapt it to the needs of the target population. But beyond this, it is necessary to associate SODIS with another message, different from that of public health, which can touch people on another level and encourage lasting behavioural change.

For more information on SODIS, please visit www.sodis.ch
Contact: Sandrine Motamed, motamed@bluewin.ch or Beat Stoll, beat.stoll@imsp.unige.ch

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4. Hurst S. *Les chemins de l'eau: Qualité bactériologique de l'eau de boisson en situation à risque en Suisse et au Cameroun*. Thèse. Faculté de Médecine de Geneva, 2001.

THE COPENHAGEN CONSENSUS MEETS THE 5TH REPORT ON THE WORLD NUTRITION SITUATION

The Copenhagen Consensus was established to set priorities for development projects to tackle among a series of pressing global challenges. The Consensus was tasked with answering the question, "What would be the best ways of advancing global welfare, and particularly the welfare of developing countries, supposing that an additional \$50 billion of resources were at governments' disposal?"

The Copenhagen Consensus, with support from the Tuborg Foundation and The Carlsberg Bequest to the Memory of Brewer IC Jacobsen, The Danish Ministry of the Environment, The Sasakawa Peace Foundation together with the Sasakawa Peace Foundation USA and *The Economist*, put together a panel of experts consisting of Jagdish Bhagwati of Columbia University, Robert Fogel of the University of Chicago (Nobel laureate), Bruno Frey of the University of Zurich, Justin Yifu Lin of Peking University, Douglass North of Washington University in St Louis (Nobel laureate), Thomas Schelling of the University of Maryland, Vernon Smith of George Mason University (Nobel laureate), and Nancy Stokey of the University of Chicago.

The expert panel reviewed a large number of development challenges provided by the United Nations agencies and came up with ten areas:

- civil conflicts
- climate change
- communicable diseases
- education
- financial stability
- governance
- hunger and malnutrition
- migration
- trade reform
- water and sanitation

These experts reviewed prepared papers (and counter views to the papers) and then prioritized action areas for donors and practitioners. On 3 June, *The Economist* reported on the process and a week long conference held in May where the expert panel examined the 30 proposals in detail. Each paper was discussed with the principal author and other specialists who wrote counter papers. The experts met privately and ranked the proposals, in descending order of desirability. From the priority list of 10 areas, the experts identified 17 projects for special attention using criteria such as scale of the problem, the technologies available to address the problem and where the greatest cost benefit would be realized.

The list places malnutrition in four different projects and also includes food security under the project on multilateral and unilateral action to reduce trade barriers and eliminate agricultural subsidies. The control of HIV/AIDS emerges as the highest priority and micronutrients emerges as the second activity, specifically tackling anaemia through supplementation. The Consensus argued that reducing the prevalence of iron-deficiency anaemia by means of food supplements, in particular, has an exceptionally high ratio of benefits to costs. Anaemia reduction has strong economic and social benefits. The expert panel ranked a second proposal under "malnutrition", to increase spending on research into new agricultural technologies appropriate for poor countries, at number five. Further proposals, for additional spending on infant and child nutrition, and on reducing the prevalence of low birth-weight, were ranked eleventh and twelfth, respectively.

The background paper for the hunger and malnutrition focus area was written by Jere R Behrman, Harold Alderman and John Hoddinott and is available from the Copenhagen Consensus website. Two commentary papers on the Behrman paper were written by Simon Appleton and Peter Svedberg. All papers and the Consensus documents are available from www.copenhagenconsensus.com/

This list of priority areas and the overall Consensus process will look familiar to *SCN News* readers as it reflects what was done for *The 5th Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes* (March 2004) www.unsystem.org/scn/Publications/html/RWNS.html

No doubt the results are controversial with the absence of education projects in the final list. The strong showing of activities to reduce malnutrition, however, again reaffirms the clear message from nutritionists, economists and others on the importance of scarce development assistance going towards food and nutrition actions.

Compiled by Bruce Cogill, FANTA, bcogill@aed.org

STOP PRESS!

CHINESE AND AFRICAN SCIENTISTS NAMED CO-WINNERS OF THE 2004 WORLD FOOD PRIZE!

On 29 March 2004, World Food Prize President, Ambassador Kenneth Quinn, announced the 2004 World Food Prize Laureates, Professor Yuan Longping of China and Dr Monty Jones of Sierra Leone. Both scientists are credited with, "breakthrough scientific achievements which have significantly increased food security for millions of people from Asia to Africa." Professor Yuan was selected as co-recipient of the World Food Prize for his breakthrough achievement in the early 70s in developing the genetic tools necessary for hybrid rice breeding, known as a three-line system. Dr Jones was selected for developing in the 90s the "New Rice for Africa", which has uniquely adapted to the growing conditions of West Africa, by successfully crossing the Asian *O. sativa* with the African *O. glaberrima* strain to produce drought and pest resistant, high yielding new rice varieties. The co-recipients will receive their award at a ceremony on 14 October 2004, at the Iowa State Capital Building in Des Moines. For more information, visit www.worldfoodprize.com

WHO/CDC EXPERT CONSULTATION AGREES ON BEST INDICATORS TO ASSESS IRON DEFICIENCY A MAJOR CAUSE OF ANAEMIA

A WHO and CDC expert consultation has reached a consensus on the best indicators to assess iron deficiency. Iron deficiency, with or without anaemia, can have important effects on people of all ages in both developed and developing countries. The purpose of the expert consultation was first, to assess the iron status of populations so that the extent of the problem can be clearly known, and second, to measure changes in iron status during programmes, so that the effect of interventions can be clearly measured. The meeting recommended that haemoglobin and ferritin, a protein that is strongly correlated with iron stores in healthy people, are the most useful indicators of the impact of programmes to control iron deficiency. Because ferritin is affected by inflammation due to infection and chronic disease, the consultation recommended that to assess iron deficiency, the transferrin receptor, in addition to haemoglobin and ferritin, should be measured in places where infection is common.

7 May 2004, WHO press release.

WHO WORLD HEALTH ASSEMBLY ADOPTS GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH

The WHO Global Strategy on Diet, Physical Activity and Health was endorsed on 22 May 2004, by Member States at WHO'S annual Health Assembly in Geneva. The strategy addresses two of the major risk factors responsible for the heavy and growing burden of noncommunicable diseases (NCDs), which include cardiovascular disease, type 2 diabetes, cancers and obesity-related conditions. The strategy emphasizes the need to limit the consumption of saturated fats and trans fatty acids, salts and sugars, and to increase consumption of fruit and vegetables and levels of physical activity. The strategy also addresses the role of prevention in health services; food and agriculture policies; fiscal policies, surveillance systems; regulatory policies; consumer education and communication including marketing, health claims and nutrition labeling; and school policies as they affect food and physical activity choices. For more information contact Catherine Le Galès-Camus, Assistant-Director General, legalescamusc@who.int. WHO press release.

WHO PUBLISHES NEW GUIDELINES ON PREVENTING MOTHER TO CHILD TRANSMISSION (MTCT) OF HIV

WHO has published new guidelines underlining the effectiveness of antiretroviral drugs to prevent the transmission of HIV from seropositive mothers to their children. Among the key recommendations contained in the guidelines, *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants*, are: women who need antiretroviral treatment for their own health should receive it in accordance to the WHO guidelines on antiretroviral treatment; HIV-infected pregnant women who do not have indications for antiretroviral treatment, or do not have access to treatment, should be offered antiretroviral prophylaxis to prevent MTCT of HIV using one of several antiretroviral regimens known to be safe and effective; and the expansion of programmes to prevent MTCT using single-dose nevirapine should not be hindered while necessary improvements in health systems are taking place to enable more complex antiretroviral regimens to be delivered. For more information, visit www.who.int.

14 July 2004 WHO press release.



THE 9TH DR ABRAHAM HORWITZ LECTURE

ANNOUNCEMENT AND CALL FOR PROPOSALS

The SCN Secretariat in Geneva announces the 9th Dr Abraham Horwitz Lecture. It is scheduled to take place in Brasilia, Brazil on Monday 14 March 2005. Proposals are invited from young professionals studying or working in the field of international nutrition.

Dr Abraham Horwitz served as the Chair of the SCN between 1986 and 1995. He died on July 10, 2000, at the age of 89 years. In an interview published in *SCN News* in late 1995, just after his retirement, Dr Horwitz sent a message to those working in nutrition:

"Keep the faith that you are committed to a most noble cause, the well-being of people whom you do not know but whose needs you feel intensely. Redouble your efforts in whatever you do in nutrition while being bold and imaginative."

The Horwitz Lecture Series' aim is to continue Dr Horwitz' heartfelt, highly valued and extremely generous tradition of mentoring young talent and their ideas for nutrition programmes. The Lecture Series was established by Sir Richard Jolly in 1996. Each year a young guest lecturer who possesses the knowledge and commitment to prepare an exceptional paper is invited to make a presentation at the SCN Annual Session.

The 9th Lecture will take place in the context of a one-day SCN symposium. The symposium's theme will be ***the resolution of hunger and malnutrition through national and regionally driven strategies, policies, programmes, and evaluations***. A suggested lecture title is "Local Action for End Hunger and Malnutrition: New Directions for National Anti-Hunger Strategies: What can we learn from country-ownership of the fight against hunger and malnutrition?" The symposium will be opened by a high level official of the Brazilian Government. The opening will be followed by a distinguished keynote and other focused presentations.

The Lecture should not just be a theoretical discussion, but build on evaluation experience, to the extent it exists. It should consider knowledge and informational needs that must be filled to meet this challenge, the human, institutional, and organizational requirements for its realization, and/or the political obligations and commitment(s) key to enabling effective programmes and/or political and policy level agendas. It should reflect an analytical evaluation of options and experience, and avoid conclusions based on anecdotal experiences other than to illustrate specific challenges. The Lecture will be published as part of the symposium proceedings in one of the SCN's publications.

Young nutrition professionals are invited to submit a three-page (double spaced) concept paper to the SCN Secretariat in Geneva by Friday 10 December 2004. All proposals should relate directly to the symposium's theme. Proposals will be evaluated against three criteria: clarity, innovation, and demonstrated knowledge of the field. All proposals meeting these criteria will be considered, however, preference will be given to those describing newer strategic, programme or policy approaches.

Proposals will be accepted by email, regular mail or fax. The proposal should contain:

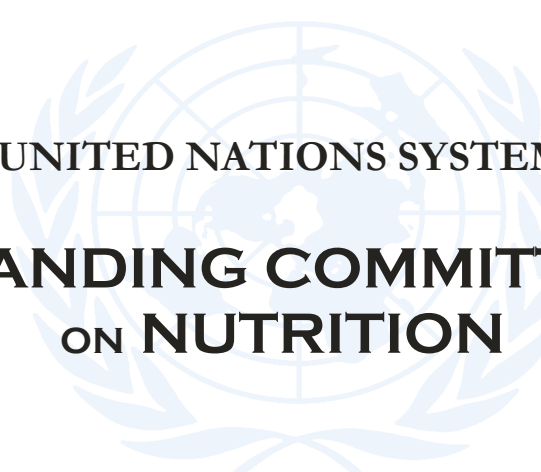
- a cover letter with the applicant's full name and contact details
- a one-page personal resume
- a three-page concept paper (double-spaced) explaining the proposed lecture's scope and clearly detailing the key issues proposed for presentation
- two supporting letters from professionals from two of the three SCN member groups, ie, UN agencies, bilateral partners, and civil society. The two supporting letters must address the writer's willingness and commitment to provide the applicant with guidance in preparing the proposed Lecture and paper that will be published.

The SCN Secretariat will select the best proposal. The successful candidate will be notified by 20 December 2004. Travel to and from Brazil and hotel/living expenses while attending the meeting will be covered by the SCN. The Lecturer also will receive an honorarium of \$500.

*Further information is available from the SCN Secretariat in Geneva:
Phone: 41-22-791 04 56, fax: 41-22-798 88 91, email: scn@who.int*

Our mailing address is

*SCN Secretariat, c/o World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland
<http://www.unsystem.org/scn>*



UNITED NATIONS SYSTEM STANDING COMMITTEE ON NUTRITION

The Administrative Committee on Coordination (ACC), which was comprised of the heads of the UN Agencies, recommended the establishment of the Sub-Committee on Nutrition in 1976, following the World Food Conference and with particular reference to Resolution V on food and nutrition. This was approved by the Economic and Social Council of the UN (ECOSOC) by resolution in July 1977. Following the reform of the ACC in 2001, the ACC/SCN was renamed the United Nations System Standing Committee on Nutrition or simply “the SCN”. The SCN reports to the Chief Executives Board of the UN, the successor of the ACC. The UN members of the SCN are ECA, FAO, IAEA, IFAD, ILO, UN, UNAIDS, UNDP, UNEP, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNRISD, UNU, WFP, WHO and the World Bank. IFPRI and the ADB are also members. From the outset, representatives of bilateral donor agencies have participated actively in SCN activities as do nongovernmental organizations (NGOs). The SCN Secretariat is hosted by WHO in Geneva.

The ***mandate of the SCN*** is to serve as the UN focal point for promoting harmonized nutrition policies and strategies throughout the UN system, and to strengthen collaboration with other partners for accelerated and more effective action against malnutrition. The ***aim of the SCN*** is to raise awareness of and concern for nutrition problems at global, regional and national levels; to refine the direction, increase the scale and strengthen the coherence and impact of actions against malnutrition worldwide; and to promote cooperation among UN agencies and partner organizations. The SCN’s annual meetings have representation from UN agencies, donor agencies and NGOs; these meetings begin with symposia on subjects of current importance for policy. The SCN brings such matters to the attention of the UN Secretary General and convenes working groups on specialized areas of nutrition. Initiatives are taken to promote coordinated activities—interagency programmes, meetings, publications—aimed at reducing malnutrition, reflecting the shared views of the agencies concerned. Regular reports on the world nutrition situation are issued. *Nutrition Policy Papers* are produced to summarize current knowledge on selected topics. *SCN News* is published twice a year, and the *NICS* (formerly *RNIS*) is published quarterly. As decided by the SCN, initiatives are taken to promote coordinated activities—interagency programmes, meetings, publications aimed at reducing malnutrition, primarily in developing countries.

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CHAIR
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