



STANDING COMMITTEE ON NUTRITION

SCN NEWS

a periodic review of developments in international nutrition



Mainstreaming nutrition

for improved development outcomes

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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, UN-AIDS, 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. 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 *RNJS* is published quarterly. As decided by the SCN, initiatives are taken to promote coordinated activities—inter-agency programmes, meetings, publications aimed at reducing malnutrition, primarily in developing countries.

*This issue of SCN NEWS was edited by Andrea D Moreira, MPS ID
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Chair: Catherine Bertini, Under-Secretary General for Management, UN
SCN c/o World Health Organization

20 Avenue Appia, CH 1211 Geneva 27, Switzerland

Email: scn@who.int Telephone: 41-22 791 04 56, Fax: 41-22 798 88 91

SCN NEWS provides information on issues of importance 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. 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.

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Chair's Round-up

One of the important aspects of the SCN's work has been to draw attention to emerging issues in the field of nutrition—this year's Symposium, *Mainstreaming Nutrition to Improve Development Outcomes*, addressed the challenges and opportunities for incorporating nutrition thinking into the development process. The debate around public-private partnerships is just one example of such a challenge to reduce malnutrition and achieve the Millennium Development Goals (MDGs). In this issue, Mr Venkatesh Mannar and Dr Judith Richter address the benefits—as well as the challenges—of engaging the private sector in combating malnutrition. A panel discussion on *Sustaining impact on a large-scale: what are the lessons?* reviewed country experiences in going-to-scale with nutrition programmes, and revealed that much work is still needed before successful nutrition mainstreaming is realized.

The success of this Symposium, and indeed of the entire week's Session, was due to the most efficient and friendly organization by Professor M S Swaminathan and his team, and in particular to the close collaboration with Ms R V Bhavani, Secretary General of the Organizing Committee. On behalf of the SCN, I would like to thank Professor Swaminathan for his warm hospitality and tireless efforts in hosting our 30th Session. Professor Swaminathan also hosted an innovative Public Forum which brought our week's discussions on development to the Chennai community.

Next year's Session will be held at the United Nations in New York, 22-26 March 2004. The Symposium will focus on Nutrition and the MDGs. The Secretariat and Steering Committee are currently working on the week's agenda in collaboration with the Institute of Human Nutrition, Columbia University. Details will be posted on the SCN website this fall.

I am also pleased to announce a call for proposals for the 8th Dr Abraham Horwitz Lecture. 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. Congratulations to Dr Pumima Menon for delivering such an excellent lecture at this year's Symposium in Chennai. Her lecture is published in this issue and provides insightful and original methods for the nutrition community to mainstream nutrition at the policy level.

Dr Sonya Rabeneck left the SCN Secretariat in June 2003. Through her dedicated service and leadership as Technical Secretary, Sonya was responsible for several innovations at SCN. We wish Sonya every success in the next phase of her career.

Congratulations on the election of Dr Lee Jong-wook as the new Director General of WHO. We applaud his appointment of Dr Graeme Clugston, former Director of Nutrition for Health and Development at WHO, on his new position as WHO Technical Ombudsman, Office of the Director-General. Graeme has been the SCN's focal point with WHO for many years and instrumental in the excellent hosting arrangement between the SCN and WHO. On behalf of the SCN family I wish Dr Clugston all the very best.

We say farewell also to Dr Gro Harlem Brundtland and thank her for her stellar leadership on nutrition issues worldwide.

Catherine Bertini



Advocacy in Practice

SCN welcomes new Distinguished Nutrition Advocate

Editor's Note: The SCN Secretariat is honoured that Bishop Dom Mauro Morelli from Brazil joined the SCN in Chennai as its new Distinguished Nutrition Advocate (DNA). Dom Mauro attended the SCN's Annual Session where he had an opportunity to meet Professor MS Swaminathan, the SCN's long-standing DNA. Below is Dom Mauro's closing statement delivered at the Session.

We do not live by bread alone, but life has to be nourished every day and at every moment. I understand my appointment as DNA as a recognition and encouragement to ensure that every human being has the right to food and nutrition. I also strongly believe that Brazil is a great partner in a world committed to freedom from hunger and malnutrition.

I would like to thank Ms Bertini for presiding as Chair of the SCN. From WFP to the SCN she has moved from the basic need of life to a crucial dimension of that same need. All of us hope that her new appointment as UN Under-Secretary General for Management will remind the whole UN System that a world free from hunger and malnutrition is a priority for obtaining peace. It is our duty to make a strong appeal for peace! Decisions to make war encourage violence and make hunger grow.

Let me also thank all of you for making the SCN your laboratory for a life with dignity for every man, woman and child. You are a group with great capacity for dialogue and research.

Let me also share with you my faith, hope and commitment to the right to food and nutrition. I believe that every child born has the right to live with dignity and hope. Yet, without adequate food and care no child will grow up healthy and happy.

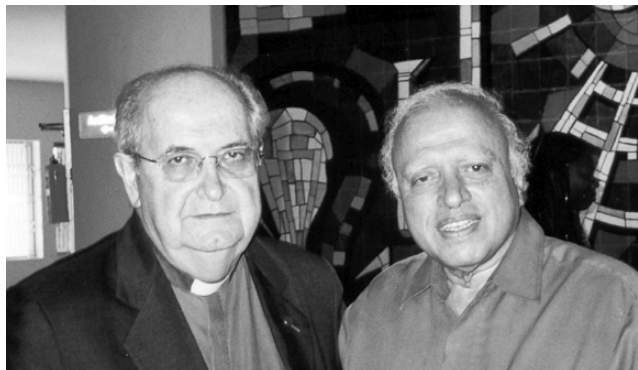
At the recent World Social Forum in Porto Alegre, Brazil people from all over the world proclaimed that another world is possible. I believe that all of us have the same vision and are committed to the process of change and renewal that is required for a new dawn.

More than a new society, I believe that we are challenged to find a new civilization. A civilization that chooses life and has respect and love for Mother Earth—a civilization of sharing and communion.

A great challenge lies ahead of us: how to be a dynamic society without fighting for first place, or be led by competition and trained to be warriors. Instead, let us pro-

mote a new world. There will be no peace as long as citizenship is denied to humans beings. By citizenship I mean a place in society where we can share with others the joys and hopes of life—a place at a table where life is nourished by food, wisdom and companionship.

The last Book of the Bible (Revelation 21) speaks about this dream—a city free from violence, hunger, corruption and idolatry.



SCN's Distinguished Nutrition Advocates, Bishop Dom Mauro Morelli (left) and Professor MS Swaminathan

*Bishop Dom Mauro Morelli
SCN Distinguished Nutrition Advocate
mmorelli@pen.terra.com.br*

Excerpts from Brazilian President Lula da Silva's speech at the G-8 Summit in Evian, France held 1-3 June 2003

...Hunger is at an intolerable level. We know that there are plain conditions to surpass this epidemic. My proposal—made in Porto Alegre and in Davos—is that a world fund be created capable of giving food to whoever is hungry and, at the same time, creating conditions to end the structural causes of hunger....There are various ways to generate resources for a fund of this nature....The first is taxation of the international arms trade—which would bring advantages from economic and ethical points of view. Another possibility is to create mechanisms to stimulate...rich countries (to) reinvest into this fund a percentage of interest payments made by debtor countries. Some developing countries have presented proposals to confront this problem. They are valid initiatives that deserve to be considered....

Mainstreaming Nutrition for Improved Development Outcomes

The SCN's 30th Annual Session was held 3-7 March 2003 in Chennai, India. The SCN is most grateful to the MS Swaminathan Research Foundation for hosting the Session at the Indian Institute of Technology.

The Secretariat would also like to recognize the following for their contributions towards local costs: IDRC Canada, IFPRI, the Government of Norway, World Bank, and World Food Programme. Funding for the travel of presenters and developing country participants was provided for by: the Government of Germany, Micronutrient Initiative, the Netherlands, and USAID.

This year's Symposium on *Mainstreaming Nutrition for Improved Development Outcomes* took place on 4 March. The Symposium focused on efforts to mainstream nutrition and accelerate progress in achieving the Millennium Development Goals (MDGs). The MDGs are a set of goals, targets and indicators to improve human development outcomes by 2015, and the nutrition community is poised to lead this process toward increased human well being. Yet the strategies of how to increase the importance of nutrition in human development dialogues and policy-making are still widely debated. The papers and panel discussion published here represent just some of the current debates, both political and technical, in moving nutrition forward.

In the first part of the Symposium, Mr Venkatesh Mannar and Dr Judith Richter take opposing views of public-private partnerships. The proliferation of public-private partnerships in the past few years has received an increasing amount of criticism due to public distrust of the private sector. Both authors acknowledge the risks of engaging the private sector in the fight against malnutrition, but they differ on how these risks can be managed. What is clear from both authors is that further dialogue is needed before collaboration with the private sector can continue.

The panel discussion—*Sustaining impact on a large scale: what are the lessons?*—moves the discussion of mainstreaming nutrition from the global level to the national level. Speakers examined challenges to nutrition programmes in four countries (Bangladesh, Vietnam, India and South Africa) that could hinder achieving the MDGs.

Dr Arabella Duffield argued for more stringent evaluation of current nutrition programmes before going to scale with new ones in Bangladesh. Subsequent discussion reflected some dilemmas nutrition profession-

als face today: increasing amounts of developing country debt due to failing programmes; what indicators to use in measuring a programme's success; and where evaluation efforts should be focused on—programmes that *do* work or those that *do not*.

In the case of Vietnam, Dr Nguyen Cong Khan pointed out that although there has been serious effort by the national government to combat malnutrition, this process is a long term commitment that requires continuous political support in order to sustain impact. Without political advocacy, nutrition programmes risk funding cuts and deteriorating nutrition outcomes.

In India, political support is not so much the problem as is interstate variations and lack of effective strategies. The current Tenth Plan attempts to correct these weaknesses and promote better inter-sectoral approaches in combating malnutrition. National goals have been set that are based on state specific goals, including better targeting and evaluation.

Finally, the successful use of research, training and advocacy in South Africa by Professor David Sanders is an example of the importance of the Triple A process in sustaining nutrition programmes. Professor Sanders provided an encouraging case study of how to improve management of malnutrition and tackle its more basic cause—household food insecurity.

This year's 7th Dr Abraham Horwitz Lecture provided the *how-to* of mainstreaming nutrition and developing strategies to reach policy-makers. Dr Purnima Menon presented a very comprehensive model to assess factors in successful policy change. She argued that in order to affect policy, nutrition professionals need effective communication planning grounded in formative research. This innovative approach is flexible enough to be used at any policy level.

Public-private partnerships for improved nutrition: how do we make them work for the public good?

MG Venkatesh Mannar

The persisting nutritional problem and opportunities for accelerated action

In the past, the government or the public sector bore the primary responsibility for the health and nutritional well being of people. For too long, nutrition issues have been dealt with in isolation by different sectors and organizations. This lack of communication and collaboration across sectors to address problems in a unified manner may, in part, be responsible for poor nutritional outcomes in many countries. Millions of people around the world continue to suffer from hunger and malnutrition with serious consequences including learning disabilities, impaired work capacity, illness and death. At current rates of progress, it is unlikely that the global nutrition and development goals will be met within the targeted time frame of the Millennium Development Goals.

It is increasingly clear that the issue we face today is no longer simply food security based on per capita calorie availability. Rather, it is a comprehensive nutrition security based on an affordable diet of high nutritional quality; a diet whose outcome is judged by mental acuity and economic productivity rather than simple physical survival. This amounts to a dietary quality revolution every bit as profound as the Green Revolution of the 60s.

Technological problems are not nearly as serious as operational ones when faced with making programmes work in communities where malnourished people live. Issues of supply and demand, logistics, communications, community participation, and partnership building across a wide spectrum of players—public and private—are equally important to ensure the success and sustainability of efforts to eliminate malnutrition. Many of these needs interact and are mutually reinforcing.

With the dawn of the new century, the roles of government and private industry are changing dramatically. Food production and consumption patterns are shifting to more centrally processed and packaged food products with increasing attention to food safety, hygiene and quality. The food industry is becoming more global with new trade agreements accelerating the global movement of food technology, products and capital. Markets in developing countries are providing unprecedented opportunities to attract private investment and entrepreneurial energy. Publicly funded food and nutrition programmes are gaining from past experience and improving in effectiveness. In this new environment there is much potential for governments, food companies, scientific establishments and development agencies to collaborate on ensuring adequate nutrition status for all.

Some of the efforts of public-private interaction in the nutrition field have already yielded dramatic results. For example, through the combined efforts of governments, international agencies and the salt industry over the past decade, the percentage of the global population with access to iodized salt has increased from 20% to 70%. As a result, it is estimated that the number of children with mental retardation due to iodine deficiency has decreased by 12m during the 90s¹. This is a testimony to the power of well-articulated and targeted joint action, and there is still room for refining these efforts.

Today, 15% of the 585m tons of wheat flour milled globally every year is fortified with iron, folic acid and B vitamins in nearly 50 countries². Food fortification is one example where industry and trade work in a largely commercial environment and play a leading role in a health intervention endeavour. By building on existing food production and distribution infrastructures, fortification engages the market system and the private food sector. While government determines priorities, sets policy and advocates for action, industry provides much of the initial investment, with the ultimate financing borne by consumers. The private sector also offers technical expertise in production and marketing and, most importantly, a businesslike approach to solving problems. For instance, analysis of investments in the salt iodization programme around the world has shown that over the past decade a public investment of nearly US\$ 400m was matched by private investment exceeding US\$ 1.5b³.

Unfortunately, such successes are still few and far between. The challenge is to build upon such successful experiences to identify and harness the complementary resources and comparative advantages of public, private and civil society organizations to create and develop partnerships that improve nutrition on a vastly expanded scale.

Rather than building a partnership in the conventional sense of the term, what we are really developing is a strategic alliance—a close association for a common objective—between disparate groups.

Defining the partnership

First, what is meant by the public and private sectors must be clarified. The public sector includes government and all public bodies associated with the supply and distribution of food to ensure adequate nutrition and health for the entire population. The public sector also includes, at an international level, global and regional bodies that support and assist in achieving objectives of food security and good health.

The private sector is a more heterogeneous group of for-profit commercial enterprises and business organizations operating in all areas of national food production, processing, packaging, marketing and distribution. Private firms vary widely in size, ownership scope and market share, and offer different products and services. Various private actors may pursue different interests, pose different risks and offer a wide range of distinct assets (eg skills, expertise, delivery infrastructure, knowledge, leverage and contacts). At one end of the private sector spectrum are the transnational corporations, at the next level are large domestic companies that process and distribute food and pharmaceutical products, and at the final level are medium and small-scale processors of staple foods and condiments such as cereals, oils and fats, dairy products, sugar and salt. All of these entities have some relationship with the provision of food of variable nutritive value and their actions have a bearing on the behavioural and food consumption patterns of people.

The fundamental difference between the sectors is that the public sector is set up to work primarily for public good. On the other hand, the private sector is not established for purposes of benevolence. It can undertake socially responsible ventures of significant magnitude only if they will be profitable and generate value for its owners and shareholders. But these are not necessarily mutually exclusive. What needs to be explored are ways in which commercial goals can work for public good as well. The private food industry is a huge entity with ever expanding outreach—increasingly in the developing world. Fifteen of the largest food corporations of the world have a throughput of US\$ 2.8t and have an inherent interest and drive to expand in the developing world. Therefore, the key issue is how to manage private sector motives and to what extent to resist them.

The partnership challenge

Interest in using business skills and capacities to address malnutrition is not new. Experience over the past 30 years has shown that such partnerships alone will not solve the problem. While the range and quantities of nutritious products available to the upper and middle income groups are growing at a phenomenal pace, the number of needy people who currently benefit from such partnerships is still small. Many of the technologies do not reach those in need either because of lack of access or their incapacity to afford centrally-processed products.

Opportunities for collaboration are hampered by a lack of communication between public agencies and private food industries. The public sector acknowledges the need for industry participation in efforts to eliminate malnutrition, but actual communication with the private sector lags behind the rhetoric. At the same time

while accepting a larger role in addressing broad social and health issues, many in the private sector are not well informed regarding the severity and widespread prevalence of different forms of malnutrition and their impacts on the health and well being of people.

The communications gap means that industry leaders have not been challenged to respond to the urgent problems of malnutrition. Many do not understand its impact on the nation or their business, nor do they realize the role they can play in providing solutions⁴. The gap also means public leaders often do not have input from the business community. This results in legislation and regulations that sometimes restrict rather than enable private sector investment in improved nutrition. In this environment, outdated mental models, such as the public sector's suspicion of the profit motive and industry doubts about the public bureaucracy's results orientation, prevent collaborative action to eliminate malnutrition.

With increasing demands on its limited resources, it is no longer fair that we expect the government alone to shoulder the full burden of improving health and nutrition. With emerging concepts of privatization, liberalization and open market economies, there is bound to be a decreasing role for public subsidies even in the

Various private actors may pursue different interests, pose different risks and offer a wide range of distinct assets...

food sector. What is needed is a better model for sharing the responsibility and risk among all stakeholders. The public sector is recognizing the need to engage and stimulate the private sector to contribute to the public good and motivate it to do more. The private sector in turn

is seeing value in expanding its market through penetration of lower-income groups that are much larger in size, but offer slimmer profit margins.

There are a number of opportunities to reconcile the interests of the public sector in public health and nutrition with the economic interests of the private food and pharmaceutical industry. How can we capitalize on an enabling global environment where governments are becoming more business-like and private industries are recognizing their social responsibilities? The world is going to increasingly see such collaboration in several sectors of human development and nutrition could be at the forefront of that movement. How do we channel the energy of this new dynamic to address nutritional deficiencies?

To some this is the answer to nutrition problems in the world. Others view public-private partnerships with scepticism on the grounds that the only motivation of the private sector is profit at the expense of public good. But an effective partnership should tread a more middle ground—where the principles of good development and good business practices are present. Large portions of the population who can be reached through such alliances are in nutritional need. In short, there is a range of need. Even if some projects or

products cannot reach the most malnourished, there still is vast room for making a consequential contribution.

Risks of partnership

Partnerships may present a wide range of opportunities for interaction that pose different kinds and levels of risk⁵. Partnerships could include formal relationships/bodies, and less formal alliances for specific purposes such as advocacy, research and development, or safety testing. They might involve special incentives to the private sector or, in reverse, contributions from the commercial sector.

For public organizations, partnerships may create perceptions of conflict of interest or impropriety and risk reputations of public and affiliated non-governmental organizations. For instance, commercial considerations may influence or undermine impartial assessment of scientific evidence in the development of norms, technical standards and guidelines or cause upstream policy development. Public sector organizational priorities may be restructured due to the interests of or funding from commercial partners. The commercial sector may also face a variety of risks through interaction with the public sector. These include decision-making subject to geographical, political or other constraints; generally slow procedures that increase the costs of activities; inconsistent messages regarding public sector priorities; and benefits incommensurate with the resources expended.

A number of different options for managing public-private relationships balance the opportunities and risks inherent in partnerships. These aim to accommodate and reinforce the different values, standards and integrity of organizations while maximizing the potential for such partnerships. To minimize these risks, many public organizations have established a range of safeguard mechanisms to determine the degree of tolerance for different types of commercial organizations. Alliances that pose significant risks (such as influencing policy-making or guidelines) might require that firewalls be erected that bar certain commercial interests in decision-making. In some cases, risks can be contained by introducing specific procedures (eg conflict of interest disclosure statements, confidentiality agreements and non-exclusivity clauses). Yet, many types of interactions pose few if any risks to public organizations provided that corporate selection criteria and processes are comprehensive, clear and transparent.

Partnerships should fundamentally be a means to setting standards or a level playing field—to ensure that everyone complies with that norm. Government identifies the need to intervene, sets the standard, advocates and regulates. Then industry complies and competes within the prescribed guidelines. Finally, government monitors, enforces and evaluates. Throughout

this process the parties need to interact and consult in a spirit of open communication and a shared goal. It is imperative that in any partnership the profit focused agenda does not compromise the goal of public good.

Public-private partnerships are obviously not developed in isolation. Other sectors such as the non-profit sector are also an important part of the equation and work as an interface between the government and the people, but to a lesser degree between the private sector and the people. In many situations civic society organizations may play a broader role within a larger alliance. They can balance the public and commercial interests and represent constituencies that have no voice in either setting policy or in shaping the market. Civic organizations could add value in terms of consumer protection, public education, media services, and research, as well as local commodity delivery. Best practices in public-private-people partnership creation and management are needed to enhance nutrition programmes at the national and regional level.

Conventional and unconventional partnership opportunities

Governments, businesses and non-profit sector can engage in several types of collaborative arrangements for public good. For ease of understanding, these can be arranged into three categories:

Core business engagement These are engagements where the private sector contributes to public good through the redesign and marketing of its products and services:

- ❑ fortifying staple foods with nutrients is an example of a collaboration that should be led by the public sector in active consultation with the private sector. It would identify the deficiencies to be addressed, the foods to be fortified, levels of nutrient addition and standards to which they should be fortified. The initiative should also set clear norms for quality assurance, product certification, product promotion, social marketing, monitoring and evaluation
- ❑ producing and marketing industrially produced fortified complementary foods targeted at 6-24 month infants could ensure higher energy density, protein quality and micronutrient bioavailability, along with safety and convenience. With government encouragement and guidance, the food processing sector could produce nutrient-dense low bulk complementary foods at affordable prices and at a fraction of the price of branded infant foods
- ❑ collaborating with governments to produce processed foods for distribution in public institutional feeding programmes
- ❑ developing fairly priced nutritional supplements. Experience in several South East Asian countries like Vietnam, Thailand and Indonesia has shown

Partnerships should fundamentally be a means to setting standards or a level playing field—to ensure that everyone complies with that norm.

that people are increasingly able and willing to purchase nutritional supplements if they are properly developed, fairly priced and encouraged by the government

- Collaborating with the public sector to lower the prices of such conventional foods such as fish, dairy products and land based crops of nutritional significance. For example, corporate experience can be helpful in designing and carrying out projects for more effective processing, storage, transport and distribution
- donating genetic information patents held by private corporations to the public domain. This could support the improvement of nutritional quality of a range of cereal and tuber crops.

Supportive partnerships These are partnerships in which the private sector offers services not necessarily central to its business actions:

- corporate distribution facilities can be used to market low cost foods produced under government programmes
- skills of private industry can be marshalled to devise education programmes that create greater nutrition awareness
- industrial research capabilities and facilities can be made available for government programmes.

Philanthropy In addition to private sector involvement in marketed products, there are growing instances of private philanthropic support for nutrition where the donors do not have a direct connection or interest in the food and pharmaceutical industry:

- recent examples include support from the UN Foundation created by Ted Turner for a range of preventative health and population programmes; and
- support from the Bill and Melinda Gates Foundation to establish the Global Alliance for Improved Nutrition (GAIN)⁶
- private voluntary organizations, such as Rotary International, have been key partners in the Universal Child Immunization effort
- Lions Clubs have done yeoman service to deliver eye care
- Kiwanis International has adopted the elimination of IDD as its global service project and raised in excess of US\$ 75m to support the effort.

Can we draw these and other organizations to expand their support to nutrition programmes?

The way forward

In an increasingly interconnected world it is impossible for any sector to work in isolation. Therefore, in order to advance the health and well being of their people, countries need to be creative in bringing together the private sector, governments, capital, information, consumers and talent in networked coalitions to work for public good.

To put a moratorium, or even abandon the partnership

concept, as suggested by some⁷, loses sight of the contribution that can potentially be made by portions of the private sector, given their vast distribution networks, their management experience, their technologies, their research capacity, and their skills in achieving behavioural change.

What are the alternatives, particularly given the very limited capacity of public institutions in many developing countries and the fragility of many governments? If not such partnerships, what? If not us, who will accept responsibility for the unnecessary suffering that may result to those who otherwise would have benefited but now will not?

The challenge, therefore, is for everyone to consider how to channel the capacities of the private sector—and the huge potential for good—in a constructive and responsible manner. Clearly adequate regulations by both governments and international bodies on public-private partnerships must be in place to prevent any actions that might in any way detract from the goal of reducing malnutrition. Along with such checks and balances, both government and industry need to devote more energy and ingenuity to building such an alliance that could exploit the potential for common good and ensure a significant corporate contribution to improve the condition of malnourished people.

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MG Venkatesh Mannar, President, Micronutrient Initiative, vmannar@micronutrient.org

Global public-private 'partnerships' how do we ensure that they are in the public interest?

Judith Richter

In response to the paper by Mr Mannar, this paper is entitled *Global public-private partnerships: how do we ensure that they are in the public interest?* This title is used in order to encourage the reader to look at the broader picture: how might the promotion of this policy paradigm affect the interests of the world's citizens?

Mr Mannar states that those who are critical of the public-private partnership trend are following "outdated mental models." He implies that those who call for abandoning the promotion of public-private 'partnerships' for health and nutrition will have to take responsibility for causing "unnecessary suffering...to those who...would have benefited but now will not."

But:

- are there truly no alternative policy models to achieve better nutrition, in particular for the marginalized and vulnerable people of this world?
- are advocates for public-private partnerships paying enough attention to the potentially negative effects of this paradigm?

What negative impacts may be seen, for example, on efforts to reduce commerciogenic malnutrition in its many forms? Among the key issues to be mentioned are the exponential increases in obesity appearing in both rich and poor countries, the deaths of millions of infants due to commercial interference with breastfeeding, and hunger among the least powerful people caused by neoliberal global restructuring (often known as structural adjustment policies and/or corporate-led globalization).

The current debate is not just about the terms applied to these relationships. Much of the debate is about the impact that promotion of this policy paradigm may have on the role of UN agencies in policy-making, norm-setting and advocacy for the interests of the impoverished and most vulnerable.

Some points in Mr Mannar's paper may shed a different light on the interactions commonly represented under the heading of public-private partnerships.

Defining public-private partnerships?

The first question that arises in this debate is what is understood by the term public-private partnerships. Mr Mannar starts his article with an outline of the public and private actors in the nutrition arena. Yet, no definition of 'public-private partnerships' is provided in the paper.

This is not uncommon. Many may take for granted general terms such as human rights, democracy, and civil society. However, even though many UN leaders have been promoting closer interactions with the commercial sector and wealthy business figures under the

partnership label for years, there is in fact no single agreed-upon definition within the UN system¹.

A definition for public-private partnerships will not be put forward here, but implicit in the conventional sense of the word 'partnership' is both equality of power and congruence of purpose^a.

Yet, as Mr Mannar rightly points out, interactions with corporations are not risk-free endeavours, automatically beneficial to the public. He calls attention to the limits for business actors, namely that they "can undertake socially responsible ventures of significant magnitude only if they will be profitable and generate value..." This is a point which is all too often overlooked in the literature on this topic.

If joint ventures must create profit for companies, would it not then make sense to continue this train of thought to its logical conclusion and simply discard 'partnership' as an overarching term? This would accord with Mr Mannar's valuable suggestion to think about many public-private interactions as "strategic alliances" rather than as partnerships in the conventional sense.

Curiously, in the rest of his paper, Mr Mannar continues to refer to partnerships between the public and the private sector. He uses 'partnership'—not 'strategic alliances'—as an overarching term, which is then subdivided into three categories:

- core business engagements
- supportive partnerships
- philanthropy.

One way to continue responding to Mr Mannar's paper would be to examine and discuss in detail the various suggested nutrition alliances and fundraising deals. Instead, a different route will be taken. The aim is to move the polarized debates about the value of public-private partnerships forward. The most important step in this endeavour is to clearly distinguish between:

- public-private partnerships as a policy paradigm
- concrete public-private 'partnerships'/interactions^b.

This theoretical distinction helps to clarify the picture. It helps explain why it is perfectly reasonable—and in the public interest—to recommend abandoning the

^aOn the question of definitions, see, for instance, Ollila 2003a, pp. 42-43; and Richter 2003 p. 11; Buse and Walt 2002, pp. 42-48

^bBorrowing from Ollila, PPIs could be seen as the more general term. It simply refers to various forms of interaction between the private sector and the public sector, while the term PPPs for these cross-sector interactions implies "that the private sector is [in one way or another] included in an agenda setting, policy making and priority setting exercise." (Ollila 2003a: 43)

public-private partnership paradigm. It also helps look more closely at the nature of specific public-private interactions which, in turn, may clarify why it makes sense, for example, to ask for a moratorium in the creation of new so-called global health alliances^{2,3}.

Are these arrangements truly new?

Many people believe that the strategic alliances characterized as public-private partnerships are the innovative—or even inevitable—policy paradigm of the new millennium. This claim is reflected in Mr Mannar's statement that "in an increasingly interconnected world it is impossible for any sector to work in isolation."

Yet, this is one of the greatest misunderstandings. None of the critics of the public-private partnership paradigm argue that the public sector should not interact with the for-profit sector. They acknowledge that these sectors have always interacted, for example, when salt manufacturers were asked to comply with mandatory regulations on salt iodisation; when infant food manufacturers were asked to comply with the International Code of Marketing of Breastmilk Substitutes, or when UN Agencies tried to persuade transnational corporations to lower the prices of essential medicines and transfer their knowledge to industries in developing countries.

Many of the so-called public-private partnerships are in fact anything but new. Currently lumped together under this term are diverse categories of public-private interaction such as:

- ❑ fundraising—requesting or accepting corporate donations in cash or in kind
- ❑ negotiations or public tenders for lower product prices
- ❑ research collaborations which are, in fact, often publicly subsidized
- ❑ negotiations, consultations and discussions with corporations and their business associations (eg regarding their willingness to iodize salt)
- ❑ co-regulatory arrangements to implement 'voluntary' (legally non-binding) codes of conduct
- ❑ corporate social responsibility projects, many of which are cause-related marketing- or other strategic sponsorship projects
- ❑ contracting out of public services, such as water supplies.

Subsuming such widely differing issues as fundraising from transnational corporations and privatization of water supplies under a common label of public-private 'partnerships' not only makes little sense but obscures important distinctions.

What then is new?

The major novelty today is that civil servants and public-interest NGOs are asked to regard transnational corporations and their business associations as 'partners' and to interact with them in a spirit of 'trust.' Those charged with the public interest are now asked to regard many of these interactions as 'win-win' situations for both parties.

This is the 'new mental model' that underlies the public-private partnership policy paradigm. The problem with this paradigm is that relationships between the public and for-profit sector do take on a new quality. Instead of encouraging vigorous scrutiny of a specific fundraising deal or joint venture in terms of its comparative advantage and its potential harm to public interests, public actors are now asked to consider whether this interaction will be of benefit for the private for-profit sector party.

Safeguarding the public interest

The public-private partnership model generates two questions:

- ❑ which public interests may be unduly traded off in the new partnership relationships?
- ❑ what may happen if an old interaction—such as a fundraising relationship—takes place under the new public-private partnership paradigm?

UN civil servants interviewed by the author informed her that they are now often told that not going

for corporate money is 'unethical' because not obtaining those funds will harm the interest of children. What is the result of this new mandate?

The most well-known example of a new UN-business fundraising public-private partnership is the UNICEF-McDonalds arrangement of 2002. The McDonalds chain offered to collect money for UNICEF through a variety of activities in its fast food outlets. UNICEF, in turn publicized McDonalds as a restaurant chain that has a heart for children. UNICEF's press release quoted UN Secretary General Kofi Annan as saying: "Whatever our role in life, there is nothing that unites us and motivates us more than the welfare of children...public-private partnerships have the power to help children in many ways."⁴

In the end, this deal turned into bad publicity for McDonalds. Unfortunately, it also turned into bad publicity for UNICEF whose mission can only be supported.

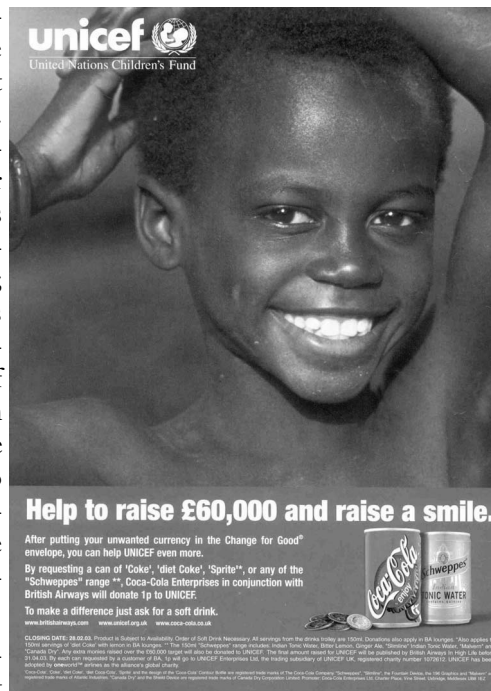


Photo 1

⁴The press-release disappeared from UNICEF's website as soon as first criticisms were voiced. For a reproduction see e.g. Richter 2003, pp. 50-51. For further reflections on the UNICEF-McDonald partnership, see also *SCN News*, December 2002, pp. 53-55

Many of us were therefore astounded when an advertisement, published in early 2003 in a British Airways Inflight magazine, called on British Airways travellers to request a Coke, Diet Coke, Schweppes or any other soft drink in the "Schweppes Range" in order to help raise £60,000 (Photo 1). For each can, Coca-Cola Enterprises, in conjunction with British Airways, would give a penny to UNICEF UK. To raise the promised amount, the passengers would have to request six million cans of soda.

This fundraising partnership was undertaken even though UNICEF and its national committees are bound by the UN Guidelines for Cooperation between the United Nations and the business community, which state that UN-business co-operation should "not imply endorsement or preference of a particular business entity or its products or services."⁵

In the view of the Director of UNICEF's Geneva Private Sector Division, this arrangement was not a product endorsement because UNICEF does not say 'Coca Cola is good for your health.'⁶

These examples may illustrate why many people are rightly concerned that public interests are being traded off when interactions with commercial actors take place under a partnership paradigm.

What are the alternatives to public-private 'partnerships'?

What then can be done to ensure that the public interest remains at the centre of all financial relationships, joint ventures and other interactions between UN agencies and the commercial sector or wealthy corporate donors?

The first step is to replace the public-private partnership policy paradigm with a policy paradigm that is centred on public-interest. This does not mean abandoning interactions between public and commercial actors. It requires coming back to the well-proven policy paradigm in which public-private relationships are seen as potentially problematic interactions between two separate spheres. It means being very clear about the purpose of business actors—which is to make a profit for their companies. It is about asking 'who wins what?', 'who risks what?', and about exercising appropriate caution.

The following measures can help to better ensure due diligence when the public sector is interacting with business actors, their political arms and wealthy corporate donors:

- re-name public-private partnerships as public-private interactions or similar, less value-laden terms
- identify the category or sub-category of the interaction that best facilitates identification of conflicts of interest; and
- establish clear and effective institutional policies

and measures that put the public interest at centre stage in all public-private interactions.

Another key measure is to examine concrete public-private initiative-types from a broad perspective, asking whether some of them are not too risky to engage in. The idea of increasingly financing the UN system through corporate funds, for example, needs to be much more widely questioned and debated: are the risks for the independence and integrity of the UN not too great?

A moratorium on new global health/nutrition alliances

Although many of the arrangements now termed public-private partnerships are anything but new, there are some newer types of public-private interactions. These include the so-called global health and nutrition alliances such as the Global Alliance for Improved Nutrition (GAIN). They also include high-level interactions between the UN and corporations, such as the Global Compact.

Some analysts have suggested looking at newer public-private linkages as social experiments⁷. But, these new arrangements raise the question of whether their price is not too high as well. GAIN, for example, was much criticized at its launch in May 2002. The main point of contention was that the World Bank website presented as GAIN 'partner' companies that had very questionable records and motives⁸.

Corporate partners included the transnational corporations Kraft Foods, Heinz, and Roche. Kraft Foods is a subsidiary of the tobacco giant Philip Morris, which is known for its plans to use the food company to undermine WHO's work on the Framework Convention on Tobacco Control. Heinz is known for violating the International Code of Marketing of Breastmilk Substitutes. Roche, Switzerland had just been fined one of the highest—if not the highest—fines in US and EU history for its role in setting up a micronutrient price-fixing cartel. The EU Commission found it particularly reprehensible that this company had thus inflated the prices of "substances which are vital elements for nutrition and essential for normal growth and maintenance of life."^{4,9}

GAIN's new Director asserts that these companies are not partners of GAIN. However, no explanation has yet been provided as to how these companies made it onto the World Bank website and how they could present themselves as GAIN partners in the *Wall Street Journal* article when GAIN was launched¹⁰.

GAIN follows the model of another global health alliance funded by Bill Gates: the Global Alliance for Vaccines and Immunization (GAVI). Like GAVI, and

The first step is to replace the public-private partnership paradigm with a policy paradigm that is centred on public-interest.

⁴For more information on GAIN at its launch, see e.g. Richter 2003, pp. 22-29. For GAIN's development since, consult, for instance, the GAIN website (www.gainhealth.org)

like the Global Fund to Fight AIDS, Malaria and TB, GAIN is legally independent of UN agencies. However, all these bodies are likely to affect global policies for years to come.

Problems which have been raised with respect to these global health alliances are the following:

- ❑ they tend to have a narrow focus. GAIN, for example, is called an initiative for improved nutrition, but its primary focus is on micronutrient fortification
- ❑ programmes are often implemented in a vertical way. This runs counter to the current trend towards broader approaches designed by asking recipients to define their own needs
- ❑ these alliances tend to give industry undue influence over public decision-making. For example, industry representatives are given voting rights on the top policy-making boards
- ❑ recipient countries are required to set up national co-ordinating committees that must include industry representatives—whether the countries want to or not
- ❑ the global health alliances tend to divert funds from established aid and development budgets
- ❑ there are many unresolved questions about the sustainability of these public-private initiatives once the catalyst funding has run out.

Broader risks for the UN System

The most problematic features, however, cannot be seen by just examining the details of a particular global health or nutrition alliance. A proliferation of these legally independent bodies may ultimately:

- ❑ distort and fragment national and international public policy agendas
- ❑ circumvent or dismantle the national and intergovernmental agencies and institutions that have dealt with these policy problems until now; and
- ❑ displace the public obligation to serve the most vulnerable and to develop locally appropriate solutions, by promoting institutional arrangements and activities that favour market-based thinking for public policy making, and larger over smaller Southern-based corporations.

The above concerns seem reason enough to call for a moratorium on the establishment of any additional major global health and nutrition alliance until the questions raised have been examined in a thorough, well-informed public debate.

Meanwhile, and as an urgent, short term measure to mitigate potential harm to public interest, UN agencies, recipient and donor countries, public-interest NGOs and citizens' alliances could join hands to request a restructuring of the existing GAVI-type alliances, both to ensure that they do not open doors to undue influence (of privileged members) of industry in public policy-making and to prevent a distortion and fragmentation of integrated public policies and programmes^c.

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*Dr Judith Richter, independent researcher and author,
judith.richter@attglobal.net*

^cA briefing paper for policy makers moreover recommended that currently "regular aid money should not be channelled to GHPPPs [Global Public-Private Partnerships for Health]. The researcher pointed out that "the initial aim of GHPPPs was to raise additional funding for development aid. (Ollila 2003a: 8) According to Ollila, "to date, the functioning GHPPPs have not presented sufficient evidence to justify their funding and there are grave concerns about their governance structure - the inclusion of corporations with vested interests in their decision making bodies and the lack of clarity on public accountability - that need to be addressed." (Ollila 2003b: 69)

Panel Discussion: Sustaining impact on a large scale: what are the lessons?

Questioning the evidence behind the effectiveness of a nutrition project in Bangladesh

Arabella Duffield

Save the Children UK (SC UK) believes the subject of the panel discussion is extremely important. SC UK's purpose is to ensure that scarce development dollars are not wasted and to ensure that it is contributing effectively towards the Millennium Development Goals.

SC UK has undertaken research looking at the effectiveness of large-scale nutrition projects in three countries: Ethiopia, Uganda and Bangladesh. Although this paper will focus on the Bangladesh project, the results of the other two country studies can be found in SC UK's publication, *Thin on the Ground* (see Publications in this issue).

The Bangladesh Integrated Nutrition Project (BINP) ran from 1995-2002. It was implemented by the Government of Bangladesh and cost US\$ 67m. The majority of the funding was obtained through a loan from the International Development Association. The project covered a population of an estimated 16m people in 59 *thanas*.

In terms of child growth, the project aimed to decrease severe underweight by 40% and decrease moderate underweight by 25% in children under two. The main project activities implemented to achieve these objectives were: community-based growth monitoring and promotion (GMP) and targeted supplementary feeding. Community-based growth promotion is defined here (according to the World Bank) as "the process of weighing a child, graphing the weight, assessing the growth and providing the caretaker with counselling and motivation for other actions to improve growth".

The BINP did have other components, including a maternal nutrition component. These will not be reviewed here. Food security activities were originally planned in the BINP implementation plan, but these largely did not take place.

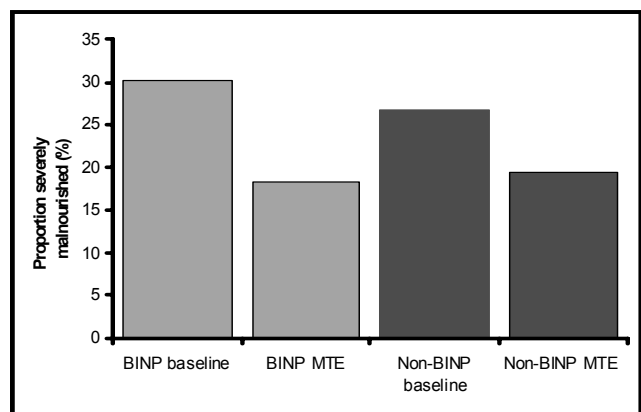
The BINP has been succeeded by the similar National Nutrition Project (NNP), which currently has a budget of US\$ 124m.

Before details of the BINP are discussed, some background information about why SC UK became involved in this work is given below:

- SC UK largely discontinued its GMP programmes over the 80s because it found that the absolute cost of the programmes was high, but the measured impact low. Even where an impact of a programme involving GMP was found, this impact

could normally be ascribed to the impact of another project component. For example, in Dhan Kuta in Nepal SC UK was able to demonstrate that the medical intervention, rather than the GMP, was creating the effect

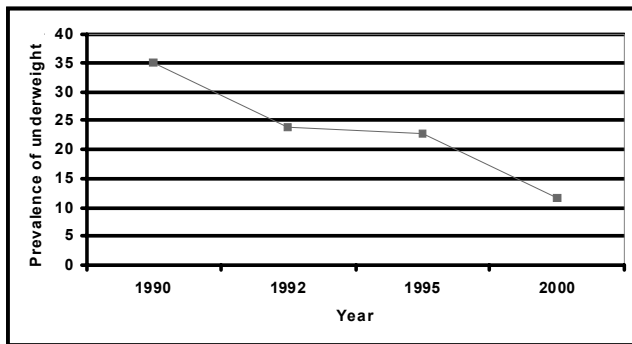
- since this time SC UK has conducted an ongoing review of the literature about GMP. It does not believe that there has been any convincing evaluation showing the effectiveness of GMP. The recent Cochrane review found insufficient evidence to support GMP¹
- the BINP programme came into SC UK's view in the mid-90s and SC UK has been involved in nutrition in Bangladesh for many years; and
- in 2001, SC UK co-convened a colloquium in Antwerp with the Institute of Tropical Medicine to examine the evidence base behind GMP. Again, no hard evidence was presented to support the hypothesis that GMP, as it is usually implemented in low income countries, is effective in reducing malnutrition².



Graph 1 BINP mid-term evaluation results

This paper will show that there is no firm evidence that the BINP has succeeded in its goals. In fact, SC UK sees this project as an example of a much wider problem. It is hard to find evidence that any large scale project that relies on GMP as the central strategy is contributing significantly to decreases in malnutrition.

Graph 1 shows the mid-term evaluation results of the BINP. This evaluation was conducted as part of the project's evaluation. The graph shows the prevalence of severe underweight (<-3 z-scores weight-for-age) in project areas and non-project areas at baseline (1995) and mid-term (1998) of the project's life for children aged 6-23 months.



Graph 2 Prevalence of severe underweight (<-3 z-scores weight for age) in children aged 6-23 months, 1990-2000

This graph shows that the rate of severe malnutrition has decreased in both the project and control areas. It appears that there is a greater decrease in malnutrition in the project areas, but SC UK has examined the mid-term evaluation quite carefully and it appears that it has several methodological problems. These include:

- ❑ a very small sample size at baseline (only 220 children under two in the control areas); and
- ❑ no statistical tests were presented in the report.

Unfortunately, because of these problems in the evaluation there is no way to tell whether or not malnutrition in the project areas decreased significantly more than the non-project areas.

In addition to the methodological problems, the evaluation report did not take into account the general improvements in nutritional status in Bangladesh. Graph 2 shows the prevalence of severe underweight (<-3 z-scores weight-for-age) in children aged 6-23 months between 1990 and 2000. This data is taken from the Bangladeshi National Nutrition surveys.

There has been a general decrease in the prevalence of severe malnutrition in Bangladesh during this period. Very briefly, the reasons for this appear to be:

- ❑ big changes in agricultural practices in Bangladesh. In particular, the introduction of a third crop in what used to be the hungry winter season has virtually eliminated the hungry season
- ❑ stabilization of rice prices
- ❑ an enormous increase in employment opportunities in Dhaka, chiefly due to expansion of textile

	Project (n=4,554)	Non-BINP (n=2,261)	P-value
Male HH	94%	95%	0.06
Formal education of Head of Household	42%	43%	0.74
Own land	42%	46%	0.20
Big bedroom	80%	82%	0.06
Lowest SES	15%	14%	0.35

Table 1 Save the Children UK's cross-sectional survey: household characteristics

	BINP (n=1,598)	Non-BINP (n=790)	P-value
Severe underweight (<-3 z-scores weight-for-age)	11.4%	12.2%	0.63
Moderate underweight (-2 and -3 z-scores weight-for-age)	35.2%	36.3%	0.62

Table 2 Save the Children UK's cross-sectional survey: Anthropometric results for children aged 6-23 months

- ❑ manufacture; and
- ❑ improved migration to Dhaka through the expansion of roads.

The BINP mid-term evaluation report did not mention these national trends in malnutrition. SC UK believes that these trends make it difficult to attribute the decreases in malnutrition to the project alone.

Given the problems described above with the BINP's mid-term evaluation and the fact that no final evaluation was undertaken despite a scale up of this project to a nation-wide project, SC UK decided to undertake a cross-sectional nutrition survey comparing the BINP and non-BINP areas.

A cross-sectional survey is not an ideal methodology for evaluating the impact of a project. However, there was no other choice because SC UK did not have access to any baseline data. In order to try and control for any socio-economic differences between the project and non-project areas, project and non-project areas were matched on a variety of socio-economic indicators.

The results of this matching can be seen in Table 1. At the household level no significant differences in the socio-economic variables between project and non-project areas were found.

The anthropometric results of SC UK's survey can be seen in Table 2. The nutritional status of children aged 6-23 months in the BINP and non-BINP areas were compared. There were no significant differences in the level of underweight between project and non-project areas after more than five years of project implementation. The same results were found for stunting and wasting: there were no significant differences between project and non-project areas.

Maternal knowledge and reported caring practices between the BINP and non-BINP areas were also compared. On the whole, mothers in the project areas scored better than mothers in the non-project areas. However, most of the differences were relatively minor. Some of these results included:

- ❑ examples of improved knowledge:
 - should give colostrum (63% vs 53%)
 - know benefits of iodised salt (68% vs 60%)
- ❑ examples of improved practices:

- give complementary foods at 5/6 months (57% vs 49%)
- use iodized salt at home (70% vs 63%)

Finally, SC UK examined some measures of project outcome in the project area. It was found that only 7% of mothers were able to correctly interpret the growth chart. Only 22% of children who were severely malnourished at the time of the survey were actually enrolled on the supplementary feeding programme. This finding was despite reports (from the project's own monitoring and evaluation records) that there was near universal enrolment in the GMP programme.

It was also found that 67% of women whose children had been enrolled in the supplementary feeding programme reported that they did not give the child any other food on the morning of the supplementary feeding. This finding implies that the supplementary feeding was used as a replacement feed.

In conclusion, SC UK believes that there is inconclusive evidence for the effectiveness of the BINP. Neither the mid-term evaluation, nor our survey, show conclusively that the project has achieved its objectives. More generally, SC UK believes that there is an absence of evidence in the literature for the effectiveness of any programmes of this kind.

SC UK's report calls for a much more open debate on this subject. There is a need for more serious and transparent efforts to monitor and evaluate these types of projects before further funds are committed.

SC UK's report, *Thin on the Ground: questioning the evidence behind World Bank-funded community nutrition projects in Bangladesh, Ethiopia and Uganda*, is available at www.nutritionnet.net. SC UK hopes that readers of the SCN will read the full report and leave comments on the website about the report's content.

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Discussion

Olivia Yambi (UNICEF): Before saying that programmes lack effectiveness, design issues need to be looked at. There needs to be a number of synergies operating at the same time in order to improve the nutrition situation. Further, are the indicators being looked at the right ones? In growth monitoring and promotion, unless the Triple A process is completed—ie assessing through weighing, analyzing why the weight is what it is, and taking actions that are relevant and linked to existing capacities in the household or enhancing those capacities—we are setting ourselves up for failure. Lets look at what else happened to produce your results.

Emorn Wasantwisut (UNU): This is not unique to the Bangladesh programme—per se. Governments of developing countries took huge loans to fund nutrition programmes, using external experts and in the end the capacity of their project staff was not better off and the countries were heavier in debt. It is unethical to let this keep happen-

ing. In the beginning, the BNIP requested technical assistance in the form of training from Mahidol University, but this was never followed-up in full. The SCN should take a look at these issues because the new national nutrition programme will probably face the same fate and the Government of Bangladesh will go into more debt.

Meera Shekar (World Bank): The main messages in Dr Duffield's presentation were that there are differences in the process indicators, knowledge in BNIP and non-BNIP areas, and practices such as breastfeeding, complementary feeding practices and iodized salt. But what was not shown in the Save the Children data was enough evidence on weight and height. The BNIP midterm evaluation was actually done two years after programmes were started and we all know what it takes to bring a project to scale of that size in a very large population. Perhaps what is needed is some time for the programme to work. The end line evaluation is currently ongoing and the World Bank is committed to strengthening the quality of the evaluation.

Would Dr Duffield explain the logic in using cross-sectional data presented in two *thanas* that have similar socio-economic characteristics at one point in time and make conclusions from that about changes over time?

Urban Jonsson (UNICEF): First, it is surprising that growth monitoring is used as an example of what does not work, instead of looking at what does work. Growth monitoring works in many places, it is a wonderful approach, and evaluators should evaluate when it does work and why it works when it does.

Arabella Duffield: Most of the questions or comments revolve around three topics: survey methods, programmes that do not work, and indicators.

Survey methods: The midterm evaluation data I presented earlier was BNIP's own, paid for by the Bangladeshi Government and the World Bank, and did not involve SC UK. It was undertaken two years after the programme started. SC UK has been obliged to present this evaluation data because to date the World Bank/Government of Bangladesh have not undertaken a final evaluation, even though the new national nutrition programme has already started.

We undertook our own evaluation to draw more attention to the fact that the BINP was not evaluated properly before national scaling-up. Our cross-sectional evaluation was conducted six years into the project. SC UK is fully aware that our survey is not able to show conclusively that the BNIP did or did not work. Yet, the data we have shown are not invalid; they represent the nutritional status of two very similar groups of people—one group exposed to the programme for five years and one group not. There is no difference in these groups' nutritional status.

Programmes that do not work: A more surprising question is why *isn't* the nutrition community interested in why programmes do not work? These are big loans—in Uganda the budget is US\$ 40m and Ethiopia US\$ 22m. The BINP cost approximately US\$ 67m, but a new loan for approximately US\$ 125m has been signed for the national scale-up. We believe the World Bank and others must show that their current nutrition programmes work before funding new ones. Currently we know of no evidence that shows that these large scale growth monitoring programmes are achieving their goals.

Indicators: The BINP and other World Bank funded nutri-

tion programmes explicitly define anthropometric objectives and outcomes. SC UK is measuring the effectiveness of these programmes by assessing whether or not their objectives have been met. We believe that governments partly buy into these programmes because the objectives are so impressive (for example, reduce severe underweight by 40%). If the World Bank believes that these programmes will actually have more effect on other indicators than they should change the programmes' objectives. Maybe governments will then be less interested in buying into the programmes.

Finally, SC UK believes that nutrition can be used as an outcome for many programmes—such as water and sanitation programmes—and that the nutrition community should not only be focusing on these very direct interventions to improve nutrition.

Dr Arabella Duffield, consultant for Save the Children UK, arabelladuffield@aol.com

Nutrition intervention programmes in Vietnam: scaling-up and challenges

Nguyen Cong Khan

Over the past 20 years, since the establishment of the National Institute of Nutrition (NIN), the development of nutrition policy has gained increased attention by researchers and policy-makers in Vietnam. Epidemiological studies and community diagnosis of problems such as protein-energy malnutrition, vitamin A deficiency and xerophthalmia, and iron deficiency anaemia have provided scientific evidence and rationale for nutrition activities. Based on these studies, the NIN has proposed many suggestions to solving nutrition problems in Vietnam.

In 1995, the Prime Minister ratified the first document on nutrition policy in Vietnam, the Plan of Action for Nutrition (1996-2000). Later, nutrition objectives were incorporated into the socio-economic development agenda of the country, including each locality and sector. The government, international agencies, and NGOs have invested in many projects in order to achieve these objectives. Many important nutritional objectives were actually achieved by 2000. Following the period of 1996-2000, the National Strategy for Nutrition (2001-2010) was adopted. It is a policy document that gives direction to food and nutrition action with comprehensive objectives proposed for the first decade of the 21st century.

Nutrition activities in Vietnam in the last decade

For a long time, the Government of Vietnam has paid increased attention to the improvement of dietary intake and the nutritional status of the population. In the 80s, in parallel with a study on determining the nutritional problems in Vietnam, nutrition interventions were carried out, which included food supplementation. Since the 90s, and particularly after the International Conference on Nutrition (ICN) in 1992, many nutrition projects were scaled-up and achieved encouraging results.

Ensuring household food security by producing locally available food through the VAC ecosystem initiative

Ensuring household food security is a key factor in the strategy for nutrition improvement in Vietnam. VAC (acronym of Vietnamese words Vuon—garden - Ao - and Chuong—cattle-shed) has existed in Vietnam

since the early 80s. It was introduced as a practical and traditional approach, providing more food for families. VAC has been widely accepted in rural areas and nationwide. The horticulture association, VACVINA, has disseminated techniques for VAC development in many areas, including poor rural and mountainous areas. This activity has resulted in not only providing food for family meals, but also increasing families' income and improving families' economic status.

Activities to provide locally available food, in conjunction with improving nutrition knowledge, were coordinated with FAO. The evaluation of these projects indicated that the VAC ecosystem, along with nutrition education, has had a good impact on the nutritional status of children and dietary diversification of families.

In addition to the household food security improvements mentioned above, several projects for agricultural reform and poverty alleviation have been implemented. The Ministry of Agriculture and Rural Development has implemented the national food security programme and the food insecurity monitoring system (FIVIMS). In 2002, the Ministry published "Vietnam Food Balance Sheet" as the basis for proposing its macro-policy on food security.

Nutrition education and capacity building activities within the Plan of Action for Nutrition (1996-2000)

The 1992 ICN acknowledged that hunger, poverty and lack of knowledge were the fundamental causes of malnutrition. The Vietnam National Plan of Action for Nutrition stressed the need for nutrition education for targeted groups in the population and considered nutrition education and capacity building as its key activities. Hence, the NIN established the nutrition education and communication centre. This centre has regularly published, "Nutrition and Development" with four volumes per year and delivered to all communes nationwide. Since 1996, nutrition education campaigns via mass media have been organized annually, including "Micronutrient Day" and "Nutrition and Development Week".

It is worthy to acknowledge the close cooperation be-

tween the health sector and social organizations, line ministries and other sectors in disseminating nutrition education for targeted groups such as health workers, agriculture staff, teachers, women and school children. Further, the Government of the Netherlands has supported two projects, “Information-Education-Communication” and “Building capacity for the effective implementation of the National Plan of Action for Nutrition.”

Ensuring the resources for the implementation of the National Plan of Action for nutrition was an important task. In addition, implementation activities and personnel training was improved at all levels. In 1994, the NIN was acknowledged by the SEAMEO-TROPED as the cooperation centre for community nutrition. A project supported by FAO contributed to the Master of Science in community nutrition (in cooperation with the Hanoi College of Medicine) and a multi-sectoral training programme. This project trained staff from different sectors such as health, agriculture, planning, education and members of social organizations at provincial and district levels. Personnel training has contributed greatly to the development of food and nutrition networks in provinces and nationwide.

Micronutrient deficiency control and prevention

VITAMIN A CONTROL AND PREVENTION Between 1985-87, an epidemiological study on vitamin A deficiency (VAD) was carried out by the NIN and the Institute of Ophthalmology. It showed that VAD and xerophthalmia were significant public health problems in Vietnam. An intervention programme was started experimentally in seven districts in 1988. By 1993, it was expanded nationwide with the support of UNICEF. The main strategy was a high dose of vitamin A supplementation in addition to nutrition education and strengthening the VAC ecosystem which provided locally available vitamin A-rich foods. An FAO project incorporated nutrition education and vitamin A and carotene rich foods for households.

In 1994, a national survey showed that xerophthalmia decreased remarkably under the WHO cut-off point as a public health problem and has been maintained since.

At present, the high dose vitamin A supplementation for children 6-36 months and post-partum mothers is maintained in parallel with nutrition education, and promotion of consumption of vitamin A rich foods. The annual micronutrient days on 1-2 June has become a routine activity of the health sector's agenda. UNICEF has played a great role in VAD control and prevention programmes in Vietnam, while all localities have invested their budget and personnel for the implementation of the micronutrient days and other activities.

NUTRITIONAL ANAEMIA CONTROL AND PREVENTION Nutritional anaemia is a significant public health problem in Vietnam. The national survey on anaemia and nutritional risk factors conducted in 1995

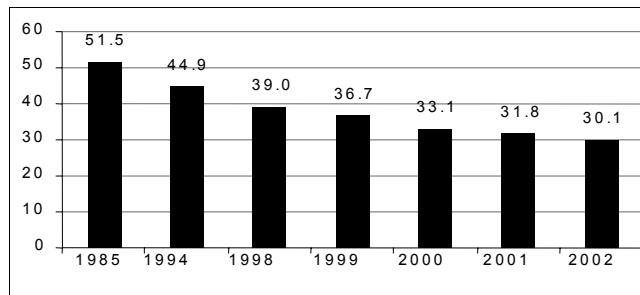


Figure 1 Malnutrition prevalence among children under-five years. Source: NIN, Nutrition Surveillance, 2002

showed a high prevalence of anaemia among reproductive age women (52.7% of pregnant women and 40.2% of non-pregnant women) and children under two (60%).

The nutritional anaemia control and prevention programme was set up in 1993. It began in 100 communes of 10 experimental districts, and its systematic implementation has continued since 1996. The key intervention of the programme is iron/folic acid supplementation of pregnant women. By 2001, the programme was expanded in 61 provinces nationwide, covering 126 districts for a total of about 500 districts (iron tablets have been funded by UNICEF). In addition to iron supplementation, education and communication of nutritional anaemia, control and prevention has been strengthened in all provinces. Many health units in the area without programmes have carried out the iron supplementation for pregnant women with different sources of iron tablets. Iron deficiency anaemia control and prevention has been incorporated into the VAD control and prevention programme. Research on the feasibility of social marketing of iron tablets for reproductive age women was supported by WHO, while ILSI has assisted in implementing research on efficacy and effectiveness of iron fortified fish sauce. Those studies have directed the selection of effective and sustainable measures for anaemia control and prevention in Vietnam.

IODINE DEFICIENCY DISORDER (IDD) CONTROL AND PREVENTION Since the 70s, Vietnam has carried out a goitre control and prevention programme. In the 90s, there were many studies that showed the extent of IDD in Vietnam. In 1995, the strategy for universal iodized salt was approved by the Government and in 1999, the Government issued the decree, “all salt must be iodized.” Presently, the coverage of iodized salt is about 60-80% of households in the country. Monitoring activity has improved, which shows improvement in IDD control.

Child malnutrition control and prevention

Since the beginning of the 80s, the NIN has conducted 25 surveys on children's nutritional status, household food intake and food habits in different ecological areas in Vietnam. These surveys provide the scientific rationale for the development of complementary food projects, as well as the Plan of Action on Nutrition.

The child malnutrition prevalence was 51.5% in 1985 but decreased to 44.9% in 1994 (Figure 1 previous page).

In 1994, the Government approved the national programme for child malnutrition control and prevention, implemented by the Committee for Child Care and Protection (today run by the Committee for Population, Family and Children). Between 1994-1997, the programme focused on nutrition education and nutrition rehabilitation for severely malnourished children with coverage in over 2,000 communes (a total of more than 10,000 communes over the country). Since 1998, the programme has been shifted to the Ministry of Health and re-designed to cover all communes nationwide. It also focuses on preventative nutrition care, meaning that all children are cared for, with priority given to children under two years and pregnant and lactating mothers. The programme provides mothers demonstrations of weaning food and has improved the effectiveness of the nutrition education carried out by nutrition collaborators at the community level.

The progress in socio-economic development, hunger elimination and poverty reduction, as well as other primary health care activities, have brought about a reduction of child malnutrition in the past years.

Ensuring food hygiene and safety

In February 1999, the Prime Minister of Vietnam created the Food Administration (FA) under the Ministry of Health. For the first time there was a government agency addressing food hygiene and safety control. Each April, the FA organizes a mass campaign for the promotion of food hygiene entitled, "Month of action for ensuring food hygiene and safety." The FA has cooperated with related sectors in developing documents, regulations, and norms and standards on food hygiene and safety. A network of food hygiene and safety control has been set up in all provinces building onto the provincial health centre. Although there were positive changes in the perception and practice of food hygiene and safety of the food producers, consumers have reported many problems needing to be resolved.

The National Plan of Action for Nutrition (1995-2000) and the National Strategy for Nutrition (2001-2010)

In 1995, National Plan of Action for Nutrition (1995-2000) was ratified. This was considered to be the first document on nutrition policy in Vietnam with a multi-sectoral approach. The Ministry of Planning and Investment was assigned as the executive body and the NIN as the national focal point. Thanks to this plan, nutrition has been incorporated into the socio-economic development agenda of the government and each locality. Some nutrition programmes are being supported by the government and being scaled-up nationwide, such as the child malnutrition control programme.

The National Strategy for Nutrition (2001-2010) was ratified in January 2001. The Government has as-

signed the Ministry of Health to act as the executive body, taking responsibility to cooperate with other related sectors and international agencies and develop, coordinate and evaluate the strategy's implementation. A steering committee for nutrition was also established at each administrative level. At the national level, the committee is led by the Minister of Health and at the local level by the vice president of the province. A master plan for the Strategy is now under development.

Main achievements, constraints and challenges in scaling-up in Vietnam

The government has ratified the nutrition policy document in the spirit of multi-sectoral cooperation, with nutrition goals integrated into the socio-economic development agenda. This nutrition policy was important for governments at the local level to increase their budgets and personnel, and for international organizations, NGOs, and others to support nutrition activities. It was acknowledged that nutrition education and communication activities have achieved a remarkable progress toward improving people's knowledge and nutrition practices. Mass education campaigns such as "Micronutrient Day" and "Nutrition and Development Week" have been well organized and have received positive responses from society.

However, there are many difficulties and challenges in scaling-up nutrition activities. The nutrition strategy has not been disseminated widely at all levels, particularly at in the grassroots authority. The leaders of the Party, local authority and the health sector need to understand why continued commitment to nutrition is important not just in the short term. Proposed nutrition objectives are not easily obtained in such a short amount of time.

Multi-sectoral and multi-organizational cooperation remains embarrassingly low, while it is important for each sector to have a concrete plan for nutrition. It is also noted that there is no specific and realistic comprehensive master plan for the implementation of a large scale nutrition strategy. In addition, nutrition education and communication activities have not been sufficiently addressed in order to target behaviour change in populations. And the implementation network at all levels needs to be strengthened in aspects of organization, capacity and budget.

In general, the allocated government budget for nutrition programmes is still modest, while international support has not increased. Implementation, monitoring and evaluation are also still weak. This does not contribute to a work plan for implementing the nutrition strategy. Instead, systematic nutritional surveillance should be implemented.

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Dr Nguyen Cong Khan, National Institute of Nutrition, nckhan@bn.vnn.vn

Lessons learnt from the national programme for food and micronutrients supplementation in India

Prema Ramachandran

At the time of independence, India faced two types of nutritional problems. One was the threat of famine and acute starvation due to low agricultural production, lack of buffer stocks and an appropriate food distribution system. The other was chronic macro- and micronutrient deficiencies due to low dietary intake because of poverty and low purchasing power. Recovering from the horror of the Bengal famine, India adopted a multi-sectoral, multi-pronged strategy to combat these problems and to improve health and nutritional status of the population. The Constitution of India has set elimination of poverty, ignorance and ill health as three important goals. Successive Five-Year Plans in India laid down the policies and strategies for achieving these goals and provided the needed funding for implementing the programmes.

Given India's vast and diverse population, several of the states and institutions have carried out numerous smaller scale food/nutrient supplementation programmes. In this paper, four national level food/micronutrient supplementation programmes are reviewed mainly to present the lessons learnt and applied in the Tenth Plan.

Integrated child development services (ICDS)

The ICDS scheme was initiated in 1975 to:

- improve the health and nutrition status of pregnant and lactating women, and children in the 0-6 age group by providing supplementary food and appropriate health care through coordination with state health departments
- provide conditions necessary for preschool children's psychological and social development through early stimulation and education
- enhance the mother's ability to provide proper child care through health and nutrition education
- achieve effective coordination of policy and implementation among the various departments to promote child development.

The central government bears the infrastructure and manpower cost of the ICDS programme. The state governments are responsible for funding the nutrition component. In addition, CARE, WFP and other agencies provide food supplements in selected blocks of some states.

Under the ICDS programme, food supplements are being provided to pregnant and lactating women who come to *anganwadis*. The reported coverage is between 15% and 20% in most blocks. The women who receive supplements are not chosen on the basis of their nutritional status and, therefore, may not be the neediest ones. Even those who come to the *anganwadi* may not be able to come regularly. In addition, food supplements at *anganwadi* might be a substitute rather than additional supplements to home food.

There has been no evaluation of this component of the ICDS. Data from nutrition surveys indicate that there has been no significant decline in maternal undernutrition over the last three decades. Global and Indian data indicate that when food supplements are provided without screening, targeting and monitoring, the improvement in maternal nutrition, and birth-weight, if any, is very limited.

Another major problem is how to reach food supplements to undernourished women. Even when the logistics of reaching women is meticulously worked out and efficiently carried out, food sharing patterns within the family results in the 'targeted' women not consuming the supplements in significant quantities. This is one of the factors responsible for the lack of beneficial effect. The lack of adequate antenatal care and continued physical work during pregnancy are two other factors that may be responsible for the lack of impact.

Food supplementation for preschool children through ICDS

Preschool children constitute one of the most nutritionally vulnerable segments of the population. Their nutritional status is considered to be a sensitive indica-

tor of community health and nutrition. Improving children's nutritional status was one of the major objectives of the nutrition component of the ICDS. The emphasis was initially on providing cooked food through on-the-spot feeding in *anganwadi*, which was to ensure that targeted child would not share food supplements with other members of the family. The *anganwadi* centres would also provide practical nutrition education to women on cooking and feeding young children.

The preschool children's nutrition component of the ICDS programme has been evaluated by a number of organizations including: the Nutrition Foundation of India (Delhi), National Institute of Public Cooperation and Child Development (Delhi), and the National Council of Applied Economic Research (Delhi). In addition, there have been several small-scale evaluations. The reviews show:

- ❑ ICDS services were much in demand, but there are problems in delivery, quality and coordination
- ❑ the programme might be improving food security at the household level, but does not effectively address the issue of prevention, detection and management of the undernourished children and mothers
- ❑ children in the 6-36 months age group and pregnant and lactating women do not come to the *anganwadi* and do not get food supplements
- ❑ available food is shared between mostly children in the 3-5 years age group irrespective of their nutritional status
- ❑ even though growth monitoring is an essential component of ICDS, this component has not been fully operationalized; there is no focused attention on the management of severely undernourished children
- ❑ no attempt in made to ensure that all children are weighed, the children with severe chronic energy deficiency are not identified and offered double the rations as envisaged in the ICDS guidelines. As a result, there is very little focused attention on the correction of undernutrition, prevention and management of health problems associated with moderate and severe undernutrition
- ❑ childcare and nutrition education of the mother is poor or non-existent
- ❑ gaps in the training and knowledge of *anganwadi* workers existed
- ❑ supervision of the programme, community support and inter-sectoral coordination is poor.

Micronutrient deficiencies

Anaemia, iodine deficiency, and vitamin A deficiency (VAD) are recognized as major public health problems in India. Specific national programmes have been initiated to prevent and control these deficiencies. Over three decades have elapsed since their initiation, but prevalence and the adverse consequences of anaemia have remained essentially unaltered during this period. Kerato malacia due to severe VAD is no longer a public health problem; yet the decline in VAD and IDD

has been slow.

National anaemia prophylaxis programme

Reported prevalence of anaemia in the general population in India is among the highest in the world. Prevalence of anaemia among pregnant women ranges between 50% to 90%. The high prevalence of anaemia is due to:

- ❑ low dietary iron and folic acid intake
- ❑ poor bio-availability of iron in phytate fibre-rich Indian diet
- ❑ infections such as malaria and hookworm.

Though no segment of the population is free from anaemia and its adverse health consequences, available clinical and epidemiological data indicate that the prevalence of anaemia and its health consequences is highest in pregnant women and preschool children. In 1973, the National Anaemia Prophylaxis Programme began distributing iron and folic acid to all pregnant women and preschool children. It was felt that since anaemia was so widely prevalent and facilities for screening for anaemia was not available, untargeted distribution was appropriate.

Initially, the coverage of pregnant women and children under the programme was poor due to the lack of primary health care infrastructure and manpower. Even those who received the tablets did not continue to take them either because they did not realize the importance of regular intake or because of the side effects. The irregularity in tablet supply and lack of perceived benefits of regular tablet intake also contributed to low coverage. Unlike the situation elsewhere in the world, oral iron therapy is not effective in correcting moderate or severe anaemia in Indian pregnant women because of poor bio-availability of iron in the Indian diet. Pregnant women with Hb between 5-8g/dl in their second trimester may have to be administered appropriate doses of parenteral iron and oral folic acid. As a result of all these factors the prevalence and the adverse consequences of anaemia in pregnancy have remained essentially unaltered over the past three decades.

Iodine deficiency disorders (IDD)

Available data suggest that there has been a substantial increase in the availability and consumption of iodized salt during the 90s. However, the National Family and Health Survey showed that even in the late 90s only 49% of households used cooking salt that was iodized at a recommended level of 15 ppm or more. About 28% of the households use salt that is not iodized at all and 22% use salt containing less than 15 ppm of iodine. The data shows that in coastal states like Tamil Nadu, Andhra Pradesh, Kerala, and Gujarat the percentage of households consuming adequate iodized salt is much lower than in many of the northern and north-eastern states where the availability of iodized salt is more than 90%. One reason for this could be the salt transported by road is not subject to any kind of check regarding iodization. This loophole in the law permits transport of non-iodized salt by road to

areas up to 250 km.

National prophylaxis programme against nutritional blindness

In an attempt to improve the coverage of vitamin A distribution—especially in the vulnerable six to 23 months age-group—the Government of India decided to link up vitamin A administration to the ongoing immunization programme during the Eighth Plan. Under the revised regimen, a dose of 100,000 IU of vitamin A was to be given to all infants at nine months along with measles vaccine. A second dose of 200,000 IU was to be administered at 18 months of age along with booster dose of DPT and OPV. Subsequently, the children were to receive three doses of 200,000 IU of vitamin A every six months until 36 months of age.

The reported coverage figures under the modified regimen indicated that there were some improvement in coverage with the first dose (50% to 75%). However, the coverage for subsequent doses was low. During the Ninth Plan, attempts were made by some states to improve the coverage for the second and subsequent doses by linking the administration of vitamin A with pulse polio immunization. Orissa reported improved coverage without any adverse consequences; but this could not be replicated elsewhere. Assam reported that some of the infants who received vitamin A along with pulse polio developed problems that had an adverse effect on coverage under both the programmes.

Available data from National Nutrition Monitoring Bureau (NNMB) indicates that over the last three decades there has not been any substantial increase in the dietary intake of vitamin A. In spite of the poor coverage under the programme and continued low intake of vitamin A rich food stuffs, there has been a substantial reduction in the prevalence of blindness due to vitamin A deficiency from 0.3% in 1971-74 to 0.04% in 1986-89. Repeat surveys carried out by the NNMB indicated that the incidence of Bitot's spots has also declined.

The Tenth Plan strategy and goals

The Tenth Plan envisages a paradigm shift from:

- household food security and freedom from hunger to nutrition security for the family and the individual; and
- untargeted supplementation to screening of all persons from vulnerable groups, identification of those with various grades of undernutrition and their appropriate management.

A national nutrition mission was established with the objective of achieving rapid reduction in undernutrition and reduction/elimination of micronutrient deficiencies of iron, iodine and vitamin A. The mission will ensure that there are focused and comprehensive interventions aimed at improving the nutritional status of the individuals. This in turn will enable the country to achieve rapid reduction in severer forms of undernutrition and ill health, which will lead to improved nutritional and health status of the population.

In order to accelerate reduction in the severer grades

of undernutrition and health hazards associated with it, the Tenth Plan envisages a change in strategy for prevention, detection and management of macro- and micronutrient undernutrition.

For the prevention of undernutrition, the strategy is:

- nutrition education through *anganwadi* workers
- administration of massive dose of vitamin A in April and October to children ages 18, 24, 30 and 36 months by the *anganwadi* workers under the supervision of the auxiliary nurse midwives (ANM).
- organization of immunization and maternal and childcare at the *anganwadi* on a fixed date at least once a month
- use of *anganwadi* workers as depot holders for iron and folic acid tablets and distribution of ORT when required in the village
- promotion of universal use of iodized salt and organizing testing home salt for adequacy of iodization.

For detection and management of undernutrition, the strategy is:

- ensuring that all children in the age group 0-6 years are weighed at least four times a year and children suffering from grade III and IV undernutrition are identified
- weighing all pregnant and lactating women and identifying those with body weight less than 40kg. These women will be provided with food grains for the remaining period of pregnancy/lactation or until they cross the cut off point
- organizing antenatal and child health clinics for screening of vulnerable population, early detection and effective treatment of anaemia, VAD and IDD.

The Tenth Plan has also set specific nutrition goals to be achieved by 2007. Massive interstate/interdistrict differences in availability and access to the nutrition related services and in nutritional status of the population means that state specific goals for 2007 have evolved based on the current level of these indices. The Tenth Plan's goals for the country have been derived from the state specific goals. The progress achieved in terms of process and impact indicators will be reviewed yearly and if necessary goals, may be reset at the time of mid-term appraisal.

A full copy of the Tenth Plan can be found at www.planningcommission.nic.in

Dr Prema Ramachandran, Health and Nutrition Adviser, prema_ramachandran@yahoo.int

Key factors in sustaining the impact of nutrition programmes: an example from Southern Africa

David Sanders

This paper covers an example of child health, nutrition and poverty in South Africa. An illustrative case study is presented on child nutrition in rural South Africa, which highlights the role of research, training and advocacy in sustaining nutrition programmes.

Nutrition situation in South Africa

The top causes of infant death in both poor and rich magisterial districts in South Africa are diarrhoea and low birth weight. In South Africa about 23% of children are stunted and stunting rates are related inversely to incomes of households. A high percentage of children have a daily intake of key nutrients (i.e., energy, zinc, calcium, iron, vitamins C and A) that is substantially less than recommended. The above nutrition situation is apparently discrepant with the fact that South Africa is a middle-income country. But this is explained by the extremely skewed income distribution in the country, with over 60% of households having an income of less than R1,000 per month (approximately US\$ 100).

Immediately after the first democratic elections in South Africa, there was a frenzy of policy-making. In terms of nutrition, policy focused on areas that covered almost every aspect (i.e., household food security, food service management, micronutrients, nutrition promotion, etc.). The challenge, though, has been to implement these policies.

Nutrition policies have largely been modelled on the UNICEF conceptual framework and its associated Triple A process (Assessment, Analysis and Action), which is intended to assist the government to implement programmes. In the case study below, the Triple A process was further elaborated and has at its centre capacity building of nutrition personnel and community members (Figure 1).

Case study: Mt. Frere health district

Mt. Frere district is in the Eastern Cape Province of South Africa and in the former Transkei, an apartheid-era homeland. The estimated population is 280,000. The infant mortality rate is 99/1000 and the under five mortality rate is 108/1000. There are two general hospitals in the Mt. Frere district.

In the early stages of this study, the researchers did some initial advocacy at regional and provincial levels and some team building to construct a district nutrition team. A component of this team was a hospital nutrition team, consisting mainly of paediatric staff.

Situation assessment

The paediatric staff, mainly made up of nurses, was asked to assess how well they were doing in terms of hospital care of severely malnourished children. Using

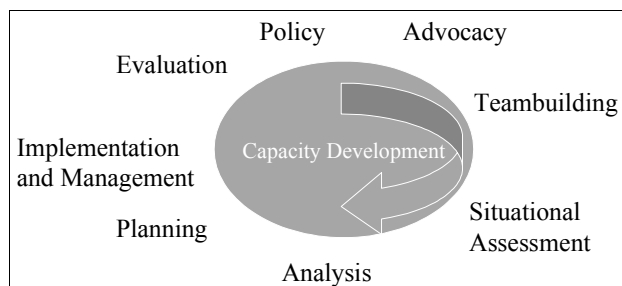


Figure 1 Adapted from the UNICEF Triple A process

the only data available, the ward registers, alarming results were revealed. On average over 30% of children were dying in the hospital wards from severe malnutrition.

Analysis

The staff analysed their own performance using the WHO 10 Step Protocol for the management of severe malnutrition, which is designed to be the hospital component of Integrated Management of Childhood Illnesses (IMCI) for malnutrition. For each of the steps the staff compared current practices to the recommended practices from the 10 Step Protocol (Table 1, next page). Next, barriers to quality care were listed in order to determine what training or extra resources were needed for the correct implementation of the steps. Finally, actions were taken to address these deficiencies, including training and support and assistance with acquisition of equipment and supplies. This resulted in considerable improvements in caring practices for severely malnourished children, including:

- ❑ separate heated wards
- ❑ three hourly feedings with appropriate special formulas and modified hospital meals
- ❑ increased administration of vitamins, micronutrients and broad spectrum antibiotics
- ❑ improved management of diarrhoea and dehydration with decreased use of IV hydration
- ❑ health education and empowerment of mothers.

Yet, problems still existed, including:

- ❑ intermittent supply problems for vitamins and micronutrients
- ❑ power cuts, leading to no heat in wards at night poor discharge follow-up
- ❑ staff shortage, of both doctors and nurses, and resultant low morale.

This above process was rolled out in 11 hospitals in the region and led to the development of Eastern Cape Provincial Guidelines for the hospital management of severe child malnutrition, which are an adaptation of the WHO Ten Steps protocol.

Situational Analysis			Implementation	
Recommended practice	Practice prior to intervention	Perceived barriers to quality care	Programmed intervention	Changes reported at follow up visits
Step 1: Treat/prevent hypoglycaemia <i>Feed every 2 hours during the day and night. Start straight away</i>	Children were left waiting in the queue in the outpatient department and during admission procedures. In the wards, they were not fed for at least 11 hours at night Hypoglycaemia not diagnosed	Lack of knowledge about risks of hypoglycaemia Lack of knowledge about how to prevent it Shortage of staff, especially during the night No supplies for testing for hypoglycaemia	Training to explain why malnourished children are at increased risk Training on how to prevent and treat hypoglycaemia Motivated for more night staff in paediatric wards Motivated the Department of health to provide resources (10% glucose and Dextrostix)	Malnourished children fed straightway and 3 hourly during the day and night The number of night staff was increased Dextrostix and 10% glucose obtained

Table 1 Comparison of recommended and actual practices in Mary Theresa and Sipeetu hospitals and perceived barriers to quality care of malnourished children

Community component

The tenth step of the protocol involved staff providing nutrition education to caregivers and planning for follow-up visits at regular intervals post discharge.

The implementation of this step was evaluated by following up a sample of children who had been successfully treated for malnutrition and discharged home. The objective of the evaluation was to determine household food security, caregiver knowledge and factors associated with malnutrition. It also looked at the rate of weight gain and health status at one and six months post discharge.

When their children were discharged, caregivers were told that there would be visitors to check on the child, but they were not told exactly when. Several visits were sometimes needed to find the caregiver and child at home. During the home visits, staff found that weight gain was extremely poor, much less than desirable for recovery. Although 76% of the caregivers remembered key messages about food fortification, 71% were unable to implement the acquired knowledge of feeding practices. Further, during the unannounced inspection of caregiver's food cabinet, 47% had very poor food supplies and very few had all the foods recommended at discharge.

Advocacy

Demographic and socio-economic indicators revealed that the average family income of the study population was R550 per month. (approximately US\$ 60) Their main sources of income were pension grant (40%) followed by income received from a migrant labourer (25%). Although all of the households qualified for the Child Support Grant (R100 per month per child), none of them were receiving it. Reasons for this centred on difficulty in applying for the grant (i.e., the bureaucratic process of obtaining the correct documentation) and the distance to the government offices.

On the basis of these findings the researchers launched an advocacy campaign that included:

- presentation of data to a Government Commission on Social Welfare
- a TV documentary 'Special Assignment' that elicited an unexpected and immediate response from both the public and government
- *Sunday Times* (a wide-circulation national newspaper) articles on child malnutrition in Eastern Cape.

The Minister of Social Development visited Mr. Frere a few days after the TV documentary and ordered a mobile team to process the Child Support Grants. Further, in October 2002, there was a massive Child Support Grant campaign in Eastern Cape.

Summary

In conclusion, this research shows that it is possible to achieve major improvements in the quality of care in very under-resourced areas and that staff are willing to address these issues. As seen from this case study, work is needed at many levels including hospital, district, provincial and national.

Improvements in the management of malnutrition and its prevention require an integrated approach, which involves a participatory process of research, support and supervision, as well as evidence-based advocacy to address its more basic causes, such as household food insecurity.

Prof David Sanders, University of Western Cape, dsanders@uwc.ac.za

The 7th Abraham Horwitz Lecture

Bringing nutrition into the political and technical mainstream: the role of effective communication

Purnima Menon

In a 1995 interview with *SCN News*, Dr Abraham Horwitz remarked

The contributions of basic and operational research for better understanding the causes and consequences of malnutrition, and the bases for controlling it, have been crucial. *However, if governments and international agencies do not ascribe priority to nutrition and do not invest in what is needed, the situation will deteriorate further* (emphasis added)¹.

In making this statement, Dr Horwitz had already summarized what a variety of recent reviews on the nutrition situation in Asia (the Asian Development Bank Regional Technical Assistance series, for instance) and other parts of the world (eg the UNICEF-World Bank Assessment) have shown to be a key barrier to achieving nutrition-related human development goals in the years ahead, ie a lack of adequate political commitment and investment in programmes and policies to improve nutrition.

Although the process of planning for policy change is long and complex, case studies of policy change and policy-making related to nutrition² have all shown that information and how it was used by policy entrepreneurs (ie communication) was key to achieving policy change. Two broad audiences can be identified for the purpose of communicating nutrition to achieve commitments to improve child nutrition. First, the policy and programme planning community, which provides a variety of resources and support for improving nutrition. And second, caregivers of children participating in nutrition programmes. Nutrition professionals often lie in between these two groups; attempting on the one hand to leverage resources, political will and support from the planning community, and on the other hand influencing changes in resource allocation and actions related to nutrition on the parts of programme participants. We have been much more successful with the latter than with the former, and have honed our skills in changing nutrition behaviour at the caregiver and household level. Numerous examples of successful attempts at nutrition behaviour change at this level provide us with a set of basic criteria and methodologies for developing effective behaviour change communication (BCC) programmes. These, in combination with recent developments in policy science and a better understanding of the process of policy-making, provides us with valuable insights on the development of effective communications strategies for mainstreaming nutrition at the policy level.

This paper combines the lessons learnt from nutrition BCC strategies with current knowledge related to the policy science frameworks and the policy-making process to provide some ideas for strategies that can be used to develop effective political and policy change-oriented communication. A planning framework is presented, which was devised for the development of a BCC programme in Haiti. A brief example of successful policy communications in the area of child nutrition and mortality is also reviewed. Finally, a set of current resources for policy mainstreaming is listed, as well as some of the gaps in these resources.

Levels of mainstreaming nutrition

The well-developed efforts of development programmes and policies to address gender equity and equality provide a framework for organizing priorities and activities in nutrition. In the literature on mainstreaming gender, one finds two major steps. The first is called "political mainstreaming" (referred to here as policy mainstreaming), which is designed to ensure that women are actively represented and that they participate in decision-making. The next step has been called "technical mainstreaming", where all programmes, policies and activities involving women are taken account of, and adapted as needed to ensure equitable participation of women. In the case of nutrition, policy mainstreaming will require that the significance of poor nutrition be presented to political decision-makers and policy-makers in terms that resonate with their priorities, ie that nutrition should be a priority at all levels in order to achieve overall development goals. The technical mainstreaming of nutrition is what is needed to turn political/policy attention into action. In the case of nutrition, this requires that communication moves from advocacy-based communication to solid, action-oriented communication that provides the policy and programme community clear solutions to improving the nutrition situation in different contexts. Ideally, the two should go hand in hand.

The need for combining policy mainstreaming with technical mainstreaming

There is a large body of empirical epidemiological research that supports the proposition that improving nutritional conditions in populations requires simultaneous improvements in resources and knowledge within the household. In particular, neither one alone is ever sufficient to bring about significant improvements in health and nutrition in conditions of poverty and underdevelopment. For instance, research on the role of education in improving nutrition at the house-

hold level suggests that neither education nor adequate household resources alone have the same type of impact on child nutrition as do the combination of improved education and adequate resources. Specifically, there is a synergistic effect of improving both knowledge and available resources that make it capable for caregivers to use improved knowledge^{3, 4, 5}.

The case for combining technical and policy mainstreaming is similar to this synergies analogy. Neither one will be sufficient in bringing about the necessary actions to improve nutrition. For improvements in nutrition that stem from policy commitments to nutrition, we will need to ensure that policy-makers are made aware of the availability of technical and human resources that can act on policy changes. In the case of policy-makers, these resources are the technical and human resources that can ensure that policy commitments and changes are born out in terms of effective nutrition actions. Thus, an effective communications strategy to address improvements in nutrition should simultaneously provide policy-makers with a strong basis for investing in nutrition as well as context-specific technical and human resource solutions for that investment. Considerations related to the development of human and technical capacity to transform policy commitments to effective nutrition programmes are an integral part of an overall long term policy change strategy.

This paper focuses mainly on policy mainstreaming because there already exists a strong resource base for technical mainstreaming, including capacity development in nutrition. Moreover, recent efforts to synthesize and analyze past experiences with improving nutrition have all concluded that political commitment is key to improving nutrition, but that nutrition advocacy has been ineffective^{6, 7}.

Lessons from successful BCC programmes

A recent review of BCC programmes related to complementary feeding practices provides evidence that BCC programmes can be effective in reducing child malnutrition in a variety of contexts⁸. This, and other reviews on successful BCC approaches⁹, suggests that the successful BCC programmes in nutrition shared most or all of the following characteristics:

- they were based on formative research that included:
 - a review of existing materials related to infant feeding in the programme areas
 - ethnographic studies to understand current infant feeding behaviours and motivations for these behaviours; and
 - an assessment of current complementary foods, and recipe trials to develop enriched complementary foods
- the programme communications strategies in the successful cases:
 - used findings from formative research
 - focused on a small number of actionable recommendations

- used multiple communications channels to reach caregivers, including individual counselling based on negotiation (rather than messages) and mass media
- included other household members
- worked with women's groups.

One of the main challenges of developing a BCC programme based on formative research is organizing the vast amounts of data generated in a useful way to develop a programme that will be meaningful and effective for its context. Nutrition BCC programme planning manuals, like the *Designing by Dialogue* manual¹⁰, provide some suggestions for how to organize findings from formative research in order to develop a programme strategy. In the following section a BCC programme planning tool developed for use in Haiti will be presented. This tool was used not only to organize formative research information to facilitate programme planning, but also in order to communicate the results of the formative research to programme staff at all levels in an NGO and stimulate discussion related to programme options. Discussion will follow on how this tool can be adapted using current understanding of decision-making in nutrition policy to develop a tool for designing effective and situation-specific strategies for policy change communication.

A BCC programme planning tool applied in Haiti

A recent experience with programme planning activities in rural Haiti provides an example of how a formative research study was used to fill the information gaps in a programme planning tool for BCC^{3, 11}. The formative research in Haiti was conducted as part of a larger programme evaluation, a collaboration between International Food Policy Research Institute (IFPRI), Cornell University and World Vision-Haiti. The objective of this formative research study was to provide information that would allow the development of improved BCC strategies for infant and young child feeding behaviours, focusing on children under 24 months of age. The formative research was grounded in ethnographic research methods and provided information on infant and young child feeding practices in programme areas, as well as on opportunities and constraints for behaviour change. Further, information was also gathered on the BCC activities within the current programme structure of World Vision, Haiti, to understand how the improved BCC programme could be set up to use the resources of the current programme structure.

The programme planning tool organized the results of formative research in a way that compared current practices to recommended infant feeding practices. Then, for each individual practice, evaluated the facilitating and constraining factors of the behaviour change that would be required to bridge the gap between the current practices and recommended practices. Using this process in Haiti, it was seen that a key barrier to improving exclusive breastfeeding rates were women's work patterns and the use of breastmilk sub-

stitutes to feed infants in their mother's absence. The formative research showed that the use of expressed breastmilk was an acceptable option for women, but that they were constrained by a lack of training on techniques of expressing breastmilk and its appropriate storage. The planning tool organized this information in a way that pointed in the direction of establishing support through the BCC programme for the use of expressed breastmilk. In addition, it showed that family support and positive role models were a key factor in women's successful experiences with exclusive breastfeeding. The formative research results related to women's work patterns outside the home also suggested that encouraging women to take their children to work with them was simply not culturally viable in this setting. Further, asking women to resume work outside the home a few months after child birth was not economically feasible, and would require strategies that went beyond BCC. These two factors were, therefore, not considered as feasible strategies to address through the BCC programme. Thus, the programme planning tool provided information on what strategies would be feasible to promote through a BCC programme and those which are not.

Once the behaviours to be promoted through the BCC programme were identified, the development process for a BCC strategy went on to evaluate the following factors for each behaviour:

- ❑ who needed to be targeted
- ❑ where (ie which programme venues) could best be used to target them
- ❑ what modifiable behaviours, facilitating and constraining factors could be addressed
- ❑ when should these behaviours be discussed for maximum effect (ie what were the key learning windows for each behaviour?)
- ❑ how should this be presented to the target audience?

The answers to these questions suggested that the individuals to be targeted (*who*) included pregnant and lactating women, their husbands, older women, and eventually, the larger community. Some key behaviours that needed to be targeted (*what*) included appropriate initiation of breastfeeding, frequency and intensity of breastfeeding, ways to deal with infant colic, and training in the use of expressed breastmilk. The most appropriate timing for addressing these different behaviours (*when*) was before the birth of the infant, ensuring support during early stages of breastfeeding as well as support to maintain exclusive breastfeeding. Finally, with regard to the *how* and *where* of communication, it was decided that peer group communications sessions, held separately in small group sessions for pregnant and lactating women, and based on principles of adult learning would be most effective.

The final programme model now provides support for behaviour change related to exclusive breastfeeding in a number of ways¹². Special Mothers' Clubs have been set up for lactating women (first six months), where

topics of discussion include infant colic, importance of exclusive breastfeeding, and problem solving and training in use of expressed breast milk. Further, these issues are reinforced at clinic-based pre- and post-natal consultations and Clubs to prepare pregnant women for breastfeeding and for exclusive breastfeeding. Finally, the food aid component of the programme for lactating women could possibly alleviate tiredness due to lack of food and also possibly delay return to work outside the home. Clubs for fathers and other communications activities targeted to the larger community (posters, radio spots, etc.) are currently being planned. Thus, from start to finish, the programme planning process was based on a systematic analysis and organization of available information. Operations research planned for 2003 will evaluate this BCC programme and provide further information on barriers to behaviour change using this model and possible solutions.

Developing policy change communications

Applying the principles of successful BCC programme development to communication for policy change suggests that effective planning must also be grounded in 'formative research'. As with planning formative research for nutrition BCC programmes, the challenge is to identify the most important decision-makers to target, and how to address them in the most effective way. Experiences with the programme planning tool in Haiti suggest that formative research for policy change communications should be oriented towards gathering information on specific policy change goals. It should also provide information on the current policy environment conditions that can facilitate the achievement of a specific policy change, as well as conditions that can constrain the achievement of this change.

In particular, the formative research for policy-making will have to shed light on:

- ❑ the decision-making and policy implementation processes at different levels of the policy-making institutions or organizations
- ❑ the values and priorities of institutions and/or decision-makers
- ❑ the environmental conditions (eg influential people with other agendas, lack of resources, etc) that drive the decision-making process.

One of the most important factors here is to understand where, how and by whom decisions are made in the public policy arena (and not just related to nutrition).

One of the major challenges in designing effective policy change-oriented communication is the identification of what types of information to gather and how to organize this material in a way that provides direction in developing a communications strategy. Formative research tools developed for use with households and communities cannot serve the purpose of gathering information on the policy process, and therefore, obtaining this type of information at the policy-making level will be challenging. The type of data that provides most information on the who, what and how as-

Rationalities in Public-Policy Decision-Making

Technical (based on cause-effect research, interventions, effectiveness, efficacy, etc.)

Economic (based on opportunity costs, incentives, cost benefits, etc.)

Social/Normative (based on rights-based, fairness, equity, ethics, etc.)

Political (based on participation, resources, groups, alliances, etc.)

Organizational (based on rules, authority, jurisdiction, etc.)

Legal (based on laws, rights, enforcement, etc.)

Multiple/integrative (based on judgement, competence in analysis, etc)

pects of policy change-oriented communication has been labelled soft data by Milio². This type of data relates primarily to the decision-making process itself and should reveal who the influential people are, what their values, priorities and decision-making rationalities are, who can influence them, and how they might be convinced to change nutrition policy or programme allocations. There are no prescribed methodologies for obtaining such information. However, a recent publication by Clark¹³ provides a framework for analyzing the policy process and also lays out some of the questions that should be asked when analyzing the social process dimensions (ie the who, what and how) of policymaking.

Under conditions where most of the relevant information can be gathered, the programme planning tool used by the team in Haiti can be used to identify communication activities in the short term and long term. It may also monitor and evaluate the environment for communication activities for other goals, so as to "strike" when the context and timing are most conducive to achieving commitments to change.

Understanding decision-making in public policy

Current thinking on the application of the frameworks of decision-making to nutrition¹⁴ suggests that it is crucial that formative research identifies and understands the rationalities that underlie the thinking and decision-making process of key policy-makers (see box for a list of the most common rationalities in public policy decision making). This sheds light on how the same problem is viewed differently by different rationalities. This in turn can provide insights on how communications strategies should be designed to address specific policy-makers or institutions. Additionally, this understanding will also suggest what types of information should be communicated to those individuals or institutions for maximum impact.

Examples of how the different rationalities presented in the box above play out can be illustrated by considering the types of questions that are asked by policy-makers who operate within the major rationalities outlined above. Using the example of a Vitamin A capsule distribution programme to prevent child mortality, the following types of questions might emerge from policy-makers operating with different decision-making rationalities:

- technical: which age group of children do we need to give Vitamin A capsules to in order to ensure

maximum effectiveness?

- economic: how much does it cost per life saved, and how should the programme be designed in order to minimize the cost per life saved?
- social/normative: how can the programme be designed to ensure that all vulnerable populations receive it?

The answers to the above questions illustrate how the final design of the programme (in terms of the age of the beneficiaries, social and geographic targeting, how it is evaluated and monitored, etc) can be different depending on the decision-making rationality of the policy-maker in charge. Thus, the onus of identifying these rationalities, and the implications of them for programming decisions is very much on the "designer" of the communication strategy. They will have to gather this type of information, organize and analyze it in a way that eventually leads to a strategic and "customized" communications plan. An example of the type of assessment that could be conducted using a policy change communications planning tool similar to the nutrition BCC programme planning tool used in Haiti includes:

- specific nutrition related policy commitments to be achieved: specifying nutrition policy related goals
- level of current commitment: assessing the current status or level of the desired action or resource allocation
- evaluating the environment for policy change (*who, what, how*) and opportunities (*when*), and organizing this information into:
 - conditions that facilitate achievement of advocacy goals
 - potential constraints to achieving advocacy goals.

Overall, this process provides a strategy for identifying what actions are necessary to achieve specific advocacy goals with specific decision-makers and how these might be facilitated or constrained by the current political, social or economic climate. Following such an analysis, a strategic plan for communication could be developed for each advocacy action that evaluates the following:

- where are policy decisions made (ie identifying key institutions and departments/divisions within institutions)
- who to direct communications and advocacy to-

Stage 1: Assessing the current situation, facilitating and constraining factors

Desired status of policy actions	Current status	Factors that facilitate and constrain bridging the gap
Examples include: -legislation -funding allocations -staff allocation -types of programmes desired	Evaluate current status based on hard data related to the status of the policy action. Examples include: -department budget and staffing data -current legislations -current status of programmes	For both facilitating and constraining factors, the following should be assessed: -where decisions are made -who makes them -who can influence the key decision-makers -what their operating “rationality” is and how this might facilitate or constrain the process of achieving change -what goals or inputs do they value -what resources are available for change -when are key decisions made

Stage 2: Planning a communications strategy (using information from Stage 1)

Strategies should be made based on:

Where & Who?	What?	How?	When?
Decisions about -which organizations should be targeted -which individuals within those organizations should be targeted	Design communications content based on -decision-maker/organizational priorities -nutrition as an input into those priorities -how to change or develop policy decisions to influence nutrition	Design communications <i>strategy</i> using understanding of the decision-making rationality and orientation. Specifically, -develop appropriate tools and methods of communication -identify influential agents of communication	Identify the most appropriate timing to target communications based on -policy and budgetary cycles -decision-making moments within those cycles

Table 1 Adapted from the BCC programme planning tool described in Ruel et al., 2003 and Menon et al., 2002

wards, and who will conduct such activities:

- decision-makers within organizations
- agent of change
- what to communicate
 - decision-maker/organizational priorities (key outcomes of interest, eg mortality, productivity, child health)
 - nutrition as an input into those priorities
 - information on programme and policy changes that will provide the most benefit as well as on their implementation and maintenance (ie technical mainstreaming)
- how to communicate: using understanding of the decision-making rationality and orientation to:
 - develop appropriate tools and methods of communication
 - identify influential agents of communication
- when to address different audiences
 - based on an understanding of policy and budgetary cycles, and decision-making moments within those cycles.

These steps towards developing a policy change communications tool that is based on our current understanding of successful behaviour change communications programmes in nutrition are summarized in Table 1.

An example of successful policy change communication

This section briefly describes how some of the strategies described above were used to ensure that child nutrition was considered in the revision of the mortality attribution chart (Figure 1, next page) used at WHO.

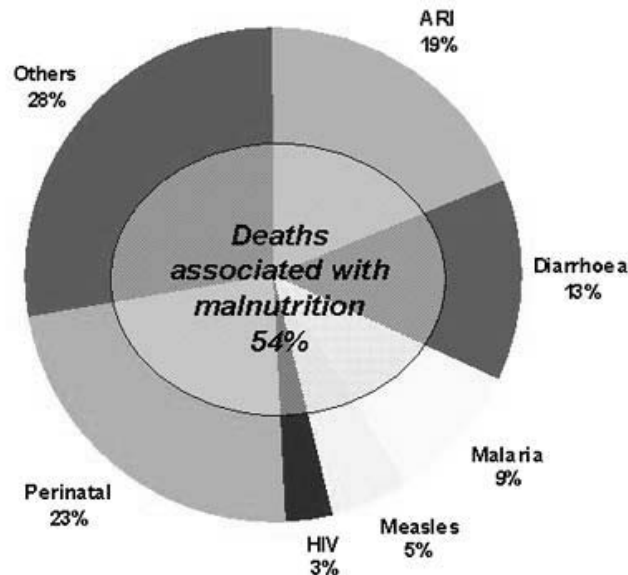
Current status vs. desired status

The child mortality attribution chart had traditionally been used for fund raising within WHO and with other donors. Prior to the research at Cornell University that demonstrated that child underweight contributed to 54% of child deaths from infectious diseases¹⁵, the chart had indicated that child underweight contributed to only 4% of mortality, with diarrhea, pneumonia, malaria, etc., contributing to a much larger proportion. Consequently, programmes aimed at controlling child deaths due to infectious diseases focused primarily on the disease prevention and treatment, rather than nutrition.

The environment for policy change

Some of the factors that facilitated easy reception of the results of the Cornell research were that infectious disease practitioners recognized the role of nutrition, as did a number of nutritionists. However, the Cornell research provided an empirical basis for this relationship and translated it into public health terms such as

Major causes of death among children under five, worldwide, 2000



Sources:

For cause-specific mortality: EIP/WHO

For malnutrition: Pelletier DL, et al. *AMJ Public Health* 1998; 88:1130-3.

Figure 1

case fatality. Further research conducted by other researchers on this topic—including those who worked primarily in infectious diseases rather than nutrition—strengthened the findings by coming up with similar numbers. This ensured that overall, their "message" was consistent. One of the possible constraining factors was that nutrition actions aimed at decreasing child mortality were in fact likely to be less cost effective than other actions. However, the larger role of nutrition for child development and other outcomes was already well-recognized in the public health community, and thus, this constraint did not deter the recognition and promotion of the role of underweight in child mortality.

The communications strategy

The research on the association between child underweight and mortality was presented simultaneously in the United States (to audiences such as the World Bank and USAID) and at WHO headquarters in Geneva. The research was presented by academic researchers who were likely considered highly credible by the receiving audiences and who were able to translate the research into the rationalities favoured by the receiving audiences. Further, the presence of nutrition researchers within WHO promoted the research to the infectious disease-oriented audiences within the organization and ensured that the mortality attribution chart, would be changed to reflect these new findings. All of this ensured that at WHO, nutrition entered into

the newly developed protocols on the Integrated Management of Childhood Illness (IMCI). The figure of 54% mortality caused by child underweight simply did not allow professionals who worked on child health to ignore nutrition. However, this translation of the pie into action was still a long process since the "how to" of improving nutrition within the IMCI clinic-based setting was complex.

Although nutrition has entered the IMCI protocols in a large way, and these protocols have been adopted by many countries across the world, there is still a long way to go. The information from WHO has yet to reach and influence various governmental policies other than IMCI, for example. This will need the same concerted communication efforts as within WHO to achieve nutrition commitments from other policy and political audiences.

Current status and resources for political and technical mainstreaming

Fortunately, this decade finds the nutrition community endowed with numerous resources to achieve the goals of communicating nutrition to achieve political commitment. Nutrition interest groups can indeed feel fortunate that the importance of nutrition is now widely recognized at some of the highest policy levels. For instance, both the MDGs and the World Summit on Children's goals include nutrition as a key element. This is combined with ample research that links nutrition to other sectors, such as health, economics, agri-

culture, education, populations, environment, etc. The current research has even been summarized in such publications as the SCN's *Nutrition as a Foundation for Development*¹⁶. Second, data sources such as the Demographic and Health Surveys (www.macint.com/dhs) provide key national and sub-national level data on nutritional status and its determinants. The availability of programmes like PROFILES¹⁷ provides tools to quantify and present the consequences of nutrition for various non-nutritional outcomes, and also quantify the improvements in these outcomes that investments in nutrition will yield. This has already proven to be effective in influencing nutrition policy in some countries¹⁸. Further, tools like the Essential Nutrition Action Toolkit from BASICS provide tools that take a potential user from advocacy for nutrition to the design of nutrition programmes¹⁹. In Asia, the Asian Development Bank Regional Technical Assistance (RETA) series^{6, 20, 21} provides nutrition advocates with policy and programme-relevant information that will be necessary to strengthen both political and technical mainstreaming activities.

Finally, we are beginning to have a better understanding of policy processes in general, but need much more information on how specific policy changes can be achieved in governments and other organizations. What is needed is to understand how nutrition related decisions, as well as non-nutrition decisions that affecting nutrition, are made at different policy and programme levels. This will provide us with the key to using the available resources for policy and technical mainstreaming to develop more effective ways of mainstreaming nutrition in policies and programmes worldwide. In order to achieve this, both human and financial resources to support policy research are key, as are the training and development of professionals who are capable of conducting sound policy research and directing policy change-oriented communications activities.

Conclusions and steps forward

In summary, policy change communication (or advocacy) is key to solving nutrition problems. Our understanding of the principles of behaviour change suggests that effective policy change communication will also be grounded in a good understanding of how policy processes work in each context, and an evaluation of the environment for policy change at every level. Further, the key dimensions of *who*, *what* and *how*, should be considered in developing methods for policy change communications, that should then tap into key opportunities for change (*when*). Still urgently needed are the financial and human resources to support and implement the process of developing policy-change communications.

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Purnima Menon, PhD, Cornell University, pm38@cornell.edu



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1—7 August 2003
World Breastfeeding Week

WBW 2003 Goals are to:

- recognize the threats and opportunities of globalization for breastfeeding practices
- maximise the potential of global communications to educate people on the benefits of breastfeeding and appropriate complementary feeding, and the disadvantages of artificial feeding
- promote and act on the Global Strategy for Infant and Young Child Feeding
- prevent the weakening of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions
- work with potential allies by building alliances with civil society movements fighting for global justice, peace and health of all
- think globally and act locally with all sectors of the community to protect promote and support breastfeeding.

Contact WABA at www.waba.org.my



Photograph kindly provided by
Deirdre Handy, Trinity Centre for Health
Sciences, Dublin

John Kevany 1932-2003

John Kevany died suddenly at Easter this year, in Dublin. John is well known to many of us working in international nutrition and health, held in enormous esteem and remembered with great affection. Over a long and productive career he took on numerous tasks and roles, becoming best known to many of us for his work in nutrition, although exerting much constructive influence with the World Bank, PAHO, Irish aid, and many others.

John Kevany qualified in medicine in Dublin in the 1950's, continuing as a research fellow at Vanderbilt University Medical School in Clinical Nutrition. He joined the Pan-American Health Organization (PAHO) to work on nutrition and infection in INCAP, Guatemala in 1959, where he worked with Nevin Scrimshaw and others in the ground-breaking research on nutrition and infection. He continued as a Medical Officer in Human Nutrition for PAHO in Latin American countries through the 1960's. This began a long partnership with Dr Horwitz, then PAHO Director—later to be highly productive in the SCN context. John returned to Trinity College as a lecturer in Social Medicine in 1970, first as Senior Lecturer then Associate Professor of Public Health Medicine, working on a range of public health and nutrition issues in Ireland and outside—with substantial focus on micronutrients.

A long involvement with World Bank projects started in the 1980's, including two years as a staff member before returning to base himself in Dublin with regular contributions to World Bank projects. John played a role in many of the large projects the Bank was setting up at that time—in Tamil Nadu, Bangladesh, Ethiopia, Zambia, Malawi, Sri Lanka, India (Integrated Child Development Services), Kenya, and the Philippines. Many millions of women and children benefited, through these projects, from his professional skills, wisdom, and commonsense. John's role was so often to bring focus to practical things that could be done to prevent ill-health and malnutrition among the poor.

More of us in nutrition got to know John Kevany during this period, and it was a particular privilege to work with him—and enjoy good times in his company—when he started with the Advisory Group on Nutrition of the UN Sub-Committee on Nutrition (AGN of the ACC/SCN). He was elected by the UN agencies to the AGN in 1986 and appointed AGN Chair by Dr Horwitz in 1987. To this role he brought a clear focus on effectiveness, encouraging everyone to make their contribution, and giving a foil (and grounding) for Dr Horwitz' farsighted but extensive ambitions. He showed a sure touch in guiding fractious international agencies, a much-needed sense of humour, and occasionally famous impatience with too much abstraction. Many new features important to nutrition were fostered in this way – including a first analysis of nutritional issues facing women, control of anaemia, understanding trends in malnutrition and their determinants, and many intricacies of international assistance to better address these problems.

I was lucky to work closely with John during this period, as Secretary of the SCN, and have many clear memories. One in my mind's eye is this. It was 1990 and the Sub-Committee was meeting, hosted by UNICEF, in one of those meeting rooms that never see daylight in the basement of the UN Secretariat building in New York. John and I were sitting near the back at the end of a long day, someone was presenting in the darkened room, and we could whisper in the back. John wanted to know what would come out of the meeting. I explained that UNICEF wanted something new to draw attention to nutrition. Like what? Well, it could be anything from a book to...a world conference. Let's make it a world conference, he said. What could it do? We scribbled some objectives, polished them a bit, then at the right moment he put them to the meeting. Thus, a week or so later, was it decided to propose to the Secretary-General to hold an International Conference on Nutrition, which duly took place (in ways that neither of us could begin to foresee) in 1992, in FAO Rome, opened by the Pope.

In Ireland, the Kevany's hosted a number of us during a meeting of an SCN group on 'Controlling Iron Deficiency'. It was not *all* held in picturesque pubs and the Kevany's pleasant home, although it seems that way now—and it was a productive meeting too.

Later John continued to support many worthwhile enterprises, including ensuring the launching and success of the Emergency Nutrition Network. He collaborated with a number of us in proposing the idea of 'public nutrition'—although with some warnings from his concern for the future of public health (which is to clinical medicine as public nutrition is to dietetics). He clearly worked effectively behind the scenes to guide Ireland's policy on international health and nutrition.

In the last few years, John Kevany articulated concerns for poverty as the 'The world's biggest killer and the greatest cause of ill health and suffering across the globe'. He went on to note wryly that '...[it] is listed almost at the end of the International Classification of Diseases. It is given code Z59.5—extreme poverty.' 'Extreme poverty...acts in obvious and direct ways to produce ill health, particularly from infectious disease, malnutrition, and reproductive hazards....Today the number of people in extreme poverty is estimated at 1.1 billion...the wealthiest fifth of the world's population now controls 85% of global gross national product and 85% of world trade, leaving the poorest quintile with 1.4% of gross national product and 0.9% of world trade. This extraordinary gap continues to widen, to an extent that human poverty has now become institutionalized on an unprecedented scale'.

John's clear vision and warmth are greatly missed.

John Mason, June 2003

John Kevany will be sorely missed by the SCN community.

—below are some of the tributes the Secretariat received over recent weeks.

Alan Berg, USA

John Kevany joined the World Bank staff in Washington in 1984 and remained there until 1986, probably the biggest mistake he ever made. Leprechauns aren't all that much at home at the World Bank.

Although predictably John was to make a significant professional contribution. Given the scale on which Bank projects operate, he must have affected the lives of tens of millions in Tamil Nadu, Bangladesh, Ethiopia and Zambia. John was never very comfortable with an institution that couldn't laugh at itself. (Nor was he overly fond of living in the country where his Bank job was located.)

For John was a man with an acerbic wit, a lilt in the voice and a twinkle in the eye. He was a man comfortable with himself, never overestimating (or underestimating) his importance. He was exceedingly bright, as professionally solid as they come and, most importantly, seized with the notion of improving the human condition. John Kevany personified all that is good about the international nutrition community—a community now the poorer for his loss.

Alan Berg also forwarded the following:

Although leaving Washington and the staff of the World Bank in 1986, John continued on, for more than a decade, serving as a Bank consultant in Kenya, Malawi, Sri Lanka, the Philippines and four states in India. *Jayshree Balachander*, who was the government's Director of the Tamil Nadu Integrated Nutrition Project when she first was exposed to John's work and then frequently led the Bank teams on which John participated as a consultant, said this of him:

'Among development professionals, John is among those I admire the most—technically very sound, but with a strong programmatic focus. A person who really knew how to get a good community health program going. As a team member, you could count on his good sense, technical excellence, ability to work well with clients and provide excellent written inputs. John was quiet, understated, cheerful—an asset to any team. He was also very principled in his work—unwilling to cut corners or to jump through unnecessary hoops if they did not add value to the program and the outcomes. He will be missed.'

Stuart Gillespie, USA

John Kevany was a wonderfully insightful, eloquent and inspiring man, who combined a sharp mind with an especially sharp sense of humour. I will miss him a lot.

Elly Leembuis-de Regt, The Netherlands

It is with great shock and deep sorrow that I learned about the sudden passing away of John Kevany. I have known John since the late eighties when John was Chairman of the Advisory Group on Nutrition to the UN Sub-Committee on Nutrition. More recently, I had the privilege of participating in health meetings with John, and we also met coincidentally at Geneva airport, where he would enlighten me about the deliberations in the Global Fund meetings—of course in his own personal style. John was such a lovely man: a pillar of respect and integrity. His vast experience and knowledge, his ability to put things in historical perspective, and above all his sense of humour have always impressed me and will always be remembered. We will all miss him, but of course not only us—his wife Rose and his family will have to learn to live with an empty seat at the table. Wishing you all lots of strength.

Simon Maxwell, UK

I have such strong memories of John on the Advisory Group on Nutrition—always enthusiastic—walking with him to and from the meetings, striding out along the lake in Geneva, arguing and laughing, encouraging those (more or less all of us) who could not keep up. A fine man. I liked him a lot.

Fiona O'Reilly, Ireland

John always expected the best—saw the best in people. As a result those around him became what he saw—the best they could be. I think I speak for many of his students when I say we rose to meet the challenges John believed we were capable of.

Julia Tagvireyi, Zimbabwe

I am indebted to John Kevany for my induction to the SCN. He was Chairman of the Advisory Group on Nutrition when I was first appointed to it. John made me feel that my contribution was valuable to the AGN, and boosted my confidence enormously. He was an excellent Chairman and he encouraged all members to actively contribute to every discussion. I also recall John's passion for long walks. Fortunately, I only participated in one such walk with him, I nearly had to be resuscitated as a result.

My sincere condolences to John's family and friends.



30th Session Working Groups

Key contacts for Working Groups		
<i>Working Group</i>	<i>Chair/Co-Chairs</i>	<i>E-Mail contact address</i>
Breastfeeding and Complementary Feeding	Miriam Labbok, UNICEF Randa Saadeh, WHO Reina Buijs, The Netherlands	mlabbok@unicef.org saadehr@who.int reina.buijs@minbuza.nl
Capacity Development in Food and Nutrition	Cutberto Garza, UNU David Sanders, U of Western Cape, South Africa Hans Schoeneberger, Germany	cg30@cornell.edu dsanders@uwc.ac.za and lmar- tin@uwc.ac.za schoeneberger. welternaehrung@web.de
Household Food Security	Kraisid Tontisirin, FAO Lawrence Haddad, IFPRI Shakuntala Thilsted, Denmark	kraisid.tontisirin@fao.org l.haddad@cgiar.org sht@kvl.dk
Micronutrients	Frances Davidson, USAID Bruno de Benoist, WHO Werner Schultink, UNICEF	fdavidson@usaid.gov debenoistb@who.int wschultink@unicef.org
Nutrition in Emergencies	Chair: Marjatta Tolvanen, UNICEF Secretariat: Saskia van der Kam, MSF/Holland	mtolvanen@unicef.org saskia.vd.kam@amsterdam.msf. org
Nutrition, Ethics and Human Rights	Urban Jonsson, UNICEF	ujonsson@unicef.org
Nutrition and HIV/AIDS	Andrew Tomkins, Institute for Child Health; UK Jos Perriens, WHO	a.tomkins@ich.ucl.ac.uk perriensj@who.int
Nutrition of School-Age Children	Joy del Rosso, Save the Children Arlene Mitchell, WFP	jdelross@savechildren.org arlene.mitchell@wfp.org
Nutrition Throughout the Life Cycle	Ricardo Uauy, INTA, Chile Ted Greiner, Sweden	uauy@uchile.cl and druauy@mi-mail.cl Ted.greiner@kbh.uu.se

WORKING GROUP ON NUTRITION THROUGHOUT THE LIFECYCLE

Ted Greiner (Sida) opened the meeting with a reminder of the purpose of this new working group and a request that participants give thought to whether any modifications are needed in the way in which it could best achieve its purposes. In particular, what are the specific needs for harmonization? How can we work from a human rights and equity perspective? Ricardo Uauy (UNU) provided background on the implications and challenges of a lifecycle or life course approach to nutrition. Deaths in early life have been reduced significantly over the past century, however, there is less improvement in adult death rates. A large range of conditions causing death and disability can be prevented through diet and physical activity. Kathy Kurz and Kavita Sethuraman (ICRW) described the new Initiative on Gender and Nutrition initiated with seed funds from the World Bank. Plans include participatory project development in West Africa and South Asia. Chizuru Nishida (WHO) presented UN perspec-

tives on diet and nutrition in the prevention of adult chronic disease. She presented the methodology for developing the newly-released WHO/FAO report on diet, nutrition and chronic disease prevention. The process for this science-based report included examining the evidence, categorizing the strength of the science and defining population nutrient intake goals to achieve optimal health. Roger Shrimpton (Institute of Child Health, UK) reviewed the UNICEF low birthweight initiative implemented in 15 projects in several countries and reported on the status of five controlled studies of micronutrient interventions to reduce low birthweight. He emphasized the importance of shifting the distribution of birthweight for whole populations. Sultana Khanum (WHO) reviewed the WHO global data base on low birthweight. WHO is planning a consultation on low birthweight later this year.

The working group decided that these issues should be given high priority in the coming year:

- low birthweight/intrauterine growth retardation

and associated gender issues

- ❑ the critical role of women in achieving lifecycle/course optimal nutrition and health
- ❑ the epidemic of nutrition-related chronic disease in developing and transitional countries
- ❑ nutrition of the elderly in developing and transitional countries
- ❑ define how to implement the lifecycle approach in practice
- ❑ integrate all stages of the lifecycle/course approach in the household family unit

WORKING GROUP ON NUTRITION IN EMERGENCIES

This working group reviewed achievements over the past year in six focus areas. Lida Lhotska (IBFAN) reported that a training module for relief staff on infant feeding in emergencies is now ready for distribution; an evaluation is also planned. A second module for health workers is nearly ready. To finalize this module there is a need to resolve confusion concerning different protocols for treatment of severe malnutrition in infants under six months. Regarding training initiatives for capacity development, Annalies Borrel (CDC) reported that an inventory of training courses has been compiled and disseminated. Working group members are currently involved in three training initiatives: Tufts/WFP training in food and nutrition in emergencies, Tufts/Columbia/CDC training of UNICEF health and nutrition officers (called "Training for improved practice"), and Sphere Project health and nutrition training. Marjatta Tolvanen (UNICEF) reported on Standardized Monitoring and Assessment of Relief and Transitions, or SMART (www.smartindicators.org). The objective is to improve the monitoring, reporting and evaluation of humanitarian assistance to ensure reliable data needed for making policy, funding and programme decisions. A workshop is planned for July to make a standard recommendation for assessing population stress. CIDA is supporting the development of a basic SMART manual on methodologies (mainly crude mortality rate and nutritional status) that will be piloted in Angola. Anna Taylor (SCF/UK) reported on the Sphere project. An evaluation of the use of the first version and revision process is underway. The final document will be available in October. Saskia van der Kam (MSF/Holland) said that www.nutritionnet.net has provided an active working environment for nutritionists and there is strong participation from Africa. The coming year will see an increased involvement of experts in specialized areas who can assist with technical nutrition issues that arise in field work. Regarding adult malnutrition, there is a need to continue the work on assessment of adult malnutrition, especially in relation to the HIV/AIDS epidemic. The working group is currently trying to identify a new focal point to provide leadership in this area.

The working group then discussed home-based treatment of severe malnutrition, as an alternative to thera-

peutic feeding centers. Steve Collins (Valid International), presented an update on the community therapeutic centers (CTC) programme, Joseph-Matthew Mfutso-Bengo (U of Malawi) on social and ethical issues related to CTCs, Anna Taylor (Save the Children/UK) on experiences with CTCs in North Sudan, and Carlos Navarro-Colorado (Action Contre la Faim) on implementation of a clinical trial in Sierra Leone. The concept of home-based treatment involves moving away from centralized therapeutic feeding centers, to home-based care, home visitation, use of ready-to-use therapeutic foods which can be made locally, systematically overcoming coverage and defaulter problems and empowering mothers and communities. A technical workshop to harmonize protocols is planned for October 2003.

WORKING GROUP ON NUTRITION AND HIV/AIDS

This working group is rather young and is still establishing its priorities for action. While the HIV epidemic is well recognized in most African countries there has been a disturbing pattern of delay in recognition of the scale of the problem in other regions. There are serious concerns that "denial" is occurring in several Asian countries. The scale of the problem globally is increasingly documented, mostly using sentinel site surveillance. The data are available on various websites through the www.unsystem.org. Members of the working group have communicated by email and a briefing document has been prepared which outlines the key elements and challenges which face the working group as it seeks to produce guidelines to prevent and manage the infection and mitigate the impact of the infection on individuals, families and children. During the Chennai meeting some of these elements were discussed and specific recommendations made for new work. This included the need to establish new knowledge to enable the development of an evidence base, the need to ensure that existing/recent knowledge is more widely disseminated, the need to insert specific nutritional interventions into health, agriculture, educational, economic and social policies and the need to monitor and support the efficient application of policies and programmes.

Work priorities for the coming year

- ❑ A small meeting planned for May 2003 in Geneva to identify new knowledge which could be used for policy development, identify knowledge gaps and how new, essential knowledge can be obtained. This will be facilitated by commissioning review papers on knowledge and how it has been applied. This will form the basis for a larger meeting in which reviews will be commissioned about how knowledge can be most effectively used to develop cost effective nutritional interventions
- ❑ The working group will collaborate as widely as possible with other related working groups and in particular will interact with the UNU African Nu-



trition Leadership Development Programme which has taken nutrition and HIV/AIDS as one of its key activities. (see update at the end of this section for other activities.)

WORKING GROUP ON MICRONUTRIENTS

Bruno de Benoist (WHO) presented the latest IDD situation from data available in the WHO global databank. Forty-four countries have carried out IDD surveys since 1993, out of which 93 were national surveys and 51 at subnational level. Only 5% of the world's population has not been surveyed for IDD. The regions most affected by IDD are Eastern Mediterranean (19.9%), Africa (10.7%) and Europe (10.2%). In most countries where IDD is a public health problem, the problem is mild. It is moderate in 14 countries and severe in 13 countries. Currently 19 countries claim that the universal salt iodization goal has been reached, with more than 90% of households having access to iodized salt. Still, 46 countries have insufficient iodization coverage.

Gary Gleason (IDPAS Project Director) presented a report on global activities related to iron nutrition in the context of the IDPAS project supported by the International Nutrition Foundation and the UNU. The report includes information from international and bilateral agencies and their supported projects, national and subnational projects and researchers. It is available on www.micronutrient.org in the IDPAS iron world pages. Werner Schultink (UNICEF) presented the results of a meta-analysis of multiple micronutrient supplementation trials supported by UNICEF in four countries. Results showed that the group receiving one RDA had an increase in Hb, ferritin, retinol, zinc and homocysteine. Prakash Kotecha (Medical College Vadodara, Gujarat) presented an evaluation of an anaemia control project for 65,000 adolescent girls in Valodara district in India, where the anaemia prevalence rate in this age group is about 75%. A weekly dose of 60 mg iron and 500 mcg folate was distributed through health clinics; coverage was 95%. Results showed a 23% reduction in anaemia prevalence; while severe anaemia was reduced by 66%. The project is being expanded to Tamil Nadu and Andhra Pradesh. Rolf Carriere (GAIN) introduced the new Global Alliance for Improved Nutrition, funded by the Gates Foundation. He presented the rationale for fortification in the context of micronutrient malnutrition and described the structure of GAIN. GAIN has already received 16 proposals for fortification programmes, these will be reviewed and submitted to the GAIN board in March. The next request for proposals will be issued in June 2003 (www.gainhealth.org).

WORKING GROUP ON NUTRITION, ETHICS AND HUMAN RIGHTS

The meeting dealt with case study presentations on human rights and ethical issues in the field of nutrition as well as strategic policy and programme business.

The working group discussed the Indian experience with the implementation of the right to adequate food, largely from a legal and juridical perspective, focusing on actions and decisions by institutions like the National Human Rights Commission and the Supreme Court. The cases challenge certain provisions in the Famine Relief Code of 1910, still in force today, and their conformity with human rights principles and question the constitutionality of situations where millions of people are at the brink of starvation in the face of surplus stocks. These challenges have led to decisions that require changes in state relief administration and hold senior officials accountable for effective food programme administration. The group also reviewed ethical issues arising from large scale nutrition programmes, based on case studies presented by John Seaman (Save the Children/UK). UN agencies are increasingly embracing a human rights perspective in their work, with the focus of attention shifting from conceptualization and the building of understanding of human rights towards operationalization in programming. A major development has been the establishment of an Intergovernmental Working Group, with the participation of stake holders, to develop voluntary guidelines for the implementation of the right to adequate food. A task force of the working group prepared an SCN position statement on the nutritional aspects of the future guidelines. Important lessons for the guidelines process can be learned from a series of national seminars that consider what a rights-based approach to food and nutrition security would entail.

The working group will focus on these activities in the coming several years:

- ❑ active participation in the Intergovernmental Working Group process for development voluntary guidelines for the realization of the right to adequate food over the next two years, including participation in sessions and related national seminars, follow-up to the SCN statement now being submitted to the Intergovernmental Working group
- ❑ sharing of experience with human rights based approaches to programming
- ❑ monitoring and evaluation: further work on rights-based benchmarks and indicators to monitor the realization of nutrition-related human rights; this will include a meeting prior to next years working group session
- ❑ human rights in emergencies: further work on the application of human rights to nutrition programming in emergency situations
- ❑ cross-cutting all areas is the need for human rights training: the working group will promote the sharing of programming guidelines, training materials among agencies, the participation of agencies in each other's training activities and involve the academic community.

WORKING GROUP ON CAPACITY DEVELOPMENT IN FOOD AND NUTRITION

The activities of this working group aim at enhancing regionally-driven capacity development initiatives. Three regions (Asia, Africa and Latin America) have written ten-year plans, which are at different stages of implementation. A quarterly newsletter keeps members of the working group informed on progress in the regions. The Asian Task Force evolved over the last year into a solid initiative called CASNA, Capacity Strengthening for Asia. CASNA provides direction in the development of human resources capable of addressing priority research and programs in food and nutrition in Asia, the generation of regional databases and assessment of the knowledge base related to priority research and programmes, optimising institutional expertise, and promoting and supporting the networking of institutions. The double burden of malnutrition, food safety empowerment of women for food based approaches are focus areas of CASNA. To ensure that CASNA meets the needs of Asian institutions, a survey is being conducted to identify human capacity needs in the region. The Latin American Task Force advanced several projects during the last several years including: the Latin American Network Programme on Copper and Health, isotopes for evaluation of nutrition intervention programmes, the LATINUT electronic forum and the Nutrition Policy Forum. The African region is organized in three task forces: southern Africa, Greater Horn of Africa, West/Central Africa. Progress was reported in four main areas: integration of HIV/AIDS topics in nutrition training, nutrition advocacy, African Nutrition Leadership, and food composition database for Africa. The working group plans to form similar task forces for the Middle East and Eastern Europe.

The working group identified these main conclusions and recommendations for SCN action:

- future activities have to take into account that capacity development comprises more than training of professionals and research, and needs to be at all levels of policy and practice
- besides the need for well trained nutritionists, there is an even greater need for well trained programme managers and nutrition advocates; knowledge on community development processes is essential as well
- professionals should be enabled to integrate nutrition into key programmes of other sectors such as health, agriculture, education and others
- more emphasis is needed on career development for the nutrition workforce
- at times donor initiatives fragment collaboration activities; large funds can attract individual institutions out of networks, to avoid this it is essential to engage donors proactively

- especially in Africa, collapsing public systems, the consequent human resource crisis, limited job opportunities and the exodus of personnel undermine capacity development initiatives
- peer-to-peer capacity building, using skilled people from one country to develop capacity in another, ie south-to-south cooperation, should be more supported.

Over the coming year the working group will concentrate its efforts on the following initiatives

- support to the regional task forces, with special emphasis on Africa. A joint effort with UNU will be undertaken, the implementation process of the existing ten-year plans revised, information on existing capacities in Africa updated, strengths and weaknesses analysed, feasible solutions to existing problems will be identified.
- enhance opportunities for collaboration with the HIV and nutrition/emergencies working groups. Both working groups can contribute research findings, concepts and approaches to the capacity development initiatives. These initiatives can also improve human resource capacities for HIV/AIDS and nutrition/emergencies programming.

WORKING GROUP ON NUTRITION OF SCHOOL-AGE CHILDREN

Celia Maier (U of London) presented an update on nutrition of school-age children based on a review published by the SCN Secretariat in the December 2002 issue of *SCN News*. *School-age children: their health and nutrition* was initiated and completed in the previous chairship of this working group, under Don Bundy, and the document was funded and supported by the World Bank. This extensive report is fully downloadable from the SCN website (<http://www.unsystem.org/scn/Publications/SCNNews/scnnews25.pdf>). The main health and nutrition issues for school-age children are: persistent problems of stunting and underweight, multiple micronutrient deficiencies, overweight and obesity in countries undergoing the nutrition transition, malaria and water and sanitation-related diseases, helminth infections and anaemia and HIV. These problems are being addressed through food-for-education programmes (replacing many old school feeding programmes), the partnership for parasite control, roll back malaria initiative, the interagency team initiative for HIV and the FRESH framework for school-based health interventions. The issue of reaching children out of school was raised. Children in school can take an active role in extending school-based services to non-enrolled children.

The working group then reviewed a number of alliances for action in school health and nutrition. Arlene Mitchell (WFP) summarized the accomplishments of WFP in school feeding for the last 40 years and described the renewed campaign in 2000. In 2001, 15m



children were reached in WFP's school feeding programmes in 57 countries. By last year, WFP was active in ten more countries. WFP has undertaken a comprehensive baseline survey of school health activities worldwide, these data appear in a global database. An overview of the school feeding programme in the Gambia was presented by Isatou Nyang Mamadi (Government of the Gambia); the success of school feeding in the Gambia can serve as a model for other national programmes in the region. Flora Sibanda-Mulder (now with WFP) presented UNICEF's priorities and strategies arising in the medium-term strategic plan; girls' education is given attention in this strategy. UNICEF and WFP are working in partnership to deliver a minimum package of health and nutrition interventions within the "education for all" objective. The working group then discussed a series of issues touching on sustainability of school-based initiatives: the role of school feeding in the health and nutrition of school aged children, the role of school gardens and community involvement, capacity building, exit strategies and the role of the private sector in long term implementation, HIV as it affects school age children. These particular concerns were noted: the need for cost analysis, local purchase for school feeding programmes, non-payment of teachers salaries, girls' security, and scaling up.

UPDATE ON 30TH SESSION—WORKING GROUP ON NUTRITION AND HIV/AIDS

The Working Group on Nutrition and HIV/AIDS, co-chaired by Andrew Tomkins and Jos Perriens, has been active since the excellent meeting in Chennai, India in March 2003 when the enormous challenges of nutrition and HIV/AIDS were discussed within and outside of the main session. There has been considerable progress.

New agency initiatives

In May 2003 the WHO convened an Expert Advisory Group on Nutrition and HIV/AIDS. This activity was coordinated by Randa Saadeh and supported by Graeme Clugston and David Nabarro of WHO, who made important contributions to the meeting. Background papers were prepared and have been updated and a state of the art review on the evidence base for nutrition interventions in relation to HIV/AIDS will be released later this year.

The meeting focused on three key issues:

- *How much are energy and protein requirements increased among those who are HIV infected and those who are infected with opportunistic infections?* The group was strengthened by the input of several researchers at the cutting edge of these issues. The overall conclusion was that energy requirements are likely to increase by about 10% as a result of HIV infection and those people who have opportunistic infections require an additional 20-30%. There was no

evidence to conclude that protein requirements are increased over and above the percentage increases that were suggested for energy

- *Nutritional factors associated with the efficacy and safety of antiretroviral drugs.* It was noted that hyperlipidaemias (and the associated increased risk of stroke and coronary artery disease) is now an increasing problem among HIV infected subjects who have received antiretrovirals for some years. The metabolic side effects are more common among those who are undernourished.
- *Several important micronutrient intervention studies are underway.* Key issues are being reviewed in relation to micronutrient efficacy and safety, particularly in terms of maternal health, mother to child transmission of HIV and pregnancy outcome including birthweight and immune status.

New dissemination of information

There is now a plethora of websites offering nutritional advice to HIV infected subjects. Many of them appear to have little evidence base for the claims and some are completely unrealistic. It is therefore important to highlight those sites which are evidence based and provide accurate state of the art information. At present, the IFPRI web site (www.ifpri.org) provides excellent reviews on nutrition and AIDS with a particular focus on household food security with full reviews and useful links to other sites. The renewal programme (Regional Network on HIV/AIDS, Rural Livelihoods and Food Security in Sub Saharan Africa) is being co-ordinated by Stuart Gillespie. The FANTA site (www.fantaproject.org) contains useful information on nutrition and HIV with important inputs by Bruce Cogill, Ellen Piwoz and Elionora Sumara. The International Association of Physicians in AIDS Care site provides useful information on clinical and public health aspects of nutrition and HIV (www.iapac.org). There will shortly be an SCN website on Nutrition and HIV/AIDS.

New knowledge

There are several new lines of evidence suggesting important roles for nutrition interventions. A study about to be published in *AIDS* describes a significant reduction in mortality among HIV infected subjects in Thailand after 12 months of receiving daily multiple micronutrient preparations. Preliminary analysis suggests that in certain circumstances, low birthweight may be prevented by antenatal micronutrient supplements. Appropriate dietary interventions may limit the metabolic complications of antiretroviral drugs.

New networks

UNICEF, under the overall direction of Arjan de Wagt, is organising several important workshops on nutrition and HIV focusing on the programmatic implications of new knowledge on nutrition interventions. WHO, in association with other agencies, is to

develop new guidelines for infant feeding by HIV infected mothers. Daniel Raiten at the National Institute of Health has drawn attention to key issues which require research in nutrition/HIV/AIDS and the SCN is about to launch a specific web site on this subject.

New challenges

Key questions have been identified at programme and policy levels that are likely to be addressed by new research in the next year if funding is made available:

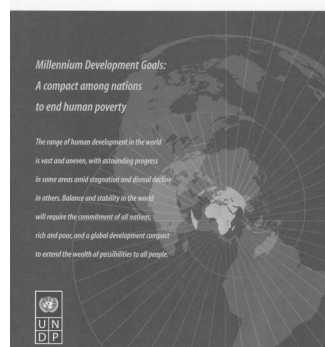
- What clinical benefits are gained by nutrition interventions in individuals who do not gain access to antiretrovirals?
- How do nutrition interventions enhance the effect

and safety of antiretrovirals?

- What agricultural/social policy and programmes support the nutritional status and household food security of families and individuals affected by HIV, particularly orphans?

The SCN Working Group is keen, through the SCN website and through information networks, to present an up to date review of nutrition and HIV/AIDS at the next SCN meeting in March 2004. At the present rate of progress there will be an enormous amount to report that will influence nutrition and health care policy. Contributions to this presentation would be welcomed by Andrew Tomkins at a.tomkins@ich.ucl.ac.uk.

HUMAN
DEVELOPMENT
REPORT 2003



Human Development Report 2003 United Nations Development Programme

This year's Human Development Report introduces the new Millennium Development Compact, which proposes new global and regional policies to kick-start growth and reduce poverty. The Compact was struck in 2002 in Monterrey, Mexico between countries from the North and South.

The new Compact urges strategic action in the fight against poverty and calls on:

developing countries to adopt pro-poor policies that reinforce each other and are targeted to the Goals
donor countries to back these reforms with more resources and trade opportunities
for nations, both rich and poor, to put the Goals at the centre of national and global decision-making.

The Report calls on developing country governments to prioritize spending on the basic services that poor people need most: primary schools, not universities; rural clinics, not technologically advanced hospitals in big cities. The Report also proposes that all poor countries formally analyze whether they are on target to meet the Millennium Development Goals and seek to turn these goals into national rallying points, embedded in existing development plans.

As in previous years, the Report ranks 172 countries according to their level of human development. It also identifies 59 "priority" countries, which require intensified effort if the Millennium Development Goals are to be met. In 31 of these countries, progress towards the goals has either stalled or, worse, has begun to reverse.

In sub-Saharan Africa, the devastation of the HIV/AIDS pandemic is responsible for the declines in the 2003 Human Development Index. Life expectancy has fallen dramatically with HIV/AIDS incidence rates as high as one in five in some countries.

Two other indices shed light on important aspects of development. The Human Poverty Index, which ranks rich countries according to their national levels of poverty, illiteracy, unemployment and life-expectancy, shows that even in middle or high income countries, inequity persists. The Gender Empowerment Measure, which shows women's participation in the political and economic arenas, shows discrimination against women persists despite high national ranking on the Human Development Index, with many poor countries outperforming far richer countries.

The Human Development Report 2003 is available at www.undp.org

Programme News

INTERAGENCY

ICRW-IFPRI-USAID

The Agriculture-Nutrition Advantage Project

An institutional study was recently completed in Uganda, Mozambique, and Nigeria to examine the opportunities for and barriers to strengthening linkages between the agriculture and nutrition communities, and the use of gender approaches and methods in that process. This study is part of The Agriculture-Nutrition Advantage Project (see *SCN News* #25, p. 33), that seeks to reduce hunger in five African countries. The International Food Policy Research Institute (IFPRI) led the study.

The institutional analysis locates the place of nutrition within government. It describes the operational, professional, political, and resource constraints in designing and implementing nutrition interventions. The influence of several common factors recur across the three countries—political dynamics, the sectoral organization of government and other institutions, the efficacy of government in providing public goods, the weight given to technical analysis in policy making, general levels of human capacity, and the competition for scarce resources.

Given this, it is not surprising that there is a lack of cross-sectoral collaboration on nutrition issues. Advocacy is critical for bringing increased attention to nutrition through agriculture-driven and other interventions, particularly given the "hidden face" of malnutrition and misconceptions about what constitutes food security. Lastly, the potential for improving the impact of nutrition interventions through gender analysis could be enhanced if capacity is built to move beyond awareness to action.

Country-specific findings include:

- Uganda: aggressive policy-making is characteristic of government; however, nutrition concerns are not well represented in policy. Nutrition needs to be inserted into the poverty eradication strategy and the agricultural modernization plan to gain currency within Uganda's development agenda. Active government decentralization and bottom-up policy-making offer substantial opportunities for improving nutrition, including its links to agriculture, but pose challenges as well.
- Mozambique: the dominant constraint facing efforts to improve nutrition is the lack of professional capacity. This occurs in both the nutrition and agriculture sectors. Nutrition does not feature within the lead policies of government, but opportunities exist to incorporate it, e.g., through SETSAN (National Food and Nutrition Security Strategy).
- Nigeria: the policy-making environment is relatively unstructured, in contrast to Mozambique and Uganda. However, a national food and nutrition policy was recently adopted, and unlike the other countries, Nigeria does not suffer from human capital deficiencies in nutrition. The policy, coupled with effective advocacy, can be used to significantly advance nutrition within the quite personalized national policy process.

The report will be available on the project website (www.agnutritionadvantage.org/) and IFPRI's website (www.ifpri.org/) in the near future.

Contact: Todd Benson t.benson@cgiar.org

IFPRI

Breeding Staple Crops for Improved Nutrition: CGIAR Biofortification Challenge Programme is up and running

Micronutrient malnutrition, primarily the result of diets poor in bioavailable vitamins and minerals, affects more than half of the world's population, especially women and preschool children. The costs of these deficiencies in terms of lives lost, forgone economic growth, and poor quality of life are staggering. To reach the Millennium Development Goal's target of halving the proportion of undernourished people by 2015, new technologies and approaches are needed to help address the problem.

Since 1995, scientists from four Future Harvest Centres of the Consultative Group on International Agricultural Research (CGIAR) and partner organizations have been evaluating the feasibility of using plant breeding techniques to produce new varieties of staple crops with high zinc, iron, and beta-carotene content. Results to date suggest that this

approach is feasible. Proof of concept research indicates that for most crops, scientists will be able to increase micronutrient densities through conventional breeding by a multiple of two for iron and zinc and by higher multiples for beta-carotene. At the end of this six-year pilot study, scientists agree that a plant breeding strategy, now coined "biofortification," is feasible, but that agronomic and human nutrition questions remain unanswered, therefore, justifying an expanded global research programme and expanded support for partnerships.

In November of 2002, the full membership of the CGIAR embraced the biofortification research agenda as one of its pioneer Challenge Programmes. Activities got under way formally this last March with the first meeting of the project advisory committee (PAC) and the selection of Dr Howarth Bouis as Programme Director. Challenge programmes as envisioned by the CGIAR are high-impact, scientific research programmes organized around complex issues of overwhelming global and/or regional significance, and require partnerships among a wide range of institutions and

disciplines in order to deliver its products. The International Centre for Tropical Research (CIAT) in Cali, Colombia and the IFPRI in Washington, DC are the convening organizations of the Biofortification Challenge Programme research agenda. With the appointment of a programme director and the convening of the Programme Advisory Committee, the research activities will now continue with added strength.

The Biofortification Challenge Programme seeks to bring the full potential of agricultural and nutrition science to bear on the persistent problem of micronutrient malnutrition. Through biofortification, the Future Harvest centres are modifying their mandates; adding food quality to quantity and bringing new resources and new commitments to end hidden hunger through close partnerships with members of the international nutrition community. Look for updates and research results reported in SCN news and on their forthcoming website www.seedsofhealth.info, or contact Bonnie McClafferty at B.McClafferty@CGLAR.org.

INACG

International Nutritional Anaemia Consultative Group

INACG Symposium - 6 February 2003 - Marrakech, Morocco

INACG held its third international symposium "Integrating Programmes to Move Iron Deficiency and Anaemia Control Forward" in conjunction with the 21st IVACG Meeting.

Dr Frances Davidson, INACG Secretary, opened the symposium, saying that she was pleased with the progress made since the last INACG symposium, in Hanoi, Vietnam, February 2001. In particular, there is now documentation of the causes and extent of anaemia and the development and evaluation of programmes to control anaemia. Dr Davidson stressed the need to integrate iron deficiency and anaemia control into health care programmes in order to create synergies.

The keynote presentation, given by Dr Peter Hotez, Professor and Chair of the Department of Microbiology and Tropical Medicine at The George Washington University, provided new insights into the development of a vaccine for hookworm, a major cause of anaemia in developing countries. Dr Hotez's lecture was followed by a presentation of a recent meta-analysis on the effect of iron supplementation on the incidence of infections in children, which concluded that iron supplementation has no deleterious effect on the incidence of infections. The third presentation, in this first session "Infectious Disease, Iron Deficiency and Anaemia Control," stressed the importance of effective antimalarial strategies to reduce episodes of malaria and anaemia in vulnerable groups such as infants, young children, and pregnant women. In addition, the potential for integrating malaria, iron deficiency and anaemia control at points of routine contact with health services was discussed.

The second session of the symposium updated attendees on recent reports and meetings related to iron deficiency and anaemia, including estimates from the Global Burden of Disease 2000 Project issued by WHO. Of the 26 risk factors included in the project, iron deficiency was ranked ninth for disability-adjusted life years lost. The estimates presented in the report could be used as an effective basis in

advocating for the control of iron deficiency. Recent advances in iron fortification, including recent data on the efficacy of iron fortification of condiments, and efforts to control iron deficiency in children less than 2 years of age were also presented.

The results of a recent INACG workshop on "Reducing the Prevalence of Anaemia: Planning and Implementing a Strategic Communication Approach" were the focus of the symposium's final session. A presentation on the role of strategic communication was followed by a description of a strategic communication plan developed by a multisectoral team from Ghana that participated in the workshop. Representatives from Ministries of Health (Morocco and Ghana), Helen Keller International (Mali), and World Vision (Malawi) also presented ongoing anaemia communication programmes in their countries.

In her concluding remarks, Dr Lena Davidsson, Chair of the INACG Steering Committee, summarized the presentations and highlighted the importance of integrated approaches to control iron deficiency and anaemia and stressed the importance of cross-sectoral collaborative efforts to control iron deficiency and anaemia.

The symposium report will be available later this year.

Contact: [Veronica Triana vtriana@ilsa.org](mailto:Veronica.Triana.vtriana@ilsa.org)

IVACG

International Vitamin A Consultative Group

IVACG Meeting - 3-5 February 2003 - Marrakech, Morocco

More than 650 policy-makers, programme managers, planners, and scientists from over 70 countries participated the 21st IVACG Meeting, "Improving the Vitamin A Status of Populations." Discussions focused on strategies to improve the vitamin A status of infants, young children and women of childbearing age in developing countries.

Data presented from a number of countries indicated that successful alternatives to delivering vitamin A supplements through National Immunization Days (NIDs) for polio are being used. Since polio eradication is becoming a reality and NIDs are ending, finding new ways to deliver supplements is essential. Successful national programmes are in place using vitamin A days, integration with child health weeks, and regular monthly outreach programmes.

Success in improving the dietary intake of vitamin A was also presented. Production and consumption of orange-flesh sweet potatoes in Africa is effective in increasing vitamin A intake. Fortification of staple foods, ie sugar and table oils, were also shown to improve vitamin A status when implemented on a national scale. Such improvements will reduce a country's requirement for supplementation programmes.

Interactions among various micronutrients are emerging as critical areas for new scientific study. Preliminary data suggest that providing a multi-micronutrient supplement may be counter-productive. More research is needed before national governments can support the use of micronutrient combinations to effectively reduce vitamin A deficiency disorders.

Data on the role of maternal vitamin A supplementation and

transmission of HIV infection to the infant were contradictory. The impact of infections, ie HIV, malaria, and tuberculosis, along with micronutrient interactions are the key future research areas for scientists interested in vitamin A deficiency disorders.

Dr Alfred Sommer, Chair of the IVACG Steering Committee, closed the three-day meeting saying that the XXI IVACG Meeting was one of the most productive ever held. The high quality of the scientific information presented and the strong evidence of successful programmes based on this information shows that controlling vitamin A deficiency disorders is an effective, sustainable, global public health movement.

Two other micronutrient groups, the INACG (see above) and the International Zinc Nutrition Consultative Group (IZiNCG) took advantage of the broad audience to hold scientific and programmatic discussions on iron deficiency anaemia and zinc deficiency. For the first time the micronutrient problems in developing countries were discussed in tandem.

The meeting report will be available later this year.

Contact: Veronica Triana: vtriana@ilsa.org

FIVIMS

Food Insecurity and Vulnerability Information and Mapping Systems

International meetings

Accurate, reliable and timely measurement of the prevalence of hunger, malnutrition, food insecurity and vulnerability is required in order to monitor progress in hunger reduction. In June 2002, the Economic Analysis Division, the Secretariat of the IAWG on FIVIMS and the Food and Nutrition and Statistics Divisions of FAO convened a symposium to discuss methodologies to monitor the achievements of this goal.

By promoting dialogue among advocates of various methods and national and international stakeholders, the Symposium served to create a greater appreciation of the strengths and weaknesses of the different methods as well as how the corresponding measures complement each other. The main consensus to emerge at the Symposium was that no single measure can capture all aspects of hunger while at the same time providing policy-makers with relevant and timely information in a cost-effective manner. Please consult the ISS proceedings online or contact fivims-secretariat@fao.org for hard copies.

On the occasion of the 29th Committee on Food Security (CFS), held at FAO's headquarters from the 12th to the 16th May 2003, the FIVIMS Secretariat presented its Annual Report on the Development of FIVIMS, which highlights progress in the past 12 months at country and agency level. This was supplemented by a further document prepared by the Secretariat 'Information Note on the Status of FIVIMS at Country Level' that provided an overview of trends in the status of FIVIMS at the regional level with a detailed matrix illustrating changes since the previous evaluation in 2000 (www.fao.org/DOCREP/MEETING/006/Y8892e.HTM). Some information products on FIVIMS success stories, as well as a world map on the status of FIVIMS in 2003, were developed on this occasion for a broader public and will

soon be featured on the FIVIMS website (www.fivims.net).

FIVIMS status at the regional/country level

Asia and the Pacific: The status of FIVIMS in this region is mixed but with an overall positive trend. South West Pacific Ministers for Agriculture held their Fifth Meeting in Suva, Fiji on 31 March and 1 April 2003. They discussed a number of food security issues in the Pacific region, including FIVIMS. The Ministers endorsed the need for enhanced monitoring of food insecurity and vulnerability in the region through information systems that apply the FIVIMS approach. Samoa, a FIVIMS pilot country, has developed a national information strategy and work plan.

Latin America and Caribbean: FIVIMS-related systems are developing quickly in this region with a strong focus on the assessment of existing information systems and the identification of vulnerable groups.

Sub-Saharan Africa: Few new activities have been started, with the exceptions of Burkina Faso and Cape Verde, two FIVIMS pilot countries. Work initiated in Central and West African countries continues. The new strategy of regional development of the Comité Permanent Inter-Etats de Lutte Contre la Sécheresse au Sahel (CILSS), member of the IAWG, is an opportunity for FIVIMS implementation in West Africa. In Eastern Africa, new activities have been initiated in Kenya (a pilot country). Moreover, recent missions by the Secretariat staff to Uganda and South Africa explored the potential for new partnerships within the framework of the FAO-Netherlands Partnership Programme (FNPP) project "Integrating FIVIMS into CCA/UNDAF/PRSP". Updates on these activities will be posted in future reports.

New national FIVIMS networks are being created in many Southern African countries such as South Africa, Swaziland, Zambia and Zimbabwe, and National FIVIMS Action Plans are being formulated in Comoros, Madagascar, South Africa and Zambia. Interest in FIVIMS in this region is high, due to the recent food crisis and thanks to the presence of the Southern African Development Community (SADC), an IAWG member. Collaboration opportunities with the Inter-Governmental Authority on Development (IGAD) in Eastern Africa and the Horn will soon also be explored.

FIVIMS Secretariat

The Secretariat is preparing for two FIVIMS related assessments: the External Assessment and Strategic Planning of the overall IAWG-FIVIMS Initiative, and the Review of the EC funded FIVIMS country projects. Both generate interesting results for future better targeting of FIVIMS activities.

Meanwhile, the Secretariat continues with its information dissemination activities. The second of the four annual FIVIMS newsletters has just been published and is accessible through the FIVIMS website. General documentation, guidelines and State of the Food Insecurity reports are regularly distributed according to requests. Work to improve user-friendliness of the FIVIMS website and to better meet users' needs continues, with the release of new profiles on FIVIMS-related activities by country and of new relevant information resources, and the enhancement of dynamic applications to facilitate access to mapping databases.

For more information please visit www.fivims.net or contact fivims-secretariat@fao.org.

PATH

Programme for Appropriate Technology in Health

Micronutrient Assessment Tools

PATH has made significant contributions to the international nutrition community in the area of micronutrient status assessment. With funding from the United States Agency for International Development (USAID) under the HealthTech: Technologies for Health programme, PATH has developed an ELISA test for the measurement of Retinol Binding Protein (RBP), as well as simple and accurate haemoglobin strip tests. Implementation and use of the RBP-ELISA can simplify vitamin A deficiency (VAD) assessment, enhance the reliability of testing, and greatly facilitate monitoring of VAD intervention programmes. The RBP-EIA is a rapid, inexpensive, and quantitative tool that can be used to assess VAD status at the population level. The RBP-EIA can be performed at district and regional laboratories, reducing the need to transport samples to centralized laboratories to determine vitamin A status. The test has been found to have close correspondence with retinol as measured by high-performance liquid chromatography (HPLC) and is recognized as a surrogate marker.

PATH is currently seeking funds to develop new, rapid tools for micronutrient assessment that are responsive to specific programme objectives, particularly food fortification. There is tremendous scope to develop alternative tools that can provide quantitative as well as semi-quantitative estimates that provide the input required for programmes and may support and accelerate the routine process monitoring of interventions. PATH plays a major role in facilitating the development, validation, commercialization and introduction of such tools.

Guidelines for the Detection of Anaemia

In collaboration with WHO, the USAID-funded Opportunities for Micronutrient Interventions (OMNI) project, and the USAID-funded HealthTech programme, PATH has produced two manuals on anaemia detection in low-resource settings. One manual, *Anaemia Detection in Health Services: Guidelines for Programme Managers*, presents an overview of programme issues in anaemia-detection programmes and reviews different options for programme managers, depending on the prevalence of anaemia and of the resources available. It provides descriptions of existing anaemia-detection devices, including the advantages and disadvantages of each and highlights problems with use. *Anaemia Detection Methods in Low Resource Settings: A Manual for Health Workers*, provides step-by-step instructions for nine anaemia-detection tests, including tips from field technicians on improving accuracy and efficiency of the methods. PATH has extensive experience in developing field guidelines to facilitate programme delivery and to support health workers.

Ultra Rice™

Ultra Rice™ is a product that PATH has been developing that allows for the fortification of the world's most commonly consumed staple. Ultra Rice™ may be defined as a micronutrient fortified premix that is typically blended with local rice in ratios approximating 1:100 before preparing in the home. Ultra Rice™ technology offers several advantages. Among them its resemblance to natural milled-rice

grains. More importantly, since it retains this form and the greater part of the included micronutrients during the typical washing and cooking stages, no special rice preparation procedures are involved. During its fabrication Ultra Rice develops a structure that helps to protect sensitive micronutrients from ultraviolet light, oxidation, and leaching during food preparation. While the original Ultra Rice™ was designed as a vehicle for vitamin A, a second formula developed includes zinc, thiamin, and folate. These two formulations are now being produced, blended with local rice, and distributed at the national level in Colombia.

Responding to worldwide interest in iron fortification, PATH is currently exploring the development of an iron-bearing Ultra Rice(tm) formula. We have identified a small number of compounds and are in the process of conducting bioavailability and consumer acceptance studies to confirm that the new formulation will have a high appeal and impart a biological impact. We are in the process of developing additional feasibility work on the introduction of Ultra Rice (tm) in India, China, Brazil and Ghana.

Support to National Nutrition Initiatives

PATH has been collaborating with the governments of several countries to support and strengthen the delivery of nutrition interventions. For example, PATH has been working with the Indonesian Government as part of the Healthy Start Plus Programme. The project aims to improve the accessibility, quality, timing, appropriateness, and utilization of essential health services. Specific objectives of Healthy Start Plus are to improve the health and nutrition of pregnant women; enhance the quality of care at delivery and in the postpartum period; and increase breastfeeding and use of family planning. Additional objectives are to improve the survival, health, and nutrition of children under five years of age; strengthen home management of illness among children under five; and enhance the ability of local health personnel and communities to manage health programmes.

PATH's work in these areas is supported by USAID and by the Bill & Melinda Gates Foundation.

For more information about the activities, technologies, and resources mentioned above, visit www.path.org. For more information on rapid diagnostics, visit www.rapid-diagnostics.org.

Next issue of

SCN News

#27—December 2003

will feature a series of articles on
complementary feeding



Speakers' Corner

Principles for food trade

George Kent

Historically, food and agriculture policies have centred on the interests of producers, especially large scale producers. However, food has consumption value as well as commodity value. The governance of international trade in food should give special attention to the concerns of those most vulnerable to food insecurity. As specified by the World Food Summit in 1996, "Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life." The definition of the human right to adequate food is similar:

The right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food or means for its procurement.¹

There is a need to design a new normative framework and appropriate institutional arrangements for the governance of international food trade. The discussions now under way regarding the revision of the World Trade Organization's (WTO's) Agreement on Agriculture provide a good opportunity for reconsidering the principles under which international food trade is managed. This essay raises some key issues, not to resolve them, but to assure that they are on the agenda.

Subsidies and dumping

Many countries subsidize selected food producers, directly or indirectly, resulting in overproduction in those sectors. To relieve the glut, some of these countries "dump" the products into poor countries. Reducing tariffs on primary commodities makes it easier for rich countries to dump their primary commodities into poor countries.

Dumping can do severe harm to food producers in the receiving countries. Since much of the employment in poorer countries is in small-scale food production, dumping can reduce the incomes of large parts of the population, thus reducing their food security. Dumping also can lead to excessive dependency of consumers on these under-priced products and subject them to considerable harm if the flow is interrupted. For example, under the North American Free Trade Association, roughly a quarter of the corn in Mexico is now imported from the United States, and many Mexican corn producers are going out of business. If that flow of corn from the United States is interrupted, or if the price suddenly increases, consumers in Mexico will have trouble getting their traditional food staple.

Large shares of the subsidies that are provided go to larger producers who are well off and have reasonable alternatives. They receive subsidies primarily as a result of their political power rather than their need. This "welfare for the rich" should be sharply reduced or eliminated.

However, the subsidies to poor, small-scale producers who have few alternative means of livelihood are a different matter. These producers may be inefficient by common eco-

omic criteria. However, subsidizing them may be good public policy, in that subsidies to small-scale food producers are part of the social safety net. For this purpose, subsidies to small-scale food producers who produce for local consumption (not export) can be very cost effective. While subsidies to small-scale producers are not economically efficient, they may be socially efficient.

Discriminatory tariffs, discriminatory pricing

Considerable attention is being given to the subsidy issue in ongoing debates about the WTO's *Agreement on Agriculture*. However, many other issues are being neglected, especially issues affecting poor countries.

There is currently a pattern of "escalating tariffs" under which tariffs are pushed down on primary commodities but left high on processed foods. Reducing tariffs on primary foods but not on processed food is discriminatory, preventing poor countries from engaging in more profitable value-added (processed) food industries. The liberalization of food trade through the reduction of tariffs should be accomplished in a way that does not discriminate against poor countries.

Even without discriminatory tariffs, the pressure on poor countries to open their domestic markets to foreign food suppliers can be very harmful to them. Local food producers in poor countries may not be able to compete with the imports. The result that their incomes plummet, destroying their food security. The effect of cheap imports can be devastating. Until alternative means of livelihood can be assured, providing protection of small producers through tariffs against cheap food imports may be just as sensible as subsidizing small-scale producers. This may appear to be economically inefficient in some frameworks of analysis, but from a social perspective it may be good policy.

In the idealized marketplace, the prices for the same product of the same quality would be the same throughout the world, with variations only due to transportation costs. However, in the real world, where prices must be negotiated, producers in poor countries often get paid less, even when they produce exactly the same products for the world market, as do producers in richer countries. For example, farmers from poor countries receive much less in real terms for a bushel of grain than farmers of the richer countries, even when their products end up in the same markets. The United Nations Development Programme observes, "... rich producers are paid more than poor ones *for identical goods*."² Their labour is paid less as well.

Even without discriminatory tariffs or discriminatory pricing, countries that export primary goods are likely to be disadvantaged by the fact that the prices they get for their primary goods remain essentially flat while the prices they must pay for their imports of processed goods rise rapidly. While it has long been known that the prices for primary goods exported by poorer countries tend to remain flat, it is now

being found that this is also true for their exports of processed goods.

The benefits received from a country's exports may be greatly diluted by the diversion of a large share of the benefits to owners from outside the country. This diversion may occur through acknowledged profit shares, or it may occur less visibly through transfer pricing. This is where prices for exchanges within branches of a corporation are manipulated through accounting practices that benefit the managers and stockholders. Multinational corporations may deal with their subsidiaries in a way designed to maximize the flow of benefits to headquarters, at the expense of the subsidiaries.

Richer countries promote trade liberalization in a way that suggests it would be beneficial to all, but it is not equally beneficial. Trade tends to provide its greatest benefits to those who are more powerful. It contributes to the widening of gaps between rich and poor.

Food flows mainly toward money, not need. Food trade is not about sending off unneeded surpluses, any more than the trade in automobiles is about getting rid of "extra" automobiles. And it is not about redistributing food to where it is most needed. On balance, food flows from food deficit countries to countries that have more than enough. The poor feed the rich.

In theory, the foreign exchange that compensates for the outflow of food could be used to meet the food needs of the poor, but often it is not. The poor are politically weak, and do not control how foreign exchange earnings are used. Since food in international trade tends to flow away from needy countries, special measures should be taken globally to assure that needs are met in those countries.

The priority of human rights

Under the principle of food sovereignty, under the principle of subsidiarity (decisions should be made at as local a level as possible), and in recognition of their obligations under the human right to adequate food, national governments should not give up control over their own food systems. They should be supported in exercising their own judgement as to when increasing openness to trade or increasing self reliance would best serve their needs. Forced trade is not free trade.

Accordingly, all countries should have the right to set their own criteria regarding the character of the food they import. They should not have to justify their judgements or doubts regarding food quality to anyone outside the country. For example, they should be free to refuse to import genetically modified foods, or foods whose characteristics they may question for any reason at all.

Countries should be free to refuse to accept imports based

not only on the character of the product, but on other grounds as well. For example, they should be free to refuse to accept products that are likely to be misused because of difficult environmental, sanitary, economic, or other conditions. They should be free to refuse to import foods that are produced through the excessive exploitation of workers or with methods that pollute or deplete the environment.

Since food is so essential to human nutrition, health, and general well being, food trade should be managed on the basis of the obligation of all states and other actors to respect human rights, particularly the human right to adequate food. The liberalization of food trade through means such as the reduction of tariffs and other obstacles might contribute to the realization of the human right to adequate food under some circumstances, but under other circumstances it may not. The realization of the human right to adequate food should take priority over the liberalization of trade.

Under appropriate management, food trade could make a major contribution toward the realization of the human right to adequate food for all people. For this reason, poor countries should have a preferential role in the design and management of a new international regime for the governance of food trade. At the very least, principles of democratic global governance require that all people are equally represented. No matter what the rationale, given the compelling need for decisive action to assure the realization of the human right to adequate food for all people, the poor should be strongly represented in establishing these new arrangements.

Food, essential to the well being of every individual, should not be treated as just another commodity. There is an urgent need to create a new international regime governing international trade in food, fully considering the need to assure the realization of the human right to adequate food for all people.

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Prof George Kent, University of Hawai'i, kent@hawaii.edu

The European Union held a summit the 21-22 June 2003, to unveil a draft for its new constitution. In an editorial in the New York Times (23 June 2003), the editor pointed out that what was

...most glaringly absent was any reform of Europe's subsidy-rich common agricultural policy, which gobbles up half the union's budget and manages to simultaneously victimize both European consumers and poor farmers in the developing world...It is too bad that in their weekend discussions about illegal immigration and asylum policies...Europe's leaders couldn't have reflected on how their agricultural policies contribute to the very desperation that provokes such migratory flows....

Publications

Editor's note—Over the past six months the Secretariat has again received a large number of publications, more than space allows in this section of SCN News. We are very grateful to the many authors, printers and publishers who have sent copies of their work.

AGRARIAN CHANGE, GENDER AND LAND RIGHTS

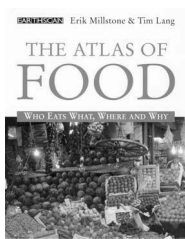
Shabra Razavi, editor, UNRISD, 2003, 296 pp

This collection of cutting-edge articles focuses on recent shifts in thinking about land rights and how they relate to women. The contributions to this book fall under two parts: 1) neoliberal macroeconomic policies, agricultural liberalization and the reform of land tenure institutions, and 2) country case studies (South Africa, Tanzania, India, Uzbekistan and Brazil) that examine diverse ways in which gender structures are implicated in the reproduction of the rural economy. Authors are deeply critical of the one-size-fits all gender and development prescriptions that advocate a blanket policy of ensuring women's land access through titling, without reference to context specificities. These articles try to move past the assumption that gender power relations at the local level are embedded in conjugal intra-household relations alone. Instead, the structure of power women confront operates at the global, national and local levels and in diverse institutional arenas.

www.blackwellpublishing.com

THE ATLAS OF FOOD

Erik Millstone and Tim Lang, Earthscan, 2003, 128 pp



This atlas provides an overview of the major issues surrounding food and its consumption, production and transportation. Vividly presented through the creative use of maps and graphics, this atlas provides clear authoritative and comprehensive accounts of the food chain—from plough to plate. It also reveals how the food chain affects the lives and livelihoods of us all—farmers and suburban shoppers alike. Four parts cover the spectrum of food production: contemporary challenges, farming, trade, and processing retailing and consumption. A fifth part presents world tables on agriculture and consumption. The fundamental theme of the atlas focuses on how poor nutrition is not a consequence of any overall scarcity of food, but more often of an outcome of poverty, lack of resources and access to food. The distance between producers and consumers has widened,

even though interconnections and loops of the food-supply chain have become increasingly complex.

www.earthscan.co.uk

INTEGRATION OF FOOD AND NUTRITION SECURITY (FNS) IN POVERTY REDUCTION STRATEGY PAPERS (PRDPS)

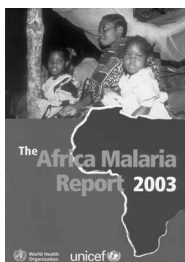
SLE, Centre for Advanced Training in Rural Development, Humboldt University, Berlin, 2002, 213 pp

This book uses cases studies to examine how FNS is integrated into PRSPs. The authors make the case for coupling the concept of FNS into PRSP since food and nutrition insecurity is both a cause and an outcome of poverty. The assessment framework uses the three complimentary dimensions of FNS: food availability, food access and utilization. It also references the four PRSP phases: elaboration and content of the poverty profile, strategy design, the implementation, and the monitoring and evaluation system. The authors list a number of recommendations for better incorporation of FNS into PRSPs including: a better profiling of poverty and its interactions; better integration of FNS into PRSP strategy design for poverty reduction; better coordination and institutional arrangement of the various implementation structures and subjects; and a separate monitoring and evaluation system in which social and institutional targets are integrated.

www.agrar.hu-berlin.de/sle

AFRICA MALARIA REPORT 2003

WHO and UNICEF, 120 pp



The first of its kind, the Africa Malaria Report 2003 takes stock of the malaria situation and continuing efforts to tackle the disease in Africa. It is based on a review of the best information available to WHO and UNICEF from sample surveys and routine reports at the end of 2002. The Report begins with a comprehensive look at the burden of malaria in the Region, followed by a review of the evidence on insecticide-treated nets. Malaria control is covered in the chapter on treatment, which stresses the greatest challenge in malaria treatment as drug resistance. The chapter on malaria

during pregnancy describes the principal impact of malaria in pregnant women as malaria-related anaemia in the mother and the presence of parasites in the placenta. This leads to impaired foetal nutrition and poorer infant survival and development. Also reviewed are epidemics, complex emergencies, and resource mobilization and financing. The 2000 Summit on Roll Back Malaria held in Abuja, endorsed a "shortlist" of relatively inexpensive malaria control interventions. The Report reviews progress and actions to achieve the Abuja targets. Country profiles are listed at the end of the Report.

www.who.int

DIET, NUTRITION AND THE PREVENTION OF CHRONIC DISEASES

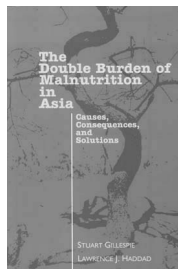
WHO and FAO, 2003, 149 pp

Part of the WHO Technical Report Series, this report is the outcome of a joint WHO/FAO Expert Consultation, held 28 January to 1 February 2002 in Geneva. The Consultation followed up the work of a WHO Study Group on Diet, Nutrition and Prevention of NCDs, which last met in 1989 to make recommendations regarding the prevention of chronic diseases and the reduction of their impact. This report reviews the evidence on the effects of diet and nutrition on chronic diseases and makes recommendations for public health policies and strategies that encompass societal, behavioural and ecological dimensions. Although the primary aim of the Consultation was to set targets related to diet and nutrition, the importance of physical activity was also emphasized. The Consultation considered diet in the context of the macro-economic implications on public health, recommendations on agriculture and the global supply, and demand for fresh and processed food stuffs. A chapter is devoted to 'strategic directions and recommendations for policy and research,' which stresses the need for public health action to prevent the adverse consequences of inappropriate dietary patterns and physical inactivity. General policy principles for the promotion of healthy diets and physical activity are provided. Effective communication and alliances and partnerships are also stressed as precursors for successful actions.

bookorders@who.int

THE DOUBLE BURDEN OF MALNUTRITION IN ASIA: CAUSES, CONSEQUENCES, AND SOLUTIONS

Stuart Gillespie and Lawrence J. Haddad
IFPRI, 2003, 236 pp

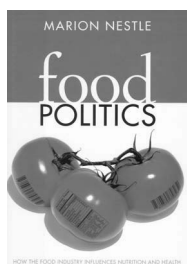


The greatest number of malnourished children in the world reside in Asia. This book is inspired by the massive challenge that this situation poses for Asia. It describes the main driving forces behind the groundswell of undernutrition, while shedding light on the emerging ‘double burden’ of co-existing underweight and overweight, and the linkages between these two different forms of malnutrition. Following detailed analyses of causes and consequences, the authors provide clear evidence-based options for remedial action in differing contexts, all based on the use of a practical approach to conceptualizing risks and opportunities through the lifecycle. Taken together, the evidence and experience presented by the authors constitute a powerful weapon in the battle against malnutrition, and one that is relevant for a wide range of actors and institutions both in Asia and beyond.

www.ifpri.org/pubs/

FOOD POLITICS: HOW THE FOOD INDUSTRY INFLUENCES NUTRITION AND HEALTH

Marion Nestle, University of California Press, 2002, 457 pp



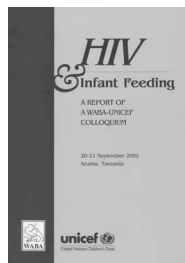
In this exposé, Marion Nestle goes behind the scenes to reveal how the food industry really works and how it affects our health. The abundance of food in the United States—enough calories to meet the needs of every man, woman and child twice over—has a downside. This over-efficient food industry must do everything possible to persuade people to eat more—more food, more often and in larger portions—no matter the consequences. This book illustrates how well the food industry plays politics and how much of it goes on outside the public view. Nestle shows that when it comes to the mass production and consumption of food, strategic decisions

are driven by economics—not science, not common sense, and certainly not health. The book begins by reviewing how the nutrition message has shifted from ‘eat more’ at the begin of the last century to ‘eat less’ by the end of the last century, but this message is severely being undermined by the massive food advertisement campaigns. A chapter on how the food industry exploits children and corrupts schools—leading to the unprecedented rates of childhood obesity—is also included. Other topics include the deregulation of dietary supplements and fortification/functional foods. For non-technical readers a useful appendix is included that provides a brief, nontechnical overview of basic principles of nutrition and fundamental issues that affect our ability to interpret research studies.

www.ucpress.edu

HIV AND INFANT FEEDING: A REPORT OF A WABA-UNICEF COLLOQUIUM

WABA and UNICEF, 2003, 90 pp



Miriam Labbok, in her preface to this report, describes the WABA Colloquium as one of those moments where bridges appear. In this case, the bridge is bringing together those working to prevent every case of HIV/AIDS and those trying to have the best overall public health outcomes for infants and young children. This report compiles presentations and outcomes of the WABA—UNICEF Colloquium held in Arusha, Tanzania, September 2002. The report is divided into three sections: meeting objectives, plenary presentations, and summary of group work reports. In the working groups, it was agreed that the goal should be a healthy child—not just preventing HIV infection. A draft UN Framework for HIV and infant feeding was presented identifying priority actions to be considered by governments in the context of the special circumstances of HIV/AIDS to ensure an environment that encourages appropriate infant and young child feeding while reducing MTCT of HIV.

secr@waba.po.my or www.waba.org.br and www.waba.org.my/colloquium/index.html to download a copy



HOW THE COWS TURNED MAD

Maxime Schwartz, University of California Press, 2003, 223 pp



Originally published in French in 2001, author Maxime Schwartz has written an investigative case history on how BSE (Mad Cow Disease) first appeared in the 1730s, then called scrapie. For nearly three centuries, scientists have been on the trail of this elusive disease and until recently nobody suspected that scrapie, BSE, Creutzfeldt-Jakob disease and kuru were all caused by the same agent. This book tells the story of a disease that continues to elude on many levels. The book concludes by addressing the question of whether we should be afraid of this mysterious disease. The English translation also includes an update to events in 2001.

www.ucpress.edu

LINKING RESEARCH AND ACTION: STRENGTHENING FOOD ASSISTANCE AND FOOD POLICY RESEARCH

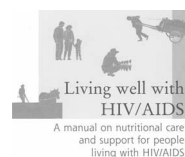
IFPRI, 2003, 12 pp

This set of six briefs summarizes research conducted at IFPRI. The briefs reflect collaboration between IFPRI and WFP to strengthen the linkage between research and food assistance programming; they draw heavily from relief and development work conducted by WFP. The briefs cover topics including: nutrition and food aid; classroom size in food for education programmes; floods, food assistance and food markets in Bangladesh; cost-effective safety nets; the use of poverty maps in food assistance programming; and community day care programmes and effective food aid targeting in urban areas in Guatemala. These briefs can be used as advocacy tools and come in a pouch.

Contact: *Bonnie McCafferty, IFPRI, b.mccafferty@cgiar.org*

LIVING WELL WITH HIV/AIDS

WHO and FAO, 2002, 97 pp



Malnutrition is a serious danger for people living with HIV/AIDS. This manual, produced jointly by WHO and FAO, is de-

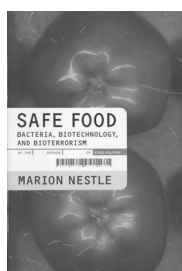
signed to help people living with and caring for patients with HIV/AIDS. Although the recommendations in the manual are generic, specific nutrition recommendations can be adapted to the needs of individuals and local communities. The manual was designed for health service providers, extension workers, community-based organizations, planners of health and social and nutrition services. Nutrition information is comprehensive, dealing with a variety of topics, including: management of diarrhoea, prevention of weight loss, micronutrient supplementation, complications with HIV/AIDS and herbal treatments and remedies. Summary sheets are provided after each chapter for quick reference. Recipes for gaining weight, combating diarrhoea, sore mouths, nausea, vomiting and other digestive problems are also included. www.who.int or www.fao.org

MEASUREMENT AND ASSESSMENT OF FOOD DEPRIVATION AND UNDERNUTRITION
FIVIMS and FAO, 2003, 411 pp

This report contains the proceedings of an international scientific symposium held in Rome, 26-28 June 2002, convened by the Agriculture and Economic Development Analysis Division of FAO. The decision to hold a scientific symposium on the measurement of food deprivation and undernutrition was motivated by the MDG goal of halving the number of hungry by 2015. Five measurement methods were covered in the symposium, including: undernourishment from information based on food balance sheets and household income, and expenditure surveys; food insecurity using household income and expenditure survey data; adequacy of dietary intake based on individual intake surveys; child nutritional status based on anthropometric surveys; and qualitative methods for measuring people's perception of food insecurity and hunger. The main consensus to emerge at the symposium was that no single measure can capture all aspects of hunger, while at the same time providing policy-makers with relevant and timely information in a cost-effective manner. www.fivims.net/EN/ISS.htm

SAFE FOOD: BACTERIA, BIOTECHNOLOGY, AND BIOTERRORISM

Marion Nestle, University of California Press, 2003, 350 pp



In this book Marion Nestle argues that ensuring food safety is a political issue. When it comes to food safety, billions of

dollars are at stake and industry, government and consumers collide over issues of values, economics, and political power, but not always with public interest in mind. Although the debates may appear to be about science, Nestle maintains that they are really about control and who decides when a food is safe. Nestle draws on three examples of recent debates challenging century-old-laws on food safety: microbial contamination of meat and poultry, genetically modified ingredients in supermarket products, and newly emerging hazards such as bioterrorism. In her conclusion, Nestle puts forward useful suggestions for the food industry, the federal government and the public in order to ensure safer foods and improve trust in the food supply. A useful appendix is also included to give non-scientific readers a better understanding of the science of food biotechnology. www.ucpress.edu

THE SURVEILLANCE OF RISK FACTORS (SURF) REPORT
WHO, 2003, 42 pp, plus CD-ROM

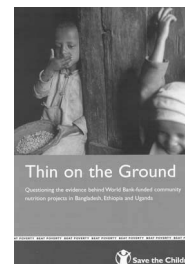


The SuRF Report captures disease country risk factor profiles from Member States. It is the first step in bringing non-communicable diseases (NCDs) under control. The *World Health Report (WHR) 2002* highlighted the importance of risk factors as indicators of future health status. The SuRF report compliments the WHR by focusing on recent, nationally representative data and presents the data as they are reported by survey sources. The risk factors reviewed in the report include: those that contribute the most to mortality and morbidity from chronic diseases; can be changed through primary intervention; and can easily be measured in populations. The risk factor prevalence profiles help to identify a country's strengths as well as gaps and deficiencies in its data. The main objective of the NCD surveillance programme is to use the collected country data to produce best estimates of country-level risk factor prevalence and trends in standard age groupings. The resulting comparable risk factor estimates will be published in the SuRF Report II. ncdsurf@who.int

TERRORIST THREATS TO FOOD
WHO, 2003, 45 pp

The deliberate contamination of food for terrorist purposes is a real and current threat, causing global public health impacts. This book responds to increasing concern that chemical, biological or radionuclear agents might be used deliberately to harm civilian populations. The book outlines the two major strategies for countering the threat of food sabotage: prevention and response (including preparedness). The book begins by placing the problem in the context of other food safety emergencies. Subsequent chapters review the preventive aspects that can be incorporated into food safety programmes to meet the new threat of food sabotage and the preparedness and response elements specific to food safety. Current activities of WHO are also reviewed in order to insure a more effective response to such terrorist threats. This timely book is designed to help improve the capacity of Member States in order to reduce the increasing burden of foodborne illnesses. publications@who.int

THIN ON THE GROUND
Save the Children UK, 2003, 69 pp



Presented at this year's SCN Annual Session, this critical look at World Bank-funded community nutrition projects questions the under-lying assumptions and evidence for three country projects (Bangladesh, Uganda, and Ethiopia). This report challenges the notion that trying to change the behaviour of poor mothers using growth monitoring and promotion will realize significant impacts on nutritional status. In Bangladesh, the Bangladesh Integrated Nutrition Project (BINP) is reviewed with a cross-sectional survey conducted by Save the Children UK. Save the Children UK's results indicate no difference in the rates of malnutrition between BINP upazilas and non-BINP upazilas after six years of project implementation. In Uganda, no evaluation of the nutrition project's impact over the first four years of implementation has been made public. And in Ethiopia, a World Bank-funded nutrition project has yet to begin, but is similar to a previous nutrition project conducted between 1984-89, where growth monitoring and promotion ceased due to lack of incentives for community nutrition workers. The report calls on the World Bank and relevant bilateral donors to: stop further scale-up of the three projects until objective reviews are completed; undertake an independent review of the evidence base

underlying current approaches to address poor child growth; and increase accountability in the design, monitoring and evaluation of projects.

enquiries@scfuk.org.uk

UNLOCK EVERY CHILD'S POTENTIAL: IRON AND EARLY CHILDHOOD

Micronutrient Initiative, 6 pp

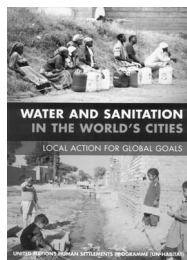


Iron deficiency anaemia is a problem that affects 48% of young children worldwide. Evidence of iron's beneficial impact on children is mounting. It is clear that the inclusion of iron in early child development programmes is both urgent and cost-effective. This practical booklet makes the case for shifting attention to prevention, as well as treatment, of iron deficiency and its most severe form, anaemia. The booklet also provides examples of early child development programmes that incorporate iron supplementation for young children. Two pull out sheets are also included on the impact of preventing and treating IDA and methods to achieve this.

www.micronutrient.org

WATER AND SANITATION IN THE WORLD'S CITIES: LOCAL ACTION FOR GLOBAL GOALS

UN-Habitat, 2003, 274 pp



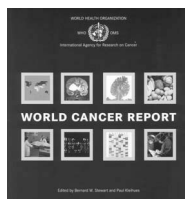
This is a comprehensive and authoritative assessment of water and sanitation problems and how they can be addressed. It sets out in detail the scale of inadequate provision of water and sanitation. The impacts on health and economic performance are also discussed, showing the potential gains of remedial action. It also analyzes the proximate and underlying causes of poor provision and identifies information gaps affecting resource allocation. It explains how resources and institutional capacities—public, private and community—can be used to deliver proper services through integrated water resource management. This report could not be more opportune, with the UN Millennium Project identifying the best strategies for meeting the Millennium Development Goals. By the target year of 2015, nearly 60% of the world's population will make cities their home. Therefore, local solutions to water

and sanitation should provide a valuable input to the work of the Millennium Task Force.

www.earthscan.co.uk

WORLD CANCER REPORT 2003

International Agency for Research on Cancer, 2003, 352 pp



This Report provides a unique global view of cancer, with more than 10m new cases reported per year. The report documents the frequency of cancer incidence and mortality as well as describes its known causes. A section on diet and nutrition summarizes their contribution to cancer rates. Up to 30% of human cancers are probably related to diet and nutrition. A Western diet (highly caloric food rich in animal fat and protein), often combined with a sedentary lifestyle is also associated with an increased risk of colon, breast, prostate and endometrial and other cancers. The report also contains an up-to-date overview of cancer prevention, screening programmes for early diagnosis, including novel drugs targeting tumour-specific signalling pathways. The Report is a useful resource for healthcare professionals and general readers.

press@iarc.fr

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

Adolescence: A Time That Matters. UNICEF, 2002, 39 pp. Looks at adolescent development and issues affecting young adults.

Combating Malnutrition: Time to Act (Executive Summary). World Bank, 44 pp. This UNICEF-World Bank Nutrition Assessment 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.

Caribbean Food and Nutrition Institute Quarterly, vol. 35(1 & 2), 2002, 59 pp. These issues include articles on: food and nutrition policy in national development planning, the Nassau Declaration on nutrition in mental health, non-communicable diseases and HIV/AIDS, micronutrient deficiencies and public health nutrition in the Caribbean.

Dietary Diversity: A Challenge Linking Human Health with Plant Genetic Resources. International Plant Genetic Resources Institute, Rome, 2003, 11 pp. This paper outlines the IPGRI Nutrition Strategy for combating simplification of human diets due to poverty, environmental degradation, agricultural interventions and socio-economic change.

Food and Health in Europe: A New Basis for Action. WHO Regional Office for Europe, 2002, 30 pp. This is a summary of a forthcoming book that provides in-depth analysis of nutritional health, foodborne disease and concerns about supply and security of food in Europe.

ICRW 2002 Annual Report. ICRW, 2003, 17 pp. This report reviews progress made in improving women's lives in the areas of health, reproductive and economic rights.

The Intestinal Microflora: Understanding the Symbiosis. Danone Vitapole, 2003, 48 pp. This booklet, eleventh in the collection "Health and Nutrition", collates the discussion and ideas raised at a workshop entitled "The Intelligent Intestine" and the 10th International Congress of Bacteriology and Applied Microbiology, part of the joint IUMS meeting.

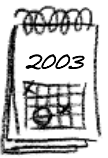
The Journal of Research Angra, vol. 30(4), 2002, 86 pp. Acharya NG Ranga Agricultural University, Hyderabad. The Journal contains articles on plant, social, home and veterinary sciences.

UNICEF's Priorities for Children 2002-2005. UNICEF, 2002, 27 pp. This is an overview of UNICEF's Medium-term strategic plan for the period of 2002-2005.

The UN Special Session on Children: A First Anniversary Report on Follow-up. Global Movement for Children, 2003, 12 pp. This follow-up report reflects on the actions taken thus far in fulfilling children's rights and improving their well-being since the UN SSC in May 2002.



PLEASE CONTINUE SENDING IN YOUR REPORTS AND PUBLICATIONS
—We will do our best to include them in an upcoming issue



Bulletin Board

Conferences

Defining the Role of Food Aid 2—4 September 2003, Berlin, Germany. The workshop is to provide specific recommendations to serve as consistent guiding principles for the use of food aid. Hosted by the Government of the Federal Republic of Germany. For more information on registration contact foodaid-berlin2003@email.de

SAAFoST Food Conference

More Science-Better Technology
1—4 September 2003, Pretoria, South Africa. Contact Thea Williams thean@jannderee.com

2nd Asia-Oceania Conference on Obesity

Combating the obesity epidemic:
a shared responsibility
7—9 September 2003 Kuala Lumpur, Malaysia. Contact Prof Mohd Ismail Noor (mismail@medic.ukm.my) for more information.

6th European Health Forum Gastein

Health and Wealth-Economic &
Social Dimensions of Health
1—4 October 2003, Bad Gastein, Salzburg, Austria.
www.ehfg.org

Asia Pacific Conference on Breastfeeding & National Convention of BPNI

Infant & young child feeding: from policy to practice, 30 November—3 December 2003, New Delhi, India. To register, contact www.bpni.org/apcbf

8th ASEAN Food Conference

Cooperation and Integration for Development
Hanoi, Vietnam. Contact Post Harvest Technology Institute phti-mard@hn.vnn.vn or VAFST@bcm.vnn.vn for more information.

Globalization, Justice and Health

3—4 November 2003, Washington, DC, USA
The Department of Clinical Bioethics and the Fogarty International Centre of the National Institutes of Health and WHO are bringing together leading thinkers on international trade, distributive justice, and health care systems for a 2-day conference. Speakers include Jeffrey Sachs (Columbia University), Julio Frenk Mora (Mexican Secretary of Health), Uwe Reinhardt (Princeton University), and more. Visit www.bioethics.nih.gov/globalization.html for more information on registration.

Forum 7

2—5 December 2003
Forum 7 is the 7th annual meeting of the Global Forum for Health Research to be held in Geneva, Switzerland. The meeting will review progress in research and other work contributing to the correction of the 10/90 gap in health research spending.
To register visit www.globalforumhealth.org

10th Asian Conference on Diarrhoeal Diseases and Nutrition

7—9 December 2003, Dhaka
The theme of this conference is 'Saving lives: Advances in the control of diarrhoea, pneumonia and malnutrition. Contact ascodd@icddr.org

10th Seminar of the European Nutrition Leadership Programme

17—25 March 2004, Luxembourg
The programme is designed for final year PhD students and postdoctoral fellows in human nutrition science in Europe. For further information and applications, contact lous.duym@wur.nl or visit www.enlp.info

New Resources

The **Agriculture-Nutrition Advantage Project** (implemented by ICRW and IFPRI, with support from USAID) is working with partners in Ghana, Kenya, Mozambique, Nigeria and Uganda to promote greater linkages between agriculture and nutrition, with careful consideration of factors that limit women's and men's contributions to family nutrition. For more information, please visit the project website at www.agnutritionadvantage.org

The **Micronutrient Fact Sheets** are a new publication from USAIDS' Micronutrient Global Leadership Project. The set of 14 fact sheets was compiled by Dr Penelope Nestel and Dr. Ritu Nalobula. These fact sheets explain the evidence base for dietary advice related to micronutrient intake. Statements are written for programme managers who are developing nutrient education and communication activities. The fact sheets are available in downloadable form: www.ilsa.org/publications/index.cfm?pubentityid=121

Discussion Group on Nutritional Care and Support for People Living with HIV/AIDS. ProNut-HIV (PLWHA), a new electronic forum, aims to share up-to-date information, knowledge, and experience on nutrition and HIV/AIDS. The purpose of the discussion group is to enhance positive living through proper nutrition care and support by promoting a constructive dialogue between PLWHA, front line workers, researchers, HIV/AIDS specialists and policy-makers. The forum intends to focus primarily on the nutrition care and support of mothers and children. The may later shift to nutrition care and support of other groups, such as adults (men and women) and elderly. As collaborating partners, SATELLIFE and Academy for Educational Development administer and support the ProNut-HIV discussion groups. Visit www.pronutrition.org for more information.

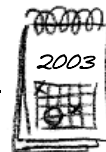
Millennium Goals Evaluation www.un.org/millenniumgoals/ First annual report on implementing the Millennium Declaration, UN 2002. It focuses on commitments made in all chapters of the Declaration and on issues that were particularly salient over the past years. Information on the Millennium Indicators Database: Goals, Targets and Indicators is available at http://millenniumindicators.un.org/unsd/mi/mi_goals.asp

The FIVIMS website is launching the **News and Events Management System (NEMS)**. The NEMS system allows an easy and quick update of the events and news/highlights section through a user-friendly interface that requires no particular technical knowledge. To obtain information on how to input data in the NEMS contact chiara.deligia@fao.org. The FIVIMS website is www.fivims.org.

Courses

7th ICDC Annual Training Course on Implementing the International Code of Marketing of Breastmilk Substitutes, 14-23 September 2003. This 9-day residential course aims to train government officials in drafting laws or other measures to implement the International Code of Marketing of Breastmilk Substitutes nationally. Organized by the International Code Documentation Centre (ICDC), the specialized arm of the International Baby Food Action Network (IBFAN) on Code Implementation, the course will be held in Penang, Malaysia. Interested applicants can register by using the form at www.ibfan.org/english/activities/training/icdc01.html or email ibanpg@tm.net.my

Training in the management of severe malnutrition. This training course on hospital-based care of severely malnourished children responds to the urgent need to reduce paediatric deaths related to severe malnutrition in many developing countries. For detailed information, please contact: Dr. Sultana Khanum, WHO, kbhanums@who.int



The 2nd series of seminars of the **African Nutrition Leadership Programme (ANLP)** will be held in South African from 30 October – 7 November 2003. The aim of the programme is to assist the development of future leaders in the field of human nutrition in Africa. Emphasis will be given on understanding the qualities and skills of leaders, team building, communication and nutrition information in a broader context. The programme is targeted for final year PhD students and postdoctoral fellows, including candidates with comparable working experience in human nutrition, working or studying in Africa. Further information, application forms and online registration can be obtained at www.africannutritionleadership.org/ or email info@africannutritionleadership.org

Food and Nutrition Security – Assessment Instruments & Intervention Strategies,

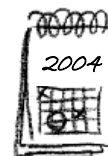
17-28 November 2003, Feldafing near Munich, Germany. The main focus of the course is to provide a holistic understanding of the complex nature of food security and nutrition, categories of causes, different levels of actors and the variety of interventions to tackle either acute or chronic food insecurity in urban and rural areas. Tuition, including room and full board amounts to EURO 2,000 per person. Contact Meike Loth-Kraemer at InWEnt – Capacity Building International meike.loth-kraemer@inwent.org for registration information.

Online Course on Nutrition Rights

Political Science 675c, Fall 2003, University of Hawai'i The purpose of this course is to study the human rights system through close examination of the human right to adequate food. This right has been clarified under initiatives led by the United Nations High Commissioner for Human Rights. Many agencies at both national and global levels are working to assure its realization. Each participant is required to undertake a specific project, culminating in a final paper on the topic. This project is to be a research-based study on the application of the human rights approach to improving the food and nutrition situation in a particular context. Full-time students at the University of Hawai'i at Mānoa may register through www.hawaii.edu/myuh/manoa. Individuals who are not registered as full-time students can register for this course through the university's Outreach College, at its website at www.aln.hawaii.edu. They must apply for admission as Non-Degree Seeking Students, and then register for the course. The tuition and fees for participants who register through Outreach College will be US\$632.40 for both Hawai'i residents and non-residents. This is an on-line course, using the Yahoo! Groups software. It begins on Monday, August 25, 2003 and ends on December 15, 2003. The syllabus is available at www2.hawaii.edu/~kent/pols675c%20Fall%202003%20Syllabus.doc

Postgraduate Courses in Oslo 2003—2004

The Institute for Nutrition Research at the University of Oslo and Akershus University College, will jointly offer two postgraduate course modules in English in 2003—2004: *Global Nutrition, Governance and Policy* and *Nutrition and Human Rights*. The first course will be held from mid-September until the end of November 2003. The second will be held April—June 2004. Requirements are normally a BSc in Human Nutrition or documented equivalent background. For further information, please contact Kaia Engesveen, kaia.engesveen@basalmed.uio.no or telephone +47 22 85 13 32, fax +41 22 85 23 41.



Would you like to post a notice on
this board?

The next issue of *SCN News*
will be published in December 2003.
Please send your contributions to
scn@who.int



Stop Press!

Catherine Bertini Selected to Receive World Food Prize. Ms Bertini was chosen as the 2003 World Food Prize Laureate on 16 July at the World Congress of Food Science and Technology in Chicago. The Selection Committee noted Ms Bertini's achievements in responding to critical emergencies around the world through her work at WFP, "In a key innovation, Ms Bertini pioneered the practice of channelling food aid through women, thus ensuring the most widespread and effective distribution of food in crisis situations." Ms Bertini will be awarded the US\$250,000 Prize at the International Symposium to be held on 16–17 October 2003 in Des Moines, Iowa. The SCN Secretariat congratulates Ms Bertini on receiving this wonderful recognition.

Codex Alimentarius: New Food Safety Regulations. The 26th session of the Codex Alimentarius was held in Rome, 30 June to 7 July. At the top of the agenda was the adoption of new food safety standards for assessing the risk of foods derived from biotechnology and a standard that would allow increased levels of radiation to be used in food irradiation. By the end of the week, the Codex found that irradiated foods were safe and do not contain any radioactive traces. A new standard was adopted that allows for higher levels of radiation to delay spoilage and eliminate bacterial spores in food. Guidelines were also adopted for biotech foods aimed at making risk analysis more uniform across the Codex's 169 member countries. The guidelines include pre-market safety evaluations and product tracing to allow modified goods to be monitored or recalled. They also cover scientific assessment of DNA-modified plants and drinks derived from DNA-modified micro-organisms, including cheese, yoghurt and beer. The Codex is a joint Commission of FAO and WHO that sets food safety and agricultural trade standards. Source: Associated Press, 9 July 2003.

World Heart Day: Women, Heart Disease and Stroke. Sunday, 28 September 2003. This year's World Heart Day focuses on the particular risks women face relating to heart disease and stroke. Women are eight times more likely to die from heart disease and stroke than breast cancer. Although strokes in women occur later in life, women suffer more disability than man. For more information on how to participate in World Heart Day, visit www.worldheartday.com. Nutrition tips are also provided on how to keep hearts healthy.



UNITED NATIONS SYSTEM
Standing Committee on Nutrition
Publications

The following SCN publications are available for download from our website: www.unsystem.org/scn

- Reports on the World Nutrition Situation
- Nutrition Policy Discussion Papers
- SCN News
- Refugee Nutrition Information System
- Country Case Studies (Brazil, Egypt, India, Indonesia, Tanzania, Thailand, and Zimbabwe)
- Nutrition: A Foundation for Development (English and Spanish versions)
- Final Report to the SCN by the Commission on the Nutrition Challenges of the 21st Century—Ending Malnutrition by 2020: an Agenda for Change in the Millennium



A limited number of CD-Roms containing all SCN publications are available by request to the SCN Secretariat scn@who.int



The 8th Dr Abraham Horwitz Lecture

ANNOUNCEMENT AND CALL FOR PROPOSALS

The SCN Secretariat in Geneva announces the 8th Dr Abraham Horwitz Lecture, which will take place at the United Nations, New York during the 31st SCN Session 22–26 March 2004. 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 aim of this Lecture series, established by Sir Richard Jolly in 1996, is to continue Dr Horwitz' heartfelt, highly-valued and extremely generous tradition of mentoring young talent and their ideas for nutrition programmes. 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 Session. The 8th Lecture will take place in the context of a one-day SCN symposium. The theme of the symposium will be *Nutrition and the Millennium Development Goals (MDGs)*. The focus of the Lecture should be on strategies to achieve the Goal of eradicating extreme poverty and hunger by 2015. The Lecture should also deal with aspects of how improving nutrition can contribute to the overall progress towards achieving other MDGs. While all proposals dealing with *Nutrition and the MDGs* will be considered, preference will be given to those which reflect original thinking, new ideas and first-hand field experience.

Young nutrition professionals are invited to submit a three-page (double-spaced) concept paper to the SCN Secretariat in Geneva by **Monday, December 8, 2003**. Proposals will be accepted by email, regular mail or by fax. The content of the proposed Lecture should relate directly to the theme of the symposium. All proposals meeting the basic criteria (set out below) will be considered, however, preference will be given to those describing new programmatic or policy approaches.

The proposal should contain:

- a cover letter with the applicant's full name and contact details
- a one-page summary CV
- a three-page concept paper explaining the scope of the Lecture and the key issues to be presented
- a letter from a professor or other senior professional colleague who is willing to provide guidance during the writing and preparation of the Lecture.

The SCN Secretariat will select the best proposal and the successful candidate will be notified by the end of December 2003. Proposals will be evaluated against three criteria: clarity, innovation, and demonstrated knowledge of the field.

The Lecture will be published as part of the symposium proceedings in one of SCN's publications (ie *SCN News*, *Nutrition Policy Discussion Papers*, etc.). Travel to and from New York next March and hotel/living expenses while attending the meeting will be covered by the SCN. The Lecturer will also receive a 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 c/o World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland

www.unsystem.org/scn