

Report on the

**First and second meetings of the
regional advisory committee on nutrition**

Cairo, Egypt
1–2 June 2009
13 December 2009



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. FIRST MEETING OF THE REGIONAL ADVISORY COMMITTEE ON NUTRITION

1.1 Introduction

The first meeting of the WHO Regional Advisory Committee on Nutrition was held at the WHO Regional Office for the Eastern Mediterranean on 1–2 June 2009, in Cairo, Egypt. The meeting was organized in collaboration with the Food and Agriculture Organization of the United Nations (FAO), United Nations Children's Organization (UNICEF), International Council for the Control of Iodine Deficiency Disorders (ICCIDD), World Food Programme (WFP), academia and Member States. The meeting's programme and list of participants are attached as Annexes 1 and 2, respectively.

The objectives of the meeting were to:

- Identify major challenges facing the nutrition and food security sectors and come up with strategic recommendations;
- Assist in preparing a regional nutrition strategy;
- Assist in preparing an action plan for implementation of the regional nutrition strategy and monitor its activities;
- Discuss nutrition-related issues in the Region.

The meeting was opened by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, who emphasized the importance of nutrition in helping to prevent noncommunicable disease. In this regard, a major issue to be considered was how to promote nutrition effectively.

Dr Haifa Madi, Director Health Protection and Promotion, defined the overall objective of the Advisory Committee on Nutrition as to advocate and sensitize policy-makers on the role of food and nutrition as a basic input to the socioeconomic development of the Region. This was to be accomplished through developing a regional nutrition strategy covering all age groups, and plan of action for five years effective 2010.

She also listed the expected outputs of the advisory committee, as follows:

- Support the development of regional nutritional strategy (2010–2015) with key strategic objectives to address the above mentioned key challenges
- Support the development of corresponding regional action plan on nutrition
- Strengthen the partnership and network with other UN agencies, nongovernmental organizations, universities and research centres
- Advocate to increase commitment and support from the national, regional and international towards the implementation of the strategy and its plan of action
- Monitor the implementation of the strategy and its action plan.

Countries of the Region are categorized into four stages, based on their nutrition profile. Countries in the advanced nutritional transition stage are characterized by high levels of

overweight and obesity, moderate under-nutrition and micronutrient deficiencies in some population sub-groups. These countries include all GCC member countries, Islamic Republic of Iran and Tunisia. Countries in the early nutritional transition stage are characterized by moderate levels of overweight and obesity, moderate levels of under-nutrition in specific population pockets and age groups, and widespread micronutrient deficiencies. Countries in this category are Egypt, Jordan, Lebanon, Libyan Arab Jamahiriya, Morocco and Syrian Arab Republic. In countries with significant under-nutrition, there are high levels of acute and chronic child malnutrition, widespread micronutrient deficiencies and emerging overweight, obesity and nutrition of indulgence in certain socioeconomic subgroups in Djibouti, Iraq, Pakistan, Palestine and Yemen are in this category. Countries in emergency and humanitarian crisis are characterized by severe child and maternal under-nutrition and widespread micronutrient deficiencies. Afghanistan, Somalia and Sudan are in this category.

1.2 Technical presentations

1.2.1 Guiding principles and the process of developing regional nutrition strategy

Dr Ayoub Aljawaldeh, WHO EMRO

Developing a strategy for the Region has become a priority due to the high prevalence of under-nutrition combined with the increasing prevalence of diet-related noncommunicable diseases. The basic aim of food policy or strategy is to provide a “safe, secure, sustainable, sufficient, nutritious diet for all, equitably” (Tansey, 1995). Over the past 50 years, the international agenda for nutrition has evolved from fear of global hunger to understanding its main causes, specifically the role of poverty and its link to food production and malnutrition.

The major nutrition strategies proposed at the international level over the past decade, including the ICN Plan of Action for Nutrition (1992), Copenhagen consensus (2008) and UN Millennium Development Goals, all emphasize combating common nutrition problems through a bottom-up as well as top-down approach.

Guiding principles of the strategy are as follows.

- Results-based orientation
- Partnership with governments, private sector, academia, donors and civil society
- Evidence-based programme selection will lead to a mix of interventions and operational strategies
- Working at all levels
- Life cycle approach of interventions
- Joint programming with key partners
- Advocacy and resource mobilization
- Disaster management and mitigation
- Efficient database and information
- Capacity development

In the Region, a number of activities have been undertaken towards capacity building in the area of food and nutrition planning since 2006. These include a regional training

workshop to develop national capacity in nutrition planning and policy formulation (2006), development of a regional strategy on food-based dietary guidelines (2009); and development of a regional strategy on nutrition communication.

It is time to establish an alliance for nutrition in the Region and to see the nutrition agenda among the national strategic priorities of governments.

1.2.2 WHO response to global nutrition challenges

Dr Francesco Branca, WHO HQ

The WHO response to global nutrition challenges addresses major challenges dealing with malnutrition in all its forms (underweight, wasting, stunting and overweight/obesity, as well as micronutrient deficiencies and nutrition-related chronic diseases). Little progress has been made towards achieving relevant targets of the MDGs. The main reasons for this inadequate progress are: inadequate investments, inadequate coordination among players, inadequate coverage, inadequate responses, not addressing life course and the fact that social determinants have not been considered.

There are four areas of strategic focus within WHO.

Area 1: Development and operationalization of integrated food and nutrition policies - *Putting health back in the food and nutrition policy agenda*

Area 2: Intelligence of needs and response - *Providing the factual dimension of nutrition issues*

Area 3: Development of evidence-based programme guidance - *Selecting effective options for each context*

Area 4: Advocacy - *Providing the rationale for investment and action*

WHO has a major responsibility for promoting healthy nutrition for the entire world's people, through collaborative support to Member States, particularly in their national nutrition programmes, in partnership with other intergovernmental and nongovernmental organizations, and their related sectoral approaches.

Three regional strategies that have been developed in other regions of WHO are: the African regional nutrition strategy 2005–2015; the regional strategy on nutrition in health and development in the Americas 2006–2015; and the European second action plan for food and nutrition policy 2007–2012 (see Annex 3).

1.2.3 Nutrition situation in the Region

Dr Nahla Houalla, WHO Temporary Adviser

The burden of disease associated with inadequate nutrition continues to grow in countries of the Eastern Mediterranean Region. Similar to many developing countries, countries of the the Region suffer from unprecedented nutritional and demographic transition, with a broad shift in disease burden. While problems of under-nutrition still exist, the burden

of overweight, obesity and diet-related chronic diseases is increasing. This nutrition transition is serious as it negatively impacts health systems in countries in the Region.

Malnutrition remains the most serious health problem, with consequences that are too grave to be ignored. It is the single biggest contributor to child mortality, and 15% of the global burden of newborn and child mortality occurs in countries of the Region. It is estimated that 50% of deaths among children under 5 years of age is attributable to mild to moderate malnutrition. Early childhood malnutrition is irreversible and intergenerational, with adverse consequences on adult health as it is implicated in poor mental and cognitive development. Unless policies and priorities are changed, the scale of the problem will prevent many countries from achieving the Millennium Development Goals (MDGs). Furthermore, malnutrition in women in their reproductive age increases maternal mortality. The maternal mortality ratio was estimated to be 210 per 100 000 live births in the Region in 2005, representing only a 20% reduction from the levels of 1990. The Region also faces other challenges that generally contribute to malnutrition, including in-country inequalities, limited natural resources (water scarcity, limited land for agriculture), recurrent drought conditions, high population growth rates, internal conflicts and HIV/AIDS. While the majority of country estimates show low HIV prevalence, ranging between <0.1% in Afghanistan and 3.1% in Djibouti, the disease should be taken seriously since there is evidence of either increased HIV risk practices and/or prevalence among specific vulnerable groups, in particular those involved in unsafe sexual behaviour and/or injecting drug use.

Several micronutrient deficiencies are still being reported from many countries of the Region, where iron, iodine, zinc, calcium, folic acid and vitamin A and D deficiencies are reported, particularly among vulnerable groups including children and women of childbearing age. Iron deficiency anaemia is presented as a serious public health problem for many countries of the Region, with the prevalence in Bahrain reaching 48.3% among children under 5 years of age and 41.6% among children between 5 and 14 years. In women of childbearing age, anaemia was also reported to be around 40% in both Bahrain and Oman. Iodine deficiency disorder is another global nutritional problem, with 266 million school-age children worldwide (31.5% of the population) considered to be at risk of iodine deficiency. Reports from the Region indicate a similar widespread occurrence of the deficiency.

Additionally, prevalence of zinc deficiency was found to range from 25% to 52% in the Region and a highly prevalent vitamin A deficiency with 0.8 million preschool-age children estimated to have night blindness and 13.2 million preschool-age children estimated to have serum retinol levels <0.70 $\mu\text{mol/l}$.

Food-borne diseases constitute a serious threat to achieving good nutritional status. Diseases of zoonotic origin represent a considerable public health burden and challenge, with salmonellosis and campylobacteriosis being the most commonly reported food-borne illnesses. The lack of hygiene standards and control measures in food preparation and the wastage and pollution of water, especially in rural areas, are examples of underlying determinants.

Alternatively, reports from the Region show alarming figures for prevalence of obesity and noncommunicable diseases. Noncommunicable diseases accounted for 52% of all deaths and 47% of the disease burden during 2005. Of particular interest is a WHO report in 2005 on the regional population above 20 years, where prevalence of diabetes was reported to be 11%, hypertension 26%, dyslipidaemia 50%, overweight and obesity 65% and physical inactivity 77%. This rise in noncommunicable diseases is paralleled by a rise in direct costs of health care resources needed for disease management, indirect costs due to loss of economic activity, and intangible costs due to associated social and personal factors.

The Region is still facing many challenges in the formulation and implementation of nutrition strategies and action plans that are holistic in their approach to addressing nutrition issues. The Region suffers from: 1) absence of clear political commitment to nutrition action and/or failure to turn the political commitment towards nutritional problems into tangible action; 2) the absence of a policy framework and institutional capacity to plan, implement and monitor sustainable nutritional programmes that respond to the multisectoral dimensions of nutritional problems; 3) recurrent conflicts and natural disasters; 4) the disproportionate allocation of health budgets, often at the expense of preventive strategies such as nutrition; 5) the abandonment of traditional diets, often more nutritious, in favour of other refined western diets, resulting in the reduction of dietary diversity; and 6) the absence of nutrition expertise in related sectors and intersectoral coordination. In addition, a complex set of other factors also affect nutrition status, including food safety, changing lifestyle patterns, and decreased food production and availability. Food distribution and catering in many countries of the Region is concentrated in the hands of few operators, who influence product supply, safety and price. The media, advertising and retail sectors and the food industry have an influence on dietary choices, sometimes in the opposite direction from that which public health specialists recommend. Urban design, too, often discourages safe, active transport, while the increasing use of television and computers encourages sedentary leisure activities, thus adding physical inactivity as underlying factor contributing to many health challenges.

1.2.4 Situation of iodine deficiency in the Region: challenges, strategies and solutions

Dr Izzeldin S. Hussein, WHO Temporary Adviser

The Fifty-fifth session of the WHO Regional Committee for the Eastern Mediterranean adopted resolution EM/RC55/R.1 (2008), which called on Member States to renew their commitment to the elimination of iodine deficiency disorders (IDD). Remarkable progress has been made since 2002 and more than 120 countries are now implementing salt iodization programmes.

In the Middle East and North Africa, remarkable progress has been made in improving household consumption of adequately iodized salt and achieving IDD elimination.

Key challenges to eradicate iodine deficiency disorders are:

- Inadequate programme coordination, monitoring, distribution and marketing
- Lack of financial and technical resources
- Non-compliance with iodization law. Animal and industrial salt?

- Primitive methods of salt production and diversity of salt in the market
- Inadequate awareness on the part of policy-makers and the general public of the magnitude of the problem
- Lack of adequate human resources for monitoring, inadequate monitoring information network and no link between monitoring and enforcement
- Lack of comprehensive and effective information, education and communication strategies.

1.2.5 Food security and food safety in the Near East: a situation analysis

Dr Fatima Hachem, FAO

Food security is an evolving concept. Based on the World Food Summit of 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”.

Ensuring food security in the rRegion faces many challenges. Despite economic growth, in-country inequalities and phenomenon of urban poor are growing problems. About one in every five persons in the region is considered poor, at the \$2 PPP line (60% of the poor live in rural areas, approximately 54 million poor rural people). Limited natural resources are another challenge in this area. The region is the most water-scarce region in the world (1.5% of the world’s renewable freshwater resources), with limited land for agriculture (8.6% of the world’s arable land and 11% of its irrigated land). Land reclamation is a major challenge in the region because of the high salinity of soil. Recurrent drought conditions, persistent desertification, high population growth (2.3%) as well as conflicts are other challenges for food security in the region.

The region depends on food imports to meet the needs of its people, a net food importer. There is high vulnerability to increases in food prices as well as to climate change.

One of the aspects of food security that requires special attention in the Region is food safety. Ensuring safe food has positive implications for food security. Access to safe food is in itself an element of food security. Food-borne illnesses may have serious social and economic consequences. Application of good agricultural practice (GAP), good manufacturing practice (GMP) and good handling practice (GHP) improves food safety and reduces food losses which itself leads to increase in food availability and food security.

Comprehensive food laws are lacking in the Region. Food safety regulations often overlap among the different institutions or ministries. Food standards are not always harmonized with Codex and not always based on scientific evidence. Major priorities in the area of food safety are as follows.

- Establishing national food safety strategies and mechanisms for coordination between the different stakeholders
- Updating food laws and harmonize legislation and standards with international references

- Modernizing, strengthening and maintaining the capacity of food inspection services
- Improving infrastructure and technical capacity of staff to support the application of modern techniques and processes in food analysis
- Promoting the use of GAP, GMP and quality assurance systems
- Enhancing the effective participation in international standard-setting forums
- Building national capacity to identify and prioritize food safety issues through risk analysis
- Reinforcing the food-borne diseases surveillance systems
- Creating a rapid alert system and mechanism for communication with food control authorities and for implementing necessary corrective measures

*1.2.6 Nutrition situation in the Gulf Cooperation Council: challenges and joint programmes
Dr Nadia Gharib, WHO Temporary Adviser*

The Gulf Cooperation Council (GCC), founded on 26 May 1981, consists of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates. Oil revenue continues to be the main source of income for the GCC economies. Statistics on population and development indicators in the GCC countries is presented in Table 1.

While micronutrient deficiencies are still prevalent in the GCC countries a rapid increase in the prevalence of diet-related non communicable disease, including obesity, cardiovascular diseases, and diabetes is being reported. It is estimated that by 2025, expenditure for cardiovascular disease will grow at a rate of almost twice that for health care as a whole.

At present several nutrition programmes are active in the GCC countries, including:

- Fortification and supplementation
- Nutrition surveillance system
- Nutrition education
- Infant and young child feeding and policies
- School nutrition.

There are many challenges in planning national strategies and programmes to address different nutrition problems of these countries. Major challenges identified are:

- Development and improvement of nutrition programmes
- Enhancing research capacity
- Improving health surveillance, monitoring and information system
- Strengthening public/private partnership to support nutrition related activities and programmes.

Table 1. Health and development indicators of GCC countries

Country	Total pop. (000s)	Life expectancy (years)	Under five mortality rate (per 1000 live births)	Maternal mortality ratio (per 10 000 live births)	Mortality between 15 and 60 years M/F (per 1000 population)	Total expenditure on health (% of GDP)	Adult (15+) literacy rate
Bahrain	1 000	74.8	10.9	0	116/84	4.1	88
Kuwait	2 700	78.6	10.1	2	68/52	2.2	94
Oman	3 400	74.3	11.1	19	160/90	3.1	81
Qatar	1 630	76.7	10.4	22	72/64	2.7	94
Saudi Arabia	27 600	73.6	22.4	12	205/136	4.0	78
United Arab Emirates	4 800	73.0	10.2	1	84/62	3.3	84

Source: World Health Organization

1.3 Country presentations

1.3.1 Diet-related noncommunicable disease in Saudi Arabia

Dr Khalid A. Al Madani

In Saudi Arabia, rapid socioeconomic development has led to changes in lifestyle and food consumption patterns. As a result, dietary diseases of affluence, including obesity, cardiovascular disease, diabetes and cancer are becoming major health problems in country.

Although reliable information on the prevalence of some of these diseases in the Saudi community is not available, the hospital-based studies and mortality statistics indicates that these diseases are increasing dramatically, accounting for most of the mortality and morbidity, and incurring substantial health care costs.

Based on the available information, there is an urgent need to initiate nutrition education programmes to correct the dietary habits and food consumption patterns, and to stress the importance of a balanced diet. There is an urgent need for a health strategy to prevent and control these diseases. Epidemiological studies on factors associated with food habits as well as the link between dietary habits and chronic diseases are highly recommended.

1.3.2 National nutrition policy and programmes: Egypt's experience

Dr Azza Gohar

The process of national nutrition programming in Egypt started in 2004; when Egypt's National Nutrition Institute (NNI) conducted a data analysis and data compilation of national studies over the past two decades in collaboration with FAO/Rome. In 2005, in collaboration with WHO, NNI took the first step towards developing a national nutrition policy and strategy in Egypt. A ministerial decree was issued formulating a national committee of government officials, experts and scientists from different sectors to overlook the development of the strategy. NNI developed a set of policy areas, along with a strategy, outlines and working group mechanism, and university professors, experts, scientists and government officials were invited to a workshops hosted by NNI.

After this workshop working group documents were integrated into one and it was discussed and approved in a general meeting. The outcome was then adopted by the national nutrition committee and approved by the Minister of Health, Prime Minister and Ministerial Cabinet. In 2007, it was presented at a meeting with WHO in Geneva, and it was distributed among involved sectors.

The objectives of Egypt's national nutrition are to:

- guarantee the quality of foods available for consumption
- promote healthy dietary practices
- prevent and control nutrition disorders
- guarantee universal access to adequate food.

As the next steps, in May 2008 (in view of the soaring food prices), the High Ministerial Committee for Food Security requested all involved Ministers for action plans. NNI was assigned to prepare a detailed action plan to improve the nutrition of the Egyptian population. A 3-year action plan was developed by NNI and approved by the Prime Minister. A ministerial decree is being issued to formulate a high coordination committee with representation of all involved sectors and UN agencies.

Current nutrition-related programmes implemented in Egypt are as follows:

- National flour fortification programme
- National oil fortification programme (vitamins A and D) (WFP)
- Rice fortification with B vitamins and iron
- National nutrition surveillance system NNS (MOH/WHO)
- Food-based dietary guidelines (NNI)
- WHO New Growth Curves (MOH/WHO)
- Improving quantity and quality of school feeding MOE/MOH (WFP)
- National food consumption study (Egyptian dietary pattern)
- Iron supplementation for pregnant and lactating women and schoolchildren
- Vitamin A supplementation for mother after delivery and for newborns
- Deworming in school age

- Fortified school biscuit
- Nutrition component in school curriculum
- Flour fortification of baladi bread with iron and folic acid
- Salt iodization
- Early detection of iodine deficiency among newborns.

1.3.3 Nutrition under development and emergency context in Sudan

Dr Amani Abdelmoniem

Sudan is the largest country in Africa, a nation of rich diversity in term of ethnicity, geographic, culture etc. It is in conflict and in transition, and in recent years has experienced both man-made and natural disasters.

Almost one third (31%) of children under the age of five are moderately or severely underweight. Around one third of children (32.5%) have moderate or severe chronic malnutrition (height for age). Nationally, the level of global acute malnutrition is just below the internationally recognized threshold (14.8%), indicating a nutrition emergency.

Major micronutrient deficiencies identified in the country are: anaemia (no national estimates; in some states it is high as 55%); goitre (22% among school-age children; iodized salt consumption is 11%); and vitamin A deficiency (no national estimates).

The nutritional situation in Darfur is precarious, with many areas of Darfur showing global acute malnutrition rates above the internationally recognized emergency thresholds. During 2004–2006, global acute malnutrition (GAM) decreased from critical emergency values of 21.8% to 12.9%. Also, severe acute malnutrition (SAM) decreased from 3.9% to 1.9%.

Based on a current situation analysis, major priorities in the area of nutrition are as follows:

- Reduction of child morbidity and mortality due to nutrition problems
- 5-year strategy
 - Operationalization of the national nutrition policy by development of multi-year strategic plan 2009–2013.
 - Strengthen evidence based decision (research)
- Nutrition services expansion
 - Minimum nutrition package (growth monitoring)
 - Service integration and continuum of care
 - Community interventions.
- Management of malnutrition
 - Activation of new protocols implementation (SAM)
 - Community-based management of acute malnutrition (CMAM)
 - In-service and pre-service training
 - Availability of supplies
- Promotion of infant and young child feeding (IYCF)

- IYCF strategy implementation
- Activation of Baby-Friendly Hospital initiative
- Community level promotion and interventions
- Micronutrient
 - Baseline data (micronutrient survey)
 - Universal salt iodization
 - Flour fortification
- Nutrition monitoring and evaluation: early warning system and surveillance system

1.3.4 Kuwait nutrition surveillance system: the experience

Dr Nawal Al-Hamad

Based on the ICN recommendation in 1992, the state of Kuwait began the nutrition surveillance system (KNSS) in 1996. It is a system for continuous monitoring of the nutrition status of the population and its associated health, economic, demographic and food-related variables. It is an informative system that provides governments, on a regular basis, with updated data on the nutrition condition of their citizens. It enhances the monitoring of nutrition-related risk factors and helps in formulation, modification and application of the national food and nutrition policy of the country. It is therefore part of the machinery by which a government can safeguard the nutritional health status of the population.

The sample size for this monitoring system was based on estimated sample size for each population group as recommended by CDC. The sample size in 2008 is shown in Table 2.

Table 2. Sample size of KNSS in 2008

Age group (years)	Males	Females	Total
<5	2039	2046	4085
5–9	3010	2927	5937
10–13	983	1003	1986
14–20	1834	1735	3569
>20	1610	2730	4340
Total	9476	10 441	19 917

Through KNSS, overweight and obesity were identified as major health problems in Kuwait affecting all age groups. KNSS also:

- Identified the size of the anaemia problem as well the most vulnerable groups affected
- Helped in excluding other causes of anemia such as parasitic infestation
- Helped in making the decision of approving the iron fortification of flour programme to prevent further increases

- Attracted the attention of other related sectors such as Ministry of Education, Ministry of Trade and Commerce.

1.3.5 Food and nutrition in the Islamic Republic of Iran

Dr Nasrin Omidvar

The Islamic Republic of Iran is a large country that has experienced an accelerated nutrition transition over the past 30 years. Major demographic and epidemiological transition has occurred. Along with population growth, the percentage of urban dwellers has increased from 47% in 1975 to more than 70% in 2006. In line with development and due to major expansion of health system and health services throughout the country, changes in health indicators are also significant (Table 3).

Table 3. Changes in health indicators in the Islamic Republic of Iran over 30 years

Indicator	1979	1999	2003	2009
Life expectancy (years)	M: 54 F: 58	M: 58 F: 61	M: 62 F: 67	M: 69 F: 73
Under-5 mortality rate	67.1	44.0	36.0	36.0 (2005)
Fertility rate	6.5	2.2	2.0	1.7
Contraceptive use	37.0	64.5	66.2	74.0

1.3.5 Process for developing the regional nutrition strategy

Dr Nahla Houalla, Professor of Nutrition at the American University of Beirut, and Dr Ayoub Al Jawaldeh, WHO/EMRO, were entrusted with the preparation of the first draft of the strategy. Inputs were solicited from the recommendation of the working groups through which the following health challenges were identified:

- Under-nutrition
- Micronutrient deficiencies
- Overweight and obesity
- Noncommunicable diseases.

A summary table of the main health challenges with their possible determinants, strategies, activities and outcomes/tools was included in the draft strategy.

1.3.6 Follow-up consultation

A follow-up technical consultation was held in Amman, Jordan on 25–26 October 2009 to discuss the modified regional strategy. Input and comments were received from Dr Ayoub Al Jawaldeh, WHO/EMRO; Dr Abdelmonem Hassan, Associate Professor at University of Qatar; Dr Nawal Ahmad, Ministry of Health, Kuwait; Mrs Randa Saadah, WHO/HQ; and Mrs

Wissam Qarqash, John Hopkins University, Jordan. Feedback was also solicited and received, and incorporated into the draft strategy by Dr Nahla Houalla. The draft was further reviewed by Dr Haifa Madi, Director of Health Protection and Promotion and Dr Ayoub Al Jawaldeh, who finalized the first draft and circulated it to all Member States.

2. SECOND MEETING OF THE REGIONAL ADVISORY COMMITTEE ON NUTRITION

2.1 Introduction

The second meeting of the regional advisory group on nutrition was held on 13 December 2009 in Cairo, Egypt, immediately following the launch of the draft regional nutrition strategy (see Annex 1). The launching ceremony was held in the presence of Dr Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean, Dr Sima Bahouth, Assistant Secretary-General and Head of Social Affairs Sector, League of Arab States and representatives from the Ministry of Health, Egypt, and all Member States. Dr Haifa Madi presented the draft strategy, after which a panel discussion took place with the participants and the media about the strategy and action plan. Following the launch and panel discussion, the regional advisory committee on nutrition met with directors of national primary health care and WHO staff to discuss next steps and the way forward for implementing the strategy.

2.2 Recommendations

1. Advocate with policy-makers to consider nutrition a high priority area.
2. Engage the private sector, nongovernmental organizations and other potential supporters and establish alliances to address nutrition-related issues.
3. Enforce legislation to improve the quality of food catering.
4. Mobilize material and financial resources.
5. Revise the current national nutrition strategy and build on it.
6. Review the national surveillance system and identify any shortcomings.
7. Strengthen community-based activities with regard to nutrition.
8. Develop a strategic partnership with the media to provide education on how to deal with nutrition issues.

2.3 Next steps

- The Libyan Arab Jamahiriya, Qatar, and United Arab Emirates are willing to accommodate a workshop on developing national nutrition strategies and plans of action.
- Participants recommended that the regional advisory committee on nutrition should meet on an annual basis.
- A workshop on obesity prevention and control will be conducted in March 2010 in Jordan.

Annex 1**PROGRAMMES****First meeting of the regional advisory committee on nutrition****Monday, 1 June 2009**

08:30–09:00	Registration
09:00–09:30	Address of Dr Hussein A. Gezairy, Regional Director, WHO EMRO Message of Regional Director, WFP Opening remarks, objectives of the committee <i>Dr Haifa Madi, WHO EMRO</i> Introduction of participants Review of agenda and programme
09:30–09:45	Guiding principles for developing the regional strategy <i>Dr Ayoub Aljawaldeh, WHO EMRO</i>
10:15–10:45	WHO Global Nutrition Strategy <i>Dr Francesco Branca, WHO HQ</i>
10:45–11:15	Nutrition situation in the Region <i>Dr Nahla Houalla, American University in Beirut</i>
11:15–11:30	Nutrition situation in GCC: challenges and joint programmes <i>Dr Nadia Gharib, Head Nutrition Section, Ministry of Health, Bahrain</i>
11:30–11:45	Food security and safety in the Region: situation analysis <i>Dr Fatimah Hachem, FAO RNE</i>
11:45–12:00	Discussions
12:00–12:15	<i>UNICEF strategy on child malnutrition and related programmes</i> <i>Dr Mahendra Sheth, UNICEF</i>
12:15–12:30	WFP monitoring of regional food security <i>Ms Sally Gregory, WFP</i>
12:30–12:45	Nutrition situation analysis among refugees and related programmes <i>Dr Ali Khader, UNRWA</i>
12:45–13:00	<i>GAIN strategic priorities</i> <i>Dr Mohammed Mansour, Consultant, GAIN</i>
13:00–13:15	Discussions
13:15–13:30	Situation of iodine deficiency in the Region and strategies for future programmes <i>Dr Izzeldine Hussein, Regional Coordinator ICCIDD, Oman</i>
13:30–13:45	Nutrition throughout the life cycle: strategic targeting <i>Dr Raanda Saadah, WHO/HQ</i>
13:45–14:00	Success nutrition programmes from India and Egypt <i>Mr Gian Pietro Bordignon, Country Representative, WFP</i>
14:30–14:45	Nutrition Situation Analysis in Saudi Arabia: strategic plans for future programmes <i>Dr Khaled Madani, Consultant in Clinical Nutrition, Saudi Arabia</i>
14:45–15:00	Discussions
15:00–15:15	Success stories from Oman in the area of developing national nutrition

- strategies and policies
Ms Deena Alasfoor, Ministry of Health, Oman
- 15:15–15:30 National nutrition strategies and food safety programmes in Egypt
Dr Azza Gohar, NNI Egypt
- 15:30–15:45 Nutrition situation analysis in Sudan under both development and emergency: role of civil society in addressing malnutrition
Dr Amani Mostafa, Sudan
- 15:45–16:00 Experience of Kuwait in nutrition surveillance and its impacts: lessons learnt could be considered at the regional level.
Dr Nawal Al-Hamad, Kuwait
- 16:00–16:15 Discussions

Tuesday, 2 June 2009

- 09:00–10:30 Identification of strategic priorities, goals and tools (working groups)
- 11:00–12:00 Identification of key features of the action plan: brainstorming for the way forward (working groups)
- 12:00–13:00 Group presentations
Closing ceremony

Launch of the draft regional nutrition strategy and second meeting of the regional advisory committee on nutrition**Sunday, 13 December 2009**

- 10:00–10:30 Registration
- 10:30–10:45 Address by Dr Hussein A. Gezairy, Regional Director, WHO EMRO
- 10:45–11:00 Address by H.E. Dr Hatem El Gabaly, Minister of Health, Ministry of Health, Cairo, Egypt
- 11:00–11:30 Key strategic direction of the draft WHO Nutrition Strategy and Action Plan for the Eastern Mediterranean Region 2010–2011
By Dr Haifa Madi, Director Health Protection and Promotion
- 11:30–11:45 Remarks by Dr Francesco Branca, Director, Department of Nutrition for Health and Development, WHO-HQ
- 11:45–12:00 Remarks by Dr Ebrahim Elmadfa, President, IUNS, Vienna
- 12:00–12:10 Documentary film on the nutrition and food security in the Region
- 12:10–12:30 Panel discussions and recommendations by the Member States, UN agencies and Member of the Advisory Committee
- 12:30–12:45 Signing a declaration on implementing the Regional Strategy at Member State level
- 13:30–15:30 The way forward for implementing the draft regional nutrition strategy by Member States (restricted to the Advisory Group on Nutrition and Directors of the Primary Health Care in Member States)

Annex 2

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Annex 3

SELECTED NUTRITION STRATEGIES AND ACTION PLANS FROM OTHER REGIONS

African nutrition strategy (2005–2015)

Eight priority areas

Monitoring the food and nutrition situation

Advocacy and communication

Policy and institutional framework

Strengthening food and nutrition programme implementation

Integrating nutrition dimensions into the development agenda

Strengthening institutional and technical capacity for nutrition at all levels (community to national)

Promoting community participation and involvement

Resource mobilization strategy

Regional strategy on nutrition in health and development for the Americas (2006–2015)

Five strategic areas and three lines of action

Development and dissemination of macropolicies targeting the most critical nutrition-related issues

Strengthening resource capacity through the health and non-health sectors based on standards

Information, knowledge management and evaluation systems

Development and dissemination of guidelines, tools and effective models

Mobilizing partnerships, networks and a regional forum in food and nutrition

Food and nutrition in health and development

Suboptimal nutrition and nutritional deficiencies

Nutrition and physical activity in obesity and nutrition-related chronic diseases

European second action plan for food and nutrition policy (2007–2012)

Supporting a healthy start

Ensuring safe, healthy and sustainable food supply

Providing comprehensive information and education to consumers

Performing integrated actions to address related determinants

Strengthening nutrition and food safety in the health sector

Monitoring, evaluation and research