

Report on the

Technical consultation on scaling up nutrition in the Eastern Mediterranean Region

Amman, Jordan
2–3 November 2011



World Health
Organization

Regional Office for the Eastern Mediterranean

Report on the

**Technical consultation on scaling up nutrition
in the Eastern Mediterranean Region**

Amman, Jordan
2–3 November 2011



**World Health
Organization**

Regional Office for the Eastern Mediterranean

© World Health Organization 2012

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Distribution and Sales, World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 2670 2535, fax: +202 2670 2492; email: PMP@emro.who.int). Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: WAP@emro.who.int.

CONTENTS

1.	INTRODUCTION.....	1
2.	BACKGROUND AND EXPECTED OUTCOMES.....	2
3.	TECHNICAL PRESENTATIONS	3
3.1	Global nutrition situation: burden and policy response	3
3.2	Strategic interventions to address malnutrition in the Region	4
3.3	Preparing for the International Conference on Nutrition (ICN + 20)	5
3.4	Child nutrition in the Middle East and North Africa Region	6
3.5	Research priorities in nutrition.....	6
3.6	Nutrition sensitive food and agriculture based approaches: lessons learned and best practices.....	7
4.	COUNTRY PRESENTATIONS	8
4.1	Afghanistan	8
4.2	Egypt	9
4.3	Islamic Republic of Iran.....	10
4.4	Iraq	11
4.5	Jordan	11
4.6	Lebanon.....	11
4.7	Libya	12
4.8	Morocco	12
4.9	Oman.....	13
4.10	Pakistan	14
4.11	Palestine	15
4.12	South Sudan	15
4.13	Sudan.....	16
4.14	Syrian Arab Republic	17
4.15	Tunisia.....	18
4.16	United Arab Emirates	18
4.17	United Nations Relief and Works Agency for Palestine Refugees in the Near East.....	19
5.	PLENARY DISCUSSION ON CROSS-CUTTING ISSUES: POLICY DEVELOPMENT AND CHALLENGES OF SCALING UP	20
6.	GROUP WORK: COMMON CHALLENGES AND PRIORITY PROGRAMMES	21
7.	RECOMMENDATIONS	23
Annexes		
1.	PROGRAMME.....	24
2.	LIST OF PARTICIPANTS	26

1. INTRODUCTION

Although improvements in nutrition have taken place worldwide as a result of economic growth and as a natural outcome of health sector development and services, in most countries of the WHO Eastern Mediterranean Region the situation has not improved greatly and nutrition has not been given the attention it merits in development plans. The Region faces a double burden of malnutrition that includes both under-nutrition and overweight. The main challenges in the Region with regard to nutrition are inadequate or unclear political commitment, insufficient policy framework and institutional capacity, chronic conflict and natural disasters, inadequate budget to support nutrition, shifting from traditional diets in favour of “fast” foods, insufficient nutrition expertise and lack of intersectoral coordination.

In order to strengthen capacity in nutrition in countries of the Region, the WHO Regional Office for the Eastern Mediterranean organized a two-day technical consultation on scaling up nutrition in Amman, Jordan from 2 to 3 November 2011. The objectives of the meeting were to:

- present country progress, needs and commitments to scale up nutrition;
- collect country contributions and perspectives on the comprehensive plan for implementation of global commitments to ;
- explore the commitment of development partners to support implementation of proposed actions; and
- prepare for the upcoming International Conference on Nutrition (+ 20) and share plans with Member States in the Region.

The consultation was organized in collaboration with the Food and Agriculture Organization of the United Nations (FAO), United Nations Children’s Fund (UNICEF) and World Food Programme (WFP). In attendance were participants from Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Iraq, Lebanon, Libya, Jordan, Morocco, Oman, Pakistan, occupied Palestinian territory, Sudan, South Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

The consultation was opened by Dr Ahmad Basel Al-Yousfi, Acting WHO Representative in Jordan, who delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message Dr Gezairy noted that many countries in the Region were developing nutrition policies, however there was urgent need to translate these policies into action plans and programmes to address nutrition challenges. WHO would provide all possible support to Member States and concerned organizations to develop, review and operationalize current nutrition policies and frameworks in order to strengthen nutrition for all.

In a speech on behalf of the Minister of Agriculture, Engineer Fuad Al Meheisen highlighted the role of the Ministry of Agriculture in providing the national market with sufficient quantity and quality of local products as well as supporting small farmers through

granting loans to cover the expenses of their work and buying their products. The Ministries of Agriculture and Health worked together closely in supporting and supervising food production and food quality in Jordan. The Ministry was participating in the development of a national food security strategy that included a nutrition component.

H.E Dr Abd Alatif Wreekat, Minister of Health of Jordan highlighted the achievements of Jordan in improving the nutritional status of its population and stressed the need for collaborative efforts from all concerned organizations in order to strengthen food security and improve the quality of food in general.

The meeting programme and list of participants are attached as Annexes 1 and 2, respectively.

2. BACKGROUND AND EXPECTED OUTCOMES

Dr Haifa Madi, WHO Regional Office for the Eastern Mediterranean

Child under-nutrition is causing 30% of deaths among children under 5, while maternal and child under-nutrition account for 11% of the global burden of disease. Iron deficiency anaemia in women is still responsible for at least one in five maternal deaths at delivery. Non-exclusive breastfeeding in the first 6 months of life accounts for 10% of the disease burden among children under 5.

In response to current global nutrition challenges, in 2010 the 63rd World Health Assembly issued resolution WHA63.23 Infant and young child nutrition, in which it urged Member States to increase political commitment in order to prevent and reduce malnutrition in all its forms, to strengthen and expedite the sustainable implementation of the global strategy for infant and young child feeding, to develop or review current policy frameworks addressing the double burden of malnutrition, and to scale up interventions to improve infant and young child nutrition and strengthen nutrition surveillance. This commitment is supported by a regional nutrition strategy which was endorsed by the Fifty-eighth Session of the Regional Committee for the Eastern Mediterranean in 2010, with an action plan addressing the double burden of malnutrition. This strategy was developed in consultation with Member States, the Arab League, FAO, UNICEF, academia and research centres.

An outline of the comprehensive plan for implementation of the resolution was prepared by WHO headquarters for country and regional consultation and for discussion at the 64th World Health Assembly. The outline is supported by four background papers that provide: 1) an analysis of the implementation of nutrition policies globally; 2) a review of effective nutrition interventions; 3) a description of country processes to scale up nutrition interventions; and 4) a framework for monitoring the implementation of the implementation plan.

A public call for comments has been launched on the outline of the plan and on the background papers. Country consultations will be held whenever possible but regional consultations will be the main opportunity for discussion. FAO and WHO will also work

together to support Member States to prepare for the next International Conference on Nutrition (ICN + 20) planned to take place in Rome in 2012.

Expected outcomes of the current consultation include country presentations on progress, needs and commitments; consolidated regional comments on the outline of the implementation plan on infant and young child nutrition; commitments to support scaling up of nutrition actions in countries; and contributions to the regional preparation for ICN + 20.

3. TECHNICAL PRESENTATIONS

3.1 Global nutrition situation: burden and policy response

Dr Francesco Branca, WHO headquarters

All countries have policies or strategies to address all important forms of malnutrition, but these policies are often not officially adopted, and do not always address existing challenges in countries. Furthermore, programmes are not officially implemented at national scale as planned, and food and agricultural strategies are not focusing on gender and vulnerable groups and new nutrition challenges.

The Scaling-Up Nutrition (SUN) movement was launched at the 63rd World Health Assembly in May 2010 and brought together government authorities from countries with high burden of malnutrition and a global coalition of partners. The strategy of SUN calls for 3–5 years of intensive efforts to scale up nutrition (2013–2015).

The five global targets are:

Global target 1: 40% reduction of childhood stunting by 2022. Stunting reduction has been documented in some countries in South America and in South East Asia.

Global target 2: 50% reduction of anaemia in women of reproductive age by 2022. Some countries have demonstrated a reduction in anaemia prevalence in non-pregnant women, with a 3%–6% relative reduction per year. A 5% relative reduction per year can be considered. Considering that approximately half of anaemia cases are due to iron deficiency, this target corresponds to the virtual elimination of iron deficiency anaemia.

Global target 3: 50% reduction of low birth weight by 2022. Reductions in low birth weight have been observed in Bangladesh, El Salvador, India, South Africa and the United Republic of Tanzania.

Global target 4: 0% increase in childhood overweight by 2022. Success in curbing increasing rates in school-age children has been documented in Sweden, France and Chile, but limited to some regions and to higher income groups.

Global target 5: Increase exclusive breastfeeding rates in the first 6 months up to 50% by 2022. Exclusive breastfeeding rates have been increasing from 14% to 38% in the decade

1985–1995, and they have then decreased in most regions. Substantial increases in exclusive breastfeeding rates have been documented in countries from all Regions, such as Cambodia, Mali and Peru.

The five action points of the SUN strategy are to: 1) create a supportive environment for the implementation of comprehensive food and nutrition policies; 2) include all required effective health interventions with an impact on nutrition in plans for scaling up; 3) stimulate the implementation of non health interventions with an impact on nutrition; 4) provide adequate human and financial resources for the implementation of health interventions with an impact on nutrition; 5) monitor and evaluate the implementation of policies and programmes.

3.2 Strategic interventions to address malnutrition in the Region

Dr Ayoub Al Jawaldeh, WHO Regional Office for the Eastern Mediterranean

Major nutrition problems in the Region include food insecurity and poverty; protein–energy malnutrition and stunting; micronutrient deficiencies such as iron deficiency anaemia, vitamin A deficiency and disorders, zinc deficiency, iodine deficiency and disorders, and other micronutrient deficits (D, B12). Other major nutrition problems relate to infections and infectious morbidity, nutrition transition and food consumption pattern as well as obesity and noncommunicable disease.

Nutrition is not well understood by many decision-makers, with the result that minimal investments have been made to address nutrient deficiencies and obesity. There is a need for multisectoral programmes to tackle the multiple determinants of malnutrition as well as interventions especially for groups at high risk. Many aspects should be strengthened including nutrition surveillance, communication and advocacy approaches and food safety (food labelling and quality control). Food security and conflict and disasters also remain a major concern,

The regional strategy on nutrition 2010–2019 is the first nutrition strategy developed at regional level. It was prepared through a consultative process by the Regional Advisory Committee on Nutrition and includes Member States, the Arab League, United Nations organizations and civil society. The plan of action of the strategy addresses the major health and nutrition problems and has been adopted by Egypt, Jordan, Iraq, Libya, Lebanon, Morocco, Qatar, South Sudan, Syrian Arab Republic and the United Arab Emirates.

In 2010 the 63rd World Health Assembly issued resolution 63.23 Infant and Young Child Nutrition, in which it urged Member States to focus on child nutrition to reduce malnutrition in all its forms, strengthen implementation of the global strategy for infant and young child feeding, address the double burden of malnutrition, and scale up interventions to improve infant and young child nutrition and strengthen nutrition surveillance.

Strategic objectives for the Region for 2011–2019 are to: 1) reduce the prevalence of wasting and stunting among children, especially children under 5 years of age, and of under-

nutrition among women; 2) reduce the prevalence of micronutrient deficiencies and diet-related noncommunicable diseases; 3) build capacity for monitoring and evaluation and emergency preparedness in nutrition; and 4) improve food safety and ensure a safe, healthy and sustainable food supply.

These objectives will be pursued through the strategic approaches identified in the regional nutrition strategy: strengthening political commitment, legislation and multisectoral approaches to ensure healthy and sustainable food supply and food safety; promoting and protecting the nutritional well-being of women and children and ensuring good nutrition throughout the life-cycle for all age groups; promoting food with adequate micronutrient content; providing comprehensive information and education to the public; promoting implementation of the WHO global strategy on diet, physical activity and health; improving nutrition services and capacity-building in the health sector, including emergency situations and support to vulnerable groups; and research, monitoring and evaluation.

It is important to support countries in addressing under-nutrition through providing technical assistance, strengthening surveillance, developing protocols and strategies, supporting implementation, monitoring and evaluation and mobilizing resources. Partnerships are essential among different agencies to promote nutrition activities. In the emergency context, special attention is needed for the promotion and protection of appropriate infant and young child feeding as well as management of severe malnutrition.

3.3 Preparing for the International Conference on Nutrition (ICN + 20)

Dr Brian Thompson, Food and Agriculture Organization of the United Nations

The Joint FAO/WHO International Conference on Nutrition (ICN) in 1992 adopted the World Declaration and Plan of Action for Nutrition. One hundred and fifty nine countries participated in the ICN and pledged to reduce starvation, chronic hunger, under-nutrition, micronutrient deficiencies, diet-related communicable and noncommunicable diseases, impediments to optimal breastfeeding, and inadequate sanitation and hygiene.

The outstanding result of the ICN 1992 was that countries prepared national plans of action to alleviate hunger and malnutrition. Despite the achievements in the two decades following the ICN, progress in reducing hunger and malnutrition has been unacceptably slow.

It is well known that malnutrition acts as a brake on development and places an intolerable burden on national health systems and on the entire cultural, social and economic structures of nations. Investing in nutrition is therefore not only a moral imperative but also a socioeconomic driver, as it improves productivity and economic growth, reduces health care costs and promotes education, intellectual capacity and social development.

ICN+20 aims to revitalize the role of nutrition at international level and strengthen governance for nutrition by supporting other initiatives, such as SUN. The purpose of ICN+20 is to mobilize the political will and resources for improving nutrition and for reaching a consensus on a World Declaration on Nutrition that will lay the basis for achieving

better nutrition for all. ICN+20 should further achieve a consensus around a global multisectoral nutrition framework indicating concrete steps to improve nutritional status.

The ICN+20 conference will be a high level political event lasting for three days. In preparation for the conference, seven regional preparatory meetings, as well as expert meetings and stakeholder consultations, will be held throughout 2011 and 2012. The purpose of the regional meetings will be to involve countries, to facilitate exchange and to provide frameworks for the preparation of the country papers. Following the regional consultations, a regional synthesis paper will be prepared drawing on the country papers to help inform the debate at the ICN+20.

3.4 Child nutrition in the Middle East and North Africa Region

Dr Mahendra Sheth, UNICEF Regional Office for the Middle East and North Africa

Under-nutrition greatly impedes a country's socioeconomic development and its potential to reduce poverty. Many of the Millennium Development Goals (MDGs), particularly MDG 1, to eradicate extreme poverty and hunger, and MDG 4, to reduce child mortality will not be reached unless national development programmes and strategies put the nutrition of women and children first. With persistently high levels of under-nutrition in the developing world, opportunities to save millions of lives are being lost, and many more children are not growing to their full potential. Cost-effective programming strategies and interventions are available today that can make a significant difference in the health and lives of children and women. These interventions urgently require scaling up, a task that will entail the collective planning and resources of developing country governments at all levels and of the international development community as a whole.

Comprehensive nutrition interventions aim at much more than food availability. They also entail: ensuring food security for poor households, in both quantity and quality; educating families on the nutritional needs of young children, including the value of breastfeeding and the importance of introducing suitable complementary foods at the right age; ensuring early childhood development is embedded at household level; protecting children from infection by immunizing them against common childhood diseases and by providing safe water and sanitation; addressing the supply and demand side barriers and bottlenecks; ensuring that children receive quality care when they fall ill; shielding children from micronutrient deficiencies, especially in iodine, iron and vitamin A, that can bring death and disabilities; paying special attention to the nutritional needs of girls and women, since chronically undernourished women tend to bear low-birth weight babies; ensuring timely collection of good quality data and course corrective measures; and ensuring that there is an equity focus in addressing nutritional problems

3.5 Research priorities in nutrition

Dr Ibrahim Elmadfa, Institute of Nutritional Sciences, University of Vienna

Causes of nutritional anaemia include deficiency of iron, folate, vitamin B12, vitamin B6, vitamin C, protein, vitamin A, zinc and copper, intoxication with lead or other heavy

metals, and medication. Other causes include parasitic infections such as hookworms (blood loss).

At present the most common forms of micronutrient malnutrition are deficiencies in iron, iodine and vitamin A. Emerging forms of micronutrient malnutrition are deficiencies in folate, zinc, calcium and others. Intervention programmes to prevent micronutrient deficiencies need evaluation.

Molecular biomarkers in nutrition are particularly well suited to enable early detection of nutrition-related diseases and preventive diet measures. Information on nutrient interaction is needed for better diagnosis and to design individualized nutrition.

Noncommunicable disease prevention targets for intervention need validation of assessment methods. Assessment of nutrient intake is based on food composition databases. However, food composition is highly variable due to differences between crop varieties and growing areas and different recipes and preparation methods. In particular, data on local/ethnic foods are often not available. This calls for regional food composition databases.

Food quality assessment and improvement require the establishment and proper use of food composition databases, reformulation of recipes for the food industry and the adoption and validation of a suitable system for the Region.

3.6 Nutrition sensitive food and agriculture based approaches: lessons learned and best practices

Dr Leslie Amoroso, Food and Agriculture Organization of the United Nations

Dr Fatma Hachem, Regional Adviser Nutrition, Food and Agriculture Organization, Egypt

Agriculture has three purposes: to produce foods for consumption; to support livelihoods, provide employment opportunities and generate incomes; and to protect and safeguard the environment for future generations in terms of land, soil and water and the flora and fauna.

FAO is working to better integrate nutrition into agriculture, food security and vulnerability policy frameworks. The terminology of “food and nutrition security” best describes the integration of nutrition into food security. Including nutrition underscores the need to not only look at the quantity of food but also the quality in terms of variety, diversity and nutrient content and care.

Food- and agriculture-based strategies focus on food as the primary tool for improving the quality of the diet and for addressing and preventing malnutrition and nutritional deficiencies.

Poor, monotonous diets low in quantity and quality lead to hunger and malnutrition. Food- and agriculture-based approaches address this problem by making more food available and accessible and by providing nutrition education and dietary counselling.

There is a need to increase access to and consumption of rich and diverse diets. Simple technologies that can help improve consumption patterns include: diversified production of fruits and vegetables with micronutrient rich varieties; production of animal source foods; investment in sustainable forest and pasture management; protection of biodiversity; selection of crops based on nutritional content in addition to yields and market value; increasing availability of and access to fertilizers; reducing post harvest losses; and training extension staff and households in basic nutrition and food preparation skills.

FAO's policy response at global and regional level to improving food and nutrition security includes: technical assistance; promotion of nutrition sensitive agriculture policies and programmes; capacity building; nutrition education strategies; promotion of improved family feeding practices and complementary feeding; conducting baseline surveys; promoting small scale food processing and preservation techniques; and improving water harvesting and irrigation systems.

4. COUNTRY PRESENTATIONS

4.1 Afghanistan

A national nutrition policy was developed in 2009 and endorsed by the Ministry of Public Health, along with an action plan. The World Bank is supporting the Nutrition Action Framework in coordination with the ministries of public health, agriculture, irrigation and livestock, commerce and industry, rural rehabilitation and development, and education. United Nations agencies are involved at different levels. The country has essential policies and strategies including infant and young child feeding, micronutrient and maternal nutrition strategies, but the implementation of these strategies is hampered by budget limitations, low capacity and the unstable security situation.

Malnutrition is still a critical challenge in Afghanistan due to political instability and food insecurity. The prevalence of severe acute and moderate acute malnutrition is 4.7% and 12.2%, respectively. The prevalence of severe and moderate malnutrition among pregnant women is 4.97 (mid upper arm circumference < 210 mm) and 13.4 (mid upper arm circumference <230–210 mm) respectively, while prevalence of underweight (body mass index less than 18.5kg/m²) among lactating mothers is 21.7%.

The major challenges faces Afghanistan are: inadequate national legislation to ensure proper nutrition services and health prevention; limited capacity in public nutrition among health practitioners and professionals from other nutrition-related sectors (agriculture, education, social affairs, etc.) to plan, coordinate and implement national nutrition programmes; and lack of multisectoral coordination between health, education, water and sanitation and agriculture to address nutrition and food security, partners tend to actively

cover capacity gaps and implement national programmes with limited government involvement.

Most of the programmes also are implemented by nongovernmental organizations, which limits the role of government and the ability to track compliance with WHO/UNICEF/FAO and international standards, policies, guidelines and protocols on nutrition and food security.

The following programmes are required immediate support to address emergency nutrition:

- Management of severe malnutrition at health facilities
- Nutrition surveillance system
- Infant and young child feeding
- Implementation of WHO growth monitoring at national level
- Nutrition education and advocacy
- Expand nutrition supplementation, fortification.

4.2 Egypt

The Ministry of Agriculture and Land Reclamation and other research centres give considerable attention to improving nutritional standards and dietary patterns through application of policies and programmes.

The Ministry of Agriculture and Land Reclamation has established the Food Security Information Center (FSIC) 2007 with the support of FAO. Its mission is to support decision-makers by providing relevant cross-sectoral data, analyses and recommendations for reducing food insecurity and hunger. The Food Security Policy Advisory Board was established by ministerial decree in 2010, with the FSIC as its technical arm. The Advisory Board aims at strengthening institutional coordination among ministries, agencies and other stakeholders for informed policy decision-making with the aim of improving the food security and nutrition situation of the Egyptian population, in particular the poor and most vulnerable.

Egypt surveys found that 29% of Egypt's children under the age of 5 years are stunted, 7% are wasted, and 6% are underweight. The level of wasting more than doubled since 2005 while the level of stunting rose by nearly 25%. Young children in Lower Egypt were twice as likely and children in Upper Egypt were around 25% more likely to be stunted as children in the urban governorates. Children in the richest three quintiles have approximately 25% lower odds of being stunted than children in the poorest quintile. A short birth interval (less than 24 months) was associated with a 45% increase in the odds a child is stunted compared to first-born children. Although neonatal mortality has been falling nationally, it has increased from 17 per 1000 live births in 2005 to 21 per 1000 live births in 2008.

The FSIC conducted a study to rank Egyptian governorates in terms of food insecurity using different indicators in order to indicate priorities for decision-makers to take into

account. The study showed that Upper Egypt ranked first in terms of food insecurity. Although the ranks of Lower Egyptian governorates varied, Lower Egypt is in a better position compared to Upper Egypt. The ranks of frontier governorates also varied but occupied a better position compared to those of Upper Egypt.

Consumers have been affected by increases in food prices resulting from the removal of food subsidies. Studies report that when subsidies were removed between 1990 and 1994, food prices increased sharply and at a higher rate than general inflation – three- to ten-fold – while wages less than doubled. Household food consumption dropped dramatically by about 20% during this period. When studying the effect of removing food subsidies and applying free market prices concluded that free market prices for cereals, legumes, oils and sugar would increase the cost of energy for the population and reduce the consumption of animal protein, particularly in vulnerable groups. The National Nutrition Institute conducted a study of family behaviours in response to increasing food prices. Samples from Cairo, Upper Egypt, Lower Egypt and industrial areas were selected. Results showed that the rise in income could not cope with that in food costs. Less expensive foods were substituted, and the frequency of meat consumption in particular declined.

4.3 Islamic Republic of Iran

Protein–energy malnutrition among children less than 5 years old is common in deprived areas of the Islamic Republic of Iran. The problem is greater in southern and south-eastern provinces. Review of the trend of protein–energy malnutrition during the 13-year period of the surveys shows that the prevalence of underweight in rural areas was reduced from 18.8% in 1995 to 11.2% in 1998 to 8.8% in 2008. Because of the implementation of intervention programmes on complementary nutrition, growth monitoring, nutrition education of mothers, food supplementation for malnourished children and breastfeeding, the prevalence of malnutrition has decreased among children. Fortifying edible salt with iodine (potassium iodide) started in 1989. At present, all kinds of salt produced in the salt factories are fortified with 150 PPM potassium iodate. Based on the last national survey in 2007, 98% of the population consumes iodized salt and the prevalence of goitre has decreased from 68% in 1981 to 6.5% in 2007. The trend of obesity and overweight has accelerated in recent years. At least one third of adult men and women of the country are overweight or obese. The situation is worse in urban areas. Distribution of milk was piloted in one region in 2000 and followed in the primary schools in rural areas of deprived provinces and then expanded to the primary schools of both rural and urban areas of those provinces. In 2001, six provinces were covered by the programme. In 2010, this programme covered 12 million 6–10 and 11–14 year-old female and male students in rural and urban areas, as well as high school females.

Fortifying flour with iron and folic acid was started in 2001 in one province. Successful results of this pilot project led to starting of flour fortification in other problematic areas. In 2007, fortification of flour with iron and folic acid was expanded to the national level. The cost of fortification was included in the bread and flour subsidies until 2010. In 2011, by cutting the subsidies, the cost of flour fortification was integrated into the cost of flour and bread.

In order to prevent and control micronutrient deficiencies, daily micronutrient supplementation for pregnant and lactating women and children under 2 years has been implemented through the primary health care system free of charge since 1981 at the national level. A supportive nutritional programme for poor families is being implemented for malnourished mothers and children. The food basket is free of charge and is provided based on dietary recommendations and also the existing customs of each area.

4.4 Iraq

In Iraq, the aim of reducing poverty and creating policies for food security has been translated through activities including an international compact with the goals of creating a social safety net and reforming subsidies. Under the public distribution system, each Iraqi is entitled to a monthly food basket for a nominal fee.

Current household food security status is based on diet, which is a good proxy indicator of household per capita consumption and household per capita caloric intake both of which are measures of the 'food accessibility' component of food security. Diets in Iraq are extremely diverse, linked in large part to its highly diversified resources and the existence of the public distribution system where all Iraqis are entitled to many food items on a monthly basis. The overall trend highlights a decrease in stunting rates over the years but an increase in wasting in 2005 having seen a drop between 2002 and 2004. The national average of malnutrition in Iraq is estimated as 4.7% for wasting, 21.8% for stunting and 9.1% for underweight.

4.5 Jordan

Micronutrient malnutrition is a public health problem in Jordan, particularly for vitamin A, iron, iodine and vitamin D. To counteract, Jordan has undertaken many national supplementation and micronutrient fortification programmes. The national salt iodization programme was initiated in 1995. The most recent study showed that the prevalence of goitre has dropped to 4.9%, with 96.3% of households consuming iodized salt, which indicates high improvement in the nutritional status regarding iodine deficiency disorders (IDD). As for wheat flour fortification, the programme was initiated in April 2002 fortifying with iron and folic acid. In 2006, zinc, niacin and vitamins A, B1, B2, B6 and B12 were added, and in 2010, vitamin D was further added. In addition, distribution of vitamin A tablets for children was initiated in 2005. All these programmes along with developing legislation and regulations, monitoring and evaluation, aim to reduce the burden of micronutrient deficiencies in Jordan.

4.6 Lebanon

Major nutritional health challenges faced in Lebanon include child underweight, stunting and wasting and food security. Overweight and noncommunicable diseases are also major challenges influenced by food consumption patterns and physical activity. Micronutrient deficiencies, mostly iron, iodine and vitamin D, cause a major challenge in

Lebanon. Interventions are being conducted including a birth registry in efforts to reduce the under-5 mortality rate, as well as assessing the Baby Friendly Hospital Initiative which showed weak implementation rate. Interventions in regard to food safety are also taking place, along with awareness-raising activities to modify dietary behaviours and reduce obesity and noncommunicable diseases. With regard to micronutrient deficiency, fortification of flour with iron has been proposed but no action was taken due to lack of consensus. However, salt iodization has been practised since 1995. Lebanon still has many priorities including preventing micronutrient deficiency and halting obesity and food insecurity in addition to monitoring, evaluation and conducting research.

4.7 Libya

Studies show that underweight does not exceed 4.7% among children under five years. Per capita contribution of food products consumption reaches 29% for cereals, followed by dairy products at 19%, meat at 5%, oil at 3%, legumes 2% and eggs 2%. The nutritional content of food was low in vitamin A, B1, B2 and Ca, but adequate in iron, K, Na and vitamin C. The majority of Libyans (97.5%) consume less than 5 serving fruits and vegetables per day. The prevalence of obesity among Libyan females was 41% and 21% among males. About 36% of males and 52% of females had low physical activity. Obesity-related diseases were common in Libya: Hypertension was prevalent among 68.4% of males and 48.5% of females, while diabetes mellitus affects 23.4% of both sexes. Libya has no data on nutrition and food security. Policies and strategies are available but there is no implementation plan or capacity for implementation. Therefore, it has been strongly recommended to conduct a national nutrition survey including the micronutrient status

4.8 Morocco

The nutritional situation of the Moroccan population has been improved as a result of three factors: the economic development of the country, improvement of health services and the development of the other sectors such as agriculture, education, food technology and other socioeconomic services. However, Morocco is still experiencing persistent nutritional problems and new emerging ones due to globalization, urbanization and changes in lifestyles and food habits.

Epidemiologically considerable changes in disease profiles are occurring in Morocco. Indeed, the current epidemiologic profile is characterized by the coexistence of three groups that contribute to the heavy burden of morbidity and mortality. Noncommunicable diseases are responsible for 55.8% of the total morbidity. Indeed, 34% of Moroccans over 20 years of age are suffering from high blood pressure and about 6.6% from diabetes.

According to the various investigations and studies held by the Ministry of Health during the past decades, malnutrition constitutes a public health problem in Morocco. Indeed, exclusive breastfeeding is practised by only 15% of the women, acute malnutrition represents approximately 9% in children under 5 years, stunting represents 18% and wasting 10% of these children. The prevalence of anaemia due to iron deficiency is about 37.2% among

pregnant women and approximately a third among under-five children. Concerning micronutrient deficiency, 37% of pregnant women and 35% of children aged 6 months to 5 years have iron deficiency, 41% of children aged 6 months to 6 years have vitamin A deficiency and 22% of children aged 6 to 12 years suffer from goitre.

As regards health in general and nutrition in particular, several strategies and programmes have been developed by the Ministry of Health and its partners: monitoring of children's growth; promotion and support and protection of breastfeeding; and control of micronutrient deficiencies.

In response to the relatively alarming nutrition situation and in accordance with the recommendations of WHO, the Ministry of Health has initiated the elaboration of a national nutrition strategy for the period 2011–2019 in collaboration with its partners. The strategy goal is to contribute to the improvement of the health status of the population by focusing on its major determinants, among which is nutrition.

4.9 Oman

The nutrition programme was established in Oman in 1991 as part of the health service package. Initially, it focused on management and control of protein–energy malnutrition among infants and young children, promotion of breastfeeding, and micronutrient supplementation for pregnant women. The importance of nutrition as a preventive and curative approach came to the forefront of health policy and planning over the past two decades, and this was reflected in the seventh five-year plan of action which spans the years 2006–2010. In this plan, the nutrition vision was realized as Better Nutrition for All; its objectives included high quality nutrition services in the health care system, as well as promotion of adequate nutritional practices, prevention of nutritionally related chronic illnesses and promoting food safety, control of child malnutrition and control of micronutrient deficiencies.

The 2010 national nutrition surveillance (NNS) shows an acute malnutrition rate of 7.3% in the population under 5 years old, which is a medium health problem according to WHO. Stunting is about 12.9%, and underweight is about 11.3% in children under 5. The prevalence of anaemia among women and children is high: 41% in children, 43% in pregnant women and 39% in non-pregnant women (national food fortification study, 2004). Poor infant and young child feeding practices remain a major contributor to childhood malnutrition. Obesity is an emerging problem in Oman its prevalence among adult is 48%.

Studies show a declining trend in vitamin A deficiency according to serum retinol levels where the first study was conducted in 1994 and showed a prevalence of 20.8% among infants; this rate went down to 5.3% in 1998 after the national supplementation programme and this achievement was maintained in 2004 as the prevalence was 5.5% among infants and less than 0.4% among women of childbearing age. The national supplementation programme is continued; and an oil fortification programme was legislated in April 2010.

Priorities for action at national level include: 1) identifying causes of anaemia; 2) implementation of the communication plan of Omani food-based dietary guidelines; 3) developing a national food and nutrition policy; 4) upgrading the dietetics practice.

4.10 Pakistan

Pakistan is the sixth most populous country in the world (>180 million in 2011), the second largest Muslim population after Indonesia and has wide diversity in terms of culture, ethnicity, language, geography and climate. Pakistan is a federal parliamentary republic consisting of four provinces and four federal territories.

Pakistan has some of the worst health and nutrition indicators in Asia. The prevalence of child malnutrition is higher than in sub-Saharan Africa and the rate of decline is significantly slower than in the rest of South Asia. A national nutrition survey conducted in 2010–2011 showed that indicators of stunting and wasting were worsening during the past 10 years. 43.7% of children were stunted; this was relatively higher than the 2001 survey (41.6%). Similar trends were observed for wasting: 15.1% children in Pakistan had wasting in the 2011 survey as compared to 14.3% in 2001. Underweight rates remained constant over the decade (31.5%).

Pakistan has faced repeated natural and man-made emergencies. These humanitarian crises have resulted in major damage to infrastructure and livelihoods, leading to increased food insecurity and malnutrition among the affected populations. The enormous floods seen in Pakistan during 2010 were rated by the United Nations as the greatest humanitarian crisis in recent history. The floods affected more than 50% of the districts in the country (78/141 districts) and at least 20 million people (one-tenth of Pakistan's population). WHO reported that ten million people were forced to drink unsafe water. The Pakistani economy was extensively disrupted by the damage to infrastructure and crops.

The effects of the floods provided considerable challenges for the health system in service delivery, notably:

- An increased burden of acute malnutrition: global acute malnutrition was found to be 15% in Punjab and 23.1% in northern Sindh, compared to 2.9 and 6.1% in the same regions prior to the floods (WHO Growth Standard 2006).
- The existing capacity of provinces to handle nutrition-specific interventions – not just community-based management of acute malnutrition – and to take a multisectoral approach falls short. As it stands, top-level advocacy and contributions from donors will provide the substance for scaling up domestic and external assistance for country-owned nutrition programme and capacity. For national level stewardship of scaling up nutrition, there is a need to maintain a national and provincial board, simplify the nutrition information system, and maintain an intersectoral working group made up of the 5–6 nutrition-related sectors. This working group would provide a coordinating framework and technical input to the Nutrition Board, to mainstream nutrition into all development and humanitarian projects.

4.11 Palestine

Palestine is implementing a national nutrition policy, strategy and action plan focusing on 9 priorities including: nutritional surveillance; prevention and treatment of micronutrient deficiencies (micronutrient supplementation, food fortification and dietary diversification); prevention and treatment of obesity and dietary-related noncommunicable diseases and enhancing the diet and physical activity programme; protection, promotion and support for exclusive breastfeeding; growth monitoring among children up to 5 years; food and nutrition services in hospitals; management of severe and moderate malnutrition; appropriate nutrition among school children; and food security.

A national nutrition surveillance system has been established in Palestine which includes: children 9–12 months, pregnant women, schoolchildren and surveys whenever needed. The micronutrient supplementation programme includes folic acid, folic acid and iron, iron drops and vitamin A drops. Flour has been fortified with 10 micronutrients including: vitamins A, D, B1, B2, B6, B12, niacin, folic acid, zinc and iron. Salt has been fortified with potassium iodate. A targeted fortification programme was directed to schoolchildren through milk and biscuit fortification. Commercial fortification has been controlled by issuing a technical regulation for addition of minerals and vitamins to food. Many nutritional protocols have been approved and implemented. Awareness campaigns concerning noncommunicable disease risk factors are usually implemented all year around. An infant and young child feeding policy, strategy and action plan are implemented including the national regulation for marketing of breast milk substitutes. A growth monitoring programme is being implemented at the national level following the WHO New Growth Standards. Food and nutrition services at hospitals are a new challenging area. Moderate and severely malnourished children are managed carefully by a nutritionist and paediatrician at health care centres. A food security programme is still under establishment.

Most nutrition indicators in Palestine are considered satisfactory except those for anaemia, which has reached very high levels like 30% among pregnant women and 57% among children between 9 and 12 months of age.

4.12 South Sudan

In South Sudan, ongoing nutrition activities implemented by the Ministry of Health include setting standards, treatment of acute malnutrition, screening and referral for and treatment of severe acute malnutrition, prevention of acute under-nutrition, blanket supplementary feeding for children under three years and pregnant and lactating women, micronutrient supplementation (vitamin A) for children under five years and pregnant and lactating women.

South Sudan has succeeded in completing guidelines for integrated management of severe acute malnutrition (IMSAM) along with a monitoring and reporting tool, in addition to the implementation of the pre-harvest survey in 2011 in 7 states. With the support of the WHO, a comprehensive reporting format for nutrition has been developed, as well as

increased involvement of agencies in nutrition. Numerous challenges are still being faced including lack of political commitment or recognition of nutrition in the development agenda, inadequate funding for preventive nutrition, lack of adequate and comprehensive data and weak nutrition surveillance system, poor coordination, lack of skilled human resources, and marginalization. As a recommendation for the future, South Sudan highlighted the importance of advocacy for political commitment and emphasized the role of partners and the United Nations in nutrition and in advocating for a multisectoral approach. More opportunities are needed for studies/research, along with the development of a minimum package for nutrition and more funding for long-term preventive nutrition.

4.13 Sudan

Approximately 41% of children are exclusively breastfed. An estimated 58% of pregnant women and 43% of non-pregnant women are anaemic. Total goitre rates range from 87% in Darfur region and 78% in central region to 17% and 13% in Khartoum and the eastern region, respectively. The national nutrition policy and key strategies have been developed and approved but a five-year implementation plan has been in draft form since 2008, as there is no budget. Ten policy themes are set out in the national nutrition policy: prevention, detection and treatment of nutrition-related disorders; addressing the inter-generational cycle of malnutrition; food utilization, using an integrated approach to address malnutrition and morbidity; HIV/AIDS; developing systems and guidelines to safeguard quality food production that meets food security standards; utilizing social mobilization; nutrition education/behaviour change communication and advocacy strategies to promote improved knowledge and nutritional practices through all health facilities; at community level and through the general media; capacity building, multisectoral engagement in nutrition-related activity, nutrition information; research and advocacy. There are also many policies and strategies that address nutrition, such as the national health policy (2006), 25-year strategic plan for the health sector (2005) and the rural development, food security and poverty alleviation act (2005).

The bulk of funds in nutrition interventions are directed towards treatment of malnutrition and less attention is given to the prevention of malnutrition. Essential nutrition programme components, especially growth monitoring (which is considered to be one of the nutrition surveillance tools), have poor coverage and get less attention from donors. Growth monitoring needs to be strengthened to act as an early warning tool for prevention of malnutrition.

Nutrition interventions include management of severe and moderate acute malnutrition; Infant and young child nutrition; vitamin A supplementation are also distributed through child health days twice a year; distribution of iron supplementation for pregnant women with collaboration of reproductive health programme and vitamin A for postpartum; a multispectral partnership formed collaboratively to formulate and implement a comprehensive national fortification plan. The essential nutrition package is implemented at national scale, covering all 15 states of Sudan. It includes routine interventions implemented through all health clinics including growth monitoring, micro-nutrient supplementation for

pregnant and post-partum women and monitoring of low birth weight and the health nutrition education programme. The plan is to increase the coverage from 47% to 65% by the end of 2013. The national nutrition programme with the support of partners has strengthened the nutrition information system to ensure the availability of high quality information from all 15 states. Nutrition programme databases have been developed including a database for routine reports and a nutrition surveys database.

4.14 Syrian Arab Republic

Most of the previous policies, reform measures, programmes and projects were planned and implemented separately and provided piecemeal solutions to the integrated and multifaceted challenge of sustainable food security. As a consequence, an urgent need has emerged to adopt a coherent, time and cost bounded and nutrition focused programme for food security. Therefore, the Syrian Government has decided to formulate a comprehensive national programme for food security to address all elements and dimensions of food security, to contribute to sustainable agricultural and rural development and to alleviate poverty. This national programme is consistent with the guidance provided by the directives of the 10th five-year plan (2006–2010) and the 11th five-year plan (2011–2015). Its implementation also extends over the 12th five-year plan (2016–2020). It targets the food insecure population in the country with special emphasis on the poor people, small farmers and other most vulnerable groups. The total number of its beneficiaries reaches about 2.24 million households. Its total cost amounts to US\$ 4.07 billion. Its outcome will be achieved through: improving the sustainable management of natural resources; enhancing agricultural production and productivity; strengthening agricultural policies, institutional capacities and supporting services; inducing food stability and risk management capabilities; and improving food access, quality and safety.

One of the main targets is the prevention of micronutrient deficiencies, which is being tackled through several approaches. One is the iodization of salt on a national level, along with health education to raise community awareness of IDD. Vitamin A deficiency is being tackled by vitamin A capsule distribution on a national level for children and lactating women. Iron deficiency is prevalent among 44% of women of childbearing age; the Ministry of Health aims to reduce the prevalence through continued distribution of folic acid and recommending the fortification of flour with iron. Malnutrition including underweight, stunting and wasting, is prevalent and is being tackled through strengthening the nutrition surveillance system and health education. Reducing low birth weight and promoting exclusive breastfeeding are also highlighted areas. The Ministry of Health has successfully established a national surveillance system, adopting national nutrition strategy. The challenges include lack of qualified human resources and financial resources, lack of comprehensive data, low levels of coordination among other directorates and low community awareness.

4.15 Tunisia

The need for food and nutrition surveillance was been apparent since the 1970s, following a national survey of nutrition that revealed several nutritional problems. These nutritional problems include endemic iodine deficiency in the north-west, stunting and underweight among children under 5 and anaemia in women and children.

Surveillance became a reality after the development of the national plan of action for nutrition and food in 1995. The National Institute of Nutrition and Food Technology has received a political mandate for the implementation of this monitoring, which will aim to assist in the planning of health policies and programmes, and evaluate response measures nutrition and health. The surveillance system was implemented with technical and logistical support of French and Belgian partners. It took place in several stages.

- Identification of current nutritional problems by conducting a second national nutrition survey (1996–1997) that highlighted some persistent problems such as anaemia and stunting in children and some noncommunicable diseases such as obesity, diabetes and cardiovascular disease;
- Selection of nutritional problems to control anaemia, stunting and obesity;
- Identification of indicators of these problems through the development of causal models;
- Selection of the most relevant indicators according to their validity, objectivity and sensitivity to change, and their availability, cost, frequency of collection and disaggregation;
- Identifying institutions and other providers of these indicators as well as potential users of monitoring;
- Monitoring experiment in two governorates as a pilot;
- Generalization of the surveillance system, the implementation of an online database of nutritional problems and their selected indicators.

Since 2004, an interactive database at www.nutrition.rns.tn provides updated information on diet, anaemia, growth retardation and obesity in Tunisia, with relevant indicators from various sources.

Another example of nutritional surveillance in Tunisia is salt iodization. It started in 1984 in the northwest region, endemic for goitre, and spread throughout the country in 1995. Salt iodization has allowed the eradication of iodine deficiency. A system for monitoring the quality of the salt iodized throughout the distribution chain and periodic control of urinary iodine in schoolchildren, ensures the success of this medical action.

4.16 United Arab Emirates

A number of challenges are being faced. Nutrition surveillance does not exist in any countries of the subregion. Limited financial resources affect the efficacy of interventions. Micronutrient interventions are addressed to the general population and are not target

oriented, and there is a lack of consensus on premixes with a doubt on the efficacy and sustainability of fortification. Other challenges include capacity building of the functionaries as well as community; water supply, large section of arid land, trade and industry for promoting food security and agriculture. Most of the countries are not prepared well to meet the emergency situations.

Each country has launched either national or local programmes to tackle nutritional issues pertaining to national nutrition policy, food security and agriculture, micronutrient deficiencies, overweight and obesity control as well as infant and young child feeding practices.

At the sub-region level, success has been reported in the micronutrient interventions including the salt iodization and in some countries flour fortification resulting in significant reduction in iodine deficiency disorders and some documented decrease in anaemia among children. Success has also been documented in programmes addressing the promotion of infant and young child feeding practices, such as the Baby-Friendly Hospital initiative and adoption of International Code and Development of Local Code of Breast Milk Substitutes.

Immense opportunities lie in realizing the political commitment and prioritizing nutrition on the government agenda, providing substantial budget to the nutritional activities, strengthening and empowering the human resources in nutrition, emphasizing the intersectoral approach and developing capacity of the functionaries and recognizing nutritional leadership. In addition, establishment of national food and nutritional monitoring surveillance systems and research centres can provide a plethora of opportunities for development.

There is need for adoption and implementation of the regional nutrition strategy 2009–2019. There must be adequate coordination with all concerned stakeholders as well as inclusion of Nutrition Directorate/Department/Division in the organizational structure of the Ministry of Health in order to ensure optimal outcome achievement of the policies and programmes. Strengthening of monitoring and evaluation is needed to enhance the micronutrient interventions integrated within primary health care and maternal and child health. National obesity prevention and control programmes should be planned and implemented. To attain and sustain food security, subsidy for healthy foods (fruits and vegetables) is recommended, priority research areas should be identified and capacity-building of health functionaries and grass-roots level functionaries and community ensured. Agriculture should focus on preserving and promoting traditional crops. Other needs include continuous national monitoring and evaluation surveillance systems; empowerment of maternal and child health centres with capacity to provide nutrition education to mothers and young children; and adoption and implementation a contingency plan for emergencies.

4.17 United Nations Relief and Works Agency for Palestine Refugees in the Near East

UNRWA is the primary health care provider to Palestine refugees aiming to protect, preserve and promote the health status of the refugees through provision of quality care. In

terms of nutrition, main concerns entail poverty and unemployment (increase the demand for food aid programme); micronutrient deficiency (iron deficiency anaemia); obesity, diabetes and cardiovascular disease; and nutrition in schools. Interventions have been conducted to tackle anaemia through screening programmes, supplementation of pregnant women and preschool children and flour fortification. Other interventions have also been conducted such as vitamin A supplementation, de-worming, promotion of exclusive breastfeeding and growth monitoring. Success has been achieved on the level of the school health programme, developing nutritional guidelines for medical centres, developing health and education materials as well as training nurses. Also, healthy life style modifications were addressed in refugee camps. UNRWA aims to continue and strengthen their ongoing programmes and focus further on improving dietary practices, physical activity and obesity prevention.

5. PLENARY DISCUSSION ON CROSS-CUTTING ISSUES: POLICY DEVELOPMENT AND CHALLENGES OF SCALING UP

Dr Francesco Branca, WHO headquarters

Nutrition policies are in place or being developed or improved in all countries. With regard to health and agriculture, national health sector plans as well as food and nutrition policies typically exist.

Multisectoral mechanisms are in place, but are sometimes too weak to be effective. With regard to interventions, most of the effective interventions are included in national plans and implemented with various degrees of success. Nutrition interventions are furthermore integrated in maternal and child health and other programmes. Agriculture interventions seem to focus mainly on crops.

The following success factors need scaling up: a) increased awareness of the multisectoral approach; b) existence of political documents and guidelines; c) good community capacity development; d) university nutrition trainings as well as public health training for nutritionists available; e) health sector leadership in most coordination platforms.

A number of challenges are impeding the implementation of nutrition interventions. High level political commitment and funding is lacking in a number of countries, and financial support from governments is limited in most countries. Nutrition funds that are available are often scattered among different programmes. Weak intersectoral collaboration, particularly the poor links between food security and nutrition sectors, is a factor in some countries. Furthermore, lack of capacity and absence of accurate data appear to be challenges; With regard to programmes, the lack of adequate legislation, for instance regarding food fortification, was mentioned.

There are several key actions needed to scale up nutrition:

- Nutrition needs to be prioritized as a national development issue.
- Advocacy is needed for more effective commitment to implementation.
- Nutrition indicators need to be integrated into health information systems.

- Coordination and funding mechanisms at different levels need to be defined.
- Better research, monitoring and evaluation and nutrition surveillance are needed.
- Nutrition and food security interventions need to be integrated into one programme.
- Linkages between programmes should be strengthened, especially with regard to maternal and child health.
- Curricula need to be developed for agriculture and nutrition.
- Stakeholder involvement needs to be strengthened.
- Community-level interventions should be improved and harmonized.
- Nutrition should be a separate department within the Ministry of Agriculture.
- Human resources need to be strengthened.

Many factors need to be taken into consideration in the development of country plans to address double burden of nutrition. All countries stressed the issue of limited nutrition capacity. In order to implement and scale up nutrition interventions, more staff will be needed at community level. While more and more countries have trained nutritionists, they might be overqualified for work at community level. Furthermore, salaries are usually not enough to pay skilled nutritionists. Therefore, nutrition skills of low cadres, like nurses, midwives, community health promoters need to be strengthened, particularly in the area of counselling for infant and young child feeding. Nutritionists are needed not only in the health sector, but also within agriculture ministries.

It was mentioned that at national level, government and civil society can ensure appropriate involvement of the private sector; it is difficult to monitor activities of the private sector at local levels. Nongovernmental organizations need to align their activities with government objectives and guidelines. It was concluded that more engagement in public-private partnerships is vital.

6. GROUP WORK: COMMON CHALLENGES AND PRIORITY PROGRAMMES

During the group work, participants were divided into three groups and identified the following challenges.

Policy and strategies

The groups discussed that there is a lack of nutrition policies, poor intersectoral coordination and lack of political commitment to nutrition. Flour fortification and iodization of salt are policies that have been carried out successfully. Further intersectoral coordination must be conducted, request stronger political commitment and adopting the regional strategy.

Coordination mechanism

Most countries have experienced a lack of or inadequate leadership and intersectoral coordination and communication between authorities as well as weak ownership by the government. Countries have been successful in multisectoral committees, but future focus

should be put on increasing awareness among decision-makers and strengthening leadership of the governments to improve coordination.

Micronutrient interventions

Micronutrient supplementation and fortification interventions mostly focused on iron, iodine and vitamin A have been successful with challenges in implementation of the action plan, legislation issues. Sustainable strategies should be developed as well as strengthening multisectoral approaches, monitoring and evaluation, enhancing public–private partnership and considering other micronutrients (evidence-based).

Obesity control and prevention

Obesity programmes have faced numerous challenges in the method of reporting, early assessment and intervention as well as lack/inadequate knowledge, determinants of obesity, physical activity and social marketing. Obesity is acknowledged as a major challenge, hence, planning and implementation of national obesity prevention and control programmes should be considered. Healthy lifestyle promotion is not enough; taxing, banning or reducing consumption of high-sugar drinks, reducing marketing of foods for children, school programmes and physical activity promotion are also important.

Agriculture and food security

Current programmes include food safety, and formulation of strategies and policies, but challenges faced are sustainability, available capacity in food security, scarcity of resources (water) and farm management. Recommendations on future programmes should be focused on capacity-building, subsidizing healthy foods, poverty alleviation, crop allocation according to comparative advantages, promoting home gardens and building up infrastructure and institutions. Also, nutrition must be an integral part of the ministries of agriculture and health, and linking nutrition with agriculture is essential.

Nutrition surveillance (monitoring and evaluation)

Countries have established or initiated the establishment of a nutrition surveillance system. However capacity-building, data collection, management, analysis and reporting remain challenges. Nevertheless, continuous monitoring and strengthening of the surveillance system is recommended.

Infant and young child nutrition

Infant and young child nutrition has been tackled by the Baby Friendly Hospital Initiative, and adoption of International Code and Development of Local Code of Breast Milk Substitutes. Exclusive breastfeeding and complementary feeding remains a challenge, thus strengthening the exclusive breastfeeding and complementary feeding interventions is a

necessity in addition to capacity-building and research. However, complementary feeding must receive a stronger focus.

Nutrition in emergencies (under-nutrition)

In cases of emergency, nutrition and food clusters are initiated and activities are implemented according to the adopted contingency plan. Challenges faced are coordination, security, inaccessibility, resources mobilization and emergency preparedness. Strengthening the surveillance system provides better preparedness for early detection in emergency situations. Additionally, emergency preparedness capacity building is essential.

7. RECOMMENDATIONS

1. Review and update national health policies, strategies and plans in relevant areas to ensure that nutrition is identified and integrated as a priority and review or develop a national nutrition strategy and action plan in line with the regional strategic approaches.
2. Strengthen political commitment for prevention and reduction of malnutrition in all its forms.
3. Strengthen and expedite the sustainable implementation of the national nutrition strategy for all age groups.
4. Develop or update policy frameworks in order to address the double burden of malnutrition and allocate adequate human and financial resources to ensure implementation.
5. Develop or strengthen legislative, regulatory and other effective measures to promote nutrition.
6. Scale up interventions to improve nutrition status among all age groups, especially infants and children, in an integrated manner, including the protection, promotion and support of breastfeeding and timely, safe and appropriate complementary feeding as core interventions.
7. Integrate the WHO child growth standards into child health programmes to ensure their implementation.
8. Ensure that national and international emergency preparedness and response plans follow the evidence-based operational guidance for emergency relief staff and programme managers to save lives of people through providing healthy and balanced food for all age groups.
9. Strengthen nutrition surveillance systems and improve use and reporting of the agreed indicators in order to monitor progress towards achievement of the relevant targets of the Millennium Development Goals.
10. Implement measures for prevention of malnutrition as specified in the WHO/UNICEF joint statement on community-based management of severe acute malnutrition, with particular attention to improving water and sanitation systems and hygiene practices to protect children against communicable disease and infections.

Annex 1

PROGRAMME

Wednesday, 2 November 2011

- 08:30–09:00 Registration
- 09:00–10:00 Address of Dr Hussein A. Gezairy, Regional Director, WHO EMRO
Opening remarks by representatives of FAO, IUNS, UNICEF and WFP
Opening Message of Minister of Agriculture, Amman, Jordan
Opening Address of Minister of Health, Amman, Jordan
Objectives of the Meeting
Introduction of participants
- 10:00–10:30 Global nutrition situation: burden and policy response/ Dr Francesco Branca, WHO HQ
- 10:30–10:50 WHO Strategic interventions to address malnutrition/ Dr Ayoub Aljawaldeh, WHO EMRO
- 10:50–11:05 Preparing for the International Conference on Nutrition (ICN + 20)/ Dr Brian Thompson, FAO
- 11:05–11:20 Child nutrition situation in MENA Region/ Dr Mahendra Sheth, UNICEF
Research priorities in nutrition/ Dr Ibrahim Elmadfa, University of Vienna
- 11:20–11:35 Highlights on the regional multi-stakeholder workshop on food security and nutrition/ Dr Fatimah Hachem, FAO
- 11:35–11:50 Nutrition – sensitive food and agriculture based approaches: lessons learned and best practices/ Dr Leslie Amoroso, FAO
- 11:50–12:05 Potentials of WFP nutrition specific and nutrition sensitive interventions
- 12:05–12:20 to contribute to scaling up nutrition-with special reference to Sudan/ Dr Pushpa Acharya, WFP
- 12:20–12:35 Discussion
- 12:35–17:00 Country presentations on situation analysis, strategies and key programmes (success stories), and challenges for scaling up nutrition: Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, United Arab Emirates

Thursday, 3 November 2011

- 08:30–10:15 Libya, Morocco, Oman, Pakistan, Palestine
- 10:15–10:30 Discussions
- 10:45–12:00 Sudan, South Sudan, Syrian Arab Republic, Tunisia, UNRWA
- 12:00–12:15 Discussions
- 12:15–13:00 Plenary discussion on cross-cutting issues: policy development and challenges for scaling up/ Dr Francesco Branca, WHO HQ
- 14:00–16:00 Group work for development national action plans considering the following interventions:
Policy and strategies
Facilitator: Dr Francesco Branca
Micronutrient interventions

Facilitator: Dr Mahendra Sheth

Obesity control and prevention

Facilitator: Dr Yousef Shahin

Agriculture and food security

Facilitator: Dr Fatimah Hachem

Nutrition Surveillance (monitoring and evaluation)

Facilitator: Dr Ayoub Aljawaldeh

Nutrition in emergencies (under-nutrition)

Facilitator: Dr Ashraf Khizar

16:15–17:15 Presentation of the group work (including discussion)

Facilitator: Dr Mahendra Sheth; Co-facilitator: Dr Pushpa Acharya

17:15–17:45 View of the UN agencies (FAO, UNICEF, UNRWA, WFP and WHO)

17:45–18:00 Recommendations and the way forward

18:00–18:15 Closing remarks

Annex 2

LIST OF PARTICIPANTS

WHO TEMPORARY ADVISERS

AFGHANISTAN

Dr Bashir Ahmad Hamid
Public Nutrition Director
Ministry of Public Health
Kabul

EGYPT

Dr Zeinab Bakry El Mofty
Director National Nutrition Institute
Ministry of Health
Cairo

ISLAMIC REPUBLIC OF IRAN

Dr Zahra Abdollahi
Nutrition Department
Ministry of Health and Medical Education
Teheran

IRAQ

Dr Alaa Shalaan
Director of Nutrition Research Institute
Ministry of Health
Baghdad

JORDAN

Dr Mohammed Bassam Hijawy
Director of Primary Health Care Administration
Ministry of Health
Amman

Mr Tarek Ayed Al Farah
Ministry of Health
Amman

Eng. Rowhiya Ibrahim Barhum
Directorate of Noncommunicable Diseases
Ministry of Health
Amman

Dr Ibrahim Khatib
Community and Metabolic Nutrition,
Faculty of Medicine-Department of Community Medicine
Jordan University of Science and Technology, (JUST)
Irbid

Eng. Wisam Qarqash
Senior Education and Curriculum Development Specialist
Johns Hopkins University Bloomberg School of Public Health
Center for Communication Programmes
Amman

Dr Huda M. Al Hourani
Faculty of Allied Health Sciences
The Hashemite University
Zarqa

Dr Mousa Numan Ahmad
Head, Department of Nutrition and Food Technology
Faculty of Agriculture
University of Jordan
Amman

LEBANON

Mrs Rindala Farhat
Head of Nutrition and Food Safety Department
Ministry of Public Health
Beirut

Dr Nahla Houalla
Professor and Dean
Faculty of Agricultural and Food Sciences
American University of Beirut
Beirut

LIBYA

Dr Youssef Mohamed Alshrek
Nutrition Consultant
General People's Committee for Health and Environment
Tripoli

MOROCCO

Dr Laila El Ammari
Ingénieur en Chef, Food technologist, Nutritionniste
Division de la Santé Maternelle et Infantile
Ministère de la Santé
Casablanca

OMAN

Dr Samia Al Ghannami
Nutrition Department, Ministry of Health
Muscat

PAKISTAN

Dr Abdul Baseer Khan Achakzai
Deputy Director General
Ministry of Health
Islamabad

PALESTINE

Mr Alaa Aburub
Director of Nutrition Department
Ministry of Health
West Bank

Mr Saleem Jayyousi
Director of Technical Regulations Committee
Palestinian Standards Institute
West Bank

Dr Zeyad R. Zakout
Nutritionist Ministry of Health
Gaza

SOUTH SUDAN

Dr Victoria Jabe Eluzai
Director of Nutrition, Ministry of Health
Juba

SUDAN

Dr Salwa Sorkatti
Director National Nutrition Programme
FMOH/NNP-Sudan
Khartoum

SYRIAN ARAB REPUBLIC

Dr Samer Arous
Chief, Nutrition Department
Ministry of Health
Damascus

Dr Mayas Al Taweel
Ministry of Health
Damascus

TUNISIA

Professor Leila Alouane
National Institute of Nutrition
Ministry of Public Health
Tunis

UNITED ARAB EMIRATES

Dr Mahmoud Fikry
Assistant Under-Secretary for Health Policies Affairs
Ministry of Health
Abu Dhabi

Dr Amita Attlee
Assistant Professor and Chair, Department of Clinical Nutrition and Dietetics
College of Health Sciences, University of Sharjah
Sharjah

Dr Ayesha Salem Al Dhaheri
United Arab Emirates University
Al Ain

OTHER ORGANIZATIONS

Food and Agriculture Organization (FAO)

Dr Fatima Hachem
Food and Nutrition Officer
FAO Regional Office for the Near East
Cairo
EGYPT

Ms Ruth Ahono Busili
Nutrition Manager
UNFAO/FSNAU
SOMALIA

Dr Leslie Amoroso
AGND
Rome
ITALY

Dr Brian Thompson
AGND
Rome
ITALY

Dr Akila Hamza
Nutrition Department
Cairo
EGYPT

Dr Mohamed El Fouly
Nutrition Department
Cairo

Dr Basma Atiya
Nutrition Department
Damascus
SYRIAN ARAB REPUBLIC

Dr Samir Jrad
Nutrition Department
Damascus
SYRIAN ARAB REPUBLIC

Dr Ahmed Albayati
Nutrition Department
Baghdad
IRAQ

Dr Adel Cortas
Nutrition Department
Beirut
LEBANON

United Nations Children's Fund (UNICEF)

Ms Marilena Viviani
Deputy Regional Director
UNICEF Middle East and North Africa Region
Amman
JORDAN

Dr Mahendra Sheth
Regional Health and Nutrition Adviser
UNICEF Middle East and North Africa Region
Amman
JORDAN

Dr James W. King'ori
Regional Nutrition Specialist
UNICEF Middle East and North Africa Region
Amman
JORDAN

Dr Nadin Samaan
Nutrition Officer
UNICEF Child Survival and Development Programme
Damascus
SYRIAN ARAB REPUBLIC

Institute of Nutritional Sciences

Professor Dr Ibrahim Elmadfa
President of the International Union of Nutritional Sciences
Director of the Institute of Nutritional Sciences
University of Vienna
AUSTRIA

Ms Verena Nowak
Research Assistant and lecturer Institute of Nutritional Sciences
University of Vienna
AUSTRIA

**United Nations Relief and Works Agency for Palestine Refugees in the Near East
(UNRWA)**

Dr Akihiro Seita
Special Representative and Director of Health
Amman
JORDAN

Dr Yousef Shahin
Chief Disease Prevention & Control
Amman
JORDAN

World Food Programme (WFP)

Dr Pushpa Acharya
Regional Adviser Nutrition
Khartoum
SUDAN

Dr Magdalena Moshi
Nutrition Department
Cairo
EGYPT

WHO SECRETARIAT

Dr Haifa Madi, Director, Health Protection and Promotion, WHO EMRO
Dr Francesco Branca, Director, Nutrition for Health and Development, WHO HQ
Dr Ahmad Basel Al-Yousfi, Acting WHO Representative, Jordan
Dr Ayoub Aljawaldeh, Regional Adviser, Nutrition, WHO EMRO
Ms Hala Khudari, Technical Officer, WHO Syrian Arab Republic
Dr Khizar Ashraf, Technical Officer Nutrition, WHO Pakistan
Dr Tayseer El Basheer, Technical Officer Nutrition, WHO Sudan
Dr Mohammad Qasem Shams, National Nutrition Officer, WHO Afghanistan
Ms Nashwa Nasr, Programme Assistant Nutrition, WHO EMRO

The image features a minimalist, abstract design composed of several rectangular blocks of color. A large teal block occupies the top right and bottom right portions. A light grey block is in the top left. A horizontal grey band runs across the middle. A dark grey block is in the bottom left. The bottom of the image is a solid grey block containing white text.

World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608, Nasr City 11371
Cairo, Egypt
www.emro.who.int