



**NEPAD TEN YEAR STRATEGY FOR THE REDUCTION  
OF VITAMIN AND MINERAL DEFICIENCIES (VMD)**

**DRAFT ACTION PLAN  
2008-2011**

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## PREFACE

- 1 The New Partnership for Africa's Development (NEPAD), is an African initiative based on a pledge by African leaders recognising their pressing duty to eradicate poverty and place their countries, both individually and collectively, on a path of sustainable growth and development while at the same time participating actively in the world economy and body politic. NEPAD, as a programme of the African Union (AU) is anchored in the determination of Africans to extricate themselves and the continent from the malaise of underdevelopment and exclusion in a globalising world.
- 2 NEPAD offers a unique opportunity to reaffirm international commitments and rededicate Africa to improving nutrition, reducing the burden of disease and protecting precious human capital. NEPAD recognizes that improved food security is a pre-requisite for sustainable development in Africa. However, focusing exclusively on food supply will not be enough to stem the rising tide of malnutrition in Africa. Within this context, there is increasing recognition that malnutrition, especially of essential vitamins and minerals, is both an indicator and determinant of poverty.
- 3 Improving nutrition requires multiple channels, integrating contributions of the public and private sectors, to provide a strategic mix of food, health care, education and other "enablers" of good nutrition. There is also a growing global consensus that fortification of basic foodstuffs, supplementation and dietary diversification which reduce vitamin and mineral deficiencies can have a dramatic and powerful leverage effect in promoting growth and tackling poverty. Fortunately all of these approaches are relatively inexpensive and cost effective. The World Bank estimates that the economic payoffs from micronutrient programmes reach as high as 84 times the programme costs.
- 4 Commitments of African governments to achieve the Millennium Development Goals (MDGs) will be largely influenced by the will to invest in lifting the burden of malnutrition. But today, with growing malnutrition throughout Africa, the opportunity to achieve the MDGs by 2015 is receding and urgent action is required. Policy makers within the private and public sector must both be motivated to take action and invest in the reduction of vitamin and mineral malnutrition.
- 5 This proposed strategic VMD framework for Africa is an adjunct to the broader Framework for African Food and Nutrition Security (FAFS) endorsed by the African leaders forms a part of a Global Ten Year Strategy to combat vitamin and mineral deficiency. It is based on extensive consultations with experts, donors and civil society organizations. The initial phase of this strategy will at the outset focus on three years to initiate, implement and upscale VMD projects and programmes with clear resource inputs and targets. Thereafter activities for the next seven years will be articulated.

## PROBLEM SUMMARY

- 6 A good proportion of Africa's 800 million consumers are not accessing diets adequate in the essential vitamins and minerals required for optimum and health and productivity.
- 7 In dealing with VMD and searching for the right solutions that are not only cost effective but also sustainable, all strategies and approaches must be viewed in the right context for the region Africa. This is because Africa has a disproportionately higher numbers of people that are going hungry and malnourished. Some of the statistics are indicated below;
  - 7.1 337million Africans consume less than 2,100KCal per day
  - 7.2 200 million Africans are chronically malnourished
  - 7.3 5 million die of hunger annually
  - 7.4 126 million children are underweight
  - 7.5 About 50% of the children are stunted
  - 7.6 25 million live with HIV/AIDS with Southern Africa being the most affected sub-region
  - 7.7 Vitamin mineral deficiencies unacceptably high
  - 7.8 Anemia due to Iron Deficiency in children under five years is about 40% while it can be as high as 80% in pregnant and lactating women and 40% of the general population
  - 7.9 Vitamin A deficiency affects some 60% of the general population
  - 7.10 Iodine Deficiency affects about 5% of the population
  - 7.11 Zinc and Folate deficiencies?
  - 7.12 12 deaths per minute are recorded as a result of hunger and malnutrition
- 8 Almost 50 percent of the population of Africa lives on less than US \$1 per day (IFPRI 2002) and as noted above, Africa continues to record some of the highest levels of hunger and malnutrition in the world with about one-third of the population being chronically malnourished. Malnutrition hampers national and continental development as malnourished individuals are unable to contribute to social and economic development on the continent. The AU/NEPAD and its partners have recognized the importance of food security and nutrition (FSN) to health, human development and productivity.
- 9 One of the biggest challenges Africa faces, with notably few exceptions, is the lack of sufficient financial capital, human resources and robust coordinated systems to undertake the required action to fight malnutrition.

## POLICY CONTEXT

- 10 Hunger is experienced in different forms; it may be chronic, acute or hidden. Chronic hunger is long term deprivation that includes consumption below minimum requirements. Malnutrition most often manifests in the chronically hungry due to

poor quality diets, inadequate intakes of essential nutrients and other facets such as inadequate access to safe drinking water and sanitation. Acute hunger is experienced when shocks affect food supply. Hidden hunger refers to situations where people consume diets that are of inadequate quality, leading to micronutrient deficiencies.

- 11 Hunger and malnutrition are both a cause and effect of poverty. Hungry people cannot be productive, thereby constraining economic growth. It is estimated that hunger leads to 6 – 10 percent in GDP losses due to low labour productivity (Task Force on Hunger, 2005). The causes of hunger and malnutrition are multiple, complex and interrelated therefore they require multi-dimensional and multi-sector approaches to tackle them.
- 12 The December 2006 Abuja Food Security Summit's resolutions and declarations, amongst others, committed stakeholders to the following actions;
  - 12.1 AUC (African Union Commissions) and NEPAD in collaboration with development partners initiate the implementation of the African Regional Nutrition Strategy, the NEPAD African Nutrition Initiative within CAADP, and the NEPAD 10-year strategy for combating Vitamin and Mineral Deficiency by 2008 with focus on long-term household food security and ending child hunger and under nutrition;
  - 12.2 MEMBER STATES and development partners to protect and promote the nutritional well being, food security and productivity of people living with and affected by HIV/AIDS in the near and longer terms;
  - 12.3 MEMBER STATES adopt and/or strengthen a holistic and multi-sectoral approach in agricultural development to better address the multi-dimensional nature of food and nutrition security;
  - 12.4 MEMBER STATES to promote home gardening and small animal husbandry as important contributions to household food security and dietary diversity.
- 13 It is clear that these objectives and targets have to be implemented in the context of achieving the MDGs by 2015, and without adequate vitamin and mineral nutrition it will prove difficult if not impossible to make inroads. The table 1 below highlights the relationships between nutrition, micronutrients and MDGs and table 2 shows the impact of VMD on health, cognition, education and productivity.

Table 1

<b>The MDG Framework and Links to Malnutrition</b>	
Goal 1: Eradicate extreme poverty and hunger.	Malnutrition erodes human capital, through irreversible and intergenerational effects on cognitive and physical development. Iron and iodine deficiencies are related to physical and mental incapacity, while zinc is associated with stunting.
Goal 2: Achieve universal primary education.	Malnutrition affects the chances that a child will go to school, stay in school, and perform well. Iron and iodine affect cognition.
Goal 3: Promote gender equality and empower women.	Anti-female biases in access to food, health and care resources may result in malnutrition, which in turn may reduce women's access to assets. Addressing malnutrition empowers women more than men. Demands of childbearing, menstruation, pregnancy and lactation place greater demand vitamins and minerals stores in women. Improving the micronutrient status of women of child bearing age will improve their overall health and productivity.
Goal 4: Reduce child mortality.	Malnutrition is directly or indirectly associated with most child deaths and it is the main contributor to the burden of disease in the developing world. Vitamin A, zinc, and iodine supplements are proven to reduce childhood illness and deaths.
Goal 5: Improve maternal health.	Maternal health is compromised by malnutrition which is associated with most of the major risk factors for maternal mortality. Maternal stunting, iron and iodine deficiencies in particular pose serious problems including complications in pregnancy and child birth.
Goal 6: Combat HIV/AIDS, malaria, and other diseases.	Malnutrition may increase risk of HIV transmission, compromise antiretroviral therapy, and hasten the onset of full-blown AIDS and premature death. It increases the chances of TB infection resulting in TB disease, and it also reduces malarial survival rates. Adequate micronutrient status may reduce the progression from HIV to AIDS and improve the quality of life overall.
Goal 7: Ensure environmental sustainability	Supplementation and fortification support environmental sustainability compared with a high consumption of animal products
Goal 8: Develop a global partnership for development	The micronutrient community continues to seek and facilitate partnerships between private and public sectors to broaden awareness on the consequences of malnutrition through quantifying and emphasizing the benefits of investing in nutrition.

**Table 2**

<b>The Impact of micronutrients and VMDs on health, cognition, education and productivity</b>	
Vitamin A	Vitamin A is a significant leading cause of preventable childhood blindness and night blindness. VAD is strongly linked to major childhood illnesses such as measles, diarrhoea, and other infectious diseases.
Iron and Anemia	Iron deficiency anemia is a risk factor for perinatal mortality and child birth complications such as preterm births and low birth weight. It also affects brain development and cognition in children. Iron deficiency is associated with reduced productivity and supplementation with iron has been shown to improve productivity in adults.
Iodine	Maternal iodine deficiency is associated with increased risk of perinatal mortality, childhood mortality, still births, miscarriages, thyroid disorders, and brain damage. The effects of IDD include cretinism, deaf mutism, and mental retardation. Studies show the average IQ to be 13.5 points lower in iodine deficient communities when compared iodine sufficient communities. Brain function is impaired by iodine deficiency during foetal development and the future productivity losses due to IDD are equal to about 0.23% of GDP.
Folic Acid	Folate deficiency is associated with increased risk of preterm deliveries and low birth weight. Folate deficiency also contributes to the prevention of congenital malformations such as neural tube defects (Spina Bifida). Folate is factor in anemia which comprises productivity.
Zinc	Zinc deficiency leads to increased episodes of diarrhoea and severity of malaria in children and contributes to a significant proportion of childhood deaths in developing countries. Stunting in children is associated with height deficiencies in adults which is a factor in lower wage earnings as compared to normal height adults.

## **PRIORITIES FOR ACTION PLAN**

- 14 It is estimated that 337 million Africans do not consume the minimum 2000 calories per day, required to obtain adequate nutrients. The inadequate dietary intake results in more than 200 million people in Africa suffering debilitating symptoms of chronic malnutrition (Food Security Assessment Research USDA 2002). Nutritional problems are most prevalent amongst children under five years, children 6 – 9 years and women of childbearing age. It is estimated that thirty six million children are undernourished. Stunting, which is an indicator of chronic malnutrition affects 30-40% children under five years, whilst 10% children are wasted, an indication of acute malnutrition. Interactions of infections and malnutrition cause death in more than half of the children at risk and nearly 60% of all malaria deaths. Malnutrition affects both the individual and the society. It is both a cause and a consequence of poverty and underdevelopment it leads to 6 -10% in GDP losses due to depressed performance in physical labour.

### ***Vitamin and Mineral Deficiency***

- 15 Vitamin and mineral deficiencies (VMDs) are major nutritional problems in Africa and other developing countries. The major cause of VMDs is inadequate dietary intake. Inhibitors in the diet also affect absorption of some nutrients. The VMDs may further be worsened by losses of nutrients in the body or poor absorption related to various illnesses. VMDs affect over 300 million people in Africa. Iodine, vitamin A, iron, zinc and folic acid are the five main VMDs of public health concern.
- 16 Iodine deficiency is mainly due to low iodine levels in the soil, foods and water from the endemic area. It is estimated that 10– 40% of the population, i.e. 150 million people in the 43 countries in the region has IDD. In the last decade, through universal salt iodation (USI) the prevalence and severity of IDD's has been reduced.
- 17 Anaemia affects 50% young children and 60% women of childbearing age. Malaria and worm infestations exacerbated anaemia. In pregnancy anaemia contributes to an estimated 18.4% deaths and 23.5% of perinatal deaths. About half of anaemia cases are associated with iron deficiency.
- 18 Vitamin A deficiency (VAD) is the most prevalent, affecting mainly children and women of child-bearing age. VAD accounts for 9% of child deaths
- 19 Whilst data available on micronutrient deficiencies such as IDD, anaemia and vitamin A are not comprehensive or current, data for other micronutrients especially folate and zinc are scanty or nonexistent. Zinc deficiency is however wide spread in Africa and is a contributing cause of an estimated 5.5% of child deaths.
- 20 VMDs cause birth defects, maternal deaths, childhood mortality, blindness, anaemia and increased vulnerability to infections. VMDs lower IQ, causing poor academic performance and reduced work productivity.

### ***Targets***

- 21 In defining targets for the reduction of VMD's within the next three years, the Nutrition Lens, Life Cycle Approach will be used. A Nutrition Lens (NL) is an investment-planning tool, which applies nutrition perspectives, methodologies, expertise, and outcome criteria to systematically assess national development investments. The Life Cycle Approach defines specific periods of acute vulnerability when nutritional needs are very high and physiologically it is very difficult to meet the nutritional needs from a normal diet. These periods are in pregnancy and lactation; infancy and young childhood; illness and disease such HIV/AIDS; and in emergencies. Target should be defined within these periods.

### ***Pregnancy and lactation:***

- 22 Maternal nutrition is important for the benefit of the mother and the child. There is a close link between maternal under nutrition, low birth weight, childhood stunting and

under weight. During pregnancy especially in the third trimester, in addition to the general nutritional needs, iron requirements triple and continue to rise in the critical final months due to the demands of the growing foetus. The normal diet cannot provide adequate iron therefore supplementation is critical.

### ***Infant and Young Children***

- 23 Children require more nutrients per kilogram of body weight for growth. Nutrient needs especially vitamin and minerals are further increased do to recurrent childhood infections. The small quantities of food consumed may not provide adequate nutrients. Even though severe vitamin A deficiency is on the decline sub-clinical vitamin A is prevalent in preschool children and is associated with increased child morbidity and mortality. In addition to appropriate breastfeeding and nutritious complementary foods supplementation with vitamin A is required.

### ***HIV and AIDS***

- 24 HIV /AIDS has contributed to the increase in malnutrition in Africa and is now the number one overall cause of death. The importance of nutrition in AIDS has long been recognized. Micronutrient deficiencies are also recognized to play a significant part in the progression of the HIV virus. Disease conditions such as sore mouth, loss of appetite, nausea and vomiting associated with frequent opportunistic infections makes PLWHA prone to malnutrition due to decreased food intake. The increased demand of micronutrients due to infections exacerbates the condition. Malnourished and ill individuals cannot produce adequate food therefore programmes targeted for PLWHA should also provide food high in nutrients. Those on ARV's treatment require appropriate food high in nutrients.

### ***Vulnerable populations***

- 25 The very poor and the displaced people are vulnerable populations, which need special consideration. The poor have inadequate access to food and therefore their micronutrient needs are usually not met. In displaced people they have no access to food and in addition their nutrient needs are increased due to stress or to lack of adequate and appropriate foods. The vulnerable population groups should be targeted.

### **CURRENT COMMITMENTS/GAP ANALYSIS**

- 26 There is commitment towards elimination of malnutrition at all levels i.e. globally, regionally and nationally. African governments pledged to address the challenge of malnutrition in various fora i.e. 1990 the World Summit for Children, in 1992 the International Conference on Nutrition, the OAU in 1993, the World Food Summit in 1996. This commitment was further affirmed in 2000 when the African leaders

committed to the Millennium Development Goals (MDGs). The MDGs set out concrete targets for a world with less poverty, hunger and disease; greater survival prospects for mothers and their infants; better educated children; equal opportunities for women; and a healthier environment. Despite all these commitments it was clear that Africa would not meet the target. The nutritional status of the African population deteriorated further in the current decade. The gains made in the 1990's seemed to be eroded and this has been attributed mainly to the HIV/ AIDS pandemic and the perpetual droughts. Refocusing is needed assessing resources available, current investments and policies against the estimated needs will to assist in identifying policy and resource gaps which need to be addressed in order to achieve the NEPAD targets on the reduction of VMDs.

### **Resources**

- 27 Resources required to address VMDs in Africa can be quantified by looking at the programme components in making this assessment only the main VMD control programmes will be used. Resource gaps will be estimated by compiling the total Africa regional population needs using the Regional Economic Communities (RECs) i.e. The Arab Maghred Union (AMU) Common Market for Eastern & Southern Africa (COMESA) Community of Sahel- Sahara States (CEN-SAD) East African Community (EAC) Economic Community of Central African States (ECCAS); Economic Community of West African Countries (ECOWAS) Southern African Development Community (SADC).
- 28 In computing the total regional needs a country, which appears in more than one group, will only be counted once. In the existing VMD programmes or the expected programmes, the following information will be computed
  - 28.1 Target population for specific micronutrients,
  - 28.2 Recommended programmes to supply the micronutrients in the population
  - 28.3 Components of the specific programmes,
  - 28.4 Cost of the components,
  - 28.5 Available resources for programmes and
  - 28.6 Short fall on resources needed.
- 29 Initially, global estimates will be used. Information will later be sought from selected core countries to verify the estimates. In scaling up the TYS individual countries will use the same format to compile their needs. Please note that programme costs will vary by type of intervention, country setting and methodology.

### **Programme Needs**

- 30 (Programme costs will be calculated for each component using references provided by various agencies, literature etc)

### **Available Resources**

- 31 SUMMARY OF WHAT KEY DONORS/IMPLEMENTERS ARE DOING (Information on available resources through donors, NGO and government will be collected and compiled)

### ***Resource Gap***

- 32 The assessment of the resource gap requires a dynamic assessment of the potential for both donor and market-driven solutions.
- 33 (Programme needs minus Available resource will indicate resource gap)

### ***Policy Gaps***

- 34 Each country should have a National policy or policies which address food and nutrition issues. Specific policies or guidelines should address issues of VMD. By the virtue of the multi-sectoral nature of VMD programmes policies which impact on addressing the VMD's may be found across many sectors e.g. in the Agriculture Sector as it relates Food Based strategies, in the Ministry of Trade as it relates importation of fortificants for Fortification
- 35 The following areas, which require policies to guide the programme:
- 35.1 National Frameworks: National assessments/ studies of VMD need to be conducted in such a manner as to collect standardized information, from programme inception. This will be used as baseline information and subsequent survey results will be used to monitor progress and trends.
  - 35.2 Standardized data collection methods should be used to enable comparison of data within countries and regions. A credible institution should conduct the surveys at specific intervals and a national budget and resources should be set aside for such an exercise.
  - 35.3 Guidelines on a reporting system is needed

### ***Weakness in donor Priorities:***

- 36 Available data indicate that Africa benefits from half of the total resources available for micronutrient programmes. Despite this no VMD programmes, have been supported in a comprehensive manner. Limited resources have been given as the reason for lack of base line and up-to date data and programme information. The following are identified weaknesses in donor priorities:

- 37 Various agencies multi- lateral, bi-lateral and national agencies provide substantial technical and financial support in the region. Major funding and programmatic gaps could be due to lack of coordination amongst the agencies.
- 37.1 Programme priorities need to be developed in consultation with all relevant key stakeholders, not to implement agency priorities.
  - 37.2 Joint agency monitoring and evaluation plans should be developed thereby availing adequate resources for comprehensive evaluations.
  - 37.3 Donor support should include a component of human capacity development.
  - 37.4 Donor priorities should include programme management. There is need to consider donor agencies to include packages to enable staff retention of key programme managers.
  - 37.5 Consumer or public awareness programme should be included as a priority.
- 38 Mechanism for public- private cooperation: Through the IDD control programme partnerships between public and private sector have been initiated. The salt industry, which includes producers, importers, packers and retailers, has been actively engaged in providing iodated salt to the communities. Other key stakeholders include other public sectors i.e. Industry and Commerce, Ministry of Health etc. A partnership has to be established between public and private sectors. Since iodated salt is required throughout life, this is a lifelong partnership, which has to be cemented. Similar partnerships have to be established with key actors of the other VMD programmes. Therefore mechanisms should be put in place to ensure sustainable partnerships between the private sector not only those in the food industry but inclusive of all industry which contributes towards addressing VMDs.
- 39 Addressing nutrition issues requires a multi –faceted approach. Strategies should be integrated working with key public and private sectors, to provide a mix of the appropriate food, health care, education and other “enablers” of good nutrition. The relationships and partnership with the industry could be well defined in Food and Nutrition Policies or guidelines provided on how these should be set up.
- 40 Gaps exist in the issue of monitoring levels of vitamins and minerals in the premixes before utilization and also in verifying levels of micronutrients in a food vehicle. This is an area where private/private/ public partnerships are required, which can facilitate setting up laboratories and systems for nutrient analysis at national or regional levels.
- 41 To develop mechanisms to further assist countries, within the three year strategy for VMD’s NEPAD will use the Pan African Nutrition Initiative and commence implementation with a core group of countries (6). Within these countries specific gaps will be identified and a multisectoral process be established of national capacity building, planning and budgeting in order to propose a 10-year investment package integrating food security and nutrition across proposed investments in Agriculture as well as other sectors.

## **OUTLINE PRIORITIES – TARGETS**

- 42 At the United Nations General Assembly Special Session (UNGASS) on Children in May 2002, UN Secretary General Kofi Annan, 70 heads of state, and high-ranking government officials from 187 countries made a commitment to reduce VMDs among children. Available data indicate that in 2007, five years down the line, only a small part of the vulnerable populations has been reached with effective interventions. The NEPAD Ten Year Strategy for the Reduction of Vitamin and Mineral Deficiency has been designed to ensure the agreed targets are achieved. The strategies to accelerate progress should be based on understanding the target groups, the disaggregated data on deficiencies, dietary deficits as well as food consumptions patterns. Supplementation and other VMDs programmes need to be considered. In order to accelerate progress there is need to develop a coordinated global strategy.
- 43 As noted above, the three-year strategy will launch the 10 Year strategy in a phased manner, by identifying pilot countries. Priority will be given to factors such as the greatest number and highest prevalence of VMDs and where there is a potential for rapid impact. Available resources will be assessed and reviewed. Additional resources required will be sourced and channeled to the selected countries. Lessons learnt will be used to scale up the programme to other countries in the region. [The following countries have been identified for the special support: Algeria, Burkina Faso, Ethiopia, Democratic Republic of Congo (DRC) Nigeria, Senegal and Zambia]

***Overall Targets:***

- 44 The targets for the programme are
- 44.1 To reduce iron deficiency anaemia in women of child –bearing age by one third
  - 44.2 To virtually eliminate iodine and vitamin A deficiencies
  - 44.3 To reduce other micronutrient deficiencies such as zinc and folate
  - 44.4 contribute to improved access to quantity and quality of food in line with CAADP priorities
- 45 The strategy for addressing the VMDs is focused on the following: i. Food Based Dietary Approach, ii. Supplementation iii. Fortification iv. Management of Parasitic Disease v. Clinical Case Management

***Food Based Dietary Approach:***

- 46 Specific programmes under the Food Based Dietary Approach would include the following:
- 46.1 Exclusive breastfeeding followed by appropriate complementary feeding.
  - 46.2 Nutrition education directed at improving micronutrient status
  - 46.3 Promotion of small livestock, eggs and aquaculture production to improve vitamin A status
  - 46.4 Increased production and utilization of vitamin A rich foods e.g. yellow sweet potatoes, palm oil etc.

- 46.5 Home Grown School Feeding Programme which is specially targeted to the growing school children (6-13years). Communities around schools are motivated to produce and sell to the schools low cost nutritious foods such as yellow sweet potatoes, groundnuts, fruits and vegetables. These are prepared as meals and used for school lunch.

### ***Supplementation***

- 47 Vitamin A: Vitamin A capsules are distributed to children 6-59 months twice a year and to post partum women within eight weeks of delivery. The unit cost for vitamin A supplementation ranges from 14 cents to US\$5.56. The single most important cost in vitamin A capsule distribution is personnel, which amounts to 65% of total costs.
- 48 Iron and Folic Acid: Iron and Folic Acid supplementation of pregnant and lactating women, of adolescent girls aged 12 and above

### ***Fortification***

- 49 Fortification of salt with iodine
- 50 Fortification of sugar with vitamin A
- 51 Fortification of maize meal with a multi-mix of vitamins and minerals
- 52 Fortification of wheat flour
- 53 Fortification of oil/ margarine

### ***Management of Parasitic Disease***

- 54 De-worming of all children 12-59 months (twice a year)
- 55 De-worming of all school children
- 56 De-worming of pregnant women through health facilities
- 57 Distribution and retreatment of ITNs for vulnerable groups
- 58 Presumptive treatment of malaria during pregnancy
- 59 Treatment of schistosomiasis in 5-12 year old school children in high risk areas

(Cost for the intervention will be estimated and indicated)

(Cost for the intervention will be estimated and indicated)

### ***Clinical Case Management***

- 60 Vitamin A supplementation for clinical case management of severe malnutrition, severe or prolonged diarrhea, measles and xerophthalmia
- 61 Zinc supplementation for clinical case management of diarrheal disease in under-five year old children

## ADVOCACY AND IMPLEMENTATION PLAN

- 62 The programme will be coordinated by the AU/NEPAD as a coherent continent-wide approach, through the continuation of the joint working group of implementing agencies coordinated by NEPAD. The Three Year Strategy 2008-11 will have three components: policy and advocacy, regional coordination, and national pilots.
- 63 The cost for the intervention in each of the above areas will be estimated and indicated where external support required.

### Policy and Advocacy

- 64 Implementation Summit on Africa's Nutrition Strategy and the MDGs. An implementation summit to align the ensemble of AU/NEPAD policies with the MDG strategy and international policies, and raise the importance of a focus on nutrition in meeting the MDGs. This implementation summit would ensure that current AU policies are reflected in international priorities. Participation would involve governments, the private sector and non-state actors. Its results will be provided to the AU and the African Partnership Forum, and feed into other relevant international fora such as the review of the mid-review of the MDGs proposed for 2008.
- 65 Information and Promotion: An information campaign involving role models and leaders from sport and culture to reach out to key targets including the young on nutrition and health. This would include an information campaign using NEPAD TV, and national and private broadcasters.

### Regional Coordination

- 66 **Reinforcing Role of RECS.** In order to diffuse the policy goals and set minimum standards for national programmes and identify partners for government a series of public- private dialogues involving the private sector and civil society with Ministers to advance a normative policy framework for national governments.
- 67 Where possible, each REC will be supported to establish focal points to support implementation of national strategies at the national and regional level.

### Rolling Out National Programmes

- 68 The key focus for the implementation strategy will be concentrated national initiatives in 6 countries with high nutrition burdens. This will aim to benefit a minimum of [500m] people by 2011.
- 69 In each country, initial planning with government will be facilitated by NEPAD and supported by the implementing agency working group.

### Summary Schedule of Implementation: Working Draft

Time ble	Planning	Roll Out	Major Events Context
<b>2008</b>			
Q1		CAADP Pillar 2 and 3 Donor Review CAADP Partnership Platform meeting	
Q2	A10YS Core Group Meeting	Donor Review of CAADP Pillar 1 COMESA Summit Dialogue	GAIN Brussels Forum African Partnership Forum (APF)
Q3	A10YS Core Group Meeting	Approval Strategy at AU Summit National Consultations convened by NEPAD+A10YS Core Group Lead Agencies Agency Dialogues at REC meetings and Identification of focal points	AU Summit G8 Summit
Q4	Implementation Meeting: Strategic Partnerships for Africa's Nutrition, (?Addis Ababa)	Identification Pilot Countries 1-3 Design Information Campaign	MDG Review, New York APF
<b>2009</b>			
Q1	A10YS Core Group Meeting	Launch Country Programmes 1-3 Identification of Phase 2 Countries Info Campaign	AU Summit
Q2		National Consultations on Phase 2 Countries	APF
Q3	A10YS Core Meeting	Launch Country Programmes 4-6	AU Summit G8 Summit
Q4			APF
<b>2010</b>			
Q1	A10YS Core Meeting Strategic Review	Identification of Additional Countries	
Q2			
Q3	A10YS Core Meeting		
Q4			
<b>2011</b>			
Q1	A10YS Core Group Meeting		
Q2			
Q3	A10YS Core Group Meeting		
Q4			

- 70 The programmes will identify a coordinating partner (lead agency) to coordinate inputs with the national government, and will set national targets and priorities and identify new resources to support implementation.
- 71 Each programme will address how to engage the private sector and strengthen order to strengthen the role of the market in promoting solutions, and reinforce the role of non-state actors in the nutrition strategy. It will identify and establish national food fortification alliances to speed up fortification of staples: and reinforcing the links between improved nutrition and increased production and marketing of beneficial new products aimed at the poor.

## **MONITORING AND REVIEW PROCESS**

- 72 The monitoring and surveillance component should be built into the VMD programmes from inception. This is important to enable allocation of adequate resources both human and financial. It is also essential to track progress and identify bottlenecks as the programmes are reviewed. Mechanisms should be established to gather data on a routine basis. Baseline studies are required to capture initial status and observe trends and programme progress from inception. However in instances where baseline information is not comprehensive to include all programme components, this should not deter the programme implementation. Where biochemical baseline data may be scant a major gap has been observed in the dietary intake data. Food consumption surveys have not been undertaken to give representative data amongst the high- risk groups. Resources are needed for adequate baseline studies to be undertaken.
- 73 Consensus is required in setting out indicators, standardized data to be collected and the reporting format to be used for the region. Guidelines should be developed based on a minimum of the identified vitamins and mineral deficiencies i.e. Iodine, Iron, Vitamin A, Folate and Zinc.
- 74 The following capacities need to be developed in setting up appropriate monitoring systems:
- 74.1 Laboratories for food nutrient analysis,
  - 74.2 Laboratories for biochemical indicators
  - 74.3 Food composition tables
  - 74.4 Human capacity
- 75 Periodic surveys should be established which collect standardized information and data to make the results comparable both in –country and within the region. Information has to be collected routinely with reporting systems and structures set up nationally e.g. Central Statistics Office. A mechanism to respond to the obtained results should be established. The monitoring system should provide results that feed into the planning and budget process in a timely way.

- 76 Nationally, each country may form and report to a parliamentary committee on Food and Nutrition which in turn would report to AU through the relevant structures. This helps to sensitize the policy makers at the highest level. It also ensures that the programme managers are kept focused in their quest.
- 77 An external evaluation and follow-up of country activities is required at appropriate times i.e. process, mid-term and impact.
- 78 Results of monitoring progress should be presented to Head of States and shared with the wider public or consumers.

## **SUMMARY OF RECOMMENDATIONS**

## ANNEXURES

Table 1. Summary of GAIN funded Food Fortification country programmes and

Country	Food Vehicle	Micronutrients	Gain Grant (US\$) millions	HK Grant (US\$)	Target Population (millions)	Country Population	Resource Gap
Cote d'Ivoire	Vegetable Oil, Wheat Flour	Oil: vitamin A Wheat: Iron, folic acid	\$3.0		15.0		
Egypt	Wheat Flour	Iron, Folic Acid	\$3.0		50.0		
Ghana	Vegetable Oil, Wheat Flour	Oil: vitamin A Wheat: Iron, zinc, vitamin A, folic acid and other B vitamins	\$1.8		19.5		
Mali	Cotton Seed Oil	Vitamin A	\$1.1		10.0		
Morocco	Vegetable Oil, Wheat Flour	Oil: Vitamin A and D Wheat:	\$3.0		30.5		

		Iron, folic acid, and B vitamins					
Nigeria	Wheat Flour, Vegetable Oil, Sugar	Wheat: iron, vitamin A, B vitamins Oil: vitamin A Sugar: vitamin A	4	\$2.	95.9		
South Africa	Maize meal, wheat flour	Iron, folic acid, B-vitamins, zinc and vitamin A	8	\$2.	38.7		
Uganda	Vegetable oil, Maize meal, wheat flour	Oil: vitamin A Flour and maize: Iron, vitamin A, folic acid, zinc and other B-vitamins	4	\$2.	26.4		
Zambia	Maize meal	Iron (NaFeEDTA), folic acid, B-vitamins, zinc and vitamin A	4	\$2.	6.1		

Table 2. HKI  
HKI – Current funding by country

Country	Funding	Source	Duration
Burkina Faso	\$1.04	GAIN	3 years, pending
	\$250, 000	MI	1 year, pre mix purchase
Cote d'ivoire	\$3.05 million	GAIN	3 years
Guinea	\$300,000	MI	1 year, pre mix purchase
	\$50,000	USAID	1 year
Mali	\$1.02 million	GAIN	3 years
Senegal	\$5, 000	MI	3 months, FRAT study
AIFO-UEMOA	\$1.4 million	USIAD	3 years, request submitted

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Table 3. MI – Country presence /programmes and budgets

Sub-region	Salt Iodation	Food – Fortification (Oil, Cereals)
West Africa	*Nigeria (DFS)+ *Senegal  Ghana (grant to UNICEF; Technoserve)	Nigeria Senegal Sahel oil Mali (small mill)
Southern Africa	*Mozambique *South Africa Angola (tbd) Tanzania (tbd)	Mozambique  South Africa
East Africa	*Kenya *Ethiopia Sudan (tbd)	Kenya Sudan
Total including Africa- wide	App. C\$2.5M	App. C\$500
Total for 07/08	App. C\$2M	App. C\$300

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