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**What works for Nutrition? Stories of success from Vietnam,
Uganda and Kenya
RESULTS UK, Concern Worldwide, and University of Westminster**

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WHAT WORKS FOR NUTRITION?

STORIES OF SUCCESS FROM
VIETNAM, UGANDA & KENYA



CONTENTS

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GLOSSARY

HIGH IMPACT NUTRITION INTERVENTIONS

In 2013, the Lancet series on Maternal and Child Undernutrition identified 10 nutrition specific interventions which, if scaled up to 90% coverage, could reduce stunting by 20%, and wasting by 61%. These include interventions such as micronutrient supplementation for children less than five years of age and pregnant women, fortification, breastfeeding and complementary feeding practices, prevention and treatment of Severe Acute Malnutrition.

MALNUTRITION

A term used to describe poor nutrition resulting from inadequate (undernutrition) or excess (overnutrition) consumption of one or more nutrients in one's diet. Undernutrition can also result from repeated illnesses, and certain malabsorptive conditions. Globally, all countries face the burden of one or more forms of malnutrition, and 1 in 3 people are malnourished.

MICRONUTRIENT DEFICIENCIES (HIDDEN HUNGER)

A form of undernutrition, resulting from a lack of intake, absorption or utilisation of one or more vitamins or minerals in the diet. It is also known as 'hidden hunger', as the symptoms of micronutrient deficiencies are often unnoticeable in early stages. Micronutrient deficiencies adversely impact physical and cognitive development and immunity, thus preventing one from reaching their true potential. Globally, over 2 billion people suffer from hidden hunger.

NUTRITION-SPECIFIC INTERVENTIONS

Interventions that have a direct impact on the immediate causes of malnutrition such as inadequate food intake, faulty feeding practices, repeated illness. For example; food or nutrient supplementation, food fortification, deworming to control helminthic infections, treatment of Severe Acute Malnutrition, dietary diversification etc.

NUTRITION-SENSITIVE INTERVENTIONS

Interventions that indirectly impact nutrition by targeting the underlying causes of malnutrition, and resulting in actions across a wide range of allied sectors, such as agriculture, social protection, Water Sanitation and Hygiene (WASH), education, gender issues.

OVERWEIGHT/OBESITY

Forms of overnutrition resulting from an excess calorie intake, lack of adequate physical activity and poor lifestyles. It

contributes to increased risk of non-communicable disorders such as hypertension, diabetes, and cardiovascular diseases

SCALING UP NUTRITION (SUN)

A global movement founded on the principle that all people have a right to food and good nutrition. It unites governments, civil society, the United Nations, donors, businesses, and researchers in a collective effort to tackle malnutrition.

STUNTING

A form of undernutrition characterised by low height-for age in children under five years of age, of more than two standard deviations below the mean. It is a result of chronic inadequate quantity and quality nutrition, and or illness, particularly between conception and first two year of life. Stunting reflects sub-optimal linear growth, compromised physical and cognitive development in the child. It is also a marker of mortality, frequent illnesses, progress in school, as well as one's economic potential as an adult.

UNITED NATIONS (UN) ZERO HUNGER CHALLENGE

At the Rio +20 Conference on Sustainable development in 2012, the UN Secretary General launched this as a call to action to achieve zero hunger for all. Five pillars of this challenge are to achieve 100% access to adequate food all year round, zero stunted children less than two years of age, sustainable food systems, 100% increase in smallholder productivity and income, and zero food wastes or losses.

WASTING

A form of undernutrition characterised by low weight-for height of more than two standard deviations below the mean. It results from inadequate and poor quality nutrition, and repeated episodes of illness. Rapid deterioration of nutritional status in children under five years of age results puts them at a high risk of mortality from common conditions. Also known as 'acute malnutrition', it can restrict linear growth and development in children.

WORLD HEALTH ASSEMBLY (WHA) NUTRITION TARGETS

Recognising the need to accelerate action against global malnutrition, member states at the World Health Assembly in 2012 unanimously agreed to set six targets on nutrition to be achieved by 2025. These include targets on reducing stunting, wasting, and overweight in children under the age of five years, anaemia in women of reproductive age, low birth weight, and increasing rates of exclusive breastfeeding.

ACRONYMS

A&T	Alive & Thrive	NCPG	Nutrition Cluster Partnership Group (Vietnam)
ASAL	Arid and Semi-Arid Land	NDMA	National Drought Management Agency (Kenya)
CSO	Civil Society Organisation	NDP	National Development Plan (Uganda)
DNCC	District Nutrition Coordination Committees (Uganda)	NFA	National Fortification Alliance (Uganda)
EBF	Exclusive Breastfeeding	NGO	Non-Governmental Organisation
ENSURRe	Enhancing Nutrition Surveillance, Response, and Resilience	NHA	National Health Accounts
EU	European Union	NIN	National Institute of Nutrition (Vietnam)
FBO	Faith Based Organisation	NNAP	National Nutrition Action Plan (Kenya)
FFL	Food Fortification Legislation (Kenya)	NNS	National Nutrition Strategy (Vietnam)
GAIN	Global Alliance for Improved Nutrition	NPAN	National Plan of Action for Nutrition (Vietnam)
GDP	Gross Domestic Product	NTP	National Target Programme (Vietnam)
GNR	Global Nutrition Report	ODA	Official Development Assistance
IDA	Iron Deficiency Anaemia	OPM	Office of the Prime Minister (Uganda)
IDA	Iron Deficiency Anaemia	PEAP	Poverty Eradication Action Plan (Uganda)
IFA	Iron and Folic Acid	PER	Public Expenditure Reports
ILS	Institute of Legislative Studies (Vietnam)	RUTF	Ready To Use Therapeutic Food
IMAM	Integrated Management of Acute Malnutrition	SAM	Severe Acute Malnutrition
IRD	Institut de Recherche pour le Développement	SDGs	Sustainable Development Goals
IYCF	Infant and Young Child Feeding	SHI	ocial Health Insurance
KDH	Kenya Demographic Health Survey	SMART	Specific Measurable Assignable Realistic and Time bound
KES	Kenyan Shillings	SUN	Scaling up Nutrition
KHSSP	Kenya Health Sector Strategic and Investment Plan	UCCO-SUN	Uganda Civil Society Coalition on Scaling Up Nutrition
LIC	Low income country	UFNP	Uganda Food and Nutrition Policy
LMIC	Lower-Middle Income country	UGAN	Uganda Action for Nutrition
MDGs	Millennium Development Goals	UN	United Nations
Mic	Middle Income Country	UNAP	Uganda Nutrition Action Plan
MNP	Multiple Micronutrient Powder	UNFC	Uganda Food and Nutrition Council
MOH	Ministry of Health	UNICEF	United Nations Children's Fund
MOLISA	Ministry of Labour Invalids, and Social Affairs	US	United States
MTP	Medium Term Plan (Kenya)	USAID	United States Agency for International Development
MUAC	Mid Upper Arm Circumference	WASH	Water, Sanitation and Hygiene
N4G	Nutrition for Growth	WHA	World Health Assembly

EXECUTIVE SUMMARY

Over the past 25 years, substantial progress has been made towards the achievement of the first Millennium Development Goal (MDG1) which committed world leaders to eradicate extreme hunger and poverty. Since 1990, the number of hungry people in the world has declined by over 200 million. The global rates of underweight and stunting in children under the age of five have also reduced by over 40%.

Despite this progress all countries suffer from one or more forms of malnutrition, and 1 in 3 people are malnourished. Around 159 million children are stunted and 50 million are wasted. Many of these children will not realise their full potential due to the adverse impact of undernutrition on their growth and development. Furthermore, over 2 billion suffer from 'hidden hunger' or micronutrient deficiencies which increase the risk of ill-health and place individuals at a physical, cognitive, and economic disadvantage. The human and economic costs associated with malnutrition are colossal, with countries losing at least 2-3% of their Gross Domestic Product (GDP) and some as high as 10%, and individuals losing up to 10% of their earnings.

Tackling global malnutrition makes development and economic sense. Every dollar invested in nutrition, yields more than US \$16 in return. The Copenhagen Consensus, a panel of economic experts, has recommended fighting malnourishment as a top priority for policy makers and philanthropists.

In 2012, recognising the need for accelerated global action against the scourge of malnutrition, leaders at the World Health Assembly (WHA) endorsed six targets to improve maternal and child nutrition by 2025. These targets if achieved would reduce the number of children under-5 who are stunted, wasted, and overweight, women who are anaemic, and children born low birth weight. Additionally, the targets aim to improve rates of exclusive breastfeeding for infants in the first six months. Global progress towards these targets has been slow and uneven. However, some countries have been able to make impressive progress through strategic policies, programmes, partnerships and investments in tackling various forms of malnutrition. Kenya, Uganda, and Vietnam are three such countries making rapid strides in improving nutrition.

Kenya is the only country on track to make progress on five of the six WHA nutrition targets; stunting, wasting, anaemia, childhood overweight, and exclusive breastfeeding. Between 1989 and 2014 under-five deaths have decreased by 42%. Stunting and wasting in children under five years of age also decreased by 9% and 3% respectively between 2008 and 2014.

This has been accompanied by an increase of more than 30% in rates of exclusive breastfeeding. Anaemia in women of reproductive age has also been reduced by nearly 48% from 1999 to 2011. Coverage of iodised salt consumption is 93%, while treatment of Severe Acute Malnutrition (SAM) has reached 100% coverage.

In Uganda, the proportion of people living below the poverty line declined from 56% (1992-93) to 20% in (2012-13). It has thus achieved MDG1 to halve the proportion of the population living in extreme poverty. The nutrition landscape has been transformed in Uganda since the early nineties, driven by the government's recognition that improving food and nutrition security could lead to socio-economic transformation. Between 1988 and 2000, the prevalence of stunting in children under the age of five years reduced by only 3%. However, between 2000 and 2012, stunting has been reduced by 11%. Over a four year period (2006-2011) wasting in children under five years of age reduced by over 3%. Uganda is on track to achieve the WHA targets on wasting, exclusive breastfeeding and childhood overweight, and it is making progress on stunting reduction.

Vietnam has made remarkable progress in poverty reduction and socioeconomic development, reducing poverty from 58% (1990s) to around 9% (2012), and also boosting agricultural production by more than 60% over this period. Targeted programmes on health and nutrition have resulted in stunting in children under five years being reduced by nearly 60% between 1985 and 2013. It has also reduced infant and under-five mortality by around 50% between 1990 and 2013, and maternal mortality by over 60% over this period. Vietnam is on track to achieve the WHA targets on stunting, wasting, anaemia, and exclusive breastfeeding.

How did these countries achieve such progress in improving nutrition for children and women? This report captures the reasons for success in these three countries. It also attempts to identify barriers to further progress and ways in which those barriers could be overcome. Finally, this report seeks to provide recommendations to guide future efforts in tackling malnutrition.

Some of the key drivers and recommendations for improved nutrition based on nutrition success in these three countries are described below.

1 | NUTRITION ON THE NATIONAL AGENDA: POLICY, INFRA-STRUCTURE & LEGISLATIVE ENVIRONMENTS FOR NUTRITION

Well defined national policies and strategies for nutrition endorsed by high level political authority, ensures nutrition is recognised as a priority issue. Setting up infrastructure dedicated to nutrition such as the National Institute of Nutrition (NIN) in Vietnam, guides policy, programmes, and research, and promotes partnerships to streamline efforts to tackle malnutrition. Key legislation such as the 'Mandatory Food Fortification' in Kenya, and the 'Labour code' in Vietnam strengthens positive nutrition practices, and helps to improve compliance by various stakeholders. However, governments should monitor the enforcement of these laws and provide support to stakeholders so as to promote sustainability, adherence, and improve coverage of services to remote communities.

2 | STRENGTHENING CAPACITIES TO IMPROVE NUTRITION OUTCOMES: AT NATIONAL, SUB-NATIONAL & COMMUNITY LEVELS

This is particularly relevant in decentralised governance structures. There is a need for nutrition plans and budgets to be clear and transparent at sub-national level. Sub-national authorities must be sensitised in relation to levels of malnutrition in their areas and they should be supported in drafting plans with the involvement of relevant experts. These plans should be financed by resource allocation to scale up nutrition interventions across sectors, and monitored across all sectors to track progress. Additionally, improving the capacities of community workers to do nutrition assessments and supporting them to deliver interventions helps to build human resource capacity for nutrition. As seen in Kenya, this contributes to improved coverage of interventions being delivered to the community.

3 | COMMITMENT TO GLOBAL PLATFORMS: SCALING UP NUTRITION (SUN) MOVEMENT, ZERO HUNGER CHALLENGE

Across all the three countries there is clear commitment to and engagement in both the SUN movement and the Zero Hunger Challenge. This has been important in strengthening commitment to nutrition both globally and in-country. Such commitment encourages domestic efforts to improve nutrition. Such initiatives provide valuable guidance on development of multi-sectoral nutrition policies and costed plans to guide resource allocation. They also support and strengthen advocacy

on nutrition. They also provide opportunities for cross-learning by sharing progress, challenges and help to identify solutions. Through the various SUN networks, stakeholders can track potential funding opportunities to scale up efforts to tackle malnutrition.

4 | EQUITY: NUTRITION FOR ALL

Inequitable nutrition outcomes based on regions, ethnicities, and income groups were prevalent across all the three countries. Governments must use disaggregated data to identify regions with the poorest nutrition outcomes and identify the reasons for them. Thereafter nutrition interventions must focus on the most backward regions and target the hardest to reach communities, which often bear the greatest burden of malnutrition, ill health, and poverty. Children from rural and the poorest households are at the very least twice as likely to be stunted as children from urban and the richest households. Resources and interventions for tackling malnutrition must be directed in a way that results in improvements for all.

5 | FINANCING FOR BETTER NUTRITION

Policies and strategies are ineffective if they are not backed with the resources required to put them into action. In Vietnam, budgetary cuts for targeted programmes have threatened sustainability of nutrition programmes. Furthermore, declining donor funding weakens the efforts in these countries and increases the risk of a reversal of progress made so far. Financing for nutrition has grown over the past few years but overall investments in nutrition are still grossly inadequate. The Nutrition for Growth (N4G) summit in 2013 raised significant resources for nutrition. However, recent evidence shows that global donors must quadruple their Official Development Assistance (ODA) to nutrition, while governments must, at the very least, double their domestic spending on nutrition for the world to meet the WHA targets.

Governments should ensure nutrition has a budget line that goes beyond the health budget within both, national and sub-national allocations. The N4G summit in 2016 in Rio is an opportunity for governments to step forward with specific, measurable, assignable, realistic, and time bound (SMART) financial and policy commitments to tackle malnutrition as it underpins multi-sectoral development in their countries. Donors must also recognise that ODA will continue to play a significant role in bridging the funding gap for nutrition. Bilateral and multilateral support for nutrition should be based on the burden of malnutrition in these countries rather than on the basis of a country's income-status categorisation.

6 | FINANCIAL TRACKING FOR NUTRITION ACROSS ALL SECTORS

Scaling up resources must be paralleled with transparent tracking of nutrition budget lines within health and allied sectors. This is imperative to assess nutrition impact and determine cost effectiveness of initiatives. It also helps hold allied sectors to account for inaction. Moreover, this helps to share in agreement the responsibility of improving nutrition, which should not just fall within the remit of the health ministry. Finally, it leads to higher gains for nutrition overall, as only 20% of stunting reduction can be achieved through nutrition specific interventions. Financial allocation and tracking are made simpler when measurable nutrition objectives and indicators are included during policy planning stages.

7 | NUTRITION SURVEILLANCE: DATA FOR EVIDENCE & ACTION

Data is critical. Frequent and routine disaggregated data on key nutrition outcomes are useful for assessing nutrition trends, identifying gaps, and guiding prioritisation of resources to achieve equitable nutrition outcomes. Furthermore, data drives accountability and supports advocacy as it strengthens the civil society voice to hold their governments to account for commitment to nutrition. Sub-national data on nutrition from Uganda and the setting up of the annual nutrition surveillance system in Vietnam are examples of good data systems that steer efforts on nutrition in the right direction. Governments should strengthen data systems so as to track progress towards reaching the internationally agreed WHA targets on tackling malnutrition.

8 | OFFICIAL RECOGNITION OF MULTI-STAKEHOLDER PARTNERSHIPS

Challenges in establishing multi-stakeholder partnerships and implementing integrated interventions for nutrition were reported across the three countries. However, success has been achieved in Vietnam in the form of its nutrition cluster partnership group, and through SUN civil society alliances in Uganda and Kenya. Officially recognising multi-stakeholder groups for nutrition, and making mandatory the involvement of various stakeholders contributes to improved sensitisation and participation of all relevant actors. Furthermore, a high level government authority as chair and housing the coalition/partnership within the office of high level political authority can ensure a sustained coordination of efforts.

9 | BRINGING NUTRITION INTERVENTIONS INTO THE ESSENTIAL HEALTH CARE PACKAGE

To promote sustainability, improve coverage and mitigate supply related challenges for essential nutrition specific interventions,

it is recommended that they be brought under the Essential Health Care Package. These include interventions such as Ready to Use Therapeutic Foods (RUTFs) to rehabilitate Severe Acute Malnutrition (SAM) in children, micronutrient supplements such as Iron and Folic Acid (IFA) and Vitamin A, and fortified food (such as fortified salt, flour, or fats).

Irregular supplies and stock-outs of micronutrient supplements are a barrier in tackling micronutrient deficiencies in women and children in Kenya. Sustainability and expansion of the Integrated Management of Acute Malnutrition (IMAM) programme using RUTF in Vietnam was also dependent to a large extent on support from development partners. To address issues such as these, and prevent funding constraints from threatening sustainability of nutrition interventions they should be integrated within the health and social insurance systems, and viewed as fundamental to achieving universal health coverage.

10 | FOSTER RESEARCH, INFORMATION SHARING AND CROSS LEARNING

Whilst evidence exists on high impact nutrition specific interventions that significantly reduce undernutrition in women and children, there is no 'one size fits all' strategy for how these should be delivered. Governments must therefore invest in the development of innovative solutions to tackle malnutrition. They should also focus on implementation research to explore how to reach the hard to reach populations with the most effective interventions, and to scale up integrated nutrition programmes. Adaptation of evidence based solutions to local contexts, such as the Vietnamese adaptation of RUTF for management of severely wasted children, plays a vital role in the success of nutrition initiatives.

11 | SUPPORT TO ADVOCACY EFFORTS

Civil society plays an important role holding governments and other stakeholders to account for their actions. In Uganda, securing funding from the Multi Partner Trust Fund has created a greater enabling environment for better and more coordinated advocacy. A strong relationship between the government and other nutrition stakeholders including civil society has resulted in greater transparency in relation to plans and budgets to enable improved nutrition outcomes. Civil society must continue to be supported to advocate for improved nutrition outcomes on behalf of communities that may otherwise not be heard and to hold Governments to account for past and present commitments.

1 | INTRODUCTION

“

The world produces enough food to feed every man, woman and child on Earth. Hunger and malnutrition therefore are not due to lack of food alone, but are also the consequences of poverty, inequality and misplaced priorities

KUL GAUTAM, UNICEF 2013¹

Fifteen years ago, world leaders committed to reducing global poverty by adopting the United Nations Millennium Declaration. There was increased momentum in relation to tackling poverty and inequity in all its dimensions, particularly focusing on hunger, disease, deaths of vulnerable groups such as women and children, education, and gender, whilst promoting environmental sustainability. This led to the eight Millennium Development Goals (MDGs) which set targets based on these priorities, to be achieved over by 2015. One of the goals was to eradicate extreme hunger and poverty by 2015.

Since 1990, the proportion of undernourished people in the developing regions has fallen by almost half², and the number of hungry people in the world has declined by over 200 million³. The global rates of underweight (low weight-for-age) and stunting (low height-for age) in children under the age of five have also reduced by over 40%⁴.



1.1 PROGRESS, BUT NOT ENOUGH

The figures above are encouraging yet they mask the scale of undernutrition that still prevails. All countries suffer from at least one form of malnutrition, and 1 in 3 people are malnourished⁵. Around 795 million people still go to bed hungry, and over 2 billion suffer from the 'hidden hunger' of micronutrient deficiencies. This threatens survival and compromises health, development, and economic potential of individuals and nations with women and children suffering the greatest burden. Even today, 159 million children are stunted, and 50 million wasted (low weight-for height)⁶. Anaemia, a result of deficiencies of micronutrients such as iron, affects half of all female adolescents⁷. It not only hinders educational attainment and productivity but is also associated with about 1 in 5 maternal deaths⁸. Undernutrition is associated with 45% of deaths of children under the age of five; over 3.1 million child deaths.

Progress in tackling undernutrition has been slow, and to a large extent uneven and inequitable. Children in rural settings or from the poorest households are twice as likely to be stunted as those in urban settings or the richest households⁹. In fact, 9 in 10 stunted children live in Low- and Lower-Middle Income Countries. Simultaneously more and more countries, irrespective of income status, are facing the burden of overnutrition and its associated health implications. Around 2 billion adults are overweight or obese whilst the number of overweight children rose to 42 million in 2013¹⁰. Countries are increasingly facing multiple and overlapping burdens of malnutrition.

1.2 NUTRITION; A CRUCIAL PILLAR FOR DEVELOPMENT

Nutrition is unquestionably critical for development. The human and economic costs of malnutrition are colossal. Undernutrition affects GDP rates by at least 2-3% but can affect both GDP and an individual's earnings by up to 10%^{11,12}. These massive human and economic losses are avoidable, and evidence based interventions exist that can help prevent and address undernutrition. Moreover, investing in nutrition offers some of the best returns on investment. Every dollar invested in nutrition yields more than 16 in return¹³. The Copenhagen Consensus, a panel of economic experts, has also recommended fighting malnourishment as a top priority for policy makers and philanthropists.

In 2012, recognising the need for accelerated global action against the scourge of malnutrition, leaders at the World Health Assembly (WHA) endorsed six targets to improve maternal and child nutrition by 2025.

- 01 Achieve a 40% reduction in the number of children under-5 who are stunted;
- 02 Achieve a 50% reduction of anaemia in women of reproductive age;
- 03 Achieve a 30% reduction in low birth weight;
- 04 Ensure that there is no increase in childhood overweight;
- 05 Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%;
- 06 Reduce and maintain childhood wasting to less than 5%.

Overall progress has been slow and uneven but some countries are making progress in meeting one or more of these WHA targets.

In 2013, the Lancet series on Maternal and Child Nutrition identified and conducted costing analysis for 10 interventions with the greatest impact on addressing undernutrition¹⁴. These are mainly 'nutrition-specific' or direct approaches such as micronutrient supplementation or infant and young child feeding practices. In addition, a significant contribution to reduction in undernutrition can be achieved through indirect or 'nutrition-sensitive' approaches such as those within associated sectors including agriculture, Water, Sanitation and Hygiene (WASH) and education. The Lancet series also estimated a need for US \$9.6 billion per year for scaling up these high impact interventions to 90% coverage, so as to reduce stunting by 20% and severe wasting by over 60%¹⁵. A multi-partner costing analysis in 2015 has established the need for an additional US \$8.5 per child annually if we are to achieve the WHA stunting target¹⁶.

1.3 FINANCING; VITAL FOR TACKLING MALNUTRITION

Although financing for nutrition has grown over the past few years it is still grossly inadequate. In 2011, 0.4% of global Official Development Assistance (ODA) was allocated to nutrition¹⁷. This increased to around 1% in 2013¹⁸. The Nutrition for Growth (N4G) summit in 2013 raised US \$4.1 billion for nutrition specific and US \$19 billion for nutrition sensitive sectors, alongside policy based non-financial commitments for nutrition. Although significant, these resources constitute a small contribution towards meeting an enormous need. To bridge the gap between the resources currently invested in nutrition and the goal to be achieved, it is imperative to increase investments from donors in High-Income Countries, mobilise resources within high-burden countries through national budgets, traditional and innovative financing mechanisms, and also bring in other stakeholders, such as the private sector, to commit resources and account for their role in addressing malnutrition. Recent evidence shows that donors need to quadruple their investment in nutrition, while governments must, at the very least, double their domestic spending on nutrition in order that the world to meet the WHA stunting target in 37 high burden countries¹⁹.

Furthermore, nutrition expenditure and outcomes need to be tracked in a transparent manner. For example; National Health Accounts (NHAs) could include a sub account line for nutrition.

Public Expenditure Reports (PER) and mid-term expenditure frameworks could also include all nutrition allocations. Countries need to improve data collection and invest in building national inter-sectoral capacity to address nutrition effectively.

1.4 NUTRITION IN THE SUSTAINABLE DEVELOPMENT AGENDA, AND RIO AS AN OPPORTUNITY

The central role of nutrition in sustainable development is reflected in Goal 2 of the Sustainable Development Goals (SDGs); 'End hunger, achieve food security and improved nutrition and promote sustainable agriculture'.

Within this, target 2.2 is more specific to nutrition; 'By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.'

Following on the success of N4G in 2013, the second N4G summit to be held in the summer of 2016 in Rio is an opportunity for the world to reaffirm its commitment to tackling all forms of malnutrition. Governments in high burden countries, as well as donor governments, must mobilise much needed additional resources towards achieving this end. Countries must also share experiences in an effort to identify the way forward for tackling all forms of malnutrition.

1.5 THIS REPORT

This report is the outcome of a collaborative effort of three organisations (RESULTS, Concern Worldwide, and the University of Westminster) to capture success stories from three countries which are on track to meet one or more WHA nutrition targets; Vietnam, Uganda, and Kenya. By highlighting successful initiatives, challenges, and potential solutions, it seeks to provide recommendations to guide policy and resource allocation in future strategies to tackle malnutrition.

This report is based on qualitative data collected through semi-structured interviews and focus group discussions with key stakeholders including government ministries and departments, international and local development organisations and civil society alliances.

“

One of the driving forces for the nutrition results achieved in this country is the strong leadership of the Minister of Health. They are committed, and also open to constructive ideas from the development partners

**RESPONDENT,
DEVELOPMENT AGENCY**

Vietnam has achieved a drastic reduction in its poverty rates and simultaneously improved nutrition in the space of 25 years. It is one of four countries on track to achieve at least four out of the six WHA targets: on stunting, wasting, anaemia, and exclusive breastfeeding²⁰. Despite these significant gains it also faces several challenges to sustain and expand progress on nutrition. These include inequitable nutrition outcomes across ethnic groups and provinces, persistent prevalence of micronutrient deficiencies, and an ever growing burden of overweight and obesity. Additionally, over the past few years, reduced funding from donors as well as national budgetary cuts has hindered the scale up of nutrition interventions.

This case study aims to share best practices from countries like Vietnam, which could provide valuable insight and guidance to other countries facing a similar burden of malnutrition. It also makes recommendations regarding priority actions for the government of Vietnam, international donors and civil society partners to address some of the challenges, and sustain improvements in nutrition in Vietnam.



2.1 POVERTY REDUCTION IN VIETNAM

Over the past few decades, Vietnam has made remarkable progress in poverty reduction and socioeconomic development. Market-oriented reforms, known as 'Doi Moi,' in the late 1980s facilitated industrialisation, private sector expansion, and trade liberalisation. This contributed to rapid growth and in 2009 the country progressed from a Low Income Country (LIC) to a Lower-Middle Income country (LMIC) status. The poverty rate fell from 58% in the early 1990s to around 9% in 2012^{21,22}. Agricultural reforms and egalitarian land redistribution also led to large scale improvements in agricultural productivity and domestic food security. Between 1990 and 2004, Vietnam increased food production by 64%. Sustained increase in agricultural output has led to Vietnam's transformation from being a food importer to a leading exporter of cereal grains²³.

2.2 IMPROVEMENTS IN HEALTH

Advances in poverty reduction have been achieved in parallel with improvements in the health sector. In the early 1990s, Vietnam introduced pilot health insurance schemes to expand health service coverage. A Health Care Fund was set up in 2002, followed by the Health Insurance Law being passed in 2009. This established Vietnam's Social Health Insurance programme (SHI), in which all children under six years of age, the elderly, and the poor are entitled to receive fully subsidised health services²⁴.

Targeted programmes for health have aided Vietnam's progress on the MDGs. Under-five mortality has reduced by 52% and infant mortality by nearly 50% between 1990 and 2013²⁵. Maternal mortality was also reduced by 64% over this period²⁶.

2.3 TACKLING UNDERNUTRITION

Poverty alleviation, health improvement, and improved food production and availability contributed to early wins for nutrition²⁷, but so have targeted efforts to tackle undernutrition. Underweight among children under five years of age has reduced by nearly 70% between 1985 and 2013²⁸. Meanwhile, stunting in the same age group has reduced by nearly 60% since 1985, to 25.9% in 2013^{29,30}.

In addition to its efforts to improve food security and reduce poverty, the Government of Vietnam has prioritised nutrition as a

national issue, with a special focus on vulnerable groups such as women, children, and ethnic minorities. This has helped continue the declining trend in undernutrition.

2.4 KEY REASONS FOR SUCCESS

2.4.1 PRIORITISING NUTRITION IN THE NATIONAL AGENDA

In 1980, Vietnam set up a National Institute of Nutrition (NIN), under the Ministry of Health (MOH). This technical agency leads nutrition policy, research, and implementation of nutrition programmes. The NIN works closely with other government departments and ministries, and national and international development partners to improve nutrition policy, advocacy, and implementation.

In 2012, NIN, international development partner agencies, and the Women's Union collaborated with the Institute of Legislative studies (ILS), to advocate the government for improving the rates of Exclusive Breastfeeding (EBF) for the first six months. These efforts resulted in two key legislations being passed by the National Assembly. The first was the amendment of the Labour Code which extended paid maternity leave from 4 to 6 months. The second was the Law on Advertisement, which bans marketing of breast milk substitutes for children less than 24 months of age (in compliance with the International Code).

A central agency for nutrition within the government helps to lead development and implementation of coordinated strategies for nutrition, and ensures nutrition remains a priority in the national development agenda.



If you look at Vietnam coming out of post-war in the early 1980s, the government has to be credited for really investing in nutrition, setting up the National Institute of Nutrition to look at food security as a priority, and then looking at nutrition security

TARGETED NATIONAL POLICIES AND PROGRAMMES FOR IMPROVING NUTRITION

Vietnam has invested in programmes to improve food security and nutrition since the early 1990s. Political emphasis on nutrition came with the launch of the National Plan of Action for Nutrition (NPAN) for 1995-2000³¹, followed by National

Nutrition Strategies for 2001-2010 and 2011-2020. These focus on improving dietary intakes, reducing maternal and child undernutrition, strengthening nutrition practices such as exclusive breastfeeding, and reinforcing human resource capacity for nutrition programmes^{32,33}. These have been endorsed by the Prime Minister, which reflects high level political commitment to nutrition as a national issue.

The current strategy outlines key nutrition indicators to guide efforts and measure outcomes, with a vision towards 2020. Through NIN and development partners, the government implements a National Target Programme (NTP) on maternal and child health. This includes nutrition specific interventions such as vitamin A supplementation, breastfeeding and complementary feeding, micronutrient supplementation for pregnant women and young children, and management of acute malnutrition.

Vietnam has just met its 2015 target for stunting (26%) and underweight (15%), and is working on further reducing all forms of malnutrition. To improve Infant and Young Child Feeding (IYCF) practices, a Plan of Action on IYCF was developed to institutionalise enabling hospital environments for breastfeeding, and promote nutrition counselling for mothers and care givers. Tackling undernutrition is also one of the objectives of Vietnam's Socio-Economic Development Plan.

A mid-term evaluation of the existing nutrition strategy is underway to prioritise resources and efforts for the forthcoming phase (2016-2020).

2.4.2 GENERATING EVIDENCE FOR NUTRITION

Routine and extensive data on nutrition helps detect positive and negative trends, identify gaps and needs, and facilitates allocation of resources for greater impact and effectiveness. It also enables timely response to crises.

Vietnam set up a Nutrition National Surveillance System in the early 1980s. Since then NIN conducts annual surveillance on nutrition indicators to generate national and provincial nutrition profiles, with data on key indicators³⁴. The work is supported by The General Statistics office, Preventive Medicine Department, and other ministries and development partners. Data is disaggregated by location, ethnicity, gender, and socio-economic status. This guides resource allocation at the centre, and helps

provincial authorities to develop localised plans and secure funding for programmes.

Additionally, comprehensive nationwide General Nutrition Surveys are undertaken every ten years (the most recent survey was in 2009-10). These identify longer term emerging trends in nutrition and food consumption, identify pressing issues, and inform resource allocation. They help to identify provinces and population groups worse-off on nutrition, and feed into policy processes to prioritise and finance interventions to improve equitable nutrition outcomes. Such surveys also provide the data to hold the government and other stakeholders to account for their investments in nutrition and ensure they take responsibility.

However, the survey does not track financing for nutrition at central, provincial, and multi-sectoral levels, which is a crucial missing part of the puzzle for what has and hasn't worked for nutrition in the country. These surveys should be conducted more frequently as a ten year interval is far too long to inform timely interventions to address malnutrition.

2.4.3 THE NUTRITION CLUSTER PARTNERSHIP GROUP

Nutrition has multiple underlying determinants. Therefore, the solution to tackling malnutrition is not just increased food production, or scaling up few nutrition-specific interventions. Investing in nutrition sensitive sectors such as agriculture, health, social protection, WASH, and gender can help address 80% of stunting (Lancet 2013)³⁵. To achieve multisectoral collaboration, government and non-government actors in these sectors should recognise that nutrition is a collective responsibility, earmark investments for nutrition, and work cohesively³⁶. Investments for nutrition should go alongside measuring their impact on nutrition outcomes.

Vietnam set up a Nutrition Cluster Partnership Group (NCPG) in 2009. The cluster, which includes the NIN and other development partners, meets every 4-6 weeks to discuss nutrition issues, share information and identify collaborative means of tackling malnutrition, particularly for joint-advocacy on nutrition. Nonetheless, the cluster is operational only at the national level, with erratic participation from other ministries. The NCPG has however recently been recognized as 1 among 6 technical working groups of the Health Partnership Group led by the MOH and development partners. With this official recognition, it hopes

to involve other sectors and agencies in this platform for Scaling Up Nutrition (SUN) coordination.



No single organisation, no single government can act alone to achieve the goal of ending hunger and global malnutrition. Working together, we have the ability to establish powerful partnerships that change the global landscape, from one of hunger to one of hope, until no one goes hungry.

ERTHARIN COUSIN, WFP EXECUTIVE DIRECTOR³⁷

2.4.4 VIETNAM'S COMMITMENT TO GLOBAL INITIATIVES ON NUTRITION

Vietnam joined the SUN movement in 2014, to help overcome the challenge in engaging actors from nutrition sensitive sectors. NIN is the liaison point for SUN, but there is a belief that government participation at the highest possible level would leverage recommendations and support from SUN into meaningful national policies. For this, an official launch of the movement in the country and the establishment of a steering committee chaired by government leadership are recommended. It would also provide a platform for outlining financial commitments and tracking, planning, and assessing nutrition outcomes.

In early 2015, Vietnam also joined the UN Zero Hunger challenge to address food and nutrition security, particularly in rural, remote and isolated areas with higher ethnic minority populations. This initiative adopts a wider 'food systems' approach to eliminate hunger by 2025. One of its five pillars is to achieve zero stunting among children less than two years of age. This is a more ambitious target as compared to the WHA target to achieve 40% reduction in stunting among children under five years of age. The strategy outlines nutrition specific interventions such as appropriate IYCF practices, management of acute malnutrition, and nutrition education and counselling, and also nutrition sensitive interventions that need to be scaled up to achieve this objective.

Signing up to initiatives such as SUN and Zero Hunger on global platforms reinforces commitment to meet national and global nutrition goals. It also strengthens government responsibility

for its investments, policies, and implementation. Lastly, it attracts support and guidance from development partners, donors, countries facing similar challenges, and civil society in efforts to address malnutrition.

2.4.5 RESEARCH, DEVELOPMENT AND INNOVATION

Investments in research and development for new ways to tackle malnutrition, and the willingness of NIN to take on-board suggestions from development partners, have resulted in considerable gains for nutrition in Vietnam.

To scale up Integrated Management of Acute Malnutrition (IMAM) to treat wasting in children under the age of five, NIN developed a local Ready-To Use Therapeutic Food (RUTF), 'Hebi' with the support of UNICEF and the Institut de Recherche pour le Développement (IRD) in 2009³⁸. Hebi is composed of rice, soy, and mung bean to suit the tastes of the Vietnamese and has been tested for acceptability and efficacy in the community. With the support of Irish Aid, UNICEF, and Plan international, the government expanded the IMAM programme to 100 communes in 19 districts. In 2015, with additional funding from the European Union this programme has been scaled up to a further 48 communes in 12 provinces that report poor nutrition indicators.

Development partners help NIN in building capacities of Commune Health and Nutrition Workers to deliver IMAM services. This programme has contributed to a decline in wasting from 7.1% (2010) to 6.6% (2013)³⁹. Advocacy efforts are underway to include Hebi in the essential drugs list which would enable sustained financing for IMAM through the Social Health Insurance scheme.

NIN has also developed a Multi-Micronutrient Powder (MNP) for home-based food fortification, particularly of complementary feeds. This has been branded as 'Bibomix' and is being promoted to address micronutrient deficiencies in children under the age of five. This MNP project has been funded by Irish Aid, and developed with the support of the Global Alliance for Improved Nutrition (GAIN). Using a social marketing approach, Bibomix was sold at an affordable cost through the Public Health system. Preliminary analysis shows a positive response to Bibomix from the community at provincial, district, and commune levels. The project evaluation will be completed in 2015 and will be used to guide the next steps for scale-up.

2.4.6 THE ROLE OF THE MEDIA

Strengthening IYCF has been a challenge for Vietnam. The rate of exclusive breastfeeding for the first six months has been lower than 20% for the past decade⁴⁰. Early weaning and poor complementary feeding practices are widespread which contribute significantly to undernutrition and ill-health among young children.

To improve rates of exclusive breastfeeding for the first six months A&T, UNICEF, and other development partners along with WHO, MOH, and NIN collaborated on a mass media campaign over 2012-2013 using television commercials promoting best practices for IYCF. These were broadcast on national and provincial channels, in hospitals, supermarkets, and through community loudspeakers. Messages have also been relayed through digital platforms and social media. Media is a powerful medium to promote nutrition awareness, improve nutrition practices and also acceptance for nutrition services.



Breastfeeding is the single most important factor in child survival and development, more important than any vaccine, modern technology or other health interventions. We therefore need to ensure that every child born in Viet Nam gets the best possible start in life – and that start begins with breastmilk⁴¹

2.5 CHALLENGES TO SCALING UP NUTRITION

2.5.1 INEQUITABLE NUTRITION OUTCOMES

Vietnam's remarkable progress on nutrition has clearly been uneven as regional and ethnic disparities are widespread. The Northern Midland and Mountainous areas, North Central and Central coastal areas, and Central highlands present some of the highest rates of stunting in the country. Kinh, the ethnic majority, are significantly better-off than ethnic minority groups. Some ethnic communities present stunting rates as high as 55%, as compared with the national average of 25.9% (see figure 1).

Poverty reduction among ethnic minorities in dimensions other than income, such as education, health, water, sanitation, housing, also lags behind national averages⁴³, and children from

the poorest households are twice as likely to be wasted as those in the richest households (see figure 2)⁴⁴.

FIGURE 1: PREVALENCE OF STUNTING BY MATERNAL ETHNICITY, VIETNAM, 2010⁴²

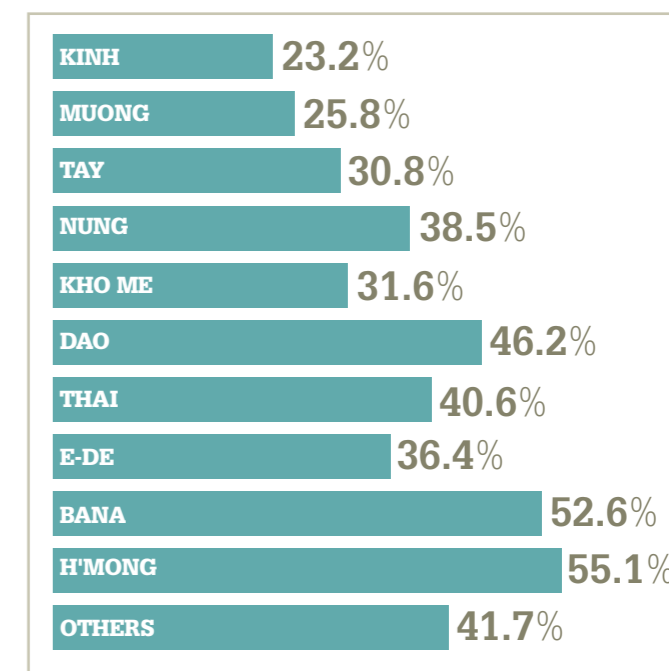
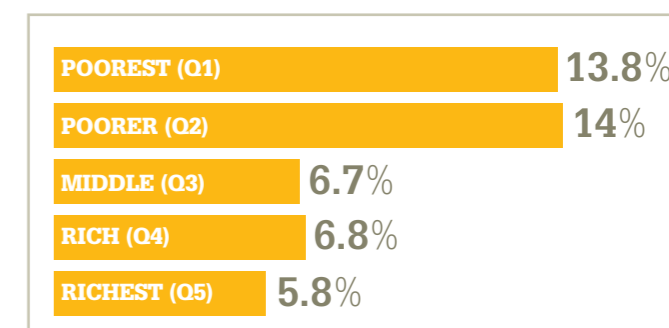


FIGURE 2: PREVALENCE OF WASTING BY HOUSEHOLD (Wealth) WEALTH, VIETNAM 2010⁴⁵



2.5.2 MULTIPLE BURDENS OF MALNUTRITION

Multiple burdens of various forms of malnutrition comprising rapidly rising rates of childhood overweight and obesity,

alongside stunting, wasting, and micronutrient deficiencies, is a grave threat to the health and development in Vietnam. It must be acknowledged that undernutrition in early life also lays the foundation for increased risk of overweight and non-communicable diseases later in life. In 2013, around 4.6% of children under five were overweight or obese⁴⁶, a substantial increase from 0.6% in 2000. The South-East region reported rates as high as 9%⁴⁷, while Ho Chi Minh City reported a prevalence of over 11%⁴⁸. Less healthy food consumption and lifestyle patterns are the main drivers of overweight and obesity, and urgent intervention is needed to prevent this situation from worsening.

Unlike its progress in reducing stunting and wasting, tackling micronutrient deficiencies has not been as successful, particularly reducing anaemia in women and children under the age of five years. In 2009-10, Iron Deficiency Anaemia (IDA) prevalence among pregnant women and children under the age of five years was around 36% and 29% respectively. Furthermore, nearly half of all children less than two years of age were anaemic⁴⁹. Micronutrient deficiencies significantly compromise immunity, growth, and development in children. This pushes them into a cycle of illness, undernutrition, poor education outcomes, lower productivity as adults, and thus into poverty. In women of reproductive age, micronutrient deficiencies such as anaemia can be life threatening particularly during pregnancy and child birth, and increase the risk of a life-long cycle of undernutrition and ill-health.

2.5.3 NUTRITION WITHIN THE HEALTH SYSTEM AND INTEGRATION WITH OTHER SECTORS

The National Nutrition Strategy was endorsed by high level political authority, and it outlines the roles and responsibilities of stakeholders beyond the health sector in improving nutrition. Despite this, there is limited ownership of nutrition as a multisectoral issue, and it continues to be viewed as the responsibility of the Health ministry.

Transparent financial tracking for nutrition also needs more attention as there is insufficient information on financial allocation to nutrition within the nutrition sensitive sectors. This makes it impossible to prioritise programmes and measure impact and cost effectiveness of interventions. More importantly, it reduces accountability of the stakeholder for action (or inaction) on undernutrition.



We have no voice as health sector alone... nutrition is predominantly considered a health issue, which makes it difficult to coordinate... especially because they (other ministries) have bigger budgets and resources, but how do we make them nutrition sensitive?

2.5.4 FUNDING FOR NUTRITION

Until now, Vietnam has implemented nutrition interventions through targeted programmes. However, early in 2015 the Vietnamese government announced a 65% reduction in the budget. Perceptions regarding budgetary cuts differed among various nutrition stakeholders. The common view was that nutrition programmes will suffer because of underfunding and that it will be difficult to maintain programs with only 35% of the original budget. This will severely restrict coverage of nutrition services. A contrary but uncommon view was that these budget cuts are a means of reprogramming funding from vertical programmes towards a health systems strengthening approach, which would have uncertain benefits for nutrition. Nevertheless, there was a consensus that these cuts threaten prioritisation and sustainability of nutrition interventions. At present less than 1% of the government's entire budget is allocated to nutrition specific and sensitive interventions combined⁵⁰.

Additionally, Vietnam's graduation from an LIC to an LMIC has also resulted in transitioning donor support. In 2012-2013 Vietnam was among the top three recipients of ODA (US \$3 billion)⁵¹. However, donors are increasingly moving away from funding traditional development and social programmes, to focus on issues such as governance and trade partnerships⁵².

The UK has decided to phase out bilateral support to Vietnam by March 2016. Furthermore, in May 2015, Australia announced an AU \$1 billion reduction to its overall foreign aid budget. This resulted in a 40% cut in its bilateral funding to Vietnam, in addition to significant reductions in ODA to other countries. The EU, with contribution of its members has been the largest grant donor to Vietnam, providing €5.8 billion in cumulative commitments over 2007-2014⁵³. While this grant supported many health, development and economic programmes, their support over 2014-2020 will focus largely on sustainable energy, governance, and rule of law⁵⁴. In the past, donors facilitated big wins for nutrition but declining donor support is endangering existing programmes and scale-up, as well as research and development for nutrition. Whilst MICs must increase their budgetary allocation for

nutrition through traditional and innovative financing, donors have a responsibility to continue supporting nutrition through bilateral and multilateral financing, for sustained improvement in global nutrition, thus promoting global development.

2.6 DISCUSSION

For a country that encountered severe food insecurity and famines in the 1970s and 1980s, Vietnam has made very impressive progress in improving food security and tackling undernutrition. Prioritisation of nutrition on the national agenda, institutional framework for guiding policies, programmes and leading research for nutrition, multi-stakeholder platform for nutrition and establishing nutrition surveillance are some of the key wins in the country. However, there is still progress to be made. Infant and young child feeding and micronutrient deficiencies need to be addressed, and overnutrition is increasing at an alarming rate. Policies such as the IYCF Plan of Action and legislation such as the Labour code and the Advertisement law are definitely steps in the right direction.

Recent funding cuts introduced by the government, and declining donor support threaten sustainability of existing programmes and the introduction of new initiatives. Whilst there is a need to increase domestic financing for nutrition both through targeted and multi-sectoral approaches, donors should support Vietnam's efforts in scaling up nutrition for millions of women and children who suffer the greatest ill-effects of malnutrition. Tackling malnutrition has to be a priority if the world wants to achieve reduction in global poverty, a commitment it has made by adopting the new set of Global Goals.

2.7 RECOMMENDATIONS

Over the years, the rates of poverty alleviation and reduction in undernutrition have been strong, but are now stagnating. Additionally, overweight and obesity are emerging as serious public health concerns. To continue on its path to tackle all forms of malnutrition, it should take steps as given below:

2.7.1 RECOMMENDATIONS FOR THE GOVERNMENT OF VIETNAM

- ◆ Recognise the significance of nutrition for overall development and increase significantly the existing 1% budgetary allocations earmarked for nutrition specific and sensitive programmes;
- ◆ Track financial allocation to nutrition at both national and

individual ministerial levels with clear indicators to measure input as well as impact. This will hold stakeholders to account for their efforts in improving nutrition;

- ◆ Legal recognition for the Nutrition Cluster partnership as a platform for integrated approaches for nutrition, and mandatory involvement of ministries;
- ◆ Tackle inequities in nutrition outcomes through targeted approaches, and greater resource allocations for the poor and marginalised provinces and ethnic communities;
- ◆ Officially launch the SUN movement in Vietnam, led by high level political authority such as the Prime Minister;
- ◆ Scale up interventions to tackle micronutrient deficiencies, particularly among vulnerable groups such as adolescent girls;
- ◆ Bring key nutrition services such as micronutrient supplementation and RUTFs within the Social Health Insurance package;
- ◆ Sensitising sub-national authorities on nutrition, and building their capacities to develop multi-sectoral provincial plans for nutrition, and allocate resources accordingly to scale up nutrition interventions;
- ◆ Create enabling environments to promote healthy dietary and lifestyle behaviours to prevent overweight and obesity.

2.7.2 RECOMMENDATIONS FOR DONORS

- ◆ Increase development assistance for nutrition in LMIC like Vietnam, through bilateral and multilateral programmes
- ◆ Increase allocation of resources for the SUN movement and the SUN civil society alliance for improved advocacy and accountability for nutrition;
- ◆ Encourage innovative financing for nutrition;
- ◆ Invest in data generation, information systems, and sharing of learning across countries that are tackling malnutrition.

2.7.3 RECOMMENDATIONS FOR DEVELOPMENT PARTNERS AND CIVIL SOCIETY

- ◆ Strengthen advocacy for nutrition, and continue using evidence to inform prioritisation of nutrition interventions;
- ◆ Collaborate with other stakeholders to improve budgetary allocations, monitoring, and thus accountability for improved nutrition outcomes.
- ◆ Work closely with government ministries to provide support and guidance on nutrition specific and sensitive programmes.

“

Malnutrition places a massive economic burden on Uganda, costing it about 5.7% of its GDP, an estimated US \$899 million each year

**AFRICAN UNION
& WORLD FOOD PROGRAM**

3.1 INTRODUCTION

Since the early 1990s, the nutrition landscape has been transformed in Uganda, driven by the government's recognition that improving food and nutrition security could lead to socio-economic transformation. As a result, Uganda has made considerable strides in improving the nutritional status of the population. This case study focuses on the successes that have enabled the scale up of nutrition across the country as well as the challenges stakeholders face in sustaining and accelerating this progress.

Between 1988 and 2000, the prevalence of stunting in children under the age of five years reduced by only 3%. However, between 2000 and 2012, levels of stunting fell by 11%⁵⁵. Over a four year period (2006-2011) wasting in children under five years of age also reduced by over 3%⁵⁶, meeting the WHA wasting target. It is evident that Uganda has made progress in reducing undernutrition for children but there is a lot to be achieved. Regional disparities exist, for example, around 1 in 2 children in the Karamoja sub-region are stunted compared with the Eastern sub-region which has already met the Uganda Nutrition Action Plan (UNAP) target of reducing stunting to 27%⁵⁷.



Micronutrient deficiencies are widespread, as 38% of children under five are deficient in vitamin A, and nearly 50% of children under five and 23% of women 15-49 years are anaemic⁵⁸.

Malnutrition places a massive economic burden on Uganda, costing it about 5.7% of its GDP, an estimated US \$899 million each year⁵⁹. Unless adequate measures are undertaken, it is estimated that malnutrition will cost Uganda US\$7.7 billion in lost productivity by 2025. Investing in nutrition, on the other hand would lead to economic gains in excess of US\$1.7 billion by 2025⁶⁰.

Uganda is seeking to address multiple burdens of malnutrition; stunting, wasting, and micronutrient deficiencies, alongside overweight and obesity, and in so doing the country has embraced multidimensional and multisectoral measures to curb all forms of malnutrition and their related impacts for the nation to achieve desired social and economic development.

3.2 UGANDA'S SUCCESS IN MEETING INTERNATIONAL AND NATIONAL NUTRITION TARGETS

The proportion of people living below the poverty line in Uganda declined from 56% (1992-93) to 20% (2012-13), meeting the Millennium Development Goal of halving the proportion of the population living in extreme poverty⁶¹. Furthermore, the 2015 Global Nutrition Report indicates that Uganda is 'on course' to achieving the World Health Assembly targets on under-5 wasting, breastfeeding and overweight targets, and that it is 'making progress' in achieving the target on under-5 stunting, but is 'off-course' to achieve the target on anaemia reduction⁶².

A study by USAID SPRING⁶³ indicates that aggregately the country is within reach of achieving its own nationally set targets under the Uganda Nutrition Action Plan (UNAP) for 2011-2016 (see Figure 1). However, data disaggregated by the 10 sub-regions reveals wide disparities in meeting these targets.

FIGURE 1: UGANDA'S PERFORMANCE IN ACHIEVING NATIONAL NUTRITION TARGETS AS PER THE UNAP 2011 - 2016

Key Indicators	UNAP TARGET (2016)*	KAMPALA	CENTRAL 1	CENTRAL 2	EAST CENTRAL	EASTERN	NORTH	KARAMAJOA	WEST NILE	WESTERN	SOUTH WEST
Underweight Children under 5 years	10%	6%	13%	11%	17%	10%	12%	32%	18%	16%	5%
Wasting Children under 5 years	5%	4%	6%	5%	5%	5%	3%	7%	6%	3%	4%
Stunting Children under 5 years	32%	14%	33%	36%	34%	25%	25%	45%	38%	44%	42%
Low birthweight (<2.5kg)	9%	11%	14%	13%	12%	7%	11%	10%	11%	8%	8%
Overweight Children under 5 years	No increase	4%	4%	5%	2%	3%	4%	0%	2%	3%	6%
Any anemia Children 6 - 59 months	50%	40%	57%	54%	66%	55%	34%	70%	64%	39%	25%
Any anemia Women of reproductive age	12%	20%	24%	31%	30%	28%	13%	43%	32%	17%	11%
Vitamin A deficiency Children 6 - 59 months	13%	28%	29%	22%	40%	42%	29%	22%	29%	30%	35%
Exclusive breastfeeding Children under 6 months	75%	44%	59%	72%	56%	63%	72%	82%	65%	68%	52%
Min acceptable diet (MAD) Children <2	**	16%	4%	8%	1%	8%	3%	2%	5%	6%	5%

■ Worse than UNAP target
 ■ Within +/- percentage points of UNAP target
 ■ Better than UNAP target

The study also identifies a range of reasons to account for the notable successes in Uganda achieving both national and global nutrition targets; these were found to be rooted in Uganda's political commitment to nutrition under the Scaling Up Nutrition movement, the combined effort of the different stakeholders under this movement, and the commitment of district and regional authorities. However it also recognised challenges that prevent achieving national nutrition targets.

3.3 KEY REASONS FOR SUCCESS

3.3.1 COMMITMENTS TO SCALING UP NUTRITION

High level political engagement has been key in ensuring the establishment of multi-sector and multi-stakeholder platform engagement to scale up nutrition. Under the leadership and coordination of the Office of the Prime Minister (OPM), relevant government ministries such as ministries of health, agriculture, education, planning and economic development

have collaborated with development partners, civil society, and academia reporting to advocacy initiatives and enabling space for joint decision-making.

As a result of advocacy efforts at the N4G Summit in 2013, the Ugandan government publically reaffirmed its commitment to implement the UNAP by 2016 including reducing stunting to 27%, underweight to 10% and increasing exclusive breastfeeding in infants 0-6 months of age to 75%⁶⁴.

As part of the commitment to contribute to the SUN initiative in Uganda, respondents interviewed described their organisations as being engaged in implementing different interventions, all of which contribute to improved nutrition outcomes. Of all the mentioned interventions respondents highlighted seven categories of interventions to be most successful in Uganda (see figure 2)

FIGURE 2: INTERVENTIONS SCALED- UP TO CONTRIBUTE TO NUTRITION PROGRESS IN UGANDA



EVOLUTION OF UGANDA'S POLICY COMMITMENTS TO SCALE UP NUTRITION

1997 POVERTY ERADICATION ACTION PLAN (PEAP): Uganda's comprehensive national development framework to guide poverty eradication in the country.

2003 UGANDA FOOD AND NUTRITION POLICY (UFNP): Provided strategic direction to undertake nutrition interventions (2003-10) within the Ministry of Health (MOH) and Ministry of Agriculture and the Ministry of Animal Industries and Fisheries (MAAIF)

2010-2015 UGANDA NATION DEVELOPMENT PLAN I (NDP I): Replacing the PEAP, the NDP I was developed as the first of the six national development plans under the National Vision of a transformed Ugandan Society; interventions to improve nutrition were considered key in overall population health improvement.

2011 UGANDA NUTRITION ACTION PLAN (UNAP): Adopted as the country's strategic framework for addressing multisectoral nutritional issues. The aim of the UNAP is to improve the nutritional status of the population, focusing on women of reproductive age, infants, and children within the first 1000 days¹.

2015-2020 SECOND UGANDA NATIONAL DEVELOPMENT PLAN (NDPII): Proposes an end to all forms of malnutrition by 2030, including achieving by 2025 the internationally agreed World Health Assembly (WHA) targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons¹.

3.3.2 STRONG POLICY ENVIRONMENT

The government has introduced several policies, frameworks and legislations on nutrition, the main ones described in Box 1. Other national policies include the Uganda Integrated Management of Acute Malnutrition Guidelines (2010), the National Policy Guidelines and Service Standards for Reproductive Health Services, and other sectoral strategies in health and agriculture. Furthermore, the National Fortification programme and National Fortification Alliance (NFA) are in place to ensure that food fortification standards increase micronutrients in the diets of mothers and children.

3.3.3 INCREASED FINANCING FOR NUTRITION

Due to an increase in the financing of nutrition programmes between 2011 and 2015, there has been an increase in the

number of nutrition related projects being implemented in different regions of the country by different stakeholders. In the same period, civil society received joint funding of US \$300,000 from the Global Multi-Partner Trust Fund to undertake nutrition advocacy related activities.

In 2013, SPRING, together with the OPM, began working on a study called Pathways to Better Nutrition⁶⁵. The aim of the study is to provide comprehensive estimates of budgeted nutrition funding for nutrition specific and sensitive interventions and to assess the extent of alignment with national targets.

3.3.4 IMPROVED RESOURCES TO NUTRITION PROGRAMMING

Nutrition-sensitive programming has increased over the past five years in Uganda fuelled by donor funding for a multi-sectoral approach. In particular, USAID and UN agencies have been

engaged in supporting the scale up of effective interventions and have provided strong support in the development of country strategies, particularly addressing stunting, underweight, wasting and micronutrient deficiencies. For example, food fortification, IMAM, promotion of IYCF practices and the consumption of bio-fortified foods have been scaled up. Interventions are undertaken through government partnerships and the coordinated action of UN agencies, civil society, donors, and the private sector under the leadership of the OPM.

Nutrition specific interventions in the country use a multi-sectoral approach. Increased buy-in from the private sector, notably through food fortification and adherence to national food safety guidelines has ensured improved access to, and utilisation of, nutrition services

3.3.5 GREATER COORDINATION FOR STRONGER ADVOCACY

Working collaboratively with the government and health stakeholders helps to leverage human and financial resources for nutrition advocacy⁶⁶. Harmonising key messages ensures that nutrition advocates speak with one voice in order to unlock more and better resources for nutrition. An example of this is the Profiles Nutrition Advocacy Package by the FANTA project which has been fundamental in the harmonisation of nutrition messages. At the sectoral level, advocacy efforts have resulted in increased prioritisation, planning and budgeting for nutrition in addition to increased employment of qualified nutritionists who work within the district and local government structures.

Improved advocacy with the media has resulted in increased print and broadcast coverage of nutrition issues⁶⁷. The National NGO Forum in collaboration with the Uganda Civil Society Coalition on Scaling Up Nutrition (UCCO-SUN) undertook a successful advocacy campaign to link nutrition research, advocacy and the media in 2013-2014. Engagements with policy makers and other decision makers raised political awareness and interest in nutrition and the need to enact the Food and Nutrition Bill. At one of the high level dialogues organised in 2013, members of parliament committed to explore links between agricultural sector development and food and nutrition, prioritise support for research on indigenous nutritious foods and support a multi-stakeholder approach in addressing nutritional challenges⁶⁸.

3.3.6 COMMITMENT TO THE SUN MOVEMENT

Uganda was one of the first countries to embrace the SUN initiative in 2011. The government embraced a multi-sectoral approach to improve nutrition and has in the process instituted nutrition coordination structures at different levels. This has included the establishment of a National Nutrition Coordination office under the OPM, a Cabinet Committee on Nutrition, a Nutrition Technical Working Group and the establishment of district Nutrition Coordination Committees in most districts.

Additionally, the UCCO-SUN plays a significant role in engagement both nationally and internationally. At the national platform it works on consolidating and building on existing civil society initiatives on maternal and child nutrition and engaging in joint advocacy platforms and audiences. Internationally, it facilitates sharing of information across other SUN network members, thus contributing to shape the agenda of the SUN civil society network.

3.3.7 EMERGING COMMITMENT TO ACCOUNTABILITY

The UNAP 2011-2016 has been Uganda's common results framework for nutrition since adoption. This also outlines the roles of the different country SUN networks, which has enabled different stakeholders to mainstream nutrition in programmes and activities. The UNAP's specified targets have been pivotal in Uganda's ability to achieve a number of gains in nutrition, notably the wasting and breastfeeding targets. Under the UNAP framework, it has been possible to achieve joint planning and coordination of different activities, raise resources for joint activities, foster information sharing among partners and utilise national technical expertise.

To strengthen advocacy further a draft national advocacy and communication strategy has been developed by the OPM in collaboration with various nutrition stakeholders to foster accountability for nutrition in Uganda. Pillar four of this strategy calls for the 'demonstration by the Government of Uganda, at the highest level, and a broad development partner group, of an annual accounting to civil society on the progress made on child under-nutrition.⁶⁹ In addition, the NDP II states the importance of good governance through stronger accountability and transparency to minimise corruption and improve service delivery. With clearly set nutrition goals under the NDP II and the draft advocacy and communication strategy, Uganda has

set avenues for holding key players in nutrition accountable. However, actions are yet to be undertaken..

3.4 CHALLENGES TO SCALING UP NUTRITION

3.4.1 EFFECTIVENESS AT SCALING UP NUTRITION AT DISTRICT AND REGIONAL LEVEL

Disparities in district readiness and effectiveness to scale up nutrition interventions exist and the delivery of nutrition services is uneven throughout most districts. This is partly due to the limited financial resources for nutrition at local government level, competing demands for the minimal financial resources, poor prioritisation of nutrition unlike at the centre, lack of costed district nutrition plans in most districts, and the failure by most districts to employ specific staff qualified in nutrition. Finances for nutrition are mainly channelled to the districts by the government through the Primary Health Care budget, but these are often inadequate. At a regional meeting organised by the Uganda Action for Nutrition (UGAN) in Kiryandongo district in 2011, the need for donors to start funding district nutrition budgets directly rather than districts waiting for funding from government was raised⁷⁰.

3.4.2 DOMESTIC FUNDING TO SCALE UP NUTRITION

Although the government is committed to the SUN initiative and has made headway on a number of fronts, it still fails to make clear multi annual investments to nutrition that reflect its strong political leadership and policy commitments. Nutrition interventions such as fortification are expensive to sustain, and financing for other nutrition activities is unpredictable. Insufficient multi-year development funding for SUN-related programming coupled with the difficulties in getting more implementing partners on board to support SUN across the country makes it challenging to fully plan for nutrition at national and local government level in Uganda.

In many instances, nutrition is still being funded as an emergency issue rather than an issue that should be fully planned and costed as a long term development issue. Another government challenge stems from the weak legal and institutional mechanisms to absorb and account for funds allocated. The delay by government to enact the Food and Nutrition Act as stipulated for in the UFPN of 2003 was considered a bottleneck in

legalising mandates of the Uganda Food and Nutrition Council (UFNC). Additionally, fixed programme cycles of development partners also makes it difficult for the government to sustain nutrition programs with their support, particularly once they conclude their nutrition programme cycle and activities. This stop-start nature of programmes implemented by development partners is detrimental to sustaining nutrition progress achieved in the country.

The government should scale up domestic resources for nutrition through allocations to Ministries such as Health and Agriculture. This will also help the government meet its Abuja declaration of 15% national budget allocated to the health sector, and the Maputo declaration of 10% national budgetary resources to agriculture and rural development policy implementation. In 2010, the government spent just 8.6% of the national budget on health and 3.9% on agriculture⁷¹.

3.4.3 ACCOUNTABILITY

Holding stakeholders to account for their commitment to nutrition is an emerging success in Uganda, but it is still a challenge at different levels. Challenges in accountability and transparency were noted to prevail not only in the government but also other national SUN platforms. The capacity of local communities has not been fully developed for them to call for stronger accountability through monitoring of resources, implementation, and outcomes. Although civil society is also seemingly strong at the national level, its engagement and coordination still remains weak at local government level. As a result, the engagement of national and local governments, donors, and civil society actors to expand coverage of evidence-based nutrition interventions has been slower than anticipated. At the time of this study, the OPM was working on finalising a nutrition monitoring and evaluation tool that would be used at the national level.

3.4.4 COORDINATION AND ENGAGEMENT OF ALL STAKEHOLDERS

Implementation of nutrition actions using a multisectoral approach is relatively new in Uganda. As such, coordination and engagement of different SUN stakeholders has faced a

number of challenges in relation to planning, implementation and service delivery. Challenges were reported to have arisen in relation to competition for limited resources allocated to nutrition, handling conflicting and challenging organisational priorities, poor information sharing amongst stakeholders, and the lack of experience in implementing collaborative multisectoral approaches for nutrition.

3.5 DISCUSSION

Stakeholders in Uganda have made joint progress in improving the nutrition of the population, ranging from the government creating a strong policy landscape, to civil society improving accountability and advocacy, from donors funding essential research to the private sector investing in nutrition interventions to improve their business. Yet domestic financing does not match the strong political commitments which have resulted in investment being unevenly allocated across regions; it is crucial this is addressed via the creation of nutrition budget lines within key ministries. Over half (57%) of Uganda's population are under 18 years of age and with a population growth rate of 3.03%, it is clear that investing into youth and adolescent nutrition today to ensure a healthy population in the future is an investment worth making.

3.6 RECOMMENDATIONS

3.6.1 RECOMMENDATIONS FOR THE GOVERNMENT OF UGANDA

- ◆ Target investments to address widespread disparities and to ensure equitable nutrition outcomes. Investments must focus on the regions such as Karamoja and the South western region, which are making poor progress against international and national targets.
- ◆ Strengthen support to the District Nutrition Coordination Committees (DNCCs). Support for nutrition at the national level must also fully reflect at the district level. DNCCs must be scaled up, and provided resources and guidance on helping districts develop costed district nutrition plans, adequate staffing, and provision of adequate nutrition supplies for cases of managing severe acute malnutrition. Local governments must also be encouraged and supported to develop evidence of what works, and share learnings.
- ◆ Increase domestic funding to nutrition. There is no direct

funding for nutrition from the government as there is an absence of a specific budget line for nutrition. The Ministry of Finance should create nutrition budget lines under Ministries of Health and Agriculture. This could also help the government meet its Abuja and Maputo commitments. The N4G Summit in Rio provides an opportunity to make new, and reaffirm old, commitments to improving nutrition in Uganda and meeting the UNAP targets by their 2016 deadline.

- ◆ Enable the tracking of nutrition specific and nutrition sensitive budget allocations. The absence of a nutrition budget line makes nutrition spending difficult to track at national, regional and district level.

3.6.2 RECOMMENDATIONS FOR DEVELOPMENT PARTNERS AND CIVIL SOCIETY

- ◆ Strengthen and improve nutrition communication and advocacy through civil society. Sustaining nutrition communication and advocacy will be imperative for all actors to be actively engaged. Civil society such as the UCCO-SUN must be supported in their efforts to track nutrition spending by the government, donors and INGOs, and ensuring that resources focus on regions with poorest nutrition outcomes. Budget tracking and analysis findings must be shared with the government and other stakeholders.
- ◆ Foster research, information sharing and cross-learning. Local governments at district level have limited resources and capacity to implement Nutrition Information Platforms, which would enable stakeholders to discuss current and foreseeable nutrition issues and to share evidence on what works. Support to local governments from the national government, donors, NGOs and development partners to conduct research and hold Nutrition Information Platforms would help to contextualise local needs as well as foster local participation.

“

Kenya has made impressive strides in tackling malnutrition. It is the only country on track to make progress on five of the six WHA nutrition targets. Between 2008 and 2014 stunting has been reduced by 9%, and exclusive breastfeeding increased by around 30%

2015 GLOBAL NUTRITION REPORT

4.1 INTRODUCTION

Kenya is one of the fastest growing economies in Africa. It boasts a stable government, and has recently achieved LMIC status⁷². Through its investment in health and education it has been able to achieve some of its Millennium Development Goal targets including halting the prevalence of HIV, and achieving near universal enrolment in education.

Kenya has also made impressive strides in tackling malnutrition. It is the only country on track to make progress on five of the six WHA nutrition targets: reducing stunting, wasting and anaemia levels, while increasing the number of infants who are exclusively breastfed and reducing the numbers of children who are overweight⁷³. However, there are still challenges such as inequitable nutrition outcomes, resource allocation and tracking, and capacity building of community health workers on nutrition. This case study explores Kenya's success in tackling malnutrition, and the challenges it faces to further this success.



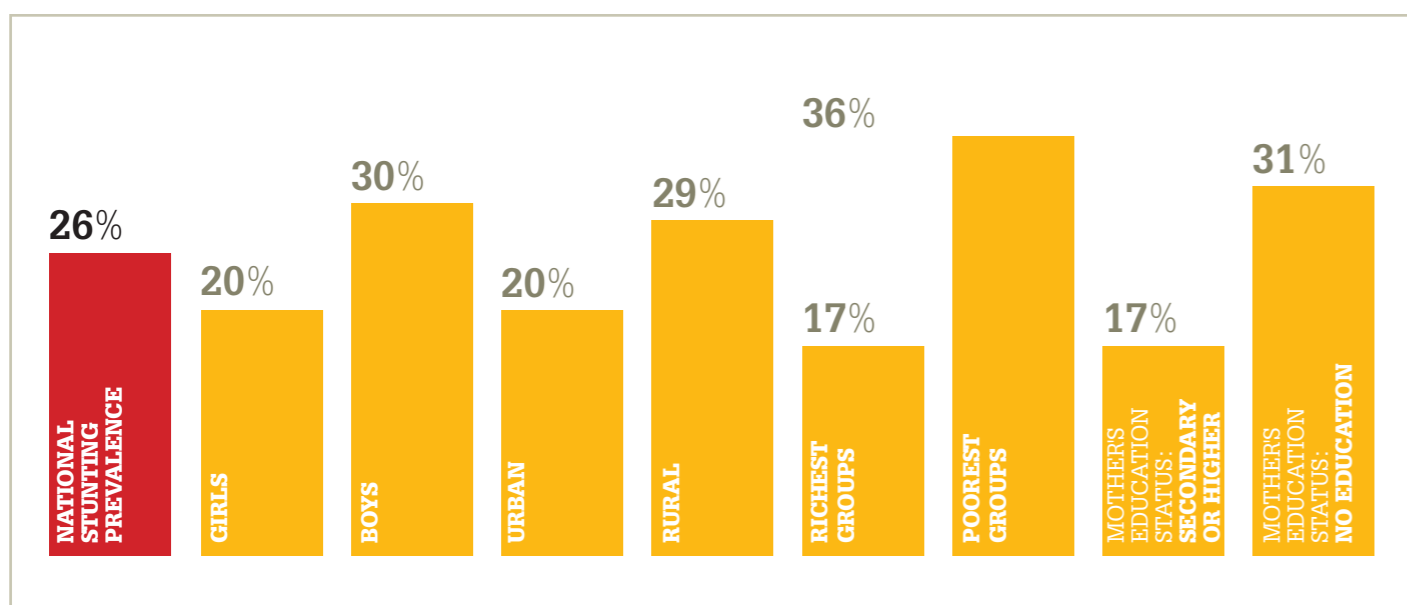
4.2 PROGRESS IN HEALTH AND NUTRITION OUTCOMES

The Kenyan Demographic and Health Survey 2014 (KDHS) provides the most compelling evidence of recent improvements in health and nutrition outcomes. Between 1989 and 2014, under-five deaths have decreased by 42%. Stunting in children under five years of age has decreased by 9% between 2008 and 2014. Wasting has been reduced from 7% to 4% over the same period. This reduction in stunting and wasting has been accompanied by an increase of more than 30% in rates of exclusive breastfeeding⁷⁴. Moreover, anaemia in women of reproductive age was reduced by nearly 48% from 1999 to 2011^{75,76}. Coverage of iodised salt consumption is 93%, while treatment of severe acute malnutrition has 100% coverage⁷⁷.

Despite these successes there are still a number of challenges, such as widespread inequity in nutrition outcomes. Nutrition outcomes vary across counties, gender, rural and urban households, income status, and mothers' education (see figure 1).

Moreover, there are wide geographical disparities. West Pokot and Kitui counties have the highest proportions (46%) of stunted children, while some other counties report stunting rates of over 35%. On the other hand, counties such as Garissa and Kiambu report less than 16% stunting in children under-five⁷⁹.

FIGURE 1: INEQUITABLE NUTRITION OUTCOMES IN KENYA⁷⁸



Additionally, a quarter of all women of reproductive age (WRA) are still anaemic, which has repercussions for their health and that of their children. Vitamin A coverage is at 66% for only two doses, but over 80% of preschool children are still Vitamin A deficient⁸⁰.

4.3 KEY REASONS FOR SUCCESS

4.3.1 SPECIFIC NUTRITION POLICIES, PLANS AND INDICATORS LINKED TO NATIONAL STRATEGY

To support the achievement of its national development goals, the government adopted a long term strategy, 'Kenya Vision 2030'⁸¹ supported by a new constitution in 2010. The constitution created a devolved system of governance with 47 counties, each of which is responsible for delivering health and nutrition programmes, to ensure all Kenyans realise their right to health⁸².

Within this strategy, the Medium Term Plan (MTP 11) has set the reduction of stunting as one of the outcome indicators. Nutrition has a budget line within the Kenyan Health Sector Strategic and Investment Plan (KHSSP) published in 2014⁸³ and the focal ministry within the government for nutrition is the MOH. The Kenyan Health Policy 2014-2030⁸⁴, lists several

TABLE 1: TOP 10 RISK FACTORS FOR MORTALITY AND MORBIDITY: KENYA HEALTH POLICY 2014 2030⁸⁵

Mortality (deaths)

RANK	RISK FACTOR	% TOTAL DEATHS
1	Unsafe Sex	29.7
2	Unsafe Water, Sanitation & Hygiene	5.3
3	Suboptimal Breastfeeding	4.1
4	Childhood & Maternal Underweight	3.5
5	Indoor Air Pollution	3.2
6	Alcohol Use	2.6
7	Vitamin A Deficiency	2.1
8	High Blood glucose	1.8
9	High Blood Pressure	1.6
10	Zinc Deficiency	1.6

nutrition related factors as contributing to the top 10 risk factors for both mortality and morbidity in the country (see table 1). Nutrition stakeholders praised the 2012 Kenyan National Nutrition Action Plan (NNAP) and reported that it has been used by other countries as an example of a well-constructed evidence based policy and framework for action⁸⁶. The NNAP provides a framework to support the effective implementation of nutrition interventions by the government and its partners, and has been used by the government as a tool to communicate its nutrition priorities. The plan focuses on high impact nutrition interventions such as IYCF, micronutrient supplementation and fortification, and the management of acute malnutrition⁸⁷. The only criticism of the plan was the absence of nutrition sensitive priorities in its 11 strategic objectives.

4.3.2 ESTABLISHMENT OF NATIONAL LAWS TO IMPROVE NUTRITION

In addition to the strong policy framework that has been developed for the nutrition sector, a number of measures have been adopted into law to support programmatic efforts with two main acts being described as having had an impact. These were the Mandatory Food Fortification Legislation (FFL) and the Breast milk Substitutes (Regulation and Control) Act 2012. The FFL requires that all maize and wheat flour in Kenya

Morbidity (DALYs)

RANK	RISK FACTOR	% TOTAL DALYs
1	Unsafe Sex	25.2
2	Unsafe Water, Sanitation & Hygiene	5.3
3	Childhood & Maternal Underweight	4.8
4	Suboptimal Breastfeeding	4.3
5	High Blood Pressure	3.1
6	Alcohol Use	2.3
7	Vitamin A Deficiency	2.1
8	Zinc Deficiency	1.8
9	Iron Deficiency	1.2
10	Lack of Contraception	1.2

be fortified with iron and zinc, and vegetable oils and fats with vitamin A. The Breast Milk Substitutes Act implements the 'WHO International Code of Marketing of Breast Milk Substitutes' and puts restrictions on the promotion and sale of products that could be used as substitutes for breast milk.

Laws that improve nutrition are necessary, but in Kenya's case the lack of allocation of sufficient government resources to implement and regulate these laws has adversely affected their enforcement. For example, regarding the law on fortification, respondents reported low levels of compliance amongst small scale millers for whom the sourcing and storing of the required vitamins and minerals seems to present a problem. Additionally questions over the applicability of the legislation for those most in need were raised, since in many rural communities people are neither able to purchase the milled flour nor access a commercial miller. Many households often milled grains themselves.

4.3.3 KENYA'S COMMITMENT TO GLOBAL INITIATIVES ON NUTRITION

Kenya joined the SUN movement in 2012 to increase coordination and collaboration with stakeholders from the nutrition sensitive sectors. By joining the SUN initiative, nutrition stakeholders hoped to improve the nutrition outcomes through partnership

and inter-sectoral interventions. This has further driven the country's commitment to nutrition. By strengthening nutrition alliances and creating a forum for the exchange of ideas and experiences it has strengthened civil society's ability to hold the government to account.

Another important component of Kenya's success is the commitment of the First Lady to reduce child mortality and malnutrition. She established the Beyond Zero Campaign in 2014 to strengthen HIV control and improve maternal, new-born and child health. Her successful work as a champion for nutrition brought the opportunity to use the Beyond Zero campaign to advocate for the role of nutrition in reducing maternal and child deaths. Such high level commitment is essential to keep nutrition firmly on the political landscape.



... Even at counties level the SUN movement has been incorporated in county nutrition action plans...

4.3.4 COORDINATION OF NUTRITION STAKEHOLDERS THROUGH THE NATIONAL SUN COMMITTEE

There is close coordination among stakeholders within the nutrition sector. A partnership approach in designing interventions was evidenced by SUN stakeholder representatives who were interviewed. Moreover, the government regularly calls on development partners to support them while planning strategies, drawing on the particular strengths of the organisations in question. The collaborative functioning of the government and development partners improves planning and implementation of nutrition interventions.

Half of the Kenyan SUN Civil Society Organisations (CSOs) network consists of national organisations. However, some participants responded that these local organisations are not as involved with decision making as the international NGOs. International NGOs reportedly had a bigger say as they are recognised as having far more influence and knowledge of the global context. The local NGOs were valued due to their long term engagement with communities, but they felt that there was still a need to leverage their knowledge of national customs and contexts brought. This is an important concern as international parties often complete their project cycles and exit the country.

Furthermore, Faith Based Organisations (FBOs) account for a large portion of rural services but they are not heavily involved in planning and strategy discussions.



I suppose the other thing was the need for greater involvement of local NGOs and faith based organisations which often aren't so engaged in coordination mechanisms but actually are very important. Often the ones who've been there before were there 5 years ago, and will be there in five years' time. They are more integrated into the community

4.3.5 EXTERNAL DONOR SUPPORT TO SCALE UP NUTRITION SPECIFIC INTERVENTIONS

Donor funding has been increasing but historically it has been short term, meaning programmes have had to be formulated to be completed within short timescales, or risk losing funding partway through. This hinders the initiation of longer term interventions and sustainability of nutrition programmes. It also has an impact on human resource allocation. More importantly, programme objectives and outcomes become dependent on short term funding where indicators are tracked on the basis of them being achieved within the timescales allowed.

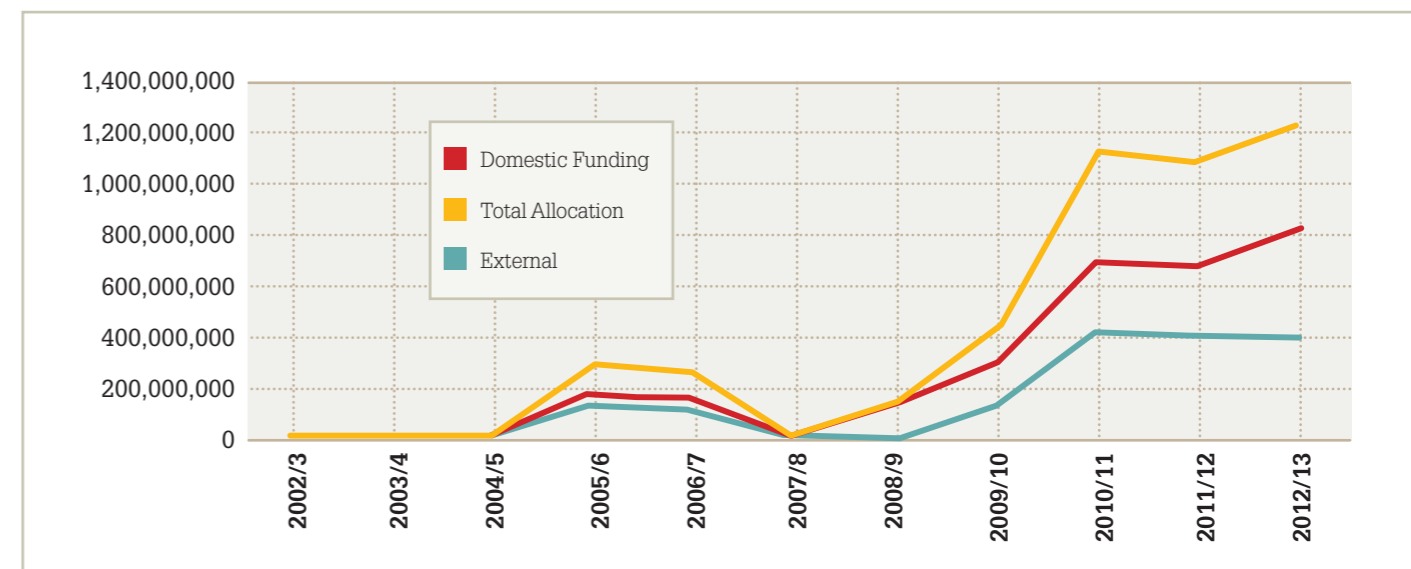
On the ground, heavy reliance on donor funds is apparent. Some health workers expressed their frustrations as their priorities were not reflected in the funding that they received.



The supply of external resources is actually donor directed... they give resources for HIV. They're hesitant to give for ... other priorities.

The external support for nutrition and health interventions remains high (see Figure 2). The funding however is largely focused on interventions such as the management of Severe Acute Malnutrition (SAM), reflecting in geographic coverage rates of 100%. The UK government's Enhancing Nutrition Surveillance, Response, and Resilience (ENSuRRe) programme (2012-2016) seeks to enhance nutrition surveillance and provide essential high impact nutrition interventions such as treatment for SAM

FIGURE 2: NUTRITION SPECIFIC FUNDING ALLOCATION IN KENYAN SHILLINGS⁸⁸



and micronutrient supplementation for women and children in Arid and Semi-Arid Lands (ASALs). In 2015, the EU contributed €19 million to UNICEF for a four year programme to improve nutrition and strengthen resilience for the most deprived populations in the country. This has led to the government recently launching its new Maternal and Child Nutrition Programme.

In discussing the motivation for projects and the possible conflict between priorities of the government versus those of the parent organisation, the majority of the time alignment of interventions with priorities of the government was deemed to be good. However, there is a need for scaling up the package of high impact interventions rather than just a few of them, and increase focus and support for nutrition sensitive programmes to ensure longer lasting impacts from external support.

4.3.6 COMMUNITY ENGAGEMENT

Respondents reported that community engagement to implement nutrition interventions such as micronutrient supplementation has had some success. However, lack of proper data on this has hindered the measurement of its impact. Engaging the communities helps to ensure that the interventions being prioritised take their needs into consideration. This can improve acceptance, and plays a role in strengthening relations between the health workers delivering interventions and their communities. Efforts to sensitise communities

on the importance of nutrition included painting messages on rocks beside roads, and radio and television advertising. Respondents also remarked that nutrition education imparted through school nutrition programmes in Western Kenya was beneficial as it rapidly transferred to the parents. Additionally, community support groups such as mother's groups were also commended for disseminating nutrition information across villages.

4.4 CHALLENGES TO SCALING UP NUTRITION

4.4.1 LACK OF NUTRITION FUNDING

In Kenya, the budgetary responsibility for nutrition lies with the Ministry of Health. At present the government is unable to meet the financial commitments required to roll out all the nutrition interventions set out within the NNAP. The health sector has been underfunded for decades despite government promises to increase spending to 15% of government expenditure in the 2001 Abuja Declaration. In 1990 health was allocated 5.4% of the government's expenditure. By 2012 it had only increased to 6%. The resources allocated within the health budget for nutrition are sustaining only a few nutrition specific interventions such as Vitamin A supplementation. According to the NHA 2012-2013⁸⁹, only 0.4% of the overall budget was spent on nutrition. Around half of the funding came from external donors, with no contribution from the private sector. A comparison of the costings for nutrition within the KHSSP against the NNAP highlights a large discrepancy in the budgets that

the MOH perceive are required for nutrition versus the nutrition unit's figures. Whilst the two plans cover different timescales, they do overlap, and the difference in scale is clear (see table 2).

TABLE 2: NUTRITION BUDGETS FROM THE NNAP & KHSSP^{90,91}

KES (millions)	2012/13	2013/14	2014/15	2015/16	2016/17	2018/18
NNAP	12,693	14,336	14,208	14,078	14,294	
KHSSP			4,386	4,607	4,849	5,070

To date the integration of the nutrition department within the MOH does not appear to be very strong, as suggested by the inclusion of nutrition within the KHSSP under the heading 'strengthen collaboration with health-related sectors'. This implies that nutrition is a separate function rather than an integral part of the health sector. The Kenyan Comprehensive Public Expenditure Review⁹², which guides national funding allocations, mentions nutrition only once within the section on health. Whilst nutrition is also contained within the 'Education', 'Agriculture and Rural Development' sections, allocation within these sectors and tracking of nutrition impact are weak.

4.4.2 LACK OF INTER-SECTORAL PLANNING AND INTEGRATION

Most respondents cited the lack of nutrition sensitivity as a gap in the NNAP and emphasised the need for greater collaboration with other sectors. They recommended the inclusion of nutrition indicators within nutrition sensitive programmes. Some felt that there were good linkages with the agriculture sector, as it catered to improving food security and livelihoods, but others felt that the agricultural sector were not prioritising engagement in nutrition interventions which fell outside their remit.

Nutrition sensitive interventions should be funded, implemented, managed, and monitored by the respective sectors. For example, the food security and livelihoods programmes are run by the Ministry of Agriculture, WASH interventions by the Ministry of Water and the Environment, and the Hunger Safety Net Programme implemented by the National Drought Management Agency (NDMA), all of which impact on nutrition. There is recognition that the linkages between nutrition and these sectors are important, as seen through the Food and Nutrition Security Policy of the Ministry of Agriculture⁹³. The NDMA's cash transfer Hunger Safety Net Programme, supported with funding from the

UK and Australian governments, aims 'to reduce poverty, food insecurity and malnutrition'⁹⁴. However, these sectors and their programmes do not track nutrition outcome indicators, and they also do not have a specific allocation to nutrition interventions.

4.4.3 LACK OF TECHNICAL CAPACITY

Kenya has around one health worker per 1000 population. Most of these work in urban areas resulting in inequity in coverage of services with skilled attendants. To reach 80% of the population with an essential health package they would need to have 2.5 health workers per 1000. At present Kenya is struggling to roll out interventions such as Iron and Folic Acid (IFA) to pregnant women to address anaemia, and zinc as a therapeutic intervention for children suffering from diarrhoeal episodes. Few counties have skilled health workers with nutrition experience or nutritionists. Kenya needs to develop a nutrition human resource strategy with a gap and distribution analysis, to ensure they train and retain sufficient numbers of nutrition specialists.

4.4.4 INADEQUATE DATA & SURVEILLANCE FOR NUTRITION

Timely and frequent nutrition data is necessary to guide nutrition priorities in Kenya. Surveys such as the DHS are conducted only every few years and the time gap between two surveys is too long to identify changing trends in nutrition. Nutritional assessment needs to be integrated into health systems and rolled out to all counties and communities. Data collection techniques need to be simplified and should integrate nutrition indicators such as Mid Upper Arm Circumference (MUAC) measurements for early detection of wasting, and assessment of micronutrient status. Data collected should also be disaggregated and should report on both process and impact indicators. Systems for the data collection and analyses need to be strengthened.

4.4.5 FAILURE IN SUPPLY CHAIN FOR NUTRITION SPECIFIC INTERVENTIONS

Recording of nutrition and health interventions, such as the number of vitamin A doses distributed, was found to be a problem. Coverage rates were reportedly lower than would be expected based on the quantities supplied. Improvement in the logging of doses would not only provide better data for programme planning but would also help to alleviate some of the supply chain issues related to micronutrient powders

and supplements. Provision of micronutrients composed a significant proportion of the cost of the NNAP's strategic objectives. Thus, a mismatch between supply and coverage, and delays in delivering micronutrient powders resulted in frustration as micronutrient sachets often expired or in other cases stock-outs were commonly reported. Respondents were unable to determine the cause of the supply failures, but comments reflected worsening of the situation post devolution.

4.4.6 THE PROBLEMS POSED BY DEVOLUTION

Some respondents considered that devolution of the country into the 47 counties has complicated the nutrition resource allocation situation, as budgetary allocations within counties are now dependant on county prioritisation systems and financial management. Although county governors control the budgets, not all governors are sensitised on the burden of malnutrition and the need to prioritise nutrition expenditure. Thus, county health and nutrition budgets are often planned based on inadequate health and nutrition awareness or data. Moreover, there is a misperception that external donors will continue to invest in efforts to tackle malnutrition. Given the competition between several development priorities, it becomes a challenge to allocate sufficient resources to nutrition, even though nutrition underpins many other development priorities. There was also an expression of disappointment about the absence of an accountability mechanism to track commitment to nutrition at county level, and respondents said that high profile projects such as international airports were favoured over investment in nutrition improvements.



Legislators at county level do not have experience and funds are politicised so allocation of funds isn't appropriate.

The fact that benefits of infrastructure expenditure are more easily demonstrable to the voting public than less tangible health and nutrition outcomes was obvious.



Infrastructure is easy because it's tangible - you can see if a road has been built. It's harder to prove to citizens that you're doing something if money is being spent on health and nutrition.

Moreover, some conflicts of opinion were observed regarding funding for the ASAL regions in north Kenya. The broad consensus was that these counties have received food aid for decades without improvement of the underlying issues, and it is to these recurrent "emergencies" that the majority of government funding is directed. Respondents agreed that action was required in these counties, but frustrations were expressed towards the focus on short term curative fixes, rather than attempting to identify and rectify the underlying causes and adopt long term sustainable interventions to improve nutrition

4.5 DISCUSSION

Kenya has done well to prioritise nutrition in the national agenda through well-structured and coherent policies. Moreover, high level commitment is reflected in the First Lady's support to nutrition and child health. Collaboration and cooperation within the nutrition sector was found to be extremely strong, with a good level of communication and respect amongst nutrition professionals interviewed. The involvement of the SUN movement in the country was largely perceived to have been a positive influence, strengthening the efforts of the Nutrition Department and bringing together stakeholders. Devolution is paving the way for bringing decision-making closer to the communities being served, but county governors often lack adequate awareness on nutrition, which results in inadequate allocation of resources. Furthermore, there are no proper mechanisms to hold devolved authorities to account for their commitments to nutrition. Community engagement has been reported to improve the outreach of interventions such as micronutrient distribution in some regions in Kenya, although the lack of record keeping and data collection has hindered the measurement of its impact. Lack of funding is the biggest barrier to improvement in nutrition, with insufficient capital available to meet the goals set by the government under the NNAP.

4.6 RECOMMENDATIONS

4.6.1 RECOMMENDATIONS FOR THE GOVERNMENT OF KENYA

- ◆ Increase financial resources for nutrition at national and county levels: an overarching committee should be established under the office of the president, to ensure inter-sectoral planning and budgeting for nutrition. The health budget itself needs to be increased to 15% in

5 | SUMMARY

compliance with the Abuja declaration, with an increase in nutrition specific funding from the existing 0.4%. Nutrition interventions need to be included into the essential health care package to improve sustainable financing for them.

- ◆ The national budget should use the MTP indicators to develop its five year government budget, highlighting gaps in resources needed to implement the MTP and bridging this gap with additional resources.
- ◆ Strengthen budgetary tracking for nutrition: The NHAs and Public Expenditure Reviews should include specific nutrition lines to enable national tracking of resources from internal and external sources at all levels.
- ◆ Improve nutrition surveillance: The government and partners need to ensure collecting more effective data on nutrition intervention coverage and outcomes to help address challenges such as stock-outs of micronutrient supplements, and identify priority areas based on nutrition outcomes.
- ◆ Build human resource capacity for nutrition: Improve awareness and develop planning skills of county level authorities. Build capacities of community health workers for more effective delivery of nutrition services, and increase the number of health workers.
- ◆ Involve local NGOs, FBOs, CSOs, community health workers and communities themselves in decision making.

4.6.2 RECOMMENDATIONS FOR DONORS

- ◆ External donors should support long term funding for nutrition, rather than short term project cycles and funding. Furthermore, donors need to increase funding for nutrition sensitive programmes which track nutrition impact through measurable indicators.
- ◆ Scaling up targeted interventions for improving nutrition, such as those for IYCF, RUTFs & micronutrient supplementation, ensuring they impact on hard to reach populations
- ◆ Health systems interventions research needs to be allocated resources to ensure that barriers to the acceptability and usage of nutrition services are identified and addressed. The enforcement and impact of the two new laws on fortification and baby milk substitutes should also be assessed.

The countries in this study demonstrate that success in tackling malnutrition, particularly in reducing under-nutrition, is achievable. These countries have faced multiple and overlapping burdens of malnutrition but have adopted structured policies and contextual approaches that have contributed to impressive declines in stunting, wasting, and to an extent in micronutrient deficiencies. There are common themes that emerge from the efforts taken to improve nutrition in these three countries, which provide valuable insight to other countries struggling to make progress against malnutrition.

However, it must also be acknowledged that these countries also face challenges that threaten sustainable improvement in nutrition, and which could also reverse progress made to date.

5.1 KEY DRIVERS OF SUCCESS FOR NUTRITION

5.1.1 NUTRITION ON THE NATIONAL AGENDA: POLICY, INFRASTRUCTURE AND LEGISLATIVE ENVIRONMENT

Well defined national policies and strategies for nutrition endorsed by high level political authority, will ensure nutrition is not relegated to a lower priority. Additionally, setting up infrastructure dedicated to nutrition such as the NIN in Vietnam, guides policy, programmes, and research, develops partnerships and helps streamline efforts to tackle malnutrition.

Key legislations such as the 'Mandatory Food Fortification' in Kenya, and the 'Labour code' in Vietnam strengthen positive nutrition practices in the community, and improve compliance by various stakeholders. However, enforcement of these laws should be monitored. In the case of initiatives such as fortification, governments should provide support to bring small scale producers and encourage large scale producers through incentives or resources to ensure sustainability and adherence, and improve coverage to remote communities.

5.1.2 STRENGTHENING CAPACITIES: NATIONAL, SUB-NATIONAL, AND COMMUNITIES

This is particularly relevant in decentralised governance structures. Planning for nutrition and budgetary allocations must not just be undertaken at the centre, but also the sub-national provincial, district or county levels. Sub-national authorities must be sensitised on malnutrition in their respective areas of gov-

ernance, and supported in drafting plans with the involvement of nutrition specific, as well as nutrition sensitive actors such as agriculture, WASH etc. These plans should be reinforced with resource allocation to scale up nutrition interventions across sectors, and monitored across all sectors to track progress.

Additionally, raising the awareness of community workers on nutrition and providing necessary support to deliver interventions helps to build human resource capacity for nutrition. As seen in Kenya, this contributes to improved coverage of interventions delivered to the community.

5.1.3 COMMITMENT TO GLOBAL INITIATIVES: SUN MOVEMENT, UN ZERO HUNGER CHALLENGE

Across all three countries a formal sign up to initiatives such as the SUN movement, and the UN Zero Hunger challenge has been useful in establishing commitment to nutrition both globally and in-country. Such commitment encourages domestic efforts to improve nutrition.

These initiatives also provide valuable guidance on development of multi-sectoral nutrition policies, costed plans for nutrition to guide resource allocation, and strengthen advocacy on nutrition. These platforms also provide opportunities for cross-learning by sharing progress and challenges, and help to identify solutions. Through the various SUN networks, stakeholders are also sign-posted to potential funding to scale up efforts to tackle malnutrition.

5.1.4 EQUITY: NUTRITION FOR ALL

Inequitable nutrition outcomes based on regions, ethnicities and income groups were prevalent across all three countries. Governments must use disaggregated data to identify regions with the poorest nutrition outcomes and identify the reasons for this. Thereafter, nutrition interventions must focus on the most backward regions and target the hardest to reach communities, which often bear the greatest burden of malnutrition, ill health, and poverty. Data on MDGs progress shows that children from rural and poorest households are at the very least twice as likely to be stunted as children from urban and the richest households⁹⁵. For progress in tackling all forms of malnutrition, resources and interventions must be directed in a way that results in improvements for all.

5.1.5 FINANCING FOR BETTER NUTRITION

Policies and strategies are ineffective if they are not backed with the resources required to put them into action. In Vietnam, budgetary cuts for targeted programmes have threatened sustainability of nutrition programmes. Furthermore, declining donor funding weakens the efforts in these countries, and increases the risk of a reversal of current progress.

Domestic resource mobilisation for nutrition in the national and sub-national level budgets is essential, and governments should ensure nutrition has a budget line that goes beyond the health budget. Donors must also recognise that ODA will continue to play a significant role in bridging the funding gap for nutrition. Bilateral and multilateral support for nutrition should be based on the burden of malnutrition in these countries rather than on the basis of a country's income-status categorisation. Governments should at the very least double their domestic spending on nutrition, whilst donors would have to quadruple their nutrition investments for the WHA targets to be achieved.

The N4G summit in 2016 in Rio is an opportunity for governments to step forward with Specific Measurable Assignable Realistic and Time bound (SMART) action plans and new commitments to nutrition that will help accelerate progress against achieving all of the WHA targets.

5.1.6 FINANCIAL TRACKING FOR NUTRITION ACROSS ALL SECTORS

There is an urgent need to scale up global resources for nutrition, but it is imperative to ensure transparent tracking of nutrition budget lines within health and allied sectors. This is necessary to assess nutrition impact and determine cost effectiveness of initiatives. It also helps hold allied sectors to account for inaction. Moreover, this helps to share in agreement the responsibility of improving nutrition, which should not just fall within the remit of the health ministry. Finally, it leads to higher gains for nutrition overall, as only 20% stunting improvements can be achieved through nutrition specific interventions. Financial allocation and tracking are made simpler when measurable nutrition objectives and indicators are included during policy planning stages.

Governments should reaffirm re-affirm SMART actions at Rio. Such commitments facilitate more accurate tracking and report-

ing, and also improve reliable data which further strengthens accountability for such commitments.

5.1.7 NUTRITION SURVEILLANCE: DATA FOR EVIDENCE AND ACTION

Data is critical. Frequent and routine disaggregated data on key nutrition outcomes are useful for assessing nutrition trends, identifying gaps, and guiding prioritisation of resources to achieve equitable nutrition outcomes. Furthermore, data drives accountability and supports advocacy as it strengthens the civil society voice to hold their governments to account for commitment to nutrition. Sub-national data on nutrition from Uganda and the setting up of the annual nutrition surveillance system in Vietnam are examples of good data systems that steer efforts on nutrition in the right direction. The international community adopted the six WHA targets in 2012 to accelerate global efforts for tackling malnutrition. Governments should strengthen data systems so as to track progress towards reaching these targets.

5.1.8 OFFICIAL RECOGNITION OF MULTI-STAKEHOLDER PARTNERSHIPS

Challenges in establishing multi-stakeholder partnerships and implementing integrated interventions for nutrition were reported across the three countries. However, success has been achieved in Vietnam in the form of its nutrition cluster partnership group, and through SUN civil society alliances in Uganda and Kenya. According official status to multi-stakeholder groups for nutrition, and making mandatory the involvement of various stakeholders contributes to improved sensitisation and participation of all relevant actors. Furthermore, a high level government authority as chair and housing the coalition/partnership within the office of high level political authority can ensure sustained coordination of efforts.

5.1.9 BRINGING NUTRITION INTERVENTIONS INTO THE ESSENTIAL HEALTHCARE PACKAGE

To promote sustainability, improve coverage and mitigate supply chain related challenges for essential nutrition specific interventions, they should be brought under the essential health care package. These include interventions such as RUTFs to rehabilitate SAM children, micronutrient supplements (such as IFA and Vitamin A) and fortified food (such as fortified salt, flour, or fats).

Irregular supplies and stock-outs of micronutrient supplements are a barrier in tackling micronutrient deficiencies in women and children in Kenya. Sustainability and expansion of the IMAM programme using RUTF in Vietnam was also dependent to a large extent on support from development partners. To address issues such as these, and prevent funding constraints from threatening sustainability of nutrition interventions, they should be integrated within the health and social insurance systems and viewed as fundamental to achieving universal health coverage.

5.1.10 FOSTER RESEARCH, INFORMATION SHARING AND CROSS LEARNING

Whilst evidence exists on high impact nutrition specific interventions that significantly reduce undernutrition in women and children, there is no 'one size fits all' strategy for how these should be delivered. Governments must therefore invest in the development of innovative solutions to tackle malnutrition. They should also focus on implementation research implementation research to explore how to reach the hard to reach populations with the most effective interventions. Adaptation of evidence based solutions to local contexts, such as the Vietnamese adaptation of RUTF for management of severely wasted children, plays a vital role in the success of nutrition initiatives.

5.1.11 SUPPORT TO ADVOCACY EFFORTS

Civil society plays an important role holding governments and other stakeholders to account for their actions. In Uganda, securing funding from the Multi Partner Trust Fund has created a greater enabling environment for better and more coordinated advocacy. A strong relationship between the government, other nutrition stakeholders, and civil society has resulted in more government transparency and commitments where it is prioritising, planning and budgeting for nutrition and committed to annual accounting on the progress made on child undernutrition. Additionally, SMART commitments to nutrition will ensure more accurate tracking and reporting and therefore more reliable data for civil society and key stakeholders to hold their governments to account. Civil society must continue to be supported to advocate for improved nutrition on behalf of the communities that may otherwise not be heard and to hold the government to account for policies and commitments it makes.

END NOTES

- [1] UNICEF (2013). *The right ingredients: the need to invest in child nutrition*. Accessed 13 July 2015. Available at http://www.unicef.org.uk/Documents/Publication-pdfs/UNICEFUK_ChildNutritionReport2013w.pdf
- [2] United Nations (2015) *The Millennium Development Goals Report*. Accessed 27 September 2015. Available at [http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%2015\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%2015).pdf)
- [3] FAO, WFP, IFAD (2015). *The State of Food Insecurity in the World*. Accessed 25 September 2015. Available at <http://www.fao.org/3/a-i4646e.pdf>
- [4] UNICEF (2015). *Progress for Children. Beyond Averages: Learning from the MDGs*. Number 11. UNICEF 2015 Accessed 14 September 2015. Available at [http://www.unicef.org/lac/Progress_for_Children_No._11_22June15\(2\).pdf](http://www.unicef.org/lac/Progress_for_Children_No._11_22June15(2).pdf)
- [5] International Food Policy Research Institute (2015). *Global Nutrition Report 2015: Actions and Accountability to Advance Nutrition and Sustainable Development*. Washington DC
- [6] WHO, UNICEF, The World Bank (2015). *Levels and trends in child malnutrition (2015)*. Key findings of the 2015 edition
- [7] Horton S and Steckel RH (2013) *Malnutrition: Global economic losses attributable to malnutrition 1900-2000 and projections to 2050*. In *How much have global problems cost the earth? A scorecard from 1900 to 2050* by B.Lamborg, 247-272 Cambridge University Press
- [8] WHO (2015). *Iron Deficiency Anaemia*. Accessed 20 September 2015. Available at <http://www.who.int/nutrition/topics/ida/en/>
- [9] 4
- [10] 5
- [11] Horton S, Shekar M, McDonald C, et al. (2010). *Scaling up Nutrition: What will it cost?* The World Bank
- [12] Horton S. and R. Steckel (2013). "Global Economic Losses Attributable to Malnutrition 1900-2000 and Projections to 2050." In *The Economics of Human Challenges*, ed B. Lomborg. Cambridge, U.K. Cambridge University Press.
- [13] International Food Policy Research Institute (2014). *Global Nutrition Report 2014: Actions and Accountability to Accelerate the World's Progress on Nutrition*. Washington, DC
- [14] Black RE, Victora CG, Walker SP et al. (2013). *Maternal and Child Undernutrition and overweight in Low-Income and Middle-Income Countries*. *The Lancet* 382.9890 (2013): 427-451
- [15] Bhutta Z, Das J, Rizvi A et al. (2013) *Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?* *The Lancet* 382.9890 (2013): 452-477
- [16] The World Bank Group, Results for Development, Children's Investment Fund Foundation, 1000 days, Bill and Melinda Gates Foundation (2015) *Reaching the Global Target to Reduce Stunting: How Much Will it Cost and How Can We Pay for it?* Accessed 16 July 2015. Available at <http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/8/460861439997767818/Stunting-Costing-and-Financing-Overview-Brief.pdf>
- [17] Development Initiatives (2013) *The Aid Financing Landscape for Nutrition*. Accessed 08 August 2015. Available at <http://devinit.org/wp-content/uploads/2013/07/Development-Initiatives-Nutrition-Report-April-20131.pdf>
- [18] 13
- [19] 5
- [20] 5
- [21] The World Bank (2012). *Well Begun, Not yet done: Vietnam's remarkable progress on poverty reduction and the emerging challenges*. Vietnam Poverty Assessment.
- [22] Socialist Republic of Vietnam (2013). *Achievements and Challenges in the Progress of Reaching Millennium Development Goals of Vietnam*. Millennium Development Goals

Full Report. Accessed 10 July 2015. Available at http://www.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/Viet%20Nam/MDG_FullReport_Final%20approved.pdf

[23] Curtis (2011). *Country successes in reducing hunger. How they did it, and why other donors and governments should change policy*. Accessed 13 July 2015. Available at http://www.actionaid.org/sites/files/actionaid/country_successes_in_reducing_hunger_mark_curtis_nov_2011_0.pdf

[24] Somanathan A et al. (2014). *Moving towards Universal Coverage of Social Health Insurance in Vietnam. Assessment and Options*. The World Bank

[25] UNICEF, WHO, The World Bank (2014). *Levels and Trends in Child Mortality. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*.

[26] *Maternal Mortality in 1990-2013*. WHO, UNICEF, UNFPA, The World Bank, and United Nations Populations Division Maternal Mortality Estimation Inter-Agency Group. Accessed 21 July 2015. Available at http://www.who.int/gho/maternal_health/countries/vnm.pdf?ua=1

[27] 26

[28] *Alive & Thrive, VDD, UNICEF (2013) Nationwide Nutrition profile, 2013*. Accessed 10 July 2015. Available at <http://viendinhduong.vn/FileUpload/Documents/Nutrition%20Profile%202013/E01n2013-0-Nationwide.pdf>

[29] 26

[30] 28

[31] 22,26

[32] *National Nutrition Strategy 2011-2020, with a vision toward 2030*. Hanoi, February 2012

[33] PMNCH, WHO, World Bank and AHPSPR. (2014). *Success Factors for Women's and Children's Health: Policy and programme highlights from 10 fast-track countries*. Geneva: WHO.

[34] Khoi HH, Giay T, and Khan NC (year unavailable). *20 years of the National Institute of Nutrition. Achievement and Perspectives*. Ministry of Health. National Institute of Nutrition. Medical Publishing House

[35] Bhutta Z, Das J, Rizvi A et al. (2013) *Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?* *The Lancet* 382.9890 (2013): 452-477

[36] *Scaling Up Nutrition (2014). Effectively Engaging Multiple Stakeholders*. Accessed 16 July 2015. Available at <http://scalingupnutrition.org/wp-content/uploads/2014/03/Sun-in-Practice-issue-1.pdf>

[37] 35

[38] *Phuong H. et al. (2014). Development and implementation of a locally produced ready-to-use therapeutic food (RUTF) in Vietnam*. *Food and Nutrition Bulletin*, vol. 35, no.2 (supplement)

[39] 28

[40] Ministry of Health, National Institute of Nutrition, UNICEF (2010). *Vietnam General Nutrition Survey 2009-10*

[41] UNICEF East Asia Pacific Website. *Mass media campaign on exclusive breastfeeding and complementary feeding to reduce rates of stunting and malnutrition in Vietnam*. Accessed 13 July 2015. Available at http://www.unicef.org/eapro/media_17850.html

[42] 40

[43] United Nations, Vietnam (2012). *Achieving the MDGs with Equity. MDG1: Eradicate Extreme Poverty and Hunger*. Accessed 12 July 2015. Available at http://www.vn.undp.org/content/dam/vietnam/docs/Publications/30162_MDG_1.pdf

[44] 22

[45] 40

[46] 28

[47] *Alive & Thrive*, VDD, UNICEF (2013) South East Region, Nutrition Profile, 2013. Accessed 10 July 2015 Available at <http://viendinhduong.vn/FileUpload/Documents/Nutrition%20Profile%202013/Southeast/E02r2013-5-South%20East.pdf>

[48] Ho Chi Minh City. *National Nutrition Profile* (2013). Accessed 05 August 2015. Available at <http://viendinhduong.vn/FileUpload/Documents/Nutrition%20Profile%202013/Southeast/E03p2013-701-Ho%20Chi%20Minh%20city.pdf>

[49] 40

[50] 5

[51] *Top Ten Recipients of ODA. Gross Bilateral ODA 2012-2013 average*. Accessed 27 July 2015 . Available at https://public.tableau.com/views/AidAtAGlance/DACmembers?:embed=y&display_count=no&showVizHome=no#1

[52] Berliner T, Thanh DK, McCarty A (2013). *Inequality, poverty reduction and the Middle Income Trap in Vietnam*. Accessed 25 July 2015. Available at <http://mekongconomics.com/dev/images/stories/FILE%20PUBLICATIONS/EU%20Blue%20Book.pdf>

[53] *Delegation of the European Union to Vietnam. Aid effectiveness*. Accessed 25 September 2015. Available at http://eeas.europa.eu/delegations/vietnam/eu_vietnam/tech_financial_cooperation/aid_effectiveness/index_en.htm

[54] *EU Cooperation in Viet Nam: An enhanced response to the development challenges. The Multiannual Indicative Programme for Viet Nam 2014 – 2020*. Accessed 25 September 2015 . Available at http://eeas.europa.eu/delegations/vietnam/documents/eu_vietnam/20141113_mip_en.pdf

[55] *Uganda Country Profile, Global Nutrition Report (2014)* Accessed 05 August 2015. Available at http://globalnutritionreport.org/files/2014/12/gnr14_cp_uganda.pdf

[56] 5

[57] *Uganda Bureau of Statistics and Macro International Inc (2011), Uganda Demographic and Health Survey*.

[58] *Uganda Bureau of Statistics and Macro International Inc (2011), Uganda Demographic and Health Survey*

[59] *African Union and WFP (2013), The Cost of Hunger in Uganda; Implications on National Development and Prosperity*

[60] *FANTA Project (2014) Uganda Agriculture Brief Profile* Accessed 16 September 2014. Available at http://www.fantaproject.org/sites/default/files/resources/Uganda-AGRICULTURE-brief-PROFILES-Sep2014_0.pdf

[61] *Poverty Status Report (2014). Structural change and poverty reduction in Uganda. Economic Development Policy and Research Development. Ministry of Finance, Planning and Economic Development. November 2014*

[62] 5

[63] *USAID SPRING website*. Accessed 25 August 2015. Available at <https://www.spring-nutrition.org/publications/briefs/factors-affecting-nutrition-around-uganda>

[64] *Nutrition for Growth Commitments. Executive summary* (2013). Accessed on 08 August 2015. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207271/nutrition-for-growth-commitments.pdf

[65] *USAID Pathways to better nutrition case studies*. Accessed 28 July 2015. Available at <https://www.spring-nutrition.org/about-us/activities/pathways-better-nutrition-case-studies>

[66] *Reducing Malnutrition in Uganda: Estimates to Support Nutrition Advocacy. Uganda PROFILES (2013). The Republic of Uganda. Office of the Prime Minister*.

[67] 60

[68] *Southern Africa Trust Initiative (2015). Creating Linkages between Research, Advocacy and the Media for Pro-Poor Policy Change in Africa*. Accessed 06 October 2015. Available at <http://www.southernafricatrust.org/wp-content/uploads/2015/07/Report-Partnerships-for-Pro-Poor-Policy-Change-in-Africa.pdf>.

[69] *Draft Nutrition Advocacy and Communication Strategy for the Uganda Nutrition*

Action Plan 2014-2018

[70] *Uganda Action for Nutrition (UGAN) society* <http://www.ugansociety.org/nutrition-dialogue-kiryandogo-district/>

[71] 55

[72] *The World Bank*, 2015

[73] 5

[74] *Kenya Demographic and Health Survey 2014. Kenya National Bureau of Statistics et al. March 2015*. Accessed 12 October 2015 Available at <https://dhsprogram.com/pubs/pdf/PR55/PR55.pdf>

[75] *Kenya National Nutrition Action Plan 2012-2017*. Accessed 02 October 2015. Available here <http://scalingupnutrition.org/wp-content/uploads/2013/10/Kenya-National-Nutrition-Action-Plan-2012-2017-final.pdf>

[76] *Kenya country profile. Global Nutrition Report (2014)* Accessed 12 October 2014. Available at http://globalnutritionreport.org/files/2014/12/gnr14_cp_kenya.pdf

[77] 76

[78] 74

[79] 76

[80] 76

[81] *Kenya Vision 2030*. Accessed 12 October 2015. Available at http://www.vision2030.go.ke/wp-content/uploads/2015/06/Popular_Version1.pdf

[82] *The Constitution of Kenya, Published by the National Council for Law Reporting with the Authority of the Attorney General*. Accessed 11 October 2015. Available at <https://www.kenyaembassy.com/pdfs/The%20Constitution%20of%20Kenya.pdf>

[83] *The Kenya Health Sector Strategic and Investment Plan (KHSSP) July 2014 – June 2018. Ministry of Health. Government of Kenya*. Accessed on 27 July 2015. Available at <http://www.health.go.ke/images/policydocs/KHSSP%20BOOK-edited.pdf>

[84] *Ministry of Health. Kenya Health Policy 2014-2030. Nairobi: Ministry of Health*. Accessed 27 July 2015: <http://www.health.go.ke/images/policydocs/KHP%20Final%20booklet.pdf>

[85] 84

[86] *UNICEF Annual Report 2012 for Kenya, ESARO. New York*. Accessed 12 October 2015 http://www.unicef.org/about/annualreport/files/Kenya_COAR_2012.pdf

[87] 75

[88] *Ministry of Health, Nutrition Department, Pers. Comm, 01 July 2015*

[89] *Kenya National Health Accounts 2012/13. Nairobi: Ministry of Health*. Accessed 12 October 2015 <http://www.health.go.ke/images/downloads/Kenya%202012.13NHA.pdf>

[90] 75

[91] 83

[92] *Ministry of Devolution and Planning (2013). Kenya Vision 2030. Second Medium Term Plan(2013-2017). Transforming Kenya: Pathway to Devolution, Socio-economic development, equity and national unity. Republic of Kenya*. Accessed 12 October 2015 http://www.vision2030.go.ke/wp-content/uploads/2015/06/Second_Medium_Term_Plan_2013_-_20172.pdf

[93] *National Food and Nutrition Security Policy (2011). Agriculture Sector Coordination Unit. Government of Kenya*. Accessed 12 October 2015 <https://extranet.who.int/nutrition/gina/sites/default/files/KEN%202011%20National%20Food%20and%20Nutrition%20Security%20Policy%5B1%5D.pdf>

[94] *Hunger Safety Net Programme (2015). National Drought Management Agency (NDMA)*. Accessed 12 October 2015 http://www.hsnp.or.ke/filedownload.php?download_file=HSNP1_Presentation.pdf

[95] 4

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