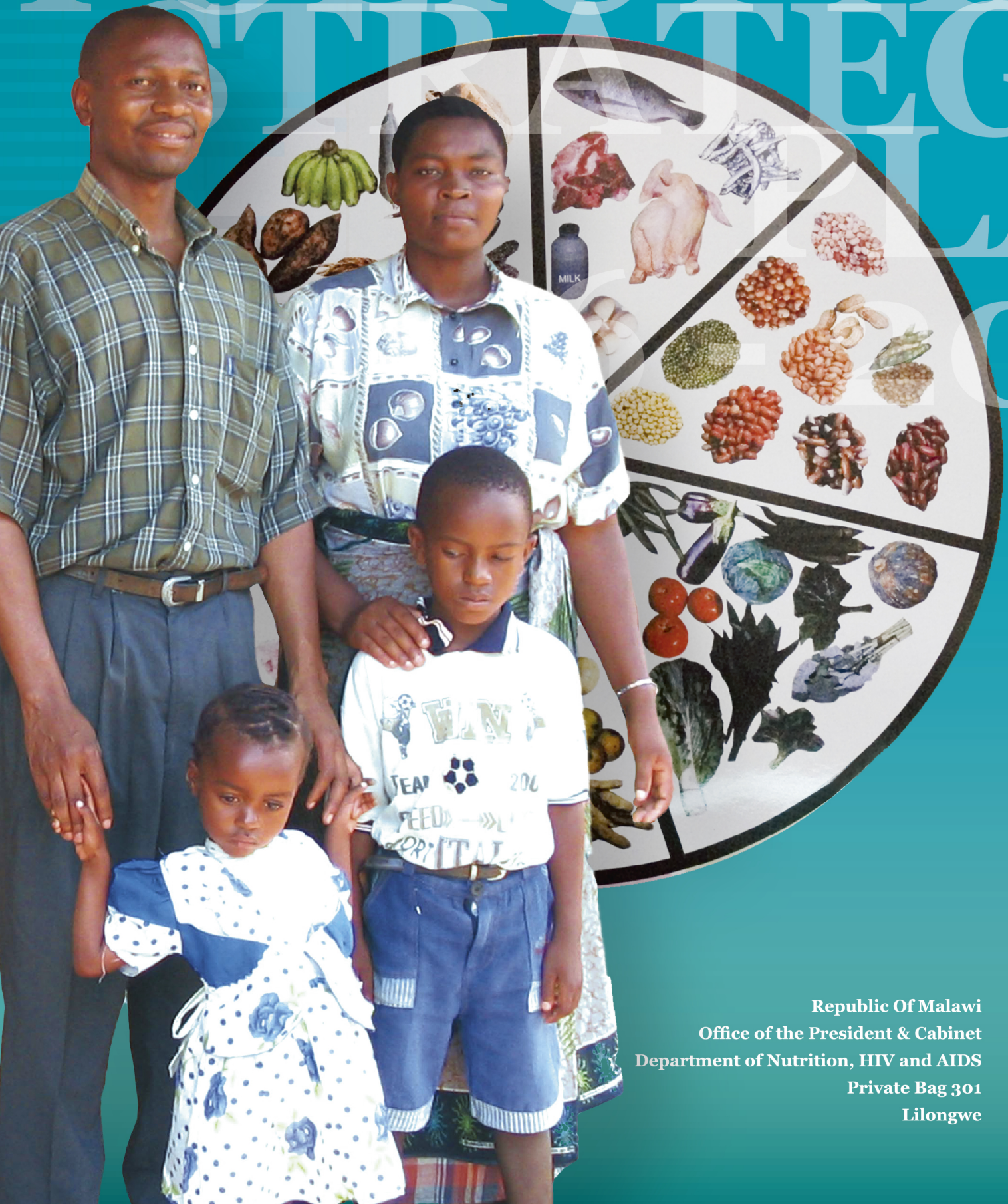
Office of the President and Cabinet

NATIONAL NUTRITION POLICY & STRATEGIC PLAN

2007 - 2012



Republic Of Malawi
Office of the President & Cabinet
Department of Nutrition, HIV and AIDS
Private Bag 301
Lilongwe

His Excellency Ngwazi Dr. Bingu wa Mutharika
President of the Republic of Malawi

FOREWORD

Adequate nutrition is a pre-requisite for human development. Improving the nutritional status of the people of Malawi is therefore, one of My Government's top priorities. My Government has developed the 'National Nutrition Policy and Strategic plan (NNPS) which will guide the implementation and provision of nutrition services, interventions, programmes and projects in the country for the period of five years running from July 2006 to June 2011.

The goal of the policy is to facilitate the improvement of the nutritional status of all Malawians, with emphasis on pregnant and lactating women, children below the age of 15 years, people living with HIV, people in emergency situations and other vulnerable groups as shall from time to time be defined or identified. The Policy is intended to provide guidance and direction; create awareness on the magnitude of the nutrition problems and their impact on the individual, household and national economic development, growth and prosperity; and galvanise the nation towards the achievement of acceptable or adequate levels of nutrition for women and children will improve child survival, growth and development and human capital development, which are fundamental prerequisites for economic growth. The Policy is, therefore, an important stepping stone for moving the country from poverty to prosperity.

My Government developed the National Nutrition Policy having noted that the Food Security and Nutrition Policy of 1990 and other development policies that contain elements of nutrition did not give adequate attention to nutrition programmes and services. Additionally, nutrition services delivery was not well coordinated, resulting in vertical implementation of activities by various stakeholders, with little or no impact on communities. The new policy is therefore a government tool for the mobilization of an ***integrated nutrition fund***, standardization, coordination and improvement of the quality of nutrition services delivery.

The policy intended to operationalise the implementation of the Malawi Growth and Development Strategy (MGDS). The Cabinet directive of February 2005 mandated the Department of Nutrition, HIV and AIDS in My Office to champion and lead the development process and implementation of the **"National Nutrition Policy"**, and improve visionary policy direction and guidance, coordination, capacity building, resources mobilization, establishment of implementation structures, supervision, monitoring and evaluation.

I am confident that by now everybody is aware that nutrition is a crosscutting issue with economic, socio-cultural, political and biomedical dimensions. In order to achieve the policy goals, it is therefore critical that all the sectors of the economy play their roles. I therefore call upon all Malawians, the public and private sectors, civil society and faith based organizations, and development partners, to support the implementation of the policy, and align their programmes, projects and interventions to it for a united response.

May God Bless Mother Malawi

Dr. Bingu wa Mutharika
PRESIDENT OF THE REPUBLIC OF MALAWI

PREFACE

Nutrition disorders continue to be a silent crisis in Malawi despite efforts by government and partners to improve the situation. This poses a serious challenge to the attainment of the national growth and development goals as set in the MGDS.

Currently, 48 percent of the under-five children are chronically malnourished (stunted), 5 percent have acute malnutrition (wasting) and 22 percent are underweight. Non-communicable nutrition related disorders such as overweight, obesity, hypertension, arthritis, gout, certain types of cancer and diabetes are becoming common and silently contributing to the high mortality rate in the country. Micronutrient deficiencies of vitamin A, iron and iodine are also high. Such high malnutrition levels have long term adverse effect on the intellectual and physical ability of an individual and undermine the individual's academic and professional achievement and productivity. Malnutrition, therefore, is one of the main factors responsible for the low human capacity development and economic growth in the country.

Malnutrition is one of the major contributing factors to the high morbidity rates among various population groups in the country. For example, in 2005 52% of under-five children mortality was due to malnutrition and enaemia contributes 57% to maternal mortality. Malnutrition is therefore major contributing factor to children, pregnant and lactating women and other vulnerable groups. At the current levels of nutrition disorders in the country, it is estimated that in every 4 seconds, a Malawian could be dying of a nutrition related problem (Bibi Giyose, NEPAD, 2005).

The National Nutrition Policy therefore, seeks to enhance Government's response towards the malnutrition crisis. It is intended to facilitate the standardisation; coordination and improvement of the quality

of nutrition services and in turn reduce the prevailing nutrition disorders to reasonable levels. The policy is expected to lead to the attainment of improved nutritional status and productivity among various population groups so that they contribute effectively to the economic growth and development of the country.

The National Nutrition Policy is accompanied by the national Nutrition strategy which describes the key focus areas, strategies, the strategic activities, targets to be achieved in the five years of implementation of the policy and the expected outcomes. It also spells out the institutional and resource requirements for the effective implementation of the policy and strategic plan. It further describes the institutional arrangements and framework as well as the key roles and responsibilities of stakeholders in operationalising the policy and strategic plan. The document has, therefore, been divided into a number of sections to provide proper guidance to the stakeholders.

The policy and strategic plan have three main focus areas which are:

1. The Prevention and control of various forms of nutrition disorders with a focus on pregnant and lactating women, children 0-2 years, under-five children, school aged children, people living with HIV, people in emergency situation and other vulnerable groups as may be defined from time to time.
2. Promoting access and quality of nutrition and related services to facilitate effective management of nutrition deficiency disorders among various population groups with a focus on under-five children, pregnant and lactating women, people living with HIV, adolescents and adults.
3. Creation of an enabling environment that adequately provides for the delivery of nutrition services and implementation of the nutrition programmes, projects and interventions.
4. The policy and strategic plan adopts the Essential Nutrition Actions and essential nutrition package approaches with clear linkage and integration of the high impact interventions that are

promoted through the Accelerated Child Survival programme and the Renewed Action to Ending Child Hunger and other relevant programmes to facilitate the prevention of various forms of nutrition disorders. The policy and strategy promotes scaling up of school feeding, health and nutrition interventions to all public primary schools. The policy is further focused on strengthening and increasing the coverage of nutrition related services such as vitamin A supplementation to children 6-59 months and lactating women within 8 weeks of child birth, Iron/folate supplementation to pregnant women, de-worming, food fortification and growth monitoring and promotion. It also adopts the Community Therapeutic Care for treatment of malnutrition in under-five children when there are no medical complications. The policy and strategic plan further maintains and strengthens the management of severe malnutrition in under-five children through Therapeutic Feeding in Nutrition Rehabilitation Units where the child presents with medical complications and where the CTC services are not available. Supplementary feeding to pregnant and lactating women and under-five children will also continue as part of the CTC, NRU and stand alone services as short term measures. In addition, the policy also promotes scaling up of the provision of nutrition treatment, care and support to people living with HIV and those in emergency situation. On the long term, the policy promotes the production of and access to high nutritive value foods for a diversified and varied diet while nutrition assessment and counselling; and education and demonstrations are to be a basis for sustaining the behaviour change. It is expected that all nutrition stakeholders in the country, and working in close collaboration with the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet, will use the policy and strategic plan to guide and direct them in designing and providing services, and implementing programmes and projects based on the national requirements and the defined priority areas.

Special tribute is paid to all the individuals who worked on the five documents namely; The Policy, Strategic Plan, Programme, Business Plan For Nutrition, HIV and AIDS and the Communication Plan. Acknowledgement is also due to those who merged the five documents into the current National Nutrition Policy and Strategic Plan. Special mention also goes to development partners who have assisted with the finalisation and printing of the document.

Dr. Mary Shawa

SECRETARY FOR NUTRITION, HIV AND AIDS

ACKNOWLEDGEMENT

The Office of the President and Cabinet (OPC), Department of Nutrition, HIV and AIDS spearheaded the development of the National Nutrition Policy and Strategic Plan through an extensive consultative process with stakeholders at all levels. The main purposes of the consultations was to analyse the prevailing nutrition situation in the country, to identify key issues that require special focus during implementation of Nutrition programmes, and also to ensure community participation and ownership of the Policy.

On behalf of the Office of the President and Cabinet the Department of Nutrition, HIV and AIDS, wish to sincerely acknowledge the great contributions and effort everyone made in the production of the National Nutrition Policy and Strategic Plan. The leadership provided by the Chief Secretary and the entire Office of the President and Cabinet, Cabinet Ministers and Principal Secretaries on Policy guidance and direction is acknowledged. Gratitude is paid to the teams that conducted the field consultations, drafted and reviewed comments after cabinet directives, worked with the consultants to consolidate and cost the Policy and including the one that proof read the document as a finalization process of the Policy.

Special thanks are extended to all who committed their resources to the development process of the Policy more especially, the Government of Malawi, UNICEF, UNDP, and individual institutions too numerous to mention, thank you all.

CONTENTS

LIST OF ABBREVIATIONS & ACRONYMS

ACSD	Accelerated Child Survival And Development
ADP	Agriculture Development Programme
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
BFHI	Baby Friendly Hospital Initiative
CAMA	Consumer Association Of Malawi
CHD	Child Health Days
CNHAO	Chief Nutrition, Hiv And Aids Officer
CSO	Civil Society Organisations
CTC	Community Therapeutic Care
DHS	Demographic Health Surveys
DIP	District Implementation Plans
DNCC	District Nutrition Coordination Committee
DPS	Development Partners
EBF	Exclusive Breastfeeding
EHP	Essential Health Package
ENA	Essential Nutrition Actions
EPI	Expanded Programme Of Immunisation
GESS	Genetically Engineered Seeds And Substances
GMO	Genetically Modified Organisms
HIV	Human Immunodeficiency Virus
IDD	Iodine Deficiency Disorders
IEC	Information, Education, Communication
IMCI	Integrated Management Of Childhood Illnesses
ITN	Insecticide Treated Net
KCN	Kamuzu College Of Nursing
KPI	Key Performance Indicators
MBS	Malawi Bureau Of Standards

MDGS	Millennium Development Goals
MDHS	Malawi Demographic And Health Survey
MGDS	Malawi Growth And Development Strategy
MICS	Multiple Indicator Cluster Survey
MPRS	Malawi Poverty Reduction Strategy
MTEF	Medium-Term Expenditure Framework
NCST	Nutrition Care, Support And Treatment
NESP	National Education Sector Programme
NGOS	Non-Governmental Organisations
NMIS	Nutrition Management Information System
NMS	National Micronutrient Survey
NNP	National Nutrition Policy
NNPSP	National Nutrition Policy And Strategic Plan
NNTCSPP	National Nutrition TreaTment, Care And Support To Plhiv
NRC	Natural Resources College
NRU	Nutrition Rehabilitation Units
OPC	Office of the President and Cabinet
ORT	Oral Re-Hydration Therapy/Office Recurrent Transactions
PEM	Protein-Energy Malnutrition
PIM	Performance Indicator For Mission
PLHIV	People Living With Hiv
PMTCT	Prevention Of Mother-To-Child Transmission
POW	Programme Of Work
PS	Principal Secretary
REACH	Renewed Action For Ending Child Hunger
SPS	Sanitary And Phytosanitary
TA	Traditional Authority
TBC	Data That Will BE Confirmed Through Baseline Assessment.
U5MR	Under-Five Mortality Rate
UNDAF	United Nations Development Assistance Framework
VAD	Vitamin A Deficiency
VAM	Vulnerability Assessment And Mapping
VAS	Vitamin A Supplementation

PART A: POLICY

POLICY STATEMENT:

The Government of Malawi has firmly positioned nutrition on the development agenda and created an enabling environment for effective and timely prevention, control and management of nutrition disorders among women, men, girls and boys.

1 PREAMBLE

1.1 OVERVIEW

Globally, 10.6 million children below 5 years of age die every year. Under-nutrition accounts for about 35% of all deaths among these children. Stunting, severe wasting and intra-uterine growth retardation are the major contributors to child mortality, accounting for about 2 million deaths of under-fives annually. Under-nutrition is also the number one cause of morbidity for all age groups, accounting for 11% of the disease burden[1]. With regard to maternal mortality, iron deficiency is the leading cause, contributing 20% of the estimated 536,000 deaths (WHO, 2005 statistics).

About 43% of all deaths among under-fives occur in Africa. In Malawi, a country with the highest rates of stunting among under-five children in Africa, an estimated 76,000 children die before their fifth birthday (under-five mortality rate (U5MR) of 118/1000) due to many factors with malnutrition being among the leading single and underlying causes. One-fifth of these deaths occur within one month of birth and are closely associated with the high maternal mortality, while 38% of all child deaths beyond infancy are closely associated with protein-energy malnutrition[2] which affects about half of Malawi's under-five population.

Increasingly, resources have been devoted to the promotion of dietary diversification based on the Malawi Six Food Groups, appropriate breastfeeding practices in the context of HIV, scaling up micronutrient supplementation (Vitamin A and iron), rehabilitation of severely malnourished children, salt iodization, and promotion of school

1 The Lancet Series on Nutrition, 2008.
2 Malawi Profiles, "Malnutrition in Malawi: A silent crisis – Invest now, 2006".

health and nutrition projects including school feeding. Policies such as the infant and young child feeding policy and strategic plans for sectors such as agriculture and food security, health and education, among others, have been developed to create an enabling environment for the implementation of nutrition interventions. Government has also invested in public health interventions such as de-worming, malaria prevention, hygiene and sanitation promotion, and nutrition education and promotion through various media channels. These initiatives by Malawi did well in achieving some reduction in underweight, malnutrition as well as infant and under-five mortality rates that decreased by about one-third from their level in the 1990s. The approaches have however so far failed to reduce stunting, whose rate has remained static since the 1930s. Hence, despite these gains, more still needs to be done in order to improve the nutritional status, educational and socio-economic wellbeing of Malawians.

Some of the reasons for the performance achieved to date by Malawi in its quest to achieve adequate nutrition for all Malawians by 2015 are related to the fact that the efforts to address malnutrition have mainly focused on poverty and food security yet recent studies show that chronic child malnutrition in Malawi is not strongly associated with either of these. There is a growing realization that although both are necessary, they are not sufficient. In addition, the nutrition-related polices that were implemented were fragmented (targeting selected ministries or groups of people), some of the interventions implemented were at project level and the resources to scale up the projects to programmes with national coverage were limited. For example, the overall expenditure on nutrition interventions was low with 0.05% and 1.45% of GDP[3] being spent by the Government of Malawi and donors, respectively. Furthermore, the implementation of nutrition interventions was characterized by weak coordination mechanisms which led to vertical programmes without adequate

3 GDP for Malawi was estimated at 6.74 billion of USD purchasing power parity in 2006 and 7.27 billion USD in 2007 (Malawi Economist Intelligence Unit – The Economist, 2009).

leveraging of resources and efforts for holistic approach and yawning gaps in implementation capacity as revealed by inadequate personnel with relevant skills, equipment, and material resources at national, district and community levels.

To overcome these challenges and make meaningful progress towards the achievement of the Millennium Development Goals (particularly Goals 1, 4 and 5 which concern the reduction of hunger and under-nutrition, child mortality and maternal mortality, respectively while having in loads to the remaining 3 MDGs), Malawi has, to move strategically in the years to come. The Five-Year National Nutrition Policy and Strategic Plan (NNPSP) therefore defines the strategic directions that Malawi should take over the five year period (2007-20012) towards addressing malnutrition. Both the policy and the plan operationalises the priorities in nutrition that have been identified in the Malawi Growth and Development Strategy (MGDS).

The policy implementation will contribute to the achievement of both medium and longer term social and economic development targets set in Malawi's Vision 2020, the Malawi Growth and Development Strategy (2007-20012), the Millennium Development Goals (to be achieved by 2015) and other international declarations. More specifically, the NNPSP partly draws inspiration from, and contributes to the achievement of the country's long term vision of ensuring adequate nutrition for all Malawians which is enshrined in the country's Constitution. It identifies high-impact low-cost nutrition interventions that must be introduced and/or strengthened and implemented at scale[4], sets performance targets, and establishes a tracking mechanism as well as a coordination framework to ensure the national efforts do reach all "at risk" population groups, including the unborn child, pregnant women, under-fives, lactating women,

4 High impact interventions are those proven to (a) reduce exposure to infection or other health condition; or (b) reduce the likelihood of exposure that leads to disease. They include both preventive and treatment approaches that reduce the likelihood that the disease or condition will lead to death (Lancet Series on Child survival, 2003).

school children and people living with HIV and AIDS, among others. The NNPSP also provides estimates of financial requirements and funding mechanisms for its implementation. As such, it sets out the priority areas for government spending in nutrition in the Medium-Term Expenditure Framework (MTEF) and the annual budget cycle at national and sub-national levels.

1.2 THE TIME PERIOD OF THE NNPSP

The time period of the NNPSP is fully harmonized with that of the MGDS. It starts on 1st January 2007 and ends on 31st December 2012. Implementation of many of the NNPSP provisions is therefore already on-going pending the formal launch.

1.3 THE PROCESS OF DEVELOPING THE NNPSP

The NNPSP is a product of two main processes. Firstly, a nation-wide consultative process that involved a combination of workshops, focus group discussions and face to face meetings at national, district and community levels. Men, women, youths, children (boys and girls), service providers inside and outside government, policy makers, traditional leaders, and local authorities were all consulted. Donors and the civil society including the private sector were also extensively consulted. These consultations were done over a period of almost one year and culminated in the production of an initial set of five documents on nutrition that were presented to Cabinet namely: the policy, the strategic plan, the programme, business plan and the communication plan.

The second step was directed by the Cabinet and involved the work to consolidate the five documents into one which is the current NNPSP document. The process of merging the five documents involved the initial consolidation by a multi-sectoral Technical Working Group and

engagement of experts through a local consulting company, to speed up the finalisation and ensure alignment of the policy and strategic plan to the MGDS. The experts were technically backstopped by the Task Force chaired by OPC (Department of Nutrition, HIV and AIDS). The Task Force comprised the key sectoral ministries involved in nutrition work and representatives of development partners and civil society. The Task Force provided both technical guidance and quality control. The exercise was commissioned in mid-October 2008 and was completed in March 2009.

1.4 OUTLINE OF THE NNPSP

The NNPSP has 10 chapters (or sections) including the introduction which also provides an overview of the strategic planning process that gave birth to the national strategy. Chapter 2 describes the nutrition situation in Malawi, the nature of the national response and the main challenges outstanding. It argues the case for committing resources and increasing the investment into nutrition. Chapter 3 defines the strategic directions by setting the vision, mission and strategic objectives of the NNPSP. In Chapter 4 the key priority areas for investing in the Strategic Plan period are highlighted and justified. Chapter 5 presents the key result areas while Chapter 6 lists the statements of intent and the guiding principles that underpin the strategies contained in the NNPSP. Chapter 7 summarizes the outcomes and outputs to be achieved through the NNPSP. For each strategic objective, a series of indicators are identified and the baseline and the future improved situation desired are also documented. Chapter 8 describes the implementation framework, tackling issues of sequencing, plan supervision, management and coordination. The chapter outlines the institutional arrangements as well as the roles and responsibilities of various actors at national; sectoral; local government; and community levels. These actors include government agencies, development partners, non-governmental and faith based organisations (NGOs) and the private sector. Chapter 9 details the

monitoring and evaluation framework whilst Chapter 10 presents the estimated cost and the financing plan for the NNPSP. Annexed to the document are further details on the activity costing and annual output targets.

2 BACKGROUND

2.1 MAGNITUDE OF THE PROBLEM

2.1.1 Nutritional status Of Children Below 5 Years Of Age In Malawi

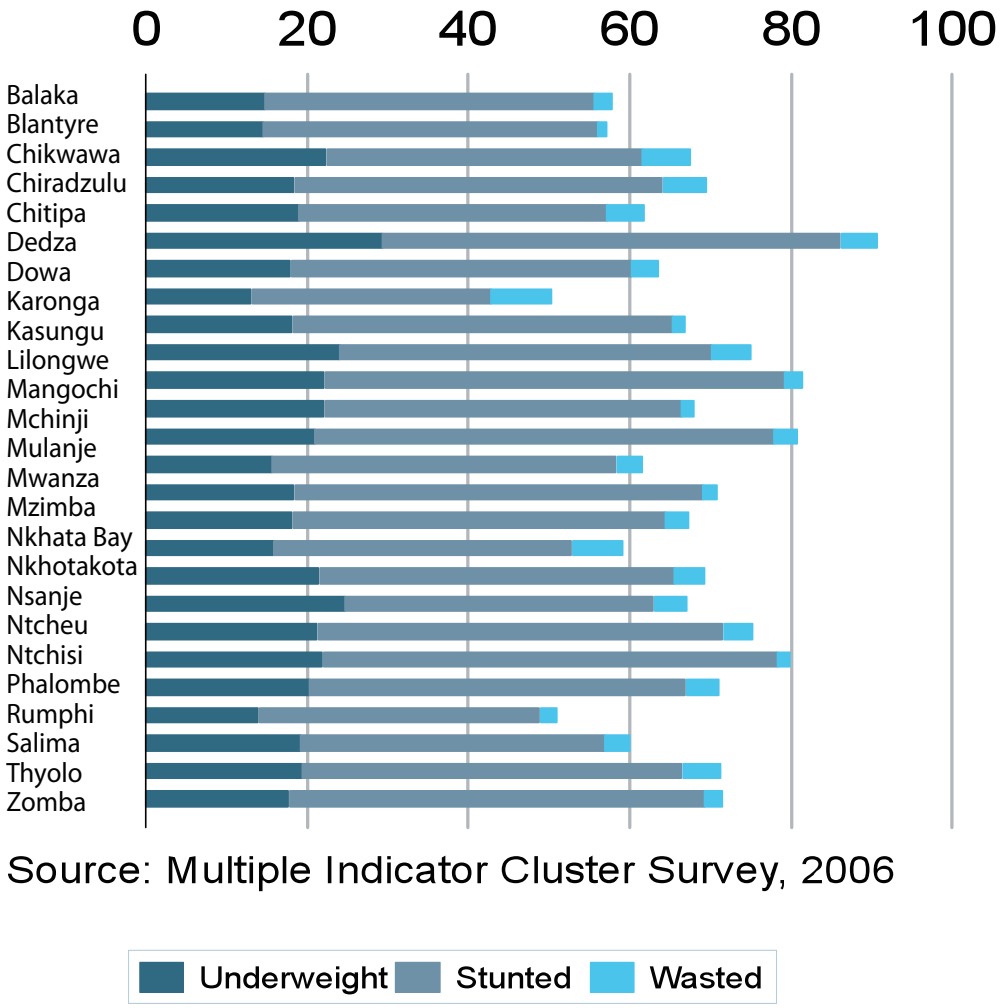
According to the Multiple Indicator Cluster Survey (MICS) conducted in 2006, one in every five children under-five years of age in Malawi were underweight (21 percent), 4 percent were severely under-weight and 6 percent were overweight. Almost two in every five children under the age of five years (46%) were stunted, while almost half of these (21 percent) were severely stunted. Stunting prevalence in under-fives living in rural areas was 48 percent and significantly higher than that in urban areas at 38 percent.

Stunting was highest in the Central Region (48 percent), followed by the Southern Region (45 percent) and lowest in the Northern Region (40%). In terms of underweight, MICS of 2006 found no significant differences between the rural and urban areas but some regional differences were observed, with children under five in the Southern and Central Regions being more likely to be underweight than those in the Northern Region. Yet, by contrast the percentage of wasting was found higher in the Northern Region than the other two regions.

District variations in nutritional status of under-fives were also stark. Prevalence of under-five stunting was lowest in Karonga district (30 percent), followed by Rumphi (35 percent), Nkhata Bay (37 percent) and Salima (38 percent), but highest in seven districts where more than half of the under-fives were stunted. These were: Dedza, Mchinji and Machinga with 57 percent each, Ntchisi (56 percent), Zomba (52 percent), Mwanza (51 percent) and Ntcheu (50 percent) (MICS,

2006) (Figure 1). Overweight was more pronounced in three districts, Mulanje (20 percent), Mchinji (13 percent) and Chikwawa (12 percent) which have significantly higher rates than the national average. These results demonstrate that Malawi has a double nutritional problem of malnutrition and dietary related non communicable diseases.

Figure 1: Percentage of under-five children undernourished by district, Malawi, 2006

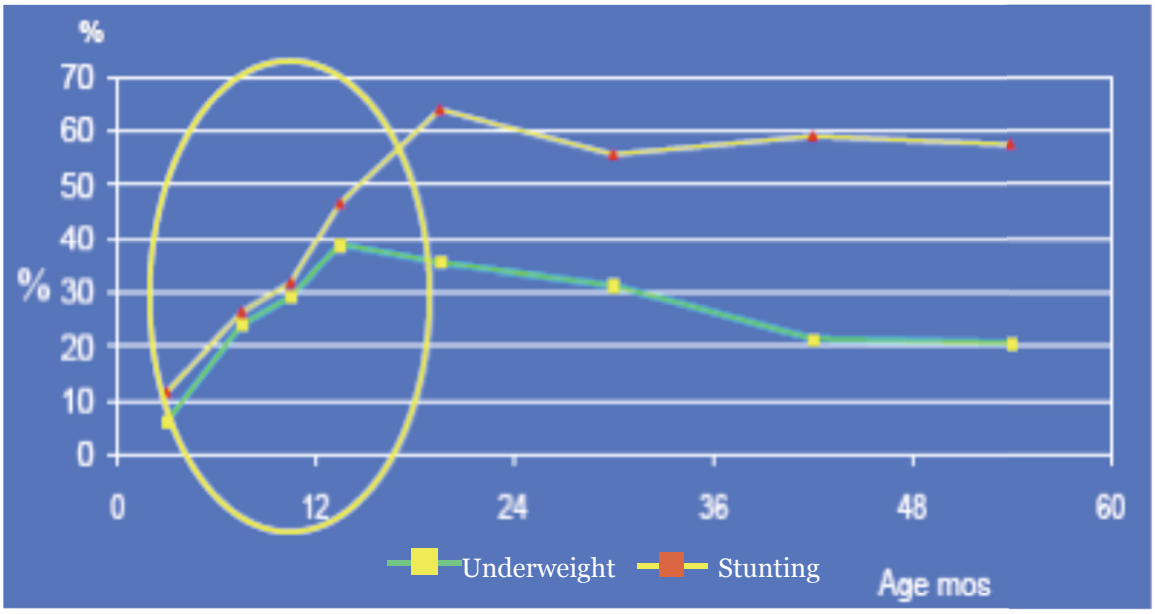


Source: Multiple Indicator Cluster Survey, 2006

Dedza, Nsanje and Lilongwe districts have the highest under-five underweight rates of above 24 percent; and the lowest rates again being found in Karonga district (13 percent). The district disparities give rise to the need for targeting of special packages of policy responses to certain districts of high concern.

Disaggregation of malnutrition prevalence statistics by age group revealed that prevalence of underweight (2 percent), stunting (11 percent) and wasting (5 percent) was lowest among infants below six months (2 percent, 11 percent and 5 percent, respectively) but highest among the age group 12-23 months. Beyond 6 months, underweight and stunting prevalence in under-fives rise steeply until they reach a peak of 29 percent and 57 percent, respectively, at age 12-23 months. Thereafter, prevalence of malnutrition declines progressively (Figure 2). The lowest wasting prevalence rates are for the age group 36-47 months (2 percent). Whilst levels of underweight and wasting drop significantly after 23 months, the level of stunting remains constantly high as recovery of height is not possible while weight deficit is.

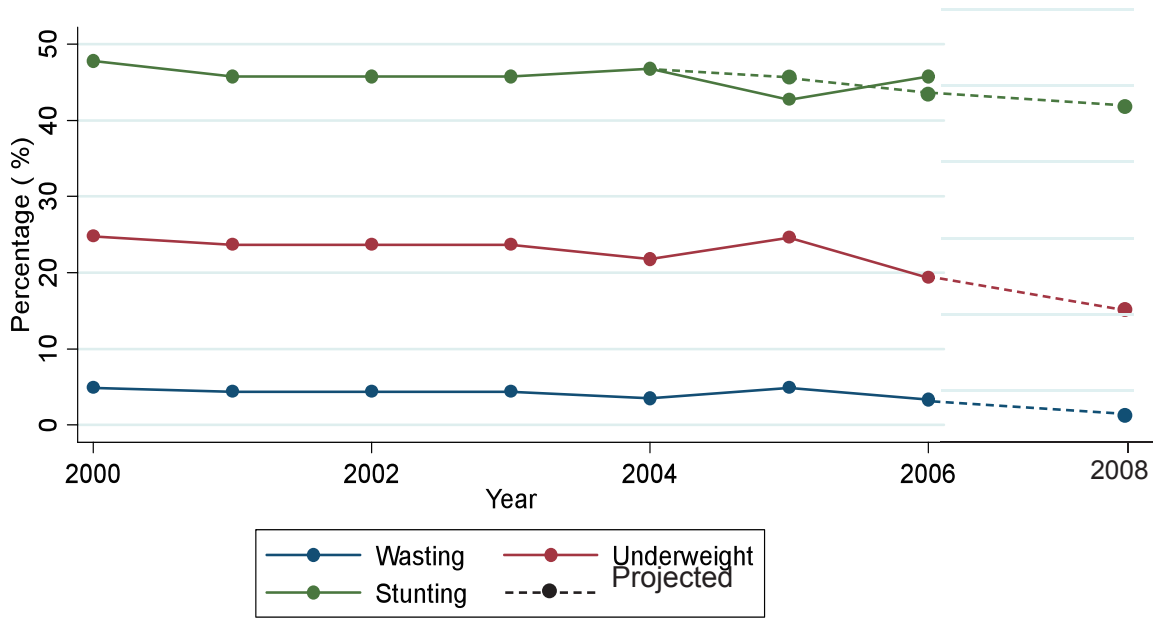
Figure 2: Onset of Malnutrition in Malawi



Source: Malawi Multiple Indicator Cluster Survey, 2006

The key message to note here is that in Malawi children become malnourished – mostly from three months (some even from or before birth) onwards peaking at 18 months. About 60 percent of deaths among children below 5 years of age occur within the first year of life (MICS, 2006) and undernutrition is the leading cause. Government programmes have increased their attention to this age group through the promotion of exclusive breastfeeding of children 0-6 months of age, Vitamin A supplementation for children 6-59 months and de-worming targeting children 12-59 months of age, but coverage of routine services has sometimes been low and maternal nutrition, complementary feeding and feeding of the sick child have not been intensive. Previously, programmes in Malawi were focusing mainly on treatment of cases of severe malnutrition through the health system, most of which were presented late when irreparable damage has already been done. This changed recently with the introduction of community therapeutic care (CTC) which has enabled early detection of cases and timely treatment. This has resulted in the declining trend of the nutrition indicators. Refer to Figure 3 below.

Figure 3: Malnutrition Trends, Malawi, 2006 - 2008



SOURCE: NNS 2000, DHS 2004, NNS 2005, MICS 2006

Inadequate attention by previous programmes to the high risk age group of 6-23 months, partially explains why Malawi's nutrition indicators, particularly protein energy malnutrition in the form of stunting, have not improved much over several decades (Table 1).

Table 1: Trends in prevalence of malnutrition in under-five children, Malawi, 1938-2004

Year	Stunting (% below - 2 SD)	Under-weight (% below -2SD)	Wasting (% below -2SD)
1938	56	-	-
1986	56	-	-
1992	47.8	7	3.7
1995	53	35	9
2000	49	25	6
2004	48	22	5
2006	46	20.5	3
2008	42*	15*	1.5*

Sources: (1) Platt B.S., Nutrition Survey in Nyasaland, 1938; (2) Chimwaza B.M., Food and Nutrition Study in Malawi, 1980; (3) Sample Survey of Agriculture, 1981; (4) Msukwa L., Review of Nutrition Situation in Malawi, 1986; (5) Integrated Household Survey 1995; USAID, 2007 ? and (6) Malawi Demographic Health Survey (MDHS), 1992, 2000 and 2004 and MICS 2008.

One of the major challenges for the under five years age group is that, in as much as most mothers breastfeed up to 23-24 months, many mothers introduce other foods and liquids before the child reaches the age of 6 months (33% of children) and the complementary feeding

is inadequate and inappropriate for about 43% of children aged 0-6 months and for 44% of children between 0-11 months (MICS 2006). This is mainly due to the poor nutritive food availability, diversity and quality. Food choices and combinations are also poor due to inadequate knowledge and skills among caregivers and extension workers and other service providers. Support to caregivers at the community level to effectively assist them to adopt and sustain optimal practices is often inadequate. A high disease burden coupled with poor feeding practices for children and during and after illnesses also affects this age group.

Another big challenge is that most of the nutrition programmes have been through the health sector, mostly facility-based focusing on the promotion of exclusive breastfeeding (0-6 months)[5], nutrition education and vitamin A supplementation (for 6-59 months) with low coverage after 1 year until recently when bi-annual child health days (CHD) were introduced in 2005. The facility based services also encompassed iron supplementation to antenatal care women and other public health interventions while complementary feeding and maternal nutrition through dietary diversification using the Malawi Six Food Groups were promoted by the Ministry of Agriculture and Food Security through farming households. The Ministry of women promoted food utilisation and dietary diversification in addition to the community based child care services. These approaches through individual sectors were often not holistic and did not effectively promote linkages. The nutrition education provided was generalized and limited without supportive counseling to promote the adoption of doable actions. This situation brought the realization that there is need to have a policy direction, guidance and oversight in nutrition service delivery. One of the areas of strategic focus of the National Nutrition Policy and Strategic Plan (2007-20012) is therefore the strengthening of delivery of a package of essential nutrition actions to prevent both chronic and acute malnutrition, especially targeting

5 This for example, is one of the main objectives of the Baby Friendly Hospital Initiative (BFHI).

children from the stage of their conception (1 day to 9 months) up to the time they reach at least 24 months; and the essential nutrition package for the entire life cycle.

Prevalence of micronutrient malnutrition (especially lack of Vitamin A, iron and iodine) is another cause for concern in Malawi because of the huge implications for public wellbeing. In addition to the more obvious clinical manifestations, micronutrient malnutrition is responsible for a wide range of non-specific physiological impairments (discussed in detail in section 2.2 below), resulting in compromised resistance to infections, and reduced nutrient uptake and delayed or impaired physical, mental and psychomotor development. Prevalence of micronutrient deficiency disorders is high among children below the age of 5 years, especially those from vulnerable population groups[6]. The only national micronutrient survey (NMS) conducted in 2001 found close to 60% of children under the age of five years having sub-clinical Vitamin A Deficiency (VAD), whilst 80 percent of children in the same age group had anemia[7]. Cretinism is estimated at 1 percent nationally and 3 percent in iodine deficient endemic areas within this age which continues to school age.

2.1.2 Nutritional status of school children in Malawi

In Malawi, 60 percent pre-school and 38 percent of school children suffer from sub-clinical Vitamin A Deficiency (National Micronutrient Survey, 2001). The National School Health and Nutrition Baseline Survey of 2006 also found 54 percent of children in school were anemic while 50 percent had iodine deficiency disorders (IDD) and 30% were stunted.

6 These population groups include ultra poor and labour constrained households. In these households, the household heads are usually chronically ill, PLHIV, widowed, disabled and old (>65 years of age).
7 Survey done by MOH, NSO, UNICEF, and CDC in 2001 and report published in 2003.

2.1.3 Nutritional Status of adult women and men in Malawi

The National Micronutrient Survey (NMS) (2001) estimated that 10 percent of Malawian women were underweight (Body Mass Index (BMI) less than 18.5) and 25 percent of all adults in Malawi were malnourished. Over-nutrition is another emerging and growing problem that needs to be controlled. The MDHS of 2004 found 14 percent of adults obese. The problem was more prevalent in urban areas (22.8 percent of adults obese) than in rural areas (only 12 percent). The NMS (2001) found 57% of women of child bearing age with Vitamin A Deficiency (VAD); 44% of non-pregnant women and 47% of pregnant women anaemic and 38% and 17% of men having VAD and anaemic respectively. Undernutrition in women of child bearing age, is a key contributor to nutrition disorders in new born babies ranging from intra-uterine growth restriction, under weight, micronutrient deficiencies and impaired physical and mental development. Undernutrition in both men and women also undermines their productivity and eventually their social and economic wellbeing.

2.2 CONSEQUENCES AND IMPACT OF MALNUTRITION ON HEALTH, EDUCATION AND ECONOMIC DEVELOPMENT

The magnitude of the impact of malnutrition problems in Malawi is enormous and overwhelming but abstract.

2.2.1 Impact on Health

Malnutrition is a major single and underlying cause of child morbidity and mortality in the country. The health-related impacts of the high rates of undernutrition in Malawi are grave and thus require urgent redress.

Impact on maternal and child morbidity and mortality

About 38% of all child deaths beyond early infancy in Malawi are associated with protein-energy malnutrition (PEM)[8]. If no improvements are done, it is estimated that malnutrition will cost the country 190,000 child deaths over the ten year period, 2006-2015. Malawi has an infant mortality rate of 76 deaths per 1,000 live births of which 19% is associated with sub-optimal breastfeeding practices. Sub-optimal breastfeeding during the first 6 months of life is costing the country approximately 8,200 infant deaths per annum. On the other hand, anaemia accounts for 57% of Malawi's maternal mortality of 807 per 100,000;

Vitamin A Deficiency which affects 60% of under-fives contributes to one out of every three deaths among children between 6-59 months of age. If no improvement is registered the country will lose 159,000 children to Vitamin A Deficiency during the period 2006-2015.

Emerging evidence from research done elsewhere also points to the fact that those children who are undernourished in the first 2 years of life and who put on weight rapidly later in childhood and in adolescence are at high risk of non communicable chronic diseases (NCDs) related to nutrition such as diabetes, hypertension, arthritis, gout, certain types of cancers and heart disease among others. Maternal nutritional status during pregnancy can affect body size and

8 Most statistics on Malawi in this section are taken from the "Malawi Profiles: Malnutrition in Malawi: A Silent Crisis – Invest Now, 2006".; Housing Population Census; NSO 2008.

composition by production of long term deficits in foetal body mass and gene expression[9]. Undernutrition in pregnant women is one of the causes of adverse pregnancy outcomes such as miscarriages and still birth. Short stature of the mother can result in intrauterine growth restriction. Children born with low birth weights are more susceptible to disease infections whose severity is also closely linked with child nutritional status. In addition recent studies on how infant size and growth relate to later risk of obesity show that larger size and growth rates are associated with increased risk of obesity in later life. In some studies, high adult waist circumference was linked to either too small or too large birth-weights (below 2.5kg or above 3.5 kg), suggesting the need to prevent maternal undernutrition.

Impact on nutritional status of the next generation

There is also growing evidence that maternal body size is strongly associated with size of the new born children. Undernourished girls tend to become shorter adults, and thus are more likely to have small children. Some studies have even shown that for every 100g increase in maternal birthweight, her child's birthweight increased by 10-20g (in developed countries) and by 29g per 100g (in low income countries)[10]. In low income countries, the same studies also show that birth length does rise by as much as 0.2cm for every 1cm increase in mother's birth length, thus maternal nutrition is a strong predictor of offspring birthweight, even after adjusting for maternal adult size[11]. In addition, maternal height is associated with birth weight of their grand children, confirming the long term repercussions of maternal nutrition.

9 (i) Waterland RA, Jirtle RL. Early nutrition, epigenetic changes at transposons and imprinted genes, and enhanced susceptibility to adult chronic diseases. Nutrition 2004; 20: 63–68; and (ii) Waterland RA, Jirtle RL. Transposable elements: targets for early nutritional effects on epigenetic gene regulation. Mol Cell Biol 2003; 23: 5293–300.

10 (i) Ramakrishnan U, Martorell R, Schroeder DG, Flores R. Role of intergenerational effects on linear growth. J Nutr 1999; 129 (suppl): 544S–9S; and (ii) Leary S, Fall C, Osmond C, et al. Geographical variation in relationships between parental body size and offspring phenotype at birth. Acta Obstet Gynecol Scand 2006; 85: 1066–79.

11 Leary S, Fall C, Osmond C, et al. Geographical variation in relationships between parental body size and offspring phenotype at birth. Acta Obstet Gynecol Scand 2006; 85: 1066–79.

The conclusion from these impacts is that good maternal nutrition is critical for the nutrition of the future generations. The effect of undernutrition can span at least three generations. If Malawi wants to improve the nutritional status of future generations, it should start with the present generation. For example in Guatemala, expectant mothers were put on a nutritional supplementation trial. Children born to women who had received a protein-energy supplement were on average 0.8cm taller than were those whose mothers received a low-energy supplement. These findings point to the need for Malawi's nutrition strategy to focus on both the new and the yet unborn children, maternal nutrition is as critical as the nutrition of those children already born.

2.2.2 Impact on Education

Good nutrition is imperative for optimal mental and physical development, learning and school performance. Undernutrition affects cognitive development by causing direct structural damage to the brain and by impairing infant motor development and exploratory behaviour[12]. This is explained by the fact that if iodine, which is critical for normal development of the child's brain, is inadequate, children may suffer from mental impairment ranging from mild mental retardation to cretinism, characterised by severe brain damage and dwarfism which are permanent. If goitre develops, it could result in traumatic effects on the affected child, eventually leading to absenteeism, inferiority complex and sometimes severe discomfort[13].

Similarly, iron deficiency anaemia delays mental development in infants and is correlated with poorer performance on cognitive tests in older children. In iodine deficient communities, a loss of IQ of the order of 13.5 points has been recorded in some studies[14]. Children

12 Pitcher J, Henderson-Smart D, Robindon J. Prenatal programming of uman motor function. In: Wintour E, Owens J, eds. Early life origins of health and disease. New York: Springer Science and Business Media, 2006.
Brown JL, Pollitt E. Malnutrition, poverty and intellectual development. Sci Am 1996; 274: 38–43.
13 Malawi Profiles, 2006. OPC.
14 Malawi Profiles, 2006. OPC.

have considerably reduced learning abilities, school performance and retention rates are low and hearing and speech are impaired and such children are not trainable.

Vitamin A Deficiency on the other hand, lowers immunity thus increasing the incidence and severity of illnesses which increase absenteeism and reduce concentration in school. In severe cases, there is night blindness, partial or total loss of sight which renders learning equally challenging unless special needs education is provided.

In Malawi, stunting at 2 years has been associated with delayed school entry, greater grade repetition and dropout rates, decreased graduation rates from primary and secondary school, and lower school performance. This compromises the impact of Government's growing investments in free primary education, and secondary and tertiary education, ultimately delaying the achievement of the Millennium Development Goal Number 2 (on education).

In Zimbabwe, a difference of 3.4 cm in height-for-age at 3 years was associated with almost an additional grade of achieved schooling[15], whilst in Guatemala, food supplementation during early childhood improved schooling in women by 1-2 years, and test scores in men and women[16]. This evidence does underline why Malawi cannot wait but intensify investment in child nutrition especially with a deliberate focus on catching them young.

15 Alderman H, Hoddinott J, Kinsey B. Long term consequences of early childhood malnutrition. Oxf Econ Pap 2006; 58: 450–74.

16 (i) Daniels MC, Adair LS. Growth in young Filipino children predicts schooling trajectories through high school. J Nutr 2004; 134: 1439–46.
(ii) Maluccio JA, Hoddinott J, Behrman JR, Martorell R, Quisumbing AR. The impact of nutrition during early childhood on education among Guatemalan adults. Middlebury College Economics Discussion Paper number 06-14. Middlebury College, VT, 2006.

2.2.3 Impact on the Economy

Economic impacts at the individual and household level

Nutrition determines the wealth status of the population in two ways: by affecting cognition and schooling on the one hand and by affecting adult earnings through reduced body mass (including shorter height) and decreased productivity in jobs requiring manual labour. Several studies show that nutrition interventions can lead to increased body size and improved work capacity[17]. Both physical and intellectual human capital, in turn, is associated with increased earnings. For example some studies confirm the positive correlation between adult height and incomes, even in urban settings and even after adjustment for education[18]. The economic returns to schooling are substantial. For instance, in Central America and Brazil, one additional year of schooling is associated with 12-14% increased lifetime earnings[19]. Exposure to improved nutrition before, and not after, 3 years of age was also associated with higher hourly wages in Guatemalan men. For exposure from 0 to 2 years, the increase was U$0.67 per hour, equating to 46% increase in average wages. Other research work carried out in India shows that most indicators of undernutrition are associated with fewer assets.

Economic impacts at national level

In Malawi, it is estimated that due to mental impairment caused by iodine deficiency, the present value of lost future wages over ten years (2006-2015) could amount to US$71 million[20]. Reduced physical capacity in stunted adults would contribute to a loss of future economic production of US$207 million for every 1% reduction in height is

17 (i) Rivera JA, Martorell R, Ruel MT, Habicht JP, Haas JD. Nutritional supplementation during the preschool years influences body size and composition of Guatemalan adolescents. J Nutr 1995; 125 (suppl): 1068S–77S.
(ii) Haas JD, Martinez EJ, Murdoch S, Conlisk E, Rivera JA, Martorell R. Nutritional supplementation during the preschool years and physical work capacity in adolescent and young adult Guatemalans. J Nutr 1995; 125 (suppl): 1078S–89S.

18 Thomas D, Strauss J. Health and wages: evidence on men and women in urban Brazil. J Econom 1997; 77: 159–85.

19 Psacharopoulos G, Patrinos HA. Returns to investment in education: a further update. Educ Econ 2004; 12: 111–34.

20 Data on economic costs on Malawi presented here is taken from the Malawi Profiles Report, 2006.

equivalent to 1.3% loss in productivity (in present value terms). Furthermore, iron deficiency anaemia which is another nutritional problem with far reaching effects on productivity could account for US$129 million loss in agricultural productivity of the female labour force and US$39 million for men. This is because each 1% drop in iron status is associated with a 1% reduction in productivity. The total economic loss over the next ten years in present value terms translates to about the same value as Malawi's external debt in 2006 of US$ 446 million at US$ 83 million per annum.. The translation is that for every US$1 Malawi invests in nutrition, there is a US$5.3 gain in productivity and therefore Malawi would gain US$1.7 billion in the same 10 years period (2006-2015).

These estimates are corroborated by a recent study by WFP and the Economic Commission for Latin America, for instance, which estimated the economic losses due to undernutrition in seven nations at a staggering 6% of annual Gross Domestic Product[21].

2.3 CURRENT EFFORTS TO ADDRESS THE PROBLEM AND WHAT ARE THE GAPS

2.3.1 National level efforts

2.3.1.1 Repositioning of the National Nutrition Programme in the Government's Development Agenda

Prevention and management of nutrition disorders is one of the key priority areas being tackled by the Malawi Growth and Development Strategy (MDGS) and several policies with a bearing on nutrition (see section 2.7). Nutrition for the first time has been singled out as one of the six priorities areas in the country's development agenda the MGDS, paving the way for the development of National Nutrition

21 Heikens G.T. How can we improve the care of severely malnourished children in Africa? PLoS Med 2007; 4: e45.6

Policy and Strategic Plan (NNPSP) and the National Nutrition Programme (NNP) with an explicit vote allocation in the government budget. Operationalization of the Nutrition component of the MGDS is under the national leadership of His Excellency the State President who is the Minister responsible for the Nutrition Sector. One key step also taken by the Government is the creation of the coordinating and implementation structures. The Department of Nutrition, HIV and AIDS was set up (in 2004) as the coordinating authority for Nutrition, HIV and AIDS. It is mandated to provide visionally policy direction, technical guidance, oversight, monitoring and evaluation and resource mobilization among other functions. The Department is the one responsible for coordinating the implementation of the NNPSP. The implementation of the NNPSP, however faces a number of constraints at the institutional, community and household levels and human and financial resource constraints must be urgently addressed. There is strong consensus in government and among the development partners that one of the biggest challenges to the implementation of the NNPSP is the lack of qualified personnel in nutrition at all levels, especially at the district and community levels.

Several nutrition committees, the major ones being the National Nutrition Committee and the Government- Development Partners Committee have been set up to facilitate joint review, planning, implementation and monitoring and evaluation of nutrition programmes, services and projects in the country. These are, in general, working well.

2.3.1.2 Integrating and Mainstreaming of nutrition into sector plans

At the sector level, nutrition positions at senior level have been created and this has facilitated the integration of nutrition in sectoral policies, programmes, plans and budgets. For example, nutrition has already been integrated and mainstreamed into: (a) the Agriculture

Development Programme (ADP) which is awaiting Government approval, the National Education Strategic Plan; (b) the Early Childhood Development and Care Policy and Strategic Plan; (c) the Integrated Management of Childhood Illnesses (IMCI); and (d) the Reproductive Health Services, Maternal and Neonatal Services; and the prevention and management of mother to child transmission (PMTCT) of HIV.

Nonetheless, additional challenges remain in the inability of the government to fill and retain staff in key posts created at sector level, mainly due to shortage of qualified personnel in the country and strong competition for the same skills with the non-government sector and other employment opportunities in the Diaspora. For example, the Ministry of Agriculture and Food Security has currently budgeted for a total of 54 nutrition posts, 28 of which are located at district level. To-date 37 posts remain unfilled, of which 17 are vacant at district level. These posts include nutrition education, nutrition surveillance, and food and nutrition programme officers. It is a challenge to find sufficient numbers of qualified personnel. To find means and ways of addressing these capacity challenges, government has commissioned a study funded by the United Nations Food and Agriculture Organisation to gain better understanding of the capacity gaps and facilitate consensus building between government and development partners on an integrated and well-coordinated framework for capacity building and development.

2.3.2 Efforts at programme level

The National Nutrition Programme has several nutrition interventions that are being implemented at national, sector, and community levels targeted at both prevention and management of nutrition disorders. Under prevention, major interventions encompass (a) the 7 (recently adopted since 2007) Essential Nutrition Actions (ENA) approach prior tested and proven to work in Ethiopia, Madagascar and Ghana

(this includes promotion of women's nutritional status before, during and after pregnancy, promotion of optimal breast-feeding in the context of HIV and AIDS, promotion of optimal complementary feeding, promotion of optimal feeding of a sick child during and after illness, control of Vitamin A Deficiency, control of anaemia, control of iodine disorders, public health interventions such as deworming, promoting hygiene and sanitation, school health and nutrition; (c) malaria control; and (d) growth monitoring and counselling; and nutritional screening.

Under management of nutrition disorders, the focus previously was on rehabilitation of children under 5 years of age with severe acute malnutrition through Nutrition Rehabilitation Units and stand alone Supplementary Feeding Programme (SFP) sites for management of moderate malnutrition. This was however, characterized by high case fatality of over 20% due to late presentation and treatment. Malawi recently (2005) adopted the Community Therapeutic Care (CTC) approach to increase access to services and facilitate early case detection and treatment. The approach has contributed to 90% reduction in mortality to 2% from above 20%, and reduced default rate to 10% from 50% due to long stays in the NRU and recovery rate of 84% for the first time in 15 years.

Performance and gaps for prevention interventions

The Lancet Series for January 2008 already documents that the Essential Nutrition Actions (ENAs) approach has already proven potential to reduce child mortality by 23-25%. Some of the ENA components such as increased Exclusive Breast Feeding (EBF) and Vitamin A Supplementation (VAS) have already been associated with declining mortality in the country. The major gap, however, is still the limited national coverage of most of the actions, inadequate funding and skill gaps. One other major gap is inadequate resources for care

at household and community level to facilitate sustainable adoption and maintenance of the recommended practices and changed behaviours.

Under optimal infant and young child feeding, the National Infant and Young Child Nutrition Policy (2005) and guidelines, have been revised in line with the new WHO recommendations for feeding HIV exposed children. Integrated infant and young child feeding and maternal nutrition promotion has been done through the Accelerated Child Survival and the of the Development Communications strategy which has resulted in intensive nutrition education and promotion programmes using various media channels in collaboration with various stakeholders including civil society organisations that use Pd heath. The coverage and effectiveness of the communication strategy is still to be assessed.

Furthermore, the Government with the support from its development partners such as UNICEF, WHO has been promoting optimal breastfeeding practices in the context of HIV and AIDS, with special focus on promoting exclusive breastfeeding (EBF) of children within the first 6 months of life. The strategy has been effective as rates of exclusive breastfeeding have accordingly risen from 3% in 1992 to 57% in 2006 but more work is still needed to ensure that all infants are exclusively breastfed for the first six months of birth, unless medically indicated.

Government has been promoting the Baby Friendly Hospital Initiative (BFHI) that has resulted in many hospitals qualifying and has boosted the rates of exclusive breastfeeding among mothers. The initiative is so far only operational in 26 BFH out of a potential 564 facilities offering maternity services in the country, a coverage of only 5%. This is still too low and additional work is needed to prepare the remaining facilities to a level where they meet the assessment criteria for baby friendliness. Even though, close to 95% of mothers in Malawi attend

antenatal clinics only close to 50% deliver at the hospital, which means, more work need to be carried out at the community level to ensure that all babies exclusively breast feed.

In addition the NNPSP promotes healthy life styles, diet diversification, increased public nutrition education and awareness, production, access and consumption of high nutritive value foods, provision of nutrition care, support for prevention and management of malnutrition in PLHIV, TB and other chronically ill patients, School Health and Nutrition and Nutrition Surveillance.

Government launched the Bi-annual Child Health Days (CHD) campaign in 2005 to increase the coverage of Vitamin "A" supplementation (VAS), de-worming, Malaria control, and sanitation promotion. VAS coverage has risen from below 40 percent and has been sustained above 90 percent for children 6-59 months and from 30 percent to above 60 percent for postnatal women. More work remains to be done to reach the remaining 40 percent of postnatal women who may not be aware or have the means to reach the CHD centres. The CHD complements the National Vitamin A Supplementation routine programme which is integrated in the Expanded Programme of Immunisation (EPI) but whose coverage for children over one year and post natal women has been very low.

Under the National Education Sector, the Government in partnership with its stakeholders such as WFP has launched a school feeding programme in response to the persistent food crisis which the country experienced over the years, targeting the most food insecure areas but with special focus on the girl child in school, and the programme has extended in order to accelerate the achievement of MDG Goal Number 2 on education. Provision of a supplementary meals to school children in primary school has increased enrolment (5%), school attendance (3%) and retention (10%). Government has decided to make school feeding universal covering all public primary schools, to

facilitate the attainment of MDG 2 but also to promote nutrition in the school age group after studies revealed high levels of malnutrition in this population group and established that most of them (70%) go to school without breakfast (National Baseline Survey for School Health and Nutrition, 2006).

Government has also been working in partnership with the private sector (salt importers) to increase the supply of iodised salt on the market alongside the civic education efforts to raise awareness on the importance of iodine. The proportion of households using iodised salt is still low as only 50 percent of the population use salt with adequate iodine (15+ parts per million). Gaps remain in the Government's capacity to monitor salt imports, enforce the relevant legislation, and test the iodine levels in salt available on the market. At the household level, knowledge gaps in the importance of iodine and use of iodised salt still exist as revealed by an independent evaluation of micronutrient promotion programmes. (MG, 2001).

Malawi has finally made a breakthrough in sugar fortification, starting with a 6 month pilot programme involving Lllovo which was launched in 2008 and has already proved successful and the intervention will be scaled up soon. The Government's food and health inspectors and captains of the industry have also been trained in quality control and assurance for centrally processed and fortified foods and in the methodology for determining fortification levels for various foods using a calculator. The major gap in Malawi is that central laboratories lack the advanced technology (equipment) for testing food quality and the country still relies on external laboratories for most of the testing of food quality.

For optimal feeding of the sick child, guidelines, booklets of key messages and training materials have been produced; and orientation of key stakeholders is being undertaken as part of the ENA initiative. Orientation of communities remains an on-going activity, the

challenge being how to reach those with no access to print and electronic media and the illiterates. Messages on appropriate feeding practices are also incorporated into the Integrated Management of Childhood Illnesses (IMCI) initiative under the Ministry of Health, which is holistic. At community level, IMCI also promotes the use of oral re-hydration therapy (ORT) for the management of diarhoea, but the practice is so far only applied to 55% of under-fives with diarrhoea. The Ministry of Health also promotes optimal maternal nutrition and infant and young child-feeding practices and this is integrated into Reproductive Health Services, Prevention of Mother to Child Transmission of HIV, Maternal and Neonatal Services guided by the Ministry of Health's (MOH) Essential Health Package (EHP) and Programme of Work (PoW). Coverage of maternal health interventions is, however, generally limited, for example, prevention of mother-to-child transmission (PMTCT) services is only reaching 26% of eligible pregnant women.

The MoH runs a national Growth Monitoring and Promotion Programme aimed at tracking child growth and providing appropriate care and support for timely intervention and the country has just adopted the new WHO growth standards which will be piloted in 3 districts. The main challenge with the current programme which focuses on children up to 5 years is low turn up of children after immunization, low institution capacity (human resource) and no follow-up support at community level; and concentration on diagnostic monitoring that growth with very limited counselling. Linked to this is the national Nutrition Surveillance System which aimed at tracking the main trends for timely interventions. The main gap with the system is that it is facility based capturing only children who come to the health facility. The other challenge is limited capacity of local authorities to analyze, interpret and respond to the data.

In addition, Government, through the Ministry of Women and Child Development (MoWCD) has been implementing the integrated Early Childhood Development and Care Policy and Strategic Plan which covers all child care practices including nutrition for mothers and children; and a food utilisation and dietary diversification programme. The Ministry used to have the home craft worker cadre working hand in hand with community development assistants whose roles include: community mobilisation for community based programmes and services delivery that included nutrition; promoting access to high nutritive value foods through economic empowerment projects; civic education on dietary diversification; and participation in nutrition assessments and community based operational research with strong bias towards training communities. The abolition of the Homecraft worker cadre has created a major gap in facilitating the adoption and maintenance of optimal practices and community level follow-up and services for child-care. The Ministry is also promoting awareness on child rights (including the right to adequate nutrition) through child protection officers stationed at the community level. The main gap that stands out in the activities of the MoWCD is staff shortages due to many inter-related factors: (a) the termination of the post of the home craft worker; (b) staff turnover; (c) funding gaps; and (d) the long process involved in filling out vacant government posts.

Promotion of the production and consumption of high nutritive value foods in agriculture has been on-going in the past (including the broadening of the scope of the Government agricultural input subsidy to target leguminous crops). The emphasis, however, has been on farm income diversification and enhancement as opposed to nutrition. The nutrition gap has been addressed, partially by integrating nutrition into the Agricultural Development Programme (ADP). The ADP is results based and has a major focus on selected high nutritive value food crops and animal production according to the country's agro-ecological zones to enhance household food availability and diversity. The ADP awaits government approval and resource allocation. The

other gaps are the low extension worker to farmer ratio, shortage of legume seed on the domestic market, and the energy shortage which affects the high nutritive value diets preparation such as those including beans among others.

Malawi has established a National Nutrition Treatment, Care and Support to People Living with the Human Immuno-Deficiency Virus (PLHIV) Programme and allocated 2% ORT from the government budget for each sector to support HIV workplace programmes in the public sector that includes nutrition. The programme is part of the national nutrition and HIV and AIDS interaction response which has reached close to 1.5 million people among whom are 38,500 civil servants including close to 7,000 teachers, Tuberculosis (TB) patients, pregnant women, chronically ill patients, 680,000 Orphans and other Vulnerable Children (OVCs), over 50,000 HIV support groups, and adults in workplaces and district assemblies. Various actors such as World Food Programme (WFP), the National AIDS Commission (NAC), Non-governmental Organisations (NGOs), OPC, and development partners are involved. Like the other programmes, the main challenge has been limited coverage, itself a function of amount of resources made available. Furthermore, a high default rate of 29% still affects the success of nutrition treatment of PLHIV taking place in 157 anti-retroviral treatment (ART) sites where the cure rate is a moderate 60%. It should be noted that nutrition support is a life long therapy for PLHIV and it needs to be adequately sustained if the beneficiaries have to response to the treatment quickly and delay the progression of HIV to fully brown AIDS.

Performance and gaps for malnutrition management interventions

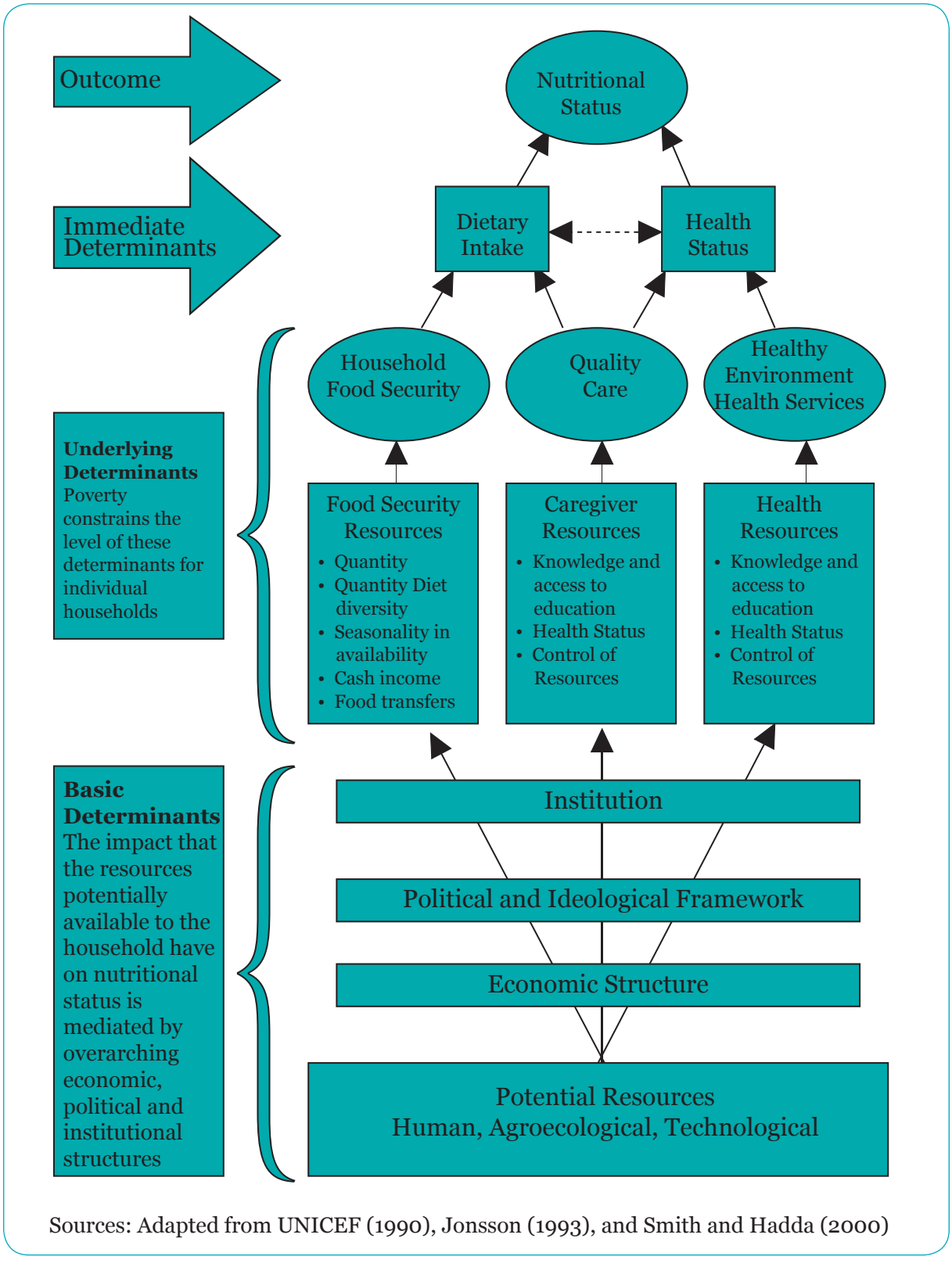
Malawi adopted the community therapeutic care (CTC) approach on a pilot basis in 2004/05 as a routine service for treating malnutrition after its successful implementation as an emergency intervention in

2002/2003 and 2003/2004, and from 2006 started scaling up the CTC services throughout the country. The CTC emphasizes three objectives: (i) early detection of cases, (ii) management of malnutrition and (iii) increasing coverage to reach previously marginalized children. Since then the CTC has been expanded to 258 sites in 21 districts (from 2 sites in 2 districts in 2004/05) reaching 28,648 children. CTC has achieved a higher cure rate of 84 percent and a lower death rate of 2.4 percent when compared to lower than 60 percent and 20%, respectively, for facility-based nutrition rehabilitation units (NRUs). The NRUs cure rate was lower than 60 percent and the average death rate was 20% due to late presentation of cases and inadequate clinical support in management. The main challenges remaining are: (a) to expand coverage within the reached districts; (b) reaching all the districts of Malawi; and (c) institutionalizing CTC by integrating it into the main health service delivery system so that it becomes fully sustainable and effective over the long term. Allocation of budgetary resources by government, full endorsement of CTC by the MoH, and the development of national CTC guidelines are big steps toward the integration into the Primary Health Care system. More work is however needed to ensure that: (i) CTC services are fully managed, implemented and supervised by District Health Office and MoH staff; (ii) the CTC services are funded through the District Implementation Plans (DIP) as part of the district health budget but involving community based service delivery for proper referral and follow up of households in order to sustain the nutritional status improvement; (iii) effective linkages with other child survival and HIV programmes are in place; (iv) CTC supplies are purchased and distributed through the essential supplies distribution system; and (v) that CTC M&E is integrated into the health management information system.

2.4 KEY CHALLENGES AND BARRIERS TO BE ADDRESSED

The key challenges and barriers for the attainment of adequate nutrition in Malawi are already well documented and, using the conceptual framework for nutrition developed by UNICEF in 1990, they can be classified into three main categories: (i) immediate causes; (ii) underlying causes; and (iii) basic causes (Figure 3).

Figure 3: Main Causes of Malnutrition in Malawi



Sources: Adapted from UNICEF (1990), Jonsson (1993), and Smith and Hadda (2000)

2.4.1 The Immediate Causes of Malnutrition in Malawi

In Malawi, there are two main immediate causes of malnutrition: (i) low dietary intake of various nutrients (for example, carbohydrate, protein, fat, vitamins like A-E, minerals such as iron, iodine, selenium, zinc, calcium and sodium among others); and (ii) high disease burden.

Low Dietary Intake

Sub-optimal infant and young child feeding practices and limited dietary diversity in Malawi are widespread problems and mainly caused by a combination of inadequate knowledge, food taboos, and low availability and access to nutritious foods in terms of quantity, diversity and quality as a result of inadequate resources for production of a variety of nutritious foods. Inadequate knowledge of appropriate food choices and combinations from the Malawi Six Food Groups and sub-optimal childcare and feeding practices are some of the major contributors to poor infant and child feeding in Malawi.

Inadequate knowledge on how to feed the unborn child, the infant and those beyond infancy or lack of resources for the proper care and support of children and mothers are widespread problems. For example, breast milk which is the best and economical food and drink for a baby; and it should be the only meal given to the baby during the first six months of life is often introduced late due to inadequate knowledge or stopped too early because of family and peer pressures to switch to complementary feeding. About 42% of new born babies are introduced to breast-milk after the recommended one hour of birth (MICS, 2006). Eighty-three percent of infants aged 0-1 month, 61 percent of those aged 2-3 months and 26 percent of those between 4-5 months are exclusively breastfed. This results in poor weight gain

and increases the risk of infections which later may even contribute to neonatal mortality. Out of all the children under the age of five years, only 57 percent are exclusively breastfed (MICS, 2006).

Knowledge on the right time and how to introduce complementary meals to the baby or how to feed a child during and after illness is also very limited among the population. For instance, the proportion of children 0-11 months appropriately fed in Malawi is about 56 percent. It is lowest for the 9-11 months age group (at 44 percent in both rural and urban areas) and among female children (55 percent)[22]. Challenges on child feeding have been further exacerbated by HIV and AIDS, because of its complex and adverse interactions with nutrition, and by low levels of literacy, especially among women. Knowledge of micronutrients such as iodine, for example, remains low with only 66 percent of the population having ever heard of iodine, some districts having below half (48 percent) of their population with knowledge of iodine (Ntchisi).

Low food diversity also arises from limited agricultural diversification. Poor agricultural diversification is mainly caused by inadequate access to farm inputs, for example, access to legume seed. In spite of recent efforts directed at diversifying agricultural production so as to produce high nutritive value foods (such as pulses, small livestock, dairy and aquaculture), the quality of diets of the majority of the population remains poor. Insufficient knowledge on diets prevents households from maximizing the nutritional benefits of available foods and other resources. Presently, on average, energy foods (cereals, roots and tubers) contribute about 86% to the total calorie intake of the national population; legumes supply 11%, while the contribution of oils, animal foods, fruits and vegetables remains a paltry 3%. This is against the recommended ratio of at least 35% for legumes or at least 35% for oils, animal foods, fruits and vegetables together[23].

22 Statistics in this section are from the MICS, 2006 Report.
23 Government of Malawi (2008), Monitoring and Evaluation System for Food Security and Nutrition Policies of Malawi: 6th M&E Report of the FNSP Working Group; 14th November 2008

Disease Burden

Increased nutritional needs or reduced dietary intake and utilisation arising from disease burden are a third major category of immediate causes of malnutrition in Malawi. The major diseases with an impact on nutrition in Malawi are malaria, diarrhoea, acute respiratory tract infections and AIDS. Incidence of malaria, Acute Respiratory Infections (ARI) and diarrhoea in under-fives is high at 107%, 24% and 38.6%, respectively (based on 2007/8 HMIS data for malaria and ARI and MICS 2006 for diarrhoea).

These diseases are mainly due to poor child care practices, for example, lack of preventive measures such as the use of mosquito nets, and adoption of safe hygiene and sanitation practices. Delays in seeking of medical attention when the child is sick and the low quality of health care often exacerbate the impact of these diseases on nutrition outcomes. Many health facilities in rural outlying areas often lack adequate stocks of medical supplies and qualified personnel. At the same time, accessibility of some of these health centres is constrained by poor transport infrastructure. Poor hygiene and sanitation is a major contributor to the burden of diarrhoeal diseases and arises from low access to potable water and the use of unsafe sanitation.

2.4.2 Challenges Related to Underlying Causes of Malnutrition

Underlying Causes Of Inadequate Dietary Nutrient Intake

Many of the vulnerable groups do not have adequate resources for own nutritious food production or market acquisition to secure access to nutritious and entitled diets at household level. Poverty is endemic at 45% with 22% as the core poor and 12% without adequate labour, land for food production and caring for large numbers of OVC and child headed households. 22% have small landholdings of less than

0.5 hectare. Apart from resource constraints, the frequency of floods and other disasters also militates against adequate nutritious food production. Every year some parts of Malawi are affected by food shortages that are exacerbated dependence on rain fed agriculture and climate change.

Even for the better resourced households, food taboos emanating from cultural practices and religious beliefs often limit consumption and use of certain foods, thus reducing nutrient intake at the household level. The lack of community nutrition workers has hindered redress of this situation since many households do not have a reliable source of information and guidance on nutrition matters that is closer to them and monitors their practices for change. In addition, gender inequalities have exacerbated malnutrition. Most nutrition education programmes have been targeting women yet household-level decisions are mostly done by men. Gender roles further skew the distribution of nutritious diets within a household. Men are often favoured in both food and resource distribution, typically at the expense of women and children.

Underlying Causes Contributing To Disease Burden

Many poor rural households do not have access to potable water, good sanitation and hygiene resources. For example, only 4 percent of the poor use improved sanitation (MICS, 2006). A significant proportion of households lack knowledge of good hygiene practices and this leads to high incidence of diarrhoea among children (14 percent during the 2007/8 financial year)[24], which in turn drastically affects diet utilisation. For example, less than 1 percent of women aged 15-49 years regularly, wash their hands before cooking whilst only 1 percent washed before feeding a child (MICS, 2006).

24 Health Management Information System, Report for Financial Year 2007/8.

A high incidence of malaria among under-fives (107% during 2007/8 financial year) is a major underlying cause of malnutrition given the resultant loss of appetite, poor food utilisation, and loss of precious time for food production and child care when it affects the adults. Many households lack the resources to prevent or control Malaria. Only 1 in every 3 children (33%) under the age of five years sleeps under bed-nets, and one in every 5 sleeps under an insecticide treated net (ITN) (MICS, 2006). This is not helped by the weak primary health care services in the country.

2.4.3 Challenges Related to Basic Causes of Malnutrition

The basic causes are many and can be further classified under three categories: human resources, policy and ideological constraints and financial. They are summarized in Box 1 below:

2.5 PURPOSE OF THE NNPSP

The NNPSP is intended to serve as the guiding document for all nutrition stakeholders, including Government, civil society and faith based organisations, the private sector and development partners in championing Government priorities on nutrition for the period 2007-20012, which are outlined in the MGDS. The NNPSP is not intended to replace or duplicate sectoral nutrition strategies, nor does it include detailed operational or implementation plans attributable to any one sector, or detailed budgets for specific interventions. Rather, the NNPSP provides the framework and context within which sectoral and other strategic plans and budgets should be formulated, monitored and coordinated (Box 2).

Box 2:

What The Nnpsp (2007-20012) Will Achieve.

More specifically, the NNPSP is intended to achieve the following 10 key goals:

- Steer the implementation of evidence-based and high impact interventions so as to have lasting improvements in the nutritional status of every Malawian with special attention being given to vulnerable groups (especially infants, young children, people living with HIV, people in emergencies, pregnant and lactating women, boys and girls in school, the elderly, people with disability and poor men and women).
- Promote the adoption of optimal nutrition practices, healthy lifestyles and appropriate dietary habits among men, women, boys and girls.
- Increases access by expanding the coverage of key nutrition services.
- Provide a framework for standardization and improvement of the quality of nutrition services in all sectors through the development and dissemination of national guidelines and use of effective communication strategies.
- Place nutrition high on the national development agenda by adequately informing policy makers, decision makers, programme managers, development partners, the private sector, civil society, local leaders, service providers and caregivers about the importance of investing in nutrition, the investment priorities and the roles of each player.
- Reposition nutrition as a cross cutting issue to be integrated and mainstreamed into all national development efforts.
- Mobilise resources, support, partnerships and greater involvement from all the key stakeholders and other duty bearers at different levels.

BOX 2: (CONTINUED)

- Set out the framework for capacity building in key nutrition areas such as clinical nutrition, dietetics and community nutrition and for strengthening institutional and sectoral capacity for the effective delivery of nutrition services and implementation of nutrition programmes.
- Facilitate the development, implementation and enforcement of nutrition legislation.
- Promote nutrition research and the sharing of best practices.

2.6 RATIONALE

The persistently high levels of malnutrition in the country, especially chronic protein energy malnutrition and micronutrient deficiency disorders continue to pose a serious threat to all Malawians. Women, children and people living with HIV and chronic diseases are particularly vulnerable. Strong policy guidance is required to reverse these trends so that such structural impediments to economic and social development can be removed.

High prevalence of malnutrition persists yet many policy and programme initiatives have been implemented in Malawi. These previous initiatives failed to make significant impact in terms of improving the nutrition well being of vulnerable population groups because several bottlenecks hindered the translation of even at times well meaning policies into effective action. Malawi, for example, adopted the first Food and Nutrition Policy in 1990, but the nutrition component was not given adequate attention, in terms of well defined implementation structures, budgetary allocation and capacity for community implementation. This limited the effective implementation

of the planned activities and delivery of nutrition services to the intended beneficiaries. The Government has identified the problem and seeks to address it by coming up with the NNPSP that strengthens the links between the various dimensions in one results-oriented and coherent policy and strategic document.

Previously, nutrition interventions were to a large extent guided by a multiplicity of sectoral policies and strategies that were developed in a fragmented manner on the basis of individual sector mandates, priority areas, key functions and comparative advantage. The policies were vertically implemented without clear coordination, national policy guidance and linkage to other national development and nutrition promotion agendas. The NNPSP has been developed specifically as a necessary overarching framework from which sectors will draw guidance on nutrition matters when developing their policies and strategic plans in future. The approach will promote synergy between sector policies and plans in the area of nutrition. To this end, the NNPSP intends to facilitate enhanced multi-sectoral approach, integration and collaboration in line with the "3 Ones" principle.

Furthermore, implementation of previous sectoral policies was undermined by a number of factors, the main ones of which were lack of political will and commitment to support nutrition at various levels. Nutrition services, programmes and projects were accorded low priority which often reflected in low budget allocations and huge funding gaps at the implementation and, resultantly, gross under-achievement of milestones of nutrition programmes. A major and self-evident consequence of the vicious spiral has been the lack of real progress in nutritional status of Malawians over many decades. The new policy breaks the cycle by placing nutrition high on the development agenda and mobilising the much needed political support at the highest level.

Widespread and rampant poverty and chronic food insecurity exacerbated malnutrition, which was not helped either by the inadequate and inappropriate nutrition information, the HIV and AIDS pandemic, gender disparities,

environmental degradation, weak implementation and coordination structures and an acute shortage of trained personnel in nutrition – both at national, district and community levels and among development partners, civil society and the private sector.

In addition, past efforts placed more emphasis on treatment of nutrition disorders with little going to prevention. Whilst treatment and rehabilitation are important, these are often at higher costs and yet coming too late since some of the damage (especially to height for age, and mental development) will have become irreparable. The policy therefore seeks to reverse the in-balance by placing more emphasis on prevention measures as a more effective, efficient and sustainable strategy of reducing all forms of malnutrition including the non-communicable nutrition related diseases, but while increasing access to timely and effective treatment as necessary.

The Malawi Government recognises the growing global and national recognition of nutrition as a cross cutting issue whose impact on economic growth and prosperity is unquestionable. Adequate nutrition is fundamental to long-term human capital development and attainment of the Millennium Development Goals. Hence the inclusion of nutrition as a priority area in the Malawi Growth and Development Strategy, the current medium-term strategy steering national efforts towards the MDGs and the Vision 2020 goals. This NNPSP proffers the operational mechanism to translate what is articulated in the MGDS under nutrition, into concrete action on the ground. It is against this background that the policy has been developed in order to promote coordinated and focused implementation of nutrition interventions or programmes and projects that will have significant impact on improving child and women nutrition, while at the same time the country's nutritional status.

2.7 LINKAGES WITH OTHER POLICIES OF THE MALAWI GOVERNMENT AND ITS DEVELOPMENT PARTNERS AS WELL AS INTERNATIONAL DECLARATIONS

Whilst the NNPSP will serve as the main driver of nutrition interventions, it has not been designed, and will not be implemented, in a vacuum. Malawi's Vision 2020, which at present is being championed through the Malawi Growth and Development Strategy (2007-20012), itself a successor to the Malawi Poverty Reduction Strategy (MPRS), provides the overarching framework from which the NNPSP is drawn. The targets set in the NNPSP are drawn from and harmonized with those already set in the MGDS. These targets are consistent with the MGDs, which at present serve as the overarching framework guiding Malawi's development partners' present and future investments. The NNPSP recognizes the existence of the United Nations Development Assistance Framework (UNDAF) and adoption of the Paris Declaration Principles on Aid Effectiveness as a policy framework guiding the relationship between (Development Partners) DPs and the Government as they strive together to develop Malawi. In this regard, the NNPSP promotes this type of partnership between Government and the DPs, as well as with non-state actors (private sector and civil society).

Recognition is also made of the fact that many other national policies exist and are being implemented over the same period of the NNPSP, some operationalize specific aspects of the NNPSP whilst others complement it by addressing other critical determinant factors of human well being which have not been included in the NNPSP since they are best addressed by other sectors (see Box 3 for the typology of policies linked to the NNPSP).

Box 3:

Policies And Programmes Complementing The Nnpsp

Category A: Policies that operationalize the NNPSP

- Infant and Young Child Nutrition Policy (2005) revised 2009
- Integrated Early Childhood Development Policy (2004) revised 2008
- Accelerated Child Survival and Development Plan (2007-20012)
- Agricultural Development Programme (ADP) (2008)
- National Education Sector Programme (NESP) (2009)

Category B: Policies that complement the NNPSP

- Agriculture and Food Security Policy (2006)
- Fisheries and Aquaculture Policy (2001)
- Strategic Plan to Improve Livestock Production (2003-2008)
- Poverty Alleviation Policy Framework (1994)
- Gender Policy (2000) and Implementation Plan (2004) revised 2008
- Ministry of Health Plan (1999 to 2004) and Programme of Work (2004)
- National HIV and AIDS Framework (2005 to 2009) revised 2009
- National Water Policy (2005) revised 2008
- Essential Health Care Package (2002)
- Reproductive Health Policy (2002)
- Orphans and Other Vulnerable Children Care Plan of Action (2005)
- Integrated Management of Childhood Illnesses (Draft, 2005-6)

Category C: Previous nutrition policies that have been succeeded by the NNPSP

- National Plan of Action for Nutrition (2000)

Finally, the Government views the NNPSP as an important step towards complying with Articles 13 and 14 in the Universal Declaration of Human Rights, 1948, which state that: "The freedom from want for food and the right to nutrition is the basic human right". The new policy is also an important instrument for achieving what is already stated in the national Constitution of Malawi: "The state shall adopt and implement policies and legislation aimed at achieving adequate nutrition for all Malawians in order to promote human wellbeing and self-sufficiency".

2.8 COORDINATION OF THE MULTI-SECTORAL APPROACH

Nutrition is a multi-disciplinary issues best addressed through well coordinated multi-sectoral approaches. The lack of an institutionalised coordination mechanism for nutrition has been one of the main contributors to the non-effectiveness of past interventions. Inadequate coordination of the planning and implementation of nutrition programmes and projects often resulted in undue duplication of services and programmes without proper equitable distribution and convergence of resources. Nutrition interventions have been implemented mostly as vertical projects with little human capacity, technical competency development and numbers in the public sector.

The NNPSP seeks to address the gap and recognises the need to strengthen the new institutional arrangements set up by Government recently to address the concern. The NNPSP specifically recognises the importance of strengthening the national level coordination. As such, the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet (OPC), in its role as secretariat for the provision of policy direction, guidance and oversight is responsible for the coordination of the implementation, monitoring and evaluation of the NNPSP. It also recognises the need to strengthen and support

nutrition coordination structures at national and local authority levels. In addition, the NNPSP advances the strengthening of sectoral capacity at national and local authority levels in order to effectively coordinate programme implementation at all levels.

3 VISION, GOAL, MISSION & OBJECTIVES

3.1 VISION

The vision of the National Nutrition Policy and Strategic Plan is that of **"ensuring adequate nutrition for all Malawians by 2015"**[25].

3.2 GOAL

The Goal of the Policy and Strategic Plan is to **"have a well nourished Malawi nation with sound human resource that effectively contributes to the economic growth and prosperity of the country."**

3.3 MISSION OF THE NNPSP

The mission of the NNPSP is to: **"provide visionary policy direction, technical guidance and oversight to policy makers and nutrition stakeholders to design, develop and implement nutrition programmes, projects and services that are effective in improving the nutritional status of all Malawians."**

25 Ideally, adequate nutrition for all Malawians is required within the next 2-5 year period. In line with the MGDS and Vision 2020, however, the policy's vision has extended the period to 2015 as a fulfilment of the MDGs.

3.4 STRATEGIC OBJECTIVES

The overall objective is to: ***lay a solid foundation for human capital development and economic growth and prosperity in Malawi through a better nourished population. Three strategic objectives shall be pursued in this regard and these define the three focus areas of intervention.***

Objective 1: To prevent and control the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups.

Objective 2: To increase access to timely and effective management of the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups.

Objective 3: To create an enabling environment for the effective implementation of nutrition services and programmes between 2007 and 2012.

4 KEY PRIORITY AREAS OF ACTION

The section presents the key priority areas of investment envisaged under each strategic objective. The emphasis is on high impact interventions that are known to reduce short-term and long-term nutrition disorders and also to promote early case detection and timely management of malnourished children, adolescents and adults.

Strategic Objective 1:

1 To prevent and control the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups

The high priority interventions targeted for support under objective 1 are:

1. Promotion of optimal breastfeeding practices for children 0-6 months in the context of HIV and AIDS at facility, community and household level.
2. Promotion of optimal feeding practices for children 6-24 months or beyond to sustain breast feeding while giving appropriate complementary feeds with emphasis on feeding frequency, amount, energy and nutrient density and diversity based on the six food groups.
3. Strengthening of optimal feeding of a sick child during and after illness.
4. Promotion of women's nutritional status among the general public.

5. Prevention and control of micronutrient deficiency disorders with emphasis on Vitamin A Deficiency, anaemia and iodine deficiency disorders.
6. Promotion of practices that promote health life styles, food availability, diversity, access, proper storage, preparation, utilisation, the consumption of a variety of foods from the six food groups every day, safety and quality in the general population.
7. Promotion of access to at least one nutritious meal and related health and nutrition services for the school-going children through the school feeding and the school health and nutrition programmes.
8. Strengthening capacities for households and communities to attain adequate nutrition for their families with emphasis on socio-economically deprived persons.
9. Promotion of food safety and quality.
10. Controlling of nutrition related non-communicable and other diseases.

Box 4:

Components Of The Essential Nutrition Actions

1. Improving women nutrition before, during and after pregnancy
2. Optimal breast feeding in the context of HIV and AIDS
3. Optimal complementary feeding
4. Feeding a sick child, during and after illness
5. Control of iodine deficiency disorders
6. Control of anaemia
7. Control of Vitamin A Deficiency

These priority areas have been carefully selected based on the recognition that the stage of foetal development and the first two years of a child's life are the most crucial for determining child survival and the potential for growth and development in later life. The major source of influence in selecting prevention interventions is the Essential Nutrition Actions (ENA) approach which promotes the implementation of small and well defined high impact nutrition actions at the lowest level, by care givers, individuals and service providers to improve women and children's nutrition. The ENA approach has proven to improve children's and women nutrition and to reducing child mortality by more than 25 percent in other countries. It has been singled out in the Lancet series for January 2008 which focused on nutrition and the global Renewed Action for Ending Child Hunger as being one of the most effective approaches for preventing malnutrition.

The choice of these priority areas of interventions have also been informed by emerging evidence on nutrition interventions that can accelerate the reduction of maternal and child undernutrition in 36 high prevalence countries. Recent research work by Black (2008) published in the January 2008 Lancet series, for instance, modelled the impact of different nutrition interventions at full coverage and concluded that breastfeeding promotion and Vitamin A supplementation would have the greatest impact on child mortality reduction infant mortality rate (IMR) by 9.1% and 7.2%, respectively) whilst zinc supplementation and promotion of optimal complementary feeding would reduce stunting by 17% and 15 respectively) and scaling up of the coverage of iron and folate supplementation would reduce maternal deaths by 20%.

Box 5:
Nutrition Interventions With High Impact When Scaled Up To Full Coverage

A. Reductions in child mortality at full coverage

A1. Child interventions that reduce child mortality

- Breastfeeding promotion – 9.1%
- Vitamin A Supplementation – 7.2%
- Zinc Supplementation – 3.6%
- Treatment of severe malnutrition – 2.2%
- Complementary feeding promotion/supplementation – 1.5%

A2. Maternal interventions that reduce child mortality

- Energy/protein supplementation – 2.9%
- Intermittent preventive malaria treatment – 1.9%
- Multiple micronutrients – 1.6%

B. Reductions in maternal mortality at full coverage

- Iron and folate supplementation - 20%

C. Reductions in child stunting at full coverage

- Zinc supplementation – 17%
- Complementary feeding promotion/supplementation – 15%
- Hygiene promotion – 2.4%

Source: Black, Robert, 2008, Nutrition Interventions that Can Accelerate the Reduction of Maternal and Child Undernutrition. The Lancet Series, 2008.January.

Ensuring adequate nutrition for women in pregnancy prevents nutrition deficiencies that affect mental, physical and physiological development of the child before birth. The Government of Malawi is aware that promotion of adequate maternal nutrition is important in order to give the expected child a good start in life in line with an old saying that "Chonona chichokera kudzira". In addition to improving pregnancy outcomes, promotion of adequate maternal nutrition before, during and after pregnancy is vital for reducing maternal morbidity and mortality which at present is very high at 807 deaths per 100,000 live births).

After birth, the child goes through various milestones such as doubling its birth weight at 6 months, sitting, crawling, walking and running, all of which increase nutrition requirements as well as the risk of infection as the child interacts with the surroundings. Appropriate feeding practices are therefore important to ensure adequate nutrition and health for the child.

Exclusive breast feeding for the first six months has shown to reduce child mortality by about 4 percent in Ethiopia. In Malawi it has also reduced infant and child mortality. Exclusive breast feeding rates have been increasing in Malawi, from 3 percent in 1992 (MDHS) to 53 percent (MDHS, 2004) and 56.7 percent (MICS 2006). The trends in exclusive breastfeeding have been associated with declining trends in the infant mortality rate[26]. Further improvements are needed since a significant proportion (43 percent) of mothers still introduce other foods and fluids earlier than six months. Such sub-optimal breast feeding practices are estimated to contribute to about 19 percent of infant mortality in the country. If no further action is taken to improve breast feeding practices among mothers, 82,000 infants are likely to die in the next 10 years which translates into 8,200 deaths per year.

26 IMR has declined from an average of 234 per 1,000 live births during the period 1988-1992 to 189 per 1,000 live births between 1996-2000 and 76 per 1,000 live births between 2000 and 2004 (MDHS, 2004). The MICS 2006 report estimated IMR at 72 live births per 1,000.

Optimal complementary feeding has been associated with about 8 percent decrease in child mortality in some countries. In Malawi, more than 70 percent of children continue to breastfeed up to 2 years, however, the additional foods and fluids that are given to the children from six months are usually inadequate in terms of quantity, quality, diversity and feeding frequency. Most are cereal based foods that are not enriched. Hence the focus by the policy on improving complementary feeding practices.

Many children in Malawi are malnourished as a result of illnesses that have an impact on nutrition (Malaria, diarrhoea, ARI, etc). Feeding a child during and after sickness facilitates recovery and protects the child from becoming worse. Appropriate feeding of sick children has been proven in some countries to contribute to a reduction in child mortality by one percent. In Malawi, this would translate to 1,900 children's lives saved over a period of 10 years. Control of micronutrient deficiencies is also associated with reduced morbidity and mortality. For example, some studies elsewhere have shown that control of anaemia can reduce child mortality by 0.4 percent.

The Government is aware that if the child is malnourished before reaching 2 years of life, the effects may be irreversible even when the nutritional status improves in the later years. The policy is therefore placing greater emphasis on promoting optimal feeding practices for children from 0-2 years in line with the best practices documented in the Essential Nutrition Actions and the Lancet series. The interventions are linked with high impact interventions already being promoted through other national policies and strategies including the Five Year National Strategic Plan for Accelerated Child Survival and Development (ACSD) in Malawi (2007) and the Infant and Young Child Nutrition Policy (2005). The focus areas have also been selected based on the recommended priority areas in the Renewed Action for Ending Child Hunger (REACH) which emphasises on paying attention

to micronutrient promotion, food availability, parasite control, management of acute malnutrition and behaviour change promotion for Infant and young child feeding.

The Essential Nutrition Actions that the policy is advocating for will be delivered based on the principles of behaviour change promotion and intensive civic education to create demand for the services and to promote sustainable adoption of key nutrition practices. Lessons from West Africa do show that a behavior change strategy that seeks to promote small "doable", culturally appropriate actions that most families can afford will be effective[27] even when applied at large scale. Furthermore, the overall conclusion which states that comprehensive, long-term communication interventions can produce significant improvements in a broad range of household-based nutrition behaviors, even in impoverished communities is very relevant for Malawi where poverty is endemic and often blamed for the limited behaviour change. For Malawi, the most significant gains in nutrition, especially reduction of chronic malnutrition, in the future are likely to come from behaviour changes and hence the policy specifically targets this objective as an integral part of the ENA approach.

The NNPSP also directs resource allocation towards increased production, proper preparation, storage and utilisation of high nutritive food crops and rearing of livestock to promote food diversity and availability at household and community level. Last but not least, on prevention measures, implementation of social protection programmes for people in emergency or vulnerable conditions through targeted food distribution and cash transfer programmes is also prioritised by the NNPSP.

27 Parlato, Margaret, and Renata Seidel, eds. 1998. Large-Scale Application of Nutrition Behavior Change Approaches: Lessons from West Africa. Published for the USAID by the Basic Support for Institutionalizing Child Survival (BASICS) Project. Arlington, Va.

The Government of Malawi also recognises the direct link that exists between nutrition, HIV and AIDS and other chronic illnesses, hence promotion of nutrition, care, treatment and support is also a key strategic area for the NNPSP.

Strategic Objective 2:

2 To increase access to timely and effective management of the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups

The key priority area of investment identified for objective 2 is promotion of access to quality nutrition and related services to facilitate timely and effective management of nutrition deficiency disorders in under-five children, adolescents and adults. To realise this objective, the NNPSP places emphasis on the promotion of early case detection and management of acute malnutrition in children less than 12 years. For the adolescent and adult group, special attention is drawn to those living with HIV, the chronically ill and those with TB. Under management of nutrition disorders, the priority services being considered are summarised in Box 6.

Box 6:

Key Priorities Areas For Strengthening Management Of Malnutrition

1. Scaling up of Community Therapeutic care (CTC), Therapeutic and Supplementary feeding services to whole district in all the 28 districts.
2. Scaling up of the provision of Nutrition Treatment, Care and support to People Living with HIV (PLHIV), TB and other chronically ill patients in all the ART sites in all the Districts and through the Home-based care, orphan care and work place programmes.
3. Strengthening of logistics, linkages and referral in the continuum of care of children, adolescents and adults with malnutrition up to the community level.
4. Strengthening of services delivery for early detection and management of Nutrition-related Non-communicable diseases such as diabetes, obesity, hyper tension, gout and many others at the community to the district and Central and hospitals.

Strategic Objective 3:

3 To create an enabling environment for the effective implementation of nutrition services and programmes

Under objective 3, the following areas of investment and action have been prioritised:

1. Establishment of a well defined coordination mechanism for nutrition services, programmes and projects at national, district and community levels.
2. Advocacy to reposition nutrition at the top of the national development agenda.
3. Development of legal and other operational instruments to guide the implementation of nutrition programmes and services.
4. Increased budgetary allocation of resources by government and development partners for the implementation of the NNPSP.
5. Building of institutional and human capacities for the effective delivery of nutrition services and design, development and implementation of relevant nutrition programmes, projects and interventions in the public sector.
6. Promoting evidence-based programming of nutrition programmes, projects, activities, interventions and services through the generation and dissemination of nutrition research information and findings and appropriate documentation and dissemination of best practices.
7. Promotion of a national nutrition response based on “the 5 ones” principle.
8. Development and operationalization of results-oriented monitoring and evaluation.

9. Government is aware that nutrition issues cut across many sectors, including health, agriculture, water and sanitation, social welfare, education, women and child development, among others. In addition, the work of many different units within a given sector directly influences nutrition outcomes of the population at large, for instance, programmes such as agricultural input subsidy programme, malaria control, reproductive health, Child Health Days initiative, direct cash transfers, food aid distribution, management of the Strategic Grain Reserve, and irrigation development, among many others.
10. The multi-sectoral nature of the response has to be harnessed. Hence the NNPSP fosters advocacy at senior policy levels among Government, development partners, Civil Society Organisations (CSOs) and the private sector to ensure that those who make decisions are aware of the implications for nutrition and the opportunities within their sector to reinforce the achievement of the objective. The NNPSP embraces guidance from other policies already being implemented and links the NNPSP to them so that the various initiatives by the Government are mutually grounded.

The NNPSP advocates for increased and predictable budgetary allocation to nutrition services and programmes as well as strong coordination and management of nutrition interventions at the national level. Previously, the absence of a coordinating mechanism affected the availability, accessibility and utilisation of quality nutrition services. Most interventions were ad-hoc, fragmented and vertical with little cross-fertilisation of ideas. No institution had an overall mandate and vision for nutrition and as such interventions were mostly opportunistic, individualistic and short-lived, mostly financed through projects as opposed to national programmes with predictable funding. They were therefore non-sustainable. Government seeks to take leadership in addressing the anomaly by allocating and ring-

fencing significant resources for nutrition through the national budget instrument and encouraging its partners to do the same and subscribe to the integrated nutrition fund.

Another key priority area identified by the NNPSP is the strengthening of knowledge and skills in nutrition. This covers a broad range of issues including the capacity for stewardship and championing of the nutrition vision (including formulation of sound policies and nutrition programmes, regulation, and monitoring and enforcement of standards), training and curriculum development, programme management and supervision. Government is mindful of the fact that the nature of capacity enhancement needed for nutrition is not only that which narrowly focuses on knowledge and skills of individuals but one that takes a holistic approach to capacity building and addresses all four tiers of capacity development and building needs: (1) structures, systems and roles, (2) staff and facilities, (3) skills, and (4) tools, hence the need for adequate resources. In doing so, Government is also cognisant of the importance of measures to retain the capacity once it has been created, hence cost-efficient and effective measures for retaining the capacity will be adopted.

KEY RESULT AREAS

In pursuit of the strategic objectives of the NNPSP, a number of key results areas have been identified for investment under each objective.

Strategic Objective 1:

4

To prevent and control the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups

The key result areas prioritised for pursuit under objective 1 are: -

1. Increase in exclusive breastfeeding rates of children 0-6 months in the context of HIV and AIDS.
2. Increase in the percentage of children 6-24 months that are breastfed while getting a variety of nutritious foods and fluids from the six food groups with increased frequency, amount, energy and nutrient density, utilisation and active feeding (FADUA) with age.
3. Increase in the number of children that are fed optimally during and after illness.
4. Increase in the percentage of women with adequate nutrition as measured by Body Mass Index.
5. (i) Increase in the number of people consuming micronutrient rich and fortified foods in Malawi.(ii) Increase or maintenance of the coverage of micronutrient supplementation to under-fiveand school-aged children, pregnant and lactating women to above 80%.
6. (i) Increase in the number of households that practice appropriate food utilization, food choices, combinations and dietary diversification and variety to achieve and sustain adequate nutrition for their families.
   (ii) Increase in the number of caregivers and households with improved knowledge and skills in appropriate food utilisation, processing, post harvest management, storage and preparation.
7. (i) Increase in the number of pupils with access to nutritious diets and other nutrition related services.

(ii) Increase in the number of pupils and teachers with appropriate knowledge and skills in promoting or for adopting practices that promote food availability, diversity, access, proper storage, preparation, utilisation, safety and quality.

8. Increase in access to economic resources for improving nutrition among family members and the socio-economically deprived persons.
9. Protection of Malawians from health and nutrition hazards that result from consumption of poor quality and contaminated processed foods.
10. Reduction in morbidity from nutrition related diseases and disorders.

The ultimate aim under this objective (see also section 7) is to reduce prevalence of nutrition disorders. Among under-fives the objective is to reduce the prevalence of (1) stunting from 46% (MICS 2006) to at least 40% by 2012, (2) underweight from 21% (MICS 2006) to at least 15%, (3) wasting from 3.5% (MICS 2006) to at least 2%, (4) VAD from 59% (NMS 2001) to 40% and (5) Anaemia (NMS 2001) from 80% to at least 60%. In school children (5-10 years) the NNPSP aims to reduce stunting from 30%[28] to 20%, underweight from 18% to less than 10%, wasting from 3% to less than 1%, VAD from 38% to 25% and anaemia from 54% to 34% by 2012. The NNPSP furthers the objective of reducing the proportion of women of child bearing age with BMI <18.5 from 10% to 6% and prevalence of anaemia among pregnant women from 47% (NMS 2001) to 35%,

28 Baseline data refers to findings of the National School Health and Nutrition Survey (NSHNBS 2006).

STRATEGIC OBJECTIVE 2:

5 To increase access to timely and effective management of the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups

The key result area for objective 2 is the improvement in the quality of management of malnutrition in under-five children through Community Therapeutic Care (CTC) and stand alone Nutrition Rehabilitation Units (NRU) and Supplementary Feeding sites where there is no CTC and in adolescents and adults.

The ultimate focus is on increasing and maintaining the cure rate above 80% in out patients (OTP) and NRU sites whilst reducing and maintaining the death rate below 2% in OTP sites and less than 10% in NRUs.

STRATEGIC OBJECTIVE 3:

6 To create an enabling environment for the effective implementation of nutrition services and programmes

Six key results have been prioritised for objective 3 and they are:

1. Incorporation of nutrition in key sectoral policies such as Agriculture, Education, Women and Child Development, National HIV Policy, National AIDS Framework and programmes like workplace programme for HIV for a multi-sectoral approach.
2. Achievement a double increase in budgetary allocation of resources by government and her bilateral, multilateral NGO partners and the private sector for the implementation of the nutrition services, programmes, projects and interventions at different levels annually.

3. Building and improving institutional capacity at all levels of the society for the effective delivery of nutrition services, programmes and interventions with a focus on the facility, community and outreach levels.
4. Facilitation of a coordinated implementation of nutrition programmes at all levels based on national and sectoral policies and guidelines.
5. Establishment of a mechanism for coordinating Nutrition Research.
6. Improvement of the Nutrition Management Information System (NMIS) at all levels to ensure timely nutrition data flow and reporting for monitoring and planning.

The policy and strategic plan aims at lobbying for a real increase in budget allocation to nutrition from the present 0.05% and 1.45% of GDP by government and donors, respectively, to at least double.

5 POLICY STATEMENTS & GUIDING PRINCIPLES

POLICY STATEMENT:

The Government of Malawi has firmly positioned nutrition on the development agenda and created an enabling environment for effective and timely prevention, control and management of nutrition disorders among women, men, girls and boys.

5.1 OPERATIONAL POLICY STATEMENTS

Operational Statement 1: Malawi shall firmly position nutrition on her development agenda through inclusion of Nutrition in key development policies and programmes, allocation of adequate resources, strengthening institutional and human capacity, putting in place necessary coordination mechanisms in all sectors for the implementation of the National Nutrition Policy at all levels.

Operational Statement 2: Malawi shall strive to create and sustain strong partnerships with public and private sector, civil society and development partners for the implementation of nutrition programmes.

Operational Statement 3: Government shall periodically develop, review and disseminate guidelines in order to standardise and improve the quality of nutrition services.

Operational Statement 4: Government shall promote nutrition education, counselling and negotiations as principles for behaviour change so as to sustain the adoption of key optimal nutrition practices.

Operational Statement 5: Government shall ensure the attainment of adequate nutrition among the population by promoting optimal nutrition practices, appropriate food choices and combinations for diversified diets and healthy lifestyles among all Malawians using a National Nutrition Programme that focuses on prevention, management, control and treatment of various forms of nutrition disorders.

Operational Statement 6: Government shall ensure and deliberately increase access to resources for care, production and access to high nutritive value foods in terms of quantity, diversity and quality.

Operational Statement 7: Government shall generate, disseminate and ensure evidence based programming of nutrition services, programmes, projects and interventions using research information and findings.

5.2 GUIDING PRINCIPLES

The implementation of the policy and the accompanying strategic plan will be guided by a set of mutually reinforcing principles, outlined below. More specifically, these principles shall inform policy decisions, programme priority setting, design of interventions, approach to the implementation and resource allocation criteria for the achievement of the Planed objectives.

VGUIDING PRINCIPLE 1: Political will and commitment
The Implementation of the policy will be done with a high level of political will, commitment and leadership that will grant nutrition high priority on the government development agenda.

GUIDING PRINCIPLE 2: Good governance.
Nutrition services shall be delivered through structures and systems that protect and benefit men, women, boys and girls at all levels.

GUIDING PRINCIPLE 3: The rule of law
The Policy will be based on the rule of law through an established set of legal principles and norms within which government and society must function. Its implementation will be supported by law enforcement and public observance of such laws. Entities of the state shall respect the verdict of the courts.

GUIDING PRINCIPLE 4: Economic governance
Sustained economic growth, shared by all members of the society, will contribute to the achievement of improved nutritional status among men, women, boys and girls.

GUIDING PRINCIPLE 5: Human rights
The right for all people to have access to safe and nutritious diets shall be observed in accordance with the fundamental basic rights of citizens to be free from malnutrition and related disorders.

GUIDING PRINCIPLE 6: Accountability and transparency
The government will ensure that the mandates contained in the policy are carried out in a responsible, efficient and transparent manner, with zero tolerance on corruption.

GUIDING PRINCIPLE 7: Community empowerment
Empowerment of communities with adequate nutrition knowledge, skills and resources will be prioritised for the successful implementation of the policy.

GUIDING PRINCIPLE 8: Sustainable Use of Natural Resources and Services
A protected environment, including proper sanitation, water protection, personal hygiene, availability of food preparation facilities and energy, shall be taken as prerequisites for the policy success.

GUIDING PRINCIPLE 9: Sustainable Use of Natural Resources and Systems
The services described will be provided through structures and systems that promote preservation of the environment and maximize environmental benefits to ensure long-term sustainability.

GUIDING PRINCIPLE 10: Gender Equity in Nutrition
Gender equality and equity will be enhanced in all nutrition initiatives to ensure improved nutritional status of women, men, girls and boys. Efforts shall be devoted to improving women's socio-economic status relative to that of men in all aspects of nutrition.

GUIDING PRINCIPLE 11: Equity in Nutrition for Vulnerable Groups
Disability, age, HIV and AIDS, and other vulnerabilities such as orphanhood shall not be a hindrance to accessing adequate nutrition.

GUIDING PRINCIPLE 12: Science and evidence based interventions
All nutrition initiatives will be based on scientifically proven evidence and best practices.

PART B:
STRATEGIC PLAN

6 STRATEGIES & EXPECTED RESULTS

This section presents the strategic outcomes expected under each objective as well as the strategic targets, strategic outputs, key strategies and the annual targets for activities envisaged under the NNPSP. A table summarising strategic outcomes for each strategic objective are provided in the respective sections. It should be noted that the key strategies presented here correspond to the key priority areas earlier highlighted in section 4. Hence key strategies have been specified for each of the three strategic objectives, namely: prevention and control of nutrition disorders; management of nutrition disorders and creating an enabling environment.

Strategic Objective 1:

1 To prevent and control the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups

The strategies identified to prevent and control nutrition disorders are expected to facilitate the adoption of appropriate nutrition practices and healthy life styles among caregivers, in households and communities in the country. They are also expected to increase access and coverage of services that encourage prevention of various forms of nutrition disorders. The nutritional status of Malawians is therefore expected to change and result in substantial improvements in nutrition outcomes for all population groups.

6.1.1 Strategic Outcomes

Table 2: Strategic outcomes for prevention and control of nutrition disorders

Expected outcome	Baseline	Source	Target	Time frame	Source
Reduced proportion of children with low birth weight	14%	MICS 2006	<10%	2012	MICS
Reduced prevalence of stunting in children under five years of age	46%	MICS	40%	2012	MDHS/ MICS
Reduced prevalence of wasting in children under five years of age	3.5%	MICS	<2%	2012	MDHS/ MICS
Reduced prevalence of underweight in under five children	21%	MICS	15%	2012	MDHS/ MICS
Reduced proportion of pre- under-five children with Vitamin A Deficiency (VAD)	59%	National Micronutrient Survey, 2001)	40%	2012	National Micronutrient Survey
Reduced prevalence of stunting in school age children (5-10 years)	30%	National SHN Baseline Survey, 2006	25%	2012	National Micronutrient Survey

Table 2 (Cont): Strategic outcomes for prevention and control of nutrition disorders

Expected outcome	Baseline	Source	Target	Time frame	Source
Reduced prevalence of wasting in school age children (5-10 years)	3%	National SHN Baseline Survey, 2006	<1%	2012	National Micronutrient Survey
Reduced prevalence of underweight in school age children (5-10 years)	18%	National SHN Baseline Survey, 2006	<10%	2012	National Micronutrient Survey
Reduced proportion of preschool aged children with anaemia	80%	National Micronutrient Survey, 2001)	60%	2012	National Micronutrient Survey
Reduced proportion of school age children with Vitamin A Deficiency	38%	National SHN Baseline Survey, 2006	25%	2012	National Micronutrient Survey
Reduced proportion of school age children (5-10 years) with anaemia	54%	National SHN Baseline Survey, 2006	34%	2012	National Micronutrient Survey

Table 2 (Cont): Strategic outcomes for prevention and control of nutrition disorders

Expected outcome	Baseline	Source	Target	Time frame	Source
Reduced median urinary iodine level in school children (µg/ litre)	100	National SHN Baseline Survey, 2006	100	2012	National Micronutrient Survey
Reduced percentage of women of child bearing age with malnutrition (BMI less than 18.5)	10%	MICS, 2006	6%	2012	MDHS/ MICS
Reduced anaemia in pregnant women	47%	NMS	35%	2012	NMS

6.1.2 Strategic Targets

Table 3[29]: Strategic targets for prevention and control of malnutrition

#	Intervention	Indicators	Baseline	Source	Target 2012
1	Use of iodised salt	% of households using adequately iodised salt (15 p.p.m)	49%	MICS 2006	90%
2	Early initiation of breastfeeding and temperature management	% of newborns initiated on breast milk within the first hour of birth	70%	MDHS 2004	>80%
4	Exclusive breastfeeding for children up to 6 months	% of children exclusively breastfed for 6 months	57%	MICS 2006	80%
5	Continued breastfeeding for children 6-24 months	% of children aged 20-23 months still breastfeeding.	70%	MICS 2006	>80%
6	Complementary feeding for children	% of children aged 6-59 months who received 5 or more feeds in the last 24 hours	49%	MoH Nutrition Surveillance Data, 2007	80%

29 Notes: a/ MoH stopped collecting data on iron supplementation. The HMIS is being reviewed in consultation with stakeholders. This indicator will be once again included in the HMIS so as to continue with its monitoring.

Table 3 (Cont): Strategic targets for prevention and control of malnutrition

#	Intervention	Indicators	Baseline	Source	Target 2012
7	Supplementary feeding based on national guidelines for pregnant and lactating women who are malnourished	% of malnourished pregnant women that are receiving supplementary food	60%	MoH Programme Reports	90%
8	Management of malnourished children aged 5 to 12 years	% of malnourished children (5-12 years) admitted to CTC and cured	80%	MoH Programme Reports	>80%
9	Vitamin A supplementation for school age children (5-10 years)	% of school age children (5-10 years) that receive Vitamin A supplementation	0%	MoH/ SHN Programme Reports	80%
10	Vitamin A supplementation for preschool children (6-59 months)	% of pre-school age children (6-59 months) that receive Vitamin A supplementation	80%	MoH/ SHN Programme Reports	>90%

Table 3 (Cont): Strategic targets for prevention and control of malnutrition

#	Intervention	Indicators	Baseline	Source	Target 2012
11	Vitamin A supplementation for post-natal women	% of post-natal women that receive Vitamin A supplementation within 8 weeks after delivery	46%	MICS 2006	>80%
12	Iron and folate supplementation for pregnant women a/	% of pregnant women that receive iron and folate supplementation	TBC	MOH	TBC
13	Iron supplementation for school age children through the SHN programme	% of school age children (5-10 years) that receive iron supplementation	0%	MoH/ SHN Programme Reports	80%
14	De-worming for pre-school age children (12-59 months)	% of children (12-59 months) that are de-wormed bi-annually	>80%	MoH/ SHN Programme Reports	>90%
15	De-worming for school age children (5-10 years)	% of school age children (5-10 years) that are de-wormed annually	0%	MOH / SHN Programme Reports	80%

6.1.3 Strategies, Strategic Outputs and Strategic Activities

To differentiate the numbering of the strategies, those for prevention are numbered P1, P2, P3 and so on, whilst those for management are numbered M1, M2, and so on and those for enabling environment are numbered E1, E2, and so on.

Strategy P1:	Promotion of optimal Breastfeeding practices for children 0-6 months in the context of HIV and AIDS at facility, community and household level

Strategic Output 1: Increase the number of the Baby Friendly Hospitals every year

Strategic Activities

1. Conduct annual advocacy and orientation meetings of management teams for the targeted health facilities
2. Conduct working sessions to review the Infant and Young Child Nutrition Policy and Guidelines in the context of HIV and AIDS to incorporate new WHO recommendations for feeding HIV exposed children
3. Orient stakeholders and trained service providers and counsellors to the revised Infant Feeding Guidelines in the context of HIV and AIDS
4. Provide technical support to health facilities to maintain or attain the Baby Friendly Hospital Initiative (BFHI) status
5. Conduct annual assessment of health facilities for BFHI status, and re- assessment of Baby Friendly Hospitals

6. Conduct bi-annual review and coordination meeting for stakeholders

Strategic Output 2: Increase the number of service providers with adequate knowledge and skills to counsel mothers and other caregivers in optimal infant and young child feeding.

Strategic Activities

1. Train service providers in infant and young child feeding counselling in PMTCT sites and other service delivery points.
2. Conduct working sessions to integrate infant and young child feeding counselling in the accelerated child survival and other relevant programmes to cover four programmes.
3. Train community based service providers in infant and young child feeding in the context of HIV and AIDS.
4. Orient community support groups for each PMTCT and BFHI facility on infant and young child feeding counselling.
5. Orient community leaders on Infant and young child feeding in each district.
6. Conduct working sessions to develop clearly defined referral network among HTC, PMTCT and Infant feeding counselling services.

Strategic Output 3: Strengthen support and protection to mothers to adequately and successfully breastfeed at national, district and community level.

Strategic Activities

1. Conduct bi-annual sensitisation and awareness campaign on the role of breastfeeding in child survival among the public, local leaders, service providers, communities and caregivers.
2. Conduct sensitization meetings with members of the civil societies to incorporate civil society involvement in the promotion of optimal Infant and young child feeding practices

by orienting all the NGOs working on Nutrition to the Essential Nutrition Actions and available guidelines and tools for nutrition promotion

3. Conduct bi-annual orientation and review meetings on the code of marketing infant and young child foods with stakeholders
4. Train code monitors in each district, City Assembly, major boarder, and at national level.
5. Conduct ad-hoc code monitoring at assembly and national levels on infant and young child foods in strategic districts in the country (cities, boarder and main towns), health facilities and other relevant Institutions.
6. Conduct regular meetings for the National Code Advisory Committee.
7. Conduct orientation meetings for men and women of the press and embark on a mass media campaign to increase awareness among employers and employees on the need for maternity protection and support to lactating mothers through various media channels.
8. Engage community based service providers and support groups in regular follow-up and support to pregnant and lactating mothers in all communities, TAs and district assemblies.
9. Conduct TOTs for growth monitors in infant feeding to link growth monitoring and promotion of the child to appropriate feeding practices according to age.

Strategy P2:	Promotion of optimal feeding practices for children 6-24 months or beyond to sustain breast feeding while giving appropriate complementary feeds with emphasis on feeding frequency, amount, energy and nutrient density and diversity based on the six food groups

Strategic Output 1: Scale up implementation and integration of the Essential Nutrition Actions (ENA) in various programmes, projects and contact points with the mother and the child at all levels.

Strategic Activities

1. Conduct stakeholders' orientation meetings on the Essential Nutrition Actions (ENA) approach.
2. Conduct a workshop to develop job aids for the integration of ENAs in the nutrition programmes, projects, child survival programmes and other development interventions and activities at all service delivery points and disseminate to service providers by 2012.
3. Conduct ENA training of trainers workshops.
4. Conduct training for the service providers from the sectoral Ministries and other stakeholders in ENA at the district and community levels
5. Mobilise communities through the various community based service providers, Nutrition, HIV and AIDS workers, community leaders and other structures to integrate ENA in community based services, activities and programmes to reach households in the country through community based campaigns.

Strategic Output 2: Increase the knowledge and skills of 6 million service providers, caregivers, households and communities in appropriate infant and young child feeding practices through a comprehensive communication strategy and civic education.

Strategic Activities

1. Conduct working sessions to develop the nutrition education kit on infant and young child feeding for information dissemination and civic education using the behaviour change communication approach.

2. Orient stakeholders such as Programme Coordinators and Managers on the use of the kit.
3. Conduct nation-wide nutrition education campaigns in collaboration with the Ministry of Information and civic education and other government sectors, civil society's organisations, the local leaders and politicians.
4. Conduct community sensitisation meetings, debates and dialogue on the recommended Infant and young child feeding practices.
5. Conduct workshops to produce standardised messages on Infant and young child feeding and print booklets with these messages for dissemination.
6. Conduct national and localised campaigns annually to disseminate key messages that promote optimal Infant and young child feeding practices in all districts.
7. Orient service providers in various child survival programmes annually to the optimal practices and the key messages on optimal Infant and young child feeding practices at all levels.
8. Conduct meetings with people from assemblies to design a well defined system for providing on-going support and follow-up to caregivers, households and communities to strengthen their skills in implementing the recommended feeding practices.

Strategy P3:	Strengthening of optimal feeding of a sick child during and after illness

Strategic Output 1: Strengthen integration of optimal practices and messages on feeding a child during and after illness in key child survival programmes such as IMCI, PMTCT, Growth monitoring and promotion.

Strategic Activities

1. Conduct working sessions to review guidelines, protocols and counselling tools for IMCI, PMTCT and growth monitoring to incorporate or update guidelines and key message on feeding a child during and after illness according to age.
2. Orient service providers on the revised materials and tools.
3. Integrate counselling services on the feeding and management of a sick child, in PMTCT, follow-up and growth monitoring services.

Strategy P4:	Promotion of women's nutritional status among the general public

Strategic Output 1: Increase the number of women eating a variety of food from the six food groups with appropriate number of meals according to their physiological status.

Strategic Activities

1. Conduct working sessions to review key policies and guidelines on promoting maternal health (PMTCT, Maternal and neonatal health, Reproductive Health) to incorporate optimal nutrition practices and key messages for promoting women's nutrition before, during and after pregnancy.
2. Orient service providers in each district such as Maternal and Child Health Coordinators, Growth Monitors, Safe Motherhood Coordinators and providers, Family planning providers, IMCI providers, PMTCT coordinators, Agriculture Extension workers and other community service providers on promoting women's nutrition.

Strategic Output 2: Promote availability, accessibility and consumption of a variety of foods from the Malawi Six Food Groups everyday by the women, men, girls and boys in order to strengthen households and communities capacities to adopt the optimal nutrition practices and health life styles for improving women's and the general population's nutritional status.

Strategic Activities

1. Conduct annual food fairs in all ADCs and EPAs on the production and consumption of indigenous, high nutritive value foods and other foods from the six food groups for varied and diversified diets.
2. Conduct field visits and working sessions to document the type and diversity of foods for various agro-ecological areas or districts in Malawi according to seasonal variations.
3. Produce, print and disseminate copies of a food calendar based on the seasonal and agro-ecological zones food variations.
4. Identify sources of seed materials for indigenous and high nutritive value foods and stocks of animals for distribution to vulnerable households (e.g. PLHIV, pregnant and lactating mothers, under 5s and OVCs) and mobilize communities.
5. Support a seed multiplication centre for planting materials and stock in each EPA in the country.
6. Conduct bi-annual consultative meetings per region and joint planning meetings to promote production of aqua-culture and other nutritious agricultural products through other development programmes and projects.
7. Advocate for agricultural practices that encourage diversified food crops production practices among farmers in all districts through other programmes and projects.
8. Provide support to the communities, households and individuals for them to run income generating activities for adequate access to a variety of foods at all times in all districts.

9. Conduct working sessions to develop recipes that use indigenous foods to diversify diets, micronutrient rich foods plus oil and fortified foods and conduct dissemination meetings in all districts and through media.
10. Conduct regular community level demonstrations in preparation and consumption of locally available nutritious foods such as indigenous fruits, vegetables, legumes, oilseed crops, staples, livestock, fish, ngumbi, bwamnoni, mbewa, nkhungu, phalabungu, mapala, sesenya, matondo and other locally available foods.

Strategy P5:	Prevention and control of micronutrient deficiency disorders with emphasis on Vitamin A Deficiency, anaemia and iodine deficiency disorders

Strategic Output 1: Promote consumption of micronutrient rich and fortified foods among all Malawians

Strategic Activities

1. Conduct working sessions to develop nutrition information kit on the importance of eating micronutrient rich foods and disseminate through mass media
2. Conduct advocacy through mass media and campaigns at all levels on the consumption of fruits rich in Vitamins A and C with every meal to aid in the utilisation of the Vitamin A from the fruits and Iron from plant sources in the body.
3. Conduct civic education campaigns using mass media and community activities on the use of iodised salt in all the family foods.
4. Conduct a food consumption survey to determine commonly consumed foods.

5. Conduct working sessions to develop or review and disseminate standards for fortification of sugar, maize meal, cooking oil, salt and Likuni Phala within the Malawi Bureau of Standards regulations or the Public Health Act.
6. Conduct workshops to orient captains of the industry and other stakeholders to the standards and engage them to fortify their centrally processed food products.
7. Conduct assessments and stakeholder consensus building meetings to identify gaps and strengthen the establishment of mechanism for the distribution of and access to fortified foods by the vulnerable groups in the country..
8. Develop and disseminate tools for monitoring fortified foods to inspectors in all districts and cities.
9. Develop a logo for fortified foods and conduct national wide social marketing campaigns on fortified foods in collaboration with the civil societies, Ministry of Information and Civic Education.
10. Conduct regular and ad-hoc monitoring of industries, port of entry and outlets of fortified foods.
11. Conduct working sessions to develop standard guidelines that include fortified foods for social protection programmes to encourage the use of fortified foods in such programmes.

Strategic Output 2: Strengthen the delivery of micronutrient supplementation to targeted beneficiaries according to schedule through routine services and targeted campaigns

Strategic Activities

1. Conduct biannual Child Health Days that cover Vitamin A supplementation, de-worming and nutrition education on child care practices and other child survival interventions.
2. Conduct national, district and community level sensitisation meetings on the importance of supplementation among caregivers, communities and service providers as part of the child health days.

3. Conduct meetings with stakeholders to review and reach consensus on a reliable supply chain logistics management system to ensure adequate availability of micronutrient supplementation supplies.
4. Conduct working sessions of MCH, IMCI, CTC and community workers for every district to facilitate the integration of Micronutrient supplementation services and promotion at each contact point with the child and the woman.

Strategy P6:	Promotion of practices that promote healthy life styles, food availability, diversity, access, proper storage, preparation, utilisation, the consumption of a variety of foods from the six food groups every day, safety and quality in the general population

Strategic Output 1: Develop and disseminate recipes and guidelines based on the various food combinations using the "Multi-mix principle" for designing family meals.

Strategic Activities

1. Conduct working sessions to develop a set of recipes and guidelines for designing and planning family meals and for the elderly, the chronically ill, and non-communicable diseases based on "Multi-mix Principle".
2. Conduct intensive national and localised nutrition education through Community Workers such as: Nutrition and HIV and AIDS Workers, Agriculture Extension Workers, Community Development Assistants, HSAs; and mass media, fairs, focus group discussions on appropriate food choices, combinations, food preparation and utilisation.

Strategic Output 2: Develop and disseminate guidelines on food utilisation, processing, post harvest management, storage, preparation techniques, based on typically available foods and quantities to maximise nutrition benefit from available foods throughout the year.

Strategic Activities

1. Conduct working sessions to review food utilization guidelines, that include collection, storage, processing and preparation techniques based on locally available foods and quantities to maximize nutritional benefits and print copies of the guidelines every year.
2. Conduct working sessions to develop information education and communication (IEC) materials on food preparation, processing and storage.
3. Disseminate the food preparation, processing, storage and utilization guidelines through civic education, mass media and village demonstrations at all levels.
4. Conduct trainings for service providers on food processing, preparation, storage and participatory recipe development.
5. Conduct meetings with research institutions on food preparation, processing and storage and engage them to produce appropriate technologies.
6. Conduct tours and exchange visits to food processing sites twice a year.
7. Orient tutors, supervisors and community nutrition workers on food processing, storage, preparation, utilisation and Community Nutrition Programmes
8. Monitor the implementation of the food processing technologies and standards through field visits twice a year.
9. Review and document existing post-harvest nutritious food management practices and IEC materials through field visits and working sessions.
10. Train extension workers in post-harvest food management.

11. Disseminate the materials on post harvest food management through multi-media messages.
12. Advocate for the development and adoption of labour saving technologies on post-harvest food management during meetings.

Strategic Output 3: Promote the consumption of a variety and adequate food in both quality and quantity to meet the nutritional needs for rural and urban households with special emphasis on vulnerable groups and low-income households.

Strategic Activities

1. Conduct field visits to collect information for developing audio-visual documentaries on food budgeting and dietary diversification, produce the documentary and air on radio and TV.
2. Conduct working sessions to develop comprehensive food composition tables, design a standard meal and produce dietary recommendations for various population groups for Malawi including those for Non Communicable Dietary related diseases (NCDs).
3. Conduct civic education on the amount of food that families should keep taking into account food seasonal variations.

Strategy P7:	Promotion of access to at least one nutritious meal and related health and nutrition services for the school-going children through the school feeding and the school health and nutrition programmes

Strategic Output 1: Scale up and strengthen the implementation of the School feeding and school Health and Nutrition Programme to all public primary schools by 2012

Strategic Activities

1. Strengthen the roles and responsibilities of the school health and nutrition committee by developing clear terms of reference, programme and budget.
2. Scale up the school feeding programmes with integration of nutrition education and growth monitoring to all public primary schools in phases.
3. Build capacity of schools (training, equipment, materials and other resources) to conduct regular nutrition assessment and health and nutrition education in all public primary schools and surrounding communities by 2012.
4. Support schools to establish school gardens and cooking demonstrations that promote appropriate food choices and combinations in all public primary schools.
5. Orient school pupils, teachers and the community in all public primary schools to the Essential Nutrition Actions.
6. Conduct school quiz and debate on the Essential Nutrition Actions.
7. Conduct bi-annual national and localised nutrition and health campaigns in schools and surrounding communities.
8. Facilitate early case detection, provision of diagnosis and treatment of minor ailments such as malaria, diarrhoea, skin conditions, mild anaemia, referral and follow up to pupils in all public primary schools.
9. Facilitate the provision of appropriate water and sanitary facilities in public schools for prevention of infectious diseases.

Strategic Output 2: Strengthen the integration of nutrition in the school curricula at different levels and the teaching of nutrition in schools.

Strategic Activities

1. Conduct working sessions to review school curricular for basic and secondary education and hold a stakeholder consultation meeting for consensus.
2. Conduct working sessions to incorporate nutrition in the curricular and accompanying teaching and learning materials.
3. Mobilise resources through advocacy meetings targeting individual donors and partners and print the revised curricular and materials.
4. Disseminate the new curricular and materials to key stakeholders at national and divisional workshops.
5. Conduct orientation sessions for teachers in the new curricular and materials.
6. Monitor the teaching of nutrition lessons in primary and secondary schools.

Strategy P8:	Strengthen the capacities of households and communities to attain adequate nutrition for their families with emphasis on socio-economically deprived persons.

Strategic Output 1: Facilitate the establishment of economic empowerment activities for improving nutrition in households and communities with a focus on the socio-economically deprived persons.

Strategic Activities

1. Conduct needs assessment.
2. Facilitate the formation of economic empowerment groups (EPGs).
3. Facilitate the training of EPGs on credit and business management.
4. Facilitate the Linking of groups to financial lending institutions.
5. Facilitate the provision of credit and business management support to the households and communities.

6. Facilitate the training of communities in financial and home management.

Strategy P9: Promotion of food safety and quality

Strategic Output 1: Strengthen enforcement of food safety and quality regulations

Strategic Activities

1. Conduct working sessions to review existing national legislation and regulations according to the international Sanitary and Phyto-Sanitary (SPS) agreements and hold regional consultative workshops and field visits and international trips to facilitate the development of the Nutrition Act to include labelling, marketing, promotion and comprehensive mandatory standards for all marketed food products, street commercial and imported foods and food aid, street food vending and marketing of food supplements.
2. Conduct working sessions to develop guidelines to regulate the development and use of minimum standards for modern biotechnology, Genetically Modified Organisms (GMO's) and Genetically Engineered Seeds and Substances (GESS)
3. Strengthen institutional capacity of the Department of Nutrition, HIV and AIDS, Malawi Bureau of Standards (MBS), Consumers Association of Malawi (CAMA) and other public watchdogs on consumer safety to monitor food safety and quality through training in food safety and quality control.
4. Conduct periodic monitoring of food industries, food packaging industries and warehouses as well as outlets including those importing or repackaging iodised salt by National team and district inspectors.

Strategic Output 2: Increase knowledge among consumers on food safety and quality

Strategic Activities

1. Develop education materials on food safety and quality.
2. Orient stakeholders to the materials developed.
3. Conduct nationwide civic education and radio and TV documentaries on food safety and quality in collaboration with Ministry of Information and Civic Education, Consumer Association of Malawi and human rights civil societies in each district.

Strategy P10:	Control of nutrition related non-communicable and other diseases

Strategic Output 1: Promote practices that reduce the risk of diseases among Malawians

Key action areas

1. Conduct advocacy meetings with key stakeholders on the provision of safe water and sanitary facilities to the communities in both rural and urban areas at national and district level.
2. Facilitate civic education on the importance of using safe water and correct use of sanitary facilities in all districts
3. Facilitate civic and health education on key practices to prevent diseases among various population groups at all levels and in early health care seeking behaviour
4. Develop and review dietary guidelines and recommendations for people suffering from specific nutrition-related diseases, such as, diabetes, hypertension and certain types of cancer among others including communicable tuberculosis, HIV and AIDS to communities, extension, Health and other social service providers
5. Conduct a series of training sessions to orient service providers on the guidelines

6. Conduct child health campaigns at national, district and community levels on Non Communicable Diseases.

6.1.4 Annual Targets and outputs

Annual targets and outputs from the key action areas are summarized in Annex 2.

STRATEGIC OBJECTIVE 2

2 To increase access to timely and effective management of the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups

6.2.1 Strategic Outcomes

Table 4: Strategic outcomes for management of nutrition disorders in children under 5 years of age

Expected outcome	Baseline	Source	Target	Time frame
Cure rate, OTP	84.4%	MOH	>85%	2012
Cure rate, NRU	80.3%	MOH	>85%	2012
Cure rate combined	83.3%	MOH	>85%	2012
Default rate, OTP	11.7%	MOH	<5%	2012
Default rate, NRU	3.5%	MOH	<5%	2012
Default rate combined	7.6%	MOH	<5%	2012
Death rate, OTP	2.4%	MOH	<2%	2012
Death rate, NRU	11.9%	MOH	<10%	2012
Death rate combined	4.7%	MOH	<2%	2012
Infant mortality rate	72/1,000 live births	MICS, 2006	68/1,000	2012
Under-five mortality rate	122/1,000 live births	MICS, 2006	117/1,000	2012

6.2.2 Strategic Targets

Table 5: Strategic targets for management of nutrition disorders

#	Inter-ven-tion	Indicators	Base-line	Source	Target 2012
1	Service provi-sion	Increase in number of NRUs	95	MoH/ UNDAF	100
		Increase in number of districts where CTC is offered	14	MoH/ UNDAF	27
		Increase in number of BFHI (with nutrition package)	20	MoH/ UNDAF	48
		Increase in number of ART sites with nutri-tion package	60	MoH/ UNDAF	120
		Increase in number of PMTCT sites with nu-trition package	119	MoH/ UNDAF	300
		Number of nutri-tion, care, treatment and support (NCTS) groups	TBC	MoH/ UN-DAF/ OPC	348
		Person reached with NCTS	13,019	MoH	18,700
		Increase in number of CTC sites	258	MoH	381
		Increase in number of OTP sites	292	MoH	381
		Increase in number of SFP sites	>270	MoH/ WFP	381

Table 5 (Cont): Strategic targets for management of nutrition disorders

#	Inter-ven-tion	Indicators	Base-line	Source	Target 2012
2	People (wom-en, men, chil-dren, adoles-cents) reached with nutri-tion therapy and clini-cal care services	Number of children reached by CTC ser-vices	28,648	MoH/ Pro-gramme reports	50,000
		Person reached with NCTS	13,019	MoH	18,700
		Number of children reached by OTP ser-vices	21,254	MoH	50,000
		% coverage of TFC	TBC	MoH	TBC
		% coverage CTC	TBC	MoH	TBC
		No. of community-based growth moni-toring and promotion groups per village (all 28 districts)	TBC	MoH	1

Table 5 (Cont): Strategic targets for management of nutrition disorders

#	Inter-ven-tion	Indicators	Base-line	Source	Target 2012
3	Skills and knowl-edge en-hance-ment of service provid-ers	Trainers trained on prevention and man-agement of moderate and severe malnutri-tion	TBC	MoH	20
		Service providers on prevention and man-agement of moderate and severe malnutri-tion trained as trainers	300	MoH	330
4	Skills and knowl-edge en-hance-ment of coun-sellors	Number of trainers of community workers trained	0	OPC	300

Table 5 (Cont): Strategic targets for management of nutrition disorders

#	Inter-ven-tion	Indicators	Base-line	Source	Target 2012
5	Moni-toring of case man-age-ment out-comes	**No. of cases moni-tored (Jan-Dec; baseline is for 2008):**		MoH	
		OTP	29,554		35,000
		NRU	8,919		10,400
		SFP	50,371		59,000
		NTCS for PLHIV	13,019		15,200
		NTCS –TB	TBC		TBC
		NTCS Chronically ill	TBC		TBC
6	Guide-lines	Number of guidelines availed	TBC	MoH/ OPC	TBC
		Number of people ori-ented and able to pro-vide case management services correctly using the guidelines	TBC	MoH/ OPC	TBC

Source: a/ Data on CTC, OTP, NRUs, SFP and NCTS is obtained from the MOH/NAC/UNCEF (2009) RCC Joint Proposal.

Notes: TBC refers to data that will be confirmed by baseline assessment.

6.2.3 Strategic Outputs

Strategy M1:	Promoting access and quality of nutrition and related services to facilitate effective management of nutrition deficiency disorders in under-five children, adolescents and adults

Strategic Output 1: Review and consolidation of guidelines for prevention and management of malnutrition in under-five children, adolescents and adults and the work place HIV and AIDS guidelines.

Strategic Activities

1. Compile existing guidelines for management of malnutrition through Community Therapeutic Care, Therapeutic and Supplementary feeding in under-five children, pregnant and lactating women, adolescents and adults from Government and other stakeholders.
2. Conduct stakeholders meetings to review the guidelines.
3. Conduct a series of working sessions to consolidate the guidelines
4. Disseminate the guidelines through in-service training of service providers, nutrition coordination, planning and committee meetings and other contact points and mass media in all districts.
5. Develop job aids and other accompanying materials on the use of the guidelines.
6. Build capacity at district and community levels for further dissemination as well as interpretation, implementation and monitoring and evaluation of the use and effectiveness of the guidelines.
7. Orient zone officers and key stakeholders on the use of the guidelines

8. Include guidelines for the provision of Nutrition Care and Support in the HIV Work Place Guidelines for the use of the 2 percent government budgetary allocation in all government sectors and departments
9. Conduct dissemination meetings with stakeholders
10. Communicate with all government sectors through a circular on the guidelines and circulation as well as orientation of key users in Government Departments to the said guidelines

Strategic Output 2: Provide necessary knowledge and skills to service providers on the management of acute malnutrition in under-five children, pregnant and lactating women and on the provision of nutrition treatment, care and support to adolescents and adults through in-service and on the job training with emphasis on mentoring the service providers and sharing of experiences.

Strategic Activities

1. Develop consolidated training materials in prevention and management of moderate and severe acute malnutrition in infants, young children, adolescents and adults.
2. Conduct training of trainers' workshops in prevention and management of moderate and severe acute malnutrition in infants, young children, adolescents and adults.
3. Train service providers with emphasis on mentoring to facilitate effective transfer of skills.
4. Conduct on-spot technical supervision of trained service providers regularly in all districts.
5. Orient tutors from pre-service institutions, DHMT and zone officers on prevention and management of moderate and severe acute malnutrition in infants, young children, adolescents and adults.

Strategic Output 3: Strengthen community follow-up and participation in treatment of clients with malnutrition.

Strategic Activities

1. Develop information kit and standardised check list for early case detection, follow up and referral of clients.
2. Conduct training of Community Nutrition Workers, HSAs, CDAs, AEDOs, AEDCs, SWAs, AEHO and others
3. Conduct community registration of various population groups
4. Conduct weekly door to door visits to households with malnourished individuals
5. Conduct community nutrition assessment sessions monthly and more frequently where deemed necessary in all districts.
6. Conduct community sensitisation meetings on prevention, causes, control, management and existing programmes for management of malnutrition in all TAs in all districts.
7. Engage the trained community members in growth monitoring and active case detection in their communities.
8. Strategic Output 4: Monitor case management outcomes for appropriate action.

Strategic Activities

1. Produce and disseminate consolidated checklist for monitoring case management outcomes to service providers in all CTC sites
2. Train DHMT, service providers and community workers on the use of the checklist in interpretation, reporting and response
3. Compile and produce district monthly reports for action and reporting to central level
4. Produce quarterly bulletin on malnutrition cases, interventions and case management outcomes.

Strategic Output 4: Provision of adequate knowledge and skills to service providers and empower them to manage and monitor malnutrition in PLHIV, TB and chronically ill patients.

Strategic Activities

1. Review guidelines and accompanying materials for Nutrition Care, Support and Treatment (NCST) of PLHIV, TB and chronically ill patients.
2. Conduct dissemination meetings with stakeholders on the guidelines
3. Develop training materials in management of moderate and severe acute malnutrition on Nutrition Care, Support and Treatment (NCST)
4. Conduct training for trainers' on the guidelines.
5. Train service providers and other stakeholders annually on the guidelines.
6. Conduct on-spot technical supervision of the trained service providers in all districts.
7. Orient tutors from pre-service institutions, DHMT and zone officers on the guidelines.
8. Train DHMT, service providers and community workers on the use of the checklist on the interpretation, reporting and response.
9. Compile and produce district monthly reports for action and reporting to central level.
10. Produce quarterly bulletin on nutrition situation, interventions and case management outcomes.

Strategic Output 5: Provide necessary knowledge and skills to caregivers and clients on nutrition management of HIV related conditions and infections

Strategic Activities

1. Conduct periodic review of nutrition education and counselling materials in NCST.
2. Print and distribute revised materials to all sites.
3. Orient nutrition counsellors and other service providers at the facility and community levels
4. Conduct nutrition education and counselling sessions for client and their caregivers at the facility and community levels.
5. Develop a comprehensive nutrition communication strategy for NTSCP.
6. Implement the strategy using various means of communication.
7. Develop IEC material for service providers, clients and caregivers based on standardised message.
8. Disseminate IEC materials at various levels using various channels at both facility and community level.

6.2.4 Annual Targets and Outputs

Annual targets and outputs are presented in Annex 2.

3 STRATEGIC OBJECTIVE 3
To create an enabling environment for the effective implementation of nutrition services and programmes

6.3.1 Strategic Targets

Table 6[30]: Strategic targets for creation of an enabling environment

#	Intervention	Indicators	Base-line	Source	Tar-get 2012
1	Development and utilization of nutrition manuals and guidelines	Nutrition policies, guidelines and training manuals developed and utilised	No	OPC	Yes
2	Development and utilization of nutrition information system	Nutrition information system established and timely reports received on at least 70% of the nutrition indicators	No	OPC	Yes

30 Notes: TBC refers to data that will be confirmed by baseline assessment.

Table 6 (Cont): Strategic targets for creation of an enabling environment

#	Intervention	Indicators	Base-line	Source	Tar-get 2012
3	Advocacy for increased resource allocations by Government and donors towards nutrition	% increase of Government and stakeholders real budgetary allocations towards nutrition activities	0	OPC	10%
4	Develop and cost nutrition plan annually and jointly	Nutrition plan developed, costed and implemented	No	OPC	Yes
5	Integration of nutrition in sectoral policies	% of sectors with policies that integrated nutrition	50%	OPC	100%
6	Establish nutrition coordination structures at national, sectoral and local authority levels	Nutrition coordination structures available at national (1), sectoral (16) and local authority (28) levels	Yes (1)	OPC	Yes (44)
7	Develop a National Research Agenda on Nutrition	National Research Agenda on Nutrition developed	No	OPC	Yes

Table 6 (Cont): Strategic targets for creation of an enabling environment

#	Intervention	Indicators	Base-line	Source	Tar-get 2012
8	Develop a National Nutrition Act	National Nutrition Act developed	No	OPC	Yes
9	Creation of positions for nutrition in key government ministries and institutions	Number of government ministries with sufficient posts created and filled for nutrition	0	OPC	16
		Number of local authorities with sufficient posts created and filled for nutrition	0	OPC	28
		% of government ministries (16) with sufficient posts created and filled for nutrition	0	OPC	100%
		% of local authorities (28) with sufficient posts created and filled for nutrition	0	OPC	100%

6.3.2 Strategic Outputs

Strategy E1:	Firmly position nutrition on the national development agenda and include Nutrition in the key development programmes, allocate adequate resources, strengthen institutional and human capacities, put in place necessary coordination mechanisms in all sectors for the implementation of the National Nutrition Policy and Strategic Plan at all levels.

Strategic Output 1: Government to ensure that all development policies adequately take nutrition on board as a priority area for achieving economic growth, stability and prosperity.

Strategic Activities

1. Conduct advocacy meetings with Heads of government ministries, departments and Institutions, national, district and local leaders on the magnitude, consequences of malnutrition and its impact on individuals, communities and national economic growth and prosperity
2. Hold meetings to reach consensus with stakeholders on the importance of incorporating nutrition as a cross-cutting issue in national and sectoral departments
3. Conduct working sessions with sectors to review existing policies and guidelines to identify gaps.
4. Conduct working sessions to incorporate nutrition in existing sectoral policies and guidelines
5. Facilitate the inclusion of nutrition in sectoral strategic and work plans through bi-annual joint planning and review meetings.

Strategic Output 2: All government sectors and departments' roles and responsibilities on nutrition clearly defined and nutrition included in their sectoral development policies and plans.

Strategic Activities

1. Conduct stakeholders analysis for nutrition to identify their roles and responsibilities based on the sectoral mandates and comparative advantage
2. Hold meetings to reach consensus on roles and responsibilities for each government sector
3. Define and disseminate the roles and responsibilities for each sector
4. Lobby for creation of nutrition positions in all the Government Ministries and Departments to facilitate the incorporation and mainstreaming of nutrition in the sectoral policies and programmes.
5. Facilitate the recruitment of Nutrition staff for the sectors.
6. Facilitate the deployment of Nutrition staff for the sectors.
7. Facilitate inclusion of nutrition in sectoral strategic and work plans through bi-annual joint planning and review meetings.

Strategic Output 3: Establish and strengthen sectoral nutrition programmes and implementation units and partnerships with well defined terms of reference and means of giving feed back to nutrition stakeholders.

Key action areas

1. Conduct Stakeholders meetings with government sectors, NGO, Bilateral and Multilateral Partners, the Private sector, Academic Institutions, the media and others to review current sectoral programmes, key achievements, lessons learnt, challenges and opportunities.

2. Conduct joint stakeholders meetings to facilitate the development of comprehensive nutrition implementation plans that clearly define objectives, outcomes, outputs, key roles and responsibilities of various government and private sectors as well as multilateral, bilateral and NGO partners based on their mandate, focus areas and comparative advantage.
3. Facilitate building of the institutional and human capacity of the sectoral institutions.
4. Facilitate quarterly reporting of nutrition services by each sector.
5. Conduct biannual Nutrition Implementers feed back meetings.

Strategic Output 4: Nutrition stakeholders in the private sector include services, programmes and projects aimed at promoting adequate nutrition for all Malawians in their policies and plans in line with the MGDS.

Strategic Activities

1. Conduct one to one advocacy and negotiation meetings with the private sector to mainstream nutrition services in their programmes.
2. Facilitate the establishment of a Business Coalition for nutrition with clear terms of reference and feed back mechanisms.
3. Identify partners for the coalition.
4. Develop terms of reference for the coalition.
5. Include the private sector in planning and review meetings.
6. Strategic Output 5: Bilateral and multilateral partners place nutrition high on their Government of Malawi support agenda in line with the MGDS and MDGs in order to contribute to the operationalization of the National Nutrition Policy and Strategic Plans.

Strategic Activities

1. Conduct an advocacy meeting with the Bilateral and multilateral partners on the magnitude of nutrition problems, consequences and priority areas for action.
2. Facilitate the establishment of a Government-Development Partners Coordination group to facilitate collaboration and networking.
3. Conduct quarterly review meeting with the partners and other stakeholders.
4. Participate in joint programme review and planning of activities under development partners' support to government (UNDAF).

Strategic Output 5: Proper alignment of nutrition programmes and projects initiated by the Non-government organizations with the National Nutrition Policy and Strategic Plan and the MGDS for maximum benefits to Malawians.

Strategic Activities

1. Orient NGOs on the National Nutrition Policy and Government priorities as defined in the MGDS.
2. Produce guidelines on project identification, targeting, implementation and monitoring for NGOs
3. Conduct meetings to disseminate the guidelines to NGOs.
4. Take stock of programmes and projects that are already underway by assessing on-going nutrition activities and existing coordination structures at all levels in order to build on them and for possible scale up with partners and NGOs.
5. Consolidate guidelines for reviewing NGO projects.
6. Review proposals from NGOs and approve where the criteria is met.
7. Conduct quarterly joint supervisory visits to NGO projects and provide feedback to stakeholders.

Strategy E2:	Increased budgetary allocation of resources by government and her partners for the implementation of the National Nutrition Policy and Strategic Plan

Strategic Output 1: Government Sectors and Departments allocate and mobilise external financial resources to support nutrition services, programmes, projects and interventions in their sectors.

Strategic Activities

1. Strengthen Government-Development Partners Committee on nutrition to spearhead the resource mobilisation campaigns.
2. Lobby for the establishment of a pool fund for nutrition supported by government and partners.
3. Establish a grants facility allocation section and allocate resources to nutrition implementing stakeholders
4. Disseminate the Nutrition Policy and Strategic Plan to many stakeholders including district assemblies and to advocate for resources.
5. Develop a targeted advocacy tool and use it to mobilise resources.
6. Conduct resource mobilisation campaigns among in-country and outside partners.
7. Make special individual contacts with the donor partners.
8. Lobby with the head of finance and other heads of sectors at national and district level to allocate resources for nutrition.
9. Document and disseminate widely nutrition interventions that have shown impact.
10. Collaborate continuously with partners through information sharing, networking and feedback meetings, learning forums.

Strategy E3:	Government shall strive to build institutional and human capacity for the effective delivery of nutrition services, including the design, development and implementation of relevant nutrition programmes, projects and interventions in the public sector

Strategic Output 1: Creation and filling of new and existing nutrition posts in key Government Ministries and Departments.

Key action areas

1. Lobby for the creation of positions for Nutrition, HIV and AIDS Officers in key Government Ministries and Departments and solicit authority to recruit.
2. Develop a recruitment and deployment plan.
3. Recruit, train and deploy Nutrition, HIV and AIDS Officers.

Strategic Output 2: Increased number of nutrition implementers that have the necessary competencies through pre- and in-service training and regular updates.

Key action areas

1. Document existing training materials in nutrition used by various stakeholders.
2. Conduct a stakeholders meeting to review the materials to identify gaps and for possible consolidation.
3. Conduct a series of working sessions to consolidate the training and accompanying materials.
4. Pre-test the materials in a TOT.
5. Print and distribute the materials.
6. Conduct a series of training session for service providers, supervisors and programme Managers in the consolidated materials.
7. Conduct annual refresher orientation sessions on emerging issues as required.

8. Conduct needs assessment for nutrition personnel at various levels.
9. Lobby for the training of a pool of technical experts in nutrition.
10. Develop training curricula for pre-service training in nutrition.
11. Recruit students for training.
12. Mobilise resources for the training.
13. Produce and implement the training plan.
14. Train students in various specialized areas of nutrition.
15. Conduct periodic orientation and up-date sessions for nutrition implementers of relevant policies and guidelines in nutrition as need arises.
16. Facilitate the participation of Malawian specialists in the international and national nutrition fora and provide for accessible and timely debriefings.
17. Build the capacity of nutrition implementing institutions in monitoring and evaluation of nutrition interventions, services, programmes and projects.

Strategic Output 3: Increased number of trained extension workers to implement nutrition services, programmes and projects in Malawi, with special focus on Community Nutrition Workers.

Strategic Activities

1. Lobby with relevant authorities for the recruitment, training and deployment of 8000 Community Workers positions to service at east 250 households each.
2. Apply for authority to recruit.
3. Conducting a working session to review existing curriculum for community based service providers from various training Institutions to identify gaps.
4. Conduct a writers working session to develop the curriculum for Community Workers.

5. Develop training modules and resource materials for the Community Workers.
6. Mobilise resources and Institutions for training the Community Workers.
7. Recruit and orient Tutors, Supervisors and other relevant staff on Community Workers' training Programme.
8. Recruit, train and deploy the Community Workers.
9. Provide follow-up and on-going support to the trained Community Workers.

Strategic Output 4: Increased institutional capacity of key government departments at national and district level to acquire or procure adequate supplies, materials and equipment for implementing nutrition services, programmes, and projects.

Strategic Activities

1. Facility and conduct community level needs assessment for various nutrition supplies, materials, and storage, equipment and kitchen facilities.
2. Produce a procurement and distribution plan and up date it from time to time as required
3. Orient District and community staff on how to estimate requirements for various nutrition programmes, timely requisition, reporting and logistics management.
4. Facilitate timely procurement and distribution of supplies, materials and equipment for nutrition.
5. Mobilise resources to up-grade storage and kitchen facilities where necessary.
6. Hire services to renovate the facilities as required.

Strategy E4:	Establishment of a well defined coordination mechanism for nutrition services, programmes and projects at central, district and community level

Strategic Output 1: Develop and disseminate a comprehensive Nutrition Business plan that clearly defines the key stakeholders, their key roles and responsibilities based on their mandate, area of focus and comparative advantage both in the public and private sectors.

Strategic Activities

1. Conduct a stakeholders' meeting to define and reach consensus on key mandates, functions, priority areas roles and responsibilities of each stakeholder in the implementation of the policy.
2. Disseminate the roles and responsibilities.
3. Follow-up the sectors quarterly for progress reports.

Strategic Output 2: Establishment and strengthening of Nutrition committee and its sub-committees that shall have well defined terms of reference, work plans and means of giving feed back to nutrition stakeholders.

Strategic Activities

1. Compile a list of all the existing nutrition committees and their Terms of Reference.
2. Identify gaps and solicit consensus from stakeholders on whether other committees should be established.
3. Develop Terms of Reference for each of the new committees.
4. Develop work plan for each committee.
5. Mobilise resources to support the functions of the committees.
6. Facilitate meetings for the committees to review various nutrition programmes in the country quarterly and more often where necessary.
7. Facilitate the circulation of feed-back reports from each of the committee and presentation to the main Nutrition Committee.
8. Consolidate and disseminate the reports quarterly for updates, transparency and accountability.
9. Conduct periodic review of TORs of various committees.

Strategic Output 3: Facilitate rational response to nutrition problems and integration of nutrition and related services by stakeholders through joint review and planning meetings in accordance with the 3 ones principle.

Strategic Activities

1. Conduct Stakeholders meetings with Government Sectors, NGO, Bilateral and Multilateral Partners, the Private sector, Academic Institutions, the media and others to review current sectoral programmes, key achievements, lessons learnt, challenges and opportunities and joint planning
2. Consolidate the sectoral plans into one comprehensive nutrition work plan.
3. Guide the implementation of the work plans based on the standardised guidelines, programme messages, tools, resource materials and formulated, periodic review and dissemination meetings..
4. Monitor the quality of nutrition services delivery through regular joint monitoring and supervisory visits, feedback meetings and updating of stakeholders on emerging issues using various channels.

Strategy E5:	Government shall ensure evidence based programming of nutrition programmes, projects, activities, interventions and services through the generation and dissemination of nutrition research information and findings and appropriate documentation and dissemination of best practices

Strategic Output 1: Facilitate coordinated implementation of Nutrition Research that is responsive to national needs.

Strategic Activities

1. Lobby for the establishment of Nutrition Ethic Research Committee as a sub-committee of the National Research Committee to particularly regulate Nutrition Research.
2. Establish a Committee on research with clear terms of reference and work plan
3. Support the Committee's activities
4. Document existing research including on-going research by various Institutions and individuals through consultative meetings with nutrition research experts.
5. Produce data for nutrition research and researchers.
6. Conduct a research needs assessment to identify priority areas in the various sectors
7. Conduct a meeting with nutrition stakeholders and key policy makers to build consensus on the identified research priority areas.
8. Conduct a working session to develop nutrition research agenda and protocols.
9. Identify potential institutions to conduct research in nutrition.
10. Disseminate the research agenda and protocols to key researchers.
11. Mobilise resources to support the research activities.
12. Conduct Bi-annual review of on-going research and annual dissemination meeting of completed research.
13. Continue tracking and cataloguing new research in nutrition
14. Produce Bi-annual bulletin on nutrition research.
15. Encourage publication and dissemination of research findings.
16. Establish a National Nutrition Information Centre in the Department of Nutrition, HIV and AIDS.
17. Collect and compile copies of research reports, presentations, publications and other information on nutrition for the nutrition resource centre.
18. Inform the public about the resource centre.

19. Conduct annual documentation of best practices.
20. Organise an annual dissemination and feedback meeting with policy makers and key government decision makers for their buy-in.
21. Conduct a stakeholders meeting at various levels to operationalize key research findings and identified best practices.
22. Facilitate regular feed back from Extension workers and other users of the research information
23. Strengthen collaboration between research and extension service providers in nutrition research.

Strategy E6: Results-oriented monitoring and evaluation

Strategic Output 1: Establishment of Nutrition Management Information Systems that is linked to all nutrition programmes, services, projects and interventions.

Strategic Activities

1. Commission consultancy and higher Technical assistant to design the national M and E framework for nutrition in line with the MGDS requirements and the Food and Nutrition Security framework.
2. Identify required management information system
3. Facilitate the recruitment of a Technical Assistant to establish a comprehensive Nutrition Information Management system (NIMS).
4. Build capacity of NIMS and that of stakeholders to include systems operators, analysts and managers at all levels to implement the NIMS and respond to the indicators accordingly.
5. Procure and distribute the necessary equipment, materials and supplies to implement the NIMS
6. Establish, manage and utilise the information system.

7. Conduct regular M and E visits to nutrition implementing Institutions, programmes and projects at all levels.

Strategic Output 2: Increase availability and access to nutrition information by stakeholders and other users at all levels

Strategic Activities

1. Conduct regular feed back and review meetings.
2. Establish a mechanism for receiving and consolidating periodic reports on nutrition programmes, projects and services from all stakeholders.
3. Disseminate the M and E results periodically and facilitate appropriate actions.
4. Produce and disseminate periodic reports and nutrition bulletin.

Strategic Output 3: Strengthen nutrition surveillance at facility and community level

Strategic Activities

1. Commission consultancy to evaluate and review current Nutrition surveillance to identify gaps.
2. Solicit consensus on identified gaps and recommendations.
3. Implement the integrated nutrition surveillance system.
4. Identify key indicators for the integrated nutrition surveillance for programmes, services and localised projects.
5. Develop a monitoring framework and indicators.
6. Train stakeholders at national, district and community levels in the monitoring framework and indicators, importance of collecting data, data collection methods, management, interpretation and utilisation.
7. Procure nutrition assessment equipment.
8. Conduct periodic nutrition assessments among school children in randomly selected schools.

9. Conduct annual nutrition surveys by constituency every year.
10. Build capacity on the utilization of the generated data for rational response to nutrition problems at various levels.
11. Facilitate the harmonization of nutrition information and periodic dissemination to service providers, policy makers, decision makers and other relevant users at all levels for evidence-based interventions.
12. Facilitate feed back meetings and reports at all levels to provide progress and outcome results continuously.
13. Develop a model for community-based nutrition support and coordination systems based on best practices.
14. Establish community resource centres.
15. Disseminate and utilise results for re-planning and re-programming.

Strategic Output 4: Strengthen the Growth monitoring and promotion services of children under five years of age at facility and community levels in all districts.

Strategic Activities

1. Review and produce growth monitoring training materials based on the new WHO growth standards.
2. Develop and produce growth monitoring counselling tools and support materials.
3. Conduct training for service providers at all levels in growth monitoring.
4. Procure and distribute growth monitoring equipment and supplies.
5. Mobilise communities for the implementation of nutrition programmes.
6. Facilitate monthly growth monitoring sessions that are linked to ENA.
7. Establish and strengthen community support systems for the identification and referral of malnourished children.

8. Establish and strengthen community support systems for counselling in maternal, infant and young child-feeding, feeding of a sick child during and after illness and control and prevention of micronutrients.

6.3.3 Annual Target and Outputs

Annual targets and outputs are presented in Annex 2.

7 IMPLEMENTATION FRAMEWORK

The implementation framework for the NNPSP is aimed at supporting nutrition stakeholders at all levels in Malawi to successfully operationalize the Nutrition Strategic Plan. Similarly, the institutional framework is designed to facilitate effective coordination of the national nutrition response at all levels (community, district, sector and national), allow for synergies across sectors towards the achievement of improved national nutrition outcomes, and facilitate the acceleration of nutrition interventions. Consequently, the efforts of the many players participating in the nutrition sector has been recognized, and deliberate effort and measures to harness these efforts while promoting greater harmonization, institutional learning, collaboration and accountability for results in the implementation of the nutrition policy will be actively pursued.

To facilitate coordination, the delivery of the nutrition response will put emphasis on the five ones framework: namely: one response strategy, one coordination framework, one consolidated nutrition fund, one joint work plan and one monitoring and evaluation system. This will assist in ensuring that efforts are concerted and that there is an accountability framework that partners can be jointly held responsible for.

7.1 IMPLEMENTATION STRATEGY

There are three interrelated and mutually reinforcing dimensions to the successful implementation of the Strategy.

- The first dimension is the concept of "nutrition from a life-cycle approach" that recognizes the importance of taking advantage of the "golden interval of intervention" from pregnancy to 2 years. This therefore emphasizes on the need to immediately start with interventions targeted at this age group (for example the 7 Essential Nutrition Actions) as these will immediately prevent further damage to the future (new) generation.
- The second dimension is based on the "UNICEF conceptual framework for nutrition" which recognizes that for nutrition interventions to be successful they have to address the three levels of causes of malnutrition: (i) immediate causes relating to the nutrient intake and wellbeing of the individual in question; (ii) underlying causes relating to the household/family level situation; and (iii) basic causes at the societal level – which are linked to institutions, political and ideological framework, economic structure and the resource environment – including technology and the people. The conceptual framework reveals two types of routes one could take to address under-nutrition: (i) the short routes which refer to interventions to address immediate causes; and (ii) the long routes entailing interventions to address underlying and basic causes of malnutrition. Both routes should be pursued simultaneously in order to have immediate and lasting impacts on the populations' nutritional outcomes.
- The third dimension recognizes that nutrition interventions have different levels of efficacy and cost-effectiveness and hence resource constraints would dictate that top priority be given to those proven to have high potential for impact and cost-efficiency. Preference will be given therefore to out- and up-scaling interventions proven in Malawi to be effective in delivering impact, and piloting of promising new interventions proven elsewhere to work but can be tested and adapted to suit Malawi.

7.2 SEQUENCING THE DELIVERY OF INTERVENTIONS

- Based on the conceptual frameworks highlighted above, the following four categories of interventions will be prioritised for immediate implementation and gradual expansion:
- Prevention and control of malnutrition;
- Management of malnutrition;
- Creating an enabling policy and legal environment and achieving capacity enhancement for institutions, communities and individuals to effectively deliver nutrition interventions; and
- Building capacity of institutions, communities and individuals for effective delivery of nutrition interventions.

7.2.1 Priority Level 1: Interventions for Years 1&2

Phase One of the delivery of the strategic plan focuses on Priority Level 1 interventions that consist of a Minimum Package that not only addresses prevention and management of malnutrition, but also system bottlenecks in order to sustain the impact of the minimum package. The aim of the Priority Level 1 interventions will be to build on what has demonstrated to work in Malawi and to expand the coverage of the same within the districts (out-scaling) by addressing system-wide bottlenecks for outreach and community-based interventions.

In sum, the following activities are envisaged under Priority Level 1:

- Intensifying implementation of the seven high-impact Essential Nutrition Actions (ENA) to strengthen prevention of child malnutrition, including targeting of mothers with ENA interventions to address maternal nutrition;

- Linking and integrating the Essential Nutrition Actions with the high impact interventions promoted through the Accelerated Child Survival programme and the Renewed Action to Ending child Hunger and other relevant programmes;
- Promotion and revitalization of growth monitoring and piloting and scale up of World Health Organisation Standards for 6-12 months in 3 districts;
- Scaling up of School and health nutrition programs;
- Community Therapeutic Centers out-scaling;
- Scale-up of Nutrition Treatment, Care and Support for PLHIV;
- Nutrition education and counseling, promotion of food security targeting PLHIV and affected by HIV, TB, chronically ill patients, intensive civic education on nutrition and HIV using both community and facility-based programmes;
- Scaling-out treatment to reach all in need based on national guidelines and nutrition support to PMTCT mothers and vulnerable OVCs;
- Promoting nutrition education and counseling using a package of developed ENA messages in various programmes such as accelerated child survival and development, maternal and neonatal health care, agriculture services, education services, community based programs, World Breastfeeding Week and Child Health Days among others; and
- Ensuring availability of adequate capacity and enabling environment for the delivery of nutrition services and programmes by lobbying for recruitment of district nutritionists, staffing key sector ministries training and placement of various nutritional cadres, equipping laboratories, undertaking resource mobilization, forging and strengthening partnerships, and ensuring the existence of enabling policy at national and sectoral levels and legislation for nutrition.

7.2.2 Priority Level 2: Interventions in Years 3-5

The aim of Priority Level 2 interventions will be to continue reducing system-wide bottlenecks and providing support for greater outreach and community level impact. Activities to be implemented that include:

- Up-scaling all interventions from Phase One so that all districts in Malawi are covered and all target groups are reached;
- Training of nutritionists (at BSc, MSc and PhD levels and Dieticians) and retaining them and filling out the posts at district and community levels;
- Sensitization, monitoring and enforcement of the National Nutrition Act and Food Safety Law;
- Undertake integrated nutrition surveillance continuously;
- Establishment of the Nutrition Management Information Systems (NIMS);
- Establishment of a functioning research framework; and
- Dissemination, monitoring and enforcement of nutrition guidelines developed under Phase 1.

7.3 INSTITUTIONAL ARRANGEMENTS

7.3.1 Nutrition Institutional and Functional Linkage Framework

The Head of State is the Minister responsible for Nutrition, HIV and AIDS in Malawi and as such holds the mandate for the overall policy direction, oversight and plan the supervision through the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet. At the sectoral and sub-national levels, appropriate institutional arrangements and capacities will be created and resources provided

to facilitate their participation at all levels including the district and community levels Institutional and functional linkage framework is presented in Figure 4 above.

7.3.1.1Coordination Arrangements

National Level

National level coordination of nutrition will be achieved through the various nutrition technical advisory committees operating at the national level. In particular, the Multi-sectoral Technical Committee on Nutrition meeting and the Government-Development Partners meeting will be key in ensuring a coordinated nutrition response. The Department of Nutrition in OPC will act as the secretariat in coordinating various nutrition working groups. In addition, bi-annual and annual review meetings which brings together all key stakeholders in the nutrition sector will be forums for coordination, drawing on implementation experiences and their implications on policy, institutional arrangements and effectiveness of the nutrition response.

District Level Coordination

District level coordination of nutrition issues will be through the District Nutrition Coordination Committees (DNCC). It will be compose of representatives from key sector departments, civil society organizations and private sector agencies implementing nutrition activities and producing food products who are operating in the district. Like all the other technical committees at the district level, the DNCC will be a sub-committee of the District Executive Committee in the Local Assembly (LA) and will provide technical advice to the LA, in addition to coordinating district-wide nutrition issues. The DNCC

will work closely with lower level structures such as the Village and Area Development and Executive Committees, focusing nutrition issues.

The Terms of Reference for the DNCC will be the following:

- Coordinate nutrition issues at the district level
- Provide advice to the Local Assembly and the District Commissioner/Chief Executive on nutrition issues
- Monitor the implementation of nutrition activities in the district
- Conduct nutrition review meetings at the district level
- Receive and review reports from stakeholders in the nutrition sector
- Provide technical advice to stakeholders implementing nutrition activities in the district

7.3.1.2 Institutional Roles and Responsibilities

In order to ensure nutrition issues are at the centre of decision making at the highest level, a number of committees will be established as described below:

a. Oversight

Parliamentary Committee on Nutrition, HIV and AIDS: The committee will be responsible for enforcing accountability in the implementation of the nutrition response, including policy and programme implementation. The Terms of Reference for the Parliamentary Committee on Nutrition are as follows:

- Monitor policy and public sector nutrition implementation.
- Provide nutrition policy implementation oversight.
- Highlight nutrition issues at parliament level.

Cabinet Committee on Nutrition, HIV and AIDS: special Cabinet Committee on Nutrition will be established. Its terms of reference will be the following:

- Provide high level political visibility of nutrition, HIV and AIDS issues.
- Facilitate the adoption of measures to fight against nutrition disorders and its effects.
- Oversee institutionalization of measures to address nutrition issues.
- Provide input into the deliberations of the Parliamentary Committee on Nutrition.

Principal Secretaries' Committee on Nutrition, HIV and AIDS: the committee will be responsible for ensuring nutrition is actively integrated and mainstreamed into the sector ministries and that they are being implemented, along with HIV and AIDS issues. It will comprise of the PS's from key sector ministries in the country. The Terms of Reference for the Committee will be:

- Ensure nutrition is integrated and mainstreamed into sector ministries through planning and budgeting processes.
- Receive and review progress reports on nutrition issues as they relate to various sectors.
- Ensure nutrition issues are actively discussed and followed up at ministerial levels.
- Ensure the implementation of planned nutrition strategies in various sectors.

b. Policy and Technical Coordination

Multi-sectoral Technical Nutrition Committee: the committee is composed of a cross section of stakeholders that include key sectoral ministries representatives development partners, civil society

organizations and academic and think tank institutions on nutrition. The composition of the Multi-sectoral Technical Committee on Nutrition is as follows:

- OPC Department of Nutrition, HIV and AIDS-Chair;
- Ministry of Health;
- Ministry of Women and Child Welfare Development;
- Ministry of Agriculture;
- Civil Society Organizations;
- Ministry of Education;
- Ministry of Trade;
- Ministry of Information and Civic Education;
- Representatives of the UN system;
- European Union; and
- Bi-lateral donors.

The terms of reference of the committee are:

- Provide technical oversight in the implementation of the National Nutrition Policy and Strategic Plan within each sector.
- Provide technical guidance on the implementation of the nutrition policy.
- Provide technical advice to the Parliamentary Committee on Nutrition, the Cabinet Committee on Nutrition, the Principal Secretaries Committee on Nutrition, and the OPC Department of Nutrition, HIV and AIDS.

Government-Development Partners Nutrition Committee: The committee is composed of key Government sector representatives and development partners in the nutrition sector. Its membership comprise of

- OPC, Department of Nutrition, HIV and AIDS Chair,
- Ministries of Agriculture and Food Security; Education, Science and Technology; Women and Child Development; Local Government; Health; Finance;
- UNICEF and other UN representatives Vice Chair,

- Bi-lateral donors
- EU and other multilateral donors among others.
- The terms of reference for the committee are:
- Promote and identify funding resources for the nutrition agenda in Malawi including research.
- Promote joint resource mobilisation, allocation and support.
- Facilitate service delivery initiatives with required resources.
- Respond to the Government of Malaw's consolidated nutrition fund requirement.
- Provide direction on policy alignment to MGDS, MDGs, UNDAF and own capitals interests.

OPC, Department of Nutrition, HIV and AIDS: The Department of Nutrition, HIV and AIDS is the secretariat and is to:

Provide policy direction, oversight and guidance on the implementation coordination and M&E of the nutrition policy.

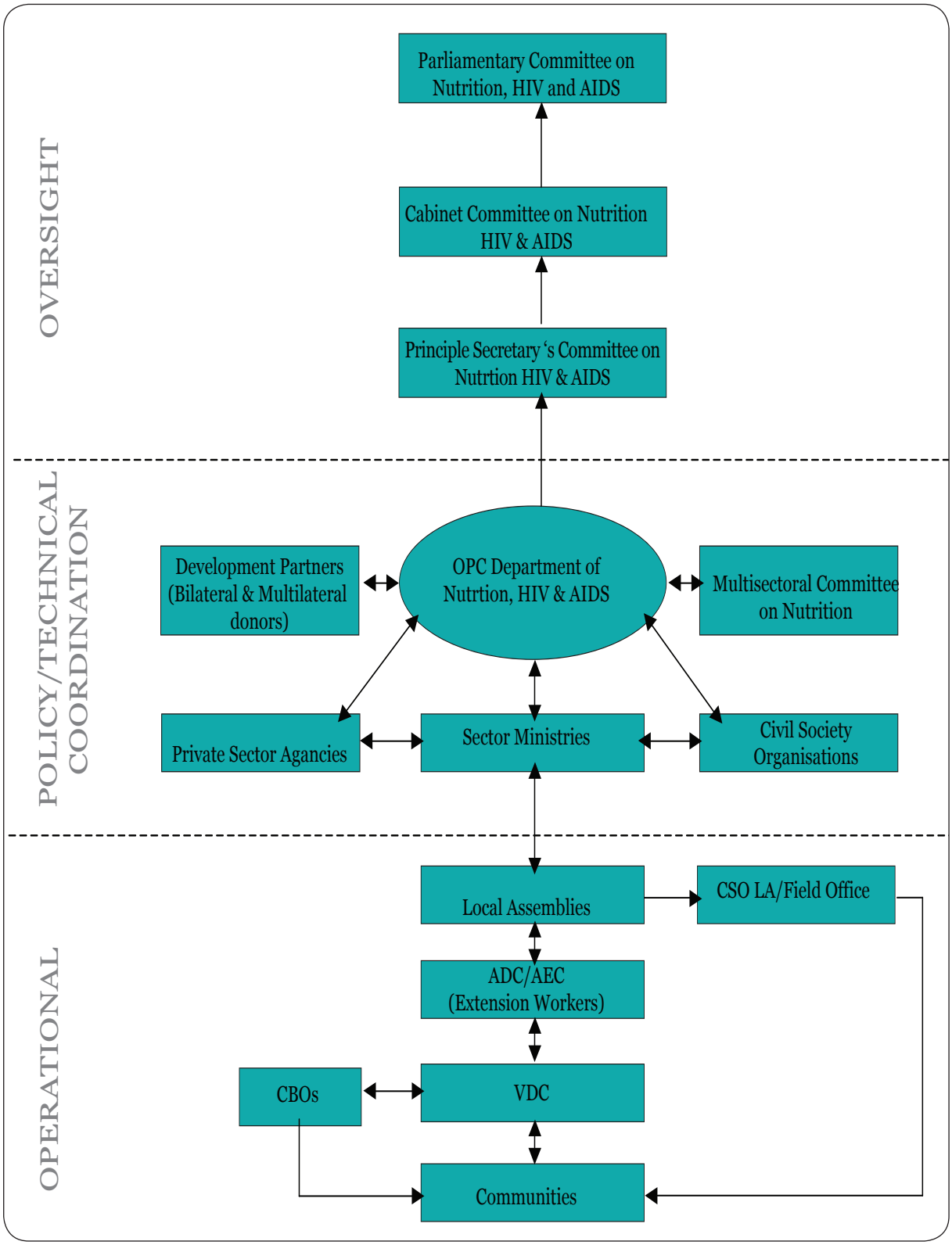
- Facilitate cross-sector collaboration and will work with the higher level committees (Cabinet and Parliament) and the multi-sectoral Technical Committee on Nutrition.
- Lobby and advocate for both the development of nutrition structures and adequate resource mobilization and allocation.
- Lobby for the establishment of nutrition SWAp (consolidated nutrition fund) to facilitate resource mobilization.
- Place or strengthen Nutrition, HIV and AIDS Specialists in each sector Ministry and department to coordinate nutrition activities within the sector.
- Provide standards and norms for nutrition.
- Mobilize resources and support for the nutrition response.
- Monitor and evaluate the nutrition response.
- Coordinate joint planning and review with other ministries and departments to ensure a comprehensive national approach to the issue of nutrition.

Sectoral Departments: they will ensure active integration of nutrition into their sectors, and support implementation efforts at the district[31] and national levels. They will:

- Coordinate nutrition programs, projects and activities within their sector
- Work with the OPC Department of Nutrition on nutrition planning and programming.
- Ensure joint planning and budgeting of nutrition activities into sectoral budgets and the implementation of the sectoral nutrition work plans.
- Prepare monitoring reports-programme and financial- for the sector and submit to the Department of Nutrition, HIV and AIDS for monitoring purposes.
- Provide technical guidance to stakeholders and service providers in the their sector.

31 Some sectors such as the Minsistry of Agriculture and Health already have nutrition units as well as functions and staff at the district and Agricultural Development Division (Agriculture) level However, in view of staff vacancies for nutrition staff, efforts will be dedicated towards filling these up and establishing and recruiting nutritionists for sectors that do not have nutrition staff

Figure 4: NNPSP Institutional and Functional Linkages



Development Partners: These are all donor agencies supporting the nutrition effort in the country. These will:

- Undertake high level advocacy for nutrition among policy and decision makers in the public and private sector, development partners and civil society organizations
- Provide all requisite technical support.
- Assist the secretariat and sectors in mobilizing additional resources for nutrition activities.
- Support analytical work to inform policy implementation and monitoring.
- Support the implementation, monitoring and evaluation of the agreed nutrition sector plans and reporting requirements.
- Align their nutrition initiatives to the nutrition policy and agreed common framework (the NNPSP) for scaling up of the nutrition response.

Civil Society Organizations they will align their programs and complement Government effort in the implementation of the nutrition policy. They will:

- Provide technical support to sectors where needed
- Implement nutrition programmes and projects in collaboration with relevant sectors.
- Provide programme and financial reports as per the NNPSP requirements.
- Conform to the standards and norms set by the Department of Nutrition, HIV and AIDS.
- Uphold standards in the production and marketing of high nutritive value foods and monitor and evaluate high nutritive value food chain lines.

Private Sector Agencies: these will:

- Ensure that the standards in the production and marketing of high nutritive value foods are upheld.

- Follow mandatory fortification requirements and recommended fortificant levels in all the centrally processed foods.
- Ensure that the provisions of the Nutrition, the Right to Food and Food Safety Acts are adhered to.
- Facilitate the provision and access to improved technology for nutrition promotion.
- Meet their social corporate obligation in nutrition for the nation and their employees.
- Monitor their activities and report to OPC Department of nutrition.

c. Operational

District Assemblies: the District Commissioner will be the person in charge of nutrition activities and he or she will be supported by the Chief Nutrition, HIV and AIDS Officer (CNHAO). The terms of reference for the district assemblies will be the following:

- Integrate nutrition in the District Implementation plans and budgets
- Provision of nutrition services
- Mobilize resources for nutrition activities at the district level
- Mobilize communities for nutrition promotion
- Implement the nutrition Strategic Plan at district level through the sectors, CSOs, Faith based organisations, community level service providers, local leaders and communities.
- Supervise implementing partners at district level.
- Backstop Area Nutrition Officers operating below the district.

Area Nutrition Officers: These will be employed and placed by the Ministry of Local Government and Rural Development in collaboration with OPC Department of Nutrition in all districts in the country. They will:

- Coordinate and facilitate various nutrition services covering a Traditional Authority or several Group Village Headpersons depending on the terrain and the size of area.
- Facilitate the implementation of nutrition activities at the area level, and supervise CBOs/CSO work.
- Follow up and receive reports from CBOs/CSOs.

Civil Society Organizations (CSO) including Faith Based organisations, Field Offices/Community Based Organizations: These will be CSOs or CBOs operating within a specific district, and possibly in a specific Traditional Authority (TA) covering a range of Group Village Heads or the whole TA. They will:

- Work closely with the Village and Area Development committees and Nutrition Extension workers.
- Participate in various nutrition activities, including growth monitoring and promotion, community mobilization and campaigns.
- Follow up on nutrition cases at community level.
- Provide progress reports to Area Nutrition Officers.
- Recommend referral cases to the rehabilitation units and follow up discharged cases from the same.

Area/Development Committee/Area Executive Committee: The Area Development Committee and the Area Executive Committees will work closely with nutrition extension workers to promote and follow up nutrition activities at the grassroots level. They will:

- Coordinate with CBOs and Community Nutrition, HIV and AIDS workers.
- Support the work of CBOs/NGOs at the community level by mobilizing communities.
- Assist in growth monitoring activities.
- Assist in nutrition sensitisation meetings.

7.3.2 Management Priorities: Linkages, Integration and Partnerships

A sustainable and long term reduction of malnutrition requires complementary actions at different levels and by all key stakeholders. The conceptual framework for nutrition reveals that actions to redress malnutrition need to be promoted simultaneously targeting three types of constraints (immediate causes, underlying causes and the basic causes). The implication of this is that the policy and strategic plan has to be linked to many other policies and initiatives already under implementation. Most activities are of a multi-disciplinary nature and will be integrated into the strategies of other sectors and financed as such. The success of the strategies championed here therefore depends on deliberate efforts to promote strong partnerships between all the actors involved in nutrition as spelled out above.

The Plan therefore seeks to strengthen and build new partnerships, and will create opportunities and entry points for new partners to participate, while devolving implementation to each sector as well as to decentralised levels in order to reach all target groups, with special emphasis on vulnerable groups (pregnant and lactating women, under fives, and adolescents). The NNPSP encourages involvement of national and international partners, including the private sector and NGOs participation in coordination and resource mobilisation undertakings.

Partners in the implementation of the NNPSP shall be bound by the following principles:

- Unequivocal declaration of interest and commitment to the NNPSP;
- Recognition of the need and acceptance of their roles within their mandates as well as their willingness to discharge their responsibilities;

- Respect for the institutional framework and their position and relations in it; and
- Shared responsibility to advocate and support other partners to discharge their accountabilities and responsibilities.
- Align their work to the NNPSP as an implementation tool for the MGDS.

7.3.3 Communication Strategy

The communication strategies for the NNPSP consist of three elements. First is the strategy for the dissemination of the contents of the.NNPSP. Second is the strategy for the policy advocacy. Third is the communication strategy that will be adopted at the programme level.

7.3.3.1 Dissemination of the NNPSP

The NNPSP is a national document and thus shall be disseminated as widely as possible in both print and electronic format. At the national level, an event shall be organised to officially launch the policy at the highest political level. After the launch the document will be distributed to all stakeholders in both print and electronic form.

7.3.3.2 Policy advocacy

In terms of policy advocacy, the main target groups will be politicians, technocrats, donors, civil society and the private sector. The proposed advocacy approach is to package and communicate key messages to suit each target audience. Among other issues, advocacy shall be around the following issues: (i) the importance of nutrition as a human right issue; (ii) the social and economic costs of malnutrition; and (iii) nutrition trends. Messages targeted to policy makers and donors will be aimed at sustaining nutrition at a the highest level on the policy and resource allocation agendas.

7.3.3.3 Communication strategy at programme level

Each programme shall have a clear communication strategy for its activities. The communication strategy should be informed by evidence of information gaps at the level of the target group and what information strategy would work best in the local setting. Emphasis will be placed on behaviour change communication as well as proven approaches like PD Hearth. All relevant communication channels will be embraced in order to reach all stakeholders. In developing their communication strategies, programmes will be guided by the following principles:

1. Mainstream information, education and communication (IEC) in all nutrition interventions;
2. Focus on promoting small "doable" actions to sustain the behavior changes with messages;
3. Use of multiple entry points for IEC;
4. Facilitate improved communication for marginalized groups;
5. Build listening skills of outside stakeholders (development agency workers and local counterparts among others) so that they can effectively listen to communities and hear what they really prefer and can do;
6. Implement communication strategies from a human rights perspective (communities should not be passive recipients) but should take full control of their development;
7. Shift from expert solutions to community solutions, from message to dialogue with the community and from problems to appreciation;
8. Target not the changing of behaviour of individuals per se, but helping people to change their social and cultural norms, after which behaviour change will naturally follow; and
9. Always be guided by the assessment of the situation first, then analysis of what is needed and relevant, then design and implement a monitored action.

8 MONITORING & EVALUATION FRAMEWORK

8.1 RATIONALE FOR M&E IN THE NNPSP

In line with the results based management, M&E will be actively integrated into the National Nutrition Strategic Plan to facilitate management for results (see section 7 for strategic outcomes). The monitoring and evaluation framework will focus on monitoring results at the outcome and impact levels, even though the tracking of the implementation will also be essential. The NNPSP M&E framework will build on the existing NFSP M&E systems, and will seek to track nutrition interventions that can be scaled out quickly and with high impact. In this regard, the role of M&E will be to provide a strategic link with the nutrition policy, and ensure that strategies are dynamic and more effective in responding to the nutrition challenges in the country by utilizing the evidence on the:

- Overall performance of the National nutrition strategic plan;
- Coverage of high impact nutrition interventions and reasons for success, as well as determining the extent of outreach of existing interventions;
- Provision and utilization of nutrition services to groups that are at risk such as women and children;
- Maternal and child epidemiology related to nutrition in order to highlight the extent of the nutrition challenge, on the basis of which a common effort can be forged; and
- Known positive and negative effects of nutrition policies, strategies and inputs on nutrition outcomes. This will inform the process of redesigning nutrition sector policies and strategies.

8.2 OBJECTIVES OF THE NNPSP M&E FRAMEWORK

The aim of the NNPSP monitoring and evaluation framework is to define and provide stakeholders in the country with relevant information that would be useful in evidence based decision making, planning and implementation of nutrition interventions. Consequently, the specific objectives of the M&E framework are to:

1. Define a list of key performance indicators that will help in tracking of the progress in the implementation of nutrition interventions;
2. Specify the key data sources to be used to gather necessary M&E data for nutrition;
3. Describe the M&E products and mechanisms for the dissemination of all critical information amongst all stakeholders, implementing agencies, beneficiaries and the general public.

8.3 INFORMATION REQUIREMENTS

Among the key outcomes to be monitored will include malnutrition among children under-five years and women of child bearing age, as well as effectiveness of nutrition programs such as service delivery, education campaigns and extent of the use of iodized salt by households.

A set of key performance indicators (KPI) has been identified (see section 7 and Annex 3), and will form the basis of the information management system for the NNPSP to track the progress towards the results. This set of indicators is mainly at the results level and represents the minimum accountability standard for stakeholders in the nutrition sector[32].

32 That is, other indicators apart from those specified in the matrix may also be monitored depending on focus area

8.4 NNPSP MONITORING AND EVALUATION ACTIVITIES

Consequently, the following activities will constitute the elements of the NNPSP M&E system:

8.4.1 Monitoring Activities

The following will be the key monitoring activities for the NNPSP:

- Quarterly Field Monitoring Visits: Field monitoring visits will be undertaken to selected sites to check the progress on service delivery and the implementation of the activities. The visits will assist in identifying challenges faced and serve as the basis for dialoguing with service providers and implementers in focusing towards the achievement of the results. The quarterly field monitoring visits will also help in checking compliance to the laid down nutrition implementation procedures and guidelines. Quarterly monitoring visits will be led by the OPC, Department of Nutrition and HIV and AIDS, although multi-sectoral and multi-agency teams will also be encouraged. A quarterly field monitoring report will be produced by the monitoring team and will include (a) key findings of the visit, (b) main challenges observed in the course of implementing the NNPSP activities, and (c) recommendations on resolving bottlenecks
- National Integrated Nutrition Surveillance[33]: National Integrated Nutrition Surveillance System will be used to track the progress on the output and outcome indicators on a Monthly/quarterly basis. The results would be discussed in the quarterly review meetings. Because these will happen throughout the implementation period, the results will also be used for the evaluation at the outcome and impact levels.

33 These may also be used for impact evaluation provided technical shortfalls identified in recent reviews such as Teller C (2008) can be addressed.

- Bi-annual Nutrition Review Meetings: These will be held to review the implementation of the activities of the NNPSP. It will also review quarterly review reports by the Nutrition and Food Security M&E working group that reports on output as well as outcome indicators. While primarily a coordination activity, the quarterly review meeting will provide a useful forum for stakeholders to appreciate the in loads made towards the NNPSP goals and challenges constraining progress. The outcome of the quarterly review meetings will be a concise brief outlining the next steps.
- Nutrition Steering Committee Meetings/Government Development Partner Meetings: these will focus on policy issues and discuss policy implementation, resource mobilization and progress towards policy outcomes. The meetings will discuss issues that have a bearing on the Nutrition policy such as inadequacies in the policy provisions that constrain the implementation and compliance, emerging issues on the ground that need to be addressed at the policy level as well as funding prospects for nutrition activities. The objective will be to ensure that the whole Nutrition Programme as envisaged in the NNPSP is moving towards the achievement of the Planed objectives.
- Develop an operational database and Coordination of Information: The OPC- Department of Nutrition and HIV and AIDS will ensure the establishment of a coordinated management information system to be able to collect data, store them, and make them easily accessible to facilitate analysis and reporting on the NNPSP. In this regard, an inventory of all agencies implementing nutrition activities will be created. The data base would include- names of nutrition projects/service providers, type of activity, budget, output and outcome indicator targets, geographical location of services/project, target group and achievements for a particular period among others.

8.4.2 Evaluation Activities

Evaluation of the nutrition outcomes and impacts will be done through population based surveys such as the Demographic Health Surveys (DHS), Multi-cluster Indicator Surveys (MICS) and others. The following will however be evaluation activities and will be in addition to these national surveys:

- Construction of Baselines and Targets: This will be a key activity as the ability of the nutrition response via the NNPSP to monitor the performance will depend on it, focusing on those targets without the baselines. In particular, baselines on the key outcome indicators in the NNPSP will be useful for determining the impact of the response at the end of the implementation period. Performance targets at annual, mid-term and end of the implementation of the plan will be critical in undertaking performance monitoring.
- Annual Nutrition Sector Reviews: These will be undertaken to review the implementation progress, challenges and the status of the outcome indicators. While focusing also on coordination and the extent to which nutrition activities are being implemented in accordance with the agreed frameworks, the sector reviews will be foras where knowledge on the implementation experiences, good practice and challenges will be shared. An outcome of the meetings will be the identification of the implementation bottlenecks and recommendations to improve the performance towards the achievement of the results.

- Periodic Nutrition Surveys: These will be used to track among others (a) the effectiveness of the interventions; and (b) impact on malnutrition levels. They will include the existing sector surveys on nutrition, Malawi Vulnerability Assessment and Mapping (VAM) work, National Statistical Office Surveys such as MICS and MDHS, Micronutrient Surveys, and National Nutrition Surveys. Impact studies focusing on specific interventions will also form part of the tracking studies. These will be population-based surveys and will be used to identify and understand the core factors and patterns fuelling chronic malnutrition, and influencing the demand for and supply of various nutrition services.
- Mid-Term Evaluation: The Nutrition National Strategic Plan will be evaluated mid-way through the implementation with the aim of gauging implementation progress at mid-stream, and devise ways of improving the performance at post mid-term of the plan. The mid term evaluation will either be conducted by an independent assessor or internally by stakeholders but led by the OPC, Department of Nutrition and HIV and AIDS.
- End of NNPSP Evaluation: The end of NNPSP evaluation will be undertaken at the end of the implementation period of the Plan in 2012 or early 2012. The focus of the end of NNPSP evaluation will be to learn lessons to inform the future national nutrition initiatives and strategies in the country. The evaluation will be undertaken by an independent reviewer. Its main aim will be for reprogramming and replanning.

8.5 MONITORING AND EVALUATION STRUCTURE

Given the decentralized nature of the implementation of the nutrition activities, monitoring will be carried out at the community, district and national levels. The overall coordination of the M&E system will be done by the OPC, Department of Nutrition, HIV and AIDS.

8.5.1 National Level

The Department of Nutrition, HIV and AIDS in OPC will retain a repository of information from various sources to report on the NNPSP performance. Stakeholder agencies at the national and sub-national levels will periodically provide reports (program and fiscal) to the secretariat on their respective areas of focus on nutrition, and in line with the agreed reporting lines and information requirements for the nutrition M&E system. These reports will form the basis upon which synthesized M&E products for the NNPSP will be prepared, including: monthly reports, quarterly reports, bi-annual reports, annual Reports, and Ad hoc Implementation Status Reports when needed. The secretariat will be responsible for:

- Planning M&E activities, including joint field visits, initiation of studies, compilation of composite M&E reports, dissemination and arranging periodic reviews on the basis of M&E results to facilitate the utilization and evidence based decision making in the nutrition response.
- Lead the development of and execution of the Nutrition research agenda.

Results of the nutrition M&E system will feed into the national level monitoring of the Malawi Growth and Development Strategy (MGDS) through the its annual reviews.

8.5.2 District Level

At the district level, the Monitoring and Evaluation Officer in the District Commissioners office will coordinate nutrition related information from various sector departments, Civil Society Organizations (CSOs) and the private sector operating at the district level that are implementing nutrition activities. This will be done through routine administrative reports such as monthly, quarterly and annual reports. The information requirements would include

progress towards monthly, quarterly and annual nutrition targets. The District databank will be modified to include a nutrition module that will facilitate the storage and retrieval of nutrition related data at the district level.

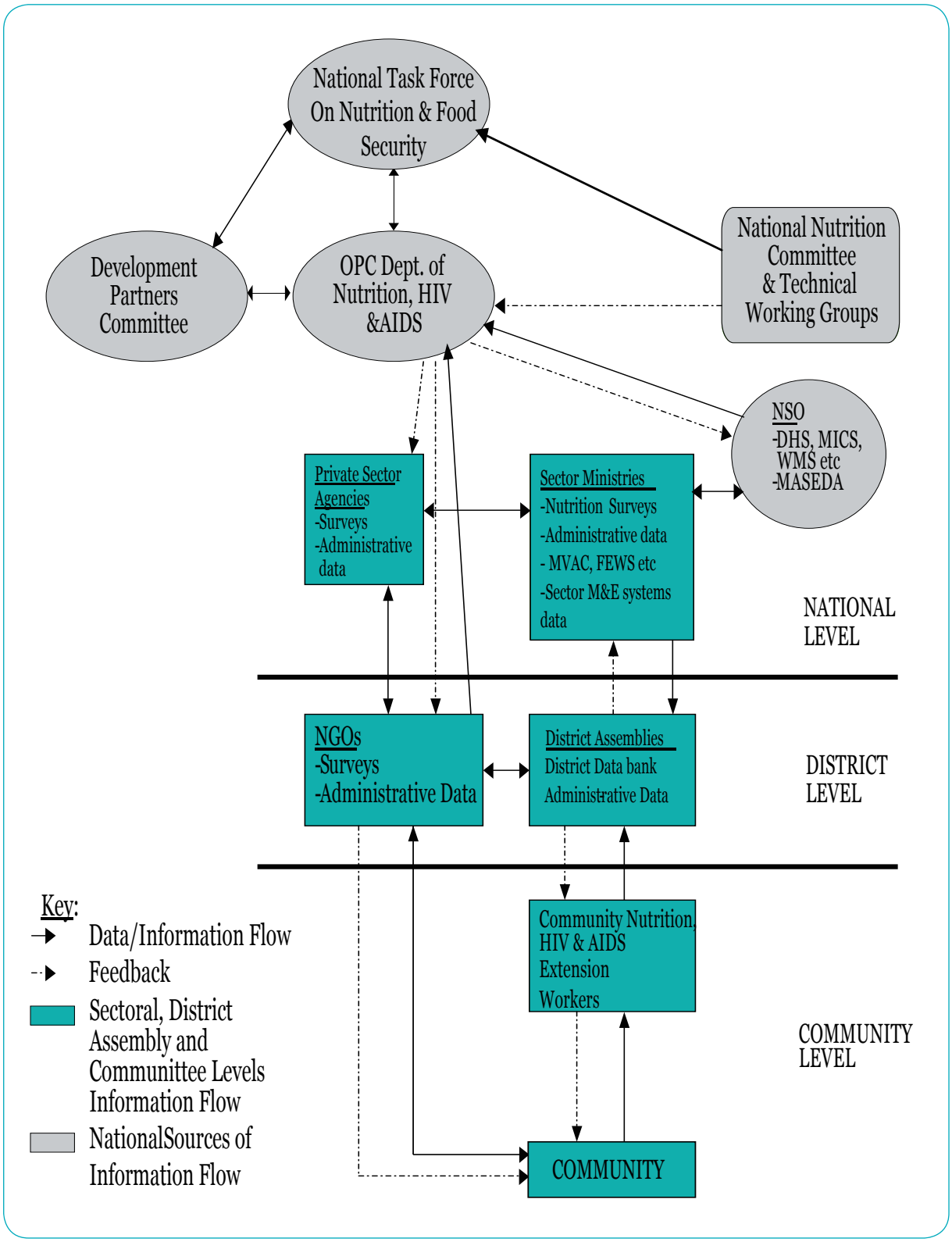
8.5.3 Community Level

At the community level, it is anticipated that the extension workers and traditional leaders will record and submit nutrition related data such as growth monitoring activities as well as participate in nutrition service delivery assessments. Monitoring reports generated at this level will be submitted to the respective sector departments and agencies at the district level, who will in turn compile reports based on their normal reporting lines. The consolidated sector reports will be submitted to the District M&E Officer to facilitate the compilation of district M&E reports, to be submitted to OPC Department of nutrition, HIV and AIDS.

8.6 INFORMATION FLOW

Information will flow from communities through various agencies to the OPC, Department of Nutrition, HIV and AIDS Secretariat. To facilitate the utilization of the results from the M&E system in implementing the NNPSP and achievement of its results, a feedback mechanism will be retained as part of the information system. The system will contribute towards the keeping of all stakeholders focused on achieving the NNPSP results. The flow of information is depicted in Figure 5.

Figure 5: NNPSP M&E Framework-Information Flow



9 COSTING & FINANCING PLAN

The main objective of this section of the National Nutrition Policy and Strategic Plan (NNPSP) is to provide cost estimates for the period 2007 to 2012 so that stakeholders know of the cost required to operationalize the policy and plan during the 5 year period. The section also provides the cost estimates to be used for advocacy and resource mobilization from stakeholders (international donors and local private sector, civil society and government) in the fight against nutritional disorders in Malawi.

9.1 COSTING

The Department of Nutrition, HIV and AIDS is the institution tasked to coordinate the implementation of the NNPSP by the government of Malawi. The viewpoint and perspective therefore of the costing is institutional, implying that the costs calculated are linked to this institution. Given the multi-disciplinary nature of nutrition, and the integration of nutrition in other Sector Strategic Plans, a large proportion of the costs will be met through resource mobilisation initiatives of OPC in collaboration with the other sectors. For example, the Health SWAP is already financing the health-related nutrition aspects and the same applies to the ADP which is expected to contribute to the mobilisation of resources for the agriculture-related aspects. New costs may also emerge as the strategies evolve and are implemented.

Micro-costing and the activity based costing is the technique used to calculate the costs for the NNPSP based on the activities related to the key priority areas, key result areas and strategic outputs in Annex 2. A rate of 10% was used to discount the costs for the years 2007 and 2008 and to calculate the future value of costs for the years 2010 and 2012 as 2009 was the base year for the costing. The approach removed the effect of inflation, which was estimated at 10%, on the cost estimates. The exchange rate used to convert the Malawi Kwacha (MK) to the United States of America Dollar (USD) is 141 MK: 1 USD.

9.2 TOTAL AND ANNUAL COSTS

The total cost required to operationalize the NNPSP for the 5 year period is 46 billion Malawi Kwacha (MK) or 324 million United States of America Dollars (USDs) and the average annual cost is MK 9 billion or USD 65 million (Table 7). A gradual increase in the annual costs occurs between 2007 and 2012.

The three key priority areas of prevention, management and creating an enabling environment require MK 36 billion (USD 256 million), MK 0,9 billion (USD 6 million) and MK 9 billion (USD 62 million) respectively. This equates to 79%, 2% and 19% of the total cost required for each of the three areas respectively. Therefore, the thrust of the NNPSP is on prevention rather than cure. The low cost for the management area is however most likely due to the fact that the health care sector manages most of the nutritional disorders; a cost borne by the Ministry of Health.

Table 7: The costs required to implement the NNPSP over a five year period

Key Priority Area	Years					Total cost (MK-millions)	Total Cost (USD-millions)
	2007	2008	2009	2010	2012		
Prevention	6,037	6,038	6,649	6,634	10,721	36,078	256
Management	182	157	201	164	161	859	6
Enabling environment	1,695	1,671	1,846	1,752	1,755	8,719	62
Totals (in millions)	7,914	7,866	8,695	8,550	12,634	45,656	324

The high costs for prevention are for the results linked to the key strategies P7, P2 and P1 in decreasing order and these refer to the promotion of access to at least one nutritious meal per day for the school going child and promoting optimal breast feeding practices (see section 7 for listing of key strategies Annex 1 for the detailed budget by result). Since the window of opportunity to reduce stunting, which has not been affected by previous interventions is the period between pregnancy and 2 years of age, there is an urgent need to consider redistribution of funds from key strategy P7 to P1 and P2 which are high impact interventions. While strategies P1 and P2 promote interventions that can reduce stunting, there is however a need for the NNPSP to vigorously monitor the effect of these interventions among Malawians.

In the key priority area of management, 78% of the cost is accounted for by three strategic outputs. Most of the costs (35%) are for strategic output three (strengthen community follow-up and participation in treatment of clients with malnutrition) (see Annex 1). Strategic Output 5 (provision of knowledge and skills to manage and monitor malnutrition in PLHIV) is the second and accounts for 27% of the cost for this key priority area. Strategic Output 4 (monitoring case management outcomes for appropriate action) is the third and

accounts for 16% of the cost for this key priority area. These are high impact interventions at the community level that reduce morbidity and mortality from malnutrition.

In the key priority area of creating an enabling environment, 86% of the cost is accounted for by strategic output three (strengthen nutrition surveillance at the facility and community levels). This is another high impact intervention.

9.3 FINANCING OF THE NNPSP

The cost estimates for the NNPSP will be used by the Department of Nutrition, HIV and AIDS to advocate for financial support from government, development partners, the private and business sectors, and international and local non-governmental organizations (NGOs). Due to the ever-changing nature of the environment that we live in where new information on high impact low cost interventions in nutrition are continuously being discovered, the NNPSP recommends that consensus meetings be held from time to time with key stakeholders on prioritization of interventions and budget allocation for utilization of available funds.

ANNEX 1: BUDGET BREAKDOWN BY KEY PRIORITY AREA AND RESULT

PREVENTION	2007	2008	2009	2010	2012	Total (MK)	Total (USD)	%
Result 1: Optimal b/feeding 0-6 months	746,525,000	741,061,750	799,392,250	795,244,750	1,093,000,750	4,175,224,500	29,611,521	9.1%
Result 2: Optimal feeding 6-24 months	347,526,000	374,382,500	381,682,500	368,393,000	4,355,243,000	5,827,227,000	41,327,851	12.8%
Result 3: Optimal feeding of sick child	65,364,500	60,423,500	60,423,500	60,423,500	60,423,500	307,058,500	2,177,720	0.7%
Result 4: Women's nutritional status	50,974,000	50,974,000	154,019,870	162,780,870	131,883,270	550,632,010	3,905,192	1.2%
Result 5: Prevention of Micronutrient DD	179,372,750	179,015,000	219,699,500	189,762,500	179,763,500	947,613,250	6,720,661	2.1%
Result 6: Healthy lifestyles	27,852,750	12,452,750	117,842,500	218,087,500	174,400,250	550,635,750	3,905,218	1.2%
Result 7: School nutrition	4,546,762,980	4,546,762,980	4,724,609,980	4,697,422,980	4,606,477,480	23,122,036,400	163,986,074	50.6%
Result 8: Nutrition for vulnerable groups	3,850,000	3,850,000	94,289,000	46,814,500	18,171,500	166,975,000	1,184,220	0.4%
Result 9: Food safety and quality	16,485,000	16,485,000	44,473,750	42,824,500	49,469,250	169,737,500	1,203,812	0.4%
Result 10: Control of nutrition-related NCDs	52,116,500	52,116,500	52,116,500	52,116,500	52,116,500	260,582,500	1,848,103	0.6%
Subtotal	6,036,829,480	6,037,523,980	6,648,549,350	6,633,870,600	10,720,949,000	36,077,722,410	255,870,372	79.0%
MANAGEMENT								
Result: Access to improved quality nutrition mgt								
Output 1: Reviewed Guidelines	-	-	26,998,500	5,986,000	2,388,000	32,984,500	233,933	0.1%
Output 2: Equip service providers with skills	21,217,500	11,343,500	11,343,500	11,343,500	11,343,500	66,591,500	472,280	0.1%
Output 3: Community participation in treatment	62,040,000	59,385,000	59,385,000	59,385,000	59,385,000	299,580,000	2,124,681	0.7%
Output 4: Monitoring of case management	31,655,000	27,461,000	27,461,000	27,461,000	27,461,000	141,499,000	1,003,539	0.3%
Output 5: Skills transfer to service providers-PLHIV	51,666,000	43,834,750	43,834,750	45,028,750	45,028,750	229,393,000	1,626,901	0.5%
Output 6: Skills transfer to caregivers-PLHIV	15,188,000	15,188,000	31,649,500	15,188,000	15,188,000	89,132,500	632,145	0.2%

Subtotal	181,766,500	157,212,250	200,672,250	164,392,250	160,794,250	859,180,500	6,093,479	1.9%
CREATING AN ENABLING ENVIRONMENT								
Result 1: Place nutrition in national dev. agenda	113,137,253	94,913,503	94,913,503	94,913,503	94,913,503	492,845,265	3,495,356	1.1%
Result 2: Resource mobilization for NNPSP	4,792,000	4,792,000	33,849,250	17,232,750	4,776,000	65,442,000	464,128	0.1%
Result 3: Institutional capacity for effective delivery	58,902,500	52,843,750	54,286,000	48,767,500	48,373,500	263,173,250	1,866,477	0.6%
Result 4: Coordination at central, district & local	14,148,000	9,770,000	20,902,750	18,158,000	19,480,750	82,459,500	584,819	0.2%
Result 5: Evidence based nutrition programming	16,000	4,439,750	68,117,500	60,732,000	75,293,500	208,598,750	1,479,424	0.5%
Result 6: Results based M&E system	1,504,317,500	1,504,317,500	1,573,718,500	1,512,251,250	1,512v,251,250	7,606,856,000	53,949,333	16.7%
Subtotal	1,695,313,253	1,671,076,503	1,845,787,503	1,752,055,003	1,755,088,503	8,719,374,765	61,839,537	19.1%
GRAND TOTAL	7,913,909,233	7,865,812,733	8,695,009,103	8,550,317,853	12,636,831,753	45,656,277,675	323,803,388	100.0%

ANNEX 2: ANNUAL TARGETS & OUTPUTS

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
KEY PRIORITY AREA: PREVENTION						
GOAL 1: Promotion of optimal Breastfeeding practices for children 0-6 months in the context of HIV and AIDS at facility, community and household level.						
STRATEGIC OUTPUT 1: Strengthen implementation of the Baby Friendly Hospital Initiative (BFHI) targeting at least 10 facilities every year to add to existing 20 BFHI facilities						
ACTIVITIES						
1. Conduct 3 day advocacy and orientation meeting of Management Teams for the targeted 10 health facilities reaching 100 people per year	100	100	100	100	100	500 people
2. Conduct a 5 day working session for 20 people to review the Infant and young child Nutrition Policy and guidelines in the context of HIV and AIDS to incorporate new WHO recommendations for feeding HIV exposed children	0	0	1	0	0	1 session
4. Orient 3000 Stakeholders and trained service providers and counsellors to the revised Infant feeding guidelines in the context of HIV and AIDS in 60 sessions of 50 participants each for 3 days	0	0	1000	1000	1000	3000 people
5. Provide technical support to Health facilities to maintain or attain the BFHI status reaching at least 80% the BFHI facilities per year by 3 teams of 4 Officer per team for 10 days per quarter	80%	80%	80%	80%	80%	80% of BFHI Facilities
6. Conduct annual assessment of Health facilities for BFHI status, and re- assessment of Baby Friendly Hospitals every two years by 5 teams of 4 Assessors per team for 12 days per assessment	30	10 new	50	10 new	70	70 facilities
7. Conduct 2 day bi-annual review and coordination meeting for stakeholders for 50 stakeholders per meeting	2	2	2	2	2	10 meetings
STRATEGIC OUTPUT 2: Increase number of service providers with adequate knowledge and skills to counsel mothers and other caregivers on infant and young child feeding at facility and community level						
ACTIVITIES						
3. Train at least 5000 service providers in Infant and young child feeding counselling in PMTCT sites and other service delivery points in 125 sessions of 40 participants for 6 days	1000	1000	1000	1000	1000	5000 people
4. Conduct 4, five day working session of 20 people to integrate Infant and young child feeding counselling in the Accelerated child survival and other relevant programmes to cover four programmes	1	0	0	1	2	4 sessions

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
5. Train at least 5,000 community based service providers in Infant and young child feeding in the context of HIV and AIDS in 125 sessions of 40 participants for 3 days per session	0	1000	1000	1500	1500	5000 people
6. Orient at least 10 community support groups for each PMTCT and BFHI facility to have at least 100 groups of 10 people per support group per year in 20 sessions of 50 participants for 2 days per session	1000	1000	1000	1000	1000	5000 people
7. Orient at least 500 Community leaders in Infant and young child feeding in each district in 10 one day sessions of 50 participants each	100	1000	1000	1000	1000	500 community leaders
8. Conduct two 5 day working sessions of 20 participants to develop clearly defined referral network among HTC, PMTCT and Infant feeding counselling services.	0	0	0	1	1	2 sessions
STRATEGIC OUTPUT 3: Strengthen support and protection to mothers to adequately and successfully breastfeed at national, district and community level						
ACTIVITIES						
1. Conduct bi-annual sensitisation and awareness campaign on the role of breast-feeding in child survival among the public, local leaders, service providers, communities and caregivers involving 20 people per district in 26 districts and 12 people from central level for 5 days per campaign to reach 1,200,000 people per year.	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000 people
2. Conduct one day sensitization meeting with 50 members of the civil societies to incorporate civil society involvement in promotion of optimal Infant and young child feeding practices by orienting all the NGOs operating in Nutrition to the Essential Nutrition Actions and available guidelines and tools for nutrition promotion	0	0	50	0	0	50 civil society members
3. Conduct a 2 day bi-annual orientation and review meeting on the code of marketing infant and young child foods with stakeholders reaching 50 stakeholders at each meeting every year	100	100	100	100	100	500 stake holders
4. Train at least 3 Code monitors per district, 5 per City Assembly, 2 per major boarder, and 12 at national level in 6 sessions of 20 participants per session for 6 days	0	0	40	40	40	120 Monitors
5. Conduct quarterly at assembly level and bi-annual at national level and ad-hoc code monitoring on infant and young child foods in strategic districts in the country (cities, boarder and main towns), health facilities and other relevant Institutions involving 3 monitors per district, 5 per city and 12 at national level per activity.	138	138	138	138	138	690 visits
6. Conduct quarterly meetings for the National Code Advisory Committee of 15 people for one day	4	4	4	4	4	20 Meetings

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
7. Conduct one day orientation for 20 men and women of the press and embark on a 1 month mass media campaign to increase awareness among employers and employees on the need for maternity protection and support to lactating mothers through various media channels to reach at least 3 million people with the messages	600,000	600,000	600,000	600,000	600,000	3,000,000 people
8. Engage community based service providers and support groups in regular follow-up and support to pregnant and lactating mothers in all communities in all TAs in all district assemblies	80%	80%	80%	80%	80%	80% of mothers followed up
9. Orient 30 local leaders, 25 District managers per district, and train 120 community workers in 3 day training sessions of 40 participants each and 500 members of the community in 10 two day sessions of 50 participants per session per district to pilot the Community Baby Friendly Initiative in 5 districts	675	0	675	675	675	2700 people
10. Train 120 per district in 3 sessions of 40 participants per session of 3 days in 26 districts and 40 TOT for growth monitors in infant feeding to link growth monitoring and promotion of the child to appropriate feeding according to age	632	632	632	632	632	3,160 people
KEY STRATEGY P2: Promotion of optimal feeding practices for children 6-24 months or beyond to sustain breast feeding while giving appropriate complementary feeds with emphasis on feeding frequency, amount, energy and nutrient density and diversity based on the six food groups.						
STRATEGIC OUTPUT 1: Promote implementation of simple doable actions for promoting optimal complementary feeding for the children 6-24 months through scale up implementation and integration of the Essential Nutrition Actions (ENA) in various programmes, projects and contact points with the mother and the child at all levels						
ACTIVITIES						
1. Conduct four 2 day orientation meetings for stakeholders (of 50 participants) per year on the Essential Nutrition Actions (ENA) approach to reach at least 1000 people by 2012	200	200	200	200	200	1000 people
2. Conduct 3 day workshop of 20 people to develop job AIDS for the integration of ENAs in the nutrition programmes, projects, child survival programmes and other development interventions and activities at all service delivery points and disseminate to 5000 service providers by 2012 in four 2 day workshops of 50 participants per year.	1000	1000	1000	1000	1000	5000 people
3. Conduct ENA training of trainers for 6 trainers per district in all the 28 districts and 32 trainers at national in 4 five day sessions of 40 participants each.	40	40	40	40	40	200 people
4. Conduct training for the service providers from the sectoral Ministries and other stakeholders in ENA at the district and community levels to reach at least 5000 people by 2012 in 25 sessions of 40 participants per year	1000	1000	1000	1000	1000	5,000 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
6. Mobilise communities through the various community based service providers, Nutrition, HIV and AIDS workers, Community leaders and other structures to integrate ENA in community based services, activities and programmes to reach at least 50% of the households in the country by 2012 through community based compaigns involving 20 people per district and 20 media people at national level conducted bi-annually for 7 days in all districts	10%	10%	10%	10%	10%	50% of households
STRATEGIC OUTPUT 2: Increase the knowledge and skills of 6 million service providers, caregivers, households and communities in appropriate infant and young child feeding practices through a comprehensive communication strategy and civic education.						
ACTIVITIES						
1. Conduct 3 day working session of 20 people to develop Nutrition education kit on infant and young child feeding for information dissemination and civic education using the Behaviour change communication approach.	0	0	1	0	0	1 session
2. Orient stakeholders on the use of the kit to reach at least 120 Programme Coordinators and Managers by 2012 in 3 sessions of 40 participants	0	0	40	40	40	120 programme coordinators
3. Conduct nation-wide nutrition education and campaigns in collaboration with the Ministry of Information and civic education and other government sectors, civil society's organisations, the Local leaders and politicians to reach at least 6 million people by 2012 involving 20 people per district in 26 districts and 20 people at national level	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000 people
4. Conduct community sensitisation meetings, debates and dialogue on the recommended Infant and young child feeding practices to reach at least 6,000,000 people by 2012 involving 20 people from each district and 20 people at national level	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000 people
6. Coduct 5 days workshop for 10 people to produce standardised messages on Infant and young child feeding and print 1000 booklets per year.	0	1000	1000	1000	1000	4,000 booklets
7. Conduct national and localised campaigns to disseminate key messages that promote optimal Infant and young child feeding practices at least once a year in all districts to reach at least 1,500,000 caregivers per year.	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	7,500,000 people
8. Orient service providers in various child survival programmes to the optimal Practices and the key messages on optimal Infant and young child feeding practices at all levels to reach at least 200 service providers per year in 4 two day sessions of 50 participants per year.	200	200	200	200	200	1000 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
10. Conducting a day's meeting with 20 people from assemblies to design a well defined system for providing on-going support and follow-up to caregivers, households and communities to strengthen their skills in implementing the recommended feeding practices.	0	0	1	0	0	1 session
KEY STRATEGY P3: Strengthening of optimal feeding of a sick child during and after illness.						
STRATEGIC OUTPUT 1: Strengthen integration of optimal practices and messages on feeding a child during and after illness in key child survival programmes such as IMCI, PMTCT, Growth monitoring and promotion.						
ACTIVITIES						
1. Conduct seven 5 day working session with 30 participants to review of guidelines, protocols and counselling tools for IMCI, PMTCT and growth monitoring to incorporate or update guidelines and key message on feeding a child during and after illness according to age	1	1	1	2	2	7 sessions
2. Orient service providers to the revised materials and tools to reach at least 1000 service providers by 2012 in four 2 day sessions of 50 participants per session per year	200	200	200	200	200	1 000 people
3. Integrate counselling services on feeding of sick child in management of a sick child, PMTCT, follow-up and growth monitoring services.	1	0	0	0	0	1 working session
KEY STRATEGY P4: Promotion of women's nutritional status among the general public.						
STRATEGIC OUTPUT 1: Increase the number of women eating a variety of food from the six food groups with appropriate number of meals according to their physiological status to reach at least 100,000 women per year.						
ACTIVITIES						
1. Conduct 2 three day working sessions of 10 people to review key policies and guidelines on promoting maternal health (PMTCT, Maternal and neonatal health, Reproductive Health) to incorporate optimal nutrition practices and key messages for promoting women nutrition before, during and after pregnancy	0	2	0	0	0	2 working sessions
2. Orient service providers in each district such as Maternal and Child Health Co-ordinators, Growth Monitors, Safe Motherhood Coordinators and providers, Family planning providers, IMCI providers, PMTCT coordinators, Agriculture Development and Extension service providers, and providers and other relevant services to reach at least 240 people per year in 6 sessions of 40 participants	0	240	240	240	240	960 sessions

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
STRATEGIC OUTPUT 2: Promote availability, accessibility and consumption of a variety of foods from the six food groups everyday by the women and the general public in order to strengthen the capacity of women, households and communities to adopt the optimal nutrition practices and health life styles for improving women nutrition						
ACTIVITIES						
1. Conduct annual one-day food fairs in 187 EPAs on production and consumption of indigenous, high nutritive value foods and other foods from the six food groups in varied and diversified diets to reach at least 6 million people with the information by 2012 involving 10 officers per district and 12 supervisors from the central level and 4 media people and other stakeholders.	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000 people
2. Conduct 7 day field visit by 12 ADD and district assembly staff and a 2 day working session of 30 people from ADD, assemblies and other technical experts to document the type and diversity of foods for various agro-ecological areas or districts in Malawi according to seasonal variations.	0	0	1	0	0	1 visit
10. Produce, print and disseminate 1000 copies per year of a food calendar based on the seasonal and agri-ecological zones food variations	1000	1000	1000	1000	1000	5000 food calendars
3. Identify sources of seed materials for indigenous and high nutritive foods and stocks of animals for distribution to 8000 vulnerable house holds (PLHIV, pregnant and lactating mothers, under 5s and OVCs) and mobilize communities).	1,600	1,600	1,600	1,600	1,600	8,000 households
4. Support a seed multiplication centre for multiplication of planting materials and stock in each of the 187 EPAs in the country.	0	0	46	76	65	187 EPAs
8. To conduct 2 bi-annual consultative meetings per region involving 50 participants and joint planning meetings to promote production of aqua-culture and other nutritious agricultural products through other development programmes/projects.	0	0	2	2	2	6 meetings
9. To advocate for agricultural practices that encourage diversified food crops production practices among farmers to reach at least 500 farmers per year in all districts through other programmes/projects	500	500	500	500	500	2500 farmers
11. Provide Support to the communities, households and individuals for them to run income generating activities for adequate access to a variety of foods at all times in all districts	5	5	5	5	8	28 districts
13. Conduct working session of 20 people for 5 days to develop recipes that use indigenous foods to diversify diets, micronutrient rich foods plus oil and fortified foods and Conduct 3 one day dissemination meetings for 50 people per district in 27 districts using a team of 20 people, and through media to reach at least 3 million people by 2012	0	0	1,000,000	1,000,000	1,000,000	3,000,000 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
14. Conduct regular community level demonstrations in preparation and consumption of locally available nutritious foods such as indigenous fruits, vegetables, legumes, oilseed crops, staples, livestock, fish, ngumbi, bwamnoni, mphalabungu, mapala, sesenya, matondo and other locally available foods at community level to reach at least 1000 farm households per year.	1000	1000	1000	1000	1000	5000 farm households
KEY STRATEGY P5: Prevention and control of micronutrient deficiency disorders with emphasis on Vitamin A deficiency, anaemia and iodine deficiency disorders						
STRATEGIC OUTPUT 1-O1: Promote consumption of micronutrient rich and fortified foods among all Malawians						
ACTIVITIES						
1. Conduct working session of 10 people for 2 days to develop nutrition information kit on the importance of eating micronutrient rich foods and disseminate to reach at least 4 million people by 2012 through mass media	500,000	500,000	1,000,000	1,000,000	1,000,000	4,000,000 people
4. Conduct advocacy and campaigns at all levels on the consumption of fruits rich in Vitamins A and C with every meal to aid in the utilisation of the Vitamin A from the fruits and Iron from plant sources in the body to reach at least 5 million people through mass media	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000 people
5. Conduct Civic Education campaigns using mass media and community activities on the use of iodised salt in all the family foods to reach at least 6 million people.	500,000	1,000,000	1,500,000	1,500,000	1,500,000	6,000,000 people
6. Conduct a food consumption survey to determine commonly consumed foods	0	0	0	0	1	1 survey
7. Conduct 5 five day working sessions of 10 people to develop or review and disseminate standards for fortification of sugar, maize meal, cooking oil, salt and Likuni Phala within the Malawi Bureau of Standards regulations or the public health Act.	0	0	2	2	1	5 sessions
8. Conduct 3 day workshop for 40 people to orient captains of the industry and other stakeholders to the standards and engage them to fortify their food products	40	40	40	40	40	200 people
9. Conduct a 7 day assessment involving 20 people to identify gaps to facilitate establishment or strengthen mechanism for facilitating distribution of and access to fortified foods by the vulnerable groups in the country and conduct a one day stakeholder meeting of 40 people for consensus.	0	0	1	0	0	1 assessment
10. Develop and disseminate tools for monitoring fortified foods to inspectors in all districts and cities in 3 sessions of 40 participants for 1 day per session to reach 120 stakeholder with the tool	0	0	40	40	40	120 stakeholders

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
11. Develop a logo for fortified foods and conduct national wide social marketing campaigns on fortified foods in collaboration with the civil societies, Ministry of Information and Civic Education to reach at least 3 million people by 2012.	0	0	500,000	1,500,000	1,000,000	3,000,000 people
12. Conduct quarterly and ad-hoc monitoring of industries, port of entry and outlets of fortified foods involving 15 people for 10 days per visit.	4	4	4	4	4	20 Visits
13. Conduct a working session for 10 people for 2 days to develop standard guidelines that include fortified foods for social protection programmes to encourage use of fortified foods in such programmes.	0	0	0	1	0	1 session
STRATEGIC OUTPUT 1-O2: Strengthen delivery of micronutrient supplementation to targeted beneficiaries according to schedule through routine services and targeted campaigns						
ACTIVITIES						
1. Conduct biannual Child Health Days that cover Vitamin A supplementation, de-worming and nutrition education on child care practices and other child survival interventions to maintain over 80% coverage of each of the intervention	80%	80%	80%	80%	80%	80% coverage
2. Conduct national, district and community level sensitisation meetings on the importance of supplementation among caregivers, communities and service providers as part of the child health days to reach at least 6 million people by 2012.	1,000,000	1,000,000	1,500,000	1,500,000	1,000,000	6,000,000 people
3. Conduct a stakeholders meeting of 30 people for 3 days to review and reach consensus on a reliable supply chain logistics management system to ensure adequate availability of micronutrient supplementation supplies	0	0	0	1	0	1 meeting
4. Conduct four 1 day sessions of 1400 MCH, IMCI, CTC service providers to facilitate integration of Micronutrient supplementation services and promotion at each contact point with the child and the woman and other child survival programmes.	0	350	350	350	350	1400 people
KEY STRATEGY P6: Promotion of practices that promote health life styles, food availability, diversity, access, proper storage, preparation, utilisation, the consumption of a variety of foods from the six food groups every day, safety and quality in the general population						
STRATEGIC OUTPUT 1-O1: Develop and disseminate recipes and guidelines based on the various food combinations using the “Multi-mix principle” for designing family meals.						
ACTIVITIES						
1. Conduct a 5 day working session of 20 participants to develop a set of recipes and guidelines for designing and planning family meals and for the elderly, the chronically ill, and non-communicable diseases based on “Multi-mix Principle”.	0	0	1	0	0	1 working session

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
2. Conduct intensive national and localised nutrition education for 7 days through Community Workers such as: Nutrition and HIV and AIDS Workers, Agriculture Extension Workers, Community Development Assistants and HSAs; and mass media, fairs, focus group discussions in appropriate food choices, combinations, food preparation and utilisation to reach at least 5 million people	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000 people
STRATEGIC OUTPUT 1-O2: Develop and disseminate guidelines on food utilisation, processing, post harvest management, storage, preparation techniques, based on typically available foods and quantities to maximise nutrition benefit from available foods throughout the year.						
ACTIVITIES						
1. Conduct 5 day working session of 20 people to review food utilization guidelines, that include collection, storage, processing and preparation techniques based on locally available foods and quantities to maximize nutritional benefits and print 1000 copies every year	0	0	1	0	0	1 working session
2. Conduct a working session of 20 participants to develop information education and communication (IEC) materials on food preparation , processing and storage, print 1000 copies per year and disseminate using various media channels and community activities to reach at least 3 million people by 2012.	0	0	500,000	1,000,000	1,500,000	3,000,000 people
3. Disseminate the food preparation, processing, storage and utilization guidelines through civic education, mass media and village demonstrations at all levels to reach at least 3 million people	0	0	500,000	1,000,000	1,500,000	3,000,000 people
4. Conduct trainings for at least 500 service providers in 10 sessions of 50 participants per session for 2 days and 200 communities in 4 sessions of 50 people per session for 1 day in each district on food processing, preparation, storage and participatory recipe development	700	700	700	700	700	3,500 people
6. Conduct meetings with research institutions on food preparation, processing and storage and engage them to produce appropriate technologies.	0	0	4	0	0	4 research institutions
7. Conduct tours and exchange visits to food processing sites involving 30 people per visit twice a year	0	0	6	6	6	18 visits
8. Orient tutors, supervisors and community nutrition workers on food processing, storage, preparation, utilisation and Community Nutrition Programmes reaching at least 500 in 10 sessions of 50 people for 3 days by 2012	0	0	100	200	200	500 people
9. Monitor the implementation of the food processing technologies and standards through 7 day field visits involving 12 people twice a year	0	0	2	2	2	6 visits

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
10. Review and document existing post-harvest nutritious food management practices and IEC materials in 5 day field visit of 15 people and 6 day working session for 20 people.	0	0	0	1	0	1 documentation
11. Train at least 3000 extension workers in post-harvest food management in 60 sessions of 50 participants each			500	1,500	1,000	3,000 people
13. Disseminate the materials through multi-media messages on post harvest food management to reach at least 5000 farmers by 2012 in a 7 day campaign per year.	0	0	1,000	2,000	2,000	5,000 people
14. Advocate for the development and adoption of labour saving technologies on post-harvest food management during a one day meeting of 50 participants	0	0	1	0	0	1 meeting
STRATEGIC OUTPUT 2-O2: Promote the consumption of adequate food in both quality and quantity to meet the nutritional needs for rural and urban households with special emphasis on vulnerable groups and low-income households.						
ACTIVITIES						
2. Conduct a 5 day field visit with 10 people to collect information for developing audio-visual documentaries on food budgeting and dietary diversification, produce the documentary and air on radio and TV to reach 3 million people	0	0	5,000,000	1,000,000	1,500,000	3,000,000 people
6. Conduct 3 working sessions of 20 people for 5 days each to develop comprehensive food composition tables for Malawi and design a standard meal for Malawi and produce dietary recommendations for various population categories including NCDs	0	0	2	1	0	3 working sessions
11. Conduct civic education on the amount of food that families should keep taking into account food seasonal variations	0	0	500,000	1,000,000	1,500,000	3,000,000 people
KEY STRATEGY P7: Promotion of access to at least one nutritious meal and related health and nutrition services for the school-going children through the school feeding and the school health and nutrition programmes.						
STRATEGIC OUTPUT1-O1: Scale up and strengthen implementation of the School feeding and school Health and Nutrition Programme to all public primary schools by 2012						
ACTIVITIES						
1. Strengthen the roles and responsibilities of the school health and nutrition committee by developing clear terms of reference, programme and budget.	0	0	1	0	0	1 working session
2. Scale up the school feeding programmes with integration of nutrition education to all public primary schools in phases	150	150	150	150	150	750 new schools
3. Build capacity of schools (training, equipment, materials and other resources) to conduct regular nutrition assessment and health and nutrition education in the public schools and surrounding communities by 2012.	150	150	150	150	150	750 new schools

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
4. Promote school gardens and cooking demonstrations that promote appropriate food choices and combinations in the public schools.	150	150	150	150	150	750 new schools
5. Promote appropriate nutrition practices based on the Essential Nutrition Actions among school pupils, teachers and the community in the public schools.	150	150	150	150	150	750 new schools
6. Promote bi-annual national and localised nutrition and health campaigns in all schools and surrounding communities.	2	2	2	2	2	10 campaigns
7. Facilitate early case detection, provision of diagnosis and treatment of minor ailments such as malaria, diarrhoea, skin conditions, mild anaemia, referral and follow up to pupils in the public schools	150	150	150	150	150	750 new schools
8. Facilitate provision of appropriate water and sanitary facilities in the public schools for prevention of infectious diseases	150	150	150	150	150	750 new schools
STRATEGIC OUTPUT 1-O2: Strengthen the integration of nutrition in the school curricula at different levels and the teaching of nutrition in schools						
ACTIVITIES						
1. Conduct review of school curricular for basic and secondary education in 5 working sessions of 20 people for 7 days, and 2 day stakeholders consultation meeting for consensus involving 50 people	0	0	1	2	2	5 Curricuula
3. Conduct 5 working sessions of 20 people for 7 days to incorporate nutrition in the curricular and accompanying teaching and learning materials	0	0	1	2	2	5 sessions
4. Mobilise resources through advocacy meetings targeting individual donors and partners and print the revised curricular and materials	0	0	1	2	2	5 advocacy meetings
5. Disseminate the new curricular and materials to key stakeholders in a national workshop of 50 participants and 6 divisional workshops for 50 participants for 2 days each session	0	0	350	700	700	1750 stakeholders reached
6. Conduct orientation sessions for teachers in the new curricular and materials to reach at least 3 teachers per institution/school by 2012	0	0	15,000	5,000	5,000	20,000 teachers/tutors
7. Monitor the teaching of nutrition lessons in primary and secondary schools.	0	0	4	4	4	12 visits

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
KEY STRATEGY P8: Strengthen capacities for households and communities to attain adequate nutrition for their families with emphasis on socio-economically deprived persons						
STRATEGIC OUTPUT 1: Facilitate establishment of income generating activities for improving nutrition in households and communities with focus on the socio-economically deprived persons.						
ACTIVITIES						
1. Conduct needs assessment.	0	0	1	0	0	1 assessment
2. Facilitate formation of IGA groups in 5 districts per year.	0	0	5	5	5	15 districts
3. Train groups on IGA management in the districts	0	0	5	5	5	15 districrs
4. Link groups to financial lending institutions.	0	0	50	50	50	150 groups linked
5. Provide on going support to the IGA groups.	0	0	50	50	50	150 groups
6. Train the IGA groups in financial and home management.	0	0	50	50	50	150 groups
KEY STRATEGY P9: Promotion of food safety and quality						
STRATEGIC OUTPUT 1: Strengthen enforcement of food safety and quality regulations						
ACTIVITIES						
1. Conduct 3 working sessions to review existing national legislation and regulations according to the international Sanitary and Phyto-Sanitary (SPS) agreements and 4 regional one day consultative workshops of 50 people and 7 day field trip of 20 participants and 3 international trips for 9 people for 3 days per trip to facilitate development of the nutrition Act to include labelling, marketing, promotion and comprehensive mandatory standards for all marketed food products, street commercial and imported foods and food aid, street food vending and marketing of food supplements	0	0	0	1	2	3 working sessions
3. Conduct a working session of 20 people for 5 days to develop guidelines to regulate the development and use of minimum standards for modern biotechnology, Genetically Modified Organisms (GMO's) and Genetically Engineered Seeds and Substances (GESS)	0	0	0	40	40	80 people
6. Strengthen institutional capacity of the Department of Nutrition, HIV and AIDS, Malawi Bureau of Standards (MBS), Consumers Association of Malawi (CAMA) and other public watchdogs on consumer safety to monitor food safety and quality through training of 40 participants for 5 days in food safety and quality control.	6	6	6	6	6	30 visits

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
8. Conduct periodic monitoring of food industries, food packaging industries and warehouses as well as outlets including those importing or repackaging iodised salt involving 20 people per field visit for 15 days by National team and quarterly involving 10 district inspectors per activity.	6	6	6	6	6	30 visits
STRATEGIC OUTPUT 2: Increase knowledge among consumers on food safety and quality						
ACTIVITIES						
1. Develop Education materials on food safety and quality in a 7 day working session of 20 people	0	0	0	1	0	1 working session
2. Orient stakeholders to the materials in 3 sessions of 40 participants per session for 5 days	0	0	0	40	80	120 people
3. Conduct national wide civic education on food safety and quality in collaboration with Ministry of Information and Civic Education, Consumer Association of Malawi and human rights civil societies involving 20 people for 15 days meeting 30 people per district, two radio and TV documentaries to reach 3000 people	0	0	0	1,500	1,500	3,000 people
KEY STRATEGY P10: Control of nutrition related non-communicable and other diseases.						
STRATEGIC OUTPUT 1: Promote practices that reduce the risk of diseases among Malawians						
1. Conduct advocacy meetings with key stakeholders on the provision of safe water and sanitary facilities to the communities in both rural and urban areas at national and district level.	1	1	1	1	1	5 advocacy meetings
2. Facilitate civic education on the importance of using safe water and correct use of sanitary facilities in all districts	0	0	0	1,500	1,500	3,000 people
3. Facilitate civic and health education on key practices to prevent diseases among various population groups at all levels and in early health care seeking behaviour	0	0	0	1,500	1,500	3,000 people
4. Develop and review dietary guidelines and recommendations for people suffering from specific nutrition-related diseases, such as, diabetes, hypertension and certain types of cancer among others including communicable tuberculosis, HIV and AIDS to community, extension, Health and other social service providers	0	0	2	2	0	4 working sessions
5. Conduct a series of training sessions to orient service providers on the guidelines	0	0	2	2	2	6 sessions
6. Conduct child health campaigns at national, district and community levels on Non Communicable Diseases.	0	0	0	1	1	2 campaigns

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
KEY PRIORITY AREA: MANAGEMENT						
KEY STRATEGY M1: Promoting access and quality of nutrition and related services to facilitate effective management of nutrition deficiency disorders in under-five children, adolescents and adults						
STRATEGIC OUTPUT 1: Review and consolidation of guidelines for prevention and management of malnutrition in under-five children, adolescents and adults and the work place HIV and AIDS guidelines.						
1. Compile existing guidelines for management of malnutrition through Community Therapeutic Care, Therapeutic and Supplementary feeding in under-five children, pregnant and lactating women, adolescents and adults from Government and other stakeholders	0	0	1	0	0	1 review
2. Conduct stakeholders meetings to review the guidelines	0	0	2	0	0	2 working sessions
3. Conduct a series of working sessions to consolidate the guidelines	0	0	3	0	0	3 working sessions
4. Disseminate the guidelines through in-service training of service providers, nutrition coordination, planning and committee meetings and other contact points and mass media to reach at least 500 people in all districts.	0	0	100	200	200	500 people
5. Develop job aids and other accompanying materials on the use of the guidelines.	0	0	2	0	0	2 working sessions
6. Build capacity at district and community levels for further dissemination as well as interpretation, implementation and monitoring and evaluation of the use and effectiveness of the guidelines.	0	0	100	200	200	500 people
7. Orient Zone officers and key stakeholders on the use of the guidelines			40	40	40	120 people
8. Include guidelines for provision of Nutrition Care and Support in the HIV Work Place Guidelines for the use of the 2 percent government budgetary allocation in all government sectors and departments	0	1	0	0	0	1 working session
9. Conduct dissemination meetings with stakeholders	0	50	50	50	50	200 people
10. Communicate with all government sectors through a circular on the guidelines and circulation as well as orientation of key users in Government Departments to the said guidelines	0	All Government Institutions	All Government Institutions	All Government Institutions	All Government Institutions	All Government Institutions

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
STRATEGIC OUTPUT 2: Provide necessary knowledge and skills to service providers in management of acute malnutrition in under-five children, pregnant and lactating women and in provision of nutrition treatment, care and support to adolescents and adults through in-service and on the job training with emphasis on mentoring the service providers and sharing of experiences.						
ACTIVITIES						
1. Develop consolidated training materials in prevention and management of moderate and severe acute malnutrition in infants, young children, adolescents and adults.	2	0	2	0	0	4 working sessoins
2. Conduct training of trainers in prevention and management of moderate and severe acute malnutrition in infants, young children, adolescents and adults..	30	30	30	30	30	150 trainers
3. Train service providers with emphasis on mentoring to facilitate effective transfer of skills.	200	200	200	200	200	1000 people
4. Conduct on-spot technical supervision of trained service providers once a quarter to reach 9 districts per quarter.	200	200	200	200	200	1000 people
7. Orientation of tutors from pre-service institutions, DHMT and zone officers	0	0	40	40	40	120 tutors
STRATEGIC OUTPUT 3: Strengthen community follow-up and participation in treatment of clients with malnutrition						
ACTIVITIES						
1. Develop information kit and standardised check list for early case detection, follow up and referral of clients	1	0	1	0	0	2 working sessions
2. Conduct training of Community Nutrition Workers, HSAs, CDAs, AEDOs, AEDCs, SWAs, AEHO and others	200	200	200	200	200	1000 people
3. Conduct community registration of various population groups	1	1	1	1	1	5 registrations
4. Conduct weekly door to door visits to households with malnourished individuals	52	52	52	52	52	260 visits
5. Conduct community nutrition assessment sessions quarterly and more frequently where deemed necessary in all districts.	4	4	4	4	4	20 assessments
6. Conduct community sensitisation meetings on prevention, causes, management and existing programmes for management of malnutrition in all TAs in all districts.	500	500	500	500	500	2,500 people
7. Engage the trained community members in growth monitoring and active case detection in their communities	12	12	12	12	12	60 sessions

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
STRATEGIC OUTPUT 4						
1.1.4. Monitor case management outcomes for appropriate action						
ACTIVITIES						
1. Produce and disseminate consolidated checklist for monitoring case management outcomes to service providers in all CTC sites	200	200	200	200	200	1000 service providers
2. Train DHMT, service providers and community workers on the use of the checklist in interpretation, reporting and response	500	500	500	500	500	2,500 people
3. Compile and produce district monthly reports for action and reporting to central level	12	12	12	12	12	60 reports per district
4. Produce quarterly bulletin on malnutrition case, interventions and case management outcomes.	4	4	4	4	4	20 bulletins
STRATEGIC OUTPUT 5						
1.1.5. Provision of adequate knowledge and skills to service providers to be able to manage and monitor malnutrition in PLWHA.						
ACTIVITIES						
1. Review guidelines and accompanying materials for Nutrition Care, Support and Treatment (NCST) of PLWHA.	0	2	1	0	0	3 working sessions
2. Conduct dissemination meeting with stakeholders on the guidelines	200	200	200	200	200	1000 people
3. Develop training materials in management of moderate and severe acute malnutrition in Nutrition Care, Support and Treatment (NCST)	2	0	2	0	0	4 working sessions
4. Conduct training of trainers in the guidelines	30	30	30	30	30	150 trainers
5. Train service providers and other stakeholders in the guidelines to reach at least 1000 people per year	1000	1000	1000	1000	1000	5000 people
6. Conduct on-spot technical supervision of the trained service providers in at least 9 districts per quarter per year	1000	1000	1000	1000	1000	5000 people
9. Orientation of tutors from pre-service institutions, DHMT and zone officers on the guidelines	0	0	40	40	40	120 tutors
10. Train DHMT, service providers and community workers on the use of the checklist in interpretation, reporting and response	500	500	500	500	500	2,500 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
11. Compile and produce district monthly reports for action and reporting to central level	12	12	12	12	12	60 reports per district
12. Produce quarterly bulletin on malnutrition case, interventions and case management outcomes.	4	4	4	4	4	20 bulletins
STRATEGIC OUTPUT 6						
1.1.6. Provide necessary knowledge and skills to caregivers and clients in nutrition management of HIV related conditions and infections						
ACTIVITIES						
1. Conduct periodic review of nutrition education and counselling materials in NCST	0	0	1	0	1	2 Reviews
2. Print and distribute revised materials to all sites	0	0	3,000	0	3,000	6,000 copies
3. Orient nutrition counsellors and other services providers at facility and community level	500	500	500	500	500	2,500 people
4. Conduct nutrition education and counselling sessions for client and their caregivers at facility and community level	1,000	1,000	1,000	1,000	1,000	5,000 people
5. Develop a comprehensive nutrition communication strategy for NTSCP	0	0	3	0	0	3 working sessions
6. Implement the strategy using various means of communication	0	0	1,000,000	1,000,000	1,000,000	3,000,000 people
7. Develop IEC material for service providers, clients and caregivers based on standardised message	2	0	0	2	0	4 working sessions
8. Disseminate IEC materials at various levels using various channels at both facility and community level	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
KEY PRIORITY AREA: CREATING AN ENABLING ENVIRONMENT FOR THE EFFECTIVE IMPLEMENTATION OF THE POLICY AND THE STRATEGIC PLAN						
KEY STRATEGY E1: Malawi shall firmly position nutrition on her development agenda and include Nutrition in the key development programmes, allocate adequate resources, strengthen institutional and human capacities, put in place necessary coordination mechanisms in all sectors for the implementation of the National Nutrition Policy at all levels.						
STRATEGIC OUTPUT 1: Government to ensure that all government development policies adequately take nutrition on board as a priority area for achieving economic growth, stability and prosperity.						
ACTIVITIES						
1. Conduct advocacy meetings with Heads of government ministries, departments and Institutions, national, district and local leaders on the magnitude, consequences of malnutrition and its impact on individuals, communities and national economic growth and prosperity	2	2	2	2	2	10 advocacy meetings
2. Hold meetings to reach consensus with stakeholders on the importance of incorporating nutrition as a cross-cutting issue in national and sectoral departments	2	2	2	0	0	6 consensus meetings
3. Conduct working sessions with sectors to review existing policies and guidelines to identify gaps.	0	1	1	1	1	4 working sessions
4. Conduct working sessions to incorporate nutrition in existing sectoral policies and guidelines	0	3	3	3	3	12 working sessions
5. Facilitate inclusion of nutrition in sectoral strategic and work plans through bi-annual joint planning and review meetings	2	2	2	2	2	10 planning and review meetings
STRATEGIC OUTPUT 2: All government sectors and departments to have a defined role and responsibility in nutrition and to include nutrition in their sectoral development policies and plans.						
ACTIVITIES						
1. Conduct stakeholders analysis for nutrition to identify their roles and responsibilities based on the sectoral mandates and comparative advantage	1	1	1	1	1	5 reviews
2. Hold meetings to reach consensus on roles and responsibilities for each government sector	1	1	1	1	1	5 meetings
3. Define and disseminate the roles and responsibilities for each sector	1	1	1	1	1	5 meetings
4. Lobby for creation of nutrition positions in all the government Ministries and departments to facilitate the mainstreaming of nutrition in the sectoral policies and programmes.	1	1	1	1	1	5 meetings

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
5a. Facilitate the recruitment of Nutrition staff for the sectors	3	3	3	3	3	15 recruitment sessions
5b. Facilitate the deployment of Nutrition staff for the sectors	3	3	3	3	3	15 deployments
STRATEGIC OUTPUT 3: Establish and strengthen sectoral nutrition programmes and implementation units and partnerships with well defined terms of reference and means of giving feed back to nutrition stakeholders.						
ACTIVITIES						
1. Conduct Stakeholders meetings with government sectors, NGO, Bilateral and Multilateral Partners, the Private sector, Academic Institutions, the media and others to review current sectoral programmes, key achievements, lessons learnt, challenges and opportunities.	1	1	1	1	1	5 meetings
2. Facilitate building of the institutional and human capacity of the sectoral Institutions.	30	30	30	30	30	150 people trained
3. Facilitate quarterly reporting of nutrition services by each sector.	4	4	4	4	4	20 reports per sector
4. Conduct biannual Nutrition Implementers feed back meetings.	2	2	2	2	2	10 meetings
STRATEGIC OUTPUT 4: Nutrition stakeholders in the private sector to include services, programmes and projects aimed at promoting adequate nutrition for all Malawians in their policies and plans in line with the MGDS.						
ACTIVITIES						
1. Conduct one to one advocacy and negotiation meetings with the private sector to mainstream nutrition services in their programmes	1	1	1	1	1	5 advocacy meetings
2. Facilitate establishment of a Business Coalition for nutrition with clear terms of reference and feed back mechanisms. • Identify partners for the coalition. • Develop terms of reference for the coalition. • Include the Private sector in planning and review meetings	0	0	0	4	4	8 meetings

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
STRATEGIC OUTPUT 5: Conduct advocacy with bilateral and multilateral partners to place nutrition high on their agenda for support to government and in line with the MGDS in order to contribute to the operationalisation of the government nutrition plans.						
ACTIVITIES						
1. Conduct an advocacy meeting with the Bilateral and multilateral partners on the magnitude of nutrition problems, consequences and priority areas for action.	1	1	1	1	1	5 advocacy meetings
2. Facilitate establishment of a Government-partners coordination group to facilitate collaboration and networking	1	2	0	0	0	3 advocacy meetings
3. Conduct Quarterly review meeting with the partners and other stakeholders	4	4	4	4	4	20 meetings
4. Participate in joint programme review and planning of activities under development partners' support to government (UNDAF)	2	2	2	2	2	10 reviews
STRATEGIC OUTPUT 6: Facilitate proper alignment of nutrition programmes and projects initiated by the Non-government organizations with the National nutrition policy and the MGDS for maximum benefits to Malawians.						
ACTIVITIES						
1. Orient NGOs on the National Nutrition Policy and Government priorities as defined in the MGDS.	0	50	50	50	50	200 NGO stakeholders
2. Produce guidelines on project identification, targeting, implementation and monitoring for NGOs	2	3	0	0	2	7 working sessions
3. Conduct meetings to disseminate the guidelines to NGOs	1	1	0	0	1	3 meetings
4. Take stock of programmes and projects that are already underway by assessing ongoing nutrition activities and existing coordination structures at all levels in order to build on them or for possible scale up with partners and NGOs.	1	1	1	1	1	5 assessments
5. Consolidate guidelines for reviewing NGO projects.	0	1	0	0	1	2
6. Review proposals from NGOs and approve where the criteria is met.	4	4	4	4	4	20 proposal review meetings
7. Conduct quarterly joint supervisory visits to NGO projects and provide feedback to stakeholders	4	4	4	4	4	20 field visits

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
KEY STRATEGY E2: Increased budgetary allocation of resources by government and her partners for implementation of the National Nutrition Policy						
STRATEGIC OUTPUT: Government sectors and departments to allocate and mobilise external financial resources to support nutrition services, programmes, projects and interventions in their sectors.						
ACTIVITIES						
1. Strengthen Government-Donor partners committee on nutrition to spearhead the resource mobilisation campaigns	0	1	1	1	1	4 advocacy meetings
2. Lobby for establishment of a pool fund for nutrition supported by government and partners.	0	3	3	3	3	12 advocacy meetings
3. Disseminate the Nutrition Policy and Strategic Plan to many stakeholders including district assemblies and to advocate for resources	0	1,500,000	1,500,000	1,500,000	1,500,000	6,000,000 people
4. Develop a targeted advocacy tool and use it to mobilise resources.	2	2	2	2	2	10 working sessions
5. Conduct resource mobilisation campaigns among in-country and outside partners.	2	2	2	2	2	10 advocacy meetings
6. Make special individual contacts with the donor partners	5	5	5	5	5	25 donors
7. Lobby with the head of finance and other heads of sectors at national and district level to allocate resources for nutrition.	1	1	1	1	1	5 meetings
9. Document and disseminate widely nutrition interventions that have shown impact.	0	0	0	2	2	4 working sessions
10. Collaborate continuously with partners through information sharing, networking and feedback meetings, learning forums.	4	4	4	4	4	20 meetings
KEY STRATEGY E3: Government shall strive to build institutional and human capacity for effective delivery of nutrition services and design, development and implementation of relevant nutrition programmes, projects and interventions in the public sector.						
STRATEGIC OUTPUT 1: Facilitate creation and filling of new and existing nutrition posts in all government Ministries and departments.						
ACTIVITIES						
1. Lobby for positions for Nutrition, HIV and AIDS Officers in all government Ministries and departments and solicit authority to recruit	1	1	1	1	1	5 lobby meetings
2. Develop a recruitment and deployment plan.	1	0	0	0	1	2 working sessions
3. Recruit, train and deploy Nutrition, HIV and AIDS Officers	30	30	30	30	30	150 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
STRATEGIC OUTPUT 2: Increase number of nutrition implementers that have the necessary competencies through pre- and in-service training and regular up dates.						
ACTIVITIES						
1. Document existing training materials in nutrition used by various stakeholders.	1	1	1	1	1	5 documentation exercises
2. Conduct a stakeholders meeting to review the materials to identify gaps and for possible consolidation.	1	1	1	1	1	5 working sessions
3. Conduct a series of working sessions to consolidate the training and accompanying materials.	2	2	2	2	2	10 working sessions
4. Pre-test the materials in a TOT.	30	30	30	30	30	150 people
5. Print and distribute the materials.	500	500	500	500	500	2,500 copies
6. Conduct a series of training session for service providers, supervisors and programme Managers in the consolidated materials.	200	200	200	200	200	1,000 people
8. Conduct annual refresher orientation sessions on emerging issues as required.	200	200	200	200	200	1,000 people
9. Conduct needs assessment for nutrition personnel at various levels.	0	0	1	0	0	1 needs assessment
10. Lobby for training of a pool of technical experts in nutrition (100 BSc nutritionists, 100 MSc nutritionists, 100 Dieticians, 60 PhDs).	72	72	72	72	72	360 people
11. Develop training curriculum for pre-service training in nutrition	0	2	3	3	3	11 working sessions
** Engage a recognised training Institution to train different nutrition cadres	1	1	1	1	1	1 institution
12. Recruit students for training	72	72	72	72	72	360 students
15. Mobilise resources for the training	2	2	2	2	2	10 meetings
16. Produce and implement the training plan	72	72	72	72	72	360 trained
17. Conduct periodic orientation or up-date sessions for nutrition implementers to relevant policies and guidelines in nutrition as need arises	200	200	200	200	200	1,000 people
18. Facilitate participation of Malawian specialists in the international and national nutrition fora and provide for accessible and timely debriefings	50	50	50	50	50	250 people

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
STRATEGIC OUTPUT 3: Increase the number of trained extension workers to implement nutrition services, programmes and projects in Malawi, with special focus on Community Nutrition Workers						
ACTIVITIES						
1. Facilitate recruitment of 8000 positions for Community Workers to work with at least 250 households each	0	0	1,600	1,600	1,600	4,800 recruited
2. Conducting a working session to review existing curriculum for community based service providers from various training Institutions to identify gaps	0	1	0	0	0	1 working session
3. Develop training curricula, modules and resource materials for the Community Workers	0	3	2	0	1	6 working sessions
5. Mobilise resources and Institutions for training the Community Workers	1	1	1	1	1	5 advocacy meetings
6. Orient Tutors, Supervisors and other relevant staff on Community Workers' training Programme	0	0	40	40	40	120 people
7. Train and deploy the Community Workers	0	0	1,600	1,600	1,600	4,800 trained
8. Provide follow-up and on-going support to the trained Community Workers	0	0	1,600	1,600	1,600	4,800 followed up
STRATEGIC OUTPUT 4: Increase the institutional capacity of key government departments at national and district level to acquire or procure adequate supplies, materials and equipment for implementing nutrition services, programmes, and projects.						
ACTIVITIES						
1. Conduct facility and community level needs assessment for various nutrition supplies, materials, equipment and storage and kitchen facilities.	1	1	1	1	1	5 assessments
2. Produce a procurement and distribution plan and update it from time to time as required	1	1	1	1	1	5 Plans
3. Orient District and community staff on how to estimate requirements for various nutrition programmes, timely requisition, reporting and logistics management	1	1	1	1	1	5 orientations
4. Mobilise resources to up-grade storage and kitchen facilities where necessary.	25	25	25	25	25	125 upgraded

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
KEY STRATEGY E4: Establishment of a well defined coordination mechanism for nutrition services, programmes and projects at central, district and community level.						
STRATEGIC OUTPUT 1: Develop and disseminate a comprehensive Nutrition Business plan that clearly defines the key stakeholders, their key roles and responsibilities based on their mandate, area of focus and comparative advantage both in the public and private sectors.						
ACTIVITIES						
1. Conduct a stakeholders' meeting to define and reach consensus on key mandates, functions, priority areas roles and responsibilities of each stakeholder in the implementation of the policy.	1	1	1	1	1	5 meetings
2. Disseminate the roles and responsibilities	1	1	1	1	1	5 meetings
3. Follow-up the sectors quarterly for progress reports.	4	4	4	4	4	20 reports per sector
STRATEGIC OUTPUT 2: Establishment and strengthening of Nutrition committee and its sub-committees that shall have well defined terms of reference, work plans and means of giving feed back to nutrition stakeholders.						
ACTIVITIES						
1. Compile a list of all the existing nutrition committees and their Terms of Reference.	1	1	1	1	1	1 list
2. Identify gaps and solicit consensus from stakeholders on whether other committees should be established.	1	1	1	1	1	5 meetings
3. Develop Terms of Reference for each of the new committees.	1	1	1	1	1	5 meetings
4. Develop work plan for each committee.	1	1	1	1	1	5 meetings
5. Mobilise resources to support the functions of the committees.	1	1	1	1	1	5 meetings
6. Facilitate meetings for the committees for review of various nutrition programmes in the country quarterly or more often where necessary.	0	4	4	4	4	16 facilitations done
7. Facilitate feed back reports from each of the committee circulated and also presented to the main Nutrition Committee.	0	4	4	4	4	16 reports per subcommittee
8. Consolidate and disseminate the reports quarterly for up date, transparency and accountability.	0	4	4	4	4	16 consolidations done and 16 dissemination of reports done

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
9. Conduct periodic review of TORs of various committees	0	1	1	1	1	4 review meetings held
KEY STRATEGY E5: Government shall ensure evidence based programming of nutrition programmes, projects, activities, interventions and services through the generation and dissemination of nutrition research information and findings and appropriate documentation and dissemination of best practices.						
STRATEGIC OUTPUT: Facilitate coordinated implementation of Nutrition Research that is responsive to national needs						
ACTIVITIES						
1. Lobby for establishment of an ethic committee on Nutrition Research as a sub-committee of the National Research Committee to particularly regulate Nutrition Research	0	0	0	2	1	3 meetings
2. Establish a Committee on research with clear terms of reference and work plan	0	0	0	1	0	1 working session
3. Document existing research including on-going research by various Institutions and individuals through consultative meetings with experts in nutritional research	0	0	0	1	1	2 documentations
4. Produce a data for nutrition research and researchers	0	0	0	1	1	2 working sessions
6. Conduct a research needs assessment to identify priority areas in the various sectors	0	0	0	1	1	2 assessments
7. Conduct a meeting with nutrition stakeholders and key policy makers to build consensus on the identified research priority areas	0	0	0	1	1	2 meetings
8. Conduct a working session to develop, review and update nutrition research agenda and protocols	0	1	2	1	1	5 working sessions
9. Identify potential institutions to conduct research in nutrition	0	1	1	1	1	4 institutions
10. Disseminate the research agenda and protocols to key researchers	0	0	2	2	2	6 dissemination meetings
11. Conduct Bi-annual review of on-going research and annual dissemination meeting of completed research	0	0	2	2	2	6 meetings
12. Produce Bi-annual bulletin on nutrition research	0	0	0	2	2	4 bulletins

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
13. Encourage publication and dissemination of research findings	0	0	0	1	1	2 research meetings
14. Establish a National Nutrition Information Centre in the Department of Nutrition, HIV and AIDS	0	0	1	0	0	1 information centre
15. Collect and compile copies of research reports, presentations, publications and other information on nutrition for the nutrition resource centre	0	0	1	1	1	3 documetations
16. Inform the public about the resource centre	0	0	0	500	500	1,000 people
19. Conduct annual documentation of best practices	1	1	1	1	1	5 documentations
20. Organise an annual dissemination and feedback meeting with policy makers and key government decision makers for their buy-in.	1	1	1	1	1	5 meetings
21. Conduct a stakeholders meeting at various levels to operationalise key research findings and identified best practices.	1	1	1	1	1	5 meetings
22. Facilitate regular feed back from Extension workers and other users of the research information	1	1	1	1	1	5 sessions
23. Strengthen collaboration between research and extension service providers in nutrition research.	1	1	1	1	1	5 joint meetings
KEY STRATEGY E7: Monitoring and Evaluation						
STRATEGIC OUTPUT 1: Establishment of Nutrition Management Information Systems that is linked to all nutrition programmes, services, projects and interventions						
ACTIVITIES						
6. Establish, manage and utilise the information system			1	1	1	1 information system
7. Conduct regular M and E visits to nutrition implementing Institutions, programmes and projects at all levels.	4	4	4	4	4	20 visits
STRATEGIC OUTPUT 2: Increase availability and access to nutrition information by stakeholders and other users at all levels						
ACTIVITIES						
1. Conduct regular feed back and review meetings	1	1	1	1	1	5 reviews
2. Establish and review a mechanism for receiving and consolidating periodic reports on nutrition programmes, projects and services from all stakeholders	1	1	1	1	1	1 system

	ANNUAL TARGETS					
	2007	2008	2009	2010	2012	TOTAL
3. Disseminate the M and E results periodically and facilitate appropriate actions	2	2	2	2	2	10 meetings
4. Produce and disseminate periodic reports and nutrition bulletin	2	2	2	2	2	10 reports
STRATEGIC OUTPUT 3: Strengthen nutrition surveillance at facility and community level						
ACTIVITIES						
1. Evaluate and review current Nutrition surveillance to identify gaps	0	1	4	1	1	7 meetings
4. Identify key indicators for the National nutrition programmes and services and for localised projects	1	1	1	1	1	5 meetings
5. Develop and review monitoring framework and indicators	1	1	1	1	1	5 meetings
6. Train stakeholders at national, district and community level in the monitoring framework and indicators, importance of collecting data, data collection methods, management, interpretation and utilisation	200	200	200	200	200	1,000 trained
7. Procure nutrition assessment equipment	1	1	1	1	1	5 procure-ments
8. Conduct periodic nutrition assessments among school children in randomly selected schools	2	2	2	2	2	10 assess-ments
9. Conduct nutrition surveys by constituency	0	0	1	0	1	2 surveys
10. Build capacity on the utilization of the generated data for rational response to nutrition problems at various levels	200	200	200	200	200	1,000 people
14. Establish community resource centres	0	0	0	2	2	4 centres
STRATEGIC OUTPUT 4: Strengthen the Growth monitoring and promotion services of children under five years of age at facility and community level in all districts.						
ACTIVITIES						
1. Review and produce growth monitoring training materials based on the new WHO growth standards	0	0	1	0	0	1 session
2. Develop and produce growth monitoring counselling tools and support materials.	0	0	1	0	0	1 session
3. Conduct training for growth monitors	800	800	800	800	800	4000 people
4. Procure and distribute growth monitoring equipment and supplies	1	1	1	1	1	5 procur-ments
6. Facilitate monthly growth monitoring sessions that are linked to ENA	5,000	5,000	5,000	5,000	5,000	5,000 chil-dren
8. Establish and strengthen community support systems for counselling in maternal, infant and young child feeding, feeding of a sick child during and after illness and control and prevention of micronutrients	5,000	5,000	5,000	5,000	5,000	5,000 chil-dren

ANNEX 3: NATIONAL NUTRITION POLICY AND STRATEGIC PLAN MONITORING AND EVALUATION FRAMEWORK

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Strategic Objective 1: To prevent and control the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups									
To achieve strategic outcomes for prevention and control of nutrition disorders.	Reduction of malnutrition in under 5s	Reduced proportion of children with low birth weight (%)	14.0	12	10	<10%	Every 4 years	MICS	
	Reduction of malnutrition in under 5s	Reduced prevalence of stunting in children under five years of age (%)	46.0	43	42	40%	Every 4 years	MDHS/ MICS	
	Reduction of malnutrition in under 5s	Reduced prevalence of wasting in children under five years of age (%)	3.5	2.5	2	<2.0	Every 4 years	MDHS/ MICS	
	Reduction of malnutrition in under 5s	Reduced prevalence of underweight in under five chil-dren (%)	21.0	18	16	15.0	Every 4 years	MDHS/ MICS	
	Reduction of malnutrition in under 5s	Reduced proportion of pre- under-five children with Vitamin A Deficiency (VAD) (%)	59.0	50	45	40.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of malnutrition in school children	Reduced prevalence of stunting in school age children (5-10 years) (%)	30.0	24	22	20.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of malnutrition in school children	Reduced prevalence of wasting in school age children (5-10 years) (%)	3.0	1.5	1	<1.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of malnutrition in school children	Reduced prevalence of underweight in school age chil-dren 5-10 years (%)	18.0	13	11	<10.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of malnutrition in school children	Reduced proportion of pre- school aged children with anaemia (%)	80.0	67	63	60.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of malnutrition in school children	Reduced proportion of school age children with Vitamin A Deficiency (%)	38.0	30	27	25.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of iron deficiency anae-mia in primary school children	Reduced proportion of school age children (5-10 years) with anaemia (%)	54.0	38	36	34.0	Every 4 years	National Micronutri-ent Survey	
	Reduction of iodine deficiency in school children	Median urinary iodine level in school children (µg/litre)	100	100	100	100	Every 4 years	National Micronutri-ent SurveyT	
	Reduction in malnutrition among women of child-bearing age	Reduced percentage of women of child bearing age with malnutrition (BMI less than 18.5) (%)	10.0	7.5	6.5	6.0	Every 4 years	MDHS/MICS	
	Reduction of anaemia among pregnant women	Reduced prevalence of anaemia in pregnant women (%)	47.0	37	36	35.0	Every 4 years	NMS	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
To achieve strategic targets for preven-tion and control of malnutrition.	Use of iodised salt	% of households using adequately iodised salt (15 p.p.m)	49.0	75	85	90.0	Every 4 years	MICS	
	Early initiation of breastfeeding and temperature management	% of newborns initiated on breast milk within the first hour of birth	70.0	76	78	>80.0	Every 4 Years	MDHS/MICS	
	Exclusive breastfeeding for chil-dren up to 6 months	% of children exclusively breastfed for 6 months	57.0	70	75	80.0	Every 4 years	MDHS/MICS	
	Continued breastfeeding for chil-dren 6-24 months	% of children aged 20-23 months still breastfeeding.	70.0	76	78	>80.0	Every 4 years	MDHS/MICS	
	Complementary feeding for children	% of children aged 6-59 months who received 5 or more feeds in the last 24 hours	49.0	69	75	80.0	Every 4 years	MDHS/MICS	
	Supplementary feeding based on national guidelines for pregnant and lactating women who are malnourished	% of malnourished pregnant women that are receiving supplementary food	60.0	78	85	90.0	Quarterly/ Annually	MOH/WFP	
	Management of malnourished children aged 5 to 12 years	% of malnourished children (5-12 years) admitted to CTC and cured	80.0	>80.0	>80.0	>80.0	Quarterly/ Annually	MOH	
	Vitamin A supplementation for school age children (5-10 years)	% of school age children (5-10 years) that receive Vita-min A supplementation	0.0	60.0	70.0	80.0	Quarterly/ Annually	MOH	
	Vitamin A supplementation for pre-school children (6-59 months)	% of pre-school age children (6-59 months) that receive Vitamin A supplementation	80.0	85.0	88.0	>90.0	Quarterly/ Annually	MOH	
	Vitamin A supplementation for post-natal women	% of post-natal women that receive Vitamin A supple-mentation within 8 weeks after delivery	60.0	70.0	75.0	>80.0	Quarterly/ Annually	MOH	
	Iron and folate supplementation for pregnant women a/	% of pregnant women that receive iron and folate supplementation	TBC	TBC	TBC	TBC	Quarterly/ Annually	MOH	
	Iron supplementation for school age children through the SHN programme	% of school age children (5-10 years) that receive iron supplementation	0.0	60.0	70.0	80.0	Quarterly/ Annually	MOH	
	De-worming for pre-school age children (12-59 months)	% of children (12-59 months) that are de-wormed bi-annually	>80.0	>85	>88	>90.0	Quarterly/ Annually	MOH	
	De-worming for school age chil-dren (5-10 years)	% of school age children (5-10 years) that are de-wormed annually	0.0	60.0	70.0	80.0	Quarterly/ Annually	MOH	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Achieve nutritional wellbeing for all Malawians for economic develop-ment	Various interventions from the three strategic objectives	% of under-fives that are stunted (MICS 2006)	46.0	44.0	42.0	40.0	Annually, MTR, Every 4 years, End of Plan	DHS,MICS,WMS,Nut. Surveillance	Macro-economic environ-ment will be stable Disaster manage-ment mecha-nisms will be effective in deal-ing with disasters when the occur High level political commit-ment towards nutrition will be sustained programs will be effective in ad-dressing nutrition challenges in the country
		% of children U/5 that are wasted	3.5.0	3.0	2.5.0	2.0	Annually, MTR, Ev-ery4 years, End of Plan	Nut. Surveillance, DHS,MICS	
		Prevalence of global acute malnutrition among under fives	6.4.0	5.0	3.6.0	2.2.0	Annually, MTR, Every 4years, End of Plan	DHS,MICS,WMS, Nut. Surveillance	
		% of low birth weight among newborn babies	14.0	12.0	10.0	8.0	Annually, MTR, Ev-ery4 years, End of Plan	DHS,MICS,WMS,FSNP M&E Reports	
		Proportion of women of reproductive age with body mass index of less than18.5 (%)	10.0	8.0	7.0	6.0	Annually, MTR, Every 4 years, End of Plan	DHS,MICS,WMS, Nut. Surveillance	
		Malnutrition rates in women of child bearing age (15-49 years), (%)	9.2.0	7.0	5.0	3.0	Annually, MTR, Every 4 years, End of Plan	DHS,MICS,WMS, Nut. Surveillance	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUENCY	DATA SOURCE	RISKS/ ASSUMPTIONS
				2009	2010	2012			
Goal P1: Promotion of optimal breast-feeding practices for children 0-6 months in the context of HIV/AIDS at facility, community and household level	Enhance skills and knowledge of care givers in caring practices using ENA and IMCI guidelines	% of care givers reached with skills to promote key caring practices using ENA and IMCI guidelines (UNDAF)	40.0	60.0	70.0	80.0	Quarterly/ Annually/ MTR	Nut. Surveillance	Capacity to implement the national nutrition response will be adequate
	Promote exclusive breast feeding for children 0-6 months	% of children 0-6 months exclusively breast feeding	51.0	56.0	60.0	65.0	Quarterly/ Annually/ MTR	Nut. Surveillance	
Goal P2: Promotion of optimal feeding practices for children 7-24 months or beyond to sustain breast-feeding while giving appropriate complimentary feeds with emphasis on frequency, amount, energy and nutrient density and diversity based on the six food groups	Promote continued breast feeding for children 7-24 months	% of children 7-24 months still breastfeeding	94.0	95.0	96.0	97.0	Quarterly/ Annually/ MTR	Nut. Surveillance	
Goal P3: Strengthen optimal feeding of a sick child during and after illness	Integrate Optimal practices and messages on feeding a child during and after illness in key child survival programs	Optimal practices and messages on feeding a child during and after illness integrated into key child survival programs (IMCI,PMTCT, Growth monitoring etc)	No	Yes	Yes	Yes	Quarterly/ Annually/ MTR	MoH/OPC-Dept. of Nutrition, HIV &AIDS	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Goal P4: Promotion of women's nutri-tional status among the general public	Promote availability, accessibility and consumption of the six food groups by women	Share of different food groups in total calorie intake							House-holds will have sufficient resources to meet adequate food require-ments
		Energy foods	84%	83%	82%	79%	Annually	MVAC	
		Vegetable protein	11%	12%	12%	13%	Annually	MVAC	
		Fats/Oils	1%	1%	1	2%	Annually	MVAC	
		Vegetables	0%	1%	1	1%	Annually	MVAC	
		Fruits	1%	1%	1	1%	Annually	MVAC	
		Animal protein	1%	1%	2%	3%	Annually	MVAC	
		Other	2%	1%	1%	1%	Annually	MVAC	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Goal P5: Prevention and control of micronutrient deficiency disorders with emphasis on Vitamin A, anaemia and iodine		Prevalence of VAD							
	Vitamin A supplementation	Pre-school children (U/5s), (%)	59.0	52.0	45.0	40.0	Quarterly/ Annually/ MTR	MoH Reports	
		School Children (5-10 yr olds.), (%)	38.0	33.0	28.0	25.0	Quarterly/ Annually/ MTR	MoH Reports	
		Pregnant women, (%)					Quarterly/ Annually/ MTR	MoH Reports	
		Anaemia							
	Iron supplementation	Pre-school children –U/5s (HB <11g/l), (%)	80.0	73.0	66.0	60.0	Quarterly/ Annually/ MTR	MoH Reports	
	De-worming	School children-5 to 10 yr olds (HB <15g/l).0	54.0	47.0	40.0	34.0	Quarterly/ Annually/ MTR	MoH Reports	
	Iron supplementation	Pregnant women (HB <11g/l), (%)	47.0	43.0	38.0	35.0	Quarterly/ Annually/ MTR	MoH Reports	
		Iodine							
	Promotion of salt iodisation and trade monitoring	% of households with salt testing 15parts per million or more of iodine	55.0	65.0	75.0	90.0	Quarterly/ Annually/ MTR	MoH Reports/ MICS	
		Prevalence of Oedema	TBC	TBC	TBC	TBC	Quarterly/ Annually/ MTR	MoH Reports	
	Expand Micronutrient supplementation program	Micronutrient intake among mothers (DHS 2004), (%)	76.3.0	80.0	85.0	90.0	Annually	MoH	
	Expand Micronutrient supplementation program	% of women Receiving Vitamin A supplementation (postnatal) increased from 46.0 (MICS 2006)	46.0	50.0	55.0	60.0	Annually	MoH Reports	
	Promote the use of iodised salt	Proportion of households using adequately iodized salt (>15 parts per million), (%)	55.0	65.0	75.0	90.0	Every 4 years	MGDS/MICS/NMS	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Goal P 6: Promo-tion of practices that encourage healthy life styles, food availability, diversity, access, proper storage, preparation, utilization and the consumption of a variety of foods from the six food groups every day, safety and qual-ity in the general population		Relevant recipes and guidelines on various food combinations and food utilization, storage, processing developed and disseminated	No	Yes	Yes	Yes	Quarterly/ Annually/ MTR	MoH Reports/ Nut. Surveillance	Guidelines will be used and house-holds and individu-als will respond positively to mes-sages
Goal P7: Promotion of access to at least one nutritious meal and related health and nutrition ser-vices for the school going children through the school feeding, health and nutrition programs	Promote and expand coverage of the school health and nutrition programs	No. of schools benefiting from school feeding activities	1000	1400	1800	2000	Annually	MoE	
	Promote and expand coverage of the school health and nutrition programs	No. of children benefiting from school feeding programs	TBC	TBC	TBC	TBC	Quarterly/ Annually	MOH/MOE	
Goal P8:Strengthen capacities for households and communities to attain adequate nutrition for their families with emphasis on socio-economically deprived persons	Facilitate establishment of IGAs to reach socio-economically deprived persons	Number of persons participating in viable Income Gen-erating Activities (by district and national levels)	TBC	5000	10000	15000	Quarterly/ Annually	Ministry of Women and Child Develop-ment	
Goal P 9:Promotion of food safety and quality	Enforce food safety and quality regulations	% of agencies producing food products that meet safety and quality standards	TBC	TBC	TBC	TBC	Annually	CAMA Reports, Malawi Bureau of Standards, OPC Dept. of Nutri-tion &HIV and AIDS reports	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Goal P 10: Control of nutrition related non-communicable diseases	Behaviour change awareness promotion	% of persons aware of practices to prevent diseases and practicing health seeking behaviour	TBC	TBC	TBC	TBC	Annually	MoH, OPC Dept. f Nutri-tion &HIV and AIDS reports	
Strategic objective 2: To increase access to timely and effective management of the most common nutrition disorders among women, men, boys, girls in Malawi by 2012 with emphasis on vulnerable groups									
Goal M1: Promote access to and improve quality of nutrition and related services to facilitate effective management of nutrition deficiency disorders in u/5 children, adoles-cents and adults	Strengthen and expand coverage of nutrition management services	Cure rate, OTP (%)	84.4	84.8	85	>85.0	Quarterly/ Annually	MOH	
		Cure rate, NRU (%)	80.3	83	84	>85.0	Quarterly/ Annually	MOH	
		Cure rate combined (%)	83.3	83.8	84	>85.0	Quarterly/ Annually	MOH	
		Default rate, OTP (%)	11.7	8	6	<5.0	Quarterly/ Annually	MOH	
		Default rate, NRU (%)	3.5	2.5	2	<2.0	Quarterly/ Annually	MOH	
		Default rate combined (%)	7.6	6.5	5	<5.0	Quarterly/ Annually	MOH	
		Death rate, OTP (%)	2.4	2.2	2	<2.0	Quarterly/ Annually	MOH	
		Death rate, NRU (%)	11.9	10.5	10	<10.0	Quarterly/ Annually	MOH	
		Death rate combined (%)	4.7	3	2	<2.0	Quarterly/ Annually	MOH	
		Infant mortality rate (Per 1000 live births)	72	70	69	68	Quarterly/ Annually	MICS, 2006	
		Under-five mortality rate (Per 1000 live births)	122	119	118	117	Quarterly/ Annually	MICS, 2006	
	Scale up NRU services	Increase in number of NRUs	95	98	99	100	Quarterly/ Annually	UNDAF/OPC/MOH	
	Scale up CTC services	Increase in number of districts where CTC is offered	14	22	25	27	Quarterly/ Annually	UNDAF/OPC/MOH	
		Increase in number of CTC sites	258	295	330	381	Quarterly/ Annually	UNDAF/OPC/MOH	
		Number of children reached by CTC services	28,648	33,000	40,000	50,000	Quarterly/ Annually	UNDAF/OPC/MOH	
		% coverage CTC	TBC	TBC	TBC	TBC	Quarterly/ Annually	UNDAF/OPC/MOH	
	Expand coverage of nutrition treatment, care and support for PLWHAs	Increase in number of ART sites with nutrition package	60	100	110	120	Quarterly/ Annually	UNDAF/OPC/MOH	
		Increase in number of PMTCT sites with nutrition pack-age	119	250	275	300	Quarterly/ Annually	UNDAF/OPC/MOH	
		Number of nutrition, care, treatment and support groups	TBC	TBC	TBC	348	Quarterly/ Annually	UNDAF/OPC/MOH	
		Person reached with NCTS	13,019	14,700	16,800	18,700	Quarterly/ Annually	UNDAF/OPC/MOH	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
	Scale up OTP services	Increase in number of OTP sites	292	320	370	381	Quarterly/ Annually	UNDAF/OPC/MOH	
		Number of children reached by OTP services	21,254	30,000	39,000	50,000	Quarterly/ Annually	UNDAF/OPC/MOH	
	Expand supplementary feeding programs	Increase in number of SFP sites	270	300	340	381	Quarterly/ Annually	UNDAF/OPC/MOH	
		No. of OVCs receiving take home food rations	TBC	TBC	TBC	TBC	Quarterly/ Annually	Min of Gender	
		% coverage of TFC	TBC	TBC	TBC	TBC	Quarterly/ Annually	UNDAF/OPC/MOH	
		Increase in number of BFHI (with nutrition package)	20	40	44	48	Quarterly/ Annually	UNDAF/OPC/MOH	
	Community level growth monitoring and promotion	No. of community-based growth monitoring and promotion groups per village (all 28 districts)	TBC	1	1	1	Quarterly/ Annually	UNDAF/OPC/MOH	
		Trainers trained on prevention and management of moderate and severe malnutrition	TBC	TBC	TBC	20	Quarterly/ Annually	UNDAF/OPC/MOH	
	Skills transfer to service providers	Service providers on prevention and management of moderate and severe malnutrition trained as trainers	300	320	325	330	Quarterly/ Annually	UNDAF/OPC/MOH	
	Skills transfer at community level	Number of trainers of community workers trained	0	250	275	300	Quarterly/ Annually	UNDAF/OPC/MOH	
	Case monitoring and follow-up	No. of cases monitored (baseline Jan-Dec 2008):							
		OTP	29,554	31,000	33,100	35,000	Quarterly/ Annually	UNDAF/OPC/MOH	
		NRU	8,919	9,300	10,000	10,400	"	"	
		SFP	50,371	53,000	56,400	59,000	"	"	
		NTCS for PLHIV	13,019	13,700	14,500	15,200	"	"	
		NTCS –TB	TBC	TBC	TBC	TBC	"	"	
		NTCS Chronically ill	TBC	TBC	TBC	TBC	"	"	
	Review and development of nutrition guidelines	Number of guidelines availed	TBC	TBC	TBC	TBC	Quarterly/ Annually	UNDAF/OPC/MOH	
		Number of people oriented and able to provide case management services correctly using the guidelines	TBC	TBC	TBC	TBC	Quarterly/ Annually	UNDAF/OPC/MOH	
Strategic Objective 3: To create an enabling environment for the effective implementation of nutrition services and programmes									

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
To achieve strategic targets for creation of an enabling environment	Development and utilization of nutrition manuals and guidelines	Nutrition policies, guidelines and training manuals developed and used	No	Yes	Yes	Yes	Annually	OPC	
	Development and utilization of nutrition information system	Nutrition information system established and timely reports on at least 70% of nutrition indicators	No	Yes	Yes	Yes	Annually	OPC	
	Advocacy for increased resource allocations by Government and donors towards nutrition	% increase Government and stakeholder real budgetary allocations towards nutrition activities	0	6.0	8.0	10.0	Quarterly/ Annually	OPC/MoF	
	Develop and cost nutrition plan annually and jointly	Nutrition development plan is prepared, costed and implemented	No	Yes	Yes	Yes	Quarterly/ Annually	OPC	
	Integration of nutrition in sectoral policies	% of sectors with nutrition integrated in sectoral policies	50.0	80.0	90.0	100.0	Quarterly/ Annually	OPC/Sector Ministries	
	Human resource: creation of positions for nutrition in key government ministries and all local authorities	Number of key government ministries with nutrition posts created and filled	3	10	13	16	Quarterly/ Annually	OPC/HRD	
	Human resource: creation of positions for nutrition in key government ministries and all local authorities	Number of local authorities with nutrition posts created and filled	0	20	24	28	Quarterly/ Annually	OPC/HRD	
	Establish nutrition coordination structures at national, sectoral and local authority levels	Nutrition coordination structures available at national (1), sectoral (16) and local authority (28) levels	Yes	Yes	Yes	Yes	Quarterly/ Annually	OPC	
	Develop a National Research Agenda on Nutrition	National Research Agenda on Nutrition developed	No	Yes	Yes	Yes	Quarterly/ Annually	OPC	
	Develop a National Nutrition Act	National Nutrition Act developed	No	Yes	Yes	Yes	Quarterly/ Annually	OPC	
	Creation of positions for nutrition in key government ministries and institutions	% of government ministries (16) with sufficient posts created for nutrition	TBC	TBC	TBC	100.0	Quarterly/ Annually	OPC	
		% of local authorities (28) with sufficient posts created for nutrition	TBC	TBC	TBC	100.0	Quarterly/ Annually	OPC	

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUENCY	DATA SOURCE	RISKS/ ASSUMPTIONS
				2009	2010	2012			
Goal E1: Position nutrition on Malawi's development agenda and implement nutrition policies and programs at all levels	Develop and implement nutrition policies	Nutrition policies and guidelines developed and in use	No	Yes	Yes	Yes	Quarterly/ Annually/ MTR	OPC Nut&HIV/AIDS Dept.	Nutrition policies and guidelines will be used
	Support sectors to integrate nutrition in their activities	% of sector ministries with nutrition activities	TBC	50.0	60.0	70.0	Annually	OPC Nut&HIV/AIDS Dept.	Nutrition mainstreaming in sectors can be achieved and sustained
Goal E2: Increase budgetary allocation of resources by Government and development partners for implementation of the National Nutrition Policy	Lobby for increased allocation of resources towards nutrition	% increase in Government and stakeholder real budgetary allocations to nutrition activities	0.0	3.5	7.0	10.0	Annually	MoF	Government and partners will commit to increasing resources for nutrition
Goal E3:To build institutional and human capacity for effective delivery of nutrition policies	Train and place nutritionists at all levels	No. of nutrition personnel trained and deployed	TBC	20	60	180	Annually	OPC Nut & HIV/AIDS Dept.	Nutritionists can be retained in their positions
Goal E 4: Establish a well defined coordination mechanism for nutrition services, programs and projects at central, district and community levels		Nutrition Business Plan developed and Nutrition coordination committee and sub-committees established	No	Yes	Yes	Yes	Annually	OPC Nut&HIV/AIDS Dept.	Coordination of the national nutrition response wil be effective
Goal E5:Promote evidence based nutrition programming through use of research results	Establish a research agenda on nutrition	A functioning research framework is in place and utilized	No	Yes	Yes	Yes	Annually	OPC Nut&HIV/AIDS Dept.	Research results will be utilized

OBJECTIVES	INTERVENTIONS	I INDICATORS	BASELINE (MICS 2006/DHS 2004/NMS 2001)	TARGETS			FREQUEN-CY	DATA SOURCE	RISKS/ ASSUMP-TIONS
				2009	2010	2012			
Goal E6: Establish a results based nutrition monitor-ing and evaluation system	Develop a nutrition information system	Nutrition information system established and timely reports on 70% of indicators	No	Yes	Yes	Yes	Quarterly/ Annually/ vMTR	OPC Nut&HIV/AIDS Dept.	Data qual-ity can be achieved

Sources: DHS (2004) NSO (MICS 2006), MoAFS Technical Secretariat (Food Security and Nutrition Project Nutrition indicators), UNDAF (2007) for some targets), FAO: Nutrition Indicators for Development.

34 Notes: TBC refers to data that will be confirmed through baseline assessment.

ANNEX 4: DOCUMENTS REVIEWED

Alderman H, Hoddinott J, Kinsey B. **Long-term consequences of early childhood malnutrition.** Oxford Economic Paper 2006; 58: 450–74.

Brown JL, Pollitt E. **Malnutrition, poverty and intellectual development.** Sci Am 1996; 274: 38–43.

Daniels MC, Adair LS. **Growth in young Filipino children predicts schooling trajectories through high school.** Journal of Nutrition 2004; 134: 1439–46.

Government of Malawi, **Fisheries and Aquaculture Policy (2001).**

Government of Malawi, Ministry of Agriculture and Food Security, **Agricultural Development Programme (ADP) (2008).**

Government of Malawi, Ministry of Agriculture and Food Security, **Agriculture and Food Security Policy (2006).**

Government of Malawi, Ministry of Agriculture and Food Security, **Food and Nutrition Security Policy (June 2005).**

Government of Malawi, Ministry of Agriculture and Food Security, **Strategic Plan to Improve Livestock Production (2003-2008).**

Government of Malawi, Ministry of Economic Planning and Development, **Malawi Growth and Development Strategy 2020.**

Government of Malawi, Ministry of Economic Planning and Development, **Poverty Alleviation Policy Framework (1994).**

Government of Malawi, Ministry of Health, **Strengthening Rapid Scale-Up of MNCH Interventions in Malawi (2008).**

Government of Malawi, **Malawi Vision 2020.**

Government of Malawi, Ministry of Education and Science and Technology, **National Education Sector Programme (NESP) (2009).**

Government of Malawi, Ministry of Health **Plan (1999 to 2004) and Programme of Work (2004).**

Government of Malawi, Ministry of Health, **Accelerated Child Survival and Development Plan (2007-20012).**

Government of Malawi, Ministry of Health, **Essential Health Care Package (2002).**

Government of Malawi, Ministry of Health, **Health Management Information System, Report for Financial Year 2007/8.**

Government of Malawi, Ministry of Health, **Infant and Young Child Nutrition Policy (2005).**

Government of Malawi, Ministry of Health, **Integrated Management of Childhood Illnesses (Draft, 2005-6).**

Government of Malawi, Ministry of Health, **National Plan of Action for Nutrition (2000).**

Government of Malawi, Ministry of Health, **Nutrition Unit Integration of Community Therapeutic Care (CTC) into Ministry of Health Services in Malawi Operational Plan. Technical Working Group CTC Steering Committee October 2008.**

Government of Malawi, Ministry of Health, **Reproductive Health Policy (2002).**

Government of Malawi, Ministry of Irrigativon and Water Development, **National Water Policy (2005).**

Government of Malawi, Ministry of Women and Child Development, **Gender Policy (2000) and Implementation Plan (2004).**

Government of Malawi, Ministry of Women and Child Development, **Integrated Early Childhood Development Policy (2004).**

Government of Malawi, Ministry of Women and Child Development, **Orphans and Other Vulnerable Children Care Plan of Action (2005).**

Government of Malawi, **Monitoring and Evaluation System for Food Security and Nutrition Policies of Malawi: 6th M&E Report of the FNSP Working Group (2008).**

Haas JD, Martinez EJ, Murdoch S, Conlisk E, Rivera JA, Martorell R. **Nutritional supplementation during the preschool years and physical work capacity in adolescent and young adult Guatemalans. Journal of Nutrition 1995; 125 (suppl): 1078S–89S.**

Heikens G.T. **How can we improve the care of severely malnourished children in Africa? PLoS Med 2007; 4: e45.6.**

Leary S, Fall C, Osmond C, et al. **Geographical variation in relationships between parental body size and offspring phenotype at birth. Acta Obstet Gynecol Scand 2006; 85: 1066–79.**

Malawi Profiles, **"Malnutrition in Malawi: A silent crisis – Invest now (2006)".**

Maluccio JA, Hoddinott J, Behrman JR, Martorell R, Quisumbing AR. **The impact of nutrition during early childhood on education among Guatemalan adults. Middlebury College Economics Discussion Paper number 06-14. Middlebury College, VT, 2006.**

National AIDS Commission, **National HIV and AIDS Framework (2005 to 2009).**

National School Health and Nutrition Survey (NSHNBS 2006).

National Statistical Office, **Malawi Demographic Health Survey (2004).**

National Statistical Office, **Multiple Indicator Cluster Survey (2006).**

OPC, Department of Nutrition, HIV and AIDS: **Performance Report for Nutrition Sector (2008).**

Parlato, Margaret, and Renata Seidel, eds. 1998. **Large-Scale Application of Nutrition Behaviour Change Approaches: Lessons from West Africa. Published for the USAID by the Basic Support for Institutionalizing Child Survival (BASICS) Project.** Arlington, Va.

Pitcher J, Henderson-Smart D, Robindon J. **Prenatal programming of human motor function. In: Wintour E, Owens J, eds. Early life origins of health and disease.** New York: Springer Science and Business Media, (2006).

Psacharopoulos G, Patrinos HA. **Returns to investment in education: a further update.** Educ Econ 2004; 12: 111–34.

Ramakrishnan U, Martorell R, Schroeder DG, Flores R. **Role of intergenerational effects on linear growth.** J Nutr 1999; 129 (suppl): 544S–9S.

Republic of Malawi **National Plan of Action for Nutrition Follow-up to the International Conference on Nutrition** (January 2000).

Rivera JA, Martorell R, Ruel MT, Habicht JP, Haas JD. **Nutritional supplementation during the preschool years influences body size and composition of Guatemalan adolescents.** J Nutr 1995; 125 (suppl): 1068S–77S.

The Lancet Series on **Child survival,** (2003).

The Lancet Series on **Nutrition,** (2008).

Thomas D, Strauss J. **Health and wages: evidence on men and women in urban Brazil.** Journal of Economics 1997; 77: 159–85.

Transposable elements: targets for early nutritional effects on epigenetic gene regulation. Molecular Cellular Biology 2003; 23: 5293–300.

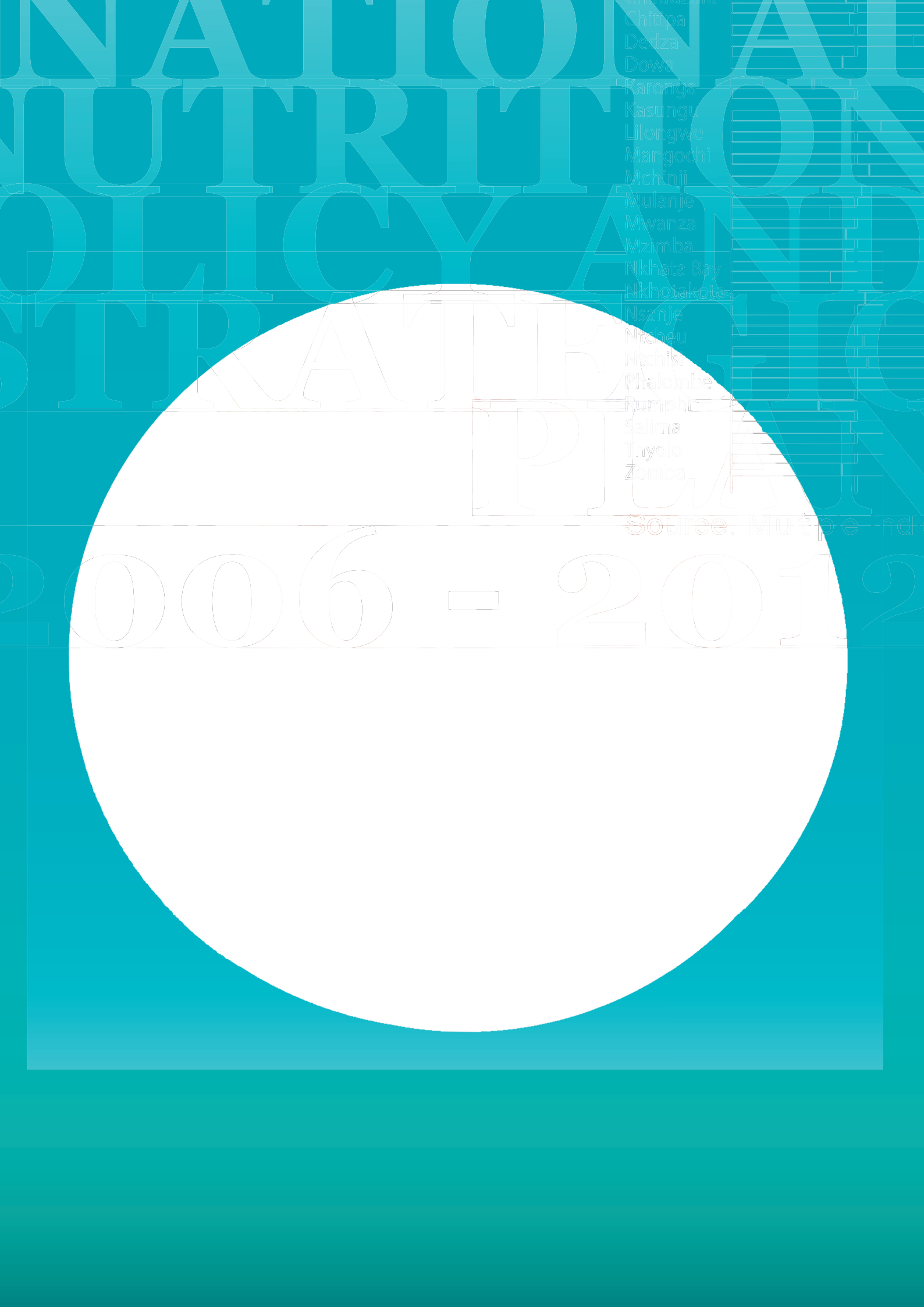
UNICEF, UNDAF **Outcomes for Nutrition.**

United Nations System Standing Committee on Nutrition (2008): **Accelerating the reduction of maternal and child under nutrition.**

Waterland RA, Jirtle RL. **Early nutrition, epigenetic changes at transposons and imprinted genes, and enhanced susceptibility to adult chronic diseases.** Nutrition 2004; 20: 63–68; and (ii) Waterland RA, Jirtle RL.

NATIONAL NUTRITION POLICY AND STRATEGIC PLAN

2006 - 2012



Source: Multiple sources