The Republic of Malawi
OFFICE OF THE PRESIDENT AND CABINET (OPC)

NATIONAL NUTRITION POLICY AND STRATEGIC PLAN

DEPARTMENT OF NUTRITION, HIV AND AIDS
PRIVATE BAG B401
LILONGWE 3

14th August 2009

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 2012.

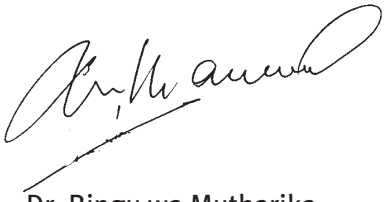
The goal of the policy is to facilitate the improvement of the nutritional status of all Malawians, with emphasis on pregnant and lactating women, children below the age of 15 years, people living with HIV, people in emergency situations and other vulnerable groups as shall from time to time be defined 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. The attainment 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 mobilisation of an *integrated nutrition fund,* standardisation, coordination and improvement of the quality of nutrition services delivery.

The policy is 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 provide visionary policy direction and guidance, coordination, capacity building, resources mobilisation, establishment of implementation structures, supervision, monitoring and evaluation.

I am confident that by now everybody is aware that nutrition is a cross-cutting 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 organisations, 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 anaemia 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.

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.

Dr. Mary Shawa

PRINCIPAL SECRETARY, DEPARTMENT OF NUTRITION, HIV AND AIDS

Contents

List of abbreviations and acronyms

ADP	Agriculture Development Programme
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
BMI	body Mass Index
CBO	Community Based organization
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
FAO	Food and Agricu lture Organization
FEWS	Famine Early Warning System
GTZ	Germany Technical Cooperation
HIV	Human Immunodeficiency Virus
MDHS	Malawi Demographic and Health Survey
MGDS	Malawi Growth and Development Strategy
MDGs	Millennium Development Goals
M & E	Monitoring and Evaluation
MVAC	Malawi vulnerability Assessment Committee
MICS	Multiple Indicator Cluster Survey
NCST	Nutrition Care, Support and Treatment
NESP	National Education Sector Programme
NGOs	Non-Governmental Organisations
NMIS	Nutrition Management Information System
NMS	National Micronutrient Survey
NNPSP	National Nutrition Policy and Strategic Plan
NRU	Nutrition Rehabilitation Units
OPC	Office of the President and Cabinet
ORT	Oral Re-hydration Therapy/Office Recurrent Transactions
PLWH	People living with HIV
SWAP	Sector Wide Approach
TA	Traditional Authority
UNICEF	United Nation Children Fund
WFP	World Food Programme
WHO	World Health Organisation

POLICY STATEMENT: MALAWI SHALL

The Government of Malawi commits itself to firmly position nutrition on the development agenda and create an enabling environment for the effective and timely prevention, control and management of nutrition disorders among women, men, girls and boys.

1.0 INTRODUCTION

Nutrition disorders continue to be a silent crisis in Malawi despite efforts by government and development partners to improve the situation. The situation poses a serious challenge to the attainment of the Malawi Growth and Development Strategy (MGDS) goals of moving the country from poverty to prosperity. The Government of Malawi recognizes the critical role of adequate nutrition in promoting human capital development which is the prerequisite for sustainable economic growth, prosperity and development. This is the reason why the MGDS the Prevention and Management of Nutrition disorders is the sixth priority area in the Malawi Growth and Development Strategy.

The operationalisation of the nutrition component of the MGDS necessitated the production of the National Nutrition Policy and Strategic Plan (NNPSP) whose implementation requires centralized coordination and multisectoral approach. The National Nutrition Policy and Strategic Plan has been developed to provide visionary guidance and direction in the process of translating the nutrition component of the MGDS into action that will facilitate the attainment of adequate nutrition of the various population groups in the country. The NNPSP Summary you are holding gives an outline of the Policy statement, strategies and action areas that will be implemented from 2007 to 2012 in order to contribute to the attainment of the MGDS goals in nutrition.

2.0 THE CURRENT SITUATION OF NUTRITION DISORDERS IN THE COUNTRY

The problem of malnutrition in Malawi is widespread and endemic. It affects all population groups especially children and women

MALNUTRITION IN UNDERFIVE CHILDREN

Almost half of the children have chronic malnutrition estimated at 48% stunting (too short for age) 5%; wasting (too thin) and 22% underweight (too light) (DHS, 2004) currently being projected at 42%, 2% and 15% respectively. Refer to Figure 1 below: The result is that the majority of women reach pregnancy in very poor nutritional status and 14% of the babies are born underweight. Underweight babies are susceptible to malnutrition and birth

Prevalence of Malnutrition in Malawi

48% of under fives are stunted

22 % of under fives are underweight

5% under fives wasted

Many babies were born with low birth weight

There has been no significant difference over the years

Source MOH Files

The Multiple Indicator Cluster Survey (MICS), 2006 showed a slight decline of 46%, 4% and 21% respectively. Further the study showed that:

- One in every five children under-five years of age in Malawi was underweight (21 percent) and 4% percent were severely under-weight
- 6% were overweight.
- Almost two in every five children under the age of five years (46%) were stunted and almost half of these (21 percent) were severely stunted.
- 4% were wasted and 0.5% were severely wasted.

The problem is universal and it is prevalent in all the districts of the country. Refer to Figure 2 below:

Prevalence of stunting by district according to MICS 2007

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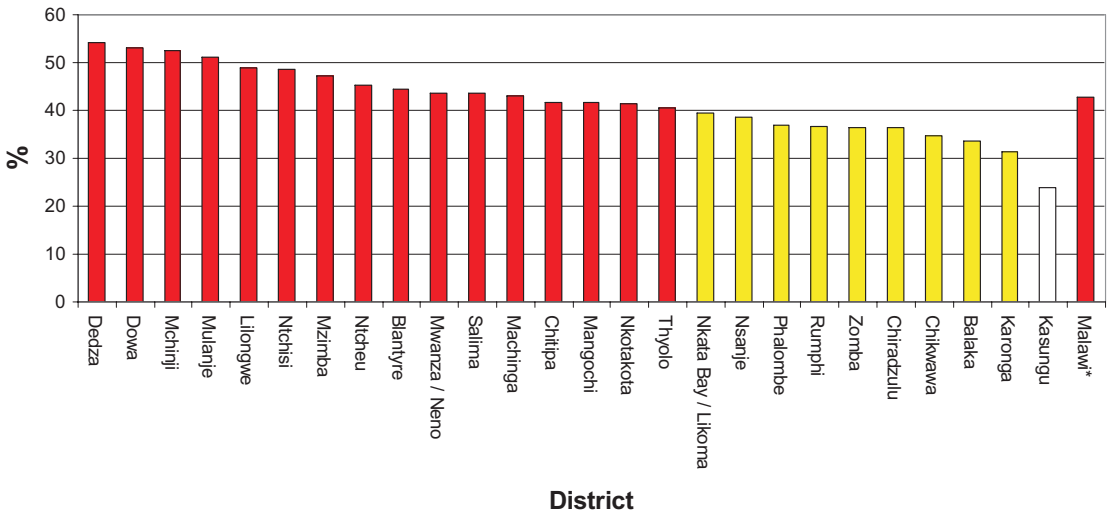


- Stunting prevalence in under-five children living in rural areas at 48 percent was significantly higher than that in urban areas at 38 percent and
- Stunting was highest in the Central Region at 48 percent, followed by the Southern Region at 45 percent and lowest in the Northern Region at 40 percent.

Seven districts were hardest hit with malnutrition where more than half of the under-five children were stunted namely:

- Dedza (57 percent)
- Mchinji (57 percent)
- Machinga (57 percent)
- Ntchisi (56 percent)
- Zomba (52 percent)
- Mwanza (51 percent) and
- Ntcheu (50 percent) (MICS, 2006) (**Error! Reference source not found.**).

Although the prevalence of under-five stunting is lowest in Karonga district at 30 percent, followed by Rumphi at 35 percent, Nkhata Bay at 37 percent and Salima 38 percent, the percentages are still very high according to World Health Organization classification (from 30 percent) for the country's human well being.

When malnutrition sets in children in the first two years of life its impact is life long. Figure 3 below shows the critical period for malnutrition on set.

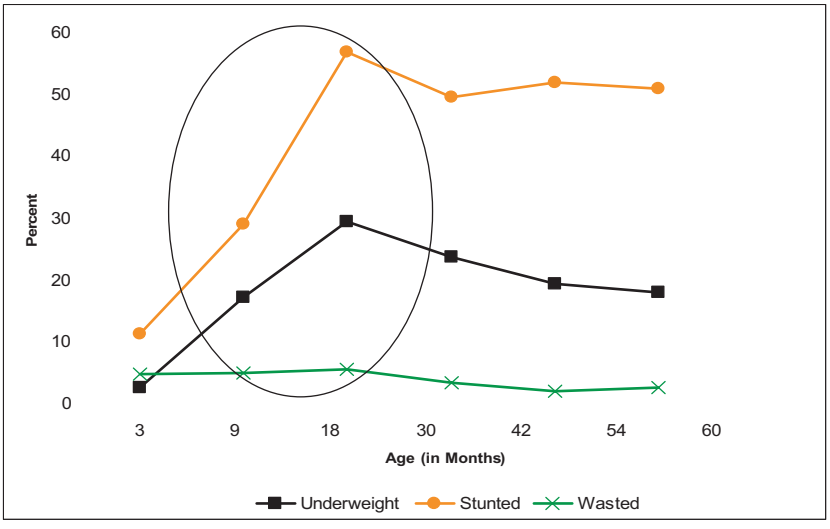


Figure 1: Percentage of under-five children un dernourished according to age pattern, Malawi, 2006

In addition, prevalence of micronutrient malnutrition especially lack of Vitamin A, iron and iodine are also of concern in Malawi because of the massive implications for human wellbeing. The National Micronutrient Survey of 2001 revealed that:

- 80% of the underfive children were anaemic
- 60% had Vitamin A deficiency

Malnutrition in school aged children (5 – 10 years)

- 30% of school aged childr en 5-10 years were stunted (too short for their age) due to long exposure to poor nutrition
- 3% were wasted (low weight for height) reflecting poor nutrition at the time of the survey
- 18% were underweight reflecting combined effect of long-term and current poor nutrition at the time of the survey
- 38% had Vitamin A deficiency
- Anaemia had shown a declining trend from 58% in 2001 to 54% in 2006

Malnutrition in women

- 9% of women were underweight with Body Mass Index (BMI) less than 18.5
- 44% of non-pregnant women were anaemic
- 47% of Pregnant women were anaemic
- 57% of child bearing age women had Vitamin A Deficiency

The country is also currently experiencing an increasing trend of the Nutrition-related non-communicable diseases such as diabete s, hypertension, heart failure, gout, arthritis and ulcers many others.

2.1 MAJOR CONTRIBUTING FACTORS TO THE HIGH LEVELS OF MALNUTRITION IN MALAWI

At the household level

- *Poor breastfeeding practices among mothers for example:*
    - Many mothers delay in putting the child to the breast after delivery. The recommended practice is that breastfeedin g should be initiated immediately after delivery hence each child should be put to the breast within 30 minutes after birth unless there is medical reason to do otherwise.

- Late initiation of breastfeeding delays the establishment of the processes that lead to the production and ejection of milk. Introduction of other foods and fluids such as glucose water and ordinary water on the assumption that milk has not yet started coming.
- Many mothers do not exclusively breastfeed their children and start giving other foods and fluids early instead of exclusively breasting baby the first six months unless there is a medical reason not to do so. No water, other fluids or foods should be given to the child before six months unless on advice from specialists.
- Many mothers do not feed the baby adequately such as breastfeeding the baby on demand as the practice facilitates more milk production and ensures that the baby is adequately fed.
- Some cultural practices promote giving new born babies some concoctions and traditional liquids such as dawale. Any liquid given to the child reduces its intake of breast milk and the breastfeeding frequency since the baby's stomach is small and the fluids may cause diarrhoea
- Many mothers do not express breast milk for the child to drink when the mother has to go away for sometime, instead the children are given formula, juice and other fluids which are all inferior to breast milk

- *Poor complementary feeding practices for children 6-24 months*

  - Many mothers do not enrich the child's meals adequately. Usually mothers feed their children plain and watery porridge. Children who are given nsima, usually are given nsima with gravy or one type of relish only (mostly vegetables).
  - The food diversity, density and frequency are usually inadequate as the child grows
  - Many mothers stop breastfeeding the child before the child is two years
  - Many caregivers like do give their children non nutritious drinks suck as freezes, sodas.
  - Many households do not use adequately iodised salt

- There is inadequate knowledge and skills among mothers, communities, service providers and the public on the vital role of breastfeeding on the child's survival, growth and development.
- Breastfeeding mothers also receive inadequate support from other members of the household and often live in environments that do not promote, protect and support breastfeeding.

- Working mothers face a major challenge as they have to go back to work after 90 days of maternity leave. Women in the private sector had their maternity leave reduced to 60 days by parliament in 2000 which puts the child life at risk.
- The high levels of poverty at the household level hinder the adoption of recommended practices. Poverty limits the ability of families to have enough and a variety of foods resources. Poor families tend to eat the same foods in their diet which are limited in diversity, quantity and quality, depriving children of the proteins, vitamins, and minerals. Few families eat animal products as often as required.
- Discrimination of women and girls which lead to women's poor access to education, low income levels and inability to have a say in household resources allocation including intra-household diet distribution.
- Cultural and faith-based beliefs that restrict consumption of certain foods.
- High disease burden, poor hygiene and sanitation and low access to health care services
- Poor health care seeking behaviours which lead to delays and late treatment of diseases.

At national, District and Community level

- Low coverage of nutrition services
- Inadequate institutional structures and capacity to effectively coordinate nutrition services especially at district and community levels.
- Inadequate staffing at all levels to implement effective nutrition interventions. There are very few technically competent people in nutrition especially in clinical nutrition and dietetics
- Inadequate knowledge and skills on nutrition among service providers, including how to manage the interaction of nutrition with diseases
- Weak capacity of nutrition training institutions
- Lack of District and community level workers to advance nutrition services and programmes at household and community levels.
- Gender, age and other disparities resulting from discrimination and inequality
- Cultural beliefs and practices which prevent adoption of nutrition strategies
- Gaps in legislation and enforcement (including that to control influx of unauthenticated manufactured food supplements and therapies)
- Inadequate allocation of financial resources to nutrition services by Government and development partners because it was not a prioty
- High dependency on the few donors funding nutrition

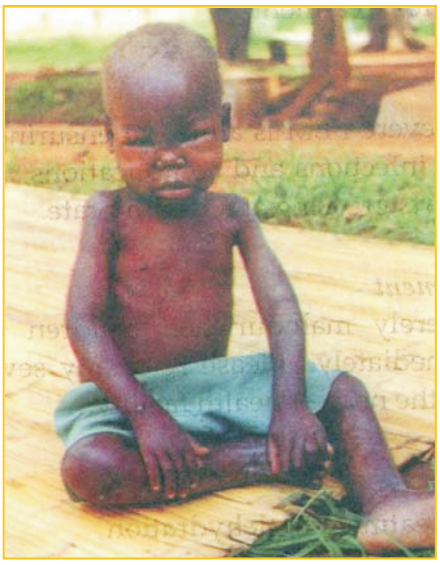
- Non-prioritisation of nutrition in resource allocation at all levels by key decision makers within Ministries such as Health, Agriculture, Education, Gender, Child Social Welfare and Community Development, Finance, and District Authorities among others.
- Inadequate resources for training in the areas of nutrition and dietetics

2.2 THE OVERWHELMING ADVERSE CONSEQUENCES OF MALNUTRITION

The high prevalence of malnutrition poses a big challenge to the attainment of the Millennium Development Goals (MDGs) and the MGDS. Figure 4 below shows a Marasmic Kwashiorkor child who is too thin on the upper arms and has oedema on the limbs and has a swollen face.

Figure 4

Malnutrition has adverse impact on human growth, development and productivity

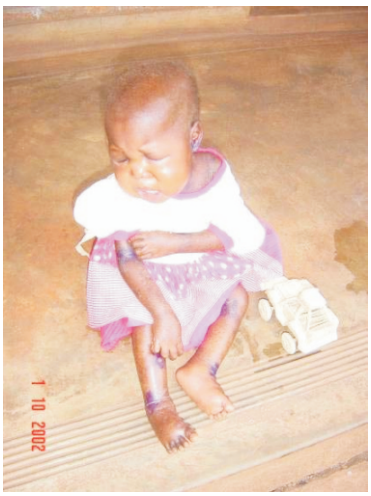


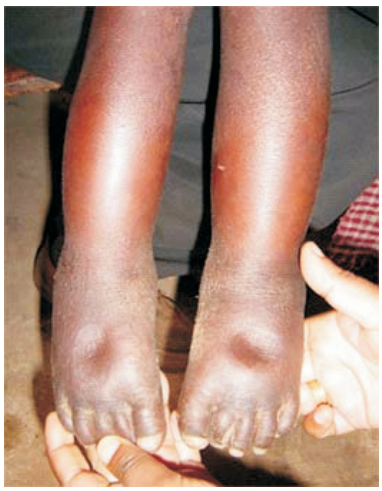
Malnutrition has adverse impact on human potential and productivity. It:

- Causes retarded physical and mental growth
- Retarded children fail to reach their physical growth and intellectual ability potential which reduces their productivity in future.
- And if it happens during pregnancy and within the first two years of the child's life, the damage caused is irreversible.
- Weakens the immune system and increases the risk of diseases. A malnourished child or individual is more likely to be sick and the diseases may be more severe and difficult to treat. Figure 5 below shows the children that were more common in the previous years.

Figure 5

Children like these are common and highly susceptible to diseases and death



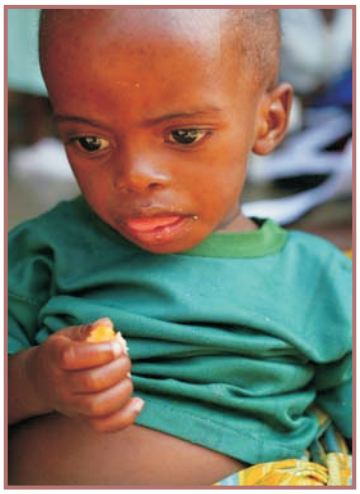


- Malnutrition undermines the child's survival; Is the single major cause of children's death and Increases the children's risk of mortality from other diseases.
- In addition under nutrition in the first 2 years of life is positively related to high risk of chronic diseases related to nutrition such as diabetes and heart disease.
- Malnutrition before and during pregnancy increases the risk of death among women and may lead to impaired physical and mental growth of the growing child. Figure 5 below shows effects of malnutrition.

Effect on Education

Reduced mental and physical development leading to

- Delayed enrollment due to stunting
- Lower cognitive development test scores
- Poor learning abilities
- Reduced concentration at school
- High repetition rates
- High absenteeism
- High dropouts rates



- With almost half (48%) of the children stunted, they enrol late in school, are likely to have lower cognitive test scores, higher absenteeism and tend to repeat classes comparable to non-stunted children.

Poor nutrition therefore is a compounding factor for Poverty. It determines future gains at individual, household, community and national level. According to Malawi Profiles (2005) Malawi stands to incur heavy losses over time if no adequate investment in nutrition is made. Figure 6 shows the amount of money Malawi would loose in productivity if stunting, iron and iodine deficiencies are not addressed over a 10 years period. If all the nutrition disorders are not addressed the loss is US$1.7 billion over the same period.

Cumulative Losses 2006-2015 (Malawi Profiles)

US$ 446 million

- If Malawi invests in nutrition, for every US$1 invested, the country realizes US$5.3 in productivity because.
    - The treatment cost for malnutrition will be reduce;
    - Lives will be saved;
    - Education outcomes will improve;

- Individual's ability to attain academic and professional potential will be achieved;
- Human productivity which is a pre-requisite for sustainable economic growth, development and prosperity at individual, household, community and national levels will be facilitated.
- The free primary education Programme benefits will increase.

2.3 WHAT IS THE CHALLENGE

- The impacts of malnutrition are overwhelming but abstract and less understood consequently inadequate superficially addressed..
- There is less demand for nutrition services by caregivers, compared to other services *such as immunization where the caregiver will remember and even ask for the next dosage date because they have seen a child die of measles or being crippled with polio. Yet it is very had to see the impact of Vitamin A deficiency and so its supplementation is not taken seriously.*

2.4 THE GOVERNMENT RESPONSE TO THE HIGH LEVELS OF MALNUTRITION

The levels of malnutrition are expected to decline due to the redefined efforts and direction taken by Government in the last five years such as:

- Positioning nutrition firmly at the centre of the development agenda as a multisectoral issue with an economic, socio-cultural, political and biomedical dimension, as reflected in the MGDS the overarching investment strategy as priority area six being closely monitored at all levels contributing towards the achievements of the MDGs targets.

- Highest Personal and political championing leading and commitment by His Excellence the State President

- The operationalising of the MGDS through the developed National Nutrition Policy and Strategic Plan (NNPSP, 2007-2012). The NNPSP is an overarching strategic framework for guiding the review and formulation of sector specific policies to incorporate nutrition using evidence based programming. It is intended to achieve the following:

What the NNPSP (2007-2011) 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 in order to attain improved and sustained nutritional status of every Malawian with special attention to vulnerable groups (especially infants, young children, people living with HIV (PLHIV), people in emergencies, pregnant and lactating women, boys and girls in school, 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 to nutrition services.
- Provide a framework for standardization and improved multisectoral quality nutrition services using the developed and disseminated national guidelines and communication strategies.
- Position nutrition high on the national development agenda that call upon every policy and decision maker, Programme managers, development partners, the private sector, civil society, local leaders, service providers and caregivers to prioritize nutrition investments and play their role effectively.
- Reposition nutrition as a crosscutting issue to be integrated into all national development efforts.
- Mobilise resources, support, partnerships and greater involvement from all the key stakeholders and other duty bearers at different levels.
- Set out the framework for capacity building in key nutrition areas such as dietary diversification, clinical nutrition, dietetics; and community nutrition and in order to strengthen institutional and sectoral capacities to effectively implement and delivery nutrition Programmes and services.
- Facilitate the development, implementation and enforcement of nutrition legislation.
- Promote nutrition research and the sharing of best practices.

3.0 THE VISION, MISSION, GOALS AND KEY PRIORITY AREAS FOR THE NATIONAL NUTRITION POLICY AND STRATEGIC PLAN

BROAD POLICY AND STRATEGIC DIRECTION

VISION

To attain adequate nutrition for all Malawians with special focus on vulnerable population groups by 2015

MISSION

To facilitate the provision of integrated nutrition services for significant improvements in the nutritional status of all Malawians

3.1 THE OVERALL OBJECTIVE:

To lay a solid foundation for human capital development that will facilitate sustainable economic growth and prosperity in Malawi and a better nourished population.

3.2 POLICY PRIORITY AREAS

It has three focus areas

Policy Focus Areas:3

1. Prevention and control of various forms of nutrition disorders.

2. Promoting access and quality of nutrition and related services for the effective management of nutrition disorders.

3. Creation of an enabling environment that adequately provides for the delivery of nutrition services and implementation of the nutrition programmes, projects and interventions

The priority areas will be pursued through three key strategic objectives which are:

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.*

The policy has a number of target groups but key ones are as follows:

Target groups

All population groups with special emphasis on

1. Infants of 0-2 years
2. Women who are pregnant, lactating or of reproductive age for a "Golden start for the child"
3. Under five children

- It also targets School age children, People Living with HIV, TB and chronically ill people, those in emergency and other vulnerable groups as may be defined from time to time.

3.3 KEY STRATEGIES

The high priority interventions under each priority area are:

Priority area one

Prevention and control of various forms of nutrition disorders among women, men, boys, girls in Malawi.

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 before, during and after pregnancy

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 and access
   - Proper storage, preparation and utilization of available foods
   - Consumption of a variety of foods from the six food groups every day
   - Food safety and quality for the child, family and 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 by food producers, distributors and in the general public.

10. Prevention and control of nutrition related non-communicable and other diseases.

Priority area two

Promoting access to quality nutrition and other related services for the effective management of nutrition disorders among women, men, boys, girls in Malawi.

1. Scaling up of Community Therapeutic Feeding (CTC), and Supplementary feeding services to the entire district in all the 28 districts.

2. Scaling up of Nutrition Treatment, Care and support provision for People Living with HIV, TB and other chronically ill patients in all the ART sites in all the Districts, 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 for early detection and management of Nutrition-related Non-communicable diseases such as diabetes, obesity, hyper tension, gout and arthritis among others at all levels.

Priority area three

Creation of an enabling environment that adequately provides for the delivery of Nutrition Services and the implementation of the Nutrition programmes, projects and interventions

1. Establishment of a well defined coordination mechanism for nutrition services programmes and projects at the national, district and community level.

2. Advocacy to reposition nutrition at the centre 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 her partners for the implementation of the NNPSP.

5. Building of institutional and human capacities for the effective delivery of nutrition services 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 3 ones principle.

8. Development and operationalization of results-oriented monitoring and evaluation.

3.4 KEY ACHIEVEMENTS TODATE

Priority area one

- 57% children are exclusively breastfe d from 3% in 1995, 42% in 2000.
- 95% children 6-59 months have receive d Vitamin A supplementation an increase from 64.9% in 2004.
- Increase the number of children 12-59 months receiving deworming medicine
- Increase the number of households using iodised salt
- 1,172 out of 4,128 public schools provide schools meals (thus 28.3% coverage).
- 38.2% of pupils in public schools (1,104,629 out of 2,890,706 pupils) receive school meals with support from WFP, GTZ, CITIHOPE, Mary Meals and ELCM.
- 125 public schools with 73,766 pupils have school gardens supported by WFP, GTZ, FAO and FISD.
- 93,015 pupils in 101 schools have benefited from hygiene and sanitation programme supported by Save the Children and UNICEF
- 3,200,000 pupils in 5,300 schools have received Micronutrients supplementation supported by WFP, World Bank, WHO and Save the Children.
- 800,000 pupils in 99 schools have benefited from Safe drinking water supported from Save the Children and UNICEF.
- 3,200,000 pupils in 5,300 schools have benefited from Drugs for minor ailments and prophylaxis supported by World Bank, WHO and Save the Children.
- 5,300 schools reaching 3,200,000 pupils are running School Health and Nutrition Education Programme.
- 80, 079 PLWH and other vulnerable groups have been reached with nutrition support through the workplace and other programmes.
- 108 PLHIV Support Groups in 27 districts (4 groups per district) received 1400 bags of UREA fertilizer for own food production during the last season.
- 4.7 million Malawians have benefited from nutrition support

Priority area two

- 258 facilities (57%) from 32 in 2004 in 21 districts provide Community Therapeutic care (CTC) from 2 districts in 2004.
- 19,299 from 2170 in 2004 malnourished children less than 12 years have ever been treated in CTC services..
- 86% cure rate and low death rate of 2.9% among the malnourished children from the CTC services due to early detection and timely treatment of the children before complications set in.

Priority area three

- Nutrition was included as a priority area in the MGDS (priority 6)
- Nutrition has been incorporated in sectoral policies such as the Agriculture Development Programme (ADP) and the National Education Strategy Plan (NESP)
- Nutrition policy direction, guidance, coordination, advocacy and oversight has been strengthened with the establishment of the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet (OPC), creation and strengthening of implementation and coordination structures, mechanism for joint planning and reporting
- Conducive policy environment, surveillance and research created.
- Development and dissemination of guidelines for service delivery and nutrition programming
- Recruitment of technical officers for key Ministries to facilitate nutrition integration.

3.5 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.

1.1 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

The key result areas prioritised are increase in the: -

1. Exclusive breastfeeding rates of children 0- 6 months in the context of HIV and AIDS.
2. 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 amounts, frequency, energy and nutrient density and diversity with age based on FADUA.
3. Number of children that are fed optimally during and after illness.
4. Percentage of women with adequate nutrition as measured by Body Mass Index.
5. (i) Number of people consuming micron utrient rich and fortified foods in Malawi.
   (ii) Maintenance of the coverage of micronutrient supplementation to under-five and school-aged children, pregnant and lactating women to above 80%.
6. (i) 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) Number of caregivers and households with improved knowledge and skills in appropriate food utilisation, processing, post harvest management, storage and preparation.
7. (i) Number of pupils with access to nutritious food and other nutrition related services.
   (ii) 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. 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 is to reduce prevalence of nutrition disorders.

1.2 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

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 in order to realise increased case outcomes such as:

Cure rate to be maintained above 80%
Death rate to be maintained below 10%
Default rate to be reduced below 10%

1.3 Strategic Objective 3: To create an enabling environment for the effective implementation of nutrition services and programmes

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

1. Incorporation of nutrition in key sectoral policies such as Agriculture, Education, Gender, Child, Social Welfare and Community Development, National HIV Policy, National AIDS Framework and programmes like HIV workplace programme for a multi-sectoral approach.
2. Achievement of a real increase (at least double the current level) in budgetary allocation of resources by government, bilateral, multilateral, private sector and NGO partners 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 society for the effective delivery of nutrition services, programmes and interventions at the individual, community and facility levels.
4. 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.
7. Wide dissemination of relevant Nutrition Guidelines and information

Implementation of the NNPSP will be guided by the following policy statement, operating statements, principle of 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* and guiding principles:

4.0 POLICY STATEMENT: Malawi shall;

Position nutrition firmly on the development agenda and create an enabling high level policy and guidelines review environment based on evidence with adequate resources in partnerships with all actors for increased, effective and timely prevention, control and management of nutrition disorders among women, men, girls and boys by 2012.

4.1 OPERATIONAL POLICY STATEMENTS

Policy Statement 1: Malawi shall firmly position nutrition on her development agenda through inclusion of Nutrition in key development 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.

Policy Statement 2: Malawi shall strive to create and sustain strong partnerships with public and private sector, civil society and development partners for implementation of nutrition programmes through a number of strategies.

Policy Statement 3: Government shall standardise and improve quality of nutrition services through development, periodic review and dissemination of nutrition guidelines.

Policy Statement 4: Government shall promote sustained adoption of key optimal nutrition practices through nutrition education, counselling and negotiation based on the principles of behaviour change communication.

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

Policy Statement 6: Government shall ensure increased access to resources for care through deliberate efforts to increase production and access to highly nutritious foods in terms of quantity, diversity and quality.

Policy Statement 7: Government shall ensure evidence based programming of nutrition services, programmes, projects and interventions through generation and dissemination of research based nutrition information.

5.0 GUIDING PRINCIPLES

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

Guiding Principle 1: Political will and commitment

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 society, will contribute to achieving 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 this 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 nutritional knowledge, skills and resources will be prioritised for the successful implementation of this policy.

Guiding Principles 8: Sustainable Use of Natural Resources - Services

A protected environment, including proper sanitation, water protection, personal hygiene, availability of food preparation facilities and energy, shall be taken as prerequisites for policy success.

Guiding Principles 9: Sustainable Use of Natural Resources - 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 Principles 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 social status relative to that of men in all aspects of nutrition.

Guiding Principles 11: Equity in Nutrition – Vulnerable Groups

Disability, age, HIV and AIDS, and other vulnerabilities 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.

6.0 COORDINATION ARRANGEMENTS

The coordination of the NNPSP will be done at national, district and community levels. At national level, a multi-sectoral Technic al and Government-Development Partners committees will be key in ensuring a coordi nated nutrition response. These will be supported by technical nutrition committee working groups and bi-annual and annual review and planning meetings. At district level, there will be District Nutrition Coordination Committees (DNCC).The DNCC will wo rk closely with lower level structures such as the Village and Area Development/Ex ecutive Committees, focusing on nutrition issues.

Institutional Roles and Responsibilities

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

a. Oversight

i. Parliamentary Committee on Nutrition, HIV and AIDS: This 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.
   - Pass facilitate the enforcement of nutrition legislation.

ii. 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 issues.
   - Facilitate adoption of measures to fight against malnutrition and its effects.
   - Oversee institutionalization of measu res to address nutrition issues.
   - Provide input into the deliberations of the Parliamentary Committee on Nutrition.

iii. Principal Secretaries' Committee on Nutrition, HIV and AIDS: this committee will be responsible for ensuring nutrition is actively mainstreamed into 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 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 level.
- Ensure implementation of planned nutrition strategies in various sectors.

b. Policy/Technical Coordination

i. Multi-sectoral Technical Committee on Nutrition: this committee will be composed of a cross section of stakeholders that will include key sector ministry representatives, representatives of development partners, civil society organizations and academic and think tank institutions on nutrition. The composition of the Multi-sectoral Technical Committee on Nutrition will be 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 this committee will be:

- 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.

i. Government-Development Partners Committee on Nutrition: The committee compose of key Government sector representatives and development partners in the nutrition sector with the following membership:

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 Malawi's consolidated nutrition fund requirement.
- Provide direction on policy alignment to MGDS, MDGs, UNDAF and own capitals interests.
- Monitor progress and resources in the nutrition sector

ii. OPC Department of Nutrition and HIV and AIDS: The Department of Nutrition, HIV and AIDS will be the secretariat and will:

- Provide policy direction, oversight and guidance on the implementation coordination and monitoring and evaluation 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 integrated nutrition fund (SWAp) to facilitate resource mobilization.
- Place and strengthen Nutrition, HIV and AIDS Specialists in each sector Ministries and Departments 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.

iv. Sector Departments: they will ensure active integration of nutrition into their sectoral policies and strategies, and support the implementation efforts at the district[1] 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 for nutrition activities in sectoral budget and the implementation of the sectoral nutrition work plans.
- Prepare programme and financial monitoring reports for the sector and submit to OPC through the Department of Nutrition, HIV and AIDS for progress tracking.
- Provide technical guidance to stakeholders and service providers in the sector

v. 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 implementation and 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.

[1] 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

vi. 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.

vii. 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

i. 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 refere nce 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, community level service providers, local leaders and communities.
- Supervise implementing partners at district level.

- Backstop Area Nutrition Officers operating below the district.

ii. Community Nutrition Workers/Extension workers: These will be either 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 or existing extension workers in the sectors. They will:
    - Coordinate and facilitate various nutrition services covering a Traditional Authority or several Group Village Headpersons depending on terrain and size of area.
    - Facilitate implementation of nutrition activities at the area level, and supervise CBOs/CSO work.
    - Follow up and receive reports from CBOs/CSOs.

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

iv. 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 community level by mobilizing communities.
    - Assist in growth monitoring activities.
    - Assist in nutrition sensitisation meetings.

7.0 MONITORING AND EVALUATION STRUCTURE

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

Information Flow

Information will flow from communities through various agencies to the OPC Department of Nutrition, HIV and AIDS Secretariat. To facilitate 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. This will contribute towards keeping all stakeholders focused on achieving the NNPSP results. The flow of information is depicted in:

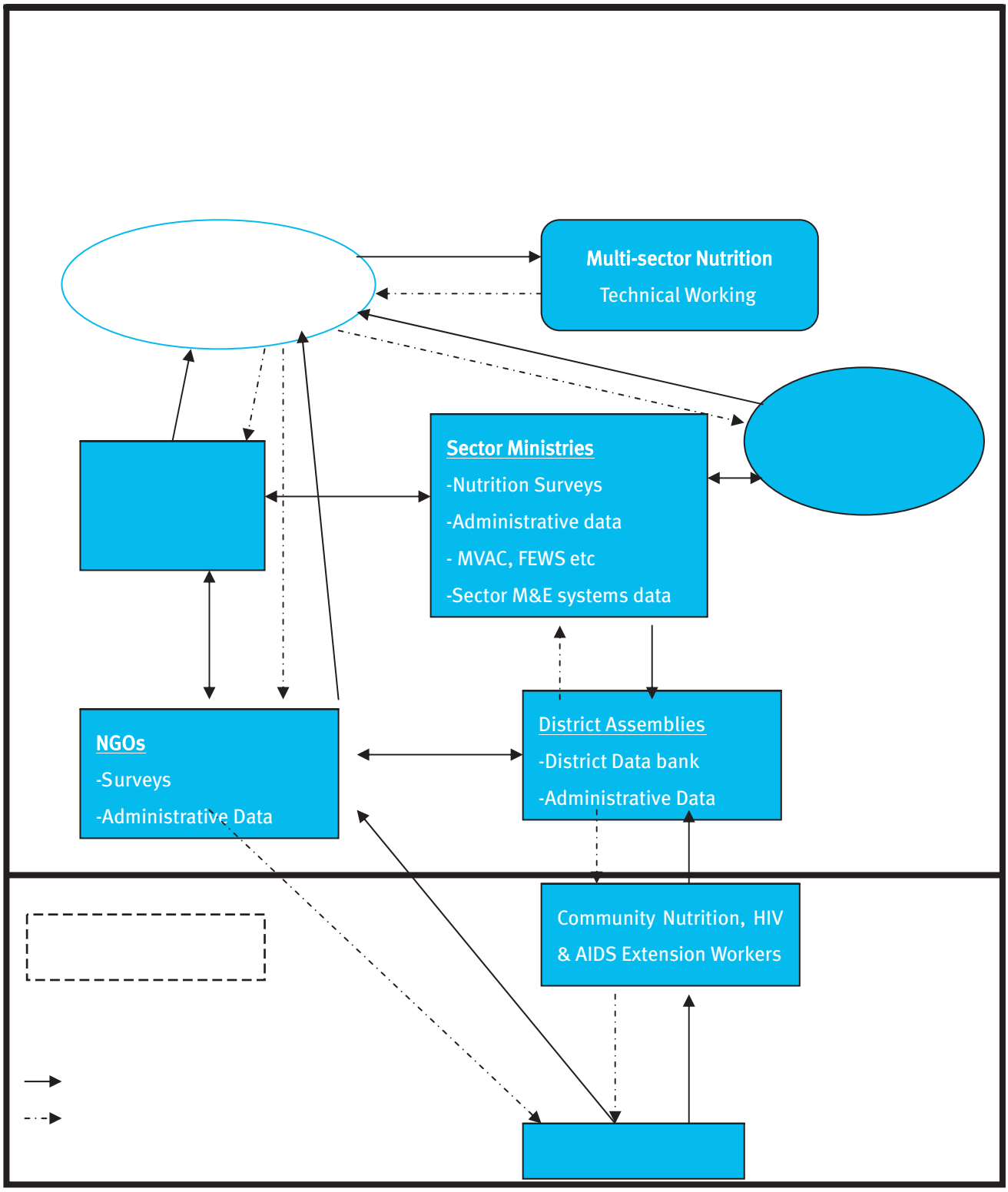


Figure 4: NNPSP M&E Framework-Information Flow

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