

FOREWORD

Good nutrition is essential for healthy and active lives and has direct bearing on intellectual capacity, which eventually impacts positively on social and economic development of a country. Underlying this principle is the practical application of appropriate diet and healthy lifestyles that are dependent on stable and sustainable food security, quality caring practices, healthy environment and accessible quality health services. Therefore in order to maximise the health and economic benefits there should be in place sound food and nutrition policies and strategies.

The Government recognises that malnutrition is a serious public health problem in Zambia. Both acute and chronic Protein Energy Malnutrition exists in high proportions in both rural and urban areas. Micronutrient malnutrition of Vitamin A, iron and iodine are also common and affect all population groups especially women and children.

The situation is a reflection of the long standing poverty that affects the majority of the Zambian population, a situation that has been exacerbated by unfavorable climatic conditions in many parts of the country in recent years. This in turn has led to inadequate food intake and an increased disease burden eminent with malnutrition.

Malnutrition occurs and remains in a society due to a multiplicity of factors in the areas of food security, and health services delivery. There are three main levels of malnutrition causality:

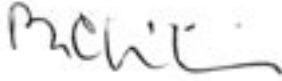
- Immediate causes such as low food intake and the high disease burden
- Underlying causes of inadequate food security, insufficient maternal and child care and poor health, environmental and sanitary conditions
- Basic causes including the socio-economic and cultural factors in society

The multi-sectoral nature of the causes call for a multi-sectoral approach to prevent or combat malnutrition. Community capacity building and increasing nutrition awareness at household and community level are seen as central to the establishment of local capacities to prevent and combat malnutrition.

The evolving National Food and Nutrition Policy is an outcome of a series of national discussions facilitated by the National Food and Nutrition

Commission based on Zambia's experiences.

Therefore I urge you all to implement this policy in its totality to improve and sustain optimal nutrition and health for all.

A handwritten signature in black ink, appearing to read 'Brian Chituwo', with a long horizontal stroke extending to the right.

Brian Chituwo (MD) MP
Minister of Health

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The Ministry of Health recognizes the invaluable contributions made by many organizations and individuals for the drafting of this policy document.

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Dr. S. K. Miti (MD)
Permanent Secretary
MINISTRY OF HEALTH

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GLOSSARY

<i>Anthropometry</i>	The use of body measurements to assess nutritional well being.
<i>Body Mass index</i>	Defined as weight (in kg) divided by height (in M) squared. This measures chronic energy deficiency in adults.
Care	Provision in the household and the community of time, attention and support to meet the physical, mental and social needs of the growing child and other family members. It leads to the optimal use of human, economic and/or organisational resources.
<i>Chronic food insecurity</i>	Long-term lack of access by all households' to food needed for a healthy life for all its members.
<i>Complementary food</i>	Any food whether manufactured or locally prepared, suitable as a complement to breast milk or to infant formula from 6 months of age when either become insufficient to satisfy the nutritional requirements.
<i>Diarrhoea</i>	Passing of watery stools for more than three times in a day.
<i>Dietitian</i>	A diet expert with a particular skill of translating dietary knowledge into practical advice for provision of food suitable for maintaining good health in all age groups, aiding recovery from disease and treating diet related conditions.
<i>Emergency</i>	Situation of hardship and human suffering that overwhelm people's capacity to manage and cope alone for a period of time and which require intervention with support from outsiders.

Food	Any solid or liquid that provides nourishment to the body.
Food Security	Access by all households to food needed for a healthy life for all its members (adequate in terms of quality, quantity, safety and culturally acceptable) and when it is not at undue risk of losing such access.
Infant	A child from birth up to the age of 12 months
Institutional Feeding	Applies to food service in establishments where the organisation provides food to the residents.
Long term emergencies	Persistent or prolonged experience of hardships and human suffering associated with levels extreme poverty and may affect part of or the whole population.
Malnutrition	Condition that results from insufficient or excessive intake of nutrients.

<i>Nutrition</i>	Nutrition encompasses the processes of accessing food, consumption and utilization of nutrients by the body.
<i>Nutritional status</i>	The condition of the body resulting from the utilization of essential nutrients available to the body.
<i>Nutritional surveillance</i>	The regular collection of nutrition information that is used for making decisions about actions or policies that will affect nutrition.
<i>Orphan</i>	A child under 15 years who has lost either one of both parents.
<i>Short term emergency</i>	Crises that may involve loss of life and injury as a result of calamities such as severe droughts, floods, famine, pest infestation, disease or acts of war.
<i>Stunting</i>	Having a low height for a given age.
<i>Supplementary Feeding</i>	Provision of extra food along with whatever is being consumed in order to satisfy the nutritional requirements of the individual.
<i>Transitory food insecurity</i>	Short-term lack of access by all households' food needed for a healthy life for all its members.
<i>Underweight</i>	Having a low weight for a given age.
<i>Vulnerability</i>	Refers to exposure to contingencies and stress, and difficulties in coping with risk, shock and stress.
<i>Wasting</i>	Having a low weight for height .

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
ARVs	Antiretrovirals
ASIP	Agricultural Sector Investment Programme
BCC	Behaviour Change Communication
BESIP	Basic Education Sector Investment Programme
BMI	Body Mass Index
CBOH	Central Board of Health
CDD	Control of Diarrhoeal Diseases
CPI	Consumer Price Index
CSO	Central Statistical Office
DMMU	Disaster Management & Mitigation Unit
ECCD	Early Childhood Care and Development
FAO	Food and Agriculture Organisation
FHANIS	Food, Health and Nutrition Information System
GRZ	Government of the Republic of Zambia
HIV	Human Immuno Virus
HMIS	Health Management Information Systems
ICPD	International Conference on Population and Development
IDD	Iodine Deficiency Disorders
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
LCMS	Living Conditions Monitoring Survey
MACO	Ministry of Agriculture and Cooperatives
MCDSS	Ministry of Community Development and Social Services
MCH	Maternal and Child Health
MYSKD	Ministry of Youth, Sport and Child Development
MENR	Ministry of Environment and Natural Resources
MIC	Malnutrition-Infection Complex
MLGH	Ministry of Local Government and Housing
MLSS	Ministry of Labour and Social Security
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
NFNC	National Food and Nutrition Commission
NGO	Non-Governmental Organisation
NRDC	Natural Resources Development College
PAM	Programme Against Malnutrition
PEM	Protein Energy malnutrition
PHC	Primary Health Care

PUSH	Project Urban Self Help
PS I and II	Priority Surveys, by FHANIS
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
PWAS	Public Welfare Assistance Schemes
SAP	Structural Adjustment Programme
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for Development
VAM	Vulnerability Analysis and Mapping
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organisation
ZDHS	Zambia Demographic and Health Survey

1.0 INTRODUCTION

Better nutrition outcomes can be realized when there is a food and nutrition policy. Apparently Zambia has not had one despite the fact that the nutritional status of the population is unhealthy. This policy is therefore formulated to provide policy guidelines in food and nutrition for the country.

The nutritional status in Zambia has been affected by a myriad of factors dating as far back as the early 1970s. A combination of factors including public policy choices, collapse of world copper prices on which the export economy was very dependent, and the burden of national debt have resulted in poor economic growth. This has been exacerbated by the recurrent unfavorable climatic changes of the 1990s, thus reducing Zambia from one of the richest countries in sub-Sahara Africa to one of the poorest countries in the World today. This has resulted in rising trends of malnutrition for example among children under five as can be seen from the table below:

Indicator	1991 ZPS I	1992 ZDHS	1995 ZPS II	1996 ZDHS	2002 ZDHS
Stunting	39.6	40	48.4	42.0	47
Wasting	6.9	5	5.7	4	5
Underweight	23.1	25	25.3	24	28

ZPS I: Zambia Priority Survey I, ZPS II: Zambia Priority Survey II, ZDHS: Zambia Demographic Health Survey

Efforts to reverse the worsening trends were aggressively implemented in the early 1990s but with the introduction of Structural Adjustment Programme (SAP) during the same period made implementation difficult. This programme entailed removal of subsidies on consumer goods and services, reduction in government spending on social services (education, health, and welfare support) and liberalization of the economy as a whole. However, SAP has had negative results associated with declining real personal incomes, inflation and erosion in purchasing power, escalating prices of essential goods and services, rising unemployment due to retrenchments and company closures. Consequently, there has been a decline in health care, education, and unprecedented increase in poverty.

The social and economic decline has contributed to increased prevalence of young child and maternal morbidity and mortality, growth failure and malnutrition. Malnutrition is caused by a multitude of interacting factors, which usually cut across many sectors. These include food insecurity, prevalence of infectious diseases, lack of care for the vulnerable especially children, environmental, economic and social conditions.

The first step towards improving the nutritional status of the population was the establishment of the National Food and Nutrition Commission (NFNC) in 1967 by an Act of Parliament as an advisory body with the broad objective of promoting and overseeing nutrition activities in the country and specifically to:

1. Assess and monitor nutritional status of the population.
2. To support the improvement of nutritional status of the population of Zambia through the health, agriculture, education, community development and other administrations, and the non-profit sector, having a bearing on nutrition;
3. Develop norms and implementation guidelines for various food and nutrition activities.
4. Promote information, education and communication activities
5. Promote and support in-service and pre-service training of staff whose activities affect nutrition.
6. Promote and perform monitoring and evaluation of nutrition-related services and;
7. Promote collaboration among the above administrations in the domain of nutrition including the preparation and periodic review of a national food and nutrition policy.

This document presents a synopsis of the situation analysis of the nutrition problems in Zambia. It suggests areas of nutrition programming, institutional policy and legal frame work measures required to tackle them.

1.1 Rationale

The nutrition situation in Zambia has remained poor and may continue to deteriorate if corrective actions are not taken now. Malnutrition is a result of complex social economic and crosscutting issues, which require coordinated efforts to correct. Although many institutions are involved in nutrition activities, there is little or no coordination among them. Further there are no explicit sectoral guidelines for developing and implementing nutrition interventions as a result there is little or no effort to incorporate

nutrition considerations in sectoral policies and programmes.

Therefore, there is need to have a national food and nutrition policy which would provide the framework for guiding the development and implementation of food and nutrition interventions that would ensure a well nourished, healthy and productive nation, and indeed eliminate all forms of malnutrition and enhance food security.

2.0 SITUATION ANALYSIS

2.1 Nutritional Status

The common nutrition problems in Zambia are Protein-Energy Malnutrition (PEM), micronutrient deficiencies and low birth weight. PEM is presented as stunting, wasting, underweight and low birth weight, while micronutrient deficiencies include vitamin A deficiency, iron deficiency anaemia and iodine deficiency disorders.

2.1.1 Protein Energy Malnutrition (PEM)

Stunting or linear growth retardation is the most prevalent form of PEM in Zambia. The prevalence of stunting currently stands at an average of 53% among children under five years of age (CSO/UNICEF 2000).

Wasting rates have remained between 4% and 7% for the under five children in the 1990's with urban areas being slightly worse off than rural areas. The prevalence of underweight in Zambia has remained between 23% and 27% (DHS 1992). According to the WHO's severity index, Zambia is rated "critical" or "very high", for stunting "medium" for wasting and "serious" or "high" for underweight.

Overall, an estimated 10% to 13% of children born in Zambia have a low birth-weight. This high incidence is related to poor maternal nutrition before and during pregnancy. According to the ZDHS 1996, 10% of all women of reproductive age surveyed had a low Body Mass Index [BMI: weight (kg)/height (m²)]. About 9% of the Zambian mothers of children under 3 years of age are malnourished, with a Body Mass Index (BMI) of less than 18.5, representing one of the lowest rates among the sub-Saharan countries (DHS1996).

2.1.2 Micro-nutrient Deficiencies

Vitamin A deficiency is a public health problem in Zambia affecting especially the poor due to inadequate dietary intake. A 1997 national survey showed a prevalence of vitamin A deficiency of 65.7% and 21.5% in children and women respectively. Night blindness rates were 6.2% for children and 11.6% for women.

Iron deficiency anaemia is prevalent in Zambia with up to 50% of women attending antenatal clinics and 15% of children under 15 years estimated

to be affected. A national baseline study on the prevalence and aetiology of anaemia conducted in 1998 showed that 65% of children, 39% of women and 23% of men were anaemic.

IDD are common health problems in Zambia. A 1993 national sample survey of primary school children found a goitre prevalence of between 9% and 82% with a national average of 32%. Iodated salt is the major source of iodine in Zambia.

2.2 Issues for Nutrition Improvement

2.2.1 Household Food Security

In Zambia a high proportion of both rural and urban households are vulnerable to food insecurity. Both chronic and transitory food insecurity are prevalent. For rural households, food entitlement is linked to agriculture, while crop production risk is a primary determinant of food insecurity. Insufficient food production capacity, lack of income diversification and unfavourable climatic conditions are therefore, the main causes of food insecurity for rural households. Urban households on the other hand, depend on wage or self-employment and as they purchase their food needs, are more susceptible to insufficient income and price increases for food and other basic necessities such as fuel and housing. As a consequence to food insecurity, consumption and nutrition status are also affected. In recent years there has been an increase in urban malnutrition.

2.2.2 Food Production

During much of the last two decades, trend data on food production indicate that the production of maize, the main staple crop, has been below national requirements. Now in particular, maize production has been severely affected mainly by recurrent unfavorable climatic conditions and removal of subsidies on agriculture inputs. As a result, large quantities of the grain have had to be imported to meet the deficit. Moreover, the liberalization of the economy and privatization of state owned institutions like NAMBOARD, have impacted negatively on maize stocks.

The production of the minor staple food crops and other crops has been fluctuating leading to increased vulnerability to food insecurity especially among the rural population who consume mostly these staple foods. In addition although production of legumes, fruits and vegetables has been encouraged and been going on for a long time, the production levels are

still low. The food production at household level has also been affected by inadequate labour due to the impact of HIV/AIDS, which is affecting the most productive age group. Other contributing factors are inappropriate technologies, especially for female-headed households. High post harvest losses due to poor practices during preservation, processing and storage further aggravate the situation. Limited markets also constrain food availability and accessibility with the majority of rural households exhausting their food stocks before the next harvest. Moreover, animal production and fish cropping for consumption has generally not been viewed as a contributing factor to household food security. Therefore to address the food security issues the Government need to put in place an agricultural policy.

In large cities, the urban poor may have a home garden or raise small animals as part of coping strategy. It affords a cheap, simple and flexible tool for productively using open urban spaces, generating employment and income, and adding value to products. Urban agriculture can provide significant amounts of food at small scales and for specific items. By growing their own food, urban inhabitants lower their food deficits and obtain an important source of fruits and vegetables.

2.2.3 Food Consumption

Food consumption is related to access and availability and the main methods of food acquisition being from production, transfers and purchases. The national nutritional status and food consumption surveys of 1970/71 identified inadequate dietary intake as a major problem. Per capita energy intake ranged from 1,580 Calories in North Western province to 1,850 Calories in Copperbelt province, which was below the then FAO recommended daily allowance of 2,030 Calories. Ten years later in 1980, the calorie intake was estimated to range from 1,185 in Luapula province to 2,103 in Lusaka and Central provinces compared to a recommended daily allowance of 2,300 calories per day.

Though there has been no update of actual food consumption data since then, FAO Food Balance Sheet information shows a decline in food availability per capita from 2,209 Calories in 1969/71 through 2,114 Calories in 1982/84 to 1,954 Calories in 1992/94.

The food consumption patterns in Zambia are poor. Generally there is a low frequency of food consumption of usually one to two meals per day, lack of variety in the diet, (about 70% of the energy is from the staple maize) and consumption of low nutrient dense foods. The low consumption

of food is influenced most by low food availability and accessibility.

2.2.4 Food Purchases

A major indicator of access to food especially in urban areas is the level of income. In Zambia, incomes for the majority have declined over the last two decades due to inflation while prices of essential goods and services including food have risen and continue to do so. This has affected people's ability to procure food. Most affected are the low-income groups for whom the Consumers Price Index (CPI) for food increased by more than 44% between 1985 and 1994.

In 1991, 55% of Zambians were below the poverty datum line. By 1996 this figure had risen to 66%. For urban areas only, the corresponding figures were 29% and 44%. Currently the poverty levels, well over four fifths of the population live below the international poverty datum line of \$1 per day. Inequality has grown to the extent that the per capita income share of the poorest 20% of households is now barely 2%.

Rising unemployment due to retrenchment and redundancies in the wake of economic restructuring deprived many families of their major and often only source of income, further aggravating food insecurity.

Because urban dwellers must buy most of their food, urban food security depends mostly on whether the household can afford to buy food, given the high prices and low incomes. Yet with little human or financial capital, the poor are forced to take casual, insecure jobs. With their abundance of labour, but often little else, the poor find competition for jobs fierce.

The Government has supported programmes such as for Urban Self-Help (PUSH) and rural food for work to supplement food availability for the vulnerable groups, which are mostly the low income. However, these programmes do not adequately cater for the increasing population of the low-income group.

2.2.5 Informally traded foods

There is unprecedented increase in informally traded foods due to rising poverty levels and diminishing economic opportunities. As a result several negative effects have emerged such as :-Encroachment on the roadsides and pavements, Hygiene and sanitation problems, Possible contribution to the deterioration of law and order (Aggressive entrepreneurs are often no exception) and sold food items tend to have a high and empty energy

content due to excessive sugar or frying.

2.3 Care for the Nutritionally Vulnerable

Care is one of the important factors that can influence an individual's health and nutrition status. Nutritional care encompasses all measures and behaviour that translate available food and resources into good health and nutrition status.

There are many groups in the Zambian society that are nutritionally vulnerable. These include, the increasing numbers of elderly people, the physically and mentally handicapped, orphans, street children, the chronically ill, young children and women of childbearing age. Of these groups, children (under 5 years of age), women of childbearing age and the chronically ill form an especially important group of nutritionally vulnerable individuals.

Resources required for care giving include; knowledge, skills and belief, health and nutrition status of caregiver, time, economic resources and support from other members of households, community and Government.

2.3.1 Women

In Zambia women of childbearing age do not receive adequate care. As a result, their health and nutrition status has been compromised. Chronic energy malnutrition, vitamin A deficiency, anaemia and HIV are among the major problems afflicting women. As a consequence, maternal mortality, currently estimated at 649 per 100,000 live births is among the highest in the region.

At the family/household level both in rural and peri-urban areas, the heavy workloads resulting from the many household responsibilities that women shoulder such as food processing and preparation, firewood and water collection and caring for the sick usually leaves them with little or no time to properly care for their children and themselves. Added to the increasing cases of abuse of women, these problems have contributed to the poor state of the majority of women in Zambia.

Several interventions have been put in place for Maternal and Child Health, among which Safe Motherhood, Reproductive Health, Family Planning and Voluntary counseling and testing for HIV and associated care.

2.3.2 Children

The integrated early childhood development is based on the idea that giving the child the best start to life requires interventions in many areas; viz. health, nutrition, water, sanitation, psychosocial care and protection. Although survival is essential, it is not enough. Learning begins at birth and therefore family support and responsive care at the earliest years of life are essential for the child's cognitive development and social and emotional well being.

The emphasis on Early Childhood Care and Development (ECCD) requires lowering maternal malnutrition and mortality, reducing the prevalence of low birth weight, child malnutrition, morbidity, growth failure and mortality and enhancing the psychosocial and cognitive development of the children. Despite the fact that breastfeeding practice is a norm in Zambia, the rate of exclusive breastfeeding is low. Further, there is a considerably high rate of early cessation of breastfeeding and introduction of complementary foods. The foods introduced are often of low energy density and lack variety and the feeding frequency is less than optimal.

Among the interventions that the government has put in place for child health and nutrition promotion and survival are Primary Health Care programme (PHC), Maternal and Child health programme (MCH), National Infant Feeding programme (supported by the international Code of Marketing of Breast milk Substitutes, and the Baby Friendly Hospital Initiative), Expanded Programme for immunization (boosted by National Immunization Days), Control of Diarrhoeal Diseases (CDD), Micronutrient Control Programme (including Vitamin A supplementation programme, Sugar fortification and promotion of consumption of micronutrient rich foods), Supplementary Feeding Programme for malnourished children, Integrated Management of Childhood Illness (IMCI), Community Based Growth Monitoring and Promotion Programme, and Prevention of Mother to Child transmission of HIV/AIDS (PMTCT).

However, while most of these interventions have focused on preventive measures, management of severely malnourished children in health facilities and in homes, (in admission and soon after discharge respectively), has not been given much attention particularly in terms of nutritional care, resulting in malnutrition related deaths.

2.3.3 Orphans and Vulnerable Children

One serious consequence of AIDS related deaths is the loss of parents in

their prime childrearing age. This contributes to increase in the number of orphans. In reality given the primacy of sexual transmission in spreading the virus, many children will lose both parents. Already, there were about 520, 000 orphans as a result of AIDS in 1999. It is projected that that number will rise to 885, 000 by 2009 and 974, 000 by 2014. Therefore, the cumulative number of children orphaned by the epidemic and other causes is much higher than can be seen at any one point in time.

There is a tremendous strain on social systems to cope with such a large number of orphans and provide them with the needed care and supervision. At the family level, there is an increased burden and stress for the extended family, which has the traditional responsibility to care for the orphans. This surge in the number of orphans comes at a time when the traditional roles of the extended family have already been weakened due to urbanisation and economic pressure. Many grand parents and adolescents are left to care for the young children. At the community and national level, there is an increased burden for society to provide health and social services for these children.

2.3.4 Adolescents

Most of the nutritional programmes usually target women and children neglecting an important stage of development – adolescents. This category requires special health and nutrition consideration. Adolescents are an important target for nutritional interventions, particularly during growth spurts when there is an increased demand for nutritional requirements to prepare for reproduction especially girls. Adolescents are most likely to get pregnant before their growth is completed, thus increasing nutritional demands and are prone to nutritional deficiencies.

2.3.5 The Elderly

The elderly are rapidly becoming a substantial proportion of the society in Zambia. The society faces new challenges in the provision of care for this group especially in the light of HIV/AIDS infections where the younger age groups are affected by the scourge and leaving behind orphans who have to be looked after by grand parents. Grand parents have diminishing income earning capacity and their health maybe compromised.

Food intake usually declines with age, associated with decreased needs due to lowered basal metabolic rate, resulting in lowered lean body mass. Increasing poverty among the elderly also increases the risk of nutritional

deficiencies. Age-related physiological changes such as progressive decline in the functioning of bodily organs that influence the absorption, transport, metabolism and/or excretion of nutrients affect both nutritional needs and nutritional status. Often the elderly suffer from a combination of inappropriate diet and unhealthy life styles.

2.3.6 The Disabled

The needs of the disabled have not been fully explored and understood to the benefit those who are affected. Caring strategies for the disabled should aim at supporting their capacity to improve their livelihood rather than increasing their dependence assistance.

2.3.7 Refugees and the Displaced Persons

Under nutrition prevalence rates occur in displaced and refugee populations. These suffer from the same type of diseases as other vulnerable groups, but their situation is exacerbated by their destitution. Malnutrition, infectious diseases and mental or emotional stress are some of the common consequences of being displaced. Their livelihoods are disturbed and compromised.

2.4 Gender and Nutrition

While the roots of gender disparities are found in social and cultural beliefs and practices, the severity of the disadvantages and discrimination experienced by women is also closely linked to their material circumstance.

Women are over represented among the poor because of cultural expectations and lack of access to productive assets. In addition, lack of information as well as centralised bureaucratic procedures intimidate most of the poor people, of which women are in the majority.

With regard to education, maternal education is associated with decreases in child mortality and improvements in family health and nutrition. Educated women make better use of their time and available resources. At the lower levels many more girls drop out of school than boys. This trend is more pronounced in rural areas where young girls find themselves in marriages. Further, more admissions and enrollment in higher-level institutions show serious gender imbalances. Out of total of 45% enrollment in the natural sciences, only one out of seven are females while out of 55% in the humanities, one out of three is a female.

These deprivations result in low participation in profitable income generating and low productivity in development activities. These contribute to the high levels of malnutrition, food insecurity and poverty especially among female-headed households. According to the Living Conditions Monitoring Survey Report, there are proportionately more males (63%) than females (53%) in employment.

2.5 Nutrition, Health and the Environment

2.5.1 Health Services

The provision of health services has been adversely affected by cuts in the real health budgetary allocation over the years resulting in limited access by the majority. This situation contributes to the perpetuation of malnutrition through the “malnutrition infection complex” (MIC). In addition, the HIV/AIDS pandemic, changing lifestyles and eating habits have also contributed to the disease burden. This is further compounded by the unfavourable doctor/nurse and patient ratio. Sporadic shortages of drugs and introduction of user fees has led to the decline in the utilization of health services.

Growth monitoring and promotion (GMP), which picked in the 1980s appears to be on the wane due to lack of support. Counseling, an important component of GMP has hardly been conducted while nutrition diagnosis and case management still requires a lot of improvement.

Currently, only 66% of Zambian households are within 5 km from a health facility, 24% are between 6 and 15 km with 10% more than 15 km away. Access to good quality health facility provides households opportunities for nutrition counseling, and protection against childhood illnesses.

2.5.2 Nutrition and Non-Communicable Diseases

Non-communicable diseases are increasingly becoming a problem in the communities especially in urban areas. The association of diet to increased risks of non-communicable diseases needs to be fully understood in the Zambian context. For example more information needs to be disseminated to the public on diabetes, heart disease, obesity, hypertension, cancers and other conditions.

2.5.3 Nutrition and HIV

The important role of nutrition and drug administration in HIV/AIDS should

aim to promote quality life of the affected persons. With the prevalence of HIV infection at 17% in adults in Zambia, there is need to strongly consider nutrition support. The magnitude of the problem has had negative impact on the households and the national economy.

2.5.4 Nutrition and Infectious Disease Control

The interaction of infection and nutrition as a cause of mortality and severe morbidity in children is well documented and has a disproportionately high impact on lower socio-economic groups. Addressing infectious disease is therefore a second essential part of actions to improve nutrition status. Inadequate dietary intake leads to low nutritional reserves manifested as weight loss, failure of growth in children and lowered immunity. For example, in PEM and vitamin A deficiencies there may be progressive damage to mucosa, lowering resistance to colonisation and invasion by pathogens.

2.5.5 Water and Sanitation

Overall access to safe water and sanitation is generally poor in Zambia. Poor access to adequate quantity and quality of domestic water and poor sanitary conditions contributes to outbreaks of water borne and other diarrhoeal diseases. These are closely associated with malnutrition. About 55% of the households have access to safe water and about 77% have access to convenient sanitary facilities.

2.5.6 Food safety

Diseases caused by contaminated food can contribute to widespread health problems. The majority of food borne diseases is caused by biological agents such as bacteria, viruses and parasites and manifest with gastrointestinal symptoms such as diarrhoea, abdominal pain, nausea and vomiting. This is attributed to bad sanitary environment and unhygienic food handling, especially in informally traded food.

Many of the health problems resulting from food contaminants do not figure in statistics on food borne disease. The problem of under reporting has been made worse by inadequate support for officers entrusted to carry out the task.

2.6 Training and Capacity Building

There is generally lack of advanced training and education opportunities

in nutrition in Zambia. At present the highest qualification attainable in nutrition in Zambia is a three-year diploma offered at NRDC. The institution experiences problems related to lack of reference materials and inadequate lecturers. Advanced education in nutrition can only be obtained outside the country and it is very difficult to obtain scholarships.

There is little incorporation of nutrition aspects in the syllabi of relevant institutions dealing with training in such fields as health, agriculture and community development. Institutions working at community level do not incorporate nutrition in their programmes. With regards to education, an effort has been made to update nutrition curriculum for basic level. This initiative needs to be extended to high school and tertiary levels.

2.7 Research and Surveillance

Nutrition information generation through research, sample surveys and routine surveillance systems, and its provision and utilization is an important aspect of successful nutrition programming. Scanty nutrition data exists from various sources in Zambia but there are still many gaps to be filled in to facilitate formulation of appropriate interventions. Currently there is inadequate capacity in institutions mandated to undertake nutrition research.

Biomedical research, applied research, and health systems research findings are inadequately disseminated. With regard to nutrient studies, available food consumption data is outdated. Moreover the effects and opportunities of culture in nutrition promotion remain inadequately researched.

Nutritional surveillance entails the regular collection of nutrition information that is used for making decisions about actions or policies that will affect nutrition. Nutrition status being an outcome of a wide range of social and economic conditions, there is need for an information system regarding nutritional status of a population to provide a machinery required to ensure coordinated and collaborative action from the different sectors to correct the underlying causes of malnutrition. A food and nutrition surveillance system is essential for provision of information for planning food security and nutrition interventions.

The National nutrition surveillance programme that exists in the country was established in the early 1980s and only looks at monthly recording of weights of children through under five clinics. This programme has been integrated into the HMIS of the CBOH. The system has experienced problems with

irregular reporting from clinics and little or no utilization of the data at all levels. However, in nutrition emergency response, underweight information is not a useful index for screening or assessments because it ignores height and fails to distinguish between short children with adequate body weight and children who are tall but thin.

2.8 Emergency Preparedness and Mitigation

Zambia has had its share of short and long-term emergency episodes ranging from disease outbreaks to unfavorable weather patterns. Drought conditions have been especially predominant in some provinces especially Southern, parts of Lusaka, Eastern, and Central as well as isolated areas in other provinces.

The May/June 2002 crop assessment by FAO/WFP indicated that 38 districts were adversely affected by the 2001/2002 drought and flash floods. The situation has impacted negatively on health, food security and nutritional status of the population, especially in rural areas.

Other emergencies that have nutrition implications in the country have been outbreaks of cholera, dysentery, measles and skin diseases. In the urban and peri-urban areas, sporadic outbreaks of cholera in the 1990s led to the loss of many lives.

Thus the government has put in place contingency measures such as the Programme Against Malnutrition (PAM) and the Disaster Management and Mitigation Unit (DMMU) to alleviate the impact of these emergencies and epidemics. International organizations and NGOs complement government efforts at this level.

2.9 Institutional Feeding

In Zambia, institutional feeding is found in establishments such as boarding schools, hospitals, hospices, prisons, nursing homes, etc. In such institutions the aim is to ensure that the food provided is nutritionally adequate and safe.

Supplementary feeding programmes are rarely provided in schools and work places in Zambia. As a result the school children and workers are hungry and less productive compared to their counterparts in private schools and companies. Due to inadequate funding and lack of feeding guidelines in government-supported institutions the diet is largely nutritionally inadequate. In addition, these institutions have insufficient service providers

such as dieticians, nutritionists, and the catering managers. So far only the four tertiary hospitals (University Teaching Hospital, Ndola Central, Arthur Davison and Kitwe Central Hospitals) have appropriately qualified staff.

Government's efforts to facilitate institutional feeding include regular financing of the institutions and in case of schools and prisons, the establishment of production units and farms respectively. However, reduced government spending on the public sector has frustrated these efforts.

2.10 Behaviour Change Communication (BCC)

Behaviour change communication is an important component of nutrition interventions that aim at creating awareness and changing behaviours for food and nutrition improvement. Since its existence, the NFNC has been developing and disseminating various nutrition education and information messages through the electronic and print media. These messages created awareness and changed behaviours to varying levels.

Unfortunately, these activities have stalled largely due to diminishing resources. Consequently this has had a negative effect in BCC activities.

2.11 Institutional Framework

Many institutions are involved in nutrition activities. However, there is little or no coordination between them. Furthermore, there are no explicit sectoral guidelines for developing and implementing nutrition interventions. The NFNC, an institution mandated to oversee all nutrition activities in the country has a weak institutional framework for effective operationalisation of its mandate.

2.11.1 National Food and Nutrition Commission (NFNC)

The NFNC established by an Act of Parliament in 1967 is mandated to promote food and nutrition activities and to advise the government accordingly. In pursuance of this mandate, the NFNC has, since inception, undertaken several activities aimed at nutritional improvement with varying degrees of success.

Although given such a broad mandate, the Act does not give the NFNC enough power and clout or responsibility over nutrition activities implemented in various sectors. In particular, its placement in the Ministry of Health limits its ability to influence sectoral development plans and programmes.

Operationally, the NFNC's ability to handle nutrition issues have been thwarted by inadequate funding, poor conditions of service and insufficiently trained technical staff.

2.11.2 Ministry of Health (MOH)

The MOH plays an important role in effecting improvements in nutrition. A lot of nutrition programmes are implemented directly by the ministry or through it. These include primary health care activities like immunizations, growth monitoring and promotion, micronutrient supplementation, breastfeeding and complementary and supplementary feeding. The MOH has several statutory bodies under its jurisdiction including the NFNC.

Since 1992, the MOH has been implementing the health reform programme through which it is intended to take health care as close to the family as possible. These reforms have seen the creation of the Central Board of Health (CBoH) and management boards to spearhead and oversee the implementation of the health reforms in the country.

Although nutrition has been included as part of the minimum package of basic health services to be delivered as close to the family as possible, the objectives, strategies and activities that have been identified are narrow and unlikely to tackle the broader nutrition issues within a health setting. There seems to be a lack of understanding of what should constitute nutrition activities in the health sector.

Another problem is that the operational relationship between the NFNC and the CboH is not in line with the National Food and Nutrition Act. Since the advent of the CBoH, it has become increasingly clear that the NFNC is being made a subordinate of and answerable to the CBoH instead of the MOH as stipulated in the Act of Parliament No. 41 of 1967. Both the NFNC and the CBoH are legal entities, each with its own Board of Directors appointed by the Minister of Health. The NFNC and CBoH are partners in the implementation of health-related nutrition interventions.

2.11.3 Ministry of Agriculture and Co-operative (MACO)

The MACO is one of the key ministries directly responsible for food and nutrition improvement. It covers the production of food and to some extent its utilization, storage and preservation. Over the years, efforts have been made to incorporate nutrition components and considerations in agricultural development programmes with some success. These activities have been

implemented mainly through the departments of Women and Youth and the Farming Systems Research. The incorporation of nutrition into mainstream agricultural sector objectives is still far from being achieved.

The critical problem has been the lack of systematic institutional collaboration and cooperation between the MACO and NFNC.

2.11.4 Ministry of Community Development and Social Services (MCDSS)

This ministry is responsible for the general welfare including food and nutrition security of the vulnerable groups which include the aged, the disabled, the chronically ill, the displaced or disaster victims, orphans /street kids and infants, young children and women of child bearing age and single/female-headed households.

The ministry has been running programmes to cushion the poor and vulnerable against hardships caused by the implementation of the economic reforms. It also runs the Public Welfare Assistance Scheme (PWAS) through which financial/material assistance is provided to the needy. Others are public works programmes through which communities/individuals perform some community work in exchange for food. The major challenge is addressing the increased needs of the poor and vulnerable within limited Government funding. Further, most of nutrition activities are conducted without any collaboration with NFNC.

2.11.5 Ministry of Commerce, Trade and Industry (MCTI)

This ministry plays a part in the importation of foodstuffs. However, there should be strong links with the MOH – Food and Drugs Control Laboratory, the Zambia Bureau of Standards and the NFNC to ensure that all imported foods meet the set nutritional standards and safety regulations. Currently, there seems to be more emphasis in the ministry on clearing than monitoring the quality of imports. Since there is inadequate inspectorate capacity in the country, many sub-standard food products have flooded the Zambian market in the advent of trade liberalization.

2.11.6 Ministry of Labour and Social Security (MLSS)

The ministry is responsible for ensuring appropriate working conditions for employees. However, many aspects of worker satisfaction especially with regard to proper nutrition have not been adequately addressed. The

ministry should work closely with the NFNC to ensure that the minimum wages take account of the nutritional requirements. Work-place canteens have not been adequately supported to maximize productivity.

2.11.7 Ministry of Education (MOE)

The MOE provides the best opportunity to provide nutrition education and ultimately influence nutrition behaviour of the population. Unfortunately, the level of collaboration between this ministry and the NFNC is not strong. Currently, consultations between the two institutions in nutrition curriculum development or nutrition expertise requirements of the ministry are minimal. Another area of concern is the lack of supplementary feeding programmes in most schools. School feeding programmes are known to contribute to improved academic performance.

2.11.8 Ministry of Local Government and Housing (MLGH)

The ministry is involved in the provision of essential social services such as housing, health, education, water and sanitation. These services have a strong bearing on health and nutritional status. However, the performance of this ministry especially as regards to the provision of adequate safe water and sanitation has been weak. Also, its public health inspectorate is weak particularly in the areas of food inspection and environmental sanitation.

2.11.9 Ministry of Finance and National Planning (MFNP)

The FHANIS was a project created to monitor the food, health and nutritional impact of the 1992/93 drought on the welfare of the people of Zambia. When the project ended, it was placed under the Central Statistical Office. However, due to lack of funding it has been none functional, as a result there has been no information for directing interventions. Continuous nutritional surveillance, collection of data analysis and dissemination for nutrition information is important to timely response to disaster.

2.11.10 Ministry of Tourism, Environment and Natural Resources (MTENR)

Although mandated to ensure efficient and sustainable utilization of natural resources to avoid environmental degradation, which is detrimental to the long-term integrity of food supplies and hence nutritional status, the ministry does not have an environmental policy as yet to provide guidance in the effective management of these resources. The threat of water, soil and air pollution, deforestation, etc to aquatic life, fauna and flora and indeed

human life cannot be over-stressed.

2.11.11 Ministry of Youth, Sport and Child Development (MYSCD)

This is the executing ministry for the National Plan of Action for Children, which was prepared in 1993 as a follow-up to the World Summit for Children of 1990. Unfortunately, there has been little or no collaboration between this ministry and the NFNC in implementing nutrition activities identified in the Plan of Action.

2.11.12 Office of the Vice President (OVP)

The DMMU under the Office of the Vice President (OVP) was established to ensure expediency in disaster response systems including food distribution. Food distribution has focused more on cereal provision without taking into account nutritional requirement of beneficiaries.

2.11.13 Non-Governmental Organizations (NGOs)

There are many NGOs involved in food and nutrition work in Zambia. Among these, PAM, World Vision and Lutheran World Federation are the leading NGOs involved in relief food distribution and food security for the vulnerable. There is apparent lack of effective coordination mechanisms between these NGOs and the NFNC on nutrition matters.

2.11.14 United Nations, Bilateral and Multilateral Systems

There are many institutions in this category involved in nutrition activities such as relief food mobilization and distribution, food production, basic health care, health and nutrition education.

2.12 Legal Framework

To coordinate the various sectors and activities involved in nutrition issues, Government in 1967 decided to establish the National Food and Nutrition Commission (NFNC) through an Act of Parliament, **Cap 41**, with mandate to:

- To take all necessary steps to facilitate the implementation of Government's approved policy in relation to the national food and nutrition programme, and to liaise with international agencies and friendly governments regarding aid to the programme subject to the

government's procedures laid down in this connection;

- Arrange for execution of work, either directly or through agencies, in relation to subjects relating to food and nutrition, which are not part of any ministerial portfolio.

This legal framework has a number of weaknesses especially in the following areas: -

- (i) the Act does not define the general functions of the NFNC, of co-ordination and advisory role instead it is merely assumed from the objects of the Commission.
- (ii) membership of the Commission is not defined in relation to institutional representation and technical competency of such Commissioners.
- (iii) the restriction of the membership of Commissioners to only five (5) does not appear to relate adequately to the multi-sectoral nature and broad spectrum of food and nutrition issues in the country.
- (iv) the absence of the frequency of meetings by the Commissioners appears to leave issues to the chairman to determine when meetings should be held. They do not appear to be bound by law to meet often as is usually the case with most other statutory boards.
- (v) the role of the Executive Director is not specified.
- (vi) the current law does not appear to take into account the changing environment in relation to food and nutrition issues.

2.13 Financing of Nutrition Activities

GRZ budgetary allocation for nutrition activities in Zambia has been declining. The mechanism by which the NFNC is funded through the MOH/CBoH has created further problems. These funds are not channeled directly to NFNC making it difficult to undertake the planned activities.

2.14 Monitoring and Evaluation

Data for monitoring and evaluation of the food and nutrition situation and programme implementation in the country is generated from a number of sources. The data obtained through the routine health system such as the NNSP (HMIS) is supplemented by periodic household based surveys undertaken principally by the CSO, the NFNC and other research institutions and organizations. However, the lack of a central national nutrition data bank, lack of coordination of information generation and inadequate analytical capacity renders monitoring and evaluation activities difficult.

3.0 VISION

The vision of the National Food and Nutrition Policy is to achieve optimum nutritional status of the Zambian population.

4.0 PRINCIPAL GOAL

The principal goal of the National Food and Nutrition Policy is to achieve sustainable food and nutrition security and to eliminate all forms of malnutrition in order to have a well-nourished and healthy population that can effectively contribute to national economic development.

5.0 POLICY OBJECTIVES

- a. To develop and implement policies and programmes that will ensure adequate nutrition, food security, food quality and safety at individual, household, community and national level.
- b. To promote and establish programmes aimed at providing quality nutrition care.
- c. To incorporate nutrition issues into developmental programmes.
- d. To monitor and evaluate all nutrition interventions.

5.1 Guiding principles

The guiding principles for this policy are;

- a. National Food & Nutrition Commission Act of Parliament of 1967 that mandates the Commission to advise on the issues of food and nutrition.
- b. Government reaffirms that equity of access to food and nutrition is a basic human right.
- c. Government realizes that its citizens have a right to adequate and safe food supply.

- d. Nutrition is a cross cutting issue and requires multi-sectoral intervention.
- e. Government's commitment to address the current food and nutrition crisis in the country.

6.0 POLICY MEASURES

6.1 Elimination of all forms of Malnutrition

In order to eliminate all forms of malnutrition, the Government shall;

- a. Create enabling environment for women to breastfeed optimally.
- b. Support appropriate infant and young child feeding practices.
- c. Support and promote micronutrient supplementation and fortification programmes.
- d. Support growth monitoring and promotion strategy as a tool for early detection of growth faltering in children.
- e. Facilitate capacity building in detection and management of malnutrition.
- f. Support appropriate feeding practices for school children and adolescents.
- g. Create awareness in changing behaviours for food and nutrition improvements.

6.2 Food Security

In order to ensure that households and individuals have access to a sufficient quality and quantity of foods, the government will:

- a. Promote increased food diversification, production, processing, storage and consumption.

- b. Promote utilization of all available food resources for improvement of nutrition status.
- c. Support and promote micronutrient supplementation and food fortification programmes.
- d. Set minimum living wage package for all persons in employment to enable them afford nutritionally adequate food basket.
- e. Formulate and support clear policies to guide and control the informally traded food sector.

6.3 Care for the nutritionally vulnerable

In order to ensure that the nutritionally vulnerable sectors of the population are adequately catered for, the government will:

- a. Facilitate access to adequate food through enhancing the marketing and distribution networks.
- b. Support programmes aimed at reducing the work burden for women.
- c. Support community based programmes to reduce the economic burden on families arising from economic hardships (safety net).
- d. Support programmes that enhance the capacity of disabled persons to improve their livelihood without increasing their dependence on assistance.

6.4 Gender and nutrition

In order to reduce the severity of the disadvantages and discrimination experienced by women, the government will:

- a. Support use of BCC in advancing the nutrition cause for positive behaviour change.
- b. Create enabling environment for women to acquire productive assets such as land, loans, etc
- c. Provide facilities for women to access information on food and nutrition.

6.5 Nutrition, health and the environment

In order to improve equity of access to health services, the government will;

- a. Support programmes aimed at promoting healthy lifestyles and health eating habits for all.
- b. Facilitate employment of appropriate personnel for the task at hand.
- c. Strengthen and support enforcement of the food and drug legislation.
- d. Facilitate employment and strengthen capacity of personnel in the area of nutrition, health and environment.

6.6 Nutrition and HIV/AIDS

In order for PLWHA to live positively, to be productive and stay emotionally and physically healthy, government shall:

- a. Strengthen nutritional care and support for people living with HIV/AIDS.
- b. Provide guidance on dietary recommendations for PLWHA.
- c. Provide guidance on feeding recommendations for infants and children regardless of HIV status.
- d. Provide guidance on nutritional issues associated with modern and traditional therapies.

6.7 Training and capacity building

In order to enhance effective and efficiency performance for the human resource in the field of food and nutrition, the government will;

- a. Facilitate establishment of degree programmes in food and nutrition at the University of Zambia and / or other institutions of higher learning.
- b. Strengthen the food and nutrition component of curricula in

the formal and informal education sector and other relevant training institutions.

- c. Support capacity building for community based organisations in food and nutrition issues.
- d. Promote human resource development in the formal and informal sector in food and nutrition.
- e. Strengthen networking among stakeholders.

6.8 Research and Surveillance

In order to address the increasing incidence of nutrition related diseases and nutrition implication of HIV/AIDS pandemic, government shall;

- a. Prioritise and facilitate relevant applied and basic food and nutritional research.
- b. Strengthen research collaboration between NFNC and other research institutions.
- c. Support food and nutrition research and surveillance activities.
- d. Build capacity to enhance data collection, analysis, report writing, interpretation and use of data in intervention programme design.
- e. Support and facilitate the development of food and nutrition data bases.

9.9 Emergency Preparedness and mitigation

To cope with nutrition emergencies, the government shall;

- a. Strengthen existing or establish new institutions to deal with food and nutrition emergencies.
- b. Facilitate establishment of food and nutrition guidelines for use in emergency situations.

6.10 Institutional Framework

In order to ensure that there is proper co-ordination and adequate capacity to undertake nutrition programmes, government shall;

- a. Strengthen the NFNC institutional framework to enable it establish strong linkages with other relevant sector ministries and collaborating partners.
- b. Amend the NFNC Act in order respond to the demands of emerging nutrition issues.
- c. Amend the National Food and Nutrition Commission Act in order to empower the NFNC to create any other bodies as may deem necessary for the promotion of food and nutrition activities.
- d. Empower NFNC to adapt to relevant strategic institutional arrangements as they deem necessary.
- e. Strengthen existing and establish new structures for undertaking nutrition activities at national, provincial, district and community levels; including the private sector.
- f. Strengthen partnerships and promote collaboration amongst all stakeholders at national, provincial, district and community levels.
- g. Establish a national food and nutrition steering committee to coordinate nutrition activities at all levels.

6.11 Legal Framework

To ensure that issues of nutrition are properly addressed, the government shall revise, update and harmonise the existing acts that relate to food and nutrition. These include the following

- a. The Food and Drugs Act CAP 303, the Public Health Act 195, National Health Services Act, Bureau of Standards Act, Importation Act, Education Acts, Agriculture Acts and any other relevant Acts as may apply.

- b. Create and enact new legislation in areas that have not been covered.

6.12 Financing of Nutrition Activities

In order to ensure that food and nutrition activities are adequately coordinated and implemented, government shall;

- a. Mobilize and directly allocate resources to the NFNC to enable it carry out its mandate.
- b. Provide financial support for capacity building at NFNC and related institutions.
- c. Support and strengthen other key stakeholders involved in nutrition activities.

6.13 Implementation

The implementation of the national food and nutrition policy will be operationalised through the national food and nutrition strategic plan that will be reviewed and updated in line with the national strategic plans.

The implementation plan and cost is as per attached schedule of implementation.

6.14 Monitoring and Evaluation

Relevant benchmarks and indicators will be developed by NFNC in conjunction with participating institutions that will be used to measure the progress of implementation of the provision of this policy and will be incorporated in the strategic plan.

Government shall Support data collection, analysis dissemination of nutritional survey and surveillance results.

