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**FOOD AND NUTRITION  
ACTIVITIES IN ERITREA**

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Tina G. Sanghvi

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## ACRONYMS

ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BF	Breastfeeding
BFHI	Baby Friendly Hospitals Initiative
CA	Cooperating Agency
CDD	Control of Diarrheal Diseases
CF	Complementary Feeding
DHS	Demographic and Health Survey
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
FP	Family Planning
GTZ	German Assistance Agency
HQ	Headquarters
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
KAP	Knowledge, Attitudes and Practices
MICS	Multiple Indicators Cluster Survey
MOH	Ministry of Health
NGO	Nongovernmental Organization
OMNI	Opportunities for Micronutrients Initiative
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PVO	Private Voluntary Organization
RP	Results Package
SO	Strategic Objectives
TDY	Temporary Duty
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## OBJECTIVES

The objectives of this technical assistance TDY were as follows:

1. To revise the draft *PHC Policy Guidelines* on food and nutrition; and,
2. To develop a framework for a five-year action plan for maternal and child nutrition.

## ACTIVITIES

The author worked with guidance from Dr. Mismay, PHC Director/MOH, on this project. The following activities were undertaken:

1. Worked with Dr. Zewdie Woldie-Gebriel, World Vision consultant, to review the national *PHC Policy Guidelines*, developed by an MOH-led task force.
2. Conducted discussions with:
  - MOH: EPI unit, community health and IEC officials;
  - Ministry of Industry (Mr. Sengal);
  - Ministry of Agriculture (Mr. Bereket, Mr. Haile Avalom, Ms. Mebrat Abraham);
  - Ministry of Local Government;
  - Ministry of Information;
  - Representative of Women's Union;
  - Representative of Youth Associations;
  - World Vision (Dr. Joe Siegel);
  - UNICEF (Dr. Ndombe, Mr. Yemane, Sister Ariam, Dr. Paul Fife); and,
  - FAO (Dr. Winston Phillips).
3. Reviewed the following documents:
  - Draft *Food and Nutrition Policy Guidelines*, Ministry of Health Task Force, August 1996
  - *Primary Health Care Policy Guidelines*, Ministry of Health, May 1996;
  - *Eritrea Food Security Policy*, ERRA;
  - *Towards the Rational Use of Emergency Food Aid in Eritrea: Challenges and Opportunities*, ERRA, January 1995;
  - *Formulation of a National Food Security and Nutrition Program: Report of the Working Session*, Keren, January 23-25, 1996;
  - *National Policy on Breastfeeding and Weaning Practices*, Ministry of Health, July 1996;
  - *Children and Women in Eritrea*, UNICEF, 1994;
  - *UNICEF Program of Cooperation for 1996-2000, Plan of Operations*;
  - BASICS work plan;
  - World Vision micronutrient initiatives;

- OMNI proposal on micronutrients;
  - BFHI plans and annual reports;
  - EPI action plan for 1996; and,
  - Ministry of Agriculture, extension/home economics. Projects.
4. Visited Mendefera hospital (maternity ward, pharmacy, antenatal care and well-baby units) and Project ACORD (rural credit scheme).
  5. Debriefed with USAID, MOH/PHC, UNICEF team and BASICS/HQ. Obtaining staff help for Dr. Mismay to carry out recommended actions was identified as the key next step.

## RESULTS

The results can be found in the appendixes as follows:

1. A revised copy of the policy guidelines is in Appendix A.
2. A draft of the national nutrition action plan is in Appendix B.
3. A memo on nutrition indicators for the USAID Mission's child survival strategy is in Appendix C.
4. An example of a nutrition activities planning tool for zonal health staff is in Appendix D.

## CONCLUSIONS

1. The main accomplishments in nutrition since Liberation in 1991 include:
  - Iodization of more than 75 percent of the salt produced in Eritrea;
  - Supportive breastfeeding policies and practices in 28 of 46 health facilities nationwide; training of 450 provincial workers; provision of education materials in health facilities;
  - Development of progressive national policy guidelines for the two major sectors (food security and PHC/maternal and child nutrition), both aimed at long-term sustained results; and,
  - Securing donor agency commitments and resources for food and nutrition.
2. Key constraints that remain to be addressed include:
  - Shortage of technical and managerial resources to plan and implement activities;
  - Gaps in awareness and understanding among the general public regarding the insidious nature and magnitude of malnutrition and the actions that need to be taken.

- Coordination mechanisms for multisectoral action at central and zonal levels yet to be developed; and,
- Limited information for planning.

3. Recommendations for the five-year maternal and child nutrition strategy:

- The first priority is to build institutional capacity within multiple sectors, especially in agriculture and health.
- Also high priority is strengthening the information base for better planning, targeting and monitoring of progress.
- It is a good time to begin implementation of a small set of focused nutrition interventions in the context of integrated health services.
- In the PHC program, two new initiatives (EPI-Plus and IMCI) offer exceptional opportunities for strengthening maternal and child nutrition services.
- The following will build on the success of BFHI and salt iodization: BFHI will add emphasis on complementary feeding and IDD will initiate actions on vitamin A and iron deficiency.
- Other activities critical to sustained reduction in high levels of malnutrition are targeted food security, women's work and nutritional status, and investing in school-age children.

**APPENDIXES**

**APPENDIX A**  
**POLICY GUIDELINES ON FOOD SECURITY AND NUTRITION**

**POLICY GUIDELINES ON  
FOOD SECURITY AND NUTRITION**

**GOVERNMENT OF THE STATE OF ERITREA  
MINISTRY OF HEALTH  
ASMARA**

**AUGUST, 1996**

## **10. Food Security and Nutrition**

### **1. Introduction**

Investments in food security and nutrition can directly and indirectly address the most fundamental causes and consequences of poverty, ignorance and ill-health. Nutrition improvements are clearly important for human well-being, but they are also investments in economic development through impacts on productivity and educability of future generations. Worldwide evidence also suggests a close association between food insecurity and political instability brought about by unrest in the population. Recent studies indicate that over half of all child mortality results from the interaction of malnutrition and infection. Food security and nutrition are therefore among the top development priorities for Eritrea, especially because the prevalence of malnutrition is among the highest in the world. Causes include inadequate dietary intake, inappropriate maternal and child care, and high disease prevalence and severity. These immediate causes are in turn due to poor access by households to sufficient food, limited health services, and a lack of awareness and support for the needs of women and mothers of young children. Addressing the multiple causality of malnutrition requires concerted action in many sectors, and at many levels - household, community, zonal and national. Regional and international support are also vital. The food and nutrition strategy of Eritrea is to implement coordinated health and agriculture sector interventions aimed at producing sustained nutritional improvements in the long-term.

### **2. Objectives**

- 2.1 To ensure food security in all households and improve the nutritional status of the population, especially women and children.
- 2.2 To eliminate iodine deficiency disorders by 2000.
- 2.3 To virtually eliminate vitamin A deficiency by 2000.
- 2.4 To reduce iron deficiency anemia by one-third by 2000.
- 2.5 To achieve food security at the national level in the coming five years.
- 2.6 To incorporate food and nutrition objectives within health, agriculture, poverty alleviation, education, industry and other sectoral priorities.
- 2.7 To develop and maintain the necessary technical, managerial and institutional capability to accomplish the above objectives.

### **3. Organization**

The Primary Health Care division of the Ministry of Health oversees maternal and child nutrition programs. The Ministries of Agriculture, Industry, and Marine Resources undertake related programs. Other concerned units include ERREC, Macro Policy, Local Government, Ministries of Information and Education. Coordination of a comprehensive national food security and nutrition strategy is to be provided by a multi sectoral council at the ministerial level, and a technical group composed of these and other agencies. It is also expected that similar coordinating bodies will function at the zonal level.

### **4. Program strategies**

4.1 Zonal administrative and sectoral departments will have the responsibility of managing the delivery of services related to food security and nutrition at the zonal and community levels. In addition, central actions will be taken by the respective ministries. In Health, integrated primary health care will be the primary approach for implementing interventions.

#### **4.2 Food security**

The objective of providing food security to the Eritrean population implies access by all people at all times to food that is adequate in calories and micronutrients and safe from contaminants, toxins and other undesirable substances. Per capita calorie needs average 2100 in communities engaged in light work, and 2200 for those engaged in moderately heavy occupations. The following approaches will be followed:

- i) Increasing food production and availability, including improved infrastructure and marketing.
- ii) Creating employment opportunities especially in the non-agricultural sector.
- iii) Establishing strategic food reserves.
- iv) Stabilizing prices.
- v) Providing a safety net for selected, disadvantaged households.

Improved nutrition is an important input to food security. Programs to reduce anemia, such as through supplementation and fortification are expected to raise agricultural productivity significantly. Priority will be given to accelerating physical infrastructure development. This has been shown to play a significant role in opening up food markets and labor/employment markets especially when implemented in chronically food insecure areas. Family planning will be critical for self-sustained food security in Eritrea. With reference to planning “safety net” programs, careful assessments of existing household and community systems will be recommended to avoid displacing them inadvertently.

#### 4.3 Improving the nutritional status of children, pregnant and lactating women

Children and women are the special focus of food and nutrition interventions because of their vulnerability to the range of causal factors and severe consequences of malnutrition. The following approaches will be used:

- i) EPI-plus: delivery of integrated PHC services by EPI workers will include breastfeeding promotion and vitamin A distribution, with possibility of phasing in growth monitoring and other interventions gradually.
- ii) IMCI: the new case management approach that combines ARI, diarrhea, malaria and other diseases - has a strong nutrition counseling component. Rapid institutionalization of this through pre- and in-service training and revised protocols will be supported. The nutrition counseling component that includes both preventive and case management messages, will be promoted at community level through comprehensive IEC strategy.
- iii) Maternal nutrition: iron/folate supplements, promotion of specific nutrition messages adapted to locally available foods and customs, and monitoring of weight gain during pregnancy wherever feasible, will be promoted.
- iv) Growth monitoring: a phased approach will be followed, beginning with systematic development of counseling guidelines to accompany weighing, gradual introduction of weighing with counseling as part of IMCI, then institutionalizing growth monitoring in all fixed facilities, and eventually developing community level growth monitoring when appropriate mothers groups or other entities have begun functioning. Growth monitoring will be encouraged as part of integrated community development to be used for motivating community action. Weight for age is a relatively simple, rapid and sensitive indicator for tracking and promoting improved health and feeding practices.
- v) Supplementary feeding: programs based on food aid are expected to be phased out in five years. Instead, emphasis will be on IEC and counseling by trained community workers, focused on improving local complementary feeding practices based on systematic assessments and formative research in each region. There may, however, be a need for targeted food distribution in a small proportion of selected households to protect nutritional status of children and mothers who cannot benefit from other interventions.

#### 4.4 Elimination and reduction of micronutrient deficiency diseases

The strategy for preventing micronutrient deficiencies will center on increasing the availability and consumption of micronutrient-rich foods. Food production, processing and preservation activities will be part of this strategy. These strategies coupled with nutrition education will correct multiple micronutrient deficiencies with long-term sustainability and in a cost effective way. It will also contribute to people's self reliance. Food fortification is one type of food-based intervention. In recognition of this fact and learning from the experiences of other countries, the Government has already embarked on salt iodization to prevent and control IDD. This endeavor will be fostered and the fortification of other food items with other micronutrients will be assessed for cost-effectiveness and feasibility.

Micronutrient supplementation is regarded as a short-term measure to be used until more sustainable food-based approaches are implemented and become effective. Public health measures provide necessary support for the above approaches. These include the prevention of infections through environmental health programs, such as safe and adequate water supply, sanitation and food hygiene, and others such as immunization, control of endemic diseases and MCH.

Specific strategies are listed below. These will be reviewed after completion of micronutrient assessments:

i) Production and consumption of food is the strategy of choice, through diversification such as horticulture, raising small animal, fish, poultry etc. This needs to be implemented at national level in order to meet food security targets for micronutrients, but also targeted to high risk areas and groups. Extension and marketing education, inputs and establishment of nurseries, for and by youth and women's groups, and schools will be encouraged.

ii) Micronutrient status assessments will be undertaken to fill gaps in understanding the epidemiologic basis for sound policy making i.e. selecting priorities, targeting, identifying causal factors.

iii) Vitamin A supplementation will be the most cost-effective strategy for eliminating vitamin A deficiency in the next 5 to 10 years, following which other interventions such as successful food production, fortification, IEC and PHC strategies may be adequate to protect vitamin A status. For case management of childhood illnesses, vitamin A supplementation will always be needed. Protocols for supplementation are as follows:

**Vitamin A Supplementation in EPI (or EPI Plus)**

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<u>Prevention</u>	<u>When to Give (Age)</u>	<u>Dose</u>	<u>Remarks</u>
<i>Lactating mothers</i>	At delivery or <u>until</u> 8 weeks after delivery ONLY. No supplements after 8 weeks postpartum	200,000 IU one dose	At this time the child is given BCG
<i>Children</i>	During 0-9 mths	(Vitamin A provided through breastmilk)	This should be exclusive for 0-6 mths; with continued breast-feeding and complementary feeding up to 24 months
			At 9 months
		100,000 IU	Child is also given measles immunization and the vitamin A recorded on child's growth chart
	1-6 years old	200,000 IU, one dose every 6 mths	If child reports to clinic, otherwise use community distribution during outreach, and vitamin A recorded on child's growth chart

Treatment\*

For eye signs of clinical VAD  
 Immediately on diagnosis 200,000 IU orally  
 The following day 200,000 IU orally  
 4 weeks later 200,000 IU orally

Treatment of ARI, malnutrition  
 Immediately on diagnosis 200,000 IU orally  
 if child has not received  
 vitamin A during the previous  
 30 days

For measles  
 Immediately on diagnosis 200,000 IU orally  
 The following day 200,000 IU orally

\* For children 6-11 months of age, the dose is 100,000 IU

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iv) Iron supplements will be distributed to all pregnant women. The protocol is as follows:

All pregnant women: One to two daily doses of an iron/folate preparation containing 60 mg. iron per dose. Assuming high levels of anemia (based on high prevalence of infant anemia, infections, number of births, deleterious practices such as blood letting etc), and the impracticality of routine universal testing for anemia screening prior to supplementation is not mandatory at present.

Pregnant women with pale conjunctiva, or hemoglobin below 8 grams (if hemoglobin testing is available): Two daily doses of an iron/folate preparation providing a total of 120 mg. iron per day.

NOTE: Results of recent trials with weekly iron supplementation of pregnant women are expected to be reviewed by WHO in 1997, and if warranted, new protocols will be issued. In addition, a national assessment of anemia prevalence and severity is planned by World Vision and UNICEF during 1997. These events warrant a review of the above iron supplementation protocols in 1997/1998. If prevalence of hookworm is found to be high in some regions, deworming medicine will be added to the anemia control strategies to reduce worm loads. However, it is recognized that environmental sanitation and hygiene education are essential for a comprehensive attack on this problem.

v) Salt is to be iodized at WHO/UNICEF recommended levels. Samples taken from factory, retail and household levels should contain adequate levels.

vi) School children are a priority group for vitamin A and iron supplements. Program guidelines will be developed collaboratively by MOH and Ministry of Education for the delivery of a package of services. School curriculum will include nutrition education on micronutrients, including the promotion of iodized salt, as well as other nutrition topics.

#### 4.5 Improvement of breastfeeding and complementary feeding practices

The following guidelines apply to the promotion of infant feeding practices:

- Exclusive breastfeeding is to be promoted to about 6 months; the routine use of the following are to be discouraged for the first 6 months of life: infant formula, other milk products, cereals, vegetable mixes, juices and baby teas, follow-on milks.

- In health facilities, for babies well enough to be with their mothers in the maternity ward, there are almost no indications for non-breast milk feeds. Exceptions are: infants whose mothers have severe illness (e.g. psychoses, eclampsia or shock); infants with inborn errors of metabolism, infants with acute water loss; infants whose mothers are taking medication which is contraindicated when breastfeeding (cytotoxic drugs, radioactive drugs, and anti-thyroid drugs other than propylthiouracil). Use of cup and spoon instead of bottles is to be encouraged for any non-breastfeeds.

- Newborn infants are not to be given any food or drink after birth (no prelacteal feeding) unless medically indicated.
- Complementary foods are to be introduced at about 6 months, and breastfeeding continued until at least 24 months.
- Fathers are to be encouraged, provided skills and information, and supported to assist mothers in improving their diets, and reducing their workloads particularly during pregnancy and lactation.
- Health workers are prohibited from distributing or selling breast milk substitutes:
  - \* Give no free samples to mothers, their families or health care providers.
  - \* Give no free or low-cost supplies of breast milk substitutes to staff of maternity wards in any health facility.
  - \* Do not encourage unsuitable products such as sweetened condensed milk for babies.
- Publicity by manufacturers of breast milk substitutes and baby foods is prohibited within health facilities:
  - \* Remove posters that advertise formula or baby cereal.
  - \* Refuse to accept free samples, gifts, or leaflets to be given to mothers.
  - \* Refuse to allow free samples etc. to be given to mothers.
  - \* Eliminate teaching of formula use to groups of mothers.
  - \* Eliminate teaching of formula use to health workers at all levels.
- Mothers, pregnant women, family members and communities should be informed about the benefits, and their role in the successful management of breastfeeding.
- Mothers are to be helped to initiate breastfeeding within half-hour, and checked for proper attachment.
- Mothers are to be shown how to breastfeed and how to maintain lactation even if they are separated from their infants.
- Rooming-in is mandatory in all health facilities. Mothers and infants are to stay together everyday, all 24 hours.
- Breastfeeding on demand is to be encouraged i.e. whenever baby desires to breastfeed.
- Breastfeeding support groups are to be established by health staff in collaboration with MOA Home Agents, Women's groups and other community groups; mothers are to be referred to them when discharged from maternities, pediatric clinics, sick child consultations.
- Family members are to be encouraged to supervise and assist all infants and young children to feed adequately, particularly the number of required meals and quantities.

- All health care staff are to be trained in the skills necessary to implement the policy.
- New personnel in the maternity wards are to be trained within six months of employment.
- Any disregard and violations of this policy are to be reported to the Ministry of Health.
- Trained staff of Baby-Friendly facilities in each region are to provide technical assistance to others.
- To ensure relevance of, and feasibility for mothers in practicing feeding guidelines, complementary feeding guidelines will be systematically adapted and tested for each region. This includes ensuring that recommended calories and micronutrients will be consumed by infants and young children.
- Legislation and regulations for maternity leave benefits to protect breastfeeding mothers, and to develop a code of marketing for substitutes will be developed and passed in 1997, to support the above.
- Counseling and IEC on infant feeding is to be integrated into PHC, and support provided to other community workers such as Home Agents (MOA), MMR, Youth and Women's organizations.

#### 4.6 Food quality and safety

The Government, food industries, consumer organizations and communities have a particularly important role to play in improving environmental hygiene, and the quality and safety of food and water. They can provide consumers with information on good food handling practice to prevent food spoilage and contamination. The Ministry of Health and Ministry of Industry will develop standards, specifications, and requirements on the basis of international standards, codes of hygienic practices and other guidelines. Effective testing, certification and labeling regulations will be developed.

#### 4.7 Nutritional surveillance

Information systems that are based on decision-makers' needs, use practical data collection methods, include efficient feedback methods, and use locally relevant indicators, will be developed. The categories of indicators include crop estimates, early warning indicators, anthropometric measures of young children, and food consumption by households, mothers, and young children. These will be collected through appropriate use of sentinel sites, special surveys, and routine service records.

### **5. Treatment of malnutrition**

Treatment protocols developed by WHO and provided in the IMCI materials will be used to complement preventive strategies discussed above for achieving the goals of reduced malnutrition and mortality.

## 6. Monitoring and evaluation

The food and nutrition situation and programs will be monitored using the following approaches as described in greater detail under Chapter 6. Child Health.

- 6.1 The epidemiology of malnutrition.
- 6.2 Measures of program performance at health facilities.
- 6.3 Measures of program performance in communities and households.
- 6.4 Research: operational, epidemiological and economic research will be conducted.

The following core indicators will be used:

- Number of children < 2 yrs. and pregnant women seen at health centers for any reason, in a given month (or on the day of survey), who are weighed, given counseling on feeding, and given micronutrient supplements according to protocols.
- Percent of infants adequately fed: exclusive breastfeeding in the 0-5 month age group; *adequate* complementary (semi-solids) feeding in the 6 - 24 month age group.
- Percent of children 6-59 months receiving vitamin A supplements.
- Percent of pregnant women receiving iron/folate supplements.
- Percent of pregnant women who are anemic.
- Percent of households consuming iodized salt.
- Percent of goitre in children.
- Percent of children 6-35 months of age who are stunted, underweight and wasted.
- Percent of school children in primary grades who are stunted i.e. low height for age, or wasted i.e. low weight for height, if ages cannot be ascertained.

## 7. Collaboration

For the successful implementation of food and nutrition activities, close collaboration is expected within the Ministry of Health divisions and among all the concerned sectors as described under organization above.

**APPENDIX B**

**MATERNAL AND CHILD NUTRITION ACTION PLAN**

**Draft**

***STATE OF ERITREA***

**MATERNAL AND CHILD NUTRITION**

**ACTION PLAN**

**1997 - 2001**

**PRIMARY HEALTH CARE DIVISION  
MINISTRY OF HEALTH  
STATE OF ERITREA  
ASMARA**

**August 1996**

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## Section 1. INTRODUCTION

This document is one of a series of five-year action plans for Primary Health Care<sup>1</sup>. It is intended to guide the prioritization, timely completion, coordination and sound planning of food and nutrition activities in health and related sectors at all levels. The document is to be used for planning zonal-level and central-level food security and nutrition activities, for generating necessary resources from internal and external sources, assuring complementarity and mutual reinforcement of efforts, and integration of nutrition in primary health care services. It is based on the Food Security and Nutrition section of the National PHC Policy Guidelines (MOH, 1996). The emphasis of activities in this initial five-year planning period are:

- \* Building an organizational foundation at central and zonal levels for sustained attention to food and nutrition issues
- \* Developing a better information base for planning
- \* Mobilizing communities and strengthening demand for better nutrition
- \* Implementing a small, focused set of interventions with high impact potential

The following table shows current levels of food and nutrition problems based on the Health and Nutrition Survey (1993), DHS (1995), and UNICEF situational analysis (1994).

**Table 1. Malnutrition in Eritrea**

Indicator	Percent	Comment
Infants and Children:		
Stunted (low height for age)	66	6-59 months, HNS 1993
Wasted (low weight for height)	10	6-59 months, HNS 1993
Underweight (low weight for age)	41	6-59 months, HNS 1993
Inadequate breastfeeding or complementary feeding	61	< 12 months, DHS 1995 and HNS 1993
Vitamin A deficient	NA	Survey planned for 1997
Anemic	55	< 12 months
Goitre	23	9-11 years, HNS 1993
Women and Mothers:		
Anemic	NA	Survey planned for 1997
Malnourished (BMI)	NA	
Low birth weight	13	Based on hospital data

These national estimates do not take into account important differences in the regions. For example, child malnutrition in Sahel and Semhar is estimated to be several times more prevalent

<sup>1</sup>To be revised in 1996-1997 based on zonal plans.

as compared with other regions. This is a reflection of the variability in access to food and basic health care services, and possibly differences in maternal and child care practices. The success of the national food and nutrition strategy will therefore depend upon achievement of high coverage with activities that successfully address these three causal factors while taking into account regional differences. A detailed plan of action for household food security is not provided in this document, it will be developed by agriculture sector experts. This plan of action does, however, refer to some key food policy and program initiatives that have a direct bearing on maternal and child nutrition.

Important steps towards achievement of the goals of food security and improved nutritional status that have already been taken since Liberation in 1991 include:

- Iodization of approximately 75% of the salt produced in Eritrea
- Institution of supportive breastfeeding policies and practices in 28 out of 46 health facilities nationwide, and training of 450 provincial workers
- Development of progressive national policy guidelines for the two major sectors: food security and PHC/maternal and child nutrition, both aimed at long-term sustained results
- Securing of donor agency commitment and resources to address food and nutrition problems

Key problems that remain to be addressed include:

- Shortage of technical and managerial resources to plan and implement activities
- Gaps in awareness and understanding among the general public regarding the insidious nature and magnitude of impacts of malnutrition and actions they need to take.
- Lack of coordination mechanisms at central and zonal levels to ensure appropriate multi sectoral actions for addressing key causal factors of food insecurity and malnutrition
- Limited information for planning

## **Section 2. OBJECTIVES**

The long-term objectives set forth in the national PHC Policy Guidelines (1996) for food and nutrition are:

- To improve the nutritional status of the population, especially women and children, and ensure food security in all households.
- To eliminate iodine deficiency disorders by 2000.
- To virtually eliminate vitamin A deficiency by 2000.
- To reduce iron deficiency anemia by one-third by 2000.
- To achieve food security at the national level in the coming five years.
- To incorporate food and nutrition objectives within health, agriculture, poverty alleviation, education, industry and other sectoral priorities.
- To develop and maintain the necessary technical, managerial and institutional capability to accomplish the above objectives.

The **program implementation objectives** for 1997-2001 are:

At the **central** level:

- To build an inter-sectoral organizational framework for ministerial, technical, and administrative actions related to food and nutrition issues
- To incorporate sound food and nutrition objectives as an integral part of health, agriculture, poverty alleviation, education, industry and other sectoral policies and plans, at the central and zonal levels
- To incorporate breastfeeding, complementary feeding, maternal dietary guidelines, and micronutrients content in the curriculum of physicians, nurses, PHC workers and TBAs by 1998
- To complete national surveys of vitamin A deficiency, iron deficiency anemia, goitre and IDD, infants feeding practices, diet during pregnancy, and nutritional status of children and women, that can be disaggregated by region, by 1998
- To ensure that 90% of households are consuming adequately iodized salt by 1998
- To provide ongoing in-service training to agricultural extension workers, staff of the Ministry of Marine Resources, youth and women's associations, school teachers and other community-level workers
  - To develop and maintain an adequate surveillance and response system for areas at high risk of severe food shortages
- To develop a safety net program for households unable to secure access to adequate food or social services through market mechanisms

**At zonal or regional level:**

- To conduct inter-sectoral planning workshops at the zonal level at least once annually starting in 1997
- To conduct nutrition advocacy workshops at least once annually starting in 1997
- To conduct at least one IEC campaign annually including mass media, print materials and interpersonal approaches on food security and nutrition topics, starting in 1997
- To complete region-specific food and nutrition situational analyses and five-year action plans by 1998
  - To establish a system for on-time service coverage and quality, and nutritional surveillance reports from all health units beginning in 1998
  - To establish a supervisory system for health facilities with standardized supervisory tools, and conduct supervisory visits at least twice a year at all levels, beginning in 1998
  - To incorporate a minimum package of school nutrition services consisting of, for example, vitamin A and iron supplements, de-worming, annual height census and nutrition education in at least 75% of primary schools by 1998
  - To provide integrated nutrition services in 90% of health facilities by 2000
  - To increase coverage of children 6 months to 6 years receiving at least 2 doses of vitamin A supplementation per year to 75% by 2000
  - To increase coverage of pregnant women receiving iron/folate supplements to 75% by 2000
  - To establish mechanisms for providing locally adapted, infant and maternal dietary counseling in at least 75% of the communities within each zone by 2000
  - To conduct at least two outreach visits per year to support nutrition activities at community level, in at least 50% of communities within the catchment area of each health facility, by 2000

Program strategies used to reach the above objectives and relevant protocols are provided in Chapter 10 of the Policy Guidelines (MOH, 1996).

### **Section 3. ORGANIZATIONAL FRAMEWORK AND CAPACITY BUILDING**

To develop a foundation for sustained, long-term impacts on food security and nutrition, the strategy is to develop a strong and efficient organizational structure that responds to specific program and policy needs in this area. Training and other motivational activities will be emphasized, teamwork and coordination will be given preference, bureaucracy will be kept to a minimum, delegation of responsibility with accountability will be encouraged, and appropriate actions will be taken to ensure quality in management.

#### **3.1 National Council of Ministers for Food Security and Nutrition (FSN)**

A cabinet-level inter-sectoral body was recommended at the Working Session on the Formulation of Food Security and Nutrition Policy, Keren (January 1996). It is proposed to be composed of MOA, MOH, Ministry of Education, Ministry of Marine Resources, with representatives from Macro Policy, ERREC, the Grain Board and others. Such an entity is expected to be formed by decree during 1996-1997.

#### **3.2 Intersectoral Coordinating Committees and Specialized Task Forces**

While the cabinet-level Council on FSN noted above will meet periodically on policy and legislative issues, the day to day planning, coordination and technical referee functions will be performed by the multi-sectoral technical body identified below:

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<b>Food Security and Nutrition Coordinating Committee</b>	
Department of Macro Policy	
(Secretary)	
Ministry of Agriculture (Co- Chairman)	Ministry of Health (Co- Chairman)
<u>Members:</u> Min. Industry, Min. Ed., Min. Info., Min. Marine Resources, ERREC, Min. Local Govt., Women's Union, Youth Assoc., CSO (Macro Policy), Standards Inst., Grain Board, WRD, Univ. Asmara and others.	
<u>Observers:</u> FAO, UNICEF, WHO, USAID, GTZ, World Vision, IEF, Catholic Church Bishop, other religious leaders, salt producers, wheat millers and others.	

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One of the first tasks of this committee will to undertake a comprehensive planning exercise to develop the first national Food Security and Nutrition Strategy as described in Table 2.

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**Table 2. Development of a National Food Security and Nutrition Strategy for 1998-2002**

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1. Formation of:

a) Ministerial Council for Food Security and Nutrition;

9/96

b) National Food Security and Nutrition  
Coordinating Committee. (Per recommendations from the  
Keren workshop and PHC Policy Guidelines)

- |   |            |
|---|------------|
| 2. Formation of specialized task forces and development of sub-strategies   | 10/96-2/97 |
| - Food Security Task Force  |            |
| - Micronutrient Task Force<br>(presently IDD Task Force)  |            |
| - Infant Feeding & Maternal Nutrition<br>Task Force (presently BFHI Task Force)   |            |
| 3. Formation of decentralized, multi sectoral Zonal Food Security and Nutrition Coordinating Committees and zonal planning for FSN                            | 3/97-8/97  |
| 4. First national workshop to draft a multi sectoral National Food Security and Nutrition Strategy  | 8/97       |
| 5. Second national workshop to synthesize regional action plans, and central plans into a draft National Food Security and Nutrition Strategy and Action Plan | 11/97      |
| 6. Broad community-wide discussion of the implications of the proposed national plan for all segments of society, revisions and finalization.                 | 12/97      |
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At the zonal level, the following multi sectoral food security and nutrition committee will be formed:

Ministry of Local Govt. (Coordinator)	
Ministry of Agriculture (Co-Chairman)	Ministry of Health (Co-Chairman)

Members: Ministry of Industry, Ministry of Education, Ministry of Information, Ministry of Marine Resources, ERREC, Ministry of Local Government, Women's Union, Youth Associations, and others.

The mandate of the zonal FSN committee will be to:

- Conduct a regional situational analysis and develop a five-year FSN plan, and annual workplans to implement national policy guidelines as locally relevant.
- Prepare budgets, estimate and procure equipment and supplies, train staff, obtain technical support from central entities.
- Assign responsibility for implementation of key actions.
- Review progress in meeting zonal targets.

### 3.3 Capacity Building for Program Planning & Implementation

Table 3. summarizes activities currently planned for building capacity to meet the specified objectives. There is also a need for a "manpower assessment" after the proposed multi sectoral food security and nutrition plan of action is developed in 1997, and the full magnitude and nature of activities are identified. At that time the remaining gaps in staffing and training needs will become clearer. For example, the current plans do not include training in food policy analysis, cost-effectiveness analysis etc.

**Table 3. Nutrition Training Activities**

Type of training	Main focus	Schedule	Assistance
Long-term, external; 2 masters degree, 5 diploma, and study tours	Nutrition	1997-1999	World Vision
In-country, for Min.Health PHC staff (MOH)	Operational aspects of counseling on infant feeding micronutrients, maternal nutrition, referral and treatment of severely malnourished	1997	USAID/ BASICS
College of Health Sciences curriculum (University, MOH)	Above, plus in-depth technical basis, planning and supervision	1996-1998	USAID/ BASICS
In-service, staff of remaining BFHI facilities (MOH)	Baby-Friendly Hospitals Initiative	1997	UNICEF
In-service, for salt producers (MOH, MOTI)	Quality control and laboratory procedures	1997-1998	USAID/ OMNI
Long-term, 2 staff ; plus short-term (MOH, Min, Ed., Min. Info.)	IEC	1997-1998	World Vision USAID/ OMNI & BASICS
In-service, Home Agents and extension agents of MMR (MOA, MOH)	Extension services including maternal nutrition & infant feeding practices	Ongoing, annual	UNICEF, Manitesse Milano & others
In-country, for health workers (MOH)	IEC, interpersonal counseling skills	1997-1998	USAID/ BASICS

In addition, on-the-job training will be ongoing through participation in activities such as micronutrient assessments (e.g. World Vision, baseline survey), formative research to develop messages (BASICS, Food Box adaptation for IMCI), and others.

### Section 4. MATERNAL AND CHILD NUTRITION

The main focus of the strategy is to deliver integrated primary health and nutrition care to the Eritrean population. In addition, MOH will develop and implement in collaboration with other sectors, key program and policy initiatives in bringing about society-wide improvements in

maternal nutrition and child feeding practices, in micronutrient status, and in school health and nutrition.

#### 4.1 INTEGRATED PRIMARY HEALTH CARE ACTIVITIES

##### 4.1.a EPI plus

Because of the expected high coverage of the EPI program, and the common approaches needed for achieving both nutrition and EPI objectives (i.e. outreach), this is a critically important initiative for Eritrea. It is expected that at each outreach to communities within their catchment area, EPI staff will provide vitamin A supplements according to the protocols in the Policy Guidelines. In addition, EPI staff will actively promote and counsel mothers on exclusive breastfeeding. This includes messages on the importance of not introducing liquids, water or supplements to infants prior to 6 months of age, increasing the frequency of feeds, referral for feeding problems etc. The EPI schedule of immunizing at 6, 10 and 14 weeks is particularly convenient for promoting exclusive breastfeeding because during this period many mothers erroneously perceive a need to start liquids, instead of increasing their milk supply.

**Table 4. Nutrition Components of EPI Plus Activities**

Activity	Agency	Schedule	Assistance
Development of sections on vitamin A capsules and breastfeeding in the EPI manual	MOH/EPI, BFHI	1996-1997	UNICEF
Micro planning for nutrition components as part of EPI	MOH	1997	UNICEF, World Vision, USAID/OMNI
Monitoring and assessments to determine progress in integrating nutrition with EPI	MOH	1998, 2000	UNICEF, USAID/OMNI & BASICS

##### 4.1.b Integrated Management of Childhood Illnesses (IMCI)

The Integrated Management of Childhood Illnesses (IMCI) initiative of WHO includes an important component on counseling mothers or caretakers about nutrition and feeding of young children. For every child under 2 years of age, who is seen by a health worker trained in IMCI, the worker is expected to assess the child's nutritional status and feeding practices, and counsel the mother on breastfeeding and complementary feeding. The development of the counseling guidelines involves formative research on feeding practices. The guidelines can also be used in IEC activities to promote improved infant feeding practices through radio and print materials, and by community workers from non-health sectors. The focus of the five-year plan is to develop the counseling guidelines adapted to each zone, implement IEC activities for broad

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dissemination of key messages, and monitor the quality of counseling at health facilities and in communities.

**Table 5. Nutrition Components of IMCI**

Activity	Agency	Schedule	Assistance
Formative research on infant feeding practices to develop guidelines	MOH, MOA, Univ. Asmara	1997	USAID/BASICS
Adaptation of the IMCI "Food Box"	MOH, MOA, Univ. Asmara	1997	USAID/BASICS
IEC activities for broader dissemination	MOH, MOA, MMR	1997-2001	UNICEF, USAID/BASICS, World Vision
Monitoring the quality of counseling	MOH, MOA, MMR	1998, 2000	USAID/BASICS

#### 4.1.c Safe Motherhood

Maternal nutrition is the foundation of infant and child nutrition. Indirect evidence points to the urgency of incorporating maternal health and nutrition actions as part of integrated primary health care in Eritrea. The Safe Motherhood workshop in October 1996 is expected to identify a comprehensive program package for implementation in the next five years. This will contain a strong nutrition component. The priorities for improving maternal nutrition are: expanded coverage with iron/folate supplements, dietary counseling for pregnancy and lactation, increasing support from community and family members to reduce workloads and improve diets, development of essential breastfeeding skills, vitamin A supplementation within 8 weeks postpartum, and where feasible frequent monitoring of weight gain during pregnancy.

**Table 6. Nutrition Components of Safe Motherhood**

Activity	Agency	Schedule	Assistance
Discussion of nutrition components at national Safe Motherhood workshop	MOH	Oct. 1996	USAID/SEATS
Development of program guidelines and education/training materials	MOH	1997	UNICEF, USAID/SEATS & OMNI
Micro planning, procurement of supplies and training	MOH	1997- 2001	UNICEF, USAID/SEATS & OMNI
Assessments and monitoring of successful integration within PHC	MOH	1998, 2000	

## 4.2 MICRONUTRIENTS

Micronutrient deficiencies are among the most widespread of nutritional problems globally and in Eritrea as well. They are also among the most easily remediable. Therefore, considering the logistical and human resource constraints in the country, special emphasis is being placed on alleviating micronutrient deficiencies. During the 1997-2001 plan period, emphasis will shift from getting the salt iodization program started to initiating interventions related to vitamin A and iron, while working on quality control and monitoring of iodized salt.

### 4.2.a Iodine Deficiency Disorders

The program for iodization of salt has achieved high coverage with over 75 percent of households in Eritrea estimated to be consuming iodized salt. The remaining issues are: whether domestically produced salt is adequately iodized at the point of consumption, the success of private small-scale producers in Assab in maintaining quality standards, and extent to which uniodized salt from neighboring countries is a threat to meeting the goal of eliminating IDD by 2000. These concerns mean that emphasis must be placed on improved quality control and monitoring, and taking action if remaining pockets of IDD are found.

**Table 7. Control of Iodine Deficiency Disorders**

Activity	Agency	Schedule	Assistance
Monitoring and quality control systems developed and implemented at: factory, retail and household levels	Ministry of Industry, MOH	1997-2001	UNICEF, USAID/OMNI, World Vision
IEC for demand creation	MOH, Ministry of Industry	1997-2001	UNICEF, USAID/OMNI
KAP surveys every 2 years on consumption of iodized salt	MOH, Ministry of Industry	1997, 1999, 2001	UNICEF, USAID/OMNI, World Vision
IDD prevalence assessment after evidence of acceptable iodine levels in salt	MOH, Ministry of Industry	1997, 1999, 2001	UNICEF, USAID/OMNI, World Vision
Training and supervision of small-scale producers	UNICEF, USAID/OMNI	Ongoing	USAID/OMNI, UNICEF, World Vision

#### **4.2.b Vitamin A Deficiency**

The priority during this plan period is the establishment of high-coverage vitamin A supplementation, identification of cost-effective food-based strategies to replace supplementation, introduction of micronutrient components into PHC curricula and IEC for demand creation. See Table 8.

#### **4.2.c Iron Deficiency**

Activities for the control of iron deficiency anemia are similar to those for vitamin A deficiency as shown in Table 8. Iron/folate supplements for pregnant women and wheat flour fortification are priority actions. In addition, interventions aimed at reducing blood loss due to hookworm and deleterious practices such as blood-letting, will be investigated and appropriate actions taken.

**Table 8. Control of Vitamin A Deficiency**

Activity	Agency	Schedule	Assistance
Zonal planning for vitamin A (and iron) distribution	MOH	1996	UNICEF, USAID/BASICS & OMNI
Review and strengthen procurement and distribution system for vitamin A (and iron supplements) supplies to cover all facilities	MOH	1997-2001	UNICEF, World Vision
Development of training curriculum for vitamin A (and iron) supplements and dietary guidelines	MOH	1997-1998	USAID/OMNI
In-service training of EPI and other health staff in vitamin A (and iron) supplementation protocols and dietary counseling.	MOH	Ongoing	USAID/OMNI, World Vision
IEC to support vitamin A (and iron) interventions	MOH, Min. Ed., Min. Info., other	Ongoing	USAID/OMNI & BASICS, UNICEF, World Vision
Identification of food vehicles for vitamin A (and other micronutrients) fortification	Wheat millers, MOH	1996-1997	World Vision
Assessment of vitamin A (and iron) status	MOH	1997, 2001	World Vision, UNICEF
Coverage survey on vitamin A (and iron) supplementation	MOH	1998, 2000	USAID/OMNI, UNICEF, World Vision

#### **4.3 BREASTFEEDING AND COMPLEMENTARY FEEDING**

Building upon the successful introduction of the Baby Friendly Hospitals Initiative, the plan is to complete certification of all remaining targeted facilities. By 1996, 28 out of 46 targeted facilities were certified, the remaining will be followed-up and re-assessed in 1997. In addition, the plan is to extend the initiative of breastfeeding promotion to communities using the resources of health and other sectors. The strategy also includes development of detailed, region-specific guidelines on complementary feeding using formative research and household trials to identify

most relevant messages. These guidelines will be used by health and other community workers. A comprehensive IEC strategy will focus on behavior change for improved child feeding. Steps to ensure sustainability include: curriculum reform for all levels of health staff, and supportive legislative actions.

**Table 9. Promotion of Breastfeeding and Complementary Feeding**

Activity	Agency	Schedule	Assistance
Training workshops on BFHI	MOH	Ongoing until all facilities are certified	UNICEF
Production and distribution of educational materials	MOH, Women's Union, MMR, other community organizations	Ongoing	UNICEF, USAID/BASICS
Development and implementation of a comprehensive IEC strategy for infant feeding	MOH, Women's Union, MMR	Ongoing	USAID/BASICS
BFHI assessments	MOH	Ongoing until all facilities are certified	UNICEF
Production and distribution of processed weaning food DMK for returnees and refugees	Ministry of Industry, MOH, MOA	Ongoing	World Vision
Development and introduction of curriculum on infant feeding for community-level workers and their supervisors	MOH, MOA (Home Agents program), MMR, and other community organizations	1997-2001	USAID/BASICS, other donors
Community-based, integrated nutrition (triple A model) in 3 regions	MOH, MOA, Women's groups, Local Govt.	1997-2001	UNICEF
Growth monitoring and feeding demonstration equipment for all health facilities	MOH	1998-2001	UNICEF
Maternity Leave legislation passed	Women's Union, Min. Justice, MOH	1997-1998	UNICEF
Training, implementing Marketing Code	MOH, Min. Industry, other	1996-1997	UNICEF

#### 4.4 SCHOOL NUTRITION AND HEALTH

Young school-age children are both vulnerable to nutritional deficiencies and an important target group for IEC activities. Development of sound nutrition principles and practices is both possible and important in this age group for bringing about sustained nutritional improvements. Approximately 50 percent of school-age children in Eritrea are enrolled in schools. The focus of this five-year plan will be to initiate a small set of interventions in a phased manner, eventually covering all schools. Key concepts and messages on nutrition and health education will be built into teacher training and student curricula. Annual height census data from primary schools can be used for tracking national and zonal nutrition trends, and for improved targeting of social services. The feasibility of routinely assessing height for age (or if ages are difficult to ascertain, weight for height) will be determined in collaboration with the Ministry of Education.

**Table 10. Activities to Support School Nutrition and Health**

Activity	Agency	Schedule	Assistance
Development of central and zonal plans to introduce vitamin A, iron supplements and nutrition education	Min. Ed., MOA	1997-1998	
Procurement and distribution of supplies	MOH, Min. Ed.	1997-2001	
Production and distribution of education materials for schools	MOH, Min.Ed.	1997-2001	
In-service and pre-service training of teachers	Min. Ed., MOA, MOH	1997-2001	
Development of food production activities, nurseries, school gardens etc.	MOA, Min. Ed.	1997-2001	UNICEF

## **Section 5. FOOD SECURITY AND RELATED STRATEGIES**

Food security is a major obstacle to resolving the malnutrition problem. Factors affecting food security range from pricing and credit policies, to physical infrastructure development, agricultural production and marketing policies, refugee and relief actions, effectiveness of early warning and response systems, safety net programs, food distribution, public works, employment generation and others. Work on the development of a comprehensive plan of action began in January 1996 with a workshop supported by FAO in Keren. A study and review undertaken by the Ministry of Agriculture under the Wartorn Societies Project of the UN is developing recommendations on priority actions as well. The design of a food security surveillance and early warning system is expected to be initiated in 1996-1997. It is also expected that further delineation of a plan of action on these issues will be forthcoming in 1997 under the leadership of the Ministry of Agriculture. The MOH will collaborate with MOA in designing appropriate elements of a comprehensive strategy that successfully address institutional and policy constraints as well as programmatic interventions.

## **Section 6. RESEARCH, ANALYSIS AND DEVELOPMENT OF NEW APPROACHES**

The focus of this initial five-year plan is the development of institutional capability in research and analysis, while initiating the application of proven interventions as described in the previous sections. Activities listed in Table 11 are aimed at providing important program and policy information, while developing experience in conducting investigations relevant for food security and nutritional issues.

## **Section 7. TRACKING PROGRESS IN IMPLEMENTING THE ACTION PLAN**

Activities listed in Table 12 are expected to provide ongoing information on progress towards achieving the objectives noted in Section 2 of this document. Additional activities and their specifications will follow the more detailed development of programs. The multi-sectoral task forces and committees described in Section 3 above, will periodically review this information and provide guidance on mid-course corrections as well as the development of new activities.

**Table 11. Research, Analysis and Development of New Approaches**

Activity	Agency	Schedule	Assistance
Research on infant feeding, maternal malnutrition, women's work in different ethnic groups	Univ. Asmara, Women's Union	1998-2001	
Development of a package of interventions to improve the nutritional status of women, based on pilot programs	Univ. Asmara, Women's Union, MOA	1998-2001	
Development of strategies for mobilizing community action against malnutrition	Univ. Asmara, MOH	1998-2001	
Development and testing of food fortification options	Univ. Asmara, private industry	1998-2001	
Assessment of existing safety nets in high risk groups	To be identified	To be identified	
Development of eligibility criteria for safety net programs	To be identified	To be identified	
Cost-effectiveness analysis of alternative food security & nutrition programs	Univ. Asmara, Dept. Macro Policy	1998-2001	

**Table 12. Monitoring and Tracking Progress**

Activity	Agency	Schedule	Assistance
Anthropometric surveys	CSO, MOH, MOA	1998, 2001	
Micronutrient status assessments	MOH, MOA	1997, 1999	World Vision, USAID/OMNI, UNICEF
Surveys of maternal & infant dietary practices	MOH, MOA	1998	
Program coverage surveys	MOH, MOA, Min. Ed.	1998, 2001	
KAP surveys related to IEC activities	MOA, Min. Ed., Min. Info., MOH	1998-2001	
Synthesis of information on indicators related to objectives in Section 2.	Inter-sectoral coordinating committees at central and zonal levels	1998, 2000	UNICEF, USAID/BASICS & OMNI, World Vision
Routine analysis of HMIS data	MOH	1997-2001	BASICS/MOH

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1. Draft Food and Nutrition Policy Guidelines, PHC Division, Ministry of Health, August 1996
2. Primary Health Care Policy Guidelines, Ministry of Health, May 1996
3. Eritrea Food Security Policy, ERRA
4. Towards the Rational Use of Emergency Food Aid in Eritrea: Challenges and Opportunities, ERRA, January 1995.
5. Formulation of a National Food Security and Nutrition Program: Report of the Working Session, Keren, January 23-25 1996.
6. National Policy on Breastfeeding and Weaning Practices, Ministry of Health, July 1996.
7. National Salt Iodization Plan, IDD Task Force, 1995
8. Children and Women in Eritrea, UNICEF, 1994
9. UNICEF Program of Cooperation for 1996-2000, Plan of Operation, September 1994.
10. Health Profile 1995/1996, Eritrea. Planning and Programming Bureau, MOH.

**APPENDIX C**  
**LETTER TO USAID/ERITREA**

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To: Judith and Steve at USAID/PHN/Eritrea  
From: Tina Sanghvi at BASICS/Nutrition  
Date: Aug. 26, 1996  
Subject: USAID Strategy/Results Indicators Related to Nutrition

The following suggestions are consistent with parameters set by USAID/Eritrea's investments in nutrition within the micronutrient (OMNI) and BASICS activities, and also compatible with program emphasis and indicators used by other donors, and national PHC policy guidelines. I have used whatever data are available, and suggested best guess estimates for others.

As we discussed, nutrition indicators have been added at the highest level - I agree they make most sense here. Please note, I have stayed away from a child malnutrition indicator (e.g. stunting or wasting) mainly to remain consistent with the others under PHC access and utilization, and also because other sectoral actions are implied (ag., food security and economic policy). Nevertheless, if it is important from your viewpoint (maybe to reflect that USAID is in fact working across all relevant sectors), we could adopt UNICEF's "one-third reduction in child malnutrition by 2000".

The following additional one is recommended at the intermediate results level, under 4.2: Fully integrated PHC services ....

**Indicator:** Increased number of children (< 2 yrs.) and pregnant women seen at health centers that day who are weighed, given counseling on feeding, and given micronutrient supplements according to protocols that day.

**Baseline:** TBE Baseline survey (please make sure the BASICS baseline has the needed questions to construct this one)

**Target:** 75% of children < 2 yrs. and pregnant women seen that day in targeted sites given integrated nutrition services

**Timeframe:** 1998

**Partners:** UNICEF, World Vision

In addition, the assumption underlying the first level indicators and targets is that nutrition components will also be added to 1.2 (curriculum and PHC training) and 2.3 (HMIS). You all at USAID can help monitor how well this integration is occurring. I will highlight this in my report and de-briefings etc., and time-permitting, will try to pull some things together for the respective BASICS advisors.

Please let me know if this is on the right track and if I can do anything more.

### USAID Child Survival Strategy

Narrative Summary	Indicator	Baseline	Target	Time	Partners
Objective:					
Improved access to....					
	Increased utilization of child health interventions and practices	a... b... c... d. <b>39%*</b> infants adequately fed (DHS, 1995, MOH 1993)	70% infants adequately fed	2001	UNICEF, WHO
		e. <5 % children receiving vitamin A supplements (est. 1995)	80% receiving vitamin A supplements	2001	UNICEF, World V., IEF
		f. <5 % pop. consuming iodized salt (est. 1993) - 23% goitre in children (MOH, 1993)	-90% consuming adequately iodized salt -<5 % goitre in children	1997 1998	UNICEF, World Vision
	Increased utilization of reproductive health services	a... b... c... d. <25 % of pregnant women receiving iron/folate supplements	75 % of pregnant women receiving iron/folate supplements	2001	UNICEF, World Vision

\* See next page for calculations for estimated % infants adequately fed.

\*Calculations for Estimating % of Infants with Adequate/recommended Feeding Practices

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Source:	Exclusively BF			Given solid/mushy food (complementary food)		Quality of complementary food adequate	
	DHS 1995			DHS 1995		UNICEF 1994 from Health & Nutrition Survey 1993	
Age (mo.)	no.	%	no.	%	no.	%	no.
0-3	313	65	203				
4-6	214	40	86				
7-9	213			54	115	30	34
10-12	200			71	142	30	43
Subtotal	940						
No. adequately fed	289					77	

Of total surveyed = 940 infants ,  
adequately fed = 289+77 = 366 infants,  
% adequately fed = 366/940 = **38.9%**

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**APPENDIX D**

**EPI EXAMPLE**

*EXAMPLE: Adapted from EPI Unit/MOH*

Maternal and Child Nutrition Planning for the Zone of \_\_\_\_\_ Date \_\_\_\_\_ 1996  
 Objectives for the Period.....1997

1	To have all facilities provide daily integrated nutrition services	5	To provide two doses of vitamin A to children and distribute iron supplements to pregnant women
2	To have all static sites perform at least one outreach per month. health centers at least two outreaches per month	6	To conduct a nutrition advocacy workshop
3	To supervise all health facilities at least once, by Provincial Medical Officer, PHC Coordinator and Baby Friendly Hospital Staff	7	To participate in one zonal multi-sectoral food and nutrition planning workshop
4	To train health and other community workers in nutrition	8	To conduct one IEC campaign on nutrition

**Summary of Planned Activities with Budget Breakdown**

DESCRIPTION		ESTIMATED BUDGET
SUPPLIES and LOGISTICS		
INCREASING SERVICE DELIVERY AND NUTRITION COVERAGE		
MANAGEMENT MONITORING & SUPERVISION		
IEC/ COMMUNITY MOBILIZATION		
TRAINING	(use separate sheet)	
<b>ESTIMATED TOTAL COSTS (Birr)</b>		