Saharawi Nutrition Strategy

Based on results from a workshop on Saharawi nutrition programme and strategy

May, 2009

This document would be adjusted in two (2) years

Preface

During the last years many surveys and research have shown that nutrition situation for the Saharawi refugee people has been difficult. Many measures from both UN organisations and NGOs have been suggested but unfortunate too little has been done. When organisations again wanted to document our difficult situation, we, the Saharawi Ministry of Health, allowed this on one condition – it had to lead to a Saharawi Nutrition Strategy. In the light of the last nutritional survey, which showed the worst results than ever, a workshop for developing the strategy was held. During 5 days 50 - 70 persons participated and the working groups were mixed of people from the different UN organisations, NGOs and Saharawi health staff from all the camps and dairas. The main topics that the working groups deal with were: discussion about the nutrition related problems and the challenges; what the symptoms and signs are; divide those in the immediate, underlying and basic causes of nutritional problems; developing objectives indicating how to address the problems defined in the working groups; identifying indicators for each objective; prioritizing which problems to address firstly; and suggest strategies and activities including responsibility and timeframes. All the working groups were active in giving response to the topics and this Saharawi Nutrition Strategy is developed upon that work.

The Saharawi Ministry of Health will thank all the participations and the Akershus University College, Norwegian Church Aid (NCA), the various UN agencies, the NGOs, and all other participating in the deliberations and contributing to the outcome of the workshop.

This document is a framework for a nutrition strategy, and as such it is focus on food and nutrition issues and only briefly on related issues such as health, hygiene and sanitation, developed for and by the Saharawi Government. It is a tool for the Government to work systematically to meet the nutrition challenges faced by the Saharawi population living in the area in Algeria. We are grateful for support from the international community through the UN and international NGOs supporting our work. Nevertheless, we are the ultimate responsible towards out own population, and will act according to international law. However, the realisation of this strategy depends on the contributions and aid from all the organisations to improve the diet for the Saharawi population in the camps. We appreciate all the support we are getting and will get in the future, which is essential for achieving this strategy's aim and objectives.

Chahid Hafed, May 2009

Sidahmed Tayeb

Minister of Health

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Staff from the Saharawi Ministry of Health

Abdalahi Nayem Mahfud
Abderahman Mohamed Lehbib (pediatre)
Ahmed Abass (Sengor)
Ahmed Labeid Bel-id
Aicha Mohamed Lamin
Aichatu Mohamed Salem
Alien Mohamed Salem
Aza Mohamed Salem
Bachir Saleh Mohamed Lamin
Belal Hama
Bouregaa Hossein
Chai-a Hamudi Mulay
Embarka Saleh
Fatimeyu Sidahmed
Fteim Chrif
Gali Cheikh Mbarek
Habib Mohamed Haimuda
Halima Mohamed
Hamudi Mohamed
Han-na Sabar
Jadi Omar
Jadiya Maaleinin
Jira Mustafa
Koria Mohamed
Legniya Hama
Mahfud Bolla
Mahmud Sidoumou
Mamiti Abdelhay
Mariam Hmetu
Mariam Mohamed Salem
Meimuna Mohamed Ali
Minetu Badi
Minetu Mohamed Salem
Mohamed Salama (Kucha)
Nura Ahmed Mohamed
Raguiya Bellali
Salama Cheikh Abdelhay
Salika Abdelkrim
Umla Mohamed
Yazid Salama
Yeslem Ali
Zeina Sidahmed

Staff from International Organisations (UN and NGOs)

Annabelle Vasseur
Arne Oshaug
Barbara Magodelo
Boulanouar Mahyud
Christina Sonzoges
Claire Burniat
Daniel Martín Santos
Eirik H. Kirkerud
Francesco Mancini
Gabanaha Nouidjem
Hugues Burrows
Ingrid Barikmo
Isabel Zabalsa
José Antonio Nsang
Keddi Abdellah
Laura Benetti
Luigi Luglo Menchini
Lyes Kesri
Meziami Chafik
Paula Dominguez Salas
Pep Bibiloni
Rosa Cañellas
Sahnoun Arezki
Saul Guerrero
Simona Capocasale
Simona Ferraiuolo

It is important to emphasise that the persons are participating as individuals not on behalf of any organisation.

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Acronyms

AUC	Akershus University College
CRA	Algeria Red Crescent Society
CRS	Saharawi Red Crescent Society
CSB	Corn Soya Blend
ECHO	European Commission Humanitarian Aid
FAO	Food and Agriculture Organization of the United Nations
HAZ	Height for Age Z score
Hb	Haemoblobin
MdM	Médicos del Mundo
MoA	Ministry of Agriculture
MoC	Ministry of Commerce
MoE	Ministry of Education
MoH	Ministry of Health
MoT	Ministry of Transport
MoW	Ministry of Water
MUAC	Mid-upper arm circumference
NCA	Norwegian Church Aid
NGO	Non Governmental Organisation
PSSN	Programme Niño Sano Saharawi
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization
WHZ	Weight for Height Z score
WSB	Wheat Soya Blend

How is it to live as refugees for more than 30 years?

To live in an uncertain situation for many years have specific impact on people. It leads to many challenges, such as mental stress, lack of self esteem, lack of human dignity, lack of hope for the future, and lack of or very limited income, with consequences difficult to imagine in a globalised and privatised market economy.

The Saharawi people have, and still do mainly live on, food rations from various donors. That is in itself is not a good situation because people cannot provide food for themselves and the food they get can be random gifts and surplus food from storage. Certainly there would be no or little link with their food culture unless that is particularly taken into consideration. Another challenge that the Saharawi population has experienced is that the quality of what they get has varied considerably. The fact that they have gotten food which has been unfamiliar to them has made it difficult to compose an adequate diet based on the food basket they get. Another challenge is that the rations have gradually been reduced, what may be perceived to be for political reasons. If that is the case food has been used as a political weapon in this situation.

This refugee situation has lead to many difficulties for the population, and one of the worst imaginable is to have a malnourished population with impaired mental and physical development and limited working capacity. Documentation of the malnutrition[1,2,3,4,5,6,7], measured as children's growth, and goitre and anaemia among children and women, has since early 2000 showed unacceptable high values in chronic malnutrition (stunting), acute malnutrition (wasting), goitre, and anaemia.

The malnutrition situation could not longer be accepted by the Saharawi authorities; survey after survey revealed big problems. Reports included recommendations, but nothing happened. Before the last survey was accepted (conducted March 2008), the Saharawi Ministry of Health (MoH) demanded to start a work on a food and nutrition strategy. The Working Group for Nutrition[8] got a mandate to start this work, and in October 2008 a work shop was held. This workshop is the background for this document. The purpose of the workshop was to support the MoH in their work of making a nutrition strategy[9] to improve the diet and the nutritional status in the Saharawi population living in the area, with particular focus on vulnerable groups[10]. It is well known that access to food, healthy diet, good hygiene and healthy behaviour, all contribute to better health and this has been taken into account

[1] Nutritional Status of highly Vulnerable Groups in Saharawi Refugee Camps (December 2001). UNHCR, CISP, INRAN.
[2] Anthropometric and Micronutrient Nutrition Survey, Saharawi Refugee Camps, Tindouf (September 2002), UNHCR, WFP, ICH.
[3] Nutrition Survey Saharawi Refugee Camps, Tindouf- Algeria (August 2005). UNHCR WFP, INRAN
[4] UNHCR/WFP Joint Assessment Mission (2007), WFP.
[5] Prevalence of goitre and evaluation of food intake among Saharawi refugees in camps in Tindouf, Algeria, (March 2008), MoH-Saharawi, NCA, AUC.
[6] Iodine-Independent Endemic Goiter in Saharawi Refugee Camps in Southwestern Algeria. (February 1998) Pezzino et.al in IDD Newsletter Volume 14 Number 1.
[7] Nutritional and Food Security Survey among the Saharawi Refugees in Camps in Tindouf, Algeria. (October 2008), MoH-Saharawi, WFP, MdM, NCA & AUC.
[8] In connection with coordination of health services a forum called "Mesa de concertación y coordinación" (Table of agreement and coordination) was established in the camps. This forum consisted on 5 working groups. The Nutrition Working Group is one of those.
[9] A strategy is a type of action plan, with several activities, where each strategy has a clear objective.
[10] In this situation vulnerable groups are defined as children, women in reproductive age, pregnant and breastfeeding women and the sick or elderly.

when the strategy has been developed. The program and outputs from the work shop is attached as annexes.

Some donors don't seem to see food and nutrition problems as human rights challenges, but rather as humanitarian aid, mainly as a charity when it is surplus food somewhere. Such an approach and attitude can lead to a situation where the food source can easily dry out, particularly in times of economic crisis over which they have little influence.

Given such a fluid situation, the long duration of being refugees and the somewhat haphazard manner things are changing, and persistent malnutrition particularly among children, it is difficult to compose a stable basket of food for the Saharawi population, based on their food culture and which is in line with the United Nation definition of the right to adequate food[11].

The Saharawi people living in Algeria have lived as refugees more than 30 years; therefore they should be treated as a normal population and as such be subject to international human regimes and not to humanitarian approaches only, because humanitarian law takes other dimensions into consideration compared to a "normal population" when it comes to dietary needs.

Why is nutrition important

Diet affects our health and nutrition challenges continue throughout the life cycle, as described in Figure 1. Nutrition and diet are of crucial importance for growth and development during foetal life and during infancy, childhood and adolescence. Diet early in life affects a person's risk of developing chronic disease as an adult. Poor nutrition often starts in uteri and extends well into adolescent and adult life. It also spans generations. Undernutrition that occurs during childhood, adolescence, and pregnancy has an additive negative impact on the birth weight of infants. Low birth weight in infants, who have suffered intrauterine growth retardation as foetuses, are born undernourished and have a higher risk of dying in the neonatal period or later infancy. If they survive, they are unlikely to significantly catch up on the lost growth later in childhood and are more likely to experience a variety of developmental deficits. A low birth weight during infancy is thus more likely to lead to underweight or stunting in early life[12].

The consequences of being born undernourished extend into adulthood. Epidemiological evidence from both developing and industrialized countries suggests a link between foetal undernutrition and increased risk of various adult chronic diseases - the "foetal origins of disease hypothesis."[13]

[11] Defined in the document:
http://www.unhchr.ch/tbs/doc.nsf/0/3d02758c707031d58025677f003b73b9?Opendocument
[12] ACC/SCN (2000) *Fourth Report on the World Nutrition Situation* .Geneva: ACC/SCN in collaboration with IFPRI.
[13] Barker DJP (1998) *Mothers, Babies and Diseases in Later Life.* London: Churchill Livingstone.

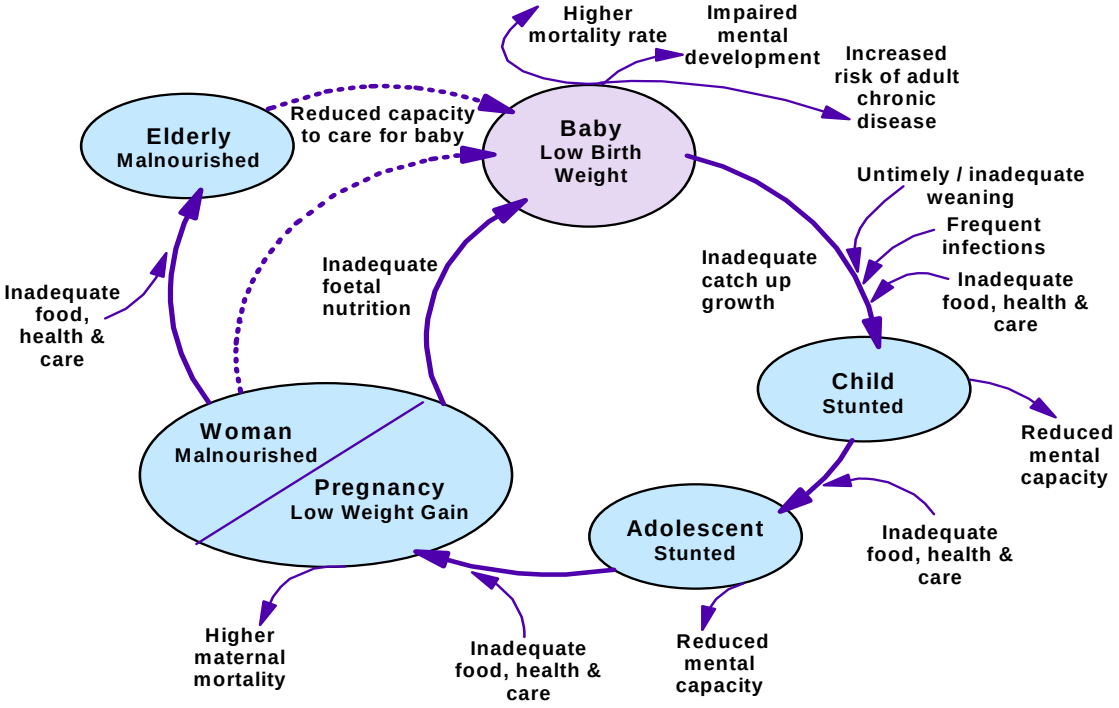

Figure 1 Nutrition challengers throughout the life-cycle[12]

Food as a recognised international human right

There is an International Bill of Human Rights, including the Universal Declaration of Human Rights, and the two covenants the International Covenant of Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights[14].

The human right to adequate food is recognized in several instruments under international law. The International Covenant on Economic, Social and Cultural Rights deals more comprehensively than any other instrument with this right, namely in its article 11.1, which says that "*the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions*", while article 11.2 recognize "*the fundamental right to freedom from hunger and malnutrition*". The human right to adequate food is of crucial importance for the enjoyment of all rights. It applies to everyone; thus the reference in Article 11.1 to "*himself and his family*" does not imply any limitation upon the applicability of this right to individuals or to female-headed households.

The Committee on Economic, Social and Cultural Rights has defined what the Right to Adequate Food means (GC 12[15]). There it is stated that the right to adequate food is indivisibly linked to the inherent dignity of the human person and is indispensable for the fulfilment of other human rights. It is also inseparable from social justice, requiring the adoption of appropriate economic, environmental and social policies, at both the national and

[14] http://www.unhchr.ch/html/menu3/b/a_cescr.htm.
[15] GC 12: General Comment 12 on the human right to adequate food. See: http://www.unhchr.ch/tbs/doc.nsf/0/3d02758c707031d58025677f003b73b9?Opendocument

international levels, oriented to the eradication of poverty and the fulfilment of all human rights for all. The General Comment 12 includes that the diet should be adequate[16].

It is apparent that this human right to adequate food is for every human being and thus also for the Saharawi population. The General Comment 12 says:

> *Food must be accessible to everyone, including victims of natural disasters, people living in disaster-prone areas and other specially disadvantaged groups may need special attention and sometimes priority consideration with respect to accessibility of food (para. 13).*

The GC 12 also point out the obligations, but they are specified for the State party, but should also apply to the international community and enable the Sahrawi Government to respect their obligations and develop policies according to this. The specified obligations are as follows:

- The obligation to respect
- The obligation to protect
- The obligation to fulfil
  - *Facilitate*
  - *Provide*

Despite the fact that the international community has frequently reaffirmed the importance of full respect for the human right to adequate food, a disturbing gap still exists between the standards set in article 11 of the Covenant and the situation prevailing in many parts of the world, including for the Saharawi population still living as refugees after more than 30 years.

A human rights based approach requires observing and following certain principles in implementation, management, evaluation and other matters in governance. Such principles include: Focus on human dignity; Non-discrimination in all matters of public policies and programmes; Accountability: political (including public), legal, administrative; Transparency in all public affairs; Participation by all members of society; Empowerment of disadvantaged groups and individuals; Responsibility on the part of each individual; Respect for the rule of law; An independent judiciary.

There are also a set of human right to food guidelines which should be consulted.[17] The objective of these guidelines is to provide practical guidance to States (here the Saharawi Government and the International community) in their implementation of the progressive realization of the human right to adequate food in the context of national food security. These guidelines take into account a wide range of important considerations and principles, and underline that food should not be used as a political weapon. These guidelines are a human rights-based practical tool; and should be applied also in further developing the strategy of the Saharawi Government.

[16] Adequacy mean according to GC 12 to meet nutritional needs, safe and culturally acceptable diets). It also underlines the importance of sustainability (food accessible "at all times" (para. 7)), that the accessible food must meet dietary needs (para. 9), and be free from adverse substances (para. 10). The food must also be cultural acceptability (para. 11), and must be available (para. 12) and accessible (para. 13, which include economic accessibility (affordability) and physical accessibility.

[17] http://www.fao.org/docrep/meeting/009/y9825e/y9825e00.htm

Dietary recommendations / Nutritional requirements[18]

WHO in collaboration with FAO, has since 1998 reviewed human nutrient requirements and recommended nutrient intakes. These standards should be adopted by the Saharawi Government since they will focus on the needs of a "normal" population and not on refugees in emergencies. The recommendations include: Vitamin and mineral requirements[19], Human energy requirements[20], Protein and amino acid requirements in human nutrition[21], Fats and oils in human nutrition[22], and Carbohydrates in human nutrition[23].

Objectives, measures and actors

To improve the diet and nutritional status demand different measures and actors involved. In planning and implementing the selected measures, special consideration must be taken in order to reach groups in the population that have the least beneficial diet. A healthy and varied diet for children and young people are important for preventing illness in the population in the future. Children and young people are in a period of life where fundamental knowledge, skills and attitudes are established, and the potential for promoting good health and preventing future illness is considerable. A varied and adequate diet for women in reproductive age is an important dimension for the health and the ability to learn of the future generation, and should thus be given high attention. Also for the rest of population a nutritionally adequate diet is important, partly in the prevention of illness and promoting wellbeing, but also hygiene measures that will improve the immediate environment where people live.

During the 5 days workshop in October 2008 14 objectives were specified based on the identified problems and causes of the malnutrition by the workshop participants (Annex 5). The working groups also pointed out several activities for some of the objectives (Annex 6).

The objectives given by the working groups have been transformed into the following 6 general objectives:

1. To change the diet for all in line with the international recommendations of the FAO/WHO
2. To coordinate the nutritional work in the camps
3. To reduce malnutrition in children
4. To reduce anaemia and other type of micro-nutrient malnutrition, particularly among women in reproductive age, infants and young children and school age children
5. To promote healthy dietary habits in accordance with local food culture for an adequate food intake for all
6. To strengthen the nutrition skills among the Saharawi public staff.

[18] http://www.who.int/nutrition/topics/nutrecomm/en/
[19] Vitamin and mineral requirements in human nutrition: report of a joint FAO/WHO expert consultation, Bangkok, Thailand, 21–30 September 1998. Second edition 2004.
[20] Human energy requirements: Report of a Joint FAO/WHO/UNU Expert Consultation Rome, 17–24 October 2001.
[21] Protein and amino acid requirements in human nutrition : Report of a joint FAO/WHO/UNU Expert Consultation (WHO Technical Report Series ; no. 935) Geneva, World Health Organization, 2007
[22] Fats and oils in human nutrition (FAO/WHO), FAO, Rome 1994
[23] Carbohydrates in human nutrition (FAO/WHO), FAO, Rome 1998.

General and specific objectives for nutritional change in the Saharawi population

The 6 general objectives have been given 19 specific objectives that will be valid for the Saharawi strategy on nutrition in the Saharawi Refugee Population for the period of 2009–2014. *The indicators and baseline data for the specific objectives are assembled in table 1 in Annex 2.*

1. **To change the diet for all in line with the international recommendations of the FAO/WHO**

If the general food distribution is improved the whole population will have an improved diet, but there are groups that are especially vulnerable such as infants, children, women in reproductive age, pregnant and breastfeeding women, and sick o r old people. The only food for infants is breast milk, and therefore breastfeeding women should be supported to do so. Pregnant and breastfeeding women need extra energy and nutrients and thus as well are covered under the other strategies. Because the children are growing they are in a special condition and they also need extra energy and nutrients[24]. Especially care for the children is necessary when food other than breast milk has to be introduced (by 6 month) and towards 2 years. In this period the children have a high demand for nutrients and at the same time a high rate of infectious diseases. It is in this age most incidence of chronic malnutrition (shortness) happens making special complementary food and feeding practises very important. It is also necessary to continue supporting sick people to recover from illness and old people need nutritional foods that are easy to eat.

1.1. Ensure access to food that is nutritionally sufficient, diverse and culturally acceptable to all the Saharawi refugee population within 3 years

1.2. Improve the nutritional security for the Saharawi refugee women and children during pregnancy, breastfeeding and complementary feeding by 50 % in 5 years

1.3. Ensure school feeding program for all the Saharawi children within 3 years

1.4. Ensure a nutritionally adequate diet at hospitals.

2. To coordinate the nutritional work in the camps

Coordination includes many dimensions that need to be seen and comprehended together. It can be defined as a systems and tools, and may include eight themes, namely 1) leadership and management; 2) negotiation and maintenance of a practical framework; 3) communicating and informing other sectors about what is done at what time with whom; 4) strategic planning; 5) mobilisation of resources for integrated programming; 6) gathering data and managing information; 7) accountability (including accountability to recipient populations); and finally 8) joint advocacy.

The first point is addressed by the Saharawi Government by developing this strategy. By doing so it takes leadership, and will provide important management for the implementation of the strategy. The strategy also takes abound of point 2 and 4. Point 3 is essential in coordination of this kind of work and needs to be assessed continuously, and point 7 would be

[24] Vitamin and mineral requirements in human nutrition: report of a joint FAO/WHO expert consultation, Bangkok, Thailand, 21–30 September 1998. Second edition 2004.
Human energy requirements: Report of a Joint FAO/WHO/UNU Expert Consultation Rome, 17–24 October 2001

respected by the Government. Point 6 is partly done already but some is left; the continuous update of information on the situation will be pending on support from the international community. Point 8 is essential and a proper plan for advocacy should be considered.

As it has been a lack of coordination of the nutrition programme in the camps concerning various forms of undernutrition among children, this is an important point. Efforts to improve diet and supplementary feeding of children are a start to address some of the nutritional problems. They include supplementary feeding in general (UNHCR/CRA), growth monitoring and vaccination (Niño Sano, PSSN), fresh food and nutrition training at hospitals (NCA) and distribution of Plumynut as a treatment of severe acute malnutrition (MdM). Records are kept in the primary health care centres and at the hospitals by those working on the projects, but the information are not assembled together and there is no clear routine on keeping statistics. This kind of information is not adequately shared with other actors. This work suffers thus from the lack coordination and management.

Without a coordinated and functional health care system and facilities, it is difficult to deal with the different kinds of deficiency and nutritional problems.

2.1. Set up a coordination system regarding all the nutritional work for the vulnerable groups in the camps within 1 year.

3. To reduce malnutrition in children

The children in the camps suffer from both acute (thinness) and chronic (shortness) malnutrition. In both cases there are moderate and sever malnutrition and it is a need of a variation of activities to both prevent and treat the conditions.

When children are severe acute malnourished they have lost weight because of recent low food intake compared to their needs and /or diarrhoea and other infections. This situation needs rapid intervention and special treatment. It is important to prevent that those who are moderate acute malnourished are getting worse.

3.1. Ensure provision of the necessary foods, supplements, training and equipment that are needed to reduce the *acute* malnutrition among Saharawi children < 5 years by 50 % within 3 years.

For the chronic malnutrition it is different; they are growth retarded because (of low food intake,) both the quality and quantity, over a longer period of time. This need another approached than those suffering from acute malnutrition. One of the problems with these children is that they can become small and overweight instead of reaching there potential height. There is research showing that the improvement of the height should be done before the age of 3 years. This childhood overweight can give problems like diabetes type 2 and heart disease later in their lives[25]. These children and their families need improved access to nourishing foods and supplements.

3.2. Ensure provision of the necessary foods, supplements, training and equipment that are needed to reduce *chronic* malnutrition among Saharawi children < 5 years by 50 % within 5 years.

[25] What works? Interventions for maternal and child undernutrition and survival. Zulfi qar A Bhutta, Tahmeed Ahmed, Robert E Black, Simon Cousens, Kathryn Dewey, Elsa Giugliani, Batool A Haider, Betty Kirkwood, Saul S Morris, H P S Sachdev, Meera Shekar, for the Maternal and Child Undernutrition Study Group*. Lancet 2008; 371: 314–40.

4. To reduce anaemia and other type of micro-nutrient malnutrition, particularly among women in reproductive age, infants and young children and school age children

Anaemia has been a problem among the Saharawi for many years. This problem warrants a specific programme of anaemia control and reduction[26].

Also goitre has been a problem for a long time and it is now evidence that the cause seems to be excess of iodine in the environment[27].

4.1 Ensure access to necessary foods for a nutritional adequate diet and supplements needed to reduce the anaemia among Saharawi refugee women in reproductive age (15 – 49 years, including pregnant and breastfeeding) by 30 % within 3 years

4.2. Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi refugee women in reproductive age (15 – 49 years, including pregnant and breastfeeding) by 30 % within 3 years

4.3. Ensure access to necessary foods for a nutritional adequate diet and supplements needed to reduce the anaemia among Saharawi school age children 5 – 14 years by 50 % within 3 years

4.4. Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi school age children 5 – 14 years by 50 % within 3 years

4.5. Ensure access of necessary foods and supplements needed to reduce anaemia among Saharawi refugee children < 5 years, by 50 % within 3 years

4.6. Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi refugee children < 5 years, by 50 % within 3 years

4.7.Improve the water quality for human and animals to reduce the intake of iodine according to international standard among Saharawi children < 12 years and women in reproductive age (15 – 49 years) within 5 years.

5. To promote healthy dietary habits in accordance with local food culture for an adequate food intake for all

Nutrition and hygiene are synergistic to each other. It is important that nutrition and hygiene promotion take place everywhere, particularly in places such as primary health care centres, schools, and women groups. Also radio and TV would be important to reach households.

5.1 Ensure nutrition and hygiene information to 80 % of users of the nutrition programmes within 3 years

5.2 Ensure nutrition and hygiene information to 80 % of the primary schools within 5 years

5.3 Ensure nutrition and hygiene information to 25 % of the Saharawi families within 5 years.

[26] This must be closely harmonized and coordinated with the UNHCR Strategic Plan for Anaemia Control and Reduction, 2008 – 2010.

[27] Prevalence of goitre and evaluation of food intake among Saharawi refugees in camps in Tindouf, Algeria. March 2008, MoH-Saharawi, NCA, AUC.

6. To strengthen the nutrition skills among the Saharawi public staff

Managing and coordinating nutritional work and promoting nutritionally healthy dietary practices are important. Therefore capacity development of local Saharawi staff is essential. This must be done in in-service training. Such training has to be done at different level.

6.1 Ensure adequate in-service nutrition training for all staff involved in the nutritional programmes within 3 years

6.2 Ensure further in-service training of local technical nutritionists to enable them to run, coordinate and improve nutrition according to peoples' dietary needs within 3 years.

Measures

To succeed in nutrition work, it is necessary to use several types of population-wide and individual based measures. Population-wide measures must focus on underlying and social reasons for behaviour and the individual based measures must focus on curing and prevention of different situations of malnutrition and nutritional deficiencies. In nutritional work it is important to achieve cooperation and collaboration across disciplines and sectors at the local, regional and national level.

On the background of the objectives specified above, on the data collected from the work shop, scientific knowledge and surveys, and other stakeholder information, the Saharawi Nutrition Strategy will emphasis the following 3 focused areas:

- **Access to food for a healthy diet**
- **Fight against malnutrition and nutritional deficiencies**
- **Capacity development.**

Access to food for a healthy diet

It is commonly accepted and a concern in the population, of the Saharawi Government, of the UN organisations and of the NGOs working in the area that the present food basket is insufficient, the distribution of the food is too unstable and that food is not coming at the time decided[28] (pipeline breaks). Also the ending of the 3 month of food buffer stock in 2006 made the food distribution unstable. This buffer stock is not yet re-established. All this have contributed to big obstacles in the provision of food to the population. It is WFP, ECHO and NGOs that are providing food; WFP the basic food, ECHO and some NGOs fresh food, other NGOs canned and dried food other than cereals and lentils. Some NGOs are giving goats and promote horticulture which contributes to the diversity of the diet.

A basket of food must be nutritionally adequate ensuring all of the population the necessary food items giving their food culture, and adequate in nutrients for all, given their needs according to gender, age, general health, and pregnancy status of women and breastfeeding.

The Saharawi women must participate when access to various food items are assessed and the selection of a food basket is done; it is important that women in general and professional women are engaged in assessing the food basket so that is fits the needs of people and takes account of their food culture.

The Saharawi authorities together with the UN organisations have the responsibility to ensure adequate food to the Saharawi population living as refugees.

[28] Food not arriving at the expected time is also called pipeline break.

The following measures are based on the objectives 1 and 5 and several activities are implied and many actors are involved.

Table 1 The strategy for the focused area: *access to food for a healthy diet*

Objectives	**Measures**	**Main respon-sible**	**Contributing partners**
1. To change the diet for all in line with the international recommendations of the FAO/WHO			
1.1 Ensure access to food that is nutritionally sufficient, diverse and culturally acceptable to all the Saharawi refugee population within 3 years ***Priority of the first 2 years***	• Mobilise resources	MoH	UNHCR, WFP CRS, CRA, ECHO, NGOs
	• Assess, select and procure adequate food items to the food basket	MoH	WFP, UNHCR, CRS, Women Groups, NGOs
	• Ensure a 3 month food buffer stock	MoH	WFP, UNHCR
	• Provide safe food storage	MoA	WFP, CRS, CRA
	• Control of food aid items; content and labelling and of local produced food	MoH	WFP, CRS, CRA, NGOs
	• Distribute the food on monthly basis within one week	MoT	WFP, CRS, CRA, UNHCR, NGOs
	• Monitoring: nutrient content of the food basket and food distribution at camp and household levels	MoH	CRS, WFP, NGOs, Women Groups
	• Provide adequate food for the hospitals and health institutions	MoH	NGOs
	• Promote agriculture activities	MoA	NGOs
	• Promote creation of small economic activities	MoC	NGOs
	• Monitoring of dietary intake and food security.	MoH	CRS, WFP, UNHCR, NGO
1.2 Improve the nutritional security for the Saharawi refugee women and children during pregnancy, breastfeeding and complementary feeding by 50 % in 5 years ***Priority of the first 2 years***	• Reinforce early initiation and exclusive breastfeeding for first six months of life	MoH	UNICEF, Women Groups, NGOs
	• Promote introduction of complementary foods at age 6 months feeding	MoH	UNICEF, Women Groups, NGOs
	• Provide optimal nutritional care of sick children		
	• Provide adequate nutrition and health care among pregnant women.	MoH	UNICEF, Women Groups, NGOs
1.3 Ensure school feeding program for all the Saharawi children within 3 years.	• Provide adequate food for school feeding for the local schools	MoE	MoH, WFP, Women Groups, NGOs, UNICEF
	• Provide adequate food for school feeding for the border schools.	MoE	MoH, UNICEF, WFP, Women Groups, NGOs

Table 1 continues

Objectives	Measures	Main respon-sible	Contributing partners
5. To promote healthy dietary habits in accordance with local food culture for an adequate food intake for all.			
5.3 Ensure nutrition and hygiene information to 25 % of the Saharawi families within 5 years	• Implement campaign for promoting healthy nutrition and hygiene habits.	MoH	MoW, NGOs

Fight against malnutrition and nutritional deficiencies

The nutritional status among children and women in reproductive age has been documented as bad for many years and the acute malnutrition for children < 5 years has the last year reached new high peaks. Also chronic malnutrition has remained high as well as the anaemia and goitre. The Saharawi nutrition strategy has to take all of this into account, but UNHCR has combat against anaemia as a priority for the next 2 years and it is important that their strategies are coordinated with central Saharawi actors and that this will include elements of both treatment and prevention of anaemia.

Also ongoing supplementary feedings programs as well as the mother and child care programme will be used and reinforced. Another important activity is to do sensibilisation among women, health staff and local authorities on the causes of anaemia and the preventive measures available. Strengthen the health care system will also be essential.

Imbalance in the iodine intake has been revealed, and so has high prevalence of goitre among children and women[29]. Usually goitre or enlarged thyroid gland is a sign of lack of iodine, but among the Saharawi refugees it is shown that it is an excess of iodine in the water and also in the local milk.

The following measures are based on objectives 2, 3, 4 and 5 but objective 1 (ensure that all people have access to adequate diet) is an underlying condition for success in a sustainable fight against malnutrition:

[29] Prevalence of goitre and evaluation of food intake among Saharawi refugees in camps in Tindouf, Algeria, March 2008, MoH-Saharawi, NCA, AUC

Table 2 The strategy for the focused area: *fight against malnutrition and nutritional deficiencies*

Objectives	Measures	Main responsible	Contributing partners
2. To coordinate the nutritional work in the camp			
2.1 Set up a coordination system regarding all the nutritional work for the vulnerable groups in the camps within 1 year ***Priority of the first 2 years***	• Establish a Saharawi nutrition coordination group	MoH	UNHCR, WFP, NGOs
	• Provide the coordination staff with necessary infrastructure such as office, stationeries, computer, communication transportation	MoH	UNHCR, UNICEF, NGOs
	• Provide the primary health care centres with necessary equipment, food items and supplements	MoH	UNHCR, WFP, UNICEF, NGOs
	• Make a system for gathering information from the primary health care centres and the hospitals on malnourished children to register in a monthly report	MoH	UNHCR, UNICEF, NGOs
	• Make statistics on the work every month.	MoH	UNHCR, UNICEF, NGOs
3. To reduce malnutrition in children			
3.1 Ensure provision of the necessary foods, supplements, training and equipment that are needed to reduce the *acute* malnutrition among Saharawi children < 5 years by 50 % within 3 years. **Priority of the first 2 years**	• Train the primary health care centres staff in prevention, detection and treatment of malnutrition.	MoH	UNHCR, UNICEF NGOs
	• Train the primary health care centres staff in prevention, detection and treatment of infections		
	• Use of Plumpynut for treatment of children < 5 years with Weight for Height Z-score WHZ) < -3 z-score (severe acute thinness)	MoH	UNHCR, UNICEF NGOs
	• Use Corn Soya Blend (CSB) for children < 5 years with Weight for Height Z-score WHZ) between -3 z-score and -2 z-score (moderate acute thinness)	MoH	WFP, UNHCR, UNICEF NGOs
	• Do active case finding among children < 5 years by using MUAC < 12.5 cm.	MoH	UNHCR, UNICEF NGOs
3.2 Ensure provision of the necessary foods, supplements, training and equipment that are needed to reduce *chronic* malnutrition among Saharawi children < 5 years by 50 % within 5 years **Priority of the first 2 years**	• Use of Corn Soya Blend (CSB) for children < 3 years with Height for Age Z-score HAZ) < -2 z-score (both severe and moderate shortness)	MoH	UNHCR, UNICEF NGOs
	• Train the primary health care centres staff in promoting adequate complementary feeding procedures	MoH	UNHCR, UNICEF, NGOs
	• Train the primary health care centres staff in growth monitoring practises	MoH	UNHCR, UNICEF, NGOs
	• Continue growth monitoring activities in the primary health care centres.	MoH	UNHCR, UNICEF, NGOs

Table 2 continues

Objectives	Measures	Main respon-sible	Contributing partners
4. To reduce anaemia and other type of micro-nutrient malnutrition, particularly among women in reproductive age, infants and young children and school age children			
4.1 Ensure access to necessary foods for a nutritional adequate diet and supplements needed to reduce the anaemia among Saharawi refugee women in reproductive age (15 – 49 years, including pregnant and breastfeeding) by 30 % within 3 year **Priority of the first 2 years**	• Prevention of anaemia: provide iron rich food and foods that promote absorption of iron to all the vulnerable groups	MoH	UNHCR, WFP, NGOs
	• Treatment of anaemia: provide an adequate product for supplementation, probably the same for women and children. Ensure provision of the product for 3 years	MoH	UNHCR, UNICEF, Women Groups, NGOs
	• Supplementation: provide products such as (WheatSoyaBlend or CornSoyaBlend) to all pregnant women in the last 6 months of the pregnancy and the 6 first month of the breast feeding period (use the protocol for treatment of malnutrition). Use also the selected product for supplementation if necessary.	MoH	WFP, UNHCR, UNICEF, NGOs
4.2 Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi refugee women in reproductive age (15 – 49 years, including pregnant and breastfeeding) by 30 % within 3 years **Priority of the first 2 years**	• Train the staff of primary health care centres in active case finding, Hb measuring and interpreting, description of the iron product (for the women to pick up at the pharmacy), instruction to the women how to use the product, register of the cases and following up plan for each individual	MoH	UNHCR, NGOs
	• Maintain or rebuild the primary health care centres for receiving and follow up anaemic women	MoH	UNHCR, UNICEF, NGOs
	• Provide the necessary equipment to the primary health care centres	MoH	UNHCR, UNICEF, NGOs
	• Conduct awareness campaigns among the population on the causes of anaemia, the need for balanced diet for all, and the specially needs for vulnerable groups (children 6 moths to 2 years, young girls and pregnant and breast feeding women).	MoH	UNHCR, UNICEF, Women Groups, NGOs

Table 2 continues

Objectives	Measures	Main respon-sible	Contributing partners
4.3 Ensure access to necessary foods for a nutritional adequate diet and supplements needed to reduce the anaemia among Saharawi school age children 5 – 14 years by 50 % within 3 years **Priority of the first 2 years**	• Provide meals in schools and other places for child care (kindergartens). Use also the selected product for supplementation if necessary.	MoH	WFP, UNICEF, Women Groups, NGOs
4.4 Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi school age children 5 – 14 years by 50 % within 3 years **Priority of the first 2 years**	• Train the staff of primary health care centres and the teachers on the causes of anaemia and the need for balanced diet for both children and women.	MoH	UNHCR, UNICEF, NGOs
4.5 Ensure access of necessary foods and supplements needed to reduce anaemia among Saharawi refugee children < 5 years, by 50 % within 3 years **Priority of the first 2 years**	• Provide iron rich food and foods that promote absorption of iron and food supplementation products such as (WheatSoyaBlend or CornSoyaBlend) to all malnourished children < 5 years, both acute and chronic malnutrition (follow the protocol for the treatment of malnutrition). Use also the selected product for supplementation if necessary.	MoH	WFP, UNHCR
4.6 Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi refugee children < 5 years, by 50 % within 3 years **Priority of the first 2 years**	• Train the staff of the primary health care centres in active case finding, Hb measuring and interpreting, description of the iron product (for the women to pick up at the pharmacy), instruction to the mothers how to use the product, register of the cases and following up plan for each individual.	MoH	UNHCR, UNICEF, NGOs
4.7 Improve the water quality for human and animals to reduce the intake of iodine according to international standard among Saharawi children < 12 years and women in reproductive age (15 – 49 years) within 5 years. **Priority of the first 2 years**	• Start the process of purifying of the present water sources • Assess if it is need for drilling new wells.	MoH MoW MoH MoW	UNHCR, NGOs UNHCR, NGOs

Table 2 continues

Objectives	Measures	Main respon-sible	Contributing partners
5. To promote healthy dietary habits in accordance with local food culture for an adequate food intake for all.			
5.1 Ensure nutrition and hygiene information to 80 % of the user of the nutrition programmes within 3 years.	• Train the primary health care centres staff in infant, child and general nutrition.	MoH	UNICEF, NGOs
	• Train the primary health care centres staff in infant, child and general hygiene.	MoH	UNICEF, NGOs
5.2 Ensure nutrition and hygiene information to 80 % of the primary schools within 5 years.	• Train the teachers in child and general nutrition and hygiene	MoH	UNICEF, NGOs
5.3 Ensure nutrition and hygiene information to 25 % of the Saharawi families within 5 years.	• Conduct awareness campaigns on nutrition and hygiene among the population.	MoH	UNICEF, Women Groups, NGOs

Capacity development

Capacity development should be given primacy to or be closely integrated in overall policies, priorities, strategies, plans, and processes. It underpins a shift from a technical assistance supply driven approach to an endogenous led process of change, and gives tangible form to the principle of national ownership. Capacity development (CD) is the business of all governments, non government entities, civil society and the UN development system, but many fail.

UNDP has suggested principles for CD. CD is here understood as the creation of an enabling environment with appropriate policy and legal frameworks, institutional development, including community participation, human resources development and strengthening of managerial systems. CD is a long-term, continuing process. These principles imply using national expertise primarily, strengthening of national institutions, and protection of social and cultural capital. The last principle is to remain accountable to the people. Any responsible government is answerable to its people, and should foster transparency as the foremost instrument of public accountability. It is therefore essential that all CD activities have this in mind, and would enable the Saharawi government to meet the needs of its people.

The education system in the camps gives children 6 years school in the camps and then the possibility to have 2 more years in border school in connection to the camps. After that the youth have to go abroad. A big part of the education abroad is education for the health system, but the last years the brain drain from the camps has increased.

The camps also have a technical[30] nurse school, which educate personnel for the hospitals and primary health care. The school has nutrition training only in minor extent so it had been adjusted nutritional training of core personnel at the hospitals (NCA) and health staff at the primary health care centres (PSSN). This training should continue but in more organised and formal way.

[30] Practical 2 or3 years nurse assistant education

The following measures are based on the objectives 6.

Table 3. The measures for the focused area: *capacity development*

Objectives	Measures	Main respon-sible	Contributing partners
6. To strengthen the nutrition skills among the Saharawi public staff			
6.1 Ensure adequate in-service nutrition training for all staff involved in the nutritional programmes within 3 years. **Priority of the first 2 years**	• Ensure training of the local staff in management, nutrition and communication skills.	MoH	UNICEF, NGOs
6.2. Ensure further in-service training of local technical nutritionists to enable them to run, coordinate and improve nutrition according to peoples' needs within 3 years	• Formalise the nutrition education	MoH	MoE, UNICEF, NGOs
	• Review the curriculum for nutrition and hygiene at the Nurse school	MoH	MoE, UNICEF, NGOs
	• Evaluate possibilities for university collaboration for nutrition training of public staff.	MoH	MoE, UNICEF, NGOs

Monitoring and evaluation

To monitor the nutritional situation in order to follow the changes[31] is necessary. To reach the objectives of the strategy each ongoing activity should have a monitoring component with specified indicators that can inform the management and the authorities about the process and outcome. This could include growth of the children, haemoglobin (anaemia) and size of the thyroid gland (goitre) in the children. An evaluation system, including monitoring, must be developed within the first year after the strategy is fully into function. Before the end of the period (2014) an impact evaluation[32] of the strategy should be completed, and the results should be used in a modification of the strategy.

Follow-up

This strategy should be followed up continuously, and revised within 2 years when experiences can give direction to eventual modifications, particularly in priorities.

A nutrition task force should be established by the Saharawi government, with the specific responsibility to follow-up the strategy, ensure that plans are developed within time, receive reports on how the strategy is positively modifying the nutrition situation, and ensure that information about progress are given to responsible ministry.

The task force should ensure that a yearly report on the function and achievement of the strategy is written and that this report and any other information are shared with interested parities (various ministries mentioned in the strategy, UN agencies, NGOs, and other interested parties).

[31] Monitoring is a continuing function that uses systematic collection of data on specified indicators to inform the management and the stakeholders of an ongoing project.
[32] Evaluation is an analysis of the relevance, effectiveness and efficiency of the strategy.

Annex 1:

How is the human right to adequate food defined?

Even if the right to food is well recognised in international human rights law, before 1999 it was not defined clearly. Therefore it was requested by the Member States of FAO during World Food Summit in 1996 that such a definition should be developed.[33] As a response to that request the Committee on Economic, Social and Cultural right a better definition of the rights relating to food in article 11 of the Covenant. The Committee was requested to give particular attention to the Summit Plan of Action of the World Food Summit. The result of that is found in the document: The right to adequate food (Art.11). General comment 12: 12/05/99. E/C.12/1999/5.

Normative content of article 11, paragraphs 1 and 2 (CG 12)

The definition is as follows:

"The right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food or means for its procurement." The definition goes on to state that:

The right to adequate food shall therefore not be interpreted in a narrow or restrictive sense which equates it with a minimum package of calories, proteins and other specific nutrients. The right to adequate food will have to be realized progressively. However, there is a core obligation to take the necessary action to mitigate and alleviate hunger[34], even in times of natural or other disasters.

The role of states and international organizations

States have a joint and individual responsibility, in accordance with the Charter of the United Nations, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task in accordance with its ability. The role of the World Food Programme (WFP) and the Office of the United Nations High Commissioner for Refugees (UNHCR), and increasingly that of UNICEF and FAO is of particular importance in this respect. Food aid should, as far as possible, take account of the local situation. Products included in international food trade or aid programmes must be safe and culturally acceptable to the recipient population.

The United Nations and other international organizations

The role of the United Nations agencies, including through the United Nations Development Assistance Framework (UNDAF) at the country level, in promoting the realization of the right to food is of special importance. Coordinated efforts for the realization of the right to food should be maintained to enhance coherence and interaction among all the partners concerned, including the various components of civil society. The food organizations, FAO, WFP and the International Fund for Agricultural Development (IFAD) in conjunction with the United Nations Development Programme (UNDP), UNICEF, the World Bank and the regional development banks, should cooperate more effectively, building on their respective expertise,

[33] Link to WFS document.
[34] As provided for in paragraph 2 of article 11 of the ICESCR.

on the implementation of the right to food at the national level, with due respect to their individual mandates

Voluntary Guidelines to support the progressive realization of the right to adequate food in the context of national food security, 2004[35]

The objective of these Voluntary Guidelines is to provide practical guidance to States (here the Saharawi Government and the International community) in their implementation of the progressive realization of the right to adequate food in the context of national food security.

The Voluntary Guidelines take into account a wide range of important considerations and principles, including equality and non-discrimination, participation and inclusion, accountability and rule of law, and the principle that all human rights are universal, indivisible, inter-related and interdependent. Food should not be used as a tool for political weapon and for economic pressure.

These Voluntary Guidelines are a human rights-based practical tool; to these Voluntary Guidelines should be applied in developing the programme and strategies for the Saharawi Government. They point out the importance of doing this without discrimination of any kind, such as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Here just one guideline is included, namely guideline 10 on nutrition. All the other guidelines would be taken into consideration whenever that is relevant.

Guideline 10 – Nutrition

It addresses dietary diversity and healthy eating habits and food preparation, as well as feeding patterns, including breastfeeding; education, information; to involve all relevant stakeholders, in particular communities and local government, in the design, implementation, management, monitoring and evaluation of programmes to increase the production and consumption of healthy and nutritious foods, especially those that are rich in micronutrients; to promote and encourage breastfeeding; to disseminate information on the feeding of infants and young children consistent and in line with current scientific knowledge and internationally accepted practices; health, education and sanitary infrastructure and promote intersectoral collaboration, necessary services to eradicate any kind of discriminatory practices; that food is a vital part of an individual's culture; fair distribution of food within communities and households with special emphasis on the needs and rights of both girls and boys and pregnant women and lactating mothers, in all cultures.

[35] http://www.fao.org/docrep/meeting/009/y9825e/y9825e00.htm

ANNEX 2

The table in this annex shows the specific objectives with the indicators and baseline data that were assembled through the process. The specific objectives build on the 6 following general objectives:

1. To change the diet for all in line with the international recommendations of the FAO/WHO
2. To coordinate the nutritional work in the camps
3. To reduce malnutrition in children
4. To reduce anaemia and other type of micro-nutrient malnutrition, particularly among women in reproductive age, infants and young children and school age children
5. To promote healthy dietary habits in accordance with local food culture for an adequate food intake for all
6. To strengthen the nutrition skills among the Saharawi public staff.

Table 1 Specific objectives, indicators and baseline data assembled during the process with the Saharawi Nutrition Strategy

	Specific objectives	**Indicators (Quantitative targets)**	**Baseline data for calculating the improvements**
1.	***Specific objective 1. 1*** Ensure access to food that is nutritionally sufficient, diverse and culturally acceptable to all the Saharawi refugee population within 3 years	• Available food basket covering the different needs for energy, fat, protein, iron, calcium, zinc, vitamin C, vitamin A, vitamin B1, B2, B6, B12, niacin and folate	The nutritional profile of the food basket received from the UN and NGOs per October 2008.
		• WFP food consumption score (FCS) covering 100 % of the population with adequate consumption (score >35)	FCS baseline per April 2008[1] covered 85 %
		• Individual Dietary Diversity Score (IDDS) with mean numbers of food groups, during a week, being 7 or more for 75 % of the women and 6 food groups or more for 85 % of the children < 5 years.	Baseline for IDDS at April 2008[1] was 7 food groups for 26 % of the women and 6 food groups for 36 % of the children.
	Specific objective 1.2 Improve the nutritional security for the Saharawi refugee women and children during pregnancy, breastfeeding and complementary feeding by 50 % in 5 years	• % of pregnant attend to maternity control • %of pregnant women having adequate weight gain during the pregnancy • % of children exclusively breast feed until 6 months • % of children having complementary feeding at appropriate at 6 months of age while continuing to breastfeed	*Baseline data need to be obtained

Table 1 continues

	Specific objectives	Indicators (Quantitative targets)	Baseline data for calculating the improvements
	Specific objective 1.3 Ensure school feeding program for all the Saharawi children within 3 years	• % of children at primary schools receiving food aid • The food distribution at boarder school covering the needs for energy, fat, protein, iron, calcium, zinc, vitamin C, vitamin A, vitamin B1, B2, B6, B12, niacin and folate.	*Baseline data need to be obtained
	Specific objective 1.4 Ensure a nutritionally adequate diet at hospitals	• The food provides to patients at the hospitals covering the needs for energy, fat, protein, iron, calcium, zinc, vitamin C, vitamin A, vitamin B1, B2, B6, B12, niacin and folate.	*Baseline data need to be obtained
2	***Specific objective 2. 1*** Set up a coordination system regarding all the nutritional work for the vulnerable groups in the camps within 1 year.	• All camps have a nutrition coordinator • The different nutrition projects are coordinated.	Starting at zero
3	***Specific objective 3. 1*** Ensure provision of the necessary foods, supplements, training and equipment that are needed to reduce the *acute* malnutrition rate among Saharawi children < 5 years by 50 % within 3 years	• Prevalence of Weight for Height Z-score (WHZ) < - 2 SD moderate and WHZ <-3 SD severe. • % of the staff given training in prevention, detection and treatment of malnutrition. • % of the staff given training in prevention, detection and treatment of infections	Prevalence of moderate acute malnutrition was 18% and severe 5 % per April 2008 [1] *Baseline data need to be obtained
	Specific objective 3.2. Ensure provision of the necessary foods, supplements, training and equipment that are needed to reduce *chronic* malnutrition among Saharawi children < 5 years by 50 % within 5 years	• Prevalence of Height-for Age Z-score (HAZ) < - 2 SD moderate and HAZ <-3 SD severe.	Prevalence of moderate chronic malnutrition was 32 % and severe 9 % per April 2008[1]
4	***Specific objective 4.1*** Ensure access to necessary foods for a nutritional adequate diet and supplements needed to reduce the anaemia among Saharawi refugee women in reproductive age (15 – 49 years, including pregnant and breastfeeding) by 30 % within 3 years	• Prevalence of Hb < 12 g/dl[36] (moderate) and Hb < 8 (severe)in women in reproductive age	Prevalence of moderate anaemia for women was 54 % and 11 % severe per April 2008[1].
		• Prevalence of Hb < 11 (moderate) and Hb < 7 (severe) in pregnant and breastfeeding women. • Adequacy of the iron intake by diet and supplement	Prevalence of moderate P/B was 66 % and 15 % severe per April 2008[1]. *Baseline data need to be obtained

[36] Iron deficiency anaemia: assessment, prevention, and control. A guide for programme managers. Geneva, World Health Organization, 2001 (WHO/NHD/01.3)

Table 1 continues

	Specific objectives	Indicators (Quantitative targets)	Baseline data for calculating the improvements
	Specific objective 4.2 Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi refugee women in reproductive age (15 – 49 years, including pregnant and breastfeeding) by 30 % within 3 years	• % of adequately trained staff at the primary health care centres • % of adequate equipped and maintained primary health care centres • Numbers of awareness campaigns executed.	*Baseline data need to be obtained
	Specific objective 4.3 Ensure access to necessary foods for a nutritional adequate diet and supplements needed to reduce the anaemia among Saharawi school age children 5 – 14 years by 50 % within 3 years	• Prevalence of Hb < 11.5 g/dl in school age children • Adequacy of the iron intake by diet and supplement • Frequency of diarrhoea • Quality (bacteriological) of portable water.	*Baseline data need to be obtained
	Specific objective 4.4 Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi school age children 5 – 14 years by 50 % within 3 years	• % of adequately trained teachers at the primary schools • % of adequate equipped primary schools.	*Baseline data need to be obtained
	Specific objective 4.5 Ensure access of necessary foods and supplements needed to reduce anaemia among Saharawi refugee children < 5 years, by 50 % within 3 years	• Prevalence of Hb < 11 g/dl (moderate) and Hb < 7 (severe) in children < 5 years. • Adequacy of the iron intake by diet and supplement • Frequency of diarrhoea • Quality (bacteriological) of portable water.	Prevalence for moderate was 62 % and severe 6 % per April 2008[1]. *Baseline data need to be obtained
	Specific objective 4.6 Ensure adequate training and equipment needed to educate on how to reduce the anaemia among Saharawi refugee children < 5 years, by 50 % within 3 years	• % of adequately trained staff at the primary health care centres • % of adequate equipped primary health care centres • Numbers of awareness campaigns executed.	*Baseline data need to be obtained

Table 1 continues

	Specific objectives	Indicators (Quantitative targets)	Baseline data for calculating the improvements
	Specific objective 4.7 Improve the water quality for human and animals to reduce the intake of iodine according to international standard among Saharawi children < 12 years and women in reproductive age (15 – 49 years) within 5 years.	• Prevalence of enlarged thyroid volume (goitre) among children • Prevalence of enlarged thyroid volume goitre among women • Median excretion of iodine in urine < 300 µg/L among children and women.	Prevalence among children was 56 % per February 2007[2] Prevalence among women was 22 % per February 2007[2] Median excretion of iodine in urine was 565 µg/L among children and 466 µg/L among women per February 2007[2]
5	***Specific objective 5.1*** Ensure nutrition and hygiene information to 80 % of users of the nutrition programmes within 3 years	• % of the beneficiaries given nutrition information • % of the beneficiaries given hygiene information.	*Baseline data need to be obtained
	Specific objective 5.2 Ensure nutrition and hygiene information to 80 % of the primary schools within 5 years	• % of the schools reached with nutrition information • % of the schools reached with nutrition information.	*Baseline data need to be obtained
	Specific objective 5.3 Ensure nutrition and hygiene information to 25 % of the Saharawi families within 5 years	• % of the families reached with nutrition and hygiene information.	*Baseline data need to be obtained
6	***Specific objective 6.1*** Ensure adequate in-service nutrition training for all staff involved in the nutritional programmes within 3 years	• % of the health care staff has been adequate trained.	*Baseline data need to be obtained
	Specific objective 6.2 Ensure further in-service training of local technical nutritionists to enable them to run, coordinate and improve nutrition according to peoples' dietary needs within 3 years.	• % of the nutritionists has been adequate trained • Dietary needs of the Saharawi population in the course curriculum • Hygiene massages according to the Saharawi population in the course curriculum • Existing plans for external cooperation in advanced nutrition training.	*Baseline data need to be obtained

*When the table suggests that "Baseline data need to be obtained" the data may be there but need to be assembled and analysed. If not available, a baseline study would be necessary.

[1]Nutritional and Food Security Survey among the Saharawi Refugees in Camps in Tindouf, Algeria. (October 2008), MoH-Saharawi, WFP, MdM, NCA & AUC.

[2] Prevalence of goitre and evaluation of food intake among Saharawi refugees in camps in Tindouf, Algeria, (March 2008), MoH-Saharawi, NCA, AUC.

Annex 3:

Different definition used during the work shop

"Specific" Objective

1. Change (What)
2. Criterion (How much)
3. Where and for whom
4. Time (When)

Example: To reduce micro-nutrient deficiencies (1), among children below 10 years of age in the Saharawi population (3), by 50% (2), within 5 years (4).

Indicator:

Indicator of micro-nutrient deficiency, dietary intake, blood analysis, anthropometric measurements

Strategy:

A strategy for a programme is a type of action plan, with several activities, where each strategy has a clear objective (specific objective) and is an integrated part of the total programme.

Example: Capacity-building

Monitoring / Process evaluation

1. A tool for monitoring the process
2. Indicate whether the decided work is done in time
3. Identifying obstacles / bottlenecks in the implementation of the strategy
4. Inform staff in order to improve the structure, design and management
5. Important for the understanding of process, and for the interpretation of results for the outcome evaluation

Annex 4:

Causes

(Summary day 2)

Symptoms & Signs / Outcome

- Malnutrition: Acute, stunting deficiencies (anaemia, vitamins, minerals, protein, fat). Malnutrition among age groups, low birth weight
- Disability: Impaired learning, vision problems
- Death: Deficiencies, pregnancies, abortions, mortality caused by malnutrition

Immediate causes

- Poor diet: Breastfeeding, supplements (constipation due to iron), dietary composition / balance, meeting needs of different groups, diversification, low intake
- Disease: Infections (immunodeficiencies for different age groups), dehydration, parasites.

Underlying causes

- Food security / family food shortages: Food shortages, food quality & quantity, access / availability, food diversity
- Inadequate practices in food preparation and caring: Food preparation, cooking for specific needs (such as children), storage capacity / quality
- Poor living conditions: General hygiene conditions, contaminated water, flies, handling of human waste.

Basic causes

- Stress: The situation of refugees
- Education, awareness & knowledge
- Insufficiency of potable water (drinking)

Annex 5: The objectives and indicators from the working groups

	Objective:	Indicator:
1	Reducing chronic malnutrition among Saharawi children of age less than (<) 5 years by 50 % within 3 years.	Height for Age Z-score (HAZ) <-2SD
2	Reducing acute malnutrition among Saharawi children of age < 5 years by 50 % within 3 years	Weight for Height Z-score (WHZ) <-2 SD
3	Reducing mortality rate particularly related to undernourishment and anaemia among Saharawi children and woman (15-49 years) within 3 years with X%	Not addressed by the working groups
4	Reducing anaemia among Saharawi refugee women in reproductive age (15 – 49 y), pregnant and breastfeeding, by 50 % within 2 years.	Haemoglobin levels and cut-offs according to WHO standards
5	Reducing anaemia among Saharawi refugee children by 50 % within 2 years.	Haemoglobin levels and cut-offs according to WHO standards
6	Ensure access to food that is nutritional sufficient, divers and cultural acceptable to all the Saharawi refugee population within 3 years	The monthly distribution calendar is respected The basic food ration is diversified Individual ration respect ?international nutritional recommendations? The food is cultural acceptable.
7	Improve the nutritional situation among Saharawi refugee women during pregnancy and lactation by X % in X years	WHO health indicators relevant to nutrition
8	Improve school feeding among Saharawi children by X %, within X years	Not addressed by the working groups
9	Improve the Saharawi living conditions by improved water and sanitation facilities for all within X years	Quality, quantity and availability (distance for water collection) according to international standards on water related diseases and hygiene
10	Improve the quality of the nutrition related health care for the Saharawi population with X% by 3 years	Not addressed by the working groups
11	Improvement of knowledge and food practices related to food habits among ??, x %, x years?	Children eating at least 5 times per day
12	Improvement in knowledge and food practices related to hygiene among ??, x %, x years?	Not addressed by the working groups
13	Have a health and nutrition information sharing system for all health and nutrition stakeholders within 3 years	Not addressed by the working groups
14	Increase Saharawi's women's participation in decision-making processes related to food nutrition and health issues in the Saharawi population within 6 months.	Not addressed by the working groups

ANNEX 6

Objective 1: Reducing chronic malnutrition among Saharawi children of age less than (<) 5 years by 50 % within 3 years.	
Strategies	**Activities**
Objective 2: Reducing acute malnutrition among Saharawi children of age < 5 years by 50 % within 3 years.	
Strategies	**Activities**
Objective 3: **(Group 1)** Reducing mortality rate particularly related to undernourishment and anaemia among Saharawi children and woman (15-49 years) within 3 years with X %	
Strategies	**Activities**
1. Set up a therapeutic structure in order to reduce mortality rate related to undernourishment and anaemia (Group 1) 2. Improved health care management in the dispensaries (Group 1) 3. Monitoring (Group 1)	
Objective 4 and 5 (Group 3 and 4): Reducing anaemia among Saharawi refugee women in reproductive age (15 – 49 years old), pregnant and lactating, by 50 % within 2 years (Group 3 and 4), and children under 5 year (Group 3)	
Strategies	**Activities**
1. Continuous sensitisation plan among women, health staff and local authorities on causes of anaemia and preventive measures (Group 4 and 3)	1. Using radio, TV, work shops with different associations and teachers (Group 4) 2. Introduce the topic of health education in school. (Group 4)
2. Development of family gardens at regional and national levels (Group 4)	Sensitisation of the importance of family gardens. (Group 4)
3. Promote development of family livestock at regional and national levels (Group 4)	Sensitisation of the importance of livestock (Group 4)
4. Improve the management of food distribution (Group 4)	1. Management of the distribution take into account social factors (Group 4) 2. Active participation of women in the management of food distribution (Group 4) 3. Request improvement in quality, quantity and diversification including fresh food. (Group 4) 4. Distribution of fortified products in individual rations (Group 3) 5. Improve the preparation of nutritional products (WSB) (Group 4) 6. Change present iron treatment by other acceptable and tolerable products. (Group

	3 and 4) 7. Provision of preventive anaemia treatment in preschool. (Group 3)
5. Improve and strengthen continuously the health systems for the women and child health programs: nutrition, mental health (Group 4)	1. Ensure the presence of the health staff (Group 4) 2. Training of staff (Group 4) 3. Team work and improved communication (Group 4) 4. Improved definition of tasks and responsibilities (Group 4) 5. Increase the demands towards the health staff while also ensuring better working conditions (Group 4) 6. Ensure that incentivising is directly related to performance attendance and working time (Group 4) 7. Improve the conditions of medical commissions that interfere with the daily work. (Group 4) 8. Follow up the patients include after treatment (Group 3) 9. Elaboration of a simplified protocol of prevention and treatment of anaemia (Group 3) 10. Distribution of equipment related to anaemia detection. (Group 3)
6. Integration and unified management of nutrition programmes. (Group 4)	1. Request of Ministry of health to the Ministry of Cooperation to ensure better the cooperation between external project 2. Strengthen the department of nutrition. Empowering its capacity, coordination and leadership
	Annually survey on prevalence of anaemia (Group 3)
Objective 6: Ensure access to food that is nutritional sufficient, divers and cultural acceptable to all the Saharawi refugee population within 3 years	
Strategies	**Activities**
	1. Resource mobilisation (Group 3) 2. Selection of products in the food basket, including products (Group 1) suggested by the Saharawi women (Group 2) 3. Procurement of the selected food basket (Group 1) 4. Organisation of transportation and distribution on monthly basis (Group 1) within one week (Group 3) 5. Monitoring at family level (Group 1)

	6. Advice and counselling on food preparation balanced diet and storage (Group 1, see also Objective 12&13) 7. Food storage (Group 3) 8. Settle a 3 month buffer stock (Group 2 and 3) 9. Share the technical specifications of the products with the Ministry of Health (Group 2 and 3) 10. Improve agriculture activities (Group 2) 11. Promote the creation of small economic activities.(Group 2) 12. Monitoring of basket and distribution (Group 3) 13. Post monitoring of distribution (Group 3)
Objective 7: Improve the nutritional situation among Saharawi refugee women during pregnancy and breastfeeding by X % in X years	
Strategies	**Activities**
Objective 8: Improve school feeding among Saharawi children by X %, within X years	
Strategies	**Activities**
Objective 9: Improve the Saharawi living conditions by improved water and sanitation facilities for all within X years	
Strategies	**Activities**
Objective 10 (Group 1): Improve the quality of the nutrition related health care for the Saharawi population with X % within 3 years	
Strategies	**Activities**
	1. Recruitment, training and recycling (Staff: Technicians, medical and nurses) (Group 1) 2. Building and maintenance of infrastructure: monitoring: Regularly visits by MoH and MDC on the following working plans (Group 1) 3. Equipment: Procure furniture/ apparatus / consumables: Monitoring: Verification of delivery installation, use and maintenance by MoH, ONGs and donors (Group 1) 4. Receive medicines. Monitoring: Verification of delivery vs. order and expiry date 5. Services: Paediatric, epi, prevention Monitoring: Patients record book, adequate use of protocols, check diagnose vis-à-vis treatment (Group 1)

	6. Health communication: information, prevention and promotion. By formal channels of communication (TV, radio, Internet) sensitisation campaigns, seminars etc. Monitoring: Check regularity of messages, surprise visits to sensitisation events (Group 1) **7.** Monitoring by MoH ONGs, UN, donors (Group 1)
Objective 11 and 12: Improve knowledge and practices related to food practices and hygiene	
Strategies	**Activities**
Use of media for food and hygiene messages (Group 3)	1. Elaboration of the message (Group 3) 2. Selection of media and elaboration of media support (Group 3) 3. Organisation of sensitisation sessions and other sensitisation activities. (Group 3) 4. Monitoring of the changes (CAP survey) (Group 3)
Community based training and information (Group 1)	1. Participating food preparation in the households (Group 1 and 3) 2. Advise how to make balanced diets (Group 1) 3. Advise on proper storage of food (Group 1)
Objective 13 (Group 1): Have a health and nutrition information sharing system for all health and nutrition stakeholders within 3 years	
Strategies	**Activities**
	1. Regular meeting with all partners / stakeholders (Group 1) 2. Web site (Group 1) 3. E-mail chain system (Group 1) 4. Resource center (Group 1)
Objective 14 (Group 2): Improve the Saharawi women‘s participation in decision-making processes related to food nutrition and health issues in the Saharawi population within 6 months.	
Strategies	**Activities**
	1. Family visits (Group 2) 2. Election of the women in each wilaya that will be represented in the Saharawi Red Crescent. (Group 2) **3.** Report from Red Crescent should monthly be submitted to the administration to be discussed with UN organisations and NGOs (Group 2)

Annex 7

Progamme for the Workshop on
Saharawi Nutrition Programme and Strategy

Start: Sunday 19 October 17.00 – 19.00

Continue: Monday, Tuesday and Wednesday from 09.00 – 13.00 and 16.00 - 19.00.

Finish: Thursday 23 October, 09.00 – 12.00.

Place: 27 February camp.

Lunch: Will be served in 27 February camp to all participants from 14 o'clock Monday, Tuesday and Wednesday.

The Saharawi Ministry of Health arranges this workshop to develop a National Saharawi Nutrition Programme and Strategy. Professionals from different NGOs, UN organisations and Saharawis are invited to participate in this work. The workshop will be facilitated by Norwegian Church Aid (NCA) and Akershus University College (AUC).

Agenda for the Workshop:

Sunday 19.10.08 from 17 .00 to 19 00

- Welcome by the authority of 27 February camp
- Opening by Sr. Yahia Bouhabeini, President of Saharawi Red Crescent
- Opening by Arne Oshaug, Professor in Public Nutrition, AUC
- Presentation of the participants by Alien Moh Salem, Director of Cooperation in MoH.
- Introduction to the workshop objectives, the working methods and the work shop program
- Plenum discussion about the nutrition related problems and the challengers

Monday 20.10.08 (09.00 – 13.00 and 16.00-19.00)

09.00 - 09.30. Plenum: Summing up the discussion from Sunday and preparing for working groups.

09.30 - 11.30. Working group discussion: What is the nutrition related problems in short and long terms? What do we know?

Tea break (11.30-12.00)

12.00 - 12.30. Plenum: Presentations of the results from the working groups

12.30 - 13.00 Plenum: Discussion about the symptoms & sign, immediate, underlying and basic causes of nutritional problems.

Lunch break (13.00 – 16.00)

16.00 - 18.00. Working groups discussion: What do we know and what do we think is the causes of the nutritional problems?

18.00 - 19.00 Plenum: Presentations of the results from the working groups

Tuesday 21.10.08 (09.00 – 13.00 and 16.00-19.00)

09.00 - 09.15. Plenum: Summary from Monday on the problems and causes of malnutrition.

09.15 - 09.30. Plenum: Definition of an objective and indicators.

09.30 - 11.30. Working group discussion: Develop objectives for each problem defined in the group.

Tea break (11.30-12.00)

12.00 - 13.00. Working groups: Identify indicators for each objective that the groups have indentified.

Lunch break (13.00 – 16.00)

16.00 - 17.00 Working groups: Prioritizing: What are the most urgent and important objective to be addressed by the program within the next 5 years?

17.00 - 19.00 Plenum: Presentations of the results from the working groups

Wednesday 22.10.08 (09.00 – 13.00 and 16.00-19.00)

09.00 - 09.30. Plenum: Summing up the achieved work of Tuesday on the objectives, indicators and prioritizing.

09.30 - 10.00. Plenum: Explication of strategy and activities and definition of monitoring, responsibility and timeframes.

10.00 - 11.30. Working groups on: strategies and activities including responsibility and timeframes

Tea break (11.30-12.00)

12.00 - 13.00. Working groups on monitoring including responsibility and timeframes

Lunch break (13.00 – 16.00)

16.00 - 18.00 Continuing working groups on strategy, activities and monitoring including responsibility and timeframe

18.00 - 19.30 Plenum: Presentation of the results from the working groups.

Thursday 23.10.08 (09.00 – 12.00)

09.00 - 09.30 Plenum: Summing up the achieved work of Wednesday on strategy, activities, responsibility and monitoring.

09.30 - 11.00 Discussion about the process and what has been discussed during the days.

Summary of the process and the background for the work with a National Nutrition Programme and strategy, by Alien Moh Salem, Director of Cooperation in MoH

Official closing ceremony by the Prime Minister Abdelkader Taleb Oumar.