

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

NATIONAL NUTRITION POLICY

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PREFACE

Nutrition is a key sector for a country's sustainable development. It contributes to achieving the Millennium Development Goals, to which Rwanda has committed itself as a member of the international community. Malnutrition in an individual or at the community level impacts negatively on the well-being of the individual as well as on the community's development.

Following the events of the 1990s, the nutritional situation of the population, in particular that of children under the age of five and of women, has worsened significantly. There are many efforts from the Government of Rwanda to improve the nutritional status of the population through various interventions at the community as well as the national level. Different nutrition interventions such as community-based nutrition programs, vitamin A supplementation in children between 6-59 months and post partum women, and promotion of the consumption of iodized salt, have been implemented.

Nevertheless, the nutrition situation remains precarious as the national prevalence of protein-energy malnutrition and micronutrient deficiencies remain high contributing directly or indirectly to the high infant, child and maternal mortality in the country. The HIV/AIDS pandemic has worsened the already deteriorating nutritional situation. Decrease in rainfall, reduction in national food production, misdistribution of food at all administrative levels and within households, household food insecurity, ignorance of good nutrition practices, and the reduction of household purchasing power are some of the factors negatively influencing the nutritional status of the population. Moreover, the lack of a strategic framework for action by Government technical departments and partners inhibits the harmonization and effectiveness of interventions.

Concerned with this situation, the Government of Rwanda has decided to focus on nutrition interventions in various sectoral development programs, by developing this multisectoral nutrition policy. A holistic approach is envisioned for the implementation of this policy given that nutrition is a multisectoral domain.

The adoption of a national nutrition policy allows the enactment of guiding principles and pertinent strategy options as well as efficient implementation mechanisms for nutrition interventions which underpin the fight against malnutrition and HIV/AIDS.

Through the adoption and promulgation of this national nutrition policy, the Government of Rwanda reaffirms its commitment to ensuring better nutrition for its population.

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ACRONYMS AND ABBREVIATIONS

ACN	: Community worker for nutrition
ARV	: Antiretroviral
ASC	: Community Health Worker
CAP	: Knowledge, Attitude and Practice
CECOM	: Center for Community Education
CRS	: Catholic Relief Services
DUHAMIC	: Action pour le Développement Rural Intégré (Rwandan rural development NGO)
RDHS	: Rwandan Demographic and Health Survey
ISLC	: Integrated Survey on household Living Conditions
FAKCO	: Food Action Kigali Corporation
FAO	: United Nations Food and Agriculture Organization
FOSA	: Health centers
FOSACOM	: Community health centers
GAIN	: Global Alliance for Improving Nutrition
GAVI	: Global Alliance for Vaccines and Immunization
UNHCR	: United Nations High Commission for Refugees
ICCIDD	: International Council against Iodine deficiency diseases
IHAB	: Initiatives for Baby Friendly Hospitals
BMI	: Body Mass Index
IRC	: International Rescue Committee
ISAR	: Institute of agronomic sciences in Rwanda
KHI	: Kigali Health Institute
WHO	: World Health Organization
ONAPO	: National Office for Population
ONG	: Non Governmental Organization
ONAIIDS	: UN aids Organization
ORINFOR	: Rwandan Information Office
ORN	: Rwanda Standardization Office
WFP	: World Food Program
PEPFAR	: Presidential Emergency Plan for Aids Relief
GDP	: Gross Domestic Product
PMTCT	: Prevention of Mother to Child Transmission
PNBC	: Community based Nutrition Program
PVV	: People living with HIV
AIDS	: Acquired Immune-Deficiency Syndrome
SIS	: National Health Information system
WBW	: World breastfeeding week
TDCI	: Iodine deficiency caused diseases.
TRAC	: Treatment and Research for AIDS Center -
UNICEF	: United Nations Children's Fund
USAID	: United States Agency for International Development
VCT	: Center for Voluntary Testing
HIV	: Human Immunodeficiency Virus

SUMMARY

Malnutrition affects all development sectors and has high social and economic costs such as increased mortality and morbidity, loss of human potential, decrease in skills and qualifications, lower productivity, and higher poverty. Some of these effects are intergenerational. Malnutrition can seriously jeopardize the achievement of the Millennium Development Goals. The fight against malnutrition is therefore of high priority.

Nutrition is essential for the development of human resources that are indispensable for poverty reduction. Simple and affordable interventions have been shown to be effective in the fight against malnutrition. One such example is exclusive breastfeeding, which is one of the most effective strategies to promote child health and survival.

Nutrition plays an important role in the fight against HIV/AIDS. It increases the efficacy of medications, decreases ARV side effects and may prolong the life of people living with HIV/AIDS.

Given the continued deterioration of the nutritional situation in Rwanda, the consequences of the HIV/AIDS pandemic on nutrition and health, especially in women and children, as well as the role of nutrition in the fight against AIDS, the adoption of a national nutrition policy is highly commended. This policy has to be adapted to realities and specifics of the country and to its development goals.

This document of National Nutrition Policy reflects the nutritional situation in the world and especially in the country.

Identified strategies to resolve nutritional problem, mechanisms and institutional framework for the implementation as well as the costs and financing are detailed in this document also by taking into consideration the multi sectoral aspect of malnutrition.

1. GENERAL CONTEXT

Adequate food and nutrition are a universal right and are essential for the physical, mental and emotional development of children as well as the quality of life for adults. Nutrition is also essential for increasing the efficacy of medications, such as antiretroviral drugs, and plays a critical role in the strategies for the prevention treatment and care of HIV/AIDS.

The National Nutrition Policy is part of the framework of the Health sector policy and is in harmony with the Government's policy on global development, as defined in Vision 2020 and in the Strategy Paper on Poverty Reduction in Rwanda. It provides a solid planning and reference base for all the interventions in the nutrition sector.

Rwanda is a landlocked mountainous country located in the Great Lakes region, with a surface area of 26,338 km². According to the 2002 Demographic Census, Rwanda has a population of 8.162.715 and a population density of about 310 inhabitants per km², one of the highest in Africa. The population growth rate is estimated at 2.9 %. The country has a high birth rate, at 43 per 1000 in 2004. With an annual per capita income of US\$ 210, Rwanda is one of the poorest countries in the world. The GNP is around 1.8 billion US dollars. Agriculture is the country's main source of foreign currency and the principal means of subsistence for the population.

Rwanda is currently engaged in a good governance policy. Political and administrative structures are decentralized and encourage the participation of the population. Rwanda also has an important political and economic liberalization program. After a transitional period of 9 years, a referendum on a new constitution was carried out and municipal, presidential, parliamentary and senatorial elections were conducted.

Given the consequences of malnutrition in the face of the development challenges in the world, the 1990 World Summit for Children set a goal of reducing the prevalence of malnutrition by one third by the year 2000. The same goal has been reiterated at other global forums such as the World Health Assembly (1991), the International Conference for Nutrition (1992) and the World Summit for Nutrition (1996). This objective is an integral part of the Millennium Development Goals. At the regional level, the African Union, NEPAD, SADC and other intergovernmental organizations, have adopted resolutions and recommendations aimed at fighting malnutrition and poverty. Rwanda has adopted the commitments, resolutions and recommendations of the above mentioned international summits and institutions. Rwanda has also adopted the Convention for the Rights of the Child (CRC) and the Convention for the Eradication of all forms of Discrimination against Women (CEDAW). Rwanda has also adopted various sectoral national policies and strategies such as Vision 2020, the PRSP, the National Policy on Health, and the National Policy on Agriculture that can have a real impact on the promotion of better nutrition for its population.

2. GENERAL ORIENTATIONS

Vision 2020, which was adopted in 2001 for the development of Rwanda, underscored in its paragraph 102, the high national prevalence of malnutrition and its adverse impact on the country's economy. It highlighted the inadequacy of the population's food intake vis-à-vis its nutritional needs, in spite of the efforts made in the agricultural sector, which involves 90% of the national workforce.

In 2001, more than 60 % of the Rwandan population was living below the poverty line. Given the significance of this problem, Rwanda adopted the **Poverty Reduction Strategy Paper (PRSP)** in order to support the development of the country. Nutrition is essential for the development of human resources indispensable for the reduction of poverty. In fact, the social and economic costs of malnutrition are enormous and include increased mortality and morbidity rates, loss of human potential, reduced learning and working capacities, lower productivity and increased poverty. Some of these effects are intergenerational.

Given the negative impact of malnutrition on survival, learning and working capacity, and productivity, the promotion of nutrition is a major investment for the country's sustainable development. Investment to improve the population's nutrition, particularly that of children and women, is an effective mechanism to improve the standard of living for generations to come and must be intensified. Rwanda has adopted a "Stratégie Nationale pour l'Accroissement des Capacités d'Investissements" as translated in the orientations of Vision 2020. The decentralization of political and administrative structures as adopted in the framework of good governance creates conditions for implementation of the Sector Wide Approach mechanisms recommended in the National Investment Strategy which facilitate financial support of grassroots entities for their development.

The **Health Sector Strategic Plan 2005-2009**, an integral part of the seven-year government program, has stressed the necessity to adopt a national nutrition policy to guide and coordinate the multisectoral interventions required to effectively fight malnutrition. The National Nutrition Policy is the fundamental tool to guide the establishment of priority strategic directions in nutrition matters and to ensure effective advocacy to mobilize the human, material and financial resources required for the realization of the government's short-term and long-term nutrition programs.

According to the diagram in Annex 2 malnutrition has a negative impact on the achievement of the **Millennium Development Goals (MDGs)**. Indeed, malnutrition jeopardizes survival by increasing infant and maternal mortality. It exacerbates the effects of HIV/AIDS on the immune system increasing the vulnerability of infected people even those on ARV. Malnutrition decreases the intelligence quotient (IQ) and reduces cognitive capacity and thereby negatively affecting the success of the universal education strategy. Malnutrition leads to stunting and reduces physical work capacities. Malnutrition particularly affects women, who form the majority of the agricultural workforce, thus leading to decreased productivity.

3. NUTRITIONAL SITUATION

The nutritional situation in Rwanda remains precarious in light of the high levels of different types of malnutrition in the country over many years. For the last two decades, protein-energy malnutrition and micronutrient deficiencies have remained significant public health problems in Rwanda, contributing to the high infant, child and maternal mortality. Although the prevalence of underweight decreased from 29% in 1992 to 22% in 2005, stunting or chronic malnutrition increased slightly during the same period (42% and 45%). This situation is a reflection of persisting difficult socio-economic conditions of the population during the last two decades, mainly related to the consequences of war in the 1990s.

3.1. Protein- Energy Malnutrition

According to the Rwandan Demographic and Health Survey (RDHS, 2005), chronic malnutrition or stunting, which results in delayed growth, affected 45% of children between 0 and 5 years. This prevalence touches all age groups with an increase from age 6 months to 59 months (8.4% between 0-6 months, 20.6% between 6-9 months and 52.2% between ages 4 to 5 years). The rural areas (47.3%) are more affected than the urban areas (33.1). Regional differences are also observed: North has 52.2%, West (46.9%), South 44.8%, and East (42.4%). Kigali, the capital city has a prevalence of 29.2%. Overall, there were no major differences by sex.

Underweight (low weight compared to age) affects 22% of children under-five. Acute protein energy malnutrition (low weight compared to height), which is associated with a high death rate, affects 4% of children in the same age group, two times higher than in a normal population of the same age group.

Malnutrition does not only affect children. According to RDHS 2000, 9 % of women between 15 and 49 years old were malnourished (BMI < 18.5), with higher rates in rural areas (9.4%) than in urban areas (6.7%).

This alarming situation is partly due to cyclical food crises and chronic food deficits at the household level. The situation requires an effective emergency response system concomitant with concerted long-term actions to improve nutrition and food security.

The 2003 annual report of the Ministry of Health ranked severe protein-energy malnutrition amongst the leading 10 causes of morbidity in health centers for children between 0 and 59 months old, and, in hospitals, the 4th cause of mortality for children between 0 and 1 year old, and 2nd cause of mortality for children between 1 and 14 years old. Cases of malnutrition reported by hospitals are those associated with severe and visible manifestations (kwashiorkor, marasmus, mixed forms of malnutrition) and these extreme cases are just the tip of the iceberg. Although often unreported, moderate and hidden malnutrition contributes to more than 60% of child deaths.

3.2. Micronutrient Deficiencies

Anemia, which is a common manifestation of iron deficiency, is an important cause of maternal mortality, of low-birth weight, and of reduced attention and scholastic achievement for children. Anemia is very widespread in Rwanda and affects 56.3% of children under 5 years of age (RDHS 2005). It is also common (32.8%) in women of reproductive age, mainly due to the fact that the diet is based on cereals and tubers that are poor sources of absorbable iron.

In addition to its role in the prevention and treatment of night blindness, Vitamin A reduces susceptibility to and the severity of infectious diseases. Consequently, Vitamin A improves child survival. While a child mortality rate higher than 70 per 1000 is considered an indicator of Vitamin A deficiency, in Rwanda, the mortality rate for children under 5 years of age is 152 per 1000 (RDHS 2005). The 1996 National Nutrition Survey reported prevalence rates of 25% and 21% for sub-clinical Vitamin A deficiency (serum retinol < 20 µg/dl) for infants under 6 months and between 6 and 12 months, respectively. This is an indication of inappropriate feeding practices in early childhood. Moreover, according to the RDHS 2000, 7% of pregnant women were suffering from night blindness, indicating the presence of Vitamin A deficiency in the population.

Iodine deficiency disorders (IDD) affect physical and mental development. In 1990, the prevalence of goiter was 49.6% among school children between 10 to 20 years of age. In 1992, Rwanda adopted the Universal Salt Iodization strategy. The 1996 National Nutrition Survey showed a goiter prevalence of 25.9% for children between 5 and 19 years. This survey also indicated that the average value of urinary excretion of iodine (298µg/l) in Rwanda was higher than the normal range (100 to 200 µg/l), which suggests a higher risk of hyperthyroidism.

Available data indicate that deficiencies in iron, Vitamin A, and iodine are significant public health problems in Rwanda. However, there is no data for other physiologically important micronutrients, such as zinc, selenium, and vitamin B₁, making it impossible to determine whether deficiencies in these micronutrients pose similar public health problems, especially in the context of the HIV/AIDS pandemic.

The Rwandan population is not only affected by undernutrition. According to the RDHS 2000, 12.5% of women between 15 and 49 years old were overweight (BMI > 25), with higher rates in urban areas (24.5%) than in rural areas (9.9%). Being overweight or obese is a risk factor for diseases such as diabetes, gout, cardiovascular diseases, etc.

3.3. Causes of malnutrition

The causes of malnutrition are commonly grouped into three categories: immediate, underlying, and root causes.

3.3.1. Immediate causes of malnutrition

Malnutrition is directly linked to inadequate food intake and to infectious diseases.

a) Insufficient food intake

According to the National Agricultural Policy (2004), Rwanda is largely food-deficient and the nutritional needs of the population are not adequately met. Compared to the daily nutritional requirements (2100kcal, 59g proteins and 40g fat), the national average coverage of daily nutritional requirements in 2001 was at 84% for energy, 73% for proteins and 17.5% for fat. Animal products, which are of higher nutritional quality, comprise only a small portion of the diet (providing only 3% of total energy intake, 7% of proteins, and 38% of fat), increasing the potential for deficiency in essential amino and fatty acids.

b) Infectious diseases

According to the 2003 annual report of the Ministry of Health, malaria, respiratory diseases, diarrhea and parasitic diseases were the cause of 80% of medical visits. Infectious diseases, especially diarrheal diseases and HIV/AIDS, reduce nutrient absorption and utilization and hasten malnutrition. In 2004, diarrhea was one of the main causes of child morbidity and mortality in Rwanda. The national prevalence of diarrhea is 16.9% while that of fever is 29% in children under the age of five (RDHS 2000). Only 7% of households have mosquito nets. HIV/AIDS prevalence in Rwanda was estimated at 8.9% in adults aged between 15 and 49 years (TRAC 2004).

3.3.2 Underlying causes of malnutrition

a) Household food insecurity

One of the main underlying causes of malnutrition is food insecurity in households. According to the Ministry of Agriculture (National Agricultural Policy, 2004), the Rwandan population suffers from food insufficiency with 7% of households only having one meal a day and only 3% having 3 meals a day. Access to food is limited by low household income as indicated by the low GDP per capita (US\$210) according to the Development Indicators for Rwanda (2003) report. Large household size (8) is another factor contributing to food insecurity and malnutrition.

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- Food availability

Food availability varies by production zone in the country. Production zones with poor soil and/or seasonally adversely affected by unfavorable climatic conditions (low rainfall) are permanent pockets of food insecurity and malnutrition (such as Bugesera, Gikongoro). In contrast, malnutrition in zones of high food production (Ruhengeri and Gisenyi) is probably due to the consumption of an imbalanced or non-diversified diet based on local products which are often sold to bring in household income. Food availability is also affected by the lack of food storage practices by households as a coping mechanism for periods of food shortage.

- Food accessibility

Access to food is limited by low household income (US\$ 210 per year per person). According to the integrated survey on household living conditions (ISLC, 2000), 60% of the adult population in Rwanda lives below the poverty line (< 1 US \$ a day) with 42% living in extreme poverty.

- National food distribution

Food is not equitably distributed throughout all regions in the country at all times. This is partly because much of the population depends on subsistence agriculture and also because food marketing mechanisms are inadequate.

- Household food distribution

Household food insecurity is also related to inequitable intra-household food distribution which most harms vulnerable groups such as women and children. Although there is little empirical evidence on intra-household food distribution in Rwanda, focus group discussions have suggested that men receive better and larger portions of meals (meat, fish, chicken, etc).

b) Inappropriate care for children and women

- Inadequate feeding practices

Malnutrition also is caused by poor feeding practices. In Rwanda, breastfeeding is a common practice amongst mothers. However, the practice is inappropriately carried out. Although the demographic and health Survey of 2000 reported that more than 60% of mothers exclusively breastfed up to 6 months, the actual proportion in practice is lower. The 2002 KAP study showed that only 17.4% of mothers breastfed their children up to 6 months without adding any other food or fluid, including water. According to the same KAP survey, complementary foods are introduced too early (starting at 4 months) or as late as at 12 months. Complementary foods such as modified portions of the family meal (85%) or cassava or cereal-based (maize or sorghum) porridge, that are commonly given to children, are nutritionally deficient. Furthermore, little oil and animal proteins are given to children. Meat is consumed by only 29% of children, cow's milk by only 12% and fat intake is even lower.

The KAP Survey 2002 also revealed that pregnant and breastfeeding women do not receive a diet appropriate for their increased nutritional needs. Similarly, nutritional care and support for other vulnerable groups (children between 0 and 5 years old, elderly people, orphans, PLWHAs) is insufficient.

- Inadequate primary healthcare

Inadequate primary healthcare also predisposes to malnutrition. Generally, nutritional interventions have a very low coverage, as shown by proportion of iron and folic acid supplementation amongst pregnant and breastfeeding women which stands at 22% (RDHS, 2000). Implementation of growth monitoring amongst children in the health system is haphazard, especially after the last vaccination at 9 months. After this, children normally come to the health facility only when they are sick and weight measurement is used mainly to determine medicine dosages, not for growth monitoring. Community based growth monitoring is not yet widespread. According to the Survey on Healthcare Services (2001), only 10% of health facilities carry out growth monitoring activities and only a small proportion of sick children are properly evaluated.

The lack of tools for nutrition monitoring, IEC materials and qualified human resources contribute to the low interest given to nutrition even in the Health Information System. Only 10% of health facilities provided growth monitoring and vaccination services, whereas 90% and 74% had baby scales and child scales, respectively (Survey on Healthcare Services, 2001). In addition, nutrition activities are generally assigned to social workers without the required qualifications.

Access to healthcare services is limited by population's insufficient financial resources hence the utilization of available services is very low. According to RDHS (2000), 76% of women did not have access to healthcare for financial reasons. Inadequate healthcare is also linked to the shortage of healthcare professionals; for example, there is only 1 doctor for 40,000 inhabitants and 1 nurse for 4,070 inhabitants. Furthermore, personnel in the health sector do not receive regular in-service training to improve their knowledge and skills, especially in nutrition related matters.

c) Inadequate access to clean water and hygienic facilities

Access to potable water amongst the population is limited. Generally, the population drinks untreated (not boiled) water and basic hygiene (for example, the washing of hands, after using the toilets or before and after a meal) is neglected. One eighth (13%) of the population use water that comes straight from the rivers and lakes.

Food hygiene practices are inadequate. For example, in marketplaces, food is often sold in its raw form, spread on the ground, and exposed to dust and microbes. Few products are sold as processed and packaged goods, particularly in rural areas.

Environmental hygiene and sanitation is also poor. According to MICS 2001, only 1% of households have flushing toilets (8.9% in urban and 0.5% in rural setting), 1.3% have improved latrines (7.6% urban versus 0.9% rural), 71.1% of households having traditional latrines (75.5% urban versus 70.8% rural) while 3.3% of households do not have any human waste management system (1.3% urban versus 3.4% rural). Insufficient drainage systems aggravate sanitation problems and favor mosquitoes and other pests that can spread malaria and other infectious and opportunistic diseases thus predisposing to malnutrition.

3.3.3. Root causes

The root causes of malnutrition include economic imbalances and weaknesses, inadequate institutional support to nutrition interventions, adverse climate changes, lack of arable land, ownership and control over family resources and, low literacy rates particularly among women.

The Rwandan economy has some structural imbalances, mainly resulting from the tragic events 1990s, poor natural resources and the fact that it is a landlocked country. Rwandan economy is agriculture-based with a production that is not only low (because of over-exploitation of land and inadequate farm inputs) but also directly dependent on climatic fluctuations.

In 2000, the Government budget allocation to nutrition was very low at 2% of the Health budget which, in turn, represented only 0.5% of GDP. According to the World Report 2004, the per capita health expenses in Rwanda in 2001 amounted to 11 US\$ per person and 24 US\$ by the government. The human and material resources allocated to nutrition are insufficient.

Adult literacy in the country, especially among women, is low. In fact, according to RDHS (2000), more than a third of the women (34.9%) compared to slightly over a quarter of men (27.5%), declared that they had no formal education. The same survey has shown that low education level of mothers negatively affects the quality of care provided to children and other household members.

4. PRESENTATION OF THE NUTRITION SUB-SECTOR

4.1. Defining the Nutrition Sub-Sector

Nutrition is a sub-sector of the Ministry of Health housed in the Maternal and Child Health (MCH) Unit. Nutrition is multi-sectoral in character and can both affect or be affected by many other development sectors which influence the nutritional well-being of the population.

4.2. Current Status of nutrition services and support structures

One of the nutrition services offered at the health center is growth monitoring in combination with immunization. Growth monitoring enables the mother to visualize the growth (which is plotted in the child's Growth Card) and discuss the child's development with the service provider. Another nutrition service that is provided is the care and treatment of acute severe protein energy malnutrition in accordance to the national protocol of 2001. Counseling on infant and young child and women feeding is also provided in health centers by health personnel during antenatal care. Plans have been made to integrate Vitamin A supplementation in routine EPI activities. Currently, Vitamin A supplementation for children (aged between 6 and 59 months) and post-partum women is done twice a year during mass national campaigns. This has led to a high coverage in children (>90%) and the post-partum women.

The government has legislated iodization of salt prohibiting importation of un-iodized salt for human consumption. As a result, 92% of Rwandan households consume iodized salt. There are also voluntary food fortification projects that are ongoing. For example, DUHAMIC fortifies weaning food with vitamins and minerals (A, B1, B2, PP, B12, C, and iron, Calcium, Zinc) to meet the needs of vulnerable people.

Additionally, a number of development partners (UNICEF, USAID, IRC, CONCERN, NUTRIPA) support community-based nutrition programs (CBNP) as well as projects on early childhood development, parenting education (CECOME), and give support to women associations.

In the area of HIV/AIDS, the Ministry of Health has developed a number of guidelines and protocols aimed at integrating nutrition into the national response to HIV/AIDS. These include the National Guidelines for Nutritional Care and Support for PLWA together with a Minimum Food Package for those infected or affected by HIV/AIDS from food insecure households.

However, there are some gaps in different domains:

- Inadequate coordination and implementation of nutrition related activities

The national coordination for nutrition is the responsibility MCH Unit of the Ministry of Health. However, this coordination is jeopardized by a lack of qualified nutrition professionals and insufficient resources at all levels, which affect effective implementation and follow up of nutritional activities. In several health centers, nutritional activities are currently carried out by social workers with no specific training. Furthermore, the follow up of nutrition related activities is not based on appropriate indicators in the National Health Information System (HIS). Coordination mechanisms, particularly the framework of continuous dialogue with nutrition partners, with the exception of links with the Nutrition Technical Working Group (NTWG) which was initially set-up to develop the guidelines for nutritional care and support for PLWHAs, are also not well developed.

- Lack of capacity building in nutritionist

Rwanda suspended the nutrition training programs in vocational schools and at university in 1994 because nutrition was not classified as a priority area during that time. The number of nutritionists is therefore very low, despite the magnitude of nutritional problems.

4.3. Constraints and potential of the Nutrition Sub-sector

4.3.1. Constraints

The analysis of the nutritional situation has shown that this sub-sector faces the following constraints:

- the nutrition sector does not receive sufficient financial and political support it deserves, despite the impact its interventions can have on sustainable development
- the unstable geo-climatic environment, with pockets of seasonal food insecurity in some parts of the country leading to high malnutrition
- low level of literacy and education, particularly among women, which reduces the quality of care provided to children and the family in general
- impact of HIV/AIDS and the high prevalence of infectious and opportunistic diseases, which adversely affect the nutritional well-being of the population.

4.3.2. Potential

The Nutrition sub-sector has a lot of potential that can be exploited for its development:

- commitment of the Government to the Millennium Development Goals, the objectives of NEPAD and those of other international summits aimed at improving the nutritional state of the population, in particular, and of the living conditions in general
- implementation of existing nutrition-related policies (both general and sectoral) and national strategies and guidelines
- implementation of a health strategy based on decentralized management allowing the integration of essential nutrition related activities district and community levels
- effective coordination and collaboration with development partners and donors that support nutrition activities
- effective use of existing personnel for social mobilization (social assistants) that can be quickly deployed on the ground to launch community based nutrition activities throughout the country
- sectoral coordination between and others (Agriculture and Animal resources, Education, Information, Gender and Family, Labor and Vocational training, Economy and Finance, Youth, Local Administration, Commerce, Environment, Infrastructures) for the promotion of food security and nutrition of the population.

5. ANALYSIS OF RESPONSE TO MALNUTRITION

A series of actions have been implemented during the last decade to fight against malnutrition. Majority of these interventions have been preventive but with little coordination. However, the lack of efficiency, synergy and low coverage has not produced a tangible reduction in malnutrition at national level. This chapter analyzes the existing programs and actions in order to tease-out good practices which can be a basis for the National Nutrition Policy and accelerate the reduction of malnutrition.

5.1. The community- based nutrition program (CBNP) as well as pilot projects for the education of young children, parental education and capacity building of women's associations, have been implemented on a small scale country wide. Useful lessons have been learnt from these experiences and the Ministry of Health has developed an Implementation Guide on the extension of the community-based nutrition.

5.2. Baby Friendly Hospitals Initiatives (BFHI) for the promotion of breastfeeding and optimal young child feeding at health centers and community levels has not yet been implemented.

5.3. Growth Monitoring of children and weight-gain monitoring of for pregnant women are carried out through regular weighing at the Health Centers. For children, GM is normally done until the age of 9 months (end of vaccination) because mothers often stop the regular health visits after this. On the other hand, *the monitoring of weight gain for pregnant women* is not carried out in health centers routinely.

5.4. Vitamin A and iron Supplementation is not routinely given in health center but there is no adopted national strategy. Vitamin A supplementation for children (aged between 6 and 59 months) and post-partum women currently relies on mass national campaigns done twice a year. However, the integration of this activity into routine health services activities is still very weak (13.9% breastfeeding women received vitamin A through routine activities in 2000), and, in addition, its implementation is vertical.

Iron supplementation is not given systematically to pregnant women during antenatal visits as a prophylactic intervention against anemia. This may be due to the fact that the supplies are not always there. The national strategy to fight iron deficiency is also yet to be developed.

5.5. Food Fortification is not widely practiced in Rwanda. Only iodine fortified salt is commonly used, as a result of the adoption in 1992 legislation forbidding the importation of non iodized salt. However, the recommended rate of iodization is still at 100 ppm of iodine when the current recommended level is 20 to 40 ppm. In addition to iodized salt, the private sector (DUHAMIC) have initiated the enrichment of flour in vitamins (A, B1, B2, PP, B12, C) and in minerals (Iron, Calcium, Zinc) at the request of some service providers (WFP, CIAT). However, accessibility is limited due to the low purchasing power the population.

5.6. Prevention of lifestyle diseases is almost non-existent. An analysis of the current situation has shown that a good proportion of the population is overweight, which can result in obesity particularly among the urban population. The promotion of balanced diets, appropriate dietary practices and health habits are indicated to avoid dietary excesses. Alcohol abuse, use of tobacco and other drugs are also not yet included in health or nutrition preventive services. On the other hand, the prevalence of diabetes, hypertension, heart diseases, renal diseases and other lifestyle diseases is increasing in Rwanda. In addition, there is no protocol for nutritional care of such diseases.

5.7. Management of malnutrition cases at rural health centers is very limited considering that only about 30% of the population utilizes health services. For example, only 4% of severe malnutrition and 22% of moderate malnutrition cases were treated by health professionals in 2000 (RDHS).

5.8. Nutrition activities in schools has limited national. Currently a few nutrition activities have been initiated by partners in schools, i.e., school gardens and feeding program. An example of such activity is a support project for primary school focusing on girls, which started in September 2001 in regions with high levels of food insecurity. The active phase of this project is from January 2004 to December 2006. The project distributes daily meals in 200 schools for 179,183 children and monthly take-home food rations for 28,000 teenage girls in classes P4, P5 and P6.

5.9 Protocol and guidelines for the rehabilitation of malnourished children have not been officially adopted. As such, the rehabilitation of hospitalized children suffering from severe malnutrition is based on therapeutic milk and enriched food preparations without proper guidelines. Nutritional counseling for newborns, young children and mothers is done by healthcare personnel during prenatal visits without clear instructions and appropriate guidance.

5.10. Nutrition and HIV/AIDS. Nutritional care and support is not fully integrated in the fight against HIV/AIDS. Recently, the government adopted Guidelines for nutritional care and support of PLWHA that can be used by service providers/personnel responsible for HIV/AIDS management including the ART and PMTCT programs.

6. PRESENTATION OF THE POLICY

6.1. Guiding principles for the National Policy on Nutrition

To ensure good nutrition throughout the country, the national nutrition policy is based on the following guiding principles:

6.1.1. Decentralization

Rwanda is committed to good governance with decentralization of the administrative and political structures. Decentralization favors direct financial support to local entities (districts) through the sector wide approach mechanisms that directly finances activities, including nutrition-related activities, planned by the community development committees. Decentralization is viewed as one of the main paths to guarantee equitable access to good nutrition by Rwandans from all walks of life.

6.1.2. Empowerment of grassroots communities

Simple and affordable techniques, easy to implement by community agents, allow a considerable improvement of the population's health and nutrition, particularly for the vulnerable groups (children less than 5 years old, pregnant and breastfeeding women, elderly people). These actions include promotion of food security for household level (together with the processing and storage of food after harvesting), and better child care and feeding practices, particularly for infants and young children. Others include growth monitoring and promotion (through regular weighting), micronutrient supplementation for target groups, family planning, improved water and food hygiene, and adult education.

Community-based nutrition is the most efficient approach to fight nutritional diseases and several health problems. It empowers grassroot communities to take responsibility in solving their problems throughout participation in the whole management process (prioritization, planning, implementation and monitoring). The government and its development partners, should give technical support and build the capacity of existing community based organizations, such as development committees and community health workers, to enable them carry out their responsibilities effectively.

6.1.3. Integration

To effectively address the malnutrition problem; preventive measures must be integrated in the development plans of various sectors (Health, Agriculture, Education, Commerce, etc.). Rwanda has adopted a health strategy for primary healthcare based on integration of medical care at the level of the district. A set of essential nutritional activities should be defined, taking into consideration the nutritional situation of the country, and integrated at the level of health centers and community based services in each district, under the coordination of the national program for nutrition. Other programs and strategies for health and development (IMCI, fight against HIV, Reproductive Health) should also integrate or reinforce the nutrition component in their activities.

6.1.4. Intersectoral collaboration and partnership

The fight against malnutrition is multisectoral and the measures that need to be adopted to solve nutritional problems are beyond the health sector. The collaboration of various sectors (development and private), based upon the complementarity of various interventions, is essential to effectively respond to the food and nutritional needs of the population and mobilize the required resources for implementation and monitoring of the nutrition activities.

6.1.5. Coordination

In order to strengthen the consistency and efficiency of actions undertaken by many sectors and partners, the nutrition activities should be coordinated at all levels from the central to the district level of the national health system. Each level has its specific mission: conceptualize policies and strategies, and mobilize resources for the central level, technical for the regional, operational for the district level.

6.2. Vision of the national nutrition policy

The vision of the national nutrition policy is to ensure good nutrition for all Rwandese. This policy is based on the values of solidarity, ethics, equity, as well as cultural diversity and the importance of gender, for the harmonious development of Rwanda as a nation.

6.3. Mission of the National nutrition policy

The mission of the national nutritional policy is to provide a favorable environment for the effective implementation of nutrition interventions that guarantee the nutritional well-being of the entire population for the sustainable development of Rwanda.

The national nutrition policy results from the situation analysis of nutrition in Rwanda, is the basis for planning and orientation for all interventions in the nutrition area. It specifies the objectives and prioritizes the strategic orientations, it also defines coordination modalities of actions at the various levels of the health system in the country, provides guidelines for monitoring and evaluation of nutrition activities as well as the implementation plan.

6.4. Objectives of the National Nutrition Policy

6.4.1. General objective

The general objective of the national nutrition policy is to improve the nutritional status of the Rwandan people.

6.4.2. Specific objectives

In order to improve the nutritional status of the population, the policy seeks to achieve the following specific objectives:

- Promote practices favorable to the improvement of the nutritional status,
- Reduce the prevalence of diseases linked to nutritional deficiencies and excesses,
- Prevent mother-to-child transmission of HIV through appropriate breastfeeding and infant and young child feeding practices,
- Assure adequate treatment of malnutrition due to nutritional deficiencies and excesses,
- Provide nutritional care and support for people living with HIV/AIDS

6.5. Expected outcomes and the link to the Millennium Development Goals

Goal 1: Reduce poverty and hungry

- The prevalence rate of protein-energy malnutrition in under five of age children is reduced from 45% to 30% for stunting, 22% to 15% for underweight, 4% to 2% for wasting.

Goal 2: Ensure primary education

- The prevalence rate of anemia is reduced by from 56% to 37% in children and from 33% to 22% in women.
- Iodine Deficiency Disorders are eliminated from 26% to less than 5% of total goiter.

Goal 3: Reduce Infant Mortality

- Increase the proportion of women exclusively breastfeeding for the first 6 months with optimal complementary feeding up to 24 months from 17,4% to 60%.
- Reduce Vitamin A deficiency in children under five from 25% to 5% in children under five years.

Goal 4: Reduce Maternal Mortality

- Reduce Vitamin A deficiency (night blindness) in pregnant women from 7% to less than 1%.
- Reduce the prevalence of anemia in pregnant women from 33% to 22%.

Goal 5: Combat HIV/AIDS and other diseases

- Nutritional support is provided to PLWA and other vulnerable people.
- Nutrition related chronic diseases are prevented.

7. STRATEGIES FOR NUTRITION IMPROVEMENT

To achieve its objectives, the national nutrition policy has the following strategies:

7. 1. Reinforcement of the political commitment

Given the magnitude and persistence of nutrition problems in the country, their multi-causal factors and impact on different development sectors, Rwanda needs to strengthen its political commitment to improve the nutritional well-being of its people and make this a priority of governmental action for its sustainable development. Some of the measures that can strengthen the political commitment are:

- Adopt and promulgate a National Nutrition Policy,
- Integrate nutrition in the socio-economic development indicators (PRSP, Vision 2020),
- Include a nutrition component in all sectoral development programs,
- Allocate and/or mobilize adequate government or partner resources for the fight against nutritional problems, in particular, the financing of nutrition activities through the medium-term expenditure framework (MTEF),
- Re-establish the training of nutritionists at A₁ level and initiate undergraduate (A₀) and graduate nutrition degree programs in the university,
- Integration of nutrition in the curriculum of basic education at primary and secondary levels, and establish an in-service training program for health professionals;
- Allocate nutrition positions for each level in the health system,
- Develop and/or adopt, and implement national strategies and protocols related to nutrition (such as the Protocol for the treatment of acute malnutrition, Guidelines for the nutritional care and support of PLWHA, Strategy for the Control of Micronutrient deficiencies, strategy and guideline for community based nutrition projects, etc),
- Promote food security for households and production of local nutrient-rich foods at community level,
- Develop and/or strengthen policies for food processing, fortification and preservation.
- Develop and enforce national legislation on standards for food fortification,
- Implement all government nutrition-relevant policies such as the agricultural policy (especially the land reform policy for improved food security),

7. 2. Promotion of optimal infant and young child feeding

Inappropriate breastfeeding and complementary feeding practices are major factors affecting infant and child mortality. Children from 0 to 6 months who are not breastfed have 7 and 5 times higher risk of dying from diarrhea and pneumonia, respectively. Promoting optimal child feeding makes it possible to reduce child deaths, the practice of breast-feeding and optimal complementary feeding respectively constitute the first and the 3rd most effective preventive interventions of child mortality. Breastfeeding is part of the culture in Rwanda, however, the practice needs to be maintained and optimally practiced through the following strategies:

- Promotion and protection of the exclusive breastfeeding in infants from birth up to six months, including infants born to HIV positive mothers who cannot meet the AFASS conditions (acceptable, accessible, feasible, sustainable and safe) for replacement feeding,
- Promotion of breastfeeding activities by establishing support groups at community level;
- Promotion of continuous breastfeeding up to twenty-four months or more, with an appropriate complementary feeding from six months,
- Adoption and implementation of the national code of marketing of breastmilk substitutes.
- Development and adoption of a national strategy on infant and young child feeding (IYCF) in the context of HIV/AIDS in Rwanda,
- Integration of IYCF in the guidelines and protocol on voluntary counseling and testing (VCT), the prevention of mother to child transmission (PMTCT) of HIV/AIDS and pediatric care.
- Support the implementation of the Guidelines and protocol for nutritional support and care of PLWHA.
- Institutionalize the celebration of the national breastfeeding week in the national calendar,
- Protection of breastfeeding women who work in all (private and public) sectors by modifying the law in favor of breastfeeding (paid maternity leave periods, prolongation of maternity leaves, creation of breast-feeding space in the work place and public areas, etc.),

- Integration of IYCF in medical and para-medical training schools,
- Support to operational research on infant and young child feeding
- Promotion of the consumption of safe locally-produced complementary foods.

7.3. Scaling up of community-based nutrition programs

Certain simple actions, easy to be implemented by community workers, have a very positive impact on the nutritional status and the survival of the population. The Community-Based Nutrition Program (CBNP) is an approach that promotes equity and efficiency in the fight against malnutrition in a participatory manner. In addition, this approach will enable the link of nutrition services and the communities, and can constitute an entry point to child survival interventions such as integrated management of childhood illnesses (IMCI) at community level. Thus, the objective of the approach is achieving coverage of up to 80% of cells (*umurenge*) in all the districts of the country. In order to achieve this objective, the following activities are planned:

- Updating of the national CBNP protocol;
- Development/validate of training modules for health and community workers;
- Training of local administrative authorities and health workers involved in the CBNP;
- Development and implementation of district CBNP action plans;
- Mobilization of the required resources for the implementation of CBNP actions plans;
- Promotion of growth monitoring of children under five years at community level;
- Organization of community nutrition week, coupled with micronutrients supplementation, deworming and promotion/preventive health activities;
- Support of income-generating activities at the household and cell level, in particular, for women associations;
- Social mobilization activities for the promotion of safe water, personal and environmental hygiene, the use of impregnated mosquito nets, family planning, HIV/AIDS prevention and community health insurance (Mutuelle de Santé);
- Mobilize communities to establish early childhood development (ECD) and school feeding programs to promote nutrition of preschoolers and school children,
- Development and production of communication tools (IEC) to ensure social behavioral change.

7.4. Food Fortification

Fortification is one of the approaches to provide essential nutrients to a large proportion of any population using commonly consumed and easily accessible foods. In Rwanda, the only food that is fortified and widely consumed is table salt which is iodized. However, there is a potential to fortify other foods to combat micronutrients deficiencies. To achieve this objective, the following activities are planned:

- Technical and financial feasibility study on fortification of various local foods;
- Fortification of the identified foods;
- Development of national standards governing the fortification of local or imported foods coupled with promulgation of relevant legislation;
- Promotion of the consumption of iodized salt as part an integrated strategy to eliminate iodine deficiency disorders,
- Strengthen the capacity of the reference laboratory for monitoring adherence to national standards

7.5. Promotion of household food security

The following strategies can improve availability, accessibility and utilization of foods at national, community and household levels:

- Develop strategies that promote equitable inter-regional and intra-household food distribution,
- Promote production and consumption of local micronutrient-rich foods,

- Promote income generating activities to improve the population's purchasing power,
- Promote post-harvest processing and preservation techniques for food,
- Promote norms and standards for food and water and food hygiene measures,
- Promote trans-border trade of food products
- Promote appropriate dietary and feeding practices and a healthy way of life to prevent dietary excesses, alcohol abuse, tobacco use, etc.,
- Implement pertinent policies that promote food production such as the agriculture and land reform policies, and those that promote women empowerment especially in access and control of household resources,
- Implement a habitat policy which favors the promotion of settlement clusters (*imidugudu*), a better management of the environment, and freeing of land for agricultural use.
- Develop nutrition IEC materials to sensitize the population.

7.6. Prevention and management of malnutrition and related diseases

The following strategies can promote prevention and management of malnutrition and related diseases:

- Regular growth monitoring of children aged between 0 to 5 years, at health center and community levels,
- Regular monitoring of weight gain for pregnant women, through the ANC at health center and community levels,
- Monitoring the implementation of the strategy for micronutrient supplementation within the IMCI (immunization, de-worming, etc),
- Implement food fortification strategies as listed in section 7.4 above,
- Establish a nutrition surveillance system integrated in the HIS.
- Develop relevant nutrition IEC materials to sensitize the population.

7.7. Nutritional support to PLWHA and their families

Nutrition care and support is now integrated into the national strategy for prevention, treatment and care for PLWHA. In line with this, the government has developed and adopted guidelines and protocol giving practical recommendations for improving the nutritional well being of PLWHA. These guidelines are intended to be used by service providers, including those providing home based care. In order to meet the nutrition needs of PLWHA and their families, the following actions should be implemented:

- Ensure that service providers implement and utilize the guidelines and protocol,
- Mobilize resources for implementation of the minimum food package for PLWHA and affected people, including infants born to HIV infected mothers,
- Develop long term strategies to sustain nutrition care and support for PLWHA including income generating activities and improved agricultural production,
- Strengthen the capacity of service providers in nutrition care and support targeting:
 - Health professionals in nutritional facilities and health centers in counseling and assessment, management and follow up,
 - Community health workers in order to promote community based nutrition interventions for PLWHAs,
 - Associations to act as a forum for setting up community-based nutrition programs and as an agent of behavioral change.

7.8. Communication for behavior change

Because clinical symptoms associated with malnutrition appear in the advanced stages of deficiency, communication for behavior change should be reinforced at the national, intermediate and community levels. Communication should provide pertinent educational messages to trigger voluntary changes in dietary behavior and practices that impact on nutrition. Appropriate Communication channels should include the mass media, radio, televisions, audio-visual press, newspaper, conferences, plays, traditional media (street shouters, songs, sketches...) e.t.c and relevant messages passed through health facilities, community health or nutrition workers, schools, churches, CBOs, NGOs, etc.... To reach rural populations, developed messages must be culturally appropriate and translated to local languages.

8. IMPLEMENTATION OF NATIONAL NUTRITION POLICY

8.1. Priority nutrition actions

To ensure nutrition improvement of the population, the following is a set of essential actions that should be implemented at all levels:

- Exclusive breastfeeding for 6 months, continuing thereafter with appropriate complementary foods up to 24 months
- Regular growth monitoring of children from 0 to 5 years
- Appropriate nutritional care and support for malnourished and sick children
- Micronutrient supplementation as detailed in the national strategy for preventing and controlling micronutrient deficiency.
- Regular monitoring of nutritional status of pregnant and lactating women,
- Prevent mother to child transmission of HIV in relation to infant and young child feeding
- Nutritional care and support for people living with HIV/AIDS

8.2. Policy Implementation steps

The National Nutrition Policy will be implemented in the following operational steps:

- Adopt and promulgate the national nutrition policy
- Adopt and implement the national nutrition strategic plan, protocols and guidelines
- Develop an operational nutrition action plan
- Evaluate the training needs (pre and in-service)
- Develop training modules and other educational materials
- Strengthen capacities of service providers at all levels (training of trainers, in-service training and pre-service training of nutritionists)
- Support regular follow up of nutritional data
- Regularly Monitoring and evaluation of nutrition intervention strategies
- Mid-term and long term evaluation of out puts

8.3. Support programs for policy implementation

The following programs will support implementation of National Nutrition Policy

- Maternal, infant and young children feeding program
- Community based nutrition program
- Food security support program
- Micronutrient supplementation and de-worming Program
- Food fortification program

- Program for prevention and control of nutritional related diseases
- Program of nutritional support for PLWHA and other vulnerable groups
- Nutrition program for preschool and school children
- Nutrition coordination support program

9. INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION

9.1. Coordination bodies and implementation structures

9.1.1. At national level:

9.1.1.1. Intersectoral nutrition Committee

To harmonize, exchange and synergize efforts for promoting nutrition and the integrated management of nutrition development programs, the intersectoral nutrition committee should be composed of representatives from:

- Ministry of health
- Ministry of local government
- Ministry of Agriculture and livestock
- Ministry of Gender and Family promotion
- Ministry of Education, Science and Technology
- Ministry of Vocational Training and Labor
- Ministry of Finances and Economic Planning
- Ministry of Youth
- Ministry of Trade, Commerce and Industry
- Ministry of Infrastructure
- Ministry of Land and Environment
- NGOs,
- Rwanda Bureau of Standards
- Rwandan Consumers Association (ASCORWA)
- Private Sector Federation
- National nutrition technical working group
- Any other partners or structures identified by the Commission.

The representation from the above institutions should be at the level of National Director or Assistant Director. The commission chairmanship will be taken in turns while the secretariat will be assumed by the Nutrition Unit under the Ministry of Health.

9.1.2.2. Nutrition Working Group

The nutrition technical working group is composed of representatives from various organizations working in collaboration with the Ministry of health in nutrition programs. The role of the working group will be to:

- Ensure the implementation of the national nutrition policy,
- Support Program conception and provide technical inputs on the essential orientations for the development of nutrition,
- Advocate for resource mobilization for development and implementation nutrition activities
- Ensure the integration of nutrition agenda in all the relevant government sectors
- Ensure technical collaboration and participation of different sectors and partners involved in nutrition.

9.2. Role of various sectors in promoting nutrition

9.2.1. The Government

The Government through its Ministries, Institutes, Committees, Departments and Agencies will support nutrition activities at various levels. Roles and responsibilities of different Ministries and departments in the implementation of the Nutrition Policy are defined in the paragraphs below. In addition, the Government can assign other supplementary responsibilities as required.

9.2.1.1. Role of the Ministry of Health

- Advocacy and Lobbying for adoption and promulgation of the national nutrition policy,
 - Increase the annual budget allocated to nutrition,
 - Coordinate implementation of national nutrition policy,
 - Adopt and elaborate national nutrition strategies and guidelines
 - Mobilize partners and resources to support activities related to research, advocacy, coordination of nutrition programs,
 - Capacity enhancement for coordination and implementation of nutrition activities,
 - Reinforce the role of nutritionists at the central and local levels ,
 - Develop communication and advocacy strategies for nutrition
 - Establish a national operational Program for research, monitoring and evaluation of nutrition Program,
 - Definition in collaboration with other ministries and partners of the norms and standards of nutrition to implement at each level,
 - Leadership for integration of nutrition in other health Programs (HIV/AIDS, IMCI, Maternal health school health etc...)
 - Reinforce nutritional surveillance system in collaboration with the Ministry of Agriculture, including mapping of food insecurity,
 - Develop nutrition contingency plan in collaboration with relevant Ministries and partners,
 - Organize coordination meetings to strengthen collaboration with partners
 - Monitoring and evaluation of the implementation of the nutrition policy.
-
- Submission of annual reports on the implementation of nutrition Program to different ministries and partners,

9.2.1.2. Role of the Ministry of local government

- Advocacy for nutrition activities,
- Support the establishment of a Nutrition Alliance at all levels (District, Sector and Cell)
- Ensure that each CDC incorporates nutrition activities in their annual plans
- Make recommendations for forecasting and financial resource mobilization for nutrition activities in the annual development plan of CDCs at the community level (Community nutrition days, CECOME, CBN, vitamin A supplementation etc...),
- Contribute in the mapping of households at risk of food insecurity and malnutrition with the Ministry of Agriculture,
- Promote household food security by supporting community based agricultural activities, land donation, promotion of improved seeds and dissemination of modern food preservation methods ,
- Reinforcement of nutritional support to PLWHA and other vulnerable groups (orphans, elderly, displaced people, women and children, child headed households and street children etc..),
- Develop a contingency plan for nutrition
- Ensure children's protection through respect of children's rights
- Monitoring of the implementation of nutrition activities at decentralized level

9.2.1.3.. Role of the Ministry of agriculture and animal resources

- Promote the policy for processing, preservation and storage of food products ,
- Promote the production and the dissemination of nutrient rich foods,
- Develop and Disseminate highly productive agricultural technologies,
- Promote irrigation in areas with insufficient rain,
- Implement agricultural policy, especially on land reform for improvement of food security and income generation and prioritize staple foods such as rice, maize, potatoes
- Promote less labour intensive agricultural technologies
- Prepare a contingency plan for nutrition
- Reinforce nutrition surveillance system in collaboration with the Ministry of Health, including mapping of food insecure zones,
- Support farmers to produce within a market oriented approach,
- Promote equitable distribution of food throughout the country,
- Identify and support food insecure households.

9.2.1.4. Role of the Ministry of Education,

- Establish operational school based nutrition and health program in collaboration with the Ministry of Health
- Incorporate nutrition in the education curriculum at all levels: primary, secondary and universities
- Institutionalize growth monitoring for preschool and school children
- Integrate small scale farming and animal husbandry in schools,
- Re-establish school feeding programs in preschool and primary schools based on community initiatives,
- Integrate nutrition education in the community parental education program,
- Provide all schools with potable water and latrines for better health and nutrition in collaboration with MININFRA,

9.2.1.5. Role of the Ministry of Gender and Family promotion

- Advocacy for nutrition as a right for women and children,
- Advocate for adequate maternity leave for breastfeeding women working in all sectors
- Advocacy for male partner involvement in the management of nutrition problems,
- Incorporate nutrition activities in women's associations and support them to promote exclusive breastfeeding, good dietary practices, growth monitoring, family planning, etc....
- Identify and support food insecure families and households

9.2.1.6. Role of the Ministry of public service, skills development, vocational training and labor

- Advocacy for nutrition,
- Provide adequate maternity leave for working women in all sectors
- Increase time-off allocated for breastfeeding for women after maternity leave,
- Support the establishment of breastfeeding women support groups in work places,
- Monitor the quality of foods sold in workplaces in collaboration with the Ministry of Health and ORN,
- Advocate for Information and sensitization on good nutrition for a better productivity.

9.2.1.7. Role of the Ministry of Finance and Economy planning

- Add improved nutrition as a development indicator
- Incorporate nutrition into PRSP priorities
- Orient ministries to allocate a budget line for nutrition in their MTEF

9.2.1.8. Role of the Ministry of Youth, Sports and Culture

- Promote, integrate and support good nutrition in the youth clubs, anti-AIDS clubs, and sports clubs, etc...
- Promote good nutrition and diet as a traditional and cultural value
- Promote a fair intra-family share of meals

9.2.1.9. Role of Ministry of Trade and industry

- Define, disseminate and ensure food quality standards,
- Reinforce food quality control
- Promote fortification of commonly consumed foods
- Establish efficient and reliable distribution and sales mechanisms for food products in all regions

9.2.1.10. Role of the Ministry of Land and Environment

- Strengthen tree planting and tree nurseries to protect ecosystems that favor agricultural production,
- Promote potable water, sanitation (disseminate PHAST methodology in all cells), and HAMS in all schools and households,
- Implement grouped housing policy (Imidugudu) that saves land for agriculture and promote collective environmental management activities.

9.2.1.11. Role of the Ministry of infrastructure

- Improve infrastructure to facilitate marketing of fresh and processed foods
- Ensure equitable distribution and management of safe water
- Develop and implement master plan for housing to reserve space for agricultural production.

9.2.1.12. Role of Ministry of information

- Integrate Nutrition in media Programs for sensitization of the population.

9.2.1.13. Role of NGOs, Associations development partners

- Advocacy for nutrition,
- Provide services and facilities for implementation of nutrition Programs ,
- Provide technical and financial support for improvement of Nutrition,

9.3. Role of private sector

The private sector will be encouraged to:

- Provide quality nutrition services
- Follow up guidelines set up by the Government in the domain of nutrition ,

9. 4. Monitoring and evaluation

To ensure effective implementation of planned activities, monitoring and evaluation is essential in all development programs. In addition, periodic evaluations are necessary for establishing level of objective achievement.

In order to follow up implementation of nutrition programs, data will be collected regularly at the health center and community level, In addition, other opportunities for nationwide surveys will be identified and utilized (MICS, EDST, EICV, etc...)

Nutritional surveys and epidemiologic surveillance will be conducted regularly, with appropriate indicators, to evaluate the progress and impact of nutritional interventions.

Operational research will also be carried out to address specific problems identified during the implementation of nutritional activities.

To prevent nutritional emergencies, nutrition unit will reinforce collaboration with all existing structures that collect and analyze bioclimatic, environmental, demographic and agricultural data for early warning and timely intervention measures against disasters that can negatively affect the nutrition.

10. FUNDING

All nutrition programs require diverse human and financial resources for implementation. Funding sources may include contributions from private sector, NGOs, development partners, international funding agencies, humanitarian organizations and the government of Rwanda through the various ministries.

The Government recognizes that nutrition is an integral part of the priorities for national development and is also a key strategy in achieving MDGs, adoption of this policy will:

- Guide the Ministry of Finance in its budgetary allocation to nutrition programs in the relevant line ministries
- Promote private sector involvement in funding and implementing nutrition programs
- Advocate for the contribution of the Rwanda Development Fund to nutrition programs
- Motivate development partners to increase their budgetary allocation to nutrition activities.

Districts will allocate a percentage of their total annual budget to nutrition programs, including income generating activities for communities, motivation of the community animators involved in Program implementation.

Families, parents, communities will contribute to nutrition Programs in terms of materials, labor or assets, provision of food for children and other vulnerable groups.

Private sector will contribute to provide quality nutrition services to the population, pay wages for their workers, train staff, contribute to care and support of PLWHA and vulnerable groups.

Development partners and NGOs will provide their technical and financial support for capacity building, Program implementation, research, dissemination of successful experiences etc...

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ANNEX 1:

Life cycle Approach – Link of Nutrition and MDGs (adapted IINACC/SCN 1997)

