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**STRATEGIC PLAN TO REDUCE THE DOUBLE BURDEN OF MALNUTRITION IN
THE AFRICAN REGION: 2019–2025**

Report of the Secretariat

EXECUTIVE SUMMARY

1. The double burden of malnutrition refers to the coexistence of undernutrition and overweight/obesity. Despite global, regional and national initiatives, rates of hunger and undernutrition remain unacceptably high in the African Region which is undergoing a nutritional transition, with an increasing incidence of overweight/obesity and diet-related noncommunicable diseases.
2. A comprehensive implementation plan on maternal, infant and young child nutrition was adopted by the World Health Assembly in 2012 to achieve six global targets by 2025 and ultimately end all forms of malnutrition by 2030. However, progress in the African Region is hampered by a policy environment that is under-equipped to control the consumption of poor-quality diets, as well as inadequate resources and capacity for effective programmes.
3. This strategy aims to reduce all forms of malnutrition throughout the life course. One objective is to strengthen policies and regulatory frameworks to promote, protect and support the consumption of safe and healthy foods. Another is to strengthen national capacity and the evidence base for nutrition programming. The guiding principles include a life-course approach, multisectoral collaboration, universal health coverage and partnerships.
4. This strategy proposes priority actions covering legislation and regulation, resource mobilization, multisectoral action, service delivery, data innovation and research. It also proposes approaches to improve efficiency by integrating nutrition actions in existing service delivery platforms. Mid-term and end-term reviews will be conducted to monitor implementation of the strategy.
5. The Regional Committee is invited to review and adopt this strategy.

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INTRODUCTION

1. The double burden of malnutrition refers to the coexistence of undernutrition and overweight/obesity in the same populations, households or individuals. It is characteristic of the nutrition transition, a phenomenon where increasing overweight/obesity emerges in predominantly undernourished populations, as is evident in the African Region. Poor quality foods are recognized as a key driver of the double burden of malnutrition worldwide¹ and throughout the life course.²
2. The immediate causes of undernutrition are inadequate food intake and recurrent infections, including foodborne diseases which cause 91 million illnesses and 137 000 deaths annually in Africa (accounting for one third of the global death toll).³ Overall, undernutrition has been estimated to contribute up to 45% of child mortality.⁴
3. In Africa, prevailing food production patterns, marketing practices and changing lifestyles have led to increasing consumption of cheap, processed foods that are high in energy, fat and salt content, but low in nutrient quality.⁵ This typical diet fails to address chronic undernutrition and micronutrient deficiencies while contributing to increased obesity and diet-related NCDs.
4. At the Sixty-fifth World Health Assembly in 2012, Member States endorsed the Comprehensive implementation plan on maternal, infant and young child nutrition (MIYCN), committing to achieve six global nutrition targets⁶ by 2025. The targets are to reduce childhood stunting, wasting and overweight, low birth weight, anaemia in women of reproductive age, and to increase the rates of exclusive breastfeeding. The MIYCN complements the Global action plan on NCDs,⁷ which includes targets to reduce obesity and other NCD risk factors by 2025.

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis

5. The African Region is experiencing the double burden of malnutrition and if current trends continue, the goal of ending hunger and all forms of malnutrition by 2030 will not be achieved.⁸ The number of undernourished people in sub-Saharan Africa rose⁹ from 181 million in 2010 to almost 222 million in 2016. Among children,¹⁰ although the prevalence of stunting decreased from 38.3% in 2000 to 30.3% in 2017, the numbers affected increased from 50.6 million to 58.7 million

¹ Swinburn BA et al. The global syndemic of obesity, undernutrition, and climate change: The lancet Commission Report. Published online January 27, 2019 [http://dx.doi.org/10.1016/S0140-6736\(18\)32822-8](http://dx.doi.org/10.1016/S0140-6736(18)32822-8), accessed 29 January 2019.

² Development Initiatives. 2018 Global Nutrition Report: Shining a light to spur action on nutrition. Bristol, UK: Development Initiatives, 2018.

³ WHO. WHO estimates of the global burden of foodborne diseases: foodborne disease burden epidemiology reference group 2007-2015. Geneva, World Health Organization, 2015.

⁴ Black RE et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet*, 382: 427–51, 2013.

⁵ Global Panel on Agriculture and Food Systems for Nutrition. Food systems and diets: Facing the challenges of the 21st century. 2016. <http://glopan.org/sites/default/files/ForesightReport.pdf>, accessed 21 February 2019.

⁶ WHO. Comprehensive implementation plan on maternal, infant and young child nutrition. Geneva, World Health Organization, 2014. http://www.who.int/nutrition/publications/CIP_document/en/, accessed 6 December 2018.

⁷ WHO. Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva, World Health Organization, 2013. http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf, accessed 4 December 2018.

⁸ UN. United Nations Sustainable Development Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture. <https://www.un.org/sustainabledevelopment/hunger/>, accessed on 19 February 2019.

⁹ FAO/IFAD/UNICEF/WFP/WHO. The State of Food Security and Nutrition in the World 2018. Building climate resilience for food security and nutrition. Rome, Food and Agriculture Organization, 2018.

¹⁰ UNICEF/WHO/World Bank. Joint child malnutrition estimates, 2018 edition. <http://www.who.int/nutgrowthdb/estimates2017/en/>, accessed 6 December 2018.

due to population growth. The rate of wasting in 2017 was 7.1% or 13.8 million children, of whom 4 million were severely wasted.

6. Despite the persistence of undernutrition, overweight rates are also increasing. The number of overweight under-fives increased from 6.6 million in 2000 to 9.7 million in 2017. For children aged 5–19 years, obesity rates doubled between 2006 and 2016, while for adults, overweight and obesity¹¹ increased¹² from 28.4% in 2000 to 41.7% in 2016.

7. Programmes addressing malnutrition currently are inspired by the Lancet framework of nutrition-specific and nutrition-sensitive interventions which focus primarily on reducing child undernutrition. The framework is not explicit on how to deal with the double burden of malnutrition.

8. According to the second Global Nutrition Policy Review (GNPR2), actions to promote healthy diets and reduce obesity and diet-related NCDs in Africa are largely limited to diet/nutrition counselling, media campaigns, nutrient labelling or dietary guidelines.¹³ Such actions have little public health impact unless many individuals in the population make sustained changes in their food consumption behaviours.¹⁴

9. In the GNPR2, only The Gambia, Liberia and Mali reported having regulations to control the marketing of foods and non-alcoholic beverages to children and no Member State reported banning industrial trans-fats. A recent WHO/UNICEF report found that 17 Member States had no legal measures to control the marketing of breastmilk substitutes.¹⁵

10. Between 2016 and 2018, eighteen Member States¹⁶ conducted reproductive, maternal, newborn, child and adolescent health (RMNCAH) programme reviews including nutrition. Many gaps were identified, notably insufficient budgetary allocations for implementation of planned activities. Most Member States rely on partner-funded nutrition projects which tend to be small-scale and of short duration. The lack of resources also undermines staff motivation and retention. There are capacity gaps for planning, coordination and monitoring. Integration of nutrition in RMNCAH services is weak and opportunities to deliver nutrition interventions are missed. Routine nutrition data collected in primary health care are rarely used for programme management or surveillance.¹⁷

Justification

11. The situation described above calls for urgent and accelerated action to end all forms of malnutrition by 2030 as pledged in the SDGs. Policies to streamline the food environment and to protect and promote the consumption of safe and healthy foods throughout the life course are

¹¹ Classification of overweight and obesity is based on body mass index (weight (kg) / height (m²)) where overweight = BMI 25.0-29.9 and obesity = BMI \geq 30.

¹² WHO. Atlas of African Health Statistics. Brazzaville, World Health Organization Regional Office for Africa, 2018. <http://www.who.int/en/atlas/atlas-african-health-statistics-2018>, accessed 6 December 2018.

¹³ WHO. Global nutrition policy review 2016-2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition. Geneva, World Health Organization, 2018.

¹⁴ Frieden TR. A framework for public health action: the health impact pyramid. *American Journal of Public Health*, 100 (4): 590–595, 2010.

¹⁵ WHO/UNICEF/IBFAN. Marketing of breast-milk substitutes: National implementation of the International Code status report 2018. Geneva, World Health Organization, 2018.

¹⁶ Botswana, Burkina Faso, Burundi, Congo, Democratic Republic of the Congo, Eritrea, Eswatini, Gabon, Lesotho, Madagascar, Malawi, Namibia, Niger, Sao Tome and Principe, Senegal, Sierra Leone, South Africa and South Sudan.

¹⁷ WHO. Nutrition in the WHO African Region. Brazzaville, World Health Organization, 2017.

urgently needed. Such action is consistent with the commitments to prevent and control NCDs, reiterated in the political declaration of the third high-level meeting of the UN General Assembly.¹⁸

12. This strategic plan provides guidance to Member States on reinforcing programmes for greater impact in reducing undernutrition and strengthening policies and regulatory frameworks to promote, protect and support the consumption of safe and healthy foods throughout the life course. Increased financial and human resources are needed for the effective delivery of nutrition interventions. Additionally, closer collaboration between research institutions and policy-makers is key to ensuring that policies are informed by science. Prompt implementation of this strategy will accelerate reductions in the double burden of malnutrition in the African Region.

THE REGIONAL STRATEGY

Aim, objectives and targets

13. The aim is to reduce all forms of malnutrition throughout the life course for better health and well-being in the African Region.

14. The objectives are:

- (a) To strengthen policies that promote, protect and support the consumption of safe and healthy diets;
- (b) To strengthen national capacity for the prevention and management of all forms of malnutrition;
- (c) To strengthen the evidence base supporting policies and programmatic action.

15. Targets¹⁹ by 2025

- (a) At least 23 Member States have full provisions in law for the International Code of Marketing of Breast-milk Substitutes (the Code);²⁰
- (b) At least 25 Member States have wasting rates below 5%;
- (c) All Member States have formulated at least one policy to protect or promote healthy diets;²¹
- (d) At least 35 Member States have strengthened food safety regulations;
- (e) At least 30 Member States achieve the exclusive breastfeeding target of 50%;
- (f) Halt any increase in the prevalence of overweight among under-fives;
- (g) At least 30 Member States have birth weight, weight-for-length and length-for-age data in their health information systems;
- (h) At least 25 Member States have implemented a facility- and community-based risk screening for NCDs in line with WHO Package of Essential NCD interventions (PEN).
- (i) All Member States have capacities for detection, risk-assessment and management of acute malnutrition and food safety events.

¹⁸ Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, New York, United Nations General Assembly 2018.

¹⁹ Milestones for 2022 are listed in the Annex. The targets for wasting, exclusive breastfeeding and overweight are aligned with the WHA global nutrition targets for 2025.

²⁰ WHO. International Code of Marketing of Breast-milk Substitutes. Geneva, World Health Organization, 1981

²¹ Includes measures to control marketing of food and non-alcoholic beverages to children and population intake of sugars, salt and fats.

16. Guiding principles

- (a) **Life-course approach:** Priority interventions targeting pre-pregnant and pregnant women, breastfeeding mothers, newborns, infants, children, adolescents, adults and the elderly with age-appropriate action for nutritional well-being are important to comprehensively address nutrition.
- (b) **Equity, gender and rights-based approach:** To ensure no one is left behind, disaggregated data by age, sex, socioeconomic status and geographical region identify vulnerable and disadvantaged groups to enable appropriate programming for equitable access to nutrition services.
- (c) **Multisectoral collaboration:** Malnutrition has multiple contextual determinants, requiring health sector and non-health sector collaboration and coordination to deliver appropriate solutions.
- (d) **South-South cooperation and international partnerships:** Member States facing similar challenges share resources and solutions to promote safe and healthy food environments.
- (e) **Universal health coverage (UHC):** Nutrition as a preserver of sound health and well-being is essential for the achievement of universal health coverage by reducing the risk of diseases that entail catastrophic costs.

Priority interventions

17. **Enacting legislation to protect and promote breastfeeding:** Member States should enact legislation and fully implement the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.²² Member States that have full provisions in law for the Code should set up monitoring systems to identify violations and apply appropriate enforcement measures, and those that have some provisions or none should strengthen their regulations. To complement the regulatory measures, it is important that mothers receive support to practise appropriate infant and young child feeding through education and enabling environments in health facilities, communities and the workplace.

18. **Regulating the marketing of foods and non-alcoholic beverages:**²³ Member States should implement the WHO recommendations on marketing of foods and non-alcoholic beverages to children. The AFRO regional nutrient profile model should be adopted by Member States to identify foods whose marketing should be restricted. Possible restrictions include banning advertising, sponsorship, brand mascots or popular characters, point-of-purchase displays and online promotions.

19. **Strengthening legislation and regulatory systems for food safety:** This should be done to ensure safety along the food chain in line with Codex Alimentarius standards, as well as to address antimicrobial resistance. With reference to the use of pesticides, Member States should be guided by the international code of conduct that aims to protect human health and the environment.²⁴ International agreements on food safety standards that are binding on all Member States regarding products for home markets and for export should be negotiated at appropriate regional forums.

20. **Defining food labelling standards:** Member States should impose a minimum requirement for packaged foods to carry a legible list of ingredients, and per 100-unit content of energy, protein,

²² WHO. The International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions (2017 Update). Geneva, Switzerland, World Health Organization, 2017.

²³ The policy options, priority actions and a target for reducing the harmful use of alcohol are detailed in the WHO Global NCD Action Plan 2013-2020.

²⁴ FAO/WHO. The International Code of Conduct on Pesticide Management. Rome, Italy, Food and Agriculture Organization of the United Nations, 2014.

total fat, saturated fat, sugar and sodium. Interpretive front-of-pack labelling should be considered to support implementation of policies to reduce intake of salt, trans-fat, saturated fat, free sugars, etc.

21. Defining standards for fortification: Member States should define standards for food fortification (including biofortification) as a strategy for filling micronutrient gaps in the local food base. The chosen fortification vehicle should not pose health risks. Thus, although fortifying sugar with vitamin A and other micronutrients increases intake,²⁵ its use should be discouraged because of public health concerns with obesity, diabetes and dental caries.

22. Using fiscal measures to incentivize healthy choices: To facilitate behaviour change in consumption practices,²⁶ Member States should consider applying fiscal measures combined with incentives. Examples include combining taxation of sugar-sweetened beverages with improved access to clean drinking-water; or taxation of ultra-processed foods while subsidizing fresh and minimally processed foods. The tax revenues could finance corresponding pro-health initiatives.

23. Exploring public-private collaboration for product reformulation: The African Region should carefully study other regions' experiences with public-private collaboration in reformulation to control intake of salt, sugars, saturated fats, etc. In some cases, legislation and fiscal incentives are necessary for the policies to be effective. However, examples exist of voluntary actions taken by industry, for example, towards eliminating industrial trans-fats from the food chain. Government leadership and consumer vigilance should be reinforced to ensure that policies from such partnerships truly benefit public health.

24. Increasing budget allocations to nutrition: African Heads of State committed to dedicate domestic funds for the elimination of child undernutrition.²⁷ Member States should honour this commitment as a demonstration of government ownership of the nutrition agenda.

25. Strengthening multisectoral action to prevent malnutrition:

- (a) Member States should intensify multisectoral action to reduce hunger, undernutrition and overweight/obesity.
- (b) Social protection programmes should especially target populations in fragile settings. This includes identifying and targeting vulnerable households to improve food security and access to clean water, sanitation and health services for disease prevention and management.
- (c) Member States should take advantage of provisions in international and regional trade agreements²⁸ under which they can legitimately restrict the marketing of certain goods when necessary to protect human life or health.
- (d) Member States should strive to implement nutrition-friendly agriculture policies that guarantee the supply of diversified, nutritious foods that satisfy hunger and prevent micronutrient deficiencies. Support for family farming should be adopted as a policy for

²⁵ Martorell R and de Romaña DL. Components of successful staple food fortification programs: Lessons from Latin America. *Food Nutr Bull.* 38:384–404, 2017.

²⁶ Global Panel on Agriculture and Food Systems for Nutrition. Improving nutrition through enhanced food environments. Policy Brief No. 7. London UK, Global Panel on Agriculture and Food Systems for Nutrition, 2017.

²⁷ African Union Assembly/AU/Decl.4(XXIII). Declaration on Nutrition Security for Inclusive Economic Growth and Sustainable Development in Africa. Decisions, Declarations and Resolution. Assembly of the Union. Twenty-Third Ordinary Session 26-27 June 2014. Malabo, Equatorial Guinea, 2014.

²⁸ Cf. General Agreement on Tariffs and Trade, Article XX (b) on the adoption or enforcement of measures necessary to protect human, animal or plant life or health. https://www.wto.org/english/docs_e/legal_e/gatt47.pdf. The same provision exists in Article 26 (b) of the Protocol on Trade in Goods (Agreement establishing the African Continental Free Trade Area, Kigali, 2018).

promoting environment-sensitive agriculture and for improving livelihoods especially among populations with low socioeconomic status.

- (e) Regarding biotechnological innovations in agriculture, Member States should adopt precautionary approaches aimed at protecting the environment and human and animal health. An example is the precautionary approach taken by the European Union to genetically modified organisms (GMOs). The approach includes specific criteria for GMO authorization, risk-assessment and monitoring of adverse environmental and human and animal health consequences. It also provides for Member States to impose restrictions on European Union-authorized GMOs.
- (f) Interventions targeting school-age children should aim to establish positive dietary, hygiene, and health-seeking habits as a foundation for positive health-determining behaviours of these future adults and caregivers. Collaboration between the health and education sectors should be fostered to support the delivery of these services in schools.

26. Adopting updated guidance on the Baby-friendly Hospital Initiative (BFHI):²⁹ Member States should adopt and implement updated guidance on BFHI. This will provide a framework for integrating the Ten Steps to successful breastfeeding in improved quality of care for mothers and newborns. The BFHI also links hospital and community-based interventions for better sustainability.

27. Integrating essential nutrition actions in health service delivery platforms:

- (a) Interventions for the benefit of women of reproductive age and their babies should be delivered through pre-conception, antenatal and postnatal care platforms. Iron-folate supplementation can be delivered within the package of antenatal care for a positive pregnancy experience,³⁰ which includes maternal nutrition counselling and preparation for a positive lactation experience.
- (b) Implementing the BFHI will provide a platform for improved maternity and newborn care, including early initiation of breastfeeding and support for exclusive breastfeeding. Postnatal care services should include promotion of safe and nutritionally adequate complementary foods from the age of 6 months with continuing breastfeeding until the age of 2 years and beyond. To ensure that children survive and thrive,³¹ Member States should integrate growth promotion and nurturing care for development³² in immunization platforms.
- (c) Member States should consider implementing the WHO Package of Essential NCD interventions in primary health care,³³ complemented by community-based screening and referral for hypertension, high body mass index and raised blood sugar.

28. Building capacity for programme management and service delivery: National capacities will be strengthened to adapt scientific guidance to address context-specific problems, ensure policies are implemented and services delivered to meet programme objectives. Member States should establish and manage monitoring systems for adherence to regulatory standards, and develop tools for translating guidance into practice, e.g., from dietary guidelines to food consumption decisions. Member States should take advantage of available training tools to build

²⁹ WHO. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva, World Health Organization, 2018.

³⁰ WHO. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva, World Health Organization, 2016.

³¹ UN. Every Woman Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). New York, United Nations, 2015.

³² WHO/UNICEF/World Bank. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva, World Health Organization, 2018.

³³ WHO. Implementation tools: Package of Essential Noncommunicable (PEN) disease interventions for primary health care in low-resource settings. Geneva, World Health Organization, 2013.

capacity for management of malnutrition in stable and humanitarian contexts; and for assessment, risk-communication and management of food safety events. Evidence should be used to advantage in shaping sound policies, managing programmes effectively and for accountability.

29. **Exploiting local expertise:** Member States should tap into their research institutions' expertise to build the evidence base on drivers of malnutrition and design responsive policies. Analyses of malnutrition profiles and trends disaggregated by geographic, socioeconomic, gender and age groups should be undertaken to determine who to target with what interventions.

30. **Promoting implementation research and exploitation of routine data:** Member States should promote the use of implementation research as a standard practice to understand what drives programme effectiveness. To ensure judicious use of limited resources, monitoring and evaluation should be a condition and incentive for investing in programmes. Data-driven monitoring and nutrition surveillance systems should be strengthened. This will entail streamlining the collection, quality assurance and utilization of nutrition data from routine health services. Key nutrition indicators should be integrated in existing health information systems to provide real-time data for harmonized reporting at regional and global forums.

Roles and responsibilities

31. Member States should:

- (a) Take leadership in defining policies, enacting regulations, monitoring implementation and applying sanctions to protect healthy diets;
- (b) Establish or strengthen food and drug regulatory authorities to monitor implementation of food safety standards;
- (c) Integrate actions to control the double burden of malnutrition in national development plans as well as in agriculture and trade policies;
- (d) Coordinate implementation of multisectoral actions and context-specific priority interventions;
- (e) Establish financing targets and increase sustainable domestic funding for nutrition, honouring the Malabo Declaration and high-level political commitment to end hunger;
- (f) Establish mechanisms to collect and use nutrition data from routine health services and establish/strengthen nutrition surveillance;
- (g) Engage research institutions in evidence-driven policy development and implementation.

32. WHO and partners should:

- (a) Mount high-level advocacy for increased investment in reducing the double burden of malnutrition;
- (b) Provide support to strengthen capacity to deliver nutrition services, programme monitoring and evaluation, surveillance and reporting;
- (c) Review existing evidence on prevention and management of obesity and develop guidance on effective interventions for the African Region;
- (d) Support regional research collaboration for solutions to regional malnutrition challenges;
- (e) Identify provisions for public health protection in international treaties on agriculture, environment and trade, and support Member States to use them effectively.

Resource implications

33. To reach 90% coverage of the 10 highest-impact nutrition interventions, the estimated annual cost for the WHO African Region is US\$ 3.4 billion.³⁴ About US\$ 1.4 million is needed annually for the Secretariat support to Member States.

34. The Secretariat will develop and implement a resource mobilization plan. In addition, Member States should mobilize resources to ensure sustained funding for the strategy's implementation. Taxation of unhealthy foods should be an option for investment in programmes to reduce undernutrition and promote safe and healthy diets.

Monitoring and evaluation

35. Member States should integrate monitoring and evaluation in programme cycles. Member States should develop logical frameworks linking inputs, processes, outputs and outcomes, along with programme performance indicators.

36. Implementation of the strategy will be evaluated using data from existing information systems and national surveys. A mid-term review will be conducted in 2023 and reported to the Regional Committee. An end-term report will be presented in 2026.

CONCLUSION

37. The current progress in reducing stunting, wasting and micronutrient deficiencies is inadequate in the African Region. Existing programmes should be reviewed to identify where and how they can be made more effective. Meanwhile, as the burden of overweight increases in all age groups, measures to reform the food environment are needed to halt the increase in obesity and diet-related NCDs.

38. This strategy is a reference tool for policy-makers seeking to reduce the double burden of malnutrition in the Region. It provides direction for Member States' action and key areas of support from the Secretariat. It also calls on each partner agency and regional institution to invest its comparative advantage in supporting Member States' efforts to end all forms of malnutrition.

39. The Regional Committee is invited to review and adopt this strategy.

³⁴ Bhutta ZA, et al & Maternal and Child Nutrition Study Group. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *The Lancet*, 382: 452–77, 2013.

STRATEGIC PLAN TO REDUCE THE DOUBLE BURDEN OF MALNUTRITION IN THE AFRICAN REGION: 2019–2025

Annex: Objectives, milestones and targets

Objective	Priority actions	Baselines	Mid-term milestones (2022)	Targets (2025)
To strengthen policies that promote, protect and support the consumption of safe and healthy diets.	Enacting legislation to protect breastfeeding; Adopting updated guidance on the Baby-friendly Hospital Initiative	In 2018, twelve Member States had comprehensive legislation on the Code (full provisions in law) ¹⁵	50% of Member States engaged in the process of strengthening regulation on marketing of breastmilk substitutes	At least 50% Member States have full provisions in law for the Code of breastmilk substitutes.
	Strengthening multisectoral action to prevent acute and chronic undernutrition	In 2016, seventeen Member States had wasting rates below 5% ¹⁸		At least 25 Member States have wasting rates below 5%.
	Regulating the marketing of foods and non-alcoholic beverages; Defining food labelling standards; Defining standards for food fortification; Exploring public-private collaboration for product reformulation; Using fiscal measures to incentivize healthy choices	In 2017, three countries had regulations to control marketing of food and non-alcoholic beverages to children ¹³ In 2017, twenty-two Member States had guidance on minimum standards for food labelling ¹³ In 2017, five Member States had in place actions for food reformulation ¹³ and none had legal measures banning industrial trans-fats	At least 10 Member States have initiated policy measures to control marketing of foods to children. At least 30 Member States have strengthened regulation on minimum standards for food labelling. At least seven Member States have initiated legal measures to reduce consumption of sugars, salt, and trans-fats.	All Member States have formulated at least one policy to protect or promote healthy diets (<i>note: includes policy measures to control marketing of foods and non-alcoholic beverages to children and population consumption of sugars, salt and fats</i>)
	Strengthening legislation and regulatory systems for food safety	In 2018, sixteen Member States had regulations on Good hygienic practices aligned with Codex standards	At least 25 Member States have regulation on Good hygienic practices aligned with Codex standards	At least 35 Member States have regulation on Good hygienic practices aligned with Codex standards
To strengthen national capacity for the prevention	Increasing budget allocations to nutrition	In 2016, sixteen Member States had an exclusive breastfeeding rate of 50% or more ¹⁷	At least 23 Member States achieve the exclusive breastfeeding target of 50%.	At least 30 Member States achieve the exclusive breastfeeding target of 50%.

Objective	Priority actions	Baselines	Mid-term milestones (2022)	Targets (2025)
and management of all forms of malnutrition	<p>Integrating essential nutrition actions in health service delivery platforms;</p> <p>Building capacity for programme management and service delivery</p>	<p>Consensus building on nutrition data collection on immunization platforms not yet initiated.</p> <p>Data unavailable on school nutrition programmes</p> <p>In 2018, twelve Member States were implementing the WHO Package of Essential Noncommunicable disease interventions (WHO PEN)</p> <p>No baseline data available on capacity for detection and management of acute malnutrition and food safety events</p>	<p>Consensus reached on ages for nutrition data collection linked with immunization visits.</p> <p>At least 10 Member States implementing school nutrition programmes addressing undernutrition or healthy diets.</p> <p>At least 10 Member States have implemented a community-based risk screening for noncommunicable diseases (NCDs) to complement WHO PEN.</p> <p>At least 23 Member States have capacities for detection, risk-assessment and management of acute malnutrition and food safety events</p>	<p>At least 25 Member States implementing facility- and community-based risk screening for NCDs in line with WHO PEN</p> <p>All Member States have capacities for detection, risk-assessment and management of acute malnutrition and food safety events</p>
To strengthen the evidence base supporting policies and programmatic action	<p>Exploiting local expertise;</p> <p>Promoting implementation research;</p> <p>Harnessing routine data</p>	Baseline data not available	<p>African research consortium established to support policy development and action in nutrition.</p> <p>Module for collection of routine nutrition data from maternity, child health and immunization services developed and adopted by at least 20 Member States.</p> <p>Nutrition indicators from national Health Management Information System routinely being transferred to WHO Regional office for Africa</p>	At least 30 Member States have birth weight, weight-for-length and length-for-age data in health information systems (for selected ages 0–2 years)