National NutritionPolicy of Sri Lanka

2021-2030

(Cabinet approval received on 05/09/2022)

Contents

National Nutrition Policy

1. Introduction

Nutrition is vital to the community health, development and productivity of an individual as well as the community. Nutrition outcomes of the community significantly depend on food[1] and nutrition[2] security which exists when all people, always have physical, social, economic and legal access to nutritious food, consumed in sufficient quantities to meet their dietary needs consistent with individual preferences.

The first National Nutrition Policy (NNP) was developed in Sri Lanka in 1986 and several revisions have been taken place thereafter. Revisions of previous policies were incorporated in the NNP 2010, and it was a continuation of all nutrition policies. There are many health and non-health nutrition-related policies that are aligned with the NNP. Despite many changes in the socio-economic status of the country and programmes that have been implemented, malnutrition[3] indicators such as wasting[4], and stunting[5] among children under-five years of age[*] are stagnant during the past two decades. Current evidence has highlighted the importance of targeted direct[6] and indirect[7] nutrition interventions to improve the nutrition status. The lifecycle approach is recognized as the best model to deliver direct and indirect nutrition interventions targeting all stages of the lifecycle. These approaches need to be implemented through multiple sectors as the determinants for nutrition cannot be addressed by the health sector alone.

Daily utilization of diversified safe food in adequate quantities is essential for the nutrition security of the population. It could be accomplished with social behaviour change communication for healthy dietary practices and proper income management at the household level. Partnership building and coalition among health and non-health sectors, as well as establishing or utilizing available community-based platforms improving liaison for nutrition interventions have proven to be successful initiatives in nutrition-related behaviour change. A strongly committed political and social leadership is necessary to address the nutritional needs of the community in terms of creating a supportive environment for sustainable behaviour change.

The requirement for use of new technologies, capacity building of raw food producers and resilience to various disaster situations including climate variability were identified measures to

**Wasting and stunting among under 5 years old children is 15% and 17% respectively (DHS, 2016).*

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enhance the production of food. Affordability of a nutritious diet needs to be ensured with ample resources for all households especially for the underprivileged, through sustainable income generation mechanisms or in some situations via safety nets, as well as through food production which meets the demand and control of market prices.

The National Nutrition Policy is intended to support the social and economic development policies of the government, whilst being coherent with specific policies of non-health and health sector, supporting their implementation. The policy will also consider the maximization of the healthcare delivery system for universal health coverage, focusing on primary health care. Implementation of health-related strategies of this policy shall be in line with primary health care reform.

All other nutrition-related national and provincial health and non-health policies such as maternal and child health, non-communicable disease (NCD), elderly health, agriculture, national drinking water policy, trade, tariff policy etc. should be supportive and coherent with the NNP.

2. Policy background

2.1. The Universal Declaration of Human Rights (1948) declared the 'right to food' as a part of the right to an adequate standard of living which is essential for improving nutritional status, quality of life as well as productivity of people in the country. Sri Lanka has achieved superior health performance, which is notable among South Asian countries and comparable to many developed countries. Population nutrition indicators show a fallback despite the implementation of all relevant evidence-based nutrition actions, which highlights the need for revisiting quality and coverage aspects. Over the past two decades, undernutrition indicators such as low birth weight, stunting and wasting among children under five years of age have been stagnant while there is a rising trend in overweight and obesity among subsets of the Sri Lankan population. In addition, micronutrient deficiencies such as nutritional anaemia among pregnant mothers and vitamin D deficiency among school children are also public health problems. This scenario of undernutrition, overnutrition and micronutrient deficiencies (hidden hunger) is termed as the "triple burden of malnutrition". Further disparities in malnutrition among districts and vulnerable population groups such as the plantation and urban under-settlement communities are observed in the country.

2.2. All member states of the United Nations (UN) adopted 17 Sustainable Development Goals (SDGs) in 2015, for the 2030 agenda of Sustainable Development. Out of them, SDG-2- 'zero

hunger' addresses nutrition directly. Achieving nine other SDGs; 'clean water and sanitation', 'affordable and clean energy', 'industry, innovation and infrastructure', 'reduce inequalities', 'sustainable cities and communities', 'responsible consumption and production', 'climate action', 'life on land', 'partnerships for goals', facilitate to accomplish nutrition targets indirectly. The World Health Organization (WHO) endorsed six global targets for improving maternal, infant and young child nutrition* by 2025, calling for the decade of action on nutrition. Accordingly, the SDGs and global targets for the decade of action were considered in the strategic framework for action of this policy.

2.3. Malnutrition has a multifaceted nature with many direct and indirect underlying causes. Improper dietary habits such as inadequate consumption of protein sources, fruits, and vegetables, consumption of high carbohydrate and high-fat diet, and sedentary lifestyle are some direct contributory factors to this situation in the country. Approximately one-tenth of the population is food insecure in the country. Hence affordability, availability and access to safe and healthy food need to be enhanced to reduce malnutrition among vulnerable populations. The availability of safe andhealthy food throughout the year is adversely affected by poor agricultural practices, lack of climate resilience in food production, lack of organized local food exchange mechanisms, and unhealthy food imports. Inadequate accessibility and utilization of nutritious food are caused by food loss[8] and wastage[9] throughout the supply chain, scarcity of healthy food outlets and unethical marketing of unhealthy food. The involvement of all partners who have responsibilities related to nutrition is essential to address these issues.

2.4. Food safety is about preventing contamination of food with hazardous material[10] throughout the supply chain including production, handling, storage, transportation and ultimate preparation of food ensuring the quality of food. The presence of hazards may make food injurious to the health of the consumer acutely or chronically leading to negative responses from consumers for nutritious food. Implementation of food safety activities is not at a satisfactory level which may be due to lack of adequate laboratory facilities, human resources, monitoring, and evaluation of services.

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*40% reduction in stunting and rate of wasting less than 5% among children under five years of age, no increase in childhood overweight under 5 years from the global baseline of 7% in 2012, reduce global prevalence of anaemia among women in reproductive age by 50% from 2012 baseline prevalence of 29% to 15% in 2025, 30% reduction of low birth weight and maintain the global level of exclusive breastfeeding (EBF) in the first six months at 50% (Global Nutrition targets, 2025).

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2.5. Influence of society and peers, economic status, day-to-day priorities, availability and accessibility of services, cultural and social norms including myths, taboos and values as well as prevailing agricultural and market systems determine how people behave in addressing their nutritional needs. Social behaviour changes to address the above needs through; advocacy, implementation of behaviour change communication strategies, community mobilization and empowerment have to be considered. Sustainable mechanisms for enabling environments that support and encourage interpersonal communication, interaction with mass and social media are vital for behaviour change through improved knowledge, attitude and practices related to nutrition. Global syndemic[11] of obesity, undernutrition and climate change is a huge risk to humans, and double[12] and triple duty[13] nutrition actions, as well as emergency responses, may change this situation.

2.6. The National Nutrition Council (NNC) chaired by His Excellency the President under the purview of the National Nutrition Secretariat (NNS) coordinates the implementation of nutrition-related policy decisions. Strengthening of administrative systems and governance, enhancement of institutional capacities including financing, infrastructure and human resource, proper functioning of National Nutrition Surveillance System(NNSS), utilization of research evidence and surveillance data for programme planning, streamlining the implementation of Food Act of 1980 and its regulations as well as Breastfeeding Code which is to be made into an act of the parliament, risk management throughout the food supply chain and active participation of non-government sector to enhance community nutrition have been acknowledged as some immediate necessities. Coordination and implementation of multi-sector nutrition interventions through an existing structure such as NNS, provincial, district and divisional systems to influence both demand and supply of nutritious and safe food commodities need to be strengthened to achieve nutrition targets.

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3. Rationale for the revision of NNP 2010

Every dollar spent on nutrition has been recognized to return 16 dollars in turn and the Government of Sri Lanka emphasizes improvement of the nutritional status of Sri Lankans as a national priority. Sri Lanka has adopted SDGs and set national targets within the global framework for improving Maternal, Infant and Young Child Nutrition (MIYCN) by 2025 for the decade of action on nutrition. Considering the relatively stagnant nutrition indices among children under five years and the current needs of the country such as escalating diet-related, the need for revision of NNP was identified to achieve global nutrition targets and SDGs within the period.

4. The policy process

Key nutrition issues of the country were prioritized by a technical team of experts representing all relevant sectors. Implementation of the NNP 2010 was reviewed by an external consultant and civil society organizations also provided recommendations on the implementation of the NNP 2010. The technical opinions of both these reviews were triangulated at a representative workshop of a wider group of participants that included middle-level managers, and policy experts of relevant sectors and civil society organizations. Several consultations with all relevant stakeholders identified the content to be reflected in the policy revision. A draft of the policy was prepared to incorporate expert views and finalized in a consultative workshop representing all related sectors for nutrition action, followed by another consultative workshop to agree on the implementation of the policy. Thereafter the NNP 2021-2030 was finalized according to public comments.

5. Vision

Optimum nutrition for all Sri Lankans

6. Goal

Achieving and maintaining the nutrition well-being of all Sri Lankans, enabling them to contribute effectively towards sustainable development.

7. Guiding Principles

The following guiding principles reflect the implementation of all strategies.

i. Inclusiveness of all
ii. Right to access safe and nutritious food
iii. People-centered policy
iv. Gender equity and sensitivity
v. Adoption of ethical and evidence-based practices
vi. Multi-stakeholder involvement
vii. Public and private partnership
viii. Community engagement and empowerment
ix. Effective and efficient utilization of resources
x. Sustainable implementation of nutrition interventions

8. Policy Objective

To ensure the accomplishment of nutrition needs of all Sri Lankans during the lifecycle through evidence-based direct and indirect nutrition actions in view of ending all forms of malnutrition by 2030

9. Policy priority areas

I. Food and nutrition security for all citizens.
II. Coordinated multi-sector collaboration and partnerships.
III. Legal framework strengthening for protection of the right to safe food and prevention of unethical marketing.
IV. Nutrition improvement throughout the lifecycle.
V. Nutrition promotion in emergency situations and extreme weather conditions.
VI. Strategic management of information and research.

10. Key Strategic directions for priority areas

Strategic directions for each policy priority area are mentioned to guide the policy implementation process**.**

10.1. Strategic directions for policy priority area I- Food and nutrition security for all citizens.

Food and nutrition security is essential to improve community nutrition while hunger and malnutrition are the major outcomes of household food insecurity. Availability, accessibility, affordability and utilization of nutritious food are the main dimensions of food and nutrition security. Food needs to be available in adequate quantities during all seasons with easy access for people. Poverty was acknowledged as one of the key constraints of food security which is exacerbated by rising prices of food. Patterns of expenditure on food across sectors (urban, rural, estate), provinces and districts indicate the utilization of various foods, driven through socio-economic and lifestyle factors. Wastage and loss of produce without making their way to needy people, unavailability of healthy food outlets, unsafe food and unethical marketing are some holdbacks for adequate utilization of nutritious food.

Residents of the estate sector, urban under-settlements, persons with acute illnesses or chronic diseases, pregnant women, low birth weight babies, undernourished children and the poorest wealth quintile of the population are recognized as most nutritionally vulnerable.

Key Strategic Directions for policy priority area I

10.1.1. Enhancement of availability, and equal access to quality and healthy food through the nutrition-sensitive food value chain[14].

10.1.2. Adoption of appropriate financing strategies to promote healthy food behaviours.

10.1.3. Community empowerment and community mobilization for optimum consumption of all nutrients through dietary diversification and to reduce food waste.

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10.2. Strategic directions for policy priority area II-Coordinated Multi-sector collaboration and partnerships.

Strengthening health and non-health systems for the provision of nutrition interventions, political commitment for nutrition, financing and accountability of nutrition programmes are the basis of achievement of nutrition goals. Mobilization of all relevant stakeholders including government, non-government, development agencies and private sector to advocate for nutrition promotion through an extensive mix of communication channels is necessary to achieve desirable outcomes. A multi-sector action plan on nutrition to harmonize direct and indirect nutrition actions is crucial to end all forms of malnutrition.

Key Strategic Directions for policy priority area II

10.2.1. Strengthen health and non-health government systems for the provision of direct and indirect nutrition interventions as per their mandate.

10.2.2. Reinstate a high-level, cohesive and strongly led strategic coordination mechanism with sustained political commitment for effective implementation of Multi-sector Action Plan for Nutrition (MsAPN).

10.2.3. Establish effective coordinating systems including accountability mechanisms for collaborative multi-sector nutrition actions at central, provincial, district, divisional and village levels.

10.3. Strategic directions for policy priority area III-Legal framework strengthening for protection of the right to safe food and prevention of unethical marketing

Food safety is supported by all relevant sectors of food production and regulatory authorities such as health (food control administration unit), trade, consumer affairs authority, police and local government authorities who ensure a safe food environment with adequate sanitation. Insecticides and pesticides in plant-based products, antibiotics and other chemical residues in fisheries and animal husbandry, and genetically modified food are some reasons for the loss of confidence in the consumption of nutritious food. The establishment of monitoring systems with facilities for analysis of water quality as well as chemical residues and genetic contents of food and proper implementation of regulatory mechanisms are needed to ensure the safety of food and water consumed in the country.

Key Strategic Directions for policy priority area III

10.3.1. Streamline food legislation systems throughout the food supply chain.
10.3.2. Control unethical marketing through a robust legislative mechanism.
10.3.3. Strengthen monitoring mechanism for food quality and safety.
10.3.4. Improve enforcement of water quality and safety regulations, standards and guidelines.
10.3.5. Empower all stakeholders to carry out food safety activities and maintain food quality.

10.4. Strategic directions for policy priority area IV-Nutrition improvement throughout the lifecycle.

The poor nutrition status of pre-pregnant women extends throughout and into the lifecycle of the offspring in a vicious cycle. It is evident that nutrition during the reproductive age influences fetal growth, birth weight and nutritional status of infants born to them. In most instances, infants born with low birth weight go through their childhood, adolescence, adulthood and older age with impaired growth and development with low productivity and quality of life. Nutrition during the lifecycle has been addressed with Maternal and Child Health (MCH) Policy, NCD Policy, Elderly Health Policy apart from NNP. Malnutrition being a risk factor for NCDs, has multiple implications at macro, community and household levels in the country. Individual and/or family-based problem analysis and triple-duty nutrition actions with the support of relevant stakeholders and maintaining proper nutrition throughout the lifecycle is important not only to improve the quality of life of the population but also for the social and economic development of the country.

There are evidence which demonstrate that nutrition anomalies exist in different geographical areas and across wealthy groups in the country. Especially, the estate population and urban under-settlement communities are most vulnerable to malnutrition while changes in dietary behaviours due to urbanization affect the nutrition status of urban populations. People with NCDs are rising alarmingly, showing the need for a sustainable multisector approach to triple-duty nutrition actions for the reduction of undernutrition, over-nutrition and micronutrient deficiencies. Nutrition status of those who are suffering from communicable diseases such as tuberculosis and Acute Immunodeficiency Syndrome (AIDS); NCDs such as obesity, cancer and mental health problems;

and those who need special attention in nutrition such as children, elderly and disabled need to be monitored and actions should be taken to improve their quality of life.

Key Strategic Directions for policy priority area IV

10.4.1. Provision of pre-pregnancy care for the couple before planning their first child or to plan subsequent pregnancies and to enter pregnancy with optimum nutrition in a supportive environment.

10.4.2. Safeguard proper nutrition for pregnant and postpartum (up to the completion of six months after delivery) women through strengthening mechanisms to provide necessary nutrition services.

10.4.3. Create enabling environment for early initiation of breastfeeding and exclusive breastfeeding for completed six months in all settings.

10.4.4. Building a strong foundation for all infants, young children and preschool children through evidence-based nutrition interventions with a special emphasis on appropriate, nutritious and safe complementary food prepared at home, and continued breastfeeding for two years and beyond together with the promotion of optimal Early Childhood Care and Development (ECCD).

10.4.5. Empower all primary school children to inculcate healthy dietary behaviours and physical activity with nutrition education through school curriculum and enabling school environment.

10.4.6. Promote optimal nutrition and development among adolescents and youth adopting adolescent and youth-friendly approaches while addressing the social determinants.

10.4.7. Empowerment of adults to adopt healthy lifestyles including healthy diet with the provision of comprehensive nutrition services.

10.4.8. Establish a conducive environment for optimal nutrition and access to appropriate nutrition services for all elders.

10.4.9. Implementation of appropriate interventions to improve the nutritional status of vulnerable populations.

10.4.10. Prevention and management of acute and chronic disease-related malnutrition.

10.5. Strategic directions for policy priority area V-Nutrition promotion in emergency situations and extreme weather conditions.

Mapping of disaster-prone areas, prediction of disasters and supply of nutritious food with targeted nutrition actions during disasters are necessary to safeguard and improve community nutrition. Recurrent and prolonged droughts and floods are frequent occurrences especially during a particular period of time annually. Climate change resilience to food systems also needs to be considered for the sustainability of food value chains. Food emergencies during pandemic situations should also be addressed with carefully planned mitigation measures to meet population nutrition needs.

Key Strategic Directions for policy priority area V

10.5.1. Strengthen and streamline resilience mechanisms to facilitate disaster preparedness plans to provide nutrition needs for affected populations.

10.5.2. Empower relevant stakeholders including emergency relief staff and programme managers to ensure safe and adequate nutrition for affected populations according to operational guidelines.

10.6. Strategic directions for policy priority area VI-Strategic management of information and research.

Targeted nutrition actions based on evidence are the most effective in overcoming population malnutrition in the country. Strategic information management systems and valid research evidence support the decision-making process for efficient and effective nutrition programmes at different organizational levels.

Key Strategic Directions for policy priority area VI

10.6.1. Strengthen strategic information management systems to support evidence-based policy and programmatic decisions.

10.6.2. Establish a dietary behaviour surveillance mechanism and incorporate it into the nutrition monitoring and evaluation.

10.6.3. Support appropriate research to generate evidence-based information and utilize them in advocacy, planning, implementation and periodic evaluations of nutrition interventions.

10. Expected impact of the policy

The expected impact of this policy is an improved nutritional status among Sri Lankan population with the minimization of geographical and socioeconomic disparities.

The following impacts need to be achieved for this purpose.

1. Reduced malnutrition in terms of undernutrition, overnutrition and micronutrient deficiencies.
2. Food and nutrition security ensured in terms of availability, accessibility, affordability and utilization of healthy food.

11.1. Malnutrition among Sri Lankan population reduced in terms of;

11.1.1. Undernutrition

11.1.1.1. Stunting among children under 5 years of age reduced from 17.3% (DHS, 2016) to 10% by 2030.

11.1.1.2. Wasting among children under 5 years of age reduced from 15.1 % (DHS, 2016) to <5% by 2030.

11.1.1.3. Low birth weight rate reduced from 15.7% (DHS, 2016) to 10% by 2030.

11.1.1.4. Low Body Mass Index for age among children 10-18 years old reduced from 26.9 % (National Survey, MRI, 2018) to 18% by 2030.

11.1.2. Overweight and obesity

11.1.2.1. No increase in overweight among children under five years of age from the baseline of 0.6% (NS- MRI, 2012) by 2030.

11.1.2.2. No increase in overweight and obesity among adolescents from the baseline of 7.6% and 2.2% respectively (NS-MRI,2018) by 2030.

11.1.2.3. Prevalence of overweight among adults and elderly (18-69 years) reduced from29.3% (STEPS, 2015) to 15%and obesity further reduced from 5.9% by 2030.

11.1.3. Micronutrient deficiencies

11.1.3.1. Reduce the prevalence of all micronutrient deficiencies among children under five years, adolescents, adults and pregnant women to less than 10% by 2030.

11.2. Food security and safety among Sri Lankan population increased in terms of;

11.2.1. Food security

11.2.1.1. Food insecurity among households reduced from 10.3 % (Food security survey DCS, 2014) to 5% by 2030.

11.2.1.2. Household Food Insecurity Access Scale (HFIAS) score reduced from 9.2 (Food security survey DCS, 2014) to 5 by 2030.

11.2.2. Food safety

11.2.2.1. All food available in the country safe for consumption

11. Implementation of the policy

The National Nutrition Policy shall be a guiding document for planning, implementation, monitoring and evaluation of nutrition-related actions at the National, Provincial, District and Divisional levels. It incorporates a wide variety of direct and indirect nutrition strategies involving public, private and industrial sectors. It shall be implemented by the government, with certain areas supported by UN organizations, other development partners, civil society organizations (CSO) and private sector agencies with defined responsibilities. This policy shall be effective until the end of 2030, while a midterm review shall be conducted in 2025 to provide the opportunity to update if needed.

A sustainable and effective institutional mechanism is mandatory for the efficient implementation of the policy. The Ministry of Health led the process of development of the NNP and is responsible for planning, implementation, monitoring and evaluation of evidence-based direct nutrition actions that are integrated into the Health Master Plan (HMP). Implementation of indirect nutrition actions is executed by the respective ministries as per their mandate.

Multi-sector Action plan for Nutrition 2018-2025 was developed by NNS which had been functioning at the Presidential Secretariat and was responsible mainly for coordination of implementation, monitoring and evaluation of direct and indirect nutrition actions.

The National Nutrition Policy and MsAPN need to be effectively coordinated, monitored and evaluated at National, Provincial, District and Divisional levels. At the National level, NNP shall be coordinated by a high-level coordinating body and a National Nutrition Steering Committee (NNSC) comprising high-level representatives of relevant ministries. They shall take nationally important evidence-based policy decisions and also monitor the implementation of NNP.

Implementation of National Nutrition Policy shall be guided by the strategic framework for action based on the policy priority areas and identified key strategic directions. The strategic framework for action includes key action areas, expected outcomes and monitoring indicators under each strategic direction. It also recognizes possible responsible sectors or organizations for the implementation of NNP. Provinces, as well as nutrition-related sectors and other agencies, may develop their nutrition-related strategic plans based on the guidance provided in this document. All these strategic plans need to be costed in terms of implementation across years.

12.1. Coordination of Multi-sector Action Plan for Nutrition

The following multi-sector coordination platforms shall ensure the effective coordination, monitoring and evaluation of the implementation of MsAPN at the National, Provincial, District and Divisional levels.

i. **The National Nutrition Council** chaired by His Excellency the President to provide policy guidance and policy-level decision-making related to nutrition. The NNC shall meet twice a year and bring together the political authority including all related Cabinet of Ministers, the Chief ministers of Provinces and members of the Parliament representing all political parties and heads of other stakeholder organizations.

ii. **The National Nutrition Secretariat** is the secretariat arm of NNC which is positioned under the purview of the Presidential Secretariat. The NNS is mainly responsible for the coordination, monitoring and evaluation of MsAPN.

iii. **The National Steering Committee on Nutrition (NSCN)** is chaired by Secretary to the President. The NSCN shall meet quarterly and bring together the Secretaries of Ministries, Chief Secretaries of Provinces, academia, representatives of development partners

including UN agencies, civil society and private sector organizations. The NSCN shall review the overall progress of implementation and solicit multi-sector support to improve nutrition-related indicators. The specific policy proposals put forward here should be referred to the National Nutrition Council for high-level intervention.

iv. **Technical Advisory Committee on Nutrition (TACN)** shall be the technical arm to support the functions of the NSCN and shall be established in order to provide technical facilitation to implement MsAPN and other nutrition-related policies and strategies. The TACN shall bring together technical experts from various disciplines such as Government, UN and other development partners, academia, civil society and private sector organizations to provide technical guidance on nutrition issues.

v. **Ministerial Steering Committees on Nutrition** shall be chaired by respective Secretaries of the Ministries and suggestions/recommendations shall be communicated to the TACN. Under these ministerial Steering Committees, technical subcommittees may beestablished to make recommendations with regard to nutrition as per the Ministry mandate.

vi. **The Provincial Steering Committee on Nutrition (PSCN)** is chaired by the Chief Secretary of the Province and shall meet once in three months. It shall bring together the Secretaries of provincial Ministries, heads of the departments of relevant government institutions, representatives of development partners, academia, civil society, and private sector organizations working in the province.

vii. **The District Steering Committee on Nutrition (DisSCN)** is chaired by the District Secretary and meets once in two months. It shall bring together the heads of departments of relevant government institutions, representatives of development partners, academia, civil society, and private sector organizations working in the district.

viii. **The Divisional Steering Committee on Nutrition (DivSCN)** is chaired by the Divisional Secretary and shall meet once a month. It shall bring together the heads of departments of relevant government institutions including Medical Officer of Health (MOH),

representatives of development partners, academia, civil society, and private sector organizations working at the divisional level.

The Provincial, District and Divisional Steering Committees shall be the key bodies monitoring the implementation of the District Nutrition Action Plans (DNAP) at the local level. They shall ensure that local nutrition problems are addressed through multi-sector coordination.

12.2. Monitoring and evaluation of National Nutrition Policy

A Strategic Information Management (SIM) Unit shall be established at the NNS to monitor and evaluate multi-sector, direct and indirect nutrition actions. The SIM Unit in the Nutrition Division of the Ministry of Health shall be the focal point for monitoring and evaluation of outcomes of direct nutrition interventions and shall liaise with the NNS.

Strategic Framework for action

Policy Priority Area I: Food and nutrition security for all citizens				
Strategic Direction	**Key action areas**	**Monitoring indicators and/or targets by 2030**	**Responsible sector/s or organization/s**	**Expected output/s or outcome/s for strategic direction**
1.1. Enhancement of availability and equal access to quality and healthy food through nutrition-sensitive food value chain.	1.1.1 a.) Strengthen sustainable nutrition-sensitive food value chains (agriculture, livestock, aquaculture, fisheries etc.) to improve healthy food availability and access. b.) Ensure the availability of diversified agricultural products including seasonal, traditional and underutilized crops. c.) Ensure the availability and accessibility of nuts and pulses through agriculture sector in a sustainable manner.	1.1.1.1. Proportion of availability of commonly utilised food out of estimated annual requirement (production + import)/ requirement) x 100. (source - Agriculture Ministry) *(Annual estimation of commonly utilized food requirement in metric tons (MT) for 2020 is Annexed).* 1.1.1.2. Reduction of Household food insecurity Access Scale Score (HFIAS Score) from 9.2 (2014) to 5 (source - DCS).	- National Nutrition Secretariat (NNS) - Agriculture - Livestock - Fisheries - Trade - Finance	1.1.1 Quality and healthy agricultural, livestock and fisheries food commodities, in adequate quantities made available for consumption in the country. 1.1.2 Access to quality and healthy food throughout the year to all citizens ensured. 1.1.3 Regulations and monitoring mechanism/s for quality and healthy food, made available in the country. 1.1.4 Infrastructure upgraded to minimize post-harvest food loss.
	1.1.2. Promote home gardening to improve availability and access to safe and nutritious food.	1.1.2.1. Percentage of home gardens established by size and type at the divisional level out of eligible increased by 30% from the baseline (source – Divisional secretariat databases).	- Agriculture - Social empowerment - Provincial/Local governments	1.1.5 Enabling environments created for food sovereignty and healthy eating in the communities.

	1.1.3. Strengthen backyard domestic animal husbandry with local breeds.	1.1.3.1. Proportion of families adequately supported for backyard animal husbandry out of estimated in each GN area increased by 30% from the baseline (source – Divisional secretariat databases).	- Livestock - Social empowerment - Provincial/Local governments	
	1.1.4. Enhance food security through improved land use efficiency, irrigation and cropping intensity.	1.1.4.1. Agricultural land use efficiency increased by 10% from the baseline (source - Department of agriculture/DOA).	- National planning - Irrigation - Agriculture	
	1.1.5. Reduce post-harvest loss by upgrading post-harvesting technologies, appropriate transport and storage facilities for the supply chain.	1.1.5.1. Food loss index reduced by 30% from the baseline (source – Department of census and statistics/DCS).	- Agriculture - Livestock - Fisheries - Province/Local governments - Transport - Science and technology - Finance	
	1.1.6. Promote eco-friendly food value chains.	1.1.6.1. Proportion of farms certified for Good Agricultural Practices (GAP) out of total registered farms (source -DOA).	- Agriculture - Livestock - Environment	
	1.1.7. Empower all relevant stakeholders on food supply chain management (quality	1.1.7.1 Proportion of trained stakeholders out of identified at provincial, district	- Agriculture - Livestock - Fisheries - Trade	

	food production, reduction of post-harvest food loss, food sovereignty[15] etc.).	and divisional level (sources – Provincial councils, District and Divisional secretariat databases).	- Finance	
	1.1.8. Strengthen food security surveillance (e.g., monitor yield and quality of food, forecast production, imports).	1.1.8.1. Availability of food security survey reports in scheduled time periods (every three years). (source - Agriculture Ministry) 1.1.8.2. Availability of reports of cost of diet surveys bi-annually (source - Agriculture Ministry).	- Agriculture - Livestock - Fisheries - Trade	
	1.1.9. Enhance the nutrient content of staple/essential food by fortification/bio-fortification as appropriate.	1.1.9.1. Number of crops bio-fortified per year (source - DOA).	- Agriculture - Trade - Health	
	1.1.10. Reformulate commercially prepared food in keeping with nutrition standards /nutrient threshold levels for healthy food.	1.1.10.1. Number of commonly consumed food items reformulated as healthy food annually (source – e-EOH & FS).	- Agriculture - Trade - Health - Industries	

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1.2. Adoption of appropriate financing strategies to promote healthy food behaviours.	1.2.1. Increase taxation of unhealthy food.	1.2.1.1. Availability of taxation regulations for unhealthy food (source – e-EOH & FS).	- Finance - Trade - Consumer Affairs	1.2.1. Affordability of quality and healthy food to all citizens is ensured. 1.2.2. Prices of essential food commodities are stabilized in the country.
	1.2.2. a.) Control the price of healthy food. b.) Coordinate decision support information systems (production, trends, climatic factors etc) in order to limit extreme food price volatility.	1.2.2.1. Indicator of food prize anomalies reduced by 30%from the baseline (source – Department of census and statistics). 1.2.2.2. Consumer price index for food & non-alcoholic beverages reduced from 131.8 (2018) to 110 (source - DCS).	- Finance - Trade - Consumer Affairs - Health - Agriculture - Livestock - Fisheries	
	1.2.3. Improve nutrition among vulnerable through targeted social security schemes.	1.2.3.1. Proportion of individuals who received the social security out of identified at the divisional level under each scheme (source – Divisional secretariat databases).	- Finance - Trade - Social empowerment	
	1.2.4. Income generation among disadvantageous populations.	1.2.4.1. Gini co-efficient of 39.8% (2016) reduced to 30% (source - World Bank). 1.2.4.2. Proportion of households	- Finance - National planning - Social empowerment - Provincial/Local governments	

		supported with income generation at the divisional level out of identified, annually (source – Divisional secretariat databases).		
	1.2.5. Improve consumption of nutritious diet with household financial management.	1.2.5.1. Number of household financial management awareness programmes conducted at the Divisional level annually (source – Divisional secretariat databases).	- Finance - National planning - Social empowerment - Health	
	1.2.6. Distribute essential and/or healthy food commodities at subsidized prices for targeted populations.	1.2.6.1. Number of essential/healthy food commodities distributed at subsidized prices annually (source – Financial ministry database).	- Finance - National planning - Social empowerment - Health	
1.3. Community empowerment and community mobilization for optimum consumption of all nutrients through dietary diversification and to reduce food waste.	1.3.1. Develop a national nutrition communication strategy and implement social behavior change communication (SBCC) to promote healthy eating.	1.3.1.1. Availability of updated national nutrition communication strategy (source - health promotion bureau - HPB database). 1.3.1.2. Number of social marketing campaigns	- Health - Indigenous medicine - Agriculture - Fisheries - Livestock - Education - Media - Social empowerment - Civil society organizations	1.3.1. Consumption of diversified diet in the community improved. 1.3.2. Optimum utilization of available food without waste achieved at the household level.

		implemented for the promotion of healthy eating annually (source - HPB database). 1.3.1.3. Percentage of 18 to 69 year old population consuming 5 servings of fruits and vegetables (2 vegetables, 1 green leafy vegetable, and 2 fruits) per day is increased from 27.5% (2015) to 40% (source – NCD Survey).	(CSO)/ Community based organizations (CBOs)	
	1.3.2. Streamline planning and implementation of district and divisional nutrition promotion activities in line with national strategies (e.g. Nutrition communication strategy, micronutrient strategy, strategy for prevention and control of NCDs).	1.3.2.1. Proportion of nutrition promotion interventions implemented as planned by district and divisional levels (source – District/Divisional secretariat databases).	- NNS - Policy Planning - Health - Provincial, district, and divisional authorities	
	1.3.3. Empower and mobilize the community influencers including civil society organizations, the private sector and	1.3.3.1. Proportion of awareness programmes on healthy eating with dietary diversification conducted for	- Health - Indigenous Medicine - Education - Media - Social empowerment	

	media personnel through awareness on scientific information on balanced diet, utilization of diversified, nutritious food and safety of food.	community influencers out of planned (source – Health sector databases).	- Relevant provincial and district authorities - CSO/ CBO	
	1.3.4. Implement evidence-based interventions to promote healthy eating at the village level.	1.3.4.1. Proportion of interventions to promote healthy eating out of planned interventions at the village level (source – MOH databases).	- District/Divisional/village level health authorities - Other nutrition-related sectors - CSO/CBO /NGOs - private sector	
	1.3.5. Empower the community to minimize food wastage at retail and consumer levels.	1.3.5.1. Percentage reduction of per capita food waste at the retail and consumer levels compared to the previous year (source - Agriculture Ministry).	- Health - Education - Media - CSO	

Policy Priority Area II- Coordinated Multi-sector collaboration and partnership				
Strategic Direction	**Key action areas**	**Monitoring indicators and/or targets by 2030**	**Responsible sector/s or organization/s**	**Expected output/s or outcome/s for strategic direction**
2.1. Strengthen health and non-health government systems for provision of direct and indirect nutrition interventions as per their mandate.	2.1.1. Strengthen organizational capacities (e.g., human, financial, infrastructure, technical) in all sectors for sustained nutrition interventions following a situational analysis.	2.1.1. Proportion of Nutrition-related cadres recruited in relevant ministries out of planned (source – databases of relevant ministries). 2.1.2. Proportion of capacity building programmes on provision of direct and indirect interventions conducted out of planned in relevant ministries (source – databases of relevant ministries). 2.1.3. Proportion of funds dedicated for nutrition activities out of planned (source – databases of relevant ministries). 2.1.4. Proportion of infrastructure facilities improved to provide nutrition interventions out of planned in relevant ministries (source – databases of relevant ministries).	- NNS - Management Services - National Planning - Finance - National Budget Department - All Ministries with nutrition-related responsibilities	2.1.1. Knowledgeable and skill mix of human resources, financial resources and infrastructure facilities in relation to nutrition is improved in relevant sectors/organizations as required.

2.2. Reinstate a high-level, cohesive and strongly led strategic coordination mechanism with sustained political commitment for effective implementation of MsAPN.	2.2.1. Streamline an advocacy mechanism for regular consultation between political leadership and other stakeholders.	2.2.1.1. Availability of high-level functioning coordinating and advocacy mechanisms for the implementation of MsAPN (source – NNS).	- NNC - NNS - NNSC	2.2.1. Sustainable high-level coordinating mechanism for effective implementation of MsAPN is established in the country.
	2.2.2. Incorporate relevant national and international policies/strategies/ standards and legislations into nutrition-related policies.	2.2.2.1. Availability of operational MsAPN aligned with related national policies, National and international nutrition strategies/standards and legislations (source – NNS).	- NNC - NNS - NNSC - All nutrition-related sectors	2.2.2. All nutrition-related policies aligned with relevant national/international policies/strategies/ standards and legislations.
2.3. Establish effective coordinating systems including accountability mechanisms for collaborative multi-sector nutrition actions at central, provincial, district, divisional and village levels.	2.3.1. Establish a functioning coordinating mechanism at central, provincial, district, divisional and village levels to manage the MsAPN.	2.3.1. Number of meetings held as per schedule; - NNC (once a year). - NNSC (once in 4 months) - TACN (As per the requirement) - PSCN (once in 3months) - DisSCN (once in 2 months) - DivSCN (once a month) - Village-level committees (once a month) (source – databases of relevant organizations).	- NNS - District Secretariat - Divisional secretariat - Health	2.3.1. Multisector action plan for nutrition (MsAPN) implemented effectively and efficiently.

	2.3.2. Coordinate implementation of nutrition policies, strategic and action plans at central, provincial, district, divisional and village levels.	2.3.2.1.Availability of review reports/ minutes of meetings on nutrition interventions at central, district, divisional and village levels (source -relevant databases).	- NNS - District Secretariat - Divisional Secretariat - Health	
	2.3.3. Strengthen partnerships with government, non-government, private sector and civil society organizations through multi-stakeholder collaboration.	2.3.3.1. Number of NGOs/CSOs/private sectors involved in nutrition actions at district/divisional/village level (source - relevant databases).	- All sectors responsible for nutrition-related activities - Non-government and civil society organizations - Private sector	

Policy Priority area III: Legal framework strengthening for protection of right to safe food and prevention of unethical marketing.				
Strategic Direction	**Key action areas**	**Monitoring indicators and/or targets by 2030**	**Responsible sector/s or organization/s**	**Expected output/s or outcome/s for strategic direction**
3.1. Streamline food legislation systems throughout the food supply chain.	3.1.1. Introduce or review and revise necessary legislation related to food safety and standards, giving priority to food items that are highly consumed by the population including street food and fast food.	3.1.1. Proportion of new legislation on food introduced as planned (source – e-EOH & FS). 3.1.2. Proportion of legislation on food revised as planned (source – e-EOH & FS).	-Health -Legal -Consumer affairs authority (CAA)	3.1.1. Biologically, chemically and physically safe food for consumption are made available in the country.
	3.1.2. Strengthen enforcement of existing and newly formulated legislations.	3.1.2.1 Proportion of food premises registered under food authority out of all food premises at divisional level (source –Divisional secretariat databases). 3.1.2.2. Proportion of public complaints investigated by CAA out of all complaints (source- CAA database).	-Health -Local authorities -CAA -Food premises	
3.2. Control unethical marketing through a robust legislative mechanism.	3.2.1. Streamline implementation of the existing mechanism to regulate the promotion of unhealthy food including nutrient profile model.	3.2.1.1. Availability of a national body to approve food advertisements (source – EOH & FS). 3.2.1.2. Number of prosecutions done for violation of labelling	-Health -CAA -Media	3.2.1. A functioning mechanism to regulate the promotion of food and beverages (including food and beveragesfor children) is

		and advertising regulations (source – e-EOH & FS).		established in the country. 3.2.2. Breastfeeding Code made into an Act of Parliament and all relevant legislations fully enforced.
	3.2.2. Implement strong legislation to regulate infant and young child formulae, milk and milk products, commercially prepared food and beverages intended for infants and young children.	3.2.2.1. Proportion of advertisements that are non-compliant with regulations on marketing of infant and young child formulae/ commercially prepared foods and beverages intended for infants and young children out of monitored advertisements (source - e-EOH & FS).	-Health -CAA -Food manufacturers and distributors -Consumer organizations	
3.3. Strengthen the monitoring mechanism for food quality and safety.	3.3.1. Strengthen analytical capacity for assessment of food for nutrient content and biological (including genetic), chemical, physical (including radiological) contaminants.	3.3.1.1. Availability of a new laboratory or upgrade of an existing laboratory as a national reference food laboratory (source – Ministry of Health). 3.3.1.2. Availability of at least one food laboratory and a branch of Department of Government Analyst per province with all resources for food analysis (source – PDHS database/ Department of Government Analysis).	-Health -Finance -National Planning -Provincial /local authorities -Department of Government Analysis	3.3.1. Food safety monitoring mechanisms strengthened to ensure right to safe food. 3.3.2. Analytical capacity including infrastructure, human and other resources for biological, chemical, physical and nutritional assessments of food strengthened.

	3.3.2. Strengthen relevant sectors to enforce Soil Conservation Act.	3.3.2.1. Number of actions taken to enforce Soil Conservation Act by relevant sectors (source – Ministry of Lands)	-Agriculture -Environment -Plantation -Finance -Other relevant sectors	
3.4. Improve enforcement of water quality and safety regulations, standards and guidelines.	3.4.1. Formulate portable water quality and safety regulations.	3.4.1. Availability of water quality and safety regulations (source - e-EOH &FS).	-Health -Water supply -Environment -Local authorities -Mahaweli Development	3.4.1. Safe drinking water from all water supply projects and bottled water assured in the country. 3.4.2. Water quality regulations enforced.
	3.4.2. Strengthen water quality surveillance.	3.4.2.1. Proportion of satisfactory water samples, out of all samples tested (source – MOH database).	-Health -Water Supply	
3.5. Empower all stakeholders to carry out food safety activities and maintain food quality.	3.5.1. Increase awareness on food safety including regulations among food producers/manufactures, distributors, handlers and consumers.	3.5.1.1. Availability of strategy to improve food safety awareness among all stakeholders (source - e-EOH &FS). 3.5.1.2. Number of consumer societies functioning at the divisional level (source - Divisional secretariat databases).	-Health -CAA	3.5.1. Capacity of relevant stakeholders and systems on food safety improved.
	3.5.2. Capacity building of all relevant stakeholders and systems to implement food safety regulations.	3.5.2.1. Availability of a hotline to complain about food safety and hygiene issues (source - EOH & FS).	-Health	

Policy Priority area IV: Nutrition improvement throughout the lifecycle.				
Strategic Direction	**Key action areas**	**Monitoring indicators and/or targets by 2030**	**Responsible sector/s or organization/s**	**Expected output/s or outcome/s for strategic direction**
4.1. Provision of pre-pregnancy care for the couple before planning their first child or to plan subsequent pregnancies and to enter pregnancy with optimum nutrition in a supportive environment.	4.1.1. a.) Streamline implementation of a pre-pregnancy care package to address risk factors for malnutrition among newly married couples. b.) Strengthen implementation of inter-pregnancy care package for couples who are planning subsequent pregnancies	4.1.1.1. More than 80% of the pregnant women received pre-pregnancy care (source - eRHMIS). 4.1.1.2. Percentage of pregnant women who have normal BMI (18.5 – 24.9) at the booking visit increased from 57% (2017) to 65% (source - eRHMIS).	- Health - Indigenous Medicine	4.1.1. Appropriate nutritional status among future parents ensured through pre-pregnancy care. 4.1.2. Women enter subsequent pregnancies with optimum nutritional status. 4.1.3. Households with reproductive-age women empowered to maintain proper pre-pregnancy nutritional status.
	4.1.2. Empower newly married couples, adolescent girls, and eligible couples to achieve optimum nutrition by establishing mechanisms to minimize social risk factors before entering pregnancy.	4.1.2.1. Underweight among ever-married women of 15-49 years reduced from baseline of 9.1% (2016) to 5% (source–DHS) 4.1.2.2. Overweight among ever-married women aged 15-49 years reduced from32% (2016) to15% (source–DHS). 4.1.2.3. Obesity among ever-married women aged 15-49 years reduced from	- Social empowerment - Education - Women's affairs - Health - Indigenous Medicine - CSO - NNS	

		13% (2016) to <10% (source–DHS). 4.1.2.4. Prevalence of anaemia in the first trimester reduced from I8.3% (20I9) to 9% (source - eRHMIS).		
	4.1.3. Establish a mechanism to monitor the nutritional status of lactating/postpartum women at six months after delivery and to address malnutrition.	4.1.3.1. 90% coverage of nutrition assessment among lactating/postpartum women at six months after delivery achieved (source - eRHMIS).	- Health - Indigenous Medicine	
4.2. Safeguard proper nutrition for pregnant and postpartum (up to completion of six months after delivery) women through strengthening mechanisms to provide necessary nutrition services.	4.2.1. Streamline implementation of national guidelines on maternal care aimed at improving/maintaining nutritional status of pregnant and postpartum women and achieving optimal birth weight.	4.2.1.1. At least 80% of the pregnant women gained intended weight during pregnancy (source - eRHMIS). 4.2.1.2. Anaemia among pregnant women by 28 weeks reduced from the baselineof 30.3% (2019) to 15% (source - eRHMIS). 4.2.1.3. Prevalence of low birth weight (LBW) reduced from 15.7% (2016) to 10% (source - IMMR and triangulate with DHS).	- Health - Indigenous Medicine	4.2.1. All pregnant and postpartum women received quality nutrition services as per national guidelines. 4.2.2. Adequate resources are made available to provide nutrition services to pregnant and postpartum women in preventive and curative health sectors. 4.2.3. All households with pregnant and postpartum women

	4.2.2. Allocate adequate resources (including skilled staff, financial allocations and other resources) to provide services in response to identified nutritional problems and to ensure optimal nutritional status of all pregnant and postpartum women.	4.2.2.1. Per capita expenditure on nutrition promotion activities targeting pregnant and post-partum women (source –Provincial Director of Health Services – PDHS Database). 4.2.2.2. Percentage of public health midwife (PHM) vacancies out of approved cadre (source – PDHS Database).	- National planning - Finance - Health - Provincial authorities	empowered to have proper nutrition. 4.2.4. All relevant stakeholders actively involved in promotion of nutritional status of pregnant and post-partum women. 4.2.5. Malnutrition among pregnant and postpartum women reduced. 4.2.6. All infants are born with optimum birth weight.
	4.2.3. Strengthen the multi-sector activities for empowering households with Pregnant and postpartum women to ensure optimum maternal nutrition.	4.2.3.1. Percentage of nutrition promotion interventions conducted by different stakeholders at each PHM area, out of planned (source - MOH, CSO, other relevant sectors databases).	- Social services - Women's affairs - Youth - Health - Indigenous Medicine - CSO	
4.3. Create enabling environment for early initiation of breastfeeding and exclusive breastfeeding for completed six months in all settings.	4.3.1. Empower households to ensure exclusive breastfeeding for six months by strengthening social support and provision of correct nutrition information.	4.3.1.1. Prevalence of exclusive breastfeeding among infants under six months increased from 82% (2016) to 90% (source - DHS).	- Health - Indigenous Medicine	4.3.1. Early initiation of breastfeeding for all newborns and improved exclusive breastfeeding for completed six months. 4.3.2. Mother and baby-friendly initiative implemented in all
	4.3.2. Ensure implementation of Mother & Baby-	4.3.2.1. Prevalence of early initiation of breastfeeding	- Finance - National planning	

	Friendly Hospital Initiative (M& BFHI).	improved and maintained at 98% (source - eRHMIS/ DHS). 4.3.2.2. Capacity building programs on breastfeeding and M & BFHI conducted at least for 90% of the service providers (source –eRHMIS, MOH databases). 4.3.2.3. M & BFHI implemented in all health care institutions (source – Ministry of Health).	- Provincial authorities - Health - Indigenous Medicine - Water supply -	hospitals with maternity services. 4.3.3. Family friendly workplace initiative implemented throughout the country. 4.3.4. All lactating mothers receive maternity benefits to facilitate exclusive breastfeeding for six months.
	4.3.3. Strengthen supportive environment for breastfeeding at all settings.	4.3.3.1. At least 75%of the government healthcare institutions having the recommended cadrefor maternal and childcare serviceprovision. (source – Ministry of Health).	- Finance - Labour - Public Administratio n - National planning - Provincial authorities - Social empowerment - Women's affairs - Government, private and informal sector organizations	

	4.3.4. Strengthen and enforce maternity benefits to all working women.	4.3.4.1. Number of workplaces certified annually as family-friendly. (source – Regional Director of Health Services / RDHS database).	- Labour - Social empowerment - Women's affairs - Public Administration - Government, private and informal sector organizations	
4.4. Building a strong foundation for all infants, young children and preschool children through evidence-based nutrition interventions with a special emphasis on appropriate, nutritious, safe, complementary food prepared at home and continued breastfeeding for two years and beyond together with the promotion of optimal Early Childhood Care and	4.4.1. a.) Empowerment of the community for appropriate IYCF. b.) Develop and implement community oriented, locally designed, customized actions for Infant and Young Child Feeding (IYCF) within the national framework to reach pockets of sub-cultures within population groups.	4.4.1.1. Prevalence of continued breastfeeding among children 20-23 months increased from 86.6% (2016) to 95% (source - DHS). 4.4.1.2. Prevalence of minimum dietary diversity[16] among children 6-23 months increased from 72.6% (2016) to 95% (source - DHS). 4.4.1.3. Prevalence of minimum meal frequency[17] among children 6-23 months increased from 86.1% (2016) to 95% (source - DHS). 4.4.1.4. Prevalence of minimum acceptable diet[18] among children	- Health - Indigenous Medicine - Children's Secretariat - Social empowerment - CSO - Finance - Private sector - Development partners - Agriculture/livestock/fisheries - Trade	4.4.1. All mothers continued to breastfeed for two years and beyond. 4.4.2. Minimum acceptable diet for infants and young children improved. 4.4.3. Minimum meal frequency, for infants and young children, improved. 4.4.4. Minimum, dietary diversity for infants and young children improved. 4.4.5. Nutrition status of children under 5 years of age improved. 4.4.6. Legislations relevant to IYCF

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Development (ECCD).		6-23 months increased from 62% (2016) to 90% (source - DHS).		including Breastfeeding Act, Food Act, and Maternity Benefits fully enforced. 4.4.7. Coverage of pre-school mid-day meal programme increased. 4.4.8. Practices of ECCD strengthened through enabling environment.
	4.4.2. Regular and quality growth monitoring and promotion of all children under five years of age with high coverage in all settings.	4.4.2.1. Stunting among children under the age of five years reduced from 17.3% (2016) to 10%(source - DHS). 4.4.2.2. Wasting among children under the age of five years reduced from 15.1% (2016) to <5% (source - DHS). 4.4.2.3. No increase in overweight[19] and obesity[20] among children under the age of five years from the baseline in 2012 (source - MRI).	- Health	
	4.4.3. Streamline and strengthen implementation of legislations relevant to IYCF including Breast-Feeding Act, Food Act and maternity benefits.	4.4.3.1. Availability of cabinet approved breastfeeding act and revised legislation on maternity benefits and Food Act available and enforced. (source– Ministry of Health, Ministry of Lobour, Ministry of Public Administration)	- Health - Legal - Consumer Affairs - Industries/Commercial establishments related to child food production/import	
	4.4.4. Ensure all preschool children develop healthy	4.4.4.1. At least 50% of identified preschools received	- Health - Indigenous Medicine	

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	dietary practices at home and preschools through relevant interventions including mid-day meal programme.	the mid-day meal. (source–Ministry of Child Affairs)	- Provincial preschool authorities - Children's Secretariat - Social empowerment - Finance - CSOs - Development agencies	
	4.4.5. Strengthen multi-sector involvement in ECCD to optimize psychosocial development as a contributor to optimum nutrition among children under the age of five years at households, daycare centres, preschools etc.	4.4.5.1. Children's access to materials (in terms of books or toys) helpful in developmental stimulation (2016) improved by 15% (source - DHS).	- Health - Indigenous Medicine - Provincial preschool authorities - Children's Secretariat - Social empowerment - CSOs	
	4.4.6. Implement relevant direct and indirect nutrition interventions as per timely requirements.	4.4.6.1. Percentage of direct nutrition interventions conducted annually for children under 5 years of age out of planned. (source -RDHS database) 4.4.6.2. Percentage of indirect nutrition interventions conducted annually for children under 5	- Health - Indigenous Medicine - Children's Secretariat - Social empowerment - Finance - Agriculture/Livestock/Fisheries - CSO	

		years of age out of planned. (source– relevant ministries)		
4.5. Empower all primary school children to inculcate healthy dietary behaviours and physical activity with nutrition education through school curriculum and enabling school environment.	4.5.1. Streamline and expand School mid-day meal programme to cover 1/3 of the daily caloric requirement of primary school children.	4.5.1.1. 100% coverage of mid-day meal programme for all primary school children in identified schools (source - Ministry of Education/MoE database). 4.5.1.2. Prevalence of thinness[21] among 6-12 years old children reduced from 30.2% (2016) to 15% (source - MRI). 4.5.1.3. Prevalence of stunting[22] among 6-12 years old children reduced from 11.5% (2016) to <10% (source - MRI). 4.5.1.4. Prevalence of anaemia among primary school children reduced from 11.7% (2016) to <10% (source - MRI).	- Education - Finance - Health - Development agencies - Civil society organizations	4.5.1. Access to nutritious meals among school children improved. 4.5.2. All school children empowered to adopt healthy lifestyles. 4.5.3. All schools facilitated to achieve optimum nutritionand lifestyle. 4.5.4. Water, Sanitation and Hygiene (WASH) facilities improved in all schools.
	4.5.2. Promote healthy dietary practices at home and schools including implementation of	4.5.2.1. Proportion of school canteens adhered to school canteen policy (grade A and B) out of total	- Health - Indigenous medicine - Education - Canteens	

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	healthy school canteen guidelines.	number of school canteens. (source - National Survey). 4.5.2.2. No further increase in overweight[23] and obesity[24] among 6-12 years old children from the 2016 baseline of 6.1% and 2.9% respectively (source - MRI).		
	4.5.3. Establish and implement legislation to regulate the availability of unhealthy food in close proximity to schools including banning unhealthy food outlets near schools (200m).	4.5.3.1. Availability of legislation to regulate the access to unhealthy food in close proximity to schools (source - e-EOH&FS).	- Legal - Trade - Food Industries - Formal and informal food establishments	
	4.5.4. Promote playing/ physical activity at all appropriate settings (schools, home etc).	4.5.4.1. All primary school children engaged in playing/physical activities at least 60min per day (source – national survey). 4.5.4.2. Availability of primary school curriculums which include 3 hours of physical activities per week (source - MoE database).	- Finance - National planning - Urban development - Sport - Education - Children's Secretariat - Local authorities	

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		4.5.4.3. Proportion of primary school children engaged in two non-competitive sports out of all primary school children. (source - MoE database).		
	4.5.5. Streamline school health programme including age-appropriate health and nutrition education.	4.5.5.1. Appropriate health and nutrition education for primary school children incorporated in the curriculum (source - MoE database). 4.5.5.2. Availability of reports on national nutrition survey among primary school children at scheduled intervals (source - MRI).	- Education - Health - Indigenous medicine	
	4.5.6. Improve and maintain water, sanitation and hygiene facilities at schools	4.5.6.1. All schools have an adequate, and microbiologically and chemically safe water supply according to the national norms (source - e EOH & FS). 4.5.6.2. 100% coverage of properly maintained toilet facilities according to national norms for schools (source - MoE database).	- Local authorities - Water supply	

		4.5.6.3. Proportion of schools with proper garbage disposal mechanisms including disposal of sanitary pads (source - MoE database).		
4.6. Promote optimal nutrition and development among adolescents and youth adopting adolescent and youth-friendly approaches while addressing the social determinants.	4.6.1. Establish/streamline implementation of canteen policies and guidelines on healthy food for schools, other educational and training institutes, and workplaces.	4.6.1.1. Availability of a grading system (grade A/B/C) in terms of healthy food availability and food safety for canteens in schools, other educational and training institutes, and workplaces (source - e-EOH&FS) 4.6.1.2. No further increase in overweight[23] and obesity[24] among 10-18 years old children from the 2018 baseline of 7.6% and 2.2% respectively (source - MRI). 4.6.1.3. No further increase in obesity (3.0%, 2015) and reduce overweight (15.8%, 2015) to 12% among 18-29 years old persons (source - NCD Survey).	- Health - Education - Higher Education - Vocational Training - Food industry - Food establishments	4.6.1. All school children monitored during School health programme to provide nutrition interventions according to requirements. 4.6.2. Canteen policies and guidelines in educational institutions implemented. 4.6.3. All needy school children received the mid-day meal at schools. 4.6.4. Adolescents and youth engaged in appropriate physical activities according to guidelines. 4.6.5. Optimal nutrition status among youth achieved.

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	4.6.2. Expand school mid-day meal programme to all targeted schools.	4.6.2.1. 100% coverage of School mid-day meal programme for adolescents in all targeted schools (source - MoE).	- Education - Finance - Health - Development agencies - CSOs	4.6.6. All youth empowered to inculcate healthy lifestyles. 4.6.7. Youth training institutions facilitated to promote healthy behaviours. 4.6.8. Global school health survey is conducted regularly.
	4.6.3. Streamline school health programme including age-appropriate health and nutrition education.	4.6.3.1. 100% coverage of age-appropriate health and nutrition education for school adolescents (source - MoE). 4.6.3.2. Availability of reports of national adolescent nutrition survey (source - MRI), and global school health survey (source - FHB) at scheduled intervals. 4.6.3.3. Prevalence of thinness among 10-18 years old children[21] reduced from baseline of 2018 - 26.9% to 18% (source - MRI). 4.6.3.4. Prevalence of stunting among 10-18 years old children[22] reduced from baseline of 2016 -13% to 10% (source - MRI).	- Education - Health - Indigenous medicine	
	4.6.4. Improve physical fitness of all	4.6.4.1. Proportion of school going	- Finance	

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	school children and youth through enabling environment.	adolescents assessed for physical fitness out of all school-going adolescents (source - MoE database). 4.6.4.2. Availability of information on physical fitness and nutritional status in information system in education sector(source - MoE database). 4.6.4.3. Proportion of students aged 13-15 who were physically active at least 60 minutes per day on all 7 days during the preceding week increased from baseline of 15.5% in 2016 to 50% or more (source - GSHS). 4.6.4.4. Proportion of students aged 13-17 who spent three or more hours per day sitting and watching television, playing computer games, or talking with friends, when not in school or doing homework during a typical or usual day reduced from 37.7% (2016) to	- National planning - Urban development - Education - Children's Secretariat - Sport - Youth - Local authorities	

		10% or less (source - GSHS)		
	4.6.5. Establish/streamline Adolescent and Youth Friendly Health Services (AYFHS) centres to promote healthy eating, physical activity and psychosocial support among adolescents and youth.	4.6.5.1. Proportion of programmes on nutrition and physical activity conducted by AYFHS centres annually out of planned (source - District review data). 4.6.5.2. Proportion of adolescents and youth (15-24 years) who never had unhealthy food during the preceding week (33.4%, 2012-13) improved up to 40% (source - National Youth Health Survey).	- Health - Education - Higher Education - Vocational Training - Youth	
	4.6.6. Establish mechanisms to assess nutrition status among youth in higher education institutions, vocational training centres and workplaces.	4.6.6.1. Availability of reports on national youth health survey at scheduled intervals (source – Family Health bureau).	- Health - Higher Education - Vocational Training - Youth	
	4.6.7. Provide adequate water, sanitation and hygiene (WASH) facilities for all schools, educational, training and work settings for youth.	4.6.7.1. Coverage of WASH facilities in all educational and training institutions/workplaces according to the national norms (source – eEOH & FS).	- Local authorities - Water supply	

4.7. Empowerment of adults to adopt healthy lifestyles including healthy diet with the provision of comprehensive nutrition services.	4.7.1. Streamline implementation of Strategic Marketing and Communication Plan for FBDG.	4.7.1.1. Availability of Strategic Marketing and Communication Plan to disseminate revised FBDGs (source – Nutrition Division). 4.7.1.2. At least 10% of the activities in the Strategic Marketing and Communication Plan to disseminate revised FBDGs completed annually (source – Nutrition Division).	- Health - Indigenous Medicine - Agriculture/livestock/fisheries - Trade - Consumer affairs authority - Science and technology - Local government - Sport - Education - Media	4.7.1. National and local government policies, legislations, and guidelines made available for improvement of healthy food availability, physical activity and to prevent substance abuse. 4.7.2. Malnutrition among adults reduced. 4.7.3. Implementation of workplace canteen policy and guidelines streamlined. 4.7.4. Availability of healthy food outlets and facilities for improving physical activity established at the community level
	4.7.2. Empower adults to inculcate healthy dietary behaviours through a supportive environment in all settings.	4.7.2.1. Prevalence of overweight[25] among adults 30-44 years reduced from 27.4% (2015) to 24% (source – NCD Survey). 4.7.2.2. Prevalence of overweight among adults 45-59 years reduced from 28.2% (2015) to 26% (source – NCD Survey). 4.7.2.3. Prevalence of obesity[26] among adults 18-59 years reduced from 5.9% (2015) to 3% (source – Survey). 4.7.2.4. Percentage of adults consuming 5	- Health - Indigenous Medicine - Agriculture/livestock/fisheries - Trade - Social empowerment - Civil society organizations - Finance - Food industry - Private sector	

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		portions of fruits and vegetables increased from 27.5% (2015) to 35% (source – NCD Survey).		
	4.7.3. Implement canteen guidelines at workplaces.	4.7.3.1. Availability of grading system (grade A/B/C) in terms of healthy food availability and food safety for canteens in workplaces (source – eEOH & FS).	- Health - Food industry - Food establishments	
	4.7.4. Provide necessary nutrition care services for adults in all settings.	4.7.4.1. Availability of mechanism for regular nutrition assessment among adult population at divisional level (source – NCD Unit). 4.7.4.2. Proportion of adults assessed for nutrition status every three years at divisional level (NCD Unit)	- Health - Indigenous medicine	
	4.7.5. Empowerment of adults including vulnerable groups on physical activities by creating awareness and enabling environment.	4.7.5.1. Number of open gymnasium/ walkingpaths established annually in each district (source – Divisional secretariat databases). 4.7.5.2. Number of healthcare institutions	- Finance - National planning - Urban development - Sport - Health - Local authorities	

		with a functioning physical activity program (source -HLC review/ NCDunit) 4.7.5.3. Number of healthcare personnel trained on physical activity promotion among the public (source - HLC review/ NCD unit). 4.7.5.4. Percentage of insufficient physical activity among 18-59 adults reduced from 30.4% (2015) to 25% (source – NCD Survey).		
	4.7.6. Monitor and evaluate nutrition interventions targeted at adults.	4.7.6.1. STEP survey reports to identify risk factors for non-Communicable diseases among adults available regularly (source - NCD unit).	- -Health - Social empowerment	
4.8. Establish conducive environment for optimal nutrition and access to appropriate nutrition services for all elders.	4.8.1. a.) Establish a comprehensive mechanism for nutrition services for elders at all settings (community /institutional) including nutrition	4.8.1.1. Coverage of nutrition assessment among elderly population at the divisional level (source–MoH database). 4.8.1.2. Prevalence of underweight among	- Health - Elderly secretariat	4.8.1. Evidence-based comprehensive nutrition care and support package for elders developed. 4.8.2. Appropriate, nutrition interventions and care services

	assessment, nutrition support and care. b.) Empower the elderly to access nutrition services.	elders of 60-69 years reduced from 16.4% (2015) to 10% or less (source – NCD Survey). 4.8.1.3. Prevalence of overweight among elders of 60-69 years reduced from 23.7% (2015) to 17% or less (source – NCD Survey). 4.8.1.4. Prevalence of obesity among elders of 60-69 years reduced from 6.3% (2015) to less than 5% (source – NCD Survey).		received by all elderly. 4.8.3. Efficient monitoring mechanism for nutrition support and care services for elderly made available.
	4.8.2. Improve resources (Human, financial, infrastructure etc.) to implement appropriate, comprehensive nutritional interventions for all elderly people.	4.8.2.1. Number of nutrition professionals recruited to the government system for proving elderly nutrition care (source - MoH).	- Health - Finance - National planning	
	4.8.3. Develop and implement national nutrition quality standards for residential care for elders.	4.8.3.1. Proportion of elderly care institutions that follow the National Nutritional Quality Standards out of registered institutions	- Health - Elderly secretariat - Social services - Residential care facilities	

		(source – Nutrition Division).		
	4.8.4. Facilitate physical activity according to the capacity of the elders in all settings.	4.8.4.1. Availability of easily accessible open spaces for physical activity for the elderly at divisional level (source – Divisional Secretariat). 4.8.4.2. Number of open gymnasium/ walkingpaths established annually in each district (source – Divisional Secretariat). 4.8.4.3. Percentage of insufficient physical activity among 60-69 adults reduced from 36% (2015) to 15% (source – NCD Survey).	- Finance - National planning - Urban development - Sport - Local authorities	
	4.8.5. Establish regular monitoring mechanism of nutritional support and care services for elderly at all settings and all levels (divisional, district, provincial and national).	4.8.5.1.Number of review meetings heldin different levels for elderly nutrition services annually (source– MoH/Provincial/District/Divisional Secretariat databases).	- Health	
4.9. Implementation of appropriate interventions to	4.9.1. Map nutritionally vulnerable individuals/	4.9.1.1. Availability of updated map on households with nutrition vulnerability	- National planning - Finance - Health	4.9.1. Nutrition status among vulnerable

improve nutritional status of vulnerable populations.	households/ populations (disadvantaged populations/ persons with acute or chronic illnesses/ estate, urban etc.) at divisional level.	at divisional level (source–Divisional Secretariat databases).	- Provincial/local authorities	populations improved. 4.9.2. Living standards enhanced and healthy environment established to prevent and control acute infections among vulnerable.
	4.9.2. Plan and implement targeted direct and indirect nutrition interventions as per the vulnerability status.	4.9.2.1. Underweight among vulnerable persons improved by 30% from the baseline (source – RDHS databases). 4.9.2.2. Overweight and obesity among vulnerable persons improved by 30% from the baseline (source – RDHS databases).	- Health - Water supply - Local authorities - Social empowerment - CSO	
4.10.Prevention and management of disease related (acute and chronic) malnutrition.	4.10.1. Strengthen health system to provide nutrition services for outdoor patients with chronic diseases.	4.10.1.1.Number of nutrition clinics established in each district (source – RDHS databases).	- Health - Indigenous medicine	4.10.1. Living standards enhanced and healthy environment established to prevent and control acute and chronic infections/ diseases among vulnerable. 4.10.2. Mechanisms to prevent and control malnutrition among patients with acute and/or chronic
	4.10.2. Streamline mechanism to ensure optimum nutrition among inward patients and during rehabilitation period.	4.10.2.1. Availability of mechanisms to prevent and control malnutrition among patients with acute and/or chronic illnesses (source - MoH).	- Health - Indigenous medicine	

	4.10.3. Empower the community to provide optimum nutrition during and after acute/chronic illnesses and palliative care at household/community level through SBCC and social safety net programmes.	4.10.3.1. Proportion of thinness among people living with HIV/AIDS (source – National STD/AIDS Control Programme) 4.10.3.2. Proportion of thinness among people with TB (source - National Programme for Tuberculosis Control & Chest Diseases). 4.10.3.3. Proportion of thinness among people with cancers (source - National Cancer Control Programme).	- Health - Indigenous medicine - Social empowerment - CSOs	illnesses implemented.
	4.10.4. Empower populations with NCDs and infections (Tuberculosis, diarrhoeal diseases, HIV/AIDS,etc.) to prevent and control malnutrition, through income generation, access to healthy diet and nutrition supplementation, safe water and sanitation.	10.4.1. Proportion of population using safe drinking water services improved from 94% (2014) to 100% (source – GLAAS). .10.1.1. Respiratory infections among children under the age of 5 years are reduced by 50% from the baseline (source – MoH). 4.10.4.3. Diarrhoeal diseases among	- Health - Indigenous medicine - Water supply - Local authorities	

		children under the age of 5 years old reduced by 50% from the baseline (source – MoH).		

Policy Priority area V- Nutrition promotion in emergency situations and extreme weather conditions				
Strategic Direction	**Key action areas**	**Monitoring indicators and/or targets by 2030**	**Responsible sector/s or organization/s**	**Expected output/s or outcome/s for strategic direction**
5.1. Strengthen and streamline resilience mechanisms to facilitate disaster preparedness plans to provide nutrition needs for affected populations.	5.1.1. Strengthen implementation of disaster preparedness and mitigation plans at all levels (national, provincial, district and divisional) in relation to nutrition.	5.1.1.1. Number of disaster preparedness and mitigation plans at central, provincial, district and divisional levels with incorporated nutrition actions (source – DMC databases). 5.1.1.2. Proportion of households received a food basket with essential nutritive commodities out of all affected (source – Divisional secretariat databases). 5.1.1.3. Proportion of vulnerable individuals who received nutrient supplements (including supplementary foods) out ofidentified at divisional level (source – Divisional secretariat databases). 5.1.1.4. Proportion of affected vulnerable population subjected to post emergency nutrient surveillance at	- Disaster management centre (DMC) - Health - NNS - Provincial/District/Divisional secretariat - Local authorities	5.1.1. Nutrition needs of vulnerable populations are adequately addressed in disaster management plans and implemented. 5.1.2. All stakeholders are empowered for early preparedness and mitigation for emergencies. 5.1.3. Resistant varieties of food plants made available to resist adverse weather conditions.

		village level (source – MOH databases).		
	5.1.2. Establish prediction and early warning mechanism for climate change and extreme weather conditions at village level with multi-sector collaboration.	5.1.2.1. Proportion of early warnings provided out of all extreme weather conditions occurred at the village levels (source – DMC databases).	- DMC - Environment - District secretariat - -Divisional secretariat - Local authorities/ GN	
	5.1.3. Empower the communities for early preparedness on climate change, extreme weather conditions and other disasters.	5.1.3.1.Proportion of communities where early preparedness programmes (drills) conducted out of estimated at the district level (source – District secretariat databases).	- DMC - Health - NNS - District secretariat - Local authorities - Environment - Development partners/CSO	
	5.1.4. Capacity building of health staff on proper management of malnutrition during emergencies and post emergencies.	5.1.4.1. Number of relevant health staff trained on proper management of malnutrition during emergency and post-emergency phase at district level (source – databases of Regional Director of Health Services – RDHS).	- Health	
	5.1.5. Introduce adverse weather-resistant varieties of plant-based food (Rice, Pulse, vegetables and fruits	5.1.5.1. Number of research conducted to identify weather-resistant varieties of plant-based food	- Agriculture - Universities - Research - institutes	

	etc.) through proper research and extension practices.	annually (source - DOA). 5.1.5.2. Proportion of new climate-resistant varieties of food plants that are cultivated out of researched annually (source - DOA).		
5.2. Empower relevant stakeholders including emergency relief staff and programme managers to ensure safe and adequate nutrition for affected populations according to operational guidelines.	5.2.1. Develop/update/revise operational guidelines for nutrition support in emergencies.	5.2.1.1. Number of operational guidelines developed/available for nutrition support in emergencies (source – DMC databases). 5.2.1.2. Proportion of updated/ revised operational guidelines out of required (source – DMC databases).	- Health - NNS - DMC	5.2.1. Stakeholders empowered to provide adequate and quality services to the affected populations
	5.2.2. Operationalize emergency nutrition planning in each district through a multidisciplinary team, emphasizing proper utilization of food and prevention of wastage.	5.2.2.1. Number of districts with a functioning multidisciplinary team to operationalize emergency nutrition planning (source – District secretariat databases).	- DMC - Health - District secretariat	
	5.2.3. Streamline a functioning health and non-health sector coordinating committee for disasters in each district to maintain	5.2.3.1. Number of districts with a functioning coordinating committee for disasters where nutrition has been incorporated in the agenda (source –	- Health - DMC - District secretariat	

	population nutrition in emergencies.	District secretariat databases).		

Policy objectives VI- Strategic management of information and research				
Strategic Direction	**Key action areas**	**Monitoring indicators and/or targets by 2030**	**Responsible sector/s or organization/s**	**Expected output/s or outcome/s for strategic direction**
6.1. Strengthen strategic information management systems to support evidence-based policy and programmatic decisions.	6.1.1. Real time monitoring and evaluation of all direct and indirect nutrition interventions.	6.1.1.1. Number of stakeholders having a functioning strategic information management system on nutrition (source – NNS).	- NNS - Department of Census & Statistics - All relevant ministries - Provincial, district and divisional authorities	6.1.1. Evidence on nutrition outcomes and predictions communicated to relevant stakeholders and/or to the community.
	6.1.2. Utilize nutrition surveillance system for making decisions to improve and protect community nutrition.	6.1.2.1. Availability of a functioning comprehensive nutrition surveillance system at the central level (source - NNS).	- All relevant ministries - Provincial, district and divisional authorities - All other sectors/ organizations responsible for nutrition related activities	
	6.1.3. Improve public awareness on nutrition related information.	6.1.3.1. Availability of nutrition data sharing mechanism with the public at district level (source – District secretariat databases).	- All relevant ministries - Provincial, district and divisional authorities	

		6.1.3.2. Availability of interactive platforms for public awareness of specific nutrition issues at divisional level (source -Divisional secretariat databases).	- Development partners - CSOs	
6.2. Establish a dietary behaviour surveillance mechanism and incorporate it into the nutrition monitoring and evaluation.	6.2.1. Monitor and evaluate dietary behaviours.	6.2.1.1. Incorporation of dietary behaviour surveillance into the strategic information management systems (source – Nutrition Division).	- NNS - Health	6.2.1. Dietary behaviours in the community monitored and effectively used in planning and implementation of nutrition interventions.
	6.2.2. Utilize behaviour surveillance information in implementing targeted SBCC interventions.	6.2.2.1. Number of social behaviour change programmes implemented for unhealthy nutrition practices at divisional level (source – MOH/CSO databases).	- NNS - Health - All sectors responsible for nutrition-related activities	
	6.2.3. Conduct periodic surveys to identify consumption patterns and nutrition outcomes in the community.	6.2.3.1. Proportion of periodic surveys conducted to identify nutrition outcomes and consumption patterns in the community out of planned (source – MoH/DCS databases).	- NNS - Health - DCS	
6.3. Support appropriate research to generate evidence-based	6.3.1. Identify research gaps for planning and implementation of evidence-based direct	6.3.1.1. Number of research conducted based on identified nutrition related research gaps (source	- All relevant ministries - Development partners - NGOs	6.3.1. Most resistant dietary behaviours identified to prioritize and implement

information and utilize them in advocacy, planning, implementation, and periodic evaluations of nutrition interventions.	and indirect nutrition interventions and conducting research based on them.	– MoH/University databases). 6.3.1.2. Number of market behaviour surveys in relation to food consumption conducted (source – MoH/University/ research institute databases).		nutrition interventions. 6.3.2. Baselines to monitor identified nutrition outcomes established.
	6.3.2. Establish baselines for all necessary direct and indirect nutrition interventions needed for monitoring of implementation of NNP.	6.3.2.1. Availa bility of baseline and periodic information for monitoring and evaluation of NNP (source - MoH/DCD/Universit y/ databases).	- All relevant ministries - DCS - Academia/res earch institutes - Development partners - NGOs	
	6.3.3. Conduct nutritional composition analysis and bioavailability research on frequently consumed and non-conventional foods.	6.3.3.1. Availability of updated food composition tables (source – MRI). 6.3.3.1. Number of research conducted on bioavailability of nutrients (MoH/University/rese arch institute databases).	- Health - Department of census and statistics - Academia / research institutes	
	6.3.4. Provide necessary resources for priority research and periodic surveys at specified intervals.	6.3.4.1. Availability of financial resources as required (source-relevant sector databases). 6.3.4.2. Availability of infrastructure	- All relevant ministries - Finance - Science and technology - National planning	

		facilities for research out of identified (source- relevant sector databases).		

I. Glossary

1. **Food Security -** Food security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life (The State of Food Insecurity in the World 2001, FAO, 2002).
2. **Nutrition Security -** Nutrition security exists when all people at all times consume food of sufficient quantity and quality in terms of variety, diversity, nutrient content and safety to meet their dietary needs and food preferences for an active and healthy life, coupled with a sanitary environment, adequate health, education and care (The state of food insecurity in the world, FAO, WFP and IFAD, 2012).
3. **Malnutrition -** Malnutrition refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients (Fact sheet World Health Organization, 2020). i.e., It includes under-nutrition, over-nutrition, and micro-nutrient deficiencies.
4. **Wasting (or thinness) among children under 5 years -** Weight-for-height more than two standard deviations below (-2SD) the WHO Child Growth Standards median. It indicates a recent and severe process of weight loss, and often associated with acute starvation.
5. **Stunting among children under 5 years -** Height-for-age more than two standard deviations below (-2SD) the WHO Child Growth Standards median. Indicates impaired growth and development. This is often due to poor nutrition, repeated infection, and inadequate psychosocial stimulation.
6. **Direct (Nutrition specific) interventions -** Interventions that address the immediate determinants of malnutrition (e.g., Vitamin A and zinc supplementation for children, exclusive breastfeeding, dietary diversity promotion and food fortification).
7. **Indirect (Nutrition sensitive) interventions -** Interventions that address the underlying determinants of nutrition (e.g., poverty; food insecurity; scarcity of access to adequate care resources) and are carried out by complementary sectors such as agriculture, social protection, early child development, education, water, and sanitation.
8. **Food loss –** Loss of food in the food value chain from post-harvest up to the retail level (but not including the retail level).
9. **Food wastage -** Decrease in the quantity or quality of food at retailer, food service provider (take away outlets, restaurants etc.) and consumer levels.
10. **Hazardous materials -** Substances that are leading to food borne diseases due to their biological, genetic, chemical, and physical properties.
11. **Global syndemic of obesity, undernutrition and climate change** – Concurrent pandemics of obesity, undernutrition and climate change represent the global syndemic.
12. **Double duty nutrition actions –** Nutrition interventions (actions) that address undernutrition and overnutrition both.
13. **Triple duty nutrition actions -** Nutrition interventions (actions) that address the undernutrition, overnutrition as well as micronutrient deficiencies.

14. **Food value chain -**The supply chain that consists of all the stakeholders who participate in coordinated production and value-adding activities that are needed to make food products. (Second international conference on nutrition, Rome 2014).
15. **Food Sovereignty -** The right of people to healthy and culturally appropriate foodproduced through ecologically sound and sustainable methods, and their right to define their own food and agriculture systems (Declaration of Nyéléni, the first global forum on food sovereignty, Mali, 2007).
16. **Minimum Dietary Diversity -** Consumption of food and beverages from at least five out of eight defined food groups to receive nutritionally adequate and diversified foods (WHO, Nutrition database). This indicator will be assessed as a percentage of children 6–23 months of age who consumed food and beverages from at least five out of eight defined food groups during the previous day according to Indicators for assessing IYCF practices 2021, WHO. However, the baseline value in strategic framework is given as per previous guide.
17. **Minimum meal frequency -** Children aged 6–23 months, who receive solid, semi-solid, or soft foods at the minimum numbers of two (for children aged 6–8 months) and three (for children aged 9–23 months) times (WHO, Nutrition database). This indicator will be assessed as the percentage of children 6–23 months of age who consumed solid, semi-solid or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times during the previous day, according to Indicators for assessing IYCF practices 2021, WHO. However, the baseline value in strategic framework is given as per previous guide.
18. **Minimum acceptable diet -** It is an indicator which combines standards of dietary diversity and feeding frequency by breastfeeding status (Adapted from WHO indicators for IYCF practices 2007).

    The minimum acceptable diet is defined as:

    For breastfed children: receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day.

    For non-breastfed children: receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day as well as at least two milk feeds.

    This indicator will be assessed as the percentage of children 6–23 months of age who consumed a minimum acceptable diet during the previous day according to Indicators for assessing IYCF practices 2021, WHO. However, the baseline value in strategic framework is given as per previous guide.

19. **Overweight among children under 5 years** - weight-for-height greater than 2 standard deviations above (+2SD) WHO Child Growth Standards median.
20. **Obesity among children under 5 years** - weight-for-height greater than 3 standard deviations above (+3SD) the WHO Child Growth Standards median.

21. **Thinness among 5-19 years old children** – Weight-for-height more than two standard deviations below (-2SD) the WHO reference standards for age 5-19 years.
22. **Stunting among 5-19 years old children** – Height-for-age more than two standard deviations below (-2SD) the WHO reference Standards for age 5-19 years.
23. **Overweight among 5-19 years old children** - BMI for age greater than one standard deviationabove (+1SD) WHO reference standards median for age 5-19 years.
24. **Obesity among 5-19 years old children** - BMI for age greater than two standard deviations above(+2SD) WHO reference standards for age 5-19 years.
25. **Overweight among adults -** BMI greater than or equal to 25 (BMI for adults is calculated dividing weight in kilograms by height in meters squared; BMI = weight (kg)/Height^2 (m^2).
26. **Obesity among adults -** BMI greater than or equal to 30.

II. Annex

Annual baseline estimation of required commonly utilized food in metric tons (MT) for 2020. (This should be changed according to the population change annually).

a) Rice - 1,663,200MT
b) Pulses - 415,800MT
c) Fish - 418,857MT
d) Chicken - 147,420MT
e) Soya 29,484
f) Beef 29,484MT
g) Mutton 29,484MT
h) Pork 29,484MT
i) Root vegetables 491,400
j) Green vegetables -491,400
k) Green leaves 737,100
l) Other vegetables 638,820
m) Fruits 1,965,600
n) Nuts (Peanuts etc) -189,000
o) Egg (Number) -7,560,000
p) Milk (Kilolitres) 756,000
q) Coconut (number of Nuts) 3,931,200
r) Coconut oil (Kilolitres) 49,140
s) Other oil (MUFA) Kilolitres 98,280
t) Sugar and Jaggery 294,840

(Source – Medical Research Institute)