EGYPT Nutrition

L a n d s c a p e

Analysis Report

2012

Forward for the Landscape Analysis Report

Egypt has successfully reduced infant mortality rates over the last decade. Our young however are faced with an alarming rate of malnutrition, especially chronic malnutrition "stunting" among children under-five years of age has reached an alarming 29%, On the other side of the spectrum, the problem of over-nutrition is also on the rise in Egypt. Rates of obesity and the risk of being overweight are increasing, especially among women and adolescents.

During the last few years the Ministry of Health and Population in Egypt has placed nutrition as one of its main priorities. Accordingly, we have developed a 10-year Food and Nutrition Policy and Strategy (2007–2017).

In order to complement the 10-year Strategy and have a better understanding of the extent of the problem and possible solutions to optimize outcomes with available resources, the Landscape Analysis (LA) study was commissioned by the MoHP with support from UNICEF Egypt Country Office, as the first study of its kind to be carried out in the region and among Arab countries.

The LA study approached the malnutrition problem through four different axes; identifying the nature and the scale of nutrition problems; the government willingness and commitment to act at scale; the capacity to act at scale; and factors enabling or hindering the commitment and capacity to act at scale.

The LA report came up with excellent recommendations; immediate, medium and long term. It covered the most critical areas of nutrition in Egypt; coordination, funding, programme planning, human resources, services and information systems.

The report comes at a critical time and will take full advantage of the willingness and high commitment from the government side to accelerate and scale up action on nutrition.

I would like to thank everyone who participated or contributed to the completion of this study and hope that this will guide us towards achieving our direct objective of combating all forms of malnutrition and our ultimate goal of improving the health and well-being of all Egyptians.

Sincerely,

Dr. Nasr El Sayed

Minister's Assistant for Primary
HealthCare, Preventive Medicine &
Family Planning

ACKNOWLEDGEMENTS

The successful completion of Egypt'sNutrition Landscape Analysis was the outcome of cooperation and support of many individuals in Egypt.The Landscape Analysis (LA) was guided and supported by two committees: a steering and technical committee. The steering committee members were: Assistant Minister for Primary Healthcare, Preventative Medicine and Family Planning, Ministry of Health and Population (MOHP);The National Nutrition Institute Director (NNI);The South African Medical Research Council President;Department of Community, Environmental and Occupational Medicine,Ain Shams University;and UNICEF Director. The technical committee comprised at least two individuals from all four institutions mentioned above.

The country assessment team would like to thank the following:

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ABBREVIATIONS

ANC:	Antenatal Care
AU:	African Union
DHS:	Demographic Health Survey
EBF:	Exclusive Breast Feeding
ECLA:	Egyptian Lactation Consultants Association
FGD:	Focus Group Discussion
IDA:	Iron Deficiency Anemia
IMCI:	Integrated management of childhood illnesses
MCH:	Maternal & Child Health
LA:	Landscape Analysis
LE:	Egyptian Pound
MDG:	Millennium Development Goals
MOE:	Ministry of Education
MOHP:	Ministry of Health and Population
MOSS:	Ministry of Social Solidarity
SAMRC:	South African Medical Research Council
NHA:	National Health Accounts
NGO:	Non-Governmental Organization
NNI:	National Nutrition Institute
OOP:	Out-of-Pocket
PHC:	Primary Health Care
RDA:	Recommended Dietary Allowance
UNICEF:	United Nations Children Fund
UNDP:	United Nations Development Program
UNFPA:	United Nations Population Fund
USAID:	United States Agency for International Development
VAD:	Vitamin A Deficiency
WHO:	World Health Organization
WFP:	World Food Programme

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THE NATURE AND THE EXTENT OF NUTRITIONAL CHALLENGES IN EGYPT

EXECUTIVE SUMMARY

The prevalence of stunting in Egypt is 29 percent, which makes it one of the 36 high-burden countries of the world (5). Egypt's nutritional challenges can be classified into two broad categories: maternal and infants and young children, youth and young adults. With regards to the former, exclusive breast feeding remains sub-optimal; consumption of vitamin A rich foods amongst children is declining and coverage with vitamin A supplementation among children and women is less than 50%; iron supplementation for infants declined from 49 percent in 2005 to 33 percent in 2008, and wasting, stunting and underweight have increased between 2005 and 2008. High consumption of micronutrients is associated with maternal education, wealth and area of residence. Major problems amongst youth and young adults include under and over nutrition; amongst young adults 15 and 16 percent of young males and females are at risk of becoming overweight, more men than women are overweight, more women are obese, and wealth and urban residence are associated with higher levels of obesity. Success of the programmatic response to these problems is varied as some programmes are doing better than others (for example food fortification) and relatively successful preventative programmes and innovative community interventions in Upper Egypt need to be expanded to other areas in the country (5).

The causes of nutrition problems in Egypt are a function of many factors: most households are food insecure because of low income, high food prices and low local agricultural production, in addition to poor dietary practices due to lack of awareness, and inadequate health service provision capacities. There are also the problems of environmental pollution and food safety challenges due to lack of enforcement of existing laws. There is an overarching health system challenge that derives from uncoordinated and disjointed planning of nutrition activities; often leading to sub-optimal use of resources and impact on nutrition status.

In recognition of its nutritional challenges, Egypt has developed a 10-year Food and Nutrition Policy and Strategy (2007 – 2017). In 2010, UNICEF Egypt Country Office, together with the Ministry of Health and Population (MOHP), commissioned this Landscape Analysis (LA). This was timely to complement Egypt's National Food and Nutrition Policy and Strategy, which had been in existence for four years. Egypt is the first country in the Middle East and North African (MENA) region to conduct this landscape analysis.

The launch of the Lancet Series on Maternal And Child Under-nutrition in January 2008 provided a unique advocacy opportunity to accelerate evidence-based action in nutrition (1). A World Health Organization (WHO)-led inter-agency working group developed the Landscape Analysis (LA)as an effort to respond to the calls for stronger coordination as well as increased nutrition action at scale. The landscape analysis reviews gaps, constraints and identifies opportunities for integrating new and existing effective nutrition actions in order to create and accelerate inter-sectoral action for improving nutrition. The ultimate aim is to lay the foundation to implement consolidated and harmonized action at scale in the 36 high-burden countries where 90% of the malnourished children live.

The LA in Egypt was driven by a country assessment team which included two committees: a technical and a steering committee under the leadership of the MOHP. These two committees included representatives from the MOHP, NNI, South African MRC, SAMRC Local partner (Ain Shams University), and UNICEF. The country assessment process had

five principal phases: preparations by the national team (phase 1); field-based, qualitative rapid assessment and interviews at national level (phase 2); analysis of findings and recommendations (phase 3); a consensus-building workshop (phase 4); preparation of final report and agreed recommendations (phase 5).

As a readiness analysis, the country assessment team looked at four sets of indicators: the nature, extent and distribution of nutrition problems; the country's willingness and commitment to act at scale; the country's ability/capacity to act at scale; and general conditions and contextual factors that will enable or constrain the commitment and capacity for Egypt to carry out nutrition actions at scale. Secondary and primary data were also collected through literature review and fieldwork from purposively selected areas that best reflect the different country experiences (Cairo, Sharkiya, Beni Suef and Ismalia)using 4 tools adapted from the traditional 8 tools originally developed for the landscape analysis. The analysis was largely informed by the four functions of a nutrition system: stewardship, resources commitment, service provision and capacity.

The landscape analysis demonstrates that there are many views on nutrition actions by different public and private stakeholders in Egypt.These actions include, amongst others, development of policies and national nutrition programmes such as food fortification, food subsidies and other social assistance, and feeding programmes including school and health facility nutrition kitchens; providing technical advice to national and sub-national levels (by UN agencies); developing an innovative community-based nutrition programmes in rural and poor settings; supporting baby-friendly facilities; interventions that target pregnant women, infants and children; research, monitoring and evaluation and information dissemination activities; targeted programmes for street kids and homeless people in urban settings; child labour and women initiatives; and various training on nutrition.Noteworthy is that none of these activities is operating at scale to meet the current needs (for example, Save the Children Project in Cairo, UNICEF's community based intervention models in Upper Egypt, NGO work in Ismalia and Beni Suef). In terms of addressing underlying food insecurity issues, there are interventions to improve quality of subsidised food commodities (reviewing the food basket), support for improved agricultural production, and improved management of water and sanitation services. Once again, these interventions remain inadequate.

The country assessment clearly shows that commitment and willingness to act are abundant but challenges remain in terms of ability to act. The predominant curative approach to nutritional problems has meant that preventative activities remain sub-opti malas evidenced by lack of nutritionists or health workers trained on nutrition and with adequate time to provide these services at PHC level. Therefore, the health system needs to be strengthened to better prevent and respond to nutritional problems. Whilst at the national level there is evidence of potentially effective nutrition governance structures (inter-ministerial committees), their inactivity and/or lack of coordination suggests the need to strengthen nutrition leadership. There are challenges at the national level to effectively communicate and coordinate nutrition priorities and set standards and enforce them across the public and private sectors. The landscape analysis also showed that lack of communication amongst stakeholders is one of the key challenges affecting policy and programmatic coordination and integration of nutrition actions. The capacity to act has largely been affected by the health systems weaknesses such as inadequate or mal-distribution of nutritionists, funding, supply of nutrition commodities, educational materials and an unwarranted focus on curative

versus preventative services. Service delivery needs to improve particularly at lower level facilities so that nutrition problems are identified early and preventive services provided. In-service training of health workers and training of specialist nutritionists to work at all levels of the health system (not just based in hospitals and research institutes) is critical.

Recommendations for the short, medium and long term were made focusing on the critical areas of nutrition in Egypt: Nutrition Coordination and roles, Budget and Funding; Planning and design of programmes; Human Resources; Service provision;and Nutrition Information Systems. In summary:

- The Inter-Ministerial Committee on Nutrition needs to be revived and capacitated with the MOHP taking the lead in inter-sectoral coordination and ensuring a harmonised approach to nutrition actions. Linkages with the Food Security Committee's activities are essential.
- The MOHP needs to relook at its organisational structure so that it gives nutrition activities visibility and prominence. Technical support for intra-MOHP coordination and inter-sectoral coordination and reorganisation might be required in the short and medium term.
- The key strategic or policy areas defined in the National Food and Nutrition Policy and Strategy provide a strong foundation for harmonised programmatic interventions to manage and prevent nutrition problems. The Strategy needs to be reviewed and updated with the involvement of all stakeholders including those involved in Food Security sector to ensure alignment and complementarities.
- Existing laws on food safety, labelling and advertising need to be reviewed to support implementation of the revised Strategy.
- The recently completed Operation Plan must be widely distributed and costed for resource mobilisation and action. A resource mobilisation strategy needs to be developed based on this Operation Plan.
- To facilitate medium and long term planning the MOHP budget for nutrition activities needs to be known in advance and within a three-year framework.
- To carry out an institutional review of the National Nutrition Institute to assess if its research priorities are aligned to the identified nutritional challenges which require a health systems strengthening approach and community nutrition initiative.
- At the national level, training should be provided on health systems stewardship and integrated planning as part of strengthening the health system to better respond to nutrition challenges. This must be linked to wider use of Think tanks on Food and Nutrition to guide policies and strategies.
- An inventory of all nutritionists and nutritionists training institutions must be established as part of a broader process for addressing current human resources shortages at service delivery levels and mal-distribution of nutritionists countrywide.

- More in-service training of health workers, including community health workers, is required to strengthen nutrition actions at all levels (national, institutional and community levels). On the short term, the idea of nutrition corners needs to be explored as part of improving coverage of nutrition services.
- To support evidence based and integrated planning, the nutrition system needs strengthening for data quality, flow and use across the sector. There is need to establish an integrated data warehouse from which information is shared, though the existing coordination platforms is critical.
- The MOHP must lead in social mobilisation and advocacy campaigns through various media to increase public awareness of nutrition issues. It is important that nutrition messages feature regularly in different media platforms covering both rural and urban areas.
- The current nutrition challenges in Egypt are likely to be resolved through better coordination and information sharing since a lot of research work has been done over the years on the nature and extent of nutrition problems. The current spirit of change provides a real opportunity for concerted nutrition actions.

INTRODUCTION

The launch of the Lancet Series on Maternal And Child Under nutrition in January 2008 provided a unique advocacy opportunity to accelerate evidence-based action in nutrition (1). A World Health Organization (WHO)-led inter-agency working group developed the *Landscape Analysis* (LA) as an effort to respond to the calls for stronger coordination as well as increased action at scale on nutrition programmes. The landscape analysis reviews gaps, constraints and identifies opportunities for integrating new and existing effective nutrition actions in order to create and accelerate inter-sectoral actions for improving nutrition. The ultimate aim is to lay the foundation to implement consolidated and harmonized action at scale in the 36 high-burden countries[1], where 90% of the malnourished children live. To date thirteen[2] countries have conducted the landscape analysis.

The prevalence of stunting in Egypt is 29 percent; hence it is amongst the 36 high-burden countries (5). In recognition of its nutritional challenges, Egypt developed a 10 year Food and Nutrition Policy and Strategy (2007 – 2017). In 2010, UNICEF (Country office) together with Ministry of Health and Population (MOHP) commissioned the Landscape Analysis. This was timely to complement Egypt's National Food and Nutrition Policy and Strategy, which had been in existence for four years. Egypt was the first country in the Middle East and North Africa (MENA) region to conduct the landscape analysis. The section below will provide an overview of the nature and extent of nutrition problems, and then describe the methodology followed as well as results and recommendations.

1. NATURE AND EXTENT OF NUTRITIONAL CHALLENGES IN EGYPT

The long standing unfinished agenda of malnutrition (under nutrition) in developing countries now co-exists with a different type of malnutrition-obesity. Egypt like other developing countries is battling with this double burden of malnutrition. The slow improvements in public health systems and community infrastructure in Egypt have been cited among the factors that contributed to the slow progress in reducing malnutrition. On the other hand the adoption of Western diets high in refined carbohydrates, saturated fats and sugars, as well as a more sedentary lifestyle are commonly cited as the major contributors to the increase in overweight and chronic diseases (2). The section below describes the nature and the extent of malnutrition problems in Egypt; it draws largely from the 2008 Demographic Health Survey (DHS), which is a reliable and nationally representative data set.

1.1 Feeding practices for children in Egypt

Child growth, development and well-being are determined by the feeding practices and nutritional status of the child amongst other things. The World Health Organisation (WHO) and UNICEF recommend exclusive breast feeding for the first six months of life and appropriate complementary foods starting from six month of age along with breastfeeding until two years and beyond (3). However, the rate of exclusive breast feeding and complementary

1 Countries with more than %20 stunting rates that were the focus of the Lancet Nutrition Series for investigating the effects of nutrition interventions.

2 Burkina Faso, Ghana, Guatemala, Madagascar, Peru, Comoros, South Africa, Timor-Lesle, Cote d'Ivoire, Ethiopia, Indonesia, Mozambique, Sri Lanka.

feeding in developing countries is far from optimum, ranging between 30-50% (4). In Egypt, the rate of exclusive breast feeding is 79 percent for infants under two months of age. This figure drops to 30 percent for infants who are 4-5 months of age (5). At first glance Egypt appears to be doing fairly well and above the range of the rate of EBF amongst developing countries. However, the observed drop after three months, demonstrates that Egypt is far from optimum. Thus, there is an urgent need to improve breastfeeding practice i.e. increase the duration of exclusive breastfeeding to ensure universal coverage of this practice.

Children must be fed a variety of foods to ensure that their daily requirements are met. Ensuring that children consume an adequate nutritional diet is a preventative strategy towards micronutrient defici encies such as vitamin A and iron deficiency. One third of children aged 6 – 35 months consumed vitamin A rich foods. This was a decline from the 45% observed in 2005. Another strategy for improving vitamin A deficiency (VAD) is supplementation. Egypt's vitamin A programme for children begins at nine months of age (typically at the time the child receives the measles vaccination), where children are given one vitamin A capsule (100,000 international units). One additional capsule (200,000 units) is given to children at age 18 months with the activated polio dose. Only 44 percent of the children aged 9–11 months received vitamin A supplementation. Coverage is highest for children aged 18-27 months at 49 percent.Both strategies for reducing VAD (i.e. consumption of vitamin A rich foods and supplementation) are suboptimal (5).

On the other hand 72 percent of children in the 6 – 35 months old group consumed iron – rich foodsaround twice the proportion consuming vitamin-A rich foods. (5). It is widely acknowledged that economic and informational factors play a role in shaping a children's diet. The likelihood that Egyptian children will consume iron and vitamin A rich foods increased with maternal education and wealth (5).

1.2 Micronutrient consumption amongst mothers

Iron deficiency anaemia is related to unfavourable pregnancy outcomes which include perinatal and maternal mortality; and low birth weight(6). The pattern of consumption for vitamin A and iron rich food was similar, to that of children. The 2008 EDHS results indicate that more than eight in ten mothers of young children consumed iron-rich foods (i.e., meat, poultry, fish and eggs) in the 24 hours preceding the survey, and 53 percent consumed vitamin A-rich fruits and vegetables. Similar to children's case,the likelihood of eating both vitamin A and iron rich foods was higher among educated women and those in the higher wealth quintiles (5).

MOHP has a program of vitamin A supplementation for new mothers and for babies through Primary Health Care Facilities. EDHS, 2008 results revealed that in nearly 57 percent of all births in the five year period prior to the survey, mothers reported receiving a postpartum vitamin A capsule and around 12 percent of children age 6-59 months had received a vitamin A (5).

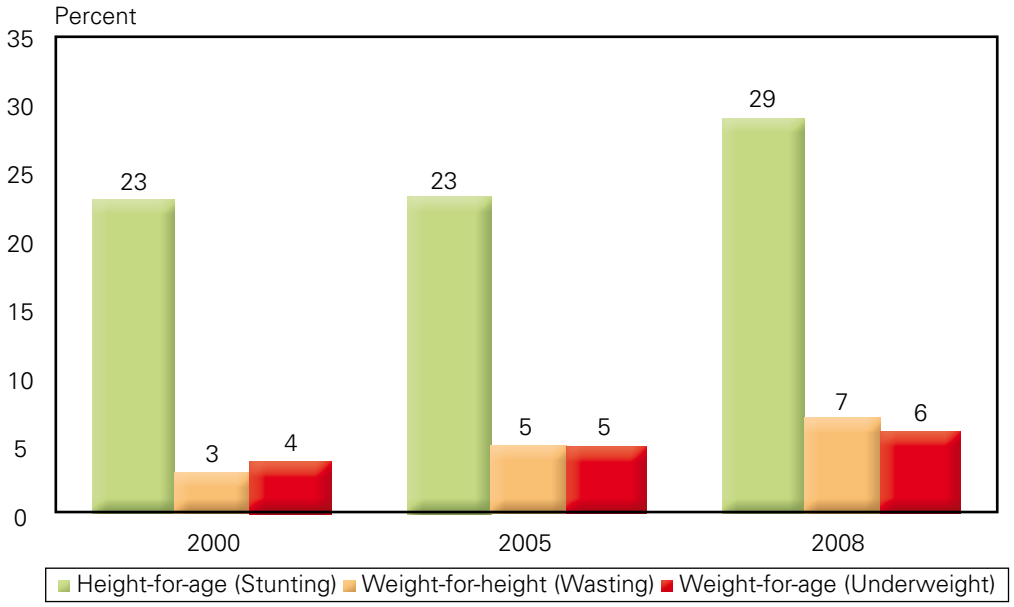
Concerning iron supplementation during pregnancy, just over one-third of women who gavebirth during the five-year period preceding the 2008 EDHS reported that they had taken iron tablets or syrup during the pregnancy preceding their last live birth[3]. This result represented a decline from the 49 percent reported in the 2005 EDHS (5).

1.3 Child malnutrition

Malnutrition in children is typically caused by a combination of inadequate food intake and infection which impairs the body's ability to absorb or assimilate food. The interplay of inadequate food intake and infection has resulted three indices for measuring malnutrition in infants and children; weight-for-height; height-for-age; and weight-for-age. The weight-for-height index measures body mass in relation to body length. Height for age is an indicator for linear growth. Finally, weight-for-age is a composite index of height-for-age and weight-for-height. For all three indices; weight-for-height; height-for-age; and weight-for-age measures that are below minus two standard deviations (-2 SD) from the median of the reference population are wasted, stunted and underweight respectively. Severe malnutrition in all three categories (wasting, stunting, and underweight) is present when measures are all below minus three standard deviations (-3 SD) from the reference population median. The usefulness of these indices is in distinguishing between acute malnutrition that is amenable to immediate interventions and chronic malnutrition which has detrimental lifetime consequences.

According to the 2008 DHS (5), acute malnutrition (wasting) affects seven percent of Egyptian children. Wasting is more prevalent among children under the age of six months and their mothers mentioned that they were underweight at delivery. In addition, six percent of children under age of five were underweight for their age and highest levels (8 percent) were among children aged 18-23 months. Stunting is considered the most reliable measure of chronic malnutrition since it is the product of a cumulative history of episodes of past or chronic or frequent illness that led to a reduction of growth rates that were not later made up for during more favourable periods. 29 percent of Egyptian children are stunted and another 14 percent are severely stunted. Rural areas had higher rates of malnutrition compared to urban areas. Historical data shows that Egypt has been unsuccessful in reducing malnutrition. Fig.(1) shows that between year 2000 and 2005 malnutrition remained stagnant and increased in 2008 for all three measures of malnutrition amongst children.

3 Iron syrup during pregnancy is not only provided through PHC, women can buy it if it is prescribed through a private physician. EDHS results do not imply that iron syrup was obtained from PHC.



Note: Data are for children under age five for whom the nutrion status measure fell below -2 SD from the WHO Child Growth Standards reference population median.

Source: Fatma El-Zanaty and Ann Way. Egypt Demographic and Health Survey 2008. Cairo, Egypt Ministry of Health, El-Zanaty and associates, and Macro International 2009

Figure 1: Trends in nutritional status of young children

1.4 Youth and Young Adult

The 2008 DHS data shows that both forms of malnutrition (over and under nutrition) are prevalent in Egypt amongst youth. Young adults tend to be affected largely by over nutrition. Five percent of males aged 10 – 19 years are under weight and the same proportion is overweight. Similar proportionsof overweight were observed in girls; six percent were overweight. Some (15 percent of males and 19 percent of females) of these young people are at risk of becoming obese. In adults there was a gender difference in overweight and obesity levels. Men (34 percent) had higher levels of overweight compared to females (28 percent). On the contrary obesity was more prevalent amongst women compared to men, 40 percent of women were obese compared to 18 percent of men. Both men and women who resided in urban areas were more likely to be obese compared to their rural counterparts. It is evident that over nutrition is a challenge for youth and adults in Egypt. Box(1) summarizes the nutrition challenges in Egypt for mothers and infants, and youth and young adults.

Box 1 The extent of nutritional challenges in Egypt as shown by selected indicators

A. Maternal and infant in dicators

- Suboptimal exclusive breast feeding
- A decline in consumption of vitamin A rich foods amongst children
- Less than 50 percent coverage of vitamin A supplementation among children
- An increase in wasting, stunting and underweight between 2005 and 2008
- About 50 percent coverage of vitamin A supplementation for women
- A decline in coverage of iron tablets or syrup from 49 percent in 2005 to 33 percent in 2008
- Socio-economic factors; maternal eduction, wealth and area of residence were associated with higher consumption of micronutrients (this applies to both food and supplementation)

A. Youth and Young Adults

- Young males suffer from both forms of malnutrition
- 15 and 16 percent of young males and frmales are at the risk of becoming overweight.
- Higher percentage of men are overweight compared to women
- Higher percentage of women are obese compared to men
- Wealth and residing in urban areas is associated with higher levels of obesity.

1.5 Food security and dietary intake

The UNICEF nutrition conceptual framework clearly depicts the multifaceted nature of malnutrition. It is essential to understand that malnutrition manifests as a result of basic, underlying and immediate causes as shown in Fig.(2), as this understanding aids the development of effective interventions. Food security and dietary intake are among the underlying causes of malnutrition due to inadequate access to food.

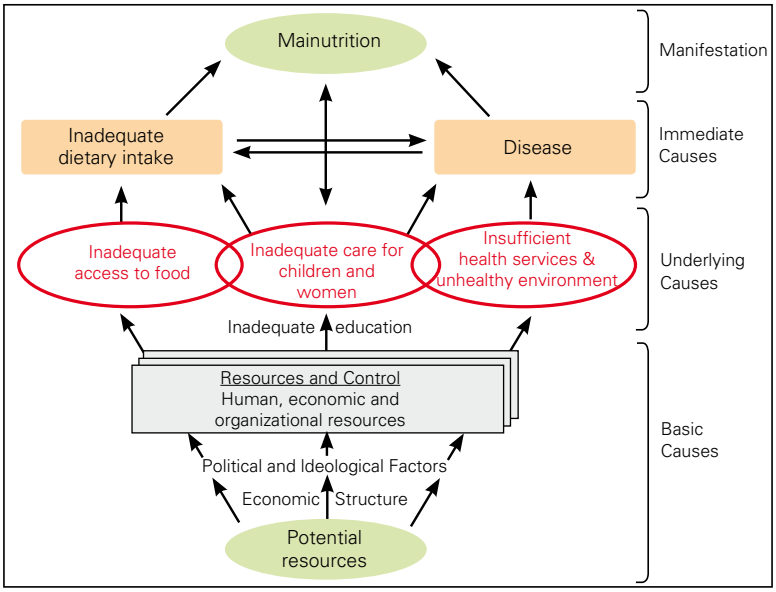


Figure 2: UNICEF Nutrition Conceptual Framework

The majority of energy supply for Egyptians is derived from carbohydrates, fats and protein. Cereals represent the main source of energy, providing about 52 percent of the total energy (Fig. 3) (15). Relatively little is consumed in terms of vegetables and fruits, and meat and dairy products. This is partly explained by the relative easy access to staples via the subsidy programme but the consumption of vegetables fruits and animal protein is improving.

Figure 3: the average dietary energy supply

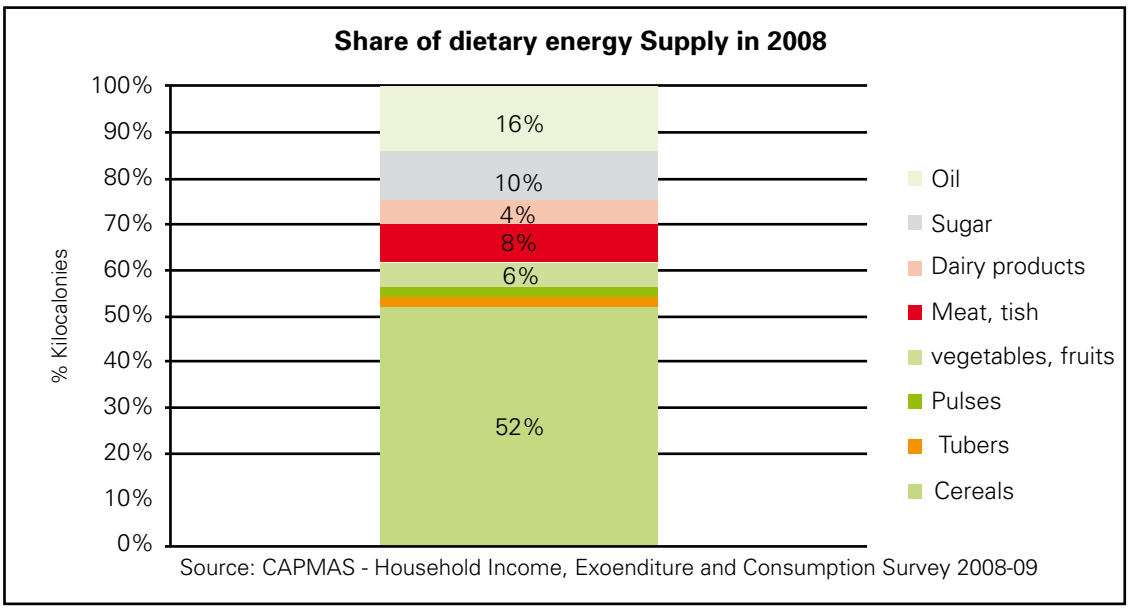


Figure 3: The average dietary energy supply

The Egyptian government has implemented several macro level interventions to ensure access to basic food. Firstly, wheat flour and bread are subsidised for the entire Egyptian population. Wheat is a key staple food crop in Egypt. Consumed mainly as bread, it provides on average, one third of the daily caloric intake of consumers and 34 percent of the daily protein consumption (8). Secondly, in 2008 the Egyptian government in partnership with the World Food Programme (WFP) and Global Alliance for Improved Nutrition (GAIN) fortified the flour used for making baladi bread with iron and folic acid. In 2010, the Egyptian government announced a five-year national project that targets 60 million Egyptians; this project will fortify subsidised vegetable oil with Vitamin A and D (Box 2).

Box 2 Macro level interventions by the Egyptian government and partners

- Wheat policy which include; reforms in pricings, production levels and a subsidy on bread.
- A- Large-scale food fortification
  - In 1996 fortification of table salt with Iodine.
  - In 2008, fortified flour used for making baladi bread with iron and folic acid.

In partnership with WFP and GAIN

  - In 2010, fortified subsidised vegetable oil with Vitamin A and D.

B- Supplementation programs

  - Vitamin A supplementation for all infants 9 & 18 months(for free)
  - Vitamin A supplementation for delivered women (for free)
  - Iron & folic a tabs supplementation for all pregnant women (for free)
  - Iron supplementation for infants 6 ms to 30 months (weekly dose)
  - Zn supplementation for infants (with diarrheal treatment)

Unfortunately child malnutrition is worsening rather than improving in Egypt. Others argued that the worsening situation could be partly attributed to the Avian Influenza (AI) that emerged in 2006 (9). Other factors such as a decline in consumption of vitamin A rich foods, and reduction in coverage of micronutrient supplementation were contributory factors. The reductions in the coverage of micronutrient supplementation are probably affected by health systems factors such as the availability of these supplements in health facilities. The emergence of obesity is not surprising given the increase in the carbohydrate intake of Egyptians. Suboptimal feeding practices, together with the worsening malnutrition amongst children and adults require urgent attention from the Egyptian Government and other stakeholders in Egypt.

A recent review of the food situation in Egypt by the WFP (15) concluded that the key underlying and basic factors of household food insecurity in Egypt include, *inter alia*:

- Low income to allow access to more diversified foods including fruits, vegetables and animal protein leading to unbalanced diets which are often high on energy but low in micro-nutrients. Such diets contribute to stunting among children, anaemia and decreased resistance to infection, overweight and obesity.
- Increased cost of living especially for non-subsidised food items and transportation.
- Low agricultural production particularly in rural areas affecting food availability.
- Sub-optimal access to social assistance systems including the ration card for subsidized staple foods and cash assistance.
- Low access to well-maintained and performing water, sanitation and health services which increases risks of infections from contaminated water and unhygienic environments, and constrained health services.

Poverty is argued to be a critical basic factor of household insecurity as it drives access to food and affects food utilisation through various pathways, namely: low crop and animal production affects food available for consumption and sale, and formal and regular employment; under-employment and unemployment; and poor living conditions.

METHODOLOGY

2. METHODOLOGY

2.1 The Landscape Analysis process in Egypt

The LA country assessment process has five principal phases: preparations by the national team (phase 1); field-based, qualitative rapid assessment and interviews at the national level (phase 2); analysis of findings and recommendations (phase 3); consensus-building workshop (phase 4), preparation of final report and agreed recommendations (phase 5) (10). It is imperative that the above process is driven by a country assessment team. In this regard, the LA in Egypt was driven by a country assessment team which included two committees: a technical and a steering committee. These two committees included representatives from the MOHP, NNI, South African MRC, SAMRC Local partner (Ain Shams University), and UNICEF.

The country assessment team communicated through meetings, teleconferences and several e-mail discussions. The first meeting was a steering committee meeting which took place on the 26th of June 2011 at the Ministry of Health and Population, office of the Minister's Assistant for Primary Health Care, Preventive Medicine and Family Planning, Cairo, Egypt. The meeting endorsed four study tools, study sites, a plan for piloting the tools, training of teams before the data collection, logistical arrangements and project coordination (Phase 1). Then the technical committee met on the 17th of July 2011 at the NNI. The purpose of this meeting was to discuss the preliminary findings and plan for the consensus workshop. Once the analysis was completed all findings were shared by e-mail, and the country assessment team was given an opportunity to comment and raise issues with the findings (Phase 3). An agreement on the proceedings, invitations and timing of the consensus building workshop was reached through several e-mail discussions. The country assessment team met a day before the consensus workshop (14th August 2011) at UNICEF to view the final presentation and agree on the proceeding of the day. Following the consensus building workshop, a draft report was prepared by the South African Medical Research Council in partnership with the local partner (Ain Shams University). The country assessment team was given a week to read and comment on the report. Thereafter a revised draft was sent to the country assessment team for approval (Phase 5). Once the final version of the report was approved it was translated into Arabic.

2.2 Site selection

The Landscape Analysis methodology is a rapid assessment using a mixed methods approach (i.e. both quantitative and qualitative). It is not an assessment method based on representative sampling methodology; rather it takes a snapshot of the current nutrition situation. This has often meant that country assessment teams have to decide on the assessment areas. Countries that have implemented the Landscape analysis have purposively selected areas based on criteria that would reflect best different country experiences (10).

Egypt consists of 27 governorates. There are 27 health directorates in operation. Two hundred and seventy three (273)health districts report to the governorate health directorates (11).

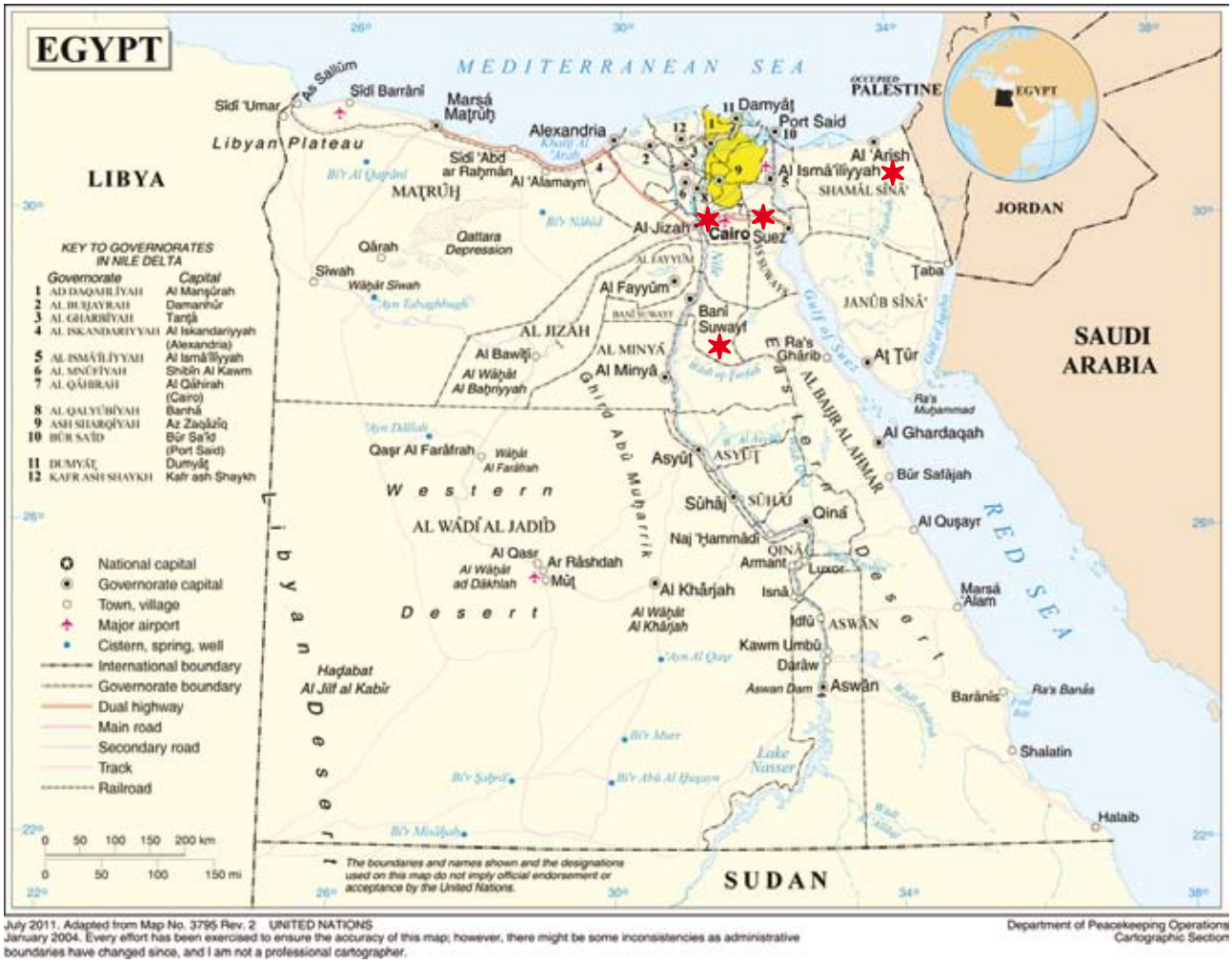


Figure 4: Map of Egypt indicating the selected governorates

Four governorates (Cairo, Sharkiya, Beni Suef, and Ismailia) were purposively selected to reflect densely populated areas, rural-urban location, and upper and lower governorates (Figure 4). 9.3% of the Egyptian population resides in Cairo, 7.4% in Sharkiya, 3.1 % in Beni Suef and 1.3% in Ismailia. Frontier governorates were excluded because only 1.8% of the population resides in these governorates and due to financial and time constrains(see Appendix 1 for list of all governorates and the percentage of population that resides in them).

Seven districts (Zakazig, Beni Suef, Ismailia, Dar El-Salam, El Basateen, Masr El Kadem, El Sayeda Zeinab were selected. The chosen districts had the highest number of new births and facilities. It was believed that these selection criteria will reflect the health status of the majority of the governorates population. The district of Ismailia is the capital of the governorate, 47% of all births in Ismailia in 2010 were in this district. Beni Suef district had the highest number of new births in 2010 representing 21% of all births in Beni Suef. The district of Zakazig is the capital of the Governorate of Sharkiya, it accounted for 18% of new births in 2010. For Cairo a different modality of selection had to be chosen as it has several influencing characteristics, Cairo has no capital city, its districts are not divided based on actual service requirements but on a city zoning scheme and the number of facilities in each district is relatively small. There are 30 districts in Cairo, three were chosen(Masr El Kadema, Al Basateen and Dar El Salam) with geographic proximity and collectively the number of new births in 2010 represents 14% of all births in Cairo. The populations living in these areas are considered to be middle to low income class families, thus the children in them are more prone to nutritional deficiencies.

Service delivery units included were public hospitals, family health centres and family health units. Public hospitals represented the referral points for the selected districts in each governorate were included. The following list represents the selected public hospitals:

- Cairo: El-Mounira general hospital
- Beni Suef Governorate: Beni Suef general hospital
- Sharkyia Governorate: Sharkyia general hospital
- IsmailiaGovernorate: Ismailia general hospital

Family health units and family health centres were randomly selected on the day of the assessment by the data collection team based on an identified sampling frame. Table 1 shows governorates, districts, and the number of facilities where data collection took place.

Table 1: Profile of selected governorates, districts and facilities

Governorate	District	Urban	Rural	Type of facility	Number of facilities
Sharkiya	Zakazig		√ √	Family Health Units Family Health Centre PublicHospital	5 4 1
Beni Suef	Beni Suef	√ √ √	√ √	Family Health Centre Family Health Centre Family Health Unit Family Health Unit PublicHospital	2 2 1 5 1
Cairo	Dar El- Salam El Basateen Masr El Kadema El Sayed Zeinab	√ √ √ √ √		Family Health Centre Family Health Centre Family Health Centre Family Health Centre PublicHospital	1 4 3 2 1
Ismailia	Ismailia	√ √	√	Family Health Centre Family Health Unit PublicHospital	5 5 1

Apart from the above-mentioned selection criteria for governorates and districts, other factors also influenced the selection criteria including; limited time frame and budget, and political instability. Even though the inception meeting and some of the preparatory work started in 2010, the data collection could only commence until July 2011 and it was done over a month. Given, the political instability concerns about security for data collection teams, geographical proximity and access to facilities was a serious consideration.

2.3 Assessment tools

The core package of the LA country assessment tool consists of 8 main tools (12). The country assessment team agreed on the use of four tools (Table 2). The rationale for using 4 instead of eight was largely because of the centralised structure of the Ministry of Health which meant that information collected at governorate, and district level would not have differed much from the national interviews especially on policies, programmes and guidelines, governance arrangements and information systems. Secondly, tool 7 and 8 were combined into one tool for the community level NGOs because of the limited fieldwork period budgeted for in the Landscape Analysis.

Table 2 Landscape analysis country assessment tools

Level	Existing tools	Tools used in Egypt
National	1. Semi-structured interview tool for national level stakeholders	√
Regional /Provincial (Governorate in the case of Egypt)	2. Semi-structured interview	
District	3. Semi-structured interview tool for provincial level stakeholders	
Facility	4. Semi-structured interview tool for the facility manager and nutrition officer. 5. Facility checklist 6. Structured questionnaire for health workers	 √ √
Field	7. Semi-structured interview tool for managers of implementing NGO's 8. Semi-structured interview tool for nutrition coordinators of implementing NGO's	√

2.4 Tool testing

On the 28th of June 2011, the facility checklist (Tool1) and health worker questionnaire (Tool2) were field tested in Giza governorate. Three teams visited three different Primary Health Care (PHC) centres:AL Talbia, Al Mounib and Arab Al Tal. Each team had a representative from MOHP, NNI, South African MRC and SAMRC local partner (Ain Shams University).

Prior to field trips, an orientation meeting was held to discuss the role of team leaders and important issues to focus on during the field visit. After the field visits, all three teams met to exchange their ideas on the field testing. During this meeting each question was discussed and amendments were made on the Arabic version after reaching consensus on any raised issues. Amendments of the wording of some questions and order of questions for better flowing of questions were done.

2.5 Training of the teams

The training of data collection teams was at the NNI on 29-30th June 2011. The purpose of the training was to ensure that each data collector understood the purpose of the LA and the role of each tool in the overall assessment.

2.6 Data collection

Data collection for the facility checklist (Tool1), health worker questionnaire (Tool2) and focus group discussion (FGD) (Tool3) with local NGO's was completed between the 3rdand 7th July 2011. Data collection was conducted by four teams- each team consisted of three to four trained staff members from MOHP, NNI, SAMRC Local partner (Ain Shams University) and South African MRC. The key informant interviews were conducted from the 10th to 14th of July 2011. The key informant interviews (Tool 4) were conducted by two representatives from the South African MRC. Each representative was accompanied by either an SAMRC LP or a representative from MOHP.

Table 3 shows the total number of completed interviews or assessments for each tool. Forty three (43) facilities are visited, 113 health workers are interviewed, 13 FGD's are held with local NGO's and 23 key informant interviews are conducted with representatives from various ministries, international agencies, academia and local associations. In some instances, more than one person is interviewed in one session.

Table 3: Total numbers of completed interviews or assessments per tool type

Tool	Sharkiya	Beni Suef	Cairo	Ismailia	Total
1. Facility check list (Quantitative)	10	11	11	11	43
2. Health worker interview (Quantitative)	30	30	29	24	113
3. Community – Focus group discussions (Qualitative)	1	4	4	4	13
4. Key informant interviews – In-depth interviews (Qualitative)	Various Ministries (Education, Health, Social Solidarity and Justice, and Trade And Industry), Academia/ research (DHS), NNI, UNICEF, WHO, WFP, USAID, Save The Children, Food and Safety Agency of Egypt, Egyptian Lactation Consultants Association, Egypt Food Security Centre.				23

2.7 Data Analysis

The assessment tools (facility checklist and health worker questionnaire) were computerized and data entry templates were developed in SPSS. The data set was then converted into Excel format. Open ended question were coded and a detailed code list was developed by a team of three with representatives from NNI, MRC local partner and South African MRC. Preliminary analysis included generating frequency tables for the facility checklist and health worker questionnaire. The preliminary findings for facility checklist and health worker questionnaire were presented to the steering committee and emerging themes were discussed.

All the data collectors who conducted the FGD were invited for an analysis workshop. Responses for each thematic area (Questions, for example, what are community needs in your area?) were mapped on flip charts. The responses were categorized and then arranged into themes. The South African MRC facilitated the workshop (with support from the NNI and SAMRC local partner) and developed a narrative of the FGD.

The key informant interviews were recorded and transcribed verbatim. The text was analyzed using thematic analysis in which common themes and emerging issues were highlighted and summarized accordingly. The findings from each tool were then collated using the landscape analysis framework i.e. Willingness to act and Capacity to act which is informed by the four functions of a nutrition system shown in Figure 5.

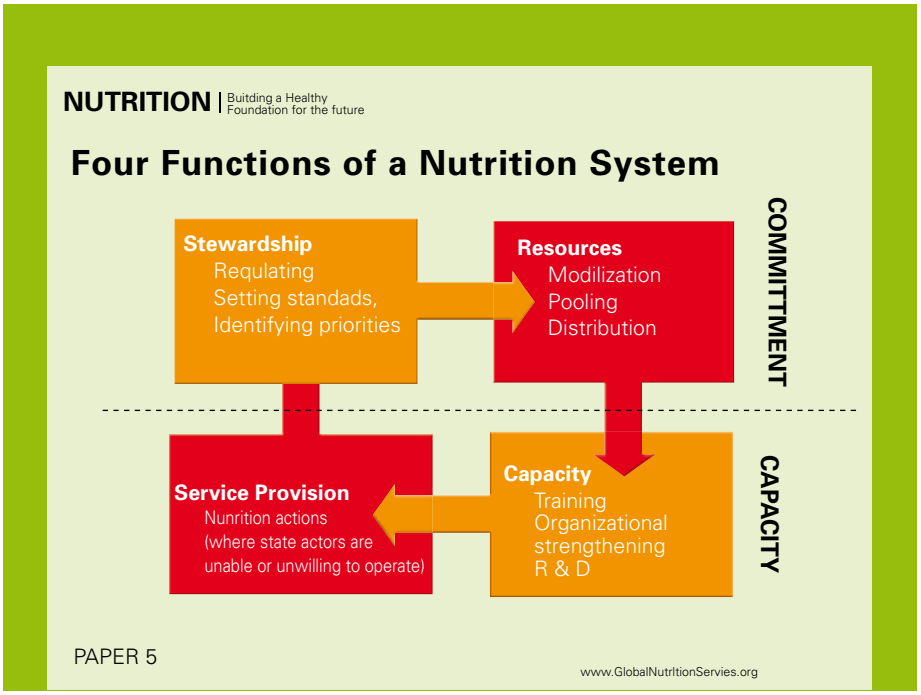


Figure 5: Functions of the Nutrition System which help define Commitment and Capacity

Worth noting is that stewardship relates more to the national and governorate level activities while service provision is largely a district level function and capacity issues cut across all levels. Egypt, as indicated earlier, is characterized by a centralized and hierarchical management structure which means that resource allocation (e.g. finance and human resources) is determined centrally. The structure of governorates is a reflection of national level structures including the location of specific nutrition activities.

2.8 Limitations

Unlike other landscape analyses conducted in other countries, the Egyptian study was done over a relatively short period of time. Furthermore, the study was interrupted and delayed by the revolution and this meant that not all stakeholders and key informants were consulted due to the rapid turnover of leaders and managers in nutrition. The change of the local partner further delayed the work as the new local partner joined mid-way of the analysis. Nonetheless, the enthusiasm and desire of the implementing team under the guidance of the leadership of the steering and technical committees saw this project through.

RESULTS OF THE LANDSCAPE ANALYSIS

3. RESULTS OF THE LANDSCAPE ANALYSIS

The results are presented in two main sections that variously cover the key functions of the nutrition system in Egypt: 1) Willingness and commitment to act, and 2) Capacity to act. The findings are a synthesis of results from all four tools and the literature review. In addition, information from the data debriefing sessions with data collectors and the consensus workshop were also included. The findings relate to the governorates, districts visited and the national stakeholders engaged and therefore should not be seen as scientifically representative of all Egyptian stakeholders.

3.1 Egypt's willingness and commitment to act at scale

Willingness and commitment to act at scale was assessed by looking at evidence that was gathered through the key informant interviews, facility checklist, health worker interviews, desk review of key nutrition related documents on Egypt, and a consensus workshop. The analysis looked at inter alia, the following issues:

- Perceptions of nutritional problems
- Priority given to nutrition sector relative to other sectors
- Nutrition governance
- Existence of nutrition policies
- Existing legislation on food and nutrition
- Integrated Action Planning
- Budgets, especially itemized budget lines for nutrition
- Nutrition Programmes
- Nutrition Protocols

In addition to assessing readiness to act, the landscape analysis also explored attitudes and perceptions of stakeholders, old versus new skills sets required, and existing levels of risk and insecurity, institutional cohesiveness, incentives and effective communication[4].

4 Landscape Analysis on countries' readiness to accelerate action in nutrition, Standing Committee on N Nutrition News, No.37 early – 2009, ISSN 3743 - 1564

3.1.1 Perceived Nutrition Priorities

Stakeholders engaged through the interviews and the consensus workshop raised a number of issues that they perceived as nutrition priorities for scaling up in Egypt (Table 4). There is general agreement on the importance of nutrition and its linkages with food security, education and health, particularly that of women and children.

There is a general perception in Egypt of the absence of solid health systems stewardship as it relates to nutrition. Part of the leadership problem is manifest in the absence of a nutrition unit in the Ministry of Health and Population.

Table 4: Summary of perceived priority nutrition interventions

- Improve system management & leadership
- School Health interventions
- Nutrition Education/Advocacy
- Child growth monitoring
- Enhanced breast feeding
- Baby-friendly facilities
- Nutrition Surveillance System
- Community-based interventions
- Revitalization of educational kitchens at primary health care facilities
- Review and establish a National Food Basket
- Building the capacity of health units
- Stunting prevention

Nutrition is therefore widely considered as not receiving the priority that it deserves in Egypt despite its clear linkages with and implications for MDGs 1, 4 and 5. The generally expressed view was that nutrition needs to be a clear and visible part of the Ministry of Health so that it gets accorded the priority it deserves in terms of resources for scaling up activities. Figure 5 shows the Ministry of Health and Population Health's organisational structure which depicts the varied nutrition components and their location in various sections. Nutrition policy and research is the mandate of the National Nutrition Institute. Appendix 3 depicts a more detailed organisational structure of the NNI.

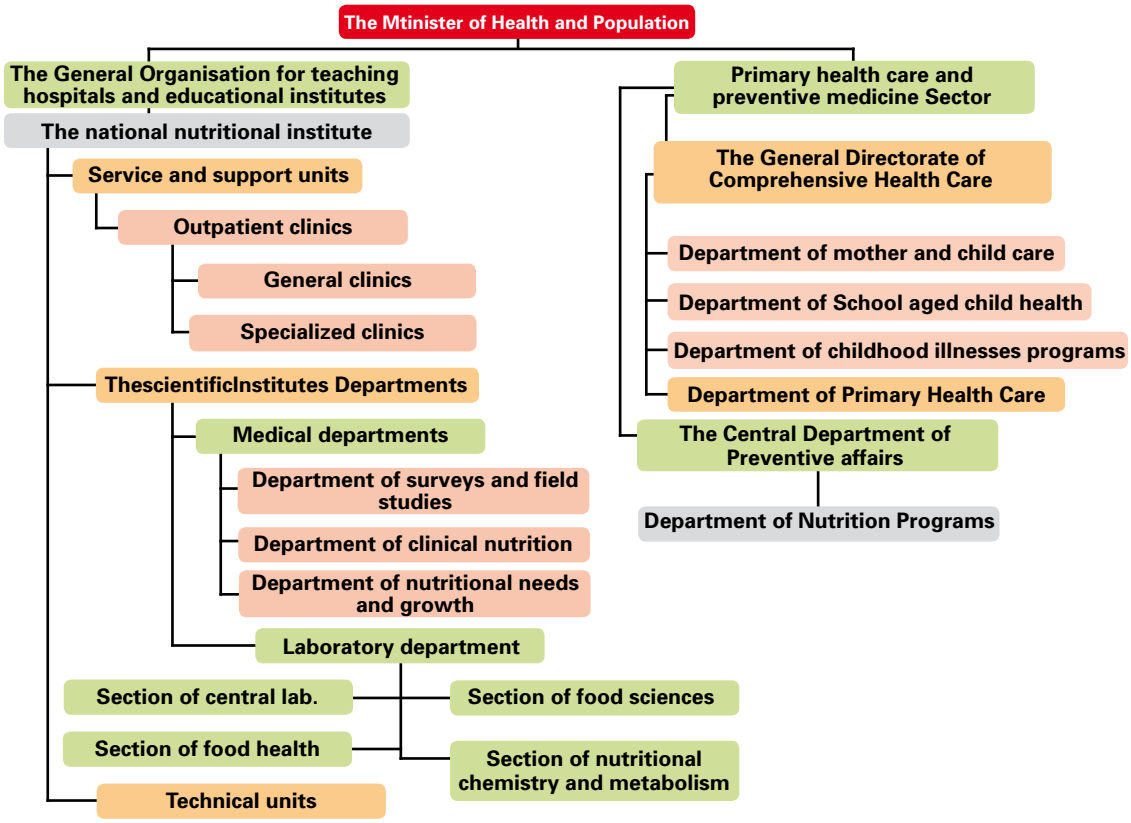


Figure 6: Organisation Structure of the Ministry of Health and Population

The school nutrition programme is considered important by all for a variety of reasons. Firstly, because it focuses on children who represent Egypt's future.Secondly, because it provides a huge opportunity to supplement the dietary intake of kids to improve their growth and cognitive development.Thirdly, because children can also be taught about balanced diets and their benefits, knowledge that they can then share with their parents at home. Fourthly, because teachers can be trained beyond just assisting in supplementary feeding to delivering a nationally designed nutrition class for children of different ages. However, concerns are raised about the current government and WFP pre-school (kindergarten) feeding programme in 9 governorates (largely in Upper Egypt), which provides biscuits (180g) and 200 ml milk packets, as being inadequate for not covering all the targeted age group with no assessment of its long-term outcomes.However, according to NNI these biscuits and milk are fortified with iron and are rich in micronutrients (zinc, calcium etc.). They provide 30% of the RDA of the child at this age group.

Given the perceived low priority given to nutrition, most stakeholders emphasized the need for intensified nutrition advocacy and awareness creation for the government, private sector and consumers. There is clear consensus that nutrition problems in Egypt are largely not caused by unavailability of food but by poor dietary habits and lifestyle. Some of these habits are a function of the socio-cultural history and habits (e.g. drinking tea after food) and the aggressive mass media advertisements by private fast food businesses. The following quotes capture the prevailing sentiments:

"Lack of information (need mass education)—at ALL levels people do not eat a balanced meal and because of poverty people tend to eat more carbohydrates."

"Lack of awareness leads to bad choices and obesity is highly prevalent and at the same time nutrition deficiency is high."

"Community awareness – people do not know what to eat and what not to eat, eating junk food, snacking is a problem."

The general sentiment is that nutrition needs to be tackled at various stages of child growth, that is, from pregnancy (balanced diet and micronutrient supplementation), exclusive breast feeding for at least 6 months, micronutrient supplementation from 8 months, pre-school feeding, and child growth monitoring. Therefore the programmes on baby-friendly facilities and revitalization of educational kitchens for pregnant women were highly recommended as priority interventions that allow for the aforementioned.

Concerns were voiced at several occasions that information on what Egyptians eat is not widely available which makes it difficult to come up with a food basket that caters for all indigenous foods in the different regions of the country. At the time of the analysis, the food basket was reported to be undergoing a review to ensure that it took into account indigenous foods found in different governorates and once completed it needs to be widely publicised.

It is important to note that the views of the key informants about the lack of information on what Egyptians eat exist in spite of the presence of:

- National food consumption survey (2000).
- Food consumption studies of children under five in Upper Egypt (2010).
- Diet, nutrition and prevention of chronic non-communicable diseases among Egyptian adolescent (2008).

The issue of the food basket is linked to a bigger issue on the nutrition surveillance system which is currently considered weak for guiding policy, programmes and most importantly actions. Most nutrition actors have said that such a system is critical in the diagnosis of nutrition problems and monitoring coverage and impact of nutrition actions. It is reported during the review that the MOHP is developing such a system and some health professionals have already been trained. There is real scope for expanding the nutrition surveillance systems to cover the entire country.

With regards to service delivery, there is general consensus that public health units need to be strengthened by providing them with the requisite human resources for nutrition actions, nutrition training, facilities (e.g. working nutrition kitchen) and provision of nutrition educational materials to support both preventative and curative nutrition activities. Health workers working in service delivery level expressed willingness to deliver quality services provided the means are available and that issues of huge workload are addressed.

3.1.2 Willingness to act opportunities

3.1.2.1 Nutrition governance

The existence of the inter-Ministerial committee on nutrition under the Prime Minister provides a real opportunity for scaling up nutrition actions in Egypt, for several reasons. Firstly, it elevates nutrition to the highest level of decision making and gives it national visibility. Secondly, because such a committee is important for inter-sectoral coordination which is a necessity given the multi-sectoral nature of nutrition actions. Thirdly, because the committee potentially has power to engage all other partners including the media— a critical instrument for public awareness and advocacy; and finally because the committee reflects national WILL and therefore the presence of strategic leadership for mobilizing significant resources for nutrition actions.

Currently, there is coordination occurring at various levels, for example, within government departments, amongst donors and at implementation levels. Various nutrition actors indicate that they coordinate with various agencies at governorate level in both the public and private sector depending on the type of nutrition intervention. The Food Security committee largely focuses on issues of food production and availability.This Committee is reported to be working well and therefore provides an opportunity for lesson learning for the nutrition committee or even for it to act as the nucleus for extending coordination functions to nutrition. The only challenge of such disparate coordination remains that of potential duplication and waste.

3.1.2.2 National Policies and legislation

Egypt has a National Food and Nutrition Policy and Strategy (2007-2017) that is generally considered comprehensive in terms of its focus areas (Policy Areas: 1-12-see Box 3). Despite the various perceptions about how well it considers nutrition issues, its presence suggests that there is a guiding framework that any stakeholder who is involved in nutrition-related activities can use as part of integrated planning of nutrition actions.

Policy Area (1): promotion of intersectoral collaboration that lead to Universal Access to adequate food and nutrition

Policy Area (2): Incorporation of Nutrition Objectives (which fall under the policy areas) into National Development Policies, Plans, Strategies, Programmes, or activities to achieve Millennium Development Goals

Policy Area (3): Improving Household Food Security

Policy Area (4): Monitoring the food and nutrition situation

Policy Area (5): Improving the Quality and Safety of Food related Services to protect consumer health

Policy Area (6): Prevention and Control of Nutrition infectious diseases

Policy Area (7): Caring for the socio-economically deprived and nutritionally vulnerable

Policy Area (8): Capacity building and development at community, institutional and authority levels

Policy Area (9): Prevention and Control of non-communicable/chronic diet-related diseases (NCDs)

Policy Area (10): Promotion of infant and young child feeding and protection of breastfeeding

Policy Area (11): Prevention and control of micronutrients deficiency

Policy Area (12): Promotion of healthy dietary practices and life styles focusing on school aged children and adolescents

Source: National Food and Nutrition Policy and Strategy Egypt 2007 - 2017

Box 3: Summary of Egypt Nutrition policy areas

The desk review and stakeholder interviews showed that Egypt is replete with legislation (Codes) on food and nutrition issues. This means that there are potentially legal instruments to support accelerated nutrition actions and to penalize those who might flout the rules and regulations. Policies and strategies that are supported by legislation tend to work if these laws are enforced by the relevant authorities. The potential to apply these rules and regulations exists and therefore represents an opportunity for improving nutrition actions and supportive behaviour by all stakeholders.

3.1.2.3 Availability of nutrition protocols

Existence of nutrition protocols in facilities where they are needed for tackling nutrition is one such indicator of the willingness to act. Figure 7 below shows the availability of various protocols in 43 public facilities visited during the fieldwork. Firstly, the availability of nutritional materials across the identified nutrition areas was sub-optimal in all the facilities (<100%). Materials for infant feeding formula, promotion and support of EBF, nutrition of infants and children, child growth and nutrition generally were more than 50% available. What is clear is that materials for what are considered priority issues in Egypt such as

micronutrient deficiencies, malnutrition, obesity and stunting were less than 20% available. In facilities where these materials were available, health workers used them and visiting patients were exposed to them (as some are framed and hung on the facility walls).

Figure 7: Educational material for clients

3.1.2.4 Stakeholders' willingness to act at scale

The overwhelming sentiment from stakeholders consulted during the interviews and the consensus workshop there is general willingness to participate in any activities that will see nutrition actions scaled up. The readiness analysis also looked at what the different agencies were already doing around nutrition actions. The profile of nutrition actions is wide and diverse and this included, amongst others: development of policies and national nutrition programmes such as food fortification, food subsidies and other social assistance, and feeding programmes; providing technical advice to national and sub-national levels; developing innovative community-based nutrition programmes in rural and poor settings; supporting baby-friendly facilities; interventions that target pregnant women, infants and children; research, monitoring and evaluation and information dissemination activities; targeted programmes for street kids and homeless people in urban settings; child labour and women initiatives; and various training on nutrition. The multiplicity of nutrition activities with local and external supports clearly shows that there is a critical mass of actors who have the commitment to do something about nutrition problems as well as willingness to accelerate what is seen to work well.

3.1.3 Willingness to act – Key challenges

3.1.3.1 Nutrition governance

The Inter ministerial committee (policy maker committee) was established by a decree from the Prime Minister and is led by MOHP with the membership of MOE, MOA and MOSS with NNI as secretary of the board. Whilst all the stakeholders indicated that the existence of the Inter-Ministerial committee on nutrition is potentially an effective mechanism for multi-sectoral coordination, it was inactive and therefore not serving its purpose. Concerns were raised that Ministers are generally busy people and are not easily accessible to people who might want to consult them or make inputs to the committee's activities. Furthermore, suggestions were made that the committee should include specialists or technical people who understand nutrition issues and must be given power to make decisions. In addition such a committee should not only focus on the clinical aspects of nutrition but also preventative activities. Suggestions were also made to expand its membership to include other Ministries, for example, the Ministry of Finance, and that it simply needed to be made functional.

Related to nutrition governance, the lack of leadership in nutrition activities has manifested itself in a variety of ways, one of which includes the low relative visibility of nutrition issues. Because of lack of leadership, it is difficult to make different stakeholders accountable and therefore most nutrition problems cannot be apportioned to anyone and therefore persist. This was attributed to the fact that the roles of the different stakeholders are not clearly defined and assigned. A strong argument was therefore made (reiterated in the consensus workshop) that if indeed nutrition was seen as a critical sector contributing towards the development of Egypt, it is important that the inter-ministerial committee be revived to do its work as soon as the situation stabilizes.

Absence of visible and effective leadership on nutrition issues was noticeable by the absence of a clear vision on nutrition to support integrated planning and intervention activities. Integrated planning was considered key to ensuring that resources in the various sectors are dedicated or allocated to nutrition-related activities. Furthermore, effective leadership was reported as necessary for effective coordination of nutrition activities.

3.1.3.2 National Policies and Legislation

The first problem with the National Food and Nutrition Policy and Strategy is that very few stakeholders acknowledged having seen the document even though it is five years old. Secondly, the National Strategy is not in Arabic. The foregoing means that the strategy was not widely disseminated and therefore may not have been widely used as the rallying document for nutrition actions in Egypt.

For those stakeholders who acknowledged seeing and reading the National Food and Nutrition Policy and Strategy (2007-2017), a mixed picture emerged regarding their perceptions about whether or not that strategy adequately incorporated all the key nutrition issues in Egypt. Some felt that the strategy was indeed comprehensive in terms of the focus areas but it was thin on concrete actions in some of the policy focus areas. Others felt that the process

of preparing the strategy was not consultative enough, and that is why many people did not know about it and therefore never used it.

What concerned nutrition actors the most was that whilst the policy was available, there is no action plan that clearly translates these strategies into concrete actions with assigned responsibilities to different stakeholders. In addition, the strategy does not have a budget to support its implementation. At the consensus workshop it emerged that such an action plan exists but unfortunately no one knew about it and or had seen it. The National Nutrition Institute made a commitment at that workshop that the nutrition action plan will be revised and launched with all stakeholders before the end of 2011.

3.1.3.3 Budgets and funding for Nutrition

Willingness to act can also be assessed by the availability of significant budgets for nutrition-related activities amongst the stakeholders. It was not easy for most stakeholders (except for the NNI) to work out the exact amounts that are being allocated to nutrition activities because of the integrated nature of these activities. The Egyptian National Health accounts report did not assist either as nutrition was not highlighted as a specific cost category. What was clearly absent was a dedicated and general budget for nutrition. However, Egypt has a specific budget line item for micronutrient supplementation (including fortification of various food items) which is managed by the MOHP. Nutrition actors estimated that they used an average of 10-15% of their budgets on nutrition activities. Donors, for example the World Food Programme spent a significant amount on the school nutrition programme, about LE 44 million was spent between 2005 and 2010. The overall finding is that most stakeholders spend notable amounts of money on nutrition activities but there is no consolidated picture of what is actually spent per year across organizations and even within one organization. Others argued that maybe the problem is not really funding but poor health systems management which has not allowed nutrition to be integrated into all other programmes. Nonetheless, there is a general agreement that funding for nutrition was inadequate to support accelerated nutrition actions.

The budget to the Ministry of Health and Population was reported as variable year on year which made it very difficult to plan concretely for nutrition. Furthermore, the training line budget is for all types of training and it is not disaggregated by priority training which means that training related to nutrition activities is not always guaranteed. The food supplementation programme in schools was reported to cover only a fifth of the children.

Various suggestions were made on how to improve funding for nutrition including: mobilization of funds from private companies operating in Egypt (e.g. banks, food manufacturers, pharmaceutical companies, etc., multi- and bilateral donors, zakat, local and international charities) and lobbying for the Ministry of Finance to increase funding for the Ministry of Health and Population. In order to get sufficient multi-sectoral collaboration and funding, others argued that nutrition must be treated as a security issue. The argument was that if nutrition is incorporated into the country's policy as a security issues then there is a great chance of getting a good budget for nutrition.

The general view was that Egyptian Food and Nutrition Policy and Strategy must be used as rallying document to mobilize funding for nutrition related activities. However, equal

emphasis is needed in prioritizing nutrition activities given the limited funding so that areas that are most affected are tackled first and that current resources are used efficiently. The idea of just throwing funds at a problem was not the only solution and that is why most respondents saw it fit that there be a national nutrition policy and coordination structure that guides stakeholders on what is needed and where so that duplication and waste is avoided. Identification of the nutrition priorities and hence fundable effective interventions for Egypt requires good research and supportive surveillance systems.

Fundable ideas on nutrition activities should focus on evidenced based interventions and not just proposals for more research as much has already been done in Egypt. So much research has been conducted in Egypt and most nutrition actors understand the underlying issues; what is required is use of this evidence in planning and designing concrete solutions,this it was argued will attract funders into nutrition activities.

3.1.3.4 Nutrition Programmes

The landscape analysis revealed that many stakeholders are involved in nutrition activities in one way or the other which reflects not only the understanding that there are nutrition problems in Egypt but also the willingness to act and do something about it. In terms of government, there are programmes on nutrition training and research, and policy formulation; food fortification, subsidized food (e.g. bread) and food assistance programmes, school feeding programmes, micronutrient (iron, iodine, zinc, vitamin A, etc.) supplementation programmes, programmes for pregnant women and children, nutrition advocacy (e.g. through the TV station of MOHP), as well as mass media interventions, baby-friendly facilities, food production interventions and many others.

Various non-governmental organizations are also involved in child protection and education, women education programmes, food assistance, development of community-based models of nutrition activities, research and information documentation and dissemination, food fortification, technical assistance to government and other national and local NGOs and other developmental programmes and projects to address poverty and hunger. Therefore the issue for Egypt is not so much about lack of nutrition programmes or willingness to act, it is more about lack of coordination and hence integrated planning and implementation. Furthermore, it is also not about the number of nutrition programmes alone that matters but equally the need for synergies and complementarities between these programmes.

3.1.3.5 Nutrition coordination

As mentioned earlier, there is a link between nutrition governance and coordination of nutrition activities in Egypt. The current perception amongst stakeholders is that nutrition activities are not well coordinated at national and even governorate level for a variety of reasons. First, because nutrition is not given the priority it deserves leading others to suggest that nutrition should be seen as a security issue to ensure that there is effective intra- and multi-sectoral collaboration. In addition, the absence of a specific nutrition body at MOHP responsible for organising implementation & delivery of activities other than NNI which is mainly a research body, contributes to the coordination challenges.

Currently, there are challenges related to inter-governmental collaboration and communication which hampers integrated planning and delivery of nutrition activities. The Ministry of Health and Population, Ministry of Education and the Ministry of Social Solidarity and Justice for example need to communicate so that they can build synergies in terms of data consolidation and resource use including human resources for nutrition activities (e.g. community health workers, agricultural extension officers, teachers, social workers, etc.). What is more worrisome is the lack of intra-departmental communication even within the MOHP. It is important that horizontal communication occurs if the Ministry of Health and Population is to take lead and collaboratively establish a vision that will ensure that nutrition actions are accelerated by all stakeholders.

Although the roles of different governmental departments or ministries are broadly known and sometimes legislated for, for example, NNI is responsible for, inter alia, policy, strategy and coordination of training and research, Ministry of Agriculture is responsible for providing the budget for feeding in the governorates, MOHP, Ministry of Industry and Trade and Ministry of Social Solidarity are responsible for auditing factories and manufacturers of biscuits and milk, and selecting suitable companies for supplies, it is not the same with non-governmental organization and UN agencies working in the field of nutrition. Various activities are coordinated at different levels and with specific partners depending on the type of interventions and this information on progress and success of these programmes are rarely shared.

Whilst the current National Food and Nutrition Policy and Strategy identifies different stakeholders' roles according to policy or programme areas, the perceptions gathered during the landscape analysis were that these roles are not clearly defined and assigned and that is why coordination was not happening effectively on the ground. This is partly explained by the limited distribution of the current strategy and hence knowledge of what it contains and does not contain. Such perceptions affect the willingness and commitment of stakeholders to act or not act.

Equally concerning are perceptions that coordination used to be a problem within government but this has now spilt over to donors who are now competing for space and credit. Clearly, coordination ought to occur within and across governmental and non-governmental agencies including donors so that nutrition activities are synergized and information is shared across partners.

Accelerated action on nutrition requires effective inter-departmental and partner coordination (with both vertical and horizontal communication). Suggestions were made that the current supportive role of UNICEF in coordination should be strengthened as part of creating the capacity of wider multi-sectoral coordination. At the implementation level, that is, district level, there was evidence of coordination between NGOs and respective governorates on specific nutrition programmes. There was insufficient evidence gathered to suggest that this was true for all governorates which means that national level coordination remains critical for joint national and governorate planning.

3.2 Assessment for ability to act (capacity)

The Landscape analysis framework assesses capacity to act using three indicators; resources at national level, human resources and quality, management systems (including information systems), and uninterrupted flow of nutrition supplies and equipment (See Figure 2). This section reports the findings of the landscape analysis with respect to the above-mentioned indicators.

3.2.1 Resources at the national level

Egypt's investment in health care is minimal, and has been declining over the years, with an increasing percentage of the healthcare spending coming from the households. The percentage of gross domestic product (GDP) spent on health in 2007/2008 was 5.99 percent. Out-of-pocket (OOP) spending is the greatest contributor to health financing in Egypt. In 2007/2008 it accounted for 60 percent of total health spending, which was an increase from 51 percent in 1994/1995 (Table 5). The Ministry of Finance contributes only 35.3 percent and donor funding accounts for a negligible 0.6 percent. Half of the health care expenditure is spent at private facilities (hospitals and clinics) (31%) and pharmacies (26%). MOHP facilities represent only 18 percent, followed by University hospitals at 8 percent, and health insurance organisations at 6 percent (13).

Egypt is struggling to live up to decision (v) of the Kampala assembly decisions reached by the African Union (AU) (14), which is:

"Provide sustainable financing by enhancing domestic resources mobilisation including meeting the 15% Abuja target, as well as, mobilising resources through public-private partnerships and by reducing out-of-pocket payments through initiatives such as waiving of user fees for pregnant women and children under five and by instituting national insurance."(14)

Egypt's expenditure on health is far below the 15 percent of Abuja standards. In addition it is not managing to reduce OOP expenditure, despite the presence of several health insurance schemes. The financial challenges in Egypt may impede accelerating nutrition actions at scale.

Table 5: Financing sources of the Egyptian health care system in 2007/2008

SOURCES	AMOUNT (LE)	PERCENT	PER CAPITA
Ministry of Finance	15,102,740,752	35.5%	201.11
Public Firms Funds	718,253,286	1.7%	9.56
Employer Funds (Private)	944,218,992	2.2%	12.57
Household Funds	25,507,964,370	60.0%	339.67
Donors	266,133,922	0.6%	3.54
Total	**42,539,311,323**	**100%**	**566.46**

Source: Ministry of Health, Egypt, and Health Systems 20/20. September 2010. National Health Accounts 2007/2008: Egypt. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

3.2.2 Human resource and quality

Egypt has multiple stakeholders who are already involved in nutrition-related activities (Table 3). All the interviewed high level stakeholders expressed a continued commitment to nutrition. The main weaknesses they identified with regards to trained personnel in nutrition were:

1. Lack of coordination at a high level;
2. Mal-distribution of health workers across governorates;
3. Lack of nutritionists;
4. Lack of training of existing health workers at service delivery points, i.e. integration of nutrition training to improve implementation of nutrition programmes, and;
5. Lack of training of staff within local NGO's.

Our sample largely consisted of nurses (48%) and doctors (42%). The lack of nutritionists (irrespective of whether they have a degree or not) is mirrored in Table 6 below as we could hardly find a nutritionist within the visited facilities. It was encouraging though to find community health workers who were working within facilities (5%). The majority of the interviewed health workers (40%) had graduated between 1990 and 1999 and 31% of the health workers were recent graduates i.e. graduated between 2000 and 2009. The recent graduates were largely physician general practitioners.

Table 6: Profile of the interviewed health workers

Staff category	Number interviews	%
Physician specialist	17	15
Physician general practitioner	30	27
Nurse	54	48
Nutritionist	2	2
Community health worker	5	4
Pharmacist	1	1
Lab Technician	1	1
Admin Clerk	1	1
Health Inspector/other	2	2
Total	113	100

Continuous training of existing health workers was suboptimal in all eight areas (Child growth and cognitive development, new growth charts, exclusive breastfeeding (EBF), complementary foods and weaning, feeding of sick infants and children, Vitamin A supplementation, Zinc supplementation (diarrhoea), and nutrition of pregnant women) (Figure 8). Training in EBF was the only area that more than 50% of health workers had received training on. Physician specialists attended more trainings compared to physician general practitioners and nurses. EBF was the only area where physicians and nurses had a similar exposure to training. There is, however, rapid turnover of physicians and nurses which means that such training is needed on a continuous basis.

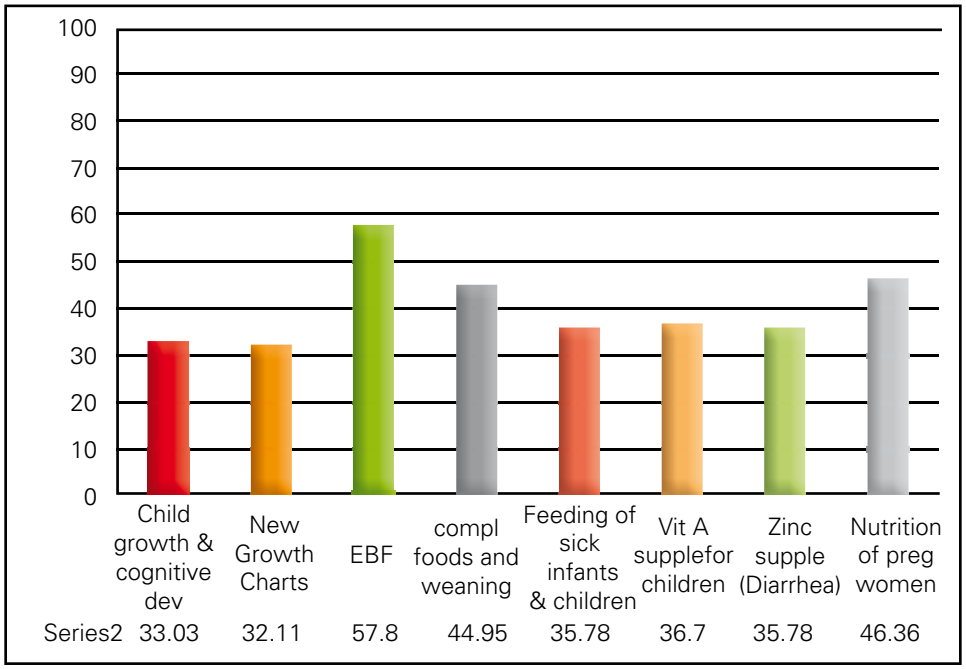


Figure 8: Type of training received by health workers in past two years

The knowledge of health workers was low for micronutrients except for folic acid and Iron. Only 45 percent of health workers knew the Vitamin A supplementation schedule for children in Egypt. Knowledge on breast and complementary feeding was relatively high at 95 and 84 percent, respectively (Figure 9). The majority of those who received training found the training useful.

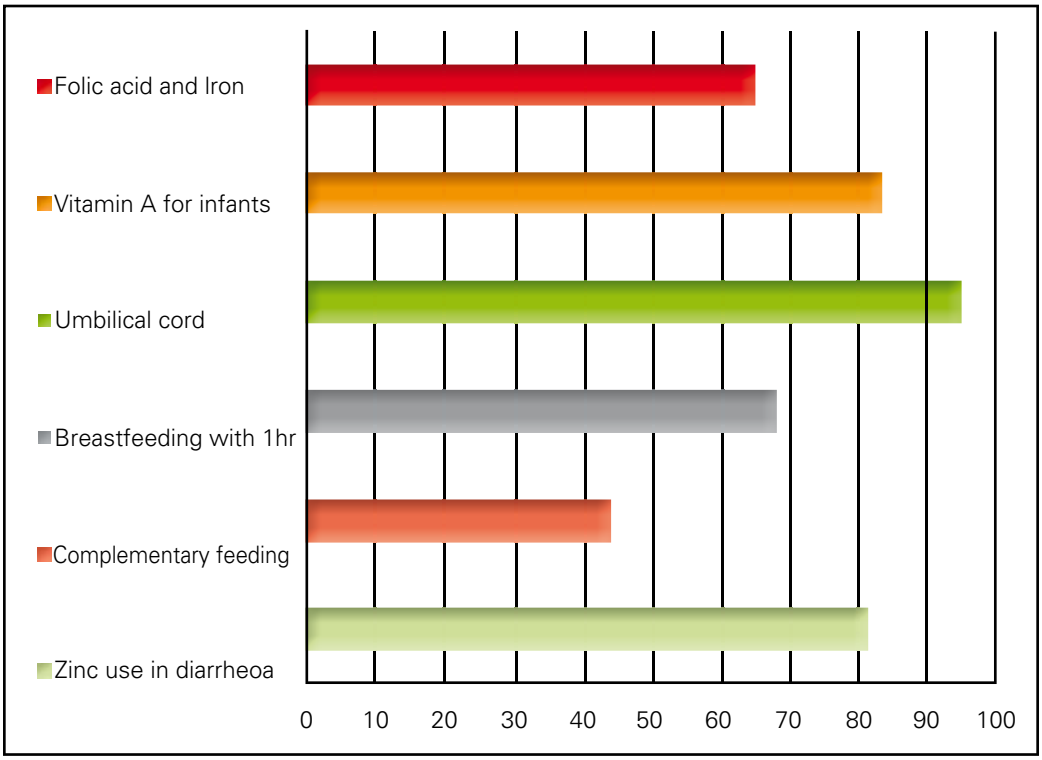


Figure 9: Health workers knowledge of nutrition protocols

The knowledge of health workers on nutrition protocols for micronutrients (particularly for infants) was lower than their knowledge on feeding. Only 45 percent of health workers knew when children should receive Vitamin A supplementation according to Egyptian Standards. The knowledge of health workers of the management of diarrhoea was suboptimal, 65 percent of health workers knew that Zinc supplements should be given to all children who have diarrhoea. In addition their knowledge of the prevention of postpartum haemorrhage was also suboptimal, as 68 percent of health workers knew that a baby's umbilical cord should be clamped at 3 minutes.

The confidence levels of health workers were average. Their confidence levels on counselling on EBF, infant feeding, and breastfeeding problems were 61 and 54 percent respectively. Adequate time for programme implementation is a challenge for most health workers in this context. Health workers stated that they do not have adequate time for growth monitoring, or patient education on EBF, infant nutrition, nutrition of sick children and nutrition of pregnant women.

When the health workers were asked how to improve nutrition services in Egypt, they suggested improvements in education and training, reviving the use of the nutritional kitchen, and the involvement of mass media in order to reach local communities with health education messages.

Their training suggestions included increasing the availability of nutritionist in the department (that is training more nutritionists). In addition, the curriculum of undergraduate training for medical doctors and nurses should include nutrition. With regard to existing health workers, they recommended on-going support and training through nutrition seminars, and the continued use of Raedat Rifeyat. Furthermore, they felt the availability of protocols at facilities could enhance their practice.

3.2.3 Management systems (including information systems) and supplies.

Nutrition information systems

The high level stakeholders interviewed highlighted the lack of information sharing among stakeholders as one of the factors that retards effective and accelerated action towards nutrition. They identified information needs to be a nutritional surveillance system, a national survey on food consumption of Egyptians and a review of the food basket.

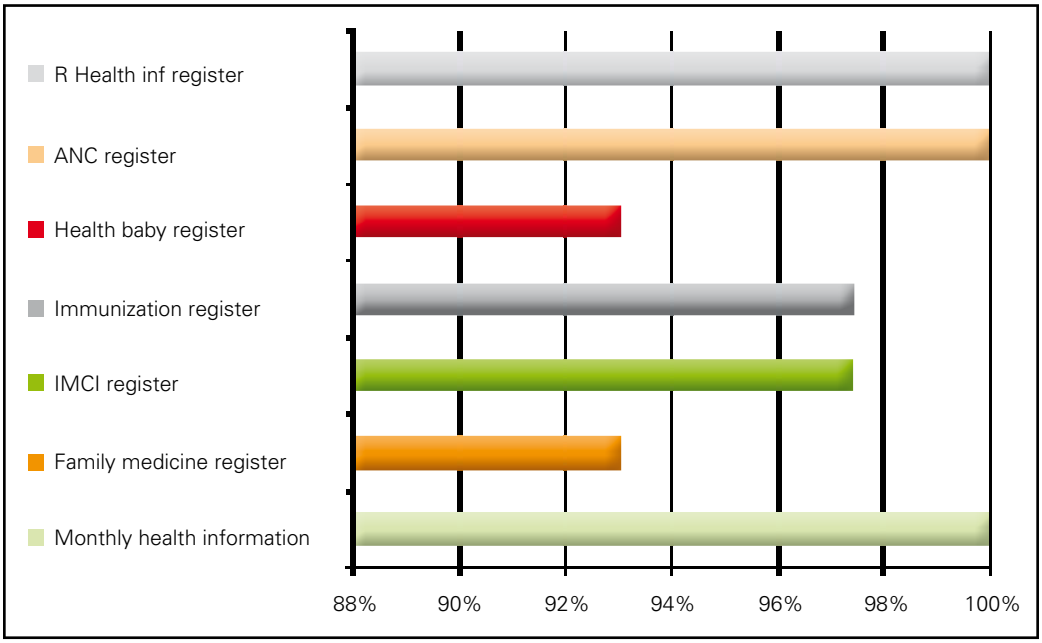


Figure 10: Health Information Management and Health Registers

All facilities had the following health registers (Figure 10): health information, family medicine and routine health information. The only facility without an immunisation and healthy baby register was reported to be situated within less than 100 meters walking distance of other family health care unit that provide the required services. The non-availability of ANC and IMCI registers is a cause for concern even though it was found in a few facilities. The facilities without IMCI registers were a public hospital (in Beni Suef) and two family health centres (in Sharkiya and Beni Suef). The three public hospitals without an ANC register were from Sharkiya, Beni Suef and Ismaila (probably because public hospitals do not receive IMCI registers and most of them do not do routine ANC).

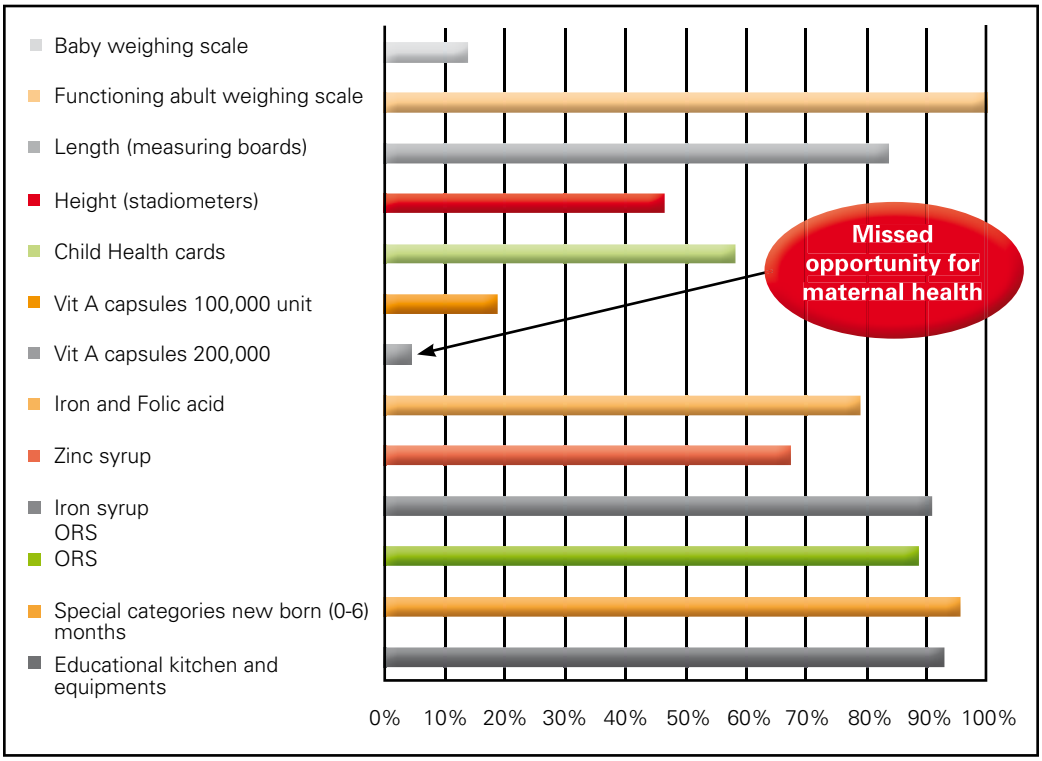


Figure 11:Availability of drugs and other materials

The availability of weighing scales (baby and adult), measuring boards (height and length), oral rehydration solution (ORS), and infant formula milk for infants in special categories new born (0-6 months) was above 80% (Figure 11). However, supplies such as iron and zinc syrup, iron and folic acid and Vitamin A capsules were suboptimal.

Availability of educational material for clients was suboptimal for all areas of maternal and child health except for the promotion of EBF, which was slightly over 80% (Figure 12). A severe shortage (below 30%) of client materials that address micronutrient deficiencies was observed.

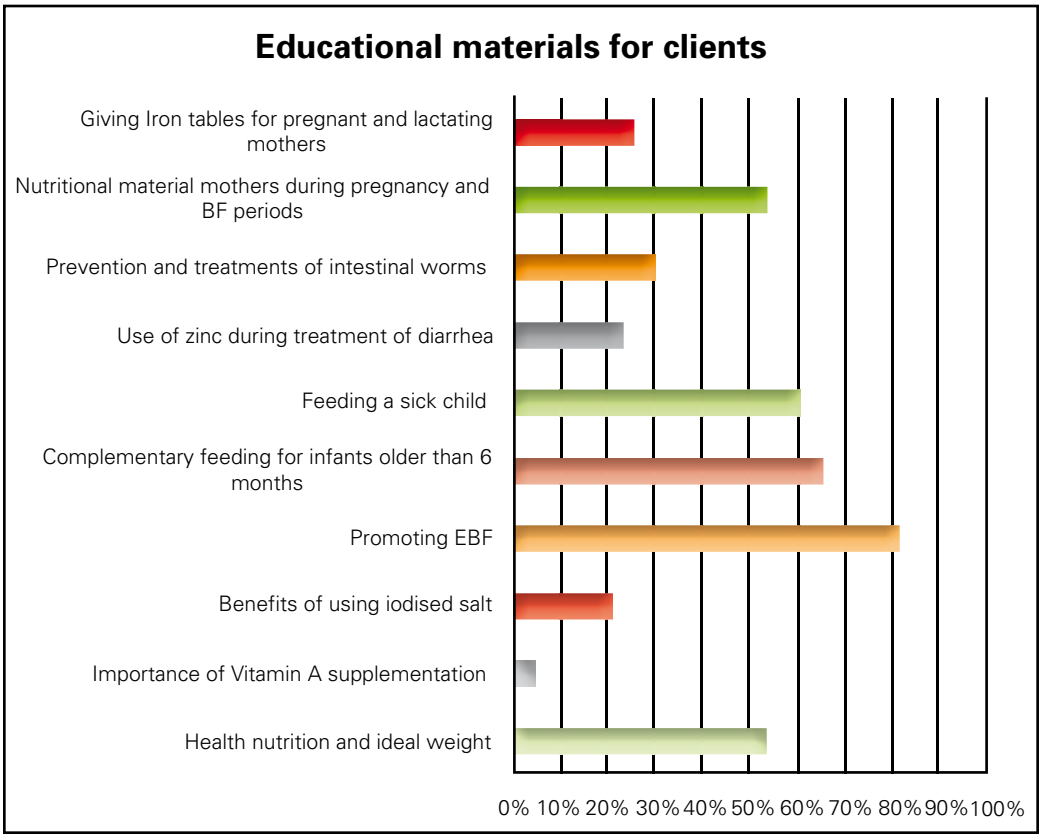


Figure 12: Educational materials for clients

Ismailia and Beni Suef had a strong NGO presence. The NGOs in these areas are doing interesting and dynamic work which goes beyond just food distribution. Their remit includes food provision for patients with special needs, families. In addition, nutritional education and promotion is provided through kitchens and printed materials. Finally, nutrition education for targeted groups such as children, adolescents and pregnant women is provided. Interactions with these targeted groups are done in an innovative appropriate ways for reaching these groups (for instance the use of youth centres and children game training). NGOs in these areas have support from donor organizations such as USAID and WFP.

It is encouraging to note that areas in greater need have more active presence of NGOs. The areas we went to in Cairo are not where the well-off reside nor are they urban slums (I stand corrected). Of the visited governorates, Cairo was the only one where one NGO received no community support. Admittedly there is a greater need for support in rural areas and some donor organizations like WFP are targeting their efforts to areas with higher vulnerability to malnutrition. However, this raises questions about how to support the urban poor.

In rural areas (Beni Suef and Ismailia) there is an opportunity to ride the existing wave of energetic and innovative NGOs. The priority needs as articulated by the NGOs themselves are in order of importance: financial resources, training, supplies, and early malnutrition detection programmes.

The key question is who should provide what support? And how should the support be provided? From our interviews we know that NGOs in this area receive support from Ministry of social solidarity (financial), USAID and WFP. It is imperative to learn from these institutions when trying to address the first two questions.

3.3 Consensus building workshop

A consensus workshop was held on the 31st August as part of the Landscape Analysis to serve two main purposes: First, to present the preliminary results of the readiness analysis to a wider audience including stakeholders that participated in the initial data collection and others who had not participated at that stage. Feedback on the preliminary results and additional inputs across the readiness analysis indicators were provided by over 40 nutrition actors present under the facilitation of the Ministry of Health and Population and Ain Shams University. Second, to generate consensus on emerging nutrition issues and key recommendations for scaling up nutrition actions in Egypt. It was clear, during and after the workshop, that this was indeed an important process of galvanising support and actions from the participating nutrition stakeholders. Table 7 provides a summary of the key issues that were raised and discuss at the workshop.

Table 7: Summary of key Nutrition Issues discussed at the Consensus Workshop

Thematic Area	Key Issues Raised
Nature, extent of nutrition problems	• Consensus on the double burden of under and over nutrition. • Malnutrition a priority issue for the next five years. • Nutrition problems generally understood and known but the need to better understand its underlying determinants still persist (including household incomes and Food Security).
Willingness and Commitment to Act	• The Structure and Organisation of Nutrition in the MOHP does not serve its objectives. • A Coordination gap between the units of MOHP exists and the need to establish intra-communication. • The National Strategy and its Action Plan are yet to be distributed widely and implemented. • An Action Plan developed by NNI and approved by the MOHP but yet to be implemented. • Nutrition surveillance system under development with WHO. • Updated Food Basket to be published soon. • MOE expressed willingness to assist with nutrition education if capacitated. Needs to: • Develop an Organising Body that oversees stakeholder activities and sharing of information is necessary [reactivation of Inter-ministerial committee]. • MOHP needs strengthening in service delivery with regards to nutrition. • Develop Nutrition programmes that focus on prevention. • School nutrition and cafeteria activities critical—need standard guidelines for school canteens. • Promotion of exclusive breastfeeding and promotion of baby-friendly facilities must be strengthened. • Engage media for creating nutrition awareness.

Capacity to act at scale	• Human resources for nutrition problem is not just about numbers but mal-distribution (Nutritionists in general & central hospitals only where they are not so effective, available specialist graduates not employed). • Unavailability of certified nutritionist at PHC level (e.g. at educational kitchens) affecting service delivery. • Current public PHC staff overworked and have inadequate time to provide nutrition messages. • Faculty of Home Economics in Menofya and Helwan are Universities that offer graduate, Masters and Doctoral degrees; in the area of nutrition these should be utilized. • Nutrition not just for specialists so NNI needs to resuscitate the 6 months training it used to have with assistance from WHO. Need: • Nutritionists needed in high flow rate facilities for diabetic children, rheumatic heart children and mothers, etc. • Needs for specialised nutritionists (at graduate level). MOE could play a key role in training nutritionists in specialised, intermediate institutes, and higher education institutes. • Interim solution is to train more health workers on nutrition until certified nutritionists are produced. • NNI to conduct a TOT with MOHP to support nutrition training in the country. • Introducing Nutrition Corners in health facilities. • Re-train graduates from Faculties of Science and Agriculture as nutrition specialists. • Capacity improvement at national, governorate, and PHC level teams (e.g. early detection of nutrition problems & nutrition counselling etc.). Each levels requires different skills mix.

The consensus workshop actually created an opportunity, for the first time after the revolution, for the different stakeholders in nutrition to share information and make suggestions on how the various nutrition actions can be implemented at scale and how each one could contribute if asked to do so. The socio-political and economic changes in Egypt provide both opportunities and challenges for enhancing willingness and commitment to act, and capacity to act at scale. Opportunities in the sense, that new leadership and national enthusiasm can be harnessed to rethink and better coordinate stakeholders and upscale best practices in nutrition in sustained way. The challenge is the current political flux which might affect nutrition governance and resourcing of the sector as the economy stabilises and democratic institutions are revived.

3.4 Launching of the final report

The Landscape analysis report was presented on the 17th of January 2012. This meeting saw a participation of forty-five people, including representatives from MOHP (from both national and governorates), NNI, international organisations (WFP, WHO, USAID), local NGO's and universities. The findings of the Landscape analysis were well received by all participants. Furthermore, participants recommitted themselves to improving the nutritional situation in Egypt.

At this meeting, the Ministry of Health and Population announced the establishment of a Nutrition unit. This announcement demonstrated a very strong political commitment to fighting malnutrition and scaling up nutrition interventions in Egypt. Amongst other things this unit will follow-up on the recommendations of the Landscape analysis. In addition, one of its responsibilities would be to improve coordination amongst stakeholders and thus ensuring that nutrition actions are harmonised.

DISCUSSION

4. DISCUSSION

4.1. Willingness and commitment to act

The landscape analysis clearly demonstrated that in order to generate and harness stakeholder willingness and capacity to act at scale, nutrition must be given the visibility and recognition it deserves at the national level. Part of that recognition could be through taking nutrition as a national security issue and hence elevating nutrition and food security issues to the highest policy- and decision-making levels. In Egypt, this seemed to have occurred prior to the revolution as evidenced by formation of the inter-ministerial committee under the Prime Minister through a decree. This means that a nutrition governance structure with the necessary decision-making power and capacity to engage all relevant stakeholders exists. However, how this structure is constituted and works is another issue that most stakeholders remained concerned about. It must be reconstituted to include various specialists and needs to meet regularly with the MOHP taking a lead. There was consensus that this structure needs to be revived immediately.

The National Food and Nutrition Policy and Strategy has been in place since 2007, but because it has not been widely circulated and discussed with some stakeholders, it is generally unknown. This is unfortunate, given its comprehensiveness in terms of policy areas and the investments that were made in consulting some partners and developing specific actions and assigning responsibilities. What is required is a review of the Strategy with all stakeholders so that any areas that need to be updated are updated and shared widely. The Strategy should provide the rallying point for engaging and galvanising all stakeholders for scaling up nutrition actions. Most importantly, an action or operational plan, which was reported to have been approved by the MOHP at the time of this assessment, needs to be shared and discussed with all nutrition actors in the country so that their efforts are synergised and duplication and waste is avoided.

In addition to the existence of a National Strategy and other related policies, Egypt has a multitude of food and nutrition laws, which are generally and unevenly complied, which means that there is need to enhance the capacity for implementation and enforcement of the laws. Both the public and the private sector must be subjected to the same policies and legislation so as to ensure that public nutrition objectives are met and the results maintained. The issue of private doctors prescribing formula feed inappropriately is one good example of the need to make sure that nutrition policies and legislation are applied across sectors.

What was evidently absent is a budget or expected resource requirements to implement the strategy (indeed the Operational Plan),such a budget is critical for resource mobilisation and ensuring that international assistance on nutrition is channelled to strategic areas as defined in the national strategy. The review also showed that funding for health and more so nutrition was relatively low against perceived needs by stakeholders. This partly explained by the relatively low priority attached to nutrition activities in practice and by the integrated nature of nutrition actions. The MOHP has specific budget line items for micronutrients supplementation and other sister Ministries have budgets for food distribution, but this was considered inadequate for holistically addressing nutrition problems in Egypt. Several suggestions were made regarding resource mobilisation with emphasis being made on developing innovative nutrition interventions that are evidence-based, and not just doing more and more research since a lot has already been done in Egypt. Stronger advocacy is

required for increased funding for the MOHP and nutrition in particular through presentations of a business case for health and nutrition and engaging with the Ministry of Finance.

Whilst resources for nutrition were reported as inadequate, it was also made clear that more could be achieved with existing resources (funds and human resources, etc.), if there was better coordination amongst partners and efficiency in service delivery (e.g. of food distribution, social assistance programmes, and use of educational nutrition kitchens for pregnant women and in schools). Nutrition problems in the country cannot only be resolved by funding but by reviewing programmes and redirecting funding to priority cost-effective interventions for scaling up.

A review of the activities of the various agencies and organisations working in the area of nutrition showed that a lot was already happening, demonstrating an ability and willingness to act that needs to be harnessed for scaling up. With proper coordination through a functioning inter-ministerial committee, it is indeed possible for Egypt to act now and act decisively in dealing with the double burden of over and under nutrition.

4.2 Capacity to act weaknesses

Egypt's minimal investment in health will impede effective implementation of nutrition-related activities. The landscape analysis has identified several nutrition-related activities that require improvement. Addressing these limitations will require increased financial resources. Therefore the MOHP as the suggested lead institution should lobby for an increased share of the GDP to at least reach the 15 percent Abuja target.

Another avenue for resource mobilisation is donor funding. Currently donor funding accounts for a negligible 0.6 percent. The health sector in Egypt receives bilateral support from African Development Fund, the European Commission, the Japanese Development Fund, the World Bank, and the United States Agency for International Development (USAID), Finland, Italy, Netherlands, Spain, and Switzerland.

Among the UN agencies represented in Egypt, technical and modest financial support to the health sector is provided by: WHO and UNFPA which have a number of agreements with MOHP in the field of family planning and reproductive health. These agencies also has agreements with other ministries and agencies that have an impact on the Egyptian health status including UNICEF (which continues to support efforts to maintain Egypt's polio free status, micronutrients programme, and women and child-related issues), UNAIDS, UNDP and ILO. The completion of the landscape analysis presents an opportunity for Egypt to strategically request assistance from international organisations for some of the actions that donor agencies may be amenable to fund. Apart from mobilising new financial resources, a process of harmonising actions by United Nations (UN) agencies working within Egypt would lead to effective use of available resources and minimise duplication. This action will be consistent with area v) of the Paris Declaration on AID effectiveness which is:

> "Eliminating duplication of efforts and rationalising donor activities to make them as cost-effective as possible". Through this Landscape Analysis process and sharing of these findings the MOHP should engage the Nutrition community and other stakeholders to: gain commitment and capacity in nutrition through increased participation by stakeholders and improved collaboration between partners and sectors."

Egypt is one of the few African countries that do not have a shortage of health workers (i.e. doctors and nurses). However, routine in-service training on infant and young child feeding and maternal health was suboptimal. In-service training received by health workers in the past two years relating to the ongoing projects was low for all, ranging from 31-59%. Only 31% of health workers received training on child growth and cognitive development and new growth charts and 59% received training on EBF. In-service training of health workers on child growth and cognitive development, new growth charts, micronutrient supplementation, including the supplementation of vitamin A and zinc, as well as the supplementation of pregnant women should be prioritized.

The low health worker knowledge levels, the lack of protocols and guidelines in facilities, the poor stock levels, and lack of materials for clients reflect poorly on the facilities' capacity to implement effective nutrition-related activities. The area of immediate attention is prevention and control of micronutrient deficiency. Table 8 shows four 'capacity to act' indicators for facilities.

Table 8: Facilities capacity to act

Nutrition Topic	Knowledge levels	Protocols	Equipment& supplies	Materials for clients
Vitamin A for infants	Low 45 %	Severe shortage 14%	Above average 79 %	Severe shortage 5%
Vitamin A for mothers			Severe shortage 2%	
Zinc use in management of diarrhoea	Above average 65%	Severe shortage 16%	Above average 58 %	Severe shortage 23%
Iron and Folic acid	Above average 82%		Severe shortage 18%	
Prevention and treatment of anaemia		Low 37%	Low 47% for children Low 19% for mothers	Low26%
Prevention of Iodine deficiency		Severe shortage 12%		Severe shortage 21%

Egypt's national food and nutrition (policy and strategy) document acknowledges the prevention and control of micronutrient deficiency (Policy area 11) as a key policy area. The strategy document identifies two service delivery points for combating micronutrient deficiencies: primary health care services and educational kitchens. Table 8 demonstrates that the prevention and management of micronutrient deficiencies is suboptimal at primary health care level, since health workers have suboptimal knowledge levels, no protocols to refer to, insufficient supplies and a severe shortage of materials for clients. The other service delivery mechanism was the use of an educational kitchen. Only 12% of the facilities had equipment for the educational kitchen, in some instances these materials were not functioning.

Malnutrition, that is both stunting and obesity, was the next area of concern; less than 10 percent of the facilities had protocols for these two conditions. However, the availability of stadiometers, measuring boards and adult and baby weighing scale was above 80 percent. An operational plan for distributing supplies and materials to facilities is urgently required.

4.3 Capacity to act strengths

The relatively higher health worker knowledge levels, availability of protocols, and educational material for clients reflected positively on the capacity to act for optimal infant feeding. The knowledge levels for breastfeeding were well over 90 percent, and both the availability of protocols for health workers and materials for clients were just over 80 percent. Egypt should build on this success. This, however, does not mean that resources and funding should be taken away from infant feeding to support areas of severe shortage. Instead, infant feeding should continue to receive support to maintain this level of success.

There are several local NGOs in Egypt. However, their scope of work turns out to be largely food provision. In some rural areas (Beni Suef and Ismailia) there were excellent examples of NGOs undertaking tasks beyond food provision. There is an opportunity to ride the existing wave of energetic and innovative NGOs in Egypt. The NGOs we spoke to recognised that community needs were beyond food provision. However, they felt they cannot extend their scope since, in some instances, they could not deliver services within their scope due to irregular financing. The priority needs as articulated by the NGOs themselves in order of importance were financial resources, training on various nutrition topics and specifically on early malnutrition detection program, and supplies. The key question is who should provide what support? And how should this support be provided? From our interviews we know that NGOs in this context receive support from Ministry of Social Solidarity and Justice (financial), USAID and WFP. It is imperative to learn from these institutions when trying to address the first two questions.

Egypt's willingness and capacity to act will be influenced by the 2011 revolution and the global economic climate and its likely impact on economic growth (which will affect government's fiscal space and budgets, and household incomes) and international aid flow. It is important that Egypt's economy recovers and begins to better support local activities including nutrition. Egypt also imports some food products and therefore any changes in international food prices might affect food availability and accessibility for many Egyptians. The agricultural sector will have to be supported for food import substitution.

CONCLUSION

5. CONCLUSION

The landscape analysis could not have come at a better or more opportune time, as the country is going through transition socially and politically. Its genesis is actually founded on the realisation by Egyptians that it is necessary that the country's readiness to implement accelerated nutrition actions needs to be systematically assessed and the findings used to effectively implement the National Food and Nutrition Policy and Strategy.

The process of implementing the LA in and of itself has galvanised interest and facilitated robust engagements amongst stakeholders on what the nutrition priorities are and, most importantly, what the key interventions for addressing these problems are. There is indeed willingness to act but capacity to do so needs to be built through better use of available resources and strategic engagements with international partners to fund and provide technical expertise in various aspects of nutrition. The health system needs to be strengthened at all levels so that Egyptians develop the necessary trust and confidence in it and therefore use it, with nutrition as a key component of the service delivery package. Best practices that we have found during the LA, by local and national NGOs and UNICEF around community-based nutrition delivery models, which need to be scaled up include, for example, UNICEF's Baby Friendly Hospital Initiative, salt Iodization, new surveillance system, Infant Young Child Feeding and community based nutrition interventions; and WFP's work on food (oil & wheat) fortification, school based stunting prevention programme, and community based livelihood projects to improve household income and access to food and education for poor families. Save the Children UK is also working with rural communities on awareness of nutrition issues in pregnancy, child labour education, and child protection in general which have a direct impact on the nutritional status of mothers and children. Experiences to date can be shared across the country and where appropriate best practices implemented.

GENERAL RECOMMENDATIONS

6. GENERAL RECOMMENDATIONS

Form the readiness analysis a number of recommendations are made for short, medium and long term action (see Table 9). These recommendations need to be viewed in the light of improving both willingness and capacity to act at scale and further described below:

Table 9: Summary recommendations by timeframe

Nutrition Activity	Short-term	Mid-term	Long-term
A. **Leadership**	Revive the Inter-Ministerial committee and its activities	Organizing body within MOHP Nutrition is part of several departments at MOHP; MCH, IMCI, Nutrition Department	Improved coordination within MOHP, between Ministries AND amongst donors. Coordination between the Nutrition and Food Security Committees
B. **National Policies & Legislation**	• Translate National Food and Nutrition Policy into Arabic • Consult on the Operation Plan and the cost of its implementation • Widely distribute the National Strategy and Operational Plan • Create awareness and enforcement of key CODES	Review and Update National Strategy National Nutrition Strategy to be aligned to Food Security activities Review laws on food labeling and advertising	One governance Nutrition and Food Security Platform Legislate for the Food Safety Agency
C. **Budgets and Funding**	Budget for the National Food and Nutrition and Policy Strategy Explore opportunities for operational efficiency and better targeting of available resources to need regions and people Food and other social assistance programmes need to be realigned to complement nutrition strategies and interventions Integrated departmental budgets to consider line items for nutrition actions	Develop a resource mobilisation strategy Advocacy for increased Health and Nutrition Funding Public budgets for nutrition need to be known within a three-year framework to allow for better planning and programming Engage private and international businesses as part of their Community Social Responsibility	Standing Nutrition budget or line items in the relevant Ministries especially MOHP

Nutrition Activity	Short-term	Mid-term	Long-term
D. **Capacity building** 1. **Policy decision makers and government**	Trainings on health systems stewardship and integrated planning Seconding technical Staff (by UNICEF/WHO for example) in MOHP to assist in nutrition activities	Support for Think Tanks on Food and Nutrition to guide policies and strategies	NNI to have decentralized offices and functions to improve reach in all governorates
2. **Institutional level/ Service delivery** 2.1 **Existing health workers (Doctors and nurses)**	In service training of health workers on • Child growth and cognitive development • New growth charts • Micronutrient supplementation vitamin A and zinc, as well as the supplementation of pregnant women should be prioritized.	Explore implementation of Nutrition Corners in Public Facilities	Nutrition integrated into curative services for special cases, e.g. diabetes Include nutrition in undergraduate training of health professionals.
2.2 Nutritionist or Dieticians	Identify existing and working Nutritionist within Egypt. Map different training activities within Egypt.	Define key competencies for clinical nutritionist and community nutritionist. Identify and establish nutrition agencies or institutions for training specialist nutritionist	Develop a health professional council that can accredit Nutritionists/ Dieticians Ensure that each facility has Nutritionist/Dietician.
3. **Community level**	Explore the role of community health workers in communicating preventative nutrition actions within their communities. Identify best practice community-based models for scaling up	Community Nutritionist to provide ongoing training and support Scale up-community based interventions	Nutrition services (preventative & referrals) integrated into PHC activities
D. **Uninterrupted flow of materials and supplies**	Above 90 % availability of Micronutrient supplies at facilities within 12 months	Above 90 % availability of protocols and materials for clients at all facilities within 18 months	Provide kitchens with educational equipment and ensure that within a facility there is anofficial.
E. **Support to Community organizations**	Identify mechanism of providing sustainable financial support and ongoing training.		
F. **Nutrition information systems**	Interventions for improving data flow, quality and utilization at all levels Sharing critical information through existing coordination platforms	Scale up the nutrition and breast feeding surveillance system Focus on priority research that translates into interventions	Integrated data warehouse on nutrition

Nutrition Activity	Short-term	Mid-term	Long-term
G. **Advocacy**	Use MDG for advocacy MOHP to lead social mobilization and advocacy campaigns through its TV station and other media Develop advocacy materials for mass campaigns at all levels to improve public awareness	Ensure that Nutrition messages features regularly in different media platforms	

Suggested recommendations for the short-term:

Leadership

1. The Inter-Ministerial Advisory Committee must be revitalised immediately including incorporation of technical or specialist staff to make sure that the work gets done.

2. The Inter-Ministerial Committee on Nutrition needs to be capacitated to improve coordination and communication amongst nutrition stakeholders in the country and region. This relates to incorporation of specialist experts and having an adequately resourced secretariat.

National policies and legislation

3. The National Food and Nutrition Strategy (2007-2017) must be reviewed and translated into Arabic, and widely circulated. This is very critical so that nutrition actors are clear on their roles and synergies within policy areas. Nutrition actions need to be harmonised for greater impact on the double burden of under- and over nutrition.

4. The recently completed Action or Operational Plan derived from the National Strategy must also be discussed and shared with all stakeholders for the same reasons given above.

5. The roles of different partners in the National Strategy must not only be defined but communicated and structures or processes established to make sure that assigned responsibilities are properly accounted for.

6. Egypt has a multitude of food and nutrition laws that are currently not complied with adequately. It is important to create public awareness on food codes, and that improved capacity to enforce the laws is coupled with incentives for those affected to comply.

7. Review the Egyptian food basket based on a national study of what Egyptians eat (Food Mapping). Results from the national study would allow for the development of a food basket (s) that is (are) appropriate to all governorates.

Budgets and funding

8. In order to adequately budget for nutrition activities in Egypt, the National Food and Nutrition Strategy and Policy must be costed for so that the resource requirements for scaling-up nutrition actions are known by all stakeholders. This nutrition budget should then be used to mobilise resources locally and externally.

9. Whilst more funding is required for nutrition actions, there is need to explore opportunities for operational efficiency and better targeting of available resources to needy regions and people. Resources could be better used within integrated programmes that the various actors are involved in, for example use of human resources in agriculture, education and health.

10. Food and other social assistance programmes need to be realigned to complement nutrition strategies and interventions. The current food subsidies must be consistent with the current nutrition interventions (e.g. national food basket) and envisaged nutrition status of Egyptians.

11. Integrated departmental budgets to include line items for nutrition actions. The review was clear in that most stakeholders could not easily estimate the resources consumed for nutrition activities and therefore one way to ensure that nutrition is included in all budgets in by having a specific line item for nutrition.

Capacity building

12. The health system needs to be strengthened to ensure service delivery at the lower levels of the systems, i.e., provision of both preventative and curative nutrition services.

National level

13. Training national staff on health systems stewardship and integrated planning. Part of health systems strengthening requires that the national capacity is enhance to plan, implement and ensure monitoring and evaluation of programmes.

14. In the short run, one solution to addressing national level capacity constraints particularly for nutrition coordination and management could be secondment of technical Staff by UNICEF or WHO, for example) to MOHP. These secondees will be solely responsible for ensuring that nutrition actions are considered in all relevant programmes and that these actions are actually implemented.

Institutional level

15. In service training of health workers on: Child growth and cognitive development, new growth charts, Micronutrient supplementation vitamin A and zinc, as well as the supplementation of pregnant women should be prioritized.

16. With regards to nutritionists or dieticians, there is need to identify existing and working Nutritionist within Egypt with the hope of exploring how to engage them where they are needed most and for training other nutritionists.

17. Map different training activities within Egypt in terms of who is training on what and producing what type of cadres. This will allow for identification of specific centres for the production of certified nutritionists and further training of health workers.

Community level

18. Explore the role of community health workers in communicating preventative nutrition actions within their communities. The experience of Upper Egypt seems to suggest that community health workers potentially effective in addressing nutrition issues at community level with the support of NGOs.

19. Identify best practice community-based models for scaling up, for instance community based models of service delivery that are currently being tested in Upper Egypt.

Educational materials and supplies

20. Development of an operational plan for distributing nutrition supplies and materials to facilities is urgently required.

Support for community organisations

21. Identify mechanisms of providing sustainable financial support and on-going training for local NGOs. This is likely to be possible though a resource mobilization strategy that uses the National strategy and operational plan as the rally point.

Nutrition information systems

22. Scale up the nutrition surveillance system that is currently being pilot tested with WHO and UNICEF's technical support.

23. In order to improve use of empirical data and evidence, interventions for improving data flow, quality, and utilization at all levels of the health systems are essential.

24. Sharing information is critical through existing coordination platforms such as the nutrition and food security subcommittees, and the LA country team.

Advocacy

25. Use MDG for advocacy by establishing clear goals to reduce maternal and child under nutrition and contributing to the achievement of MDGS 1, 4, 5 and 6. During the review, most actors understood MDGs but acknowledged that they were not effective for advocacy.

26. Develop advocacy materials for mass campaigns at all levels.

27. MOHP to lead public advocacy campaigns through its own TV station and other media.

Suggested recommendations for the medium-term:

Leadership

28. The MOHP must create an internal platform to ensure that nutrition gets visibility and that it is integrated into other programmes. Internal communication on nutrition actions must be improved first, to allow it to be a LEADER and therefore communicate effectively with other stakeholders. An organising body to be established within the MOHP to coordinate several departments: MCH, IMCI, Nutrition and others.

National policies and legislation

29. The National Food and Nutrition Strategy and Policy is five years old and therefore needs to be reviewed and updated with the involvement of all the stakeholders to ensure buy-in and comprehensiveness.

30. There has been general consensus during the review that the National Nutrition Strategy should be aligned further with the Food Security activities to make sure that it does not only deal with nutrition problems but also the underlying causes.

31. Whilst Egypt has many food laws, it is necessary that these laws are reviewed particularly laws that relate to food safety, labelling and advertising.

Budgets and funding

32. Develop a resource mobilisation and funding strategy for the National Food and Nutrition Policy and Strategy including engaging private business, international donors, zakat, and other funding agencies in nutrition.

33. Advocacy for increased Health and Nutrition Funding by all concerned stakeholders is critical including development of a business case (or financial advocacy tools) for nutrition for the Ministry of Finance.

34. Public budgets for nutrition need to be known within a three-year framework to allow for better planning and programming. This could be done within the medium term framework of the Ministry of Finance. It is currently not possible to plan because resource allocations are unknown to allow such.

35. Engage private national and international businesses to contribute to nutrition funding as part of their Corporate Social Responsibility.

Capacity building

National level

36. Support for Think Tanks on Food and Nutrition to guide policies and strategies. Some of these think tanks already exist for food security.

Institutional level

37. Explore implementation of Nutrition Corners in Public Facilities. This idea was debated during the consensus workshop and can potentially address human resources constraints in the interim.

38. In order to recruit and train more specialised nutritionists, it is important to define the key competencies for a clinical nutritionist and community nutritionist.

39. Once the competencies are identified and mapping of existing training institutions is done, it is necessary to identify and establish nutrition agencies or institutions for training specialist nutritionist.

Community level

40. Community Nutritionist to provide on-going training and support.

41. Scale up community based interventions.

Educational materials and supplies

42. Above 90 % availability of protocols and materials for clients at all facilities to be achieved within 18 months.

Nutrition information systems

43. Scale up the nutrition and breast feeding surveillance system.

44. Focus on priority research that translates into interventions.

Advocacy

45. The MOHP together with its partners, must ensure that Nutrition messages are featured regularly in different media platforms.

Suggested recommendations for the long-term:

Leadership

46. Once intra-communication and coordination within MOHP is established and functioning, it is important to improve coordination between MOHP and other Ministries and also amongst donors. UNICEF could potentially provide support to ensure that an appropriate structure is created to facilitate this broader coordination including coordination between the Nutrition and the Food Security Inter-Ministerial Committees.

National policies and legislation

47. In the long term, it is recommended that there be one governance platform for Nutrition and Food Security to allow for greater coordination and management of nutrition activities.

Budgets and funding

48. Create a standing Nutrition budget or line items in the relevant Ministries especially MOHP. Currently, the only line item budget for nutrition activities is for micronutrient supplementation. This could gradually expanded to include the budget for all other key activities.

Capacity building

National level

49. NNI to have decentralized offices and functions to improve reach in all governorates.

Institutional level

50. Integrate nutrition education into curative services for special cases, e.g. diabetes.

51. Include nutrition in undergraduate training of all health professionals.

52. Develop a health professional council that can accredit Nutritionists/ Dieticians.

53. Ensure that each facility has a Nutritionist/Dietician.

Community level

54. Nutrition services (preventative & referrals) integrated into PHC activities.

Educational materials and supplies

55. Provide kitchens with educational equipment and ensure that within a facility there is anofficial.

Nutrition information systems

56. Implementation of effective programmes on Nutrition required an integrated data warehouse on nutrition issues from which all nutrition actors in Egypt, regional and international reporting can draw.

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Appendix 1: List of governorates

List of governorates and population that reside in these governorates

Population according to 2006 census (% of total population)	Governorate
Urban governorates	
9.3	Cairo
5.7	Alexandria
0.8	Port-Said
0.7	Suez
Lower Egypt governorates	
1.5	Domiate
6.9	Dakahlia
7.4	Sharkiya
5.9	Kalyoubia
3.6	Kafr El Sheikh
5.5	Gharbia
6.5	Behera
4.5	Menoufia
1.3	Ismailia
Upper Egypt governorates	
4.3	Giza
3.1	Beni Suef
3.4	Fayoum
5.7	Menia
4.7	Asyout
5.1	Sohag
0.6	Luxor
4.1	Qena
1.7	Aswan
2.4	Helwan
3.5	6th October
Frontier governorates	
0.4	Matrouh
0.3	Wadi el Gadid
0.4	Red Sea
0.5	North Sinai
0.2	South Sinai

Appendix 2: (Tools)

Tool 1- Facility checklist

FACILITY CHECKLIST

عند استخدام هذه القائمة تأكد من رؤيتك لكل بند من البنود الواردة

تاريخ الزيارة (date)	يوم day	شهر month	سنة year

الكود code	التوضيح Description	
	كود1- كود 4 طبقا لإختيار وزارة الصحة والمعهد القومى للتغذية code 1- 4 according to NNI and MOH	كود المحافظة governorate code
	كود1- كود 4 طبقا لإختيار وزارة الصحة والمعهد القومى للتغذية code 1-4 according to NNI and MOH	كود المنطقة / الإدارة District/ directorate code
	الكود طبقا لعدد الإدارات حيث يتم إختيارها عشوائيا Code according to number of randomly chosen districts	اسم المنطقة/ الإدارة District/directorate name
كود جامع البيانات Code of interviewer	الكود طبقا لمكان العمل Code	الاسم جامع البيانات Name of interviewer

الكود code	3 وحده صحة الأسرة Family Health unit	2 مركز طب الأسرة Family Health Center	المستشفيات 1.3 مستشفى تخصصي أو تعليمى Specialized / Academic hospital	1.2 مستشفى عام Public Hospital	1.1 مستشفى مركزى District Hospital	Facility Type نوع المنشأة

1- Nutrition Program Material (FOR Health Care Providers)

١- توافر مواد للتعريف ببرامج التغذية (لمقدمي الخدمة الصحية)

نوع المواد	كود المواد code	كود الإجابة			
- MOHP official document. - Patient education material - In-service program training material - Academic material		1 Yes	0 No	هل تتوفر أية مطبوعات عن التغذية Is there any reference material on Nutrition	**1.1**
		1 Yes	0 No	هل تتوفر أية مطبوعات عن النمو و التطور للأطفال Is there any reference material on Children growth and Development	**2.1**
		1 Yes	0 No	هل تتوفر أية مطبوعات عن سوء التغذية عند الأطفال خاصة بقصر القامة(التقزم) Is there any reference material on malnutrition about stunting	**3.1**
		1 Yes	0 No	هل تتوفر أية مطبوعات عن سوء التغذية عند الأطفال خاصة بالبدانة أو السمنة Is there any reference material on malnutrition about overweight and obesity	**4.1**
		1 Yes	0 No	هل تتوفر أية مطبوعات عن برنامج الإمداد بفيتامين أ Is there any reference material with about Vit A Supplementation	**5.1**

6. 1	هل تتوفر أية مطبوعات عن طرق الوقايه من الأنيميا و علاجها. Is there any reference material related to the management and treatment of Anaemia	0 No	1 Yes	كود	نوع المواد
7.1	هل تتوفر أية مطبوعات عن طرق الوقايه من نقص اليود Is there any reference material on the prevention of Iodine deficiency	0 No	1 Yes		- MOHP official document - Patient education material - In-service program training material - Academic material
8.1	هل تتوفر أية مطبوعات عن طرق الوقاية من الديدان المعوية وعلاجها Is there any reference material related to prevention and management of worms	0 No	1 Yes		
9.1	هل تتوفر أية مطبوعات عن طرق الوقايه وعلاج أسهال الأطفال Is there any reference material related to the management of childhood diarrhoea	0 No	1 Yes		
10.1	هل تتوفر أية مطبوعات عن الزنك Is there any reference material related to Zinc as a supplementation	0 No	1 Yes		
11.1	هل تتوفر أية مطبوعات عنالتغذيه السليمه للرضع و الأطفال صغار السن Is there any reference material related to optimal nutrition of infants and children	0 No	1 Yes		
12.1	هل تتوفر أية مطبوعات عن تشجيع الرضاعة الطبيعية المطلقهup to 6 months Is there any reference material on promotion and support of exclusive breast feeding up to 6 months	0 No	1 Yes		
13.1	هل يوجد ضوابط لصرف الالبان الصناعية Is there any regulations for the delivery of artificial formula?	0 No	1 Yes		

2- Health Information Management

٢- إدارة المعلومات الصحية

CODE	كود الإجابة			
	1 Yes	0 No	هل توجد سجلات الخدمة الصحية اليومية Routine health information daily register	1.2
	1 Yes	0 No	هل توجد سجلات لمتابعة الحوامل. Is there ante natal care register	2.2
	1 Yes	0 No	هل توجد سجلات لمتابعة الأطفال الأصحاء. Is there a healthy baby (monitoring) register	3.2
	1 Yes	0 No	هل توجد سجلات التطعيمات Is there immunization registers	4.2
	1 Yes	0 No	هل توجد سجلات الرعاية المتكامله للطفل المريض Is there IMCI register	5.2
	1 Yes	0 No	هل توجد ملفات طب الأسرة Is there family register	6.2
	1 Yes	0 No	هل توجد تقارير صحية شهرية Is there monthly health information reports	7.2

3- Health Education Material for clients: posters, brochures, flipcharts....

٣- مواد توعية للجمهور: مثل بوسترات- كتيبات- وسائل ايضاح – لوحات اعلانية

CODE	كود الإجابة			
	1 Yes	0 No	هل توجد مواد توعية للتغذية السليمة أو الوزن المثالي Is there promotional material on healthy eating and ideal weight	**1.3**
	1 Yes	0 No	هل توجد مواد توعية بأهمية الأمداد بفيتامين أ Is there promotional material on importance of Vit A supplementation	**2.3**
	1 Yes	0 No	هل توجد مواد توعية بأهمية استخدام الملح المدعم باليود. Is there promotional material on benefits of using iodized salt	**3.3**
	1 Yes	0 No	هل توجد مواد توعية و تشجيع للرضاعة الطبيعية المطلقة Is there promotional material promoting exclusive breast feeding	**4.3**
	1 Yes	0 No	هل توجد مواد توعية بالتغذية التكميلية السليمة (للأطفال بعد سن الستة اشهر). Is there promotional material on optimal complementary feeding for infants older than 6 months of age	**5.3**
	1 Yes	0 No	هل توجد مواد توعية عن تغذية الطفل أثناء المرض. Is there any promotional material on feeding of the sick child	**6.3**
	1 Yes	0 No	هل توجد مواد توعية عن اهمية أستخدام الزنك أثناءعلاج الإسهال Is there promotional material on the use of Zinc for the management of Diarrhea	**7.3**
	1 Yes	0 No	هل توجد مواد توعية بطرق الوقاية و العلاج من الإصابة بالديدان المعوية. Is there promotional material on prevention and management of intestinal worms	**8.3**
	1 Yes	0 No	هل توجد مواد توعية صحية للأم خلال فترة الحمل أو الرضاعة الطبيعية Is there Health promotional material for mothers during pregnancy and breast feeding periods	**9.3**
	1 Yes	0 No	هل توجد ارشادات توعية عن أقراص الحديد أثناء الحمل و الرضاعة Is there education for mothers on Iron tablets during pregnancy and Breast Feeding periods	**10.3**

4- Availability of Drugs and other Supplies

٤- توفر الأدوية و إمدادات أخرى

CODE	كود الإجابة			
	1 Yes	0 No	هل توجد ميزان أطفال سليم و يعمل Is there functioning baby weighing scales(balance)	1.4
	1 Yes	0 No	هل توجد ميزان كبار سليم و يعمل Is there functioning adult weighing scales(balance)	2.4
	1 Yes	0 No	هل يوجد مقياس طول أفقى Is there length horizontal scale (measuring boards)	3.4
	1 Yes	0 No	هل يوجد مقياس طول رأسى Is there height measuring vertical scale (stadiometers)	4.4
	1 Yes	0 No	هل توجد بطاقات صحية للأطفال Is there child health cards	5.4
	1 Yes	0 No	هل يوجد كبسولات فيتامين (أ) 100000وحدة Is there Vit A capsules 100,000 unit	6.4
	1 Yes	0 No	هل يوجد كبسولات فيتامين (أ) 200000 وحدة Is there Vit A capsules 200,000 unit	7.4
	1 Yes	0 No	هل يوجد أقراص حديد وحمض الفوليك Is there Iron – Folic acid tablets	8.4
	1 Yes	0 No	هل يوجد شراب الزنك Is there Zinc syrup	9.4
	1 Yes	0 No	هل يوجد شراب حديد للأطفال Is there Iron syrup	10.4
	1 Yes	0 No	هل يوجد محلول معالجة الجفاف Is there ORS	11.4
	1 Yes	0 No	فى حالة نعم هل يوجد ألبان صناعية للأطفال حديثى الولادة 0-6 شهور للفئات المستحقة المحددة. Is there infant formula for due new born babies (0 – 6 months)	12.4
	1 Yes	0 No	هل يوجد مطبخ تعليمى (ثلاجة- فرن – بوتجاز) Is there any educational kitchen and equipments (stove ,oven, fridge)	13.4

Tool 2- Health Worker

Health Worker: Structured questionnaire

يستكمل هذا الاستبيان بواسطة الموظفين بالمرفق اللذين يقدمون خدمات صحية للسيدات الحوامل والأمهات والأطفال

تاريخ الزيارة (date)	يوم day	شهر month	سنة year

الكود code	التوضيح Description	
	كود 1- كود 4 طبقا لإختيار وزارة الصحة والمعهد القومى للتغذية code 1-4 according to NNI and MOH	كود المحافظة governorate code
	كود 1- كود 4 طبقا لإختيار وزارة الصحة والمعهد القومى للتغذية code 1-4 according to NNI and MOH	كود المنطقة / الإدارة District/ directorate code
	الكود طبقا لعدد الإدارات حيث يتم إختيارها عشوائيا Code according to number of randomly chosen districts	اسم المنطقة/ الإدارة District/directorate name
كود جامع البيانات Code of interviewer	الكود طبقا لمكان العمل Code	الاسم جامع البيانات Name of interviewer

الكود code	3 وحده صحة الأسرة Family health unit	2 مركز طب الأسرة Family health center	hospitals المستشفيات 1.3 مستشفى تخصصي أو تعليمى Specialized / teaching hospital	1.2 مستشفى عام PublicHospital	1.1 مستشفى مركزى DistrictHospital	نوع المنشأة Facility type

الكود code	9 مراقب صحي او أخرى (تذكر) Health inspector/ other mention	8 موظف إداري Admin Clerk	7 فني معمل Lab technician	6 صيدلي Pharmacist	5 رائدة ريفية Community health worker	4 مسئول تغذية Nutrition specialist	3 ممرضة Nurse: مدرسة التمريض Nursing school	3 ممرضة Nurse: المعهد العالي للتمريض High Nursing Institute	2 طبيب ممارس عام Physician General practitioner	1 طبيب أخصائي Physician specialist

الجزء الأول: الخلفية والتدريب

Part one: Background and Training

١-١ برجاء تحديد متى تأهلت فى مهنتك

1.1 Please specify when you qualified in your profession

الكود code	4. 2000-2009	3. 1990-1999	2. 1980-1989	1. 1970- 1979

١-٢ خلال العامين السابقين هل تم تدريبك على

1-2 in the last two years have you been trained on:

الكود code			
	1 نعم Yes	0 لا No	١-٢-١ متابعة النمو و التطور الإدراكى للأطفال Child growth and cognitive development
	1 نعم Yes	0 لا No	١-٢-٢ منحنيات النمو الحديثة (منحنيات النمو لمنظمة الصحة العالمية، ٢٠٠٧-٢٠٠٨) New Growth Charts (WHO growth charts، 2007-2008)
	1 نعم Yes	0 لا No	١-٢-٣ الرضاعة الطبيعية المطلقة Exclusive breast feeding
	1 نعم Yes	0 لا No	١-٢-٤ التغذية التكميلية والفطام complementary foods and weaning
	1 نعم Yes	0 لا No	١-٢-٥ تغذية الرضع والأطفال الصغار المرضى Feeding of sick infants and children
	1 نعم Yes	0 لا No	١-٢-٦ إمداد الأطفال بفيتامين أ Vit A Supplementation for children
	1 نعم Yes	0 لا No	١-٢-٧ الامداد بالزنك للعلاج والوقاية من الإسهال Zinc supplementation for the management and prevention of diarrhea
	1 نعم Yes	0 لا No	١-٢-٨ تغذية الأم الحامل Nutrition of pregnant women

الجزء الثانى: تنفيذ البرنامج (برجاء إختيار إجابة واحدة)

Part two: program implementation (select only one response)

٢-١ بالرجوع للتدريبات الواردة بالسؤال الأول، هل أفادك التدريب الذي تلقيته خلال السنتين الماضيتين فى عملك الحالي فى مجال التغذية ؟

2.1 With reference to trainings in question 1, did the training received during the last two years benefit you currently in your work in nutrition?

الكود code	3 مفيد useful	2 مفيد جزئيا (الى حد ما) Somewhat /partially useful	1 غير مفيد Not useful

٢-٢. هل التدريب الذى تلقيته جعلك متمكن من تقديم المشورة للأم عن الرضاعة الطبيعية المطلقة لمدة ٦ شهور؟

2.2 Did the training qualify you in providing counseling to mothers on exclusive breast feeding during the first 6 months?

الكود code	3 متمكن من كل الجوانب Qualified in all aspects	2 متمكن من بعض الجوانب Partially qualified	1 غير متمكن على الإطلاق unqualified

٢-٣ هل التدريب الذى تلقيته جعلك متمكن من تقديم المشورة للأم عن ممارسات تغذية الرضع؟

2.3 Did the training qualify you in providing counseling to mothers on infant feeding practices?

الكود code	3 متمكن من كل الجوانب Qualified in all aspects	2 متمكن من بعض الجوانب Partially qualified	1 غير متمكن على الإطلاق unqualified

٢-٤. هل التدريب الذى تلقيته جعلك متمكن من تقديم المشورة و دعم للأم التي لديها مشاكل فى الرضاعة الطبيعية؟

2.4 Did the training qualify you in providing counseling to mothers who have difficulties with Breast Feeding?

الكود code	3 متمكن من كل الجوانب Qualified in all aspects	2 متمكن من بعض الجوانب Partially qualified	1 غير متمكن على الإطلاق unqualified

٢-٥ أسئلة خاصة بتوفر الوقت في العمل.

2.5 Questions related to availability of time during working hours

الكود code	2 نعم Yes	1 أحيانا Sometimes	0 لا No	**2-5- أ** هل عندك وقت كافى فى عملك للقيام بتقييم النمو عند الأطفال؟ Do you have enough time to assess and monitor growth for children?
الكود code	2 نعم Yes	1 أحيانا Sometimes	0 لا No	**2-5- ب** هل عندك وقت كافى فى عملك لتقديم المشورة و التوعية بالرضاعة الطبيعية المطلقة؟ Do you have enough time to provide counseling on exclusive breast feeding?
الكود code	2 نعم Yes	1 أحيانا Sometimes	0 لا No	**2-5- ج** هل عندك وقت كافى فى عملك لتقديم المشورة والتوعية بالتغذية التكميلية؟ Do you have enough time to provide counseling on complementary feeding?
الكود code	2 نعم Yes	1 أحيانا Sometimes	0 لا No	**2-5- د** هل عندك وقت كافى فى عملك لتقديم المشورة و التوعية بتغذية الطفل المريض؟ Do you have enough time to provide counseling on the feeding of the sick child?
الكود code	2 نعم Yes	1 أحيانا Sometimes	0 لا No	**2-5- هـ** هل عندك وقت كافى فى عملك لتقديم المشورة و التوعية بتغذية الأم الحامل. Do you have enough time to provide counseling on the nutrition of pregnant women?

٢-٦ برجاء ذكر الصعوبات

2.6 Please mention of the difficulties

الكود code	الإجابة answer
	.1
	.2
	.3

الجزء الثالث – معرفة بروتوكولات التغذية

Part 3: Knowledge of nutrition protocols (select only one response)

٣-١ خلال فترة الحمل ما هى المغذيات الدقيقة التى يجب ان تتناولها الأم؟

3.1 During pregnancy what micronutrients supplementation should women receive?

الكود code	6 لا أعلم Don't know	5 حديد مع حمض الفوليك Iron and folic acid	4 حديد فى حالة الأنيميا Iron in case of anaemia	3 حمض الفوليك فقط Only folic acid	2 حديد فقط Only iron	1 لا شيء Nothing

٣-٢ ما هو برنامج الإمداد بفيتامين «أ» للأطفال فى مصر؟

3.2 What is the Vit A supplementation schedule for children in Egypt?

الكود code	5 لا أعلم Don't know	4 فى حال المرض During sickness	3 عند سنة و نصف At 1 year and half of age	2 عند سنة At 1 year of age	1 عند 9 شهور At 9 months

٣-٣ للوقاية من الأنيميا، ربط الحبل السري للطفل يجب أن يتم بعد الولادة:

3.3 For anemia prevention how soon after delivery a baby's umbilical cord is clamped?

الكود code	5 لا أعلم Don't know	4 بعد ساعة من الولادة After 1 hour	3 بعد ثلاث دقائق من الولادة After 3 minutes	2 بعد دقيقة واحدة من الولادة After 1 minute	1 مباشرة immediately

٣-٤ للتغذية المثلى ، يجب إعطاء الطفل ثدى الأم بعد الولادة ؟

3.4 For optimal nutrition how soon after delivery should the baby be given his mother's breast?

الكود code	5	4	3	2	1
	لا أعلم Don't know	بعد تعافى الأم After mother recovery	خلال 24 ساعة Within 24 hours	خلال 6 ساعات Within 6 hours	مباشرة / خلال ساعة Immediately/ within an hour

٣-٥ للتغذية المثلى متى يجب للطفل الرضيع أن يتناول الأطعمة التكميلية؟

3.5 For optimal nutrition when should infants start receiving complementary foods?

الكود code	5	4	3	2	1
	لا أعلم Don't know	عندما يخرج للطفل أسنان At appearance of teeth	عند 8 شهور من العمر At 8 months of age	عند 6 شهور من العمر At 6 months of age	عند 4-6 شهور من العمر At 4-6 months of age

٣-٦ الزنك يجب أن يعطى لكل الأطفال المصابين بالإسهال؟

3.6 Zinc should be given to all children who have diarrhea?

الكود code	3	2	1
	لا أعلم Don't know	خطأ false	صح true

الجزء الرابع: دعم الرضاعة الطبيعية

Part four: Breast feeding support

٤-١ كم عدد المرات التي تشاهد فيها وتقدم المشورة لأم تعانى من صعوبات في الرضاعة الطبيعية؟
(برجاء إختيار إجابة واحدة)

4.1 How often do you see and counsel mothers with Breast Feeding difficulties? (Please select one response only)

٤-٢ هل تتوفر بالمنشأه البان صناعية للفئات المستحقة:

4-2 Are there any available infant formulas for due categories in your health facility?

الكود code	6 لا أعلم Don't know	5 مطلقا Never	4 بشكل متقطع intermittently	3 كل شهر monthly	2 كل أسبوع weekly	1 كل يوم daily

الكود code		2 لا No	1 نعم Yes

٤-٣ كم عدد المرات التي تشاهد فيها أطفال من الفئات التى تستحق الرضاعة بألبان أخرى غير لبن الأم وتقدم المشورة لأمهاتهم عن كيفية تحضير رضعة الطفل (برجاء إختيار إجابة واحدة)

4-3 How often do you see children who should be fed with formula and not Breast milk and you counsel their mothers on how to prepare the feed? (One response only)

الكود code	6 لا أعلم Don't know	5 مطلقا Never	4 بشكل متقطع Intermittently	3 كل شهر monthly	2 كل أسبوع Weekly	1 كل يوم Daily

٤-٤ (أ) هل يوجد بالمنشأة الصحية أية ملصقات / منشورات / عينات مجانية للألبان أو / أقلام/ هدايا / حفاضات ورقية مقدمة من شركات تصنيع الألبان؟

4.4 (A) Does your health facility have any posters, pamphlets,gifts,pens or free formula milk samples by formula manufacturing companies?

الكود code	2 لا أعلم Don't know	1 نعم Yes	0 لا No

٤-٥ (ب) إذا كانت الإجابة نعم، برجاء الإيضاح بالتفصيل

4.5 (B) If yes please clarify

الكود code	إجابة answer
	.1
	.2
	.3
	أخرى other

الجزء الخامس: إشراك المجتمع المحلي ومجموعات الدعم

Part five: community participation and support groups

٥-١ هل توجد أية أنشطة خاصة بالتغذية فى المنشأة الصحية مع الجمعيات الأهلية فى المجتمع المحلى؟

5.1 Is there any nutrition concerned activities in your health facility done with NGOs in the local community?

الكود code	2 لا أعلم Don't know	1 نعم Yes	0 لا No

٥-٢ اذكر بعض الامثلة لهذه الانشطة

5.2 Please mention some examples

الكود code	إجابة answer

الجزء السادس : الدعم

Part six: Support

٦-١ من الذى تقوم بإستشارته في حالة الاحتياج للمشورة الفنية، معلومات عن أحدث التقدمات فى مجال التغذية ؟

6.1 Who do you consult if you need nutritional technical support, or information about recent advances in nutrition?

الكود code	الإجابة answer
	.1
	.2
	.3
	أخرى other

٦-٢ ما هى مصادر تحديث معلوماتك الخاصة بالتغذية؟

6.2 What are your sources of updated information on nutrition?

الكود code	الإجابة answer

٦-٣ (أ) هل هناك أى مجال من مجالات التغذية التي تشعر بأنك تحتاج لمزيد من التدريب به؟

6.3 (A) Are there any areas in nutrition which you feel you need more training in it?

الكود code	1 نعم Yes	0 لا No

٦-٣ (ب) إذا كانت الإجابة بنعم برجاء شرح نوع التدريب

6.3 (B) If yes please describe type of training

الكود code	الإجابة answer
	.1
	.2
	.3
	أخرى other

الجزء السابع: المقترحات لتحسين الخدمات التغذوية

Part seven: Suggestions to improve nutrition services

كيف يمكن تحسين برامج التغذية؟

How can the nutrition programs be improved?

الكود code	الإجابة answer
	.1
	.2
	.3
	أخرى other

Thank you for your participation

شكراً لإشتراككم معنا

Tool 3 Focus group discussion with NGO's

Community-based Health-worker Interview Guide for Focus Group Discussions

Semi-structured interview guide with community-based Health-workers who are providing services to women and children.

دليل مقابلة شبه منظم مع العاملين فى مجال الصحة المجتمعية و الذين يقدمون الخدمات للنساء والأطفال

Date of visit								
تاريخ الزيارة	يوم		شهر		سنة			
	d	d	m	M	y	y	y	y

Indicator	Explanation التوضيح	code
Governorate كود المحافظة	Coded 1 to 4 as selected by MoH/NNI كود-1 كود 4 طبقا لإختيار وزارة الصحة والمعهد القومى للتغذية	
District كود المنطقة	Coded 1 to 4 as selected by MoH/NNI كود-1 كود 4 طبقا لإختيار وزارة الصحة و المعهد القومى للتغذية	
Organizational Name اسم المنظمة	1 = International NGO ١. منظمات غير حكومية دولية 2 = National NGO ٢. منظمات غير حكومية قومية 3 = Local NGO ٣. منظمات غير حكومية محلية 4 = Community-Based Organization (CBO) ٤. منظمات المجتمع المحلى 5 = Faith-based Organization (FBO) ٥. المنظمات الدينية 6 = Civil Organization ٦. المنظمات المدنية 7 = Other ٧. أخرى	
Facilitator's Name اسم المحاور	Individual data collector by organization الكود طبقا لمكان العمل	

Note taker's name اسم مدون الملاحظات	
Number of Focus Group Discussion participants عدد المشاركين فى مجموعات النقاش البؤرية	

Please complete if possible and only included a maximum of 8 FGD participants

برجاء الإستكمال اسماء المشاركين فى مجموعات النقاش البؤرية على أن لا يتجاوز العدد ٨ افراد.

Name of FGD Participant اسم المشارك فى مجموعات النقاش البؤرية	Position المنصب	Length of time with the organization المدة التى قضاها فى المنظمة	الكود code
١)			
٢)			
٣)			
٤)			
٥)			
٦)			
٧)			
٨)			

1. Community needs

١. إحتياجات المجتمع

1.1 What do you feel are the biggest needs of the communities that you serve? (Note— DO NOT prompt for the listed options, tick as mentioned by FGD participants)

١- ١ فى رأيك ما هي أكبر احتياجات المجتمعات المحلية التي تقوم بخدمتها؟ (ملاحظة لا تعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين فى مجموعة المناقشة)

Needs الإحتياجات	Mentioned المذكورة		Code الكود
i. Jobs/employment ١- وظائف/ توظيف (تشغيل، إستعمال)	0 No	1 Yes	
ii. Health services ٢- خدمات صحية	0 No	1 Yes	
iii. Education and training ٣- التعليم و التدريب	0 No	1 Yes	
iv. Recreation and entertainment (e.g. play parks, community centers for the elderly) ٤- اماكن الترويح و الترفيه (مثلا الملاعب، مراكز لرعاية المسنين)	0 No	1 Yes	
v. Safe environment (for children, for the elderly for people with disabilities, more police services) ٥- بيئة أمنة (للأطفال، للمسنين، للأشخاص المعوقين، مذيد من خدمات الشرطة	0 No	1 Yes	
vi. Food and Nutrition services (e.g. food distribution, food safety control, nutrition education) ٦- خدمات الغذاء و التغذية (مثلا توزيع الطعام، الرقابة على سلامة الغذاء، التثقيف الغذائى)	0 No	1 Yes	
أخرى ٧- ٨-			

2. Organization's mandate and activities

٢. أولويات وأنشطة المنظمة

2.1 Please share with me the type of nutrition activities which your organization undertakes or that you are currently implementing *(Note—DO NOT prompt for the listed options, tick as mentioned by FGD participants)*

٢-١ يرجىحصرانوع الأنشطة التغذوية التي تقوم بها المؤسسة (المنظمة) أو التى تقوم أنت حاليا بتنفيذها (ملاحظة لاتعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين فى مجموعة المناقشة)

Activities الأنشطة	Mentioned المذكورة		Code الكود
1- Nutrition promotion / communication ١- الترويج و نقل المعلومات عن التغذية السليمة	0 No	1 Yes	
2- Food distribution ٢- توزيع الطعام	0 No	1 Yes	
3- Distribution of nutritional supplements-3 ٣-توزيع المكملات الغذائية	0 No	1 Yes	
4- Nutrition counseling ٤-الإرشاد التغذوى	0 No	1 Yes	
5- Training in nutrition ٥-التدريب فى مجال التغذية	0 No	1 Yes	
6- Nutrition information material development ٦- تطوير وسائل وأدوات تثقيفية عن اتلغذية	0 No	1 Yes	
			أخرى ٧- ٨-

2.2 Can you name any other organizations in your area that provide similar services?

٢-٢ هل يمكن أن تقوم بذكر أي منظمات أو جمعيات أخرى في منطقتك تقدم خدمات مماثلة

Response الإجابة	0 No	1 Yes	
Names of other organizations أسامى المنظمات الأخرى ١- ٢- ٣-			

2.3 Is there any cooperation between your organization and local Governmental health care service providers/policy makers in performing your nutrition activities?

٢- ٣ هل هناك أي تعاون بين المنظمة الخاصة بك ومقدمي خدمات الرعاية الصحية الحكومية المحلية/ أو واضعي السياسات العامة في تنفيذ أنشطتكم التغذوية

Response الإجابة	0 No	1 Yes	
please explain nature of cooperation برجاء شرح طبيعة التعاون ١- ٢- ٣-			

3. Program implementation

٣- تنفيذ البرنامج

3.1 Do you feel that you are/ have been successful in implementing your organization's activities? Please explain.

٣-١ هل تشعر بأنك كنت ناجحا في تنفيذ الأنشطة الخاصة بالمؤسسة؟ يرجى توضيح ذلك (الشرح)

Response الإجابة	0 No	1 Yes	
please explain برجاء الشرح			

3.2 What helps you to be successful in your nutrition related activities? *(Note—DO NOT prompt for the listed options, tick as mentioned by FGD participants)*

٣-٢ ما الذى يساعدك على أن تكون ناجحا في أنشطة التغذية الخاصة بك. (ملاحظة: لا تعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين في مجموعة المناقشة)

Helpful factors العوامل المساعدة	Mentioned المذكورة		Code
i. My community knows me ١-مجتمعى يعرفنى	0 No	1 Yes	
ii. I know the needs of my community ٢- أنا أعلم إحتياجات مجتمعى	0 No	1 Yes	
iii. I have received good training ٣- أنا تلقيت تدريبا جيدا	0 No	1 Yes	
iv. My superiors are very supportive and helpful ٤-رؤسائى يدعمونى ويساعدونى	0 No	1 Yes	
v. We have good funding for our activities ٥- عندنا تمويل جيد للأنشطة التى نقوم بها	0 No	1 Yes	
vi. My community is interested in our activities ٦- مجتمعى مهتم بالأنشطة التى نقوم بها	0 No	1 Yes	
			أخرى ٧- ٨-

3.3 What are the main obstacles or difficulties, if any;that you face that hindered the implementation of your organizations nutritionactivities? *(Note—DO NOT prompt for the listed options, tick as mentioned by FGD participants)*

٣-٣ ما هي العقبات الرئيسية أو الصعوبات، إن وجدت، التي تواجهونها والتي تعوق تنفيذ أنشطة التغذية الخاصة بالمنظمة/ المؤسسة؟ (ملاحظة: لا تعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين في مجموعة المناقشة)

Difficulties الصعوبات	Mentioned المذكورة		Code
i. Not enough staff ١-عدد الموظفين غير كافى	0 No	1 Yes	
ii. Too many activities or people to service ٢-علينا تنفيذ أنشطة كثيرة و خدمة عدد كبير من الناس	0 No	1 Yes	
iii. Poor or no training received ٣- التدريب غير موجود أو ضعيف او علي فترات متباعدة	0 No	1 Yes	
iv. The community is not interested in our activities ٤- المجتمع غير مهتم بالأنشطة التى نقوم بها	0 No	1 Yes	
v. We don't have funding for our activities ٥- لا يوجد لدينا تمويل للأنشطة التى نقوم بها	0 No	1 Yes	
أخرى ٦- ٧-			

3.4 How do different governmental agencies such as MOH, NNI, MOSS assist your nutrition activities such as distribution of nutritional products or other servicesbased on cooperation or data provided

٣-٤ كيف تقوم الهيئات الحكومية المختلفة مثل وزارة الصحة ، المعهد القومى للتغذية، وزارة التضامن الاجتماعي بالمساعدة فى أنشطة التغذية الخاصة بكم؟ مثل توزيع المنتجات الغذائية أو غيرها من الخدمات على أساس التعاون المتبادل أو البيانات المقدمة

Is there any cooperation Response ،	هناك أي نوع من التعاون الإجابة	0 No	1 Yes	

Activities الأنشطة	Mentioned المذكورة		Code الكود
i. provide technical information ١- توفير معلومات تقنية	0 No	1 Yes	
ii. provide statistical information ٢- توفير معلومات إحصائية	0 No	1 Yes	
iii. Training in nutrition ٣- التدريب فى مجال التغذية	0 No	1 Yes	
iv. Nutrition information material development ٤- تنمية مواد المعلومات التغذوية	0 No	1 Yes	
v. help establish Nutrition promotion / communication events ٥- المساعدة والمشاركة في حملات توعية للجمهور ونشر المعلومات الصحية	0 No	1 Yes	
Other: vi. vii.			أخرى ٦- ٧-

4. Training and capacity development

٤-التدريب وتنمية القدرات

4.1 In the last two years can you tell me what nutrition-related training you have received? *(Note—DO NOT prompt for the listed options, tick as mentioned by the FGD participants)*

٤-١ خلال العامين الماضيين هل يمكن أن تخبرني ما هى التدريبات الخاصة بالتغذية التي تلقيتها؟ (ملاحظة : لا تعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين في مجموعة المناقشة)

			Code الكود
4.1(a) No training at all ٤-١(أ) لم أتلقى أي تدريبات في مجال التغذية على الإطلاق	No training received at all لم يتم تلقى اى تدريبات		77
4.1(b) Infant and young child feeding? ٤-٢(ب) تغذية الرضع و الأطفال الصغار	0 No	1 Yes	
4.1(c) Infant and young child feeding of the sick child? ٤-١(ج) تغذية الرضع و الأطفال الصغار المرضى	0 No	1 Yes	
4.1(d) Vitamin A supplementation for children? ٤-١(د) إمداد الأطفال بفيتامين «أ»	0 No	1 Yes	
4.1(e) Zinc supplementation for the management of diarrhoea? ٤-١(ل) الإمداد بالزنك للعلاج والوقاية من الإسهال	0 No	1 Yes	
4.1(f) Nutritional assessment of children ٤-١(م) التقييم الغذائي للأطفال	0 No	1 Yes	
4.1(g) Healthy eating for good health ٤-١(ه) الأكل الصحي من أجل صحة جيدة	0 No	1 Yes	
4.1(h) Other			أخرى

4.2 In the last two years can you tell me what nutrition-related training your organization has provided to others? (Note—DO NOT prompt for the listed options, tick as mentioned by the FGD participants)

٤-٢ في العامين الماضيين هل يمكن أن تخبرني ما هى التدريبات الخاصة بالتغذية التى قدمتها مؤسستك للآخرين؟
(ملاحظة : لا تعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين في مجموعة المناقشة)

			Code الكود
4.2(a) No training provided at all ٤-٢(أ) لم أتلقى أي تدريبات في مجال التغذية على الإطلاق	No training provided at all لم يتم تلقى اى تدريبات		77
4.2(b) Infant and young child feeding? ٤-٢(ب) تغذية الرضع و الأطفال الصغار	0 No	1 Yes	
4.2(c) Infant and young child feeding of the sick child? ٤-٢(ج) تغذية الرضع و الأطفال الصغار المرضى	0 No	1 Yes	
4.2(d) Vitamin A supplementation for children? ٤-٢(د) إمداد الأطفال بفيتامين "أ"	0 No	1 Yes	
4.2(e) Zinc supplementation for the management of diarrhoea? ٤-٢(ل) الإمداد بالزنك للعلاج و الوقاية من الإسهال	0 No	1 Yes	
4.2(f) Nutritional assessment of children ٤-٢(م) التقييم الغذائي للأطفال	0 No	1 Yes	
4.2(g)Healthy eating for good health ٤-٢(هـ) الأكل الصحي من أجل صحة جيدة	0 No	1 Yes	
4.2(h) Other			٤-٢ هـ أخرى

5. Concluding questions

٥ - الأسئلة الختامية

In your opinion, what are the top three priority needs of your NGO in order to accelerate reduction of malnutrition?(Note DO NOT prompt for options listed, rank as mentioned by the FGD participants.

(في رأيك، ما هي أكبر ثلاث احتياجات ذات الأولوية لمنظمتكم الغير حكومية من أجل تسريع الحد من أعراض سوء التغذية.)

ملاحظة: لا تعلن الخيارات المذكورة فقط ضع علامة على حسب ما يذكره المشاركين في مجموعة المناقشة)

	Rank (1,2,3) المرتبة (٣،٢،١)	Code الكود
1. Human resources (more staff, better salaries) ١ – الموارد البشرية (مزيد من الموظفين، مرتبات أفضل)		
2. Training (more training, better training modules or trainers) ٢ – التدريب (مزيد من التدريب، مناهج تدريبية أفضل أو مدربين أكثر كفائة)		
3. supplies (food and supply systems) ٣ – المستلزمات(الغذاء ونظم الإمداد)		
4. infrastructure (more space, better equipment) ٤ – البنية التحتية (مساحة أكبر، و معدات أفضل)		
5. financial resources (bigger budget, more external funding) ٥ – الموارد المالية (ميزانية أكبر، مزيد من التمويل الخارجي)		
6. Other		٦ – أخرى

Thank you for your time and participation

شكراً لك على وقتك وعلى المشاركة معنا

Tool 4 Key informant interviews

NATIONAL STAKEHOLDERS INTERVIEW QUESTIONNAIRE

استمارة استبيان خاصة بالمسؤلين على المستوى القومي

To complete this questionnaire you may have to interview more than one person in a particular organization/institution/ministry

تاريخ الزيارة [Date of visit [verification of data)	يوم day	شهر month	سنة year

Data Collector Name اسم جامع البيانات	Interviewer Code كود جامع البيانات	**organization code** **الكود طبقا لمكان العمل**

Stakeholder(s): Name: ..... أسم المسؤل:

Position/Agency: ..... المنصب/ مكان العمل:

Stakeholder(s): Name: .....

Position/Agency: .....

Stakeholder(s): Name: .....

Position/Agency: .....

1. Nutrition situation and priorities in Egypt

١ - الوضع التغذوى والأوليات فى مصر

1.1 What do you perceive as the 3 major nutrition problems in Egypt? (List according to importance and if more than 3 problems are identified, add them on the list as well.)

١-١ في رأيك ما هي أهم ثلاث مشكلات تغذوية في مصر؟ (برجاء ذكرها وفقا لأهميتها، و إذا تم تحديد أكثر من ثلاث مشكلات برجاء إضافتها على القائمة كذلك)

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

1.2 Do you feel that these identified problems are adequately addressed in the Egyptian National Food & Nutrition Policy & Strategy 2007-2017?

١-٢ هل تشعرأن المشاكل التي تم تحديدها يتم التصدي لها بشكل كاف في الإستراتيجية والسياسة المصرية للتغذية والغذاء ٢٠٠٧-٢٠١٧؟

Answer	الإجابة	Code الكود
Yes, describe نعم: يرجى الإيضاح		
No, explain لا: اشرح		
Don't Know لا أعلم		

1.3 What do you perceive as the most important causes of these nutritional problems? (List according to importance)

١ – ٣ في رأيك ما هي أهم أسباب هذه المشاكل الغذائية؟ (القائمة وفقا للأهمية)

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

1.4 What do you perceive as the major barriers for scaling up nutrition actions in Egypt? (List according to importance).

١-٤ في رأيك ما هي المعوقات الرئيسية التي تحول دون تسريع وتيرة العمل لحل المشاكل الغذائيةفي مصر؟ (القائمة وفقا للأهمية)

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

2. Nutrition coordination system

٢- نظم التعاون في مجال التغذية

2.1 What do you perceive as the major strengths of the current system/mechanism for coordinating nutrition actions under the inter-ministerial Cabinet (List according to importance)

٢-١ فى رأيك ما هي نقاط القوة الرئيسيةللنظام الحالي للتعاون في مجال التغذية في إطار عمل المجموعة الوزارية لإستراتيجية الغذاء والتغذية(القائمة وفقا للأهمية)

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

2.2 What do you perceive as the major aspects of the coordination of nutrition actions that should be improved? (List according to importance.)

٢-٢ في رأيك ما هي الجوانب الرئيسية التي ينبغي تحسينها في عملية تنسيق التعاون في مجال التغذية الحالي؟(القائمة وفقا للأهمية)

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

3. Agency nutrition activities and policies

٣- الأنشطة والسياسات التغذوية للهيئات / الوكالات

3.1 What specific actions, if any, does your Department/Unit/Section/Agency support in the area of nutrition? If possible, please describe your Department / Unit / Section / Agency's actions and support at the different levels:

٣-١ ما هي الإجراءات المحددة، إن وجد، التي تقوم بها الإدارة/ الوحدة/ القسم/ الوكالة الخاصة بك في مجال التغذية؟ ويرجى وصف هيكل العمل والإجراءات/ الأعمال التي تقومون بها لدعم مجال لتغذية في المستويات المختلفة في هيكلكم

Level المستوى		Actions and support الإجراءات والدعم	**Code** الكود
3.1a	National المركزي		
3.1b	Governorate المحافظات		
3.1c	District الإدارة		
3.1d	Community المجتمع		

3.2 Are there any policies (formulated and endorsed documents in your Department / Unit /Section /Agency that support these actions?

٣-٢ هل هناك أية سياسات (وثائق وضعت وأقرت) في الإدارة/الوحدة/ القسم/ الوكالةالخاصة بكتدعم هذه الإجراءات؟

Answer	الإجابة	**Code** الكود
Yes, describe نعم، صف		
	No	
	Don't Know لا أعرف	

3.3 Please describe how your Department/Unit/Section/Agency provides this support in the area of nutrition.

٣-٣ يرجى وصف كيف تقوم الإدارة/ الوحدة/ القسم/ الوكالة الخاصة بك بتوفير هذا الدعم في مجال التغذية.

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

4. Budget and funding

٤ - الميزانية والتمويل

4.1 Could you estimate the annual budget of your Department/Unit/Section/Agency that is dedicated to nutrition actions?

٤-١ هل يمكن أن تقوم بتقدير الميزانية السنوية المخصصة لمجال التغذية في للقسم /الوحدة/ الوكالة الخاص بك؟

Current year: ..... في العام الحالي :

Last year: ..... في العام الماضي :

4.2 Approximately, what percentage of your Department/Unit/Section/Agency total annual budget does this represent?

٤-٢ تقريبا، ما هي النسبة المئوية التي تمثلها هذه الميزانية من إجمالي الميزانية السنوية للقسم/ الوحدة/ الوكالة الخاص بك ؟

Current year: ..... العام الحالية :

Last year: ..... العام الماضي :

4.3 What are the sources of funding for nutrition activities implemented by your Department/Unit/Section/Agency?

٤-٣ ما هي مصادر التمويل لتنفيذ أنشطة التغذية من قبل القسم/ الوحدة/ القسم/ الوكالة الخاص بكم ؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

4.4 Do you feel there is adequate funding to tackle the nutrition situation of the Country?

٤-٤ هل تشعر أن هناك تمويل كاف لمعالجة الوضع الغذائي في مصر؟

Answer		الإجابة	Code الكود
Yes, describe نعم، صف			
	No	لا	
	Don't Know	لا أعرف	

4.5 If no, do you have any specific plans or ideas for increasing funding?

٤-٥ إذا كانت الإجابة للسؤال السابق لا، هل لديكم أي خطط محددة أو أفكار لزيادة التمويل؟

Answer	الإجابة	Code الكود
Yes, describe نعم، صف		
	No لا	
	Don't Know لا أعرف	

5.Human resources for nutrition

٥ - الموارد البشرية في مجال التغذية

5.1 Do you think that there is enough staff, which is appropriately trained in nutrition at the different levels within the national health services and institutionsin Egypt?

٥-١ هل تعتقد أن هناك عدد كافي من الموظفين المدربين تدريبا مناسبا في مجال التغذية في المستويات المختلفة ضمن منظومة الخدمات الصحية القومية والمؤسسات المختلفة في مصر؟

Answer	الإجابة	Code الكود
Yes, describe نعم، صف		
	No لا	
	Don't Know لا أعرف	

5.2 If no, what do you think should be done to strengthen nutrition capacity in Egypt?

٥-٢ إذا كانت الإجابة للسؤال السابق لا، في اعتقادك ما الذي ينبغي القيام به لتعزيز القدرات البشرية العاملة في مجال التغذية في مصر؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

5.3 Does your Department/Unit/Section/Agency have staff dedicated part-time or full-time for the implementation of the nutrition activities?

٥-٣ هل لدي الوحدة / القسم / الإدارة / الوكالة الخاص بك موظفين مخصصين لتنفيذ أنشطة التغذية سواء بدوام كامل أو بدوام جزئي؟

Response	الإجابة	Code
Yes, go to 5.4	نعم، أنتقل إلى سؤال رقم ٥-٤	
No, go to 5.6	لا، أنتقل إلى سؤال رقم ٥-٦	
Don't Know, go to 5.6	لا أعلم، أنتقل إلى سؤال رقم ٥-٦	

5.4 Please indicate how many staff at the different levels are dedicated to nutrition actions/activities?

٥-٤ يرجى توضيح كم عدد الموظفين المخصصين للأنشطة التغذية على مختلف المستويات ؟

Level المستوى	Full-Time دوام كامل	**Code** الكود	Part-Time دوام جزئي	**Code** الكود
a. National المركزي				
b. Governorate المحافظة				
c. District المنطقة				
d. Community المجتمع				

5.5 How many of those staff has formal training in nutrition?

٥-٥ كم من هؤلاء الموظفين تلقي تدريب رسمي في مجال التغذية؟

Service Level المستوى	Number of staff عدد الموظفين				
	Total العدد الكلى	Trained in nutrition المدربين في مجال التغذية	**Code** الكود	Not trained in nutrition لم يتم تدريبهم فى مجال التغذية	**Code** الكود
a. National المركزي					
b. Governorate المحافظة					
c. District المنطقة					
d. Community المجتمع					

5.6 Could you describe any of the short or longer-term in-service training programs that your staff has participated in over the last 2 years?

٥-٦ هل يمكن أن تصف لنا بعض برامج التدريب القصيرة أو الطويلة الأجل التي شارك فيها الموظفين لديكم خلال السنتين الماضيتين؟

Level of training مستوى التدريب	Number of staff trained عدد الموظفين اللذين تم تدريبهم	Topic of training موضوع التدريب	Code الكود
a. International أ – الدولى			
b. Regional ب – الإقليمى			
c. National ج – القومى			
d. None		لا يوجد	

5.7 If none, please explain why not.

٥-٧ إذا كانت الإجابة للسؤال السابق لا يوجد، يرجى توضيح الأسباب

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

6. Nutrition information system

٦- نظم المعلومات للوضع التغذوي

6.1 What types of information/data on nutrition do you use regularly?

٦- ١ ما هي أنواع المعلومات والبيانات المتعلقة بالتغذية التي تقوم باستخدامها بانتظام؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

6.2 How is the data collected (surveys, routine data, etc.) and who assembles them?

٦-٢ كيف يتم جمع هذه البيانات (الدراسات الاستقصائية، أو البيانات روتينية، الخ) ومن يقوم بتجميعها؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

6.3 How does your Department/Unit/Section/Agency use this data?

٦-٣ كيف تقوم الوحدة / الوكالة/ القسم الخاصة بك باستخدام هذه البيانات؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

7. Advocacy and scaling-up

٧- أنشطة رفع المستوى والترويج

7.1 In your experience, what could facilitate working together among nutrition partners in Egypt?

٧-١ من خلال تجربتك (خبرتك)، ما الذى يمكن أن يسهل العمل المشترك بين المهتمين بالتغذية في مصر؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

7.2 Do you think the Millennium Development Goals (MDGs) were useful in this field?

٧-٢ هل تعتقد أن الأهداف الإنمائية للألفية (MDGs) كان لها دور فعال فيهذاالمجال؟

Answer	الإجابة	Code الكود
Yes, describe نعم، صف		
	No لا	
	Don't Know لا أعرف	

7.3 Have you used advocacy tools / presentationssuch as presenting the financial burden of disease to help scale up actions on nutrition in Egypt?

٧-٣ هل قمت باستخدام أي أدوات للدعوة إلي أو عرض مشاكل التغذية مثل تقديم العبء المالي للمرض للمساعدة في توسيع نطاق العمل لمواجهة سوء التغذية في مصر؟

Answer	الإجابة	Code الكود
Yes, describe نعم، صف		
	No لا	
	Don't Know لا أعرف	

7.4 Which type of intervention or support could your Department/Unit/Section/ Agency provide to support scaling-up of nutrition actions?

٧-٤ ما هو أنواع التدخلات أو الدعم الذي يمكن أن يقدمه القسم/ الوحدة/ الوكالة الخاص بك لرفع وتوسيع نطاق العمل لمواجهة سوء التغذية في مصر؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

7.5 If your Department/Unit/Section/Agency could do only one thing at scale to improve nutrition – what would that be?

٧-٥ إذا كان بإمكان القسم/ الوحدة/ الوكالة الخاص بك أن يفعل شيئا واحدا فقط على نطاق واسع لتحسين التغذية في مصر- ماذا سيكون ذلك الشيء؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

8. Concluding question

٨ - السؤال الختامي

8.1 Is there anything else that you think you should tell us to have a better understanding about the nutrition situation in Egypt?

٨-١ في اعتقادك هل هناك شيء آخر يجب أنت خبرنا به للحصول على فهم أفضل عن الوضع التغذوي في مصر؟

Answer	الإجابة	Code الكود
	١)	
	٢)	
	٣)	
Other	أخرى	

Thank you for your participation

شكراً لمشاركتك

Appendix 3: National Nutrition Institute Organogram