Regional workshop on Nutrition Capacity Building: Dissemination of results and way forward
Bangkok, 16 May 2013

Meeting Report
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List of Acronyms

AEC: ASEAN Economic Community
APSSC: Asia-Pacific Shared Service Center
ASEAN: Association of Southeast Asian Countries
BINP: Bangladesh Integrated Nutrition Program
BMI: Body Mass Index
BRAC: Bangladesh Rural Advancement Committee
CEDAW: Convention on the Elimination of all forms of Discrimination Against Women
CRC: Convention on the Rights of the Child
DHS: Demographic Health Survey
EBF: Exclusive Breastfeeding
HMIS: Health Management Information System
ICCPR: International Convention on Civil and Political Rights
ICESCR: International Convention on Economic, Social and Cultural Rights
INMU: Institute of Nutrition, Mahidol University
JPGSPH: James P. Grant School of Public Health
LNS: Lancet Nutrition Series
MAF: Ministry of Agriculture and Forestry (Lao PDR)
MCU: Maternal and Child Undernutrition
MDG: Millennium Development Goals
MICS: Multi-Indicator Cluster Survey MIS:
Management Information System MOEC:
Ministry of Education and Culture MOH:
Ministry of Health
MPH: Masters in Public Health
MSNP: Multi Sectoral Nutrition Plan (Nepal)
MYCNSIA: Maternal and Young Child Nutrition Security Initiative in Asia
NFNC: National Food and Nutrition Commission (Bangladesh)
NNC: National Nutrition Centre (Lao PDR)
NNC: National Nutrition Council (Bangladesh)
NNS: National Nutrition Services (Bangladesh)
NPC: National Planning Commission (Nepal)
PHSL: Public Health Solutions Limited
PIC: Pacific Island Country
SAARC: South Asian Association for Regional Cooperation
SEAMEO TROPMED: Southeast Asian Ministers of Education Tropical Medicine and Public Health Network
SGS: School of Global Studies
SPC: Secretariat of the Pacific Community
SUN: Scale Up Nutrition movement
WPHNA: World Public Health Nutrition Association
Executive Summary:¹

Responding to the need for a viable approach to the persistent problem of stunting and anaemia in children and women in South and Southeast Asia, the EU has partnered with UNICEF to support a new initiative: the Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA). One of the four interrelated Result Areas of that initiative is to develop an approach for capacity building of decision-makers, service delivery personnel and communities. To begin the process, UNICEF contracted an international consultancy firm to do a nutrition capacity assessment in three of the five countries targeted by MYCNSIA: Nepal, Indonesia, and Bangladesh. A team of two international nutrition consultants working with the local UNICEF office assessed nutrition capacity in each country through literature review, key stakeholder interviews, and institutional visits to academic and other training venues. A written report was prepared with recommendations to government counterparts and other stakeholders. Reports were consolidated into a Regional Overview Report and summary presentation. A meeting was organized to discuss the summary report and summaries of each country report, attended by donor agencies, academia, NGOs, and representatives of government and the United Nations. The results of the assessment were organized around capacity needs at the individual and community, workplace, organizational and systems level.

At the individual and community level, the most immediate need is for raised community awareness around the prevalence, prevention, mitigation and seriousness of undernutrition, particularly stunting and anaemia, and a recognition that their causes go beyond food alone. A focus on the community is essential as this is where inequalities have their greatest impact; capacities at this level dictate those needed at each level of the system. At the workplace level, there is a need to define job competencies needed for public nutritionists, along with those needed for supportive supervisors. Adequate job descriptions would capture these. At the organizational level, multisectoral coordination and collaboration among involved sectors through a mandate from the highest authority in the government is the greatest need; using the authority of a line ministry has not been successful. All countries are in need of a professional work force in public nutrition; even where a work force exists, large numbers of nutritionists are not being used appropriately for public nutrition. Considerable effort is needed to train and coordinate the enormous community workforce that exists across sectors in each country. At the system level, there must be greater academic and other institutional support for public nutrition. Most training in nutrition is clinical and individual based; there are no courses or institutions with accreditation in public nutrition; certification of public nutritionists through a formal licensure process is absent. The kind of regulatory councils that exist for medicine and nursing do not exist in public nutrition. These functions will take on new significance with the inauguration of the ASEAN Economic Community in 2015 with easy cross-border movements of professionals from member countries.

Initially, since countries will have to outsource training from regional institutions, a

¹ This report has been produced with the financial assistance of the European Union, as part of the Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA). The views expressed herein can in no way be taken to reflect the official opinion of the European Union.
capacity assessment was done of educational institutions in Southeast Asia for nutrition training. Most courses surveyed, though under the name ‘nutrition,’ provide clinical nutrition, food sciences and dietetics courses. A local list of five institutions in South and Southeast Asia and one in Australia are imminently available. The group were told
about hybrid distance learning models that combined on-line learning with episodic face-to-face encounters.

Recommendations are organized according to their impact horizon: impact in 2-3 years (short term), 4-6 years (medium term) and 7-10 years (long term). All are to be started now if they are to be implemented in a timely and efficient manner. A key recommendation is to develop area based programs in focused districts where capacity in all spheres of the analysis could be developed and applied. This would require: in-service training of available staff and supervisors initially by outside trainers; placement of a District level nutrition professional under the District government to plan and coordinate multi-sectoral inputs; improvements in logistics and infrastructure; the development of a nutrition monitoring system. Simultaneously, each country needs to develop its own academic capacity in public nutrition through collaboration with regional institutions by sending a significant group of national staff to participate in 3-4 month graduate certificate programs, and a smaller group of promising junior professionals to enrol in 1-2 year Master’s level courses in public nutrition. The senior government chairperson of the multi-sectoral steering committee should assign accountabilities in nutrition specific and nutrition sensitive interventions to appropriate sectors, and then ask for direct periodic progress reports. Additionally, policies will be needed that regulate the marketing of breast milk substitutes and the importation of highly processed and calorically dense foods, that protect the poor from food price fluctuations, and that protect women for the six months of exclusive breastfeeding. Involvement of the ASEAN community was recommended.

There were two additional presentations:

Menzies School of Health Research reported on the major findings of a desk based review of nutrition capacity development issues and activities in 30 countries across Asia and the Pacific. The presentation included findings on nutrition profile data, currency of nutrition policies, strategies and plans, existing in-service and pre service nutrition courses and some of the content of these courses available to countries in the region, nutrition capacity needs assessments and other reported issues related to nutrition capacity.

The review found that while there are similarities in nutrition capacity needs and issues across Asia and Pacific Island Countries (PICs), there are unique challenges to both. Positioning PICs to address the double burden of undernutrition and overweight and obesity will require targeted investment in the development of appropriate and accessible nutrition training and supporting the development of realistic nutrition polices strategies and plans. With an exception of a few, most countries in Asia had updated nutrition strategies and plans. The on-going issue of underweight and the emerging issues of overweight and obesity in many countries requires attention and capacity developed to address both issues. While a range of pre-service and in-service nutrition training is available, the quality and relevance is unknown with many courses focused mostly on clinical nutrition.

Capacity development in the Scaling Up Nutrition (SUN) movement was presented to differentiate between ‘supply’ driven training programs and those driven by ‘demand’; it
was anticipated that SUN member countries would make their needs for capacity development known, and that programs to respond to those needs would be planned accordingly.

A final Panel Discussion of participants from academic institutions discussed the viability of developing a regional network for capacity development. The lively discussion resulted in agreement on the following: enriching existing curricula made more sense than developing a new regional Public Nutrition curriculum; regional structures like ASEAN or SAARC should be enlisted for regional coordination; short courses offered by regional institutions made more sense initially than longer diploma level courses; joint courses between regional institutions including student exchanges should be explored; development of a hybrid distance learning model was advocated.

The workshop concluded with a sense of urgency to get work on the recommendations started but with caution to dedicate the same depth of analysis used for this capacity assessment to developing a regional approach. Convening a small working group that can start developing a regional approach was recommended as a logical first step to moving things forward.

**Background:**

While there is evidence of good economic growth in Asia, and signs that countries in both South and Southeast Asia have made significant progress in achieving many of the Millennium Development Goals (MDG), inequalities persist related to income, gender and education and are reflected in high prevalence rates of stunting and anaemia in women and children throughout the region. In order to address the problem of malnutrition, and to guarantee that each child not only has the best start in life, but an equal chance to realize his or her full development potential, the European Union has partnered with UNICEF to support a new initiative to tackle maternal and child undernutrition in South and Southeast Asia. The Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA) is designed around four interrelated Result Areas: (i) Up-stream policy work regarding nutrition security, (ii) Capacity building of decision-makers, service delivery personnel and communities, (iii) Data analysis and knowledge sharing, and (iv) scaling up of key proven interventions. MYCNSIA activities are to be implemented in five targeted countries: Bangladesh, Indonesia, Laos, Nepal and the Philippines. Through the MYCNSIA, UNICEF is working with other stakeholders to improve child growth and development in Asia by improving nutrition security using inter-sectoral approaches.

UNICEF contracted an international consultancy firm to do an assessment of existing capacity in public and clinical nutrition in three countries: Nepal, Bangladesh, and Indonesia before designing an approach to building capacity in the region. While the primary purpose of the assessment was to inform UNICEF EAPRO how best to support actions for the development of nutrition capacity to address Mother and Child Undernutrition (MCU) at the country level, it is also intended to inform governments about their current capacity needs and assist them in developing their plans to build nutrition capacity of national and mid-level (i.e., district-level) staff in relevant sectors.
The results of the capacity assessment and gap analysis were presented at a regional workshop at the Amari Watergate Hotel in Bangkok on 16 May 2013. The workshop was attended by key stakeholders from donor agencies, academia, and representatives of government and the United Nations from each of the countries surveyed and from the region. There was also a delegation from Lao PDR, which included representatives from the Ministry of Health (MOH) (i.e., the Director of the National Nutrition Centre), Ministry of Agriculture and Forests (MAF), and the UNICEF Lao country office, as this country will complete a similar exercise at the end of the month.

Participants
(for full list, see Annex 2)

Participation was both physical as well as virtual. There were representatives from Government and UNICEF from Bangladesh and Laos; Teams from Indonesia and Nepal participated by Webinar teleconference.

Descriptive Agenda

Methodology
The methodology, common to each of the three assessments, was reviewed. Capacity was assessed at four levels: (i) the individual/community (examining the critical link between communities – represented often by mothers groups and village health committees – and health and social service systems), (ii) the workplace (including competencies in knowledge, skills, and attitudes required by those in nutrition related jobs), (iii) organizational (including government service delivery sectors, NGOs, educational and training institutions, and factors that enable workforce effectiveness in leadership, human and financial resource availability, management and so on), and (iv) systems (considering the broader socio-, cultural, economic and political environment that influences how nutrition capacity develops and has its operational effects.) The System level includes the legal framework (global and national) and supporting policies, as well as states’ commitments to human rights instruments: the ICESCR, CEDAW, and the CRC.
The methodology is diagrammatically represented in the accompanying figure (Figure 1) that represents an adaptation of the ecological system of social analysis as presented by Bronfenbrenner. While the assessment and analysis was organized around these four levels of function, the recommendations were divided loosely between immediate, medium-term and long-term strategies and interventions. And though each of these has a different impact horizon (i.e., short term = 2-4 year, medium term = 5 years, and long term = 10 years), the point was made that each type of strategy, regardless of their impact horizon, is to be initiated by governments at the same time if they are to be accomplished in a reasonable time.

Presentations of Findings

France Bégin, Regional Nutrition Advisor, UNICEF EAPRO, welcomed participants and reviewed the history of the cooperation between UNICEF and EU and the evolution of MYCNSIA. She also clarified two themes of the workshop: (i) Nutrition is more than food and not the responsibility of the health sector alone, and (ii) capacity building is about more than just training. She described the structure of the country assessments that examined nutrition capacities of individuals, communities, and the workforce as they existed within organizations and the overall system environment of policies and legislation. She noted that the expected outcome of the day was for agreement among participants on a common and coordinated approach to short and long term interventions, and on ways to network institutions for improved nutrition capacity.

Dr. Steve Atwood (SJA), Director, Public Health Solutions, Ltd. (PHSL) gave an overview of the assessments done by the three consultant teams from his organization: Barrie Marjettas and Roger Hughes in Indonesia; Jacky Knowles and Geoff Marks in Bangladesh; and Roger Shrimpton and Atwood in Nepal. David Sanders and John Mason provided technical advice, reviewing the overall design of the assessments and providing input to the final report. A summary of the full reports from Nepal, Bangladesh and Indonesia were presented.

For clarity, important terms to be used in each of the presentations were defined:

- **Nutrition Specific** interventions were those that lead directly to an improvement in nutritional status (e.g., breastfeeding, vitamin and mineral supplements, reduction of diseases, etc.);

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2 Full country reports and minutes from the in-country assessment presentations are available from each UNICEF country office.
Nutrition Sensitive interventions were those that had indirect effect on nutritional status by impacting on underlying and basic causes of undernutrition (e.g., keeping girls in school through secondary years to avoid adolescent pregnancies, improvements in personal and environmental hygiene through water and sanitation initiatives, etc.);

Clinical Nutrition and Dietetics were nutritional interventions focused on individuals, involving food science, etc.;

Public Health Nutrition encompassed those interventions that focused on populations, the nutritional component of public health;

Public Nutrition, which goes beyond the health sector to include nutrition sensitive as well as nutrition specific interventions that form a multisectoral approach to sustainable improved population nutrition;

Capacity defined as the ability to carry out a stated objective on population based nutrition, and

Capacity Building, the process by which individual groups, organizations and societies increase their ability to perform, solve problems, define objectives, understand and deal with development needs to achieve objectives in a sustainable manner.

Individual and community level

The need to improve capacity originates in the high prevalence of population-based nutrition problems (like stunting and anemia) that result from the public's lack of awareness about the extent and effect of these problems on children and in women of reproductive age. The general concept of nutrition is limited in most communities: nutrition is equated with food; nutrition based education is about improving the advice that can be given to individuals with clinical problems who need dietary modification to improve their conditions (e.g., diabetics, people with coronary artery disease, etc.) The concept of nutrition affecting populations is missing; nutrition being part of a population-based approach to improving health is not clearly understood. The two most important population based nutrition problems – anemia and stunting – are largely invisible in the community. Stunting is hard to see when most other children are stunted; anemia is not apparent until it is severe.

The need for greater capacity to understand and improve undernutrition originates at the community level and dictates what capacities are needed at each level that supports the community. The focus on the community is essential as this is the level where inequalities have their greatest impact, with the highest levels of undernutrition in the most vulnerable populations. Improving capacity at this level requires strengthening human resources as a component of the system that includes logistics, supervision, finances, and monitoring. Strengthening human resource capacity is a particular challenge at this level, as most community level workers are volunteers without training in nutrition. The challenge is increased when a supportive social or physical environment is missing - where logistics, infrastructure, and supervision is lacking; or where social capital is minimal.
Social capital – the social relations that have productive benefit – is known to affect nutrition. Communities with higher levels of social capital are better able to withstand economic and other shocks. The two most common types of social capital – bonding (among members of a group that is more or less homogenous) and bridging (between two dissimilar groups joined by a common cause) – could provide a structure for community empowerment, particularly around nutrition sensitive public goods like environmental improvement, educational attainment, and reduction of adolescent pregnancies. This concept not only applies to the way communities can support themselves through collaboration around common cause, but how organizations can unify to support and strengthen the efficiency and effectiveness of their programs for better outcomes. “Linking” social capital is a newer concept that represents the bond between different levels of a hierarchy – usually between government structures and the citizenry – where trust is developed in the belief that government bodies, or others in power, are actually there to help the community achieve its goals and objectives.

Evidence of empowering social capital in the communities examined was weak, though a full assessment of it may require a more in-depth investigation. Most communities were passive recipients (or non-recipients) of aid and of government services, failing to organize as claim holders of essential rights to health and food.

**Workplace level**

To improve capacity at the workplace requires the creation of suitable jobs with improved job descriptions for nutritionists. Competencies need to be defined that dictate the ability to perform a particular activity to a prescribed standard, and that reflect what people can do, and not just what they know. These competencies form an essential element of the job description and should be a part of a review system that updates them regularly. (For example, there were job descriptions in Nepal that had been in place since the 1980s without modification.) One of the key elements missing from workplaces in the three countries was adequate and supportive supervision by staff knowledgeable in nutrition. Workplace infrastructure lacked essential materials for nutritional assessments: functioning body weight and length board measures; equipment to measure Hemoglobin, etc.

**Organizational level**

Organizationally, it was clear that all three countries needed to improve national multisectoral coordination and collaboration among involved sectors. Nepal was the furthest along in having a Multisectoral Nutrition Plan (MSNP) and a multisectoral steering committee that functioned at the level of the Planning Commission; Bangladesh has a National Nutrition Council (NNC) chaired by the Prime Minister, but it hasn’t met in years; in Indonesia there is a National Food Council but it focuses on improving food security to get rid of hunger. Experience in all countries indicated that trying to create multisectoral collaboration using the authority level of a line ministry was unsuccessful.

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For intersectoral collaboration to work, authority and coordination had to exist at a level above the line ministries, preferably from the office of the Prime Minister.

In Nepal, the National Planning Commission (NPC) has announced that the MSNP is being rolled out in the next months in selected districts where the focus will be on capacity development. In Bangladesh, an exercise that mapped nutrition stakeholders identified more than 40 entities and stakeholders. And the new National Nutrition Services (NNS) launched in 2011, also involves multiple stakeholders. There is a National Food and Nutrition Commission (NFNC) in the Prime Minister’s office, but it does not meet. What coordination that does exist within sectors is not well organized or unified, and this limits its synergy. The same applies to the enormous potential workforce at the ground level. In Bangladesh, as in Nepal, there is a need for this large workforce to organize itself as a collective force alongside of but coordinated with Government. An institution like the Institute of Public Health Nutrition in Dhaka, which has the potential of being an organizing forum but is at present marginalized, could facilitate coordination at various levels.

The SUN movement pictures coordination using the organizing principle of ‘the three ones’: One national framework, One coordinating authority, and One Monitoring and Evaluation plan. None of the three countries had succeeded in developing all three.

All three countries needed to strengthen factors that would enable the development of a professional workforce in public nutrition. In the present assessment, there were no nutrition professionals in Nepal and Bangladesh working in the public sector. The large numbers of nutritionists in Indonesia (and nutrition graduates in Bangladesh) were often being used in other capacities, or had migrated to the private sector. This internal ‘brain drain’ was of concern, as was the external drain of students who had studied nutrition abroad and then been taken up by international organizations.

Planning and management were two skills that were missing at the district or equivalent administrative level above the village/community. In all countries, there is a large community workforce (with great potential capacity given training and support) that outnumbered the professional nutrition staff. This lack of a professional nutrition staff leads to a shortage of supervisors capable of monitoring and supporting the large community workforce. In each country, there is no centrally directed command line to the periphery that standardizes supervisory quality and competence. Usually, supervision of the workforce is done by staff from the next level up. The problem is that the staff from the level above does not know more about public nutrition than the level they are ‘supervising’. This unsatisfactory situation is made worse by the absence of nutrition data available for local decision-making. Even where a Health Management Information System (HMIS) exists, nutrition indicators are glaringly absent, and those that are present are related to nutrition specific problems alone (e.g., EBF rates, Vitamin A coverage). In an annual review of the health sector in Nepal, of twenty four indicators included, only two were related to undernutrition: the percent of children underweight, and the percent of diarrheal cases treated with zinc. Multi sectoral monitoring systems that would cover both nutrition specific and nutrition sensitive interventions are non-existent. As a result, most information regarding nutrition comes from national surveys (i.e., MICS, DHS) done every 3-5 years and MICS.
Most nutrition interventions in each country are specific, mostly curative, and follow the lead of the 2008 Lancet Nutrition Series (LNS), or the SUN movement. Despite a growing knowledge of the intrauterine role in stunting, there is little being done to improve maternal (let alone women’s) nutrition, with the possible exception of the Bangladesh Integrated Nutrition Program (BINP) that gives food supplements to women whose BMI is < 18.5. In general, there are few interventions for behavioral change, few functioning Baby Friendly Hospital Initiatives (or hospitals), the Code of Marketing of Breast milk Substitutes is largely ignored, there are no programs yet on overnutrition though the prevalence is increasing across the region, and there are rare examples of formal nutrition-sensitive interventions like cash-transfers.

System level

The encompassing system of broad social, cultural, economic and political influences that provides the enabling environment for nutrition capacity development includes the states’ commitments to human rights instruments especially the International Convention on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the International Convention on Civil and Political Rights (ICCPR) and the Convention of the Rights of the Child (CRC). These global conventions have enshrined the right to health and food as the responsibility of the state as duty-bearer to its citizens. However, ratification of these conventions is of little use without legal frameworks and supportive policies that must be enforced to be effective. As a reflection of national commitment to human rights, all three countries have ratified the ICESCR, CEDAW, CRC, and the ICCPR, and have incorporated into their constitutions the right to education, a healthy environment, health care, work, and social security. All are committed to achieving the MDGs with specific emphasis on MDG 1.

In Indonesia in particular and to a lesser extent in Nepal, decentralization plays a key role and offers organizational challenges to capacity development. Decentralized governance means decentralized capacity development. While administrative decentralization allows for developing area specific plans and strategies responsive to the needs of the community, it can also create fragmentation of materials and messages. It increases the workload of those involved in capacity development since a plan needs to be developed for each decentralized unit.

Academic support of public nutrition is largely missing. The existing courses are usually strongly clinical or are involved in food science and food security; the courses that come closest to preventive, population based nutrition are in ‘community nutrition’ but these are generally a few hours of instruction in a larger course. In general, there are no departments of nutrition (clinical or public) and no career tracks for those interested in an academic career in public nutrition. Furthermore, while there are accredited programs in public health, none exist for public nutrition. Accreditation of institutions, where it exists, often lies with the Ministry of Education whose responsibility it is to assure that adequate curricula are in place, and that graduates have been taught adequately.

Indonesia, however, with its long history of nutrition education, provides an exception. Professional education for nutrition is now focused in the Regional Center for Food and
Nutrition, which is part of the SEAMEO TROPMED network and offers a diploma of community nutrition, along with masters and doctoral programs. In addition, the Academy of Nutrition, which formerly offered a BSc degree in nutrition, now provides a vocational diploma. Academic programs in nutrition are accredited through the MOEC, while vocational programs are the responsibility of the MOH. These multiple offerings tend to create contested responsibilities with resulting inefficiencies, and would benefit from an integrated system with clear definition of roles and responsibilities. The result in Indonesia is that although nutrition specialists with basic training in curative and preventive nutrition are produced, their role at the lower levels of the system is not clear and as a result they are undervalued and underused. This is a common outcome where job descriptions with clear competencies and roles are lacking.

Professional associations exist in some countries that look after the interests of doctors and other professionals (i.e., employment conditions, career paths, continuing education, etc.), and there are medical councils, nursing councils, and other licensing bodies in Nepal and Bangladesh. There are, however, no independent nutrition councils\(^4\) that look after the interests of the public by guaranteeing competence of certified professionals. In most countries, the graduate diploma or certificate is used for professional accreditation. The drawback is that degrees and certificates cannot be withdrawn and, as a result, provide accreditation for life, unlike licenses that must be renewed and can be revoked for poor performance.

The system analysis goes beyond the national sphere to include regional programs and political influences. On the broadest scale, Southeast Asian states are aware of the social changes that are in store with the inauguration and opening of the ASEAN Economic Community (AEC) in 2015. As borders open, workforces will move more freely between nations, and graduation from accredited institutions with certified competencies represented by accepted licensure procedures will be the common currency. Those graduates or workforce members without either will be disadvantaged and could find themselves without jobs in the newly competitive market. From a more positive perspective, the view is that the AEC could facilitate cross-country exchanges for study and capacity building.

At present, however, regional capacity in public nutrition is limited but changing. A study done by UNICEF’s Asia-Pacific Shared Service Center (APSSC) in 2009 looked at regional capacity in nutrition and found that most programs were in food science and technology and dietetics; some with a population focus were present (as mentioned above) in community nutrition. There were many courses labeled ‘nutrition’, but their content and emphasis was unclear. And, while many regional courses offer bachelors and masters level degrees in Public Health, there were none in public nutrition or public health nutrition.

Changes are coming regionally from institutions in Thailand (i.e., Institute of Nutrition at Mahidol University [INMU]; School of Global Studies [SGS], Thammasat University), Indonesia (i.e., SEAMEO TROPMED Regional Centre for Community Nutrition, University of Indonesia), Bangladesh (i.e., Institute of Nutrition and Food Sciences, Dhaka)

\(^4\) A Nutritionists Association exists in Indonesia that provides its own professional accreditation.
University; James P. Grant School of Public Health, BRAC University) and Australia (i.e., many but particularly the community and public health nutrition field of study in the MPH program at University of Queensland).  

Recommendations

Regional recommendations are not intended to duplicate those made in individual country reports, but should focus on what is needed at the regional level to facilitate capacity development at all levels and in all countries. It was reiterated that all recommended interventions (short, medium, or long-term) should start at the same time, as shown in the accompanying figure (Figure 2).

![Figure 2: Timing of initiation of short, medium, and long-term strategies](image)

Short Term Strategies

The short-term strategies were focussed on working at the District level, but in a smaller number of selected districts where the implementation of an area-based program with full public nutrition inputs would increase capacity from individual and community level up to the system. The targeted short term public nutrition ‘workforce’ would be those already on the job, trained by ‘outsiders’ who would bring externally acquired expertise as an interim solution to the lack of in-country capacity. To support this, countries are asked to establish national multi-sectoral steering committees to bring together all Ministries involved in nutrition specific and nutrition sensitive interventions. This would facilitate an assessment of total numbers whose capacities in public nutrition needed enhancement. At the very least, this would include Ministries of Health, Education, Environment, and Agriculture. Key to the success of the area-based programme is the development of an adequate monitoring system, linked to the existing HMIS but with carefully selected nutrition indicators that could be used in local decision-making.

Initially, training of available field staff would be done by trainers affiliated with regional centres in public nutrition – through a combination of approaches that include outsourcing the trainers, and/or sending local staff abroad for training. As a means of training a large number of staff at the least amount of expense, experimentation is needed in regional distance learning linked with periodic face-to-face contacts with academic support groups in the region. Methods for standardizing curricula and

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5 Also Griffith University program in Public Health Nutrition; Deakin University, graduate certificate of Public Health Nutrition, Menzies University MPH, and the University of Sydney course in Public Health and Community Nutrition.
establishing competencies are suggested, supported by the World Public Health Nutrition Association (WPHNA).

Medium term strategies
As the interim measures above are taken, each country must simultaneously begin the process of developing its own academic capacity in public nutrition. Regionally this would mean (i) strengthening both intra- and inter-national collaboration to develop academic career paths in public health nutrition; (ii) supporting institutions in developing multi-sectoral research as well as interventions in improving public health nutrition (e.g., research in double burden, social transfer in nutrition, women’s health before pregnancy, urban agriculture, etc.); (iii) sponsoring or supporting in-country and regional conferences on multi-sectoral approaches to public health nutrition problems of significance.

To develop sustainable public health capacity in each country, countries should identify a significant group of Nutrition Officers and Medical Officers (public health and nutrition) to participate in graduate certificate programmes (~3 month duration), and a smaller group (4-5) of promising junior professionals for enrolment in selected Masters in Public health nutrition courses, preferably in the region. This should be done against a background of continuing development of distance learning models, professional councils and accreditation bodies to improve the professional credibility of each country in public nutrition, and working within regional networks to establish robust monitoring and evaluations strategies that would be more comprehensive than those in the short term.

Long term strategies
Long-term strategies require the multi-sectoral collaboration and cooperation that should be the overriding intervention started immediately. These strategies address the basic and underlying nutrition sensitive causes of malnutrition. Depending on local conditions, these would include (i) improving the entrance and retention of girls in mid- and higher secondary education; (ii) reducing teen age pregnancies; (iii) working with Ministries of Environment, Water and Sanitation to improve personal and environmental hygiene, and to be certain that open defecation is halted, and that school sanitation is guaranteed particularly at the secondary school level where it can influence girls retention; (iv) begin planning responses to increasing urbanization and consequent overnutrition; (v) examining culturally appropriate ways to improve the health and nutrition of all women – pregnant and non-pregnant – by changing the emphasis of government programs from maternal and child health (MCH) to women and child health (WCH).

These long term strategies will require policies and legislation that are nutritionally appropriate and sustainable: (i) to support the Code of Marketing of Breast Milk Substitutes, (ii) that regulate the importation of processed and calorically dense foods, (iii) that protect the poor from the effects of food price increases, (iv) that guarantee girls equal access to mandatory secondary education, (v) that protect women’s ability to exclusively breastfeed for six months by extending maternity leave with full pay.

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Finally, identify ways to put improved public nutrition on the agenda of the ASEAN Economic Community and prepare countries for the level of professionalism that will be necessary in each country that participates in the AEC.

Discussions
Participants expressed support for the "1000 days" and for reaching pregnant women as important both for the health of the mother and for the newborn. There was also support for reaching women outside the 1000 days period as it prepared them to be healthy (i.e., disease free) and well nourished as they entered pregnancy.

Participants also endorsed the need for multisectoral involvement, though how to accomplish this was a point of major discussion. Participants asked for examples of multisectoral programs, both national and regional. The problems of in-service training were discussed, in an environment without multisectoral cooperation and collaboration. Often community level staff was pulled to multiple (and sometimes similar) training by different organizations and sectors leading to redundancy and inefficiency. With coordination, common topics – even with different emphases – could be covered in the same training by a training team drawn from different sectors.

Other issues, summarized below, were raised during the country specific presentations.

Nepal Discussion
Participants acknowledged the strength of Nepal in the MSNP, and asked if recommendations and capacity gaps, which are presently very public health oriented, could be expanded to include other sectors? Can indicators for nutrition, for example, be included in the monitoring systems of other sectors? Can Agriculture Extension Workers (AEWs) be made to understand their responsibility for nutrition as well as for food?

The suggestion was made to strengthen the capacities of existing professionals by expanding their education in public nutrition rather than trying to create a nutritionist career path from scratch. In part, this could be facilitated by adding accountability for nutrition outputs to the standard job descriptions of multisectoral workers from the district level and below.

The Nepal participants (on webinar) responded by emphasizing that there is a large pool of manpower at the community level, some of them funded through outside donors (e.g., USAID, World Bank, etc.). In response to the question of whether there could be a specific government line to fund a district level nutrition officer, the MOH representative pointed out that the Ministry was working to have budget for district level staff funded and appointed from the government side, as this was seen as important for the development of district level action plans. This would include absorbing the district officer posts presently funded by outside donors.

There was also a generic request that the training needs of each country be aggregated so that the requirements for regional courses and support, could be calculated and developed.
Bangladesh Discussion

The government had planned since 1997 to have a nutrition officer posted in every Upazila, but to date these posts remain vacant. This is for many reasons: (i) because these services were contracted out to NGOs, (ii) because it was difficult to make an argument to the Ministry of Finance under pressure to ‘trim the workforce’ for more positions. The presence of these vacant positions argues against pushing for additional staff, but argues for ‘capacitating’ existing staff to improve their nutrition competencies and fill the space required for nutritional improvements. The Bangladesh team noted that it was not always technical skills lacking in these staff members, but communication and advocacy capabilities to convince local leaders about the importance of public nutrition.

There remains a strong commitment from Development Partners and the Government to have a nutritionist in every district, though if this was enacted immediately, the human resources would not be found to staff those positions. There remains a poor understanding of the role such public nutritionists would play. The fear is that within days, they would be assigned to kitchens in hospitals, preparing diets and counselling individuals, because at present there is no notion of nutritionists being on the same level as doctors, nurses, or even agriculturalists with regard to public nutrition. Furthermore, personnel in high-level positions in the MOH are required to have MDs, which, since unnecessary for this role acts as a barrier to appropriate recruitment. As nutrition becomes mainstreamed within the government (as it evolves from a parallel system), there has been the beginning of interagency and intersectoral agreement among NGOs and other actors on indicators that will be included in the MIS, plus the health sector has agreed on common goals and interventions. Progress is being made, but more coordination is needed.

Considerable work is done in Bangladesh by the NGO community, which is seen as a very positive development as long as the system could be strengthened to absorb staff trained by the NGOs when they leave or finish funding a project. At present, it was observed that there are so many ‘trainings’ going on that staff are pulled from their posts and do not have time to apply what they are learning. Multi-sectoral approaches – as a theme – are needed.

The JP Grant School of Public Health (JPGSPH) at BRAC has an MPH program that trains students in problem solving using case studies that demonstrate a multi-sectoral approach. For nutrition, they encourage graduates to go and work for at least six months ‘on the front lines’. They are also promoting the development of joint resources whereby Bangladesh can use the considerable potential regionally and globally for joint training (e.g., public sourced distance learning).

Indonesia discussion

Building on the lessons of ‘multisectorality’ from Nepal, and ‘working with NGOs’ from Bangladesh, Indonesia presents an example of a country with a nutrition workforce operating in a highly decentralized administrative environment. Indonesia has decentralized down to the District level (rather than only to the Provincial level), which makes it an example of increased accountability to local communities, but with challenges around assessing competencies and skills in the absence of a standard
measure applied to each district. A problem with the complex decentralization model in Indonesia is the disconnect between planning and budgeting processes from the national to the provincial and then to the district level. With a country as diverse as Indonesia, local area programming seems to be genuinely needed. There is an enormous workforce of 15,000 nutrition officers (however, not enormous given the population and geographic size of Indonesia) operating at District level and below but without a clearly defined role. Indonesia also has the potential of using the mothers’ groups in its Posyandu system, though they are generally passive in their roles, and lacking full empowerment to change nutritional practices.

The team from Indonesia clarified issues about the roles and training of the 15,000 nutritionists in Indonesia. In fact, the challenge of Indonesia is that there are nutritionists, but they may not be serving the function intended for them. Although some believe that there is sufficient training of nutritionists on preventive nutrition, the graduates of the training programs often end up in clinical settings. Most nutritionists only provide services at the health centres, rather than serving in an advisory or supervisory role. The real need, members of the Indonesia team stressed, was for a nutrition focal point at the community level where they could interact with mothers. However, since the ratio of Posyandu to trained nutrition specialists is so high, the latter serve better in an advisory role. In the present situation without a clearly defined role, they often do not have full time work as nutrition advisors at the health centre, and get pulled instead into administrative tasks unrelated to their primary responsibilities.

Decentralization plays a key role as well. When the number of nutritionists is broken down across populations in 500 districts, there are approximately 500 under five year old children per nutritionist. This has led support to the idea of working first within a smaller number of selected districts in order to get job descriptions, accountabilities, capacity needs of all workers in these districts is important. This should be done before there is any advocacy for new ‘public health nutrition’ positions, since it might make more sense to see how to strengthen the existing nutrition positions before moving ahead.

Training in this decentralized environment of Indonesia starts at the central and provincial level where the Training of Trainers occurs. The budgeting process, however, has to be adapted to ensure that trainings will happen in all districts. Supervision tools are developed at the central level, but implemented by district nutritionists who are responsible for supervising the lower level nutritionists and midwives; the latter supervise the community level workers. Other sector involvement may start with the AEWs (who were part of a highly developed system of community support in the past) brought into the nutrition training once the SUN is signed into effect.

From the recommendations, it was clear that interventions had to be started from the bottom up. And even in Indonesia, the question of ‘what is a nutritionist?’ still needs answering with clarity to define the difference between population vs. individual roles and responsibilities.
Other Presentations

Menzies School of Health Research: Report on mapping of nutrition capacity development in the region

Heather Grieve and Jennifer Busch-Hallen from Menzies emphasised that the mapping exercise completed in 2012 was not conducted as a research activity, but intended to identify gaps in a very wide geographical area (i.e., 30 countries across Asia and the Pacific). One focus of their presentation and supported by a policy brief written in response to the findings was on the unique capacity issues identified in Pacific Island Countries (PICs) where the double burden of malnutrition is an ongoing issue. Eg 7 PICs have adult obesity levels of more than 80% They reported that 17 PICS had current plans for non-communicable diseases, but only three had current nutrition plans. Pre-service training is only available in Fiji, with a focus on clinical dietetics. Because of the extent and spread of the region, it was difficult to assess current in-service training opportunities, except that most were offered regionally, requiring expensive and often time consuming travel for most participants or offered asE-learning, which might be relevant in other areas of the world, but is is limited by poor connectivity and ongoing support and mentoring in PICs. In addition, staff (trained and un-trained) are often absent as they need to move out of the region to attend courses or degrees.

Nutrition policies, strategies and plans appear to more current in Asia than in the Pacific, with most plans focused on the obvious issue of undernutrition Pre-service training opportunities are similar to those presented in the earlier presentations. In-service training often employs a ‘cascade’ approach, which, by the time it reaches community level workers, the quality of the training content is unknown.

Discussion on the Menzies presentation

Training in the region is not only hampered by the lack of supervision, but also (with an example from Cambodia) from a lack of teachers particularly at the Masters level. Sufficient resources are not available for travel expenses, lodging, etc., even when there is an acceptance of Asian levels of academic remuneration or honorarium.

An important observation reflected the major problem of developing capacity in a region like the Pacific: where populations are so scattered and population density so low, it is difficult to develop the number of skilled and educated nutritionists who could provide service to those vast under-populated and inaccessible areas. It was noted, however, that even some small nations (e.g., Palau) were doing better in terms of systems and indicators, not just those nations associated with New Zealand or Australia.

The growing pandemic of obesity is most obvious in the Pacific. The question was raised about trend data and the ability to identify a ‘tipping point’ where rates of overweight started to soar. Could a study of these trends give some predictive information to other countries as to how fast the pandemic was likely to spread, in order to increase the accuracy of future plans? Further to this, attention was drawn to a 2010 Food and Nutrition Summit in the Pacific that looked at how to work cross-sectorally with Trade, Fisheries, and Agriculture to ensure that the tracking of NCDs, overnutrition and
undernutrition was made more efficient. More needs to be done to alert governments to the risks and the costs of the double burden.

One participant noted that ‘Capacity building’ may not be the correct terminology, since a lot of capacity already exists. Participants agreed that the baseline today was not ‘starting from scratch’. There was reiteration that advocacy and communication should be strengthened to make sure there is recognition of the need for capacity development at the highest level. For coordination, it is encouraging to look at South-South collaboration, noting that there will be a second high-level meeting on South-South in India in October 2013. Can nutrition be put on the agenda of this meeting? Finally, more use should be made of trend analyses to uncover inequalities that can grow as the gap between rich and poor increases despite improvements in national economies. Inequalities will not be addressed without better data that can be used at the local level for decision-making.

**Capacity Building and the SUN movement**

Dr. Emorn Wasantwisut, from the Institution of Nutrition at Mahidol University (INMU) presented an update on capacity development in the SUN movement. The major point made was that, until the present, the development community has been very supply driven for capacity development. While there have been very good training programs, they may not be well attended since they do not serve the needs of the staff targeted: “I cannot use it now”, “I have no system to get the data I need”, “I am the only staff person, how can I leave for training,” etc. The SUN Movement hopes to shift training to a demand driven model, helping member countries identify their needs and then designing a capacity development model that will meet those needs. It wasn’t clear who in SUN was responsible for Capacity Development as a crosscutting issue. The concern was that if everyone is accountable, no one is accountable. The answer: Capacity Development is housed under the SUN Secretariat, so by definition David Nabarro is responsible. REACH is also involved in helping countries identify needs; capacity development cannot be driven from the national level but must evolve from the community.

It was clarified that SUN does not provide financial resources – it leverages resources from the donor network.

It was suggested that the goal be to do the minimum necessary to strengthen capacity in order to stay within available resource constraints. Perhaps Masters level programs are not needed; community level skills can be developed through local capacity development. (Although it was not clear who would train those community level workers without a training force of well-educated and skilled people.) Consideration should also be given to the ‘next generation’ – responding to the long-term intervention of improving the education of primary and secondary school children in public nutrition.
Panel Discussion: Feedback from Capacity Developing Institutions

There were to be two panel discussions: one on Feedback from Capacity Developing Institutions involving academicians participating in the workshop, and one on A regional approach to developing capacity in public nutrition that was to involve all stakeholders from agencies and donor organizations. Because of the active participation of the group (and despite the fact that discussions continued until late in the day), there was inadequate time for the second panel discussion of stakeholders.

The participants in the first panel had been given a list of questions to consider prior to the day's conference. Those questions included the following:

1. As most reports indicate an acceptance of a multi-sectoral approach to the problem of public nutrition, it is important to strategize about how this can be done, particularly in an academic or institutional environment. What do you see as the issues related to linking public nutrition topics with faculties, departments, or sectors other than your own?

2. There is also recognition that in many countries, the capacity to train public health nutritionists will require outsourcing initially, since in-country capacity may not yet exist to do this. This may mean bringing together a number of training and higher educational institutions in the region to provide necessary training of national staff in order to prepare them for work back in their own countries. This raises a number of questions: (a) Do you think it is possible to develop a regional network of educational and academic institutions around public nutrition education, where curriculum, courses and methods could be discussed and standardized so as to provide consistent training throughout the region? How would you see this happening? (b) At present, capacity does
not seem to be there for the sheer numbers of persons that need to be trained. How would you go about increasing that capacity?

3. In the country assessments, there seemed to be some confusion at the academic level with the difference between clinical (i.e., individual focussed) nutrition, and public health (i.e., population based) nutrition. In fact, in most cases, when nutrition was discussed, people immediately talked about food. How would you go about changing those widely held perceptions?

Because of time, the group was asked to respond to one of the questions: (2a) Do you think it is possible to develop a regional network of educational and academic institutions around public nutrition education, where curriculum, courses and methods could be discussed and standardized so as to provide consistent training throughout the region? How would you see this happening?

There was general support for such a regional network, as the problems and aspirations of the countries in the region were similar so each could be well served by such a function. However, there were many specific questions raised that panellists felt would need to be answered in advance of establishing a network. For example, (i) Who would be trained in this network, and for what purpose? (ii) Would it be a post-graduate level of training, or aimed at front-line workers? (Do academic institutions have any role in training at the community level?) (iii) What methodologies would be advocated, and would they be consistent across the network? (iv) Who would finance the trainees’ participation? (v) Developing curriculum is hard work and takes time and finances, who would be tasked with doing this? Would it involve each member of the network? (vi) Who would do the training? How could their capacities be standardized and monitored? (vii) Does the network have to present a unified offering, or can we acknowledge the differences between programs and actually build on those differences and use them appropriately across institutions? (viii) Is the desire to work together ultimately subverted by the desire to do good business, which creates a competitive rather than a collaborative atmosphere?

There was no overall consensus on answers to these questions or on the details of how such a network would function. There was some degree of agreement around the following ideas, which are offered as suggestions for the way forward:

- At present, the group does not feel that developing a new curriculum around Public Nutrition is practical, but would prefer to look at enriching curricula that already exist. This could be done by reviewing contents and methods used in various institutions in the region. Those that are relevant could be chosen for adaptation to a particular task.

- It will be useful to use Regional Structures (e.g., ASEAN, SAARC, the Secretariat of the Pacific Community [SPC]) as a basis for coordination and collaboration, as these bodies are created to facilitate the same. The opening of the AEC may be a powerful tool in encouraging governments to develop accreditation and certification bodies, and to standardize job descriptions and competencies in public nutrition.
Short courses offered by regional institutions may be more practical than developing longer, diploma level courses. It would be wise to coordinate the offerings from individual institutions in order to avoid redundancy. However, it may be necessary to offer the same courses in some areas (and on some topics) in order to meet the large demand from the region.

Joint courses are another possibility, with student exchanges between institutions with different strengths.

It will be important to answer the question about who is to be trained. The distinct difference of opinion about the role of the academic institution in training community level workers vs training future leaders in public nutrition needs resolving.

There must be a systematic approach to this that may require the formation of a working group that can advise regarding the optimal use of existing resources: institutional, human resources, and financial. Harmonizing curricula to meet the demands of the countries will require more than one academic institution. We must review how we can cover the vast needs in the region.

Further work is needed in optimum use of distance learning as recommended in the day's presentations. This may offer a solution that is efficient, inexpensive, and open to quality standardization without underestimating the challenges of connectivity and language.

Conclusions

There was a general sense of urgency to get started. Participants were worried that the interest in nutrition may last only for 2-3 years, particularly if no progress was made. The capacity assessment presented in this conference defined the needs in the three countries, and is the first step in a deliberate process to establish a regional approach for capacity development. The next step urgently needed is to dedicate the same degree of analysis and intensity to developing a regional approach that will (i) include local, national and regional interventions, (ii) identify modalities, venues, and human resources capable of providing high quality capacity development, (iii) answer financial questions about paying for capacity development, and (iv) support the implementation of the recommendations (short-, medium-, and long-term) from the capacity needs assessment that include the following:

Short Term Strategies (impact in 2-3 years)

1. **Work with country level staff in each country to identify suitable districts for full implementation of public health nutrition inputs required for short term improvements in selected nutrition indicators. (area based programming)**
   a. Assess available curricula and on-going training plans, before developing new plans for in-service training in public health nutrition linking all relevant sectors
b. Examine the existing HMIS systems for ways to include nutrition-specific/sensitive indicators for use in local decision-making.

c. Work with partners in other sectoral agencies to review and revise job descriptions initially at community level, subsequently at higher levels and across sectors

Establishing multi-sectoral steering committees at national level and local levels

2. **Provide transitional public health nutrition support for capacity development to each country and District.**

   a. Identify a roster of institutions and work with Regional academic institutions to develop a master plan for capacity development

   b. Work with National, INGOs to develop National NGO Nutrition Network to standardise training curricula, and monitoring indicators for use across many organizations/sectors.

   c. Develop an inter-institutional working group (the WPHNA could support) that will standardize curricula and competencies, and define a means of assessing the quality of training

   d. Support development of regional distance learning for District Public Health Nutrition Officers, linked to two weeks of episodic face-to-face contact with their academic support in nutrition.

**Medium Term Strategies (impact in 4-6 years)**

1. **Begin process of in-country Academic capacity development**

   a. Strengthen intra- and inter-national collaboration using international models from other specialties to develop academic career paths in public health nutrition.

   b. Support institutions in multi-sectoral research into innovative approaches to improve public health nutrition (e.g., research in double burden, social transfer in nutrition, women’s health before pregnancy, urban agriculture, etc.)

   c. Sponsor or support in-country and regional conferences on multi-sectoral approaches to public health nutrition problems of significance.

2. **Develop sustainable public health nutrition capacity in country**

   a. Identify a significant group of Nutrition Officers and Medical Officers (public health and nutrition) from each country to participate in regional graduate certificate programmes (3 mo)

   b. Identify a smaller group (4-5) of promising junior professionals for enrolment in selected Masters in Public health nutrition courses, preferably in the region

   c. Work with countries’ ministries of health and education as appropriate to develop professional associations that can advocate for public health nutrition staff, and professional councils that can provide professional certification of public health nutritionists, and accredit academic
programs.

d. Using regional networks (e.g., institutional working group, SEAMEO, etc.), establish a robust monitoring and evaluation strategy

**Long Term Strategies (impact in 7-10 years)**

1. **Focus on nutrition sensitive interventions that will profoundly effect reduction in malnutrition in a sustainable way.**
   a. MoE to improve entrance and retention of girls in mid-, higher secondary education
   b. Focus on reducing teen-age pregnancies
   c. Work with MoEWS to improve personal and environmental hygiene
   d. Begin planning responses to prevent overnutrition
   e. Examine culturally appropriate ways to improve health and nutrition of pregnant and pre-pregnant women

2. **At policy level, begin the process of developing nutrition appropriate policies and legislation.**
   a. Policies to strengthen the code
   b. Policies that restrict importation of processed foods
   c. Policies that protect the poor from the effects of food price increases

3. **Develop regional networks for future support to other Asian countries**
   a. Identify liaisons within ASEAN for integration of improved public nutrition as an objective of the upcoming ASEAN Economic Community.
   b. Work with other Regional networks (e.g., like SEAMEO TROPED) to develop standardized approaches to public nutrition capacity development that can be modified according to individual country situations.

The final recommendation from the day’s workshop was to develop a small working group that can start reviewing available well-designed short courses, and developing a regional approach as a necessary step to move things forward.
## Annex 1: Workshop Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Method</th>
<th>Presenter/Facilitator</th>
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<tbody>
<tr>
<td>8.15</td>
<td>Registration</td>
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<tr>
<td>8.30</td>
<td>Welcome and introduction</td>
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<td>UNICEF</td>
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<tr>
<td>8.45</td>
<td>Introduction to the project: vision and objectives. What the results are intended for.</td>
<td>Presentation with slides</td>
<td>France Begin [FB]</td>
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<tr>
<td>9.00</td>
<td>Overview of the results: regional findings, implications, patterns, trends, etc.</td>
<td>Presentation with slides, followed by Q&amp;A</td>
<td>Stephen Atwood [SJA] FB to chair.</td>
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<td>10.00</td>
<td>Tea break</td>
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<tr>
<td>10.30</td>
<td>Nepal: Country level findings with Q&amp;A</td>
<td>Presentation with slides</td>
<td>SJA</td>
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<td></td>
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<td>Country Panel</td>
<td>UNICEF Nepal &amp; GoN representative (to join remotely)</td>
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<tr>
<td>11.15</td>
<td>Bangladesh: Country level findings with Q&amp;A</td>
<td>Presentation with slides</td>
<td>SJA</td>
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<td>Country Panel</td>
<td>UNICEF Bangladesh Univ. of Dhaka &amp; James P. Grant School of Public Health, BRAC Univ</td>
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<td>12.00</td>
<td><strong>LUNCH BREAK</strong></td>
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<tr>
<td>13.00</td>
<td>Report on mapping of Capacity development institutions in the region</td>
<td>Presentation with slides</td>
<td>Menzies School of Health Research</td>
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<td>13.30</td>
<td>Indonesia: country level findings with Q&amp;A</td>
<td>Presentation with slides</td>
<td>SJA/Roger Shrimpton [RS] by remote UNICEF Indonesia, Public Health Nut Dept., SEAMEO</td>
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<td>Country Panel</td>
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<td>14.15</td>
<td>Feedback from capacity development institutions</td>
<td>Panel of faculty from various regional institutions</td>
<td>SJA /RS by remote Representatives from academic institutions</td>
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<td>15.15</td>
<td>Tea Break</td>
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<tr>
<td>15.30</td>
<td>Capacity building and the SUN movement</td>
<td>Presentation with slides</td>
<td>Emorn Wasantwisut</td>
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<tr>
<td>16.00</td>
<td>A regional approach to developing capacity in public nutrition</td>
<td>Stakeholders panel</td>
<td>SJA: Session Cancelled due to lack of time.</td>
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<tr>
<td>17.00</td>
<td>Next steps: actions, resource requirements</td>
<td>Open group discussion</td>
<td>FB /SJA</td>
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<tr>
<td>17.30</td>
<td>Close</td>
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