ANALYSIS & PERSPECTIVE: 15 YEARS OF EXPERIENCE IN THE DEVELOPMENT OF NUTRITION POLICY IN SENEGAL

Evolution of Nutrition Policy in Senegal

Andrea L. Spray

Cellule de Lutte contre la Malnutrition

WORLD BANK GROUP

Evolution of Nutrition Policy in Senegal

June 2018

Andrea L. Spray

Analysis & Perspective: 15 Years of Experience in the Development of Nutrition Policy in Senegal

Cellule de Lutte contre la Malnutrition

1818 H Street NW, Washington, DC 20433
Telephone: 202-473-1000; Internet: www.worldbank.org

Cover photo: Adama Cissé/CLM

Cover design: The Word Express, Inc.

Acknowledgments

This report was written by Andrea L. Spray, Nutrition Consultant with the World Bank. Special appreciation goes to Dr Guelaye Sall (Professor of Pediatrics, University of Dakar) for his early draft on which this report is largely based. The author is greatly indebted to the authors and curators of the many historical documents that have chronicled Senegal's fight against malnutrition over time and through its various stages.

Reviewers. We are grateful to all reviewers of the reports of the series—Elodie Becquey (IFPRI), Patrick Eozenou (World Bank), Dominic Haazen (World Bank), Derek Headey (IFPRI), Abdoulaye Ka (CLM), Jakub Kakietek (World Bank), Ashi Kohli Kathuria (World Bank), Christine Lao Pena (World Bank), Biram Ndiaye (UNICEF), Jumana Qamruddin (World Bank), Claudia Rokx (World Bank). They each generously dedicated their time and effort, and their invaluable input played an important role in the evolution of the series.

Partners. We would also like to give thanks to the following members of the task force of development partner organizations, who provided guidance on the conceptualization, implementation and finalization of the series: Sophie Cowpplibony (REACH), Aissatou Dioum (UNICEF), George Fom Ameh (UNICEF), Julie Desloges (Government of Canada), Aida Gadiaga (WFP), Laylee Moshiri (UNICEF), Aminata Ndiaye (Government of Canada), Marie Solange N'Dione (Consultant), and Victoria Wise (REACH).

Client. Finally, our greatest appreciation is extended to the dedicated staff of the CLM, whose work is chronicled in the series, and the thousands of health workers and volunteers who are daily delivering life-saving nutrition services to vulnerable populations throughout Senegal.

This work was conducted under the guidance of Menno Mulder-Sibanda (Task Team Lead and Senior Nutrition Specialist, World Bank). The series was prepared by a team led by Andrea L. Spray (Consultant). Aaron Buchsbaum (World Bank) supported publishing and dissemination, along with Janice Meerman (Consultant) and Laura Figazzolo (Consultant). Information regarding the financial support for the series is provided at the end of the report.

About the Series

The government of Senegal, through the Cellule de Lutte contre la Malnutrition (Nutrition Coordination Unit) (CLM) in the Prime Minister's Office is embarking on the development of a new Plan Stratégique Multisectoriel de Nutrition (Multisectoral Strategic Nutrition Plan) (PSMN), which will have two broad focus areas: (1) expanding and improving nutrition services; and (2) a reform agenda for the sector. The reform agenda will include policy reorientation, governance, and financing of the PSMN. The PSMN will discuss the framework and timeline for the development of a nutrition financing strategy, which will require specific analysis of the sector spending and financial basis, linking it to the coverage and quality of nutrition services.

Senegal is known for having one of the most effective and far-reaching nutrition service delivery systems in Africa. Chronic malnutrition has dropped to less than 20 percent, one of the lowest in continental Sub-Saharan Africa. Government ownership of the nutrition program has grown from US$0.3 million a year in 2002 to US$5.7 million a year in 2015, increasing from approximately 0.02 percent to 0.12 percent of the national budget. Yet, these developments have not led to enhanced visibility of nutrition-sensitive interventions in relevant sectors such as agriculture, education, water and sanitation, social protection, and health. The absence of nutrition-sensitive interventions in the relevant sectors, combined with the recent series of external shocks, has favored continued fragmentation of approaches, discourse, and interventions that address nutrition. In addition, there is no overall framework for investment decision making around nutrition, which puts achievements made to date in jeopardy. Meanwhile, nutrition indicators are stagnating and other issues with major implications (such as low birth weight, iron deficiency anemia, maternal undernutrition, and acute malnutrition) have received little or no attention.

A review of policy effectiveness can help raise the importance of these issues, including household and community resilience to food and nutrition insecurity shocks, as a new priority in nutrition policy development. This series of analytical and advisory activities, collectively entitled *Analysis & Perspective: 15 Years of Experience in the Development of Nutrition Policy in Senegal* ("the series"), aims to support the government of Senegal in providing policy and strategic leadership for nutrition. Further, the series will inform an investment case for nutrition (*The Case for Investment in Nutrition in Senegal*) that will: (1) rationalize the use of resources for cost-effective interventions; (2) mobilize actors and resources; (3) strengthen the visibility of nutrition interventions in different sectors; and (4) favor synergy of interventions and investments.

The series was produced with guidance from a task force of development partner organizations under the leadership of the World Bank, and in close collaboration with the CLM. The task force comprised representatives from the following organizations: Government of Canada, REACH, UNICEF and the World Bank.

Documents in the series:

Report	Description
Nutrition Situation in Senegal *Marc Nene*	An analysis of the nutritional status of key demographic groups in Senegal, including the geographic and sociodemographic inequalities in nutrition outcomes and their determinants.
Evolution of Nutrition Policy in Senegal *Andrea L. Spray*	An historical analysis of the nutrition policy landscape in Senegal, including the evolution of nutrition policies and institutions and their respective implications for programming and prioritization of interventions.
Political Economy of Nutrition Policy in Senegal *Ashley M. Fox*	An analysis of the policy and political levers that can be used in Senegal to foster government leadership and galvanize the intersectoral coordination needed to mainstream nutrition into government policies and programs, and effectively, efficiently, and sustainably deliver nutrition interventions.
Nutrition Financing in Senegal *Marie-Jeanne Offosse N.*	An analysis of the allocated funding to nutrition interventions in Senegal from 2016 to 2019, estimates of budgetary capacity for financing nutrition by government, and estimated costs for selected high-impact interventions.
Capacities of the Nutrition Sector in Senegal *Gabriel Deussom N., Victoria Wise, Marie Solange Ndione, Aida Gadiaga*	An analysis of the organizational and institutional capacities for addressing nutrition in Senegal, covering the CLM, key ministries, and other stakeholders contributing to improvements in nutrition at the central, regional, and local levels.
Cost and Benefits of Scaling Up Nutrition Interventions in Senegal *Christian Yao*	Analysis of the relative costs and effectiveness of alternative scenarios for scaling up nutrition interventions in Senegal over the five years covering the PSMN.
Risks for Scaling Up Nutrition in Senegal *Babacar Ba*	Analysis of the potential risks to the scale-up of nutrition in Senegal, their likelihood of occurrence, potential impact, and potential mitigation measures.
A Decade of World Bank Support to Senegal's Nutrition Program *Denise Vaillancourt*	The World Bank Independent Evaluation Group Project Performance Assessment Report, which evaluates the extent to which World Bank operations supporting nutrition in Senegal from 2002–14 achieved their intended outcomes and draws lessons to inform future investments.

Acronyms

Acronym	English	Acronyme	Français
AEC	Community Executing Agency	AEC	Agence d'Exécution Communautaire
AEN	Essential Nutrition Actions	AEN	Actions Essentielles en Nutrition
AGETIP	Executing Agency for Public Works and Employment	AGETIP	Agence d'Exécution des Travaux d'Intérêt Public
AGIR	Global Alliance for Resilience (AGIR)—Sahel and West Africa	AGIR	Alliance Globale pour la Résilience (AGIR)—Sahel et Afrique de l'Ouest
BANAS	Office for Food and Applied Nutrition in Senegal	BANAS	Bureau National d'Alimentation et de la Nutrition Appliquée au Sénégal
BCC	Behavior Change Communication	CCC	Communication de Changement de Comportement
BEN	National Executive Bureau	BEN	Bureau Exécutif National
BER	Regional Executive Office	BER	Bureau Exécutif Régional
CANAS	Committee of Food and Nutritional Analysis in Senegal	CANAS	Comité d'Analyse Nutritionnelle et Alimentaire au Sénégal
CIFF	Children's Investment Fund Foundation	CIFF	Fondation du Fonds d'Investissement pour l'Enfance
CLM	Nutrition Coordination Unit	CLM	Cellule de Lutte contre la Malnutrition
CMAM	Community Management of Acute Malnutrition	PCMA	Prise en Charge Communautaire de la Malnutrition Aiguë
CNLM	National Committee for the Fight Against Malnutrition	CNLM	Commission Nationale de Lutte contre la Malnutrition
CNSA	National Food Security Council	CNSA	Conseil National sur la Sécurité Alimentaire
COSFAM	Senegalese Committee for Food Fortification	COSFAM	Comité Sénégalais pour la Fortification des Aliments en Micronutriments
CREN	Center of Recovery and Nutritional Education	CREN	Centre de Récupération et d'Education Nutritionnelle
CRS	Catholic Relief Services	CRS	Catholic Relief Services
CTC	Community Therapeutic Care	STC	Soins Thérapeutiques Communautaires

Acronym	English	Acronyme	Français
CTIUS	Technical Committee for Universal Salt Iodization	CTIUS	Comité Technique pour l'Iodation Universelle du Sel
DAN	Division of Food and Nutrition	DAN	Division de l'Alimentation et de la Nutrition
DANSE	Division of Food, Nutrition and Child Survival	DANSE	Division de l'Alimentation de la Nutrition et de la Survie de l'Enfant
DBM	Double Burden of Malnutrition	DFM	Double Fardeau de la Malnutrition
DHS	Demographic and Health Survey	EDS	Enquête sur la Démographique et la Santé
DPNDN	National Policy for the Development of Nutrition	DPNDN	Document de Politique Nationale de Développement de la Nutrition
DSE	Division of Child Survival	DSE	Division de la Survie de l'Enfant
DSRP	Poverty Reduction Strategy Paper	DSRP	Document de Stratégie de Réduction de la Pauvreté
ECD	Early Childhood Development	DPE	Développement de la Petite Enfance
FAO	Food and Agriculture Organization of the United Nations	FAO	Organisation des Nations Unies pour l'Alimentation et l'Agriculture
GAIN	Global Alliance for Improved Nutrition	GAIN	Alliance mondiale pour l'amélioration de la nutrition
GDP	Gross domestic product	PIB	Produit Intérieur Brut
GIE	Microenterprises	GIE	Groupement d'Intérêt Economique
GNP	Gross national product	PNB	Produit National Brut
HKI	Helen Keller International	HKI	Helen Keller International
ICN	International Conference on Nutrition	CIN	Conférence Internationale sur la Nutrition
ICN2	Second International Conference on Nutrition	CIN2	Deuxième Conférence Internationale sur la Nutrition
IDD	Iodine Deficiency Disorder	IDD	Troubles liés à la carence en iode
IEC	Information, Education and Communication	EIC	Education, Information et Communication
IFPRI	International Food Policy Research Institute	IFPRI	Institut international de recherche sur les politiques alimentaires

Acronym	English	Acronyme	Français
ILO	International Labor Organization	OIT	Organisation Internationale du Travail
IMF	International Monetary Fund	FMI	Fonds Monétaire International
ITA	Food Technology Institute	ITA	Institut de Technologie Alimentaire
LPDN	Nutrition Policy Letter	LPDN	Lettre de Politique de Developpement de la Nutrition
MDG	Millennium Development Goals	OMD	Objectifs du Millénaire pour le Développement
MI	Micronutrient Initiative	MI	Micronutrient Initiative
NASAN	New Alliance for Food Security and Nutrition	NASAN	Nouvelle Alliance pour la Sécurité Alimentaire et Nutritionnelle
NEPAD	New Partnership for Africa's Development	NEPAD	Nouveau Partenariat pour le Développement de l'Afrique
NESA	Child Food and Nutrition Security	NESA	Nutrition Enfant et Sécurité Alimentaire
NETS	Child Targeted Nutrition and Social Transfers	NETS	Nutrition Ciblée sur l'Enfant et les Transferts Sociaux
NGO	Nongovernmental Organization	ONG	Organisation Nongouvernementale
OCCGE	Coordination and Cooperation Organization for the Control of the Major Endemic Diseases	OCCGE	Organisation de Coordination et de Coopération pour La Lutte contre les Grandes Endémies
ORANA	Research Organization for Food and Nutrition in Africa	ORANA	Office de Recherches sur l'Alimentation et la Nutrition Africaine
ORSTOM	Office for Scientific and Technical Research Overseas	ORSTOM	Office de la Recherche Scientifique et Technique Outre-Mer
PAIN	Package of Integrated Nutrition Actions	PAIN	Paquet d'Activités Intégrées de Nutrition
PASAV	Food Security Support for Vulnerable Households Project	PASAV	Projet d'Appui à la Sécurité Alimentaire des Ménages Vulnérables
PCIME	Integrated Management of Childhood Illness	PCIME	Prise en Charge Intégrée des Maladies de l'Enfant
PCIME-C	Community Integrated Management of Childhood Illnesses	PCIME-C	Prise en Charge Intégrée des Maladies de l'Enfant Communautaire
PDC	Communal Development Plan	PDC	Plan de Développement Communal

Acronym	English	Acronyme	Français
PDEF	Ten-Year Education and Training Program	PDEF	Programme Décennal de l'Education et de la Formation
PECMA	Community Management of Acute Malnutrition	PECMA	Prise en Charge Communautaire de la Malnutrition Aiguë
PINKK	Integrated Nutrition Project in Kolda and Kédégou Regions	PINKK	Projet Intégré de Nutrition dans les Régions de Kolda et de Kédougou
PIUS	Universal Salt Iodization Program	PIUS	Programme d'Iodation Universelle du Sel
PLW	Pregnant and Lactating Women	FEA	Femmes Enceintes et Allaitantes
PNC	Community Nutrition Project	PNC	Projet de Nutrition Communautaire
PNDL	National Program for Local Development	PNDL	Programme National de Développement Local
PNDS	National Health Development Plan	PNDS	Plan National Développement Sanitaire et Social
PNIA	National Agriculture Investment Program	PNIA	Programme National d'Investissement Agricole
PNSE	Child Survival Strategic Plan	PNSE	Plan National de Survie de l'Enfant
PPNS	Nutrition and Health Protection Program	PPNS	Programme de Protection Nutritionnelle et Sanitaire
PQDES	Quadrennial Economic and Social Development Plan	PQDES	Plan Quadriennal de Développement Economique et Social
PODES	Policy Plan for Economic and Social Development	PODES	Plan d'Orientation pour le Développement Economic et Social
PRF	Program for the Enhancement of Fortification	PRF	Programme de Renforcement de la Fortification
PRN	Nutrition Enhancement Program	PRN	Programme de Renforcement de la Nutrition
PSD-CMU	Health Coverage Strategic Plan	PSD-CMU	Plan Stratégique de Développement de la Couverture Maladie
PSMI/PF	Maternal and Child Health and Family Planning Program	PSMI/PF	Programme de Santé Maternelle et Infantile et de Planification Familiale
PSMN	Multisectoral Strategic Nutrition Plan	PSMN	Plan Stratégique Multisectoriel de la Nutrition
SAM	Severe Acute Malnutrition	MAS	Malnutrition Aiguë Sévère

Acronym	English	Acronyme	Français
SANAS	Nutrition and Food Service of Senegal	SANAS	Service de l'Alimentation et de la Nutrition Appliquée du Sénégal
SBCC	Social Behavior Change Communication	CCCS	Communication pour le Changement de Comportement Social
SDG	Sustainable Development Goals	ODD	Objectifs de Développement Durable
SMART Survey	Standardized Monitoring and Assessment of Relief and Transitions Survey	Enquêtes SMART	Enquêtes Suivi et évaluation Standardisés des Urgences et Transitions
SNAN	National Service of Food and Nutrition	SNAN	Service National de l'Alimentation et de la Nutrition
SUN	Scaling Up Nutrition Movement	SUN	Mouvement pour le Renforcement de la Nutrition
UNDP	United Nations Development Programme	PNUD	Programme des Nations Unies pour le Développement
UNESCO	United Nations Educational, Scientific and Cultural Organization	UNESCO	Organisation des Nations Unies pour l'Education, la Science et la Culture
UNICEF	United Nations Children's Fund	UNICEF	Fonds des Nations Unies pour l'enfance
URO-CREN	Oral Rehydration Unit—Center of Recovery and Nutritional Education	URO-CREN	Unité de Réhydratation Orale—Centre de Récupération et d'Education Nutritionnelle
USAID	United States Agency for International Development	USAID	Agence des États-Unis pour le Développement International
USI	Universal Salt Iodization	IUS	Iodation Universelle du Sel
WFP	World Food Programme	PAM	Programme Alimentaire Mondial
WHA	World Health Assembly	AMS	Assemblée Mondiale de la Santé
WHO	World Health Organization	OMS	Organisation Mondiale de la Santé
ZACH	Zinc Alliance for Child Health	ZACH	Programme Alliance Zinc pour de la santé de l'enfant

Unless otherwise indicated, child nutrition indicators referenced in this report are taken from the UNICEF-WHO-World Bank Joint Child Malnutrition Estimates[1].

Contents

List of Boxes

List of Figures

Photo: Adama Cissé/CLM

Executive Summary

With a 46 percent reduction in under-five stunting, from 34.4 percent in 1992 to 19.4 percent in 2014, Senegal has witnessed one of the biggest rates of improvement in the fight against undernutrition in the world and currently has one of the lowest rates of stunting in Sub-Saharan Africa. How was this achieved and what contributions did various nutrition policies make over time? The purpose of this report is to provide an historical overview of nutrition policies in Senegal, including analysis of the nutrition policy landscape, the evolution of nutrition policies and institutions, and their implications for programming and prioritization of interventions.

Nutrition policy in Senegal has evolved over a series of distinct generations, defined here as: building the foundation (1950s–1970s); the curative approach (1970s–1990s); institutionalization of nutrition (1990s–2000s); intensification and decentralization (2000s–2010s); and multisectoral approach (2010s). Six factors have been identified as crucial to the success of each generation: (1) nutrition championship; (2) institutional ownership; (3) multisectoral coordination and collaboration; (4) community ownership; (5) integrated services and delivery platforms; and (6) partner engagement.

Building the Foundation (1950s–1970s). By Senegal's independence in 1960, food and nutrition security was already a high-level priority, and stable leadership over four decades helped to keep it so. During this generation, in 1961, the first Plan Quadriennal de Développement Economique et Social (Quadrennial Economic and Social Development Plan) (PQDES) prioritized improving food and nutrition security, defined women and children as a vulnerable group, and budgeted resources for food and nutrition research. Major institutions were established with long-term importance for nutrition. Facility- and community-based nutrition programs and nutrition-sensitive agriculture and social protection programs were being implemented, albeit at small scale. Facility-based nutrition programs, to the extent they existed, focused on curative care and food distribution. Nutrition services during this period were decidedly not integrated, but rather a patchwork of isolated and, arguably, ineffective initiatives. Senegalese food consumption surveys dating from 1946 indicated widespread micronutrient and protein deficiencies; nationally representative nutrition data were not available until 1986.

Curative Approach (1970s–1990s). During this generation, Senegal lost social and economic ground.

The Sahelian drought (1968–74) was Senegal's first postindependence large-scale environmental crisis. In 1979, Senegal adopted a series of structural adjustment reforms, supported by the World Bank and the International Monetary Fund (IMF), aimed at reducing the state's role in the economy. Formal nutrition policy during this generation was still primarily articulated in national documents of reference. Senegal was ahead of the global curve in articulating in national policy the nascent global understanding of the importance of nutrition and the causes and consequences of malnutrition. However, the 1977 Food Investment Strategy for achieving these goals was criticized for failing to address the key drivers of malnutrition. By 1980, Senegal's health infrastructure was in shambles and suffering from lost credibility. Coordination and delivery of nutrition services in Senegal during this period was weak and remained focused primarily on facility-based curative care and food supplementation targeted at urban centers. Despite increasing efforts to reach vulnerable populations with nutrition services, rates of stunting continued to increase considerably.

Institutionalization of Nutrition (1990s–2000s). Gross domestic product (GDP) per capita in Senegal at this time was still in decline, over two-thirds of the population was living below the poverty line, and Senegal's economic and social indicators were poor, even in comparison to neighboring countries and low-income countries generally. Then, in 1994, structural adjustment reforms of the 1980s culminated in a sudden devaluation of the CFA franc, imposed by the IMF. The consequence was rapid inflation, deterioration of food and nutrition security, and urban unrest, particularly among young urban professionals. National nutrition policy during this period was, in effect, defined by whatever nutrition programs were in place. However, during this period, operationalization of nutrition intervention was granted to the Agence d'Exécution des Travaux d'Intérêt Public (Executing Agency for Public Works and Employment) (AGETIP). AGETIP had no prior experience in health or nutrition programming, but it was the institutional home of the newly started World Bank-funded Projet de Nutrition Communautaire (Community Nutrition Project) (PNC). Concurrently, the Commission Nationale de Lutte contre la Malnutrition (National Committee for the Fight Against Malnutrition) (CNLM) was created in the President's office with a mandate to ensure the availability of a safety net for the poor and responsibility for oversight of PNC. The nutrition objective of PNC was to prevent the deterioration of nutrition among the most vulnerable in targeted poor urban areas. However, PNC was as much a youth employment operation as it was a nutrition intervention. PNC was innovative for contracting young people for the management, training, delivery, and supervision of preventive nutrition services at the community level. Ultimately, although PNC was a popular project because it delivered nutritional services and much-needed employment in urban areas, it suffered from severe challenges with targeting, cost, coordination, quality, and corruption. During this period, there was a slight decrease in stunting, from 34.4 percent in 1992 to 29.5 percent in 2000.

Intensification and Decentralization (2000s–2010s). The newly elected Wade administration promoted a more progressive approach to economic development characterized by a more pluralistic environment, promotion of the private sector, and greater emphasis on the development of human capital. Nutrition was understood to be a critical component of human development, and President Abdoulaye and First Lady Wade were visible nutrition champions. In 2001, the Cellule de Lutte Contre la Malnutrition (the Nutrition Coordination Unit) (CLM) was created to replace the CNLM; the institutional home for nutrition was henceforth moved to the Prime Minister's Office. The Bureau Exécutif National (the National Executive Bureau) (BEN) was created as part of the CLM to be the permanent executive office in charge of day-to-day management and the implementing agency responsible for executing the new World Bank-funded Programme de Renforcement de la Nutrition (Nutrition Enhancement Program) (PRN). Nutrition was also added as a distinct investment line in the national budget. The Lettre de Politique de Développement de la Nutrition (Nutrition Policy Letter) (LPDN) defined—for the first time—national nutrition policy and set out appropriate strategies for programming and monitoring. PRN operates through

multilevel and multisectoral collaboration across participating ministries, nongovernmental organizations (NGOs), the private sector, local government, and the community. Indicators were established against which progress was measured, including nutrition practices, coverage of nutrition services, and nutrition knowledge. From 2000 to 2012, stunting dropped from 29.5 percent to 19.2 percent. These results were achieved at significantly lower cost than under PNC.

Multisectoral Approach (2010s). The end of 2015 marked the end date of the Millennium Development Goals (MDGs); Senegal had mixed results. Progress against hunger was nil: 24.5 percent in 1991 and 24.6 percent in 2015. However, during the period of the MDGs, stunting decreased a remarkable 44 percent, from 34.4 percent in 1992 to 19.4 percent in 2014. This singular achievement has solidified Senegal's place as a global leader in nutrition policy. The transition in leadership from President Wade to President Macky Sall in 2012 closed a chapter in which nutrition policy benefitted from unusually high political visibility. Global recognition has translated into increased funding for nutrition in Senegal; the government financial commitment to nutrition—both in total and as a proportion of nutrition spending—is also increasing. In 2015, the Document de Politique National de Développement de la Nutrition (National Policy for the Development of Nutrition) (DPNDN) outlined a new vision. The Plan Stratégique Multisectoriel de la Nutrition (Multisectoral Strategic Nutrition Plan) (PSMN)—currently under development—will operationalize the DPNDN and be the principal tool for nutrition coordination going forward. PRN continues to be Senegal's flagship nutrition program.

In 2014, President Sall launched the Emerging Senegal Plan with the goal of taking Senegal to emerging country status by 2035 through improving the well-being of the population and guaranteeing access to social services. Senegal cannot achieve emerging country status without continued improvement in nutrition. Evidence available at the launch of the Sustainable Development Goals (SDGs) indicates that progress toward new nutrition targets has stalled and Senegal is considered to be "off course." Needed are more pronutrition interventions through other sectors; improved targeting to identify areas of highest burden; and increased efforts to extend services to hard-to-reach areas. To meet World Health Assembly (WHA) and SDG goals, more financial resources are needed.

Photo: Adama Cissé/CLM

1 Introduction

Rationale. Nutrition has been ingrained in key social and economic development policies in Senegal since the birth of the Republic. The evolution of nutrition policy—and its impact on the state of nutrition in Senegal—is the result of a constant interplay between social, environmental, and economic events; politics; the state of nutrition knowledge; and the engagement and influence of external stakeholders. Nutrition policy also encompasses what actually gets implemented; therefore, it is also influenced by available capacity and resources at all levels. With a 46 percent reduction in under-five stunting, from 34.4 percent in 1992 to just over 19.4 percent in 2014, Senegal has witnessed one of the biggest rates of improvement in the world and currently has one of the lowest rates of stunting in West Africa. This success has put Senegal in the spotlight, and other countries, especially those in Francophone Sub-Saharan Africa, look to Senegal as a model for nutrition intervention. Indeed, in the global fight against malnutrition, more often than not Senegal has been ahead of the curve—in a position of informing global advocacy initiatives—not just a beneficiary of the global evidence base.

Objective. The purpose of this report is to provide an historical overview of nutrition policies in Senegal including analysis of the nutrition policy landscape, the evolution of nutrition policies and institutions, and their implications in terms of programming and prioritization of interventions. In so doing, the report aims to provide context to future nutrition investment and the PSMN currently under development, and to inform the decision-making process at this critical juncture. Here, "policy" refers to all guidance for the management of nutrition—be it effective (everyone does it) or ineffective (it never leaves the paper it is written on), formal (written and adopted) or informal (unwritten institutional behaviors and practices). The timeline of nutrition policies and related initiatives is provided in appendix A.

Overarching Trends. Nutrition policy in Senegal has evolved over a series of distinct generations,[2] defined here as: building the foundation (1950s–1970s); the curative approach (1970s–1990s); institutionalization of nutrition (1990s–2000s); intensification and decentralization (2000s–2010s); and multisectoral approach (2010s). These are briefly summarized below. The remainder of the report describes the evolution of nutrition policy by generation and its intersection with projects and programs, institutions, global and regional initiatives, social and political events, and nutrition

knowledge and advocacy. For each generation, the report also discusses the following six themes of particular relevance to the evolution of nutrition policy in Senegal and arguably factors crucial to its success: (1) nutrition championship; (2) institutional ownership; (3) multisectoral coordination and collaboration; (4) community ownership; (5) integrated services and delivery platforms; and (6) partner engagement.

Nutrition Policy Generations

First was the **building the foundation generation (1950s–1970s)**, preindependence to the Sahelian drought. During this generation, global knowledge about malnutrition, how it manifests and its short- and long-term consequences, was in its nascent stage. Interventions to address malnutrition—especially at scale—were virtually unheard of, although nutritional rehabilitation and food distribution were carried out. Notable about this generation is that nutrition already had visibility at the highest levels at the launch of the Republic in 1960. This is evidenced most strongly by the first (1961), second (1965) and third (1969) PQDES, which among other things, established a series of institutions dedicated to food and nutrition and codified maternal and infant protection as national priorities.

Next was the **curative approach generation (1970s–1990s)**, marked by growing awareness of the importance and extent of malnutrition in Senegal, largely in response to the Sahelian drought, and the first large-scale nutrition emergency response projects to address it. Implemented with the support of global partners, these initial forays into large-scale intervention planted seeds of nutrition infrastructure that would evolve and be strengthened over subsequent decades. During this period, nutrition interventions primarily involved identification and treatment of cases of acute malnutrition, despite mounting evidence of the multisectoral determinants of malnutrition, the importance of early preventive intervention, and the long-term consequences of malnutrition for human development. As a result, these early large-scale nutrition interventions conspicuously failed to improve nutrition status.

Deepening understanding of the causes and consequences of malnutrition—and the highly visible failure of early nutrition projects to achieve results—ushered in the **institutionalization of nutrition generation (1990s–2000s).** This generation was marked by a reorientation toward a preventive approach through integrated intervention packages and community-based interventions in an effort to "do things better" for nutrition. This generation also witnessed the entry of the World Bank into financing for nutrition in Senegal. A change in institutional ownership of nutrition during this period would prove to be a major turning point and signaled the politicization of nutrition policy.

The **intensification and decentralization generation (2000s–2010s)** is delineated by the election of President Abdoulaye Wade, the subsequent creation of the CLM and launch of PRN, and Senegal's eventual joining of the Scaling Up Nutrition (SUN) Movement. It was a decade of action for nutrition that turned the tide for nutrition policy in Senegal with rapid improvement in nutrition outcomes. For the first time, Senegal developed a national nutrition policy and instituted a coherent multisectoral approach to improving nutrition with a dedicated budget line. Strong political support during the Wade administration, combined with concerted effort fueled by the race to reach the MDGs, resulted in securing widespread improvements in stunting, firmly placing Senegal in the national and global spotlight. This period also witnessed the emergence of the first serious efforts at nutrition-sensitive interventions in Senegal.

The current **multisectoral approach generation (2010s)** commenced with the transition from President Wade to President Macky Sall in 2012, and Senegal's assuming a position of prominence as a global leader in nutrition intervention. National leaders have leveraged achievements in the dramatic reduction of malnutrition to increase financing for nutrition, including through government resources. New evidence demonstrating the limitations of nutrition-specific inter-

ventions alone for improvement in stunting, combined with unprecedented levels of cross-sectoral commitment and collaboration, have redoubled the focus on nutrition-sensitive interventions in key sectors. Efforts are underway to define the future for nutrition policy in a Sall administration determined to achieve emerging country status by 2035.

The evolution of nutrition policy and its impact on nutrition outcomes have earned Senegal global recognition, but serious challenges remain and new global threats are on the horizon. Evidence available at the launch of the SDGs indicates that progress against new nutrition targets has stalled, and Senegal is considered to be "off course." Senegal cannot achieve emerging country status without continued improvement in nutrition. If Senegal hopes to benefit from its hard-fought gains, achieve its goals, and maintain its position as a global leader in nutrition intervention, then increased decentralization and ownership among regional and local authorities fueled by enhanced investments are required.

Photo: Adama Cissé/CLM

2
Building the Foundation (1950s–1970s)

Preindependence to the Sahelian drought

Nutrition Context

Senegal. To understand the evolution of nutrition policy in Senegal and how Senegal came to be a leader in nutrition intervention, it is important to recognize that by the time of independence several important nutrition-related inroads had already been made. Dakar's history as the capital of the Federation of French West Africa from 1895 to 1958 solidified Senegal's position early on as a seat of regional authority for nutrition and other issues. Senegal gained independence in 1960 and had just two presidents, both from the Socialist Party, in forty years until 2000. Food and nutrition security was a high-level priority at the outset, and stable leadership helped to keep it so. Moreover, the first decentralization reforms were made in 1964, laying the foundation for what would ultimately become the platform for multisectoral coordination of nutrition activities at the local level.

Global and Regional. In 1956, prior to independence, the Office de Recherches sur l'Alimentation et la Nutrition Africaine (Research Organization for Food and Nutrition in Africa) (ORANA)[3] was established by the French and based in Dakar. Since 1961, ORANA has operated as an institute of the Organisation de Coordination et de Cooperation pour la Lutte contre les Grandes Endémies (Coordination and Cooperation Organization for the Control of the Major Endemic Diseases) (OCCGE). Although ORANA and OCCGE covered the former colonies of French West Africa,[4] in practice ORANA functioned as a reference center on nutrition for the entire Sahel region, undertaking research in the science of nutrition biochemistry, disease, treatment, and surveillance. ORANA is perhaps most notable for creating the first African food composition table. More germane to this report, however, through partnerships with ORANA and several universities, Senegal trained a cadre of nutrition specialists, a valuable resource uncommon among other African nations at the time, that would contribute to the championing of nutrition in Senegal for decades to come.

The West African Conference on Nutrition and Child Feeding, sponsored by the U.S. Agency for International Development (USAID), with representatives from thirteen West African countries and participation from UN agencies (Food and Agricultural Organization (FAO), World Health Organization (WHO), and UNICEF), OCCGE, and ORANA, was hosted in Dakar in 1968, with welcoming remarks made by

future president (then–Minister of Planning and Industrial Development), Abdou Diouf. The conference proceedings focused on factors related to "the permanent conditions of undernourishment," including the "apparently unrelated disciplines such as agriculture, economics, food technology and education" (Republic of Senegal and USAID 1968). The conference proceedings are remarkable for providing insight into the understanding of the causes and consequences of malnutrition at that time, as well as the perspective of world leaders on the importance, and effective means, of intervention.

In his welcoming remarks, Abdou Diouf attested to the importance of political will and government ownership of nutrition and stated that "no amount of foreign aid can replace the effort of each nation concerned to confront nutrition problems as they exist in each country and to develop and consolidate a concrete policy aimed at their solution." (Republic of Senegal and USAID 1968) The keynote address by the Senegal Director of Rural Animation and Expansion, Ben Mady Cisse, noted that "healthy nutrition has become a medical and social problem at the same time, and … the solution capable of bringing results to these problems can be found only within the framework of multidisciplinary collaboration." (Republic of Senegal and USAID 1968).

Nutrition Policy

Policies. This generation elaborated policies and created institutions that would lay the foundation for and codify the prioritization of maternal and child health in Senegal, with far-reaching ramifications for nutrition. Starting in 1954, prior to independence, the Maternity Leave Regulation guaranteed cash benefits, health protections, and employment security for women working in the formal sector for a period of 14 weeks, and explicit protections for breastfeeding and against onerous physical labor. Of key importance is the role played over the course of Senegalese history by national documents of reference in defining nutrition policy, starting with the first PQDES in 1961, which unequivocally established nutrition as a national priority.

The first PQDES prioritized the improvement of food and nutrition security through rural cooperatives and assistance to farmers, established women and children as a vulnerable group, and budgeted resources for food and nutrition research, including creation of the Institute de Technologie Alimentaire (Food Technology Institute) (ITA), which thrives to this day. The second PQDES in 1965 further developed nutrition infrastructure and capacity in Senegal by creating a discrete nutrition unit[5]—the Bureau National d'Alimentation et de la Nutrition Appliquée au Sénégal (Office for Food and Applied Nutrition in Senegal) (BANAS)—and making ORANA responsible for training a cadre of young African nutritionists. The third PQDES in 1969 signaled increased high-level political commitment to nutrition-related outcomes by codifying, as the first priority action in urban areas, prevention of child mortality, and, as the second priority action in rural areas, maternal and infant protection.

Institutions. During this generation, two major institutions were forged with long-term importance for nutrition. First is ITA, a research institute created by the first PQDES and established in 1963 to direct and coordinate research on the treatment, transformation, and use of local food products. During this period, Senegal was already exploring food fortification and production of nutrient-dense supplemental foods to address nutrition deficiencies and determining how to produce them cheaply enough to be accessible and affordable to the most vulnerable segments of society. Through many iterations and with the support of partners such as FAO and USAID, ITA's mission today remains applied food science: generating added value to locally produced foods through processing and quality assurance to improve food and nutrition security and increase exports. Second was BANAS, which, situated within the Ministry of Health and Social Affairs (referred to throughout this series as the Ministry of Health),[6] was responsible, in collaboration with ORANA and ITA, for coordinating and intensifying action against food and nutrition deficiencies through

development, dissemination, and oversight of norms for nutrition service delivery.

Programs. Until the 1970s, historical records of the health and nutrition landscape in Senegal are sparse but it is reported that, in 1939, there were only 3 hospitals, 4 medical centers, 42 maternity hospitals, 10 rural consultation centers, and several leprosaria (UNESCO 1964). By the end of the 1970s, with the support of WHO and the International Labor Organization (ILO), Senegal had trained hundreds of students in medicine, midwifery, pediatrics, social work, economics, and nursing. Although facility- and community-based nutrition programs and nutrition-sensitive agriculture and social protection programs were being implemented, records from this time indicate that they were carried out on a small scale with limited impact on nutrition outcomes.

Facility-based nutrition programmes, to the extent they existed, fell under the supervision of the Ministry of Health and focused on curative care and food distribution through Unites de Rehydration Orale—Centres de Récuperation et d'Education Nutritionnelle (Oral Rehydration Units—Centers of Recovery and Nutritional Education) (URO-CRENs). Typically, a Centre de Récuperation et d'Education Nutritionnelle (Center of Recovery and Nutritional Education) (CREN) was a ward or small area of a health facility or hospital dedicated to the treatment of children with Severe Acute Malnutrition (SAM). URO-CRENs treated SAM cases with dehydration caused by severe diarrhea. Less commonly, a CREN might be a separate facility managed by an NGO or faith-based organization. These nutrition activities had high visibility, addressed an immediate need, and were effective in garnering political support. In practice, however, CRENs were often unable to provide substantive care because of shortages of required therapeutic products (such as milk-based F75 and F100) resulting from insufficient financial resources, supply chain mismanagement, or perishability; lack of trained medical staff; or negligence on the part of health workers.

Recognition of the limitations of facility-based curative care and the importance of both adequate quantity and quality of food in the diet[7] prompted implementation of small-scale community-based nutrition projects and health promotion interventions. For instance, there is some indication that a more preventive approach was taken by rural day care centers **(**Mehra, Kurz and Paolisso 1992). These centers were implemented by the education sector (through the Department of Animation Rurale, Promotion Humaine) with support from NGOs and were nominally responsible for delivering nutrition education through cooking demonstrations, "not only for mothers but for all women who, through their families, are involved in the growth of children" (Republic of Senegal and USAID 1968). Some of these projects evolved into platforms for delivery of routine health services such as immunizations; however, their primary purpose was to provide a safe place to keep children from six months to five years of age while their caregivers worked in the fields.[8] Although a historically significant early foray into nutrition-sensitive intervention, these and other preventive initiatives were of limited scope and coverage.

Other innovative nutrition-sensitive interventions were carried out at this time through the agriculture and social protection sectors, albeit also at small scale. Spurred by efforts to improve food and nutrition security and using the latest evidence from nutrition science, projects implemented during this period aimed to increase production diversity through agriculture and nutrition education and behavior change communication (BCC). A mass media campaign supported by the U.N. Educational, Scientific and Cultural Organization (UNESCO) encouraged the Senegalese population to be "producers as well as consumers" (Republic of Senegal and USAID 1968). Education sessions were facilitated by trained animatrices,[9] community volunteer promoters of health, agriculture, and human development, through rural expansion centers, with technical support from Maternal and Child Protection, BANAS, Health Education and Home Economics. Small-scale school feeding and gardening programs were also implemented, as were model villages integrating agriculture and nutrition education and activities.

Although efforts aimed at ameliorating malnutrition were primarily focused on kwashiorkor and micronu-

IMPACT

Records from this generation indicate that "the incidence of malnutrition is poorly understood in Africa. Some people see it everywhere and others deny its existence" (Republic of Senegal and USAID 1968). However, remarks from Abdou Diouf at the West African Conference on Nutrition and Child Feeding indicate informed concern about the inability of food production to keep up with increasing rates of population growth and recognition of the links between nutrition deficiencies that cause "early mortality, . . . retardation in the somatic and psychomotor development of our children and limit the productive capacity of our adults" (Republic of Senegal and USAID 1968).

Senegalese food consumption surveys, dating from 1946 and indicating widespread micronutrient and protein deficiencies, are corroborated by nutrition surveys at the time that reported 3 percent kwashiorkor rate, 25 percent pre-kwashiorkor rate, and 30 percent infant mortality. Research conducted in Dakar in 1965 indicated that malnutrition was implicated in 50 to 55 percent of infant hospitalizations. More precise nationally representative nutrition data are not available for Senegal until 1986.

trient deficiencies, records from this time remarkably already indicate concern in urban areas of "the so-called prestige foods" and evidence of "disturbing incidence of obesity," going so far as to note "Coca-Cola could be the ruin of some of our States." (Republic of Senegal and USAID 1968). It is a testament both to the emerging discrepancies in nutrition between rural and urban populations of Senegal and to the awareness, at least among nutrition experts, of these evolving trends.

Key Themes

By the 1970s, many of the key hallmarks of Senegal's nutrition policy were in place. Early attempts at nutrition intervention drew attention to challenges that would be addressed only in later decades.

Nutrition Championship. Political commitment to nutrition was high from the start of the Republic, evidenced by its prioritization in the first PQDES, creation of an institutional home for nutrition and support for nutrition programming albeit at small scale, and statements made by leaders at high-level regional events. The technical dialogue around nutrition in Senegal at this time was sophisticated, reflecting a deep understanding among national leaders of the causes and consequences of malnutrition. Investment in the development of the next generation of nutrition specialists would prove to have far-reaching implications for the evolution of nutrition policy.

Institutional Ownership. Records hint at high-level debate around the institutional arrangements for nutrition and the distinct roles for delivery of nutrition services versus coordination of nutrition interventions across sectors.[10] The politics of nutrition were evidently already in play. Senegal's first documents of reference delegated BANAS, in the Ministry of Health, as the institutional home for nutrition, with the support and collaboration of ITA and ORANA. Despite political commitment to nutrition, institutionally the nutrition unit was situated too low in the Ministry to influence the key decision-making processes (with respect, for example, to budgets, human resources, policies, and programs) that would improve nutrition policy.

Multisectoral Coordination and Collaboration. By 1968, there was already understanding of the importance of multisectoral coordination in the fight against malnutrition and the role played by key sectors.[11] Even at this early period, nutrition curative care delivered by the health system was supplemented by various isolated nutrition-sensitive interventions, including school gardening, school feeding, nutrition education and use of mass media to promote behavior change, and efforts to involve the private sector and industry in the production of nutritious foods.

Community Ownership. Although Abdou Diouf boldly asserted in 1968 that, "the essential infrastructure of the country was established and put into the hands of the citizens" (Republic of Senegal and USAID

1968), community-based nutrition services during this period were nascent. Small animation, or sensitization, projects operated at the community level with trained volunteers delivering agriculture and nutrition education and BCC, and in some projects mothers coordinated among themselves to run nurseries for agriculture workers. Although these initiatives were carried out on a small scale, their results would contribute to the global evidence base for community-based nutrition programming and form the foundation for later, more comprehensive, projects.

Integrated Services and Delivery Platforms. Nutrition services during this period were decidedly not integrated, but rather a patchwork of isolated and, arguably, ineffective initiatives. The Ministry of Health, supported by international partners, delivered nutrition curative care through CRENs, which had a limited effect on nutrition outcomes. The number of children with SAM that could be treated in these centers was low and bore almost no relation to the number of children with SAM in the community. Preventive nutrition activities carried out during this period were also spotty and uncoordinated.

Partner Engagement. Partnerships have been integral to Senegal's success in improving nutrition outcomes. Partner engagement even during this early period is evidenced by the strong research relationship with ORANA, the investment of donors such as FAO and USAID to build nutrition capacity through training programs, and the involvement of USAID and the UN agencies in the West Africa Infant and Child Feeding conference hosted by Senegal in 1968.

The key nutrition-related policies and influences for this generation are listed in box 1.

BOX 1: Nutrition-Related Policies and Influences during the *Building the Foundation Generation*

Policies
- Maternity Leave Regulation (1954)
- 1st PQDES (1961)
- Decentralization reforms (1964)
- 2nd PQDES (1965)
- 3rd PQDES (1969)

Institutions
- ITA (1963)
- BANAS (1965)

Programs
- CRENs (beginning in the 1960s)

Key National Influences
- Dakar as the capital of French West Africa (1895–1958)
- Independence (1960)

Key Regional and Global Influences
- ORANA (1956)
- West African Conference on Nutrition and Child Feeding (1968)
- Sahelian drought (1968–74)

Photo: Adama Cissé/CLM

3

Curative Approach (1970s–1990s)

Growing awareness of the importance and extent of malnutrition in Senegal, largely in response to the Sahelian drought and the first large-scale nutrition emergency response projects to address it

Nutrition Context

Senegal. The Sahelian drought, which began in 1968 and continued through 1974, was Senegal's first postindependence large-scale environmental crisis. Beginning in 1979, Senegal adopted a series of structural adjustment reforms, supported by the World Bank and the IMF, aimed at reducing the state's role in the economy. These reforms curtailed public expenditures, especially in health and education. This period also witnessed Senegal's first transfer of power, from President Léopold Sédar Senghor to President Abdou Diouf. Despite President Diouf's apparent support for nutrition, evidenced by his remarks at the West African Conference on Nutrition and Child Feeding in 1968, the combined effect of the drought and restricted social services resulting from economic reforms had serious consequences for social welfare and major repercussions for health and nutrition. By 1980, international partners were predicting sharp decreases in nutrition security (USAID 1980). During this period, Senegal indeed lost social and economic ground; by 1994, Senegal had one of the lowest levels of gross national income among lower-middle-income countries, and social indicators compared poorly with the average for Sub-Saharan Africa and other low-income countries.

Global and Regional. Notwithstanding Senegal's difficulties, the 1970s–1990s was a hugely important historical era in the field of nutrition globally, producing groundbreaking work, such as the UNICEF framework for the multisectoral conceptualization of nutrition, the Iringa project (1983–88) in Tanzania, which demonstrated the potential of community-based nutrition programming to improve nutrition outcomes, and a slew of international agreements related to improving child nutrition and health. Chief among these with particular relevance to nutrition were the Alma Ata Declaration in 1978, which solidified international commitment to the importance of primary health care; the International Code of Marketing of Breastmilk Substitutes in 1981, which prescribed restrictions on the marketing of breastmilk substitutes to ensure that mothers would not be discouraged from breastfeeding; the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding in 1990, which further recognized breastmilk as the ideal source of nutrition for infants and promoted exclusive breastfeeding for the first four to six months; and the World Summit for Children in

1990, which marked the largest gathering of world leaders in history and resulted in the Declaration on the Survival, Protection and Development of Children and Plan of Action. Together these initiatives firmly established nutrition as a matter of global concern and galvanized international momentum for action.

Nutrition Policy

Policies. Formal nutrition policy during this generation was still primarily articulated in national documents of reference. Of chief importance was the 4th PQDES in 1973, which described the nutrition situation in Senegal, linked malnutrition to child infectious diseases, highlighted poor maternal education and weaning practices as key contributors to malnutrition, and recognized malnutrition as an important factor in child mortality. To a degree, Senegal was ahead of the global curve in articulating in national policy the nascent global understanding of the importance of nutrition, and the causes and consequences of malnutrition. The 4th PQDES established the objectives of Senegal's first large-scale nutrition project, the Programme de Protection Nutritionelle et Sanitaire (Nutrition and Health Protection Program) (PPNS). An amendment made in 1975 to address the growing impact of the drought put in place the Programme Santé Sécheresse, complementary programming to benefit vulnerable groups.

Subsequent PQDES—the 5th PQDES in 1977, the 6th PQDES in 1981, and the 7th PQDES in 1985—collectively signaled a substantive shift in food and nutrition policy in Senegal toward integrated interventions and, programmatically, would all reinforce PPNS. In particular, the objectives of the 5th PQDES included (1) increasing food supplies to compensate for seasonal, regional, and socioeconomic deficiencies; (2) improving and extending nutritional education; (3) developing and distributing a Senegalese weaning food; (4) consideration of an iron fortification program; and (5) detailed food consumption surveys, particularly in areas of widespread malnutrition. The Food Investment Strategy 1977–1985 was created by the Ministry of Rural Development and Water Resources to achieve these goals.

Having a food and nutrition strategy marked an important step in the progression of nutrition policy in Senegal; however the Food Investment Strategy was deeply criticized for not addressing what were believed to be the key drivers to malnutrition: "[T]here is far more concern with reducing the burden of foreign exchange earnings imposed by imported cereals, especially rice, than on improving diets or preventing their deterioration over time" (USAID 1980). In particular there was concern that the Food Investment Strategy did nothing to address preharvest hunger, believed by some international stakeholders to be a major contributor to malnutrition in Senegal. More generally, it was agreed by all stakeholders that the data required to diagnose and strategically address the problem of nutrition were lacking.

The 6th PQDES, too, marked a substantive departure from business as usual in public health policy with implications for nutrition. It prioritized provision of primary health care services, including integrated maternal and child health and family planning programs, upgrading the network of basic health services, and promoting public health care in rural areas. Chief among the objectives was to reestablish the credibility of the public health system. However, in 1986 the first Demographic and Health Survey (DHS) for Senegal was published, indicating—after over a decade of nutrition programming—a nearly 30 percent prevalence of under-three stunting. Persistently high rates of malnutrition were attributed to poor execution and corruption of PPNS.[12] Consequently, in 1989, under severe criticism, PPNS was closed in the 8th Plan d'Orientation pour le Développement Economic et Social (Policy Plan for Economic and Social Development) (PODES). In its place, the 8th PODES launched the Programme de Réhabilitation et de Surveillance Nutritionnelle (Nutritional Rehabilitation and Surveillance Program) and the Programme de Santé Maternelle et Infantile et de Planification Familiale (Maternal and Child Health and Family Planning Program) (PSMI/PF).

Also relevant to nutrition policy were decentralization reforms adopted in 1972 that granted greater power to the regions, fostered the creation of regional and local participatory structures, and created a new ad-

ministrative unit—the "rural community"—consisting of several villages within a radius of 10 kilometers. Under decentralization, rural communities determined how tax proceeds would be used. Much of the proceeds went toward community health activities, such as the construction of maternities and pharmacies and the training of midwives and community health workers. Rural communities thereby provided, for the first time, the institutional framework for extending the health system to the village level.

Institutions. Along with the shift in nutrition policy came a major institutional reorganization. Records indicate that in 1979, the Ministry of Health was reorganized in an attempt to help it better support the government's primary health care policies by integrating curative and preventive health care; decentralizing technical support functions; creating an in-service training capability; and improving the coordination and planning of the entire system ultimately to strengthen local services (World Bank 1982). The key nutrition-related institutions at the time remained BANAS, ITA, and ORANA, in addition to a newly created coordinating body, the Comite d'Analyse Nutritionnelle et Alimentaire au Sénégal (Committee of Food and Nutritional Analysis in Senegal) (CANAS).

Under the reorganization,

- BANAS remained responsible for all nutrition issues and services at the national level. Specifically, during this period BANAS was the institutional home for PPNS and other nutrition projects carried out by ORANA, was responsible for the nutrition education component of PSMI/PF, and published several reports related to the composition of foods and food consumption patterns. However, reports at the time suggest that a lack of adequate resources made BANAS ineffectual. A change in the name of the nutrition unit from BANAS to the Service de l'Alimentation et de la Nutrition Appliquée du Sénégal (Nutrition and Food Service of Senegal) (SANAS) during this period was inconsequential.
- ITA continued to function primarily as a food technology research center, carrying out the development of a millet-flour bread, pain-mi-blé, as a part of a government policy to increase consumption of millet, research in storage and preservation of staple foods, development of supplemental weaning foods, and research exploring the potential of soybeans as a cash crop.
- ORANA continued to conduct food and nutrition research and nutrition status surveys in Senegal and other West African countries in collaboration with the Office de la Recherche Scientifique et Technique Outre-Mer (Office for Scientific and Technical Research Overseas) (ORSTOM).
- CANAS was established in 1979 under the Ministry of Plan and Cooperation as a coordinating body in the design and implementation of policies and programs "to solve the country's food problems" (USAID 1980). It included representatives from the Ministries of Finance and Economic Affairs; Plan and Cooperation; Rural Development; Public Health; and the Secretaries of State from Promotion Humaine; Specialized Research and Technique; and Women's Affairs.

By 1980, Senegal's health infrastructure was in shambles and suffering from lost credibility: "Out of 36 health centers, only 24 were considered operational and 17 were currently in need of repair. About half of Senegal's 492 health posts are also in poor operating condition. Many health centers are 30 to 50 years old. Basic commodities, such as water, latrines and electricity are unavailable. Technical equipment is missing or in disrepair; laboratory facilities are poor or non-existent" (World Bank 1982). At the same time, and as a result of new decentralization reforms, village-level services, such as rural maternities, village pharmacies, and "health huts," were expanding, applying mounting pressure on the Ministry of Health to train the growing cadre of community health workers. In the simultaneous moves toward decentralization and integrated services, rural health centers were seen as "strategic fixed points for integrating and coordinating key preventive and curative programs" (World Bank 1982). The shift in policy "far outstripped the Government's ability to put in place basic pre-conditions" (World Bank 1982).

IMPACT

Surveys during this time indicate that, despite increasing efforts to reach vulnerable populations with nutrition services, rates of stunting and wasting continued to climb precipitously.[13] Although the distribution and causes of malnutrition were debated in historical records and the paucity of good nutrition data was widely bemoaned, that Senegal's food and nutrition situation was both serious and deteriorating was generally understood among nutrition partners.

Contemporary understanding of the causes of malnutrition included seasonal preharvest hunger; protein-calorie malnutrition among impoverished children in rural and periurban areas; and micronutrient deficiencies, most notably of iron, certain B vitamins, and iodine (USAID 1980). Surveys at the time—much maligned, however, among some experts—suggest calorie intake of approximately 2000 calories per day, 300–400 less than international standard.

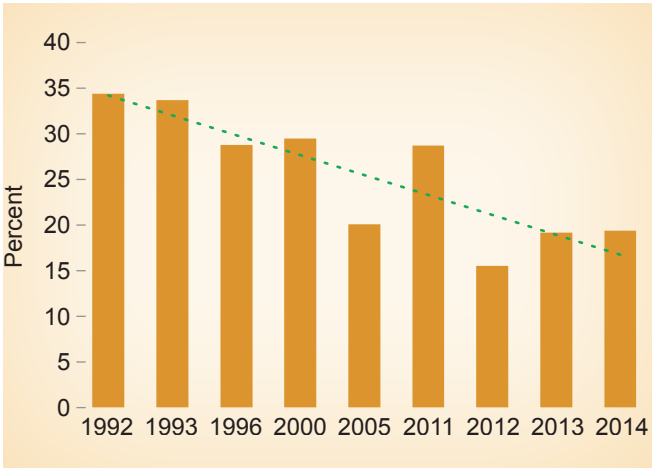
Through PPNS, approximately 400 centers were established to provide pre- and postnatal care, and growth monitoring of children and food supplementation, covering approximately 10 percent of children under three (World Bank 1995). However, project evaluations indicated that several design and operational flaws hampered PPNS. Not only was the program untargeted (by either season or geography), but mothers were obliged to pay a fee (about US$0.67 per month) to participate. It was also determined that beneficiaries received approximately half the take-home rations intended, and only 6–11 percent of the calories were consumed by the intended beneficiary. A World Bank assessment conducted at the time indicated that there was no nutritional difference between families who were beneficiaries of PPNS and those who were not. After PPNS supplementary food distribution was discontinued in 1987, many mothers stopped participating.

Programs. All told, despite progressive policies, the infrastructure for coordination and delivery of nutrition services in Senegal during this period was weak and remained focused primarily on facility-based curative care and food supplementation targeted at urban centers.[14] This period witnessed Senegal's first large-scale nutrition programs, financed and implemented with substantial support of international donors (bilaterals, UN agencies and international NGOs), even though, in the global nutrition discourse, questions were being raised about the merits of these types of interventions and their prospects for improving nutrition outcomes.[15] Key programs implemented during this period—the PPNS (1973–88), complemented by Programme Santé Sécheresse starting in 1975, and later replaced by the Nutritional Rehabilitation and Surveillance Program (1989–95) and the PSMI/PF (1989–95)—were formally launched by national documents of reference.

Though ultimately deemed a failure, PPNS supported delivery of nutrition services through health posts, including nutritional rehabilitation, distribution of food to malnourished children and pregnant and lactating women (PLW), pre- and postnatal consultations, growth monitoring of children under five, and nutrition education. The program suffered from poor targeting, poor quality care, and food thefts that resulted in the arrest of community agents and the closing of the project in disgrace. Concurrently, Programme Santé Sécheresse, implemented by the World Food Programme (WFP) provided direct response to drought victims. After PPNS was finally closed, the Nutritional Rehabilitation and Surveillance Programme to provide food assistance and nutritional rehabilitation and PSMI/PF were instituted.

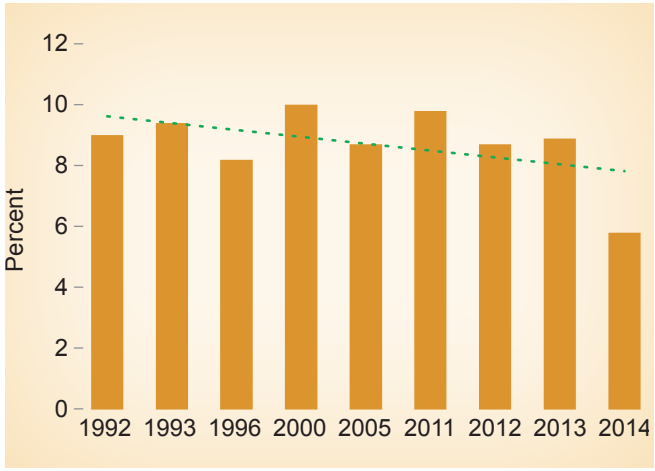
Meanwhile, in 1982 the World Bank launched the Rural Health Project, the Bank's first operation in the health sector in Senegal. Although not strictly a nutrition project, it aimed to strengthen Senegal's institutional and health services delivery capabilities and, in doing so, to restore the credibility of the health system and capacity to manage outreach programs at the village level. A separate nutrition project—the Integrated Food and Nutrition project—was prepared but was not approved because of the complexity of its proposed village-level interventions and the degree of institution building required (World Bank 1982). Other international partners, including the UN agencies (United Nations Development Programme (UNDP), FAO, WHO, and UNICEF) and bilateral donors (Bel-

FIGURE 1: Stunting of Children Under Five in Senegal, 1992–2014



Source: UNICEF et al. 2016.

FIGURE 2: Wasting of Children Under Five in Senegal, 1992–2014



Source: UNICEF et al. 2016.

gium, Canada, the Federal Republic of Germany, France, the Netherlands, and the United Kingdom), were also implementing or providing technical support and training for nutrition-related health, agriculture, and education projects of various sizes.[16] In the agriculture sector, however, many crop development and diversification schemes were implemented with slight regard for their social or nutritional relevance.

Key Themes

By the early 1990s, when the global nutrition community was gaining momentum, Senegal already had over 15 years' experience in multisectoral nutrition intervention, albeit with limited success and many lessons learned. During this period, the nutrition situation sharply deteriorated. Early mismanagement and poor results set the stage for the overt politicization of nutrition.

Nutrition Championship. Under the presidency of Abdou Diouf, nutrition continued to feature prominently in national documents of reference and, formally, remained high on the political agenda. Political commitment was made serious by promulgation of the 1977 Food Investment Strategy for food and nutrition. Financial commitment to nutrition, however, did not keep pace.[17] Although public investment in the development of public health infrastructure would ultimately be good for nutrition, the nutrition unit itself was severely underresourced.

Institutional Ownership. Despite significant restructuring during this period, the institutional home for nutrition formally remained with the nutrition unit of the Ministry of Health, now called SANAS. However, the designation of CANAS as a coordinating body and the sponsorship of key food and nutrition policy by a ministry other than the Ministry of Health indicate that, informally at least, ownership of nutrition may have lain elsewhere. Also, there are indications that commitment to nutrition within the Ministry of Health itself was weak.[18]

Multisectoral Coordination and Collaboration. Various nutrition-related activities were carried out during this period by several ministries. The debate, first documented in the 1960s, around the distinct roles for coordination of nutrition versus delivery of direct nutrition services seems to have culminated in this period in the creation of CANAS, a cross-sectoral body responsible for coordination across ministries of nutrition activities. The actual degree of coordination and collaboration among ministries is unknown, but given limited capacity at the community level it seems likely that ground-level coordination and collaboration for nutrition activities may also have been quite limited.

Community Ownership. Decentralization reforms during this period were intended to give more power to local government and increase community ownership of public monies. Creation of the rural community administrative unit created for the first time a platform for delivery of services at the village level. Nutrition services, to the extent they existed, continued to consist of facility-based curative care targeted at urban areas. Nutrition services in rural areas were primarily carried out by NGOs, and often with minimal coordination with stakeholders. Community-based nutrition services were nascent. Pilot studies carried out by USAID and others during this period evaluating the effectiveness of community-based delivery of growth monitoring, food distribution, and nutrition education were criticized for circumventing the network of public health centers.

Integrated Services and Delivery Platforms. The Sahelian drought and the emergency that ensued shifted the focus from development to humanitarian assistance and relief. The prevailing perception during this period was that public facilities failed to meet the health needs of the population. A major shift in public health policy was underway, however, toward integrated services, including nutrition. Despite deep design and operational flaws in nutrition programming, the foundation for integrated services and delivery platforms was laid.

Partner Engagement. Faced with simultaneous environmental and social crises, government dependence on international partner financing and support increased during this period. Meanwhile, the presence of regionally influential research organizations and the implementation of operational research conducted by donors made Senegal a testing ground for community-based nutrition intervention and secured Senegal's place as a contributor to the growing global evidence base.

The key nutrition-related policies and influences for this generation are listed in box 2.

BOX 2: Nutrition-Related Policies and Influences during the *Curative Approach Generation*

Policies
- Decentralization reforms create the rural community administrative unit (1972)
- 4th PQDES (1973)
- 5th PQDES (1975)
- Food Investment Strategy 1977–1985 (1977)
- 6th PQDES (1981)
- 7th PQDES (1985)
- 8th PODES (1989)

Institutions
- CANAS (1979)
- SANAS replaces BANAS (mid-1980s)

Programs
- PPNS (1973)
- Programme Santé Sécheresse (1975)
- Rural Health Project (1982)
- Nutritional Rehabilitation and Surveillance (1989)
- PSMI/PF (1989)

Key National Influences
- Stabilization Programme (1979)
- Adjustment Programme (1985)
- DHS (1986)

Key Regional and Global Influences
- Sahelian drought (1970s)
- Alma Ata Declaration (1978)
- International Code of Marketing of Breastmilk Substitutes (1981)
- Iringa Project (Tanzania) (1983)
- Publication of Sommer et al., *Impact of Vitamin A Supplementation on Childhood Mortality* (1986)
- Innocenti Declaration (1990)
- World Summit for Children (1990)
- African Charter on Rights and Welfare (1990)
- UNICEF Nutrition Conceptual Framework (1990)

4
Institutionalization of Nutrition (1990s–2000s)

A reorientation toward a preventive approach through integrated intervention packages and community-based interventions in an effort to "do things better" for nutrition

Nutrition Context

Senegal. As we enter the 1990s, GDP per capita in Senegal was still in decline, over two-thirds of the population was living below the poverty line, and Senegal's economic and social indicators were poor, even in comparison to neighboring countries and low-income countries generally. In 1994, structural adjustment reforms of the 1980s culminated in a sudden devaluation of the CFA franc, imposed by the IMF. The consequence was rapid inflation, deterioration of food and nutrition security, and urban unrest, particularly among young urban professionals. Existing nutrition programs had proven to be unsuccessful, and the government lacked or was unable to allocate adequate resources to support social programs; the unfolding financial and social crises shifted national nutrition discourse to a focus on humanitarian assistance. Riding in on this wave of unprecedented economic and social upheaval, President Wade, elected in 2000—Senegal's first democratic transfer of power to another political party—would emerge as a strong champion for nutrition.

Global and Regional. Failure to achieve results for nutrition during this period were not unique to Senegal. In 1991 it was reported that, "no country in sub-Saharan Africa has improved its nutrition status since 1980." (Abosede and McGuire 1991, 4). However, early operational research in the delivery of community-based nutrition services in the 1980s led, during this period, to remarkable progress in the design of preventive integrated nutrition interventions such as the Actions Essentielles en Nutrition (Essential Nutrition Actions) (AEN) and the Prise en Charge Intégrée des Maladies de l'Enfant (Integrated Management of Childhood Illness) (PCIME). Also during this period, mounting evidence provided by Sommer et al. (1986) on the impact of vitamin A deficiency on mortality motivated global commitment to the delivery of periodic high dose vitamin A supplementation through mass supplementation campaigns that began in the mid-1990s with support from the World Bank, USAID, and Canada.

AEN is a framework originally developed by USAID, WHO, and UNICEF for managing the advocacy, planning, and delivery of an integrated package of nutrition interventions to improve public health (USAID et al. 2011). AEN promotes a "nutrition through the life cycle" approach—comprising seven areas of action: (1) women's nutrition; (2) breastfeeding; (3) complementa-

ry feeding; (4) nutritional care of sick and malnourished children; (5) prevention and control of anemia; (6) vitamin A deficiency; and (7) iodine deficiency—to deliver the right services and messages to the right person at the right time using all relevant program platforms.

PCIME is a strategy originally developed by WHO and UNICEF to reduce child mortality and morbidity in developing countries. PCIME addresses the major causes of death in children by improving case management skills of health workers, strengthening the health care system, and addressing family and community practices (Partnership for Maternal, Newborn and Child Health 2006). PCIME became the main child survival strategy in many African countries.

The global community of nutrition partners, the World Bank included, set about advocating for and implementing community-based and integrated nutrition projects in Senegal and elsewhere. In 1992, FAO and WHO convened the International Conference on Nutrition (ICN), the first global conference devoted solely to nutrition, with representatives of 159 countries and the participation of the UN agencies and over one hundred NGOs. The year 2000 marked the Millennium Summit and adoption of the MDGs, including the goal to halve, between 1990 and 2015, the proportion of people who suffer from hunger. By the end of this period, all eyes turned toward galvanizing action to reach the MDGs.

Nutrition Policy

Policies. An historic shift in nutrition policy was underway in Senegal. This period witnessed institutionalization of the first national nutrition-specific policies, largely echoing global advocacy in preceding years, such as the Interministerial Decree Establishing the Conditions for Marketing Breastmilk Substitutes and ratification of the Baby Friendly Hospital Initiative (both in 1994) and, also in 1994, the Salt Iodization Strategy to Fight Iodine Deficiency Disorder (IDD), which culminated in 2000 in a Decree Mandating Universal Salt Iodization. Each of these policy initiatives was led by the Ministry of Health with the support of international partners. National documents of reference during this period continued to prioritize nutrition and played an important role in guiding nutrition programming. In particular, the 1996 9th PODES for the first time explicitly framed malnutrition as a public health problem, in recognition of its widespread and long-term impact, and reoriented intervention toward holistic preventive, rather than curative, approaches.

Lacking any formal, overarching national nutrition strategy, however, nutrition policy during this period was in effect defined by whatever nutrition programs were in place. Institutional ownership of nutrition was transferred from the Ministry of Health—the institutional home for nutrition since independence—to AGETIP. Even though AGETIP had no prior experience in health or nutrition programming, it was chosen as the institutional home of the new World Bank-funded Projet de Nutrition Communautaire (Community Nutrition Project) (PNC). Previous World Bank-supported health projects[19] had been deemed unsatisfactory and, in accord with the experiences of other international nutrition partners working in Senegal at this time, the World Bank considered the Ministry of Health to be cumbersome and ineffective. PNC was designed to operate in "rapid response" to the crisis; AGETIP was determined to be both a more efficient and effective institution and to have the capacity required to manage a project that was ostensibly a nutrition-sensitive social safety net and youth employment operation.

PNC was the World Bank's first foray into nutrition programming in Senegal. During this period, governments, including Senegal, were urged by the World Bank to create agencies like AGETIP to circumvent the corruption common to large public works contracts. However, this shift in responsibility for nutrition—perceived by some as a "marginalization" (Ndiaye 2010) of the Ministry of Health—would prove pivotal and would influence nutrition policy and politics in Senegal for the next 20 years. In fulfillment of its new mandate—and with the confidence of the President—AGETIP made decisions without the engagement of the Ministry of Health and without regard for existing Ministry policies. The importance of this momentous shift in nutrition policy is

FIGURE 3: Organogram of PNC

Source: Marek et al. 1999.
Note: NGO = nongovernmental organization. GIE = microenterprises.

further underscored by the development in 1997 of a National Plan of Action for Nutrition[20] by the Ministry of Health in collaboration with ITA, the Ministry of Agriculture, and the Ministry of Rural Development. The 1997 National Plan of Action was never executed for lack of funds; it is notable, however, for being the first effort in Senegal to develop a national multisectoral plan for nutrition and indicative, therefore, of important progress in the evolution of nutrition policy.

Institutions. Like other international organizations at the time, and with mounting evidence as to the importance of early nutrition on long-term human capital development, the World Bank nutrition staff were anxious to start a nutrition project in Senegal. Previous investments had been made to expand and improve health infrastructure, but there was neither investment specifically for nutrition nor work being done at scale at the community level. A nutrition project prepared in 1982 had been deferred for lack of local capacity. The 1994 devaluation of the CFA franc and the deteriorating economic and social situation offered a window of opportunity for engagement in nutrition. the World Bank approached the Ministry of Health to initiate a community-based nutrition project, but the Ministry purportedly was not interested. Having failed to gain traction and skeptical that the Ministry had sufficient "implementation capacity, management structures, or practices to deliver" (Garrett and Natalicchio 2011, 68), the World Bank management for nutrition in Senegal approached AGETIP.

AGETIP had a strong track record for good management, as well as institutional and absorptive capacity; that is, AGETIP had the capacity to execute projects and disburse money. AGETIP was receptive to the project as a means of fulfilling its mandate for job creation through the delivery of nutrition services. It was an innovative, if controversial, approach. the World Bank conditioned the project financing on creation of a high-level oversight committee. According to interviews conducted for this report, the head of AGETIP had connections to then–President Diouf, and an agreement was made to create the CNLM in the President's office with a mandate to ensure the availability of a safety net for the poor and responsibility for oversight of PNC (figure 3). As a result, in 1995, Senegal's first at-scale multisectoral community-based nutrition project was born with almost no engagement of the Ministry of Health.

A Technical Advisory Committee consisting of "leading professionals from Senegalese universities and medical schools and representatives from international technical agencies" (Garrett and Natalicchio 2011, 69) was created to design and support AGETIP. CNLM itself was composed of representatives from the Prime Minister's Office, the Ministries of Economy, Finance, Health (including the nutrition unit, now called the Service National de l'Alimentation et de la Nutrition (National Service of Food and Nutrition) (SNAN), Women's, Children's and Family Affairs, the Food Security Commission, AGETIP, and NGOs and civil society organizations. However, lacking any incentive structure, budget for supervision, or clear roles and responsibilities to maintain the engagement of implementing partners, representatives became "indifferent" and the CNLM "dysfunctional" (Ndiaye 2007).

Regular CNLM meetings occurred but they were largely formalities. Partner line ministries were not involved in project implementation and monitoring and

evaluation processes were weak. “Anchorage” of the CNLM in the President’s office and “marginalization” of the Ministry of Health were “perceived as . . . deliberate move[s] to keep financial resources outside the control of the Ministry . . .” (Ndiaye 2007). In essence, implementation of PNC created a parallel system, and the shift in institutional ownership of nutrition to AGETIP sidelined the Ministry of Health’s involvement in PNC’s design and implementation. In turn, rather than reap benefits for the sitting administration, the Minister of Public Health, who was from the opposition party, purportedly instituted a Ministry-wide unwritten policy of noncooperation with CNLM and PNC.

Programs. Given its catalytic role, PNC (funded by the World Bank with support from WFP and the German Development Bank) is the most historically important nutrition program implemented during this period. Designed by the Technical Advisory Committee of the CNLM, it was a large-scale nutrition intervention that was innovative in several ways, first and foremost for being multisectoral. Given its institutional home in AGETIP, PNC was necessarily as much a youth employment operation as it was a nutrition intervention. The nutrition objective was to prevent the deterioration of nutrition among the most vulnerable (defined as malnourished children under three and PLW) in targeted poor urban areas.

Through Community Nutrition Centers, PNC activities included growth monitoring of children under three; provision of a weekly take-home food supplement for six months for underweight children; weekly nutrition and health education sessions for PLW; provision of a weekly take-home food supplement for three months for pregnant women during the last trimester of their first pregnancy and for six months for all lactating women with a child in the program or with an infant younger than six months; referrals for unvaccinated women and children; and provision of communal potable water sources (drinking water stand pipes), managed by local women’s groups. The food supplement was locally produced in Senegal. In addition to individual nutrition counseling, mass media was used to deliver nutrition messaging to the population at large.

PNC was also innovative for contracting with young people organized in Groupements d’Interet Economique (microenterprises) (GIEs) for the management, training, delivery, and supervision of preventive nutrition services at the community level. The design was based on India’s Tamil Nadu and Tanzania’s Iringa projects, and other projects that used a contract approach for hospital-based care (Marek et al. 1999). PNC’s nutrition and youth employment objectives met at the community level, and, in essence, PNC was a community-based nutrition project created in response to urban unrest. Nutrition services were delivered by the GIE, four previously unemployed youth from the community—although with only nominal expertise in nutrition—who themselves had been trained by local consultants or institutions and supervised by a Maître d’Oeuvre Communautaire (project manager) directly hired by AGETIP. Establishment of local steering committees in each PNC community and district level coordination mechanisms helped to ensure efficient execution of project activities.

Ultimately, although PNC was a popular project because it delivered nutrition services and much-needed employment in urban areas, it suffered from severe challenges of targeting, cost, coordination, quality, and corruption. Because PNC was intended, in part, to quell urban unrest in the aftermath of the devaluation of the CFA franc, it targeted urban areas even though the highest burden of malnutrition was in rural areas. And, because the program relied heavily on food distribution and was run out of community nutrition centers, PNC costs were very high. Despite PNC’s catalytic importance for putting multisectoral cooperation on the national development agenda, reports indicate that cross-sectoral coordination was largely unsuccessful, with line ministries inadequately involved and little effort made to build the capacity of state actors. In particular, coordination of referrals from PNC community nutrition centers to the Ministry of Health–supported health centers for identified cases of SAM were a key failure. Health centers purportedly suffered a “lack of expertise in nutrition case management, inadequate materials, and failure to provide needed special nutritional supplements” (Garrett and Natalicchio 2011, 72).

IMPACT

During this period, there was a slight decrease in stunting, from 34.4 percent in 1992 to 29.5 percent in 2000 (see figure 1). At the end of this period, nearly a third of children under five in Senegal were still suffering from chronic malnutrition; however the trend was in the right direction and by 2005 stunting dropped nearly 10 percentage points to 20.1 percent. Prevalence of wasting was less responsive, from 9 percent in 1992 to 10 percent in 2000 and 8.7 percent in 2005 (see figure 2). Results from PNC indicate that the impact on malnutrition measured by the reduced prevalence of underweight among children in communities reached was significant. This is also largely borne out by national surveys: Underweight held steady at 20.4 percent in 1992 and 20.3 percent in 2000 before dipping to 14.5 percent in 2005.

Finally, PNC was not the only nutrition project implemented at this time; duplication of effort and parallel programming are among the many criticisms of PNC. During this period SNAN carried out various nutrition activities with support from international partners such as USAID, UNICEF, WHO, and World Vision. Although these activities collectively are referred to in historical records as the "National Nutrition Programme" (Ndiaye 2010), it is more accurate to say that it was a collection of nutrition activities that remained under the Ministry of Health's control. Chief among these activities were policy-level advocacy initiatives, such as support of the International Code of Marketing of Breastmilk Substitutes, the Baby-Friendly Hospital Initiative, and mandated salt iodization and micronutrient supplementation; training of Agents Communautaires (Community Agents); continued support of nutritional rehabilitation through the CRENs; and oversight of several important at-scale projects, including the USAID/BASICS project, biannual National Micronutrient Supplementation Days for vitamin A, and biannual National Vaccination Days, which were (finally) initiated with support from the Micronutrient Initiative (MI) and UNICEF.[21]

From 1994–2006, BASICS was USAID's multipartner child survival project that supported the Ministry of Health in scaling up implementation of evidence-based interventions proven to be effective in preventing and treating the major causes of newborn and childhood death, including malaria, pneumonia, diarrhea, malnutrition, birth complications, and HIV/AIDS. BASICS was operational in over 20 countries and worked in 22 of Senegal's 56 health districts, placing strong emphasis on improving the reach of health programs through community-based intervention. BASICS piloted a Paquet d'Activités Intégrées de Nutrition (Package of Integrated Nutrition Actions) (PAIN) that combined AEN and PCIME, and was later adopted as a national strategy by the Ministry of Health. BASICS also conducted important formative research on nutrition communication to identify best practices of community-based nutrition programming, and developed information, education and communication (IEC) materials, including counseling cards and the use of radio for social marketing of behavior change. As cited in the 2001 LPDN, all of this was carried out through the SNAN with no coordination with CNLM or PNC.

Key Themes

This period represents a deepening institutionalization and politicization of nutrition through a controversial move to anchor nutrition outside the Ministry of Health. There were also some important firsts, including the first nutrition-specific legislation, an attempt at an overarching multisectoral national plan (which was never implemented), and the first large-scale community-based nutrition project. PNC is, however, best understood as a rapid response operation: Nutrition interventions were still primarily oriented toward identification and rehabilitation of malnourished children; most PNC funding was spent on food supplementation and provision of drinking water; and the overriding objective was to quell urban unrest through youth employment. Although ultimately deemed a failure, PNC provided valuable lessons and led to mobilization

around the importance of multisectoral collaboration that would later inform the design of the PRN.

Nutrition Championship. This was a period of crisis, and any momentum for nutrition built in previous generations was subsumed by the emergency response. Important progress was made, however, when the responsibility for nutrition was rescued from oblivion in the Ministry of Health and placed in a position of relative prominence in the President's office under the competent management of AGETIP.

Institutional Ownership. The monumental shift in anchorage that established institutional ownership of nutrition outside the Ministry of Health set an important precedent. However, the specific institutional arrangements and the political tensions that resulted from the move created "a weak basis for sustained action" (Garrett and Natalicchio 2011, 71).

Multisectoral Coordination and Collaboration. Substantive, if partial, progress was also made in cross-sectoral collaboration for nutrition. First was the development of the National Plan of Action for Nutrition, a multisectoral national nutrition plan, spearheaded by the Ministry of Health in partnership with ITA, and the ministries of Agriculture and Rural Development. Although the National Plan of Action for Nutrition was never implemented, it marked an important advance. Second was creation of the CNLM, which also marked an important development in Senegal's path to institutionalizing multisectoral cooperation for nutrition. That this effort at coordination failed because of insufficient incentives and mechanisms for engagement of other ministries provided valuable lessons for the future.

Community Ownership. Important and innovative accomplishments increased community engagement and demonstrated that decentralized preventive services contracted through local NGOs could have an impact on nutrition outcomes. Through PNC, the proximity of contracted GIEs to the communities they served was leveraged to increase coverage of nutrition services while employing locally appropriate approaches and intervention strategies. By and large, this would form "the foundation of the operational scheme and success of PRN" (Ndiaye 2010, 11). In addition, the USAID/BASICS project supported the Ministry of Health's efforts to capitalize on and implement global innovations in community-based delivery of nutrition services.

Integrated Services and Delivery Platforms. This was the generation that launched large-scale implementation of preventive integrated services and delivery platforms. With support from USAID, the Ministry of Health adopted PAIN as the strategy for nutrition service delivery. Efforts were underway to build capacity to deliver nutrition services at the community level and to link these community-based interventions to the health system. Although PNC implemented an innovative approach to engaging local organizations and communities in community-based nutrition service delivery, the failure of PNC and the Ministry of Health to coordinate (there was no link whatsoever) meant that health facilities were ill-prepared to receive and follow up on referrals from the community. Most health facilities were too poorly staffed and too poorly equipped to manage the referrals received. Moreover, with BASICS operational in fewer than half of Senegal's districts and PNC operating only in urban areas, nutrition service delivery was not yet at scale.

Partner Engagement. This period marks a significant increase in the number of international partners working on nutrition in Senegal, and the first World Bank nutrition investment. Also, for the first time, private organizations were contracted by government to deliver preventive nutrition services.

The key nutrition-related policies and influences for this generation are listed in box 3.

BOX 3: Nutrition-Related Policies and Influences during the *Institutionalization of Nutrition Generation*

Policies

- Salt Iodization Strategy to Fight IDD (1994)
- Baby-Friendly Hospital Initiative (1994)
- Interministerial Decree Establishing the Conditions for Marketing Breastmilk Substitutes (1994)
- 9th PODES (1996)
- Decentralization reforms to transfer nine responsibilities to local communities (1996)
- National Plan of Action for Nutrition (1997)
- PAIN adopted by the Ministry of Health as national nutrition strategy (1998)

Institutions

- CNLM (1994)
- AGETIP (1994)
- SNAN replaces SANAS (mid-1990s)
- Laboratoire de Nutrition de la Faculté des Sciences (1997)
- CNSA (1998)

Programs

- USAID/BASICS (1994)
- Salt Iodization project (1994)
- PNC (1995)
- National Vaccination Days and National Micronutrient Supplementation Days (1999)

Key National Influences

- DHS 1992–93
- Devaluation of the CFA franc & resulting urban unrest (1994)
- DHS1997
- DHS1999
- Election of President Abdoulaye Wade (2000)

Key Regional and Global Influences

- PCIME (1990)
- ICN and global push to develop national multisectoral nutrition plans of actions (1992)
- AEN framework (1997)
- Millennium Summit (2000) and the adoption of the Millennium Development Goals for 1990–2015
- Global Strategy for the Prevention and Control of Noncommunicable Diseases (2000)

Photo: Adama Cissé/CLM

5
Intensification and Decentralization (2000s–2010s)

A decade of action for nutrition that turned the tide for nutrition policy in Senegal with rapid improvement in nutrition outcomes

Nutrition Context

Senegal. The election of Abdoulaye Wade in March 2000 changed the political scene in Senegal dramatically. After 40 years of leadership by the Socialist Party, Wade was Senegal's first president from the Senegalese Democratic Party. Whereas the Socialist Party espoused state control, the Wade administration promoted a more progressive approach to economic development characterized by a more pluralistic environment, promotion of the private sector and—in stark contrast to the economic reforms of the previous generation—greater emphasis on the development of human capital through improvements in healthcare, education, and employment. Despite earlier efforts to expand the reach of social services, access remained limited, quality was poor, and there were marked inequities across regions and between urban and rural areas. At this time, approximately 80 percent of the urban population lived within 30 minutes of a health facility, compared to only 42 percent of the rural population.

In 2000, the prevalence of stunting remained high at 29.5 percent, although there was a small but marked decrease compared to a decade prior (figure 1), and stunting prevalence in Senegal was lower than the average for Sub-Saharan Africa. Prevalence of wasting and underweight held steady at about 10 percent and 20 percent, respectively. With persistent high rates of stunting, a scandal-ridden and fractured system of nutrition service delivery, and a newly elected administration with a mandate for change, it was an uncertain time for the future of nutrition policy. However, in this period nutrition was understood to be a critical component of human development, and President and First Lady Wade were visible nutrition champions. The decade of the Wade administration—from 2000 to 2012—marked a period of unprecedented intensification of action to reduce malnutrition in Senegal that produced unprecedented results.

During this period, efforts to decentralize social services were redoubled, and policy change—formal, institutional, and programmatic—finally turned the tide for nutrition in Senegal. Revision of the national constitution in 2001 included codification of the right to food. Another important milestone for Senegal was participation in the first Countdown to 2015 event in London in 2005. In the lead-up to the event, then–Prime Minister, and current President, Macky Sall coauthored

with the Prime Minister of Madagascar a letter to the editor of *The Lancet*, entitled "African Prime Ministers Take Lead in Child Survival" (Sall and Sylla 2005), in response to the journal's admonishment that "global child-survival efforts now need to broaden to include not just international organisations but also ministers of health, prime ministers, and presidents in the most affected countries" (Lancet 2005).

Global and Regional. Globally, this period was marked by increasing momentum for nutrition in the MDGs, fed by landmarks such as work by David Pelletier et al. (1994) demonstrating that approximately half of child mortality was attributable to malnutrition; the Copenhagen Consensus in 2004, which concluded that nutrition was among the top development investments; publications such as the Global Strategy for Infant and Young Child Feeding (WHO and UNICEF 2003), which advocated and provided a framework for action to improve nutrition and child survival through optimal feeding; the WHO Child Growth Standards: Methods and development (WHO 2006), which provided a new international benchmark for assessing the nutrition status of children; Repositioning Nutrition as Central to Development in 2006 (World Bank 2006), which offered a global development strategy; the Lancet Series on Maternal and Child Undernutrition (2008), which catalogued the evidence for the causes and consequences of malnutrition, identified a package of proven interventions, and called for global action to improve nutrition for mothers and children; and the emergence of the SUN Movement in 2010.

Another important influence on global nutrition discourse and a huge advancement in nutrition service delivery was the innovation of Community Management of Acute Malnutrition (CMAM), first piloted by Valid International in Ethiopia and Malawi. CMAM's use of Ready to Use Therapeutic Food was nothing short of a revolution in the treatment of SAM, for which previous treatments had been considered by the World Bank and other international nutrition partners to be inefficient and ineffective. The 2008 Lancet Series included CMAM among the cost-effective nutrition interventions, paving the way for global advocacy and support.

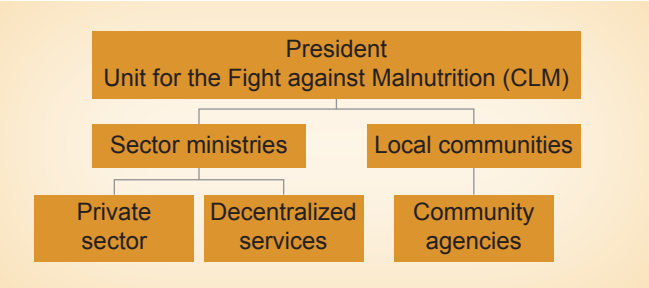
This period is also notable for the 2007–08 global food price crisis which, while not having a major impact on Senegal, helped to reinvigorate donor commitment to nutrition and support the rollout of CMAM. As the Paris Declaration[22] committed donors to support government ownership, the push for scale-up in financing for nutrition took place against the backdrop of donor concern that increasing foreign assistance might weaken government commitment to reforms.

Nutrition Policy

Policies. With the inauguration of the Wade administration came a flurry of new policies and initiatives having far-reaching implications for nutrition. In 2000, Senegal, with support from the World Bank, developed its first Document de Stratégie de Réduction de la Pauvreté (Poverty Reduction Strategy Paper) (DSRP) based on four pillars: wealth creation through economic reform and private sector development; capacity building and development of social services; improvements in the living conditions of vulnerable groups; and implementation of the strategy and monitoring of its outcomes. Importantly with regard to nutrition policy, both the first DSRP in 2000 and the second DSRP in 2006 codified what had been learned through the preceding five years of nutrition programming with PNC—it articulated the importance of a coherent multisectoral approach to addressing malnutrition and provided the institutional and financial means for it.

In essence, President Wade doubled down on the institutional approach to nutrition introduced by PNC, albeit with major modifications. Widespread criticism of PNC, especially with regard to the marginalization of key ministries and the overall failure of efforts at multisectoral coordination, accusations of corruption, and little evidence of impact on nutrition, fueled calls for restructuring. In 2001, an executive decree created a new entity, the CLM to replace the CNLM; the institutional home for nutrition was moved to the Prime Minister's office. The BEN was created as part of the CLM to be the permanent executive office in charge of day-to-day management. The BEN was then identified as

FIGURE 4: Organogram of PRN



Source: Ka 2011.

the implementing agency responsible for executing the new World Bank-funded nutrition project, PRN (figure 4). At this time, nutrition was also added as a distinct investment line in the national budget.[23] Though the investment line was time-bound (as opposed to an operational line, which covers overhead costs and is more permanent), it was a major step toward ensuring institutionalization and sustainability of funding for nutrition beyond the life of any single project or administration.

CLM was charged with articulating a "new vision" for nutrition intervention in Senegal. Among its first responsibilities was writing the LPDN to define—for the first time—national nutrition policy and elaborate appropriate strategies for programming and monitoring. Although underlying party politics likely played a role, the World Bank conditioned receipt of PRN financing on these institutional arrangements in an effort to establish a long-term, national, community-based program for nutrition (rather than a project), anchored in a policy and institutional framework with high political visibility to secure the enabling environment required for effective multisectoral cooperation. That is, the LPDN was a prerequisite for the World Bank financing; as a result, through PRN nutrition intervention in Senegal evolved from a "project approach" to a "program approach" (Ndiaye 2007).

The LPDN called for urgent attacks—both direct and indirect—on the multiple causes of malnutrition and food and nutrition insecurity across all sectors, in particular by the Ministries of Health, Education, Agriculture and Livestock, Fisheries, Family and National Solidarity, Early Childhood, and Trade. It defined eight strategic principles for action: equity, decentralization, partnership, contractualization (outsourcing of services), community ownership, transparency, sustainability, and ethics. The 2001 LPDN nutrition strategy encompassed the following nine components, each with clearly delineated priority actions:

- Strengthening of the community approach with PAIN and the Prise en Charge Intégrée de la Maladie l'Enfant au Niveau Communautaire (Community Integrated Management of Childhood Illnesses) (PCIME-C);
- Strengthening food security by improving agricultural production, food research, and distribution of food;
- Improving the supply of potable water and sanitary living conditions;
- Reorganization and strengthening of institutional frameworks for piloting and managing nutrition projects;
- Strengthening partnerships with local collectives, NGOs, associations, Agences d'Exécution Communautaire (Community Executing Agencies) (AECs), and the private sector in the implementation of programs to fight malnutrition;
- Improving systems for collecting, analyzing, and disseminating data on food, nutrition, and promotion of studies and research;
- Strengthening the capacity of human resources at the community level;
- Strengthening IEC and BCC programs; and
- Development of income-generating activities

In the lead-up to PRN, the World Bank management for nutrition in Senegal had changed. A bold and innovative approach to the preparation of PRN was undertaken that would prove to be instrumental to the long-term success of the program. PRN was designed through a series of participatory workshops that included representatives from all nutrition-related ministries, the Ministry of Finance, donors, and NGOs. The purpose of the participatory process went beyond simply project preparation. The workshops enabled the participants to bring to light and debate emerging global evidence for the causes and consequences of malnutrition and

appropriate strategies for intervention in Senegal. Having all stakeholders at the table—many of whom were not nutrition experts—enabled an authentic dialogue and a transparent decision-making process.

Instrumental to the effectiveness of these discussions was the strategic use of the USAID-funded PROFILES policy development and advocacy tool, which estimated the economic and social benefits, as well as the program costs, of nutrition intervention in Senegal, enabling decision makers to "see for themselves the return on investment in nutrition" (Garrett and Natalicchio 2011). In short, the evidence laid bare what many already knew, that is, the need for action in multiple sectors in order to improve nutrition in Senegal. What also was evident was the need to pivot "away from food distribution to a stronger focus on prevention, behavior change, and education" (Garrett and Natalicchio 2011) and to target rural areas where the burden of malnutrition was higher. Lessons learned from PNC also provided clues to key challenges that would need to be addressed, such as implementation capacity, coordination, and community engagement. Even well thought out design decisions would invoke resistance from entities with long-standing financial and political interests in existing systems, such as those for food distribution. However, the workshops were successful at building consensus and buy-in among key decision makers; shared understanding among the participants from varied backgrounds and experiences; and the trust and commitment required to pave the way for effective collaboration.

Among the lessons drawn from the PNC was the importance of having an effective platform for ongoing multisectoral collaboration. It was crucial that partners remain engaged with the program well beyond the design stage. At the central level, the CLM and BEN entered into collaborative agreements with the various ministries. Of note, the Ministry of Health was the delegated entity responsible for nutrition policy within the CLM. Also, money was unabashedly used as a "lubricant for intersectoral collaboration" (Garrett and Natalicchio 2011)—PRN funded incentives such as training, equipment, and technical support for participating ministries. Local governments were the focal points for coordination. At the lowest level, the commune, the AEC was in charge of the community-based nutrition projects with higher administrative levels (such as the sous-Préfecture, Préfecture and Regional Governor) involved in program monitoring and coordination across sectors. PRN was further specified in Strategic Plans for each phase of the program.

In 2006, the LPDN was revised to account for the evolving global, regional, and national contexts, such as the emergence of the MDGs, the Global Strategy for Infant and Young Child Feeding, the New Partnership for Africa's Development (NEPAD), and the 10th PODES, which defined the vision for Senegal as "a country where every individual has a satisfactory nutritional status and takes appropriate behavior for their welfare and development of the community" (République de Sénégal 2006). The 2006 LPDN also reflected the evolving nutrition situation, which was shown by new data to include widespread food insecurity and disparities in access to nutritious food, as well as significantly reduced rates of undernutrition and improved nutrition practices. National nutrition policy objectives were framed in terms of the MDGs, and the guiding principles were reduced from eight to four: equity, ethics, transparency, and contractualization. The revised strategies included prioritization of community-based delivery of efficacious nutrition interventions; strengthening of food security; strengthening of the institutional and organizational capacity of CLM and community-level partners; and improving nutrition information systems. Finally, the 2006 LPDN reflected renewed commitment to the institutional arrangements put in place in 2000. Senegal was headed in the right direction, but there was still a lot of work to do.

Among the strategies included in the 2006 LPDN was improvement of the legislative and regulatory framework for food and nutrition. The evolution of the nutrition political climate is evident in significant efforts during this period to strengthen the normative framework for nutrition, and the capacity of the Ministry of Health to implement nutrition interventions. Initiatives led by the nutrition unit of the Ministry (now called Division de l'Alimentation de la Nutrition et de

la Survie de l'Enfant (Division of Food, Nutrition and Child Survival) (DANSE)) with technical and financial support of external partners—such as the 2001 Nutrition Standards and Protocols, which established criteria for service quality; the PCIME Strategic Plan 2002–2007; the Politique National pour l'Alimentation du Nourrisson et du Jeune Enfant (National Policy for Infant and Young Child Feeding) in 2006; and the Plan National de Survie de l'Enfant (Strategic Plan for Child Survival) (PNSE) in 2007—over time came to be developed in coordination with CLM. In 2009, the Plan National Développement Sanitaire et Social (National Health Development Plan) (PNDS), for 2009–18, committed to the protection of women and children through delivery of a community-based intervention package (such as PCIME) that included promotion of exclusive breastfeeding as a priority action.

Also during this period, years of work by key partners such as Helen Keller International (HKI), MI, and UNICEF culminated in 2009 with two landmark nutrition policies: the Decree Mandating Vitamin A Fortification of Oil and the Decree Mandating the Fortification of Wheat with Iron and Folic Acid. Policy developments in other sectors also contributed to the improvement of nutrition service delivery. The Plan de Développement Communal (Communal Development Plan) (PDC) and the Programme Nationale de Développement Local (National Program for Local Development) (PNDL) in 2002 aimed to strengthen the capacity of local government to supply social services to the population.

Institutions. The institutional arrangements established in the 2000 DSRP and reinforced by the 2006 revision of the LPDN remain in place as of 2016. CLM is charged with defining national nutrition policies and strategies; planning, coordinating, and overseeing implementation of nutrition projects and programs; and monitoring results. It is chaired by the chief of staff of the Prime Minister's office with participation from eleven ministries and representatives of NGOs and the Mayors' Association. CLM is the primary reference and monitoring body for nutrition policy, and Senegal's SUN Focal Point. It provides technical nutrition advice, supports the design of technical reference guides, and has oversight of national nutrition studies. With responsibility for the facilitation and management of resources, CLM is also the primary forum for strengthening cooperation among partners and determining concrete actions that enhance collaboration for nutrition.

Finally, the CLM is also responsible, through the BEN, for managing the implementation of PRN. The CLM does not have its own personnel; rather, direct implementation is done through local government, NGOs, and public service providers. However, the CLM raises and allocates money, and through three Bureaux Exécutif Regional (Regional Executive Offices) (BERs) monitors implementation.[24] The BEN is the administrative and technical arm of the CLM, composed of a subset of CLM members. The CLM convenes periodically while the BEN provides day-to-day support, including disbursement of CLM budget. The head of the BEN is the National Coordinator for Nutrition. As PRN is a program of the CLM managed through the BEN, the National Coordinator for Nutrition is also the coordinator of PRN. CLM's dual role in the coordination and implementation of nutrition policy has been viewed as one of the key factors for its success.

Several other institutions played a key role in the evolution of nutrition policy in Senegal during this period. The Comité Sénégalais pour la Fortification des Aliments en Micronutriments (Committee for Food Fortification) (COSFAM), formed in 2006, is a subcommittee of CLM focused on reduction of the prevalence of micronutrient deficiencies (such as iron, vitamin A, and iodine) among women of reproductive age and children under five. With the support of Global Alliance for Improved Nutrition (GAIN), MI, and other public and private partners, the committee was instrumental in the passage of the decrees mandating oil and wheat fortification in 2009. Likewise, the Comité Technique pour l'Iodation Universelle du Sel (Technical Committee for USI (Universal Salt Iodization)) (CTIUS), was formed in 2006, consisting of representatives from the Ministries of Health, Trade, Industry and Cottage Industry, the private sector, local governments, and NGOs to support adequate salt iodization among small-scale producers and compliance with the 2000 mandate for universal salt iodization.

The Conseil National sur la Sécurité Alimentaire (National Food Security Council) (CNSA), formed in 1998, sits in the office of the Prime Minister; it predates and is a member of the CLM. It was originally established for the purpose of regularly evaluating the food supply and nutritional situation. In 2006 it instituted a food security early warning system and is involved primarily in decisions concerning food distribution. Given the overlapping mandates, coordination between CLM and CNSA is important.

Programs. The overall objective of PRN was to support the LPDN and contribute to reaching the first MDG of eradicating extreme poverty and hunger in Senegal. PRN was conceptualized and funded in three phases: first, the development of strategies and demonstrating results;[25] second, scaling to the national level and between sectors;[26] and third, consolidating achievements. The original 10-year horizon (2002–12)[27] provided a structure for gradual scale-up irrespective of political administration, and the phased approach imposed a "sense of urgency for action" (Garrett and Natalicchio 2011). Initial funding for PRN was from the World Bank. Since 2011, the government has increased its ownership, with support from other donors, such as UNICEF, the Spanish Cooperation, the African Development Bank, and the European Union. PRN was not the only instrument for achieving LPDN goals, however. With direct oversight from CLM and the BEN and as the government's flagship nutrition project, PRN spearheaded changes in delivery and monitoring of nutrition services throughout the system.

PRN operates through multilevel and multisectoral collaboration across participating ministries, NGOs, the private sector, local government, and the community. Among the many lessons applied from PNC was the importance of leveraging existing structures and programs. The PRN took a different approach to contractualization, which was first introduced by PNC. Given the variation in characteristics and capacities across regions, it was crucial to empower local NGOs to develop their own locally relevant strategies for engaging the community. Local NGOs, selected through a competitive and transparent process, were contracted to do community mobilization for nutrition actions on behalf of local governments, in collaboration with public service providers and communities, through community steering committees and Agents Communautaires. These contracted NGOs constituted the AEC.

Specifically, Agents Communautaires deliver nutrition social behavior change communication (SBCC) through periodic meetings with women's groups and other nontechnical sensitization and mobilization activities. They also screen (on a quarterly basis), manage, and refer SAM cases to health facilities as required by shared protocols, and ensure follow up at the community level. Genuine community engagement and the involvement of local NGOs in the delivery of nutrition services and monitoring of results infused a real sense of local ownership and responsibility and better supported capacity development of public systems. Originally it was anticipated that government health staff would be responsible for supportive supervision of the Agents Communautaires, but this arrangement was untenable. Instead, training and supportive supervision of Agents Communautaires was provided by the contracted NGOs.

Simply coordinating nutrition services at the community level (delivered through NGOs and volunteers) and facility-based nutrition services (Ministry of Health–led and delivered by health staff)—with all partners operating under the same protocol—was a significant undertaking. Both the 2001 and 2006 LPDNs explicitly promoted specific nutrition strategies, including PCIME, the Global Strategy for Infant and Young Child Feeding, and the integrated approach to addressing micronutrient deficiencies. These constituted the operational framework developed by the Ministry of Health, with the support of external partners, such as USAID, in the mid-1990s. The PCIME model consists of three components: (1) integrated management of ill children in facilities and health centers; (2) health system strengthening, particularly access to drugs and logistics support; and (3) promotion of key family and community practices. It prioritizes prevention, but incorporates both preventive and curative interventions.[28] In particular, PCIME aims to address gaps in knowledge, skill, and community practices regarding children's health,

recognition of illness, home management of the sick child, and appropriate care-seeking behavior.

Small pilots of the full PCIME approach had been implemented in Senegal, but never at scale. The lack of integration in nutrition service delivery created huge inefficiencies and missed opportunities, as evidenced in PNC. PCIME-C—the third component of the model—was innovative for approaching child growth holistically by integrating interventions. PCIME-C principles and strategies were used in PRN in an effort to build on existing structures and programs; link community-based nutrition services with facility-based nutrition services; and signal a spirit of cooperation between PRN and the Ministry of Health. Use of the PCIME model services underscores that PRN could not achieve its objectives by functioning as an isolated project; PCIME was "a strategic way to work more closely with the health service delivery system to promote measures that help prevent malnutrition" (Garrett and Natalicchio 2011, 93).

Community ownership and results-based management went hand in hand. With PRN, nutrition services expanded to rural areas where the burden of stunting was highest. Unlike PNC, PRN's primary objective was to improve nutrition outcomes. Specific nutrition outcome indicators were established against which progress was measured, including nutrition practices, coverage of nutrition services, and nutrition knowledge.[29] Simple monitoring and evaluation tools were used to track, on a monthly basis, results at community, regional, and national levels and inform supportive supervision. Sharing of results against expectations and problem solving at the community level were other mechanisms of community engagement.

In this way, the PRN "monitoring and learning system involved every partner and stakeholder in measuring and discussing results" (Garrett and Natalicchio 2011, 91). Results-based management "contributed to the quality and results focus of the services provided" (World Bank 2007, 11) across the entire system. Participating NGOs received not only extensive training but also technical assistance when problems were detected through regular monitoring. In this way PRN facilitated local capacity building through "learning by doing," providing "the bare minimum of instructions but maximum support" (World Bank 2007, 13). NGOs also benefited from the visibility gained by being associated with a national program, and all partners were encouraged to "take credit for results, thus enhancing ownership and incentives for participation" (Garrett and Natalicchio 2011, 92).

By 2011, CLM was responsible for implementing four other major programs in addition to PRN[30]: (1) the Programme Iodation Universelle du Sel (Universal Salt Iodization) (PIUS) project with support from the Ministries of Health, Commerce, and Industry, and partners such as MI, WFP, and UNICEF; (2) the Nutrition Enfant et Sécurité Alimentaire (Child Food and Nutrition Security) (NESA) project with support from the MDG Fund through WHO, FAO, WFP and UNICEF; (3) the Nutrition Ciblée sur l'Enfant et les Transferts Sociaux (Child Targeted Nutrition and Social Transfers) (NETS) project with support from the World Bank; and (4) the Programme de Renforcement de la Fortification (Program for the Enhancement of Fortification) (PRF), also through the Ministries of Commerce and Industry and supported by GAIN and HKI—a "harmonious convergence of different interventions towards a single goal" (Ka 2011), to improve the health of children under five and PLW. Descriptions of the programs follow:

- PIUS (2009–15) involved local governments in facilitating adequate salt iodization among small-scale producers. The project had regional implications—80 percent of the salt produced by Senegal is exported to other West African countries.
- NESA (2009–12) focused on the prevention and management of malnutrition and reduction of extreme poverty in response to the 2006–07 drought, and promoted improvement of food security and nutrition in highly vulnerable areas.
- NETS (2009–11) was one of the first nutrition-sensitive social protection interventions to use cash transfers as a rapid response to mitigate the negative impact of the food price crisis on vulnerable populations (mothers and children under five).

IMPACT

In PRN Phase I (2002–06), approximately 200,000 mother-child pairs were reached and the prevalence of underweight in PRN zones decreased 42 percent; Phase II (2007–11) provided nutrition services to approximately 700,000 children under five, 50,000 pregnant women, 65,000 lactating women, and 177,000 adolescents. Nationally from 2000 to 2012, stunting dropped from 29.5 percent to 19.2 percent (see figure 1). These represent singularly remarkable achievements for nutrition and the health and welfare of women and children in Senegal. Moreover, these results were achieved at significantly less expense than before: costs for PNC were US$40 (US$67.70 if the child received food supplements) compared to US$3.70 in rural areas and US$5.00 in urban areas for PRN Phase I.

From a nutrition policy perspective, the ability to monitor progress against malnutrition, and the strategic use of results to foster engagement at all levels and leverage additional financing was also remarkable. "Transparency as a management rule has strengthened the creditworthiness of the BEN vis-à-vis local authorities and donors" (Ndiaye 2007) and in 2010, PRN was the recipient of the Senegal Ministry of Economy & Financing Alpha Award for the best project or program team out of a pool of 700 projects. Leaders used the results to demonstrate progress toward the MDGs and signal the creditworthiness of Senegal, redoubling political commitment to nutrition and support for the institutional arrangements.

Success and global visibility gave government partners the incentive to stay engaged in PRN and improve their own performance. The extensive collaboration and intrinsic interdependence of PRN "influenced the public health service delivery system and interventions and strategies of various partner organizations" (World Bank 2007, 18). PRN "became a major roll-out mechanism of existing programs for infant and young child feeding, PCIME-C, and mass and routine distribution of vitamin A supplements. The public service delivery of vitamin A supplements and insecticide treated bed nets greatly improved" (World Bank 2007, 18). NGO partners gained credibility for participating in a government program, and at the community level, social monitoring of the data made visible decreasing rates of malnutrition, which in turn fostered a strong sense of ownership among communities.

- PRF (2006–11) supported the 2009 Decrees Mandating Vitamin A Fortification of Oil and Fortification of Wheat with Iron and Folic Acid by assisting industry partners to upgrade and adapt their production chain, conduct monitoring and evaluation to ensure quality processing, and carry out communication and social marketing.

Other nutrition-sensitive projects were also being carried out during this period in coordination with CLM, including: (1) the Programme Décennal de l'Education et de la Formation (Ten-Year Education and Training Program) (PDEF) (2001–11) through the Ministry of Education with support from PRN and WFP, a school nutrition project that included deworming, iron supplementation, canteens, and hygiene and nutrition education; (2) the Programme National d'Investissement Agricole (National Agriculture Investment Program) (PNIA) (2009–20), which established Community Agricultural Areas and farms incorporating breeding, aviculture, and aquaculture in support of food security; and (3) the Yaajeende project (2010–17) implemented by USAID, which promotes agricultural development (such as the raising of small ruminants, homestead gardening, and aquaculture) for food diversification and to improve child survival and nutrition at the community level.

Key Themes

The decade of the Wade administration represents a peak in both political will and progress for improved nutrition outcomes. In this period, all six key themes coalesce. The launch of PRN coincided with landmark policy development and a major restructuring of institutional responsibility for delivery and oversight of nutrition services. Through a highly inclusive approach facilitated by CLM and BEN, PRN spearheaded systematic change that improved the coherence, efficiency, and effectiveness of nutrition policy across all channels of service delivery. By 2011, Senegal was hailed as a global success story in the progress against malnutrition. Leadership astutely leveraged

the "visibility of success" to secure additional financing (Garrett and Natalicchio 2011, 94).

Nutrition Championship. From the start of the Wade administration, nutrition was taken on as the cause célèbre for the President and First Lady. Use of results-based management meant that early successes could be—and were—heralded to promote increased investment among donors and redouble the commitment of implementation partners. The spirit of shared success created a cadre of nutrition champions at all levels.

Institutional Ownership. With PRN came another major shift in the institutional anchorage of nutrition, but this time with adequate resources and mechanisms to foster effective and sustained collaboration across levels and sectors. Among the first duties of the newly instituted CLM, was the development—after forty years of nutrition intervention—of Senegal's first national nutrition policy, based on equity, ethics, transparency, and contractualization. Over time—and with demonstration of good will and good results—many of the political fissures that crippled PNC were overcome.

Multisectoral Coordination and Collaboration. The political environment for nutrition at the close of PNC was polarized—marked by active resistance from a few key actors and total disengagement from most others. By contrast, PRN was launched with a spirit of inclusiveness and cooperation. With all stakeholders engaged in the preparation of PRN, there was "a greater sense of ownership from the outset" (Garrett and Natalicchio 2011). And although the CLM was initially "plagued by high turnover of representatives from key ministries" (World Bank 2007, 12) (despite operational and financial incentives), as the project produced results, participation and ownership increased. As all partners were engaged in the delivery of PRN, all partners were invited to share in its success. Over time, this "coordination and success" became synergistic, as ministries began to "lobby for their own budgets to support their own nutrition activities" (Garrett and Natalicchio 2011, 95).

Community Ownership. By the year 2000, there had been many attempts to pilot community-based nutrition services in Senegal that never reached beyond a small scale. Its operational flaws notwithstanding, PNC's innovative use of contractualization added an important facet to effective and sustainable community-based service delivery. The concept of contractualization was repurposed—this time around the PCIME framework—to great effect for PRN. Rather than working in isolation, local NGOs were contracted by and on behalf of local governments to deliver the community component of PCIME in collaboration with public service providers and communities. In so doing, PRN built upon existing structures and, through PCIME, linked community-based nutrition services with facility-based nutrition services. Results-based management also enabled NGOs to determine for themselves the most effective strategies for engaging their communities while still providing a means of ensuring that results were achieved. Monitoring of results at the community level was itself a means of garnering community ownership.

Integrated Services and Delivery Platforms. The launch of the first national nutrition policy in Senegal instituted a momentous shift from a "project approach" to a "program approach" and, through cooperation between PRN and the Ministry of Health using the PCIME framework, from a fractured patchwork of services toward a more integrated delivery platform (Ndiaye 2007). Combined, these two achievements marked "a significant reorientation in institutional thinking," fostered collaboration across levels and sectors, and promoted long-term planning (Garrett and Natalicchio 2011, 76).

Partner Engagement. In addition to national and local government entities, external technical and advocacy partners played a critical role in the design of PRN, as well as in the development of key nutrition legislation during this period. Moreover, the decentralized approach to implementing PRN required the engagement of more partners. The national nutrition policy provided a framework and the CLM provided the forum to better coordinate efforts to maximize impact on nutrition outcomes.

The key nutrition-related policies and influences for this generation are listed in box 4.

BOX 4: Nutrition-Related Policies and Influences during the *Intensification and Decentralization Generation*

Policies

- DSRP (2000)
- Decree Mandating USI (2000)
- Revised national constitution (2001)
- LPDN (2001)
- Executive Decree 2001–770 and Executive Order creating the CLM and BEN (2001)
- Nutrition Standards and Protocols (2001)
- PCIME Strategic Plan (2002–07)
- 10th PODES (2002–07)
- PNDL (2002)
- LPDN (revised) (2006)
- National Policy for Infant and Young Child Feeding (2006)
- 11th DSRP (2007)
- PNSE (2007)
- PRN Strategic Plan (2007)
- PNDS (2009)
- Decree Mandating Vitamin A Fortification of Oil (2009)
- Decree Mandating the Fortification of Wheat with Iron and Folic Acid (2009)

Institutions

- CLM, BEN, and BER (2001)
- AEC (2001)
- Nutrition line item added to national budget (2001) followed by a 10-fold increase (2007)
- DANSE replaces SNAN (2003)
- COSFAM (2006)
- CTIUS (2006)

Programs

- PDEF (2001)
- PRN Phase I (2002–05)
- PCIME-C (2002)
- Essential Nutrition Services Integrated Package for People Living with HIV (2005)
- PRN Phase II (2007)
- NETS (2009)
- NESA (2009)
- PNIA (2010)
- National Child Survival Program (2010)
- Salt iodization project (2010)
- USAID/Yaajeende (2010)

Key National Influences

- PROFILES Senegal (2002)
- DHS (2001) (2005)
- Flooding (2009)
- Senegal Ministry of Economy & Financing Alpha Award to PRN (2010)

Key Regional and Global Influences

- NEPAD (2001)
- CMAM (2001) (2005)
- World Food Summit (2002)
- A World Fit for Children (2002)
- Global Strategy for Infant and Young Child Feeding (2003)
- Maputo Declaration on Agriculture and Food Security (2003)
- Copenhagen Consensus (2004)
- Global Strategy on Diet, Physical Activity and Health (2004)
- Countdown to 2015 event in London (2005)
- Paris Declaration and Accra Agenda for Action (2005)
- *WHO Child Growth Standards: Methods and development* (2006)
- *Repositioning Nutrition as Central to Development* (2006)
- Global Food Price Crisis (2007–08)
- *Lancet Series on Maternal and Child Undernutrition* (2008)
- *SUN Movement & Scaling Up Nutrition: A Framework for Action* (2010)
- WHA Resolution WHA63.23 on Infant and Young Child Nutrition (2010)

6
Multisectoral Approach (2010s)

Senegal assumes its position as a global leader in nutrition intervention; meanwhile efforts are underway to define the future for nutrition policy in a Sall administration determined to achieve emerging country status by 2035

Nutrition Context

Senegal. In 2012, Macky Sall was elected President of Senegal, taking over after two terms of the Wade administration. Economic growth and poverty reduction had already begun to slow. Almost immediately he was faced with a natural disaster—flooding following torrential rains—that nearly crippled the new administration.[31] The severe flooding of 2012 was followed by poor rainfall in 2014. The end of 2015 marked the end of the MDGs; final scorecards are not yet available but it appears that Senegal had mixed results. Reduction in extreme poverty (MDG 1a) and gender equality in schooling (MDG 3) were achieved. Substantial progress against child mortality (MDG 4) and toward access to safe drinking water (MDG 7) was made, but likely not enough to reach the goals. Progress on universal primary education (MDG 2), maternal mortality (MDG 5), and HIV/AIDS (MDG 6) was clearly insufficient.

After having achieved significant progress against hunger (MDG 1c) from 1990 to 2010, the prevalence of undernourishment has increased. In fact, the latest data show that progress against hunger has been nil: 24.5 percent in 1991 and 24.6 percent in 2015. Undernourishment is a measure of food security rather than nutrition, however, and progress against stunting during this same period appears to have been sustained. During the period of the MDGs, stunting decreased a remarkable 44 percent, from 34.4 percent in 1992 to 19.4 percent in 2014. This singular achievement has solidified Senegal's place as a global leader in nutrition policy.

In 2011, Senegal was invited to present the International Food Policy Research Institute (IFPRI) 21st Annual Martin J. Forman Memorial Lecture, in honor of its success "in developing a multisectoral strategy to achieve sustainable nutrition outcomes" (Ka 2011). In the same year, Senegal signed on as a SUN Movement country, signaling its commitment and further raising the visibility of Senegal's position as a leader in nutrition intervention. In his previous post as Prime Minister—the institutional home for CLM and BEN—Macky Sall had a close perspective on the evolution of the nutrition policy that unfolded over the previous decade. The role that nutrition will play in the Sall administration is as yet undetermined, but the foundation from which to redouble efforts to make progress for nutrition is strong. In 2014, President Sall launched the Emerging Senegal Plan with the goal of taking Senegal to emerging country status by 2035 through improving the well-being of the population and guar-

anteeing access to social services. In 2015, Senegal joined the SUN Movement Executive Committee.

Global and Regional. After decades of mounting evidence of the need for global action in nutrition, this period was marked by several important transitions. Global partners were at once galvanizing to take action in the few years remaining before the close of the MDGs; looking backward to take stock and assess what was accomplished; and looking forward to what was next after the 2015 deadline.

Although the nutrition community had been lauding the importance of multisectoral approaches for nearly 50 years, newfound resurgence was generated by the publication of the *Lancet Series on Maternal and Child Nutrition* (2013). This follow-up to the landmark 2008 series highlighted the limitations of reducing stunting through the scale-up of nutrition-specific interventions alone and re-emphasized the need for nutrition-sensitive interventions in key sectors. In creating an at-scale community-based multisectoral platform for nutrition, Senegal did what few other countries managed to do. Senegal was a leader not only in having achieved remarkable reductions in stunting, but in the knowledge gained through having instituted an effective collaborative system that had been sustained for nearly two decades. All eyes turned to Senegal and other rare success stories (such as Peru) in an effort to replicate their success.

Also during this period was the emergence of another global trend: burgeoning rates of overweight and obesity. Popularly perceived to be a problem only in high-income populations, during this period the Double Burden of Malnutrition (DBM)—the coexistence of undernutrition and overweight and obesity in the same population, largely as a result of changing lifestyles and food systems—was acknowledged as another manifestation of the challenge of malnutrition. The global emergence of the DBM and its link to noncommunicable diseases, and the scale-up of nutrition-sensitive interventions including emphasis on engaging the private sector,[32] were key themes highlighted at the Second International Conference on Nutrition (ICN2) in 2014, 22 years after the first ICN in 1992.

Ahead of the launch of the new SDGs, in 2010 the WHA announced six priority nutrition indicators and targets for 2025,[33] which served to align the post-2015 advocacy efforts among global nutrition partners. Soon after, in 2012, the UN launched the global Zero Hunger Challenge to galvanize actions to "end hunger, eliminate all forms of malnutrition, and build inclusive and sustainable food systems." Building off the Zero Hunger targets and more regionally specific, the Global Alliance for Resilience (AGIR) was also launched in 2012, with the goal of "foster[ing] improved synergy, coherence and effectiveness in support of resilience initiatives in the 17 West African and Sahelian countries" through establishing a common results framework.

During this period, on the heels of global momentum for nutrition generated by the SUN Movement and the launch of the SDGs, new efforts arose to: (1) estimate the costs of scaling up nutrition (World Bank 2010); (2) establish clear commitments from donors and governments; (3) hold donors and governments accountable for commitments made; and (4) raise new funding for nutrition through innovative financing mechanisms from organizations such as the Clinton Foundation, the Bill & Melinda Gates Foundation, the Children's Investment Fund Foundation (CIFF), and most recently, the Power of Nutrition. In 2013, the United Kingdom, Brazil, and CIFF hosted the Nutrition for Growth Summit in London "to bring together business leaders, scientists, governments and civil society to make the political and financial commitments needed to prevent undernutrition, enabling people and nations to prosper." In 2014, the first in a series of Global Nutrition Reports was published to "track[] worldwide progress in improving nutrition status, identif[y] bottlenecks to change, highlight[] opportunities for action, and contribute[] to strengthened nutrition accountability." (IFPRI 2014, *xiv*). The Global Nutrition Report motivated an initiative among the SUN Donor Network to establish a common and systematic approach to calculating and tracking contributions to nutrition.

Growing evidence on the combined impact of nutrition and early stimulation on brain development has

induced a shift among global partners toward a broader focus on Early Childhood Development (ECD), as signaled by the launch in 2016 of the World Bank/UNICEF Initiative for Investing in the Early Years. Packaging nutrition under an ECD umbrella reinforces convergence toward multisectoral approaches.

Nutrition Policy

Policies. The transition in leadership from President Abdoulaye Wade to President Macky Sall in 2012 closed a chapter in which nutrition policy benefitted from unusually high political visibility. Global recognition has translated into increased funding for nutrition in Senegal; the government's financial commitment to nutrition—both in total nutrition spending and nutrition spending as a proportion of the overall national budget—is also increasing. Yet nutrition policy in Senegal is in a period of transition. Progress against global targets has stagnated and challenges remain, including limited capacity to deliver and monitor results through multisectoral engagement and inadequate funding. In 2015, the DPNDN outlined the new vision. Currently under development—with engagement of global partners such as the World Bank and UNICEF—is the PSMN, which will operationalize the DPNDN and be the principal tool for nutrition coordination going forward.

Also during this period, the Ministry of Health continued to build upon the operative framework for nutrition service delivery and published the Prise en Charge de la Malnutrition Aigué (Community Management of Acute Malnutrition) (PECMA) protocol in 2013; the Nutrition Monitoring Guide in 2014; and the Communication Strategy for the Promotion of Exclusive Breastfeeding in 2015. Efforts at decentralization—beginning in 1964 and continuing, in 1972, with the creation of rural communities and, in 1996, with the transfer of power to local authorities—culminated, in 2014, with a phase of widespread communalization. Policies in other sectors with implications for nutrition launched during this period include the Economic and Social Policy Document in 2011, which became the basis for increased government financial ownership of PRN, the Social Protection Policy Document, also in 2011, and the Health Coverage Strategic Plan (PSD-CMU) in 2013, constituting crucial components of the development of universal health care in Senegal, including the strengthening of free services for children under five.

Institutions. The institutional arrangements and stewardship for nutrition have not changed since 2001. During this time there have been three National Coordinators of CLM. Despite competition among partner ministries for the limited nutrition budget, which led to a brief period of sectorial strife, the principle of inclusiveness has only been reaffirmed. The early success of PRN reinforced commitment at all levels, and ministries are starting to see how they can use the PRN's structures to accomplish their own sector-specific goals (Garrett and Natalicchio 2011).

Preparation of the new PSMN has once again brought all stakeholders to the table to look holistically at the problem of malnutrition in Senegal and together identify strategies and priorities for addressing it. In this way, CLM continues to function as the primary forum for multisectoral collaboration, the "glue" to "bring partners together and eliminate barriers to reducing the burden of malnutrition."[34] Among the factors for successful engagement are strong role definition and clear lines of accountability. In Senegal, nutrition is a shared responsibility, and each sector has an important contribution to make in terms of action and financing.

Programs. The World Bank funding for PRN came to end in 2014, but Senegal leveraged the success of the program to raise funds from other donors. Since instituting a budget line item for nutrition, government contributions to nutrition have increased to CFAF 3 billion in 2016. PRN continues to be Senegal's flagship nutrition program. Building on the results achieved through the scale-up of CMAM, PCIME-C, and Growth Monitoring and Promotion through decentralized structures, Phase III ("consolidating achievements"), with continued support from international partners, undertakes to: (1) scale up nutrition-specific interventions at the community level, notably those targeting the first 1,000-day window from pregnancy to two

years of age; and (2) institutionalize the multisectoral planning, implementation, and financing of nutrition-sensitive interventions.

Projects such as MI's Integrated Nutrition Project in Kolda and Kédégou Regions (PINKK), MI's Zinc Alliance for Child Health (ZACH) project, and USAID's Health Services Improvement Program, Community Health Program, and Yaajeende Project, contribute to strengthening Senegal's system for delivery of nutrition-specific and nutrition-sensitive services.

Key Themes

To a large degree, the story of this generation is yet to be written. With Senegal at the forefront of global nutrition policy, there are not many models of success. Senegal's progress depends on the success of the PSMN and the ability of global partners to raise adequate financing.

The key nutrition-related policies and influences for this generation are listed in box 5.

BOX 5: Nutrition-Related Policies and Influences during the *Multisectoral Approach Generation*

Policies
- Social Protection Policy Document (2011)
- Economic and Social Policy Document (2011)
- Senegal joins the global SUN Movement (2011)
- (NSESD) National Strategy for Economic and Social Development (2013)
- PSD-CMU (2013)
- PECMA protocol (2013)
- Emerging Senegal Plan Priority Action Plan (2014)
- Nutrition Monitoring Guide (2014)
- Communication Strategy for the Promotion of Exclusive Breastfeeding (2015)
- DPNDN (2015)
- Senegal joins the SUN Executive Committee (2015)
- PSMN (in development)

Institutions
- (DAN) Division de l'Alimentation de la Nutrition (Division of Food and Nutrition) and (DSE) Division de la Survie de l'Enfant (Division of Child Survival) replace DANSE (2012)
- Annual nutrition budget increase from CFAF 1.4 billion in 2011 to CFAF 3.6 billion (2016)

Programs
- PRN (continued)
- Yaajeende (continued)
- (ZACH) Zinc Alliance for Child Health (2012)
- (PAQUET) Improvement of Quality Education, Equity and Transparency Program (2012)
- Results-Based Financing (2013–18)
- (PINKK) Integrated Nutrition Project for the Kolda and Kedougou Regions (2015)

Key National Influences
- DHS (2010–11)
- 21st Annual Martin J. Forman Memorial Lecture (2011)
- SMART (Standardized Monitoring and Assessment of Relief and Transitions) Survey (2011)
- Election of President Macky Sall (2012)
- SMART Survey (2012)
- Regional SMART Survey (yearly)
- Flooding and drought (2012)
- DHS (continued 2012–13)
- SMART Survey (2014)
- DHS (continued 2014)

Key Regional/Global Influences
- Zero Hunger Challenge (2012)
- AGIR (2012)
- (NASAN) New Alliance for Food Security and Nutrition (2013)
- *Lancet Series on Maternal and Child Nutrition* (2013)
- Global Nutrition Report (2014)
- ICN2 (2014)
- Power of Nutrition Partnership (2014)
- Political Declaration and Framework for Action to Tackle Hunger and Obesity (2014)
- Global Nutrition Report (2015)
- SDGs (2016)
- Global Nutrition Report (2016)
- World Bank/UNICEF Initiative for Investing in the Early Years (2016)

7
Conclusion

The course of nearly sixty years in the evolution of nutrition policy in Senegal can be traced through six themes, whose seeds were planted in the earliest days of the republic: nutrition championship, institutional ownership, multisectoral coordination and collaboration, community ownership, integrated services and delivery platforms, and partner engagement.

There are two significant turning points for nutrition policy in Senegal. First was the social and political crisis in the early 1990s, which resulted, in large part, from structural adjustment reforms that exacerbated an already deteriorating nutrition situation, revealed the inadequacy of the health system to address it, and ultimately resulted in creation of the CNLM and PNC. Changing institutional ownership of nutrition from the Ministry of Health to a government agency with no experience implementing health projects was a radical—and political—move. For a period, while the system readjusted, key institutional relationships were severely fractured. Although not at all clear at the time, in hindsight it seems evident that the dramatic change was necessary to build back stronger.

The second key turning point in nutrition policy in Senegal was the election in 2000 of President Abdoulaye Wade, who became Senegal's top nutrition champion. Under the Wade administration, the damage done in the dissolution of the institutional arrangements for nutrition was righted. Hard lessons learned from CNLM and PNC were applied. Institutional ownership of nutrition changed to the newly created CLM, and PRN became Senegal's flagship nutrition program. Through a participatory and multisectoral approach, decentralized delivery of preventive nutrition services and integrated platforms, and a spirit of shared responsibility and shared success, an effective system was built with the results to prove it.

As Senegal hovers on the cusp of yet another major transition for nutrition policy, its strengths are evident. Institutionally, the CLM provides an effective platform for coordination at national and local levels, with clear lines of accountability, and partner commitment and collaboration. Leaders have managed to leverage positive results to mobilize additional financing from external donors and increased government financing for nutrition. The commitment to building off gains already made in improving social services and advancing human capital remains strong in the Sall administration. The DPNDN, a vision for nutrition policy that will carry Senegal well into the SDGs, has been

launched, and the PSMN is under development with the engagement and support of all partners.

The remarkable drop in stunting by approximately half during the period of the MDGs is a direct result of Senegal's doing more for nutrition and doing it better. However, as noted, progress toward nutrition targets has stagnated and challenges remain, including limited capacity to deliver and monitor results through multisectoral engagement and inadequate funding. PRN reaches approximately 70 to 80 percent of children under five with quarterly nutrition screening; however, monthly growth monitoring and promotion activities reach only about 30 percent of children under two. Senegal needs more pronutrition interventions through other sectors, improved targeting to identify areas of highest burden, and increased effort to extend services to hard-to-reach areas. To meet WHA/SDG goals, more financial resources are needed.

Mainstreaming nutrition is Senegal's biggest challenge for the next 10 years, and all sectors need to contribute. A core strength is that the network is already in place. All regions in Senegal are covered with an entry point through local leaders who are able to convene actors in all sectors. The process of developing the PSMN has examined what each sector is doing in its core mission and identified the links with nutrition, opportunities for fundraising, and specific areas in need of capacity building. In addition, each region requires an assessment of its nutrition situation and key determinants, the development of locally relevant plans for action, the identification of local capacities that need to be strengthened, and sources of funding.

By and large, nutrition has always been high on the political agenda in Senegal. Global visibility and prominence as a leader in nutrition hit a peak in 2010–11. The lack of a high-level champion and nutrition's subsequent drop on the political agenda since the end of the Wade administration is another challenge for nutrition leadership in Senegal during this period of transition. If history is any indication, this and many other challenges will be overcome in yet unforeseen—but no doubt remarkable—ways.

APPENDIX A
Senegal Nutrition Policy Timeline

Start	English	Française
1948	Universal Declaration of Human Rights	Déclaration Universelle des Droits de l'Homme
1954	Maternity Leave Regulation	Règlementation du congé de maternité
1956	(ORANA) Research Organization for Food and Nutrition in Africa	(ORANA) Organisme de Recherche sur l'Alimentation et la Nutrition Africaines
1960	(CRENs) Centers of Recovery and Nutritional Education	(CREN) Centres de Récupération et d'Education Nutritionnelle
1960	Independence of Senegal	Indépendance du Sénégal
1960	Presidency of Léopold Sédar Senghor	Présidence sous Léopold Sédar Senghor
1961	1st PQDES	1er PQDES
1963	Constitution	La Constitution
1963	(ITA) Food Technology Institute	(ITA) Institut de Technologie Alimentaire
1964	Decentralization reforms	Réformes de la décentralisation
1965	2nd PQDES	2ème PQDES
1965	(BANAS) Office for Food and Applied Nutrition in Senegal	(BANAS) Bureau National d'Alimentation et de la Nutrition Appliquée au Sénégal
1968	West African Conference on Nutrition and Child Feeding	Conférence Ouest Africaine sur la Nutrition et l'Alimentation de l'Enfance
1968	Sahelian drought	Sécheresse au Sahel
1969	3rd PQDES	3ème PQDES
1972	Decentralization reforms	Réformes de la Décentralisation
1973	4th PQDES	4ème PQDES
1973	(PPNS) Nutrition and Health Protection Program	(PPNS) Programme de Protection Nutritionnelle et Sanitaire
1975	Programme Santé Sécheresse	Programme Santé Sécheresse
1977	5th PQDES	5ème PQDES
1977	Food Investment Strategy 1977–85	Stratégie d'Investissement dans l'Alimentation 1977–85
1978	Alma Ata Declaration	Déclaration d'Alma Ata

(continued on next page)

(continued)

Start	English	Française
1979	Stabilization Program	Programme de Stabilisation
1979	(CANAS) Committee of Food and Nutritional Analysis in Senegal	(CANAS) Comité d'Analyse Nutritionnelle et Alimentaire au Sénégal
1981	6th PQDES	6ème PQDES
1981	International Code of Marketing of Breastmilk Substitutes	Code international de commercialisation des substituts du lait maternel
1981	Presidency of Abdou Diouf	Présidence sous Abdou Diouf
1982	World Bank Rural Health Project	Projet de Santé Rurale de la BM
1983	Iringa Project (Tanzania)	Projet Iringa (Tanzanie)
1985	7th PQDES	7ème PQDES
1985	Adjustment Program	Programme d'Ajustement
1986	Publication of Sommer et al., "Impact of Vitamin A Supplementation on Childhood Mortality"	Publication de Sommer et al., "Impact de l'apport de suppléments en vitamine A sur la mortalité infantile"
1986	DHS 1986	EDS 1986
1988	(SANAS) Nutrition and Food Service of Senegal	(SANAS) Service de l'Alimentation et de la Nutrition Appliquée du Sénégal
1989	8th PODES	8ème PODES
1989	Nutritional Rehabilitation and Surveillance Program	Programme de Réhabilitation et de Surveillance Nutritionnelle
1989	(PSMI/PF) Maternal and Child Health and Family Planning Program	(PSMI/PF) Programme de Santé Maternelle et Infantile et de Planification Familiale
1990	Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding	Déclaration d'Innocenti en faveur de la Protection, la Promotion et le Soutien à l'Allaitement
1990	World Summit for Children	Sommet Mondial sur l'Enfance
1990	(PCIME) Integrated Management of Childhood Illness	(PCIME) Prise en Charge Intégrée des Maladies de l'Enfant
1990	UNICEF Nutrition Conceptual Framework	Cadre conceptuel de la nutrition de l'UNICEF
1992	(ICN) International Conference on Nutrition	(CIN) Conférence Internationale sur la Nutrition
1992	DHS 1992–93	EDS 1992–93
1994	Salt Iodization Strategy to Fight IDD	Stratégie d'iodation du sel pour lutter contre les troubles liés à la carence en iode
1994	Interministerial Decree Establishing the Conditions for Marketing Breastmilk Substitutes	Arrêté Interministériel fixant les conditions de commercialisation des substituts du lait maternel
1994	Baby-Friendly Hospital Initiative	L'Initiative Hôpitaux Amis des Bébés
1994	USAID/BASICS	USAID/BASICS
1994	Salt Iodization Project	Projet d'Iodation du Sel
1994	(CNLM) National Committee for the Fight against Malnutrition	(CNLM) Commission Nationale de Lutte contre la Malnutrition
1994	(AGETIP) Executing Agency for Works of Public Interest Against Unemployment	(AGETIP) Agence d'Exécution des Travaux d'Intérêt Public
1994	(SNAN) National Service of Food and Nutrition	(SNAN) Service National de l'Alimentation et de la Nutrition
1994	Devaluation of the CFA franc & resulting urban unrest	Dévaluation du franc CFA suivie d'agitation urbaine
1994	Publication of Pelletier et al., "A Methodology for Estimating the Contribution of Malnutrition to Child Mortality in Developing Countries"	Publication de Pelletier et al., "A Methodology for Estimating the Contribution of Malnutrition to Child Mortality in Developing Countries"
1995	(PNC) Community Nutrition Project	(PNC) Projet de Nutrition Communautaire
1995	World Summit for Social Development Copenhagen	Sommet de Copenhague pour l'Elimination de la Pauvreté

(continued on next page)

(continued)

Start	English	Française
1996	9th PODES	9ème PODES
1996	(PCIME) Integrated Management of Childhood Illness	(PCIME) Prise en Charge Intégrée des Maladies de l'Enfant
1997	National Plan of Action for Nutrition	Plan National d'Action pour la Nutrition
1997	(AEN) Essential Nutrition Actions framework	(AEN) Cadre de Actions Essentielles en Nutrition
1997	DHS 1997	EDS 1997
1998	(PAIN) Package of Integrated Nutrition Actions and AEN	(PAIN) Paquet d'Activités Intégrées de Nutrition et AEN
1998	(CNSA) National Food Security Council	(CNSA) Conseil National de Sécurité Alimentaire
1999	National Vaccination Days and National Micronutrient Supplementation Days	Journées Nationales de Vaccination et Journées Nationales de Supplémentation en Micronutriments
1999	DHS 1999	EDS 1999
2000	(DSRP) Poverty Reduction Strategy Paper	(DSRP) Document de Stratégie pour la Réduction de la Pauvreté
2000	Decree Mandating Universal Salt Iodization	Décret portant sur l'iodation universelle du sel
2000	Millennium Development Declaration and the MDGs (2000–15)	(OMD) Objectifs du Millénaire pour le Développement (2000–15)
2000	Global Strategy for the Prevention and Control of Noncommunicable Diseases	Stratégie Mondiale pour la prévention et la lutte contre les maladies non transmissibles
2000	Presidency of Abdoulaye Wade	Présidence sous Abdoulaye Wade
2001	Revised National Constitution	Révision de la Constitution nationale
2001	(LPDN) Policy Letter on Nutrition and Development	(LPDN) Lettre de Politique de Développement de la Nutrition
2001	Nutrition Standards and Protocols	Normes et Protocoles en Nutrition
2001	(PDEF) Ten-Year Education and Training Program	(PDEF) Programme Décennal de l'Education et de la Formation
2001	(CLM) Nutrition Coordination Unit	(CLM) Cellule de Lutte contre la Malnutrition
2001	(BEN) National Executive Bureau	(BEN) Bureau Exécutif National
2001	(BER) Regional Executive Bureau	(BER) Bureau Exécutif Régional
2001	(AEC) Community Executing Agency	(AEC) Agence d'Exécution Communautaire
2001	(NEPAD) New Partnership for Africa's Development	(NEPAD) Nouveau Partenariat pour le Développement de l'Afrique
2001	(CMAM) Community-Based Management of Acute Malnutrition	(PCMA) Prise en Charge Communautaire de la Malnutrition Aiguë
2001	Appointment of Biram Ndiaye as Coordinator of CLM	Coordonnateur de la CLM : Biram Ndiaye
2002	10th PODES	10ème PODES
2002	(DSRP) Poverty Reduction Strategy Paper	(DSRP) Document de Stratégie pour la Réduction de la Pauvreté
2002	PCIME Strategic Plan (2002–07)	PCIME Plan Stratégique 2002–07
2002	(PDC) Communal Development Plan	(PDC) Plan de Développement Communal
2002	(PNDL) National Program for Local Development	(PNDL) Programme National de Développement Local
2002	(PRN) Nutrition Enhancement Program Phase I (2002–05)	(PRN) Programme de Renforcement de la Nutrition Phase 1 (2002–05)
2002	(PCIME-C)) Community Integrated Management of Childhood Illnesses	(PCIME-C) Prise en Charge Intégrée de la Maladie l'Enfant au Niveau Communautaire
2002	World Food Summit	Sommet Mondial de l'Alimentation
2002	A World Fit for Children	Un Monde digne des enfants
2002	PROFILES Senegal	PROFILES Sénégal

(continued on next page)

(continued)

Start	English	Française
2003	(DANSE) Division of Food Nutrition and Child Survival	(DANSE) Division de l'Alimentation de la Nutrition et de la Survie de l'Enfant
2003	Global Strategy for Infant and Young Child Feeding	Stratégie Mondiale pour l'Alimentation du Nourrisson et de Jeune Enfant
2003	Maputo Declaration on Agriculture and Food Security	Déclaration de Maputo sue l'Agriculture et la Sécurité alimentaire
2004	Copenhagen Consensus	Consensus de Copenhague
2004	Global Strategy on Diet, Physical Activity and Health	Stratégie mondiale sur l'alimentation, l'exercice physique et la santé
2005	Countdown to 2015 event in London	Compte à rebours vers 2015 à Londres
2005	Paris Declaration and Accra Agenda for Action	Déclaration de Paris et Agenda d'Accra pour l'Action
2005	DHS 2005	EDS 2005
2005	Macky Sall and Jacques Sylla, Letter to the Editor of the *Lancet*, "African Prime Ministers Take Lead in Child Survival"	Lettre de Macky Sall et Jacques Sylla à l'éditeur du Lancet : "Les Premiers Ministres africains aux commandes pour la survie de l'enfant"
2006	(LPDN) Policy Letter on Nutrition and Development (Revised)	(LPDN) Lettre de Politique de Développement de la Nutrition (Révisée)
2006	National Policy for Infant and Young Child Feeding	Politique Nationale pour l'Alimentation du Nourrisson et du Jeune Enfant
2006	Program for the Enhancement of Fortification	Programme de Renforcement de la Fortification Alimentaire
2006	(COSFAM) Committee for Food Fortification	(COSFAM) Comité Sénégalais pour la Fortification des Aliments en Micronutriments
2006	(CTIUS) Technical Committee for USI (Universal Salt Iodization)	(CTIUS) Comité Technique pour l'Iodation Universelle du Sel
2006	WHO Child Growth Standards: Methods and Development	Normes OMS de Croissance de l'Enfant: Méthodes et Élaboration
2006	Repositioning Nutrition as Central to Development	Repositionnement de la Nutrition comme point essentiel au développement
2007	11th DSRP	11ème DSRP
2007	Increase in nutrition line item in the national budget	Augmentation de l'enveloppe budgétaire allouée à la nutrition
2007	(PNSE) National Plan for Child Survival	(PNSE) Plan National de Survie de l'Enfant
2007	(PRN) Nutrition Enhancement Program Phase II	(PRN) Programme de Renforcement de la Nutrition Phase 2
2007	Global Food Price Crisis	Crise mondiale des prix de denrées alimentaires
2008	Appointment of Khadidiatou Dieng as Coordinator of CLM	Coordonnatrice de la CLM : Khadidiatou Dieng
2008	Lancet Series on Maternal and Child Undernutrition	Série du Lancet sur la malnutrition maternelle et infantile
2009	(PNDS) National Health Development Plan	(PNDS) Plan National Développement Sanitaire et Social
2009	Decree Mandating Vitamin A Fortification of Oil	Décret portant sur la fortification de l'huile en vitamine A
2009	Decree Mandating the Fortification of Wheat with Iron and Folic Acid	Décret portant sur la fortification du blé avec du fer et de l'acide folique
2009	Comprehensive Africa Agriculture Development Program Compact	Programme Détaillé de Développement de l'Agriculture en Afrique
2009	(NETS) Child Targeted Nutrition and Social Transfers Program	(NETS) Projet de nutrition ciblée sur l'enfant et les transferts sociaux
2009	(NESA) Child Food and Nutrition Security Project	(NESA) Project Nutrition Enfant et Sécurité Alimentaire
2009	Salt Iodization Project	Projet d'Iodation du Sel
2010	National Child Survival Program	Programme National de Survie de l'Enfant
2010	Yaajeende	Yaajeende

(continued on next page)

(continued)

Start	English	Française
2010	(SUN) Scaling Up Nutrition Movement	(SUN) Mouvement de Renforcement de la Nutrition
2010	WHA Resolution WHA63.23 on Infant and Young Child Nutrition	Résolution de l'AMS 62–23 sur la Nutrition des Nourrissons et des Jeunes Enfants
2010	Senegal Ministry of Economy and Financing Alpha Award given to PRN	Prix Alpha du Ministère de l'Economie et des Finances à PRN
2010	DHS 2010–11	EDS 2010–11
2011	Social Protection Policy Document (2011–15)	Document de Politique de Protection Sociale (2011–15)
2011	Economic and Social Policy Document (2011–15)	Document de Politique de développement économique et social (2011–15)
2011	(PNIA) National Agricultural Investment Program (2011–15)	(PNIA) Programme National d'Investissement Agricole (2011–15)
2011	Health Services Improvement Program	Programme de renforcement des services de santé
2011	Community Health Program	Programme de santé communautaire
2011	SUN country	Pays SUN
2011	SMART Survey 2011	Enquête SMART 2011
2012	(ZACH) Zinc Alliance for Child Health	(ZACH) Projet Zinc Alliance for Child Health
2012	(PAQUET) Improvement of Quality Education, Equity and Transparency Program	(PAQUET) Programme d'Amélioration de la Qualité de l'Enseignement, de l'Équité et de la Transparence
2012	Zero Hunger Challenge	Programme Zéro Faim
2012	(AGIR) Global Alliance for Resilience—Sahel and West Africa	(AGIR) Alliance Globale pour la Résilience—Sahel et Afrique de l'Ouest
2012	Appointment of Abdoulaye Ka as Coordinator of CLM	Coordonnateur CLM: Abdoulaye Ka
2012	Presidency of Macky Sall	Présidence sous Macky Sall
2012	SMART Survey 2012	Enquête SMART 2012
2012	DHS 2012–13	EDS 2012–13
2013	(NSESD) National Strategy for Economic and Social Development (2013–17)	(SNDES) Stratégie Nationale de Développement Economique et Social (2013–17)
2013	(PSD-CMU) Health Coverage Strategic Plan	(PSD-CMU) Plan Stratégique de Développement de la Couverture Maladie
2013	PECMA protocol	Protocole de PECMA
2013	Nutrition for Growth Summit, London	Sommet sur la Nutrition pour la Croissance, Londres
2013	(NASAN) New Alliance for Food Security and Nutrition	(NASAN) Nouvelle Alliance pour la Sécurité Alimentaire et Nutritionnelle
2013	Lancet Series on Maternal and Child Nutrition	Série du Lancet sur la nutrition maternelle et infantile
2014	Emerging Senegal Plan Priority Action Plan (2014–18)	Plan Sénégal Emergent Plan d'Actions Prioritaires (2014–18)
2014	Nutrition Monitoring Guide	Guide de surveillance nutritionnelle
2014	(PRN) Nutrition Enhancement Program Phase III	(PRN) Programme de Renforcement de la Nutrition Phase 3
2014	(ICN2) Second International Conference on Nutrition	(CIN2) Deuxième Conférence Internationale sur la Nutrition
2014	Political Declaration and Framework for Action to Tackle Hunger and Obesity	Déclaration politique et Cadre d'action contre la famine et l'obésité
2014	Global Nutrition Report 2014	Rapport Mondial sur la nutrition 2014
2014	SMART Survey 2014	Enquête SMART 2014
2014	DHS 2014	EDS 2014
2015	(DPNDN) National Policy for the Development of Nutrition (2015–25)	(DPNDN) Document de Politique Nationale de développement de la Nutrition (2015–25)
2015	Policy Document of Health/Nutrition/Environment in the Education System	Document de Politique Sanitaire/Nutritionnelle/ Environnementale du Système Educatif

(continued on next page)

(continued)

Start	English	Française
2015	Communication Strategy for the Promotion of Exclusive Breastfeeding	Stratégie Communication pour la Promotion de l'AME
2015	(PINKK) Integrated Nutrition Project for the Kolda and Kedougou Regions	(PINKK) Projet Intégré de Nutrition Dans les Régions de Kolda et de Kédougou
2015	(SDGs) Sustainable Development Goals	(ODD) Objectifs de Développement Durable des Nations Unies
2015	Global Nutrition Report 2015	Rapport Mondial sur la nutrition 2015
2016	(PSMN) Multisectoral Strategic Nutrition Plan	(PSMN) Plan Stratégique Multisectoriel de la Nutrition
2016	World Bank/UNICEF Initiative for Investing in the Early Years	Initiative BM/UNICEF pour l'investissement dans l'enfance
2016	Global Nutrition Report 2016	Rapport Mondial sur la Nutrition 2016

Endnotes

1. Joint Child Malnutrition Estimates, UNICEF (United Nations Children's Fund), WHO (World Health Organization) and World Bank (accessed 2017), http://datatopics.worldbank.org/child-malnutrition/.
2. There have been several attempts to characterize the generations of nutrition policy in Senegal. This report draws upon those first introduced in Ndiaye (2010).
3. Specifically, the mandate for ORANA is the following: "The role of ORANA is to know the people of the countries in which it is based, their eating habits, their diseases, their economic and social status, and their beliefs. It also has the role of assessing the actual food consumption and nutritional status of populations and determining the deficiencies that have repercussions on their health status." (Kokou-Alonou 2007).
4. The original member states were: Benin (formerly Dahomey), Burkina Faso (formerly Upper Volta), Côte d'Ivoire, Mali (formerly French Sudan), Mauritania, Niger, and Senegal. Guinea and Togo (formerly French Togoland) joined as member states later.
5. Over time, the nutrition unit would have many names: the Bureau National d'Alimentation et de la Nutrition Appliquée au Sénégal (Office for Food and Applied Nutrition in Senegal) (BANAS), starting in 1965; the Service de l'Alimentation et de la Nutrition Appliquée du Sénégal (Nutrition and Food Service of Senegal) (SANAS) in the 1980s; the Service National de l'Alimentation et de la Nutrition (National Service of Food and Nutrition) (SNAN) in the 1990s; the Division de l'Alimentation, de la Nutrition et de la Survie de l'Enfant (Division of Food, Nutrition and Child Survival) (DANSE) in the mid-2000s; and, as of 2012, the Division de l'Alimentation et de la Nutrition (the Division of Food and Nutrition) (DAN), separate from the Division of Child Survival (Division de la Survie de l'Enfant) (DSE), under the Directorate of Reproductive Health and Child Survival.
6. The name of the ministry responsible for nutrition would also change over time, from the Ministère de la Santé et des Affaires Sociales (Ministry of Health and Social Affairs) at independence in the 1960s, to the Ministère de la Santé Publique (Ministry of Public Health) in the 1970s, to the Ministère de la Santé et de la Prévention (Ministry of Health and Social Welfare) in the 2000s, and, as of 2012, Ministère de la Santé et de l'Action Sociale (Ministry of Health and Social Action).
7. It was recognized at the time that facility-based curative care was not an effective or viable solution

in real-world conditions: “These experiments have always been made in the best possible scientific conditions: these children have been treated and conditioned away from their homes. Under those circumstances, we do what we want with a child; but every time that we have undertaken the experiment in village surroundings, the benefits obtained were less evident and diluted in many. I think that the solution here is to be found at the village level in the context of rural markets” (Republic of Senegal and USAID 1968).

8. The primary purpose of the rural day care centers was to provide a safe place to keep children while their mothers worked in the field: “Women have organized, with help from the instructors, village nurseries for which they are materially and morally responsible, so that the children would not be left to themselves during that time” (Republic of Senegal and USAID 1968).
9. In this UNESCO-supported project, community volunteers were trained in health, agriculture, and human development and carried out activities to promote good nutrition practices in their communities: “During the phases of first degree instruction where male and female instructors are trained, practical sessions are provided, as well as discussions and examples of decisions to be made on short notice. Second degree classes complete the training of female instructors in nutrition of infants, pregnant women and nursing mothers. Subsequently, these female instructors meet with the women of their villages and neighborhoods on a voluntary basis in order to convey, in a lively fashion, the acquired knowledge, along with dietary advice” (Republic of Senegal and USAID 1968).
10. High-level debates about the appropriate placement of the nutrition unit in Senegal would continue for decades to come: “I have often heard mention being made of a Nutrition Division located in the Department of Rural Economy, or of a Nutrition Division located in a Department of so forth, and I believe that it is necessary to Coordination, and differentiate between a Nutrition Division within a Department and the National Nutrition Service. This is also a matter of coordination. The National Nutrition Service, or whatever its title may be, is unique. Very often, this service is attached to the Ministry of Health but it is not mandatory that it be this way; it is a service which can be attached to the highest echelon possible, even to the Secretariat of the Presidency of the Republic” (Republic of Senegal and USAID 1968).
11. The importance of other sectors, such as agriculture, to improving nutrition outcomes was already well understood (“[The] fight against nutritional deficiencies and the development of food crops are primarily the responsibilities of the Health Department and the Agriculture Department; but these operations demand education, which should be viewed in its broadest sense…” (Republic of Senegal and USAID 1968), as was the need for multisectoral collaboration (“The improvement of nutrition for the populations, as well as the struggle against malnutrition, demands the cooperation of a broad spectrum of expertise and all available goodwill. It cannot consist of purely sectorial operations; it necessitates teamwork and planning at different levels. Therefore, it is desirable that the governments treat this problem as an interministerial matter and that it be included in regular meetings where experts from different fields and different services would meet to harmonize concepts and operations. In addition, representatives of voluntary agencies can probably contribute to these meetings” (Republic of Senegal and USAID 1968)).
12. Failure to achieve marked improvement in nutrition status after a decade of nutrition programming was met with frustration: “Past efforts of the government to increase local food production and raise nutrition standards have met with relatively little success. No substantive programs to make a permanent impact on malnutrition among the most needy populations have been successful” (USAID 1980).
13. There were numerous nutrition-related programs being carried out in Senegal with funding from the donor community during this period: “UNDP has financed a number of projects in food crop and fishery development, and an eight-year project

to establish and develop ITA. FAO has provided funds, equipment and training, in health and nutrition centers-and health posts, rural maternities and village pharmacies, and for a pilot nutrition project in the Sine Saloum region. WHO is assisting several small projects for development of health services training of medical and paramedical personnel, combatting infectious diseases and improving environmental health. UNICEF works primarily in rural maternities and health posts. WFP is currently operating six supplementary feeding projects in primary and technical schools and rural training centers, and food-for-work projects in Sine Saloum and Eastern Senegal" (USAID 1980).

14. Documents at the time highlight the overemphasis on curative rather than preventive nutrition intervention: "Nutrition problems are studied primarily as a public health issue with the health sector concentrating heavily on curative rather than preventive care, on large urban hospitals rather than rural community services, and on training physicians rather than village health workers" (USAID 1980).
15. The limitations of current nutrition interventions were well understood: "The value of supplementary feeding has been increasingly challenged in terms of its effect on improving child growth. Vegetable gardens have met with very limited success" (World Bank 1982).
16. Direct comparisons between child anthropometrics for 1986 and following years cannot be made because the 1986 anthropometrics were collected for children under three, whereas anthropometrics for the following years were collected for children under five.
17. Nutrition had high prominence in national policies during this period, but financing did not keep pace: "The [government of Senegal] seems to have the "political will," the commitment, to solve its problems of hunger and malnutrition, but it does not have the resources to do so" (USAID 1980).
18. Support for nutrition within the Ministry of Health was weak: "[The National Nutrition Program] in the early 1990s … resulted in few concrete activities due to the lack of political will and resources as well as institutional problems encountered within the Ministry" (Ndiaye 2007).
19. Early World Bank health projects in Senegal with nutrition components included the Rural Health Project (1982–91); PNC (1995–2001); the Integrated Health Sector Development Project (1998–2005); and the HIV/AIDS Prevention & Control Project (2002–10).
20. The countries participating in the 1992 ICN were obligated to develop national plans of action based on ICN strategies. As was typical, Senegal's 1997 National Plan of Action for Nutrition was expansive and unfunded.
21. Senegal was a late adopter—among the very last in West and Central Africa—of the twice-yearly vitamin A supplementation campaigns.
22. The Paris Declaration and Accra Agenda for Action of 2005 committed donors to five principles: ownership, alignment, harmonization, results, and mutual accountability.
23. The nutrition budget started in 2002 at US$300,000 per year and increased to US$2.7 million in 2007 and US$5.7 million in 2015.
24. CLM began in 2002 with six regional offices, reduced to three in 2007.
25. Phase I (2002–06) development objectives were to: (1) extend nutrition and growth promotion intervention into rural areas; (2) consolidate and sustain the results gained with the earlier PNC, which contributed to reversing the negative trend in nutritional status among children under three in urban areas; and (3) strengthen the institutional capacity of the CLM as well as that of its partners in the public and private sector to develop, implement, and monitor multisectoral nutrition activities. PRN Phase I comprised three components: Component I: community nutrition and growth promotion; Component II: capacity building and monitoring and evaluation; and Component III: program management.
26. The Phase II (2007–11) development objective was to expand access to and enhance nutritional conditions of vulnerable populations, in particular those affecting growth of children under five in poor urban and rural areas. PRN Phase II comprised three components: Component 1: community-based nutrition; Component 2: multisectoral

support to nutrition; and Component 3: support to implementation, monitoring and evaluation of the nutrition development policy.

27. Although the original World Bank Adaptable Program Lending instrument and the three phases of the PRN were aligned for a total of 10 years, the second phase of the PRN started a year late and lasted for 8 to 9 years, and the third phase started in earnest only in 2015, 13 years after the launch of the PRN. Phase III is expected to take far longer than the two to three years originally anticipated.
28. Illness prevention and growth promotion interventions at the home and community level comprise: community or home-based promotion of appropriate infant feeding practices; peer counseling for breastfeeding and complementary feeding; use of insecticide-treated bed nets; and appropriate infection control practices. Illness prevention and growth promotion interventions at the health services level comprise: vaccinations; micronutrient supplementation; and health worker counseling for breastfeeding and appropriate complementary feeding. Curative care interventions at the home and community level comprise: early recognition and home management of illness; appropriate care seeking; and adherence to treatment recommendations. Curative care interventions at the health services level comprise: case management of acute respiratory infection, diarrhea, measles, malaria, malnutrition, and other serious infections; counseling on feeding problems; iron for treatment of anemia; and antihelminthic treatment.
29. Anthropometric outcomes (prevalence of underweight and severe underweight) were measured in PRN Phase I, but removed for Phase II.
30. PRN also includes pilot projects such as the Projet d'Appui à la Sécurité Alimentaire des Ménages Vulnérables (Food Security Support for Vulnerable Households Project), which aims to enhance the impact of nutrition activities by improving the availability and accessibility of agricultural and livestock products.
31. The Senegal Senate was temporarily abolished in order, purportedly, to pay for the emergency response.
32. In particular, NASAN, launched in 2013, aims to "engage the private sector in nutrition-sensitive interventions and mobilize national and foreign private investments to stimulate and support the agricultural sector."
33. The six indicators and targets are under-five stunting, anemia in women of reproductive age, low birth weight, childhood overweight, exclusive breastfeeding, and under-five wasting.
34. Abdoulaye Ka, National Coordinator of the CLM, interview with the author, August, 2016.

References

Abosede, O., and J. McGuire. 1991. "Improving Women's and Children's Nutrition in Sub-Saharan Africa: An Issues Paper." Policy, Research, and External Affairs Working Paper WPS 723, World Bank, Washington, DC.

Garrett, J., and M. Natalicchio, eds. 2011. *Working Multisectorally in Nutrition*. Washington, DC: International Food Policy Research Institute.

(IFPRI) International Food Policy Research Institute. 2014. *Global Nutrition Report 2014: Actions and Accountability to Accelerate the World's Progress on Nutrition*. Washington, DC: IFPRI.

Ka, Abdoulaye. 2011. "Nutrition in Senegal: Achievements and Prospects" (21st Annual Martin J. Forman Lecture). http://www.ifpri.org/event/21st-annual-martin-j-forman-memorial-lecture.

Kokou-Alonou, B. 2007. "La Politique Sanitaire de l'Organisation de Coordination et de Cooperation Pour La Lutte Contre Les Grandes Endemies (OCCGE) 1960–1998." *Sciences Sociales et Humaines*, vol. 008: No. 1–2007.

Lancet. 2005. "Editorial: The Second Child Survival Revolution." *Lancet* 365 (9478): 2152.

Lancet Series on Maternal and Child Undernutrition. 2008. Amsterdam: Elsevier Inc.

Lancet Series on Maternal and Child Nutrition. 2013. Amsterdam: Elsevier Inc.

Marek, T., I. Diallo, B. Ndiaye, and J. Rakotosalama. 1999. "Successful Contracting of Prevention Services: Fighting Malnutrition in Senegal and Madagascar." *Health Policy and Planning* 14 (4): 382–89.

Mehra, R., K. Kurz, and M. Paolisso. 1992. "Child Care Options for Working Mothers in Developing Countries." International Center for Research on Women, Washington, DC.

Ndiaye, A.I. 2010. "Sénégal—Comprendre les facteurs politiques et institutionnels conduisant au changement de politiques de nutrition." HNP Discussion Paper Series, World Bank, Washington, DC.

Ndiaye, B. 2007. Evolution of Public Nutrition Policies in Senegal." Paper prepared for the World Bank workshop, "Carrots and Sticks: Political Economy of Nutrition Reforms," Washington, DC, May 2007.

Partnership for Maternal, Newborn and Child Health. 2006. *Opportunities for Africa's Newborns: Practical Data, Policy and Programmatic Support for Newborn Care in Africa*. Geneva, Switzerland: World Health Organization.

Pelletier, D.L., E.A. Frongillo, D.G. Schroeder, and J.P. Habicht. 1994. "A Methodology for Estimating the Contribution of Malnutrition to Child Mortality in Developing Countries." *Journal of Nutrition* 124 (10 Suppl.): 2106S–2122S.

Republic of Senegal and USAID. 1968. "Proceedings of the West African Conference on Nutrition and Child Feeding," Dakar, Senegal, March 25–29.

Sall, Macky, and J. Sylla. 2005. "African Prime Ministers Take Lead in Child Survival." *Lancet* 366 (9502): 1988–89.

Sommer, A., I. Tarwotjo, E. Djunaedi, K.P. West, Jr., A.A. Loeden, R. Tilden, and L. Mele. 1986. "Impact of Vitamin A Supplementation on Childhood Mortality." *Lancet* 327 (8491): 1169–73.

UNESCO (United Nations Educational, Scientific and Cultural Organization). 1964. *Planning for Balanced Social and Economic Development in Senegal*. New York: UNESCO.

UNICEF (United Nations Children's Fund), WHO (World Health Organization) and World Bank. 2016. *Joint Child Malnutrition Estimates*. New York: UNICEF.

USAID (United States Agency for International Development). 1980. *An Analysis of Nutrition in Senegal*. Washington, DC: USAID.

USAID (United States Agency for International Development), HKI (Helen Keller International), JSI (John Snow International), and CORE Group. 2011. *Understanding the Essential Nutrition Actions (ENA) Framework*. Washington, DC: USAID.

World Bank. 1982. Staff Appraisal Report (SAR): *Senegal Rural Health Project*. Washington, DC: World Bank.

_____. 1995. Staff Appraisal Report (SAR): *Republic of Senegal Community Nutrition Project*. Washington, DC: World Bank.

_____ . 2006. *Repositioning Nutrition as Central to Development: A Strategy for Large Scale Action*. Washington, DC: World Bank.

_____. 2007. *Implementation Completion and Results Report (ICR): Republic of Senegal in Support of the First Phase Nutrition Enhancement Program*. Washington, DC: World Bank.

_____. 2010. *Scaling Up Nutrition: What Will it Cost?* Washington, DC: World Bank.

_____ . 2013. *Scaling Up Nutrition: A Framework for Action*. Washington DC: World Bank.

WHO Multicentre Growth Reference Study Group. 2006. *WHO Child Growth Standards: Length/Height-for-Age, Weight-for-Age, Weight-for-Length, Weight-for-Height and Body Mass Index-for-Age: Methods and Development*. Geneva: World Health Organization.

WHO (World Health Organization) and UNICEF. 2003. *Global Strategy for Infant and Young Child Feeding*. Geneva, Switzerland: World Health Organization.

WORLD BANK GROUP

1818 H Street, NW
Washington, DC 20433

Funding for the report was provided by the World Bank and the Japanese Trust Fund for Nutrition.

WORLD BANK GROUP

The task force providing oversight of the series was composed of members of the following organizations:

Canada

REACH
ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS

WORLD BANK GROUP

unicef