SESSION I: INTERNATIONAL PERSPECTIVES
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I'm going to be talking about The Gambia. I'm going to be very specific, because Dr. Patrick Webb has given a global overview. I was talking about The Gambia to a few people, and they kept on saying, Zambia. I said, "No. Gambia." "Zambia." "No. Gambia." And it's not just Gambia, it's "The Gambia," a small country with 1.5 million people. It is one of the smallest countries in West Africa, where agriculture is the main source of economy for the majority of the people.

We have high child mortality rates. Mortality rates, even though declining, are still very high. We have malnutrition, both malnutrition and overnutrition and micronutrient deficiencies.

Now, what has the situation been for nutrition in The Gambia, the institutional environment for nutrition? Prior to 1983, nutrition was seen as food and food only. In fact, there was no separate nutrition unit; it was part of the MCH Unit of the Ministry of Health, until 1983 when it was moved as a separate unit but still with a budget under the Child Health Unit. And the challenge was limited human and financial resources.

Now, I'm not going to talk about the process, but it was a very long process to get to1999-2000 when we developed, approved and adopted a national nutrition policy with the support of the World Bank. Now, if you look at the policy carefully, we have translated it into one of the local languages.

If you look at the center, what you have there is nutrition security, surrounded by care, food, health and the environment. Because we use that to advocate for nutrition as not just being about food but that the environment, health and care must also be adequate if we are to achieve nutrition security. And we've got a team of people from different sectors to work on this nutrition policy.

And if you look in nutrition policy, apart from breastfeeding, we have food security. We have food quality and safety issues, things that are not normally addressed as nutritionists. And we also have diet-related, non-communicable diseases. And we have principal instruments which we hope to use to address these priority areas – nutrition information, education and communication. Assessing, analyzing and monitoring the tuitions, and of course institutional elements.

Now, finally, the government of The Gambia recognizes this as a development issue. When I was being introduced, it was said that the National Nutrition Agency was under the Minister of Health. I wish to correct that to say that we transformed the Nutrition Unit, which is under the

Minister of Health, into a National Nutrition Agency under the Office of the Vice President. So the Office of the Vice President is now the boss of nutrition in The Gambia.

These are examples of programs. Like the Nutrition Surveillance Program is a community-based program. We have the IDD controlled program. And for the first time in the history of The Gambia, we are producing iodized salt. And the World Food Program now produces iodized salt for the school feeding program.

We also have a school education program where a children's club has been established for child-to-child and child-to-parent nutrition education.

Now, I'm going to give an example of one of our most successful interventions, and that is what we call "The Baby-Friendly Community Initiative." This is about working with communities to find solutions to improve nutrition. Because as long as I've worked at the Nutrition Unit, we've always done nutrition education but with limited success. We've gone to the communities, talked to the communities, sent extension workers to talk to the communities – but with limited success as far as certain areas of behavioral change were concerned.

Now, the Baby-Friendly Community Initiative came with a difference. This was about using communities to implement a project that normally extension workers would implement. And these are the different activities of the Baby-Friendly Community Initiative.

A very important point to emphasize is that we built on traditional and local knowledge, beliefs and practices to improve nutrition. Because usually when we talk about traditional, local practices, etc. we tend to focus on the negative. We focus on what the communities are doing wrong and how we can rectify them, how we can get them to correct their behavior – rather than looking at what they're doing that is right, or how you can use so-called negative behavior to strengthen whatever message you want to give them on how you can change their behavior.

Now, being an agricultural community, we know that exclusive breastfeeding is an extremely difficult practice for mothers to do; because, how can you come to a mother and tell her, if she doesn't know from before, that you can feed your infant on breastmilk only for six months and give nothing else to the child, and that child will survive. In fact, when we tried it in a number of communities, we were almost booed out of those communities because they just didn't believe it. We were accused of giving the wrong information that would kill the children.

Now, using the Baby-Friendly Community Initiative and doing an assessment, learning about the traditional knowledge and practices, we learned that, because these people lived with their livestock, they understood their livestock, they studied their livestock, and they knew that when a cow or a sheep gets a baby, that baby animal feeds on the mother's milk for a period of time without drinking any water, and that baby animal survives. So we used that information to strengthen the fact that human babies also can survive on breastmilk only, for a period of time. And that's how we got mothers in these communities to practice exclusive breastfeeding.

We also used the fact that, in the olden days when mothers were going to the fields, they had the established structures of the fields so that they could take the infants with them and work at the fields; at the same time they could breastfeed their infants. But this was a practice that was no

longer being done in these communities. But we used that knowledge to encourage them to establish these structures again in the fields.

Now, a mistake we have always made at the community level: When we come to the communities, who do we talk to? We talk to mothers, mothers only. We give them all sorts of information: This is the way to breastfeed your child, this is the way to feed your child, this is the way to care for your child. So they have the information. And we sort of exclude the fathers. And then we turn around and see the fathers are not interested in the nutrition of their wives and children. Well, it is because we as nutritionists have made the mistake of excluding them right from the beginning.

So in this initiative, we decided to take on the men, to take on the fathers as equal partners. So what did we do? We used the fathers as service providers and also as a target for information.

Now, what you see is a typical village support group where we have built local capacity. The communities are asked to select representatives to be trained, and these representatives include men and women. Where normally we had focused on training only women, we now trained men as well. And they're trained on maternal nutrition, what the pregnant and lactating mother should eat. They're trained on exclusive breastfeeding. They're trained on complementary feeding, environmental sanitation, personal hygiene, and community support.

Yes, we're trying to promote exclusive breastfeeding, but we didn't want to do it in isolation. We wanted a whole package that could encourage community participation. And can you imagine, where before you talk to a man about breastfeeding, now a man could go around to a woman and tell her how to position her baby properly so that that baby could feed from the breast and get the maximum out of the breast. So that was really an achievement with these men.

Now, these communities were supposed to implement the project themselves, and it was up to them to use all sorts of methods to implement the project. They have been trained on these areas, on these messages. And how they disseminated the information was up to them.

Now, what we discovered was: They took the ten steps we had developed for this project and turned it into songs and dances and used every opportunity to sing and dance with these songs. And in that way, the message went around the whole community instead of just targeting mothers and their spouses.

And the reason why I have the little picture on the side is that is a man dancing as well to songs on breastfeeding, on maternal nutrition, on environmental sanitation and on personal hygiene. So everybody in the community was involved.

Now, it was also important that the target wasn't just limited to mothers, because as we know in our communities, caregiving is across generations. You have grandmothers. You have all the siblings. So it is crucial for a whole community to be involved if you want to improve the nutrition of that community**.**

Now, this is a typical baby-friendly rest house of the fields. It is low cost, and it is constructed by the community. All we do to support them would be with the seed grant, and they construct these rest houses. And it means that if a mother is breastfeeding and she is working at the fields, she can take her infant with her to the fields while she is working. Because what we found from our

study was that, when they didn't have these structures, they would leave a three-week-old baby behind to be fed on other foods while the mothers were at the fields. And that increased diarrhea, increased morbidity and mortality.

The Baby-Friendly Community Initiative, as we see it, united agriculture, health and nutrition in The Gambia. Because the farming communities in The Gambia were the ones implementing the initiative. And here you see them being designated as "Baby-Friendly" after they had been evaluated on how they were implementing the ten steps.

Now, some lessons learned: The first one was that nutrition information disseminated by community representatives to their peers was more effective in influencing behavior. And building the capacity of communities pays dividends in terms of sustainability of programs. But the most important one was – men are crucial for the success and sustainability of community nutrition interventions and should be engaged both as service providers and sources of information, just as much as women**.**

Another important point also was that we constantly talk about our politicians and our policymakers, and we assume that they're educated on issues that you want to move forward. But we learned that politicians cannot be committed to issues if they are not educated on the issues.

Now, the Task Force on Hunger report – I like that report, by the way; I carry it all the time. There's a key message there for political leaders, which is that halting hunger is well within our means. What has been lacking is action to implement and skill of known solutions. Building local capacity should be the center goal of both national government and donor-funded activities. We agree with that. Because when we started, we only had 12 communities in 1995, and we now have 263 communities, which is 52% of all the primary healthcare communities in The Gambia. So we are actually scaling up. Because usually we tend to say that, when we have successful, community-based interventions as pilot, it's so difficult to scale up. But we are escalating up in The Gambia. And the target is to cover all rural communities in The Gambia – in fact, it's a government policy.

Now, we are also using the Baby-Friendly Community Initiative as an entry point for other programs. For example, we now have a diet education program where we support communities to establish micronutrient-rich gardens and orchards to enhance micronutrient status and improve food security. So the community inputs are: land, labor and some garden materials. Whereas, from our side we provide some garden materials: seeds, training, monitoring and supervision.

And this is what we say now: Eat local, grow healthy and live healthy.

Now, the performance. We've found out that, when it comes to exclusive breastfeeding, Baby-Friendly communities are way ahead of non-Baby-Friendly communities. But on the other hand also, we have money to influence the national breastfeeding rates. Because we've moved from 17.4% in 1998 to 36% in 2000 to almost 49% in 2005. And health-seeking behavior is also better amongst the Baby-Friendly communities with more children in Baby-Friendly communities receiving at least one dose of vitamin A per day.

Now, what is the situation of nutrition in The Gambia today? It is said that Gambia is one of the six countries in Subsahara in Africa estimated to be on track to meet the hunger goal if the current trend continues. Stunting has declined from 23% in 1996 to 17.8% in 2000. Acute malnutrition has declined from 9% in 2000 to 7% in 2005.

Even though the National Nutrition Agency was established in 2000, just recently, about a month ago, we were established by an act of Parliament with the legal mandate to coordinate all nutrition in The Gambia. So we now have an institution which has authority, responsibility and can be held accountable for nutrition. We also have, for the first time in the history of the country, a food program which has the capability by Parliament to look at food quality and safety issues.

So resources: Who finances nutrition in The Gambia today? The major ones have been the World Bank and UNICEF. FAO and WHO have been involved, and potential ones are the ADB and World Food Program. But where we have a resource gap is when it comes to food quality and safety issues and diet-related, noncommunicable diseases. Because when the donors come, they want to talk about undernutrition, they want to talk about rural communities – even though we now know that there was a study done, and 16% of urban women were found to be obese, overweight. So we have a rising problem in The Gambia as far as overnutrition is concerned.

But what we may consider a problem, often isn't considered a problem by those whom it affects, because in some of our countries we see overweight as a sign of not only affluence but beauty. Because what I'm wearing now can hide a multitude of sins. You won't see what's behind me, you won't see what's in front of me.

So what are the challenges now? Sustaining the downward trend of malnutrition – and it's not easy, because malnutrition is not just about nutrition. It's working in nutrition to improve nutrition. It's about the performance of other sectors such as health, agriculture, education – all those sectors are important in improving nutrition.

Reducing maternal and child anemia is also a challenge. Reducing iodine deficiency disorders is about iodizing salt, and you have quick results. When it comes to anemia, it is much more complicated, so it is a challenge for us now to reduce anemia in women and children.

Addressing diet-related, noncommunicable diseases, addressing food quality and safety issues. I was very lucky when it comes to addressing diet-related, noncommunicable diseases. I happened to meet up with Dr. Jim Slevin, and I think he'll be interested in working with us on that.

In 2004, in the Conference on Assuring Food and Nutrition Security in Africa by 2020, it was concluded that the roadmap for the way forward in ending hunger in Africa is clearly drawn. If actors are strengthened and walk forward together in new partnerships, then the goal can be reached in this generation. Now, what we believe in The Gambia is to work with communities to achieve universal coverage with known interventions.

And I can't help but bring this slide where, if you want to improve nutrition, while as we're going to work with the men, we have to focus and invest in women. We know that women, us women, we link nutrition, health and food security. We produce, we nurture and we care – not just childcare, but if I may also say this, husband care. So we, you need to invest in us. And men

need to be invested in. If we were asked three most pressing needs to accelerate sustainable nutrition action, I would say that nutrition needs to be on the international agenda. We must have resources that are specific for nutrition. We must have national governments' commitment. And in most countries in Africa, there is no institution that is responsible, that has the authority, and that can be held accountable for nutrition. And that is crucial if you're going to improve nutrition.

The title of the Hunger Task Force Report is "Halting Hunger – It can be done." And I sincerely believe in that.