



Countdown to 2030 West African Initiative on Nutrition

**Leaving No Woman and Child Behind:
Inequalities In Nutrition Coverage and Status Among
Women, Children and Adolescents in West Africa**



May 2020





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A Multi-Country Analysis

May 2020

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Acknowledgment

This report is based on two regional analysis workshops conducted in June and October 2019 in Dakar, Senegal. These workshops were part of the Countdown to 2030 regional initiative for evidence generation and analytical capacity strengthening in West and Central Africa. They were led by the West African Health Organization (WAHO) with support from the Johns Hopkins University, the African Population and Health Research Center (APHRC), the International Center for Equity in Health of the Federal University of Pelotas, the University of Manitoba, Alive & Thrive / FHI360, Transform Nutrition West Africa / IFPRI, WHO and UNICEF.

The workshops were funded by Countdown to 2030 for Women's, Children's and Adolescents' Health based on a grant from the Bill & Melinda Gates Foundation through Grant OPP1148933 and from the Alive & Thrive Project of FHI360.

The focus is on the 15 West African countries, including the Alive & Thrive focus countries and Transform Project focus countries. We are sincerely thankful to all the workshop participants from the 15 ECOWAS countries (Benin, Burkina Faso, Cabo Verde, Cote d'Ivoire, Gambia The, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo).

The findings of the workshops have been disseminated in regional meetings including the ECOWAS Nutrition Forum in Monrovia, Liberia in November 2019 and at a West African Regional Data Summit in Saly, Senegal in February 2020. Policy briefs and scientific articles have also been prepared. WAHO and Partners would like to thank to all the contributors involved in these dissemination efforts.



Abbreviations

APHRC	African Population Health Research Center
BMI	Body Mass Index
CD2030	Countdown to 2030: Women's, Children's and Adolescents' Health
DHIS2	District Health Information System version 2
EBF	Exclusive Breastfeeding
ECOWAS	Economic Community of West African States
GINA	Global database on Implementation of Nutrition Action
HMIS	Health Management Information System
ICEH	International Center for Equity in Health
IFA	Iron and Folic Acid
IFPRI	International Food Policy Research Institute
IYCF	Infant and Young Child Feeding
JHU	Johns Hopkins University
MAM	Moderate Acute Malnutrition
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHD	WHO Department of Nutrition for Health and Development
PMA	Performance Monitoring for Action
RMNCH	Reproductive, Maternal, Newborn and Child Health
RMNCH-N	Reproductive, Maternal, Newborn, Child Health and Nutrition
SAM	Severe Acute Malnutrition
SUN	Scaling-Up Nutrition
U5	Under-five years old
UN	United Nations
UNICEF	United Nations Children's Fund
WA	West Africa(n)
WAHO	West African Health Organization
WHA	World Health Assembly
WHO	World Health Organization



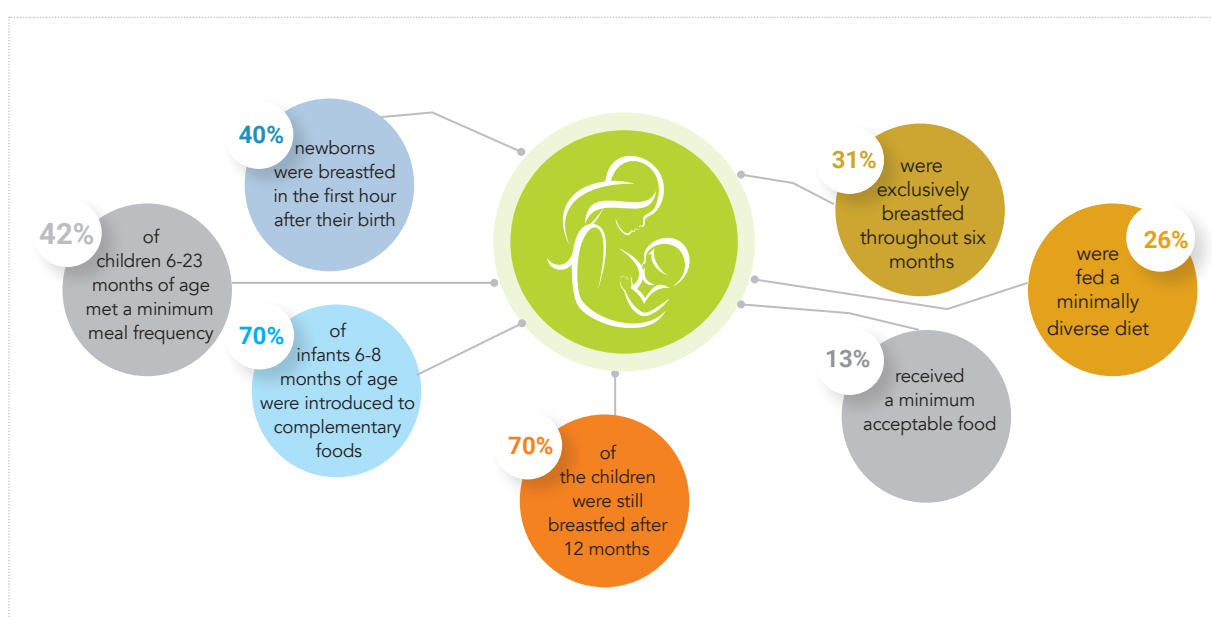
Executive Summary

Malnutrition is considered a significant public health problem in the Economic Community of West African States (ECOWAS). An estimated 18 million women in the region are anemic, and 6 million are obese, based on United Nations population figures. Among children under five years, 18.5 million were stunted, and 5.1 million wasted. Exceptional efforts and investment will be required in the region to meet the 2030 Sustainable Development Goals relating to food security, eradication of hunger, improvement of nutritional status, and promotion of sustainable agriculture.

Food and nutrition security, particularly for children, adolescent girls, and women of reproductive age remain a priority for all ECOWAS Member States as there has been limited progress in achieving global nutrition targets. It is with the view to assisting national and regional authorities to define evidence-led policies and actions that the Countdown to 2030 Initiative for Women's, Children, and Adolescents (CD 2030) organized two workshops in the ECOWAS region to strengthen the capacity of Member States in advanced data analysis. The workshop's objectives were:

- to enhance evidence for nutrition-related issues for women, adolescents and children in West Africa;
- to strengthen the capacity for analysis of nutrition data from publicly-available sources.

The data analysis adopted the United Nations Children's Fund (UNICEF) framework that characterizes the causes and consequences of malnutrition. The framework includes a set of indicators to assess nutritional status for children, adolescents, and adult women (e.g., anthropometry and anemia), and Infant and Young Child Feeding (IYCF) practices (e.g., early initiation of breastfeeding, exclusive breastfeeding, the introduction of complementary foods and continued breastfeeding). These indicators were the focus of the workshops and are summarized in this report. Several data sources were used to evaluate the core indicators. These included publicly available national health surveys; global databases included the WHO Gina database and country-level program monitoring data.



The analysis showed that the levels of IYCF practices are low in the region. On average, only 40% of newborns were breastfed in the first hour after their birth, and less than 1 in 3 infants (31%) were exclusively breastfed throughout six months. Seventy percent (70%) of infants 6-8 months of age were introduced to complementary foods, 42% of children 6-23 months of age met a minimum meal frequency, 26% were fed a minimally diverse diet, and only 13% received a minimum acceptable food. Finally, 70% of the children were still breastfed after 12 months. Significant inequalities exist in terms of IYCF practices within and between countries.

Stunting is a primary concern in the region, with 29% of children under-five affected. Niger, Mali, and Sierra Leone are most impacted by stunting, with prevalence exceeding 40%. Children most affected are those living in rural areas and those in the lowest wealth quintile. Malnutrition is also prevalent in women of reproductive age, with 8% being underweight and 7% obese in West Africa. There has been a reduction in underweight prevalence. However overweight and obesity is still increasing rapidly. The difference in terms of anemia among the groups are minimal, suggesting that this problem concerns the entire population.

National nutrition strategies are available in each of the 15 ECOWAS countries. However, not all countries have a monitoring and evaluation plan to assess the impact of these strategies. Available policies generally address undernutrition and nutritional deficiency issues such as vitamin A or iron supplementation and Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) management. Additionally, food-based dietary guidelines are absent in most countries. Togo, Guinea, Gambia, Senegal, and Burkina Faso have committed to the highest number of nutrition policies while Sierra Leone, Benin, Mali, and Cote d'Ivoire have committed to the fewest.

As key results on program analysis in West Africa, the following was noted:

- Majority of countries are implementing food/nutrient fortification, breastfeeding promotion, assessment/management of childhood wasting, child vitamin A supplementation, deworming for school children (adolescents), iron/folate supplementation for pregnant women and nutritional support for women/children/infants with HIV and/or TB. However, the level and coverage of implementation is different between countries;
 - For example, Mali implemented almost all the WHO Essential Nutrition Actions, while Gambia & Nigeria are implementing only half of them.
- Regionally, adolescents and children under five years of age are well covered by these nutritional interventions.
- The least implemented interventions are vitamin A and calcium supplementation for pregnant women, zinc supplementation of a child with diarrhea, and umbilical cord clamping.

Several recommendations can be made based on the results— one of which consists of expanding the dissemination of this evidence for decision making, principally through policy briefs. Decision-makers should tailor policies to address unequal coverage of nutrition interventions. The issue of data availability should be prioritized. Countries need to improve the quality, the timeliness, and the availability of data to support monitoring the programs and policies.



1.0

Introduction

The West African region (ECOWAS) is home to 348 million people, including 29 million children under the age of five years, and 80 million women of reproductive age (15 to 49 years). Despite current efforts and progress, the population faces enormous challenges in fully realizing the optimal nutritional status required to develop and thrive. In the region, more than 18 million women are anemic, and 6 million obese. The situation is particularly difficult for children and women living in conditions of vulnerability and disadvantage, and even those relatively well-off face increasing health threats of obesity. Under the Sustainable Development Goals (SDGs), all West African countries have committed to adequate food security, eradication of hunger, improvement of nutritional status, and promotion of sustainable agriculture. Considering the current level of nutrition indicators, the goals cannot be achieved by 2030 unless more robust and accelerated actions are taken in prioritizing nutrition and addressing significant inequalities among children, adolescents, and women in each country and the region as a whole. Malnutrition is a public health issue that substantially increases the risk of mortality and morbidity. The health and nutrition of adolescent girls and women (particularly of reproductive age) are critical and a priority as they are linked with child health and survival. Healthier adolescents and adult women are more likely to have children with better nutritional status than those who are less healthy.

Box 1: Political Commitment of ECOWAS Leaders

According to Her Excellency Dr Jewel Howard Taylor, Vice President of the Republic of Liberia in her opening address at the ECOWAS Nutrition Forum, November 2019:

"... The health and nutrition of adolescents is a political issue that not only depend on healthy food systems, but also, on public policy choices. Fortunately, there is a growing global and international momentum to tackle malnutrition... In Africa, the African Development Bank has championed accountability through the development of scorecards. Fourteen of the 15 ECOWAS countries have signed up as members of the Scaling- Up Nutrition Movement – a reflection of the recognition of the importance of high-level multisector engagement in nutrition governance.

... The multi-sectoral nature of the fight against malnutrition including the fight against hunger implies major investments in all key sectors, including health, agriculture, animal and fish resources, basic education, in particular, of the girl child, women empowerment, social protection, water, hygiene, sanitation and electricity. A profound change in the approach to improving nutrition involving increased political commitment, transformation of working methods, a stronger focus on results and a focus on the long term, is needed.

... I encourage you to exploit the opportunities offered by the United Nations Decade of Action on Nutrition 2016 – 2025 and by the 25th anniversary of the International Conference on Population and Development (ICPD25) and propose policies and programmes to delay pregnancy and promote women's rights in order to break the intergenerational cycle of undernutrition...

We need innovative ideas of how we can leverage our demographic dividend into a potential driver of growth and transformation in the region. I expect you to propose sustainable actions.



Current levels of children, adolescents, and women malnutrition could hinder the achievement of the SDG targets as well as the national and regional socio-economic development in West Africa. In November 2019, the 16th ECOWAS Nutrition Forum was organized in Monrovia, Liberia, under the theme “Adolescent nutrition: institutionalizing sustainable actions for improved outcomes in West Africa.” The Forum was officially opened by Her Excellency Dr. Jewel Howard Taylor, Vice-President of the Republic of Liberia, who took the opportunity to reaffirm the national and regional vision and commitment on nutrition (Box1).

To understand the data, and build the capacity of key stakeholders in the ECOWAS region, the Countdown 2030 project, in cooperation with WAHO, developed the regional initiative for capacity building in data analysis in/on maternal, child and adolescents nutrition. The initiative focused on two key analytical questions:

- What are the existing gaps between rich and poor, between urban and rural populations and between different administrative units within the same country regarding nutrition status?
- What improvements can be made for data analysis and use the information to advocate for related policy changes?



Photo source: Unicef

2.0

Methodology

2.1. Advanced data analysis workshops

This report presents the results of the multi-country analyses from advanced data analyses workshop with participation and contribution from the 15 ECOWAS country representatives. The primary data sources were from national health surveys such as Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), etc. Data on infant and young child feeding practices and child anthropometry were extracted from UNICEF global databases, which include other surveys such as SMART surveys, and specific country surveillance surveys. When available, PMA (Performance Monitoring for Action) surveys and last available routine health information system data were also used.

The two advanced data analysis workshops were organized in Senegal (June and October 2019). The intermediate phase between the two workshops was used to collect and compile additional information and data by countries to improve the depth of analyses. Participants were national nutrition program managers and data analyses experts from national research institutions or health information management systems of the 15 ECOWAS countries. They were trained on nutrition data analysis, principally on IYCF indicators. Following the first workshop, participants prepared the nutrition health profile of their state-based on publicly available data, then drafted policy briefs based on the findings of their research.

2.2. Data analysis

Several data sources were used, including administrative data, population-based survey data, and country profiles. These data are generally available in public portals, including UNICEF and WHO. Several web-based analysis and visualization tools are used, such as DataDENT (<https://datadent.org/landscaping-of-global-data-visualization-tools-for-nutrition/>), SUN (<https://scalingupnutrition.org/>) and Statcompiler (<https://www.statcompiler.com/>). The indicators were also driven from these sources. Additional analysis for inequality in terms of rural-urban residence, residence in the capital city versus elsewhere, population age-based sub-groups, wealth quintiles, equiplots (www.equidade.org), mapping, or other figures.



2.3. Nutrition indicators

Nutrition indicators used in these analyses are defined according to a framework proposed by the UNICEF . Selected nutrition indicators include adolescents' nutritional status, women's nutritional status, IYCF practices, and children's anthropometric status (Table 1).

Table 1: List of the indicators used for the CD2030 workshops

Indicator	Category	Definition
Anemia	Adolescent girls Adult women	Percentage of adolescents aged 15-19 years with any type of anemia (mild, moderate, severe) Percentage of women aged 20-49 years with any type of anemia (mild, moderate, severe)
Obesity	Adolescent girls Adult women	Percentage of adolescents aged 15-19 years who are >2 standard deviations above the median BMI-for-age growth reference ¹ Percentage of adults aged 20-49 years with a BMI ≥ 30 kg/m ²
Underweight	Adolescent girls Adult women	Percentage of adolescents aged 15-19 years who are <2 standard deviations below the median BMI-for-age growth reference ³ Percentage of adults aged 20-49 years with BMI < 18.5 kg/m ² (Body Mass Index = BMI)
Iron and Folic Acid supplementation	Pregnancy	Percentage of women 15-49 years who received iron-folic acid tablets for 90+ days during pregnancy
Low birthweight	Birth	Percentage of births weights less than 2,500 grams (up to and including 2,499 grams)
Early initiation of breastfeeding	IYCF	Percentage of newborns breastfed within 1 hour of birth
Exclusive breastfeeding	IYCF	Percentage of infants aged 0-5months receiving only breastmilk
Introduction to solid, semi-solid or soft foods	IYCF	Percentage of infants aged 6-8 months receiving solid or semi-solid food
Minimum diet diversity	IYCF	Percentage of children aged 6-23 months receiving 5 of the eight recommended food groups
Minimum meal frequency	IYCF	Percentage of children aged 6-23 months receiving the recommended minimum number of solid/liquid feeds as per the age of a child
Minimum acceptable diet	IYCF	Percentage of children aged 6-23 months receiving the minimum diversity of foods and the minimum number of feeds
Continued breastfeeding	IYCF	Percentage of children aged 12-23 months receiving breastmilk
Stunting	Child anthropometry	This refers to a child who is too short for his or her age. This is defined as the proportion of under-fives falling below minus two standard deviations (moderate and severe) from the median length/height-for-age of the reference population
Wasting	Child anthropometry	This refers to a child who is too thin for his or her height. This is defined as the proportion of under-fives falling below minus two standard deviations (moderate and severe) from the median weight-for-height of the reference population
Overweight	Child anthropometry	Refers to a child who is too heavy for his or her height This is defined as the proportion of under-fives above plus one standard deviation (moderate and severe) from the median weight-for-height of the reference population

3.0

Results

Key results, as analysed in the workshops, are presented using the data sources and indicators highlighted above. The following results are presented in the ensuing sections:

- levels and trends of infant and young child feeding (IYCF) practices will be described including subnational inequalities
- under-five nutritional profile and trends are presented at the regional level and then at country level stratified by different inequality dimensions
- national differences in malnutrition and anemia in adolescents and adult women are described

3.1. Infant and young child feeding (IYCF)

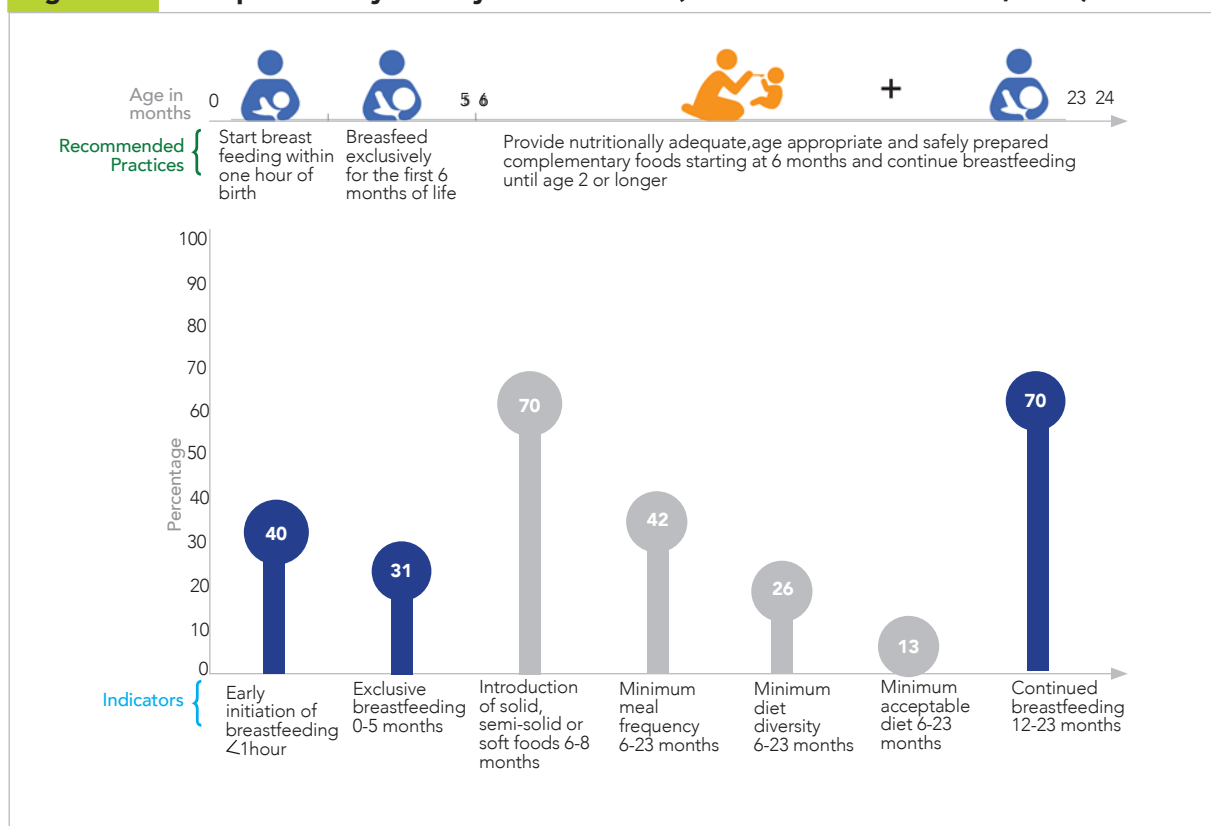
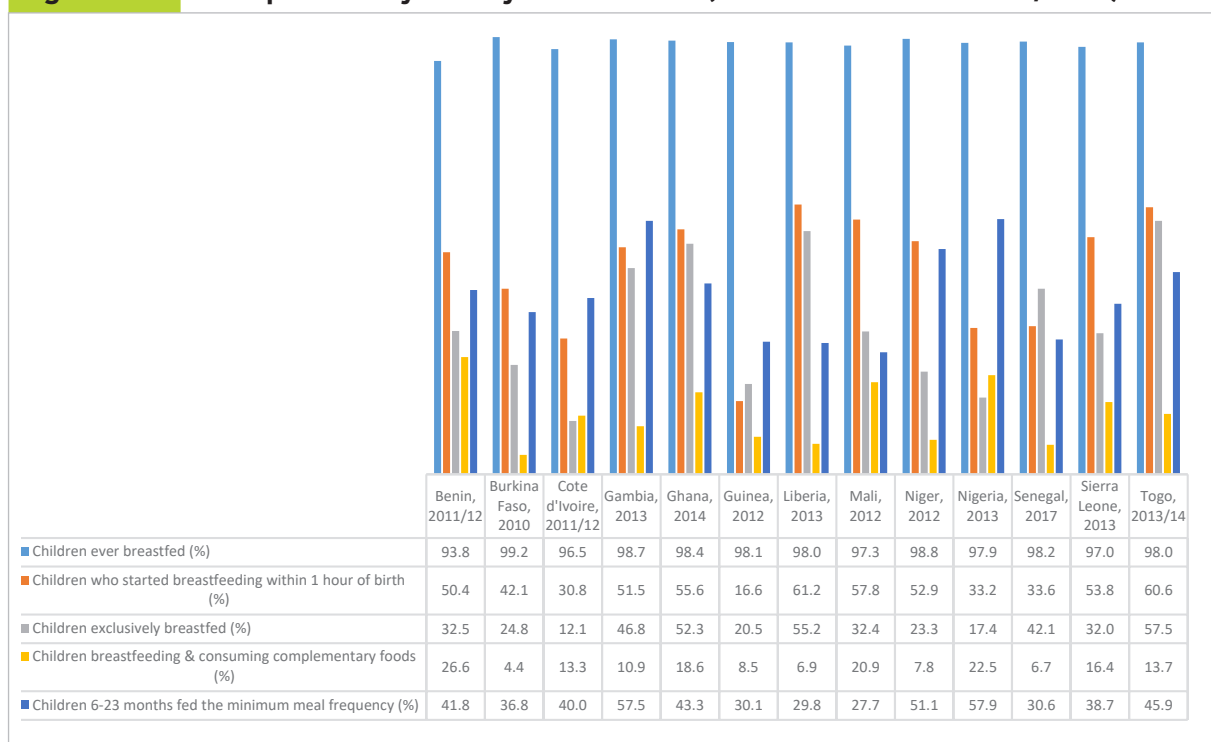
3.1.1. Levels and trends in IYCF practices

WHO and UNICEF recommend:

- early initiation of breastfeeding within 1 hour of birth
- exclusive breastfeeding for the first six months of life
- introduction of nutritionally-adequate and safe complementary (solid) foods at six months together with continued breastfeeding up to 2 years of age or beyond

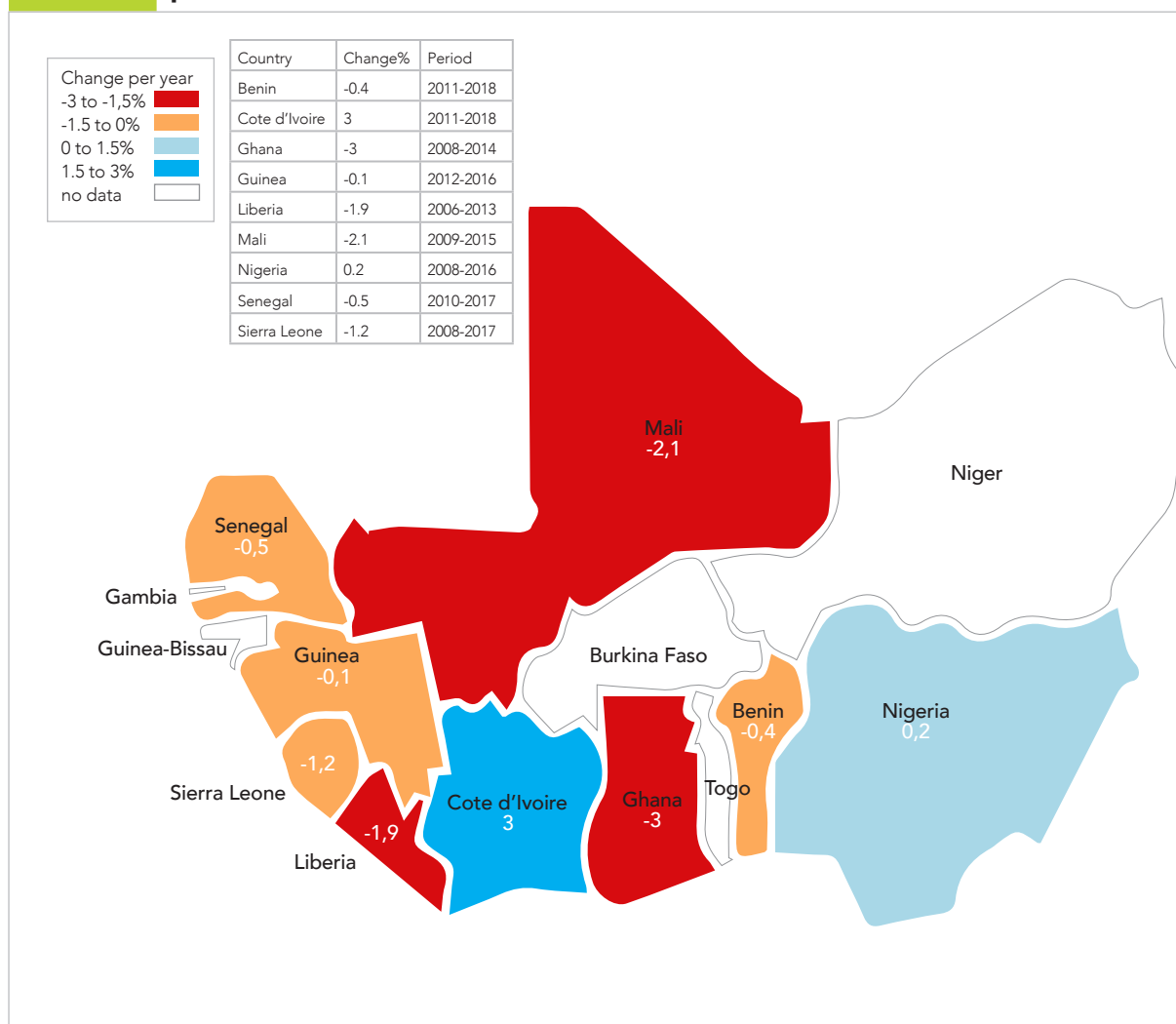
The prevalence percentages of IYCF indicators in Western Africa are presented in Figure 1. The average level for early initiation of breastfeeding in West Africa is 40%. This ranged from 60% in Liberia to 33% in Nigeria (fig.1.1). While the prevalence of continued breastfeeding is high, with nearly 70% of children over 12 months of age being breastfed, the prevalence of exclusive breastfeeding among infants under six months is still low, estimated at 31% ranging from 12% in Côte d'Ivoire to 57.5% in Togo.



Figure 1: IYCF practices by country in West Africa (UNICEF Global Data Base, 2019)

Figure 1.1: IYCF practices by country in West Africa (UNICEF Global Data Base, 2019)


Trends in minimum dietary diversity show a decrease in the majority of countries (Figure 2). Only two countries, Cote d'Ivoire and Nigeria experienced improvements.

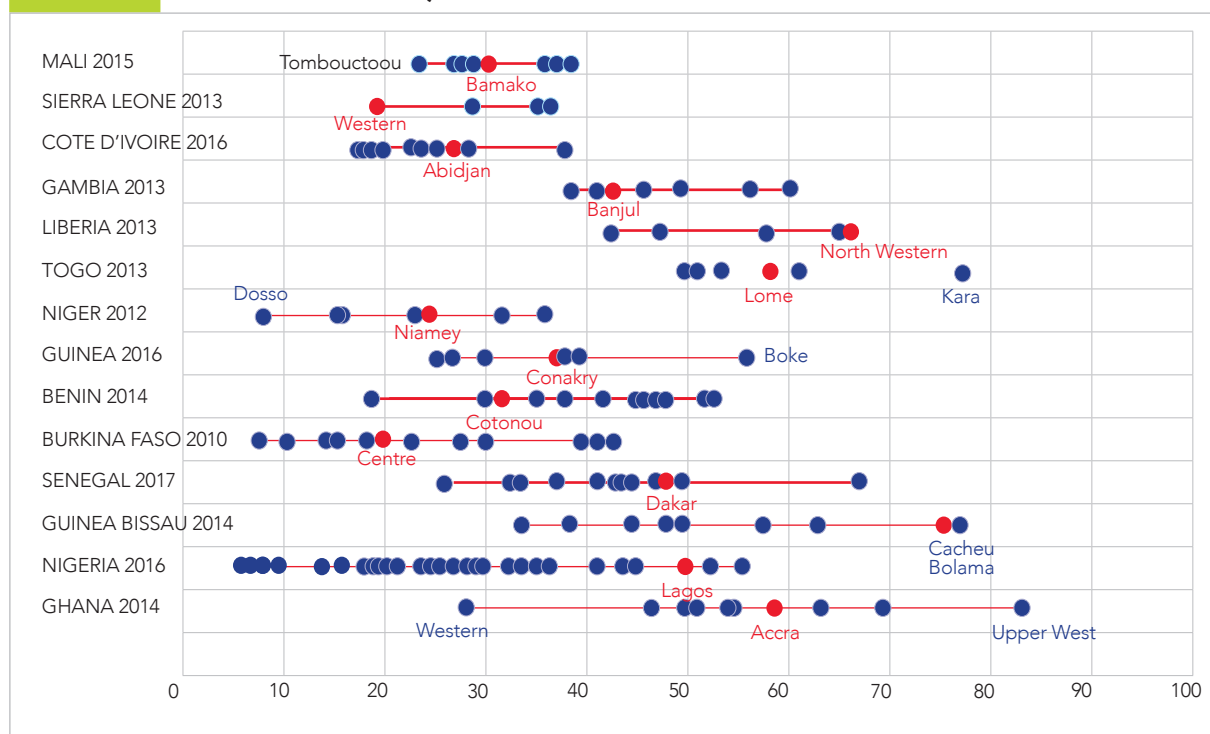
Figure 2: Change per year (in percentage points) in minimum dietary diversity prevalence in Nine West African Countries



3.1.2. Subnational inequalities in exclusive breastfeeding (EBF) practice

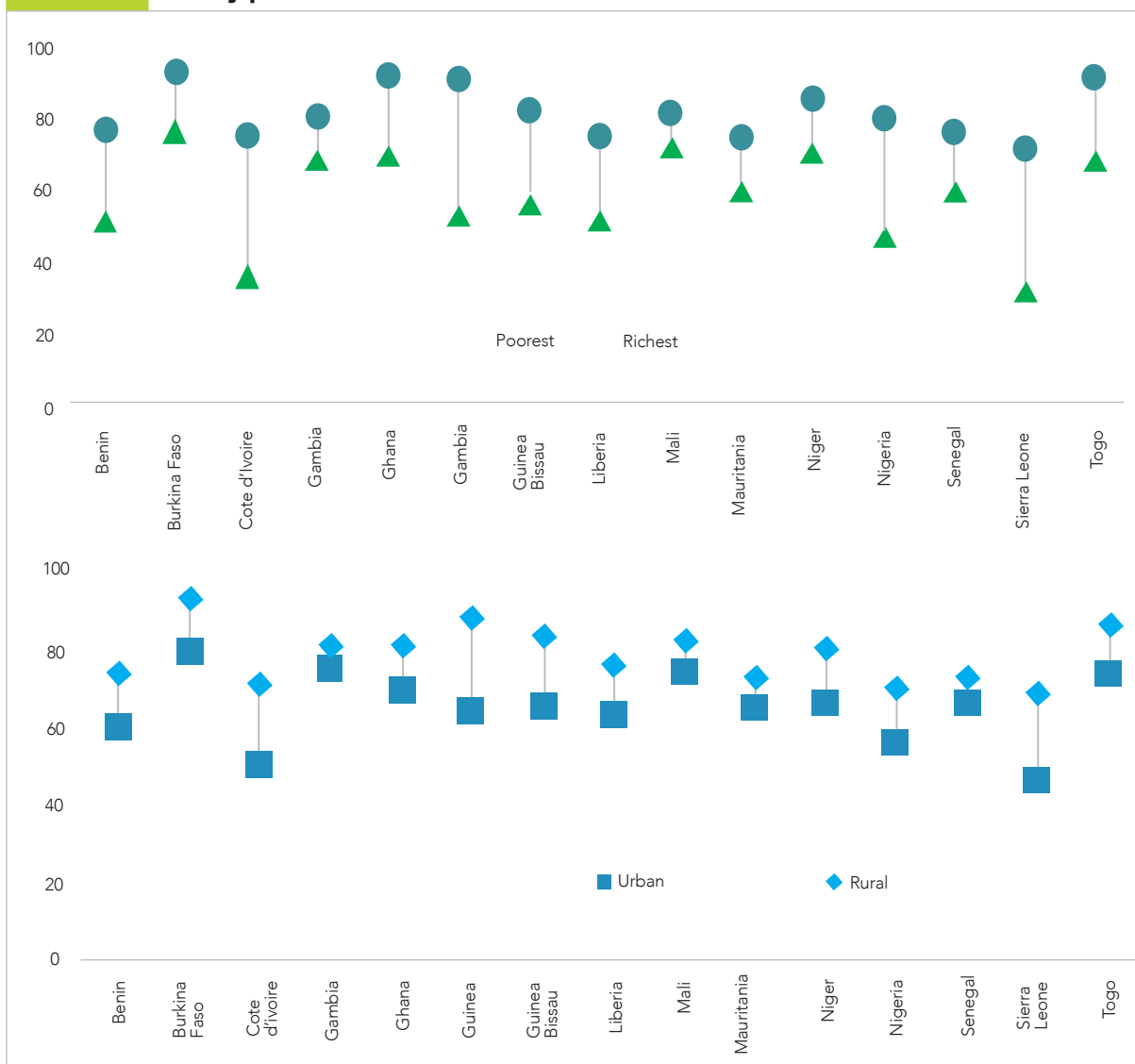
The IYCF is characterized by substantial disparities between and within the ECOWAS countries. Considering exclusive breastfeeding, for example, significant differences are observed across the region (Figure 3). Ghana and Nigeria present the widest gap (i.e., the distance between best performing to poorest performing regions) in exclusive breastfeeding across sub-regions within the country, with a 55.6 and a 50.4 percentage point difference, respectively. Residing in the capital of the country's largest city does not confer any advantage (or disadvantage) in the EBF coverage.



Figure 3: Prevalence of exclusive breastfeeding (%) according to the region by country (last available information)

3.1.3. Other inequalities in IYCF practices

There are clear patterns in several IYCF practices common to all the Western African countries. The prevalence of IYCF practices does not differ by the sex of the child. The prevalence of continued breastfeeding at age 12-23 months was consistently higher among children from the poorest households than those from the wealthiest households, with the widest inequality gaps observed in Cote d'Ivoire, Guinea, and Sierra Leone (Figure 4). Similarly, children living in rural residents consistently had a higher prevalence of continued breastfeeding than urban residents, although the inequality gaps were much smaller than observed with wealth quintiles. There was practically no urban-rural inequality observed in Gambia, Mali, or Senegal. An opposite pattern was observed with complementary feeding indicators where children born in most affluent and urban households had better diets in terms of diversity and frequency.

Figure 4: Prevalence of continued breastfeeding between 12-23 months (%) by wealth level and by place of residence

3.2. Child nutrition anthropometric indicators

Key nutrition indicators are based on anthropometric data. These data are critical for making decisions on how to implement health and nutrition interventions and are primarily gathered in population-representative surveys.

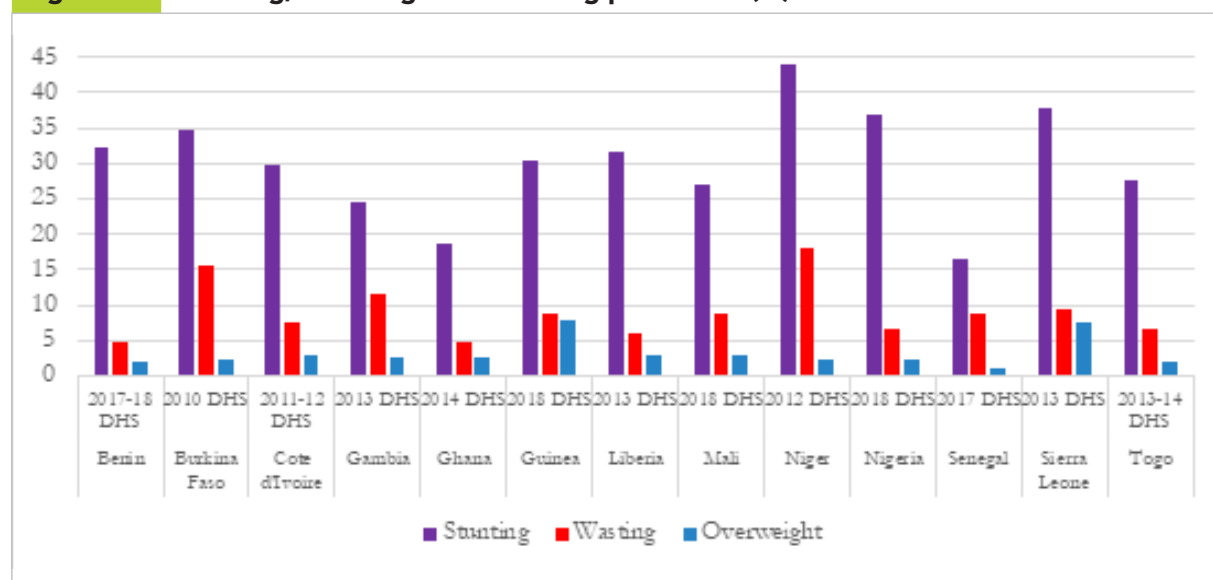
Anthropometric indicators are based on measurements of weight, length/height, and age, among which the following anthropometric indices are crucial:

- weight-for-age
- length-for-age or height-for-age (stunting)
- weight-for-length or weight-for-height (wasting and overweight)



For children under 5, the prevalence of stunting is significantly higher than other forms of under nutrition (Figure 5). However, there is also a need to pay attention to emerging health problems such as for overweight.

Figure 5: Stunting, overweight and wasting prevalence (%) in Western Africa



3.2.1. Trends in children's nutritional status

The trends in the children's nutritional status were directly drawn using STATcompiler . Trends in stunting, wasting, and overweight are not present and are generally consistent over time (Figures 6, 7, and 8).

Figure 6: Trends in child stunting

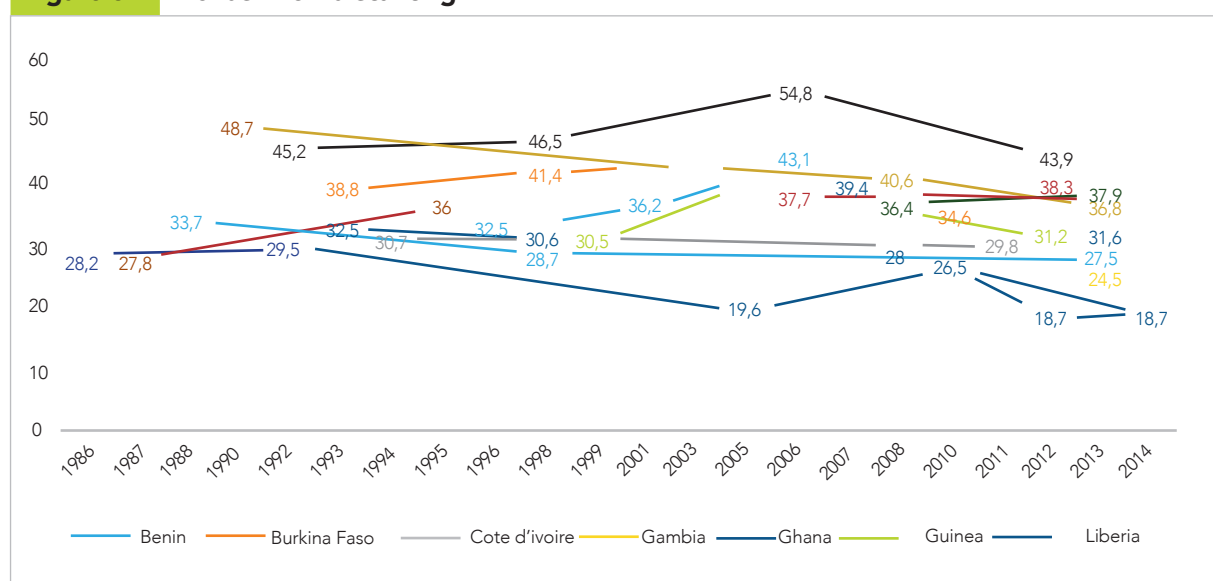
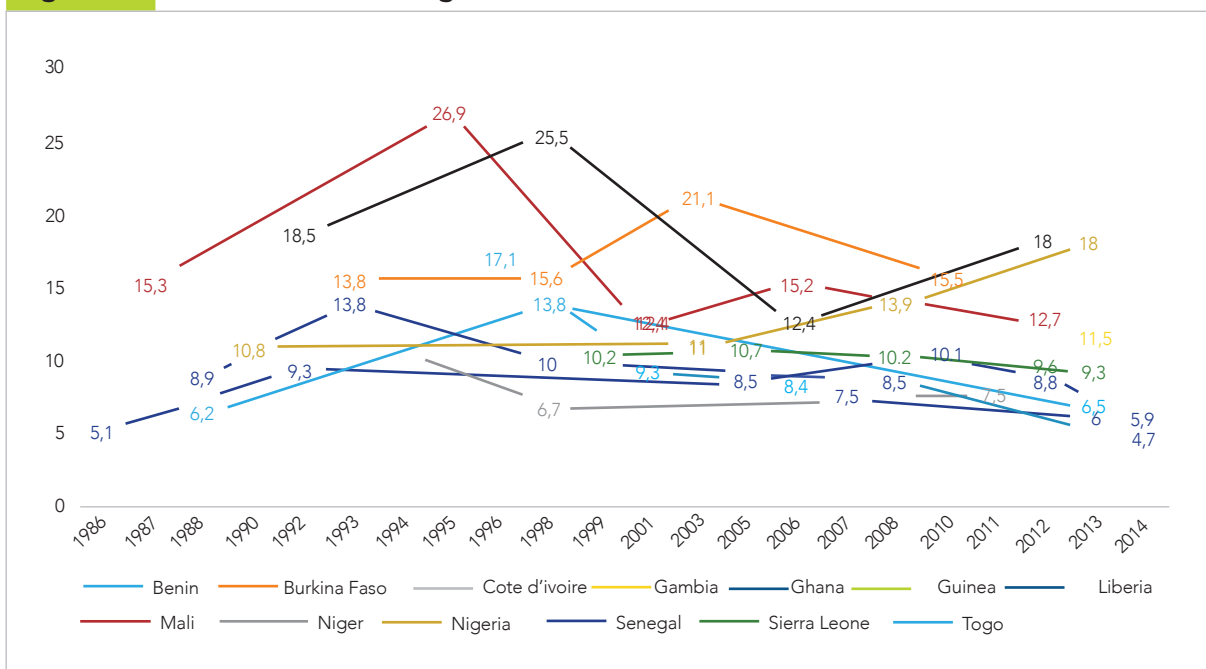
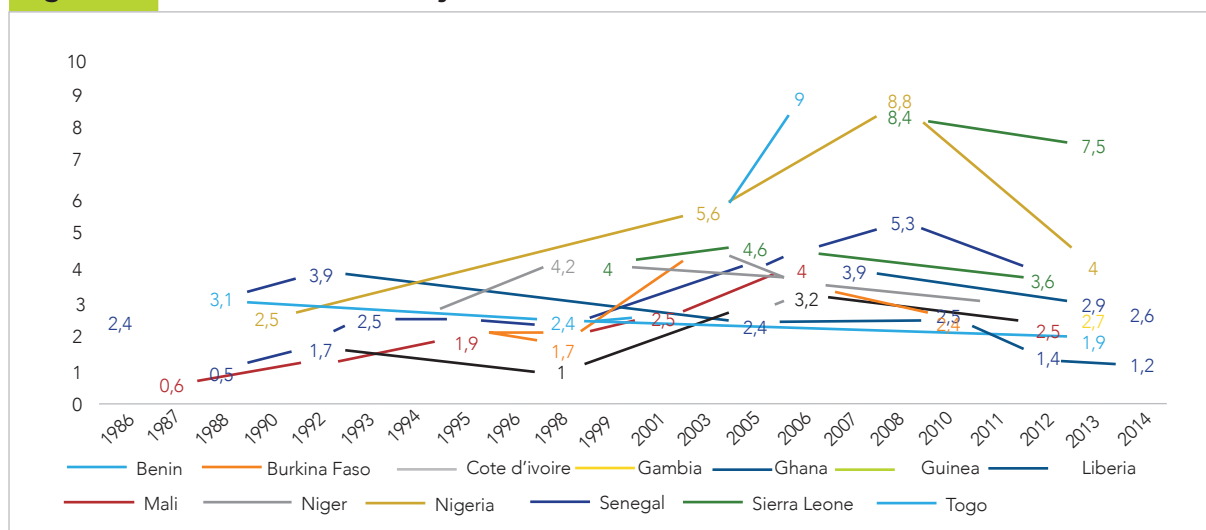


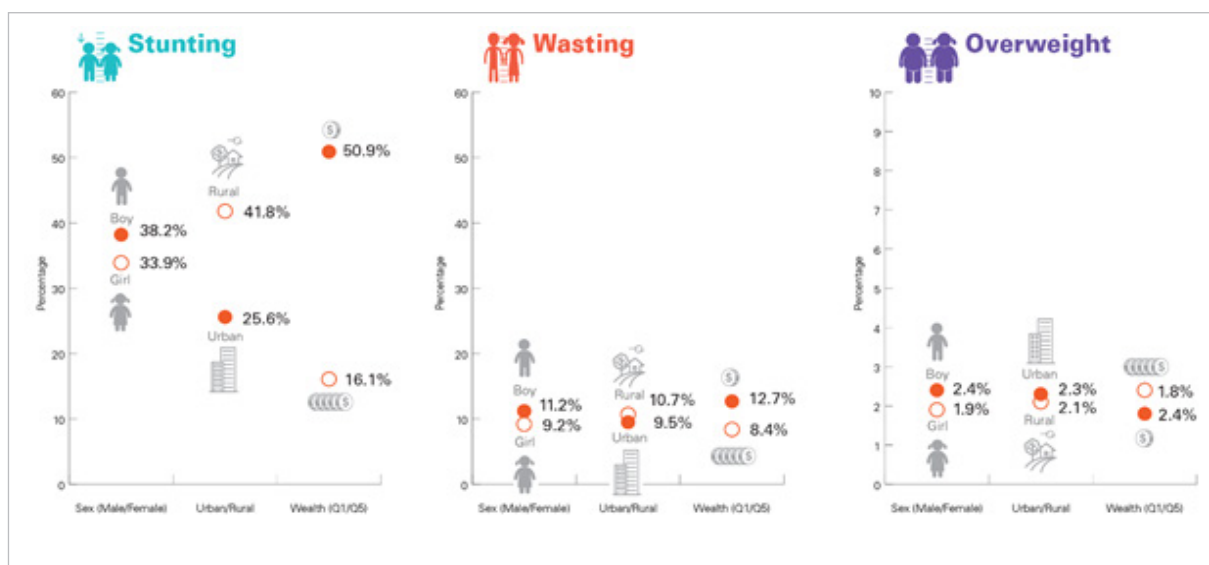
Figure 7: Trends in child wasting

Figure 8: Trends in child obesity


3.2.2. Inequality patterns on children's nutritional status

The disparities in the prevalence of under-five malnutrition by sex, residence, and wealth at the regional level were widest in stunting compared to wasting or overweight (Figure 9). A 16-percentage point gap in stunting was observed between rural and urban residents (41.8% versus 25.6%), while a 35-percentage point gap was found between children in the poorest and wealthiest households (50.9% versus 16.1%). Thus, on a ratio scale, children in the lowest wealth quintile in the region were more than three times as likely to be stunted as those in the highest wealth quintile. There were only minor inequalities in the prevalence of child overweight by sex, residence, or wealth quintile.



Figure 9: Inequalities by sex, place of residence and wealth index for the leading anthropometric indicators for under-five years old children in West Africa (Based on UNICEF global databases)



The absence of inequalities in child overweight at the regional level was also evident in most ECOWAS countries, except for Ghana, Guinea-Bissau, and Sierra Leone, where children in the wealthiest households or urban areas tended to be more overweight children.

Figure 10.1: Prevalence (%) of children overweight by wealth level

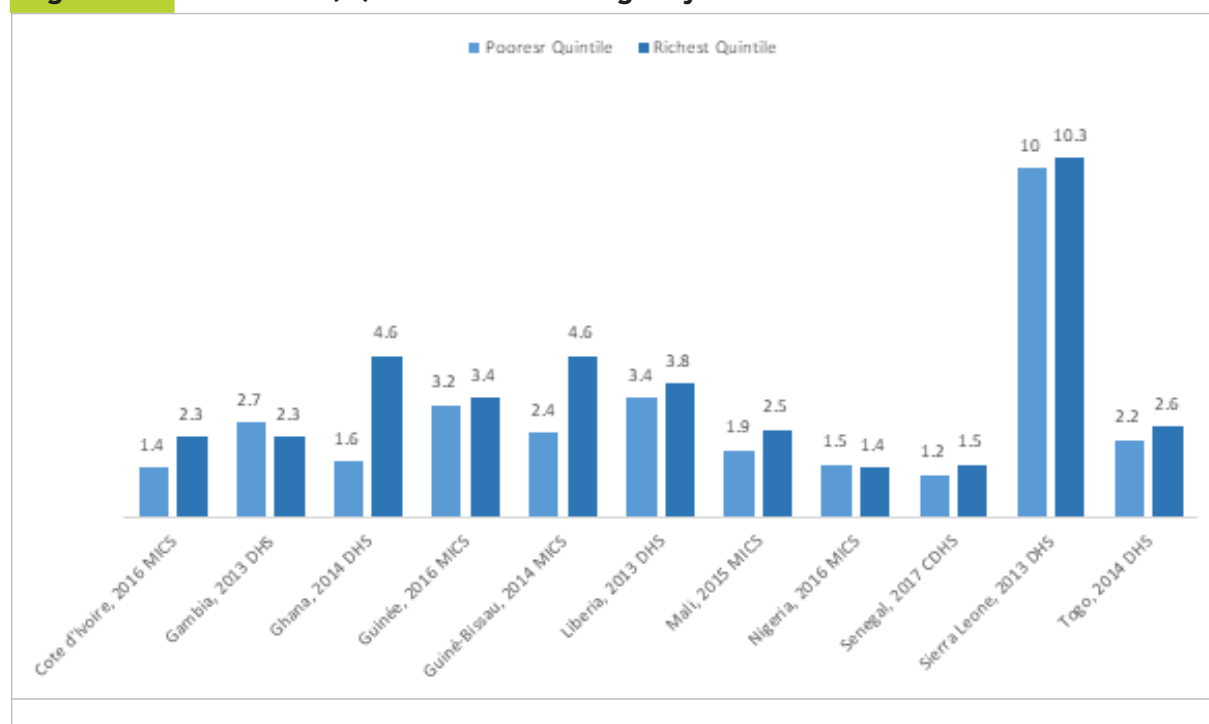
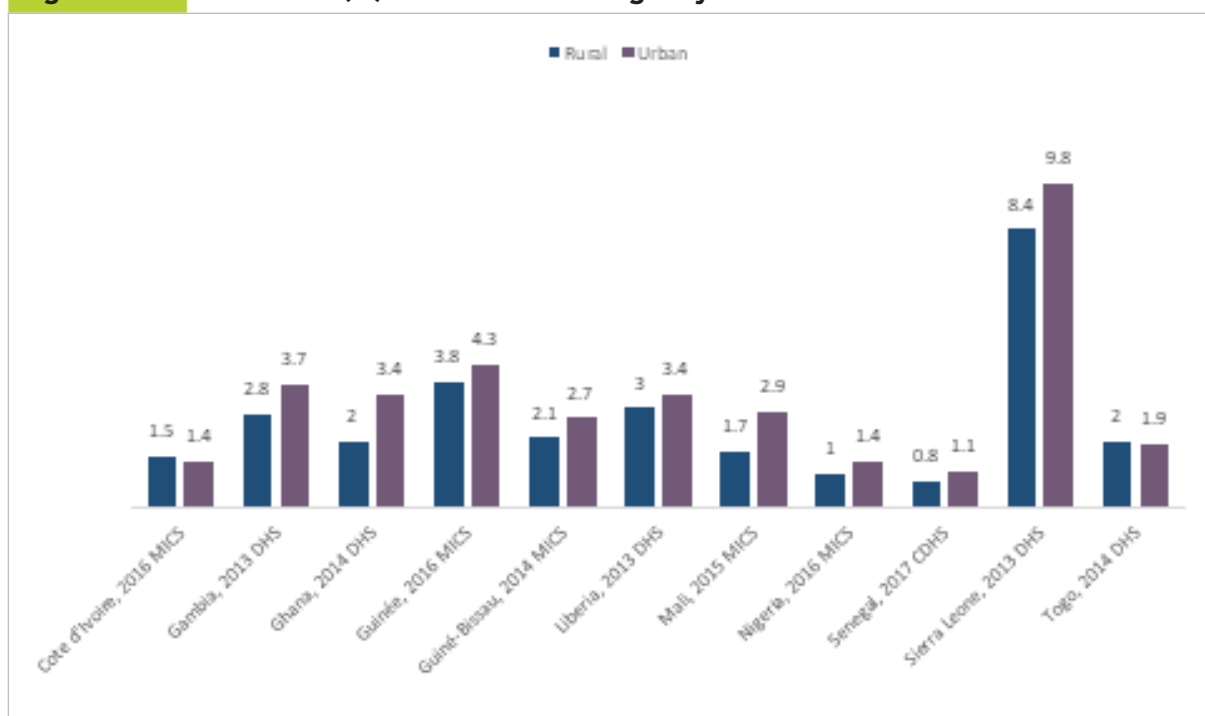


Figure 10.2: Prevalence (%) of children overweight by area of residence

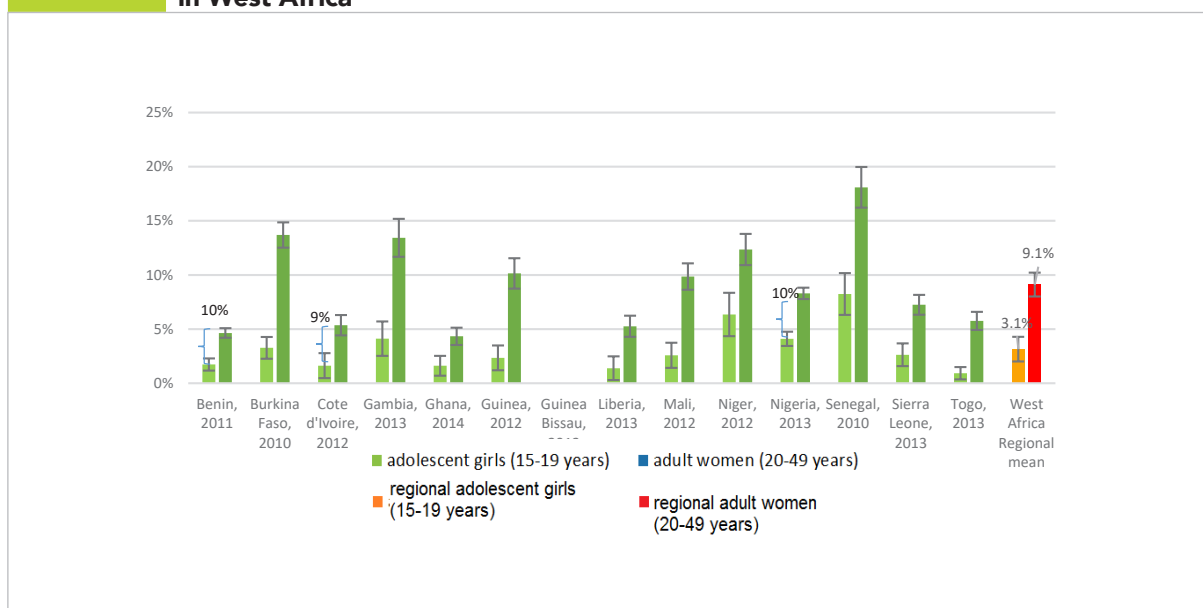
3.3. Adolescent and adult women nutritional status

3.3.1. Regional coverage

The nutritional status of women during pregnancy is associated with pregnancy outcomes and child health outcomes. The “first thousand days” from pre-conception to two years of age is known as the window of opportunity for nutritional interventions. It is, therefore, essential for all women to have an optimal nutritional status during adolescence and adulthood.

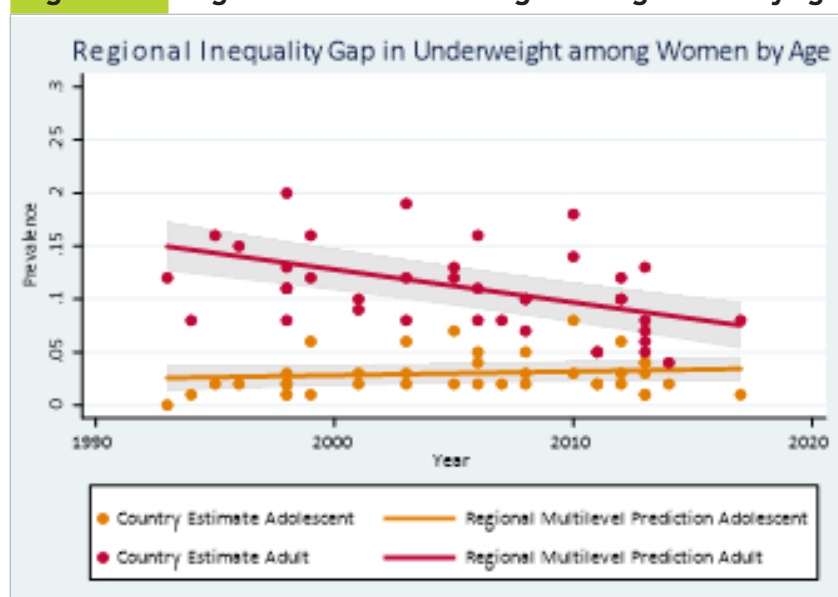
The regional prevalence of underweight in women aged 20-49 years is estimated at 9%, ranging from 3% in Ghana (2014) to 16% in Senegal (2010) (Figure 11). The burden of underweight is concentrated among adult women with no formal education and living in rural areas. About 3% of adolescent girls aged 15-19 years in the region are underweight.



Figure 11: Prevalence of underweight in adolescent girls and adult women aged 20-49 years in West Africa

Obesity impacts 7% of the West African women (20 – 49), ranging from 3% in Burkina Faso (2010) to 15% in Ghana (2014) with the burden more concentrated among educated women, living in the country's largest cities. Fifty percent of all women in West Africa are anemic. The prevalence exceeds 50% for pregnant women. There are no significant differences in the prevalence of anemia between adolescents (50%) and adult women (52%). However, women with no formal education and those living in rural areas experience the highest burden. Finally, the regional percentage of pregnant women who received iron and folic acid (IFA) supplementation is around 35%.

3.3.2. Trends in adolescents girls' and women's nutritional status

Figure 12: Regional trend in underweight among women by age

Two figures are used to summarize regional trends in terms of malnutrition regarding adolescent girls and adult women. Figure 12 presents the trend of the regional prevalence of underweight adolescent girls and adult women. Figure 13 shows adolescent girls and adult women in terms of obesity.

Both figures denote that the prevalence of underweight and obesity in adolescent girls has been nearly constant over time. However, for the case of adult women, two patterns are observed.

The prevalence of underweight is decreasing, thus reducing the inequality between adults and adolescents at a regional level. In contrast, regional disparities in terms of obesity are steadily increasing, fuelled by a rapid rise in the prevalence of obesity among adult women. This denotes a situation of the double burden of malnutrition where underweight is persisting (slowly decreasing), and obesity is rising rapidly in the region.

Figure 13: Regional trend in obesity among women by age

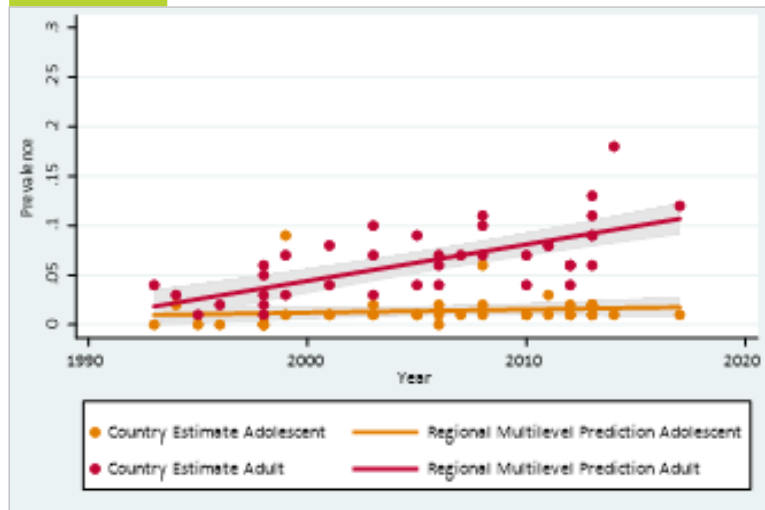
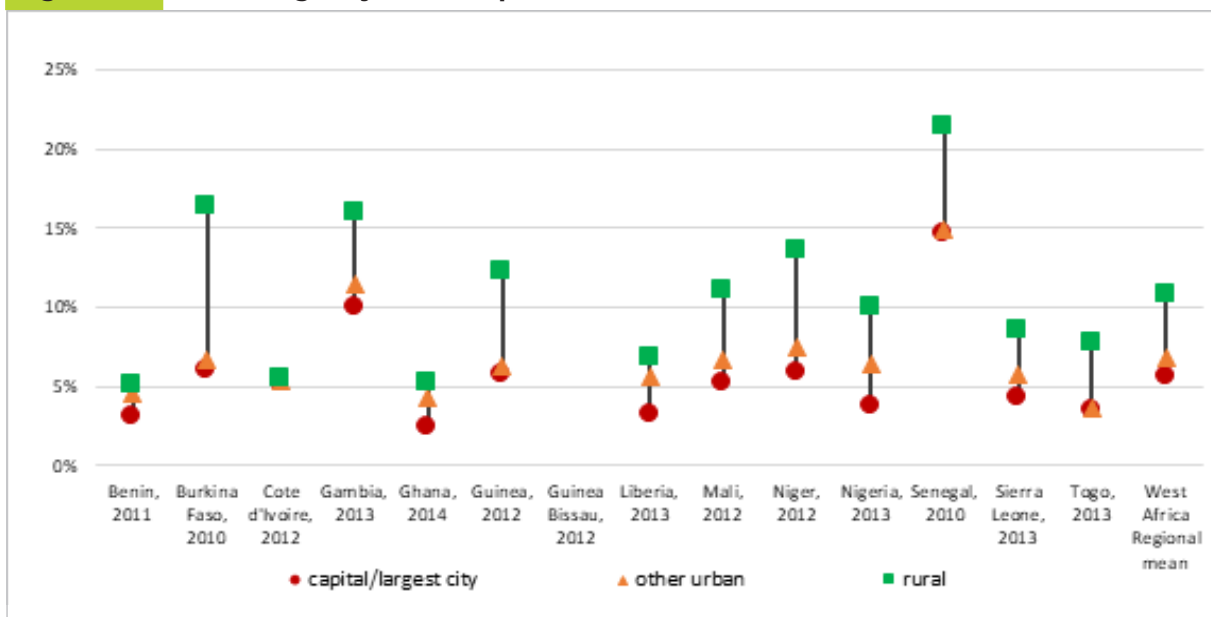


Figure 14: Underweight by woman's place of residence



3.3.3. Other difference between adolescent and women status

Adolescents' (15 -19) and adults' (20-49) nutritional status presents vast inequalities according to the women's place of residence. The country's capital city of the country's largest city (i.e., Lagos, Abidjan, Cotonou) is characterized by the lowest prevalence of underweight (Figure 14).

However, it is also in the largest capital cities where the prevalence of obesity is highest within countries. Finally, this shows that urban and rural areas present two different nutritional challenges for women; therefore, nutrition policies should be undertaken according to residency.



4.0

Analysis of the Nutrition Policies and Programs in West Africa

4.1. Explanation of GINA Database and analysis

The countries' progress in developing, implementing, monitoring, and assessing national nutrition policies and programs is monitored using the Global database on the Implementation of Nutrition Action (GINA). GINA was developed and launched in 2012 with the support of the Bill & Melinda Gates Foundation. It is informed by WHO's global policy reviews and policy monitoring activities in collaboration with Regional and Country Offices as well as by partners' databases. GINA provides a repository of policies, actions/programs, and mechanisms related to nutrition.

Policy analysis was conducted by extracting data the GINA database and using the following six policy categories:

- **Category 1:** Nutrition policies such as strategic plans, M&E, or guidelines
- **Category 2:** Nutrition protocols such as management of low birth weight infants, or infant feeding in HIV or emergency/humanitarian context
- **Category 3:** Fortification policies such as legislation or standards of fortification and breastmilk substitute marketing
- **Category 4:** Nutritional intervention policies such as micronutrient supplementation or "Baby-Friendly Hospital" initiatives
- **Category 5:** Inclusion of nutritional goals or targets specific for infants, children, adolescents, and women
- **Category 6:** Inclusion of goals, targets, or indicators for general nutritional outcomes such as for overweight/obesity or general vitamin/mineral supplementation

For each of the specific policies, they were classified whether the country had a (1) policy present; (2) adopted a policy at the national level; or (3) missing/unknown policy. It was also analysed the year the policy was introduced, and the yearly range in which it was active.

For the actions or program analysis, information was extracted from the GINA database for the WHO essential nutrition actions. We organized the actions by target population: infant, children under-five, adolescents, pregnant women, emergency populations, multisectoral, or other (Box 2).

Also created was a summative score of nutrition actions implemented by each country and overall by the target population (table 2). A score of 1.0 signifies that a country has achieved all essential nutrition actions for a target population, and a score of 0.0 means that a country has implemented none of the critical nutrition actions.



Presented is the score across all the countries by each target population. The information on policies and programs was extracted from the GINA database in October 2019.

Box 2: Nutritional actions by target population

Multisectoral: Health diet promotion and fortification.

Infant: cord clamping, breastfeeding, low-birthweight care, and assessment/management of wasting.

Child: Complementary feeding, growth monitoring, assessment/management of wasting, deworming, and iron, iodine, vitamin A and zinc (diarrhea cases only) supplementation.

Adolescent: Iron supplementation and deworming.

Pregnant women: nutritional counseling, deworming, and vitamin A, calcium, iodine, iron/multinutrient, iron/folate and energy/protein supplementation.

Emergency: nutritional support for women, infants and children.

Other: Nutrition systems strengthening, nutritional support for TB/HIV/other diseases, school feeding programs, water/sanitation, vitamin A supplementation for postpartum women and IEC programs.

Table 2: Summative score of nutritional actions by country and target population.

Country	Total	Multisectoral	Infant	Children under-five	Adolescent	Pregnant women
Mali	0.96	1.00	1.00	1.00	1.00	0.88
Cote d'Ivoire	0.79	1.00	0.50	1.00	0.50	0.75
Guinea	0.75	1.00	0.75	0.88	1.00	0.50
Senegal	0.75	1.00	0.75	0.88	1.00	0.50
Benin	0.71	1.00	0.75	0.88	1.00	0.38
Burkina Faso	0.71	0.50	0.75	0.88	1.00	0.50
Togo	0.71	0.50	0.50	0.75	1.00	0.75
Niger	0.67	1.00	1.00	0.75	1.00	0.25
Ghana	0.63	1.00	0.50	0.63	1.00	0.50
Guinea Bissau	0.63	0.50	0.75	0.88	1.00	0.25
Sierra Leone	0.63	0.50	0.75	0.88	1.00	0.25
Cape Verde	0.58	1.00	0.50	0.75	1.00	0.25
Liberia	0.58	1.00	0.50	0.75	1.00	0.25
Gambia	0.50	1.00	0.50	0.63	0.50	0.25
Nigeria	0.50	0.50	0.25	0.75	0.50	0.38
Summative scores	0.67	0.83	0.65	0.82	0.90	0.44



4.2. Nutrition Policies in West Africa: Critical results from GINA Analysis

- Every country has some form of a National Nutrition Strategy, although few countries have built a monitoring and evaluation plan to assess the implementation of their strategy.
- There are no food-based dietary guidelines in most countries.
- Every country has adopted various provisions of the International Code of Marketing of Breastmilk Substitutes. In most cases, it has been rolled out nationally; however, the different requirements are not implemented or enforced.
- Most countries have policies surrounding vitamin A supplementation in children, antenatal iron-folic acid 90+, supplementary foods for management of SAM or MAM, school health and nutrition programs, Baby-friendly Hospital Initiative.
- Across the board, there are nutrition goals and targets for children, women, and adolescents.
- Most countries do not have guidelines to promote food supplementation during pregnancy (balanced protein-energy supplementation) or calcium supplementation during pregnancy.
- Overall, there is little commitment to policies related to restrictions on marketing of foods to children and healthy foods promotion (restrict the promotion and increase taxes of unhealthy foods, reduces taxes of healthy foods, etc.).

Goals related to the inclusion of targets or indicators are less common in:

- National policies on overweight, obesity, and diet-related NCDs and inclusion of goals, targets, or indicators.
- National policies on dietary habits (fat, salt, sugars, potassium, fruit, vegetables, etc. intake).
- Togo, Guinea, Gambia, Senegal, and Burkina Faso have committed to the most number of nutrition policies while Sierra Leone, Benin, Mali, and Cote d'Ivoire have committed to the fewest.

4.3. Nutrition programs in West Africa: Key results from GINA analysis

- Mali implemented almost all the WHO Essential Nutrition Actions, and Gambia & Nigeria are achieving half.
- At regional level, adolescents (score: 0.90) and children under-five (score: 0.82) are best covered by these nutritional interventions. The lowest program coverage was for pregnant women (score: 0.44).

- The two adolescent targeted interventions (iron micronutrient supplementation and deworming) were mostly delivered through school-based programs; therefore, coverage among adolescents not attending school may be lower.
- Every country is implementing food/condiment fortification, breastfeeding promotion, assessment/management of childhood wasting, child vitamin A supplementation, deworming for school children (adolescents), iron/folate supplementation for pregnant women, and nutritional support for women/children/infants with HIV and/or TB.
- The least implemented are vitamin A and calcium supplementation for pregnant women, zinc supplementation of child diarrhoea cases, and umbilical cord clamping.

The Countdown to 2030 nutrition initiative has been useful in several ways. First, this was an essential opportunity of networking amongst nutrition and health information professionals within and across the different ECOWAS countries. Participants had the chance to know each other, learn from others, and build future support networks. Secondly, this was an essential opportunity for capacity reinforcement and skill-building. Participants were introduced to data analysis using accessible and publicly available data sources; they learned how to prepare country nutrition profiles based on priority indicators and interpret results to propose recommendations and future action.

Gaps within capacities for data analysis and data interpretation still exist. This hinders the production of high quality and data-driven evidence for decision making at the country level. However, Countdown to 2030's workshops have helped increase analytical capacity and improve the data interpretation skills of key individuals within the nutrition community in West Africa. This foundation paves the way for evidence-driven decision making in the future.

The analyses have revealed that:

- The prevalence of child stunting is high in most ECOWAS Countries with wide disparities within countries
- Children from rural and poorest households are most affected by stunting. They should be differentially targeted to ensure that no child is left behind. In contrast, there is little or no inequality in child overweight by sex, residence, or wealth quintile in most countries.
- Little national progress has been made in reducing the levels of child malnutrition since 1986, particularly for child wasting and overweight which have been relatively low.
- The practice of minimum dietary diversity has declined in most ECOWAS Countries.
- There are vast inequalities within countries on IYCF practices. Prolonged breastfeeding is more widely practiced by rural residents and mothers from the poorest households. There is no clear pattern with exclusive breastfeeding. There is no advantage or disadvantage for mothers residing in the capital city of the largest city in ECOWAS countries in terms of exclusive breastfeeding coverage.
- Half of all adolescents aged 15-19 years and adult women aged 20-49 years in the ECOWAS region are anemic, with similar prevalence between the two age groups.
- The nutritional status of adolescent girls has been stable since 1990. However the prevalence of underweight in adult women aged 20-49 years has declined while obesity levels have increased in the group over the same period.



5.0

Conclusions and Recommendations

Based on the workshop results, some consensus on critical actions or recommendations for countries moving forward were drawn:

- Policy briefs were prepared for each country and regional institutions. This will be crucial to monitor nutrition policies in the region.
- Governments should develop guidelines for the screening and management of malnutrition in adolescent girls and adult women. Furthermore, countries need to make child, adolescent, and women's nutrition a top national priority, including strengthening nutrition service delivery within health systems and reducing rates of malnutrition. There is an urgent need to focus on investments, particularly in the poorest performing countries. Increased investment should not, however, mean shifting resources from better-performing countries. Instead, undernutrition and overnutrition should be addressed. This recommendation is in alignment with WAHO's multisector nutrition plan.
- The policies should target known disparities within the urban and rural population, educated and non-educated, male and female, etc. The policies should integrate strategies and health information to ensure appropriate monitoring of the process and effective evaluation of the results.
- Countries should increase efforts to collect and make available useful data. These include improvement and promotion of routine health data. The use of this information will provide more focused evidence and help improve analyses of the program's impact.
- WAHO and all ECOWAS countries should continue to organize in-depth analysis workshops on health topics with national health information officers and national specialists in the chosen topic. This will allow the production of scientific evidence that will lead directly to effective policies for the management of health problems. It will also encourage a culture of producing advanced evidence for decision-making.

Finally, the initiative was a significant opportunity to address important research questions and to develop policy briefs as an essential tool for policy makers.



**Research
question 1:**

Levels and trends in national and subnational indicators of nutrition coverage interventions and status among women, children, and adolescents in West Africa:

- Indicators of IYCF is generally low in West Africa: Only about a third of babies are exclusively breastfed, and 13% are fed a minimum acceptable diet
- Trends in exclusive breastfeeding are increasing but too slowly.
- Stunting levels remain high and declining only slowly and with persistent inequalities.
- The double burden of malnutrition with persisting underweight exists, while obesity is rapidly increasing among women in West Africa. The rising trend in obesity in the West African region is particularly rapid in Ghana and Togo, with few exceptions: Sierra Leone & Senegal.
- Levels of obesity by women's place of residence: considerable capital disadvantage are observed in all countries. The average regional capital level of obesity is 15%, the double of the regional mean prevalence of 7%.
- Half of all women 15-49 years are anemic in West Africa. During pregnancy, around 60% of women are anemic in the region.

**Research
question 2:**

Who are being left behind?

- Exclusive breastfeeding by a sub-national unit in West Africa: At the subnational level, there are consistently vast inequalities in exclusive breastfeeding across countries,
- U5 stunting in West Africa: Poorest and rural populations in each country consistently presented higher stunting prevalence. Also, vast sub-national inequalities are observed within countries

**Research
question 3:**

The current policy and data gaps associated with nutrition measurement

- Significant data gaps remain, especially for adolescents and adult women
- Only two countries have data for 2017 or 2018 in this category of the population all others for 2010 and 2011



5.1. Annexes

Annex 1 Policy briefs associated with the report

**SENEGAL**
DOCUMENT D'ORIENTATION STRATEGIQUE
Août 2020

Anémie chez les enfants au Sénégal: ne laisser personne en rade



critique défini par l'OMS qui est de 40%. En effet, les données disponibles montrent que 71% des 6-59 ans sont touchés par l'anémie, une situation qui ne s'est pas nettement améliorée si l'on sait qu'en 2010, 76% des enfants étaient anémiques. De plus, des inégalités persistent entre régions et classes sociales du pays.

Dans le cadre de l'Initiative Countdown 2030 pour la santé des femmes, des enfants et des adolescents (<http://countdown2030.org/>), une équipe du Sénégal a travaillé aux côtés d'autres pays d'Afrique de l'Ouest pour conduire des analyses approfondies sur les progrès et les inégalités relatives à l'anémie au Sénégal.

Ces analyses ont porté sur les données des Enquêtes Démographiques et de Santé (EDS) 2011, 2014, 2016 et 2017) et se sont focalisées sur l'anémie chez les moins de 5 ans. Les inégalités ont été analysées au regard de quatre dimensions principales : niveau régional ; niveau résidence (urbain/ rural) ; niveau de bien-être socio-économique et selon l'âge.

Le présent document est un résumé des résultats de ces analyses, destinés aux pouvoirs publics, partenaires au développement et acteurs communautaires, dans le but d'informer les stratégies et interventions qui s'avèrent nécessaires pour accompagner le pays vers l'atteinte des ODD notamment l'ODD 2 relatif à l'élimination de la faim dans le monde et l'amélioration du statut nutritionnel.

- 1. Le contexte et justification du problème**

À l'instar des autres pays du monde, le Sénégal s'est engagé à l'atteinte des Objectifs de Développement Durable (ODD) en particulier l'ODD 2 qui consiste à éliminer la faim, assurer la sécurité alimentaire, améliorer la nutrition et promouvoir l'agriculture durable d'ici 2030. Le pays s'est aussi engagé à l'atteinte des cibles intermédiaires de l'Assemblée mondiale de la santé d'ici 2025. C'est dans ce cadre que le pays a développé un Plan Stratégique Multisectoriel de la Nutrition (2018-2022) et s'est doté de son premier Document de Politique de Développement de la Nutrition (2015-2025) dont l'objectif est « d'assurer à tous un état nutritionnel satisfaisant particulièrement pour les enfants de moins de cinq ans ». Par ailleurs, les questions de nutrition figurent en bonne place dans le Plan Sénégal Emergent (PSE) qui constitue le référentiel de la politique économique et sociale sur le moyen et le long terme.

Malgré les interventions développées et les efforts fournis par le gouvernement du Sénégal et ses partenaires dans le domaine de la nutrition, la situation de l'anémie demeure problématique dans le pays et reste supérieure au seul
- 2. Principaux résultats au Sénégal**

2.1. Tendances et inégalités régionales

Au Sénégal, la prévalence de l'anémie qui est de 71% (EDS, 2017), dépasse le seul critère défini par l'OMS fixé à 40%. Entre 2014 et 2017, la prévalence de l'anémie chez les 6-59 ans n'a pas baissé sensiblement. La figure 1 montre l'évolution de la tendance au cours de la période. On observe ainsi une hausse de la prévalence de l'anémie dans la plupart des régions pendant que l'écart entre les régions s'est creusé légèrement passant de 21,1% à 24,4%. Dakar est restée la région la moins affectée par l'anémie où la tendance est passée de 60,6% en 2014 à 59,4% en 2017.

Sénégal - Document d'orientation stratégique

**BENIN**
DOCUMENT D'ORIENTATION STRATEGIQUE
Août 2020

Agir pour l'éradication du retard de croissance chez les enfants moins de 5 ans au Bénin



de nutrition de qualité pour atteindre l'Objectif de Développement Durable (ODD) 2 qui prime l'élimination de la faim. Des interventions basées sur une approche multisectorielle sont menées dans les structures de santé et dans la communauté pour améliorer la pratique alimentaire et nutritionnelle de la population en général et des cibles vulnérables en particulier. Malgré ces actions, l'évolution des indicateurs reste lente notamment la prévalence du retard de croissance. Des investissements et des mesures supplémentaires sont donc nécessaires pour atteindre la cible fixée par l'Assemblée mondiale de la Santé pour 2025.

Dans le cadre de l'Initiative Countdown 2030 pour la santé des femmes, des enfants et des adolescents (<http://countdown2030.org/>), une équipe du Bénin a travaillé aux côtés d'autres pays d'Afrique de l'Ouest pour conduire des analyses approfondies sur les progrès et les inégalités par rapport au retard de croissance. Ces analyses ont porté sur les données des Enquêtes Démographiques et de Santé (EDS), MICS du Bénin de 1996 à 2018, ainsi que des données récentes recueillies auprès des structures sanitaires. Le présent document est un résumé des résultats de ces analyses, destiné aux pouvoirs publics, partenaires au développement et acteurs communautaires, dans le but d'informer les stratégies et interventions nécessaires pour atteindre les objectifs fixés.

- 1. Le contexte et le problème**

Le retard de croissance est l'un des principaux obstacles au développement humain, touchant près de 162 millions d'enfants de moins de 5 ans dans le monde. Causé de séquelles neurologiques irréversibles dans l'enfance, le retard de croissance réduit la capacité physique et intellectuelle de l'homme pour sa contribution à la création de la richesse.

En 2012, l'Assemblée Mondiale de la Santé a redéfini ses priorités dans le plan d'application exhaustif concernant la nutrition chez la mère, le nourrisson et le jeune enfant (MNA45.4, 2012). Une série de mesures avaient été retenues pour améliorer l'état nutritionnel des cibles vulnérables à l'horizon 2025. L'une de ces mesures est de "réduire de 40% le nombre d'enfants de moins de 5 ans présentant un retard de croissance". Pour ce faire, les États et leurs partenaires devaient mettre en œuvre des stratégies et interventions basées sur les données et susceptibles d'accélérer les progrès actuels en vue d'une réduction significative du retard de croissance chez les enfants de moins de 5 ans.

Au Bénin, le Plan National de Développement Sanitaire 2018-2022 préconise le renforcement de l'offre de service
- 2. Principaux résultats**

2.1. Evolution au niveau national

De 2001 à 2018, la prévalence du retard de croissance chez les enfants de moins de 5 ans est restée au-dessus du seuil d'alerte de 30% fixé par l'OMS bien qu'elle soit passée de 36,2% à 32,1%.

De 2001 à 2018, la prévalence est passée de 36,2% à 32,1%

Benin - Document d'orientation stratégique

**NIGER**
DOCUMENT D'ORIENTATION STRATEGIQUE
Août 2020

S'attaquer au retard de croissance, c'est sauver la vie et l'avenir



Dans le cadre de l'Initiative Countdown 2030 pour la santé des femmes, des enfants et des adolescents (<http://countdown2030.org/>), une équipe du Niger a travaillé aux côtés d'autres pays d'Afrique de l'Ouest pour conduire des analyses approfondies sur les progrès et les inégalités par rapport au retard de croissance au Niger.

Ces analyses ont porté sur les données des Enquêtes Démographiques et de Santé du Niger (EDSN) de 1998, 2004 et 2012 ainsi que des données récentes recueillies lors des enquêtes nutritionnelles SMART de 2012 à 2016. Elles se sont concentrées principalement sur le retard de croissance parmi les enfants de moins de cinq ans.

Le présent document est un résumé des résultats de ces analyses, destinés aux pouvoirs publics, partenaires au développement et acteurs communautaires, dans le but d'informer les stratégies et interventions qui s'avèrent nécessaires pour accompagner le pays vers l'atteinte des ODD, particulièrement, ODD 2, et 10 relatifs à la suppression de la faim dans le monde et la réduction des inégalités.

- 1. Contexte**

À l'instar d'autres pays du monde, le Niger a souscrit à l'atteinte des Objectifs de Développement Durable (ODD), particulièrement l'ODD2 : éliminer la faim, assurer la sécurité alimentaire, améliorer la nutrition et promouvoir une agriculture durable à l'horizon 2030. Dans cette perspective, l'État nigérien et ses partenaires ont consenti d'importants efforts au cours des deux dernières décennies pour réduire la malnutrition et l'insécurité alimentaire dans le pays. En effet, le Niger a élaboré une Politique Nationale de Sécurité Nutritionnelle (PNSN) et mis en œuvre plusieurs plans d'actions au cours des années 2016-2020 dans le but de favoriser l'atteinte de l'ODD2.

En dépit des progrès observés, force est de constater que le retard de croissance demeure un problème majeur au Niger, particulièrement chez les enfants de moins de 5 ans. En effet, les données récentes montrent que près d'un enfant sur deux souffre de retard de croissance, encore loin de l'objectif national de réduire de 40% la malnutrition infantile à l'horizon 2030. De plus, des inégalités persistent entre régions et classes sociales du pays.
- 2. Principaux résultats**

2.1 Retard de croissance: Ampleur et défis



Graphique 1: Niveau de retard de croissance dans la sous-région

Niger - Document d'orientation stratégique

Annex 2 Participants in the workshop that led to the development of the report

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	Boro Gosso	Médecin de santé publique, chef de service coordination du SNIS Direction des statistiques sanitaires
	Traore Ben Idrissa	Ressource Person (Health Informatics Expert)
Cabo Verde	Monteiro Spencer Maia Irina	Coordenadora do programa nacional de nutrição
	Carvalho Mendez Moniz Graça Maria	Tecnica de estatistica
Cote D'ivoire	Kouame Oka René	Directeur Coordonnation Programme Nutrition Analyste nutritionniste
	Kone Daouda	Expert principal en analyse des données sanitaire ; Adjoint Technique de la statistique, Chef du service statistique
Gambia (THE)	Grante Sagnia Phebian Ina	Principal Health Researcher MOH
	Fofana Malang N.	Public Health
	Sanjally Trawalley	Ag. Director health Promotion
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	Moffat Alexander Kpakpo	Research Officer
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	Camara Facely	Chef Section Surveillance Nutritionnelle
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Country / Institution	Participant's Name	Fonction
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	Coulibaly Adama Balla	Chef de la Division Nutrition Direction Générale de la Santé et de l'Hygiène Publique / Sous-Direction Nutrition
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	Phillips Abimbola Samuel	Ressource Person
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