Towards Nutrition MDGs in Burkina Faso: Will Capacity to Act Follow the Commitment?
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Abstract: The past few years have witnessed an increasing interest in nutrition interventions, which have emerged as a key matter to achieve MDGs. While political commitment is widely spread, more needs to be done to improve operational capacity. This article, resulting from the Landscape Analysis Country Assessment, provides an overall picture of Burkina Faso’s nutrition situation and outlines the steps to be taken over the next few years to develop more effective nutrition programmes and improve nutritional status across the whole population. It addresses several topics from policy down to services delivery levels and community involvement.

Key words: Nutrition policy, Burkina Faso, nutritional status, operational capacity, political commitment

Country Nutritional Profile: Where are we?

With a per capita gross domestic product of 440 (2006), Burkina Faso is one of the poorest countries in the world. Despite considerable progress made on social and economic fronts, as indicated by improvements in indicators such as life expectancy, infant mortality rate (IMR), maternal mortality rate (MMR), under five mortality and literacy rates, the nutritional status of the population, especially children and women, has lagged behind.

According to DHS 2003 results, 35% of children below five years in the country are underweight, 38% suffer from stunting, and 19% suffer from wasting. Data on the nutritional status of adults as determined by Body Mass Index (BMI) shows that 21% of women suffered from different grades of chronic-energy deficiency (CED) with BMI<18.5. Nearly 18% of all infants born in Burkina Faso are of low birth weight (<2500 g), reflecting intrauterine growth retardation, usually caused by maternal malnutrition (DHS 2003).

Growth monitoring and promotion is an important activity to meet mothers and provide nutrition counselling and source of data on child growth but recent monitoring missions showed that various factors negatively affect it. These include non-availability of growth charts at health centre level, lack of skills in recording measurements and lack of appropriate equipment or weighing scales in poor working condition.

Anaemia is one of the most widespread problems. Nine out of ten children aged 6-59 months suffer from anaemia: 19% have moderate anaemia, whereas 60% and 13% respectively, have severe and very severe anaemia (DHS 2003). The prevalence of anaemia among women is also very high: five out of ten women suffer from anaemia and the proportion increases to 63% among pregnant women. Moreover, recent evaluations show that the current strategy of combating anaemia of pregnancy through distribution of iron and folic acid to pregnant women has made only a limited impact.

The last data on total goitre rate (TGR) date from 1996, when a survey covering 15 out of 30 provinces indicated an average goitre prevalence rate of 46% (Burkina Faso 1996). Nevertheless, the broad variation among different geographical areas in the country does not allow us to conclude upon a nationwide decline of TGR. The most affected populations for Iodine Deficiency Disorders (IDD) are children from 6 months to 10 years of age and women aged 26 to 39 years. A survey conducted in 2004 by the MOH Department of Nutrition showed that the median urinary iodine excretion (UIE) level in school-age children was 62.4µg/L, indicating that IDD was still a public health problem (Burkina Faso 2004). In Burkina Faso, there is neither local salt production nor a salt industry. All salt is imported primarily from Ghana (55%) and Senegal (42%) and in small quantities (3%) from other countries. Although 84% of households have access to iodized salt, only 48% possessed salt with adequate levels of iodine (DHS 2003). To control IDD, the national programme includes making iodized salt available to the population, undertaking regular quality control at market level, and raising public awareness.

Data on the national prevalence of vitamin A deficiency (VAD) are not available. The national vitamin A control programme covers children 6-59 months and includes the provision of a high dose (appropriate for age) supplement through health centres, as well as the provision of Vitamin A supplementation during measles and polio immunisations. The current coverage in children 6-59 months delivered through comprehensive vaccination days is estimated at around 98%. On the contrary, the maternal postpartum vitamin A supplementation programme reveals several limits due to the low proportion of babies who are delivered in a health facility, as well as lack of adequate in-service training. Appropriate breastfeeding and young infant and child feeding practices remain a major and most neglected issue. While the percentage of children breastfed is very high (98.4%), only 18.8% of infants <6 months are...
exclusively breastfed (DHS 2003). More than 75% of children receive a pre-lacteal feed, only 33% of women start breastfeeding within one hour of birth, more than 37% of women do not breastfeed during the first day of birth and less than 20% of youngest children age 6-23 months living with their mother are fed the minimum number of foods groups or more (DHS 2003). The last Multiple Indicator Cluster Survey (MICS 2006) reports a situation which is even more alarming with an exclusive breastfeeding rate of 7% among infants of 0-5 months (which increases to only 8% in children of 0-3 months) and less than 20% of children being breastfed within the first hour of birth. According to DHS 2003, only 38% of children between 6 and 9 months receive complementary food, whereas MICS 2006 indicates 49%. Moreover, the complementary foods given are often inadequate and unsafe. Legislation and guidelines on the use and marketing of breast milk substitutes have been revised since 2005 but they have not yet been adopted.

The Landscape Analysis: An opportunity to make the point and plan the future

The Burkina Faso Assessment was carried out jointly by a national team from the Nutrition Directorate (DN\textsuperscript{1} of the Ministry of Health) and an interagency team represented by the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the UN Standing Committee on Nutrition (SCN), and Helen Keller International (HKI). The assessment lasted five days. The first day was dedicated to official meetings with national level authorities and used to develop, revise, test and study the assessment tools (questionnaires and interview guidelines).

During the second and third days, the team split into four groups in order to cover different field locations. In addition to the central level in Ouagadougou, the assessment involved three health regions (North, East and Centre-West) (Figure 1), six health districts (Ouahigouya, Gourcy, Koudougou, Nanoro, Fada and Bogandé), three regional hospitals (CHR\textsuperscript{2}), nine primary health care centers (CSPS\textsuperscript{3}), four Public Referral Facilities for SAM (CREN\textsuperscript{4}) and two NGOs. In total, fifteen open interviews were conducted, involving key partners from WHO, UNICEF, the World Food Programme (WFP), World Bank, Institut de Recherche pour le développement (IRD), HKI and Groupe de Recherche et d'Echanges Technologiques (GRET)-Nutrifaso, together with seven Ministries: Agriculture, Hydraulics and Halieutic Resources\textsuperscript{5}, Social Services and National Solidarity\textsuperscript{6}, Secondary, Higher Education and Scientific Research\textsuperscript{7}, Promotion of Women\textsuperscript{8} and three different departments within Health\textsuperscript{9}.

Research findings were analyzed, discussed and agreed upon by all team members on the fourth day of assessment. Recommendations were finally presented on the fifth day during a stakeholder meeting which saw the participation of fifty-two people, including members of the multisectoral National Council for Nutrition Coordination (CNCN\textsuperscript{10}), representatives of donor agencies, NGOs, research institutes, universities and all interested Ministries.

Willingness and Capacity to Act: Are we ready for scaling-up?

Willingness to act

Research findings at all levels confirmed that the actual political commitment to fight malnutrition and scale up nutrition interventions is very strong. Proof of this willingness to act can be seen in several areas.

First of all, in order to give more importance to nutrition related issues, in 2002, the Ministry of Health turned the previous National Nutrition Centre (CNN\textsuperscript{11}) into the current Nutrition Directorate, which is under the auspices of the General Health Directorate (DGS\textsuperscript{12}). Second, the recent creation of the CNCN has provided a broadly represented coordination mechanism and a good forum for discussion, advocacy and policy agreement, involving most of the nutrition policy makers, actors and stakeholders in the country. Third, nutrition is recognized as a key subject and considered as a major concern within the existing Interagency Emergency Working Group.

The National Nutrition Policy (Burkina Faso 2007a) provides a policy framework and directions for all nutrition programmes. The National Protocol for Management of Acute and Severe Malnutrition (Burkina Faso 2007b), finalized in March 2007, guides and harmonizes health workers’ interventions to ensure appropriate care and

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treatment to malnourished people, especially children. Currently, the Protocol is being rolled-out through a cascade of training of trainers and it seems to be well received at district and facility levels. The Minimum Nutrition Package is recognized as a high impact intervention and has been included in all district action plans. Finally, nutrition is integrated in the National Poverty Reduction Strategic Plan and in the United Nations Development Assistance Framework, hereby confirming political awareness towards the importance of nutrition as a cross-cutting area and priority.

With respect to financial resources and budget allocation, several actors have increased their financial support to nutrition programmes. For instance, the Nutrition Directorate has increased its human capacity by employing additional staff members. The UNICEF Country Office has also reinforced its nutrition team with a threefold increase in its nutrition budget over the past three years. The World Bank has just approved a grant worth of 10,000,000 USD to finance community based nutrition interventions. Furthermore, non governmental organizations (NGOs) and civil society organizations - by applying to different budget lines from a variety of multilateral and bilateral funding agencies (WFP, European Community Humanitarian Aid (ECHO), Office of U.S. Foreign Disaster Assistance (OFDA), Japan International Cooperation Agency (JICA), etc.) - have mobilized resources committed to nutrition and invested them in the country.

At the district level, it was reported that support from the central level has been strengthened since 2007 in terms of improved communication, yearly monitoring, supervision visits, and organization of training of trainers for the management of severe acute malnutrition (SAM). Moreover, a range of coordination mechanisms are already in place at decentralized levels within the health sector and might be used to harmonize and strengthen nutrition interventions. These mechanisms include the Regional Technical Health Committee (CTRS\textsuperscript{1}), the District Leadership Team (ECD\textsuperscript{2}) and the Primary Health Facility Management Committee (COGES\textsuperscript{3}). Two out of thirteen health regions have also created specific Regional Nutrition Coordination Committees.

Finally, the country can benefit from several existing and potential nutrition partners, which might support and facilitate the scale-up of nutrition interventions.

1. Comité Technique Régional de Santé; 2. Equipe Cadre de District; 3. Comité de Gestion
Despite the considerable achievements, some major weaknesses still affect the current willingness to act. The CNCN, which has been greeted with enthusiasm by all nutrition partners, needs to be integrated with small thematic commissions (or working groups), able to address specific problems and suggest timely concrete solutions. Moreover, its anchorage in the health sector might challenge the multisectoral approach, which would then need to be safeguarded through the introduction of some special measures. These could include the organization of periodical meetings, the creation of coordination panel or special information flow among different ministries and/or directorates. Finally, the CNCN does not involve the regional level, whose commitment is crucial to enforce CNCN’s decisions and translate them into action.

Although the National Nutrition Policy and the National Protocol for Management of SAM are appreciated, they are not always available at district and facility levels. In addition, the Minimum Nutrition Package Booklet (Burkina Faso 2005b) and the Practical Guide for Appropriate IYCF (Burkina Faso 2005a) are often missing at these levels. There is no specific support in operational planning, and nutrition is not always adequately incorporated into the regional and district action plans. Even if the Minimum Nutrition Package is part of the recommended high impact interventions (HII), the budget allocated to it is usually underestimated and far below the proportion allocated to other interventions, with the IYCF aspect frequently ignored.

Financial resources directed at tackling the nutrition problem were perceived to be insufficient by all people interviewed. Moreover, the allocation of national funds to nutrition programmes does not reflect the political commitment. Financial resources at regional and district levels are also perceived to be insufficient, with little allocation of regular funds from the national level to sub-national action plans.

Finally, support from partners at the decentralized level is unevenly distributed and insufficient compared to actual needs.

Capacity to act

Nutrition services delivery has made significant progress over the last few years in terms of human resources, infrastructures, equipment, partners, coordination, monitoring and supervision. Nevertheless, a rapid scale-up is still elusive, with poor human resources and a lack of coordination at the community level being identified as the major cause preventing better performances.

Human resources capacity at the national level is definitely on the increase, with twenty-one nutritionists currently working for the public system. The majority of health facilities meet staffing requirements and measures have also been taken to counter staff turnover, which remains a major obstacle to an effective capacity building. There is a good basis for strengthening nutrition, including good interpersonal communication skills, acknowledgement that nutrition is important, recognition that responses must be community-based, motivation to solve nutrition problems and to increase nutrition know-how. However, the general perception is that human resources are insufficient, especially at the sub-national level, where there is a shortage of staff with formal training in nutrition and very few health workers able to strengthen capacity at the community level.

Services for management of moderate and severe acute malnutrition do not cover the whole country and are often characterized by sub-optimal quality standards. Referral facilities for SAM (CREN) are not functional in all districts yet. Counter-reference performances are usually inadequate. Moreover, the fact that caregivers can not be accommodated enhances the defaulter rate and affects the overall attendance. Prevention of Mother-to-Child Transmission (PMTCT) programmes do not adequately integrate nutrition issues and even if Integrated Management of Childhood Illness (IMCI) and community IMCI (c-IMCI) include nutrition, their coverage is insufficient.

Lack of anthropometric minimum equipment (measuring boards and scales) and Behaviour Change Communication (BCC) material is recurrent at all sub-national levels. Health booklets and growth charts exist but they are not available everywhere. Appropriate stocks of essential drugs and therapeutic food depend to a large extent on the presence of partners in the area. There are many reasons for this, including inadequate stock management and inadequate forecasts which are largely based on official DHS data instead of reflecting the real situation.

Some pilot projects have been started in order to raise public awareness and contribute to nutrition behavioural change by disseminating nutrition messages throughout local radio and other media. Unfortunately, this is not intensive and not all communities can be reached by radio. Furthermore, messages...
still need to be adapted to the different environments. In general terms, nutrition promotion activities are weak, particularly those promoting IYCF. There is a lack of BCC material and poor harmonization of messages among partners. A National Nutrition Communication Plan is being developed by the Nutrition Directorate and should help to improve the situation.

With respect to nutrition data, national level policy makers use a variety of sources such as DHS, Annual Health Statistics, MICS, etc. Even so, data management - especially day to day data collection at the facility level - needs to be greatly improved. The National Health Information System (SNIS1) does not include several nutrition-relevant indicators, such as weight/height, and lacks important data on coverage and delivery of services and consumable supplies. Second, the quality of the information collected varies and data are not always collected on a representative basis. Third, many facilities lack nutrition registers, revised cards, and adequate training on data management. Fourth, data transfer suffers from frequent delays and monitoring reports are often incomplete despite the considerable amount of time spent on preparing them.

At the community level, existing resources are not well valorised and utilized. Supervisions and support received from health centres are very poor and the lack of any kind of compensation for community health workers penalizes sustainability, motivation and commitment.

Making It Happen: Nationally, regionally and locally

To move forward and scale up nutrition interventions in Burkina Faso, the Landscape Analysis Country Assessment showed that some of the major political commitments that exist have not been translated into action and several operational weaknesses still need to be addressed. Box 1 presents a set of concrete recommendations agreed by nutrition stakeholders at the consensus meeting on Friday 16 May.

At the national level, the CNCN has to be reinforced by the establishment of thematic groups designed to work on specific subjects and to suggest concrete solutions to a number of issues related to policy, planning, accountability and management. Moreover, to engage the regional level and make sure that CNCN's decisions will be implemented on the field, information flow from central to decentralized institutions has to be rapidly reinforced.

The Strategic Nutrition Plan, which is being finalized by the Nutrition Directorate, needs to be integrated with an action plan, a detailed budget, resource mapping and a clear definition of responsibilities for both implementation outputs and achievement of results. This would encourage policy makers to set priorities and link them to existing financial resources and future mobilization of funds.

The most significant constraint to a rapid scale up is indeed inadequacy of regular funds. The financing gap therefore needs to be filled through additional resources, a substantial portion of which may have to come from development partners. Nevertheless, to simply increase the availability of external funds is not enough. Improving predictability of aid flows and enhancing donor coordination (in terms of planning, practices, procedures, accountability, reporting and monitoring) are a prerequisite to ensuring more effectiveness. Furthermore, the central level has to enforce its political commitment by increasing the government budget allocation to nutrition. This would contribute to reduce dependence on external donors and decrease the concern for future sustainability if their priorities change. Tracking resource flows to nutrition through the national health accounts is also needed in order to hold governments accountable and to give cost-effectiveness evidence to results. Finally, the availability of new funds through new funding channels (such as the World Bank grant) is likely to compound the problem of low absorptive capacities. This must be seen as an opportunity to analyze existing country capacity limitations and to work on them.

To engage national leaders in policy dialogue about public health nutrition, PROFILES has been identified as a valuable advocacy tool, which can also be used to facilitate the design of new programmes and as a working model in training situations.

Partnerships are a fundamental feature of the effort to mobilize public, private and civil society actors. Complementary strengths among partners have been identified as a key feature of success. Nevertheless, to ensure that partners work well and address country priorities, and to avoid competition between government and NGOs for new resources, it is necessary to put into place strong coordination mechanisms and control

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Box 1: Suggestions and recommendations arising from the assessment and agreed at the consensus meeting on 16 May

**National level**

**Coordination**
- Increasingly involve partners in development of documents
- Establish thematic working groups under the CNCN, starting with working groups on nutrition data, training, communication plan, strategic plan
- Establish decentralized CNCN structures at regional level

**Resource mobilization**
- Develop an Action Plan for coming years, with budget and document successful experiences
- Advocate for increased nutrition budget using PROFILES (an evidence-based nutrition advocacy tool already developed for Burkina Faso and widely used in Africa).
- Solicit more technical support from partners

**Strengthening human resources capacity in nutrition**
- Develop a training plan that covers:
  - In-service training of nutritionists
  - Strengthening of nutrition competencies among health workers, in other sectors, and among community leaders
  - Training on the continuum of care from prevention of malnutrition to management of acute malnutrition
- Consider training of health workers
- Promote nutrition among school aged children

**Sub-national level**

**Commitment to act:**
- Establish or strengthen coordination mechanisms at regional level to enhance involvement of partners and better coordinate activities
- Give more importance to nutrition in Regional and District Action Plans, including more and increasing allocated budget
- Ensure, without delay, that all relevant policy and protocol documents are available at sub-national levels
- Strengthen technical and financial support from partners to districts and regions in all country

**Capacity to act - Human resources**
- Accelerate recruitment of nutritionists at national and regional levels in order to have one nutritionist in each region
- Identify training needs for health workers (themes and numbers)
- Ensure in-service training at decentralized levels;
- Take into account staff mobility
- Increase frequency of trainings
- Enhance knowledge transfer by health workers who have received training
- Strengthen nutrition expertise in CRENs
- Include nutrition in curricula of initial training in health, agriculture, social services, education

**Capacity to act - Nutrition promotion**
- Implement at scale a National Nutrition Communication Plan that is being finalized
- Strengthen communication competencies among health workers
- Ensure IEC material is available throughout the health system
- Mobilize partners to support scaling-up the package of essential nutrition actions
- Develop community-based nutrition throughout the country

**Capacity to act - Management and information systems**
- Strengthen health infrastructure, including space for nutrition education, storage room
- As soon as possible, make CREN, the referral structure, operational in all regions
- Strengthen health structures in terms of financial and logistic resources for supervision at all levels
- Ensure adequate provision and storage of all supplies in health facilities and in the community
- Establish a motivation system for nutrition activities
- Review the list of nutrition indicators used by the Directorate of Studies and Planning in the SNIS
- Harmonize tools used by partners according to the national protocol
- Reproduce and disseminate as appropriate tools for data collection

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systems. CNCN is a good starting point but it is not enough. Systematic mapping of partners is needed in terms of their benefit, problems, governance and management characteristics. It is also necessary to learn and share lessons on best practices and on other West African countries’ experiences.
Also, national solutions to the production of complementary food should be encouraged by supporting operational research and pilot projects.

Each health region has to benefit from the employment of a nutritionist, who must be responsible for all nutrition activities as well as supervision of nutrition at the district level and integration of nutrition with social services and education institutions. Moreover, a regional coordination mechanism among partners needs to be established in order to ensure harmonization of interventions, information sharing and the representation of all stakeholders. In regional and district action plans nutrition needs to be strengthened especially with respect to HII and the promotion of appropriate IYCF practices.

At all services delivery levels, from health regions down to primary health units, human resources have been recognized as the bottleneck that impedes better performances. Problems associated with recruitment, training, updating, motivation, mobility, per diems, absenteeism, workload and migration of staff out of the public sector urgently need to be addressed. To start with, recommendations were formulated to develop a training plan which should cover both training of nutritionists and strengthening of nutrition competencies among all health workers. Training on the job and more frequent supervisions also emerged as two key strategies to build and reinforce capacity in the field.

Together with human resources, the nutrition information system remains one of the biggest operational limits and needs to be addressed by formulating new nutrition monitoring indicators and reinforcing nutrition surveillance during child monitoring activities and ANC services.

At the local level, the involvement of the community in all nutrition initiatives has been recognized as essential for success. Community based approaches have to be developed and implemented across the country. In addition, a study of motivation and possible incentives for community-based health workers (CBHWs) is strongly recommended together with a CBHWs census. Also, multisectoriality and a local ownership approach can only be achieved by matching nutrition initiatives promoted by the health sector with Local Development Plans (PDL), which represent the planning platform for development at the bottom level.

To make it happen, the new roadmap has to concentrate on four elements: prevention, multisectoriality, national leadership and community involvement. Although big pressure exists on the scaling up of nutrition programmes and progress on nutrition MDGs, all actors involved should be committed not just to do in order to show rapid results, but to do well and thereby build long lasting capacities at the national, regional and local levels.

Follow-up and next steps

The consensus meeting was held on 16 May 2008 to review and discuss the outcomes of the Landscape Analysis country assessment. Fifty-two stakeholders participated and agreed on several recommendations, which will be integrated into the National Nutrition Strategic Plan and into the Global Nutrition Communication Plan, both expected to be finalized in 2009.

As suggested by the Landscape Analysis, on 1 October 2008, the CNCN created the following four thematic groups to work on specific issues and provide technical solutions:

1. **Nutrition and Community Participation Group** to define and implement an effective strategy aimed at strengthening community involvement through local, national and international NGOs;
2. **Nutrition and Food Security Group** to work on strategies to prevent and manage food insecurity as well as to integrate the National Nutrition Policy with the National Food Security Plan;
3. **Nutrition and School Health Group** to follow up on nutrition activities at schools and to develop and improve teachers’ skills and curricula on nutrition;
4. **Nutrition and Public Health Groups** to define procedures, rules and protocols as well as to build national capacities on nutrition and to develop a national strategy for nutrition promotion.

Moreover, as part of the follow-up to the Landscape Analysis, measures are being taken to strengthen nutrition at decentralized regional level. In support of these efforts, during the course of 2009 UNICEF will provide all thirteen Health Regions with a vehicle to be used to undertake specific nutrition supervision visits to health districts and health posts and to support health staff with appropriate training on the job and assistance on
nutrition related issues. In addition, in order to strengthen nutrition action at regional level, five regions (North-Center, North, East, Sahel and South-West) have created their own Regional Nutrition Council and four regions (Sahel, Cascades, East-Center and South-West) have designed a Regional Nutrition Action Plan.

In order to alleviate the impact of rising food and fuel prices, UNICEF and other development partners provided additional funds that are being spent in implementing some of the recommendations make through the Landscape Analysis. These include the signing of eight project agreements in 2009 between UNICEF and humanitarian NGOs intervening on community nutrition in order to support the national scaling up of the essential nutrition actions package as well as to encourage new community-based approaches around the country.

Finally, the Nutrition Directorate in collaboration with financial and technical partners is working to develop a nutrition surveillance system which will include both annual SMART surveys and day-to-day nutrition data collected by health facilities. This was also one of the areas recommended to be strengthened.

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VACANCY ANNOUNCEMENT:

International Atomic Energy Agency (IAEA) Nutrition Scientist (P-3)

**Main purpose:** As a team member reporting to the Section Head, the Nutrition Scientist formulates and implements nutrition projects to combat malnutrition in all its forms in IAEA Member States.

**Role:** The Nutrition Scientist is a *specialist*, in particular in the use of nuclear techniques in nutrition within the Section, and a *contributor* to the IAEA's activities in human nutrition.

**Functions:** Assist in the conceptualization, design and implementation of CRPs. Provide technical assistance to nutrition projects supported by the IAEA technical cooperation programme. Develop guidelines and distance learning modules on nuclear techniques in nutrition. Organize technical meetings and consultants meetings to review current knowledge in nutrition. Prepare reports, proceedings and scientific publications.

**Knowledge, Skills and Abilities:** Excellent knowledge of nutrition, in particular at the international level; Good knowledge of relevant analytical techniques; Sound knowledge of biochemistry and physiology; Understanding of the specific needs and conditions of developing countries as regards nutrition.

**Application Deadline:** 30 June 2009