NATIONAL NUTRITION STRATEGY AND ACTION PLAN (2021-2025)

NUTRITION PROGRAM
DEPARTMENT OF PUBLIC HEALTH
MINISTRY OF HEALTH
ROYAL GOVERNMENT OF BHUTAN

LEAD WRITERS / EDITORS

Laigden Dzed, Deputy Chief Program Officer, Nutrition Program, Ministry of Health
Hari Prasad Pokhrel, Senior Program Officer, Nutrition Program, Ministry of Health

PUBLISHED BY

Nutrition Program
Department of Public Health
Ministry of Health
Thimphu Bhutan

SUGGESTED CITATION

National Nutrition Strategy and Action Plan 2021-2025, Nutrition Program, Ministry of Health, Bhutan:2021.

NATIONAL NUTRITION STRATEGY AND ACTION PLAN (2021-2025)

NUTRITION PROGRAM
DEPARTMENT OF PUBLIC HEALTH
MINISTRY OF HEALTH
ROYAL GOVERNMENT OF BHUTAN

"As a country, we must continue to focus on the pursuit of higher standards. Whatever we do, we have to strive for excellence. As I always say, good is not good enough."

- His Majesty's address at the 11th Royal University of Bhutan Convocation, 8th June 2016.

FOREWORD

Food and nutrition security worldwide is recognized as a human right and a critical ingredient for economic, social and human development. The causes of recent food crises and the proposed responses show the complexity of the global food system and highlight the growing importance of factors that go beyond agriculture and the household level. Yet, interventions to address food insecurity have often focused on agriculture-based approaches and have been geared towards improving the households' access to food. As a result, progress reports show that the developing world is particularly off-track in achieving the goals closely linked to food and nutrition security (FNS).

In line with the *'Food Security and Nutrition Policy'* (2014), and to achieve the goals of 12 FYP and other global commitments, the Ministry of Health has developed and adopted the *National Nutrition Strategy and Action Plan (2021-2025).* It aims to identify the various challenges of malnutrition and positions a strategic plan of action to tackle these at an appropriate time when the world is gearing towards achieving Sustainable Development Goals on food security and improving nutrition.

Bhutan has witnessed improvement in the child growth indicators but high rates of undernutrition, particularly stunting and micronutrient deficiencies among vulnerable populations still persists which is of grave concern for us. The need to address the immediate and underlying causes of under nutrition especially among children, adolescent girls and women remains a top priority for the overall improvement of the social and economic conditions of our people.

The multidimensional aspects of malnutrition have been viewed carefully during the development of this document in recognition of the direct and indirect roles played by other sectors and agencies. If food and nutrition security of the country is to be improved, a cross-sectoral approach has to be adopted. Improving food and nutrition security of the country is not only central for achievement of the Sustainable Development Goals but also for the development of the country.

With this strategy, we take a crucial step towards ensuring food and nutrition security for our people, so that they would be able to contribute to the social and economic development of the country.

Dr Pandup Tshering
SECRETARY, MoH

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AES	Annual Education Statistics
AFHS	Adolescent Friendly Health Services
AHP	Adolescent Health Program
ANC	Antenatal Care
APD	Agriculture Production Division
BAFRA	Bhutan Agriculture and Food Regulatory Authority
BHU	Basic Health Unit
BMIS	Bhutan Multiple Indicator Survey
C4CD	Care for Child Development
CF	Complementary Feeding
CHP	Child Health Program
CMO	Chief Medical Officer
CPO	Chief Program Officer
CVD	Cardiovascular disease
DAMC	Department of Agricultural Marketing & Co-operatives
DDM	Department of Disaster Management
DHO	District Health Officer
DHS	District Health Services
DMS	Department of Medical Services
DoA	Department of Agriculture
DoL	Department of Livestock
DoPH	Department of Public Health
DoT	Department of Trade
EmONC	Emergency Obstetric and Newborn Care
EMSD	Emergency Medical Services Division
FCBL	Food Corporation of Bhutan Limited
FCS	Food Consumption Score
FNPH	Faculty of Nursing and Public Health
FNS	Food and Nutrition Security
FYP	Five Year Plan
GNHC	Gross National Happiness Commission
HAZ	Height for Age z-Score
HPD	Health Promotion Division
ICT	Information and Communication Technology
IDD	Iodine Deficiency Disorder
IMNCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
KPI	Key Performance Indicator
LG	Local Government
LSRD	Lifestyle Related Disease

MAM	Moderate Acute Malnutrition
MBFHI	Mother and Baby Friendly Health Facility Initiative
MCH	Maternal and Child Health
MNT	Medical Nutrition Therapy
MoAF	Ministry of Agriculture and Forest
MoEA	Ministry of Economic Affairs
MoE	Ministry of Education
MoH	Ministry of Health
MoHCA	Ministry of Home and Cultural Affair
MoWHS	Ministry of Works and Human Settlement
NCD	Non-Communicable Disease
NCDD	Non-Communicable Disease Division
NGO	Non-Governmental Organization
NKRA	National Key Result Area
NNSAP	National Nutrition Strategy and Action Plan
NNS	National Nutrition Survey
NNTF	National Nutrition Task Force
NP	Nutrition Program
NRU	Nutrition Rehabilitation Unit
PAR	Poverty Analysis Report
PEN	Package of Essential Non-Communicable Disease
PNC	Postnatal Care
PN	Peripheral Neuropathy
RCDC	Royal Centre for Disease Control
RGoB	Royal Government of Bhutan
RH	Reproductive Health
RMNHP	Reproductive, Maternal and Newborn Health Programme
SABER	System Approach for Better Education Results
SAM	Severe Acute Malnutrition
SAP	School Agriculture Program
SBCC	Social Behavior Change Communication
SHND	School Health and Nutrition Division
UNICEF	United Nations Children's Fund
VAD	Vitamin A Deficiency
VAR	Variety Release Committee
WASH	Water Sanitation and Hygiene
WB	World Bank
WFP	World Food Program
WHO	World Health Organization
WSFS	World Submit on Food Security

EXECUTIVE SUMMARY

Overview

The results from the National Nutrition Survey 2015 show that the child stunting prevalence still stands at 21.2%. Although stunting has dropped from 33.5% in 2010, regional disparities remain persistently elevated with 29.1% prevalence rate in the eastern region followed by 18.5% and 16.2% in the central and western regions respectively.

Investing in nutrition is also recognized as crucial for the fulfillment of the fundamental rights- especially of the most vulnerable children, girls and women. The National Nutrition Strategy and Action Plan (NNSAP) aims to translate the national policies into a clear guiding document that will facilitate the operational planning, implementation, monitoring and resource mobilization to address the many underlying and direct causes of malnutrition in Bhutan.

The development process of the NNSAP was driven by the Nutrition Program of the Ministry of Health, and was widely consultative, involving all key nutrition stakeholders through the multisectoral process that was open, inclusive and built on existing and emerging alliances, institutions and initiatives. The process of the development ensured that the plan is evidence-informed and recognized successes while also taking care to create a result- based appraoch which provides a common results and accountability framework for monitoring and evaluation.

Objectives

The main objective of the NNSAP is to improve nutritional security, especially for those at higher risk of malnutrition such as children, women, adolescents, the elderly and people with special needs in collaboration with multiple sectors to achieve the national and global targets for malnutrition across all age groups by 2025.

Implementation

For the implementation of NNSAP, Nutrition Program, MoH will lead the coordination between all relevant sectors. The NNSAP is to be incorporated in the plans of all the relevant stakeholders - Annual Work Plans (AWPs) and Annual Performance Agreement (APA) or equivalent. Nutrition Program, Department of Public Health (DoPH) will be responsible for coordination and management of NNSAP at the national level. The program will also

advocate and encourage the districts and other relevant stakeholders to plan and take up planning and implementation of the NNSAP through the multisectoral National Nutrition Task Force (NNTF) committee.

Strategic Result Areas

The nutrition agenda for next five years is shaped along the following strategies across life cycle and their subsequent implementation of interventions in the priorities by all relevant stakeholders.

1 To improve the nutritional status of infants and young children (preschool age) with special focus on 1000 golden days

- Promote, protect and support breastfeeding for children: early initiation of breastfeeding, exclusive breastfeeding for the first six months of baby's life and continued breastfeeding for at least two years
- Promote optimal complementary feeding with a special focus to improve the dietary diversity from locally available foods
- Provide appropriate micronutrient supplements to children under five years
- Strengthen growth monitoring and promotion for children under five years of age
- Strengthen the screening and management of acute malnutrition, low birth weight infants and improve referral mechanism and linkage between the health facilities
- Strengthen the screening and management of child development including prevention and early management of childhood illnesses
- Improve advocacy and encourage community engagement to achieve optimal child nutritional status

2 To improve the nutritional status of school aged-children including monastic institutions through improved knowledge, skills and practices

- Optimize school meals using Plus School Menu, incorporation of food fortification and strengthen linkages to local farmers, to ensure nutritional requirements of school-aged children are met

- Develop and implement a comprehensive Social Behavior Communication Change (SBCC) Strategy to improve dietary and health practices for school aged children and their parents/communities
- Improving school kitchen and store infrastructure and facilities in place for schools to be able to provide nutritious and safe school meals
- Strengthening online, digital, monitoring and reporting systems for school health and nutrition program to enable better programming and decision-making
- Capacity building of relevant staff on an integrated approach of managing school feeding and nutrition program including food preparation, storage, food safety and WASH
- Provide recommended micronutrient supplements to school aged children
- Strengthening the healthy food environments in schools and monastic institutions to manage and control the marketing of unhealthy foods and beverages
- Implement the required physical activity recommendations including sports as part of school curriculum

3 To improve the nutritional status of adolescents, youth, women of reproductive age, pregnant and lactating mothers

- Improving and strengthening the coverage of recommended 8 ANC visits, 4 PNC, and early booking for the pregnant women and provision of nutrition services at each visit in line with the WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience
- Improving the counselling services on nutritious and safe diets, physical activity, rest and weight gain
- Promoting, strengthening and supporting the supply and consumption of multiple micronutrients including Iron Folic Acid tablets, Vitamins and calcium lactate for pregnant women
- Strengthening the management and screening of anemia for adolescent girls, and women in the reproductive age group

- Strengthening and expanding the implementation of package of preconception nutritional care
- Strengthening and expanding Adolescent Friendly Health Services to deliver nutrition services
- Improving advocacy to promote healthy dietary practices among adolescents
- Reducing micro-nutrient deficiency status among the adolescents

4 To improve the nutritional status of the general population by promotion of healthy diets and physical activity to prevent overweight, obesity and non-communicable diseases

- Implementing a comprehensive strategy and guideline for prevention, management and control of diet related NCDs
- Improve capacity of service providers on prevention, management and control of diet related NCDs through capacity building as well as ensuring a steady supply chain of necessary equipment
- Creating awareness for both the general public as well as policy makers on the importance of prevention, management and control of diet related NCDs
- Involving community leaders in the prevention and control of NCDs
- Ensuring consumer rights to access good quality and appropriate foods in line with the provisions of the consumer protection act
- Ensuring trade and marketing policies are geared towards providing healthy and nutritious foods
- Ensuring consumers' right to information through labelling of foods

5 To strengthen food and nutrition security, water sanitation and hygiene as nutrition sensitive interventions

- Improve the availability of – physical and economic access to – and the consumption of diversified food commodities (cereals, legumes) and fruits and vegetables through enhanced production

- Improve the availability of – physical and economic access to – and the consumption of diversified animal proteins
- Promote food diversification and fortification
- Ensuring food safety at all levels
- Increase access to safe drinking water
- Increase access to safe and sustainable improved sanitation services
- Improve hygiene behavior practices and their management

6 To improve and scale-up services and practices related to clinical nutrition and dietetics

- Improve the hospital food service system
- Standardize the implementation of Medical Nutrition Therapy (MNT) including enteral and parenteral nutrition
- Advocating and familiarizing health staff on clinical nutrition
- Participation in the community nutrition initiatives.
- Promoting continued professional development and improving coordination among nutrition professionals

7 Strengthening governance and multi-sectoral partnerships in support of nutrition interventions and have resilient systems for nutrition in emergency preparedness

- Establishing a platform for multi-sectoral coordination for implementing and strategizing nutrition interventions across all sectors and levels
- Identifying and empowering all relevant sectors to buy-in the nutrition agenda
- Conducting regular planning and review meetings to align the annual nutrition planning process in alignment with nutrition action plan
- Advocacy for partnerships and resource mobilization
- Strengthen preparedness for nutrition in emergency situations

8 To improve monitoring and evaluation of nutrition security situations and related interventions

- Strengthen feedback mechanisms on nutrition information among nutrition stakeholders
- Strengthen and mainstream nutrition information system with DHIS 2 platform
- Conduct periodic nutrition surveys and need-based assessment/ research to inform policy, program design and implementation

CHAPTER 1: INTRODUCTION

BACKGROUND

The National Nutrition Strategy and Action Plan (NNSAP), 2021-2025, is underpinned from the policy directives reflected in the *National Food and Nutrition Security Policy of the Kingdom of Bhutan (FNS) 2014, The National Health Policy 2011* and the *12th Five Year Plans (2019-2023).* These National Policies and Strategies, in one form or the other, have components that place importance on the improvement of the nutrition status of Bhutanese population, through multisectoral action, while also recognizing investments for nutrition as a critical development imperative.

The NNSAP is meant to translate the national policies into a clear guiding document that will facilitate the operational planning, implementation, monitoring and resource mobilization to address the many underlying and direct causes of malnutrition in Bhutan

Investing in nutrition is also recognized as crucial for the fulfillment of the fundamental rights- especially of the most vulnerable children, girls and women. It constitutes the foundation for human development, by reducing susceptibility to infections, related morbidity, disability and mortality burden, enhancing cognitive ability, cumulative lifelong learning capacities and adult productivity. Nutrition is acknowledged as one of the most effective entry points for human development, poverty reduction and economic development, with high economic returns.

The NNSAP is meant to translate the national policies into a clear guiding document that will facilitate the operational planning, implementation, monitoring and resource mobilization to address the many underlying and direct causes of malnutrition in Bhutan, taking into account the goals set for the *12th Five Year Plans (2019-2023),* and commitment to the Global Nutrition Targets endorsed by the sixty fifth World Health Assembly resolution WHA65.6, as well as Bhutan's continued commitment to the Sustainable Development Goals (SDGs).

CROSS-SECTORAL COLLABORATION

The NNSAP acknowledges that improving the nutrition status of the Bhutanese population requires cross-sectoral initiatives, taking into account the many faceted dimensions of the issue prevalent in the country.

The key sectors contributing to ensure good nutritional status in Bhutan are identified as Ministry of Health (MoH), Ministry of Agriculture and Forest (MoAF), Ministry of Education (MoE), and various supporting sectors such as Ministry of Economic Affairs (MoEA), *Dratshang Lhentshog*, other monastic institutions, academic institutions, Ministry of Works and Human Settlement (MoWHS), Non-Governmental Organizations (NGOs), Civil Society Organizations (CSO), community groups, Youth and Adolescents Development agency and Local Governments (LGs).

The MoH has responsibility to identify the nutritional problems in each group, throughout the life cycle, and to help identify the respective roles of various sectors in achieving nutrition and food security and safety.

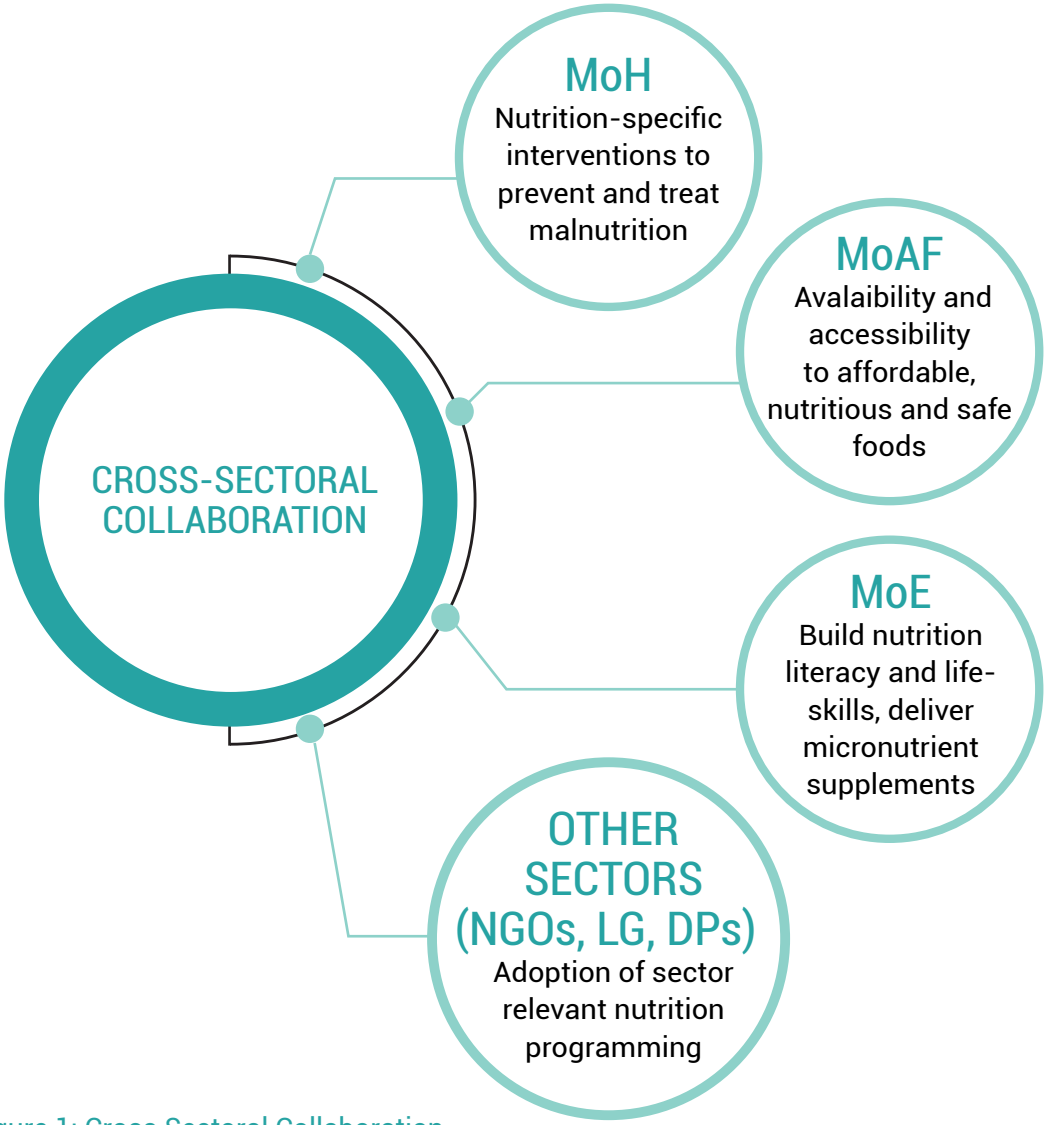


Figure 1: Cross Sectoral Collaboration

The MoAF has responsibility to ensure food security in the country, in particular with regard to three pillars of food security: food availability, accessibility and stability (WSFS 2009). The Bhutan Agriculture and Food Regulatory Authority (BAFRA) has an important role in ensuring food safety & quality standards for the population of Bhutan.

The MoE has a special role and responsibility of collaborating with the MoH and MoAF to translate the findings of the nutrition and food security situational analysis into recommendations for improved knowledge, skills, better learning outcome and practices of school children and pre-school children, thus playing a key role in ensuring good health and nutrition in the young, as well as for the future generations.

The role of social sectors—primarily health, education and agriculture—is critical for the prevention and treatment of nutritional deficiencies. The MoH has a special responsibility with regard to food utilization, since nutrition security is achieved for a household when secure access to food is coupled with a sanitary environment, adequate health services, and adequate care to ensure a healthy life for all household members.

The role of the MoEA is to improve the distribution system and the accessibility of food in the country. It plays a major role in the distribution of healthy food, making them accessible and affordable for everyone, especially foods produced in Bhutan.

> Improving the nutrition status of the Bhutanese population requires cross-sectoral initiatives, taking into account the many faceted dimensions of the issue prevalent in the country

The Department of Trade (DoT) of MoEA can contribute to achieve this through price controls, reduce and monitor the import of foods high in salt, fat, sugar, and of soft drinks, presence of harmful foods, or harmful substances in food, at the wholesale and retail level.

NGOs, monastic bodies, CSOs and others can all contribute to health promotion, communication and community mobilization for quality nutrition behavioral practices. Local governments and communities have an equally important role.

CHAPTER 2: ANALYSIS OF THE CURRENT SITUATION

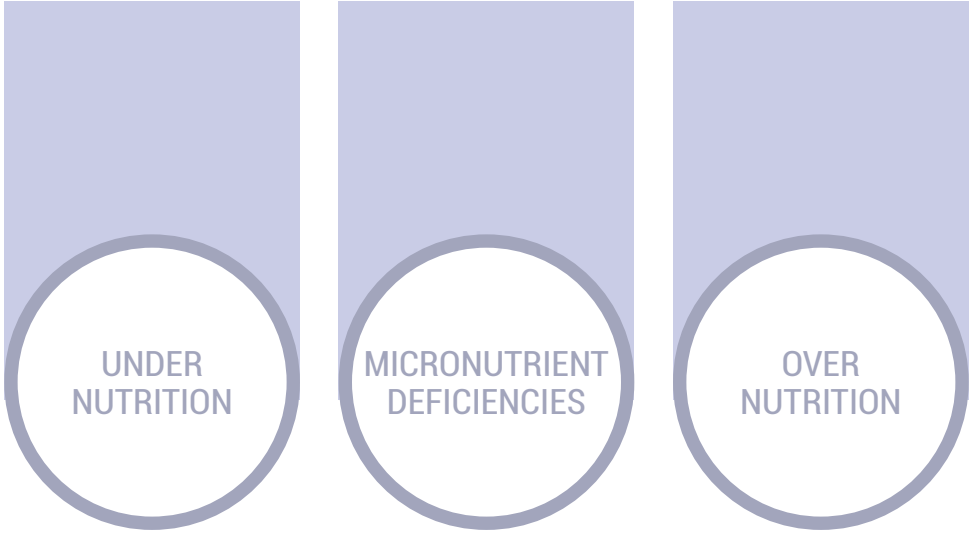


Figure 2: Triple Burden of Malnutrition

TRIPLE BURDEN OF MALNUTRITION

Triple burden of malnutrition refers to the coexistence of over nutrition, undernutrition and micronutrient deficiencies. Over nutrition, undernutrition, and micronutrient deficiencies equally increase the risk of various health problems. Child undernutrition increases the risk of childhood mortality and poor cognitive development, and overnutrition is associated with increased risk of various non-communicable diseases such as high blood glucose levels, raised blood pressure, abdominal obesity and high lipid profiles. Overweight/obesity during pregnancy is linked with several adverse maternal and fetal consequences during pregnancy, delivery and the postpartum period.

CHILD UNDERNUTRITION

The results from the National Nutrition Survey 2015 show that the child stunting prevalence still stands at 21.2%. Although stunting has dropped from 33.5% in 2010, regional disparities remain persistently elevated with 29.1% prevalence rate in the eastern region followed by 18.5% and 16.2% in the central and western region respectively[1].

The prevalence of acute malnutrition (wasting) stands at 4.3% at the national level with the highest rates of acute malnutrition being found in the poorest section (7%) in the society. Severe wasting (SAM- Severe acute malnutrition[2]) is > 1 percent in all wealth quintiles except Q5 (Q1 4.3 percent, Q2 1.8 percent, Q3 1.2 percent and Q4 2.6 percent), which is of severe public health significance as per WHO standards. Children with SAM have nine-times higher risk of death than their normal counterparts.

1 National Nutrition Survey 2015
2 Weight for height <-3 standard deviation as per WHO reference standards.

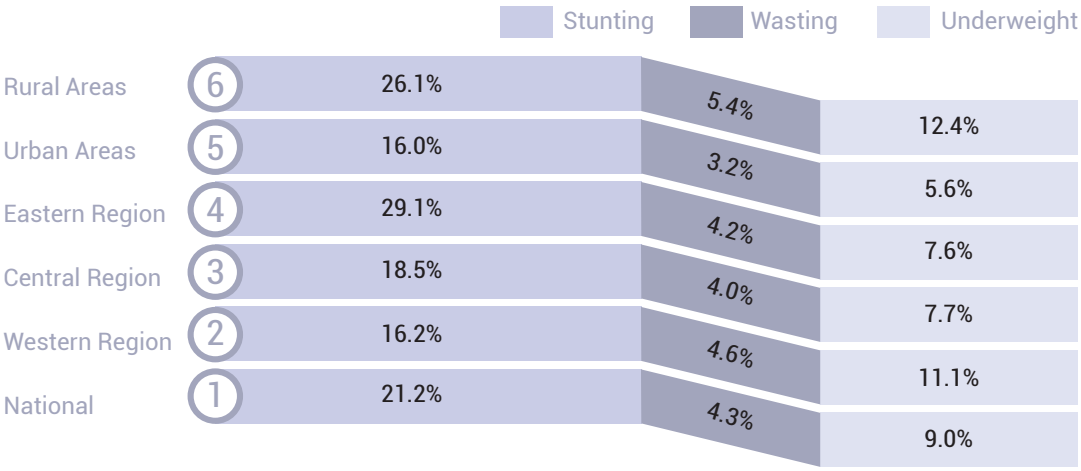


Figure 3: Stunting, Wasting and Underweight status in children under five
National Nutrition Survey 2015

ANEMIA

Anemia in Bhutan is a significant public health problem. The National Nutrition Survey 2015 shows that 43.8% of children (6-59 months), 31.3% of adolescent girls (10-19 years), 34.9% of non-pregnant women (15-49 years) and 27.3% of pregnant women are anemic. These findings demonstrate that anemia is a lifecycle problem, and to correct anemia in children, anemia in women must be corrected before they become pregnant, maintaining good iron levels throughout pregnancy and lactation.

However, Bhutan has also made significant reductions in the anemia prevalence over the past 12 years. Since the national anemia study in 2003, prevalence of anemia among children less than five years of age has reduced by half of 2003 level. Similarly, anemia prevalence among non-pregnant women has reduced by over a third of its 2003 levels.

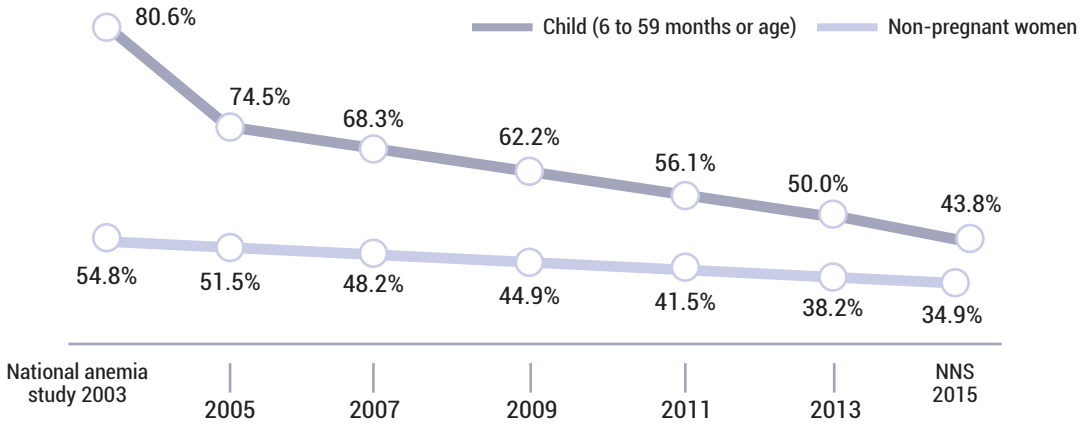


Figure 4: Anemia trends
National Nutrition Survey 2015

MICRONUTRIENT DEFICIENCIES

There is limited biochemical and dietary information on micronutrient status in Bhutan suggesting a need to conduct a micronutrient survey, including biochemical, dietary and clinical components.

The generally poor dietary diversity prevalent among the Bhutanese households as indicated in the NNS 2015, can be indicative of the inadequacy of the intake many micronutrients

The generally poor dietary diversity prevalent among the Bhutanese households as indicated in the NNS 2015, can be indicative of the inadequate intake of many micronutrients such as B vitamins, but also of iron, folate, vitamin A and possibly other key nutrients, such as zinc, found especially in fresh foods. A national micronutrient survey is needed to understand the extent of the micronutrient deficiencies in Bhutan.

IODINE DEFICIENCY DISORDER (IDD)	VITAMIN A DEFICIENCY (VAD)	VITAMIN B DEFICIENCIES
In 1983 IDD was a national public health problem in Bhutan and IDD control program was initiated by MoH	In 1984, the prevalance of VAD among pre-school children was 14%. Control program was initiated	1998 and 2012 Peripheral neuropathy (PN) outbreaks observed in schools and B vitamin defficiency was suspected
In 2003 IDD was eliminated from Bhutan and a followup study in 2010 indicated the IDD elimination was sustained	In 1999, VAD was found to be absent among pregnant women and children. Supplementation program was continued	MOH, in 2014, found a high prevalence of thiamine and cobalamin deficiency in school children
In 2015 the household iodised salt coverage was 99% but there is a need for periodic surveys on iodine status, and regular monitoring of iodine in salt.	Vitamin A supplementation given to women and children. There is a need for study to acertain the status of VAD	NNS 2015 also shows inadequate animal sourced proteins, fruits and vegetables in the diets of Bhutanese

Figure 5: Micronutrient Deficiencies

21% OF CHILDREN UNDER FIVE ARE STUNTED

44% CHILDREN UNDER 5 ARE ANEMIC

33.5% ARE OVERWEIGHT AND 11.4% OF OBESE (BHUTANESE AGED 15-69 YEARS)

OVERWEIGHT AND OBESITY

The NCD STEP Survey 2019 which collected the data for Bhutanese aged 15-69 shows: 33.5% are overweight and 11.4% are obese compared to 27% men and 40% women were overweight in 2014; 87% do not consume sufficient fruits and vegetables; 17% engaging in heavy episodic drinking; 7% did not meet the WHO recommended physical activity of 150 minutes of moderate intensity physical activity per week; 18% having high blood pressure, and 1.9% of the population having raised blood sugar.

Based on the available data, NCDs cause the highest proportion of deaths for all age groups accounting for 71% of all deaths[3]. This makes NCDs Bhutan's biggest health challenge.

The NNSAP will coordinate closely with related strategies and plans to ensure best outcomes and optimize the use of resources, with greater focus on interventions targeted to vulnerable populations in the context of a life cycle approach for disease prevention and control.

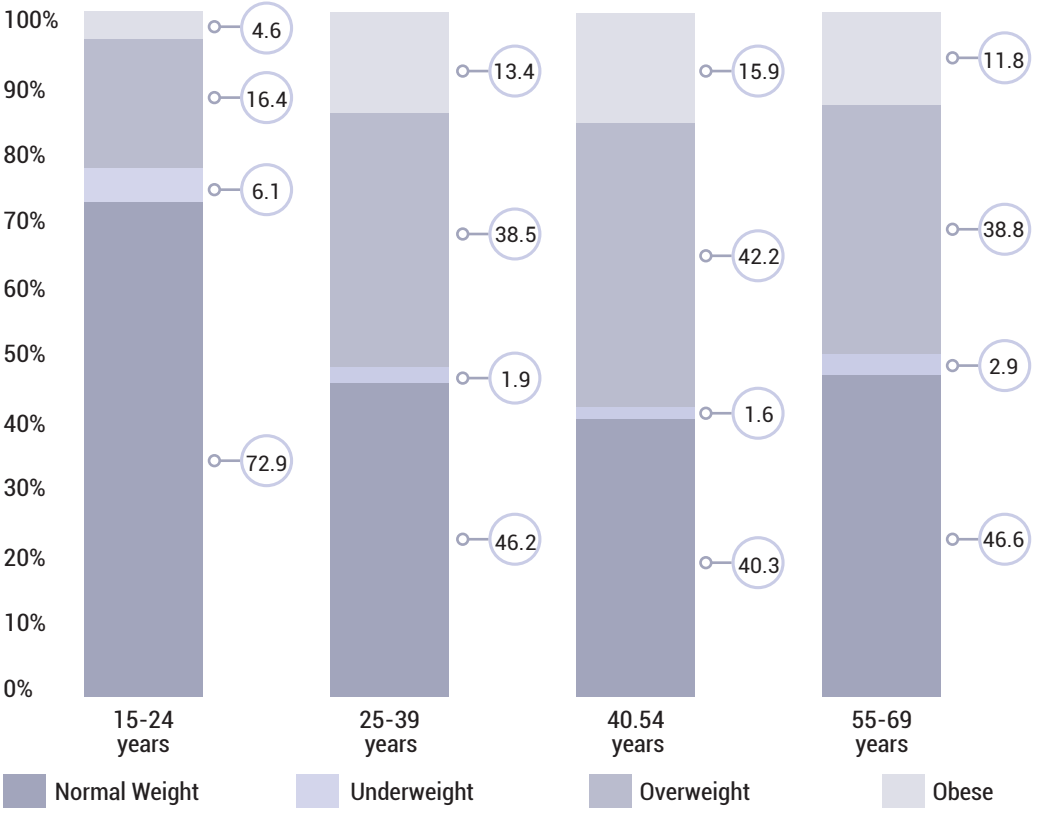


Figure 6: Overweigh and Obesity as reported by the Non-Communicable Diseases STEPS survey 2019

3 Annual Health Bulletin, Ministry of Health, 2020.


Big truck
STAR
VITAMIN

THE TRIPLE BURDEN OF MALNUTRITION THROUGH THE LIFE CYCLE AND ACROSS GENERATIONS AND SHARED DRIVERS

The causes of malnutrition are directly related to inadequate dietary intake and diseases. However, household food security, health status, maternal and child care services, environmental factors and others contribute indirectly. While most nutrition interventions are delivered through the health sector, non-health interventions are also critical. Actions should target the different causes to reach sustainable change, which require multi-sectoral approaches.

It is imperative that nutritional disparities and the triple burden of malnutrition must be considered from a life course perspective. This is because there is evidence that shows the intergenerational transmissibility of malnutrition. For example, women of childbearing age living in socioeconomically deprived circumstances have documented the intergenerational transmission of both stunting and obesity. Similarly, paternal excessive body weight has also been associated with increased obesity risk in children.

The triple burden of malnutrition through the life cycle and across generations and shared drivers presented in Figure 7.

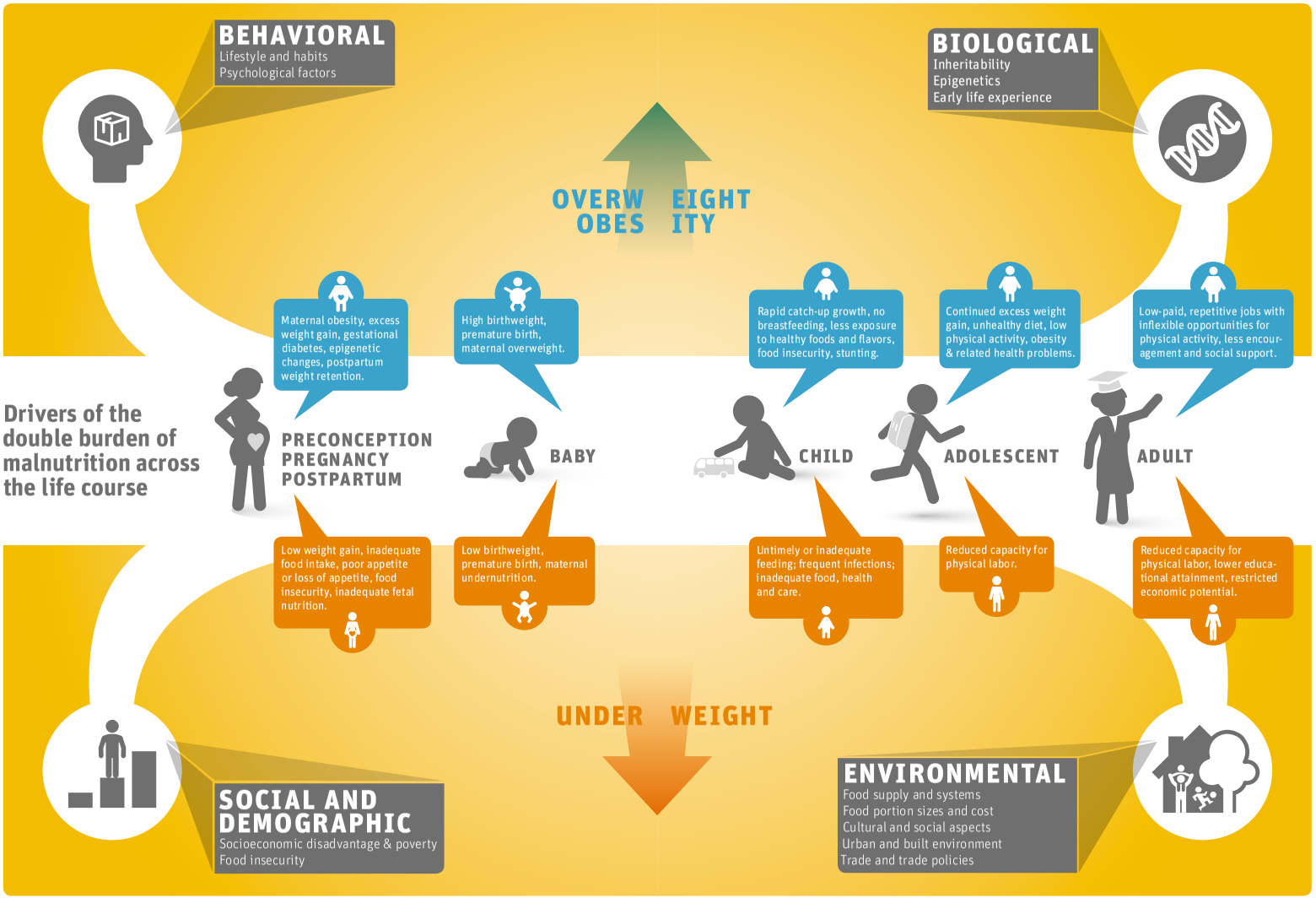


Figure 7: Drivers of Malnutrition

- 8% (WFP FCS index) of households in Bhutan have a poor or borderline diet– diets that do not contain balanced food intake that is sufficiently diverse and nutritious food (NNS 2015)
- Only around 77% newborn have best start of life that is colostrum feeding and initiation of breastfeeding in first hour of birth and 51% of the children were exclusively breastfed (NNS 2015)
- Only 11.7% of children are fed with minimum acceptable diet, 16.6% given iron rich food and 15.3% provided with 4 or more food groups (NNS 2015)
- Thiamin deficiency among school children 90.13% during mid-academic year and cobalamin deficiency of 64.7% detected in school children from 7 districts[4].
- Diarrheal diseases affect 25% of under-5 children (BMIS, 2011).
- Nationally more than 4 in 10 children under five are anemic and 3 in 10 adolescent girls are anemic.
- 40% of student's drink carbonated drink and 32.2% students eating fast food (School based health survey 2016)
- 87% respondents have insufficient fruits and vegetables (STEP survey 2019)
- Nationally 2.2% of households faced food insecurity while dietary diversity in households are very poor (NNS 2015).
- Food shortages and chronic food insecurity are greater in the rural areas (PAR, 2017), where poverty is also higher.
- Only 52% reported starting ANC visits in the first trimester, and only 17.7% of women in the eastern region received Bhutan's recommended 8 ANC visits (NNS, 2015).
- 16% of the pregnant women reported consuming alcohol, and 42%consumed betel nut (NNS, 2015).
- Almost 40 percent of rural households still uses pit toilets which are as lethal as open defecation which can lead to diseases contributing to malnutrition.
- Also, there are inadequate WASH facilities in Health Care Units which makes hospital environments unsafe for the patients, health staff and attendants.
- Rapid urbanization (37% so far, with an additional 3.7% change each year (World Bank, 2012) affects Bhutan's agricultural productivity as young people leave the countryside to find education or jobs in the cities (Maetz, 2012).
- There is gender parity through secondary school, however in tertiary education the ratio of girls to boys is only 0.79 (AES 2015). The adult literacy rate for females is 45.2% compared to 66% for males. 60% of males have attended or previously attended school in comparison to only 48% of females (BLSS 2012).
- In the richest quintile, 94% used improved sanitation, versus 31.6% of the poorest; 8.2% of the poorest used unimproved drinking water versus 0.2% of the wealthiest. Where the head of household had no education, 42% of households used an unimproved sanitation facility versus 5.8% of those with secondary or higher education (BMIS 2010).

4 Prevalence of Thiamine and Cobalamin deficiency in boarding school children from seven districts of Bhutan with history of Peripheral Neuropathy outbreaks. Nutrition Program, Ministry of Health, 2014.

CHAPTER 3: RATIONALE, VISION, MISSION & GUIDING PRINCIPLES

DEVELOPMENT PROCESS

The development process of the NNSAP was driven by the Nutrition Program of the Ministry of Health, and was widely consultative, involving all key nutrition stakeholders through the multisectoral process that was open, inclusive and built on existing and emerging alliances, institutions and initiatives. At the national level all relevant key stakeholders and development partners - both from the country office as well as from regional offices were involved. Consultative workshops with the relevant field workers were conducted and the document was shared with all relevant officials including the District Health Officers, Chief Medical Offices and other field workers for comments and feedback.

The process of the development ensured that the plan is evidence-informed and recognized successes while also taking care to create a result-based system which provides common results and accountability framework for monitoring and evaluation.

RATIONALE

The National Nutrition Survey 2015, shows that chronic malnutrition in children under five is still a public health concern. Anemia prevalence despite the significant decline in the last twelve years, still remains a public health problem for children under five, pregnant women, adolescent girls and women of reproductive age. Even though the survey indicates the percentage of households suffering from food insecurity is very low, household dietary diversity is very poor in the country. The high burden of all forms of malnutrition in Bhutan warrants appropriate national level interventions.

Nutrition is identified as one of the key national priorities in the 12th Five Year Plans (2019-2023). The National Key Result Area (NKRA) 8 is about ensuring food and nutrition security, a key contribution from the health sector is to ensure the improvement of the nutrition status of the general population. Key performance indicators for NKRA 8 have already been linked to achieving the global nutrition commitments. The NNSAP is meant to guide the operational planning, implementation, monitoring and resource mobilization for achieving the targets set in the 12 FYP and beyond.


6
ATHL.
DEPT.
19

VISION

A nation free from all forms of malnutrition where all her people achieve optimal health, nutrition and wellbeing.

The key strategic elements reflected in this vision are;

- **A nation:** where the NNSAP strives to impact the whole of the country
- **All forms of malnutrition:** where there is a need to address the triple burden of malnutrition as well as diet-related non-communicable diseases
- **All (her) people:** a life-course approach is essential, including all population groups i.e., infants, children, adolescents, mothers, the general population
- **Health and wellbeing:** NNSAP will take into consideration the wider definition of health adopted by WHO, where the health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"

This vision is also aligned with the Royal Governments of Bhutan's development philosophy of **Gross National Happiness**.

MISSION

To implement evidence-informed nutrition interventions and work with relevant agencies and partners to ensure universal access to effective nutrition actions and to healthy and sustainable diversified diets.

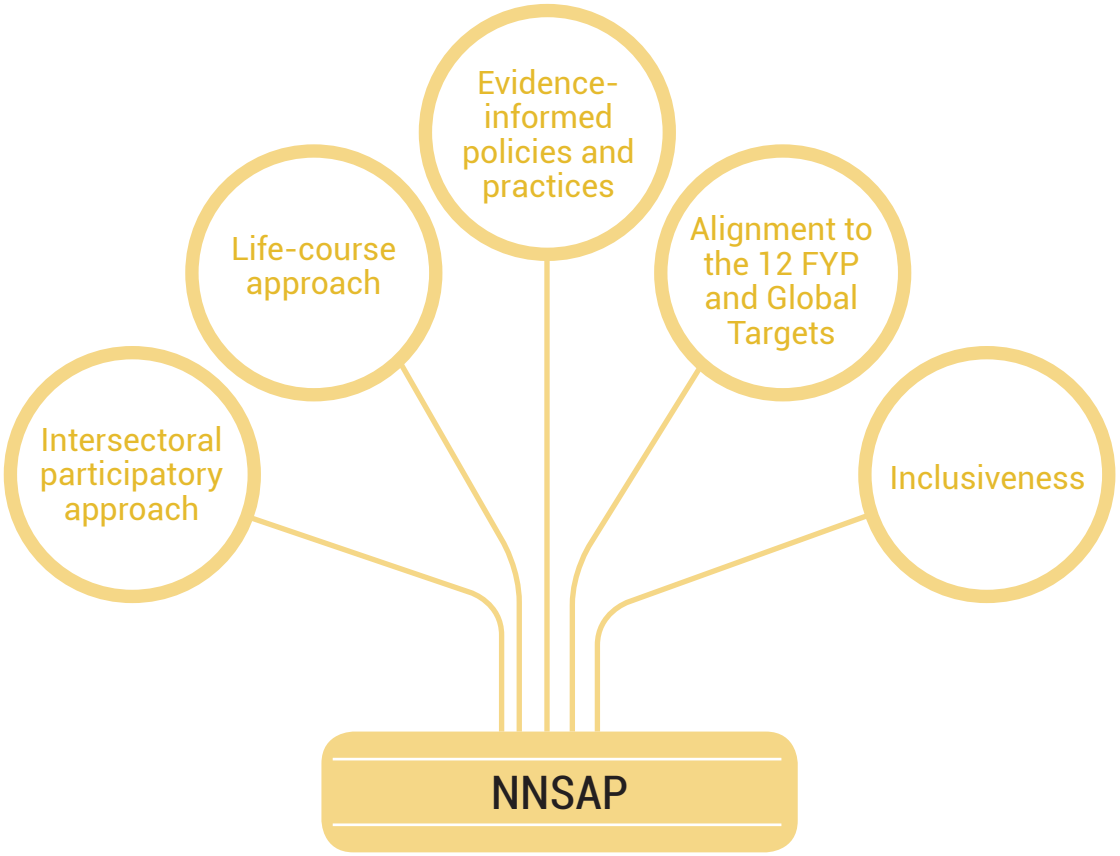
To do this NNSAP will;

- Set, align and advocate for priority actions to improve nutrition;
- Develop evidence-informed guidance based on robust scientific and ethical frameworks;
- Support the adoption of guidance and implementation of effective actions;
- Monitor and evaluate policy and program implementation and nutrition outcomes.

The key elements of the mission statements are:

- **Implementing evidence-informed nutrition interventions**: evidence-informed guidance developed through robust scientific and ethical framework free from conflict of interest, must underline the development of effective and efficient nutrition-specific and nutrition-sensitive solutions;
- **Working with relevant agencies and partners:** NNSAP will help set, align and advocate for priorities to move the nutrition agenda to achieve the goals and targets set for the year 2023 and 2025;
- **Healthy and Sustainable diets:** the fundamental role of healthy diets at all stages of life, as well as the importance of sustainable environments and food systems in achieving the nutrition targets are recognized.

GUIDING PRINCIPLES



The NNSAP is guided by the following principles:

Intersectoral participatory approach

Multi-sector collaboration for developing effective interventions to address the triple burden of malnutrition; it requires commitment and actions by various sectors (agriculture, health, education as key sectors, and trade, social support, media as supporting sectors) to ensure supportive policy coherence. It requires meaningful community participation and engagement, as well as active partnerships among national authorities, civil society organizations, academia and the private sector –free from conflicts of interest. The National Nutrition Strategy is evidence and rights based, equity focused, gender responsive and system centered.

Life-course approach

A life-course approach starts with maternal health. Integral components of a life-course approach include preconception care, antenatal and post natal care, early initiation of breastfeeding, promotion of breastfeeding; appropriate infant and young child feeding practices; a healthy lifestyle for children, adolescents and youth; a healthy working life; healthy ageing; and care of people in later life.

Evidence-informed policies and practices

Evidence-informed guidance for nutrition interventions should be considered, where available. Country-specific research is needed to identify the common causal pathways of the double burden of malnutrition, the risks of economic (price surges) and environmental (climate variability) shocks that jeopardize the availability and affordability of and access to healthy diets and feeding practices and options for dietary diversification.

Alignment to 12 FYP and Global Targets

The strategy and action plan will be mainstreamed into the 12 Five Year Development Plans and committed global targets, as well as aligning to the policies of all relevant sectors while also ensuring that relevant sector policies are responsive to improving the nutrition situation in the country.

Inclusiveness

The NNSAP will ensure that all interventions are geared to meet the requirements of all population groups. It will ensure that no one is left behind and that vulnerable populations are given equitable access to nutrition services. The strategy will ensure the services are gender responsive, disability friendly as well and ensure that the access to services due to difficult geographic locations and socioeconomic factors are minimized.

CHAPTER 4: OBJECTIVES

The general objective of the NNSAP is to improve nutritional security, especially for those at higher risk of malnutrition such as children, women, adolescents, the elderly and people with special needs in collaboration with multiple sectors to achieve the targets by 2025.

The specific objectives of the NNSAP are as follows:

1. To reduce the prevalence of childhood stunting to 18% by 2023 and further reduce by 40% in the year 2025 from the baseline.
2. To reduce and maintain the prevalence of childhood wasting to less than 5%
3. To reduce the prevalence of anemia in children 6-59 months to 29% in the year 2023.
4. To halt the rise of overweight and obesity in all population groups.
5. To prevent undernutrition including micronutrient deficiencies in middle childhood and adolescents and adults.
6. To reduce the prevalence of anemia in adolescent girls (10-19 years) to less than 18% in the year 2023.
7. To reduce the prevalence of anemia in pregnant women to 18% in 2023.
8. To monitor and evaluate nutrition security situations and related interventions across life courses.

The NNSAP also strives to achieve the global targets:

Global targets 2025 to improve maternal, infant and young child nutrition

- 40% reduction in the number of children under 5 who are stunted
- 50% reduction of anemia in women of reproductive age
- 30% reduction in the low birth weight
- No increase in childhood overweight
- Increase in the rate of exclusive breastfeeding rates in the first 6 months up to at least 50%
- Reduce and maintain childhood wasting to less than 5%

Nutrition as an enabler for NCD targets and objectives

- Reduce premature mortality from NCDs

Diet-related global NCD targets

- 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances
- 30% relative reduction in the mean population intake of salt/sodium
- Halt the rise of diabetes and obesity

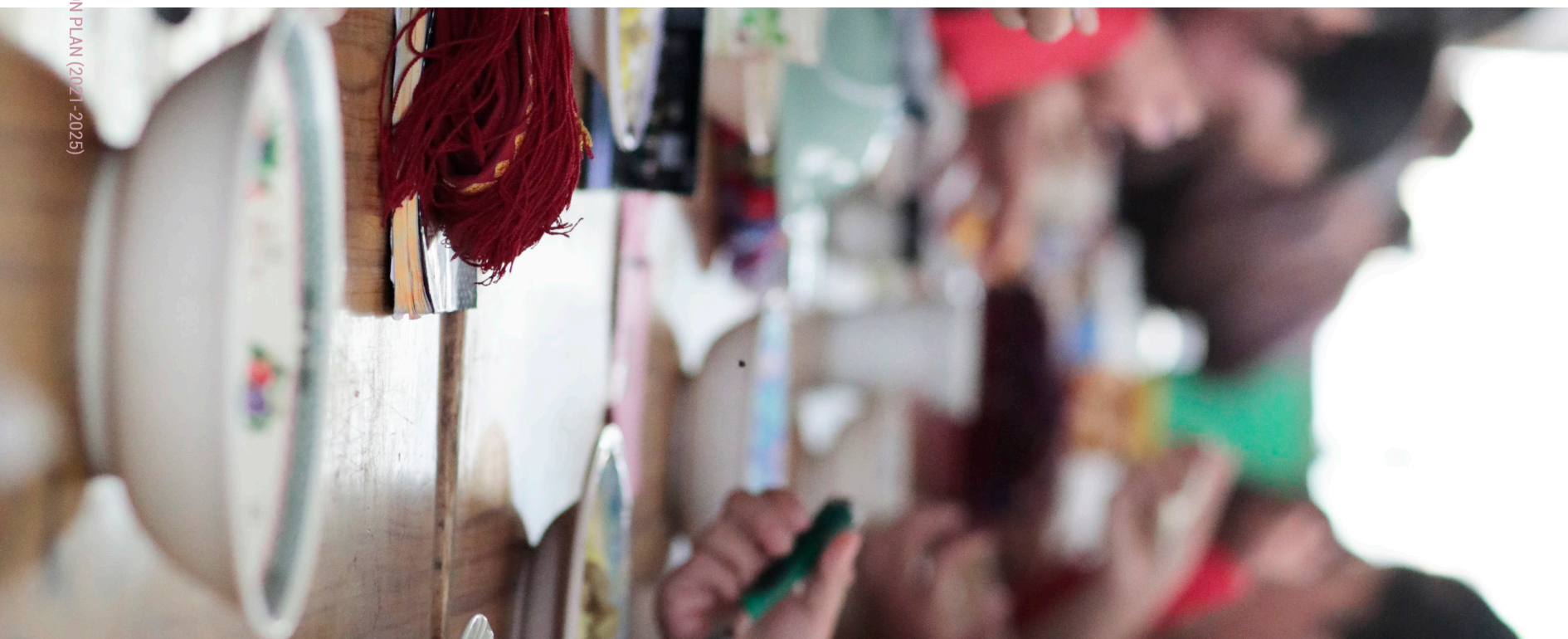
RESULTS FRAMEWORK

Outcomes	Indicators	Baseline	2023	2025
1 Improved nutritional status of infants and young children (preschool age) with special focus on 1000 golden days	Prevalence of stunting under five (0-59 months)	21.2 %	18%	13%
	Prevalence of wasting under five (0-59 months)	< 5 %	< 5 %	< 5 %
	Prevalence of anemia among children 6-59 months	43.8%	31%	22%
	Prevalence of exclusive breastfeeding children under six months of age	51.4%	57%	>50%
	Prevalence of children 6-23 months receiving a minimum acceptable diet	11.7%	22%	30 %
	Prevalence of childhood overweight and obesity	2.4%	2.40%	2.40%
2 Improved nutritional status of school aged-children including monastic institutions through improved knowledge, skills and practices	Proportions of schools implementing micronutrient supplementation and deworming program	-	80%	>95%
	Proportion of schools achieving “Good Dietary Diversity Score”	7.7%	80%	>90%
	Proportion of school children who are overweight/obese	13%	<7%	<5%
	Proportion of monastic institutions and nunneries implementing nutrition advocacy package (dietary guidelines, food baskets)	-	90%	>95%
3 Improved nutritional status of adolescents, youth, women of reproductive age, pregnant and lactating mothers;	Prevalence of anemia in adolescent girls (10-19 years)	31.3%	18%	12.8%
	Prevalence of anemia among women of reproductive age	34.9%	28%	17.5%

4 Improved nutritional status of the general population by promotion of healthy diets and physical activity to prevent overweight, obesity and NCDs	Raised fasting blood sugar among adults (15-69 years)	6.4%	No rise	No rise
	Mean salt intake in the population	8.3 gm/day	7.6 gm/ day	5.8 gm/ day
	Prevalence of adult obesity	6.2 %	No rise	No rise
5 Improved food security, water sanitation & hygiene as nutrition sensitive	*Increase in production of cereals	123847 MT	131042 MT	137746 MT
	Increase in vegetable production	58697 MT	694435 MT	694435 MT
	Increase in production of fruits	53961 MT	75855 MT	83440 MT
	Percentage increase in distribution of fortified foods	6000 MT	>20%	>20%
	Self-sufficiency ratio of flesh foods	0.37	0.4	0.47
	Self-sufficiency ratio of dairy products	0.88	0.88	0.91
	Self-sufficiency ratio of vegetables	86	100	100
	Per capita consumption of eggs	166	207	217
	Percentage of households with access to 24X7 water supply for drinking and maintaining hygiene and sanitation	53.47 % (Rural), 26.58 % (Urban)	100 %	100 %
	Percentage of household using safely managed sanitation facilities	53.6 %	70 %	70 %
6 Improved and scaled-up services and practices related to clinical nutrition and dietetics	Proportion of health facilities (with nutritionist / dietitian) implementing essential nutrition care package	-	100%	100%
	Proportion of health facilities implementing the food service system guidelines	-	100%	100%

7	Improved governance, policies and multi-sectoral partnerships in support of nutrition interventions	Minimum number of National Nutrition Task Force meetings conducted annually	-	2	2
8	Improved monitoring and evaluation of nutrition security situation and related interventions	Number of national level surveys conducted to inform on the policies and interventions	-	2	3

**The latest published census data has been used as a basis for projected production.*



CHAPTER 5: IMPLEMENTATION MODALITY

GOVERNANCE STRUCTURE

Nutrition is a cross cutting issue which requires multi-system collaborative efforts of various sectors both within and outside the government. The successful implementation of NNSAP will entail effective collaboration with multiple agencies. Therefore, a National Nutrition Task Force committee (NNTF) comprising of representatives from multiple agencies would function as the custodian of NNSAP.

NATIONAL NUTRITION TASK FORCE (NNTF)

1. Director, Department of Public Health (Chairperson)
2. Pediatrician (Technical Adviser)
3. Chief Program Officer, School Health and Nutrition Division, Department of School Education, Ministry of Education
4. Chief Agriculture Officer, Agriculture Production Division, Department of Agriculture, Ministry of Agriculture and Forests
5. Chief Livestock Officer, Livestock Production Division, Department of Livestock, Ministry of Agriculture and Forests
6. Chief Engineer, Water and Sanitation Division, Department of Engineering, Ministry of Works and Human Settlement
7. Head, Food and Nutrition Laboratory, Royal Centre for Disease Control
8. Representatives from development partners and non-governmental organization
9. Other members to be co-opted as and when required

SECRETARIAT TO THE NNTF

The Nutrition Program, DOPH, MoH under the supervision of the relevant Chief Program Officer (CPO), will be the secretariat to the NNTF.

MANDATES OF THE NNTF

The National Nutrition Task Force is mandated to:

- Oversee and ensure the smooth implementation of the NNSAP
- Act as national advisory group for all matters within the purview of the NNSAP
- Meet periodically to provide technical guidance and support to ensure that the deliverables in the NNSAP are met
- Conduct periodic evaluations of the NNSAP when deemed necessary and appropriate
- Coordinate cross-sectoral responses and actions for routine nutrition programs and emergency nutrition preparedness

IMPLEMENTATION OF NNSAP

For the implementation of NNSAP, Nutrition Program, MoH will lead the coordination between all relevant sectors, while also guiding and facilitating the implementation process. The arrangement for the implementation will be as follows:

Planning and budgeting:

NNSAP will be incorporated in the plans of all the relevant stakeholders. The development of Annual Work Plans (AWPs) and budgets will be in line with NNSAP. In order to ensure quality implementation, important key indicators will be encouraged to be incorporated in the Governments Performance Management System (GMPS) – Annual Performance Agreement (APA) or equivalent.

Coordination and management:

Nutrition Program, DoPH will be responsible for coordination and management of NNSAP at the national level. The Program will also advocate and encourage the districts and other relevant stakeholders to take up planning and implementation of the NNSAP through the NNTF committee.

Information and communication:

SBCC will be developed and organized to raise awareness on nutrition issues. High level decision makers including parliamentarians and other elected officials will be periodically advocated on nutrition to garner support and keep nutrition at the helm of the country's development agenda.

Monitoring:

Periodic monitoring of activity implementation will be conducted during the NNTF meetings. Key indicators of NNSAP will be incorporated in the sectoral monitoring systems - Health Management Information Systems (HMIS), Education Management Information Systems (EMIS) etc. National level surveys will be conducted to evaluate the impact of NNSAP as well as inform on policies and strategies.

CHAPTER 6: STRATEGIC RESULT AREAS

STRATEGIC RESULT AREAS

To achieve the goals set in the 12th FYP, the national health policy and other global commitments, NNSAP will play a crucial role in the successful mobilization of efforts and resources to engage and follow through in planning and implementing robust work plans. In this regard, the nutrition agenda for next five years will be shaped along the following strategies:

1. To improve the nutritional status of infants and young children (preschool age) with special focus on 1000 golden days
2. To improve the nutritional status of school aged-children including monastic institutions through improved knowledge, skills and practices
3. To improve the nutritional status of adolescents, youth, women of reproductive age, pregnant and lactating mothers
4. To improve the nutritional status of the general population by promotion of healthy diets and physical activity to prevent overweight, obesity and NCDs
5. To strengthen the food and nutrition security, water sanitation & hygiene as nutrition sensitive interventions
6. To improve and scale-up services and practices related to clinical nutrition and dietetics
7. Strengthening governance and multi-sectoral partnerships in support of nutrition interventions and have resilient systems for nutrition in emergency preparedness
8. To improve monitoring and evaluation of nutrition security situations and related interventions

STRATEGIC RESULT AREA 1

To improve the nutritional status of infants and young children with special focus on 1000 golden days

Malnutrition remains a major threat to the survival, growth and development of children in Bhutan. Poor nutrition in infancy and early childhood increases the risk of child morbidity and mortality, diminished cognitive and physical development marked by poor performance in school. Malnutrition also impacts on productivity later in life. Appropriately, one of the key indicators used

Uptake of Essential Nutrition Interventions from conception period till two years of age will reduce infant mortality by 25%, maternal mortality by 20% and chronic malnutrition/ stunting in children by 30%.

as NKRA in the 12FYP is the prevalence of stunting among children under the age of 5 years. Malnutrition in children can be attributed to a variety of factors including poor infant and young child feeding practices, poor maternal nutrition, low access to adequate and diversified diets, childhood illnesses and inadequate access to health and nutrition services.

This Plan focuses on activities that will contribute by optimal utilization of the critical 'window of opportunity' from pre-pregnancy until two years of age as endorsed in the 2010 UN summit resolution on nutrition. According to Lancet Nutrition Series published in 2008, if the package of Essential Nutrition Interventions is effectively accessed by mothers from the conception period and children up to two years of age and implemented on a wider scale, in the short run, infant mortality would reduce by 25%, maternal mortality by 20% and chronic malnutrition/stunting in children by 30%.

Priority Areas

- Promote, protect and support breastfeeding for children: early initiation of breastfeeding, exclusive breastfeeding for the first six months of baby's life and continued breastfeeding for at least two years
- Promote optimal complementary feeding with a special focus to improve the dietary diversity from locally available foods
- Provide appropriate micronutrient supplements to children under five years
- Strengthen growth monitoring and promotion for children under five years of age
- Strengthen the screening and management of acute malnutrition, low birth weight infants and improve referral mechanism and linkage between the health facilities
- Strengthen the screening and management of child development including prevention and early management of childhood illnesses
- Improve advocacy and encourage community engagement to achieve optimal child nutritional status

STRATEGIC RESULT AREA 2

To improve the nutritional status of school aged-children including monastic institutions through improved knowledge, skills and practices;

Schools provide an ideal platform to build the human capital of the country by securing the gains from the first 1,000 days' investment and addressing the missed growth during the catch-up phase in school going children, thereby contributing towards a holistic approach of 8,000 days.

12

12. COMPLEMENTARY FEEDING CLASS

There are evidences that well-designed school feeding programs contribute to health and nutrition, school enrollment, attendance, cognition and educational achievement which supports improved conditions for individuals and the community. School feeding promotes school participation, especially for children from hard-to-reach areas and vulnerable groups; provides a social safety net; and stimulates rural economies with schools as markets for local produce. School feeding can reduce a household's food needs over the school year so that they have more disposable income to meet other immediate needs.

Well-designed programs for school aged children contribute to health and nutrition, school enrolment, attendance, cognition and educational achievement

Schools are a place where children learn life skills and can develop healthy dietary habits. Evidence shows that habits developed in childhood tend to persist to adulthood and even result in their transmission from one generation to another. The development of healthy dietary habits during childhood can also help to prevent diet-related diseases later in life.

Creating partnerships among relevant agencies makes the best use of the available resources to improve health, nutrition and education outcomes. Linking the National Nutrition Strategy with other relevant programs on health, nutrition and school agriculture, food safety and WASH complement ongoing efforts, avoid duplication and build on synergies for a more effective and efficient implementation

Besides ensuring that children receive meals in schools, the RGoB is investing in improving the nutritional quality of the meals. Improving nutrition education and healthy eating habits, addressing the double burden of over and under nutrition, and integrating school meals to local eating habits are among the programs' objectives.

Priority areas

- Optimize school meals using Plus School Menu, incorporation of food fortification and strengthen linkages to local farmers, to ensure nutritional requirements of school-aged children are met
- Develop and implement a comprehensive Social Behavior Communication Change (SBCC) Strategy to improve dietary and health practices for school aged children and their parents/communities
- Improving school kitchen and store infrastructure and facilities in place for schools to be able to provide nutritious and safe school meals
- Strengthening online, digital, monitoring and reporting systems for school health and nutrition programs to enable better programming and decision-making

- Capacity building of relevant staff on an integrated approach of managing school feeding and nutrition programs including food preparation, storage, food safety and WASH
- Provide recommended micronutrient supplements to school aged children
- Strengthening the healthy food environments in schools and monastic institutions to manage and control the marketing of unhealthy foods and beverages
- Implement the required physical activity recommendations including sports as part of school curriculum

STRATEGIC RESULT AREA 3

To improve the nutritional status of adolescents, women of reproductive age, pregnant and lactating mothers

Improving nutritional status of adolescents, women of reproductive age, pregnant and lactating mothers is a priority

The National Nutrition Survey (2015) reported that 27% of pregnant women and 31.3% of adolescent girls were anemic. Nutritional status of women of reproductive age, pregnant and lactating mothers is of significant importance for the healthy delivery and development of babies. Realizing the need to improve the nutritional status of pregnant and lactating mothers, the Ministry of Health has prioritized on a holistic and comprehensive approach to strengthen the mother and child health outcomes through the 'Accelerating mother and child health program' where, the nutrition of pregnant and lactating mothers is prioritized. Further, the improvement of nutritional status of adolescent girls, women in reproductive age, pregnant and lactating mothers constitute some of the important indicators for the national key result area.

The National Adolescent Health Program in its effort to improve the nutritional status of adolescents complements the National Nutrition Program by supporting and promoting the importance of nutrition among adolescents through Adolescent Friendly Health Services (AFHS). Reduction of anemia among adolescents is one of the priorities of the program in the 12th FYP.

Priority Areas

- Improving and strengthening the coverage of recommended 8 ANC visits, 4 PNC, and early booking for the pregnant women and provision of nutrition services at each visit in line with the WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience

- Improving the counselling services on nutritious and safe diets, physical activity and rest and weight gain
- Promoting, strengthening and supporting the supply and consumption of multiple micronutrients including Iron Folic Acid tablets, Vitamins and calcium lactate for pregnant women
- Strengthening the management and screening of anemia for adolescent girls, and women in the reproductive age group
- Strengthening and expanding the implementation of package of preconception nutritional care
- Strengthening and expanding Adolescent Friendly Health Services to deliver nutrition services
- Improving advocacy to promote healthy dietary practices among adolescents
- Reducing micro-nutrient deficiency status among the adolescents

STRATEGIC RESULT AREA 4

To improve the nutritional status of the general population by promotion of healthy diets and physical activities to prevent non-communicable diseases;

The prevalence of diet related non-communicable diseases has been on the rise. The steps survey 2019 indicated around 45% of the Bhutanese populating aged 15-69 years are either overweight or obese. Furthermore, the survey indicates that almost 9 out of every 10 people do not consume the recommended fruits and vegetables. Coupled with engagement of unhealthy behavioral practices such as physical inactivity, consumption of alcohol and irregular health screening has given rise to the NCD menace in Bhutan. The annual health bulletin of 2019 reported 71% of all deaths as a direct result of NCDs.

> Nine out of every ten people do not consume the recommended fruits and vegetables

Priority Areas

- Implementing a comprehensive strategy and guideline for prevention, management and control of diet related NCDs
- Improve capacity of service providers on prevention, management and control of diet related NCDs through capacity building as well as ensuring a steady supply chain of necessary equipment
- Creating awareness for both the general public as well as policy makers on the importance of prevention, management and control of diet related NCDs

- Involving community leaders in the prevention and control of NCDs
- Ensuring consumer rights to access good quality and appropriate foods in line with the provisions of the consumer protection act
- Ensuring trade and marketing policies are geared towards providing healthy and nutritious foods
- Ensuring consumers' right to information through labelling of foods

STRATEGIC RESULT AREA 5

To strengthen the food and nutrition security, water sanitation & hygiene as nutrition sensitive interventions

The RNR sector comprising agriculture, livestock and forests is considered one of the five important drivers of economic development in terms of its potential to ensure self-reliance (EDP, 2016). It provides engagement to 49.9% of the total employed population (LFS, 2020) and contributes to the Bhutanese food basket comprising 53 commodities contributing to 70% of the domestic food requirement (MoAF, 2020). Farmers hold an average farm size of 2.22 acres, practicing mostly subsistence to semi-subsistence integrated farming systems. Over the last two plan periods, farming in Bhutan has seen a dynamic shift from subsistence nature to commercialized farming.

> 'All people living in Bhutan at all times have physical, economic and social access to safe and adequate nutritious food for a healthy and active life contributing to realization of Gross National Happiness'

The Food and Nutrition Security Policy of Kingdom of Bhutan, 2014 underpins the sectoral development and envisions that 'all people living in Bhutan at all times have physical, economic and social access to safe and adequate nutritious food for a healthy and active life contributing to realization of Gross National Happiness'. Bhutan has already achieved self-sufficiency in fruits (132%), potatoes (162%) and eggs (100%) and self-sufficiency for other food commodities are on a progressive trajectory (MoAF, 2020). With a vegetable self-sufficiency rate of about 88%, availability is not an issue rather it is about personal preference for consumption and affordability. It is reported that 97.3 % of the total population is sufficient with food during 12 months (BLSS, 2017). This translates to 2.7% of the total population experiencing food insufficiency in the country. Food shortage is reportedly experienced by the rural inhabitants, especially during the months of May-August. Further, with rapid urbanization and change in food consumption pattern, there is an increased demand for processed food and meat which cannot be met by local production. As an import dependent economy that relies heavily on imported food to meet our nutritional demand, food safety is a major area of concern. Additional efforts and emphasis on

the nutritional aspects of food being produced need to be incorporated in plans and programs.

Water is a fundamental human right and an essential resource that supports life and livelihoods. Potable water is required for drinking and sanitation, food preparation and for maintaining personal hygiene. As per the Water Act of Bhutan 2011 and the Water Regulation of Bhutan 2014, water for drinking and sanitation is the first priority for water allocation. Additionally, National Sanitation and Hygiene Policy 2020 is developed with the objective to achieve universal coverage and access to sustainable services. Therefore, provision of adequate and reliable, clean drinking water and improved sanitation is an essential service that the state needs to ensure its citizens.

Water is a fundamental human right and an essential resource that supports life and livelihoods

Priority Areas

- Improve the availability of – physical and economic access to – and the consumption of diversified food commodities (cereals, legumes) and fruits and vegetables through enhanced production
- Improve the availability of – physical and economic access to –– and the consumption of diversified animal source proteins
- Promote food diversification and fortification
- Ensuring food safety at all levels
- Increase access to safe drinking water
- Increase access to safe and sustainable improved sanitation services
- Improve hygiene behavior practices and their management

STRATEGIC RESULT AREA 6

To improve and scale-up services and practices related to clinical nutrition and dietetics

Optimal nutrition care should be the first line of nutrition intervention in disease management and should be integrated as a critical and important component of health care. Clinical nutrition and dietetics services given at health care institutions can be complemented through strengthening follow-up and linkages at the community level and including promotive, preventive and nutrition rehabilitative services

Optimal nutrition care should be the first line of nutrition intervention in disease management and should be integrated as a critical and important component of health care

The Royal Government of Bhutan provides free meals to all the patients requiring hospital admission. Adequate nutrition during illnesses have an important role in the health outcomes of the patients. Studies show that patients receiving nutritionally sound meals have faster recovery, shorter hospital stays and ultimately reduced costs. However, some critically ill patients are not able to feed orally and they must be provided nutrition through an enteral and or parenteral route. Thus, the strategy focuses on providing nutritional support to all patients through provision of different types of diet. It is also equally important to provide nutrition education to other health workers as many health facilities do not have nutritionists and they play an important role as nutrition educators in the community.

Priority areas

- Improve the hospital food service system
- Standardize the implementation of Medical Nutrition Therapy (MNT) including enteral and parenteral nutrition
- Advocating and familiarizing health staff on clinical nutrition
- Participation in the community nutrition initiatives
- Promoting continued professional development and improving coordination among nutrition professionals

STRATEGIC RESULT AREA 7

Strengthening governance and multi-sectoral partnerships in support of nutrition interventions and have resilient systems for nutrition in emergency preparedness

Malnutrition is a cross-cutting issue requiring multi-system, multi-agency partnerships including; MoAF, MoE, MoEA, MoH, NGOs among others.

Coordinating efforts to implement nutrition interventions is key to achieving optimal nutritional status of the population. Thus, the Nutrition program must look beyond the health sector and address many of the key issues through an integrated approach with multiple relevant sectors.

Priority Areas

- Establishing a platform for multi-sectoral coordination for implementing and strategizing nutrition interventions across all sectors and levels
- Identifying and empowering all relevant sectors to buy-in the nutrition agenda
- Conducting regular planning and review meetings to align the annual nutrition planning process in alignment with nutrition action plan
- Advocacy for partnerships and resource mobilization
- Strengthen preparedness for nutrition in emergency situations

STRATEGIC RESULT AREA 8

Monitoring and evaluating nutrition security situation and related interventions

Monitoring and evaluation are important in measuring program performance and evaluating the impact of interventions. It includes routine recording and reporting of important nutrition indicators as well as generating evidence to assess the impact and performance of the interventions periodically. The evidence generated will be useful for decision making and guiding the implementation of nutrition programs.

Priority areas

- Strengthen feedback mechanisms on nutrition information among nutrition stakeholders
- Strengthen and mainstream nutrition information system with DHIS 2 platform
- Conduct periodic nutrition surveys and need-based assessment/ research to inform policy, program design and implementation

ACTION PLANS

SRA 1: Improving the nutrition status infants and young children (with special focus on 1000 golden days)

Action Plans		Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
1.1	Expand the Mother and Baby-friendly health facility initiative (MBFHI) for early initiation of breastfeeding and monitoring exclusive breast-feeding	Proportion of health facilities implementing MBFHI initiative	NA	90%	X	X	X	X	X	NP (MoH)	RH, UNICEF,DHOs, MCH	10
1.2	Advocate to incorporate WHO Breastmilk Code and subsequent WHA resolutions in relevant ACTS and Policies	Number of acts and policies with WHO Breastmilk Code clause	NA	1	X	X	X	X	X	NP	RH, UNICEF,DHOs, MCH	0.5
1.3	Scale up sprinkles project (multiple micronutrient powder) for micronutrient supplementation for children 6-23 months	Proportion of health facilities implementing sprinkles program	NA	99%	X	X	X	X	X	NP (MoH)	RH, UNICEF, DHOs, MCH	40
1.4	Strengthen the U5 growth monitoring plus package (growth monitoring, vitamin A supplementation, deworming and counselling)	Proportion of health facilities implementing GM plus program	NA	99%	X	X	X	X	X	NP (MoH)	RH, UNICEF, DHOs, MCH	30
1.5	Strengthen IYCF counseling and improve quality of complementary feeding for children 6-59 months by promotion of locally available foods/recipes.	Proportion of health facilities conducting counselling session on IYCF (and CF)	NA	97%	X	X	X	X	X	NP (MoH)	RH, UNICEF, DHOs, MCH	20

1.6	Strengthen management of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) in Hospitals and strengthen referral mechanism	Number of NRUs implementing the treatment protocol for SAM and MAM	NA	20		X	X	X	X	NP (MoH)	RH, UNICEF, DHOs, MCH	3
1.7	Strengthen identification, classification and treatment of childhood illness through IMNCI program	Proportion of BHU's implementing IMNCI program	NA	>90%	X	X	X	X	X	CHP (MoH)	RGoB, UNICEF, WHO, FNPH, DMS	21.0
1.8	Scale up C4CD plus for holistic child development through initiation of early stimulation	Proportion of health facilities	NA	20	X	X	X	X	X	CHP (MoH)	RGoB, UNICEF, WHO, Save the Children, DMS	41.4
1.9	Implement SBCC campaign for community engagement to improve child feeding (Engagement with local leaders (gups, tshogpas and MSTF/CBSS; engagement with faith-based agencies; mass media, VHWs)	No of SBCC campaigns conducted	NA	5		X	X	X	X	HPD/ NP/	NP, UNICEF, WHO,	8

SRA 2: Improving the nutritional status of school going children and monastic institutions through improved knowledge, skills and practices, including improved diets

	Action Plans	Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
School Children												
2.1	Optimize school meals using Plus School Menu, incorporation of food fortification and strengthen linkages to local farmers, to ensure nutritional requirements	Proportion of schools providing nutritious meals	0	80%	X	X	X	X	X	SHND (MoE)	MoH, MoE, MoAF, BAFRA, FCBL, WFP	6.57
2.2	Develop and implement comprehensive Social Behavior Communication Change (SBCC) Strategy to improve dietary and health practices for school children and their parents/ communities	Percentage of activities in the strategy completed	None	60%	X	X	X	X	X	SHND (MoE)	MoH, MoE, MoAF, BAFRA, FCBL, WFP, UNICEF	36.5
2.3	Improve school kitchen and store infrastructure and facilities for schools to provide nutritious and safe school meals	Proportion of schools meeting the minimum standards for school kitchen, store, food commodities supply and professional cooks (at least one / school)	NA	40%	X	X	X	X	X	SHND(MoE)	MoH, MoE, MoAF, FCBL, WFP	146
2.4	Develop and implement Good Food Safety Practices and Standards in Schools	Proportion of schools implementing good food safety standards	NA	95%	X	X	X	X	X	SHND(MoE	BAFRA, FCBL, Schools, DEOs	36.5

2.5	Strengthen online, digital, monitoring and reporting systems for school health and nutrition programs to enable better programming and decision-making.	Proportion of schools reporting through the online system	NA	95%	X	X	X	X	X	SHND(MoE)	WFP	4.38
2.6	Capacity building of relevant staff on integrated approach of managing school feeding and nutrition programs including food preparation, storage, food safety and WASH.	Proportion of schools with trained staff	NA	80%					X	SHND(MoE)	MoH, MoE, MoAF, BAFRA, FCBL, WFP	14.6
2.7	Provide recommended micronutrient supplements to school children	Proportion of schools implementing micronutrient supplementation and deworming program	NA	100%	X	X	X	X	X	SHND(MoE)	MoH, MoE, WHO	10.0
2.8	Ensure access to safe drinking water and clean toilets and education in sanitation and hygiene based on WASH in school guidelines	Proportion of schools implementing the program	NA	95%	X	X	X	X	X	SHND(MoE)	MoH, MoE,	20.0
2.9	Strengthen school feeding supply chain to ensure procurement and distribution of safe and nutritious food commodities while minimizing food loss.	Percentage of schools effectively implementing the School Feeding and Nutrition Programme	NA	100%	X	X	X	X	X	SHND(MoE)	MoH, MoE, MoAF, FCBL, WFP	36.5
Monastic Institutions												
2.10	Assess health and nutrition status of the monks and nuns to guide health and nutrition programming for monks and nuns	No. of assessments conducted	0	1	X	X	X	X		HPD (MoH)	Nutrition Program/ Dratshang Lhentshog/WFP	1.0

2.11	Develop and implement nutrition advocacy package in the monastic institutions and nunneries (*Dietary guidelines, food baskets etc*)	Proportion of monastic institutions and nunneries implementing the advocacy package	0	90%	x	x	x	x	x	HPD (MoH)	Nutrition Program/ Dratshang Lhentshog/WFP	2.5
2.12	Establish national committee in Dratshang Lhentshog to steer the nutrition and health agenda for monks and nuns	National committee established	0	1	x	x	x	x	x	HPD (MoH)	DL	5.0
2.13	Capacity Building of dratshangs/nunneries to coordinate, advocate and deliver key health and nutrition interventions *(health coordinators)*	Proportion of Dratshangs with functional health coordinators		90%	x	x	x	x	x	HPD (MoH)	Nutrition Program/ Dratshang Lhentshog	1.2
2.14	Initiate a systematic health screening and referral mechanism for dratshangs and nunneries	Proportion of monastic institutions implementing the program	0	90%	x					HPD (MoH)	Nutrition Program/ Dratshang Lhentshog	6.5
2.15	Implement micronutrient supplementation or food fortification initiatives to reduce micronutrient deficiencies	Proportion of monastic institutions implementing the program	0	90%	X	X	X	X	X	HPD (MoH)	Nutrition Program/ Dratshang Lhentshog	73
2.16	Improve Food Hygiene and Sanitation at Monastic Institutions through awareness and introducing good food hygiene and sanitation practices	Proportion of monastic institutions with good food hygiene and sanitation practices	0	90%						BAFRA	Dratshang Lhentshog	5 M

SRA 3: Improving the nutrition status of adolescents, women of reproductive age, pregnant and lactating women

	Action Plans	Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
Adolescents												
3.1	Scale up the implementation of minimum nutrition package for adolescent girls	No. of HFs providing minimum nutrition package for adolescent girls	7	22	X	X	X	X	X	AHP	Nutrition Program & UNICEF	0.7
3.2	Develop and implement advocacy packages on healthy diet.	No. of AFHS providing advocacy on healthy diet	NA	22	X	X	X	X	X	AHP	Nutrition Program & UNICEF	1.0
3.3	Develop and implement mass media advocacy on healthy diets for adolescents.	No. of mass media campaigns conducted	NA	5	X	X	X	X	X	AHP	HPD & Nutrition program	10.0
3.4	Improve access to health information and education for 'at risk adolescents' by developing and implementing a Peer Based Adolescent Health Education Program by using ICT tools	No. of targeted sites implementing the Peer Education Program	NA	5	X	X	X	X	X	AHP	HPD, Nutrition, UNICEF	1.5
3.5	Enhance the engagement of Family and Community Members in community-based interventions to respond to the Nutritional needs of the adolescents	No. of Communities promoting Adolescent Health	NA	5	X	X	X	X	X	AHP	HPD, UNICEF, DLG, Community	1.2
3.6	Develop and institute nutrition programing; fortified foods, food basket, advocacy and monitoring systems in tertiary institutes	Proportion of tertiary institutes with nutrition programming	NA	100	X	X	X	X	X	NP	RUB, KGUMSB, MOLHR	3.0

3.7	Provide recommended micronutrient supplements to adolescent girls in tertiary institutes	Proportion of tertiary institutes implementing micronutrient supplementation program	NA	100	X	X	X	X	X	NP	RUB, KGUMSB, MOLHR	10.0
Women of reproductive age												
3.8	Scale up the implementation of Pre-conception Voluntary Nutrition Service Package for women of reproductive age	Percentage of HFs implementing pre-conception voluntary nutrition service package for women of reproductive age	NA	90%	X	X	X	X	X	RMNH	RMNH, Nutrition and UNICEF	0.8
3.9	Screening and management of anemia in the women of reproductive age during out-reach camps	No. of outreach camps conducting screening and management of anemia in the women of reproductive age	NA	120	X	X	X	X	X	DMS	RMNH	1.5
Pregnant women												
3.10	Strengthen and sustain micronutrient supplementation program (Iron Folic Acid, Calcium and Vitamins)	Proportion of pregnant women receiving supplementation program	90%	>97%	X	X	X	X	X	RMNH	Nutrition and RMNH	0.6
3.11	Enhance quality of ANC by strengthening nutrition counselling and pregnancy weight monitoring	Percentage increase in ANC coverage	26	80%	X	X	X	X	X	RMNH	Nutrition and RMNH	1
3.12	Improve Dietary Diversity for pregnant women through education and counselling	Percentage of HFs providing education and counseling on dietary diversity	NA	>70%	X	X	X	X	X	RMNH	Nutrition and RMNH	1.2

3.13	Strengthen Line listing for pregnant women and early booking of ANC and completion of PNC visits	Proportion of pregnant women booked for ANC and completion of PNC visits	51%	>90%	X	X	X	X	X	RMNH	RMNH	1.0
3.14	Scale up the online MCH tracking system	Proportion of health facilities implementing the MCH tracking system	NA	95%	X	X	X	X	X	RMNH	RMNH	
Lactating mothers												
3.15	Establish lactation support unit in EmONC centers	Number of EmONC centers with Lactation unit	1	6		X	X	X	X	RMNH	RMNH	1.5
3.16	Implement Nutrition Counselling package for Pregnant and lactating women (MCH Guideline)	Proportion of HFs providing Nutrition Counselling package based on MCH guideline	NA	95%	X	X	X	X	X	NP	RMNH	1.0
3.17	Strengthen supplementation program for lactating women (Complete Implementation of MCH Guideline)	Proportion of lactating women receiving supplementation	90%	>97%	X	X	X	X	X	RMNH	RMNH and Nutrition	0.8
3.18	Screening and management of overweight and obese lactating mothers during growth monitoring and immunization visits (implementation of PEN Protocol)	Proportion of HF implementing the activity	NA	95%	X	X	X	X	X	RMHH	RMNH, LSRD and Nutrition	1.5

SRA 4: Improving the nutritional status of the population by promoting healthy diets and physical activities to prevent NCDs

Action Plans		Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
4.1	Review and revise the food based dietary guideline	Revised guideline	1	1	X	X	X	X	X	LSRD	MoEA, BAFRA, MoA, FNPH, NP	1.0
4.2	Roll out national salt, fat and sugar strategy	% of schools/health facilities implement-ing the guideline	0	95%	X	X	X	X	X	LSRDP	MoEA, BAFRA, MoA, FNPH, NP	10
4.3	Review and revise nutrition components for pre-service and in-service curriculum of health professionals and formal and non- formal education	Revised Curriculum	0	1	X	X	X	X	X	NP	MOE KGUMSB	0.5
4.4	Sensitize policy makers on the food based dietary guide-line including food safety	Number of sensitiza-tions conducted	0	5	X	X	X	X	X	LSRD	HPD	.05
4.5	Conduct behavior change communication workshops for the local leaders	Number of BCC workshops conduct-ed	NA	5	X	X	X	X	X	LSRD	HPD, NP	.05
4.6	Supply stadiometer and weighing scale to the PHC's	Percentage of health facilities with BMI apparatus	NA	95%	X	X	X	X	X	LSRD	DoMSHI	30
4.7	Advocate and promote physical activity among the general population	Number of advo-cacies on physical activity	NA	5	X	X	X	X	X	LSRD	DYS, BoC	1.0
4.8	Roll out PEN hearts protocol in all health facilities in the country	Proportion of health facilities implement-ing the protocol	NA	100	X	X	X	X	X	LSRD	KGUMSB	4.25
4.9	Conduct STEPS Risk factor Survey	Number of surveys conducted	2	1				X	X	LSRD	MoH, FNPH, Developing partners	50

4.10	Develop and implement appropriate food labeling standards	Number of foods with standard food labels	0	50			X	X	X	OCP	NP LSRD BAFRA BSB	1.5
4.11	Promote and regulate food environment to ensure healthy food behavior	Number of consumer awareness conducted	0	30		X	X	X	X	OCP	NP, LSRDP,	0.5
4.12	Ensure trade and marketing policies are geared towards providing healthy and nutritious foods	No of trade and marketing policies geared towards healthy and nutritious foods	0	2		X	X	X	X	DoT	NP,LSRDP	0.5

SRA 5: Improving food security and water, sanitation and hygiene (WASH)

Action Plans		Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
5.1	Increase production of cereals (maize, rice, quinoa, wheat, barley)	Percentage increase from baseline	124, 626 (MT)	45%	X	X	X	X	X	DoA, MoAF	MoH/LG	10
5.2	Increase production of fruit crops (apple, mandarin, peach, plumb, banana)	Percentage increase from baseline	51, 337 (MT)	45%	X	X	X	X	X	DoA, MoAF	MoH//LG	20
5.3	Increase production of vegetables	Percentage increase from baseline	48, 798 (MT)	45%	X	X	X	X	X	DoA, MoAF	MoH/LG	20
5.4	Introduce and promote food crops as part of food diversification	Number of crop varieties released	Nos	25	X	X	X	X	X	DoA, MoAF	MoH/LG	0.50
5.5	Review and implement of concept for model nutrition garden in the communities	Number of model nutrition garden promoted	-	45	X	X	X	X	X	DoA, MoAF	MoH/LG/ MoE/WFP	8.0
5.6	Promote nutrition garden in schools	number of schools implementing the school nutrition gardens	280	330	X	X	X	X	X	DoA, MoAF	MoH/LG/ MoE/WFP	6.0
5.7	Promote organic farming for nutritious and safe food	Percentage increase in production of organic food	700 (MT)	5700	X	X	X	X	X	DoA, MoAF	MoH/LG/ MoE/DoL/ DoFPS/WFP	250

5.8	Introduce nutrient dense food to schools	Proportion of non-rice cereals replaced in school meals	NA	>15%	X	X	X	X	X	DoA/MOAF	MoH/MOE	
5.9	Increase meat production (chicken, Pork, fish, and chevon)	Self-sufficiency ratio of Meat	37%	47%	X	X	X	X	X	DoL/ MoAF	Dzongkhag/ LG/ MoH	10.55
5.10	Increase per capita egg consumption	Per Capita egg Consumption	166 eggs	207 eggs per capita	X	X	X	X	X	DoL/ MoAF	Dzongkhag/ LG/ MoH	8.11
5.11	Enhance dairy production (milk, cheese and butter)	Self-sufficiency ratio of dairy products	88%	91%	X	X	X	X	X	DoL/ MoAF	Dzongkhag/ LG/ MoH	10.55
5.12	Enhance linkages of producer groups with markets	Nos of business linkages created	Nos	50	X	X	X	X	X	DAMC, MoAF	MoH/MoE/ LG/WFP	26
5.13	Access to improved sanitation facilities	Percentage of rural households with access to improved sanitation	84%	95%	X	X	X	X	X	RSAHP	UNICEF SNV	4.5
5.14	Improving access to hand washing facilities with soap and water	Percentage of rural households with access to hand washing facilities with soap and water	>80%	>90%	X	X	X	X	X	RSAHP	UNICEF SNV	

5.15	Access to 24X7 safe drinking water ensured.	Percentage of rural and urban households with access t0 24X7 safe drinking water.	53.47 % (rural), 26.58 % (Urban)	100%	X	X	X	X	X	MoWHS and LGs	GNHC, MoF, Devel-opment Partners	5000.0
5.16	Household using safely managed sanitation facilities	Percentage of urban house-holds using safely managed sanitation facilities.	53.6 %	70 %	X	X	X	X	X	MoWHS, LGs	GNHC, MoF, Devel-opment Partners	50.0

SRA 6: Strengthening clinical nutrition

	Action Plans	Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
6.1	Implement the Inpatient food service guidelines 2019 translating it into local context. • Develop and implement TOR for FSS staff *(Capacity building of food service store in-charges and cooks. Food service infrastructure,*	Proportion of health facilities implementing the guideline	0	100%	X	X	X	X	X	NP	DMS and DOPH, DHOs, CMOs	6.0
6.2	Develop and implement essential nutrition and dietetics care package	Proportion of health facilities with nutrition professionals implementing the package	0	>95%		X	X	X	X	NP	NP, Nutritionists and relevant specialists	1.5
6.3	Standardize and implement screening and assessment protocols for clinical nutritionists/ dietitians.	Proportion of health facilities with nutrition professionals implementing the standardized protocols.	0	100%		X	X	X	X	NP	NP, Nutritionists	0.7
6.4	Enhance the capacity of nutrition professionals to deliver enteral and parenteral nutrition for critically ill patients. • Develop and scale up implementation of parenteral and enteral nutrition guidelines.	Proportion of health facilities with nutrition professionals implementing enteral and parenteral nutrition		>90%			X	X	X	NP	DHS and development partners	2.5
6.5	Develop and promote nutrition screening, assessment and triage to all individuals seeking healthcare	Proportion of health facilities with nutrition professionals implementing the protocol		100%			X	X	X	NP / DHS	Development partners	1.5

6.6	Develop and implement community initiatives to prevent/reduce nutrition related health issues.	No of initiatives initiated	0	5		X	X	X	X	NP	Nutritionist	4.0
6.7	Develop and implement Nutrition Education package for Health workers	Proportion of health workers with nutrition education	0	>95%		X	X	X	X	NP	DHS, Health workers	10
6.8	Promote continued professional development and improve coordination among nutrition professionals.	No of CMEs conducted	0	5	X	X	X	X	X	NP	Nutritionist	4.0

SRA 7: Strengthening governance and partnerships in support of nutrition interventions

Action Plans		Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
7.1	Establish a National Nutrition Task Force to guide the implementation of nutrition actions across all relevant sectors	National Nutrition Task Force established	0	Multiagency taskforce team		X				NP	All relevant sectors	0.5
7.2	Conduct National Nutrition Task Force coordination meeting every six months	No of National Nutrition Task Force meetings conducted	0	7		X	X	X	X	NP	All relevant sectors	5.0
7.3	Strengthen emergency preparedness and response capacity of district emergency nutrition coordinators	Proportion of districts with trained coordinators	NA	100%		X	X	X	X	NP	District nutrition coordinators	1.5

SRA 8: Monitoring and evaluating nutrition security situation and related interventions

Action Plans		Output indicators	Baseline	Targets	Year					Responsibility	Collaborating partners	Estimated Cost (Nu in million)
					1	2	3	4	5			
8.1	Evaluate the sustenance of Iodine Deficiency Disorder Status.	No. of evaluations conducted	NA	1	X	X				NP	WHO UNICEF	4.0
8.2	Conduct national level nutrition survey to assess the nutrition situation and give evidence for evaluation and nutrition programming	No of surveys conducted	NA	1			X	X	X	NP	All relevant sectors	50
8.3	Explore the implementation of national micronutrient survey	No of surveys conducted	NA	1			X	X	X	NP	All relevant sectors	80
8.4	Review and revise the nutrition information system for quality monitoring and implementation of nutrition activities by the field workers	Revision of NIS in the HMIS	NA	Revision of NIS conducted	X	X	X	X	X	NP	HMIS, PPD UNICEF	5
8.5	Implement need-based assessment/ study to inform policy, program design and implementation	No. of assessments/ studies conducted	NA	NA	X	X	X	X	X	NP	HMIS, PPD UNICEF	20
8.6	Strengthen research capacity in the field of nutrition	No of capacity building trainings conducted	NA	2			X	X	X	NP	Development partners	5.0

ANNEXURE

List of contributors

Sl. No.	Name	Designation	Agency
1	Sangay Phuntsho	Sr. Program Officer	DoPH, MoH
2	Choney Dema	Assistant Program Officer	DMS, MoH
3	Karma Tenzin	Program Officer	DoPH,MoH
4	Wangdi Gyeltshen	Chief Program Officer	DoPH,MoH
5	Pemba Yangchen	Dy.Chief Program Officer	DoPH,MoH
6	Chimmi Dem	Sr.Program Officer	DoPH, MoH
7	Hari Prasad Pokhrel	Sr.Nutritionist	Gidakom Hospital
8	Passang Lhamo	Assistant Professor	FNPH
9	Dr. Phillip Erbele	Assistant Professor/Pediatrician	FNPH
10	Dr. Indrani Chakma	Health & Nutrition Specialist	UNICEF
11	Thukten Penjor	Sr.Nutritionist	JDWNRH
12	Laigden Dzed	Dy.Chief Program Officer	NCDD, MoH
13	Loday Zangpo	Sr.Program Officer	NCDD, MoH
14	Tshewang Lhadon	Assistant Program Officer	LSRD, MoH
15	Dr. Chandra Lal Mongar	Health & Nutrition Officer	UNICEF
16	Watanabe Kozo	Chief Representative	JICA
17	Manasi Shukla	Consultant (food tech)	WFP
18	Gyem Bidha	Dy. Chief Regulatory Quality Officer	BAFRA
19	Tshering Penjor	Marketing Officer	DAMC, MoAF
20	Wangda Dukpa	Chief Agriculture Officer	DoA, MoAF
21	Sonam Choden	Dy. Chief Program Officer	DoFPS, MoAF
22	Ganga Maya Rizal	Dy. Chief FFO	DoL, MoAF
23	BB Rai	Head SAP	SAP, DoA
24	Ryo Namiki	Volunteer Coordinator	JICA
25	Tashi Yangzom	Dy. Chief Planning Officer	PPD, MoAF
26	Kinley Wangmo	Information Media Officer	PMO
27	Tobgay	C4D Specialist	UNICEF
28	Kencho Wangdi	National Professional Officer	WHO
29	Kuenzang Deki	Nutritionist	MoE
30	Kencho Wangmo	NPO	WFP
31	Namgay Thinley	Chief Agriculture Officer	MoAF
32	Choney Zangmo	Dy Chief Horticulture Officer	MoAF

33	Rinchen Wangmo	Sr. Agriculture Officer	MoAF
34	Sherab Dorji	Sr. Planning Officer	MoAF
35	Yeshi Jamtsho	Sr. Program Officer	OCP, MoEA
36	Rinchen Lhazom	Offing.DG	DoT, MoEA
37	Pema Khandu	Sr. TO	DoT, MoEA
38	Nidup Tshering	Sr.TO	DoT, MoEA
39	Lobzang	TO	DoT, MoEA
40	Sonam T Dorji	Chief Trade Officer	DoT, MoEA
41	Dr.Tulsi Ram Sharma	Pediatrician	JDWNRH
42	Namgay Thinley	Chief Agriculture Production Officer	MoAF
43	Choney Zangmo	Dy. Chief Horticulture Officer	MoAF
44	Rinchen Wangmo	Sr. Agriculture Officer	MoAF
45	Sherab Dorji	Sr. Planning Officer	MoAF
46	Kinley Wangchuk	Sr. Program Officer	DoPH, MoH
47	Dechen Yangden	Chief Engineer	MoWHS
48	Thinley Choden	Principal Engineer	MoWHS
49	Kubir Nath Bhattarai	Dy. CRQO	BAFRA
50	Vishal Chhetri	DCLO	RCDC

TERMS OF REFERENCE (TOR) FOR NNTF

1. Membership to the NNTF is based on official position and will be automatically transferred to the person assuming the position when an incumbent member is transferred.
2. The National Nutrition Task Force will meet every six months to review the implementation of nutrition related activities in the country.
3. The Nutrition program will inform the task force members at-least one week in advance regarding the meeting.
4. At least one-third of the members must be present for a sitting.
5. The task force may call for alternate members as required by the agenda from time to time.
6. The NNTF members will provide guidance to their respective agencies to discuss and push forward the nutrition agenda.
7. A detailed term of reference and responsibilities for each member will be discussed and finalized during the first sitting after the formation of the task force.

Director, DoPH (Chairperson)

- Provide directives and guidance to the NNTF.

Pediatrician (Technical Adviser)

- Provide technical guidance to the NNTF.

Chief Program Officer, School Health and Nutrition Division, Department of School Education, Ministry of Education

- Provide guidance to the Ministry of Education and school feeding program in particular.
- Act as a bridge between DSE, MoE and NNTF

Chief Agriculture Officer, Agriculture Production Division, Department of Agriculture, Ministry of Agriculture and Forests

- Provide technical backstopping to the NNTF on agricultural and bio-fortification and food fortification efforts in Bhutan.
- Act as a bridge between NNTF and DoA, MoAF.

Chief Livestock Officer, Livestock Production Division, Department of Livestock, Ministry of Agriculture and Forests

- Provide technical backstopping to the NNTF on livestock produce and ways to enhance nutrition and production.
- Act as a bridge between NNTF and DoL, MoAF.

Chief Engineer, Water and Sanitation Division, Department of Engineering, Ministry of Works and Human Settlement

- Promote and strengthen Water, Sanitation and Hygiene (WASH) as a part of infrastructure development in the country.
- Act as a bridge between NNTF and DoE, MoWHS.

Head, Food and Nutrition Laboratory, Royal Centre for Disease Control

- Provide technical backstoppings and reference laboratory for all nutrition activities requiring laboratory testing.

Representatives from development partners and non-governmental organization

- Provide technical and financial assistance to conduct nutrition related activities.

Other members to be co-opted as and when required

- The task force may call for alternate members / experts from time to time as required by the agenda.

Nutrition Program, DoPH, MoH (Secretariat to the NNTF)

- Convene NNTF meeting.
- Update the NNTF on nutrition situation in the country.
- Keep records of all the meetings, decisions made and follow up on the implementation of nutrition activities in the country.

World Health Organization
Bhutan

WFP
wfp.org
World Food Programme

unicef
for every child

Designed and Printed at Bhutan Printing Solutions (www.prints.bt)