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“The Impact of Health and Nutrition Programmes in the Participation of Vulnerable Groups in Economic, Social and political Life”

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The Impact of Health and Nutrition Programmes in the Participation of Vulnerable Groups in Economic, Social and Political Life – with Particular Relevance to Africa

I Introduction

Sustainable development requires the full participation of all people in economic, social and political life. Governments, civil society organizations and private sector must work together to build capacity, bridge gaps and ensure safety nets so that the most vulnerable and most marginalized are able to rise with the tide of investment that is intended to float all boats. Global indicators that monitor impact of these investments on human growth, dignity and full participation, guide policies and programmes, and indicate the floor for social protection. Indicators tend to be sectoral such as health and food security, although some, such as nutrition and gender equity are crosscutting and have emerged as indispensable to social and economic progress. But how far has this approach taken us and what has been overlooked? For example, will achievement of food security address the needs of the 25% of Burkinabe women between 15 and 19 years of age who are suffering from acute chronic energy deficiency (CED)? Food security does not equal nutritional security and bridging this gap must connect across health, agriculture and food security addressing cultural and political issues and with attending intersectoral interventions.

As we approach 2015 and plan for a post-MDG framework, silos simply will not achieve results. Intersectoral approaches are needed to address such issues as Africa’s burgeoning population explosion; the impact of climate change; particular challenges of stagnation in the Sahel, and more widely, pockets of stagnation that more closely resemble 1915 than 2015. Inclusive, layered, intersectoral approaches are required to enable countries to move beyond systemic failure and take advantage of global momentum.

Using the MDGs as a guide this paper evaluates how policies and programmes aimed at strengthening systems of health and nutrition have contributed to empowering excluded and disadvantaged groups and what is required to address problems such as those outlined above. The paper addresses two major gaps: Nutrition, recently described by the Lancet Series as “a quintessential sustainable development goal;” and Reproductive Health and Rights. About the latter, The African Union Commission (AUC) Sexual and Reproductive Health Rights: Continental Health Framework (SRHR)indicates that “the most important objective” of the International Conference on Population and Development/Plan of Action (ICPD/PoA) - universal access to reproductive health services by 2015 has been overlooked in the MDGs. This resulted in a “decade of relative neglect.” UNDESA, Population Division projects a population explosion in Africa where the population of Africa will quadruple over the next 90 years growing at a factor of 5.18, more than twice the 2.4 projected in the AUC report. Even with appropriate interventions, given 2013 projections in 25 year most of Africa’s families will still have an estimate of 4 children, Niger is projected to have an average fertility rate of 7 and Mali 6. Nigeria, already the most populous country in Africa will increase its population by a factor of 8.

Finally, this paper evaluates the question: “is social protection empowering?” And provides examples of where and how social protection has created conditions for the participation of excluded and disadvantaged groups. Data will focus disproportionately on Africa because some of the primary health and under-nutrition indicators and threats to development continue to be off-the-chart in Africa:

2 World Population Prospects: The 2012 Revision
4 Sexual and Reproductive Health Rights: Continental Health Framework. African Union Commission,
HIV/AIDS prevalence, nutritional deficiency, maternal mortality and morbidity, infant and child mortality, lack of access to potable water in rural household, population growth and marginalization of large numbers of vulnerable populations including orphans and vulnerable children, those with disabilities, the elderly and post-conflict youth.

II MDGs 4, 5 and 6 – How far have we come?

MDG’s 4, 5, and 6 focus directly on health indicators that enable the monitoring of development progress. MDG 4 to reduce child mortality, MDG 5 to improve maternal health and MDG 6 to combat HIV/AIDS, malaria and other diseases have all shown significant process since 2000.

This progress includes reduction in global maternal mortality (MM) rates between 1990 and 2010. Africa led the world with 850/100,000 in 1990. Although still leading the world at 500/100,000 in 2010, Africa has shown a 42% decline on average. Countries such as Chad still have a MM rate of over 900/100,000. Africa’s Current low is almost as high as the world’s second highest rate – Southern Asia which in 1990 had a ratio of 590/100,000, reduced to 220/100,000 in 2010. As an African woman has a one-in-39 lifetime risk of dying from pregnancy and delivery-related complications compared to 1 in 4000 in developed countries, Africa’s gains still leaves a long way to realize the AU position that “Africa Cares: No woman should die while giving life.”

In 2009, with roadmaps and strategic health development plans, 37 African countries operationalized an attack on maternal mortality with the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) to reduce MM rates by 75% (of 1990 statistics) by 2015. The initiatives were launched across Africa in 2010. Many countries implemented CARMMA as Campaign on Accelerated Reduction of Maternal, New Born and Child Mortality in Africa. CARMMA accelerated the 2006 Maputo Plan of Action where 48 African countries declared a woman’s right to health and pledged to curb maternal mortality and promote Sexual and Reproductive Health Rights (SRHR).

Because the MDGs do not explicitly articulate the most significant objective of the ICPD/PoA - universal access to reproductive health services by 2015, in 2002 UN Secretary General, Kofi Annan set up a Reproductive Health Task Force to advise his office on the implementation of the MDGs and emphasized -that the MDGs could not be met without addressing questions of population and reproductive health.

In Africa, health systems are inadequate or non-functioning in most countries, The Maputo Plan of Action calls this an indication of the low priority given to the wellbeing of people and to the fundamental right to health. The AU blames the vertically organized health systems inherited from the colonial era as an obstacle to a more integrated approach to health and to adoption of the ICPD/PoA. To address the low implementation of ICPD/PoA and the continued unmet needs of women and their families across Africa, and to advance the Maputo Plan commitments, the AU supported by the International Planned Parenthood Federation Africa Regional Office (IPPF/AFRO) and UNFPA initiated 6 subregional meetings between 2004 and 2005 and developed the SRHR framework across 10 issues: demographic, maternal mortality and morbidity, infant and child mortality, unsafe abortion, contraception, Female Genital Mutilation (FGM), adolescent health, STDs and HIV/AIDS, domestic violence, low allocation of national budgets (Table 1 below).

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7 [http://pages.au.int/carmma](http://pages.au.int/carmma) (accessed 8/30/13)


9 [http://pages.au.int/sites/default/files/SRHR%20English_0.pdf](http://pages.au.int/sites/default/files/SRHR%20English_0.pdf) (accessed 8/30/13)
Table 1 - Findings from 6 African Subregional SRHR Meetings 2004-2005

<table>
<thead>
<tr>
<th>Issue</th>
<th>Africa Average</th>
<th>Africa High</th>
<th>Africa low</th>
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<tbody>
<tr>
<td>Demographic Situation*</td>
<td>38 births/ 14 deaths per 1,000</td>
<td>Births 51/1000: Malawi</td>
<td>Births 16/1000: Mauritius</td>
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<tr>
<td></td>
<td>natural increase (NI) of 2.4%</td>
<td>Deaths 29/1000: Sierra Leone</td>
<td>Deaths 4/1000: Algeria</td>
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<tr>
<td></td>
<td>Estimated average Total</td>
<td>NI: Niger and Comoros – 3.5%</td>
<td>NI: Botswana – 0.1%</td>
</tr>
<tr>
<td>Fertility Rates (TFR): 5.1***</td>
<td></td>
<td>Niger TFR: 8</td>
<td>Mauritius TFR: 1.9</td>
</tr>
<tr>
<td>Maternal Mortality and Mobility</td>
<td>Average maternal deaths 400/</td>
<td>Chad and Somalia:</td>
<td>Mauritius: 36/100,000***</td>
</tr>
<tr>
<td></td>
<td>100,000 live births***</td>
<td>1200/100,000)***</td>
<td></td>
</tr>
<tr>
<td>Infant and Child Mortality (under 5 years)</td>
<td>Infant mortality: 88.5/1000 for</td>
<td>Infant Mortality: 177/1000 live</td>
<td>Infant mortality 16/1000 live</td>
</tr>
<tr>
<td></td>
<td>the period 2000-2004</td>
<td>births- Sierra Leone</td>
<td>births- Mauritius &gt;5 year mortality: 52 per 1,000 live births among the richest fifth of the population of Ghana.</td>
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<tr>
<td></td>
<td>(96/1000 for SSA)</td>
<td>&gt;5 year mortality 282 per 1,000 live births among the poorest fifth of the population of Niger</td>
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<td></td>
<td>Child mortality: 148.4 for the</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>period 2000-2004****</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Use (modern)#*</td>
<td>Modern contraceptive use 28% in</td>
<td>Modern contraceptive use: Mauritius (76%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Africa (21% in Sub-Saharan Africa)</td>
<td></td>
<td></td>
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<tr>
<td>Unsafe Abortions</td>
<td>Prevalent and accounting for a</td>
<td>Eritrea estimated 40%</td>
<td>West Africa regional meeting</td>
</tr>
<tr>
<td></td>
<td>significant % of maternal mortality</td>
<td></td>
<td>estimated 13%</td>
</tr>
<tr>
<td>STDs+ HIV/AIDS</td>
<td>HIV/AIDS: 38% in Swaziland</td>
<td>HIV/AIDS: 2% in Madagascar</td>
<td></td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>widely practiced in most ECOWAS and some African Arab countries. A frequency of 80 – 90%</td>
<td>FGM: 89% in Eritrea</td>
<td>FGM: 10% in DRC</td>
</tr>
<tr>
<td>Sexual and Domestic Violence</td>
<td>Prevalent and under-reported due to socio-cultural reasons and to the legal vacuum surrounding this issue.</td>
<td>Maputo Plan 5-yr Review reports that n much of Africa, annual health expenditure is less than US$30 per person</td>
<td></td>
</tr>
<tr>
<td>Health budget Allocation</td>
<td>Inadequate across all regions</td>
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</tbody>
</table>

**TFR estimated at 5.1 results in total estimated population in Africa of 885 million and is expected to reach 1,323 million in 2025 and 1,941 million in 2050. The projected population change between 2004 and 2050 is 119% in Africa in general and 132% in Sub-Saharan Africa.
*** Subregional meetings reported number. If PRB 2008 data is used, maternal mortality average for Sub-Sahara Africa is approx. 571/100,000 live births in 2008. PRB: The World's Women and Girls 2011 Data Sheet (2008 data). Africa accounts for 165,000 or 57.5 per cent of the global estimate of 287,000 women who die each year from pregnancy and delivery-related complications. Inspite of progress the maternal mortality ratio between developed and developing countries remain the “widest disparity in all of statistics of public health” - 240 deaths per 100,000 live birth in developing countries, 15X higher than in developed countries (Grepin and Klugman)
****45 African countries have not met the goal of lowering child mortality rates to less than 70 deaths per 1,000 live births by year 2000.
#### Only 11% of those infected with AIDS in Africa have access to anti-retroviral therapy (as opposed to 62% in Latin America and 14% in Asia). About twice as many young women as men are infected with HIV in sub-Saharan Africa - In 2001, it was estimated that 6% to 11% of young women were living with HIV/AIDS, compared to 3% to 6% of young men.
##### Maputo Plan Review indicates children under age 15 constitute 41.2 per cent of the population. Children and youth aged 30 and below constitute over 70 per cent of the continent’s total population (UN World Population Prospects – 2008 Revision). Adolescents and young people aged 15-19 are at risk of early and unwanted pregnancy leading to unsafe abortion, sexually transmitted diseases and dropping out of school. The UN Population Division estimates that 51% of African girls and 90% of African boys sexually active by the age 20 initiated sexual activity before marriage. Child marriage data was not reported by the SRHR Report nor was a goal set to reduce child marriage.
III MDG 1 – Freedom from Hunger and Hidden Hunger

If MDG 1 had called for the eradication of extreme poverty, hunger and hidden hunger (micronutrient deficiency), access to nutritious food might have been stated as a right combining freedom from hunger and the right to health. India and China are on course to meet MDG 1 even though UNICEF reports that 221 million people in India and 142 million in China are still chronically or acutely malnourished. On the other hand, Insipe of significant investments in increased food production Sub-Sahara Africa with 204 million hungry is the only region of the world where hunger is increasing. Undernutrition in Sub-Saharan Africa is also increasing resulting micro nutrient deficiency contributes to weak immune systems and impaired physical and mental development in children. 20 of the top 25 micronutrient deficient countries are in Africa with Niger having the highest rate out of all countries. As an intersectoral issue, nutrition has been neglected and, like other crosscutting issues it suffers from lack of ownership, research, replication of innovations and investment of scarce resources. Yet, other MDGs, health, education and workforce participation will be compromised by wasting and stunting along with diseases relating to Protein Energy Malnutrition (PEM) and Chronic Energy Deficiency (CED). Failure to work at the intersections will miss critical connections for intersectoral behavior change communication to prioritize advocacy on issues such as child spacing. Recent research has shown that short child space with poor nutrition often results in low energy replenishment and poor maternal outcomes.

The 2011 Maputo Plan 5-year Review report argues that “food security in Africa is worse than it was in 1970” and that the proportion of the Sub-Saharan population that is malnourished has remained within the 33–35 per cent range with over 70 per cent of the food insecure populations on the continent living in rural areas.” The report indicated that nutrient deficiency negatively impacts efforts to improve maternal and child health and survival and results in irreversible physical and intellectual stunting.

This growing awareness that food must build resilience through nutritional content – particularly iron, vitamin A, zinc, folic acid, riboflavin, iodine and Vitamin has given rise to innovative “pull strategies” for changing consumer preference for biofortified foods such as orange maize. It created new donor attention to nutrition through programs such as Scaling Up Nutrition (SUN) aimed at increasing resources available for coherent, aligned approaches, and the REACH framework that promotes global advocacy, knowledge sharing, partnerships and monitoring and evaluation of programs attempting to achieve nutritional security. These global programs are enabling nutrition to create bridges between agriculture, food security and health and traditional practices blended with technological innovation. Universally accepted is the focus on the first 1000 days of a child’s life as the most important investment window. This brings renewed commitment to

A young African woman typically in the age range of 15-19 years is the face of Chronic Energy Deficiency (CED)

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14 Micronutrient Initiative. www.micronutrient.org/ (accessed 8/30/13)
promoting exclusive breastfeeding for the first 6 months as important for the child’s protection and micronutrient access, with the provision of supplementation beyond that as critical for the child’s health. In May, 2012 WHO which called nutrition “a foundation for health” launched the Global Nutrition for Growth Compact at its World Health Assembly. 90 stakeholders including governments, donor agencies, scientific and civil society and private sector signed the compact to reduce stunting of 20 million children by 2025. This compact will save 1.7 million lives.

**Nutrition on the Agenda** “The international nutrition system – made up of international donor organizations, academia, civil society and the private sector – is fragmented and dysfunctional” S. Morris et. Al. (Lancet, 2008)

In 2008 *The Lancet* published a series on undernutrition which the World Health organization claimed catalyzed the international community. The Maternal and Child Nutrition Study Group (MCNSG) of the Johns Hopkins Bloomberg School of Public Health made significant contributions to *The Lancet* series and has been at the forefront of nutrition research and finding solutions to undernutrition and its impacts. They developed a life cycle protocol for the delivery of evidence-based interventions and delivery platforms for prevention and treatment of undernutrition applicable to 34 countries (budget of US$9.6 billion annually) across Africa, Asia and the Middle East. This area represents 90% of the global occurrence of undernutrition. Within three years of *The Lancet*’s 2008 series, funding for nutrition increased from US$259 million to US$412 million in 2011 peaking at US$541 in 2009. June 2013, through a second *Lancet* series the MCNSG presented new data on the effect of undernutrition on the health and mortality of children positing 45% of child deaths in 2011 and 3.1 million children under 5 years die every year from undernutrition. They confirmed the relationship between adolescent girls, undernutrition and CED and low birth babies (fetal growth restriction) and maternal undernutrition.

In addition to expanding the quality and coverage of nutrition-specific interventions, the MCNSG developed a framework for preserving the political momentum evidenced by the global trend of systemic approaches as well as maximizing “nutrition sensitivity of more distal interventions” that includes related sectors of agriculture, social protection, food security and water and sanitation(WASH) and macro-level drivers that affect undernutrition reduction such as climate change, trade and food price patterns. Drawing on other studies, MCNSG found that although household income growth was necessary it was not sufficient as a predictor of undernutrition reduction. They identified four other factors that were necessary: secondary education for girls, fertility rate reduction, household asset accumulation and access to healthcare services.

The political and policy environment that would facilitate changes at national and local levels requires the support of international actors – support represented by the complex of global initiatives and donor support described in this section.

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In June, 2013, the Africa Union launched the Zero Hunger initiative. In order for this initiative to be successful it must be owned by national governments. Success stories in nutrition thrive at the national level with leadership commitment such as occurred in Guatemala recently and in Brazil before that. Like their commitment to CARMMA to fight maternal mortality, African governments must move beyond calls to action and commit to ending Hunger and to undernutrition reduction. They must commit to SUN (currently the 100+ commitments to SUN are primarily among civil society organizations). The 2013 Lancet articles recommend embedding nutrition indicators in child survival projects, integrating nutrition programs into national health systems with application by local government structures and tracking spending on nutrition in non-nutrition projects while ensuring that nutrition funding is indeed spent on undernutrition reduction.

As the post-2015 development agenda takes shape, undernutrition emerges as a collective action problem. It is described as the “quintessential” example of a sustainable development objective and will require champions and leadership as well as increased investment for both nutrition specific and nutrition-sensitive programmes.19

Major donors’ new lens on nutrition and development "Over the past few decades, we have learned the real cost of hidden hunger and undernutrition, which leads to more child deaths every year than any other disease. President Obama has made nutrition a central pillar of Feed the Future. Over the next five years, we will reduce stunting by 20 percent - which means that 2 million fewer children will suffer from this devastating condition. “ - USAID Administrator Rajiv Shah, Feed the Future Progress Report Launch Event, July 25, 2013

Promises not-withstanding, only a fraction of pledged official development assistance actually materializes. Yet, there is a different sort of promise in North – South donor agendas such as Feed the Future which applies a nutrition-sensitive lens to development programming putting building local capacity for under nutrition reduction at the fore. USAID through its Joint Planning Cell initiative REGIS (Resilience and Economic Growth in the Sahel) and The EU-led Global Alliance for Resilience Initiative (AGIR) are teaming up in a strategy to layer, sequence and coordinate interventions working with AU-led Zero Hunger initiative and national nutrition plans such as Niger’s 3Ns - to address the chronic indicators of undernutrition and food insecurity beginning in one of the most vulnerable neighborhoods - the Sahel. officially launched in December 2012 both AGIR and REGIS use a resilience framework to sustainably intensify agriculture, increase fortified foods and protein value chains, increase small scale farmer capacity, livelihoods and access to markets and technology through long and short term vertically and horizontally linked strategies and put women at the center of it all.

Given the issues covered in this paper, donor governments will do well to integrate family planning components (education, behavior change communication, referrals, services) into food security and nutrition programs and vice versa. For success of such integrated programs care must be taken to include men and influencers such as mothers-in-law.20

IV Gender Equality, Empowerment of Women and the Bonus Demographic Window

Africa’s must position itself to take advantage of its demographic window before the expected population explosion. The work force boom of a “larger, healthier, working-age population”21 (provided

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unemployment is low and women increase rates of secondary education and part of the workforce) will depend on how governments plan and enable its population to plan – contraception, education and infrastructure. A generation with more productive workers and fewer dependent children and relatively fewer dependent elderly can result in a window of high productivity, increased savings, economic growth and well being – if this dividend is not squandered, fertility rates are managed and infrastructure is put in place, the payoff can enable takeoff for Africa. Europe (1950 to 2000), China (1990 and expected to last until 2015), India (began 2010) have benefited from the demographic window and other countries such as Egypt are positioning themselves for that bonus. UNFPA data projects this boom for 11 African countries to occur between 2040 and 2050. African leaders must invest in the now widely accepted knowledge that gender equality can turbocharge development and help position Africa for the demographic dividend. Africa will not be able to enjoy a dividend if women are not educated and do not have full access to good-paying jobs and opportunities for sustainable enterprises in the formal sector.

Projections of unprecedented population growth in Africa, plus UNFPA’s determination based on analysis of household surveys of a demand for contraception from 220 million women in poor countries has mobilized donors including the British government, the Bill & Melinda Gates Foundation, and other governmental and nonprofit organizations that met in London last year to reinvigorate the effort to provide contraceptives to women who want them. They are developing plans to reach 120 million women who don’t have access to contraceptives by the year 2020.

Life expectancy in Africa has increased from 39 years in 1955 to 54 years in 2010 (68 years for North Africa and 51.6 for Sub-Sahara Africa). In 1995 Average life expectancy climbed as high as 61 years but was severely impacted by AIDS-related mortality - a significant reversal of gains in health, including reproductive health.

**IV Social Protection – the right to a floor** Social protection refers to processes, policies and interventions, and entities (such as the government, private sector and civil society) who respond to the economic, political, and security risks faced by a region’s population, particularly those categorized as the poor and vulnerable (Suharto, 2007).

Human dignity requires a floor. “a floor of social protection, is thus a perquisite investment in the empowerment of people.” Cichon M., Dir. of Social Security Department BIT (ILO), Geneva (2013)

In this paper we have referred to workings of systems to ensure delivery of various development functions and to include social protection for the most vulnerable. Recognizing that Social Protection and Labor systems represent a society’s social contract with its people and thus is rooted in local context, there are

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22 Grepin & Klugman. Closing the Deadly Gap Between What we Know and What We Do” 2012 World Development Report
23 The report of the 15-year review of the implementation of the ICPD in Africa 1994–2009 (ICPD+15, UNECA et al., 2009)
vast differences between what presents as systems of social protection in the developing vs that of developed countries. In the former they often are not “systems” as they operate from end-to-end with little coordination or coherence (developed countries may also lack coherence by implementing programs in silos). While this coherence is indicative of development, at the same time, it is required for development. Many African countries are aggressively pursuing working with international mechanisms to rebuild its basic health systems. In the meantime functions that belong to “systems” have been provided by international agencies through emergency relief and recovery programs using mechanisms such as Conditional Cash Transfer (CCT) vehicles. CCT can improve access to better nutrition, healthcare and education for families and in optimal when governments invest in systems CCT can be very efficient when it links payments to family investments in education and healthcare.

Economic and social development requires an enabling environment that is the result of coordination at 3 levels: policy, program and administrative (Robalino et al.). This includes the commitment of private and public actors and the mobilization, education and full participation of communities, households and individuals. It involves mechanisms for the mitigation of barriers for all who must overcome limiting conditions that prevent full participation. Without this mitigation of barriers the policies, practices and tools and systems that result from coordination leave vast numbers of vulnerable groups behind. Development requires full participation of vulnerable groups in economic and social development. They must be enabled: whether a young woman married at 14 and suffering from micronutrient depletion; a orphan affected by HIV-AIDS; a pregnant woman without resources; a child under 2; an elderly man with a disability; an excombatant drafted to war at 12 – retired at 16; a family displaced by that war.

In June 2012 the International Labor Conference with delegations from more than 180 countries unanimously adopted a new legal international instrument that calls for national floors for social protection. This is described in Recommendation 202. In developing national applications African governments may examine such polices as the Mahatma Gandhi National Rural Employment Guarantee Act of 2005 which has lifted 52.5 million Indian households out of poverty between 2009-2010 by guaranteeing poor rural households at least 100 days of minimum wage employment – or equivalent unemployment payments. While household benefit social infrastructure such public goods such as water harvesting and conservation systems were created.

V Conclusion

The MDG goals are tied to each other and failure to reduce child mortality or improve maternal is an indication of failure to meet other goals such as promoting gender equality and empowerment of women. Although not dealt with in this paper significant strides has been made in combating HIV/AIDS and the goal of zero mother to child transmission in childbirth and with Africa responsible for 90% of malaria prevalence there is progress toward the zero number of deaths goal due to Malaria. What has been established is that real progress on any of the MDGs is compromised unless undernutrition and its effects on weakened immune systems is addressed. National commitment and leadership must invite

25 SRHR: AUC.
collaboration from private sector and civil society to implement highly integrated programs such as expanding resilience frameworks to address women’s agency by integrating reproductive health and rights components into agriculture, food security and nutrition programs; leveraging zero hunger initiatives with zero hidden hunger approaches to improve fortification, agricultural innovation, system coordination; improve household incomes and formal sector participation through enterprise development, good jobs, skill building; slow down population explosion and prepare to capitalize on the demographic window as the dependence ratio falls; building a floor of social protection for the most vulnerable.