

APPENDIX 1

PROFILES OF SOME COMMUNITY-BASED NUTRITION INTERVENTIONS IN ASIAN COUNTRIES, FROM THE ASIAN DEVELOPMENT BANK REGIONAL TECHNICAL ASSISTANCE (RETA) PROJECT 5671 ON “INVESTING IN CHILD NUTRITION IN ASIA” AND OTHER RELEVANT PROJECTS AND STUDIES

Summary details are given here, by country, of some recent and ongoing nutrition-related programmes in Asia.

BANGLADESH

The Government of Bangladesh implements several programmes which aim to address undernutrition. The Bangladesh Integrated Nutrition Project (BINP), which started in 1996 and planned to cover 40 rural thanas by 2000 (i.e., 8 million population or 8.6% of total rural *thanas*), is the only community-based nutrition project in the country. The BINP is implemented by the Ministry of Health and Family Welfare (MOHFW) with financial assistance from the World Bank and technical assistance from UNICEF. It has three major components: national level nutrition activities, such as strengthening of existing nutrition activities, information, education and communication, programme development and institution building; community-based nutrition (CBNC); and intersectoral nutrition programme development.

The CBNC addresses protein energy undernutrition, LBW and micronutrient deficiency. PEM is addressed: in the short run, through supplementary feeding to growth faltering and severely malnourished children; and in the long run, through behavioural changes related to the major problems of caring (for example, low levels of exclusive breastfeeding, delayed complementary feeding, and inadequate maternal nutrition during

pregnancy) and through improved food security from intersectoral subprojects. The BINP attempts to address LBW directly, and the increased likelihood of infant mortality and morbidity associated with it, by providing pregnant women with the calories needed for proper weight gain during pregnancy. Micronutrient deficiency is combated through supplementing pregnant women with iron and folic acid, by motivating families to consume iodized salt, and by providing mothers with vitamin A capsules within two weeks of delivery.

The CBNC operates through Community Nutrition Centres (CNCs) which are each staffed by one volunteer Community Nutrition Promoter (CNP) who, with the help of an assistant, provides nutrition counselling, conducts growth monitoring and oversees feeding of infants and women. At present there are two ratios of CNCs to population: in one-half of the project, one CNC to 1,000 persons and in the other half, one CNC to 1,500 persons.

The CNPs report to Community Nutrition Organizers (CNOs) each of whom oversees 10 CNPs. CNOs in turn report to the thana manager who coordinates all BINP activities within the thana. At the central level, the project is administered through a Project Director, Deputy Project Directors for Management Information Systems, Training, IEC, and Administration, along with national consultants for MIS and Programme, Training, IEC, and Intersectoral Activities. At the village, union, thana, and national levels, Nutrition Management Committees, comprising community leaders and representatives of related sectors (e.g., health, agriculture), provide inputs to project activities.

The BINP uses the food-health-care conceptual framework of the causes of undernutrition. The CBNC activities address caring practices directly and the intersectoral component BINP component contributes to food security, but there is no direct BINP activity concerned with health care. The BINP activities are designed and planned for rural areas only.

Among other programmes in Bangladesh, the Campaign for Promotion and Protection of Breastfeeding, Nutritional Blindness Prevention Programme, Antenatal and Postnatal Care, Expanded Programme on Immunization (EPI), Family Planning, Control of Diarrhoeal Diseases, Control of Acute Respiratory Infection, and Water and Sanitation relate to nutrition service delivery and are supported by the Ministry of Health and Family Welfare (MOHFW). The Vulnerable Group Development Programme, Rural Development Project, and Micro Credit programmes that all relate to 'social safety net' initiatives, are managed by other government sectors and NGOs.

The MOHFW is responsible for providing health services in rural areas and has a well established organizational structure down to the village level. The Ministry of Local Government, Rural Development and Cooperatives has responsibility for delivering health services in urban areas, where 20% of the population live. Urban health care delivery is relatively less organized, and most of the services are provided by NGOs and the private sector.

The government service delivery programmes are vertical. Except for the EPI, the utilization rates of the programmes are poor: mainly due to inadequate mobilization, communication and service quality which, in turn, are due to nonavailability of sufficient quantities of drugs and lack of trained manpower. The nutrition effects of these programmes are further limited by their poor nutrition focus.

CAMBODIA

In Cambodia, programmes with nutrition components are limited in scope and scale and uncoordinated, with nutrition not articulated explicitly as an outcome. The one exception is the UNICEF-assisted Community Action for Social Development (CASD) programme which is integrative, large scale and has an explicit nutrition goal. The CASD programme supports the establishment of village development committees (VDCs), as instruments for community development. In 1998, 552 villages in 8 provinces had VDCs. The model used by the CASD derives from UNICEF's global experience with integrated, community-based

programmes and the holistic UNICEF Nutrition Strategy. The CASD is a cross-sectoral programme, implemented with support from several ministries, notably the Ministries of Planning, Rural Development, Women Affairs, Agriculture, Education, Health, and Interior (in charge of local government). The focus is on enhancing community capacity by working towards basic social goals, through VDCs, civic organizations, and NGOs. This process of "building from below" is supported by national, provincial, district and commune structures of government in the relevant ministries. The process of VDC formation, through a gender-sensitive, free and fair election, and the training of VDC members, was adopted as the model approach by the Ministry of Rural Development in 1997. The development of Village Action Plans (VAPs) through which services are delivered, makes the approach demand driven.

The CASD Programme, with an annual budget of US\$ 4 million for the period 1996-2000, uses nutrition as the outcome indicator and has six components: Capacity Building; Community Education and Care; Food, Water and Environment; Health, Hygiene and Care; Protection of Vulnerable Children and Women; and Credit, Employment and Income. Together, these address the three main food-, health- and care-related determinants of nutrition. The UNICEF-supported Multiple Indicator Cluster Survey (MICS), first conducted in 1996, provides a foundation for a national level, nutrition information database.

Regarding other relevant programmes in Cambodia, the United Nations Development Programme (UNDP) supports the CAREERE programme, which is similar in concept to the CASD programme, in five provinces covering 380 villages. The EU-sponsored PRASAC programmes work with more than 600 VDCs. The Basic Health Services Project, initiated in 1996 and supported by the ADB, aims to strengthen the basic health care system as well as to improve management capacity in five provinces which lack a basic health care system. Numerous international and local NGOs are also working at the village level in community development.

Numerous donor-financed investment programmes are addressing the issue of household-level food security. The World Food Programme provides major support to the Rural Development Ministry for an extensive, national 'food-for-work' programme. The Australian development agency AusAID is actively engaged in developing agricultural extension programmes for small farmer support. The World Bank supports the strengthening of the central Agriculture and Rural Development Ministries, with a large social funds project, and is

in the process of developing an integrated rural development initiative for neglected areas. The ADB supports programmes in agriculture and rural development that include rural roads, small irrigation development, employment generation and microcredit.

Programmes to address care and health considerations are more diffuse. As the health care system is being rebuilt, much of the emphasis of donor-assisted programmes is on communicable disease prevention and control, combined with strengthening the Central Health Ministry. NGOs support a wide variety of health and integrated programmes but these have not yet been systematically reviewed for lessons learned. Maternal and child feeding and nutrition practices are being addressed largely through UNICEF and NGO programmes.

With regard to micronutrients, universal salt iodization (USI) was expected by end of 1998, through UNICEF, Helen Keller International and United States Agency for International Development (USAID) support with substantial funding from the Canadian International Development Agency (CIDA), (through the Micronutrient Initiative), Kiwanis International, and the US National Committee for UNICEF. The only component of a national VAD control programme is vitamin A capsule distribution, supported since 1995 by UNICEF and HKI and linked to National Immunization Days (NIDs). Regarding IDA, it is reported that all health units have iron and folate supplements available as part of their minimum package of services. However, there is no specific information regarding the use of such supplements.

All nutrition-specific interventions are thus supported by, and largely driven by, agencies and/or NGOs. Moreover, the human and organizational resources provided by the government for such programmes cannot operate without external assistance. Current and future nutrition-relevant programmes need to be coordinated in order to improve complementarity, share experiences and lessons and develop best practices. The ADB's RETA 5671 country report argued that a community-based strategy, supported by national level strategies, offers the best basis for progressive and sustained nutrition improvement in Cambodia. In order to achieve the overall national nutrition objectives of the National Nutrition Plan of Action (NNPA), the strategy should be to move the current small scale, community-based programmes that have nutrition-relevance to a larger scale.

PEOPLE'S REPUBLIC OF CHINA

The health care system is the most prominent organization involved in the delivery of direct nutrition programmes in the PRC, and it is in a state of transition. Prior to the 1980s, it was one of the most progressive and effective health care systems in the world, achieving basic health outcomes at low cost. Since the 1980s, however, following economic reform measures, the rural health service delivery system has disintegrated. A lack of coordination of health programmes, coupled with escalating health care costs, has caused a crisis here in health care. Duplication of services strains government health budgets. Competition between maternal and health services and the vertical family planning programme, together with distinct western and traditional medical facilities, have resulted in inefficient resource allocation and poorly coordinated services.

Nevertheless, the health infrastructure in the PRC remains one of the most impressive in the world and the government is in the process of adopting major health system reforms, including: revitalization of community financing schemes; increased public financing of public health interventions; development of regional planning models; and improved health care pricing policies.

Direct nutrition programmes comprise both vertical and community-based programmes. Vertical programmes include the Baby-Friendly Hospital Initiative (BFHI) supported by UNICEF and now covering over 6,700 hospitals, and the National IDD Elimination Programme (NIDDEP), co-financed by the World Bank, UNICEF and UNDP since 1993. The main elements of the NIDDEP comprise: establishment of a multisectoral organization and management framework; revision, promulgation and implementation of relevant legislation; salt iodization and distribution; iodized oil supplementation to remote areas; and mechanisms for training, monitoring and evaluation. By 1994, a law mandating nationwide salt iodization was in place. By 1997, iodized salt coverage was over 80% in 23 provinces and autonomous regions and iodine content of the salt was adequate in 16 of 31 provinces.

For more than a decade, UNICEF and the Government of the PRC have developed jointly an area-based approach to nutrition problems. During the period 1985-1989, commune level programmes were introduced to 18 rural townships in seven provinces. A key management strategy for this project was the establishment of township and county committees, to manage activities related to nutrition. More than 11,000

field workers were trained during the five-year period. Intervention components focused on: promotion of home gardening and animal husbandry; nutrition communications, emphasizing breastfeeding and complementary feeding practices; disease prevention and management; anaemia control, through iron supplementation of pregnant women; and fortification of foods. In 1990, an enhanced, community-based, Child Nutrition Surveillance and Intervention Programme was initiated. This covered more than 120,000 preschool children, in 700 villages within 101 poor rural counties. A subsequent evaluation showed reduced levels of anaemia and stunting and made recommendations for management; e.g., the need to strengthen further local organizational capacity.

INDIA

The most important national nutrition programmes in India are the Integrated Child Development Services Programme (ICDS), the Targeted Public Distribution System (TPDS), food-for-work, the National Mid-Day Meals Programme (NMMP), and micronutrient (iron-folate and vitamin A distribution, and salt iodization) schemes. These programmes aim to address significant segments of India's undernourished population: poor households, through the TPDS and employment schemes; young children and mothers, through the ICDS and health efforts; and school children through the NMMP.

The ICDS provides six services for 0- to 6-year-old children and mothers: supplementary feeding; immunization against the preventable diseases of childhood; health check-ups and referral; health and nutrition education to adult women; and preschool education to 3 to 6 year-olds. Although the 0-6-year-old population in areas covered by the ICDS is already 63 million, and the population of pregnant and lactating women is 13.6 million, only 30 million children and 5.2 million mothers are actually covered by the supplementary feeding, and 15 million 3-6 year-olds by preschool education. Coverage figures are not available for the other services. The ICDS also includes, in fewer than 10% of the, 4,200 programme blocks, schemes for adolescent girls' nutrition, health, awareness and skill development. In some areas, it has also been linked with women's income generating programmes. All ICDS services are delivered through a village centre, the *anganwadi*, by a trained village woman who is assisted periodically in the health tasks by an Auxiliary Nurse Midwife (ANM) from the health subcentre.

The ICDS is targeted at poor areas and increasingly at poor households, largely as a result of self-targeting rather than design at poor households.

Programme guidelines call for the food supplements (which are limited to 40% of the expected beneficiary population of an *anganwadi*) to be given preferentially to children and pregnant women from households at high risk of malnutrition: those of landless labourers, marginal farmers, scheduled castes or tribes. The adolescent girls' and women's programmes are intended to improve health and nutrition over the longer term through improvements in the roles of women.

Evaluations of the ICDS have found its impact on nutrition status to be limited. Among the reasons for this are: inadequate coverage of children below 3 years of age and at greatest risk of undernutrition, and of women and children living in hamlets; irregular food supply, irregular feeding and inadequate rations; poor nutrition education of mothers or families, to encourage improved feeding practices in the home and other relevant behavioural changes; inadequate training of workers, particularly in nutrition, growth monitoring, and communication; *anganwadi* worker (AGW) overload, and weak and unsupportive supervision of the AGW, resulting in the neglect of crucial nutrition-related tasks the mobilizer/community ratio of around one per 200 families is grossly inadequate; top-down management; lack of community ownership, particularly women's participation; and poor linkages between the ICDS and the health system.

In general, the quality of ICDS services has been low. Although the services are much in demand, they have been generally poorly delivered and uncoordinated. Worker training, in-service supervision, community support, and indeed community involvement in any sense; remain major gaps. Although there are exceptions, *anganwadi* facilities and environments are sorely inadequate and the programme does not inspire the good health, hygiene and nutrition-related behaviour that is so essential to changing the status of children and women in poor households. To make a significant impact on nutrition and health, a great number of changes are needed in the ICDS.

With regard to household food security, both national and state governments have made substantial efforts in designing and implementing food distribution and nonfood programmes to ensure household food security. However, IEC was found to be the weakest link in most of these programmes. The limited involvement, if any, of the community in programme design and implementation was the major cause for poor community response and lack of ownership.

Multiplicity and frequent changes in programmes to alleviate poverty have created confusion, making

their monitoring difficult. Poor targeting of poverty alleviation programmes, with consequent substantial wastage of scarce resources, is the major area of concern. Many evaluations indicate that the poorer sections of the society could not benefit much from the safety net provided by the Public Distribution System (PDS). The PDS has been fraught with problems of leakages and with inefficiencies in storage and distribution, particularly in poorer states where undernutrition is very high. Only 22% of the total expenditure on PDS was estimated to reach the poorer sections of society, defeating the basic purpose of this safety net. The revamped TPDS, launched in 1992, has not managed to overcome these constraints.

The NMMP has the dual objective of improving both school attendance and child nutrition. It has had more success with the former, which is not surprising considering that the age group targeted is older than those who would benefit most readily in terms of growth. Progress with the micronutrient deficiency control efforts has been patchy: little success with anaemia control, some success with VAD control, and definite progress with salt iodization and IDD control.

PAKISTAN

Pakistan has community-based and service delivery programmes, designed to improve child and maternal nutrition directly, and programmes with components to improve nutrition. The community-based programmes provide nutrition-related services to mothers and children in the community. Service delivery programmes may provide nutrition services in the community, but they may also be centered at institutions outside the community, such as hospitals, or may deliver a service through national level programmes such as food fortification. Community-based programmes also differ from indirect programmes which may provide training to medical and support staff, health services such as the EPI, or poverty alleviation efforts that affect nutrition indirectly.

The community level programmes include the Rural Child Survival Project, the Prime Minister's Programme, the World Food Programme, and two NGO programmes: Health and Nutritional Development Society (HANDS) and the Aga Khan University (AKU) School Nutrition Programme. Two noncommunity-based service delivery programmes are the IDD Elimination Programme, and the BFHI. They vary considerably in coverage, intensity, and unit costs. There is evidence for success of community-based programmes which employ local women as community health workers. The HANDS and AKU Programmes in Sindh combine education and nutrition, and have a special focus on including

girls in the process. Improved education and literacy is empowering and correlates strongly with the ability to assimilate information and to improve the use of available resources, leading to improved child nutrition. The HANDS programme covers 35,000 under-12 year-old children in 50 villages. The AKU programme covers 72 schools in 5 districts. Both have shown positive results, but neither has been successful in all communities. These projects are small, and are possibly difficult to replicate on a wider scale.

The small scale, pilot UNICEF-funded Rural Child Survival Project, which covers 28 villages in Islamabad Capital Territory, has a similar community-based focus. This project made an explicit link to the Ministry of Health (MOH) infrastructure, although there were problems of turnover and lack of interest by MOH staff, and the absence of a link to traditional birth attendants (TBAs or *dais*). An evaluation of the World Food Programme-supported supplementary feeding programme in Sindh suggested that its contribution to nutrition of the under-two year-old child was limited by problems of targeting and by irregular food supply.

The Prime Minister's Family Planning and Primary Health Care Programme represents a major attempt to use community health workers in order to provide some of the kinds of services of NGOs. "Lady Health Workers" (LHWs) can provide the linkage, and community responsiveness that basic health units are unable to provide. The LHWs' nutrition promotion activities centre on communications, in areas such as optimal feeding and caring practices and preventative, home-based, health care education. They are also given the tasks of mobilizing the community and of forming community organizations that can eventually take charge of their own health. Several pilot projects indicate that the programme can be successful, but no large scale evaluations of the national level effort have been done.

In 1999, a Women's Health Project was initiated in 20 districts, with support from the ADB. This has a specific focus on improving compliance with micronutrient supplementation and dietary quality during pregnancy, through counselling undertaken by LHWs.

The BFHI and the IDD programmes are not community-based, but provide important nutrition services. Both are reasonably effective, but need to extend their services more effectively to the community level, and to form linkages with existing services. The IDD programme has attempted to reach a number of education and health providers, doctors, and school children to spread the message about the importance of IDD. However, they are apparently not

supported very effectively by front line MOH workers in emphasizing the importance of iodine.

The BFHI has been quite successful in its work with hospitals. However, since the vast number of women do not deliver in hospitals, the initiative would be more effective if it could work at the community level, providing information for TBAs and encouraging exclusive breastfeeding and timely complementary feeding.

SRI LANKA

There are several ongoing efforts to strengthen the community-based nutrition approach in Sri Lanka. At present, there are four special programmes, implemented with substantial support from the state. The Participatory Nutrition Improvement Project (PNIP) is being implemented by the communities, in selected *Grama Niladhari* (GN) Divisions in 25 District Secretary's Divisions (DSD), with the assistance of multiple sectors and Ministry of Plan Implementation, and UNICEF support for coordination and monitoring. Basic nutrition programmes were implemented by the Janasaviya Trust Fund (JTF) in the 1990-1994 period and thereafter by the National Development Trust Fund (NDTF) which replaced the JTF. Another nutrition-oriented programme was implemented under the Samurdhi Programme, in 25 Divisions. The *Thripasha* Supplementary Feeding Programme, introduced in 1973, covers 32% of its target group, including pregnant and lactating women and under 4 year-old children who meet certain eligibility criteria. *Thripasha* is a blended fortified food that is distributed as a take-home ration, through Mother and Child Health clinics.

In addition, there are several NGOs working in the field of nutrition, using the community-based approach. The largest NGO programme is the Early Childhood Development programme of Sarvodaya that covers 6,000 villages. It does not have specific nutrition-related objectives but it incorporates nutrition interventions, in the form of a food aid programme for preschool children and nutrition education of mothers, through preschool teachers.

The coverage of such community-based programmes is as yet very limited. Excluding the North and Eastern Province, there are approximately 12,000 GN units of which the community-based programmes cover only about 5%. The three main programmes, as well as the individual programmes of NGOs, function independently of each other. Although the programmes have drawn on each other's experience informally, there is no formal or institutionalized arrangement for the regular and systematic exchange of information and knowledge.

The interaction between workers of the community-based programmes and the health workers who deliver services to mothers and children is limited, and is not structured and institutionalized in a regular and systematic way. There is no sharing of information between the two groups for purposes of regular monitoring. The community-based programmes such as the PNIP, have not yet installed an adequate information and monitoring system, with necessary documentation for their own work programme. One of the major problems of most of these programmes is sustainability, when the supportive agencies withdraw from the communities.

Despite these limitations, the models that are being developed in these programmes, particularly the model of the PNIP, address directly the issue of capacity building at community and household levels, for reduction of undernutrition. These programmes help to fill gaps within the state delivery system, which is not able to intervene adequately at the household level so as to promote desired behavioural changes.

Under these programmes, women's groups from the community are functioning as informal teams and are engaged in frequent dialogues with mothers on issues such as breastfeeding, complementary feeding and growth monitoring. Women leaders have developed their own indicators for monitoring nutrition activities and have continued to monitor changes in the community. Participatory development of communication materials and other methods of raising awareness (e.g., as role playing, skits, short dramas) have become very popular. Focus groups have developed their own themes and dialogues and have involved their family members, including their children, in these dramas, aimed at disseminating nutrition messages. House visits have been used to monitor informally the adherence to practices suggested through education. The growth chart is the main instrument around which the education programme is built. There appears to be a general awareness of the interrelatedness of nutrition with poverty and other factors, and a concern for safe water, sanitation, caring practices is reflected in many of the programmes. There have also been efforts to develop and to implement a system of monitoring and evaluation, with the use of simple indicators.

The persistence of a high level of undernutrition appears to be rooted in conditions that cannot be overcome entirely by the existing combination of interventions. The strategy for reduction of maternal and child undernutrition has been based essentially on the delivery of services, when the mother visits the clinic or when the public health midwife (PHM) visits the home. It is a top-down process in which the involvement and responsibility of households and the

community for monitoring and management is limited. The hard core problems of undernutrition do not seem to yield to this top-down process. This was substantiated in the ADB's RETA 5671. The following were among the critical gaps and shortfalls identified. LBW infants are a highly vulnerable group requiring special attention. Yet programmes of maternal and child health which monitor the growth of preschool children do not appear to follow up LBW babies systematically and to monitor their later performance. Moreover, although growth monitoring is an essential feature of the system for child care in Sri Lanka, this confined largely to MCH clinics, without full parental and family involvement. The services provided by the clinics have achieved only very limited coverage. The number of weighings of children 1-2 years is available but without any percentages and any reference to their nutrition status over time. The data suggest that clinics do not obtain information on preschool weighings after 2 years. Generally the links between disease and undernutrition are not monitored and managed, and there is no information on growth monitoring cards on episodes of illness.

The present delivery system is encountering problems of implementation that are related first to nonutilization and nonparticipation by households, and second to lack of understanding of the causes of undernutrition at different levels. Such a complex interaction of a wide variety of processes requires a community-based approach to child undernutrition, capable of identifying the diversity of the real situations and different combinations of the variables that operate at community and household levels. A much more intensive and sustained effort is therefore needed to address the problem of child undernutrition at the place of its occurrence; i.e., in the community and the household.

VIET NAM

In Viet Nam, 24 nutrition and nutrition-related programmes and projects, implemented by government institutions, ministries, nongovernmental organizations and international agencies were reviewed in the ADB's RETA 5671. A general summary follows here.

The main national programme is the National Programme of Protein Energy Malnutrition Control for Viet Nameese Children, initiated in 1994. This

targets under-five-year-old children and pregnant women, with a core package of services revolving around growth monitoring and promotional activities, carried out by community-level volunteers and mobilizers. Other directly relevant national level programmes include those focusing on the control of the three main micronutrient deficiencies (iron, iodine and vitamin A), breastfeeding promotion, EPI, control of diarrhoeal and acute respiratory diseases and household food security. In addition, there are several small scale, pilot projects.

The following lessons emerged from the RETA 5671. The national PEM control programme should emphasize preventative over curative approaches and become more household-focused, in order to improve caring practices for women and children.

The micronutrient interventions are well justified and should continue, as they have had a demonstrable impact on VAD and IDD. The anaemia control programme, which has lagged behind largely because of poor compliance with supplementation, needs increased prioritization.

National vertical programmes that address the diseases that contribute to PEM should be continued, while recognizing their limitations. Current household food security interventions, which focus primarily on income generation, through food production diversification, employment generation and kitchen gardening and animal husbandry development, need to be better targeted geographically, with respect to need. Caring practices which address the central underlying causes of PEM are clearly in need of more attention, support and financing. Water and sanitation issues will remain a central concern for at least the next decade. The underutilization of health centres, due to poor service quality is serious and requires urgent remedial action. Interventions that address the education-related basic causes of PEM also have room for expansion and improvement.

As ongoing market liberalization continues to marginalize a fraction of the population, interventions that alleviate poverty and hunger through credit and other support will remain essential. Moreover, social mobilization is indispensable to sustained, nationwide success in nutrition. People have to get involved in assessing, analyzing and taking action on the determinants of PEM. Community-based growth monitoring, with the emphasis on growth promotion, is one avenue to explore.

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