UNITED NATIONS
HUMAN RIGHTS
SPECIAL PROCEDURES
SPECIAL RAPPORTEURS, INDEPENDENT EXPERTS & WORKING GROUPS

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QUESTIONNAIRE

Contact Details

Please provide your contact details in case we need to contact you in connection with this questionnaire. Note that this is optional.

Type of Stakeholder (please select one)	☐ Member State ☐ Observer State x☐ Other (please specify)
Name of State Name of Survey Respondent	South Africa Lori Lake, Children's Institute, University of Cape Town Professor Rina Swart, Dr Chantell Witten, and Dr Katie Pereira, DSI/NRF Centre of Excellence in Food Security, University of the Western Cape Professor Lisanne du Plessis, Department of Nutrition, University of Stellenbosch Professor Julian May, UNESCO Chair in African Food Systems
Email	Lori.lake@uct.ac.za
Can we attribute responses to this questionnaire to your State publicly*? *On OHCHR website, under the section of SR health	**Yes** No Comments (if any): bearing in mind we are not representing the state, but are a group of concerned child health and nutrition academics and advocates

Background

Within the framework of Human Rights Council resolution 51/21, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, has identified analyzing the progress and challenges to attaining the Sustainable Development Goals (SDGs) as one of the strategic priorities during her tenure, along with analysing the role of the underlying determinants of health, such as climate change and environment, water and sanitation, education and gender equality (See: A/HRC/47/28 para. 108). In compliance with her mandate and in line with these priorities, she has decided to devote her next thematic report to the General Assembly, to be held in October 2023, to the issue of "Food, nutrition and the right to health".

All Permanent Missions to the United Nations Office and Observers Missions at Geneva

Objectives of the report

In the report, the Special Rapporteur will turn her attention to the underlying determinants of health, with a focus on how food and nutrition positively or negatively impact the right to health. In particular, she will rely on the frameworks of the social and commercial determinants of health to address how colonialism, racism, and other power asymmetries continue to build and maintain inequitable food systems and environments, influencing activities across the production, aggregation, processing, distribution, consumption, and disposal of food products,[1] and ultimately shaping the context in which consumers acquire, prepare, and consume food.[2] The Special Rapporteur's analysis will consider the double impact of malnutrition,[3] which refers to the co-existence of undernutrition with diet-related non-communicable diseases (NCDs) such as diabetes, cardiovascular diseases, and cancer. In this sense, she will emphasize that rights-based approaches to food and nutrition must reconcile and address both concerns, often misconstrued as competing. The Special Rapporteur will also report on new and emerging trends related to the impact of climate change, conflict, and COVID-19 on food and nutrition, as well as related responses.

Importantly, the Special Rapporteur will adopt an intersectional approach and consider the multiple forms of discrimination affecting persons in the context of food and nutrition. She will analyse the links between inequities in accessing adequate food and sex, gender, poverty, class, and the rural and urban divide, as well as related systems of oppression.

The Special Rapporteur intends to analyse the obligations and responsibilities of actors, such as States and corporations respectively, in relation to food and nutrition under the framework of the right to health. The Special Rapporteur would therefore like to identify **specific challenges and opportunities** related to food and nutrition in countries and within communities around the world. She would also like to **identify good practices** that affirm the right to health in this context, as well as seek examples of **how to combat discrimination** in accessing adequate food.

Glossary of definitions for the purpose of this questionnaire:

- **Double burden of malnutrition**: refers to "the coexistence of undernutrition along with overweight, obesity or diet-related NCDs, within individuals, households and populations, and across the life-course."[4]

- **Food environments**: refer to "the physical, economic, political and socio-cultural context in which consumers engage with the food system to make their decisions about acquiring, preparing and consuming food."[5]

- **Food systems**: refer to "the entire range of actors and their interlinked value-adding activities involved in the production, aggregation, processing,

[1] FAO, IFAD, UNICEF, WFP and WHO. 2020. The State of Food Security and Nutrition in the World 2020. Transforming food systems for affordable healthy diets. Rome, FAO, available at: https://doi.org/10.4060/ca9692en
[2] HLPE, Nutrition and food systems. A report by the High-Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security, 2017, Rome, available at: https://www.fao.org/3/i7846e/i7846e.pdf
[3] World Health Organization, The double burden of malnutrition: Policy brief, 2017, available at: WHO/NMH/NHD/17.3
[4] *Ibid.*
[5] HLPE, Nutrition and food systems. A report by the High-Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security, 2017 Rome, available at: https://www.fao.org/3/i7846e/i7846e.pdf

distribution, consumption and disposal of food products. Food systems comprise all food products that originate from crop and livestock production, forestry, fisheries and aquaculture, as well as the broader economic, societal and natural environments in which these diverse production systems are embedded."[6]

Questionnaire

The questionnaire can be downloaded below in English (original language), French and Spanish (unofficial translations). Responses can address some of the questions or all of them, as feasible or preferred.

- Download the questionnaire (WORD): English | Français | Español

How and where to submit inputs

Inputs may be sent by e-mail by 24 March 2023.

E-mail address	ohchr-srhealth@un.org
E-mail subject line	Contribution to GA report - SR right to health
Word limit	750 words per question
File formats	Word, PDF (Please note that only word docs will be posted online)
Accepted languages	English, French, Spanish

Treatment of inputs/comments received

Please note that all responses will be published on the official webpage of the Special Rapporteur.

Key Questions

You can choose to answer all or some of the questions below. (750 words limit per question).

1. What are the major factors that challenge quantitatively and qualitatively adequate access to food and nutrition in your country and/or community (including external to your country)? Taking into consideration the underlying determinants of health, in what ways do they contribute to health inequities?

The following submission draws on the findings of the *2020 South African Child Gauge* an annual report of the Children's Institute, University of Cape Town that tracks progress towards children's rights and makes the latest research accessible to support evidence-based policy and programming. For more information see the full report, poster and policy brief.

Poverty and inequality

- Despite progressive policies, South Africa (SA) has struggled to uproot the legacy of colonialism, and income inequality has intensified in the post-apartheid period. 39% of children live below the food poverty line and a staggering 63% below the upper-bound poverty line.[7]

[6] FAO, IFAD, UNICEF, WFP and WHO, The State of Food Security and Nutrition in the World 2020. Transforming food systems for affordable healthy diets Rome, 2020, available at: https://doi.org/10.4060/ca9692en

[7] See www.childrencount.uct.ac.za for a child-centred analysis of 2019 survey data.

- Poverty is also gendered with individuals in female dominated households 4 times more likely to be living in poverty than those in male dominated HH[8]. In addition, only 1 in 3 children live with their biological fathers, leaving mothers and grandmothers to carry the burden of child care.
- Poverty compromises children's access to water (30%), sanitation (21%) and health care services (20%) giving rise to frequent infections that further undermine child health and nutrition.[9]

Unhealthy food environments

- Individual food choices are shaped in powerful ways by local food environments and the broader food system which is increasingly profit-driven.
- Global food corporations are expanding their markets in the global South, directly targeting children as consumers, and flooding local markets with cheap ultra-processed foods.[10]
- These foods – low in micronutrients, high in sugar, salt and saturated fats– are fuelling a rapid rise in obesity and NCDs – with many children living in 'food deserts' where healthy foods are unaffordable or unavailable.

COVID-19 further intensified these challenges

- Rising unemployment coupled with food price inflation pushed families even deeper into poverty: By November/December 2020, 1 in 6 households reported that a child went to bed hungry in the week before the NIDS-CRAM survey.
- Child hunger is just the tip of the iceberg. Mothers attempted to shield their children from hunger by eating less and purchasing cheaper, less nutritious meals, but these empty calories are likely to further exacerbate already high rates of stunting, micronutrient deficiencies and obesity.
- "Children eat the same food every day. Starch every day. People are not okay. It is not healthy to eat starch every day. We do want to eat right but we don't have a choice. We can only buy the basic foods now. We buy the same things over and over again. We have no choice; we have to survive." Du Noon, Cape Town, November 2020
- Over 9 million children were denied access to school meals following the closure of schools and early childhood development (ECD) centres; and the disruption of routine health care services made it harder to identify and support children at risk of malnutrition. This raises concerns about how the rights of vulnerable children are sidelined in emergencies such as COVID, civil unrest, climate change and the current economic recession:
- With the war on Ukraine food and fuel prices continued to soar, with food price inflation standing at 13.5% in January 2023, at a time when the Child Support Grant (R480/child/month in March 2023) falls way below the Food Poverty Line (R663 in 2022), and austerity budgets are eroding expenditure on health services threatening to further compromise children's health and nutrition as evidenced by suboptimal immunisation and measles outbreaks across the country

[8] Posel D, Hall K & Goagoses L (2023) Going beyond female-headed households: Household composition and gender differences in poverty. *Development Southern Africa.* DOI: 10.1080/0376835X.2023.2182760

[9] See www.childrencount.uct.ac.za

[10] Swart R, van der Merwe M, Spires M, Drimrie S. Child-centred food systems: Ensuring health diets for children. In: J M, Witten C, Lake L, editors. *South African Child Gauge 2020*. Cape Town: Children's Institute, University of Cape Town; 2020.

A child-rights perspective

Section 28 of the Bill of Rights affirms the state's immediate obligation to respect, protect, promote and fulfil children's right to basic nutrition and basic health care services. Unlike section 27, children's rights are not subject to progressive realisation.

In addition, the Gauteng High Court in its judgement calling for the reinstatement of the National School Nutrition Programme upheld the UN Committee on the Rights of the Child's stipulation that "even in an economic crisis, the State may only introduce regressive measures as a last resort and must ensure that children are the last to be affected"[11].

The UN Secretary General and Committee on the Rights of the Child called on states to prioritise children in their COVID-19 response plans, and to "activate immediate measures to ensure that children are fed nutritious food during periods of emergency, disaster or lockdown".[12]

This should include surveillance systems to identify and support children at risk of severe acute malnutrition; a standardised food package that meets children's specific dietary needs; expanded social protection; and using health facilities, community health workers, schools and ECD programmes to reach children most in need.

[11] Equal Education and others v Minister of Basic Education and others (22588/2020) [2020] ZAGPPHC 306 (17 July 2020) para 23.

[12] United Nations Committee on the Rights of the Child. ***CRC - COVID-19 Statement.*** Geneva: UNCRC; 2020. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CRC/STA/9095&Lang=en ; United Nations Executive Office of the Secretary General. ***Policy Brief: The Impact of COVID-19 on children***. Geneva: UN; 2020.

2. What legislative or regulatory measures (such as those related to nutrition standards, labelling, marketing, procurement in institutional settings including – but not limited to – schools and prisons, and fiscal measures) have been considered or adopted in your country and/or community to improve food and nutrition, especially for persons in vulnerable situations? Where relevant, how are those measures being enforced?

The 2020 issue of the South African Child Gauge identified 6 key opportunities to enhance child nutrition:

1. Invest in maternal health and nutrition

Women's nutritional needs increase dramatically during pregnancy, and food insecurity, micronutrient deficiencies, overweight, gestational diabetes and pre-eclampsia pose a threat to the health of mother and unborn child. It is therefore essential to adopt a double-duty approach and not only provide micronutrient supplements, but also monitor weight gain and integrate dietary counselling into routine antenatal care with an emphasis on nutrient density and dietary diversity. Yet, the 2012-2016 Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition makes no mention of maternal nutrition, and while the maternal care guidelines speak to the identification of malnutrition, they don't include any actionable measures to address the problem.

Ideally, we should intervene even earlier by helping adolescent girls and women optimise their health, weight and micronutrient status preconception. For example, by providing micronutrient supplements through the Integrated School Health Policy.

Food insecurity increases the risk of domestic violence, depression and anxiety that can further compromise mothers' capacity to feed and care for their children.[13] It is therefore vital to extend social assistance to pregnant women, integrate mental health screening and support into antenatal and postnatal care, and scale up prevention of teenage and unwanted pregnancies.

2. Improve infant and young child feeding practices

Only 32% of infants in SA are exclusively breastfed during the first six months of life, and only 23% of children 6 – 23 months are fed a minimum acceptable diet.[14] Greater efforts are needed to promote optimal infant and young child feeding practices as this is when children are most vulnerable to stunting and severe acute malnutrition. This includes scaling up support for breastfeeding women (eg parental leave, child care and breastfeeding breaks), improving health workers' nutrition knowledge and counselling skills, and promoting local, nutrient-dense and affordable complementary foods. Facility- and community-based surveillance and support systems must be strengthened in the context of rising hunger and food insecuerity.

3. Invest in early childhood development

Early learning programmes offer a platform for supporting nutrition of preschool children. While registered ECD centres qualify for a subsidy of R15 - R17 per child per day and 40% of which is earmarked for nutritious food, stringent registration

[13] Abrahams Z, Boisits S, Schneider M, Prince M, Lund C. Domestic violence, food insecurity and mental health of pregnant women in the COVID-19 lockdown in Cape Town, South Africa. *Resesarch Square* [Internet]. 2020.

[14] Department of Health, Statistics South Africa, Medical Research Council, ICF. *South African Demographic Health Survey 2016. Key Indicator Report*.
Pretoria: DOH, Stats SA, MRC & ICF; 2017

requirements have until recently excluded centres serving those communities most in need. Only 10% of young children benefit from the subsidy – in marked contrast to the National School Nutrition Programme (NSNP) which supports 77% of learners. We therefore need to increase access and the value of the ECD subsidy.

4. Use schools to support older children and adolescents

The NSNP provides a daily meal to over 9 million learners but in context of rising food prices, we need to monitor and enforce the DBE's guidelines to improve the nutritional quality of school meals and limit the sale of unhealthy, obesogenic foods. Schools also provide a platform for nutrition education, food gardens and school health services. SA,s children are increasingly sedentary: Less than half of learners get enough exercise to promote health and prevent chronic disease, and one in three schools are without sporting facilities.[15] Greater effort is needed to scale up the National School Sport Programme and provide safe spaces for physical activity.

5. Create a healthy, equitable and child-centred food system

Direct intervention by the state is needed to ensure that the food system supports, protects and promotes children's health, nutrition and food security. This includes regulations to protect children from the marketing of unhealthy foods; front-of-pack labelling to enable consumers to make informed choices; taxes to limit the consumption of unhealthy foods and subsidies to make healthy foods more affordable.[3]

6. Expand social protection

The Child Support Grant (CSG) provides a lifeline for nearly 13 million children and over 7 million caregivers.[16] But the grant amount (R480 a month/ R16 a day in March 2023) is not enough to meet children's dietary needs.
Take up remains low – especially in the first year of life – with 1 in 3 infants in poor households not benefiting from social assistance.[17] This is worrying as infants are particularly vulnerable to the immediate shock and long-term effects of malnutrition. Academics and civil society are therefore advocating for an increase of the CSG to the food poverty line (R663/per month), the extension of social assistance to pregnant women, and the introduction of basic income support in the context of high unemployment.

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[15] Draper CE, Tomaz SA, Bassett SH, Harbron J, Kruger HS, Micklesfield LK, et al. Results from the Healthy Active Kids South Africa 2018 Report Card. ***South African Journal of Child Health***. 2019;13:130-6.
Department of Basic Education. ***National Education Infrastructure Management System Standard Report, August 2019***. Pretoria: DBE; 2019

[16] Conradie I, Hall K, Devereux S. Transforming social protection to strengthen child nutrition security. In: May J, Witten C, Lake L, editors. ***South African Child Gauge 2020.*** Cape Town:

[17] Children's Institute, University of Cape Town; 2020. [11] Hall K, Sambu W, Almeleh C, Mabaso K, Giese S, Proudlock P. ***South African Early Childhood Review 2019.*** Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana 2019.

3. In your context, have any legislative or regulatory measures attempted to simultaneously address undernutrition, on the one hand, and diet-related non-communicable diseases such as diabetes, cardiovascular diseases, and cancer, on the other hand? In doing so, have they been successful? Please provide concrete examples.

Hofman et al identified the following actions needed to address the double-burden of child malnutrition[18]:

Interventions and Programmes	**Undernutrition**	**Micronutrient deficiency**	**Overnutrition**	**Potential and actions needed**
Humanitarian Food Assistance	✓	✓	X	- Introduce and establish humanitarian food assistance mechanisms and systems at district level under DoH - Introduce and establish a standardized food package for infants, children under 5, and older children - Introduce and establish district level food distribution tracking systems - Introduce standards on healthy foods linked to nutrient profile - Use food based dietary guidelines as an education tool to promote healthy eating.
Maternal nutrition	✓	✓	✓	- Promote healthy eating and provide food support during pregnancy - Replace routine antenatal iron folic acid with routine multi-micronutrient supplements - Establish a maternal nutrition working group to guide policy and programmes - Extend social assistance to pregnant women - Establish psychosocial support programmes for pregnant women - Institute surveillance data for pregnant women
Breastfeeding Support	✓	✓	✓	- Extend the Mother- and Baby-Friendly Hospital Initiative to private institutions - Strengthen maternity protection and introduce 6-months paid maternity leave - Strengthen workplace support for breastfeeding mothers - Provide community-based psycho-social support to pregnant women and mothers of young children - Launch a public awareness campaign to build a positive breastfeeding culture and

[18] Hofman K, Erzse A, Kruger P, Abdool-Kariem S, May J (2020) Double burden and double duty: Government policies to improve child nutrition. In: May J, Witten C, Lake L (eds) *South African Child Gauge 2020*. Children's Institute, UCT.

				to challenge hostile responses to breastfeeding in public - Provide training and monitor health workers' breastfeeding knowledge and skills - Link breastfeeding mothers to food support programmes
Regulations around breast milk substitutes	✓	✓	✓	- Launch a public awareness campaign and reporting system for R991 violations and monitor and enforce R991.
Complementary Feeding Support	✓	✓	✓	- Establish and promote Paediatric Food Based Dietary Guidelines - Promote and support parenting and childcare programmes to include healthy eating guidance - Promote and regulate front of pack labelling to promote low calorie, fat, sugar and salt content of foods marketed to children - Link mothers with children under-five to food support programmes
Nutrition Assessment, Education and Counselling	✓	✓	✓	- Establish routine and mandatory nutrition assessment at health facilities - Promote and support of paediatric food based dietary guidelines - Promote and support for the South African healthy eating guidelines - Provide training and monitoring of health worker nutrition skills and competencies
Micronutrient control programmes • Targeted food supplementation • Food fortification • Distribution of multiple micronutrient supplements	X	✓	X	- Institute regular micronutrient surveys to track prevalence and progress towards elimination of micronutrient deficiencies - Establish a reference working group on micronutrient nutrition to stay abreast of the developments in the field and to advise government and the food industry
Distribution of therapeutic foods	✓	✓	X	- Integrate counselling on healthy diets and snacks for mothers and young children in all therapeutic nutrition programmes
Food Security (household and small holder production)	✓	✓	X	- Integrate small holder production programmes with social grant recipients - Integrate targeted small grower assistance for households with adolescents, pregnant women and mothers with children under 5 years old - Support households and small holder farmers with agriculture extension assistance.
Popular restaurants and food outlets	✓	✓	X	- Use incentives and/or regulations to improve the nutritional quality
Food provisioning in ECD programmes and schools	✓	✓	X	- Introduce and establish food and meal audits of meals provided by schools and ECD programmes to ensure they are aligned with the school and ECD nutrition guidelines

				- Introduce and establish routine growth monitoring of all children at least every six months - Introduce and establish an early warning system if more than 10% of the ECD population is under- or overweight
Food prices	✓	✓	X	- Use taxes and subsidies to subsidize healthy food baskets for low income households and households relying on social grants - Introduce loyalty programme for low income households and households reliant on social grants for selecting high nutrient foods over luxury foods - Provide discounts on healthy foods for the broader public
Social assistance	X	X	X	- Adopt a child-centred approach to social assistance by increasing the value of the CSG and introducing basic income support and a maternal grant to support pregnant women
South African Food Based Dietary Guidelines	✓	✓	✓	- Consuming foods in line with the FBDGs promotes good nutrition and prevents under- and over nutrition - The FBDGs emphasize plant-based foods with low intake of sugar, fats and salt.

4. Beyond diet-related non-communicable diseases, food and nutrition are also relevant in relation to infectious diseases and other illnesses. For example, contaminated food can lead to foodborne illnesses, poor nutrition can make persons more susceptible to infectious diseases, and individuals living with infectious diseases and other chronic illnesses may have unique dietary requirements for health. Please describe any challenges and progress made in this regard in your country and/or within your community.

Impact of HIV on infant feeding

The HIV/AIDS pandemic had a profound impact on infant and young child feeding practices in SA. Initial guidelines sought to prevent mother-to-child transmission (MTCT) of HIV and counselled mothers to either exclusively breastfeed with early weaning at 4–6 months, or exclusive formula feed - with free commercial milk formula provided by the NDOH until six months. These measures created confusion around the relative risks and benefits of breastfeeding and undermined breastfeeding practices for all mothers.

In 2011, the policy shifted in response to new evidence of the benefits of exclusive and continued breastfeeding for both HIV-positive and HIV-negative mothers, and SA signalled its commitment to promote, protect and support breastfeeding through the landmark Tshwane Declaration of Support for Breastfeeding in South Africa. This was followed by the adoption of new guidelines that encouraged HIV-positive mothers to breastfeed their infants exclusively for the first six months of life, while receiving ART to prevent MTCT, and to continue breastfeeding until their infants are one year of age[19].

[19] Du Plessis LM, Peer N, Honikman S, English R. Breastfeeding in South Africa: are we making progress? In: Padarath A, King J, Mackie E, Casciola J, editors. *South African Health Review 2016.* Durban: Health Systems Trust; 2016. URL: http://www.hst.org.za/publications/south-african-health-review-2016.

Yet despite recent efforts, SA continues to have one of the lowest breastfeeding rates on the African continent, with only 31.6% of infants (0-6 months) exclusively breastfed. Greater efforts are needed to support breastfeeding women (including a maternity grant, 6 months maternity leave, and breast-, child- and family-centred workplace policies).

In addition, we need to strengthen and enforce local regulations designed to protect women and health workers from the predatory marketing tactics of the commercial formula milk industry – which continues to exploit mothers' hopes and fears to build a multibillion-dollar industry and is expanding markets in the global South - with sales of formula milk more than doubling by volume in SA from 2000 - 2019. [20]

Impact of food insecurity on compliance with medical treatment including ART
We also note with concern emerging reports that mothers on ART and children on chronic medication are now defaulting or struggling to comply with treatment because they cannot afford food to line their stomachs[21].

[20] Euromonitor International (2015) *Global Infant Formula Analysis. A custom report compiled by Euromonitor International for the World Health Organisation. Final report*. 18 February 2015.
[21] https://www.dailymaverick.co.za/article/2022-12-01-children-eating-dung-just-to-line-stomach-for-arvs-researchers-2/

5. Multi-stakeholder approaches to food and nutrition are often affected by power asymmetries that exclude persons and communities in situations of vulnerability.

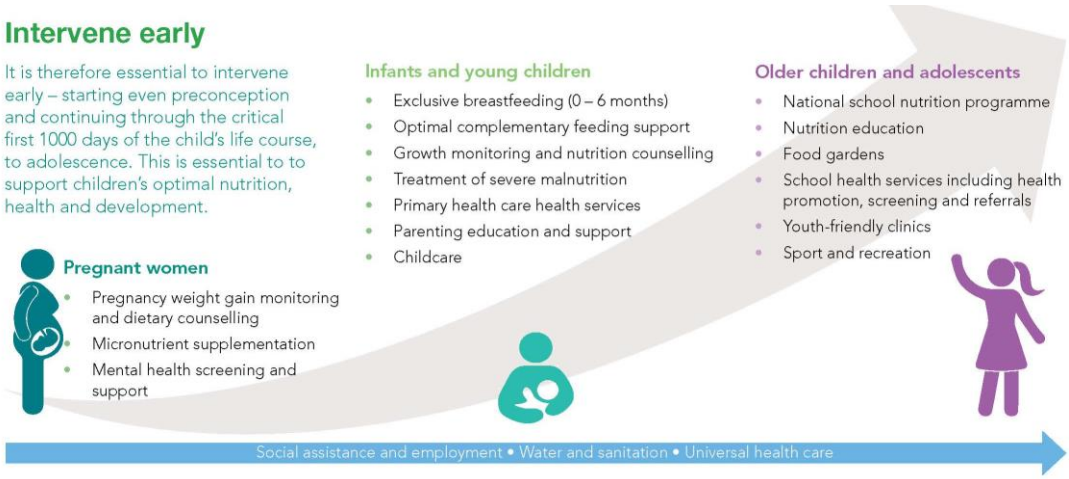
   5.1. Please provide concrete examples of the barriers and opportunities for these persons or communities, such as Indigenous peoples, women, children, and migrants, to participate in national and/or international policymaking processes pertaining to food and nutrition, including the process of participation.

   5.2. What proactive steps or good practices can you report on taken by the State to engage in activities to strengthen people's access to and utilization of resources for food security in this regard?

The 2020 South African Child Gauge identified three core principles that should guide our approach to the double burden of child malnutrition:

1. Intervene early and across the life course

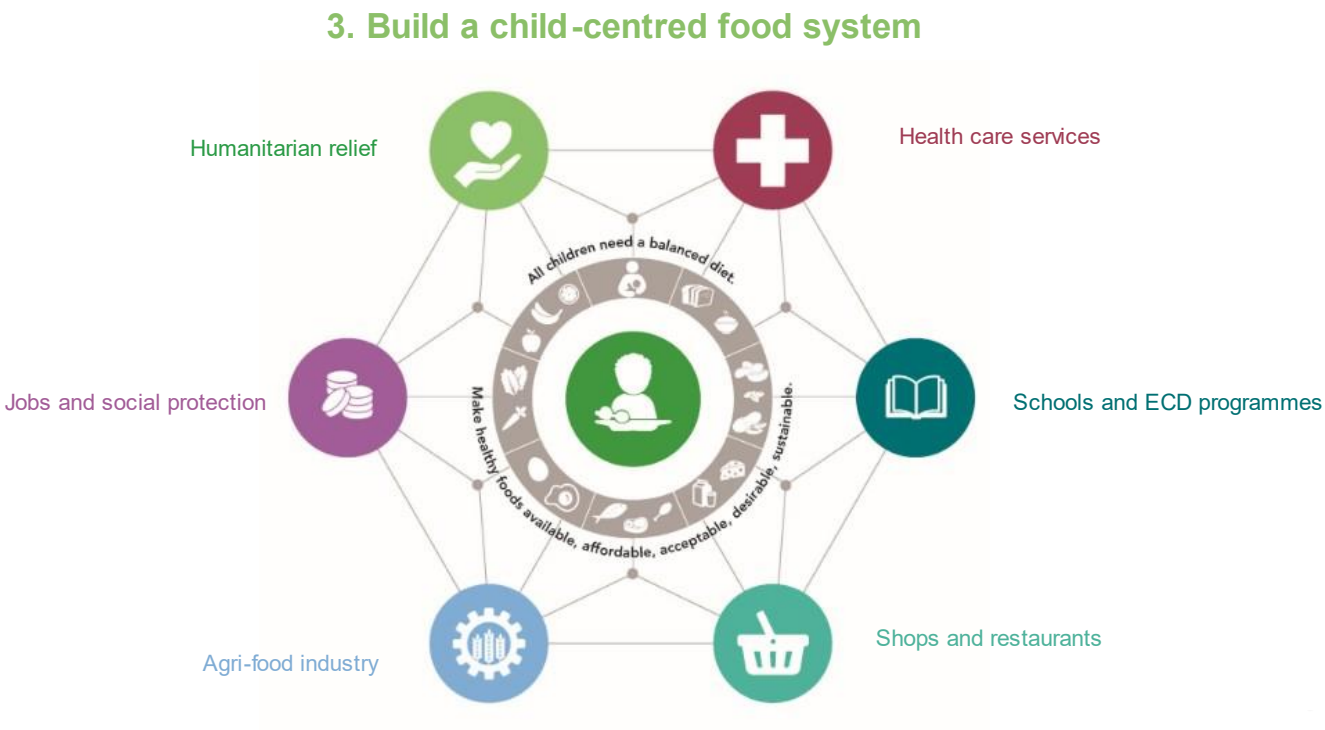
Exposure to malnutrition during sensitive periods of development can have an irreversible impact on their long-term health and development. Therefore, we need to intervene early to disrupt an intergenerational cycle of malnutrition and poverty, and make use of every point of contact with children and families to promote optimal nutrition – starting early (even preconception) and continuing through the critical first 1000 days of life through to adolescence – as these early investments are more effective and cost effective than treating NCDs later in life.



SA also needs to adopt double-duty actions that simultaneously prevent or reduce the risk of undernutrition, overnutrition or diet-related non-communicable disease. For example, exclusive breastfeeding for the first six months has been found to reduce both stunting and obesity. The table in response to question 2 highlights how existing interventions can be adapted to ensure that efforts to address one form of malnutrition do not cause further harm. For example, food-relief parcels and school meals should not only meet children's energy requirements, they should also be high in nutrients and low in salt, sugar and saturated and trans fats.

3. Build a child-centred food system

There is much that we can do as individuals to protect and promote our own health and that of our children, but we cannot do this in isolation. We need to create a more healthy, equitable and child-centred food system and to make use of every point of contact with children and families to promote optimal nutrition. Creating such an enabling environment requires a whole of society approach and collective action from government, civil society and the private sector to ensure that child health comes before profit. This includes representation from the children's sector on the National Food and Nutrition Security Committee/Council to ensure that children's nutrition is prioritised.



6. What is the impact of gentrification, development, technology, industry activity and deforestation on food security? Please share some concrete examples.

7. Please provide examples related to the impact of food production, on the right to health of the population living or the people working in or near the areas of production/cultivation?