

Child and Maternal Nutrition: A Global Challenge

By

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Our shared vision is a world in which children enjoy the highest attainable standard of health and development, a world that meets their needs, respect, protects and fulfils their rights enabling them to live to their full potential.

The Global Nutritional Challenge

In the year 2000, 10.8 million under five years of age died, over half of them due to five preventable communicable diseases compounded by malnutrition. Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life. Malnourished children who survive are more frequently sick and suffer the life-long consequences of impaired development. Malnutrition remains the world's most serious problem and the single biggest contributor to child mortality. Nearly one-third of children in the developing world are either underweight or stunted and more than 30 percent of the developing world's population suffers from micronutrient deficiencies. Rising incidences of overweight and obesity in children are also a matter of serious concern.

The health and nutritional status of mothers and children are intimately linked. Improved infant and young child feeding begins with ensuring the health and nutritional status of women, in their own right, throughout all stages of life and continues with women as providers for their children and families. Mothers and infants form a biological and social unit; they also share problems of malnutrition and ill-health. Whatever is done to solve these problems concerns both mothers and children together.

Good nutrition is a foundation for healthy development. Furthermore, nutrition and ill-health are part of a circle: poor nutrition leads to ill-health and ill health causes further

deterioration of nutritional status. These effects are observed most dramatically in infants and young children, who bear the brunt of malnutrition, and the highest risk of death and disability associated with it. More than half of all children's deaths in 2000 were associated with malnutrition. However, the number of children who die represent only a small part of the total burden due to nutritional deficiency. Maternal malnutrition and inadequate breastfeeding and complementary feeding represent huge risk to health of those children who survive. Deficiencies in diet of vitamin A, iodine, iron and zinc are still widespread and are a common cause of excess morbidity and mortality, particularly among young children. Over 50 million children are wasted, and in low income countries one in every three children under age five is stunted. Anemia affects two out of every five children under two years of age, as a result of the interaction between poor nutrition and infectious and parasitic diseases. The effect of poor nutrition continues over the child's life, contributing to poor school performance, reduced productivity, and other measures of impaired intellectual and social development.

Poor feeding practices are a major threat to social and economic development; they are among the most serious obstacles to attaining and maintaining health in the under-five age group. Only 35% of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate and unsafe.

While access to sufficient amount of adequate foods is an important determinant of nutritional status, repeated infections and inappropriate feeding practices are the two major direct causes of the onset of malnutrition in young children. Children who are not breastfed are six times more likely to die by the age of one month than children who receive at least some breast milk. From the end of six months onwards, when breastfeeding is no longer sufficient to meet all nutritional requirements, infants enter a particularly vulnerable period of complementary feeding during which they make a gradual transition to eating family foods. The incidence of malnutrition rises sharply from 6 to 18 months in most countries, and the deficit acquired at this age are difficult to compensate later in childhood

Rapid social and economic change only intensifies the difficulties that families face in properly feeding and caring for their children. Expanding urbanization results in more families that depend on informal or intermittent employment with uncertain incomes and few or no maternity benefits. Both self-employed and nominally employed rural women face heavy workloads, usually with no maternity protection. Meanwhile, traditional family and community support structures are being eroded, resources devoted to supporting health- and, especially, nutrition-related, services are dwindling, accurate information on optimal feeding practices is lacking, and the number of food-insecure rural and urban households is on the increase.

The world has witnessed some achievement in decreasing child mortality from 97 per 100 live births in the early 1980s to 67 per 100 live births in 1999. Effective public health interventions such as immunization, oral rehydration therapy and exclusive breastfeeding delivered to large numbers of children are responsible for a major part of this success. While local diets lack essential micronutrients; successful experiences with iodine fortification and vitamin A supplementation have shown that it is possible to make rapid improvement through focused interventions. Nonetheless, the prevailing situation is unacceptable. Unless policies and priorities are changed, the scale of the problem of infant and maternal malnutrition will prevent many countries from achieving the Millennium Development Goals.

The Global Response

Improving Nutrition

The Global Strategy for Infant and Young Child Feeding, endorsed by the 55th World Health Assembly in 2002, provides a framework for action to protect, promote and support appropriate infant and young child feeding. The strategy defines responsibility for all concerned parties: to enable mothers and families to exclusively breastfeed their infants for six months, to introduce adequate complementary feeds after six months with continued breastfeeding, and to implement the breastfeeding options for special circumstances, such as with low birth weight babies, infants of mothers living with HIV, families living in emergency situations. The strategy also

recognizes the intricate links between maternal nutrition and child health outcomes, and promotes effective interventions to improve maternal nutrition status.

Improving the access of caregivers to a person who can provide feeding counselling is one of the critical pillars in the strategy. While breastfeeding and complementary feeding seem natural acts, they are also learned behaviors. Recent research has demonstrated that when mothers are counselled on infant feeding, exclusive breastfeeding improves dramatically in infants less than six months of age. Similarly for older children, feeding counselling improves maternal knowledge and practices related to appropriate complementary feeding and continued breastfeeding, leading to increased energy and nutrient intake and child growth. The strategy is intended as a guide for action; it is based on accumulated evidence of the significance of the early months and years of life for child growth and development and it identifies interventions with a proven positive impact during this period. The strategy recognises that no single intervention or group can succeed in meeting the challenge; implementing the strategy thus calls for increased political will, public investment, awareness among health workers, involvement of families and communities, and collaboration between governments, international organizations and other concerned parties that will ultimately ensure that all necessary action is taken. Thus the global strategy for infant and young child feeding is based on respect, protection, facilitation and fulfilment of accepted human rights principles.

In promoting appropriate feeding for infants and young children specific recommendations can be found in the attached IYCF Strategy.

Investing in Nutrition

Good nutrition is the building block of human capital and as such contributes to economic development. In turn, sustainable and equitable growth in developing countries will convert these countries to ‘developed’ states.

The Copenhagen Consensus describes productivity losses caused by malnutrition to be linked to three kinds of losses—those due to:

1. Direct losses in physical productivity
2. Indirect losses from poor cognitive losses and loss in schooling
3. Losses from resources and increased health care cost

Thus investing in nutrition in order to improve nutrition increases productivity and economic growth.

Nutrition and the Millennium Development Goals.

Malnutrition is one of the most important constraints to achieving the MDGs. Improving nutrition is essential to reducing extreme poverty. Recognition of this requirement is evident in the definition of the first MDG, which aims to eradicate extreme poverty and hunger. Therefore improving nutrition is in itself an MDG target

Nutrition and Human Rights

The 1948 Universal Declaration of Human Rights established adequate health, including adequate food, as a basic human right. The right to health and nutrition was reiterated in the 1989 Convention on the rights of the child, adopted by all but two United Nations member countries. The right to adequate nutrition is also enshrined in the constitution of many countries. Nutrition is a crucial, universally recognized component of the child's right to the enjoyment of the highest attainable standard of health as stated in the Convention on the Rights of the Child. Children have the right to adequate nutrition and access to safe and nutritious food, and both are essential for fulfilling their right to the highest attainable standard of health. Women, in turn, have the right to proper nutrition, to decide how to feed their children, and to full information and appropriate conditions that will enable them to carry out their decisions. These rights are not yet realized in many environments.

WHO Child Growth Standards

Growth Monitoring presents health care providers with the opportunity to assess the nutritional status of individual children as well as the trends in pattern of growth and development of the children within their communities. This assessment provides the basis for analysis and application of corrective measures regarding feeding, hygienic and other practices that are found to influence the nutritional status adversely.

A comprehensive review of the uses and interpretation of existing anthropometric references was undertaken by the WHO in the early 1990s. It was concluded that new growth curves were needed to replace the existing international reference. In order to

develop the new standards, a multi-country study was carried out to collect primary growth data and related information from 8440 healthy breastfed infants and young children from diverse ethnic backgrounds and cultural settings (Brazil, Ghana, India, Norway, Oman and the USA). The first set of growth standards (length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age) were presented at the 59th World Health Assembly in January this year. The curves represent the best description of physiological growth for children under-five years of age. The standards depict normal early childhood growth under optimal environmental conditions and can be used to assess children everywhere, regardless of ethnicity, socioeconomic status and type of feeding.

The WHO Multi-centered Growth Reference Study Group (MGRS) was designed with the objective of providing curves that depict *how children should grow* when their needs are met rather than merely describing how they grow in a particular region and time. The new standards establish the breastfed infant as the normative growth model. The pooled sample from the six participating countries creates a truly international standard and reiterates the fact that child populations grow similarly across the world's major regions when their health and care needs are met.

Managing Nutritional Programmes on a National Level,

Successful nutritional programmes have been managed by a variety of line agencies in different countries, with effective oversight from a variety of coordinating or managing bodies: for example, in Burkina Faso, from a national food policy coordinating committee; in Madagascar, from the Prime Minister's office; in Senegal, from the President's office; and in Honduras, from the Ministerial-level body in charge of coordinating foreign-assisted projects. One set of emerging lessons are as follows:

- There should be clear division of responsibilities among implementing institutions.

- Although oversight agencies should not be given implementation responsibilities, they should be able to influence inter-sectoral resource allocation so they have a way to give implementing agencies an incentive to perform.
- Where the oversight institution is located is less important than that it is at a high level and that it backed by strong political and bureaucratic commitment.
- Best results are obtained when stakeholders cooperate as willing partners, whether in programmes involving multiple government agencies, public-private partnerships such as those for food fortification, or programmes bringing together multiple development partners or co-financers. Food fortification programmes harness the institutional capacity of the commercial private sector for production and marketing, while the government's role is usually to build awareness, monitor and regulate.
- The Micronutrient Initiative (MI), The United Nations Children Funds (UNICEF) and The World Bank have had successful experience in assisting government in this area, especially with soil iodization. A new international nongovernmental organization (NGO), the Global Alliance for improving nutrition, has been created to help to foster partnership for food fortification. Similarly, a new Network for sustained elimination of iodine deficiency is emerging from the Micronutrient Initiative- although questions remain about whether approaches that deal with single nutrients are the best way forward.

Collaboration between Development Partners and the Private Sector around a Common Nutritional Agenda.

Most development partners and the private sector supporting nutrition focus on food security, agriculture, and rural development, followed by HIV and nutrition as part of maternal and child health services. Addressing micronutrient deficiencies, seizing the window of opportunity to address under-nutrition among young children, and

controlling overweight and obesity come lower in the current priorities of most partners. Few agencies are working towards mainstreaming nutrition into Poverty Reduction Strategy Credits (PRSCs), Poverty Reduction Strategy Papers (PRSPs) or Sector Wide approaches (SWAs), or even across other intersectoral programmes such as gender and community driven development(CDD) programmes.

Most partners support capacity development activities in some form but much of their effort goes into training nutritionists to be better nutritionists. Though some advocacy agencies are actively building commitments, their efforts are mainly limited to narrow focused areas (such as breastfeeding for the World alliance for Breastfeeding action and La Leche League, and micronutrient fortification in selected countries for the Global Alliance for Improving Nutrition (GAIN).

According to the World bank, each country needs to drive its own investment agenda and hence should lead the repositioning of nutrition in the development agenda. When countries request help in nutrition, the role of development partners is to respond, first by helping countries develop a shared vision and consensus on what needs to be done, how and by whom, and providing financial and other assistance. The role of the development partners must extend beyond responding when requested to do so by the government, to use their combined resources for analysis, advocacy about capacity building to encourage and influence government to put nutrition higher on the agenda whenever it is holding back achievement of the MDGs, poverty reduction and human capital formation. This role can be fulfilled only if the development partners share a common view of malnutrition problems and broad strategies to address it and speak with a common voice.

Key Operational Changes to Scaling up

Nutrition is an integral part of the first MDG, which aims to reduce poverty and hunger. It is reckoned that while most countries are on track in reducing income poverty, most are not on track in improving non-income poverty (malnutrition and hunger). It has been

suggested by the World Bank that without direct investment in nutrition, countries will continue to be off track, not only on the first MDG, but also on health.

The key is to mainstream nutrition intervention into programmes in the health, agriculture and other sectors. It is therefore recommended that when developing national or regional strategies, countries and their partners should pay special attention to the following:

- Focusing strategies and action on the poor to address the non-income aspect of poverty reduction.
- Focusing intervention on the window of opportunity-conception through the first two years of life.
- Improving mother–child caring practices to reduce incidence of low birth weight and to improve infant feeding practices
- Scaling up micronutrient programmes because of their widespread prevalence, effort on productivity, affordability and extraordinarily high benefit-cost ratios
- Building on the countries capacities development through micronutrient programming to extend actions to community based nutrition programmes.
- Working to improve nutrition not only through health but also through appropriate actions in agriculture, rural development, water supply, sanitation, gender and social protection and education in order to reorient some existing large scale nutrition investments that are not achieving the desired effect. This can be remedied by:
 - ❖ Giving more attention to financial and technical assistance for improving programme design, monitoring, evaluation and management.

- ❖ Providing technical support for cost-effectiveness analysis to identify issues of intensity of resource use and providing finance for resolving them.
- ❖ Providing coordinated support and guidance for overcoming bureaucratic and political resistance to change in programme strategy and design
- ❖ Building commitment and capacities required to underpin the scaling up and reorientation needed. Commitment building needs to be professionalized, drawing on skills from the field of strategic communication, political and policy analysis, and organizational behavior.

Well-informed nutrition champions need to work systematically to:

- Build local partnership of individuals and institutions that can influence politicians, implementing agencies, and development partners to press for increased budgets for the right kind of nutrition investment.
- Identify gaps in the countries' capacity to build commitment to improving nutrition and seek help to fill those gaps from local institutions, other developing countries or nongovernmental organizations (NGOs) and other development partners and the private sector.