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Accelerating the reduction of maternal and child undernutrition

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Secretary's Round-Up

This edition of the SCN News is of special relevance for a variety of reasons, not least of which being the recommendations agreed at the 35th Session ([p.51](#)) held in Hanoi in March 2008, hosted by the Government of Vietnam (SCN 2008a). The 35th Session was aimed at understanding how to accelerate the reduction of maternal and child undernutrition, drawing on the recently launched Lancet Nutrition Series (LNS) on maternal and child undernutrition (Maternal and Child Undernutrition Study Group 2008). The papers presented in Hanoi are featured here, together with the recommendations concerning actions needed to accelerate the reduction of maternal and child undernutrition. The recommendations draw on the presentations and discussions in the Symposium, as well the inputs of the SCN Working Groups, also included in this edition ([p.57](#)), and have been further elaborated on and agreed to by all three constituencies of the SCN. The recommendations have become of even greater relevance because of the soaring food prices crisis, that broke almost immediately after the 35th Session had finished.

In their welcoming speeches at the opening of the Session the SCN Chair Ann M. Veneman ([p.4](#)) and the Standing Deputy Minister of Vietnam H.E. Nguyen Sinh Hung ([p.7](#)) recognized the multisectoral nature of malnutrition and emphasized the urgency to address the high rates with multiple strategies. In his keynote speech, the Minister of Social Development and Fight against Hunger of Brazil Patrus Ananias further emphasized a rights-based approach and shared experiences of the "Zero Hunger" programme from Brazil ([p.8](#)).

The Symposium papers presented at the 35th Session include two covering the main findings and recommendations from the LNS together with three other papers that comment on them and place them in a national and programmatic context. These five papers are extremely complementary, and I recommend you to read all of them together, rather than any one of them alone. The presenters of the LNS papers, Mercedes de Onis ([p.12](#)) and Robert Black ([p.17](#)), described the enormity of the maternal and child undernutrition problem, as well as the negative life course consequences in store for those that survive. They also described the evidence base for discreet interventions that operate at the immediate level of causality and that are proven to work, as well as how or whether the proven interventions are being implemented "at scale" in countries most affected, and the adequacy of the international nutrition institutions to guide and facilitate country level implementation. The first contextual paper, by Marie Ruel ([p.21](#)), emphasized the need for multisectoral approaches involving ministries of agriculture and health, and presented plausibility based evidence of programmatic approaches, operating at the more distal household and community level of causality, to improve food intake and care dimensions of the nutrition problematic, and that are needed in addition to the LNS package of interventions. Dr Khan ([p.30](#)) presented an ambitious proposal to accelerate the reduction of stunting in Vietnam that contemplates all of these levels of causality and proposes to adapt the package of interventions to suit sub-national variations in conditions. The last contextual paper, by David Pelletier ([p.38](#)) looks at the various factors (positive and negative) that have helped and/or stopped the nutrition agenda from moving forward at the country level, in order to allow effective programmes to be set up and operate at scale to accelerate the reduction of maternal and child undernutrition. In Hanoi, many of the SCN Working Groups discussed the implications of the LNS in their respective thematic areas ([p.57](#)). We also publish a commentary by André Briend et al on management of severe acute malnutrition ([p. 63](#)).

To celebrate the 30th Anniversary of the SCN, Alan Berg, one of the founder members of the SCN, was invited to give the 12th Dr Abraham Horwitz lecture at the Session in Hanoi ([p.44](#)). Alan presented the results of a survey of nutrition practitioners across the globe, researched through the SCN mailing list. The same questions were used as those used in a survey Alan did back in the early seventies, the results of which formed the basis of his famous book entitled the "Nutrition Factor" (Berg 1973). Comparing the results of the two surveys across the thirty years of the SCN's existence provided some interesting and encouraging findings, which Alan presented at the end of the Session Symposium. Taking advantage of the occasion the SCN presented Awards of Honour to Alan Berg and to Michael Latham in recognition of their life time contributions to international nutrition. Awards were also presented to Professors Khoi and Tsai, the founding fathers of nutrition science in Vietnam, both for their remarkable life time contributions to nutrition science, which have undoubtedly laid the foundation for the remarkable progress towards the MDGs that Vietnam has made (SCN 2008a, 2008b).

The overall balance of results achieved at the 35th Session is a remarkably positive one. The recommendations from the Session are potentially very useful for practitioners at the country level that have the hardest task i.e that of putting nutrition science into practice as successful programmes acting at scale. There were some low points in the Session proceedings however, with the usual tensions surfacing that seem to mark discussions among the practitio-

ners of nutrition science. Indeed the facility with which the nutrition community takes "either-or" positions is quite remarkable. While some for example advocate in favour of doing more research on the "what" of nutrition or in improving knowledge about outcomes, there are those that insist on the need to invest more in the "how", or in improving the processes of nutrition programmes. Similarly there are those that advocate for the need for a better evidence base at the immediate causality level, and others that argue instead of an improved evidence base on programmes aiming at the underlying family and community level of causality, including the importance of food security. Surely none of these are "either-or" scenarios, but instead ones where both are right and both are needed. We need to be continually improving the evidence bases both for the process as well as the outcomes being pursued.

Far greater recognition is needed that nutrition is not an "either-or" science. There are some forty nutrients that are each essential but alone insufficient elements needed for optimal growth and development of the human body. The conceptual framework of nutrition causality accepted by one and all, teaches us that resolving the problems of "food" "health" and "care" at the underlying causality level are each essential but alone insufficient conditions that all need to be fulfilled in order to achieve successful nutrition outcomes. But unfortunately discussions of nutrition science and practice rarely seem to get beyond the level of "either-or". Somehow or other we need to better embrace the "all of the above" mentality.

The recommendations from the 35th SCN Session ([p.51](#)) are therefore a real advance, because they recognize that package of nutrition interventions coming from the LNS for example are not "either-or", but instead are needed "on top" of the underlying cause interventions, especially those related to income and food security. This is a truly encouraging situation, because as the paper of David Pelletier ([p.38](#)) reminds us, it is these "either-or" disagreements, repeated by middle level technicians, that are the greatest block to moving the nutrition agenda forward at the national level. In order to facilitate the work of those at country level, we also have added the references and links for the relevant policy and programme guidance for each of the recommendations from the 35th Session. This is done, recognizing the difficulty to find this in any one place as described by the LNS papers.

It is also increasingly recognized that a new way of building the evidence base for nutrition programming is required, and that randomized controlled trials alone don't fit the bill for nutrition programmes, which are essentially multisectoral. This is not to belittle the contribution of the LNS to an improved evidence base for nutrition programming in the health sector for example, i.e. this is not an "either-or" situation. But it is the lack of an "either-or" nature of nutritional science that demands a new type of "translational science" that builds on the plausibility approach proposed by Habicht et al (1999) and Victoria et al (2004), and creates evidence of the effectiveness of packages of interventions, operating at various levels of causality, as referred to by Marie Ruel ([p.21](#)) in her symposium paper. Such translational science must also look at effects across different stages of the life cycle, with special attention on the period of foetal and infant growth looking for effects later in the life course. The SCN Task Force on Assessment Monitoring and Evaluation could provide a vehicle for trying to carry forward such ideas, and indeed the SCN Action Plan does envisage the need for such an approach.

The Global Food Price Crisis which has broken on the scene since the 35th Session, provides an important new context for the recommendations from the Session. In late April the Chief Executives Board (CEB) of the UN established a High Level Task Force on the Global Food Security Crisis headed by the Secretary General¹. Furthermore at the High Level Conference on World Food Security held at FAO in Rome in early June,² and attended by some 40 heads of state, nations committed US\$ 11.7 billion of new funds for agricultural development and the fight against hunger over the next few years. They further pledged to carry out a series of immediate short-term as well as medium and long-term measures to seek ways of achieving world food security. A Comprehensive Framework for Action of the CEB Task Force is also being developed and a draft widely shared for comments.³ To be successful the Framework for Action, must contemplate both food security and nutrition security, and incorporate the recommendations from the 35th Session.

The current food price crisis is different in many ways to the one in 1974, that led to the establishment of the SCN. The previous crisis, although similarly provoked by an increase in oil prices and a shortage of fertilizers, was relatively short lived with oil production being normalized and prices falling again within a year. But the perspective

1. A website has been established for the Secretary General's High Level Task Force on the Global Food Security Crisis at <http://un.org/issues/food/taskforce>

2. Conference documents, reports and declaration on World Food Security area available from www.fao.org/foodclimate/hlc-home/en

3. The High Level Task Force on The Global Food Crisis (2008) *Elements of a Comprehensive Framework for Action*. Draft For Informal Distribution at Rome High Level Conference on Food Security is available online at www.un.org/issues/food/taskforce/Documentation/Framework_for_action_on_Food_Security.pdf

for oil prices to fall now is remote as global production capacity seems to have peaked. The price of food is strongly correlated with the price of oil, so there seems little likelihood of food becoming cheap again either. The unprecedented economic growth that has marked the last sixty years of global peace, has also meant that the demand for animal foods has grown enormously. Although the global grain production is double that needed to feed the global population, over a half of this grain is fed to animals. In addition the global population has almost doubled since 1970, and just over a half now live in urban areas. But in addition there are other important new drivers of the food price crisis now that didn't exist thirty years ago and that make the situation now much more complicated. These include a globalized financial sector which allows speculation in the food commodity markets plus the provision of financial incentives to produce biofuels from corn as a response to the climate change crisis. How the Comprehensive Framework for Action will deal with all of these complex challenges still remain to be seen, but the results of the latest DOHA round at the World Trade Organization in Geneva this week are more likely to be the ones that will have the greatest impact on the likelihood of solving the crisis in the medium and long term. Hopefully the trade of agricultural products will be given a level playing field, as agreed by member states at the United Nations Conference on Trade and Development (UNCTAD), at its twelfth session in Accra (UNCTAD 2008).

Another event which has placed nutrition on the international agenda this year is the Copenhagen Consensus which updated its ranked list of solutions to major world challenges from 2004. As Bjørn Lomborg, the founder and leader of this initiative said: "It's not very often you get 5 Nobel Laureates being locked up in the same room for 4 days talking about the biggest world issues, and I hope that the dedication they've put into compiling this unique overview of the best spending options to improve the world will resonate with decision-makers all over the world." From this economist point of view, interventions to address hunger and malnutrition rank at the top of the suggested solutions in terms of cost-benefit analysis, which will surely help bring further leverage to the advocacy claims of the nutrition community. The initiative is briefly described in this issue along with a Speaker's Corner commentary where the long-time SCN participant George Kent shares his own views ([p.73](#)).

This year also sees the 60th Anniversary of signing of the Universal Declaration of Human Rights (UN 1948), and as is explained in the Programme News section (p.65), there have been many important new achievements in this field in the first half of the year. In May the Human Rights Council held a special session on the negative impact of the food price crisis on the realization of the right to food. The session was called by the newly appointed UN Special Rapporteur on the right to food, Mr Olivier De Schutter. The Human Rights Council also approved by consensus an Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, which brings one step closer the possibility of international remedy mechanisms for violation of this covenant.

It is also encouraging that nutrition is being given a new priority by WHO (Chan 2008), which also celebrates its 60th Anniversary this year. It is great that Francesco Branca has been appointed to the Division of Nutrition in Health and Development of WHO. We welcome Francesco, who comes from being the regional adviser for the European Region of WHO, and wish him all success in his new role. Thanks are due to Jørgen Schlundt, who has served as the Acting Director of NHD for the last year, and who now returns to just looking after food safety in WHO. There are also new Chairs in the Civil Society constituency, with Ted Greiner taking over as Chair, with Ricardo Uauy, Urban Jonsson and Elisabet Sterken as Vice Chairs. In the bilateral constituency, Biram Ndiaye, previously Coordinator of the National Committee Against Malnutrition of Senegal, acted as Vice Chair for a short period before he joined UNICEF.

In the meantime the call for a review of the international nutrition architecture made by the LNS has been heeded, and two reviews are in hand. The larger review of the international nutrition architecture is being supported by the Bill and Melinda Gates Foundation (BMGF), and the smaller review of UN coordination mechanisms has been carried out by the SCN Steering Committee. We look forward to seeing the results of these two processes being published.

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Features

35th SCN Session Opening Speech by the SCN Chair, Monday 3 March 2008

Ann M. Veneman, Executive Director, UNICEF

The SCN Chair, Ms Ann M Veneman, Executive Director of UNICEF, opened the 35th SCN Session by welcoming all participants, in particular the Standing Deputy Prime Minister of Viet Nam, the Minister of Social Development and Fight against Hunger of Brazil, and other distinguished guests. She thanked the Government of Viet Nam for hosting the important meeting, and all the participants for contributing to a successful meeting.

Sound nutrition for mothers as well as children is central to health, learning, economic development and well-being. New developments and improvements in coverage of nutrition interventions are taking place, which are helping to drive results across the Millennium Development Goals (MDGs).

The recent Lancet Nutrition Series (LNS) strengthens the evidence base for nutrition and calls for reviewing the international nutrition architecture in order to enable more effective efforts while scaling up interventions backed by appropriate levels of resources and capacity.

The UNICEF 2008 State of the World's Children Report on child survival, focuses on community based integrated approaches for health and nutrition (UNICEF 2007a). For the first time since data have been collected globally on the death of children under the age of five, the number of child deaths went below 10 million, as recorded in 2006, to an estimated 9.7 million in 2007, which represents a 60% decline in the rate of child mortality since 1960. Viet Nam achieved the MDG4 on child survival already in 1999 - nine years earlier than the global targets. The under five mortality rate in the country went down from 53 per 1000 live births in 1990 to 17 in 2006 (UNICEF 2007b).

Nutrition is critical in helping to save and improve the lives of children and families, and progress has been made in many areas. The coverage of essential micronutrients such as vitamin A has improved. Since 1999, there has been a 50% increase in the proportion of children age 6 months to 5 years who received at least one dose of vitamin A in the last six months. Recent data, from the developing world, also show increases in the rates of exclusive breastfeeding for the first 6 months of life. In Sub-Saharan Africa, exclusive breastfeeding rates went from 22% in 1996 to 30% in 2006. In South Asia the rate of exclusive breastfeeding remains around 45% (UNICEF 2007b). It is estimated that 1.3 million additional children's lives could be saved annually if the rate of exclusive breastfeeding exceeded 90% in the developing world (Bhutta et al 2008).

Despite remarkable economic growth during the past two decades, the number of undernourished people in the developing countries remains stubbornly high, at around 854 million according to the Food and Agriculture Organization (FAO 2006).

A target indicator of MDG1 is the underweight prevalence for children younger than 5 years, which has declined from 32% in 1990 to 27% in 2006. Yet, this improvement is still falling short of the global target of 16.5% that represents a 50% reduction. Some of the highest underweight rates are found in Asia, with South Asia being home to more than half of the total 143 million under-five underweight children in the world. Underweight prevalence in South Asia is on average 42%, with Bangladesh at 48%, India at 43%, Nepal at 39% and Pakistan at 38%. Viet Nam, which has seen a reduction in underweight from 41% in 1996 to 25% in 2006, is on track for the MDG1 target. Other Asian success stories include China, Malaysia and Thailand. Yet, according to the December 2007 Progress for Children for the 109 developing countries for which data have been collected, nearly half of them - 51 countries - are making insufficient progress on the underweight target, with 18 out of these 51 countries making no progress or getting worse.

Proven interventions must be accelerated to reach the target. Nutrition needs to be an integrated part of community based child services backed by strong national health systems. Broad public-private collaboration helps drive results by building a comparative strength and by leveraging resources. As was emphasized in the Lancet Nutrition Series, proven interventions must be rapidly scaled up to improve results.

The case is compelling. Undernutrition is the underlying cause of an estimated 3.5 million deaths annually. It

is estimated that for more than a third of all child deaths, maternal and child undernutrition are the main contributors (Black et al 2008).

Good nutrition in early childhood is crucial for the health and long-term development of the child. In some countries an estimated 40-50% of children under five suffer from stunting. Stunted children have greater difficulty in learning. As a result millions of children do not benefit fully from their education, which deprives the country of a healthy and educated population to spur economic development. Studies indicate that about 6% of the productivity of adult manual labour is lost due to stunting and children who are stunted do on average 10% worse in school than their peers.

The conclusions from the 35th SCN Session should give direction to the actions needed to accelerate the reduction of maternal and child undernutrition. The recent LNS is providing a helpful platform to move ahead in a more harmonized way while taking into account multiple solutions, situations and needs. Such advice should underscore ways to help ensure that people have access to food that is safe for consumption and has the right nutritional benefits. This in addition to services such as health care, nutrition and hygiene education, and access to clean water and basic sanitation, will help save lives.

One critical nutrition intervention is salt iodization as a lack of iodine in the diet can reduce IQ by as much as 13 points. Nigeria is one of the success stories where the percentage of households using iodized salt has gone from 40% in 1993 to 97% in 2003, which can be attributed to government leadership, commitment of the salt industry, effective legislation and strong enforcement. In Senegal the World Food Programme (WFP), the Micronutrient Initiative (MI), UNICEF and other partners are supporting local production of iodized salt and its consumption within households. WFP purchases salt locally from some 7,000 small producers, most of them women, many of whom live in villages in food insecure areas (SCN 2007). Governments and private sector actors have also successfully collaborated in the fortification of wheat flour with iron and folic acid. Large scale fortification is currently taking place in over 50 countries.

Severe acute malnutrition continues to affect an estimated 20 million children under the age of 5 years. An effective means to treating severe acute malnutrition at the community level is with ready to use therapeutic foods (RUTFs). Last year, at the opening speech of the 34th SCN Session in Rome, I told you about a recent visit to Ethiopia where I participated in the opening of a processing plant that was using primarily local resources to make RUTF. Since then, I have seen RUTF being produced on site in Haiti. Yet, in the capital city, Port-au-Prince, where I visited a hospital, children had been hospitalized for two months with acute malnutrition. RUTFs could help significantly shorten their hospital stay, thereby reducing cost and allowing the children to return home much earlier. In countries such as Ethiopia, Malawi and Niger, recovery rates for severely undernourished children have been as high as 90 to 95% by using RUTF as a therapeutic intervention. The processing plant in Ethiopia is part of an expanding production network with 12 more plants expected in Africa, the Middle East, South Asia and the Caribbean. Between 2004 and 2007, UNICEF's purchases of RUTF increased nine-fold, from about USD 2 million up to USD 18 million. These products were used in developing countries around the world.

In May 2007, WHO, WFP, UNICEF and SCN released a Joint Statement supporting treatment of children with severe acute malnutrition with ready to use therapeutic foods in community settings (WHO/WFP/SCN/UNICEF 2007). RUTFs are also effective in treating undernutrition in HIV positive people, who are at higher risk of death when they lack adequate nutrition. Thus, RUTF makes a useful addition to life-prolonging antiretroviral treatment. It is still unclear whether RUTF can be effectively used to reduce mild or modern malnutrition and prevent deterioration to the severe acute form. It is also unclear whether such foods provided to pregnant women, could reduce low birth weight. More research is needed to assess the various effective uses for ready to use foods.

Cultural and traditional practices are important determinants of nutrition. At the launch of the UNICEF progress report for children on nutrition (UNICEF 2006), I was struck by the high rates of underweight in Asia and how they often tend to primarily be a cultural issue. In India for example, early marriage prevails, and the young new daughter-in-law in the household eats last and is given less food, particularly during her pregnancy. Moreover, many believe that you should not begin breastfeeding for at least two weeks as colostrum

is not thought to be beneficial. These traditional and cultural practices need to be understood and addressed.

I recently visited to Liberia and Sierra Leone. Sierra Leone is the country that is the lowest on the Human Development Report published by UNDP, with no country ranking any lower (UNDP 2008). It has the highest under 5 mortality rate and the highest maternal mortality rate in the world. The under 5 mortality rate is 270 deaths per 1000 live births. The maternal mortality, which represents the life time risk of dying in connection with child birth, is 1 in 8, compared to 1 in 76 in the rest of developing world on average, and 1 in 8,000 in the developed world. Inadequate nutrition is a major factor in these high rates in Sierra Leone. Although years of conflict clearly have taken its toll on food production, culture and tradition are also undermining the nutritional wellbeing of people in this country. Early marriages are a problem along with teenage pregnancies. This is driven by a very high incidence of sexual violence in the country. Female genital mutilation is being wildly practiced, estimated to be at over 90%. Very interestingly, in this traditional society, breastfeeding is at only about 10%. Moreover, there is a cultural tradition of giving the new-born a spoonful of water, in a country where clean water is not a plentiful resource. Another cultural practice is to feed the child rice-water instead of breastmilk, undermining the overall nutritional value.

If we are going to make progress in reducing undernutrition, there is a need to clearly understand these cultural and traditional practices, as they underlie many of the causes of inadequate nutrition. This understanding must be coupled with strong programmes for communications for behaviour change if we are going to make any progress.

The LNS suggested that the international nutrition system is broken with an absence of leadership, far too few resources, fragile in-country capacity, and fragmented emergency responses. Several stakeholders are reviewing the global nutrition architecture with all the sectors involved. There has also been an examination of the role and future of the SCN, hosted by Tufts University. The recommendations of this review should be taken seriously with a view to strengthening overall nutrition architecture. Some of these recommendations concern working together to scale up approved activities, speaking with a consistent voice, demonstrating impact that will surely be followed by more adequate resources, and improving country capacity.

There is much to do, but probably never before has the opportunity been better, to ensure nutrition interventions, to complement those in health, education, water and sanitation, to help accelerate progress in saving and improving the lives of those most in need - the mothers and the children. The task ahead must be approached with a shared sense of urgency. As I have said before, one underweight and undernourished child is an individual tragedy, but multiplied by tens of millions, undernutrition becomes a global threat to societies and economies.

Contact: scn@who.int

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H.E. Nguyen Sinh Hung, Standing Deputy Prime Minister of the Social Republic of Vietnam

Welcome speech at the 35th SCN Session, Monday 3 March 2008

The Standing Deputy Prime Minister H.E. Nguyen Sinh Hung welcomed, on behalf of the Government of the Social Republic of Vietnam, the representatives from foreign countries and international organizations.

The annual session of the UN Standing Committee on Nutrition is a very important event to review global nutrition activities, to discuss and propose national strategic nutrition-related interventions and approaches for improved nutrition. The conference is also a great opportunity for different countries and international agencies to share experiences and to co-ordinate efforts and join resources for further improvement of nutrition.

Vietnam is honoured to host the 35th SCN session with the theme “Accelerating the reduction of maternal and child undernutrition”. This is a critical issue towards the achievement of Millennium Development Goals numbers 1, 4 and 5, which concern reduction of hunger, and child and maternal mortality. All UN member countries have committed to achieve these goals.

Nutrition is a significant factor related to health, life quality, population quality and social development. In the past few decades, with the active and effective support from UN agencies such as WHO and FAO, Vietnam has made a great effort and received remarkable achievements in nutrition status, particularly in the improvement of maternal and child nutrition. Underweight rates in children have consistently been reduced, and has dropped by 12% compared to that in 2000 with an average reduction rate of 1.5% per year. The prevalence of anaemia and chronic energy deficiency in reproductive aged women has also been significantly reduced. However, due to the long-lasting aftermath of war, nutritional indicators and the stature of Vietnamese people are still lower than those of neighbouring countries. In 2007, there were still 1.6 million children under 5 being underweight (21.2%) and 2.6 millions were stunted (33.9%). Child malnutrition has long lasting and serious consequences on social-economic development. Food insecurity due to natural disasters such as floods and droughts threaten certain localities. Additionally, poverty and little nutrition knowledge are great challenges in some isolated areas.

To address this challenging nutrition situation, the Government of Vietnam has ratified the National Plan of Action for Nutrition and the follow-up of the National Nutrition Strategy 2001-2010. The National Nutrition Strategy aims to reducing food shortages, reducing malnutrition and controlling nutrition-related emerging health issues. The Vietnamese Government remains committed to achieving the nutrition related MDG goals: to reduce child malnutrition rate to under 20% by 2010 and to under 15% by 2015, and to reduce micro-nutrient deficiencies.

Vietnam highly appreciates the 35th Session of the SCN with the theme “Accelerating the reduction of maternal and child undernutrition” with the participation of experienced experts coming from all over the world. The Session is not only an important forum to discuss how to accelerate the reduction of undernutrition, but also an opportunity to reconfirm the international commitments and efforts in the global battle to address malnutrition. I believe that the Session will put forward strategies and effective action plans for improving maternal and child nutrition globally.

On this occasion, on behalf of the Government of Vietnam, I would like to acknowledge and highly appreciate the meaningful support and assistance of UN agencies, foreign governments and international organizations in the success of nutrition activities in Vietnam so far.

I would like to wish great success for the 35th SCN Session and wish you all good health and happiness and further cooperation between Vietnam and the international community in nutrition and health.

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Accelerating the reduction of maternal and child malnutrition: Contributions to the debate based on the Brazilian experience

Patrus Ananias, Minister of Social Development and Fight against Hunger of Brazil

Development and the right to adequate food

In recent years, the international community has made considerable progress in understanding that economic growth must not be considered an end in itself, but a fundamental tool for the promotion of human development. The Millennium Development Goals (MDGs) clearly express this expanded concept of development, with goals related to food and nutrition, health, education and environment. All of these converge to create a development model based on solidarity – which benefits everyone, but with special emphasis on regions with lower levels of economic prosperity and to families and individuals with greater vulnerability.

Integral human development is only achieved when the rights of all members of a society are fully guaranteed and when they can fully realize their capacities and aspirations. Realizing the human right to adequate food is a fundamental step in that direction. Ensuring an adequate nutrition among pregnant and lactating women and children is fundamental, taking into consideration its subsequent impact upon the different stages of the life cycle.

The recent Lancet Nutrition Series prove that maternal and child malnutrition is responsible for more than one third of all deaths of children under 5 years old around the globe. Each year, about 3.5 million children die as a result of undernutrition. The Series shows the importance of an early and integrated intervention strategy targeted at malnutrition in pregnant women and children under two years old for healthy development. A complete development relies not only on good health and nutritional status including the prevention of obesity, but also on intellectual aptitude, school performance, and other elements necessary for a life of dignity with freedom from want. A set of actions directed towards maternal and child nutrition could prevent 25% of the deaths of children in the most affected countries (Maternal and Child Undernutrition Study Group 2008). Thus, investing in the pregnancy period and in early childhood years is an efficient measure for reducing inequalities, fighting against poverty and building a more equitable society.

Ensuring the human right to adequate food has been Brazil's priority since the beginning of President Lula's government, in 2003. This commitment was materialized with a unilateral decision to strengthen the MDG1 targets. The first target calls for a 50% reduction in the proportion of the population living in extreme poverty in the period 1990-2015. The target adopted by Brazil is a 75% reduction in the proportion of persons living on less than 1 USD/day, adjusted for purchasing power parity, in the same period. It is worth mentioning that the global agreed goal of halving extreme poverty has already been accomplished. In 1990, 8.8% of the Brazilian population lived in a situation of extreme poverty; by 2005, this percentage had fallen to 4.2%, which means that in this period 4.7 million people were freed from extreme poverty. If the current trend continues until 2008, that segment will represent 2.2% of the population. Moreover, the non-income target associated with MDG1 has also been strengthened by the Brazilian government. Rather than halving the population living in hunger from 1990 to 2015, Brazil has pledged to eliminate hunger in the country altogether by 2015 (Brasil 2007).

Social Development in Brazil

A few contextual elements provide a better understanding of the recent progress obtained by Brazil. The country has a population of approximately 184 million people, and it ranks among the largest economies in the world. Despite its sheer size, inequality is still very high. However, in recent years, there has been significant progress towards the improvement of the living conditions of the population, through a combination of economic and political stability, economic growth, environmental responsibility and social justice.

According to the 2007/2008 UN Human Development Report, Brazil has achieved a Human Development Index of 0.8 for the first time, which places it in the group of high human development countries (UNDP 2007).

Between 2003 and 2006, the reduction of poverty reached 31.4%, which means that fourteen million people overcame extreme poverty during this period. In 2006 the Brazilian income concentration reached its lowest rate in the last 30 years (Neri 2007).

Despite the recent progress, a large share of the population still lives in a situation of poverty. Brazil still has one of the highest Gini coefficients in the world, as a result of a historic process of economic growth with inequitable distribution of income and opportunities.

Given this context, overcoming the serious and interrelated problems of poverty and inequality in Brazil requires a sustained and integrated effort from all levels of government and also from civil society.

The Zero Hunger Strategy

The Zero Hunger strategy (Fome Zero), which coordinates programmes from 11 ministries, in partnership with civil society, plays a fundamental role in improving the living conditions of the population. It also contributes to the introduction of the food and nutrition security element to the public policies agenda, both in Brazil and abroad.

We have implemented integrated actions concerning the human right to adequate food. These in turn provide the foundations for the Zero Hunger strategy, in order to ensure the production, availability and regular access to high quality food for everyone. We have also invested in strategies for impact evaluation of food and nutrition security policies and programmes. One important step was the creation in 2004 of a baseline measuring the various levels of food insecurity in Brazil, based on the Brazilian Scale of Food Insecurity (EBIA). This will allow subsequent impact evaluations of Brazilian food and nutrition security policies (SAGI/MDS 2007).

The Federal Law for Food and Nutrition Security

Another important step to ensure the human right to adequate food in Brazil was the introduction of a Federal Law for Food and Nutrition Security – Law No. 11346, from September 15, 2006. This created the National System for Food and Nutrition Security which aims to integrate initiatives within this area. This law grants the status of public policy to food and nutrition security, thus requiring the State to enforce the universal right to regular and permanent access to good quality food in sufficient quantities, based on healthy food practices which respect cultural diversity and which are environmentally, culturally, socially and economically sustainable.

The National Council on Food and Nutrition Security – CONSEA

The Brazilian policy on food and nutrition security is monitored by the National Council on Food and Nutrition Security – CONSEA, which congregates 18 State Ministers and 36 representatives of civil society, and is directly linked to the Presidency of the Republic.

The policy implementation includes strategies for: strengthening family agriculture through financing, technical assistance and purchase guarantees; local initiatives to allow for access to food and water (subsidized restaurants, food banks, community kitchens, cisterns) and strategies directed towards school meals and the promotion of healthy food habits.

The Bolsa Familia Program

The cornerstone programme for the promotion of food and nutrition security is the Bolsa Familia Program, which benefits 11 million poor families. In return for a cash transfer, which allows for food purchases and some immediate relief of the difficulties created by poverty, families must keep their children in school, giving them the opportunity to break the intergenerational poverty cycle. They also must comply with an agenda for health monitoring, which includes vaccination, prenatal care and nutritional monitoring of pregnant and lactating women and children under 7 years old, thus ensuring their basic rights to health access.

Bolsa Familia introduces an intersectoral approach, which is key to the social development debate, since there is a strong interdependence among all public actions directed to citizens living in poverty. In this sense, food and nutrition security policy must work in an articulated and synergetic manner with other policies on social assistance, health, education, and labour, thereby adding more effectiveness to the resources invested.

Other initiatives

Taking into consideration the intersectoral approach to public policy, the Brazilian Government has promoted various actions which have resulted in the improvement of the nutritional indicators of pregnant women and

children. In this sense, the Family Health Strategy is worthy of mention, and has benefited more than 93 million people as of February 2008 (a sheer half of the Brazilian population).

Moreover, the Food and Nutrition Surveillance System – SISVAN - allows for continuous access to information about the food and nutritional status of the population and the factors that influence it. It is used to monitor the Bolsa Familia Program beneficiaries, including more than 3 million children during the second semester of 2007.

Another fundamental action carried out to ensure adequate nutrition has been the distribution of essential micronutrients, such as iron and vitamin A, as part of the basic health assistance.

Achieved results

As a result of these various programmes and initiatives, both child malnutrition and mortality rates have dropped. Brazil has showed great progress in lowering the child mortality rate, which dropped from 47 per thousand live births in 1990, to 25 in 2006 – a 45% drop. Among children between 1 and 2 years old, malnutrition has fallen from 20% to 5%, which represents a reduction of 75% in seven years (UNICEF 2008).

Between 2002 and 2007, the rates of hospitalization due to malnutrition and nutritional insufficiency fell in every region of Brazil. The average reduction in Brazil was 35%, reaching as high as 44% in the Northeast region, according to administrative data from Ministry of Health.

Such improvement may be partly attributed to the reorganization of the primary care system by means of the Family Health Strategy, which focuses on the family in its physical and social environment in an integral and continuous manner, developing actions for health promotion and disease prevention. An important impact of the Family Health Strategy is observed in the health of children: studies show that a 10% raise in its coverage is associated with in a 4.6% reduction in the child death rate (Macinko et al 2006).

Research also shows a significant contribution given by the Bolsa Familia Program to the food and nutrition security of families; particularly their children. According to a study with beneficiaries, 93% of children and 82% of the adult beneficiaries eat three or more meals a day (Silva et al 2007). Research regarding the nutritional status of the population living in the Northeastern semi-arid region – one of the poorest regions in Brazil – has showed a strong reduction in the malnutrition rate, which dropped from 17.9% in 1996 to 6.6% in 2005. The role played by social programmes in the improvement of the nutritional conditions of the poorest population was clear: for children under 5 years old, the research predicts that participation in the Bolsa Familia Program would be associated with a 30% reduction in the occurrence of height for age deficits – indicating a corresponding reduction in the prevalence of chronic malnutrition. The malnutrition rates would be 6.8% among children that did not receive the programme and 4.8% for children that received the programme. When the focus of the analysis is on the range between 6 and 11 months of age, the reduction in the prevalence of malnutrition due to the programme would be even greater: 62% (from 5.3% to 2.0%) (Santos et al 2007).

This context indicates clear progress in food and nutrition security in Brazil. Nevertheless, it is necessary to develop the policies and programmes even further, strengthening the focus upon families and upon specific territories, and to pursue the goals of universal social protection and promotion and the guarantee of food and nutrition security. Universal social rights in Brazil require more investment in regions where economic activity is less intense, and also for families and individuals in situations of greater vulnerability. It is also necessary to improve management practices of social policies through a stronger coordination among their elements, to define clear goals, and to strive towards transparency, accountability and continuous impact evaluation of the programmes.

Final remarks – towards a global commitment against hunger and malnutrition

The current models for socio-economic development have been limited in environmental and social terms. The risks of environmental changes and global warming can negatively affect the current social situation, furthering inequalities worldwide.

It is necessary to rethink the current development models, given the high levels of inequality that still persist in spite of poverty reduction between 1990 and 2004. Around the world, 800 million people still suffer from

hunger. Among those, 170 million are children under 5 years old. More than 500,000 women around the world still die each year due to complications during pregnancy and delivery that could be easily avoided or treated. And half of the population in the developing world still doesn't have access to basic sanitation.

President Lula has given priority to a development model with income redistribution and social inclusion and has committed his administration to a solidarity effort towards the reduction of hunger and malnutrition in the world. We consider this to be a challenge to be overcome by the entirety of humankind, and it will only be possible with cooperation and commitment from governments, multilateral organisms and actors in international civil society.

In that sense, we have maintained an intense cooperation with international organisms and governments of other countries, giving and receiving technical cooperation. There is still a lot to learn, but we have already gathered various experiences that we consider to be worthy of being shared with our partner nations. We are continuously working in cooperative projects with multilateral organisms, and with development organs of the governments of Latin American and African countries as well as in other regions.

The conclusions and propositions from the 35th Session of the UN Standing Committee on Nutrition have a key role, because they help to define strategies for large-scale implementation of necessary interventions designed to reduce maternal and child malnutrition. In doing this, important steps are taken towards a more equitable and fraternal world, gathered around the promotion of the highest human values.

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TRAINING ANNOUNCEMENT:

BPNI Certificate Course on “Infant and Young Child Feeding Counseling Specialist”

BPNI/IBFAN Asia is organizing certificate training Courses on Infant and Young Child Feeding Counseling: A Training Course – The 3 in 1 Course (An Integrated Course on Breastfeeding, Complementary Feeding and Infant Feeding & HIV-Counseling). *Interest and commitment:* Protecting, promoting and supporting breastfeeding and complementary feeding. Help for solving mother's problems. *Who can do it:* Doctors, Staff nurses, Graduates in nutrition, science, dietetics, home science, social work etc. *Duration of training:* 7 days (51 Hours) including 5 X 2 hrs clinical practice in hospital. *Competence after receiving training:* Participants will be able to provide individual counselling on breastfeeding, complementary feeding HIV and Infant Feeding Initiate setting up a infant and young child feeding counseling center Provide referral level support. *Training:* 4 National Trainers will train 24 infant and young child feeding counseling specialists in one training session. *Course Fees:* Rs. 5,000/- (includes training materials, lunch and tea). *Training Venue and Date:* Ranchi, Jharkhand from 26 September - 2 October 2008. For more information please visit www.bpni.org

Child undernutrition based on the new WHO growth standards and rates of reduction to 2015

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Introduction

Maternal and child undernutrition contributes to more than one third of child deaths and more than 10% of the total global disease burden (Black et al 2008). The number of global deaths and disability-adjusted life-years (DALYs) in children less than 5 years old attributed to stunting, severe wasting, and intrauterine growth restriction constitutes the largest percentage of any risk factor in this age group (Black et al 2008). Therefore, reducing infant and young child growth retardation is essential to achieve the Millennium Development Goals (MDG) related to child survival (MDG4) as well as the eradication of extreme poverty and hunger (MDG1).

Maternal undernutrition, including chronic energy and micronutrient deficiencies, is prevalent in many regions, especially in south-central Asia, where in some countries more than 10% of women 15-49 years old have short stature. Similarly, maternal low body mass index (BMI < 18.5 kg/m²) ranges from 10-19% in many developing countries (Black et al 2008). The nutritional status of a woman before and during pregnancy is critical to a successful outcome, and among the factors known to increase the likelihood of a baby small for gestational age, both short stature and low pre-pregnancy weight or body mass index figure prominently (Kramer 1987; Kramer and Victora 2001).

Child undernutrition encompasses stunting, wasting, underweight, and micronutrient deficiencies (essential vitamins and minerals). The thrust of this paper focuses mainly on stunting (i.e., low height-for-age, indicating chronic restriction of a child's potential linear growth) and wasting (i.e., low weight-for-height, indicating acute weight loss) because these two conditions can have different determinants and, more importantly, respond to different interventions (WHO 1995).

Magnitude of the problem of childhood stunting and wasting

For all developing countries 32% (or 178 million) of under-five year olds were estimated to be stunted in 2005 based on the new WHO Child Growth Standards (WHO 2006). Eastern and middle Africa present the highest estimated prevalence among UN sub-regions with 50% and 42%, respectively, while the highest estimated number of children affected by stunting, 74 million, are found in south-central Asia (Black et al 2008). These regional estimates are based on the analysis of 388 national surveys from 139 countries applying a well-established methodology (de Onis and Blössner 2003; de Onis et al 2004a; de Onis et al 2004b). Importantly, the prevalence of stunting is about 10-15% higher with the WHO standards than with the previous NCHS reference from 1977. These higher rates apply to all age groups, but are especially noticeable within the first six months of life and from 24 to 35 months of age (de Onis et al 2006).

Of the 40 countries with child stunting prevalence of 40% or more, 23 are in Africa, 16 in Asia and one in Latin America; while of the 52 countries with prevalence <20%, 17 are in Latin America and the Caribbean, 16 in Asia, 11 in Europe, and 4 each in Africa and Oceania (WHO 2008a). Of countries with a stunting prevalence of 20% or more, 36 countries account for 90% of all stunted children worldwide. Twenty-one of these countries are in Africa and although fewer countries are in Asia (n=13) they account for 61% of the total number of stunted children because of their large populations.

The global estimate of wasting (i.e. below -2SD weight-for-height median) as based on the WHO Child Growth Standards in under-five year olds is 10% (or 55 million). The highest prevalence and numbers affected, 16% and 29 million, respectively, are estimated for south-central Asia. The same regional pattern is found for severe wasting (i.e. below -3SD weight-for-height median), with a prevalence of 4% or 19 million children. The highest percentages of children with severe wasting are seen in south-central Asia and middle Africa. These severely wasted children have an extremely high risk of death (odds ratio: 9.4 (5.3-16.8)) (Black 2008). Overall, compared to the previous NCHS reference, wasting and severe wasting are substantially higher during the first half of infancy when assessed using the WHO standards. Thereafter, the prevalence of severe wasting as defined by the WHO standards continues to be 1.5 to 2.5 times that of the NCHS reference (de Onis et al 2006).

In general, the prevalence of severe wasting is higher at younger ages and then declines and reaches a plateau by 24 months. Conversely, stunting prevalence increases progressively until reaching a plateau at around 24 months of age (WHO 2008a). In a recent analysis, severe wasting was not accompanied by stunting in 80-100% of younger children and 40-50% of older children (Black et al 2008). Thus, identifying children who are stunted will not capture most of those who suffer from severe wasting. In addition, stunting and severe wasting are not necessarily associated on a geographical basis, that is, countries with a similar stunting rate can have considerably different prevalence of severe wasting (WHO 2008a).

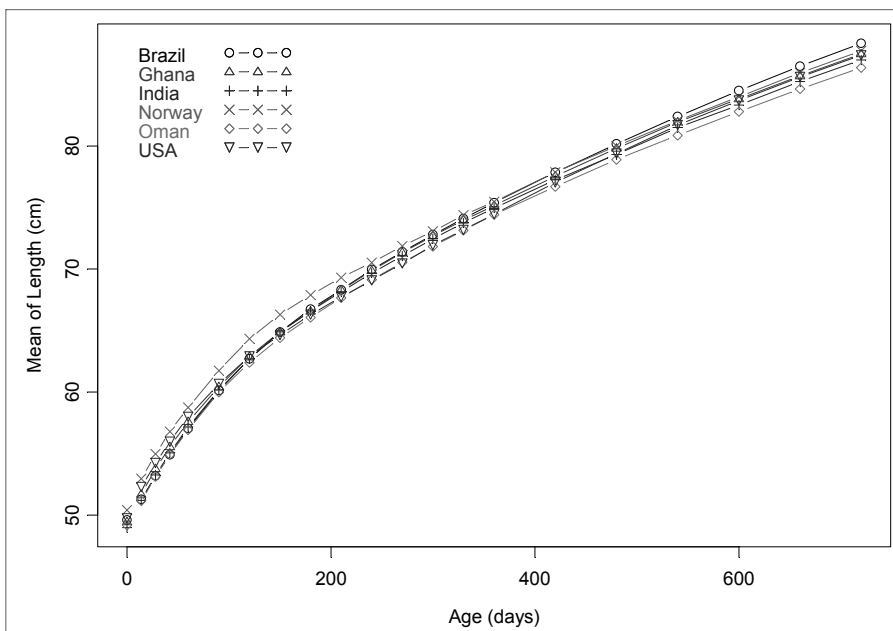
The great magnitude of undernutrition, which continues to hamper the growth and development of one third of the world's children, threatening their very survival, is unacceptable given the solid evidence that children from different areas and ethnic backgrounds experience very similar patterns of linear growth provided they are raised under appropriate environmental conditions (mainly proper feeding practices and free of infections). This has been shown by several studies, and more recently reconfirmed by the WHO Multicentre Growth Reference Study, where the length of children was strikingly similar among the six study sites (Figure 1) with only about 3% of variability in length being due to inter-site differences compared to 70% for individuals within sites (WHO Multicentre Growth Reference Study Group 2006). The striking similarity in growth during early childhood across human populations means either a recent common origin as some suggest (Rosenberg et al 2002) or a strong selective advantage associated with the current pattern of growth and development across human environments.

Projections of childhood stunting to 2015

At the Millennium Summit in 2000, representatives from 189 countries committed themselves towards a world in which sustaining development and eliminating poverty would have the highest priority. The increased recognition of nutrition as a basic pillar for social and economic development placed childhood undernutrition among the targets of the first Millennium Development Goal, "to eradicate extreme poverty and hunger" (United Nations 2002). The specific target goal is to reduce by 50% the prevalence of underweight among children younger than 5 years between 1990 and 2015.

Monitoring progress towards the MDG targets, requires reliable and standardized data collection systems that enable comparison over time. In an effort to monitor progress towards MDG1, we presented in 2004 estimates of global and regional trends of childhood underweight to 2015 (de Onis et al 2004b). We have since been asked how progress would be if we were to use the indicator of stunting instead of underweight. With the occasion of the 35th SCN Session we presented these results, based on analyses of 388 national surveys from 139 countries applying the same methodology as before (de Onis et al 2004b) and using the new WHO Child Growth Standards (WHO 2006). The great majority of the surveys were re-analyzed to obtain the stunting

Figure 1: Mean length (cm) from birth through two years for each of the 6 study sites.



estimates based on the WHO standards; however, for surveys for which the raw data were not available, the estimates were derived applying an algorithm that allows converting estimates of child stunting based on the NCHS reference into estimates based on the WHO Child Growth Standards (Yang and de Onis 2008).

Figure 2 presents projections of prevalence of stunting for 2015 compared with the MDG estimate. An overall improvement in the global situation is anticipated; however, neither the world as a whole, nor the developing regions, are expected to

achieve the MDG1 in terms of stunting. The same is true for underweight, as reported elsewhere (de Onis et al 2004b). This is largely due to the deteriorating situation in Africa, especially Sub-Saharan Africa. In Asia, the MDG1 is expected to be achieved, but the overall anticipated stunting rate for this region in 2015 will be above 20%, still a very high prevalence considering the large population of children that live in this region.

Figure 3 presents projections of the number of stunted children for 2015 compared with the MDG estimate. The vast majority of stunted children live in developing countries, mainly Asia and Africa. The projected trends in the prevalence of stunted children combined with the different population growth these regions are experiencing (increasing in Africa, decreasing in Asia) will narrow the gap between their respective contributions to the total number of stunted children. Overall, it is projected that in 2015 there will still be about 157 million stunted children living in developing countries.

These projections have a number of limitations. First, the availability of trend data is limited for a number of countries and some have not yet conducted national surveys. Second, surveys were not done randomly. Depending on where and when surveys were conducted, this may have biased the estimates of past and future estimates. Third, although the surveys included in the WHO database undergo data quality control that results in the exclusion of surveys with obvious flawed data (de Onis and Blössner 2003), there are variations in data quality between the different surveys included in the analysis. Lastly, when estimating trends involving numbers of stunted children, a degree of uncertainty in the UN population estimates must be taken into consideration. Nevertheless, despite these limitations and the inherent speculative nature of extrapolations to 2015, the present estimates provide a useful base for monitoring progress towards the achievement of the goal using the indicator of stunting.

Tackling the problem

Tackling the problem of childhood stunting and wasting is a major challenge for most countries affected by the problem. Applying the new WHO Child Growth Standards in the analyses increases the magnitude of the problem of childhood stunting and wasting as rates of these two conditions augment when using the WHO standards compared to the previous NCHS reference (de Onis et al 2006). The WHO standards also affect the interpretation of the nature of the problem by focusing greater attention on the problem of dietary quality and diversity, and possibly intergenerational factors limiting linear growth, rather than the problem of providing enough energy. The new standards also reveal that undernutrition during the first six months of life is a much greater problem than previously believed, thus bringing coherence between the rates of undernutrition observed in young infants and the prevalence of low birth weight and early abandonment of exclusive breastfeeding. The NCHS reference - due to its technical and biological deficiencies - did not pick up this early faltering and incorrectly made it

Figure 2: Projections of prevalence of stunting compared with MDG. Source: Data from WHO Global Database on Child Growth and Malnutrition; methods based on de Onis et al (2004b) using WHO Child Growth Standards.

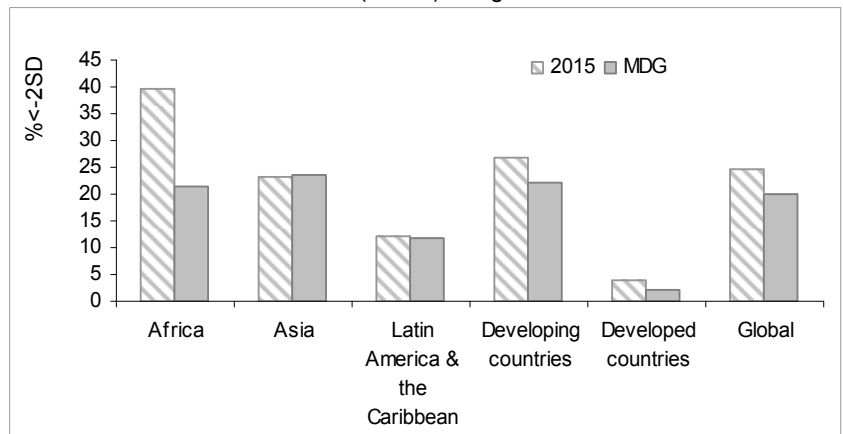
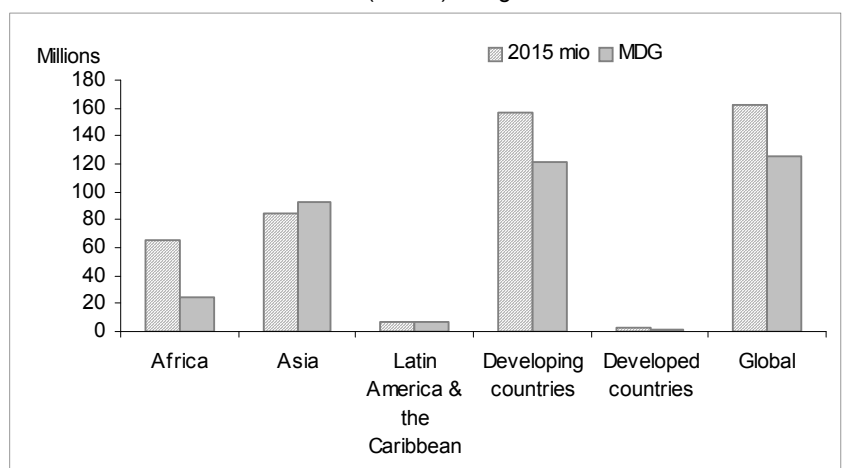


Figure 3: Projections of stunted children compared with MDG. Source: Data from WHO Global Database on Child Growth and Malnutrition; methods based on de Onis et al (2004b) using WHO Child Growth Standards.



appear that growth was protected during the first months of life. These findings highlight the need for prenatal and early life interventions to prevent growth failure which mainly happens during the first 2-3 years of life.

Understanding the reasons for the high prevalence of stunting in each setting will be important for implementation of appropriate interventions that will effectively tackle this form of undernutrition. Generally, interventions should focus on the promotion and protection of exclusive breastfeeding for the first six months of life with continued breastfeeding until 2 years or more; improving complementary feeding practices, including caregiver feeding behaviours; and interventions for maternal nutrition to improve pregnancy outcomes. Appropriate prevention and treatment of common early childhood illnesses would also be essential to improving child growth.

It is well known that complementary feeding diets are frequently deficient in key micronutrients and that the proportion of energy provided by animal source foods tends to be low. In addition, the common practice of the early introduction of complementary foods displaces breast milk and increases the chances of infectious morbidity. Thus, to prevent stunting, greater attention will need to be placed on improving the duration of exclusive breastfeeding as well as complementary foods and behaviours. Guidelines for complementary feeding are available (PAHO/WHO 2003; WHO 2004) and it is important that clear and consistent messages for how to feed infants and young children are disseminated at both facility and community levels. In addition, maternal education affects how well these messages are received and translated into improved nutrition outcomes. There is solid empirical evidence showing a strong association between low height-for-age and a lack of maternal education, with rates of stunting declining as levels of education increase (de Onis 2003). Therefore, elimination of stunting will require long-term investments to improve maternal education and empowerment of women, and to reduce current poverty levels.

Although fewer children are severely wasted worldwide compared to those affected by stunting, these children are at very high risk of death and their treatment should be taken as a priority. The scale up and improvement of hospital-based case management to prevent this important cause of death is important, however, hospital-based management reaches only a small percentage of children. Therefore, equally important will be to promote the new community-based approach currently recommended by UN agencies as an integral part of the management of severely wasted children (WHO/WFP/UNSCN/UNICEF 2007). This is critical if we are to reach the majority of children with severe wasting at the large-scale required to significantly impact this important cause of death.

Conclusions

The causes of growth retardation are deeply rooted in poverty and lack of education. As the WHO Child Growth Standards demonstrate, children up to the age of 5 years across large populations - regardless of their racial or ethnic background - grow to remarkably similar heights when given the best possible growth conditions in early life. To continue to allow underprivileged environments to affect children's development not only perpetuates the vicious cycle of poverty but also leads to an enormous waste of human potential (Victora et al 2008). Moreover, a growth standard based on a worldwide sample and recognition that environmental differences – not genetic endowment – are the principal determinants of disparities in child growth should contribute to fulfilment of accepted human rights principles, notably those stipulated in the Convention on the Rights of the Child (WHO 2008b). If the nutritional well-being of people is a precondition for the development of societies, it is all the more so where their most vulnerable members - children - are concerned. Efforts to significantly accelerate economic development will be unsuccessful until optimal child growth and development are ensured for the majority.

The WHO Child Growth Standards have been generally well received, providing an opportunity to redefine, refocus and reenergize all actions to promote child growth and development. Their introduction into countries can put a new focus on reducing malnutrition. As part of the implementation process, many countries that previously only monitored weight-for-age are incorporating the measurement of height which will allow them not only to assess stunting at an individual level, but equally importantly to monitor the growing problem of childhood overweight and obesity (WHO 2008c). By doing so they will be better prepared to address the double burden of malnutrition which increasingly is affecting all developing countries in the world.

Improving infant and young child nutrition must be a priority for all health personnel. They must have the knowledge and skills to appropriately counsel mothers on breastfeeding and complementary feeding and to treat illnesses that lead to poor nutrition. In this regard, the importance of early childhood nutrition can no longer be on the margin of discussions about maternal and child health but must instead become an integral part of all child survival strategies.

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Nutrition interventions that can accelerate the reduction of maternal and child undernutrition

Robert Black, Johns Hopkins University, lead author from the Lancet Nutrition Series

Introduction

The Maternal and Child Undernutrition Study Group, comprised of leading academics and nutrition experts from the UK, USA, Asia, and Africa, has been working over the last two years on a series of five papers on maternal and child undernutrition in developing countries, the Lancet Nutrition Series (Maternal and Child Undernutrition Study Group 2008). The Series follows a number of earlier important Series from *The Lancet*, such as those on child survival and neonatal health, maternal health and child development, which have shaped policy and action and show the journal's commitment to global health. The special series on child survival, for example, brought additional attention to the issues of child survival (The Bellagio Study Group on Child Survival 2003). While the Lancet Child Survival Series of course paid some attention to nutrition issues and interventions, such as the importance of promoting breastfeeding and complementary feeding and to some of the micronutrients, I think those of us who were involved in that series felt that we had not done full justice to the issues of nutrition and therefore proposed to do more. As we still felt that there was a big gap with regard to nutrition, we volunteered to the journal to take on this task, with the five papers of the Lancet Nutrition Series being the combination of that work (Maternal and Child Undernutrition Study Group 2008). The Series examines evidence-based interventions that, if implemented at scale, could significantly reduce the effects of maternal and child undernutrition.

The first two papers quantify the prevalence of maternal and child undernutrition and consider the short-term consequences in terms of deaths and disease burden, as measured by Disability-Adjusted Life Years (DALYs), and long-term educational and economic effects and associations with adult chronic diseases bringing in an array of new and important analysis (Black et al 2008; Victoria et al 2008). The third paper estimates the potential benefits of implementing health and nutrition interventions that current evidence indicates are effective and applicable in low- and middle-income countries (Bhutta et al 2008). The last two papers consider the current state of such interventions and how they could be implemented at scale through actions at national and global levels, what commitments are required at the country level to respond to the existing challenges and what action is needed from the international nutrition system (Bryce et al 2008; Morris et al 2008). As Ms Veneman said in her opening speech, the international nutrition system needs to see more work, coordination and certainly funding, which is justified for the problem of undernutrition (Veneman 2008).

This paper mainly focuses on the nutrition-related interventions described in paper 3. It also describes some of the background for these analyses which concern the basis for describing the problem of maternal and child undernutrition as described in paper 1 and by Mercedes de Onis in this SCN News (de Onis 2008).

Background for the intervention modelling

Undernutrition begins with the mother. In the series, we talk about maternal undernutrition for the mother's health as well as for foetal development and the application in early childhood. This includes not only the body size issues in terms of low BMI, but also less visible micronutrient deficiencies that can lead to serious health problems for the mother and intra-uterine growth restriction (IUGR).

We do in the series look at stunting, wasting, underweight and the related disease burden. While previous work that we and others have done regarding the nutrition-related burden of disease and intervention effectiveness used underweight, we decided, as described by de Onis in this issue of SCN News, that it would be much better to look at stunting and wasting separately, because they do have different programmatic implications. While both stunting and wasting begin in early childhood, stunting reflects a chronic restriction of linear growth, as indicated by low height for age, whereas wasting reflects acute weight loss as indicated by a low weight for height. Both conditions are usually caused by diets that do not provide sufficient nutrients and by high rates of infectious disease.

As described by de Onis, 90% of the 178 million children under five who are stunted in the world live in just 36 countries. These 36 countries were used in the intervention modelling that we did in paper 3 with actual

information on the current coverage of interventions to look at the additional effect of scaling-up nutrition interventions on mortality or on stunting. In paper 4, which deals with national program issues, we used the 20 countries where 80% of the stunted children live, because it was a smaller task to contact 20 countries, find out existing policies and what was being implemented on the ground. In addition to the 178 million stunted children, LNS also estimates that there are 13 millions babies born with intrauterine growth restriction and 19 million children suffering from severe wasting (Black et al 2008).

Paper 1 attributes death and disease burden to undernutrition and suboptimal breastfeeding. We have tried to not only look at mortality, which has been done before, but also disability and morbidity, calculating DALYs. The concept of DALYs, which represent lost years of "healthy" life, has become a common metric for describing disease burden because it allows us to combine the years of life lost due to the conditions that cause mortality with the non-fatal sequelae, including cognitive impairment and physical disability. We can therefore compare disease burden across different conditions, including those that do not cause much mortality, such as deficiencies in iodine and iron.

We estimated that nutrient and growth restriction, stunting and severe wasting combined, and without double counting, are responsible for 2 million deaths and 91 million DALYs, or 21% of the total DALYs among children under five. This represents 7% of the total global disease burden for any age group, which is the highest of any risk factor, once again highlighting the importance of undernutrition measures and the urgency of addressing undernutrition. For some of the micronutrient deficiencies, notably zinc and vitamin A, we calculated separately the disease burden. In combination, vitamin A and zinc deficiencies are the most important among the micronutrient deficiencies in contributing to the disease burden, accounting for about 10% of the global childhood DALYs. In addition, we found that iron deficiency is an important risk factor for maternal mortality, accounting for about 20% of maternal deaths each year. Suboptimal breastfeeding is another important risk factor which increases the risk of poor nutrient intake and infectious diseases and was estimated to be responsible for 1.4 million child deaths and 44 million DALYs (about 10% of global childhood DALYs).

The key messages from paper 1 are that, together these risk factors account for more than one third, about 35%, of child deaths, and 11% of the total global disease burden of all ages and individuals in the world; and about 3.6 million maternal and child deaths per year. The very high mortality and disease burden resulting from nutrition-related factors make a compelling case for the urgent implementation of proven interventions.

Regarding the longer-term consequences, paper 2 in the series presents extensive analysis that demonstrates how nutrition-related damage suffered in early life leads to permanent impairment. Undernourished children are more likely to become short adults and to give birth to smaller babies, thus there is a second generation effect. Moreover, strong evidence exists that links stunting to cognitive development, school performance and educational achievement. Poor foetal growth or stunting in the first two years of life leads to reduced economic productivity in adulthood. Paper 2 found that a child's height for age is the best predictor for human capital. We also looked extensively at the relationship between foetal and early childhood undernutrition and later chronic disease and have found some very strong relationships. Children whose early growth is restricted and gain weight rapidly later are more likely to have high blood pressure, diabetes and other metabolic conditions. A key finding from these analyses is that even with a low birth weight or IUGR the weight gained rapidly in the first two years of life is actually not harmful, but rather beneficial. This gives important indications that childhood nutritional interventions need to be directed to the first two years of life.

Evidence-based nutrition interventions

Paper 3 presents a systematic review of efficacy or effectiveness of 45 possible interventions that affect maternal and child undernutrition and nutrition-related outcomes. These potential ranged widely from the more specific interventions on breastfeeding promotion, complementary feeding promotion strategies with or without provision of food supplements and micronutrient interventions, to broader ones on supporting strategies for improving family and community nutrition and disease burden reduction and of course interventions for the treatment of severe acute malnutrition.

Table 1 summarizes the various interventions with demonstrated impact on maternal and child undernutrition in all countries. These are interventions that have sufficient evidence to be implemented in all countries to improve maternal and birth outcomes and nutrition of newborns, infants and young children. Promotion of breastfeeding and complementary feeding comes out as a very important intervention, along with micronutrients provided in pregnancy and maternal protein-energy supplementation. Importantly, for each of the conditions contributing to nutrition-related disability and death there are already highly effective interventions available. Other interventions were found to be appropriate in certain situational contexts, such as in malaria endemic areas or areas with high deficiency rates of particular micronutrients.

Modelling the impact of nutrition interventions

For the purpose of modelling the effect of these interventions, we developed a cohort model with data from the 36 high burden countries. Taking into account existing intervention coverage, we calculated the potential effect of scaling-up the proven nutrition and health-related interventions to 70%, 90% and 99% to see how much additional disease burden (DALYs) or mortality (deaths) could be averted. The major aspect of the model is a cohort structure that follows children from birth to 36 months, with death, stunting and no stunting as potential outcomes. Figure 1 shows the sort of information generated by the model and what happens between birth and 36 months of age. Starting at birth and then progressively looking over time, by 36 months of age about 9% of children have died (mortality showed in top part of figure) and of those who survive over half (58%) are stunted (stunting showed in middle part of figure). This cohort was mainly used for the preventive interventions, whereas for the therapeutic treatment of severe acute malnutrition we modelled separately to calculate the number of deaths that could be averted.

Table 3 lists some of the results from the modelling. For reductions in child mortality at full coverage of the evidence-based interventions, breastfeeding promotion is expected to have high impact. The calculations are based on the best available evidence for how well breastfeeding promotion programmes have changed practices. Individual peer counselling, for example, has been rather successful in changing breastfeeding practices towards more exclusive breastfeeding. Supplementation with vitamin A and of zinc has important preventive effects on mortality. Complementary feeding promotion and supplementation in food insecure areas

Figure 1: Cohort model for mortality and stunting used to model the effectiveness of interventions

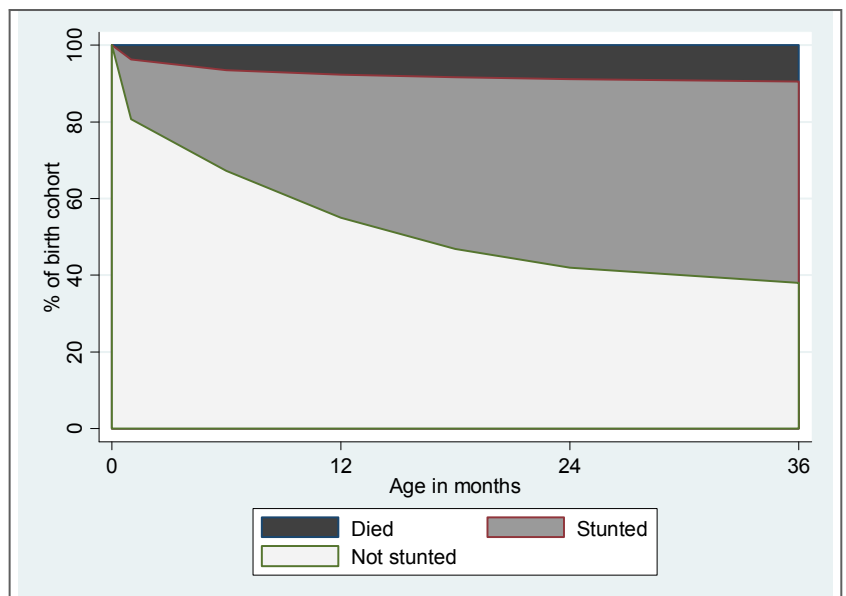


Table 3: Reductions in child mortality at full coverage

Child interventions

- Breastfeeding promotion – 9.1%
- Vitamin A supplementation – 7.2%
- Zinc supplementation – 3.6%
- Treatment of severe malnutrition – 2.2%
- Comp. feeding promotion/supplement. – 1.5%

Maternal interventions

- Energy/protein supplementation – 2.9%
- Intermittent preventive malaria treatment – 1.9%
- Multiple micronutrients – 1.6%

Table 4: Other intervention effects at full coverage

- Zinc supplementation – 17% reduction in stunting
- Complementary feeding promotion/supplementation – 15% reduction in stunting
- Iron and folate supplementation – 20% reduction in maternal deaths
- Hygiene promotion – 2.4% reduction in stunting

were looked at very extensively. The effect of these intervention programmes was found to be less than what we had hoped, and I think there is tremendous room for improvement and a need for more research and evaluation of how to best implement these programmes for improving complementary feeding. Maternal interventions during pregnancy, such as energy/protein supplementation, intermittent preventive treatment in malaria areas and provision of multiple micronutrients, may also contribute to reducing child mortality. When looking at other outcomes than mortality, zinc supplementation, improved complementary feeding and hygiene promotion would be expected to reduce stunting, whereas iron supplementation would reduce maternal mortality (Table 4). Other interventions not shown here include iodization of salt.

Conclusion

In summary, effective interventions are available to reduce stunting, micronutrient deficiencies, child mortality as well as maternal health conditions. The most promising interventions with regard to reducing mortality and disease burden would be the promotion of breastfeeding and complementary feeding and supplementation or, if possible, fortification with vitamin A and zinc, as well as appropriate management of severe acute malnutrition.

So, our key message concerning interventions, is that we have evidence-based interventions that work. The task ahead lies in implementing these interventions at scale to the entire population of mothers and children who need them. If we were able to deliver these interventions at scale, we could very quickly reduce the prevalence of stunting by a third, and reduce child deaths by at least one quarter.

We need to focus on the critical window from conception to 24 months of age, which should be our target for interventions and where we should direct our programmes. This may sometimes require shifting efforts that are directed at other age groups.

Progress is definitely possible, nutrition needs to become more of a priority, and an essential component of human, social and economic development. If we were able to implement these programmes, we would not only achieve - or come close to achieving - MDG1 on hunger, but we would also make more major contributions to achieving MDGs 4 and 5 on child and maternal mortality.

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Addressing the underlying determinants of undernutrition:

Examples of successful integration of nutrition in poverty-reduction and agriculture strategies

Marie T. Ruel, Director, Food Consumption and Nutrition Division, International Food Policy Research Institute (IFPRI)

Introduction

The third paper of the *Lancet Series on Maternal and Child Undernutrition* argues that effective, targeted nutrition interventions exist; and that if implemented at scale during the window of opportunity (pregnancy and up to the child's second birthday), these interventions could reduce undernutrition-related mortality and disease burden by 25% in the short term (Bhutta et al 2008). The set of interventions recommended addresses mainly the "food" (and nutrient) intake needs of mothers and children because this is where most of the quantitative evidence of efficacy and effectiveness lies. Interventions to directly improve health and care – the other two proximal determinants of undernutrition - are largely absent from the discussion, as are interventions targeting the more distal, underlying determinants of undernutrition such as poverty, food insecurity and lack of education. These omissions are justified, given the dearth of quantitative data on the effectiveness of interventions aimed at improving the underlying determinants of malnutrition. Examples of such programme and policy actions include strategies to reduce poverty, empower women and reduce gender inequality; agriculture development approaches to increase food production, income and food security and to stimulate overall economic growth; education to build human capital and empower future generations; and health systems strengthening to achieve high-quality health coverage for all. The *Lancet Series'* review of interventions also applies an additive model, which assumes that interventions act independently of one another. No allowance is given for interventions implemented jointly with the possibility of interactive, synergistic effects on improving nutrition, health and education, or for integrated packages of interventions that simultaneously address the direct and underlying determinants of nutrition.

This paper highlights the importance of addressing the global context in which undernutrition occurs, and argues that significant and sustained progress in improving maternal and child nutrition cannot be achieved unless appropriate actions are put in place to address the underlying determinants of undernutrition. The paper also emphasizes the importance of using a life-cycle approach to address undernutrition. While the nutrition community has finally reached a consensus on the importance of focusing on the window of opportunity for intervening in nutrition – i.e. the period between -9 months (pregnancy) and the child's second birthday (24 months) (Black et al 2008) – it is important to also ensure that other phases of the lifecycle are addressed and that the specific nutritional needs of individuals throughout the lifecycle are adequately met. The paper's main line of argument is that in order to address, in a sustainable way, the multiple causes of undernutrition and the different needs of individuals throughout the life-cycle, we need to: 1) work across sectors ; 2) mainstream nutrition within the health, agriculture and social development sectors, among others; and 3) scale up nutrition as part of cross-sectoral initiatives.

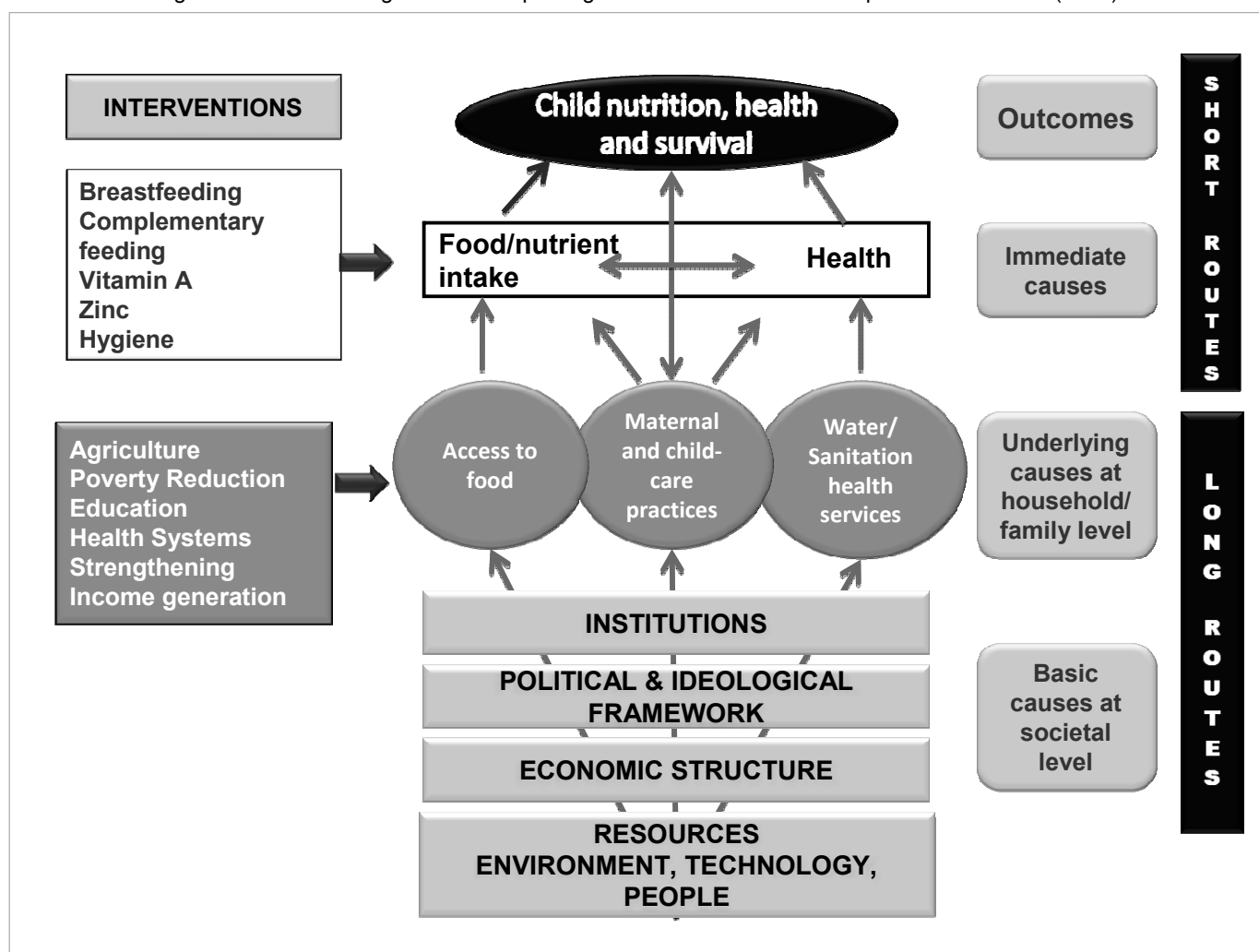
The Conceptual Framework of the determinants of undernutrition

The UNICEF conceptual model, which has been widely used since it was first developed in the early 1990s, clearly distinguishes the immediate, underlying and basic determinants of child undernutrition and their interdependence (UNICEF 1990). Figure 1 illustrates where, in the impact pathway, the targeted nutrition interventions with demonstrated effect highlighted in the *Lancet Series* will act (e.g. breastfeeding, complementary feeding, vitamin A, zinc, hygiene; see top left column). It shows that all these interventions focus on the immediate causes of undernutrition, i.e. improving food and nutrient intake and health. These types of interventions are referred to here as "short routes" to reducing undernutrition, borrowing from the terminology used by the World Bank (World Bank 2005).

The present paper focuses on the "long routes"¹ to improving nutrition (bottom part of the framework; also

1. The terms "short-route" and "long-route" to reducing undernutrition are borrowed from the World Bank *Repositioning Nutrition* (World Bank 2005) publication. The interpretation is that: "short-route" interventions are more likely to achieve impact on nutrition in the relatively short term, say within 1 or so, whereas "long-route" interventions may take longer to confer nutritional benefits. This is because these latter types of interventions are less "direct", as they address the underlying causes of malnutrition rather than the immediate causes.

Figure 1: Short and long routes for improving child nutrition. Source: Adapted from UNICEF (1990).



see Box 1), and on actions that influence the underlying determinants of nutrition – improved food security, adequate maternal and child care-giving resources and practices, and improved availability and access to adequate health care services and a healthy environment. It focuses on the processes, programmes and policies that need to happen at the more global level to ensure that reductions in maternal and child undernutrition will not only be achieved in the short term, but will be maintained in the long term, will be sustainable, and will be transmitted from one generation to another. The paper emphasizes that both the short-routes and the long-routes to improving nutrition need to be addressed simultaneously to create an enabling environment for sustained improvements. The short routes will ensure quick nutritional benefits; the long routes will ensure that benefits are maintained over time and will allow individuals, communities and countries to move out of poverty, food insecurity, gender discrimination, poor health and undernutrition in a sustainable way.

The paper showcases a subset of these long route strategies to improve nutrition, and provides a few relevant examples, namely the role of agriculture, of large-scale poverty alleviation programmes and of successful national strategies that used multi-sectoral approaches to curb childhood undernutrition.

The central role of agriculture in improving nutrition²

Agriculture is fundamental to the achievement of nutrition goals, as it produces the food, energy, and nutrients essential for human health and well-being. About 75% of the developing world's poor live in rural areas, particularly in Asia and Africa (Ravallion et al 2007), and for most of them, agriculture is the major source of livelihood. Poor households also host the majority of undernourished mothers and children, and are disproportionately headed by women, many of whom work in agriculture. Agriculture is thus central to poverty reduction, and

2. This section draws from the following publications: von Braun, Ruel and Gillespie forthcoming; World Bank and IFPRI 2007; Hawkes and Ruel 2006b).

higher agricultural productivity is critical for the attainment of the millennium development goals (MDGs). By increasing food availability, generating income for farmers, and improving the purchasing power and asset levels of the poor, agricultural growth can contribute directly to MDG1 of halving hunger and poverty by 2015 and reducing childhood undernutrition (Rosegrant et al 2006).

Agriculture is also linked – indirectly or directly – to all other goals, and in particular to those of gender equality and empowerment of women (MDG3), maternal and child health, nutrition and survival (MDG4 and MDG5), and HIV/AIDS and other illnesses (MDG6) (von Braun et al, forthcoming). Agriculture contributes to MDG3 through the economic empowerment of women farmers. By increasing women’s control over income, agriculture can help ease their time burden and improve their quality of life, health, and well-being as well as that of their children. There is strong evidence that women who have control over income are more likely than men to invest in their children’s education, health and nutrition (Hoddinott and Haddad 1994, Katz 1994, Quisumbing 2003). Agriculture can also contribute to reducing child and maternal mortality (MDG4 and MDG5) and to combating HIV/AIDS and other diseases (MDG6) by increasing the diversity of the food supply, increasing the micronutrient density of staple crops (e.g. through biofortification) and improving the overall quality of diets; and by increasing income and making more resources available to prevent and manage illnesses (Bouis 2002, von Braun et al 2004). Achieving these goals, in turn is also essential to boost agricultural performance and productivity and to eradicate poverty. Thus, agriculture, health and nutrition are closely linked, and their linkages are bi-directional: agriculture affects health and nutrition; health and nutrition affect agriculture; and health and nutrition affect each other (Hawkes and Ruel 2006a). This implies that solutions to solve the health and nutrition problems of the poor need to integrate agriculture, health and nutrition actions, and they need to be designed jointly (Hawkes and Ruel 2006b).

The five main pathways by which agriculture affects nutrition can be summarized as follows (see World Bank and IFPRI (2007) and Hawkes and Ruel (2006b) for a detailed description of these pathways):

- Increased consumption from increased food production (production for own consumption)
- Increased income from the sale of agricultural commodities (production for income)
- Empowerment of women agriculturalists and related gains in children’s nutrition and welfare
- Lower real food prices resulting from increased food production
- Macroeconomic growth arising from agricultural growth.

Over time, changes in the global environment have modified the pathways by which agriculture affects nutrition, and have made the need for integrating agriculture and nutrition even more imperative. Globalization and other changes in agricultural policy, the growth of agricultural technology, the increasingly important role of markets in the food chain, and the related changes in food consumption patterns are affecting the pathways through which agriculture and nutrition are linked (World Bank and IFPRI 2007). For instance, the more market-oriented nature of agriculture policies means that agriculture technology and markets play a more important role in determining food prices and rural incomes, as more food is consumed from the marketplace and less from households’ own production. Changing food and nutritional demands resulting from income growth and urbanizing populations increasingly affect agriculture production decisions (Hawkes and Ruel 2006b). The current wave of rising food and fuel prices and the manifestations of climate change on agriculture are additional forces that will dramatically affect how agriculture, health and nutrition

Box 1: Examples of long routes programmes and policies to improve nutrition. Adapted from World Bank 2005.

- Agricultural programs and policies to increase the supply and consumption of safe, nutritious foods (e.g. support to the production of fruit and vegetables and/or small animals, fish, etc; biofortification to increase the density and bioavailability of micronutrients in staple foods)
- Poverty alleviation strategies, social safety nets, social protection and social policy
- Strategies to empower women, improve their social status, employment opportunities, access to and control over assets; strategies to reduce women’s work load and provide assistance with child care
- Education policies, which help build human capital for future generations
- Health sector policies
- Water, sanitation, infrastructure
- Favourable food price policies
- Pro-poor economic development and related increases in employment opportunities and income of the poor

are inter-linked. Hence, agricultural development programmes and policies can no longer ignore nutrition; programme planners and policy-makers need to take the changing environment into account in designing programmes and policies to ensure that the synergies between agriculture and nutrition are successfully exploited and lead to better overall development outcomes (World Bank and IFPRI 2007).

Conditional Cash Transfer programmes : Poverty-alleviation with a focus on human capital formation

Social protection policies and programmes are another set of instruments used to reduce poverty and undernutrition. They encompass a variety of approaches, including safety nets, social assistance and social insurance. A novel approach to social safety nets developed in Mexico in the late nineteen nineties is the conditional cash transfer programme (CCT) (Levy 2006). CCT programmes involve the direct transfer of cash to poor households, with the condition that the household undertakes specific actions such as enrolling and maintaining their children in school, and complying with a schedule of health visits for mothers, young children and other household members. CCT programmes are usually targeted to poor households or other vulnerable population groups, and benefits are often specifically targeted to the woman in the household (Adato et al 2004). The overarching goal of CCTs is to reduce poverty and food insecurity in the short term, while providing an incentive for poor families to invest in their children and hence alleviate poverty in the long term. By improving human capital formation through improved health, nutrition and education of children, CCTs aim at reducing the intergenerational transmission of poverty. These programmes also take into consideration the specific health, nutritional and educational needs of household members at different stages of the lifecycle. With their strong focus on strengthening women's health and -wellbeing, and by targeting transfers to women (as most programmes do), they also capitalize on the added benefits on children's welfare of empowering women and giving them increased control over income.

Several CCT programmes also include a supply side component and allocate funds to improving the quantity and quality of schools and health services. These programmes then address both the demand and the supply constraints to human capital formation among poor populations.

The benefits of CCTs on poverty reduction are well documented, especially for Latin American countries.³ The landmark programme PROGRESA, now *Oportunidades*, launched by the Government of Mexico in 1997 has now been scaled up to cover more than 5 million households in all 31 Mexican states. Rigorous evaluations of the programme have shown that it has contributed to reducing the poverty headcount by 10%, the poverty gap by 30%, and the severity of poverty by 45% (Skoufias 2005). Greater impacts were achieved among the poorest households. Large poverty reduction impacts were also documented in Nicaragua with the *Red de Protección Social* programme, where extreme poverty fell by 22 percentage points in 2001 and 16 percentage points in 2002 (Maluccio and Flores 2005). Other programmes in Brazil (*Bolsa Escola*, now *Bolsa Familia*) and Colombia (*Familias en Acción*) have also documented impacts on poverty reduction, although of smaller magnitude (Adato and Bassett 2007). It is important to recognize that programmes differ markedly in terms of the size of cash transfers and the proportion of household income they represent. A review of 6 programmes in Latin America and the Caribbean suggest that the size of the transfer varies from 10% in Honduras to 30% of pre-transfer household total consumption expenditure (Glassman et al 2007). Programmes also differ in targeting efficiency, and thus impacts on poverty are expected to vary between programmes. Irrespective of these considerations, all Latin American programmes evaluated, with the exception of Honduras's programme which suffered some implementation constraints, have shown a positive impact on household total consumption (Adato and Bassett 2007), a proxy indicator of income.

Similarly, CCT programmes in Latin America have shown significant benefits in increasing household food security and consumption of nutritious foods such as meat, dairy, fruit and vegetables, and in improving overall household dietary quality. The programmes have also consistently improved school enrolment and in many cases attendance in primary or secondary school, or both. Differences in impacts in relation to schooling depend on both design issues (i.e. whether primary or secondary school level children are targeted

3. For a detailed review of the impact of cash transfers – conditional and non conditional – see Adato and Bassett (2007). For a brief overview of conditional cash transfer programs, see Adato and Hoddinott (2007).

by the program), and on the baseline levels of schooling (e.g. whether school enrolment and attendance in primary and secondary school were low or high at baseline) (Adato and Bassett 2007).

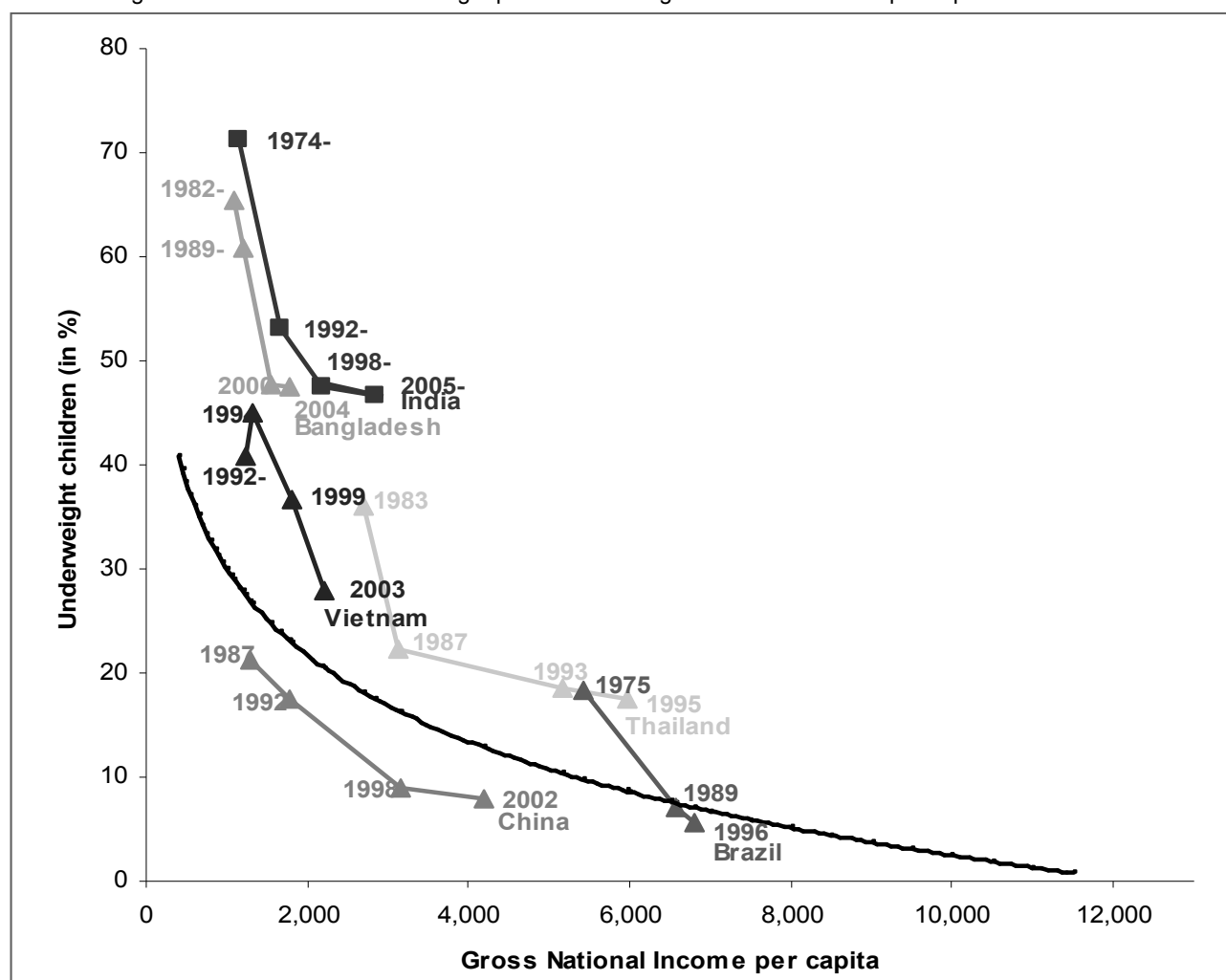
The impact of CCTs on the use of health services and health outcomes has also been reviewed, especially in Latin American countries where most of the experience exists. Overall, the picture again is one of positive impacts on the use of preventive health services (e.g. increased number and frequency of preventive health visits), while impacts on immunization coverage and health outcomes are more mixed (see Glassman et al 2007, Lagarde et al 2007). Lack of impact on immunization and health outcomes is believed to be related to weaknesses in the supply side – i.e. if services are of poor quality, increased attendance is unlikely to lead to positive health outcomes.

Impacts on child anthropometry are also mixed, but significant and large impacts were found in Nicaragua, where a reduction in the prevalence of underweight of 6 percentage points in 2 years was found among children less than 5 years of age (Maluccio and Flores 2005). Results from Mexico also suggest a significant impact of the programme on reducing childhood undernutrition, but the exact magnitude of impact is difficult to report, as results differ depending on the round of data collection, the population groups studied, and the analytical models used (Glassman et al 2007, Lagarde et al 2007). Overall, however, the results are consistent in showing a reduction in stunting prevalence. There is also evidence of a small reduction in the prevalence of anaemia among children participating in the programme in Mexico, but no impact was found in Nicaragua (Rivera et al 2004, Maluccio and Flores 2005).

This brief overview of the impact of CCT programmes on health and nutrition outcomes raises several questions. Although the programmes clearly seem to increase the demand for health services, the impacts on health and nutrition outcomes are less consistent. As noted above, this is likely due to variations in the quality of health services, and in the availability of supplies such as vaccines or micronutrient supplements at the health centers. The impacts on child anthropometry outcomes, which in the case of Nicaragua are of large magnitude (6 percentage points in 2 years) are also observed in some, but not all countries where this outcome was assessed.

The main factor that complicates interpretation of the nutrition impacts of CCT programmes is the lack of initial conceptualization of what these programmes are expected to achieve in terms of nutritional impacts, and how they may achieve these impacts. There is a dearth of information throughout the CCT evaluation literature on what the mechanisms by which these programmes are expected to improve nutrition are; similarly, there is lack of analysis, using appropriate modelling techniques, of the mechanisms by which nutrition improvements actually do occur (or not). Future evaluations of these programmes should use a programme theory framework to conceptualize and document the specific pathways by which CCT programmes are impacting nutrition (Rossi et al 2004, Loechl et al forthcoming). Referring to Figure 1, we can expect that CCT programmes could affect nutrition through a combination of several pathways; one potential pathway is through increasing income and access to food, thereby increasing household food consumption; another pathway may be through improved child care and feeding practices (e.g., as a result of greater maternal control over income and/or improved knowledge from exposure to nutrition education); and another potential pathway is through improved water and sanitation and/or greater use of health services and the resulting prevention and better control of infectious diseases. Understanding the pathways of impact of CCTs is important because it will help better define the package, dose, and combinations of interventions that should be incorporated in these programmes to enhance their nutritional impact, and it will allow more effective and successful replication and scaling up of the programmes in different contexts. As CCTs are becoming increasingly popular and are being replicated widely in Africa and Asia, it is time for nutritionists to start paying attention to how these programmes' nutrition intervention packages are designed and implemented, which mechanisms and pathways ensure maximum impacts on nutrition, and how they can be replicated and scaled up most successfully. It is also important to collect appropriate data on the supply side to better understand the role of service delivery and quality in achieving nutritional impacts. Through the conditions they impose on households, CCT programmes necessarily establish a link to health systems and thus may provide an opportunity for mainstreaming and strengthening nutrition within the health sector.

Figure 2. Trends in child underweight prevalence and gross national income per capita in select countries



Examples of success stories in reducing child undernutrition at scale (national level) and lessons learned⁴

Figure 2 presents some data on the relationship between trends in economic development and the prevalence of underweight for select countries in the past 2-3 decades (Wiessman et al 2006, 2007). The curved line depicts the expected prevalence of underweight children for a country, given its economic development (gross national income per capita), based on data from 110 countries. It shows that countries like Vietnam and Thailand have been making significant progress since the early eighties in reducing the prevalence of underweight children, as their national income per capita has increased over time. The same is true for Brazil, which has been doing particularly well in the nineties, crossing the line and showing larger rates of reduction in the prevalence of underweight children than expected, given its rate of economic development. China is an example of a positive outlier, which has consistently had a lower prevalence of underweight for its GNI since the mid eighties.

India and Bangladesh, on the other hand, are examples of negative outliers in the sense that they have excessively high prevalences of underweight for their level of economic development; and India has continued to do so in spite of the rapid economic growth it has experienced in recent years.

Box 2 gives a short summary of the experience of three of these countries, Thailand, China and Brazil, which highlights the policy instruments that have been particularly successful at reducing childhood undernutrition at scale in these countries over the course of one or two decades. The diversity in the approaches that successful countries have adopted emphasizes that there is no one-size-fits-all solution to improving nutrition at scale. Each country has to tailor its set of policies to its own reality. However, a few lessons learned

4. This section draws from: von Braun et al 2007.

emerge from the country examples highlighted; key enabling conditions can be summarized as follows:

- Strong government action coordinated across central, state, and local levels; and across sectors;
- Leadership at the highest level to ensure attention across branches of government and regions;
- Inclusion of vulnerable groups and their communities in terms of mobilization and information sharing;
- A strong monitoring and evaluation culture that provides a basis for incentives and correction of policy actions in the context of implementation;
- Significant scaling up of public spending.

Conclusions

The nutrition community rightly focuses on the short routes to improving nutrition; the *Lancet Series* confirms that implementing a given set of targeted nutrition interventions, at scale, will result in substantial reductions in maternal and child undernutrition, mortality and disability in the short term. The urgency of achieving these goals is irrefutable. However, the focus on targeted nutrition interventions should not preclude investing in developing the foundations and the enabling environment that will allow nutrition gains to be maintained in the long term and in a sustainable way. This will require a more aggressive involvement of the nutrition community in strategies to address the underlying determinants of undernutrition. This inevitably will involve working more effectively across sectors. The nutrition community needs to be more involved and more forceful in positioning nutrition within the larger social development context. This will require working to improve nutrition not only through health, but also through agriculture and rural development, water and sanitation, education, gender, and social policy, social protection and poverty reduction strategies and programmes. Nutrition provides an opportunity to overcome some of the traditional sectoral divides, and for collaborative approaches to be designed and implemented. Clearly, the complexity of such inter-sectoral efforts has discouraged many in the past. But in current times, with the globalization of the food system, climate change, and the current food and fuel price crisis, we have no choice but to try again, with innovative approaches and new energy. And this time, we need to better document successes; we need to document not just impact, but impact pathways using well defined programme theory framework; and we need to better understand the policy processes and the political and social conditions that contribute to nutrition impact. In sum, we need strategies that effectively integrate long and short routes to improved nutrition, are multi-sectoral in nature, address the lifecycle, and are carefully monitored and evaluated to facilitate replication and scaling up.

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Box 2: Summary of policy instruments and success factors in three countries that have reduced child undernutrition at scale

Thailand: Halved child malnutrition between 1982 and 1986 (from 50% to 25% in less than a decade)^a

Policy instruments:

- Thailand's 2nd National Health and Nutrition Policy (1982–86) focused on targeted nutrition interventions to eliminate severe malnutrition, and behaviour change and communication to prevent mild to moderate malnutrition.
- The policy used social mobilization and relied on community-based primary health care as a delivery system for nutrition and health interventions.
- Health volunteers underwent extensive training and massively increased in numbers, reaching a ratio of 1 health volunteer for 20 households.
- The targeted and achieved coverage was high.

Success factors:

- The country's leaders had a vision of what was to be achieved and planned adequately for the scaling-up process.
- Nutrition was integrated within the National Economic and Social Development Plan, and linkages between agriculture and nutrition were established, ensuring sustainability.
- Social mobilization and community-level involvement were highly successful.
- A strong local, action-oriented surveillance system allowed for monitoring and evaluating progress.
- The country made a large investment, accounting for approximately 20% of total government expenditure on health and a similarly high percentage on education during these years.

China: Reduced child malnutrition by more than half between 1990 and 2002 (from 25% to 8% in 12 years)^b; China achieved the MDG 1 in 2002^c

Policy Instruments:

- China pursued a successful poverty alleviation strategy along with rapid economic growth.
- Effective nutrition, health, and family-planning interventions were implemented at a large scale.
- China also focused on complementary interventions to address other determinants of child malnutrition, such as water and sanitation (which help reduce illness from infectious diseases) and education (between 1992 and 2005, the share of mothers who had completed middle school increased from 32% to 57% and the share of illiterate women fell from 22.5% to 7%)

Success factors:

- Central leadership was combined with a commitment to the process and the establishment of local government ownership
- China established an effective data collection system that provides regular data for monitoring progress, and the country's strong research institutions ensure that data and information are effectively communicated to policymakers and used for policymaking.
- Strong and effective partnerships were established between the Chinese government and international partners.
- The budget share of government expenditure on education increased to 20% during the 1990s, although the share spent on health was relatively low (~3–4%).

Brazil: 60% reduction in child malnutrition (from 18% to 7%); and reductions in infant mortality from 85 to 36 deaths per 1,000 live births from 1975 to 1989^d

Policy Instruments:

- The period of sharpest economic growth and poverty reduction occurred in Brazil from 1970 to 1980, before improvements in child malnutrition and infant mortality (that is, there was a lagged response).
- Coverage of safe water increased from 35% in 1967 to 80% in 1980. Sewerage coverage increased to 50% by 1980.
- Immunization coverage more than tripled from 1975 to 1988; the number of physicians per 1,000 people doubled.
- Major investments were made in direct nutrition inputs (food programmes) and in social sector spending on water and sanitation, health, and education.

Success factors:

- Various food and nutrition programmes, including food distribution programmes (via both private and or public sector channels) and direct subsidies, were implemented; these programmes were almost entirely supported by national resources.
- Food programme expenditures went from 0.06% of GDP in 1980 to 0.21% of GDP in 1989. Food- and nutrition-related expenses went from 0.16% to 0.25% of social sector expenses.
- Investments in health showed an upward trend from 1975 to 1982, with lower levels in 1983–84. They further increased to a peak of US\$68.73 per capita in 1989 (2.4 times the expenditures in 1975).
- Spending on education increased during 1976–82. Per capita education expenditure was US\$31.9 in 1982, dipped to US\$24.5 in 1984, but increased again to reach US\$54.8 in 1988 (a sevenfold increase compared with 1970).

Since 2004 Brazil has further accelerated its nutrition policy efforts with its Zero Hunger program, and nutrition has improved significantly. That programme more than doubled food and nutrition spending between 2003 and 2007 (to about US\$13 billion annually in 2007).

Sources: a) Heaver 2002; Tontisirin and Bhattacharjee 2001; b) Information on China was obtained from Dr. Chen Chunming who gave the 17th Annual Martin J. Forman Memorial Lecture, entitled: "Nutrition and Health in China -- From Science to Policymaking", at IFPRI, Washington, DC, January 26, 2007. Available from www.ifpri.org/events/seminars/2007/20070126Forman.asp; d) Svedberg 2007.

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A National Plan of Action to Accelerate Stunting Reduction in Vietnam

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Abstract: Purpose of paper: To outline current maternal and child undernutrition in Vietnam and proposed strategies to overcome the problems. **Main findings:** During the last decade, Vietnam has achieved remarkable improvement in the nutritional status of its people, especially regarding the nutritional well-being of mothers and children. However, malnutrition is still a serious challenge for health and development. In 2007, 1.6 million children under 5 were underweight (21.2%), and 2.6 million were stunted (33.9%) country-wide (WHO standards). Micronutrient deficiencies, especially sub-clinical deficiencies in vitamin A, iron and iodine, are still significant public health problems. To accelerate the reduction of maternal and child undernutrition, the Vietnamese government is committed to prioritized investment for nutrition in order to achieve the MDGs. Special attention will be given to pre-pregnant and pregnant women to reduce intrauterine malnutrition. A key point of the intervention strategy is that more focus will be placed upon women and children in the first two years of life. The current national malnutrition control program should be maintained and expanded, focusing more on care at the household level. Resources should be prioritized for areas that are disadvantaged in social economic development, geographical features, and access to health and social services. **Principal conclusion:** Nutrition is fundamental for development of the Vietnamese society. Multi-sectoral cooperation, public-private partnerships and further assistance and support from international organizations, NGOs and UN agencies, should be sought out for malnutrition control activities in Vietnam along with improved monitoring and evaluation activities.

Introduction

Child malnutrition impairs the physical and mental development of the child and, potentially, of future generations, which will have long term effects on socio-economic development. It is estimated that there are about 32% under five children in developing countries (178 million) being stunted and 20% being underweight (Black et al 2008). Reducing malnutrition among children under five is critical in achieving Millennium Development Goals (MDGs) 1, 4 and 5, which concern the reduction of hunger and undernutrition, child mortality and maternal mortality, respectively.

Over the last decade, Vietnam has been regarded by UNICEF/EAPRO as one of the countries in the region with the most striking reduction of malnutrition (UNICEF/EAPRO 2003). However, malnutrition is still a major public health problem in the country. Reduction of child malnutrition is high on the government's agenda (Government of Vietnam 2001) but the prevalence of stunting in the country was still around 30% in 2005 (NIN/GSO 2005) and therefore a continued major concern and threat to the success of national development plans. In Vietnam, malnutrition limits the stature and productivity of future adults, increases the child mortality rate by 2.5 to 8.4 times and contributes to 7,000 young child deaths a year (NIN unpublished).

In this paper, we describe observed changes in the prevalence of undernutrition in children under five years old based on annual surveys from 1999 to 2005 conducted by the National Institute of Nutrition, Vietnam, and present main directions and plans for accelerating the reduction of child stunting in the period 2008 to 2010 and beyond.

Trends in child undernutrition in Vietnam (1985 - 2006) and risk factors of malnutrition

Trends in child undernutrition in the period 1985 - 2006

There has been remarkable progress made in reducing child undernutrition in Vietnam over the past two decades. The prevalence of underweight has fallen from 51.5% in 1985 to 24.6% in 2006, which represents an average 1.3% per year (NCHS reference). The prevalence of stunting also exhibits a substantial decrease of 1.5% per year in the same period, from 59.7% in 1985 to 27.9% in 2006 (NCHS reference) (Figure 1). These trends, together with declining fertility rates, have led to annual decreases in the numbers of underweight and stunted children. About 0.6 million and 0.5 million fewer children were underweight and stunted, respectively, in 2005 than in 2000 (Table 1). However, the current prevalence of child malnutrition, in terms of both underweight and stunting in Vietnam remains high based on the classification of the World Health Organization (WHO 1995).

Regional differences exist for child malnutrition prevalence and trends in Vietnam. Between 1999 and 2005, the Central Highlands, where malnutrition rates are the highest, has seen the largest reduction, of almost 15% in underweight and 12% in stunting, equivalent to 2.4% and 1.9% per year on average in underweight and stunting, respectively. The Mekong River Delta had the smallest average yearly reduction in underweight, 1.5% per year, while the Southeast had the smallest average yearly reduction in stunting, 1.0% per year. However, these two regions had some of the lowest rates of malnutrition in Vietnam (Table 2).

Low birth weight (LBW) (<2500g) is regarded as an important indicator of maternal undernutrition during pregnancy and predicts the nutritional status of the child. In recent years, the prevalence of LBW in Vietnam has decreased considerably from 8.0% in 1999 to 5.1% in 2005, with an average reduction of 0.5% per year (Figure 2).

We recognize that the LBW rates reported through official reporting systems are often not representative of the population as a whole. A study of the maternal factors associated with LBW in northern Vietnam found rates varying from 7.9 to 12.5%, with rates higher in rural communities than in urban ones. LBW was furthermore found to be associated with Body Mass Index (BMI), food availability during pregnancy, maternity leave before delivery, and parity (Dinh et al 1996).

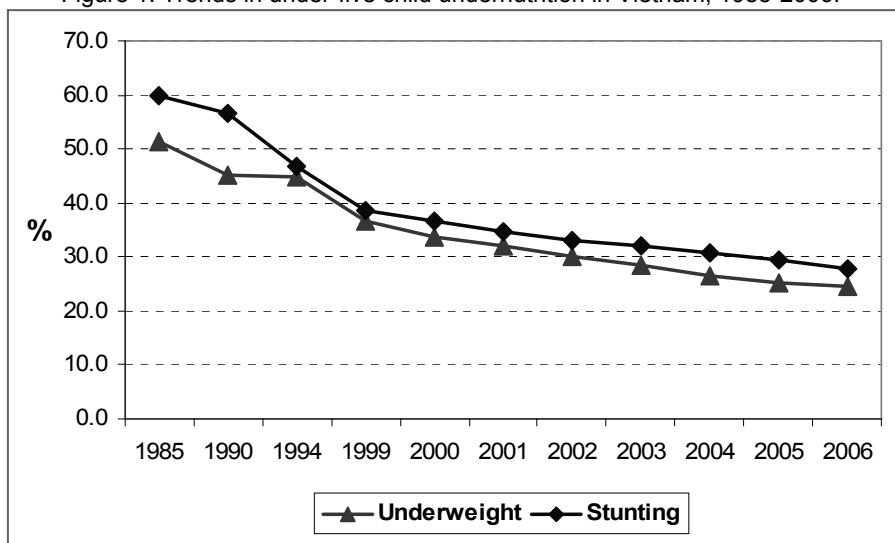
Risk factors of child stunting

Risk factors for child stunting were analyzed using data from the National Protein Energy Malnutrition (PEM) monitoring and evaluation survey in 2004 (NIN/GSO 2005). Economic status and living condition of the family

were found to have a very strong impact on the child's nutritional status. Poor households and lower economic areas posed a high risk for child malnutrition. Stunting was higher in children whose parents were farmers and higher in households with more children, and was lower in households with safe water access and hygienic toilets. No differences were observed in stunting prevalence between boys and girls (Khan et al. 2007). Maternal health and nutritional status played a critical role in child stunting in Vietnam (Khoi et al. 2000).

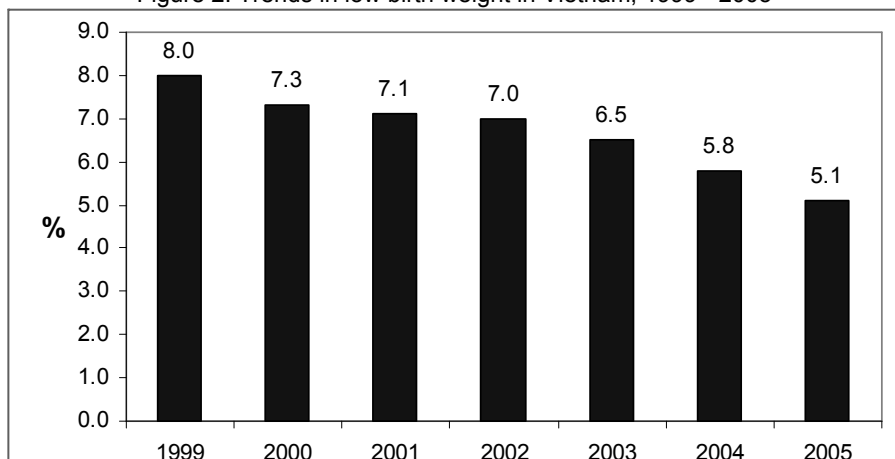
Child care affects the nutritional status of children. Child care practices depend on many factors such as culture, habit, family economic status, and knowledge of primary caregivers. In rural and mountainous areas of Vietnam, where the proportion of children who attend day-care centres is very low, mothers' knowledge about selecting and processing food and feeding patterns has been found to be generally limited (MOET 1999).

Figure 1. Trends in under-five child undernutrition in Vietnam, 1985-2006.



Sources: 1985: National survey 1981-1985; 1990: General Nutrition survey 1987-1990; 1994: National Vitamin A Deficiency and Protein-Energy Malnutrition survey; 1999-2006: Annual Protein-Energy Malnutrition Monitoring and Evaluation surveys. Data based on NCHS reference

Figure 2. Trends in low birth weight in Vietnam, 1999 - 2005



Source: Health Statistics Yearbook, years from 1999 to 2005 (MOH 1999-2005)

Contributions to child undernutrition reduction

There are many factors contributing to undernutrition reduction in Vietnam. The success of the country's family planning program may have created opportunities for families to better invest in child nutrition and health care. The effect of health care activities, including immunization, control of diarrhoea, control of respiratory infections and other maternal and child health care programs might also have contributed to a reduction in child malnutrition. Since 1999, the Government of Vietnam has had a 'pro-poor' policy in order to support the poverty reduction programs such as 'program 135' (one of Vietnam's principal National Target Programs (NTP) for poverty reduction: Program for Socio-Economic Development in Communes Facing Extreme Hardship in Ethnic Minority and Mountainous Areas, known more familiarly in Vietnam as Program 135, implemented by the Committee for Ethnic Minorities) which covered 2,374 of the poorest communes in the whole country, mainly in remote, mountainous and border areas. Poverty alleviation programs have had an important impact on reducing child malnutrition in Vietnam in the past (Ponce et al 1998).

It is recognized that nutrition intervention activities in Vietnam have played a critical role in the reduction of child undernutrition (Pachon et al 2002). Since 1999, with increasing investment from the government over the years, the PEM control program has covered all communes nationwide (NIN 2004). The role of the PEM control program was not only to provide care to target children and mothers, but also to raise awareness and commitment from authorities at all levels. Reducing malnutrition was included as a goal in the government's socio-economic development agenda and many organizations such as the Women's Union, the Youth's Union and the Farmer Association have actively participated in the PEM control program. Along with poverty reduction, it is likely that the PEM control program had a significant contribution to the high rate of child under nutrition reduction in the period from 1999 to 2005. But it seems that this progress is tailing off, and some modifications to the PEM control program strategies are necessary.

Table 1. Numbers of malnourished children over the period 2000 to 2005.

	2000	2002	2005
Vietnam^a			
No. of underweight children (million)	2.5	2.05	1.912
No. of stunted children (million)	2.7	2.24	2.246
South-eastern Vietnam Asia^b			
No. of stunted children (million)	18.9		15.8
Proportion of stunted children in South-East Asia living in Vietnam (%)	14.3		14.2

Source: a) Estimation based on annual Protein-Energy Malnutrition Monitoring and Evaluation surveys; b) de Onis et al 2000

Table 2. Prevalence and average reduction of child undernutrition in Vietnam over the period 1999 to 2005 by region and age group (%)

		1999	2005	Total reduction 1999-2005	Average reduction per year
Underweight: Total		36.7	25.2	11.5	1.9
By region	Red River Delta	33.8	21.3	12.5	2.1
	Northeast	40.9	28.4	12.5	2.1
	Northwest	41.6	30.4	11.2	1.9
	North Central Coast	42.6	30.0	12.6	2.1
	South Central Coast	39.2	25.9	13.3	2.2
	Central Highlands	49.1	34.5	14.6	2.4
	Southeast	29.6	18.9	10.7	1.8
	Mekong River Delta	32.3	23.6	8.7	1.5
Stunting: Total		38.7	29.6	9.1	1.5
By region	Red River Delta	35.4	24.4	11.0	1.8
	Northeast	43.2	33.6	9.6	1.6
	Northwest	45.3	35.6	9.7	1.6
	North Central Coast	46.7	35.1	11.6	1.9
	South Central Coast	40.1	29.3	10.8	1.8
	Central Highlands	53.2	41.5	11.7	1.9
	Southeast	27.7	21.6	6.1	1.0
	Mekong River Delta	35.5	28.1	7.4	1.2

Main directions and plans for the control of child malnutrition in Vietnam in the period 2006-2010

Main strategy directions

Accelerating the reduction of child malnutrition is one of the priorities within the comprehensive human development strategy of the Government of Vietnam. Reducing child malnutrition is a goal in the 10th Party Conference's document and has become an action objective of authorities and sectors at all levels. The main strategy directions, described in Khan and Khoi (2007), of the Child Malnutrition Control Program in the period 2006 to 2010 are:

- The *Early care strategy* requires nutrition care activities for every child and mother. According to this strategy, nutrition care should be started before and during pregnancy in order to prevent foetal malnutrition. Every child should receive good care and feeding right after delivery. Special attention to nutrition care should be given during the first two years of life.
- The *Specific priority strategy* includes specific interventions based on an analysis of the actual situation at each locality. According to this strategy, Priority should be given to interventions involving stunting reduction in difficult regions, and urgent nutrition interventions should be conducted in case of emergency. However in some regions focus will be upon prevention of overweight/obesity. Therefore, activities on malnutrition prevention for each region in the next period will not be the same.
- The *Nutrition improvement strategy based on the life cycle* is founded on scientific evidence of a close and continuous relationship between nutritional status and its health consequences in all periods of the life cycle. It is clear that nutrition interventions should be implemented for various subjects, including pupils and adolescents. This strategy requires an application of nutrition activities for all members in a household.

Implementation plans

Specific implementation plans of the Child Malnutrition Control Program 2006-2010 are listed in Box 1.

Evaluations, Assessments and Evolving Insights

Although there have been no formal or extensive evaluations of the national PEM control strategy, limited studies of integrated nutrition programs for preschool children in Vietnam have shown that they successfully improve complementary food intake (Pachon et al 2002). In addition, they reduce both morbidity (Sripaipam et al 2002), and weight growth faltering during infancy among the most malnourished (Schoroeder et al 2002). However such programs seem to do little to prevent or cure moderate undernutrition, which is more a reflection of stunting than underweight per se.

It is now well recognized that the process of stunting is largely complete by two years of age in almost all populations and is caused by inadequate diet and frequent infections (Shrimpton et al 2001). Furthermore half of the stunting at two years of age is due to growth faltering in the uterus and another half to inadequate growth in the first two years of life (Victoria et al 2008). The Lancet Nutrition Series has listed a package of interventions that it considers suitable for reducing maternal and child undernutrition, which are for implementation in all 36 countries that are home to 90% of the worlds stunted children (Bhutta et al 2008). This includes Vietnam.

Most of these interventions are included in the implementation plans listed in Box 1, but they make up less than a half of the planned activities. This suggests that it is necessary to focus and prioritize the national plan, and concentrate on those activities aimed at the window of opportunity from conception to two years of age when most growth faltering takes place. In other words, as recommended in the Lancet paper 4, "doing the right things, and doing far less of the wrong things that don't impact on maternal and child undernutrition" (Bryce et al 2008). Of the list of interventions in Table 3, those aimed at reducing intra-uterine growth faltering have received the least attention in Vietnam. Moreover, it is necessary to focus on implementing the proven interventions at scale and as a continuum of care, beginning from conception through to two years of age.

Preliminary review information coming from the work of the Mainstreaming Nutrition Initiative points to inadequate provincial planning capacity as a constraint for achieving high coverage of the various nutrition activities (MNI 2008). Not only is it difficult to link nutrition activities across programs within the health sector, (antenatal care, integrated management of childhood illness, primary health care) but also across sectors to the agricultural and education sectors.

Box 1: Implementation plan of Child Malnutrition Control Program 2006-2010

1. *To implement nutrition and health care for mothers and to improve the nutritional status of mothers*
 - To educate for every woman and newly married couple about proper nutrition, control of malnutrition in mothers and children (in collaboration with the Vietnamese Women's Union, the Ho Chi Minh Youth's Union, from 2007)
 - To supplement multi-micronutrients for pregnant and reproductive age women in disadvantaged regions together with nutrition education and counselling (from 2006)
 - To guide pregnant women to taking iron/folic acid tablets from pregnancy and one month after delivery (women buy iron/folic acid tablets at health centres)
 - To follow up weight at least three times during pregnancy and birth weight of the baby at health centers, antenatal clinics and hospitals (from 2008)
 - To guide mothers to using iron/folic acid fortification foods
2. *To implement the national plan of action on feeding infants and children in the control of child malnutrition*
 - To breastfeed children within the first half hour after delivery, to breastfeed children exclusively in the first six months of life and to continue breastfeeding until 24 months of age
 - To guide mothers to proper complementary feeding together with using available foods at the locality
 - To guide mothers to care and feeding for children in and after diseases
 - To make a pilot model on introducing micronutrient-fortified complementary foods (semi-industrial foods) in some localities with the community participation (from 2007)
 - To disseminate menu and to guide to using menu for children in day-care centres and kindergartens (from 2008)
 - To weight children under two years old monthly and to apply a new growth monitoring chart of the WHO (from 2008)
 - To improve hygienic practices at the household level: personal hygiene, environmental hygiene and food hygiene
3. *To improve the micronutrient status of children*
 - To maintain highly-dosed vitamin A supplementation for children, to extend the age of taking vitamin A until 60 months old in collaboration with regular de-worming in 18 difficult provinces, which will be carried out nationwide in 2010
 - To supplement zinc for children getting diarrhoea based on the WHO's recommendations (from 2008)
 - To supplement micronutrients for children in case of nutrition emergency and in places having the high prevalence of stunting (from 2008)
 - To make a regular budget plan of the government on vitamin A capsules, iron/folic acid tablets and micronutrient tablets
4. *To promote nutrition education and to encourage production and usage of food at the household level to improve the diet for mothers and children*
 - To produce nutrient-rich food sources from the Vegetation-Aquaculture-Cages for animal husbandry system at the household level (regular activity)
 - To implement processing techniques and food and agricultural product preservation at the household level (from 2008)
 - To guide to processing reasonable meals for the family and complementary foods for children (regular activity)
 - To integrate nutrition education into schools (kindergartens and primary schools, from 2009)
5. *To promote social mobilization of malnutrition prevention activities*
 - To maintain the same steering committee system and organizations at all levels as in the period 2001 - 2005
 - To promote inter-sectoral collaboration, to mobilize participation from every sector and the whole society. Malnutrition prevention is a duty of the whole society; improvements in nutrition should be regarded as the output of hunger elimination and poverty reduction activities
 - To mobilize every source, to maintain and increase the government budget and to promote supports from local budgets
 - To increase supports from international organizations such as UNICEF
 - To collaborate with social organizations such as the fund for child protection, the Red Cross association, the hunger elimination and poverty reduction program, and economic organizations
6. *To strengthen implementation systems*
 - Health departments: are members of the steering committee on child malnutrition control programme at the provincial level and are responsible for directing and managing child malnutrition control activities at the community
 - Reproductive Health Care centres: to implement care and education activities for pregnant women and children.
 - Preventive Health centres: to implement vitamin A supplementation for children under three years old, to supplement iron tablets for pregnant women, to hold evaluation surveys.

Developing a national plan to accelerate stunting reduction in Vietnam in the period 2008 - 2013

The objectives for the Stunting Reduction Plan are, by 2013, to

- Reduce stunting prevalence to under 20% nationally
- Ensure that no province will have stunting prevalence of over 30%
- Reduce the LBW rate to under 6%

To develop this plan, Vietnam will have to specify the priority of nutrition actions, in order to determine how they can best be implemented and to ensure a supportive environment including consensus, commitment and resources. To further accelerate stunting reduction, there is an obvious need to refine, refocus and further strengthen the Protein Energy Malnutrition Program of NIN, so that it embraces prenatal and well as postnatal care. We propose to carry out this "refashioning" in the period from 2008 to 2013, so that a package of "essential nutrition actions" can be mainstreamed into the national poverty reduction plan for 2010-2020, and be implemented at scale. A prime aim will be to strengthen provincial level capacity to develop and manage provincial nutrition plans that can employ not just central level and donor funds, but their own funds, in order to act at scale with a continuum of care covering the period from conception to two years of age.

In order to develop this sort of approach the provinces will be classified into three categories based on the severity of maternal and child undernutrition. The indicators used to categorize the provinces will be child stunting, poverty indicators and geographic determinants. Based on these parameters, different mixes of priority or "essential" nutrition actions will be recommended. Depending on the typology of the province the distribution channels will be varied.

A package of essential nutrition actions

Table 3 shows the interventions to be implemented to accelerate the reduction of child stunting in three categories of provinces. It includes an indication of when central government funding vs. provincial funding would be used and differentiates between public and private distribution systems as appropriate.

Decentralized implementation

In order to carry out this differential approach by province, a capacity building package will be developed to assist provinces in building provincial plans for accelerating maternal and child undernutrition. This package will use the Nutrition Essentials training manuals developed by BASICS/AED (BASICS 2003), modified to accommodate the package of nutrition actions listed above and translated into Vietnamese. In addition to this implementation guide, planning and budgeting training modules will be developed to assist the provinces to themselves develop their provincial plans, including unit costs, staffing patterns, equipment and supplies needed etc. Province level monitoring will rely less on the collection of information from all commune health centres and more on regular district level cluster surveys. Provinces goals and targets will be established including both coverage (e.g. >80% of pregnancies weight monitored) and impact targets. These will apply to maternal anaemia, weight gain during pregnancy, LBW rates, and stunting in children under two.

A changing role for the National Institute of Nutrition (NIN)

NIN will assume more of a facilitating and overseeing role: approving provincial plans for accelerating the reduction of maternal and child undernutrition; and providing the funds necessary for carrying out these plans in the priority provinces. NIN will also take on a capacity building role: training provincial actors to develop plans and training of trainers for implementing essential nutrition actions. NIN will also become the monitoring and evaluation centre for national nutrition actions, training provincial teams to carry out cluster surveys and collecting and analyzing data.

Conclusion

Malnutrition in the first years of life causes major consequences through the life cycle. Reducing child stunting contributes to improvements in the health status of children in particular and the health status of the community in general, which will translate into the stabilization of socio-economic development of the country in

Table 3 Essential Nutrition Packages by priority groups

	Essential Nutrition Package for Top Priority Provinces	Essential Nutrition Package for Priority Provinces	Minimum Package for Low Priority Provinces
Province categorization	High priority	Second priority	Third priority
Indicators	Proxy indicators of stunting prevalence, poverty and geographic determinants will be used to categorize provinces. All these data are available by province.		
Reproductive-age women	Free/subsidized weekly MMNs* De-worming	Social marketed weekly MMNs De-worming	Social marketed weekly iron/folate supplements De-worming
Pregnant women	Daily MMNs through government program	Daily MMNs through government program	Daily iron folate through government program
Young children <2 years	Sprinkles, free/subsidized fortified complementary food	Private sector fortified complementary food, GMP**	Private sector fortified complementary food, GMP
	Breastfeeding promotion, Vitamin A supplementation, IEC/BCC*** for complementary feeding, de-worming, Zn supplementation for diarrhoea, Iodized salt		
Family	Subsidized/free fortified rice		
	Promotion of food production, support in times of natural or other disaster, nutrition education, provision of health care services, promotion of hygiene and sanitation		
Society	Supportive policies, infrastructure, education, sustainable development and environment		
Funding source	All provided using central government funding		Only guidance provided, no central funding

*MMNs: Multiple micronutrient supplements; **GMP: Growth Monitoring Promotion; ***IEC/BCC: Information, education and communication/Behaviour Change Communication

the long term. With such comprehension, Vietnam is underway to developing a national plan of action in order to accelerate the progress in child stunting reduction in the period 2008–2013. The achievement of its objectives requires a strong and serious commitment of partners to implementing this plan.

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ANNOUNCEMENT:

ILSI seeks Editor-in-Chief for Nutrition Reviews®

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The deadline for submissions is September 15, 2008 or until a suitable candidate is identified.

Nominations are also welcome.

Commitment, Consensus and Strategic Capacity: An Evidence-Based Agenda

David Pelletier and the Mainstreaming Nutrition Initiative¹

The nutrition community may debate and disagree about many things, but we do agree on a few key points. Malnutrition impairs human, social and economic development and is the major cause of the burden of disease in the developing world. It generally does not receive the level of attention it deserves within governments, international agencies and many other organizations, even though effective solutions are available. We also tend to agree that our responses to the problem should be based on evidence.

Normally the evidence we seek relates to the efficacy and effectiveness of interventions. In contrast, the Mainstreaming Nutrition Initiative (MNI) is an action research project that has gathered evidence on the factors that help and hinder the movement of nutrition agendas at the country level. This is the type of evidence required if nutrition is to receive the attention we feel it deserves. For the past two years MNI staff from International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and collaborating institutions have partnered in various ways with governmental and non-governmental organizations in Bolivia, Guatemala, Peru, Bangladesh, Pakistan, Vietnam, Uganda and Ethiopia. We have been participant-observers in various phases of the nutrition policy process in these countries, from commitment-building to implementation and evaluation. We also have interviewed a wide range of people from a number of other developing countries and international organizations, participated in international meetings and examined grey literature to understand the issues from diverse perspectives.

Although the Initiative is still underway and lessons are still being learned, it is timely to share some of the findings with a larger audience. The findings that follow are based on experiences in nineteen countries: The Philippines, Thailand, Bangladesh, Benin, Burkina Faso, Ethiopia, Kenya, Madagascar, Malawi, Mali, Mauritania, Senegal, Tanzania, Uganda, Bolivia, Chile, Guatemala, Haiti and Peru, as reported by government officials and staff from international agencies, NGOs and universities, or researcher institutions.

What shapes nutrition agendas?

The study identified a wide range of factors that influence the movement and shape of nutrition agendas, but they can be grouped into the following categories: social conditions, catalytic events, structural factors, points of contention, strategies and tactics (Figure 1 and Table 1).

Societal conditions and catalytic events

These two themes represent factors that have created opportunities and challenges to the national nutrition agenda. Societal conditions refer to events and processes that tend to persist for many years and affect many aspects of the development agenda in a country, with direct or indirect effects on the nutrition agenda. Catalytic events are typically shorter in duration, and are more closely related to the nutrition agenda itself. They are sometimes created by actors in the national nutrition system in the normal course of nutrition research, testing of interventions, piloting or implementing of nutrition programs, responding to crises, or conducting policy dialogue.

Societal conditions and catalytic events often provide opportunities for advancing the nutrition agenda. They focus attention on conditions closely related to food security and nutrition (e.g., drought in Tanzania, Ethiopia, Kenya, basic needs development and primary health care in Thailand, social inclusion in Bolivia and Guatemala). They create not only a larger policy discourse within which nutrition can be strategically framed by nutrition actors (e.g., currency devaluation in Senegal, results-based budgeting in Peru), but also venues for policy discussions where nutrition actors can seek a seat at the table and position nutrition within the larger policy issues of the day (e.g., MDG discussions in many countries, the HIV pandemic in Kenya, Uganda and Malawi). Catalytic events which are more closely related to nutrition and more readily influenced or used by nutrition actors. (e.g., publicizing a model community-based program in Thailand, attendance of

The Mainstreaming Nutrition Initiative (MNI) is World Bank-funded project of the International Centre for Diarrhoeal Diseases, Bangladesh and collaborators at Cornell University, the International Food Policy Research Centre, the University of South Carolina and participating developing countries. <http://mainstreamingnutrition.org/default.aspx>. Purnima Menon, Tien Ngo and Dominic Frongillo contributed to the study reported here. Tahmeed

Figure 1: Five categories of factors affecting nutrition agendas

Societal Conditions	Catalytic Events	Structural Factors & Behaviors	Points of Contention
<ul style="list-style-type: none"> • Disasters • War • Civil unrest • Economic downturns • Sector reforms • Elections • HIV • etc. 	<ul style="list-style-type: none"> • Food crises • Nutrition surveys • Small-scale projects • Positive experiences: <ul style="list-style-type: none"> • Salt iodization • Vitamin A suppl • PRSP windows • National or international conferences • Visits by high profile actors • MDG-1 • Lancet series • etc. 	<ul style="list-style-type: none"> • Institutional arrangements for leadership, coordination, implementation • Limited authority & budget control • Divergent perspectives, interests and power • Fragmented, shifting & short-term funding • Weak capacity & credibility of nutrition units • Competition & rivalry • Avoidance and weak accountability • Decentralization • etc. 	<ul style="list-style-type: none"> • Food programs • Targeting • Micronutrient strategies • GMP • Stunting vs underweight • RUTF for moderate malnutrition • U2 vs U5 • School feeding • Vertical vs integrated • Long vs short routes • etc.
Strategies and Tactics			

policy makers at the International Conference on Nutrition in 1992, re-estimating malnutrition prevalence based on international standards in Vietnam), and have been used successfully in many countries to advance the nutrition agenda. However, they may not command the same level or duration of attention as the broader factors included under societal conditions.

While societal conditions and catalytic events both have presented opportunities for the nutrition agenda, they have also sometimes resulted in serious challenges. The most common example is when a drought, complex emergency, economic downturn, war, right-to-food movement, or other event stimulates food distribution by the government and/or its partners. In many cases this has led to the institutionalization of food distribution (often encouraged by food aid donors and NGOs), the delegation of responsibility for nutrition to a Ministry of Agriculture, and/or the tendency for policy makers to associate malnutrition with lack of food. All of these outcomes tend to orient the nutrition policy agenda towards food distribution, food access, and agriculture. Although this can be useful for enhancing food and economic security in countries where these are important causes of malnutrition, it makes it difficult to create a more balanced agenda that addresses the care, feeding and health status of infants and young children. Such dynamics have been evident in Bolivia, Chile, Guatemala, Mexico, Peru, Senegal, Tanzania, Ethiopia, Vietnam and many other countries not included in this study.

“As happened to quite a few other countries, nutrition appeared on the political agenda of (country) following a series of natural disasters that brought about a looming nutrition crisis.” (Country nutrition actor)

“Every time, the country tried to put a feeding program into project documents and we had to erase it.” (Donor agency)

“We know the fact that the food supplementation takes so much time to actually execute for the frontline work on nutrition. The community nutrition workers, do not have the time to counsel the women. And they’re feeding women in groups so they don’t have individual follow-up.” (International NGO)

Other examples of challenges created by societal conditions and catalytic events include the narrowing of the nutrition agenda by the international micronutrient focus, the erosion of support for successful nutrition programs due to health sector reform, struggles over the institutional home for nutrition due to party politics, or simply the neglect of nutrition due to more pressing priorities.

Points of contention

One of the most prominent themes in these countries relates to disagreements and conflicts over strategies and interventions, complicated by politics among mid-level actors. Such points of contention were evident in almost all nineteen countries. They can arise over virtually the entire range of potential interventions and strategies, depending on which are under consideration in a given country (Table 1).

A striking feature of these disagreements is that they take place primarily among mid-level actors in the national nutrition system, rather than among politicians or at high administrative levels. They occur in countries with both

Table 1: Strategies and tactics in the nutrition policy process

<p>Molding and adapting to institutions</p> <ul style="list-style-type: none"> • Bolster & support promising nutrition units • Form working groups under one overall coordinating committee • Help lesser units lead and compensate for ineffective coordinating structures • Assign lead roles where good people are located not bureaucratic considerations • Foster strategic alliances across diverse orgs with an active core group to make things happen • Get allies inserted into strategic positions in government • Use technical and politically independent institutions for long-term agenda work • Involve MEF and PM as allies • Build relationships with key ministries and actors • Find roles for each actor, exploit complementary strengths of various donors, NGOs, academics and other actors • Use soft touch with decentralized actors not mandates, MOUs with local government on only a few activities initially • Take advantage of political, bureaucratic or staff transitions that create unexpected opportunities and chemistry for alignment
<p>Planning and agenda formation</p> <ul style="list-style-type: none"> • Develop a coherent government owned plan to bring donors in line and coordinate sector roles • Engage implementing orgs in developing operational plans • Foster resource pooling to foster ownership and commitment • Frame a “National Program” rather than “World Bank Project” to foster broader buy-in • Plan from community and local government then upwards • Pursue and evaluate parallel actions for a few years rather than destructive in-fighting • Pursue one or two objectives initially if needed to avoid paralysis through analysis • Form a group and a safe space (with neutral facilitation if necessary) for information sharing, relationship building, strategizing and consensus-seeking • Create, support or strengthen an effective (bureaucratic) focal point or coordinating structure
<p>Leadership and strategic capacity</p> <ul style="list-style-type: none"> • Build leadership, strategic capacity and confidence in a national team • Negotiate, discuss tradeoffs and compromise rather than fighting government • Identify allies and opponents through regular dialogue and interaction • Argue behind close doors and come out with a common voice • Fill policy and implementation void with external projects that catalyze not displace • Use village tours, videos, PROFILES and other powerful methods with policy makers and shapers to get concrete, grounded and see the big picture • Have concrete examples, anecdotes and stories at fingertips when needed • Use external actors as catalysts for change, agenda consolidation and/or consensus seeking • Strategically stimulate and use small but visible accomplishments • Seek allies who can think and work outside the box • Use national meetings strategically to advance the agenda • Strategically frame the issues to fit prevailing policy environment • Seek international allies to legitimize the agenda • Envision and pursue a 10-15 year strategic agenda • Work outside and beyond official mandates and job descriptions to get the job done

Source: Pelletier et al (forthcoming)

high and low levels of political commitment to nutrition; with very high burdens of malnutrition and relatively low burdens; and over interventions that have been judged to be “right actions” as well as “wrong actions” by international experts evaluating the available evidence. The language used in the data sources clearly indicates that these disagreements fundamentally revolve around divergent institutional perspectives and interests rather than policy debates based on effectiveness, cost-effectiveness, sustainability or other considerations.

“The big question now is, will the remaining nutrition actors be able to overcome their sectoral fears, consolidate their interests and have enough voice left to be heard during the PRSC [Poverty Reduction Support Credit] discussions in order to get nutrition back on the agenda?” (Government nutrition actor)

“The donors and NGOs basically could not get their act together because they were all arguing for their own special interest or their own view of how things ought to be handled for nutrition.” (International researcher and consultant to countries)

“They (NGOs) are at odds with one another in many respects, and that makes the situation a little more confusing. That’s true for [all three countries].” (International NGO)

Structural factors

As suggested above, many of the disagreements concerning nutrition strategies and interventions are intimately related to divergence in institutional perspectives, interests and agendas. Other structural factors can also create challenges for the relevant actors. One such factor relates to short funding periods for externally-financed projects, interventions favoured by donors and other donor procedures and practices.

“So at the time, the pervasive impression from the nutrition community was that that shift occurred because there was a lot of advocacy and a lot of pressure from donor agents, who wanted their micronutrient programs implemented in the (country).” (University professor in developing country)

“Not being committed to intervention undermines the process. What we saw was efficient small scale programs financed by (donors), but these did not manage to make the jump to larger scale program. Whenever financing ends [], they just leave program to dead” (Donor agency)

One of the most common problematic structural factors relates to institutional arrangements for promoting and coordinating a multisectoral approach to nutrition.

“Multisectoral committee? It is fragmented. It was in the strategy that MoH should have the implementation role, and be coordinated by the Prime Minister. However, the Prime Minister does not have a coordinating power or mandate to coordinate the ministries” (Country nutrition actor)

“[Country] established a National Food and Nutrition Committee in 1996, chaired by the Ministry of Agriculture. [] However, without any budgetary authority, this committee remained largely ineffective in shaping nutrition policy and action.” (Country nutrition actor)

Finally, poorly implemented de-centralization was a common structural sub-theme in many countries:

“Decentralization, although it’s a great idea, really was more a failure than anything else because there was a total lack of capacity at the regional level to absorb those resources and (to) absorb the new mandates.” (International NGO)

“Most of the de-centralization process is completely stuck on taxes that local government gets, and (on) the ministries refusing to give up their control over their system. ” (Donor agency)

Strategies and tactics

One of the most insightful and valuable themes to emerge from this study of country experiences relates to the wide variety of strategies and tactics used by nutrition actors to address, overcome or circumvent the many obstacles and complications described in the first four themes. These are clustered in three overlapping categories (Table 1). Molding and adapting to institutions refers primarily to strategies used to deal with the Structural Factors described above. Planning and agenda formation refers to strategies used specifically to seek agreement on a common agenda, and Leadership and Strategic Capacity refers to personal, interpersonal and tactical considerations involved in forming and advancing the agenda. Though the boundaries among these sub-themes are quite fuzzy, they begin to reveal a body of craft knowledge with considerable practical utility.

The following quotes illustrate some strategies used to form agreement on a common agenda despite the existence of structural barriers, diverging institutional interests and points of contention:

“NGOs got together and sort of formed a networking organization or an alliance. They agreed to put their logo on all the national program reports rather than trying to claim ownership for themselves, and things like that. So there was a period where there was a lot of, fairly large NGO-run programs, and they wanted to make it one national program, and they managed to get their act together to do that.” (International NGO)

“[] they had a lot of disagreements but they always went ahead with one voice. They sat behind closed doors and didn’t get out, but then they put on a good face when they came out and had one recommendation. (Donor agency)

“The 10-year plan and 5-year program became the references for external assistance to the health sector. The World Bank agreed to a US\$40 million credit to assist the implementation of (the program).” (Country nutrition actor)

These quotes reveal some strategies that have proven useful in aligning the diverse actors, building ownership and ensuring sustainability of commitment over time:

“[] for the development of national guidelines, one thing that was really helpful in many of the countries, was establishing a technical working group. [] the establishment of these technical working groups helped to sort of rally some commitment, some ownership, for the national guideline process. [] And in some countries, that working group and that momentum continued beyond national guidelines, where they were able to then help with implementation, and in others, less so.” (International NGO)

“[] it is important to apply modern management practices. In (my country), most traditional management is not working well. We try to have a strategic plan, action plan oriented, staff evaluations, and progress review of our action plans. These things are not very common in the current administration in (my country). We have set up our vision, mission statement, core values and try to apply them.” (Country nutrition actor)

“If you look at the plans, on paper they look very good. But then you look into how much money do they actually put into activities that matter? Who actually takes charge? Who’s accountable? How do they measure whether their objectives are met? These things are either not specified in the plans, or they’re um, not clear. And those are the things that will make those linkages really become a reality.” (University professor in developing country)

Although not mentioned in many sources, there has been some experience using strategies to forge a more constructive working relationship between donors and government actors:

“All of us, going in and saying this is wrong and you should do this. You are doing food supplementation, no, do growth promotion. We really went against them instead of working with them. We have lost a lot of goodwill and opportunities that way. We have been more successful with whatever opportunities came up. Education and schools, ok let us work with them. Let us see which has the best effect. Go ahead and take the risk for two years and see effects then maybe they will see.” (Donor agency)

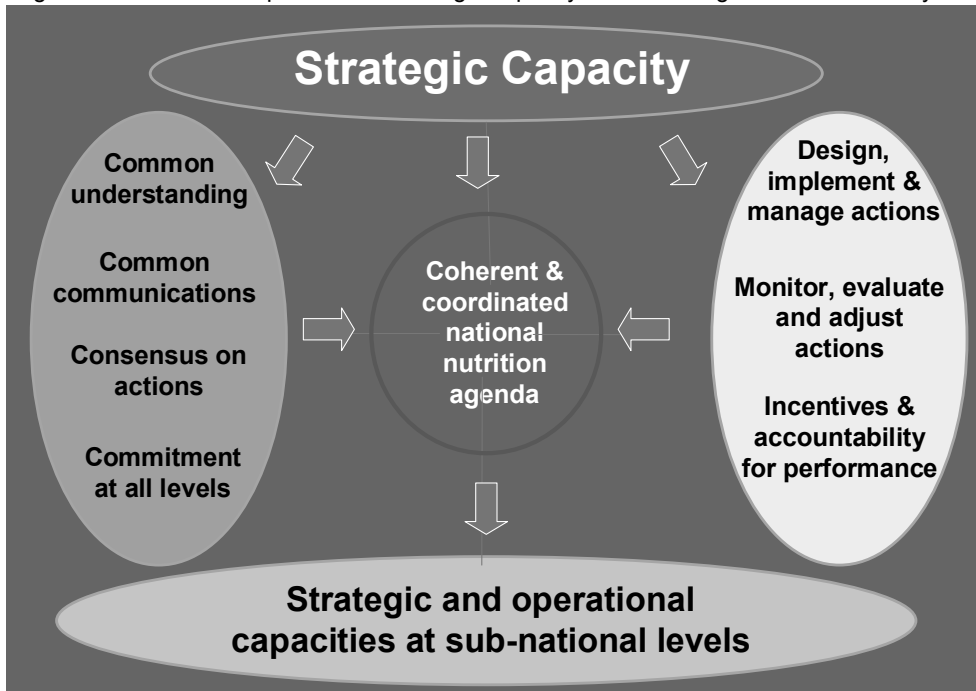
“It is again like what you do with governments. You do not shut them out; you do not tell them they are doing the wrong thing. You just try to work with them. Its negotiations and trade-offs and trying to find a consensus.” (Donor agency)

Moving forward

The accounts of the policy process analyzed in this paper have a number of implications for future efforts to improve nutrition. First, they suggest that the ability to mobilize a wide variety of strategies and tactics, as shown in Table 1, plays a crucial role in strengthening commitment, coherence, consensus and coordination in relation to the nutrition agenda. This ability, here termed *strategic capacity*, involves the human and institutional capacity to build commitment and consensus towards a long-term strategy. Strategic capacity includes brokering agreements and resolving conflicts, responding to recurring challenges and opportunities, building relationships among nutrition actors, undertaking strategic communications with varied audiences, and many other tasks. At the individual level this demands socially-attuned leadership, management and communication, negotiation and conflict management skills. At the institutional level it requires formal and/or informal venues and practices for nutrition actors and others to exchange information, discuss common concerns, strategize, coordinate efforts, build relationships, seek consensus, resolve conflicts and sustain momentum. The notion of strategic capacity as used here implies that all of the nutrition actors share a responsibility to form and support a coherent national nutrition agenda. In some of the countries studied here, these individual and institutional capacities were in evidence and played a key role in advancing the nutrition agenda; in most of the countries, they were either not present or they were not effective in overcoming the particular structural factors at work in those settings. This is an area that has received virtually no systematic attention in nutrition capacity building and should be a priority for the future.

A second implication is that many of the enduring themes in national nutrition policy might be re-examined in relation to strategic capacity, especially from a sustainability perspective (Figure 2). These themes include the role of political will, institutional arrangements (formal) and operational capacity for acting at scale. The accounts analyzed here reveal that political will, in the sense of the commitment of politicians to nutrition, is an asset that can be created through the application of strategic capacity, but also undermined through disagreements and conflicts that persist among mid-level actors when strategic capacity is lacking. This is very similar to the findings related to the maternal mortality policy community (Shiffman and Smith 2007). Moreover, commitment to nutrition is needed in many sectors beyond national politicians, such as ministry officials and staff, international partners, the private sector and civil society. These areas can only become the focus of sustained attention if strategic capacity exists. This is an especially important consideration in the context of decentralization in which commitment building must be undertaken at multiple sub-national levels. Indeed, in

Figure 2: The central importance of strategic capacity for advancing nutrition at country level



some contexts strong sub-national commitment might compensate for weak commitment at the national level. Although formal institutional arrangements for nutrition leadership, coordination and implementation are crucial assets when they exist they are more often serious constraints when they do not. However, the present study documents a wide range of strategies available to nutrition actors, especially non-state actors, for strengthening, working within or circumventing sub-optimal institutional arrangements.

A third implication relates to implementation and acting at scale. In the first instance the strengthening of strategic capacity is intended to correspondingly strengthen commitment and coherence to the nutrition agenda. But it will also enhance implementation and acting at scale insofar as the strengthening of operational capacity should be a core part of the national nutrition agenda. Operational capacity here refers to the totality of individual and institutional capacities for program and policy design, management, implementation, training, monitoring, evaluation, research and analysis. Strengthening this range of capacities in a sustainable way requires resources well beyond the means of most governments as well as time horizons and resources well beyond that of most donors. This is a major reason why it has been neglected in most countries. As such, the strengthening of operational capacities should be a major component of the long-term nutrition agenda of a country and the focus of strategic attention alongside that given to intervention programs and policies. This is unlikely to occur in the absence of stronger strategic capacity at country level.

In summary, we are well aware of the many external factors that stand in the way of advancing nutrition at country level and often are perceived as being outside our immediate control, such as political will, competing priorities of governments and other actors, fragmented institutional agendas, and so on. The discomfiting message coming from country experiences is that the failure to forge common agendas among ourselves (as mid-level nutrition actors) is also an important factor holding back nutrition agendas. The encouraging message is that it is possible to forge common agendas, as demonstrated in some countries, and once this is accomplished it becomes possible to manage the external constraints and advance the nutrition agenda. In other words, commitment building for nutrition begins at home and it begins with a commitment to working together towards common purposes.

"There's so much human resource and so much potential to really think about solutions. We are just not all on the same page so we never can come up with a solution and I think it's got to go back to looking at the failings of nutrition and what do they want to see nutrition look like and what kind of orientations should [nutrition actors] have in [this country] to make nutrition work. I hope these aren't too negative and too complicated." (International NGO)

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Reflections from the Front Lines: Swimming Upstream with Optimism

A survey of the international nutrition community¹

Alan Berg (The Brookings Institution, Wolfensohn Center for Development), F. James Levinson (Tufts University) and Denish Moorthy (Tufts University)

It was a great honour to give the 12th Dr. Abraham Horwitz memorial lecture at the Symposium of the 35th SCN Session. Having known him well over the years (Alan and Jim) both professionally and personally, we suspect that this eminent doctor – who died five years ago at the age of 89 – would have been a bit ambivalent about this lecture in his name. On the one hand, he would have been disappointed to have speaking this year, not a representative from the younger generation, as had generally been the case, but rather one from the chronologically advantaged generation. At the same time, we are quite sure that he would have been intrigued with the idea of a survey of members of the international nutrition community. He was, indeed, particularly interested in a comparable survey carried out by Jim ten years ago, and presented in the SCN News (Levinson 1997).

The formidable Dr. Horwitz was unabashedly pro-nutrition. He served the SCN faithfully, including as its Chair for ten years, bringing to it both extraordinary intellectual energy and an abiding integrity and humanity – so much so that under his leadership, the SCN was acknowledged by the United Nations as a model for such ACC Sub-Committees.

Having earlier served as Director-General of Health in Chile, and then as Director of the Pan American Health Organization, Dr. Horwitz became keenly aware of the importance of nutrition in reducing maternal and child mortality and improving the health of vulnerable populations. He came to this recognition rather late in his official career. But once the conversion took place, he was seized with it, and devoted the rest of his life to the nutrition cause.

What we would like to do is consider the findings of the survey we carried out in the final months of 2007, not only in their own right, but also as Dr. Horwitz might have seen them, and imagining how he might have reacted to them.

What was not anticipated when we organized the survey, but perhaps makes some of these survey findings yet more relevant at the moment, is its juxtaposition to the recent Lancet Nutrition Series (Maternal and Child Undernutrition Study Group 2008). This was brought home to us in February in a note received from a major figure in operational nutrition programs in Asia and Africa; a senior person known to many of us here who was writing to thank Jim, Denish and me for doing the survey. We quote: “Your survey of those of us in the front lines of nutrition (*it was, incidentally, this note that gave us the idea for the title of this paper*) represents an important counterweight to the Lancet series, which was written not by practitioners, but almost exclusively by researchers. Those of us involved in operational programmes felt shut out of that process. They did some surveying but only to find out the status of current policies and programmes, not to seek our opinions and our feelings and our accumulated wisdom. The Lancet series is good on the ‘why’ and ‘what’ of nutrition, information that has been clear for a long time now. But the factor most seriously impeding effective programmes is not the ‘why’ or the ‘what,’ but the ‘how.’ While the Lancet series has much to commend it, I’m afraid it does not speak for me.”

Our friend obviously does not mince words. And while the three of us have not witnessed the Lancet process first hand, and while, indeed, we have found much to admire in the Lancet analysis, the sentiments are not inconsistent with what we have also heard from others.

Whether seen as a counterweight to the Lancet series, as suggested in the note we received – hardly, given the magnitude of that undertaking – or simply as a different set of voices, this survey seeks to offer a perspective a bit closer to the action, a survey which asks most essentially, “How have we been doing in navigating the rapids, and what do we see as the primary challenges and needs ahead?”

This paper is largely that presented by Alan Berg as the Abraham Horwitz Memorial Lecture at the 35th Session of the Standing Committee on Nutrition, March 3, 2008 in Hanoi, Vietnam. Due to space limitations, a number of the tables from the lecture do not appear here but are available on the [SCN Annual Sessions website](#).

Methods/Respondents

The online anonymous survey had 529 respondents, more than three times the number participating in the similar survey carried out 10 years ago (Levinson 1997). The respondents, individuals both from developing and industrialized countries, average 15.4 and 10.5 years of professional work in nutrition, respectively, and 12.3 and 10.1 years spent working in developing countries. The largest number of respondents, 124 of them, indicate that their primary nutrition-related work (in the ten categories from which they chose) is in project implementation and management, and that goes up to 200 when including those identifying themselves as working primarily on project design. In terms of the substance of the work done, the largest number of respondents, 162 of them, work in community-based nutrition, 126 work with international NGOs, and 93 work for government agencies. Overall, 60.6 % of respondents to the survey categorized themselves primarily as practitioners, involved in operational programs or policy aspects of international nutrition (OPP), while the remaining 39.4% categorized their work primarily as research, teaching or training (RTT).

Findings and reflections

Those of us who had the privilege of knowing Dr. Horwitz appreciated that he was as astute as he was compassionate, and would have been fully aware of some of the bare facts of international nutrition today. He would have noted, and we believe lamented, the already grossly insufficient donor agency spending on nutrition programs. Such spending, excluding food aid, presently totals about \$250 million a year, one-tenth the amount spent on HIV/AIDS (Morris et al 2008), and a figure that has decreased significantly since the 1980s and '90s. He would have been unhappy to observe that what is provided is often poorly targeted. He would have been sorry to see that the nutrition training our young people are receiving today is not much better geared to the management of such programs – and to making those programs more effective at scale – than was the case 15 years ago. Then, based on a review of North American university programs in nutrition, such academic inadequacy was referred to simply as “nutrition malpractice” (Berg 1993).

Dr. Horwitz would, of course, also have been dismayed at the continued tragically high prevalence of malnutrition in the world today, as is so graphically presented in the Lancet series (Black et al 2008).

But Dr. Horwitz would have been gratified to see the extraordinary optimism of individuals working in the nutrition field today – this emerging as a primary and, to us, quite surprising finding from the survey. As we head toward the future, only 11.2% of the respondents in our survey believe that there is less momentum today in our international nutrition community than was the case 10 years ago.

When asked how seriously development economists and others from the larger international development community regard our field relative to 10 years ago, only 12.7% believe that it is now taken less seriously – and that figure drops by half when the same question is asked about expectations for momentum a decade in the future. Only 6.5% believe the development community will regard international nutrition less seriously 10 years from now, while two-thirds believe it will be taken more seriously.

Here is another reflection of this same optimism. When respondents were asked in the survey 10 years ago whether they would recommend the field of international nutrition to students, 40% indicated “definitely.” The percentage answering so positively to the same question in this survey is 58.5%, with 89.8% responding either “probably” or “definitely”, and 0.7% indicating “definitely not”.

Similarly, when assessing future job prospects in international nutrition, respondents in the present survey were more optimistic. Of this survey’s respondents, 80.7% considered that job prospects will be excellent or fairly good for students from developing countries with 82.7% being similarly optimistic about the prospects for students from industrialized countries. Ten years ago, the comparable percentages were 73% and 62%. These increases of eight and 21 percentage points over the earlier survey seemingly reflect the expectation of increasing opportunities, both programmatic and research related, becoming available for young people.

Interestingly, apropos of this, when asked to speculate on the primary problems a young person entering the nutrition field will most likely face over her or his professional life, inadequate job satisfaction was indicated by only 7.5% of the respondents. Perhaps that says something significant about the work we do.

What then is the basis for such optimism today within our community? When respondents were asked to explain why nutrition is taken more seriously, the most common response, 44.7%, was better advocacy, with that figure jumping to 49.1% among those closer to the action, the OPP respondents.

Dr. Horwitz surely would have resonated positively with the importance that respondents place here upon advocacy. He constantly urged us to intensify our advocacy efforts to those who formulate national agendas, and to upgrade nutrition to a “hot” issue status in these countries.

Next, respondents were asked to identify, specifically, the most important advances in our field over the past 10 years, and then to identify the advances that would be necessary during the coming 10 years to advance nutrition further. The juxtaposition of the resulting two sets of rankings is interesting. The top past achievements were essentially sets of biological research findings, which were selected as four of the top five choices (out of the 11 provided). By a wide margin, the first choice cited was our better understanding of the consequences of malnutrition. It was selected as the first priority by 44.8% of respondents, and either first or second by 60.8%. When combining percentages among the top three of the 11 priorities, as is done in Table 1, the figure rises to 69.7%.

By contrast, when we look at what these same respondents believe needs to be done to advance nutrition in the future, additional understanding of consequences drops to a third of its earlier importance, and the other high research categories— increased understanding of the relationship of nutrition to communicable disease, including HIV/AIDS and to non-communicable disease, and a better understanding of causality – also fall markedly (Table 1). Replacing these research-related advances are now program-related ones: better designed and managed nutrition interventions and programs, increased availability of financial resources directed to nutrition, and greater community involvement in project design and implementation.

These results are worthy of some reflection. The survey respondents argue that while a better understanding of the consequences of malnutrition has constituted a vital advance in our field in the past, it may not warrant such priority attention in the future. The message emerging from respondents from this portion of the survey is that we now know a great deal about consequences, and that our priority now, rather than further refining these kinds of research findings, is to better communicate this information to policy makers through effective advocacy, thereby garnering increased resources; and to improve and expand the operations of our programs and increase the involvement of communities in their design and implementation.

Interestingly, of the factors contributing to the programmatic successes that we have seen, it is worth noting that only 8% of respondents listed technical assistance among their top three explanations, this perhaps reflecting an increasing tendency among governments to take responsibility for their own destinies and to depend less on external agencies, at least for technical help.

While Dr. Horwitz would surely have been delighted by the reflections of optimism from the international nutrition community, he also, however, was a realist, continually probing the shortcomings and constraints inhibiting our progress in this field. Those of us who were associated with the SCN over the years will remember that he was particularly impatient with the differences taking place within our fractious community. So Dr. Horwitz would not have been surprised to see that the primary disappointment or negative factor experienced by

Table 1: Most important factors in advancing nutrition

	Past 10 years *	Next 10 years *
Better understanding of the consequences of malnutrition, including its economic significance	69.7	33.3
Increased understanding of the relationship of nutrition to communicable disease, including HIV/AIDS	38.7	15.7
Better designed and managed nutrition interventions	29.5	58.5
Better understanding of the causality of malnutrition	27.4	17.4
Increased understanding of the relationship of nutrition to non-communicable disease	27.5	10.1
Greater community involvement in design & implementation	26.4	46.3
Increased financial resources directed to nutrition	13.5	54.6

* Numbers represent combined percentages among top 3 priorities (from 11 choices) of the respondents

survey respondents was in fact the bickering among ourselves and our lack of consensus on priorities. That same finding was identified prominently by OPP respondents in the survey 10 years ago (Table 2).

This time, infighting and the absence of consensus on priorities was cited (from among 13 options) as the main disappointment or negative factor by more than a quarter of the respondents, with this figure increasing to 44.4% among the 90 international agency respondents (three times higher than their second ranking disappointment). The finding supports the compelling plea for consensus made at the 33rd SCN Annual Session by then-World Bank Senior Vice President Jean-Louis Sarbib, and his argument that the absence of consensus has reduced our credibility and, in turn, has constituted a primary constraint in our efforts to advance nutrition (Sarbib 2006). Some of this need for consensus was also highlighted in the new Lancet series (Morris et al 2008), and examples of infighting with serious consequences abound, e.g. one nutrition project blocked because it was to be run by the Department of Social Welfare rather than the Department of Health; another blocked because it might divert field staff from an agency's family planning priority.

When asked to identify the primary substantive limiting factor where malnutrition rates have not fallen significantly, i.e., comparing the three primary determinants of malnutrition in the UNICEF causality model, food insecurity was ranked highest (53.2%), followed by inadequate caring practices (28.4%), and then inadequacies in health services, hygiene and sanitation (18.4%). (The percentage of OPP respondents – those on or closer to the front lines -- listing inadequate caring practices as a primary limiting factor (36.8%), was more than double that of RTT respondents (16.6%).) Clearly, however, the balance of attention here, as on several other issues raised in the survey, will have to be responsive to the specific primary limiting factors facing individual countries and regions.

When asked to rank the population groups deserving primary attention in future nutrition interventions, “under twos” ranked highest, with 67.4% selecting this group as their first or second priority – suggesting that the compelling evidence on the importance of addressing the needs of this group is now getting through, especially among those dealing with operations. If the very young miss the boat during the first two years, they miss it for life, and are likely to suffer the consequences throughout their lives (Victoria et al 2008, World Bank 2006). Pregnant women ranked second with 49.1%.

The “under five” age group, which not too many years ago was the reflex reaction answer to such a question and would then have been first, has diminished in importance, especially among those closer to the action. Worthy of note are the considerable differences between the OPP and RTT in responding to this under five group (35.0% versus 50.4%, respectively) and also in the school age group (10.1% versus 17.5%, respectively).

When asked about the balance of attention that should be given to under versus over-nutrition in developing countries in the next 10 years, the overall tally indicated preference for a three-to- one balance (75% to 25%) in favour of undernutrition, with nearly two- thirds of program operations and policy respondents (65.1%) supporting that position.

When asked if nutrition should maintain its own identity and institutionalization, as opposed to being encompassed by larger health sector or MCH programs, nearly four out of five respondents (79.2%) agreed, with more than half of these agreeing strongly. This level of agreement is substantially higher than the 54% who indicated that opinion to the same question in the survey 10 years ago. Whereas 20% disagreed strongly a decade ago, now only 2.4% do. It might be argued here that nutrition professionals are seeing increasing evidence of nutrition activity being marginalized when absorbed into broader health sector programs, and that they do not like what they see.

Relatedly, when asked if the best means of addressing malnutrition problems in developing countries is through inputs which are solely nutrition/MCH-based, as opposed to multisectoral, 56.8% disagreed or disagreed strongly (32.4% agreed or agreed strongly with the rest remaining neutral). The nutrition community clearly would choose to have an independent identity in its programmatic activity, but would wish its efforts in such programs to be multisectoral.

When respondents were asked specifically if they agreed that growth monitoring and promotion is not an effective means of facilitating nutrition improvement at the community level, 63.8% disagreed or disagreed

strongly, with that figure increasing to 88.9% among those working with local NGOs. This finding contrasts sharply with a conclusion of the fourth Lancet paper, which cites growth monitoring as one of its "wrong things not to do," despite the fact that it has become a cornerstone of paediatric practice and nutrition care, and despite the fact that so many operational programs have used anthropometric monitoring successfully (Bryce et al 2008). Strangely, that Lancet paper qualifies itself by adding to its not-to-do recommendation on growth monitoring and promotion the words, "unless linked to adequate nutrition counselling and referrals." And yet why else would one do growth monitoring? It is unlikely that many designing child nutrition programs would expect children to grow better simply by placing them on a scale.

Another current hot topic in the nutrition field at present is whether the cost and time devoted to community therapeutic care (CTC) for severely malnourished children in developing countries – beyond emergency situations – will result in less attention to prevention. On this issue, respondents were divided, with 41.9% agreeing that CTC costs and time would indeed have consequences for preventive action, and 35.8% disagreeing. Clearly such divided opinion underlies the intense debates taking place around this topic in countries around the world. Given the importance of these issues, many were puzzled to find that the third Lancet paper wrote in positive terms about such therapeutic care without including information on the absolute costs or the opportunity costs of such interventions (Bhutta et al 2008).

Nearly two-thirds of respondents (64.6%) were critical of efforts by external nutrition research entities that advance their own nutrition research interests in the work they do with developing countries, rather than addressing the highest priority needs of the countries involved. The surprise here is not the high level of agreement – it is no secret that many in our community view this tendency as exploitative – but rather that we find nearly the same level of agreement (62.7%) among those whose work is in basic nutrition or food science. And less than one quarter of respondents (24.1%) believe that ministries of agriculture in developing countries have played a

Table 2: Primary disappointments*

	(%)
Infighting of nutrition community & absence of consensus on priorities	27.1
Inadequate commitment by governments	22.0
Reduced funding	11.9

* These were the top three of thirteen options

Table 3: Investing in nutrition

Investment opportunities	(%) *
Maternal and child care	67.0
Nutrition education / Behavioural change communication	62.5
Micronutrients	43.2
Income generation	33.1
Hygiene and sanitation	31.5
Agriculture extension	16.5
HIV and nutrition	15.7
Conditional cash transfers	13.5
Feeding programs	8.7
Other	8.3

* Numbers represent combined percentages among top 3 choices of the respondents

Table 4: Ranking of organizations by respondents

	1997	Now	Change
UNICEF	3.83	3.78	-0.05
Micronutrient Initiative	3.40	3.72	+0.32
International NGOs	3.24	3.62	+0.38
IFPRI	3.23	3.47	+0.24
World Food Programme	-	3.45	
Academic institutions (industrialized country)	2.76	3.37	+0.61
Indigenous NGOs	2.92	3.35	+0.43
ACC/SCN	2.94	3.34	+0.40
WHO	2.49	3.23	+0.74
Bilateral agencies	2.79	3.22	+0.43
Private foundations	2.63	3.19	+0.56
Academic institutions (developing country)	2.73	3.06	+0.33
GAIN	-	3.05	
World Bank	2.92	2.99	+0.07
FAO	2.28	2.85	+0.57
Private consulting organizations	2.37	2.67	+0.30
PAMM	3.07	-	

Rating Scale: 5 = Extremely Well; 1 = Poorly

significant role in improving nutritional well-being – beyond their role in increasing overall food production.

As the penultimate question, respondents were asked how they would spend an additional \$50 million on nutrition in developing countries, and were permitted three priorities among 10 choices, plus the opportunity for write-in votes. When the first, second and third priorities were added together, maternal and child care and behavioral change communications received the most votes, 67.0% and 62.5%, respectively (Table 3).

Finally, respondents were asked to score, on a 1-to-5 scale, specific organizations or groups of organizations on how well they have served the field of nutrition, relative to standards the respondents themselves would have set for them. When this same question was asked 10 years ago, the scores were those presented in Table 4. UNICEF was first, followed surprisingly by a then quite young organization, the Micronutrient Initiative. International NGOs and IFPRI were nearly tied in the third and fourth positions. At the bottom of this list: private foundations, two UN technical agencies and private consulting organizations.

The scores in the current survey, with a couple of additional organizations added, are also presented in Table 4, along with the change in score. UNICEF, although down a bit, again tops the list with an average score of 3.78. And, once again, the Micronutrient Initiative has come in second, even closer to the top spot, with a score of 3.72. International NGOs and IFPRI retain their third and fourth slots. On the bottom of the list, we find the World Bank and GAIN and, once again, consulting firms and FAO, this time with the latter two switching positions, but with both registering higher scores than in the earlier survey.

Concluding remarks

Taken as a whole, the international nutrition community is optimistic about its mission and about its future, and is cognizant and appreciative of the research done in the past to elucidate the consequences of malnutrition and the relationships between nutrition and particular communicable diseases. But it believes that primary attention in the future needs to be given not to further refinement of these research findings on causality and consequences but rather to:

- effective high-level advocacy, utilizing the powerful evidence already available,
- generation of adequate resources to properly address malnutrition, and
- improved management and implementation at scale of our programs, with particular attention to opportunities for community participation.

And so let us return to Dr. Horwitz and to the remarkable optimism of those working in this field – an optimism that may be quite surprising to some of us, given what we as a community have experienced over the decades – but which probably would not have been so surprising to Dr. Horwitz. He would have pointed quickly to the increased understanding of the effect that malnutrition is having on mortality and on illness, and, in turn, its negative effect on national development. He would have noted the attention given to nutrition in the formulation of the Millennium Development Goals, the high premium placed on micronutrients by the Copenhagen Consensus, and the high profile identification of the importance of nutrition recently, for instance, in the statement of India's Prime Minister on that country's 60th Independence Day, and the placing of nutrition for the first time on the agenda of the most recent Economic Summit in Davos. Dr. Horwitz would have enumerated for us the rapid increase in attractive and efficacious nutrition intervention opportunities that have emerged in recent years, from the proliferation of options to address micronutrient deficiencies in young children, to newborn vitamin A supplementation, to double fortified salt. He would have lauded the increasing attention now finally being directed to the long-recognized importance of the nutritional well-being of children under the age of two. We would guess, at the same time, that he would continue to lament the management and implementation shortfalls, which so often constrain the effectiveness of technically sound programs when they are taken to scale.

Overall, however, we believe he would have been pleased with the community for having navigated at least some of the rapids, for having had to learn to swim upstream in the process, for having realized some notable successes, perhaps particularly in mobilizing communities, and also for having explicitly recognized the challenges that lay ahead.

If Dr. Horwitz were here, we imagine we would be thanking him on this 30th anniversary of the SCN for his vision, for his patience with us, and for simply refusing to take no for an answer when it comes to combating what he frequently observed to be one of the great avoidable tragedies of our time.

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VACANCY ANNOUNCEMENT:

International Relief and Development, Inc.

International Relief and Development (IRD) seeks a **Senior Technical Advisor in Food Technology and Nutrition** for the Sustainable Food and Agriculture Systems (SFAS) unit, one of IRD's five technical sectors (Health, Civil Society, Economic Development, SFAS, and Infrastructure). The Senior Technical Advisor will provide overall leadership and technical advice for research and program development related to food technology and human nutrition. This position is an open-ended, renewable appointment based at IRD headquarters in Washington DC. Building upon its pioneering noodle fortification program in Indonesia, The Sustainable Food and Agriculture Systems (SFAS) unit within IRD seeks expand its innovative initiative to build capacity within the private sector food processing industry of the developing world to fortify a range of food products, from Ready to Use Foods (RUFs) to supplemental foods to school feeding provisions to commercial sales for general consumption. The Senior Technical Advisor will play a pivotal role in identifying opportunities, developing partnerships with private sector entities, ensuring the nutritional quality of products, overseeing monitoring on-going programs, and evaluating program impact at the individual and population level.

Major Responsibilities: Specific duties and responsibilities include but are not limited to: • Provide technical oversight to IRD's expanding portfolio of food aid and food processing programs to ensure the highest quality according to international standard. • Develop relationships with international agencies, research institutions, foundations, multi-lateral organizations, non-profit agencies, private sector companies, and government ministries to support IRD's programming. • Along with the IRD program development team, identify potential sources of funding for specific for food and nutrition-related activities; participate in proposal writing, and reporting to the international donor community. • Recommend strategic directions for the Program especially relating to food and nutrition activities and their interface with other components (i.e. agriculture, income generation) of the SFAS program. • Conduct outreach/networking with food and nutrition communities, both domestic and international institutions and the interested public as required.

Minimum Qualifications: MS degree (PhD preferred) with specialization in food technology and human nutrition. • Minimum 10 years working experience in developing countries, with experience in private sector development. • Good knowledge and understanding of the links between food fortification and nutrition, in particular on the role of food fortification in integrated strategies to combat macro- and micronutrient deficiency disorders. • Good interpersonal communication skills, writing ability and administrative skills; and ability to work in multidisciplinary teams. • Substantial international travel. • Excellent written and spoken English. • Already possesses the legal right to work in the United States. IRD will NOT sponsor applicants.

Preferred Qualifications: Experience in supervising food and nutrition research projects in developing countries. • Good understanding of private sector development.

To Apply: Please apply online at www.ird-dc.org under "Careers/Headquarters Positions" reference, "**Senior Technical Advisor – Food Technology and Nutrition**"

35th SCN Session Recommendations

The participants at the 35th SCN Session, in the Working Groups and Constituency meetings, discussed a set of recommendations that was later agreed by email and in the SCN Steering Committee. We have reprinted here the one-page Executive Summary, the full set of recommendations, as well as detailed notes with programme and policy guidance.



RECOMMENDATIONS FROM THE SCN 35TH SESSION "ACCELERATING THE REDUCTION OF MATERNAL AND CHILD UNDERNUTRITION"

EXECUTIVE SUMMARY

The 35th Session of the SCN held in Hanoi in March 2008, which focussed on accelerating the reduction of maternal and child undernutrition, made the following recommendations:

Recognizing that:

- The global burden of maternal and child undernutrition remains unconscionably large, and is the single greatest constraint facing global development efforts.
- A renewed and strengthened evidence base exists for a set of essential nutrition interventions that if effectively targeted to mothers and children from conception to two years of age, could prevent at least a quarter of child deaths under 36 months of age, and reduce the prevalence of stunting by about a third.
- Although this important set of interventions cannot replace socio-economic development, they can help accelerate the reduction of maternal and child undernutrition, especially when main-streamed into efforts to tackle poverty, improve food security and livelihood support, and strengthen health service delivery.
- Remarkably little is being done to tackle the problem of maternal and child undernutrition, especially in the countries most affected. Increased mobilization is therefore needed at all levels of society in order to act at scale with this set of essential nutrition interventions.
- The recent increases in food prices and the reduction of grain stocks to a 30 year low threaten the capacity to provided assistance and ensure the right to food, especially in those nations showing least progress towards achieving the non-income targets of MDG1.
- Global nutrition leadership needs to be further strengthened in order to facilitate technical and policy consensus that will permit accelerated reduction of maternal and child undernutrition.

Recommends that:

- Governments give greater recognition to the importance of maternal and child undernutrition and their contribution to development, as well as their legal obligation under international human rights law, and provide leadership in ensuring that the appropriate policies and programmes are put in place, so that the essential nutrition interventions are implemented at scale, and the most vulnerable households are protected in the face of unexpected economic and/or environmental shocks.
- Donors, foundations and other funding sources, while aligning and adapting global initiatives to national priorities, as part of their assistance to those countries most affected by maternal and child undernutrition, give a far greater priority to funding and facilitating at scale coverage of the essential nutrition actions as an integral part of poverty reduction and health system strengthening.
- The UN system through its country teams give greater priority in its development assistance to maternal and child undernutrition, supporting Member States actions to ensure the essential set of nutrition interventions at scale as part of the poverty reduction activities, as well as realizing human rights relevant to nutrition, including the right to adequate food and to health.
- The UN take the lead in developing extraordinary measures to counteract escalating food prices, and ensure the capacity to respect, protect and fulfil the right to food, especially of the most vulnerable, in the event of natural disasters and other emergencies.
- All actors give greater attention to monitoring and evaluating programmes aimed at accelerating the reduction of maternal and child undernutrition. Policies at global, regional and country level be reviewed, harmonized and monitored, with a view to encourage integrated support to at risk families, and to promote and protect maternal and child nutrition. Furthermore progress towards the achievement of MDG 1 should be reported against reductions in the prevalence of stunting in children below the age of five, not just underweight.
- The upcoming reviews of the SCN and the global nutrition architecture, which are welcomed, should examine the different structures and alternative approaches being used by other sectors.

RECOMMENDATIONS OF THE 35TH SESSION OF THE SCN IN HANOI MARCH 2008

Introduction

The 35th Session of the SCN in Hanoi focused on the theme: Accelerating the reduction of maternal and child undernutrition. Discussions of this issue of central concern of the SCN, took advantage of new analysis and suggestions coming from the recent Lancet Nutrition Series.¹ An additional consideration was the recognition that the realization of the right to adequate food², to health³ and to other human rights relevant to the attainment of good nutrition⁴, are essential to achieve the aims of the Millennium Declaration⁵, including those expressed by the Millennium Development Goals⁶.

Recognizing that:

1. The global burden of maternal and child undernutrition remains unconscionably large, and is the single greatest constraint facing global development efforts.
 - Maternal and child undernutrition is the underlying cause of at least 3.5 million deaths each year, 35% of the disease burden in children younger than 5 years of age, and 11% of the total global disease burden.
 - 138 million children under five (32%) are stunted and 18 million are severely wasted. Furthermore 13 million babies are born each year with Intrauterine Growth Restriction (IUGR). Together these conditions constitute a quarter of the risk of death and disease burden, the largest risk in this age group.
 - Suboptimal breastfeeding, especially non-exclusive breastfeeding in the first six months of life, results in 1.4 million deaths each year and 10% of the disease burden in children younger than 5 years.
 - Iron deficiency anaemia accounts for at least 20% of maternal mortality.
 - Progress towards the non-income targets of the first Millennium Development Goal (MDG1) is still far from adequate. Despite remarkable economic growth in many countries during the last two decades, the prevalence of child underweight has declined at only sixty percent of the rate needed to achieve the MDG1 non-income target globally.
 - Lack of progress in tackling maternal and child undernutrition not only impacts on the non-income targets of MDG1, but also on maternal and child mortality (MDG 4 and MDG 5). Furthermore stunting leads to irreversible damage later in the course of life, including lowered attained schooling (MDG2) and decreased earnings.
2. A deeper understanding of the implications of stunting and wasting has emerged which the measure of underweight alone does not capture. This understanding provides important insights into how and when to tackle the problem of maternal and child undernutrition.
 - Stunting, or length growth faltering, is as much a reflection of poor maternal nutrition as it is of poor infant and young child feeding.⁷
 - The process of stunting is largely over by two years of age, providing a new "window of opportunity" for delivery of nutrition interventions from conception to two years of age.⁸
 - Advances in the treatment of severe acute malnutrition mean that severely wasted children without medical complications can be effectively treated with ready to use therapeutic foods (RUTF) in the community with much reduced case fatality rates.⁹
 - Accelerated weight growth after two to three years of age in children that are stunted but not wasted increases the likelihood of nutrition related chronic disease (obesity, diabetes, high blood pressure) later in life.¹⁰
3. A renewed and strengthened evidence base exists for a set of essential nutrition interventions¹¹ that if effectively targeted at mothers and children from conception to two years of age, could prevent at least a quarter of child deaths under 36 months of age, and reduce the prevalence of stunting by about a third. These preventive and curative interventions are mutually reinforcing elements of an effective response. They must be integrated in a comprehensive approach, including:
 - Infant and young child feeding¹² (promotion of early and exclusive breastfeeding through individual and group counselling¹³; behaviour change communication for improved complementary feeding¹⁴ and continued breastfeeding)
 - Micronutrients (iron/folate¹⁵ or multiple micronutrient¹⁶, and calcium supplements for mothers during pregnancy and lactation, fortification of complementary foods¹⁷, fortification of salt with iodine¹⁸, zinc supplementation in the management of diarrhoea in young children¹⁹, vitamin A fortification and/or supplementation²⁰);
 - Treatment of severe acute malnutrition using special therapeutic foods²¹ (linked community and facility based treatment), along with anti-retroviral drugs for HIV/AIDS.
 - Context specific interventions²²:
 - in areas of food insecurity²³ (maternal food supplements that are balanced in energy and protein²⁴, complementary food supplements for children 6-24 months²⁵ especially if through conditional cash transfer²⁶ with nutritional education).
 - in malaria areas²⁷ (presumptive treatment during pregnancy, insecticide treated bed nets);
 - in areas with high loads of gastrointestinal parasites²⁸ (deworming in pregnancy as well as in infancy and early childhood, hand washing and hygiene²⁹).
4. Although this important set of interventions cannot replace socio-economic development, they can accelerate reduction of maternal and child undernutrition, especially when delivered as part of such efforts. Improved maternal and child nutrition is not an automatic by-product of poverty reduction and economic advance³⁰. Therefore this set of essential nutrition interventions must be added "on top" and mainstreamed into national poverty reduction strategies³¹ through various sectors including: efforts aimed at strengthening household food security; conditional cash transfer programmes and other social security safety nets; efforts aimed at strengthening health services, including those aimed at ensuring a continuum of maternal³²,

newborn and child health care through community based outreach, as well as other international health partnerships.

5. Remarkably little is being done to tackle the problem of maternal and child undernutrition, especially in the countries most affected. Indeed coverage data shows that most countries with high levels of maternal and child undernutrition are failing to reach the majority of mothers and young children with these essential nutrition interventions. Furthermore resources devoted to combating maternal and child undernutrition are not commensurate with the magnitude of the problem. Donor assistance to basic nutrition is five times smaller than to food aid and nineteen times smaller than to HIV/AIDS. A Landscape Analysis is now being undertaken to better understand the challenges and the opportunities for acting at scale to accelerate the reduction of maternal and child undernutrition in countries most affected by stunting, with a view to improving the allocation of resources in this area.³³

6. Increased mobilization is needed at all levels of society in order to act at scale with this set of essential nutrition interventions³⁴, while empowering mothers to nourish themselves and their children with support from their families and communities. Such efforts must be placed in the context of promoting improved legal protection of women's and children's rights and enabling people to understand and claim their rights to adequate food, health and care. Likewise the corresponding duty bearers in all sectors and at all levels of government, are responsible for making the necessary resources and conditions available, so that the set of essential nutrition interventions is delivered at scale.³⁵ Civil Society Organizations have an important role to play in encouraging communities to claim their rights, as well as counteracting the many cultural practices and traditional behaviours that adversely affect maternal and child undernutrition, including child marriages. The private sector has an important role to play in the production and distribution of adequately fortified foods for the general population, of adequate complementary foods preferably processed from locally available foods, and therapeutic foods for the severely malnourished, as well as adhering to internationally agreed food standards, as developed by the Codex Alimentarius and complying with the International Code of Marketing of Breast-milk Substitutes.

7. The present increases in food prices and the reduction of food stocks to a 30 year low are largely a reflection of accelerating demographic change, increased socio-economic disparities and environmental degradation - associated with unsustainable production, trade and consumption practices - all important determinants of food insecurity and malnutrition. The trend towards biofuel production is further aggravating this precarious situation. Unless urgent actions are taken, and assistance provided, especially in those nations showing least progress towards achieving the non-income targets of MDG1, much of the progress achieved during the last decades is likely to be eroded.³⁶

8. Global nutrition leadership needs to be further strengthened in order to facilitate technical and policy consensus that will permit accelerated reduction of maternal and child undernutrition.

Recommends that:

9. Governments give greater recognition to the importance of maternal and child undernutrition and their contribution to development, as well as their legal obligation under international human rights law, and provide leadership in ensuring that the appropriate policies and programmes are put in place, so that the essential nutrition interventions are implemented at scale and the most vulnerable households are protected in the face of unexpected economic and/or environmental changes.

10. Donors, foundations and other funding sources, while aligning and adapting global initiatives to national priorities, as part of their assistance to those countries most affected by maternal and child undernutrition, give a far greater priority to funding and facilitating at scale coverage of the essential nutrition actions as an integral part of poverty reduction and health and food system strengthening.

11. The UN system through its country teams, give greater priority in its development assistance to maternal and child undernutrition, supporting its Member States actions to ensure the essential set of nutrition interventions at scale as part of the poverty reduction activities, as well as realizing human rights relevant to nutrition, including the right to adequate food and to health.

12. The UN take the lead in developing extraordinary measures to counteract escalating food prices and ensure the capacity to respect, protect and fulfil the right to food, especially of the most vulnerable, in the event of natural disasters and other emergencies.

13. All actors give greater attention to monitoring and evaluating programmes aimed at accelerating the reduction of maternal and child undernutrition. Policies at global, regional and country level be reviewed, harmonized and monitored, with a view to encourage integrated support to at-risk families, and to promote and protect maternal and child nutrition. National nutrition data should be disaggregated in order to establish whether and to what extent nutritional discrepancies exist among vulnerable groups and to inform policies towards realizing the human right to adequate food and the highest attainable standard of health. Furthermore progress towards the achievement of MDG 1, should be reported against reductions in the prevalence of stunting in children below the age of five, not just underweight. Stunting should eventually become the internationally agreed best single over-arching indicator for tracking poverty reduction efforts.

14. The upcoming review of the global nutrition architecture, which is welcomed, should examine the different structures and alternative approaches being used by other sectors. Such a review should recognize the core role of the SCN in harmonizing the efforts of the UN agencies in the field of nutrition and acknowledge the prominent place of human rights on the agenda of the United Nations.

NOTES:

The purpose of these notes is to provide access to programme and policy guidance of relevance to the recommendations from the SCN 35th Session. The Lancet Nutrition Series (LNS) Paper 5 cites the lack of clear programme guidance as one of the shortcomings of the international nutrition system. The LNS provides little or no links to the programme guidance that is available, but then the LNS is much more about the "what" and the "why" of improving maternal and child under-nutrition, and less about the "how". These notes aim to inform national level actors in this regard, so that they are better able to better interpret and use the recommendations and to help establish successful nutrition programmes that will contribute to accelerating the reduction of maternal and child undernutrition. These notes recognize that there are various existing sources of programme guidance in nutrition, but there is no "one stop" place where national level actors can find such guidance that is still up-to-date.³⁹

The links can be accessed in the online SCN News 36, at www.unsystem.org/SCN/Publications/html/scnnews.html and the full URLs are written out in the 35th SCN Session Recommendations on the SCN website at www.unsystem.org/SCN/Publications/AnnualMeeting/SCN35/35th_Session_Recommendations.pdf

1. The Lancet Nutrition Series (LNS) is a series of five articles published in the first few months of 2008. Links to each of the articles are available [online](#) and an executive summary in English and in French is available [online](#).
2. Art. 11 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) defines the right to food as "the right of everyone to adequate food and to be free from hunger". The ICESCR, which entered into force in 1976, is available [online](#). The normative content of the right to adequate food is elaborated in General Comment 12 (GC12) to the ICESCR from 1999 ([online](#)). See also the *Voluntary Guidelines to support the progressive realization of the right to adequate food in the context of national food security*, adopted by the 127th Session of the FAO Council, November 2004, which provides practical guidance ([online](#)).
3. ICESCR Art. 12 defines the right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" ([online](#)). The normative content of the right to health is described in GC14 to the ICESCR from 2000 ([online](#)).
4. All human rights are universal, indivisible, interrelated and interdependent. Besides the rights to food and to health described above, the rights of particular relevance to nutrition include children's right to food, health, care as well as survival and development as defined in Arts. 24 and 6 of the *Convention on the Rights of the Child* (CRC) ([online](#)). The CRC entered into force in 1991 and enjoys almost universal ratification by virtually all nation states. Of particular importance to maternal and child undernutrition are the right of mothers to appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation, as defined in Art. 12.2 of the *Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW), which entered into force in 1990 ([online](#)), as well as the right to work, social security, women's rights, etc, see further in the Voluntary Guidelines referenced in note 2.
5. United Nations (2000) *United Nations Millennium Declaration*. Resolution adopted by the General Assembly [without reference to a Main Committee (A/55/L.2)]. 55/2. ([online](#)).
6. United Nations (2000) *The Millennium Development Goals* ([online](#)).
7. Paper two in the LNS concludes that half of the stunting at two years of age is caused by poor growth in uterus and half is due to poor growth in the first two years of life. The conclusions are based on evidence from cohort studies following the health, growth and development of children across their life cycle. Victora CG, Adair L, Fall C et al., for the Maternal and Child Undernutrition Study Group (2008) Maternal and child undernutrition: consequences for adult health and human capital. *Lancet* 371:340-357.
8. Shrimpton R, Victora CG, de Onis M, et al. (2001) Worldwide Timing of Growth Faltering: Implications for Nutritional Interventions. *Pediatrics* 107(5), e75.
9. The LNS only considered evidence for facility based treatment of severe acute malnutrition, even though international guidance is already promoting the use of community based treatment using RUTFs in conjunction with facility based treatment. A *Joint Statement on the community based management of severe acute malnutrition* made by WHO, WFP, SCN and UNICEF is available [online](#). The statement largely draws on the conclusions from an informal consultation as described in the *SCN Nutrition Policy Paper 21* ([online](#)).
10. Many nutrition programmes rely on weight growth monitoring as a platform for both providing appropriate guidance as well as monitoring impact. Weight growth monitoring on its own is not enough however, and certainly beyond two years of age weight and height must be measured in order to ensure that weight growth is adequate in relation to height. With the development of the new WHO growth standards, up-to-date programme guidance is available on how to measure and interpret children's growth. WHO (2006) *Training Course on Child Growth Assessment*. Version 1. WHO:Geneva ([online](#)).
11. Paper three of the LNS lists a set of "core" interventions, for which it considers there is sufficient evidence for implementation in all 36 countries that are home to 90% of stunted children in the world. Further interventions ("non-core") are indicated for use in "specific situational contexts". Bhutta ZA, Ahmed T, Black RE, et al, for the Maternal and Child Undernutrition Study Group (2008) What works? Interventions for maternal and child undernutrition and survival. *Lancet* 371(9610):417-440.
12. Guidance on the feeding of infants and young children is available from the WHO/UNICEF *Global Strategy for Infant and Young Child Feeding* from 2003 ([online](#)). Two further guidelines to support the implementation of the strategy are also available at the same website: the WHO *Infant and young child feeding: A tool for assessing national practices, policies and programmes* from 2003 and the WHO *Planning guide for national implementation of the global strategy for infant and young child feeding* (Working draft) from 2006. An integrated course for training health workers in *Infant and Young Child Feeding Counseling* is also available [online](#). An important dimension to the infant feeding guidance concerns the marketing of breastmilk substitutes, on which guidance was first issued over 25 years ago in the WHO *International Code of Marketing of Breastmilk Substitutes* from 1981 ([online](#)). The Code has been the subject of many subsequent resolutions by the World Health Assembly, an overview with full text of all these are available [online](#) from the International Baby Food Action Network (www.ibfan.org)

13. The LNS recommends that community based strategies for breastfeeding promotion should be integrated into health system support strategies. One such strategy is the *Baby Friendly Hospital Initiative* (BFHI), launched by WHO and UNICEF in 1991, following the *Innocenti Declaration* of 1990. BFHI is based on the *Ten Steps to Successful Breastfeeding*. The first BFHI material was published in 1992, the most recent revised BFHI package from 2006, which takes account of HIV concerns, is available [online](#). The evidence base for the Ten Steps is available [online](#).

14. LNS considers that in "food secure" populations, evidence shows that nutrition education improves complementary feeding which improves linear growth. How to promote the adoption of optimal complementary feeding practices, is described in a document providing the scientific rationale of each guideline; see PAHO/WHO (2003) *Guiding principles for complementary feeding of the breastfed child*. Division of Health Promotion and Protection/Food and Nutrition Program. PAHO/WHO:Washington DC ([online](#)). One of the guidelines is on the use of fortified complementary foods or vitamin-mineral supplements for the infant, which in summary states that it is difficult to meet the recommended intakes of certain key nutrients (particularly iron, zinc and calcium) through complementary food mixtures without the inclusion of animal food sources. As these increase the cost and/or may not be culturally appropriate, the use of either fortified complementary foods or vitamin-mineral supplements should be considered "as needed" in most settings. Even in developed country settings the prevention of anaemia in children has largely been achieved by fortifying complementary foods.

15. The LNS considers there is sufficient evidence that iron-folate supplementation during pregnancy reduces anaemia at term, and that their effective use at scale would reduce maternal mortality by 23%. Although most if not all countries have a national policy to give iron supplements to women during pregnancy, anaemia rates in women of reproductive age are greater than 50% in all of the 36 countries that harbour 90% of global stunting. Coverage of iron supplements in women during pregnancy, although rarely measured or monitored, are often reported to be around 50%, but in reality are likely to be much lower; see Mason J, et al (2001) *The Micronutrient Report*. The Micronutrient Initiative:Ottawa ([online](#)). The UN agencies recommend that in populations where more than 40% of women of reproductive age are anaemic, supplementation with 60 mg iron and 400 mcg of folic acid should be given to all women during pregnancy and lactation for at least three months; see UNICEF/UNU/WHO (2001) *Iron Deficiency Anemia: Assessment, Prevention and Control. A guide for programme managers* ([online](#)). The UN also recommends that strategies to control anaemia should consider infection control in addition to increased dietary intake; see WHO/UNICEF (2004) *Focusing on Anemia: Towards an integrated approach for effective anemia control*. Joint UNICEF/WHO statement ([online](#)). Care is also needed in the distribution of iron supplements in malaria endemic areas, and a joint WHO/UNICEF Statement is available on this ([online](#)).

16. Anaemic mothers are rarely just iron deficient, but instead have multiple micronutrient deficiencies. For these reasons a multiple micronutrient supplement (MMS) that could potentially replace the iron-folic acid supplement has been developed for trial purposes; UNICEF/WHO/UNU (1999) *Composition of a Multi-Micronutrient Supplement to Be Used in Pilot Programmes among Pregnant Women in Developing Countries* ([online](#)). Although the LNS concluded that use of MMS in pregnancy can reduce the risk of low birth weight, and recommended it as a core intervention, there is still no UN guidance on the use of MMS in non-emergency situations. UN agencies have issued a joint statement which covers the use of MMS in populations affected by an emergency; see WHO/UNICEF/WFP (2007) *Preventing and controlling micronutrient deficiencies in populations affected by an emergency*. WHO:Geneva ([online](#)).

17. Although comprehensive programme guidance on fortification of food exists (WHO/FAO (2006) *Guidelines on food fortification with micronutrients*. Allen L, de Benoist B, Dary O, Hurrell R (Eds), WHO:Geneva ([online](#))), specific guidance on how to fortify complementary foods, especially in developing country settings is more difficult to find. Although no adverse effects of increasing iron intake through fortification or home fortification of complementary foods have been reported, large-scale studies that include sufficient numbers of iron-replete children are still lacking. Further research is needed to verify the safety of iron-fortification strategies, particularly in malarial areas; Dewey KG (2007) Increasing iron intake of children through complementary foods. *Food Nutr Bull*. 28 (4 Suppl):S595-609.

18. There is considerable guidance available on the elimination of iodine deficiency; see ICCIDD/MI/UNICEF/WHO (1995) *Salt Iodization for the Elimination of Iodine Deficiency*. Mannar V and Dunn J. International Council for the Control of Iodine Deficiency Disorders ([online](#)). Universal Salt Iodization was the main focus of the last edition of the SCN News, [online](#).

19. Guidelines are available on the use of zinc supplements in the treatment of diarrhoea; see USAID/UNICEF/WHO (2005) *Diarrhea treatment guidelines including new recommendations for the use of ORS and zinc supplementation for clinic-based healthcare workers*. WHO:Geneva ([online](#))

20. A variety of sources of guidance on the control of vitamin A deficiency is also available [online](#) through the Nutrition in Health and Development website at WHO.

21. Guidelines on the use of RUTF in community settings are available; see Valid International (2006) *Community-based Therapeutic Care (CTC): A Field Manual* ([online](#)).

22. These context specific interventions are more related to the three groups of underlying causes (Food, Health and Care) of malnutrition, which operate at the household and community level. The 1990 UNICEF Nutrition Strategy proposed the use of the **Triple A** method (**A**ssessing the problem, **A**nalysing the causes and implementing appropriate **A**ctions) in order to decide which actions should be taken to improve nutrition, i.e. the decision on which actions to take is context specific. The Analysis part of the Triple A is informed by the use of a **Conceptual Framework** which identifies the basic, underlying and immediate causes of malnutrition. The three groups of underlying causes are each essential but alone insufficient, meaning that for maximum impact, all three potential problem areas have to be resolved. The Basic causes are related to the natural resources available to the nation, the national income per capita, the quality of the human capital and of the institutions that provide governance. See Jonsson U (1995) Ethics and Child Nutrition. *Food and Nutrition Bulletin* 16(4), [online](#). The immediate level of causality includes individual disease status and nutrient intake, and is where the LNS "core" or essential nutrition interventions operate at.

23. Guidance on how to classify food security of a specific population in a defined geographic area is available from a variety of sources; see WFP (2005) *Emergency Food Security Assessment Hand Book* ([online](#)), IFRC (2006) *How to conduct a food security Assessment* ([online](#)). The *Food Insecurity Vulnerability Information and Mapping System* (FIVIMS) (www.fivims.org) promotes cross-sectoral analysis of underlying causes of food insecurity, hunger and malnutrition for improved policy making, programming and action. The *Integrated Food Security Phase Classification* (IPC) has developed a concrete set of indicators of food security. This innovative tool for improving food security analysis and decision-making, provides a standardized scale that integrates food security, nutrition and livelihood information into a clear statement about the nature and severity of a crisis and implications for strategic response (www.ipcinfo.org). The IPC has been developed to help

- coordinate the delivery of humanitarian aid in emergency situations. Similar scales for use in non-emergency settings have yet to be developed however. The Food and Nutrition Technical Assistance (FANTA) website is also a good source of guidance on the measurement of food security work as used to guide USAID technical assistance to Title II emergency programs and more than 80 development, nutrition, and food security programs in 27 countries ([online](#)).
24. Programme guidance on when and how to provide balanced energy-protein supplements to mothers during pregnancy is not readily available. The LNS Paper 3 used a cut off of 10% for excessive thinness (i.e. with a BMI less than 18.5) in women of reproductive age, in order to model the effects of the intervention. Improving maternal nutrition status to improve foetal development is not simply a question of improving dietary intake however as has been reported by several technical consultations. See WHO (2003) *Promoting optimal fetal development: Report of a technical consultation*. WHO:Geneva ([online](#)), ACC/SCN (2000) *Low Birth Weight*. Nutrition Policy Paper No 18. Standing Committee on Nutrition:Geneva ([online](#)).
25. LNS paper 3 considers that in areas of food insecurity efforts to improve complementary feeding requires the provision of food supplements. Operational guidance exists on infant and young child feeding in emergency situations; see IFE Core Group (2007) *Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers*. Version 2.1 – February 2007 ([online](#)). Guidance on when and how to use food supplements in children 6-24 months in non-emergency situations in food insecure areas is less easy to find.
26. The programmatic guidelines on the use of cash assistance that are available are more applicable to emergency situations than regular development settings ([online](#)). For a review of cash assistance use in more regular development settings; see Chapman K (2006) *Using social transfers to scale up equitable access to education and health services*. DFID Background Paper, London ([online](#)).
27. Guidelines exist on how to control malaria infections that will contribute of improved maternal and child nutrition; see Roll Back Malaria (2008) *Malaria in pregnancy*. Infosheet ([online](#)).
28. Guidelines on preventive chemotherapy for the control of helminth infections in humans is available for health programme managers; see WHO (2006) *Preventive chemotherapy in human helminthiasis. Coordinated use of anthelmintic drugs in control interventions: a manual for health professionals and programme managers* ([online](#)). Specific guidelines also exist for use of chemotherapy during pregnancy and lactation and in young children; see WHO (2002) *Report of the WHO Informal Consultation on the use of Praziquantel during Pregnancy/Lactation and Albendazole/Mebendazole in Children under 24 months* ([online](#)).
29. The LNS includes hand washing and hygiene interventions among the core measures that reduces the risk of diarrhoea, under the assumption that these reductions contribute to reduce stunting. While it is recognized that reducing diarrhoeal diseases rates are not necessarily associated with improvements in child growth (Poskitt EM, Cole TJ, Whitehead RG (1999) Less diarrhoea but no change in growth: 15 years' data from three Gambian villages. *Arch Dis Child*. 80(2):115-9), the hygiene and hand washing dimensions of complementary food preparation are an important part of the child “care” component of nutrition programmes. This is especially so in areas where water and sanitation measures are poor. Programme guidelines exist on hand washing and hygiene, such as those described under the UNICEF WASH Strategies ([online](#)).
30. Haddad L, Alderman H, Appleton S, Song L and Yohannes Y (2003) Reducing Child Malnutrition: How Far Does Income Growth Take Us? *The World Bank Economic Review* 17(1) 107-31.
31. The World Bank publication *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action* from 2006 makes the case that development partners and developing countries must increase investment in nutrition programs, and proposes to the international development community and national governments a global strategy for accelerated action in nutrition. Full report and executive summary in several languages are available [online](#).
32. The LNS did not include any interventions related to improved maternal care, although they agreed that there is evidence that too many pregnancies as well as smoking during pregnancy and exposure to household smoke could all have a negative impact on maternal health as well as foetal growth. Programming guidance on how to improve maternal care is provided in the UNICEF Care Initiative, (UNICEF (1997) *The Care Initiative: Assessment, Analysis and Action to Improve Care for Nutrition*. UNICEF:New York), which is explained in the SCN Nutrition Policy Paper No 18 on *Low Birth Weight* ([online](#)).
33. The results of this work in progress will be posted at the WHO Nutrition for Health and Development webpage www.who.int/nutrition
34. Important advocacy tools include the executive summaries of the LNS available in English and French, and of the World Bank *Repositioning Nutrition as Central to Development* available in English, French, Spanish and Chinese, referenced in notes 1 and 27 above, respectively.
35. Important advocacy tools for national implementation of the right to food, for example, is available from the FAO Right to Food resources page at www.fao.org/righttofood/publi_en.htm, along with other material.
36. FAO has established a webpage on the issue of increasing food prices www.fao.org/worldfoodsituation/nfs-home, and the topic was in focus at the High-Level Conference on World Food Security: the Challenges of Climate Change and Bioenergy 3-5 June 2008.
37. Programme guidance for nutrition in emergency situations is available through the *Toolkit for Addressing Nutrition in Emergency Situations* produced by the Nutrition Cluster of the Inter Agency Standing Committee ([online](#)).
38. The SCN Task Force on Assessment, Monitoring & Evaluation (March 2008) has recommended that for monitoring the progress made towards the achievement of MDG1, both countries and development partners report against the prevalence of stunting in children below the age of five as an internationally agreed indicator of endemic poverty. Furthermore stunting should be used as an additional indicator of endemic poverty to monitor progress made towards the achievement of MDG1 ([online](#)).
39. Other sources of programme guidance include the Basics *Nutrition Essentials*, the World Bank *Nutrition Tool Kit* and the SCN Nutrition Policy Paper No 19 *What Works?*. The latter was developed for use in Asia with the purpose of defining for the Asian Development Bank a core menu of proven investment options supported by sound evidence of efficacy ([online](#)). *Nutrition Essentials* is a guide for health managers in developing countries, and was produced in the late nineties by Basics in collaboration with UNICEF and WHO ([online](#)). The World Bank' “Nutrition Toolkit” is aimed at helping World Bank staff design and supervise effective and feasible nutrition projects and project components and to carry out comprehensive analysis of sectoral and policy issues affecting nutrition. The documentation is comprehensive covering project design, basic facts on nutrition through to programme communication ([online](#)).

Working Groups

WORKING GROUP ON BREASTFEEDING AND COMPLEMENTARY FEEDING

Chair: David Clark ([UNICEF](#)), Co-Chairs: Isatou Jallow ([WFP](#)) and Kay Dewey ([University of California, Davis](#))

Highlights from discussions 2 and 5 March

Kay Dewey reported on efforts to set up a **Maternal and Infant and Young Child Nutrition (MIYCN) Forum**, including the need for the forum, its proposed objectives and anticipated benefits. See also recommendations.

David Clark reported that [UNICEF had endorsed the Innocenti Declaration 2005](#), translated and published it [in 6 UN languages, plus Italian](#), carrying the UNICEF logo, and shared with UNICEF Executive Board during 2007.

UNICEF, WHO and other partners are working closely with the [Partnership on Maternal, Newborn and Child Health](#); the prevalence of early initiation of breastfeeding (within the first hour) has been included as a [Countdown to 2015](#) indicator for the first time in 2008, meaning that it is recognised and promoted as an intervention essential for the attainment of MDGs 4 and 5.

Two country presentations focused on **Experiences of complementary feeding from Oportunidades Program in Mexico**, Salvador Villalpando (National Institute of Public Health) and **Community-based Mother-Baby friendly neonatal care units in Zambia**, Agness Aongola (Ministry of Health)

Robert Black, Johns Hopkins University, presented the **Lancet Nutrition Series and Implications for Policies and Programs, with focus on** breastfeeding and complementary feeding/supplementation and consideration of improving zinc intake including supplementation/fortification

Regarding the **Revitalization and expansion of BFHI**, Kay Dewey presented a comparison between two health facilities, one in Peru and the other in the U.S. [BFHI tools are available on the WHO website](#), but they are not used. A planned [WHO meeting in June 2008](#) meeting in Geneva for BFHI Managers from Industrialized countries could indicate the beginning of new activities.

Bernadette Daelmans (WHO) reported on the **New/revised indicators for IYCF**, including history and research questions. See also page

Nune Mangasaryan (UNICEF) discussed **Growth monitoring promotion: intervention or platform for action?** describing the history of GM/P from the 1960s to the 2007 consultation that defines **Growth monitoring (GM)** as the process of following child growth rate in comparison to a standard and **Growth monitoring and promotion (GMP)** as a preventive and promotive activity that uses GM to facilitate communication and interaction with caregiver.

Comments to the Lancet Nutrition Series: The LNS represents an important platform to advocate for greater attention, support and financing for programmes supporting optimal infant and young child nutrition, although certain limitations in the series will require explanation when using the findings for advocacy purposes. This included the fact that certain interventions were not included on the list of "effective" interventions because of lack of published evidence. A good example is the BFHI, with the result that breastfeeding counseling is the only intervention included in the calculation of the impact of breastfeeding interventions, without mentioning the fact that breastfeeding needs to be protected, promoted and supported via multiple channels. The WG acknowledged that the importance of complementary feeding is underestimated in the series, while poor complementary feeding remains the main obstacle to improving the nutritional status of children in the 6-24 months age group. On the other hand, the calculation in respect of the impact of zinc supplementation was based on efficacy studies alone, and the actual impact in supplementation programmes is thus likely to be lower. The WG noted that the series does not provide any programming guidance to governments or implementing agencies.

Topics discussed

MIYCN Forum

Indicators

- New/revised indicators on IYCF
 - Early breastfeeding in Countdown
- Revitalization and expansion of BFHI
Lancet Nutrition Series
Growth Monitoring and Promotion
Country reports: Mexico, Zambia
Innocenti Declaration

MIYCN Forum Recommendations

1. The Task Force should continue to work on the setting up of the Forum with the proposed objectives related to sharing information on programme relevant research, reviews, meta-analysis, evaluations, survey data, programme implementation and monitoring by organizations and governments, current and future activities and programmes of NGOs and funders, and to discuss private sector initiatives and public-private partnerships
2. The Group recommends proceeding on a progressive basis, starting with newsletter/website while working on the holding of a meeting.
3. The Task Force should consider holding the first forum meeting as a satellite to the 2009 Micronutrient Initiative Meeting.
4. The Forum should also consider the issue of infant feeding in emergencies and should include a rigorous assessment of field activities in all aspects of IYCN. This requires the marrying of academic research with field programs, including food security and economic issues.

For more details, please see [Working Group report](#) and [presentations at the SCN Session](#)

WORKING GROUP ON NUTRITION, ETHICS AND HUMAN RIGHTS

Chair: Margret Vidar ([FAO](#)), Co-Chairs: Asako Hattori ([OHCHR](#)), Marlis Lindecke ([GTZ](#)), Flavio Valente ([FIAN](#)), Rapporteur: Marc Cohen ([IFPRI](#))

Topics discussed

Lancet Nutrition Series

Discrimination and Undernutrition

Updates from four Task Forces

Indigenous People

International Dimensions

Corporate Food Sector

Capacity Development

Defining Fundamental Right to be Free from Hunger

Book launch 4 March: *Global Obligations for the Right to Food* ([p.78](#))

Recommendations to SCN

1. For future SCN Sessions, to extend invitation to WGNEHR pre-session meeting
2. Efforts to review SCN in the context of an overall assessment of the international nutrition system should be carried out in a transparent manner; recognize the core role of SCN in harmonizing the efforts of UN agencies in the field of nutrition, with the advice of bilateral partners and civil society; and acknowledge the prominent place of human rights on the agenda of the United Nations and in the vision and mission of SCN.
3. SCN should continue to focus on economic, social, political and cultural factors as causes of malnutrition
4. Other SCN Working Groups should pursue their particular focus within a human rights perspective

Planned activities

(extract from 2008 Work Plan)

1. Monitor developments on global obligations for the right to food
2. Continue Task Forces' work
3. Explore activities to address the human rights implications of ready-to-use therapeutic foods

For more details, please see [Working Group report, presentations and background documents](#)

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Highlights from discussions 2 and 4 March

Updates and work plans from the Task Forces

- *TF on the Human Rights Responsibilities of the Corporate Food Sector* will focus on regulation of industry marketing practices, especially as regards pressure on children, and may change its name accordingly. A legal expert will be invited to serve as vice-coordinator.
- *TF on the Capacity Development for Human Rights in Nutrition* will continue to bring a human rights perspective to nutrition meetings, take part in training initiatives, and assist in the development of curricula on the linkages between food/nutrition and human rights.
- *TF on Indigenous Peoples and the Right to Adequate Food* will complete its study of this topic and present it, together with policy recommendations, at the IUNS meeting. The 36th Session of the SCN will receive an update.
- *TF on the Fundamental Right of Everyone to be Free from Hunger* will continue efforts to clarify the content of this right.

Discrimination and undernutrition. Veena Shatrugna (India National Institute of Nutrition) presented data from India, demonstrating the role of cultural factors for good nutrition.

Recommendations on the Global Obligations for the Right to Food, available from [WG-NEHR webpage](#) based on the [book](#) by the Task Force, concern starting a process towards clarifying international or extraterritorial obligations under the Covenant on Economic, Social and Cultural Rights of States' Parties as well as for international agencies and NGOs in relation to food and nutrition. The UN Committee on Economic, Social and Cultural Rights (CESCR) should prepare a *General Comment* on this theme, taking into account ongoing work in the Human Rights Council and other relevant bodies. Future General Comment should contain guidelines for international or extraterritorial obligations.

Comments to the Lancet Nutrition Series: The WG welcomed attention to the serious problem of maternal and child undernutrition in developing countries in such a prestigious health sciences journal. The WG appreciated in particular the call for research into the accountability and responses of governments to their nutrition-relevant commitments under international conventions such as the UN convention on the rights of the child and the convention on the elimination of all forms of discrimination against women. However, the WG also had a number of concerns about the series as a whole, including:

- It tends to take a top-down approach to issues, focusing on getting the interventions right, and frequently views malnourished people as clients and beneficiaries, rather than human beings with rights who are key actors in achieving their own development. Instead, it tends to re-medicalize discussion on nutrition and miss out on the important role and contribution of policy and legal frameworks, including those on human rights in nutrition.
- It tends to neglect the important role that the U.N. system has played and must continue to play in overcoming undernutrition.
- The series seems to blame the nutrition community for the persistence of undernutrition, while it neglects social, political, economic, and cultural determinants of malnutrition.

See also: SCN Working Groups on Nutrition, Ethics and Human Rights and on Nutrition Throughout the Life Cycle. *Human Right of Children and Adolescents to Adequate Food and to be Free from Obesity and Related Diseases: The Responsibilities of Food and Beverage Corporations and Related Media and Marketing Industries.* [Joint Statement](#), 33rd SCN Session, Geneva, 2006.

WORKING GROUP ON HOUSEHOLD FOOD SECURITY

Chair: Florence Egal (FAO), Co-Chair: Jeanineke Dahl Kristensen (DANIDA), H el ene Deret (ACF)

Highlights from discussions 5 March

Florence Egal presented the work carried out since the last annual session on a combination of tools expected to support the work of the Working Group, for which FAO has recruited a part-time facilitator

- the [D-group on Food Security, Nutrition and Livelihoods](#)
- a template for documenting lessons learnt at local level and preparation of fact sheets for advocacy and replication/adaptation.
- a 3W contact management directory (in collaboration with OCHA) of nutrition stakeholders at country level

Dr. Aminuzzaman Talukder (HKI)'s presentation on **lessons learned in Asia-Pacific Region from promoting Household Food Security** brought up a series of issues in the following discussions: in particular the difficulties of upscaling given limited donor interest, of targeting and identifying vulnerable households, and the problems of access to natural resources in particular land.

Dr. Ismail Thiam (WAHO), in the context of **advocacy work in ECOWAS for Biodiversity for Food and Nutrition**, reported on WAHO-SCN collaboration at the 10th ECOWAS Nutrition forum held in Mindelo, Cape Verde, 2006 (see [SCN News 33](#)), and the [Bioversity International/WAHO Regional workshop on Partnerships for Mobilizing the Diversity in Traditional Food Systems to Ensure Adequate Nutrition and Health](#) held in Ouagadougou, Burkina Faso, 2007. He looked forward to continued support for the 11th ECOWAS Nutrition forum to be held in September in Freetown, Sierra Leone on Food security and nutrition

Discussions on **the emerging issues of bio energy and climate change** in relation to food security:

Swantje Helbing, [German Federal Ministry of Food, Agriculture and Consumer Protection](#), presented the results of the [Policies Against Hunger](#)

[International Conference on Bioenergy and Food Security](#) held in Berlin, December 2007. Participants highlighted that bio fuels could be a good opportunity for farmers but the impact on food security would depend on how governments apply policies. Bio energy can be one of many causes of higher food prices. The process needs to be followed up closely as the consequences could be even greater in the second generation of biofuel production. The production of bio energy has to be an integrated part of global development and take into consideration consequences on food security.

Mark Cohen (IFPRI) presented the work being carried out with FAO on **Climate change, bio energy and nutrition**, in preparation of the [June 2008 High Level Conference in Rome on Climate Change](#). He pointed out that climate change will probably have a substantial impact especially in sub-Saharan Africa and Asia. Climate change is likely to increase the frequency of shocks (droughts or floods) which will have an impact on poor people and on their nutrition and health. Participants mentioned that climate change and bio energy constituted additional aggressions on the Right to Food. The EU proposal to adopt a 20% quota for bio energy would have major consequences on household food security and nutrition and the audience expressed strong concerns.

Comments to the Lancet Nutrition Series: Bruce Cogill, co-author of the LNS, highlighted the biomedical focus of the series. Since limited attention had been given to analysing of the impact of food security programmes on malnutrition, the working group was not in a position to contribute insights.

The Working Group on Household Food Security is pleased to welcome H el ene Deret as new Co-Chair from the SCN Civil Society constituency. H el ene Deret is currently Food Security Senior Adviser in Action Contre la Faim (ACF) based in Paris, France.

Topics discussed

HFS in Asia and in West Africa

Emerging issues:

- Bio energy and bio fuels
- Climate change

Action Plan 2008/2009

- Document local practices
- Expand and facilitate the network of practitioners interested in food security and nutrition
- Ensure that nutrition is mainstreamed in relevant food security meetings and vice-versa. A list of events was established
- Develop the WG webpage

Recommendations

Accelerating demographic change, increased socio-economic disparities and environmental degradation – associated with unsustainable production, trade and consumption practices – are key determinants of food insecurity and malnutrition. This is reflected in the present increase in food prices, the reduction of food stocks, and potentially further aggravated by the emerging biofuel production.

Policies at global, regional and country level should be reviewed, harmonised and monitored with a view to encourage integrated support to at risk families and to promote and protect maternal and child nutrition

It is essential that families have and maintain the means, the information and access to basic services to ensure appropriate maternal and child nutrition.

The interventions recommended in the Lancet series should be systematically articulated with relevant food security and livelihood support – combining short and longer term action – to families and communities of under-nourished mothers and children.

For more details, please see [Working Group report](#) and [presentations at the SCN Session](#)

WORKING GROUP ON CAPACITY DEVELOPMENT IN FOOD AND NUTRITION

Chair: Patrick Stover ([UNU](#)), Co-Chairs: David Sanders ([Univ. of the Western Cape, SA](#)), Emorn Wasantwisut ([Mahidol University, Thailand](#))

Topics discussed

- Current state of academic and research institutions in developing regions, and the need to strengthen their capacity and sustainability
- Universities' role in addressing regional public health nutrition needs
- Lancet Nutrition Series

Working Group mission

The WG's focused mission, as part of UNU-FNP, remains unchanged and is expressed through three goals

- 1) to assist developing regions enhance individual, organizational and institutional capacity in the area of food and nutrition
- 2) to undertake research activities that require global efforts
- 3) to serve as the academic arm for the UN System in areas of food and nutrition that are best addressed in a non-regulatory, non-normative environment.

Recommendations (extract)

- Conduct and publish a comprehensive review of graduate training in international nutrition, including recommendations for curriculum and cost/benefit analysis of education in regional versus western universities
- Strengthen south-south collaborations among training and research institutions
- Renew efforts towards north-south collaborations among training and research institutions
- For countries without nutrition training institutions, UNU can facilitate the training of their staff by linking them with well established nutrition training institutions in the region

Planned Activities 2008-2009

UNU-FNP Task Forces' planned activities are described in the [report](#)

For more details please see [Working Group report](#) and [presentations](#) at the SCN Session

Presentations and discussions 5 March

Patrick Stover gave a brief update on the [United Nations University Food and Nutrition Programme for Human and Social Development \(UNU-FNP\)](#), and explained that SCN Capacity Development focuses on Research, Training, Networking and Advocacy, in particular through Regional Networks of Universities, Institutes and Research Centers.

Anna Larrey ([University of Ghana](#)) gave a presentation on **Strengthening capacity in academic institutions & institutionalizing these efforts for sustainable faculty and research programs**

Arne Oshaug ([Akershus University College](#), Norway) gave a presentation on **Strengthening capacity in academic institutions to serve regional local food and nutrition programmes (training, monitoring, evaluation, programme research) for improving public health**

Osman Galal ([IUNS](#)) presented the **Strategic plan for engagement: the academic network in the Middle East**

Comments were given by a **UNU-FNP panel** (Mirjana Pavlovic, University of Belgrade; Emorn Wasantwisut, University of Mahidol, Thailand; Azza Gohar National Nutrition Institute, Cairo; Joseph Ashong, Cornell University, AGSNet)

Conclusions on the state of academic and research institutions in developing regions and the role of universities: Within universities, the retention of young faculty is increasingly a challenge due to low salaries, deteriorating infrastructure, inadequate resources to conduct research, and increased teaching obligations. North-South collaborations among universities can be effective in training new faculty and providing resources to seed research programs for young faculty. Universities play a key role in addressing local public health needs in the areas of program research, monitoring, evaluation and training. The importance of integrating context, interdisciplinary approaches, qualitative & quantitative methodologies, project/programme cycle, globalization, transitions, policy developments and governance was emphasized. An assessment of current practices in program research, monitoring, evaluation and training indicates gaps in addressing many of these key parameters. The group also recognizes the importance of south-south collaborations in informing and enhancing nutrition training.

Comments to the Lancet Nutrition Series: The overall sentiment of the discussion reflected the conclusions reached in the LNS regarding training and institutional capacities. There was general agreement that there is a shortage of appropriately trained academics, professionals and technicians in nutrition, and that current nutrition training and education at all levels does not adequately prepare new graduates for careers in nutrition. Current approaches to training were described as "outdated", "irrelevant", and not regionally informed with a western bias. There was less agreement in the WG regarding the value of educating students from developing regions in American and European universities.

Some useful websites:

- United Nations University Food and Nutrition Programme for Human and Social Development (UNU-FNP) www.unu.edu/capacitybuilding/foodnutrition/pg.html
- Asian Capacity Building Initiative: Capacity Strengthening In Nutrition-Asia (CASNA) www.casna.net
- Middle East and North African Nutrition Capacity Building Initiative (MENANA) www.menana.net
- Network for Capacity Development in Nutrition Central and Eastern Europe (NCDNCEE) www.agrowebcee.net/subnetwork/ncdn
- African Graduate Student Network (AGSNet) www.unu.edu/capacitybuilding/foodnutrition/agsnet
- African Nutrition Leadership Programme (ANLP) www.africannutritionleadership.org

WORKING GROUP ON NUTRITION IN EMERGENCIES

Chair: Caroline Wilkinson ([ACF France](#)), Co-Chairs: Zita Weise Prinzo ([WHO](#)), Caroline Abla ([USAID](#)), Anne Callanan ([WFP](#))

Presentations and discussions 2 and 4 March

The WG reviewed progress in main areas of the work plan: HIV/AIDS, infant feeding, maternal nutrition, micronutrients, assessment and community management of acute malnutrition (CMAM). Some thematic groups had been very active during the year with concrete achievements. Stronger linkages are needed between NIEWG thematic groups and other SCN WGs in order to avoid overlap and to highlight the specific needs in emergency affected populations.

Andrew Tomkins ([ICH](#)) gave an update of the SCN WG on **Nutrition & HIV/AIDS** and told that this working group was reviewing the challenge of management of severe acute malnutrition (SAM). Mortality is three times higher in HIV infected individuals who are severely malnourished and the dose and timing of antiretrovirals is not clear. The two working groups will work together.

On **maternal nutrition**, the WG discussed assessment including MUAC cutoffs, maternal nutrition and HIV, composition of rations for supplementary feeding and monitoring indicators for maternal nutrition interventions. The WG concluded that food rations need to be improved and policy guidelines need to be changed.

On **micronutrients**, the WG noted the ICH review paper, discussed recent field experiences with supplementation and concluded that adaptation of formula should not delay action in emergencies. *Recommendations:* Work together to provide evidence and to advocate for an improved range of formulas and foods; compile a list of research issues and on going research.

Claudine Prudhon ([SCN](#)) discussed **Implications of switching to the use of WHO Standards**, she presented 5 papers that had been commissioned and informed that the issue will be further discussed in a meeting in June.

Recommendation: Study relationship between the risk of death of children and infants by height (apply the Prudhon index) which will assist with further refinement of TFP protocols.

Carlos Navarro, Frances Mason ([SC-UK](#)) and Jeremy Shoham ([ENN](#)), in reviewing **Supplementary Feeding Programmes (SFP)**, noted that the reporting often is weak, the coverage low, and many did not show much impact. *Recommendations:* Development and endorsement of common minimum reporting standards for SFP and TFP; Assess alternative approaches to treating and preventing moderate acute malnutrition in emergencies; analyse factors leading to defaulting and non-response.

On **Management of malnourished infants under 6 months of age**, Andrew Seal ([ICH](#)) and Jeremy Shoham ([ENN](#)) presented the **MAMI initiative** (Management of Acute malnutrition in infants) which aims to document current guidelines, policies and strategies, numbers and proportions of infants treated and what is currently carried out in practice. Cécile Bizouerne ([ACF](#)) discussed **psycho-social barriers to successful breastfeeding** in emergencies. Caroline Wilkinson ([ACF](#)) presented research comparing the use of two different artificial milks in the treatment of infants.

In two **LQAS presentations with evidence from field**, Hedwig Deconinck ([FANTA](#)) first discussed alternative sampling and experiences in using LQAS methods to assess the prevalence of acute malnutrition in emergency settings. Grainne Moloney ([FSAU](#)), compared two cross-sectional assessments conducted in parallel with different methodologies in 2007 in Somalia.

Melody Tondeur ([ACF](#)) presented **training in the SMART methodologies** which showed how capacity is being built not only within the international emergency actors, but also within national governments.

Topics discussed

- WHO Growth Standards in emergencies
- Supplementary Feeding Programmes
- Management of infant malnutrition
- LQAS—evidence from the field
- SMART training
- The Lancet Nutrition Series

Key Working Areas 2008/2009

- Treatment and prevention of acute malnutrition should be at the forefront of action and research in emergency situations.
- Issues of micronutrient content and availability in relief products needs further work
- Treatment of malnourished infants under 6 months of age was recognized as a main focus area for work during the year
- Further focus on nutritional needs of pregnant and lactating women in emergency situation is needed

Comments to the Lancet Nutrition Series:

- The WG welcomed the recognition by the Lancet Series of the importance of appropriate treatment of severe acute malnutrition for reducing childhood mortality
- The WG was encouraged by the endorsement of community based treatment and the use of RUTF and would like to see this further emphasized in follow up work on the series.
- The WG supported the call for more research on the implementation and cost-effectiveness of intervention strategies for reducing childhood and infant malnutrition and mortality including groups not currently included in WHO treatment protocols.
- Nutritional oedema should be fully recognized as an important life threatening manifestation on severe acute malnutrition.

Statement:

Contribution of the treatment and prevention of Acute Malnutrition to child mortality should be kept high on agendas and the importance of these interventions is to be duly recognised.

For more details, please see Working Group report and [presentations at the SCN Session](#)

WORKING GROUP ON NUTRITION OF SCHOOL-AGE CHILDREN

Chair: Francisco Espejo ([WFP](#)), Co-Chairs: Lesley Drake ([Partnership for Child Development](#)), Natalie Roschnik ([Save the Children US](#))

Topics discussed

- Nutrition of street children
- WHO Growth Standards for school children and adolescents
- Significance of parents' education for child nutrition
- Significance of nutrition information versus education for child nutrition

Comments to the Lancet Nutrition Series:

- LNS rightly remarks the why and the what should be done to expand human capital and improve lives by addressing undernutrition during the "window of opportunity". However, the Series neglects education as an important determinant of undernutrition
- Every year of maternal education counts to reduce the risk of malnutrition. Improving access and quality of education should be a key intervention to address undernutrition in the long term
- Essential health and nutrition education to mothers and fathers prevents child undernutrition. Schools provide an effective way to transfer that information to communities now and to parents in the future
- SHN interventions, including school feeding address key health and nutrition problems that affect school children and prevent them from participating fully in school, therefore SHN interventions are a key element for reaching Education for All. Education and Nutrition are central to reaching all MDGs
- Another potential contribution: using schools as a window to monitor child (human) development:
- First grade stunting rates measured yearly in every school could be a feasible indicator to monitor the effectiveness of under five health and nutrition community interventions

For more details please see Working Group report and [presentations](#) at the SCN Session

Presentations and discussions 2 and 5 March

Saiqa Siraj ([BRAC](#)) presented results of a joint study by BRAC and ICDDR,B of the **sociocultural correlates of nutrition and health amongst street children in Dhaka**, Bangladesh.

Mercedes de Onis ([WHO](#)) presented her recent paper on the development of a **WHO growth reference for school-aged children and adolescents**, *de Onis et al. [Bulletin of the World Health Organisation, September 2007, 85, 9.](#)*

Martin Bloem ([WFP](#)) presented results from surveillance data collected by Helen Keller International from nearly 600,000 families in Indonesia and 400,00 families in Bangladesh. The results showed how **every year of maternal as well as paternal education counts in improving child nutrition**. These results are published in *Semba RD et al. [Effect of parental formal education on risk of child stunting in Indonesia and Bangladesh: a cross sectional study. Lancet 2008; 371: 322-28.](#)*

Patrick Webb ([Tufts University](#)) drew from various studies to discuss the specific **role of nutrition knowledge versus schooling** on child stunting and wasting. The key conclusions were that nutrition knowledge dominates schooling in determining Weight for Age; schooling dominates knowledge in determining Weight for Height; Mothers with both do best, but mothers with only nutrition knowledge also benefit; well targeted nutrition information focusing on a minimum set of messages that mothers can remember is essential. This presentation is summarised in *Webb P. [Nutrition Information and Formal Schooling as Inputs to Child Nutrition, Economic Development and Cultural Change; 2004; 52, 4.](#)*

SCN SAC Working Group key achievements during 2007

- **Directory of support to school-based health and nutrition programmes updated** by the Partnership for Child development www.schoolsandhealth.org/Pages/DocumentDownloads.aspx
- **School Health, Nutrition and Education for All, Levelling the Playing Field**, 2008 by Jukes M, Drake L and Bundy D, available for purchase
- **Two reviews of school feeding published:** 1) Realist review to understand the efficacy of school feeding programmes by Greenhalgh T, Kristjansson E and Robinson V, *BMJ 2007; 335, 858-861*, and 2) School feeding for improving the physical and psychosocial health of disadvantaged elementary school children, by Kristjansson EA, *Cochrane Database Syst Rev. 2007, Jan 24;(1):CD004676*
- **Monitoring School Health and Nutrition programs, Guidelines for Program Managers**, by Save the Children USA developed and to be finalised with comments from the SCN SAC Working Group.
- A **review of Home Grown School Feeding** by WFP, also to be finalised with comments from the SCN SAC working group.
- Development of **dietary guidelines for school feeding programs and food provided at school**, by FAO and WHO, still in progress
- The development of a **new website on Food For Education:** www.schoolsandhealth.org/sites/ffe/Pages/Default.aspx

2008 Work Plan, main headings extracted from [summary of discussions](#)

1. Advance the state of the art in School Health and Nutrition policy and programming
2. Develop a coordinating mechanisms to promote and support a multi-sectoral, multi-partner approach
3. Advocate for schools to become effective venues to enhance SAC and the nutrition of their communities

Comments to the Lancet Nutrition Series

In addition to the comments from the Working Groups on the preceding pages, the SCN Secretariat has received this article by Briend et al as a comment to the Lancet Nutrition Series.

Management of severe acute malnutrition

A comment to the Lancet Series on maternal and child nutrition

André Briend (WHO), Zita Weise-Prinzo (WHO), Flora Sibanda-Mulder (UNICEF), Tanya Khara (UNICEF), Martin Bloem (WFP), Tina van den Briel (WFP) and Claudine Prudhon (SCN)

We welcome the new Lancet Series on Maternal and Child Undernutrition, an excellent opportunity to galvanise the nutrition community and governments into common action. The Series rightly identifies severe acute malnutrition (SAM) as an important cause of child death and lists its treatment among the recommended priority interventions. Paper 3 of the Series, however, only recommends the scale up and improvement of hospital based SAM management to prevent this important cause of death. We agree that improvement of hospital-based management is indeed important, and an integral part of a strategy to address SAM. However, documented experience in countries - especially developing countries - demonstrates that hospital-based management reaches only a small percentage of children and falls far short of a sufficient response (Schoffield and Ashworth 1996, Briend 2001, Karaolis et al 2007). On the other hand, the addition of a community based component leads to a sharp increase in programme coverage (Sadler et al 2007).

This motivated UN agencies and partners to review the evidence of the effectiveness of a community-based approach relying on ready-to-use therapeutic foods (RUTF) to treat children in their own homes at an informal WHO/UNICEF/WFP/SCN meeting held in November 2005 (Prudhon et al 2006) As a result of the review, WHO, UNICEF, WFP and SCN recommended concerted action to develop and strengthen the community-based component of SAM management as a means of reaching the majority of children suffering from SAM (WHO/WFP/UNSCN/UNICEF 2007). This recommendation is already bringing partners and governments together to address this important cause of child mortality.

The authors of the Lancet Series do acknowledge that observational data based on large scale programmes from Ethiopia, Malawi and Sudan suggest that the community based approach is largely successful (Collins et al 2006). We very much support the inclusion of this type of observational evidence in paper 3 of the series, as for evaluating large-scale interventions, studies with plausibility designs are often the only feasible option and may provide valid evidence of impact (Victoria et al 2004). This is particularly true in the case of community-based management of SAM.

The authors state that their methodology included identifying unpublished literature by contacting experts and agencies that work on undernutrition. Again we very much support this, given the large amount of unpublished literature that is building on the subject of community-based management of SAM. Growing numbers of programme reports of a whole range of agencies (such as Concern Worldwide, Save the Children UK and US, MSF, CARE, ACF, Tearfund, World Vision), show that the community based approach allows the successful treatment of unprecedented large numbers of children with SAM. They also provide valuable evidence of the effectiveness of the approach. Examples of this type of literature are available on the web (Chamois 2006, Defourny et al 2006).

It would have been useful to have a more detailed set of recommendations on the type of research recommended for covering the gaps the authors summarize in the evidence-gap section. The present UN recommendation is to implement both the community and facility based treatment in parallel, the community component ensuring a high coverage, and the facility component also providing medical treatment for complicated cases recognising that strong ongoing monitoring of these programmes is vital (WHO/WFP/UNSCN/UNICEF 2007). Robust experiments, as suggested by the authors of the Lancet Series, that test these components in isolation would deprive some children of optimal treatment and lead to unnecessary deaths. Specifically, through hospital care children would not be reached due to low coverage and in community-based care children with medical complications would not receive adequate medical treatment.

In conclusion, while the importance of the Lancet series for prioritizing research as well as interventions is evident, we would like to greater recognition for the need to promote the new community based approach as an integral part of the management of children with SAM (WHO/WFP/UNSCN/UNICEF 2007). This is critical if we are to reach the majority of children with SAM at the large-scale required to significantly impact this important cause of death.

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The authors declare no conflict of interest. AB and ZWP are staff members of the World Health Organization. These authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or stated policies of the World Health Organization.

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IASC Global Nutrition Cluster Toolkit for Addressing Nutrition in Emergency Situations

The 87 page document is a compilation of key interventions in nutrition in emergencies (in English) dated June 2008 is the cumulative work of many individuals on the Nutrition Cluster and outside.

The Toolkit focuses on the following interventions: Infant and Young Child Feeding in Emergencies • Treatment of diarrhoea with ORT/Zinc • Prevention and Treatment of Vitamin A Deficiency • Prevention and Treatment of Micronutrient Deficiencies • Management of Moderate Acute Malnutrition • Management of Severe Acute Malnutrition • Nutrition, HIV and AIDS • The Psychosocial Components of Nutrition • Nutritional care for Groups with Special Needs • The Use and Role of Food Assistance • Food Handling, Storage and Preparation • Household Food Security and Livelihoods

The Toolkit provides the *what, why, when, and how* for different nutrition interventions, including basic monitoring benchmarks and expected standards. It offers guidance and support for nutritionists and humanitarian workers to ensure that basic guidelines are followed and the basic nutritional needs of populations in emergencies are met. It is not intended to be an exhaustive resource for each intervention presented, but rather an overview for interventions to be considered with references and links to more detailed technical guidance for each issue.

The basic right to adequate food and nutrition is implicit in any emergency response and is reflected in humanitarian law. The purpose of this toolkit is to provide an easy reference tool for nutritional response during and after an emergency situation. Too often, in the high-pressure context of emergencies, key aspects of nutritional health and well-being are not adequately addressed. Poor decisions are made in the short-term, which have long-term negative impacts on the nutritional stability of the affected populations. Failure to meet the nutritional needs of populations in emergencies jeopardizes the ability to resist and fight infectious diseases. Growth and development, particularly of children and women, is disrupted resulting in increased childhood malnutrition, poor reproductive health and worsening pregnancy outcomes.

The toolkit is intended as an easy-to-use field guide that outlines the key basic interventions for nutritional support to individuals and groups during an emergency situation. In most emergencies, we focus on two key aspects: risk assessment and risk management. This toolkit focuses on risk management. What it takes to ensure that emergency needs are met with tools and approaches representing the current thinking in nutrition. The toolkit does not provide information on measuring nutritional status, rapid assessments, needs assessments, early warning or evaluating interventions

Support for the Toolkit came from various sources including governments of the United Kingdom, Sweden, Denmark, Norway, Ireland and the United States. Their support is gratefully acknowledged along with the countless hours provided by Nutrition Cluster Members in providing input and comments on the document. The Toolkit was developed with the participation of a wide range of humanitarian nutrition actors. Initiated by the Capacity Development Working Group of the IASC Nutrition Cluster, the Toolkit has received technical inputs from the cluster members and two consultants; Ms. Oman and Ms de Menezes. Through feedback from practitioners in the field on how to make it even more practical and user-friendly, the Toolkit will be improved over time.

The toolkit may be reproduced without permission from The Global Nutrition Cluster for educational and non-profit purposes if the source is acknowledged. The document can be downloaded from the IASC Nutrition Cluster website: www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=74

The Global Nutrition Cluster is part of the Inter Agency Steering Committee and is the result of the humanitarian reform process which has the Cluster Approach as one of its four pillars: Partnership, Humanitarian Coordinators, Humanitarian financing, and the Cluster Approach. The Cluster has four main areas of work: 1) technical standards, lessons learned, protocols and approaches; 2) coordination, 3) networks; and 4) resource mobilization. The Global Cluster supports cluster and cluster-like approaches in rapid-onset and chronic emergencies such as in Myanmar, Somalia, Ethiopia and Democratic Republic of Congo.

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Programme News

Primary Health Care, Health Family Strategy and Food and Nutrition actions **Brazil**

The Primary Health Care in Brazil is mostly based on Family Health Teams. In their work, it is very important that these Teams understand the social processes in the region or the country, and to be pro-active within the communities. Community health agents are at the core of the Brazilian Primary Health Care Strategy, because they are living in the same area where they work, know the local problems and are able to facilitate and improve the connection between the primary care professionals and the community, so-called *cultural competency*. The Family Health Support Units (NASFs) reinforces primary health care through supportive actions for the Family Health Teams in all municipalities. These Support Units are particularly important for **nutrition actions** within the municipalities, because many teams have nutritionists who can guide Family Health Teams on food and nutrition related issues.

The Brazilian Food and Nutrition Policy is the key instrument in planning, implementing and evaluating food and nutrition actions in Brazil by all three government levels. It was jointly formulated by the Ministry of Health and other ministries, representatives of states and municipalities, universities and research centres and by representatives of non-governmental organizations and of the population in general. Its main objective and purpose is to guarantee the promotion of healthy eating habits; to prevent and control nutritional disorders; and, to monitoring nutritional conditions.

Primary health care and the National Food and Nutrition Policy are closely related because primary health care is the main locus for implementing food and nutrition actions and services as this is the level where food and nutrition related diseases can be prevented. Thus, the National Food and Nutrition Policy is implemented by Community Health Agents, Family Health Teams and Family Health Units, particularly by Units with nutritional services. Strengthening nutrition ensures that the population's health conditions and quality of life are improved.

The National Food and Nutrition Policy is being implemented through official dietary directives (Food Guides); through information campaigns on breastfeeding, complementary feeding, consumption of local fruits and vegetables, and healthy diet promotion in primary health care and in schools; and finally, through negotiating the regulatory environment in terms of nutritional labelling, food marketing and initiatives to reduce sugar, fat and salt content.

The National Food and Nutrition Policy also has several intersectoral actions, that are now part of SISAN and LOSAN – Food and Nutrition Security System and Organic Law. The Food and Nutrition Security System comprises all sectors directly and indirectly related to food security and intends to organize and coordinate intersectoral actions within all government levels and in the civil society, industry and commerce.

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GAIN-China program team completed the first quality control system for fortified flour **China**

In China, the introduction and making of nutritional fortification of flour is new, therefore, flour mills, consumers and governmental regulatory bodies are faced with tremendous opportunities along with serious challenges. In order to better develop the nutritional fortification of flour, the introduction and use of a sophisticated quality control system play a critical role. A newsletter, named GAIN-China program team completed the first quality control system for fortified flour, issued by the Center for Public Nutrition and Development of China on March 20, 2008, addressed nutritional fortification from the standpoint of quality control system and highlighted the promotional program in Shanxi province and Gansu province sponsored by GAIN. Relying on international practice and domestic experience, the GAIN-China Program team has designed a strict and comprehensive product quality control system for the first time. The primary features of the new quality control system are: nutrient source management; production system management, product quality testing capability management; on-site sampling management and comparative management of nutrient sales volume versus flour production volume. The in-mill trial implementation in Shanxi province and Gansu province has produced encouraging results with ample room for continuous improvement overtime. This new nutritional fortification quality control system is the key to strengthening food safety in china. It improved quality assurance of flour mills; provided strong support for marketing and promotion of fortified flour in China; laid solid foundation for issuance of state regulations; provided important reference and experience for law enforcement agencies in market surveillance. The new system also made it possible for the Chinese quality regulatory bodies to carry out comprehensive supervision and administration.

Please send an email to yxd@pndc.gov.cn to sign up for the newsletter issued by the Center of Public Nutrition and Development of China.

China Nutritional Fortified Wheat Flour state standard

A newsletter named "Issuance of Nutritional Fortified Wheat Flour State Standard, a strong governmental signal towards the mill industry" issued by the Center of Public Nutrition and Development of China on March 24, 2008 covered the following issues: GAIN sponsored the Chinese program of fortified flour policy system which is being implemented as planned. As defined in the program, the specific task of assisting the relevant Chinese governmental agencies in formulating and officially issuing the "Nutritional Fortified Wheat Flour" state standard has been accomplished. This regulation endorsed by the highest standard administration agency, Standardization Administration of China, has clarified its stand on promotion of fortified flour for nationwide governmental agencies, flour mills and consumers. The regulation addressed consumers' concern over the safety and necessity of fortified flour. Furthermore, this standard also provided flour mills with regulatory support and an overall promotion of flour fortification is foreseeable, which will lead to greater improvement in public nutrition in China.

Please send an email to yxd@pndc.gov.cn to sign up for the newsletter issued by the Center of Public Nutrition and Development of China.

Senegal Nutrition actors mobilize for the launch of the Lancet's Nutrition Series

Senegal records the lowest undernutrition prevalence in West Africa. This is why it was selected for the launch of the Lancet Nutrition Series (LNS). Thus, Senegal through the National Committee for the Fight Against Malnutrition and its partners such as West African Health Organization (WAHO/ECOWAS), Unicef, World Food Programme (WFP), World Bank, USAID, ECHO, the Bill and Melinda Gates Foundation, Helen Keller International and Micronutrient Initiative organized on February 18, 2008 a video conference to launch (i) the articles and (ii) the second phase of the Nutrition Enhancement Program.

A video conference promoting nutrition: Chaired by Mrs. Safietou Thiam, the Senegalese Minister of Health and Prevention, the launch of LNS in West Africa held in Dakar gathered through the video conference more than 120 participants from the national and international press, line ministries, the academia, the UN system, donors and NGOs, nutrition focal points in Mali, Togo, Guinea Conakry and Niger as well as participants from Benin, Burkina Faso, Ivory Coast and Mauritania.

During the event, the speakers – Saul Morris, author of the series of articles and Program Officer in the field of child health and survival at Bill & Melinda Gates Foundation; Ismael Thiam, Nutrition and Child Survival Advisor for the West African Health Organisation (WAHO); Banda Ndiaye, Program Officer for the Micronutrient Initiative (MI) in Senegal and in the Sahel; Mustapha Darboe, West Africa Regional Director for the World Food Programme (WFP); and Eva Jarawan, Sector Manager, Human Development, West Africa, for the World Bank – seized the opportunity to draw the attention of the international community on the critical role played by infant nutrition on the health and development of children as well as on the economic growth of nations.

Scaling up nutrition interventions in Senegal: The event was also an opportunity for Senegal to officially launch the second phase of the Nutrition Enhancement Program 2007–2011, which marks the scaling up of nutrition interventions nationwide and the attainment of the most vulnerable populations.

The ceremony has enabled to give (i) an overview of nutrition interventions through an exposition fair of more than 20 stands held by nutrition actors in Senegal and (ii) advocate for additional funding of nutrition to achieve the MDGs by 2015 in Senegal.

Further to the addresses, Mrs. Awa Ndiaye, Minister of the Family, Women's Entrepreneurship and Microfinance reconfirmed the commitment of the Government of Senegal to the fight against undernutrition as well as the achievement of the MDGs.

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Zanzibar Zanzibar launches its first Food Security and Nutrition Policy and Programme

On April 8, 2008 the Revolutionary Government of Zanzibar adopted the Zanzibar Food Security and Nutrition Policy and Programme. An inter-sectoral committee oversaw the formulation of both the Policy and Programme, under the leadership of the Ministry of Agriculture, Livestock and the Environment (MALE), and with the assistance of FAO. MALE has been given the mandate for food security by the Revolutionary Council of Zanzibar.

In Zanzibar food insecurity and malnutrition is highly prevalent in both rural and urban areas, with poverty constituting a key causal factor. Food is produced domestically by the subsistence farming sector characterised by low productivity, thus resulting in high dependency on purchases of imported foods to meet basic food requirements. The challenge faced by Zanzibar households is achieving an adequate and appropriate level of dietary energy and nutrient intake throughout the year. Children and women are mostly affected: 23 percent of under-five children are chronically undernourished, 40 percent suffer from Vitamin A deficiency and 75 percent suffer from iron-deficiency. The prevalence

of anaemia among adult women is 63 percent, while 17 percent are underweight (BMI <18.5) and 27 percent overweight (BMI > 25). Infant mortality stood in 2004/5 at 61/1.000 live births and maternal mortality at 377/100.000.

The Policy and Programme have been formulated within the context of the national poverty reduction strategy* and together with this Strategy provide a broad and inclusive policy framework aimed at reducing food insecurity and malnutrition in Zanzibar. The Policy clearly states that Government is committed to realizing the right to adequate food for all Zanzibari. Focusing on increasing in sustainable ways food availability and equitable access to safe and nutritious food for all, the Policy and Programme envisage the implementation of integrated and well-coordinated multi-sector measures at all levels of Government, directly involving civil society and the private sector. The Policy and Programme aim for existing sector policies and budgets to focus on food security and nutrition issues, and to maximize inter-sector synergies to effectively strengthen and protect food security and nutrition in Zanzibar. Efforts are currently underway to strengthen planning capacity at district level to mainstream food security and nutrition in harmony with the Policy and Programme.

* Zanzibar Strategy for Growth and Reduction of Poverty 2007 - 2012

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Prevention more effective than treatment

IFPRI

When it comes to child malnutrition, early intervention is crucial. Two studies conducted by IFPRI researchers and published in the leading medical journal *The Lancet* have made clear that preventing malnutrition is much more effective than treating it and that action must be taken in the first two years of a child's life to avoid lifelong repercussions.

The first study, conducted in Haiti, found that the rates of child stunting, underweight, and wasting were lower among poor communities participating in programs to prevent malnutrition rather than treat it. "Malnutrition must be addressed in the first two years of life, the crucial period for a child's physical and cognitive development," said Marie Ruel, lead author of *The Lancet* article and director of IFPRI's Food Consumption and Nutrition Division. "If nutrition programs wait until children have already become malnourished, their benefits are significantly diminished."

The study—conducted by IFPRI and Cornell University in conjunction with World Vision-Haiti and the U.S. Agency for International Development—indicated that it is essential for food-assisted maternal and child health and nutrition programs to proactively target all children under the age of two in poor communities. "Common sense tells us that preventing malnutrition is better than treating it, especially because children can suffer irreparable harm if undernourished during the first two years of life," said Ruel.

The harm is not only physical, but economic as well. By analyzing the significant economic benefits accruing to Guatemalan adults who received adequate nourishment as children, the second IFPRI-led study published in *The Lancet* highlights some of the lifelong, negative impacts on those who did not. It, too, stresses the importance of action during the first two years of a child's life. Specifically, the study found that boys who received a nutritional supplement in the first two years of life earned on average 46 percent higher wages as adults, while boys who received it in their first three years earned 37 percent higher wages on average. Those who first received the supplement after age three did not gain any economic benefits as adults.

This study is the first to present direct evidence of the effects of early childhood nutrition programs on adult economic productivity and incomes. The research was conducted in Guatemala by IFPRI, Emory University, the Institute of Nutrition of Central America and Panama, the University of Pennsylvania, and Middlebury College.

To download from IFPRI website go to <http://www.ifpri.org/PUBS/newsletters/IFPRIForum/200803/if21prevent.asp>

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Partnership for improving HIV/AIDS and Nutrition Programming

IFPRI

Despite increased activity and attention to food and nutrition security interventions integrated into AIDS care and treatment programs, such interventions remain in their infancy. They tend to be ad-hoc, small scale, with limited capability to function across sectors, and poorly monitored. As a consequence, there is a lack of information about specific factors which influence their delivery and uptake by clients, and little robust evidence regarding the impact of these efforts and the ability of these boutique interventions to scale-up.

The Regional Network on AIDS, Livelihoods and Food Security (RENEWAL) facilitated by the International Food Policy research Institute (IFPRI), The AIDS Support Organization (TASO) in Uganda, and Concern Worldwide have initiated two operational research studies in Uganda and Zambia to explicitly fill this information gap. Their main purpose is to systematically collect information along the flow of program implementation, monitoring and evaluation process to ultimately improve program processes, develop key monitoring and evaluation indicators, and identify key conditions for impact and for scaling-up such programs. The preliminary results are expected by November 2008.

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OHCHR**The Global Food Crisis and Human Rights: Human Rights Council Special Session and the FAO High-Level Conference**

On 22 May, the United Nations Human Rights Council held a special session on *the negative impact on the realization of the right to food of the worsening of the world food crisis, caused inter alia by the soaring food prices* in Geneva. The session, which had been called for by the UN Special Rapporteur on the right to food, Mr. Olivier De Schutter, drew active participation from States, international organizations (such as FAO, WFP, UNDP, World Bank and IMF), as well as NGOs.

In its resolution adopted by consensus, the Council recognized that the world food crisis "seriously undermines the realization of the right to food for all". It further called upon States, international organizations, and other relevant stakeholders "to take all necessary measures to ensure the realization of the right to food as an essential human rights objective" and "consider reviewing any policy or measure which could have a negative impact on the realization of the right to food, particularly the right of everyone to be free from hunger". In addition to the renewed commitment by States to the realization of the right to food, the UN High Commissioner for Human Rights, the (recently appointed) UN Special Rapporteur on the right to food, and the UN Committee on Economic, Social and Cultural Rights all underscored the importance of integrating human rights at the core of national and international responses to the current food crisis.

The Council further requested the High Commissioner and the Special Rapporteur to participate in the FAO High Level Conference on World Food Security: the Challenges of Climate Change and Bioenergy (3-5 June, Rome), "so as to help to mainstream a human rights perspective in the analysis of the world food crisis, with a focus on the realization of the right to food." In her statement to the FAO Summit, the High Commissioner reminded that human rights can bring in dimensions of non-discrimination, participation, empowerment and accountability to the crisis response. The Special Rapporteur highlighted elements lacking in the current discussion on the crisis, including concrete ways to increase investment in agriculture without losing focus on smallholder farmers, and ways to involve the private sector taking existing structural power imbalances into consideration.

On 6 May, the Special Rapporteur reported back to the Human Rights Council on the outcome of the FAO conference. He observed that the response to the crisis, including the draft joint UN Comprehensive Framework for Action (CFA) for activities at the country level, needs to be further strengthened by addressing accountability and participation. While welcoming the agreement of all actors on the need to massively reinvest in agriculture, he noted that this unanimous view left open the question about the nature of agricultural development we require. He also pointed out the need to address the role of price speculations, to differentiate between various models of agricultural development considering existing power imbalances in the food production and distribution chain, and to carefully examine the impact of agrofuel production. The Special Rapporteur will submit his report with a set of recommendations on the response to the crisis, based on his consultation with States and all other relevant stakeholders, to the 9th session of the Council in September.

The full texts of interventions made at the Human Rights Council are available [online](#).

Statement made by the UN High Commissioner for Human Rights at the FAO High-Level Conference is available [online](#)

All statements of the Special Rapporteur on the right to food relating to the global food crisis are available [online](#) at the Special Rapporteur on the right to food website: <http://www2.ohchr.org/english/issues/food/index.htm> Contact: AHattori@ohchr.org

HarvestPlus**A new discovery will accelerate breeding of provitamin A maize to combat VAD**

Maize is arguably one of the most important staple food crops in Africa and, thus, an ideal vehicle to deliver micronutrients to alleviate hidden hunger. HarvestPlus scientists are breeding varieties of maize biofortified with higher levels of beta-carotene to combat Vitamin A deficiency in the region.

Maize exhibits tremendous genetic diversity and its grain carotenoid content can be quite variable. Maize kernels that have higher total carotenoid content tend to be dark yellow or orange in colour, but not all of this is due to beta-carotene. HarvestPlus is screening specific lines of seed for the desired beta-carotene. Through nutrient screening techniques HarvestPlus has discovered lines of maize with naturally high levels of beta-carotene, but the process for doing this has, until now, been time consuming and expensive, greatly limiting the number of seed that can be processed. Recently this laborious process has been made less arduous. In research partly funded by HarvestPlus, and recently published in *Science*, a team of scientists at the University of Illinois analyzed a genetically diverse panel of almost 300 maize lines. For the first time, they were able to identify a gene, and develop genetic markers, associated with higher levels of beta-carotene in the grain. This method of identifying and selecting breeding lines that are rich in beta-carotene is much simpler and faster than running standard chemical analysis, and up to 1,000 times cheaper. This discovery is expected to significantly accelerate research in maize biofortification, especially by scientists working in labs in developing countries.

This important breakthrough in genetic marker screening will make it far easier to identify desirable maize varieties, and should help HarvestPlus and its national partners remain on target to release naturally biofortified provitamin A maize in Africa as early as 2012.

Carlos E. Harjes, Torbert R. Rocheford, Ling Bai, Thomas P. Brutnell, Catherine Bermudez, Kandianis, Stephen G. Sowinski, Ann E. Stapleton, Ratnakar Vallabhaneni, Mark Williams, Eleanore T. Wurtzel, Jianbing Yan, and Edward S. Buckler. *Natural Genetic Variation in Lycopene Epsilon Cyclase Tapped for Maize Biofortification*. 2008. *Science* 18 January 2008. Vol. 319. no. 5861, pp. 330–333 DOI: 10.1126/science.1150255

Optional Protocol on ICESCR**FIAN**

Good news for the children, women and men who are hungry, malnourished, ill, or who do not have access to clean water, sanitation, education and other ESC rights due to national and international public policy actions or omissions.

The UN Human Rights Council - in a historical decision – approved by consensus on June 18th, the Optional Protocol for the International Covenant on Economic, Social and Cultural Rights (ICESCR). The most important step was taken towards the establishment of an international recourse mechanism for the investigation and redress of violations of the ICESCR. Once approved by the UN General Assembly, economic, social and cultural rights will finally have equal standing with civil and political rights in face of the International Human Rights System.

The Optional protocol is the result of several decades of work by governments, civil society, experts and UN human rights bodies. The ICESCR was one of the few major human rights treaties which did not count with a mechanism for the presentation of petitions related to violations. An intergovernmental working group had been working on the draft since 2004.

With the adoption of the Protocol, governments recognize the competence of the UN Committee on Economic, Social and Cultural Rights to receive and investigate communications of violations from individuals and groups; to request the governments to adopt urgent cautionary measures to avoid further and irreparable damage to victims of potential violations; to investigate claims of serious and systematic violations received from reliable sources, related to ESC rights. The text of the protocol establishes as well that States should guarantee that individuals presenting such claims are not harassed or intimidated from presenting them.

The entry in force of the Protocol, in the year that the Universal Declaration of Human Rights completes 60 years, is an important step towards the effective incorporation of the Human Rights paradigm into economic and development policy. Individuals and groups, affected by violation of any of the rights included in the Covenant, will be able to hold their governments accountable, as well as the international community, towards the effective realization of these rights. The full implementation of the Protocol will certainly strengthen the push for more participation, transparency, public accountability, policy coherence and adequate budget allocation, with the participatory establishment of goals, benchmarks and timelines, suitable for adequate public monitoring of the implementation and impact of public policies on the realization of ESC rights for all, in special traditional excluded and discriminated against individuals, groups and communities.

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Countdown to 2015 Conference 17-19 April, Cape Town**PMNCH**

The mission of the Countdown to 2015 for maternal, newborn and child survival is to track progress made towards the achievement of the United Nations Millennium Development Goals 1, 4 and 5 in 68 Countdown priority countries and promote evidence-based information for better health investments and decisions by policy-makers regarding health needs at the county level.

The second Countdown to 2015 Conference was held in Cape Town, South Africa from 17-19 April 2008 in conjunction with the 118th Assembly of the [Inter-Parliamentary Union](#) (IPU). One of the highlights of the Conference was the Countdown/IPU Special Session in which a delegation of IPU parliamentarians actively participated, together with 14 Ministers and country delegations from 61 out of 68 Countdown priority countries. The special session was an advocacy exercise to sensitize IPU parliamentarians and all participants to maternal, newborn and child survival and to have them take action in their countries to reach the goals for MDGs 1, 4 and 5.

Nutrition was among topics discussed at the Countdown to 2015 Conference, as reflected in a presentation by Dr Robert Black of John Hopkins University on the findings and key messages from the Lancet Nutrition Series ([see full agenda with presentation material here](#)) as well as in the final [Statement of commitment](#) concerning maternal, newborn and child survival. This statement takes note that "adequate nutrition, and food security, water and sanitation should be a priority at all levels and in particular at the family level, given their strong relationship to overall health, productivity and ultimately to social and economic development". In "affirming that the achievement of the MDGs must be based on a strong commitment of all governments, organizations, and partners to protecting the human rights of women, children and adolescents", the Ministers, parliamentarians and all participants present at the Countdown to 2015 Conference committed themselves to "an intensive effort to:

- Sustain and expand successful efforts to achieve high and equitable coverage of effective and high-impact interventions that save lives and improve the health of mothers and children, and thereby contribute to the fight against poverty;
- Integrate efforts to address undernutrition with broader maternal and child health strategies;
- Support initiatives to stop early marriage, early childbirth and harmful practices, to keep adolescent girls in schools and to promote good health-seeking behaviour among them;
- Strengthen primary health care, linked to the achievement of measurable results;
- Invest in strengthening health systems, including efforts to improve the quality, accessibility, affordability and coverage of essential health services, with a particular focus on priority periods within the continuum of care and strengthening links with interventions addressing HIV/AIDS;
- Invest in infrastructure development and human resources in relation to ethical recruitment and training of health workers, particularly skilled attendants, at all levels, assuring a committed and motivated health workforce;
- Allocate more resources to research, monitoring and evaluation for maternal,

reproductive, newborn and child health, and strengthening use of data to guide implementation;

- Address inequities in coverage of care among different geographic, socioeconomic, age and gender groups;
- Hold governments, financing institutions and international organizations accountable for making adequate resources available to achieve MDGs 4 and 5, and other health-related MDGs;
- Ensure predictable, long-term financing for reproductive, maternal, newborn and child health which reflects countries' priorities and plans."

Read the full statement in [English \(Statement of commitment\)](#) or in [French \(Déclaration d'engagement\)](#)

Contact: The secretariat: Countdown to 2015 c/o The Partnership for Maternal, Newborn and Child Health EMail: secretariat@countdown2015mnch.org, Website: www.countdown2015mnch.org

WHO

Revised indicators for assessing Infant and Young Child Feeding practices

The revised IYCF indicators are the product of a multi-agency collaboration, including WHO, IFPRI, UC Davis, USAID, FANTA and UNICEF. They were developed in response to a recommendation for new and improved indicators for assessing feeding in children 6-23 months of age, made by participants in the WHO consultation on complementary feeding, 2001 (1). The indicators are based on feeding recommendations presented in two documents: the Guiding Principles for complementary feeding of the breastfed child and the Guiding Principles for feeding non-breastfed children 6-24 months of age (2,3). The indicators are a result of analyses of ten data sets, representing breastfed and non-breastfed children in various countries and regions. The main research questions were:

- How well can indicators of dietary diversity or sentinel food groups predict dietary quality for infants and young children in different populations with varying dietary patterns?
- How well does the frequency of feeding of foods and nutritive liquids other than breast milk predict energy intake - from foods alone or total - in different populations with varying dietary patterns?

The conclusions of this work are reported in two documents available on the FANTA website (4,5). In addition to identifying new indicators for assessing infant and young child feeding, working group members also reviewed and updated existing indicators for assessing breastfeeding practices. Consensus on the indicators was reached in a meeting held at the WHO Regional Office for the Americas, 6-8 November 2007. New and revised recommended indicators for assessing IYCF practices are:

Recommended core indicators

1. Early initiation of breastfeeding: proportion of children born in the last 24 months who were put to the breast within one hour of birth
2. Exclusive breastfeeding under 6 months: proportion of children 0 – 5 months of age who are fed exclusively with breastmilk
3. Continued breastfeeding at 1 year: Proportion of children 12 – 15 months of age who are fed breastmilk
4. Introduction of solid, semi-solid or soft foods: Proportion of children 6-8 months of age who receive solid, semi-solid or soft foods
5. Minimum dietary diversity: Proportion of children 6-23 months of age who receive foods from 4 or more food groups
6. Minimum meal frequency: Proportion of breastfed and non-breastfed children 6-23 months of age who receive solid, semi-solid, or soft foods (but also milk feeds for non-breastfed children) the minimum number of times or more
 - 2 times for breastfed infants 6-8 months
 - 3 times for breastfed infants 9-23 months
 - 4 times for non-breastfed children 6-23 months
7. Minimum acceptable diet: Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breastmilk)
 - Breastfed children who had at least minimum dietary diversity and minimum meal frequency
 - Non-breastfed children who received at least 2 milk feedings and had minimum dietary diversity and minimum meal frequency
8. Consumption of iron-rich or iron-fortified foods: Proportion of children 6-23 months of age who receive an iron-rich food or an iron fortified food that is specially designed for infants and young children, or that is fortified at home

Recommended optional indicators

1. Children ever breastfed
2. Continued breastfeeding at 2 years
3. Age-appropriate breastfeeding
4. Predominant breastfeeding under 6 months
5. Duration of breastfeeding
6. Bottle feeding
7. Milk feeding for non-breastfed children

The final document presenting the indicators is under publication by WHO and will be available on partner websites in the third quarter of 2008. An operational guide with questions to elicit the information and address methodological issues related to sampling will also become available in 2008.

Contact: daelmansb@who.int

1. Daelmans B et al: Special Issue based on a World Health Organization expert consultation on complementary feeding, *Food and Nutrition Bulletin*. Vol 24, no 1, 2003.
2. PAHO. *Guiding Principles for feeding the breastfed child*. Washington: Pan American Health Organization, WHO, 2003. ([online](#))
3. WHO. *Guiding Principles for feeding non-breastfed children 6-24 months of age*. Geneva: World Health Organization, 2005
4. Working Group on Infant and Young Child Feeding Indicators. Developing and validating simple indicators of dietary quality and energy intake of infants and young children in developing countries: summary of findings from analysis of 10 data sets. August, 2006. ([online](#))
5. Working Group on Infant and Young Child Feeding Indicators. Developing and validating simple indicators of dietary quality of infants and young children in developing countries: additional analysis of 10 data sets. July, 2007. ([online](#))

Infant and Young Child Situational Analysis in the Sahel

HKI

The Sahel has some of the highest under-five mortality rates in the world. An estimated 4 million children under the age of 5 suffer from chronic malnutrition and 1.5 million suffer from acute malnutrition throughout the region. To address the high prevalence of malnutrition, the Food and Agriculture Organization (FAO), Helen Keller International (HKI), the Micronutrient Initiative (MI) UNICEF, and the World Food Programme (WFP) created an initiative to “Reposition Children’s Right to Adequate Nutrition in the Sahel” in Burkina Faso, Chad, Mali, Mauritania, Niger and Senegal.

This initiative will commence with a situational analysis on infant and young child nutrition in the Sahel region to assess available information in the six target countries. Since 65% of children under five who suffer from acute under-nutrition are infants and young children under two years, the analysis will focus on children from 0-24 months.

Key contributors to the high levels of malnutrition include non-optimal breast feeding practices and lack of access to age-appropriate complementary foods. To aid the development of intervention strategies, up-to-date information is required on food availability, nutritional intake, behavioural aspects of child feeding and current public policies and programs in the region.

The objective of the initiative is to develop innovative recommendations to overcome barriers and actions to enhance infant and young child nutrition during these critical first two years of life. The findings from the situational analysis will guide the development of a framework to implement large-scale interventions. These interventions will be part of the Nutrition for Child Survival and Development package that aims to improve the nutritional status, development, survival and quality of life of children in the Sahel.

Website: www.hki.org, Contact: Sara Wuehler, PhD, Project Coordinator, Email: swuehler@hki.org

Food Fortification Making Strides in West Africa with HKI and Partner

HKI

Deficiencies in essential vitamins and minerals (VMDs), such as vitamin A and iron can lead to child blindness, disability, and unacceptably high child mortality rates. VMDs account for 10% of the global health burden. One of the most cost-effective strategies to control VMDs is by fortifying staple foods with essential vitamins and minerals.

At last year’s Clinton Global Initiative, Helen Keller International (HKI) pledged to “Fortify West Africa” by working with the private sector to fortify wheat flour and cooking oil. HKI is also collaborating with the UEMOA commission, a political authority that represents 8 West Africa countries. These countries have a total population of 85 million, 15.6 million of whom are children under 5, and some of the highest under-five mortality rates in the world. The initiative aims to reach at least 70% of the population with fortified products by the end of 2010.

All vegetable oil producers that belong to UEMOA are committed to fortifying their vegetable oils with vitamin A; nine have already begun. Ten regional standards have been adopted for fortifying vegetable oil with vitamin A and a regional logo is being finalized for branding fortified foods.

HKI and partners are also creating a network of flour milling industries to accelerate wheat flour fortification. All wheat flour industries in the region have demonstrated a willingness to fortify wheat flour with micronutrients and it is anticipated that fortification standards will be adopted within the year.

Great progress has already been made. The oil producers, in Côte d’Ivoire, reach an estimated 50% of women and children with their fortified product, and are exporting fortified oil to neighbouring countries in the UEMOA. In February, 2008, Côte d’Ivoire launched its nationwide fortification program. Likewise in Burkina Faso, almost 50% of internal markets are being reached with fortified vegetable oils.

“Fortify West Africa” is the first regional initiative on food fortification in sub-Saharan Africa with a strong multi-lateral private and public sector partnership that is committed to improve the nutritional status of women and children in West Africa.

Website: www.hki.org, Contact: Mawuli Sablah, HKI Africa Regional Fortification Coordinator, email: msablah@hki.org

HKI**West Africa Essential Nutrition Actions (ENA) training of trainers (TOT) workshop**

The West Africa Health Organization (WAHO) with support from Africa's Health in 2010 project/AED and in collaboration with Helen Keller International (HKI) and UNICEF/WARO hosted the second phase of the USAID funded West Africa Essential Nutrition Actions (ENA) training of trainers (TOT) workshop from April 7th – 12th, 2008 in Mbour, Senegal. According to the Lancet Child Survival Series universal coverage of a preventative package of nutrition interventions including optimal breastfeeding and complementary feeding as well as micronutrient supplementation could avert 25% of child mortality. Countries need support to strengthen the nutrition and related community service delivery aspects of their existing programs. The ENA approach one that can be taken to scale which embodies the recommendations of the Lancet Series. The ENA approach is an integrated package of scientifically proven nutrition actions to improve nutrition for women and children.

The two phase training is intended to develop and strengthen the capacity in Francophone West Africa for the implementation of the ENA approach into maternal, child and other related programs to improve the nutrition of women and children in the region. Target countries for the ENA TOT include 5 countries from the Economic Commission for West African States (ECOWAS): Burkina Faso, Côte d'Ivoire, Guinea, Mali and Niger with support from Africa's health in 2010 and HKI. Through UNICEF/WARO and HKI support was extended to Cameroon and Democratic Republic of Congo to attend the TOT.

The first phase ENA TOT was a technical update on ENA to provide all participants with up to date nutritional information. The same participants attended the second phase training in April on ENA Behavior Change Communication TOT. The training aimed to inform participating agencies on community knowledge relative to breast-feeding, complementary food and nutrition of women, and especially to provide communication tools enabling actors to better communicate optimal feeding practices for infants and young children.

WAHO, in collaboration with HKI, UNICEF and Africa's Health in 2010 project took a leadership role in both ENA TOTs which held a high and varied attendance of actors from the field including a multi-sector team from government agencies, international partners and non-government organizations.

The next step in the coming months will be a follow up to be undertaken by WAHO to track the progress and implementation of the ENA approach in the areas of policy development, program implementation, and service provision in the five ECOWAS countries represented at the ENA TOTs.

Website: www.hki.org, Contact: Sara Zalman, HKI Regional Communications Officer, Email: szalman@hki.org

WHO/Interagency**Summary Update on the Landscape Analysis on Countries' Readiness to Accelerate Action in Nutrition**

The Landscape Analysis was developed as part of WHO-led interagency efforts in strengthening the contributing to the achievement of the Millennium Development Goals (MDGs), in particular MDG 1, 4 and 5. It was launched in November 2007 with a kick-off partner agency meeting participated by concerned UN Agencies, bilateral and NGO representatives.

The Lancet Series on Maternal and Child Undernutrition launched in early 2008 provided a unique advocacy opportunity to accelerate evidence-based action in nutrition. Despite the recognized benefits, commitment to food and nutrition programmes as reflected in budget support and consolidated action is remarkably poor. The Landscape Analysis, therefore, is an effort to respond to the calls for stronger coordination as well as increased action at scale.

The Landscape Analysis is a readiness analysis of countries to act in nutrition and builds on the experiences of countries in developing and implementing national nutrition plans and policies developed as a follow-up to the 1992 International Conference on Nutrition (ICN). It will review gaps and constraints and identify opportunities for integrating new and existing effective nutrition actions in order to create and accelerate intersectoral action for improving nutrition. The final aim is to lay the foundation to implement consolidated and harmonized action at scale in the 36 high-burden countries, home to 90% of the 178 million stunted children in the world. In addition, following a more in-depth analysis this landscape analysis will aim to develop action plan at the country level as well as to guide not only the understanding of *where best to invest*, but also *how to invest* in order to accelerate the reduction of maternal and child undernutrition. The analysis will also establish a baseline on current status of nutrition action in 36 high-burden countries, allowing tracking of their progress in the future through pulling together all existing nutrition-related data and information not only in WHO, but also in various concerned agencies.

The analysis focuses in four parts: 1) nature, severity, distribution of the maternal and child malnutrition problems; 2) commitment to resolve these problems; 3) capacity to resolve these problems; and 4) overarching constraints for acting at scale for improved maternal and child undernutrition. To date, the Landscape Analysis country assessment has been undertaken in Burkina Faso, Ghana, Guatemala and Madagascar and the country assessment in Peru, South Africa and Timor Leste are currently being planned.

For more information please contact Dr Chizuru Nishida at nishidac@who.int

Speaker's Corner

The Copenhagen Consensus: “The world’s best investment: Vitamins for undernourished children”

Summary overview and introduction by the SCN Secretariat

In Speaker's Corner of this SCN News George Kent presents his views of the Copenhagen Consensus 2008 paper on hunger and malnutrition, where he lists the shortcomings he sees in relation to important issues such as sustainability, local solutions and global capacity for implementation. Being a democratic forum with room for many voices, we publish the paper, in addition to this brief summary overview and introduction as we feel it is important that the SCN News readers understand this project and are able to access the material to make their own judgements or to use it for advocacy.

The Copenhagen Consensus (CC) project is a strictly economic analysis, which looks at how to prioritize among a set of proposed solutions to major world challenges, such as malnutrition and hunger, disease, global warming, air pollution, gender issues, education, trade, conflict and terrorism. It focuses on the international community's effort to solve these challenges and on how to do this in the most cost-efficient manner - based on facts, science, and calculations rather than on political motives or media coverage which is far too often the case. Conceived in 2002 by a group at the Copenhagen Business School and headed by Bjørn Lomborg, the CC took place in 2004 (CC04) and again in 2008 (CC08).

The basic idea of the CC project is to gather some of the world's leading economists to assess and rank some 30 proposed solutions to address the identified challenges. For each challenge, a paper was commissioned from leading specialists in the field to propose solutions and estimate their costs and benefits. The challenge papers were then assessed by an expert panel of economists, many of whom Nobel Laureates. The panel discussed each of the challenge paper proposals in detail with its principal author and with other specialists who had been commissioned to write critical appraisals, before meeting in private to rank the proposals based on the costs and benefits of the solutions. The panel was asked to answer the question: "what would be the best ways of advancing global welfare, and particularly the welfare of the developing countries, illustrated by supposing that an additional \$75 billion of resources were at their disposal over a four year initial period?"

While we in the nutrition community all know that nutrition is one of the most worthwhile investments, it is encouraging to see how a group of leading economists ranked a nutrition intervention at the very top in CC08. Furthermore all five nutrition proposals included ranked among the top 10 out of the 30 solutions considered: micronutrient supplements ranked at 1st, fortification at 3rd, biofortification at 5th, deworming and other nutrition programs at school at 6th and community-based nutrition promotion at 9th. The CC04 which ranked outcomes (e.g. improved micronutrient status) rather than interventions, ranked four nutrition outcomes at 2nd, 5th, 11th and 12th among a set of 17 opportunities. The analysis and results are elaborated in the respective challenge and perspective papers listed below.

The CC analysis surely leverages global attention to nutrition in a way that we should welcome. Although the CC08 only concerned key interventions that do not address the underlying and basic causes of malnutrition, if implemented at scale they would contribute to reducing malnutrition rates today and therefore also improve nutrition of tomorrow's generation through improved maternal and child nutrition as well as empowering the affected communities through enhanced work capacity and educational performance. Thus, while the set of solutions proposed by one group of influential economists by no means suffice to achieve the SCN vision of a world free from hunger and malnutrition, we welcome the conclusions drawn by the prominent CC panel and recognize the need to implement at scale and without delay these essential actions while simultaneously addressing more structural causes and strengthening nutrition actors. Importantly, the CC process can be helpful when we advocate for nutrition to economists and budget planners. We hope the links provided below will facilitate for our readership to make full use of the CC project.

Useful links at www.copenhagenconsensus.com

- [CC08 Malnutrition and hunger website](#)
- CC08 Ranked list of solutions: Copenhagen Consensus (2008) *Results* ([online](#))
- CC08 Challenge Paper: Horton S, Alderman H and Rivera JA (2008) *Copenhagen Consensus 2008 Challenge Paper. Hunger and Malnutrition*. Draft, May 11 2008 (Online [full paper](#), [summary](#))
- CC08 Perspective papers:
 - Martorell R (2008) *Copenhagen Consensus 2008 Perspective Paper. Malnutrition & Hunger* ([online](#))
 - Deolalikar AB (2008) *Copenhagen Consensus 2008 Perspective Paper. Malnutrition & Hunger*. May 10, 2008 ([online](#))
- CC08 Press release: *The world's best investment: Vitamins for undernourished children, according to top economists, including 5 Nobel Laureates* ([online](#))
- [CC04 Malnutrition and hunger website](#)
- CC04 Ranked list of solutions: Copenhagen Consensus (2004) *Results* ([online](#))
- CC04 Challenge Paper: Behrman JR, Alderman H and Hoddinott J (2004) *Copenhagen Consensus – Challenges and Opportunities. Hunger and Malnutrition*. 19 February 2004 (Online [full paper](#), [summary](#))
- CC08 Opponents notes:
 - Svedberg P (2004) *Has the Relationship between Undernutrition and Income Changed?* Comment by Peter Svedberg on: “HUNGER AND MALNUTRITION” by Jere R Behrman, Harold Alderman and John Hoddinott ([online](#))
 - Appleton S (2004) *Hunger and malnutrition - comments*. 19 April 2004 ([online](#))
 - Summary of the two opponents notes ([online](#))

Meeting the challenge of global malnutrition

George Kent, University of Hawai'i

As part of its broad program of addressing major global issues, The Copenhagen Consensus 2008 (CC08) *Challenge Paper on Hunger and Malnutrition* makes an important contribution to the global discussion of nutrition issues. It is timely because recent rapid increases in the price of food worldwide are drawing a great deal of attention to the failures of the global food system.

However, the group's analysis is flawed in several ways. For example, it is based on the premise that there is a global pot of money that could be used to deal with problems of hunger and malnutrition. It asks how that money could be allocated most efficiently. The reality is that different types of hunger and malnutrition problems attract money in different ways from different sources. The funds are not fungible, meaning they cannot be readily transferred from one use to another. For example, the funds that are available for the preparation of therapeutic foods could not easily be reallocated to breastfeeding promotion. Similarly, if food aid funds were required to be used for purchases at the destination rather than in the donating countries, the level of funding made available by donating countries would be sharply reduced. They would be reduced even further if the purported beneficiaries were to decide how the money should be spent. Humanitarian assistance generally cannot be untied without reductions in the total amounts available. The Copenhagen Consensus (CC) group identifies "solutions" to problems of hunger and malnutrition by identifying those courses of action that are most likely to be cost-effective. We have been told these things many times before, by Lancet, UNICEF, and others. The CC group focuses on what could be done to solve the problems, but it does not give enough attention to what it would take to actually get them done.

The CC08 website says "More than 55 international economists, including 5 Nobel Laureates, will assess more than 50 solutions and assemble a list of priorities for everyone involved in solving the world's biggest challenges." This is not an auspicious start. Who gave these 55 wise people the authority to assemble a list of priorities for everyone? The CC is a consensus among a small number of intellectuals, based on the naïve assumption that everyone wants to have these problems solved, and that there is some unique best way to solve them that all will accept. Theirs is an engineering approach, devoid of political analysis. Are those who would have to take the action sufficiently motivated? We should not assume that those who control the resources are eager to get on with the work, and are just waiting to be told the "solutions". In many cases, the costs would have to be borne by one group while another group enjoys the benefits. The evidence we have so far indicates that those who have the resources do not really care enough about those who have the problems.

The CC people, like the World Bank and others, use misleading language about "investment" in solving nutrition problems. Yes, there might be a high benefit to cost ratio from, say, the iodization of salt to prevent goitre, but if I am interested in buying a bigger car, I am not going to "invest" in salt iodization programs on the other side of the world. Investment normally means pulling some money out of my pocket in order to get a larger amount of money into my pocket a while later. When the benefits go to someone else, that is not anything like investment as normally understood. The conclusion of the CC08 paper says, "there is no question that intervention in nutrition is highly desirable and highly beneficial." For whom? Is it beneficial for the factory owner who benefits from the cheap labour that hungry

people are willing to provide? Is it beneficial to consumers who enjoy products made with cheap labour—including food? If solving nutrition problems really were beneficial to all, there would be no trouble in raising funds for nutrition interventions, even for those that might be second best. Let's not fool ourselves in a way that conceals the real challenges that need to be addressed. The language of "investment" in relation to nutrition interventions masks the disconnect between those who have the power and those who have the problem. If we don't look at that disconnect in a straightforward and honest way, we are not dealing with the realities that need to be addressed.

The CC group has focused on interventions whose impacts are not likely to continue long after the intervention has ended. It is really not difficult to find ways of helping to overcome malnutrition now. If a child is seriously deficient in a particular nutrient, you provide that nutrient. The real puzzle, however, is to figure how that nutrient could be provided after you are gone. How does one create sustainable impacts? That question cannot be addressed by looking only at household level or clinical level interventions. One must begin to look at societal forces, economics, and politics. The answers must deal with institutional arrangements, and find ways to replace those structures that endlessly reproduce poverty and malnutrition. You can end hunger in the world by providing sandwiches for everyone, but that sort of answer really misses the point.

The CC group speaks as if there were a need to identify which of several alternative approaches to nutrition problems is the best globally. Why do that? Would it make sense to study which is the best material for building houses globally? Choices need to be attuned to local circumstances. There is no need for a single global choice. Such choices should be made locally to the extent possible, with full participation of the people who are supposed to benefit from them. The CC group has prepared an elegant analysis, but on the wrong question.

There are things that should be done at the global level to facilitate the making of good choices locally. However, there has been little serious global planning and management to deal with hunger and malnutrition. The Millennium Development Goals are not really global at all; they place all the responsibility on the separate national governments. If the CC people really were able to come up with "solutions" to the world's nutrition problem, to whom would it hand those answers? There is no agency in place ready to receive and act on such advice. There is little actual global planning and management to deal with nutrition issues, and little capacity for such activities. This is partly due a broad aversion among the nations of the world to global governance or global government of any kind. As the problems continue to get worse, however, it becomes increasingly clear that we will have to overcome that aversion. The current wave of increases in the price of food highlights the need for doing something to fix the global food system. Official responses so far seem to be more concerned with quelling the food riots than with addressing the deeper problems. If more and more people are falling off the edge of a cliff, we have to do more than put them back up on that cliff edge. We need to address the fact that there are so many millions of people so close to that edge all the time. So far there has been no serious global conversation about how to fix the global food system. Instead of presenting their own views, the world's intellectual leaders would do a greater service by facilitating a well designed broadly participatory global planning process for fixing the badly broken global food system.

Publications

The State of the World's Children 2008: Child Survival

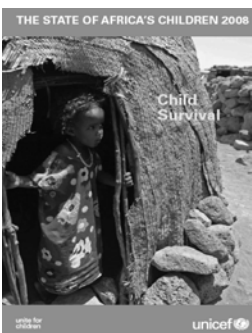


UNICEF ([online](#), E/F/S)

The State of the World's Children 2008 assesses the state of child survival and primary health care for mothers, newborns and children today. These issues serve as sensitive barometers of a country's development and wellbeing and as evidence of its priorities and values. Investing in the health of children and their mothers is a human rights imperative and one of the surest ways for a country to set its course towards a better future.

www.unicef.org

The State of Africa's Children 2008: Child Survival

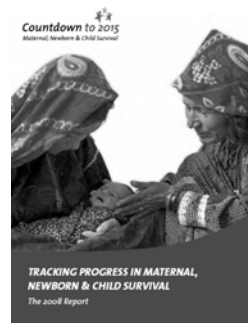


UNICEF ([online](#), E/F)

The State of Africa's Children 2008 highlights the need to position child survival at the heart of Africa's development and human rights agenda. It begins by examining the state of child survival and progress towards the health-related MDGs for children and mothers in each of the continent's five main subregions: Eastern, Central, North, Southern and West Africa. Although much of the report concentrates on sub-Saharan Africa, cases and analysis from North Africa are examined as well.

www.unicef.org

Tracking Progress in Maternal, Newborn and Child Survival, The 2008 Report

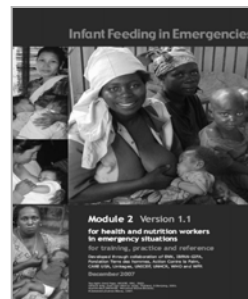


UNICEF ([online](#), E/F/S)

The second in a series of reports, Countdown 2008 is based primarily on data drawn from national surveys and global databases. It measures coverage of basic health services proven to reduce maternal and child mortality. It also assesses the strength of health systems, the status of policies related to maternal, newborn and child health and how equitably health services are distributed.

www.unicef.org

Infant Feeding in Emergencies—Module 2, Version 1.1



ENN ([online](#), E/F)

This course aims to provide those directly involved with infants and caregivers with the basic knowledge and skills to support safe and appropriate infant and young child feeding. It contains special chapters, in the additional material booklet, on relactation and the management of breast conditions. Additional material also covers the management of severely malnourished infants less than 6 months as well as artificial feeding. The information has been simplified and streamlined, so that health and nutrition workers with little time and little opportunity for study can learn and use effective interventions with the minimum of training.

www.ennonline.net

Accelerating Progress towards Reducing Child Malnutrition in India: A Concept for Action

IFPRI ([online](#))

www.ifpri.org



Review of Community-based Management of Acute Malnutrition (CMAM) in Post-Emergency Context: Synthesis of Lessons in Integration of CMAM Into National Health Systems

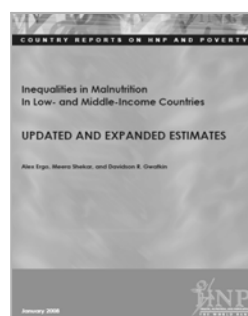


FANTA/USAID ([online](#))

With CMAM incorporated into government health facilities and protocols to varying degrees in Ethiopia, Malawi and Niger, FANTA Project undertook a comprehensive review of the challenges, successes and lessons learned from the experience in these three countries. This document discusses recommendations for successful and sustainable integration of CMAM, outlining specific steps donors, Ministries of Health, the UN and NGOs can take to facilitate the process and next steps needed to expand the knowledge and evidence base for CMAM integration.

www.fantaproject.org

www.usaid.gov

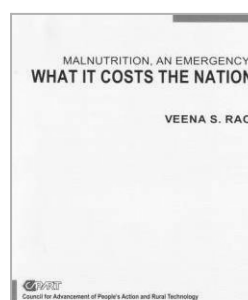


Inequalities in Malnutrition in Low- and Middle-Income Countries

Ergo A, Shekar M, Gwatkin D

The World Bank ([online](#))

www.worldbank.org



Malnutrition, an Emergency: What it costs the nation

Rao VS

Council for Advancement of People's Action and Rural Technology (India) (CAPART)

<http://capart.nic.in>

Improving Nutrition as a Development Priority Addressing Undernutrition in National Policy Processes in Sub-Saharan Africa

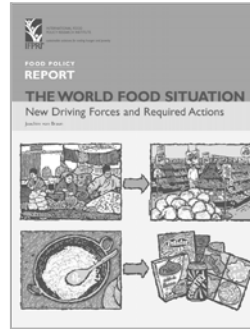


Benson T - IFPRI ([online](#))

This report investigates undernutrition's persistence, drawing on case studies of the public response to the problem in Ghana, Mozambique, Nigeria, and Uganda. Analyzing each nation's policymaking structures, political actors, understanding of undernutrition, and the timing of public responses, the author explains why none of these four nations has mounted an effective campaign to eliminate undernutrition. The author identifies several different causes of this shortcoming, with one underlying flaw in the various public responses standing out: a fundamental failure on the part of political leaders to see undernutrition as a grave problem that undermines development efforts in their nations. The author concludes that an effective response to undernutrition in these countries requires the formation of national advocacy coalitions that can raise public awareness of the problem, highlight policymakers' duty to ensure the nutrition of their citizens, and link proper nutrition to general national development.

www.ifpri.org

The world food situation: New driving forces and required actions.



von Braun J - IFPRI

([online](#), E/S/C)

The world food situation is currently being rapidly redefined by new driving forces. Income growth, climate change, high energy prices, globalization, and urbanization are transforming food consumption, production, and markets. The influence of the private sector in the world food system, especially the leverage of food retailers, is also rapidly increasing. Changes in food availability, rising commodity prices, and new producer-consumer linkages have crucial implications for the livelihoods of poor and food-insecure people. Analyzing and interpreting recent trends and emerging challenges in the world food situation is essential in order to provide policymakers with the necessary information to mobilize adequate responses at the local, national, regional, and international levels. It is also critical for helping to appropriately adjust research agendas in agriculture, nutrition, and health. Not surprisingly, renewed global attention is being given to the role of agriculture and food in development policy, as can be seen from the World Bank's World Development Report, accelerated public action in African agriculture under the New Partnership for Africa's Development (NEPAD), and the Asian Development Bank's recent initiatives for more investment in agriculture, to name just a few examples.

www.ifpri.org

Underfed, Underpaid and Overlooked: Women, the Key to Food Security in South Asia



Ramachandran N - IIED ([online](#))

A fresh approach to food security is called for in South Asia. Despite increasing per capita availability of cereals in almost every country, endemic pockets of hunger remain, seasonal shortfalls are manifest and malnutrition is widespread across the region. Women and children are the greatest sufferers. This paper asserts that without addressing the widespread discrimination faced by women in the region, the situation is unlikely to improve. Malnourished and poorly educated women perpetuate the poverty cycle. The paper concludes with a set of actions which could help women in their struggle to secure adequate food for their families.

www.iied.org

Gender difference in the long-term impact of famine



Mu R, Zhang X IFPRI ([online](#))

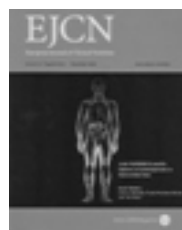
An increasing literature examines the association between restricted fetal or early childhood growth and the incidence of diseases in adulthood. Little is known, however, about gender difference in this association. The authors assess the impact of nutritional deficiency in the early lives of survivors of the Chinese Great Famine in terms of health and economic welfare, paying special attention to gender differences. They found evidence of several significant negative impacts for female-but not male-survivors, and the gender differences are statistically significant.

www.ifpri.org

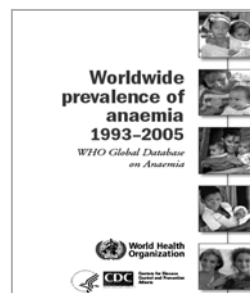
Joint FAO/WHO Scientific update on carbohydrates in human nutrition

European Journal of Clinical Nutrition,
Volume 61 (Supplement 1), December
2007, available upon request at

www.who.int



Worldwide prevalence of anaemia 1993-2005: WHO Global Database on Anaemia



WHO/CDC ([online](#))

In this report, the prevalence of anaemia is presented by country and by WHO regions. Because these prevalence data may be used to identify programme needs by other United Nations agencies, the estimates are classified by United Nations regions in the annexes. In addition, one chapter is dedicated to the criteria used to identify, revise, and select the surveys, and the methodology developed to generate national, regional, and global estimates. This report is intended for public health officials, nutritionists, and researchers.

www.who.int



IFPRI Forum: What goes down must come up: Global food prices reach new heights

IFPRI ([online](#))

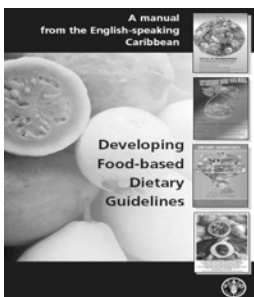
www.ifpri.org

Food Labelling: Fifth edition

WHO/FAO (E/F/S)

Food labelling is the primary means of communication between the producer and seller of food on one hand, and the purchaser and consumer on the other. The Codex Alimentarius standards and guidelines on food labelling are now collected in this compact format to allow their wide use and understanding by governments, regulatory authorities, food industries and retailers, and consumers. This fifth edition includes all texts adopted by the Codex Alimentarius Commission up to 2007.

www.earthprint.com

**Developing Food-based Dietary Guidelines
A manual from the English-speaking Caribbean**FAO ([online](#))

This manual intend to offer practical advice to nutritionists and others working in related fields for producing national Food-based Dietary Guidelines (FBDGs) for the general public. It explains the rationale behind national FBDGs and outlines the steps needed for producing FBDGs. It also gives advice on ways to communicate this information to the public.

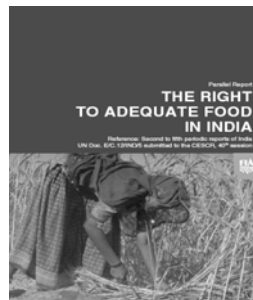
www.fao.org

Expert Consultation on Nutrition Indicators for Biodiversity**1. Food composition**

FAO

Biological diversity is the variety of life on Earth, from the simplest micro-organisms to complex ecosystems such as the rainforests of the Amazon. Biodiversity is important for nutrition and health, and can help to combat micronutrient deficiencies and other forms of malnutrition. Nutrition indicators need to be developed to address the three dimensions of biodiversity - ecosystems, the species they contain and the genetic diversity within species. The indicators will measure the food composition and consumption of cultivars, varieties, breeds and subspecies of commonly consumed foods. This first booklet on nutrition indicator for biodiversity is related to food composition. It reports on progress regarding food composition for biodiversity and will help us value and preserve our planet's existing biodiversity within well-managed ecosystems, with their many sources of nutritionally-rich foods.

www.earthprint.com

The right to adequate food in IndiaFIAN ([online](#))

This report, aimed at providing detailed information concerning the right to food in India, is the outcome of several years of FIAN and civil society work. As elaborated in this report, food availability is not the problem in India. There is plenty of food to feed every man, woman and child; yet there are several reports of starvation death from the country as case studies indicate. The problem lies in the accessibility of food to those most vulnerable to hunger and starvation and the failure of the State to take effective steps to prevent such a situation. The Government of India has designed several policies and schemes to support the most vulnerable sections of the Indian society to overcome hunger and malnutrition. These are efforts by the Government of India which have to be acknowledged. However, there are still numerous shortcomings in the policies and schemes and with regard to their implementation.

www.fian.org

Agrofuels in BrazilFIAN International ([online](#))

FIAN International and other organizations conducted a Fact-Finding Mission in Brazil from April 3 to 10, 2008 to investigate, from the perspective of human rights, the current impacts of the Brazilian governmental policies and programs related to the production of agrofuels. www.fian.org



**Review of Incorporation of
Essential Nutrition Actions into
Public Health Programs in Ethiopia**
FANTA/USAID ([online](#))

www.fantaproject.org

**Rice Fortification in
Developing Countries:
A Critical Review of the
Technical and Economic
Feasibility**

USAID/A2Z/AED/IFT

([online](#))

www.a2zproject.org

Sustainable Elimination of Iodine DeficiencyUNICEF ([online](#), E/F/S)

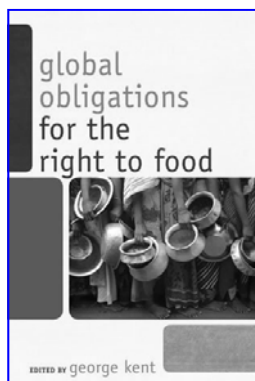
Iodine deficiency disorders (IDD) are the single greatest cause of preventable brain damage worldwide. This report reviews global and national efforts to eliminate iodine deficiency disorders since the 1990 World Summit for Children set the goal of virtual elimination of IDD. It captures the lessons learned and best practices in various countries and proposes an

agenda against IDD to stem adverse effects on international development and human potential. www.unicef.org

The SCN News Editor also recommends:

SCN News 35 on *Universal Salt Iodization* ([online](#)), which looks at the global progress and public health success stories to address IDD through Universal Salt Iodization (USI), including key programme components, lessons learned at country level, and the way forward to reach USI globally. www.unsystem.org/scn

Global obligations for the right to food



Kent G (ed.)

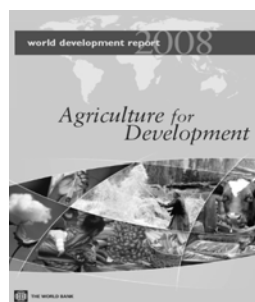
The purpose of this book is to clarify and strengthen the obligations of the global community in relation to the human right to adequate food. It explores the various actions that should be taken by governments, non-governmental organizations, and individuals to ensure that all people of the world have access to adequate food, and assesses the nature and depth of the global responsibility to ensure adequate food for the

world's population. This book was prepared by a Task Force of the Working Group on Nutrition, Ethics, and Human Rights of the SCN. Its eight chapters authored by Kent G, Künnemann R and Ratjen S, Donati F and Vidar M, Brady M, Gupta A, Latham M, Cohen M and Ramanna A, and Vivek S, are followed by reflections by the editor and a total of 43 specific recommendations formulated by the group of individual authors and addressed to the global community and a broad range of actors, including UN agencies, governments and civil society actors. The recommendations are grouped into seven broad areas of global-level state obligations, intergovernmental organizations, nonstate transnational actors, humanitarian assistance, nutrition of mothers, infants and pre-school children, nutrition of school-age children, access to plant genetic resources for food and agriculture, and food sovereignty. The recommendations concern the role that the global community should play in implementing rights-based plans to eradicate hunger and malnutrition, and could serve as building blocks for such a global plan.

www.rowmanlittlefield.com

The book is based in part on an earlier book by George Kent, *Freedom from Want: The Human Right to Adequate Food* ([online](#))

World Development Report 2008: Agriculture for Development



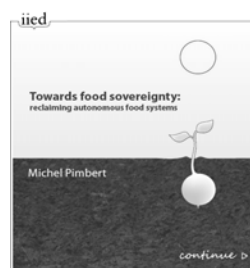
The World Bank ([online](#), E/F/S/P/A/R/C)

This report provides guidance to governments and the international community on designing and implementing agriculture-for-development agendas that can make a difference in the lives of hundreds of millions of rural poor. The Report highlights two major regional challenges. In much

of Sub-Saharan Africa, agriculture is a strong option for spurring growth, overcoming poverty, and enhancing food security. Agricultural productivity growth is vital for stimulating growth in other parts of the economy. But accelerated growth requires a sharp productivity increase in smallholder farming combined with more effective support to the millions coping as subsistence farmers, many of them in remote areas. Recent improved performance holds promise, and this report identifies many emerging successes that can be scaled up. This Report addresses three main questions: What can agriculture do for development? What are effective instruments in using agriculture for development? How can agriculture-for-development agendas best be implemented?

www.worldbank.org

Towards food sovereignty: reclaiming autonomous food systems



Pimbert M ([online](#))

Towards Food Sovereignty is an online book with linked video and audio files. The first three chapters, available here, begin to describe the ecological basis of food and agriculture, the social and environmental costs of modern food systems, and the policy reversals needed to democratize food systems. The video and audio clips show farmers, indigenous peoples and consumers all working to promote food sovereignty, it highlights the importance of locally controlled food systems to sustain both people and nature.

www.iied.org

Nutrition Beyond the Health Sector: A Profile of World Bank Lending in Nutrition from 2000 to 2006



Garrett J and El Hag El-Tahir S ([online](#))

The World Bank report Repositioning Nutrition as Central to Development explicitly recommended improving nutrition by not only working through the health sector, but also in non-health sectors such as agriculture and education. This report provides descriptive and financial profiles of the Bank's recent portfolio in nutrition (from FY2000 to late FY2006) to note the extent to which the Bank has actually gone outside the health sector to work on nutrition. In this period, 41 projects were assigned a theme of "food and nutrition security." Just over half of them (22 out of 41) had nutrition-related components or activities. Of these 22 projects, half fell within the health sector, and half fell outside.

www.worldbank.org

Dietary Diversity as a Measure of Women's Diet Quality in Resource-Poor Areas: Results from Rural Bangladesh Site



FANTA/USAID/IFPRI ([online](#))

Results from Rural Bangladesh Site Simple population-level indicators are needed to assess the quality of women's diets and to monitor progress in improving diets. FANTA is working with a number of researchers on a Women's Dietary Diversity Project (WDDP), whose broad objective is to use existing data sets with dietary intake data from 24-hour recall to analyze the relationship between simple indicators of diet diversity—such as those that could be derived from the new Demographic and Health Surveys (DHS)—and dietary quality for women. With funding from USAID's Bureau for Global Health, the WDDP is analyzing data sets from five countries: Bangladesh, Burkina Faso, Mali, Mozambique and the Philippines. The final report for Bangladesh indicates that food group diversity indicators may be a simple and valid option for population-level assessment and for monitoring progress toward improved micronutrient intakes among women of reproductive age.

www.fantaproject.org www.usaid.gov www.ifpri.org

Water and the Rural Poor: Interventions for improving livelihoods in Sub-Saharan Africa



FAO ([online](#))

The document looks at the water resources that are available in sub-Saharan Africa and at their potential role in improving agriculture and the livelihoods of the rural poor. The report argues that improvements in agriculture are one of the options to reduce poverty, and that interventions should be adapted to local conditions and populations, as

there is no one-fits-all solution. To this effect for instance, the report distinguishes 13 types of livelihood zones across sub-Saharan Africa. This comprehensive report is articulated around 3 broad themes: Water, agriculture and rural livelihoods; Mapping poverty, water and agriculture in sub-Saharan Africa; Interventions in water to improve livelihoods in rural areas. www.fao.org

Protein-Energy Malnutrition

JC Waterlow FRS with contributions from A Ashworth, AM Tomkins and SM Grantham McGregor

Reprint with added new material 2007

Hailed on first publication in 1992 as 'a state-of-the-art publication on nutrition and PEM for the 90s' Protein-energy Malnutrition is a critical, authoritative review of the subject for doctors and health workers. The reprinted version now presented here is supplemented by 22 pages of updated new material. The detailed discussion of treatment, aimed specifically at paediatricians and health workers, is supported by an analysis of the nature of severe and fatal cases. An account of how the existence of malnutrition is characterized in the community by impaired growth, frequent infections and retardation of mental development leads to an analysis of the still controversial question of strategy and methods for prevention. Thus the potential readership is widened to include public health officials, aid agencies and medical advisers.

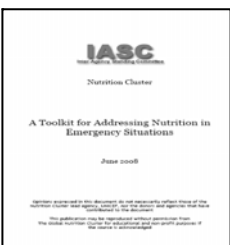
Available from Smith-Gordon priced at £35.

For students and health professionals in the field who work in countries experiencing PEM the book is available at lower cost of £10.

Contact cvenditti@smith-gordon-publishing.com

See also www.talcuk.org/books/protein-energy-malnutrition.htm

Toolkit for Addressing Nutrition in Emergency Situations



IASC Global Nutrition Cluster

([online](#))

The Nutrition Cluster Toolkit is intended as an easy-to-use field guide that outlines the key basic interventions for nutritional support to individuals and groups during an emergency situation. It provides the what, why, when, and how for different nutrition interventions,

including basic monitoring benchmarks and expected standards. The Toolkit offers guidance and support for nutritionists and humanitarian workers to ensure that basic guidelines are followed and the basic nutritional needs of populations in emergencies are met. It is not intended to be an exhaustive resource for each intervention presented, but rather an overview for interventions to be considered with references and links to more detailed technical guidance for each issue.

<http://ocha.unog.ch/humanitarianreform>

See also detailed description [p.64](#)

Impact of Climate Change and Bioenergy on Nutrition



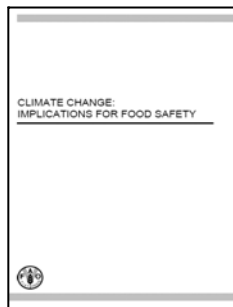
Cohen MJ, Tirado C, Aberman NL, Thompson B - IFPRI/FAO

([online](#))

This paper, prepared for the High Level Conference on World Food Security: The Challenge of Climate Change and Bioenergy (Rome, 3-5 June 2008), explores the implications of climate change and rising bioenergy demand for nutrition. It examines the direct nutrition effects of rising

bioenergy demand, as well as its contribution to rising food prices. The paper begins by describing the current state of global food insecurity and malnutrition and the causes, consequences and costs of food insecurity and malnutrition. A number of factors besides climate change, bioenergy and rising prices that can contribute to malnutrition in the future are also discussed. Finally, a chapter on policy implications provides several options for improving food security and nutrition, as well as for addressing the links between climate change and bioenergy demand and nutrition. www.ifpri.org www.fao.org

Climate Change: implication for Food Safety



FAO ([online](#))

The paper aims to identify potential impacts of anticipated changes in climate on food safety and their control at all stages of the food chain. The purpose is to raise awareness of the issue and to facilitate international cooperation in better understanding the changing food safety situation and in developing and implementing strategies to address them. www.fao.org



Feeding the world: Sustainable Management of Natural Resources

FAO ([online](#))

www.fao.org

1. Dairy Development for the Resource Poor: A Comparison of Dairy Policies and Development in South Asia and East Africa
2. Dairy Development for the Resource Poor: Kenya and Ethiopia Dairy Development Case Studies.
3. Dairy Development for the Resource Poor: Pakistan and India Dairy Development Case Studies.

Staal SJ, Pratt AN, Jabbar M

([online](#) 1, 2 and 3)

This study examines dairy development in two key dairy producing regions in the developing world: East Africa and South Asia. The aim of the study is to analyse the trends in dairy development in these two regions and identify their key determinants, to assess the impact of policy interventions on those trends and to identify impacts of dairy development, particularly on the poor. The study is reported in three parts.

www.fao.org

The state of food and agriculture in Asia and the Pacific region 2008

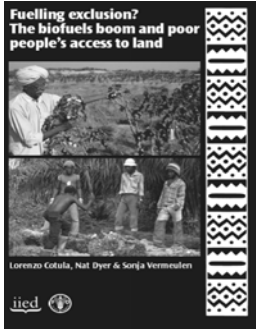


FAO ([online](#))

The first part of the publication examines hunger and poverty in the region, changes in dietary patterns, agricultural commodity trends, and the outlook for the future, including the major challenges that need to be addressed. The second part provides a special focus on the new "gold rush": biofuels development in Asia and the Pacific. As biofuels are likely to have a major influence on agricultural commodity prices and rural incomes for some time to come, the status of biofuels development in the region is assessed. The main focus of the analysis is on the potential effects of the demand for biofuels on regional household food security. www.fao.org

Fuelling exclusion?

The biofuels boom and poor people's access to land



Cotula L, Dyer N, Vermeulen S - IIED/FAO ([online](#))

What are the impacts of the increasing spread of biofuels on access to land in producer countries, particularly for poorer rural people? Biofuels could revitalise rural agriculture and livelihoods – or, where there are competing claims on land – exclude poorer land and resource users. This study documents current knowledge on current and potential impacts of commercial biofuel production for access to land in Africa, Latin America and Asia, charting both negative experiences and promising approaches. www.iied.org www.fao.org

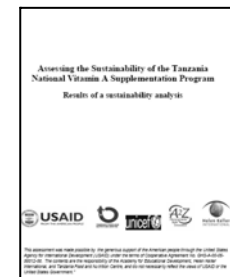


HIV, Food Security and Nutrition

WFP/WHO/UNAIDS

([online](#))

www.unaids.org



Assessing the Sustainability of the Tanzania National Vitamin A Supplementation Program

Results of a sustainability analysis

USAID/Tanzanian Food and Nutrition Centre/HKI/UNICEF/A2Z

([online](#))

www.hki.org



Tackling a global crisis:

International Year of Sanitation 2008

UN-Water ([online](#))

www.un.org/esa



How effective are food-for-education programs?

2020 Vision Focus Brief Special Edition

Adelman S, Gilligan DO, Leher K IFPRI ([online](#))

www.ifpri.org

Beyond survival: Integrated delivery care practices for long-term maternal and infant nutrition, health and development

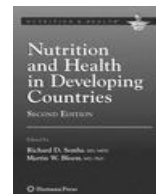


PAHO ([online](#), E/S)

The Pan American Health Organization has developed two documents to increase awareness of the importance of "nutrition-related" delivery care practices and encourage their implementation. We may be missing a crucial opportunity to implement simple practices that go beyond ensuring immediate survival by improving long-term infant and maternal nutrition, health and developmental outcomes. Such practices include delayed umbilical cord clamping, immediate mother-to-newborn skin-to-skin contact, and early initiation of exclusive breastfeeding. *Beyond Survival: Integrated delivery care practices for long-term maternal and infant nutrition, health and development* establishes the evidence-base



for all three practices, and describes the short- and long-term benefits for both mother and infant. It also provides practical descriptions of the recommended practices, discusses frequently asked questions regarding their application, and addresses the issue of integration of these practices into standard delivery care in coordination with existing efforts to improve maternal and neonatal survival. *Essential delivery care practices for maternal and newborn health and nutrition* provides a shorter review of the importance of these three practices, as well as practical guidelines for practitioners for their incorporation into standard delivery care. www.paho.org



Nutrition and Health in Developing Countries Series:

Nutrition and Health

Semba RD, Bloem MW (eds)

www.springer.com



Eat Your Heart Out:

Why the food business is bad for the planet and your health

Lawrence F (ed)

www.penguin.co.uk

Bulletin Board

Miscellaneous:

- **Enhancing Partnership Value: A Tool for Assessing Sustainability and Impact:** This interactive tool helps project managers assess the sustainability and impact of UN/business partnerships. For more information contact Cecile Hultmann at Hultmann@un.org
- **The Southern Sudan Medical Bulletin:** (SSMB) is a new quarterly peer-reviewed online publication intended for healthcare professionals who are working in the Southern Sudan or are seeking information on health in the Southern Sudan. To access the Bulletin go to www.iow.nhs.uk/juba and click on the link for the SSMB. Or contact eluzai_hakim@yahoo.co.uk
- **TALC informs:** Update for 'Caring for Severely Malnourished Children': A short 4-pages update for this useful book has been prepared and is being inserted into all copies of the book sold by TALC (Teaching-aids At Low Cost). It is also available in e-format from info@talcuk.org, Ann.Hill@lshrm.ac.uk or annpatriciaburgess@yahoo.co.uk. 'Caring for Severely Malnourished Children' was published by Macmillan, Oxford in 2003 and costs £4.00 (£5.35 with an accompanying CD) plus postage from TALC, P.O. Box 49, St Albans, Herts AL1 5TX, UK. Fax: +44 1727 846852. www.talcuk.org

Newsletters:

- **New & Noteworthy in Nutrition**—Issue 2, June 2008 now available from <http://www.prb.org/NewandNoteworthy.aspx>
- **Field Exchange**—contains field level articles, research and evaluation findings and news items on food and nutrition in emergencies. Published 3 times a year. Contact the Emergency Nutrition Network (ENN) at office@enonline.net or access it online www.enonline.net/fex.
- **IDD Newsletter** by the Council for the Control of Iodine Deficiency Disorders (ICCIDD). It is published quarterly and carries articles and news items related to iodine deficiencies disorders from around the world. To join the mailing list contact ETH Zurich, Human Nutrition Laboratory: iccidd.newsletter@ilw.agrl.ethz.ch. Free online at www.iccidd.org
- **Right to Food Quarterly**—by FIAN gives information and analysis on the right to food and important trends concerning ESC-Rights. Available at: www.fian.org/resources/documents/categoria-3
- **Water and sanitation** – to subscribe to the mailing list and receive email when documents are published please send a email to listserv@who.int

Training and Courses:

Breastfeeding: Advocacy & Practice A Regional Outreach Course

17-29 November 2008, Penang, Malaysia
Organised by the Infant Feeding Consortium (IFC), from the Institute of Child Health, London and the World Alliance for Breastfeeding Action (WABA), Penang.
www.waba.org.my/pdf/bapbrochure2008.pdf

BPNI

Infant and Young Child Feeding Counseling Specialist

26 September - 2 October 2008
Ranchi, Jharkhand (See [p.11](#))

15th European Nutrition Leadership Programme Seminar 2009

1-9 April 2009, Luxembourg
Deadline 30 November 2008
www.enlp.eu.com

Nutrition In Emergencies

1-5 September 2008, London, UK

A week long course in Nutrition in Emergencies is being run by the Centre for Public Health Nutrition, University of Westminster. This intensive training introduces current best practice within this rapidly evolving sector. The aim is to give an overview of nutrition programming in humanitarian emergencies. Topics studied include an overview of the different types of malnutrition, their direct and underlying causes, how malnutrition is measured, and common nutritional interventions. Trainers and facilitators are all experienced in the humanitarian sector.

For more information see

www.wmin.ac.uk/sih/page-979

or email: cav-admissions@wmin.ac.uk

Meetings and Conferences:

11th ECOWAS Nutrition Forum

"Food and Nutrition Security:
Challenges in a context of Globalization"
September 2008 (dates tbc)
Freetown, Sierra Leone
Organized by West African Health Organization
(WAHO)
Information to come at www.ecowas.int

5th European Congress on Nutrition and Health in the Elderly People

15-17 September 2008, Warsaw, Poland
<http://nhecongress2008.sggw.pl>

High Level Meeting on Africa's Development Needs

State of Implementation of Various
Commitments Challenges and
the Way Forward
22 September 2008
UN Headquarters, New York, USA

Roundtable on Health and Education

UN Headquarters New York, USA
MDGs 4 and 5 Side Event
UN Millennium Hotel, New York, USA
25 September 2008

Right to Food Forum

1-3 October 2008, FAO, Rome, Italy
www.fao.org/righttofood

Mega Event Nutrition 2008

2-4 October 2008, Sao Paulo, Brazil
www.nutricaoempauta.com.br

Academy of Breastfeeding Medicine

2nd European Conference for Physicians
4-5 October 2008, Vienna, Austria
www.bfmed.org

First European Food Congress

4-9 November 2008, Ljubljana, Slovenia
www.foodcongress.eu

2nd Micronutrient Forum: Micronutrients, Health, and Development:

Evidence-based Programs
12-15 May 2009, Beijing, China
www.micronutrientforum.org

19th International Congress of Nutrition 2009

Nutrition Security for All
4-9 October 2009, Bangkok, Thailand
www.icn2009.com

Vacancies:

**International Relief and Development
(IRD) - Senior Technical Advisor in Food
Technology and Nutrition (see [p.50](#))**

Nutrition Reviews®

Editor-in-Chief (see [p.37](#))

SCN EMail Update

Receive news and updates by email on a monthly basis! Ask us to add you to our contact list, at scn@who.int

UNITED NATIONS SYSTEM

**STANDING COMMITTEE
ON NUTRITION**

The Administrative Committee on Coordination (ACC), which was comprised of the heads of the UN Agencies, recommended the establishment of the Sub-Committee on Nutrition in 1976, following the World Food Conference and with particular reference to Resolution V on food and nutrition. This was approved by the Economic and Social Council of the UN (ECOSOC) by resolution in July 1977. Following the reform of the ACC in 2001, the ACC/SCN was renamed the United Nations System Standing Committee on Nutrition or simply “the SCN”. The SCN reports to the Chief Executives Board of the UN, the successor of the ACC. The UN members of the SCN are ECA, FAO, IAEA, IFAD, ILO, UN, UNAIDS, UNDP, UNEP, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNRISD, UNU, WFP, WHO and the World Bank. IFPRI and the ADB are also members. From the outset, representatives of bilateral donor agencies have participated actively in SCN activities as do nongovernmental organizations (NGOs). The SCN Secretariat is hosted by WHO in Geneva.

The *mandate of the SCN* is to serve as the UN focal point for promoting harmonized nutrition policies and strategies throughout the UN system, and to strengthen collaboration with other partners for accelerated and more effective action against malnutrition. The *aim of the SCN* is to raise awareness of and concern for nutrition problems at global, regional and national levels; to refine the direction, increase the scale and strengthen the coherence and impact of actions against malnutrition worldwide; and to promote cooperation among UN agencies and partner organizations. The SCN’s annual meetings have representation from UN agencies, donor agencies and NGOs; these meetings begin with symposia on subjects of current importance for policy. The SCN brings such matters to the attention of the UN Secretary General and convenes working groups on specialized areas of nutrition. Initiatives are taken to promote coordinated activities—interagency programmes, meetings, publications—aimed at reducing malnutrition, reflecting the shared views of the agencies concerned. Regular reports on the world nutrition situation are issued. *Nutrition Policy Papers* are produced to summarize current knowledge on selected topics. *SCN News* is published twice a year, and the *NICS* (formerly *RNIS*) is published quarterly. As decided by the SCN, initiatives are taken to promote coordinated activities—interagency programmes, meetings, publications aimed at reducing malnutrition, primarily in developing countries.

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CHAIR

ROGER SHRIMPTON
SECRETARY

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USAID
FROM THE AMERICAN PEOPLE

Update on REACH – Ending Child Hunger and Undernutrition

Denise Costa Coitinho on behalf of the Inter-Agency Team hosted by WFP

Nutrition is a desperately neglected aspect of maternal, newborn, and child health. The medical journal *The Lancet* in its new maternal and child undernutrition series (Maternal and Child Undernutrition Study Group 2008), finds that 90% of the world's undernourished children live in just 36 countries, and intensified nutrition action in these countries would greatly contribute to the achievement of the first Millennium Development Goal (MDG1) and substantially increase the chances of achieving goals for reducing child and maternal mortality and disease (MDGs 4, 5 and 6). UNICEF (2007) found that 51 developing countries are making insufficient progress towards MDG1's 'hunger target', as measured by the prevalence of underweight among under-fives. Eighteen of these were making no progress at all or were going backwards.

To accelerate countries' progress on MDG-1, Target 2 (halve the proportion of underweight under-fives), the global community has realised that there is an urgent need for renewed efforts against child hunger, as a priority in the identified 36 countries. Such a renewed effort requires government-led, solution-focused partnerships among the UN, civil society and private sectors. What is also needed is a redirection of funds and attention to support the delivery of proven nutrition interventions at scale. There is a need for seamless nutrition support between children under five and those of school age. A coherent joint response from the UN and partners in support of national governments is urgently required to move these efforts forward. To fulfil this perceived need, WFP, UNICEF and partners, have been developing the Ending Child Hunger and Undernutrition Initiative (ECHUI) since 2006.

ECHUI was first presented to the SCN during its 34th session, in Rome. The SCN welcomed ECHUI, endorsed its goals, and recommended that it be a broad-based partnership with close links to the SCN. A series of concrete recommendations were made with various offers of technical or managerial support to further strengthen ECHUI:

1. The SCN should provide an advisory role to ECHUI;
2. ECHUI should build on existing SCN structures (Working Groups and Task Forces);
3. The SCN and ECHUI Secretariats should be closely articulated; and,
4. ECHUI should report on progress at the SCN Annual Sessions.

The progress report to the 35th session of the SCN aimed at meeting the fourth recommendation.

In July 2007, ECHUI was approved by WFP and UNICEF Executive Boards. The two organizations were requested to continue developing ECHUI including further refining of the workplan, developing the Partners Group, and preparing the ground for the Secretariat. In the same month, ECHUI preliminary studies in Mauritania and Niger were concluded and by the end of 2007 the WHO-led Landscape Analysis on Countries' Readiness to Accelerate Action in Nutrition was initiated (WHO 2008). In November 2007, the WHO Director-General Dr Margaret Chan joined the effort and seconded a staff member to Rome. The Inter-Agency Team was then established in Rome, hosted by WFP. Following these good developments, the FAO Director-General Dr Jacques Diouf joined the effort as the fourth core partner, in January 2008.

In February 2008, the Lancet series on maternal and child undernutrition was launched and ECHUI-promoted interventions accordingly revised and organized into "big five" priority action areas, to achieve four agreed outcomes:

1. increased awareness and understanding of the problem of hunger and undernutrition, and of known solutions;
2. supported national policy and programme development;
3. increased capacity for action at all levels; and,
4. increased monitoring, efficiency and accountability of global efforts

More focus and a roll-out plan that brings together on-going initiatives was then proposed by the Inter-Agency Team. The new brand 'REACH: ending child hunger and undernutrition' was also proposed. Progress to date is presented now to the SCN for further advise.

What is REACH?

REACH is intended to become a network of government-led, solution-focused partnerships among the UN, civil society, government and private sectors. Bringing together the collective resources of numerous organizations within and outside of the UN, REACH will promote acting at scale with well-targeted solutions, drawn from a menu of five proven, effective areas of interventions, around the four agreed outcomes. REACH is intended to facilitate country-level analysis of readiness, gaps and opportunities to scale up key interventions; joint action planning, including costing, resource matching and resource mobilization; national-level advocacy and communications; and tracking and monitoring of results.

This coordinated, solution-oriented approach represents a change from “business as usual”. Currently most programs are ‘single-product’-oriented, insofar as each agency focuses on the specific intervention it delivers. REACH turns this around. It starts with the overall objective and focuses on what each agency can contribute towards achieving a common solution. Moreover, REACH provides a platform and innovative process for in-country coordination and, with the combined ‘influencing power’ of all UN agencies and partners, is a potentially powerful platform to raise awareness of the problem of undernutrition and of solutions. Consistent messages and approach will enhance the cost-effectiveness of all participants’ investment, and focus efforts on the difficult-to-reach, worst-off populations.

Learning agenda

To support country action, REACH also aims systematically to capture, analyse and share practical knowledge on strategic and operational features that determine the effectiveness and sustainability of nutrition solutions when implemented at scale in diverse settings. REACH aims at contributing to the ‘delivery science’ as called for a recent letter to the editor of the *Lancet* co-authored by several renowned nutrition scientists. In future, REACH could provide a platform for the sharing of successful practices within and among countries; for consistent, integrated M&E across programmes; and opportunities for operational and effectiveness research.

Policy framework

REACH believes that renewed efforts against child hunger (for children under five) are needed and require an immediate scale-up of the ‘big-five’ action areas by national governments with interventions to be selected from a possible menu, focusing on the identified 36 countries. The policy framework agreed to comprises of five main action areas “big five”, each of them with a menu of interventions as follows:

1. Improve maternal and infant nutrition (interventions include: providing nutritionally-balanced supplements to pregnant and lactating women; promoting early initiation of breastfeeding and exclusive breastfeeding; promoting quality complementary feeding and ensure that fortified complementary foods are locally available)
2. Treat severe acute malnutrition (interventions include: providing facility-based therapeutic feeding for children and mothers, integrated into national health services; supporting community management of severe malnutrition using ready-to-use therapeutic foods; ensuring availability of and access to ready-to-use therapeutic foods)
3. Increase micronutrient intake for children and mothers (interventions include: providing micronutrient supplements for women and children (vitamin A, iron, zinc); promoting food fortification (iron, zinc, iodine); promoting diet diversification)
4. Improve hygiene & parasite control (interventions include: making household water treatments available; promoting hand-washing with soap; preventing malaria and de-worming)
5. Increase food availability and accessibility (interventions include: promoting local/homestead food production; providing conditional cash transfers; providing supplementary food to vulnerable children and mothers)

Strategic approach

To scale up such hunger and undernutrition interventions, national governments together with partners will need to work through the following steps, bearing in mind lessons learned and success stories from the Sahel Alliance and Latin America, and elsewhere:

- Undertake a country specific analysis of current status, country willingness and existing interventions in the five categories to identify gaps and challenges and select priority interventions for scale up
- Develop a detailed country-level action plan
- Map and organize the demand/need for inputs and human and financial resources
- Cost the action plan
- Match programme and resource supply and demand at country level
- Support resource mobilization to meet gaps
- Implement the country-level action plans, through existing and proposed operations and delivery channels
- Track progress and evaluate results of above actions

Country-level action, in practical terms for UN Teams, will require UN agencies to support and work within a nationally-led country-level planning action to identify how they can respond to nationally defined needs.

For Country Offices level, this will mean engaging in the action planning exercise with the government and partners in the 36 countries identified. The results will likely reinforce the relevance of much of existing work. The above activities are part of the four agencies' core business and many country offices are already engaged in inter-agency efforts to act at scale in nutrition. For those Country Offices, REACH should build upon and strengthen on-going efforts. However, in several other countries REACH could be an opportunity to bring synergy within UN country teams to support governments to adjust, modify and identify opportunities to scale-up as appropriate, to fit within the country-level action plan.

The REACH team aims to support new efforts and to boost on-going efforts, as defined under the proposed scope of work below. In 2008, REACH plans to support two countries: Mauritania and Laos. A third country will also be identified to link in a local food purchase pilot. In 2009, additional countries will be supported by the REACH coalition, including eight countries where WHO is already undertaking an in-depth readiness analysis (WHO 2008).

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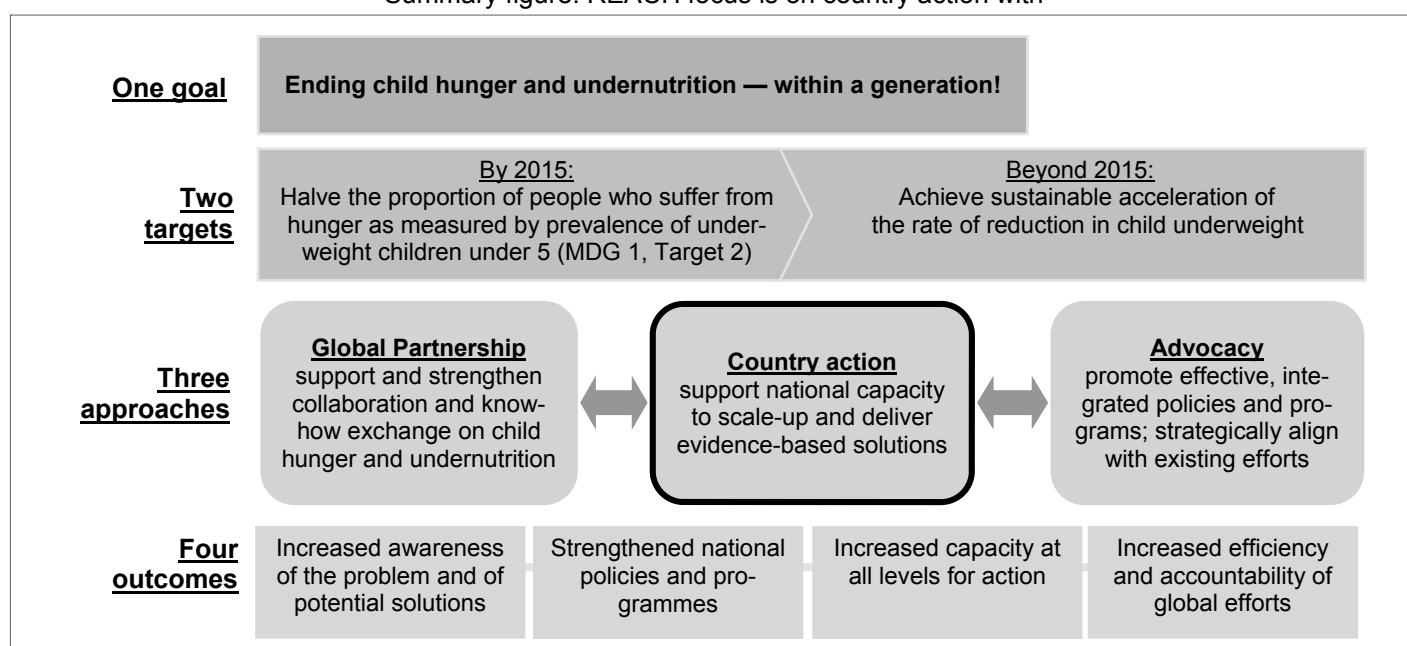
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Summary figure: REACH focus is on country action with



Source: REACH internal communication

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