UNICEF's Role in Reducing Malnutrition

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THE COMCEC POVERTY ALLEVIATION WORKING GROUP MEETİNG,
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Backround - Terminology

- **Malnutrition** is a broad term that refers to all forms of poor nutrition. Malnutrition includes both undernutrition and overnutrition.
- **Undernutrition** is caused by the insufficient intake and/or inadequate absorption of energy, protein or vitamins and minerals (micronutrients) **or** childhood diseases, such as diarrhoea or intestinal worm infestation, can affect the absorption of, or requirements, for nutrients. An estimated one third of deaths among children under age 5 are attributed to undernutrition.
- Most commonly, anthropometric indicators of nutritional status are used which measure a child's height/length and weight and compares it to a reference population.
- A **stunted** child is too short for his or her age.
- An **underweight** child has low weight for his or her age
- A **wasted** child has low weight for his or her height.
- A child who is **micronutrient deficient** lacks essential vitamin and minerals that promote good nutrition and health and advance physical and intellectual growth.
- UNICEF will address the problems of stunting and other forms of undernutrition, as well as child overweight and obesity.

Backround- indicators and targets

Stunting was endorsed as a key indicator for monitoring maternal, infant and young child nutrition by the World Health Assembly (WHA) in 2012. During the 2012 WHA, a 13-year (2012–2025) comprehensive implementation plan to address maternal, infant, and child nutrition was endorsed. UNICEF will contribute to this plan to alleviate the triple burden of undernutrition, micronutrient deficiencies and overweight and obesity in children, by supporting attainment of six global targets:

1	40% REDUCTION in the number of children under 5 who are stunted
2	50% REDUCTION in anaemia in women of reproductive age
3	30% REDUCTION in low birthweight
4	NO INCREASE in childhood overweight
5	INCREASE the rate of exclusive breastfeeding in the first 6 months up to AT LEAST 50%
6	REDUCE AND MAINTAIN childhood wasting to LESS THAN 5%

There is recognition of the importance of investing in stunting reduction, given stunting's critical link to child development and consequently to national development.

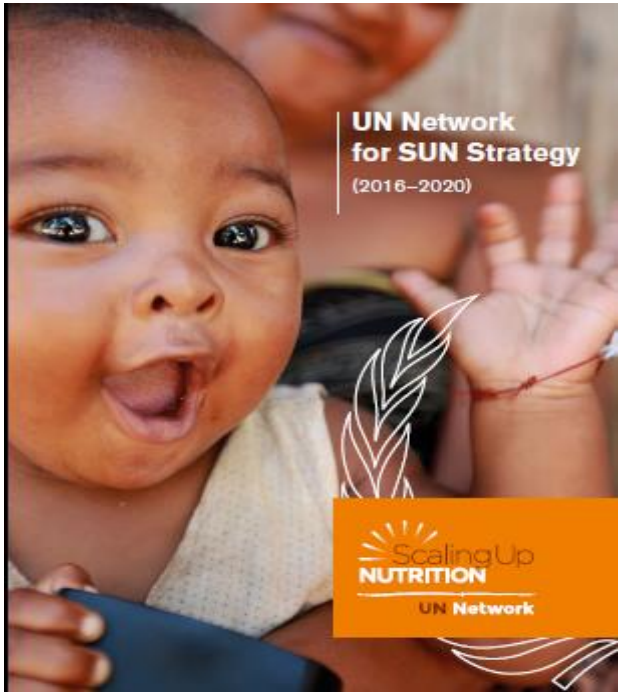
There is greater understanding of consequences of undernutrition, especially during the critical period of **the first 1,000 days of life** (between conception and a child's second birthday) are potentially irreversible.

Global attention to improving nutrition has increased. Scaling Up Nutrition (SUN) movement and other initiatives, networks and partnerships for nutrition have been strengthened.

THE 17 HEADLINE GOALS OF THE SDGS

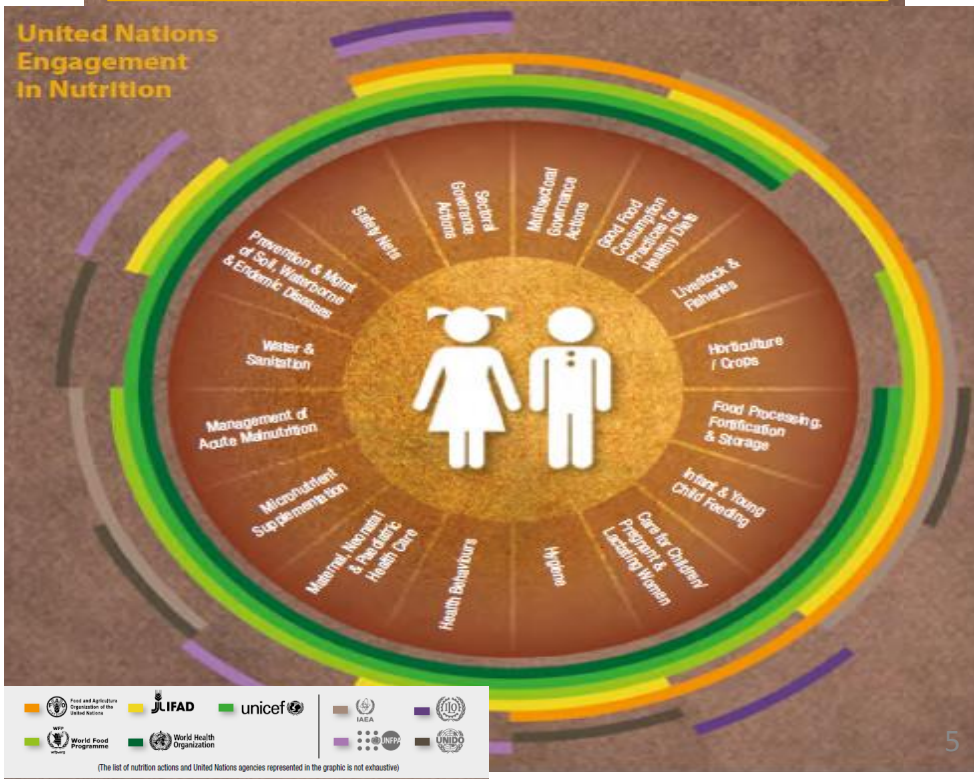
Link to report: https://sustainabledevelopment.un.org/post2015/transformingourworld

#EVERYCHILD 2030



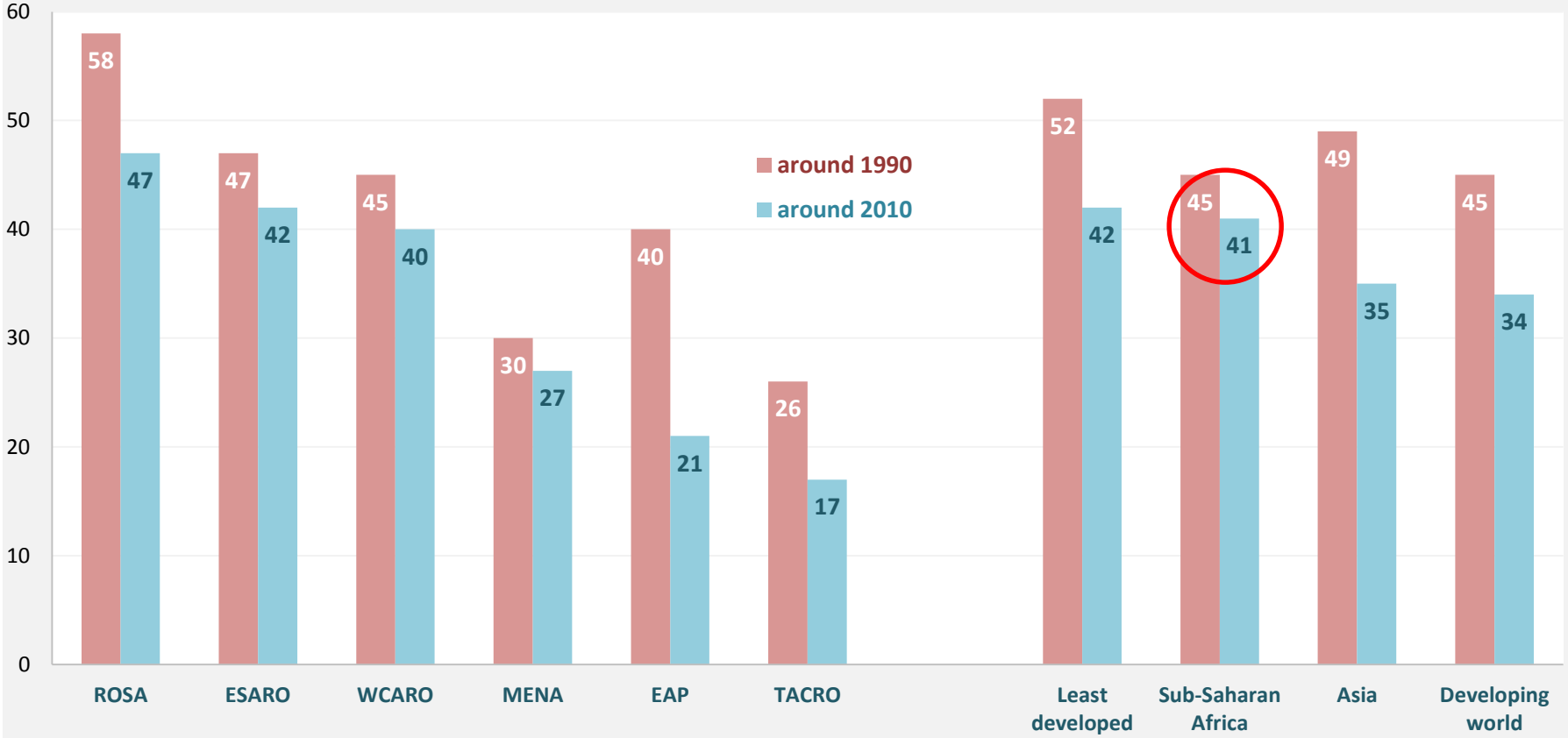
This document outlines the five-year strategy for the UN Network for Scaling Up Nutrition (SUN) 2016–2020 as a contribution to the Scaling Up Nutrition (SUN) Movement. The UN Network for SUN (UN Network), formally established in 2013, brings together United Nations agencies at the country, regional and global levels in pursuit of the Sustainable Development Goals (SDGs) and global nutrition targets within the context of the SUN Movement.[1]

The strategy, endorsed by the Food and Agriculture Organization of the United Nations (FAO), International Fund for Agricultural Development (IFAD), United Nations Children's Fund (UNICEF), World Food Programme (WFP) and World Health Organization (WHO), reaffirms the United Nations commitments and contributions to the aims of the SUN Movement.[2]



Trends in stunting prevalence among under-five children

Proportion of children under five years who are stunted (percentage)

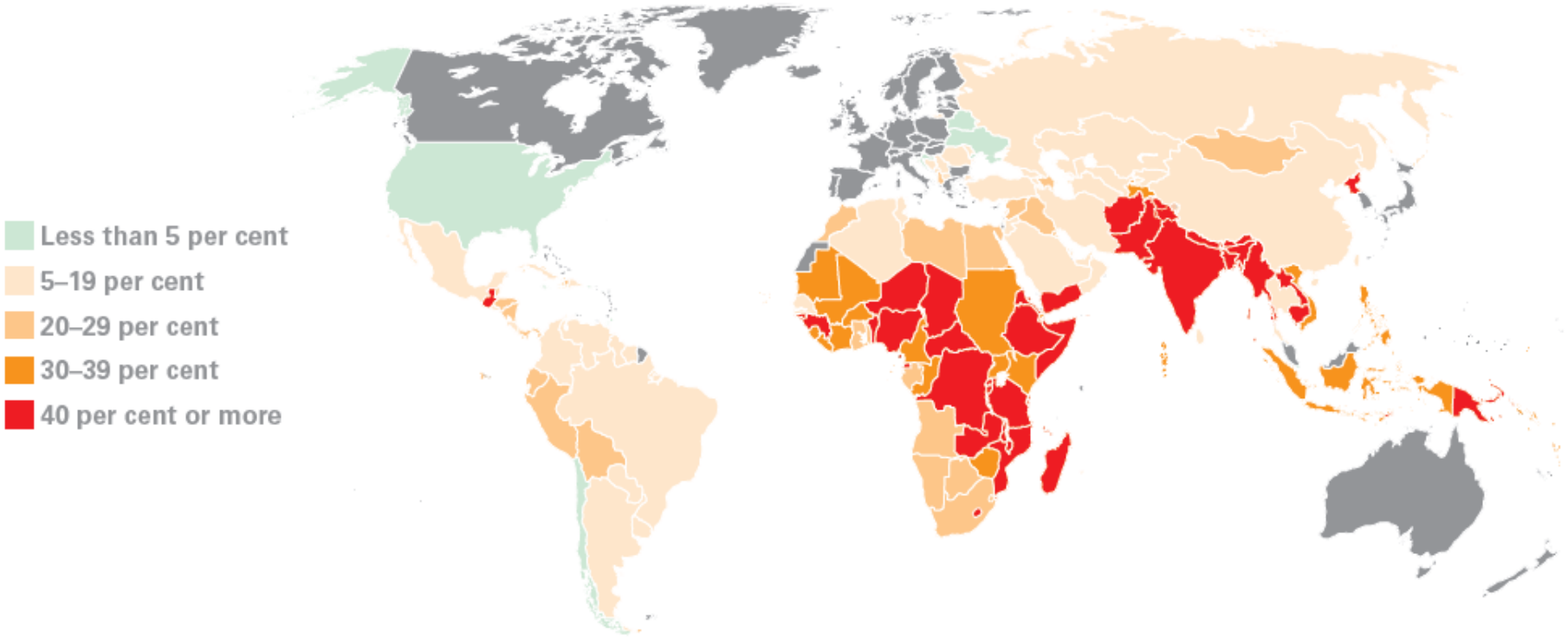


Note: prevalence estimates calculated according to WHO Child Growth Standards

Source: DHS, MICS and national nutrition surveys, 1990 - 2010, and additional analysis by UNICEF

Stunting prevalence

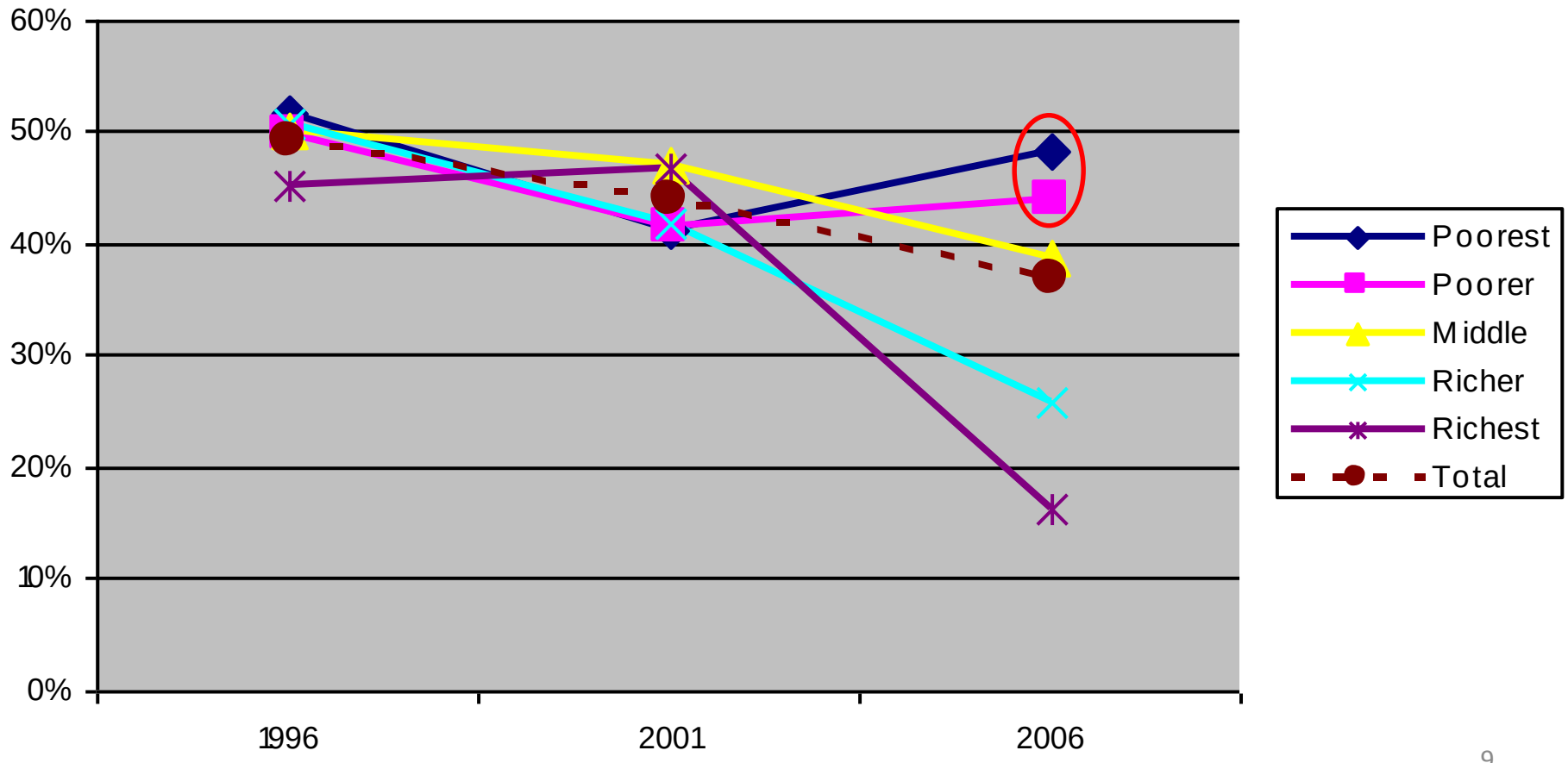
Stunting affects approximately 183 million under-fives in the developing world; about one in three



Source: UNICEF Global Database, Nov 2009
Compiled from MICS, DHS and other national surveys

Nepal stunting trends and equity

Fig-25: Stunting Trend for children (6-23 months) by Wealth Status



Source: DHS data. From NAGA pg. 27

Impact of undernutrition

- Increased risk of dying from infectious diseases
- Stunting is associated with reduced school performance equivalent to 2-3 yrs of schooling
- Stunting associated with reduced income earning capacity
- Increased risk of non-communicable diseases in adult life
- Stunted girl is more likely to give birth to undernourished baby
- Reduced GMP by 2-3%
- About 20 million children suffer from severe acute malnutrition (SAM) which greatly increases risk of death

Core Commitments for Children

We face serious global pressures including climate change, transitioning diets, population growth, urbanization, communicable and non-communicable disease threats, and continuing poverty. Communities including children need to be supported to improve their resilience, cushioning against shocks and volatility, so that attainments in nutrition and development are sustained. Moreover, humanitarian crises are expected to increase in scale, severity and frequency.

UNICEF remains committed to upholding the rights of children affected by humanitarian crisis and is guided by the Core Commitments for Children in Humanitarian Action*.

A risk-informed programming approach, which better integrates humanitarian and developmental assistance, will allow UNICEF to more flexibly and sustainably meet current and future demands.

* The CCCs are realized through close collaboration among partners, host governments, civil society organizations, nongovernmental organizations (NGOs) – both national and international – UN agencies and donors. This is consistent with UNICEF commitments under inter-agency humanitarian reform, including the Principles of Partnership.

Core Commitments for Children in Humanitarian Action

THE CONVENTION ON THE RIGHTS OF THE CHILD

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Figure 3: Programme and operational commitments

Rapid Assessment, Monitoring and Evaluation

Operational Commitments

Security	Media and communication	Human resources	Resource mobilization	Finance and management	Information and communications technology

Programme Commitments

Nutrition	Health	WASH	Child protection	HIV and AIDS	Education

Advocacy

Communication for Development

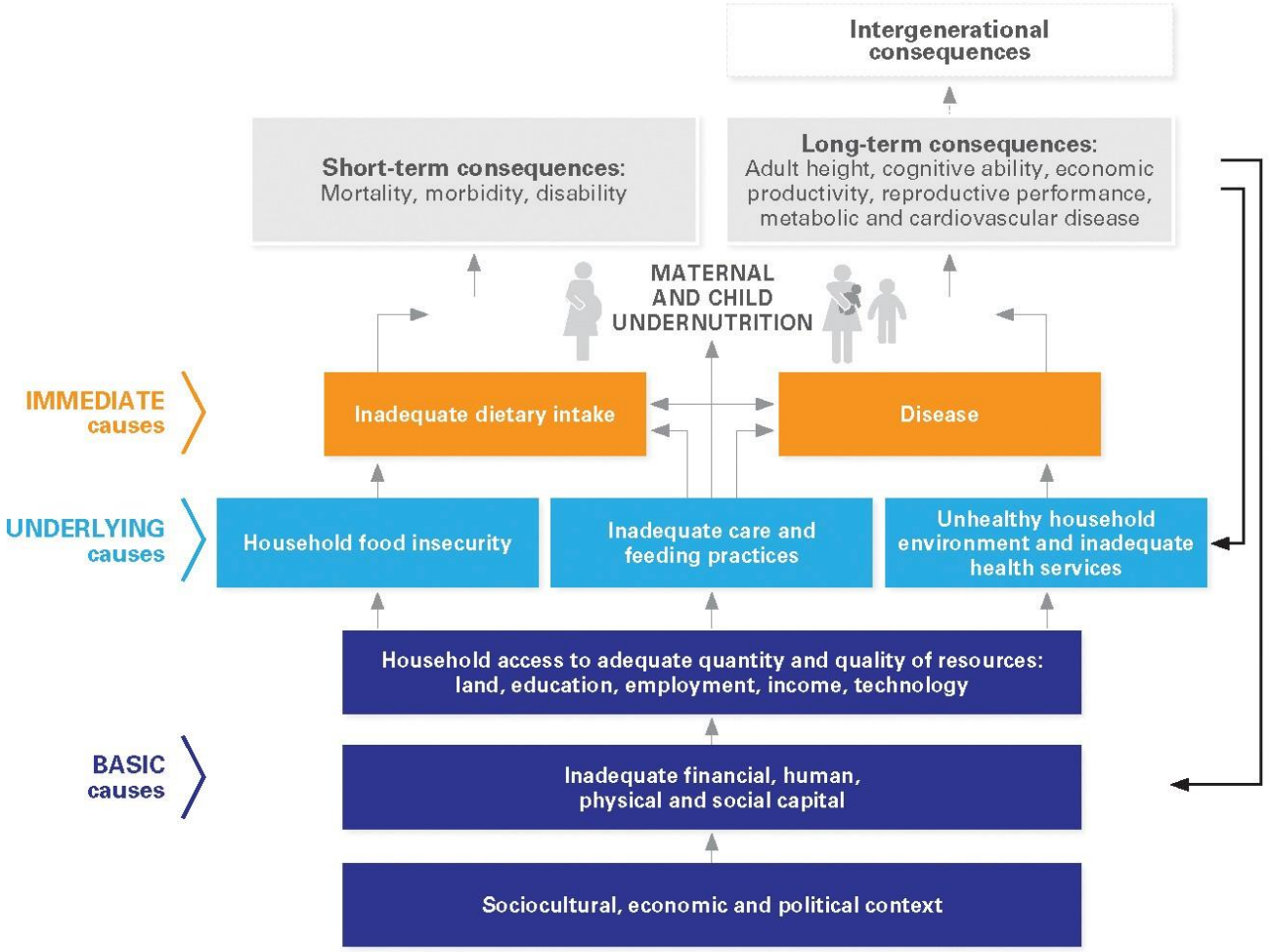
Supply

Nutrition strategic result

The nutritional status of girls, boys and women is protected from the effects of humanitarian crisis.

Commitments	Benchmarks
Commitment 1: Effective leadership is established for nutrition cluster inter-agency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.	**Benchmark 1**: Coordination mechanism provides guidance to all partners regarding common standards, strategies and approaches, ensuring that all critical nutrition gaps and vulnerabilities are identified; also provides information on roles, responsibilities and accountability to ensure that all gaps are addressed without duplication.
Commitment 2: Timely nutritional assessment and surveillance systems are established and/or reinforced.	**Benchmark 2**: Quality assessments are reported on in a timely fashion and provide sufficient information for decision-making, including the scope and severity of the nutritional situation, the underlying causes of malnutrition and contextual factors.
Commitment 3: Support for appropriate infant and young child feeding (IYCF) is accessed by affected women and children.	**Benchmark 3**: All emergency-affected areas have an adequate number of skilled IYCF counsellors and/or functioning support groups.
Commitment 4: Children and women with acute malnutrition access appropriate management services.	**Benchmark 4**: Effective management of acute malnutrition (recovery rate is >75%, and mortality rates are <10% in therapeutic care and <3% in supplementary care) reaches the majority of the target population (coverage is >50% in rural areas, >70% in urban areas, >90% in camps).
Commitment 5: Children and women access micronutrients from fortified foods, supplements or multiple-micronutrient preparations.	**Benchmark 5**: Micronutrient needs of affected populations are met: >90% coverage of supplementation activities, or >90% have access to additional sources of micronutrients for women and children.
Commitment 6: Children and women access relevant information about nutrition programme activities.	**Benchmark 6**: Communication activities providing information on nutrition services (including how and where to access them) and entitlements are conducted in all emergency-affected areas.

UNICEF Conceptual Framework of the Determinants of Child Undernutrition



The black arrows show that the consequences of undernutrition can feed back to the underlying and basic causes of undernutrition, perpetuating the cycle of undernutrition, poverty and inequities.

Source: Adapted from UNICEF, 1990.

FIGURE 2

NUTRITION-SPECIFIC AND NUTRITION-SENSITIVE INTERVENTIONS AND APPROACHES THAT ADDRESS THETRIPLE BURDEN OF UNDERNUTRITION, MICRONUTRIENT DEFICIENCIES AND OVERWEIGHT AND OBESITY

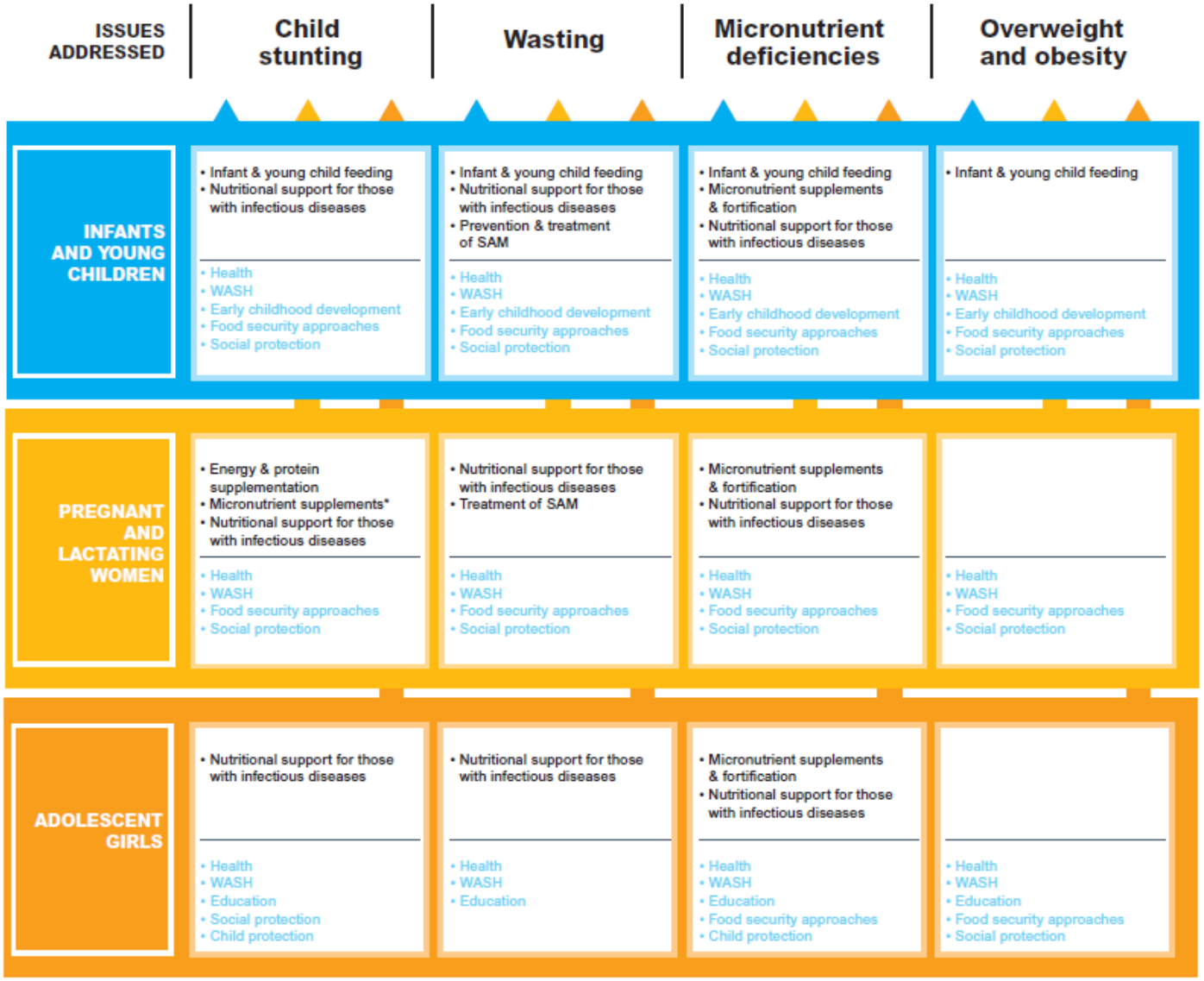


FIGURE 3

UNICEF'S PROGRAMMATIC WORK IN NUTRITION

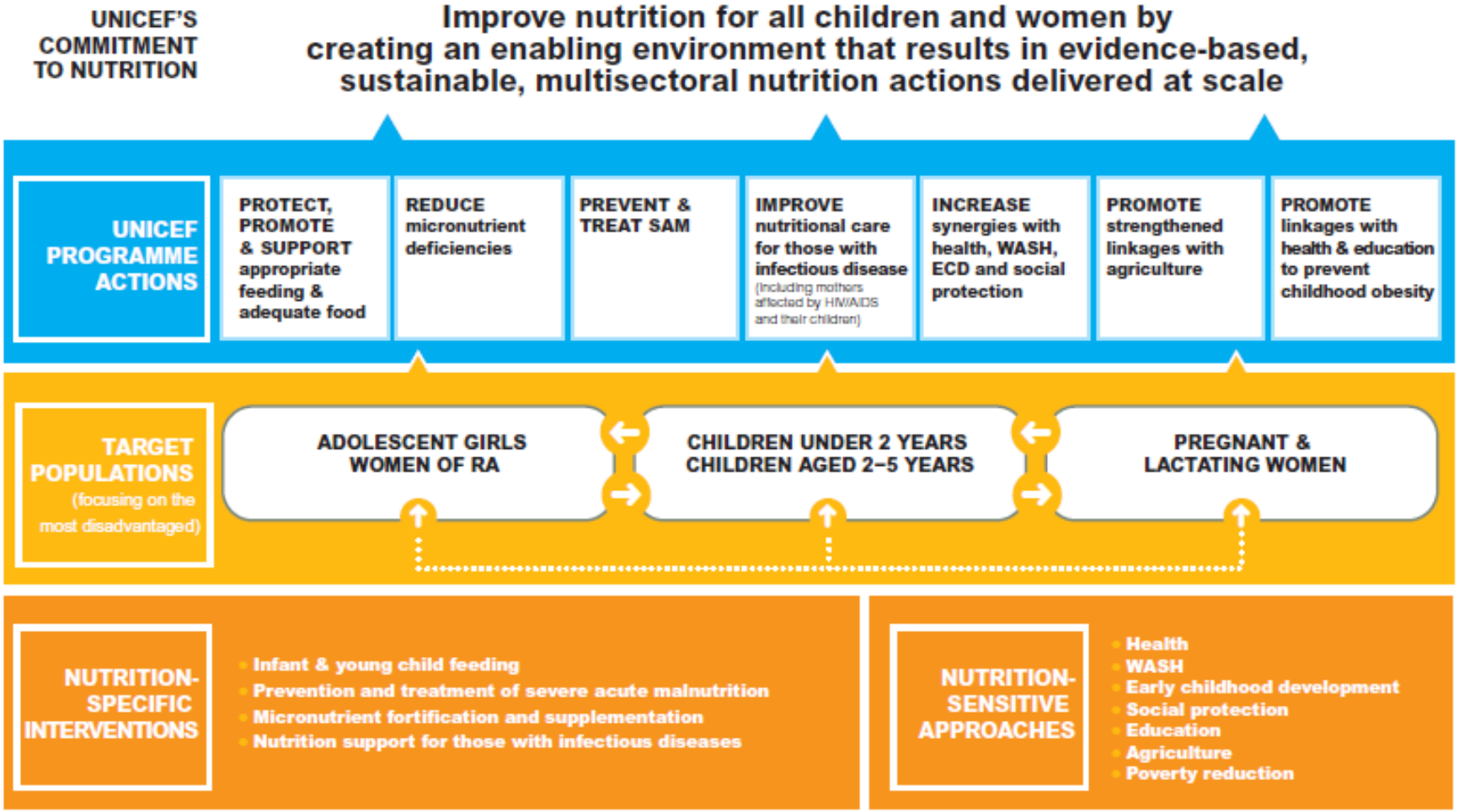
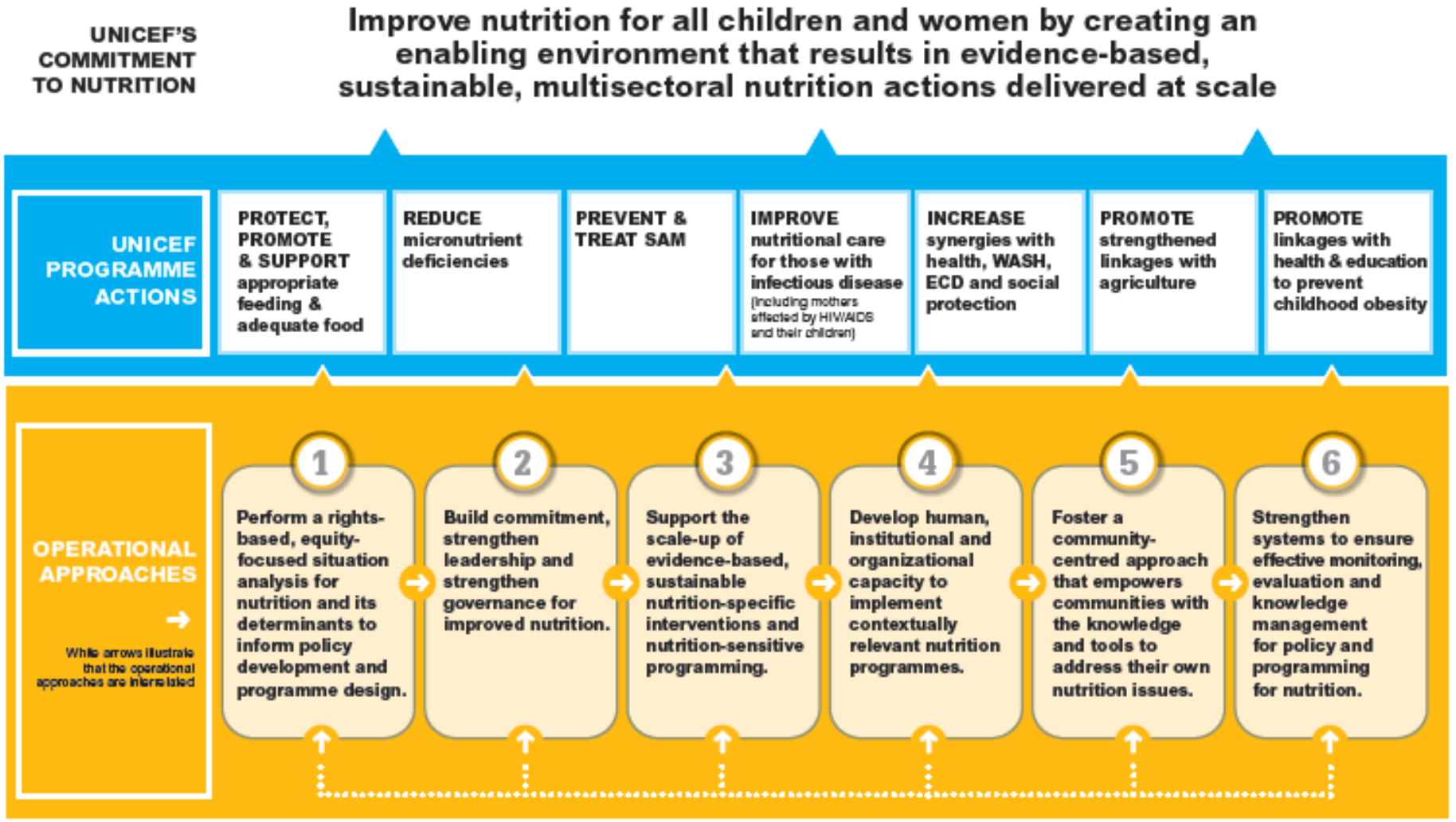


FIGURE 4

UNICEF'S OPERATIONAL APPROACHES TO IMPROVING NUTRITION PROGRAMMING FOR MOTHERS AND CHILDREN



Key practices, services and policy interventions for preventing and treating stunding and other form of undernutrition and overweight and obesity troughout the life cycle

Nutrition spesific interventions

Nutrition sensitive approach

NUTRITION-SPECIFIC INTERVENTIONS

ADOLESCENCE → PREGNANCY

- Food fortification including salt iodization
- Iron and folic acid or multiple micronutrient supplementation for pregnant women
- Intermittent (weekly) iron and folic acid supplementation for reproductive-age women
- Fortified food supplements for undernourished mothers
- Nutrition counselling for improved dietary intake during pregnancy

BIRTH

- Delayed cord clamping
- Initiation of breastfeeding within one hour (including colostrum)
- Appropriate infant feeding practices and anti-retroviral therapy for HIV-exposed infants

0-5 MONTHS

- Exclusive breastfeeding counselling and lay support on breastfeeding through community-based and facility-based contacts
- Control of the marketing of breast milk substitutes
- Appropriate infant feeding practices and anti-retroviral therapy for HIV-exposed infants
- Vitamin A supplementation in first 8 weeks after delivery
- Use of fortified foods, micronutrients supplementation and home fortification with multiple micronutrients for undernourished women
- Nutrition counselling for improved dietary intakeduring lactation
- Communication for behavioural and socialchange

6-23 MONTHS

- Timely, adequate, safe & appropriate complementary feeding
- Continued breastfeeding
- Control of the marketing of breast milk substitutes
- Appropriate infant feeding practices and anti-retroviral therapy for HIV-exposed infants
- Micronutrient supplementation, including vitamin A, zinc treatment for diarrhea
- Management of SAM
- Food fortification, including salt iodization
- Home fortification with multiple micronutrients
- Zinc supplementation with oral rehydration salts for diarrhoea treatment and management

24-59 MONTHS

- Counselling and nutrition advice to women of reproductive age/adults
- Communication for behavioural and socialchange to prevent childhood obesity
- Vitamin A supplementation
- Management of SAM (and moderate acute malnutrition)
- Food fortification, including salt iodization
- Zinc supplementation with oral rehydration salts for diarrhoea treatment and management

NUTRITION-SENSITIVE APPROACHES

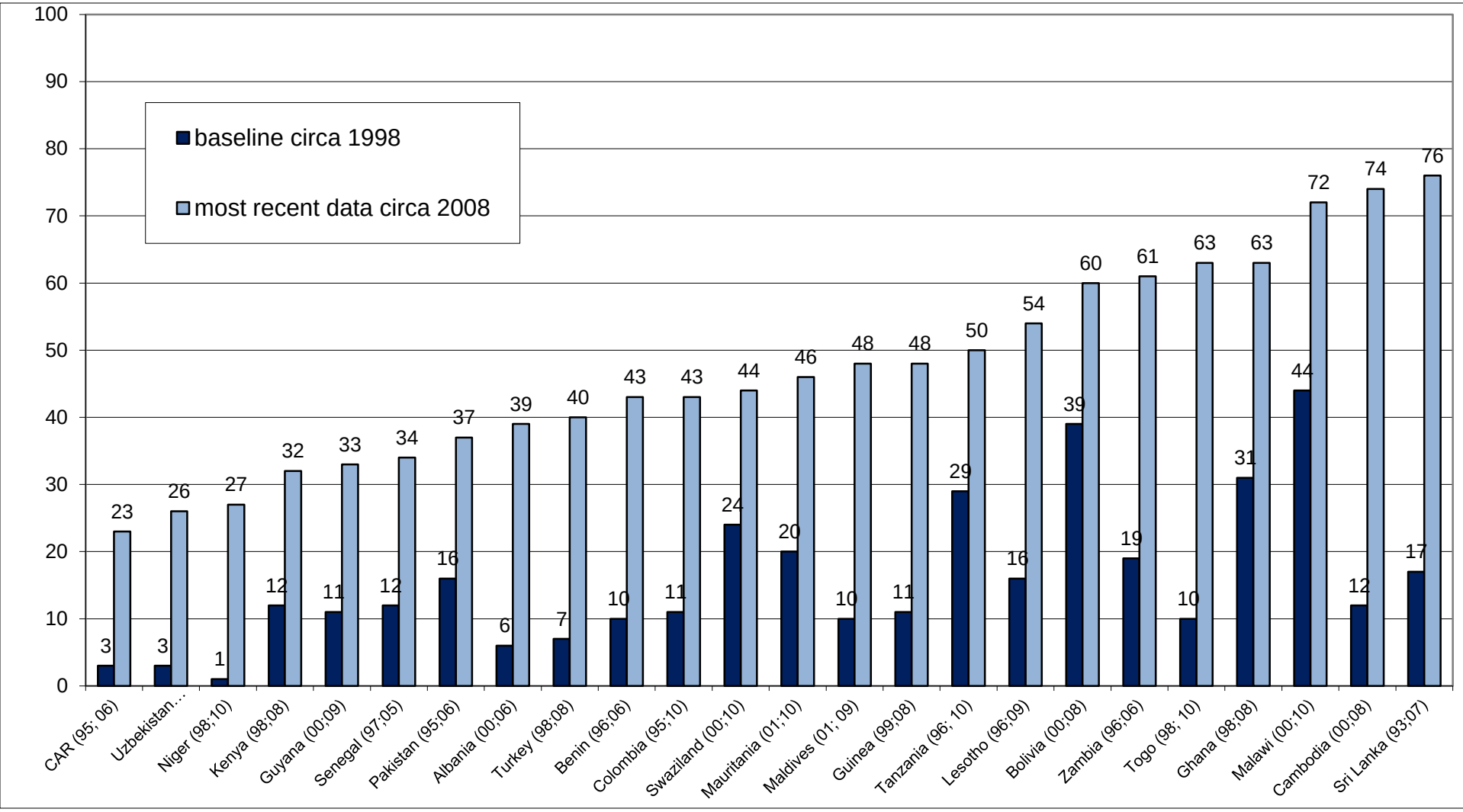
ADOLESCENCE → PREGNANCY	BIRTH	0-5 MONTHS	6-23 MONTHS	24-59 MONTHS
Improved availability, access and use of locally available foods	Kangaroo care	Maternity protection in the workplace	Hand washing with soap and improved water andsanitation practices	Hand washing with soap and improved water and sanitation practices
Increased access to primary and secondary education for girls	Support for birth registration an strengthening of civil-registration systems	Early childhood development: responsive care	Early childhood stimulation & education	Provision of healthy foods in schools
Adolescent health services that provide access to contracep-tives and care			Improved use of locally available foods for infants (improved food access and dietary diversification)	Nutrition and physical education in school
Promotion of hand washing with soap and improved water and sanitation practices			Deworming for children	Deworming for school-age children
Antenatal care, including HIV testing & deworming			Prevention and treatment of infectious disease	Prevention & treatment of infectious disease
Intermittent preventative treatment and promotion of insecticide-treated bed nets for pregnant women in highmalaria areas			Early childhood development: responsive care	Early childhood development: child to child & school readiness
Social protection and safety nets targeting vulnerable women				
Promotion of increased age at marriage and reduced gender discrimination and genderbased violence				
Parenting and life skills for early childhood development				

Nutrition interventions in the life cycle needed to reduce stunting and wasting and their coverage rates

Pregnancy	Iron & folic acid supplements Multi micronutrient supplementation Iodized salt Food supplements	- - 71% -
Birth	Initiation of breastfeeding within 1 hr (Colostrum)	43%
0-6 months	Exclusive breastfeeding Implementation of the Code on marketing of formula	37% 100 countries
6-24 months	Introduction of complementary feeding Continued Breastfeeding up to 1 yr Multi micronutrient supplementation Vitamin A supplementation (& de-worming) Zinc supplementation Treatment of severe malnutrition Treatment of moderate malnutrition Social safety net programmes	60% 75% 20 countries 66% - <10%* - -
24-60 months	Vitamin A supplementation (& de-worming) Treatment of severe malnutrition Treatment of moderate malnutrition Social safety net programmes	66% <10%* - -

Developing country data based on SOWC 2012; * based on estimation

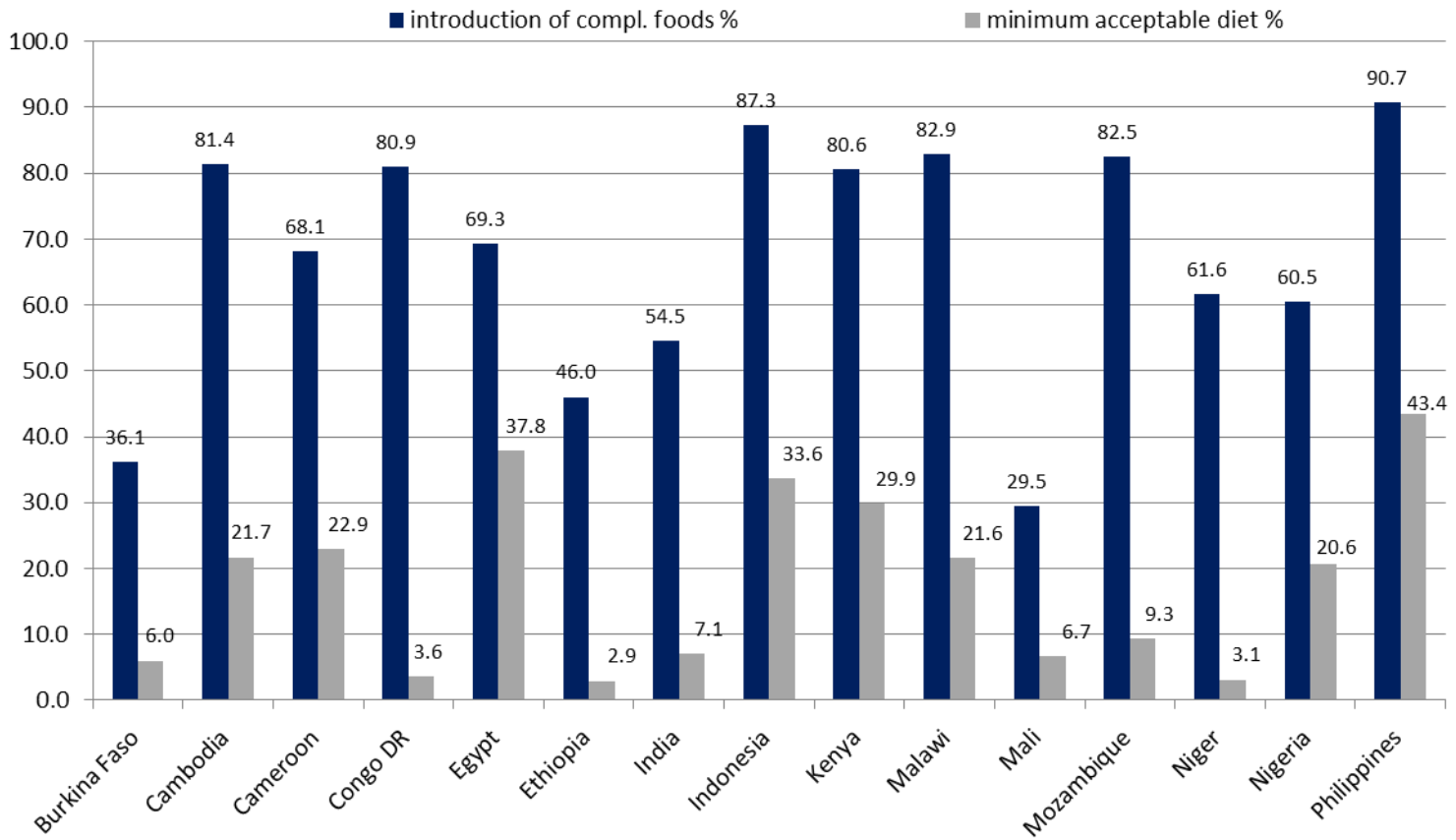
24 countries with increases in exclusive breastfeeding > 20 percentage points



Source: UNICEF database 2011. The baseline is defined as between circa 1998 (1995-2001) and circa 2008 (2005-2011)

Status of complementary feeding

Select countries with data on “minimum acceptable diet” (breastfed, 6-23 m), and “introduction of complementary foods” (6-8m old, BF & non BF children)



Can it be done?

Stunting reduction at scale:

presence of community based systems

- Ethiopia: between 2005 and 2010 stunting reduced from 52.2% to 44.4% (DHS)
- Nepal: between 2006 and 2011 stunting decreased from 49% to 41% (Nepal DHS)
- Rwanda: between 2005 and 2010 stunting reduced from 51% to 44% (DHS).
- Peru: 54% to 37% from 2000 to 2004 (subnational among 75000 children).

1	**40% REDUCTION in the number of children under 5 who are stunted**
2	**50% REDUCTION in anaemia in women of reproductive age**
3	**30% REDUCTION in low birthweight**
4	**NO INCREASE in childhood overweight**
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