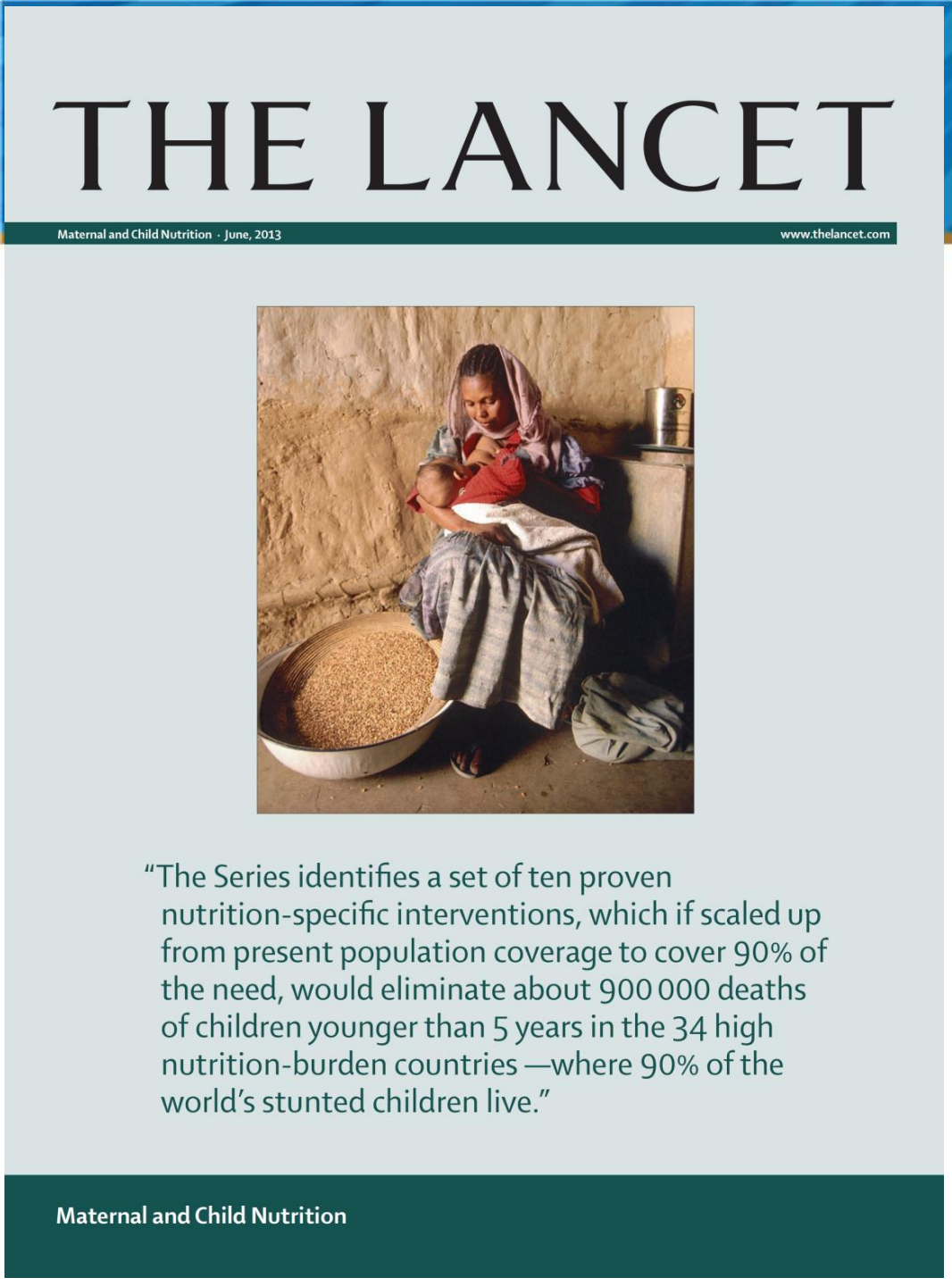
Nutrition-Specific Actions

Multi-Sectoral Nutrition Strategy
Global Learning and Evidence Exchange Workshop
January 19, 2016
Accra, Ghana

Fred Grant, Regional Nutrition Advisor
Helen Keller International, Africa Regional Office

2013



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165 million children <5 yr are stunted

Undernutrition responsible for 45% of all <5 yr child deaths

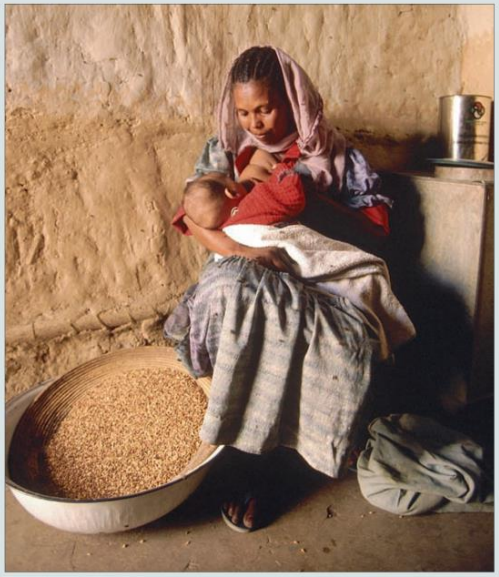
UNDERNUTRITION CAUSES 45% OF CHILD DEATHS RESULTING IN 3.1 MILLION DEATHS/YR

Nutritional Disorders	Attributable deaths with UN prevalences*	Proportion of total deaths of children younger than 5 years
Fetal growth restriction (<1 month)		
Stunting (1-59 months)		
Underweight (1-59 months)		
Wasting (1-59 months) Severe Wasting (1-59 months)		
Zinc deficiency (12-59 months)		
Vitamin A deficiency (6-59 months)		
Suboptimum breastfeeding (0-23 months)		
Joint effects of fetal growth restriction and suboptimum breastfeeding in neonates		
Joint effects of fetal growth restriction, suboptimum breastfeeding, stunting, wasting, and vitamin A and zinc deficiencies (<5 years)		

Data are to the nearest thousand. *Prevalence estimates from the UN.

Black R et al, Lancet, 2013

Current evidence & ***modeling*** of impacts 10 interventions @ 90% coverage can reduce stunting by at least 20% (range 11%-29%)



What about the remaining 80% of stunting?

2013

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PROVEN PACKAGES OF NUTRITION INTERVENTIONS

Optimal maternal nutrition during pregnancy

- Maternal multiple micronutrient supplements to all
- Calcium supplementation to mothers at-risk of low intake[3]
- Maternal balanced energy protein supplements as needed
- Universal salt iodization

Spoiler alert: Breastfeeding is still in!

Infant and young child feeding

- Promotion of early, exclusive breastfeeding for 6 months; continued breastfeeding until 24 months
- Appropriate complementary feeding education in food secure populations and additional complementary food supplements in food insecure populations

Micronutrient supplementation in children at risk

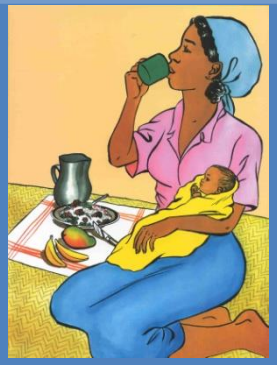
- Vitamin A supplementation between 6-59 months age
- Preventive zinc supplements between 12-59 months of age

Management of acute malnutrition

- Supplementary feeding for moderate acute malnutrition
- Management of severe acute malnutrition

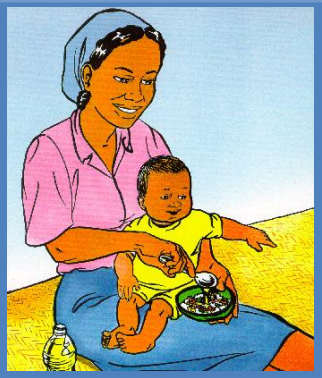
PROVEN ESSENTIAL NUTRITION ACTIONS

Women's Nutrition

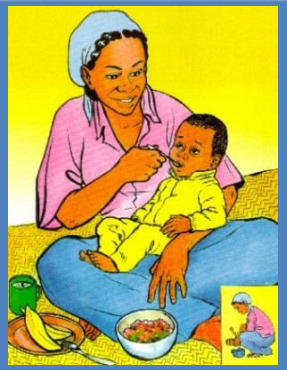


Breastfeeding

Complementary Feeding



Feeding of sick children



Integrated Control of Anemia

Control of Vitamin A deficiency

SEL IODE

SIRA MISY IODA

Control of Iodine Deficiency Disorders

DELIVERING ENA-EHA

- **Agreement on the "what" (Essential Actions)**
- **Challenge is the "how"**
- **ENA Framework:**
  - Life Cycle approach
  - Integration to avoid missed opportunities
  - Harmonized approaches, messages, tools, and tunes
  - SBCC
  - Capacity building
  - Coverage and scale

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CRITICAL LIFE-CYCLE CONTACT POINTS

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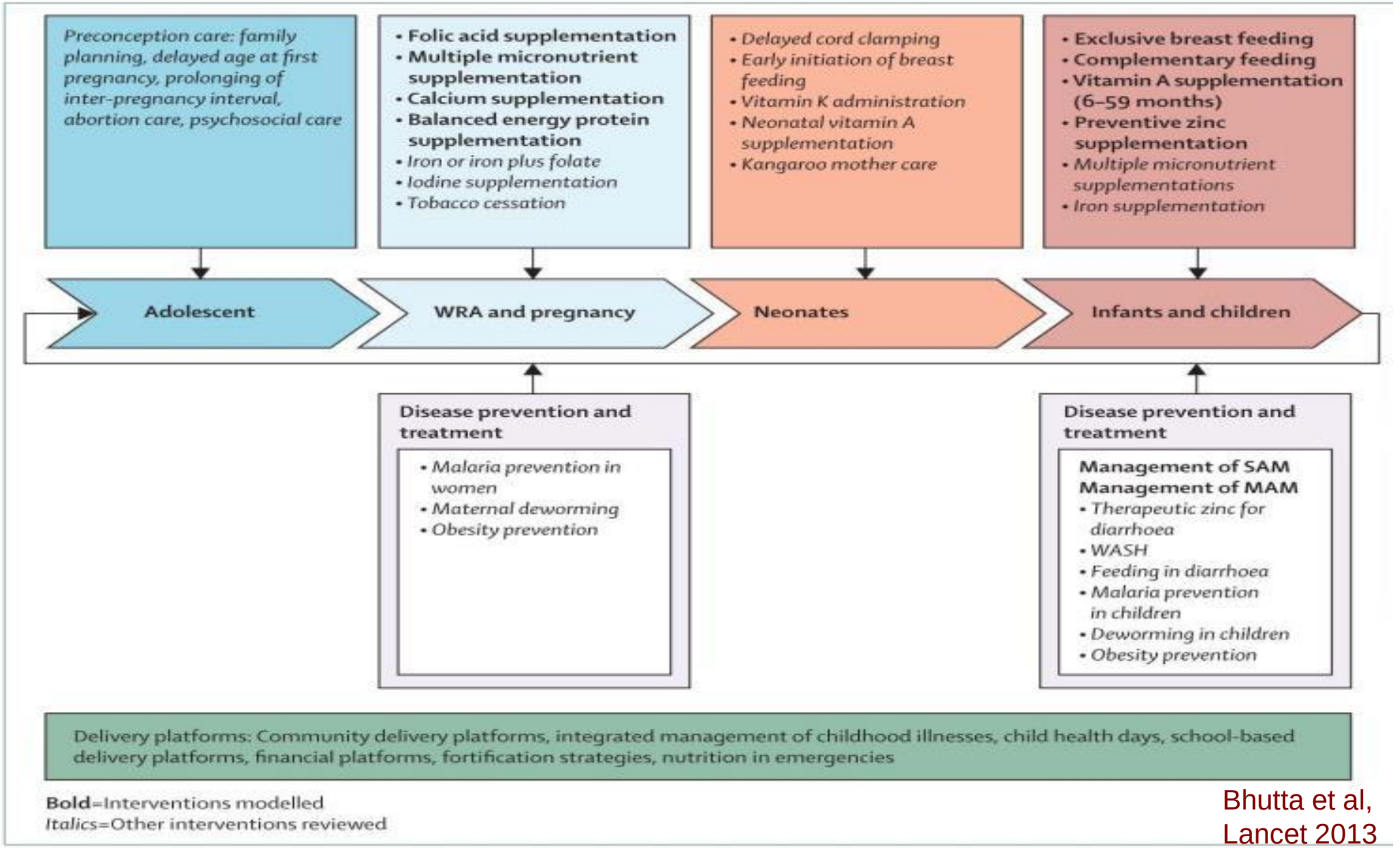
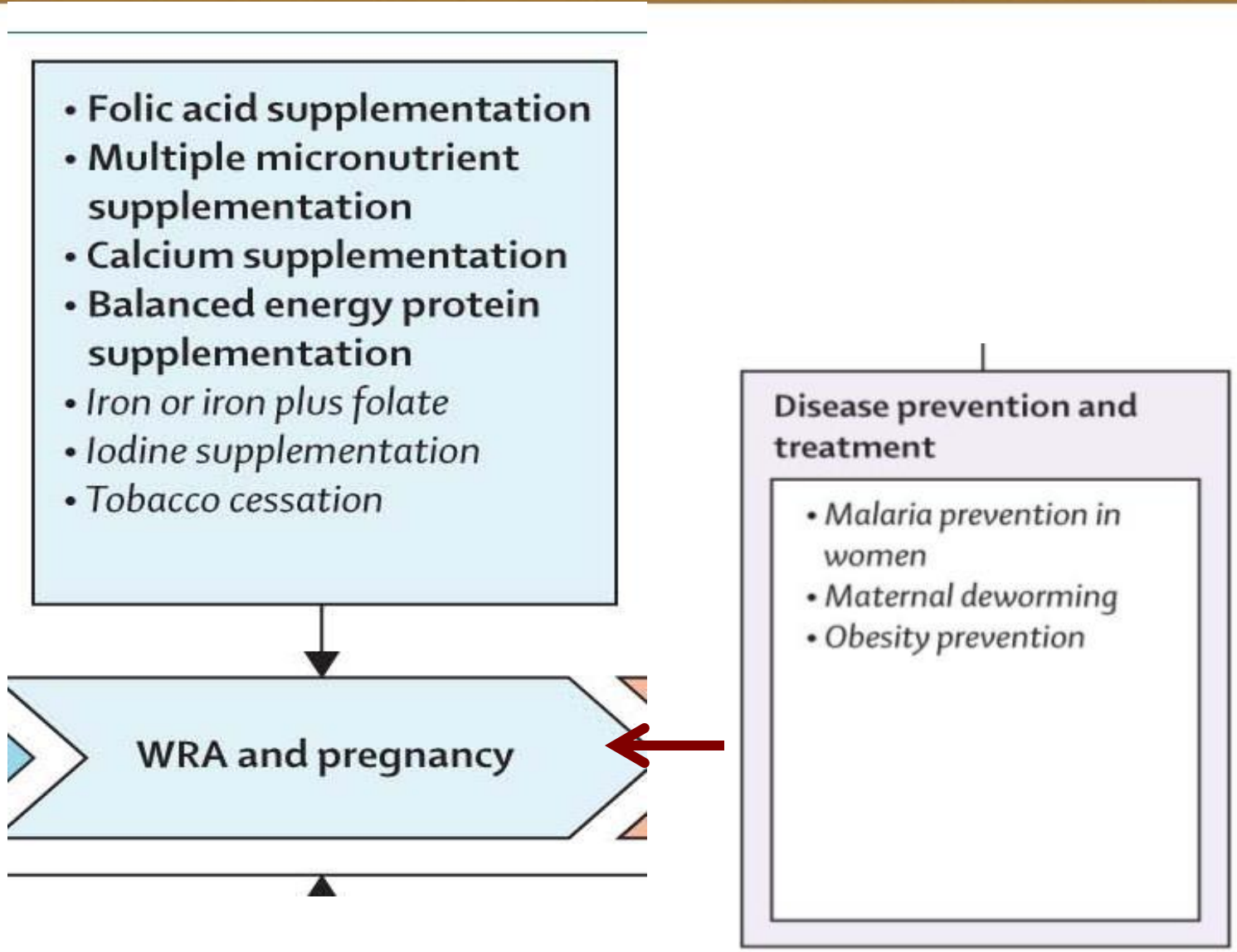
- ✓ *pre-pregnancy and adolescence*
- ✓ *during pregnancy & lactation*
- ✓ *at birth*
- ✓ *during post-natal period*
- ✓ *from 0-6 months*
- ✓ *from 6-24 months*

PROVIDING THE RIGHT SUPPORT AT THE RIGHT TIME TO THE RIGHT PERSON



Bhutta et al, Lancet 2013

INTERVENTIONS ACROSS THE LIFECYCLE

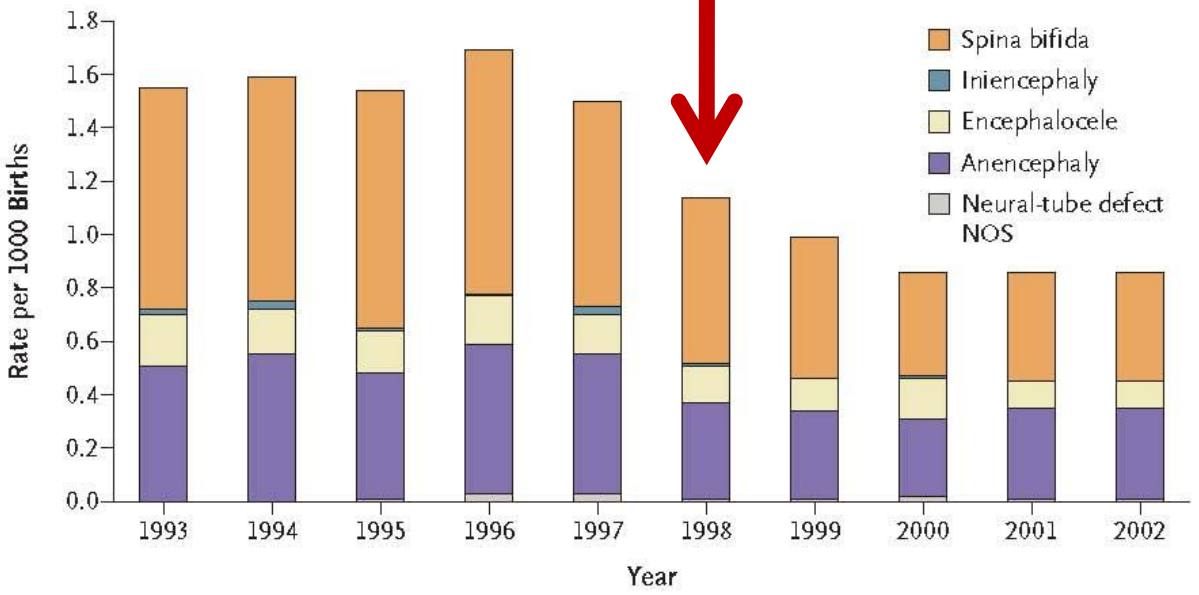


Bhutta et al, Lancet 2013

46% REDUCTION IN NEURAL-TUBE DEFECTS AFTER FOLIC ACID FORTIFICATION IN CANADA

Mandatory fortification of cereals with folic acid

Spina Bifida



All neural-tube defects	1.55	1.59	1.55	1.69	1.50	1.14	0.99	0.86	0.86	0.86
Spina bifida	0.83	0.84	0.89	0.91	0.77	0.62	0.53	0.39	0.41	0.41
Iniencephaly	0.02	0.03	0.01	0.01	0.03	0.01	0.00	0.01	0.00	0.00
Encephalocele	0.19	0.17	0.16	0.18	0.15	0.14	0.12	0.15	0.10	0.10
Anencephaly	0.51	0.55	0.47	0.56	0.52	0.36	0.33	0.29	0.34	0.34
Neural-tube defect NOS	0.00	0.00	0.01	0.03	0.03	0.01	0.01	0.02	0.01	0.01

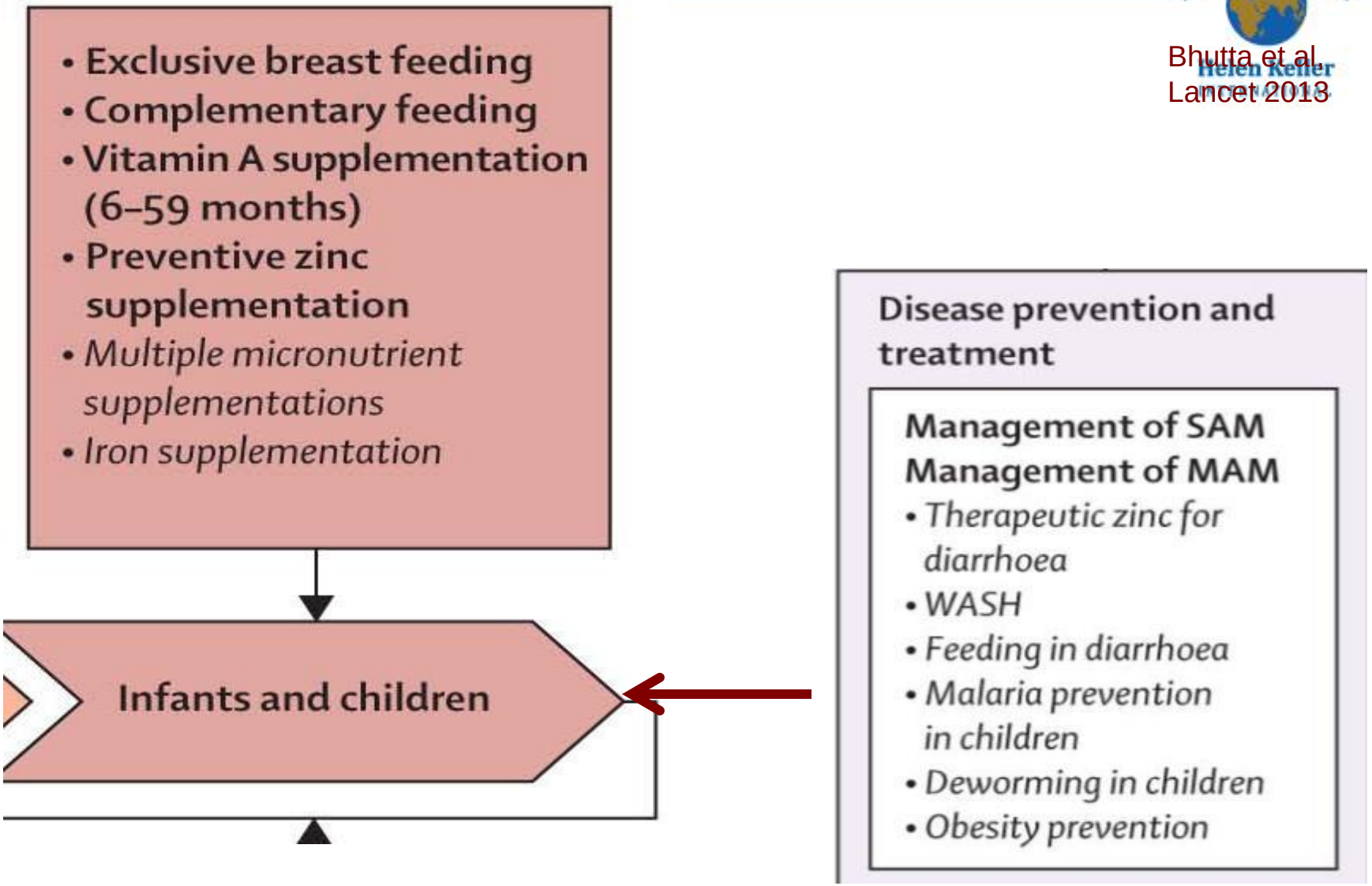
Figure 1. Prevalence of Neural-Tube Defects, According to Diagnostic Category, in Seven Canadian Provinces from 1993 through 2002.

NOS denotes not otherwise specified.

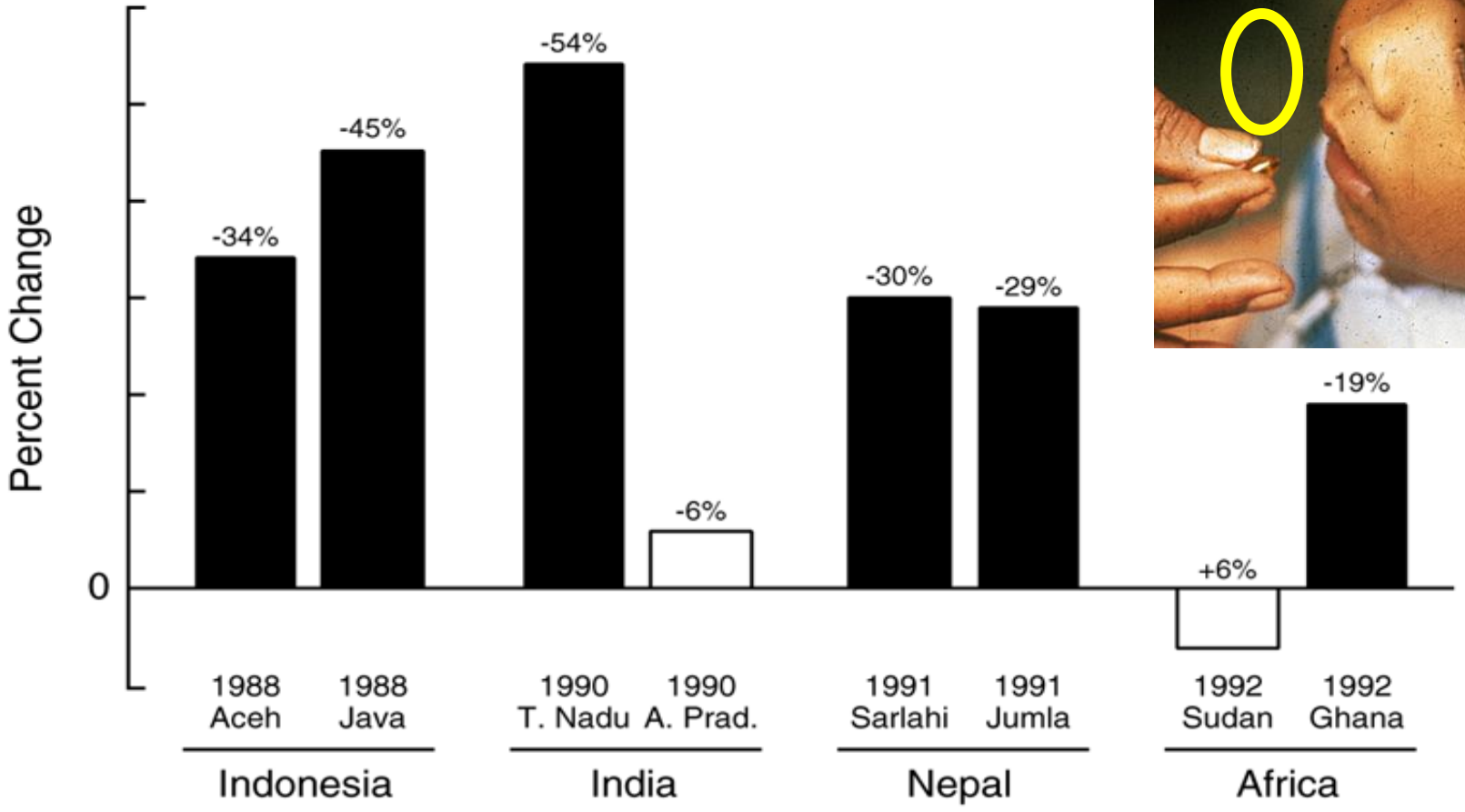
De Wals, NEJM, 2007

INTERVENTIONS ACROSS THE LIFECYCLE

Bhutta et al. Lancet 2013

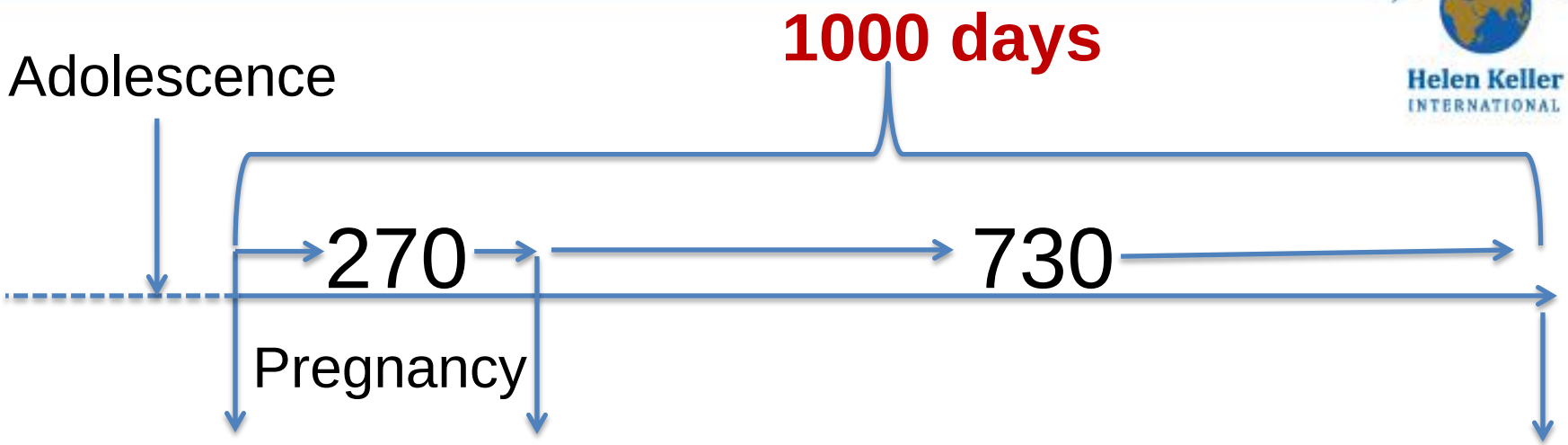


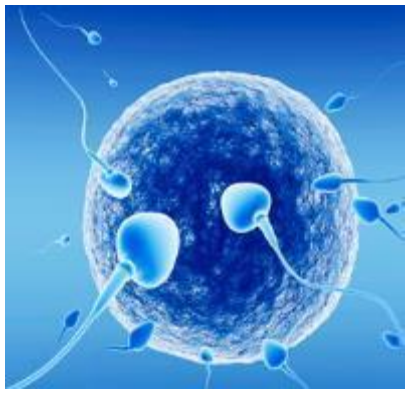
VITAMIN A SUPPLEMENTATION TO REDUCE CHILD MORTALITY



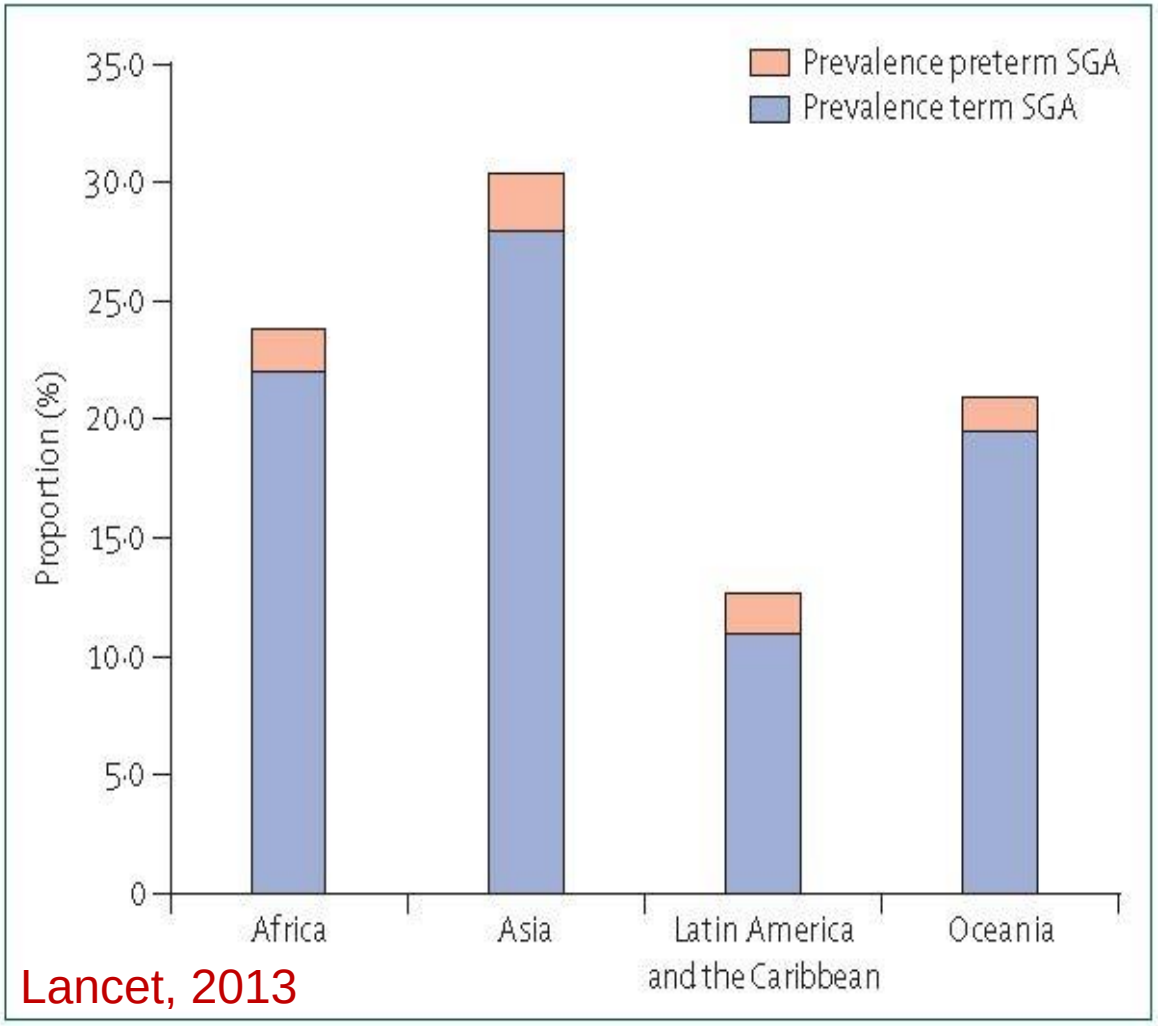
Sommer & West, 1996

FIRST 1000 DAYS OR LAST 730 DAYS?





SMALL-FOR-GESTATIONAL AGE



Lancet, 2013

- 3x ↑ risk of neonatal death
- 2x ↑ risk of post-neonatal death
- 11.8% of death<5 y
- 4.5x ↑ of stunting
- Responsible for ~20% of childhood stunting

DELIVERING ENA-EHA

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MISSED OPPORTUNITIES TO INTEGRATE NUTRITION SUPPORT INTO HEALTH SYSTEMS

Public Health Nutrition 7(8), 1047–1053 DOI: 10.1079/PHN2004641

Delivery of nutrition services in health systems in sub-Saharan Africa: opportunities in Burkina Faso, Mozambique and Niger

Rachel D Hampshire[1,*], Victor M Aguayo[2], Hamani Harouna[3], Julie A Roley[4], Ann Tarini[1] and Shawn K Baker[5]

[1]Helen Keller International, BP 8150 Ouagadougou 04, Burkina Faso: [2]UNICEF Regional Office for West and Central Africa, BP 29720, Dakar, Senegal: [3]HKI/Niger: [4]HKI/Mozambique: [5]HKI Africa Region

Submitted 18 August 2003: Accepted 21 May 2004

Abstract

Background: In sub-Saharan Africa, underweight and micronutrient deficiencies account for an estimated 25% of the burden of disease. As the coverage of national health systems expands, increased opportunities exist to address the needs of children and women, the most vulnerable to these deficiencies, through high-quality nutrition services.

Objectives: To assess health providers' knowledge and practice with regard to essential nutrition services for women and children in Burkina Faso, Mozambique and Niger, in order to assist the development of a standard guide and tools to assess and monitor the quality of the nutrition services delivered through national health

MISSED OPPORTUNITIES TO INTEGRATE NUTRITION SUPPORT INTO HEALTH SYSTEMS

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Ante-Natal Contacts:

- In Niger and Burkina, only 38% and 14% of women observed at consultations received counseling on pregnancy related dietary improvement

Well-child Contacts:

- In Niger, all children were weighed but only 62% of their caregivers were asked/or counselled about feeding practices

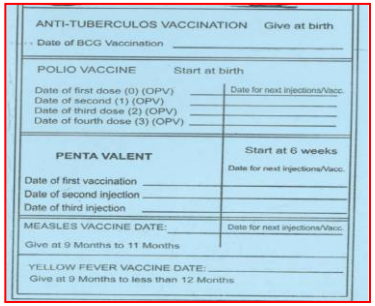
- In Mozambique, while 87% of new mothers received counseling on breastfeeding, only 8% were advised to breastfeed exclusively

ENA FRAMEWORK – HEALTH SECTOR CONTACT POINTS TO PROVIDE NUTRITION SUPPORT

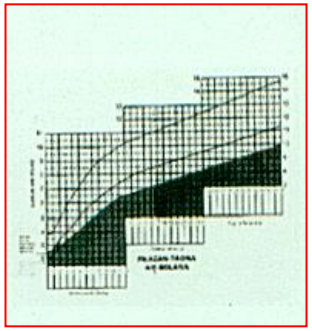
PREGNANCY : TT, antenatal visits, FP, STI prevention, safe delivery, VCT, Options, safe sex, danger signs, Prepare for breastfeeding (BF), iodized salt, iron/folic acid, de-worming, anti-malarials, ITNs, diet

DELIVERY: safe delivery, FP, STI prevention, Optimal delivery, ARVs, Delay cord clamping. Early initiation of BF, vitamin A, iron/folic acid, diet

POSTNATAL AND FAMILY PLANNING: FP, STI prevention, child's vaccination, VCT, safe sex, support optimal BF, diet, iron/folic acid



IMMUNIZATION: vaccinations, FP, and STI referral, VCT, safe sex, support optimal infant and young child feeding (IYCF), vitamin A, de-worming, assess and treat infant's anemia



WELL CHILD AND GMP: check and complete vaccination, VCT, safe sex, monitor growth, assess and counsel on IYCF, iodized salt

SICK/MALNOURISHED CHILD: assess and treat per IMCI, /immunization/ VCT, manage MAM/SAM, counsel on IYCF, assess and treat for anemia, check and complete vitamin A, de-worming, ITNs

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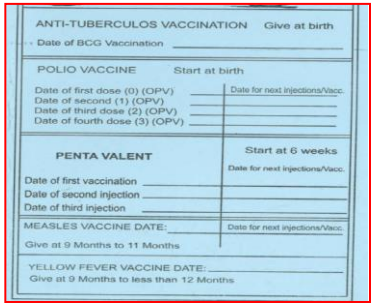

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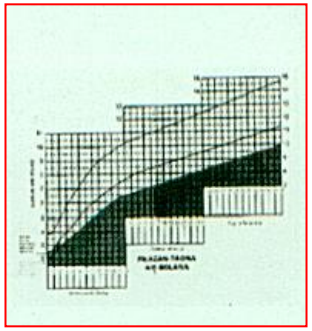

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REDUCING MISSED OPPORTUNITIES: INTEGRATE INTO RELEVANT SECTORS

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REDUCING MISSED OPPORTUNITIES: INTEGRATE INTO RELEVANT SECTORS

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- Nutrition Programs
- Child survival programs
- Neonatal
- Reproductive health
- Infectious diseases

Within the health sector

REDUCING MISSED OPPORTUNITIES: INTEGRATE INTO RELEVANT SECTORS

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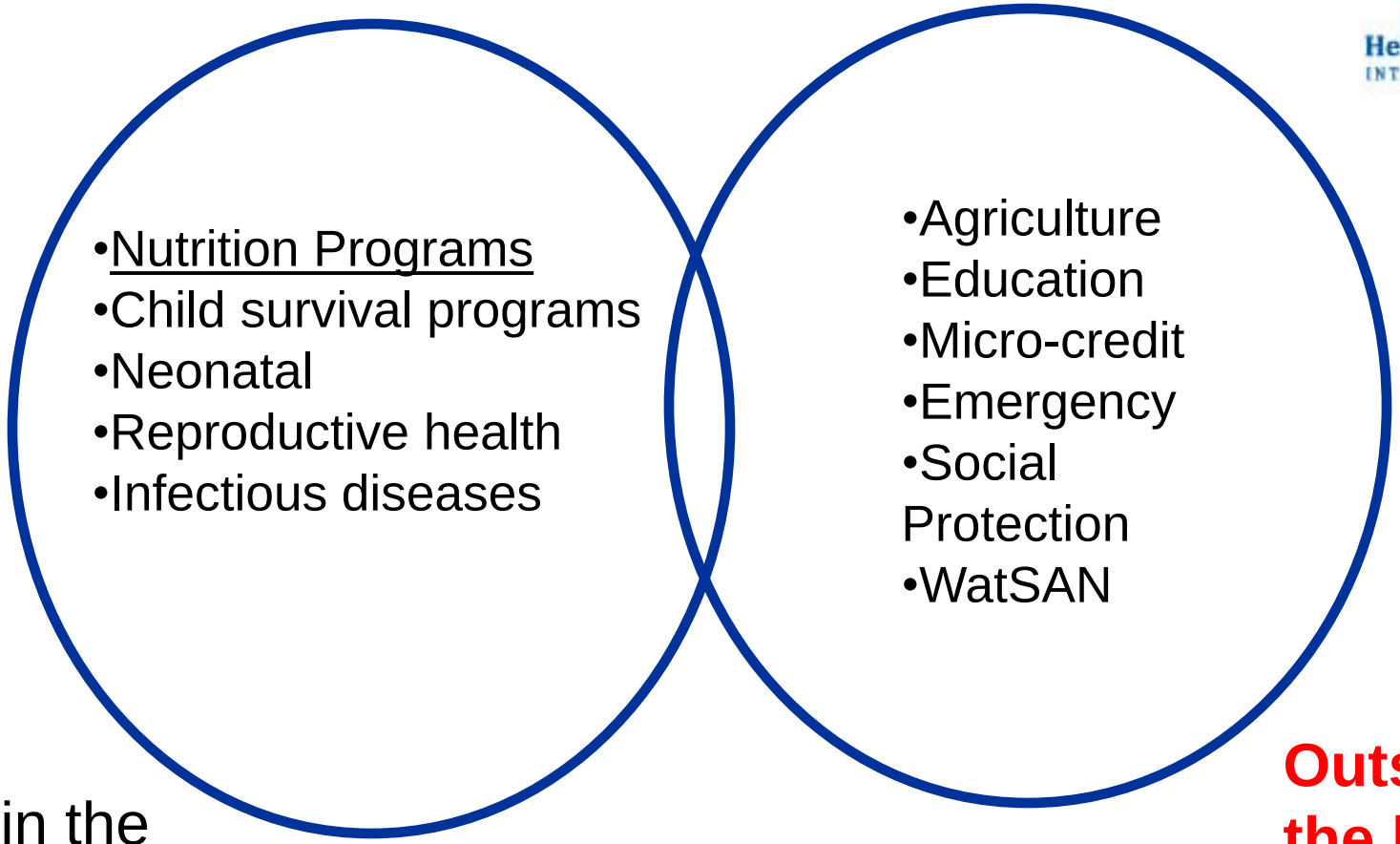

Within the health sector

Outside the health sector

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BUILD ON WHAT ALREADY EXISTS USING CURRENT PROGRAMS AND SYSTEMS

- Existing services & interventions

- Existing people

- Existing community groups and structures to the extent possible

HARMONIZE EXISTING FIELD PROGRAMS

Strive for h

All partners singing the same nutrition song from the same music sheet!

ers together – team
nical up-dates, training of their trainers…

TRUE COORDINATION OR "LOGO SOUP"?

Scaling Up Nutrition

A FRAMEWORK FOR ACTION

This policy brief was prepared with financial support from the Bill and Melinda Gates Foundation, the Government of Japan, UNICEF and the World Bank. It is based on a series of consultations hosted by the Center for Global Development, the European Commission, the International Congress of Nutrition (ICN), United Nations Standing Committee on Nutrition (SCN), USAID, UNICEF, WHO and the World Bank. Many developing country partners, CSOs, bilateral partners, UN and multilateral agencies have contributed to this effort.

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MULTI-CHANNEL SBCC

- Reinforce ENA messages through social & behavior change communications at all levels, promoting simple “do-able” actions, using inter-personal communication, mass media and community mobilization

#BreastfedEarlyAdopters

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CAPACITY BUILDING IN ENA

Customized ENA training targeted to:

- Health workers (gov't & NGOs)
- Community volunteers (less literate)

Integrated training

- avoid "technical silos"

Short-term, skills-based focus

Heavy on counseling/negotiation skills

Lots of practice with real mothers

GENERIC ENA BEHAVIOR CHANGE TRAINING

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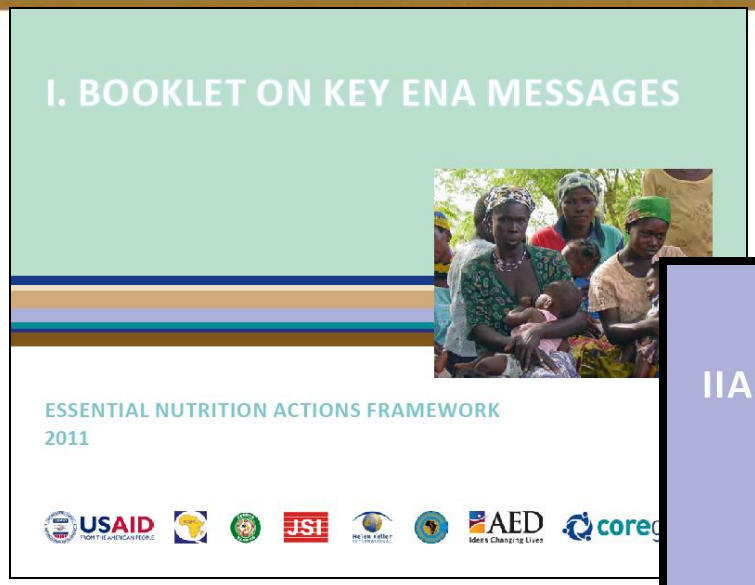
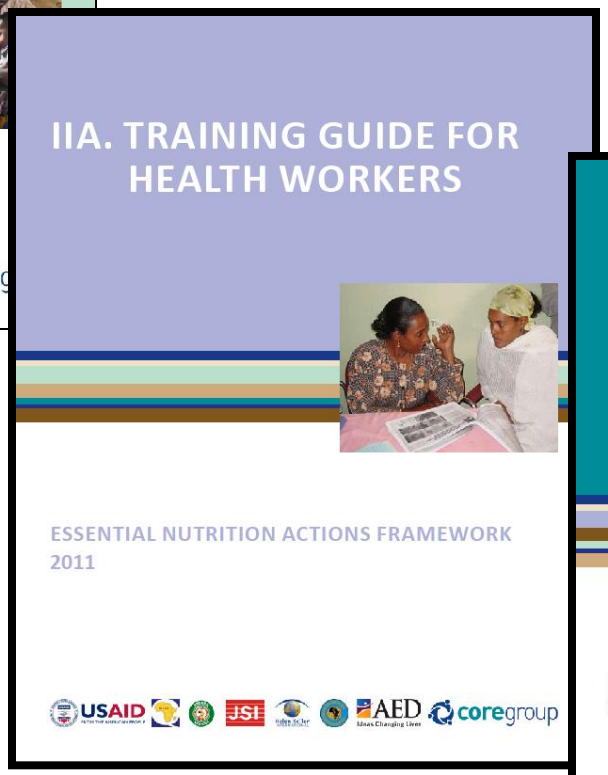
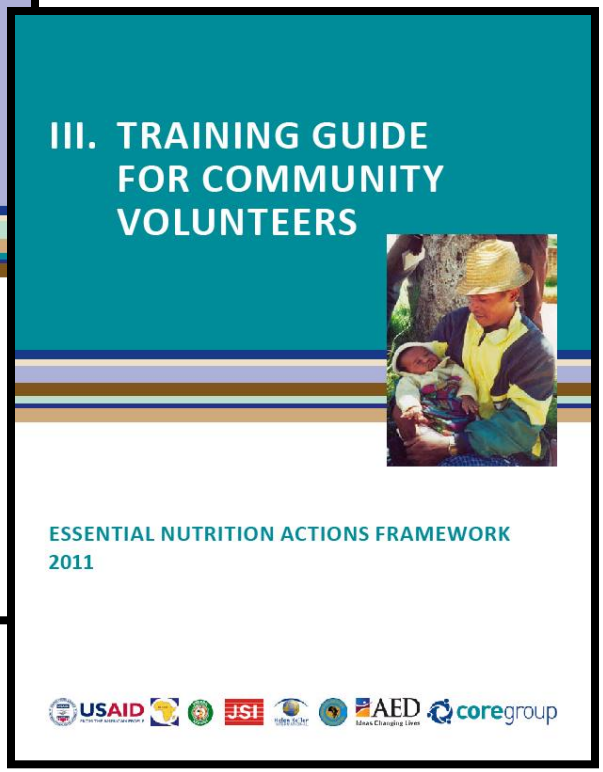
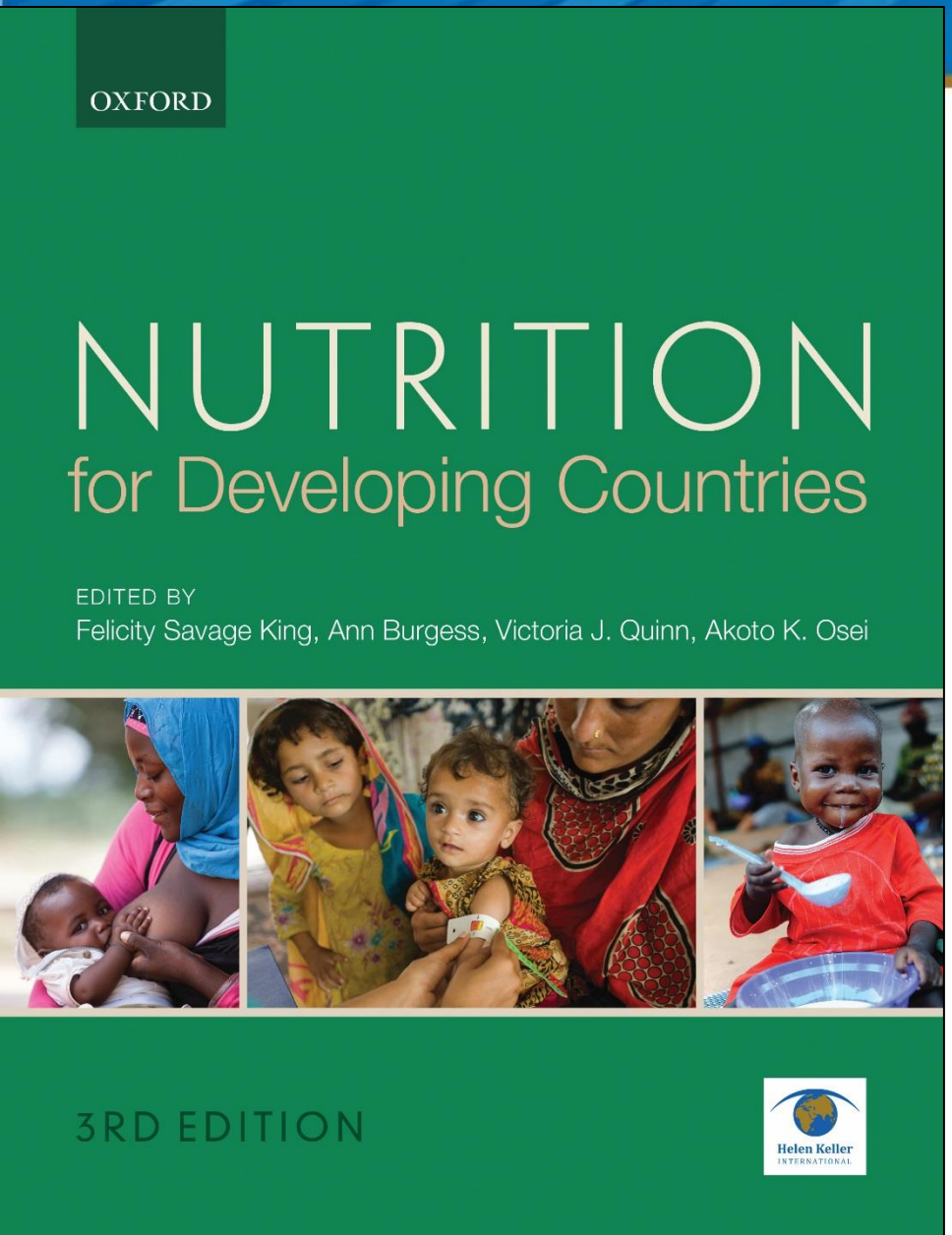






The Core Group
http://www.coregroup.org/resources/core-tools



Helen Keller
INTERNATIONAL

Brand new 3rd edition!

Focuses on Africa but also includes South Asia for first time

Targets nutrition and health workers

Very practical

Just released

French and online versions coming soon

NUTRITION CAPACITY DEVELOPMENT

Consensus that:

- There is a need to accelerate progress for nutrition in West Africa
- A major initiative is required to develop the needed capacity to accelerate progress for nutrition in the region

THE WEST AFRICAN NUTRITION CAPACITY DEVELOPMENT INITIATIVE

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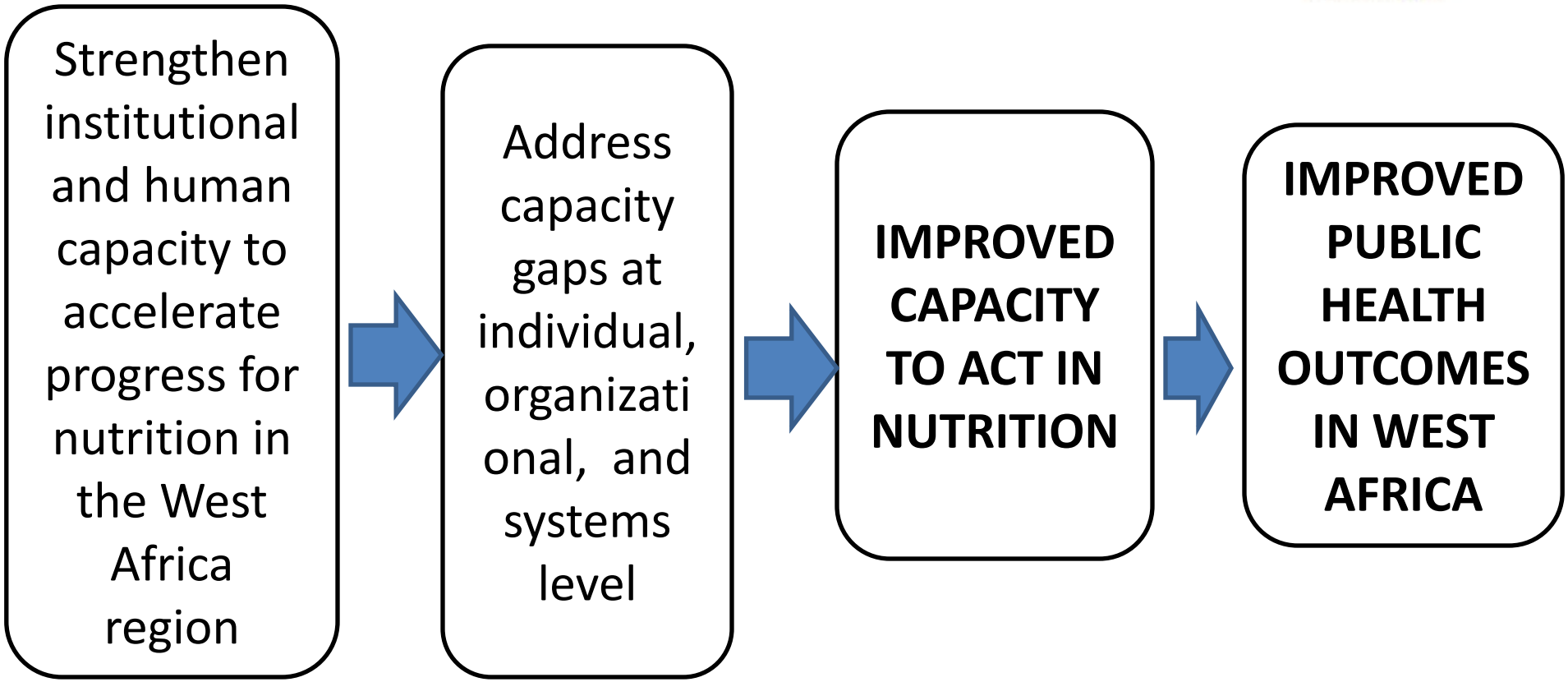
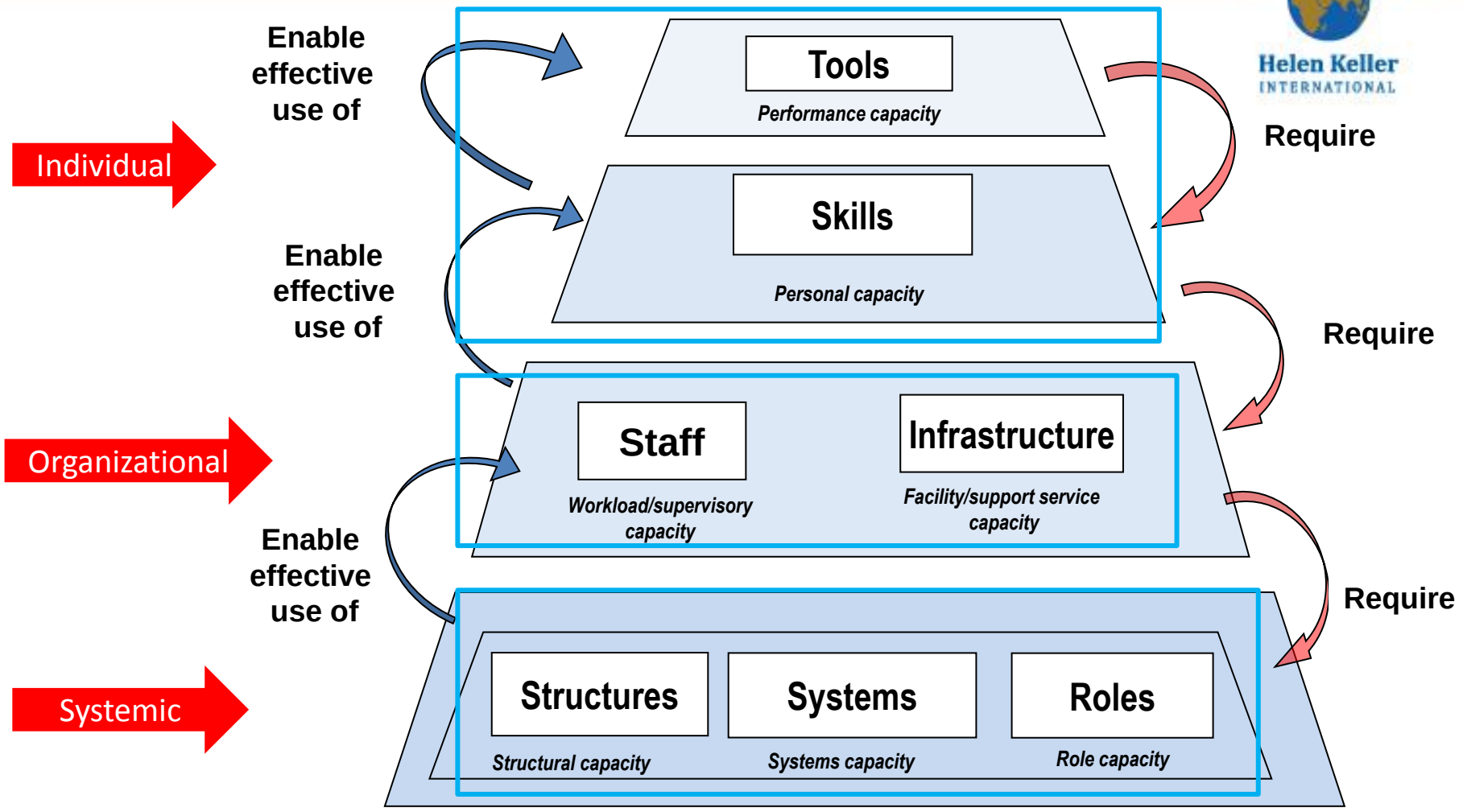


Build on existing capacities

NUTRITION CAPACITY ASSESSMENT



Potter, C., and R. Brough. 2004. Systemic Capacity Building: A Hierarchy of Needs. *Health Policy and Planning. 19(5): 336-345.*

SUMMARY OF EXISTING CAPACITY GAPS

LEVELS OF CAPACITY		
INDIVIDUAL (skills)	**ORGANIZATONAL**	**SYSTEMS**
• Lack of pre-service and in-service training • In-service training- mainly on CMAM • Didactic training • Focus on food science • Training curricula not aligned to regional nutrition priorities • Lack of uniformity in training curricula within/between countries • Shortage of faculty	• Critical shortage of HR for nutrition • Limited capacity to support the expansion of a nutrition workforce • High staff turnover • Nutrition roles and tasks not well-defined in job descriptions • No minimum standard to qualify as a nutritionist • Lack of equipment and infrastructure	• Lack of institutional capacity to design and implement nutrition programs that responds to the multi-sectoral dimensions of nutrition problems • Limited capacity for multisectoral coordination of nutrition programs • Inadequate nutrition information systems

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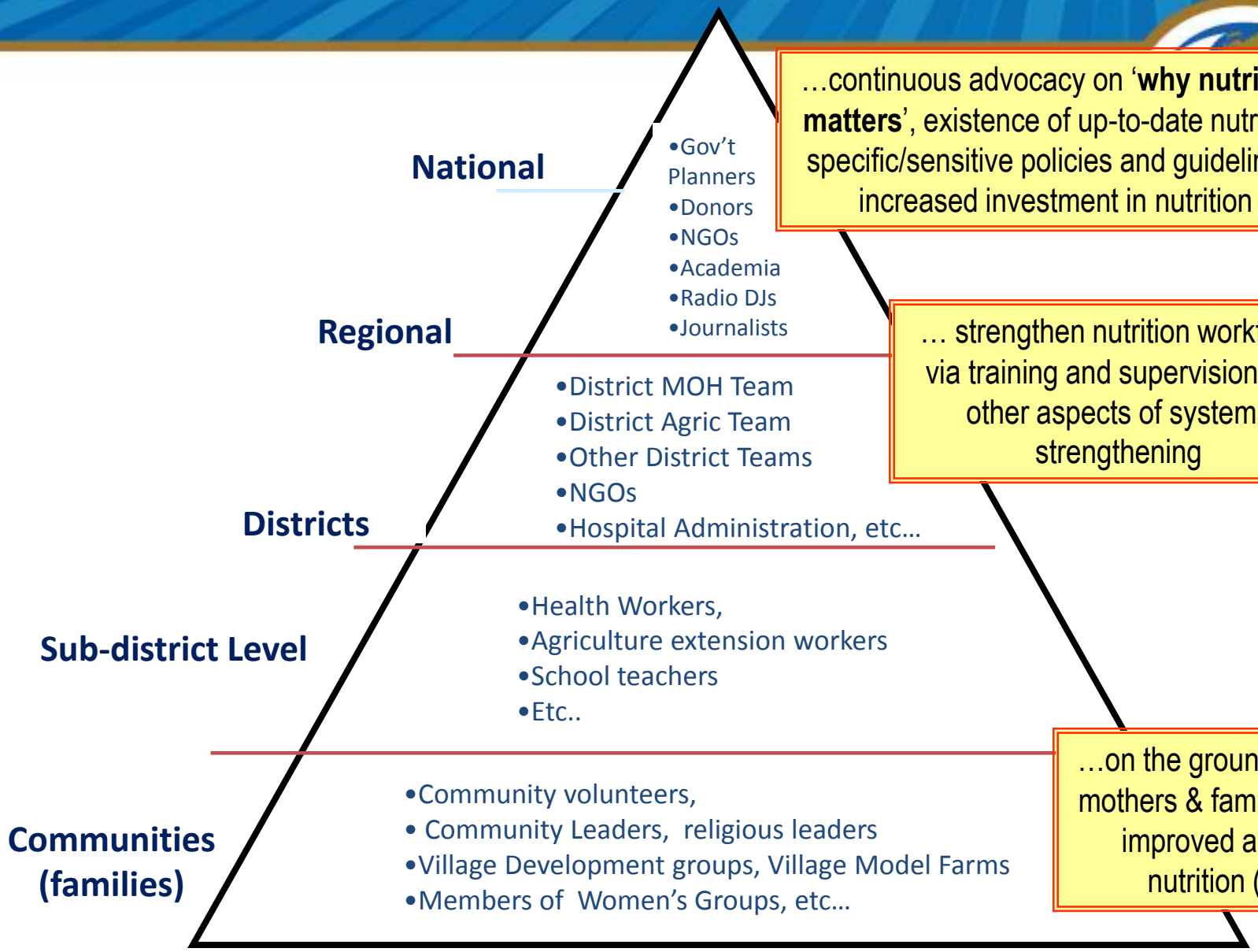
ENA - SCALE

Health Agriculture Education Finance Trade



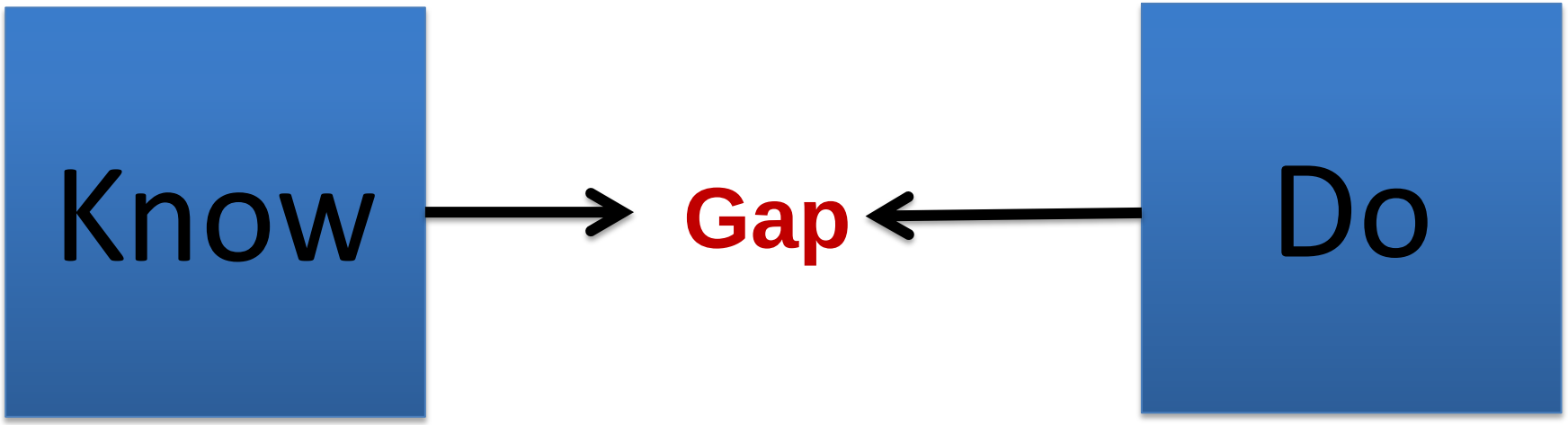
…continuous advocacy on '**why nutrition matters**', existence of up-to-date nutrition specific/sensitive policies and guidelines; increased investment in nutrition

… strengthen nutrition workforce via training and supervision and other aspects of systems strengthening

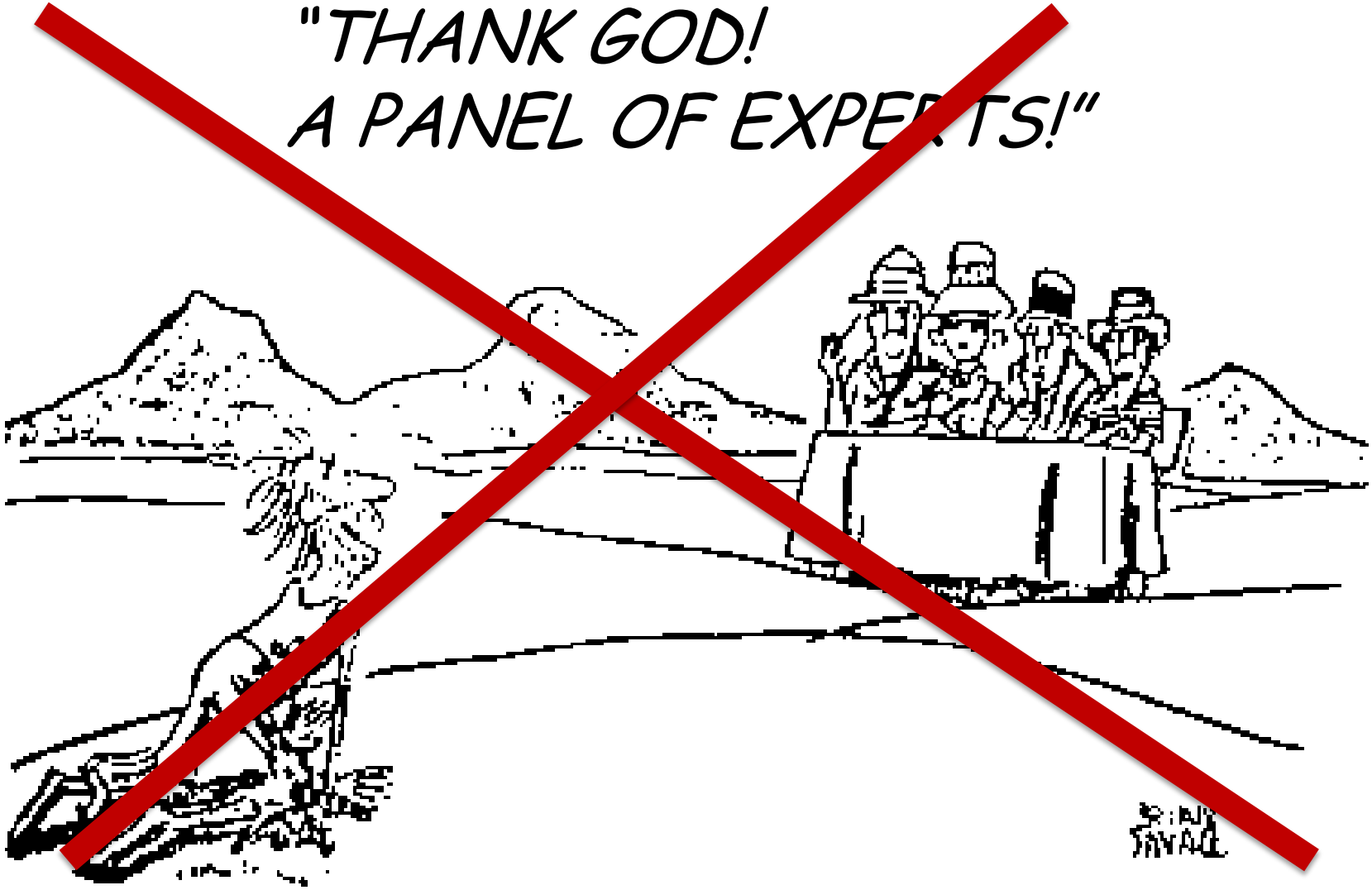
…on the ground support to mothers & families to adopt improved actions on nutrition (ENAs)

CLOSING THE "KNOW-DO" GAP

Strengthen capacity to use "**implementation science**" methods to generate evidence on how to take efficacious interventions to scale



GOING TO SCALE: HOW TO CLOSE THE KNOW-DO GAP?



TANAHASHI FRAMEWORK FOR EFFECTIVE COVERAGE

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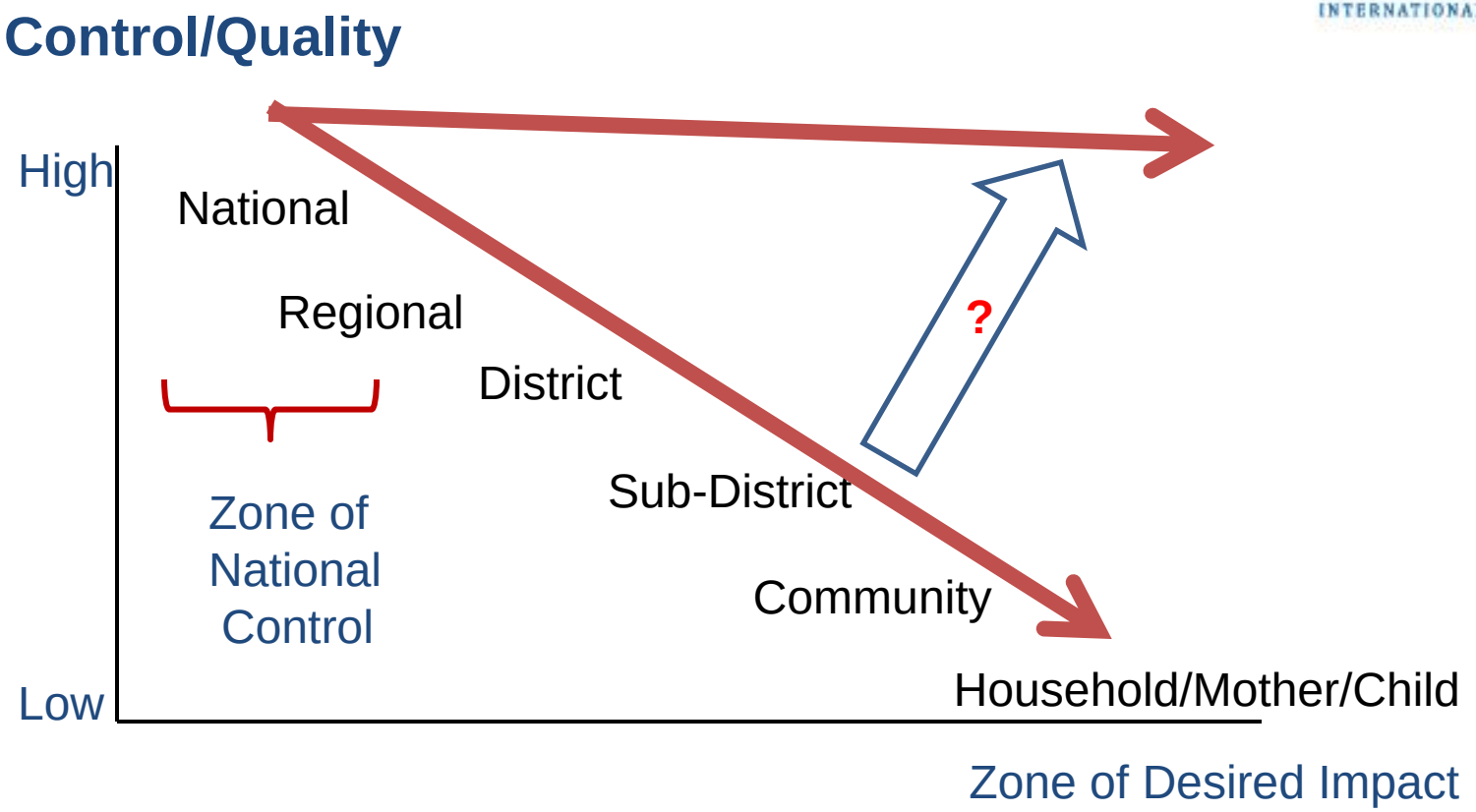
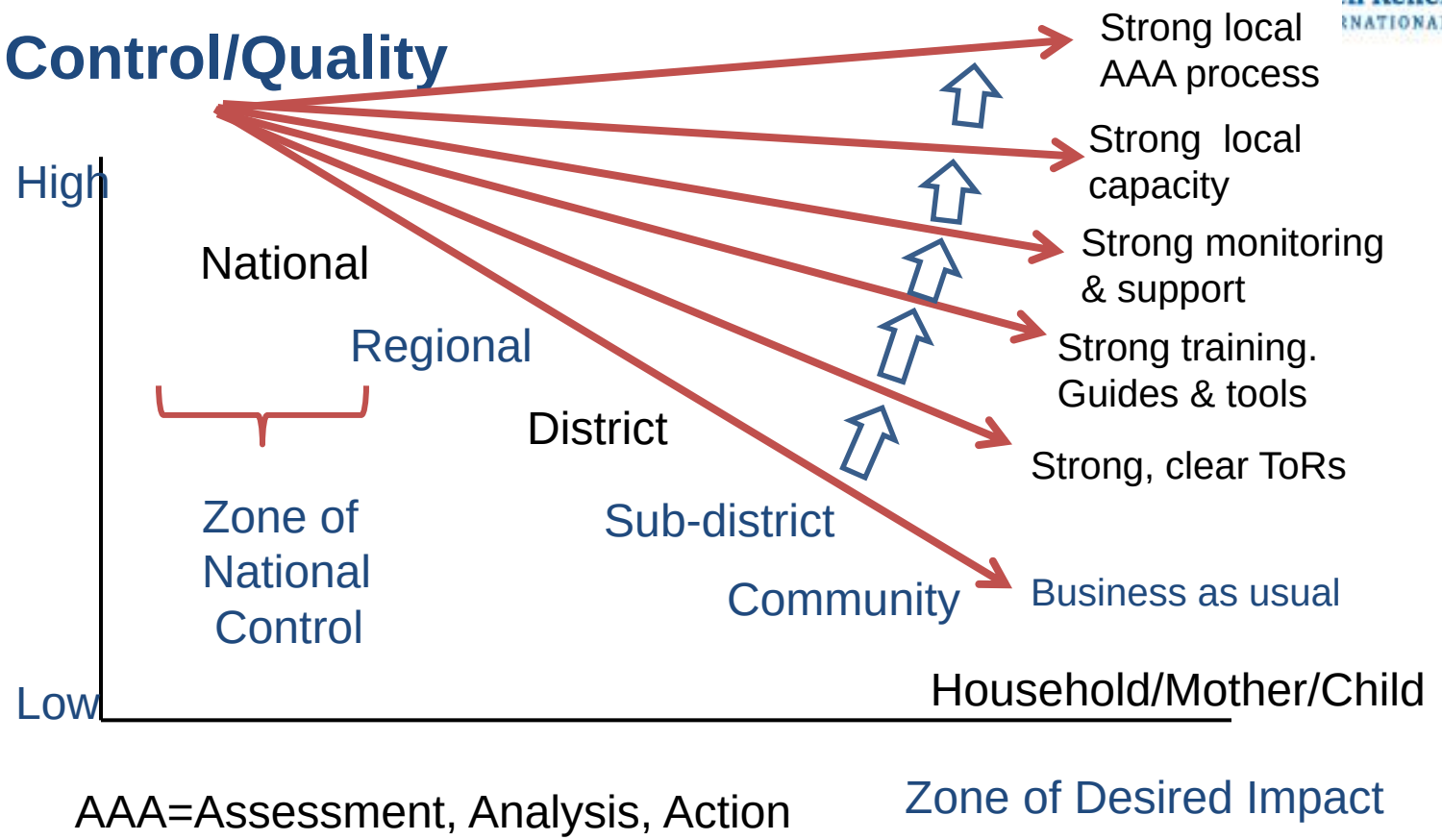
IMPLEMENTATION: THE "VOLTAGE DROP"



PREVENTING THE VOLTAGE DROP



AAA=Assessment, Analysis, Action

Helen Keller
INTERNATIONAL

THANK YOU

"Alone we can do so little; together we can do so much."

- Helen Keller