

Child undernutrition: Where are we now?

In 2005 in developing countries 32% of children under 5 years of age, or 178 million children, were estimated to be stunted, i.e. their height fell -2 standard deviations below the median height-for-age of the reference population.

More than 40% of that stunting occurred in Africa and Southeast Asia, around 25% in the eastern Mediterranean region, and 10 - 15% in the Americas and Western Pacific. Of the 39 countries with a prevalence of stunting of 40% and higher, 22 countries were in the African region.

These were among the statistics presented by the World Health Organization (WHO) in its World Health Statistics 2007.

Wasting was a strong predictor of mortality among children and was found to occur in 10%, or 55 million children under 5 years of age, based on the WHO's new standards. In this case the highest number of affected children (29 million) was estimated to live in south central Asia.

A similar regional pattern was found for severe wasting, i.e. being -3 standard deviations below the median, with an estimated total prevalence of 4%, or 19 million children affected.

Innovative approach to tackle malnutrition

Subsequent to the release of the above figures the WHO reported that an innovative approach combining community-based care with traditional hospital-based treatment is showing progress in addressing severe acute malnutrition in children under 5 years.

According to the WHO, in a statement released in conjunction with the World Food Programme

(WFP), the United Nations Standing Committee on Nutrition (SCN) and UNICEF, there is new evidence that about three-quarters of children with severe acute malnutrition, i.e. those who have a good appetite and no medical complications, can be treated at home with highly fortified (nutrient- and energy-rich) palatable, soft or crushable ready-to-use therapeutic foods (RUTFs).

The approach, in which children are treated with basic oral medication and given a weekly supply of RUTF by health workers, while parents learn how to help malnourished children and pinpoint danger signs, has been tested in Ethiopia, Malawi, Niger and Sudan.

The technology to produce RUTFs, which may be eaten by children over the age of 6 months without adding water, is relatively simple, costing about US\$3 per kilogram, and could be used in all countries with high levels of severe acute malnutrition. A child being treated for severe acute malnutrition would need 10 - 15 kg of RUTF, given over a period of 6 - 8 weeks.

The WHO also notes the importance of RUTFs in the management of HIV-positive children suffering from severe acute malnutrition.

The WHO says that investing in prevention should be the first line of attack to ending severe acute malnutrition. However, treatment is urgently needed for those who are malnourished. Key strategies for countries are:

- adopting and promoting national policies and programmes for the identification and management of children with severe acute malnutrition
- providing the resources needed for management of severe acute malnutrition
- integrating the management of severe acute malnutrition with

other health activities, such as preventive nutrition initiatives and integrated management of childhood illness at first and referral levels.

For their part, the WHO and other international organisations and their partners would assist by, among other actions, mobilising resources to support the implementation of these recommendations, and facilitating the local production or procurement of RUTF for countries.

Source: www.who.int

Nutrition Development Marketplace winners

Two nutrition projects from Africa, out of 6 projects from the continent and 22 from around the world, have been awarded funding in the World Bank's Development Marketplace awards for 2007.

Under the theme 'Improving Results in Health, Nutrition and Population for the Poor', the competition attracted a record of more than 2 900 applicants and the awarding of grants with a total value of \$4 million.

The two winning African nutrition projects included one from Kenya, comprising a partnership between the Tanzanian Medical Institute for Medical Research, the Tukwamuane Women's Group and the University of Western Ontario, aimed at improving health and nutrition levels and alleviating suffering from malnutrition among vulnerable social groups in the Oyugis-Rachuonyo district through the establishment of a sustainable, probiotic yoghurt-producing enterprise. The other was from Zambia, from the organisation Valid International, aimed at establishing a city-wide community-based therapeutic care system for the treatment of severe acute malnutrition in Lusaka.

Source: www.developmentmarketplace.org