ROSA Focus

This Month's Highlight

Actions to address undernutrition: the dilemma of where to invest

The European Commission and EuropeAid are in the process of reviewing their involvement in the field of nutrition in developing countries. This initiative was triggered firstly by the desire to maximise the impact of EC resources on food security and nutrition and better support progress towards the first MDG target: halving, between 1990 and 2015, the proportion of people who suffer from hunger. Secondly, it was prompted by the awareness that ***'structural' malnutrition, and namely chronic malnutrition, have largely been overlooked*** and features too infrequently in development priorities. Thirdly, there is need to better ***articulate responses to malnutrition during emergencies and post-crisis actions*** and hence strengthen the LRRD (Linking Relief Rehabilitation and Development) within the European Commission in order to properly tackle malnutrition.

How to prioritise actions to address undernutrition?

Decisions about what actions should be prioritised to address undernutrition are made difficult by the complex and inter-related causes at stake which are shown on **Figure 1**. Decision makers are faced with ***two broad dilemmas to allocate resources***: 1) what sectors should be prioritised? Health? Water? Economic sector? All ?; 2) what level of causation (immediate, underlying or basic causes) should the action target? For example, should there be more emphasis on advocacy to change economic and trade policies? Should more resources be allocated to micronutrient supplementation? It is important to note that choosing to invest in one sector or at one level rather than another might result in loosing a synergy which is essential to a long term reduction of undernutrition.

This issue also presents itself as a slightly different question: how much emphasis should be placed on ***prevention versus treatment of undernutrition***?

Moreover, preventive measures can also be subdivided into investment in short term prevention (e.g. a blanket food distribution prior to a food gap) versus long term prevention (e.g. support to veterinary services to strengthen households' assets base, income/food security and subsequently increase their ability to provide for their children). The 'prevention versus treatment' and 'long term versus short term' debates lie also at the heart of the emergency – development divide.

The above questions are often difficult to answer because of a lack of understanding of: 1) the causes of undernutrition and their relative importance in a given context; 2) what works, what will be most cost-effective and what will have a long lasting effect. Adequate information is of paramount importance to determine the right packages of actions suited to the problems. Rather than describe what is typically being done, we deliberately focuse on what works and what needs to happen to **ensure the adoption of effective actions to tackle undernutrition**. We will first focus on actions typically found in 'nutrition programmes' (e.g. nutrition education, micronutrient interventions). Then, we will discuss actions which can equally have an impact on undernutrition but are often not seen as part of comprehensive package of nutrition interventions and are too rarely designed with a specific nutrition objective.

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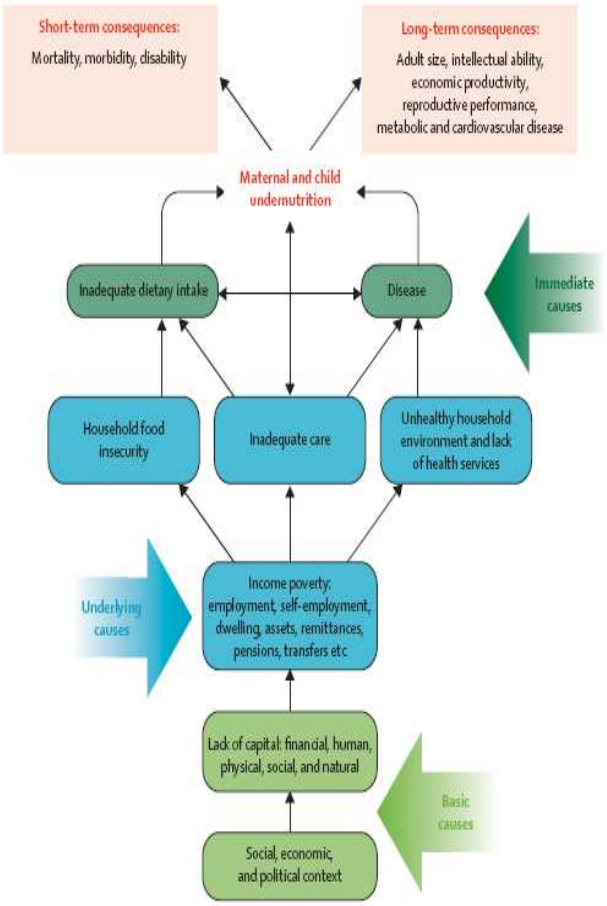
Figure 1: Framework of the relations between poverty, food insecurity, and other causes to maternal and child undernutrition and its short-term and long-term consequences



Source: Lancet Series, 2008

Actions typically/often found in "nutrition intervention packages"

The lancet Series 08 offer an answer to the 'what works' question specifically for a set of actions traditionally included in nutrition programmes. These aim to address mostly the ***upper part of the causal model*** (see Figure 1). Among these 'traditional' nutrition interventions, those with demonstrated impact on maternal and child undernutrition are presented on **Figure 2.**

According to the authors, these **actions have to be implemented at scale and need to effectively reach those in need** in order to tackle undernutrition. They also stress the fact that **ineffective actions should be dropped** to avoid waste of resources.

Figure 2: Interventions with a demonstrated impact on maternal and child undernutrition amongst traditional nutrition programmes

Sufficient evidence for implementation in all 36 countries	Evidence for implementation in specific, situational contexts
Maternal and birth outcomes	
Iron folate supplementation	Maternal supplements of balanced energy and protein
Maternal supplements of multiple micronutrients	Maternal iodine supplements
Maternal iodine through iodisation of salt	Maternal deworming in pregnancy
Maternal calcium supplementation	Intermittent preventive treatment for malaria
Interventions to reduce tobacco consumption or indoor air pollution	Insecticide-treated bednets
Newborn babies	
Promotion of breastfeeding (individual and group counselling)	Neonatal vitamin A supplementation
	Delayed cord clamping
Infants and children	
Promotion of breastfeeding (individual and group counselling)	Conditional cash transfer programmes (with nutritional education)
Behaviour change communication for improved complementary feeding*	
Zinc supplementation	Deworming
Zinc in management of diarrhoea	Iron fortification and supplementation programmes
Vitamin A fortification or supplementation	Insecticide-treated bednets
Universal salt iodisation	
Handwashing or hygiene interventions	
Treatment of severe acute malnutrition	

*Additional food supplements in food-insecure populations.

Source: Lancet Series, 2008

Although the seminar will not focus on crisis contexts specifically, improving the 'emergency-development' link is a priority for the EC. As part of this, the treatment of acute malnutrition presents a particular challenge and provides an example where the implementation of LRRD can make a difference.

In emergency settings, Therapeutic Feeding Programmes (TFP), Supplementary Feeding Programmes (SFP) and Community-based Management of Acute Malnutrition (CMAM)[1] aim to treat acute malnutrition amongst children under five (as a priority). The treatment has greatly evolved in past years with the development of community-based approaches and new products (RUTF). From a public nutrition point of view, key challenges remain: re-

[1] Formerly called Community Therapeutic Care(CTC)

ducing the cost of these programmes[2], achieving greater coverage to meaningfully contribute to the reduction of acute malnutrition prevalence and strengthening the capacity of national health systems to treat malnutrition. Several initiatives are underway to attempt to address the above[3].

Once the crisis is over or when emergency funding runs out, the most common exit strategy for these programmes consists in attempting to 'integrate' the service into the health system. It often fails as 'integration' can be perceived by the health service as being 'pushed' on them and they often do not have the required financial resources. What could be the role of LRRD in such a case?

Other actions less frenquently designed to address undernutrition

In addition to the interventions traditionally included in 'nutrition packages', there are others which ***focus on basic and underlying causes*** such as lack of capital, policy environment, income poverty, household access to health care and household food security. Addressing these determinants is essential to prevent and ensure long term reduction of undernutrition. Some examples are land reforms, safety-nets/social transfers, food assistance, livestock restocking, primary health care, education, agriculture and water programmes.

Actions aimed at reducing lack of capital, income poverty and food insecurity are of particular interest to this seminar[4]. Reducing economic determinants is of paramount importance to tackle undernutrition. Historically, the EC has substantially invested in food security and rural development amongst other areas. Rising world food prices is adding another unprecedented challenge for household economies, food security and nutrition.

The impact on nutrition of these 'indirect' actions is generally less well understood and documented. There are several reasons for this. First, such interventions are not necessarily designed with a nutrition objective in mind and hence are not evaluated by this criterion. It is also difficult to ascertain their impact on undernutrition when they are used as preventative measures and/or when a complex causal pathway is involved.

The further down the intervention is (in the causal model) from undernutrition, the broader its impact might be (i.e. affecting several causes at the level above). However, the further down the intervention the lesser likelihood there is of the 'trickle up' effect all the way to undernutrition. Therefore, having an impact on undernutrition is more uncertain. For example, an employment creation scheme can lead to a rise in household purchasing power and an improved diet for the child while at the same time the employment opportunity may result in increased workload for the mothers caring for young children, resulting in poorer quality of care.

The 'indirect' interventions' are rarely incorporated in a comprehensive package to address undernutrition. When they are implemented as part of a livelihood / food security programme for example, they are not necessarily designed in a way that would maximise their impact on undernutrition. For instance, a food security programme could be targeted at areas with the highest malnutrition prevalence if food insecurity was identified as a determinant of undernutrition. Cash transfers targeted at households with children under two (and during the later stages of pregnancy) could be considered in some contexts.

The questions of prioritizing actions to address malnutrition is complex, with several key implications, priorities and challenges (cf. **Box**) that will be discussed during the seminar organized by EuropeAid.

→ Some implications, priorities and challenges:

- How to prioritise actions in the current 'nutrition intervention packages' that address the most common and recurrent problems and have proven to be effective?

- What would it take to ensure these actions operate at scale and effectively reach those in need?

- What are the next steps to increase/re-structure the set of actions designed to address the underlying and basic causes of undernutrition according to the contexts?

- How could the LRRD ensure a smoother shift from emergency nutrition (with high ECHO investment) to post-crisis situations?

This article is largely based on the concept note written by Claire Chastre to prepare EC seminar. Thanks to her !

[2] According to MSF, the cost of RUTF alone was about 30 Euros/malnourished child in 2006 in Niger while the national health budget was 5 Euros/person/year.

[3] One example is the work of Valid International, which is considering ways of reducing costs and easing integration of treatment of acute malnutrition into health systems. The latter is also the focus of a FANTA/USAID initiative. Another example is the work of Emergency Nutrition Network and Save the Children UK which is looking at coverage and impact of SFPs and alternative actions to reduce the prevalence of acute malnutrition.

[4] Considering the health, water and education dimensions are of equal importance. However, it was not possible to do justice to all of these in this paper.

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Current food security situation

Eritrea is a chronically food insecure country, at national, household and individual level

The society is highly rural (about 80% of total population). The majority of the population relies almost exclusively on rain fed agriculture and pastoralist activities. Even in good years, the country produces only about 60% of the total grain needs, while in poor years it falls to about 25% of the domestic requirements. As a consequence and since the import capacity is limited, sufficient national food availability is a recurrent problem. It is somewhat difficult to obtain detailed data on the domestic food production. In addition, since the agricultural statistics system is at an embryonic stage, the accuracy of data can be questioned. In 2007, for the 3rd consecutive year, the government declined the offer of conducting the FAO/WFP Crop and Food Assessment Mission (CFSAM) which is usually a good discussion platform between the government and its foreign partners in many food insecure countries.

With a predominance of rain-fed agricultural production, erratic rainfall is a major impediment towards achieving food security. The lack of adequate water harvesting structures compounds the problems caused by climatic conditions. Other factors that contribute to high levels of food insecurity at national level are: limited access to productive assets, to labour (most of the able-bodied male are in the military), to credit and inputs (in particular, improved seeds and labour-saving tools); soil degradation resulting from inadequate natural resources management, and a limited import capacity. This low productivity explains why agriculture's contribution to GDP is only 23%, while it employs 60% of the population[5] (a common feature among agriculture-based developing countries).

As a consequence, until recently, Eritrea relied heavily on food imports, partly commercial and partly food assistance, to cover nearly 50% of its food requirements.

At household level, insufficient access to food is both a source and consequence of poverty and addressing it is a main target and challenge for the government. Food insecure populations in Eritrea suffer from limited market outlets for their produce and limited access to income generating opportunities in non-agricultural sectors. Ill-functioning food markets add to the problem (insufficient storage, transport and food processing facilities, excessive numbers of intermediaries between producers and consumers). The 2003 LSMS[6] survey indicates that 66% of Eritrean population was at that date below the national poverty line and that 37% lived below the food poverty line.

Grain prices on the Asmara market have gone up dramatically in the past months[7]. This is especially true for wheat and flour whose March prices are 60-70% higher than they were in September, despite the national harvest in October-December 2007. To a lesser extent, this is also true for other less tradable cereals (millet, sorghum).

At individual level, nutritional surveys indicate that Eritrean women and children are particularly vulnerable to food insecurity, and show malnutrition rates well above WHO standards. According to the most recent regional nutrition surveys[8], global acute malnutrition rates typically range from 11 to 21% among children under 5, while 30 to 48% of the mothers of the surveyed children are undernourished (BMI[9]<18). Malnutrition can be explained by insufficient access to quality food but also by many other factors such as inadequate weaning practices, poor sanitation conditions, and also limited access to basic services such as health centres and safe water points.

In this context, it is critical for the Country to be able to assess the nutritional situation of the population. **Box 1** shows main lessons to be learned from the National Nutrition Surveillance System experience.

[5] IMF and World Bank PER

[6] Leaving Standards Measurement Study

[7] WFP price survey, April 2008

[8] SRS (December 2005), Gash Barka (February 2006), Maekel (February 2006). Source: MoH (NNSS)

[9] Body Mass Index

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Box 1: National Nutrition Surveillance System (NNSS)

The NNSS was launched in 2003 in a coordinated effort between the Ministry of Health (MoH), UN agencies (UNICEF, WFP) and some international NGOs to adopt a standardised method of collecting nutrition data.

The main thrust of the NNSS was to conduct 6-monthly surveys in rural areas of each of the 6 administrative regions of Eritrea. Anthropometric nutrition data were collected on children under 5 (stunting, wasting) and mothers or caretakers (BMI). In addition, each sampled household was interviewed with a livelihood questionnaire covering inter alia the coping strategies, access to water / sanitation / food aid.

Between December 2003 and February 2006, several round of nutrition surveys have been carried out, financed by the NNSS foreign partners, but it has not been possible for the MoH to stick strictly to the original plan of having one survey every 6 months in each region (21 surveys effectively performed against 30 planned surveys).

Survey reports prepared by the MoH were detailed and informative, albeit released with delay, about 4-5 months after the survey had taken place.

In March 2006, the EC financed an assessment of the NNSS through the Dutch NGO ICCO.

The main findings were that:

- In its present design, the sustainability of the NNSS was questionable as it put a great strain on the MoH human resources and required constant external funding. The NNSS should be less intensive.

- Reports must be released more quickly.

- Reports have to be more focused on i) malnutrition levels of the vulnerable groups (children <5, mothers, elderly), ii) child feeding practices and U5 morbidity and mortality, iii) service coverage (health services, food aid, SFP, TFP, water…). A maximum 2-page note for decision-makers should highlight the main findings and make practical recommendations.

In 2006, the MoH de facto suspended the NNSS. Lack of funds cannot be the explanation: the EC had just approved a 2.5-year project to support and expand the NNSS. A more reasonable explanation could be that the government feared that high chronic and acute malnutrition rates would contradict the official assertion that food security in Eritrea is improving fast. Another reason could be the government's decision to shift to a sentinel site approach, which is being experimented with UNICEF, but no data have been released yet.

The NNSS story in Eritrea probably shows that i) a systematic and regular data collection has a cost that can prove unsustainable in the long run; ii) the political agenda can interfere; iii) due care must be given to effectively link the findings to the decision-making process.

Regarding food assistance in Eritrea, it has undergone drastic changes. In September 2005, the government suspended a nationwide and massive free distribution programme of food aid, which had been running for years, following the armed conflict with Ethiopia, making Eritrea one of the highest recipients of food aid per capita in the world[10]. In April 2006, the government launched a national Cash-for-work (CfW) programme, aiming at creating and restoring community productive assets and initially financed by the monetisation of the in-country food aid stocks (which resulted in a confrontational relation with the EC, WFP and the US government).

In Eritrea, all the three components of food security, namely availability, access and utilization of food represent major challenges at national, household and individual level that have to be tackled by the Government in collaboration with donors.

This article is a contribution of the European Commission's Delegation to Eritrea. Many thanks to Stephane Halgand, Head of the Food Security and Rural Development Section.

[10] Up to 100 kg / capita in 2003 (source: WFP)

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Brèves internationales

Retour sur la XIIème Conférence internationale de la CNUCED

Créée en 1964, à l'initiative des pays en développement, la Conférence des Nations Unies sur le commerce et le développement (CNUCED) vise à faire bénéficier les PED du commerce mondial. Initialement, cet organe subsidiaire de l'Assemblée générale des Nations Unies était imaginé comme un instrument de régulation du commerce : il est à l'origine des accords internationaux sur les produits de base et du Système de préférence généralisé, qui est encore aujourd'hui le régime commercial dominant dans les relations entre pays en développement et les pays développés. La CNUCED voit son mandat évoluer dans les années 80 à mesure du renforcement du GATT, pour se concentrer sur trois fonctions principales : recherche et expertise, assistance technique et lieu de débat entre les gouvernements. Traditionnellement, la CNUCED promeut les positions des PED afin de leur faire bénéficier des effets positifs du commerce. Elle se réunit tous les 4 ans pour définir le programme de travail pour les 4 années suivantes.

La douzième conférence se réunit dans un contexte particulièrement sensible : les négociations multilatérales du cycle de Doha au sein de l'OMC - dit cycle du développement - patinent, la multiplication des accords de libre échanges régionaux soulève de vives oppositions, et la montée en flèche des prix des matières premières provoque des troubles dans nombre de pays, remettant la sécurité alimentaire au cœur des débats sur le commerce et le développement. Face à ces défis, de nombreux PED souhaitent élargir et renforcer le mandat de la CNUCED.

Pour en savoir plus : http://www.unctadxii.org/fr

The Integrated Food Security Phase Classification (IPC) - Le cadre intégré de classification de la sécurité alimentaire (IPC)

The Integrated Food Security Phase Classification (IPC) is a join initiative of Care International, EC-JRC, FAO, FEWS NET, Oxfam GB, Save the Children UK and US, and WFP.

It is innovative tool for improving food security analysis and decision-making. The IPC was originally developed in Somalia under the FAO Food Security Analysis Unit (FSAU). This successful experience led to the development of a standardized IPC approach that is now being used in several countries. It is a standardised 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.

It is 1) A tool for classifying the **severity** of food security situations; 2) A « forum » for reaching **technical consensus**; 3) A framework for **situation analysis** - which can be adapted to different food security contexts

For more information, please visit the new IPC website: http://www.ipcinfo.org

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