

# Background Note for the Global Partnership on Children with Disabilities

## Inclusive Nutrition for Children and Mothers with Disabilities

### Current Situation

- Over one billion people worldwide are undernourished. This includes an estimated 171 million children aged <5 years who are stunted (chronically malnourished).<sup>1</sup>
- Over one billion people worldwide live with a disability.<sup>2</sup>
- An estimated 150 million infants and children aged <5 years<sup>3</sup>, often have poor health and limited life opportunities<sup>4</sup>. Ensuring access to appropriate services and support and tackling marginalization is key to improving their nutritional status and development.
- Nutrition and disability are intimately related: both are global development priorities; and for both the elimination of malnutrition and ensuring the health and well-being of children with disabilities can only be addressed by also tackling issues of poverty, ensuring equity and guaranteeing the human rights of at-risk individuals.
- Children and adults with disabilities often do not benefit from the same level of services, such as health and social welfare services, as the non-disabled population.<sup>2</sup> This is due to a variety of reasons, including: inaccessible premises, and professionals that are not able to adequately communicate with persons with disabilities.<sup>4-7</sup>
- Very often, general campaigns (e.g. prevention of HIV/AIDS, awareness on landmines) are not designed in a way to ensure access to all persons with disabilities<sup>8</sup>, and this is certainly true of campaigns that have addressed nutrition and hunger.
- In situations of limited resources, the exclusion of children with disabilities may sometimes be based on the incorrect belief among some health professionals, community members and even some family members, that preserving the health and welfare (and even life) of children with disabilities is a lower priority than preserving those of a non-disabled child.<sup>4</sup> In fact, children with disabilities are equally entitled to all resources to preserve health and life. They cannot be given a lower priority simply because they are disabled<sup>6</sup>.

### Summary of the links between Nutrition and Disability

Among the key points of convergence are the following:

#### 1. Undernutrition can lead to impairments

Undernutrition in mothers can lead to a number of preventable impairments prenatally as well in the months and years following birth. For example:

- Infants whose mothers are deficient in folic acid are more likely to have neural tube disorders,<sup>9</sup>
- Maternal iodine deficiency can result in a range of intellectual, motor and hearing problems in infants,<sup>10</sup>
- Prenatal undernutrition can contribute to poorer infant health<sup>11,12</sup> which increases the risk of diseases associated with disability,

- Undernutrition causing poor or distorted pelvic growth in girls is associated with increased risk of obstructed labour when they have their own children: an important cause of foetal injury and related disability.<sup>13</sup>

Undernutrition in children can cause lifelong impairments that are otherwise preventable. For example:

- Undernourished infants and children are at an increased risk of severe illness, including cerebral malaria and meningitis, both causes of neurological impairments in developing countries,<sup>14</sup>
- Undernourished infants and children are at risk of a number of disabilities linked to specific micronutrient deficiencies (e.g. vitamin A deficiency is a cause of blindness).<sup>15</sup>

## **2. Having a disability can lead to under-nutrition in new-borns and infants.**

While issues of undernutrition are often framed in terms of 'disability prevention', access to good nutrition among children who are born with an impairment or who become disabled at some point after birth, is equally important.

Infants and children with disabilities can suffer from the ill-effects of undernutrition in the same way as children without disabilities, leading to:

- Poorer health outcomes;
- Missing or delay in reaching developmental milestones;
- Acquiring avoidable secondary conditions as well as unnecessary stunting and wasting;
- In extreme circumstances, preventable death.

In some infants and children, undernutrition may be a direct consequence of a specific impairment or medical condition. For example:

- New-borns and infants with disabilities may have poorer nutritional intake. e.g. an infant with cleft palate may not be able to be breastfed effectively;
- Infants and children with certain medical conditions may have less ability to absorb or use nutrients in the food they do get (e.g. malabsorption in cystic fibrosis);
- Some infants and children with disabilities may have greater nutritional needs (e.g. frequent infections and bedsores in an immobile toddler may mean that that child will need additional nutritious food in order to maintain her health);
- Lack of knowledge among caretakers of how to deal with disabling health conditions and specific problems associated with disability may be an issue. For example, if caretakers lack knowledge about correct positioning to feed a child with cerebral palsy, muscle spasms may occur causing complications in the feeding process and risking insufficient food intake for the child. In other infants and children with disabilities, undernutrition is not directly related to their disability. For example:
- Stigma and discrimination may mean a child with a disability is offered less food than his/her siblings (intentionally not fed);

- A combination of physical and attitudinal issues may also be involved. For example, a child with cerebral palsy may need additional time to be fed and mothers may be less willing or able to devote this time to them, or may even be actively discouraged from breastfeeding or feeding them solid food because of stigma and discrimination (a form of traditional infanticide practiced in some communities against children with visible disabilities in infancy).
- There has been little research, particularly in the context of poverty and malnutrition, on the effects of poor nutrition on children with pre-existing disabilities. It is often assumed that these children do not grow and thrive because of their disability, but in fact, it is probable that in some cases what is assumed to be disability-associated ill health and wastage in fact may be connected with feeding problems or withholding of adequate nutrition (particularly in households with scarce resources when it is assumed a child with a disability will not live to adulthood in any case).

Finally, access to enough food and sufficient nutritious food is an issue that is often of concern to adults with disabilities because of poverty and unequal distribution of resources within the household. The issue of access to nutritious food for women with disabilities and their children is consistently overlooked by many in both the nutrition and disability sectors, placing women and their children at increased risk.

### **Potential Areas where the Global Partnership may Influence the Global Agenda**

- Awareness of the link between nutrition and disabilities among both the nutrition and disability communities and governments at all levels.
- Access for children and mothers with disabilities to nutrition services
- Knowledge and understanding about the situation for children and mothers with disabilities through data collection and research initiatives that drive programmes.
- Approaches to nutrition campaigns and communications that are disability-friendly and therefore do not lead to further stigmatization of people living with disabilities.
- The need for a twin-track approach, which includes both disability mainstreaming and setting up special services, where needed to reach children with disabilities and their families or caretakers.

## References

1. Scaling Up Nutrition. [cited; Available from: <http://www.scalingupnutrition.org/>]
2. WHO/World Bank. 2011. World Report on Disability. Geneva.  
[http://www.who.int/disabilities/world\\_report/2011/en/index.html](http://www.who.int/disabilities/world_report/2011/en/index.html)
3. Maulik PK, Darmstadt GL. Childhood Disability in Low- and Middle-Income Countries: Overview of Screening, Prevention, Services, Legislation, and Epidemiology. *Pediatrics*. 2007; **120**(Supplement 1): S1-S55.
4. Groce N. 2009. People with Disabilities. in B. Levy and V. Sidel. *Social Injustice and Public Health*. NY: Oxford University Press.
5. The Universal Declaration of Human Rights. 1948 [cited; Available from: <http://www.un.org/en/documents/udhr/>]
6. Convention on the Rights of Persons with Disabilities. G.A. Res. 61/106, U.N. Doc. A/RES/61/106. 2006 [cited; Available from: <http://www.un.org/disabilities/convention/conventionfull.shtml>]
7. Shakespeare T, Iezzoni LI, Groce NE. Disability and the training of health professionals. *Lancet*. 2009; **374**(9704): 1815-6.
8. World Bank. 2004. HIV/AIDS & Disability: Capturing Hidden Voices. The World Bank/Yale University Global Survey on HIV/AIDS and Disability.  
[http://www.dodd.nl/data/1187771560035\\_capturing\\_hidden\\_voices\\_english.pdf](http://www.dodd.nl/data/1187771560035_capturing_hidden_voices_english.pdf).
9. Blencowe H, Cousens S, Modell B, Lawn J. Folic acid to reduce neonatal mortality from neural tube disorders. *Int J Epidemiol*. 2010; **39 Suppl 1**: i110-21.
10. Maberly GF, Haxton DP, van der Haar F. Iodine deficiency: consequences and progress toward elimination. *Food Nutr Bull*. 2003; **24**(4 Suppl): S91-8.
11. Scholl TO. Maternal iron status: relation to fetal growth, length of gestation, and iron endowment of the neonate. *Nutr Rev*. 2011; **69 Suppl 1**: S23-9.
12. Vaughan OR, Sferruzzi-Perri AN, Coan PM, Fowden AL. Environmental regulation of placental phenotype: implications for fetal growth. *Reprod Fertil Dev*. 2011; **24**(1): 80-96.
13. Konje JC, Ladipo OA. Nutrition and obstructed labor. *The American Journal of Clinical Nutrition*. 2000; **72**(1): 291S-7S.
14. Gladstone M. A review of the incidence and prevalence, types and aetiology of childhood cerebral palsy in resource-poor settings. *Ann Trop Paediatr*. 2010; **30**(3): 181-96.
15. Courtright P, Hutchinson AK, Lewallen S. Visual impairment in children in middle- and lower-income countries. *Arch Dis Child*. 2011; **96**(12): 1129-34.