Undernutrition is the underlying factor in up to 50 per cent of under-five deaths, and there is evidence of links between a mother’s nutritional status and the risk of maternal and child death. Among the developing countries and territories, more than one quarter of children under age five were moderately or severely underweight or stunted in 2000–2006, and 28 per cent of children aged 6–59 months were still not receiving vitamin A supplementation in 2005.

Food security, though necessary, is insufficient by itself to avoid undernutrition, as evidenced by the many children who have been found to be underweight or stunted in food-secure or non-poverty environments. Undernutrition results from an array of interrelated factors, including inappropriate feeding and care practices, inadequate sanitation, disease, poor access to health services, and weak knowledge of the benefits of exclusive breastfeeding, complementary feeding practices and the role of micronutrients. Diarrhoea, which often results from poor sanitation facilities and hygiene practices, is a contributing factor to undernutrition. Another contributing factor to undernutrition among infants and young children is the lack of supportive environments for many mothers, who may have limited time to care for themselves during pregnancy, or for their infants, due to household demands and insufficient access to health services.

Scaling up effective nutrition strategies across a continuum of care with others, evidenced by the many children’s needs and demands an integrated approach. It requires the sustained engagement of parents and communities, supported by local and national development of primary health care and environmental health services, particularly water and sanitation. When these prerequisites are in place, they can lead to remarkable results in a relatively short time. In Thailand, for example, moderate and severe undernutrition were reduced through such means by 75 per cent or more in those without medical complications with ready-to-use therapeutic foods that in many cases are affordable, with costs varying between US$12 and US$132 per year of life gained. Community-based therapeutic care programmes use new, ready-to-use therapeutic foods that in many cases are made locally from local crops. Their implementation is based on three premises:

• Underlying all programmes is a strong emphasis on the importance of early care in the evolution of malnutrition and the need for patients to remain in a nutritional programme until recovery.

• Programmes start from the assumption that in order to present early and comply with treatment, families and communities must understand, accept and participate in the programmes.

• Programmes focus on the involvement of key stakeholders who can benefit from the feedback and attention successful programmes generate and thus have a stake in their long-term sustainability.

The results of community-based programmes to address severe acute undernutrition suggest that, even though they cannot eliminate the need for external assistance, scaled-up treatment can have a major public health impact, preventing hundreds of thousands of child deaths.

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Recent evidence from Ethiopia, Malawi and Sudan illustrates the high impact and cost-effectiveness of community-based management of severe acute malnutrition. In contrast to treatment in health facilities – where in most developing countries fatality rates have remained largely unchanged for the past five decades – community-based therapeutic care has brought about a fundamental shift in the understanding of the disease and the implementation of treatment. To date, data from more than 20 programmed implemented in Ethiopia, Malawi, and North and South Sudan between 2000 and 2005 indicate these programmes achieved recovery rates of almost 80 per cent and reduced mortality rates to as little as 4 per cent. Coverage rates reached 73 per cent, while more than three quarters of the severely undernourished children who were treated were treated solely as outpatients. Furthermore, initial data indicate these programmes are affordable, with costs varying between US$12 and US$132 per year of life gained. Community-based therapeutic care programmes use new, ready-to-use therapeutic foods that in many cases are made locally from local crops. Their implementation is based on three premises:

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