Nutrition Programme Overview

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Presentation outline

• Global development in nutrition
• UNICEF’s Nutrition programme overview
• Strategic priorities
• Q & A
Global development in Nutrition
Global developments nutrition

1. Nutrition high in the global agenda: increased attention from governments, donors, development agencies, private sector, foundations, civil society, research community

Initiatives

- SUN Movement
- REACH
- ZERO Hunger Initiative
The SUN Movement - 42 countries
The SUN Movement

Unprecedented opportunities created by SUN

- Global and national advocacy
  - Building partnerships
- Providing technical support
  - Multisectoral coordination
- Civil society & private sector involvement
  - Promotion of mutual accountability

- Clear evidence of investment in nutrition – ($ 4.15 Billion)
- Partnerships are more operational, enhanced complementarity
  - Programmes being scaled up in many countries
- Large scale results can been achieved quickly (good policy, integrated programmes, community outreach)
Global developments nutrition

2. Conceptual development

- Evidence based interventions across life cycle – (pre-)pregnancy → 2 years
- Maternal-child seen as nutrition survival (SAM, BF, vit A) AND development priority (stunting, micronutrients)
- SAM treatment at community level in non-emergencies, linked to preventive action
- Comprehensive approach – health, water, sanitation, nutrition, food security, social protection, education
- Equity: reaching disadvantaged, most affected is cost-effective vis a vis reaching MDGs
FIGURE 18: Key proven practices, services and policy interventions for the prevention and treatment of stunting and other forms of undernutrition throughout the life cycle

- **Adolescence/Pregnancy**
  - Improved use of locally available foods
  - Food fortification, including salt iodization
  - Micronutrient supplementation and deworming
  - Fortified food supplements for undernourished mothers
  - Antenatal care, including HIV testing

- **Birth**
  - Early initiation of breastfeeding within one hour of delivery (including colostrum)
  - Appropriate infant feeding practices for HIV-exposed infants, and antivirals (ARV)

- **0–5 Months**
  - Exclusive breastfeeding
  - Appropriate infant feeding practices for HIV-exposed infants, and ARV
  - Vitamin A supplementation in first eight weeks after delivery
  - Multi-micronutrient supplementation
  - Improved use of locally available foods, fortified foods, micronutrient supplementation/home fortification for undernourished women

- **6–23 Months**
  - Timely introduction of adequate, safe and appropriate complementary feeding
  - Continued breastfeeding
  - Appropriate infant feeding practices for HIV-exposed infants, and ARV
  - Micronutrient supplementation, including vitamin A, multi-micronutrients; zinc treatment for diarrhea; deworming
  - Community-based management of severe acute malnutrition; management of moderate acute malnutrition
  - Food fortification, including salt iodization
  - Prevention and treatment of infectious disease; hand washing with soap and improved water and sanitation practices
  - Improved use of locally available foods, fortified foods, micronutrient supplementation/home fortification for undernourished women, hand washing with soap

**Note:** Blue refers to interventions for women of reproductive age and mothers.
Black refers to interventions for young children.

Nutrition Programme Overview
UNICEF approach -nutrition action

• Scaling up evidence-based cost-effective interventions to prevent and treat undernutrition with priority to the window of opportunity: pre-pregnancy to child < 2 years

• Stunting is complex requiring an integrated, multi-sectoral approach, both nutrition sensitive and specific interventions:
  – Improved dietary quality (improved feeding and breastfeeding practices, improved micronutrient intakes)
  – Link with food security and social protection
  – Clean drinking water, hygiene and environmental sanitation
  – Health services (preventive and curative)
  – Women’s empowerment
  – Women’s and girls education
## UNICEF's work in the window of opportunity

### Adolescence → Pregnancy
- Micronutrient supplementation
- Antenatal care, including HIV testing
- Food fortification

### Birth
- Early initiation of breastfeeding
- Optimal infant feeding practice for HIV-exposed infants with ARV

### 0-5 months
- International Code of Marketing of Breastmilk Substitutes; maternity protection in accordance with ILO Convention 183
- Exclusive breastfeeding (<6 months), with ARV for HIV-exposed infants
- Timely introduction of adequate complementary foods
- Continued breastfeeding, with ARV for HIV-exposed infants
- Micronutrient supplementation, including vitamin A, zinc, multiminerals
- Community based management of SAM
- Food fortification, including salt iodization
- Prevention and treatment of infectious disease, including through improved water and sanitation

### 6-23 months

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### UNICEF's approach

- Equity focus
- Evidence-based policy, programme design and implementation
- Monitoring and evaluation, MoRES
- Capacity development
- **Supply provision**
- Large scale communication
Micronutrients deficiency control and prevention programmes
1. Micronutrient supplementation
   - Vitamin A (6-59m) mortality risk reduction
   - Therapeutic zinc (<5 years): more rapid recovery, increased immunity & growth
   - Maternal micronutrients (adol. girls, women child bearing age): birth outcomes, maternal MN status, child growth & development

2. Home fortification (6-24m): micronutrient status, feeding practices

3. Food fortification: salt (I), flour (Fe, Zn, FA), oil/sugar (Vit A) (women child bearing age, infants): IQ, NTDs, rickets, micronutrient status
Vitamin A developments

- A very high (75%), but not yet universal coverage across developing countries
- Child health days successful delivery mechanism for combined interventions; shift to routine approach from campaign
- Shift from donor funding to country financing
- Improve outreach coverage among disadvantaged groups
- Technical consultation on vit A supplementation direction; fortification, progress MDGs
Maternal micronutrients

• Iron folic acid and multimicronutrient supplements
• Some countries use IFA some multi MN. Guidelines accommodate both
• Understand bottlenecks to scale up
• Improve demand/uptake of antenatal care at community level
• Need for innovative programming to reach adolescent girls/pre-pregnancy
• Need to address the high costs IFA
• Packaging of IFA
Zinc

1. Preventative in specialized products
   • Optimal dosing for functional impact (diarrhea, growth)

2. Treatment in supplements in combination with ORS
   • Many countries adopted the zinc treatment in national policy
   • Product registration
   • Programme design and delivery
Households iodized salt consumption over time (%)

HHIS (% Adequate)

- >90% (SOWC 2002: 21, SOWC 2012: 37)
- 70-90 (SOWC 2002: 17, SOWC 2012: 27)
- <20 (SOWC 2002: 13, SOWC 2012: 12)
Grain Fortification Legislation

78 countries require fortification of wheat flour, maize flour, and/or rice

31% of all industrial milled flour is fortified

To request data, e-mail info@ffinetwork.org
Micronutrient premix for food fortification

• KIO3 price increase – consequences for salt iodization programmes
• Development of devices for testing micronutrients in food (vitamin A, iron, iodine) – need for further development
• Premix procurement services at country level – GAIN premix facility and UNICEF support
• SUN business Network – taxes and levies on premix
Home fortification

• Micronutrient powder (MNP) and lipid based nutrient supplement (LNS)
• LNS for home fortification includes small quantity spreads (20g) to be mixed with the food, one per day
• Guidelines for MNP by WHO, including for malaria areas
• No guidelines yet for LNS
• Home Fortification Technical Advisory Group to coordinate, develop program manuals, and provide technical support
• Rapid scale up in MNPs many countries
Home Fortification - MNP

• MNP priority intervention (6-24m, compl feeding, effective to address iron and zinc)

• 5 regional workshops: 66 countries

• Scaled up programmes: about 40 countries; estimated 12 million children reached; good impact >20% anemia

• Investments in impact evaluations, innovations and business delivery models

• Demand for MNP supplies increasing rapidly, quality and availability is critical
Countries that have participated in each of the five regional UNICEF-CDC workshops to support the scaling-up of home fortification to improve the quality of complementary foods for young children.
Micronutrient procurement powder – UNICEF only

Quantities of Micronutrient Powder in sachets supplied

- 15 component - standard layout
- 15 component - local layout
- 5 component

Home Fortification - LNS

• A promising strategy; not yet recommended for scale up
  • Numerous trials on going
  • Lack of established supply chains
  • Little programmatic experience regarding package design, provision of information regarding use
  • Inconclusive about impact on growth

• More attention to essential fatty acids intake
  • Emphasis on the first 1000 days of life
  • Omega-6 and (specially) Omega-3
  • LNS considered a potential source for pregnant and lactating women and infants and children
Home Fortification - LNS

- Acceptability, change in dietary habits
- Interest by countries, particularly those affected by emergency and food insecurity situations
- Peanut allergy concerns
- Populations where peanuts are not part of diet
- Sustainability: long term adherence, cost, 3 times as expensive as MNP (no data on implementations costs)
- Research gaps
- Pilot operational research (e.g. costs, shelf-life & storage, usage in home, process evaluation)
- No official WHO recommendation
Home Fortification Interventions – 2011 Global Assessment

- MNP implemented, n=34 interventions
- LNS implemented, n=17 interventions
- CFS implemented, n=12 interventions
Prevention and management of acute malnutrition
Current program / situation

- The management of severe acute malnutrition (SAM) is critical for child survival and is a key component of the scaling up nutrition (SUN) framework for addressing undernutrition.

- About 20 million children are affected by SAM globally – with the majority of children being in Asia.

- Only 2.6 million were reached with treatment in 2012. Although this represents a significant increase from 2011 (1.9 million) and 2009 (1M), access to treatment remains critically low.

<table>
<thead>
<tr>
<th>Region</th>
<th>2009</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESARO</td>
<td>414,412</td>
<td>806,919</td>
<td>890,414</td>
</tr>
<tr>
<td>WCARO</td>
<td>488,366</td>
<td>784,660</td>
<td>1,235,302</td>
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<tr>
<td>ROSA</td>
<td>29,116</td>
<td>207,215</td>
<td>258,366</td>
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<tr>
<td>MENA</td>
<td>64,124</td>
<td>128,647</td>
<td>217,935</td>
</tr>
<tr>
<td>TACRO</td>
<td>0</td>
<td>21,660</td>
<td>28,882</td>
</tr>
<tr>
<td>EAPRO</td>
<td>5,600</td>
<td>12,671</td>
<td>31,813</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,001,618</td>
<td>1,961,772</td>
<td>2,662,712</td>
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</table>
Community based nutrition model

Community mobilization

Supplementary feeding

In-patient

Out-patient

Ready to use therapeutic food

Link with prevention

F75
F100
ReMol
UNICEF provides technical support and capacity building for Ministries of Health (MoHs) and non-governmental organisations (NGOs) involved in treating children with SAM in more than 60 countries.

Globally, UNICEF remains the main procurer of Ready to Use Therapeutic Food (RUTF) - procuring approximately 80% of global needs - therapeutic milk (F-75, F100) and ReSoMal, which are essential for SAM treatment.

Governments are facing great challenges to consolidate, build capacity and sustain with their own resources to treat the children affected with SAM due to:

- short-term funding (mostly emergency)
- limited commitment and leadership from governments,
- lack of comprehensive national scale-up plans,
- lack of clear policies on national production of therapeutic foods,
- lack of integration within existing systems and with other key health and nutrition interventions

High dependency on RUTF (with standards recipes and raw ingredients), limiting local based solutions (more sustainable, more acceptable, less costly).
Infant and young child feeding programme
Key Components of IYCF Programme

**Legislation**
(Code of marketing of BMS
Maternity protection)

**Skilled support by the health system**

**Community-based counselling, support & promotion**

**Communication**

**Additional complementary feeding components**

**IYCF in difficult circumstances**
(HIV, emergency)
Complementary feeding: A programming challenge

Status of complementary feeding in selected countries with data on “minimum acceptable diet” (breastfed children 6-23 m), & “introduction of complementary foods” (6-8m old, BF & non BF children)

Data source: DHS, most recent survey for each country, from 2002-2008, re-analyzed by WHO to produce “minimum acceptable diet” data. Note M.A.D only presented for breastfed children, therefore does not reflect the standard, complete indicator.

**Additional complementary feeding components**

- Improving the quality of CF through **optimal use** of locally available foods
- Improving the **availability** of **high quality local foods** through **increasing agricultural production** (e.g. homestead production, animal husbandry, etc)

**Provision of supplements** for complementary feeding (MNPs, LNS, fortified complementary foods) in food-insecure populations, and

**social & commercial marketing** of nutrition supplements and foods for complementary feeding in general population, including stimulating local production

**Social protection schemes with nutrition component** - complementary feeding. (e.g. in kind complementary foods, vouchers, cash transfers for the vulnerable families with children 6-24 months)
Strategic Priorities

- UNICEF continue supporting the **scale-up of community based management of SAM** and aim to increase coverage by about **30% every year**, while also working on reducing the burden of acute malnutrition through preventive actions.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total EXPECTED number of SAM admissions</th>
<th>Number of cartons of RUTF needed for full treatment (1 carton per child per cure)</th>
<th>Total MTs (72 cartons per MT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>3.1-3.3 million</td>
<td>31000000 - 33000000</td>
<td>43,056 - 45,833</td>
</tr>
<tr>
<td>2014</td>
<td>3.7-4.1 million</td>
<td>37000000 - 41000000</td>
<td>51,389 - 56,944</td>
</tr>
<tr>
<td>2015</td>
<td>4.5-5.1 million</td>
<td>45000000 - 51000000</td>
<td>62,500 - 70,833</td>
</tr>
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<td>2016</td>
<td>5.4-6.4 million</td>
<td>54000000 - 64000000</td>
<td>75,000 - 88,889</td>
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<tr>
<td>2017</td>
<td>6.5-7.8 million</td>
<td>65000000 - 78000000</td>
<td>90,278 - 10,833</td>
</tr>
</tbody>
</table>
Strategic priorities

• Sustainability interventions
  • National ownership & financing of nutrition interventions

• Innovations
  • Business models for delivery and self financing (micronutrient powder)
  • Reduce cost of essential commodities
  • Improve access & quality of nutrition essential supplies - regional, country levels
  • Improve uptake adherence of micronutrients (FeFA)
Strategic priorities

• Improve outreach coverage among disadvantaged groups: prevention & treatment of SAM, vit A, iodized salt, fortified foods, home fortification, CF

• **Reduce stunting in 6-24 months**: scale up community-based IYCF interventions & communication activities among populations with high stunting rates

• **Catalyze partnerships** & enhance complementarity across sectors

• Increase emphasis on improving maternal nutrition and complementary feeding