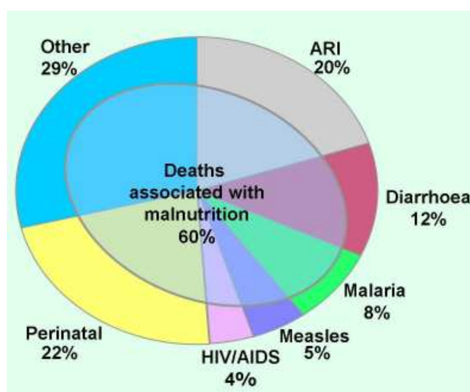
MALNUTRITION TASK FORCE

International Union of
Nutritional Sciences
(IUNS)

Why do we need an IUNS Task Force?

We need to raise the profile of malnutrition.

- Malnutrition contributes to 60% of deaths of children under-five, so reducing malnutrition is vital in child survival strategies.
- Most child deaths occur in south Asia and sub-Saharan Africa so efforts in these regions are especially important. HIV/AIDS and humanitarian emergencies aggravate the problem of severe malnutrition.
- Although there are as many deaths from the potentiating effects of malnutrition as from AIDS, tuberculosis and malaria (6 million/ year), malnutrition fails to receive the attention it warrants in health policies and resource allocation.



Above: Malnutrition contributes to 60% of child deaths. *Source WHO 2002*

The IUNS is well-placed to contribute to Millennium Development Goal 4 which seeks to reduce child mortality by two-thirds.

We need to build capacity to prevent and treat malnutrition.

- In hospitals in developing countries, severely malnourished children comprise a significant proportion of paediatric deaths. Most deaths can be prevented by following treatment guidelines.
- Community-based care can shorten inpatient treatment for severe malnutrition and also benefit children with moderate malnutrition.
- An integrated system of prevention, timely referral, correct inpatient treatment, and effective community-based care will improve child survival and development, as well as build health worker capacity and strengthen health systems.

What are the objectives?

- to establish three regional networks (south Asia; sub-Saharan Africa; Latin America) to coordinate technical expertise and develop capacity-building partnerships
- to raise the profile of malnutrition among health policy makers and donor agencies and advocate for increased recognition of its importance in child survival
- to work with partners to build capacity to prevent and treat malnutrition, especially in countries with high child mortality
- to advocate for inclusion of malnutrition in medical and nursing curricula and for WHO case-management guidelines to be implemented in paediatric wards
- to facilitate the scaling-up of effective interventions to reduce malnutrition deaths
- to encourage health workers to undertake operational research to monitor and improve their performance and provide data for advocacy action
- to raise resources
- to publish and disseminate the findings and experiences.

The IUNS Malnutrition Task Force is an advocacy and capacity-building initiative that will re-instate young child malnutrition as a key focus for child survival.

Effective treatment leads to rapid recovery (Source: ICDDRB).

Right: Child on admission

Left: Five weeks later

Country	Case fatality rate (%)	
	Before	After
Asia:		
Bangladesh	17	4
India	8	4
India	22	7
Myanmar	16	8
	18	5
Latin America:		
Brazil	34	16
Africa:		
Malawi	55	16
South Africa	35	20
	46	21
	30	8

Above: Implementing WHO guidelines for severe malnutrition reduces deaths

How will the networks function?

The networks will be centred around existing focal points:

South Asia: International Centre for Diarrhoeal Disease Research, Bangladesh (Dr Tahmeed Ahmed)

Sub-Saharan Africa: School of Public Health (focal point for Southern Africa Nutrition Capacity Development Initiative), University of the Western Cape, South Africa (Professor David Sanders)

Latin America: Instituto de Investigaciones en Salud y Desarrollo Facultad de Medicina Universidad Mayor de San Andres, La Paz, Bolivia (Dr Ana Maria Aguilar).

Who are the partners?

We encourage all interested organisations and individuals to be Partners.

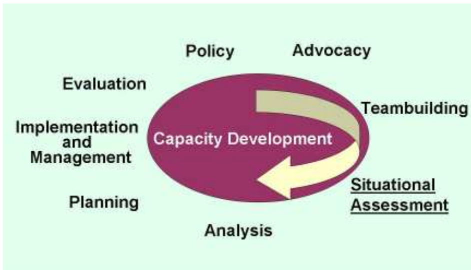
Potential international partners, some of whom have already expressed interest include: UNICEF, WHO, Child Survival Partnership, Royal College of Paediatrics and Child Health, Tropical Health Education Trust, Academy for Educational Development, Southern Africa Nutrition Capacity Development Initiative, Regional Centre for Quality of Health Care, Latin America Nutrition Network, Bolivian Paediatric Society, United Nations University

Examples of capacity building

In South Africa:

Nursing staff were shown how to calculate case-fatality rates. They found that 25-50% of children admitted with severe malnutrition died. They identified shortcomings in treatment and took action by implementing the WHO malnutrition guidelines. Malnutrition deaths were halved and several operational aspects of the health system improved. Some nurses became trainers and helped staff at other hospitals improve their practices. This example shows that:

- building health worker capacity improved child survival
- malnutrition was the lens through which staff were able to pinpoint inappropriate ward practices and weaknesses in the health system



Above: Capacity development and the assessment, analysis, action cycle.
Source: UWC

- the initial capacity-building investment had a multiplier effect that improved child survival in other hospitals and strengthened the health system.
- malnutrition can be the catalyst to building human resources.

The knowledge and skills learned in assessment, analysis and action can be applied to other health and nutrition interventions.

In Bolivia:

One clinic in each municipality of La Paz has been designated a 'nutrition clinic'. Staff are trained to help mothers rehabilitate severely malnourished children at home, after early discharge from hospital. Malnutrition is the catalyst for building human resources and developing an integrated programme that has both preventive and curative elements. The 'nutrition clinic' has become the base for an integrated service to deliver:

- improved prenatal nutrtion
- breastfeeding support
- growth monitoring and counselling
- improved complementary feeding

This integrated expansion has been included in the Nutrition Strategic Plan.

Example of advocacy

In South Africa:

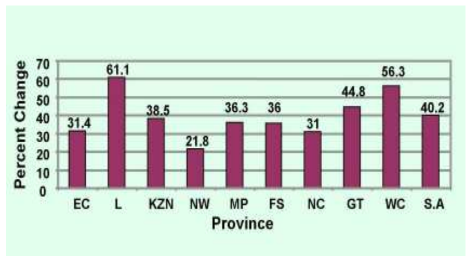
Thirty carers of severely malnourished children were visited at home one month after the children were discharged from hospital. Over 70% could repeat the home-feeding advice but few had implemented it as basic food items were lacking. All had very low incomes that entitled them to the Government's child support grant, yet none received it.

The data were used to advocate for better access to the child support grant and were:

- presented to the Commission on Social Welfare
- reported as front page news
- used as the basis for a TV documentary
- used to ask questions in Parliament.

The result was that the Minister for Social Development took steps to improve access. This improved by 40% countrywide.

This example shows that simple low-cost operational research provided evidence to advocate successfully for a change in policy. It illustrates the cycle of assessment, analysis and advocacy culminating in action at the national level. When health workers witness inadequacies and inequities being rectified through advocacy, they are empowered by the process. The same is true for civil society.



Above: Advocacy improved access to the child support grant by 40%.
Source: T Guthrie, UCT & ACESS, Feb 2003.

To participate, or obtain more information, please contact:

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