World Health Organization

PROPOSED GLOBAL TARGETS FOR MATERNAL, INFANT AND YOUNG CHILD NUTRITION

SUMMARY OF MAIN ISSUES RAISED AND WHO RESPONSES (4 April 2012)

Introduction

As a result of the web consultation on proposed global targets for maternal, infant and young child nutrition run between 6 and 27 February 2012 WHO has received 10 submissions from Member States and 5 submissions from international and regional organizations. Additional comments have also been received from NGOs.

Submissions have been consolidated in the following document, that includes 16 issues. The WHO response is provided below. Action has been taken to update document EB 130/10 accordingly.

1 - The process of target development should start at country level and global targets should reflect country level targets

The WHA is discussing global targets, focusing on priority areas and helping to monitor global progress. They are not meant to replace targets developed for individual countries and regions.

Establishing a quantifiable goal and determination with a clear time frame allows for a clear measurement of tangible progress, to which all actors may contribute with investments, policy measures and advocacy initiatives.

Global targets aim to call for action, and encourage desire and determination to achieve success at country level. The indicators identified for the global targets reflect the priority nutrition issues countries have identified in their national nutrition policies and strategies and the method used for the development of global targets may be applied at regional and country level to develop regional and country targets as needed.

2 - Not all targets are equally relevant to different countries

The set of targets is intended to address different health conditions that can be addressed through effective implementation of nutrition actions. These targets are illustrative of the complexity of the challenges and the multiple burden that countries are facing - undernutrition, micronutrient deficiencies and overweight - throughout critical stages of the life course - from conception to early childhood in stable and emergency settings.

Countries will have to assess the relevance of such targets for them and decide on the need to act and on the level of commitment in their respective countries. On the other hand, some of the issues may be given a different consideration and national targets may be developed for issues, that were not receiving attention at the national level. An example is that of overweight an increasingly important condition for the developing world.

3 - Global targets are being discussed in several contexts and alignment should be sought

The Commission on information and accountability for *Women's and Children's Health,* convened at the request of the UN Secretary General to "determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health", linked to the *Global Strategy for Women's and Children's Health* has developed a list of 11 indicators of maternal, newborn and child health. Stunting of children under 5 is one of the three main health indicators while exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed) is one of the eight tracer indicators of coverage for interventions to address mother and child health.

The high-level meeting of the United Nations General Assembly on the Prevention and Control of non communicable diseases (NCDs) adopted a Political Declaration calling on WHO to develop recommendations for a set of voluntary global targets for the prevention and control of NCDs. Obesity prevalence is included in the list of indicators but does not include a target for childhood obesity reduction.

The *United Nations Conference on Sustainable Development* (Rio +20) might be discussing Sustainable Development Goals and related targets and indicators. In this context, a draft proposal that includes a global goal of nutritious food for all, a target to reduce by two-thirds the proportion of people who suffer from hunger, and uses the prevalence of stunted children under five years of age as an indicator has been formulated.

In the context of the discussion of post-MDG, the Secretary-General has suggested the appointment of a UN Task Team to be led by the Un Department of Economic and Social Affairs (DESA) and UN Development Programme (UNDP), as conveners of the Executive Committee on Economic and Social Affairs (ECESA) and UN Development Group (UNDG) respectively, to coordinate system-wide preparations and propose 'a unified vision and road map for the definition of a UN development

agenda post-2015, in consultation with all stakeholders'. Food security is a priority area for such development, although nutrition is not explicitly mentioned.

The "*Progress Report from countries and their partners in the Movement to Scale Up Nutrition*" released in September 2011 indicates that "Stakeholders in the Scaling Up Nutrition Movement are discussing with SUN countries how best to articulate global impact targets for conditions that are responsible for a large burden of nutrition related morbidity and mortality during the first 1,000 days of life. These goals will be based on success stories and on the existence of effective interventions."

In conclusion, the discussion on nutrition targets at the World Health Assembly would be able to feed into the different process, and there is no apparent misalignment or duplication at the time.

4 - Data underlying the development of the targets are incomplete and they refer to different baseline years, often several years back

A 3-5 year time lag has been considered appropriate for several development objectives, considering the time required for data collection, analysis and reporting. In the case of the proposed targets, data on childhood anthropometry allow to confidently establish a baseline for 2010, which underpins the target of stunting and the target on childhood obesity. In the case of women's anemia, a previous WHO publication (quoted in the background paper on targets) refers to information collected in 1993-2005. The Micronutrients Database of the WHO Vitamin and Mineral Nutrition Information System have now been updated with data collected up to 2011. and is currently being used to develop a baseline for 2010. New estimates of the prevalence of exclusive breastfeeding (37%) and LBW (15%) have been published in the State of the World Children 2012, that allow to establish a baseline with data collected in 2006-2010.

5 - Weakness of surveillance systems limit the possibility to monitor progress towards the achievement of the targets

The establishment of an agreed indicators' framework and the refinement of data collection methodologies, supported by several donors and multilateral agencies, is rapidly improving the quality of surveillance systems. It is acknowledged that while the quality and coverage of information on childhood anthropometry is overall very good, some other areas e.g. the measurement of birth weight and the assessment of anemia rates, pose greater challenges,. The establishment of global targets are expected to intensify the efforts of Member States in strengthening their surveillance systems.

6 - Better information on the actions required to achieve the goals, the failures and successes is required to appreciate the effort required to achieve the goals

The 2010 Review of Nutrition Policies analyzes the achievements and the failures in different policy areas and has been used as a basis to formulate the comprehensive implementation plan on maternal, infant and young child nutrition. The detailed country by country results are included in the *WHO Global Database on the Implementation of Nutrition Actions (GINA)*, which is to be presented in time for the 65th World Health Assembly. Detailed information about effective interventions are presented in the W*HO e-Library of Evidence on Nutrition Actions (eLENA)*, which has also fed into the draft Comprehensive Implementation Plan. The Landscape Analysis country assessment is being undertaken in a number of countries to assess the gaps and constraints being faced by countries to accelerate action in nutrition. The approach used by the *WHO evidence informed policy network* (EVIPNet) is then being used to assist countries to choose among the different policy options based on the global and local evidence of effectiveness. This level of country analysis would be more appropriate to identify the most effective strategy to achieve the proposed goals.

7 - The end date for the achievement of the target should be aligned to that of other global development frameworks

Since a medium-term timeframe has been considered for the comprehensive implementation plan, an alignment with the end date of the MDG (2015) would not be feasible.

While there is no clear end date for the post MDG as yet, a 10-15 year follow up period has been discussed, with potential end dates of 2025-2030. The alternative scenario of a 25 year time frame (2040) might suit better the time frame for some development objectives but might negatively affect political accountability. In both cases, 5 year follow ups have been proposed.

If a 2025 date was selected, this would also align with the date for the NCD targets.

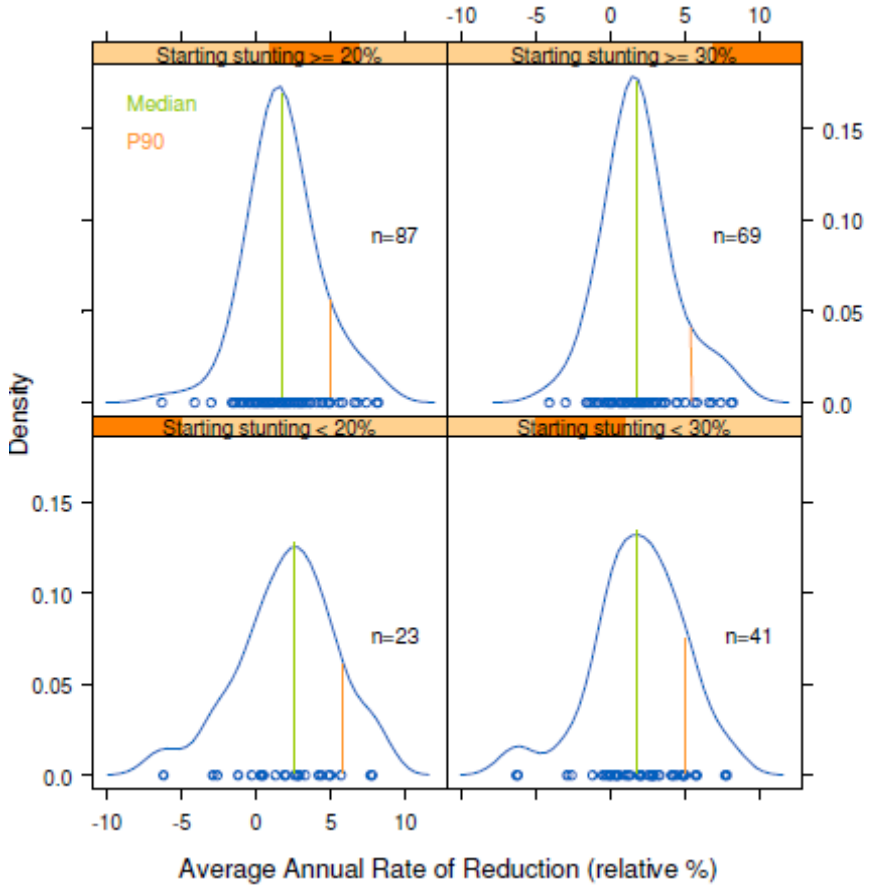
8 - There is not a strong empirical case for a 40% reduction of stunting within 10 years

Analysis on 110 countries for which stunting prevalence is available in at least two occasions in the 1995-2010 period reveals that global stunting is dropping at the rate of 1.8% per year (2.6% in countries with prevalence higher than 30%). In this period 10% of the countries have reduced stunting at a rate of 5.1% or higher, which is what the reduction of 40% would entail. Their baseline prevalence ranged between 9.5% (Jamaica) and 64 % (DPR Korea) and the majority above 20%.

If the current average annual rate of reduction (AARR) of 1.8% is used, global stunting would be reduced by 17% in ten years.

Figure 1 shows the current distribution of stunting variation rates for countries that have a baseline for stunting below 20% (or 30%) and that for stunting ≥ 20% (or 30%). The baseline is the earliest data point for the period 1995-2010 and the end point is the latest available in the same time interval. The 90th centile for countries with baseline stunting ≥30% is 5.12 while it is 5.0 for countries with baseline stunting < 30%

Figure 1 - Distribution of average annual reduction rates of stunting[1]



Countries that in the late '80s or early '90s had stunting rates of 20% or more and that have managed to reduce by 40% or more (41-77%) achieved it in 15-24 years. It therefore seems that a 40% reduction in a single generation can be achieved.

9 - Local and not WHO growth standards should be used to evaluate stunting and obesity

The WHO growth standards describe normal child growth from birth to 5 years under optimal environmental conditions and can be applied to all children everywhere, regardless of ethnicity, socioeconomic status and type of feeding.

[1] Source : WHO, 2012.

A notable effect is that stunting (low height for age) will be greater throughout childhood when assessed using the new WHO standards compared to the previous international reference. There will be a substantial increase in underweight rates during the first half of infancy (i.e., 0-6 months) and a decrease thereafter. With respect to overweight, use of the new WHO standards will result in a greater prevalence that will vary by age, sex and nutritional status of the index population.

Adherence to the WHO growth standards will ensure optimal levels of health globally. The implementation of the WHO standards was recommended by WHA Resolution 63.23

10 - Programmes and policies required to reduce stunting should be spelled out to allow a clear understanding of the feasibility to achieve a stunting reduction target, as well as the cost and the division of labour between global and national actors

The *comprehensive implementation plan on maternal, infant and young child nutrition* identifies a series of actions that can be delivered by the health services to address the priority nutrition conditions, including stunting. It also highlights that such actions include both direct nutrition actions, such as the provision of nutrient supplements, as well as other health actions, such as the treatment of diarrhoea, that influence the intake and the losses of nutrients. The plan also acknowledges the fundamental role of other sectors that need to take action to address nutrition conditions such as stunting. Hence, the provision of safe water, the improvement of sanitation systems, the role of the food system and the contribution of social support schemes are highlighted. It is acknowledged that assembling the guidance and the information on good practices for each of the named conditions, as well as additional modeling studies to calculate the impact of investments in each of the intervention components would facilitate country policy choices.

While it is important to have clarity about effective interventions that are informed by evidence, their application and how to deliver those interventions will depend on the country context and it is difficult to develop a global prescriptive package that would apply in the same way to all countries. The costing and the division of labour have also been addressed in general terms in the comprehensive implementation plan on maternal, infant and young child nutrition, but the specific arrangements need to be discussed at country level.

11 - The target for stunting reduction should be referred to children under the age of 2

Currently we do not have specific data on the under 2, and establishing a target for this age group would have the problems discussed before of establishing a solid baseline and allowing proper monitoring.

Some programme components to address stunting (e.g. breastfeeding and complementary feeding) are specifically directed to children under 2, while other

components (e.g. treatment of moderate and severe malnutrition, vitamin and mineral supplementation) are targeting the broader group of under 5. Monitoring under 2 only would not capture all the nutritional benefits of such comprehensive nutrition intervention approaches.

Combined nutrition interventions show an effect on stunting reduction at least until the 3rd year of life[2] and a life course approach to stunting prevention would still need to be considered so that to prevent a simple shifting of the problem to a later age.

More rapid prevalence changes may be expected if under 2 are separately monitored, but this is not relevant if a 10-15 year time frame is considered.

We do not recommend setting a target for children under the age 2.

12 - How can the anemia target be pursued in absence of considerable progress ?

The absence of considerable global progress is due to inadequate attention given to the issue in terms of investments and programme options adopted. Success in drastic reduction has been documented in several countries.

Causes of anemia are multiple and include inadequate iron intake, concomitant micronutrient deficiencies, short birth spacing, infections and parasite infestations (e.g. malaria, hookworm, HIV, diarrhea). Solutions should be targeted to country needs and cover multiple areas.

While dietary improvement with increased consumption of animal source foods and increased availability of iron fortified products may improve iron status, such benefits may be limited to geographical areas and less vulnerable population groups. Supplementation programmes have also been unsuccessful in terms of coverage or compliance. Several constraints in the way that health services address anemia that are currently limiting progress have been reported, including access to and participation in antenatal care services, coverage of malaria preventive treatment for pregnant women and presumptive treatment of hookworms[3].

Using complementary approaches with fortification and supplementation, using programme approaches that improve efficiency and compliance, such as intermittent supplementation of iron and folic acid, targeting younger age groups such as adolescents would allow greater progress. The need to increase political commitment, to integrate with health programs, better provision of pharmaceuticals and supplies (iron and folic acid, oxytocin or misoprostol, contraceptives for birth spacing, antihelminths antimalarial medications, bednets, and insecticides), to expand roles for

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[2] Bhutta ZA, Ahmed T, Black RE, Cousens S, Dewey K, Giugliani E, Haider BA, Kirkwood B, Morris SS, Sachdev HP, Shekar M; Maternal and Child Undernutrition Study Group. What works? Interventions for maternal and child undernutrition and survival. Lancet. 2008;371(9610):417-40

[3] Klemm R, Sommerfelt AE, Boyo A, Barba C, Kotecha P, Steffen M, and Franklin N. Are We Making Progress on Reducing Anemia in Women? Cross-country Comparison of Anemia Prevalence, Reach, and Use of Antenatal Care and Anemia Reduction Interventions. AED, June 2011.

communities, to increase demand for services through social mobilization and to strengthen monitoring and evaluation are also important considerations[3].

13 - Achieving a 50% reduction in low birth weight will depend a great deal on the effectiveness of maternal care/health systems. A discussion of how maternal care and maternal health systems are to be strengthened in support of reaching these targets would be a welcomed addition to this paper.

We would refer to relevant discussions and documents on the improvement of maternal care and health systems, such as the *Global Strategy for Women's and Children's Health* of the UN Secretary-General. This document highlights, among the priority measures, the need to invest more in programmes and services (with an estimated funding gap for the 49 lowest income countries of US$42 billion in 2015), to improve efficiency (by integrating the care of women and children with other services, using innovation and strengthening the workforce[4]).

In light of a new report on pre-term births and an analysis of the relationship between pre-term and Small for Gestational Age (SGA) the target for the reduction of Low Birth Weight has been revised[5] . Currently, an estimated 15% of all live births are LBW (approximately 20 million births out of 135 million live births annually) and 50% of infants born LBW are pre-term[6]. Approximately less than 10% of pre-term births can be prevented with known interventions, while a larger proportion of SGA births can be prevented (32% with balanced energy and protein supplements during pregnancy and 16% with multiple micronutrient supplements[2]). A global reduction of 30% of the LBW seems more in line with these findings.

14 - Additional data sources are needed in order to fully assess the feasibility of this indicator at a global level.

While several comments expressed concerns about the feasibility of a zero growth of childhood obesity, others found this target not ambitious enough.

The rates of increase are variable in different parts of the world, with more rapid increases in countries that are rapidly expanding their food systems, such as those in northern Africa. In higher income countries national and regional level information indicate that higher socio-economic groups have a lower increase in childhood obesity. Lifestyle and environmental interventions used in such circumstances can be used as an example of good practice. In low-middle income countries little programmatic experience exists. Programmes aimed at curbing childhood obesity have mainly

[4] Access for all to skilled, motivated, and supported health workers. Background paper 4 for the Global Strategy for women and children's health (http://www.who.int/pmnch/activities/jointactionplan/20101007_4_skilledworkers.pdf)
[5] Global pre-term birth report (in publication)
[6] Barros FC, et al. How many low birthweight babies in low- and middle-income countries are preterm? Rev Saude Publica. 2011; 45(3): 607-16

targeted schoolage children[7]. However, the establishment of preventive policies can tackle the issue at its start, while it seems more difficult to intervene once the trend has taken off. It would also be important to prevent an increase in childhood overweight in countries that are addressing the reduction of stunting. Intervention strategies should therefore aim at the improvement of linear growth rather than weight gain.[8]

15 - A target on adequate complementary feeding should be added

In general, the proliferation of targets should be avoided, not to reduce the value of a targeting exercise. Comprehensiveness might be at the expense of focus and measurability.

On the other hand, the advantage of such a target would be to highlight the continuum of feeding practices.

Should Member States wish to introduce such a target, the UNICEF Childinfo database presents information on the proportion of children for whom solid food has been introduced at the age of 6-8 months[9]. It is more difficult to get information on the quality of complementary food.

The *comprehensive implementation plan on maternal, infant and young child nutrition* includes the "Proportion of children receiving a minimum acceptable diet at 6–23 months of age" as an indicator. The composite indicator is calculated from: the proportion of breastfed children aged 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day and, the proportion of non-breastfed children aged 6–23 months who received at least two milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day. Data can be obtained from National Surveys, Demographoc Health Surveys (DHS) and Multiple Indicators' Cluster surveys (MICS), but the availability of the data is still insufficient to allow set global targets.

16 - A target on wasting should be added, with the following formulation : "40% reduction of the global number of children under five who are wasted" and the following indicator : "percentage of children under two years of age whose weight for height or MUAC is below minus two standard deviations from the median of the WHO Child Growth Standards"

[7] Population-based prevention strategies for childhood obesity: report of a WHO forum and technical meeting, Geneva, 15–17 December 2009
[8] Uauy R, Kain J, Mericq V, Rojas J, Corvalán C. Nutrition, child growth, and chronic disease prevention. Ann Med. 2008;40(1):11-20
[9] http://www.childinfo.org/nutrition.html

Wasting is an important issue in some of the countries and this would be an important addition to the set of targets, although the increase in the number of targets would lead to lack of focus.

Wasting reduction would be relevant for a subset of countries who are more prone to food insecurity and emergencies, including conflicts or financial instability.

Wasting prevalence is also much more volatile than stunting and a target on wasting reduction may be more important in the short term. On the other hand, keeping wasting rates low would also be important to reduce chronic undernutrition and child mortality.

A recommendation might be made to include wasting reduction as a country target in areas where the problems still exists and in areas that are prone to vulnerabilities. Such wasting reduction should be sustained and should not be considered as achieved in the first instance of success.