IBFAN ASIA PACIFIC

Achieving the Millenium Development Goals (MDGs)

Invest More in Infancy and Prevent Child Malnutrition and Deaths

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CALLING THE ATTENTION OF

- Ministers of Health
- Ministers of Women and Children's issues.
- Members of Parliaments/Legislative assemblies.
- Civil servants
- Donors, International agencies e.g. World Bank, UNICEF, WHO, UNAIDs

At the

7th East Asia and Pacific Ministerial Consultation on Children Siem Reap, Cambodia. 23-25 March 2005.

"We strive towards the day when nations will be judged not by their military or economic strength, nor by the splendour of their capital cities and public buildings, but by the well-being of their children"

PROGRESS FOR CHILDREN September 2004 UNICEF New York

According to UNICEF estimates, at present rates, under-five mortality will be reduced by 23 per cent globally over the 1990-2015 periods –well below the goal of a two-thirds reduction. Although steady progress has been made in East Asia and the Pacific since the early 1990s, it has been an average annual reduction rate of child mortality that would fall short of meeting the Millennium Development Goal 4. For East Asia and Pacific, it is a worrying slowdown of under-five child deaths.

This paper provides insight into the issue of infant and young child undernutrition and mortality and argues for increased allocation of resources for the infant and the young child nutrition . If the region is to achieve the Millennium Development Goal 4 to reduce child mortality, some bold decisions are needed to scale up substantially the investment for the newborn, infant and the very young child. And that too, urgently, since this action stands critical for success.

INTRODUCTION

The *Global Strategy for Infant and Young Child Feeding* was adopted by consensus at the World Health Assembly in May 2002 and UNICEF Executive Board in September 2002. It recognises that *"Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life."* Optimal infant and young child nutrition is necessary for a solid start in life and would cut 19% of total under five child mortality, or over 1.8 million deaths annually. Child malnutrition contributes to more deaths than any other health condition. Worse yet, the survivors are not able to develop to their full potential. The very statement makes sound case for investments in the health and development of infants.

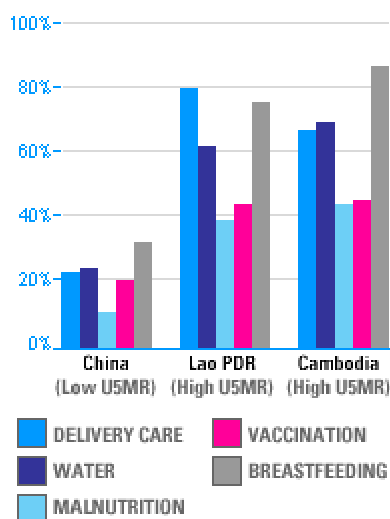
According to the UNICEF's report Progress for Children, the East Asia and Pacific region has cut child mortality rates by over 75 per cent since 1960. At present only 43 children out of 1000 live births do not reach there 5th birthday. Unlike Latin America and the Caribbean, however, the momentum of reduction has slowed sharply over the past two decades. Between1980 and 2000, the annual reduction rate averaged just 2.8 per cent, compared with almost 5 per cent in 1960s and 1970s.The slowdown mostly reflects trends in China with U-5 mortality at 39 per 1000 live births; in the past two decades progress on reducing child mortality has slowed sharply, and was less than 2 per cent during the 1990s. In contrast, under-5 mortality has fallen rapidly in Indonesia, the second most populous country in the region. Indonesia managed to halve its infant mortality from 91 per 1,000 live births in 1990 to just 45 in 2002, a level approaching China's rate for the same year. Indonesia remains on schedule to meet MDG 4. Other than Indonesia, the best performing countries in the region over the past decade are those that enjoyed the lowest levels of child mortality in 1990: Brunei Darussalam, Malaysia, Republic of Korea and Singapore. All four countries have managed to reduce their child mortality rates to levels comparable to those in industrialized countries. The Philippines also remains on schedule to meet MDG 4, having cut its child mortality rate by 40 per cent. Greater efforts are required to lower the child mortality in the Pacific islands that are falling behind. Cambodia has unfortunately seen an increase in child mortality since 1990. Progress has been slow in other countries like Myanmar, and Papua New Guinea and it has stagnated in Peoples Republic of Korea.

KEY FACTORS ASSOCIATED WITH CHILD MORTALITY

The report identifies following risk factors of under-five child mortality, and how these could be monitored. The graphic figure provides some data from select countries e.g. China, Laos PDR and Cambodia.

1. **Delivery care** – Percentage of births NOT attended by skilled health personnel.

2. **Water** – Percentage of population NOT using improved water sources.
3. **Malnutrition** – Percentage of under- fives moderately or severely underweight.
4. **Vaccination** – Percentage of one year old children that did NOT receive three doses of DPT.
5. **Breastfeeding** – Percentage of children under 6 months of age who are NOT exclusively breastfed.



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Most countries in the region would need to scale up their efforts to enhance the average rate of reduction of child deaths varying from 4.5 to 9 per year from 2002 to 2015. Action is required in all the identified areas; however, in this paper we focus on reduction of newborn and infant mortality through exclusive breastfeeding. An analysis of 2005 data on exclusive breastfeeding in East Asia and Pacific reveals that only about half of babies are NOT exclusively breastfed during 0-6 months. This dismally low rate of exclusive breastfeeding is closely related to newborn and infant mortality as well as child malnutrition. Inadequate complementary feeding further adds to the problem of malnutrition. Of particular value is to scale up coverage of exclusive breastfeeding for the first six months and adequate complementary feeding from 7-24 months. It is not like delivery of a 'vaccine' but deserves similar count as far as coverage is concerned.

PREVENTING CHILD DEATHS: THE EVIDENCE

The Lancet a year ago published child survival series, which showed that interventions to reduce child deaths are available. The vital role of optimal infant feeding practices in reducing child mortality has once again been highlighted by the international health community. This has noted that 13 % of the roughly 10 million under-five deaths could be prevented through improved breastfeeding practices[1], with a further 6% reduction possible through better complementary feeding. Thus, optimal infant and young child nutrition would cut 19% of total under five child mortality or over 1.8 million deaths annually. They also note that if all these preventive and curative interventions were universally available, then something like 63 per cent of child deaths would be prevented. In other words, the interventions needed to achieve the UN mandated Millennium Development Goal of

[1] Jones G, Steketee R, Bhutta Z, Morris S. and the Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *Lancet* 2003; **362:**65-71.

reducing child mortality by two-thirds by 2015 are available, but not being delivered to the mothers and children who need them.

TACKLING MALNUTRITION IN ITS INFANCY

Malnutrition among children occurs almost entirely during first two years of life and is virtually irreversible after that. Obviously, it tremendously impacts the development outcomes, as global research indicates that 85% of a child's core brain structure is already formed by the age 3. Malnutrition impairs cognitive development, intelligence, strength, energy and productivity of a nation. In spite of these costs to the nations, workable solutions to this problem are yet to be found. As malnutrition strikes the most during first two years, it disturbs the very foundation of life and development. It is thus critical to invest in the early years of life. More specifically, it is crucial to identify investments for spending on ensuring optimal infant and young child feeding practices that would lead to improved nutrition, health and development outcomes. The fact that child malnutrition and related deaths, and inappropriate feeding practices contribute to 2/3rds of these deaths needs to be better understood by the policy makers and decision makers.

Malnutrition in young children is frequently not mainly a problem of food availability and access to food. It is often due to the lack of optimal feeding during first two years, particularly lack of exclusive breastfeeding during the first six months and adequate complementary feeding along with continued breastfeeding after six months to two years or beyond. While addressing *Food Security* of a nation, a child 0-24 months is hardly counted. Lack of recognition of breastfeeding as a means of food security for the young, and its role in providing all the care and stimulation for them to develop well has been a matter of general concern. Lack of food is responded by proving 'food', lack of exclusive breastfeeding is hardly made up through efforts that can bring it up. Programmes aimed at food supplies cannot be expected to solve this problem.

EARLY ACTION IS CRITICAL

Clearly, direct nutrition interventions before two years of age, including those to improve maternal nutritional status, are therefore essential. Since these are critical to human development, and thus cannot be ignored. The first steps among proven cost-effective direct nutrition interventions are efforts to assure that every child receives her god-given right to mother's milk, exclusive breastfeeding for the first six months, adequate and appropriate complementary feeding along with continued breastfeeding after six months to two years or beyond. Yet, very few babies under the age of six months are exclusively breastfed in the region. Ideally this percentage should be 90 per cent to achieve reasonable reduction in prevalence of child malnutrition and mortality. According to the available evidence it is possible to scale up the exclusive breastfeeding rates to 80-90%.

EXTRA BENEFITS

Preventing Obesity

More and more data continues to flow, there is compelling evidence that breastfeeding protects against obesity later in childhood. Breastfeeding is therefore potentially useful for population-based strategies aimed at obesity prevention, particularly with the other benefits that breastfeeding provides. For nations who are facing the problem of obesity significantly, this provides a wonderful opportunity to use breastfeeding promotion as a long- term strategy for reducing obesity. Early nutrition in fact may act as a programming agent in critical early years of life. This is also relevant in the context of rapidly increasing levels of child and adult obesity and obesity related diseases such as Type II diabetes.

Long Term Health Outcomes

There is also strong evidence available to support that breastfeeding has beneficial effects on later cardiovascular risk factors including blood pressure and plasma lipid profile, it significantly improves cognitive development, and reduces the incidence of atopy.

Prevention of HIV Infection among Infants

The UN General Assembly Special Sessions for Children and on HIV/AIDS sets out goals for 2010 that include reducing proportion of infants infected with HIV by 50%. To achieve these goals prevention of HIV infection in pregnant women, mothers and their children, including transmission to young children through breastfeeding, should be part of a comprehensive approach both to HIV prevention and care for women and children and to Maternal and Child Health (MCH)/Reproductive Child Health (RCH) care services.

HIV is not a major cause of deaths in the region but definitely poses a future challenge. Universal exclusive breastfeeding, as has been confirmed by several studies, is the most feasible way to keep the majority of babies born in HIV endemic countries alive and healthy through infancy. And a mother can reduce the risk of transmission to her child by more than half by exclusively breastfeeding, compared with a mother who combines breastfeeding with other foods or liquids so called –"mixed feeding". 'Safer' exclusive breastfeeding is now coming up as an option in the majority of situations where replacement feeding is not acceptable, feasible, affordable, sustainable & safe (AFASS), and leads to reduced rates of HIV transmission. This means providing breastfeeding education, prevention of breastfeeding problems such as sore nipples/mastitis, and may include ARV for infants. By scaling up coverage of exclusive breastfeeding in the countries, it would also contribute to achieving MDG 6 aiming at preventing HIV. According to most recent study of programmes across the world, it has been found that HIV positive women are more likely to sustain exclusive breastfeeding for at least first six months when they receive infant feeding information, counseling and support through HIV outreach programmes. The *HIV and Infant Feeding Framework for Priority Action* endorsed by 9 UN

agencies clearly points out 5 areas of priority action and this action is contained in. These international commitments provide a human rights perspective and show the way forward on how to address the most complex issue of preventing infant HIV in HIV positive women keeping in mind the importance of primary prevention in women as an essential basis for action.

POLITICAL RESPONSE

A 2005 report on the Millennium Project to the UN Secretary General , *"Investing in Development: A Practical Plan to Achieve the Millennium Development Goals"* points out interventions by area: Poverty and hunger reduction and Urban hunger all have the following components on *Nutrition for infants, pregnant women, and nursing mothers.*

1. Promotion of mother- and baby-friendly community initiatives, including exclusive breastfeeding for first 6 months and complementary feeding with continuing breastfeeding for infants ages 7–24 months.
2. HIV-positive mothers should use replacement feeding when it is acceptable, feasible, affordable, sustainable, and safe.
3. Provision of sufficient calories, protein, and micronutrients to pregnant women and nursing mothers, supported by nutrition extension workers and using locally produced food to the extent possible.

Additionally the Child health area of action includes;

4. Integrated neonatal integrated health package that has clean delivery, newborn resuscitation, prevention of hypothermia, and **breastfeeding education (including education on replacement feeding for HIV positive mothers).**

And for "Prevention of mother-to-child transmission

5. Prevention of transmission of HIV from infected women to their infants during pregnancy, labor, and delivery, as well as during breastfeeding (that is, replacement feeding when it is acceptable, feasible, affordable, sustainable, and safe); includes short-term antiretroviral prophylactic treatment; infant feeding, counseling, and support; and the use of safer infant feeding methods.

The interventions mentioned have been the result of global team effort and a wide consultative process of all concerned. Of course require additional spending. It needs high level political response. It is here, leaders in the region need to take some positive and forward looking decisions. While you may continue to put money for the health and development of older children, for food and education, sufficient resources must also be identified to **focus on newborn, infants and the young child nutrition.** This is an "investment gap" which we must try and bridge. All countries are called upon to do an analysis of the 'investment gap' and mobilize action for resource mobilization. Specific resources must be identified to ensure optimal infant and young child feeding practices as well as home hygiene and stimulating environment at home. Most may argue, we are

already doing enough but we need to carefully re-look at the current situation and efforts needed to achieve 90% coverage for exclusive breastfeeding and adequate complementary feeding.

INFANTS AND YOUNG CHILDREN CAN'T WAIT!

Nutrition during the early years of life is critical for early child development and human development not only because young babies are vulnerable, but also because the time is critical for almost all of brain growth during this period. In the long run, healthier adults contribute to greater economic productivity. To conclude, it would be alarming if we fail to attend to such direct and cost saving actions to improve infant well being, health and development. Benefits of such direct interventions during the first two years of life are proven, affordable and sustainable. The costs of further non-action are virtually unaffordable to nation building. Spending on infant and young child nutrition, especially on improving infant and young child feeding, should be treated as an "investment pillar" for improved health and development outcomes of the children and the society. Benefits actually go much beyond the perceived. Policies and interventions that are not dependant on economic growth must now be applied to achieve the MDGs of reducing mortality and preventing HIV.

KEY ACTIONS

Following are some of the key actions that can initiate implementation of the Global Strategy for Infant and Young Child Feeding in your country. IBFAN Asia Pacific would be very willing to support and assist in the area of capacity building in counselling, trend analysis and advocacy.

1. Ask for trend analysis of breastfeeding in your country
2. Call for a national consultation of all possible partners (without the baby food industry) to implement the *Global Strategy for Infant and Young Child Feeding*, assess its current status and identify gaps. The strategy provides framework for all and also in difficult circumstances like HIV and emergency disaster situations.
3. Draw an action plan on protecting, promoting and supporting optimal Infant and young child feeding in your country with identified budgets, clears objectives, activities and monitoring and evaluation components in place.
4. Find out 'investment gap' and mobilize resources.
5. Identify capacity building needs particularly for infant and young feeding counselling as well as infant feeding in HIV situations.
6. Exclusive breastfeeding during the first six months must be kept as a lead proxy indicator and monitored on a yearly basis for review of actions.