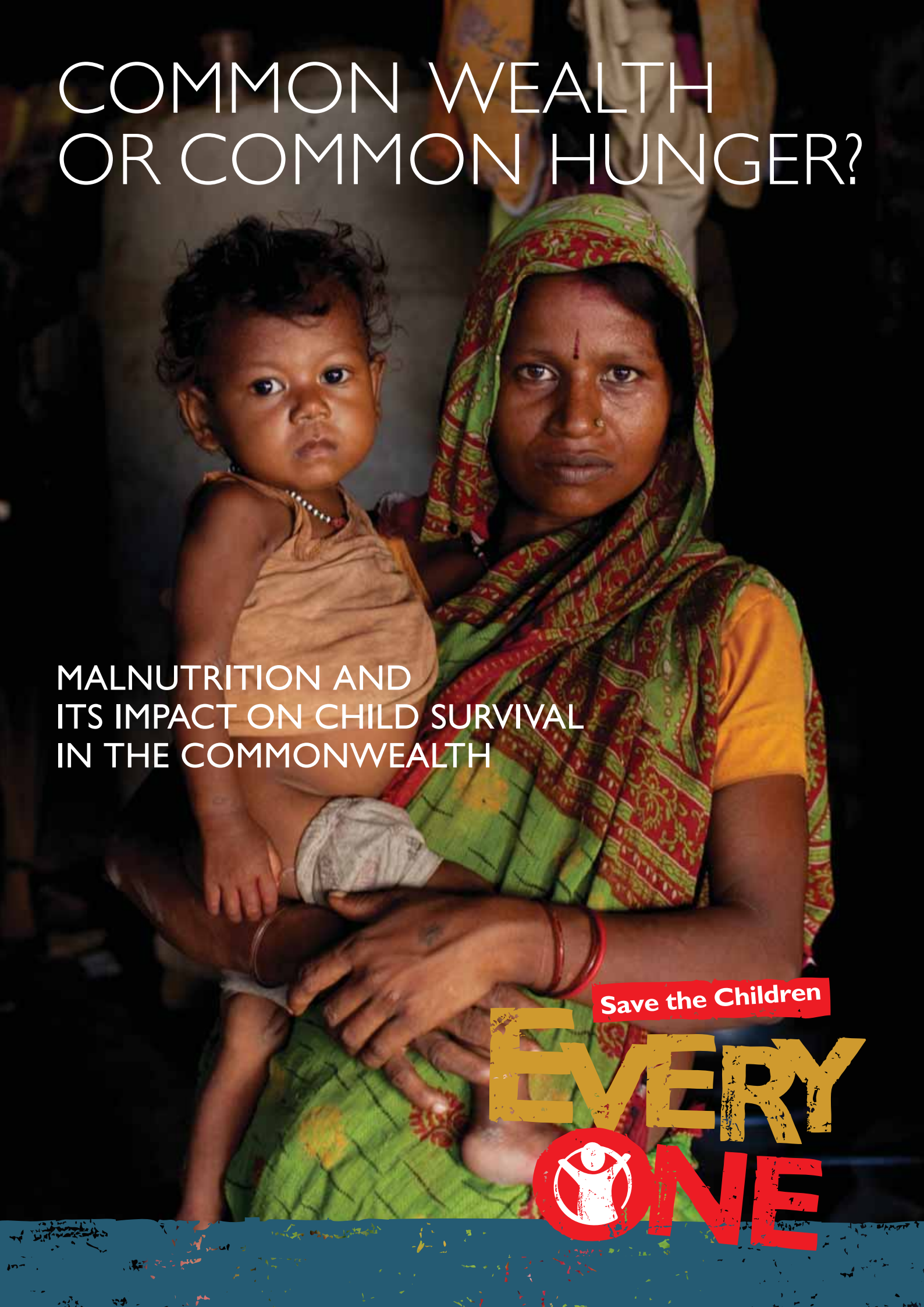
COMMON WEALTH OR COMMON HUNGER?



MALNUTRITION AND ITS IMPACT ON CHILD SURVIVAL IN THE COMMONWEALTH

Save the Children

EVERY ONE

COMMON WEALTH OR COMMON HUNGER?

MALNUTRITION AND ITS IMPACT ON CHILD SURVIVAL IN THE COMMONWEALTH

Save the Children is the world's leading independent children's rights organisation, with members in 29 countries and operational programmes in more than 120. We fight for children's rights and deliver lasting improvements to children's lives worldwide.

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Cover photo: Rambha lives in Bihar, India and lost her first child when she was a year old. "Her arms were thin and her legs were thin. She lost all her weight. She just got thinner and thinner and I didn't know what to do. Rani, my one-year-old baby girl, is also thin. I'm worried that she could get thinner and die too, but there is nothing I can do." (Photo: Anna Kari/Save the Children)

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THE STORY IN NUMBERS

India, host to the 2010 Commonwealth Games, has led the largest food and nutrition security programmes, such as the Integrated Child Development Services (which reaches over 50 million children), the Midday Meal Scheme and the Public Distribution System, although it still remains home to the highest number of malnourished children.

Globally, more than **3 million** children die every year from undernutrition-related causes.

An estimated one-third of children under five years old in the developing world are stunted – that's 195 million children – and 129 million are underweight.

The critical period, when malnutrition can have the most irrevocable impact, is during the 33 months from conception to a child's second birthday – the first 1,000 days.

After two years of age, it is much harder to reverse the effects of chronic malnutrition, particularly its impact on the development of the brain.

Thirty per cent of the world's population lives in the 54 diverse countries that make up the Commonwealth – and at least 64% of the world's underweight children.

Nearly half of all under-fives in India are undernourished, almost 7 million of them with severe acute malnutrition.

Bangladesh and Pakistan have high rates of malnourished children – 41% and 31% respectively.

Of the African Commonwealth countries, Sierra Leone (21%) and Nigeria (23%) have the highest proportions of malnourished children, Nigeria having the highest actual number, with more than 5.57 million.

FOREWORD

I am glad to write a foreword to this report highlighting the issues of child undernutrition in countries of the Commonwealth. The Commonwealth, while representing 30% of the countries of the world, is home to 64% of the world's underweight children. We therefore have a particular responsibility in sharing information and driving forward action.

Efforts to share knowledge on malnutrition are the basis of the betterment of our societies as the young represent the pinnacle of our potential. The Commonwealth Games are a celebration of the physical expression of the talent available in these countries – a talent that is fuelled by good nutrition and support for children's development.

When the young suffer from undernourishment, society must make every effort to improve their nutrition, so that our children can grow and develop to their greatest potential.

The Commonwealth is not only a great association of democratic countries, it is a meeting ground of some of the world's greatest leaders. We know that child malnutrition will only be tackled with strong leadership and a coalition of the compassionate. This is because the interventions needed to tackle malnutrition are delivered by different government ministries and a range of programmes.

India has a vast burden of malnutrition among children and mothers, and the Prime Minister has called it a national shame. We now need to see urgent action that will deliver real change in the lives of mothers and their children in India. But I hope that we will see changes that can be shared with other countries across the Commonwealth.

To start this task USAID through its Vistaar project, in collaboration with a large number of stakeholders, set up the Coalition for Sustainable Nutrition Security in India in 2007, a group of policy and programme leaders committed to raising awareness, fostering collaboration, and advocating for improved programmes to achieve nutrition security (www.nutritioncoalition.in).

I hope this report will also help civil society groups to persuade governments to overcome hunger and malnutrition in their countries. But my appeal to the international organisations supporting the race to meet the challenges of the Millennium Development Goals on hunger and malnutrition is to start thinking together, to mainstream nutrition in all human development and healthcare programmes.

Professor M. S. Swaminathan
Member of Parliament (Rajya Sabha)
Chairman, M. S. Swaminathan Research Foundation
Chairman, Coalition for Sustainable Nutrition Security of India

INTRODUCTION

Thirty per cent of the world's population lives in the 54 diverse countries that make up the Commonwealth – and **64% of the world's underweight children**. India, host to the 2010 Commonwealth Games, has both the highest number and the highest proportion of malnourished children in the world. Nearly half of all under-fives in India – 55 million children – are malnourished, almost 7 million of them with severe acute malnutrition. Bangladesh and Pakistan also have appallingly high rates of malnourished children – 41% and 31% respectively. Of the African Commonwealth countries, Sierra Leone (21%) and Nigeria (23%) have the highest proportions of malnourished children, Nigeria having the highest actual number, with more than 5.75 million.

In 2000, all Commonwealth governments committed to achieving the Millennium Development Goals (MDGs), the first of which is to halve hunger and malnutrition by 2015. MDG 1 also has a direct impact on progress towards other goals, such as MDG 4 to reduce child mortality. More than 3 million children die every year from malnutrition-related causes.[1]

Yet, of the 28 Commonwealth countries for which data is available, only nine are on track to achieve MDG 1.[2] Botswana is the most impressive, having achieved an average 7.8% annual reduction in its percentage of underweight children. South Africa and Cameroon, on the other hand, have gone backwards, with higher rates of under-five malnutrition in 2008 than they had in 1990 (a reduction of minus 2.8% and minus 2.5% annually respectively).

India, which is going through a period of unprecedented economic growth, has achieved just 0.9% progress – not enough to get anywhere near achieving MDG 1. Bangladesh and Pakistan have done slightly better (with a 2.3% and 1.7% reduction respectively) but it is still too little too late. Impressively, Botswana, Sri Lanka, Ghana, Mozambique, Swaziland, Jamaica, Malaysia and the Maldives are all on course to achieve the goal. There are clearly lessons to be learned from these countries and some examples are shared in this report. However, the global financial crisis and preceding hike in food prices also threatens progress in even these countries, and there is potential for further price increases with the resurgence of global growth.

This report focuses on seven Commonwealth countries with the highest number of malnourished children and which are not on track to achieve MDG 1. It shares recommendations for leaders across the Commonwealth to accelerate progress towards the goal.

A sustained high-level political focus on nutrition is needed to achieve MDG 1 across the Commonwealth. If the Commonwealth is to mean anything at all for future generations, and if the majority of its children are ever to stand a fair chance of survival – let alone of competing in the Commonwealth Games – its leaders must urgently work together, sharing best practice and comparing progress.

PREVALENCE OF CHILD MALNUTRITION IN THE COMMONWEALTH

WHAT IS CHILD MALNUTRITION?

Malnutrition is the result of a range of causes at the international, national, community, household and individual levels. The most immediate causes are related to the dietary intake and health status of individuals. They are influenced by underlying causes at the household level, including food insecurity and inadequate care for mothers and children. The low status of women; poverty; inadequate economic, social and cultural institutions; poor health services and unhealthy living conditions all contribute to these underlying causes.

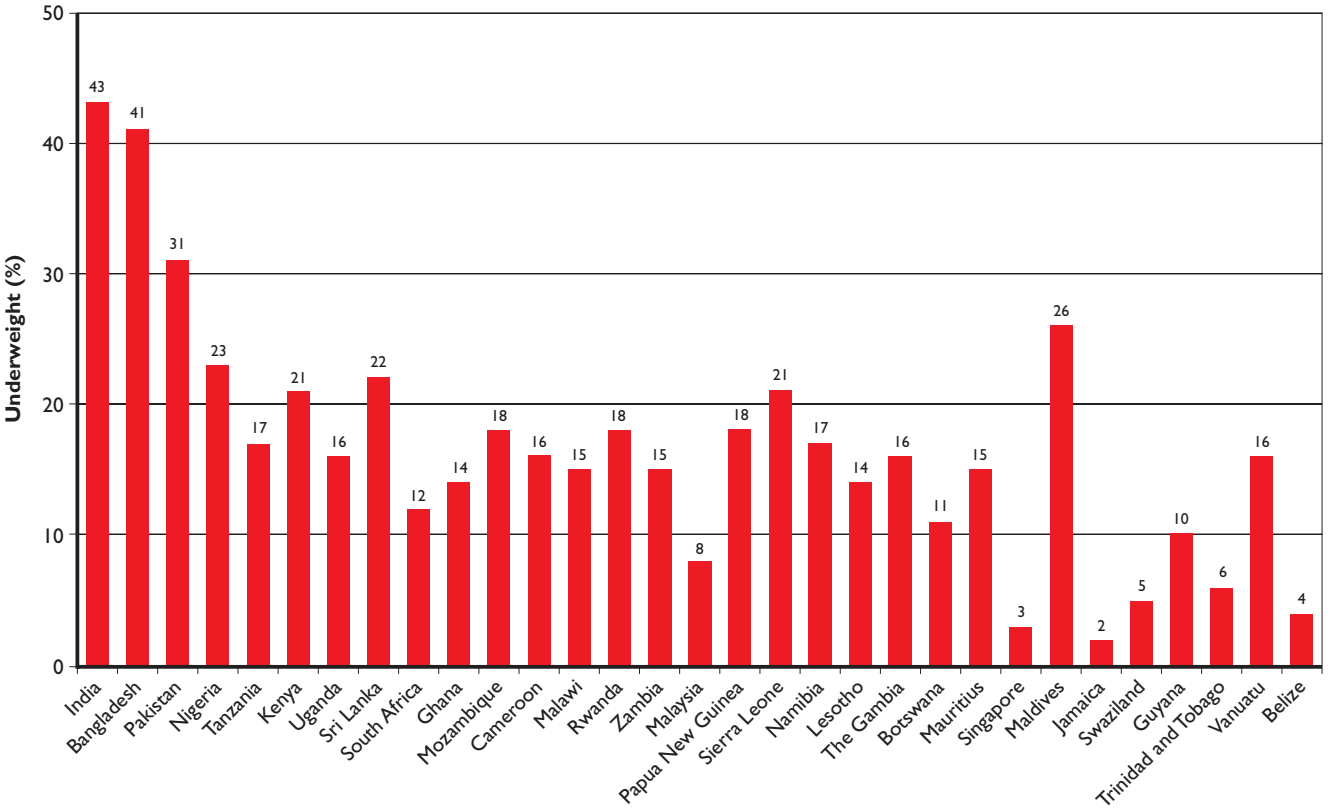
Undernourished children have reduced immunity and are less able to recover from infection. Malnutrition is also an **underlying cause in 35% of all preventable deaths in children under five each year**.[3] Even those who survive are likely to suffer from recurring sickness, impaired physical and mental development, and reduced productivity.

There are three measures of child malnutrition:

- **Chronic**, long-term malnutrition can result in children being too short for their age (stunted).
- **Acute**, fast-onset malnutrition results in a child being dangerously thin for their height (wasted).
- An **underweight** child has a low weight for their age and could be chronically and/or acutely malnourished. It is also the key indicator for MDG 1.

An estimated one third of children under five years old in the developing world are stunted – that's 195 million – and 129 million are underweight. **More than two-thirds of stunted children (88.5 million, 68.6%) and nearly half of those who are underweight (95 million, 48.7%) live in just seven Commonwealth countries** – India, Bangladesh, Pakistan, Nigeria, Tanzania, Kenya and Uganda. India, alone, has 55.5 million underweight children.[4]

Chart 1: Percentage of children underweight among different countries

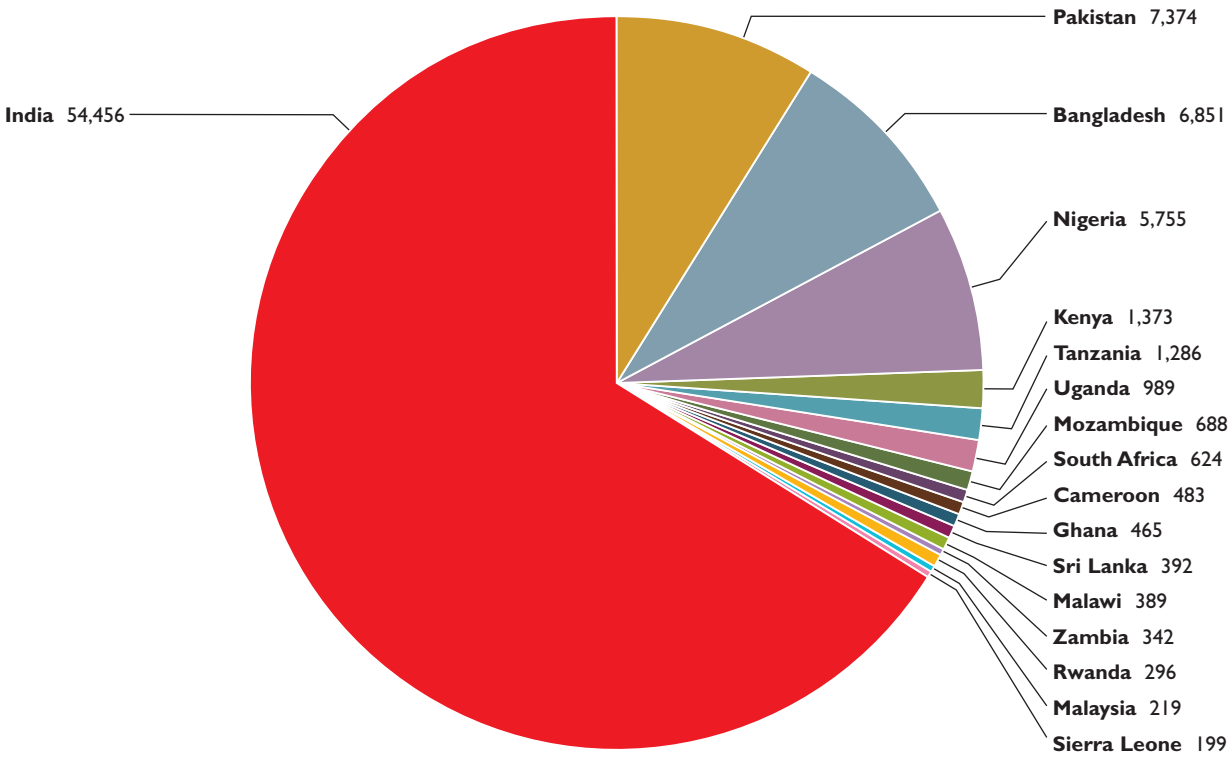


Source: UNICEF (2009), *Tracking Progress on Child and Maternal Nutrition*

Note:

1. Estimates are calculated according to the WHO child growth standards (See the General notes on data in *Tracking Progress on Child and Maternal Nutrition* (UNICEF (2009)) except in the countries of Kenya, Malaysia, Mozambique, Mauritius, South Africa, and Vanuatu, where data based on WHO child growth standards were not available and therefore the National Centre for Health Statistics (NCHS) based data has been used to estimate percentage of underweight
2. For Pakistan, the Maldives, Singapore, Botswana, Papua New Guinea and Lesotho, the reference period is different from the other countries mentioned (2003–2008) and does not use the standard definition of underweight children. The data of all such countries irrespective of data inadequacies are presented here to show the prevalence of underweight children

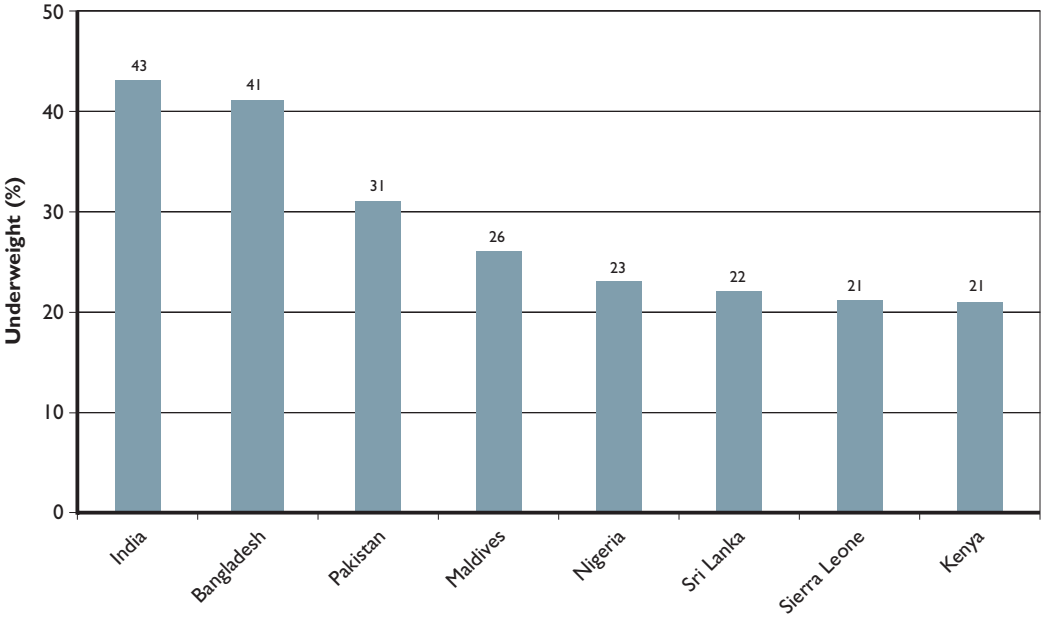
Chart 2: Underweight children in selected Commonwealth countries ('000s)



Source: UNICEF (2009), *Tracking Progress on Child and Maternal Nutrition*

Note: Percentage of underweight children below five years used to calculate number of underweight children from the absolute number of under five child population in respective countries. Data for the 17 countries with the highest number of underweight children is presented here.

Chart 3: Commonwealth countries with highest prevalence rates of underweight children (percent)



Source: UNICEF (2009), *Tracking Progress on Child and Maternal Nutrition*

WHAT CAUSES MALNUTRITION?

A major cause of malnutrition is a poor diet, which makes newborn babies and infants more vulnerable to infection and less able to recover from common childhood illnesses such as pneumonia and diarrhoea. Poverty; household food insecurity; the low status of women; poor hygiene, sanitation and access to clean water; and inadequate public health services all contribute to malnutrition and are a threat to children's survival.

The critical period – when malnutrition can have the most irrevocable impact – is during the 33 months from conception to a child's second birthday. During this time, it is possible to significantly catch up but after two years of age, it is much harder to reverse the effects of chronic malnutrition, particularly its impact on the development of the brain.

Deficiencies in key nutrients such as vitamin A and zinc are substantial contributors to child deaths attributable to micronutrient deficiencies. For example, Vitamin A deficiency contributes to slowed growth and poor immune function, and is associated with increased morbidity and mortality.[5]

More than half of pregnant women in developing countries, and 85% in South Asia, are affected by anaemia, which increases the risk of pre-term delivery, low birth weight, haemorrhage and sepsis.

WHY IS CHILD MALNUTRITION SO PREVALENT IN SOME COMMONWEALTH COUNTRIES?

India, Pakistan and Bangladesh continue to have excessively high rates of child malnutrition, even compared with nations of similar or lower levels of economic development.

One explanation is that malnutrition starts earlier, before conception. In India, 36% of women are malnourished with a body mass index of less than 18.5 kg/m^2 compared with 12% in Nigeria.[6] Malnourished mothers often give birth to smaller children. India, Pakistan and Bangladesh all have significantly higher levels of children being born at low birth weight than developing countries in other parts of the world. In these three countries, between 22% and 32% of babies are born weighing less than 2.5kg. They begin life already malnourished and at a disadvantage. Many are unable to catch up and therefore remain underweight. With the exception of Sierra Leone, with a low birth weight rate of 24%, rates in Africa are around half of those in these three South Asian countries.[7]

Political failures

A major cause of child malnutrition is lack of investment in healthcare, education and support for the poorest families. Interventions are also uncoordinated and ineffectual because of the number of ministries and agencies involved, and a lack of leadership.

Rich Commonwealth countries are failing poor ones, and most high-burden countries lack national strategies to combat malnutrition. A failure to address issues of equity means that poor children are more likely to be underweight than their wealthy counterparts – by as much as three times in India and Kenya.[8]

Low status of women

Women's low social and nutrition status in India, Pakistan and Bangladesh is partly responsible for the high levels of low birth weight.[9] Low status can mean that women are unable to seek healthcare without the permission of their family. In India and Pakistan, less than half of women receive the recommended number of antenatal care visits compared with 62% in Tanzania and 57% in Malawi. Small mothers without access to adequate are more likely to deliver small babies, who will in turn be at greater risk of poor development, high rates of illness and higher mortality rates.

Low levels of breastfeeding

Starting breastfeeding within an hour of delivery can reduce neonatal deaths by 22%.[10] It ensures that the baby gets the first milk, the colostrum, when the antibody content is highest and takes advantage of newborn babies' immediate sucking reflex. Breast milk provides all the energy and nutrients an infant needs during the first six months of life. It also reduces the risk of infection and death from common childhood illnesses, and helps ill children to recover and regain their strength.

While breast milk alone is sufficient for the first six months of life, after this age it is necessary to introduce solid or semi-solid foods to a child's diet to complement continued breastfeeding up to two years and beyond. Complementary feeding needs to be of appropriate diversity and frequency to prevent children from becoming malnourished.

However, as Table 1 (below) shows, while most mothers breastfeed, rates of early and exclusive breastfeeding are low in six of the seven high-burden Commonwealth countries. Rates of exclusive breastfeeding are poor at 37% to 46% in Pakistan, Bangladesh and India respectively, but are even lower in Nigeria and at 13%.

Pakistan has the lowest rate of complementary feeding, with only a third of children receiving solid or semi-solid food at six months. Rates of continued breastfeeding vary greatly, from under a third of 20–23-month-olds still receiving breastmilk in Nigeria, to a study of a village in Bangladesh where the rates were 91%.

Food insecurity and rising prices

Agriculture, agro-pastoralism or pastoralism is the mainstay of the rural economy in all the seven high-burden Commonwealth countries. However, most of the poorest families have to buy much of their food using income gained from working for others. UN Food and Agriculture Organization data from 12 countries has shown that, on average, only 31% of households in rural areas are net sellers of food.[11] Save the Children found that in Bangladesh's Kurigram district, families categorised as poor or very poor got no food from their own livestock. In Kenya's Wajir South Grassland Zone, no families derived any benefit from their own agricultural production, and only 2–5% of families categorised as poor and very poor (approximately 55% of total population) derived food from their own livestock.[12]

Table 1: Newborn, infant and young child feeding in high-burden Commonwealth countries

Country	Initiation of breastfeeding within an hour of delivery	Exclusively breastfed (children <6 months) (%)	Breastfed with complementary food (6–9 months) (%)	Continued breastfeeding (20–23 months) (%)
India	25	46	57	77
Bangladesh	43	43	74	91
Pakistan	29	37	36	55
Nigeria	32	13	75	32
Tanzania	67	41	91	55
Kenya	52	13	84	57
Uganda	42	60	80	54

Source: UNICEF Childinfo: Monitoring the Situation of Children and Women www.childinfo.org

Recent food price rises have put nutritious food even further out of reach for many families in developing countries. This is especially true for poor rural families who have to spend a high proportion of their income on food (in some cases as much as 80%, compared with 9% in the UK). Instead, the incidence of stunting has remained the same. In Mozambique – currently on track to achieve MDG 1 – a 17% rise in the price of bread led to food riots in September 2010.

Emergencies

Emergencies triggered by climatic events, market fluctuations or conflict are becoming more frequent and they inevitably place children at even greater risk of malnutrition, particularly acute malnutrition. Yet many governments are ill prepared for emergencies, increasing the risk of acute malnutrition among children.

Early intervention in emergency situations can prevent an increase in acute malnutrition, and save a lot of money.[13] Governments across the Commonwealth need to have in place information systems that make it possible to conduct vulnerability analysis, map the risks that different communities are exposed to, predict when crises will occur, and trigger appropriate responses. These information systems should provide the basis for long-term planning (design of safety nets, emergency preparedness and risk-reduction strategies that cross government departments) and for rapid response in times of emergency.

COST-EFFECTIVE STRATEGIES TO TACKLE CHILD MALNUTRITION

Despite the continuing high prevalence of child malnutrition in some Commonwealth countries, a number of cost-effective strategies have been developed and are being implemented.

In 2008, *The Lancet* provided the groundwork for a package of interventions recommended by Save the Children and the UK Government's Department for International Development.[14, 15, 16] The Coalition for Sustainable Nutrition Security in India also suggested ten Essential Interventions for Children in its 'Leadership Agenda for Action.'

The recommended interventions fall into four broad themes:

- improving newborn, infant and young child feeding practices
- addressing micronutrient deficiencies
- community-based treatment for severe acute malnutrition
- improvements in household economy.

1. IMPROVING NEWBORN, INFANT AND YOUNG CHILD FEEDING PRACTICES

Support for breastfeeding is one of the most cost-effective public health interventions and could reduce under-five mortality by as much as 20%.[17] Training midwives, community health workers, lay home-visitors, mothers' support groups and peer counsellors to provide breastfeeding support improves babies' and infants' chances of survival. The best results are achieved when other family members are involved. It is important that staff delivering babies in health facilities are well trained in supporting breastfeeding.

In some countries, aggressive marketing of breastmilk substitutes has led many mothers to believe that bottle feeding is as good, if not better, than breastfeeding. This poses a health threat to their babies and also takes money away from purchasing vital foodstuffs for the rest of the family. National codes for the marketing of breastmilk substitutes have had a strong impact on reducing the influence of formula companies in Bangladesh and Sri Lanka.[18]

Commonwealth governments need to implement laws enforcing the International Code of Marketing of Breastmilk Substitutes (adopted by the World Health Assembly in 1981) to prevent the commercial promotion of breastmilk substitutes, bottles and teats.

SRI LANKA CHAMPIONS BREASTFEEDING

Sri Lanka has managed to increase early breastfeeding rates from 17% in 1995 to 76% in 2006/07, and is on track to achieve MDG 1. Over 95% of women now get antenatal care, deliver their babies in health centres or hospitals and are visited twice by a midwife within the first ten days of delivery. Community and hospital-based health workers have been trained to support mothers and there has been a multi-channel communication strategy to promote breastfeeding.

Trained community and hospital-based health workers provide skilled assistance to mothers, and messages promoting breastfeeding have been broadcast through different communication channels.[19]

2. ADDRESSING MICRONUTRIENT DEFICIENCIES

The success of vitamin A supplementation programmes targeting children 6–59 months of age has been proven, with an estimated 24% reduction in all-cause mortality.[20]

In May 2008, the Copenhagen Consensus, a panel of top economists, determined that providing micronutrients in the form of iodised salt, vitamin A capsules and iron-fortified flour for 80% of the world's malnourished children would cost US$347 million a year and yield US$5 billion from avoided deaths, improved earnings and reduced healthcare spending.[21]

Some Commonwealth countries have made significant progress with vitamin A supplementation, with five countries in Table 2 reaching 70% or more of their target age group with two doses per year. This can be largely attributed to well-funded

Table 2: Coverage of micronutrient interventions

Country	Vitamin A supplementation (6–59 months) 2 doses in a calendar year (%)	Households consuming iodised salt (%)	Use of iron-folate supplements in pregnancy (%)
India	53	51	23
Bangladesh	97	84	–
Pakistan	97	17	16
Nigeria	74	97	21
Tanzania	93	43	10
Kenya	27	91	3
Uganda	67	96	1

– Indicates data not available

Source: UNICEF (2009) *Tracking Progress on child and maternal nutrition – a survival and development priority*

mass immunisation campaigns. However, with the Eradication of Polio Initiative nearing its goal, these are being phased out and many countries have not developed a strategy or budgeted for continuing large-scale vitamin A campaigns.

Some countries are replacing national immunisation campaigns with integrated child health days, which combine vitamin A supplementation with vaccinations and other services such as deworming, and the distribution of insecticide-treated bednets.[22] Reports suggest that where health services are combined, coverage of all the interventions increases.[23]

Micronutrient supplements also provide nutrients during critical periods of pregnancy and childhood, but are not intended to cover the full range of micronutrients required for optimal growth and health. The inclusion of foods fortified with essential micronutrients can ensure that women and children consume a wider range of nutrients on a longer-term basis.

Large-scale strengthening of commodities that are eaten by most people (such as flour, oil or sugar) can help achieve this.

CHILD HEALTH DAYS IN GHANA AND CHHATTISGARH, INDIA

Child Health Days in Ghana provide a package of services twice a year to more than 80% of children aged 6–59 months, including vitamin A supplementation, immunisation, deworming, re-treatment of insecticide-treated bednets, issuing of child health cards and undertaking birth registration.[24]

In Chhattisgarh, a 'child protection month' is celebrated twice a year (April and October) and delivers a package of services to more than 85% of children. The services include vitamin A supplementation, deworming, growth monitoring, immunisation focused on children never or only partially vaccinated, and salt testing for iodine content in households and community feeding centres.

ANNA KARI/SAVE THE CHILDREN

Rambha lives in Bihar, India and lost her first child when she was a year old. "I don't know what she died from, but she was very thin. Her arms were thin and her legs were thin. She lost all her weight. She just got thinner and thinner and I didn't know what to do. Rani, my one-year-old baby girl is also thin. I'm worried that she could get thinner and die too, but there is nothing I can do."

BANGLADESH'S FORTIFIED WHEAT PROGRAMME

The Bangladesh government's Vulnerable Group Development Project (supported by the World Food Programme) is distributing fortified wheat flour to targeted groups, particularly women and adolescent girls.

While the private sector is playing a critical role in developing new fortified food products, the challenge is to find a way of reaching the poorest households in a sustainable way and ensuring that these products do not undermine the benefits of traditional diets.

3. COMMUNITY-BASED TREATMENT OF SEVERE ACUTE MALNUTRITION

Severe acute malnutrition (SAM) is the most dangerous form of malnutrition and the most predictive of mortality. SAM results in extreme weight loss and/or swelling and damaged immune systems. Nearly 10 million children in the countries in the table below suffer from this dangerous form of malnutrition, just under 7 million of them in India.

Children with SAM have deficiencies in key nutrients such as potassium, zinc, phosphate, vitamin A and energy and excesses of other nutrients such as sodium. As a result, these children need specialised treatment that addresses these imbalances, stimulates appetite and supports weight gain, as well as restoring the metabolism and immune function. Nutrition formulations for the treatment of SAM have been developed, tested and adopted by the World Health Organization and UNICEF and numerous countries around the world.

Table 3: Rates of severe acute malnutrition (SAM) in high-burden Commonwealth countries

Country	SAM in children 6–59 months (%)	Estimated number of SAM children
India	6	6,941,387
Pakistan	6	1,047,471
Nigeria	7	1,044,604
Bangladesh	3	468,153
Kenya	2	78,006
Uganda	2	64,739
Tanzania	0.4	16,994

Source: UNICEF Childinfo: Monitoring the Situation of Children and Women www.childinfo.org

*UNICEF *State of the World's Children 2008* estimates that 10% of the population in developing countries is under the age of five

The Lancet series on undernutrition and a Lancet article 'Wasting time for wasted children'[23] highlighted to the international community that severe wasting was not only an issue in emergencies. The failure to address high rates of SAM is unacceptable given that proven effective strategies are known.

WHO/UNICEF guidelines state that the SAM treatment programmes should use a community-based model that treats the majority of children at home and allows for a significantly higher number of children to be treated. With regular screening in the community using middle upper arm circumference (MUAC) measurements, which are quick and easy to take, cases of SAM are found early, before medical complications develop. They therefore do not require specialist care and can be treated at home. Home treatment has been made possible by the recent development of ready-to-use therapeutic foods (RUTF) – pastes that are rich in energy, protein and micronutrients.

However, not all countries have rolled this out at national level. For example, India with close to 7 million severely acutely malnourished children, does not have an effective community-based mechanism for screening for acute malnutrition and treats SAM in inpatient facilities. As a result, coverage for treatment of SAM in India is believed to be less than 0.1%.[24] Globally, only about 5% of the 19 million children with SAM are treated[25] and of the seven high-burden Commonwealth countries, only three – Tanzania, Kenya and Uganda – have national guidelines on community-based management of SAM.

4. IMPROVEMENTS IN HOUSEHOLD ECONOMY

Nutrition-friendly agriculture and livestock policies

Food secure nations are not always 'nutrition secure' and this is seen at the household level. In Africa, for example, agricultural production and food imports have gradually been increasing over the past decade, and there is now sufficient food energy available to provide everyone with an average of 2,500 kilocalories per person per day, yet this region has made the least progress in tackling malnutrition.

COMMUNITY-BASED MANAGEMENT OF SEVERE ACUTE MALNUTRITION IN MALAWI

Malawi has had significant success in treating severely acutely malnourished children in the community. Malawi has long suffered from high levels of malnutrition. Prior to the introduction of the community-based approach, management of severe acute malnutrition was in inpatient facilities using milk-based therapeutic preparations.

In 2002, NGOs piloted a community-based approach. Communities were to identify severely undernourished children using MUAC and effective treatment was then given on a weekly basis at local health services, with only complicated cases referred for inpatient care. This approach expanded coverage of effective treatment, reaching 74% of cases, compared to 25% with the inpatient approach. In 2006, the model was adopted as a national strategy. It has been scaled up and integrated in the national health system in all districts across the country.[26]

Agricultural policies must be designed to increase the availability and reduce the cost of nutritious food – not simply staple foods or cereals. Agricultural policies must also be designed specifically to increase the incomes of the poorest sections of society and take into account the difficulties they face in accessing land, inputs and labour. The majority of farming activities are performed by women, so they will need extra support to free up enough time to make use of complementary feeding guidelines and be able to feed their children 4–5 times a day.

Safety nets and social cash transfers

Food security in poor households is often dependent on public social safety nets and cash/food transfers. Child and maternity benefit schemes are now in place in all Commonwealth countries and targeting them for the benefit of nutritional improvements in young children can go a long way in helping to meet MDG 1. There is also evidence that food transfers given to pregnant women can reduce intra-uterine growth retardation by 32% and that results are best when supplementation begins early in pregnancy.

CONCLUSION AND RECOMMENDATIONS

Sustained political leadership on nutrition would ensure that key actions are taken to address undernutrition in Commonwealth nations off track to achieve MDG 1. This must include leadership at national and federal levels but also a global network of Commonwealth leaders sharing best practice and comparing progress. So far, only eight of the 28 Commonwealth countries for which data is available are on track to achieve MDG 1 (see Table 4).

RECOMMENDATIONS

- The seven countries with the worst levels of malnutrition should develop or ensure a technical and political platform in their country to ensure action is taken and progress monitored towards 2015. They should also appoint a national-level champion to facilitate partnership between government and others on child nutrition. The national and state level plans developed must be based on proven and agreed interventions.

- Commonwealth leaders should use child malnutrition indicators as a key measure of the progress of the Commonwealth as a whole as it gives a clear picture of how well a society is performing alongside other indicators such as economic growth. Child malnutrition should be used to drive action and investment in countries performing less well.

- Commonwealth leaders should establish measures to monitor spending on nutrition across the different departmental budget lines. They need to establish their current baseline spend and commit to increasing this in the future in order to tackle high levels of undernutrition.

- Commonwealth leaders should actively engage at a global level with global mechanisms such as the new Scale up Nutrition (SUN) movement launched at the UN Summit, which provides a key framework for action. It is actively seeking out engagement with national stakeholders in the coming months and countries should show leadership by committing to move ahead with these global partners to tackle the problem.

- Commonwealth leaders should host a Commonwealth summit on child and maternal undernutrition and make the resource and action commitments (highlighted in this report) a key indicator of progress to be monitored at future Commonwealth Heads of Governments (CHOGM) meetings. Commonwealth leaders must come together to share learning and drive progress on tackling child malnutrition with regular meetings and identify their own high-level champions to drive forward action. The Commonwealth donor countries should fund a detailed report into nutrition successes across Commonwealth countries in order to share learning.

- Civil society groups must rally to address malnutrition and ensure the meaningful participation of affected communities and children. They must play a key role in monitoring and holding their governments accountable. Influencing appropriate legislation through citizens' actions is becoming more evident and is welcome. The Scale up Nutrition (SUN) movement is one way to encourage this involvement.

Table 4: Progress towards MDG 1 in 28 Commonwealth countries

Country	Average annual rate of reduction of underweight (%) 1990–2008	Progress towards the MDG 1 target
On track		
Botswana	7.8	On track
Ghana	3.1	On track
Jamaica	5.8	On track
Malaysia	7.6	On track
Maldives	4.3	On track
Mozambique	2.9	On track
Singapore	-	On track
Sri Lanka	2.9	On track
Swaziland	5.4	On track
Insufficient progress		
Bangladesh	2.3	Insufficient progress
Gambia, The	2.1	Insufficient progress
Guyana	2.4	Insufficient progress
India	0.9	Insufficient progress
Kenya	0.8	Insufficient progress
Malawi	2.4	Insufficient progress
Namibia	1.5	Insufficient progress
Nigeria	1.6	Insufficient progress
Pakistan	1.7	Insufficient progress
Rwanda	1.9	Insufficient progress
Tanzania	2.2	Insufficient progress
Trinidad and Tobago	1.3	Insufficient progress
Uganda	0.7	Insufficient progress
Zambia	1.6	Insufficient progress
No progress		
Belize	-0.2	No progress
Cameroon	-2.3	No progress
Lesotho	-2.0	No progress
Sierra Leone	-0.2	No progress
South Africa	-2.6	No progress
Papua New Guinea	–	–

Source: UNICEF (2009) *Tracking progress on Child and Maternal Nutrition*

ENDNOTES

Introduction

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COMMON WEALTH OR COMMON HUNGER?

MALNUTRITION AND ITS IMPACT ON CHILD SURVIVAL IN THE COMMONWEALTH

"The problem of malnutrition is a matter of national shame… However, success requires sustained effort at the grassroots. Infants need to be breastfed, have access to safe drinking water and healthcare… I appeal to the nation to resolve and work hard to eradicate malnutrition within five years."

Manmohan Singh
Prime Minister of India
Independence Day speech, 2007

"Efforts to share knowledge on malnutrition are the basis of the betterment of our societies as the young represent the pinnacle of our potential. The Commonwealth Games are a celebration of the physical expression of the talent available in these countries – a talent that is fuelled by good nutrition and support for children's development.

"When the young suffer from undernourishment, society must make every effort to improve their nutrition, so that our children can grow and develop to their greatest potential."

Professor M. S. Swaminathan
Member of Parliament (Rajya Sabha)
Chairman of the M. S. Swaminathan Research Foundation
Chairman of the Coalition for Sustainable Nutrition Security of India

Save the Children

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