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research findings for development policymakers and practitioners

Improving the nutrition status of children and women

The high world food prices that we are currently experiencing provide a chilling reminder of the vulnerability of large parts of sub-Saharan Africa and South Asia to hunger and undernutrition. Many children in these regions are vulnerable to poor growth, poor development and death.

Even before these high prices, child undernutrition was increasing in Africa. In booming South Asia, stubborn child undernutrition rates provide a sombre reminder that income growth does not solve all problems.

Good nutrition status for children and adolescent girls is fundamental for attaining many of the Millennium Development Goals. Despite this, donors and governments underinvest in interventions to improve nutrition.

In this issue of *id21 insights*, **Andy Sumner**, **Johanna Lindstrom** and **Lawrence Haddad** argue that this underinvestment is due to a lack of incentives for donors; few take a strategic approach to investments that have the potential to improve nutrition and they have little idea whether current investments are making a difference. Furthermore, their 'critical friends' – research institutes and non-governmental organisations – lack the leadership to engage with donors strategically on this issue.

What types of nutrition intervention work? Many families in Africa and Asia simply do not have enough money for a healthy diet. **David Mepham** argues that cash transfer programmes, which are popular in Africa, improve diets and protect against shocks. But could they achieve even more by being conditional on participation in health care, as is the case in Latin America? **David Sanders** and **John Mason** highlight the importance of building community and household resilience to shocks, noting the success of several programmes in Africa.

Nicolas Alipui reminds us that private sector resources are vital in the drive to accelerate reductions in child undernutrition. There have been successes (such as salt iodisation) but also examples of where great care must be taken to establish common vision and values, such as the appropriate use of breastmilk substitutes.

Barbara MacDonald highlights philanthropic giving as another source of resources, and a way to channel them – the Global Alliance for Improved Nutrition. However, donors face coordination problems in delivering nutrition resources. There is an urgent need for more field workers to empower communities to demand and use these resources effectively. **Isatou Jallow** echoes these messages, outlining the World Food Programme's new initiatives for greater community engagement in maternal and child nutrition.

Ricardo Uauy focuses on the challenges for international nutrition organisations. He highlights the lack of leadership, strategy, resource mobilisation and connection with country priorities as areas in need of major improvement.

The nutrition of the world's children and women desperately needs improving. Failure to do so violates their human rights and will undermine development today and in the next generation. If undernourished children survive their first few months of life, they will suffer more illness, learn less in school and be less productive in the workforce. In turn, their children are more likely to be born undernourished.

This desperate cycle can only be broken by a new alliance between donors, governments and critical friends. This will require new leaders to come forward and develop politically aware strategies that raise public consciousness and put human and financial resources, both public and private, to effective use.

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Breastfeeding campaign billboard in Viet Nam.
© 2007 Richard McCann, Courtesy of Photoshare

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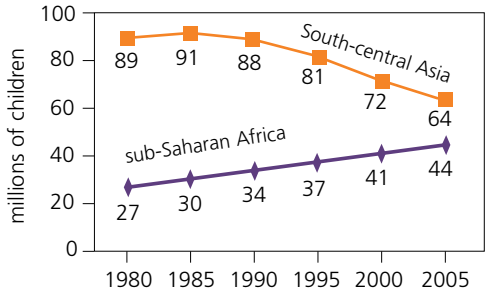
Why is undernutrition not a higher priority for donors?

The prevention of chronic undernutrition is vital for reducing mortality and morbidity, for economic productivity, and for the respect and protection of human rights. Yet nutrition interventions tend to be low priorities for donors and developing country governments.

Despite past efforts by aid agencies, undernutrition still affects 2-3 billion people worldwide. In South Asia and sub-Saharan Africa, one third of children under 5 are chronically undernourished. In South Asia, the number of children under 5 who are low weight for age, or low height for age, is steadily declining in most but not all countries – but in sub-Saharan Africa (SSA), the number is steadily increasing (see Figure 1). Measuring the nutrition status of children is particularly important because nutrition losses incurred in childhood represent losses children will carry throughout life.

Figure 1: Numbers of undernourished children (aged under 5) in sub-Saharan Africa and South-central Asia, 1980–2005



Based on estimates from: The World Health Organization Global Database on Child Growth and Malnutrition: Methodology and Applications, *International Journal of Epidemiology*, 32, pages 518-526, de Onis and Blossner, 2003

These numbers remain high in South Asia and are worsening in SSA, despite undernutrition being fundamental for attaining the Millennium Development Goals relating to poverty, education, maternal mortality and child health. Do donors prioritise undernutrition? If not, why?

DFID and the EC

Research from the Institute of Development Studies, in the UK, looks at how highly two particular donors prioritise undernutrition – the UK's Department for International Development (DFID) and the European Commission (EC). This analysis was based on:

- their public commitments, from evidence of speeches and press releases
- their expenditure, based on data from the Organisation for Economic Co-operation and Development's Development Assistance Committee
- their opinions, assessed by interviews with key informants.

The research suggests that whilst DFID and the EC recognise chronic undernutrition to be important, they do not see investments in reducing it as fundamental to development. Whilst this is better than some countries, others prioritise nutrition more highly, including Canada, Norway, The Netherlands and the USA.

Much of this assessment depends on how 'nutrition-friendly' interventions in other sectors are, such as health care, water supply and sanitation, social protection and food security. The EC and DFID spend relatively large amounts in these areas (see Figure 2). These indirect nutrition interventions can have a positive impact on people's nutrition status. But the absence of a nutrition strategy to guide them does not generate confidence that they are having the maximum impact in improving nutrition.

Challenges to prioritising undernutrition

Why is the commitment by DFID and the EC so lukewarm? First, there is the problem that chronic undernutrition is affected by many different sectors. It is therefore everyone's problem but no one's responsibility – a classic failure of collective action. As a result, there are few 'champions' promoting nutrition within the EC or DFID. This failure is mirrored in the nutrition community of research institutes, 'think tanks' and international non-governmental organisations. They should be putting pressure on DFID and the EC to demonstrate how their work is reducing undernutrition.

Second, there are issues specific to DFID and the EC. The current focus on achieving good governance does not easily support the allocation of resources to nutrition – links between governance and nutrition concerns are rarely highlighted. Nevertheless, there are clear opportunities to show that failures to reduce undernutrition represent a massive shortcoming in a state's capacity, accountability and responsiveness to their citizens

Third, the way in which DFID and the EC report on their progress means there are few incentives to prioritise nutrition. For example, DFID measures poverty using statistics about the number of people living on less than one dollar a day; a more reliable guide is how many children are underweight, as it is more consistent over regions and time.

Finally, DFID and the EC are not engaging with the international agencies responsible for nutrition. These agencies are too dependent on the donors to sufficiently challenge them, and so rely on the donors to proactively engage.

DFID and the EC could do more on nutrition. We recommend the following actions:

- Highlight the importance of nutrition for achieving the Millennium Development Goals, not only those on poverty and child mortality, but also on education, gender equality, maternal health and communicable diseases.
- Appoint a 'champion' to promote nutrition in all departments and build stronger links with and support for other agencies, particularly the Standing Committee on Nutrition – the only United Nations agency devoted to combating undernutrition.
- Use nutrition indicators (such as underweight for age) to report on progress towards reducing poverty.
- Conduct a nutrition audit of their spending in areas which have a potential nutrition impact – for example, are investments in social protection, agriculture and water as nutrition friendly as they could be?

The nutrition community needs stronger leadership to challenge DFID and the EC more effectively. They need resources to conduct independent nutrition audits, and to find better ways to link nutrition to existing donor priorities. The international agencies also need stronger coordinated action to argue the case for nutrition.

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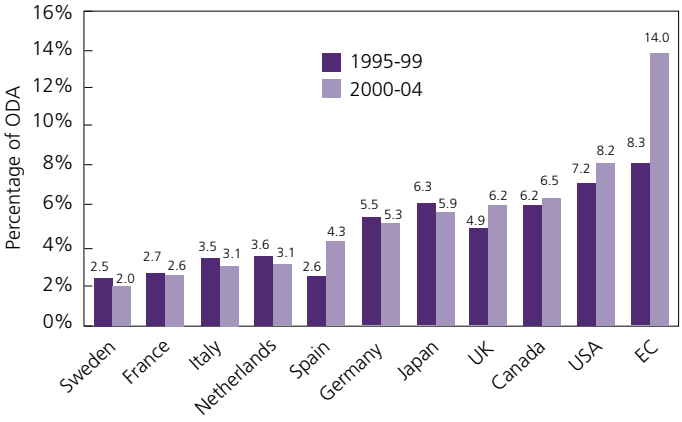
See also
Greater DFID and EC Leadership on Chronic Malnutrition: Opportunities and Constraints, Report to Save the Children UK, by Andy Sumner, Johanna Lindstrom and Lawrence Haddad, 2007 (PDF)
www.ids.ac.uk/UserFiles/File/news/2007/Greater_DFID_EC_Leadership_Chronic_Malnutrition.pdf

Figure 2: Percentage of total overseas development assistance (ODA) spent on indirect nutrition interventions, 1995-99 and 2000-04



Source:
International Development Statistics (IDS) online: Databases on Aid and Other Resource Flows
www.oecd.org/dataoecd/50/17/5037721.htm

Strong public-private sector partnerships can help to reduce undernutrition

Global progress towards reducing undernutrition has been made through enlightened public policies, targeted development assistance, private sector actions and commitments from civil society. Yet every year, the deaths of more than 3.5 million children under the age of 5 can be attributed to undernutrition.

Evidence informs us that much more can be done to reduce undernutrition. It is also increasingly clear that well focused, strategic partnerships between the private and public sectors can make these further contributions happen.

Ready-To-Use Therapeutic Foods

An emerging area for potentially strong public-private partnerships is the production of Ready-To-Use Therapeutic Foods (RUTFs). These soft, crushable foods, which can be easily consumed by children from 6 months old, can contribute to the treatment of Severe Acute Malnutrition (SAM).

- Preparation of RUTFs does not require water. This means that bacteria cannot grow in them and they can be used safely in people's homes. Also, health centre and community health staff can prescribe RUTFs, decreasing the pressure on in-patient health facilities.
- RUTFs are only recommended for use in treatment of SAM. Efforts to solve the problem of undernutrition should also focus on prevention, through educating caregivers to make the best use of locally available foods and other effective interventions.

RUTFs have been highly effective at reaching and treating large numbers of children in their own homes in many African countries (including Ethiopia, Malawi, Niger, and the Democratic Republic of Congo) and increasingly in Asia (including Sri Lanka, Indonesia and Pakistan).

The United Nations Children's Fund (UNICEF) is working with partners to support the private sector in increasing the scale of RUTF production. This is needed to supply the increasing demand, meet industry standards and keep a balance between global and local production of RUTFs. If successful, this has the potential to save up to a million lives each year by reaching and treating the majority of children with SAM.

Infant feeding

Challenges remain, however, in reaching a shared vision about infant feeding amongst the public and private sectors. Guidelines from the World Health Organization and UNICEF clearly recommend and promote exclusive breastfeeding during the first six months of a child's life, and appropriate complementary feeding in addition to breastfeeding from 6 to 24 months. These are among the most effective interventions in preventing child mortality, ensuring optimal nutrition and development, and protecting against long-term chronic disease.

However, these efforts are undermined by the aggressive marketing of breastmilk substitutes by some manufacturers. Substitutes are often nutritionally inferior, incorrectly diluted and may depend on contaminated water, leading to diarrhea and undernutrition. UNICEF is strongly committed to supporting governments in enforcing the International Code of Marketing of Breastmilk Substitutes. This seeks to protect parents from commercial pressures to purchase infant milk substitutes.

In addition to breastfeeding, children need appropriate, safe and high quality foods to complement their diets after 6 months of age. If a common public health goal can be agreed between the public and private sectors, a promising area of collaboration would be the production of optimal complementary foods. These would need to be affordable, acceptable to local people and readily available to all sectors of society.

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See also
Community-Based Management of Severe Acute Malnutrition, A Joint Statement by the World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund, 2007 (PDF)
www.who.int/nutrition/topics/Statement_community_based_man_sev_acute_mal_eng.pdf

Undernutrition

Undernutrition includes a wide range of effects including intrauterine growth restriction resulting in low birth weight; being underweight (indicated by low weight-for-age); stunting (low height-for-age); wasting (low weight-for-height); and less visible micronutrient deficiencies. Undernutrition is caused by a poor dietary intake that may not provide sufficient nutrients, and/or by common infectious diseases, such as diarrhoea.

Source: *The Lancet's* Series on Maternal and Child Undernutrition, Executive Summary, January 2008

The success of salt iodisation

A shortage of iodine in a diet can cause cretinism, mental retardation and premature birth. These iodine deficiency disorders (IDD) can be eliminated by adding iodine to cooking salt.

Partnerships between governments and the salt industry have been one of the key factors in eliminating IDD. In many countries, the salt industry has taken up the cost of adding iodine to salt as part of their business.

- 70 percent of the world population is now protected from losses of learning ability due to iodine deficiency, a huge jump from 20 percent in early 1990s.
- At least 72 developing countries have adopted national public-private coalitions with the salt industry, which provides practical and effective mechanisms to raise and sustain commitments to iodine deficiency elimination. As a result, 34 countries have now eliminated iodine deficiency.

Economists at the Copenhagen Consensus in 2004 concluded that the benefits-costs ratio for iodine interventions can be as high as 520 – a cost between US$0.25 and US$5.0 can have benefits valued between US$70 and US$130. This is one of the highest among interventions related to combating hunger and undernutrition.

See also
Micronutrients - Iodine, Iron and Vitamin A
www.unicef.org/nutrition/index_iodine.html
Copenhagen Consensus – Challenges and Opportunities. Hunger and Malnutrition, Copenhagen Consensus Challenge Paper, Jere R. Behrman, Harold Alderman and John Hoddinott, 2004 (PDF)
www.copenhagenconsensus.com/Admin/Public/Download.aspx?file=Files/Filer/CC/Papers/Hunger_and_Malnutrition_070504.pdf

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The price of hunger

The relationship between poverty and food intake

The first Millennium Development Goal – to eradicate extreme poverty and hunger – reflects the fact that undernutrition is both a symptom and a cause of poverty. The first measure of success is well known: to halve the number of people earning less than US$1 a day. The other – to halve the number of people suffering from inadequate food consumption – is equally important but less well known.

Income poverty and inadequate food consumption are firmly linked. Undernutrition, caused in part by poor diets, impairs growth and development. This results in lower achievement in school and lower productivity in adulthood. As a result, poverty is entrenched in the next generation, in part because parents cannot afford to feed their children sufficiently.

The cost of a healthy diet

Research by Save the Children UK compares the cost of a healthy diet for a family of five with what they earn in Bangladesh, Ethiopia, Myanmar and Tanzania. We calculated the cost of a diet made from foods available locally that would meet a family's minimum nutritional needs in each location. Estimates were based on surveys of market prices of foodstuffs over different seasons.

- In Ayeyarwaddy Division, Myanmar, around half of studied families live on about US$1.08, but a healthy diet would cost US$1.15 per family – 1.1 times the daily average salary.
- In Kurigram district, Bangladesh, about 80 percent of households studied cannot afford a minimum healthy diet; for the poorest people, this costs three times what they usually earn.

In all these places, families do not have enough money for a nutritious diet, let alone fuel, clothes, school fees and health costs. They have to eat food that is not nutritious enough for their children to be healthy or protected from sickness.

These figures also put into perspective the struggle to emerge from poverty for families in many developing countries. To improve their livelihoods, they need enough income to invest in productive assets, such as cattle or livestock for a small business, or to invest in their longer term future by providing an education for their children. But what hope do they have if they cannot even afford the food they need to keep themselves and their children healthy and alive?

The implications are clear: undernutrition and poverty must be tackled together. In some cases, income is the constraint, in some education, and in some both.

- Simply trying to educate the poorest families about good nutrition – a popular approach with development agencies for a long time – will not work if families do not have the money to put this knowledge into practice.

Malnutrition

Malnutrition concerns not enough food, too much food, the wrong types of food, and the body's response to a wide range of infections that result in malabsorption of nutrients, or the inability to use nutrients properly to maintain health. Clinically, malnutrition is characterised by inadequate or excess intake of protein, energy, and micronutrients such as vitamins, and the frequent infections and disorders that result.

Source: World Health Organization
www.who.int/water_sanitation_health/diseases/malnutrition/en

Aduri, 3, lives in the Kurigram district, Bangladesh. When Save the Children first met Aduri, she was undernourished. They linked her family to their credit programme, which allowed Aduri's father to buy a rickshaw van and provide her with regular, good quality meals.
Madhuri Dass / Save the Children, 2007

- Putting cash into families' hands can help to improve their diet. Save the Children UK's projects in Ethiopia show that when families are given small sums of cash, they spend it on more food and a better variety of food.
- Although we have not studied this, it is likely that the impacts of cash transfers could be further multiplied if combined with nutrition education.

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See also
The Minimum Cost of a Healthy Diet, Save the Children UK, by Claire Chastre, Arabella Duffield, Heather Kindness, Sonya LeJeune and Anna Taylor, 2007 (PDF)
www.savethechildren.org.uk/en/docs/The_Minimum_Cost_of_a_Healthy_Diet_Final.pdf
'Maternal and Child Undernutrition: Consequences for Adult Health and Human Capital', *The Lancet Maternal and Child Undernutrition Series*, by C G Victora *et al*, 2008

The persistence of child malnutrition in Africa

Malnutrition affects about 30 percent of children in Africa, caused by low birth weight and post-natal growth faltering. Child malnutrition is a persistent problem. The long term trend shows only slow improvement, and malnutrition rates worsen during droughts, economic crises, conflicts and displacement, and HIV.

Resilience to these crises is better than anticipated. Slow progress towards reducing malnutrition is re-established when they recede. The provision of food or income support (through cash transfers) can help this resilience. Documented examples include:

- the Enhanced Outreach Strategy following drought in Ethiopia in the early 2000s
- supplementary feeding programmes in Zimbabwe in the early 2000s, following drought and economic stresses
- drought mitigation programmes in Botswana.

Sustained improvement in the nutrition status of children requires fair social and economic development. Education is particularly important, notably for women. Community-based programmes and health services can reduce malnutrition, usually without food distribution. This has been seen in Tanzania through the Iringa and Child Health and Development programmes during the 1980-90's, and the Community Nutrition Project in Senegal in 1996. Experiences from effective community-based programmes in Asia and Latin America also need to be applied in Africa.

The accelerating globalisation of food production, trade and marketing threatens the food security of poor communities in Africa, however. Removing barriers to trade (such as tariffs) and reductions in income support to farmers in richer countries would help to create greater export opportunities for African farmers. These actions would also reduce the price of food and other commodities imported into Africa. Both of these changes would improve the nutrition status of poor communities.

Without greater attention to nutrition, increased child mortality, morbidity and impaired intellectual development are inevitable.

- Policies must tackle intermittent crises through emergency programmes and support sustained community-based programmes.
- Nutrition should be reinstated as a priority programme area alongside HIV, tuberculosis and malaria.

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See also
Impact of Drought and HIV on Child Nutrition in Eastern and Southern Africa, Working Papers in International Health and Development 07-03, by John B. Mason and the Tulane/UNICEF Team, 2007 (PDF)
www.sph.tulane.edu/IHD/publications/Impact%20of%20Drought%20and%20HIV%20on%20Child%20Nutrition.pdf
'Community Health and Nutrition Programs', by John B. Mason, David Sanders, Philip Musgrove, Soekirman and Rae Galloway, pages 1056-1074 in *Disease Control Priorities in Developing Countries 2nd Edition*, edited by Dean T. Jamieson *et al*, 2006 (PDF)
http://files.dcp2.org/pdf/DCP/DCP56.pdf

Nutrition for mothers and children

Article 25.2 of the Universal Declaration of Human Rights establishes that motherhood and childhood are entitled to special care and assistance. Yet maternal and child undernutrition are still highly prevalent in most developing countries.

Suboptimum breastfeeding in the first six months of life, especially non-exclusive breastfeeding, results in 1.4 million child deaths each year and accounts for 10 percent of disease in children younger than 5 years globally. Maternal short stature and iron deficiency anaemia (both symptoms of poor nutrition) increase the risk a mother dying during delivery – these conditions cause at least 20 percent of maternal deaths worldwide.

The World Food Programme (WFP) is in a unique position to improve maternal and child nutrition through its Mother and Child Health and Nutrition Programme (MCHN) – over 80 percent of the WFP target population are women and children.

WFP-supported MCHN programmes are implemented in collaboration with government partners, local communities, non-governmental organisations and other international agencies. The programme comprises supplementary feeding as well as preventive health and nutrition education.

The need for community involvement

A key focus of WFP interventions is community involvement and support for improving the nutritional situation of mothers and children. To be sustainable, community-based interventions must build on traditional beliefs and care-giving activities, and extend these to the nutritional needs of mothers and children.

Amna Hamid is an Eritrean refugee in Wad Sharifey, Eastern Sudan. When she was pregnant, she attended ante-natal care at a Mother and Child Health clinic. Amna received iron tablets and WFP-supplementary feeding rations until she delivered her daughters. Amna now takes her two children to the clinic for regular growth monitoring, vaccinations and health education sessions.
© World Food Programme, 2007

An example of this is the Mother and Baby Friendly Community Initiative in The Gambia, which builds on traditional knowledge and practices for ensuring nutrition. For example, food-based approaches, including community and household gardens, can be combined with preventive health and nutrition interventions, such as reducing the workloads of pregnant women, community support for breastfeeding and hygiene promotion. A crucial element is that nutrition interventions are delivered through trained Community Support Groups, which include both women and men, in each community.

Through this initiative and in collaboration with partners, the WFP can sustain the maximum impact in its mother and child health and nutrition interventions. Furthermore:

- It can contribute to breaking traditional gender barriers, for example the view that caring for children is the sole responsibility of women.
- It can bring communities together around a common goal of improving maternal and child nutrition for the benefit of society.
- In communities where the WFP also operates School Feeding programmes, there are opportunities to link the two and advocate the importance of nutrition throughout a person's lifecycle.

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See also

Halving Hunger: It Can Be Done, United Nation Millennium Project Taskforce on Hunger, by Pedro Sanchez, M.S. Swaminathan, Philip Dobie and Nalan Yuksel, 2005 (PDF)
www.unmillenniumproject.org/documents/HTF-SumVers_FINAL.pdf

Why have donors committed so few direct investments to eliminate child undernutrition?

The mandate of most international donors is to reduce poverty, suffering and inequity. Addressing child undernutrition falls within this. However, current donor investment to directly address undernutrition is estimated to be well under half of the resources required.

Most countries have committed to specific international goals to reduce undernutrition, particularly at the World Summit for Children in 1990. However, recent articles in *The Lancet* and the *Food and Nutrition Bulletin* show that an alarming level of undernutrition still exists.

The Lancet estimates that donor spending on programmes to reduce undernutrition is US$250-300 million per year. Even under a 'best case' scenario, in which this is perfectly targeted, this is just US$2 per child (aged 0-5 years) per year; effective nutrition programmes require US$5-10 per child.

Increasing donor investment

There are several constraints to increasing investment. These include:

- the lack of effective coordination amongst the key international and state organisations responsible for reducing undernutrition
- gaps in evidence about the impacts of nutrition interventions, including rigorous evaluation of current programmes
- the daunting challenge of insufficient trained people to design, implement and evaluate programmes.

Donor resources are required to address all of these. International nutrition organisations need to agree with donors on the priorities, and the cost and time-frame for addressing them. If achieved, this will be a massive step forward in stimulating the change in investment that is required.

New initiatives

Encouragingly, some new initiatives to increase investment and improve coordination are already underway. Several international agencies are working together to develop a Ten Year Strategy to reduce vitamin and mineral deficiencies. These include the United Nations Children's Fund (UNICEF), the Academy for Educational Development and the Global Alliance for Improved Nutrition (GAIN). They have completed a technical situation analysis (published in the *Food and Nutrition Bulletin*) and formed working groups to better coordinate their actions, including monitoring and evaluation activities.

Furthermore:

- *The Lancet* articles, combined with the increasing global awareness of rising food prices, will hopefully lead to an internal review of food and nutrition investment portfolios among key donors.
- GAIN is helping to form national multi-sectoral alliances to better plan and coordinate food fortification programmes in several countries, including Mali, Ghana and Uganda.
- These alliances bring together public, private and civil society organisations, and could be broadened to include other organisations and programmes that seek to reduce undernutrition.

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See also

'Maternal and Child Undernutrition Series', *The Lancet* 371, edited by R. Horton, January 2008
'Vitamin and Mineral Deficiencies Technical Situation Analysis: a Report for the Ten Year Strategy for the Reduction of Vitamin and Mineral Deficiencies', *Food and Nutrition Bulletin*, 28(1) supplement, edited by T. Sanghvi, M. van Ameringen, J. Baker and J. Fiedler, 2007

What can be done to accelerate progress against undernutrition?

Many organisations work to eliminate undernutrition in children and pregnant and lactating women in developing countries. These organisations – international organisations, donors, academia, civil society and private sector – are loosely linked as an international nutrition system. However, this system is fragmented and dysfunctional.

Research published in *The Lancet* identifies four areas in which the international system must improve.

Stewardship and guidance

The international nutrition system develops international legislation and provides guidance to national nutrition groups. However, this is often inconsistent, not prioritised and impractical. For example, the guidelines produced by different organisations on how to address micronutrient deficiencies offer conflicting evidence about the effectiveness of different approaches.

International organisations must work together to create simple, consistent and prioritised guidance. This should be based on evidence from impact evaluations of past projects and programmes, and careful analysis of the implications for nutrition of major global changes, such as climate change and rising energy prices.

Aid and investment

The amount of aid for direct nutrition interventions, such as vitamin supplementation and infant feeding, is comparatively low. From 2000 to 2005, aid for basic nutrition in low and middle-income countries (which includes providing key micronutrients and covering the needs of severely undernourished people) was between US$250 million and US$300 million each year.

By comparison, donor funding for HIV/AIDS was US$5.7 billion – about 20 times greater – even though no more Disability Adjusted Life Years (the years of life lost due to premature death) are lost to HIV than to maternal and child undernutrition. Funds for nutrition are an important investment in the future of low and middle-income countries. International donors should increase aid flows and better target them to the neediest population groups.

Direct service provision

Natural disasters and armed conflict can limit the effectiveness of nutrition interventions, for example by reducing local food availability. In these situations, the international system can support humanitarian responses. However, there is currently little published information on the impact of humanitarian responses on nutrition, or the impact of nutrition interventions in emergencies.

Although several organisations provide guidance on best practice in emergencies, no agency has overall responsibility for assessing the effectiveness (and cost-effectiveness) of different interventions. Documenting these and building on experiences will create a minimum set of operational standards. Meanwhile, better coordination would allow humanitarian organisations to improve emergency responses.

Strengthening resources

The shortage of appropriately skilled personnel is a major constraint to better nutrition programmes. Interviews at training centres and universities showed that, with some notable exceptions, social, economic and food sciences are poorly represented amongst academic staff.

Funding bodies must provide incentives to re-orientate research to more programme-relevant topics, such as ways to increase the scale of effective nutrition interventions. Better leadership from academic journals would support this; editors of academic journals should meet in 2008 to develop a strategy to increase the profile and relevance of nutrition research.

To improve in these four areas, individual organisations and the system as a whole must examine their strategies, resources and motivations. Organisations must significantly improve their links with national level processes, so that country level priorities are better reflected in international guidance, donor funding, research and training.

Useful web links

Global Alliance for Improved Nutrition – GAIN
www.gainhealth.org

Micronutrient Initiative
www.micronutrient.org/home.asp

Save the Children
www.savethechildren.org

School Feeding global website
http://ffe.schoolsandhealth.org

Towards 4 + 5 - Research Programme Consortium on Maternal, Newborn and Child Health
www.towards4and5.org.uk/research.htm

UNICEF - United Nations Children's Fund
www.unicef.org

United Nations System Standing Committee on Nutrition
www.unsystem.org/scn

World Food Programme
www.wfp.org

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See also
'Effective International Action Against Undernutrition: Why has it Proven so Difficult and What can be Done to Accelerate Progress?' *The Lancet* 371 pages 608–21, by Saul Morris, Bruce Cogill and Ricardo Uauy, January 2008
'Hunger And Malnutrition' *Copenhagen Consensus Challenge Paper*, by Jere R Behrman, Harold Alderman and John Hoddinott, 2004

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