

## **SCN News, Number 01**



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# SCN News, Number 01

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## ADMINISTRATIVE COMMITTEE ON COORDINATION – SUBCOMMITTEE ON NUTRITION

30 March 1988

A periodic review of developments in international nutrition compiled from information available to the  
ACC/Sub-Committee on Nutrition

SCN News is issued twice yearly by the Secretariat of the UN ACC Sub-Committee on Nutrition. Contributions for future issues would be welcome which should be sent to the Secretary. A description of the ACC/SCN is given on the back cover.

Your help would be appreciated in launching the SCN News. We would appreciate your views on content of future issues, and items on sections you feel are particularly useful. We would welcome letters to the Editor for possible publication in future issues. This issue is being distributed with UNU Food & Nutrition Bulletin, and through other channels. If you do not receive UNU Food & Nutrition Bulletin, would like additional copies of SCN News, or would like to suggest other names to be added, please write to the Secretary, ACC/SCN.

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### **Ten-Year Programme Against Vitamin A Deficiency**

Recent evidence that vitamin A supplementation may save the lives – as well as the sight – of children affected by the eye disease xerophthalmia due to vitamin A deficiency has given new urgency to a 10-year United Nations programme aimed at the control and prevention of vitamin A deficiency. Launched by a UN interagency meeting in October 1985, the programme focuses on 34 developing countries known to have serious vitamin A deficiency problems. Despite unprecedented agreement on the need for the programme,

however, the SCN annual session in February 1987 noted with concern that commitment of resources has been with few exceptions slow and requests for assistance from national governments limited in number and scope. A shortage of “start-up” funding is causing considerable problems for the programme. In 1987 WHO transferred operational responsibility of the programme to its regional offices. Now, a study in Indonesia of the effectiveness of vitamin A capsule distribution in preventing eye damage has provided crucial evidence that the vitamin may have a direct effect in reducing mortality. After reviewing the study's findings in 1986, the SCN's Advisory Group on Nutrition said a difference of some 30 percent in pre-school child mortality between treated and control villages was “likely to be attributable” to vitamin A supplementation. The AGN statement continued: “It is appropriate to advise countries mounting high dose vitamin A programmes for the control of xerophthalmia that reduction of childhood mortality is a reasonable expectation and is a further justification for such programmes.”

The AGN statement adds weight to the SCN's call for concerted international action to reduce the worldwide prevalence and severity of vitamin A deficiency, xerophthalmia and nutritional blindness to a point where they are no longer significant public health problems. At present, the effects of vitamin A deficiency in the developing world are devastating, especially among children. Of an estimated 700,000 pre-school children who develop severe corneal xerophthalmia each year, as many as 400,000 die from the deficiency and accompanying factors such as protein-energy malnutrition, debilitating diarrhoea, respiratory tract infections and measles. About 25 percent of the survivors remain totally blind and 50 to 60 percent partially blind. Every year another eight to 10 million children are believed to develop milder, non-corneal xerophthalmia, leading to night blindness and associated with a higher risk of respiratory infections and diarrhoea. Research has also established that inadequate vitamin A causes damage to urinary and gastrointestinal tracts, impairs growth, bone formation and immune functions, and may cause anaemia. “At this point,” concluded an SCN study, “we should recognize that vitamin A deficiency may be as far-reaching in its pathological effects on the individual as proteinenergy malnutrition, and that prevention of the deficiency syndrome, even in its mild form, may have very important effects on child health, development and survival.”



Vitamin A Saves Sight

[Source: WHO, 'Let There Be Sight']

## Nutritional Disease

Vitamin A deficiency is a nutritional disease, caused by inadequate dietary intake of the vitamin, or its plant-based precursors, and often aggravated by low absorption from the intestine. It has a primary, nutritional solution: improving vitamin A status to a physiologically acceptable level. In theory, this is as simple and inexpensive as administering to each affected child twice yearly a 200,000 IU vitamin A capsule costing two cents. But effective prevention and control of the disease depends on the correct choice of interventions and action to reach a much larger population than those immediately affected. This is because many more people are believed to be at risk than actually show signs of the deficiency and because preventive measures cannot be targeted only to those who would otherwise develop it. In practical terms, prevention depends on establishing national programmes employing various types of intervention, including mass distribution of oral doses of vitamin A, fortification of widely distributed food commodities and, in the longer term, dietary modification to increase the intake of the vitamin. The SCN reports that while national efforts are increasing, by 1987 only eight of the 34 countries known to be affected had such programmes and in most of these the coverage of preventative programmes was still very low.

Reaching the estimated 40 million pre-school children already suffering from mild or moderate vitamin A deficiency in the 34 target countries is a considerable challenge. Providing total coverage for these countries' pre-school child population of 280 million – and for children in a further 23 countries considered at risk – is an even more mammoth task. The 10-year UN programme aims to greatly accelerate the process of prevention and control of vitamin A deficiency by marshalling international assistance in five main areas: assessment of the prevalence and severity of the deficiency; prevention of the deficiency in high-prevalence areas; treatment of those suffering from vitamin A deficiency, xerophthalmia and nutritional blindness; training of health personnel and community workers; and investigation of technical, logistical and other problems affecting the implementation of programmes. An essential part of this process is the setting up, or strengthening, of national prevention and control programmes. This will involve a number of government sectors, particularly agriculture, health, education and the social services. Programme development will require assessment of the problem and of potential interventions, decisions on policy and resource commitments and, in many cases, external financial, material and technical assistance from UN agencies and donors.

### **Missions, Reviews**

Since the programme's launch, several UN members and bilateral agencies have undertaken a variety of activities. WHO, the lead agency, has helped Bhutan, Burma, India and Sri Lanka assess their programme needs and prepare requests for assistance, while its regional offices for Africa and Southeast Asia have begun developing with concerned member states regional strategies for prevention and control of vitamin A deficiency. WHO has also prepared a technical review on the relationship between vitamin A and diarrhoea, explored the feasibility of distributing vitamin A through immunization schemes and distributed information on vitamin A deficiency to publishers in 40 countries. FAO has prepared and begun implementing a long-term plan for increasing the production and consumption of foods rich in the vitamin. It is conducting food consumption surveys of vitamin A and carotene intake in urban and rural areas, is planning nutrition education programmes and has sent experts to help a number of countries to assess their programme needs. It fielded missions with WHO to Bangladesh, Indonesia and Nepal. UNICEF, as part of its plan of action to complement the activities of WHO and FAO, has conferred with 10 countries of Africa and Asia to ascertain their needs and in 1986 provided a record number of vitamin A capsules – more than 80 million – to meet a growing demand from developing countries. WFP continues to provide skim milk fortified with vitamin A to vulnerable groups, particularly pre-school age children, while USAID has committed some \$3 million to preventative programmes in six countries.

In a recent review of its efforts, WHO said “these steps are only the start of what must be, by definition, a sustained effort of an appropriate scale if the programme's primary objective is to be achieved”. It said further progress seemed to require greater efforts in developing countries to formulate and implement prevention/control strategies and to create mechanisms to harmonize and maximize the effectiveness of external support; greater support from donors; and sustained technical, managerial and financial assistance from UN agencies.

The SCN 14th Session recalled a statement by participants at the October 1985 interagency meeting which launched the programme: “It would be a terrible irony if, at a time when all the major ingredients of success are at hand – scientific knowledge, inexpensive and effective technology, and accumulated practical experience – the world community were prevented from taking concerted action for want of a modest shift in resources.” While discussions go on, vitamin A deficiency continues to kill or blind hundreds of thousands of children each year.

## Costs and Benefits of Vitamin A Capsules

A single 200,000 I.U. dose of vitamin A, delivered every four to six months at a cost of less than 50 cents a year, may be enough to protect a young child against vitamin A deficiency and the threat of nutritional blindness and death. That is one conclusion of an SCN policy discussion paper on the prevention of vitamin A deficiency, published in June 1987. "Preliminary cost-benefit analysis shows that the benefits of preventing xerophthalmia calculated in monetary terms can far outweigh programme costs," said the paper, "Delivery of Oral Doses of Vitamin A to prevent Vitamin A Deficiency and Nutritional Blindness." What is more, "given the emerging evidence that vitamin A supplementation may reduce mortality among children with even mild deficiency, the benefit from improving vitamin A nutrition in a population may be even greater than those so far assessed". However, the paper cautioned, while vitamin A supplementation programmes were conceptually simple, ensuring their adequacy and efficiency posed major challenges.



Capsules Containing Doses of Vitamin A are Given Six-Monthly by Mouth

## Rapid Urbanization Poses Challenge to Health, Nutrition

A demographic revolution is moving hunger and poverty problems in developing countries from rural to urban areas. Since 1950 the proportion of the Third World population living in cities has more than doubled to an estimated 36 percent or 1.3 billion people. About half of these urban dwellers are migrants from rural areas and the majority live in overcrowded slums or makeshift squatter settlements. And their numbers are increasing rapidly. The developing world's urban population is growing at an annual rate of 3.7 per cent a year, almost four times faster than population growth in the countryside. Slums and shantytowns are generally expanding faster than other urban zones and certainly faster than city infrastructure, essential services and employment. At the end of the century, UN projections indicate, total urban population in the Third World will be more than 2000 million people. By then, more than half the developing world's poor will be living in cities, a major shift in the locus of poverty. The relative changes in city sizes since 1950 is dramatic, Europe and the U.S. being displaced by Asia and Latin America, as illustrated in the graph.

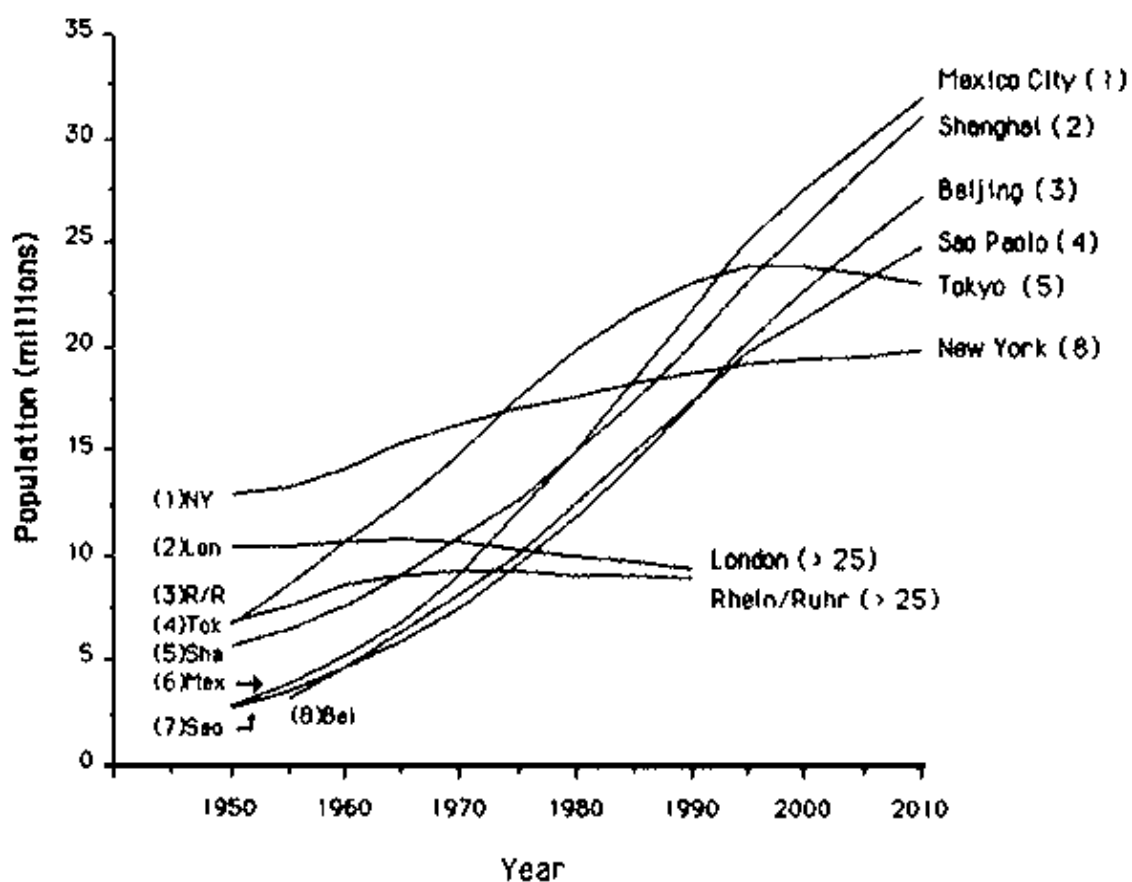
UN agencies are concerned about the effects of this unprecedented urbanization on the nutritional status of the urban poor. This was the subject of a Symposium on the SCN's annual session in February 1987. By one estimate, at least half of the urban population in eight developing countries – Brazil, India, Egypt, Indonesia, Sri Lanka, Sudan, Thailand and Tunisia – is undernourished. Studies in several large Third World cities indicate that energy intake in slums and squatter areas is as little as half of city averages. Anaemia is twice as prevalent and up to 50 percent of children may show signs of malnutrition, 10 percent in severe form. In New Delhi, 40 to 55 percent of shantytown children have been found to suffer various grades of malnutrition and mortality rates among children under five years have reached up to 450 per 1000.

## Rural Diets "Superior"?



The health and nutrition status of the urban poor may, in fact, be worse than that of the rural poor, despite the concentration of health facilities in cities. Research indicates that urban infants suffer growth retardation at an earlier age than their rural counterparts, and that urban children are more likely to have rickets. While the urban diets are often more varied and include higher levels of animal protein and fat, rural diets may be superior in terms of calories and total protein intake. Average food consumption is lower and estimates of undernutrition generally higher in urban areas. However, physical malnutrition in children is markedly worse in the rural population, possibly because urban dwellers, of whatever social group, have lower energy demand than subsistence farmers.

Several associated factors account for nutritional deprivation among slum dwellers. One problem is the inability to adapt to new staples and a new structure of food prices. Food purchases of the urban poor are heavily dependent on competing demand for unavoidable non-food expenditure such as transport to work, housing and remittances to relatives in the countryside. The urban poor seldom have easy access to central markets due to public transport costs and are thus compelled to buy their food in small quantities from local shops at higher prices. They may have little time to prepare food, no suitable space for cooking and no money for fuel. Result: the poor often rely mainly on small-scale local vendors to prepare meals with little regard for hygiene or food safety.



Projected population and rank of major cities for the year 2010 (rank shown in brackets)

Source: UN Estimates and projections of urban, rural and city populations. 1950–2025. The 1980 Assessment (ST/ESA/SER.R/45)

One major issue in urban undernutrition identified by most UN agencies is that of time constraints on urban women. They are more likely to be household heads, particularly in Latin America, and often lack social support networks found in rural areas. For many low-income female workers who leave home early in the morning and return late at night, bottle feeding of infants has become an absolute necessity. But commercial milk powders are often unhygienically prepared, creating a positive threat to infants' health. In some urban communities, large scale introduction of bottle feeding has already changed the type and incidence of protein-energy malnutrition. Marasmus, a severe form of protein-energy deficiency, is becoming more frequent among younger children in urban areas. In four Bangkok slums, the prevalence of protein-calorie malnutrition was attributed to failure to breastfeed, early weaning and inadequate artificial feeding.

### Solutions: Rural Development

The basic cause of hunger and malnutrition in cities is poverty. Long-term solutions will depend, therefore, on the provision of jobs and services to match the requirements of a growing urban population. Because this could take generations to achieve in some low-income countries, urgent action is needed to avert serious problems in the near future. One priority is a slow-down in the pace of urbanization by expanding rural infrastructure and services and creating rural employment. In addition, improvements are needed in the production, marketing, distribution, handling and control of food for the urban market. Recent FAO studies in eight developing countries indicate that much more attention should be paid to the “supply side” in the urban food equation: a decreasing number of rural producers are ill-prepared to meet the food needs of ever-increasing numbers of urban dwellers. Responding to urban food demand is also difficult because of marked differences in diet composition between rural and urban areas.



[Source: FAO Photo Library]

### **Primary Health Care**

Improvements to urban health services would have significant impact. More comprehensive health coverage, including immunization campaigns, would improve nutrition among the urban poor by preventing gastrointestinal and infectious diseases, promoting adequate diet among pregnant and lactating women and encouraging proper infant and child feeding. However, urban health services often observe an “inverse care law”: those in greatest need of care have the poorest access to it. Few governments have formulated urban health policies giving priority to the poor and, even when such plans and programmes do exist, their implementation is hampered by resource shortages aggravated in recent years by economic recession. A further barrier is the chaotic administration typical of many overcrowded Third World cities.

Agencies agree, therefore, on the need to adapt WHO's Primary Health Care (PHC) approach – until now a mainly rural phenomenon – to the needs of the urban poor. Described as a “renaissance in community health”, PHC is a strategy encompassing total, primary-level health coverage as well as action to attack the fundamental causes of health problems through policies establishing equity in employment, income, education, housing and planning. One increasingly popular instrument for applying this approach in poor urban areas is neighbourhood health programmes, the equivalent district level PHC arrangements promoted by WHO in rural areas. While no established blueprint for such programmes exists, successful neighbourhood schemes have emerged in Cali, Addis Ababa, Djakarta and Manila, usually based on community health centres with a wide deployment of health workers and emphasis on public health education campaigns. Coverage so far has been limited, but the neighbourhood programmes could be expanded and consolidated. Essential to the PHC approach, WHO stresses, is the parallel development of a decentralized network of hospitals supporting the primary system. This reorganization was successful in Cali, where the strengthening of peripheral health units benefited particularly the poor populations of outlying barrios.

But improved health coverage is only one part of PHC. It is unrealistic, research has shown, to expect healthy behaviour and compliance with medical advice from a population whose basic needs are grossly unsatisfied. All relevant sectors of socio-economic development must be mobilized and organized into functional networks to contribute to clearly defined health objectives. This entails multisectoral action, including the upgrading of water supply and sanitation facilities, development of income-generating activities and the

provision of basic education, family planning advice, decent housing and low-cost transport.

## **Nutrition Programmes**

Along with primary health care, there is an urgent need to expand direct nutrition intervention programmes. Among the easier and less costly interventions are fortification of food and mass distributions of capsules and tablets to eliminate deficiencies of iodine, iron, folic acid, and vitamin A. Success in fortification programmes will depend on the choice of a food carrier which is centrally processed and consumed on a regular basis. Another delivery system, successfully operated in Sri Lanka during the 1970's, is fair price (or ration) shops which distribute staples at subsidized prices in low-income urban areas. While many international agencies advise against the general use of food subsidies, studies show that it is possible to design targeted interventions based on particular commodities or types of ration shop.

Large-scale feeding programmes are able to reach vulnerable groups, such as young children and pregnant and lactating women, but present logistical and some targeting problems. On-site meals programmes require infrastructure, while take-home programmes carry the risk of "leakage" – the sharing of food with others or the sale of the rations. Other problems encountered include sporadic attendance, difficulties in maintaining the ration size and generally high cost. FAO says supplementary feeding programmes are likely to be cost effective if the food supplement is sufficient to provide the incentive for regular participation, if criteria based on the degree of malnutrition and response to feeding are established for entry to and exit from the programme, and if the programme is integrated with nutrition education and primary health care. Active community participation is also recommended: in Calcutta, slum residents pooled resources to buy staple food in bulk and ran community kitchens which fed 135,000 pre-school children. In Latin America, communities have addressed one of the most critical nutritional problems facing the urban poor – the feeding of infants – by establishing creches for working mothers. Nutrition education aimed at motivating people to change their dietary behaviour and make better use of available food is a basic component of intervention programmes for the rural poor. In urban areas, where malnutrition is normally the result of low purchasing power, advice will concentrate mainly on making the best use of limited money by purchasing the cheapest combinations of nutritious food and making better combinations of weaning foods for children. Nutrition education can also be designed to promote improved food handling and preparation and address constraints on slum dwellers' time and use of fuel.

## **UN Action**

Although UN agencies agree on the broad outlines of strategies and programmes, members of the SCN believe more information, more awareness and more concerted action are needed in order to deal with the urban poor's nutrition needs. Of major concern to the UN agencies at present is the effect of economic recession in the 1980's and of structural adjustment policies. Since the urban poor rely more heavily than rural people on cash for survival, reductions in employment and wage rates, increases in food and petrol prices and cuts in government services could lead to greater hardship. "There is a real danger," the SCN noted at its 1987 annual session, "that the current policy pursued by many low-income countries, combined with stringent economic conditions, might lead to a decline in the nutritional status of the urban poor due to neglect of programmes and policies needed to secure essential services." At the same time, the report cautioned, socio-economic policies aimed at assisting the urban poor should take into account the possibility of negative consequences for the rural poor.

The SCN Symposium identified three areas for action by UN and bilateral agencies. First, more information is needed for formulating cost-effective nutrition and health policies for the urban poor. UN agencies' efforts should assist in achieving better cohesion in research, help define priority questions and stimulate work to obtain answers. Second, UN and bilateral agencies should make high level contact with governments to advocate greater attention to the dimensions of the urban nutrition problem. The Symposium suggested that UNICEF introduce the topic with higher priority in its contacts with governments and country programme planning and urged all UN agencies – particularly UNDP, with its key role in country programming – to focus attention on the problem and mobilize resources for its solution. Third, nutrition objectives should be introduced into a much wider range of programmes. This could entail either more efficient use of resources already available for urban areas, or allocation of new resources.

## News in Brief

*Tanzanian Workshop on Social Mobilization for Nutrition.* An international workshop has identified seven “key elements” in the use of social mobilization for promotion of child survival/development and primary health care. The workshop, held in Iringa, Tanzania, on 9–11 March 1987 discussed the role of social mobilization in the Iringa Nutrition Programme, which is funded by the Joint UNICEF/WHO Nutrition Support Programme. “One of the major conclusions of the workshop was that projects and programmes must be seen in the broader frame of a process oriented strategy for development,” WHO reports. Participants concluded that social mobilization “is really a matter of resource mobilization”. The main issues in social mobilization were sustainability, replicability and cost effectiveness. Key elements to be considered in programming for child survival/development and primary health care with a social mobilization approach were: advocacy emphasizing participation, information and communication, training and education, provision of services, mobilizing agents, organization and relations and social, mobilization analysis. [Source: WHO Report, July 1987]

*Safe Motherhood.* Death and illness resulting from complications of pregnancy and childbirth are distressing symptoms of poverty and disadvantage. When a woman in a developing country becomes pregnant, her chances of dying can be up to 200 times higher than those of a pregnant woman in an affluent society. To heighten awareness and concern about the neglect of women's health, particularly in the developing world, the World Bank, the World Health Organization, and the United Nations Fund for Population Activities jointly sponsored an international conference on Safe Motherhood, held in Nairobi, Kenya, in February 1987. Following the Conference, a fund to promote safe motherhood is being established, with World Bank support, by WHO. [Source: World Health Forum, Volume 8, pp. 155–160, 1987]

*Vitamin A in Africa.* A national symposium on Vitamin A was held in Addis Ababa on 7–8 December 1987. The symposium, organized by the Ethiopian Ministry of Health, the Italian Ministry of Foreign Affairs and the International Vitamin A Consultancy Group (IVACG), discussed a range of topics related to vitamin A deficiency, including its effects on growth and the management of interventions, as well as vitamin A deficiency in 11 African and 5 other countries. The symposium was followed by the 12th meeting of the IVACG in Addis Ababa, 9–12 December 1987, which had as a major theme the development of country strategies to control and prevent vitamin A deficiency in African countries.

*Cassava: Pros and Cons.* Agencies interested in fostering the production of cassava for human consumption should assure that member countries are aware of both its advantages and limitations, the SCN's Advisory Group on Nutrition (AGN) has recommended. At its meeting in Washington, DC in February 1987, the AGN said cassava was a cheap source of calories, could be targeted towards the poor and could serve as a cheap and easily-prepared weaning food. However, it contains inadequate protein to sustain life, especially in young children, and contains toxic cyanogenic-goitrogenic substances. The first problem could be dealt with by adding protein-rich foods, such as lentils and peanuts. The second limitation can be overcome by adequate preparation (which, however, might be difficult to ensure); by low consumption, which make cassava of limited utility; or by introduction and use of 'sweeter' (lower toxicity) cassavas – but these may have less yield and less good storage characteristics. The AGN has further recommended that where cassava is being rapidly commercialized (e.g. for animal feed) opportunities for poor households to grow cassava for household food and income security should be protected. [Source: Report of Meeting of the Advisory Group on Nutrition of the ACC/SCN, February 1987. SCN 88/AGN A. p.4]

*Radioactive Contamination of Foods.* An international expert consultation convened by FAO has recommended “interim action levels” for radioactive contamination of foods entering international trade. The consultation, held in Rome in December 1986, was called following the Chernobyl nuclear power station accident. In the absence of international recommendations on unavoidable levels of radiation in foodstuffs, food trade was severely disrupted in many countries of Europe and Asia. The consultation's interim levels are based on safety recommendations established by WHO and the International Commission on Radiological Protection. Consumption of contaminated foods with radionuclides at or below the interim levels would not create additional health risks to consumers, the experts said. Their proposals were based on the “very conservative” assumption that all foods consumed by an individual would be equally contaminated, FAO reported. The levels chosen were intended to protect the most sensitive consumer groups, such as infants, and took into account such factors as preferential absorption by certain parts of the body. [Source: Report of the Expert Consultation Recommended Limits for Radionuclide Contamination of Foods, FAO December 1986]

*OCEANIAFOODS Established.* Twenty-five South Pacific countries have set up OCEANIAFOODS as a regional committee of the International Network of Food Data Systems (INFOODS). The decisions was made

at a conference in Canberra in May 1987 sponsored by the Australian Department of Community Services and Health and attended by delegates from Australia, Fiji, New Zealand, Papua New Guinea and the South Pacific Commission, representing 21 Pacific Island States. They agreed that Australia would provide the OCEANIAFOODS secretariat for the first two years, after which it would rotate on a two-yearly basis among Australia, New Zealand and the South Pacific Commission in Noumea. INFOODS, a UNU-sponsored project, was set up in 1984 and is based at the Massachusetts Institute of Technology, USA.

*Food and Nutrition Course in Benin.* Thirty-one development personnel from six African countries and Italy attended an International Food and Nutrition Course in Porto Novo, Benin, in April/May 1987. The course, part of a four-year programme sponsored by Italy's Direction General for Development Cooperation, Ministry of Foreign Affairs, included seven one-week modules covering: the integration of peripheral structures into a national food and nutrition surveillance system; surveys of food consumption and living conditions; surveys of nutritional status; food composition and nutritional value of foods; food hygiene and laboratory analysis of contamination; food and nutrition education; and computer analysis of survey data. Participants were drawn from Ministries of Agriculture, Health, Education and Public Information. On the suggestion of participants, Italian authorities are examining the possibility of repeating the course each year in a different country of francophone Africa. One objective of the four-year nutrition programme is to train national and provincial level cadres from West and Central Africa in food and nutrition. [Source: Istituto Nazionale della Nutrizione, August 1987]

*Germinated Cereals for Weaning Foods: SIDA Project.* Field trials using germinated flour as a weaning food in Zambia is starting under a one-year project funded by the Swedish International Development Agency (SIDA). The project is one of several focussed on weaning foods, particularly germinated cereals, to be launched with SIDA assistance. To deepen knowledge on the subject, SIDA sponsored with UNICEF and IDRC a workshop in Nairobi in October 1987. At present, SIDA's Health Bureau is cooperating with UNICEF in assistance to the Tanzania Food and Nutrition Centre, the Zambia National Nutritional Surveillance Programme and Zimbabwe's Supplementary Food Production Programme. The agency is now planning a project with the International College of Midwives on breastfeeding.

*Polished White Rice.* "Malnutrition in Vietnam has become serious and widespread, and beri-beri, a diet-related nervous disorder, is occurring in the army in epidemic proportions, according to the head of a military medical institute in Hanoi", the New York Times reported in May, 1987. The report said international health and welfare organizations had been concerned for several years about mounting evidence of malnutrition in Vietnam. It said beri-beri was common in Asian countries in which people subsist on a diet of polished white rice. [Source: New York Times, May 14, 1987]

*Breastfed Infants.* Data from a Malaysian Family Life Survey had shown an increase in the percentage of infants breastfed, at least initially, from 75 percent in 1970-74 to 79 percent in 1975-77, the American Journal of Public Health reported. Contrary to trends in some developed countries, the increase had occurred among poor and uneducated women as well as among the more fortunate.

## **Programme News**

### **Joint Nutrition Support Programme**

UNICEF and WHO have fully committed \$85.3 million in funding to 18 projects under their Joint Nutrition Support Programme (JNSP). Funded since 1982 by the Italian Government, the programme has three long term objectives: to reduce child and infant mortality and morbidity, improve child growth and development, and improve maternal nutrition. It seeks to do so through a strategy described as "multisectoral, preventative and developmental". Country projects within the JNSP are designed and executed according to the principles of Primary Health Care, involving health sector development activities such as immunization and diarrhoeal disease control. They also promote nutritional objectives in sectors such as agriculture, education and social development.

In Burma, for example, the JNSP has been instrumental in the integration of nutrition-related activities, such as growth monitoring, nutrition education and the distribution of essential drugs, into the country's national primary health care system. In Haiti, the JNSP project is using social mobilization to increase public use of oral rehydration therapy, while in nearby Dominica and St. Vincent and the Grenadines project activities

include the training of community workers and development of income-generating activities for women.

## **Projects in Africa**

Almost half of the projects are underway in Africa. A multisectoral project in Mozambique is supporting household food production, use of improved crop varieties and agricultural training for women and promoting greater community awareness of nutrition issues. Two projects in northeast and southern Sudan seek to integrate services in health, agriculture, animal husbandry, water, education and social welfare. In Ethiopia, a project of multisectoral action is being tested as a model for other such projects throughout the country.

WHO and UNICEF report that almost 90 percent of the Joint Nutrition Support Programme's resources have been committed to such projects, the remainder being used for intercountry support activities such as public information, research, special programming for nomads and development of training methodologies.

## **Inter-Agency Food and Nutrition Surveillance Programme**

FAO, UNICEF and WHO, with the ACC/SCN, have launched a five-year programme to help the rapid expansion of food and nutritional surveillance systems in developing countries.

The immediate impetus came from concern for the effects of economic recession and adjustment policies on nutrition of the poor. This was the topic of a symposium convened by the SCN in March 1986 in Tokyo, which called for better and more up-to-date information on malnutrition. A proposal for renewed inter-agency efforts in this subject was endorsed by the SCN in early 1987, and put to the UNICEF Executive Board in April. The programme was accepted, with a budget to be raised of \$10 million for 5 years, aimed at assisting up to 40 developing countries.

During 1987, plans and organizational arrangements have been developed. As a first step, a report on recent trends in nutrition, with reference to economic adjustment, will be issued in mid-1988. This will draw on information from at least 20 developing countries. Regional meetings to draw up national plans and review needs are proposed for 1988 in Latin America, Asia and Africa. UNICEF is responsible for fund-raising, WHO and FAO will participate in project development and implementation.

This 5-year programme has both short and long-term objectives. For the former it is intended that existing data, e.g. on anthropometry, incidence of low birth weight, and access to food, etc., from a substantial number of countries will be collated and analyzed with a view to producing a situation report by mid-1988. This report will provide an update to information given in the SCN's First Report on the World Nutrition Situation.

For the longer term the programme will attempt to strengthen the institutional capacity of some 40 countries to produce, analyze, and use food and nutrition data for the proper and integrated development of policies and programmes.

The major portion of the funding will be used to support institutions directly in individual countries, for work in those countries. The major required output is assistance within the country in developing nutritional surveillance – system's design, management, data interpretation, and information usage at different levels in policy and programme decision making. The implementation of the programme at country level will thus be primarily in the hands of these national institutions.

The programme was launched during the latter half of 1987; proposals from national institutes will be sought during the first half of 1988. Guidelines will be made available both directly and through a series of regional meetings, where consultation with potential participants will provide essential feedback on the management of the programme. Provisionally, these meetings are scheduled for September; in Latin America (organized by PAHO); for Asia, organized with WHO and UNICEF; and hopefully in association with a regional nutrition meeting planned in Zimbabwe, also in September. Further information can be obtained from Alan Kelly, ACC/SCN; and/or Beverly Carlson, UNICEF, New York.

## Effects of Iron Deficiency on Behaviour

UNU are promoting research into the effects of “less than severe” iron deficiency on child behaviour. While severe iron deficiency anemia has been long recognized as a health risk, the functional significance of iron depletion and mild depression of hemoglobin levels remains uncertain. However, findings have suggested possible long-term effects, including an accumulated learning deficit among anaemic children and persistent lower levels of brain iron among individuals who were iron-deficient in infancy. There is also a suggestion that mother-child bonding may be affected because the behaviourally disturbed infant is less able to evoke positive stimulation from its mother.

### “Suggestive links”

Following a request from the United Nations University (UNU) for an SCN-UNU sponsored conference on the behavioural consequences of iron deficiency, the AGN examined the issue at its meeting in Washington DC in August 1986. It found much evidence of association between iron depletion and psychological function/cognitive development, but no direct evidence that clearly established causation. It recognized “suggestive links” between iron depletion and other areas of functions, including work performance, immunologic competence and resistance to infection. It was decided to explore with UNU the possibility of a workshop to define research questions, develop competent protocols to address these questions and disseminate, after peer review, a research design report to potential investigators and interested funding agencies.

UNU is now preparing to organize and co-sponsor with the SCN a conference on iron deficiency, cognitive performance and behaviour.

## WHO: Global Surveillance Through Anthropometric Measurements

WHO Nutrition Unit has compiled, analyzed and published data on wasting, stunting and growth failure in children from some 230 survey reports from countries all over the world. The results are presented in a consistent format, showing percentages below standard cut-off points, by age group. References to all sources are listed. An example of the data format is this:

The results, originally published by WHO region in the WHO Weekly Epidemiological Record, have now been put together in one document – “Global Nutritional Status” (NUT/ANTREF/3/87) – available from the Nutrition Unit, Division of Family Health, WHO, Geneva.

**Table 1. Anthropometric indicators of nutritional status in the WHO African Region: prevalence of wasting and stunting. Tableau 1. Indicateurs anthropométriques de l'état nutritionnel dans la Région OMS de l'Afrique: prévalence de l'émaciation et du retard de croissance**

	Date of survey Dates des enquêtes				Wasted Emaciation	Stunted Retard de croissance	Low Insuffisance	Obese Obésité
Region, country, area Région, pays, zone	Month(s) Mois	Year(s) Année(s)	Number examined Nombre examiné	Age group (years) Groupe d'âge (années)	weight for height (poids/ taille)	height for age (taille/ âge)	weight for age (poids/ âge)	weight for height (poids/ taille)
					Percentage below/above median Pourcentage au-dessous/au-dessus de la médiane			
					-2 S.D. -2 E.T.	-2 S.D. -2 E.T.	-2 S.D. -2 E.T.	+2 S.D. +2 E.T.

Botswana		1978–79	136E	0–0.99	2.0	24.7	18.8		2 villag in Cen Dist
District .....			136E	1	12.5	55.9	49.3		2 villag du Dist cent
			136E	2	6.8	36.8	47.0		
			136E	3	5.7	46.1	44.0		
			136E	4	7.0	40.0	42.6		
Burkina Faso	Jan.–Dec.	1973–82	902	0–0.49	2.0	3.7	3.4		Mos Trib Trib de Mos
Local .....	Janv.–déc.		1458	0.5–0.99	12.1	19.2	32.5		
			2189	1	18.2	29.2	39.2		
			1843	2	7.8	20.8	32.9		
			1226	3	6.7	23.2	26.0		
			470	4	7.0	28.1	28.9		
		1974	225E	0–0.99	7.4	24.2	25.2		
			225E	1	16.6	36.5	46.9		
			225E	2	12.1	26.3	39.7		
			225E	3	7.6	26.3	30.8		
			225E	4	12.9	25.8	38.7		

## Publications

### Policies for Protecting the Poor During Economic Adjustment

**Adjustment With A Human Face. UNICEF.** Giovanni Andrea Cornia, Richard Jolly and Frances Stewart (eds.) Vol. 1, Protecting the Vulnerable and Promoting Growth. (Clarendon Press, Oxford, 1987 313 pp.)

[The following review is reprinted with permission from Trocaire Development Review 1987: Trocaire – The Catholic Agency for World Development, 169 Booterstown Avenue, Blackrock, Co. Dublin, Ireland.]

“There is a tendency among economists to quantify human capital in terms of the pricing of the factors of production by supply and demand, as in the textbook theory of distribution. Economics is an evolutionary science, however, and must accommodate the idea of “a human face”. There is more than sufficient evidence that economic decline threatens human health and welfare in vulnerable groups and this fact contributes a moral dimension to economics. Reducing poverty is an ethical and pragmatic good, which properly negotiated, can be cost-effective. This idea is at the root of the thinking of Giovanni Cornia, Richard Jolly, Frances Stewart, et al, the authors of **Adjustment With A Human Face**. The foci of their research are the indicators of the deterioration of human welfare in the 1980–1985 period caused by world recession, and the



crucial need to factor these indicators into an alternative adjustment policy. The 1983 UNICEF report 'The Impact of World Recession on Children' defined these indicators in terms of infant mortality rates, low birth rates and measurable declines in nutrition levels. The authors of **Adjustment With A Human Face** have collaborated in writing a series of monographs which study the existing national and international order within an economic frame of analysis, and their conclusions and recommendations on the decline of social welfare in developing countries are specifically addressed to policymakers, practitioners and analysts of the process.

“The effect of deceleration of growth in industrial market economies during the 80's has been particularly painful in its transmission to the developing countries of Latin America and Sub-Saharan Africa. The contraction of trade and capital flows and the cut-backs in commercial bank lending from \$38 billion in 1980 to \$15 billion in 1985 (World Bank, 1986), together with the stagnation of official development assistance have caused capital importing developing countries to suffer negative transfers and become exporters of resources to the industrialized world. This depletion is compounded by depressed commodity prices, U.S. monetarist policies produced an increase in the real rate of interest which aggravated the debtor nations' crises. These changes in macro-economic performance relate directly to changes in social welfare of developing countries due to the contraction of their government expenditure per capita. A look at the input indicators: decline in gross domestic product, employment and real salaries, and at the process indicators: non-availability of food and social services, and it is not hard to predict the outcome: a drop in the real resources of the poor.

“The term “adjustment” is a policy response designed for developing countries to cope with deficits in their current and capital accounts in the balance of payments, and consequent fluctuations in government budget, and is a policy antidote to rapid inflation and negative economic growth. Prevailing economic adjustment to the effects of recession generally take the form of stabilization policies deflationary in nature, which reduce the real incomes of the poorer sector. This form of adjustment relegates vulnerable groups to a marginal welfare component. **Adjustment With A Human Face** is a proposal for a radical change of emphasis: “alternative adjustment”, a strategy which decides that poverty alleviation must be an integral part of adjustment policy. The former Director of the International Monetary Fund (IMF), M. de Larosiere, is quoted on this controversial topic: “The forms of adjustment that are most conducive to growth and protection will not emerge by accident. They have to be encouraged by an appropriate set of incentives and policies. They will also require political courage.” (July, 1986). Such incentives for poverty reduction are described in detail, with particular attention to health maintenance. Health, nutrition and education are, in their view, the most important determinants of a nation's potential. Health care is not a consumption good, but a positive economic product which contributes to national development. A mother is the producer at the household level of health as output. Health care projects are vitally useful social capital.

“Immunization and hygiene programmes have high survival impact. Vaccines against measles and polio, and oral rehydration therapy saved the lives of one million children in 1985. Nutrition intervention is as economically productive as financial structural adjustment. “Investment in human resources is at least as vital for economic growth, and exhibits as high returns, as physical investment.” The authors argue a convincing case for a humanitarian programme, using the language of benefit-to-cost ratios and economic efficiency. Economic erosion need not mean erosion of health and welfare.

“Giovanni Cornia, Richard Jolly and Frances Stewart insist that adjustment packages can be designed which simultaneously protect vulnerable groups while restoring economic growth and point to a policy turnaround made by U.S. Secretary of the Treasury, James Baker, at the Annual Meeting of the Fund and World Bank in Seoul, in October, 1985, in which he promoted “growth-oriented adjustment policy”. Essentially, multilateral development banks as well as commercial banks were invited to increase lending; the resulting growth would buoy welfare services. Halting the decline in per capita income is the crucial element in adjustment with a human dimension. In this context, the authors have some criticism to direct to IMF stabilization programmes which they judge give minor consideration traditionally to the effect of income distribution on particular social groups. IMF monitoring is solely on the basis of the performance criteria (the rate of increase of the money supply, the budget deficit as a proportion of gross national product) of the adjustment process, and neglects welfare variables such as the incomes of the poor, or the rate of malnutrition (infant mortality rate, food availability). They feel that emphasis on economic growth is minimal, and little attention given to the distribution of wealth.

“Between 1980 and 1985, forty-seven countries utilized IMF adjustment programmes. In looking at the effect of IMF policies on growth, distributive equity, poverty and child welfare, the authors feel that methodologically, it is not possible to attribute causal responsibility to the IMF for the direct negative effect of macro-economic policies on the poor. However, they do ask for a change of objective. They suggest “meso policies” in taxation, aid, credit and asset distribution, specifically tailored to promote economic growth while meeting the needs of vulnerable groups. This means to prioritize, select, redistribute, and restructure resources and expenditures to

maintain the incomes of the poor. They propose sectoral policies which promote small-scale agriculture and industry. They specify targeting of interventions so that resources are redistributed to basic services: housing, sanitation, social security, together with compensatory programmes to subsidize food prices and underwrite public work schemes. Botswana, South Korea, Zimbabwe and Chile are useful examples of countries where "alternative adjustment" projects protect vulnerable sectors.

"Because the absence of adequate data is both a symptom and a cause of the low priority of the human factor, statistics are urgently needed for a comprehensive dossier of information on infant mortality rates and nutrition levels. Malnutrition must be monitored as closely as monetary variables. This stock-taking would be co-ordinated by a central technical unit which would establish a line of reporting to bureaucrats and political decision-makers, involving them directly in matters of social responsibility. Publication of forward indicators of social stress should be included in government statistical publications or in Central Bank Reports.

"In summary, the authors state that it is a matter of national conscience that the human dimension of adjustment be incorporated into political thinking. It should be an intrinsic part of IMF policy requirements and dialogue. The identification of social stress statistics should be a sine qua non in the design of international and government strategy for economic relief.

Rosemary Kevany"

### Lessons from Ethiopia

**Macalle 1985** (Ministero degli Affari Esteri/Istituto Superiore di Sanita 1986) 128 pp.

When the Italian Medical Team arrived in Makale district, northern Ethiopia, in November 1984, some 80 000 displaced people faced death from starvation and disease. The subsequent Italian-sponsored and conducted relief operation is fully documented in **Macalle 1985**. At the outset, Italian and Ethiopian authorities agreed on the creation of a series of seven tent camps, each housing about 10,000 people, established an "airbridge" to ferry in some 5000 tonnes of relief supplies and drilled new wells guaranteeing up to 15 litres of water per person per day. The Italian team organized a monthly general distribution of raw foods, providing about 2000 Kcals per person daily, and controlled malnutrition through a supplementary feeding programme for high-risk groups, therapeutic feeding of severely malnourished children and oral doses of vitamin A for every child. These measures, combined with vaccination of children against infectious diseases, led to a reduction in camp deaths to below the Ethiopian national mortality rate. Following seasonal rains in mid-1985, authorities encouraged camp residents to return to their homes by supplying them with farm inputs and food rations. "For the first time," the authors state, "a grave emergency was resolved in a relatively short time (10 months in all), thus averting what has always been the problem of displaced camps: the dramatic conversion of the intervention into a chronic condition, and the development of a total dependence of thousands of people on international assistance."

### Food Systems Studies from UNRISD

UNRISD has published two new studies in its Food Systems series: **Food Systems and Society in Eastern India: Selected Readings**, edited by B. Chattopadhyay and P. Spitz; and **The Assault That Failed: A Profile of Absolute Poverty in Six Villages of Bangladesh**, by M. Hossain. The first contains four essays examining the origins of the 1943 Bengal Famine, the decline of irrigation and crop production in West Bengal between 1850 and 1925, the growth and fluctuation of food grain output in India since independence, and the increasing strength of the Indian farm lobby. **The Assault that Failed** presents the results of a household survey conducted among 178 poor households in Bangladesh during the 1984/85 agricultural year, when massive food grain imports were needed to stave off the threat of famine. Decisive national action prevented speculation with prices. However, the study says, "It is clear that, at least in the villages studied, a significant proportion of the rural poor were in fact starving. Grains were available locally, but most respondents could not earn a monetary income sufficient to purchase them in adequate quantity, nor did they have access to the land required for self-provisioning". In the final analysis, the study shows, starvation and hunger must be attacked by removing socio-economic obstacles to adequate food intake. The two studies are the latest in a series of nine produced as part of UNRISD's Food Systems and Society Programme, which has promoted studies in ten countries of Africa, Asia and Latin America.

### IN BRIEF

Recent WHO publications include **Guidelines for Training Community Health Workers in Nutrition** (Geneva, 1986) and **The Growth Chart – Tool For Use in Infant and Child Health Care** (Geneva, 1986),

which is also available in French and Spanish. The Joint WHO/UNICEF Nutrition Support Programmes has produced **Traditional Practices Concerning Dietary Management During and After Diarrhoea** (1986).

**Comparative Analyses of Nutritional Effectiveness of Food Subsidies and Other Food-Related Interventions**, by E. T. Kennedy and H. H. Alderman (IFPRI, 1987). Intended as a guide for policy makers. Uses cost-effective analysis to evaluate the success of different strategies in attaining similar nutritional objectives.

Recent publications in FAO's Food and Nutrition Paper Series include: **Review of Food Consumption Surveys – 1985**, No. 35 (1986), **Specifications for Identity and Purity of Certain Food Additives**, No. 37 (1986) and **Guidelines For Manufacturers and Food Canners**. Two new papers have been added to the sub-series of manuals on food quality control: **Food Analysis: General Techniques, Additives, Contaminants and Composition**, No. 14/7 (1986) and **Food Analysis: Quality, Adulteration, and Tests of Identity**, No. 14/8 (1986).

Requests for publications should be addressed to the appropriate publisher or agency.

#### **UNITED NATIONS ADMINISTRATIVE COMMITTEE ON COORDINATION – SUB-COMMITTEE ON NUTRITION (ACC/SCN)**

The ACC/SCN is the focal point for harmonizing the policies and activities in nutrition of the United Nations system. The Administrative Committee on Coordination (ACC), which is comprised of the heads of the UN agencies, recommended the establishment of the Sub-Committee on Nutrition in 1977, following the World Food Conference (with particular reference to Resolution V on food and nutrition). This was approved by the Economic and Social Council of the UN (ECOSOC). The role of the SCN is to serve as a coordinating mechanism, for exchange of information and technical guidance, and to act dynamically to help the UN respond to nutritional problems.

The UN members of the SCN are: FAO, IAEA, IBRD, IFAD, ILO, UN, UNDP, UNEP, UNESCO, UNFPA, UNHCR, UNICEF, UNRISD, UNU, WFC, WFP and WHO. From the outset, representatives of bilateral donor agencies have participated actively in SCN activities. The SCN is assisted by the Advisory Group on Nutrition (AGN), with six to eight experienced individuals drawn from relevant disciplines and with wide geographical representation. The Secretariat is hosted by FAO in Rome.

The SCN undertakes a range of activities to meet its mandate. Annual meetings have representation from the concerned UN agencies, from some 10 to 20 donor agencies, the AGN, as well as invitees on specific topics; these meetings begin with symposia on topics of current importance for policy. The SCN brings certain such matters to the attention of the ACC. The SCN sponsors working groups on inter-sectoral and sector-specific topics. Ten-year programmes to address two major deficiencies, vitamin A and iodine, have been launched.

The SCN compiles and disseminates information on nutrition, reflecting the shared views of the agencies concerned. A regular Report on the World Nutrition Situation is being issued. State-of-the-Art papers are produced to summarize current knowledge on selected topics. Research priorities for solving nutrition problems are proposed in consultation with agencies and researchers in the field. As decided by the Sub-Committee, initiatives are taken to promote coordinated activities – inter-agency programmes, meetings, publications aimed at reducing malnutrition, primarily in developing countries.

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