NUTRITION KIT
FOR MEMBERS OF PARLIAMENT

December 2009

INTRODUCTION

The Malawi Government is committed to attain the Millennium Development Goals (MDGs) and to lead the country to sustainable economic growth and prosperity. The government's major policy on economic growth and development is built, among other factors, on effective human capital development that would sustainably spearhead the development agenda.

The Government recognises nutrition as one of the prerequisite for human capital development. Prevention and management of nutrition disorders is, therefore, one of the priority areas in the Malawi Growth and Development Strategy (MGDS). It realises that improved nutritional status contributes to reduced morbidity and mortality (diseases and death) among children, women, People Living with HIV and other vulnerable groups. The Government of Malawi further realises that adequate nutrition improves education outcomes, professional development and promotes productivity. In addition adequate nutrition and wellbeing are among the key child rights provisions as stipulated in the International Charter for child rights of 1991 and Human Rights of 1948.

The attainment of adequate nutrition and human wellbeing as prerequisites for the achievement of the MGDS and MDGs objectives and targets requires multisectoral approach and collective efforts in order to facilitate the human capacity development in the country. Members of Parliament as key duty bearers have a very big role to play in guiding and passing the necessary legislation which promotes investment and nutrition undertakings.

The MPs kit has therefore been, developed to provide simple information and tips that the Legislators should use in their role as facilitators of development for the parents, caregivers, members of the society, agents of change, policy makers, servants of the people and role models beyond the political arena.

WHO SHOULD USE THE GUIDE

The guide is meant for use by Members of Parliament in Malawi and it can also be used by other community and local leaders such as Paramount and Senior Chiefs, Traditional Authorities, Village Headmen, Faith based leaders and other development facilitators in various communities of this country.

HOW TO USE THE GUIDE

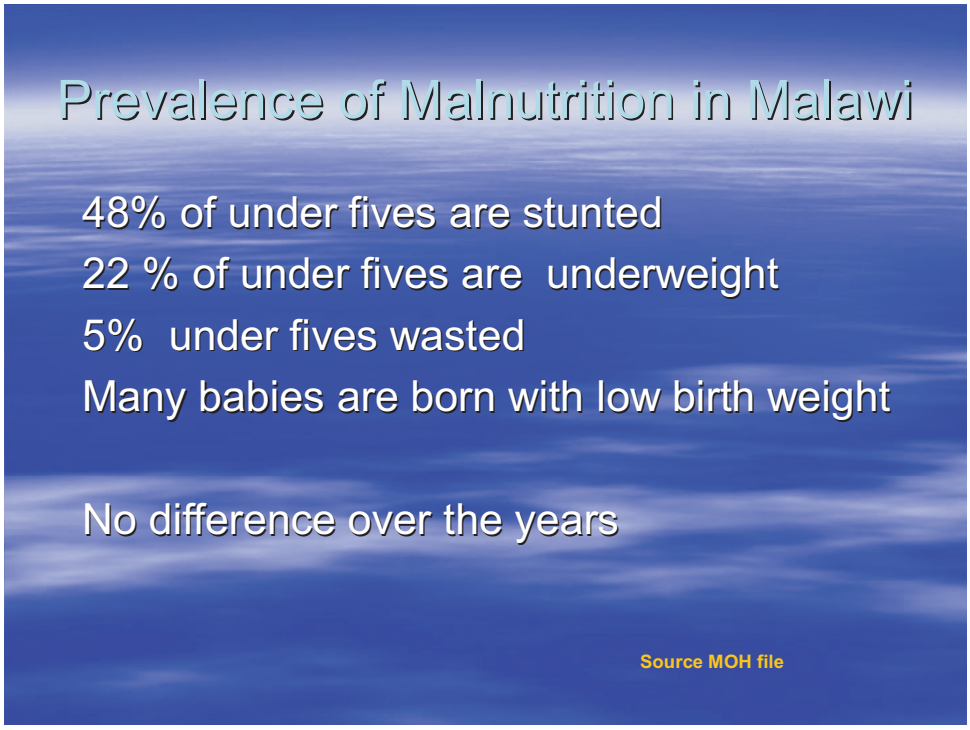
The guide should be used as a guide or reference material in delivering key messages that promote nutrition in the various constituencies during various community functions by local, government and political leaders. It should also be used as a guide to promote nutrition services and programmes that are being implemented by various stakeholders in the constituencies and for resource and community mobilisation to support and promote nutrition interventions.

The guide is meant to assist the Members of Parliament to pass legislation laws that promote resources and support mobilisation for nutrition among various stakeholders. It emphasis on the need for Legislators ensure the implementation and monitoring of nutrition programmes and services being implemented in their constituencies by Government, NGOs and other stakeholders.

THE CURRENT SITUATION OF NUTRITION DEFICIENCY DISORDERS IN THE COUNTRY

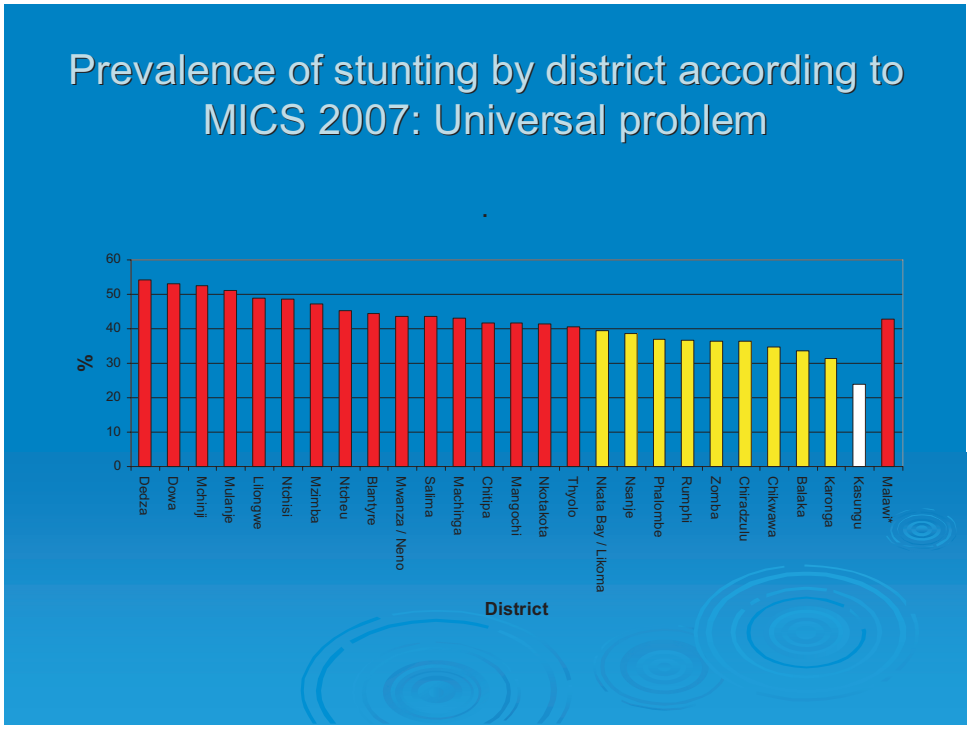
The problem of malnutrition in Malawi is widespread and endemic. Almost half of the children had chronic malnutrition (MDHS, 2004). Refer to Figure 1 below

Fig. 1



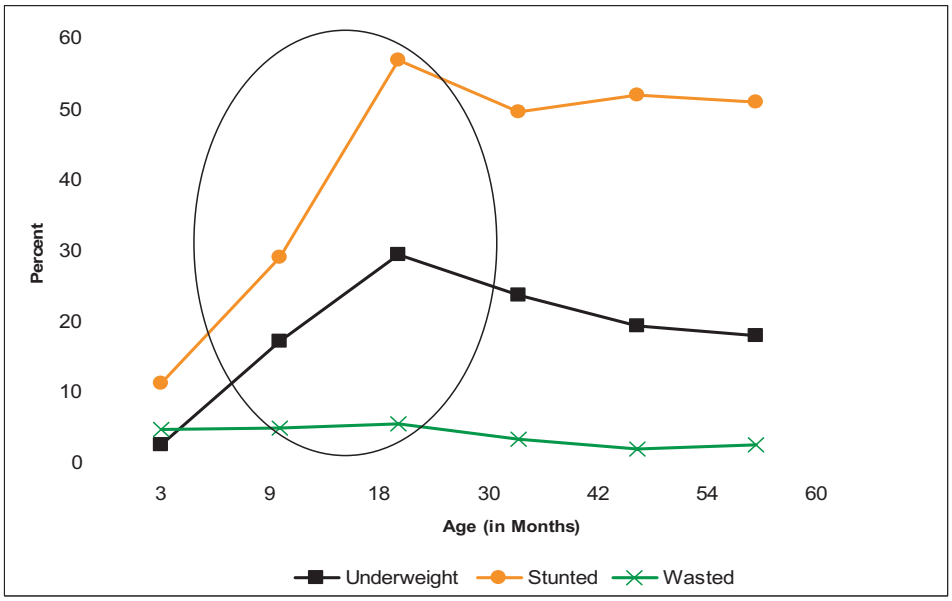
The problem is universal as it is prevalent in all the districts in the country. Refer to Figure 2 below.

Fig.2



Most of the malnutrition sets in the first two years of life a shown in Figure 3 below: But its impact is life long.

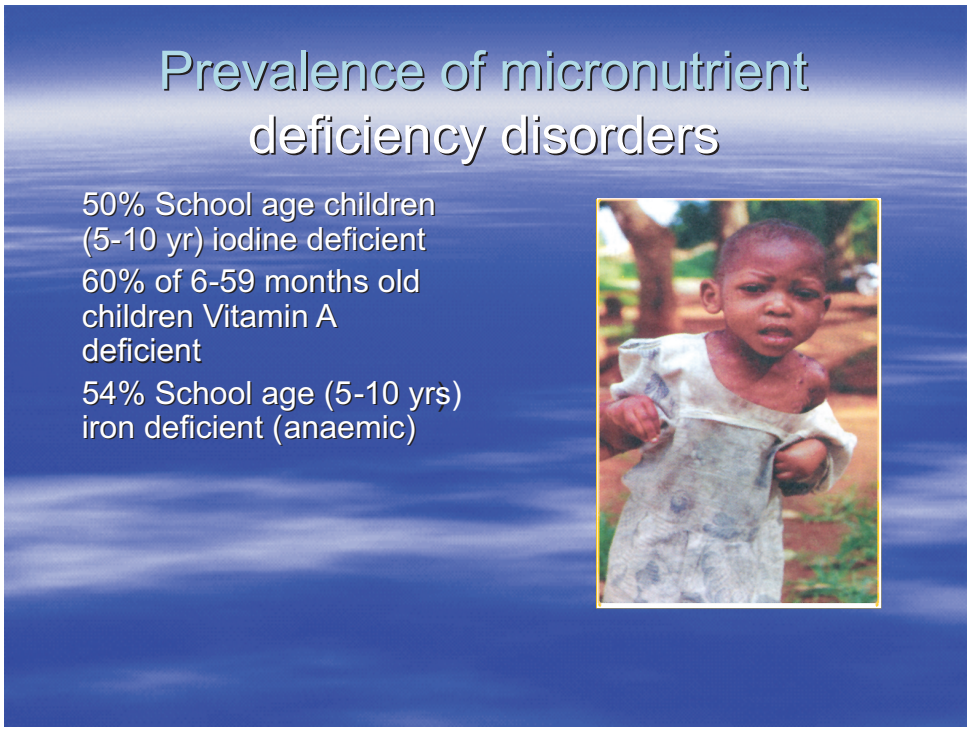
Fig.3



Percentage of under-five children undernourished according to age pattern, Malawi, 2006

Malawi also experiences high prevalence of rates of micronutrient deficiencies especially Vitamin A deficiency, iron deficiency and Iodine deficiency disorders as shown in Figure 4 below. Figure 4 below shows some of the statistics for Vitamin A, iron and iodine deficiencies. Iodine deficiency which is as high as 87% in endemic iodine deficiency area and goitre is about 3% in women. If the woman with goitre becomes pregnant and the iodine deficiency persists, she gives borth to a child with brain retardation and such a child is called a cretin who looks like the one in the picture below. In Malawi permanent brain retardation is 1% nationally and 3% in endemic iodine deficient areas such as Dedza, Ntcheu, parts of Dowa, Chitipa, Kasungu, Mzimba and Chikwawa among others while permanent low intelligence index is at 13.5%.

Fig. 4

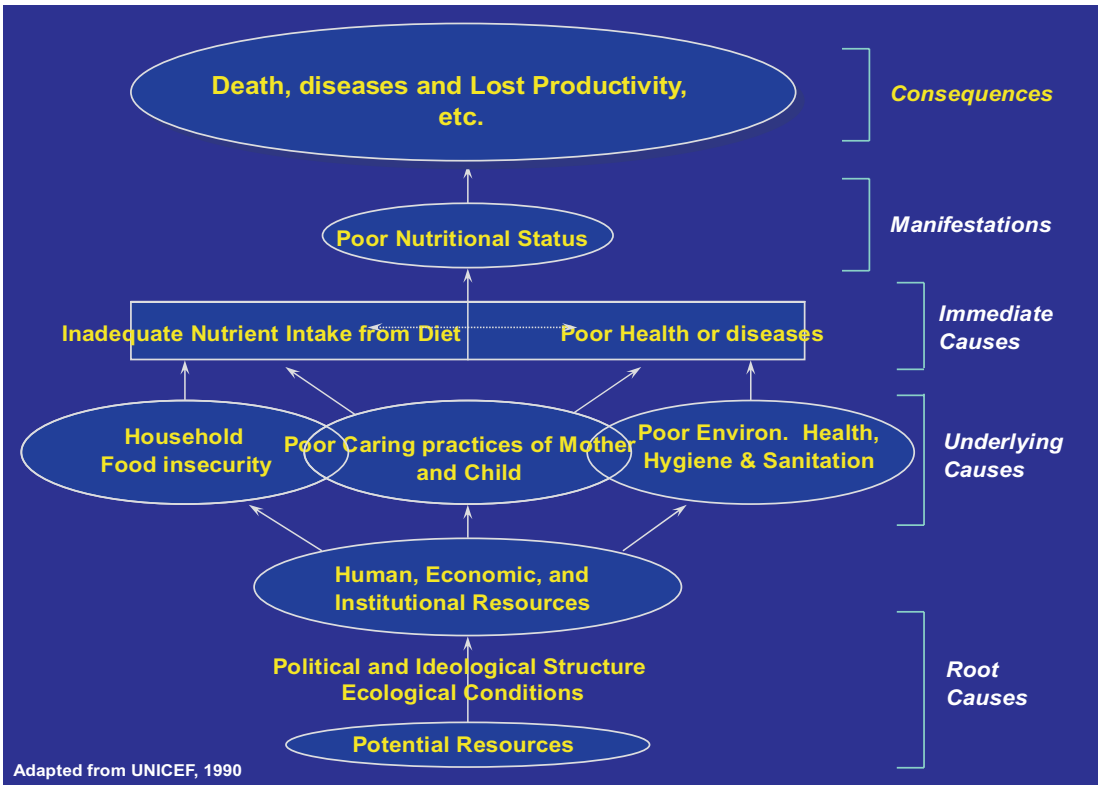


WHAT CAUSES MALNUTRITION IN MALAWI

Malnutrition is caused by inadequate dietary intake of nutrients, in terms of variety, diversity, quality and quantity coupled with household food insecurity which affects the frequency, amount and quality of meals at the household level. Inadequate nutrient intake may also result from poor feeding practices and other child care practices such as poor hygiene and environmental sanitation may lead to diseases which, increases nutrient requirements by the body.

The diseases may cause loss of appetite and poor absorption of the nutrients taken. Lack of access to safe water and sanitation and poor hygiene contributes to children suffering frequent bouts of diarrhoea. Delays in seeking medical care lead to longer period of sickness and if complications set in, recovery is slowed down. The child is likely to become malnourished. The diagram below illustrates the immediate, underlying and basic or root causes of malnutrition. Refer to Figure 5 next page:

Fig.5



MAJOR CONTRIBUTING FACTORS TO MALNUTRITION IN MALAWI

There are a number of factors that contribute to the high levels of malnutrition in the country including:

At household and community level

- Poor breastfeeding practices among mothers. Many mothers delay in putting the child to the breast after delivery. This delays initiation and establishment of the processes that lead to milk production and ejection. Many mothers will complain of breast milk not coming out and they start giving other fluids such as glucose water and ordinary water. In some communities, new born babies are given some concoctions and traditional liquids such as dawale.

- Any liquid given to the child reduces its intake of breast milk and the breastfeeding frequency, which further delays the establishment of the breastfeeding frequency and causing mothers to often complain of not having enough milk. Many more caregivers give the child artificial teats which reduce the baby's frequency of breastfeeding. Such practices cause many mothers (43%) not exclusively breastfeed their children.

- In addition, many mothers do not enrich the child's meal adequately. Usually mothers feed their children plain and watery porridge. Children, who are given nsima, usually are given nsima with gravy or one type of relish only (mostly vegetables). The child is not given fruit with a meal. Many caregivers like to give their children non nutritious drinks suck as freezes, sodas.
- Many mothers do not express breast milk for the child to drink when the mother has to go away for sometime, instead the kids are given formula, juice and other fluids which are all inferior to breast milk
- There is inadequate knowledge and skills among mothers, communities, service providers and the public in the vital role of breastfeeding in child survival, growth and development. Breastfeeding mothers also receive inadequate support from other members of the household and often live in environments that do not promote, protect and support breastfeeding. For working mothers, this problem is particularly acute.
- High level of poverty at household level hinders the adoption of recommended practices. Poverty limits the ability of families to have enough and a variety of foods. Poor families tend to eat the same foods which are limited in diversity, quantity and quality, depriving children of the proteins, vitamins, and minerals. Few families eat animal products as often as required.
- Discrimination of women and girls which lead to women's poor access to education, low income levels and inability to have a say in how resources are allocated at household level.
- Cultural and faith-based beliefs that restrict consumption of certain foods.
- High disease burden, poor hygiene and sanitation and low access to health care services
- Poor health care seeking behaviours which lead to delays and late treatment of diseases.

At national level

- Inadequate institutional structures and capacity to effectively coordinate nutrition services especially at district and community level.
- Inadequate staffing at all levels to implement effective nutrition interventions
- Inadequate knowledge and skills in nutrition, including how to manage the interaction of nutrition with diseases

- Weak capacity of nutrition training institutions
- Lack of community level workers to advance nutrition services and programmes at household and community levels.
- Gender, age and other disparities resulting from discrimination and inequality
- Cultural beliefs and practices which prevent adoption of nutrition strategies
- Gaps in legislation and enforcement (including that to control influx of unauthenticated manufactured food supplements and therapies)
- Inadequate allocation of financial resources to nutrition services by Government and development partners (Nutrition less prioritised by donors)
- High dependency on the few donors funding nutrition
- Non-prioritisation of nutrition in resource allocation at all levels by key decision makers (Ministries such as Health, Agriculture, Education, Gender, Child and Community Development, Finance, District Authorities among others.
- Inadequate resources for training in the areas of nutrition and dietetics

THE OVERWHELMING ADVERSE CONSEQUENCES OF MALNUTRITION

The high prevalence of malnutrition poses a big challenge to the attainment of the MDGs and the MGDS. Refer to Figure 6 next page:

Fig. 6

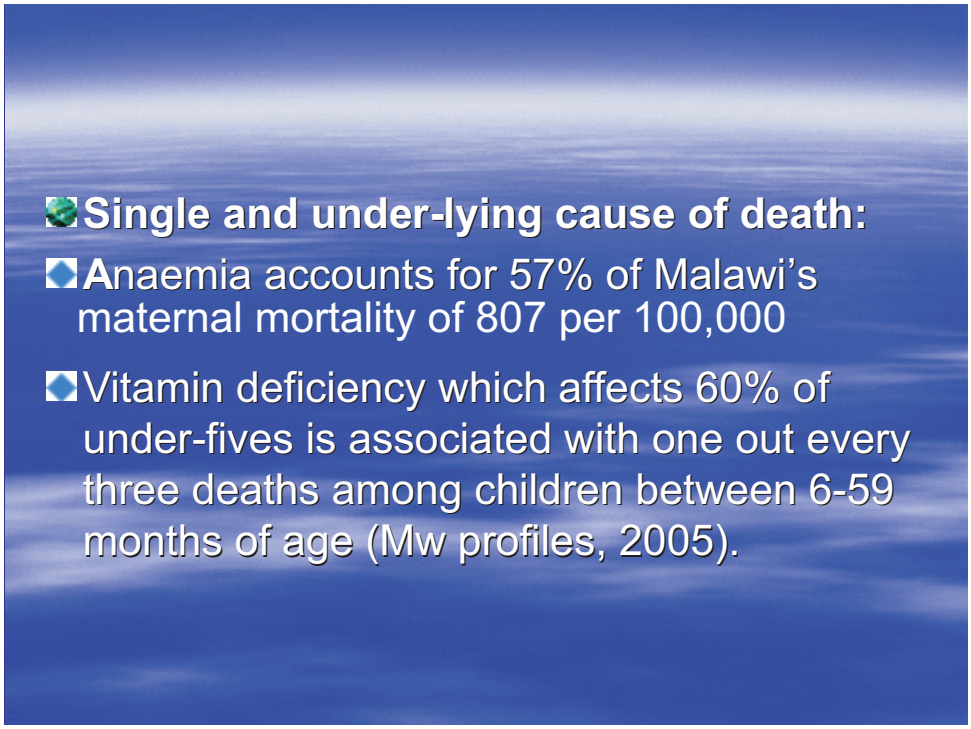
Malnutrition has adverse impact on human productivity. Malnutrition causes retarded physical and mental growth and if it happens during pregnancy and within the first two years of the child's life, the damage caused is irreversible.

Malnutrition weakens the immune system and increases the risk of diseases. A malnourished child or individual is more likely to be sick and the diseases more likely to be more severe and difficult to treat. Refer to Figure 7 below:

Fig.7

Malnutrition undermines the child's survival. It is a single major cause of child death. It also increases the risk of child death from other diseases. Refer to Figure 8 below:

Fig. 8



About 38% of all child deaths beyond early infancy are associated with PEM. In addition under nutrition in the first 2 years of life is positively related to high risk of chronic diseases related to nutrition such as diabetes and heart disease in later life.

Malnutrition before and during pregnancy increases the risk of death among women and may lead to impaired physical and mental growth of the growing child. Malnourished children fail to reach their physical and intellectual potential and ability which reduces their productivity in future. Refer to Figure 9 next page giving information on effects of malnutrition on education a picture of a child with retarded growth.

Fig.9

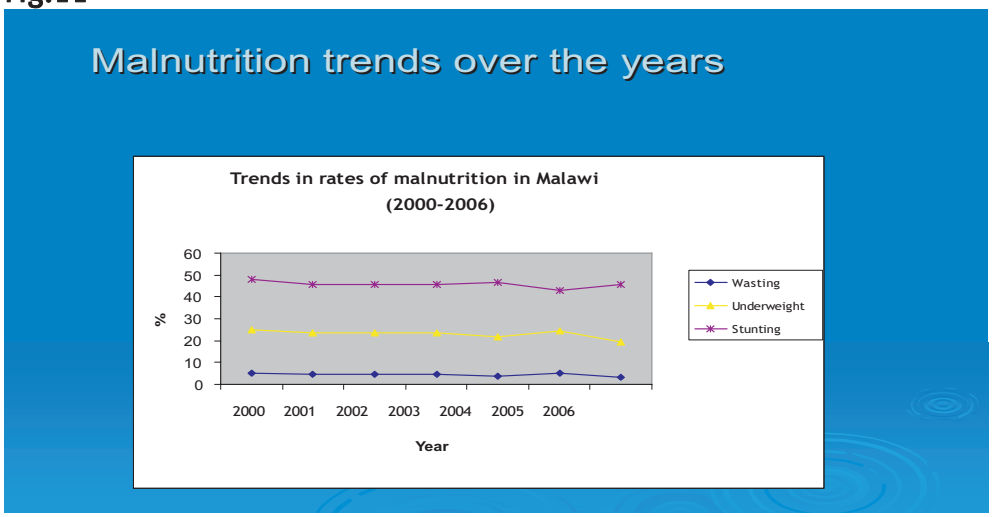
Poor nutrition therefore is a compounding factor for Poverty. It determines future gains at individual, household, community and national level. According to Malawi Profiles (2005) Malawi stands to incur heavy losses over time if no adequate investment in nutrition is made for stunting, iodine and iron deficiency as shown in Figure 10 below: The losses can go up to US$2.7 billion if all the nutrition disorders are included

Fig.10.

WHAT IS THE CHALLENGE

The levels of malnutrition have remained high without any significant change over the years till recently as shown in Figure 11 below: It should be noted that in 1938 stunting was 56%, in 1992 it was 47.8%, in 2000 it is 48% having gone down from 59% in 1999 and has remained in this range up to 2006 when it has shown signs of declining.

Fig.11



The problem is enormous, its impact is overwhelming but abstract; as a result nutrition programmes and services are less prioritized by: key Government decision makers and managers, service providers, bilateral and multilateral partners, NGOs, the private sector, the media, the caregiver and even Members of Parliament. Consequently, there is low coverage of nutrition services and demand for nutrition services by caregivers. For example, a health worker will remind the mother of to return for immunization and a caregiver will remember and even ask when to come back for immunization because they have seen a child die of measles or getting crippled because of polio but they do not take Vitamin A supplementation seriously since it is difficult to link it to the measles outbreak directly..

THE GOVERNMENT RESPONSE TO THE HIGH LEVELS OF MALNUTRITION

The levels of malnutrition are expected to decline due to redefined efforts and direction taken by Government in the last five years. There is currently increased recognition of the role of nutrition in global and national economic and social development. The Government of Malawi recognises investment in nutrition as a prerequisite for attaining the MGDS and Millennium Development Goals (MDGs). There is personal commitment by His Excellence the State President, and the Vice President under whose jurisdiction the Nutrition Sector falls to ensure that the nutritional status of Malawian improves. The centrally position of nutrition on the national development agenda demonstrates highest political level commitment, leadership and personal championing. In this regard, Nutrition is a priority area in the Malawi Growth and Development Strategy (MGDS) which is the overarching Government's investment strategy.

Prevention of nutrition disorders is, therefore, one of the key focus areas which is closely monitored in line with the expected sectoral and district level performances according to the MGDS and MDGs targets

In order to operationalise the MGDS, a National Nutrition Policy and Strategic Plan (NNPSP) covering the period 2007 to 2012 which will continue to 2014 has been developed and it was approved by cabinet on 6th December 2007. The NNPSP is an overarching strategic framework for guiding results and evidence based nutrition programming at the different levels of operation.

The NNPSP is intended to serve as the guiding document for all nutrition stakeholders, including Government, MPs, civil society, faith based organisations, the private sector and development partners in championing Government priorities on nutrition for the period 2007-2012 and beyond, which are outlined in the MGDS. The NNPSP describes the vision, mission goals and key strategies for improving the nutritional status of people of Malawi. Refer to Figure 12 next page:

Fig. 12

BROAD POLICY AND STRATEGIC DIRECTION

VISION

To attain adequate nutrition for all Malawians with Special focus on vulnerable population groups by 2015.

MISSION

To facilitate the provision of integrated nutrition services that will cause significant improvement in nutritional status of all Malawians.

The overall objective of the NNPSP is to lay a solid foundation for human capital development that will facilitate sustainable economic growth and prosperity in Malawi through a better nourished population. It has three focus areas as outlined in Figure 13below

Fig.13

Policy Focus Areas:3

1. Prevention and control of various forms of nutrition disorders
2. Promoting access and quality of nutrition and related services for effective management of nutrition disorders
3. Creation of an enabling environment that adequately provides for delivery of nutrition services and implementation of the nutrition programmes, projects and interventions.

The policy has a number of target groups but the key ones are as follows outlined in Figure 14 below:

Fig.14

- It also targets School age children, People Living with HIV, TB and chronically ill and people in emergency and other vulnerable groups as may be defined from time to time. The NNPSP has three strategic objectives namely:

Objective 1:

To prevent and control the most common nutrition disorders among women, men, boys, girls in Malawi by 2011 with emphasis on vulnerable groups.

Objective 2:

To increase access to timely and effective management of the most common nutrition disorders among women, men, boys, girls in Malawi by 2011 with emphasis on vulnerable groups.

Objective 3:

To create an enabling environment for the effective implementation of nutrition services and programmes between 2007 and 2011.

KEY STRATEGIES

The Government of Malawi has put in place a number of strategies as defined in the NNPSP to improve nutrition. The priority ones include:

- Implementation of high impact interventions in promoting child and women's nutritional status through the Essential Nutrition Actions approach. These actions are outline in Figure 15 below:

Fig.15

1. Improving women nutrition before, during and after pregnancy
2. Optimal breast feeding in the context of HIV and AIDS
3. Optimal complementary feeding
4. Feeding a sick child, during and after illness
5. Control of iodine deficiency disorders
6. Control of anaemia
7. Control of Vitamin A deficiency

- Promotion of the consumption of fortified foods such as iodised salt, Likuni Phala.Very soon the country will start fortifying sugar with vitamin A
- Scaling up of universal school feeding and the school health and nutrition programmes
- Scaling up of the Nutrition Care, Support and treatment for PLHIV, TB and chronically ill
- Promoting production and access to high nutritive foods in terms of quantity, quality and diversity
- Promotion of practices that ensure proper food preparation. Processing, storage and utilisation
- .Intensive public education in nutrition
- Advocacy for support from Government, civil societies, private sector, community and development partners
- Promotion of access to nutrition information and resources for sustainable adoption of optimal nutrition practices

- Scaling up of services that prevent malnutrition such as Vitamin A supplementation, deworming, and disease control and prevention among others.
- Scale up of services for timely treatment of malnutrition
- Strengthening Institutional, human capacity and legal framework for improving nutrition.

BENEFITS OF ELIMINATING MALNUTRITION

It is easy to dismiss the figures on malnutrition in Malawi as plain and meaningless statistics. But behind the statistics, lies the real faces of children, women and other vulnerable individuals whose lives are shaped by chronic hunger, malnutrition and a persistent disease have enormous cost implications for the country.

Improving the nutritional status of the population should therefore be at the centre of the development agenda and efforts for human capital development and wellbeing. Improved nutritional status is a win-win situation for the child, the family and the nation.

Adequate investments in nutrition in Malawi would therefore:

- Lead to substantial savings for the country and households because it will reduce the treatment costs of children suffering from malnutrition and other diseases and time spent by care givers in hospital which is a loss in productivity.
- Save children's lives
- Improve education outcomes. Adequate nutrition will increase the individual's ability to attain academic potential and professional achievements. In turn the government's and country's benefits from the free primary education programme will be increased. Currently the education sector in Malawi is characterised by high repetition, drop out and absenteeism rates.
- Only nine per cent of 13 year-olds complete primary school. Malnutrition is among the leading causes of the high rates of absenteeism, repetition and dropout in Malawian schools. With almost half of the children stunted, many children enrol late, are likely to have lower cognitive test scores, higher absenteeism and more repetition of classes than comparable non-stunted children.

Similarly, the promotion of households using iodised salt will also improve the nutritional status and education outcomes. Iodine is needed for the normal development of the baby's brain during pregnancy. Pregnant women living in iodine deficient regions are more likely to give birth to children suffering from mental impairment ranging from mild mental retardation to cretinism, characterized by severe brain damage and dwarfism.

In iodine deficient communities, there is an average loss of IQ of about 13.5 points. The effects are permanent and result in school children with considerably reduced learning ability, poor school performance and retention rates and speech and hearing defects.

With appropriate interventions to counter iodine deficiency such as iodized salt, over 70,000 newborns could be saved from various forms of mental retardation over the next 10 years.

PARLIAMENTARIANS CAN MAKE A DIFFERENCE

When leaders show a strong political will and commitment to tackle a problem, they have usually succeeded with spectacular results. The challenge facing Malawian political leaders at present, including honourable Members of Parliament, is to ensure that adequate investments are made in today's children in order to guarantee a safe, prosperous future. Poverty reduction begins with making the right investment choices for children, mothers and the human capital in general. Investing in nutrition is one such right choice for the country's, individuals and families prosperity. Your role is crucial and as duty bearers, you are called upon to ensure that the right of the child and the entire human capital to adequate nutrition, wellbeing and future prosperity is attained.

WHAT YOU CAN DO TO DEFEAT MAL NUTRITION: A 12-POINT CHECKLIST

1. Conduct public awareness campaigns on key nutrition policy areas and recommended practices for improving the nutritional status among various population groups in your constituencies and areas.

2. Mobilise communities to demand and take up nutrition and health care services such as:
    - Pregnant women should take iron supplements during pregnancy
    - Taking children who are 6-59 months (under five years) for Vitamin A supplementation at the under five clinic or during campaigns such as child health days twice every year until the child is five years
    - Women who are breast feeding should take Vitamin A supplementation immediately after the birth of the child or at least within 8 weeks after the birth of the child.
    - Taking children 12-59 months for de-worming
    - Taking children for immunisations according to schedule
    - Women and men to go for HIV testing before they decide to become pregnant, and they should start antenatal early for proper care once they are pregnant.
    - Encourage pregnant women to deliver at the hospital in order to ensure proper care
    - Encourage communities to take a lead role in preventing maternal mortality by ensuring that pregnant women are adequately supported to start antenatal at the right time, take them to the hospital at the right time and follow the advice given strictly including breastfeeding initiation and taking children for vaccination at the right time.
3. Promote key practices that promote nutrition such as:
    - Exclusive breastfeeding of children for the first six months of life unless there is a medical problem. During this time children should not be given any other food or fluid
    - Encourage mothers to breastfeed on demand
    - Women should continue to breastfeed until the child is 24 months or more unless there is a medical problem. At 6 months (180 days from child's birth), they should start giving the child other foods and fluids from the six food groups.
    - Encourage women who are pregnant to eat a variety of foods from the six food groups every day, and to eat an extra meal (total of 4 meals a day instead of the normal 3 meals per day).

- Encourage mothers who are breastfeeding to eat a variety of foods from the six food groups everyday with two extra meals a day (total of 5 meals)
- Promote use of iodises salt in all meal preparations
- Encourage caregivers to enrich baby food with at least 2-3 different foods at each meal and to increase the amount, thickness and frequency of feeding as the child grows.
- Encourage caregivers to feed their children, pregnant and breastfeeding women some animal food such as matemba, ngumbi, usipa, chambiko, milk, meat, chicken, rabbits, chambo, mila mba, eggs, mphalabungu, sesenya, bwanoni, mbewa every day
- Encourage caregivers to feed their children from individual plate and to sit with the child and encourage the child to eat
- Encourage families to eat foods rich in Vitamin A such as mangoes, carrots, pawpaw, pumpkins, meat, fish, eggs and chicken every day.
- Encourage families to add or eat the plant sources of vitamin A with some fat rich food such as groundnuts or add cooking oil or eat with a meal with some fat to facilitate adequate absorption of vitamin A.
- Encourage families to eat vegetables an d fruits rich in vitamin C such as kholowa, bonongwe, chisoso. Mnkhwa ni, mpiru, rape, kamganje, masau, masuku, oranges, tomato, tangerines, bwemba, guava, malambe at every meal. The Vitamin C helps the body to use iron from vegetables and other plant sources.
- Encourage households to have fruit trees, vegetable gardens and small livestock to improve food availability and diversity.
- Encourage people to do exercises that promote health such as walking, jogging and games
- Avoid practices that promote too much weight gain such as eating junky foods such as chips, fizzy sweetened drinks, biscuits, sweets, chocolates, cakes, too much fried foods such as d eep fried chicken, and fatty foods such as butter, margarine in order to help reduce excessive weight gain (obesity). Obesity increases the risk of diabetes, hypertension and heart failure.
- Encourage caregivers and households to seek early medical care when sick and pregnant women to start antenatal care early
- Under five children and women to sleep in treated bed nets.

4. Initiate projects and programmes that promote access and availability of diversified, varied and nutritious household food resources in your constituencies such as:
    - Community based fruit nurseries and trees growing, hatcheries and seed multiplication
    - Encourage planting of fruit trees during national tree planting day
    - Multiplication and distribution of cassava and potato vines, guinea fouls, rabbits, goats and chickens
    - Bee keeping

5. Encourage interventions that promote food security such as crop diversification, livestock production, fish farming, winter cropping, use of manure, proper food storage and utilisation.
6. Support and participate in community nutrition programmes in your constituency. Mobilise communities to participate in nutrition programmes in their area such as the school feeding, Community therapeutic care, growth monitoring, promotion campaigns and displays.
7. Advocate for inclusion of nutrition in the district development plans and budgets and monitor their implementation
8. Monitor nutrition programmes implemented or supported by NGOs in your constituency
9. Lobby and advocate for real increase in budgetary allocation for nutrition by Government, development partners, civil societies and the private sector
10. Provide support to the communities, households and individuals for them to run income generating activities for adequate access to a variety of food resource at all times for example by linking them to micro-financing programmes such as MADERF for a diversified diet.

11. Support legislative and political efforts to combat malnutrition, discrimination and exploitation of women. Support measures that promote women's adequate access to resources and care at all levels of society such as:
    - Increasing the duration of maternity leave for women in the private sector in the country's labour laws. Parliament reduced this leave in 2001 from 90 days to 60 days in the private sector, which, gender activists believed it would enhance the competitiveness of women in the market place. Their counterparts in the public sector meanwhile

had theirs increased from 30 to 90 days. The reduction in leave days, unfortunately, forces women to rush back to work at the expense of providing optimal breastfeeding and care for their young babies. When mothers return to work early, child health and growth are compromised as mothers introduce other diets and fluids before six months.

- Such meals and fluids are inferior to breast milk which is naturally meant for the child containing all the nutrients the baby needs in the right amount and proportion and easy to digest. The other meals and fluids that mothers introduce, have no protective factors and the child is likely to be sick often which will make the mother to be absent from work more often. Mothers, who go back to work early, are likely to experience some emotional stress as they worry about their child and such kind of stress reduces their work productivity and breast milk supply. As the breast milk supply reduces, the child becomes more vulnerable to malnutrition and diseases.

- Introduction of child care centres at the working place to give mothers chance to breastfeed the babies adequately while at work.
- Mandatory fortification of selected centrally processed foods such as sugar, salt, cooking oil, maize meal, Likuni Phala, complementary foods with vitamins and minerals and ensure enforcement of the fortification laws. This is the most cost-effective, sustainable option for eliminating micronutrient deficiencies. As law, it will set goals and define roles of food producers, health and nutrition authorities and scientific institutions.

12. Advocate and pass the legislation on Nutrition to guide the programmes and services including control of food products and nutrition that come with an confirmed health claims.

These efforts will facilitate human wellbeing and development among children and mothers, a prosperous constituency and Malawi as shown in Figure 16 below of the ideal mother and child in Malawi.

Fig 16

Vibrant and Happy Malawi Nation!!!

FOR MORE INFORMATION, CONTACT:

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