April blog

Reggie Annan

Hmmm... There are people who normally wake up in the morning in a reflective mood. Others are ready to face the world immediately they awake. There are also those who prefer to reflect at the end of the day. Which are you? I believe reflection is needed, for our quest to make a difference in what we do. I reflect in the morning, harnessing the experiences of the previous day to prepare for the day ahead. This forms part of my routine in a religious sense. I however became more entrenched with reflection when I attended the African Nutrition Leadership Programme (ANLP) in 2009. As soon as I have completed this column I will be attending the 2010 ANLP, and will report on it next month.

My task here is to reflect, mainly from a young public health nutritionist perspective, on current programmes, policies and practices that impact on the well-being of communities and society as a whole. I will concentrate on issues in sub-Saharan Africa, the region where I come from. Please make comments as well, especially if you disagree with me. I begin with leadership, because this concept is dear to my heart and very important as well

Leadership in Africa

Team building

We are developing an improved system for membership payment, details, and records. This is for existing as well as new members. Please enquire within

Editorial

Seeing the big public health picture

Food insecurity
Economic instability
Soil and water degradation
Destruction of resources

What all this means for us
What we can do

Reggie Annan

A view from sub-Saharan Africa
Inspiring young leaders in the field
The politics of severe malnutrition
HIV-AIDS: an end to this scourge?

RIO 2012

Here you see a team building exercise, during the African Nutrition Leadership Programme seminar last year. These have been held annually since 2003 in South Africa. Their aim is to assist the development of future leaders in the field of human nutrition in Africa. The emphasis of the programme is on understanding and developing the qualities and skills of leaders, by team building, communication, and understanding nutrition information in a broader context.

Each seminar brings around 25-30 participants from different countries in Africa working or studying in different fields of nutrition. The very composition of the group helps so much in creating the different backgrounds needed to allow sharing and earning from each other, and the diversity of the fields of practice and study makes lif time networking and collaboration inevitable. As a graduate of ANLP 2009, I learnt so much about leadership. I see above all, three qualities: team building, communication, and being responsible.

Team building is needed to ensure that different people with different abilities can work together, supporting one another and also performing specific roles within the team. It is possible for one person to do a lot but there is a limit. In so many organisations, just a few people try to do everything, but achieve very little for lack of teamwork. Teamwork also ensures multidisciplinary and multinational collaborative efforts towards achieving a goal. Networking and learning from other research groups on what has worked and to undertake effective multinational studies also involve teamwork.

The second quality is effective communication. This ensures good interpersonal relationship and transparency, and allows people to contribute and criticise when needed for the good of the team.

The third quality is being responsible. A responsible leader is caring, thinks of others, is interested in other team members' welfare, and has an internal locus of control. He takes the responsibility when things go wrong and is able to share the glory when there are successes.

The African Nutrition Leadership Programme is an unforgettable experience. These are some of the things past alumni have to say about their experience and the programme as a whole.'ANLP has changed my attitude and revealed in me my capacity and responsibility'. 'Being a good leader requires some to change first and especially to keep good relationship with others. I have gained those skills'. 'It is a blessing for nutritionists in Africa'.

I believe the ANLP is one of the major breakthroughs of nutrition for Africa. The seminars equip even nutritionists without any background in public health with skills needed to practice public health nutrition. An official extensive evaluation of all the alumni of ANLP is yet to be carried out, but a look around the globe shows that almost all the successful public health nutritionists in Africa are ANLP alumni. As I mentioned, I'll report back from the 2010 seminar next month.

Ready to use therapeutic foods
RUTF stuff - policies, or politics?

More about our third Congress in Rio de Janeiro

Fabio Gomes

In praise of the fruits of nature
Private-public partnership problems
Can soft drinks be like cigarettes?
Advertising to children: latest news

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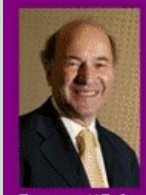
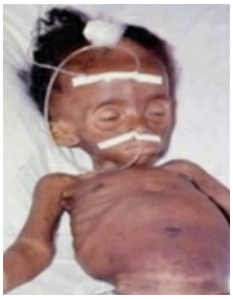


Former US food chief slams industry
PepsiCo says it's saving the children
Nutrition power to impoverished people
Three score years and ten – is that it?

Our aims and objectives
The voice of public health nutrition as advocated, taught and practiced worldwide



To repeat: policies or politics? I have realised in my few years so far of studying and working, that there are politics in public health nutrition, because we deal with politicians. We need to lobby and advocate. But we may be jeopardising the lives of innocent malnourished children, as the little child you see here, if we meddle in politics rather than policies.

At any one time, Severe Acute Malnutrition (SAM) affects about 13 million children under the age of 5, and is associated with 1-2 million preventable deaths each year. In most relatively impoverished countries, case fatality rates remain high at about 20-30% for maramus and up to 50-60% for kwashiorkor. Severe acute malnutrition has traditionally been managed in inpatient facilities with the WHO 10 Steps to the management of SAM. However in several large scale humanitarian crises in the 1990s it became evident that this in-patient care was unable to provide an effective response – it could not cope. Therefore Community based Therapeutic Care (CTC) was devised. This is designed to address issues including low medical coverage, lack of access to medical care, and risks of cross infection that come with hospitalisation. The aim of CTC is to maximise coverage and access. Undernourished children are identified through screening of the population, or by referral, or by community.

This is where Ready to Use Therapeutic Foods come in. RUTFs in their more recent forms were devised in the late 1990s. A RUTF is an energy-dense mineral/vitamin-enriched food specifically designed to treat SAM. It is equivalent to Formula 100 , the therapeutic food recommended by WHO for treating malnutrition. The property that makes RUTFs extremely useful is that they are oil-based with little water content; this makes them microbiologically safe, so they keep for a long time. They also are eaten uncooked and are therefore ideal for delivering many micronutrients. RUTFs are also used for treatment of less severe malnutrition in the community.

Last year, a series of debates on RUTFs took place on the International Malnutrition Task Force (IMTF) website *www.imtf.org* Another debate at the International Congress on Nutrition in Bangkok followed a position paper entitled 'Should India Use Commercially Produced RUTF for SAM?' In turn this followed media reports that the government of India had asked UNICEF to stop distributing RUTFs with a value of millions of dollars.

At the ICN there were diverse opinions. Some felt that commercial production of RUTFs was not sustainable, and therefore local production should be encouraged. Others felt even if local production was to be encouraged, the short term approach was the tried and tested branded product Plumpy'Nut. Others felt that the government of India was not fully committed to combating severe acute malnutrition. You can access the full debate at *http://imtf.org/page/discussions-current/*.

Clearly debate is needed. It is good that these issues are being raised and discussed in Asia. There are debates in Africa too, but these are not publicised. However, we must be cautious. In spite of our zeal, dying children could be caught up in the middle of the politics of public health nutrition. On the controversy in India, I think Moses Mokaya makes a wise comment:

'It is unfortunate that the children who were receiving the feeds are caught in the cross fire of two forces. The effectiveness of any intervention is very dependent on all stakeholders, including the government, researchers, relief organisations, the target population etc.

'If what is in the media is right, then there must have been a breach of protocol, because UNICEF caries out its projects in close consultation with the government. If the project was being evaluated on a continuous basis, and action taken, then the issue of cultural acceptability, political will, and community involvement would have been picked out and addressed before the government intervened. That aside, the most important action is to find an amenable step to save the children that may be at risk of death'.

HIV transmission from mother to child

The rights of children in Africa

Nelson Mandela is one of the greatest leaders of all time. At the 13th International AIDS Conference held in July 2000, he said: 'In the face of the grave threat posed by HIV/AIDS, we have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now'. Later, on World Aids Day in December 2006, he said: 'The vast majority of the estimated 40-million people living with HIV are unaware of their status. Fear of being stigmatised is a great factor. It requires bold and visible action by top leadership – at all levels of society – to root out this deadly form of discrimination'.

What is the right advice for mothers living with HIV, who as all mothers do, want to give their children the best start in life?

Infant and young child feeding is critical for child health and survival. WHO and UNICEF jointly developed the Global Strategy for Infant and Young Child Feeding whose aim is to improve – through optimal feeding – the nutritional status, growth and development, health, and thus the very survival of infants and young children. It also aims to revitalise efforts to promote, protect and support appropriate infant and young child feeding, building on past initiatives and addressing the needs of all children. These include those living in difficult circumstances, such as infants of mothers living with HIV, as well as low-birth-weight infants and infants in emergency situations.

According to UNAIDS, around 430,000 children under the age of 15 became infected with HIV in 2008, mainly through mother-to-child transmission. The majority were in Africa. About a third of babies born to HIV positive women could become infected with HIV during pregnancy and delivery, and between 10 and 20 per cent will become infected through breastfeeding.

WHO recommends women with HIV infection to take different regimens and combinations of anti-retroviral therapy beginning at 28 weeks of pregnancy, or as soon as delivery and during delivery, and also seven days after delivery, to prevent mother-to-child HIV transmission and to reduce risk of drug resistance. There are recommendations for the baby as well immediately after birth and for the first seven days. The lives of many children would be saved if these guidelines are followed.

In high-income countries mother to child transmission (MTCT) has been virtually eliminated for various reasons, including access to antiretroviral therapy availability, and safe use of breast-milk substitutes. But in under-resourced settings such as sub-Saharan Africa, where access to treatment is poor and the majority of MTCT and deaths of AIDS children occur, the problem still persists.

Meanwhile, WHO and UNICEF recommend that infants be exclusively breastfed for the first 6 months of life and thereafter receive adequate complementary foods in addition to continued breastfeeding until 2 years of age or beyond. The Global Strategy on infant and young child feeding emphasises that the absolute risk of HIV transmission through breastfeeding for more than one year – globally between 10% and 20% – needs to be balanced against the increased risk of morbidity and mortality when infants are not breastfed.

HIV infected mothers could choose not to breastfed if acceptable, feasible, affordable, sustainable and safe substitutes are available. But in resource- poor countries, especially in a typical village situation, provision of the above conditions may be impossible, especially if the woman is ill due to HIV, and too poor to afford breastmilk substitute. Even if the conditions are met, the child is likely to loss certain micronutrients when not breastfed. On the other hand, certain studies have documented diminished effects of anti-retroviral treatment as a result of continued exposure to breastfeeding.

HIV infection is a social as well as a health issue. In Africa the epidemic has devastated the very fabric of society. Several years after Nelson Mandela's calls to action, we are yet to eliminate stigmatisation associated with HIV infection. This limits uptake of HIV testing and even acceptance of treatment. Clearly, there is still a lot of work to be done.

More generally, do children in resource-poor countries have the right to life just as much as children in high-income countries? Is this an issue of inequity, or one of lack of leadership in public health nutrition? These are questions we need to ask, even though we may not have immediate answers.

Leadership
The need for capacity

So I come back to the challenges and opportunities of leadership.

Malnutrition remains a major problem in many countries and many children die from severe malnutrition and starvation especially in sub-Saharan African, and certain parts of Asia. Now, over-nutrition has also become a crisis in sub-Saharan Africa. Coupled with the HIV/AIDS pandemic, this triple burden of disease poses a major challenge for all nutrition scientists, requiring action both in terms of research, programmes and advocacy for good policies.

Nutrition research should lead to interventions and programmes that favourably impact communities and people and influence change to promote health and wellbeing. This cannot be achieved without good and effective leadership.
The lack of good leadership, found in all levels of society including government, is the reason why nutrition progress is often slow, and even deteriorating in Africa. I believe in having academic degrees, but I am realising more and more that good leadership is what makes the difference.

It's said sometimes that to be a good leader requires the leader to have good followers. Although there may be some truth to this, I think the onus is mainly on the leader rather than the followers, for a team to succeed. This is why I commend the originators of the Nutrition Leadership Programmes and the organisers of the African version in particular for their great work.

All of us public health nutritionists need to reflect on these issues and look for the way forward. I am not saying there is a straightforward answer. The world is a complex place. So are the problems. However in the midst of the complexities sometimes lie simple solutions which take one step at a time. If we desire to make a difference then we cannot avoid these issues. These are real predicaments that need our attention.

Request and acknowledgement

You are invited please to respond, comment, disagree, as you wish. Please use the response facility below. You are free to make use of the material in this column, provided you acknowledge the Association, and me please, and cite the Association's website.

My thanks go to my mentors at Southampton University, Professor Alan Jackson and Professor Barrie Margetts.

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Please respond ☼