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Mothers First
Fieldwork and Advocacy for Maternal Nutrition

Spotlight on Maternal Nutrition for Global Nutrition Report 2020

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About Mothers First

Mothers First is a community based targeted nutrition project in India. Its mission is to provide nutrition to malnourished pregnant mothers and their children, breaking the cycle of malnutrition in communities. It advocates for the inclusion of maternal nutrition in global nutrition policy and global targets. It was established in 2004 as the Varanasi Children's Hospital. Mothers First is a registered charity, number CHY 19325.

Spotlight Overview

There is a moral imperative enshrined in the Sustainable Development Goals principle of ***'not leaving the furthest behind'***, but there has been no clear narrative on who the furthest behind are, so that we can act on this call.[1] If we apply this question to all groupings in the society, it is clear that women will always be the most marginalised. We can say this with confidence because their role as life giver and instinctive protector predisposes them to a unique predetermined vulnerability. This vulnerability increases further when they are pregnant and further again when they are malnourished and pregnant.[2] Therefore, we suggest that the individuals that are the "furthest behind" in every context are the malnourished pregnant mothers and their unborn. We request you to bear this in mind as you read this Spotlight report, as it is this belief that guides our discourse.

While this report throws a spotlight on maternal nutrition, it further explores its impact on foetal nutrition and the intergenerational cycle of malnutrition. Interventions that target vulnerable mothers during pregnancy are effectively non-existent. This spotlight explores the questions in the domain of maternal nutrition and highlights the causal relationship between the lack of an advocacy mandated structure and the significant programming gap for maternal nutrition interventions.

Why we need a Mother's First approach?

The World Health Assembly set six global nutrition targets to be achieved by 2025, and currently, we are not on the track to achieve five of these targets.[3] Evidence suggests that enhancing maternal nutrition during pregnancy would help achieve two targets directly (low birth weight and wasting at birth) and address the other three (reduction of childhood stunting and anaemia in women) indirectly.[4]

The prenatal environment has a profound impact on human growth and health throughout the individual's lifetime. Low birth weight has been directly linked to the mother's nutritional status and has been shown to predict "mortality, stunting, and adult onset of chronic conditions."[5] Therefore, despite the best efforts to increase nutrition for children and adults, we believe that this critical developmental period is not being well addressed.

It is for this reason that the spotlight focuses on nutrition specific interventions during pregnancy, which seek to address the immediate needs of maternal nutrition and alleviate the burden of malnutrition through direct prevention strategies. Scaling up these interventions is the key to achieving the WHA global nutrition targets and we suggest that it is an unexplored narrative in both identifying and addressing our commitment to leave no one behind.

Our Call to Action

We at Mother's First are calling for a strategic realignment of policies, funding and advocacy for food-based interventions that address the immediate needs of mothers and the unborn. Such interventions are double duty actions, because they address the immediate needs, build resilience, and in doing so, heighten the effectiveness of nutrition sensitive interventions, which focus on the underlying causes of malnutrition such as agriculture, health and food security.

Spotlight Framework

The spotlight report will determine the scale of the problem of maternal malnutrition and identify the interlinkages to short- and long-term birth outcomes. The spotlight will look through the lens

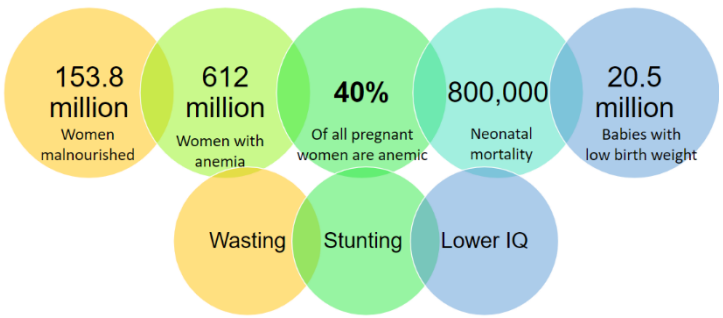
of recommended evidence-based actions for nutrition specific interventions, political commitments, funding, policy and mandated structures, which have all, as of yet, failed to bring effective impact solutions to the field.

The spotlight sets out to provide an overview of the key determining factors that have led to our failure as a global community to scale up direct nutrition interventions that would enable us to reach the global nutrition targets. It will strongly suggest that the one core reason for the programming failure is the absence of an agency with a clear focused mandate for maternal and foetal nutrition. Furthermore, we will outline the rationale for recommending that UNICEF is the best placed agency to lead us in maternal nutritional programming. This spotlight will end with 6 key recommendations that call for a significant transition in program funding, policy and mandated structures, that will help break the intergenerational cycle of malnutrition.

Scale of maternal malnutrition, including direct interlinkages

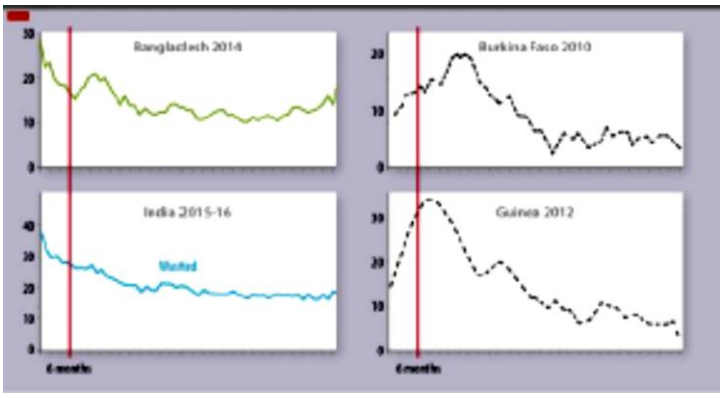
The magnitude of the problem is overwhelming with 153.8 million women (9.7%) suffering from malnutrition with a Body Mass Index (BMI) <18.5 kg/m². Anaemia (>11 g/dl) affects 612.2 million women of reproductive age, which accounts for 32% of all women worldwide. During pregnancy, 35.3 million women are anaemic, which represents 40.1% of all pregnancies.[3] We cannot afford to continue ignoring how these figures impact the cycle of malnutrition, that stretches across generations, if we are to achieve the 2025 global nutrition targets.

Figure 1: Scale of Malnutrition



There is a direct link between the nutritional status of the mother and the low birth weight outcome (<2500g) of 14.6% (20.5 million) of the pregnancies.[5] According to the 2019 Lancet global health paper on Low Birth Weight (LBW), '*low birth weight is an important marker for maternal and foetal health, predicting mortality, stunting, and adult onset of chronic diseases.*' The paper provides a timely reminder of the interlinkages between low birth weight, outlining how 80% of all neonatal deaths occur in LBW new-borns, of which two thirds are preterm and one third are termed 'small-for-gestational-age'.[5]

A new narrative is emerging, which demonstrates that wasting at birth in South East Asia is as high as 38% (in India) and declines within the first 6 months.[6] As the graph (Graph 1) indicates, Africa differs with respect to the wasting rates, which increase from birth to the first 6 months. The biological linkages between the mother and the child in the first 450 days serve as further evidence to the scaling up of interventions.



Graph 1: Wasting prevalence (%) by age, DHS survey reports

Contextual setting of maternal malnutrition

In 2012, the world committed to the global nutrition targets that were to be achieved by 2025. With five years left, we are on course to reach just one of the six targets, which is breast feeding. As it currently stands, anaemia for women is on the rise globally and maternal malnutrition has seen very small decreases (9.8% -9.4%) over the past 20 years.[3] The Lancet 2019 paper on Low Birth weight outlined what we need to double the rate of current progress to achieve the global nutrition targets.[5] Wasting has also seen minimal declines in recent years. Simultaneously, while adult and child overweight and obesity is rising globally, a modest decline in maternal underweight has been achieved.[3]

Figure 2 tells a stark story of how the global food system is failing individual women and children. A paradigm shift in programming is required to break the intergenerational cycle of malnutrition and thereby achieve the global nutrition goals and not leave the furthest behind. This shift in focus will need to centre around pregnancy and oriented specifically, but not limited to, the foetal period of the first 1000 days. UNICEF has thoughtfully and consciously expressed it in this way, '*Undernourished girls have a greater likelihood of becoming undernourished mothers who in turn have a greater chance of giving birth to low birth weight babies, perpetuating an intergenerational cycle*'.[7]

Figure 2: World Health Assembly (WHA) Targets. Source: WHO. 2014

Within a limited resource structure, we are funding interventions to tackle the underlying determinants or root causes of malnutrition through nutrition sensitive programming. There is however a failure in prioritising funding for the field impact scale up of direct nutrition specific interventions particularly during pregnancy and the first 1000 days.

Without both interventions interacting effectively with a target-based approach, our ability to intercede directly to break the intergenerational cycle of malnutrition and thereby tackle the consequences of this food system inequality is impaired. To reach the 2025 global nutrition targets will require us to highlight program gaps and offer implementation solutions, which is the key objective of this Spotlight.

An analogy that may be apt is that we are blindly fighting a war (nutrition sensitive) without an ambulance structure (nutrition specific) in place to

Core Message:

Despite clear recommendations backed by research we have not scaled up key essential nutrient specific actions for mothers from conception to birth. This lack of scale up correlates with the absence of an institutional structure holding the mandate for maternal and fetal nutrition. Maternal nutrition during pregnancy and the first 1000 days offers a unique opportunity that we have yet to capitalise on to significantly break the intergenerational cycle of malnutrition.

treat our fallen comrades who are suffering from malnutrition right now.

Failure of the political landscape to impact maternal nutrition

There has long been a strong political landscape for maternal nutrition which recognises the irrefutable evidence of the interrelationship between maternal, foetal and child nutrition. Despite this evidence base for action and political goodwill, there has been a failure to translate into implementation impact.

● The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was, and remains, an important document for all of us. Celebrating its 40th year, Article 12 of the convention, which states that 'States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation', explicitly recognizes the importance of maternal nutritional.[8]
While article 12 in CEDAW has identified adequate nutrition during pregnancy as a right, one which has been endorsed by over 180 countries, the gap in nutrition programming for women tells us that this commitment has failed to deliver action. This is further evidenced by the 2014 Comprehensive Implementation Plan where they stated "correcting maternal undernutrition was not a priority in countries with a high burden of maternal mortality."[9]

● The six global nutrition targets, endorsed by the World Health Assembly (WHA) in 2012, positively reinforce the critical role maternal nutrition plays in nutrition with anaemia, breastfeeding and low birthweight are central components to the targets.

● The SDGs have also recognized the importance of maternal nutrition in SDG 2.2, where it states that it aims to 'provide adequate nutrition to adolescent girls, pregnant and lactating mothers and older people.'[10]
The core problem with SDG 2.2 is that it set the target to provide adequate nutrition to adolescent girls, pregnant and lactating mothers and older people, but did not outline indicators to monitor this target. Up to October of this year, the indicator framework only included children under-5. In a positive first step the Inter-agency and Expert Group on Sustainable Development Goals (IAEG - SDGs) added anaemia in women to the indicator framework.[11] While this is welcomed, we need a far greater alignment between maternal nutrition and SDG2, to end malnutrition in all its forms.

● In 2013, the Nutrition for Growth Global Compact made three time-bound commitments to be achieved by 2020. The first of these was to 'ensure that at least 500 million pregnant women and children under two are reached with effective nutrition interventions.'[12]
It is clear that the Nutrition For Growth Compact commitment has not been achieved as there was a significant difference between commitments and funding to match its first target, with just 2% of intervention commitments referring to maternal nutrition.[13] Thus, the Compact typifies where we stand as a global nutrition community in terms of inaction for maternal nutrition on funding policy and scale up.

Despite the political will surrounding maternal nutrition, research-based direct interventions have failed to reach any degree of scale. This lack of alignment highlights a fundamental flaw in how we prioritise nutrition intervention for impact and to achieve the global nutrition targets.

Recommended research-based interventions

The 2013 Lancet series on maternal and child nutrition outlined ten key direct nutrition specific interventions.[14] These evidence-based interventions were intended at the time to act as the foundation for direct impact. Eight of these ten interventions were endorsed by the World Health Organisation. Of the ten interventions, three interventions have seen no scale up and the remaining seven interventions has seen no significant scale up in the intervening years apart from Vitamin A.

For the purpose of this Spotlight, we will focus primarily on those interventions that are directed at pregnant women and relate to Body Mass Index (BMI) <18.5 kg/m², which affects the primary outcomes of anaemia >11(g/dl) and Low Birth Weight (LBW) >2.500g.

Figure 3 outlines the Recommended Maternal Nutrition Specific Interventions, that focus on the four key recommended nutrition-specific interventions centred around the mother in the preconception and antenatal period, and their contribution towards the global targets if brought to scale.[15] From the table we can see that the key nutrition interventions for women have very poor to non-existent coverage rates. This is despite the strong recommendations for action from both the Lancet and the World Health Organisation, as well as their predicted impact on anaemia, wasting and low birth weight.

What is perhaps most disheartening about the research and how they correspond with actions is that despite the strong evidence base for nutrition specific interventions, they have not translated into actions in the field. No scale up of three key interventions (Energy protein supplementation, Prenatal Iron and Folic Acid and Multiple micronutrients) equates to an unrealised opportunity for these actions to impact the low birth weight, anaemia, stunting and wasting targets. While coverage rates exist for the remaining interventions, they remain extremely low.

Recommended maternal nutrition specific interventions

Intervention	Target Group	*Coverage	Recommended by	Positive reductions
18.1 Energy Protein Supplementation	Undernourished pregnant mothers	0%	Lancet WHO	34% LBW
18.2 Iron folic acid	Pregnant mothers	26%	Lancet WHO	19% LBW 27% Anemia
18.3 Iron folic acid	Non-Pregnant Mothers	0%	WHO	31% Anemia
18.4 Presumptive malaria treatment*	Pregnant mothers	26%	WHO	40% Anemia

Coverage: intervention coverage—defined as the proportion of individuals in need of a service that actually receive the service. Coverage rates span from 0% (meaning no one who needs the intervention receives it) to 90% which is generally considered to be the maximum coverage rate achievable.

Figure 3: Recommended Maternal Nutrition Specific Interventions

Intervention Spotlight

We will now focus on the first key intervention of energy protein supplementation and what a zero% coverage rate means in the field.

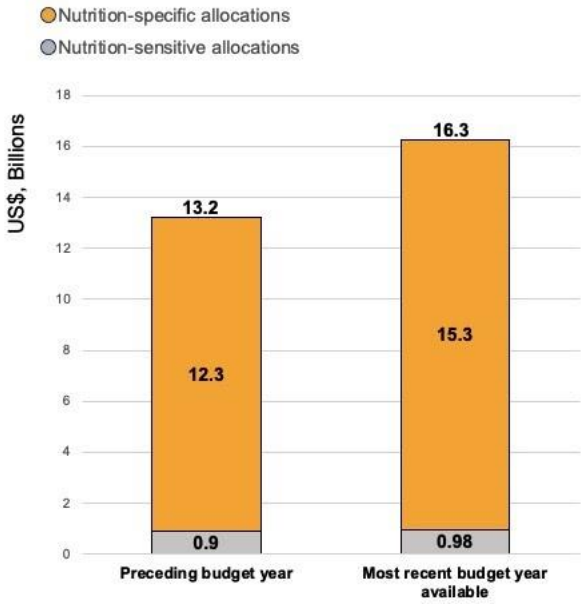
Energy Protein supplementation and the programming gap

Energy protein supplementation is the provision of food with an energy content of 25% of total energy requirements. It recognises the increased nutritional needs of a mother during pregnancy and the effects these unmet needs will have on birth weight and mortality.

The zero percent scale up of this intervention lies at the heart of the nutrition programming gap for maternal and foetal nutrition. In very basic terms, it means that no undernourished and pregnant mothers are receiving food as an intervention solution. This is despite the strong evidence and ethical basis for action, which has translated into this intervention being a key recommendation by the World Health Organisation and the Lancet commission. This intervention has the most significant impact on Low Birth Weight, decreasing it by 34%, and as a basic food provision can, and needs to, stand as the cornerstone of an intervention framework model.

Funding for Impact

Nutrition investments broadly intersect at two common points; nutrition specific investments that seek to address the immediate causes of malnutrition, and nutrition sensitive investments that focus on the underlying determinants or root causes of undernutrition. Both sets of interventions have nutrition improvement as their underlying mandated rationale. How effectively these programs interact with each other in achieving nutrition outcomes will be one of the key determinants for achieving the WHA goals.



Graph 2
Source: Budget analysis exercise, 2018 SUN Movement Secretariat.
Notes: Based on national budgets of 25 countries (GDP deflators added to correct for inflation and express the changes in real terms).

As the Investment Framework for Nutrition has pointed out, for global nutrition targets to be achieved, funding streams will need to increase substantially and will need to be channelled into nutrition specific interventions.[15] The budget analysis of 25 SUN (Scaling Up Nutrition) countries (Graph 2) gives us an indication of the domestic funding ratios between nutrition specific and nutrition sensitive interventions.[15] It provides a clear picture of the funding, which prioritises nutrition sensitive over nutrition specific interventions by 16 to 1. The analysis shows that funding for nutrition sensitive interventions has increased by 3 billion dollars, whereas that for nutrition specific interventions has only increased by 800 million dollars.

As the Investment Framework for Nutrition has pointed out *'the evidence base for the impact of nutrition-sensitive interventions on stunting, anemia, breastfeeding, and wasting remains limited.'*

On the other hand, thanks to the work done by the Investment Framework for Nutrition, we have a clear intervention map based on research data showing how the 800 million dollars increase in nutrition specific funding would help us achieve those targets. This points to a core dilemma of funding priorities and evidence-based interventions to reach
the global nutrition targets. A key question for funders, advocates and policy makers is how to achieve an equitable funding balance between nutrition specific and nutrition sensitive approaches. How effectively these programs interact with each other in achieving nutrition outcomes will be one of the key determinants for achieving the WHA goals.

Why do we need a common goal focused approach between intervention models?

In a looped system, nutrition specific and nutrition sensitive investments occur in tandem. When malnutrition occurs, it shows that despite the best efforts of nutrition sensitive interventions they failed to prevent the incidence of malnutrition. The intervention point, or what we refer to as the 'overflow', is when biometric indicators and or policy guidelines suggest action. These intervention points always require nutrition specific interventions because they address the immediate need of malnutrition. It is not a question of one intervention type or another, but the forethought on equitable funding and policy to achieve the global nutrition targets and, at the same time, reach the furthest behind. The further away we move from recommended intervention points (which can be seen in low coverage rates), the graver the consequences for malnutrition, leading to the adverse consequences of low birth weight, neonatal mortality, stunting, wasting, child and maternal mortality.
Effective targeted interventions should ensure that the 'overflow' of poor nutrition from nutrition sensitive approaches would be taken up by nutrition specific interventions.

A funding model needs to be centered on equity in terms of the greatest impact to reach the WHA targets, given the available resources that we

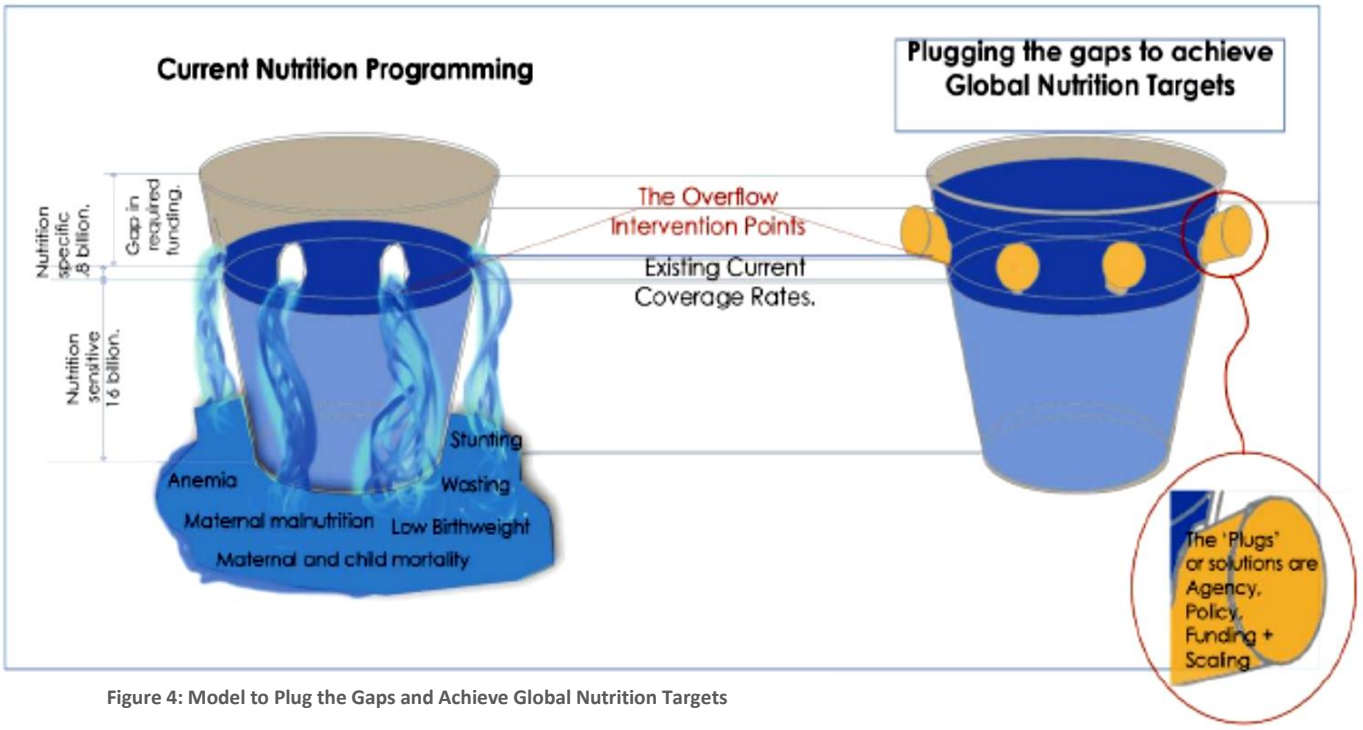


Figure 4: Model to Plug the Gaps and Achieve Global Nutrition Targets

have. How ethical is a funding model that spends up to 16 times as much on nutrition sensitive interventions where there is little evidence base for impact? This translates to a reality in the field of significant Low Birth Weight, and related interlinkages (the overflow), which have low or non-existent scale up of interventions. We are leaving those furthest behind only with the promise of a better life for the future generations.

Moreover, it is difficult for funders to fund interventions that are currently non-existent, or have very low coverage. Despite globally agreed targets and political commitment, the key issues remain with scale up, effective national policy, and lack of an effective intervention agency.

What agency is best placed to undertake this scale up?

Despite the clear and well documented evidence of the role it plays in the intergenerational cycle of malnutrition, we have no UN Agency that has a strong and sufficient mandate or responsibility for maternal or foetal nutrition. As noted above, this lack of a mandate is evidenced by the low to non-existent scale up of the 4 key essential nutrition actions around maternal nutrition recommended by the 2013 Lancet series and the World Health Organization. It is difficult to envision a scale up to the degree required without such a structure to weave the thread between policy, funding and impact.

The understanding that we have gained on the intergenerational linkages between foetal nutrition and long-term birth outcomes means that the protection of children's rights cannot be siloed from positive birth outcomes. Given the biological dependency between maternal and foetal nutrition, the extended mandate will need to include the mothers both during pregnancy and at the preconception stage. UNICEF has been given an unequivocal mandate for children to *'advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential*.'[16]

UNICEF in its distinguished past has already been established as a strong precedent for maternal nutrition programming by the introduction of the Child Survival and Development Revolution in 1982, which initially included maternal nutrition as one of its components. The acronym of GOBI-FFF was used to encapsulate the small number of high impact interventions for child health. The letters represented Growth monitoring, Oral rehydration therapy, Breast feeding, Immunisation, Family planning, Female education and Food supplements (for at risk pregnant mothers). Over time, the 3 later components were dropped.[17]

UNICEF Executive Director Henrietta H. Fore in her forward to the 2019 State of The World's Children has substantially added to the mandate debate by stating that *'I want to emphasize again my commitment, and the commitment of UNICEF, to use all of these opportunities to work for better nutrition for every child, especially in the crucial first 1,000 days – from conception to age two years – and during adolescence, the two unparalleled windows of opportunity*.'[18]

For Field Impact

UNICEF's strong mandate for children, and their recognition of the role that maternal nutrition plays in a child's future, makes it the most appropriate and logical choice to take on the extended mandate of maternal and foetal nutrition. On a field impact level, it makes strong and logical operational sense given their global presence, experience in advocacy and funding streams as well as its operational ability to implement nutrition specific program for children such as vaccination and the Community Management of Acute Malnutrition (CMAM).

The intergenerational reality of malnutrition, which has its origins in maternal and foetal nutrition, and continues through the life cycle of the child means that where there are malnourished children, there will be malnourished mothers. This is an important point because it means that the existing intervention areas that UNICEF and its partner agencies and governments operate in for children will hold the operational key for scaling up nutrition specific interventions for mothers.

Key recommendations

The intergenerational reality of malnutrition and the low scale up of nutrition specific interventions to correct the nutrition deficits, which manifests in poor birth outcomes, offers us a strong mandate for action. While it is not the entire the problem, the arena of nutrition specific intervention offers a significant [and timely] part of the solution with a wide implementation scope. Given a goal-oriented mandated funding approach, significant progress can be achieved within the available funding streams.

1st Recommendation

The siloed approaches in nutrition need to be integrated in order to avail of a single funding source, region by region, triggered by the achievement of the WHA targets. Just as the humanitarian development divide has been called to deconstruct itself, a similar call is required for nutrition specific and nutrition sensitive interventions in a goal mandated approach. Siloed walls serve no one, least of all those furthest behind.

2nd Recommendation

We have highlighted the implementation gap in maternal and foetal nutrition programming. To effectively join the string between policy, funding and field impact we recommend that UNICEF's mandate be formally extended to include foetal and maternal nutrition.

3rd Recommendation

The Nutrition for Growth Summit in Japan this year offers a strong opportunity for advocacy due to expiry of the timeline on the first Global Compact of reaching 500 million women and children with effective nutrition intervention by 2020. A degree of humility will be required to acknowledge that this commitment has not been reached. This spotlight report offers reasons why this commitment could never have been met, given current mandated nutrition architecture. We are calling for the 3 global compact Commitments to be extended to 2030.

4th Recommendation

As the Spotlight has outlined, we are not on track to reach 5 of the 6 global nutrition targets by 2025. It is also clear that we are unlikely to achieve them by 2030, given current trajectories and existing mandates and architecture in place.
The Investment Framework for Nutrition by the World Bank offered us clear scale up solutions to achieve the WHA targets. A paradigm shift in the narrative, a resource management framework, and a renewed framework for action is required. In order to achieve the global nutrition targets we will need to act on the solutions offered to us by Investment Framework for Nutrition and formulate a renewed global commitment and narrative to that end.

5th Recommendation.

Article 12 of CEDAW recognises the right to maternal nutrition during pregnancy and lactation. It is clear that this has not been given a high priority from agencies, governments or civil society due to a completely inadequate coverage or policy framework. The committee *'makes*

recommendations on any issue affecting women to which it believes the States parties should devote more attention' and has made 37 such recommendations.[19] No recommendation has yet been issued for article 12. We recommend that the committee make such a recommendation and align this recommendation for the Nutrition for Growth summit in Japan next year (2020).

6th and final recommendation

This spotlight seeks to be a voice for women, mothers and their unborn. Our final recommendation goes to the heart and ideology of the nutrition programming gap for maternal nutrition. We are calling for the scaling up of Energy Protein Supplementation as a basic yet targeted food intervention for malnourished pregnant mothers. Such a scale up will require significant political and global will considering that no existing programming currently exists. Given the interlinkages between maternal nutrition and the global nutrition targets, it becomes not just a moral imperative but a strategic one as well.

Concluding points

The Spotlight report outlines the scale of the problem of maternal malnutrition and the interlinkages this has for short- and long-term birth outcomes as well as the positive political landscape that surrounds this issue. It also highlights the high wasting rates at birth in South East Asia, which represents half of all the wasted children in the world and is directly linked to maternal and foetal nutrition from conception.

It identifies the poor coverage rates of key nutrition specific intervention for the mother as well lack of funding streams as core areas of concern. Furthermore, it the nutrition specific and sensitive divide and called for greater alignment with policy and funding to reach the global nutrition targets. Finally, having outlined the rationale for UNICEF to take custodian ownership of maternal and foetal nutrition, it formulates six key recommendations for action.

The mothers who bare us into the world remain repressed and segregated in many parts of the world. Gender equality needs to include gender nutritional equality and foetal nutrition as a core intervention for the first part of the 1000-day window of opportunity.

For those of us that advocate for the empowerment of women, our last recommendation for the scale up of food as a targeted basic provision for malnourished pregnant mothers, which currently has a zero% scale up, needs to be seen as an issue to lend your voice to.

At the start of this Spotlight, we suggested that the furthest behind in every situation will always be the malnourished pregnant mother and her unborn. We hope that this spotlight report has demonstrated the validity of this argument and has contributed to this narrative in a holistic and practical way.

Acknowledgments

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