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# MAKING HEALTH A RIGHT FOR ALL: UNIVERSAL HEALTH COVERAGE (UHC) AND NUTRITION

## 'WHAT': UHC MUST DELIVER ON NUTRITION

The road to UHC will look different in every country, both in how it is financed and how the health system is structured. But it is clear that UHC must deliver on nutrition, in order to fully realise the right to health.

Addressing nutrition is critical to fulfil the right to health. Globally, regardless of the level of development, national governments already engaged in health system reforms, need to take into **account the links between nutrition and health**. *Undernutrition* remains a *major threat* to the survival, growth and development of children. Globally, 165 million children under five are estimated to be stunted and 45% of child deaths are attributable to undernutrition. Obesity and diabetes are growing problems in both developed and developing countries, leading to a double burden of malnutrition in which some individuals are chronically undernourished, while others are chronically overweight. Yet nutrition is still a neglected area in public health.

Above all undernutrition disproportionately affects the poorest in society, and perpetuates generational

poverty (see box). Current debates on UHC must recognise that exclusion and equity gaps are often not accidental but the result of a range of factors. These include neglect or political apathy towards a particular group or groups; deliberate exclusion as an expression of discrimination, and attempts to achieve other policy objectives.

The setting up and implementation of UHC policies in many developing countries, combined with the increasing interest from UN agencies and donor(s) towards this approach, represents an important opportunity for nutrition to be part of national health policies. In low income countries in particular, government needs to decide what interventions should be prioritised when defining universal health coverage policies, how will they be delivered and how they will be financed from their often very limited health budgets. These debates are taking place at national level by ministries of health and finance and at global level by UN agencies and governments.

This briefing paper explores how UHC can deliver on nutrition, and addresses in particular maternal and child undernutrition.

## The impact of undernutrition

- Key indicators show that globally, 165 million children aged under five are stunted due to chronic malnutrition and 52 million were acutely malnourished (wasted) in 2011. According to the Lancet, the lives of 8% of children younger than five years worldwide are at risk because of undernutrition and 26% will have physical or mental growth restrictions that will prevent them from developing to their full potential.
- According to the 2013 MDG report, children in the poorest households are more than twice as likely to be stunted as children from the richest households. At a micro level, it weakens the family circle, as stunted mothers are more likely to give birth to low birth weight children, perpetuating the cycle of poor nutrition.
- At a macro level, it reduces the future labour force of countries, impacting an individual's future earnings. According to the World Bank, undernutrition annually costs Sub-Saharan Africa \$ 25 billion in lost wages and productivity. The economic cost of undernutrition represents a loss of 2 to 3% of GDP for affected countries and is recognised as a major obstacle to development in the poorest countries.

### Maternal and Child nutrition

Maternal and child undernutrition accounts for more than 10% of the global burden of diseases.<sup>1</sup> Many of the diseases, physical disabilities and abnormalities, and even deaths caused by undernutrition, could be prevented through nutrition-specific interventions and programmes. Adequate nutrition is a key factor in the physical and mental growth especially for children during the

<sup>1</sup> Robert E Black, Lindsay H Allen, Zulfiqar A Bhutta, Laura E Caulfield, Mercedes de Onis, Majid Ezzati, Colin Mathers, Juan Rivera, for the Maternal and Child Undernutrition Study Group, "Maternal and child undernutrition: global and regional exposures and health consequences", The Lancet, January 2008, p.16

crucial period of intrauterine growth until age two which determines the future health to a great extent.

In the absence of good quality and nutritious food, children in particular are more vulnerable to infectious and non-communicable diseases. Access to new evidence reveals undernutrition contributed to the deaths of 3.1 million children under five and was an underlying factor in 45 per cent of all child deaths in 2011.<sup>2</sup>

### What we know can be done

Technical and scientific research, as well as indigenous knowledge on the fight against undernutrition lead to the development of effective tools and interventions. A list of evidence based interventions<sup>3</sup> have been proven to be effective in reducing undernutrition,

#### Evidence-based interventions that affect maternal and child undernutrition

Sufficient evidence for implementation in all 36 countries	Evidence for implementation in specific, situational contexts
<b>Maternal and birth outcomes</b>	
Iron folate supplementation	Maternal supplements of balanced energy and protein
Maternal supplements of micronutrients	Maternal iodine supplements
Maternal iodine through iodisation of salt	Maternal deworming in pregnancy
Maternal calcium supplementation	Intermittent preventive treatment for malaria
Interventions to reduce tobacco consumption or indoor air pollution	Insecticide-treated bednets
<b>Newborn babies</b>	
Promotion of breastfeeding (individual and group counselling)	Neonatal vitamin A supplementation
	Delayed cord clamping
<b>Infants and children</b>	
Promotion of breastfeeding (individual and group counselling)	Conditional cash transfer programmes (with nutritional education)
Behaviour change communication for improved complementary feeding*	
Zinc supplementation	Deworming
Zinc in management of diarrhoea	Iron fortification and supplementation programmes
Vitamin A fortification or supplementation	Insecticide-treated bednets
Universal salt iodisation	
Handwashing or hygienic interventions	
Treatment of severe acute malnutrition	

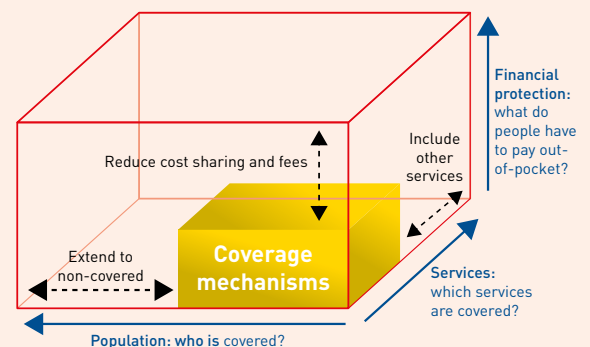
<sup>2</sup> Zulfiqar A Bhutta, Jai K Das, Arjumand Rizvi, Michelle F Gaffey, Neff Walker, Susan Horton, Patrick Webb, Anna Lartey, Robert E Black, The Lancet Nutrition Interventions Review Group, and the Maternal and Child Nutrition Study Group "Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?", The Lancet, Vol. 382, Issue 9890, Pages 452, June 2013

<sup>3</sup> Prof Zulfiqar A Bhutta PhD, Tahmeed Ahmed PhD, Prof Robert E Black MD, Prof Simon Cousens PhD, Prof Kathryn Dewey PhD, Elsa Giugliani, Batool A Haider MD, Prof Betty Kirkwood PhD, Saul S Morris PhD, Prof HPS Sachdev, Meera Shekar PhD, for the Maternal and Child Undernutrition Study Group "What works? Interventions for maternal and child undernutrition and survival", The Lancet, Volume 371, Issue 9610, Pages 417 - 440, 2 February 2008



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## Towards universal coverage



and further evidence underlines how it is crucial to determine **who** has access to the interventions.<sup>4</sup>

The provision of high impact interventions needs to be taken up across the life cycle, with each specific age and gender group needs specific targeted interventions for greater results. Interventions aimed at women and girls of reproductive age or during pregnancy, focusing on improving health outcomes for infants and young children are well known. These include food supplements, or education on the importance of diversified diets and adequate complementary feeding based on local context and resources, including information on and elimination of harmful traditional feeding practices that affect the health of pregnant women, new-borns and infants.<sup>5</sup>

### How nutrition interventions can be integrated in UHC policies

This new evidence on the effectiveness of interventions on nutrition comes at a crucial moment building health policies to reach UHC in developing countries. According to the WHO, more than eighty countries have asked assistance to implement UHC reforms in their national plans.

**Universal health coverage**, is ensuring that all people have access to health information and services (promotive, preventive, curative and rehabilitative) of sufficient quality to cover the variety of their needs (including SRHR, HIV, TB and Malaria), while also ensuring that people do not suffer financial hardship when paying for these services.

UHC is to be reached by ensuring health services to be:

- **Available** facilities and skilled Health Workers in sufficient quantity
- **Accessible** for all: equity in access - those who need the services should get them, not only those who can pay for them;
- **Acceptable**, respectful of medical ethics and culturally appropriate
- **Affordable** - ensuring that the cost of using care does not put people at risk of financial hardship; and
- **Quality** sufficient to improve the health of those receiving services.

**Note:** we define UHC according to the core principles adapted from the 2010 World Health Report; consistent with a Primary Health Care approach (WHA62.12) and Committee on Economic, Social and Cultural Rights – CESCR comment n°19; principle of person-centeredness, ensuring comprehensiveness and integration, continuity of care, and meaningful participation of patients, families and communities

<sup>4</sup> Zulfiqar A Bhutta, Jai K Das, Arjumand Rizvi, Michelle F Gaffey, Neff Walker, Susan Horton, Patrick Webb, Anna Lartey, Robert E Black, The Lancet Nutrition Interventions Review Group, and the Maternal and Child Nutrition Study Group "Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?", The Lancet, Vol. 382, Issue 9890, Pages 457-458, June 2013

<sup>5</sup> Harmful traditional practices towards Women and Girls in Africa, African Union Commission - Department of Social Affairs - April 2012, page 33 -34

Both the treatment and prevention of severe malnutrition are linked to maternal and child health and should therefore be better integrated within a primary healthcare package. However today, this remains the exception rather than the rule. For instance, at the global level, the WHO module developed in 2012 on the Integrated Management of Childhood Illnesses (IMCI)<sup>6</sup> does not integrate the treatment of severe acute malnutrition. At the national level few countries have integrated preventing and treating chronic malnutrition or acute malnutrition in their primary health care package.

This paper explores hereunder different components of an integrated health policy needed to achieve equitable access to quality health services for all – UHC including the integration of nutrition interventions within the health service package, and access to essential medicines, to build on health workers and community based initiatives, to monitor interventions based on evidence and data, to provide sufficient funding and, above all, to commit politically.

## → Nutrition interventions within the health services package

Nutrition must be integrated into the health delivery system with a shift from emergency-focused interventions to the ones that prevent and treat undernutrition<sup>7</sup>. It is crucial to ensure that those interventions are done through an integrated approach.

*Today many barriers in access to healthcare are due to the fact that facilities chose to deliver interventions separately on different days of the week. A woman that has come for a malaria consultation on a Monday is unlikely to come back to the health centre on the Tuesday for nutrition intervention.*

<sup>6</sup>Part of scaling up nutrition should not only be medical interventions but also the re-introduction of indigenous nutritious food, diversified diets, the promotion of breastfeeding and hygienic measures, counselling on the right feeding practices and behaviour change as well as the elimination of harmful traditional feeding practices. Reference to "Harmful traditional practices towards Women and Girls in Africa", published by the African Union Commission – Department of Social Affairs – April 2012, pp. 33 -34

<sup>6</sup>Integrated Management of Childhood illnesses,  
[http://www.who.int/maternal\\_child\\_adolescent/topics/child/imci/en/](http://www.who.int/maternal_child_adolescent/topics/child/imci/en/)



An integrated service delivery approach will allow a package of interventions to be delivered that can address numerous diseases and other health problems, encompassing prevention, treatment, and care. Whether in the community, at the health centre or at the district hospital, planning needs to ensure that interventions are delivered with the adequate delivery mechanism.

Important scaling up of essential health intervention has been possible thanks to stronger community health workforce, resulting in progress in health and nutrition outcomes especially for hard to reach population. The buy in and engagement of the community is a prerequisite to ensure demand, behaviour changes and access to the services. The best model of these services needs to be addressed on a local context-specific level but could include, for example a facility post or outreach interventions, mixing campaigns and routine services.

### → Nutrition products and treatment as part of essential medicines

Defining which medicines should be included within the primary healthcare package is essential for building health policies to reach UHC. It should aim to ensure the supply of good quality affordable and appropriate medicines. If a country faces a high level of undernutrition amongst children and mothers, it should integrate all relevant products to treat severe acute and chronic undernutrition related to the evidence based interventions within its list of essential medicines. This will not only ensure the procurement and availability of the necessary inputs (vitamins, zinc, oral rehydration, ready to use therapeutic food, iodised salt) but also guarantee that the health workers are trained to diagnose, prevent and treat undernutrition. Such inputs and services ought to be free at the point of use to ensure equal access for all.

The definition of the national list of essential medicines will also provide guidance on which products should be available at each level of the health system (community, district, national level). For the specific inputs of food fortification and supplementation priority should be made on locally prepared or manufactured, culturally accepted ready-to-use supplementary or therapeutic food.

### Health workers

Building an effective health policy to reach UHC will depend on the knowledge, skills, motivation and distribution of the health workforce. Sufficient health

workers<sup>9</sup> must be available at each level (community health workers, nutritionist, nurses, midwives and doctors as well as also public health managers) with adequate training and incentives to deliver good quality services.

The scaling up of the health and nutrition interventions will have greater impact when they are delivered at the community level. This approach would not only reduce the burden of undernutrition of the country but it will also help closing the equity gap both in terms of mortality and access to healthcare. Community health workers have to be trained to diagnose the different forms of undernutrition, to assist help early detection and to manage severe acute malnutrition. They play a vital role when it comes to promote health and nutrition education through counselling of the right feeding practices, behaviour changes and other strategies to fortify food. To increase acceptance within the community, health workers should be ideally from the same community or at least be familiar with the language and cultural practices.

*Experience from Bangladesh show that a community-based approach was associated with a significant increase in exclusive breastfeeding and comparatively faster reduction in the prevalence of stunting in children aged 24–59 months. Training in of the integrated approach needs therefore to be included within the different curriculum for each of level of the health workforce, from district training to medical college<sup>9</sup>.*

### → The information system

A strong information system allows good monitoring of the population's state of health. It is a paramount to ensure that policies are heading in the right direction, if programmes must be adjusted or specific emergency actions must be taken. Mother and child surveillance must be put in place with outcome targets and related indicators on stunting and wasting as well as targets related to access to services and supplies. Most importantly, the related indicators must be disaggregated by wealth quintile as well as by target populations<sup>10</sup>. Adding such reached targets and indicators within UHC policies will ensure that the country impacts on the nutritional status of children, mother and women through its health policy.

<sup>9</sup>World Health Organisation WHO recommends a threshold of 2.3 doctors, nurses and midwives per 1,000 people. WHO global code of practice on the international recruitment of health personnel, [http://www.who.int/hrh/migration/code/WHO\\_global\\_code\\_of\\_practice\\_](http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_)

<sup>9</sup>P 464 : Zulfi qar A Bhutta, Jai K Das, Arjumand Rizvi, Michelle F Gaffey, Neff Walker, Susan Horton, Patrick Webb, Anna Lartey, Robert E Black, The Lancet Nutrition Interventions Review Group, and the Maternal and Child Nutrition Study Group "Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?", The Lancet, Vol. 382, Issue 9890, Pages 457

<sup>10</sup>a) reproductive age and during pregnancy b) neonates c) infants and children.



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This will require routine data sources and specific surveys on nutrition and more broadly on maternal and child health. One important component to make timely use of this information will be to ensure the release of the data at the earliest stage possible and make sure that information is shared across relevant actors.

*The release of SMART surveys in Senegal at the end of 2011 showed that 70% of the country exceeded the alert thresholds of WHO standards<sup>11</sup>. This led to immediate response from the Senegalese government who raised an alert and sought support via external funding but it also guided the building of immediate regional plans. In the medium term, it helped take into account the burden of undernutrition at the political level and today, discussions are ongoing to ensure that nutrition is part of the future UHC policy in Senegal. In addition the Senegalese government has promised to release 10 billions Franc CFA for the most deadliest childhood diseases including under-nutrition.*

<sup>11</sup> UNICEF, Situation report #1 Senegal, Food and Nutrition Crisis, 28 March 2012, [http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20SENEGAL%20Sitrep%20\(March%2028%202012\).pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20SENEGAL%20Sitrep%20(March%2028%202012).pdf)

## → Health system financing

A mother will more likely come with her child to the health facility if she knows that the consultation is free at the point of use. More importantly all the related cost such as the transport, the food and medicines, will influence the likelihood of early visits rather than waiting to see a health professional with the risk of possible health complications of the health situation. In many developing countries setting social and financial protection systems will tend to concentrate limited resources on a set of services or interventions generally for targeted populations. It is key that Governments, through pooled risk funding, ensure access for marginalised and most vulnerable groups as defined by the specific country context. Increases in coverage for mother and child health interventions including nutrition are directly related to the removal of user fees and the availability of financial incentives.

*In Rwanda, the increase of community health insurance schemes (called mutuelles) between 2000 and 2010 led to a decrease of the prevalence of underweight and anaemia among under-5 children during the same period<sup>12</sup>. Similarly the cash transfer programme in Brazil, "Bolsa Familia" also led to important progress in the fight against under nutrition with children under*

<sup>12</sup> International Health Economics Association <http://ihe2013.abstractsubmit.org/presentations/10346/>

*5 years enrolled in the programme having 26% higher chance of adequate height for age and weight for age than a child not enrolled*<sup>13</sup>.

Nutrition will benefit from government efforts of pooled risk funding and considerably reduction of out-of-pocket payments. Regardless the choice for funding of the national health policy to reach UHC (general taxes, specific insurance schemes, payroll taxes, member contribution, donor support) nutrition needs to be part of the essential package. For governments the main cost of health interventions is service delivery – namely the cost of health care workers and supply transport. Adding nutrition-specific interventions to an already existing program will be very limited, but will have a greater impact in terms of health outcomes.

### → Political commitment and governance

The integration of nutrition within health policies to reach UHC needs to be embedded at programmatic level as discussed above. However the impetus needs to come from the political level.

The first step is the acknowledgement that nutrition needs a multi-sector approach by the highest decision making bodies such as the President or Prime Minister, the Minister of Finance and Health, and the Members of parliament. This will incentivise the health decision-making bodies to prioritise nutrition when defining the UHC policy in the country.

Additionally the choice of the package of healthcare, the delivery mechanism and the financing system has to be evidence-based and designed with the full involvement of civil society organisations and community representation. In countries with limited resources, such an approach will guarantee the right prioritisation and the building of a UHC policy based on the needs of the population. A decentralised governance with district-based planning can ensure country-wide coverage and a tailored approach for specific contexts (e.g. cross borders, district with specific climate conditions which will affect the health and nutrition status).

Addressing undernutrition needs a multi-sectoral response with elements that fall outside UHC<sup>14</sup>. Additional investments need to be made to supporting nutrition sensitive interventions and policies for key sectors including agriculture and food security, women empowerment, water and sanitation and

education. For instance to ensure long-term-solutions to malnutrition the promotion of indigenous nutritious food and recipes need to be part of agriculture and food security policies.<sup>15</sup> Developing sustainable local agricultural markets is required to ensure access to food which is sufficient but also adequate and culturally acceptable. This demands measures to protect small local farmers, including facilitating access to land, water and credit. Equally important is the development of infrastructure to make sure everyone has access to clean drinking water. Finally, the inclusion of nutrition in school programmes is a powerful awareness-raising mechanism as good feeding practices are taught, helping to break the intergenerational malnutrition cycle.

### Conclusion

Nutrition is a vital aspect of health policies. Integrating nutrition within UHC policies is paramount to achieving the right to health for all. It will help to scale up the needed interventions to fight under nutrition and by doing so enhance healthy lives of mothers and children. In the context of the ongoing debates on UHC at national level by ministers of health and finance and at global level by UN agencies and governments, this briefing paper calls to include nutrition interventions within universal health coverage policies. The donor community must support as to ensure that this approach is implemented.

<sup>15</sup> Global Health Watch 3: An Alternative World Health Report, People's Health Movement, Medact, Health Action International, Medico International, Third World Network, 2011. Pages 249-266.

<sup>13</sup> <http://www.who.int/bulletin/volumes/89/7/10-084202.pdf>

<sup>14</sup> Report A/HRC/19/59 to the United Nations Human Rights Council by Mr Oliver De Schutter, UN Special Rapporteur on the Right to Food. 26 December 2011

## KEY MESSAGES

- Ensure Universal Health Coverage can deliver on the fight against undernutrition.
- National, European and global development policies should consider a shift from emergency-focused interventions to the ones that prevent and treat undernutrition. Budgetary and extra-budgetary resources need to be mobilised within health programs to reach UHC for scaling up the implementation of nutrition interventions.
- A country-led and tailored approach to nutrition and universal health coverage:
  - a. The implementation of community approaches will be mostly effective if designed in an integrated manner combining the most effective child and maternal interventions.
  - b. Governments, through pooled risk funding, should ensure access for the most vulnerable and marginalised groups as defined by the specific country context
- Scale-up the implementation of effective nutrition specific interventions within the health policies to reach Universal Health Coverage;
  - a. Integrating the prevention and treatment against chronic and severe acute malnutrition into the management of childhood illnesses of WHO guidelines.
  - b. Integrating at the national level the prevention and treatment of chronic acute malnutrition or severe acute malnutrition into primary health care packages.
- Apply an integrated approach, to include the fight against undernutrition within other health related policies such as education, agriculture, gender, water, sanitation and hygiene policies
- Apply a multi-stakeholder dialogue, coordination and harmonisation for the definition, implementation and evaluation of UHC policies in order to ensure a UHC based on population needs that include appropriate nutrition.

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**Action Against Hunger | ACF International** is an international humanitarian organization committed to saving the lives of malnourished children while providing communities with sustainable access to safe water and long-term solutions to hunger. With 30 years of expertise in emergency situations of conflict, natural disaster, and chronic food insecurity, ACF runs life-saving programs in some 40 countries benefiting five million people each year.

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**Global Health Advocates** is an organisation that promotes equitable access to health worldwide. Through networking an partnership building GHA advocates for social changes and mobilise society against diseases that keep people in poverty. As part of this effort, we work to ensure continued leadership and political commitment to global health, development and the fight against poverty at the French, the EU level and globally.

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**Terre des hommes** is an independent association for development and children rights founded in 1967. It is supporting nearly 500 projects in 32 countries worldwide to enforce children rights. The right of the child to the highest attainable standard of health is one of the main working areas at project as well as at advocacy level. It is active in various networks among them VENRO and Action for Global Health.

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