



NUTRITION at a GLANCE

RWANDA



Photo: Arne Hoel.

Country Context

HDI ranking: 167th out of 182 countries¹

Life expectancy: 50 years²

Lifetime risk of maternal death: 1 in 16²

Under-five mortality rate: 112 per 1,000 live births²

Global ranking of stunting prevalence: 8th highest out of 136 countries²

Technical Notes

Stunting is low height for age.

Underweight is low weight for age.

Wasting is low weight for height.

Current stunting, underweight, and wasting estimates² are based on comparison of the most recent survey data with the WHO Child Growth Standards, released in 2006. They are not directly comparable to the wealth quintile data shown in Figure 2, which are calculated according to the previously-used NCHS/WHO reference population.

Low birth weight is a birth weight less than 2500g.

The methodology for calculating nationwide costs of vitamin and mineral deficiencies, and interventions included in the cost of scaling up, can be found at: www.worldbank.org/nutrition/profiles

The Costs of Undernutrition

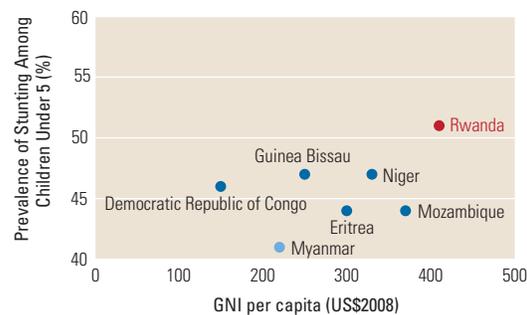
- Globally, over one-third of child deaths are due to undernutrition, mostly from increased severity of disease.²
- Children who are undernourished between conception and age two are at high risk for impaired cognitive development, which adversely affects the country's productivity and growth.

Where Does Rwanda Stand?

- 52% of children under the age of five are stunted, 16% are underweight, and 5% are wasted.¹²
- 6% of infants are born with a low birth weight.²
- Rwanda's progress over the past two decades has not improved to meet MDG 1c (halving 1990 rates of child underweight by 2015) with business as usual.⁶

As seen in **Figure 1**, Rwanda performs worse than countries in its region and income group. Countries with lower per capita incomes, such as Togo and DRC exhibit reduced rates of child stunting.

FIGURE 1 Rwanda has Higher Rates of Stunting than Lower-Income Peers



Source: Stunting rates were obtained from WHO Global Database on Child Growth and Malnutrition (figures based on WHO child growth standards). GNI data were obtained from the World Bank's World Development Indicators.

Undernutrition is not just a problem of poverty. As **Figure 2** shows, children are undernourished in close to one-third of even the richest households. This is not typically an issue of food access, but of caring practices and disease.

Most of the irreversible damage due to malnutrition happens during gestation and in the first 24 months of life.⁶

Annually, Rwanda loses nearly US\$50 million in GDP to vitamin and mineral deficiencies.^{3,4}

Scaling up core micronutrient interventions would cost US\$6 million per year.

(See *Technical Notes* for more information)

Key Actions to Address Malnutrition:

Increase nutrition capacity within the Ministries of Health and Agriculture.

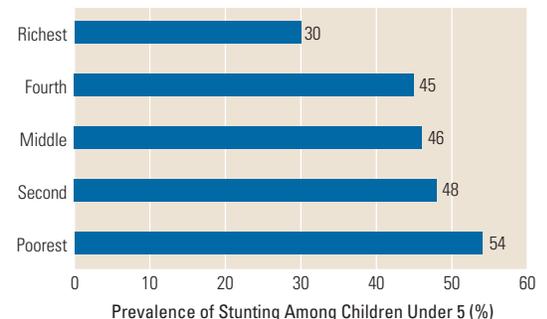
Improve infant and young child feeding through effective education and counseling services.

Improve dietary diversity through promoting home production of a diversity of foods and market and infrastructure development.

Continue high coverage of vitamin A supplementation for young children, and progress toward universal salt iodization.

Ensure deworming of preschool children to help control anemia.

FIGURE 2 Undernutrition Affects all Wealth Quintiles – Poor Infant Feeding Practices and Disease are Major Causes



Source: DHS 2005 (figures based on NCHS/WHO reference population).

Vitamin and Mineral Deficiencies Cause Hidden Hunger

Although they may not be visible to the naked eye, micronutrient deficiencies are widespread in Rwanda, as shown in **Figure 3**.

- **Iron:** Current rates of anemia among preschool aged children and pregnant women are 42% and 11% respectively.⁹ Provision of multiple micronutrient supplements to infants and young children,

Poor Infant Feeding Practices

- 59% of all newborns do not receive breast milk within one hour of birth.²
- 1 out of 8 infants under six months are not exclusively breastfed.²
- During the important transition period to a mix of breast milk and solid foods between six and nine months of age, almost 1 in 3 infants are not fed appropriately with *both* breast milk and other foods.²

Solution: Support women and their families to practice optimal breastfeeding and ensure timely and adequate complementary feeding. Breast milk fulfills all nutritional needs of infants up to six months of age, boosts their immunity, and reduces exposure to infections. In high HIV settings, follow WHO 2009 HIV and infant feeding revised principles and recommendations.¹¹

High Disease Burden

- Undernutrition increases the likelihood of falling sick and severity of disease.
- Undernourished children who fall sick are much more likely to die from illness than well-nourished children.
- Parasitic infestation diverts nutrients from the body and can cause blood loss and anemia.

Solution: Prevent and treat childhood infection and other disease. Hand-washing, deworming, zinc supplements during and after diarrhea, and continued feeding during illness are important.

Limited Access to Nutritious Food

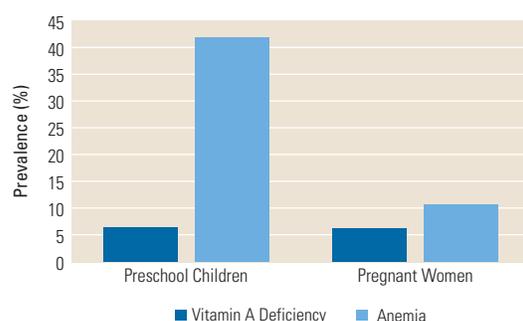
- 40% of households are food insecure as defined as per capita access to calories.⁷ Many more households likely lack access to diverse diets year round.
- Achieving food security means ensuring quality and continuity of food access, in addition to quantity, for all household members.
- Adequate calories and micronutrients are essential for child growth and development. These can be provided by diverse diets.

Solution: Involve multiple sectors including agriculture, education, transport, gender, the food industry, health and other sectors, to ensure that diverse, nutritious diets are available and accessible to all household members.

References

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FIGURE 3 High Rates of Vitamin A and Iron Deficiency Contribute to Lost Lives and Diminished Productivity



Source: WHO Global Prevalence of Vitamin A Deficiency in Populations at Risk 1995–2005; WHO Worldwide Prevalence of Anemia 1993–2005.

deworming, iron-folic acid supplementation of pregnant women, and fortification of staple foods are effective strategies to improve the iron status of these vulnerable subgroups.

- **Vitamin A:** Coverage of vitamin A supplementation is high in Rwanda, with 91% of children receiving a twice-yearly vitamin A supplement.¹² High coverage should be continued, and is a positive factor in relatively low prevalence of vitamin A deficiency: 6% of preschool aged children and pregnant women are deficient in vitamin A.⁸

- **Iodine:** In Rwanda, 88% of households consume iodized salt.² Consumption of iodized salt is a major factor in controlling iodine deficiency, which can cause IQ loss in infants and young children. Progress toward universal salt iodization should be continued.
- Adequate intake of micronutrients, particularly iron, vitamin A, iodine and zinc, from conception to age 24 months is critical for child growth and mental development.

Addressing undernutrition is cost effective: Costs of core micronutrient interventions are as low as US\$0.05–3.60 per person annually. Returns on investment are as high as 8–30 times the costs.¹⁰

World Bank Nutrition-Related Activities in Rwanda:

<http://go.worldbank.org/R2KBERG1X0>



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