

Child Malnutrition and the Relation with HIV/AIDS in Jamaica

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In the last two decades, Jamaica has taken great strides in eliminating severe malnutrition in the majority of its population. In fact, like many of the Caribbean countries, Jamaica's health concerns are transitioning towards an increased prevalence of diet-related chronic diseases¹ where the concern lies more with inappropriate food intake rather than an insufficient intake. Key indicators of malnutrition (reports of low birth weight babies, underweight, stunted, or wasted children) continue to decrease each year, yet the public health services responsible for such declines rely on an economy which may not be able to support intensely targeted nutrition policies and programmes in the future, particularly with the threat of HIV/AIDS looming throughout the Caribbean.

CHILD MALNUTRITION

Traditionally, those most vulnerable to malnutrition were those least able to gain access to economic or social

resources. Jamaica's Public Health system, supplemented by private sector and NGO projects, has implemented numerous programmes designed to reach out to the underserved communities, both facility and community based. These include the Food Stamp Programme, PATH, the School Feeding Programme, Nationwide Food Fortification, Breastfeeding Promotion Programmes (including the Baby Friendly Hospital Initiative), the training/implementation of Community Health Aides, and structured antenatal and nutritional educational/counseling programmes. The prevalence of malnutrition, in children ages 0-59 months, held steady at around 16% from 1975-1985, however the following table² shows the most recent published numbers:

Malnutrition in Jamaica occurs most frequently in households of the unemployed, among subsistence farmers in rural areas, in the lowest urban areas, in large families with no paternal support, and among very young mothers. The population most at risk

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^bFAO – Nutrition Country Profiles (Jamaica). 2002. pg. 6.

Region	Underweight < -2 SD	Stunting < -2 SD	Wasting < -2 SD
Kingston Metro Area	4.3% (11.9%)	5.1% (7.3%)	2.4% (3.7%)
Other Towns	2.7% (5.3%)	3.9% (6.8%)	3.0% (2.6%)
Rural Areas	3.7% (4.2%)	5.0% (5.1%)	2.3% (2.5%)
National	3.6% (6.4%)	4.8% (5.9%)	2.4% (2.8%)

continues to be children ages 12-23 months. The consequences of nutritional deprivation range from the immediate to the long-term, and most certainly affect the future of a country. Children diagnosed as suffering from malnutrition often have a low IQ and impaired cognitive development, when compared with their counterparts. Often these children have difficulties in education achievement and are seen to have lower than normal enrollment rates, as well as higher drop-out rates. Malnourished children often suffer from a failure to thrive, with increased morbidity and mortality rates and small adult body types. Combining cognitive and physical deficits creates both social and economic problems in the long-term, as malnourished children have decreased mental and physical capacity as adults. Often this is reflected in a decreased work capacity, which not only affects households (both economically and emotionally), but the economics of the country as a whole.

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unemployed, among subsistence farmers in rural areas, in the lowest urban areas, in large families with no paternal support, and among very young mothers. The population most at risk continues to be children ages 12-23 months. The consequences of nutritional deprivation range from the immediate to the long-term, and most certainly affect the future of a country. mically and emotionally), but the economics of the country as a whole.

RISK FACTORS

In 1990, UNICEF developed a conceptual framework regarding the consequences of malnutrition, and divided the causes into three categories: basic, underlying, and immediate. For many years, much attention was given to the most prevalent immediate problems, disease and inadequate dietary intake. However, these issues are not occurring in a vacuum. To deal with child malnutrition, it was necessary to understand the background issues causing the deficiencies in health and food.

On a contextual level, child malnutrition is a result of the political and economic structure of a country. It is on this basic ground that potential resources are organized and allocated into an ideological structure to serve the citizens. Underlying causes stem from the chosen structure of human and economic resources. If a child is suffering from disease or a micronutrient deficiency it can be assumed that the child is subject to an insufficient health system, inaccessible food supply, and an unhealthy environment. There could be multitudes of reasons for these inadequacies, but in most cases they stem from poverty. Impoverished households are of low-income, have limited access to health care, may be uneducated in health care practices, and often have unstable supplies of clean water and good sanitation.

HIV/AIDS

In 2001, it was estimated that the adult prevalence of HIV/AIDS in Jamaica was 1.2% of the population (both men and women) ages 15-49.⁵ Reported AIDS cases have increased

from 1 in 1982 to 445 in 2001, with a peak of 892 and 903 in 1999 and 2000, respectively.⁶

Though the estimated number of children (ages 0-15 years) living with HIV/AIDS in 2001 in Jamaica was 800, the estimated number of children who had lost their mother, father, or both parents to AIDS was 5,100 (2001).⁷ This number pales in comparisons with the AIDS orphans in countries such as Africa, but these are living children who are now vulnerable to many of the same risk factors that are seen to underlie malnutrition. The prevalence of HIV/AIDS in Jamaica is currently below the Caribbean average of 2%, but the country is not isolated from the fact that the Caribbean has the highest incidence of new cases in the Americas.⁸ The World Bank identified seven unique attributes to the disease⁹:

- HIV/AIDS spreads very fast.
- People who contract HIV may remain infectious for many years without knowing they have the virus or showing any symptoms. The potential for spread is high.

⁵UNAIDS/WHO *Epidemiology Fact Sheet on HIV/AIDS and Sexually Transmitted Infections, Jamaica. 2002 Update.*

⁶*Ibid.*

⁷*Ibid.*

⁸[http://wbln0018.worldbank.org/LAC/lacinfoclient.nsf/0/0191899ca02a3f6885256905007be3d0/\\$FILE/HIVAIDSCaribbean.pdf](http://wbln0018.worldbank.org/LAC/lacinfoclient.nsf/0/0191899ca02a3f6885256905007be3d0/$FILE/HIVAIDSCaribbean.pdf)

⁹*Ibid.*

- It reduces life expectancy which is positively related to savings, productivity, and education.
- HIV/AIDS primarily affects young people, ages 15-49, who are in the prime of their lives as workers and parents.
- People with AIDS suffer repeated and prolonged illnesses, imposing great costs on households and health systems.
- AIDS breaks down social cohesion, challenges value systems, and raises deeply rooted and sensitive gender inequalities.
- There is no AIDS vaccine and no cure.
- Understaffing – like any social projects, Jamaica's programs to reach underserved communities are constantly at the mercy of available funding. Particularly labour and time-intensive are the Community Health Aide projects, which are invaluable in creating links and communication within the community.
- Insufficient resources and distribution network for supplementation programmes – often when patients are seen at the clinic, there are shortages of the necessary nutrient supplements. This can leave clients with a sense of frustration, as they have been educated as to what they need, and shown where their needs can be met, yet they leave empty-handed and at a loss.
- Underutilized programmes and inadequate targeting – Jamaica has many programmes targeted to preventing child malnutrition yet only a fraction of the population knows or takes advantage of these situations.
- Unidentified malnutrition pockets – it is known that only certain localized areas in Jamaica continue to suffer from severe malnutrition, though the nation as a whole continues to improve.

Of these seven factors, four are related to both economic and social systems. If Jamaica is required to transfer human and capital resources to fight HIV/AIDS in the future, what will be the expense to the community health systems that have worked so well for the past twenty years in deterring malnutrition?

IDENTIFIED PROGRAMME GAPS

Having discussed the fact that Jamaica has done an excellent job in developing a successful public health sector, there are some issues that garner review.

Possible Recommendations

Based on the CFNI/Tulane University Study Tour of the Jamaican Public Health System, the following recommendations are put forth for consideration:

Continued and improved mapping of malnutrition pockets – surveillance and monitoring in these areas will lead to a better analysis of the community level situations and more appropriate interventions.

- Further research on the HIV/AIDS issue in Jamaica and the disease's affect on the affected populations.
- Improved monitoring and evaluation of nutritional programmes – each programme has its individual goal and target population to reach, but a thorough process of M and E will allow public health officials to accurately review programme procession, efficiency, and necessity.
- Strengthening of the health care referral system for clients with HIV/AIDS.
- Integration of social workers within the community of public health nutrition workers for a more holistic approach.
- Continued expansion of the Parish AIDS committees.
- Increases in the number of Community Health Aides, and an

increase in the number of workers who are educated on HIV/AIDS.

- Integrated health information systems.
- Proper targeting of the school feeding programme – in 2001, school lunches and snacks accounted for 33% of reported school related expenses, and “school expense” being the most commonly cited reason for children's absence from school. To have the school feeding programme properly targeted and then utilized would provide benefits beyond the nutritional.
- Integration of research, policy, and programme implementation.
- Formation of public/private partnerships to support the work of the Child Development Agency (CDA).



Source: *Healthy Eating for Better Living*