



**Complementary Feeding Practices among Children 6–24 Months of Age in Zambia: Tackling Sub-Optimal Feeding Practices that Contribute to Poor Growth, Undernutrition, and Stunting**  
**A Policy Brief**

**Executive Summary**

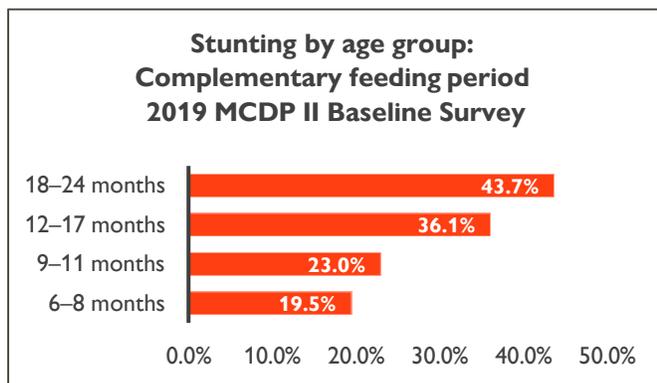
The recent First 1000 Most Critical Days Programme Phase II (MCDP II) 2019 Baseline Survey, conducted in 30 priority MCDP II districts across the 10 provinces of Zambia, found that only 19% of young children 6–24 months of age were receiving the recommended minimum acceptable diet (MAD), adequate in quality and quantity to meet their growth needs.<sup>1</sup> The survey found unacceptable levels of stunting among children in this same age group, with almost 1 in 3 children (30%) stunted. Levels of stunting among children in rural areas (33%) were significantly higher than those for children in urban areas (25%). Children who are stunted are at a greater risk for mortality, morbidity, irreversible poor cognitive development, and diseases later in life.<sup>2</sup> Improving complementary feeding of infants and young children, in combination with improvements in their home and community environment, is critical for the prevention of undernutrition and stunting in Zambia and to ensure a future with better health and development and human productivity.<sup>3</sup> This policy brief focuses on understanding and tackling the sub-optimal complementary feeding practices that contribute to poor growth, undernutrition, and stunting among young children in Zambia.<sup>4</sup>



**Background**

The Government of the Republic of Zambia has rallied at the highest levels to tackle childhood malnutrition, especially stunting, through a combination of broad and specific policy and strategy initiatives that bring together both the public and private sectors to prioritise nutrition and address the determinants of stunting.<sup>5</sup> Although there has been a decline in stunting in the last 5 years,<sup>6</sup> stunting levels are still *very high*, requiring immediate action for additional advocacy and scaling up of programmes.<sup>7</sup>

The 2019 MCDP II Baseline Survey, which included 7,486 households with children under 2 years of age, found that stunting levels increased significantly during a child’s second year of life, peaking at 43% among children 18–24 months of age. The high prevalence of stunting coincides with the child’s most rapid period of growth, known as the complementary feeding period, from 6 to 24



months of age, when nutrient and energy needs are at their peak and children are at increased risk for growth faltering, undernutrition, and infection.<sup>8</sup>

According to the World Health Organization, a child meets the minimum infant and young child feeding (IYCF) standards if the child:

- 0–6 months of age is exclusively breastfed
- 6–8 months of age was breastfed and had at least two meals per day
- 9–23 months of age was breastfed and had at least three meals per day
- 6–23 months of age was not breastfeeding and had at least four meals per day
- 6–23 months of age consumed at least four or more foods from different groups

In the 2019 MCDP II Baseline Survey, only 28.5% of children met the minimum IYCF standards. Districts with lower percentages of children meeting the standards had higher levels of stunting (see table to the right). The notable geographical variations in the prevalence of undernutrition and stunting across the 30 districts highlighted significant gaps and constraints to optimal infant and child feeding in Zambia, including

Districts with >30% stunting and low percentage of children 0–24 months of age meeting minimum IYCF standards		
District/province	% children 0–24 months stunted	% children 0–24 months with minimum IYCF standards
Nchelenge/Luapula	43.1	21.4
Samfya/Luapula	43.0	25.7
Kaputa/Northern	39.5	15.7
Mwinilunga/Northwestern	34.9	26.9
Kaoma/Western	34.1	21.6
Chinsali/Muchinga	32.4	21.7
Shang’ombo/Western	31.8	18.4
Mpika/Muchinga	30.1	16.9

low diversity in diets, low continued breastfeeding rates, low number of meals per day, household hunger, poor household hygiene practices, and a high prevalence of childhood diarrhoea, among others.

## Complementary Feeding of Infants and Young Children: 2019 MCDP II Baseline Survey Findings

From the moment of birth through the first 6 months, an infant should be exclusively breastfed—that is, given breastmilk only, no water or other liquid or food—to ensure good growth. At 6 months of age, an infant requires diverse and nutritious foods in addition to breastmilk.

Breastmilk is still an essential source of protein, essential fatty acids, antibodies that protect against illness, and calories for the growing child until at least 2 years of age. Continued breastfeeding through at least 2 years of age and timely, adequate, safe, complementary feeding are protective against undernutrition and stunting.<sup>9</sup> The 2019 MCDP II Baseline Survey measured key indicators to track progress towards optimal complementary feeding practices for children 6–24 months of age. The following table shows several of the indicators and their results.

### Did you know?

- Infants can get all the calories and nutrients they need from exclusive breastfeeding until 6 months of age.
- Children 6–12 months of age get about half of their calories from breastmilk.
- Children 12–23 months of age get about one-third of their calories from breastmilk.

Source: [https://www.who.int/health-topics/breastfeeding#tab=tab\\_1](https://www.who.int/health-topics/breastfeeding#tab=tab_1)

Indicators associated with optimal complementary feeding green=acceptable, yellow=concerning, red=alarming	2019 MCDP II Baseline Survey
Infants who receive complementary foods by 6 months (Note: 30% of these children were given food too early—that is, before 6 months)	98.9%
Continued breastfeeding up to 2 years	28.2%
<b>Minimum acceptable diet</b> for children 6–24 months	19.1%
<b>Minimum dietary diversity</b> for children 6–24 months	33.8%
<b>Minimum meal frequency</b> for children 6–24 months	44.5%
Percent of households reporting moderate or severe hunger	75.6%
Percent of households practicing safe food processing/preparation/improved storage practices	7.6%
Percent of households practicing essential hygiene actions	5.6%
Percent of children under 2 years who had diarrhoea in the preceding 2 weeks	34.7% (46% for 9–11months)
Percent of mothers who report they received nutrition education on complementary feeding of young children	62.4%

*Introduction of solid, semi-solid, or soft foods.* Almost all infants (98.9%) received complementary foods at 6 months of age in addition to breastmilk. However, more than 30% of these infants were introduced to food too early, many at 3 or 4 months of age, before their stomachs are mature enough. This puts them at risk for stunting due to illness from exposure to environmental pathogens from an unsanitary environment, as well as decreased consumption of nutritious breastmilk.<sup>10</sup>

*Continued breastfeeding* on demand through 12 months of age was encouragingly high at 89.6%; in contrast, by 24 months of age, it was low at 28.2%. These findings indicate that exclusive breastfeeding through 6 months of age and continued breastfeeding through at least 2 years of age require further promotion, protection, and support among mothers, fathers, families, and members of the community to ensure that young children benefit from the important calories and nutrients that breastmilk provides to protect from undernutrition and stunting.

*Minimum meal frequency (MMF)* is defined as the number of meals a child is provided according to the age of the child and is a proxy for energy or calorie requirements.<sup>11</sup> Less than 1 out of 2 children (44.5%) are fed the recommended number of times per day, resulting in low calorie intake and an increased vulnerability to poor growth and stunting. Children who met MMF were less likely to be stunted (29.7%), compared to children who did not (35.3%). In rural areas, children were significantly less likely to meet MMF (40.7%), compared to children in urban areas (52.8%). Children from food insecure households were less likely to meet MMF (40.9%), compared to children from food secure households

**Benefits of optimal complementary feeding (timely, adequate, safe)**

- Prevention of undernutrition and stunting
- Less likely to die
- Less diarrhoea and respiratory infections
- Less risk of anaemia and other micronutrient deficiencies
- Prevention of overweight/obesity later in life
- Optimal growth
- Strengthened immunity
- Improved cognitive development
- Better psychosocial development
- Improved productivity and economic status later in life

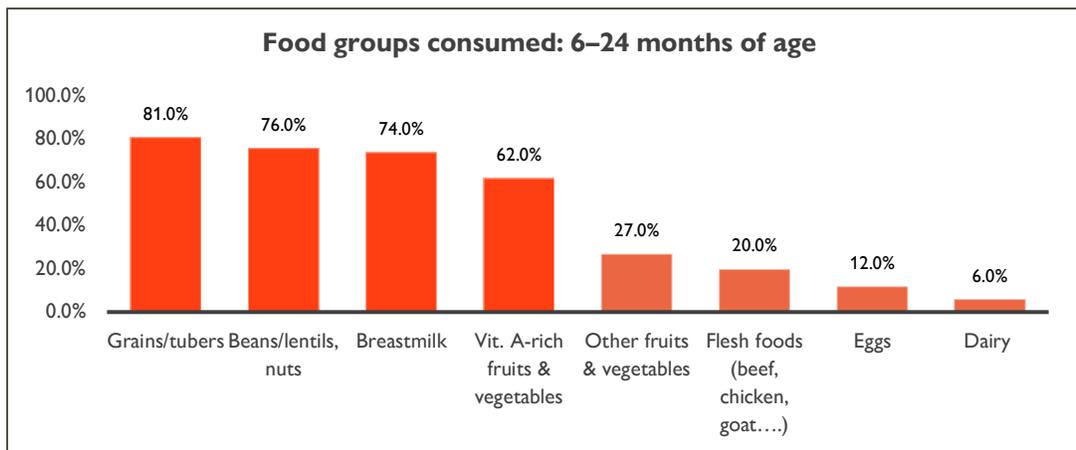
“Children who are fed enough of the **right foods**, in the **right way**, at the **right time** in their development, are more likely to survive, grow, develop, and learn. They are better equipped to thrive, even when faced with disease, disaster, or crisis.”

Source: *Improving Young Children’s Diets during the Complementary Feeding Period.* UNICEF. 2020.

(56.1%). Caregivers, mothers, and other family members need additional education on the importance of feeding a child several meals a day while continuing to breastfeed on demand until at least 2 years of age. It is also vital that households and communities have supportive interventions that address hunger and improve household food security.

*Minimum dietary diversity (MDD)* measures the diversity or quality of the foods offered to a child and is a proxy for measuring the adequacy of nutrients and micronutrients in the diet, with the standard being five or more food groups out of eight offered each day. Food groups include breastmilk; grains, roots, and tubers; legumes and nuts; dairy products; flesh foods (meat, fish, poultry, and liver/organ meats); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables.<sup>12</sup> Only 1 in 3 children (33.8%) met MDD. Children who met MDD were less likely to be stunted (30.8%), compared to children who did not (33.6%). Significantly,

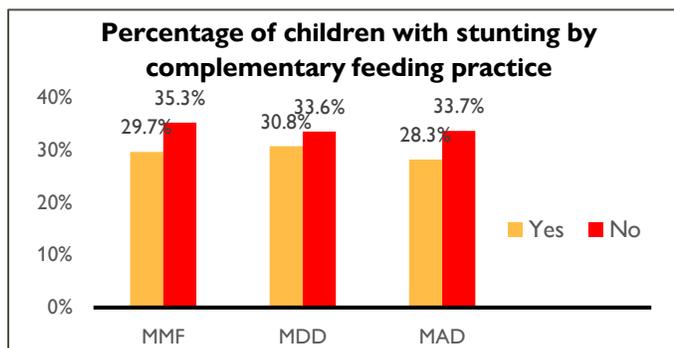
fewer children in rural areas (27%) met MDD, compared to those in urban areas (47.9%). The figure at the right shows consumption



of the various food groups. More dietary diversity, particularly consumption of iron- and protein-rich animal flesh foods, and eggs, is needed to improve the quality and density of the diet to positively impact growth and cognitive development and reduce the prevalence of stunting and micronutrient deficiencies.<sup>13</sup> The consumption of empty calories is also of concern: in the day before the survey, 1 in 4 children (25%) in the 12–24 month age group consumed sugar-sweetened beverages, and 1 in 5 children (22%) in this age group ate sweets or a salty or fried snack. When children fill up on processed, sugar-loaded beverages and salty foods and empty calories, it places them at risk for undernutrition, tooth decay, and unhealthy food preferences that can lead to obesity.<sup>14</sup>

*Minimum acceptable diet (MAD)* is a key indicator for tracking complementary feeding. It combines the MMF and MDD measurements to assess whether children are being fed often enough and provided a diverse diet adequate in density and micronutrients.<sup>15</sup> Only 1 in 5 children (19.1%) met MAD. As with MMF

and MDD, children who met MAD were statistically less likely to be stunted (28.3%) than children who did not meet MAD (33.7%). Also, statistically significantly fewer children in rural areas (14.7%) met MAD, compared to children in urban areas (28.5%). Only 15.3% of children in food insecure households met MAD, compared to 31.1% of children in food



secure households. Limited availability of diverse foods throughout the year, inadequate caregiver knowledge, and cultural food preferences and taboos contribute to low MAD levels in Zambia.<sup>16</sup> This indicator highlights the need for critical action to educate and support families to produce and access enough and diverse food throughout the year to ensure the optimal growth and cognitive development of their infants and young children.

*Household food insecurity.* Three-quarters of households (75.6%) reported moderate or severe hunger, and children in these households were significantly less likely to have MMF, MDD, and MAD. Hunger was measured using the *Household Food Insecurity Access Scale*, which asks how many times a household reduced the number and diversity of meals due to food shortages during the 4-week period leading up to the survey.<sup>17</sup> These findings indicate that households are struggling with food security and highlight the need for responsive monitoring systems and targeted social safety nets that can address seasonal food shortages while agricultural investments are being made to address the problem over the longer term.

*Essential hygiene actions for hygienic storage and preparation of food and consumption of safe food.* The survey measured alarmingly low coverage of essential hygiene actions (5.6%), including access to clean drinking water, soap available at a handwashing station, and access to a clean latrine and environment. Also of concern is that only 7.6% of households practiced safe food processing, preparation, and storage. Both of these indicator measurements mean that children are at an elevated risk for eating contaminated food, eating with dirty hands or dishes, and experiencing recurrent illness episodes that result in reduced appetite, increased nutrient demands, poor absorption of vital nutrients, and weight loss contributing to undernutrition and stunting. One in 3 children (34.7%) under 24 months of age had diarrhoea in the 2 weeks leading up to the survey, with the highest rates in children 9–17 months of age (46.0%). Children who had diarrhoea were more likely to be stunted (39.0%) than those who did not (33.2%). Improvements in community-wide water and sanitation are critical for young child nutrition, given the importance of providing children safe food and hygienic environments and the known links between environmental enteropathy and childhood stunting.<sup>18</sup>

*Responsive feeding* refers to how children are engaged during mealtimes. Feeding a young child requires time and patience. Children who are spoken to and patiently engaged are more likely to eat well and benefit from the psycho-social stimulation, an important aspect of early childhood development.<sup>19</sup> Responsive feeding means that the caregiver patiently engages the young child during meals, speaking with them and watching for feeding cues.<sup>20</sup> The survey inquired what mothers do if their child refuses to eat. Although 32% of mothers said that they encourage the child to eat, 42% said that they do nothing, and 22% said that they force the child to eat. A mother's responsive engagement and patience is also critical when feeding a sick child who is at a heightened risk for growth faltering and stunting.

## **Policy Context**

Zambia has worked diligently to create an enabling policy and strategy environment to reduce stunting and propel a multi-sectoral response that can prioritise, coordinate, and allocate more resources for nutrition-specific and nutrition-sensitive interventions to address stunting. The National Food and Nutrition Commission serves as the national coordinating unit for nutrition, with investments and learning being strengthened through participation in the Scaling Up Nutrition Network since 2010.<sup>21</sup> Provincial Nutrition Coordinating Committees have been established in 7 of the 10 provinces in Zambia and facilitate multi-sectoral planning. Since 2012, District and Ward Nutrition Coordination Committees have been scaled

up as resources become available. Community Care Groups and Farmer Groups provide platforms for multi-sectoral interventions reaching the community and households.

Recent initiatives, including the January 2020 launch of the National Food and Nutrition Strategic Plan 2017-2021 and the National Community Health Strategy 2019-2021, advocate a comprehensive multi-sectoral approach that engages communities and households to prevent undernutrition and promote well-being among mothers, infants and young children. The MCDP, now in Phase II, focuses on preventing undernutrition and stunting during the most critical periods of a child’s growth including the pre-natal period, infancy and early childhood. The MCDP has supported the development of practical tools, including the Field Worker’s Reference Guide for First 1000 Most Critical Days (April 2014), to orient front-line workers across the sectors on the importance of and actions needed for supporting households to promote and protect the nutritional status of children.<sup>22</sup> The evaluation of MCDP Phase I highlighted the need for strengthened sector coordination and implementation at the district and ward levels for increased coverage of essential nutrition actions and, in particular, nutrition-sensitive interventions that can complement nutrition education and lead to improved household food security benefiting maternal, infant, and young child nutrition.<sup>23</sup>

Laws in place, including *The Food and Drugs (Marketing of Breast Milk Substitutes) Regulations 48, 2006*, *The International Labor Convention No 183 on Maternity Protection*, and other relevant food and drug acts that protect and support breastfeeding as well as prevent advertising of sugar-sweetened beverages and unhealthy processed convenience foods towards young children, need to be upheld and monitored for compliance.<sup>24</sup> The Baby-Friendly Hospital Initiative, with 10 Steps to Successful Breastfeeding, is one of the strategies being used to promote, protect, and support breastfeeding.

## Complementary Feeding Guidelines

The Zambia 2016 Infant and Young Child Feeding Guidelines incorporate the internationally recognised guidance for complementary feeding listed in the following table.<sup>25</sup> To ensure that the guidelines are put into practice and have an impact on child nutrition and development and the prevention of stunting, there is an urgent need for advocacy, capacity building at all levels, and targeted investment and support to geographical areas with high levels of undernutrition and stunting.

Guiding principles for complementary feeding for young children 6–24 months of age <sup>26</sup>	
<ul style="list-style-type: none"> <li>• Continue frequent, on-demand breastfeeding until 2 years of age or beyond.</li> <li>• Start at 6 months with small amounts of food and increase gradually as child gets older.</li> <li>• Practice <b>active</b> feeding—mother positively engages young child while feeding, encouraging child to eat, and monitoring consistency and intake.</li> <li>• Practice good hygiene and proper food handling, ensuring that food is hygienically prepared and stored; wash hands before preparing food, before eating, and after changing baby’s diaper.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide two to three meals per day for breastfed infants 6–8 months of age**</li> <li>• Provide three to four meals per day for breastfed infants 9–23 months of age, with one to two snacks as required.**</li> </ul> <p>**Non-breastfed infants require one to two cups of milk each day and one to two extra meals each day.</p> <ul style="list-style-type: none"> <li>• Incorporate traditional food that are rich in nutrients, and address taboos as needed.</li> <li>• Use fortified complementary foods or vitamin-mineral supplements as needed.</li> <li>• <b>AVOID</b> added sugar, sugar-sweetened beverages, and processed foods.</li> </ul>

<ul style="list-style-type: none"> <li>• Gradually increase food texture, consistency, and variety, providing foods from at least five or more food groups (includes breastfeeding) each day using locally available foods.</li> </ul>	<ul style="list-style-type: none"> <li>• During illness, increase fluid intake, including more breastfeeding, and offer soft, favourite foods. After illness is over, increase amount of food and encourage child to eat as much as possible for at least 1 week (“catch-up” feeding).</li> </ul>
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## Recommendations for Policies and Programmes

Optimal infant and young child complementary feeding is key to the prevention of undernutrition and the reduction of stunting. It will require deeper investments and strong advocacy for a multi-sectoral approach that engages Zambian public and private institutions and civil society to partner with households and communities to provide a minimal acceptable diet to their infants and young children—a diet that is diverse, safe, and adequate, with continued breastfeeding until at least 2 years of age. Key actions should:

- Promote and support the production and consumption of nutrient-rich, diverse local foods for complementary feeding, with an emphasis on interventions that reduce hunger and result in the availability of safe, nutritious food throughout the year, including increased resources for women’s economic empowerment activities, household gardens, and improved harvest processing and storage methods.<sup>27</sup> Investments should prioritise rural food insecure households with young mothers and children.
- Protect and promote early, exclusive, and continued breastfeeding by enforcing the Code on Marketing of Breastmilk Substitutes,<sup>28</sup> supporting and scaling up the Baby-Friendly Hospital Initiative/10 Steps to Successful Breastfeeding,<sup>29</sup> and stopping the inappropriate promotion of foods to infants and young children.<sup>30</sup>
- Strengthen community-wide water, sanitation, and hygiene investments and household actions to create and sustain clean and healthy environments that reduce the prevalence of childhood infections.
- Provide consistent and accurate maternal, infant, and young child feeding messages through all communication channels, with follow up and additional supportive networks for vulnerable mothers, infants, and children.<sup>31</sup>

Page 1, Executive Summary, Photo credit: *Daily Mail* 2018– <http://www.daily-mail.co.zm/changing-fortunes-of-households/>

<sup>1</sup> United States Agency for International Development Scaling Up Nutrition Learning and Evaluation. (2019). *Baseline Survey Report Scaling Up Nutrition (SUN) 2.0/ MCDP II (Most Critical Days Program)*.

<sup>2</sup> World Health Organization. (2014). *Global Nutrition Targets 2025: Stunting Policy Brief*. Available at: [https://apps.who.int/iris/bitstream/handle/10665/149019/WHO\\_NMH\\_NHD\\_14.3\\_eng.pdf?ua=1](https://apps.who.int/iris/bitstream/handle/10665/149019/WHO_NMH_NHD_14.3_eng.pdf?ua=1)

<sup>3</sup> Zambia Ministry of Health, National Nutrition and Food Commission and Food, & Nutrition Technical Assistance Project III. (2017). *Reducing Malnutrition in Zambia: Estimates to Support Nutrition Advocacy. Zambia Nutrition Profiles*. Available at: <https://www.fantaproject.org/sites/default/files/resources/Zambia-PROFILES-Report-Aug2017.pdf>

<sup>4</sup> Other briefs that present critical interventions for the multi-sectoral approach to address stunting and promote good maternal, infant, and young child nutrition can be found at the National Food and Nutrition Commission site: <https://www.nfnc.org.zm/policy-documents/>

<sup>5</sup> Harris, J., et al. (2017). From coherence towards commitment: Changes and challenges in Zambia’s nutrition policy environment. *Global Food Security*, 13, 49-56. Available at: <https://www.sciencedirect.com/science/article/pii/S2211912416300943>

<sup>6</sup> Central Statistical Office Zambia, Ministry of Health (Zambia), & ICF. (2019). *Zambia Demographic and Health Survey. 2018*. Available at: <https://www.dhsprogram.com/publications/publication-FR361-DHS-Final-Reports.cfm>

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## ABOUT SCALING UP NUTRITION Zambia

The Government of the Republic of Zambia (GRZ) is a member of Scaling Up Nutrition (SUN)—a global movement uniting governments, civil society, businesses, and citizens in a worldwide effort to end undernutrition. Phase 1 of the Zambia SUN programme began in 2013 with the goal to reduce stunting among children less than 24 months old in 15 districts.

Currently in its second phase, SUN has increased from 15 to 30 districts, coordinated by the National Food and Nutrition Commission of Zambia, and supported by a variety of partners and donors, including USAID/Zambia who supports the SUN programme through the SUN Learning and Evaluation (SUN LE) project.

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