

---

# Basic document, conceptual premises and strategic principles

---

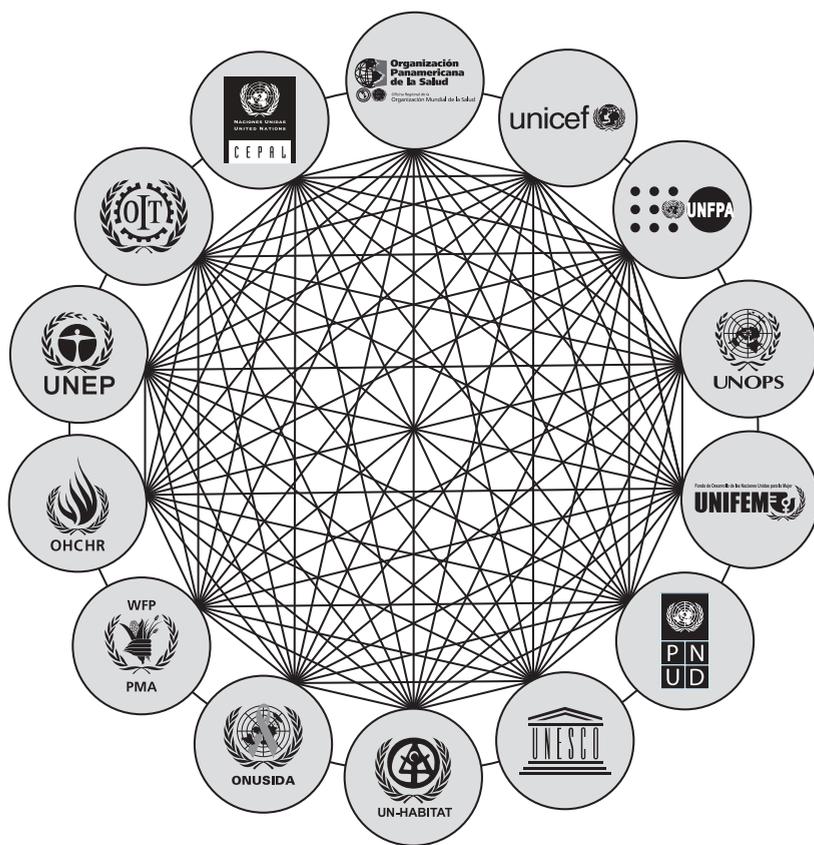


**Pan American Alliance for Nutrition  
and Development**

---

# Basic document, conceptual premises and strategic principles

---



**Pan American Alliance for Nutrition and Development**

Knowledge Management Center PAHO/WHO Peru – Cataloging

Pan American Alliance for Nutrition and Development  
“Pan American Alliance for Nutrition and Development. Basic document, conceptual premises and strategic principles”

Lima: Pan American Alliance for Nutrition and Development, 2009

I. Title

1. Nutrition, Public Health
2. Public Policies
3. Development
4. Social Determinants

Made the Legal Deposit in the Peruvian National Library: N° 2009-12100

© Pan American Alliance for Nutrition and Development

300 copies

Design and printing: S.A.C. Editores SINCO

Jr. Huaraz 449 - Breña • at.: 433-5974 • [sincoeditores@yahoo.com](mailto:sincoeditores@yahoo.com)

All rights are reserved by the Pan American Alliance for Nutrition and Development. The contents of this document may not be reported, reproduced or translated fully or in part, without prior authorization, unless you specify the source and not use for commercial purposes. The authors are responsible for the views expressed herein.

# Content

## *Chapter 1*

Pan American Alliance for Nutrition and Development for  
Achievement of the Millennium Development Goals.

Basic document	5
1. Background	5
2. Basic concepts	7
3. Definition and purpose	10
4. Structure and organization	11
5. Products and services	12
6. Channels for promoting technical cooperation with countries	14
7. Immediate tasks	14
8. Additional considerations	15
Addendum 1	17
Addendum 2	19

## *Chapter 2*

Conceptual Premises and Strategic Principles	21
1. Introduction	21
2. Background	22
3. Conceptual premises	23
4. Policy and strategy elements	25
5. References	27



## Chapter I

# Pan American Alliance for Nutrition and Development for Achievement of the Millennium Development Goals Basic document

### 1. BACKGROUND

At the meeting of Regional Directors of United Nations agencies, held 24-25 July 2008 at PAHO Headquarters, in Washington, D.C., the creation of the Pan American Alliance for Nutrition and Development [Addendum I] was approved. The purpose of the Alliance is to implement comprehensive intersectoral programs that are both sustainable and coordinated, within the framework of an intercultural rights-based gender approach in order to accelerate achievement of the Millennium Development Goals (MDGs).

The initiative to create the Alliance recognized that malnutrition and health result from the interaction of many factors, some originating in the individual person, but many others directly linked to the social and economic conditions in which the individual lives, [1.2] The "social determinants" approach to health recognizes this interaction and the importance of the underlying determinants of health. [3] Traditional approaches to the problem of malnutrition have targeted the individual through vertical food and/or health programs, downplaying or simply not recognizing the importance of social determinants, which include food security, the physical and social environment, education, access to information, maternal health status, family planning, access to health services, the exercise of human rights and fundamental freedoms, household income, and working conditions, among others. Efforts to rectify this traditional, but reductionist, approach will require simultaneous, coordinated, and complementary technical cooperation from all United Nations agencies and other stakeholders committed to the development and well-being of the population.

The Alliance is an interagency institutional initiative that will facilitate the coordination of international cooperation efforts and resources to promote, agree on, implement, monitor, and evaluate effective evidence-based multisectoral interprogrammatic interventions that recognize the multiple causes with a multicausal approach to malnutrition. It will provide an opportunity for planning on the basis of lessons

learned and current country activities. It is not intended to compete with, much less eliminate, replace, or disregard other initiatives such as the Interagency Strategic Consensus for the Reduction of Neonatal Morbidity in Latin America and the Caribbean, the Regional Interagency Task Force for the Reduction of Maternal Mortality and Morbidity, the Alliance for Maternal, Newborn, and Child Health, the Faces, Voices, and Places Initiative, the Latin America and the Caribbean without Hunger Initiative, or the Towards the Eradication of Child Undernutrition Initiative, but rather, to reinforce or improve them, providing a useful framework for integrating and consolidating efforts, together with some complementary conceptual and strategic values.

The conceptual premises of the Alliance are:

- a) To develop approaches with an emphasis on modifying the determinants, rather than simply averting their impact, and on targeting activities not only to individuals but to highly vulnerable geodemographic areas.
- b) To replace the unisectorial approach with a multisectoral one based on social determinants and inequalities.
- c) To build an adequate institutional framework for coordinating joint efforts at the local, national, transnational, and regional level.
- d) To identify sustainable integrated interventions based on evidence from different sectors, and to develop, monitor, and evaluate them in a uniform, rather than fragmented, way.
- e) To identify geodemographic scenarios and opportunities for implementing these interventions.

As part of progress made since its official approval in July 2008:

- a) A great deal of information about the rationale for the Alliance has been distributed to the Regional Director's Team, and the conceptual premises mentioned above have been endorsed;
- b) The specific evidence-based contributions (in terms of instruments, interventions and good practices) for meeting the Alliance's objectives have been identified and debated;
- c) The main features of the interventions to be developed and encouraged through a social determinants-based causality approach, have been outlined, and finally;
- d) the main criteria for identifying interventions opportunities in national or transnational areas have been discussed and agreed upon.<sup>1</sup>

---

<sup>1</sup> The two criteria are vulnerability, for obvious reasons, and homogeneity, to permit their evaluation through classical procedures in field studies.

This progress has laid the foundation for the terms of reference and the preparation of this report.

## 2. BASIC CONCEPTS

### *a. The centrality of nutrition in the creation of the Alliance*

Malnutrition, especially in the more vulnerable populations such as children and pregnant women, has played a cardinal role in the creation of the Alliance and the formulation of its policies and strategies. The justification for the Alliance is closely linked to the social determinants approach and the modern epidemiology perspectives that focus on the life course. The rationale is summarized below: [3,4]

- i. If the selection of the geodemographic scenarios or areas alluded to in point (e) under the conceptual premises of the Alliance were based not on vulnerability but on the prevalence of growth retardation, the resulting ranking would coincide with what is seen on poverty and vulnerability maps, an affirmation backed by overwhelming evidence inside and outside the Region. In other words, the poverty and vulnerability map is virtually identical to the map of chronic malnutrition or stunting. Therefore, if one opts to target by geographic areas and demographic groups instead of individuals, as the Alliance does, growth retardation is an optimal identifier tracer of vulnerabilities or more precisely, of the history of these vulnerabilities in a retrospective horizon of several years. Thus, the reduction of growth retardation is a sensitive, though nonspecific, indicator of changes in the configuration of its determinants and can be used to monitor and evaluate the interventions that the Alliance intends to encourage and promote.
- ii. Gearing interventions to the prevention of nutritional problems, especially growth retardation would also have a positive effect in terms of the vast majority of health events and health conditions that occur throughout the life course. These interventions would promote better health and have a trans-generational effect that would also have an impact on human development, given the well-known association between nutrition, health, and development. Consider, for example, the fact that children born small for their gestational age are at greater risk of obesity in adolescence (if certain environmental conditions currently prevailing in many poor countries are present), and thus, are more likely to be obese and develop chronic non communicable diseases in adulthood. This problem is not exclusive to nutrition; however, no other indicator like growth retardation exhibits such a broad and obvious horizontal intersection with health and development and their determinants.
- iii. No other condition is as attractive a symbol for advocacy and for bringing public policymakers and implementers on board.

- iv. Finally, successfully tackling the problem of malnutrition requires the cooperation of all agencies, making the Alliance a very good opportunity for crystallizing the spirit of reform in U.N. agencies into concrete action.

*b. The social determinants approach*

*“The conditions in which people live and work can help create or destroy their health. Low income or lack of income, poor housing, unsafe workplaces, and lack of access to health systems are some of the social determinants of health that lead to inequalities.”*

*... Factors such as poverty, food insecurity, social exclusion, and discrimination, poor housing, unhealthy conditions in childhood, and low occupational status are major determinants of the vast majority of disease, death, and health inequalities among and within countries.*

*[World Health Organization, 2008] [5].*

There is a constellation of known factors operating as social determinants of health that include the socioeconomic context, poverty and inequality, social exclusion, socioeconomic status, income<sup>2</sup>, public policies, education, the quality of housing, transportation, the physical and social environment, and social and community support networks. It is easy to see that these factors are found at different levels of a hierarchy. Their influence is not added on; some factors behave like underlying causes and others like intermediate causes, some modify the effects of others in a causative network whose mechanisms are not well understood and are the object of debate. It should be pointed out, however that:

- a) The social determinants produce health inequalities, not only in society as a whole but, far more importantly, among specific social groups; and this occurs basically because they are not uniformly distributed among these groups.
- b) Social determinants affect health directly and indirectly. For example, the use of biofuels in poorly ventilated environments is a direct cause of respiratory disorders, while illiteracy and under enrollment in school limit access to the labor market and thus, increases the risk of being poor, which in turn adversely impacts health.

---

<sup>2</sup> Although income, poverty, socioeconomic status, and inequality are similar and closely related concepts, they are not one and the same. Income and socioeconomic status are highly correlated, but the former is an absolute indicator, while the latter is a relative indicator associated with a hierarchy. Poverty is a condition defined by income and a more or less arbitrary threshold, and, finally, inequalities are an expression of a nonhomogeneous distribution of the social determinants among population groups or strata.

- c) The social determinants are interconnected. Poverty is related to poor housing, access to health services, and the quality of the diet, all of which, in turn, are related to health.
- d) The development of analytical resources, and especially, the use of mixed models, has led to substantial progress in understanding the influence of contextual factors on the health of individuals and, especially, how these factors modify the influence of individual factors and other, more immediate contextual factors of the individual in the structural hierarchy. [6]

### c. *Integrated interventions with an intersectoral strategy*

If a child receives early childhood stimulation and education, an adequate diet, and does not get sick, he will in all probability reach his full biological and genetic growth and development potential. These three conditions require a dense complex of other conditions that together make up the social determinants of nutrition and health, to which reference has already been made in this text. Adequately nourishing a child and providing it with the proper health care are essential activities, but in isolation are not the most efficient, because they leave the mechanisms that generate food insecurity and greater vulnerability to disease intact. This fact, a certainty at the individual level, is even truer at the population level.

Consequently, if health and nutrition are socially determined, the objective of the interventions must not be just individual people, but also the physical and social environment that produces and reproduces their health.

It is important to look beyond interventions that target the individual, notwithstanding the existing evidence of their success, and consider intervention strategies that include them as well as more basic structural interventions that take advantage of their mutual synergies. We shall call these programs “*integrated modular interventions*” (IMI)

Structural interventions are public health interventions that impact personal health by altering the structural context in which health occurs and is reproduced. [7] The physical and social environment is structured hierarchically: the environment closest to the individual, or the microsystem, consists of the home, the family, the workers’ group or union; the intermediate physical and social environment, or the ecosystem, consists of the school, the community, the health services; the environment most distant from the individual, or the macrosystem, consists of the political and economic system, the culture, and society. Structural interventions, which transcend the individual, must target one or more levels of the physical and social environment or ecosystem by making use of a theoretical model and the practical circumstances specific to each context or scenario.

Structural interventions focus on the contextual factors that influence vulnerability, individual risks, and other determinants of diseases and their risk profiles, instead of the focusing only on the characteristics of the affected individuals. In contrast, traditional approaches that center on the individual assume that the relationship between individuals and society leaves a wide margin for personal autonomy that enables each individual to choose freely among options, while the structural approach considers individual actions to be limited by external constraints or coercion.

It is hard to conceive of pure or radical structural interventions that will have the desired impact on chronic nutrition. In practice, the specific conditions of the environment (political, cultural, geographical, economic, social) need to be considered in the construction of integrated modular interventions (IMIs) resulting from the synergy between classical evidence-based interventions and these specific structural or contextual conditions.

It is the aspiration of the Pan American Alliance for Nutrition and Development to become an inter-institutional, interagency framework for technical cooperation in the search for and identification, implementation, and evaluation of integrated interventions adapted to the specific conditions of geographic areas and demographic groups, based on the criterion of vulnerability or some of its proxies. For the reasons already mentioned, nutritional status is one of the key response variables (but not the only one) for identifying and evaluating interventions. One of the goals of the Alliance, therefore, is to promote a culture of evaluation that would make it possible to identify the most effective and efficient strategies.

The greatest challenge facing the Alliance, however, will be to scale up the interventions and increase their sustainability, so that they become sustainable public policies. This presupposes political will on the part of the governments and resource allocation, within the framework of democratic governance and a community participation strategy.

### *3. DEFINITION AND PURPOSE*

The Alliance is an interagency and institutional framework for integrated joint action to achieve the Millennium Development Goals, especially those most closely associated with nutrition (Goals 1, 4, 5, and 7). Furthermore, the Alliance is distinguished by its social determinants approach, intersectoral strategy, and targeting of efforts toward vulnerable geodemographic areas.

Consistent with its nature and purposes, spelled out in the previous paragraph, the Alliance is expected to make a substantial contribution toward:

- Better, more effective interagency coordination.
- Greater integration of mandates and work plans.
- Identifying effective integrated multisectoral interventions that address social determinants and the multicausality of malnutrition and health and that consequently promote development.
- Strengthening and invigorating current strategic frameworks, programs, and initiatives.
- Mobilizing resources and optimizing efficiency in their use.
- Promoting a culture of intervention evaluation.
- Generating evidence-based information and contributing to greater visibility and more extensive use of the existing platforms devoted to nutrition, health, and development and their determinants.
- Constructing a common language, strategy, and voice to scale up interventions so that they become public policy through active advocacy; and, orienting country programs toward a multisectoral social determinants approach with broad community participation (“scaling-up/ scaling down”).

#### 4. STRUCTURE AND ORGANIZATION

At the regional level, the Alliance is comprised of the directors of the United Nations agencies (UNDP, UNICEF, UNFPA, WFP, PAHO/WHO, ECLAC, CERF, UNIFEM, UNAIDS, ILO, UNEP, OHCHR, UNOPS, UNCHR, and UN Habitat), which, for executive and technical purposes, rely directly on a Regional Technical Team (RTT), whose secretariat is PAHO/WHO. In addition to serving as the advisory body, the Regional Directors Team (RDT) will offer support and technical assistance to the technical teams of the United Nations agencies in the countries.<sup>3</sup> The goal is to improve technical and financial coordination and thus provide more efficient and effective support for national efforts to improve nutrition and health within their borders and in transnational areas, thus promoting development and accelerating achievement of the MDGs. The composition of this RTT should be determined as soon as possible.

At the national level, the Alliance will have a technical secretariat overseen by the UN Country Team (UNCT). The secretariat will be responsible for the coordination and effective delivery of interagency technical cooperation. The representatives of each agency in the countries should be informed by the regional entities about tech-

---

<sup>3</sup> To this end, the regional entities of each agency will be informed, and they, in turn, will inform the countries to ensure internal interagency coordination in each country

nical assistance missions, projects, or agreements reached at the regional level so that they can support their cooperation to the country through the UNCT.

At the **local level**, the Alliance's actors will be the parties named by the local governments in priority geographic and demographic scenarios, members of the local management teams, and community representatives. They will act within the framework of specific programs or projects and receive coordinated support from the United Nations Country Team (UNCT).

The Alliance's technical teams in the countries, designated by the UNCT, will coordinate efforts in **transnational areas**, which the Alliance has identified as areas of special interest.

Alliance activities will be deployed in three areas: 1) **technical cooperation**, which includes the search for and generation and dissemination of evidence on good practices and effective interventions, the joint creation and use of knowledge platforms, databases, and other information resources, the processing of information on experiences, the design, execution, and evaluation of integrated interventions based on the social determinants approach (this cooperation will be technical in nature and only exceptionally operational); 2) **mobilization and management of human and financial resources** to increase support for the UNCT in program and project execution and the consolidation of links with the private sector, academia, and other cooperation and financing entities; and 3) **political action**, chiefly advocacy and the promotion of agreements and commitments for public policy development.

## 5. PRODUCTS AND SERVICES

The results of the Alliance will depend on the joint efforts and commitments of the United Nations system in Latin America and the Caribbean, the preparation of its work agenda, and the use and application of the experiences, capacities, and potential of the respective country teams. It is therefore as critical as it is urgent to conduct an interagency inventory of skilled human resources and draw up an education and training plan for those resources in the specific work areas of the Alliance.

As stated in the previous section, the Regional Technical Team (RTT) will be responsible for providing technical cooperation to the Country Teams (UNCT), either directly or through the identification of competent specialists, and for serving as an advisory group for the RDT. The lines of technical assistance and technical cooperation would be:

- Generating evidence on nutrition, health, and development as the basis for public policy advocacy.

- Identifying effective, sustainable interventions.
- Identifying intervention areas in the countries and border areas, as well as activities to promote and facilitate the coordination of the work in these areas.
- Developing and implementing methodologies for rapid diagnosis of the health and nutrition situation and their determinants, identifying the most urgent needs through community participation.
- Monitoring and evaluating interventions.
- Utilizing and developing knowledge management platforms to share information on effective interventions, management tools, and databases of mutual interest.
- Strengthening interagency cooperation at the regional level.
- Monitoring and evaluating progress in the implementation of the Alliance.

It is also important to note the vital need for interagency coordination at the regional and national level; in the case of the former, to create an RTT capable of advising the country teams (either directly or through horizontal contact with duly identified competent personnel); and in the case of the latter, to create a highly committed technically competent country team imbued with the conceptual and strategic principles of the Alliance.

The nature of the integrated interventions discussed earlier implies a geographical approach to the interventions, rooted in the local level and characterized by active community participation. Such an approach would be impossible without close coordination between the national and local level. Thus, the Alliance must become a bridge for promoting other alliances and aiding country efforts.<sup>4</sup> This means working to promote public policies and not simply employing a programmatic or project approach.

The systematization and dissemination of knowledge is an issue that merits a separate section. In this regard, the agencies that make up the Alliance have committed to sharing virtual forums for knowledge and information management, taking advantage of the existing experiences of the agencies and the networks or forums of other potential partners. Especially promising are the use of the World Food Program's NUTRINET platform and the creation of a SharePoint within it or another platform to serve the specific purposes of the Alliance.

---

<sup>4</sup> The joint projects at the national level in 8 Latin American and Caribbean countries, within the framework of the AECID-UNDP, the initiative "Towards the Eradication of Child Undernutrition in Latin America and the Caribbean", and the Lima Act committing national governments to make the issue of nutrition and its determinants a permanent item on their public agenda is important to highlight.

## 6. CHANNELS FOR PROMOTING TECHNICAL COOPERATION WITH THE COUNTRIES

Within the framework of the UNDP-Spain MDG Achievement Fund's Thematic Window: Children, Food Security, and Nutrition AECID-UNDP projects, the grants that have been awarded are considered a special opportunity for beginning technical cooperation with the countries where these awards have taken place. Developing the successful grants resulted from a coordinated effort between UN agency teams and their counterparts in the countries. Once the Alliance's regional and national teams have been formed, technical cooperation for the final development of the projects and their execution will be one of their priority tasks.

A pending issue is the eventual selection of countries in special circumstances (e.g., Haiti at the present time) or countries that constitute a priority for various reasons (e.g., slow progress toward achievement of the Millennium Development Goals, which are the origin and guideposts of the Alliance).

Of particular interest as a work objective are transnational areas, which have been identified and chosen because of their special vulnerability, corroborated in a recent study by the PAHO/WHO Health Analysis and Statistics Area, using an *ad hoc* vulnerability index that was presented and discussed at the Panama meetings of October and November.<sup>5</sup> As soon as possible (when the Alliance's technical plan for the regional and country level is completed), contacts will be opened with the offices in the respective countries to evaluate activities, strategies, and opportunity costs, as well as harmonization with country interests, programs, and policies.

## 7. IMMEDIATE TASKS

All are subordinated to the basic task of developing a joint interagency action plan for strengthening an integrated national, subnational, and transnational response to accelerate achievement of the MDGs.

Based on the shared premises and progress made at the previous meetings, the following tasks have been identified for the short term:

- Define and complete the Alliance's regional and national structures in terms of human resources.
- Disseminate information about the Alliance, its purpose, its rationale, and its conceptual premises—first, to country technical teams, next to the national offices of each agency in the Alliance, and finally, to the national counterparts.

---

<sup>5</sup> One of these areas is the Paraguayan-Argentine Chaco region.

- Make contacts to begin providing technical cooperation that will promote and facilitate an intersectoral social determinants approach that employs integrated interventions, within the framework of the projects for the UNDP-Spain MDG Achievement Fund's Thematic Window: Children, Food Security, and Nutrition.
- Make contacts to identify other areas for cooperation to promote and activate projects or programs under way in the countries that are in synch with the conceptual premises of the Alliance.
- Draw up and disseminate an inventory of good practices and interventions in the agencies' respective areas of competence and of prior joint activities in the countries in the field of health, nutrition, and development.
- Develop a framework and common strategy for monitoring and evaluating the actions and interventions promoted by the Alliance, both conceptually and operationally.

## 8. ADDITIONAL CONSIDERATIONS

PAHO/WHO has been designated the Secretariat of the Alliance. The Regional Directors will determine whether this function will be on a rotating or permanent basis.

Each agency will participate pursuant to its mandates but will contribute added value to the regional interagency technical team according to its specific strengths and competencies, without renouncing the right to promote and encourage the strengthening of existing partnerships and the forging of new ones with civil society, the private sector, universities, and academia in the immediate future.

The RTT will hold in-person meetings twice a year. It will convene other special sessions when necessary, taking advantage of all technology resources available for this purpose. *Ad hoc* working groups will be formed, whose composition will depend on the matters to be considered.

In consultation with the members of the RTT, the Secretariat will develop the agenda for the meetings and coordinate the preparation of any necessary documentation.

Each organization will cover the costs of its focal point's participation at meetings and other events. Each agency will continue financing its activities pursuant to its mandates. The RTT will promote efforts to mobilize resources for joint activities at the national level.

The RTT will prepare an annual progress report based on the Alliance's Action Plan, which will be submitted to the RDT for approval. RTT operations will be governed by an Annual Work Plan. The meetings will serve as a mechanism for monitoring and evaluating Alliance operations.



## Addendum 1

### Excerpts from the proceedings of the session creating the Pan American Alliance for Nutrition and Development for the achievement of MDGs

Regional Directors' Team  
Latin America and the Caribbean



LAC RDT Workshop on MDGs  
24-25 July 2008, Washington DC, PAHO Headquarters  
Summary & Action Points/Agreements

#### Overview:

On July 24 and 25 2008 the Regional Directors of 13 agencies (UNDP, UNFPA, UNICEF, WFP, PAHO/WHO, ECLAC, UNIFEM, UNAIDS, ILO, UNEP, UNOPs, OHCHR and UNODC) met at PAHO and discussed progress, trends and obstacles in achieving the MDGs in the Region and developed a common strategy for their achievement of the General Assembly targets. The RDT identified linkages across thematic areas, identified groups and places needing further assistance and agreed on key actions for collaborative work, summarized in a work plan (*see annex table of key agreements/action points English/ Español*). The RDT also discussed raising food price and energy crises, their impact on the Region and the need for a common approach. They also considered the afro-descendent people's situation with the participation of an Afro-descendent group leader. For further information and to see the presentations and documents presented, see LAC RDT Meeting on MDGs.

Key result = Development of an agreed work plan on MDGs (key areas, actions, timeframe)

Important agreed actions include:

- To harmonize information and data on the Region and use it for advocacy and awareness raising
- To further develop and use the Atlas tool developed by PAHO and ECLAC and complement it with other key information, in particular the HDI, to map municipalities and areas with low indicators in development, and focus on those identified (eg in study of Rostros, Voces y Lugares/Faces, Voices, Places)
- To target vulnerable groups such as indigenous, afro-descendent, youth, women, and migrants;
- To establish a Regional Technical Team (RTT) on Nutrition and Development to support UNCTs; and
- To collaborate on MDG 7 on Sustainable Environment, including developing and launching the next regional inter-agency report thereon.
- To act together to support strategies and programs defined by the UN Countries teams within these frameworks.

## Pan American Alliance for Nutrition and Development

Dr. Roses presented a proposal for the *Pan America Alliance for Nutrition and Development*

- The Proposal was developed based on experience and recommendations of regional coordination groups in health MDGs (4, 5, & 6).
- She recommended the RDT establish a regional technical group to support and develop guidance for UNCTs.
- She proposed that each country (UNCT) form an inter-sectoral high-level committee to coordinate efforts and strengthen capacity of health and not health sectors.

### RDT AGREEMENT/ACTION POINTS:

- Nominate a group of advisors per agency to be a *Regional Technical Team* to support UNCTs.
- It was agreed that there would be a Chair and Vice Chair/Co-Chair which rotates. For 2008, PAHO would chair this RTT.

This team would support UNCTs in the development of projects for nutrition and development

## Addendum 2

### References:

1. De Henauw S, Matthys C, de Backer G. Socioeconomic status, nutrition and health. *Arch Public Health* 2003; 61: 15-31.
2. Smith GD, Brunner E. Socio-economic differentials in health: the role of nutrition. *Proceedings of the Nutrition Society* 1997; 56: 75-90.
3. Wilkinson R, Marmot M. *The solid facts: the social determinants of health* (2nd. Ed). Denmark. World Health Organization. 2003.
4. Horsley K, Ciske SJ. From neurons to King County neighborhoods: partnering to promote policies based on the science of early childhood development. *Am J Public Health* 2005; 95: 562-567.
5. OMS. Informe final de la comisión OMS sobre determinantes sociales de la salud. Geneva 2008.
6. Greenland S. A review of multilevel theory for ecologic analysis. *Statistics in Medicine* 2002; 21: 389-395.
7. Blankenship KM, Friedman SR, Dworkin S, Mantell JE. Structural interventions: concepts, challenges and opportunities for research. *Bull New Y Acad Sci* 2006; 21: 59-72.



## Chapter 2

# Conceptual Premises and Strategic Principles

### 1. INTRODUCTION

Malnutrition, especially chronic malnutrition and anemia, is a serious public health problem in Latin America and the Caribbean, reflecting the poverty and lack of equity in income and access to basic services that millions endure in our Region. Poverty and inequity also contribute to the coexistence of specific or multiple micronutrients deficiencies such as vitamin A, iodine, zinc, folic acid, and vitamin B-12.

Nearly 9 million children under 5 suffer from chronic malnutrition; (1) in addition, 22.3 million preschool-age children, 33 million women of reproductive age, and some 3.6 million pregnant women suffer from anemia. (2) These disorders are not distributed evenly among or within countries, but especially affect rural populations and indigenous peoples due to the inequities that characterize our Region. Overweight and obesity are growing problems in the Region, where, as part of the epidemiological transition, they coexist with chronic malnutrition and poverty. However, targeting actions to chronic malnutrition and its determinants will make a major contribution to reducing the prevalence of obesity and the risk of chronic diseases in adulthood. Malnutrition, overweight, and obesity are in many cases increasingly visible manifestations of a common underlying cause: poverty and inequity.

The prevalence of low height-for-age in Latin America ranges from 3% (Chile) to 54% (Guatemala). (3) The prevalence rates for this same indicator are 20%, 22%, and 20% among non-indigenous children under 5 in Bolivia, Ecuador, and Peru, respectively; and 40%, 50%, and 45% among indigenous children in those same countries. (4) In Peru, the Demographic and Health Surveys (DHS) from 1992 to 2006 show that the prevalence rates of low height-for-age in rural areas double those in urban areas. (5)

The prevalence of anemia in children under 5 ranges from 14% to 64%, with a Regional average of 39.5%. Among women of reproductive age and pregnant women, the prevalence of anemia ranges from 20% to 64%, with a Regional average of 23.5% and

31.1%, respectively. (6) In the developing countries, iron deficiency is considered the main cause of anemia.

Chronic malnutrition is closely linked with poverty. (7) Data from nine countries in the Region show that 33% of children under 5 in households in the lowest income quintile suffer from chronic malnutrition, compared to only 4.6% in the highest income quintile. (8) The educational level of mothers “explains” some 40% of child malnutrition; only 32.5% of women aged 15 to 49 in the lowest income quintile complete the fifth grade. (8,9)

In addition to poverty, limited access to a healthy environment, adequate housing, safe water, basic sanitation, and timely, good-quality health services are also observed. Studies based on Demographic and Health Survey (DHS) data show that combined interventions in the areas of nutrition, safe drinking water supply, basic sanitation, and the use of clean fuels can reduce mortality in children under 5 by 14%. (10) In several Caribbean countries, HIV/AIDS is closely linked with poverty and inequity and is often a cause of malnutrition.

## 2. BACKGROUND

The initiative for the creation of the Alliance acknowledges that malnutrition and overall health result from the interaction of many factors, some of them associated with individual issues, but many others directly linked to the socioeconomic conditions in which we live. (11,12) The latter category is generically known as “social determinants”. (13) Traditional approaches to malnutrition have targeted individual factors through food and vertical health programs, while downplaying or ignoring the importance of social determinants, which include food security, the conditions of the physical and social environments, education, access to information, maternal and child health, access to health services, family planning, the exercise of human rights and fundamental freedoms, household income, and working conditions. Efforts to correct these reductionist approaches will require simultaneous, coordinated, complementary technical cooperation from all United Nations agencies and other stakeholders committed to the development and well-being of the population.

The Alliance is an interagency initiative that will facilitate the pooling and coordination of international cooperation efforts and resources to promote, agree on, carry out, monitor, and evaluate effective evidence-based, interprogrammatic, multisectoral interventions designed to tackle the multicausal problem of malnutrition. The Alliance will offer opportunities for planning that draws on lessons learned and on the countries’ experiences. The Alliance does not pretend to compete with—much less eliminate, replace, or ignore—other initiatives. Rather, it seeks to build on and strengthen such initiatives by creating an enabling framework to integrate and consolidate efforts and complementary conceptual and strategic values.

Given the current international situation, characterized by an unprecedented economic and financial crisis, health and nutritional status can be seriously affected. Therefore, joint action by the United Nations community to support the countries and governments can make a significant contribution to preserving, insofar as possible, the foundations of development. Accordingly, the creation of the Alliance, with its explicit focus on contextual and structural problems, will prove an invaluable resource for moving beyond the traditional approach that targets only the immediate determinants.

### 3. CONCEPTUAL PREMISES

Low height-for-age is the result of many factors (e.g., improper child care and child-rearing practices, inadequate health care, lack of access to safe water and basic sanitation, repeated bouts of infection throughout the life course, and low levels of education, added to other problems such as food insecurity), which occur simultaneously over extended periods (10). It also is a reliable, easy-to-measure indicator, whose monitoring is standard practice in the health services and the education sector. For these reasons, it is considered a proxy indicator for a population's living conditions and useful for evaluating poverty-reduction policies and programs over the long term.

Poverty and vulnerability maps overlap with the malnutrition map, especially the chronic malnutrition map. In the targeting of scenarios—which is the approach adopted by the Alliance, as opposed to the targeting of individuals—low height-for-age is an optimal tracer of the history of vulnerabilities in a retrospective horizon of several years. The reduction of chronic malnutrition is a sensitive, though nonspecific, indicator of changes in the configuration of its determinants.

Interventions to prevent nutritional problems, especially chronic malnutrition, are effective for a wide range of events and conditions that occur in pregnancy, the first two years of life, and throughout life, as they impact health and human development (through the well-known association between nutrition, health, and development) and have transgenerational effects. (14,15) Although this quality is not exclusive to nutrition, low-height-for-age has the broadest and most visible horizontal intersection with health and development and their determinants than any other condition or indicator.

Moreover, no other condition is as attractive a political symbol for advocacy and for enlisting the involvement of those responsible for designing and implementing public policy.

Finally, successfully tackling malnutrition will require the support of all the agencies. In this regard, the Alliance is especially well-positioned to crystallize into specific action the spirit of reform in the United Nations organizations.

A constellation of known factors operate as social determinants of health, including socioeconomic context, poverty and inequality, social exclusion, socioeconomic status, income, public policies, education, housing quality, transportation, the physical and social environments, and social and community support networks. Clearly, these factors are found at different hierarchical levels. (16) Their influence is not cumulative: some behave as underlying causes while others intermediate, and some modify the effects of others in a causal network whose mechanisms are not well known and are still being debated.

If a child receives stimulation, an adequate diet, and does not get sick, she or he will likely attain his biological and genetic growth and development potential. Whether or not these three conditions are satisfied will, in turn, depend on a dense complex of other conditions that together shape the social determinants of nutrition and health. While providing a child with adequate food and health care are critical, these actions alone are not the most efficient, since they do not address the mechanisms that generate food insecurity and greater vulnerability to disease. This fact, which is true for the individual, is even more so at the population level. The main objective of the Alliance is to reduce malnutrition through a determinants-based approach. However, given the common causality spectrum, actions and interventions to address the determinants of chronic malnutrition will have a positive impact in terms of the reduction of overweight and obesity, and given the known causative relationship between early nutrition and the health of adults, will help reduce the prevalence of chronic diseases

Consequently, if it is recognized that health and nutrition are determined by social factors, the object of the interventions must be not only at the individual level, but also at the physical and social environment that produces and reproduces the individual's health. It is essential to reach beyond interventions that merely target the individual, regardless of the evidence of their success, and consider programs that include these interventions but also incorporate their mutual synergies.

In view of the foregoing arguments, the conceptual underpinnings of the Alliance are:

- a) Formulating approaches that give special priority to modifying the determinants beyond simply mitigating their effects, and concentrating activities not only on individuals, but on highly vulnerable geodemographic areas, including border areas and vulnerable populations throughout the life course.
- b) Replacing the unisectoral approach with a multisectoral one that addresses social determinants and inequalities.
- c) Setting up an appropriate institutional framework to coordinate joint activities at the local, national, transnational, and Regional levels.

- d) Identifying evidence-based, integrated, and sustainable interventions from the various spheres of activity, with a view to formulating, monitoring, and evaluating them in a uniform and unfragmented manner.
- e) Identifying situations and geodemographic opportunities for implementing such interventions.

#### 4. POLICY AND STRATEGY ELEMENTS

Structural interventions are public health interventions that affect the population's health by modifying the structural context in which health is produced and reproduced. (17) The physical and social environments are hierarchical in structure: the home, family, and work group or collective represent an individual's immediate environment, or "microsystem;" the intermediate physical and social environments, or "ecosystem," include the school, community, and health services; and an individual's most distant environment, or "macrosystem," includes the political and economic system, culture, and society. Structural interventions that target beyond the individual should aim at one or more levels of the physical and social environments (ecosystem) and should be based on a type of theoretical model and practical circumstances that apply to each context or scenario.

In public health, structural interventions differ from programming interventions in that they attribute the cause of health problems to contextual factors that influence vulnerability, individual risks, and other determinants of disease and risk profiles, not simply to the characteristics of individuals. People-based approaches assume that the relationship between the person and society includes a wide margin of individual autonomy that allows every person to freely choose among his or her options, while the structural approach assumes that individual actions are limited by external constraints. (17)

It is almost impossible to conceive of pure or radical structural interventions. In practice, structural interventions entail incorporating specific environmental conditions (e.g., political, cultural, geographical, economic, social) into the creation of integrated modular interventions (IMI), derived from the synergies of classical, evidence-based interventions that include those specific structural or contextual conditions.

The Pan American Alliance for Nutrition and Development aspires to become a useful interagency framework for providing technical cooperation to identify, implement, and evaluate integrated interventions that can be adapted to the specific conditions of preselected situations, based on vulnerability criteria or some of its proxies. The nutritional situation will be one of the key variables of the response—but not the only one—to identify and evaluate interventions. In this regard, the purpose of the Alliance is to promote a culture of evaluation, with a view to identifying the most effective and efficient strategies.

The Alliance is an interagency framework of joint integrated action, designed to advance in the achievement of the Millennium Development Goals, especially those closely linked to nutrition (Goals 1, 4, 5, and 7). Moreover, the Alliance is characterized by its innovative approach (based on social determinants), strategy (intersectoral), and targeting criteria (vulnerable geodemographic areas).

In accordance with its essence and the purposes outlined in the preceding paragraph, the Alliance will substantially contribute to:

- Better, more effective interagency coordination.
- Greater integration of mandates and work plans.
- Identification of effective, integrated, multisectoral interventions that address the social determinants and multiple causes of malnutrition and health and, thus, promote development.
- Strengthen and invigorate the strategic frameworks, programs, and initiatives under way.
- Mobilize resources and optimize their efficient use.
- Promote a culture of evaluating interventions.
- Generate evidence-based information and contribute to greater visibility and expanded use of existing platforms in the areas of nutrition, health, and development, as well as their determinants.
- Establish a common language, strategy, and voice to expand interventions within the public policy-making sphere through, on the one hand, the exercise of a defense of the active causes, and on the other, helping to steer country programs toward a multisectoral approach based on social determinants with broad community participation (“scaling-up/scaling down”).
- Establish mechanisms to minimize and mitigate, insofar as is possible, the effects of the global financial and economic crisis on an area as sensitive as nutrition, that will have a short-, medium-, and long-term impact on health and are crucial for ensuring the continuity of development.

## 5. REFERENCES

1. Black RE, Allen LH, Bhutta ZA, Caulfield LE, de Onis M, Ezzati M, Mathers C, Rivera J; Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet*. 2008; 19: 243-260.
2. McLean, E. Egli, I. Cogswell M. de Benoist, B. Wojdyla, D. Worldwide prevalence of anemia in preschool aged children, pregnant women and non-pregnant women of reproductive age. In: Badman, J, Kraemer, K and Simmermann, MB. *Nutritional Anemia*. Sight and Life Press. Switzerland. 2007.
3. Human Development Report 2007/2008. Fighting climate change: Human solidarity in a divided world. United Nations Development Programme (UNDP). New York, 2007.
4. Martínez, R, Fernández, A. Desnutrición infantil en América Latina y el Caribe. *Desafíos. Boletín de la infancia y adolescencia sobre el avance de los Objetivos de Desarrollo del Milenio* 2006; 2: 4-7.
5. Lutter CK, Chaparro CM. La desnutrición en lactantes y niños pequeños en América Latina y el Caribe: alcanzando los Objetivos de Desarrollo del Milenio. Organización Panamericana de la Salud. Washington DC, 2008.
6. WHO Global database on Anaemia. Available at <http://www.who.int/vmnis/anaemia/en/>. Consulted 18 June 2008.
7. Peña, M., Bacallao, J. Malnutrition and Poverty. *Annual Review of Nutrition* 2002; 22: 241-253.
8. Gwatkin, DR., Rutstein, S., Johnson, K., Suliman, E., Wagstaff, A., Amouzou, A. Country Reports on HNP and Poverty. Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries - An Overview. HNP. World Bank, September 2007.
9. Gakidou E, Oza S, Vidal Fuertes C, Li AY, Lee DK, Sousa A, Hogan MC, Vander Hoorn S, Ezzati M. Improving child survival through environmental and nutritional interventions: the importance of targeting interventions toward the poor. *JAMA* 2007; 298:1876-1887.
10. El estado físico: uso e interpretación de la antropometría. Informe de un Comité de Expertos de la OMS. Serie de Informes Técnicos 854. Geneva 1995.
11. De Henauw S, Matthys C, de Backer G. Socioeconomic status, nutrition and health. *Arch Public Health* 2003; 61: 15-31.
12. Smith GD, Brunner E. Socio-economic differentials in health: the role of nutrition. *Proceedings of the Nutrition Society* 1997; 56: 75-90.
13. Wilkinson R, Marmot M. *The solid facts: the social determinants of health* (2nd. Ed). Denmark. World Health Organization. 2003.

14. Huang RC, Burke V, Newnham JP, Stanley FJ, Kendall GE, Landau LI, Oddy WH, Blake KV, Palmer LJ, Beilin LJ. Perinatal and childhood origins of cardiovascular disease. *Int J Obesitu* 2007; 31: 236-244.
15. WHO/NMH/HPS 00.2. Un enfoque de la salud que abarca la totalidad del ciclo vital. Geneva 2000.
16. Berkman LF, Lochner KA. Social determinants of health: meeting at the crossroads. *Health Affairs* 2002; 21: 291-293.
17. Blankenship KM, Friedman SR, Dworkin S, Mantell JE. Structural interventions: concepts, challenges and opportunities for research. *Bull New Y Acad Sci* 2006; 21: 59-72.