Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

55th DIRECTING COUNCIL

68th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 26-30 September 2016

Provisional Agenda Item 7.9

CD55/INF/9
8 July 2016
Original: Spanish

STRATEGY AND PLAN OF ACTION FOR THE REDUCTION OF CHRONIC MALNUTRITION: FINAL REPORT

Background

1. In the 50th Directing Council of the Pan American Health Organization (PAHO), the Member States, through Resolution CD50.R11 (2010), adopted the *Strategy and Plan of Action for the Reduction of Chronic Malnutrition* (Document CD50/13) *(1)*.

2. This plan was developed to accelerate the reduction of chronic malnutrition, establishing six programmatic goals and three regional targets to be reached by 2015, as described below.

3. For the preparation of this report, the Pan American Sanitary Bureau commissioned three studies on the following subjects: *a)* Nutritional situation in Latin America and the Caribbean *(2)*; *b)* Policy mapping of the nutrition and sectoral policies to address malnutrition in Latin America *(3)*; and *c)* Conditional cash transfers and the health and nutrition of Latin American children *(4)*. These reports were based on systematic searches at ministry of health websites and relevant databases on policies, legislative and regulatory frameworks, standards of care, and initiatives to promote healthy eating habits and active lifestyles, as well as the control of obesity and chronic diseases related to nutrition.

Update on the Progress Made Toward the Goals and Objectives of the Plan of Action

Regional goals

4. **Target a:**[1] In the last 20 years, 16 of the countries with available information have managed to reduce the prevalence of chronic malnutrition by an average of 12

[1] ***Target a***: Reduce chronic malnutrition (height-for-age < -2 SD from the WHO reference standard) by five percentage points in children under 5.

percentage points (0.69% per year). In relative terms, the Dominican Republic, Brazil, and Peru have reduced chronic malnutrition by 72%, 66%, and 59%, respectively, in the last 30 years. Despite these achievements, chronic malnutrition is twice as high among children in rural areas and children of indigenous women, and up to 13 times higher among children in homes in the lowest wealth quintile throughout the Region, although in some countries, such as Brazil, the gap has been bridged between these groups and the rest of the population *(2)*.

5. **Target b:**[2] It is estimated that in 2011 the prevalence of anemia in the Region was 44.5% among young children (22.5 million), 30.9% among pregnant women (3.5 million), and 22.5% among women of reproductive age (31.7 million) *(10)*. Current data indicate that anemia has been reduced in some countries among children under 5, women of reproductive age, and pregnant women; however, it has increased in other groups and continues to be a serious public health problem (prevalence ≥ 40%) among children 6-23 months old *(2)*.

6. **Target c:**[3] Overweight and obesity have increased in children under 5, from 3.5% in the 1990s to 7% in recent years *(11)*. The increase in overweight and obesity not only is observed in children under 5, but affects school-age children and adolescents *(2, 12)*. It is estimated that more than 50% of women of reproductive age are overweight and obese (Body Mass Index ≥ 25 kg/m^2) *(2)*.

Objectives

7. Advances have been made toward the objectives, as is described in the table below:

Objective	Indicator	Baseline	Achievement
Objective 1. To develop, strengthen and implement interministerial policies, plans, and programs for nutrition, health, and development that meet the following requirements: *a)* a social determinants approach; *b)* resource allocation; *c)* interministerial coordination and planning; *d)* active national, municipal, and local government involvement; and *e)* surveillance, evaluation, and	**Indicator 1.** Eight countries have approved policies, plans, and interministerial (health, agriculture, education, labor, environment, housing, women, development and finances) programs, with resources allocated to the national, municipal, and local levels for the prevention of chronic malnutrition and the	4 countries	18 countries have established policies or strategies on nutrition and food security that include activities on the environment, water and sanitation, and health and education.

[2] ***Target b***: Reduce the prevalence of nutritional anemia by five percentage points in pregnant women and children under 5.

[3] ***Target c***: Prevent an increase or reduce the prevalence of overweight and obesity.

Objective	Indicator	Baseline	Achievement
accountability of programs and interventions.	promotion of development.		
Objective 2. Incorporate indicators of nutritional status and its social determinants into health surveillance systems that are not limited simply to compiling health information but include the analysis of this information by gender, ethnicity, and geographical area and permit forecasting and the timely prevention of nutritional problems.	**Indicator 2.** Eight countries have up-to-date, timely, reliable, and sustainably obtained information on the prevalence and trends in malnutrition and its social determinants.	4 countries	14 countries have conducted surveillance of nutritional status with data from surveys that collect anthropometric information, as well as data on breastfeeding and anemia, disaggregated by gender, ethnic group, and geographical area.
Objective 3. Increase the number of integrated, intersectoral, evidence-based programs and interventions—rooted in the principles of primary health care renewal, health promotion, universal access, human rights, gender-responsiveness, and interculturalism—in the areas of food, nutrition, health, and development.	**Indicator 3.** Fifty percent of vulnerable are implementing sustainable, integrated, intersectoral programs or interventions in the areas of food, nutrition, and health.	4 countries	Vulnerable municipalities in 18 countries are implementing integrated, intersectoral programs or interventions in the areas of food, nutrition, and health.
Objective 4. Boost the technical/administrative and decision-making capacity of health workers and personnel from other sectors for the implementation of integrated, intersectoral life-course interventions in the areas of food, nutrition, health, and development.	**Indicator 4.** Fifty percent of health workers and personnel from other sectors in vulnerable municipalities trained in the social management of intersectoral programs for the prevention of malnutrition.	4 countries	There were no reports of a system to determine the number of health care providers trained in food and nutrition issues or the social management of these issues.
Objective 5. Achieve women's empowerment and community participation in health and development planning processes.	**Indicator 5.** Fifty percent of vulnerable municipalities have established mechanisms for community participation throughout the planning and	4 countries	19 countries have legally established municipal or community committees on water and sanitation,

Objective	Indicator	Baseline	Achievement
	implementation of their health and development plans.		agriculture, education, development, health, or nutrition and food security.
Objective 6. Establish intersectoral alliances with strategic partners, at the various levels of government, that prioritize nutrition, health, and development in their plans and budgets.	**Indicator 6.** Fifty percent of vulnerable municipalities have established intersectoral alliances with strategic partners and prioritized nutrition, health, and development interventions in their work plans and budgets.	4 countries	Vulnerable municipalities in 18 countries have established intersectoral alliances or coordination mechanisms with strategic partners and prioritize interventions in nutrition, health, and development in their work plans and budgets.

8. **Objective 1:** The number of countries and territories in the Region of the Americas that have established policies or strategies on nutrition and food security that integrate activities on the environment, water and sanitation, health, and education has doubled. Most of these policies are supported by legislative frameworks and regulations that, in addition to establishing the nutrition and food security system, create interministerial coordination entities at the national, departmental, municipal, and community levels. Examples include the National Food and Nutrition Board (CONAN)* in Bolivia; the National Nutrition and Food Security Board (CONSEA)* in Brazil; the Secretariat of the National Policy of Food and Nutrition (SEPAN),* and the Cantonal Councils on Nutrition and Food Security (COSAN)* in Costa Rica; the National Nutrition and Food Security System in Ecuador; the National Nutrition and Food Security Board (CONASAN)* in El Salvador; and the National Nutrition and Food Security System (SINASAN)* in Guatemala, among others. In order to continue advancing, the Member States should prioritize the allocation of resources and strengthen surveillance systems *(3)*.

9. **Objective 2:** During the period, in compliance with this objective, 14 countries monitored nutritional status using data collected through demographic and health surveys or multiple-indicator cluster surveys that collect anthropometric data and information on breastfeeding and anemia, disaggregated by gender, ethnic group, and geographical area. Member States have also incorporated indicators of the social determinants of nutrition in order to target, monitor, and evaluate social protection interventions. Mexico and

* Acronym in Spanish.

Colombia conduct surveys of nutrition in the life course every five years. All countries in the Region have patient medical record systems and report adverse incidents, but only Ecuador, Peru, and Venezuela use the information as part of nutrition surveillance systems. Costa Rica and Guatemala have included obesity and acute malnutrition, respectively, among diseases of compulsory notification. Bolivia, Colombia, Ecuador, El Salvador, Guatemala, and Peru have subnational early warning systems to identify outbreaks of acute malnutrition in geographical areas affected by food and nutrition insecurity or poverty. Thirty-three countries or territories are implementing the Global School-based Student Health Survey to measure and evaluate eating habits and physical activity in young people 13-17 years old. Despite the progress, 24 countries or territories do not have information on the nutritional status of women of reproductive age and children under 5 and, in general, the Region does not have information on the nutritional status of school-age children, adult men, or older adults.

10. **Objective 3:** There was not sufficient disaggregated data to document the number of vulnerable municipalities that have implemented integrated, intersectoral programs or interventions on food, nutrition, health, and development. However, most countries have recognized nutrition or food and nutrition security as determinants of economic and social development, which means that nutritional interventions are among the conditionalities of conditional cash transfer programs. These programs include conditionalities that help increase the use of health services, school enrollment and level of schooling achieved, access to water and sanitation services, and family purchasing power, among others. These programs use poverty or prevalence of chronic malnutrition among children 6-9 years old as criteria for identifying beneficiaries. At present, these programs are implemented in 18 countries of the Region and benefit 129 million people. Among them, the Family Allowance (*Bolsa Família*) program in Brazil, More Families in Action (*Más Familias en Acción*) in Colombia, and Prosper (*Prospera*) in Mexico are noteworthy examples that have been operating for over 10 years. These three programs have been monitored and evaluated in depth, using quasi-experimental designs, and show a positive impact in terms of improved health and nutrition outcomes, especially among the most vulnerable children. Evaluation of these programs has shown that children who receive benefits are significantly taller in the three countries (+ 0.44–1.1 cm), and have better hemoglobin levels in Mexico and higher food security levels in Brazil *(5-9)*.

11. **Objective 4:** An exact count of health care providers trained in food and nutrition issues or the social management of these issues could not be accurately determined. During the period, both the Regional Office and the representative offices in the countries organized, in coordination with the ministries of health and other strategic partners, numerous training, dissemination, and knowledge exchange activities. These include workshops for the review, adaptation, and adoption of WHO growth standards, WHO guidelines for micronutrient supplementation, and design and implementation of monitoring and evaluation systems for food fortification programs. It should also be pointed out that the Member States systematically held training and experience-sharing activities.

12. **Objective 5:** The consulted studies did not report on the number of vulnerable municipalities where women and the community participate actively in health planning and community development processes. However, 19 Latin American countries have legally established municipal or community committees on water and sanitation, agriculture, education, development, health, or nutrition and food security, which are proposing or implementing participatory planning processes at the municipal and community levels. Examples include the Women's City (*Ciudad Mujer*) program promoted by the Social Inclusion Secretariat of El Salvador, which is intended to guarantee Salvadorian women's basic right to sexual and reproductive health, a comprehensive approach to tackling gender violence, economic empowerment, and the promotion of women's rights; and the Community Councils on Urban and Rural Development (COCODE)* in Guatemala, among others *(3)*.

13. **Objective 6:** Vulnerable municipalities in 18 Member States have established intersectoral alliances and coordination mechanisms with strategic partners, leading to the implementation of intersectoral policies and programs that include interventions in agriculture, water and sanitation, education, health, and development. However, no system was identified to determine the number of municipalities where these mechanisms are operating efficiently. In July 2008, the United Nations Regional Directors for Latin America established the Pan American Alliance for Nutrition and Development, which continued until 2012. This effort strengthened the food security groups within UN teams at the national level, as well as intersectoral coordination. Recently, the Scaling Up Nutrition (SUN) initiative has been promoting intersectoral partnerships in Costa Rica, El Salvador, Guatemala, Haiti, and Peru.

Conclusions

14. The Member States made progress in the implementation of interministerial policies, plans, and programs, especially in vulnerable municipalities. Improvements were made in the technical capability of health workers and the formation of partnerships. Community involvement remains to be determined, especially the involvement of women in community planning processes, ensuring the human and financial resources for program implementation, and strengthening food and nutrition surveillance systems.

15. In this period, chronic malnutrition was reduced in all countries, while anemia was reduced in children under 5, women of reproductive age, and pregnant women in some countries. Between the 1990s and 2015, an increase in the prevalence of overweight and obesity was observed, but data to identify changes in the last five years are very scarce. Future challenges include taking a comprehensive approach to the dual burden of malnutrition and overweight and obesity.

* Acronym in Spanish.

Actions Needed to Improve the Situation

16. Recognizing the United Nations' proclamation of the Decade of Action on Nutrition and the progress made by the countries in the implementation of policies and programs, and in the reduction of chronic malnutrition, and given the persistence of anemia as a public health problem and the increase in overweight and obesity, PAHO recommends that the Member States review their policies and programs on food and nutrition in order to tackle the double burden of malnutrition in a comprehensive manner.

17. In this regard, it is necessary to: *a)* strengthen programs for primary health care and extended coverage, emphasizing interventions in the health sector and other sectors that have an impact on nutrition; *b)* promote comprehensive policies and multisectoral action on food and nutrition, respecting cultural differences; *c)* forge strategic alliances with other partners; *d)* revitalize the implementation of policies to protect, promote, and support breastfeeding and complementary feeding, including the International Code of Marketing of Breastmilk Substitutes, the Baby-friendly Hospital Initiative, counseling services and clinical support (when necessary), and maternity protection policies, including policies to protect breastfeeding in the workplace; *e)* promote the sharing of lessons learned among the countries; and *f)* strengthen nutritional surveillance systems and program monitoring and evaluation systems.

Action by the Directing Council

18. The Directing Council is invited to take note of this report and support the formulated recommendations.

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