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STRATEGY AND PLAN OF ACTION FOR THE REDUCTION OF CHRONIC MALNUTRITION

Introduction

1. Population groups at the lower levels of the socioeconomic scale have higher morbidity and mortality rates, and this association is manifested throughout the social hierarchy. The underlying mechanisms are complex and probably differ from country to country and culture to culture. Part of this complexity derives from the fact that socioeconomic status is not a directly observable variable but a multifactorial construct, woven into a framework of physical, environmental, and personal circumstances that interact, mutually impact one another, and tend to be perpetuated intergenerationally.
2. A key component of this framework is nutrition, which is not a simple intermediary factor between the individual and household economy and health, but also plays a causative role of its own in both senses: as a link between the economy and health and as a crucial factor in development.
3. Malnutrition during the preconception period, life *in utero*, childhood, and throughout life course increases the risk of illness and premature death. The earlier malnutrition occurs, the more severe its consequences (1-2). Furthermore, it has a deleterious effect on growth and development and can even blunt the immune response and reduce physical, mental and learning capacity (3). Much more recent, however, and still evolving, is knowledge about the relationship between poor nutrition during critical periods of prenatal and postnatal life and the risk of chronic noncommunicable diseases in adulthood.
4. Short stature in women increases obstetric risk to the mother, and maternal malnutrition affects fetal growth and development, increasing the number of newborns with intrauterine growth retardation and neonatal morbidity and mortality. It is also

associated with a decrease in human capital, lower productivity and individual and group income (4), and higher social expenditure due to avoidable deaths, care and treatment of the consequences of malnutrition, and the cost attributable to years of productive life lost, thus perpetuating the cycle of malnutrition and poverty.

5. Chronic malnutrition, whose marker *par excellence* is low height-for-age, is the result of multiple factors, among which the following must be distinguished: immediate causes, such as maternal malnutrition, poor diet, and repeated infections; underlying causes, such as low levels of maternal schooling, adolescent pregnancy, poor maternal and child care, poor parenting practices, and lack of access to basic sanitation and health services, among others; and, finally, basic causes, such as inequality of opportunities, exclusion and discrimination on the basis of gender, race, or political belief. These factors act synergistically and simultaneously over prolonged periods (5-6).

6. Low height-for-age objectively reflects imbalances in health determinants; it is relatively easy to measure and is part of the routine nutrition and health assessment. Furthermore, it provides a means of evaluating social inequities between countries and regions. It is therefore considered a proxy for the living conditions of the population and a useful indicator for the medium- and long-term monitoring and assessment of policies and programs for poverty reduction. All of these factors make it a useful tool in advocating for the establishment of policies and programs for poverty reduction.

Background

7. This Strategy and Plan of Action for the Reduction of Chronic Malnutrition proposes a series of innovative actions for meeting, in an integrated and intersectoral manner, the commitments made by the Member States to achieving the Millennium Development Goals (MDG), the Health Agenda for the Americas, the World Food Summit, the World Summit for Children, the Convention on the Rights of the Child, and the OAS resolution on Support for Efforts to Eradicate Child Malnutrition in the Americas (AG/RES. 2346 (XXXVII-O/07)). It furthermore strengthens the activities proposed in the Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015 and in the PAHO Strategic Plan 2008-2012, and incorporates the principles of primary health care renewal, health promotion, and social protection. The Strategy focuses on family and community health, gender equality, and interculturalism as its frame of reference and responds to human rights conventions and commitments. The Strategy has the “Faces, Voices, and Places” initiative, the Pan American Alliance for Nutrition and Development for the Achievement of the Millennium Development Goals, and PAHO’s Cross-Organizational Team for Nutrition and Development as its operational entities.

Conceptual framework

8. For operational purposes, chronic malnutrition is defined as height-for-age of more than two standard deviations (SD) below the reference standards of the World Health Organization (WHO), which, excepting a minority of cases attributable to other biological causes, reflects the outcome of the cumulative effect of adverse nutritional, health, and social conditions that have affected or are affecting growth rate.

Principles

- (a) Emphasize the modification of determinants rather than simply addressing their effects.
- (b) Target activities not only to individuals but also to highly vulnerable geodemographic areas, and to reducing inequalities in access.
- (c) Promote a multisectoral approach that addresses social and environmental health determinants.
- (d) Recognize opportunities for intervention throughout the life course.
- (e) Coordinate joint activities at the local, national, transnational, and regional levels.
- (f) Identify integrated, sustainable, evidence-based interventions and formulate, monitor, and evaluate them in a unified manner.
- (g) Ensure autonomy, the exercise of human rights, and social participation.

Evidence and lessons learned

9. There are several successful examples of reductions in the prevalence of population-wide chronic malnutrition achieved relatively quickly through strategies that address social determinants (7) and employ interventions of proven effectiveness in primary health care (8).

10. **Brazil:** Between 1996 and 2006, a dramatic decline in chronic malnutrition (from 13.5% to 6.8%) was achieved in children under 5, and acute malnutrition was virtually eliminated (7). The greatest reduction, from 22.2% to 5.9%, was achieved in the poorest region of the country, the northeast, with significant differences among regions (9). The factors that contributed most to this achievement were, in descending order: improvements in education for women; an increase in purchasing power among the poorest families; greater access to and improved quality of mother and child health services under the Family Health Program; and improvements in water quality and sanitation.

11. **Mexico:** Between 1988 and 2006, the prevalence of stunting fell from 27% to 15.5%. In the south, the poorest part of the country, growth retardation rates fell from 39% to 22%—evidence of a reduction in inequality (10). In 1999, the “Progresa” (“Making Progress”) program, later called “Oportunidades” (“Opportunities”), began to focus on rural and poor communities, with conditional monetary transfers and improved

care for children in the health services and schools. Key elements of the strategy were its targeted nature, the creation of demand for services on the part of the beneficiary population, and the setting up of a surveillance and impact assessment system not only to ascertain the effectiveness of activities, but to justify their continuity through successive governments.

12. **Peru:** During the 1990s, the national prevalence of stunting held constant at around 30%. This apparent “stability” was due to a worsening of the situation in poorer regions and slight improvements in the least poor areas, which reflected existing inequities. In 2004 onward, an analysis of the causes of malnutrition was launched, revealing a lack of maternal schooling, serious basic sanitation and environmental safety issues, adolescent pregnancy, a high incidence of infectious diseases, and food insecurity as the most critical factors. In 2006, with the support of international agencies, the national “CRECER” (“Growing”) strategy was adopted, spearheaded by the President of the Republic and coordinated by the Presidency of the Cabinet. The strategy prioritized districts in extreme poverty, coordinated intersectoral work, fostered regional and local government involvement, and deployed a wide range of interventions targeting the most critical determinants: promoting the registration of all newborns; expanding health services coverage; campaigning for improvements in housing conditions; a literacy program; among others. This combination of interventions achieved a reduction of more than five percentage points in chronic malnutrition in rural areas between 2007 and 2009; moreover, the proposed 2015 goal for infant mortality reduction was reached six years ahead of time.

Situation Analysis

13. An estimated 35% of deaths in children under 5 and 11% of the global burden of disease can be attributed to nutritional deficiencies (*I*). Anemia during pregnancy is associated with 20% of maternal mortality and a 10% loss in personal income throughout the life course and a 2% to 3% loss in gross domestic product.

14. Chronic malnutrition is the most common growth disorder in Latin America and the Caribbean. Nearly 9 million children under the age of 5 suffer from chronic malnutrition (*I*). Furthermore, 22.3 million preschoolers, 33 million women of childbearing age, and 3.6 million pregnant women suffer from anemia (*II*). These are ethically unacceptable figures for a Region whose food production capacity exceeds what would be necessary for adequately meeting the nutritional requirements of its entire population by 30%.

15. The estimated average prevalences of malnutrition mask profound differences between subregions and countries, ranging from 5.6% in Costa Rica to 54.5% in Guatemala (*6*). These differences are also found within countries. Peru having the

greatest internal inequalities, with malnutrition rates of 53% in Huancavelica and 2.1% in Tacna (ENDES 2009). The demographic and health surveys conducted between 1992 and 2006 show that the prevalence of growth retardation in rural areas is almost threefold that of urban areas (40.3% versus 14.2%). That same indicator shows prevalence rates of 20%, 22%, and 20% among non-indigenous children under the age of 5 in Bolivia, Ecuador, and Peru, respectively, and 40%, 50%, and 45% among indigenous children in those same countries(12). A similar scenario is seen with anemia, whose prevalence in children under 5 ranges from 14% to 64%, with a regional average of 39.5%. Among women of childbearing age and pregnant women, prevalence rates range from 20% to 64%, with regional averages of 23.5% and 31.1%, respectively (2).

16. Data for nine countries in the Region show that 33% of the children under 5 living in households in the lowest income quintile suffer from chronic malnutrition, versus 4.6% of those living in the highest quintile. That same study showed that only 32.5% of women between the ages of 15 and 49 in the lowest income quintile complete the fifth grade. According to a multicenter study, 40% of malnutrition in children is associated with maternal education (13). Low levels of schooling also impede the development or acquisition of the abilities and skills required for work, limiting access to decent, well-paid employment.

17. Fetal malnutrition and/or malnutrition in the early years of life is one of the risk factors for overweight, obesity, and chronic diseases in youth and adulthood, which are growing exponentially in the Region, particularly in populations at the lower end of the socioeconomic spectrum (14-16). Studies in Latin America have reported that child stunting and maternal obesity or overweight may coexist in a single household. This overweight is usually due to excessive consumption of energy-rich, nutrient-poor foods, combined with a relative reduction in physical activity.

18. Acute malnutrition (weight-for-height of more than 2 SD below reference standards) is relatively uncommon in the Region. In Haiti, the country with the highest prevalence, 10.3% of children under the age of 5 suffer from acute malnutrition(6). However, the worsening financial, food, and fuel crises, combined with the effects of climate change, may increase the rate of acute malnutrition and its consequences, as recently seen in some countries in the Region.

19. Promoting breastfeeding and complementary feeding can prevent 19% of under-5 child mortality (17). Studies using DHS data show that the combination of interventions aimed at improving nutrition, providing safe water and basic sanitation, and promoting use of clean fuels can reduce mortality in children under 5 by 14% (18). Studies have shown that interventions geared to promoting early development should be synergistic with and complementary to nutritional interventions.

20. High malnutrition rates will lead to significant losses in human capital, have an adverse impact on morbidity and mortality, and increase potential years of life lost to death or disability. They also reduce productivity and entail a high economic and social cost.

Pan American Alliance for Nutrition and Development for the Achievement of the MDGs

21. In July 2008 the Regional Directors of the United Nations agencies established the “Pan American Alliance for Nutrition and Development” (PAND)¹, for the purpose of proposing and implementing comprehensive, coordinated, and sustainable intersectoral programs, within the framework of a human rights and gender-responsive approach, to improve nutrition and health, promote development, and help accelerate achievement of the MDGs. To date, the Alliance is made up of 15 agencies, which together have assembled a regional technical team in charge of coordinating the conceptual and strategic premises of the Alliance, providing technical support for United Nations Country Teams and serving as an advisory body for the Regional Directors Group for Latin America and the Caribbean.

22. The Alliance rests on two pillars: a) the social determinants of health and its inequalities and b) the life-course approach. From these two principles derive its strategy of action, which focuses on determinants and their synergies, with actions in the health sector based on integrated, multisectoral interventions geared to the prevention and control of malnutrition (acute and clinical malnutrition, overweight and obesity, and micronutrient deficiencies) in the earliest stages of life and in highly vulnerable geodemographic areas, coordinated at the local, national, transnational, and regional levels, monitored, and evaluated (1–2).

23. The Alliance proposes simultaneous, integrated, intersectoral interventions in order to improve: a) the physical and social environment of the population; b) access to safe and healthy housing, including permanent access to clean water, basic sanitation, and hygiene; c) education and information, woman and child care, and parenting practices; d) food security; e) access to quality health services, including nutritional interventions of proven effectiveness throughout the life course, as well as the promotion of reproductive health with emphasis on the gestational and pre-gestational period; f) decent work, employment, and income conditions; g) social participation, empowerment, full enjoyment of human rights, fundamental freedoms, a gender-responsive approach, and interculturalism (3).

¹ Pan American Alliance for Nutrition and Development.
<http://www.bvsde.paho.org/texcom/nutricion/alidocen.pdf>.

24. The Alliance is an instrument that allows the pooling and coordination of international cooperation efforts and resources to promote, agree on, implement, monitor, and evaluate effective, evidence-based, multisectoral, interprogrammatic interventions that respond with a multicausal approach to malnutrition. Additionally, it provides an opportunity for planning on the basis of the lessons learned and experience gained in the countries. Furthermore, it seeks to recognize and harmonize 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”, and the “Latin America without Hunger Initiative”, and the Master Plan for Nutrition of the Mesoamerican Public Health System, and to reinforce them, providing a useful framework for integrating and consolidating efforts, as well as some complementary conceptual and strategic values.

Projects of the MDG Achievement Fund

25. The Millennium Development Goal Achievement Fund (MDG-F)² is an international cooperation mechanism whose aim is to fight poverty and accelerate achievement of the Millennium Development Goals (MDGs) through intersectoral, interprogrammatic interventions. To this end, the Fund has eight program areas, one of which—Children, Food Security, and Nutrition—promotes the implementation of integrated interventions aimed at reducing hunger and malnutrition, promoting policies that facilitate access to proper child feeding and nutrition, and strengthening monitoring and evaluation systems.

26. At the country level, programs are implemented by United Nations agencies in cooperation with national and local governments, as well as governmental and nongovernmental organizations. The Pan American Health Organization has provided the Region’s countries with technical cooperation to help them devise and implement projects in the various program areas supported by the Fund. Particularly noteworthy is the Organization’s involvement in eight projects within the scope of the Children, Food Security and Nutrition area, which have helped women and children of different ethnicities living in poverty or affected by food insecurity in eight countries.

27. This Strategy and Plan of Action includes a framework for interventions within the scope of the Fund’s projects; furthermore, its interministerial approach seeks to integrate and heighten the effects of other initiatives and interventions targeting the social determinants of health or geared to the achievement of the Millennium Development Goals.

² MDG Achievement Fund (MDG-F). <http://www.mdgfund.org/aboutus>

Proposal

Strategy

28. This strategy is based on a health determinants approach to the reduction of inequalities and on the life-course approach within the framework of family and community, autonomy, exercise of human rights, a gender-responsive approach, and interculturalism. Its principles are the renewal of primary health care, health promotion, and universal social protection, for which five strategic areas are proposed:

- (a) *Generation and exchange of strategic information and lessons learned for evidence-based decision-making.* Promotes nutrition, health, and social-determinant surveillance systems and accountability systems that help guide intersectoral policies, plans, and programs for preventing malnutrition and fostering development.
- (b) *Advocacy and coordination at the interministerial and interagency level for the development of intersectoral policies and programs.* Targets the highest political level to create the environment needed to establish a suprasectoral coordinating mechanism to coordinate and implement healthy public policies, as well as interministerial plans and programs that help to address the key determinants of nutrition in an integrated and simultaneous manner.
- (c) *Capacity building and strengthening of health systems based on the renewal of primary health care* for the delivery of integrated health services, the achievement of universal coverage, and the implementation of interventions of proven efficacy in compliance with global and regional guidelines.
- (d) *Integration of activities into the family and community.* Promotes the empowerment of women, adolescent girls, and young girls, and the equal participation of women and men from all populations and their families and communities in planning and decision-making, with particular emphasis on addressing social determinants.
- (e) *Mobilization of resources and strategic alliances and partnerships.* Promotes the formation of intersectoral partnerships at the various levels of government, including bilateral and multilateral international cooperation agencies, national NGOs and centers of excellence, as well as the integration of mandates, joint planning, and efficient use of the resources allocated to nutrition, health, and

development policies, plans, and programs, fostering the principles set forth in the Paris Declaration and Accra Agenda for Action.³

Five-year Action Plan

29. *Goal:* Contribute to the achievement of MDGs 1, 2, 3, 4, and 5,⁴ and to the improvement in the health of the peoples of Latin America and the Caribbean throughout the life course, with a multisectoral, multiethnic, multicultural, and gender-responsive approach that fully respects the right to health.

30. *Purpose:* To improve nutrition, health, and development throughout the life course.

31. *Regional Goal for the Americas by 2015:*

- (a) Reduce chronic malnutrition (height-for-age < -2 SD from the WHO reference standard) by five percentage points in children under 5.
- (b) Reduce the prevalence of nutritional anemia by five percentage points in pregnant women and children under 5.
- (c) Prevent an increase or reduce the prevalence of overweight and obesity.

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 accountability of programs and interventions.

³ The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. <http://www.oecd.org/dataoecd/53/56/34580968.pdf>

⁴ MDG 1: Eradicate extreme poverty and hunger.
MDG 2: Achieve universal primary education.
MDG 3: Promote gender equality and empower women.
MDG 4: Reduce the under-five mortality rate. [TN: This is indicator 13. MDG 4 is Reduce Child Mortality.
MDG 5: Improve maternal health.

Goal 1

Double the number of countries that have approved policies, plans, and interministerial programs, with resources allocated at the national, municipal, and local levels, to address the determinants of nutrition and health, emphasizing: education for girls and women; food security; household income and purchasing power; adolescent, female, and mother and child health; and access to healthy housing (air quality, clean water, basic sanitation, and hygiene).

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 promotion of development.

Activities for the Member States

- 1.1 Identify, assess, and rank the role of the main social determinants of nutrition.
- 1.2 Establish a suprasectoral coordinating mechanism that ensures the participation of ministries and national institutions in the development of comprehensive policies and programs in nutrition and development.
- 1.3 Identify, mobilize, and allocate interministerial resources for the implementation of policies, plans, and programs.
- 1.4 Include the fight against malnutrition as a core issue for priority discussion at regional and global summits.
- 1.5 Include that advances made in nutrition and health in presidential reports to the nation.

Activities for the Pan American Sanitary Bureau

- 1.6 Advocate, at the highest political level, for including the fight against malnutrition as the linchpin that integrates social programs.
- 1.7 Provide technical cooperation for the analysis and classification of nutrition determinants.
- 1.8 Provide technical cooperation for joint, coordinated, interministerial planning and the strengthening of decentralized technical cooperation at the local level.
- 1.9 Document and publicize successful experiences.

- 1.10 Advocate for the development of decentralized interagency cooperation, in coordination with national authorities, within the framework of the Pan American Alliance for Nutrition and Development and lead strategic partnerships with bilateral and multilateral agencies.

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.

Goal 2

Double the number of countries that include indicators of nutritional status⁵ and its social determinants in their national health surveillance systems and report biennially on the prevalence of chronic malnutrition, acute malnutrition, overweight, obesity, and anemia in pregnant women and children under 5.

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.

Activities for the Member States

- 2.1 Identify and prioritize, by relevance and timeliness, the indicators for malnutrition determinants.
- 2.2 Add indicators of nutritional status, health, and development determinants to national statistics systems.
- 2.3 Establish mechanisms to ensure the quality, relevance, and timeliness of information collected through health surveillance systems.
- 2.4 Use the information obtained by surveillance systems to devise or reorient intersectoral public policies and programs.
- 2.5 Ensure the sharing, at the national and international level, of information and lessons learned about the prevalence and trends in nutritional and health status and, as well as the analysis of their determinants.
- 2.6 Ensure the sharing of successful experiences at the national and international level.

⁵ Including indicators of breastfeeding, complementary feeding, anthropometric measurements, iron deficiency anemia, vitamin A deficiency, and iodine deficiency, disaggregated by age, gender, place of residence, ethnicity, and income level.

- 2.7 Implement and incorporate external evaluation of programs by independent entities and set up accountability and social audit mechanisms.

Activities for the Pan American Sanitary Bureau

- 2.8 Advocate, at the highest political level, for the inclusion of indicators of nutritional status and its social determinants in national statistical systems.
- 2.9 Provide technical cooperation to identify and prioritize, by relevance and timeliness, the indicators of nutritional and health status determinants.
- 2.10 Give priority to the measurement of height-for-age and weight-for-height as the most important anthropometric indicators for population-wide surveillance.
- 2.11 Provide technical cooperation for the inclusion of indicators of nutritional and health status, and their determinants, in national statistics systems.
- 2.12 Provide technical cooperation for incorporating the analysis of nutrition and health determinants into the formulation and reorientation of intersectoral policies, plans, and programs.
- 2.13 Provide technical cooperation to promote the sharing of information and lessons learned at the national level and between countries.
- 2.14 Provide technical cooperation and spearhead the implementation of program evaluation systems and accountability and social audit mechanisms.

Objective 3

Increase the number of integrated,⁶ intersectoral,⁷ 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,⁸ nutrition,⁹ health,¹⁰ and development¹¹.

⁶ Integrated plans and programs for nutrition, health, and development at the municipal and local level are those that meet the following requirements: a) identification and proposal of interventions acting on social determinants; b) active community and local and municipal government involvement; c) intersectoral and community-wide coordination and planning; d) surveillance and evaluation of programs and interventions; e) resource allocation; and f) strengthening of local management.

⁷ Intersectoral plans and programs are those developed with the involvement of the health, agriculture, education, labor, environment, housing, women, development, and finance sectors, as well as civil society as a whole.

⁸ Proper food purchasing, handling, and preparation practices.

⁹ Breastfeeding and complementary feeding, prevention and management of micronutrient deficiencies, and growth counseling.

¹⁰ Reproductive health, adolescent pregnancy prevention, pregnancy spacing, vaccination, and prevention of infections.

¹¹ Early stimulation; parenting support.

Goal 3

Increase in the number of vulnerable municipios (as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%¹²) that have implemented integrated intersectoral programs or interventions in the areas of food, nutrition, health, and development.

Indicator 3

Fifty percent of vulnerable municipalities, as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%, are implementing sustainable, integrated, intersectoral programs or interventions in the areas of food, nutrition, and health.¹³

Activities for the Member States

- 3.1 The Member States must set objective, concrete goals for the reduction of low height-for-age, low weight-for-age, and nutritional anemia, and must break down these goals at the departmental, state/provincial, or municipal level, bearing in mind that internal gaps must be bridged or, at the very least, not widened.
- 3.2 Develop the ability to design, administer, carry out, monitor, and evaluate integrated interventions in food, nutrition, health, and development.
- 3.3 Mobilize national resources for sustainable implementation of integrated life-course interventions in food, nutrition, health, and development.
- 3.4 Mobilize resources at the municipal and local level for the sustainable application of integrated life-course interventions in food, nutrition, health, and development.
- 3.5 Identify a set of life-course interventions for the promotion of adequate diet, monitoring of growth and physical and cognitive development, and women's, maternal, and child health care as an integral part of development-related programs or interventions (education, food production, water and sanitation, healthy housing, income generation, and social participation).
- 3.6 Establish intersectoral coordination mechanisms at the municipal and local levels for the implementation of life-course interventions that promote adequate diet, monitoring of growth and physical and cognitive development, and

¹² Comprehensive criteria that include the prevalence of low height-for-age and human development indicators shall be used, in accordance with the multifactorial nature of malnutrition.

¹³ The goals for increasing coverage will vary from country to country and region to region and will be set using two basic criteria: 1) the reduction in stunting rates to the levels set by each country, and 2) the achievement of these levels of reduction without increasing inequalities and, if possible, decreasing them.

women's, maternal, and child health care as an integral part of development-related programs or interventions.

3.7 Undertake activities to promote health services utilization.

3.8 Strengthen the response capacity of intersectoral bodies.

Activities for the Pan American Sanitary Bureau

3.9 Provide technical cooperation for capacity building for the management, design, implementation, monitoring, and evaluation of integrated food, nutrition, health, and development interventions.¹⁴

3.10 Engage in advocacy at the different levels to mobilize national resources for the sustainable implementation of integrated food, nutrition, health, and development interventions.

3.11 Provide technical cooperation for the development of a series of integrated interventions to promote an adequate diet, monitoring of growth and physical and cognitive development, and women's, maternal, and child health care as an integral part of development-related programs or interventions.

3.12 Provide intersectoral technical cooperation for any coordination mechanisms established at the municipal and local level.

3.13 Provide technical cooperation for incorporating a life-course, rights-based, gender-responsive, intercultural, and community participation approach into the design and implementation of integrated interventions.

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.

Goal 4

Strengthen the technical and social management capacity of intersectoral human resources programs in the health sector and other sectors working to reduce malnutrition.

Indicator 4

Fifty percent of health workers and personnel from other sectors in vulnerable municipios (as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%) trained in the social management of intersectoral programs for the prevention of malnutrition.

¹⁴ A key component of technical cooperation is the development of goals that have gap reduction as a condition. To this end, the Bureau should capitalize on the experience of countries such as Brazil, which has achieved significant reductions in malnutrition rates and has bridged gaps between geographical areas and populations that previously exhibited striking inequalities.

Activities for the Member States

- 4.1 Develop and finance a national plan for capacity building of human resources in the social management of programs or interventions in the areas of food, nutrition, and health throughout the life-course, including the design, implementation, monitoring, and evaluation of these interventions and their technical and programming content, as well as counseling and direct observation of individuals, their families and their communities.
- 4.2 Develop the response capacity of the health services and of other sectors, in keeping with the priority food, nutrition, and health issues.

Activities for the Pan American Sanitary Bureau

- 4.3 Provide technical cooperation for capacity building of the human resources in the areas of food, nutrition, and health throughout the life-course, including the design, execution, monitoring, and evaluation of these interventions and their technical and programming content, as well as counseling and direct observation of individuals, their families and their communities.
- 4.4 Mobilize interagency resources for training health workers and developing health service response capacity, in keeping with the priority food, nutrition, and health issues.

Objective 5

Achieve women's empowerment and community participation in health and development planning processes.

Goal 5

Increase the number of vulnerable municipios—as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%—in which women and the community actively take part in community health and development planning.

Indicator 5

Fifty percent of vulnerable municipios —as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%—have established mechanisms for community participation throughout the planning and implementation of their health and development plans.

Activities for the Member States

- 5.1 Create municipal entities that ensure the involvement of women and community actors in health and development planning.
- 5.2 Empower communities to take part in plan/program planning and management.

Activities for the Pan American Sanitary Bureau

- 5.3 Provide technical cooperation for the creation of municipal entities that permit participatory health and development planning.
- 5.4 Conduct participatory health and development planning processes in a manner consistent with the UN Convention on the Elimination of All Forms of Discrimination against Women^{15,16} and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (“Convention of Belém do Pará”)¹⁷ and supported by the “Faces, Voices, and Places” Initiative.

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.

Goal 6

Increase the number of 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 municipios, as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%, have established intersectoral alliances with strategic partners and prioritized nutrition, health, and development interventions in their work plans and budgets.

¹⁵ Declaration on the Elimination of Violence against Women. General Assembly resolution 48/104 of 20 December 1993. Available at <http://www.un.org/documents/ga/res/48/a48r104.htm>.

¹⁶ LA ONU Y LA MUJER. Compilación de mandatos, marzo de 2007. Centro de información de las Naciones Unidas para Argentina y Uruguay, CINU Buenos Aires, March 2007. Available at <http://www.un.org/spanish/events/women/iwd/2007/compilacion.pdf>

¹⁷ PAHO – 49th Directing Council. Plan of Action for Implementing the Gender Equality Policy. Washington, D.C.: PAHO; July 15, 2009. (Document CD49/13). Available at http://new.paho.org/hq/index.php?option=com_content&task=view&id=1640&Itemid=1425&lang=en

Activities for the Member States

- 6.1 Promote the establishment of strategic partnerships at the various levels of governance between the public sector, society at large, the private sector, academia, bilateral and multilateral cooperation agencies, etc.
- 6.2 Establish and strengthen links between national and regional projects and initiatives geared to promoting nutrition, health, and development.
- 6.3 Promote joint planning and the integration of budgets, ensuring effective resource use and preventing duplication of efforts.

Activities for the Pan American Sanitary Bureau

- 6.4 Provide technical cooperation to support the establishment of strategic partnerships between the public sector, society at large, the private sector, academia, and bilateral and multilateral cooperation agencies.
- 6.5 Promote and spearhead the establishment of strategic partnerships among these sectors.

Monitoring and Evaluation of the Plan

PAHO shall implement a monitoring and evaluation system to allow the documentation and biennial reporting of progress in the execution of the Strategy and Plan of Action, as measured by the following indicators:

- Number of countries that have developed intersectoral policies to prevent malnutrition and foster development.
- Number of countries that have established interministerial coordination mechanisms for addressing nutrition and development.
- Proportion of health budgets allocated to integrated, intersectoral interventions aimed at promoting food issues.
- Number of countries with up-to-date information and biennial reporting on the prevalence of chronic malnutrition, obesity, overweight, and anemia in children under 5.
- Number of vulnerable municipios—as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess of 15%—that have implemented intersectoral programs or interventions that integrate housing, water and sanitation, agriculture, education, and health to promote nutrition and development.
- Number of countries with human resource training plans in place that prioritize intersectoral interventions for addressing nutrition, health, and development.
- Percentage of health ministry workers at vulnerable municipios—as determined by the extreme poverty rate or by a prevalence of low height-for-age in excess

of 15%—that have received training in the social management of intersectoral programs geared to preventing malnutrition.

- Number of vulnerable municipios—as determined by the extreme poverty rate or a prevalence of low height-for-age in excess of 15%—that have mechanisms at the municipal level to permit the participation of women and other community actors in health and development planning.

Action by the Directing Council

32. The Directing Council is invited to review the Strategy and Plan of Action for the Reduction of Chronic Malnutrition and study the possibility of approving the proposed resolution contained in Annex B.

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Annexes



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CD50/13 (Eng.)
 Annex A

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.9. Strategy and Plan of Action for the Reduction of Chronic Malnutrition

2. Responsible unit: Family and Community Health

3. Preparing officer: Manuel Peña

4. List of collaborating centers and national institutions linked to this Agenda item:

- Professional associations working in health and development
- National Institute of Public Health (INSP), Mexico
- Institute of Nutrition and Food Hygiene, Cuba
- National Nutrition Institute (INN), Venezuela
- National Food and Nutrition Institute (INAN), Paraguay
- Nutritional Research Institute (ICI), Peru
- Institute of Nutrition and Food Technology (INTA), Chile
- Ministries or Secretariats of Health
- Social Ministries or Secretariats
- Ministries of Development
- Ministries of Agriculture
- Ministries of Education
- Ministries of Housing
- Ministries of Trade
- Ministries of Development
- Universities

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

This Strategy and Plan of Action seeks to strengthen the national health authority, address health determinants, increase social protection and access to quality health services, reduce health inequalities between countries and health inequities within them, reduce the risks and burden of disease, and take advantage of knowledge, science, and technology. Specifically, the Plan of Action seeks to develop and implement intersectoral policies and interventions that improve: housing conditions (healthy housing, access to safe water, and proper waste management); the education of women, enabling them to make informed decisions about their health; the availability of and access to a balanced diet that fulfills nutritional requirements; the availability of and access to health services, with an emphasis on primary care, health promotion, and social protection programs; working conditions, family income and purchasing power, and social participation and the exercise of human rights.

6. Link between Agenda item and Strategic Plan 2008-2012:

Strategic Objective 9: To improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development.

Strategic Objective 4: To reduce morbidity and mortality and improve health during key stages of life, such as pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.

Strategic Objective 7: To address the underlying social and economic determinants of health through policies and programs which enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

Strategic Objective 10: To improve the organization, management, and delivery of health services.

7. Best practices in this area and examples from countries within the Region of the Americas:

Brazil: In the Northeast Region of Brazil, the prevalence of low height-for-age (< -2 SD) in children under 5 decreased from 33.9% in 1986 to 22.2% in 1996 and 5.9% in 2006, a rate of one percentage point per year in the first period and 1.6 percentage points per year in the second period¹. The factors that contributed most to this success were, in descending order: improvements in education for women; an increase in purchasing power among the poorest families; expansion of the health services, with greater coverage for mothers and children under the Family Health Program; and improvements in water and sanitation services.

Mexico: Between 1988 and 2006, an 11.5-percentage point reduction in the prevalence of stunting was achieved. In 1999, the “Progresses” program, later called “Opportunities”, began to focus on rural and poor communities, with conditional monetary transfers and improvements in care for children in the health services and schools.

Peru: Between 2006 and 2008, chronic malnutrition rates in rural areas fell by more than six percentage points. The “Growing” strategy prioritized districts in extreme poverty, coordinated intersectoral work, fostered regional and local government involvement, and deployed a wide range of interventions targeting the most critical determinants: promoting the registration of all newborns, expanding health services coverage, campaigning for better housing conditions, literacy programs, etc.

8. Financial implications of this Agenda item:

PAHO cannot execute this Plan by itself. Cooperation with other United Nations agencies and other direct stakeholders is essential for its execution.

The estimated cost of executing the Plan of Action is US\$ 4.6 million per year. This includes maintenance of the current staff, the hiring of additional staff, and the implementation of activities at the regional, subregional, and national level in eight priority countries.

¹ de Lima AL, da Silva AC, Konno SC, Conde WL, Benicio MH, Monteiro CA. Causes of the accelerated decline in child undernutrition in Northeastern Brazil (1986-1996-2006). Rev Saude Publica 2010 Feb;44(1):17-27.



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



50th DIRECTING COUNCIL
62nd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 27 September-1 October 2010

CD50/13 (Eng.)
Annex B
ORIGINAL: SPANISH

PROPOSED RESOLUTION

**STRATEGY AND PLAN OF ACTION FOR THE REDUCTION
OF CHRONIC MALNUTRITION**

THE 50th DIRECTING COUNCIL,

Having reviewed the Director's report, *Strategy and Plan of Action for the Reduction of Chronic Malnutrition* (Document CD50/13);

Mindful of the international mandates emerging from the World Health Assembly, in particular Resolutions WHA55.23 (2002) and WHA56.23 (2003), as well as the commitments by the Member States of the Region of the Americas to meeting the Millennium Development Goals (MDG);

Recognizing the consequences of child undernutrition for physical and cognitive development, immune response, and the risk of illness or premature death, as well as for educational performance and functional capacity, human capital formation, productivity, and individual and collective well-being;

Recognizing the right of children to develop physically, mentally, morally, spiritually, and socially in a healthy and normal manner and with freedom and dignity;

Recognizing that living conditions and undernutrition early in life contribute to the development of overweight, obesity, and chronic diseases (including diabetes, hypertension, and atherosclerosis, and others), with serious consequences for the well-being of the population, the social burden of resulting disability, and the years of productive life lost;

Underscoring that, in the Region of the Americas, the height-for-age indicator is a better reflection of both prolonged lack of access to an adequate diet and the effect of other social factors associated with poverty, and that, with the current trend in this indicator, several countries may not be able to meet target 2 of MDG 1 by the year 2015 and are unlikely to achieve MDGs 4 and 5;

Reiterating that nutrition is a determinant of human development and, at the same time, is affected by a series of social and economic determinants;

Recognizing the high degree of complementarity between this and other strategies, such as the Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015, and OAS General Assembly resolution “Support for Efforts to Eradicate Child Malnutrition in the Americas” (AG/RES. 2346 [XXXVII-O/07]);

Welcoming the conceptual and operational framework for addressing malnutrition (acute and chronic malnutrition, overweight, obesity, and specific micronutrient deficiencies) reached by interagency consensus in the Pan American Alliance for Nutrition and Development (APND),

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action for the Reduction of Chronic Malnutrition and its consideration in development policies, plans and programs, proposals, and the discussion of national budgets to enable the creation of the conditions for preventing chronic malnutrition.
2. To urge Member States to:
 - (a) give priority to intersectoral actions for the prevention of chronic malnutrition;
 - (b) promote dialogue and coordination between ministries and other public institutions, as well as between the public and private sectors and civil society, in order to achieve national consensus on the social determinants and life course approaches to the prevention of chronic malnutrition;
 - (c) propose and implement interministerial policies, plans, programs, and interventions with a view to preventing chronic malnutrition at all levels of government of the Member States;
 - (d) set up an integrated monitoring, evaluation, and accountability system for policies, plans, programs, and interventions that will make it possible not only to determine their impact in terms of reducing chronic malnutrition but the situation of their social determinants and guide timely decision-making;

- (e) put processes in place for internal review and analysis of the relevance and viability of the Strategy and Plan of Action based on national priorities, needs, and capabilities.
3. To request the Director to:
- (a) provide support to the Member States, in collaboration with other international agencies, for an internal analysis of the applicability of the Strategy and Plan of Action and the implementation of activities for its execution;
 - (b) promote the implementation and coordination of the Strategy and Plan of Action, ensuring that it cuts across the Organization's various program areas and different regional and subregional contexts;
 - (c) promote and consolidate cooperation with and among countries, as well as the sharing of experiences and lessons learned;
 - (d) promote the inclusion of independent external evaluations in measuring the reduction of chronic malnutrition;
 - (e) support human resources development and capacity building and the delivery of quality services;
 - (f) promote the establishment of national, municipal, and local partnerships with other international agencies, scientific and technical institutions, nongovernmental organizations, organized civil society, the private sector, and others, employing the integrated interventions agreed upon by the Alliance;
 - (g) report periodically to the Governing Bodies on progress and constraints in the execution of the Strategy and Plan of Action, as well as its adaptation to new contexts and needs.



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CD50/13 (Eng.)
 Annex C

**Report on the Financial and Administrative Implications for the
 Secretariat of the Proposed Resolution**

1. Agenda item: 4.9: Strategy and Plan of Action for the Reduction of Chronic Malnutrition

2. Linkage to Program Budget:

(a) Area of work:

<p>Strategic Objective 9: To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development</p>	<p>RER 9.1.1 RER 9.2.1 RER 9.3.1, RER 9.3.2 RER 9.4.1, RER 9.4.2, RER 9.4.3</p>
<p>Strategic Objective 4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals</p>	<p>RER 4.1.1 RER 4.3.1 RER 4.4.1 RER 4.5.1 RER 4.6.2 RER 4.7.1</p>
<p>Strategic Objective 7: To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches</p>	<p>RER 7.1.1 RER 7.2.3 RER 7.4.1 RER 7.5.3 RER 7.6.1</p>
<p>Strategic Objective 10: To improve the organization, management and delivery of health services</p>	<p>RER 10.1.3 RER 10.1.4 RER 10.2.1</p>

(b) Expected result:

Between 2010 and 2015, will have:

- Reduced chronic malnutrition (height-for-age <- 2 SD) by five percentage points in children under 5.
- Reduced nutritional anemia by five percentage points in pregnant women and in children under 5.
- Prevented an increase or reduced the prevalence of overweight and obesity.

3. Financial implications

(a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities):

PAHO cannot execute this Plan by itself. Cooperation with other United Nations agencies and other stakeholders is essential for its execution.

The estimated cost of executing the Plan of Action is US\$ 4.6 million per year. This cost includes maintenance of the current staff, the hiring of additional staff, and the implementation of activities at the regional, subregional, and national level in eight priority countries.

The Healthy Life-course Project should mobilize resources to increase its budget and ensure that it is able to respond to higher demand that will be generated by this Strategy and Plan of action.

Throughout the planning process, Member States should estimate the costs of implementing the present Plan of Action in their respective countries and make budget adjustments as required.

(b) Estimated cost for the biennium 2010-2011 (estimated to the nearest US\$ 10,000, including staff and activities):

US\$ 4.6 million per year.

- | | |
|---|------------------|
| • Current staff at the regional and national levels | US\$ 2.0 million |
| • Additional national staff in priority countries | US\$ 0.6 million |
| • Support for interventions in priority countries | US\$ 2.0 million |

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities?: US\$ 2.0 million could be subsumed under existing program activities.

4. Administrative implications

(a) **Indicate the levels of the Organization at which the work will be undertaken:**

Chronic malnutrition should be prevented in all the countries of the Region; however, priority is being given to the countries where it is most prevalent (Guatemala, Bolivia, Honduras, Peru, Ecuador, Nicaragua, El Salvador and Paraguay), where the effect of interventions will contribute significantly to its prevention. In Haiti, the approach will be implemented separately, within the framework of response to the current emergency. At the national level, priority is given to the municipios in poverty or extreme poverty and to vulnerable geodemographic areas. Interventions are integrated with other Organization programs.

Coordination mechanisms in support of the Strategy and Plan of Action

- **Regional level:** Pan American Alliance for Nutrition and Development; cross-organizational technical teams; PAHO/WHO Collaborating Centers in the Region.
- **Subregional level:** Institute of Nutrition of Central America and Panama (INCAP).
- **National level:** PAHO, Ministries of Health, agencies of the United Nations System, bilateral cooperation agencies, NGOs.

(b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

Hiring of full-time national consultants to work in the priority countries, who fit the following profile: health professional with academic training in nutrition/public health and experience in: 1) negotiating, developing, and implementing integrated intersectoral policies and programs with a human-rights, gender-responsive, and intercultural approach; 2) developing and implementing information systems that make it possible to monitor nutritional status and its determinants; 3) developing, implementing, and evaluating life-course interventions that help improve health and nutritional status; 4) intersectoral coordination at the local level (housing, environment, education, agriculture, health, work, development) to promote and implement integrated interventions; and 5) applying the principles of primary care renewal to the development and implementation of health, food and nutrition programs and interventions as part of intersectoral approaches.

(c) **Time frames (indicate broad time frames for the implementation and evaluation):**

- | | |
|-----------|---|
| 2010 | Approval and dissemination of the Strategy and Plan of Action, preparation of initial diagnosis |
| 2011-2012 | Implementation, surveillance, and development in four priority countries (4/8). |
| 2013-2014 | Implementation, surveillance, and development in four priority countries (8/8) and expansion to other countries |
| 2015 | Evaluation of the implementation of the Strategy and Plan of Action. |