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METHODOLOGIES FOR THE FORMULATION OF NATIONAL FOOD AND NUTRITION POLICIES AND THEIR INTERSECTORAL IMPLEMENTATION

Final Report of the Technical Discussions

The Technical Discussions of the XXIII Meeting of the Directing Council of the Pan American Health Organization took place on 3 October 1975, at the Headquarters of the Organization in Washington, D.C. The theme was "Methodologies for the Formulation of National Food and Nutrition Policies and their Intersectoral Implementation."

In accordance with the regulations governing the Technical Discussions, Dr. Rogelio Valladares (Venezuela) was elected Moderator and Dr. Jeffrey Wilson (Jamaica) Rapporteur. Dr. Carlos Hernân Daza (PASB) acted as Technical Secretary and the consultants were: Dr. Robert Cook (PASB/CFNI), Dr. Felipe García Sânchez (Mexico), Dr. Carlos Tejada (PASB/INCAP), and Dr. Javier Toro (IAP/NFNP).

The participants decided to remain in one group during the Discussions. Several changes were introduced this year in the manner of conducting these Discussions. The consultants did not, as on previous occasions, make presentations on the theme prior to the Discussions, other than a brief introduction and review by the Technical Secretary of the working document previously distributed to governments, participants and observers. Instead, the participants spoke on the general and particular subjects raised and the consultants then summarized the discussion.

It was pointed out from the very start that particular emphasis was to be placed on the role of Ministries of Health in the formulation and evaluation of these policies and programs, and on their responsibilities with respect to their own sector in the implementation of specific nutritional programs. After a general discussion on the theme, the following questions were put to the participants:

1. What is the role of the health sector in the formulation and implementation of national multisectoral food and nutrition policies and plans?

2. What nutrition programs should be given priority attention in health planning for the prevention and treatment of malnutrition, and is there in the Ministries of Health the necessary infrastructure to carry out these programs?

3. Do programs exist for training of personnel in nutrition, and are these programs in keeping with the real needs of the countries?

4. What are the priorities in food and nutrition research in the light of present needs for formulation, implementation and evaluation of policies and programs?

There was keen participation throughout and 45 contributions were made from the floor by 31 participants. The following are the summary reports of the discussions on the above four questions.

1. With reference to the first question, it was recognized that it is the task of the health sector to exercise the main leadership in the search for solutions to food and nutrition problems affecting large numbers of people, particularly the economically, socially and geographically marginal groups.

The sector exercises its responsibility both directly, through the health services, in activities for the prevention of and recovery from the most prevalent nutritional diseases, and indirectly, by stimulating, advising and guiding the other sectors that help to shape a national food and nutrition system.

The formulation and execution of national food and nutrition policies through coordinated intersectoral action designed to develop and implement programs aimed at increased production and consumption of food in order to meet the biological needs of the population is undoubtedly the catalyst the Ministries of Health need in order to attain the food and nutrition targets that were set by the governments in the Ten-Year Health Plan for the Americas, 1971-1980.

Nevertheless, an analysis of the degree of development of nutrition programs in Latin America and the Caribbean shows that in general they have not yet attained any significant level in national planning and in the allocation of financial resources to the sector.

In addition, the effectiveness of the programs is reduced by the limitations placed on them by the other socioeconomic and cultural factors that affect the health level of the population. In order to change this situation, it is essential for the health services to coordinate their activities with all the sectors that directly or indirectly influence the production, processing, marketing and consumption of foods; otherwise, its activities will continue to have very little effect.

The dynamics of population variables in the Region and the rate of development of agricultural production and other economic activities seem to indicate that the present conditions of undernourishment and malnutrition may worsen unless there are significant economic and social readjustments.

Once we recognize that the factors causing malnutrition operate simultaneously in a number of sectors, we have to envisage the need for coordinated programs ensuring the availability and adequate consumption of food and, at the same time, fostering the prevention, control and treatment of those diseases--especially acute communicable diseases--which interfere with the proper biological utilization of nutrients.

On the other hand, the participation of the health sector in multisectoral nutrition and food programs is identified with its responsibility for the diagnosis and surveillance of the nutritional and dietary status of the population; formulation of recommendations on nutrient requirements and food consumption levels; implementation of specific programs for the prevention, control of and recovery from deficiency and infectious diseases; and the necessary nutritional promotion and orientation of the food production, distribution and consumption plans.

It must be pointed out that modification of the economic, social and political factors directly related to the activities enumerated above depends on the situation in each country and, while that process is going on, large sectors of the population will continue to suffer the consequences of malnutrition, and that the problem is likely to increase in magnitude and to take a toll difficult to justify in human terms.

It must be recognized that the greatest obstacle to the formulation and execution of national food and nutrition plans is the lack of political will to establish the necessary intersectoral coordination. This may be explained by inadequate knowledge of the magnitude of the problem or by failure to recognize its existence, or else because the alternatives for solving it proposed by expert groups are not clearly understood.

Traditionally, little attention has been paid by economists to the microeconomic variables of the problem, while the nutrition experts have focused their analysis almost exclusively on the macroeconomic aspects related to income, unemployment, poor land distribution, etc. It is accordingly important for the two disciplines to achieve a sufficient measure of mutual understanding to enable them to fix priorities which will satisfy the nutritional needs of the population on the one hand and the economic exigencies of the development process on the other.

So long as public health officers do not provide the economists and the technicians of the agricultural sector with appropriate indicators for measuring the magnitude of the nutritional problem, nutritional recommendations for orienting agricultural, livestock and fish production, and an

evaluation of the effectiveness of the programs in course of execution, there will continue to be delays in taking important decisions in the field of food and nutrition to improve the situation.

Accordingly, if there are a number of sectors involved with the problem, they must all contribute to its solution, through a food and nutrition policy in which they participate on a permanent basis. The diversity of sectors thus requires soundly based supersectoral coordination.

In order for the coordination to be effective it is essential for the representatives of the different sectors to have a responsible technical group to prepare the necessary studies for its analysis, propose alternative solutions and provide the backing needed for achieving coherence in the decisions and convergence of the objectives. The other major determinant of the effectiveness of coordination is the political will at the top, which ensures that all the sectors work in agreement and harmonize their activities into a pattern of coherent policies with a common purpose. When this political will is lacking or there is no proper technical secretariat, coordination becomes impossible and fails.

2. As regards the question of which nutrition programs should be given priority in the plans of the health sector, there was general agreement that certain deficiencies are highly prevalent in the countries of the Region and contribute to aggravating the health problems. Particular mention was made of protein-calorie malnutrition in children, which results in high mortality and morbidity rates particularly in those under five years of age; iron and folate deficiency anemias; endemic goiter; and hypovitaminosis A.

The synergism between malnutrition and infections sets up a vicious circle, whose end result can be seen in varying degrees of retardation, often irreversible, in the child's physical growth. Moreover, this nutritional stunting is frequently accompanied by varying degrees of mental retardation, whose characteristics and significance have been pointed out by a number of research workers.

It should also be borne in mind that nutritional status exerts a specific influence on the capacity of the individual for physical work, with respect both to its duration and to its intensity and productivity.

Thus, in view of its role as a factor determining the health level of the population, malnutrition is obviously an important dimension of the overall problem and must be systematically attacked, without limiting it strictly to the health field but on the contrary with due regard to its repercussions on the productivity and well-being of the countries.

Obviously, if the health sector merely deals with malnutrition as a disease, and action is not taken at the same time to promote better levels of income, education and nutrition, there is unlikely to be significant and lasting success in achieving an optimum nutritional status for the entire population.

Generally speaking, it may be said that among the factors external to the health sector which affect the problem of nutrition, the most important are purchasing power, availability and effective consumption of food, and consumer education, whereas within the sector the problem is confined to prevention and control of malnutrition as a disease in itself and as a determining factor in other pathological conditions. The interrelationship between the two areas makes it imperative to seek a solution through complementary efforts based on preventive and curative health activities, including the promotion of good nutrition.

In the light of the present nutritional and dietary situation and the existing problems and restrictions, the following areas should be given high priority in the plans and programs of the health sector:

(a) Strengthening and expansion of nutritional activities in primary health services, as an integral part of family health programs;

(b) Surveillance of the nutritional status of the population, and especially of the groups most at risk--mothers and children;

(c) Measures of intervention for the control of specific nutritional diseases;

(d) Technical and administrative strengthening of feeding services in schools, hospitals, day nurseries, communal undertakings, etc.

(e) Preparation and training in nutrition of the staff of the health services, with emphasis on intermediate-level and auxiliary personnel.

For purposes of the planning and implementation of nutrition programs in the health services, the members of the medical and paramedical team must possess some basic knowledge of nutrition, particularly those directly responsible for the maternal and child care and family health services.

Health programs require nutrition personnel of various categories: some will have primary responsibility and competence in the field of nutrition within the sector, while others will be working in disciplines other than health which are essential for coordinating multisectoral programs. Both categories of personnel should familiarize themselves with the basic concepts of nutrition during their training.

In view of the multisectoral and multidisciplinary nature of nutrition, it is important for the health sector to promote and actively participate in training programs for high-level executive personnel who will be responsible for sectoral planning.

These planning officers may come from public health, economic activities, agriculture, and the social sciences, inter alia, and should have

a broad knowledge of economics, human nutrition and food science so that they can take an active part in the process of planning the economic and social development of the country.

As regards the evaluation of food and nutrition policy, the health sector has a dual responsibility: on the one hand, it must assess the effectiveness of the policy as a whole in terms of how it improves the nutritional status of the population, and on the other hand it must evaluate its own contribution as responsible and participating sector in the implementation of that policy. That evaluation is essential because it will make it possible to identify the changes that may be required in the policy which has been adopted and to establish how the sector's role should be adjusted in continuing the policy.

In the absence of a national food and nutrition policy, the Ministry of Health is in any case responsible for programming the nutritional activities within the national health plan, establishing standards and regulations for the implementation and evaluation of those programs, and promoting the concerted participation of the different sectors contributing to the solution of the food and nutrition problem.

The nutrition units or technical groups participate, together with the professionals working in maternal and child health, communicable disease control, environmental sanitation and health education in planning and coordinating programs, including the prevention, control and treatment of deficiency diseases.

Moreover, the Ministries of Health should establish recommended dietary allowances for the various population groups, including model diets for individuals and groups in the care of the health services, standards for quality control of food and food hygiene, and recommendations for the treatment and prevention of specific deficiency diseases.

The infrastructure required for carrying out the programs will be the same as already exists in the health services of each country.

Obviously, at the central and intermediate levels, there must be the necessary minimum of personnel with specialized training in nutrition (medical nutritionist and nutritionist/dietitian) to cooperate with all the general health personnel in the design, execution, supervision and evaluation of the nutrition program.

With regard to which nutrition programs should be included in primary health care for the rural areas, agreement was reached as to general aspects that should be given consideration.

Although there exist wide differences in magnitude and type of nutritional problems between countries, and even between different areas within each country, the conclusion was reached that these problems call for priority attention in the rural areas.

An analysis of the various multicausal factors responsible for the problems at this level shows the most important to be illiteracy and lack of basic dietary knowledge on the part of the mother, leading to unsuitable choice and distribution of foods at the family level.

These considerations make it imperative to regard nutritional activities as an integral part of the basic functions of the primary health services which have already been mentioned.

Among the specific activities concerning nutrition which the non-specialized personnel of the primary health services should carry out are the conduct of surveys with special emphasis on preschool and school examinations (weight and height) and on dietary habits, and their interpretation for educational and supplementary feeding.

In the treatment of malnutrition, the demand for services that arises must be coped with and those patients who need them referred to the hospitals. In addition, a selection can be made of certain cases that require dietary supplementation.

Particular emphasis should be laid on provision of guidance to mothers concerning utilization of local foodstuffs for supplementary feeding.

Community action should be based on the principle that the staff of the primary health services should carry their activities into the family, the school and the community, using methods and techniques that will enlist the effective participation of the population.

It was recognized that community participation has proved a sound answer in this approach to health care, since the motivation, organization and education of the communities is enabling them to take an active part in programs for nutritional improvement and other activities which raise their health levels.

All community activities should be accompanied by living education, for when we speak of education of adults in the rural areas, we are not concerned with communication of scientific or literacy knowledge appropriate for professionals or middle-class people, but with an education that has its roots in the study of the problems, ideas and aspirations of the actual community, i.e., in life itself, and which helps to solve problems of day-to-day living by translating the knowledge into action.

3. As regards the human resources required for developing nutrition programs, the participants agreed that within the health sector it is the non-specialized personnel, i.e. the physician, the nurse and the health auxiliary, who are the most important and essential for developing such activities, especially those which are carried out through the primary health services. Hence, it is indeed necessary to train all this personnel in the basics of

nutrition. There was also agreement, however, as to the great need for staff specialized in nutrition, at both professional and non-professional levels.

Specific mention was made of the following categories of personnel: (a) medical nutritionist, i.e., a professional physician who had done post-graduate studies in public health and nutrition; (b) nutritionist/dietitian, a university-trained professional with degree-level academic qualification; and (c) nutrition auxiliary, a type of personnel with relatively low qualifications and varying as regards the type of training received.

The last category of personnel is designated by a different name in each country, the most frequent being nutrition auxiliary, assistant or technician.

Among the functions assigned to the specialized professionals (medical nutritionists and nutritionists/dietitians) are those of planning and evaluating food and nutrition programs and also advising and supervising the general health personnel. They are also required, as agents of change, to cooperate in training, both academic and inservice, covering the subjects related to nutrition and diet.

Several of the participants pointed out that the functions of such personnel are not clearly enough understood and defined in some of the countries and that consequently the resource they represent is sometimes underutilized by assigning them direct care duties, with the result that their coverage capacity is greatly reduced and therefore expensive. This occurs particularly in the case of the nutritionist/dietitian.

The nutritional assistant, technician or auxiliary is generally used for carrying out nutrition activities at the level of the primary care services; in some countries, however, this category of personnel has also being given responsibility for counseling and supervising nursing auxiliaries and health and/or community development promotors. Emphasis was nevertheless laid on the danger entailed in the possibility of such personnel being utilized in the implementation of independent and therefore verticalized nutrition programs.

Some participants mentioned the role to be played by the professional nutrition specialist in the development of food and nutrition policies. It was felt that it is part of the intersectoral team which has the responsibility for formulating the policies. These professionals represent the health sector and can be a valuable catalytic factor, providing advice on nutrition to the rest of the multidisciplinary team. The same personnel, again within the framework of food and nutrition policies, is also assigned responsibility for functioning as an agent of training and change, participating in the teaching of nutrition and food at training schools for professionals and technicians of the other sectors involved in the problem area of food and nutrition.

Finally, attention was drawn to the need for medical nutritionists and nutritionists/dietitians, since their numbers are at present still very small. Reference was also made to the importance of making the role of these professionals better known. That role also needs to be adapted to the additional functions which the formulation of food and nutrition policies will entail for them. In the case of the nutrition technician, assistant or auxiliary, stress was laid on the need to train them with due regard to the functions they are required to perform within the food and nutrition programs established and defined by each country.

4. In reference to present research priorities in food and nutrition, in the last twenty-five years basic nutritional science has developed a great deal. There is much more knowledge than there was before, for example, of nutrient requirements or the physiopathology of protein-calorie malnutrition. It is impossible ever to say that there is enough knowledge, but at least one can say that there is more knowledge than seemingly can be applied. This is the problem, the application of present knowledge to present problems, and therefore this is where the main emphasis of nutrition research in the next decade should be directed.

National nutrition surveys in the past have usually failed to provide to those responsible for national policy and programs the facts which can be used to make choices between alternative actions. They have usually, at one point in time, taken a still photograph, so to speak, not very well-focused, of the situation as it was, showing how much malnutrition existed, of what kind, and recounting what were the average levels of food consumption both as foods and translated into nutrients. However, there has often been a failure to describe how and why there is malnutrition; and data have usually been presented as national averages, which can be very misleading when there is unequal distribution of resources.

There is great need to develop the capability to produce simple, specific, objective indicators of the food and nutrition situation. These indicators are: biological, socioeconomic, of food availability, and of food consumption. Moreover, its use must not be limited to once in a long period of time but must be provided regularly, so that there is continuous surveillance of the situation.

National averages are not enough. It is necessary to show what is happening in different parts of the country, and above all in the different income groups. It is this latter information which gives to the politician and the planner the additional knowledge with which to make choices, for it often illustrates the great differences between classes, and illustrates precisely the importance, sometimes unexpected importance, of certain basic foods in the socioeconomic groups in which malnutrition exists.

The second major priority in research is evaluation of nutrition interventions. This is needed both at national or regional level, and at the

level of family and community. However, on the large scale this is no more than to say that food and nutrition policies must be formulated and programs to implement them, and the cost and the effects of these programs must be continuously evaluated.

At the level of the family or community, the evaluation of nutrition interventions (e.g., nutrition activities in primary health services) is an area both of considerable need and also sometimes of difficulty, because when such evaluations are made they are often not made in the best way. The proper people to evaluate the cost and effectiveness of a program are the people who are carrying it out, since the objective is to learn how to do it better. Therefore, a high level of sophistication is not usually required. Instead, prudence and objectivity are necessary as well as common sense. If this is not done, then judgments cannot be made as to how to make programs more effective, nor even whether to continue them or not.

Lastly, certain priorities in food and nutrition research are acknowledged which relate to the balance between food and population in the last quarter of this century, and these are: research to find new sources of food, research to increase the nutritive value of existing foods, and research to use for feeding livestock agricultural byproducts now wasted.

To sum up the general feeling of the participants in the Technical Discussions, the following conclusions can be reached:

(a) There is a need for the health sector to participate actively in the promotion, formulation and execution of national food and nutrition policies and plans;

(b) The services should carry out nutrition activities as an integral part of the family health programs at the various levels of the health structure; and

(c) In the extension of the coverage of the primary health service, nutrition should be an essential component of activities for the promotion, protection and restoration of health.