Landscape Analysis on countries' readiness to accelerate action to reduce maternal and child undernutrition: The Peru Assessment

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Nutrition situation in Peru

In Peru, like all other countries in the region of Latin Americas and the Caribbean, stunting is the most prevalent growth problem among children. The most recent nationally representative Demographic and Health Survey in 2004, analyzed using the new WHO Child Growth Standards, showed that 30% of Peruvian children under the age of five years are stunted (Lutter and Chaparro, 2008). However, this national estimate masks enormous regional differences, which range from 6% in the best-off areas to 60% in the poorest. Stunting is three times higher among children whose mothers speak Quechua compared to children of mothers who speak Spanish. Stunting is also higher among children whose mothers speak Aymara or other indigenous languages compared to children whose mothers speak Spanish.

A recent comprehensive analysis of nationally representative surveys over the past 15 years shows that the gap in stunting between children living in poverty versus those living in better conditions has not been reduced (Lutter and Chaparro 2008). Changes in the prevalence of stunting with regard to level of maternal education show that in 1992 the prevalence of stunting among children of mothers with post-secondary education was 9% compared to a prevalence of 65% in children of mothers with no education; a gap of 56 percentage points. In 2004, 14 years later, the gap remained virtually unchanged (6% among children of mothers with post-secondary education vs. 62% among children of mothers with no education). Between 1992 and 2004, the prevalence of stunting decreased by roughly 8 percentage points, or 0.6 percentage points per year. However, most of the decrease occurred between 1992 and 1996; thereafter very little reduction has occurred. The high prevalence of stunting of 30% is particularly striking when compared to the much lower prevalence of underweight of 6%, which translates into five children who are stunted for every child who is underweight. Weight-for-age stabilizes at approximately -0.5 Z-scores; however, length-for-age stabilizes at approximately -1.5 Z-scores. As a result of the difference in Z-score between weight and length, weight-for-length Z-scores are positive, ranging between 0.5 and 1.0 Z-scores. Thus, the “average” Peruvian child is short and “chubby”.

The prevalence of anaemia is very high and affects 44.5% of children 6 to 59 months of age. Among children aged 6 to 24 months, nearly 3 in every 4 are anaemic (PAHO 2009). The highest prevalence is in children 10 to 11 months of age, where the prevalence is 83%. Between 1996 and 2004, the prevalence of anaemia declined twelve percentage points.

Country assessment in Peru: methodology

The Peru Landscape Assessment was carried out August 25-29, 2008 by a national team which included representatives from both UNICEF and PAHO/WHO and an international interagency team represented by WHO and PAHO. The international team together with the members of the national team visited two different field locations in addition to the assessment at the national level. The team members and a list of institutions and persons contacted to conduct interviews and assessment are described in detail in the mission report.

During the assessment, briefings were held with the First Lady, the Vice-Minister of Health, the Director of Strategies CRECER and JUNTOS1, and government officials from various ministries and sectors including the National Food and Nutrition Centre (CENAN2) and Health Promotion in the Ministry of Health and officials in the Ministry of Economics and Finance. Interviews and meetings were conducted with representatives of UN Agencies (UNICEF, WFP and UNFPA), the bilateral agency USAID; and a number of non-governmental organizations (CARE, PRISMA, Agencia Adventista para el Desarrollo y Recursos Asistenciales (ADRA), Caritas, Future Generations and the Institute for Investigation in Nutrition (IIN). The Team also met with representatives of the Mesa de Concertación para la Lucha Contra la Pobreza.4 Key stakeholder interviews and assessment were

1. See Box 1 describing CRECER and JUNTOS; 2. National Food and Nutrition Centre (CENAN); 3. Future Generations.
conducted in Ayacucho in the central mountains and Piura along the northern coast. Interviews were held with stakeholders (health, economic development) at the regional level and with health providers at the district levels. The main themes and findings from the assessments were presented and discussed at a stakeholder meeting presided over by the Vice Minister of Health.

Observations

Assessment of the commitment to scale-up nutrition actions

The Government of Peru is committed to reducing the prevalence of stunting by 9 percentage points. This commitment resulted from the Initiative to Reduce Child Malnutrition, an alliance of thirteen UN, bilateral and non-governmental organizations, including the Pan American Health Organization, that advocated for the placement of stunting as the most important problem preventing economic and social development in Peru. As part of their advocacy effort, they invited all presidential candidates to sign a commitment to reduce stunting if elected. President Alan Garcia signed this commitment and, when elected, placed the reduction of stunting as the key goal of his government’s social policies. The main strategy to implement this commitment is CRECER. The many examples of this high level political commitment include, but are not limited to, the following items:

- Legal frameworks, such as the Macroeconomic Framework of 2009-2011, which includes the reduction of malnutrition as a key social and economic objective and establishes the goal of reducing the prevalence of chronic malnutrition by nine percentage points between 2005 and 2011, and two supreme declarations that prioritize both investments in nutrition and interventions to reduce chronic malnutrition and improve maternal and neonatal health.
- Normative frameworks, such as the creation of CRECER and a list of priority maternal-child health services.
- Operational frameworks, such as budgeting for results, expansion of JUNTOS, assignment of medical students to priority districts, improved information systems for monitoring and evaluation, and the identification of 880 districts for priority action
- Programmes that include the Articulated Nutrition Program, the Maternal-Neonatal Health Program, and the Integrated Nutrition Program, among others.

There were very few observations with respect to weaknesses in the willingness to act. The primary one observed was that in some districts CRECER was seen as an element of the current government rather than a long-term institutionalized non-partisan initiative and therefore concerns were raised as to its sustainability under a subsequent government.

Assessment of the capacity to scale-up nutrition actions

The National Strategy against Child Malnutrition CRECER is an example of the national governments ability to act. This Strategy seeks to coordinate the different sectors that can contribute toward the reduction of childhood malnutrition at the national, regional, and district levels. JUNTOS, a government sponsored conditional cash transfer programme to the poorest sector of the population, seeks to improve resources at the household level and to increase utilization of health and nutrition services and educational opportunities. Field visits to Piura and Ayacucho confirmed that the national commitment to focus on reducing chronic malnutrition had reached the local level. Legal, normative and operational frameworks had been developed. Regional and district level CRECER committees had been formed, budgets committed, and personnel recruited for this task. Similar to the national level, specific targets for the reduction of chronic malnutrition had been set at the regional level. The Ministry of Health had organized networks to coordinate actions in the districts and communities. Health centres and posts appeared to be equipped with measuring boards and scales, as well as vitamin A capsules and iron for children and pregnant women.

The many NGOs and UN Agencies working in Peru possess a wealth of expertise and ground-breaking experiences in reducing undernutrition. The Initiative Against Infant Malnutrition is a particularly important example of how non-governmental stakeholders can come together to influence government action. This Initiative is made up of thirteen institutions from NGOs, UN Agencies, research centres, and mixed government-civil society entities. During the political campaign leading up to the last election, the Initiative worked to call attention to the problem of
undernutrition, its causes and consequences, and reasons why efforts to date had not been effective. At the same time, it identified a number of successful interventions that could be scaled up. The Initiative was successful in getting the majority of the presidential candidates, including the current President, to sign a commitment to reduce stunting by five percentage points. Once elected, the President was presented with his signed commitment and asked 1) to make the reduction of stunting a government priority; 2) to request that the Council of Ministers coordinate the fight against stunting among different sectors and programmes, assigning clear goals and responsibilities; and, 3) to present a Presidential report each year outlining the actions taken. The Initiative also made a number of concrete recommendations for the first 100 days of the new government in 2006 and again in 2008. It issued a report on the actions the government has undertaken to date and a series of recommendations on issues still needing to be addressed. The different organizations that make up the Initiative have also provided technical cooperation and capacity building support to the government at the national, regional and local levels in the implementation of the CRECER national strategy.

Nonetheless, the team also noted some weaknesses that could reduce the potential effectiveness of the government’s ability to act. The weaknesses articulated at all levels (national, regional and local) concerned the lack of coordination between different sectors and stakeholders and the capacity to plan, budget and execute programmes at the local level. Although the government is promoting the model of Budgeting for Results in the health sector, there is little capacity at the local level to budget in this manner and there does not appear to be an operational plan to develop this capacity.

In addition, at the regional and local level the following weaknesses were noted:

- In Ayacucho, the operation of the Regional CRECER Committee struggled with the fact that many members of the Committee reported to the national level rather than regional level and, therefore, didn’t always share the same objectives and mandates.
- District level CRECER Committees functioned where outside technical assistance from NGOs was available to support the development of operational plans, but this assistance was not available to all districts.
Although lack of resources was not identified as a key problem, the inability to programme and execute these resources was noted. There exists a gap between planners and executors, and there is a need for technical assistance in logical frameworks and budgeting for results.

Regional Ministry of Health officials identified resource constraints and labour problems, particularly strikes and staff turnover, as weaknesses. In health centres, preventive actions were separated from those related to curative care and medical personnel did not necessarily think that they were responsible for nutritional assessment and counselling. Lack of knowledge of counselling techniques was also cited as a problem. There was revealed to be a need for a new kind of health professional who understands how to organize the community to improve health and nutrition outcomes.

While it cannot be stated with certainty that the failure to address these weaknesses will result in the inability to reach the government’s stated goal of reducing stunting by nine percentage points, the probability that the goal will not be reached is increased. Addressing these weaknesses, in addition to facilitating the attainment of the stated goal, will also result in many other benefits related to improving the efficiency and effectiveness of government resources and the well-being of Peruvian children.

**Recommendations and next steps**

A draft of the recommendations listed below was developed by the international team after the assessment was completed. They were presented at the final stakeholders meeting, and as a result of the ensuing discussions, some modifications were made. Therefore, the recommendations discussed in detail below and summarized in Box 2 are final.

1. **Strengthen the capacity to plan, budget and execute programmes at the local level.** While lack of resources was not seen as a major problem at the local level, the capacity to plan, budget, and execute programmes and to budget for results was seen as a major challenge. An operational plan is needed for continuous technical cooperation with regional and local governments, including development of skills in planning and budgeting, as well as the execution, monitoring and evaluation of nutrition-related interventions. Specific actions could include the development of modules for capacity development (both virtual and traditional); formation of travelling teams to provide training, and exchange experiences among districts. This is the responsibility of both the Ministry of Health and the Ministry of Economics and Finance as successful implementation of nutrition-related policies and programmes requires successful planning, budgeting, and execution. In addition, it is important to ensure that information about the execution of local budgets maintained by the Ministry of Economics and Finance is available at all levels.

   An important aspect of strengthening the capacity to plan is the use and interpretation of data on child nutrition and its determinants. In this regard, support to regions and districts in the use and interpretation of data for information generated from Informed Decisions is necessary. It would also be helpful to agree on a simple model, adapted for different audiences and decision makers, which can be used to present all survey results of undernutrition and its determinants. Technical support to regions and districts conducting their own baseline surveys is also needed.

2. **Provide technical assistance for the establishment and operational success of local CRECER committees.** All regional and local governments should be supported to establish CRECER committees and prioritize the reduction of stunting. Technical assistance is needed to develop local plans of action, budget by results, and to improve management. An incentive system should be developed to encourage and reward efforts to reduce stunting. To the extent that data permits, local targets for the reduction of chronic malnutrition should be set.

3. **Promote the integration of nutrition interventions with health interventions.** The capacity for nutrition actions among health workers needs to be developed, while also advocating for all health workers to incorporate nutrition actions in their services to mothers and children. A major weakness observed was the apparent separation of child nutrition actions provided as part of the government’s health services from curative services, and a lack of ownership by physicians of these actions. Improving infant and young child nutrition must be a priority for all health personnel—and not limited to the domain of nutritionists—and health workers must have the technical knowledge and skills needed to assess growth, and to counsel in breastfeeding, complementary feeding, and household hygiene.

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1. Informed Decision is an initiative developed by the Ministry of Health involving small scale surveys to help with local decision making.
Cost-effective interventions identified in the Lancet series on Maternal and Child Undernutrition (Bhutta et al 2008), such as treatment with zinc during diarrhoea, need to be incorporated into national norms. For both pregnant women and children, actions need to be taken to improve the coverage of micronutrient supplements, and in particular iron. Messages about complementary feeding and child health need to be harmonized among the different sectors and stakeholders so that mothers/caregivers receive consistent information.

4. Strengthen nutrition coordination and leadership across sectors and at all levels and clarify the roles and responsibilities of different actors. While nutrition coordination at the national level is strong and leadership assured, specific roles, responsibilities, and coordination mechanisms need to be defined at regional and local levels. Given the large inter-regional variation in stunting prevalence, regional targets should be set and process indicators established to define progress.

5. Develop a national communication strategy to promote CRECER and the Fight Against Child Malnutrition. A sustainable programme is difficult to build if the communities benefiting from it do not see the programme as serving their own interests and needs. This requires that the population of Peru, particularly the rural poor and indigenous population, views stunting as a problem limiting the growth and development of their children and communities and understands the main aspects of its causes and solutions. In this regard, the implementation of a communication strategy appealing to the commitment of the population for reducing stunting is important. In addition, the programmes Maternal-Neonatal Health, Articulated Program in Nutrition, Integrated Program in Nutrition and budgeting for results need to be socialized among all Regional Ministries of Health. User-friendly communications materials based on the Lancet series that include the window of opportunity for preventing growth retardation and cost-effective interventions should be developed and disseminated.

6. Strengthen the quality of services and increase funds for child nutrition activities. To respond appropriately to an increased demand for services in health and nutrition generated by the JUNTOS programme, it is necessary to improve the quality of such services, allocating appropriately trained human resources as well as supplies and equipment as needed. Insomuch as the population most affected by poverty and malnutrition lives in rural areas, these areas should be prioritized.

It was noted that while most of the recommendations from the international team have been or are being implemented by national, regional and local governments, they require a public audience broader than the health sector and should therefore be disseminated to other relevant ministries, including the Ministry of Economics and Finance. The opportunity to have, through the Landscape Analysis Country Assessment, the advances made by Peru in the fight against stunting highlighted in the international community was seen as important and useful. However, the need for continued support from international organizations at this stage was stressed.

All agreed upon the need for a good communication strategy in order to ensure that the population of Peru, particularly the rural poor and indigenous population, also sees stunting as a problem and understands its causes and solutions. A sustainable programme is difficult to build if the communities receiving it do not see it in their own interests.

Follow-up Actions

The Landscape Analysis has resulted in a number of follow-up actions designed to strengthen nutrition actions for pregnant women and young children, summarized as follows:

- Initiation of supplementation with microencapsulated micronutrient powder in three priority regions where CRECER is actively working (Ayacucho, Apurimar and Huancavelica). This project is being carried out by the Ministry of Health in collaboration with the Ministry of Women’s Affairs and Development, PAHO/WHO, UNICEF, and the World Food Programme, as well as with other institutions such as the Institute for Investigation in Nutrition and the World Bank.
- Initiation of a comprehensive evaluation of food assistance programmes (Glass of Milk, Integrated Nutrition Program, School Feeding Program, etc) and their reformulation in the context of decentralized social programmes.
- Legislative approval of a law for Universal Health Insurance (Aseguramiento Universal en Salud), which guarantees access of the entire population to basic cost-effective health services recommended by the Lancet. Among these basic health services are many related to nutrition.
Advances in the Strategy CRECER to peri-urban poor areas, where a large proportion of stunted children live.

Coordination by the Ministry of Health, Pan American Health Organization, UNICEF and the World Food Programme of a major regional meeting on infant and young child feeding and nutrition (PAHO/WFP/UNICEF 2009). This meeting was attended by teams from the Ministries of Health throughout South America, including a large Peruvian delegation from all regions.

Conclusion

The Government of Peru has placed the fight against child malnutrition at the top of the political agenda and invested resources accordingly to address both the determinants of malnutrition and to improve the delivery of nutrition interventions through health services. The country has highly educated and skilled political and technical leadership to implement policies and programmes. This effort is supported by United Nations, particularly the country office of the Pan American Health Organization, and a number of other non governmental organizations. The Landscape Analysis country assessment validated the important work being done by the stakeholders in Peru, provided an opportunity for self-reflection, and identified areas where current actions could be strengthened.

References


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Box 2: Summary of recommendations

1. Strengthen the capacity to plan, budget and execute programmes at the local level.
2. Provide technical assistance for the establishment and operational success of local CRECER committees.
3. Promote the integration of nutrition interventions with health interventions.
4. Strengthen nutrition coordination and leadership across sectors and at all levels and clarify the roles and responsibilities of different actors.
5. Develop a national communication strategy to promote CRECER and the Fight Against Child Malnutrition.
6. Strengthen the quality of services and increase funds for child nutrition activities.

VACANCY ANNOUNCEMENT:

WHO Roster of qualified and experienced nutritionists with public health background

A roster of CVs is being established. Candidates with nutrition qualifications and at least five years experience in international public health nutrition are welcome to submit their CVs to nutrition@who.int. The roster is open and candidates will be contacted directly by the interested Regional and Country Offices.

In order to better respond to increased global challenges WHO has committed to strategic nutrition repositioning and refocusing. Priority functions are the development and operationalization of integrated food and nutrition policies, the intelligence of needs and response, the development of evidence-based programme guidance and the advocacy for nutrition in the context of the global and regional health policy fora.

Currently, approximately 50 staff are involved in nutrition activities in headquarters, regional and country offices and about 80 additional staff dedicate some time to nutrition-related work. In order to further strengthen capacities at regional and country level WHO is looking for qualified and experienced nutritionists with public health background.

Specific Vacancy Notices appear in the WHO e-recruitment web site www.who.int/employment/vacancies/en