Malnutrition in Peru
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Problem

• Malnutrition today:
  • 10% in urban regions.
  • 30% in rural regions.¹
• In 1993, 48% of children were malnourished.²

Causes

• Children are not receiving adequate nutrients or adequate breastfeeding.
• Breastfeeding is becoming less and less popular.
• There is a lack of access and knowledge of nutritious foods.
• Lack of maternal education is a contributing factor.³

Consequences

• Stunting: 50% of Andean children experience stunting.⁴
• Infant mortality: 2/3 of these deaths are attributed to malnutrition.⁵
• Vitamin deficiencies: anemia is the most common.
• Diarrheal diseases.⁶
• Poor performance in school and other activities.

Programs

Complementary Feeding Programs

• There is a lack of proper nutrients with complementary feeding during breastfeeding.
• ProPAN is a research program that identifies nutritional and dietary problems and suggests combinations of foods that would satisfy nutritional requirements using local foods.⁷
• Optifood is a computer based program that collects data on what foods are being fed to children, gives recommended nutrient intakes, and identifies the lowest cost but nutritionally best diet.⁸

Child Nutrition Education Program

• The Integrated Management of Childhood Illness (IMCI) has identified nutrition education as a way to achieve the goal of improved breastfeeding and complementary feeding practices. They implemented an intervention in Trujillo, Peru.
• The intervention promoted nutrition messages, counseling, and demonstrations of preparing nutritious complementary foods.⁹

School Breakfast Programs

• FONCODES, the National Compensation and Social Development Fund, provides a daily breakfast with the majority of daily nutrients to 500,000 children throughout Peru.²
• In 1993, the Instituto de Investigacion Nutricional in Lima provided a ready to eat breakfast that would satisfy a child’s daily vitamin and mineral requirements.⁸

Results

• The use of ProPAN and Optifood to recommend effective complementary feeding practices has promoted community kitchens that prepare recommended foods. The community kitchens have helped reduce anemia.⁷
• In Trujillo, children in the intervention area gained more weight than children in non-intervention areas. Stunting was reduced to 4.7% and the infant mortality rate decreased to 7.3 deaths per 1000 children in the intervention area.⁹
• School breakfasts have caused anemia to drop from 66 to 14%. There is an increase in school attendance with lower dropout rates. Verbal skills have also improved. The government has decided to continue its funding for these breakfast programs.⁴

References


Table IV-2. The monitoring and evaluation conceptual framework: An example from a Peruvian program (Cred-Kanashiro & et al., 1998).

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<thead>
<tr>
<th>Program</th>
<th>Impact</th>
<th>Benefits</th>
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<tbody>
<tr>
<td>Training of “community kitchen” cooks</td>
<td>Increased consumption of chicken liver at “community kitchens” by women and children</td>
<td>Reduced prevalence of iron-deficiency anemia among women and children</td>
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<tr>
<td>Adequate supplies of chicken livers provided three times weekly to women and children attending “community kitchen”</td>
<td></td>
<td>Improved learning and work capacity</td>
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Monitoring Evaluation

| Chicken livers provided three times weekly to women and children attending “community kitchen” | Adequate supplies of chicken livers provided three times weekly to women and children attending “community kitchen” |

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