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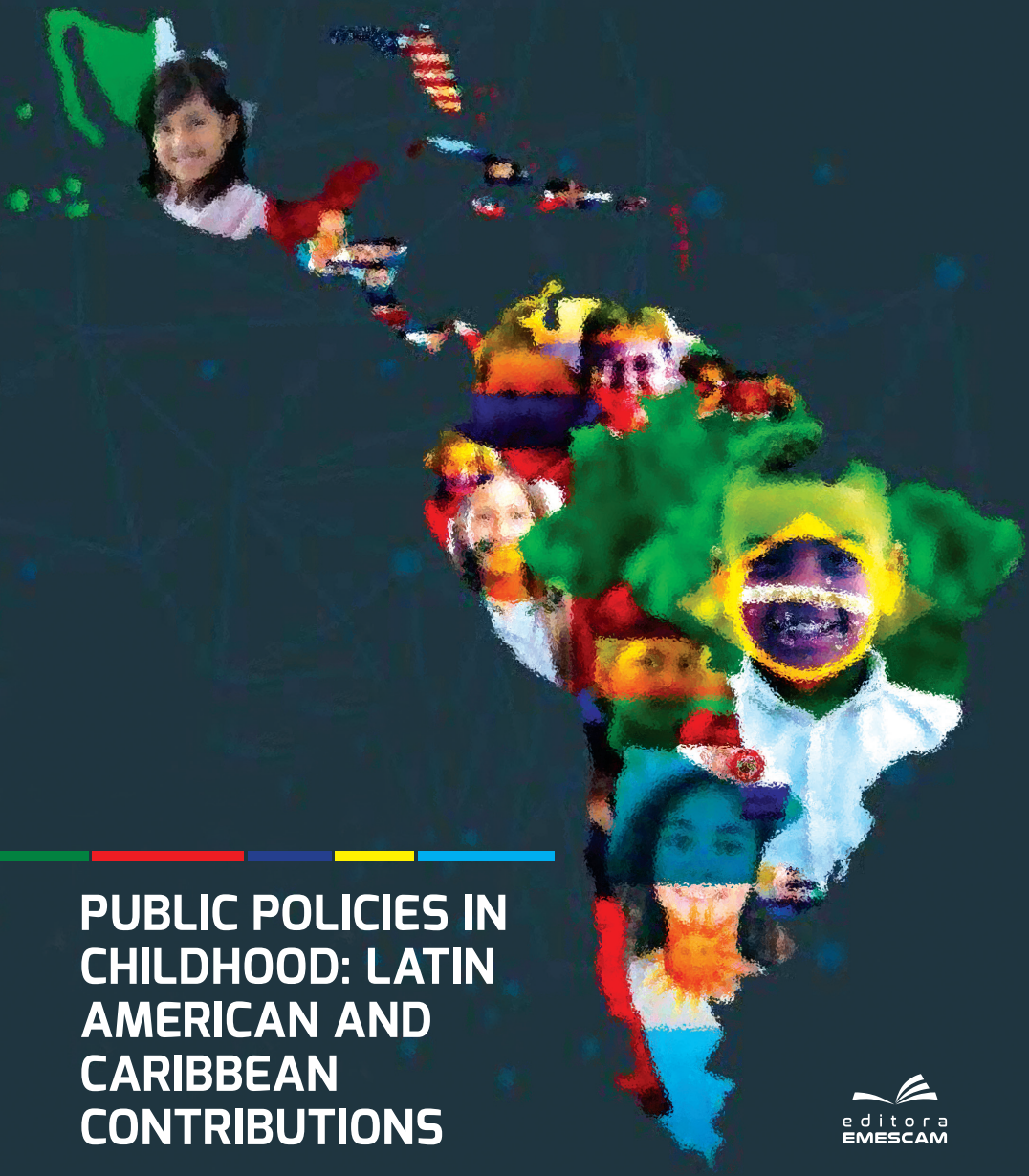

PUBLIC POLICIES IN CHILDHOOD: LATIN AMERICAN AND CARIBBEAN CONTRIBUTIONS

editora EMESCAM

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Resumen

Capítulo 1 THE DOUBLE BURDEN OF MALNUTRITION, INEQUALITY AND THE FOOD SYSTEM 15

Gerardo Weisstaub, Enrique O. Abeyá-Gilardon, Gustavo Cediel, Ana María Aguilar Liendo y Israel Ríos-Castillo

Capítulo 2 CHALLENGE AND INNOVATION IN PUBLIC POLICIES FOR CHILDREN IN SITUATIONS OF VIOLENCE IN BRAZIL: VIOLATION OF RIGHTS 29

Adelma Alves de Figueirêdo, Blenda Avelino Garcia, Priscila Campos de Matos Lacerda y Denise Abreu Cavalcanti

Capítulo 3 PUBLIC POLICY CHALLENGES FOR THE CONTROL OF CHILDHOOD OBESITY IN LATIN AMERICA AND THE CARIBBEAN 47

Asha V. Badaloo, Shelley McFarlane, Carolyn Taylor-Bryan y Daniel Thomas

Capítulo 4 FOOD AND NUTRITION SECURITY POLICY IN BRAZIL: FOCUS ON TACKLING MICRONUTRIENT DEFICIENCY 65

Wendell Costa Bila, Joel Alves Lamounier, Inocencia Palmira Peralta López, Ana María Lozano Alemán y Camilo Adauton Mariano da Silva

Capítulo 5 POLICIES TO COMBAT CHILD POVERTY IN LATIN AMERICA AND THE CARIBBEAN 81

Matilde Peguero y Amarilis Then-Paulino

Capítulo 6 PUBLIC NUTRITION POLICIES IN LATIN AMERICA AND THE CARIBBEAN: SOCIAL AND ANTHROPOLOGICAL REFLECTIONS 99

María Elena Díaz Sánchez

Capítulo 7 CHILD MORTALITY IN LATIN AMERICA AND THE CARIBBEAN: INTERFACE WITH PUBLIC AND SOCIAL POLICIES 115

Maressa Cristiane Malini de Lima; Janine Pereira da Silva, Eugenia de las Mercedes Aguilar Lema, Faride E. Rodríguez Díaz, Helder Gomes, Valmin Ramos-Silva

Presentation

> We work for children, because children are the ones who know how to love, because children are the hope of the world. [...] What we want is for the children to be happy, like the little brothers in our engraving; and that if ever a child from America finds us, all over the world he will squeeze our hands a lot, like an old friend, and say where everyone hears him: 'This man from the Golden Age was my friend!'. (José Martí, to the children who read The Golden Age).

The present Collection consists of texts by Brazilian and foreign authors, products of conceptual, theoretical reflection and indicators from Latin America and the Caribbean, involving analysis of propositions in the sphere of public policies, possibilities, obstacles, and challenges in its materialization process in Latin American countries.

It is worth mentioning that foreign authors and some Brazilians are part of a research group that addresses food, nutritional and other issues that compromise childhood, takes away the opportunity to access goods and services, with losses to children health. The group is linked to international technical cooperation projects, with the participation of Latin American and Caribbean countries, approved, coordinated and financed by the International Atomic Energy Agency (IAEA) and by the Nuclear Energy Agencies of the countries involved. Participate in these projects, professors from the Escola Superior da Santa Casa de Misericórdia (EMESCAM) and the Graduate Program in Public Policies and Local Development of this institution, coordinated by Professor Valmin Ramos-Silva.

These knowledge productions result from investigations which articulate several knowledge domains, through the interface between different areas of knowledge, in particular, Health Sciences, Human Sciences and Applied Social Sciences, thus contributing to broad analyzes of the concrete reality

and of public policies directed to children in Latin American and Caribbean countries. It is emphasized that public policies have an interdisciplinary character, as they constitute a field of study and work for researchers with different backgrounds, which results in dissimilar conceptions in relation to them, converging and diverging in certain aspects. Complementarity and the construction of new knowledge, common purposes, collective and integrated actions make it possible to produce changes and responses to social demands and needs.

Resides here, one of the impacts of this bibliographic production for different areas in relation to the dissemination of knowledge, the improvement of the processes of formulating, executing and evaluating public policies, and contributions to perform analyzes of relevant historical and social phenomena and processes at the local, regional, national and international levels, and in proposing alternatives for intervention to the socioeconomic problems that affect the population, safeguarding the diversity of each concrete reality and social formation that interfere in the action plans, purposes and means specified for the realization of rights and policies, especially those focused on childhood, defined as an analytical field in this Collection.

The international recognition of the urgency in providing a childhood with full protection, aiming at the development of the autonomy and personality of each human being, has demanded special and systematic attention by the State and Civil Society. Its incorporation as a priority in the list of enforceable rights and public policies aimed at children in Latin America and the Caribbean and in the world, results from social and historical struggles waged by collective movements demanding for the constitution, defense and materialization of children's rights, that excel in cooperative and intersectoral actions, considering social needs and different demands emerging from the concrete reality of each country.

The expansion of inequalities, poverty, hunger, obesity and malnutrition, of violence that affects childhood in different countries, including Latin Americans, have caused serious losses to the process of cognitive / linguistic, psychomotor, affective / social development, point out studies and researches by national and international institutions and bodies, such as the World Health Organization (WHO), Pan American Health Organization (PAHO), the

United Nations Children's Fund (UNICEF), the United Nations Organization for Food and Agriculture (FAO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Information System on Early Childhood in Latin America (SIPI).

Since it establishes a public responsibility for all people and an ethical duty that cannot be abdicated, it commits both the State and the Society to guarantee the satisfaction of social needs, essential for the material and subjective life of every human being. Thus, the struggle to affirm the protection of childhood as a right, as well as the recognition that they are "subjects of rights" and "people in a peculiar condition of development" requires the establishment of parameters for their regulation and assurance, through normative instruments, public bodies, promotion mechanisms, aiming at its implementation.

In that respect, the importance of the international treaties adopted and ratified, throughout the 20th century, by different countries in the world, in which the Participating States assumed a set of political commitments, which should guide the formulation and execution of public policies aimed at childhood protection. Thus, the following stand out: Geneva Declaration of the Rights of the Child (1924); Declaration of the Rights of the Child (1959); Universal Declaration of Human Rights (1948); International Covenant on Civil and Political Rights (1966); International Covenant on Economic, Social and Cultural Rights (1966); San José of Costa Rica Pact (1969); Convention on the Rights of the Child (1990).

Certainly, these historical and normative milestones have driven advances in several countries around the world, and continue to do so, in Latin America and the Caribbean with regard to the protection of children, which differ and direct to: regulation of rights in the Constitution and specific normative instruments (laws, resolutions, decrees, etc); establishment of a conceptual framework, guidelines and comprehensive strategies in the design and implementation of different public policies; constitution of specific public policies for children, materialized through services, programs, projects and benefits. However, it is still necessary to make qualitative progress so that these initiatives become concrete actions, which allow all children to enjoy full development and a childhood with full protection. This depends on the

political will to prioritize resources for public policies towards universal access and coverage, integrality, equity and efficiency. It constitutes one of the biggest challenges, given the capital crisis and the fiscal adjustment measures to face it, which generate inflections in the materialization of public policies.

This collection intends to stimulate discussions about public policies directed to children, which allows showing the current state of the art of the issue, exchanging lessons learned and reflections to advance in the arduous struggles that lie ahead, with the objective shared by all: that children in the Latin American and Caribbean region should enjoy a full childhood in all aspects of life. That said, the seven chapters that constitute the production of knowledge in this work are presented.

The first chapter, entitled "the double burden of malnutrition, inequality and the food system", by the authors: Gerardo Weisstaub, Enrique O. Abeyá-Gilardon, Gustavo Cediel, Ana María Liendo, Israel Ríos-Castillo, discusses the coexistence of malnutrition with excess weight and chronic diseases linked to inadequate diets, composed of ultra-processed foods and physical inactivity throughout life, as a result of the economic model of development. It draws attention to the advancement of forms of malnutrition in developing countries, which suffer the most inequities linked to social determinants.

The second chapter, Challenge and innovation in public policies for children in situations of violence in Brazil: violation of rights, by the authors Adelma Alves de Figueirêdo, Blenda Avelino Garcia, Priscila Campos de Matos Lacerda, Denise Abreu Cavalcanti, addresses the forms of children violence, with inputs of data on the international and Brazilian reality and in so doing, points to changes in the vision and practices involving childhood, in relation to the constitutional text and infraconstitutional legislation in the achievement of the rights of children and adolescents, insurers of social protection. In this text, the authors discuss public policies, specifying concepts and norms that institute them, with examples of concrete experiences, explaining challenges and innovations to face violence in its different configurations.

The third chapter, Public policy challenges for the control of childhood obesity in Latin America and the Caribbean, by the authors Daniel Thomas; Carolyn Taylor-Bryan; Shelley McFarlane; Asha V. Badaloo, discusses chil-

dhood obesity, its expressions and implications for childhood. They contextualize this problem in the studied region, using indicators to portray the issue of obesity and strategies and action plans for overcoming it, worldwide, that involve different public policies, such as health, education, food and nutrition security, in addition to the challenges posed to them in their process of execution, monitoring and evaluation, involving government, market, and civil society.

The fourth chapter, Food and Nutrition Security Policy in Brazil: Focus on tackling micronutrient deficiency, by the authors Wendell Costa Bila, Joel Alves Lamounier, Inocencia Palmira Peralta López, Ana María Lozano Alemán and Camilo Adauton Mariano da Silva, focus the discussion of the main issues related to nutritional needs and the consequences of a lack or excess of macro and micronutrients in health, especially for healthy child growth and development, establishing an association with social inequalities and poverty. It also brings the main public policies for food and nutrition security in Latin America and the Caribbean to face hunger, malnutrition and obesity.

The fifth chapter, Policies to combat child poverty in Latin America and the Caribbean, by authors Matilde Peguero and Amarilis Then-Paulino, is dedicated to the main public policies aimed at children in countries of the region, focusing on poverty reduction and inequities in early childhood development, and protection offered in the form of government systems, policies, plans, programs, and strategies. It is proposed to make explicit its objectives, the target audience, limits and challenges set for its achievement, due to the inflections produced by the adherence to the dictatorial neoliberal policy of countries and external governments.

The sixth chapter, Public nutrition policies in Latin America and the Caribbean: social and anthropological reflections, by anthropologist María Elena Díaz Sánchez, outlines her analysis of the obstacles to the formulation and implementation of public policies from institutional and socio-cultural contexts, language and from the speech of the formulators, from the decisions that are made, the rules that originate them, the impact and the way they respond to the demands they propose to meet, including food and nutrition. In its analysis logic, it addresses political, economic and social aspects which contribute to the permanence of food insecurity for children in the Latin

American region. It also points out the importance of food sovereignty as a right of peoples in the definition of policies and strategies for the production, distribution and consumption of food for the entire population.

The seventh chapter, Public Policy Challenges for reducing child mortality in Latin America and the Caribbean, by the authors Maressa Cristiane Malini de Lima; Janine Pereira da Silva, Helder Gomes, Eugênia Aguilar Lema de Las Mercedes, Valmin Ramos-Silva, outlines an overview of child mortality in some countries in the region, with a discussion of the causes of this problem. The developed approach takes into account neoliberal political systems and policies implemented based on guidelines from the International Monetary Fund, which has resulted in an increase in child mortality. In addition, the study presents the countries with greater frequency and actions to reduce child mortality.

Vitória, ES, November 2020

Gissele Carraro Loise, ***Cristina Passos Drumond*** e ***Valmin Ramos-Silva***
(Organizers)

Chapter 1

THE DOUBLE BURDEN OF MALNUTRITION, INEQUALITY AND THE FOOD SYSTEM

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Abstract: The dual burden of malnutrition is characterized by the coexistence of malnutrition with overweight, obesity or chronic non-communicable diseases related to diet throughout the life cycle. As a result of the economic model of development, urbanization, demographic change and increased consumption of highly processed foods, there has been a significant change in the quality of food. This type of disease can manifest itself at both individual and population levels, from childhood to adulthood. Today, approximately one in three people worldwide suffer from at least one form of malnutrition, especially in developing countries. The distribution of social determinants, conditions of inequity, can explain the prevalence and combination of pathologies that coexist in the same place and population. Access to healthy food is based on an adequate supply of food that includes

environmentally sustainable forms of production, adequate channels of marketing and distribution. Despite the responsibility of states to regulate food consumption, some malnutrition prevention programs focus most of the responsibility for food on the individual, a view that depoliticizes the difficulty behind this type of decision. Since the factors that condition this type of malnutrition, underlying food systems occur simultaneously and interact with those that generated climate change. Synergistic actions will be essential to achieve planetary health, which we define as the health and well-being of human beings and the natural environments on which we depend.

Keywords: Protein Malnutrition; Pediatric Obesity; Chronic disease; Economic development; Social Inequality, Child.

Definition and epidemiology of double disease burden

What do we mean by double burden? The simultaneity of two or more conditions, different and often contrary at first sight, that occurs simultaneously in a territory, in a house or in the same person.

The first publication on dual load and malnutrition is from 1995 in Brazil, applied in homes of malnourished children and obese mothers[1]. In the last 10 years, there has been an important increase in the bibliography indexed in PubMed and the concept has been extended to broader groups, such as communities and countries[2,3].

The nutritional realities represented by the double burden tend to be more complex situations than in the apparent double burden and which even in the literature have been extended to triple and quadruple burden[4]. In a first approach, the double burden meant the continuity of infectious diseases with a high incidence in maternal and infant mortality rates (diarrhea, malaria, pneumonia, neonatal sepsis, among others) and macro and micronutrient malnutrition along with chronic diseases associated with a Western lifestyle and excessive calorie intake, which traditionally existed in countries with large resources[5].

At the family level, the double burden of malnutrition has been described in four varieties: i) Individual: child with growth retardation and obesity; and in the same household: ii) overweight or obese mother and children under five years of age with low weight; iii) overweight or obese mother and child under five with growth retardation; iv) mother with low weight and child under five with obesity[6]. The latter has a frequency less than 1%; while the third variety is the most frequent. The common denominator of this diversity of combinations is the absence of a healthy diet and the complexity of metabolic interactions that can affect the course of life.

Most countries, regardless of their income, have one or more varieties, in addition to micronutrient deficiency, constituting what is known as the new nutritional reality. Achieving healthy food in countries is the successful realization of the four components that the United Nations Food and Agriculture Organization (FAO) recognize as components of food security: availability, accessibility / consumption, use and stability.

In Central America, FAO also recognizes a fifth component: institutionality. All these components have different implications and relevance for the occurrence of double loads depending on the food system in each country to ensure a healthy diet. Added to this is the deficit of micronutrients highly prevalent in low and middle income countries[7].

The double burden of disease does not manifest itself in the same way everywhere, so to understand the different forms of malnutrition that can coexist with higher prevalence, it is important to know the epidemiological situation. For example, if the location (countries and regions within the countries) referred to is in nutritional transition, this process influences the way the population eats, drinks, transports, has fun and moves to work, if in the family environment it has affected the distribution of body composition and yielded to nutritional problems. The transition produced major changes in physical activity and diet, and a rapid increase in overweight, obesity and chronic non-communicable diseases. To understand how the epidemiological context influences how the double burden manifests, it is essential to analyze the degree of inequality in society.

Desigualdade no acesso a alimentos e desnutrição

The inequality in the double burden of disease can be explained in large part by the distribution of social determinants in the population[8,9], which allows us to identify those comprehensive interventions throughout life and with an epigenetic look that would improve the situation[9].

The simultaneous presence of malnutrition and obesity, in the same individual or in individuals of the same family, has been widely documented in low- and middle-income countries. An increase of 0.1 point in the Gini coefficient is associated with an 8 to 12% increase in the chances of an individual being obese and being underweight[10].

Thus, one can find obese mothers with malnourished children or children with dwarfism and obesity. Lee J et al[11], in a study held in Guatemala, sought to identify the socioeconomic factors associated with this duality of malnutrition in a sample of almost 2,500 households. The results revealed a higher prevalence of stunting in childhood, but a lower prevalence of maternal overweight among the poor compared to wealthy families. Economic inequality in short stature was greater than economic inequality in maternal overweight. In addition, it was found that an obese mother / child with short stature were more likely to be found in households in the average consumption quintile than in the first quintile (best SES). A study carried out in Sri Lanka with children aged 5 to 10 years showed that a lower level of education of the mothers was associated with a greater occurrence of thinness of the child (OR = 2.3 95% CI 1.08-5.00)12.

One of the recommendations to prevent obesity is to perform daily physical activity, mainly of moderate or vigorous intensity. To put this recommendation into practice, adequate public spaces are needed. However, its distribution is also not equitable. In Santiago de Chile, the four highest-income communities concentrate a third of the total green area, while the four poorest communities only 4%. The same study shows that in a low-income community, only 20% of the population has access to a green area of at least 5,000m^2 close to their home (300m), which contrasts with the 74% found in a community of high income[13]. The practice of physical exercises is not evenly distributed among the different socioeconomic levels

of society. In the last National Health Survey carried out in Chile, it was observed that the highest prevalence of sedentary lifestyle (90%) occurs in women with less than 8 years of study[14]. The same phenomenon can also be observed in schoolchildren. In Chile's "National Physical Education Study" conducted with almost ten thousand boys and girls across the country, it was found that the aerobic physical condition assessed by the Navette test was satisfactory in only 31% of schoolchildren who attended municipal schools against 41% of those who attended paid private schools (of better socioeconomic status)[15].

Moving forward on a path of greater equity and equality is not just an ethical imperative in a region with social gaps that are expressed in several areas. It is necessary to think about a new style of development, that is, how a society is organized for the production, distribution and consumption of food and how economic growth is linked to the quality of life[16].

Double burden of disease and food production: social and environmental sustainability

A healthy diet is essential to reduce, prevent and control the different forms of malnutrition that coexist with double burden and chronic non-communicable diseases, which cause high morbidity and mortality worldwide[17]. Access to healthy diets, especially fruits, greens, vegetables, fish, nuts and seeds, are part of an adequate food supply that includes environmentally sustainable forms of production, adequate channels of marketing and distribution[18,19]. Despite the above, some prevention programs focus much of the individual's food and nutritional responsibility, a neoliberal view of "selections" that depoliticizes the difficulty behind each individual[20]. On the contrary, this view may be part of the cause of the current epidemiological reality of the multiple forms of malnutrition, which profoundly affect the most vulnerable population[21,22]. Trying to generate strategies to overcome the individual view of the problem, another initiative emerged, such as the theory of food environments with three fundamental elements: physical and economic access to food (proximity and

accessibility); the promotion of food, labeling, advertising and information (informative food environment); and food quality and safety[23].

In this scenario, actors such as provincial and national governments and the food industry are identified as the two groups of stakeholders with the greatest capacity to modify the population's dietary and dietary environments. With this view, some countries have been working to promote government policies and actions in healthy eating environments to reduce obesity, chronic non-communicable diseases related to diet and their associated inequalities[24]. This alternative, although unprecedented and which constitutes an advance, still has influences of nutritionism, with regulation of physical and economic access to food, based on the concept of adequate food, which is reduced to the presence or absence of nutrients and food safety only in safety terms[25].

It is from this point of view that FAO emphasizes that healthy and sustainable diets are dietary standards that must be promoted to reach all dimensions of people's health and well-being; present low pressure and environmental impact; be accessible, cheap, safe and equitable; and be culturally acceptable[19]. Social protection programs that incorporate the food and nutritional dimension favor access to healthy food, especially for the most vulnerable populations. Social policies and programs must allow physical and economic access to healthy diets, for example, in schools and early childhood development centers[26]. These social programs must be coordinated and articulated with the food, agriculture and health sector to promote the production, supply and delivery of fresh, minimally processed and natural food, in accordance with national healthy eating guidelines, such as the Food Guidelines and programs for the prevention and control of obesity and chronic non-communicable diseases[27].

The sustainability dimension must, therefore, consider the necessary measures to increase the resilience of food systems so that they can facilitate the availability of healthy foods, even in periods of anthropogenic or natural crises[18]. However, the current food system is characterized by high availability and access to cheap and processed and ultra-processed products, with a high perception of convenience and with large budgets for its promotion and advertising[28,29]. One can also mention the resistance of

the private sector to public health measures that promote healthy eating environments, such as frontal labeling laws for nutritional warning, taxes on sugary drinks and unhealthy food; and the regulation of its advertising, among others[30,31].

In the food supply chain, the lack of agricultural inputs, labor and difficulties in transport, storage and distribution affect the cultivation and marketing of food, especially fruits and vegetables[32]. The lack of agricultural inputs, for various reasons, including higher prices, leads to high production costs, making healthy diets inaccessible to the poorest segments of the population. Food transport and distribution are especially relevant for fresh and perishable foods, essential for maintaining nutritious, diverse and healthy diets. Therefore, it is necessary to have solutions in terms of policies and programs to support agricultural production. This supply chain must also guarantee the quality and safety of food[33]. Likewise, other players in the supply chain, such as food bank operations, non-governmental organizations, community groups and private charities, should be considered. In addition, interventions and initiatives are needed to reduce food losses and waste at different links in the food supply chain[34]. E-commerce is another disruptive element in the food chain, which can facilitate access to perishable products such as fruits, vegetables, dairy products and fish, but also for unhealthy diets, like unhealthy food and sugary drinks. Therefore, it is necessary to expand the political approach to regulate mobile e-commerce and social e-commerce, so that healthy diets are accessible to all social segments of the population[35].

In some countries, such as Argentina, the food system is highly dependent on exporting agribusiness with a high oligopolistic concentration. This system is only interested in profit, so it is essential to regulate the collection, commercialization and export[36,37]. Family farming and small and medium-sized farmers are key players in increasing the availability of healthy diets[38]. They are mainly formed by peasant and indigenous people who sell in local markets[39]. Another critical node in the production chain for greater availability of healthy diets is the low participation of family farmers, small and medium producers in local markets. This will improve local economies and facilitate access to healthier diets. Other initiatives to

increase the availability of healthy food in the food supply chain include school, community, urban and peri-urban home gardens, with the aim of increasing local production of fresh food[40].

Therefore, at the level of the food system, practical, innovative and safe measures must be implemented to keep the food chain active, stimulate local production and ensure the availability of fresh and healthy food for the population[32]. Having differentiated policies for the family farming segment, small and medium agricultural producers, as it stimulates the constant demand for fresh and healthy food. In particular, they have programs that facilitate the public purchase of healthy, socially and environmentally sustainable food for various institutional spaces such as schools, hospitals, orphanages, nursing homes, military service, penitentiaries, among others, also considering traditional food production systems[41]. But the food system is not an isolated element on our planet, its development and sustainability impact other systems that are the same or more complex than this, such as the climate system. The interaction between the two generated a "Global Syndemic".

Dual burden of disease, food system and climate change

Malnutrition, overweight, obesity and "climate change" pose serious risks to the well-being and health of humanity as a whole. They occur simultaneously, interact, increase and share common and underlying factors in food systems, transport, urban design and land use. The Lancet magazine commission described this synergy of pandemics as a global syndemic that jeopardizes the achievements made in the health sector in the last half century.

Both pandemics malnutrition and climate change, are caused by the high use of cheap energy sources. A diet constituted by highly processed foods and red meats will increase malnutrition due to excess and related diseases. They generate about a third of greenhouse gas emissions as they use energy sources derived from fossil fuels for transportation[42].

The prevalence of malnutrition and obesity combined has increased in recent decades, especially in the poorest sectors of the population where both types of malnutrition coexist. From an economic point of view, it is estimated that the estimated economic loss from obesity represents 2.8% of the world gross domestic product. To this is added the estimated economic loss due to climate change, which represents 5 to 10% of the same indicator.

In environmental terms, this type of food also has a negative impact. For example, to produce a kilo of tomato, 65 liters of water are used, but to produce a kilo of chocolate, 25 thousand liters of water are taken into account, without considering the carbon footprint, use of pesticides, deforestation and land use change. Not only due to its long processes, which often include import-processing-export, consider a large footprint, but also the waste that is generated with the packaging, especially ultra- processed products, which always require it.

Overall, the COVID-19 pandemic has already led to significant increases in unemployment and it is expected to lead to unprecedented increases in poverty and food insecurity, as well as health and nutrition problems[43]. Confinement and the economic crisis affect the food and agricultural sector, putting the continuity of food supply chains at risk. In addition, the same factors affect our environments and eating habits, especially in the most vulnerable groups. In some countries, data exist showing how food insecurity increased during the pandemic. In the metropolitan area of Buenos Aires, the percentage of households with children and adolescents in which the amount of food was reduced increased from 26% to 30%. In the same group, the increase in severe food insecurity was even greater, since the situations of "hunger" due to lack of food increased from 6.5% to 15%[44]. The current context is adverse and obesity is also likely to increase, due to the increase in sedentary lifestyle and the consumption of highly processed and low-cost foods, a condition also described as being at greater risk for the severity of coronavirus disease[45].

Conclusions

The dual burden of malnutrition appears as the clearest expression of an epidemiological nutritional transition from one stage with a clear predominance of acute infectious diseases to another with a predominance of chronic non-communicable diseases. In this transition there is concomitance of both situations expressed in the two paradigmatic morbidities, one of malnutrition due to protein energy deficiency and the other of overweight due to excess caloric and food imbalance, the latter as a consequence of greater accessibility to processed foods and cheap and unhealthy sugary drinks (high in calories, saturated fat and sodium). This dual burden process of malnutrition has been more pronounced in low and middle income countries, increasing inequality in health according to socioeconomic levels.

Many current recommendations for reducing obesity and malnutrition are also beneficial for mitigating and adapting to climate change and vice versa. It is expected that the impact on both pandemics is possible, that the interventions carried out take into account human well-being and health, social equity, respect for the environment and economic development. The changes required are so complex that they must include profound changes in the legal, political and economic spheres that define the development models of our society. In the area of food, some examples are redirecting existing government subsidies for beef, dairy, and sugar, to sustainable agriculture (for example, peasant and family farming) for healthy foods. Adding the carbon footprint and the consumption of water per kilo to produce it to the labels of nutritional and health warnings of foods and, thus, stimulate a reformulation of products within the industry.

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Chapter 2

CHALLENGE AND INNOVATION IN PUBLIC POLICIES FOR CHILDREN IN SITUATIONS OF VIOLENCE IN BRAZIL: VIOLATION OF RIGHTS

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Children, when well cared for, are a seed of peace and hope.
Zilda Arns Neumann

Abstract: This chapter uses the conceptualization of the different types of child violence defined by the World Health Organization. Brazil is recognized as a country with a high rate of violence in the world and, as a result, many children are victims of some type of violence. However, despite this violence, there is great national mobilization to guarantee the rights of this vulnerable group. One observes that effective public policies exist to face the problem, however the reflection of authoritarian practices and child subjugation, frequently implemented by those who should protect, provide to the underreporting of cases, which makes this a critical public health and violation of health problem. Human rights, connected with rising rates of domestic sexual abuse and

teenage homicides. In that regard, we strive to consider on the social causes of violence and its association with the violation of the rights of children and adolescents, showing the evolution of public policies and the entire legal apparatus to confront the problem, exhibiting the scenario of challenges and innovations.

Keywords: Child Abuse; Child Neglect; Child Violence.

Introduction

The World Health Organization (WHO) establishes as violence, in the case of children and adolescents, attitudes of emotional and/or physical abuse, sexual abuse, neglect or negligent, commercial treatment, with a probability of real or potential damage to health children's survival, development or dignity in the context of a relationship of responsibility, trust or power[1].

In 2016, one billion children, more than 50% between 2 and 7 years of age, worldwide, have suffered psychological, physical or sexual violence[2]. In Brazil, cases of violence against children and adolescents have been growing at an exponential rate over the years. In 2017 solely, SINAN[3] (Notifiable Diseases Information System) registered 126,230 cases of violence against children under 19 years of age.

Accordingly, violence has been currently addressed as a critical public health and human rights problem. Nevertheless, a considerable number of occurrences do not achieve social visibility and proper notification, leading to believe that such records represent merely the principle of problematic everyday violence[4].

One may explain this reality in Brazil, paying attention to the behavior of Brazilian society since its historical formation. From the Colonial Period to the establishment of the Republic, children did not have citizenship, that is, a few decades ago, the child and youth population was seen from an adult-centric perspective marked, above all, by the devaluation and unawareness

of its existence. At that time, minors were subjugated by authoritarian, coercive practices, in addition to physical punishment, justified by the exercise of their homeland power[5].

Those practices were revised in Brazil in the late 1980s, after the promulgation of the Constitution of the Republic in 1988 and, subsequently, the Statute of Children and Adolescents (Law No. 8.069/90)[6]. From then on, the country started to adopt the rule of integral protection, effectively transforming children and adolescents into subjects of rights.

Consequently, the doctrine of entire protection arose as a way of articulating a policy to safeguard the social rights of children and adolescents in regard to joint action between government and society. As a result, the family, society, the Union, the States and the Municipalities were jointly and compelled to ensure broad access to fundamental rights: Health, Family and Community Living, Education, Sports and Leisure, Dignity, Respect, Freedom, Preparation and Protection at Work. For this reason, any violation of these rights is now considered a practice of violence[7].

Slowly, Brazil has been achieving achievements in the protection of children and adolescents. The reduction in infant mortality was one of the major milestones attained, as reported by the Millennium Development Goals, suggested by the UN, in 2015. Despite that, there are increasing rates of homicides in adolescence[8].

Homicide is the most severe form of violence and violation of rights. Statistics indicate a significant rise in homicide rates of adolescents since 2012 which outcome is pro rata greater in this age group than in other segments of the population. Furthermore, the male gender and the black race bulge out in the midst of notifications[9].

Brazil is considered the fifth most violent country in the world, presenting a higher homicide rate than that of countries at war. With a view to battle and face the "lost youth" phenomenon, it is required to fully analyze the social causes of violence, the strengthening of measures towards education, the provision of employment for the most vulnerable adolescents and the promptitude to suppress the impunity of each case of homicide against that social group[10].

This chapter proposes to position the reader on the theme, contextualizing it as an essential public health and human rights matter. Likewise, it was considered to make a brief survey of public policies geared towards addressing the issue, revealing challenges and innovations scenario.

Forms of violenc against children and adolescents

It is essential to distinguish the concept of violence against children and adolescents and to distinguish it in its different forms, when it is intended to resume its breadth. It is understood that the violence practiced goes beyond the limits of physical aggression, making its characterization more comprehensive, categorizing it into structural, psychological, physical and sexual – including the subdivisions. However, it is not rare that one form is added to the others[11].

Structural Violence

Structural violence is possibly the least perceived or the most disguised of violence. This kind of violence refers to the social injustices that children, even before birth, historically endure, like the absence of public policies geared towards their protection. Some situations illustrate the historical path of social vulnerability connected with this type of violence, such as birth in poorly structured homes, where the child is the result of an unplanned pregnancy, family bonds are fragile, the social disparities and parental illiteracy. As stated in Minayo (2001)[12], this kind of violence appears to be naturalized in Brazil, either because of the continuity of its character or because it does not quickly visualize the binomial author-action, namely, the political authors of the socioeconomic actions that engendered such violence.

Psychological Violence

The forms of psychological violence against children and adolescents are: humiliating, emotionally abandoning, criticizing excessively, controlling, embarrassing or making people feel guilty The more traumas the individual endures in childhood, the lower his emotional adaptive capacity and the greater the impacts on personality, besides a 17 times greater risk of suicide in adulthood[13].

Physical Violence

This type concerns violence resulting from the use of physical force, which can lead to pain without injury, injuries from mild to severe or even death. Unfortunately, not only are the streets and institutions vulnerable to this type of violence, but so are the homes of children and adolescents. A study performed by UNICEF (2014)[14], demonstrated that physical violence is current in the daily lives of children between 2 and 14 years of age worldwide. The results reveal that around 6 out of 10 minors are subjected to physical punishment regularly as a way of instituting discipline.

In Brazil, data from SINAN (2017)[15] displays an increase in the number of notifications for physical violence in children under 19 years old each year. The results indicated in Figure 1 associates to a historical series between the years 2009 to 2017.

Besides the progressive increase in the number of notifications, over the years, it projects as the age group most affected by physical problems, in Brazil, that of adolescents between 15 and 19 years old. Nevertheless, the authors deduced that cases of physical violence against younger children are underreported, as a result of child's own fear of reporting what happened, along with the fear of other punishments. Moreover, reporting difficulties can result from both diagnostic failures and lack of standardized and effective devices, throughout the conduct of cases, by the health system.

Table 1 - Increase in the Number of Notifications for Physical Violence registered by age group between the years 2009 to 2017 in Brazil

YEAR	AGE (YEAR)				
	<1	1 a 4	5 a 9	10 a 14	15 a 19
2009	472	884	1291	2279	4164
2010	837	1450	2016	4117	7437
2011	1339	1917	2709	6136	12668
2012	1774	3028	3975	8575	18992
2013	1705	2885	3922	9669	22368
2014	1511	3329	4182	10215	24426
2015	1742	3442	4522	10140	25577
2016	1643	3699	4696	10741	27307
2017	2886	4247	5235	13372	33553
TOTAL	**13.909**	**24.881**	**32.548**	**75.244**	**176.942**

Source: Ministry of Health – Information System for Notifiable Diseases – SINAN Net15

According to Gawryszewski et al (2009)[16], Mascarenhas et al. (2010)[17] and Garbin et al. (2011)[18] the most frequent form of violence against children is presented through physical abuse. These records may be connected with the existence of easily identifiable bodily injuries, favoring the occurrence of complaints.

Sexual Violence

Sexual violence against children and adolescents is defined as any sexual act or game with the intention of sexually stimulating the child or adolescent, which aims to submit to a practice to obtain sexual satisfaction, in which the perpetrators of the violence are in an earlier psychosexual development than the victims[19].

Law No. 12,015/2009[20] amended the Brazilian Penal Code, establishing the figure of vulnerable rape. Consequently, it is considered that people under the age of 14 are at absolute vulnerability, and that the sexual act,

alone, already constitutes a crime, despite whether there was consent from the minor and / or those responsible, from the physical complexion, and even if the victim has had previous sexual experience.

Children and adolescents are in the development stage and, therefore, the violence suffered by them will have a much greater impact than in adults, because this type of violence, in addition to affecting the subject a lot, negatively influences the biopsychosocial development of this citizen. The younger, greater and more prolonged this violence is, the more current and future problems will occur, which may result in "toxic stress"[21].

Neurodevelopment is comprehended as a complex process in which the brain, in order to reach its genetic potential, demands good nutrition, affective security and psychomotor stimulation. Otherwise stated, for a good development, qualitative integration between neurobiological and environmental conditions is required. Infants who were raised with proper affection, stimulation, education and nutrition and who do not endure traumatic experiences will have better cognitive performance and emotional skills in adulthood. This was physically evidenced through images of neuronal pruning and is described in Figure 2, which displays the negative impact of neglect and maltreatment on the development of a baby's brain.

Nevertheless, every child who undergoes stress, like illness, birth of a sibling, family adversities, inter alia, but he still receives good family and / or institutional support, will succeed in resolving this stress, preventing it from becoming toxic. Otherwise, brain structural changes and irreparable emotional and cognitive skills loss will befall[21].

The rights of children and adolescents insured by law

As reported by Federal Constitution of Brazil (1988)[22], the rights of the child are thus guaranteed:

Art. 227: It is the duty of the family, society and the State to ensure the right to life, health, food, education, leisure, professionalism, culture, for children, adolescents and young people, with absolute priority, dignity,

respect, freedom and family and community coexistence, in addition to putting them safe from all forms of negligence, discrimination, exploitation, violence, cruelty and oppression.

Art. 228: Minors under eighteen years of age are subject to criminal liability, subject to the rules of special legislation.

In that regard, with Law no. 8.0696, of July 13, 1990, the Child and Adolescent Statute (ECA) was created, in defiance of the old Code of Minors and in accordance with the Convention on the Rights of the Child, adopted by the United Nations General Assembly. Accordingly, the family, society, the Union, the States and the Municipalities, jointly and severally, must guarantee and ensure broad access to the fundamental rights listed in the Constitution and the ECA.

The National Council for the Rights of Children and Adolescents – CONANDA, was instituted in 1991, through Law no. 8.242/1991[23] aiming, among others, at the elaboration of general norms for the care of the rights of children and adolescents, to supervise the execution actions, observing the Statute.

Law 13.431/2017[24] created the system for guaranteeing the rights of minor victims or witnesses of violence and amended Law 8,069 / 19906 that regulated ECA.

Public policies

Law no. 13.257/2016[25] amended article 8 of the ECA ensuring that all women and pregnant women have access to public policies within the scope of the Unified Health System. Still, it questions what these measures may be and how they apply. In terms of the Law, "These are actions and programs developed by the State to guarantee and put into practice rights that are provided for in the Federal Constitution and other laws. These are measures and programs created by governments dedicated to ensuring the well-being of the population". Recent definitions consider that public policy goes beyond a government decision, given that it can be the result of decisions and actions by other actors, in particular civil society[26].

In the case under analysis, the subjects of rights (children and adolescents), as per the national legislation, are entitled to public policies designed and implemented by the State, in agreement with their specificities and that with their nature, are social public policies.

In his study, Hofling (2001)[27] declares that "social policies make reference to actions that establish the standard of social protection implemented by the State, purposing at the redistribution of social benefits aiming at the reduction of structural inequalities generated by socioeconomic development".

In that regard, the Law no. 13,257/2016[25] provided significant innovation, by establishing the Early Childhood Statute and by providing for public policies to serve children from 0 to 6 years of age. Each State develops its own public policies, in conformity with current legal rules and specificities.

Nonetheless, there is a discrepancy between social public policies and their effective implementation. In order to endorse this study, policies involving food security were used in schools[28], in the State of Roraima and in its municipalities. The PNAE – National School Feeding Program (2013)[29] – provides, among others, that the schools' menu "must respect nutritional references, eating habits, the local food culture". It also stresses that it must "meet the cultural specificities of indigenous and / or quilombola communities".

The Law 13.431/2017[24] instituted the obligation of qualified listening to children and adolescents, in an appropriate environment and with qualified professionals. Nonetheless, not all states have created such a structure, which should count on specialized police stations to investigate crimes in which children and adolescents are victims or witnesses, avoiding, as already said elsewhere, revictimization and its consequent abuses.

Even though the law has advanced, many families, society and the government still reveal difficulty in following the new guidelines. The discoveries of science that study the effects of violence on children require to bring about profound changes in the treatment of children and young people, which are also reflected in the Brazilian criminal justice system itself. In spite of these findings, the fight for children is essential, and it must be exhaustive for the rights to be established, the gains achieved to be reproduced, recognized and valued.

a. Challenges

In what way can you protect a population that is physically and emotionally dependent? How is it possible to identify violence, considering that it is subtle, culturally accepted and that takes place in the home environment? How to make small children, or even teenagers, say that they are raped, given that the aggressor often has family ancestry over the victim? And yet, how can we create a culture of non-violence in Brazil, a country so broad, diverse and cruelly unequal? These rhetorical questions converge on the constant challenges, for which all efforts to cope must be uninterrupted.

It is known that there are some projects, plans and strategies in Brazil. Some of them are incipient and others are well established, but none of them reach the entire target population. This is due to the lack of coordination of actions, through a public policy of the state that cuts across governments and, this way, the efforts are not so efficient.

It will probably be necessary not only to create new projects, but also to survey those that exist, those that have given better results in the short and long term to make them work. Therefore, it is essential that there is central coordination, with the integration of several related portfolios – health, education, security, social security, among others – since violence has an interface in the most varied segments of society.

b. Innovations

In 2018, Brazil turned out to be a member of the Global Partnership for the End of Violence against Children and Adolescents, headed by the UN, whose purpose is contributed to the achievement of the Sustainable Development Goals (SDGs), especially those that are destined to end all the forms of violence and torture against children. Upon entering this Global Partnership, Brazil made a commitment to establish a National Roadmap (integrated roadmap) of integrated actions and committed to develop a system of indicators of violations of the rights of children and adolescents.

Brazil created the National Secretariat for the Rights of Children and Adolescents (SNDCA), connected to the Ministry of Human Rights, the body in charge of articulating public policies to battle manifestations of violence against children and adolescents[30]. For this purpose, it established Dial 100,

which receives reports of human rights violations; in partnership with Unicef, since 2013, it has expanded with the "Protect Brazil" application, which encourages and strengthens reports of violence. In 2016, a new version was launched, expanding its functionality and integrating it into Dial 100[31].

Furthermore, it signed a partnership with the Brazilian Society of Pediatrics (SBP), the Federal Council of Medicine (CFM) and the Ministry of Human Rights to search solutions that oppose aggressions against children and adolescents. An example of this conquer was the preparation of the Manual for Assistance to Children and Adolescents Victims of Violence, targeted at health professionals[32].

c. Inspire

It is a draft of measures developed by PAHO/WHO and by a number of entities, namely the United States Center for Disease Control and Prevention, the United Nations Children's Fund (UNICEF), the World Bank, inter alia. INSPIRE is composed of seven strategies and guides transversal activities that contribute to connect and strengthen the seven strategies, in addition to assess their progress[33]. It does not refer to a new program, but to well-defined strategies that must be adapted to each reality for them to work. The strategies are described in Figure 3:

Table 2 - INSPIRE strategies to prevent and tackle childhood violence

Strategies	Measures
Implementation and enforcement of laws	• Laws that prohibit fathers, mothers, teachers or other caregivers from applying violent punishments to children • Laws that criminalize sexual abuse and child exploitation • Laws that prevent the misuse of alcohol • Laws that limit youth access to firearms and other weapons
Norms and values	• Change in adherence to social and gender norms which are restrictive • Community mobilization programs • Interventions with witnesses

Strategies	Measures
Environmental safety	• Reducing violence by acting in "critical areas" • Stopping the spread of violence • Through urban space Improvement
Fathers, mothers and caregivers receive support	• Through home visits • Through groups in communities • Through comprehensive programs
Increased income and economic strengthening	• Cash transfer • Savings and loan associations combined with education for gender equity • Microfinance combined with education on gender norms
Response of care and support services	• Counseling and therapeutic support • Case tracking combined with interventions • Treatment programs for young people in conflict with the law in the criminal justice system • Family care interventions, with the participation of social welfare services
Education and life skills	• Increase in enrollment rates in pre-school and primary and secondary schools • Creating a safe and stimulating school environment • Improving children's knowledge about sexual abuse and ways to protect themselves • Formation of social and life skills • Programs aimed at teenagers to prevent violence inflicted by an intimate partner

Source: OPAS, 2017[33]

d. First childhood project best – Porto Alegre/RS

It is a Public policy for children, socio-educational, preventive, fostering integral development, which enhances affective bonds and strengthens family identity, from pregnancy to six years of age. It is a pioneering Public Policy in Brazil. It involves three Municipal, Education, Health and Culture departments to assist social vulnerable families[34].

e. Grow with your child program – Fortaleza/CE

This program is performed in conjunction with the Family Health Strategy in the city of Fortaleza – CE. Its primary purpose is to support social vulnerable families by promoting the integral development of children, from pregnancy to 3 years. Throughout weekly visits to registered families, the community health agent accomplishes activities in agreement with the child's age group, with a view to strengthen the domains of cognitive, affective, motor and language development, encouraging and training caregivers in their recreational activities[35].

f. Welcome family program – Boa Vista/RR

It refers to an integrated public policy aimed at Early Childhood, which ensures the child's full development, enhancing bonds of affection and stability between families. It involves a great number of departments, from the creation of planned physical spaces for children and their families to the integration of all services offered with a focus on Early Childhood. The pregnant woman enters the program until the 20th gestational week, will be monitored during prenatal care, counseling for care after the baby's birth, will receive the trousseau and will have medical-psychosocial monitoring, besides a guaranteed full-time daycare center from the age of two (Figures 1 and 2)[36].

Figure 1 – Baby University. Family themed groups

Source: Boa Vista City Hall - RR

Figure 2 – Paths of Early Childhood – Adaptation of routes that comprise the Basic Health Unit, the Social Assistance Center, schools, daycare centers, the Mother House and a square; so that children can have fun with their families and strengthen bonds.

Source: Boa Vista City Hall - RR

Final considerations

The authors appraise the programs as significant initiatives to assist, confront and combat violence, considering that with family planning children are generated, desired and expected. This understanding shuns the violence of teenage pregnancy, the physical and psychological violence of clandestine abortion and neglect of caring for an unwanted baby. Furthermore, it guarantees the quality of the first thousand days of life and avoids excessive neuronal pruning, which prevents not only adequate cognitive growth, but also the acquisition of psycho-affective skills, such as empathy, so important for the non-perpetration of violence.

Additionally, it is recorded that, when engaging the bibliographic review for the production of this chapter, the authors were confronted with a considerable collection of classifications, strategies, programs and projects aimed to prevent and settle the misfortune resulting from violence against the child juvenile population. Significant and complex proposals stand out, like INSPIRE, from the World Health Organization, and the other ones existing in Brazil and referred in this work. Nevertheless, by virtue of the persistence of such cruelty towards children, one may infer that good ideas are not fully implemented, or are for the smallest part of the target

population, leaving the majority to the margin of this vital protection, which should be the rule. Oppositely, while humanity in the 21st century has already developed to the point of creating solutions, using artificial intelligence, the rights of children and adolescents continue to be violated and, still, dependent on backward policies. Thus, it is required to claim such a modernization.

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Chapter 3

PUBLIC POLICY CHALLENGES FOR THE CONTROL OF CHILDHOOD OBESITY IN LATIN AMERICA AND THE CARIBBEAN

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Abstract: Obesity is a global epidemic, characterized by soaring morbidity and mortality, associated with Chronic Non-communicable Diseases, which begin to manifest in childhood and persist quickly among young adults and in other life cycles. This chapter discusses issues associated with the strength of the power of capital to the detriment of healthy living, the impediment to controlling obesity in childhood and adolescence. It presents an analysis of the main policies to promote healthy food and lifestyles, within the scope of health and food and nutritional security policies, with a focus on the implementation of actions and the conditions that aim to control obesity. It discusses the potential disputes of interests and mechanisms of pressure from organized groups that influence the formal control of the government to produce the failure of policies to promote the common good. It shows the power of the food industry to prevent actions aimed at advertising, labeling, and the availability of unhealthy products for children. It also discusses the

difficulties to practice a healthy life as well as the cult of sedentary lifestyle.

Keywords: Obesity control, Obesity Management Systems, Pediatric obesity, social inequity.

Introduction

In the past few decades, the prevalence of obesity in children has increased dramatically. This worldwide epidemic possesses important consequences, including psychiatric, psychological and psychosocial disorders in childhood and an increased risk of developing chronic non-communicable diseases (CNCD) later in life[1]. Obesity treatment is arduous and overweight children tend to become adults with obesity[2]. Since 2016, the World Health Organization (WHO) has classified childhood obesity as "one of the most serious public health challenges of the 21st century"[3]. The global increase in overweight in the population has prompted governmental actions aimed at preventing the health impacts generated by obesity. These trends have led WHO member states[4] to endorse the goal of "No increase in childhood obesity by 2025".

Childhood obesity is typically driven by the interaction of nutrition and physical activity influenced by socio-ecological factors. This interaction confers distinct challenges and opportunities for action throughout the course of life. Well-recognized factors related to physical inactivity and reduced energy expenditure which contributed to the global obesity epidemic include reduced walking due to increased use of motorized transport, a decline in occupational physical activities as a result of increased automation and use of technology, and an increase in leisure time spent on sedentary behaviors. The sedentary lifestyle is high in Latin America and the Caribbean (LAC). A birth cohort study in Pelotas, Brazil, showed 58% of sedentary lifestyles among young people, characterized by excessive TV time and lack of physical activity[5,6,7]. Similar results were observed by Gaskin et al8 in a school study with children aged 9-11 years in Barbados. Alarmingly,

43% of adults and adolescents in Latin America were classified as inactive, indicating that the region is the most inactive in the word[9,10].

Changes in the diet have occurred in parallel and in bidirectional causality, with changes in the broad food system – the set of supply chains on the farms, through the intermediate processing, wholesale and logistics segments, to the downstream retail and food service segments (restaurants and fast food chains)[11]. This reflects in the availability of greater quantities and variety of energy-dense foods and increased levels of promotion and commercialization of high-energy foods. Furthermore, it has been observed frequent and widespread food purchase opportunities; increased use of restaurants and fast food stores; larger portions of food offering better "value" for money; higher frequency of occasions to eat; increased use of soft drinks as a substitute for water, for example, in schools[7,8].

Context of childhood obesity in Latin America and the Caribbean

Currently, the region of Latin America and the Caribbean possesses the highest prevalence of overweight and obesity in the world, and it faces a combination of important health problems and physical inactivity related to diet, accompanied by enormous economic and social costs. Dietary changes are profound, with rapid alterations observed towards very high levels of overweight and obesity at all ages, and, in some countries, associated with an increase in growth retardation. Although Latin American countries have made progress in reducing malnutrition and micronutrient comprehensive deficiencies, inter-sectorial policies are needed to address obesity.[12]

The estimated prevalence of obesity in 2014 was 21.7% in Latin American children under 20 years of age[13,14,15]. Lower levels of overweight in children under 5 years old were reported by WHO[15] in 2013 in the Latin American and Caribbean (LAC) regions, with little change in the previous 13 years; but countries with large populations, such as Argentina, Brazil, Chile, Peru and Bolivia, observed levels of increase of 7% or higher[16]. At the end of 2010, the reported prevalence of 14% in Caribbean children under the age of 5 was even higher than for LA; and it reached 27% in girls and 33% in boys aged 11 to 13 years[17].

In order to specifically prevent and control obesity in children under 5, the World Health Assembly in 2012 approved an extensive implementation plan for maternal and child nutrition, comprising six nutritional targets for 2025; the fourth goal is "no increase in childhood overweight in 2025"[18]. In this context, the task force provided the consumer with several clear information and recommendations, such as:

a) food labeling;
b) encourage food companies to provide more nutritious and less energy foods to children, and to develop criteria for advertising that promote healthier eating;
c) improve maternal nutrition and encourage breastfeeding of babies;
d) design safe recreational facilities and neighborhoods with safer locations;
e) encourage schools to enact consistent policies on food, nutrition and physical activity;
f) encourage all health professionals to participate in the development of public health programs.

In line with these guideline recommendations, LAC has been working together to implement these public health policies. It was in the following decade that the Pan American Health Organization (PAHO, 2014) published an Action Plan for the prevention of obesity in children and adolescents in the Americas (available athttps:// www.paho.org/bra/images/stories/UTFGCV/planofactionchildobesity-por.pdf?ua=1). Also in 2014, a complementary action plan was published by the Caribbean Public Health Agency (CARPHA), available athttps://www.paho.org/nutricionydesarrollo/wp-content/uploads/2014/09/Plano-de-Acao-para-Prevencao-da-Obesidade-em-Criancas-e-Adolescentes.pdf. These two documents followed the recommendations of the Internal Obesity Task Force of 2004. But why did it take a decade for these policies to be adopted by the regions? What were the challenges faced to reach this point? Where are we now? This chapter will attempt to deal with these issues.

Public Policies to Address Childhood Obesity in the Latin American

Region Increased levels of childhood obesity in Latin America (LA) are propelled by high levels of urbanization, around 80%[19], reduced space and time for physical activities, and the nutritional transition that is characterized by an increased intake of energy-dense foods and sugar, Sweetened Beverages (SSB) since 1900. This is accompanied by easy and convenient access to highly processed and high fat and sugar foods. Food insecurity, which is a proxy for economic disparities, has been shown to be associated with the pervasiveness of obesity in LA, with LA countries having some of the largest income disparities in the world, despite significant economic development[19,20,21]. However, Latin America has been leading the implementation of programs to reduce childhood obesity[14,19,22,23]. These programs can be organized into two categories: diet and nutrition, and physical activity programs.

Policies related to diet and nutrition in Latin America

The following are some significant fiscal and non-fiscal policies in Latin America that aim to reduce the intake of foods rich in energy and poor in nutrients[12,23].

1. The special tax on sugar-sweetened drinks (SSBs) in Mexico;
2. Front packaging requirements in Chile, Ecuador and Mexico;
3. Policies that limit the advertisement of non-alcoholic SSBs with high-calorie and low-nutrient foods for children in Bolivia, Brazil, Chile, Colombia, Ecuador, Mexico, Peru and Uruguay;
4. Economic incentives for the consumption of healthy foods in Chile, Colombia, Costa Rica, Ecuador, Peru and Uruguay;
5. Removal of trans fatty acids from processed foods in Argentina, Brazil, Chile, Costa Rica, Mexico.

The excise duty on SSB was based on important research that revealed the high energy density of the children's diet, and that SSBs are the main sources of added sugar[24]. Research studies have also created evidence-based support for SSB taxation, specifically that a 10% increase in price was associated with an 11.6% reduction in demand, where the main substitutes were water and milk. These results were disseminated in conferences, publications and presented to bodies such as Congress and the Ministry of Finance, and are in the monitoring and evaluation phase[23].

While many countries have created policies related to food labeling, several others still need to establish any form of policy or regulation. Even among those with some form of regulatory guidelines, not all have mandatory nutrition labeling standards. In Chile and Ecuador, labeling policies on the front of the packaging have proven effective, with 95% of mothers of preschool children and adolescents interviewed agreeing that the Ministry of Health is helping consumers to identify unhealthy foods. Other Guidelines for the Labeling of the Packaging Front, as in the case of Mexico, showed a lack of clarity and transparence[9].

Despite the fact that the removal of trans fatty acids (TFAs) from the food supply has been identified by WHO as a 'best-buy' public health intervention for low- and middle-income countries[23], many countries in Latin America have not yet removed TFAs as a global monitoring goal due to concerns about the feasibility, achievability and public health effect of removing them from food supply. Argentina is one of the few countries in Latin America that has created effective policy regulations to restrict dietary TFAs. The government has initiated mandatory regulations that specify that TFAs in foods must not exceed 2% of total fats in vegetable oils and margarines for direct consumption and 5% of total fats in other foods. Argentina has also successfully researched and enforced industry compliance with these regulations. The policy was subsequently evaluated by a modeling study that predicted the translatable health benefits of this intervention, creating additional scientific evidence to support this policy[23].

Physical activity programs in Latin America

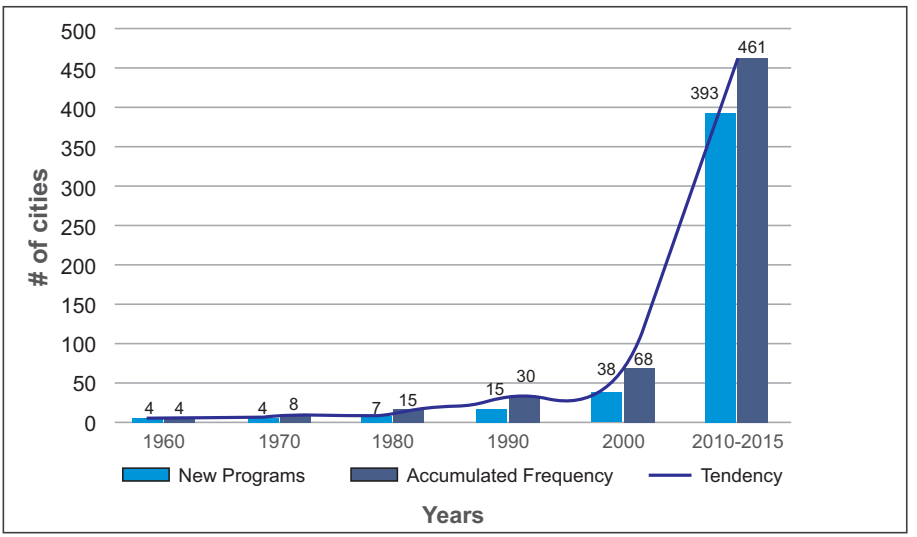
In Latin America (LA), Physical Activity (PA) interventions in schools and Bike routes (open streets) have been the main strategies to combat physical inactivity and enhance energy expenditure. A Useful Intervention Guide for Activities in LA (GUIA) has been started since 2005 to examine and promote evidence-based strategies with the aim of increasing PA in LA[6,25]. School PA was perceived as an intervention, and a body of evidence strong enough to make a practice recommendation.

In 2010, there was a methodical review of 5 interventions in schools6. One study was conducted in Brazil, two studies in Chile and two were carried out on the US/Mexico border. Three of them used randomized group design and two did not use randomized with a comparison group. The review showed consistent positive increases in PA in all three randomized studies. The authors concluded that the results provide impetus to implement PA interventions in high-quality schools in the region; and that improving the quality of PA in schools depends on qualification and training for Physical Education (PE) teachers and instructors, appropriate changes in the PE curriculum, adequate infrastructure, including equipment and materials, and adjustments to various political, cultural and socioeconomic conditions.

Nearly eight years after the beginning of the GUIA, other reviews[25,26] were still at the stage of making recommendations that school interventions should be promoted as an important component for integrated programs, policies and monitoring structures designed to reverse childhood obesity in the region.

The bike route strategy (open streets) has been the dominant PA policy in the LA region. This involves temporarily closing streets to motorized traffic to transform them into safe spaces for activities such as cycling, walking, jogging and participating in social, health promotion and cultural events. Based on the success of the Bike Paths in Bogotá, this program has spread to 461 cities in LA, as shown in Figure 1[23].

Figure 1 – Exponential growth of bike paths over time in Latin merican cities.



Source: Adapted from Pérez-Escamilla et al[23].

Public policies to deal with childhood obesity in the Caribbean region

At a CARICOM meeting in 2013, the Caribbean region established an action plan in line with the Global Action Plan for the Prevention and Control of Chronic Non- Communicable Diseases 2013-2020 and a previous Comprehensive Implementation Plan on Maternal and Child Nutrition 2012. Both plans proposed the use of taxes and subsidies as basic population-based policies to allow healthy food choices and to fight obesity and diabetes[27,28]. From this meeting of CARICOM leaders, a 6-point Action Plan was developed. This Action Plan for the Promotion of Healthy Weights in the Caribbean: Prevention and Control of Childhood Obesity (2014-2019), established goals for the Caribbean region and developed scorecards to monitor and evaluate each Caribbean island in achieving the goals[29,30].

Most of the policies implemented in the Caribbean region were based on nutrition. The application of tax strategies is much less utilized in the Caribbean compared to LA. Some of the main policy programs of Caribbean

countries in response to the childhood obesity epidemic are:

a) The CARICOM Regional Standard: Specification for labeling pre--packaged foods: There is no information available on whether the policy has been implemented in any Caribbean country[27].

b) National Strategic Plan for the Prevention and Control of Chronic Non- communicable Diseases (NCDs): One of the goals of this policy is to reduce the occurrence of obesity in children and adolescents. Areas of action include the promotion of maternal and child nutrition, which includes the promotion of exclusive breastfeeding for six months, health and nutrition programs in schools and the introduction of nutrition in the school curriculum. This policy was adopted in Jamaica. Although a similar policy is available in Trinidad and Tobago, Bahamas, Guyana, Barbados, Grenada, Saint Vincent, the Grenadines, Saint Kitts and Nevis, there is no information available on whether these programs have been successfully implemented[27].

c) National Action Plan for the Prevention and Control of Childhood Obesity: This policy was developed to operationalize the obesity prevention activities of the Strategic Plan and National Action for the Prevention and Control of NCDs. It was adopted in Barbados. Jamaica also has this policy, but there is no information available on its implementation. The objective of this policy is to reverse the trend of increasing obesity by promoting exclusive breastfeeding for 6 months, reducing the prevalence of low physical activity in adolescents and implementing health and nutrition programs at school, and proposed the introduction of nutrition in the school curriculum[27].

d) National Infant and Young Child Feeding Policy: This policy was adopted in Jamaica. It serves to increase access to breastfeeding support in communities and in the workplace and to achieve Baby Friendly Hospital status in all institutions offering maternity and child health services. Five other countries have also implemented the Baby Friendly Hospital Initiative (BFHI) and have school nutrition policies, and several were in the process of implementing legislation on the marketing of breast milk substitutes[27]. Saint Vincent and the Grenadines

have a National Action Plan for Babies and Young Children and a National Breastfeeding Policy, and Dominica also has a breastfeeding policy (Dominica Community Breastfeeding Policy), which was adopted since 1993 and subsequently revised in 1999. Grenada has a School Nutrition Policy with goals similar to those listed above[27].

e) Defense of Civil Society – Healthy Caribbean Coalition (HCC) Action Plan 2017-2021: Preventing Childhood Obesity in the Caribbean (CSAP): The HCC is a non-governmental organization comprising members of all associations and societies that support prevention of obesity in children. The coalition has acted as a link between civil society, the private sector and the government in an effort to take a cohesive multi-sectorial approach to the childhood obesity epidemic. This type of citizenship in the Caribbean exemplifies the role of public--private partnerships in the fight against childhood obesity[29].

f) Tax interventions: In 2015, Barbados was the first country in the Caribbean and the tenth country in the world to implement a special tax on sugary drinks. They introduced a 10% excise duty on all sugar--sweetened drinks[29]. A few months later, Dominica applied a 10% excise duty on sugary drinks and foods with high sugar content, such as chewing gum and chocolate bars[31]. Several countries have also implemented subsidies for local fruits and vegetables[27]. However, to this date, there are no Caribbean countries with regulations in effect that prohibit the marketing of unhealthy foods to children[27].

Public policy challenges in Latin America and the Caribbean

All nutrition policies are available for each country by WHO: Global database on the implementation of nutritional actions (GINA)[27]. A look at this site shows that many of the policies, including those aimed at reducing childhood obesity in LAC, were not adopted, or information on their status is not available. This fact points to a weakness in their implementation, monitoring and evaluation, as highlighted in a recent workshop held in 2014 with support from the US National Institute of Health. At the workshop, an

agenda for regional research and strategic partnership to prevent childhood obesity in LA was examined. Many gaps and opportunities were revealed in four publications[14,19,22,23] in the workshop proceedings. This is almost 12 years after the GUIDE and five years after setting the WHO target of "No increase in childhood obesity in 2025"[18]. It is not surprising that workshop members summarized progress to address the growing childhood obesity epidemic as slow and inconsistent.

1. Research gaps

Despite the successful implementation of some policy programs to prevent and reduce childhood obesity in Latin America, limited scientific evidence prevents the development and implementation of more innovative and effective interventions across the region[19]. Local, culturally appropriate evidence that takes into account the particularities of the region's food and physical activity environment is necessary to determine the most effective actions for preventing obesity[32].

Many countries possess limited data availability due to the absence of systematic nutrition information systems. In several countries in the region, information on nutritional status indicators, such as anthropometric and biochemical indicators, as well as biomarkers of micronutrient status, are out of date or nonexistent[12]. This inhibits the process of informed and timely decision-making and the formulation of targeted nutritional interventions among vulnerable populations. The health and nutrition surveys available are representative at the national level, using standardized methodologies and probabilistic samples. However, because they are not carried out systematically and, often, at different time intervals, it is difficult to make comparisons and draw conclusions from the date[12].

The research capacity for preventing childhood obesity in LA was reviewed by Parra et al[14]. The authors noted that the very low number of publication intervention studies and almost no policy research suggests a lack of relevant research capacity. Similarly, in the Caribbean countries, the scarcity of published literature on some interventions makes it difficult to translate these findings into policies. Given that research is essential to understand, monitor and implement strategies, policies and programs to face the obesity

epidemic, it is recommended that there is a demand to increase research capacity and include more translational research and implementation in the country's portfolios[13]. For example, although there is strong evidence to support PA intervention in schools to prevent childhood obesity in LA since 2005, this has not become a policy. The challenges to achieve this action may be related to the need for future research to identify other practical key elements, such as legislation, policy, barriers and facilitators for the promotion of PE in schools[6]. In addition, research publications show few apparent collaborations between countries in LA[14], which we also see in the Caribbean. Another area about which there is scarce information for the region is the effect of maternal nutrition and low intrauterine growth predisposing to the development of obesity in the offspring[33]. Intervention before and during pregnancy has the potential to reduce the prevalence of obesity in children[34].

2. Food Composition Tables

In Latin America and the Caribbean, there is a specific need for detailed measurement of food and activities and the underlying food or energy expenditure/composition for these items to inform programs and policy planning for the prevention of childhood obesity. Current databases provide limited, and in some cases questionable data, on the quality of macronutrients, nutrients and ingredients, especially for many locally produced foods and drinks. To create accurate food composition measures, national dietary surveys and updated food composition tables are required. The INFORMAAS[22] project is documenting and creating limited databases of food and drinks with bar codes in Brazil, Chile, Mexico and other Latin American countries and in selected countries such as Mexico, Brazil, Colombia and Chile, and evaluation efforts are collecting complete databases of all packaged processed foods. In spite of the fact that all countries in the region gather income and expenditure data, there are only a few countries where scholars use this data for nutritional analysis, which is partly due to the limited data they provide. Chemical analysis of foods is necessary to validate some of these data[22].

Enhanced surveillance through representative research at the national or sub- national level, in combination with improved food composition tables, would allow researchers to gain a better understand of diets in Latin America throughout the life cycle and in different demographic subgroups. As a result, the analysis could determine which foods in local diets are most responsible for excessive energy intake and the impacts of various foods and other factors, including the context and timing of food and beverage intake, on appetite and satiety. Technologies to reduce the time and expense required to collect dietary data are urgently needed; as well as physical activity data, aggregate measures are inadequate to develop childhood obesity prevention policies and programs[22].

3. Monitoring and evaluation of implemented policies

The implemented programs need to be monitored and assessed continuously. This has been a frailty in most of LAC. This lack of monitoring prevents the early identification of barriers related to the implementation, access and use of health services, as well as compliance and coverage. Information on human and financial resources for the implementation of nutrition actions is scarce in the region and there is a flagrant lack of comprehensive reports and peer-reviewed articles on the evaluation of these policies. In most LAC countries, monitoring programs or monitoring nutritional status as part of efforts to assess the implementation of nutrition actions is a fragile or absent part of health information systems[12].

There is also a general deficiency of published information on the implementation and evaluation of policies and programs and on human and financial resources for nutrition goals. Recently, Ribeiro et al.[6] indicated that many promising PA interventions are being carried out in LA, but their effectiveness has generally not been evaluated. In the Caribbean, the development of the Caribbean Childhood Obesity Scorecard (COPS) sought to provide monitoring and surveillance of the various school and childhood obesity programs that have been initiated. However, the effectiveness of the programs has also not been evaluated[30].

4. Government and stakeholders

Nutrition policies and actions are present in regulatory legislation, but countries lack the capacity to monitor and enforce their implementation. This is largely due to the absence of awareness or "adherence" of successive governments in the region. This is largely due to the lack of governments and cooperation agencies awareness regarding the importance and need to identify and allocate adequate funding for the implementation of sustainable information systems, results in environments with few resources for the expansion of proven interventions and in limited acceptance and promotion of development initiatives policies. Consequently, this resulted in long delays in transferring programs and initiatives to policy documents. The lack of political will is a major impediment in the implementation and monitoring of policies. In addition, there is a perception on the part of the government of a high regulatory burden for policy implementation, resulting in a lack of funding for policy monitoring and evaluation activities. This is particularly challenging for Latin America and the Caribbean region, which comprises low- and middle-income countries. It is noteworthy that Latin American countries have some of the largest income disparities in the world, despite significant economic development[19,20,21]. Therefore, it is not surprising that food insecurity has been associated to obesity in some countries in Latin America. Food insecurity can lead to obesity not only due to excessive energy consumption of energy-rich and low- cost foods that are easily available, but also in relation to previous malnutrition[16].

Although most countries in LA and the Caribbean have established national food and nutrition security policies, coordination mechanisms between national, regional and local levels need to be strengthened. Nutritional goals and actions have not been entirely incorporated into national development or poverty reduction policies[12].

5. Private sector challenges

The lobbying of entities such as the food industry, which are opposed to policy changes, is one of the biggest challenges for public policymaking worldwide, and LAC is no exception. Special interest groups played on the public's fears, particularly the fear of losing economic opportunities, as

ammunition against the implementation of many policies. In particular, the beverage industry is a vital partner in reducing the sugar content of drinks sold on the market. Globally, the beverage industry has resisted efforts to implement sugar taxes and this has greatly influenced the markets in Latin America and the Caribbean. Based on experience, Barbados recommends that policy makers seek to involve stakeholders, such as the agricultural and manufacturing sectors, before policy implementation to address concerns and ease fears in sectors that oppose the introduction of beverage taxes sweetened with sugar[29].

Similarly, the introduction of Bike Paths encountered some resistance from companies and other sectors, including transportation companies that were affected by road closures[23]. In most cases, however, these challenges have been overcome by providing evidence-based best practices for the implementation of Bike Paths, along with the strong participation of civil society, highlighting new opportunities for economic development for small business owners[23].

6. Civil society advocacy

There is also the challenge of creating, at the community level, a conscious attitude towards health and the necessary changes in behavior. While in the Caribbean HCC acts as a vibrant civilian advocate and watchdog, in Latin America, there has been difficulty in garnering support from informed advocates and supporters of public reach at the regional level, who can influence public perception through the diffusion of concise information and messages[23]. Governments and stakeholders need to promote civil society engagement to strengthen social responsibility[12].

Final considerations

Several attempts to address childhood obesity in LAC were discussed here, showing varying results, since the prevalence remains high. Challenges to address this major health problem include the lack of robust evidence to inform implementation programs. Even when implemented,

there is often inadequate monitoring and evaluation, which is a barrier to translating into policies. The research of prospective policies can be useful for the advancement of knowledge translation[23]. Generally, at each stage of the process, more research publications are needed not only to inform implementation, but also to provide knowledge of the programs implemented, extended to the policy and its successes.

In addition, the influence of socio-ecological factors is important, indicating that a multisectoral approach is necessary. In 2018, at the 39th Summit, Heads of Government and State of CARICOM, the UN resident coordinator indicated that, for a successful multisectoral approach to fight obesity, there is a need for 3Ps – "Political will, public policy and intersectoral partners". This principle is also emphasized in LA, as highlighted by Mariachiara et al[4], that the work of governments, civil society, private companies and other important stakeholders must be well coordinated to face the epidemic. If this approach is implemented at all levels, there will be fewer barriers to dealing with childhood obesity in the region. Collaboration between countries in separate regions can also be an advantage.

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Chapter 4

FOOD AND NUTRITION SECURITY POLICY IN BRAZIL: FOCUS ON TACKLING MICRONUTRIENT DEFICIENCY

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Abstract: In this chapter, the main issues related to micronutrient deficiencies are discussed in the context of public policies to fight hunger and its consequences for the health of populations in Latin America and the Caribbean (LAC). The nutritional needs and the consequences of the lack or excess of macro and micronutrients on health are described, especially for child growth and development. Next, it is discussed the social issue related to these deficiencies and their association with social inequalities and poverty in Latin America and the Caribbean, regions that face major human rights violations. The text also examines the main food and nutritional security and healthy food policies in the region, in addition to government programs that aim to combat hunger.

Keywords: Food and Nutritional Security; Nutritional Rights; Integrated Health Action.

Introduction

Macro and Micronutrients

Macronutrients are nutrients that help provide the body with necessary energy in large quantities. Water, carbohydrates, fats and proteins are classified as macronutrients. Proteins are necessary for the growth, construction and repair of tissues and are also present in the constitution of cells. Carbohydrates prevent tissue proteins from being used for energy supply. Fats protect organs from injury, help maintain body temperature, contribute to the absorption of some vitamins and the feeling of satiety[1-3].

Micronutrients are minerals and vitamins. The organism needs less micronutrients compared to macronutrients. They are necessary nutrients for the maintenance of the organism, although they are required in small amounts, from milligrams to micrograms. Because they are essential nutrients, they must be present in the daily diet. Micronutrients deficit can cause illnesses or dysfunctions while their excess cause intoxications. Therefore, the diet should always be balanced and varied[1,2].

Micronutrients main function is to facilitate the chemical reactions that take place in the body. Vitamins, for example, are essential for the functioning of metabolism and regulation of cellular function. In the vitamin group, vitamin B is present in green leafy vegetables. Vitamin C is found in citrus fruits. Vitamins A, D, E and K are found in milk, dairy products, vegetable oils and green leafy vegetables. In the minerals category are calcium, potassium, iron, sodium, magnesium, copper, zinc, cobalt, chromium and fluorine. Micronutrients are necessary in all stages and life cycles[1,2].

This chapter addresses the main issues related to micronutrient deficiencies in the Brazilian population in the context of public policies to fight hunger and its consequences for people's health.

Micronutrients and nutritional needs

The most important minerals for man, in addition to iron, are: calcium, phosphorus, magnesium, sodium, chlorine, potassium, sulfur, zinc, iodine, selenium, copper, manganese, fluorine, chromium, molybdenum and cobalt.

Among other repercussions, deficiencies in these nutrients have consequences for the organism, and may compromise normal growth and development[2]. In addition, micronutrient deficiency also causes problems with growth deficit in children, being the most relevant the deficiencies of vitamin A, C, D, E and minerals such as calcium, iron, magnesium and zinc are important[4].

Epidemiological Aspects

According to FAO, malnutrition in the world population, under the aspect of food insufficiency, declined between 2005 and 2015 and, thereafter, showed an increase, returning to the values of 2011[3]. As a result of this insufficiency, protein-energy malnutrition (EPD), especially in children, has been considered an important public health problem in several countries around the world[4-7]. In Brazil, from the National Family Expenditure Study – Endef8 until the 2008-20099 Family Budget Survey (POF), malnutrition among children aged 5 to 9 years (height / age) decreased from 29.3% in to 7,2%. Along this path, another important piece of information concerns the prevalence of micronutrient deficiency in Latin America and the Caribbean. Results showed that vitamin A deficiency appeared to be reduced in several countries, folate deficiency is currently almost nonexistent and B12 status is deficient in most regions. Iron deficiency anemia remains a public health problem for children under 6 and women of childbearing age[2].

Recent data released by the National Household Sample Survey (Pnad Continua) of the Brazilian Institute of Geography and Statistics (IBGE)[5] indicate an increase in extreme poverty in the country by about 11%, from 2016 to 2017 (13.3 for 14.8 million people). Such an increase in extreme poverty may, yes, be reflected in the increase in the number of people going hungry in the country. In Brazil, the numbers show that, in 2017, more than 5.2 million people spent one day or more without consuming food, which corresponds to 2.5% of the population. This puts us on alert about the possibility that hunger will again plague the most vulnerable Brazilian families[6].

Regarding diseases associated with micronutrient deficiencies, the National Demography and Health Survey of Children and Women, carried

out in 2006[7], reaffirmed that iron and vitamin A deficiencies still persisted as public health problems in Brazil. In fact, 17.4% of children and 12.3% of women of childbearing age had hypovitaminosis A, while 20.9% and 29.4% of these population groups, respectively, had iron deficiency anemia[8]. These findings classified the country according to the 1996 World Health Organization (WHO) criteria as a moderate public health problem.

Food and nutritional security and insecurity – SAN

SAN policy is understood as a set of actions planned to guarantee the offer and access to food to the entire population, promoting nutrition and health. It must be a sustainable strategy, that is, it must be developed by articulating conditions that allow its long-term maintenance. It requires the involvement of both government and organized civil society, in its different sectors or areas of action – health, education, work, agriculture, social development, environment, among others – and in different spheres (production, marketing, quality control, access and consumption) [9,10].

The human right to adequate food (DHAA) has been recognized internationally as a fundamental prerogative of the human person since 1947. DHAA is the fundamental principle of SAN[9]. This right is violated whenever people, groups or communities do not have access to food in adequate quantity and quality to meet their nutritional needs, which directly affects the individual's nutritional status[11].

For the National Council for Food and Nutritional Security (CONSEA), situations of food and nutritional insecurity can be detected from different types of problems, such as hunger, obesity, diseases associated with poor diet and the consumption of foods of dubious quality or harmful to health. Predatory food production in relation to the environment, abusive prices and the imposition of food standards that do not respect cultural diversity are also causes of food insecurity[9].

Food insecurity is generally related to social vulnerability and is also the result of a combination of situations that negatively influence quality of life, such as unemployment, insufficient family income, inadequate food production and distribution, among other aspects[10].

Initially, in the 2000s, the situation motivated not only the construction of public income transfer policies to combat hunger, but also policies focused on strengthening food sovereignty, including the development of family agricultural production and its inclusion in the Brazilian agri-food supply system. Despite some advances, the current situation still reveals SAN problems with challenges related to the elaboration of innovative programs, projects and actions[11].

To promote SAN by governments, there are legal apparatus and structures materialized in a National System for Food and Nutritional Security called SISAN. Through this system, instituted by National Law No. 11,346/2006, the SAN policy is designed to be implemented in all spheres of government (Federal, State and Municipal) [11].

The Intersectoral Commission on Food and Nutrition is one of the commissions of the National Health Council (CNS) provided for in Law No. 8.080/90 and aims to monitor, propose and evaluate the operationalization of the guidelines and priorities of the National Food and Nutrition Policy (PNAN). It is in charge of promoting the articulation and complementarity of policies, programs and actions of interest to health, whose execution involves areas not included in the specific scope of the Unified Health System (SUS). The planning of actions that guarantee the safety and nutritional quality of food, controlling and preventing health risks, is present in the agenda of promoting adequate and healthy food and health protection[12]. The implement and use of good agricultural practices, adequate manufacturing practices, fine nutritional practices and the Hazard Analysis and Critical Control Points System (HACCP), in the food production chain, enhances and ensures consumer health protection actions. Nutritional labeling of foods is a central instrument in improving the right to information[12].

The approach to contemporary food and nutritional security allows the expansion of the narrow framework of traditional social programs, recognizing that the population at risk may be more numerous than that normally identified. In addition, food and nutrition security policies must address the need to provide access to food for unsafe groups, given the dimensions of quantity, quality and regularity in food consumption[10].

Rocha's study in 2017 assessed anemia and food and nutritional insecurity in families of children of preschool age, as well as sought to identify dietary patterns and their relationship with food security and nutritional status, investigating the relationship between insecurity diet and hemoglobin concentration in preschoolers. Families that presented a higher risk of inadequate food consumption also increase the long-term nutritional problems[13].

SAN became part of Brazil's public agenda, increasingly occupying a prominent place in debates and in intersectoral programs and actions. However, this occurs in a process in which different understandings on the theme coexist, each with specific implications for research designs, in the definition of monitoring and evaluation indicators and in the construction of public policies[10]. Therefore, the institution of SAN as a national, regional and local policy has been one of the focuses of government actions at different levels articulated with civil society, in the formulation, execution, monitoring and control of their actions[13].

Food and nutrition surveillance

In the health sector, Food and Nutrition Surveillance (VAN) must be understood as the product of a set of actions that seek, ultimately, the diagnosis, health promotion, prevention and rehabilitation of morbidities that have, directly or indirectly, relationship with food, either individually or collectively. Thus, within this scope, the actions recommended by the WHO are included, such as Integrated Care for Childhood Illnesses (IMCI)[14], actions for monitoring child growth and development[15-17], actions related to maternal care[18], and acute or chronic-degenerative diseases recommended by the Ministry of Health for all age groups.

Food and nutrition surveillance consists of the continuous description and prediction of trends in the population's food and nutrition conditions and their determining factors[12]. Thus, the attitude of vigilance is understood as the approach and subsequent intervention in the individual or community, derived from the perception that the health team has developed about the determinants and factors involved in the health or nutritional status of its

population or target individual, in addition to the ability to transform data into actions, yearnings into information supporting the diagnosis and the intervention itself. VAN, therefore, allows providing disaggregated data for different geographical areas, categories of gender, age, race/ethnicity, specific populations (such as indigenous and traditional peoples and communities) and others of interest for a broad understanding of nutritional diversity and dynamics of the Brazilian population[12]. The attitude of vigilance presupposes the identification and recognition of individual or collective realities.

Within the SUS management spheres, SISVAN (Food and Nutrition Surveillance System), operated within VAN, possesses as its main objective to monitor the dietary pattern and nutritional status of individuals assisted by SUS, in all phases of the course of life[12]. It aims to contribute to the planning of nutritional care and actions related to the promotion of health and adequate and healthy food, and to the quality and regulation of food. It consists of a permanent and regular process of collecting, analyzing and distributing the information necessary to maintain updated knowledge of the production, quality and consumption of food and the nutritional status of the population, capable of identifying its causes and trends, predicting its possible variations and defining, timely, the preventive or corrective actions that the case requires.

It is also important to emphasize that it is not up to the health sector, in isolation, to solve food problems in which the origin is located in another sphere of determination. Generally, drug prescriptions for the treatment of micronutrient deficiencies do not consider a series of factors, such as bioavailability, interactions between drugs and vitamin supplements, especially food access and, therefore, the cost-benefit of this practice. Thus, the real need for such practices is questionable and, at the same time, the substitution of food as a natural vehicle for satisfying nutritional and food needs.

Public Policies and Institutional Programs

Food and nutrition are present in the recent legislation of the Brazilian State, with emphasis on Law 8080, of 19/09/1990. This law understands food as a conditioning factor and determinant of health and that food and nutrition actions must be performed in a transversal way to health actions, in a complementary character and with formulation, execution and evaluation within the activities and responsibilities of the health system[12].

The new food challenges in Latin America and the Caribbean take into account the new Sustainable Development Goals (SDGs) and are, to a large extent, a reflection of social and economic changes experienced in the world in recent years. In particular, the goal for the success of food and nutrition security in Agenda 2030 is exactly the SDG, in the sense of ending hunger, achieving food security and improving nutrition, and promoting sustainable agriculture. Among the 8 goals and the 15 indicators, there are 2 goals that make direct reference to the eradication of hunger and malnutrition[12].

Although the composition of a healthy diet depends on the cultural particularities of each country or region, there is a consensus that the diet should contain a balanced combination of macronutrients, such as carbohydrates, proteins and fats, and essential micronutrients, such as vitamins and minerals. This was reflected in the establishment of food-based food guides (GABAs) in most countries in the world, which recommend, based on an adequate diet, the consumption of fresh foods, including varieties of cereals, especially whole grains, vegetables, fruits and vegetables, as well as foods of animal origin[19].

All initiatives aimed at changing the diet from the point of view of consumption go through aspects linked to policies that aim to encourage the adoption of healthy diets, such as the propositional actions related to dietary guidelines and nutritional education. Changing in diet can also be achieved through regulatory actions, such as the definition of standards for food advertising, the labeling of food products or the implementation of fiscal instruments (taxes or subsidies) to encourage the purchase of healthy foods, or even discourage the purchase of products with high caloric

content, sugar, salt or fat, depending on the case[19].

Among these instruments are food-based food guides, which are one of the most widely used policies to promote healthy eating in the region, and are currently present in 28 of the 33 countries in Latin America and the Caribbean. They are the basis for the implementation of policies that, at this moment, have been concentrated mainly in the health and education sectors, in face of a smaller presence in agricultural and social development policies. It should be noted that, in any case, food guides have been considered in the elaboration of food and nutrition security policies in Costa Rica, Brazil, Argentina, El Salvador, Belize and Guyana[19].

To address the negative effects of food advertising, some countries in the region have begun to generate laws and/or regulations to regulate the generation of advertising for food and non-alcoholic drinks to children. In particular, six countries in the region have established, through national laws, the regulation of food advertising, among them Brazil[19].

With regard to food strengthening policy, its costs are extraordinarily low, compared to the social costs of disability. The nutritional education strategy, which aims at the adequate quantitative and qualitative consumption of food, sources of various nutrients, is an alternative that has low cost and does not produce undesirable effects.

In 2001, the Brazilian Ministry of Health determined the mandatory addition of iron and folic acid to corn and wheat flour. Fortification was no longer optional and became mandatory. Various types of foods as well as different iron salts have been used to combat nutritional deficiency, as shown in table 1. The strategy of fortifying infant feeding with powdered micronutrients is also important and consists in adding a mixture of vitamins and minerals, packed in a sachet, which are distributed in daycare centers participating in the Health at School Program (PSE), covering all enrolled children, with a focus on the age group between 06 and 48 months.

On September 15, 2006, came into effect Law number 11346, known as the Organic Law on Food and Nutrition Security (LOSAN), which created the National System of Food and Nutrition Security (SISAN) and established definitions, principles, guidelines and objectives of the System. Through

SISAN, the public authorities (bodies and entities of the Union, the States, the Federal District and the Municipalities), with the participation of organized civil society, must formulate and implement policies, plans, programs and actions with the goal to ensuring human right to adequate food[15].

Even though the exercise of DHAA requires immediate actions in health and in food and nutrition, these actions demonstrate the difficulty, for decades, of our society to eliminate hidden hunger. For a country characterized as one of the main producers and exporters of food, chronic nutritional deficiencies demonstrate that the main problem is still physical/financial access to food consumption.

Table 1 – Iron food fortification in Brazil

Author / Year	Food venue	Iron salt	Redução da anemia	Duration of the study
Nogueira et al. (1992)	Cookies	Bovinehemoglobin	75% para 0%	3 months
Dutra de Oliveiraet al. (1994)	Water	Ferroussulphate	58% to 3%	8 months
Torres et al. (1995)	Powdered Milk	Ferroussulphate+vitamin C	66.4% to 20.6%	6 months
Torres et al. (1996)	Milk	Iron chelate aminoacid	62.3% to 26.4%	12 months
Fisberg et al. (1998b)	Cookies and breads	Iron aminoquelate	32% to 11%	2 months
Ferreira (2000)	Milk	Ferroussulphate+vitamin C	63.24% to 33.82%	6 months
Giorginiet al. (2001)	Breads	Chelatediron	62% to 22%	6 months
De Paula e Fisberg (2001)	Sugar	Chelatetriglycinate	38.1% to 19.7%	6 months

Author / Year	Food venue	Iron salt	Redução da anemia	Duration of the study
Tuma et al. (2003)	Cassava flour	Iron amino-quelate	22.7% to 8.0%	4 months
Fisberg et al. (2003)	Powdered beans	Ferricpyrophos-phate	13% to 0%	4 months
Almeida et al. (2003)	Orange juice	Ferroussulphate	60% to 20%	4 months
Beinner ET al. (2005)	Water	Ferroussulphate	43,2% to 21%	8 months
de Almeida et al. (2005)	Water	Ferreoussuphate + vitamin C	45,9% to 31,1%	6 months

Source: Lamounier et al., 201023.

It is noteworthy that in Brazil, there are integrated actions such as the Amamenta e Alimenta Brasil Strategy (promoting healthy eating), the National Iron Supplementation Program for at-risk populations, the fortification of wheat and corn flours and the recent Fortification Strategy of Infant Feeding with Micronutrient Powder (NutriSUS) for children in a school enviroment[2].

In the last decade, it is noted that the main advance was the incorporation of food as a social right. In this sense, the Brazilian State, busy with the construction of a new approach to act in the fight against hunger, poverty and in the promotion of adequate and healthy food, published Law number 11346/2006 – Organic Law on Food and Nutritional Security and the Decree 7272/2010 – National Policy on Food and Nutritional Security. Both the Law and the Decree present, among their directive bases, the strengthening of the actions of food and nutrition in the health system. Brazil also adopts international recommendations, guiding exclusive breastfeeding until the sixth month and continued until the second year of life. According to the National Demography and Health Survey (PNDS), carried out in 2006, 95% of Brazilian children were ever breastfed, but this number drops dramatically over the first two years of life[12].

The Brazilian government's alignment with international recommendations was intensified through the proposal, in May 1999, of the "Social Commitment to Reduce Iron Deficiency Anemia, resulting later in the development in the fortification of wheat and corn flours. This strategy was approved by the federal government, and required iron fortification using dehydrated ferrous sulfate, ferrous fumarate, reduced iron and electrolytic iron, iron and sodium ethylene diaminetetraacetate and chelated bisglycine iron in domestically produced or imported corn and wheat flours[16]. In this sense, supplementation actions have been taking place since 1983, but suffered discontinuity and disruption between 1998 and 2000, due to the extinction of the national management body. From the year 2000 onwards, the supplementation program became more regular, expanding its coverage and perfecting the processes[13].

At this point, it is relevant to emphasize some important policies and programs in the Brazilian scenario.

PNAE

The National School Feeding Program (PNAE) is the oldest social program in the country in the area of Food and Nutritional Security, and is characterized, since its inception, by large numbers in terms of population coverage.

The purpose of the PNAE is to meet the nutritional needs of students during their stay in the school environment, contributing to their biopsychosocial development, learning and school performance and promoting the construction of correct eating habits.

PNAN

The National Food and Nutrition Policy (PNAN), approved in 1999, as an integral part of the national health policy, integrates the efforts of the Brazilian State, which, through a set of public policies, proposes to respect, protect, promote and provide human rights to health and food[12].

PNAN's objective is exactly to guarantee the quality of the food offered for consumption in the country, the promotion of healthy eating practices,

and the prevention and control of nutritional disorders, as well as the encouragement of intersectoral actions that ensure universal access to food.

In this sense, PNAN rescues nutritional surveillance as an "attitude" for nutritional and food monitoring, that is, it imposes on us a proactive epidemiological approach, identifying both the causal factors of diseases, as well as their temporal tendencies and, thus, facilitating the proposition of indicators for the planning, execution and self- assessment of policies for the sector.

PNSAN

The Decree No. 7272, of August 25, 2010, defined the guidelines and objectives of the National Food and Nutritional Security Policy (PNSAN), provided for its management, financing, monitoring and evaluation mechanisms, within the scope of SISAN, and established the parameters for the preparation of the National Food and Nutritional Security Plan (PLANSAN)[15]. Thus, PNAN must interact with PNSAN and other economic and social development policies, playing a relevant role in the development strategy of SAN policies, mainly in aspects related to the diagnosis and surveillance of the food and nutritional situation and the promotion of adequate and healthy food[12].

PNSF

There are programs that we can call "medicated", such as the National Iron Supplementation Program (PNSF), the National Vitamin A Supplementation Program (VITA A MAIS), and more recently implemented, the Strategy to fortify infant feeding with powdered micronutrients (NutriSUS)[7] aimed at combating micronutrient deficiencies.

According to the seriousness of the problem and the commitment that PNAN has to improve the conditions of food, nutrition and health of the Brazilian population, actions for the prevention and control of iron deficiency anemia have been established within the scope of SUS, such as the PNSF, where iron supplements are used in foods, such as iron-rich flour. In this program, prophylactic supplementation with ferrous sulfate has been

developed since 2005, as it is a cost-effective and effective measure. It is available to all children aged 6 to 24 months[20]. Despite all efforts already undertaken, according to PNDS data, anemia still has a high prevalence in the population, indicating the low impact achieved by national interventions to control iron deficiency, even though isolated improvements were observed (BRASIL, 2009)[16].

In Brazil, innovative public policies in the field of food and nutritional security demonstrate that, combined with other policies, it was possible to reduce hunger and malnutrition, and at the same time stimulate the production and consumption of healthy foods. However, hunger still affects many people, and malnutrition, especially micronutrient deficiency, as well as the increase in overweight and obesity, are increasingly present[11]. This constitutes a paradoxical situation of the epidemiological and nutritional transition, characterized in recent decades. Therefore, we can be in a country in which the two extremes of malnutrition – malnutrition due to lack and obesity due to excess – share the same scenario. A situation called the nutritional paradox, typical of the nutritional transition[21-23].

The fight against hunger is justified, since there are still pockets of poverty with malnutrition. On the other hand, families tend to include high calorie foods in their diet, which are generally less expensive. The issue could be seen from the angle of lack of nutritional information, which requires a focus on promoting education and not on food distribution. Another issue is also the cruel distribution of income, concentrated mostly in the hands of a small portion of the population. These are factors that must be considered in a sound analysis of the nutritional issue and its implications for the health of the Brazilian population. Zero hunger and zero obesity must be part of the same policy that includes a nutritional education program and better income distribution, so that families can have more knowledge and more access to food of good nutritional quality.

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Chapter 5

POLICIES TO COMBAT CHILD POVERTY IN LATIN AMERICA AND THE CARIBBEAN

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Abstract: Countries in Latin America, committed to improving child health, including as a primary point of poverty reduction, have set up Public Policies that would provide the well-being of children and adolescents in Latin American and Caribbean countries, if they were implemented. Nevertheless, many of these policies are no more than business cards on the government pages of many countries, which have chosen to adhere to the dictatorial neoliberal policy of countries and external governments. This chapter will present the prime policies concerned the legal framework for the protection of the rights of children and adolescents. By reason of the location of few or no studies in some countries, the collection of information was standardized on the website concerned the "National Early Childhood Policy" which involves most Latin American countries, with description of the policies, their beginning of creation and implementation and definition of objectives and political frameworks. Regrettably, Guatemala and Haiti appear as countries of high social vulnerability for children, while Chile is the country with the greatest well-being for children and adolescents.

Keywords: Poverty, Public Policy, Equal Opportunities, Social marginalization

Introduction

The Convention on the Rights of the Child enshrines the right of all children to the full development of their potential[1], which is why it is necessary to advance in child development policies. Thus, there is a commitment and great effort from all countries to comply with these policies. Childhood is a period in which people need special care and support, as it is the phase in which the foundations are laid for the development of their capacities, aptitudes and potential. Therefore, the child during their development and growth must have an adequate public system of social protection[2].

Equitable early childhood policies and programs are crucial to achieving the Sustainable Development Goals (SDGs). Furthermore, its implementation helps children to develop the intellectual skills, creativity and well-being necessary to become healthy and productive adults[3]. Children under 5 years old living in low-income countries are exposed to multiple risks: poverty, malnutrition, unsafe and stimulating home environments that negatively affect their cognitive, motor and socio-emotional development[2]; as well as its impact on social and economic development in general[4]. In addition, there is neuroscientific evidence linking adverse situations in childhood with nutritional deficiencies and poor development of brain functions that impact throughout life[5]; the application of policies aimed at early childhood is insufficient to reverse the situation in the vast majority of low-income countries[3].

In developing countries, children under 5 are exposed to multiple risks: poverty, malnutrition, poor health and unsafe and unstimulating home environments, which negatively influence on their cognitive, motor and socio-emotional development[3]. Moreover, there is an impact on social and economic development in general[4]. Furthermore, there is neuroscientific evidence that relates adverse situations in childhood, adversities, including nutritional deficiencies, with the poor development of brain functions throughout life[5]. Regardless, policies geared towards early childhood are insufficient to overturn the situation[6].

Eliminating risks to integral early childhood development is a challenge that requires knowledge of the developmental status of children in early childhood. Thus, SDG number 1 expresses the commitment to “Eradicate

poverty in all its forms in the world"; and its goal 1.1 emphasizes the eradication of extreme poverty for all people in the world by 2030; goal 1.2 proposes, by 2030, to reduce to less than half the proportion of men, women and children of all ages living in poverty in all its dimensions. Extreme poverty is measured by who earns $1.25 a day[6].

SDG 1 refers to a multidimensional concept of poverty and explicitly mentions children as a fundamental part of the target population. To achieve this goal, governments and civil society must consider scaling up early childhood development programs to make them cost-effective and of high quality[7]. The child population is more vulnerable to poverty, due to the high dependence on care on the part of adults and for suffering the greatest biopsychosocial consequences derived from it.

The number of obese children and adolescents has increased tenfold in the last four decades. The strategic lines of action proposed to help the countries of the region face the growing epidemic of overweight and obesity are: a) primary health care; b) promotion of breastfeeding and healthy eating; c) improvement of nutritional and health environments; d) school physical activity; e) fiscal policies; f) regulation of food marketing and labeling, among other multi-sector actions[8].

Main policies to combat child poverty in Latin America and in Caribbean

In Latin America, countries pledged to improving child health especially considering poverty reduction, have established several initiatives that sketch common goals, yet that vary in scope and development methodology. The primary public policies on child development were compiled by Aulicino and Langou (2016)[9] as follows: Brazil Carinhoso (Brazil); Children's ranches (Mexico), Comprehensive Early Childhood Care Strategy from Zero to Forever (Colombia), Comprehensive Early Childhood Care Plan – PAIPI (Panama), National Action Plan for the Rights of Children and Adolescents (Argentina), National Plan for Integral Development of Early Childhood (Paraguay), Integral Child Development Policy (Ecuador), National Education and Integral Development Policy for Early Childhood (El Salvador), National

Early Childhood Policy "Love for Little Children" (Nicaragua) , Public Policy for Integral Development of Early Childhood (Guatemala), Public Policy for Integral Development of Early Childhood (Honduras), Quisqueya Begins With You (Dominican Republic), National Child Care and Development Network (Costa Rica), Comprehensive Care System to Children and Adolescents (Peru), Subsystem for Comprehensive Child Protection Chile Grows with You (Chile) and Uruguay Grow with You (Uruguay).

If the implementation of policies, as an approach to diminish inequities in early childhood development, is made to supply early assistance to the child, in an integrated and intersectoral manner, it will have greater potential in reducing these inequities. This implementation practice must include the following mechanisms: a) intersectoral articulation in accordance with previously outlined policies for children, through the intersectoral network of services such as health, education and social development; b) creation of spaces for discussion on local viability, leadership training and program continuity; c) systematic training of human resources working in early childhood, using health education methodologies; d) monitor political actions with specific indicators, indicating barriers related to the organization of systems and services, in addition to those located in the field of culture and social representations at the level of patients / individuals, decision makers, health workers, organization of services and health systems. In this context, the policies implemented in Latin American and Caribbean countries will be listed.

National Action Plan for the Rights of Children and Adolescents (Argentina)

The plan in Argentina was created in 2012, with the objective of creating conditions for the effective fulfillment of the rights of children and adolescents, in their capacity as citizens, through the development of comprehensive public policies, with inter-institutional and inter-sectorial implementation and with a focus territorial. The plan sought to: 1) guarantee the rights of children and adolescents as a priority policy of the State; 2) increase the degrees of equality, mainly territorial and gender; 3) ensure access to goods and services of equal quality[9].

Accordingly, Argentina underwent some progress in the safeguard of early childhood, namely, the Universal Family Salary per Child and for Pregnancy; the SUMAR Plan (universal health coverage); compulsory education in kindergarten at the age of four, going from 57.3% (2003) to 86.2 (2013), however, the advances in these policies were incomplete, on account of the disarticulation between sectors and levels of government, the challenges in the management of Argentine federalism, including relations between levels of government with different technical and fiscal capacities[10]. Likewise, the Center for the Implementation of Public Policies for Equity and Growth (CIPPEC), suggested the institutional construction for early childhood, which included:

a) the definition of a body bounded to the Presidency of the Country to supervise the budget of sectoral implementing bodies strategic policies for early childhood;
b) elaboration of a federal pact for early childhood policies and investments at different government levels,
c) in 2019 to invest 1.82% of GDP in health and nutrition, initial education and childcare,
d) guarantee management mechanisms in all levels of government management,
e) ongoing training of public officials on the topic[11].

Brazil Carinhoso Program (Brazil)

The Brazil Carinhoso program is a project developed by the Federal Government of Brazil, created in 2011, by Provisional Measure No. 570, of May 14, 2012. It is linked to the Ministry of Social Development and represents the transfer of income to finance the development of education. Contribute to actions of comprehensive care, food and nutrition security, in addition to ensuring access and permanence of the child in early childhood education, for students from zero to 18 months old, enrolled in public day care centers or in an agreement with the government, whose families are beneficiaries of the Bolsa Família Program (BRAZIL)[12].

Chile Grows with You (Chile)

It is an Integral Child Protection System, created in 2006 and which remains evolving. It consists of fully monitoring and protecting all the most vulnerable children in the population and their families, through universal actions and services, in addition to special support for those who are more vulnerable. The monitoring of growth and development is done in the public health system, in a personalized way, from the prenatal period until entering the school system at the first level of transition or pre- Kindergarten. From the year 2016 there was a gradual expansion until the age of 8 or 9 or the end of the first basic cycle[13]. The policy has three lines of action:

1) Massive educational program: aimed at the entire national population with the aim of generating a social environment with family and community environments favorable to early childhood, through awareness, promotion and education actions;
2) Program to support the development of the newborn: through the delivery of practical and educational elements to families served in an establishment belonging to the Health Services Assistance Network;
3) Differentiated benefits for vulnerable families. The comprehensive child protection policy continues to be implemented and the indicators updatade[13].

From Cero to Siempre (Colombia).

It was created in 2012 with the mission of promoting and guaranteeing the child development of children in early childhood, through unified and intersectoral work from the perspective of rights. It is aimed at all children from 0 to 5 years old and their families. It seeks to guarantee the fulfillment of its rights, to define a long-term quality policy that is technically and financially sustainable, to raise awareness in Colombian society and to strengthen the role of the family as a fundamental actor. Integral development is understood to be centered on the child's needs based on five structural elements: caring and nurturing; health, food and nutrition;

initial education; recreation; exercise of citizenship and participation. These five structuring axes must be worked on in four environments: home, health, education and public spaces[14].

National Assistance and Child Development Network (RNADI) of Costa Rica

The RNADI establishes the child development and assistance system, with universal public access and solidarity financing. It articulates the different modalities of providing public and private services in the field of childcare and development, to strengthen and expand comprehensive childcare alternatives. RNADI's services are complementary and not a substitute for pre-school education services provided directly by the Ministry of Public Education. It guarantees the right of all children from zero to six years of age to participate in the Program, in the pursuit of its integral development, according to the different needs, and according to the different types of care they require[15].

Even during the pandemic caused by COVID-19, RNADI will continue to serve the child population, through its three executing units: CENCINAI, PANI and IMAS and in conjunction with other State institutions and service providers that comprise it. This allows the user families to continue working in activities that have not been suspended, maintaining the service to the population that needs it in the Childcare and Protection (API) modality and the service of meals served and the distribution of food[16].

Educate Your Child Program (Cuba)

The Educate your child program seeks the integral development of children and the strengthening of personal, cognitive, physical, affective and social training. It aims to allow the insertion of children in the cultural context where they will be recognized as diverse and unique subjects, who do not attend children's institutions, from birth to entry into school. It has a community and intersectoral character and has the family as its basic nucleus. It seeks to transmit essential knowledge to families to prepare

their children for school entry. The conception of this non-institutional model prioritizes, among its fundamental objectives, the training of its main protagonists, constituting a teaching modality equivalent to that carried out by the institutional path and not a means of transmitting selected contents to specific population groups. Therefore, the initial education system in Cuba is characterized by being sponsored, coordinated and regulated by the Ministry of Education through the "pre-school education" subsystem in two modalities: institutional and non-institutional[17].

Infancia Plena Strategy (Ecuador)

The Full Childhood Strategy is in action since 2012, it aims to promote the integral development of children under 5 years of age, considering that living conditions, early stimulation, education, food and affectivity in early childhood condition people's future. The strategy is aligned with the National Good Living Plan (2013-2017), and seeks to reduce inequities, addressing the starting point of the human development process, from the time of pregnancy. Thus, an adequate education by mothers, fathers and caregivers, in addition to a quality and timely intervention by the State and community support, will allow the definitive eradication of poverty, strengthening capacities and generating greater opportunities in the population. Ecuador's constitution establishes the right of individuals and communities to safe and permanent access to healthy, sufficient and nutritious food; recognizes the population's right to live in a healthy and ecologically balanced environment, which guarantees sustainability and good living. It states that the State, society and the family will promote, as a priority, the integral development of children and adolescents and will ensure the full exercise of their rights, and these rights will prevail over those of other people. It assumes that education, with universal access, constitutes an inescapable and inexcusable duty of the State1. Children under the age of six are guaranteed food, health, education and daily care, within a framework of full protection of their rights, guaranteeing the right to health and its conditions, such as the right to water, food, education, physical culture, adult work, social security, healthy environments and others that support good living[18].

Universal Social Protection System (El Salvador)

This is considered a social policy instrument based on the human rights approach that improves people's human development and seeks to guarantee all citizens, especially the population living in worse conditions of poverty and social exclusion. The components of the program are: supply of uniforms, useful goods and footwear, school meals, milk, house for all, family farming, temporary rent support program, universal basic pension[23]. Despite the perspective of seeking social welfare, it is necessary to align the oligarchy, the armed forces, the clergy, the external interventions in the economy and politics, as well as geopolitical interests that have generated serious political and social conflicts, such as there has been a civil war and a deep social crisis in the country.

Public Policy for Integral Development of Early Childhood (Guatemala)

Public Policy for Comprehensive Early Childhood Development (Guatemala). It presents a policy whose objective is to guarantee that Guatemalan men and women, from the moment they start living in the womb until the age of six, enjoy their basic services. It promotes the construction of a system that guarantees health care and comprehensive development, respecting the country's cultural diversity. It defines the intervention areas and establishes the actions according to the life cycle stages.

Despite the information on the government's website, the right to food and the fight against hunger and extreme poverty remain a challenge for Guatemala, which seeks to meet the goals established in international agreements and guarantee the right to food established by its Federal Council Constitution and which mainly affects the Mayan childhood. Popular participation is necessary to demand public policies that help advance the fight for food security and break the intergenerational chain of malnutrition and hunger. These policies must respect the culture of the Mayan people and ensure adequate social and health conditions[19]. Specific policies can be found

at: https: // www. siteal.iiep.unesco.org/en/politicas[20]. Legislative Decree n° 12 – National Education Law; Decree n° 27 – Law for the Comprehensive Protection of Children and Adolescents (PINA); Strategic Education Plan 2016-2020; K'atun Development Plan: Our Guatemala 2032 and the Annual Operating Plan and Fiscal Year and World 2021-2025.

Social Protection Program (Haití)

The review carried out on the social protection of children in early childhood, in the particular case of Haiti, of the information available on the web can be found in several documents dealing with the topic of health protection and promotion. Also in regional documents such as the production of ECLAC: Social protection systems in Latin America and the Caribbean (2013), as well as Promotion and social protection of children and adolescents in Haiti (2014), both ECLAC documents[21,22]. This limits a more detailed description of the social protection of children in early childhood.

Public Policy for the Integral Development of Early Childhood (Honduras)

The PAIPI Program was approved in 2012 and serves all children under 6 years of age. Its objectives are to promote the fulfillment of the rights of early childhood, the formation of the human capital of the future, focusing on rights and co-responsibility with this group of the population. It recognizes that a child's family environment is fundamental to the development of his/her abilities and that early intervention aimed at remedying some differences between families contributes to reduce inequality[23].

The 2014-2025 PAIPI strategic plan sets the goal that Honduras' early childhood receive comprehensive care to ensure the fulfillment of their rights. In the health area, it ensures that pregnancy and early childhood develop in a healthy environment: a) Maternal and child care (home training, maternal homes, personalized care during childbirth, vaccination, reduction of infant mortality, dental care); b) Access to drinking water and sanitation; c) Assistance to the vulnerable population (sexually transmitted diseases,

multidisciplinary itinerant teams, coordination of training programs).

In Education, two components are established to provide quality educational services: a) Education for early childhood educators (training, supporting documentation and certification, information plan, education and communication on the importance of comprehensive early childhood care); b) Quality and coverage of initial education (curriculum, institution building and expansion of alternative programs). In the area of food and nutritional security, it defines two components to ensure access to optimal and safe food and nutrition: a) Food security (institutionalize the growth patterns of PAHO/WHO, space for articulation and coordination of policies); b) Institutional strengthening (prevention of future problems). In the protection area, two components are established to create the social conditions that contribute to the well-being of vulnerable early childhood: a) Guarantee of fundamental rights (registration and National Early Childhood Registry System (RENPI); b) Protection services (temporary community reception, comprehensive care centers compatible with working hours and special protection). Finally, in the area of recreation and value formation, two components are defined to boost the conditions necessary to develop leisure, participation and values with the contribution of the family and the community: a) Cultural and recreational spaces (construction and improvement); b) Training in values for families and workers dedicated to childcare[24].

Children's Resorts Program (Mexico)

It is a program to support mothers, single parents, tutors or primary caregivers who work, seek employment or study, whose per capita income per household does not exceed the Social Security Line (LB) and declare they do not have access to childcare and care services through public social security institutions or other means. The value of $ 900 pesos per month is offered for each child under three years and eleven months of age and $ 1800 pesos per month for children under six years of age with a special need (disability) attested by a doctor from the government health service[25].

National Early Childhood Policy "Love for the Little Ones" (Nicaragua)

Nicaragua's "Love for the Little Ones" policy was created in 2011 with the goal of strengthening the inter-institutional articulations of the actions carried out in connection with early childhood, in addition to presenting all programs aimed at this sector of the population. In particular: 1) to restore the human rights of children under 6, pregnant women and breastfeeding women, and to promote their full human development; 2) present all state programs, centers and actions to be universal, free, of quality, equitable, with human warmth, cultural and social relevance. The policy includes the following components: a) Education: universality of Early Education and access to pre-school and quality centers; b) Health: complete guarantee of health for the mother-child binomial (prenatal, delivery and newborn health), with specialized services and promotion of preventive health; c) Early stimulation: consolidate the municipal and community organization through the formation of Solidarity Promoters to reach families. Strengthen the role of the family based on a model of responsible parenting. d) Identity: registration of children and promotion of their self-esteem and participation. e) Food security: reduction of the nutritional deficit of children under 6 years old, promotion of maternal breastfeeding, guarantee of available food; f) Prevention of child violence: care for victims and sanctions for aggressors: socio-educational programs and comprehensive care; g) Restriction of rights: protection of children at risk on the streets, children of mothers and fathers with addiction problems, adolescents, migrants, lawbreakers and deprived of liberty, children with disabilities, with HIV or AIDS, and indigenous children; h) Safe homes: guaranteeing the right to decent and safe housing[26].

Comprehensive Early Childhood Care Plan – PAIPI) (Panamá)

PAIPI was initiated in 2011 to facilitate the adoption of public policy aimed at Panama's early childhood. It includes programs and lines of action that ensure the integral development of children from zero to six years of age.

To this end, the program uses the following strategies: 1) To position a strategic perspective that places the child at the center; 2) To establish and implement quality standards in comprehensive early childhood care; 3) To ensure timely relevant and comprehensive early childhood care and its context; 4) To maximize the effectiveness of the technical and economic resources invested; 5) To strengthen the capacity of institutions to respond, in an effective and sustainable manner, to the challenge of providing comprehensive early childhood care; 6) To facilitate the strengthening of the family context, so that children from 0 to 6 years of age can be fully assisted, in a balanced, committed and informed manner; 7) promote community strengthening in order to ensure that children from 0 to 6 years old can develop in a safe environment, have access to basic, institutional and recreational services to facilitate their integral development (Advisory Council for Early Childhood, 2011)[27].

The National Plan for Integral Development of Early Childhood (Paraguay)

Created in 2011 to be implemented until 2020 with support from UNICEF, to consolidate, at all levels of Government, public policies in favor of the country's early childhood (defined up to 8 years of age), together with families, communities, civil society organizations and international cooperation. The plan seeks to a) raise the quality of life of early childhood, ensuring full access to health and nutrition services, the necessary documentation, and entry and permanence in the educational system; b) protect and include children in situations of social vulnerability, fully promoting their rights; c) provide the necessary legal protection for early childhood, through the articulation of all responsible institutions; d) generate awareness, based on communication and visibility actions. The Plan created the National Commission for Early Childhood (CONPI), which is the managing body, together with the departmental and municipal commissions of early childhood, by the Councils for Children and Adolescents, within the National System for the Protection and Comprehensive Promotion of Childhood and Adolescence[28].

Comprehensive Care System for Children and Adolescents SNAINA (Peru)

Created in 1995, it came into force in 1996 by Law No. 26,518, in compliance with the Children and Adolescents Code, with the purpose of guiding, integrating, structuring, coordinating, supervising and evaluating policies, plans, programs and actions at the national level, intended for the comprehensive care of children and adolescents. In 2002, the National Action Plan for Children and Adolescents 2002-2010 was launched, as a landmark document of national public policies in favor of children and adolescents[29].

Quisqueya starts with you (Dominican Republic)

This program was created in 2013 with the objective of establishing a comprehensive system of protection and care for early childhood. It sought to organize, articulate, integrate and regulate the offer of existing services in the country, as well as expand the offer of coverage and quality through a set of comprehensive care strategies aimed at children from 0 to 5 years old, their families and communities. The policy has eight lines of action: 1) initial education; 2) health and nutrition; 3) detection and early attention to special educational needs and disability; 4) protection against abuse and violence; 5) birth and identity registration; 6) family and community participation; 7) awareness and mobilization in favor of early childhood; and 8) training of human resources. As part of the Plan's objectives, a considerable increase in coverage of services for early childhood was envisaged through the programs: 1) Program of Comprehensive Care Centers for Early Childhood ("Estâncias Infantis"), run directly from government agencies. They are centers that offer education, health and nutrition services to children from 45 days of birth to 4 years and 11 months; 2) Comprehensive Care Program for Early Family and Community Infancy (Community Centers), which is carried out under the management of civil society organizations. The program consists of four strategies for its implementation: 1) formation of families in Education Opportunity (early stimulation); 2) comprehensive care for children aged 3 and 4; 3) comprehensive home care; and 4) formation of families through an organized and articulated service provision network[26].

Uruguay grows with you (Uruguay)

It was created in 2012 with the objective of consolidating a comprehensive protection system for early childhood through a policy that guarantees adequate attention and protection for pregnant women and the integral development of children under 4, from the perspective of human rights. It combines focused and universal actions, and comprises the following actions: a) socio-educational actions: media campaigns, welcome set (educational and didactic material, which is delivered to all participating public and private hospitals in the country, to the participating families; b) Knowledge generation: conducting the national health, nutrition and child development survey, establishing an agreement with the University of the Republic to investigate UCC priority themes and external evaluation; c) Strengthening of institutional capacities: technical support for the revision of health care standards and criteria and for the construction of a common curricular project for the initial education of children from 0 to 6 years old, hiring 30 human resources to strengthen graduates in pregnancy control and nutrition, and strengthening information systems; d) Family support and close work: strengthen the capacities of families for the development of good parenting practices, through work in the most vulnerable households carried out by 211 technicians from the social and health area. The Proximity Technical Teams (ETC) monitor families with pregnant women and children under 4 years of age who present a situation of biological and social risk[30].

Conclusion

The documentary review carried out shows that the vast majority of Latin American countries have endeavored to define policies aimed at early childhood, with the launch of comprehensive plans, or of massive services and transfers directed at this population. However, there are still important challenges for these initiatives to translate into concrete improvements in the situation of the youngest children, allowing the enjoyment of the right of all children to the full development of their potential.

Among the challenges to be faced is the lack of articulation of early childhood policies with the other policies implemented. Thus, governments must have an integrating role in society, and act as an articulator in the system so that there is no duplication of efforts in services, and consequent waste of resources. Winning this battle of child poverty must be considered as a challenge that countries have to face to achieve economic efficiencies, since the disabilities suffered in childhood will reverberate throughout their lives, due to the loss of opportunities in school, which contributes to the perpetuation of poverty in the region.

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Chapter 6

PUBLIC NUTRITION POLICIES IN LATIN AMERICA AND THE CARIBBEAN: SOCIAL AND ANTHROPOLOGICAL REFLECTIONS

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Abstract: This chapter discusses the issue of public policies aimed at Nutrition for the Latin American and Caribbean Region, from an anthropological perspective, providing methodological and theoretical tools to explore the meaning of policies and their cultural implications, in a holistic perspective. The article discusses the obstacles to the formulation of public policies that contemplate social processes, cultural practices, applied to conflict situations based on the foundations of anthropological study, based on the language and discourses of policy makers, echoes of the predominant socioeconomic regime and its impacts on society, victimized by the neoliberal policy demanded by the dominators, reinforcing the economic, political and social crisis in the Region, increasing poverty, hunger and malnutrition, with increasing overweight and obesity in alarming ways, in addition to micronutrient deficiency. It draws attention to the existence of norms, legal aspects, agreements and guarantees on social rights that the programs must consider and not violate, but which are not always fulfilled, allowing the permanence of food insecurity for children in Latin America and the Caribbean.

Keywords: Infant Feeding; Health Policies; Cultural Anthropology.

Introduction

When we start to discuss the issue of public policies in the context of Nutrition for the Latin American and Caribbean Region from an anthropological perspective, it is relevant to consider some clarifications.

The formulation of public policies today has become an activity immersed in social processes, cultural practices, applied to conflict situations and this implies decisions, actions, agreements, instruments with the participation of the public power and other social actors to prevent or solve a problem. It has been stated in the literature that, if this policy-making work is defined as socio-cultural practices and organizational forms to generate them, we are already at the foundation of anthropological study[1,2].

The answer to several questions about the analysis of a public policy carried out by Shore[1] goes through the consideration of its object of study, the actions it generates, the institutional and socio-cultural contexts in which they are implemented, the language and discourse of the formulators, the decisions that are taken, the rules that originate them, as well as the impact they have on beneficiaries and the way they respond. This author reaffirms that Anthropology offers its own approaches to the study of public policies, in which, in addition to conceptual and methodological elements, they help understand its operation and provide a critical understanding of the processes that structure society. It is the regimes of power and their relations with other social actors, to name a few, the leaders, administrators, facilitators and, above all, the last link in the chain, who are the subjects towards whom political action is directed. Faced with such a plurality of situations, gaps in policy descriptions can be identified among people outside the process, such as academics and analysts and the participants who design them, in addition to the impact that these contrasts can have on the people who receive them.

It is known that policies reflect worldviews, which are echoes of the predominant socioeconomic regime represented by the states. For example, in most countries in Latin America and the Caribbean, a neoliberal line is followed in the development of their social policies. Therefore, when policies are constituted as instruments of intervention and social action,

they can impose their order, because within their functions it is to legitimize the decisions of the highest administrative authority, which is the state apparatus. In this way, a political will is exercised in accordance with visions and interests, which is related to the cultural complexity in which civil society is immersed, but these policies are not always successful. These strategies depend on the instability of the political cycle in the countries, so their projection can be temporary and decreasing.

Anthropological approaches make it possible to analyze the rationality of public policies, which are situated cultural practices, crossed by social actors such as the State, humanitarian agencies, the World Bank, the United Nations, civil society, etc. and in its design, power relations are manifested, but their purpose is to try to solve a social problem.

According to Huerta[3], the public sphere differentiates the political process, by the achievement of its objectives and by a differentiated power. According to this approach, power is perceived in a relationship that obtains obedience from the other interacting party, but with a request for subsequent obligations and, in this sense, constitutes a symbolic means that legitimizes the governmental[4]. There is a relationship here, where the empowered sector has control over economic resources, and seeks to dominate the social and symbolic[5], over the silenced population, articulating a hegemonic discourse, and in this interaction, the subjects assume collective identities[2]. That is why the analysis of public policies requires an anthropological, ethnographic, multisituational approach to understand the different points of view of the actors involved in their relationship, from a global perspective (State x Populations), or local, with the interpretation of the community, which allows us to understand the complexity of these processes.

Anthropology, in one of its lines of work, it deals with the analysis of categories of socio-cultural complexity, useful for analyzing public policies that States develop with other social actors, and that act effectively for the beneficiaries who need them. Anthropology constitutes an application instrument, from an academic and practical point of view, which may contribute with its working methods for organizational strategies and assessment of their impacts, among others, on the mission of the State and humanitarian institutions, for the execution of public policies directed at the citizen.

The state is a people-generated institution, which has within its functions to manage, prioritize and distribute resources, define and implement social policies aimed at improving the quality of life of the vulnerable population, which in terms of human rights needs to be protected. In this action, new categories are created to describe people (for example: citizen, peasant, student, woman, etc.).

Anthropology provides methodological and theoretical tools to explore the meaning of policies and their cultural implications from a holistic perspective. It can assist in the implementation of strategies, verifying if the actions would really and directly benefit the most vulnerable groups of citizens, with a human rights approach, respecting their beliefs and social imaginations. But even at an earlier stage, anthropology can contribute to the analysis of the construction of the policy itself (whether appropriate or not), in the identification of the difficulties of its application. It would consider the characteristics of the direct actors responsible for its implementation, in terms of honesty, effectiveness of their functions and leadership as facilitators, among other important aspects for their development.

Finally, it can be said that the various anthropological techniques, based on qualitative research[6], are also prepared to assess the impact of interventions, based on plans and programs generated by policies, through interpretive work that can be carried out in research, interviews, discussion groups, case studies. On some occasions, depending on the type of actions performed, it is also possible for a physical or anthropometric assessment of individuals.

An old criticism of the anthropological approach has been the limitation of work in specific areas or communities, although such an approach provides a greater body of knowledge of socio-cultural complexity. However, for some time now, "multilocal" ethnography[7] has been recognized in these spaces, which implies the application of studies in different places, areas or cities, providing more information on a given theme, with less extensive instruments for fieldwork.

The surveyed elements contribute to know, along with aspects that may be of an economic, legal nature, among others, if a given public policy fulfilled the purpose for which it was conceived, and, otherwise, it would

allow guiding which modifications or new lines of work would be required to make it work. In other words, we would obtain collective knowledge as feedback from one or more public policies applied to a target population or populations. For this reason, it is very important to know with certainty the argument of those who have their human and civil rights violated.

Among the public policies developed in the countries of Latin America and the Caribbean, those related to food and nutrition have been very frequent, due to the great problem of food insecurity, caused by inequality in access to food, especially among the most impoverished populations.

This has been happening since the last century in the context of neoliberal agreements and changes in governments that have this model, in parallel to the difficulties of the labor market, with falling wages, unemployment, among many other situations. These policies in Latin America are well known, as they have been replicated in different countries in the Region and are published in several reports[8-11].

Food policies are considered welfare policies based on their objectives, selection criteria and segmentation of the beneficiary population[10]. This concept in its adaptation to modern times is based, as Soldano and Adrenacci[12] point out, on the fact that the social security policy delivered goods and services to a part of society that was not integrated into the labor market, or that its irregular situation did not meet basic needs of life in market societies. Other approaches concern hegemonic power relations, with social inequalities becoming more and more tangible.

In the development of public policies of the State or with a sectorial approach, with regard to food, a set of decisions, conflicts or situations of the various actors in their complexity are also imposed, which must be analyzed. On the other hand, there are also rules, legal aspects, agreements and guarantees on social rights that programs must consider and not violate, therefore, it is not enough that agreements are signed in relation to rights, but that they are enforced. The links between public order and law are not clear and, therefore, are not necessarily designed according to it[10]. With regard to food needs, despite being a survival factor, policies do not always go deeper to obtain a positive result, in order to satisfy the needs of the most precarious social groups, thus violating the legal approach.

In Latin America, national food assistance programs were initially developed, as compensatory measures in contexts of deprivation, accompanied by social inclusion policies, related to income, wage labor, education, health and others. Subsequently, some countries were highlighted for food supply and donations, granting subsidies, as well as direct interventions from complementary feeding programs, supplementation and education in aspects of nutrition, aimed at the most vulnerable, not always well selected. The shift to other strategies with more selective complementation and supplementation programs favored short-term implementation, beneficial to policy implementers with regard to costs, but difficult to measure the impact, without monitoring and evaluation, prevalent in urban sectors[10]. Attention was also paid to nutritional surveillance in the Region.

Another very important aspect discussed was the lack of rationality in the organizational management of benefits in territories with different scenarios of severity and the existence at the same time of a large number of programs in operation. Given the complexity of eating situations, experts argue that assistance programs, which create an improvement framework, have become assistance programs, related to the continuity and maintenance of inequality schemes[13]. During the events in the Region, these assistance-based food interventions were expanded, until they became the State's area of action par excellence, in comparison with other sectors, such as the agrifood industry.

On the other hand, the right to food is reflected in the Universal Declaration of Human Rights[14], and the State, as guarantor of them for the population, must comply with this maxim. However, the neoliberalism that exists in most countries in Latin America and the Caribbean limits the role of the State as guarantor of the development of the free market, without taking actions that generate a global benefit for citizens. This has reinforced the economic, political and social crisis in the Region, with the consequent increase in poverty, hunger and malnutrition. Therefore, there is an increase in overweight and obesity, in alarming ways, also showing states of micronutrient deficiency.

The need for universal action to ensure people's right to adequate food in terms of culture and nutrition was not addressed. Violations are

serious and far from being overcome. These occur during the food process chain, which includes the production and obtaining of food from nature, its transformation, exchange, consumption and nutrition[15], impacting social relations and the environment.

The role of United Nations agencies and other non-governmental organizations (NGOs) has been represented in the implementation of humanitarian aid programs[16], which have served to alleviate situations of food crisis, among others, but in no way solve the problem.

The unfavorable social situation that the Region is going through is recognized by several technical and administrative reports, as well as in scientific publications[17,18,19].

Several reports deal with the evolution of the food-nutritional problem in the region, through the confirmations obtained by the food assistance programs[15,20,21].

Recently, it was reiterated that hunger and malnutrition had a high impact on the population's quality of life, increased health, social and economic costs, and there is strong evidence of a double burden of malnutrition.

Although a rapid reduction in the prevalence of stunting and current malnutrition in children has been reported, the figures achieved may mask inequalities in the countries of the Region[22]. Updated data at the World Health Organization (WHO) nutrition observatory for children under five years of age confirm this approach (growth retardation, year 2020: 6.3% [3.7-10.0]; malnutrition, year 2019: 0.8% [0.5-1.4]), with emphasis on the values of excess weight at these ages (year 2019: 7.3% [6.1-8.7]). Likewise, it is indicated that the Americas are already considered the region with the highest overweight and obesity in the world, with a prevalence of over 18 years of age of 63.4% [61.3-65.3] for overweight (year 2016) and almost one in 3 people with obesity (year 2016: 29.0% [27.1-31.0]). Anemia (data from 2016) is present in 19.1% [13.9-26.5] of women of reproductive age and in young children it reaches values of 22.7% [16.8-30, 1], all this accompanied by an increase in chronic non-communicable diseases[23].

In order to reverse this scenario, it is necessary to transform Food Systems into other sustainable models that guarantee adequate nutrition. To this end, public food policies must be formulated, where the State and other

social actors guarantee Food Security and nutritional well-being for all ages and groups of citizens.

In the current political-economic regimes that prevail in the Region, food, before fulfilling its role of satisfying the needs of the population, is perceived as a commodity, has a price and is consumed as long as there is purchasing power. If there are no possibilities for individuals identified as consumers, then there is a gap that must be filled, not with assistance food interventions, but with a deep intersectoral transformation of Food Systems; in fact, they are responsible for providing food to the population, increasing availability, access and consumption, with diversity in food, safe and culturally appropriate.

The neoliberal model in force in many countries in the Region considers a food system of a corporatist type, with interests and methods of economic management aimed at exercising a strategy of expropriation, with cultural and consumption changes based on the empowerment of corporations that monopolize everyone. in the food chain, restricting the alternatives of small producers and consumers[15]. On the other hand, when it is insisted that the peasantry has obsolete productive practices, imposing the use of certified seeds instead of the original ones, its modernizing thinking leads to the destruction of traditional agriculture. Thus, they recommend the globalization of flavors and consumption, and express control by spreading junk food in different ways, establishing competition in relation to traditional foods. Despite the undeniable current food problems, they defend the free market as a source of wealth and progress. This corporate food system intervenes in decisions about food production, processing and consumption, reducing the capacity of other social actors who should participate in these provisions. In their actions, they also gain the multilateral participation of cooperation agencies and regional bodies, becoming financial donors.

In this complex situation there is the abuse of ultra-processed foods, poor in nutrients, but rich in sugar, salt or fat[24,25], which are associated with the increase in chronic non-communicable diseases, with emphasis on obesity.

By contextualizing food assistance, through public policies in the various countries of the Region in the fight against poverty, within the framework

of a human rights approach, since the last century, Food Security has been invoked in agreements, regulations, conventions for the implementation of programs10 and evidence of the situation, planning and results in this regard was published, with different perspectives of analysis[26-30].

The concept of Food Security has undergone many changes[31], whereas some of these changes have made concrete food policy actions difficult. The conceptual consolidation that has been taking place is a consequence of the worsening of the problems presented in the world. It has evolved holistically and with greater rigor due to its use in different scenarios, with the contribution of different actors linked to the process. One can mention, among others, governments, civil society, scientific research, as well as relevant multinational agencies. In this context of situations, the factors that influence food insecurity present in the contemporary world were identified.

Most of the definitions of Food Security have as main objective the achievement of a healthy and active life, which allows the integral development of people and society. In this sense, a human rights approach is invoked when considering that people should have permanent physical, social and economic access to safe and nutritious food in sufficient quantity to satisfy their nutritional needs and to be able to develop an active and healthy life (published in documents FAO, 2011)[32]. Related to this conceptual framework, in Food Security policies, macro and microeconomic aspects are touched on three axes, which involve the availability and access to food, consumption, use and biological use of these, as well as their quality and safety.

In this sense, it is worth highlighting the arguments of the NGO forum during the World Food Summit 2002. The documents available from that meeting[33] show the rejection of social movements to the unresolved problems for the eradication of hunger and the failure of policies applied in the countries. It was openly exposed to monopolization and unbridled concentration of resources and productive processes in the hands of a few large companies, as well as increased short-term productivity with the use of genetically modified organisms, among other approaches, which is why food insecurity has increased.

In this scenario, it was advocated by Food Sovereignty, for the primacy of the right of people and communities to food, with the support and promotion of local markets and producers with regard to food import and export production. In other words, society as a whole participates in the formulation of policies and strategies that guarantee the food system (production, transformation, elaboration, distribution, preparation, commercialization and consumption of food) in the corresponding temporal and spatial dimension, according to specifics socioeconomic and cultural contexts.

Food Sovereignty presents a broader concept by including a position of rights in its statement, considering the cultural practices of citizens and respecting the environment, taking different social movements as a strategic framework. It was developed by Via Campesina (LVC), discussed during the 1996 FAO Summit and later modified until the Nyéléni Declaration at the 2007 Food Sovereignty forum[34]. Thus, the definition states the right of peoples to obtain healthy food and culturally appropriate products produced with ecological and sustainable methods, as well as defining their own Food and Agricultural Systems.

Common aspects were pointed out between Food Security and Food Sovereignty, but also different perspectives between agrifood systems with alternative frameworks, these contrasts being the epistemic views corresponding to each definition[35]. Based on these approaches, they propose that Food Security be related to agronomy and natural sciences, concentrating knowledge at the individual or domestic level to identify cultures considered efficient according to nutritional content, conditions and production costs, but this local participation is officially reduced by production methods with technical knowledge, following agricultural advances, improved seeds, new products, among others.

In turn, Food Sovereignty is more associated with ecology and the social sciences, and tends to raise a multidisciplinary view of agricultural systems, which is complemented at the local level, considering farming methods, peasant production, food habits and preferences. It also proposes changes in consumption, transport and processing patterns and others, in order to improve agricultural processes, defend small and medium agriculture, as opposed to industry.

The most up-to-date FAO estimates for the 2012-2014 period indicate that 37 million people are hungry in Latin America, 15% less than in the 1990-1992 period, but the situation is far from being controlled, despite having been reduced to half, in line with the goal set by the Millennium Development Goals (MDGs). To reverse this situation, it was proposed to develop several public policies with a great impact on the most vulnerable populations, stating that in the Region there is enough food to cover needs, but access to it is difficult[36].

The 2030 Agenda for Sustainable Development proposes a 15-year limit to eliminate poverty and hunger, for which all countries are called to work in a coordinated manner and to eliminate the causes that keep people in a situation of food insecurity and malnutrition, with the FAO's commitment to follow-up actions[37].

To understand the impact of Food Systems on the design and implementation of policies, programs, monitoring and evaluation, governance and financial support, more information is needed on interventions that promote nutritional well-being, as well as multisectoral studies for healthier lifestyles. For that, data from 33 CELAC[21] member countries were considered. From the analysis of the interventions, the promotion and use of nutritious foods, the use of food guides, food diversity, traditional culinary culture, nutritional labeling and advertising regulations for ultra-processed foods were observed. Likewise, activities of direct benefit to the population were identified (periodic delivery of food, money transfers, nutritional education, among others). Such activities aim to guarantee the functioning of the program (technical commissions, training, monitoring, supervision, assessment of nutritional status, and others). Program strengthening activities are also identified (articulation between programs, public policy management, rescue of traditions, citizen empowerment and others).

These results allow us to see that the countries of Latin America and the Caribbean are working to promote more appropriate eating behaviors, while expanding their public policies. This has the potential to improve nutritional well-being, despite the existing combined malnutrition burdens.

Regarding public policies to improve nutritional well-being in childhood, although various forms of malnutrition[38] persist today, overweight and obesity[39] stand out due to the increase in prevalence in the Region[23], with a multisectoral approach that combines consumption of healthier food, physical activity and reduced screen time, related to the abuse of computer products, limitation of advertising and other negative factors of the Food Environment, which characterize the obesity inducer environment in which it operates.

For public policies to combat obesity to be effective, for example, at school and in adolescence, it is necessary to study the perceptions and representations of children and their families about the problem in the collective imagination. Educational intervention on food and nutrition is essential, within the approach of rights, accompanied by the existence and legitimacy of healthy products for consumption. Nevertheless, assessing the impact on growth and nutritional status in the short, medium and long term through monitoring will help show the success of the programs. The study of the cultural complexity of the family is important in addressing public nutrition policies in childhood, to promote safe eating practices based on dietary guidelines and, in the first 1000 days of life, to promote exclusive breastfeeding. From a hegemonic perspective, childhood constitutes the transition to adulthood and requires a family model; it is a phase of great plasticity for growth and development, where habits, customs, in short, lifestyles are instilled with which the individual will evolve towards a final result, much more difficult to transform.

Currently, the scourge of the pandemic COVID-19 is affecting food systems. There are disruptions in the production process, affecting the distribution and access to food. In the long run, food security will suffer an impact of enormous proportions, which will be felt in the most affected countries by the crises, the marginalized and the vulnerable[40]. In this way, the achievement of the 2030 target is committed, which is why it is proposed to act strongly in the mobilization of governments, civil society and other social actors for the formulation of adequate public policies that promote Food Security.

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Chapter 7

CHILD MORTALITY IN LATIN AMERICA AND THE CARIBBEAN: INTERFACE WITH PUBLIC AND SOCIAL POLICIES

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Abstract:

Introduction: Infant mortality, represented by the number of deaths in children under one year of age, per thousand live births is a social indicator and reflects on a global level, the conditions of life and health, linked to the socioeconomic situation of a country. Objective: to describe the evolution of infant mortality in Latin America and the Caribbean over the past 18 years. Method: Queries to Latin American Databases, followed by the organization and descriptive analysis of the data. Results: Cuba is a country that has always had infant mortality rates

much lower than those recommended by WHO, while Haiti, although it has reduced rates by more than 50% over the years, still remains with extremely high rates. Conclusion: It is perceived that the neoliberal policies implemented in Latin America, contributed to the increase of poverty and to the worsening of the living conditions of the population. Countries that resorted to the IMF have the worst performance in the infant mortality indicator.

Keywords: Basic health indicators; Health policies; Child Mortality; Child.

Introduction

The infant mortality rate is a social indicator represented by the "number of deaths of children under one year of age, per thousand live births, in a given geographic space, in the year considered", being used to "analyze geographical and temporal variations in infant mortality; contribute to the assessment of the population's health and socioeconomic development levels, in addition to subsidizing processes of planning, management and evaluation of health policies and actions aimed at prenatal care, childbirth and the protection of child health"[1].

Neonatal death (0 to the 27th day of life), an important component of infant mortality, has a high global prevalence and may be associated with low APGAR rates (<7) in the fifth minute after birth, complications during birth, birth defects or infections, low maternal education, prematurity (<37 weeks of gestation), less than three prenatal consultations, low birth weight (<2500g) and black / mixed race / color[2,3].

Newborns are most vulnerable during and immediately after delivery, and it is estimated that mortality in this group is 2.8 million each year, mainly from preventable causes. However, since 2000, there has been a drop in the infant (50.0%) and maternal (30.0%) mortality rates, associated, in particular, with improved access to quality health services. Still, according to the goal proposed in the 2030 Agenda on Sustainable Development, Member States have committed themselves to reducing the maternal mortality rate to less

than 70 cases for every 100,000 live newborns by 2030. As for newborns, the objective is to have less than 12 cases for every thousand briths[4].

Thus, infant mortality is an important indicator of the well-being[5], the quality of life and health services, basic sanitation and education in a city, country or region4. High infant mortality rates have plagued Latin America and the Caribbean for a long time and have been decreasing slowly; however, in some countries in the region, little improvement has been seen in the past 20 years[6,7].

In this chapter, the infant mortality rate in the countries of Latin America and the Caribbean in the years 2000, 2006, 2012 and 2018 will be presented, discussing the political and social role in the genesis of the problem, valuing the political perspectives proposed and implemented throughout this period to tackle this question of notorious relevance for the evolution of the countries and peoples of this region.

It also seeks to approximate and base the new trend in the production of knowledge to integrate social needs into research, in order to strengthen the process of discussing public and social policies in Latin America and the Caribbean, fostering the democratic process and spaces for equitable interaction in the region[8]. In particular, as this region is still struggling to develop and strengthen the processes of democratic practices, linked to elections, participation and expansion of social programs, improving the administrative capacity of countries, which requires seizing knowledge to reduce infant mortality rates and contribute to human development[5,9].

Latin America and the Caribbean encompasses 33 countries: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Granada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Saint Kitts and Nevis, San Vicente and the Grenadines, Saint Lucia, Suriname, Trinidad and Tabago, Uruguay and Venezuela[7].

In this region, life expectancy and infant mortality are quite variable, showing contrasts between countries and within countries, especially when considering regional, rural and urban differences in large cities[10]. Despite this, Latin American and Caribbean countries have made substantial

progress in terms of reducing inequalities in reproductive, maternal, newborn and child health, infant mortality and nutrition interventions. However, the poorest 20.0% of the population in most of these countries still do not have a minimum quality of life, and further actions are needed to improve equity[11].

Historically, infant mortality has always been higher in rural areas, linked to the low level of maternal education, poverty, as well as among indigenous peoples. This is because in Latin America, these groups do not fully benefit from technological resources and health knowledge[12], which can explain the higher occurrence of infant mortality. There is growing evidence supporting the existence of a link between income inequalities and health outcomes[13-16].

In many countries, by controlling the gross national income per capita, the literacy rate and spending on health, the Gini index is independently associated with the worst health outcomes. The Gini index represents a scale that varies from zero, indicating the absence of inequality to one, representing the maximum inequality[17]. Income inequality results in high infant mortality rates, which are even worse in countries that are debtors to the International Monetary Fund (IMF). In Latin America, for each percentage point increase in the Gini index, the infant mortality rate grows by 0.467 deaths per 1,000 live births, keeping all other variables constant. Therefore, it is necessary to combat income inequalities and rethink the role of international financial institutions that dictate foreign policies[14].

Since the first years of the 21st century, the deepening of the global economic crisis has ended up revealing chronic structural problems, which are not always visible, especially after the inflation control policies widely promoted in the continent in the 1990s, following the so-called *Washington Consensus*.

> The Washington Consensus was a movement by a group of economists from different countries that, motivated by Multilateral agencies (IBRD, IMF etc.), formulated a model of monetary stabilization in the late 1980s, whose base was the fixed parity of currencies nationals of countries indebted to the United States dollar. The model

> called for trade openness to imports and public debt for the accumulation of dollar reserves. As a consequence, the orientation was to adopt fiscal adjustment measures, privatization of state companies and services and the deregulation of capital flows. In fact, a new international division of labor was underway, with the imperialist imposition of a new stage of productive specialization for dependent nations[18].

More recently, it is on the rise to speak of social policies, fiscal austerity, recession, economic crisis and the requalification of the State, all with the objective of reducing the demand and the right of the largest portion of society to access and function of the State in all aspects, particularly with regard to social well-being[19].

Despite all the attacks on social policies for the loss of rights, it is undeniable that there has been a reduction in infant mortality, and this can be attributed, among other factors, to the population's access to primary and secondary health care, in addition to reforms in the public health system and improvements in health conditions. This reinforces the importance of fighting and popular struggle for the maintenance of public policies which contribute to the reduction of social inequality, access to quality housing, basic sanitation and encouragement of breastfeeding, which are essential for reducing child mortality in Latin America and Caribbean[10,20,21].

Furthermore, diarrheal diseases were important causes of mortality, and the adoption of vaccines against rotavirus contributed greatly to the reduction of these diseases and, consequently, to lower infant mortality, even among countries with low vaccination coverage[22,23]. Also, the application of protocols of the World Health Organization (WHO) for the treatment of severe acute malnutrition among hospitalized children contributed to the reduction of infant mortality from this cause[13,15,24].

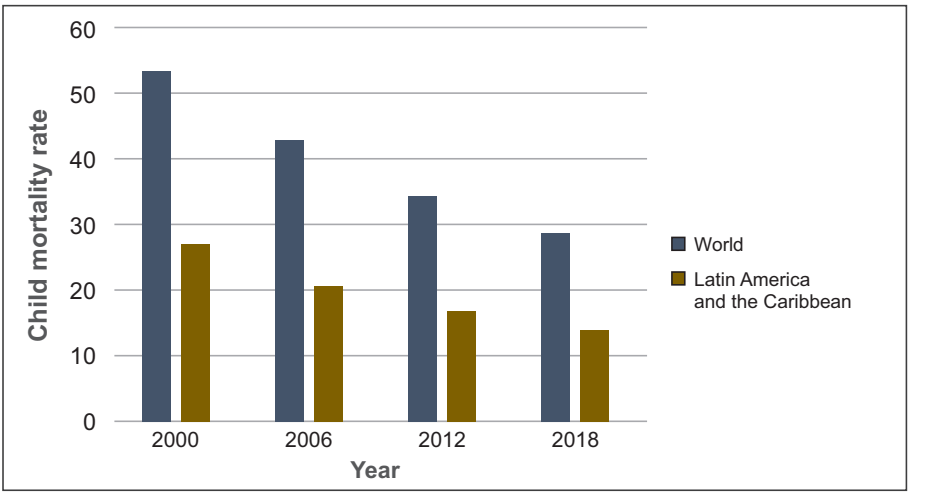
Despite the contribution of studies on the infant mortality rate in LAC, there is a limitation associated with the reliability of data released by countries, generating great differences when assessing data between central and peripheral countries[12]. Thus, the objective of this chapter is to analyze

infant mortality rates in Latin America and the Caribbean and their interface with public and social policies, in order to contribute with theoretical and practical subsidies for the (re) planning of policies and programs for tackling child mortality in the region. This is descriptive, exploratory and documentary research, based on the analysis of infant mortality rates in the countries of Latin America and the Caribbean, in the years 2000, 2006, 2012 and 2018, available in the database of the Economic Commission for America Latin America and the Caribbean[7].

Development

Sub-Saharan Africa, South Asia and the Middle East were among the regions with the highest infant mortality rates in the world, between the years 1970 and 2003[25]. Latin America and the Caribbean, on the other hand, accounted for an average of 48, 8% of the world infant mortality rate from 2000 to 2018. Despite this high mortality rate, the data also reveal a downward trend in this region and in the world (Figure 1).

Figure 1 - Comparison of the infant mortality rate in Latin America and the Caribbean in relation to the World, between 2000 and 2018.



Source: Health Nutrition and Population Statistics, 2020.

In 2000, the six countries most at risk for a child to die in Latin America and the Caribbean were represented by Haiti (74.2%), Bolivia (55.7%), Guatemala (40.6%), Guyana (37,1%), Dominican Republic (33.1%) and Brazil (30.4%) while those with the lowest risk were Cuba (6.8%), Chile (9.2%), Costa Rica (11.1%), Dominica (12.7%), Bahamas (13.0%) and Antigua and Barbuda (13.1%).

After a period of 18 years (2000 – 2018) it was possible to observe that infant mortality remained high in countries like Haiti (49.5%), Dominican Republic (which should not be confused with Dominica) and Bolivia (21.8%), also corresponding to places that present great risks for the birth of children. A significant change is observed in the mortality rate in Brazil, which managed to reach a child mortality rate of 12.8 in 2018.

Another important aspect observed in this study was in relation to the behavior of infant mortality rates in Venezuela, Dominica and Granada. In these countries, these rales, these rales changed in an opposite direction of the rates of other countries in Latin America and the World, that is, an increase in infant mortality was observed. In 2018, all countries in the region with the lowest infant mortality rates in 2000 also maintained mortality rates below 10.0 (Table 1).

Table 1 – Infant mortality rate in Latin America and the Caribbean, in the years 2000, 2006, 2012 and 2018.

INFANT MORTALITY RATE / YEAR					% REDUCTION
COUNTRIES	**2000**	**2006**	**2012**	**2018**	**(2000-2018)**
Antigua and Barbuda	13,1	9,7	6,7	5,0	61,8
Argentina	17,5	14,4	11,8	8,8	49,7
Bahamas	13,0	11,9	9,9	8,3	36,2
Barbados	13,7	14,2	13,1	11,3	17,5
Belize	20,0	17,6	15,2	11,2	44,0
Bolívia	55,7	40,6	29,2	21,8	60,9
Brazil	30,4	20,7	15,4	12,8	57,9
Chile	9,2	7,6	7,2	6,2	32,6
Colômbia	21,1	17,8	14,9	12,2	42,2
Costa Rica	11,1	8,9	8,4	7,6	31,5
Cuba	6,8	5,4	4,4	3,7	45,6

INFANT MORTALITY RATE / YEAR					% REDUCTION
COUNTRIES	2000	2006	2012	2018	(2000-2018)
Dominica	12,7	14,5	22,7	32,9	-159,1#
Ecuador	24,3	18,6	14,4	12,2	49,8
El Salvador	27,2	20,0	15,0	11,8	56,6
Granada	13,3	12,5	12,9	13,7	-3,0#
Guatemala	40,6	33,0	26,8	22,1	45,6
Guyana	37,1	32,9	29,4	25,1	32,4
Haiti	74,2	63,8	56,8	49,5	33,3
Honduras	30,3	23,6	18,6	15,1	50,2
Jamaica	19,0	16,9	14,9	12,4	34,7
Mexico	22,2	16,9	14,1	11,0	50,5
Nicarágua	29,9	21,1	16,6	15,7	47,5
Panama	21,8	19,0	16,0	13,1	39,9
Paraguay	27,9	24,4	20,7	17,2	38,4
Peru	29,6	19,5	14,3	11,1	62,5
Dominican Republic	33,1	29,6	27,5	24,1	27,2
Saint Kitts and Nevis	19,0	13,7	11,4	9,8	48,4
San Vicente and the Grenadines	19,4	19,7	17,6	14,8	23,7
Saint Lucia	15,4	16,1	16,3	14,9	3,3
Suriname	30,1	24,9	20,4	16,9	43,9
Trinidad and Tabago	25,4	23,2	19,7	16,4	35,4
Uruguay	14,8	11,7	8,5	6,4	56,8
Venezuela	18,4	15,4	14,8	21,4	-16,3#
Latin America and the Caribbean*	27,2	20,5	16,6	14,0	61,8

Source: ECLAC, 2020. *Estimate based on 33 countries. # The negative index indicates the percentage of worsening of the infant mortality rate.

The persistent high infant mortality rate in Latin America and the Caribbean is strengthened by economic crises that have generated unemployment and inflation[27]. Also, the low investment in infrastructure, the lack of water supply and sewage system, which would guarantee the improvement in the population's quality of life, were neglected and contributed to the permanence

of diseases that were associated with the increase in infant mortality in the 21st century. Another important factor is associated with the low commitment to the implementation of public policies to improve the levels of exclusive breastfeeding, at least until the fourth month of life in this region[28].

This whole process can be justified by the neoliberal policy, which defends an orientation contrary to investment in social policies, which, due to the requirement of the IMF, was implemented in countries in Latin America and the Caribbean to negotiate the foreign debt of these countries. This policy, as expected, resulted in negative impacts on socioeconomic indicators and high social costs (Table 2), such as impaired access to basic infrastructure services, increased social inequalities, unemployment and precarious employment, thus interfering in the indicators of human development[29].

In this sense, the tightening of the public debt trap ended up involving the expanded reproduction of internal fiscal problems in each country. Paradoxically, the search for solutions to these serious problems, based on fiscal austerity, as opposed to promoting the possibility of new sources of financing for social policies, ended up generating an even more striking presence of private logic in the management of public services[18].

Table 2 - Total current expenditure on health as a proportion of GDP in the years 2000, 2006, 2012 and 2018

HEALTH EXPEDITURE (% GDP)				
COUNTRIES	**2000**	**2006**	**2012**	**2018**
Antigua and Barbuda	4,5	4,7	5,2	4,5
Argentina	8,5	7,6	8,5	9,1
Bahamas	4,0	5,4	6,0	5,8
Barbados	5,3	6,6	7,8	6,8
Belize	4,1	4,6	5,4	5,6
Bolívia	4,4	4,8	5,4	6,4
Brazil	8,3	8,3	7,7	9,5
Chile	7,0	6,0	7,0	9,0
Colômbia	5,7	6,4	6,8	7,2
Costa Rica	6,6	7,0	7,9	7,3
Cuba	6,6	8,3	9,3	11,7

HEALTH EXPEDITURE (% GDP)				
COUNTRIES	**2000**	**2006**	**2012**	**2018**
Dominica	5,2	5,2	5,8	5,9
Ecuador	3,3	5,7	8,5	8,3
El Salvador	8,9	7,9	7,5	7,2
Granada	5,3	6,0	5,9	4,8
Guatemala	5,7	6,6	6,0	5,8
Guyana	3,9	5,0	4,9	4,9
Haiti	6,9	5,5	9,7	8,0
Honduras	6,4	8,1	8,6	7,9
Jamaica	5,8	4,5	5,0	6,0
Mexico	4,4	5,7	5,8	5,5
Nicarágua	5,2	6,0	7,6	8,6
Panama	7,0	6,6	6,6	7,3
Paraguay	5,5	4,2	6,5	6,7
Peru	4,5	4,5	4,8	5,0
Dominican Republic	4,9	4,0	5,9	6,1
Saint Kitts and Nevis	4,7	4,9	5,2	5,0
San Vicente and theGrenadines	4,3	3,8	4,7	4,5
Saint Lucia	5,4	5,7	5,6	4,5
Suriname	6,3	6,3	4,6	6,2
Trinidad and Tabago	4,2	4,2	4,9	7,0
Uruguay	10,0	8,4	8,8	9,3
Venezuela	7,3	8,1	6,4	1,2

Fonte: CEPAL, 2020. * Estimación basada en 33 países. # El índice negativo indica el porcentaje de empeoramiento de la tasa de mortalidad infantil

Consequently, the early 1990s were marked by neoliberal policies, while in the following decade there was a predominance of social advances, with a small reduction in social inequalities. There was a reduction in the export of manufactured goods and an increase in the export of primary products, of low technological composition and low economic value, which contributed to harm the economy, and the economic, political and social sustainability of the Latin American and Caribbean region[30].

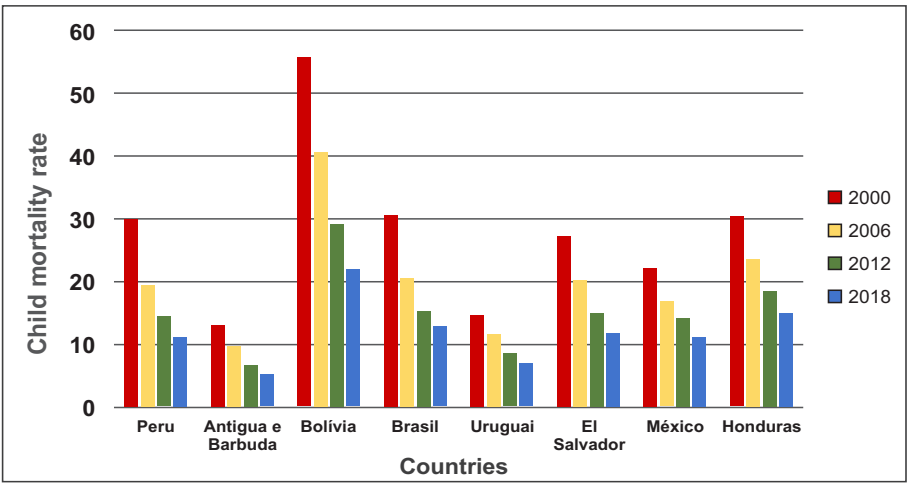
Fortunately, it is observed that the widespread implementation of conditional cash transfer programs, an important instrument to combat intergenerational poverty, has been adopted by almost all Latin American countries[31], which brings immediate benefits, but can compromise the strengthening of effective policies and the permanence of unwanted governments, which strengthens in the region the maintenance of infant mortality rates above that recommended by WHO.

It is noteworthy that since the beginning of the 21st century, the crisis of the Social Welfare State has expanded the role of the market as the mechanism for meeting basic needs, reducing public budgets for social policies. This contributed to the maintenance of economic and political crises, resulting in an increase in social vulnerability, making room for public policies that sought to overcome the aid-based approach logic of dependency, producing development and social emancipation, reflecting, among others, in improving the rates of infant mortality[32].

The political issue is fundamental for tackling social issues, which include progress for children and youth and, consequently, for the evolution of Latin American countries. Thus, in the early 2000s, there was a public perception of the importance of parties in the political life of Latin America and, despite the involvement of elites, parties sometimes remain legitimate, structuring competition and shaping electoral results, guiding citizens and elites regarding the understanding of political reality, building agreements around government policies and effective legislative actions. Despite the shortcomings, with some exceptions, they continued to structure the Latin American political dynamics and more than half of the population believed, at that time, which the quality of the vote would change things in the future, especially among Uruguayans and venezuelans[33].

Among the countries analyzed in this study, eight showed a greater than 50% reduction in their infant mortality rate, as highlighted in Figure 2. The average reduction in the infant mortality rate for these countries was: Peru (62.50%), Antigua and Barbuda (61.8%), Bolivia (60.9%), Brazil (57.9%), Uruguay (56.8%), El Salvador (56.6%), Mexico (50.5%), Honduras (50.2%). These results can be attributed, in part, to "the political will to improve access to quality health services, investing in the health workforce, introducing free care for pregnant women and children and supporting family planning"[4].

Figure 2 – Countries in Latin America and the Caribbean which presented a reduction greater than 50.0% in the infant mortality rate, in the period from 2000 to 2018.



Source: Health Nutrition and Population Statistics, 2020

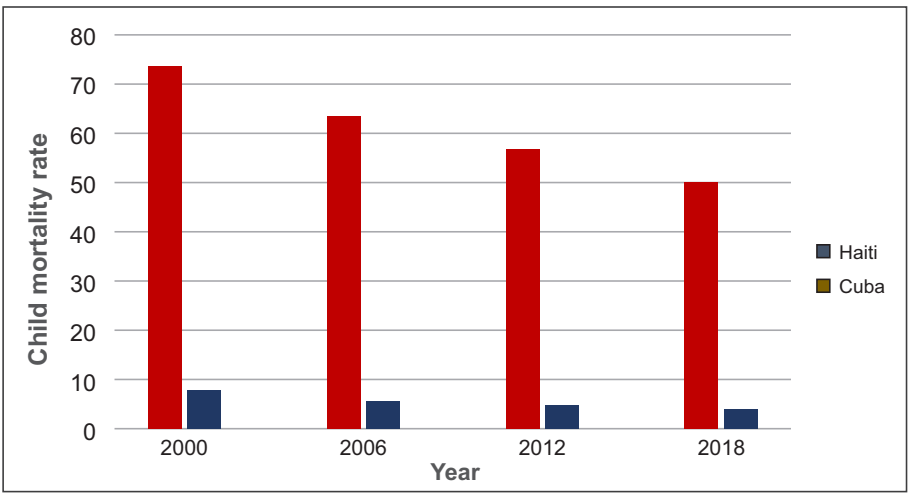
The social panorama of Latin America continues to reflect income inequality, poverty and reduced social spending, with a strong influence of migration, a topic of great relevance in the political and social agenda of the region. It can be seen that the income of the (1.0%) richest continues to grow. The small improvement in the income of the middle class was not reflected in the elimination of vulnerabilities for the majority of the population, which remained with low educational level, unemployment or low quality employment, low coverage and insufficient benefits in the retirement and pension system. For the effectiveness of social equality it is necessary to establish a pact of distributive equity and sustainability of social protection for the practice of social equality[7].

Harmful institutions in many of these countries contribute to widening of social inequalities, which have a negative impact on the economic development process[34]. In Brazil, despite high social inequality[31], the reduction in infant mortality rate can be attributed to conditional cash transfer programs to the poorest, to investments in primary health care, the reduction of illiteracy rates, low fertility levels and improvement of the access to water supply and basic sanitation[35].

In the early 2000s, demographic and epidemiological indicators in Latin America indicated similarities and contrasts in some countries, perceived as a social setback. To reduce the advertising of the opposition, some international organizations attributed the loss of social rights to the demographic transition, and not to the policies of neoliberal natural[36].

In Figure 3, it is possible to see the picture of the disparity that occurs in Latin America and the Caribbean. On one hand, Cuba, with its very small, sustained mortality rate and with a tendency to fall in the analyzed period, and on the other hand, Haiti, which despite having decreased its infant mortality rate by 33.3% over this 18-year period, still has a rate close to 50%.

Figure 3 - Comparison between infant mortality rates in Cuba and Haiti, from 2000 to 2018



Source: Health Nutrition and Population Statistics, 2020

The dire consequences of the action of American savage imperialism and European predatory colonialism, left as an inheritance for the region of Latin America and the Caribbean, influences of cultural oppression for the implantation of racisms and invisibility for all forms of prejudice, which reduce the people's self-esteem, in all life cycles. It implanted in the collective unconscious the bases to minimize the economic dependence, favoring the establishment of public policies which resulted in the increase

in poverty, low quality of the education and health systems, and of the loss or violation of social rights[37], which directly affected the childhood in the Region, reducing the chances of a healthy life in a highly selective and competitive world.

Final considerations

In short, the global economic crisis has spelled out chronic structural problems, sometimes invisible, in response to public policies to control inflation since 1990. Many countries in the region have even managed to hide many of their difficulties in financing development plans through behind the tune of multilateral agencies (IMF, IBRD, etc.), which forced the idea of artificially converting underdeveloped nations into emerging economies, given the boom in China's demand for basic products. It is interesting that, even with the rise of progressive governments in some countries in Latin America, in the period, the exacerbation of the debt trap prevented any possibility of advancing with the (neo) developmental plans that they tried to put in motion. Thus, unlike formal speeches, fiscal austerity policies set the tone for macroeconomic policy. Controlling expenditures for essential policies remained a priority of the model, as the continuous conversion of private external debt into domestic public debt was maintained, whose partial payments of increasing interest destroyed the already precarious capacity to foster new investments and promote essential public policies, that could sustain and advance quality of life in general. Thus, the tightening of the public debt trap ended up involving the extended reproduction of internal fiscal problems in each country. Paradoxically, the search for solutions to these serious problems, based on fiscal austerity, as opposed to promoting the possibility of new sources of financing for social policies, ended up generating an even more striking presence of private logic in the management of public services.

In the case of health policies, in particular, this perspective provided the outsourcing of services to social organizations and foundations and, even, the advance of the processing of proposals for the privatization of units in

favor of big capital. Within this logic, access to essential health services is increasingly restrictive, from preventive infrastructure, such as that linked to environmental sanitation, to primary care and more intensive diagnostic and treatment procedures. In this context, the advances made in preventive care and emergency care, which have been showing positive results in reducing child mortality in Latin America and the Caribbean, are being hindered. It is necessary to face this trend that points to a camouflaged scenario of definitive conversion of prenatal and postpartum into privileges for those who can pay for them, immediately, at the time of providing these services, as a prerequisite for the mother and child be assisted.

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