Peru case study:

Building comprehensive multi-sectoral policy and practice on child poverty and nutrition

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1. Introduction

This case study is implemented within the project 'Fostering policy support for child and family wellbeing - Learning from international experience'. Using a thematic and analytic framework for the project that draws on Kingdon's multi-streams theory,[2] we are gathering and sharing evidence and learning on what has led to increased policy recognition of and policy change in family and child health and wellbeing (FCHW). In specific countries that have demonstrated policy recognition and change in FCHW post 2000, we are exploring within their context how different policy actors have come together to raise policy attention, develop policy options and promote their political adoption as processes for policy change, taking advantage of windows of opportunity for that change. The case studies do not evaluate policy content or impact. They were implemented with a local focal person with direct knowledge or experience of the policy process and include evidence from published and grey literature and interview of key informants involved in the policy processes.

This case study explores the drivers of a shift from targeted strategies on food and welfare assistance towards comprehensive, multi-sectoral strategies to address child poverty through improved food security, access to health services and social protection.

It indicates how opportunities that opened in three rounds of political and electoral change after 2000 were used to raise policy attention, develop, adopt and institutionalise policy change.

The first opened after President Fujimori's resignation in 2000, with social dialogue for a shift from targeted social assistance for poverty and under-nutrition to more comprehensive universal approaches. Thematic policy round tables (Mesas) were set up for inclusive dialogue across civil society, technical and political actors to set a vision, priorities and a new policy approach and directions. The Mesas continued thereafter as forums for social communication and accountability. A non-state coalition (IDI) used evidence and local experience to build and sustain cross party political support on child stunting through advocacy on electoral pledges and 100-day commitments.

In the Garcia presidency from 2006, technical work to develop options from experience in the regions and Mesa dialogues used the policy space to promote the adoption and high level placement in government of co-ordinated multi-sectoral strategies for child poverty, health and nutrition, such as CRECER. Improved funding and results-based budgets with the finance ministry, together with communication outreach and capacity support incentivised policy uptake.

The Humala presidency in 2011 provided the opportunity to consolidate the institutional arrangements for co-ordination of cross sectoral work for social inclusion. A new Ministry of Development and Social Inclusion used evidence from annual household surveys and monitoring, dialogue with implementers and visible service delivery to consolidate political and public support. In all these phases, capable technical actors moved between civil society, state and government coalitions. This community of policy actors prepared and were ready for opportunities that opened, while building the evidence, exchange, consensus and trust for policy change.

2. The context

Peru is an upper middle-income country in Latin America, with a population of 32 million, three quarters living in urban areas and a large Amerindian population. After a history of military rule, a 20 year civil war in the 1980s and 1990s against a 'Shining Path' guerilla movement and a 'presidential coup' in 1992, the country is now under civilian rule as a unitary, representative democratic republic. In 1968-1975 the military government introduced agrarian reforms and expanded state-ownership in the economy to strengthen income redistribution. Yet economic conditions deteriorated and in the 1980s Peruvians experienced violence, hyper-inflation, instability and economic shocks. In 1991, 51% of the population were in poverty (Herrera, 2017).

Liberalization reforms (Fujimorism), introduced from the 1990s, lifted price controls, privatized state enterprises and removed state subsidies. Infrastructure investment and targeted food assistance was applied to reduce poverty. Although this stabilized the macro-economy, it weakened civil society. Social deficits and inequality widened, with a Gini coefficient of 0.54 by 2003 (Herrera, 2017).

Peru map, Source: CIA WFB in Wikimedia Commons

By the 2000s many Peruvians were disadvantaged due to their origin, status, residence, region or gender, living in precarious homes, lacking access to electricity, safe water, sewerage, adequate quality food, education, employment and secure incomes. Poverty disproportionately affected children and adolescents. The share of poor people amongst under 14 years was almost twice that of those older than 14 years (Oxfam, 2015). Child malnutrition was more closely linked to poverty levels than to aggregate economic growth (Acosta, 2011). A higher share of Peruvians see this level of inequality to be very unjust than in other countries in the region. Socio-economic inequality is reported to generate dissatisfaction with and distrust in government, especially where it reflects that *the rules of the game are not the same for all* (Levitsky, 2014; Herrera, 2017:18).

Peruvian child, Pxfuel, undated

For poor and undernourished children, the social policy response pre-2000 was targeted and fragmented: Health sector reforms opened the first level of care to private providers and used targeted insurance to support access to care for particular vulnerable groups, for school children in public schools and in 1998, for mothers and children under 5 years (Altobelli 2001; PAHO 2001; Iwami and Petchey 2002). While government created a National Office for Food Support (ONAA), its programs were reported to be weak and inconsistent, with implementation largely left to non-government organisations (NGOs).

Targeted state food assistance in the 1980s was through *Comedores Populares* (soup kitchens), a *Direct Assistance Program* (Programa de Asistencia Directa – PAD) for employment-based food assistance and a *Glass of Milk Program* managed by municipal governments for at-risk children under 6 years. In the 1990s these programs (except for the *Glass of Milk program*) were brought under a centrally managed *National Program for Food Assistance* (Programa Nacional de Asistencia Alimentaria; PRONAA) (Acosta and Haddad 2014).

Partly due to poor coverage, these programs in the 1990s had minimal impact on reducing child malnutrition, which continued to affect one in three children under five years old (UNICEF, 2004; World Bank, 2008). The country was spending US$250 million annually on food and nutrition programs without an overarching strategy to ensure their effectiveness and with shortfalls in reaching target populations. By 2000, for example, 28% of the districts with the highest child stunting rates received no nutrition services. In contrast, 47% of districts with a low prevalence of stunting received these services (Acosta and Haddad, 2014).

Food assistance programs operated in isolation of health and education interventions (World Bank 2006). They were largely reactive, targeted and aimed less at structural determinants than at their consequences. Yet the government preferred these targeted responses because they were highly visible and could generate political support, especially during electoral periods (Acosta and Haddad 2014).

This domestic context coincided with increasing international attention in the 1990s to debt relief and children's and women's rights, expressed in UN processes such as the 1989 Child Rights Convention, the UN conferences on reproductive health and women's rights, the 1996 Copenhagen conference on social development and the Millennium Declaration and Millennium Development Goals (MDGs) in 2000.

These international processes and particularly the MDGs provided an important policy impulse throughout the 2000s. The MDGs set concrete goals that were synergistic with social and professional demand in Peru. There was thus pressure to achieve them, especially given that Peru's sustained average annual GDP growth rate of 6.1% between 2002 and 2013 provided an economic opportunity to do this. International platforms and the MDGs also created space for civil society advocacy on social development, child health, nutrition and development and on applying a human rights language to family and child wellbeing (Oxfam, 2015; Herrera, 2017).

3. The policy change: investing in cross sectoral policy responses to child poverty and stunting

A range of policies took more holistic universal approaches to child wellbeing post 2000, while still including support to vulnerable families. While macroeconomic liberalisation was maintained, there was a paradigm shift in the early 2000s from 'growth for inclusion' to 'inclusion for growth', with programmatic developments and institutional changes to support this. This covered a number of dimensions of social development, including the change and investment in cross sectoral strategies to address child poverty and stunting, the focus of this case study. This section outlines the **content** of these policy changes, while the subsequent sections discuss how they came about.

As detailed in the next section, there were changes in *social participation and in the democratisation of the policy process*. In 2001, interim President Paniagua created through law the *Roundtable for Poverty Reduction* (*Mesa de Concertación para la Lucha Contra la Pobreza)* (MCLCP). This was a participatory mechanism for government, civil society and stakeholders to set a vision and the goals for Peru's future, to inform the transitional and future governments. Roundtables or 'Mesas' were a convening space for state and civil society contribution to and co-ordination of poverty- related and rights-based proposals, initiatives and programs and for building the local awareness and activism that was needed to achieve them (Acosta and Haddad, 2014; Paniagua 2001; UNDP 2010).

The democratisation of the policy process was enabled through multiple formal measures: The 2001 *Peruvian Social Charter,* created by the Mesa de Concertación para la Lucha positioned the state as servant of the people with guarantees of access to health, education and culture. New laws in 2002 (*Ley de Bases de la Descentralizacion, Ley Organica de Gobiernos Regionales, and Ley Organica de Municipalidades*) included citizen participation as a right and principle of regional and local governance. *Ley Organica de Municipalidades* created various institutions for representative participation in local authorities, including local roundtables of the MCLCP, Regional Coordination Councils, Local Coordination Councils, the National Health Council in 2002 (Consejo Nacional de Salud), the National Council on Education, and a process for participatory budgeting (World Bank 2006, 2008). The 2002 *Law of Transparency and Public Information* and subsequent laws set duties for state transparency, requiring central, regional and municipal governments to regularly publish information on services (World Bank, 2006). The Mesas grew in number and form, providing social input to decision-making on social policy at municipal, regional and national levels.

Consistent with the MDGs, priority was given to poverty, stimulating a *numerous policy measures to address child poverty and stunting*. A National Agreement (*Acuerdo Nacional* (AN)) in 2002 set long-term commitments to enhance social inclusion and reduce poverty and inequality through: universal rather than targeted access to health services and social security, the promotion of food security and nutrition and strengthening families for protection and promotion of child wellbeing (WHO and PAHO, 2015; Huicho et al., 2016, World Bank, 2008). A 2004 *Strategy to Overcome Poverty and Develop Economic Opportunities for the Poor* aimed to address poverty by creating economic opportunities; providing a social protection network; strengthening human, social, and institutional capacities and promoting transparency and citizens' participation, especially for poor communities (World Bank, 2008).

A conditional cash transfer program known as '*Juntos*' was launched in 2005 and a *National Strategy for Poverty Reduction* (CRECER) was created by Executive Decree in 2007. CRECER was launched as a coordinated poverty reduction strategy. It was located in the Office of the Prime Minister to give it leverage in co-ordinating different sectors, private, international and civil society agencies and supported by an Inter-Ministerial Commission for Social Affairs (CT-CIAS) involving ministers and chaired by the Prime Minister (Acosta and Haddad, 2014).

CRECER represented a change from past government interventions to alleviate malnutrition in that: *a) it promoted a wider set of policy interventions that went beyond food distribution, b) it promoted complementarity of interventions and facilitated policy coordination within government agencies and between government and non-governmental agencies, c) decentralised the scope of interventions, devolving administrative, financial and political responsibilities to regional and municipal governments, and d) sought to adequately fund policy interventions through integrated financing and results based budgeting, a budgeting tool which allowed for focused and transparent government spending* (Acosta, 2011:3; Huicho et al., 2016).

CRECER included complementary interventions for improved nutrition, including: training of health workers, improved cooking practices for mothers, improved hygienic conditions, access to clean water and conditional cash transfers through *Juntos* (Acosta and Haddad, 2014). In 2011, CRECER was replaced by the [Programa Articulado Nutricional](#) (PAN) that aimed to reduce chronic malnutrition in children under 5 years through a deepened mix of sectoral strategies, including literacy, growth monitoring (CRED), family health, water, sanitation, immunization, clean energy and food supplements and linking to comprehensive health insurance, social promoters and community agents. It too involved multi-sectoral work under the Presidency of the Council of Ministers, together with the regional and local governments, under the technical co-ordination of the Ministry of Health (MEF, 2019; Sun 2018).

Health sector reforms played a role in both child poverty and nutrition, through universal and increased access to comprehensive services. In 2002, the various fragmented insurance schemes described earlier evolved into the *Seguro Integral de Salud* (SIS), a comprehensive health insurance that aims to increase the delivery of comprehensive health services at all levels, removing user fees for poor people, and with 44% of its resources devoted to the two poorest quintiles in the population (Huicho et al., 2016, Altobelli 2001; World Bank 2006). Public investment in health increased significantly, as shown adjacent.

Trend in the public health budget, Peru, 2002-2018
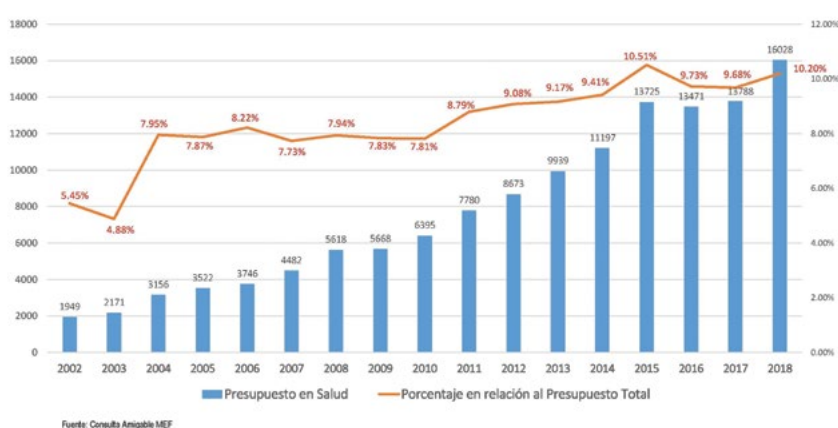
Source: del Carmen J, 2019:7

The reform set up Local Health Administration Committees for community participation (World Bank 2006). A further phase of health reform post 2009 (PARSALUD) focused on decentralising services and on families with pregnant women and children under age of three in the nine poorest, largely rural regions or Peru. The 2015 [Programa Nacional de Inversion de Salud](#) (PRONIS) allows regions to set their own priorities in health and request funding from the central level (World Bank 2016).

As a further reflection of the change, there were *institutional reforms for and investments to deliver and ensure implementation of these policies.* As described in subsequent sections, this included the establishment of a Ministry of Development and Social Inclusion (MIDIS) and of mechanisms to review and provide feasible options for achieving the goals set in the AN; the organization of additional resources for these areas; and the organization of evidence on and review of the achievement of results to show effective use of the investment and delivery on policy goals.

A timeline of the main policy events is shown below, and graphically in Annex 1

Year	Policy/ law/ program
1970s 80s and 1990s	National Office for Food Support, Direct Assistance Program; Glass of Milk Program and soup kitchens set up. The School Health Insurance program founded and launch of the first health-insurance program for mothers and children under 5 years. Alberto Fujimori president 1990-2000 when Alejandro Toledo became president after ousting of President Fujimori, interim President Paniagua and elections in 2001.
2001	The Roundtables for Poverty Reduction formalized by Supreme Decree 001-2001. The Decentralization of Health Services funded and Comprehensive Health Insurance (SIS) proposed. Decentralisation of elections for all Regional governments.
2002	Law 27657 of the Ministry of Health creates SIS and decentralization of the Ministry. A National Agreement (Acuerdo Nacional) institutionalises dialogue and negotiation as a principle of the State. Various laws are passed recognizing citizen participation as a right and principle of governance and on transparency and public Information. A participatory budget process is piloted by Ministry of Finance officials in nine regions.
2003	1,283 Roundtables (MCLCP) in the country discuss poverty reduction initiatives
2004	Participatory Budgeting is made mandatory by law. Peru's Demographic Health survey (ENDES) moves from a five yearly cycle to an annual survey.
2005	Launch of JUNTOS conditional cash transfer program. Supreme Decree 052-2005-PC transfers health-related functions to regions and local government after accreditation. The Child Malnutrition Initiative (IDI) is formed. Acuerdo on universal health insurance
2006	IDI challenge to Presidential candidates to make the fight against malnutrition a national priority and reduce child malnutrition during the first 100 days. President Garcia elected in 2006 and commits to reducing malnutrition by 9%, issues the National Plan for Human Rights 2006-2010 and launches the Integrated Nutrition Program,. Reglamento de Alimentación Infantil and Act No. 26,790 Modernizing Social Security for Health. Results-based budgeting introduced by law.
2007	The National Strategy for Poverty Reduction (CRECER) is established
2008	Sample size of the demographic health survey is increased to be able to estimate prevalence of malnutrition. Law enacted to decentralize implementation of CRECER.
2009	Ley Marco De Aseguramiento en Salud passed on universal health insurance.
2011	IDI replicates its 2006 advocacy campaign during regional national elections with 25 regional presidents agreeing to commit to reducing chronic malnutrition. Ollanta Humala becomes president. CRECER replaced by the Estrategia Nacional de Desarrollo e Inclusión Social "Incluir para Crecer" and the Programa Articulado Nutricional (PAN). The Ministry of Development and Social Inclusion (MIDIS) created with a mandate to integrate multisectoral antipoverty programs including in health.
2013	Estrategia Nacional de Seguridad Alimentaria y Nutricional 2013 – 2021 developed.
2015	Programa Nacional de Inversion de Salud (PRONIS) is approved and operationalized for regions to set their own health priorities and request funding from the central level.
2016	IDI advocates for political support for the reduction of malnutrition during the election. Pedro Pablo Kuczynski elected president.
2018	Government announces plans to dramatically reduce levels of child anaemia and malnutrition using a multi-sectoral strategy involving the mobilization of social program promoters and community agents.

Sources: Huicho et al., 2016; Altobelli 2001; Garatea 2007; World Bank, 2006; Sun 2018; Acosta and Haddad, 2014; World Bank 2016

Trend in chronic malnutrition in infants, 2000-2016
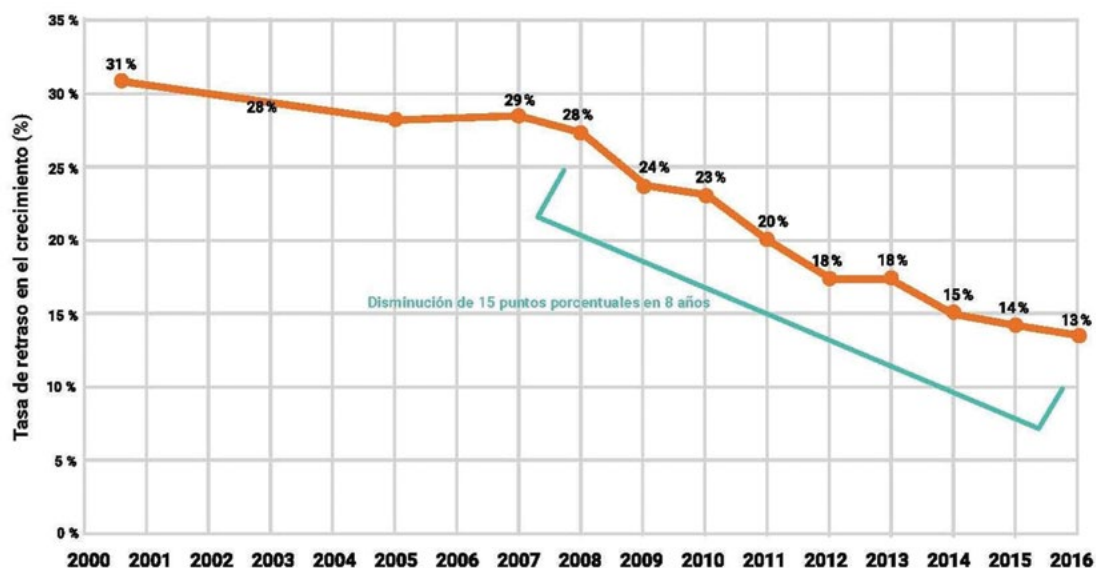
Source: Marini et al., 2017:49

While this paper does not aim to evaluate the impact of these policies, there is evidence that the country experienced one of the most significant declines in income poverty in the region, contributed to in part by these policy changes. The incidence of poverty fell from 48% in 2000 to 24% in 2013 and extreme poverty fell from 16% to 4% between 2004 and 2015 (Boyden et al., 2019). Inequality, measured by the Gini coefficient, showed a smaller decline from 0.55 in 2004 to 0.50 in 2009 (PAHO 2001; Iwami and Petchey 2002; Huicho et al., 2016; Escobal, 2010) The fall in poverty, improved access to health services and to a wider variety of foods and urbanisation contributed to a fall in child stunting.

After a decade of no progress in 1996-2005, child stunting fell from 23% in 2005, to 18% in 2013 (Herrera, 2017). In 2019, Peru was reported to have achieved an annual reduction in multidimensional poverty (MPI) of 7.1% against its baseline, reducing deprivation in all 10 MPI indicators (UNDP, 2019). Under 5 year mortality per thousand fell from 39.8 in 2000 to 16.7 in 2013. Social, urban–rural, and regional inequalities in education, health service coverage, mortality and stunting all declined substantially (Escobal, 2010; Acosta, 2011; Huicho et al., 2016; NLIS, 2019).

We do not intend to analyse or explain the cause of these improvements. Various authors have attributed the changes to a combination of improvements in social determinants of health, sustained investment in inter-sectoral programs and child-focused interventions within broad anti-poverty strategies, backed by political support and participation of civil society (Huicho et al., 2016). There is also report that while child stunting and poverty have fallen, new challenges have emerged, such child anemia, child overweight and obesity due to poor quality diets (Boyden et al., 2019).

This case study explores in the subsequent sections what led to the changes in policy described in this section, from reactive, targeted approaches towards the more holistic, cross sectoral approaches that addressed child poverty and stunting within a broader goal of social inclusion.

4. The story of the change

4.1 Raising the profile of child poverty and nutrition

The resignation of the Fujimori government in 2000 and successive democratic changes opened a window of opportunity for social mobilization around public perceptions of high levels of poverty and inequality and a demand for social consultation in national policy dialogue (Arce, 2008). Civil society held dialogues within regions and nationally on people's vision for the country and on the proposals and programs that could deliver on social expectations. As noted earlier, policy attention was also promoted by the international policy processes described earlier, particularly the MDGs, but also the Cairo and Beijing conferences and the 2000 World Social Forum (Arce 2008). The *Mesas* (roundtables) provided an important mechanism for social input. They were inspired in part by the success of the national *Mesa de Diálogo Democrático*, organized by the Organization of American States as a non- violent measure for post-Fujimori political resolution. The Mesas initially focused on the electoral process and the national constitution, within the changes brought by the resignation of the Fujimori Government in 2000 and the organization of elections in 2001 (Huicho et al., 2016).

The establishment in 2002 of the *National Agreement* (Acuerdo Nacional, AN) was pivotal in consolidating political and policy attention on child poverty, health and nutrition. To signal its importance, the national AN forum was presided over by the President of the Republic or the president of the Council of Ministers. The AN involved government, political party and civil society participants in forums from local to national level, to discuss various matters of national importance and reach consensus on summary policy positions.

The AN website describes a citizen participation that included over 200 000 surveys distributed (with 44 777 responses), a website for inquiries and suggestions, a free telephone line that received over 1 000 calls for information and 107 additional survey responses. The widespread and organised consultative process used by the AN and the adoption of policies by consensus meant that the areas included in the agreement were widely known. One survey found, for example, that 61% of those interviewed felt informed about it (Huicho et al., 2016; Altobelli, 2001; World Bank, 2008; Acuerdo Nacional, 2014).

From the electoral process, the Mesa dialogues turned to priority challenges. Poverty and child stunting were identified in these processes as high priority issues, with the MCLCP Mesa established for dialogue on it. Advocacy within the Mesas took on a programmatic focus, advocating for budgets for specific program areas, such as multi-sectoral interventions for improved nutrition. Mesas were also formed on other issues, such as the *Consejo de Negociacion* between state, employers and labour on labour matters. The roundtables increased from 200 to 1400 in the first two years. They were stronger at national level, with their strength in regions depending in part on the strength of civil society in those regions (Garatea 2007; World Bank 2006). As the decade progressed, policy dialogue became more institutionalised within government. However, with the adoption of decentralisation and the establishment in 2006 of regional governments, the Mesas also provided social input to decentralised government and connected this from local to national level.

These dialogue processes were informed by the *significant body of evidence generated from various ad hoc surveys and national household surveys*. Local NGOs that had worked with UNICEF in the 1990s provided evidence on the scale of child undernutrition. As recipients of substantial international resources in that period and the early 2000s, non-state actors were able to innovate and implement local trials of interventions for child poverty and nutrition that showed the potential to produce gains in child stunting. In an international collaboration, a 'young lives' program in Peru established in 2001 a cohort of 2000 children from one year of age in 20 sites nationally. It has held rounds of monitoring every 3-4 years up to the current date on a number of dimensions of child wellbeing (Boyden et al., 2019).

Large-scale communications campaigns were implemented and videos broadcast to inform the public on policies and services (Graham 2018). In 2004, Peru's Demographic and Family Health Survey (ENDES) implemented by the Instituto Nacional de Estadistica e Informatica changed from being held every 5 years

to annual data collection. Peru was the first country globally to implement this. It responded to a demand discussed later for information from policy actors such as the finance ministry to manage change and to assess progress on national performance goals and on the MDGs (Rutstein and Way, 2014). Evidence from the ENDES on children's conditions and on the delivery of policy interventions also provided credible information for social and policy dialogue (Rutstein and Way, 2014).

Public access to information and analysis and use of evidence was also supported by government and other institutions making information available online. They used maps and visual tools to make it more accessible to the public. MIDIS, for example, developed a platform for publishing information from household surveys on the web. This platform, INFOMIDIS, enables communities and service providers to see visually who is covered by programs. These processes have widened the use of evidence in policy dialogue. There is acknowledgement of a digital divide that still needs to be overcome to properly address citizen's rights to such information, and a need for more in-depth analysis and accessible presentation of the rich data set (MIDIS, 2012; Rutstein and Way, 2014).

Online information on program coverage, MIDIS website, 2019

Civil society also played an important role in raising and keeping the focus of policy attention on child nutrition, both directly at national level, and indirectly in their contribution to the Mesas and regional processes. For example, regions that had higher levels of poverty (Andean and particularly Trapecio Andino) were more vocal on child poverty and stunting, in part due to the larger presence of international and civil society agencies operating in these regions. They raised issues to national level through both the council of regional governments and the Mesas. Groups of civil society also took up advocacy on specific thematic issues. The Grupo Iniciativa Nacional por los Derechos del Nino (GIN), a forum of 30 NGOs advocating on children's situation and rights.

A *Child Malnutrition Initiative* (Iniciativa contra la Desnutrición Infantil) (IDI) brought together non-state actors and technical actors to draw evidence from local practice on strategies for improved child nutrition, including improving feeding and hygiene practices; access to micronutrient supplements; community health surveillance; household income and food availability (Acosta and Haddad, 2014). IDI profiled child stunting on the policy agenda. The coalition included eighteen member institutions: Action Against Hunger , ADRA Perú, CARE Perú, CARITAS Perú, UNICEF, UN Population Fund, Future Generations, Institute of Nutritional Research, the MCLCP, FAO, PAHO, Plan International, PRISMA, World Food Program and USAID, although in later years the international organizations did not participate as members. The NGOs realised they would have greater influence working together rather than competitively.

The forum provided a means to co-ordinate and share information, enhancing their ability to engage with technical and political actors (Acosta and Haddad 2014, Bill and Melinda Gates, 2017). The NGOs in the IDI communicated with people in communities, like teachers, to raise awareness. In regions they worked within the Mesas as the main means for social participation to draw attention to opportunities to effectively respond to child poverty and stunting. From 2005, as described in later sections, IDI promoted the political commitment to this agenda and engaged government on actions to address infant nutrition as a national priority, documenting the learning from local approaches.

Civil society advocacy continued in the decades that followed, albeit with some increase in resource insecurity, weakening capacities and a growth in confrontational approaches. Transnational mining companies experienced repeated local and national social protest around their poor social investment and harm to health and environment (Arce, 2008).

In health, a broad alliance of social and health workers' organizations in an increasingly organised health civil society formed *ForoSalud*, a network of health rights organizations and activists. It included technical NGOs and membership-based organisations of patients, women, health promoters and others. Forosalud provided a civil society vehicle for consultation with government on national policy issues on health. It produced independent views and contested changes that were seen to be undermining the public sector health system, or where the health ministry was seen to be abandoning universal approaches, health promotion and social determinants, including in relation to child nutrition. In 2013, for example, Forosalud mounted a 5000 strong protest at a government and WHO dialogue alliance on deepening market-led health insurance (PHM, 2015).

The processes used to translate this policy attention into specific policy content and programs are described later. By 2015, thirty-four "State Policies' had been approved with other medium and long-term commitments in 111 plenary sessions in the AN (Iguiniz, 2015). *Notably, the social processes described in this section, together with the experience of service changes and wider socio-economic changes, are said to have changed social perceptions.* Women in particular are reported to have a greater understanding of the investment needed in the early years for their children's long-term development. The changes are said to have been slower in men, especially in rural areas. This is a work in progress and new issues are also being raised for policy attention, such as taking wider action on early child development.

Forosalud collage: A Frisancho and SUNASA

4.2 Engaging and ensuring political commitment for policy adoption

Peru had a decisive political window of opportunity with the end of the Fujimori government in 2000-2001. The relatively high level of electoral change thereafter opened opportunities for further advances, but also raised a challenge of potential reversals in social policy. The next section describes how a more continuous policy trajectory was enabled despite these many electoral changes. This section outlines key features of the political drivers of the policy change and the decisions to formalise the changes in law, policy and institutional practice.

The AN, as a concerted political agreement, reflected a long-term commitment to reinforcing the democratic system, enhancing human rights and social justice and reducing inequalities. It was to be advanced through a social and political consensus that included political actors, civil society and the private sector, served by the consistent adoption of sound, evidence-based programs and interventions (Huicho et al., 2016). The Mesas facilitated direct inclusion of local political actors and many former members of the roundtables became politicians themselves (Garatea 2007).

The involvement of political actors in the working groups and roundtables raised their awareness of prioritised issues such as child poverty and nutrition and exposed them to the views and evidence from other stakeholders (WHO ad PAHO, 2015). The AN not only provided a high level instrument for political and policy coordination on its key directions, but also levered a political commitment to investing in and increasing public budgets for the priority areas (Nepo-Linares and Velásquez , 2016). The engagement of political actors was not only important to support the policy change, but to also ensure its implementation. For example, local governments where the mayor came from a leftist, indigenous or union background were more supportive of the initiatives and had better outcomes (Wittek, 2014). In contrast, policy uptake was weaker where there was opposition from municipal politicians or traditional community leaders, where political changes in the regional governments led to poor political continuity and where there was political fragmentation, including between local regional and national levels (Acosta and Haddad 2014; World Bank 2008).

Building on the AN and the Mesa engagement of political actors, civil society and professionals engaged political actors on child nutrition in different electoral processes. In the presidential, regional and municipal elections in 2006, IDI campaigned to secure political commitments in all these levels to reduce child malnutrition. With national and regional electoral candidates keen to sign public declarations and increased public awareness, child poverty and stunting was given wide coverage by independent (non-government) print media such as Revista Caretas and Radio Programas del Peru (Acosta and Haddad, 2014). The IDI involved the Mesas in its advocacy, especially at regional level, although in 2006, the political engagement and policy response was more top-down than bottom-up. The presence of a World Bank nutrition advocate (John Newmann) in 2006 reportedly helped to bring the IDI's evidence and processes to cabinet attention and to elevate the campaign to presidential level, given the World Bank's connections with economic and political actors.

During the 2006 presidential campaign, the IDI challenged the ten running Presidential candidates to make the fight against malnutrition a national priority, if elected. IDI provided evidence on a package of successful interventions to stimulate the confidence of political actors in making this commitment. A pledge was signed by all the candidates to reduce chronic child malnutrition (stunting among children under 5) by five percentage points in children under 5 years old in 5 years (the 5x5x5 campaign) (Acosta and Haddad, 2014). President Garcia was one of ten candidates who signed this pledge (Acosta and Haddad 2014). When he was elected, IDI drafted a further policy document for action during the first 100 days of government, *10 recommendations for the first 100 days*, with proposals for action on child malnutrition (Acosta and Haddad, 2014; World Bank 2008). Reducing child undernutrition was adopted by President Garcia as a legacy issue and he committed to an even more significant reduction in malnutrition of 9%. The IDI then reported regularly on the actions the government had undertaken to meet these policy commitments, with recommendations on issues still needing to be addressed.

Over the decade the emphasis shifted from building political support for policy adoption to ensuring political support for delivery on policy commitments. This raised the importance of the strength of horizontal policy coalitions across representatives of different government and non-government agencies; the co-ordination of agencies and programs between national, regional and municipal governments; and the allocation of government resources to fund the initiatives (Acosta, 2011).

The annual ENDES household survey provided rapid evidence of changes to show both progress and gaps to political actors. For example, a plateauing improvement in child undernutrition in 2009-2010 after a sustained period of decline in the preceding 3 years, shown earlier, raised political concern and sustained support for investment in the sectors and strategies in CRECER. The positioning of key programmatic strategies such as CRECER in the Office of the Prime Minister (Presidencia del Consejo de Ministros) and the chairing of the Technical Secretariat of the Inter-Ministerial Commission for Social Affairs (CT-CIAS) by the Prime Minister signaled high-level ministerial support for these programs and gave them the leverage needed to convene other government ministries and entities (Acosta and Haddad, 2014). The evidence-based support by the Ministry of Economy and Finance (MEF) and its co-operation with the Ministry of Development and Social Inclusion (MIDIS) helped to inform and build support from political actors in both the legislative and executive branches (Huicho et al., 2016).The more detailed processes in the state that incentivised and institutionalised this political support are described in the next section.

When the regional governments were formed, the National Assembly of Regional Governments signed a *National Commitment to the Inter-departmental Fight against Chronic Infant Undernutrition in Peru* to co-ordinate sector and regional action towards achieving shared goals and targets related to poverty and chronic child undernutrition (MIDIS, 2012). Prior to the 2011 regional and national elections, IDI again campaigned for the continuation of an integrated, coordinated and decentralised strategy for addressing child malnutrition. A *Vota por la Niñez* coalition co-ordinated by the IDI during the 2010-2011 campaign advocated for specific targets for reducing chronic child malnutrition and anaemia, as well as other critical areas of child rights (health, education, identity, working children, participation, violence) (Acosta, 2011).The coalition sought to engage Peru's regional government leaders, along with other allies such as the World Bank. The Presidents of the 25 Regions in Peru signed a Declaration on Child Malnutrition that committed them to reducing chronic child malnutrition by 5 percentage points. (Acosta and Haddad, 2014).

Again in the 2016 elections, IDI campaigned to get the question of nutrition in the electoral debates. They tapped their networks and got 2000 people to send the same question to the election board: *What will you do to continue reducing chronic malnutrition in the country?* (Stanojevich and Luna, 2017). The coalition became a sustained "advocacy conscience", to remind, guide and monitor government commitments to reducing malnutrition. It advocated for implementation of the national CRECER policy with national and sub-national authorities. When there was a change of premier in 2009, the coalition swiftly reminded the incoming premier of the political commitments signed by his predecessor (Acosta and Haddad, 2014).

These various forms of political advocacy and engagement with political actors from all parties built a cross party consensus on child poverty and nutrition, so that consensus often existed by the time policies were brought to the Congress for formal adoption in law. The Humala government in 2011 brought in to his Cabinet political actors that had a commitment to social inclusion. This opened a further window of opportunity for deepening the institutional changes, described further in the next section. Government established the MIDIS and its processes for analysing and presenting evidence on the social, technical, economic and political feasibility of programs to motivate political support for them. In contrast to the experience in the 1990s of a significant influence of international actors in policy adoption, by 2011, the international and local investment in domestic capacities, academia and in evidence such as the ENDES enabled a consistent domestic input to political decision-making.

In a context where Peru has had frequent changes in government and political leadership, the institutionalisation of capacities, methods, evidence-based approaches and resources within the state helped to stabilise, consolidate and sustain policy implementation across political changes. This is described in the next section.

4.3 Developing and implementing credible options for inclusive policies

This section outlines the actors and processes that generated the policy content and sustained policy implementation in response to the demand and political commitment for a more holistic approach to child poverty and nutrition.

In the window of opportunity provided by the democratic political changes, in the early 2000s, discussions in the Mesas, civil society and state sectors contributed programmatic approaches (Garatea, 2007). In the early stages they drew on local experiences, such as that of Ayacucho region, where child nutrition improved at a time when it did not in other regions. This region addressed child nutrition through a mix of health, education and nutrition interventions, supported by community level health workers. The success of Ayacucho pointed to the potential of multi-sectoral approaches to child nutrition. Such approaches were also supported by social and political actors in the Mesas and the IDI advocacy. Piura region provided a further positive experience of how dialogue between different stakeholders and sectors supported such multi-sectoral approaches.

Services in one sector and constituency were linked to and mutually reinforced by those in another. The *Juntos* cash transfer program, for example, launched in 2005, gives 200 Peruvian Soles ($61) to mothers in poor families every two months in return for them regularly taking their young children to check-ups at health centres and interacting with other child care services, supported by community health workers. *The service design itself thus communicated shifts in policy orientation*. The *Juntos* program seeks over the longer-term to change the relationship between citizens and state-funded social programs for citizens to input to and demand accountability from service providers (Sánchez et al., 2016; Jones et al., 2007). As a universal approach, the SIS health insurance launched in 2002 made clear the universal approach to users. It provided a negotiated annual level of per capita funding for comprehensive services, with 80% of the population covered by health insurance and 49% by the SIS (Velasquez, 2018).

Social dialogue in policy development and inclusion of affected populations in implementation and review has helped to integrate social issues and to provide review feedback from practice. In *Juntos*, for example, an *Oversight committee on supervision and transparency* includes members of the church and civil society.

The oversight committee identifies operational issues to feed into policy review. Community facilitators from the beneficiary population not only link families to services, but also give public talks and verify whether program commitments are being achieved in assemblies with villagers (Jones et al., 2007). Improving household incomes and improved access to these service interventions have shifted public attitudes, awareness and practice from short term actions to secure immediate survival to longer term planning for wellbeing of families and children.

The specific programs were described earlier, including PRONAA, Juntos, CRECER and after 2011, the PAN. In their initial stages, they were located in the Prime minister's office, to facilitate co-operation across the health, education, women, and other sectoral ministries involved (Acosta and Haddad, 2014). The central level set the framework and guiding principles and convened and co-ordinated key ministries at national level (MIDIS, 2012). The sectoral ministries, particularly health, delivered their program inputs through their regional and local structures and personnel, while the regional governments provided political support and co-ordination. The sectoral ministries had their own roles and budgets, but linked initiatives where relevant, such as in the link between the health services and social funds in *Juntos*.

The regional assemblies and Mesas provided platforms for social participation and oversaw implementation, monitoring delivery on the intended co-operation /articulation between sectors. The regional governments also had some latitude to put their own stamp on the programs. For example, in Ayacucho's CRECER-Wari program, local authorities in the region worked with social coalitions and external funders to address food security and poverty through locally planned public investment projects on water and sanitation, to effectively use natural resources and promote of healthy homes (COEECI 2012). While these local experiences provided input to national policy options, in most cases regions implemented centrally designed interventions and engaging local communities on their uptake (World Bank, 2016).

Two key policy features incentivising uptake of policy options were established in the financing approaches and the use of evidence to monitor progress. A 2006 law established a results-based budgeting approach, applied in practice in 2007. While in line with the wider macroeconomic liberalization being promoted by the World Bank and IMF to improve cost efficiency, the approach incentivized the social programs in health, education, housing, labour, Juntos, PRONAA and others to achieve complementary goals. Each sector had its own performance indicators and budgets that together matched the priority areas for cross sectoral intervention. The approach was applied to encourage the regional governments, ministries and Mesas to identify how they would achieve the identified outcomes by applying the proven interventions and to share information on the results achieved. The regions had some flexibility and could apply their own funds to local priorities and innovations (Acosta, 2011; Acosta and Haddad, 2014; Marini et al., 2017; Stanojevich and Luna, 2017).

The visibility of the policies and success of approaches such as results based financing depended on the capacities to implement them. This triggered various measures to support these capacities and incentivize implementation. The capacities varied widely and many regions and sectors were not well prepared. Key informants point out that regions such as San Martin were able to overcome limitations in capacity and actively use evidence to assess results and apply incentives also had better nutrition outcomes.

In 2009, after the finance ministry observed that many sectors were not adequately responding to the results based budgeting, they further stimulated the approach by providing a template for costing the inputs needed to achieve results to inform budget bids. They also provided equity grants to address differential capacities and conditions within regions. Beyond improving budget allocations for the different sectoral inputs, the MEF also took part in joint outreach to engage the regions on the planning for and use of these resources. For example, in 2007 the health and finance ministries engaged local government levels on rearranging existing budgets to refocus them on chronic malnutrition, supported by additional financial resources for all sectors for nutrition. Further, in 2016, the health ministry was given legal power (Ley 30423) to intervene in underperforming regions. A combination of legal power, financial incentives, capacity support and active monitoring were thus applied to facilitate the policy implementation (Velasquez, 2016).

The electoral changes in 2011 and the opportunities it opened, noted earlier, included the creation by law of the Ministry of Development and Social Inclusion (MIDIS). The MIDIS took on a leading role in framing and co-ordinating population-focused policies aimed at strengthening social inclusion and closing the poverty gap (MIDIS, 2012). It drew personnel from the finance ministry and built a strong link with this ministry to support co-ordination.

In close co-operation with the finance ministry, in 2011 MIDIS set up a monitoring and evaluation system that developed instruments to ensure that the evidence generated not only fulfils the highest quality standards, *but also is translated in a learning source to continuously improve development and social inclusion interventions* (Velasquez et al, 2014: 186). The system provided evidence to inform the planning, budget prioritisation, management and accountability of programs and performance improvement plans, appreciating how the evidence needed is different at different phases of the program. Interventions to implement the key policy directions were developed and proposed by state technical actors through evaluations of past practice, and drawing on local studies and international experience. The technical, economic, social and political feasibility of these options were then assessed in the MIDIS. Social feasibility was assessed through opinion polling and, on some issues, discussions in the Mesas and journalist briefings. Where there were concerns, modifications were discussed to enhance feasibility, before presenting the options to political actors.

The approaches in MEF and MIDIS further motivated demand for the ENDES surveys, to provide annual evidence for assessing and reporting results to government, sectors and stakeholders. There is a perception that further complementary information is now needed to assess implementation issues and social differentials in outcomes and practices (Rutstein and Way, 2014).

MIDIS has thus developed a mix of area-based and community-centred approaches, including both the supply-based provision of services and infrastructure and demand-based initiatives arising from communities. Some of its approaches were piloted in provinces, with a learning stage to draw evidence, community and service feedback to inform policy (MIDIS, 2012). *The organisation of evidence by MIDIS to assess policy options and from monitoring of implementation has provided an important feedback loop to inform policy choice and design, as an important means for ensuring the support for and success of policies.* Hence, for example, when a 2012 evaluation of the PRONAA food assistance program found poor targeting, access and uptake by children and issues with its quality and transparency, decision makers closed the program (Velasquez et al, 2014).

These strong central capacities, mechanisms and incentives for coordination of the different sectors and programs for in child poverty and stunting has made the top-down, vertical co-ordination of policy from national to municipal level stronger than the bottom-up influence. On the one hand, it has enabled the design and delivery of policy measures and services across very different regions and local power relations. On the other, the horizontal co-ordination at lower levels is judged to be weaker, with lower levels less institutionally able to manage the turnover in elected leaders, the gaps technical and administrative capacities and social disengagement due to local power relations (Acosta and Haddad, 2014; Graham 2018; Jones et al., 2007).

Co-operation across sectors was noted to also depend on the professional, non-partisan and personal affinities of stakeholders and the leadership of the regional governors (Acosta, 2011). Where this existed, as for example in Ayacucho region, the combination of policy coordination across sectors and political co-operation across elected officials at the sub national level was reported to have led to a reduction in chronic malnutrition and poverty rates of 6% and 16% respectively between 2005 and 2009 (Acosta, 2011). Despite such positive experiences, implementation of the policy commitment to sustained co–operation or integration across sectors remains a challenge, with individual sectors still more focused on their own budgets, programs and goals. With the central level dominant in policy processes and a context of frequent electoral change, the Mesas, the evidence from ENDES and other sources and the competence and orientation of state actors at central level appear to be key factors in institutionalising and delivering the longer term policy measures on child poverty and nutrition.

5. Summary of and learning on key drivers of the policy change

5.1 Summary of drivers and processes fostering policy change

The case study suggests that there were several windows of opportunity for the policy change on child poverty and nutrition in Peru, mainly associated with political and electoral changes. The first opened after President Fujimori's resignation and enabled social dialogue for a shift from targeted social assistance for poverty and under-nutrition to more comprehensive universal approaches. The second came with the Garcia presidency, providing space for the co-ordinated multi-sectoral strategies in CRECER, and the increased funding and results based budgeting to support it. The third window appears to have emerged with the Humala presidency, used to consolidate the institutional arrangements for co-ordination of cross sectoral work for social inclusion.

Hence while frequent electoral change and neoliberal macroeconomic policies across three decades created challenges, it also provided openings for policy change to better reflect 'inclusion for growth', particularly on child poverty and stunting. A progressive expansion of participatory mechanisms for policy dialogue, of comprehensive and networked social protection systems, a universal health system; active use of evidence and incentives to support implementation and support of cross sectoral co-ordination, while still work in progress, contributed to advancing policy changes that were then associated with impressive reductions in child poverty and stunting. The opportunities that opened with electoral change were taken advantage of by a mix of actors that had built relations and work from the 1900s, with different 'centres of gravity' in each of the three electoral 'openings'.

In the first phase the social institutions, particularly in the Mesa roundtables, created a visible mechanism from local to national level for social dialogue on policy that brought different actors, including political actors together around shared vision and goals, given further impetus by the need to deliver on international commitments in the MDGs.

The socio-political process that framed the AN set a framework of policy commitments that helped to sustain the direction of policy development for many years. The Mesas have themselves been sustained over about two decades as platforms that other civil society coalitions and the state have participated in to provide or listen to social input on policy and to build social accountability on its delivery.

As policy processes moved to becoming more top-down in the ensuring years, they have helped to bring local voice to national level dialogue, albeit with varying degrees of influence and representativeness. Other organizational forms have also supported social input to policy. The successful use of electoral pledges in the IDI campaigns on child stunting and their demands for the first 100 days took advantage of electoral opportunities to build sustained cross party support, while monitoring delivery on the pledges made.

The technical community played a key role in preparing for and consolidating progress when the second window of opportunity opened. While drawing positive experiences from regions to inform policy options in Mesa processes in the early stages, the strategies became more centrally developed and strategically located in the Prime Minister's office to signal the high level support and lever the necessary co-operation for their uptake.

Funding increases and results-based budgeting by the MEF; and investment in the ENDES and other evidence enabled the central level to incentivise the uptake of new policy strategies like CRECER, backed by work and outreach with sectors such as health to support uptake by regions and municipalities. The communication of evidence and delivery of change was important to sustain political, regional and social support.

The third electoral change provided an opportunity to more deeply institutionalise the approaches and sustain their delivery. The establishment of MIDIS and its use of evidence and dialogue to review and monitor both supply and demand driven policy options has facilitated their credibility with political actors and built public support from visible changes in services. Institutionalising the policy changes has helped to make them less susceptible to reversals after electoral change.

In each phase the social, technical and political drivers interacted with each other, whether directly in mechanisms like the Mesas or indirectly in informal networks and in the transition of people between civil society, technical and political (ministerial) roles. The link to and sometimes strategic intervention from international agencies and policies gave leverage to these largely domestic forces.

The social and political interactions in the initial period focused on ensuring that child poverty and stunting would be prioritised in the policy agenda. The technical and political interactions in the later periods focused on developing the policy strategies to deliver on the directions agreed in the AN and in electoral commitments, and then on institutionalizing their implementation. Over time this has led to a range of multi-sectoral approaches, some universal such as the SIS, some more targeted such as the links to Juntos, but all demanding co-ordination across sectors and institutions to address determinants of child poverty and nutrition. The successful implementation of services has been important to change social mindsets and generate public support. The interactions between the social, technical and political actors that have produced - and are still needed for - these policies build on relations that have grown over many years, in both formal and informal networks. Evidence of different types, on the situation, on experience of options, on delivery and results and now on outcomes has played a role across all stages in sustaining and institutionalizing policy shifts across electoral changes. With new challenges such as overweight and anemia, and limitations in direct and decentralised participation and in cross sectoral integration, the process continues.

5.2 Learning and insights on the facilitators of policy change

The reflections of those involved in these policy changes raise further insights from the experience:

In raising and keeping the issue on the policy and political agenda, in the early period, political leaderships in 'listening mode', civil society advocates with technical competencies and motivated technical actors combined their evidence and experience to create persuasive arguments to advocate for and shape policy. In these earlier stages, international policy commitments helped to lever political attention, generate dialogue and bring diverse sectors together around a view of development in which each could see their own goals. The thematic roundtables and consultations at different levels and social literacy on the issues helped to bring out stakeholder and social perspectives, to make clear people's conditions and how policies would affect people's lives and to engage political actors to obtain broad political commitments. The evidence for this takes many forms, including data from surveys, media stories and narratives of local experience. Having a relevant academia providing technical support and analysis also contributed. This calls for capacities to bring and communicate the kind of evidence that is relevant for engaging in policy processes.

The coming together of a coalition of informed, well-resourced NGOs, 'moving from competition to synergy' and working together on advocacy raised the policy and political profile of child stunting, especially by linking it to electoral processes. Key informants argue that civil society should link with and keep listening to communities as policy processes progress, noting that this does not always happen. Further, while this engagement used experiences and capacities that had been building over time, sometimes it was a case of having the right people in the right place at the right time!

For the development and adoption of policy options, when political windows of opportunity open for policy change, the technical personnel, methods and policy options to respond need to be ready, including through prior investments in capacities and approaches. A longer term planning perspective is often needed, contrary to liberal economic approaches or electoral cycles. While projections can help to show the longer term implications of policy choices, it is also important to make clear the interim gains that align to strategic plans and political time frames.

Policy options that demand the co-operation across sectors need to build a consensus between sectors and to integrate the capacities, funding, evidence, incentives and mechanisms to facilitate this. Financing is important for this but so too is transparency and trust. The sharing of evidence and analysis between actors and levels and the movement of people between civil society, technical and government institutions has brought perspectives and experience from across institutional cultures.

In building political and public support and sustaining policy implementation, for matters already broadly on the political agenda, taking these forward from broad commitments to policy implementation and uptake calls for a mix of strong evidence, technical input, institutional capacities and resources and support from public opinion. Policies can fail at this stage and social support can be lost if the capacity to implement is weak! Communication is key and the opportunity of acting and opportunity cost of not acting needs to be made clear. Given often competing demands, it was useful for policy decision-making to have a process for designing and choosing policies that integrated their political, social, technical and economic feasibility. An understanding of progressive realization also helps to create space and resources for approaches that achieve change over time. Sustaining policy uptake also demands measures and evidence for continuous learning and evaluation of impact of new interventions, to understand what has worked, under what conditions and why.

Peru has shared its policy approaches on child poverty and stunting through UN organisations and hosting missions from countries, such as from Kenya and Tanzania. It has a community of policy actors that have shared insights on how to facilitate policy change and translate policy into practice in sometimes volatile conditions and that see the need to continue to do so.

There is evidence from the work on child poverty and nutrition that implementation contributes to policy success and that an effective political and public sector response to social conditions can positively change social awareness and practice. There is also awareness that the opposite can lead to public cynicism of both policy processes and services. In a society that has seen many changes in the past decades and with new challenges emerging, like anaemia, overweight and obesity, there is a recognition that we should not assume to know public mindsets: Public communication, especially with young people, needs to be active and ongoing. There are now opportunities for taking successful approaches from the past in new ways, perhaps as online consejos!


Peruvian youth, Pxhere, undated

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Annex 1: Timeline of policy and program changes on child health and nutrition, 1990-2013
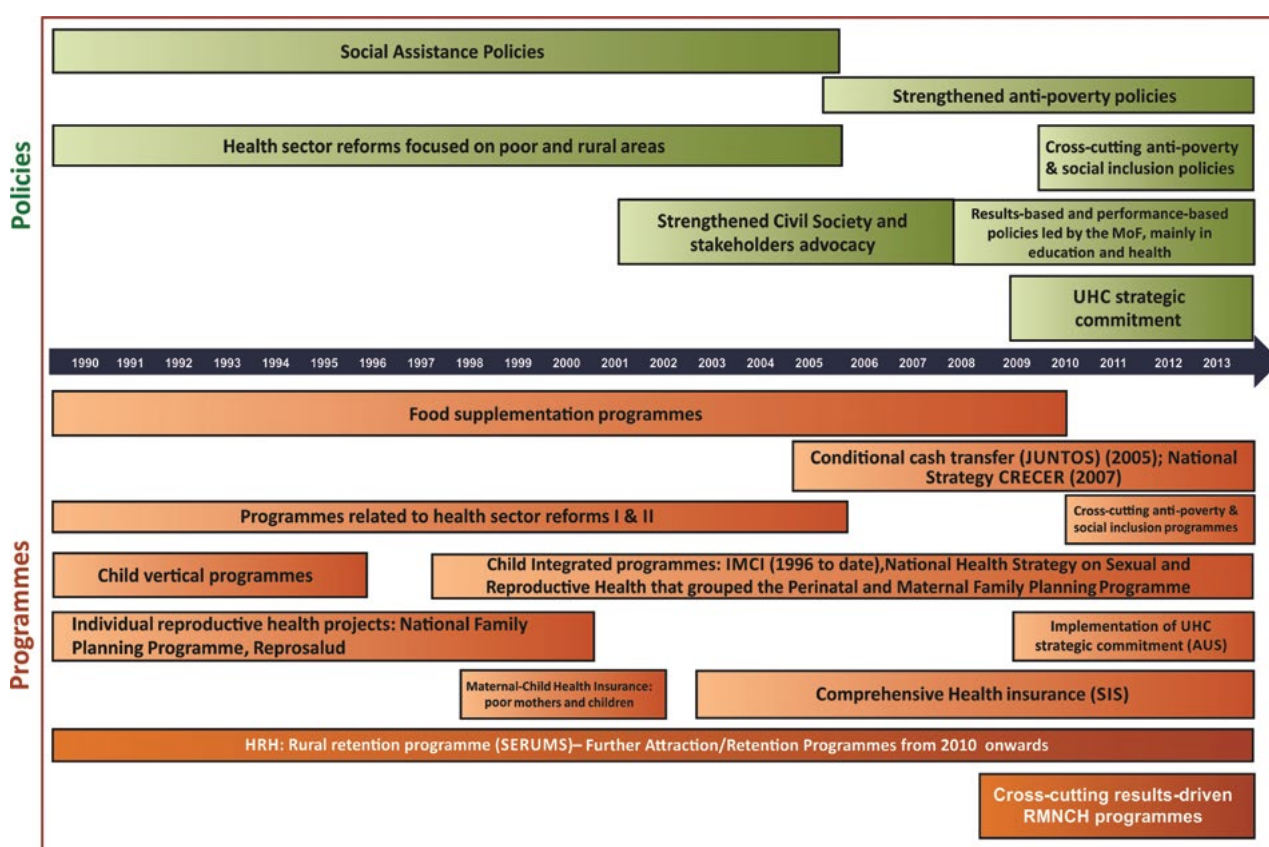
Source: Huicho et al., 2016:e419, with author's permission

Endnotes

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2 See Loewenson and Masotya (2018) for information on the conceptual and analytic framework used.