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CHILD HEALTH

Child health in the Americas represents a serious challenge. Ten years after the World Summit for Children, steady progress can be seen in areas such as infectious disease control, immunization coverage, nutritional aspects, prenatal care coverage, and professional care in childbirth. Health, in its integral positive sense, is a social product that is a determinant of human development and, hence, progress. It is well-known that appropriate policies and strategies can change reality for the better and generate expectations of human development through the development of children. This is the key to progress toward equity and global development in the Region.

Many of the countries are currently in a stage of epidemiological and demographic transition, facing new challenges and old ones as yet unresolved, as well as the emergence of new diseases and social challenges that impact on health. At the same time, they must be vigilant to lay foundations for children to enjoy good health throughout life. There are human, ethical, social, and economic reasons to make child health a priority for action and investment. The new millennium offers an opportunity to take stock of the situation, disseminate the successes, and design appropriate strategies for this transitional phase in the Region.

This document is the product of an internal discussion within the units of the Pan American Sanitary Bureau with responsibilities in child health, and it is being submitted for deliberation. Recognizing that a both multidisciplinary approach and multisectoral action are necessary for promoting integral child development, it concentrates insofar as possible on the health sector and its contribution. The document begins with an analysis of the current situation, developing a frame of reference for the reorientation of efforts to achieve child health, based on evidence from the different disciplines. Suggestions for strategies and lines of action are presented, together with projections of expected results. Finally, the role of PAHO is defined, accompanied by some estimates of the cost involved.

The present document is submitted for consideration by the Subcommittee on Planning and Programming for review and discussion. The members of the Subcommittee are requested to provide orientation, with a view to establishing the direction and priorities of PAHO in this area.

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1. Introduction

The health situation of children aged 0-10 in the Americas has steadily improved as a result of social, economic, environmental, and technology development, communicable disease control, and greater coverage and quality in the health services. However, the challenge of unsolved problems and unaddressed issues must be met to develop a generation of healthy, happy children able to contribute to their own well-being and that of their families, societies, and nations.

A decade after the World Summit for Children, it is necessary to view the situation within the context of the demographic, epidemiological, economic, social, and political realities of the Region of the Americas.

The foundations for integral development are laid during preconception, gestation, birth, breast-feeding, preschool, and primary school and produce an impact on the health and environment of an individual that lasts throughout life. It is known that the interaction among biological, psychological, social, environmental, economic, cultural, and political factors, as well as the more immediate environment, determines the susceptibility to illness, as well as the strengths that protect against disease

Given the demonstrated impact of promoting integral development in the early ages, there is a consensus that the best and most profitable social investment is that which is made in children.

The health sector, working with other sectors, has a window of opportunity to take the lead and help to set priorities, investing in a better future through healthy children.

This document analyzes the current child health situation and the services designed to serve this population. It offers a frame of reference that can serve to reorient efforts, based on evidence from the various disciplines. It also sketches the principal strategies and lines of action necessary for promoting the integral health and development of children, furnishing projections of expected results. The document concludes with suggestions to begin the process for drafting a Regional Plan, defining the projected role of the Pan American Health Organization (PAHO) and providing an estimate of the costs involved.

The Subcommittee on Planning and Programming is requested to review and discuss the document and provide orientation for establishing the direction and priorities of PAHO in this area.

2. Analysis of the Child Health Situation in the Americas

2.1 *Demographic Situation*

There has been a significant decline in population growth, although children still constitute the majority of the population, with higher concentrations in rural areas. Growing migration from rural areas to the cities has resulted in chaotic growth. As a result, children have little access to basic public services, living in conditions marked by overcrowding and poverty and exposed to a wide variety of social risks and abuse. Armed conflicts and natural disasters (for example, hurricanes Mitch and Georges and the floods in Venezuela) have contributed to this precarious situation. These demographic trends are generating ever-smaller and more nuclear family groups, with a consequent reduction in social support networks.

2.2 *Epidemiological Situation*

2.2.1 *Mortality*

Every country in the Region has reduced its infant mortality rate, although the profiles vary. Despite a significant decline in the past 40 years, infant mortality from communicable diseases is 10 times higher in the Latin American and Caribbean Region than in Canada.

Infant mortality is higher in impoverished and rural areas, and it is up to 300% higher in children whose mothers have no schooling. Deaths from perinatal disorders are closely linked with maternal and fetal malnutrition, neonatal fetal infection, premature rupture of the membranes, prematurity, chronic hypertension, dystocia, iatrogenesis, and neonatal fetal hypoxia.

The leading causes of death in children aged 1 to 4 are communicable diseases and accidents. External causes and congenital diseases are relatively higher in countries that already have low levels of infant mortality. Communicable diseases associated with malnutrition are more prevalent in countries with high mortality, although external causes are significant. Accidents also constitute the leading cause of death in children 5 to 10 years of age, with a sharp rise in the trend.

2.2.2 *Morbidity*

The information on morbidity is based on the cases identified in the health services, with no projections for the unserved population. The mortality figures do not show what accidents represent in terms of services, costs, and disabilities. For every

pedestrian death in children aged 1 to 14, for example, 16 children in this age group were treated in a health facility or emergency center.

From the information available, it is known that acute respiratory infections (ARI) and acute diarrheal diseases (ADD) are still the principal diseases affecting children. Septicemia, meningitis, malnutrition, and malaria are major causes of morbidity in some countries (accounting for some 50% to 95% of consultations and hospitalizations). The strategy for Integrated Management of Childhood Illness (IMCI), implemented in 19 countries of the Region, has been a relevant factor in reductions in the majority of the indicators of communicable disease.

From 1977 to 1999, the immunization coverage for children under 1 year of age increased from 25% to over 80%. In 1971, the Region of the Americas was the first region to eradicate smallpox; the eradication of poliomyelitis followed in 1991, and the Region is on the verge of eradicating measles by the end of year 2000. The majority of the countries administer six vaccines to prevent major diseases responsible for morbidity and mortality in the Region: poliomyelitis, whooping cough, tetanus, measles, diphtheria, and tuberculosis. Progress has been made in the introduction of other vaccines to prevent rubella and congenital rubella syndrome, as well as *Haemophilus influenzae* type B (Hib) and hepatitis B infections. The impact of immunization is increasing with the incorporation of the Hib and triple viral vaccine (measles, mumps and rubella) in the routine vaccination programs of the majority of the countries of the Americas.

There are other emerging causes of morbidity in the Americas that are troubling. The percentage of pediatric AIDS cases in the cumulative total of cases reported in the Region is 1.8%. An estimated 90% of children between the ages of 5 and 14 have caries, and around 50% suffer from inflammatory gum disease.

2.3 *Nutritional Situation*

An estimated 8% of newborns in the Region have low birthweight, which is closely associated with neonatal mortality and the risk of stunted growth and development. Some studies suggest a relationship between low birthweight and a higher prevalence of chronic noncommunicable diseases in adulthood. Growth retardation in children under 5 is difficult to measure. However, an estimated 20% are affected—especially children under 2 years. Only Mexico (6%) and Haiti (9%) keep records on severe emaciation. In the Southern Cone, malnutrition linked with obesity is observed.

Strategies to promote breast-feeding have increased the number of mothers who breast-feed their children; 90% of newborns are now breast-fed. However, the proportion of women who breast-feed for the recommended four to six months is much lower.

Anemia is a serious problem in the Region, with a 20% to 60% prevalence in pregnant women and children under 2. Vitamin A deficiency is a problem requiring urgent attention in Brazil, the Dominican Republic, Guatemala, Peru, El Salvador, and Mexico. Since 97% of the countries have iodized salt, iodine problems are related to sustainability and surveillance. Some countries have begun to fortify food products with folic acid.

2.4 *Violence, Work, Abandonment, and Abuse in Childhood*

Early entry in the workforce is an emerging problem in the Region, especially in rural areas. An estimated 20 million children under the age of 15 are working, more than half of them less than 10 years old and only 10% in the formal sector.

In addition to locking children out of the educational system, child labor intensifies inequalities in childhood, exposing children to sexual abuse, mistreatment, accidents, delinquency, and risk behaviors (smoking, drugs, sexual activity, etc.). In the long run, locking children out of the educational system means 20% less income during their lifetime. Studies note the presence of depression, passivity, sleep and eating disorders among children, and little information is available on child abandonment and child abuse. Many countries are beginning to be concerned about the growing number of children who are not in the school system, who have no direct support network--the so-called "street children." While their numbers are difficult to estimate, it is known that they are subject to many physical and psychosocial risks that affect their growth and development.

Violence, both intra-family and social, in addition to other public health problems, such as smoking and drug abuse, continue on the rise in some populations, impacting the health of the children involved. Sexual abuse is beginning to be recognized as a public health problem. The proportion of girls who are abused increases after the age of 5. Every day children are drawn into pornography, which has increased with global communication; and the fear of contracting AIDS has promoted and intensified the sexual demand for boys and girls.

2.5 *Environmental Problems*

The traditional risks associated with poverty and underdevelopment are the lack of drinking water and excreta disposal services, indoor air pollution, and food contamination. Modern life has brought with it other risks, such as the dumping of hazardous solid waste, air pollution from toxic industrial or vehicle emissions, the pollution of water resources with industrial waste, the improper use of chemical or radioactive substances linked with new technologies, traffic accidents, and climate and atmospheric changes, such as the thinning of the ozone layer and the greenhouse effect.

All these factors affect the health of the general population, but their effects are more intense in the most vulnerable groups, especially young children.

2.6 *The Health Services*

The majority of the countries in the Region are in the process of health sector reform and political-administrative decentralization, and are experiencing paradigmatic conflicts between curative care versus health promotion and disease prevention. With few exceptions, the health services respond to the spontaneous demand generated by morbidity with an eminently biomedical, curative, and depersonalized approach to care that is very individualistic. Preventive activities for children center basically on immunization, while health promotion and early detection of problems in growth and development continue to be rare; in some systems, health promotion activities are conducted separately from curative and preventive activities, resulting in missed opportunities for health education.

The response capacity of the primary level is relatively low. Several studies indicate that a lack of confidence in the system and the quality of services reduces their utilization. Deficient referral and back-referral systems hinder the continuity of care, evidenced by disjointed service networks and the difficult access to the levels of greater complexity, especially for the population sectors with fewer resources. There is a tendency to emphasize unidirectional activities, which compartmentalizes care aimed at integral child development. The adoption of immunization and the IMCI strategy has strengthened the health services in the areas of epidemiological information, planning, and evaluation, in addition to emphasizing care to children in health service operations. Immunization and the monitoring of growth and development prompt mothers to bring their children for regular visits to the health services during their first year of life. However, after the first year of life, children’s contact with the health system is only occasional and motivated by episodes of acute morbidity. In the critical period of child development, ages 1 to 5, the health systems offer no programmed care.

In short, the child health situation in the Region is critical. Transition processes are responsible for maintaining significant morbidity and mortality gaps between and within countries, and new problems linked with socioeconomic development are emerging, with repercussions for the physical and psychosocial environment. Although in the process of reform, the health systems have focused on financial aspects, and much remains to be done with respect to the organization and operation of the services and their role in promoting the health and well-being of children. The evidence points to the need to reorient the health services toward more integrated activities for children and families, accompanying them throughout the life cycle.

3. Political-Conceptual Framework of Child Health

Child health in the Americas represents an important challenge, not only because of the existing morbidity and mortality, but because it promotes the human development of children and is key to progress toward equity and development in the Region in the global sense. There is no doubt about the need to continue the struggle against disease through prevention and treatment, incorporating therein strategies to promote child health and development.

The World Summit for Children, held in 1990, was a critical milestone in the efforts to improve the health and living conditions of children around the world. The goals established at the Summit target child health, nutrition, and education, as well as the environment. In the Region of the Americas, these goals have been reiterated and expanded at the ministerial follow-up meetings held in Mexico (Declaration of Tlatelcolco, 1992), Colombia (Nariño Commitment, 1994), Chile (Santiago Agreement, 1996) and Peru (Lima Agreement, 1998). The Governments of the Region, moreover, have made a commitment to implement the agreements entered into at the World Conference on Human Rights in Vienna (1993), the International Conference on Population and Development in Cairo (1994), the World Summit for Social Development in Copenhagen (1995), and the IV World Conference on Women in Beijing (1995).

The majority of the countries of the Region have ratified the International Convention on the Rights of the Child, which is the ethical and legal framework for implementing public policy on children and adolescents. They have also called for the elimination of all forms of discrimination against woman, an aspect that has an enormous impact on child health. In addition, the agreements on health promotion (Ottawa 1986, Jakarta 1997) laid out clear and feasible guidelines for dealing with the complexities of achieving Health for All.

PAHO proposes to move forward with a model for integral child development (ICD), with health as the centerpiece. ICD is understood as full human realization in a specific life cycle, with the highest possible quality of life and the exercise of citizen's rights. To operationalize this concept, the merging of three integrating foci is foreseen: (a) at the individual level, recognition of biopsychosocial integrity in the child's development; (b) at the population level, recognition of the importance of strengthening activities with individuals, families, communities, and different environments; and (c) in health systems and services, ensuring the adoption of health promotion and protection and the delivery of services that respond to the needs of the whole child and to the determinants that influence its development.

Each stage, from preconception, through pregnancy, infancy, preschool, primary school, and preadolescence, contributes to the optimal development of the child. The stages follow a continuum, where omissions or harm in an earlier stage adversely affect the capacity to progress to subsequent stages, and conversely, achievements lead to more and better development in subsequent stages.

Recent research shows a direct relationship between the health status and well-being of an adult man or woman and their capacity to deal with problems, their resiliency, self-esteem, confidence, respect, and self-sufficiency. There is strong evidence that such competencies are acquired in the initial years of life. Childhood, thus, becomes the single irreeplaceable opportunity for acquiring the tools necessary for the maximum development of potential and the achievement of optimal health status. (See Table 1 for an example of activities that could be emphasized at different points in the cycle of childhood.)

The Perry Preschool Project is a longitudinal study on the effects of preschool education. The results reveal the psychosocial and economic benefits of early intervention. In adulthood, study participants demonstrated better academic and social behavior, obtaining better jobs and higher incomes. In economic terms, the study showed that the investment would yield seven its value in savings in expenditures for social welfare services, special education, and justice.

At the individual level, the neurosciences confirm that development of the central nervous system in the prenatal period and first year of life is a determinant of later development and is linked with nutrition, care, emotional ties, and environmental stimuli. In contrast, negative experiences, including severe neglect, the lack of stimulation, or inappropriate stimulation, have irreversible effects on optimal development. Table 2 gives examples of some of the psychosocial factors (risk and protective) identified in the literature as direct contributors to the health and well-being of children.

The family is the most powerful group for the social and emotional development of the child. Some studies have emphasized that a child's relationship and interactions with its parents in the first years of life have a decisive impact on its development as a human being, its capacity to learn and to regulate and moderate its emotions, its behavior, and its risk of falling ill. Families are under stress due to serious inequities, competition, individualism, migration from the country to the city, inadequate social safety systems, and the lack of social cohesiveness.

Table 1: Examples of Interventions and Results

	Preconception	Prenatal	Birth	0-3 years	3-6 years	6-10 years
Examples of interventions	• Education in healthy sexuality. • Education in family and development. • Support and counseling in healthy lifestyles. • Strengthening of participation	• Support and education in pregnancy that involves the father. • Prenatal screening. • Evaluation and monitoring of psychosocial aspects such as mental health, violence, isolation, emotional deprivation, substance abuse. • Maternal nutrition: education; Iron, folic acid supplementation. • Preparation for breast-feeding. • Oral health; treatment of infections.	• Care in childbirth. • Involvement of the father. • Physical and psychosocial screening of newborns. • Support and promotion of breast-feeding. • Immunization. • House calls.	• Evaluation and monitoring of integral growth and development. • Immunization. • Support and education for parents or caretakers. • Facilitation and strengthening of social support networks • Necessary referral to more complex medical and psychosocial levels. • Interaction with the day-care system • Habits for oral health	• Continuing of ICD monitoring. • Permanent synergistic interaction with the preschool education system. • Immunization. • Timely investigation of developmental disorders • Referral, if necessary. • Strengthening of protective factors for individuals, families, and communities – psychosocial factors of self-esteem, resiliency, self-sufficiency, etc. • Oral health monitoring	• Continuing of ICD monitoring; emphasis on learning disabilities, hearing and vision impairment, osteoarticular and emotional disorders. • Immunization. • Necessary referral for resolution of the problems investigated. • Incorporation of health promotion contents into curriculum matrices and into the global policy of the educational establishment (healthy schools) • Oral health monitoring
Examples of results	• Planned, wanted, and healthy conception. • Reduction of unwanted pregnancies. • Healthy choices. • Exercise of citizenship	• Prevention of smoking, and alcohol and drug use. • Healthy pregnancy. • Pregnancy to term. • Healthy women	• Healthy newborns with adequate birthweight. • Safe and healthy spaces.	• Adequate physical and psychomotor development (ICD). • The family is welcomed, protected, and supported by the health system. • The family becomes part of the social network and participates.	• ICD in the best conditions. • Satisfactory incorporation in the school system. • Timely care of the disorders found through screening. • Family involved in the child's development and health.	• Schoolchildren with good academic performance. • Schoolchildren aware of the role of the health in their future lives. • Schoolchildren who have not acquired unhealthy habits such as smoking or alcohol and drug use. • Schoolchildren with social skills. • Healthy children

Table 2: Psychosocial Factors that Contribute to the Health and Welfare of Children

Level	Psychosocial Factors	
	Risk Factor	**Protective Factor**
Individual	Hostility, desperation, low self-esteem, alexithimia, low self-sufficiency	Resiliency, high self-esteem, self-sufficiency, coping mechanisms
Family	Divorce, limited support network, family dysfunction, violence	Resiliency, communication, sense of humor
Community	Alteration of cultural patterns and lack of shared history in periurban settlements. Lack of social cohesiveness	Social support networks. Organized community. Resiliency, empowerment (level of participation)

For children to reach their optimal integral development, it is essential to provide them with healthy spaces, defined as the physical and psychosocial elements in a particular culture that interact with each other and have a positive impact on the physical and mental health and well-being of individuals and communities. Several authors have introduced the concept of ecology in development and discuss concepts of interaction in which the developing individual actively participates, for example, in the home, the school, and the neighborhood. These systems are interconnected and are powerful determinants of the integral development of the child and its health status throughout life. With active participation, the child ceases to be a passive receiver of actions or incentives, becoming instead a proactive agent in his/her environment.

Programs that support child development should include activities in health promotion, disease prevention, and treatment, geared to individuals, groups, and the environment and based on a vision of health as a positive, evolutionary process. This implies linking the current models of approach to risk and harm (disease) in order to build a bridge to with the new biopsychosocial paradigm. To achieve this, it is essential to adopt a multidisciplinary approach and create a culture of health in the population, turning it into a value and standard. The health system should take the lead, joining with other sectors and institutions in a synergistic effort, and, through advocacy, place child and family development permanently on the public agenda.

There is a running debate on the desirability of targeting the specific groups at greater risk of illness because of their socioeconomic status or ethnic, cultural, and geographical characteristics. This targeting has been successful in certain groups, especially when it comes to addressing health problems with epidemiological

information, and has contributed to the identification and correction of inequities in service delivery. However, in development and health promotion, this approach has resulted in a compartmentalization of services that emphasizes disease rather than health, without promoting capacity-building in the population. There is evidence of populations considered not at risk, with significant percentages of children with development problems who would benefit from early and timely interventions. Research and experience suggest that broad-based community interventions are the most adequate accompanied when necessary by specific reinforcement in families or individuals identified as being at greater risk.

3.1 *Basic Principles of the Conceptual Framework that Constitute the Foundation for Developing a Strategic Plan*

- Full respect for the rights of the child, which will be the guideline for PAHO policies and strategies.

- Consideration of childhood as a unique window of opportunity for health promotion, disease prevention, and future development throughout the life cycle.

- Recognition of the need to take an individual and collective approach with a family emphasis in the health care model.

- Extension of health promotion activities to the daily environment of the child and its parents.

- The articulation and development of synergy between the health sector and other developmental sectors, such as education, housing, labor, agriculture, the economy, and planning.

- The interdisciplinary application of knowledge in the health sciences, behavioral sciences, and social, political, and economic sciences.

- The adoption of appropriate technologies; for example, the inclusion of new vaccines in routine vaccination schedules, as well as technologies to improve health service delivery.

3.2 *Most Important Challenges for Adopting the New Paradigm*

- Identification of the more sensitive elements that, when they are modified or strengthened, create conditions that foster the integral development and promotion

of child and family health and that demand greater knowledge of epidemiology and research/action.

- The individual characteristics of each child and its family and physical and psychosocial environment compel us to reject the idea of a universal child whose development needs and health problems can be met with a single standard response. Instead, we must construct a common frame of reference that is evidence-based, developing particularized activities through the potential offered by decentralization and local programming of health actions.

- The available information makes it clear that reducing poverty and inequity in the Region will require making integral child development a priority in public and private policies.

- The development and adoption of effective strategies to create healthy spaces or environments for integral child development, such as the home and the school, require the health services to assume responsibility for working with the population in a proactive manner.

4. Strategies

Over the years, the Pan American Health Organization has promoted strategies that have led to improvements in the health and well-being of children. The emergence of new problems and scenarios and the recognition of the complexity and variety of health determinants make health promotion a strategic field with great potential for children.

4.1 *Strategic Objectives to Consider in the Orientations of PAHO and its Member States for Integral Child Health and Development*

4.1.1 *On Inequities*

Contribute to the regional effort to eliminate poverty, creating conditions within the family and the community that will make it possible to interrupt the poverty cycle early on. Work to reduce inequities between children disadvantaged by their socioeconomic level, gender, or ethnicity, through joint activities for disease prevention, health promotion, and development, mobilizing resources from different areas and sectors for the implementation of child health policies.

4.1.2 *On the Public Agenda*

Place integral child health and development on the countries' agendas, turning it into State policy, strengthening local leadership and developing strategic partnerships that facilitate synergy and complementarity. Participate in the evaluation of the World Summit for Children of 2000 and in the design of proposals and goals for the next decade, considering the new, anticipatory conceptual and promotional framework.

4.1.3 *On the Health Services*

Emphasize technical cooperation, reorientation of the health services and care models, the strengthening of multidisciplinary and intersectoral activities, and empowerment, permitting families and communities to work with the health sector in the prioritization of problems and the planning, execution, and evaluation of activities in child health.

4.2 *Lines of Action*

4.2.1 *Strategic Partnerships*

- Interagency level: Continue support of the working group by the international agencies involved in children's issues, and continue strengthening the Interagency Committee to monitor fulfillment of the goals of the World Summit for Children, issued in 1992.

- Regional level: Develop regional networks to disseminate knowledge, share experiences, and work collaboratively.

- National level: Strengthen intersectoral and interinstitutional agencies working in child health and development (educational and scientific societies, NGOs, private sector, labor organizations etc.).

4.2.2 *Advocacy and Coordination.*

- Develop a working group "for integral child health" in PAHO, with the participation of the Expanded Program on Immunization; IMCI; the Programs on Food and Nutrition, Women, Health and Development, Family Health and Population, Mental Health, Organization and Management of Health Systems and Services, Oral Health, and the Division of Health and Environment, which will prepare a Regional Plan for Child Health.

- Disseminate information for advocacy purposes, sharing knowledge and experience.

- Incorporate social communication in the promotion of child health.

4.3 *Plans, Programs, and Services*

- Prepare, review, and adapt technical support materials (technical standards, guidelines for action, specific instruments, etc.).

- Strengthen the comprehensiveness of interventions by disseminating the conceptual frameworks and supporting the countries in the reorientation of services and the use of evidence-based and cost-effective methodologies and interventions.

- Give neglected groups access to the services system, i.e.,: the disabled, children with chronic diseases, groups disadvantaged because of their socioeconomic level, gender, or ethnicity, and marginalized individuals (street children, institutionalized children, etc.).

- Support and promote new vaccines with a demonstrable impact on public health; for example, the *Haemophilus influenzae* (Hib), hepatitis B, and rubella vaccines.

- Promote and strengthen public policies and educational strategies, improving access to preschool and adult education, with literacy plans geared to women.

- Strengthen information systems and monitor integral child health and development through the development of positive indicators.

- Prepare and apply models for evaluating the strategies implemented. For example, support Bolivia, Ecuador, and Peru in the evaluation of universal maternal and child insurance schemes.

4.4 *Human Resources Development*

- Include the integrated child development approach in undergraduate and graduate programs and strengthen IMCI.

- Develop continuing education programs that employ various on-site and distance learning methodologies to provide in-service training to health care providers.

- Create educational and incentives programs for parents, civil authorities, labor organizations, and other extrasectoral teams.

4.5 *Continued Development of Knowledge*

- Give priority to the development of information on topics that contribute to knowledge about inequities and the evaluation of interventions.

- Promote contributions that enrich the conceptual framework with case studies of significant achievements stemming from the implementation of public social policies.

- Improve epidemiological databases and their use, including additional information that contributes to the development of an integral view of children (psychosocial, family aspects, etc.)

5. Mobilization of National and International Resources

Implementation of a Regional Plan for Child Health under the proposed conceptual framework requires innovative efforts and action that will permit a qualitative leap toward integral child health and development, within a framework of consistency, complementarity, and synergistic collaboration among all those working to improve the health and quality of life of children.

At PAHO, coordination among the various units with an interest in child health will be necessary. The cross-disciplinarity and variety of areas (individual, family, community, environment) involved in integral child development and health make the Division of Health Promotion and Protection the ideal focal point for this effort to coordinate joint initiatives, optimizing resources and opportunities and thus avoiding a duplication of efforts. Jointly undertaking this process with the countries requires the presence of a permanent Regional Adviser to assist the countries in developing their policies, plans, and programs. It also requires the incorporation of high-impact technologies, the building of strategic partnerships, human resources development, and the mobilization of sufficient resources for achieving the proposed objectives.

The preliminary estimate for the PAHO biennial program budget to provide the personnel and activities necessary for a Regional Plan is US$ 1,000,000. This would permit activities for consolidation, start-up, and support of the development and initial implementation of the Regional Plan for Child Health. Once this first stage is consolidated, project and program proposals will be prepared and submitted to the international community in order to sustain and expand the effort.

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