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STRATEGY AND PLAN OF ACTION FOR INTEGRATED CHILD HEALTH

Introduction

1. The children of the Region of the Americas are its greatest asset, and the recognition and protection of their distinct needs and human rights is essential for effective development. The Region has made great strides in reducing child mortality and morbidity, using evidence-based interventions and new knowledge and technology. Investment in child health has been on the public policy agenda for over 40 years, and Member States have achieved better levels of integration of child health services in health facilities. However, to make such integration even more effective, national health policies, strategies, plans, as well as legislation and regulations, require renewed attention using an intersectoral, interprogrammatic, and life course approach in a manner consistent with international mandates.

2. Persistent social exclusion, inequalities of gender, class, and ethnicity, and pervasive inequities all have detrimental effects on children's development and constitute one of the greatest challenges in the Region. Children who lag behind developmentally in their first five years may never catch up to those who had a better start in life (1). Interventions that protect children and promote the maximum realization of their potential can improve cognitive and emotional development and boost educational achievement, which in turn facilitates access to productive employment, greater social mobility, and reduction of inequities in the future. New research demonstrates that some adult health and medical conditions result from predisease pathways that have their beginnings in utero or in early infancy, and that early interventions can have an impact on the prevalence of noncommunicable diseases (NCDs) in later life. Additionally, according to Heckman, preschool education is an efficient and effective investment for strengthening economic development and the workforce. The earlier investments are made, the quicker the returns (2).

3. This Strategy and Plan of Action proposes a framework coherent with Member States' commitments to the United Nations (UN) Convention on the Rights of the Child and other international human rights instruments and their principles (3–7) and supports other Pan American Health Organization (PAHO) resolutions. It will expand and strengthen the continuum of care to promote the optimal development of the child (see Annex A); prevent and reduce the burden of disease in children younger than 5 years of age; improve child nutrition and nutritional status; improve the quality of care provided to all children; build capacity of the health care workforce; empower parents, families, and communities to support child care efforts; create social and physical environments that promote safety and good health; and strengthen collaboration among various institutions and sectors, enabling them to work more effectively.

Background

4. This strategy aligns with the United Nations Millennium Declaration, the Health Agenda for the Americas (2008–2017), the PAHO Strategic Plan (2008–2012), the United Nations Global Strategy for Women's and Children's Health (2010), the PAHO Gender Equality Policy, the Rio Political Declaration on Social Determinants of Health (2011), the Pan American Alliance for Nutrition and Development, and other PAHO and international organization initiatives and resolutions that contribute to and directly affect the well-being of women, children, and caregivers as well as provide important resources, strategic planning, and technical and normative guidance to health personnel (8–21).

5. Countries face challenges in scaling up health service delivery strategies, both clinical and community-based, to achieve health goals, and in estimating the resource requirements and financial implications of these strategies, especially for excluded populations. Efforts to strengthen health systems are severely underfunded in many countries, with inadequate resources to support retention of health workers; improvement of health information systems; universal access to essential medicines, vaccines, and technologies; and sustained good governance in the sector. It is widely recognized that a strong policy, strategy, and planning framework for the health sector along with a strong and well-resourced national health plan are the foundations for effective implementation.

6. Progress toward reaching the Millennium Development Goals (MDGs) has been inconsistent within and across countries, with frequent neglect of the poorest groups (often girls and indigenous populations) and those lacking access to education (often populations living in remote areas). Early childhood development programs have low coverage, and many child survival strategies still use a vertical approach that fails to consider the environmental conditions and other social determinants of health.

7. These constraints are major obstacles to meeting the needs of children, improving their living conditions, and protecting their fundamental rights, and to achieving greater equality among different social sectors with respect to child health.

Situation Analysis

8. Although Latin America and the Caribbean (LAC) is a middle-income region, it is the most unequal region in the world with regard to income. Countries in Latin America face increasing challenges of poverty. According to estimates based on household income, in 2008 some 33% of the Region's population was living in poverty, and around 13% lived in households with incomes insufficient to satisfy their basic nutritional needs. One of every three children living in extreme poverty is deprived of more than one of the fundamental rights whose absence constitutes poverty. Along with material deprivation, this approach to child poverty focuses on access to basic health services and other factors associated with survival, discrimination, and exclusion that affect children's psychosocial development (22).

9. The United Nations Development Programme's *Human Development Report 2010* spotlights long-term national progress as measured by the Human Development Index. Among countries in LAC, Guatemala, Bolivia, and Brazil made the greatest gains; other countries in the Region were found to be approaching nearly full school enrollment and average 80-year life expectancies (23). The Region has also succeeded in dramatically increasing effective vaccination coverage during the first year of life (93% immunized against measles in 2009) (24) and eradicating many childhood diseases. Social protection has been expanded. This has been achieved despite the high levels of inequity seen in the Region.

10. The Region faces new and emerging challenges due to social changes, the rising prevalence of NCDs—which are expected to continue increasing substantially in the decades to come—and demographic shifts linked to aging, urbanization, population growth, and mobility. In Latin America and the Caribbean, approximately 50% of all years of life lost are related to NCDs, whereas only 30% are due to communicable diseases and 20% to injuries (25). In 2010, an estimated 77.7% of the population in LAC lived in urban areas, and this is projected to increase to 86.9% by 2040 (24). The gross enrollment rate in tertiary education has risen only to 37.9% from 22.3% in 2000 (24). Life expectancy in LAC countries increased from 63.4 years in 1975–1980 to 72.2 in 2000–2005, and the percentage of the population aged 65 years and older is expected to almost double, from 5.5% to 9.8%, between 2000 and 2025 (24). Interventions and wellness programs to prevent NCDs can begin early in life and continue through old age, and can be scaled up to reach a large proportion of the population.

11. Between 1990 and 2010, the average under-5 mortality rate in Latin America and the Caribbean was reduced from 54 to 23 deaths per 1,000 live births (26). This represented an average annual decline of 4.3% in under-5 mortality for the Region. In 2010 LAC contributed only 3.3% of global under-5 deaths, far lower than Sub-Saharan Africa (48.7%) and South Asia (33.2%) (26). This rate of reduction indicates that the Region as a whole has been successful in reducing childhood mortality. If this trend continues, the Region will reach the MDG Goal 4 target 4.A of a two-thirds reduction in under-5 mortality by 2015. However, regional averages for under-5 mortality mask major disparities between and within countries. For example, in 2011 it was estimated that Haiti and Bolivia had under-5 mortality rates of 87 and 51 deaths per 1,000 live births respectively, compared to reported under-5 mortality rates of 19 in Colombia, 8 in Chile, and 6 in Cuba (26). These differences show the importance of addressing the social and environmental determinants of health and the persistent inequalities in access to and utilization of basic health services. Population groups living in pockets of poverty, border areas, and geographically remote places, as well as indigenous population groups have a wide range of unmet health needs that require more attention and investment.

12. These inequalities of access are partly explained by the varying share of the population that lives on less than US\$ 1.25 per day (54.9% in Haiti compared to 3.5% in Venezuela in 2007). Another factor is the low national expenditure on health in several countries (in 2008, for example, health spending as a share of gross domestic product was 11.5% in the Netherlands Antilles compared with 1.8% in the Dominican Republic) (22).

13. In LAC in 2010, almost half (47%) of under-5 mortality occurred in the neonatal age group. Of these neonatal deaths, 31% were due to infections and 29% to asphyxia. Deaths in the post-neonatal age group (from 1 month to 1 year of age) accounted for 29% of total under-5 mortality; principal causes include acute respiratory infections (48%), diarrheal diseases (36%), and undernutrition (9%) (24). In the Americas, suffocation was the leading cause of death among children less than 1 year of age, and drowning among children aged 1 to 4 (29). The majority of childhood deaths are preventable. In countries with high mortality, selected high-impact, low-cost interventions (27) could reduce the number of deaths by more than 50%, but levels of coverage for those interventions are still unacceptably low in most low- and middle-income countries.

14. It has been shown that mortality in children under 5 years of age is associated with child abuse and with violence against women by an intimate partner. Alcohol and substance abuse are common risk factors usually present in one or both parents in such situations. There is sufficient evidence in the scientific literature to state that child maltreatment can be prevented (28). Children who either experience violence directly or witness violence between their parents are at higher risk of a number of negative health outcomes, including psychological and behavioral effects. Violence affects communities and societies, leading to losses in the business sectors and increased burden on the health

care and justice systems. Once children reach the age of 5 years, the most significant threats to their survival are injuries, both intentional (homicide, child abuse, or collective violence such as war) and unintentional (road traffic injuries, burns, poisoning, and falls). Finally, depression in a parent, especially a mother, can also affect the development of the child. The proper diagnosis and treatment of mental health problems in parents is therefore essential.

15. The prevalence of child malnutrition in the Region is low at 4.5% (30). However, chronic malnutrition is still one of the most common growth disorders in LAC, with nearly 9 million children under the age of 5 years who suffer from this condition (31). Rates of breastfeeding and complementary feeding practices, essential for healthy growth and development, are far from optimal. In LAC, only 58% of newborns are breastfed within the first hour after birth, and only 44% of infants less than 6 months of age benefit from exclusive breastfeeding (32). It is estimated that promotion of exclusive breastfeeding and adequate complementary feeding practices can prevent 19% of under-5 child mortality (32). In addition, childhood obesity is one of the most serious public health challenges affecting countries of the Region, particularly in urban settings. The problem of childhood obesity is so severe in the Americas that in 2009, the government of the United States of America declared it a national epidemic. In Mexico in 2010, President Calderon announced a national strategy aimed at combating obesity in the country. Moreover, 7 to 12% of children under 5 years old in LAC are obese, which represents six times the current percentage of undernutrition for the same age group (33). Micronutrient deficiencies have a significant impact on human development and economic productivity. In LAC, the prevalence of anemia is 44.5% in young children (22.5 million), 30.9% in pregnant women (3.5 million), and 22.5% in women of reproductive age (31.7 million) (34).

16. Children in the Region also die from a number of largely preventable environment-related causes. Evidence increasingly shows that environmental degradation, harmful chemicals and toxic metals such as lead and mercury, radiation, air and water pollution, asbestos, and secondhand smoke pose major threats to the health, development, and survival of the world's children. These problems are exacerbated by increasing urbanization and by the effects of climate change. Environmental conditions affect the quality and availability of food, as well as levels of physical activity (35). Indoor air pollution from solid fuel use is a neglected problem that requires urgent action. In seven countries of the Region, more than 50% of the population uses solid fuels (35, 37).

17. The estimated coverage of antiretroviral drugs for prevention of mother-to-child HIV transmission was 54% in LAC in 2008 (36). However, this figure masks significant in-country variances, with low coverage in certain population groups. Access to infant diagnostic services is still limited and many infants are lost to follow-up before their HIV

status is confirmed. A total of 19 countries reported data on the number of infants diagnosed with congenital syphilis in 2009, ranging from 5,117 in Brazil to 1 in Barbados. Experts suspect important degrees of underreporting in many countries (37).

18. Soil-transmitted helminths infect millions of young children across Latin America and the Caribbean. The illnesses caused by these intestinal parasites, including anemia, vitamin A deficiency, stunted growth, and malnutrition, among others, slow children's mental and physical growth and have long-term effects on educational achievement and economic productivity (38). Parasitic worms disproportionately affect the most disadvantaged groups, particularly in rural areas and urban shantytowns, and contribute to keeping vulnerable people trapped in a cycle of poverty. Fortunately, there are highly cost-effective, proven interventions to treat intestinal parasites. Deworming interventions can easily be integrated into various existing programs that many countries and their partners are already implementing in the areas of health, nutrition, immunization, education, water and sanitation, and income support.

19. The Region of the Americas certified interruption of poliomyelitis in 1994. The Region has been free of endemic measles and rubella viruses ever since indigenous diseases were eliminated in 2002 and 2009 respectively, and efforts to eliminate neonatal tetanus and congenital rubella syndrome as public health problems are making progress. Diphtheria and pertussis are currently under control: vaccine coverage with DPT3 for children under 1 year was 90% in 2009 (39). New vaccines such as rotavirus and pneumococcus are being introduced.

20. Children with disabilities are among the most excluded groups and face serious barriers to the full enjoyment of their human rights (40). Eighty percent of the brain's capacity develops before 3 years of age. The developmental period from birth to primary school presents numerous opportunities to implement prevention programs that enable children with disabilities to fully realize their potential (40).

21. Neglect of young children's development needs can have serious consequences for their physical and mental growth and development. This is of particular concern in times of emergency or disaster, when populations are dispersed and basic services disrupted. The Region of the Americas has made progress in the design and implementation of early childhood development programs such as *Primeros Años* in Argentina, *Chile Crece Contigo*, *De Cero a Siempre* in Colombia, *Arranque Parejo* in Mexico, and others. These programs have been successful in helping children grow and thrive, physically, mentally, emotionally, and socially, from birth onward. The Chile program provides children with early access to services and benefits to meet their needs, along with ongoing support at each stage of growth. The aim is to build a more equitable society by providing equal opportunities starting at birth. In 2009, enactment of

Law 20.379, the Intersectoral Social Protection System, raised the program to institutional status.

22. Integrated health services models and policies in the Region are growing, though few have been thoroughly studied and evaluated. Some make use of the Integrated Management of Childhood Illness (IMCI) strategy. In Guyana, the National Integrated Child Health Strategy (2011–2015) integrates actions on child health. In Honduras, the IMCI strategy is included in the *Programa de Atención Integral a la Niñez*. In Peru, the *Modelo de Atención Integral en Salud* is a major intervention program to combat the country's malnutrition problems, and CRECER is the national plan to combat malnutrition and poverty. Nicaragua, under National Law 423, Article 38, mandated the creation of a *Modelo de Salud Familiar y Comunitario*, providing a basic package of services. And in Bolivia, the *Programa Desnutrición Cero* is a massive national public health mobilization using the IMCI strategy to strengthen nutrition and growth activities in multiple sectors.

23. The IMCI strategy, following rigorous international evaluations, has become the centerpiece of interventions to improve child health in the Americas, mainly in the health centers (41–46). Community-based IMCI programs have also shown success in promoting child health (47–50). In LAC, IMCI has addressed the prevention, control, and treatment of diseases and conditions affecting women, fetuses, newborns, and children, such as malnutrition; periconceptional folic acid deficiency and calcium deficiency during pregnancy; tuberculosis; tooth decay; Chagas' disease; perinatal and neonatal disorders; accidents, family abuse, and violence; mental health disorders; asthma and broncho-obstructive syndrome; early childhood development problems; and HIV/AIDS. It has also extended the strategy for improving the health of indigenous communities.

Proposed Strategy

24. The Strategy and Plan of Action for Integrated Child Health builds upon Member States' accomplishments and experiences and on initiatives implemented by a wide range of partners in development. Horizontal cooperation and a South-South approach will be encouraged. Implementation will require the participation of existing alliances that are working to achieve the MDGs and improve child health and development, and will follow the accountability framework and indicators proposed by the Commission on Information and Accountability for Women's and Children's Health and the Convention on the Rights of the Child.

25. The conceptual framework for the Strategy is based on the ecological model, which considers child health to be the result of interaction between factors related to health systems at different levels and the social determinants of health. This work will require coordination among various social and governmental sectors, including the

executive, legislative, and judicial branches, to ensure strong health sector governance, equitable delivery of services, sufficient financing of the health system, a critical mass of well-prepared health workers, functioning information systems, and availability of medicines and technologies.

26. A Plan of Action is proposed to guide countries in developing policies and programs to help families and communities access a timely, adequate, and integrated set of services to protect children's rights and promote their development. This set of services would constitute a portfolio of entitlements composed of cost-effective and evidence-based interventions, using a primary health care strategy and a gender, intercultural, and right-to-health approach. The Plan of Action will support and encourage the preparation of national policies, plans, and laws for social protection and contribute to strengthening health systems that are responsive to the needs of women, families, and children and that ensure access without financial, geographic, or social barriers.

27. To achieve this degree of support, the cooperation of many entities in both the public and private sectors will be required. These include national and local authorities, legislatures, municipal governments and community leaders, nongovernmental organizations (NGOs), faith-based organizations (FBOs), professional associations, women's bureaus, and the education, environment, finance, agriculture, housing, energy, and water and sanitation sectors. We propose that PAHO coordinate the regional response, with direct leadership from the ministries of health and other stakeholders. As part of the plan will be implemented in the post-MDG period, that is, after 2015, adjustments will be made in light of any new global agreements for health and development that may be formulated by national governments.

28. The proposal calls for establishing a Regional Alliance for Integrated Child Health to strengthen partnerships and collaboration with United Nations agencies, national and international organizations, NGOs, FBOs, civil society organizations, and so on, to promote integrated child health (ICH) interventions and mobilize resources with national partners. A National Intersectoral Working Group for ICH will be formed in each country and will develop a national working definition of "integrated child health" consistent with the country's policies, laws, epidemiological profile, and health system requirements. The working groups will also provide planning and technical cooperation.

29. The overall vision is to ensure that children younger than 5 years of age survive, thrive, and go on to lead healthy, happy lives. This means taking action to ensure a high quality of life, free of preventable diseases, disability, sexual violence, neglect, injury, and premature death, and working for the improvement of child health, the elimination of inequities, and the achievement of health equity in a manner consistent with the Convention on the Rights of the Child. We have the means and the technology; what is

needed now is commitment from a wider range of stakeholders and increased funding for integrated child health.

Proposed Plan of Action 2012–2017

30. The proposed Plan of Action will address five strategic areas in Latin America and the Caribbean. For all indicators, the baseline is 0 and the target is 12 countries.

Strategic Area 1: Developing harmonized, intersectoral, and interprogrammatic policies, national plans, and laws to protect and enhance children's health, rights, and development.

Objective 1.1: To create an enabling environment for advocacy, coordination, and development of intersectoral and interprogrammatic policies and programs for integrated child health (ICH) consistent with human rights instruments of the United Nations and Organization of American States.

Indicators:

- Number of countries that have established a national ICH policy, strategy, or plan consistent with their legal frameworks and regulations.
- Number of countries with an ICH program that have a medium- to long-term plan of action, with resources allocated and a focal person assigned.

Strategic Area 2: Strengthening integrated health systems and services and community interventions through alternative service delivery strategies, especially in marginalized areas.

Objective 2.1: Develop and strengthen health system capacity for the management, planning, and implementation of ICH strategies, with an emphasis on primary health care.

Indicators:

- Number of countries that have a national policy, strategy, or plan for strengthening the capacity of the health system to scale up effective ICH interventions.
- Number of countries with ICH programs that have developed technical guidelines and norms based on PAHO/WHO models.

Strategic Area 3: Building competencies in the health workforce, academic institutions, and families and communities using a rights-based approach that prioritizes primary health care and takes into account gender and ethnicity.

Objective 3.1: To support the development and strengthening of human resource training programs for ICH.

Indicators:

- Number of countries with an established and operational human resource and management training program for ICH.
- Number of countries implementing ICH evidenced-based interventions using PAHO/WHO tools and materials.

Objective 3.2: To promote social mobilization and community participation for the implementation and expansion of effective interventions to improve ICH and the well-being of children.

Indicators:

- Number of countries with established mechanisms and/or strategies for promoting community participation for the implementation of intervention-based ICH programs.
- Number of countries that have an operational plan to scale up and extend to new districts the community and family component, which promotes parenting skills, social mobilization, and community participation in ICH.

Strategic Area 4: Strengthening the health information system and improving the knowledge base on the effectiveness of interventions.

Objective 4.1: To strengthen country information systems and monitoring capacity in the framework of ICH, and to strengthen the capacity of information and vital statistics systems to generate and use quality information disaggregated by sex, age, ethnicity, and socioeconomic level.

Indicator:

- Number of countries with a national information system that delivers annual information on ICH indicators and data.

Strategic Area 5: Mobilizing resources, strategic alliances, and partnerships.

Objective 5.1: To engage in advocacy to establish and strengthen intersectoral alliances with strategic partners and mobilize international and national funds to sustain implementation and expansion of ICH activities.

Indicator

- Number of countries that have established an intersectoral coordinating committee for ICH.

Monitoring and Evaluation

31. This Plan of Action contributes to the achievement of Strategic Objectives (SOs) 4,¹ 7,² and 9³ of the PAHO Strategic Plan. Additional SOs, as well as the specific Region-wide Expected Results (RERs) to which this Plan of Action contributes, are detailed in Annex C. The monitoring, assessment, and evaluation of this Strategy and Plan of Action will follow the guidelines established by the Organization. Accordingly, it will include actions to monitor and assess the indicators identified, and progress reports will be delivered at the midterm and conclusion of the Plan of Action. Countries will work with all sectors to reach agreement on a list of standardized basic indicators for ICH and share data with other international agencies using websites, regional observatories, SharePoint, portal systems, and other networks.

32. PAHO and Member States will implement selected planning, monitoring, and evaluation tools for active follow-up of country policies, strategies, and plans using process and impact indicators, country reports, and the concluding observations of the Committee on the Rights of the Child. The information collected will be disaggregated by age, sex, and ethnicity to enable governments and service providers to target the most vulnerable or excluded populations. A final evaluation will be undertaken at the end of the plan in 2017.

¹ **SO4:** To reduce morbidity and mortality and improve health during key stages of life, such as pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.

² **SO7:** To address the underlying social and economic determinants of health through policies and programs which enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approach.

³ **SO9:** To improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development

Action by the Executive Committee

33. The Executive Committee is invited to review the information in this document and consider adopting the proposed resolution in Annex B.

Annexes

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**SOME EXAMPLES OF INTERVENTIONS FOR INTEGRATED
CHILD HEALTH
(Children Less than 5 Years of Age by Level of Influence)**

Individual – Positive parenting – Increase access to prenatal and postnatal services – Early childhood development programs – Safe sex
Family and Community – Safe and clean environment – Early recognition of danger signs and referral – Clean cook stoves for cleaner indoor air* – Eliminate tobacco smoke and indoor mites – Risk communication programs* – Active participation of social actors implementing key family practices * – Pre-natal and postnatal visits to reduce child abuse
Prevention* – Exclusive breastfeeding up to 6 months of age – Complementary feeding – Insecticide treated materials – Water sanitation and hygiene – Hib vaccine – Zinc – Vitamin A – Measles vaccine – Tetanus toxoid – Home visits during pregnancy
Treatment* – Vitamin A – Antibiotics for pneumonia – Antibiotics for dysentery – Antimalarials – Oral rehydration therapy (ORT) – Antibiotics for sepsis – Newborn resuscitation – Zinc (in acute diarrhea and severe child under-nutrition)
Societal – Translating the Convention on the Rights of the Child into national laws – Promoting social, economic and cultural rights – Providing early childhood education and care – Ensuring universal primary and secondary education – Reducing the availability of alcohol – Monitoring levels of lead, mercury, pesticides, etc., and removing environmental toxins – Control of urban air pollution*

*Evidenced-based intervention.



PAN AMERICAN HEALTH ORGANIZATION
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150th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 18-22 June 2012

CE150/15 (Eng.)
Annex B
ORIGINAL: ENGLISH

PROPOSED RESOLUTION

STRATEGY AND PLAN OF ACTION FOR INTEGRATED CHILD HEALTH

THE 150th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the *Strategy and Plan of Action for Integrated Child Health* (Document CE150/15);

RESOLVES:

To recommend that the 28th Pan American Sanitary Conference adopt a resolution along the following lines:

THE 28th PAN AMERICAN SANITARY CONFERENCE,

Having reviewed the *Strategy and Plan of Action for Integrated Child Health* (Document CSP28/__);

Recalling the right of children to enjoy the highest attainable standard of health, as set forth in the Constitution of the World Health Organization, the UN Convention on the Rights of the Child, and other international and regional human rights instruments;

Mindful of the international mandates emerging from the World Health Assembly, in particular Resolution WHA56.21 (2003), *Strategy for Child and Adolescent Health and Development*, and Resolution WHA58.31 (2005), *Working towards Universal Coverage of Maternal, Newborn, and Child Health Interventions*, the commitments by the Member States of the Region of the Americas to meeting the Millennium Development Goals (MDG), and other PAHO Resolutions that contribute to and directly affect the well-being of women, children, and caregivers;

Recognizing that the children of the Region of the Americas are its greatest resource, and that recognition and protection of their distinct needs and human rights is essential for effective development, and noting that national health policies, strategies, plans, and laws require renewed attention to promote the effective integration of child health services in health facilities, using an intersectoral and life course approach based on the social determinants of health and consistent with international mandates;

Considering that this Strategy and Plan of Action proposes to build upon the continuum of care to promote the optimal development of the child; prevent and reduce the burden of disease in children younger than 5 years of age; improve child nutrition; empower parents, families, and communities to support child care efforts; create social and physical environments that promote safety and good health; and strengthen collaboration among various institutions in the health sector and other sectors, enabling them to work more effectively,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action for Integrated Child Health, and to encourage its consideration in development policies, plans, programs, and proposals, and in the discussion of national budgets, with a view to creating conditions for scaling up integrated child health interventions.
2. To urge Member States to:
 - (a) give priority to and advocate at the highest levels for the implementation of evidence-based, effective interventions to prevent child health morbidity and mortality;
 - (b) support the development of integrated child health policies, strategies, and plans as part of overall national health plans, build capacity for high-quality integrated child health services, and ensure universal access to these services;
 - (c) promote dialogue and coordination between ministries and other public and academic institutions, as well as between the public and private sectors and civil society, with a view to achieving national consensus for the implementation of integrated child health services based on the social determinants and life course approaches;
 - (d) build capacity of national and local managers for effective program planning and management of health workers in first- and referral-level health facilities to deliver quality integrated child health services;

- (e) support caregivers working at the family, community, and individual levels to improve care-seeking behavior, health promotion, and care in the home and community based on primary health care practices;
- (f) strengthen health systems and health services to support implementation of quality care in a manner consistent with the UN Convention on the Rights of the Child and the application of innovative training processes, including distance education and other innovative models;
- (g) promote the collection, sharing, and use of data on integrated child health disaggregated by age, sex, and ethnicity;
- (h) establish an integrated monitoring, evaluation, and accountability system for policies, plans, programs, legislation, and interventions that will make it possible to determine the impacts of integrated child health services;
- (i) ensure that processes are established for conducting external reviews and analysis of the Plan's implementation based on national priorities, needs, and capabilities.

3. To request the Director to:

- (a) establish a technical advisory group to provide guidance on topics related to integrated child health;
- (b) provide support to the Member States, in collaboration with other international agencies and sectors, to help them work collectively to support and strengthen national plans and the implementation of integrated child health activities at the country level;
- (c) promote the implementation and coordination of the Strategy and Plan of Action to ensure that activities are cross-cutting across the Organization's various program areas and different regional and country contexts;
- (d) promote and consolidate horizontal (South-South) technical cooperation and the sharing of successful experiences and lessons learned by Member States;
- (e) support and maximize human resources development, capacity building, and the delivery of quality services;
- (f) support the development of integrated technical guidelines and tools to facilitate implementation of the Strategy and Plan of Action;
- (g) promote the establishment of national, municipal, and local partnerships with other international agencies, scientific and technical institutions, academic

institutions, nongovernmental organizations, organized civil society, the private sector, the UN Committee on the Rights of the Child, and others, for the purpose of implementing integrated child health services;

- (h) conduct midterm and final evaluations and report these results to the Governing Bodies.



PAN AMERICAN HEALTH ORGANIZATION
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CE150/15 (Eng.)
Annex C

**Report on the Financial and Administrative Implications for the
Secretariat of the Proposed Resolution**

1. Agenda item: 4.5: Strategy and Plan of Action for Integrated Child Health
2. Linkage to Program Budget 2012-2013: (a) Area of work: <i>Strategic Objective 1:</i> To reduce the health, social and economic burden of communicable diseases RER 1.1 RER 1.4 <i>Strategic Objective 2:</i> To combat HIV/AIDS, tuberculosis and malaria RER 2.1 RER 2.2 <i>Strategic Objective 3:</i> To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries RER 3.1 RER 3.2 RER 3.5 <i>Strategic Objective 4:</i> To reduce morbidity and mortality and improve health during key stages of life, such as pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals. RER 4.1 RER 4.2 RER 4.3 RER 4.4 RER 4.5 <i>Strategic Objective 7:</i> To address the underlying social and economic determinants of health through policies and programs which enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approach. RER 7.1 RER 7.2 RER 7.4 RER 7.5 RER 7.6

Strategic Objective 8: To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

RER 8.2

RER 8.5

Strategic Objective 9: To improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development.

RER 9.1

RER 9.2

RER 9.3

RER 9.4

Strategic Objective 10: To improve the organization, management, and delivery of health services.

RER 10.1

RER 10.2

(b) Expected result:

Between 2012-2017, the Plan will have met the strategic objectives to: (a) scale-up coverage of effective newborn, ICH and early childhood development interventions, (b) create social and physical environments and promote health and healthy development and behaviors using a rights approach within an intersectoral, intercultural and gender frameworks, and (c) strengthen the health systems response with alternative strategies to reach underserved populations.

3. Financial implications:

(a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities):

Technical and financial cooperation with other United Nations agencies and other direct stakeholders, multi-national, foundations, faith-based organizations, private-sectors, bi-lateral and international organizations are essential for the successful execution of this Plan. From 2012-2017, it is estimated that the expenditures for the staff and activities required to implement the Plan successfully will be an estimated US\$ 30.0 million. This includes maintenance of current staff, the hiring of additional staff, and the implementation of activities at the regional, subregional and national levels.

(b) Estimated cost for the biennium 2012–2013 (estimated to the nearest US\$ 10,000, including staff and activities):

Estimated cost per year = US\$ 6.0 million

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities?

Current funding using PAHO Regular, WHO Extra-budgetary and donor funds is scarce. A massive resource mobilization effort will need to be made. Improved coordination and

utilization of funding between the PAHO SOs at the regional and country levels outlined above will require strengthening. Additional funding will also be identified at the country level from other sources and utilized appropriately.

4. Administrative implications

(a) Indicate the levels of the Organization at which the work will be undertaken:

Regional, sub regional, national and especially local areas of highest vulnerability and hardest to reach. Country interventions will be integrated with other Organization and ministry programs.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

- Continuation of the Advisor for Integrated Child Health post in FCH/HL
- Establishing a P4 Early Childhood Development full-time post in FCH/HL
- Establishing a P3 Program Officer full-time post in FCH/HL
- Continuing full-time PAHO country national professional officer positions in priority countries
- Strengthening and improving the utilization and coordination of current PAHO staff working in PAHO
- Country Offices to work in an integrated fashion and maximize human resources

(c) Time frames (indicate broad time frames for the implementation and evaluation):

- September 2012: PAHO Directing Council approves the Strategy and Plan of Action.
- November-December 2012: Initial country and subregional planning meetings held with all interested partner.
- December 2012: Dissemination of the Strategy and Plan of Action in four languages.
- January-July 2013: Advocacy, country interest expressed, preparation of initial diagnosis and development of country strategic integrated plans.
- March 2013: Hold partners meeting.
- 2013-2014: Implementation, surveillance, and development in priority countries.
- 2013: Collection of best practices and evaluation of country activities.
- 2013-2016: Implementation, surveillance, and development in priority countries.
- 2017: Evaluation of country activities.
- 2017: Final Evaluation of the implementation of the Strategy and Plan of Action.



PAN AMERICAN HEALTH ORGANIZATION
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CE150/15 (Eng.)
Annex D

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES
1. Agenda item: 4.5: Strategy and Plan of Action for Integrated Child Health
2. Responsible unit: Family and Community Health (FCH), Healthy Life Course Project (HL)
3. Preparing officer: Christopher Drasbek
4. List of collaborating centers and national institutions linked to this Agenda item: • Professional associations and organizations working in health and development • National Institute of Child Health (Peru) • School of Medicine, University of Javeriana (Colombia) • Texas Children's Hospital, Houston, USA • Ministries or Secretariats of Health • Social Ministries or Secretariats • Ministries of Development • Ministries of Finance • Ministries of Planning • Ministries of Social Protection • Ministries of Education • Ministries of Housing • Ministries of Environment • Ministries of Trade • Junior Chamber Internationals (JCIs) • WHO/PAHO Collaborating Centers for Family and Community Health and other related child health centers • Social Security institutions, armed forces, police, State enterprises, and other institutions with health services. • Faith-based organizations (Seventh-Day Adventist Church, Church of Latter-Day Saints, Catholic Churches) and others • Schools and universities of health sciences, medicine, nursing, nutrition, public health • Other national and international institutions and foundations associated with health services in children less than five years of age

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

The proposed topic *Strategy and Plan of Action for Integrated Child Health* (ICH) is an ongoing effort to support and expand the concept of integration of actions to achieve child well-being and human development potential at health systems, health services, and family and community levels in Member Countries. The *Strategy and Plan of Action* proposes to build upon the continuum of care to promote the optimal development of the child; prevent and reduce the burden of disease in children less than 5 years of age; improve child nutrition; empower parents, families, and communities to support child care efforts; create social and physical environments that promote safety and good health; and strengthen collaboration among various institutions in the health and other sectors to work more effectively.

The proposed strategy intends to guide countries policy and program development to support families and communities to access a timely, adequate and integrated set of services to protect children's right and promote their development and fundamental human rights. It will support and encourage Member States in the elaboration of social protection policies, plans and national laws for children, women and families. It will contribute to strengthening a health system responsive to the needs of the family and child that progressively ensures access without financial, geographical, or social barriers to an integrated package of health and social services that includes nutrition; physical, mental and environmental health; and other critical interventions. This set of services would constitute a portfolio of entitlements for children, composed of cost-effective and evidence-based interventions related to the primary health care strategy using a gender, intercultural, and right-to-health approach.

This work will require actions to ensure strong public sector governance, equitable delivery of services, sufficient financing of the health system, a critical mass of well-prepared health workers and coordination among the various social and governmental sectors, including executive, legislative and judicial branches. At the core of this strategy is the reduction of child health inequalities. The overall vision is to ensure that newborns and children, survive, thrive, and lead healthy, happy lives. The goal is to attain high-quality lives, free of preventable diseases, disability, sexual violence, neglect, injury and premature death and contribute to the improvement of child health, elimination of disparities and achievement of health equity in a manner consistent with CRC.

6. Link between Agenda item and Strategic Plan 2008–2012:

SO1: To reduce the health, social and economic burden of communicable diseases.

SO2: To combat HIV/AIDS, tuberculosis and malaria.

SO3 To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries.

SO4: To reduce morbidity and mortality and improve health during key stages of life, such as pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.

SO7: To address the underlying social and economic determinants of health through policies and programs which enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approach.

SO8: To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

SO9: To improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development.

SO10: To improve the organization, management, and delivery of health services.

7. Best practices in this area and examples from countries within the Region of the Americas:

- Over the years, an extensive collection of best practices has been documented based on evidence in support of implementing integrated child health packages in the countries of the Americas. Experience with integrated health services models and policies in the Region are growing but few have been thoroughly studied and evaluated.

In Bolivia, the *Zero Malnutrition Program* is a massive national public health mobilization effort using the IMCI strategy as one of the platforms to strengthen nutrition and growth activities using a multi-sectorial approach.

Guyana developed a *2011-2015 National Integrated Child Health Strategy* which includes integrated child health actions.

In Honduras, the IMCI Strategy is included within the *Programa de Atención Integral a la Niñez*.

In Nicaragua in July 2008, National Law 423, Article 38 mandated the creation of a *Modelo de Salud Familiar y Comunitario* (MOSFC) framework, providing a basic package of services in the country.

In Peru, the *Modelo Atención Integral del Niño* is a major intervention program to combat the country's malnutrition problems and *CRECER* is the national plan for malnutrition and poverty

- A good example of integrating effective child health interventions can be illustrated during the 2010 National Vaccination Week for the Americas. In many countries immunizations were provided and delivered to families and communities:
 - Vitamin A in Bolivia, Mexico, and Honduras.
 - Treatment for intestinal parasites in Bolivia, Haiti, Mexico, and Nicaragua.
 - Distribution of ORS packets, vitamins, and other mineral supplements in Mexico.
 - In Guyana community vaccination fairs provided nutrition and health education, as well as substance abuse information.
 - In Panama, those presenting symptoms of malnutrition were referred to local nutrition rehabilitation centers for treatment.
- Over the years, the IMCI strategy in the Americas responded to the evolving epidemiological profile in the countries related to prevalent diseases by incorporating additional actions to cover other problems that impair child health and impinge negatively on healthy growth and development. National child health programs and plans have been modified reflecting these changes. Since 2000, member countries successfully implemented the WHO/UNICEF Key Family Practices (KFP) for the prevention of common childhood illnesses as the primary intervention to change behaviors and improve growth and development at the family and community levels. This work supported integrated social mobilization efforts implemented by the Ministries of Health in

tandem with community leaders and networks, community health workers (CHW), non-governmental organizations (NGOs), families and other social actors and institutions.

- More recently, in the *CIDA/PAHO Program on the Prevention and Control of Priority Communicable Diseases in South America* and the *CIDA/PAHO Grant Program: Improved Health and Increased Protection from Communicable Diseases for Women, Children and Excluded Populations in Latin America and the Caribbean*, integrated child health activities were successfully implemented with other programs at the national and local levels targeting vulnerable populations for the prevention and control of childhood prevalent diseases, and national diseases prevention and control programs are targeting interventions to meet gaps in health service delivery, health information systems, leadership, governance and finance and monitoring and evaluation.
- The care and development of young children must be the foundation of social relations and the starting point of human resources development strategies from community to national levels. The Region of the Americas has made progress in the development and implementation of ECD programs (e.g.: Argentina- *The Early Years*, Chile- *Crece Contigo*, Colombia- *De Cero a Siempre*, Mexico- *Arranque Parejo*, and others). These programs have successfully demonstrated processes by which from birth children grow and thrive, physically, mentally, emotionally and socially.

8. Financial implications of this Agenda item:

The Latin American and Caribbean region is experiencing a financial crisis unprecedented in its nature. In the Americas, MDG 4 has been prioritized but minimal funding allocated from WHO, PAHO and international donors. This will impact low-income countries especially and prompt governments to possibly reduce social spending in health, education and social protection. Many countries have been successful with obtaining bi-lateral support for integrated activities (Nicaragua-Luxemburg, Bolivia-CIDA, Haiti-French Government, etc.). However, technical and financial cooperation with other United Nations agencies and other direct stakeholders, multi-national, faith-based organizations, foundations, private-sectors, bi-lateral and international organizations are essential for the successful execution of this Plan. From 2012-2017, it is estimated that the expenditures for the staff and activities required to implement the Plan successfully will be an estimated US\$ 30.0 million. This includes maintenance of current staff, the hiring of additional staff, and the implementation of activities at the regional, subregional and national levels.