

## 162nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 18-22 June 2018

---

Provisional Agenda Item 4.4

CE162/14  
22 May 2018\*  
Original: English

### PLAN OF ACTION FOR WOMEN'S, CHILDREN'S, AND ADOLESCENTS' HEALTH 2018-2030

#### Introduction

1. The Global Strategy for Women's, Children's, and Adolescents' Health 2016-2030 (1) was adopted by the Member States of the World Health Organization (WHO) in 2015, reflecting the explicit commitment of the global community to pursue the health and well-being of every woman, child, and adolescent throughout the world. The Global Strategy has three objectives: *Survive*—end preventable deaths; *Thrive*—ensure physical and mental health and well-being, and *Transform*—expand enabling environments. Dissemination and discussion of the Global Strategy in the Region of the Americas led to endorsement of the Santiago Commitment to Action at a high-level meeting in Santiago, Chile, in July 2017 (2). This pledge calls for innovative and more effective efforts to reduce health inequities and ensure that every woman, child, and adolescent in Latin America and the Caribbean not only survives but thrives in a transformative environment in which they can realize their right to enjoy the highest attainable standard of physical, mental, and sexual/reproductive health and well-being; have social and economic opportunities; and participate fully in shaping prosperous and sustainable societies. Also in 2017, the Member States of the Pan American Health Organization (PAHO), working within the framework of the Strategy for Universal Access to Health and Universal Health Coverage (3) and the 2030 Sustainable Development Goals (SDGs) (4), and with the vision of achieving the highest attainable standard of health for all people in the Americas, adopted the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) (5).

2. Mindful that realization of this vision and attainment of the specific goals and targets call for concerted action by the health sector as well as the wider sphere of public authority, PAHO is proposing an integrated Plan of Action for Women's, Children's and Adolescents' Health 2018-2030.<sup>1</sup> Implementation of this plan will contribute toward

---

\* This version contains minor editorial changes in paragraph 40 (a) and 40 (c).

<sup>1</sup> Member States could include youth age 20-24 years in programs and interventions, as feasible and appropriate, in line with the Adolescents and Youth Regional Strategy and Plan of Action 2010-2018—for example, in discussions related to youth violence, since young males age 15-24 years are the age

---

overcoming the common barriers and challenges to addressing the health and well-being of women, children, and adolescents in a more effective, integrated manner across the life course, leaving no one behind and closing health inequity gaps. This comprehensive approach will facilitate multisectoral action and support more efficient use of human and financial resources, thus further increasing the already high return on investments in the health of women, infants, children, and adolescents.

3. Within the context of the Global Strategy and SHAA2030, successful implementation of this Plan will require a comprehensive, interprogrammatic, and multisectoral response to address the immediate causes of preventable mortality, morbidity, and disability in women, children, and adolescents, as well as their underlying determinants, and to promote positive development, health, and well-being. The comprehensive nature of the Plan of Action is innovative in that it combines areas of work previously addressed under four separate strategies and plans. This approach will facilitate the application of a life course approach to building health and wellness; reducing inequities; increasing healthy life expectancy for women, children, and adolescents from preconception to aging; and addressing the common determinants of health, while also providing optimal opportunities to address the specific health-related issues and challenges of each group.

## **Background**

4. The core rationale for development of this Plan is the fact that progress in women's children's and adolescents' health in the Region has been unequal. Advancements have not benefited everyone in an even manner. Significant differences in health status persist between and within countries, and certain population groups—indigenous, Afro-descendant, lower-educated, poor, and rural, as well as women, children, and adolescents—consistently suffer higher burdens of preventable mortality and morbidity (6). However, given the substantial social and economic progress in the Region, as well as the knowledge, experience, and lessons learned while working to meet the Millennium Development Goals (MDG), there is reason to be confident that the achievements to date can be accelerated and expanded.

5. The development of this Plan of Action has benefited from the orientations contained in the global and regional documents cited above, as well as from analysis of the recent evaluations and lessons learned from implementation of the following four regional strategies and plans of action: *a*) the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity (2012-2017), approved under Resolution CD51.R12 (2011); *b*) the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (2008-2015), approved under Resolution CD48.R4 Rev.1(2008); *c*) the Strategy and Plan of Action for Integrated Child Health (2012-2017), approved under Resolution CSP28.R20 (2012); and *d*) the Adolescent and Youth Regional Strategy and Plan of Action (2010-2018) (7-10).

6. The Plan adopts a pro-equity and a public policy perspective to adequately address the underlying determinants of the health of women, children, and adolescents in a multisectoral approach. It aligns with and builds upon the principles of PAHO's work on health equity and the social determinants of health; the PAHO Gender Equality Policy, approved in 2005 (Resolution CD46.R16) (11); the Plan of Action on Health in all Policies, approved in 2014 under Resolution CD53.R2 (12), the Strategy for Universal Access to Health and Universal Health Coverage, approved in 2014 through resolution CD53.R14 (5), PAHO's Policy on Ethnicity and Health, approved in 2017 under resolution CSP29.R3 (13); and the PAHO Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, approved in 2015 under Resolution CD54.R12 (14).

## **Situation Analysis**

### *Survive*

7. The neonatal mortality rate in Latin America and the Caribbean (LAC) declined from 22.1 neonatal deaths per 1,000 live births in 1990 to 9.3 in 2014, representing a drop of 57.9%. Between 2008 and 2014, the reduction was 13.9%, from 10.8 to 9.3. Perinatal conditions and birth defects are the leading causes of death in neonates in the Region of the Americas. Major variances in neonatal mortality persist between and within countries (15). With a 67% reduction in child mortality between 1990 and 2015 (from 53.8 to 17.9 per 1,000 live births), the Region achieved the target for Millennium Development Goal 4. Congenital malformations, influenza and pneumonia, and injuries are among the leading causes of death in children aged 1-4 years. The burden of diarrhea, pneumonia, undernutrition, and vaccine-preventable diseases decreased significantly between 2000 and 2015 (16). The declines were uneven between countries: some countries made great progress, while others less so.

8. Adolescent mortality rates in LAC remained stagnant between 2008 and 2015. Homicide, suicide, and road traffic injuries are the leading causes of death, with males disproportionately affected. Iron-deficiency anemia and skin diseases are the leading causes of disability-adjusted life years (DALYs) lost in both males and females aged 10-14 years, while in the group 15-19 years, interpersonal violence and road traffic injuries topped the list for males and skin diseases and depressive disorders were the main causes for females. Malnutrition and alcohol and drug use are the leading risk factors for DALYs lost in those aged 10-14 years, and alcohol and drug use and occupational risks are the risk factors for DALYs lost in those 15-19 year old (17, 18).

9. Female life expectancy has doubled since 1950. However, healthy life expectancy has not increased at the same pace, and the longer lives are not necessarily healthy lives (19). Significant challenges remain, from addressing the risk factors and determinants of preventable mortality and morbidity in women, including violence against them and noncommunicable diseases, to promoting mental health and healthy aging (20, 21).

10. Only 23 countries reported maternal mortality ratios (MMRs) during the period 2010-2015, which illustrates the persisting challenges with monitoring of maternal mortality and maternal health. These 23 countries saw an 11% reduction overall, from 63.8 per 100,000 in 2010 to 56.6 per 100,000 in 2015 (22). Hypertension and hemorrhage continued to be the leading causes of maternal death. The third-ranking causes of maternal death, those linked to abortion, saw a reduction from 9% in 2010 to 7% in 2015 (22).

11. According to available data, the Region has an unfinished agenda with regard to inequity under the “Survive” objective. Consistently, women, children, and adolescents from the lower socio-economic levels, along with those living in rural settings, indigenous groups, Afro-descendants, and the less educated, have higher burdens of morbidity and mortality. In 2010, for example, maternal mortality ratios in rural areas were four times higher than in urban areas in the 20 countries that reported this information. However, by 2015 the proportion had fallen to only slightly more than half, indicating progress in this type of inequity. In 2015, three countries reported MMRs higher than 125 per 100,000 live births in indigenous and Afro-descendant groups, contrasting sharply with the 2017 estimated MMR of 44.2 for the Region (22, 23).

### *Thrive*

12. The SDGs and the Global Strategy urge stakeholders to go beyond survival to aim for the highest possible level of well-being throughout the life course. In particular, the Global Strategy proposes the following targets for the “Thrive” objective: end all forms of malnutrition and address nutritional needs; ensure universal access to sexual and reproductive health (SRH) services<sup>2</sup> and rights; ensure that all girls and boys have access to good-quality early childhood development; substantially reduce pollution-related deaths and illnesses; and achieve universal health coverage.

13. According to the available data, children and adolescents in the Region face the triple burden of undernutrition, micronutrient deficiencies, and overweight/obesity. The prevalence of stunting decreased from 18.4% in 2000 to 11.3% in 2015, with major variances between countries, ranging from 1.8% to 48%. In 2015, the estimated regional prevalence of wasting was 1.3% and that of severe wasting was 0.3% (16). The prevalence of obesity and overweight among children is increasing: 7% of children under 5 years old and 15% of school-age children are estimated to be obese or overweight. In 19 countries with data for the period 2009-2016, the proportion of overweight students aged 13-15 years ranged from 15.9% in Guyana to 47.1% in the Bahamas (17).

14. Between 2010 and 2016, contraceptive prevalence in women of reproductive age (15-49 years) remained stable at around 68% and the Region maintained a high coverage of trained attendance at antenatal care and delivery. LAC noted a modest reduction in the adolescent fertility rate, from 70.4 per 1,000 girls aged 15-19 years in 2005-2010 to 66.5

---

<sup>2</sup> In no case should abortion be promoted as a method of family planning. Report of the International Conference on Population and Development [1994]. Available from: <http://www.un.org/popin/icpd/conference/offeng/poa.htm>

in 2010-2015, but it remains the region with the second highest adolescent fertility rate in the world and the lowest rate of decline globally (17). Indigenous, rural, less educated, and adolescent women from lower socio-economic levels are up to four times more likely to initiate childbearing compared with their nonindigenous, urban, and more educated counterparts and those in the higher wealth index quintiles. LAC is also the only region in the world with a rising trend in pregnancies among girls younger than 15 years old. Furthermore, adolescents continue to face significant legal, societal, policy and health system-related barriers that deny them access to confidential and quality SRH services and commodities.

15. Increasingly, governments in the Region are recognizing the economic, ethical, and social benefits of investing early in life. A shift is already taking place from emphasis on preventing disease and death in children to a human development perspective. Nineteen countries already have policies or strategies that address early childhood development. In fact, the Region has had several positive experiences in this regard, such as the *Chile Crece Contigo* [Chile Grows with You] program, Colombia's *Cero a Siempre* [From Zero to Always], Jamaica's Early Child Development Strategy, and Cuba's *Educa a tu hijo* [Educate Your Child] program (16). However, this momentum needs to be expanded to all countries and to those subgroups that are most in need. The health sector is still struggling to define its role in the context of early child development. Children and adolescents aged 5-14 have historically been underserved in child and adolescent health programs (16, 17). While this period of life may well carry the lowest risk of mortality and morbidity, from a life course perspective it remains important for the continuous building of positive health.

16. Beyond an approach that focuses on adolescent mortality, morbidity, and risk factors, positive adolescent health approaches aim to nurture affirmative developmental assets such as connectedness; resilience; social, emotional, and cognitive competence; self-determination; spirituality; self-efficacy; positive identity; and belief in the future. The Region made substantial investments in positive adolescent health approaches through such programs as *Familias Fuertes: Amor y Limites* [Strong Families: Love and Boundaries], *Aventuras Inesperadas* [Unexpected Adventures], and *Escuelas de Futbol Jugados por la Salud* [Football Schools Playing for Health]. At least 13 countries initiated programs of this kind in the last decade, although in most cases implementation has remained limited (17). The school also continues to be an underutilized platform for reaching children and adolescents with health information, programs, and services.

17. Women's health is often confined to reproductive health. While critical, this focus is not sufficient to improve the health and well-being of women throughout the life course. In addition to interventions in childhood and through adolescence, the promotion of women's health requires a coherent approach that addresses the interplay of biological and social determinants of women's health, including the role of gender inequality in increasing exposure and vulnerability to risk and limiting access to health care and information (21). Women represent a growing proportion of older people and face increasing levels of chronic noncommunicable diseases, including cancers associated with ageing. Therefore, countries need to invest in strategies that address these conditions

and foster healthy habits at younger ages. The Plan of Action will contribute to an improved response to the health needs of women throughout the life course.

18. Certain groups of women, children, and adolescents remain structurally underserved or even invisible in health programs, strategies, and plans. These include persons with disabilities; lesbian, gay, bisexual, and transgender (LGBT) persons; migrants; indigenous and Afro-descendent groups; and persons deprived of their liberty. Targeted efforts are needed to make these groups visible, understand their specific health and wellness needs, and implement strategies that respond to their needs.

### ***Transform***

19. The Global Strategy's proposed markers for the "Transform" objective are eradication of extreme poverty, completion of primary and secondary education, elimination of harmful practices, discrimination and violence against women and girls, universal and equitable access to safe and affordable drinking water, sanitation and hygiene, scientific research, empowerment of women and girls, and innovation.

20. Work on the social determinants of health has made it clear that the conditions in which women, children, and adolescents are born, grow up, live, play, and work have a major impact on their health. Gender equality and education are predictors of well-being and health at different stages of the life course. In women, higher levels of education have been associated with lower levels of poverty and improved health status of their offspring. Specifically, education beyond the primary level has been identified as a critical determinant of health across the life course, including lower male mortality from injuries, lower female fertility, improved adult health, and increased survival of future children (17). Conversely, countries in the Region with the lowest quintile for mean years of schooling have significantly higher homicide rates and higher adolescent homicide rates than all the other quintiles combined (17). In LAC, literacy and enrollment in primary education rates are high, estimated at >95%. However, enrollment in secondary education is significantly lower, ranging from below 50% to 80% in LAC countries (17). According to the Economic Commission for Latin America and the Caribbean (ECLAC), after a 12-year period of declines in poverty and extreme poverty (2002-2014), LAC saw an increase in the number of persons living in poverty or extreme poverty in 2015-2016, the most affected groups being women, children, and adolescents (24).

21. Many forms of violence disproportionately affect women across the life course, including intimate partner violence; sexual violence; child, early, and forced marriage; human trafficking; femicide; and sexual harassment in schools and workplaces. Violence by an intimate partner is the most common form of violence experienced by women. WHO estimates that 30% of women in the Americas have experienced physical and/or sexual violence by a partner, while 11% have experienced sexual violence by a non-partner. An estimated 58% of children in the LAC region, or 99 million, experience physical, sexual, or emotional abuse (20, 25). The Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (14) aims to draw attention to and catalyze action around the issue of violence against women and provides guidance for health systems to address violence perpetrated against adolescent and adult

women. Youth violence and self-harm disproportionately affect young males. During 2008-2014, nine out of 10 homicide deaths and two out of three suicide deaths in the 10-19 year age group in the region were among males (17).

### **Common Barriers and Challenges within a New Paradigm**

22. The steady increase in life expectancy and the need to surpass survival as a final health objective have made it necessary to redefine and expand the health goals for women, children, and adolescents. To achieve the objectives of this Plan of Action, efforts should go beyond the prevention of diseases and guarantee the maximum development of capacities and access to opportunities to build health and well-being over time and across generations. Within this new paradigm, the following common challenges and barriers affecting the health of women, children, and adolescents in the Region are key.

- a) **Lack of equitable access to high quality and continuous health services.** Evidence suggests that health system inefficiency and lack of equity were largely responsible for the slow progress made by some countries in achieving the MDGs (6). The life course perspective promotes an approach toward health services that is different from the traditional way of providing services. The life course causality model requires that health systems move beyond structures that function on the basis of vertical programs and responds to episodic demands for care and instead become proactive systems that contribute to the ongoing building of health and wellness across the life span, thus interrupting the inter- and intra-generational transmission of poor health.
- b) **Limited systematic promotive and preventive health action in families, schools, and communities.** The significance and role of these settings differ across the life course but remain relevant throughout. Health interventions targeting families, schools, and communities have been limited in scope and subsequently fail to reach those most in need. Evidence suggests that working with individuals, families, and communities is critical to ensuring the recommended continuum of care throughout pregnancy, childbirth, and the postpartum period (26). Mothers, fathers, and other caretakers/guardians (male and female) are critically important to the health and development of children and adolescents, while school, peers, and social media increase in significance during childhood and adolescence into adulthood.
- c) **Lack of systematic and consistent engagement of women, children, and adolescents in their own health.** As stated in the Global Strategy, women, children, and adolescents are the most powerful agents for improving their own health and achieving prosperous and sustainable societies. However, inclusive community action does not happen in a vacuum. It must be systematically encouraged and facilitated with supportive policies, funding, and institutionalized mechanisms for the systematic empowerment and engagement of stakeholders, while mindful not to reproduce or perpetuate unequal gender distribution of health promotion and health care responsibilities.

- d) **Lack of strategic information to monitor health status and inequities and to inform the development of transformative approaches to health interventions.** The paucity of data on mortality, morbidity, and disability constrain the understanding of the survival and well-being of women, children, and adolescents in general and their subgroups. Where available, datasets are often limited to national averages and not disaggregated by cause, age, race/ethnicity, and place of residence, thus hiding inequities in subpopulations. In addition, life course-based approaches to health require different types of data, including longitudinal data on exposures and evolving health trajectories in individuals and groups that link with other data sets outside of the health sector. The limited availability of this type of data makes it difficult to assess and monitor health development from a life course perspective. Finally, health indicators tend to measure mortality and morbidity, while measuring of positive health remains limited.
- e) **Lack of a multisectoral approach to address the determinants of health.** Many factors influencing the health and wellness of women, children, and adolescents come from outside the health sector. As a result, key entry points for addressing health inequities are also outside the health sector. Moreover, factors contributing to inequities and vulnerabilities are often complex and multidimensional, requiring the involvement of multiple sectors on multiple levels to address inequities and the social determinants of health. Multisectoral action can take place on various levels, including: *a)* cooperation: interaction between sectors to align the actions of each sector to achieve greater efficiency toward a common goal; *b)* coordination: synergies between sectors and joint implementation of elements of policies and programs, both with and without shared financial sources; *c)* integration: joint definition of policies and programs and sharing of resources, responsibilities, and actions. Effective and sustained multisectoral action depends on political leadership, the willingness of key actors in the relevant sectors, and the presence of a supportive policy framework. The health sector can play an important role in mobilizing multisectoral action for the health of women, children, and adolescents by sharing information on their health status, risks and determinants; identifying priority areas for cross-sector action; and supporting mechanisms for multisectoral cooperation, coordination, and integration. Depending on the country context, multisectoral approaches will be more effective if a broad range of stakeholders are included, such as various sectors and levels of government, international agencies, nongovernmental organizations, civil society, community-based organizations, the private sector, and the individuals who are expected to receive the benefits.
- f) **Lack of a life course perspective and approach.** The life course approach allows for timely identification of critical and sensitive periods and supports the construction of health in each specific life stage, while also providing inputs to increase health trajectories over time. This approach provides a greater appreciation of the intergenerational dimension of health as a resource that is transferred from one generation to the next. The approach also supports increased appreciation of health and well-being as a means to achieve sustainable development with higher equity, while looking at health as an essential resource



for the generation of intrinsic capacities and functional reserves of people throughout their life. As such, the life course perspective views health and development as a continuum encompassing the entire life course, requiring an expanded, prospective public health lens that will increase the capacity to meet the real health and development needs and priorities of the population at each stage of life and over time.

### **Proposal**

23. The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, SHAA2030, and the Strategy for Universal Access to Health and Universal Health Coverage are the framework for this Plan of Action. The overall goal of the Plan is to protect the gains achieved so far and close the remaining gaps toward ensuring healthy lives and promoting well-being for all women, children, and adolescents in the Americas.

24. The following values and principles, outlined in greater detail in Annex A, guide the Plan of Action:

- a) Health equity
- b) Community and adolescent participation
- c) Evidence-based and multisectoral action
- d) Human rights and gender equality
- e) The life course approach
- f) Innovation and integration
- g) Accountability

### **Strategic Lines of Action**

25. This Plan of Action is based on four complementary and mutually reinforcing strategic lines of action. Inasmuch as countries have made different degrees of progress toward the Survive, Thrive, and Transform objectives, and each country will need to establish its own action plan appropriate to its national context and priorities, the proposed strategic lines of action are simply intended to guide national and subnational actions.

- a) Strengthen a transformative policy environment to reduce health inequities among women, children, and adolescents.
- b) Promote equitable health and wellness for women, children, and adolescents in their families, schools, and communities throughout the life course.
- c) Expand equitable access and coverage for women, children, and adolescents with comprehensive, integrated, quality health services that are people-, family-, and community-centered.

- d) Improve the availability and quality of strategic information on the health of women, children and adolescents.

26. Successful implementation of this Plan of Action will require strategic and sustained multisectoral action. In the context of this Plan, synergies, joint planning, implementation, monitoring and evaluation of actions with other sectors, including education, social protection, justice, NGOs and civil society, are critical to addressing the social determinants that influence the health of women, children, and adolescents and to reducing health inequities. Coherent and integrated implementation of the proposed lines of action, as appropriate to national context and priorities, will contribute to achievement of the following impact targets:<sup>3</sup>

Goal	Indicator	Baseline 2018 <sup>4</sup>	Target 2026 <sup>5</sup>	Target 2030
<b>1. Reduction of maternal mortality ratio (MMR)</b>	Regional MMR	44.2 (2017)	35.1	< 30 per 100,000 live births <sup>6</sup>
	Number of countries and territories with MMR < 30 per 100,000 <sup>7</sup> live births in all population groups (disaggregated by age, place of residence, race/ethnicity, and cause)	5	10	15
<b>2. Reduction of neonatal mortality rate</b>	Regional neonatal mortality rate	8.0 (2016)	7.5	7 per 1,000 live births
	Number of countries and territories with Neonatal mortality rate < 9 per 1,000 live births in all population groups <sup>8</sup> (disaggregated by age, place of residence, and race/ethnicity, as applicable in each country)	6	13	18
	Regional under-5 mortality rate	15.9 (2016)	15.2	< 14 per 1,000 live births <sup>9</sup>

<sup>3</sup> The impact targets will be harmonized with the targets in SHAA2030 and the new PAHO Strategic Plan.

<sup>4</sup> Once the assessment of Vital Statistics in the Region is completed, according to the 'Plan of Action for the Strengthening of Vital Statistics 2017-2022', adjustments may be made to the Baselines.

<sup>5</sup> The 2026 targets will be aligned with the targets in the new PAHO Strategic Plan.

<sup>6</sup> SHAA2030 target.

<sup>7</sup> SHAA2030 target.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

Goal	Indicator		Baseline 2018 <sup>4</sup>	Target 2026 <sup>5</sup>	Target 2030
3. Reduction of under-5 mortality rate	Number of countries and territories with Under-5 mortality rate < 16 per 1,000 live births in all population groups (disaggregated by age, place of residence, and race/ethnicity, as applicable in each country)		6	13	18
4. Reduction of mortality rate due to homicides in males aged 10-24 years	Regional homicide rate in males aged 15-24 years	15-19 years	TBD	TBD	Reduced by one-third <sup>10</sup>
		20-24 years	TBD	TBD	Reduced by one-third <sup>11</sup>
	Number of countries and territories that have reduced by one third the homicide rate in males aged 10-24 years in all population groups (disaggregated by place of residence and race/ethnicity)		0	5	10
5. Reduction of suicide mortality rate in males and females aged 10-19 years	Regional suicide rate in males and females aged 10-19 years	Males 10-19 years	5.6 per 100,000 (2014)	Reduced by one-sixth	Reduced by one-third
		Females 10-19 years	2.7 per 100,000 (2014)	Reduced by one-sixth	Reduced by one-third
	Number of countries and territories that have reduced by one third the suicide rate in males and females aged 10-19 years in all population groups (disaggregated by place of residence and race/ethnicity)		0	5	10
6. Reduction of specific fertility rate in girls 10-14 and 15-19 years old	a) Regional fertility rate in girls 10-14 years and 15-19 years in Latin America and the Caribbean	10-14 years	NA <sup>12</sup>	5% Reduction	10% Reduction
		15-19 years	66.5 (2010-2015) <sup>13</sup>	5% Reduction	10% Reduction

<sup>10</sup> SDG target.

<sup>11</sup> Ibid.

<sup>12</sup> Data not currently available, but pregnancy in girls 10-14 years has been included as an SDG target, which will enhance efforts to generate this data.

<sup>13</sup> United Nations, Department of Economic and Social Affairs, Population Division. World fertility patterns 2015. Available from: <http://www.un.org/en/development/desa/population/publications/pdf/fertility/world-fertility-patterns-2015.pdf>

Goal	Indicator	Baseline 2018 <sup>4</sup>	Target 2026 <sup>5</sup>	Target 2030
	b) Number of countries and territories that measure specific fertility rate in girls 10-14 years and 15-19 years by place or residence, race/ethnicity, and education level	0	5	10
	c) Number of countries and territories that have reduced by 10% the fertility rate in girls 10-14 years and 15-19 years in the lowest performing groups	0	3	8
7. Increase in healthy life expectancy (HALE) in females in the Americas	Healthy life expectancy (HALE) in females in the Americas	69.2 years (2018) <sup>14</sup>	TBD	At least one year added

***Strategic Line of Action 1: Strengthen a transformative policy environment to reduce health inequities among women, children, and adolescents***

27. Health inequities are generated or perpetuated at different levels, including the level of policy. In order to effectively and systematically addressing health inequities that affect women, children, and adolescents, it is critically important to understand how health inequities develop within and outside the health sector, and how an equitable culture of health can be fostered. An assessment of the impact of current policies, strategies, and plans on the health and wellness of women, children, and adolescents is needed, as well as a revision of these policies, strategies and plans to create the transformative policy environment needed to ensure that no woman, child, or young person is left behind.

28. Efforts under this line of action will include support for the implementation of health policy analysis and transformation of these policies to reduce avoidable inequalities affecting the health of women, children, and adolescents. PAHO's ongoing work on Health in All Policies will be an important element in the activities under this line of action, complemented with activities targeting the specific policies and issues affecting the health of women, children, and adolescents.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
1.1 Strengthen the capacity of countries to implement policies that measure, monitor, and systematically	1.1.1 Number of countries and territories that have implemented intersectoral policies to address the social determinants of health in women, children, and adolescents	10	20	30	40

<sup>14</sup> PAHO calculation based on data from 37 countries and territories.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
analyze and transform health inequalities affecting women, children, and adolescents	<b>1.1.2</b> Number of countries and territories that have set targets for reduction of inequities in the health of women, children, and adolescents at the national level (subnational level if country is decentralized)	TBD	15	30	40
<b>1.2</b> Increase the participation of relevant stakeholders, including adolescents, civil society, and communities, in the policy-making and implementation processes aimed at achieving health equity for women, children, and adolescents	<b>1.2.1</b> Number of countries and territories with specific mechanisms through which women and adolescents can engage in public policy development, implementation, monitoring, and evaluation	12	20	30	40

29. Structural and genuine participation of women, adolescents, and communities is essential for better results. Therefore, it will be essential to have policies, mechanisms, and opportunities for empowering these stakeholders and engaging them in the design, implementation, monitoring, and evaluation of actions for improvement of their health. Accountability is also essential to accelerate progress, as it enables the tracking of resources and results and provides information on what works, what needs improvement, and what requires increased attention. Inclusive and transparent accountability will be used as a tool to engage all stakeholders in the cycle of continuous learning and improvement, thus contributing to the acceleration of progress.

30. Key regional activities will include:

- a) Promoting and supporting implementation of innovative approaches such as the Innov8 tool (27) to analyze policy and program-level inequities affecting the health of women, children, and adolescents.
- b) Documenting and sharing good practices and lessons learned in countries in the promotion of sustainable engagement and participation of young persons, communities, and other sectors in public policy development, implementation, monitoring, and evaluation.

- c) Monitoring progress and publication of periodic regional reports on health equity for women, children, and adolescents at the Regional level.
31. Key country-level activities will include:
- a) Reviewing and reforming national policies and developing country roadmaps for the health of women, children and adolescents, with a focus on addressing health inequities affecting these groups
  - b) Establishing mechanisms for tracking results and resources related to the health of women, children and adolescents, that include civil society.
  - c) Implementing the Health in All Policies Framework to guide multisectoral action to address the determinants of the health of women, children, and adolescents.

***Strategic Line of Action 2: Promote equitable health and wellness for women, children, and adolescents in their families, schools, and communities throughout the life course***

32. The social environment plays an important role in construction and protection of the health and well-being of women, children, and adolescents. Parents, schools and communities, in addition to their role in reducing risk factors for preventable mortality and morbidity, can significantly contribute to the fostering of positive health through family-based early child development interventions, family- and school-based child and adolescent health interventions, and community-based actions for the prevention of maternal and neonatal mortality and the promotion of women's health.

33. A life course approach to interventions in families, schools, communities, and other social settings implies that interventions not only address the common health issues and those relevant to the specific life stage, but also adopt forward-looking approaches to build health in each life stage and support intergenerational transmission of good health. The timing of key interventions should coincide with critical moments in the development of health trajectories in order to achieve maximum positive impact.

34. It is critically important that interventions be evidence-based, targeting and empowering groups in conditions of vulnerability, and that they be implemented at the scale needed to achieve results. Given the disproportionate burden of poor health in indigenous, afro-descendent, and rural populations, interventions should include intercultural/culturally sensitive approaches adapted to the context and needs of these groups. In addition, targeted strategies should be designed to reach marginalized or invisible groups such as migrant women, children and adolescents, those living with disabilities, LGBT persons, and those deprived of their liberty. Participation of these groups in the development of interventions is essential and will contribute to innovative and more effective approaches.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
<b>2.1</b> Ensure mental, physical, sexual, and reproductive health and well-being of women, children, and adolescents in families	<b>2.1.1</b> Percentage of infants under 6 months of age who are exclusively breastfed <sup>15</sup>	30.5%	50%	60%	70%
	<b>2.1.2</b> Number of countries and territories that are implementing parenting programs for children and/or adolescents with specific targets for vulnerable groups	14	20	25	30
<b>2.2</b> Ensure mental, physical, sexual, and reproductive health and well-being of women, children, and adolescents in the community	<b>2.2.1</b> Percentage of children under 5 years who are developmentally on track in health, learning, and psychosocial well-being <sup>16</sup>	TBD	TBD	TBD	TBD
	<b>2.2.2</b> Number of countries and territories with at least one national-level program with specific targets for the health and empowerment of women	TBD	10	20	25
	<b>2.2.3</b> Number of countries and territories with recent data (5 years or less) on the proportion of women aged 15-49 years involved in decision-making on contraceptive use	3	5	7	10
<b>2.3</b> Enhance the use of the school platform for the mental, physical, sexual, and reproductive health and well-being of children and adolescents	<b>2.3.1</b> Number of countries and territories implementing a national comprehensive school health program <sup>17</sup> that reaches at least 50% of public schools	2	10	20	25

<sup>15</sup> WHO and the Global Breastfeeding Collective proposed a 2030 target of 70%.

<sup>16</sup> SDG indicator. The standardized definition and methodology are being defined and are expected to be available in 2019.

<sup>17</sup> A comprehensive school health program has four elements: 1) equitable school health policies; 2) healthy and safe learning environments; 3) skills-based health education, include age-appropriate sexuality education; and 4) school-based health services, including age-appropriate SRH, mental health and physical health care.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
2.4 Strengthen the health sector capacity to engage effectively with other sectors and civil society	2.4.1 Number of countries and territories with specific mechanisms by which civil society can engage in the development, implementation, monitoring and evaluation of health programs for women and/or children and/or adolescents	TBD	20	30	40

35. Key regional activities will include:

- a) Sharing normative guidance and strengthening capacity-building on life course-based actions for the health of women, children, and adolescents.
- b) Supporting, documenting, evaluating, and disseminating lessons learned from countries that have adopted life course-based country programs and approaches.
- c) Supporting countries in updating their national strategies and plans of action with a more visionary, multisectoral, and innovative focus, using evidence-based guidance such as the Global Accelerated Action for the Health of Adolescents (AA-HA!) (28) and the Nurturing Care Framework (29).
- d) Providing evidence-based guidance and capacity-building on early childhood development and positive adolescent health and development.
- e) Coordinate the development and implementation of a regional roadmap for strengthening school-based health programs and services
- f) Providing Member States with technical support for effective implementation of evidence-based, multisectoral, and innovative approaches and interventions in families and communities to promote the health of women, children, and adolescents, such as the *Familias Fuertes* program, *Chile Crece Contigo*, and other emerging evidence-based programs such as the Parenting for Lifelong Health program.

36. Key country-level activities will include:

- a) Reviewing and revising national and subnational programs and approaches toward more life course-based approaches.
- b) Implementing, evaluating, and documenting promotive and preventive life course-based interventions in families, schools, and communities for the health of women, children, and adolescents at scale, prioritizing groups in conditions of vulnerability.
- c) Establishing national and sub-national multi-stakeholder mechanisms to facilitate civil society participation in the development, implementation, monitoring and evaluation of health actions for women, children and adolescents.



- d) Strengthening partnerships with the education sector, social protection, justice, gender and other sectors and stakeholders to design and implement joint actions for the health and well-being of women, children and adolescents.

***Strategic Line of Action 3: Expand equitable access and coverage for women, children, and adolescents with comprehensive, integrated, quality health services that are people-, family-, and community-centered***

37. In 2009, the PAHO Member States adopted the regional policy for developing integrated health services delivery networks (IHSDNs) based on primary health care (PHC) to respond to the major challenges posed by health services fragmentation and contribute to the delivery of more accessible, equitable, and efficient health services of higher technical quality. In 2014, the Member States adopted the Strategy for Universal Access to Health and Universal Health Coverage, with the following four lines of action: *a)* expanding equitable access to comprehensive, quality, people- and community-centered health services; *b)* strengthening stewardship and governance; *c)* increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service; and *d)* strengthening intersectoral coordination to address the social determinants of health. Since that time, the Region has worked progressively on implementation of these commitments.

38. The activities proposed under this line of action are designed to contribute to these efforts, with specific focus on four areas:

- a) Completing the unfinished work initiated under previous plans of action for the prevention of maternal mortality and severe morbidity and neonatal mortality by ensuring universal access to continuous care that starts prior to conception and continues during pregnancy, childbirth, puerperium, and newborn care, prioritizing subgroups in conditions of vulnerability.
- b) Supporting articulation of the health sector's role and contribution to the positive health and development of children, adolescents, and women, including early childhood development, positive adolescent health and development, and health of women beyond their reproductive functions.
- c) Supporting articulation and application of a life course perspective on health services for women, children, and adolescents, moving from health systems structured to respond to episodic demands for care toward proactive systems that contribute to the ongoing building of health and wellness throughout the life course and across generations and social contexts.
- d) Supporting systematic analysis of the barriers faced by specific groups of women, children, and adolescents in conditions of vulnerability in accessing health services, and designing strategies to address these barriers.

39. This line of action will be aligned with and implemented in close collaboration with PAHO's work on IHSDNs, universal health access and coverage, and cancer prevention.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
3.1. Ensure universal access for women, children, and adolescents to health services, including sexual and reproductive health care services and information	3.1.1 Percentage of women of reproductive age who have their need for family planning satisfied with modern methods	69% (2017)	75%	80%	90%
	3.1.2 Number of countries and territories that measure percentage of women of reproductive age in countries who have their need for family planning satisfied with modern methods, disaggregated by age, race/ethnicity, place of residence, and income level	9	12	17	25
	3.1.3 Number of countries and territories that do not have legal restrictions for access to sexual and reproductive health service, including contraceptives	24	28	30	35
	3.1.4 a) Number of countries and territories that measure percentage of pregnant women who received antenatal care four or more times	48	48	48	48
	b) Number of countries and territories that measure percentage of pregnant women who received antenatal care four or more times, disaggregated by age, race/ethnicity, and place of residence	0	5	10	15

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
	c) Number of countries and territories that measure percentage of pregnant women who received antenatal care four or more times, disaggregated by age, race/ethnicity, and place of residence, and achieve an increase of 20% of the percentage of women in the lowest performing groups with four or more visits	0	3	6	10
	<b>3.1.5</b>				
	a) Number of countries and territories that measure births attended at health facilities, disaggregated by age, race/ethnicity, and place of residence of the mother	0	3	6	10
	b) Number of countries and territories that measure births attended at health facilities, disaggregated by age, race/ethnicity, and place of residence of the mother, and that have increased by 20% in the lowest performing groups	0	5	10	15
	<b>3.1.6</b> Number of countries and territories that have increased their composite coverage index <sup>18</sup> for maternal and child health	TBD	TBD	TBD	TBD

<sup>18</sup> The composite coverage index (CCI) is a summary measure to identify who is being left behind. The index is a weighted average of the coverage of selected interventions across the continuum of maternal and child care: demand for family planning satisfied with modern methods, at least four antenatal care visits, skilled birth attendant, immunization (DTP3 and measles), treatment of diarrhea with ORS, care-seeking for children with symptoms of pneumonia. Countdown to 2030 is tracking this indicator.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
	<b>3.1.7</b> Number of countries and territories that have introduced HPV in their immunization schedule	31	35	40	45
<b>3.2</b> Improve the quality of health services for women, children and adolescents	<b>3.2.1</b> Number of countries and territories implementing regular maternal and perinatal death reviews and audits	8	15	25	35
	<b>3.2.2</b> Number of countries and territories implementing national standards for quality health care services for adolescents	11	20	30	40
	<b>3.2.3</b> Number of countries and territories with national data regarding the use of magnesium sulfate in pregnant women with severe pre-eclampsia or eclampsia.	2	6	10	15
	<b>3.2.4</b> Number of countries and territories with national data regarding the use of oxytocic to prevent post-partum hemorrhage.	2	6	10	15

40. Key regional activities will include:

- a) Continuing with training of trainers of health professionals in Managing Complications in Pregnancy and Childbirth (MCPC) and Continuum of Care for reproductive, maternal, newborn and child health (RMNCH) for the provision of high-quality pregestational, prenatal, delivery, and postnatal health care services.
- b) Supporting integration of a life course perspective into the design and delivery of health services for women, children, and adolescents.
- c) Documenting and sharing successful models and best practices related to pro-equity, life course-based, and innovative approaches to health services for women, children, and adolescents.
- d) Supporting the development and implementation of adolescent-responsive health services, including the formulation of comprehensive packages of care, developing standards for adolescent health services, and establishing mechanisms for ongoing pre- and in-service competency-based training of service providers.

41. Key country-level activities will include:
- a) Developing or strengthening systems for timely referral and counter-referral for antenatal, delivery, and postnatal care by implementing the Assessment of Essential Conditions for the First Level of Attention and Specialized Care (AEC) to measure readiness.
  - b) Implementing evidence-based PAHO/WHO training tools such as the toolkit for Strengthening Professional Midwifery in the Americas and the WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience, to improve the quality of pregestational, prenatal, delivery, and postnatal health care, including post-obstetric event contraception.
  - c) Conducting regular assessments and ongoing monitoring of barriers to access to health services for the groups of women, children, and adolescents with the highest burden of preventable mortality and morbidity using Innov8 and other equity-based assessment tools.
  - d) Reorganizing health services for women, children, and adolescents to include more proactive, continuous, and life course-based approaches.
  - e) Expanding access to modern contraceptives for all women and adolescents, including long-acting reversible contraception (LARC), by prioritizing the strategic approaches and recommendations generated through a technical consultation and captured in the document “Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean” (30). The Member States could also consider the promotion of implants and modern contraception as Argentina and Uruguay do, with significant results in the reduction of the adolescent fertility rate.
  - f) Implementing standards for adolescent health services and mechanisms for ongoing monitoring of the quality and coverage of comprehensive health services for adolescents, including sexual and reproductive health services and information.

***Strategic Line of Action 4: Improve the availability and quality of strategic information on the health of women, children and adolescents***

42. Accelerating the reduction of preventable mortality and morbidity in women, children and adolescents will require increased understanding of the circumstances of these deaths, and the most affected groups. This requires the availability of valid and reliable data that has been generated through standardized methods, and can be analyzed according to the dimensions of inequality, including but not limited to sex/gender, wealth, education, place of residence, ethnic group, sexual orientation, and migration status, among others. Therefore, improved monitoring of inequities in the health of women, children, and adolescents will require continued strengthening of health information systems, systematic and ongoing analysis of specific events, such as maternal deaths, deaths in children, and deaths in adolescents from external causes, as well as analysis of data using equity-based measures.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
<b>4.1.</b> Increase the availability of data on preventable mortality of women, children and adolescents	<b>4.1.1</b> Number of countries and territories that conduct active searches for maternal deaths, to reduce the under-registration and misclassification of these deaths.	8	15	20	25
	<b>4.1.2</b> Number countries and territories that increase the capture, registration, and analysis of deaths in children under 5 (disaggregated by age, sex, and place of residence) and cause of death.	0	15	20	25
	<b>4.1.3</b> Number of countries and territories that conduct periodic analysis of the distribution and circumstances of the leading causes of adolescent mortality	1	10	15	20
<b>4.2</b> Build capacity for ongoing health inequity monitoring	<b>4.2.1</b> Number of countries and territories that have established mechanisms for ongoing monitoring of health inequities affecting women, children and adolescents.	TBD	15	30	40

43. Key regional activities will include:
- a) Sharing normative guidance and building capacity on health inequality monitoring with a special focus on women, children and adolescents
  - b) Support implementation of the Plan of Action for the Strengthening of Vital Statistics 2017-2022, to increase the availability of data on the health of women, children and adolescents disaggregated by age, race/ethnicity, place of residence, and income level.
  - c) Sharing guidance and capacity building on the implementation of the Maternal and Perinatal Death Surveillance and Response guidelines and the WHO Near-miss approach
  - d) Sharing guidance and supporting implementation of standardized methodologies to analyze adolescent mortality due to external causes.

44. Key country-level activities will include:
- a) Implementing the Maternal and Perinatal Death Surveillance and Response guidelines and the WHO Near-miss approach to strengthen the surveillance of neonatal and maternal mortality and morbidity, including mortality audits and monitoring of near-misses.
  - b) Implementing the Plan of Action for the Strengthening of Vital Statistics 2017-2022, to increase the availability of data on the health of women, children and adolescents disaggregated by dimensions of inequality such as age, race/ethnicity, place of residence, and income level.
  - c) Implementing standardized approaches towards the analysis of adolescent deaths due to homicide, suicide and land traffic accidents
  - d) Development and dissemination of equity-based profiles on the health of women, children and adolescents

### **Monitoring and Evaluation**

45. The achievements of this Plan of Action will be measured through a core set of indicators with baselines and targets for 2022, 2026, and 2030, the final year of the plan. These indicators are aligned with the SDGs, SHAA2030, and other existing regional and global reporting commitments. A methodologic guide will be developed to explain how each indicator will be measured. Data will be collected from such sources as national information systems, global and regional reports, standardized global and regional estimates, and policy and program surveys.

46. Two intermediate reviews of this Plan of Action will be performed, the first in 2022 and the second in 2026, to assess progress toward the targets and, if necessary, to incorporate adjustments. A final report will be prepared for the PAHO Governing Bodies in 2031.

### **Financial Implications**

47. The total estimated cost of implementing the resolution during its life cycle (2018-2030) is US\$ 208 million. Investments from Member States are expected for appropriate and comprehensive country-level implementation of this Plan but they are not estimated here.

### **Action by the Executive Committee**

48. The Executive Committee is invited to review the Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030, make the recommendations it deems pertinent, and consider adopting the proposed resolution presented in Annex B.

Annexes

## References

1. Every Woman Every Child. The Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) [Internet]. New York: EWEC; 2015 [cited 2017 June 10]. Available from:  
[http://www.everywomaneverychild.org/wp-content/uploads/2016/11/EWEC\\_globalstrategyreport\\_200915\\_FINAL\\_WEB.pdf](http://www.everywomaneverychild.org/wp-content/uploads/2016/11/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf)
2. Every Woman Every Child – Latin America and the Caribbean. Commitment to Action of Santiago [Internet]. Santiago: EWEC LAC; 2017 [cited 2018 January 15]. Available from:  
[http://www.paho.org/chi/index.php?option=com\\_docman&view=document&alias=217-commitment-to-action-santiago-president-bachelet&category\\_slug=agenda2017&Itemid=1145](http://www.paho.org/chi/index.php?option=com_docman&view=document&alias=217-commitment-to-action-santiago-president-bachelet&category_slug=agenda2017&Itemid=1145)
3. Pan American Health Organization. Strategy for universal access to health and universal health coverage [Internet]. 53rd Directing Council of PAHO, 66th Session of the Regional Committee of WHO for the Americas; 2014 Sep 29-Oct 3; Washington, DC. Washington, DC: PAHO; 2014 (Document CD53/5, Rev. 2) [cited 2017 June 10]. Available from:  
<http://www.paho.org/uhexchange/index.php/en/uhexchange-documents/technical-information/26-strategy-for-universal-access-to-health-and-universal-health-coverage/file>
4. United Nations. Transforming our world: the 2030 Agenda for Sustainable Development [Internet]. General Assembly, Seventieth Session of the General Assembly of the United Nations; 2015 Sep 11-18; New York, NY. New York: UN; 2015 [cited 2017 July 12]. Available from:  
<http://www.refworld.org/docid/57b6e3e44.html>
5. Pan American Health Organization. Sustainable Health Agenda for the Americas 2018-2030: a call to action for health and well-being in the Region [Internet]. 29th Pan American Sanitary Conference, 69th Session of the Regional Committee of WHO for the Americas; 2017 Sep 25-29; Washington, DC. Washington, DC: PAHO; 2017 (Document CSP29/6, Rev.3) [cited 2018 January 15]. Available from:  
[http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=41946&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=41946&Itemid=270&lang=en)
6. Pan American Health Organization. Health in the Americas 2017 [Internet]. Washington, DC: PAHO; 2017 [Cited 2018 January 17]. Available from:  
<http://www.paho.org/salud-en-las-americas-2017>.



7. Pan American Health Organization. Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity [Internet]. 51st Directing Council of PAHO, 64th Session of the Regional Committee of WHO for the Americas; 2011 Sep 26-30; Washington, DC. Washington, DC: PAHO; 2012 (Document CD51/12) [cited 2018 January 16]. Available from:  
[http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=14676&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=14676&Itemid=270&lang=en)
8. Pan American Health Organization. Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care [Internet]. 48th Directing Council of the Pan American Health Organization, 60th Session of the Regional Committee of WHO for the Americas; 2008 Sep 29-Oct 3; Washington, DC. Washington, DC: PAHO; 2008 (Document CD48/07) [cited 2018 January 16]. Available from:  
<http://www1.paho.org/english/gov/cd/cd48-07-e.pdf?ua=1>
9. Pan American Health Organization. Strategy and Plan of Action for Integrated Child Health [Internet]. 28th Pan American Sanitary Conference, 64th Session of the Regional Committee of WHO for the Americas; 2012 Sep 17-21; Washington, DC. Washington, DC: PAHO; 2012 (Document CSP28/10) Washington, DC: PAHO; 2012 [cited 2018 January 16]. Available from:  
[http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_view&gid=21101&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21101&Itemid=270&lang=en)
10. Pan American Health Organization. Adolescent and Youth Regional Strategy and Plan of Action 2010-2018 [Internet]. Washington, DC: PAHO; 2010 [cited 2017 June 10]. Available from:  
<http://new.paho.org/hq/dmdocuments/2011/Adolescent%20and%20Youth%20Regional%20Strategy%20and%20Plan%20of%20Action.pdf>
11. Pan American Health Organization. Gender equality policy. [Internet]. 46th Directing Council of the Pan American Health Organization, 57th Session of the Regional Committee of WHO for the Americas; 2005 Sep 26-30; Washington, DC. (Document CD46/12) Washington, DC: PAHO; 2005 [cited 2018 March 30]. Available from:  
<http://www1.paho.org/english/gov/cd/CD46-12-e.pdf>
12. Pan American Health Organization. Plan of Action on Health in All Policies. [Internet]. 53rd Directing Council of the Pan American Health Organization, 66th Session of the Regional Committee of WHO for the Americas; 2014 Sep 29-Oct 3; Washington, DC. (Document CD53/10, Rev.1) Washington, DC: PAHO; 2014 [cited 2017 July 20]. Available from:  
[http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=26797&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=26797&Itemid=270&lang=en)

13. Pan American Health Organization. Policy on ethnicity and health [Internet]. 29th Pan American Sanitary Conference, 69th Session of the Regional Committee of WHO for the Americas; 2017 Sep 25-29; Washington, DC. (Resolution CSP29.R3) Washington, DC: PAHO; 2017 [cited 2017 July 24]. Available from: [https://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=42294&Itemid=270&lang=en](https://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=42294&Itemid=270&lang=en)
14. Pan American Health Organization. Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women. [Internet]. 54th Directing Council of the Pan American Health Organization, 67th Session of the Regional Committee of WHO for the Americas; 2015 Sep 28-Oct 2; Washington, DC. (Document CD54/9, Rev.2) Washington, DC: PAHO; 2015. Available from: [http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=31508&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=31508&Itemid=270&lang=en)
15. Pan American Health Organization. Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: final report [Internet]. 55th Directing Council of the Pan American Health Organization, 68th Session of the Regional Committee of WHO for the Americas; 2016 Sep 26-30; Washington, DC. (Document CD55/INF/11) Washington, DC: PAHO; 2016 [cited 2018 January 15]. Available from: [http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=35789&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35789&Itemid=270&lang=en)
16. Pan American Health Organization. Strategy and Plan of Action for Integrated Child Health: Final Report. 162nd Session of the Executive Committee; 2018 June 18-22; Washington, DC (Document CE162/INF/13) [unavailable on the Internet at the moment of writing of this document].
17. Pan American Health Organization. The health of adolescents and youth in the Americas: implementation of the Regional Strategy and Plan of Action on Adolescent and Youth Health 2010-2018. Washington, DC: PAHO/WHO; 2018. In press.
18. Pan American Health Organization/World Health Organization. Regional mortality database [Internet]. Washington, DC: PAHO; 2016 [updated 2016 June 16; cited 2018 January 15]. Available from: <https://hiss.paho.org/pahosys/lcd.php>
19. World Health Organization. Healthy life expectancy (HALE) at birth. [Internet]. Data and interactive graphs. Geneva: WHO; 2016 [cited 2018 January 15]. Available from: [http://www.who.int/gho/mortality\\_burden\\_disease/life\\_tables/hale/en/](http://www.who.int/gho/mortality_burden_disease/life_tables/hale/en/)
20. Hills S, Mercy J, Amobi A, Kress H. Global prevalence of past year violence against children: a systematic review and minimum estimates. *Pediatrics* 2016;137(3): e2015407

21. World Health Organization. Women and health: today's evidence; tomorrow's agenda [Internet]. Geneva (Switzerland): WHO; 2009 [cited 2018 March 30]. Available from: <http://www.who.int/gender-equity-rights/knowledge/9789241563857/en/>
22. Pan American Health Organization. Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity: Final Report. 162nd Session of the Executive Committee; 2018 June 18-22; Washington, DC (Document CE162/INF/12) Washington, DC: PAHO; 2017 [cited 2018 May 16]. Available from: [https://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=45218&Itemid=270&lang=en](https://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=45218&Itemid=270&lang=en)
23. Pan American Health Organization. Health Situation in the Americas: Core Indicators 2017. [Internet]. Washington, DC: PAHO; 2017 [cited 2018 March 30]. Available from: [http://iris.paho.org/xmlui/bitstream/handle/123456789/34329/CoreIndicators2017\\_eng.pdf?sequence=1&isAllowed=y](http://iris.paho.org/xmlui/bitstream/handle/123456789/34329/CoreIndicators2017_eng.pdf?sequence=1&isAllowed=y)
24. Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2017 [Internet]. Santiago (Chile): ECLAC; 2018 [cited 2018 March 30]. Available from: <https://www.cepal.org/en/publicaciones/ps>
25. Stoltenborgh M, Ijzendoorn MH, Euser EM, Bakermans-Kranenburg MJ. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreatment* 2011; 16(2):79-101.
26. World Health Organization. Working with individuals, families, and communities to improve maternal and newborn health: a toolkit for implementation. [Internet]. Geneva (Switzerland): WHO; 2017 [cited 2018 March 30]. Available from: [www.who.int/maternal\\_child\\_adolescent/documents/community-engagement-mnh-toolkit/en/](http://www.who.int/maternal_child_adolescent/documents/community-engagement-mnh-toolkit/en/)
27. World Health Organization. Innov8 technical handbook [Internet]. Geneva: WHO; 2016 [cited 2018 March 30]. Available from: <http://www.who.int/life-course/partners/innov8/innov8-technical-handbook/en/>
28. World Health Organization. Global accelerated action for the health of adolescents (AA-HA!) guidance to support country implementation [Internet]. Geneva: WHO; 2017 [cited 2017 June 10]. Available from: [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/framework-accelerated-action/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/)
29. World Health Organization. Nurturing care for early childhood development. A framework for linking survive and thrive to transform health and human development. Draft for consultation [Internet]. Geneva: WHO; 2018 [cited 2018 May 11]. Available from: [http://www.who.int/maternal\\_child\\_adolescent/child/draft2-nurturing-care-framework.pdf?ua=1](http://www.who.int/maternal_child_adolescent/child/draft2-nurturing-care-framework.pdf?ua=1)

30. Pan American Health Organization; United Nations Population Fund; United Nations Children's Fund. Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean: a meeting report. Washington, D.C.: PAHO.

## Annex A

### Values and Principles

- a) *Health equity.* Health equity refers to the absence of unfair and avoidable differences in health status, access to health care, and healthy environments. Equity-based approaches strive for fairness and justice by eliminating differences that are unnecessary and avoidable.
  - b) *Community and adolescent participation.* Structural and genuine participation of communities and adolescents is essential for better results. It requires the design and enactment of policies, mechanisms, and opportunities for empowerment and engagement of these stakeholders in the design, implementation, monitoring, and evaluation of actions.
  - c) *Evidence-based and multisectoral action.* Programs, policies, and services to improve the health and well-being of women, children, and adolescents must be based on the best scientific evidence available and/or best practice consensus, and it must be tailored to the specific sociocultural context. Interventions beyond the health sector must be seen as core to national strategies on women's, children's, and adolescents' health. Health sector actions must be situated within a comprehensive and coordinated multisectoral response. The health sector provides leadership to mobilize and support the engagement of other sectors and stakeholders in the development of coherent and harmonized multisectoral actions to improve the health and well-being of women, children, and adolescents.
  - d) *Human rights and gender equality.* The basic rights and freedoms to which all human beings are entitled include the right to enjoyment of the highest attainable standard of health. Gender equality in health means that women and men have equal conditions for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results.
  - e) *Life course approach.* This approach recognizes that positive and negative factors influence the trajectories and outcomes of an individual's health and development. These influences are the greatest when action occurs during sensitive periods of human growth and development and accumulate across the life course of individuals and across generations.
  - f) *Innovation and integration.* Scientific, technological, social, business, and financial innovations are needed to achieve transformative effects. Innovative solutions can be encouraged through investing in and nurturing the cycle of research, evidence, knowledge, policy and programming, and supporting the testing and scaling up of innovations.
  - g) *Accountability.* Regional and national partners involved in the efforts to improve the health and well-being of women, children, and adolescents are accountable for their commitments and promises, for the effective use of resources, and for the outcomes of the health policies and programs they design and implement. Accountability mechanisms that are transparent and include all stakeholders must be put in place and adhered to.
-

## 162nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 18-22 June 2018

---

CE162/14  
Annex B  
Original: English

### ***PROPOSED RESOLUTION***

#### **PLAN OF ACTION FOR WOMEN'S, CHILDREN'S AND ADOLESCENT'S HEALTH, 2018-2030**

#### ***THE 162nd SESSION OF THE EXECUTIVE COMMITTEE,***

(PP1) Having reviewed the proposed *Plan of Action for Women's, Children's and Adolescents' Health 2018-2030* (Document CE162/14);

(PP2) Aware of the efforts made and the achievements obtained thus far through the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity (2012-2017); the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (2008-2015); the Strategy and Plan of Action for Integrated Child Health (2012-2017); and the Adolescent and Youth Regional Strategy and Plan of Action (2010-2018);

(PP3) Considering the importance of a new action plan that is aligned with the Sustainable Health Agenda for the Americas 2018-2030 and aims to close the remaining gaps towards ensuring healthy lives and well-being for all women, children, and adolescents in the Americas,

#### ***RESOLVES:***

(OP)1. To recommend that the Directing Council adopt a resolution along the following lines:

---

**PLAN OF ACTION FOR WOMEN’S, CHILDREN’S, AND ADOLESCENTS’  
HEALTH 2018-2030**

***THE 56th DIRECTING COUNCIL,***

(PP1) Having reviewed the *Plan of Action for Women’s, Children’s, and Adolescents’ Health 2018-2030* (Document CD56/\_\_);

(PP2) Aware of the efforts made and the achievements obtained thus far through the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity (2012-2017); the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (2008-2015); the Strategy and Plan of Action for Integrated Child Health (2012-2017); and the Adolescent and Youth Regional Strategy and Plan of Action (2010-2018);

(PP3) Acknowledging the slow and unequal progress and the need to accelerate progress and reduce health inequities affecting the health and wellness of women, children, and adolescents through integrated and multisectoral approaches that address the underlying determinants;

(PP4) Reaffirming the right of all women, children, and adolescents to the enjoyment of the highest attainable standard of health, and the interrelated principles and values adopted by PAHO Member States with the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) of solidarity, equity in health, universality, and social inclusion;

(PP5) Considering the importance of having a new action plan that is aligned with the Sustainable Health Agenda for the Americas 2018-2030 and closes the remaining gaps to ensuring healthy lives and physical, mental, sexual and reproductive well-being for all women, children, and adolescents in the Americas,

***RESOLVES:***

(OP)1. To approve the Plan of Action for Women’s, Children’s, and Adolescents’ Health 2018-2030 within the context of the specific conditions of each country.

(OP)2. To urge the Member States to:

- a) make efforts to foster a transformative policy environment to reduce health inequities in women, children, and adolescents;
- b) expand equitable access and coverage for women, children, and adolescents to comprehensive and quality health services, including mental health and sexual and reproductive health services, that contribute to the ongoing building of health and wellness throughout the life course and across generations;

- c) invest in mechanisms to empower and equip individuals, families, and communities to actively engage in the protection and promotion of the health of women, children, and adolescents;
- d) exchange experiences and good practices and promote partnerships within and between countries aimed at achieving the targets and objectives of the Plan of Action;
- e) increase the effectiveness of multisectoral government coordination and the participation of civil society organizations, women, and adolescents in order to ensure progress and promote accountability.

(OP)3. To request the Director to:

- a) work with the Member States to evaluate and update their national action plans and disseminate tools that facilitate integrated, equity-based, and innovative approaches toward the health of women, children, and adolescents;
- b) strengthen coordination of the Plan of Action with similar initiatives developed by other international technical and financial agencies and global initiatives for the health and well-being of women, children, and adolescents;
- c) report periodically to the Governing Bodies on the progress made and challenges faced in implementation of the Plan of Action.



## Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

**1. Agenda item:** Item 4.4 Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030

**2. Linkage to [PAHO Program and Budget 2018-2019](#):**

- a) **Category:** 3. Determinants of Health and Promoting Health throughout the Life Course: Promoting good health at key stages of life, taking into account the need to address the social determinants of health (social conditions in which people are born, grow, live, work, and age) and implementing approaches based on gender equality, ethnicity, equity, and human rights.
- b) **Program areas and outcomes:**  
 Program Area: 3.1. Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health.  
 Outcome 3.1: Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health.

**3. Financial implications:**

a) **Total estimated cost for implementation over the life cycle of the resolution (including staff and activities):**

The total estimated cost for the Plan of Action is \$208,150,000. This estimate takes into account the total sum needed for PASB activities. However, the results will only be achieved if Member States also increase their strategic investments in the health of women, children, and adolescents. Therefore, total amount needed for the key country-level activities is not reflected in this estimate. The amount calculated for human resources (see table below) considers the current PAHO staff dedicated to Program Area 3.1 at Regional and Country levels. The amounts estimated for activities (training, consultants, travel and meetings, publications, and supplies) were calculated considering regular funds and voluntary contributions that will need to be mobilized throughout the life span of the Plan of Action.

Areas	Estimated cost
Human resources	\$56,700,000
Training	\$60,650,000
Consultants/service contracts	\$30,300,000
Travel and meetings	\$38,000,000
Publications	\$15,000,000
Supplies and other expenses	\$7,500,000
<b>Total</b>	<b>\$208,150,000</b>

- b) Estimated cost for the 2018-2019 biennium (including staff and activities):**  
The estimated cost for the 2018-2019 biennium is \$16,875,000 (cost of implementing the Plan of Action from October 2018 to December 2019, 15 months).
- c) Of the estimated cost noted in b), how much can be subsumed under existing programmed activities? \$14,000,000.**

**4. Administrative implications:**

- a) Indicate the levels of the Organization at which the work will be undertaken:**  
All levels of the Organization will be involved: Regional, country and subregional. Active participation by the Ministries of Health of the Member States, as well as other sectors at the national and local level will also be necessary. Involvement of other agencies in the United Nations system and subregional organizations and mechanisms will facilitate the efficient and harmonized implementation of needed multisectoral action.
- b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**  
A full-time specialist in early childhood development and a full-time specialist in positive adolescent health and development are required in order to support implementation of the Plan of Action.
- c) Time frames (indicate broad time frames for the implementation and evaluation):**  
Execution will begin as soon as this Plan of Action is approved by the Directing Council in order to ensure its inclusion in the new Strategic Plan and the Program and Budget.
- Two intermediate reviews of this Plan of Action will be performed in 2022 and 2026 to assess progress toward the goals and, if necessary, to incorporate adjustments. A final report will be prepared for the Governing Bodies In 2031.

## ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** Item 4.4 Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030

2. **Responsible unit:** Family, Health Promotion, and Life Course (FPL)

3. **Preparing officer:** Dr. Sonja Caffè

4. **Link between Agenda item and [Sustainable Health Agenda for the Americas 2018-2030](#):**

The proposed Plan of Action (PoA) is fully aligned with the principles and values of the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), in particular the right to the enjoyment of the highest attainable standard of health, the universality of equity in health, and social inclusion. The PoA seeks to realize the vision of SHAA2030 for all women, children, and adolescents in the Americas.

The PoA touches on the full scope of SHAA2030, with particular emphasis on Goals 1, 2, 3, 4, 5, 6, 7, 9, and 11

Similarly, it is anticipated that the PoA will contribute to the majority of the SHAA2030 targets, with particular emphasis on targets 1.2, 1.3, 1.4, 1.6, 2.1, 2.3, 2.4, 2.5, 4.2, 4.3, 6.2, 6.3, 7.3, 9.1, 9.4, 9.5, 9.6, 9.7, and 11.1.

5. **Link between Agenda item and the [Strategic Plan of the Pan American Health Organization 2014-2019 \(Amended\)](#):**

The scope of the PoA is related to the areas of work under categories 2, 3, and 4 of the PAHO Strategic Plan, with particular focus on categories 3 and 4:

Category 2: Noncommunicable Diseases and Risk Factors

Category 3: Determinants of Health and Promoting Health throughout the Life Course

Category 4: Health Systems

**6. List of collaborating centers and national institutions linked to this Agenda item:**

- **For the countries of the Region.** Ministries of health, ministries of education, ministries of social protection and development, ministries and offices of women’s affairs, national institutes of statistics, civil registries, civil society organizations and networks such as women’s groups and youth-led organizations, and academic and research institutions.
- **Subregional initiatives.** Southern Common Market (MERCOSUR), Andean Health Organization–Hipólito Unanue Agreement (ORAS-CONHU), Union of South American Nations (UNASUR), Meeting of Ministers of Health of Central America (COMISCA), Caribbean Community (CARICOM).
- **United Nations Agencies and development partners.** The interagency coordinating mechanism for implementation of the Global Strategy for Women’s, Children’s. and Adolescents’ Health, with focus on reducing health inequalities; EWEC LAC, consisting of UNICEF, the United Nations Population Fund (UNFPA), the World Bank, the Joint United Nations Program on AIDS (UNAIDS), the U.S. Agency for International Development (USAID), and the Interamerican Development Bank (IDB).
- **Others.** The Neonatal Alliance for Latin America and the Caribbean, Regional Working Group for Reduction of Maternal Mortality (GTR), Iowa State University.

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

- Sustainable and at-scale implementation of comprehensive child health and development interventions that engage families and communities, such as *Chile Crece Contigo* (Chile), *Cero a Siempre* (Colombia), *Uruguay Crece Contigo* (Uruguay), and *Amor por los más Chiquitos y Chiquitas* (Nicaragua), among others
- At-scale implementation of the *Familias Fuertes* program in Peru, Colombia, and Guatemala, working with parents/caregivers and adolescents, reaching more than 200,000 families annually
- The interprogrammatic project for Zero Maternal Deaths, supported by the Director of PAHO
- PAHO Safe Motherhood Initiative, which documented 121 experiences and good practices for improvement of maternal health, including intercultural approaches toward maternal health
- Implementation of the Perinatal Information System (SIP) at the population level in Uruguay and El Salvador

**8. Financial implications of this Agenda item:**

The total estimated cost for the Plan of Action (2018-2030) is \$208,150,000. This estimate takes into account the total sum for PASB activities, including Regional capacity-building and technical support to Member States. The estimated cost for the 2018-2019 biennium is \$16,875,000.

- - -