

56th DIRECTING COUNCIL

70th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS
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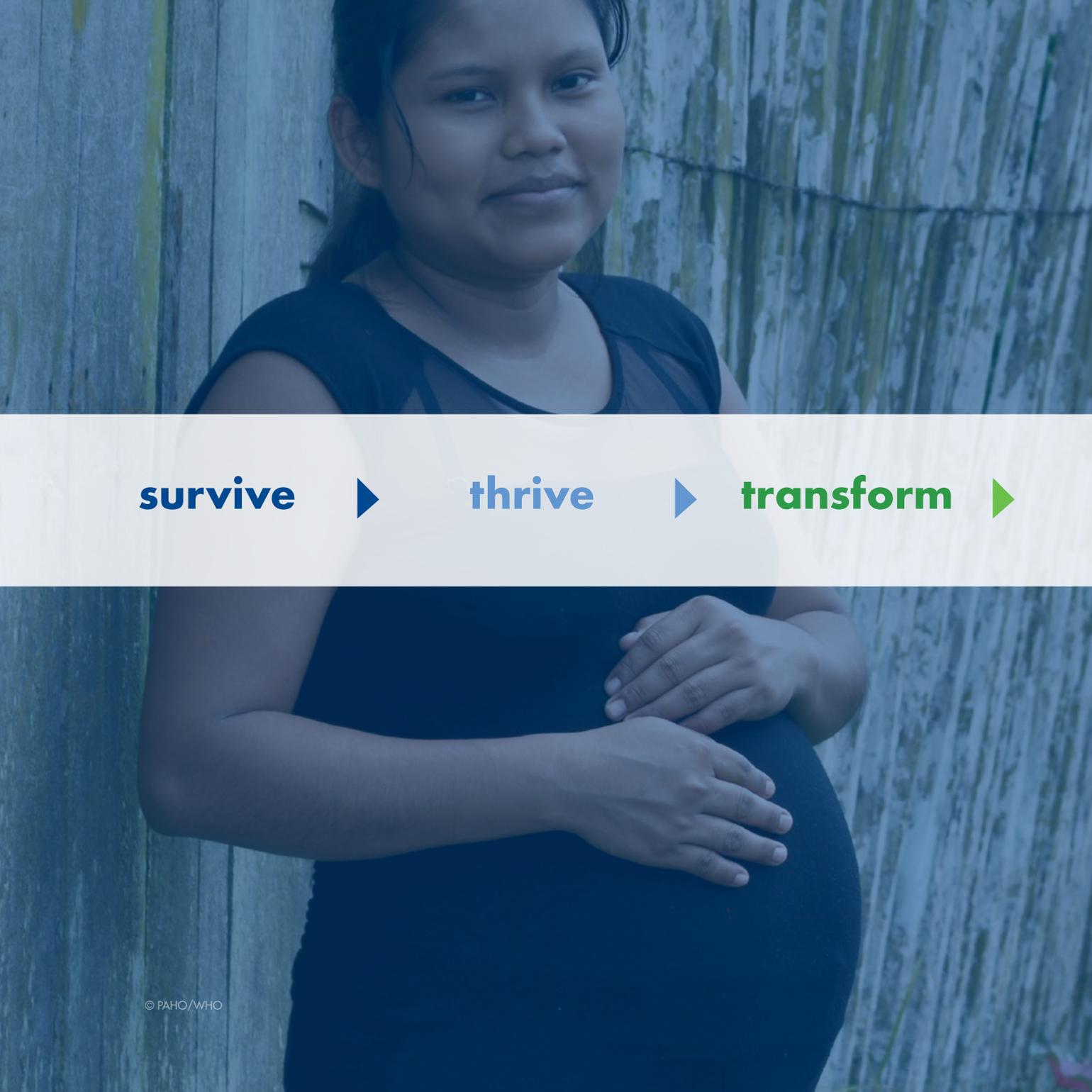
PLAN OF ACTION FOR **WOMEN'S, CHILDREN'S, AND ADOLESCENTS' HEALTH** 2018 – 2030



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas



survive



thrive



transform





PLAN OF ACTION FOR
**WOMEN'S, CHILDREN'S,
AND ADOLESCENTS' HEALTH**
2018 – 2030



PREFACE

Over the past years, our Region has made important progress toward improving the health of women, children, and adolescents. Neonatal, child, and maternal mortality have declined. However, the advancements have not benefitted all population groups equally: major variances exist between and within countries. Consistently, women and children 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. Adolescent mortality, mainly due to preventable causes, has remained stagnant or has increased, and adolescent pregnancy remains unacceptably high.

Further progress to improve the health of all women, children, and adolescents in the Americas was made in September 2018, when Member States of the Pan American Health Organization (PAHO) adopted The Plan of Action for Women's, Children's and Adolescents' Health 2018-2030.

The Plan of Action was developed with the goal of protecting the gains achieved so far and closing the remaining gaps toward ensuring healthy lives and promoting well-being for all women, children, and adolescents in the Americas. While previous regional mandates and work related to the health of women, children, and adolescents were captured in separate plans and resolutions, this Plan proposes an integrated life-course approach to address the common challenges and barriers, to build health and well-being over time and across generations. The Plan aligns with the Sustainable Development Goals, the Global Strategy for Women's, Children's and Adolescents' Health, the Sustainable Health Agenda for the Americas 2018-2030 and resonates with the Declaration of Astana 2018.

The Plan of Action proposes four lines of action, specifying essential actions to be taken at country and regional levels to strengthen a transformative policy environment to reduce health inequities; promote universal, effective and equitable health and well-being in families, schools, and communities throughout the life course; expand equitable access to comprehensive, integrated and quality health services that respond to the differentiated needs of the various groups of women, children and adolescents; and strengthen the generation and use of strategic information.

The Plan of Action recognizes and emphasizes health as a fundamental human right, and the pursuit of equity in health as a shared and urgent responsibility. It identifies gender equality, intercultural approaches, a life course approach, accountability, and transparency as key cross-cutting principles.

Effective implementation of this Plan will require strong leadership from health authorities, in partnership with other sectors, to facilitate the development and adoption of coherent, equity-based policies and regulations that will promote and protect the health and wellness of women, children and adolescents, in particular those in situations of vulnerability. It will require consistent application of evidence-based approaches and interventions, as well as the identification of innovative and creative strategies to improve efficiency and impact, and engage communities, including young people, in policy and program development, implementation, and monitoring.

It is our hope that, by implementing this Plan, the countries of the Americas will accelerate progress toward realizing the right to health for all women, children, and adolescents in our Region, leaving no one behind. I am convinced that collectively we can meet this challenge.

Carissa F. Etienne
Director

Pan American Health Organization/World Health Organization (PAHO/WHO)



*During 2010-2015,
adolescent girls
15-19-years still had
the second highest
fertility rate in the
world and the lowest
rate of decline globally.*







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INTRODUCTION

1. In May 2016, Member States of the World Health Organization (WHO) adopted Resolution WHA69.2 (1), inviting Member States to commit to implementation of the Global Strategy for Women’s, Children’s, and Adolescents’ Health (2). 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 the Santiago Commitment to Action, endorsed at a high-level meeting in Santiago, Chile, in July 2017 (3). This pledge calls for implementation of the Global Strategy along with innovative and more effective efforts to reduce health inequities, increasing access to health care and services, and ensuring that every woman, child, and adolescent in the Americas not only survives but thrives in a transformative environment in which they can realize their right to enjoy the highest attainable standard health. The Global Strategy calls for the realization of physical and mental health and well-being for every woman, child and adolescent, with universal access to health care and services, including sexual and reproductive health and rights; social and economic opportunities; and full participation 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 (4) and the 2030 Sustainable Development Goals (SDGs) (5), 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) (6) which aligns with the Global Strategy.

2. Mindful that realization of this vision and attainment of the specific goals and targets call for concerted action by the health sector and the wider sphere of public authority, as well as necessary action related to the social determinants of health, PAHO is proposing an integrated Plan of Action for Women’s, Children’s and Adolescents’ Health 2018–2030. Implementation of this plan will contribute toward 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 and intersectoral 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 in the framework of rights, gender, life course, and cultural diversity, 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 well-being, reducing health inequities, increasing access to integrated health care and services, 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 uneven. Advancements have not benefited some subgroups within national populations. Significant differences in health status persist between and within countries, and certain population groups—indigenous, Afro-descendant, less-educated, poor, and rural groups, as well as some populations of women, children, and adolescents—consistently suffer higher burdens of preventable mortality and morbidity (7). 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) (8–11).



10x



In the countries with the highest neonatal mortality rates, values are up to 10 times higher than in the countries with the lowest values.

SITUATION ANALYSIS

Survive

6. 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 (12). Complications of prematurity, birth defects, birth asphyxia and trauma, and sepsis account for more than 40% of neonatal deaths. Inequalities in neonatal mortality should be underscored, with major variations persisting between and within countries (ranging from 1.5 deaths per 1,000 live births in Cayman Islands to 31.0 in Haiti) (13). In 2008, neonatal mortality rates in the countries of the Region ranged from 2.9 to 28.5 per 1,000 live births. This difference, which represents an estimated range of 25.6, has not been substantially reduced. In the countries with the highest neonatal mortality rates, values are up to 10 times higher than in the countries with the lowest values. The proportional contribution of neonatal mortality to under-5 mortality has increased due to the significant drop in the post-neonatal and 1–4 years component. 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 (14). The declines were uneven between countries: some countries made more progress than others. Pollution exposures that have a disproportionate health impact on children are also of concern, including air pollution, hazardous chemicals, climate change, and inadequate water, sanitation, and hygiene (15). More efforts are needed to systematically promote healthy environments and prevent exposure to harmful chemicals such as lead and air pollutants during pregnancy and in early life, with possible impacts on healthy life expectancy.

7. Adolescent mortality rates in LAC remained stagnant between 2008 and 2015. Homicide, suicide, and road traffic injuries are the leading causes of death, with disproportionately higher mortality in adolescent males compared with adolescent females. 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. In the 15–19-year-olds, interpersonal violence and road traffic injuries were the leading causes of DALYs lost in males, while skin diseases and depressive disorders were the leading causes in 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 years old (16, 17).
8. 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 (18). 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 (19, 20).
9. Only 23 countries reported maternal mortality ratios (MMRs) during the period 2010–2015, which illustrates the persisting challenges associated with monitoring of maternal mortality and maternal health. These 23 countries saw an 11% reduction overall in maternal mortality, from 63.8 per 100,000 in 2010 to 56.6 per 100,000 in 2015 (21). While progress has been made, the Region did not reach the MDG target of reducing the maternal mortality by three quarters between 1990 and 2015. This challenge remains for the SDGs. Hypertension and hemorrhage continued to be the leading causes of maternal death. The third-ranking cause of maternal death, those linked to abortion, saw a reduction from 9% in 2010 to 7% in 2015 (21).

10. 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 (13, 21).





The prevalence of stunting greatly varies between countries, ranging from 1.8% to 48% in 2015.

Thrive

11. 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, thereby better enabling individuals to thrive by adopting the following Global Strategy Objectives: end all forms of malnutrition by addressing nutritional needs; ensure universal access to sexual and reproductive health-care services and rights;¹ ensure that all girls and boys have access to resources to promote good-quality early childhood development; substantially reduce pollution-related deaths and illnesses; and achieve universal health coverage.

12. According to the available data, children and adolescents in the Region face a triple burden of malnutrition: undernutrition, micronutrient deficiencies, and overweight/obesity. The prevalence of stunting decreased from 18.4% in 2000 to 11.3% in 2015, with major differences 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% (12). 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 overweight or obese. 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 (16). Available data shows variation between countries in current alcohol use among adolescents aged 13–15 years. The countries with the highest percentages of current alcohol use are Dominica (54%), Saint Lucia (54%), Jamaica (52%), Saint Vincent and the Grenadines (51%), and Argentina (50%). The use of other psychoactive substances such as marijuana, inhalants, and cocaine among adolescents in the Region remains relatively low. Lifetime marijuana use in adolescents aged 13–15 years ranged from 3% in Bolivia to 16% in Anguilla, and lifetime use of cocaine in the secondary school population ranged from 0.6% in Venezuela to 6.0% in Chile, with most countries in the 1–3% range (16).

¹ In no case should abortion be promoted as a method of family planning. Report of the International Conference on Population and Development [1994]. Available at: <http://www.un.org/popin/icpd/conference/offeng/poa.htm>



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- 13 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. In LAC, there was 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 in 2010–2015, but the 15–19-year age group still had the second highest fertility rate in the world and the lowest rate of decline globally (16). 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. Data regarding fertility in girls younger than 15 years is limited. However, it is estimated that about 2% of women in LAC initiate reproduction before age 15 years (16). LAC is also the only region in the world with a rising trend in the estimated number of pregnancies among girls under 15 (16). Furthermore, adolescents continue to face legal, societal, policy and health system-related barriers that deny them access to confidential and quality sexual and reproductive health services and commodities which may prevent them from enjoying a healthy and satisfying youth and a productive and prosperous future. Adolescents should receive information, counseling and services for comprehensive sexual and reproductive health including contraception as well as the risks associated with early pregnancy, particularly as a result of early or forced marriage (2).²

² In the United States, Sexual Risk Avoidance (SRA) education is an option to delay sexual initiation (22). Colombia has successfully extended sexual and reproductive health services and sexual education for youth in more than 536 cities, which contributed to the reduction in adolescent pregnancy in the country (23).

In 2010, maternal mortality ratios in rural areas were 4 times higher than in urban areas.



14. Increasingly, governments in the Region are recognizing the economic, ethical, and social benefits of investing early in life. Along with the emphasis on reducing preventable infant mortality, a shift is already taking place to a human development perspective. Nineteen countries already have policies or strategies that address early childhood development.³ However, this momentum needs to be expanded to all countries and to those subgroups that are most in need. The health sector has an important role to play in ensuring access to health services to help children have opportunities to thrive. Greater efforts are needed to reinforce multisectoral approaches and early interventions with an active role from the health sector, ensuring that health services become sources of information, support to parents, and linkages with other social resources. Children and adolescents aged 5–14 years have historically been underserved in child and adolescent health programs (14, 16). 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 health.
15. Beyond an approach that focuses on adolescent mortality, morbidity, and risk factors, adolescent health approaches aim to nurture affirmative developmental assets such as empowerment of women and girls, strong relationships within the family, connectedness, resilience, social, emotional, and cognitive competence, progressive self-determination, spirituality, and self-efficacy,

³ 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 (14).

all of which contribute to life projects and personal development. The Region made substantial investments in comprehensive adolescent health approaches through such programs as *Familias Fuertes: Amor y Limites* [Strengthening Families: Love and Limits], *Aventuras Inesperadas* [Unexpected Adventures], and *Escuelas de Fútbol 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 (16). The school also continues to be an important platform for reaching children and adolescents with health information, programs, and services.

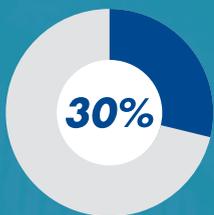
16. Women's health is often confined to reproductive health. While critical, this focus is not sufficient to improve the health and well-being of women throughout the life course. This Plan of Action therefore proposes a vision for integrated and preventive health care and services that transcends fragmented approaches. 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 (20). Women represent a growing proportion of older adults and face increasing levels of chronic noncommunicable diseases, including different kinds of cancers, among them those associated with ageing. Therefore, countries need to invest in strategies that address these conditions and foster healthy habits and practices at younger ages. The Plan of Action will contribute to an improved response to the health needs of women throughout the life course.



It is estimated that about 2% of women in LAC initiate reproduction before age 15 years.

17. There are significant differences within and between countries in the health of certain population groups, such as indigenous peoples, Afro-descendants, less educated groups, those living in rural areas, those with disabilities, migrants, lesbian, gay, bisexual and transgender (LGBT) persons, and other groups. Research is needed to determine how and why these groups experience differential morbidity and mortality compared with other groups, and targeted, multisector efforts are needed to understand their specific health and well-being needs, and to implement strategies that respond to their needs.





***of women in
the Americas have
experienced physical
and/or sexual violence
by a partner.***

Transform

18. 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 and discrimination and all forms of violence against women and girls, universal access to safe and affordable drinking water, sanitation and hygiene, support for and dissemination of scientific research, empowerment of women and girls, and innovation.
19. Analyses of the social determinants of health have made it clear that the conditions in which women, children, and adolescents are born, grow up, develop, 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 maternal mortality, lower 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 (16). Conversely, countries in the Region in the lowest quintile for mean years of schooling have significantly higher overall homicide rates and higher adolescent homicide rates than all the other quintiles combined (16). 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 (16). 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).

20. Many forms of violence disproportionately affect women of all ages across the life course, including intimate partner violence; sexual and gender-based violence; child, early, and forced marriage; human trafficking; femicide; and sexual harassment, abuse, and exploitation in schools, workplaces, and public places. Violence, especially sexual and gender-based violence by an intimate partner, is the most common form of violence experienced by women and remains one of the greatest barriers to the achievement of gender equality, with far-reaching impacts on adolescent girls, impeding their education and increasing their risks of early marriage, early pregnancy, and contracting HIV and other sexually transmitted infections. 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 nonpartner. An estimated 58% of children in the LAC region, or 99 million, experience physical, sexual, or emotional abuse (19, 25). The Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (26) aims to draw attention to and catalyze action around the issue of violence against women and adolescent girls 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 years age group in the region were among males (16).



COMMON BARRIERS AND CHALLENGES WITHIN A NEW PARADIGM

21. 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 care and services for all.** 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 (7). The life course perspective promotes an approach to comprehensive health care and services that is different from the traditional way of providing care. The life course causality model requires that health systems move beyond structures that function on the basis of vertical programs which respond to episodic demands for care and instead become proactive systems that contribute to the ongoing building of health and well-being 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, educational settings, 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 (27). 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. Limited opportunities for systematic and consistent participation 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 in LAC constrain the understanding of the survival and well-being of women, children, and adolescents. Available datasets, including data on morbidity and mortality, are often limited to national averages and not disaggregated by cause, age, ethnicity, and place of residence, and therefore do not show 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 measurement of health as an outcome remains limited.

e. Lack of a multisectoral approach to address the determinants of health.

Many factors influencing the health and well-being 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, key actors' willingness to participate 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, academia, research institutions, 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 greater equity, while considering health as an essential right and resource for the generation of intrinsic capacities and functional reserves of people throughout their life course. 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

22. 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.

23. The following values and principles, outlined in greater detail in Annex A, guide the Plan of Action:
 - a. Health equity
 - b. Community participation
 - c. Evidence-based and multisectoral action
 - d. Human rights, gender equality, and interculturality
 - e. The life course approach
 - f. Innovation and research
 - g. Accountability, transparency and financial sustainability



STRATEGIC LINES OF ACTION

24. 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 intended to guide national and subnational actions.
 - a. Strengthen a transformative policy environment to reduce health inequities among women, children, and adolescents.
 - b. Promote universal, effective, and equitable health and well-being for all women, children, and adolescents in their families, schools, and communities throughout the life course.
 - c. Expand equitable access to comprehensive, integrated, quality health services for women, children, adolescents, and families, that are people-, family-, and community-centered.
 - d. Strengthen information systems for the collection, availability, accessibility, quality, and dissemination of strategic information, including health data and statistics on the health of women, children and adolescents, within the framework of the principles proposed in this Plan.

25. 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 with a multisectoral approach. It aligns with and builds upon existing regional commitments and actions, including PAHO's work on health equity and the social determinants of health; the PAHO Gender Equality Policy, approved in 2005 (Resolution CD46.R16) (28); the Plan of Action on Health in all Policies, approved in 2014 through Resolution CD53.R2 (29); the Strategy for Universal Access to Health and Universal Health Coverage (4), approved in 2014 through Resolution CD53.R14; PAHO's Policy on Ethnicity and Health, approved in 2017 through Resolution CSP29.R3 (30); PAHO's Action Plan on Mental Health, approved through Resolution CD53.R8 (31); the PAHO Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (26), approved in 2015 through Resolution CD54.R12; the Plan of Action for the Prevention and Control of Noncommunicable Diseases in the Americas 2013–2019, approved through Resolution CD52.R9 (32); the Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections

2016–2021, approved through Resolution CD55.R5 (33); the Plan of Action for the Strengthening of Vital Statistics 2017–2022, approved through Resolution CSP29.R4 (34); the Plan of Action on Immunization for the period 2016–2020, approved through Resolution CD54.R8 (35); and the Strategy on Human Resources for Universal Access to Health and Universal Health Coverage 2018-2023, approved through Resolution CSP29.R15 (36).

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, 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:

Goal	Indicator	Baseline 2018 ⁴	Target 2026 ⁵	Target 2030
1. Reduction of maternal mortality ratio (MMR)	Regional MMR	TBD	TBD	< 30 per 100,000 live births ⁶
	Number of countries and territories with MMR <30 per 100,000 ⁷ live births (disaggregated by age, place of residence, ethnicity, and cause)	5	10	15
	Number of countries and territories that have reduced MMR by at least 30% (disaggregated by age, place of residence, ethnicity, and cause)	TBD	TBD	TBD

(continued)

4 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.

5 The 2026 targets will be aligned with the targets in the new PAHO Strategic Plan.

6 SHAA2030 target.

7 SHAA2030 target.

Goal	Indicator	Baseline 2018 ⁴	Target 2026 ⁵	Target 2030	
2. Reduction of neonatal mortality rate	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 ⁸ (disaggregated by place of residence, and ethnicity, as applicable in each country)	6	13	18	
	Number of countries and territories that have reduced neonatal mortality rate by at least 10% in all population groups (disaggregated by age, place of residence, ethnicity, and cause)	0	TBD	TBD	
	Number of countries and territories in which low birth weight babies (proportion of newborns weighing less than 2,500 grams) has decreased at least 10%	0	8	12	
3. Reduction of under-5 mortality rate	Regional under-5 mortality rate	15.9 (2016)	15.2	< 14 per 1,000 live births ⁹	
	Number of countries and territories with under-5 mortality rate < 16 per 1,000 live births in all population groups (disaggregated by age (<1 and <5), place of residence, and ethnicity, as applicable in each country)	6	13	18	
4. Reduction of mortality rate due to homicides in males and females aged 10–19 (disaggregated by 10–14 and 15–19)	Regional homicide rate in males and females aged 10–19 years (disaggregated by 10–14 and 15–19)	Males 10–14 years	TBD	TBD	Reduced by one-third ⁷
		Females 10–14 years	TBD	TBD	Reduced by one-third
		Males 15–19 years	TBD	TBD	Reduced by one-third
		Females 15–19 years	TBD	TBD	Reduce by one-third

(continued)

8 Ibid.

9 Ibid.

IMPACT TARGETS (continued)

Goal	Indicator		Baseline 2018 ⁴	Target 2026 ⁵	Target 2030
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 (disaggregated by place of residence and ethnicity)		0	5	10
6. Reduction of the age-specific fertility rate in girls 10–14 ¹¹ years and 15–19 years old	a) Regional age-specific fertility rate in girls and adolescents 10–14 years and 15–19 years	10–14 years	NA ¹²	5% Reduction	10% Reduction
		66.5 (2010-2015) ¹³	5% Reduction	10% Reduction	
	b) Number of countries and territories that measure age-specific fertility rate in girls 10–14 years and 15–19 years (disaggregated by place or residence, ethnicity, and education level)		0	5	10
	c) Number of countries and territories that have reduced by 10% the age-specific fertility rate in girls 10–14 years and 15–19 years in the lowest-performing groups ¹⁴		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) ¹⁵	TBD	At least one year added

10 SDG target.

11 Some countries will apply other age groups, in accordance with national context.

12 Data not currently available, but pregnancy in girls 10-14 years has been included as an SDG target, which will enhance efforts

13 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>

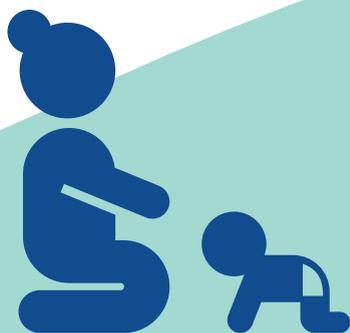
14 In this context, lowest-performing means high fertility rates.

15 PAHO calculation based on data from 37 countries and territories.

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 and most effectively addressed at multiple levels, including the level of policy. To effectively and systematically address 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 well-being 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 inequities 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.



19 countries already have policies or strategies that address early childhood development.

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 analyze and transform health inequities affecting women, children, and adolescents	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
	1.1.2 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
1.2 Increase the participation of relevant stakeholders, including women, adolescents, families, civil society, and communities, in policy-making processes and policy monitoring aimed at achieving health equity for women, children, and adolescents	1.2.1 Number of countries and territories with specific mechanisms through which women and adolescents can engage in public policy development, monitoring, and evaluation	12	20	30	40



There are significant differences within and between countries in the health of certain population groups, such as indigenous peoples, Afro-descendants, less-educated groups, those living in rural areas, those with disabilities migrants, LGBT persons, and other groups.

29. Structural, genuine, and free participation of women, children, adolescents, families, groups in situations of vulnerability, and communities is essential for better results. Therefore, it will be crucial 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 important in order 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 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 (37) 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 the development, implementation, monitoring, and evaluation of public policy.
 - c. Monitoring progress and publication of periodic regional reports on reductions in health inequity 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 as appropriate, civil society and the private sector.
 - c. Implementing, in each country, a conceptual framework for health in all policies and a roadmap to guide multisectoral action to address the determinants of the health of women, children, and adolescents.

Strategic Line of Action 2:

Promote universal, effective, and equitable health and well-being for all 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 families, 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 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 health problems 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, lesbian, gay, bisexual, and transgender (LGBT) persons, those deprived of their liberty, and other populations in situations of vulnerability, to assess and reduce health inequities affecting marginalized groups. 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
2.1 Improve mental, physical, sexual and reproductive health and well-being of women, children, and adolescents in families	2.1.1 Percentage of infants under 6 months of age who are exclusively breastfed ¹⁶	30.5%	50%	60%	70%
	2.1.2 Number of countries and territories that are implementing parenting programs ¹⁷ for parents of children and adolescents, with specific targets for vulnerable groups (according to region, residency, and age subgroup: <1 year, 1-5 years, 6-10 years, >10 years)	14	20	25	30
	2.1.3 Prevalence of the use of modern contraceptive methods for women of reproductive age, by age groups	TBD	TBD	TBD	TBD

(continued)

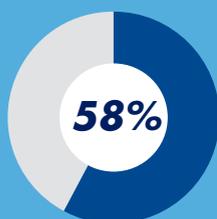
¹⁶ WHO and the Global Breastfeeding Collective proposed a 2030 target of 70%.

¹⁷ Other terms include, among others: programs for parents, parental skills programs, or programs aimed at mothers and fathers.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
2.2 Improve mental, physical, sexual and reproductive health and well-being of women, children, and adolescents in families in communities	2.2.1 Percentage of children under 5 years who are developmentally on track in health, learning, and psychosocial well-being ¹⁸	TBD	TBD	TBD	TBD
	2.2.2 Number of countries and territories with at least one national-level program with specific targets for the health and empowerment of women, children, and adolescents	TBD	10	20	25
	2.2.3 Number of countries and territories with recent data (five years or less) on the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care	3	5	7	10

(continued)

18 SDG indicator. The standardized definition and methodology are being defined and are expected to be available in 2019



of children in the LAC region, or 99 million, experience physical, sexual, or emotional abuse.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
2.3 Enhance the use of the school platform for the promotion of mental and physical, sexual and reproductive health and well-being of children and adolescents, including comprehensive sexuality education (2) ¹⁹	2.3.1 Number of countries and territories implementing a national comprehensive school health program ²⁰ that reaches at least 50% of public schools on pre-primary, primary, and secondary levels.	2	10	20	25
2.4 Strengthen the health sector capacity for effective inter-sectoral and inter-institutional articulation including with civil society	2.4.1 Number of countries and territories with specific mechanisms by which civil society and the private sector, as appropriate, can participate in the development, monitoring and evaluation of health programs for women and/or children and/or adolescents	TBD	20	30	40

19 UN definition Comprehensive Sexuality Education: a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationship; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives. United Nations Education Scientific and Cultural Organization. International technical guidance on sexuality education: An evidence-informed approach. Available at: <http://unesdoc.unesco.org/images/0026/002607/260770e.pdf>

20 A comprehensive school health program has four elements: 1) equitable school health policies; 2) healthy and safe learning environments; 3) skills-based health education, including age-appropriate sexuality education; and 4) school-based health services, including age-appropriate SRF, mental health and physical health care. World Health Organization; United Nations Education Scientific and Cultural Organization; United Nations Children's Fund; and the World Bank. Focusing Resources on Effective School Health: a FRESH Start to Enhancing the Quality and Equity of Education. Available at: <https://www.unicef.org/lifeskills/files/FreshDocument.pdf>

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, adolescents, and families.
 - 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!) (38) and the Nurturing Care Framework (39).
 - d. Providing evidence-based guidance and capacity-building on early childhood (0–8 years)²¹ development, and health and development of children aged 6–9 years and adolescents (subgroups 10–14 years and 15–19 years).
 - 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.

²¹ Age range for early childhood as defined in the UN Convention on the Rights of the Child (2005). This range may vary depending on specific country context.

36. Key country-level activities will include:
- a. Reviewing and revising national and subnational programs and approaches toward 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.
 - 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 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 to comprehensive, integrated, quality health services for women, children, and adolescents that are people-, family-, and community-centered

37. In 2009, the PAHO Member States adopted a regional policy for developing integrated health services delivery networks (IHSDNs) based on primary health care (PHC) to respond to the major challenges posed by the fragmentation of health care and services, and contribute to the delivery of more accessible, equitable, efficient, and higher quality health care. 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) expand equitable access to comprehensive, quality, people- and community-centered health services; b) strengthen stewardship and governance; c) increase and improve financing, with equity and efficiency, and advance toward the elimination of direct payment that constitutes a barrier to access at the point of service; and d) strengthen 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 health and development of children, adolescents, and women, including early childhood development, age-appropriate adolescent health and development, and health of women beyond their reproductive functions.
 - c. Supporting articulation and application of a life-course perspective on health care and 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 well-being 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 universal access to health and universal health coverage.

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
3.1 Progressively promote universal and equitable access for women, children, and adolescents to quality and comprehensive health services	3.1.1 Percentage of women and adolescents of reproductive age who have their need for family planning satisfied with modern and quality contraceptive 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, ethnicity, place of residence, and income level)	9	12	17	25
	3.1.3 Number of countries and territories that include caring for victims of sexual exploitation and trafficking of persons in their technical standards	TBD	TBD	TBD	TBD
	3.1.4	TBD	TBD	TBD	TBD
	a) Number of countries and territories that measure percentage of pregnant women who received antenatal care four or more times				
	b) Number of countries and territories that measure percentage of pregnant women who received antenatal care four or more times, disaggregated by age, ethnicity, and place of residence	0	5	10	15
c) Number of countries and territories that measure percentage of pregnant women who received antenatal care four or more times, disaggregated by age, ethnicity, and place of residence, and achieve an increase of 20% of the percentage of women in the lowest quintiles with four or more visits	0	3	6	10	

(continued)

Objective	Indicator	Baseline 2018	Target 2022	Target 2026	Target 2030
	3.1.5 a) Number of countries and territories that measure births attended at health facilities (disaggregated by age, ethnicity, and place of residence of the mother)	0	3	6	10
	b) Number of countries and territories that measure the percentage of births attended at health facilities, disaggregated by age, ethnicity, and place of residence of the mother, and that have increased by 20% in the lowest performing quintiles or those with the least economic resources	0	5	10	15
	3.1.6 Number of countries and territories that have increased their composite coverage index ²² for maternal and child health	TBD	TBD	TBD	TBD
	3.1.7 Number of countries and territories that have introduced HPV in their immunization schedule	31	35	40	45
	3.1.8 Number of countries that have policies in place to promote that women have informed, voluntary, non-coercive access to the family planning method of their choice	TBD	TBD	TBD	TBD
	3.2 Improve the quality of health care and services for women, children and adolescents	3.2.1 Number of countries and territories implementing regular maternal and perinatal death reviews and audits	8	15	25
3.2.2 Number of countries and territories implementing national standards for quality health care and services for adolescents		11	20	30	40

(continued)

22 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
	3.2.3 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
	3.2.3 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
	3.2.4 Number of countries and territories with national data regarding the use of oxytocic drugs 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 preconception, prenatal, delivery, and postnatal health care and services.
 - b. Supporting integration of a life course perspective into the design and delivery of health care and 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 care and services for women, children, and adolescents.
 - d. Supporting the development and implementation of comprehensive adolescent-responsive health care and services, including 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 preconception, prenatal, delivery, and postnatal health care, including post-obstetric-event contraceptives.
 - c. Conducting regular assessments and ongoing monitoring of barriers to access to health care and services for women, children, and adolescents with the highest burden of preventable mortality and morbidity.
 - d. Reorganizing health care and services for women, children, and adolescents to include more proactive, continuous, and life course-based approaches.
 - e. Expanding access to a broad range of informed and voluntary modern family planning methods that meet the needs of all women and adolescents, including fertility awareness methods and long-acting reversible contraception (LARC).
 - f. Implementing standards for age-appropriate adolescent health care and services and mechanisms for ongoing monitoring of the quality and coverage of access to integrated and preventive health care for adolescents.
 - g. Promoting and implementing vaccination programs against HPV and programs to screen women for cervical cancer and treat pre-cancerous cells designed to empower them to attain the highest level of physical and mental health.

Strategic Line of Action 4:

Strengthen information systems for the collection, availability, accessibility, quality, and dissemination of strategic information, including health data and statistics on the health of women, children, and adolescents, within the framework of the principles proposed in this Plan

42. Accelerating the reduction of preventable mortality and morbidity in women, children and adolescents will require increased understanding of their circumstances, 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
4.1 Strengthen the capacity of health information systems to increase the availability of data on preventable mortality of women, children and adolescents	4.1.1 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
	4.1.2 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
	4.1.3 Number of countries and territories that conduct periodic analysis of the distribution and circumstances of leading preventable causes of mortality in women, children, and adolescents	1	10	15	20
4.2 Build capacity of information systems for ongoing health inequity monitoring	4.2.1 Number of countries and territories that have established mechanisms for ongoing monitoring of health inequities, including sexual and reproductive health, 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 and improve information systems on the health of women, children and adolescents disaggregated by age, 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 WHO near-miss approach and the Maternal and Perinatal Death Surveillance and Response guidelines (40, 41) 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, ethnicity, place of residence, and income level.
 - c. Implementing standardized approaches and methodologies towards the analysis of adolescent deaths due to homicide, suicide, and road 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 DIRECTING COUNCIL

48. The Directing Council 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.



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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 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, gender equality, and interculturality.* The basic rights and freedoms to which all human beings are entitled include the right to enjoyment of the highest attainable standard of health. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human rights, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. These rights are universal, indivisible, interdependent and interrelated. 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. Intercultural approaches acknowledge the differences among ethnic groups between and within countries as well as the differences in their challenges and needs. These approaches promote intercultural health models that include the perspective of the ancestral and spiritual wisdom and practices of the members of the various ethnic groups and support the implementation of intercultural approaches to health systems and services.

- 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 research.* 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, transparency, and financial sustainability.* 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. Achieving financial sustainability for women's, children's and adolescents' health will require a combination of increased government spending in line with GDP growth, incentivizing private sector investments in health, mobilization of external support, making better use of existing resources and improving efficiency, and adopting integrated and innovative approaches to financing.



56th DIRECTING COUNCIL

70th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 23 – 27 September 2018

CD56/8, Rev. 1
Original: English

RESOLUTION

CD56.R8

PLAN OF ACTION FOR
**WOMEN'S, CHILDREN'S,
AND ADOLESCENTS' HEALTH**
2018 – 2030

THE 56th DIRECTING COUNCIL,

Having reviewed the *Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030* (Document CD56/8, Rev. 1);

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);

Acknowledging the slow and unequal progress and the need to accelerate progress and reduce health inequities affecting the health and well-being of women, children, and adolescents through integrated and multisectoral approaches that address the underlying determinants;

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 of solidarity, equity in health, universality, and social inclusion adopted by PAHO Member States in the Sustainable Health Agenda for the Americas 2018-2030;

Recognizing that the achievement of Goal 3 of the 2030 Agenda for Sustainable Development and its 13 targets, together with many other health-related goals and targets in the 2030 Agenda, will require the adoption of intersectoral measures for the health of women, children, and adolescents;

Considering the importance of having a new action plan that is aligned with the Sustainable Health Agenda for the Americas 2018-2030,

RESOLVES:

1. To approve the *Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030* (Document CD56/8, Rev. 1) within the context of the specific conditions of each country.
2. To urge the Member States to:
 - a) strengthen a transformative policy environment to reduce health inequities among women, children, and adolescents;
 - b) promote universal, effective, and equitable health and well-being for all women, children, and adolescents in their families, schools, and communities throughout the life course;
 - c) expand equitable access to comprehensive, integrated, quality health services for women, children, adolescents, and families that are people-, family-, and community-centered;
 - d) strengthen information systems for the collection, availability, accessibility, quality, and dissemination of strategic information, including health data and statistics on the health of women, children, and adolescents, within the framework of the principles proposed in this Plan;
 - e) invest in mechanisms to empower people, families, and communities to actively engage in the protection and promotion of the health of women, children, and adolescents, particularly those in situations of vulnerability.
3. To request the Director to:
 - a) provide technical cooperation to Member States for the development of updated national action plans and to disseminate tools that facilitate integrated, equity-based, and innovative approaches to 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.

(Eighth meeting, 26 September 2018)



**Pan American
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