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MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMS

This third progress report of the Director reviews the changes that have been taking place in the principal demographic variables and how they will evolve in the future, as well as the repercussions they will have on the health of the population. The report identifies adolescents, the marginal urban population, and the scattered rural population as the most neglected groups, in which a concentration of such problems as undernutrition, low levels of education, poor socioeconomic conditions, and decreasing access to health services have a negative impact on health and create sizable differences with respect to other population groups. The progress achieved under the maternal and child health and family planning programs is examined, along with the strategies that have been implemented by mandate of the Governing Bodies to improve the programs, coverage, and quality of care. It is concluded that the matter of quality of care should be addressed on a priority basis during the coming decade.

As a result of the UN-sponsored World Summit for Children and adoption of the organization's strategic orientations and program priorities for the quadrennium 1991-1994 by the Governing Bodies, as well as the plans of action in the area of maternal and child health care and family planning, there is now political agreement at the highest level, as well as a commitment to undertake action. This, added to the knowledge and technology that are available and the awareness and commitment on the part of society in general, will make it possible to accelerate efforts to focus on problems and attain the targets that have been agreed on, thus confirming the will to work toward a better life for future generations.

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MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMS

I. BACKGROUND

Pursuant to paragraph 2.C of Resolution XIII of the XXXI Meeting of the PAHO Directing Council (1988), the Executive Committee is hereby presented with the third progress report on implementation of the Pan American Health Organization's action policy with respect to population matters, adopted by the XXX Meeting of the Directing Council in Resolution VIII (1984). This report also covers progress under related mandates contained in resolutions CD31.R18 (1985), CSP23.R2 and CSP23.R17 (1990).

The report reviews achievements in maternal and child health and family planning at a time of profound crisis, and it emphasizes existing or emerging problems with a view to securing mandates and commitments to joint action that will make it possible to comply with agreements and attain the targets (Annexes I and II) that have been set by the Governing Bodies and recently endorsed by representatives of 159 countries at the UN-sponsored World Summit for Children, which brought together, from the Americas alone, 19 heads of state.

II. MAJOR EVENTS AND TRENDS, 1980-2000

1. The Crisis

The 1990s are posing special challenges for the countries of the Hemisphere as a result of the major sociopolitical and economic changes they are experiencing at the national and international level. These events have had a marked impact on the social, educational, and health sectors, which are generally the first to feel the effects of a crisis. In tandem with the state of chronic economic deterioration there is persistent political and social instability, which in turn is a reflection in part of that same deterioration.

In the late 1980s there was still a marked spread in the demographic indicators for the various countries in the Region, for different geographical areas, and for the socioeconomic strata within each country (1, 2, 3). These differences were exacerbated in some of the countries by the deterioration of their economies during the last decade and by the adjustment policies implemented in response to the economic crisis. These policies have not been equitable: as is usually the case, those who were hit the hardest were the most vulnerable sectors of the population, namely, women and children (1, 2).

Latin America and the Caribbean has been the second most seriously affected region. In the last decade the gross domestic product has not kept up with population growth. When the gross domestic product is prorated for the entire population, the resources available in

1990 were 10% less than in 1980, showing a decline in 18 of 24 countries studied (1, 2). The outlook for 1989-2000 is for a possible 2.3% per capita growth in the gross domestic product (Tables 1 and 2). The external debt continues to be an obstacle to development and economic growth; net transfers of resources were on the order of one-fifth of export income (1, 3, 4).

2. Distribution, Growth and Structure of the Population

The most important demographic phenomenon of the 1990s will be the urbanization of the Latin American population. In the absence of national policies on internal migration, the cities have become targets of mass, largely unplanned, migratory influxes from rural areas. As a result, the poverty belts around the major cities in the developing countries will be growing twice as fast as the cities themselves. For example, in estimates made around 1987, the proportion of urban population found living in shantytowns or slums (callampas, favelas, pueblos jóvenes, ciudades perdidas) was 60% in Bogotá and 42% in Mexico City. It is estimated that by the year 2000 more than 75% of the population will be living in urban areas.

In 1950 the Americas had a total population of 332 million. This figure had risen to 714 million by 1989 and is expected to reach 835 million by the year 2000, according to a United Nations estimate of average growth variance. This will mean a net increase of 121 million inhabitants between 1990 and the year 2000 (6).

During the 1980s, Latin America had the second highest natural growth rate in the world--2.2 % a year--a rate more than double that of the developed countries. This rate is already a decline relative to the 1960s, and it is expected to continue to fall, reaching 1.6% a year in 2000-2005 and 1.1% a year in 2020-2025. If these assumptions are correct, the population of Latin America can be expected to double again in approximately 44 years (3-6).

Life expectancy increased from an estimated 51.8 years in 1950-1955 to 66.6 years in 1985-1990. However, there are still significant differences between countries such as Bolivia and Haiti, with life expectancies of 53.1 and 54.7 respectively, and Costa Rica, Cuba, and Uruguay, with figures of 74.7, 75.2, and 72.0 (5-8). Although the Region's target is to achieve an average life expectancy of 70 by the year 2000, some of the countries will not be able to accomplish this (Table 3).

In terms of age structure of the population, in Latin America and the Caribbean the group aged 0-14 is expected to increase from 161 million in 1990 to 176 million by the year 2000. There is an aging trend: the average age will increase from 20.9 in 1985 to 24.1 years by the year 2000 (Figure 1). The population aged 15-24 will increase from 88 to 101 million between 1990 and 2000. The population over 60 will continue to increase gradually; between 1990 and the year 2000 it will show a net increase of 10 million (3, 4, 6).

TABLE 1
Gross Domestic Product
Outlook for the 1990s

Groups and Regions	Real GDP Growth			Real GDP Growth per Capita		
	Trend, 1965-80	Recent Experience, 1980-89	Projection, 1989-2000	Trend, 1965-80	Recent Experience, 1980-89	Projection, 1989-2000
INDUSTRIALIZED COUNTRIES	3.7	3	3	2.8	2.5	2.6
DEVELOPING COUNTRIES	5.9	4.3	5.1	3.4	2.3	3.2
Africa south of the Sahara	5.2	1	3.7	2	-2.2	0.5
East Asia	7.3	8.4	6.6	4.8	6.7	5.1
China	6.4	10.1	6.8	4.1	8.7	5.4
Others	8.1	6.4	6.3	5.5	4.2	4.6
Southern Asia	3.6	5.5	5.1	1.2	3.2	3.2
India	3.6	5.6	5.2	1.2	3.5	3.4
Others	3.9	5	4.8	1.2	2.2	2.4
Eastern Europe	5.3 *	1.4 *	1.9	4.5 *	0.8 *	1.5
Middle East, North Africa, and other European countries	6.3	2.9	4.3	3.9	0.8	2.1
Latin America and the Caribbean	6	1.6	4.2	3.4	-0.6	2.3

Source: World Bank, World Development Report, 1990, Table 1.3, p. 17.

TABLE 2
LATIN AMERICA AND THE CARIBBEAN: GROWTH OF PER CAPITA GROSS DOMESTIC PRODUCT

	Annual Growth Rates								Cumulative Change 1981-1990 ^a
	1983	1984	1985	1986	1987	1988	1989	1990 ^a	
Latin America and the Caribbean ^b	-4.8	1.2	1.2	1.5	0.9	-1.2	-0.6	-2.6	-9.6
Petroleum-exporting countries	-6.0	0.4	-0.1	-2.2	0.2	-0.1	-2.0	0.2	-9.4
Bolivia	-6.9	-3.1	-3.4	-4.9	0.1	0.5	0.2	0.2	-23.3
Colombia	-0.2	1.7	1.7	4.8	3.5	1.7	1.4	1.7	16.2
Ecuador	-3.9	2.0	2.1	0.7	-11.6	12.5	-2.8	-1.0	-4.6
Mexico	-6.5	1.2	0.2	-5.9	-0.6	-0.9	0.8	0.4	-8.4
Peru	-14.3	2.1	-0.3	6.0	5.3	-10.3	-13.1	-7.3	-30.2
Trinidad y Tobago	17.7	-3.1	-3.1	-3.7	-8.1	-5.3	-2.9	-1.0	-13.8
Venezuela	-8.1	-4.2	-2.8	4.0	2.3	3.3	-9.5	1.9	-19.9
Non-petroleum-exporting countries ^b	-3.9	1.9	2.3	4.4	1.5	-2.0	0.5	-4.6	-9.8
South America	-4.1	2.3	2.8	4.9	1.5	-1.9	0.5	-4.8	-9.1
Argentina	1.2	1.0	-5.7	4.6	0.8	-4.1	-5.7	-3.2	-24.3
Brazil	-5.6	2.8	6.1	5.2	1.5	-2.1	1.5	-5.9	-5.5
Chile	-4.1	3.9	0.4	3.7	3.2	5.8	7.5	0.2	9.2
Guyana	-10.8	1.4	0.4	0.0	0.6	-2.9	-5.1	-1.7	-27.9
Paraguay	-6.0	0.0	0.9	-3.3	1.4	3.6	2.9	0.1	0.4
Uruguay	-6.6	-1.9	-0.4	7.2	5.8	-0.4	0.7	-0.2	-6.7
Central America and the Caribbean ^b	-1.2	-1.3	-2.6	-0.2	1.7	-2.8	0.6	-2.2	-13.0
Barbados	0.4	3.2	0.6	5.1	2.8	3.0	4.1	-3.0	8.0
Cuba ^c	3.9	6.2	3.5	0.2	-4.8	1.4	0.0	0.4	31.6
Haiti	-1.2	-1.5	-1.5	-1.0	-2.2	-2.2	-1.6	-4.0	-22.3
Jamaica	0.2	-2.4	-6.8	0.9	5.4	-0.1	5.1	0.8	1.9
Panama	-2.2	-2.6	2.6	1.3	-0.1	-17.7	-2.7	-1.2	-18.3
Dominican Republic	2.5	-2.0	-4.1	0.8	5.3	-1.1	2.4	-5.8	-2.2
Central American Common Market	-2.6	-0.7	-2.7	-1.0	0.4	-0.8	0.0	-1.0	-17.2
Costa Rica	-0.3	4.8	-2.1	2.4	1.7	0.6	2.8	1.0	-5.0
El Salvador	-0.3	1.3	0.5	-1.2	0.8	-0.5	-1.1	0.6	-15.3
Guatemala	-5.4	-2.8	-3.3	-2.6	0.7	1.0	0.9	0.1	-18.0
Honduras	-3.6	-1.2	-1.5	1.3	1.2	1.7	-0.8	-3.8	-14.2
Nicaragua	1.2	-4.8	-7.3	-4.3	-4.0	-13.9	-6.1	-8.8	-40.8

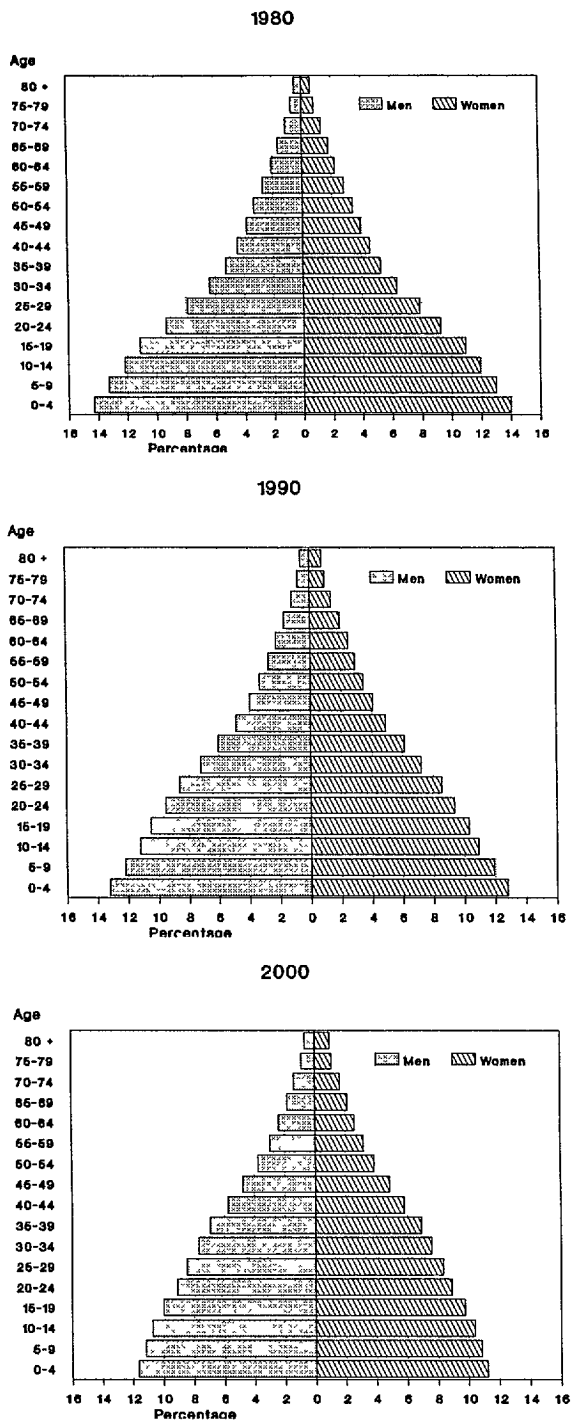
Source: ECLA, based on official figures. The population figures come from unpublished estimates by the Latin American Demographic Center.
^a Preliminary estimates, subject to revision. ^b Does not include Cuba. ^c Refers to the concept of a global social product.

TABLE 3
THE AMERICAS: LIFE EXPECTANCY AT BIRTH
BY SUBREGION AND COUNTRY, 1950-2000

SUBREGIONS AND COUNTRIES	Life expectancy (e(o))			5-year increase		e(o)	Population in 1990	
	1950-55	1970-75	1985-90	1950-55 a 1970-75	1970-75 a 1985-90	Year 2000	millions	percentage
LATIN AMERICA	51.8	61.2	66.6	2.4	1.8	69.7	438.0	100.0
BOLIVIA	40.4	46.7	53.1	1.6	2.1	60.5	7.3	
HAITI	37.6	48.5	54.7	2.7	2.1	59.4	6.5	
Total							13.8	3.2
PERU	43.9	55.5	61.4	2.9	2.0	67.9	22.3	
GUATEMALA	42.1	54.0	62.0	3.0	2.7	68.1	9.2	
EL SALVADOR	45.3	58.8	62.2	3.4	1.1	68.8	5.3	
NICARAGUA	42.3	54.7	63.3	3.1	2.9	69.3	3.9	
HONDURAS	42.3	54.0	64.0	2.9	3.3	68.2	5.1	
Total							45.8	10.5
BRAZIL	51.0	59.8	64.9	2.2	1.7	68.0	150.4	
ECUADOR	48.4	58.9	65.4	2.6	2.2	68.2	10.6	
DOMINICAN REP	46.0	59.9	65.9	3.5	2.0	69.7	7.2	
PARAGUAY	62.6	65.6	66.9	0.7	0.4	67.9	4.3	
COLOMBIA	50.6	61.6	68.2	2.8	2.2	70.7	33.0	
MEXICO	50.8	62.6	68.9	3.0	2.1	72.1	88.6	
VENEZUELA	55.2	66.2	69.7	2.8	1.1	71.3	19.7	
Total							313.8	71.6
ARGENTINA	62.7	67.3	70.6	1.1	1.1	72.3	32.3	
CHILE	53.8	63.6	71.5	2.5	2.6	72.7	13.2	
URUGUAY	66.3	68.8	72.0	0.6	1.1	73.0	3.1	
PANAMA	55.3	66.3	72.1	2.8	1.9	73.5	2.4	
Total							51.0	11.6
COSTA RICA	57.3	68.1	74.7	2.7	2.2	75.8	3.0	
CUBA	59.5	71.0	75.2	2.9	1.4	76.3	10.6	
Total							13.6	3.1
ENGLISH-SPEAKING CARIBBEAN	56.4	67.1	72.4	2.7	1.8	74.7	6.2	100.0
SURINAME	56.0	64.9	69.5	2.2	1.5	72.6	0.4	
GUYANA	55.2	64.1	69.7	2.2	1.9	72.8	1.0	
TRINIDAD AND TOBAGO	57.9	66.5	70.2	2.2	1.2	73.1	1.3	
Total							2.7	44.1
GUADELOUPE	56.5	67.8	73.3	2.8	1.8	75.7	0.3	
BARBADOS	57.2	69.4	73.9	3.1	1.5	76.2	0.3	
JAMAICA	57.2	67.8	74.0	2.6	2.1	76.2	2.3	
MARTINIQUE	56.5	68.8	74.2	3.1	1.8	76.4	0.3	
Total							3.5	55.9
NORTH AMERICA	69.1	72.2	76.1	0.8	1.3	78.1	275.7	
UNITED STATES	69.0	71.5	75.4	0.6	1.4	77.6	249.2	
CANADA	69.1	73.1	76.7	1.0	1.2	78.5	26.5	

Source: CELADE (1990) and United Nations (1989)

FIGURE 1
LATIN AMERICA AND THE CARIBBEAN
POPULATION BY 5-YEAR AGE GROUPS,
1980-1990-2000



Source: Boletín Demográfico 20(40), Santiago (Chile),
CELADE, July 1987.

Adolescents play a significant role in these demographic changes. In Latin America and the Caribbean alone, the number of adolescents has doubled in the last 30 years. The impact that this population group will have on economic and social development during the coming decade is clear (3, 6).

These figures are important in light of some of the special situations that affect adolescents. For example, the number of teen-age mothers has increased markedly over the last 25 years--both in absolute figures and in percentage of births--because of the fact that there are more adolescent women and also because older women are having fewer children (7, 9).

Teen-age pregnancy is important because of its effects on adolescent mothers and their children. Among the most significant of these effects are: the high rate of induced abortions, many of them septic; the increased percentage of such complications as anemia, eclampsia, and urinary infection; the high percentage of premature or low-birthweight babies; and the fact that, in Latin America and the Caribbean, women who have their first child during adolescence end up having an average of two to three more babies than women who begin to have children after adolescence (7, 8, 9, 11).

In addition to the foregoing consequences, pregnant teen-agers have lower levels of education, they are more isolated from their peers, and they are associated with higher poverty indexes than teen-age girls who are not pregnant (9). Added to all this, teen-age fertility rates are higher in countries where the indexes of socioeconomic development are lower and in countries that have inadequate family planning programs or none at all. Such correlations show how important it is for these programs to meet the needs and demands of the population.

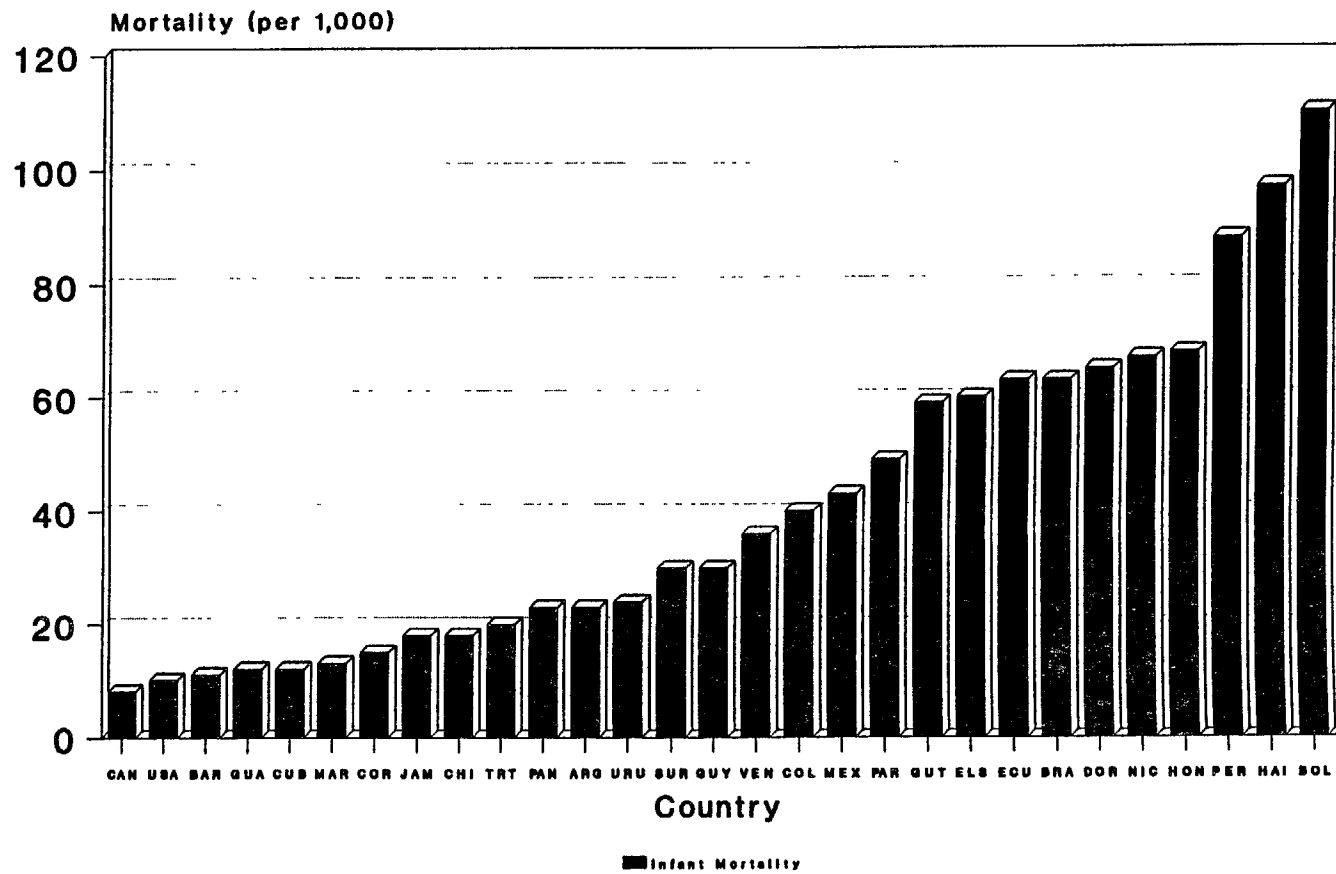
It is impossible to ignore the high prevalence of accidents, use and abuse of tobacco, drugs, and alcohol, suicide, personality disorders, and in general risk behavior that require a comprehensive response by society, especially by the educational and health systems (6, 8, 9, 10).

3. Infant Mortality

Infant mortality continues to be a valuable and sensitive indicator of changes in the living conditions of the population. The continued high rates of infant mortality are a problem that has yet to be resolved in a number of countries in the Region (Figure 2), including some of the more developed ones. This is especially true when the indicator is broken down by subregion and social groups (1, 3, 4, 7, 10).

Infant mortality has declined in all the countries of the Hemisphere. In Latin America, for example, the averages for 1970-1975, 1980-1985, and 1985-1990 were 127, 82, and 55 per 1,000, respectively (7, 10). These figures, however, are still six times higher than the levels in the United States, Canada, Cuba, and Costa Rica, and 2.6 times higher than the figures for the Caribbean. This situation is significant, because it is estimated that 75% of all births in the Americas occur in

FIGURE 2
INFANT MORTALITY IN THE COUNTRIES OF THE
AMERICAS. 1985-1990



Source: CELADE (1989) and U.N. (1989)

Latin America (8, 10). Despite marked declines observed in Bolivia, Haiti, and Peru, the rates in these three countries are still in excess of 80 per 1,000 (Table 4). An important cause of the decline in the post-neonatal component (Table 5) is the reduction of diseases preventable by immunization and diarrheal and respiratory diseases.

The proportional decrease in the last-mentioned areas has made perinatal causes the leading factor in infant mortality in 21 countries of the Region. Mortality occurring during the first month of life is the most difficult to reduce and is associated with biological factors, delivery care, and prenatal care. Special strategies are needed in order to decrease infant mortality from perinatal and neonatal causes. Among these strategies, the highest priority is accorded to improving the nutritional status of the mother; increasing the space between births; improving the quality and accessibility of prenatal monitoring services, delivery and newborn care; and fertility regulation--in the last instance, using a risk-based approach that will make unwanted pregnancy the top priority among the factors to be prevented, since it substantially increases the risk of induced abortion and death (7, 10).

The geographical differences in infant mortality continue to indicate that rural areas, where the rates are higher, are at a significant disadvantage (10). There also tends to be more underreporting in these areas. For this reason it is recommended that indirect estimates be used. Such measurements have revealed, for example, that in Bolivia, Haiti, and Peru, excess rural mortality ranges between 38 and 47 points (Table 6). Studies in Central America have shown that between 41% and 71% of the births occurred in rural areas, and that they were responsible for 50% to 77% of the deaths in children under 1 year of age (10).

There is also excess mortality in the marginal urban areas compared with the metropolitan area as a whole. And, as in the rural areas, there are socioeconomic differences, especially in terms of occupation of the head of household, women's work, housing conditions, and educational level of the parents, especially the mother. Such a situation clearly calls for priority attention to neglected groups if progress is to be made in reducing differences, improving quality of life, and furthering national development (7, 10).

With regard to children, an important social and health consideration that cannot be disregarded is the growing bane of "street kids," who are estimated to number several million in the countries of Latin America and the Caribbean, particularly Argentina, Brazil, Colombia, the Dominican Republic, Mexico, and Peru (7).

These children, as both the victims and the perpetrators of violence, pose a special challenge for health and social welfare services, from which they are cut off for all extents and purposes. Homeless and without any family or social support, these children frequently suffer from a wide range of problems, including poor health, abuse, drug addiction, delinquency, alcoholism, malnutrition, prostitution, sexually transmitted diseases, and induced abortion (7, 9).

TABLE 4
THE AMERICAS: INFANT MORTALITY, 1950-55, 1970-75, 1985-90 AND PROJECTED
RATES FOR THE YEAR 2000. BIRTHS IN 1985-1990, BY SUBREGIONS AND
COUNTRIES, LISTED IN RANKED ORDER OF MORTALITY

COUNTRIES	Mortality (per 1,000)			5-year decrease		Rate Year 2000	Births 1985-90	
	1950-55	1970-75	1985-90	1950-70	1970-85		(Thousands)	Percentage
LATIN AMERICA	127	82	55	11.2	8.9	41	11,993	100.0
BOLIVIA	176	151	110	6.1	13.8	69	293	
HAITI	220	133	97	21.2	12.8	72	213	
PERU	139	110	88	12	7	63	636	
Total							1,142	9.5
HONDURAS	196	101	68	23.8	10.7	49	189	
NICARAGUA	167	100	67	16.8	11.0	42	149	
DOMINICAN REP	149	94	65	14.0	9.5	46	213	
Total							551	4.6
BRAZIL	135	91	63	11.1	9.1	48	4,086	
ECUADOR	140	95	63	11.1	10.5	49	328	
GUATEMALA	141	95	59	11.4	12.1	37	350	
EL SALVADOR	151	99	60	13.0	13.0	36	182	
Total							4,946	41.3
PARAGUAY	73	35	49	4.7	2.0	44	159	
MEXICO	114	71	43	10.7	9.4	28	2,438	
COLOMBIA	123	73	40	12.5	11.1	33	861	
VENEZUELA	106	49	36	14.4	4.2	30	569	
Total							4,007	33.4
URUGUAY	57	46	24	2.8	7.3	16	54	
PANAMA	93	43	23	12.6	6.7	19	61	
ARGENTINA	66	49	23	4	9	17	669	
CHILE	126	70	18	14	17	15	301	
COSTA RICA	94	33	15	10	13	11	80	
CUBA	81	38	12	11	9	10	181	
Total							1,346	11.2
ENGLISH-SPEAKING CARIBBEAN	83	40	21	10.8	6.3	15	140	100.0
GUYANA	93	36	30	9.3	8.7	21	26	
SURINAME	89	49	30	10.0	6.3	21	11	
Total							37	26.4
TRINIDAD AND TOBAGO	79	30	20	12	3	14	30	
JAMAICA	85	36	18	12.3	6.0	14	63	
MARTINIQUE	63	35	13	7.5	7.3	10	6	
GUADELOUPE	68	42	12	6.5	10.0	8	7	
BARBADOS	61	33	11		-5.3	8	5	
Total							111	79.3
NORTH AMERICA	29	18	10	2.7	2.7	7	3,702	
UNITED STATES	28	18	10	2.5	2.7	7	3,340	
CANADA	36	16	8	5.0	2.7	7	362	

TABLE 5
 INFANT, NEONATAL, AND POSTNEONATAL MORTALITY IN
 SELECTED COUNTRIES OF THE AMERICAS.
 1970-1985

YEARS	Rates (per 1,000)					
	Guatemala	Chile	Costa Rica	Panama	Cuba	US
INFANT MORTALITY						
1970	111	83	68	49	39	20
1980	83	33	21	27	20	13
1985	71	20	15	26	16	11
5-year decrease:						
1970-80	14.0	25.0	23.6	11.5	9.6	3.7
1980-85	12.0	13.5	6.0	0.5	3.6	2.1
NEONATAL MORTALITY						
1970	39	32	28	25	24	15
1980	27	17	12	15	14	9
1985	24	10	8	16	10	7
5-year decrease:						
1970-80	6.0	7.5	8.0	5.4	5.2	3.3
1980-85	3.0	6.8	3.9	-1.5	3.3	1.7
POSTNEONATAL MORTALITY						
1970	72	51	40	24	15	5
1980	56	16	9	12	6	4
1985	47	10	7	10	6	4
5-year decrease:						
1970-80	8.0	17.1	15.9	6.1	4.5	0.4
1980-85	9.0	6.7	1.7	1.4	-0.1	0.4
Percentage decrease in mortality during 1970-80 due to:						
Neonatal mortality	43	30	34	47	54	89
Postneonatal mortality	57	68	67	53	47	11
Percentage distribution of infant deaths in 1985:						
Neonatal deaths	34	51	53	62	64	65
Postneonatal deaths	66	49	45	40	38	35

Source: National publications of vital statistics, corrected for Guatemala.

TABLE 6
INFANT MORTALITY, BY URBAN AND RURAL AREA, IN
SELECTED COUNTRIES OF LATIN AMERICA,
1970-1986

COUNTRY	Year	Rate (per 1,000)			Rural Excess
		Total	Urban	Rural	
BOLIVIA	1962	163	132	176	44
	1973	152	124	171	47
	1980	119	100	138	38
HAITI	1970	128	97	141	44
	1980	107	77	123	46
PERU	1961-70	113	95	171	76
	1976	114	74	158	84
	1981-86	76	54	101	47
HONDURAS	1960	135	122	135	13
	1970	115	92	119	27
	1980	75	65	85	20
NICARAGUA	1972-83	83	67	98	31
DOMINICAN REP.	1978	75	78	72	-6
	1986	68	69	66	-3
ECUADOR	1972-76	97	78	115	37
	1977-81	72	52	91	39
	1982-86	58	52	64	12
GUATEMALA	1971	100	89	119	30
	1977-87	99	65	84	19
EL SALVADOR	1971	110	91	118	27
	1981	81	72	110	38
MEXICO	1984	47	30	73	43
COLOMBIA	1971-75	62	57	70	13
	1976-80	47	46	50	4
	1981-86	33	33	34	1
URUGUAY	1975	47	41	51	10
PANAMA	1969-71	16	9	21	12
	1983-85	8	6	9	3
COSTA RICA	1970	68	5	78	73
	1981	20	17	22	5
CUBA	1973-75	29	26	31	5

4. Maternal Mortality

Another important health indicator is maternal mortality (Figure 3), which may be underreported by as much as 70%. Maternal mortality reflects not only the accessibility, coverage, and quality of the health services but also the level of social development, since it is an indicator that reveals the disparities between countries at different levels of development (12, 13). Maternal mortality has been declining steadily in all the countries of the Region. The subject was covered extensively by the Pan American Sanitary Conference in 1990, and the following facts are presented by way of summary.

It is estimated that around 28,000 pregnant women die annually in the Region of the Americas (13). Maternal mortality has two essential characteristics: the causes are preventable in a large percentage of cases using knowledge and technology that are currently available, and it tends to occur in the most unprotected social groups--i.e. those who live in marginal rural or suburban areas without access to adequate hospital care.

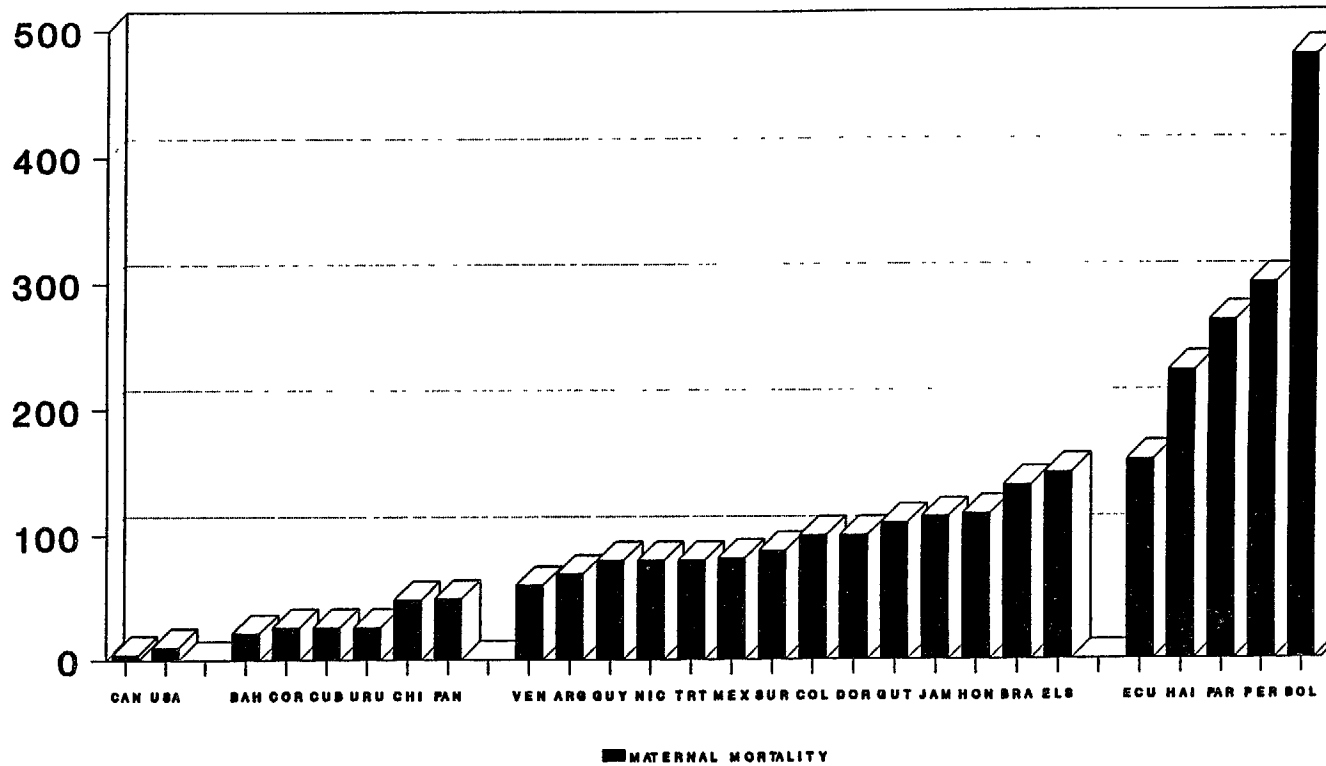
Much still remains to be done to improve the quality and coverage of services for prenatal and delivery care, as well as to provide better contraceptive coverage. An evaluation of conditions of efficiency in the maternal and child health care services in 15 countries of the Region, carried out during 1985-1989, showed that many outpatient and in-patient obstetrical care services were deficient; only 39% and 8% of these services, respectively, were judged to be acceptable (15).

With regard to induced abortion, it is estimated that around 5,000,000 abortions are performed annually in Latin America. Induced abortion, which is illegal in most of the countries of Latin America and the Caribbean, is among the leading causes of death in women between the ages of 15 and 49. Induced abortion thus assumes tragic proportions when one considers that in some countries it may be responsible for almost half of all maternal deaths (4, 12, 16, 17).

In addition to the physical and psychological consequences of abortion, there is the burden placed on the health services, which are frequently forced to deal with the ensuing complications. It is estimated that in Latin America between 10% and 30% of the hospital beds in the gynecological and obstetrical services are occupied by women suffering from consequences of this procedure, posing a heavy cost burden for hospital budgets that are already stretched thin (12, 13, 16, 17).

The foregoing description gives an idea of the problems yet to be dealt with by the countries, despite the progress so far, through their maternal and child health programs. It also serves as a basis for the programs carried out by the Maternal and Child Health Program of the Pan American Health Organization in fulfillment of the mandates of the Governing Bodies.

FIGURE 3
MATERNAL MORTALITY IN COUNTRIES OF THE
AMERICAS. CIRCA 1986 *



* Rate per 100,000 live births, based on the most recent information available.
 Source: TIS, PAHO/WHO

III. ANALYSIS OF THE STRATEGIES FOR ACTION APPROVED BY THE GOVERNING BODIES, 1984-1990

The Organization's work in population, health, and development, viewed in terms of the basic principles for action for the 1987-1990 period (18), Priority has been given to activities for the development and strengthening of local health services. For this purpose, national and international resources from the health and other sectors have been used. Priority continued to be accorded to the most unprotected groups: women, children, and adolescents, especially those living in marginal urban and scattered rural areas and those suffering from extreme poverty. Emphasis was placed on the dissemination of scientific and technical information about population, health, and development. As a strategy for maximizing the limited resources available, the risk approach was used in addressing the most urgent problems: early sexual initiation of and unprotected sexual activity; high adolescent fertility; priority care during pregnancy and delivery as well as care for high-risk newborns; care of premature and low-birthweight babies; and fertility regulation for women or couples who openly express a desire to avoid future pregnancies (12, 13, 18, 19).

The maternal and child health programs continue to contribute to and support the transformation and strengthening of local health services, paving the way for increased participation in intersectoral activities and social participation that will make it possible to improve the quality and coverage of care, thus encouraging equity, efficiency, and effectiveness in the activities that fall under their responsibility (20).

The following sections examine the advances that have been made in terms of the lines of action recommended. In addition, some activities that should continue to be executed are identified, and new activities are recommended for the future.

1. Formulation and implementation of population policies that are in alignment with social and economic development plans

The Constitutions of El Salvador (1983), Haiti (1983), and Panama (1983) contain language that explicitly expresses the need for population policies and sets forth the goals of such policies. The national constitutions of Brazil (1988), Ecuador (1979), Peru (1979), and Mexico (1974) establish the right of individuals and couples to make free and informed decisions about the number and spacing of their children (21).

At the present time, all countries of the Region directly or indirectly support the provision of family planning services, usually as part of their maternal and child health services (22). In addition, aspects of population, development, and health have been regularly included in the political and technical agendas of all the countries, and there has been participation from PAHO at the highest levels.

The Region was represented at the World Congress of Gynecology and Obstetrics (1988) and the Latin American Congress of Gynecology and Obstetrics (1990), which were convened by FIGO and FLASOG; at the International Forum on Population in the Twenty-first Century, held in Amsterdam (1989, UNFPA), with 12 countries from the Region taking part; at the Latin American Congress on Family Planning, held in Rio de Janeiro (1989); and at the Second Conference of Western Hemisphere Legislators on Population and Development, held in Quito, Ecuador (1990), with 27 countries from the Region participating. In addition, 22 general maternal and child health directors, plus representatives of UNICEF, PAHO, UNFPA, and the World Bank, took part in the First Meeting of Maternal and Child Health Directors of Latin America and the Caribbean, which was held in Quito, Ecuador (1989). Nineteen heads of state from the Americas were also present at the World Summit for Children (1990).

At all these events, family health issues were in the forefront, and it was reiterated that family planning services should be integrated into maternal health care services, that they should be of high quality and accessible to the entire population, and that special attention should be paid to the needs of adolescents. There was also a call to action, not just in terms of child survival but for a better quality of life for children, especially street children. Improvements were sought in women's health care services, as well as advancement of the status of women through increased opportunities in the areas of education, work, and health, the fundamental axes for ensuring that women participate in the development process. Another important area of discussion was environmental deterioration and pollution, especially in urban population centers, as well as the destruction of the tropical rain forests and protection of water sources, flora, and fauna.

A call went out for all the countries to ratify the United Nations Conventions on the Rights of the Child and the Elimination of All the Forms of Discrimination Against Women, and to review and update their population policies to ensure that they are rational, equitable, and consistent with national goals. It was recommended to strengthen and build up the groups of lawmakers interested in "Population and Development," which already exist in 14 countries of the Region.

The national and international movement focusing on population, health, and development has made it possible to do the following: first, to refine the proposals for action by the Region of the Americas; second, to have these adopted at the XXXIII Pan American Sanitary Conference in its Resolution CSP33.R2; and third, to participate in the United Nations World Summit for Children (1990), where heads of state from almost the entire world endorsed these goals and committed themselves to making the necessary effort to achieve them during the final decade of the twentieth century (Annexes I and II). The health sector needs to assume a position of leadership in order to ensure that these commitments are turned into reality at the national level as soon as possible and that programs aimed at fulfilling them are implemented.

With this background, it is felt that the political stage has been set and that there is sufficient commitment at the highest level, as well

as sufficient sensitivity and commitment on the part of society in general to focus on the problems and attain the targets that have been agreed on, thus confirming the will to work toward a better life for future generations.

Finally, it is important to promote active participation by the health sector in future international conferences: on the environment (Brazil, 1992); the International Year of the Family (1994); the International Conference on Population (1994); and the International Conference on Women (1995). These conferences will be extremely important and will make it possible not only to monitor progress but also to modify proposals by making any necessary adjustments to the programs during the last five years of the century.

2. Improvement of the quality and utilization of demographic data and statistics in the health services for the identification of population related health problems, the needs of the services, and the groups at greatest risk, with a view to upgrading health planning and programming by the local health systems (SILOS)

With the exception of five countries and territories (Anguilla, Bolivia, El Salvador, Honduras, and Nicaragua), all the countries in the Region conducted population censuses during the 1980s.

The health sector and the maternal and child health programs have been encouraged to use the population bases and estimates produced by the statistical offices from the latest censuses, since otherwise, as is always the case, these rates and indicators tend to fluctuate, making it difficult to document any trends or variations or to make comparisons at the national and international level. It will also be necessary to emphasize the necessity and importance of conducting censuses during the 1990s, since these will provide the foundation for economic and social development plans, including plans in the area of health, during the first decade of the twenty-first century.

When the Tenth Revision of the WHO International Classification of Diseases goes into effect in 1993, it is proposed to extend the registration of maternal deaths to include all maternal deaths occurring within a period of one year after delivery, with "delayed maternal deaths" being those deaths from direct and indirect obstetrical causes that occur after 42 days and up to one year after delivery. This will make it possible to continue to evaluate maternal mortality occurring within the 42 days after delivery, which is considered useful, since the data and trends will still be comparable. At the same time, the inclusion of deaths beyond 42 days after delivery will provide a broader view of the magnitude and causes of maternal mortality.

With regard to the demographic and health surveys that have been carried out with the collaboration of the Demographic and Health Surveys Program (DHS), as of this date information has been collected in 10 country reports have been completed.. The Organization participated both in the collection of data and in the seminars for disseminating the results, held in Bolivia, Colombia, Guatemala, and Paraguay. A joint publication is being developed by DHS, the United States Agency for International

Development (USAID), and the Pan American Health Organization, which will make it possible to disseminate the data more widely and to make better use of it. It is recommended that those countries that did not carry out surveys consider the possibility of doing so. The methodology and the computer software for analyzing the results are available at a reasonable cost. A secondary analysis of data from these surveys has begun under the sponsorship of the WHO Special Program of Research, Development, and Research Training in Human Reproduction (HRP) and the Population Council. The DHS project has entered its second phase, and during this period it is expected to canvass five countries of the Region beginning in 1991: Bolivia, Northeastern Brazil, the Dominican Republic, Guatemala, and Peru. A world conference to present technical and methodological findings and discussing their implications for population and health policy in developing countries is scheduled to take place in Washington, D.C., in August 1991.

Since it has not always been possible to maintain a useful data base on maternal, child, and adolescent health, in the last two years the Organization and the Maternal and Child Health Program have been investing in the development of an open computer system that will make it possible to do so. In order to keep this data base up to date, the Member Countries will have to report their official statistics to PAHO each year on a timely basis, since otherwise it will be necessary to use alternative sources.

The Perinatal Information System (SIP), developed by the Latin American Center for Perinatology and Human Development, continued to be implemented throughout the Region. The surveillance of perinatal health has been improved at the level of hospital units, and currently the system is being applied more extensively among the open population in four countries: Bolivia, Honduras, Nicaragua, and Peru. This was made possible through the inclusion of SIP in a perinatal health project sponsored by the Canadian International Development Agency (CIDA). The corresponding development of the information system on children has been completed, and the system is being tested.

During this period the United States Centers for Disease Control (CDC) continued to carry out surveys of adolescent health in the Region of the Americas. USAID, PAHO, UNFPA, and the Carnegie Corporation collaborated with CDC on a survey of adolescent reproductive health in Chile and on the development of funding proposals and instruments for surveys of the comprehensive health of adolescents and young adults, to be carried out in the Mexico-United States border area and in Venezuela. In addition, the government of Brazil, working in collaboration with UNFPA, PAHO, and BENFAM, conducted a national survey of adolescents which was used in the design of an adolescent health program.

The occasional lack of specific data should not be an obstacle to action. Despite the limitations imposed by problems with the timeliness, integrity, and quality of the data, the most important issue facing the Region is the need to develop the capacity to analyze and make use of the information available in order to improve programs and interventions in the area of population and maternal and child health. This issue is

being addressed through the special importance being given to direct technical cooperation for improving the management of programs in the countries.

3. Promotion of research and financial assistance to train the human resources needed in order to make maternal and child health care and family planning programs viable

A variety of research activities were carried out, financed (in decreasing order of the contribution) by the WHO Special Program of Research, Development, and Research Training in Human Reproduction (HRP), UNFPA extrabudgetary funds, and the Organization itself. The WHO Special Program of Research, Development, and Research Training in Human Reproduction collaborates with scientists and institutions in 14 countries of the Americas, awarding an annual average of 19 institutional grants. Most of the cooperation took place in Argentina, Brazil, Chile, Cuba, Mexico, Panama, and Peru, and to a lesser extent in Bolivia, Colombia, and Costa Rica, while development activities were initiated with Guatemala and Venezuela and the Caribbean in 1989-1991 (23).

Pursuant to the recommendations of a Scientific Technical Advisory Group convened in 1989, networking in the areas of inter-regional training and research networking was increased. In Cuba, a workshop was held in 1990 to decide on standardized methodologies for research on reproductive health and to set Regional priorities for research in this area. In April 1991, HRP convened a subcommittee meeting, held in Mexico, to explore research resources for the Americas. The country-directed orientation and the decentralization of activities in the Region is viewed as a positive development. The Region is adequately represented on policy committees, technical committees, and working groups.

In the area of human growth, development, and reproduction, special attention was paid to studies of maternal mortality and the health needs of adolescents, the safety and effectiveness of contraceptives, and abortion and its cost to the health services. Research on maternal mortality has borne out the importance of having a regional plan of action for the reduction of mortality in the Americas and it has already been presented to the Governing Bodies.

Activities continued in connection with the survey on the teaching of growth and development in Latin America being carried out in conjunction with the Latin American Pediatrics Association (ALAPE), and a maternal and child health model for local health systems was studied. The efficiency of more than 3,000 services in 22 countries has been evaluated. It is a matter for concern that, despite the availability of information on the failings of the services, few countries have taken corrective action.

The Latin American Center for Perinatology and Human Development continued to carry out a broad range of collaborative research through a network of institutions in several different countries. The lines of work include the epidemiology of cesarean section, fetal-natal risk, low birthweight, and postnatal growth and development.

In the area of diarrheal disease control (DDC), the project for vaccination against rotavirus in Peru continued, and support was provided for studies of risk factors, the management of diarrhea treatment, and community oral hydration units. Other important work included the quality control of oral rehydration fluid and the development of operations research models for the evaluation of training activities.

Under the Expanded Program on Immunization (EPI) research was carried out on missed opportunities vaccination and the cost thereof in Colombia, Ecuador, El Salvador, Mexico, and Venezuela. The use of vaccination certificates was evaluated in several countries, risk factors for neonatal tetanus were identified, and the idea of tetanus vaccination by traditional midwives was introduced in four countries. The investigation of paralytic cases has forced the countries to make improvements in other surveillance systems.

The Program for the Prevention and Treatment of Acute Respiratory Infections (ARI) used resources from PAHO/WHO to support four projects on etiologic agents: the application of antimicrobial agents, risk factors, the epidemiology of ARI, and the perceptions of mothers and health personnel regarding the seriousness of signs of disease. Steps were taken to establish DDC/ARI sentinel sites, which can be important for the development of programming models. These activities were carried out in Argentina, Bolivia, Brazil, Colombia, Ecuador, Mexico, and Venezuela.

Through the research project on maternal and child health being carried out in the United States-Mexico border area, a network of institutions was strengthened on both sides of the border. This made it possible to carry out studies on risks during adolescence, including an investigation of the parts-assembly industry in the border states of Mexico.

It is important to emphasize the coordination that was established with INOPAL II (Operations Research for Latin America), which the Population Council carried out in order to develop research protocols in those countries in which PAHO does not have specialized resources.

In summary, most of the research supported by the Maternal and Child Health Program helped to support scientific and technical policies that have been approved by the Governing Bodies and at the country level. This is true of the mandates on population, maternal mortality, adolescent health, and the Expanded Program on Immunization. In other cases it contributed substantially to the development of programs at the national level, to training at various levels, and to the improved delivery of services. In 1991 the Program will be addressing the need to review and adapt its lines of research, giving priority to operations research on problems that are preventing health activities from reaching the entire population.

With regard to human resources development, training activities were developed in all the Program's areas, with the participation of all the countries of the Region. Priority was given to the work done in conjunction with the chairs of pediatrics, gynecology and obstetrics, and public health at training schools for human resources in the health sciences. The courses included clinical aspects of public health and

program management. Responsibility for funding was shared by WHO, UNFPA, the W.K. Kellogg Foundation, the Carnegie Corporation, the Pew Charitable Trusts, USAID, and other agencies, and there were Regional, subregional, and country-level activities.

Training in the management of maternal and child health and family planning programs was provided to almost 100 professionals each year through Regional courses held in conjunction with the schools of public health in Medellín and Sao Paulo and nongovernmental institutions such as the Institute for Advanced Studies in Administration (IESA) and the Central American Institute of Public Administration (ICAP). A meeting was held at which it was agreed to include this important topic in the maternal and child health courses that the Organization supports in Brazil, Chile, Colombia, Costa Rica, and Cuba. When the participants return to their countries they will already have generated and refined a set of proposals for management training through national projects.

The programs for the prevention and treatment of diarrheal diseases and acute respiratory infections, in addition to their national training activities in management and supervision have begun to develop clinical training units in which both the operations personnel and the students who attend them are trained. Training of personnel from nongovernmental organizations was initiated in coordination with the NGOs, using materials developed by PAHO/WHO. This approach, which was considered successful in Colombia, Ecuador, Guatemala, and Peru, helps to ensure that the technical subject matter and standards of these institutions are in alignment, regardless of their affiliation.

The Latin American Center for Perinatology and Human Development continued to fulfill its teaching function on an intramural and extramural basis, offering courses in perinatology, research methodology, and maternal and child and perinatal public health.

The challenge for continued human resource development is the ever-increasing urgency of integrating technical components and the establishment of continuing education programs that are strengthened through in-service supervisory training activities. The fact that some countries lack programs for the development of human resources in maternal and child health and family planning, both for and within the health sector, seriously impairs the effectiveness of this activity.

4. Dissemination of information and advisory services to the community with a view to enlisting its participation

The Program continued to make progress in its defined task in the area of the social participation: consciousness-raising among different groups so that, within their spheres of activity, they will be more resolute about making a commitment and staying involved. Toward this end, the Program disseminated technical and scientific information aimed at all levels--political, legislative, ministerial, and technical--and reaching out to universities, Ministries of Health, Social Security institutions, and scientific associations for pediatrics, gynecology and obstetrics, public health, and nursing. PAHO consultants and documentation centers in the countries were kept up to date.

Pamphlets were developed on community participation in perinatology, growth and development, and family planning, along with manuals on oral rehydration for community health volunteers and promotional videotapes on the treatment of ARI and diarrheal diseases and the promotion of breast-feeding. Social communication and participation in support of national vaccination programs and special vaccination days paved the way for improved popular response to health interventions.

Of special interest is the promotional material on maternal and child health found in the book Facts for Life, developed jointly by WHO, UNICEF, and UNESCO, which contains basic technical messages and supporting information on each of the subjects it covers. Some countries have added messages about accidents and drugs. This material saves time and effort at the country level in the improvement of educational messages.

There was also research on models of community participation in perinatology, which is being carried out in areas of Bolivia, Honduras, Nicaragua, and Peru with technical cooperation from the Latin American Center for Perinatology and Human Development and the Canadian International Development Agency.

5. Integration of family planning services into maternal and child health services

The integration of maternal and child health and family planning services is already an accomplished fact in most countries of the Region. At the same time, however, activities aimed at providing comprehensive care of individuals continued to be promoted. This situation has become more evident with the emergence of new problems--inter alia, the rising rate of AIDS in mothers, children, and adolescents; the initiation of adolescent comprehensive health programs; and the need for more active male involvement in the reproduction process as well as in the care and raising of children. In addition, the introduction of new contraceptive methods and implementation of the strategies for the reduction of maternal mortality makes it mandatory to continue efforts to incorporate these new components into existing services. Thus they will progressively lay the groundwork for the provision of care that is more complete and has greater impact on the various population groups addressed by the Program. However, it is important to proceed with caution, since the efforts to integrate services must be financed by the various care components involved, and the addition of new functions to the Maternal and Child Health Program without a corresponding injection of new resources not only fails to strengthen but actually weakens programs already under way, undermines progress to date, and endangers the quality of services.

6. Education and training for the countries in sexual and family life issues, and establishment of integrated programs on adolescent health

The knowledge of and experience with adolescent health activities that was built up during the 1975-1985 period allowed the Organization to contribute more actively and extensively to the technical discussions at the 1989 World Health Assembly. During this period, a level of development was achieved which made it possible to establish a Regional program on the health of adolescents and young people, following the mandates given by the Directing Council in 1985 and 1988. This program, along with the comprehensive care that it provides for individual welfare, also incorporates the concept of youths not only as persons seeking services but also as participants in programs for their age group and as important community resources. Starting in the biennium 1990-1991, this program has its own budget and Regional human resources.

In 1989 a consultative meeting of national experts was convened to consider priorities, strategies, and plans for adolescent health. In that same year, work was done on the design of instruments to establish guidelines and criteria for the programming and evaluation of comprehensive adolescent health programs. At the subregional level, a second round of courses and meetings was held in the Andean area (1990); the Southern Cone (1991); and Central America and Mexico (1991).

From the beginning, the Organization's activities in support of the countries have been carried out with the help of nongovernmental organizations that work with this age group. Events were held in Ecuador and Uruguay in conjunction with the World Assembly of Youth (1990); a training seminar was developed for young people in the English-speaking Caribbean by the Association of Girl Scouts (1991); and there was participation in the international meeting on adolescence in coordination with the Center for Population Options. During 1990-1991, 17 meetings and congresses were held, and technical cooperation was provided for the formulation and running of programs in Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Guatemala, Honduras, and Venezuela, in addition to all those countries that have UNFPA projects and regard adolescents as a priority, especially the countries of the English-speaking Caribbean (Table 7).

7. Intensified coordination between the Organization and United Nations agencies, as well as governmental and nongovernmental organizations, with a view to enlisting maximum resources for maternal and child health and family planning programs

In order to fulfill the mandates and agreements on coordination and joint efforts, meetings between agencies were strengthened, and by 1991 this initiative had evolved into a series of joint multiagency meetings which identified common and complementary strategies in support of the countries. An example is the coordination meeting that led to the memorandum on PAHO/WHO, UNFPA, and UNICEF interagency collaboration to support execution of plans of action in this area (Annex III). Within the countries there was strengthening of the interinstitutional

TABLE 7

MAJOR MEETINGS ON ADOLESCENT HEALTH IN 1989-1990

Meeting on Adolescent Health: Bases for a Plan of Action. Washington, D.C., 9-13 January 1989.

Technical Discussions: "The Health of Youth." Geneva, 11-13 May 1989.

II National Workshop on Adolescent Health. Santiago, Chile, 17-19 July 1989.

III Brazilian Congress on Adolescence, and Post-Congress Discussions. Porto Alegre, Brazil, 25 August-1 September 1989.

Meeting of the Argentine Society for Adolescent Health. Buenos Aires, Argentina, 5-9 August 1989.

Technical assistance to the countries for the formulation and administration of comprehensive adolescent health programs as an ongoing activity. In Argentina, Brazil, Chile, Colombia, Venezuela, Ecuador, Bolivia, Costa Rica, Honduras, Guatemala (almost all the countries with and UNFPA program), 1988-1990.

International Conference on Adolescent Fertility in Latin America and the Caribbean. Oaxaca, Mexico, 6-10 November 1989.

Seminar on Adolescence. Atlanta, Georgia, 22 March 1990.

Meeting of Consultants on the Comprehensive Health of Adolescents. Washington, D.C., 26-28 March 1990.

Planning of Workshops on Adolescent Health for Teaching Multipliers in the Comprehensive Health of Adolescents. São Paulo, Brazil, 11-13 June 1990.

Interagency Meeting of Youth in Latin America. ECLA, Quito, Ecuador, 27 June 1990.

Workshop for the Training of Brazilian Educators. São Paulo, Brazil, 12-16 July 1990.

World Assembly of Youth, Workshop on the Formulation of Messages to Educate Youth Leaders. Quito, Ecuador, 6-10 August 1990.

Workshop for the Training of Brazilian Teachers. São Paulo, Brazil, 19 November-14 December 1990.

I Meeting on Nursing and Maternal and Child Health. Antigua, Guatemala, 11-15 February 1991.

Workshop Counseling Skills. Rio de Janeiro, Brazil, 4-8 March 1991, and Life-Plan Development in the Brazilian Adolescent and Young Population. São Paulo, Brazil, 11-15 March 1991.

Workshop on Adolescent Health, Montevideo, Uruguay (CLAP), 1-5 April 1991.

II Informal Interagency Meeting on Youth in Latin America. Santiago, Chile (ECLA), Santiago, Chile, 5 April 1991.

committees through which United Nations agencies (PAHO, UNICEF, UNFPA), as well as bilateral and nongovernmental cooperation agencies, identify the national program areas that they will support.

Three basic conditions are required in order for this mechanism to yield maximum benefit, although not all of them need always be present: a) a decision on the part of the government/health sector to coordinate the international cooperation being received from various sources; b) the existence of joint Regional plans of action previously agreed upon by the Governing Bodies in their strategies, objectives, goals, and activities that will make it possible to standardize messages and technical aspects; and c) the existence of national, state, and local plans of action that will enable the countries and agencies to work together to identify activities for which support is to be provided.

During the period, the coordination of interprogram activities within PAHO was strongest in the programs on Health of Adults; Women, Health, and Development; Health Services Development; Human Resource Development; Health Situation and Trend Assessment; Health Policies Development; and Nutrition. It is safe to say that the programming and execution of joint interprogram activities has become a reality. The work that the programs and countries of the Region have done with WHO has not only permitted a more substantial technical contribution but has also improved the coordination and programming of joint activities and facilitated major WHO inputs to our Region.

Participation by the United Nations agencies or bilateral or nongovernmental cooperation agencies that have decided to pool their efforts and resources on behalf of the countries in pursuit of common goals has opened the door to important contributions by UNFPA, UNICEF, USAID, IDB, CIDA, SIDA, BODA, the W.K. Kellogg Foundation, the Carnegie Corporation, the Pew Charitable Trusts, JHPIEGO, the Population Council, and Rotary International. This has increased the extrabudgetary resources that the Organization has had at its disposal for the countries throughout the Region. Resources doubled between 1988 and 1990, reaching a total of some US\$32 million dollars in the last year. Of all the amounts available to the countries, 84% were extrabudgetary funds and 16% were regular funds, and 90% of all funds were executed at the local level (20).

In terms of subregions, Central America saw continued collaboration with the Swedish Government, the European Economic Community, and the Italian Government; in the Caribbean, maternal and child health and family planning projects in the Caribbean received support from the Italian Government and the Carnegie Corporation. And in the Andean area and Southern Cone, the maternal and child health and family planning projects included initiatives for which donors are still being sought. Within the PAHO country budgets, funds were allocated for maternal and child health activities in 29 countries.

The foregoing situation needs to be thoroughly discussed, since the use of external resources for critical inputs such as vaccines, oral rehydration salts, or contraceptive devices makes the programs very

vulnerable and threatens their continuity and future growth. Joint participation by nongovernmental organizations and scientific associations in government programs for the improvement of maternal and child health should continue to be developed and promoted, since they are in the beginning stages and the potential for mobilization is very great.

8. Assistance in increasing national capacity for the design, execution, and evaluation of plans, programs, and projects for strengthening local health systems and increasing the coverage and quality of services

Technical cooperation activities have supported the process of designing national and local plans and programs and have helped to bring about a palpable improvement during the period. All the countries have plans of action for eradicating wild poliovirus and strengthening the Expanded Program on Immunization; 22 countries have drawn up programs for the reduction of maternal mortality, and all of them have family planning programs under way; 20 countries have formed national commissions or groups specialized in adolescent health; 20 countries are conducting ARI control activities in the health services based on the standards proposed by PAHO/WHO; and all the countries in the Region have operational programs or activities for the control of diarrheal diseases (12, 13, 19, 23, 24, 25).

The existence of specific targets increases commitment on the part of the countries and the Organization and also makes it possible to evaluate the strategies and processes used in order to attain them.

This situation is reflected in the following figures which, although they show some progress, also reflect the limitations that continue to exist, as well as the challenges that will need to be faced in the future.

There is still insufficient prenatal care coverage in Latin America and the Caribbean, since prenatal care in some form was only available for about 60% of an estimated 13 million births, with wide variations between the countries (12, 13, 20) (Figure 4). The coverage of institutional or professional delivery care is 72% (Figure 5), with 3.8 million births (28%) in the Region still being attended at home by family members or traditional midwives. These figures are especially significant in view of the fact that between 15% and 20% of the pregnancies are high-risk (12, 13, 20).

The best available figures on the prevalence of contraception indicate that 60% of women between 15 and 49 years of age are covered in those countries that have the information, representing 79% of the population of Latin America and the Caribbean (Figure 6). This means that the demand for contraceptives in about 20% of the women of reproductive age remains unmet, that many contraceptive users do not have access to their method of choice, and that, on average, an estimated 10% to 15% still use traditional methods. The health sector accounted for about 50% of the users, followed by prescriptions in pharmacies and nongovernmental programs (26).

FIGURE 4
Coverage of Prenatal Care
in Countries of the Americas

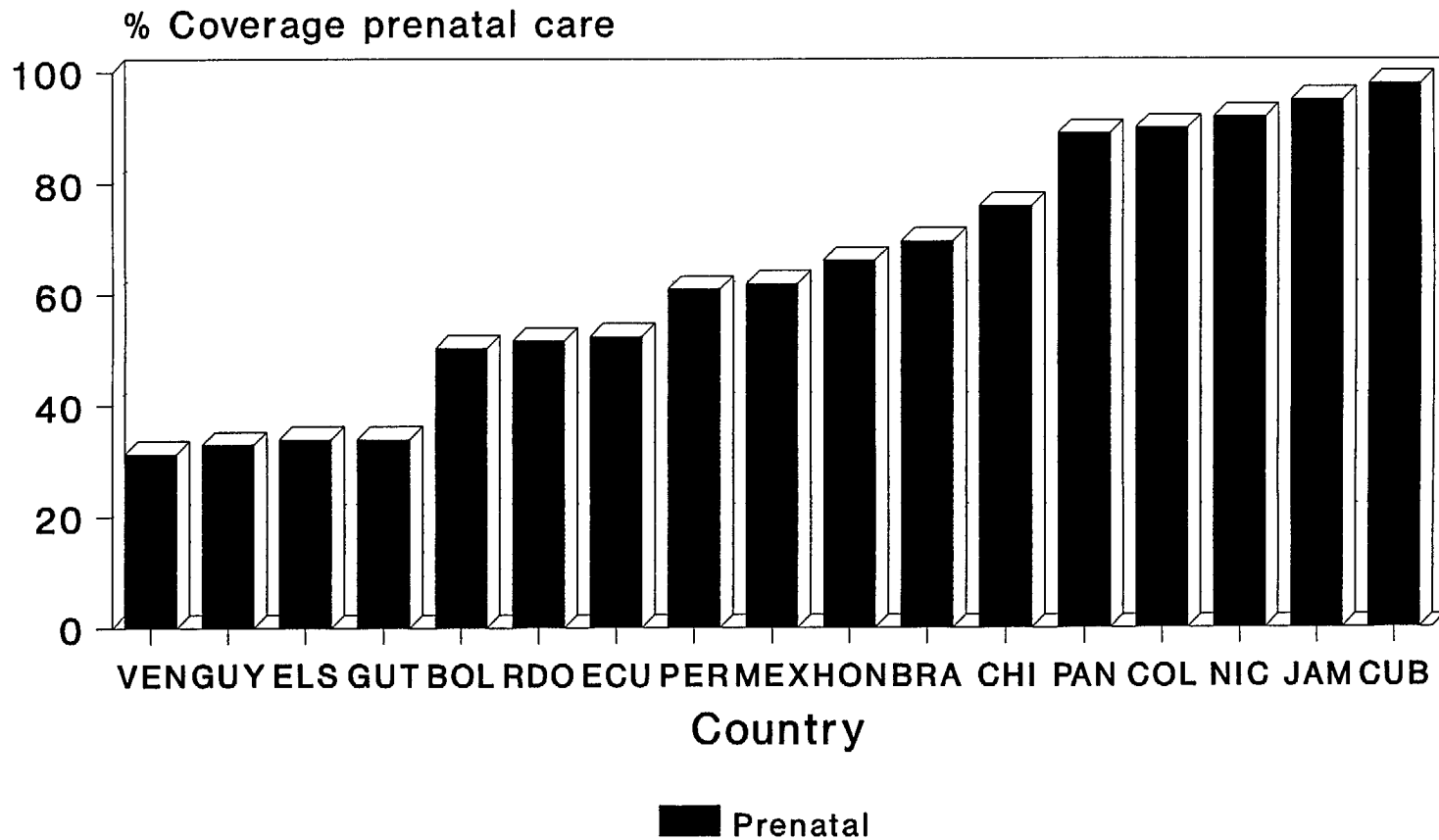


FIGURE 5
Coverage of Delivery Care
in Countries of the Americas.

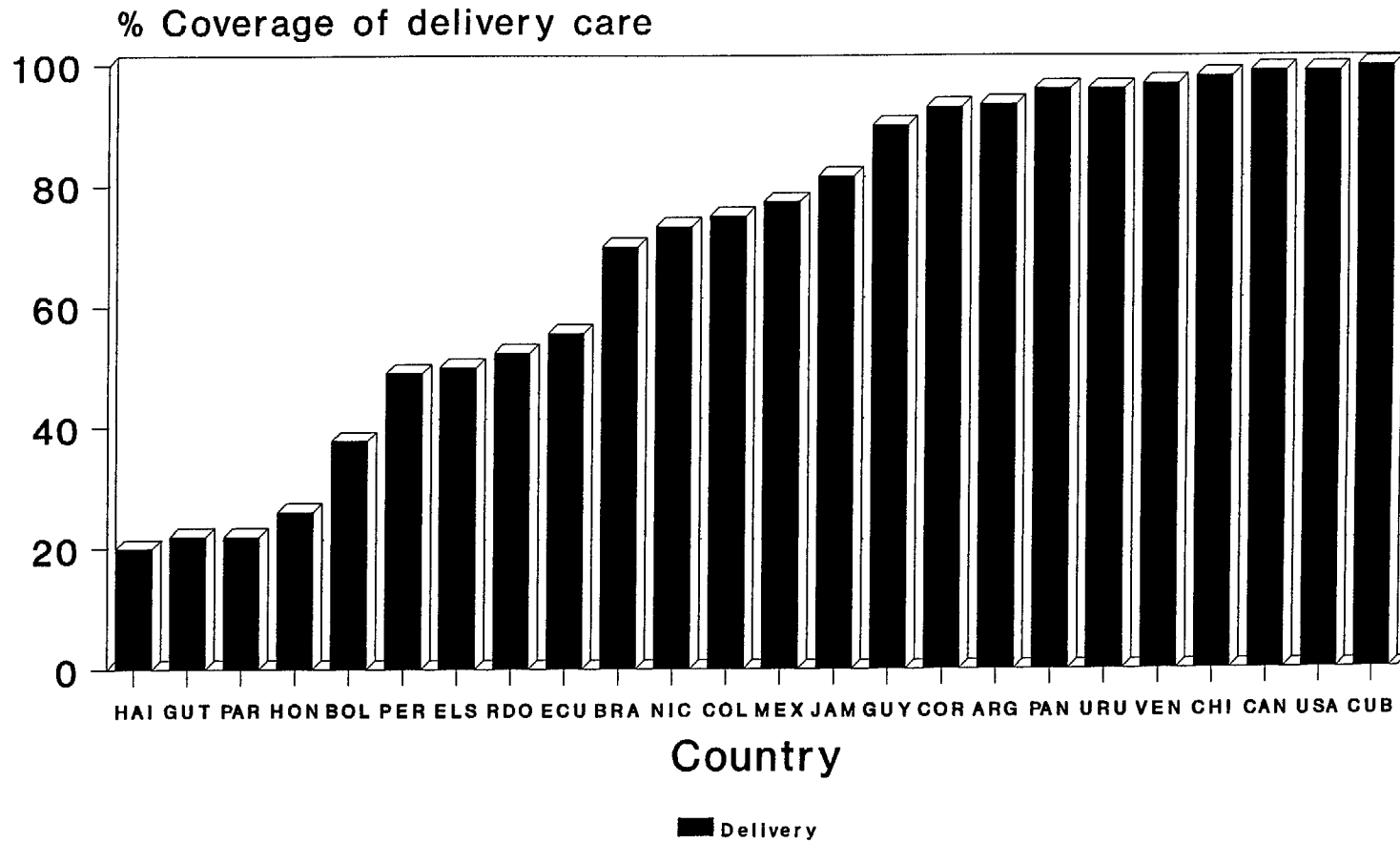
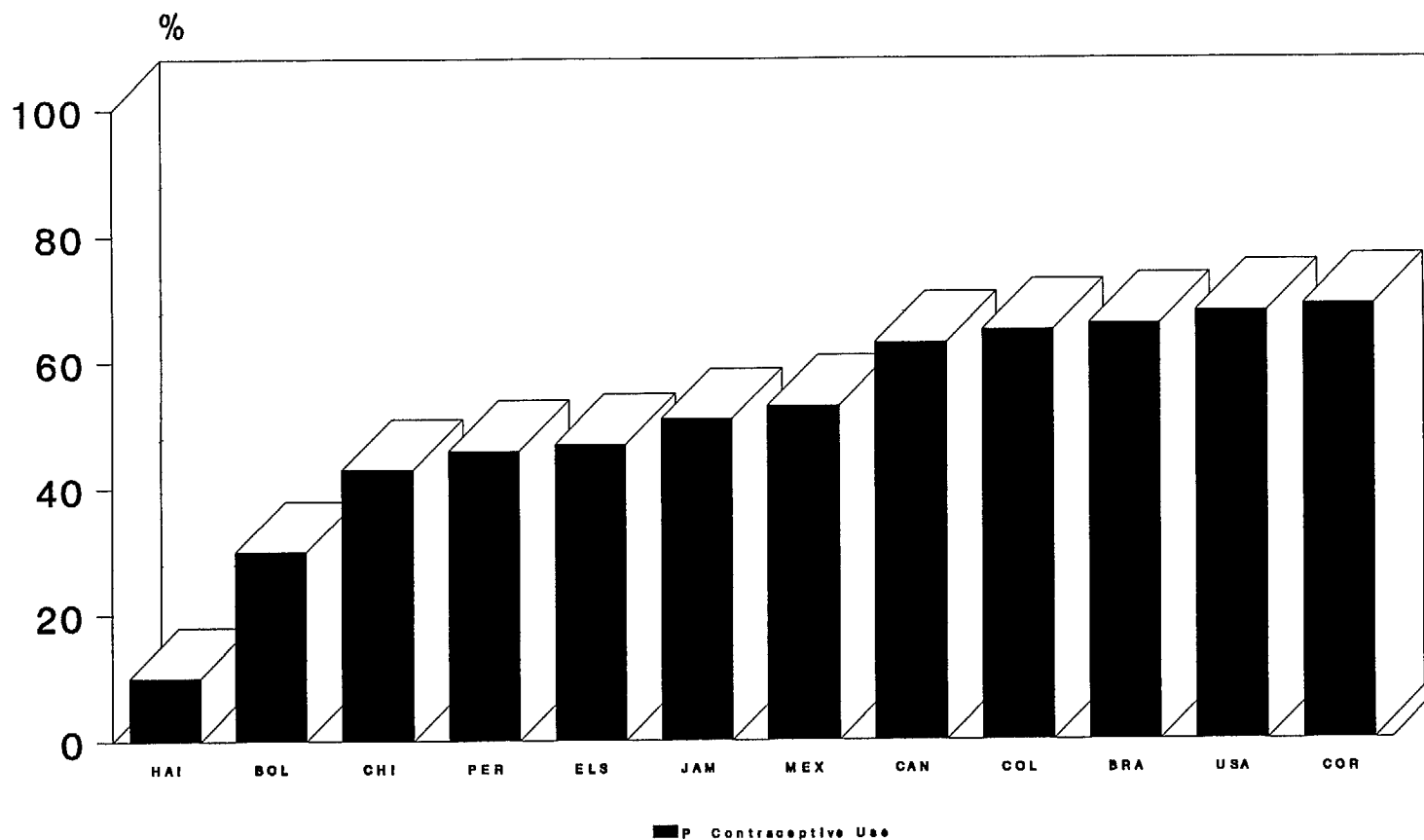


FIGURE 6
PREVALENCE OF CONTRACEPTIVE USE
IN SELECTED COUNTRIES OF THE AMERICAS
DE LAS AMERICAS



Most recent information available.
 ** Percentage prevalence.

Comprehensive adolescent health activities are being implemented on an increasing basis. However, the information systems do not yet register the activities, so it is difficult to know how much progress has been made in terms of coverage. On the basis of some surveys, it can be said that reproductive and sexual health services for adolescents are still deficient (9, 11, 12).

Surveillance of child growth and development continues to be limited and also goes unreported; it is estimated that not more than 60% of the child population are involved in surveillance activities. The situation calls for a plan of action that will make it possible to work with the population and the services to develop an attitude that encourages adequate surveillance and maintenance of child growth and development and which stresses the importance of taking advantage of every possible contact with the community and the health services to evaluate these processes.

With regard to specific interventions aimed at reducing the problems that affect children, the national vaccination programs increased their coverage in all the countries of the Region and as a result have attained the highest average in history (70%). Certification of the eradication of wild poliovirus transmission has been initiated. The rate of access to oral rehydration salts was 65% for the entire population of children under the age of 5, with a 41% utilization rate in that population. Eighteen countries have become self-sufficient in their production of oral rehydration salts, and there has been a documented decline in specific mortality due to diarrhea, along with evidence that this is related to the introduction of oral rehydration programs. Twenty countries of the Region are utilizing the standards for reidentification and treatment of acute respiratory infections (20).

It is clear that the coverage achieved is consistent with the health-disease situation mentioned at the beginning of this document and that it is reaching the point where it will have an increasingly rapid impact, especially if it is broadened to focus on the most neglected groups and if the quality of service is upgraded.

IV. CONCLUSIONS

Improvements in maternal, child, and adolescent health call for the consolidation of activities currently under way and the initiation of new activities that respond on a global basis to problems as they arise. However, a comprehensive approach should not stand in the way of actions and targets aimed at addressing specific problems. This has been allowed for in the Organization's strategic orientations and program priorities for 1991-1994 (27). It is also necessary to keep in mind that when strategies for the reduction of maternal and child morbidity and mortality lead to joint, coordinated activities, the benefits are more far-reaching than the sum total of isolated activities. Thus, maternal, child, adolescent, and family health mean much more than the health of the individuals involved. Maternal and child health is part of an ongoing process; improvements made in this area will be reflected during

later stages in life and even in future generations. Thus, the economic benefits of programs that promote health and disease prevention for mothers and children are incalculable.

It can be said without exaggeration that the Region of the Americas currently has the necessary political will, technical know-how, low-cost technology, and human resources, as well as the capacity to apply them, in areas that will improve the health of mothers, children, and adolescents. The fact that not all the proposed targets (Annex II) have been met is a sign that it is important to renew commitments, redouble efforts, and increase resources in order to improve the health of the people who are most in need. It is the responsibility of the Governments to provide the health services with critical supplies and vaccines, oral rehydration salts, antibiotics, antianemics, and contraceptives.

It should be stressed that health is an essential component of the social, political, and economic development of our peoples; experience has shown that those peoples and governments which have given the highest priority to health sector activities that have had the highest indexes of improvement. The time has come to move from talk to action.

Several international meetings that have addressed health and population problems in recent years have served to sensitize political leaders to the great needs that exist. It is now time for the health sector to share its concern and responsibility with the rest of society and for effective actions to be planned and implemented. Success will come when the health and well-being of the many take precedence over the needs of the few.

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WORLD DECLARATION ON THE SURVIVAL,
PROTECTION AND DEVELOPMENT OF CHILDREN

1. We have gathered at the World Summit for Children to undertake a joint commitment and to make an urgent universal appeal - to give every child a better future.
2. The children of the world are innocent, vulnerable and dependent. They are also curious, active and full of hope. Their time should be one of joy and peace, of playing, learning and growing. Their future should be shaped in harmony and co-operation. Their lives should mature, as they broaden their perspectives and gain new experiences.
3. But for many children, the reality of childhood is altogether different.

The challenge

4. Each day, countless children around the world are exposed to dangers that hamper their growth and development. They suffer immensely as casualties of war and violence; as victims of racial discrimination, apartheid, aggression, foreign occupation and annexation; as refugees and displaced children, forced to abandon their homes and their roots; as disabled; or as victims of neglect, cruelty and exploitation.
5. Each day, millions of children suffer from the scourges of poverty and economic crisis - from hunger and homelessness, from epidemics and illiteracy, from degradation of the environment. They suffer from the grave effects of the problems of external indebtedness and also from the lack of sustained and sustainable growth in many developing countries, particularly the least developed ones.
6. Each day, 40,000 children die from malnutrition and disease, including acquired immunodeficiency syndrome (AIDS), from the lack of clean water and inadequate sanitation and from the effects of the drug problem.
7. These are challenges that we, as political leaders, must meet.

The opportunity

8. Together, our nations have the means and the knowledge to protect the lives and to diminish enormously the suffering of children, to promote the full development of their human potential and to make them aware of their needs, rights and opportunities. The Convention on the Rights of the Child provides a new opportunity to make respect for children's rights and welfare truly universal.
9. Recent improvements in the international political climate can facilitate this task. Through international co-operation and solidarity it should now be possible to achieve concrete results in many fields--to-revitalize economic growth and development, to protect the environment, to prevent the spread of fatal and crippling diseases and to achieve greater social and economic justice. The current moves towards disarmament also mean that significant resources could be released for purposes other than military ones. Improving the well-being of children must be a very high priority when these resources are reallocated.

The task

10. Enhancement of children's health and nutrition is a first duty, and also a task for which solutions are now within reach. The lives of tens of thousands of boys and girls can be saved every day, because the causes of their death are readily preventable. Child and infant mortality is unacceptably high in many parts of the world, but can be lowered dramatically with means that are already known and easily accessible.
11. Further attention, care and support should be accorded to disabled children, as well as to other children in very difficult circumstances.
12. Strengthening the role of women in general and ensuring their equal rights will be to the advantage of the world's children. Girls must be given equal treatment and opportunities from the very beginning.
13. At present, over 100 million children are without basic schooling, and two-thirds of them are girls. The provision of basic education and literacy for all are among the most important contributions that can be made to the development of the world's children.
14. Half a million mothers die each year from causes related to childbirth. Safe motherhood must be promoted in all possible ways. Emphasis must be placed on responsible planning of family size and on child spacing. The family, as a fundamental group and natural environment for the growth and well-being of children, should be given all necessary protection and assistance.

15. All children must be given the chance to find their identity and realize their worth in a safe and supportive environment, through families and other caregivers committed to their welfare. They must be prepared for responsible life in a free society. They should, from their early years, be encouraged to participate in the cultural life of their societies.
16. Economic conditions will continue to influence greatly the fate of children, especially in developing nations. For the sake of the future of all children, it is urgently necessary to ensure or reactivate sustained and sustainable economic growth and development in all countries and also to continue to give urgent attention to an early, broad, and durable solution to the external debt problems facing developing debtor countries.
17. These tasks require a continued and concerted effort by all nations, through national action and international co-operation.

The commitment

18. The well-being of children requires political action at the highest level. We are determined to take that action.
19. We ourselves hereby make a solemn commitment to give high priority to the rights of children, to their survival and to their protection and development. This will also ensure the well-being of all societies.
20. We have agreed that we will act together, in international co-operation, as well as in our respective countries. We now commit ourselves to the following 10 point programme to protect the rights of children and to improve their lives:
 - 1) We will work to promote earliest possible ratification and implementation of the Convention on the Rights of the Child. Programmes to encourage information about children's rights should be launched world-wide, taking into account the distinct cultural and social values in different countries.
 - 2) We will work for a solid effort of national and international action to enhance children's health, to promote pre-natal care and to lower infant and child mortality in all countries and among all peoples. We will promote the provision of clean water in all communities for all their children, as well as universal access to sanitation.
 - 3) We will work for optimal growth and development in childhood, through measures to eradicate hunger, malnutrition and famine, and thus to relieve millions of children of tragic sufferings in a world that has the means to feed all its citizens.

- 4) We will work to strengthen the role and status of women. We will promote responsible planning of family size, child spacing, breastfeeding and safe motherhood.
- 5) We will work for respect for the role of the family in providing for children and will support the efforts of parents, other caregivers and communities to nurture and care for children, from the earliest stages of childhood through adolescence. We also recognize the special needs of children who are separated from their families.
- 6) We will work for programmes that reduce illiteracy and provide educational opportunities for all children, irrespective of their background and gender, that prepare children for productive employment and lifelong learning opportunities, i.e. through vocational training; and that enable children to grow to adulthood within a supportive and nurturing cultural and social context.
- 7) We will work to ameliorate the plight of millions of children who live under especially difficult circumstances - as victims of apartheid and foreign occupation; orphans and street children and children of migrant workers, the displaced children and victims of natural and man-made disasters; the disabled and the abused, the socially disadvantaged and the exploited. Refugee children must be helped to find new roots in life. We will work for special protection of the working child and for the abolition of illegal child labour. We will do our best to ensure that children are not drawn into becoming victims of the scourge of illicit drugs.
- 8) We will work carefully to protect children from the scourge of war and to take measures to prevent further armed conflicts, in order to give children everywhere a peaceful and secure future. We will promote the values of peace, understanding and dialogue in the education of children. The essential needs of children and families must be protected even in times of war and in violence-ridden areas. We ask that periods of tranquility and special relief corridors be observed for the benefit of children, where war and violence are still taking place.
- 9) We will work for common measures for the protection of the environment, at all levels, so that all children can enjoy a safer and healthier future.
- 10) We will work for a global attack on poverty, which would have immediate benefits for children's welfare. The vulnerability and special needs of the children of the developing countries, and in particular the least developed ones, deserve priority. But growth and development need promotion in all States, through national action and international cooperation. That

calls for transfers of appropriate additional resources to developing countries as well as improved terms of trade, further trade liberalization and measures for debt relief. It also implies structural adjustments that promote world economic growth, particularly in developing countries, while ensuring the well-being of the most vulnerable sectors of the populations, in particular the children.

The next steps

21. The World Summit for Children has presented us with a challenge to take action. We have agreed to take up that challenge.
22. Among the partnerships we seek, we turn especially to children themselves. We appeal to them to participate in this effort.
23. We also seek the support of the United Nations system, as well as other international and regional organizations, in the universal effort to promote the well-being of children. We ask for greater involvement on the part of nongovernmental organization, in complementing national efforts and joint international action in this field.
24. We have decided to adopt and implement a Plan of Action, as a framework for more specific national and international undertakings. We appeal to all our colleagues to endorse that Plan. We are prepared to make available the resources to meet these commitments, as part of the priorities of our national plans.
25. We do this not only for the present generation, but for all generations to come. There can be no task nobler than giving every child a better future.

United Nations, New York, 30 September 1990

GOALS FOR CHILDREN AND DEVELOPMENT IN THE 1990s

The following goals have been formulated through extensive consultation in various international forums attended by virtually all Governments, the relevant United Nations agencies including the World Health Organization (WHO), UNICEF, the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme (UNDP) and the International Bank for Reconstruction and Development (IBRD) and a large number of NGOs. These goals are recommended for implementation by all countries where they are applicable, with appropriate adaptation to the specific situation of each country in terms of phasing standards, priorities and availability of resources, with respect for cultural, religious and social traditions. Additional goals that are particularly relevant to a country's specific situation should be added to its national plan of action.

1. Major goals for child survival, development and protection:
 - (a) Between 1990 and the year 2000, reduction of infant and under 5 child mortality rate by one third or to 50 and 70 per 1,000 live births respectively, whichever is less;
 - (b) Between 1990 and the year 2000, reduction of maternal mortality rate by half;
 - (c) Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under 5 children by half;
 - (d) Universal access to safe drinking water and to sanitary means of excreta disposal;
 - (e) By the year 2000 universal access to basic education and completion of primary education by at least 80 per cent of primary school-age children;
 - (f) Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level with emphasis on female literacy;
 - (g) Improved protection of children in especially difficult circumstances.
- II. Supporting-Sectoral goals
 - A. Women's health and education
 - (i) Special attention to the health and nutrition of the female child and to pregnant and lactating women;

- (ii) Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many.
- (iii) Access by all pregnant women to pre-natal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies.
- (iv) Universal access to primary education with special emphasis for girls and accelerated literacy programmes for women.

B. Nutrition

- (i) Reduction in severe, as well as moderate malnutrition among under-5 children by half of 1990 levels;
- (ii) Reduction of the rate of low birth weight (2.5 kg or less) to less than 10 per cent.
- (iii) Reduction of iron deficiency anaemia in women by one third of the 1990 levels.
- (iv) Virtual elimination of iodine deficiency disorders;
- (v) Virtual elimination of vitamin A deficiency and its consequences, including blindness;
- (vi) Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding, with complementary food, well into the second year;
- (vii) Growth promotion and its regular monitoring to be institutionalized in all countries by the end of the 1990s;
- (viii) Dissemination of knowledge and supporting services to increase food production to ensure household food security.

C. Child health

- (i) Global eradication of poliomyelitis by the year 2000;
- (ii) Elimination of neonatal tetanus by 1995;
- (iii) Reduction by 95 per cent in measles deaths and reduction by 90 per cent of measles cases compared to pre-immunization levels by 1995, as a major step to the global eradication of measles in the longer run;

- (iv) Maintenance of a high level of immunization coverage (at least 90 per cent of children under one year of age by the year 2000) against diphtheria; pertussis, tetanus, measles, poliomyelitis, tuberculosis and against tetanus for women of child-bearing age;
- (v) Reduction by 50 per cent in the deaths due to diarrhoea in children under the age of five years and 25 per cent reduction in the diarrhoea incidence rate;
- (vi) Reduction by one third in the deaths due to acute respiratory infections in children under five years.

D. Water and sanitation

- (i) Universal access to safe drinking water;
- (ii) Universal access to sanitary means of excreta disposal;
- (iii) Elimination of guinea-worm disease (dracunculiasis) by the year 2000.

E. Basic education

- (i) Expansion of early childhood development activities, including appropriate low-cost family and community-based interventions;
- (ii) Universal access to basic education and achievement of primary education by at least 80 per cent of primary school-age children through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls;
- (iii) Reduction of the adult literacy rate (the appropriate age group to be determined in each country) to at least half its 1990 level, with emphasis on female literacy;
- (iv) Increased acquisition by individuals and families of the knowledge, skills and values required for better living, made available through all educational channels, including the mass media, other forms of modern and traditional communication and social action, with effectiveness measured in terms of behavioural change;

F. Children in difficult circumstances

Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situations.

MEMORANDUM OF PAHO/WHO, UNFPA, AND UNICEF INTERAGENCY
COLLABORATION TO SUPPORT IMPLEMENTATION OF THE AGREEMENTS
OF THE WORLD SUMMIT FOR CHILDREN, IN THE AMERICAS*

The Representatives of PAHO/WHO, UNFPA, and UNICEF, meeting at PAHO/WHO Headquarters in Washington, D.C., 25-26 Marzo 1991, in accordance with the mandates of their Directing Bodies, which are in agreement with regard to providing support to actions to promote the health of children, adolescents, and women and the appeals of the United Nations General Assembly to execute these actions in a coordinated and complementary manner.

Bearing in mind that active technical cooperation has been taking place between PAHO/WHO, UNFPA, and UNICEF in the field of maternal and child health, and that it has provided substantial support to the governments of the Region and contributed to improving the health of the population;

Further bearing in mind that the World Summit for Children, held at United Nations Headquarters, 29-30 September 1990, approved the World Declaration on the Survival, Protection, and Development of Children as the supreme expression of the political will to organize the actions to be taken in the 1990s, and that the Heads of State and Government approved a Plan of Action for governments, international organizations, and other organizations for the adoption of national and regional measures to promote maternal and child health, combat undernutrition and illiteracy, improve sanitation and the provision of drinking water, reduce the high rates of disease and death among children and women, and improve the social situation of women;

Considering that the World Declaration and the Plan of Action constitute a commitment on the part of the governments to carry out actions in the short, medium, and long terms to promote a favorable climate for reaffirming and strengthening the role of collaboration between the agencies and the governments; and

Taking due account of the proposals contained in paragraphs 34 and 35 of the Plan of Action for implementation of the World Declaration on Survival, Protection, and Development of Children in the 1990s, hereby draw up and subscribe to the present MEMORANDUM OF INTERAGENCY COLLABORATION, and

*Official English Version

RESOLVE:

To unite their forces to develop joint lines of action so as to provide technical cooperation to the countries of the Region of the Americas for the preparation, execution, follow-up, and evaluation of the Plans of Action for Maternal and Child Health, including the health of women, children and adolescents.

To promote jointly the following lines of action:

1. Interagency Coordination:

- To support the governments in developing and consolidating interagency coordination mechanisms around national plans.
- To hold meetings between the Representatives of the agencies and their technical personnel at the country level to collaborate in preparing work plans for carrying out the activities agreed upon in the present Memorandum.
- To hold annual interagency coordination meetings at the regional level.
- To invite other bilateral and multilateral cooperation agencies and NGOs to participate in coordination and action and to inform them of the present proposals.

2. Formulation of Plans of Action for Maternal and Child Health at the Country Level

- To promote and support in each country the establishment of National Commissions and/or Intersectorial Working Groups to formulate National Maternal and Child Health Plans.
- To provide technical support to the governments in defining the base line according to which the goals that each country pledges to attain in the short, medium, and long terms and by the end of the decade will be defined and adopted.
- To develop and/or improve methodological guidelines to support the formulation of National Maternal and Child Health Plans, including mechanisms for follow-up, evaluation, and cost estimation.
- To provide direct technical cooperation for the preparation, adjustment, and execution of National Maternal and Child Health Plans.

3. Promotion and Mobilization:

- To provide widespread dissemination at the regional and national levels and within the agencies of the maternal and child health goals included in the World Declaration and the Plan of Action as a means of creating awareness of their content.
- To promote in each agency the adoption of resolutions by their directing bodies that include a commitment to support the governments in formulating and implementing the National Plans.
- To publicize, at the level of the countries and the Region, the work carried out to achieve the goals proposed, and to mobilize civil society and the organized community to participate actively in this process.

4. Technical Cooperation Between Countries:

- To promote an exchange of experience between the countries to assist in implementing the actions.
- To promote technical cooperation in the framework of subregional health initiatives.

5. Financing:

- To support the governments in seeking sources of external financing and mobilizing national resources in order to carry out the actions provided for in their National Plans.
- To support, in accordance with financing criteria and the availability of resources of each agency, the implementation of actions and programs in a complementary manner, reorienting, if required, their regional and country resources in conformity with the development of the Plans of Action.

6. Monitoring and Evaluation:

- To identify the basic indicators for measuring the progress achieved in fulfilling the goals proposed and to support the design of mechanisms to monitor and evaluate the National Plans.

WORK PLAN

An interagency work plan will be prepared in which joint activities will be identified along with other agency activities that may be articulated so as to contribute to achieving common goals. An interagency meeting will be convened annually to evaluate the extent of fulfillment of the activities agreed upon the previous year and a work plan will be proposed for the following year.

Dr. Teresa Albanez
Regional Director for
Latin America and the Caribbean,
UNICEF

Dr. Kerstin Trone
Chief, Division of Latin
America and the Caribbean,
UNFPA

Dr. Carlyle Guerra de Macedo
Director, PAHO/WHO

*executive committee of
the directing council*



PAN AMERICAN
HEALTH
ORGANIZATION

*working party of
the regional committee*

WORLD
HEALTH
ORGANIZATION



107th Meeting
Washington, D.C.
June 1991

Provisional Agenda Item 4.6

CE107/11 (Eng.)
ANNEX III (Revised)
24 June 1991
ORIGINAL: ENGLISH-SPANISH

MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMS

Revised Annex III, "Memorandum of Interagency Collaboration to Support Implementation of the Agreements of the World Summit for Children in the Region of the Americas," is attached.

MEMORANDUM OF INTERAGENCY COLLABORATION
TO SUPPORT IMPLEMENTATION OF THE AGREEMENTS
OF THE WORLD SUMMIT FOR CHILDREN IN THE REGION OF THE AMERICAS

The Representatives of the Pan American Health Organization (PAHO), the United Nations Fund for Population Activities (UNPFA), and the United Nations International Children's Fund (UNICEF), met at PAHO/WHO Headquarters in Washington, D.C., 25-26 March 1991, and again on 16-17 May 1991 together with the Agency for International Development of the United States of America (AID) and the Inter-American Development Bank (IDB) representatives, in accordance with the mandates of their Directing Bodies, which are in agreement with regard to providing support to actions to promote the health of children, adolescents, and women and the appeals of the United Nations General Assembly to execute these actions in a coordinated and complementary manner;

Bearing in mind that active technical cooperation has been taking place between these various agencies in the field of maternal and child health, and that this has provided substantial support to the governments of the Region and contributed to improving the health of the population;

Considering that the World Summit for Children, held at United Nations Headquarters, 29-30 September 1990, approved the World Declaration on the Survival, Protection, and Development of Children as the supreme expression of the political will to organize the actions to be taken in the 1990s, and that the Heads of State and Government approved a Plan of Action for governments, international organizations, and other organizations for the adoption of national and regional measures to promote maternal and child health, combat malnutrition and illiteracy, improve sanitation and the provision of drinking water, reduce the high rates of disease and death among children and women, and improve the social condition of women;

Considering that the World Declaration and the Plan of Action constitute a commitment on the part of the governments to carry out actions in the short, medium, and long terms to promote a favorable climate for reaffirming and strengthening the role of collaboration between the agencies and the governments; and

Taking due account of the proposals contained in paragraphs 34 and 35 of the Plan of Action for Implementation of the World Declaration on Survival, Protection, and Development of Children in the 1990s, hereby draw up and subscribe to the present MEMORANDUM OF INTERAGENCY COLLABORATION and

RESOLVE:

To unite their forces to develop joint lines of action so as to provide technical cooperation to the countries of the Region of the Americas for the preparation, execution, follow-up, and evaluation of the Plans of Action for Maternal and Child Health, including the health of women, children, and adolescents; and to promote jointly the following lines of action:

1. Interagency Coordination:

- . To encourage the governments establish and/or consolidate interagency health coordination mechanisms to be chaired by a government official with decision-making authority.
- . To assist these interagency health coordinating mechanisms to hold regular meetings between the representatives of the agencies and their technical personnel at the country level to collaborate in preparing and monitoring the implementation of plans of action, including costs, for carrying out the activities agreed upon in the Plan of Action.
- . To invite other bilateral, non-governmental organizations (NGOs), private sector and multilateral cooperation agencies to participate as needed in coordination and implementation of plans of action and to inform them of the present proposals.
- . To hold annual interagency coordination meetings at the regional or sub-regional levels.

2. Formulation of Plans of Action for Maternal and Child Health at the Country Level

- . To promote and support in each country the establishment of National Commissions and/or Intersectoral Working Groups to formulate National Maternal and Child Health Plans.
- . To provide technical support to the governments in defining the baseline data according to which the goals that each country pledges to attain in the short and medium terms and by the end of the decade will be defined and adopted.
- . To develop and/or improve the guidelines to support the formulation of National Maternal and Child Health Plans, including mechanisms for follow-up, evaluation, and cost estimation.
- . To provide direct technical cooperation for the preparation, adjustment, and execution of National Maternal and Child Health Plans.

3. Promotion and Mobilization:

- . To provide further widespread dissemination at national and regional levels and within the participating agencies of the maternal and child health goals included in the World Declaration and the Plan of Action as a means of creating awareness of their content.
- . To promote in each participating agency, whenever applicable, the adoption of resolutions by their directing bodies that include a commitment to support the governments in formulating and implementing the National Plans.
- . To publicize at the regional level and to assist countries to publicize at the national level, the work carried out to achieve the goals proposed, and to mobilize civil society and the organized community to participate actively in this process.

4. Technical Cooperation Between Countries:

- . To promote and facilitate an exchange of experiences between the countries to assist in implementing the actions.
- . To promote technical cooperation in the framework of subregional health initiatives.

5. Financing:

- . To support the governments in mobilizing national resources and in seeking sources of external financing in order to carry out the actions provided for in their National Plans.
- . To support, in accordance with the mandates and the availability of resources of each agency, the implementation of actions and programs in a complementary manner, reorienting, if required, their regional and country resources in conformity with the development of the Plans of Action.
- . In accordance with the mandate of each agency, support the strengthening of health sector planning, coordination, advocacy and management capabilities essential to the achievement of the goals of the World Summit for Children.

6. Monitoring and Evaluation:

- To identify and promote the use of standardized basic indicators for measuring the progress achieved in fulfilling the goals proposed and to support the design of mechanisms to monitor and evaluate the National Plans.

WORK PLAN

An interagency work plan for 1991-1992 is annexed, in which joint activities are identified along with other agency activities that may be articulated so as to contribute to achieving common goals. An interagency meeting will be convened annually to evaluate the extent of fulfillment of the activities agreed upon the previous year and a new work plan will be proposed for the following year.

The present MEMORANDUM OF INTERAGENCY COLLABORATION is hereby subscribed to at PAHO/WHO Headquarters, Washington, D.C., on 17 May 1991.

Dr. Teresa Albanez
Regional Director for
Latin America and the Caribbean,
UNICEF

Ms. Kerstin Trone
Director, Latin America and
Caribbean Division,
UNFPA

Dr. Carlyle Guerra de Macedo
Director, PAHO/WHO

Mr Peter Bloom
Acting Assistant Administrator
Latin American Bureau, AID

Inter-American Development Bank
Mr. Enrique Iglesias
President

JOINT ACTIVITIES FOR 1991-1992
AGREED UPON IN THE INTERAGENCY MEETINGS

1. Each agency will transmit a copy of this Memorandum of Collaboration and annexes to the Representatives of their agencies in the countries, May-June 1991.
2. Promotion of interagency meetings in the countries to identify the state of progress achieved in designing and implementing the National Plans of Action required by the World Summit for Children. In each country PAHO will convene the first meeting, and will transmit the results to the respective participating agency headquarters. June-July, 1991.
3. Constitution of ad-hoc Interagency Technical Working Groups to address specific technical issues as they may arise.
4. Meeting of an Interagency Technical Working Group to review and adjust the guidelines for preparation of the Maternal and Child Health Plans of Action, Bogotá, Colombia, 6-10 May 1991.
5. Review and validate available guidelines for the development of the National Plans, duly adjusted to the characteristics of each country. June, 1991.
6. Transmittal of the guidelines, including criteria for estimation of costs. July 1991.
7. Support for preparation of the National Plans of Action, July-November 1991.
8. Collection, analysis, and synthesis of National Plans of Action and regional integration of strategies and common activities. Interagency Technical Working Group. January to March, 1992.
9. Holding the Second Meeting of Chiefs of Maternal and Child Health Programs of Latin America and the Caribbean, April 1992.
10. Holding the Second Regional Interagency Meeting. First quarter of 1992.
11. Active promotion of the contents of the World Declaration, the Plan of Action, and of the present Memorandum of Interagency Collaboration by the participating agencies in order to achieve their objectives.
12. Identification of the specific activities in each agency, especially at country level, that articulate and support achievement, in a complementary manner, of the goals and actions included in the World Declaration, the Plan of Action and the present Memorandum of Interagency Collaboration.