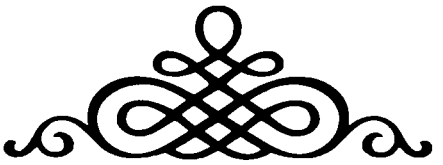
Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

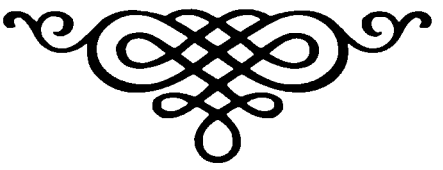
This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

7

Divider Title: _____



PRESENTATION 1



Organization: **Inter-American Commission of Women (CIM)**

Subject: Violence Against Women, Eradication of Poverty, Education/Information Network and Participation of Women in Power and Decision-Making Structures.

Presenter: **Ms. Carmen Lomellin**

Description:

Violence against women:
As of this year, 29 of the 34 countries in the Hemisphere have ratified the Convention of Belen do Pra on Violence Against Women. This is the only regional instrument that addresses and protects the rights of women who are victims of violence. This year, CIM will do a follow-up and impact analysis of the Convention, reviewing each member state's compliance.

Another form of violence against women is the trafficking of women and children for sexual exploitation. In co-ordination with the International Human Rights Law Institute of DePaul University, seven or eight countries will be selected to participate in a pilot project. The information collected will be presented at a meeting in Washington DC in November 2000.

Eradication of poverty:
In 1999, CIM will co-host the Women's Economic Summit of the Americas in Buenos Aires, Argentina. The summit will bring together business women and professional and entrepreneurial leaders from the Hemisphere to explore and share strategies through which to expand women's business and trade capacity in the Hemisphere.

Education/Information Network:
This project will link women of the Americas electronically by providing on-line access to information on programs, projects, politics and business opportunities that affect women throughout the Hemisphere. This project was developed as a direct response to the need for information at the local, national and international levels. Its objective is to educate and strengthen the capacity of women's organizations through information.

Participation of Women in Power and Decision-Making Structures:
In the spring of 2000, CIM is convening a hemispheric meeting of women ministers and others responsible for gender issues in their respective countries. Among the issues up for ministerial approval will be a draft Inter-American Program on the Promotion of Women's Rights and Gender Equity, which is to be presented to the OAS General Assembly in 2000. CIM will also be providing technical assistance and co-ordination of women's themes for the next Summit of the Americas. They will contact international and regional partners to request input and the inclusion of women's issues in the summit process and follow-up.

PRESENTATION 2

Organization: **Inter-American Development Bank (IDB)**

Presenter: **Ricardo Moran**

Subject: **Reproductive Health**

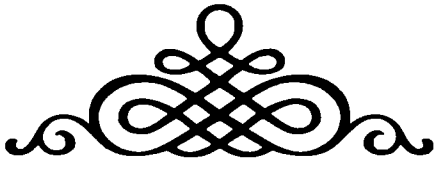
Description

The linkage between poverty, low levels of education, high birth rates and poor health among mothers and children has been well documented. Birth rates drop steadily as levels of schooling increase. In Latin America and the Caribbean, women who live in urban areas and women who supplement the family income by working have fewer children than other women. The death of a mother during childbirth, apart from representing a loss of productivity for the national economy, also reduces the likelihood that her other children will survive and be healthy.

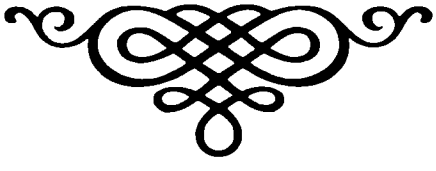
The welfare of mothers and their young children is closely linked. To invest in women is to invest in children, particularly among the poor. Women suffering from malnutrition prior to and during pregnancy tend to give birth to babies that have not developed fully in the womb and consequently have low birth weights. Maternal malnutrition owing to low calorie and protein consumption may be complicated by the fact that many poor women, particularly in rural areas, are unable to cut back on their levels of physical activity during the final months of pregnancy, which increases their energy imbalance even more.

The Inter-American Development Bank can introduce changes, through a set of specific interventions designed to reform the health care sector. Efficiency analyses are performed in function of the costs of new sets of reproductive health services designed specifically for the region to respond to its needs and socioeconomic levels. The Bank is interested in exploring opportunities to strengthen ties between governments and NGOs through health sector reform and other activities.

In 1998, the IDB approved loans totalling US$48.6 million to modernize reproductive health services.



PRESENTATION 3



Organization: **Inter-American Development Bank (IDB)**

Presenter: **Ricardo Moran**

Subject: **Early childhood interventions and poverty reduction in Latin America**

Description

Very slow progress has been made in many Latin American countries in reducing poverty and improving income distribution. One of the main reasons for this failure has been the excessively slow universalization of education. Although a considerable part of GDP is spent on public education, school enrolment rates are disheartening. Clearly, if better distribution of education is one of the necessary conditions for more equitable income distribution and poverty reduction, then steps must be taken to increase school enrolment and retention rates. All the evidence indicates that the best way to bring about these changes is to provide programs for early childhood intervention. Programs of this kind report very valuable benefits, such as greater equality of opportunity for boys and girls, higher rates of participation in the workforce by women, lower birth rates, and better health. Another highly valuable benefit is the likely reduction in crime and antisocial behaviour brought about by better interpersonal relationships in the family and less domestic violence.

The kinds of intervention are also very important. Clearly, the greatest impact on children's potential is obtained if the program includes health and nutrition monitoring, care in nurseries and pre-school education. However, programs of this kind can be very expensive and almost all the developing countries have limitations on their spending. Therefore, it is necessary to single out the program components that produce the desired benefits at reasonable costs.

At the start of this decade, the Inter-American Development Bank launched an initiative to devote a significant percentage of its soft loans to projects that would directly benefit children at risk in the region. The IDB's function is to promote the initiatives of civil society, providing technical support to make them more preventive in nature so that they do not just attack the symptoms of the problems but their root causes as well, working with boys and girls and with their mothers and families.

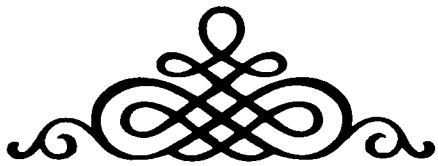
Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

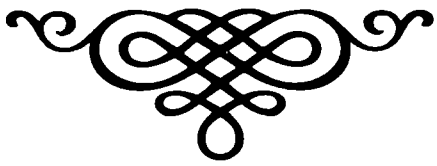
This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

8

Divider Title: _____



PRESENTATION 1



ORGANIZATION OF AMERICAN STATES
INTER-AMERICAN COMMISSION OF WOMEN

The Inter-American Commission of Women is the voice of the women of the Americas and their advocate before the 34 member governments of the Inter-American system. Since its establishment in 1928, the Commission has fought for the rights of women, guarded their interests and promoted their progress. It is the only regional intergovernmental organization in the world created expressly to ensure recognition of the civil and political rights of women.

The Commission is dedicated to bettering the status of women and, through its delegates, providing support and recognition to national women's movements at the governmental, NGO and grass roots levels. It formulates strategies that promote gender equality, proposes solutions to make compatible the role of women as mothers, workers, and fully integrated members of society.

The Commission also conducts research into those areas considered necessary to step up the integral participation of women in the economic and social development of people. It serves as an advisory body to the Organization of American States and to its various components in all matters related to the women of the hemisphere. It promotes access by all women to education, paying particular attention to the status of working women and of women in the disadvantaged sectors.

Finally, the Inter-American Commission of Women reports to the governments of the member states and to the General Assembly of the Organization of American States on all

aspects of the status of women in the hemisphere and on the progress being made in this arena. It identifies issues and problems for consideration and submits recommendations for solutions.

Over the last decade, major changes have occurred in the international arena, including a growing globalization, economic interdependence, shifts in the world power structures, technological innovations and progress in improving the status of women, both in the individual countries and in the international community as a whole. These elements, together with new ways of relating between the genders, make up an ever-changing scenario.

In November of 1994, at the Fourth World Conference on Women held in Beijing, the Commission presented its Strategic Plan of Action and identified the following as priority areas:

Participation of Women in Power and Decision-making Structures

Legal and Institutional Framework

Employment

Education

Health

Elimination of Violence

Eradication of Poverty

National machinery responsible for the advancement of women

Regional Cooperation

Migration of Women in Areas of Conflict

Of these ten priorities areas, education, the elimination of violence against women, the eradication of poverty and the participation of women in the structures of power and decision-making, have taken on even greater importance. At the CIM, we are focusing our efforts on these areas.

Violence against Women: As we have all witnessed since the Beijing World Conference on Women, violence against women has taken center stage. Once a topic that was whispered and barely mentioned publicly, violence against women has become the #1 issue affecting the women of the entire world. It is certainly no different in our hemisphere.

In 1994, the General Assembly of the OAS approved the Convention of Belem do Para, drafted and promoted by the Inter-American Commission of Women. As of this year, 1999, twenty-nine of the thirty-four member-states of the OAS have ratified the Convention. It remains the only regional instrument that addresses and protects the rights of women that are victims of violence. It has been the catalyst for legislation, educational programs, innovative law enforcement approaches and training programs.

This year, the CIM will do a follow-up and impact analysis of the Convention. We will review each member state's compliance with the Convention by addressing not only criminal law, procedures, law enforcement, sentencing and corrections, but also health services, victim assistance programs, crime prevention measures and awareness campaigns that have been introduced in the last five years. The research will be followed up by a major meeting of experts in the area of violence against women for analysis and additional

recommendations on effective implementation to the member states.

Another insidious form of violence against women and children is the trafficking of women and children for sexual exploitation. We expect to receive funding shortly to research this issue regionally. In coordination with the International Human Rights Law Institute of De Paul University, we will select 7 – 8 pilot countries and work with Human Rights NGOs in the compilation of data. This data will be compiled by country and experts from the region will be chosen to participate in the analysis of the collected data. A meeting, hosted by the Commission, will be held in Washington, D.C. to review and discuss the data and to make recommendations. We expect that these deliberations will be presented to the delegates of the Commission at the biennial Assembly of Delegates in November 2000. These findings will be used to make recommendations to the member states for action, and will be published and disseminated throughout the hemisphere.

Eradication of Poverty/Economic Empowerment: In November of 1999, the CIM will cohost the "**Women's Economic Summit of the Americas**" in Buenos Aires, Argentina. This Summit will bring together women business, professional and entrepreneurial leaders from throughout the Americas to explore and share strategies through which to expand women's business and trade capacity in the Hemisphere. As a follow-up to the 1998 ***Vital Voices for Democracy*** held in Montevideo, the Summit will provide:

Information on the Latin American market and its growth areas;

Data on *Women as a Market* in the region;

A Basic primer on trade pacts and their impact on women's capacity to do business within the region and globally;

Training on how to use technology to increase an enterprise's ability to do cross-border business and more practical sessions that will open up hemispheric business opportunities to participants.

The Summit will be co-chaired by the Secretary General of the OAS, Dr. Cesar Gaviria, Ana Kessler, Minister for Small Business Administration in Argentina; and, Aida Alvarez, U.S. Small Business Administrator. There are also plans in the making for U.S. and Canadian trade missions to join the Summit. As co-host, the Inter-American Commission of Women will provide access to the entire region through its network of delegates.

Education/Information Network (Proyecto *Enlace)*: Using a model developed by the Women's Ministry in Argentina, this project will electronically link the women of the Americas by providing online access to information on programs, projects, policies, business opportunities, etc. affecting women throughout the hemisphere. The project will be developed sub-regionally, beginning the Mercosur region. This model was developed as a direct response to the need for information at the local, national and international levels. Its objective is to educate and strengthen the capacity of women's organizations through information.

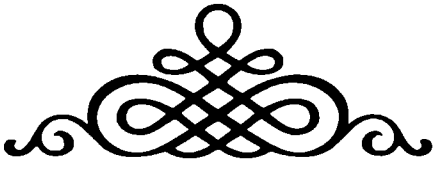
The Commission is also close to completing research on ***Education and Gender Equity***. This study looks at the status of women's education. It analyzes the status of women in the education process, literacy levels, the relevancy of education for the workplace, access to education for rural women and the educational levels for women twenty-five years of age and older. Recommendations will be made on improving access to education and the inclusion of a gender perspective in education systems. The results will be disseminated

throughout the region.

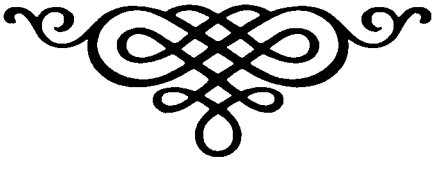
Participation of Women in Power and Decision-making Structures: In the spring of 2000, the CIM is convening a hemispheric meeting of Women Ministers and others responsible for gender issues in their respective countries. At this meeting, among the issues presented will be a draft Inter-American Program on the Promotion of Women's Rights and Gender Equity for approval by the ministers for later presentation to the 2000 General Assembly of the OAS. This meeting will be key since it will be the only regional meeting of women held prior to the United Nations Beijing +5 meeting in June, 2000.

It is important to note that, at the request of the government of Nicaragua, the CIM is providing technical assistance and coordination on the women's theme for the next Summit of the Americas. We will be reaching out to our international and regional partners in effort to have strong and positive input and the inclusion of women's issues on the summit process and subsequent follow-up.

There has been much activity at the Inter-American Commission of Women. We are working diligently to modernize and keep abreast of developments and trends in the arena of "women's issues". We must, and will, ensure that the programs and policies that are developed do what they are intended to do – and that is, to protect the rights of all women and to be their voice and advocate before the thirty-four member governments of the Inter-American system.



PRESENTATION 2



INNOVATIVE PROGRAMMING IN REPRODUCTIVE HEALTH IN LATIN AMERICA AND THE CARIBBEAN

- **Community definition and implementation of reproductive health: the Warmi Project in Bolivia.** Motivated by the bleak health conditions of women and children in Inquisivi province, Bolivia, in 1990, a US NGO, Save the Children, launched Project Warmi, a comprehensive maternal and neonatal health project. A primary goal of the project was to develop and test a community-based approach to improving maternal and neonatal health in a remote setting with little access to adequate formal health services. Project Warmi employed staff from the area who spoke the local languages and were knowledgeable about community social and cultural norms. The project organized women's groups to raise women's awareness that their individual problems are often common to others and that together they are more likely to find solutions, but was careful not to exclude men from community meetings. Groups followed a four-stage "Community Action Cycle" to identify needs and practical solutions beginning with an "auto-diagnosis" where women themselves identified the three most important maternal and neonatal health problems to be addressed by the community, and followed by a "planning together" phase in which community plans were developed by men and women to address problems identified in the prior stage. The last two stages were the implementation and participatory evaluation stages. In 1993, at the end of its three year implementation schedule, the project could claim responsibility for halving the number of detected cases of perinatal and neonatal mortality, doubling tetanus toxoid coverage and the proportion of women seeking prenatal care, increasing contraceptive use from 1 to 27 percent of women of reproductive age, and increasing the use of trained birth attendants from 13 percent to 57 percent in the last year of the project. The project spent approximately $67.50 per woman to implement reproductive health care interventions. The project methodology is being replicated through a network of NGOs working on child survival issues, however, it remains to be seen whether the Warmi methodology, whose success is based on careful design and quality implementation, can be replicated on a larger scale.

- **Adolescent pregnancy prevention: the Women's Centre Foundation of Jamaica.** The Women's Centre Foundation of Jamaica runs a drop-in center for adolescent mothers and fathers ages 9-15. The organization provides sex education and family life education, parenting skills and nutrition education, prevention of sexually-transmitted disease, individual counseling, family planning, job training and placement, day care, and a special program to help teen mothers return to school. The program has been successful; a recent evaluation demonstrated significantly higher school retention rates among program participants than their counterparts and higher wages among teen fathers.

- **Reproductive health care in the private sector: PROFAMILIA.** PROFAMILIA, a Colombian non-governmental organization (NGO), has provided comprehensive reproductive health services to Colombian women and men since 1965. The organization provides clinical contraceptive services; runs a community-based counseling and distribution program; manages a condom social marketing program to confront rising AIDS rates and provide a source of income; operates three clinics exclusively for men; a teen reproductive health center which runs a peer counseling program; and provides a full range of reproductive health services including infertility diagnosis and treatment, pap smears, pregnancy tests, gynecological exams, lab work, and treatment of sexually-transmitted diseases. In addition, the organization offers legal services, advising women of their rights and dealing with domestic violence and child support cases. The organization is completely self-sufficient through cost recovery and a donor-created trust fund, and provides technical assistance to similar organizations in the field. According to evaluation data, 60 percent of all couples of reproductive age in Colombia have used PROFAMILIA services to prevent unwanted pregnancies and receive reproductive health services.

- **Reproductive health through empowerment and income generation: the ReproSalud project in Peru.** Through a program of self-diagnosis of reproductive health problems, community action, and income generation activities, the ReproSalud project in implementation since 1995 works with women's organizations in rural and periurban areas to empower women to make informed use of existing reproductive health services. Six educational subprojects have been completed, and a comprehensive evaluation of the approach is anticipated for 1999.

References

Mehra, Rekha, ed. Taking women into account: lessons learned from NGO project experiences. Washington, DC: International Center for Research on Women, 1996.

Movimiento Manuela Ramos. ReproSalud (brochure and personal communication). 1997.

Population Council. "Jamaica: Teen Mothers Return to School," Alternatives. New York: Population Council, 1989.

Population Reference Bureau. Family Planning Programs: Diverse Solutions for a Global Challenge. Washington, DC: PRB, 1996.

Women's Centre Foundation of Jamaica. Evaluation. Kingston, Jamaica: WCFJ, 1997.

MALNUTRITION, MICRONUTRIENT DEFICIENCIES AND REPRODUCTIVE ILL HEALTH IN THE LAC REGION[i]

Protein-energy and micronutrient malnutrition are proximate determinants of women's reproductive morbidity and mortality.

- Throughout the developing world women die during pregnancy and in childbirth from hemorrhage (20-35%), unsafe abortion (10-15%), eclampsia or hypertension (10-15%), infection (10-15%), and obstructed labor (10-15%) (see Technical Note 1). Those that survive spend their reproductive years suffering from chronic anemia and the debilitating consequences of complications associated with reproductive events. This note describes how nutritional deficiencies in women of reproductive age set them up for these tragic outcomes and presents evidence of nutritional deficiencies among women in the LAC region.

The links:

- **Short stature can lead to obstructed labor:** Stunting (low height for age) in childhood leads to short stature in adult life. Stunted women have greater risk of obstructed labor due to cephalo-pelvic disproportion. The risks of death from obstructed labor increase when women give birth without skilled attendance or far from emergency obstetric services. A critical feature of short adult stature due to malnutrition is that it can only be modified during the first two years of life.

- **Undernutrition during pregnancy contributes to adverse outcomes including low birth weight (LBW):** Women who are undernourished prior to and during pregnancy (measured by low BMI[ii]) tend to have babies with intrauterine growth retardation leading to low birth weight (less than 2500 g). About 80% of LBW cases in developing countries are due to intrauterine growth retardation. LBW infants are at higher risk of dying during the perinatal period than babies born with normal weight. LBW infants whose birth weight was low for gestational age have higher risk of anemia and other micronutrient deficiences. Furthermore, LBW is an important determinant of morbidity and motor development up to age two. Small for gestational age babies are at increased risk of growth retardation as children. LBW children may also be at higher risk of developing chronic diseases as adults. Undernutrition due to insufficient protein/calorie consumption may become complicated by the fact that many poor women, especially in rural areas, are not capable of reducing the levels of physical activity during the last months of pregnancy, exacerbating their energy imbalance.
- **Nutritional anemia intensifies delivery complications:** Women suffering

from anemia (iron, folate and B12 deficiencies) are more likely to die from spontaneous abortions and postpartum hemorrhage than women whose blood hemoglobin levels are adequate[iii]. They are also at higher risk of pregnancy complications such as urinary tract infections and eclampsia. Anemia decreases the body's ability to fight infections. It increases the chances a woman will have LBW babies and endangers the survival of these infants. Severe anemia is an associated cause in over 50% of cases of maternal deaths in the developing world. The situation is complicated by the fact that iron requirements typically increase for women during pregnancy and lactation.

- **Vitamin A deficiency (VAD) increases susceptibility to infection:** Infection during pregnancy and the postpartum period is a danger to all women, but especially to those who are malnourished. Death during the postpartum period[iv] is just as high or higher than death during delivery, due to bleeding and infection. VAD reduces the body's capacity to fight infections. Inadequate vitamin A status appears to hasten the progression of AIDS. VAD during pregnancy increases the risk of HIV transmission by infected women to their fetuses three or fourfold. Unsafe abortions can be deadly to women with VAD due to heightened vulnerability to infection.

- **Obesity tends to increase with parity among urban women and predisposes them to cardiovascular and other chronic diseases:** Urban diets and sedentary lifestyles in Latin America have precipitated the epidemiological transition. High intakes of fat, refined sugars and processed foods, and little physical activity contribute to problems of obesity, diabetes, high blood cholesterol levels, and hypertension. Poor, urban women are at greatest risk of obesity. Overweight and obesity increase with each successive pregnancy. Pregnancy outcomes, both maternal and infant, are endangered by obesity. Cardiovascular and other chronic diseases, including cancers of the reproductive organs are causally related to obesity.

The evidence:

- **Short stature:** In the absence of data on low adult female height (<145 cm) and thinness, stunting in childhood (low height-for-age[v]) can be used. There is a strong positive relation between growth retardation in the first three years of life and short stature in adulthood. Unfortunately, height-for-age data are not reported by sex. In the LAC region two different trends emerge with regard to stunting in children 5 years and under:

  § South America in general has the lowest rates of stunting in the developing world. Yet Bolivia (26.8%, 1994-95), Ecuador (34%, 1986), and Peru (25.8%, 1996) are flagged as having extremely high prevalences for their subregion. Subregional average stunting prevalence stands at 12.9% (1995). Brazil accounts for the largest share of stunted children in the subregion—41%.

  § In contrast, Central America, Mexico, and the Caribbean experienced the least improvement in stunting rates over the last 10 years or so of the five developing regions. Overall, stunting rates are considerably higher among these countries than in South America, 27.8% (1995), with wide inter-country variation. Thus, Guatemala reports 49.7% of children with low height for age (1993) whereas Costa Rica reports 9.2% (1989) and Panama 9.9% (1992). Rural Mexico, with a stunting prevalence of 35.1% (1989) accounts for two thirds of the stunted children in the subregion. *Source: ACC/SCN, 1997.*

- **Undernutrition during pregnancy and LBW:** Data on protein-energy undernutrition, weight gain, and food intake during pregnancy are scant for the LAC region. LBW data can be used instead; although, this method will frequently underestimate the prevalence of maternal undernutrition since a mother generally acts as a buffer to the growing fetus, and her stores will be mobilized to depletion to protect fetal growth. National LBW data are available for 30 countries, albeit of variable quality. A full half of these countries have LBW rates of 10% or higher. A LBW rate of 10% or more is considered a signal of serious levels of malnutrition in pregnancy. Rates of 15% and up should trigger immediate public health actions according to the World Health Organization. The poorest countries in Sub-Saharan Africa exhibit LBW prevalences of 15-16%. In the LAC region, Brazil and Peru stand out as having LBW rates at odds with their level of economic development.

LBW Rates 10% or Higher by Country, 1990-1994, LAC Region

Country	LBW Percentage Rate
Guyana	19
Haiti	15
Guatemala	15
Nicaragua	15
Ecuador	13
Surinam	13
Bolivia	12
Brazil	11
Dominican Republic	11
El Salvador	11
Peru	11
Barbados	10
Belize	10
Jamaica	10
Trinidad and Tobago	10

Source: UNICEF, 1998

Nutritional anemia: Nutritional anemia is the most prevalent nutritional deficiency in the LAC region, especially among women of reproductive age, pregnant and adolescent women. Forty five million women in LAC suffer from iron-deficiency anemia. A third of the countries exhibit levels of nutritional anemia in pregnant women similar to those of Sub-Saharan Africa, that is, over 40%. In contrast, Canada has an astoundingly low 3%.

Anemia in Pregnant Women by Prevalence Group, 1985-1997

Group 1*: 40% and over	Group 2: Between 20 and 39%	Group 3: Below 20%
Peru (highest)	Panama (highest)	Chile
Belize	Honduras	
Jamaica	Paraguay	
Bolivia	Nicaragua	
Guatemala	Dominican Republic	
El Salvador	Bahamas	
Ecuador	Venezuela	
Colombia	Guyana	
Brazil (lowest)	Trinidad and Tobago	
	Barbados	
	Suriname	
	Costa Rica	
	Argentina	
	Uruguay	
	Mexico (lowest)	

*Although no data are available for Haiti, it probably falls in this group. *Source: Mora & Mora, 1998*

Vitamin A deficiency (VAD): Information available is not specific to women of reproductive age or disaggregated by sex. The estimations presented, prevalence of subclinical VAD in children <5 years[vi], most likely underestimate the level of deficiency among women alone and certainly underestimate vitamin A deficiency among pregnant and lactating women.

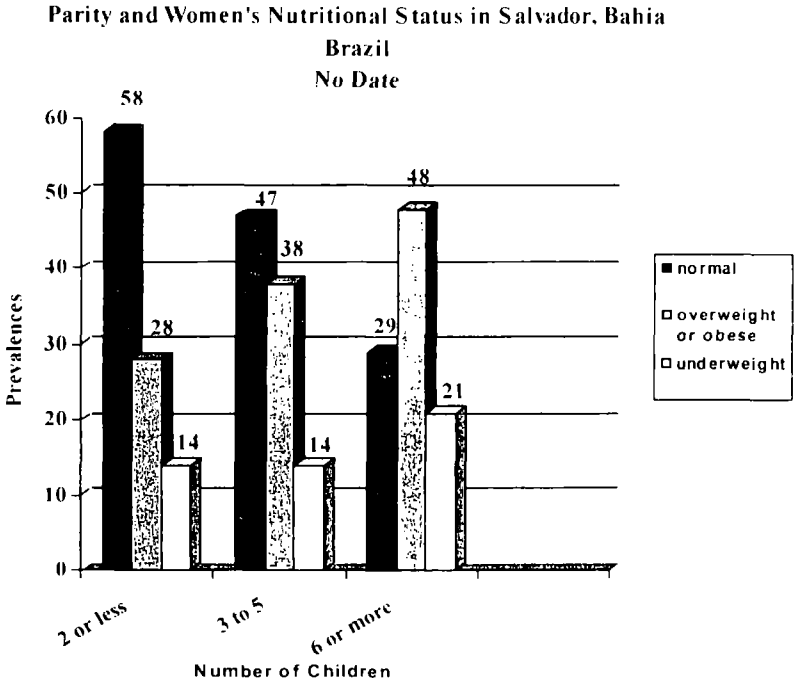
LAC Countries Classified by Degree of Public Health Significance of Subclinical VAD in Children, 1997

Severe >20%	Moderate 10-19%	Mild 5-9%	No Problem	Insufficient Information
Brazil	Bolivia	Argentina	Chile	English Caribbean
Dominican Republic	Colombia	Belize		Haiti
El Salvador	Ecuador	Costa Rica		Paraguay
Nicaragua	Guatemala	Panama		Uruguay
Peru	Honduras	Venezuela		
	Mexico			

Source: Mora & Mora, 1998

Obesity: Using the WHO definition of obesity (see end note 2), prevalences among Latin American women of reproductive age, with the exception of Haiti, are between 34 and 49%. More conservative definitions of the condition lower prevalences to 17 to 23%. Most of these women live in cities (except in Brazil, Mexico, and Colombia where they are equally distributed in rural and urban settings). In all countries, except Guatemala

and Haiti, there is a tendency for higher prevalences of obesity in poorly educated women. In the Dominican Republic, Guatemala, and Peru; girls have a greater tendency than boys to develop obesity.



Source: Martorell et al., 1998

- Recent data from Brazil (previous figure) illustrate the direct relationship between obesity and parity. It also illustrates how, in one same setting, repeated pregnancies are associated with maternal undernutrition in one sub-population and with obesity in another.

What can be done?

- **Design projects with both short- and long-term impact horizons:** Take into account that one intervention or set of interventions at one point in the life-cycle of one generation of women cannot break the cycle of malnutrition, poverty, and disease. In order for women to reach reproductive age with adequate nutritional status and to prevent stunting, they have to be well-nourished, especially intra-uterus and during the first two years of life. Commit to financing countries with the worst female nutritional problems for the long-term and plan consecutive and progressive health and nutrition projects to improve infant and child nutrition cross-generationally.

- **Finance essential drugs procurement programs that include iron-folate and vitamin A tablets.**

- **Target adolescent girls through multisectoral programs or through health, nutrition, and education projects**: Provide services to delay first pregnancy, distribute micronutrient supplements (iron-folate and vitamin A), administer anthelminthics, offer education and treatment for STDs, treat malaria, provide immunization for or treat TB, involve the male partners. School-based nutrition programs should target pre-puberal and adolescent girls for micronutrient supplementation. Promote physical activity among adolescents, especially girls living in cities.

- **Target pregnant adolescents:** Pregnant adolescents should be targeted for promotion of improved diets and micronutrient supplements. In populations with undernutrition problems, balance diets should be promoted. If food supplements are available, they should be targeted to pregnant teens. These women need to increase their daily caloric intake to cover their physical growth needs and those of the growing fetus as well as the nutritional demands of lactation postpartum. In populations with obesity problems, weight and physical activity should be managed. Introduce family planning education and referral during the prenatal period; provide family planning referrals and services to women and their partners during the post-partum period.

- **Use windows of opportunity to reach pre-pregnant women with nutritional services:** Reproductive health programs for non pregnant women (family planning, STD screening and treatment, sexual education, pregnancy prevention for adolescents, etc.) are adequate but little utilized "entry points" for nutritional interventions at critical life-cycle stages in order to address maternal nutrition issues before women become pregnant, including issues of overweight and obesity. The latter are particularly relevant to reproductive health programs to space or limit births.

- **To combat anemia**: Promote pregnancy prevention; promote the delay of first pregnancy until past 18 years. Provide iron-folate supplementation to pre-pregnant women, especially adolescents who are anemic or borderline; provide iron-folate supplements during the second and third trimesters of pregnancy (if daily, provide one ferrous sulphate tablet of 60mg elemental iron + 400mg folic acid). Explore possibilities for Bank financing of national iron food-fortification programs. Provide deworming drugs in schools, health centers, etc.; especially treatment for hookworm. Introduce effective IEC projects to change household-level dietary patterns. Promote and actively support lactation to extend lactational amenorrhea, reduce iron loss, and delay next pregnancy. Pay attention to the micronutrient composition of complementary foods fed to girls and boys 4-6 to 24 months.

Promote and support breastfeeding: Help women initiate and sustain exclusive breastfeeding for as long as feasible up to 4-6 months and promote lactation up to 2 years. Lactation benefits women by lowering the risk of post-partum hemorrhage, pregnancy, anemia, and breast and uterine cancer. By increasing child spacing (exclusive), breastfeeding increases the inter-gestational period and decreases the exposure to maternal mortality risks. Although breastfeeding also increases a woman's nutritional demands, the known benefits of lactation to women and their children outweigh the risks of maternal malnutrition. Breastfeeding may also influence post-partum weight and reduce the tendency for obesity with increased parity.

- **Integrate nutrition services in prenatal and post-partum care:** Incorporate focussed and highly effective nutrition measures in safe motherhood programs. Key services include iron supplementation (daily or weekly iron-folate tablets); supplementation with vitamin A (one 200,000 IU megadose) only during and up to the 6th week postpartum; anthelminthics (single dose during 2nd or 3rd trimesters); screening for and treating malaria (or presumptive treatment of pregnant women in high endemic areas), especially in primigravidae with a safe antimalaria drug; measures to reduce physical activity and workload during the last trimester (appropriate technologies for household work, transportation to health establishment, targeted income transfers); and improved IEC measures to ensure adequate weight gain during pregnancy, especially in adolescents and promotion/support of breastfeeding. This is also the time to promote adequate and active complementary feeding for infant girls and boys 4-6 to 24 months, including supplementary foods and fortified complementary food mixes, to promote optimal longitudinal growth and, eventually, reduce adult stunting in women.

- **Integrate, integrate, integrate:** Integrate key nutrition/health services for women in programs targeted to their children. Child survival programs and integrated management of childhood illnesses initiatives are little used opportunities to provide women with nutrition services between and during pregnancies. Deworming; TB; malaria and STD prevention; screening and treatment; micronutrient supplementation; lactation promotion; IEC for improved food intake and targeted food supplements to malnourished women, pregnant adolescents, and undernourished lactating mothers are all measures whose integration in child-centered programs do not posit insurmountable logistical challenges given that most of these programs already provide these services to children. Diet-based weight management and promotion of physical activity among overweight and obese women post-partum can also be adequately addressed in this type of program.

Target, target, target: IEC to promote and support balanced diets should effectively target women. Supplementary feeding should effectively target malnourished women, pregnant adolescents, and women who are lactating. Food supplements should go to the lactating mother, not to the infant less than 6 months. Ensure targeting is effective by involving male partners to promote adequate intra-household food distribution; presenting food commodities in ways more appealing to women (snacks, cookies); encouraging consumption of supplements as "between meals" foods; installing feeding sites near residential districts to directly deliver them to women; and/or distributing food supplements in "ready-made" form to be consumed immediately.

References

Administrative Committee on Coordination/ Subcommittee on Nutrition. ACC/SCN. "Third Report on the World Nutrition Situation." Geneva: ACC/SCN. 1997.

Allen, L.H. (ed.). Recent Developments in Maternal Nutrition and Their Implications for Practitioners. *American Journal of Clinical Nutrition*, 59 (2S): 437S-545S. 1993.

Baker, J.; L. Martin; and E. Piwoz. The Time to Act: Women s Nutrition and Its Consequences for Child Survival and Reproductive Health in Africa. Washington, D.C.: Academy for Educational Development, SARA Project, 1996.

de Nóbrega, F.J. "Projeto de Atencao a Crianca Desnutrida em Areas Urbanas." Manuscript. n.d.

Huffman, S.L. "Maternal Malnutrition and Breastfeeding: Is There Really a Choice for Policy Makers?" *Journal of Tropical Pediatrics*, 37 (Supp. 1): 19-22.1991.

Martorell, R.; L.K.Khan; M.L.Hughes; and L.M. Grummer-Strawn. "Obesity in Latin American Women and Children." *Journal of Nutrition*, 128:1464-1473. 1998.

Merchant, K.M. "New Directions in Policies to Improve the Nutritional Status of Women." Women's Health and Nutrition Work Program Working Paper Series. Washington, D.C.: The World Bank, 1993.

Mora, J. and O. Mora. Micronutrient Deficiencies in Latin America and the Caribbean. Washington, D.C.: Pan American Health Organization. 1998.

Tinker, A.G. and M. T.H. Post. "The Influence of Maternal Health on Child Survival." Paper prepared for Annual American Public Health Association Conference. 1991.

UNICEF. "The State of the World's Children, 1998." New York: UNICEF. 1997.

Walker, S. "Nutritional Issues for Women in Developing Countries." *Proceedings of the Nutrition Society*, 56: 345-356. 1997.

World Bank. "World Development Report, 1993: Investing in Health." Washington, D.C.: The World Bank. 1993.

MAKING THE CONNECTION BETWEEN REPRODUCTIVE ILL HEALTH AND POVERTY IN LATIN AMERICA AND THE CARIBBEAN

- **The connections between poverty and reproductive ill health, as expressed through high fertility and perinatal mortality, are multidimensional.** Conceptually, poverty is both a determinant and a consequence of reproductive ill health, either directly or through a series of proximate determinants. The links between poverty, low educational attainment, high fertility, and poor child and maternal health are well documented. Fertility decreases monotonically as education increases. Across Latin America and the Caribbean, women who live in urban areas and women who work for cash have fewer children than do other women. A mother's death during childbirth means not only the loss of her productivity to both the national economy and the household, but also has an inter-generational effect through her child's reduced chances of survival and health. Studies show that surviving children are three times more likely to die within two years than children who live with both parents; and many motherless children, particularly girls, get less health care and education as they grow up. Thus a mother's sickness and death affects her household's socioeconomic status, and this status in turn affects the proximate determinants of health.

- **Socioeconomic inequalities in the distribution of high-risk fertility and mortality and in the use of services affect the distribution of human capital.** This is particularly disturbing since recent studies show that the distribution of human capital (see Technical Note 3) affects overall rates of economic growth, and the current highly inequitable distribution patterns in Latin America and the Caribbean affect the income growth of the poor disproportionately (Birdsall and Londoño 1997).

- **Social status, a distal determinant of fertility, acts on fertility levels through "proximate determinants," such as age at marriage, use of contraception, and duration of breastfeeding[1]. Proximate determinants of fertility do not simply act on fertility, they act on a woman's entire life, thereby recreating poverty conditions for women and their children.** In Bolivia, poor women marry in their teens and have very high fertility up to the age of 30, while the poorest women marry even younger and continue to have children throughout their entire reproductive lives (Vidal-Zeballos 1994). These reproductive patterns have profoundly negative implications for women's life choices in schooling, employment and child care.

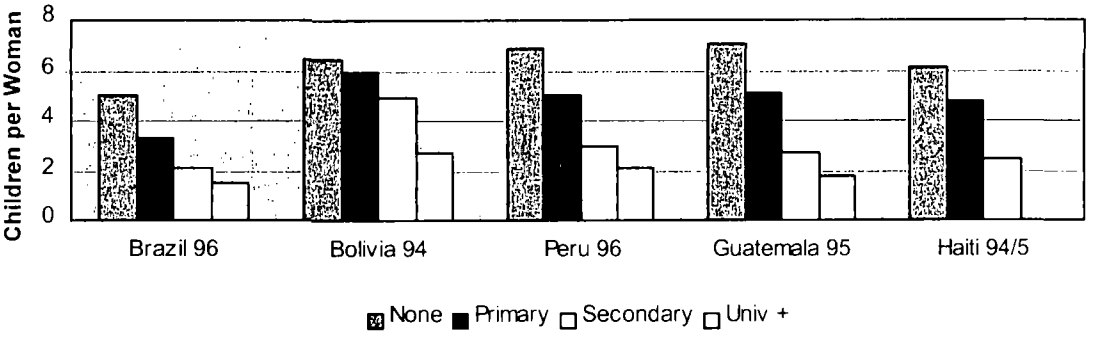
---

[1] Studies have found that between 94 and 97 percent of variations in fertility levels can be explained by these three proximate determinants (Bongaarts 1978, 1982; Bongaarts and Kirmeyer 1982; Vidal-Zeballos 1994; and others).

- Using educational attainment[vii] and place of residence[viii] as a proxy for socioeconomic status[ix], indicators of fertility and perinatal (neonatal) mortality coincide with socioeconomic disparities in the region. Fertility is higher among rural than urban women and women with primary or no education compared to women with secondary education and above. Perinatal mortality among these women is highest, as is maternal mortality. Attended births predominate among urban, relatively well educated women.

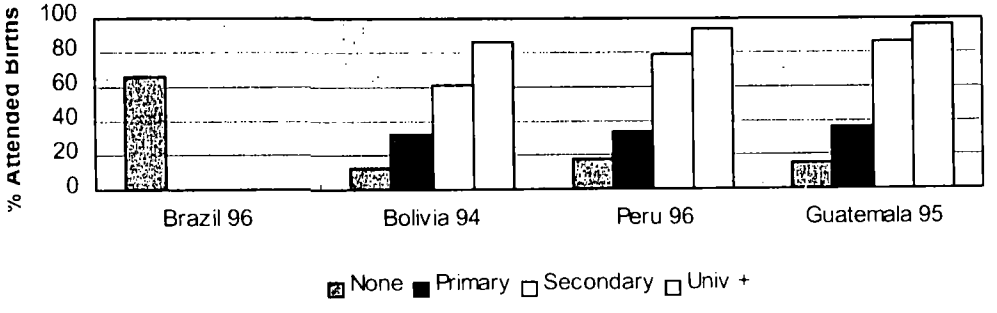
There are striking differentials in the number of children a woman will have over her lifetime according to place of residence and the level of a woman's educational attainment. Urban-rural differentials in fertility have narrowed in most countries over the past two decades, but widened in Peru and Mexico (Muhuri et al 1994). Other studies show that while total fertility has declined over time, the sharp differences in Latin America and the Caribbean between poor countries and rich countries and, within countries, between the poor and the rich has been maintained over time (CELADE 1997). Women who work for cash for a non-family enterprise have lower fertility than non-working women. The difference in TFRs is more than 2 children in Bolivia and Guatemala and approximately 1.5 children in Brazil, Ecuador and Trinidad and Tobago.

Total Fertility Rates and Educational Attainment



Service utilization follows these same inequitable patterns. The number of births attended by trained personnel (medical doctors, nurses and trained midwives) varies dramatically between educational groups. This is a well-known finding: in Peru, individuals in rich and poor households have roughly equal chance of being ill at any given time; but of those who fall ill, individuals in wealthy families are twice as likely to obtain care (Baker and van der Gaag, 1993).

% Attended Births by Educational Attainment



Indigenous women. The Guatemala survey found that indigenous women had 2 more children on average than *ladina* women, that indigenous women experienced 5 additional infant deaths per 1,000 live births, and that only 11.7 percent of indigenous women received trained medical care during delivery compared to 52 percent of *ladina* women.

- Data for this note came from nationally and sub-nationally representative samples surveyed in the Demographic and Health Surveys program conducted in Brazil in 1996, Bolivia 1994, Peru 1996, Guatemala 1995 and Haiti 1994/5. Further work should be done on the burden of reproductive ill-health by socioeconomic status and further analyses of Demographic and Health Surveys data can provide us with an index of household assets that could be cross-tabulated with less examined measures such as pregnancy complications, sexually-transmitted disease reports, ethnic/language groups and other parameters.

Glossary

Maternal mortality ratio: the number of deaths to women due to pregnancy and childbirth complications per 100,000 live births in a given year (also called *maternal mortality rate*).

Perinatal mortality rate: the number of fetal deaths after 28 weeks of pregnancy (late fetal deaths), plus the number of deaths to infants under seven days of age, per 1,000 live births.

Total fertility rate (TFR): the average number of children that would be born alive to a woman (or a group of women) during her lifetime if she were to pass through her childbearing years conforming to the age-specific fertility rates of a given year.

References

Baker, Judy and Jacques van der Gaag. "Equity in health care and health care financing: evidence from five developing countries," in van Doorslaer, Eddy, Adam Wagstaff, and Frans Rutten. Equity in the finance and delivery of health care: an international perspectives. Oxford: Oxford University Press, 1993.

Bicego, George T. and J. Ties Boerma. Maternal education, use of health services, and child survival: an analysis of data from the Bolivia DHS. Calverton, MD: Macro International Inc., December 1990.

Birdsall, Nancy and Juan Luis Londoño. Asset inequality does matter: lessons from Latin America. Washington, DC: Inter American Development Bank, March 1997.

Centro Latinoamericano de Demografía (CELADE). Impacto de las tendencias demográficas sobre los sectores sociales en América Latina. CEPAL/CELADE/BID, 1996.

Muhuri, Pradip K., Ann K. Blanc and Shea O. Rutstein. Socioeconomic differentials in fertility. Calverton, MD: Macro International Inc., May 1994.

Tórrez Pinto, Hugo. Características socioeconómicas y culturales de las mujeres con necesidad insatisfecha en anticoncepción y su relación con los diferenciales de la fecundidad. Calverton, MD: Macro International Inc., September 1994.

Vidal-Zeballos, David. Social strata and its influence on the determinants of reproductive behavior in Bolivia. Calverton, MD: Macro International Inc., May 1994.

END NOTES

[i] Thanks to Chessa Lutter of the Food and Nutrition Division of the Pan American Health Organization for serving as external reviewer for this note.

[ii] BMI: In adults nutritional status is not assessed with reference to age, as it is in children. Body-mass index is a measure that relates an adult's weight to his/her height squared. Cut off points for thinness and obesity provide guidelines for interpretation of index values. Although no international guidelines have been adopted, WHO criteria defined female obesity as being equal to or greater than BMI 25.

•

[iii] Anemia is defined as hemoglobin <110 g/l in pregnant women, <120 g/l in non-pregnant women.

•

[iv] Postpartum or puerperium is a four-to eight-week time interval starting 24 hours after delivery.

•

[v] This measurement reflects linear growth achieved both intra-uterus and post-natally. Deficits in height for a given age are indicative of long-term, chronic and cumulative effects of inadequate food intake, care and health. Stunting is defined as 2 or more SD below the median of the international growth reference curve.

•

[vi] Percentage of the population with serum retinol levels <20μg/dl.

vii.

Education is strongly correlated with income. The "positive correlation between education and earnings is indisputable and universal." (Psacharopoulos 1994)

viii.

Rural residence is strongly associated with lower income levels. Although many countries are highly urbanized, the countries highlighted in this analysis vary. In 1990, Brazil's population was 26.1% rural, Bolivia's 47.6% rural, Peru's 30%, Guatemala's 61.9%, and Haiti's 69.4%. Furthermore, migration between rural and urban areas has plateaued since the 1970s; leaving interurban migration the primary population movement in the region.

ix.

Place of residence and educational attainment were used as proxy measures for socioeconomic status because Demographic and Health Surveys (DHS) data do not collect information on household income. However, the DHS does collect information on household characteristics that may be combined to form a household assets index. In a future version of this note, household assets will be used to complement place of

residence and educational attainment descriptors. In any case, place of residence is strongly associated with income levels in LAC, with urban areas (including peri-urban areas) relatively well off when compared to rural areas. The same holds true for educational attainment. Higher levels of education are associated with higher levels of household income, the converse is also true.

PRESENTATION 3

THE IMPACT OF EARLY CHILDHOOD INTERVENTION PROGRAMS ON ECONOMIC GROWTH AND EQUITY

INTRODUCTION

In the early nineteen seventies in Colombia a group of economists became aware of research by nutritionists, some of it carried out in our country, which showed that malnourished children became seriously impaired physically and intellectually, and that the harm produced might not be reversible. When drawing up the development plan for 1975 / 78, which had as an objective the decrease in poverty and maldistribution of income, an infant nutrition program was made one of the strategic aspects of government policy. The Plan document, which was titled «To Close the Gap» in reference to the policy of decreasing inequality, analyzed the benefits of an infant nutrition plan in very similar terms to those that are now used to justify the initiation of early childhood intervention projects.[1] The assumptions behind the program were:

1) An adequate diet has a beneficial impact on the health of children and mothers, and therefore decreases the call on funds from the public health system.

(2) The elimination of malnutrition affects positively the productive capacity, both physical and intellectual, of the labor force both in the present and future generations.

(3) An appropriate nutrition intervention increases the productivity of educational investment, by increasing the study and absorption capacity of students, as well as diminishing school desertion rates.

(4) A large proportion of foodstuffs is produced in Colombia by small holders, and a food supplement program will benefit the poorest groups in the agricultural sector by increasing the demand for foodstuffs.

• **Governor Central Bank of Colombia. Document presented at the Seminar "Breaking**

---

[1] Departamento Nacional de Planeación. Para Cerrar la Brecha; Plan de Desarrollo Social, Económico y Regional 1975-78. (Bogotá, República de Colombia, Departamento Nacional de Planeación, 1975.)

the Poverty Cycle: Investing in Early Childhood", organized in the Annual Meeting of the Boards of Governors of the Inter-American Development Bank. Paris France, March 14th, 1999. The views expressed in this conference are the author's, and do not reflect the official position of Banco de la República or its Board of Directors.

(6) The water supply component of the nutrition plan also improves nutrition and health.

(7) The food coupon program also had a nutrition education component and was implemented through health posts and pre-school centers.

The nutrition program was presented to the World Bank, which approved in record time a loan for its implementation. At the same time, the IDB and World Bank approved loans for ambitious integrated rural development projects which were to increase the production of foodstuff that would facilitate an improvement in nutrition.

The evaluation of the nutrition plan was quite positive,[2] but the food supplements program was discontinued during the fiscal crisis of the eighties.[3] Clearly the benefits of the program had not created powerful stakeholders to defend it. The integrated rural development programs were also fairly successful, unlike the experience in many other countries, and these programs have continued, with ups and downs, for twenty years. The integrated rural development programs turned out to be politically more popular, in part because community participation mechanisms were included in the definition of the projects to be supported.

At the same time in 1974, very much on the initiative of Ms. Maria Elena de Crovo, as labor minister, the Government established a 2% payroll tax to finance day-care centers. Ms Crovo, who was a former union activist, was motivated by the desire to improve the lot of working women, and originally the idea was to create the day-care centers at, or near, the place of employment of working mothers.

The payroll tax which later was increased to 3%, produces substantial revenues and gives the Instituto de Bienestar Familiar, which supports the day care-centers, independence from budget cuts at times of fiscal adjustment. The day care center program has expanded substantially and has traditionally given nutrition supplements.

---

[2] Tomas Uribe Mosquera, "The Right to Food: A Critical Review" in Government of the Netherlands, Seminar on Food Aid, Report of the World Food Programme (The Hague , 3-5 Oct. 1983)

[3] Tomas Uribe Mosquera "The Political Economy of Colombia's PAN " in Per Pinstrup- Andersen. The Political Economy of Food and Nutrition Policies. (Washington: IFPRI, 1983)

The first lesson from the experience described above is one of political economy. Why do some early childhood interventions survive and others not? The Colombian experience suggests that the design of the programs must take into account the creation of groups ready to defend them. The nutrition program was coordinated among many executing agencies by the Planning Department. None of the agencies felt the program as their own, and the Planning Department is an institution made up of high level technocrats with high turnover and many objectives. The Department is not the type of bureaucracy that depends for its budget or continuity on a specific program, and the idea of discontinuing the program came from the head of the Department after a change in the government

The child care program, on the other hand, was given independent resources and was in charge of a permanent bureaucracy whose main objective is child development. Children and mothers of poor families have little political clout, but a dedicated bureaucracy has been shown to defend successfully social programs, as long as care is taken that the bureaucracy does not absorb the bulk of resources in its own salaries, as has happened with the teacher's union in Colombia and other countries. Employed women are also more likely to organize to defend day care centers, which are a necessary complement for their labor force activity, than pregnant or lactating mothers are able to organize in defense of food supplements.

The nature of the nutrition problem also changed rather rapidly in Colombia. Tomás Uribe has shown how malnutrition changed from being predominantly a rural phenomenon in Colombia to being primarily an urban problem, in the short span of a decade (1972-1981). Economic growth and improvements in income distribution lowered nutrition insecurity from affecting the 40% poorest portion of the population in 1971, to affecting from 10% to 20% in 1981. At the same time, the risk of nutrition insecurity was higher in urban areas than in rural areas by 1981. Food insecurity passed from being 70% rural in 1972 to being 60% urban in 1981[4]. These changes required major strategic adjustments in the nutrition programs which were not carried out.

The new consensus with respect to the need for early childhood intervention.

Even during the time of the nutrition program, there were more integrated childhood intervention programs being carried out in Colombia with very impressive results on health and school performance of the participating children. Particularly impressive was the health and day care program carried out by the Fundación de

---

[4] Tomás Uribe Mosquera, "Revaluación de la inseguridad alimentaria en Colombia" Coyuntura Económica, Vol XVII No 1, April 987.

Investigaciones de Ecologia Humana in Cali[5]. The problem with such a program, however, was that it had a higher cost per child. These type of programs are much closer to what today is considered the correct type of early childhood intervention programs.

Apparently the most effective programs aimed at children in the early years of life consist of a combination of nutrition , health care and cognitive development components[6]. Generally speaking, Early Child Development (ECD) programs are expensive. It is therefore important to design them such as to ensure a high benefit/cost ratio.

The renewed interest in early childhood is stimulated by a growing body of evidence from a diverse array of disciplines that continues to confirm that the period of early childhood, from conception through at least age 3, is critical to a child's development. Research and clinical work have found that the experience of the infant and young child provides the foundation for long-term physical and mental health as well as cognitive development [7]. Early childhood interventions are formal attempts by agents outside the family to maintain or improve the quality of life of youngsters, starting with the prenatal period and continuing through entry into school.

The effects of health care, nutrition, and mental stimulation on children's mental and emotional growth -as reflected in their ability to master ever more complex activities- and physical growth are synergistic and cannot be broken up into separate domains. Integrated programs therefore seek to address all of children's basic needs. In addition to food, protection, and health care, child care programs must also provide affection, intellectual stimulation, supportive human interaction, and opportunities and activities that promote learning.[8]

If improved life chances only occur as a result of actions in all these areas, it is clear that Early Child Development Interventions can be quite costly. Given limited Government budgets, such programs will not be implemented unless the

---

[5] Harrison Mckey and others, "Improving Cognitive Ability in Chronically Deprived Children", Science vol 200 (april 2, 1978)

[6] Jacques van der Gaag and Jee – Peng Tan "the Benefits of Early Child Development Programs; An economic Analysis".

[7] Lynn Karoly et al, Investing in our children (Washington D.C.: RAND, 1998)

[8] Mary Eming Young; Early Child Development: Investing in the future. (Washington: The World Bank, 1996). P. 4

benefits exceed by a substantial amount the costs.

It is useful therefore to list some of the benefits of these programs.

(1) The most immediate benefit is to facilitate the labor force participation of mothers from low income families. This reduces poverty, improves nutrition, and reduces fertility.

(2) The benefits for children will only be evident after many years. But longitudinal studies show that the influence of early environment on brain development is long lasting. There is evidence from some evaluation studies showing that infants exposed to good nutrition, toys and playmates had measurable better brain function at twelve years of age than those raised in a less stimulating environment. This is particularly true for participants in these programs that come from the poorest households.

(3) Participating children have higher school enrollment rates, less repetition and fewer of them drop out of school. Not surprisingly, in the evaluations of some U.S. programs, where monitoring of participants has been carried out for more than two decades, the income of participating children is much higher at age 27 than for non-participants.[9]

(4) Child care centers allow girls to go to school instead of caring for their younger siblings.

(5) In the survey of U.S. programs Rand was able to identify four programs that attempted to measure crime and delinquency behavior among youth when they were followed at older ages. In the four cases, the results were generally favorable with lower incidence and seriousness associated with juvenile offenses of those in treatment versus control groups[10]. This finding is particularly relevant for Colombia and other South American countries were the incidence of crime is high. By itself this result would justify such programs in many of our societies.

Quantifying the benefit/cost ratio of Early Child Development Interventions.

To justify early child development programs it is very important to design

---

[9] Lynn A. Karoly et al, op. cit. p. 36

[10] Lynn A. Karoly et al, op. cit. P.67

evaluation methodologies which make possible the quantification of the benefits of the program. Unfortunately such methodologies have seldom been included in the programs. In particular, control groups have not been identified and followed for comparison purposes with the children that participate in the programs.

In the United States some programs have provided sufficient information for children participating and for control groups. RAND has surveyed the literature on these programs and has identified substantial benefits for the children participating as well as savings for the Government in less use of welfare, special education, and less crime. The savings are greater than the costs of the program.

Such savings may be less in developing countries where there are fewer welfare programs. An evaluation of a specific program of early child development in Bolivia (the PIDI), however, estimates benefit/cost ratios of between 2.38 and 3.10 [11]. This implies a very high rate of return on the investment.

Most of the measured benefits have to do with improved schooling for the PIDI participants, which in turn generates more highly productive workers. The increase in labor force participation of the mothers also increases family income significantly.

The lack of adequate evaluation procedures, however, leaves us in the dark about what sort of early childhood intervention programs produce the most benefits. Given the high cost of the programs, it is crucial to design them is such a way that they can be evaluated, so that the most efficient combination of interventions can be adopted.

Low cost versus costly integrated programs.

From 1982 to 1986 Turkey's Early Enrichment Project, seeking the optimal combination of home-based and center-based custodial and educational day care services for very young children, studied effects of different approaches on preschool-age children. While educational day-care got the best results in all measures of psycho social development, the children whose mothers had received training and outside support also showed significant gains.[12] Since the latter system is less costly, it is more attractive for cash-strapped governments. On the other hand, the benefit/cost ratio may be lower and the promotion of equal opportunity for all children less. In Turkey it was decided to choose the cheaper model -parental education- instead of the center-based care.

---

[11] Jacques van der Gag and Jee-Peng Tam op.cit p. 33

[12] Mary Eming Young, op. Cit.,p, 57

Although less desirable from the point of view of improving income distribution and creating equal opportunities for all young people, the lower cost programs may still have high rates of return on investments in human capital. Such seems to be the case of the Bolivia PIDI project (Proyecto Integral de Desarrollo Infantil). The program consists of non-formal home based day-care centers where children receive nutrition, health and cognitive development services.

The environment of the home based programs may be, however, less than optimal. In the Colombian Hogares de Bienestar Program, the day-care is carried out in the homes of volunteer mothers. It appears that often these homes have inadequate sanitation, dirt floors, too small a space per child and the education and play stimulus for the children is absent. In addition, the day care volunteers do not recognize the signs of malnutrition, the nutrition supplements are inadequate, and there is very little training of day care helpers and mothers on health. Those deficiencies may diminish seriously the benefits to the children. It is interesting that the agency in charge of the program resisted for many years the possibility of and independent outside evaluation, and when such an evaluation was carried out it identified all of the above problems.

On paper, however, the program looked very impressive. It covered 745,100 children 0-6 years old, and 84% of the target group (the poorest 2 of 6 economic strata). An inadequate evaluation procedure, however, makes it difficult to say whether the program has produced tangible benefits. What has been shown, however, is that the better quality day- care centers do produce better results than the average for the program in terms of nutrition, health, and psychosocial behavior.[13]

In most social programs the high costs are due to salary payments. If that is the case, then it is a mistake to skimp on investing on the physical infrastructure for the day care centers and didactic and cooking materials. Investment in such centers would guarantee a better environment for the child, and yet most of the cost of the program would continue to be caused by the payment of the honoraria of volunteer mothers and the administrative apparatus of the program.

Another interesting result of the evaluation of the program in Colombia was the finding that the health and nutrition status of the children was highly dependent on the prenatal care received by the mother, and this is not a component of the early childhood intervention program. The nutrition program of the 1970's had a very interesting program of food coupons distributed by health centers at the time of the prenatal visits. The coupons were a good incentive for mothers to go to the health centers, and at the same time the nutrition supplements and the health care and health

---

[13] ICBF, Primera Encuesta Sistema de Evaluación de Impacto Hogares Comunitarios de Bienestar Social,
(Bogotá : ICBF, 1997)

education provided on the visit helped avoid low weight babies. It would seem that a coordinated approach through health centers and day- care centers might be an effective way to reach children from birth to 6 years.

In summary, although the best early childhood intervention programs may be well targeted integrated programs carried out in very good facilities, it may be possible to increase coverage by designing more participative programs, with volunteer or semi-volunteer helpers. It is important not to allow the staff of the program to absorb in salaries ever greater proportions of the assigned revenues.

Despite the emphasis that has to be put on avoiding large fiscal expenditures in the present fiscal crisis in most latinamerican countries, it should be mentioned that some estimates on the cost of equalizing access to education , including preschool education and health services, comes out at 1% of GNP for most countries in the continent [14]. This is a small cost for breaking the vicious cycle of intergenerational transfer of poverty.

CONCLUSION

In many Latin-American countries progress has been very slow both in the reduction of poverty and the improvement of income distribution. One of the major causes of this failure has been the excessively slow increase in the universalization of education. Despite dedicating a not insubstantial proportion of GNP to public education, school enrolment rates are disappointing. While according to UNESCO Colombia spent 3.5% of GNP in public education, Hong Kong spent 2.8% and Korea 3.7%. Yet in Colombia only 61% of an age cohort finishes the 5th grade, against 100% in Korea and Hong Kong.

Clearly if a better distribution of education is a necessary condition for an improvement in income distribution and a reduction in poverty , then measures must be taken to increase school enrolment, retention rates, and to decrease grade repetition. All evidence suggests that the best way to achieve these changes is early childhood intervention programs of the sort that have been described here.

Universal coverage in both primary and secondary education not only improves income distribution. All economic growth models also show that increased education is a major determinant of rapid economic development.

In addition, early childhood intervention programs provide other valuable benefits. Greater equality of opportunity between men and women, higher female

---

[14] Jacques van der Gag and Donald R. Winklar, " Children of the Poor in Latin America and the Caribbean", in World Bank , Annual Conference in Development in Latin America and the Caribbean, (Washington PC, 1998)

labor force participation rates, decreased fertility, and better health. An additional benefit of great value is a probable decrease in the incidence of crime and antisocial behavior, through better interpersonal relations within the family and less domestic violence.

What is not so clear is the type of early intervention which is most effective. Clearly the effects on a child's potential are better if the program includes health and nutrition monitoring , day care, and preschool education , but such a program can be quite expensive and most developing countries have limited fiscal resources. There is therefore a need to determine the components of programs that at a reasonable cost produce the desired benefits, particularly in the area of school enrolment and retention.

Determining an adequate design for the programs will require that all the different projects financed by IDB include a methodology for following the children that participate and compare them to a control group. The resulting cost/benefit analysis can help determine the type of programs that in the future should be carried out.

Defining the technical aspects of the programs is important because in the absence of some degree of scientific consensus on what components must be included in the projects, there will be delays in their implementation and excuses for not carrying out the program in favor of disadvantaged children.

I remember the never-ending discussions, when the Colombian nutrition plan was in preparation, on whether the important thing was to attack protein or calorie deficiencies, and what type of food supplements to give. It was also an exhausting task to determine what agency should be in charge of which service, and how to target the programs to the poor.

I believe international experience has now provided answers to many of the technical problems that concern the design of early childhood intervention programs. But serious evaluations can help to determine the degree of trade-of acceptable between lower quality and less professional services delivered at low cost and higher quality but more expensive programs. Clear research results will avoid many delays in design and implementation, and make arguments against the programs less convincing and effective.

In my experience the strongest arguments that those opposed to investing in education use is that public schools are of such low quality that they are a waste of money. I hope this argument about quality will not deter investments in programs targeted at vulnerable children.

Paris, France; March 14th, 1999

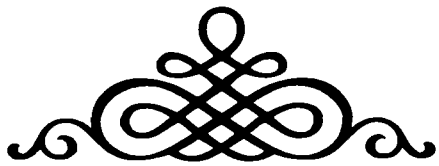
Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

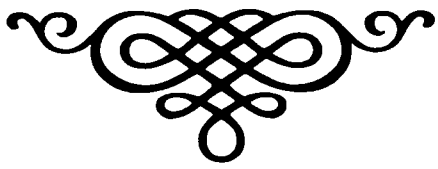
This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

9

Divider Title: _____



PROJECT 1

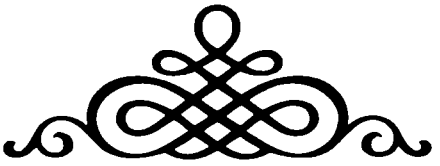


THIS DOCUMENT

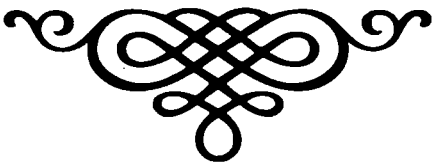
WILL BE DISTRIBUTED

DURING THE

TECHNICAL MEETING



PROJECT 2

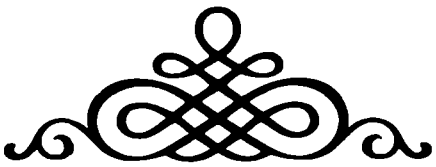


THIS DOCUMENT

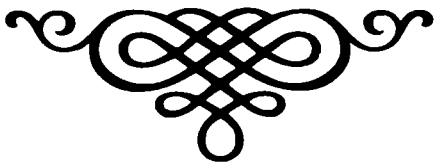
WILL BE DISTRIBUTED

DURING THE

TECHNICAL MEETING



PROJECT 3



Organization: **United Nations Children's Fund**

Project: **Early Childhood Care for Survival, Growth and Development (ECCSGD) in Latin America and the Caribbean**

Presenter: **Dr. Gladys Acosta**

Description

The main objective of this project is to promote the development of policies, strategies and programs in line with the rights and gender approaches that favour increased coverage of and improvement in the quality of child care and early education services, to guarantee the integral development of the children's potential during their early childhood.

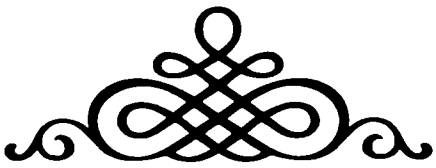
The following activities have been organized to reach this objective:

- development of research or processes for "best practices on ECCSGD" for the region;
- development of audio-visuals on ECCSGD in order to achieve a greater impact on advocacy and resources mobilization; and
- organization of a ECCSGD network using a team of specialists and institutions from various countries in the region.

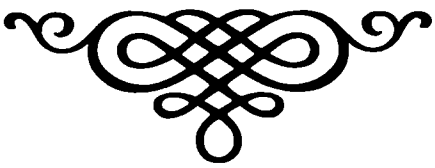
Context/Background

Learning begins at birth. Indeed, it is the learning that takes place from the first hours of life, which continues as children enter formal education systems and beyond, that can provide them with the skills and values they need to make the most of their lives.

Early childhood should not only be seen as a period during which children need care to ensure their survival, their physical well-being and protection against illness. Care and education should also provide the cognitive and psychosocial development of all children without any sort of discrimination. They should guarantee the satisfaction of children's needs, and should give priority to the acquisition of skills and capacities that have been shown to be the keys to life. They should also encourage the development of such values as tolerance, respect, solidarity and autonomy, which determine the attitudes that children will have later about themselves, others and society in general.



PROJECT 4



Organization: **Organization of American States - Unit for Social Development and Education**

Project: **Cooperation between the Health and Education Sectors in Support of a Comprehensive Approach to Child Development**

Presenter: **Dr. Gaby Fujimoto**

Description

This project intends to foster joint efforts between the health and education sectors to create a healthy and educational environment that favours the comprehensive development of Latin American children. The project is divided into three major areas of action. The first pertains to early childhood development, targeting the family, community and health and education workers. The second is the design and implementation of programs with a focus on child development. Finally, the third involves political and social activities to disseminate information on the project, including the launching of public awareness campaigns. Six countries will participate in the first phase of the project, and an additional six will join annually until the third year, making a total of 18 participants.

Expected Results

The project will produce comprehensive education models for children, families and their communities, to increase awareness on child development through public campaigns. Eighteen trained national groups will develop, maintain, execute and evaluate comprehensive activities in early childhood education.

Dollar Value

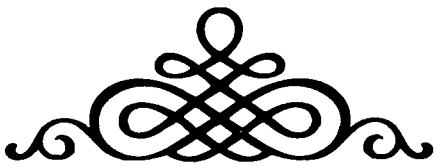
$4 762 000 million plus 10% overhead

Date of inception and duration

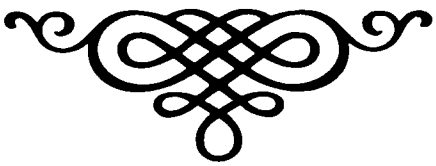
1999-2002 (four years)

Context/Background

In recent years, the governments of Latin America have made significant strides to combat poverty and infant mortality, and to provide universal access to education. However, despite efforts by health and education sectors to ensure the development of all children, services and progress devoted to childhood education remain inadequate in quality and coverage. This project has been developed using the experience of the OAS in working with governments, NGOs and international organizations in the field of early childhood education.



PROJECT 5



Organization: **Pan American Health Organization (PAHO)**

Project: **Integrated Management of Childhood Illness**

Presenter: **Ms. Julia Wayand**

Description

The Integrated Management of Childhood Illness (IMCI) program hopes to reduce high mortality from preventable causes among children under five years of age. The program's goal are as follows:

- to improve the quality of health care for children at the first level of care, in the home and in the community; and
- to strengthen the application of preventive methods (vaccination), health promotion and nutrition measures (breastfeeding, etc) in the population through education of parents during health service visits.

Expected Results

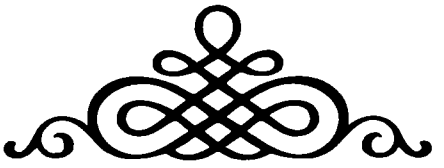
The provision of complete health care would help to reduce deaths among children aged five and under.

Date of inception and duration

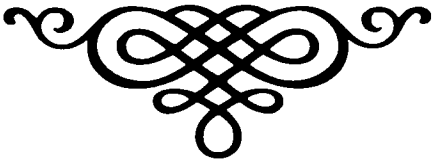
This project began as part of the 1996 Peruvian National Health Plan.

Context/Background

Every year, more than 250 000 children under five years of age die in Latin America due to preventable illnesses. The IMCI program helps to reduce these deaths by educating parents, communities and health providers on health promotion and prevention. This project focusses on the complete health care of the child — from nutrition and preventive methods to treatment of illnesses.



PROJECT 6



Organization: **Inter-American Children's Institute**

Project: **Prevention of Domestic Violence During Childhood**

Presenter: **Mr. Brian Ward**

Description

The project is based on violence prevention through family education; through schooling as an essential tool for teaching social values; and through the media. The main objective of the project is to educate society about violence. The project is conceived not only as an educational tool, but also as a means of transmitting values and principles, and as a socialization process whereby children themselves are guarantors of public safety. In order to achieve this goal, activities will be carried out to:

- organize awareness campaigns in co-operation with local media;
- participate in the planning, development and promotion of national policies and legislation related to women, children, and the family;
- train human resources personnel in the prevention of domestic violence; and
- include the subject of non-violence in primary and secondary school curricula.

Expected Results

This project is expected to result in the following:

- increased social awareness of violence toward children, women, men, and the most vulnerable groups in general by encouraging public participation and responsibility;
- co-operation with the media to change viewer attitudes toward violence;
- involvement of parents, educators, students and the community in violence prevention programs;
- development of anti-domestic violence policies; and
- development of suitable laws that take all family members into consideration.

Cost

US$123 000

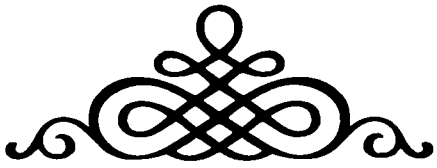
Date of inception and duration

The project will begin once funding has been obtained.

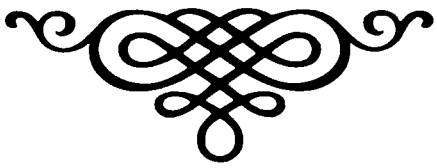
Background

Violence has been proven to have more than just psychological and emotional effects; it diminishes the productivity of individuals and affects the development of countries. Domestic violence, when witnessed or experienced by children, affects their scholastic performance and social adaptation in general, as well as their future development. Children who live in a violent family, school or social environment learn to be violent and to justify violence. Furthermore, since violence is inherent to human nature, it must be tamed in order to live with it.

Prevention is widely recognized as the best way to eliminate or reduce violence.



PROJECT 7



Organization: **Pan American Health Organization (PAHO)**

Project: **DESAPER**

Presenter: **Julia Wayand**

Description

This project aims to improve prenatal and maternal care through training of health ministries, mobilization and community participation strategies. In each country, management of the project was assigned to a National Facilitator and two local coordinators. In addition, each area had a team composed of an obstetrician, a pediatrician, nursing personnel from both specialties and personnel from the community. As a result of joint interventions by health professionals and the community, an improvement has been seen on health indicators. Overall, institutional maternal mortality decreased from 6.5% to 5.7%. The early neonatal mortality rate has been reduced from 11.3% to 6.2%. Health services have not only become more prepared to deal with the technical aspects of prenatal and infant care, but are also more sensitive to the way in which they deliver their care.

Expected Results:

The project is expected to result in the following:

- higher quality prenatal, maternal and child health services.
- greater community participation, organization and training and use of community resources to achieve the objectives of the project; and
- strengthening of linkages and coordination between the services and the community.

Dollar Value

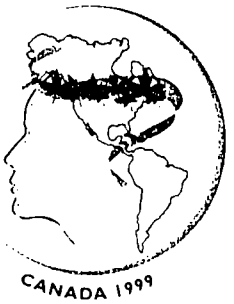
A total of C$7 million has been allocated for the project since 1989.

Date of inception and duration

The project started in 1989. The last phase is to conclude in December 1999.

Context/Background

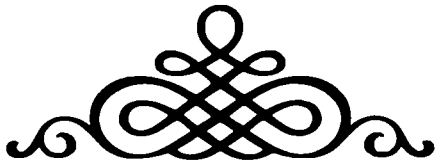
The DESAPER project, launched in 1989, is being carried out by the Latin American Centre for Perinatology and Human Development (CLAP) and the Pan American Health Organization (PAHO) with the collaboration of the International Development Division of the University of Calgary. It is funded by the Canadian International Development Agency (CIDA) and is being executed



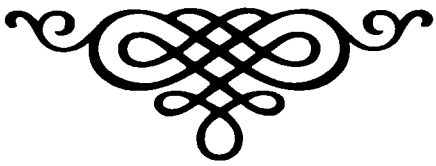
in eight areas (San Gabriel and Chapare Tropical in Bolivia, Tahuantinsuyo Bajo and César Lopez Silva sectors in Peru; Santa Rosa de Copán and La Paz in Honduras; and Nandaime and Tipitapa in Nicaragua). The total geographical area covered by this project is 30 800 km^2 with a population of approximately 500 000 in 1998.

Rationale for seeking endorsement

PAHO would like the First Spouses to see this project as a successful initiative in prenatal and maternal health care.



PROJECT 8



Organization: **United Nations AIDS Program**

Project: **Advocacy for a Healthy Start: Prevention of HIV/AIDS in Women and Children**

Presenter: **Dr. Mercedes Weissenbacher**

Description

The goal of this project is to mobilize political and public support to stimulate local responses to reduce the transmission of HIV and related stigma through advocacy and awareness-raising activities under the sponsorship of the Ninth Conference of Spouses of Heads of State and Government of the Americas.

Expected Results:

Education of HIV/AIDS would help to dissipate the stigma that people associate with the disease. Public awareness would lead to an understanding of the disease, and probably to a decrease in the number of incidences.

Dollar Value

Initial budget is $50 000

Date of inception and duration
October 1999-2001 (two years)

Context/Background

AIDS prevention campaigns often fail to meet the needs of women by assuming that they are low risk, or by urging prevention methods that women have little or no power to apply. HIV/AIDS can be transmitted to the child during pregnancy, childbirth or breastfeeding. Until recently, there were only two main strategies for limiting the numbers of HIV infected infants: to prevent women of child-bearing age from becoming infected; and to provide assistance to HIV infected women to prevent pregnancy. Now there is a third method: HIV positive women who wish to give birth may follow a short course of anti-retroviral drugs, and the child would receive replacement feedings. This new method can cut the rate of HIV transmission by half.

Rationale for seeking endorsement

The project aims to receive the sponsorship of the Ninth Conference of Spouses of Heads of State and Government of the Americas, in order to stimulate effective responses to the prevention of mother-to-child transmission of HIV. This is to be done through a combination of advocacy efforts, which will include public speaking, supporting sensitization campaigns, participation in special events, and radio/TV programs. The project includes three-month advisory services to help prepare a strategy for advocacy, in collaboration with the offices of the First Spouses in selected countries. The budget also includes a provision for the production and dissemination of relevant information material.

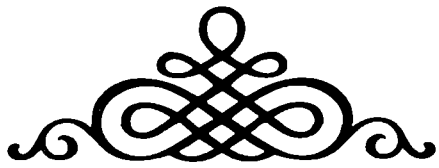
Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

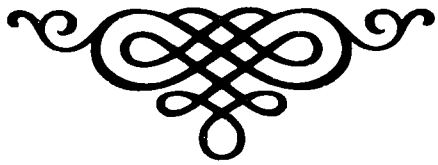
This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

10

Divider Title: _____



PROJECT 1

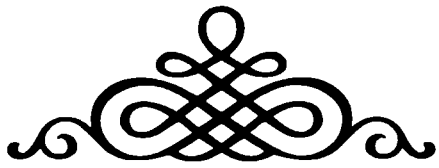


THIS DOCUMENT

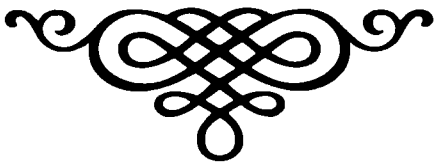
WILL BE DISTRIBUTED

DURING THE

TECHNICAL MEETING



PROJECT 2

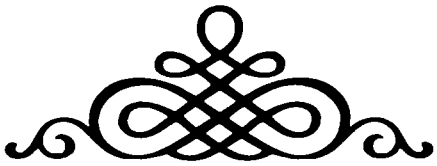


THIS DOCUMENT

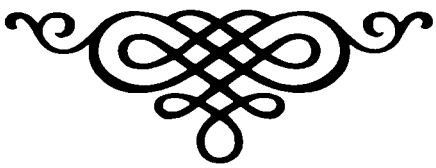
WILL BE DISTRIBUTED

DURING THE

TECHNICAL MEETING



PROJECT 3



EARLY CHILDHOOD CARE FOR SURVIVAL, GROWTH AND DEVELOPMENT IN LATIN AMERICA AND THE CARIBBEAN

IX Conference of Spouses of Heads of State in the Americas
Proposal for Technical Meeting
6-9 July 1999

UNICEF
REGIONAL OFFICE FOR LATIN AMERICA AND THE CARIBBEAN
EDUCATION AREA

"Early Childhood Care for Survival, Growth and Development" is an integral approach that prepares children for life and learning, and trains teachers, parents and members of the community who care for children, to respect, protect, facilitate and made effective children's rights to survival, growth, protection, development and participation. From UNICEF's perspective, ECCSGD should be **centered on children, focused on the family, supported socially and promoted globally.**

Learning begins at birth. It is precisely the learning that takes place from the first hours of life and continues until girls and boys enter the formal basic education systems, that can provide them with the skills and values necessary for each of them to become what she or he wants to be, and have a greater chance of living well. Thus education, now is recognized as a process that begins with life itself and never ends, and which should guarantee that every human being can make the most of himself or herself.

Early childhood cannot only be seen as a period where the child needs care to ensure survival, physical growth and protection against illness. Care and education should provide the cognitive and psychosocial development of all children without any sort of discrimination. It should guarantee the satisfaction of his or her needs and give priority to the acquisition of skills and capacities that have been shown to be the keys to life. These include linguistic skills, the development of intelligence and socio-affective capacities that strengthen creativity, a critical attitude and the construction of knowledge as part of every child's development. Also the development of values that are learned from a very early age, such as tolerance, respect, solidarity and autonomy, and that determine the attitudes that children will have later on - about themselves, others and society in general

EARLY CHILDHOOD CARE FOR SURVIVAL, GROWTH AND DEVELOPMEN IN LATIN AMERICA AND THE CARIBBEAN

IX Conference of Spouses of Heads of State in the Americas
Proposal for Technical Meeting
6-9 July 1999

UNICEF

REGIONAL OFFICE FOR LATIN AMERICA AND THE CARIBBEAN

EDUCATION AREA

TABLE OF CONTENTS

EARLY CHILDHOOD CARE FOR SURVIVAL, GROWTH AND DEVELOPMENT IN LATIN AMERICA AND THE CARIBBEAN

UNICEF

A. JUSTIFICATION

We have taken several centuries to recognize explicitly that learning begins at birth. It is precisely the learning that takes place from the first hours of life and continues until girls and boys enter the formal basic education systems, that can provide them with the skills and values necessary for each of them to become what she or he wants to be, and have a greater chance of living well. Thus education, which previously was understood to be a process that began at the age of six or seven and ended with the end of adolescence, now is recognized as a process that begins with life itself and never ends, and which should guarantee that every human being can make the most of himself or herself.

UNICEF is convinced that early childhood cannot only be seen as a period where the child needs care to ensure survival, physical growth and protection against illness. Care and education should provide the cognitive and psychosocial development of all children without any sort of discrimination. It should guarantee the satisfaction of his or her needs and give priority to the acquisition of skills and capacities that have been shown to be the keys to life. These include linguistic skills, the development of intelligence and socio-affective capacities that strengthen creativity, a critical attitude and the construction of knowledge as part of every child's development.

Care and education in the first years of life should contribute to the development of values that are learned from a very early age, such as tolerance, respect, solidarity and autonomy, and that determine the attitudes that children will have later on – about themselves, others and society in general. In synthesis, they should guarantee all children the necessary learning for them to be able to exercise their rights and become fundamental actors and builders of just, equitable and peaceful societies.

Therefore, UNICEF talks of "**Early Child Care for Survival, Growth and Development**" (referred to as ECCSGD in the rest of the document) as an integral approach that prepares children for life and learning, and trains teachers, parents and members of the community who care for children, to respect, protect, facilitate and made effective children's rights to survival, growth, protection, development and participation. From UNICEF's perspective, ECCSGD should be **centered on children, focused on the family, supported socially and promoted globally.**[1]

There are several spheres where early development and education can occur, but the main ones are the family, the community and child-care and preschool programs and institutions. There is no ideal concept of child development and early education that should be considered universal. However the conceptual and operational models should be constructed using multidisciplinary principles that respond to the specific problems and opportunities of each child, each family and each culture, and that are oriented to achieve the maximum development in all the child's dimensions - physical, cognitive and affective.

Three types of arguments have been designed to show the importance and validity of actions related to Early Child Care for Survival, Growth and Development:

- Because of their preventive nature, ECCSGD actions are seen as a medium- and long-term social investment, that is highly profitable in human, social and economic terms.

Investment in ECCSGD pays off in quite varied ways, in both economic and human resources. It reduces primary school grade repetition and dropout rates, increases those children's productivity when they reach adulthood, helps parents and the community to learn, reinforces and stimulates social participation, and helps to reduce economic and social inequalities. To give an example, High/Scope Perry Preschool made a longitudinal study comparing children who participated in high quality preschool programs with children who did not, and the amount of return on each dollar invested was found to be US$ 7.16.

These arguments already have begun to be understood by governments. A concrete example of this is the explicit recognition given by the representatives of the governments of 32 nations that participated last November in the Fourth Ministerial Meeting on Children and Social Policy in the Americas. At this

[1] **Taken from the draft document that was produced in the discussion held at the Innocenti Seminar in October 1998.**

meeting, the governments of the hemisphere committed themselves, for the remainder of this century, to adopting and expanding activities for early stimulation that incorporate the family and the community as key elements in child development.

- A synergistic effect of early child care and education activities, especially at the local level.

Interventions in early childcare and education have a high capacity to mobilize and involve multiple social actors and to generate actions and intersectorial plans with a high level of community participation.

Very frequently we have seen that the "simple" act of installing a daycare center or beginning a parent education project in a community generates a shock wave of mobilization and social participation involving public functionaries in the areas of health, education, social welfare, parents, the church, local social organization and political leaders.

Early child care and education programs' special capacity to generate "value added" is directly associated with integrality, which characterizes or should characterize ECCSGD proposals, and with their low level of "sectorialness" or institutionality. Institutionality is a trait that should be handled carefully when executing projects, in order to avoid the perception that they are the sort of "no-man's land" (or "everybody's land") that so confuses social investors and planners. The complex relationship between integrality and institutionality should be examined very carefully when formulating strategies.

For UNICEF, this synergistic potential of ECCSGD actions makes them an excellent way of planning and executing intersectorial coordination strategies aimed at reaching the health and education goals that form part of the commitments acquired in the World Summit for Children.

- There is a third kind of argumentation – socio -psychological in nature – that concerns children and their right to life, to development, to being cared for and protected by their families and social institutions, to express themselves and communicate, to learn and be educated, whose spokesperson and champion *par excellence* has been and should continue to be UNICEF.

There are various sources of information that give socio-psychological arguments in favor of ECCSGD as a basic strategy for the integral development of children.

One of these sources comes from experience and research in the field of child or evolutionary psychology, especially longitudinal or cohort studies, which clearly show that children who have participated in early child care and education programs have higher indices of development of their intellectual, linguistic and socio-affective capacities, greater capacity to adapt to new and socializing experiences, and greater success at school than children who do not attend educative programs.

Another contribution from evolutionary psychology and the neural sciences consists of having been able to prove that the "**windows of opportunity**" for developing intellectual, linguistic and psycho-motor capacities (in neural sciences they talk about the "wiring" of neuron tissues) have their apogee or **sensitive period** during the first three years of life, after which there begins a non-lineal decline of these windows or potentialities for development. From there we get the expression or concept of early and **opportune** stimulation.

The concept of opportunity in no way should lead to any fatalistic interpretation that what is not done before the age of three is not remediable afterwards. On the contrary, it has a purposeful meaning: **let us act now, at the most opportune moment.**

The other source of this kind of argument comes to us from the child rights approach, which establishes the concept of the **child as a subject of rights**, leaving behind the notion of the child as an "object" – a passive beneficiary or receiver of social action. Rights are constructed or won, not given.

The Convention on the Rights of the Child, in its Articles 6,18.1, 18.2, 18.3, 24,28 and 29, especially emphasizes those aspects that accompany the development of the child at an early age.

Furthermore, the rights approach postulates that care and attention to children through provision of quality social and educative services are not an option for more or less beneficence or greater or smaller political will on the part of governments. They are a right of children and, as such, an imperative condition. Similarly, we find the non-transferable and central role of the family in caring for and educating its children. These imperatives are rounded out with the notion of **the progressive exercise of rights**, based on the evolving development of the child.

It is not difficult to appreciate how the notion of the child as a subject that intervenes actively and progressively, to the limits of his or her evolving development, in acquiring the full exercise of his/her rights provides us with a

broad frame of reference within which other kinds of arguments can and should become integrated and converge with the arguments for ECCSGD - each with its own validity, but incomplete if taken separately.

This is an important sphere for elaborating our discourse on EGGSGD: to integrate the child rights approach into the evolving life cycle perspective on children.

From this perspective, let us take a look at the region's panorama in the area of ECCSGD.

B. REGIONAL CONTEXT

1. The situation of program coverage

There is a large problem of lack of consensus regarding the criteria of age and denomination of the program, which is reflected in the lack of uniformity in the sources of information. Each country, and within each country different institutions, speak of preschool education, nursery school education, early education, initial education and others that refer to different population groups (0 to 5, 4 to 6, 5 to 6-or-7) and programs. For some, preschool education goes from 0 to 6 or 7; for others it only refers to the group that lacks one year before entering school (5-6 years); others consider the group between 4 and 6, or between 3 and 5. Something similar happens with the terms for initial, early and other kinds of education.

Therefore, the country data that we have only can help us understand the advances in the region's coverage in global terms; the relative inconsistency of the information won't let us go any further in terms of comparisons among countries or other kinds of analysis.

According to 1991 UNESCO figures (taken from Myers, 1995), coverage of pre-school education[2] in Latin America and the Caribbean reaches an average of 58.25%. There are, however, enormous disparities within the region. In the Caribbean, for example, the figure rises to 82% while in Central America it ranges around 27% and in South America it is 42%. These marked differences in coverage among groups of countries in the region indicate the need to construct diversified regional strategies in order for UNICEF to provide support for the broadening of delivery of integral ECCSGD services.

[2] **Myers, R. "Preschool education in Latin America". Paper presented for the Inter-American Dialogue, Nov. 1995.**

Several common traits can be found in the information:

- **Coverage data tend to be strongly concentrated on children who are in the year just before entering the first grade of primary school (5-6). Many of them attend pre-primary, preschool or kindergarten in regular primary (basic education) schools; and others, possibly the minority, attend infant-care centers. In some countries, like Ecuador, the preschool grade has been assimilated as the first year of basic education, and therefore it is the responsibility of the Ministry of Education and Culture.**

- **When data on is available on exclusive coverage of early education programs without including the preschool level of primary schools, the numbers are incomparably lower. Let us look at a few examples. In 1990 Chile reported coverage of 69.3% for children under five, and coverage of 20.7% for children under four. Costa Rica reported coverage of 62% for the cohort of five-year-olds, and of only 14% for the cohort between three and five. Ecuador reports a 48% coverage for the five-year-olds, and 9% for children between zero and four.**

- **A survey carried out in the regional office[3] showed an estimated average coverage of 17% for the region, in the area of early education programmes.**

- **Virtually no country reports data for the population under the age of three.**

From these two facts it is easy to infer that most of the data refer to preschool education programs and services offered by primary schools, and less frequently include early education programs that give integral services that stimulate the development of children's potentiality in their physical, affective and intellectual dimensions.

The other idea that is inferred is that, for the population under three, there is very little information available and/or few programs for caring for this important segment of the child population.

---

[3] **UNICEF, "Rol Estratégico en el Area de Educación para América Latina y el Caribe}". Bogotá: Regional Office, 1998.**

Looking more closely at the countries the disparities are readily visible. A large percentage of the child population made up of girls and boys from low-income families is excluded from preschool programs. In addition to the disparities linked to socio-economic factors, the geographic location (rural/urban), the type of household (single- or two-parent families), gender, and ethnicity affect the real possibilities for access to preschool education.

R. Myers (1995) stresses that an important factor in a country's progress or backwardness is closely related to political will and the differences in the design and implementation of policies. We find, for example, that countries like Jamaica, which in 1992 had a per-capita income of only US$ 1,390 – which is more than US$ 2,000 dollars below the average for Latin America –had an enrolment level of 83%, while in Colombia, with a similar income, only 44% of all boys and girls under five have access to a preschool education. Argentina, for its part, with a per-capita income that is four times higher – US$6,050 –enrolled 68% of the children between four and five.

Even in some of the countries with a high coverage, highly inequitable structures lead to children from the lowest socio-economic strata being excluded from access to preschool education. This is shown by data from Argentina, Uruguay and Chile, based on household surveys. In the case of Chile, for example, they indicated that, while the 1992 preschool coverage in "Nursery Schools" was 24% at the national level, it only reached 19% in the lowest-income quintile, but rose to 43% in the top quintile. (Myers, 1995). Although there are no reliable and disaggregated statistical data for other countries, it can be inferred that, very probably, in the majority of the region's countries there is a clear bias toward the highest-income groups.

Similarly, there is higher coverage in urban areas. Overall in the region, the rate of female coverage is similar to that of males; when there are differences they do not surpass 4% of the total. It would be very useful to get data about permanence in school, unemployment, and the general quality of the preschool education for girls.

Coverage of indigenous groups is presumably lower than that of non-indigenous groups. Even though there is little information available, the data for Mexico help support this affirmation. Official statistics show a coverage of 82% of all children in Mexico City, while in Chiapas coverage is only 38%.

According to OREALC (1992), private school care by subregion shows that in South America coverage is 29% of the population; in Central America and Panama it is 32%; in the Gulf of Mexico it is 11% and in the English-speaking Caribbean it is 80%.

Preschool programs have increased persistently since 1980. However, the preschool enrolment rate seems to have been higher during the "lost decade" of the eighties than in the first five years of the nineties, when the region experienced a certain degree of economic recovery. This reaffirms the importance of political will for the development of programs based on rights and in agreement with the goals.

2. Determinant factors and problems detected

Four factors have been selected that are shown by joint work experience to be determinants of the success of ECCSGD strategies and programs. These should help us identify the most significant problems that are found in many countries in the region, and subsequently show some lessons learned and successful experiences in several countries.

These factors are:

a. National policies that give priority to early childcare and education.

b. Integrality of approach and action in ECCSGD-related strategies and programs.

c. Family and community participation. Diversification of modes of child care.

d. Criteria and indicators of the quality of services provided and their adjustment to the different age groups. Monitoring and evaluation. Formation and training strategies for educators and social actors.

2.1 Problems found

- **Low priority assigned to ECCSGD in governments' policy and budget agendas**

As we have shown in our analysis of the data on coverage, governments still dedicate a very small part of public spending on education to attending to the specific needs of early childhood. For example, the percentage of Jamaica's education budget spent on ECCSGD is 2%, while children of preschool age represent almost 20% of the total number of children in education programs.

ECCSGD-related services cross many bureaucratic and budgetary lines, and no sector is directly responsible, thus diminishing the possibility for political and financial support. This is a possible consequence of the slight sectorial or institutional definition of programs aimed at early childhood, a lack of definition that not only affects the priority given by national governments, but often complicates dialogue and negotiation of international cooperation with the many "counterparts" and actors involved - each of which has its own interests.

The countries have more or less well-defined health and education sectors, while ECCSGD does not have its own sectorial system. Many countries have incorporated their preschool programs into the education system, in some cases with an age limit (starting at age 3 or 4). In others, the health sector is responsible for some of the programs, while in yet others, the social welfare system takes them on. In several countries it is NGOs or autonomous or semi-autonomous national institutes that are in charge of the main programs. Some countries have begun dialogues on the creation of a multisectorial early education system.

It is true that increased political will and national capacities can have a major effect on widening ECCSGD coverage, but there also are technical criteria that have been enriching institutions' vision of program expansion. The principal one, **called "diversification of modes of attention for early childhood"**, has helped many countries to overcome the rigid and unworkable scheme of creating day care centers as the only method of attending the entire population of at-risk children, and expand their services by other means, such as family education.

- **Lack of integrality of approach to, and action on, early childhood**

In early child care programs in Latin America and the Caribbean, the dominant perspective is non-integral care, which does not adequately combine the elements of survival, growth and psycho-social and cognitive development. In only a very few programs is nutrition dealt with in an integral way in program design. Food assistance, in most programs, does not consider the nutritional needs of children, is of low coverage and is characterized by problems of hygiene and poor preparation of the foods. Generally, neither nutritious diet nor related size and weight follow-up is considered.

In most programs there is no articulation between health and child-care programs, and health actions generally are not integrated into development and early education services.

Likewise, there is very little information on the type of interventions related to psycho-social and cognitive development, and what there is shows a lack of quality of educative actions.

There would seem to be **two predominant tendencies** in child institutions and programs. In some cases, the **emphasis** is placed on **offering preschool education** to prepare children to enter school, and there is little attention to health and nutrition. In others, the educative component is given little or no priority, and the **emphasis is on "caring" for the child**, carrying out routines of rest, feeding and play until the parents come for them. There is not an abundance of programs that provide integral care in the different aspects of child development.

- **Weak family and community participation**

For a long time, and still today, an inadequate and schematic treatment of family and community participation predominates in the programs, where these factors are included to reduce costs by using the parents' and community organizations' labour and other contributions to educative centers. This institution-centered approach is beginning to give way to a family and community approach that is centered on the child.

In various countries in the region, with Chile and Cuba at the lead, community participation and the involvement of the family have begun to be part of the strategies for an adequate early child formation, and not mere instruments for lowering program costs and widening coverage.

The problem is that the way of conceiving of and using the family in ECCSGD programs still is quite incipient, and in most programs treatment still is inadequate and restricted. However, the new tendency being seen is heartening, and UNICEF should play a technical role of promoter and stimulator of projects, to establish **the authentic role of the family and the community in early child development from a rights perspective.**

Therefore, this is not a simple formula to help poor countries lower costs and widen coverage, although in fact it may contribute to such economies. The greatest development of family education programs and projects for ECCSGD has taken place in the developed countries, especially in the United States. In this region, as has been pointed out, Chile, Cuba and some other countries like Mexico, Brazil and Ecuador have made significant advances in this area.

- **Absence of quality criteria and indicators on services delivered and their "fit" according to age. Poor monitoring and evaluation.**

Another element that is noticed in the systematization is the lack of control, evaluation and follow-up of programs - much less, evaluation and direct follow-up of the children receiving attention.

In these programs, no curriculum or plan for learning and developing skills and capacities were found that might allow the establishment of goals other than the form of care that is understood in "daycare".

- **Weakness of policies and strategies for forming and training educators and community mothers**

There is a marked weakness in policies and strategies for forming and training educators and community mothers, who are the ones who provide the care for children. Nonetheless, in various countries there are advances and achievements in personnel formation and training that should be known and disseminated, to overcome this difficulty that many consider to be the principal cause of low quality in non-formal programs for children.

- **A marked scarcity of programs for children under three**

The majority of the cases documented make reference to children of preschool age, beginning at 4 or 5 years, and we found an absence of programs that direct their attention to children between 0 and 3, which is disturbing, considering that these first years are critical for the formation of intelligence, personality and social behavior.

3. Lessons Learned in the Programs in Our Region

Among the most important aspects for guaranteeing a good development and outcome from the early child care programs for development and learning, we find the following:

- **Strengthening of national capacities and political will to give priority to actions and care programs for early childhood**

There is a need for a strengthening of the national resources and capacities to finance, organize, manage and supervise these programmers. Also, the demand for programs of early education should be consolidated, and knowledge of its

advantages should be extended – at the level of families, the community and the government. It is widely recognized that spending on early education benefits the neediest socio-economic groups, and also constitutes a highly profitable investment. Achieving these advances in the area of education does not only call for greater resources; an efficient re-distribution of funds among the budgetary lines has an enormous potential and is a firm step toward construction of an equitable, pacific and just Latin America and Caribbean region. It is here, in the mobilization of governments, that we can make an effort and achieve an advance in the recognition of the importance of early childcare for development and learning.

- **Integral strategies that guarantee the development of the child in all his or her facets, with equity between the genders.**

The criterion of integrality does not have to be translated directly into a need for each institution responsible for a program to offer the whole package of services in order to be integral, as sometimes happens. The programs should manage and guarantee integrality of actions and services for children through strategies of coordination and articulation, with a group of institutions with different profiles, aimed at providing services to a common population.

Many countries, in the region and outside it, have promoted the creation of modalities of attention that enrich and extend the traditional modality of early childhood daycare centers with which the ECCSGD programs began. The countries have learned to combine and selectively use diverse strategies according to needs and characteristics of the object population. The cases of Mexico and Costa Rica – among others – are examples of this.

- **Participation of the Family and Community to ensure the creation of appropriate environments for the healthy development of children.**

The kind of parental and community participation is a determinant of quality. UNICEF takes the perspective that the family and the community are the environments closest to the child, that stimulate her growth and physical and mental development. It is there that the child finds, or doesn't find, the basic sanitary conditions for an environment that controls diseases; balanced, nutritious and well prepared meals; and a space where the risk of accidents is reduced. It is in the family and community environment that affective ties are created and where, through interaction, values for democracy can be constructed, rights can be lived, and an idea of a life project can be formed. These spaces

also are the first places for learning and discovery, whose practices can stimulate and promote development of skills and capacities for learning and for life.

- **Monitoring and evaluation of the programs to guarantee their follow-up and effectiveness**

Monitoring and Evaluation has shown that programmes can be adjusted to the real needs of children and offer quality attention. UNICEF wants monitoring to be effectively included in mechanisms for follow-up of growth and the age-specific achievements of each child in terms of size, weight – and motor, psycho-affective, cognitive, social and other kinds of development. These should permit the promotion of knowledge and practices in all environments, stimulate the child, reduce risks, prevent disabilities and achieve the development of all the children's capacities that strengthen all their opportunities for a life of well being.
We include in this theme the definition of adequate program quality indicators that show us when a program is producing good results and when it is not. Quality is a concept that is complex, culturally defined, and relative, but we should generate categories, standards and components of quality that we can use to measure programs.

A list of factors to be taken into account for measuring quality should include the following:

- A curriculum that is appropriate for a development that includes learning activities for children in a supportive environment.

- A careful selection of personnel, with a strategy for service and training in the center itself. It is more effective when the training is practical and is carried out with the children.

- Attention to the ratio of personnel-to-children.

- Capacity to commit to and establish partnerships with the parents and the community, empowering them with access to information and an opportunity to internalize positive child-rearing practices.

- Strong administrative support, with direct provision of services like health and nutrition.

- Effective monitoring and evaluation processes, allowing personnel and caregivers like mothers and fathers to monitor and observe the children's

progress. It also should be possible to have access to data for evaluation, which would allow us to improve strategies.

- Taking into account cultural child-rearing traditions and new pedagogical practices, in order to avoid the discarding of good cultural practices and importing centralist plans that do not attract the families.

- Incorporating gender into pedagogical materials for parent education, using statistics that are disaggregated by gender.

- Adopting the time schedule and school calendar to local circumstances, such as agricultural seasons in rural areas. Adopting the work plan to local needs.

- Placing schools or care centers near the children and their families.[4] When the child population is dispersed, such means as distance education with television, radio and roving teachers can be used.

Until now there has been an absence of monitoring and evaluation, owing to many factors, among them the lack of experts, lack of widely acceptable instruments and measures for ECCSGD, and lack of clearly conceived objectives. The need for strong and well-designed evaluations is underrated if one considers the potential effects of their results. It also is very useful to identify the factor that can be fundamental for achieving the objectives. Comparison among countries, and among the regions within a single country is necessary to be able to observe the effectiveness of the different programmatic strategies. The results can be used to guide a re-adaptation or refinement to achieve the objectives.

- **Strategies and mechanisms for promoting, disseminating, and educating through the communications media**

The use of the media can help to create political will and national consciousness, but the education of caregivers also can be benefited by a choosing a medium that reaches them with good format and contents.

Documentary programs based on the following points could be implemented:

- Specific practices, policies and programs, according to the country.

[4] **For every kilometer that a child has to walk to reach school, there is a 2.5% decline in the probability of his or her attending school.**

- Techniques for stimulating development, which are easily provided by parents and caregivers, with emphasis on the society's need for these activities and the benefits for the children.
- The offer of innovative services, either for organizations or for individual work with local or national personnel.
- Traditional child rearing practices and patterns that aid development, also indicating those that contribute negatively.

Various countries have had successful experiences in the use of radio for disseminating messages and educating families.

- **Valid strategies for forming and training educators and social actors**

Perhaps the most critical point for the quality of the services provided by early education programs is the formation and training of their personnel. Authors like Cassie Landers consider it the principal factor for quality. The principal criticism that formal educative programs, teachers and educative authorities make of non-formal programs is that the care and early education of small children is left in the hands of persons without professional formation, with low academic levels and who are little or badly trained for this work.

In various countries, initiatives and strategies have been developed to improve the processes of progressive and on-going training for personnel through well structured plans and curricula, and to link training to the improvement of service quality.

Private preschool institutions in the region have developed a considerable technical level, and have highly trained professionals who could be a excellent resource for developing sustainable educative and training strategies for public-sector community educators – to the extent that the barriers that historically have separated the public and private sectors can be eliminated, including cooperation agencies' policies and norms.

C. THE STRATEGIC PROPOSAL

1. UNICEF's objectives in the area of ECCSGD in the region, 1999-2001

1.1 General objective

To promote the development of policies, strategies and programs in line with the rights and gender approaches that favor the increase of coverage and the improvement of the quality of child care and early education services, to

guarantee the integral development of the children's potential during their early childhood.

In this way ECCSGD actions become an important vehicle for reaching goals of the World Summit for Children.

1.2 Specific objectives

- To promote the formulation of policies including legal and budgetary measures that give priority to ECCSGD strategies in the countries adressing working women and adolescent mothers, including regional actors like the church, the productive sector and other organizations

- To promote and disseminate successful experiences and programs from the region, especially those that contribute to motivate the role of the family and the community in providing attention for the smallest children, within the rights and gender approaches.

- To promote the integral approach and full coverage in ECCSGD programs - including health, nutrition, growth, development of psycho-affective and cognitive capacities - that are being developed by the governments in every country of the region, with special emphasis on the child population between 0 and 3.

- To create regional mechanisms for supervision, follow-up, analysis and communication of the programs implemented by the governments including the elaboration of criteria and basic quality indicators to orient follow-up and monitoring.

2. Activities proposed to the achieving of objectives:

- **Development of a research or documentation process on "Best practices on ECCSGD" for the region. We will start documenting the cases of those countries more relevant for different criteria such as the coverage of the attention, integrality of the program, results achieved, etc. The first countries to analyze are: Colombia, Costa Rica, Brazil, Chile, Jamaica, Cuba, and Mexico.**

- **Development of audiovisual resources on ECCSGD successful to achieve a greater impact on advocacy and resource mobilization.**

- Edition of a videotape with testimonies, interviews with ECCSGD program managers in the field, extracts of experts' positions on the topic and direct exhibition of some projects on the field and results observed by the families and communities. A long version of the video will be showed in specialized meetings. A short version will be showed to policymakers in the governments, and supranational organizations.

- **Organization of the ECCSGD network in the region using a team of specialists and institutions from various countries in the region.**

  - Contact with experts on the ECCSGD academy, experts on child mobilization, practitioners.

  - Organization of regional meetings to exchange ideas and knowledge and designing a regional strategy for the action.

- **Development of materials and tools for the improvement of the educative components of ECCSGD programs, such as:**

  - Indicators of accomplishment of psychosocial development of children, well differentiated by age.

  - Strategies for forming and training educators, caregivers and parents

  - Curricula of educative activities, reinforcing the integrality and institutionality of the programs

  - Development of alternative modes of attention, with emphasis on the participation of the family and the community.

  - Promotion of the development of models of sustainable management.

  - Incorporation of the rights and gender approaches from an evolutionary perspective.

- **Construction of systems of basic indicators of quality.**

-Reinforce the monitoring and evaluation part of every program on ECCSGD.

- **Technical assistance to groups of countries in the design of projects to be financed by donor countries and other organisms.**

- **Influencing and advocacy to promote:**

  - Budgetary changes leading to social investment in early childhood within the framework of the 20/20 Initiative.

  - Legislative changes that affect women and children, and facilitate ECCSGD services for all the children in the country.

  - Laws that facilitate maternity for working women, with help for child rearing, in terms of both leaves and care services.

D. PROJECT MANAGEMENT

The management of the project will be located in the UNICEF Regional Office for Latin America and The Caribbean, with very close contact with the country office Representatives and Education Officers. Education officers in the region are connected via an e-mail network; herefore, communication is fluid and constant.

The Regional Office, Education section, will be responsible for:

1. Development of a research or documentation process on "Best practices on ECCSGD" for the region
2. Development of audiovisual resources on ECCSGD
3. Organization of the ECCSGD network in the region
4. Developing materials and tools linked to the improvement of the educative components of ECCSGD programs
5. Designing a monitoring system and selecting the basic indicators.
6. Technical assistance
7. Advocacy on behalf of the project to governments in the region.

E. GEOGRAPHIC AREA

We intent to cover the whole region of Latin America and the Caribbean. Regarding activity number 1 and 2 we would start with those countries more experienced in successful programs on ECCSGD, such as Costa Rica, Colombia, Brazil, Chile, Cuba, Jamaica and Mexico.

Once we have the systematization of those experiences we will expand our research to Peru, Bolivia, Paraguay, Guyana, Guatemala, El Salvador, Nicaragua and Barbados.
For activities number 3 to 7 the geographic area will be the entire region of Latin America and Caribbean.

BIBLIOGRAPHY

AAVV. "Encuentro de Educación Inicial en el Distrito Federal", México D.F.: Secretaría de Educación Pública, Dirección de Educación Inicial, 1997.

AAVV. "Orientaciones sobre Educación Inicial de 0 a 4 Años", México D.F.: Secretaría de Educación Pública, Dirección de Educación Inicial, 1997.

Cordus, Joyce and van Oudenhoven, Nico. "Early Intervention: Examples of Practice. Averroes Programs for Children - An Experience to be Shared". In: *Action Research in Family and Early Childhood*, Paris: UNESCO, 1997.

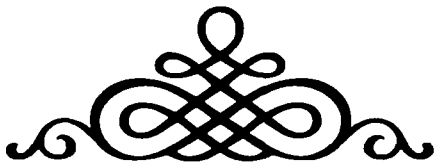
Myers, Robert. *The Twelve who Survive.* London: Routledge, 1992.

Myers, Robert. Technical Working Group on ECCD. UNICEF: "Child Development in UNICEF Programming. A Contribution to Human Development through Early Childhood Care for Survival, Growth and Development". New York: UNICEF Program Division, 1998.

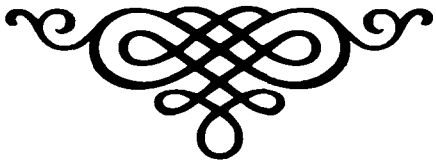
UNICEF. *El Estado Mundial de la Infancia 1999 - Educación.* New York: UNICEF, 1998.

UNICEF. Innocenti Document on Education, "A Vision for the 21st Century". Italy, 1998.

UNICEF, AAVV. *Manual de Educación para la Democracia en América Latin y Caribe.* Bogotá: UNICEF Oficina Regional para América Latina y el Caribe. 1999. (Próxima publicación abril 1999).



PROJECT 4



COOPERATION BETWEEN THE HEALTH AND EDUCATION SECTORS IN SUPPORT OF A COMPREHENSIVE APPROACH TO CHILD DEVELOPMENT
SUMMARY

Proposal Submitted by: ORGANIZATION OF AMERICAN STATES
Unit for Social Development and Education

PAN AMERICAN HEALTH ORGANIZATION
Division of Health Promotion and Protection

Geographic Location: Latin American Countries (18)

Proposed duration: Four years, starting in 1999. (1999/2002)

Description of proposal: This project, prepared with the participation of six Latin America countries, is divided into three major action areas designed to promote a comprehensive approach to early childhood development through regional coordination and the use of new communications technologies. The first action area proposes the synthesis and dissemination of information on early child development; it targets the family, community agents, and technical personnel of both the health and education sectors. Through studies and regional meetings coordinated by an expert committee, the project seeks to contribute to the development of guidelines for a comprehensive approach to early child development: an approach that includes concern for the education, physical and mental health, nutrition and socioeconomic development of the child, the mother and the family.

The second action area addresses experiences in comprehensive education at the national level and will develop operational program guidelines. Implementation will include national and regional meetings to design service delivery systems, together with workshops to train technical personnel in program development and management, the use of radio and television in comprehensive education, and the development of community support networks.

The third action area will promote public awareness of the importance of a comprehensive approach to education and mobilize social and political support at all levels: from the grassroots to policy-makers. The project proposes to inform policy makers, educational administrators, technical staff, and community organizers about the effectiveness of the comprehensive approach through participation at summits, organization of regional symposia, and promotion of public awareness campaigns. Specifically, the project anticipates a major presence at the World Symposium to be convened in Chile in 2000.

Objective: To promote and consolidate cooperation between the health and education sectors in order to develop safe and stimulating spaces that support and foster early child development, using new communications technologies.

Potential Partners: Participating countries will seek links with existing local initiatives in early childhood stimulation, already financed by international organizations such as the IDB, UNESCO, World Bank, European Union, and UNICEF, as well as by local funding sources.

Cost: US$4,762,000 million plus 10% OH

Additional Information on Project # 4

COOPERATION BETWEEN THE HEALTH AND EDUCATION SECTORS IN SUPPORT OF A COMPREHENSIVE APPROACH TO CHILD DEVELOPMENT

EXECUTIVE SUMMARY:

In recent decades, the governments of Latin America have made significant strides in terms of combating poverty, and infant mortality and providing universal access to education. However, despite efforts by the health and education sectors to ensure the sound development of all children, services and programs devoted to early stimulation remain inadequate in terms of quality and coverage.

Recent studies show that it is critically important to offer healthy spaces and adequate health and nutritional conditions for children in their first 10 years of life, in order to facilitate the comprehensive development of their cognitive, social, emotional, and motor potential. In Latin America, however, the majority of young children live in poverty, in environments that are unhealthy and potentially harmful. Many of these children do not have access to basic health services, nutrition, and education services. Thus, there is an identified need to mobilize the political, financial, and technical resources necessary to promote investment in early childhood comprehensive development programs: programs that include concern for the education, physical and mental health, nutrition and socioeconomic development of the child, the mother and the family.

This project is intended to foster joint efforts between the health and education sectors to create healthy and educational environments that favor the comprehensive development of Latin America's children. Consistent with this objective, the project involves conducting and publishing research, designing and

executing pilot programs based on a comprehensive approach, and mobilizing political will and public commitment

The project is conceived within a four-year time frame and will include both national and international activities. Six countries will participate in the initial phase, and six additional countries will join annually, until the third year, when 18 countries of the Region will be involved.

The direct beneficiary population will be boys and girls from 0 to 10 years of age and their families in poor urban communities. The total cost of the project is US$ 4,762 million dollars over four years, among 18 countries. The greatest percentage of resources will be devoted to the development and implementation of integrated programs to promote early child development. Administrative costs have not been included, as they vary from one institution or country to another However, these expenditures will represent approximately 10 percent of the total cost.

This project represents a joint effort among Bolivia, Chile, Colombia, Mexico, Peru, and; Venezuela. The Organization of American States (OAS) and the Pan American Health Organization (PAHO) are providing technical advice and multinational administration capability. The countries decided to create an international Steering Committee, comprised of the OAS, PAHO, one representative of the countries, and one of the donor institutions.

1. PARTICIPATING INSTITUTIONS (Year 1)

Bolivia: Rural Development Program (DIPRAD), Chile: National Board of Kindergarten Schools (JUNJI); Colombia: Ministry of Education; Mexico: the Secretary of Education; Peru: : Department of National Early and Primary Schooling, Ministry of Education; and; Venezuela: Ministry of Education.

2. BACKGROUND:

The project has been developed using the experience of the Organization of American States, as the only intergovernmental institution in the Americas currently working with governments, academics, NGOS and grassroots organizations in the field of early childhood education. In this capacity, the OAS has accumulated both on-site experience and administrative capability, while serving as the lead organization in training technical personnel for UNICEF and organizing hemispheric symposia on the theme for the World Bank.

At the same time, the OAS and PAHO have long cooperated on a number of initiatives relevant to comprehensive early childhood education, among them: infant development, prevention of drug abuse, and mental health for children and mothers.

Based on this experience, the OAS and PAHO are prepared to address the concerns expressed by the Heads of State and Government at the II Summit of the Americas when they directed both organizations to assign high priority to early childhood education, to the needs of the women of the Americas and to the family.

3. BRIEF DESCRIPTION OF THE PROJECT

The project is divided into three major areas of action. The first pertains to the synthesis and dissemination of information on early child development, targeting the family, community agents, and technical personnel of the health and education sectors.

To this end, the creation of an expert committee is proposed in order to design and lead studies and regional meetings of multidisciplinary teams, consolidate studies at the regional level, and hold workshops with technicians from the different sectors to design standards that will serve as the foundation and guidelines for an integrated approach to child development.

The second area of the project is the most complex and pertains to the design and implementation of programs with an integrated approach to child development. In this instance, national and regional meetings for the design and preparation of programs and services will be held, together with workshops for training technical personnel in the development and management of integrated programs, activities to create and produce radio and television programs, and to train community agents for the development of community support networks.

For the third area, political and social mobilization, activities to disseminate information on the project at the political, administrative, technical, and community levels are proposed. Among these activities are participation at summits, the organization of regional symposia, and the launching of public awareness campaigns. Appendix 2 contains the logical framework and the proposed work plan, with more detailed information on programmed activities and tasks.

This project contains has been prepared with the participation of six countries of the Region for the benefit of the Region as a whole A considerable percentage of the budget will be devoted to activities at the national level, with international support on a smaller scale. Implementation requires the use of international technical cooperation resources, which will increase with the use of horizontal cooperation and mutual support strategies among the countries. The countries will also attempt to link this project with existing local early childhood stimulation initiatives already financed by international organizations such as the IDB, UNESCO, World Bank, European Union, and UNICEF, or by local sources.

In order to facilitate technical financing operations, the regional project will have a Steering Committee, on which the sponsoring and financing institutions plus

one representative of each country will serve. The Committee will draft regulations governing functions, responsibilities, and resource management.

Each country will have a multidisciplinary technical steering committee, which will serve as a link to the international Steering Committee. These national committees will submit their annual plans and requests for resources to the International Steering Committee. Other forms of organization can be used within each country to establish links with the technical steering committee. These alternatives will be subject only to national oversight in order to prevent the bureaucratization of the project.

Participating countries and institutions agreed that resources contributed to the project may be deposited with the OAS. The resources would governed by OAS Administrative Rules and Regulations, approved by PAHO, the countries, and the donor institutions.

4 – PURPOSE OF THE PROJECT

To promote and consolidate joint work by the health and education sectors for the development of healthy and educational spaces that support and foster early child development.

5. - OBJECTIVES

- Strengthen the capacity of the countries to develop and implement intersectoral programs and services that support the early stimulation in marginal urban areas[1]
- Increase the political support for investment in early child development and strengthen the capacity of the family and community to participate in early stimulation to promote child development.

[1] Marginal urban areas are areas located on the outskirts of cities and capital cities, which are characterized by high population density, poverty, and insecurity.

6 – PROJECT STRATEGY

In order to meet these objectives, three groups of strategies are proposed for the project:

a) Synthesis and dissemination of technical information concerned with comprehensive early childhood development in order to establish a frame of reference for the design of plans and models using this approach.
   - Studies and research (bibliographic, operational, and field).
   - Drafting and validation of standards for orienting and laying the foundations of early stimulation.
   - Use of the mass media and mass communication methods for disseminating information and mobilizing the different sectors of society to promote early stimulation.
   - Sharing of local, regional, and international experiences.

(b) Design, implementation, and validation of models of comprehensive early childcare[2] in order to promote integrated health care services.

(c) Human resource training and development to increase the knowledge of professionals, technicians, and health, education, and community services workers about early child development and its importance in order to support and promote it.

   - Setting of priorities and implementation of plans in support of early child development, through the use of a frame of reference for integrated child development.
   - Search for innovative intervention methods that incorporate the use of the mass media and distance education in order to support and promote early child development.
   - Development of validated models of integrated approaches in on-site facilities (in existing community spaces or through the establishment of recreational, educational, and health worker facilities), and distance models (through radio and television programs) directed at children, the family, community, and community agents.

---

[2] *Programs for the comprehensive care of children* are coordinated services and activities between the health and education sectors that promote and support the stimulation of early development. This concept involves the integration at all the different levels at which this can and must occur, that is the design, planning, organization, and implementation of these programs.

d) Political mobilization and social participation to promote the political, financial, and social sustainability of actions to promote early child development

- International, interagency, and intersectoral coordination focus on early childhhod development.
- Promotion of social participation—that is, of the community, family, and children—in the development of priorities, plans, and programs that lead to healthy children.
- Development and strengthening of community support and community networks and development of local capacity.
- Political mobilization to raise awareness among local and regional governments and institutions about the importance of supporting early child development.

7 – INTERESTED PARTIES

At the international level, the Social Development and Education Unit of the OAS and the Division of Health Promotion and Protection of PAHO will coordinate project activities. At the national level, the following six countries will participate through their respective institutions: Chile (National Board of Kindergartens and the Center for Pedagogical Research, C.P.E.I.P), Colombia (General Bureau of Research and Pedagogical Development, Department of Education), Costa Rica (Ministry of Public Education), Mexico (University of Monterrey, Secretariat of Public Education of Nuevo León, SEP, and Integrated Family Development of Nuevo León, DIF), Peru (National Directorate of Initial and Primary Education, Ministry of Education), and Venezuela (General Sectoral Bureau of Planning and Budget, Ministry of Education).

In the different countries, various health, social welfare, family ministry, and other entities will participate, and national coordinating institutions will collaborate with them.

8. - GEOGRAPHICAL AREA OF THE PROJECT AND BENEFICIARY GROUP

During the first year, the project will be carried out with the participation of the six countries mentioned above (Chile, Colombia, Costa Rica, Mexico, Peru, and Venezuela). During the second year, tentative plans include Bolivia, Argentina, Uruguay, Honduras, and Guatemala. During the third year, six additional Latin American countries will be incorporated.

The beneficiaries of the project activities can to be divided into two groups:

a) Children 0 to 4 years, 4 to 6 years, and 6 to 10 years, who live in marginal urban areas, and their parents and communities.

b) Educators, community workers, technicians, and administrators from the health, education, and other sectors involved in the project.

9. - CURRENT STATUS AND PROJECTED STATUS AT THE CONCLUSION OF THE PROJECT

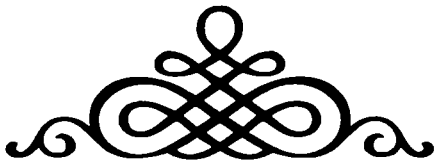
The health sector is playing a central and successful role in combating infant mortality and morbidity. While it is true that the efforts geared toward the control, treatment, and prevention of diseases are crucial, and from a qualitative standpoint yield positive results, the education sector also plays an important role in promoting early child. It is in this regard, i.e. contributing early child development, that the health sector of the countries of the Region needs to define its role and responsibility, and to develop and strengthen its capacity. This is becoming increasingly important, given that the demands currently placed on the health sector go beyond combating mortality and include issues related to equity and the quality of life.

Educational sectors, in turn, have expanded their coverage, but the sector requires more rigorous scientific information to orient policy decisions. This information is increasingly necessary to guide the implementation of formal and non-formal early childhood education programs, as well as to improve educational services for children up to 10 years of age.

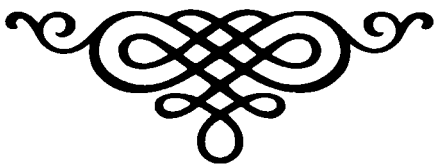
8.1 EXPECTED RESULTS:

Project activities will produce the following products and services:

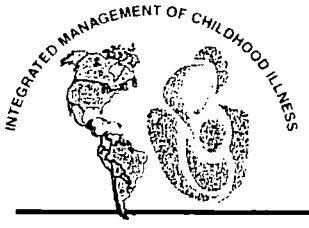
- Comprehensive education models for children targeting boys and girls, families and communities, community agents, and technical personnel..
- Awareness and mobilization campaigns promoting comprehensive education for children, directed at political levels, technical personnel, and public, private, and community groups.
- Eighteen trained national groups, prepared to maintain the development, execution, and evaluation of activities in comprehensive early childhood education.



PROJECT 5



Basis of the IMCI Strategy



imci

The **IMCI strategy** is designed to improve the health status of children under 5 by preventing the occurrence of cases of disease and deaths from causes that can be avoided through prevention, early diagnosis, and treatment. The application of this strategy, both in health services and in the community, can help to prevent 25,000 deaths of children under 5 every year in the Region of the Americas. Concerted effort to support effective implementation of the IMCI strategy in the countries should receive high priority in order to reduce the burden of avoidable disease and death that continues to affect thousands of children in the Region.

Why the IMCI Strategy?

1. The strategy of integrated management of childhood illness (IMCI) was developed to address the principal child health problems and ensure children access to prevention and health promotion measures that make it possible to reduce the most frequent risks of illness and death.

2. Development of the strategy began with analysis and identification of:

   The leading causes of mortality among children under 5, as well as causes which, though they do not account for a high number of deaths, can be avoided through the use of available control strategies.

   The leading causes of illness among children under 5, also including those that are not of large magnitude but are avoidable.

The principal strategies and interventions available for the prevention of disease and the promotion of healthy habits in the family, which can contribute to a better child health.

1. It was also taken into account that the care normally provided to children in health services has the following characteristics:

Focus on the reason for the visit, as explained by the parents: The health care provider seldom looks for other health problems that may be affecting the child.

Failure to systematically apply preventive and health promotion measures: The provider generally does not spend time during the visit to check the child's vaccination or nutritional status or take the opportunity to provide parents with information on disease prevention and proper care of the child in the home.

Lack of monitoring and follow-up on the child's progress: The outcome of the prescribed treatment is not checked, and the parents do not receive incentives for completing the treatment or applying disease prevention and child health promotion measures.

1. The principal problems seen in health services were also taken into account, including:

Deficiencies in the organization of health care: Lack of organization leads to overburdening of the health services, long waits for patients, lack of prioritization based on the severity of the illness, limited and difficult access to referral services, etc.

Failure by parents to seek early attention: By the time many children are seen, they have been ill for several days and their condition has become serious because the parents do not know the warning signs that should prompt them to seek prompt attention from a health care provider or service.

Failure of health personnel to recognize the signs of severe illness: As a result, classification and treatment of the child are delayed, and the risks of more severe illness, complications, and death increase.

Excessive and inappropriate use of diagnostic technologies: Laboratory and radiology services are requested unnecessarily for many children who are seen in health services. Often, the results are never used for diagnosis or treatment.

Excessive and improper use of drugs for treatment: Antibiotics are prescribed inappropriately and in excess for the treatment of many cases that do not require them. Many children receive contraindicated drugs, such as cough syrups and antidiarrheals for the treatment of acute respiratory infections (ARI) and diarrhea, respectively.

Unnecessary hospitalization for the treatment of many children with ARI and diarrhea.

2. It was recognized that the foregoing problems are generally due to the following causes:

The population's lack of access to health personnel or services: Lack of geographic, cultural, social, or economic access limits parents' ability to seek care for their children.

Health workers' lack of capacity at the first level of care: Health workers are unable to provide appropriate care owing to lack of essential supplies for the diagnosis and treatment of children or lack of knowledge and skills in the correct management of the cases they are called on to treat.

The community's failure to utilize trained health workers: The community may not seek care from health workers due to cultural constraints or lack of knowledge about the warning signs of serious illness.

What is the IMCI Strategy?

3. The IMCI strategy was conceived as a means of reducing high mortality from avoidable causes among children under 5, decreasing the number of cases of illness, and improving the quality of care for children. The strategy has the following features:

Focus on care of the whole child, not just on the cause for the visit, which enables the health care provider to assess and detect other health problems and illnesses and evaluate the child's overall condition (vaccination status, nutritional status), apply preventive measures (vaccination, administration of vitamin A, etc.), and educate the parents on how to improve child care practices in the home.

Early detection of all critically ill children through rapid assessment of nonspecific signs that may be associated with serious illness requiring hospital treatment so that the child can be referred immediately.

Treatment of all diseases that may be affecting the child, not just the illness that prompted the parents to bring the child to the health service.

Application of preventive measures together with treatment of the diseases and health problems detected, which helps increase vaccination coverage and monitoring of growth, development, and nutritional status, as well as application of other specific measures, such as administration of vitamin A.

Activities aimed at improving parents' child care behaviors at home by systematically talking to them about better eating habits, care, and child stimulation in the home.

Adaptable to the local epidemiological situation through the incorporation of other health problems of local importance (dengue, Chagas' disease, parasitic disease, etc.) and the exclusion of others that do not occur in some places (malaria, measles).

1. The IMCI strategy has the following advantages:

   Addresses the major child health problems, thus contributing to the child's recovery, which is the parents' primary concern.

   Systematically incorporates currently available prevention and child health promotion measures, thus helping reduce the risk of disease and reinforcing healthy habits in the family.

   Responds to the demands of the population by helping restore children to health and reducing the number of episodes of illness.

   Has a significant impact on child health by reducing the probability of illness and death from the most common childhood diseases.

   Is cost-effective, thus optimizing use of the resources that the population allocates to health protection and promotion and saving resources, which can then be devoted to the overall improvement of living conditions.

   Improves equity by making available to all children a package of basic interventions that help to improve their health status and reduce the gap that separates children in the developing countries from those in the developed countries with regard to child mortality and morbidity rates.

2. The IMCI strategy was also considered the most appropriate vehicle for improving parents' knowledge and practices in caring for children, since the opportunity is taken to educate parents each time a child is brought to a health service for any cause.

Principal Objectives of the IMCI Strategy

3. The IMCI strategy has three essential objectives:

   To reduce deaths among children under 5 due to communicable diseases and nutritional deficiencies for which effective interventions and prevention or treatment measures are available, especially deaths due to pneumonia, other infectious respiratory diseases, diarrhea, tuberculosis, malaria, dengue,

measles, other vaccine-preventable diseases, and infectious complications such as meningitis and septicemia.

To reduce episodes of illness due to diarrheal diseases, measles and other vaccine-preventable diseases, tuberculosis, malaria, dengue, and Chagas' disease, as well as malnutrition in children under 5 and serious episodes of diseases such as pneumonia and other respiratory infections.

To improve the health status of children under 5 through better quality of care, both in health services and in the home, through community action.

Activities to Implement the IMCI Strategy in the Countries

4. In the Region of the Americas, priority in the implementation of the IMCI strategy is being given to countries or areas within countries that have a high infant mortality rate (IMR)—over 40 per 1,000 live births. The strategy can have the greatest impact in these areas, and it will help increase the population's access to basic disease prevention and treatment interventions and improve equity in the health conditions of children.

5. Because application of the IMCI strategy improves the quality of health care for children in health services and in the home, its implementation is also considered important in countries and areas with an IMR of less than 40 per 1,000. In these areas, application of the IMCI strategy can:

   Contribute to a rapid and sustained decline in mortality among children under 5 through control of the principal causes of illness and death in this age group.

   Improve the quality of health care for children in health services at the first level of care, in the home, and in the community.

   Strengthen the application of preventive interventions (vaccination) and health promotion measures (breastfeeding, growth monitoring, etc.) in the population through systematic education and guidance of parents during health service visits.

6. The process of implementing the IMCI strategy includes three complementary components, all of which are crucial:

   Improvement of health workers' capacity to provide care for childhood diseases and health problems, including their detection, treatment, and application of preventive and child health promotion measures.

   Strengthening of the organization of health service activities at the first level of care in order to optimize the use of available material and human resources to ensure better quality of care for the population and greater user satisfaction.

   Improvement of family and community child care practices in order to increase the use of available measures for disease prevention and improvement of children's living conditions.

7. The activities to be carried out to **improve health workers' capacity** to apply the IMCI strategy are:

   Training in the use and application of the strategy in order to provide health workers with the knowledge and skills necessary to assess, classify, and treat children using this approach, as well as the knowledge and skills necessary for health education and promotion.

   Support and monitoring after training to ensure that the IMCI strategy is being effectively applied in the normal reality of the health services, thus contributing to the identification of obstacles and problems and to the design and implementation of appropriate solutions at each level.

1. The activities to be carried out to **strengthen health services' capacity** to apply the IMCI strategy, are:

   Assurance of continuous availability of the supplies necessary for the care of children in accordance with the procedures established under the strategy, in particular the drugs for treatment of diseases.

   Design and implementation of efficient and effective mechanisms to guarantee children's access to the various levels of care, especially in order

to avoid delays in referral of children to a hospital when the disease cannot be adequately treated at the first level of care.

Implementation of appropriate mechanisms to reduce waiting times in health services, improve follow-up to assess whether children are responding to treatment, and incorporate systematic education and prevention activities.

2. The activities to be carried out to **improve family and community child care practices** using the IMCI strategy are:

Education and interpersonal communication with the child's mother and family members during the health service visit with regard to treatment of the illness that prompted the visit and general care of the child in the home in order to prevent the recurrence of episodes or reduce their severity.

Education and interpersonal communication in all childcare settings (schools, nursery schools, daycare centers, etc.) or areas in which mothers and families congregate (churches, clubs, fairs, etc.) in regard to prevention and child health promotion (vaccination, breastfeeding, diet, housing, stimulation, etc.).

Mass dissemination of basic educational information on caring for children in the home and on prevention measures that will help to protect children from diseases and improve their overall health status.

3. In addition to the foregoing, the IMCI strategy also includes activities relating to monitoring, follow-up, and evaluation of the implementation process and the results obtained vis-à-vis the objectives. It can thus be confirmed that the effort made by all the countries represents progress in terms of a significant reduction in the number of deaths and cases of disease that can be prevented through the use and application of the IMCI strategy.

How Can we Support the Implementation of the IMCI Strategy in the Countries?

4. To achieve the benefits of the IMCI strategy in reducing the number of deaths and cases of preventable diseases and improving the quality of life of children under 5 in the countries of the Americas, it is fundamental to obtain the commitment of all sectors in support of the strategy's application. Political authorities, academic institutions, scientific societies, public and private health care providers, social security, businesses and other influential sectors of the economy, religious leaders, and in general all people and institutions with influence in society should support practical application of the strategy in the community and in all settings in which children are cared for.

5. To that end, it is necessary:

   To collaborate in publicizing the importance of the IMCI strategy among the key institutions and people in the community, on whom decision-making in support of better health conditions for children depends.

   To help ensure that health services and workers—especially in the areas that are most underdeveloped socially and economically—are in a position to apply the IMCI strategy. This means ensuring that they receive the information and training necessary to enable them to apply the strategy, as well as continuous availability of essential drugs for the treatment of diseases and support mechanisms to identify and resolve obstacles and problems, both in the provision of care (for example, referral to hospital) and in application of the strategy in daily practice (for example, supervision).

   To support the dissemination of educational information on disease prevention and child health promotion in the community, encouraging interpersonal communication activities in health services or other places in which children and families congregate and supporting dissemination to the population of basic information on preventive measures, such as vaccination, exclusive breast-feeding during the first four to six months of life, and proper feeding of children.

The persistence of preventable deaths and diseases among children under 5 in all countries of the Americas is a constant reminder of the lack of equity in access to knowledge and basic preventive, diagnostic, and treatment interventions.

The IMCI strategy provides the opportunity to put this knowledge and these interventions within reach of the entire population.
A concerted effort can help accelerate the achievement of universal access

Progress in Implementing the IMCI Strategy in the Countries

1. The IMCI strategy has been adopted in 13 countries of the Americas (Table 1) as the principal intervention for reducing child mortality, decreasing the number and severity of episodes of illness that affect children under 5, and improving the quality of child health care in the community and in health services.

2. Twelve of these thirteen countries have already developed national plans for implementation of the IMCI strategy (Table 1), selecting the regions or areas of the country with the highest mortality for the initiation of the activities in order to achieve a rapid impact.

3. The 13 countries that have adopted the IMCI strategy have carried out national clinical training courses (Table 1) for the health workers who are responsible for applying the strategy in caring for children and transmitting to the community the knowledge and practices necessary to improve the health status of children under 5.

4. Hence, 13 countries now have health services with staff trained to provide the population access to the benefits of the IMCI strategy, thus improving the response to the illnesses that affect the health and threaten the lives of children.

5. As of May 1999, approximately 10,000 people in the countries of the Region had been trained and can now provide access to the IMCI strategy in the health services in which they serve. During 1999, continued support is to be given to the countries in order to increase the number of trained staff, the goal being to have 20,000 trained health care providers before January 2000.

6. An additional effort is expected to increase children's access to the IMCI strategy, especially in the areas that have the highest mortality figures and lack access to health services located within a reasonable distance. The training of community health agents (CHA), auxiliaries, and other technical personnel in these areas to serve as transmitters of knowledge and good child care practices will help improve the coverage of preventive and child health promotion measures.

Table 1
Progress in Implementing the IMCI Strategy in Countries of the Region of the Americas
1999

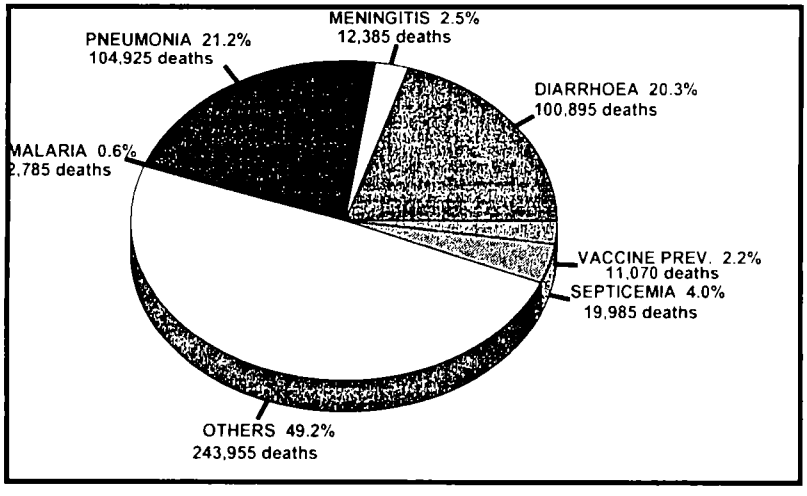
Country	Adoption of the Strategy by the Country	Development of a National Implementation Plan	Execution of the IMCI Clinical Course	Health Services with Staff Trained in IMCI
Argentina		x	x	x
Bolivia	x	x	x	x
Brazil	x	x	x	x
Colombia	x	x	x	x
Costa Rica				
Cuba				
Chile				
Dominican Republic	x	x	x	x
Ecuador	x	x	x	x
El Salvador	x	x	x	x
Guatemala	(*)			
Guyana	(**)			
Haiti	x	x	x	x
Honduras	x	x	x	x
Mexico	(*)			
Nicaragua	x	x	x	x
Panama				
Paraguay	x	x	x	x
Peru	x	x	x	x
Uruguay				
Venezuela	x	x	x	x
TOTAL	15	12	13	13

Note: Countries not mentioned in the table have not initiated activities for the implementation of the IMCI strategy
(*) Countries that have an integrated child health care model
(**) Countries in the process of introducing the IMCI strategy

imci

Integrated Management of Childhood Illness Informative Summary

Every year, more than 250,000 children under 5 years of age die in the countries of the Americas due to illnesses that could easily be prevented or treated.



The three leading causes of these deaths are acute respiratory infections, which cause more than 97,000 deaths; diarrheal diseases, which are responsible for more than 90,000 deaths; and malnutrition, which accounts for almost 30,000 deaths a year. Malaria is another cause of illness and death among some children. Measles also continues to be a serious problem, especially where malnutrition is common, although the incidence and mortality from the disease have been significantly reduced as a result of mass vaccination campaigns in the countries.

To help reduce these deaths, a new strategy, Integrated Management of Childhood Illness (IMCI), is being implemented by the Pan American Health Organization, Regional Office of the World Health Organization (PAHO/WHO) and the United Nations Children's Fund (UNICEF), together with other cooperation agencies. The approach under this new strategy is to treat the whole child, rather than focusing on only part of the problem. Through IMCI, the principal problems and diseases that affect the health of children are systematically assessed in order to detect and treat any specific diseases or general signs of danger.

The IMCI strategy calls for preventive interventions and education of parents on the care of children in the home in order to help prevent illness and improve their overall health status.

The World Bank's World Development Report for 1993 identified integrated management of childhood illness as the most efficient health intervention in terms of its impact on the burden of disease and death in the population, as well as its cost-effectiveness.

The World Summit for Children, held in 1990, set the goal of reducing infant mortality one-third by the year 2000. Implementation of the IMCI strategy is essential to achieve this important goal.

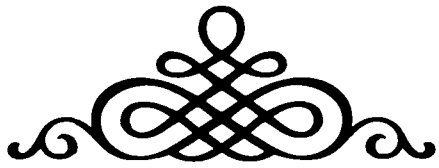
The Pan American Health Organization and the United Nations Children's Fund are committed to implementing the IMCI strategy in the Region of the Americas in order to prevent the unnecessary childhood deaths that occur daily in our countries. This strategy aims to achieve the following:

- **Reduce mortality** from prevalent illnesses in children under 5, specifically deaths due to diarrheal diseases, acute respiratory infections, malnutrition, measles, and malaria.
- **Reduce the number and severity of cases** of diarrheal diseases, acute respiratory infections, and measles.
- **Improve quality of care for children** in health services, reducing inappropriate use of diagnostic and treatment technologies.
- **Introduce child health promotion and disease prevention interventions** into the routine care provided by health services.
- **Extend integrated care to the community level.**

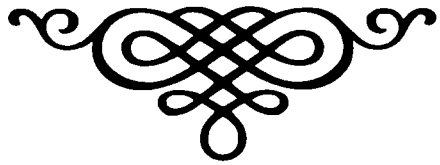
Pan American Health Organization/World Health Organization
(PAHO/WHO)
Division of Disease Prevention and Control
Communicable Diseases Program
Integrated Management of Childhood Illness
Internet: http://www.paho.org

11-Jun-99

I:\lxd\Spouses\Technical Meeting\Projects\Endorsement\IMCI strategy formatted.wpd



PROJECT 6



PREVENTION OF DOMESTIC VIOLENCE THROUGH CHILDHOOD EDUCATION

BACKGROUND

Introduction

This project is based on close co-operation among the region's countries, and takes into account successful experiences in the effort to eliminate violence during childhood. Its purpose is to have a multiplier effect on activities and specific tasks that can be adapted to the needs of the countries that require them.

General Objective

The project's general objective is to prevent domestic violence through family education, schooling, and positive use of the media.

It aims at raising society's and government's awareness of the problem and strengthening their determination to solve it.

Childhood education should also be examined, emphasizing non-violent solutions to conflicts and assessing gender differences.

The project also aims to introduce a form of education that emphasizes non-violence; such a system would not only educate, but also help create values and principles in the socialization process whereby children themselves are the guarantors of public safety.

Specific Objectives

- Participate, according to specific needs, in the planning, design, development, and promotion of national policies and legislation related to women, children and the family.

- Train human resources in the prevention of domestic violence:

  i) Advise women about their rights and those of their families
  ii) Advise families about children's rights and non-violence
  iii) Prevent family crisis situations

- Help to change society's attitudes towards domestic violence, as is being done in current environmental and anti-smoking campaigns.

- Organize awareness campaigns in cooperation with local media (radio, TV and newspaper) to inform the public about national laws and

international agreements to combat domestic violence.

- Work to have the subject of non-violence included in primary and secondary school curricula.

Expected Results

The following are the expected results of the studies and activities described in the attached project:

- Short Term

i) Increase social awareness of violence towards children, women, the elderly, the disabled and the most vulnerable groups in general by encouraging public participation and responsibility.

ii) Involve parents, educators, students and the community in violence prevention programs.

- Medium Term

i) Develop anti-domestic violence policies.

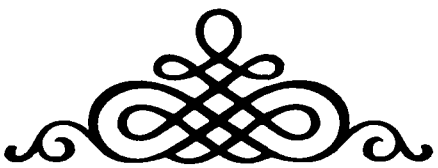
ii) Develop suitable laws that take all family members into consideration.

iii) Include the subject of violence in the curricula of primary and secondary school.

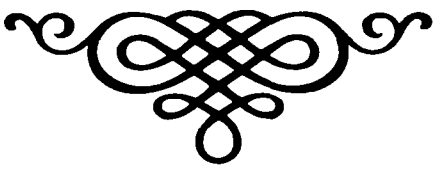
iv) Work with the media to change viewer attitudes toward violence.

Project Starting Date

The Project was drafted at the IACI and will begin once funding has been obtained.



PROJECT 7



DESAPER PROJECT: NARRATIVE SUMMARY

1. - BACKGROUND

The DESAPER Project, launched in 1989, is being carried out by the Latin American Center for Perinatology and Human Development (CLAP) of the Pan American Health Organization (PAHO), with the collaboration of the International Development Division of the University of Calgary.

The DESAPER Project is funded by the Canadian International Development Agency (CIDA) and is being executed in eight program areas in four countries of the Region: Bolivia, Honduras, Nicaragua, and Peru. A total of Can$ 7,000,000 has been allocated for project implementation.

Of the eight program areas selected for the implementation of this Project (two for each participating country), three are periurban areas (San Gabriel in Bolivia and the Tahuantinsuyo Bajo and César López Silva sectors in Peru), while the five others are urban/rural (Chapare Tropical in Bolivia, Santa Rosa de Copán and La Paz in Honduras, and Nandaime and Tipitapa in Nicaragua).

The total geographical area covered by the Project is 30,800 km^2 (ranging from 17 km^2 in Tahuantinsuyo Bajo, Peru to 10,000 km^2 in Chapare Tropical, Bolivia), with a population of approximately 500,000 in 1998 (ranging from 30,000 inhabitants in Tahunatinsuyo Bajo, Peru to 116,000 in Santa Rosa de Copán, Honduras). The average population density in the periurban areas is 1,250 inhabitants per km^2 and 44 inhabitants per km^2 in the urban/rural areas.

The services network is made up of 85 peripheral health centers, 8 major area hospitals, and 8 regional referral hospitals. The expected population of pregnant women was 18,528 in 1991 and 24,600 in 1997. The expected number births in 1991 was 15,960 and in 1997, 21,650.

In each country, management of the Project was assigned to a National Facilitator and two Local Coordinators (one for each work area). In addition, each area had a team comprised of an obstetrician, a pediatrician, nursing personnel from both specialties, and personnel from the communities.

2. – GENERAL OBJECTIVES AND PURPOSES OF THE PROJECT

2.1 - GENERAL OBJECTIVE

a) To improve perinatal and maternal and child health in eight areas of four Latin American countries (Bolivia, Honduras, Nicaragua, and Peru).

2.2 - PURPOSE

a) To strengthen the local health services and secure the active participation of the community and its resources, with a view to of improving perinatal and maternal and child health.

b) To disseminate information on positive experiences in the countries where the Project is in place and in other countries of the Region.

2.3 EXPECTED RESULTS

a) Improvement in the quality of perinatal and maternal and child health services.

b) Greater community participation, organization, and training, and use of community resources to achieve the objectives and purposes of the Project.

c) Strengthening of linkage and coordination between the services and the community.

d) Incorporation of positive Project experiences by the participating countries (and by other countries of the Region), with a view to their application at the national level.

In order to achieve these results, three basic components served as the foundation for the Project:

- Development of appropriate state-of-the-art technologies and information systems and participatory processes. These were developed for health workers and the community alike. Therefore, guidelines were issued for care during pregnancy, childbirth, and the puerperium, the immediate care of newborns, management of obstetric emergencies, and pediatric care. These state-of-the-art approaches were supported by technologies developed to facilitate the different aspects of care for pregnant women and normal and asphyctic newborns, and to detect changes in the growth and development of children.

The lack of information in the services, however, necessitated the rapid implementation of systems for the recording and automated analysis of perinatal and infant data to establish a baseline that would make it possible to monitor and evaluate the progress of the Project. The data recorded through modular, precoded clinical histories, which served, moreover, to orient individual care. A similar system was developed for community use. These systems were furnished with the

respective software, computer equipment, and user self-instruction manuals and guides for the utilization, analysis, and interpretation of the data processed. For the community component, a number of participatory games were developed to promote care during pregnancy and the puerperium, as well as pediatric care and community development. Educational videotapes were also produced, together with manuals on participatory techniques and perinatal health for use by community promoters in their communities.

- **Systematic training.** This was directed to health workers, community agents, and communities, with special emphasis on pregnant women and women of childbearing age, following a model of gradual inclusion.

In June 1990, all personnel in the eight areas had received training on care during pregnancy, childbirth, and the puerperium, care for newborns, and training on the use of support technologies and procedures and on the information systems mentioned above.

The initial training was conducted over an eight-month period, targeted to approximately 1,000 health professionals such as physicians, nurses, auxiliary personnel, as well as community personnel. These workshops were aimed at incorporating the proposal into the areas of work. All the material prepared was distributed during these workshops. The operating requirements were met during the course of one year. Furthermore, in keeping with local requirements, a program was set up for annual shipment of these and other materials produced in the future. This made full coverage with these materials possible throughout the Project.

During that year and the two years that followed, the personnel selected from local area teams received fellowships for courses on Maternal and Child Public Health, Research Methodology, and Perinatal Technologies conducted at CLAP headquarters.

Between 1991 and 1994, many workshops were held in the eight areas, employing the different state-of-the-art technologies that were being developed at the time: self-instruction manuals on utilizing the data in the information systems, state-of-the-art technologies for different obstetric emergencies, participatory games, manuals for community promoters, and various support technologies for monitoring labor, etc.. Finally, between 1995 and 1996, guidelines were adopted for monitoring growth and development and health promotion and protection for children; family planning; prevention of STDs and cervical and breast cancer; as well as support technologies for assessing fetal, neonatal, and infant growth.

Activities were frequently monitored during the 1989-1993 period in the eight areas of the Project. The objective was to monitor the development and execution of the different components of the Project in an orderly and systematic fashion, based on supervision that provided guidance and training.

The object was to consolidate the processes implemented and to strengthen the capacity of the local Project teams to exercise leadership in this task. This was a slow process due to the frequent turnover of the personnel assigned to these teams in the different countries. This weakness affected training in the services, where the high rate of turnover necessitated permanent training and local supervision by the Project teams.

By late 1993 and into 1994, greater stability among Project personnel was achieved. The countries also began implementation of a number of DESAPER proposals, while community efforts for the first time began to yield tangible results. These aspects were probably important to the general stability of the Project. As a result, in 1994, in terms of supervision and training, the local Project teams managed to maintain a training rate for local personnel of over 85% (despite the frequent turnover of these resources). These levels were even surpassed in subsequent years.

This period marked an important point for CLAP and the DID, since it enabled them to gradually reduce their presence in the areas, allowing them to begin training and supervision at the country level.

Therefore, out of a total of 1,203 consulting days in the Project areas (excluding management and regional or subregional meetings), 78% of this time (939 consulting days) corresponds to the period 1989-1993, 8% to 1994 (96 consulting days), 7% to 1995 (84 consulting days), 3.5% to 1996 (42 consulting days), and the remaining 3.5%, to 1997.

- Support and strengthening of the organization and infrastructure of the health services. In 1990, training activities were complemented with visits to the health services. During these visits it was possible to determine the basic equipment requirements for ensuring a minimum quality of care for mothers and children. In the two subsequent years, the same procedure was followed with respect to equipment supply.

Through contacts with other international cooperation agencies, it was possible to procure other equipment that, because of its cost or other constraints, had not been programmed for the Project.

With regard to infrastructure, contacts were developed with other international agencies, NGOs, and organizations to obtain resources to address the urgent infrastructure deficiencies at a number of institutions. These funds facilitated the construction of two maternity wards and two maternity centers, as well as the construction and rehabilitation of various health centers.

Concerning the internal organization of the services, an effort was made to achieve suitable technical and administrative reorganization, delineating roles and responsibilities in areas and sectors. Standards for biosafety and emergency care were established, committees to analyze information on maternal, perinatal, and

cesarean mortality were formed, and the review and discussion of cases were encouraged, all of which gradually became regular institutional practice.

- **Support and strengthening for the development of local processes and initiatives.** In the area of community participation, one of the most important elements of DESAPER has been training for community staff on their home turf and their direct and effective inclusion in maternal and child health promotion efforts. This aspect was especially important in the development of local plans based on an organized, planned community structure. This process resulted in diversity and creativity, in mobilization and participation strategies, as well as the creation of microprojects. More than 300 microprojects were implemented while the Project was under way, with a direct impact on maternal and child health and the integral development of communities. These activities provided opportunities for reflection and for establishing links with the health services, thus permitting active community participation in the identification and solution of the most urgent health problems and facilitating community involvement in health service activities. These processes fostered broad and growing intersectoral cooperation, resulting in sponsorship from several sources outside the Project, among them international cooperation agencies, NGOs, local government agencies, and private organizations.

Broader links among the different Project activities have led to better communication and relations between the communities and the health services. However, it should be recognized that this process requires time and an ongoing commitment on the part of the various actors involved.

The participation of women has been promoted intensely by the Project. Their involvement in the development and implementation of a number of microprojects and community processes has been especially significant. However, it should be acknowledged that these achievements notwithstanding, women can play an even more decisive role in terms of their participation in the processes that influence practices and policies in health centers and hospitals.

3. RESULTS

Multilateral links were developed among the four categories of interventions, whose level of development determined the impact achieved in each Project area.

Based on all of this, positive results were achieved in the different aspects of maternal and child health. These results expressed themselves in biomedical terms, with improvements in a number of epidemiological indicators (see the Executive Summary), and also in social terms, generally in greater awareness and empowerment of communities and individuals regarding maternal and perinatal health and social development.

Concerning these results, it should be noted that it was possible to construct the baseline approximately one year into the Project; it can therefore be assumed that these values reflect a certain degree of change resulting from the Project interventions.

4. LESSONS LEARNED

Some of the most important lessons learned are summarized below.

4.1 Cooperation between Institutions and Agencies

- Cooperation between CLAP and DID. This has had a significant impact on the development of the Project. These institutions have joined efforts and worked together to achieve the same result. The key to building this partnership has been an ongoing dialogue, openness to new ideas, and negotiation, seeking to place the different professional visions of the two institutions in a contemporary context in the search for the solutions best suited to the management and development of the Project.

- Cooperation between CLAP/DID and the ministries of health of the countries. This was a process that required ongoing adaptation to conditions in the countries--particularly, to changes in policy and personnel, which led to temporary lapses in continuity. Similarly, the personnel directly linked to the Project often exercise different and important functions in their ministries, which sometimes affects their work in the Project. One very important lesson has been the need to adapt plans and strategies of action to local conditions.

- Cooperation between the ministries of health and PAHO. This relationship has been very important in each country. PAHO involvement lent great credibility to the national authorities in the countries with respect to the Project's potential. The Representative Offices assumed responsibility in the countries for the administration of funds and the supply and distribution of work materials and equipment, in addition to providing logistical and technical support. PAHO participation was indispensable for ensuring the proper management of the Project at each level.

4.2 Working teams and Cooperation

- Cooperation between components. At all times, the Project sought to promote cooperation between the health services and communities. Although each component was developed independently, the activities benefited from integration strategies resulting from the ongoing dialogue and coordination between those responsible for the two components in CLAP, DID, and the countries. The role of the working teams in this regard was clear. There is sufficient evidence that many of the indicators of the services evaluated benefited greatly from the community interventions.

Maintaining this cooperation entailed a tremendous effort. The geographical distance between CLAP and DID created additional difficulties. The presence of CLAP and DID in the countries was decisive in this regard, and other impersonal forms of communication (fax, e-mail, and open telephone lines) provided useful alternatives.

- **Management committees.** The work of these committees made it possible to monitor the progress of the Project and the planning of joint activities and strategies.

- **Ongoing evaluation and participatory evaluation.** The evaluation processes provided an opportunity for continued learning at all levels. This activity can be considered one of the most important keys to the planning and implementation of activities, and to the development of the training processes. The Project has invested a significant portion of its time, effort, and resources in these activities.

- **Interagency and intersectoral coordination.** The coordination or links among the various agencies, NGOs, and different local government entities, in terms of objectives and purposes that are compatible with those of the various components of DESAPER, made important achievements possible in the areas of technical support, equipment, funds for infrastructure and buildings, and for the development of community microprojects.

5. GENDER

Concerning the role of women, several facts are clear: the principal beneficiaries of the project have been women of childbearing age. They have been provided with better quality maternal and perinatal care services, health education, and expanded possibilities for greater participation in the decision-making processes of the communities in which they live. The inclusion of community strategies in health processes has allowed women to participate directly in many activities and become involved in a wide variety of processes.

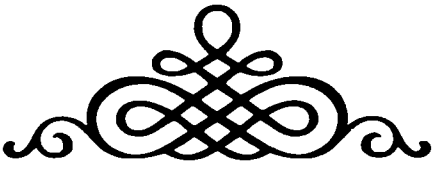
DESAPER has helped to train women at the professional level--physicians, nurses, social workers, and health workers. Women have been represented on the working teams at the local and central levels, in the services, and in community processes. Their perspectives have eagerly been incorporated into the management of perinatal and maternal and child health care in the local health services of the areas, thereby fostering important changes.

These aspects have not only had an impact on the indicators of maternal, perinatal, and child health, but have promoted recognition of women's contribution at the family and community levels.

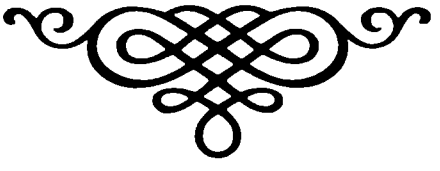
6. DISSEMINATION

The positive experiences of the DESAPER Project have been taken up, to varying degrees, by the different governments through specific projects (UNICEF, USAID, European Union and the Government of the Netherlands in Honduras, the World Bank, PL480 and the Government of Sweden in Nicaragua, USAID in Peru, and by various NGOs in Bolivia). These experiences have not, however, been included in a specific plan for dissemination--that is, incorporated logistically into the national health policies of the participating ministries. In general terms, at the most recent Project management meeting, held in Santa Cruz, Bolivia in June 1998, the governments of the four countries expressed an interest in adopting and disseminating information on some of the positive experiences of the Project.

In response to this initiative, CIDA proposed that CLAP and DID work on developing a proposal for a new phase, with that objective in mind. This proposal, which was adopted last November, is in its initial stages and will conclude in December 1999. CIDA has approved funding in the amount of Can$ 500,000 for its execution. The activities will consist of training for personnel from participating countries in evidence-based medicine, the use of electronic libraries, epidemiological surveillance and diagnosis, and public education for the development of perinatal health.



PROJECT 8



Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

PROJECT DOCUMENT

Presented to the IXth Conference of Spouses of Heads of States and Government of the Americas, Ottawa, Canada (29 September to 1 October 1999)

Conference Theme: "A Healthy Start: Children from 0-6 and Women's Health"

Project Title:	**Advocacy for a "Healthy Start": Prevention of HIV/AIDS in Mothers and Children**
Countries/regions covered:	Latin American and Caribbean countries
Project duration:	2 years (October 1999 - October 2001)
Implementation/Coordination:	UNAIDS (Joint United Nations Programme on HIV/AIDS)
Sponsorship:	Conference of Spouses of Heads of States and Government of the Americas; First Ladies in their respective countries
Primary beneficiaries:	HIV-positive pregnant women, mothers and infants
Secondary beneficiaries:	Women, children, men, parents to be
Initial project budget:	US$ 50,000

Of the estimated total number of 1,730,000 people living with HIV/AIDS in Latin America and the Caribbean, 390,000 are women and nearly 30,000 are children. Mother-to-child transmission (MTCT) is by far the largest source of HIV infection in children below the age of 15. Recently, many advances have been made in developing effective and affordable interventions that reduce the likelihood that a mother will pass HIV on to her baby. However, in order to benefit from them, HIV-infected women would have to know their HIV status. This is far from being the case since 9 out of 10 seropositive people do not know that they are infected.

There is an imperative need for increasing awareness of the basic facts about HIV transmission and prevention, especially among young people, about Mother-to-child transmission and the possibility of having an uninfected baby through a package of preventive measures, about availability and advantages of voluntary counselling and testing, and about issues such as stigma, denial, fear, human rights and solidarity with people infected and affected by HIV/AIDS.

80 mil - mild

40 mil-1, my

98 6 mil new infection

2 1/2 mil deaths

This project is to mobilize political and public support to stimulate effective local responses to reduce the transmission of HIV and related stigma through advocacy and awareness raising activities under the sponsorship of the IX. Conference of Spouses of Heads of States of the Americas.

I. Background Information

The status of the HIV/AIDS epidemic

With an estimated 5.8 million new infections in 1998 - nearly 16,000 every day - the total number of people living with HIV/AIDS worldwide grew to 33.4 million, including 1.2 million children under 15. Sub-Saharan Africa is the region with the fastest growing epidemic, with 70% of the global infections. But the virus is now spreading fast in other regions of the world: in Asia, a doubling of infections has occurred in almost every country since 1994. 1,730,000 people (including 390,000 women and nearly 30,000 children) are living with HIV/AIDS in Latin America and the Caribbean where HIV is concentrated for the most part in disadvantaged populations living on the social and economic margins of society, with rising rates in women. The Caribbean shows the highest HIV rates in the world after sub-Saharan Africa and in the Central American sub-region, recent epidemiological indicators point towards an important progression of the HIV/AIDS epidemic.

Everywhere, the proportion of women among those infected is growing. More children are contracting HIV than ever before and there is no sign that the infection rate is slowing. The effects of the epidemic among young children are far-reaching: AIDS threatens to reverse years of steady progress in child survival, and has already doubled infant mortality in the worst affected countries.

Women accounted for 43% of HIV infected adults living worldwide at the end of 1998. The virus is firmly embedded among women for whom, very often, the only risk behaviour is having sexual intercourse with their husband or regular live-in partner. AIDS prevention campaigns often fail to meet the needs of women by assuming that they are at low risk, or by urging prevention methods that women have little or no power to apply. Globally, there are around 12 million women of childbearing age who are HIV-positive. And the number of infants who acquire the virus from their mothers is rising rapidly.

Mother-to-child transmission (MTCT)

MTCT is by far the largest source of HIV infection in children below the age of 15. The virus can be transmitted during pregnancy, childbirth, or breastfeeding.

In the absence of antiretrovirals and viable alternatives to breastfeeding, children born to HIV-positive mothers have one chance in three of contracting the virus. About one third of these become infected through breast milk, with the other two-thirds infected in utero or during birth.

In 1998 and 1999 several short antiretroviral regimens to reduce MTCT, that are easier to administer and less expensive than the previously available regimens, proved their efficacy in studies in Thailand, Ivory Coast and Burkina Faso as well as in the UNAIDS-sponsored perinatal transmission trials.

Given the importance of breastfeeding to infant health, but recognizing the part breast milk plays in Mother-to-child transmission, UNAIDS, UNICEF and WHO recommend that appropriate alternatives to breastfeeding are made available and affordable for women who test HIV-positive, while efforts to protect, promote and support breastfeeding by women who are HIV-negative or are of unknown HIV status, need to be strengthened.

Prevention strategies

Until recently, there were only two main strategies for limiting the numbers of HIV-infected infants: (1) primary prevention of MTCT - taking steps to protect women of childbearing age from becoming infected with HIV in the first place; and (2) the provision of family planning services for HIV infected women to help them prevent unwanted pregnancies.

Today, there is a third option for HIV- positive women who want to give birth consisting of a short course of antiretroviral drugs for the mother (and sometimes the child) and replacement feeding for the infant. Recent trials show that a short regimen of zidovudine pills given during the last weeks of pregnancy cuts the rate of Mother-to-child transmission during childbirth by half, at less than a tenth of the cost of the longer course. Pilot projects to examine strategies to increase alternate infant feeding methods for HIV positive mothers are underway.

Introducing a strategy of antiretroviral drug use and replacement feeding is a complex process. To begin, expectant mothers and their partners need to know whether they are HIV-positive, and they must therefore have increased access to voluntary counselling and testing.

Counselling and voluntary testing

For women to take advantage of measures to reduce MTCT, they will need to know and accept their HIV status. Ideally, everyone should have access to such services since there are clear advantages to knowing one's serostatus. However, currently in many countries, there is only limited access to good quality voluntary and confidential HIV testing and counselling services.

Stigma, discrimination and human rights

It is essential to the safety and acceptability of MTCT interventions that effective steps be taken to combat discrimination and rejection of people with HIV/AIDS. Where women fear discrimination and violence if they are identified as HIV-infected, they will

be reluctant or unable to take advantage of opportunities offered to protect their infants from infection. It is still common for women to be blamed for spreading sexually transmitted diseases (STDs), including HIV, despite the fact that very often they are infected by the husband or partner to whom they are faithful and whom they trust. Special attention must be paid also to developing positive and non-judgemental attitudes towards HIV/AIDS among health staff who provide assistance to people living with HIV/AIDS.

Respect for the general human rights and dignity of People living with HIV/AIDS provide the foundation for effective and ethical practice in many areas of AIDS prevention and care. Combating stigma and negative community attitudes, the protection of human rights of people living with HIV as well as the expression of support and solidarity towards those infected and affected by the epidemic is not only a moral imperative but a prerequisite for effective prevention and care efforts.

Health-care systems

Mother-and-child health services, including widely available and acceptable antenatal, delivery and postnatal services, are essential. Counselling services and medical care for HIV-positive women and their children should also be part of the basic health care provision. Where the basic services are already in place and operating efficiently, the cost of providing HIV counselling and testing, antiretroviral drugs and replacement feeding is likely to be well distributed across the health system and relatively easy to absorb.

The wider benefits

Providing voluntary counselling and testing, antiretroviral drugs and replacement feeding for the reduction of MTCT has benefits that extend way beyond the direct benefits to the health and survival of infants. All pregnant women, mothers and infants will benefit from the expanded provision and improved quality of health care, especially mother-and-child health, antenatal, delivery and postnatal services. And the population as a whole will benefit from general strengthening of the health infrastructure, as well as from the increased understanding of the HIV/AIDS epidemic and its implications. The introduction of a strategy for the prevention of HIV infection in infants and young children can be a force for social change, providing the opportunity and impetus needed to tackle often long-standing problems of inadequate services and oppressive attitudes related to HIV/AIDS prevention and care and the broader social issues.

The UN Inter Agency Task Group on prevention of MTCT.

UNICEF, WHO and UNFPA, together with the UNAIDS Secretariat are members of the Task Group on MTCT which was set up in March 1998.

The goal of the inter-agency Task Group is to reduce HIV infection rates in infants and young children through the prevention of HIV infection among parents-to-be, the prevention of unwanted pregnancies of HIV infected women, and the prevention of transmission from HIV+ women to their offspring. A first step is to assist countries to identify locally appropriate ways of dealing with these issues.

II. Justification and Contents of the Project

The number of new infections in females is growing faster than in males and women of childbearing age make up an ever-increasing proportion of people with HIV worldwide.

Mother-to-child transmission of HIV is the leading cause of HIV infection in children. In 1998 alone, half a million children worldwide were born with HIV and their number will increase. There is urgency to expand the access to antiretroviral drugs and to replacement feeding methods as alternatives to breastfeeding among HIV infected women.

The attention given to antiretroviral therapy as a means of decreasing mother-to-child transmission should not, however, hide the fact that it is only one of the elements that contributes towards a decrease in MTCT and is only effective in the larger context which includes better access to voluntary counselling and testing services, access to pregnancy prevention methods for HIV infected women, improvement of ante-natal care services, as well as the broader issue of prevention of HIV infection, through education and information, among women of child-bearing age.

Intense advocacy and awareness raising efforts are necessary to stimulate effective local responses, to overcome stigma and discrimination and to draw attention to the need, and the feasibility, of creating a supportive environment.

Proposed action

Based on the experience that effective action on the HIV/AIDS epidemic is directly linked to strong political support from the highest levels of society and in the belief that behaviour change addressing socio-cultural and structural factors is critical in the prevention of HIV risk and vulnerability, **this project aims at receiving the sponsorship of the IX. Conference of Spouses of Heads of States of the Americas** in order **to stimulate** effective responses to the prevention of Mother-to-child transmission of HIV through a combination of advocacy efforts.

In the context of this corporate sponsorship, First Ladies in their respective countries will exert personal efforts which may include public speaking, supporting sensitization campaigns, participation in special events and radio/TV programmes/debates or other involvements and initiatives in favour of the prevention of mother-to-child transmission of HIV/AIDS, by addressing issues such as prevention of HIV/AIDS among young people, voluntary counselling and testing, stigma, denial, human rights and solidarity.

The project includes a provision for 3-month advisory services to help prepare a strategy for advocacy in collaboration with offices of First Ladies in selected countries and for advice on availability of global and regional technical resources networks on HIV/AIDS. The budget also includes a provision for the production and dissemination of relevant Best Practice and information material.

•III. Objectives

To help reduce the transmission of HIV and related stigma through advocacy and awareness raising activities, including public speaking, addressing seminars, conferences, meetings, schools, universities, cultural events, supporting sensitization campaigns, public information, radio/TV programmes, press, visits to VCT and health care centers and to People Living with HIV/AIDS, etc, and by addressing issues such as:

- Prevention of Mother-to-child transmission through a combination of efforts, including Voluntary Counselling and Testing and safe alternatives to breastfeeding for HIV-positive mothers;
- The children's right to survival, protection and development;
- Prevention of HIV/AIDS, especially among young people, considering that the best MTCT prevention is the prevention of infections among young men and women of child-bearing age in the first place;
- Stigma, denial, human rights, solidarity;
- Individual, institutional and community behaviours and the need for creating a supportive environment.

IV. Budget

US$ 50,000	- 3-month advisory services for resource person (1) to help prepare strategic information/advocacy material for/with First Ladies of high-prevalence countries and advising their offices on global and regional technical resources information coordination/ networking; (2) prepare review report for next (Xth)Conference of Spouses of Heads of States and Government of the Americas and propose follow- Up action based on progress achieved and challenges faced. - Production and dissemination of relevant Best Practice and information material

./.

UNAIDS

Established in 1995 and launched in 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) is an innovative joint venture of the United Nations family. UNAIDS brings together the efforts and resources of seven UN system organizations (UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank) to help prevent new HIV infections, care for those already infected and mitigate the impact of the epidemic. Its aim is to help mount and support an expanded response - one that engages the efforts of many sectors and partners from government and civil society.

The global mission of UNAIDS as the main advocate for worldwide action against HIV/AIDS is to lead, strengthen and support an expanded response to the epidemic with a view to

- preventing the spread of HIV;
- providing care and support for those infected and affected by the disease;
- reducing the vulnerability of individuals and communities to HIV/AIDS;
- alleviating the socio-economic and human impact of the epidemic.

One of the critical goals the UNAIDS programme since its inception and major rationale for its creation, has been the development of a coherent United Nations system response to the epidemic by mobilizing nations and civil societies to redirect and expand national and international political, programme and financial commitment and action to address the HIV/AIDS epidemic and its impact on life and development.

The UNAIDS Secretariat is located in Geneva, Switzerland (20, avenue Appia, 1211 Geneva 27 - Internet: http://www.unaids.org - e-mail: unaids@unaids.org - Telephone (4122) 791 3666 - Fax (4122) 791 4187.

The UNAIDS Liaison Office in New York: UNAIDS c/o UNICEF, TA 26 C, 3 United Nations Plaza, New York, NY 10017 - Tel. (1212) 824 6643 - Fax (1212) 824 6493

At the country-level, UNAIDS is represented by the UN Theme Group on HIV/AIDS and in certain countries, by a UNAIDS InterCountry Programme Adviser (both can be contacted through the office of the UN Resident Coordinator/UNDP Resident Representative)

Highlights of UNAIDS advocacy and awareness raising activities in Latin America and the Caribbean

Following are examples of UNAIDS involvement in helping build an effective expanded response to HIV/AIDS in Latin America and the Caribbean through advocacy and awareness raising:

-
- Advocacy efforts to include HIV/AIDS in the agenda of presidents of the countries of the region. For example, the 1999 World AIDS Campaign launch took place in Brazil, in the presence of the president, diplomatic corps and world-wide media. The presidents of Haiti and Uruguay issued messages on the occasion of the 1998 World AIDS Campaign. The president of Mexico addressed the public on AIDS to support condom promotion and sexual education.
- UNICEF, in collaboration with UNAIDS, has developed a regional communication initiative with focus on youth. Activities included the Red Ribbon Campaign and cooperation with the Latin American Episcopal Conference.
- Cooperation with the Catholic Church in Argentina resulted for example in some 150,000 AIDS prevention messages included in the leaflets that are used to follow the mass, every weekend.
- Following the Caribbean Consultation on HIV/AIDS among 22 countries from the region, a Regional Task Force on HIV/AIDS has been established under the chairmanship of CARICOM with a formal mandate from the Ministers of Health for the development and implementation of a Regional Strategic Plan for the Caribbean, with a budget of 6.3 million Euro under approval by the European Commission.
- In the context of the sub-regional initiative for Central America which supports national efforts in developing national strategic plans on HIV/AIDS, UNAIDS promotes bilateral partnerships and provides support to an extensive situation analysis on migration and HIV.
- The Southern Cone Initiative includes a sub-regional programme focusing on HIV and Injecting Drug Use in Argentina, Uruguay, Paraguay and Chile, being implemented with the support of the Spanish government, UNAIDS and the United Nations Drug Control Programme.
- Continued support to the work of the Horizontal Technical Cooperation Group (HTCG) dedicated to an egalitarian "horizontal" transfer of experiences, knowledge and technology (a South-South technical collaboration network of Latin American and Caribbean countries).

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

11

Divider Title: _____

THIS DOCUMENT

WILL BE DISTRIBUTED

DURING THE

TECHNICAL MEETING

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

12

Divider Title: _____

NINTH CONFERENCE OF SPOUSES OF HEADS OF STATE AND GOVERNMENT OF THE AMERICAS

WOMEN OF THE AMERICAS: AGENTS OF CHANGE

Ottawa, Canada September 29 - October 1, 1999

Draft Conference Program

Wednesday, September 29

3:00 - 6:00 pm	Registration
6:00 - 7:30 pm	Opening Ceremony and Reception **National Art Gallery**

Thursday, September 30

7:30 am - 8:30 am	Registration
8:30 am - 9:00 am	**Follow-up Report to Eight Conference** Brief presentation summarizing actions taken by the First Spouses since the last conference.
9:00 am - 10:00 am	***Dr. Paul Steinhauer: "Why Zero to Six Matters"*** 45-minute presentation by Dr. Steinhauer on child brain development and why the years 0 to 6 are critical determinants of a child's long term life chances, followed by a 15-minute question period.
10:00 am - 10:15 am	**Remarks from First Spouses** 3 First Spouses deliver their remarks on the first theme: A Healthy Start: Investing in Children 0-6.
10:15 am - 10:30 am	**Coffee break**
10:30 am - 10:50 am	**Remarks from First Spouses** 4 First Spouses deliver their remarks on the first theme: A Healthy Start: Investing in Children 0-6.
10:50 am - 11:20 am	**Follow up of IICA's Project: Business Development Program for Rural Women (PADEMUR).** Representatives from IICA will report on the results of the project the First Spouses endorsed at the 1997 conference in Panama.
11:30 am - 12:30 pm	**First Spouses and Delegations tour NGO exhibits** Approximately 30 Canadian NGOs and NGOs from the Americas whose missions are relevant to the Conference themes who are active internationally or wish to be, will be invited to participate in a half-day NGO fair where they can exchange ideas and experiences and exhibit information on their programs.

NINTH CONFERENCE OF SPOUSES OF HEADS OF STATE AND GOVERNMENT OF THE AMERICAS

Hemisphere Summit Office (LXD)
Department of Foreign Affairs
and International Trade
125 promenade Sussex Dr.
Ottawa, Canada K1A 0G2
Tel. (613) 944-1692
Fax: (613) 944-1737
E-mail: Danielle.Vinette@dfait-maeci.gc.ca

NEUVIÈME CONFÉRENCE DES ÉPOUSES DES CHEFS D'ÉTAT ET DE GOUVERNEMENT DES AMÉRIQUES

Bureau du Sommet hémisphérique (LXD)
Ministère des Affaires étrangères
et du Commerce international
125 promenade Sussex Dr.
Ottawa, Canada K1A 0G2
Tél: (613) 944-1692
Téléc. (613) 944-1737
Courriel : Danielle.Vinette@dfait-maeci.g

NOVENA CONFERENCIA DE ESPOSAS DE JEFES DE ESTADO Y DE GOBIERNO DE LAS AMÉRICAS

Oficina de la Cumbre Hemisférica (LXD)
Ministerio de Asuntos Exteriores y
Comercio Internacional
125 promenade Sussex Dr.
Ottawa, Canada K1A 0G2
Tel: (613) 944-1692
Fax: (613) 944-1737
E-mail. Danielle.Vinette@dfait-maeci.gc.ca

12:45 pm - 2:15 pm	**Lunch** First Spouses to lunch separately at Daly's restaurant in the Westin. Buffet luncheon to be served to other conference participants in another room.
2:30 pm - 3:00 pm	**Follow-up on Integra project** Representatives from the Fundación Integra to report on the results of the information sharing project the First Spouses endorsed at last year's conference in Santiago.
3:00 pm - 4:00 pm	**Presentation on proposed Projects Children 0-6**
(3:00 -3:15 pm)	*International Symposia on Early Childhood Education* Presented by the Education Unit for Social Development and Education (UDSE) of the Organization of American States (OAS)
(3:15-3:30 pm)	*Registration of Children Across the Americas* Presented by the United Nations Children's Fund (UNICEF)
(3:30-3:45 pm)	*Early Childhood Development in the Latin America and the Caribbean Region*, Presented by the United Nations Children's Fund (UNICEF)
(3:45-4:00 pm)	Question and answers
4:00 pm - 4:15 pm	**Coffee Break**
4:15 pm - 5:05 pm	**Remarks by First Spouses** 10 First Spouses deliver their remarks on the theme of children 0-6.
5:00 pm - 7:15 pm	**Break**
7:15 pm - 7:30 pm	First Spouses travel to cocktail reception/dinner
7:30 pm - 8:15 pm	**Cocktail Reception** Museum of Canadian Civilization
8:15 pm - 10:30 pm	**Dinner and Cultural Event** Museum of Canadian Civilization

Friday, October 1

9:00 am - 10:00 am	**Presentation on proposed Projects for endorsement on the second Theme of Women's Health**
(9:00-9:15 am)	*Prevention of Domestic Violence through Children's Education* Presented by the Inter-American Children's Institute (IACI)
(9:15-9:30 am)	*The DESAPER project* - Presented by the Pan American Health Organization (PAHO)
(9:30-9:45 am)	*Prevention of AIDS in Mothers and Children* - Presented by the United Nations AIDS Program (UNAIDS)

(9:45-10:00 am)	Questions and answers
10:00 am - 10:15 am	**Coffee Break**
10:15 am - 11:00 am	**First Spouses remarks** 9 First Spouses deliver their remarks on the second theme:Women's Health.
11:00 am - 12:00 pm	**First Spouses and Delegations tour NGO exhibits**
12:15 pm - 1:15 pm	**Lunch** First Spouses dine separately at Daly's. Buffet lunch for other conference participants
1:30 pm - 3:00 pm	**Telehealth Presentation**
(1:30-2:30 pm)	Demonstration of telehealth technology. Focus on telehealth as an efficient and effective means of providing health care services to rural and remote communities.
(2:30-3:00 pm)	Telehealth Video
3:00 pm - 3:15 pm	**Coffee Break**
3:15 pm - 3:55 pm	**Remarks by First Spouses** 8 First Spouses deliver their remarks on the second theme:Women's Health.
5:00 pm - 6:30 pm	**Closing Ceremony and signing of Ottawa Declaration**