Regional Expert Meeting on Multisectoral Action for the Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean

REPORT

City of Panama, Panama.
Regional Expert Meeting on Multisectoral Action for the Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean. REPORT

June, 2017
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This meeting was facilitated by UNICEF LACRO as part of the joint work of the A Promise Renewed for the Americas (APR LAC) initiative, in its process to become the Regional Coordinating Mechanism for Every Woman Every Child Latin America and Caribbean (EWEC LAC) of the Global Strategy for Women’s, Children’s and Adolescent’s Health in Latin America and the Caribbean.

UNICEF HQ – Implementation Research Unit, Health Section, provided technical and financial support to convene the meeting. UNICEF LACRO drafted the report and incorporated the views and contributions of the experts. The EWEC LAC Executive Management Committee and meeting participants approved the final version of this report.

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Content

Introduction ................................................................................................................................................. 4
Meeting information ..................................................................................................................................... 6
Major bottlenecks identified by multisectoral action on health experts: ........................................... 8
  a) Governance ........................................................................................................................................ 8
  b) Financing and allocation of resources .............................................................................................. 9
  c) Joint monitoring and accountability .............................................................................................. 9
  d) Prospective impact evaluation ...................................................................................................... 10
General recommendations of the experts for multisectoral action for Women’s, Children’s and Adolescents’ health: .................................................................................................................. 11
  e) Governance ...................................................................................................................................... 12
  f) Financing and allocation of resources .......................................................................................... 13
  g) Joint monitoring and accountability .......................................................................................... 13
  h) Prospective impact evaluation ................................................................................................ 14
Next Steps ................................................................................................................................................ 15
Annexes: ................................................................................................................................................... 16
  I. Country Experiences .................................................................................................................. 17
  II. Global Strategy targets and corresponding SDG targets ......................................................... 32
  III. List of participants .................................................................................................................... 33
  IV. Relevant documentation and materials .................................................................................... 35
**Introduction**

Action by different thematic sectors beyond the health sector (such as education, infrastructure, agriculture, finance and energy) on the social determinants of health is well recognized as being fundamental to health progress. For example, half of the progress in infant mortality between 1990 and 2010 in low- and middle-income countries can be attributed to actions outside of the health sector. Yet such multisectoral action has often proved difficult in practice, including challenges to the alignment of incentives and actions for coordinated work with other sectors, and the fact that health policies and programs have focused primarily on health services.

v provides new momentum while encouraging countries to implement multisectoral measures that address complex problems that will certainly aid in meeting the ambitious SDGs health targets. The UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) (GS WCAH) highlights 17 key targets across SDG areas (see Table 1) that are fundamental for women, girls, boys and adolescents not only to survive, but to thrive and develop in a transformative environment, and positions multisectoral action as one of its key action areas.

Therefore, greater support for countries to implement multisectoral action for health is required to accelerate the achievement of SDGs, including the actions outlined in the Global Strategy. There is increasing consensus on what policies and interventions are required in various sectors to achieve improvements in health outcomes. However, countries need greater support to implement multisectoral action, in particular on governance, co-financing and joint responsibility. The discourse around “Health in all policies” is extremely useful and it is necessary to consider how this approach, with other multisectoral strategies, can be leveraged to support the achievement of SDGs in health.

**The A Promise Renewed for the Americas (APR-LAC) initiative and the Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean**

Since 2013, the A Promise Renewed for the Americas (APR-LAC) initiative has brought together the Inter-American Development Bank, the World Bank, Pan American Health Organization, USAID, and UNICEF to work together towards the vision of ending preventable maternal and neonatal deaths, and under-five mortality, with special emphasis on reducing inequity. This vision is now integrated within the SDGs and the Global Strategy (see objectives 1 to 3 in Table 2), hence the opportunity for the APR-LAC to play a key role in supporting the “regionalization” of the Strategy Global, including support for multisectoral work in the countries.

To carry this out, APR-ALC is proposing a series of regional and national transformations and activities with the purpose of facilitating the interpretation and implementation of the Global Strategy in the

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4 World Health Organization, Government of South Australia. Adelaide Statement on health in all policies. Adelaide, 2010
regional context of the Americas. At the global level, the World Bank Group, World Health Organization, UN Women, UN AIDS, UNFPA and UNICEF (H6) provide joint support for the implementation of GS WCAH. At the beginning of 2017, the United Nations Population Fund (UNFPA) joined the members of the Executive Management Committee (EMC) of A Promise Renewed for the Americas and the mission, objectives, work areas, structure and members were adjusted to become the new regional inter-agency coordination mechanism of the Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean.

**Multisectoral implementation in Latin America and the Caribbean**

The countries of Latin America and the Caribbean provide many of the vanguard experiences in implementing successful multisectoral action to improve the health of women, children and adolescents. These experiences can be usefully shared within the region and with the rest of the world to support the achievement of the SDGs and the Global Strategy. The inter-agency A Promise Renewed for the Americas (APR-LAC) is convening a multi-stakeholder partnership to support the implementation of the Global Strategy in the region, to which UNICEF will contribute strongly, in particular on the subject of multisectoral action.

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Meeting information

The Regional Expert Meeting on Multisectoral Action for the Global Strategy on Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean took place on March 20 and 21 in Panama City, Panama, convened by APR-LAC under the leadership of UNICEF. The purpose of the meeting was to share and discuss the experiences in the region to provide inputs and recommendations to improve the multisectoral mechanisms for the implementation of the Global Health Strategy within the specific regional context in the countries of Latin America and the Caribbean.

The objectives of the meeting included:

1. To contribute to the existing regional initiatives on Women’s, Children’s and Adolescents’ Health and to the regionalization processes of the Global Strategy worldwide, by drafting a document to feed into the regional multisectoral implementation approach.
2. To facilitate discussions, based on country experiences, to identify support needs for multisectoral action.
3. To jointly define and identify multisectoral actions and strategies to improve regional and national collaboration on the health of women, children and adolescents.
4. To share new or existing tools and guides available, including examples of multidisciplinary and multisectoral partnerships.

Participants:

Participants included experts in multisectoral action from eight countries in Latin America and the Caribbean, three representatives from sub regional integration mechanisms, three representatives of local and international civil society, and representatives of United Nations agencies and development partners that are part of the APR-LAC coordination mechanism. A detailed description of the participants is provided in the annexes.

Expected products of the meeting are as follows:

1. Gather existing experiences, models and instruments for the regional multisectoral implementation of the efforts in Women’s, Children’s and Adolescents’ Health (WCAH).
2. Prepare a set of recommendations from the meeting to be made available to the countries and to facilitate their progress in the implementation of multisectoral actions that will contribute to the implementation of the GS for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean.

The meeting took place over two days. The first day was devoted to reviewing the context and to the discussion on countries’ experiences, the second day focused on exploring the best way to support countries in multisectoral implementation and next steps.

The meeting was opened by the UNICEF Regional Director for Latin America and the Caribbean, María Cristina Perceval, together with a panel of representatives from the different agencies that are part of the regional coordination mechanism to support the implementation of the GS WCAH: Luisa Brumana, UNICEF Regional Health Adviser; Emma Iriarte, Executive Secretary of the Mesoamerican Health Initiative at the Inter-American Development Bank; Kira Fortune, Head of PAHO’s Special Program on Sustainable...
Development and Health Equity; Virginia Camacho, Regional Adviser on Sexual and Reproductive Health, UNFPA; Anabela Abreu, Representative of the World Bank in Panama; and Katie Qutub, USAID for Latin America and the Caribbean. After presenting the meeting agenda and objectives, an overview of the Global Strategy and the state of WCAH in the region was introduced, as well as various models, existing schemes and fundamentals of multisectoral approaches to health outcomes. Followed by the countries’ experiences on the “fundamental pillars of multisectoral action”:

- Governance
- Financing and allocation of resources
- Joint monitoring and accountability
- Prospective evaluation of impact

The experts and representatives were able to exchange and share their wide range of experiences in multisectoral implementation in the Latin American and Caribbean region, as well as the main program outlines and results, including the experiences of: the National School Feeding Program (Brazil) and the Income Distribution Program of “Bolsa Familia” (Brazil); “Chile Crece Contigo” Programme (Chile); the Foundation for Child Care (Colombia); the National Directorate of CEN-CINAI (Costa Rica); the Programs for Integrated Care for Women, Children and Adolescents, and the Family Doctor-and-Nurse Program (Cuba); the Adolescent Pregnancy Reduction Program (Jamaica); and the “PROSPERA” program (Mexico).

Subsequently, a roundtable was held on the role of non-state agents and civil society with the participation of Save the Children, the Federation of Panamanian Black Organizations, and the General Emberá Congress of Alto Bayano. The rest of the afternoon was used for group discussions on the bottlenecks encountered in multisectoral implementation, which are summarized in the next section of the report.

The second day began with a review and discussion on the group discussions to put forward the recommendations on multisectoral action for WCAH in Latin America and the Caribbean and an overview of existing United Nations agencies’ regional and global instruments for multisectoral implementation. This part was followed by a roundtable on South-South collaboration in LAC for multisectoral implementation which involved COMISCA, Andean Health Agency and UNASUR. Finally, and before closing the meeting, funding alternatives and resource allocation mechanisms for the multisectoral work on WCAH health were presented.
# Major bottlenecks identified by multisectoral action on health experts

## Governance

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Instances of limited transparency in governance and political will</th>
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<tbody>
<tr>
<td>Transparency</td>
<td>Lack of instruments and mechanisms to control public spending and low accountability rate of resource use in relation to political promises and government programs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Lack of social pacts with academia, private sector, NGOs and government for the 2030 agenda</th>
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</thead>
<tbody>
<tr>
<td>Consensus and appropriation</td>
<td>Low rate of knowledge and adherence of popular sectors in relation to the objectives of the 2030 Agenda</td>
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</table>

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Lack of legal platforms guaranteeing the rights granted by national and international laws.</th>
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<tbody>
<tr>
<td>Legal frameworks</td>
<td>Non-compliance with international agreements related to human rights, “Charters of Principles” or international letters of intent.</td>
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<tr>
<td></td>
<td>Absence of the human rights approach in the multisectoral implementation of programs.</td>
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<td></td>
<td>No conception of social protection until 18 years of age has been ensured</td>
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</table>

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>In general, organizations work sectorally and resist to change.</th>
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<tbody>
<tr>
<td>Multisector operativity</td>
<td>Sometimes health priorities conflict or are different from the priorities of other sectors and there is a conflict between the expected and reflected results of these priorities across sectors.</td>
</tr>
<tr>
<td></td>
<td>Other sectors do not necessarily see the value of investing in health outcomes.</td>
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<td></td>
<td>Skepticism in relation to multisectoral action.</td>
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</table>

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Current commitment to models with a multisectoral approach are not flexible enough to be carried out to scale.</th>
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<tbody>
<tr>
<td>Suitable guides and models</td>
<td>Lack of guidelines for policies and lack of specificity in multisectoral implementation.</td>
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<td></td>
<td>Lack of current clear rules and regulations to maintain the programs in a sustainable manner until 2030.</td>
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<td></td>
<td>Marked dichotomization of the population where health is not considered as an integral process but as fragmented events from different approaches.</td>
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<tr>
<th>Bottlenecks</th>
<th>Fragile and developing states suffer impacts that sometimes involve the destabilization of systems and changes in investment that are far from the multisectoral objectives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shocks to the system</td>
<td>Political and operational responses focus on contingency and not on evidence or long-term development objectives.</td>
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<td></td>
<td>In the region of the Americas, changes of government may involve different approaches in relation to multisectoral action and discontinue already established projects.</td>
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</tbody>
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6 For example, adolescent suicide is sometimes viewed as a mental health issue and sometimes as an adolescent health issue, but it actually deals with the same population group.
### Territoriality
- Little territorial contextualization and adaptation in the implementation of multisectoral policies and programs.
- Actions that do not consider territoriality have the risk of moving away from the population; effective community participation is difficult in very diffuse actions.

### Vulnerable groups
- Children and adolescents in prisons lack programs of re-socialization and insertion into society, similar to women in prisons (breastfeeding) and minorities (ethnic, gender, religion...).

### Financing and resource allocation

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<tr>
<th>Bottlenecks</th>
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| Availability of resources | - In general, lack of sufficient funding for multisectoral policies and programs, and little funding for multisectoral actions.  
- Countries not receiving international development assistance lack economic resources or do not allocate sufficient resources, particularly for vulnerable populations.  
- Efficiency from a multisectoral point of view is not considered in the expenditure of programs and interventions.  
- During global economic crises, resource scarcity increases. |
| Resource allocation | - The estimation of costs and budgets and the allocation of resources, does not consider the specific requirements and needs of the populations.  
- Great competition between the different sectors for the fiscal space.  
- Lack of continuity in public policy and, inherently, funding and allocation.  
- An allocation of resources adapted to the reality is not promoted  
- Government budgets are sectoral and not very inclined to allocating resources for multisectoral actions |
| Transparency | - Lack of taxonomy in spending (i.e. MEX PER HON). Lack of transparency.  
- Lack of measures to evaluate the economic impact of strategies and the cost of non-action. |

### Joint monitoring and accountability

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| Availability of data | - Lack of baseline evidence since it is not incorporated into the design of the programs.  
- Limited use of available data, especially in real time and for planning purposes.  
- Limited availability of disaggregated data.  
- Limited quality, availability, robustness and access to data. |
| Joint monitoring | - Difficulty in measuring and monitoring the efficiency of multisectoral action.  
- Limited appropriate multisectoral indicators. |
| Equity and diversity approach | - Lack of general monitoring, and in particular of invisible and vulnerable population groups.  
- Lack of recognition of multiculturalism and indigenous communities.  
- The comprehensive approach weakens throughout the life course of WCAH |
| Accountability | - Lack of effective, efficient and transparent allocation of resources. |
- Lack of mainstreaming of government and private sector initiatives.
- The timing of electoral processes and the rotation of committees, officers, civil servants and programs hinders the implementation of long-term policies.
- Few accountability instruments exist (reporting of results and expenditures) that are accessible to the population that is the main beneficiary.

**Prospective evaluation of impact**

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<th><strong>Bottlenecks</strong></th>
<th><strong>Description</strong></th>
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| **Evaluation culture** | - Lack of systematic evaluation at the different levels of strategy and indicator monitoring.  
- Limited evaluation culture.  
- There is a gap Existence of gaps between the collection of the information and the reporting lines.  
- Lack of capacity for analysis with other approaches, i.e. gender. |
| **Coordination** | - Dissociation between the evaluation timeframes and the planning and design of the programs. |
| **Cooperation** | - Lack of regional knowledge exchange to feed into multisectoral programs, based on evidence of proven events.  
- Low budgeting interest by international agencies to encourage cooperation among developing countries in multisectoral actions. |
| **Resources** | - Shortage of scientific evidence and resources for impact studies. |
General recommendations of experts for multisectoral action in Women’s, Children’s and Adolescents’ Health

Multisectorality should become the central axis of new policies, including health and its social determinants of health which are inherently multisectoral, since multisectoral action is built politically, technically and operationally. In addition to policy aspects, multisectoriality efficiency in financing, governance, monitoring and accountability, which require an inclusive approach. Preferably, the leadership of multisectoral strategies does not fall within a single sector and decision-making is carried out jointly. In general, it is a challenge for different sectors to have equal priorities; therefore, it is important for the expected results to be reflected positively across sectors and objectives, and for them to be aligned.

Areas of consensus on multisectoral action include the mandate, leadership and shared responsibilities, and how to make them effective; the need to contribute with evidence, national councils, state and social protection public policies; as well as shared and equitably transferred financing in intra- and intersectoral distribution and the study of different schemes of shared financing (i.e. agreements, funds).

Multisectoral action can and should be built bottom-up, from more homogeneous territories and adapted to the community context, and incorporate the communities support and engagement. It was recommended to focus on the coordination of services and sectors at the local level, accompanying, strengthening and building on existing programs. Support at the administrative level was also highlighted as well as addressing the challenges of information systems analysis bearing in mind population diversity and the social determinants, to be able to monitor and evaluate accordingly and adapt the goals, interventions and strategies. It was noted that the multisectoral management unit be a local territorial unit.

Accountability is a key process of multisectoral action and it should be guided the population, congress or parliament, and joint monitoring and evaluation commissions, among others. Multisectoral action requires the capacities of the various sectors and other social actors to respond with development-oriented policies that impact health outcomes and is strongly enhanced with the participation of civil society.

The health sector and Ministries of Health should consider how they will develop their capacities to commit to other sectors in efforts to achieve Universal Health Coverage (UHC) and to achieve the 2030 Agenda health goals and targets. UHC aims to achieve better health and development results in line with the Sustainable Development Goals, which will guide the post 2015 agenda until 2030, and to which the Global Strategy aims to contribute. SDG 3 includes a specific target to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” which is inherently a multisectoral call to action. In turn, SDGs consider health as an outcome and requirement for social and economic development, individual and global security and, therefore, political security.
Recommendations on Governance

The recommendations of the group of experts in this area focused on the different aspects of governance with potential impact on multisectoral action. To achieve maximum consensus and ownership of the process by the various actors, as well as to increase transparency, the recommendation was to promote social pacts with academia, the private sector, civil society and government, and call for a National and regional agreement for the 2030 agenda, generating an electoral shield and advocating for long-term state agreements of the programs of Women’s, Children’s and Adolescents’ Health. This would contribute to a greater alignment of high-level public policy and participation of executive and legislative power. In turn, to facilitate the role of civil society, it was recommended to promote their partnership, collaboration and participation, and encourage public consultations on issues with potential impact on WCAH.

Legal frameworks also have a key role in the protection and guarantee of rights, for which the recommendation was to promote compliance with international agreements by the states, establish or strengthen juridical platforms of guarantees of the rights of women and children, as well as ensure a conception of social protection until the age of 18.

To strengthen multisectoral operation, the recommendation was to establish a non-sectoral and independent coordination mechanism, to map the multiple actors in WCAH and their interests, to evaluate and integrate the connections between sectors in the design and implementation of policies and programs, as well as encourage awareness, training, monitoring, evaluation, and dissemination processes among all sectors and actors to inform decision making. In addition, the performance of multi-level advocacy was also highlighted.

With regard to the provision of appropriate guidelines and models for multisectoral action in health, it the recommended actions were to promote the universalization of programs and the flexibility to adapt to the needs of different contexts, to establish or strengthen the review of policies and models based on evidence, to promote comprehensive and multisectoral approach to national plans, as well as to focus on the life course, taking into account an integrated approach to the human being. This would be enhanced by the prioritizing and addressing inequities as well as the institutionalization of invisible and vulnerable populations for greater visibility and representativeness.

The Latin America and the Caribbean region includes countries with very different capacities to effectively absorb shocks to the system where there are recurrent emergencies of various kinds. To strengthen resilience in these situations and to integrate the territorial characteristics of WCAH, the recommendation was to promote risk-informed programming and planning that facilitates a multisectoral, evidence-based and sustainable response, as well as to adapt national intersectoral emergency policies to the local level.

It was lastly recommended that leadership in multisectoral action responds to the needs of populations and their context, and it be driven by the demand in society with an ecosystem approach, developing a common understanding of the problem to establish priorities and actions as a country/region/society, with a focus on vulnerable groups and issues that may be a priority for the region.
Recommendations on Financing and Allocation of Resources

Experts at the meeting noted the following regarding funding and allocation of resources for multisectoral action in health. First, regarding the availability of resources, the need to advocate for management of economic, financial, and material resources to ensure that multisectoral program budgets are permanent and sustainable, in addition to recognizing multisectoral collaboration as a solution to the lack of resources. Secondly, the need to promote a fiscal pact for WCA health was highlighted. Regarding international financing, the proposal was to classify the countries that receive international aid not only by economic growth, but also by vulnerability and capacity for resilience.

In relation to resource allocation for multisectoral action, alternatives such as the creation of common funds for multisectoral projects, results-based financing, and investment on implementation studies and research according to the contexts and indicators of each country and territory, obtaining baseline and impact studies based on scientific evidence, were recommended. It was also pointed out the need to adapt and adjust investment budgets to planning budgets as well as objectives, and to involve all actors in the drafting of national and local participatory budgets, to also promote process ownership. To increase transparency in funding, the recommendation was to amend the legislation to make the implementation of resources transparent and to encourage the efficient, effective and transparent implementation of resources.

Recommendations on Joint Monitoring and Accountability

Responding to identified bottlenecks in monitoring and accountability for multisectoral action in health, experts recommended strengthening data availability by establishing a set of key processes that maintain a standard in policy implementation (i.e. monitoring, evaluation, accountability, resource allocation, training and technical transfer, technical support) and to simplify the collection and use of data, as well as to promote the interoperability of information systems and the modernization and utilization of data collection by all sectors. It was also identified as necessary the establishment of national and pro-equitable multisectoral indicators and objectives, identifying all the multisectoral actors and their contributions and responsibilities.

Monitoring and accountability are directly related to participation, assigned responsibilities and the appointment of parties, which is closely linked to political decisions and, therefore, to the degree of democratic values of public institutions and of the society such as equity, dignity, and representation, among others.

To strengthen joint monitoring of multisectoral action, it was recommended to encourage the participation of all sectors and actors in the coordination and consultation platforms, in addition to creating regional alliances with important social and political actors, and to import and adapt international best practices to the country context.

Next, to increase the focus on equity and diversity in monitoring and accountability, the recommendation was to strengthen communication programs and to promote the participation of society in the region in its diversity, i.e. indigenous societies, stressing the need to strengthen or establish a monitoring culture in general and specifically for invisible and vulnerable population groups, promoting the recognition of multiculturalism and the indigenous communities.
Also highlighted in this section were other recommendations interrelated with the other aspects of multisectoral action, such as to reinforcing the integrated approach to the individual and to WCA health throughout the life course, the general recommendation to electorally and politically shield these programs, i.e. reaching state consensus for WCAH, to ensure that national audit complies with current regulations, to carry out a transparent allocation of resources, and to adapt capacity building and management methods to provide local authorities with better policy management instruments.

**Recommendations on Prospective Evaluation of Impact**

The experts considered the need to create and encourage a *culture of evaluation* to be critical. To this end, recommendations included the systematic evaluation of strategies at the different levels as part of the design of public policies to assess impact, promoting the ownership of program results across all levels and sectors, and incorporating the obligation to carry out impact studies to the standard operation rules. It was further recommended to carry out monitoring in accordance with racial, economic and cultural realities, and to promote social stimuli and recognition of impact, using indicators that reflect the multisectoriality.

To strengthen *coordination and cooperation* in multisectoral action, the recommendation was to clarify and assign from the onset roles and responsibilities, at each level and actor, as well as to disseminate results through national and subregional bodies. Finally, the last recommendation was to provide material, economic and social incentives to the best service providers and multisectoral programs after evaluating program impact.
Next steps

This consultation and the subsequent work will aim to strengthen the visibility and attention to multisectoral action as the Latin American and Caribbean region advances in the implementation Global Strategy. Building on the inputs received during the meeting, it was agreed that the following steps would include:

1. The drawing up of a first meeting report draft with the contributions by experts on multisectoral action in the region to be circulated for consultation and comments by the different participants as well as other parties interested in the progress of the 2030 Agenda.

2. The final product with multisectoral recommendations for the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 will be delivered as input to the series of subregional consultations that will take place in the context of the regionalization of the Strategy in the upcoming months.

3. To provide continuity and sustainability to the regional capacity for multisectoral action in WCAH, the proposal was to establish a Working Group on Multisectoral Action in WCAH in LAC deriving in part from the experts who participated in the meeting and also from new participants.

The group’s work could focus, among others, on next steps needed to address identified gaps, for example:

- i. Better understanding of the costing to compare actions across sectors and the cost of multisectoral action itself.
- ii. Drawing on existing shared methodologies and experiences, to consider guidance on how to conduct the prospective evaluation.
- iii. Requesting agencies to consolidate their work in support of countries in the multisectoral action connected to the Strategy.
- iv. Provide support to the interoperability of data systems for women, children and adolescents in all sectors.
Table 1. Experiences in multisectoral action in health in Latin America and the Caribbean

Brazil – National School Feeding Program (PNAE)

Program background and objectives, achievements and impact

Brazil’s National School Feeding Program (PNAE – for the acronym in Portuguese) was created in 1955 to contribute to child development and improve learning, as well as to create new eating habits through the provision of food in schools and food and nutrition education actions. In 2009, when the PNAE assumed its multisectoral character, the program increased its reach, adding the program of family agriculture product acquisition, school health interventions and school transport.

Experiences in multisectoral actions under the pillars that specifically took place

• Governance
  The schools enrolled in the program must be in the School Census conducted by the Ministry of Education, and the school menu must be prepared by a nutritionist respecting local habits. The implementing agencies (municipal and provincial) are responsible for the implementation of the PNAE and guarantee the purchase and supply of food to school children.

• Financing and resource allocation
  The financial resources of the PNAE come from the National Treasury and are guaranteed by the Union Budget through the National Fund for Educational Development (FNDE – for the acronym in Portuguese) that transfers the money to specific accounts opened on behalf of each implementing unit. The transfers are made in ten installments (February to December) that cover the 200 school days.

• Joint monitoring and accountability
  Monitoring is done by the Ministry of Education with accountability for FNDE, but the social control of the PNAE is carried out through a School Feeding Council (CAE – for the acronym in Portuguese) that involves different actors, including family members and civil society. The existence of a CAE is a precondition for financing.

• Prospective evaluation of impact
  The program helped to reduce child malnutrition, increase the anthropomorphic data of boys and girls, and reduce course repetition.

Key milestones/actions in multisectoral action that took place for the success of the program

The inclusion in the program of family agriculture product acquisition, school health interventions and school transport in 2009 were key multisectoral actions for greater achievement and impact of the program.

Bottlenecks identified in multisectoral implementation

Many municipalities still need to encourage the registration of new family farmers in the lists of producers for schools.

Have other key challenges been found that may not be included in the pillars?

Some municipalities need to improve their food and school transportation network.
Actions needed to overcome identified challenges

Municipal governments should seek public-private alternatives to improve food and school transportation, as well as foster greater social participation so that School Feeding Councils are not simply a bureaucratic organ but rather an accountability and social control body.
Chile – “Chile Crece Contigo” Programme

Program background and objectives, achievements and impact

In 2006, the Presidential Advisory Council for Child Policy Reforms was established. After a diagnosis of the living conditions of children and their families, a proposal was made for the design and implementation of a comprehensive child protection system. The proposals were adopted by the Committee of Ministers and the “Chile Crece Contigo” (ChCC) Subsystem was created and began its implementation in 2007 with coverage for children 0-4 years of age. Currently, it has been extended to the first basic cycle, until children enter to 5th grade or they turn 10 years old. ChCC is defined as an intersectoral policy that is committed to the development of comprehensive policies. Its objective is to accompany the developmental trajectory of children to reach their maximum potential.

Law No. 20.379 created the Intersectoral Social Protection System in 2009 and institutionalized the Chile Crece Contigo Subsystem (ChCC).

Health sector

It begins with the installation of the Biopsychosocial Development Support Program (PADB – for the acronym in Spanish) in 2007, axial program of the ChCC Subsystem. In 2009, it was strengthened by the Newborn Support Program (PARN – for the acronym in Spanish), and during the year 2016 the implementation of the Children’s Mental Health Support Program (PASMI – for the acronym in Spanish) was implemented. Among its main achievements and impacts are sector and population cultural shifts, as well as in health outcomes, such as:

- More than 90,000 participants, 14,000 workshops and 2,000 NEP facilitators trained in parental skills
- More than 160,000 participants trained in the promotion of early stimulation, motor and language skills, including mothers, fathers and caregivers.
- 312,402 comprehensive in-home visits to families with children with altered psychomotor development
- More than 79,000 children admitted to the Stimulation Room
- Over 20% increase in parental participation in the child’s check-ups
- Over 70% coverage of newborns weighing more than or equal to 2,500 grams with skin-to-skin contact greater than or equal to 30 minutes supervised by team (2016)
- Over 1 million kits, supported by education by the health professional
- 90% of children discharged by the from maternity ward with exclusive breastfeeding (2016)
- Over 60% of children under 5 years old attended by a professional psychosocial team in hospitals (2016)
- 48% of the children between 7 and 11 months with altered psychomotor development improved their outcome (2016).
- 92% of the children admitted to and re-evaluated in the Stimulation Room improved their outcome or recovered from their altered psychomotor development (2016).

Experiences in multisectoral actions under the pillars that took place, specifically

- Governance

The Ministry of Social Development (MDS – for the acronym in Spanish) coordinates the subsystem as a non-sectoral Ministry with the possibility of reaching consensus and delivering comprehensive guidelines beyond the action of a specific sector. The MDS Committee of Ministers supervises the subsystem and both the Ministry of Health and the MDS have a specific technical team. There are
coordinators in the regional secretariats of the Ministry of Health and the MDS and in the different health services.

At the local or community level, the subsystem is organized in **Community Networks** that are configured as part of the **fourth component** and their mission is to accompany the developmental track of children, monitoring the various benefits and making the necessary referrals and arrangements in a timely, relevant and effective manner. The ChCC Network comprises three key players: Education, Health and Social Protection who are responsible for delivering benefits to children requiring it.

- **Financing and resource allocation**
  The financial resources are allocated in the Nation’s Budget through the Ministry of Social Development. The implementation of the core program is carried out in health, through a transfer agreement, and the distribution of resources is conditioned to population health and vulnerability targets.

- **Joint monitoring and accountability**
  The Ministry of Health and the Ministry of Education periodically report on their accountability associated to the transfer of resources. Monthly reports are carried out involving regional and local teams, and Key Performance Indicators of the community and regional teams are monitored. A free access system is in place to allow the monitoring of program indicators, and also complementary to Childhood and Women’s Health: http://chcc.minsal.cl/indicadores and the document is available at: www.chccsalud.cl/p/gestion.html

- **Prospective evaluation of impact**
  Coordination with the community network to contribute to decreasing risk factors in children with altered psychomotor development is a determining factor, within the framework of evidence showing that risk accumulation increases the chances of having a psychomotor development (PMD) alteration. Aspiring to the recovery of an altered PMD is in many cases correlated with: access to drinking water, hygiene, adequate food, quality of housing, general living conditions, etc.

**Key milestones/actions in multisectoral action that took place for the success of the program**

Law No. 20.379 which institutionalizes the subsystem has allowed for its establishment as a State policy and the sustainability of the implementation.

**Bottlenecks for multisectoral implementation**

- Difficulty in the interoperability of computer systems, which must converge in the registry, referral and monitoring system.
- Maintaining a multisectoral effectiveness index, calculated through indicators from different sectors is necessary.
- We have many indicators in the health sector, and professionals comply with or manage policies that are not only aimed at children.

**Have other key challenges been found that may not be included in the pillars?**

The technical advisory capacity of the regional teams at the local level, to strengthen the management of community networks. The time dedicated to the subsystem management by the community managers, since they fulfill multiple functions, also for other government programs with local impact.
Actions needed to overcome identified challenges

- To reduce the gap in the Registration, Referral and Monitoring System (SRDM – for the acronym in Spanish).
- Involving the education sector to the various actions and commitments in the different national, regional and communal management areas since the extension of the subsystem to 9 years of age.
- To work on a results-based monitoring and evaluation methodology that is capable of measuring impacts and effects, considering micro, mezzo and macro levels of management.
Colombia – Foundation for Child Care (FAN)

Program background and objectives, achievements and impact

FAN was created in 1964 to provide protection and education services to a small group of children in the city of Medellin. Currently, it is projected as a leading national organization in integrated care, and in the promotion, prevention and realization of rights of early childhood and their families, through various intervention models (See Figure 1). It is one of the main partners of the national and local governments, as well as the business sector in the care provision to low income groups and diverse conditions and sectors of Colombia, such as populations in urban poverty, rurality, mining and hydrocarbon sector, Indigenous and Afro-Colombian zones.

FAN has served more than 20,000 families and has trained about 35,000 caregivers and adults in early childhood care and parenting guidelines. It has 39 offices with an approximate coverage of 7,500 infants and toddlers who receive integrated care with balanced nutrition, pedagogical experiences and psychosocial care, education and support to their families. It also has projects and programs that collect their experience in social intervention strategies for early childhood, adolescence and families.

Experiences in multisectoral actions under the pillars that specifically took place specifically:

• Governance:
The Board of Directors is made up of entrepreneurs and individuals who held public positions related to Social Development, Family and Childhood and Adolescence, which facilitates a rational use of resources and a responsible strategic direction. FAN has an interdisciplinary team and is aligned with public policies with active participation in networks and working groups including NGOs, municipal and local authorities, institutions in defense of the rights of children and representatives of the education sector.

• Financing and resource allocation
The financial resources for the operation of services and the implementation of projects come mainly from donations, benefic and other fundraising activities; partners; donations from the private sector; self-financing and own resources; state funds, central government, subsidies, municipal, district and local funds; and management of international development cooperation projects.

• Joint monitoring and accountability
The foundation features a quality management system that allows compliance with standards and continuous improvement of the services that children and their families receive. In addition, it features
a strategic plan, operational plans by processes, indicators and surveillance and monitoring system, as well as monthly meetings of the board and the primary group, and annual public accountability.

• Prospective evaluation of impact
The development of integrated care programs and special projects and initiatives has improved the quality of life of children and their families, their socioeconomic conditions, their health and nutrition indicators; reduced child and adolescent pregnancy; prevented untimely pregnancy; and qualified various early childhood caregivers.

Key milestones/actions in multisectoral action that took place for the success of the program

Regularly convening various organizations (public, private and non-governmental) to intervene collectively in early childhood issues, involving different bodies (decision-makers, political and technical bodies, and representatives of civil society) in the development of the integrated care programs and special projects. Transparency in the management of resources and periodical and public accountability, encouraging innovation in early childhood intervention approaches.

Bottlenecks for multisectoral implementation

The alignment of agendas, reaching agreements in financial and other contributions to carry out integrated care programs and special projects, restrictions on access to information systems, local and national oversupply in programs and services targeting early childhood (which requires greater articulation among actors in the care industry).

Have other key challenges been found that may not be included in the pillars?

Decentralization of operations, reduction of national and local public budget for early childhood care, implementation of innovative projects with high investments in resources and infrastructure, involve more private actors in the development of projects, particularly small and medium-sized enterprises.

Actions needed to overcome identified challenges

Identify and manage new funding sources for the development of innovative strategies that involve taking risks of success or failure; increase the number of partners, donors and volunteers to increase the gathering of financial and other resources; and coverage and scope of services, among others. Systematizing good practices and promoting knowledge exchange with national and international peer organizations.
Costa Rica – National Directorate of CEN-CINAI

Program background and objectives, achievements and impact

In 1951, the Nutrition Division was created to promote and develop actions to combat nutritional issues, such as the approval of decrees for food fortification and conducting national nutrition surveys. These achievements were complemented by extended coverage strategies through the opening of daily care services at the Education and Nutrition Center (CEN – for the acronym in Spanish) and the creation of Centers for Integrated Child Care (CINAI – for the acronym in Spanish) to provide comprehensive care services that favor the incorporation of women into the workforce, providing interdisciplinary care to the children’s population and including the educational, health promotion and preventive nutrition components.

In 2010, Law 8809 was approved for the creation of the National Directorate of CEN-CINAI, which functions as an entity attached to the Ministry of Health to provide nutrition, health and early education services, as well as to care for pregnant and lactating women.

Starting 1966, child malnutrition declined from 54% to 2.1%, and then to 1.1% in the most recent 2008-2009 survey, which shows that the CEN-CINAI services have contributed to the decline.

Experiences in multisectoral actions under the pillars that took place, specifically:

- Governance
  With the approval of Law 8809, the challenge of evolving into an institution that guarantees the delivery of timely, efficient and quality services was assumed. To this end, expertise must be developed in public management, separate from the Ministry of Health, and in inter-institutional and intersectoral coordination.

- Financing and resource allocation
  The National Directorate of CEN-CINAI has a budget from Costa Rica’s Central Government and financing from the Social Development and Family Allowance Fund of Costa Rica, as well as contributions from the communities where the CEN-CINAI establishments operate.

- Joint monitoring and accountability
  The National Directorate is governed by Public Administration regulations and it meets the requirements of the General Comptrollership of the Republic, Ministry of Finance, Ministry of Planning, among others. It also implements the Child Growth and Development Surveillance System (SISVENDI – for the acronym in Spanish) and a family grouping characterization system, which presents timely information for decision-making and for monitoring the actions of the services provided. The National Directorate issues a periodic report on the scope of services, which shows that the population served by CEN-CINAI is the one it should legally serve.

- Prospective evaluation of impact
  CEN-CINAI generates positive and beneficial effects on the health of the child population, which contributes to human capital in better conditions of health, education and nutrition in the adult stage. The 2014-2015 annual evaluation of the effects on nutritional status and child development, showed that 87% of boys and girls progress in achieving the expected skills and behavior for their age. On the other hand, 45% of children that presented malnutrition in the first assessment of the study, according to the weight-for-height indicator, improved their nutritional status; and 27% of the children improved their Body Mass Index.
Regional Expert Meeting on Multisectoral Action for the Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean

Table 1. Population served by the National Directorate of CEN-CINAI, by type of service, in 2016

<table>
<thead>
<tr>
<th>Population served</th>
<th>Child care and protection</th>
<th>Meals served</th>
<th>Food Distribution to Families</th>
<th>Distribution of milk for consumption</th>
<th>Total</th>
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<tr>
<td>Boys and girls</td>
<td>21636</td>
<td>9835</td>
<td>80241</td>
<td>111712</td>
<td></td>
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<tr>
<td>Women who are breastfeeding or pregnant</td>
<td>4339</td>
<td>4339</td>
<td>18755</td>
<td>23094</td>
<td></td>
</tr>
<tr>
<td>Family groups in DAF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9726</td>
</tr>
</tbody>
</table>


Key milestones/actions in multisectoral action that took place for the success of the program

1. The selection of the target population.
2. The achievement of national coverage of CEN-CINAI, with presence in 445 districts of the 477 in the country.
3. The active participation of the community for over 66 years, currently through the CEN-CINAI Committees.
4. Granted budgeting by law to extend coverage and improve the quality of services.
5. The provision of integrated care to mother and children in the context of vulnerability due to poverty or health aspects.

Bottlenecks for multisectoral implementation

Delay in consolidating the status as an entity attached to the Ministry of Health and implementing separately the appropriate institutional management.

Have other key challenges been found that may not be included in the pillars?

The development of strategies to compensate the containment of public expenditure in the integrated care of the target population.

Actions needed to overcome identified challenges

- To promote the right to food and the importance of consuming nutritional and balanced and foods appropriate to age in the population of CEN-CINAI users, and breastfeeding practice, to raise awareness of the benefits of meals provided, and child care and protection in relation to other services.
- To develop permanent human resource training processes.
- To continue support to the family in relation to the tasks of parenting, health promotion and preventive nutrition.
- To strengthen the Child Growth and Development Surveillance System and the Integrated Care Strategy for the target population, through intra and extramural activities.
Cuba – Maternal and Child Care Program

Program background and objectives, achievements and impact

In 1970, the Maternal and Child Care Program (PAMI – for the acronym in Spanish) was implemented with the purpose of guaranteeing the proper health of women, children and adolescents. The development of the Program includes intersectoral actions coordinated by the health sector convening other sectors of the State such as education, environment, economy, water and sanitation, sports, culture, media and civil society organizations such as the Federation of Cuban Women, CENESEX, CDR, ANAP, FEU, FEEM, UJC and others.

In the context of the PAMI, a large number of additional specialized programs are developed including services for sexual and reproductive health, special perinatal care rooms, neonatal research programs, responsible maternity and paternity subprograms, prevention of low birth weight, reduction of maternal morbidity and mortality, genetic diseases, integrated care for the healthy child, integrated health care in adolescence, promotion of breastfeeding, and immunizations, among others. All these programs include cross-sectoral actions coordinated and centrally evaluated and implemented in each locality by the health teams of the Family Doctor-and-Nurse Program. As an alternative to the growing needs of the country in pre-school education, the program “Educate Your Child” has been generalized since 1992, an educational stream that is not schooled but supported by the participation of families and local communities. Currently it serves more than 600,000 children and intersectoriality is coordinated by education and with the participation of health and other sectors.

Experiences in multisectoral actions under the pillars that specifically took place:

• Governance
  The Cuban State prioritizes health, particularly of women and children, and includes strategies and actions developed to ensure equity and access to health. These experiences have been established on a legal basis, using scientifically developed health policies, with intersectoral nature involving other sectors of society and with the participation of popular social organizations in health programs. Law 41 of Public Health/1983 documents the relationship of the health sector with the implementation of population health care and its interaction with the rest of the central government. Popular civil society organizations, such as the Federation of Cuban Women and others endorsed in the Constitution, favor cross-sectoral actions from central state-level to communities. In 2011, in the Congress of the Communist Party of Cuba, after discussions with all sectors of society, the economic and social policy guidelines of the Party and the Revolution were approved, including those related to health, particularly women and children. Number 159 is indicative of the decision to maintain the development of intersectoral and community participation in health actions.

• Financing and resource allocation
  The budget of the Health System is provided by the State and approved by the central government body (National Assembly of People’s Power). The budget includes, among other things, the payment of salaries to National Health System workers, the construction and maintenance of units, the purchase of equipment, medicines and supplies used to guarantee health with priority given vulnerable groups such as women and children.

• Joint monitoring and accountability
  The program is considered a monitor of the sector’s activity and is systematically controlled by the top management of the Ministry of Public Health. The centralized health department conducts permanent supervision of PAMI’s intersectoral and interdisciplinary activities with emphasis on equity, health
monitoring, use of the scientific basis and social participation in solving identified problems, and selects effective interventions. Some indicators such as severe infant and maternal morbidity are collected by the health registry system daily for analysis by program management and health managers in each territory and national instances. The care processes are systematically audited throughout the country and the main indicators evaluated on an ongoing basis.

- **Prospective evaluation of impact**

  The strategies and actions developed around the health of women, children and adolescents by PAMI place Cuba among the first in the world in terms of key health indicators in the pediatric ages. For more than 50 years there has been a sustained decrease in the infant and under-five mortality rate with a similar evolution of the rates in girls and boys. The main causes of death are reported as perinatal conditions, congenital malformations and infectious diseases. These favorable results aided in placing Cuba among the best countries to care for sick children in the Save the Children report, and is among the first 40 countries attending to infant and under-five mortality indicators in The State of the World's Children 2015.

**Bottlenecks identified in multisectoral implementation**

The economic difficulties of being a developing country, in addition to the economic and financial blockade on the part of the United States government for over five decades. This situation is stressed by the effects caused by natural disasters, including tropical cyclones and drought.

**Actions needed to overcome identified challenges**

To overcome the negative effects of economic difficulties and threats from natural or epidemiological disasters, the program should continue to strengthen interdisciplinary and intersectorally, particularly at the community level. The introduction of new technologies in maternal and child health and the development of care policies that contribute to raising the quality of life of patients with special needs should also be maintained. These are challenges to maintaining and improving the favorable results achieved in the health of women, children and adolescents and achieving the Sustainable Development Goals of the 2030 Agenda.
Regional Expert Meeting on Multisectoral Action for the
Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean

Jamaica – Teen Pregnancy Reduction Program

Program background and objectives, achievements and impact

The program to address adolescent pregnancy is implemented in the health, education and social protection sectors in Jamaica. It seeks to reduce the number of unplanned pregnancies in adolescents; ensure continued education when adolescent pregnancies occur; and reduce the number of repeated pregnancies during adolescence. Achievements between 2010 and 2015 include life skills based health and family life education (early childhood - secondary); the policy for reintegration of adolescent mothers in school passed in the parliament; the submission of proposed amendments to the laws submitted to the Cabinet recommending that adolescents may access health services/counseling without parental consent starting from age 12; the evaluation of local best practices at the “Victoria Jubilee” maternity hospital, prenatal clinic and package of services for adolescent mothers.

Experiences in multisectoral actions under the pillars that specifically took place:

The national strategic plan on adolescent health establishes the overall strategic results for adolescents across sectors. The National Strategic Plan for Preadolescent and Adolescent Health establishes the policy working group for adolescents (chaired by the Ministry of Health) as the mechanism for multisectoral collaboration and dialogue. Civil society stakeholders are also included. Among them are the Jamaica Youth Advocacy Network, a youth-led advocacy group.

The funding and allocation of resources is carried out at the ministerial level. Multisectoral collaboration, including development partners, is widely used to draft and implement policies and programs, as well as joint oversight and accountability. For example, the Ministry of Education, Youth and Information (Guidance and Counseling Unit) and the Ministry of Culture, Gender, Entertainment and Sport (Jamaica Women’s Centre) are jointly responsible for the implementation of the Reintegration policy. They co-chair the Policy Steering Committee and report to the Office of the Cabinet.

Key milestones/actions in multisectoral action that took place for the success of the program

Significant milestones that laid the foundation and set precedents for the success of the national program include the establishment of the National Family Planning Board in the 1960s as an agency to help reduce the country’s high fertility rate including teen pregnancy rate; the founding of the Jamaica Women’s Centre in 1974 as a means to ensure the continuing education of pregnant girls not accommodated in the school system; and the social protection system that provides low-income mothers, including adolescent mothers, with the Programme of Advancement through Health and Education through cash transfers for breastfeeding mothers.

Bottlenecks for multisectoral implementation

- The legislative framework restricts access to services for adolescents under the age of 16.
- Action in silos to address adolescent pregnancies despite having structures for coordination;
- Non cross-sectoral monitoring and evaluation.
- Community standards - having a baby is an important hallmark of femininity.
- Curbing the drop-out rate – provision of support at community level for adolescent mothers to attend school regularly.
• Access to counselling and services that strengthen resilience and build skills for good parenting practices among adolescent parents. This is key to ending the teenage parenting cycle.
• High rates of sexual abuse and exploitation of girls.

**Actions needed to overcome identified challenges**

Measures to overcome the challenges identified are: strengthening multi-sectoral collaboration and coordination to improve efficiency in policy formulation and implementation and service delivery; engaging civil society as a critical partner for the effectiveness of any strategy that must be implemented due to its scope and adaptability; updating data on adolescent pregnancy and behavior (key data systems, MOE data on school dropout); ensure that the budgets of the Government of Jamaica give priority to the well-being of adolescents, since most programs receive external financing and are therefore unsustainable. The Ministry of Health, NFPB-SHA and the Ministry of Education should take advantage of existing synergies in the interests of adolescent health by working more closely.
Mexico – “Prospera” Program

Program background and objectives, achievements and impact

The “Progresa” program was launched in 1997 with the objective of promoting intersectoral actions on education, health and food for families living in extreme poverty, mainly in the rural and indigenous regions of the country, to promote and strengthen their capacities and potentialities, raise their quality of life and foster their incorporation into development.

The creation of “Progresa” responded to a structural vision established in the 1995-2000 National Development Plan, which recognized the importance of breaking the vicious circle of poverty, taking advantage of accumulated experience and strengthening it through simultaneous, complementary and comprehensive measures.

In 2002, it changed to Human Development Program “Oportunidades”, and in 2014, President Enrique Peña Nieto announced the transition from “Oportunidades” to Social Inclusion Program “PROSPERA”). The main objective is to contribute to strengthening the effective fulfillment of social rights that enhance the capacities of people living in poverty, through actions that expand their capacities in food, health and education, and improve their access to other aspects in well-being.

Substantial changes to the program have benefited some 25 million Mexicans, including a population of more than 264,000 pregnant and lactating women, as well as 1.2 million children under five, with results endorsed by Mexican and foreign scientific experts. The Social Program has served as an example to more than 60 countries.

Experiences in multisectoral actions under the pillars that specifically took place:

• Governance
In this context, the Prospera Social Inclusion Program maintains and strengthens interventions that seek to expand educational, health and food capacities, mainly for the children and youth from families in poverty, while broadening the scope of their inter-sectoral interventions around fostering a productive labor and financial inclusion of the members of these families, as well as their effective access to social rights.

• Financing and resource allocation
Taking into account the multisectoral nature of the program, the actions of the agencies and parastatal entities related to its operation must be included in their respective budgets, subject to the Secretariat of Finance and Public Credit, for their subsequent integration and approval by the Chamber of Deputies for the corresponding fiscal year, and must incorporate public expenditure forecasts that will guarantee compliance in a timely manner with the program objectives and goals, and the continuity of the comprehensive actions.

• Joint monitoring and accountability
To promote continuous improvement of the program operations, an Operational Monitoring Model will be applied agreed with the Sectors involved. This model allows for obtaining detailed information about the operation, with the purpose of supporting decision-making, detecting operational off-tracks and implementing actions for continuous improvement of the program operational processes through the generation and analysis of indicators.

The Operational Monitoring Framework, which is additional to the internal monitoring mechanisms of each sector, implements the processes in the cycles stipulated in the operational guidelines, integrating information from the operational results of each federation entity.
Prospective evaluation of impact

External program evaluations will be carried out in accordance with the Federal Law on Budget and Fiscal Responsibility, with the aim of focusing program management on the achievement of results to improve the living conditions of the beneficiary population, as well as strengthening accountability and transparency in the execution of resources.

Key milestones/actions in multisectoral action that took place for the success of the program

Expand the capacities associated with food, health and education, and access to other welfare aspects of the beneficiary families of the program by:

- Providing support to beneficiary families to improve the nutrition of all its members.
- Ensuring access to the Basic Guaranteed Health Package and the progressive extension to the 27 Public Health interventions of the Universal Catalog of Health Services to beneficiary families, with the purpose of promoting the use of preventive health services and health and nutrition self-care of all its members, with an emphasis on the most vulnerable populations, such as children, pregnant and lactating women.
- Provide increasing educational support in primary, secondary, and upper secondary education to girls, boys and young people from the beneficiary families, to encourage their enrollment, regular attendance and completion at school.
- Foster commitment to the objectives of the Program and the active participation of all members of the beneficiary families in the actions associated with the interventions of the Program.
- Promote access of the population served to preferential financial services, as well as the institutional offer of social development programs, income generation and labor inclusion that increase the productive capacities of beneficiary families and their members, to improve their economic well-being or within other dimensions, through coordination actions and institutional engagement.
- Establish the implementation of the Crusade against Hunger as a strategy of inclusion and social welfare, encouraging the participation of the public, social and private sectors, of national and international organizations and institutions to fulfill its objectives.
- Strengthen the effects of the program through the delivery of other financial support established by the Government of the Republic for the beneficiary population of the program.

Bottlenecks for multisectoral implementation

The operation of the program rests with the National Health and Education Services, both state and decentralized, which often makes it difficult to operate, since there are 32 different ways of working throughout the country.

Also, since it is a conditional cash transfer program, compliance with the co-responsibilities of the beneficiary families is essential for the achievement of the program objectives.

Actions needed to overcome identified challenges

Further strengthening of the intersectoral actions at the federal level, and at the state level, strengthen the operation of the program with the corresponding agencies, all for the benefit of the Prospera families.
### Table 2. Global Strategy targets and corresponding SDG targets

**SURVIVE (end preventable mortality)**

1. Reduce global maternal mortality to less than 70 per 100,000 live births (SDG 3.1)
2. Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)
3. Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)
4. End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)
5. Reduce by 1/3 premature mortality from no communicable diseases and promote mental health and well-being (SDG 3.4)

**THRIVE (promote health and well-being)**

6. End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women (SDG 2.2)
7. Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)
8. Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)
9. Substantially reduce pollution-related deaths and illnesses (SDG 3.9)
10. Achieve universal health coverage including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)

**TRANSFORM (expand enabling environments)**

11. Eradicate extreme poverty (SDG 1.1)
12. Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)
13. Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)
14. Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene (SDG 6.1 and 6.2)
15. Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 9.5)
16. Provide legal identity for all including birth registration (SDG 16.9)
17. Enhance the global partnership for sustainable development (SDG 17.16)
### iii. List of participants

**National experts:**

<table>
<thead>
<tr>
<th>Country</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brazil:</strong></td>
<td>Luiz Eduardo Fonseca, Centro de Relaciones Internacionales en Salud / CRIS, Fundación Oswaldo Cruz – Fiocruz.</td>
</tr>
</tbody>
</table>
| **Chile:** | Luz Cole, Responsible for Chile Crece Contigo from the Deputy Secretariat of Public Health.  
Alfredo Peña, Professional advisor of Chile Crece Contigo from the Division of Primary Care in the Secretariat of Care Networks.  
Claudia Saavedra, Professional in charge of Chile Crece Contigo from the Ministry of Social Development. |
| **Colombia:** | Sofía Botero, Director of Cooperation, Development, Management.  
Luz Amalia Botero, Executive Director, Fundación de Atención a la Niñez.  
Jaime Matute, Head of International Cooperation of the Ministry of Health of Colombia.  
Ana Peñuela, Advisor of the Ministry of Health of Colombia. |
| **Costa Rica:** | Fernando Llorca Castro, Minister of Health of Costa Rica. |
| **Cuba:** | Gisela Álvarez, Head of the National Child Care Group, Ministry of Health.  
Berta Castro, Head of the National Pediatric Group, MINSAP.  
Maria Gallo, representative of the Ministry of Education. |
| **Jamaica:** | Denise Chevannes, Executive Director of the National Family Board - Sexual Health Agency.  
Marion Scott, Coordinator of Adolescents and AIDS, Ministry of Health.  
Fern McFarlane, Deputy Director of Education for Guidance and Counseling, Ministry of Education. |
| **Mexico:** | Dr. Daniel Aceves Villagrán, General Director of PROSPERA, Social Inclusion Program. |

**Sub regional integration bodies:**

<table>
<thead>
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<th>Organization</th>
<th>Participants</th>
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<tr>
<td><strong>COMISCA:</strong></td>
<td>Nelson Guzmán, Director of Cooperation and Institutional Relations, Council of Ministers of Health of Central America and Dominican Republic.</td>
</tr>
<tr>
<td><strong>Andean Health Organization:</strong></td>
<td>Gloria Lagos, Manager of Strategic Lines and International Cooperation.</td>
</tr>
<tr>
<td><strong>UNASUR:</strong></td>
<td>Francisco Armada, Technical Advisor of Social Determinants of Health.</td>
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**Civil society:**

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<tr>
<th><strong>Save The Children:</strong></th>
<th>Victoria Ward, Regional Director.</th>
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<tr>
<td><strong>General Emberá Congress of Alto Bayano:</strong></td>
<td>Sara Omi, President.</td>
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<td><strong>Federation of Panamanian Black Organizations:</strong></td>
<td>Samuel M. Samuels, Technical Secretary. Marlena Moreno.</td>
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**Members of APR-LAC**

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<tr>
<th><strong>World Bank:</strong></th>
<th>Anabela Abreu, Representative to the World Bank in Panama.</th>
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<td><strong>USAID:</strong></td>
<td>Katie Qutub, USAID Bureau for Latin America and the Caribbean.</td>
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<td><strong>IDB:</strong></td>
<td>Emma Margarita Iriarte, Executive Secretary of the Mesoamerican Health Initiative.</td>
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<td><strong>UNFPA:</strong></td>
<td>Virginia Camacho, Regional Advisor - Sexual and Reproductive Health for Latin America and the Caribbean. Sheila Roseau, Deputy Regional Director.</td>
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<td><strong>UNAIDS:</strong></td>
<td>César Núñez, Director of the UNAIDS Regional Support Team.</td>
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</table>
iv. Documentation and relevant materials

- Database on Intersectoral Action for Health Equity [https://extranet.who.int/isacs/](https://extranet.who.int/isacs/)
- Gender equality interventions for improved RMNCAH outcomes: a right-based programming resource guide and tool (under development)
- Health in All Policies Training Manual [http://www.hiaptraining.org](http://www.hiaptraining.org)