

**STRATEGIC ORIENTATION OF  
UNICEF IN LATIN AMERICA  
AND THE CARIBBEAN FOR  
CONTRIBUTING TO THE  
REDUCTION OF MATERNAL,  
NEONATAL AND CHILD  
MORBIDITY AND MORTALITY.  
2011-2015**

## **Introduction**

The UNICEF Regional Office for Latin America and the Caribbean (TACRO) has organised its response to fulfilment of the rights of children with regard to survival and child development in Focus Area 1 (FA1), which is composed of the health, nutrition, and water and sanitation units.

As a response to UNICEF's MTSP and regional ROPM programming, the Health Section, in coordination with regional actors, has proposed the reduction of maternal, neonatal and child morbidity and mortality with an equity perspective as a priority in priority countries of the region in order to achieve the MDGs, with emphasis on goals 4 and 5.

## **Background**

### ***Maternal and child mortality and the MDGs***

During the nineties, high maternal and child mortality rates and under-five mortality rates promoted – in the world and in the region of Latin America and the Caribbean (LAC) – the commitment of member countries and international cooperation agencies to implementing strategies to reverse this situation, a commitment that was reaffirmed with the Millennium Development Goals (MDGs) declaration in 2000.

However, despite the efforts made by countries, the trends in the current reduction of maternal mortality and under-five mortality, especially those at early age, show that goals 4 and 5 of the MDGs will not be met in diverse regions of the world.<sup>1</sup>

In LAC, evaluations of the MDGs show that there is little reduction with regard to goals 4 and 5, which should fall at a rate of 6.3% and 5.5% annually in order to be met by 2015.

It is estimated that in LAC around one million pregnant women do not have access to birth attendance by qualified personnel, and that approximately 744,000 women have no control of pregnancy. Due to this situation, more than 20,000 mothers die during pregnancy and birth, and more than 200,000 newborns die during the 28 days following birth.<sup>2</sup>

With this information, the MDG evaluations have made it clear that in LAC this reality is due to the presence of various kinds of disparities to which part of the population is exposed.

### ***The situation in Latin America and the Caribbean***

LAC is considered one of the most unequal regions of the world as it includes fourteen of the twenty countries recognised as being the most inequitable in the world, having countries showing great progress in the reduction of maternal and child mortality and others whose rates continue

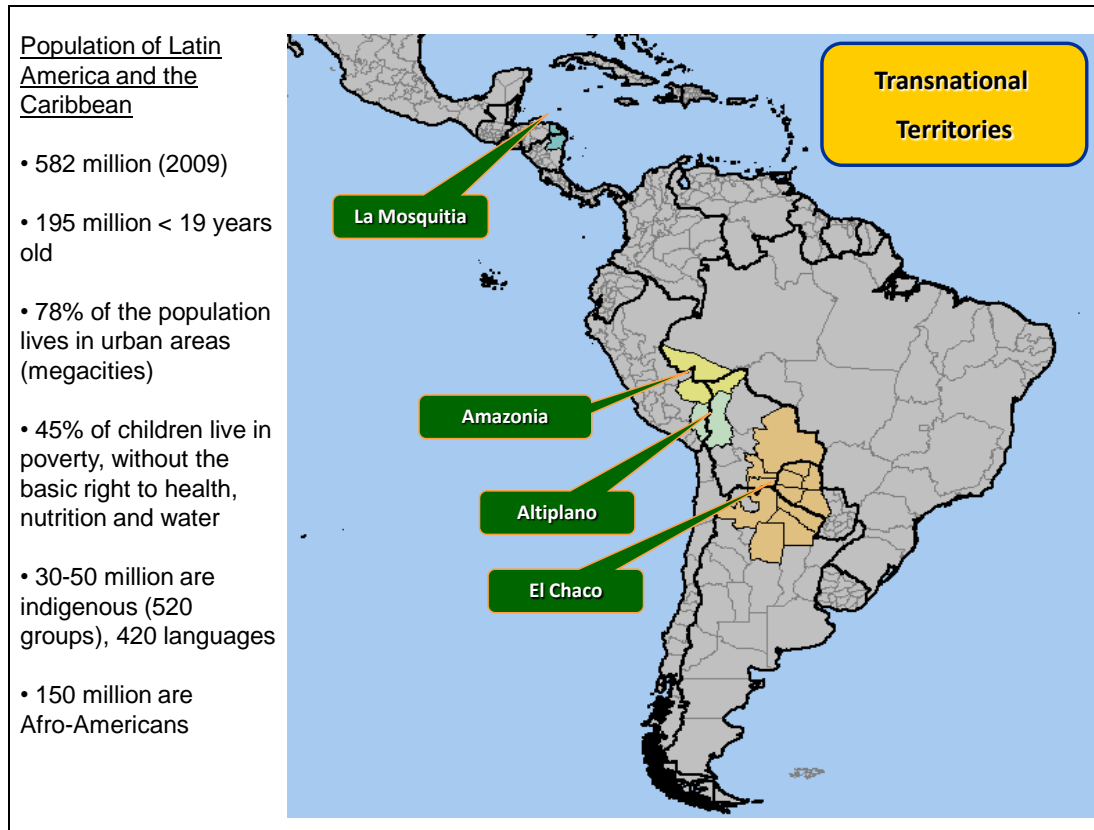
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<sup>1</sup> *MDG Report Inform 2010*. United Nations.

<sup>2</sup> *Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care*. Washington DC: Pan American Health Organization, 2008.

high despite the efforts made. This leads to the existence of large differences in health indicators among the countries and enormous inequities within each of them.

Among the most affected regions of LAC are the following:



- Mosquitia: In Central America, located along the Mosquito Coast northwest of Honduras, its population includes indigenous groups such as the Miskito, Pechel, Rama, Sumo and Tawakha. Access is mainly by water and air.
- Amazonia: Includes parts of Brazil, Peru, Colombia, Venezuela, Ecuador, Bolivia, Guyana, Suriname and French Guiana. Diverse indigenous groups live here, such as the Shuar (Jibaro), Cofan, Piaroa, Ash'aninka, Kayapo, Assurini, Machiguenga, Cimarrones, Wai Wai and Yanomami, among others.
- The Altiplano: Located in Chile, Argentina, Bolivia and Peru. Aboriginal populations, such as the Aymara and Quechua, live here.
- The Chaco: A region of lowlands occupying territory of Bolivia, Paraguay, Argentina and Brazil. The indigenous peoples who live in this region are the Wichi, Qom, Macovies and Tupi-Guarani, among others.

These populations share a characteristic: they inhabit regions distant from urban centres and of difficult geographic access.

### *Situation of the vulnerable groups*

This reality is present mainly in vulnerable groups, understanding such groups to be those in a situation of poverty, with little education, in marginalised periurban belts, aboriginal populations, ethnic groups and Afro-Americans. These populations generally have less access to health services and interventions.

Despite the little existing information, various studies carried out in the region – especially local ones – show that the greatest levels of inequity in indicators related to health and nutrition exist among indigenous mothers, children and adolescents.

The ratio of maternal mortality, child mortality and chronic malnutrition is two to three times greater in areas where indigenous populations live compared to areas where Spanish-speaking populations live. In these groups, in addition to less supply of health services, especially those with sufficient capacity to attend the complications that are a direct cause of maternal and child mortality, there is less access to the services, resulting from geographic dispersion and the scarcity of paths of communication due to the cultural gaps between beliefs and health care practices that exist between communities and health centres.

### *The commitment of the United Nations*

To ratify its commitment to cooperation with countries for achievement of the Millennium Goals, the United Nations Headquarters, through the Secretary-General, Ban Ki-Moon, presented a Global Strategy for Women's and Children's Health focussed on the groups most affected:

- Pregnant women and newborns, especially during the first hours and days after birth.
- Adolescent girls with regard to the vital decisions they take, including decisions about their fecundity.
- Vulnerable groups, who suffer difficulty in access to services due to being part of the poorest groups, living with HIV/AIDS, being orphans, belonging to indigenous peoples or living at a greater distance from health services.

The global strategy recognises that even some of the poorest countries have reduced maternal and newborn mortality considerably and have improved the health of women and children. However, it emphasises that innovative strategies are required to eliminate the barriers that hinder access to health and achievement of better results.

These innovative strategies need to be applied to all activities: leadership, funding, instruments and interventions, service provision, surveillance and evaluation.

The fundamental areas in which urgent innovative measures are required in order to improve funding, strengthen policies and improve service provision are:

- Support to health plans directed by the countries and supported through greater, predictable and sustainable investment.

- Integration of the provision of health services and life-saving interventions in order to give women and their children access to prevention, treatment and assistance when and where they are needed.
- Strengthening of health systems so they possess sufficient well-prepared health personnel.
- Introduction of innovative proposals in funding, product development and efficient provision of health services.
- Improvement of monitoring and evaluation in order to achieve the accountability of all parties interested in the results.

### *Alliances in Latin America and the Caribbean*

With the purpose of fulfilling their commitment, cooperation agencies in LAC have promoted the creation of various strategic alliances for technical assistance to countries for meeting the goals. Among these the Newborn Alliance (Alianza Neonatal), the Working Group for the Reduction of Maternal Mortality (GTR: Grupo de Trabajo para la Reducción de la Mortalidad Materna) and the Pan American Alliance on Nutrition and Development, of all of which UNICEF is an active member, stand out.

### *The role of UNICEF*

Sharing the same vision, UNICEF strengthened its institutional commitment to support countries in the improvement of their capacity and systems for guaranteeing the right of mothers and children to survival, growth and development with the aim of reaching the highest possible level of health.

In accord with this commitment, UNICEF defined an articulated strategy on health and nutrition (2006-2015)<sup>3</sup> and a global strategic guideline on the role of UNICEF on maternal and newborn health<sup>4</sup> focussed on goals 4 and 5. In this guidance, key areas in which UNICEF has a primary mission or shows comparative advantage in the synergy of its action in health and nutrition are highlighted:

- Knowledge management to support the development of policies, plans and strategies in maternal, neonatal and child health at national, district and local level.
- Evidence-based advocacy and mobilisation of resources generated through knowledge management.
- Improvement of the quality of care and expansion of interventions that have great impact on maternal and neonatal health.
- Community-based interventions to improve practices at the level of the family, generate demand and improve service use.
- Intersectorality for dealing with the underlying determinants of maternal, neonatal and child health.

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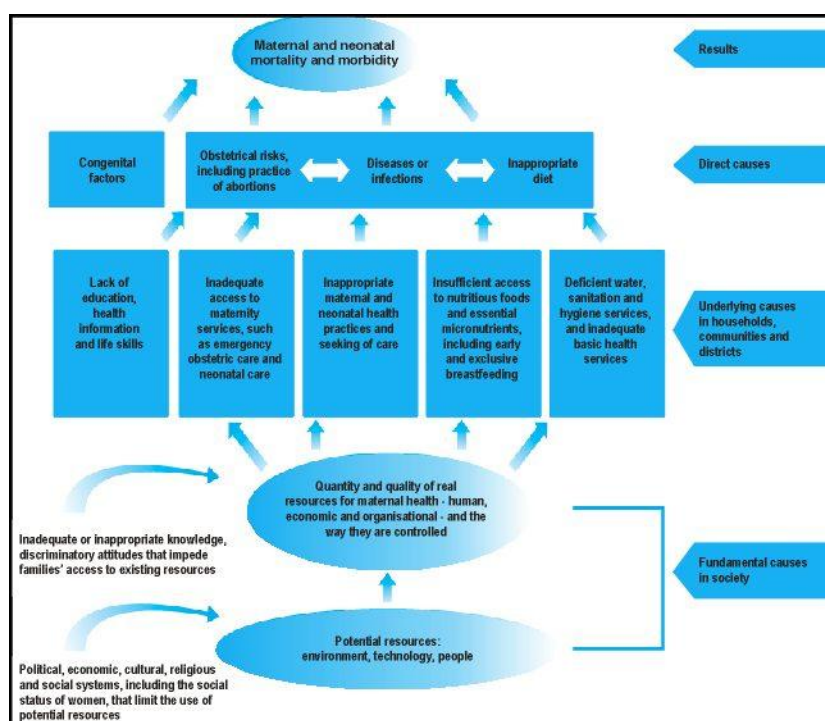
<sup>3</sup> UNICEF joint health and nutrition strategy for 2006-2015.

<sup>4</sup> Strategic Guidance Note on UNICEF's Role in Maternal and Neonatal Health 2010.

As part of its contribution to maternal and neonatal health, UNICEF developed two tools that are highly useful when assessing and analysing the causes of maternal and neonatal mortality and morbidity, as well as when planning concrete actions to improve maternal and neonatal health. These tools are the conceptual framework on the causes of maternal and neonatal mortality<sup>5</sup> and the equity-based model for care in the poorest areas.<sup>6</sup>

### *Conceptual framework on causes of maternal and neonatal mortality*

Analysis of the conceptual framework shows that results with regard to maternal and neonatal health are determined by interrelated factors that include, among others, nutrition, water, sanitation and hygiene, health care services and the practice of healthy habits, and disease control. These factors are defined as immediate (proceeding from the individual), underlying (proceeding from households, communities and districts) and fundamental (proceeding from society). The factors of one area influence the other areas.



### *Equity-based model*

With this model it is hoped to accelerate progress, reduce inequalities and decrease direct spending in poor areas by means of three essential measures: improvement of facilities for care for children and newborns, reduction of the obstacles that prevent the poorest from using

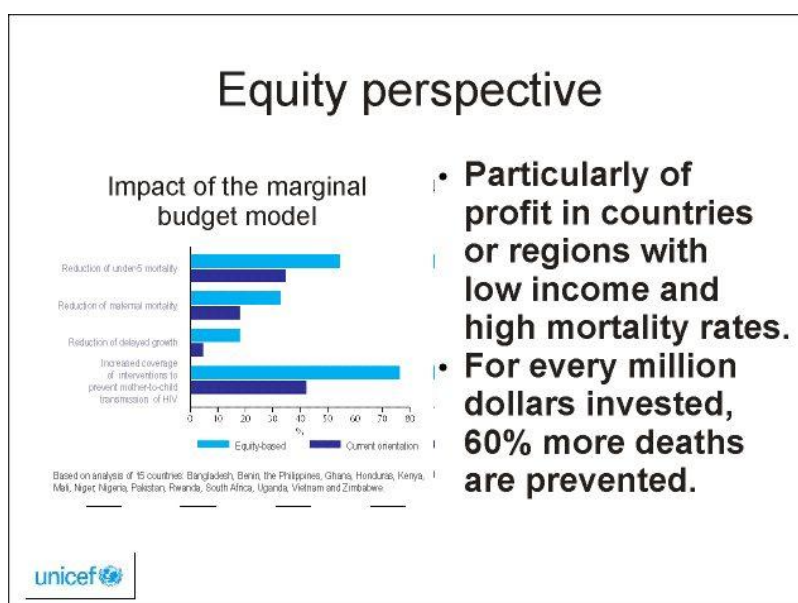
<sup>5</sup> *The State of the World's Children 2009: Maternal and Newborn Health*. New York: UNICEF, 2008.

<sup>6</sup> *Reducir las diferencias para alcanzar los objetivos*. UNICEF, 2010.

services (even when they are available) and provision of services outside of facilities and increasing community participation in the promotion of healthy practices.

Application of the equity-based model results in fewer deaths of children and mothers, lower delayed growth rates and greater coverage of prevention interventions. In addition, it reduces the differences between poorer and less poor areas and groups, while reducing direct expenditure by user families.

The equity-based model is particularly of profit in countries with low income and high mortality rates. In these contexts, for every additional million dollars invested, this model prevents another 60% of deaths compared to the current care model.



## **JUSTIFICATION**

### *Health disparities in LAC*

Recognising that the reality is not the same throughout LAC, between countries or within each country, disparities of any kind can directly affect the achievement of the MDGs. The existence of inequities translates into the poorest or most vulnerable populations having less access to health systems and interventions. This forces assessment of the situation, associating the relationship existing between health indicators and the results of multiple conditions of vulnerability, such as ethnic group, education, age, place of residence, income distribution, wealth and other social factors.<sup>7</sup>

<sup>7</sup> MDG Report Inform 2010. United Nations.

***Inequities in access to birth attendance by qualified personnel:***

Birth attendance is an excellent example of this: as birth attendance by trained personnel increases, complications and deaths decrease. In this area great progress has been achieved, which extends to the entire population. In LAC, birth attendance by trained personnel in medical institutions increased from 72% to 86% between 1990 and 2008.<sup>8</sup>

When birth attendance by trained personnel is analysed for each country, great differences emerge associated with inequities in income distribution:

**Table 1: Percentage of births attended by qualified health personnel, by income quintiles**

Country	Information year	Lowest quintile	Highest quintile	Lowest to highest coefficient
Bolivia (Plurinational State)	2008	38	99	2.6
Colombia	2005	72	99	1.4
Guyana	2006	64	93	2.5
Haiti	2005-2006	6	68	10.5
Honduras	2005-2006	33	99	3
Nicaragua	2001	78	99	1.3
Peru	2004-2005	28	100	3.5
Trinidad and Tobago	2006	98	100	1

Women in the wealthiest quintile have more access to birth attendance by qualified health personnel than those in the poorest quintile. These differences are so marked that they can vary from 10:1 in Haiti to 1:1 in Trinidad y Tobago. What is desirable is that this ratio be 1:1 in all countries in LAC.<sup>9</sup>

<sup>8</sup> *MDG Report Inform 2010*. United Nations.

<sup>9</sup> *Overview of Health and Nutrition Disparities*. UNICEF.

**Table 2: Percentage of births attended by qualified health personnel, urban-rural**

Country	Information year	Rural	Urban	Urban-rural coefficient
Belize	2006	93	99	1.1
Bolivia (Plurinational State)	2008	51	88	1.7
Colombia	2005	77	97	1.3
Guyana	2006	82	89	1.1
Haiti	2005-2006	15	47	3
Honduras	2005-2006	50	90	1.8
Jamaica	2005	94	99	1
Nicaragua	2001	83	97	1.2
Peru	2004-2005	43	92	2.1

Analysing this situation by urban-rural area, the ratio is similar. While in several countries this ratio is almost 1:1, there is another group in which there are still differences in access to care by trained personnel, reaching twice as much in urban areas as in rural areas. What is to be expected is that in 2015 these differences will not exist.<sup>10</sup>

#### ***Inequities in access to vaccination programmes:***

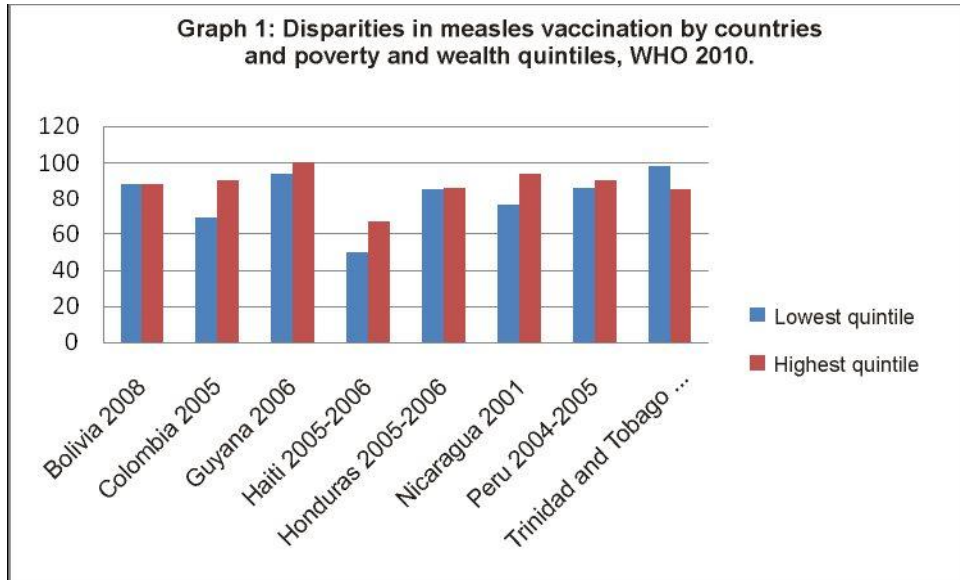
Vaccination programmes have had a great impact on the reduction of morbidity and mortality due to preventable diseases by means of vaccines. They are characterised by being universal and involving strategies that ensure access by and coverage of the entire population.

The existing goals for this preventive activity are currently focussed on reducing child mortality due to measles, and upon analysing the existing data one sees that LAC has achieved increasing the coverage of this vaccination from 92% in 2000 to 93% in 2008.

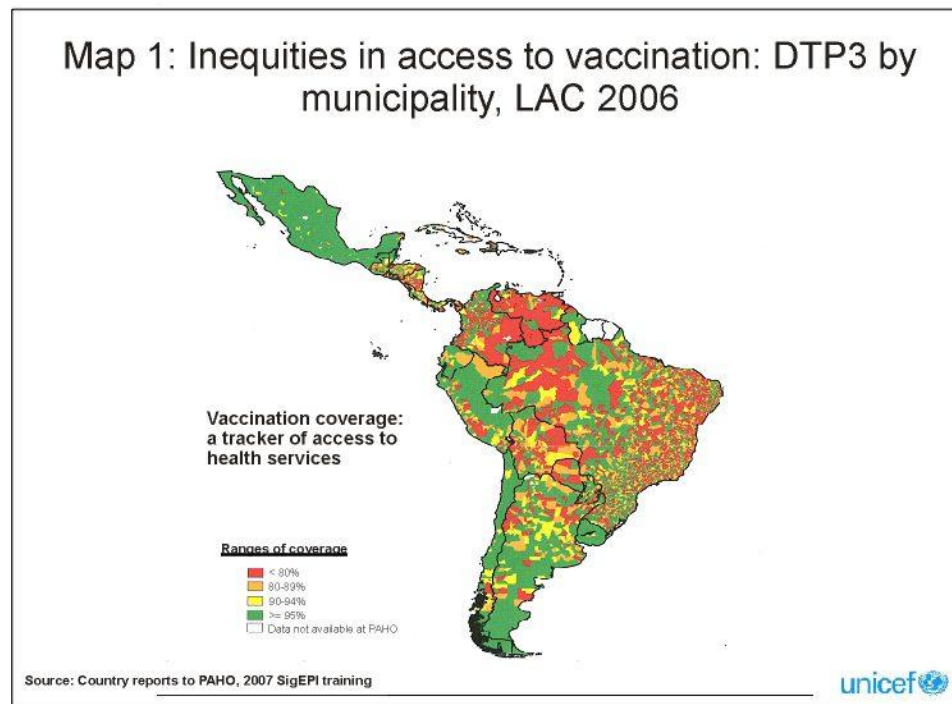
Graph 1 shows the coverage of vaccination against measles by income quintiles,<sup>11</sup> showing inequities between the poorest and wealthiest quintiles that, despite not being severe, show that in each country there is a population group that does not use this life-saving preventive intervention.

<sup>10</sup> *Overview of Health and Nutrition Disparities*. UNICEF.

<sup>11</sup> *Overview of Health and Nutrition Disparities*. UNICEF.



However, upon evaluating the vaccination coverage of regular children’s programmes, the reality is different from that of measles vaccination. Map 1 shows us that the reality of the coverage of the three-dose DTP vaccination, administered at six months of age, is different among countries and among the municipalities of each country. While there are countries with coverage over 95%, optimum coverage for eradicating disease, there are other countries – and some municipalities in the countries – whose coverage is below 80%, that is, completely insufficient even for controlling the propagation of a disease.



*Inequities in under-five mortality, by income quintile:*

If we disaggregate under-five mortality by income quintiles, we see that mortality is greater in the poorest population of each country (Table 3), with double or triple the mortality of the highest income sector.

**Table 3: Under-five mortality, by income quintile; WHO 2010**

Area	Time period	Lowest quintile	Highest quintile	Lowest to highest coefficient
Bolivia	2008	116	31	3.7
Colombia	2005	39	16	2.4
Haiti	2005-2006	125	55	2.3
Honduras	2005-2006	50	20	2.5
Nicaragua	2001	64	19	3.3
Peru	2004-2005	63	11	5.7

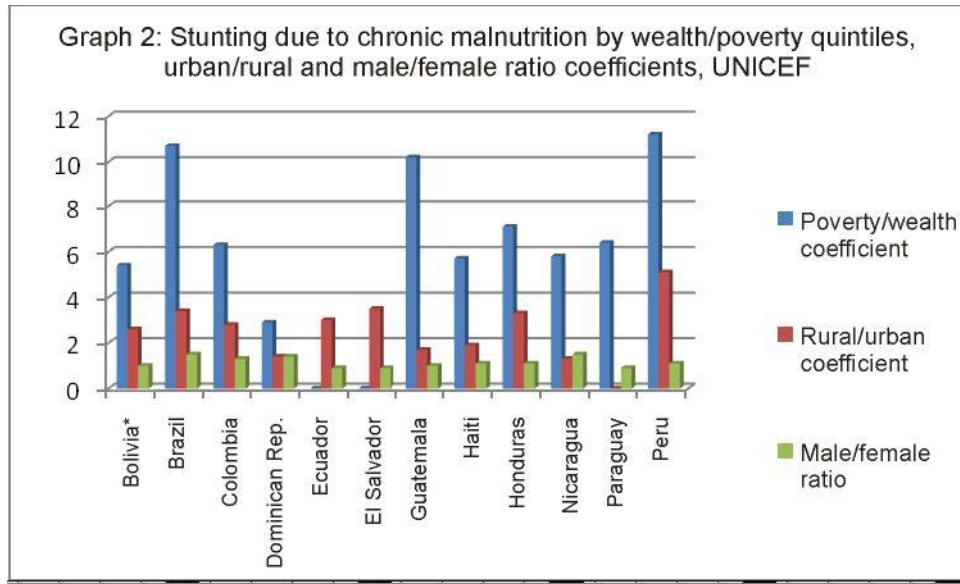
*Inequities in child nutritional status, by income quintile:*

The disparities can affect the health status of the population. A clear example of this is the association existing between stunting due to chronic malnutrition and some social factors.

When we associate stunting with income quintiles, we can see that in Guatemala for every ten children in the poorest quintile who present stunting due to chronic malnutrition, only one presents it in the wealthiest quintile. This reality is observed in all of the countries of LAC, with different equity gaps, and is also observed at urban-rural level (Graph 2).<sup>12</sup>

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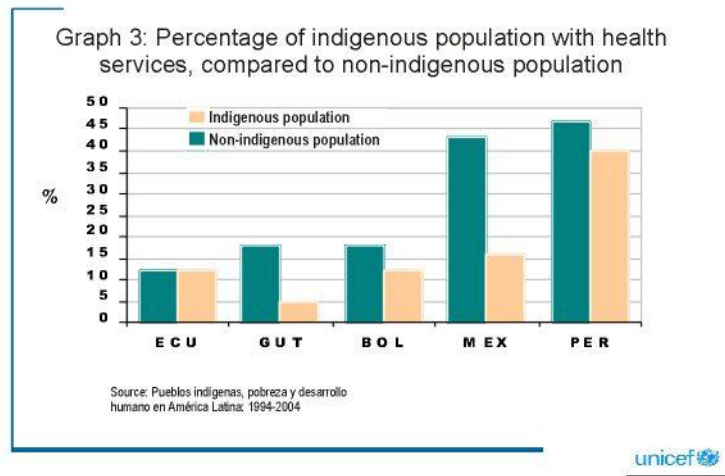
<sup>12</sup> *Overview of Health and Nutrition Disparities*. UNICEF.



***Ethnic inequities:***

In LAC there are a large number of aboriginal or indigenous peoples, reaching a total of 520 groups with 420 different languages.

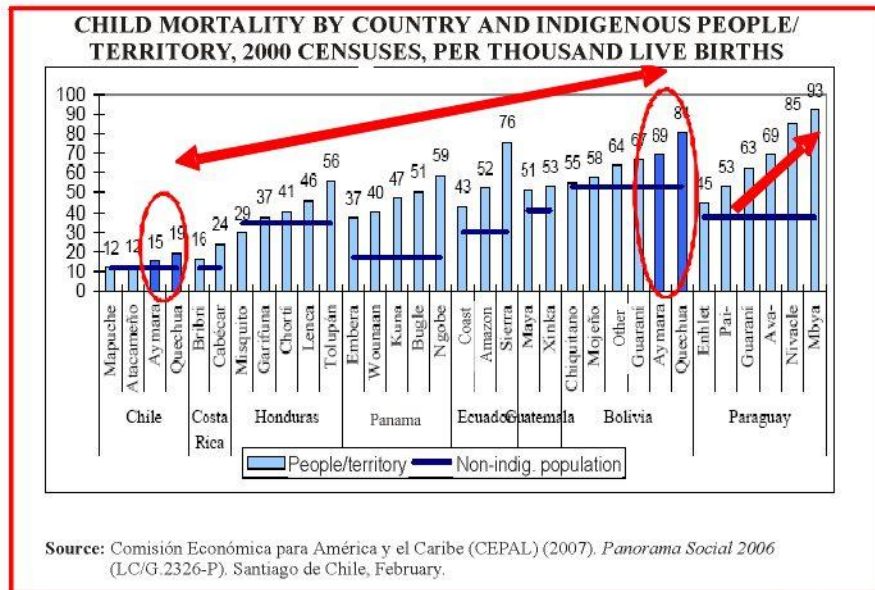
As Graph 3 shows, the access of these groups to health care compared to the non-indigenous population is not homogeneous. While access is equitable in Ecuador, the reality of Guatemala and Mexico shows us that in some countries these groups still continue to be vulnerable due to not possessing accessible health services.



As a great diversity of aboriginal groups exist in LAC, the reality between the same populations that live in different countries bordering on each other is not the same, either. Graph 4 shows that in nearly all countries the child mortality rate of ethnic groups is greater than that of the

non-indigenous population. However, while there are Aymara and Quechua groups in both Chile and Bolivia, the child mortality rate in the two aboriginal groups is different.

**Graph 4: Child mortality by country and indigenous people**



Source: Comisión Económica para América y el Caribe (CEPAL) (2007). *Panorama Social 2006* (LC/G.2326-P). Santiago de Chile, February.

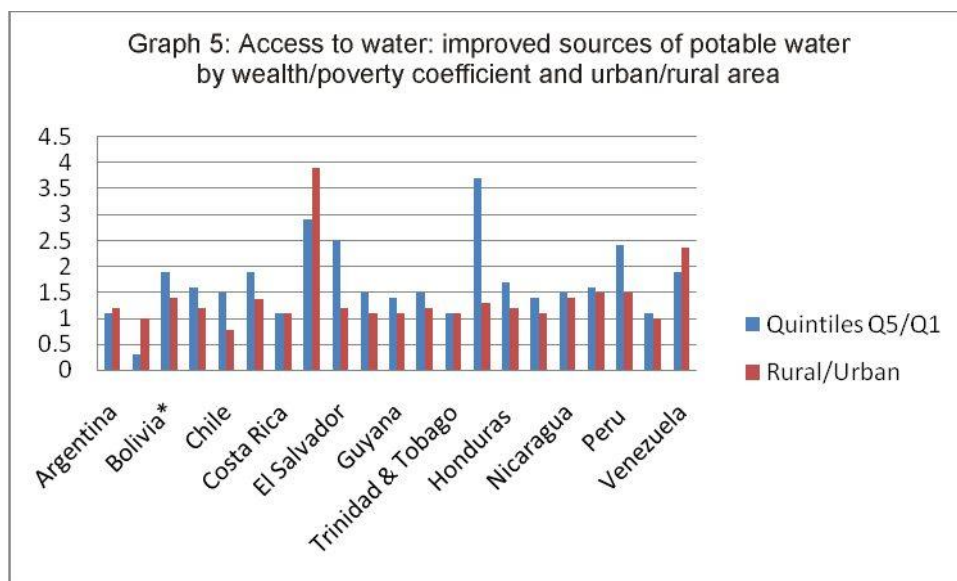


***Inequities in access to water:***

There are many diseases associated with the lack of potable water and sanitation. For this reason it is pertinent to integrate it in health as a crosscutting strategy that benefits health.<sup>13</sup>

In this regard, there are still inequities in LAC, both by income quintiles and by urban-rural place of residence. People in the poorest quintiles have less access to potable water; the same is true of people in rural areas.

<sup>13</sup> *Overview of Health and Nutrition Disparities*. UNICEF.



All of the data that we have analysed so far show us that in excluded populations a larger percentage of children and women lose their lives due to preventable or treatable health problems and have less access to quality health systems or effective timely interventions. For this reason, intervention in these populations can accelerate progress towards meeting goals 4 and 5 of the MDGs.<sup>14</sup>

***UNICEF's added value: a care approach based on equity and children's rights<sup>15</sup>***

As in other regions of the world, in LAC UNICEF carries out work that combines the promotion of high-level policies with specific initiatives to achieve concrete improvements in the lives of children, adolescents and women, at national and subnational level.

Fulfilling this mandate with the premise of improving work with vulnerable groups in order to reach the most disadvantaged children and women, UNICEF emphasises that countries' plans and programmes should reorient their priorities towards serving vulnerable groups, with an equity-based perspective, as the most practical and profitable way to achieve the Millennium Development Goals related to maternal and child health.

The equity-based care perspective assigns priority to health care in vulnerable groups, with a primordial foundation: using additional investment to reinforce training and the deployment of health professionals to the community, to expand or modernise existing infrastructure and to take advantage of social communication media for the promotion of healthy practices in order to motivate vulnerable groups to seek health care.

Following the recommendations of the equity-based model, countries in the LAC region should include the following in their policies and plans:

<sup>14</sup> *Reducir las diferencias para alcanzar los objetivos*. UNICEF, 2010.

<sup>15</sup> *Reducir las diferencias para alcanzar los objetivos*. UNICEF, 2010.

- **Detection of the most disadvantaged communities, population groups, children and women** through disaggregation of national data in order to identify these groups and assess the factors that cause their exclusion.
- **Resources for profitable interventions of proven efficacy**, in the context of intersectorality.
- **Overcoming bottlenecks and barriers** to providing services to the poor and marginalised, among others, as well as to promoting and facilitating the use of such services.
- **Creation of alliances with the community**, as participation of the community is vital for providing and using the services, and for promoting practices and behaviour that lead to better health.

On this basis, the need for strategies for the reduction of maternal, neonatal and child mortality in the context of the continuum of care<sup>16</sup> with evidence-based interventions and practices, promoting community mobilisation<sup>17,18</sup> with a vision of giving priority to the equity-based approach, is essential for providing technical assistance to the most affected countries of the region.<sup>5</sup>

The equity-based model is particularly of profit in countries with low income and high mortality rates. In these contexts, for every additional million dollars invested, applying this model prevents another 60% of deaths compared to the current care model.

Based on its institutional experience in health programmes, UNICEF has a comparative advantage in contributing to the reduction of maternal, neonatal and child mortality in the region through:

- a) Promotion of an explicit equity-based orientation of the health policies and plans of the region.
- b) Support for distribution of the health system to expand it to vulnerable groups.
- c) Reinforcement of participatory processes and social mobilisation.
- d) Focus on specific health results aimed at goals 4 and 5 of the MDGs.
- e) Ensuring national leadership in the process of formulation and implementation of equity-based policies.

### **Purpose of the document**

The aim of this document is to provide strategic orientation to UNICEF country offices in Latin America and the Caribbean with regard to dealing with the equity-based approach in order to contribute to achieving goals 4 and 5 of the Millennium Development Goals.

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<sup>16</sup> *Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care*. Washington DC: Pan American Health Organization, 2008.

<sup>17</sup> *The State of the World's Children 2009: Maternal and Newborn Health*. New York: UNICEF, 2008.

<sup>18</sup> *Una visión de salud intercultural para los pueblos indígenas de las Américas*. Washington DC: PAHO, 2008.

## Guiding objective

To contribute to the reduction of maternal, neonatal and child morbidity and mortality in LAC countries, aimed at meeting goals 4 and 5 of the MDGs, catalysing integral equity-based policies, plans, programmes and strategies, with emphasis on populations in a situation of vulnerability, during the 2011-2015 period.

## Strategic objectives

1. To contribute to LAC countries in the development of **methodologies for diagnosis and situation analysis** of their national and subnational population, focussed on equity and vulnerable groups.
2. To collaborate in the **building of local capacity and local management processes** at national and subnational level, in the context of the continuum of care.
3. To promote **social and community mobilisation** in the implementation of interventions focussed on the reduction of maternal, neonatal and child mortality.
4. To contribute to the leadership of **strategic alliances** committed to the health of mothers and children in order to fight inequalities and inequities.

Strategic objective	Strategic area of UNICEF FA1	Geographic area	Relevance to MDGs
1. To contribute to LAC countries in the development of methodologies for diagnosis and situation analysis of their national and subnational population, focussed on equity and vulnerable groups.	- Knowledge management	All countries	1, 4, 5 and 6
2. To collaborate in the building of local capacity and local management processes at national and subnational level, in the context of the continuum of care.	- Advocacy and resource mobilisation - Improvement of quality of care and expansion of interventions	Priority countries	1, 4, 5 and 6 Special emphasis on MDGs 4 and 5
3. To promote social and community mobilisation in the implementation of interventions focussed on the reduction of maternal, neonatal and child mortality.	- Intersectorality in dealing with determinants - Community-based interventions	Priority countries	1, 4, 5 and 6 Special emphasis on MDGs 4 and 5
4. To contribute to the leadership of strategic alliances committed to the health of mothers and children in order to fight inequalities and inequities.	- Intersectorality in dealing with determinants	All countries	1, 4, 5 and 6 Special emphasis on MDGs 4 and 5

## **Principles**

The guiding principles of the strategic orientation are:

- i. Human rights, with priority for children and women
- ii. Equity
- iii. Continuum of care and life cycles
- iv. Community participation
- v. Interculturality
- vi. Quality and safety perspective
- vii. Gender perspective
- viii. Multisectoral, determinant-based approach
- ix. Catalysing of alliances
- x. Alignment and coordination
- xi. Monitoring by results
- xii. Scaling up
- xiii. Universality
- xiv. Sustainability

## **Crosscutting character**

The factors that cause maternal and neonatal morbidity and mortality are interrelated. Causal analysis following the conceptual framework of maternal and neonatal mortality shows that the problem has a multifactor origin and is related to deficits in nutrition, water, sanitation and hygiene, health care services, incorporation of healthy practices and poor disease control.

Identification of the underlying causes (proceeding from the households, communities and districts) and fundamental causes (proceeding from society) shows the need for crosscutting themes and intersectoral actions for the reduction of maternal, neonatal and child deaths, with a vision of sustainability.

In this regard, the crosscutting themes of the strategic orientation are immunisation, nutrition, water/sanitation/hygiene, and treatment of childhood illnesses (diarrhoea, pneumonia), HIV, malaria, TB and tropical diseases, among the main ones.

## **Sustainability**

Over the last ten years, the countries of the region have shown sustained growth of the Human Development Index, which measures three dimensions: health, education and standard of living (Annex).<sup>19</sup>

Among the indicators used for its measurement is the GDP in the standard of living dimension. Upon analysing this indicator individually, one also sees improvement in the countries of the region.

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<sup>19</sup> Accessed at <http://hdr.undp.org/es/estadisticas> on 15 November, 2010.

This favourable regional economic panorama would allow increasing public investment for sustainable actions in maternal, neonatal and child health, with emphasis on vulnerable groups (Annex).

**Human Development Ranking, LAC 2010**

Very high human development	High human development	Medium human development	Low human development
4. USA	45. Chile	96. Paraguay	
8. Canada	46. Argentina	95. Bolivia	
	52. Uruguay	90. El Salvador	
	54. Panama	88. Dominican Rep.	
	56. Mexico	116. Guatemala	
	62. Costa Rica	115. Nicaragua	
	63. Peru	106. Honduras	
	73. Brazil		
	75. Venezuela		
	77. Ecuador		
	78. Belize		
	79. Colombia		
	80. Jamaica		

### **Beneficiary population**

The strategic orientation of UNICEF aims at achieving that pregnant women, newborns and children improve their survival and reach their development potential in order to have a healthy life.

- ◆ Direct beneficiaries: Pregnant women and newborns, with emphasis on vulnerable groups
- ◆ Indirect beneficiaries: Women of fertile age and children up to two years of age in vulnerable groups

### **Strategic areas and activities**

Following the equity perspective proposed by UNICEF and working on the basis of the agreements and alliances made in the region, the Regional Office will promote priority equity-based activities for the reduction of maternal, neonatal and child mortality in Latin America and the Caribbean, in accordance with the strategic areas of the institution:

<b>Strategic objective 1. To contribute to LAC countries in the development of methodologies for diagnosis and situation analysis of their national and subnational population, focussed on equity and vulnerable groups.</b>			
<b>Strategic area</b>	<b>Activity</b>	<b>Base indicator: % of countries with ...</b>	<b>Sources of verification</b>
Knowledge management	Promotion of situation analysis of maternal, neonatal and child health focussed on inequities and vulnerable groups	... situation analysis with an equity perspective	National statistical report on health and nutrition document Equity Tracker
	Promotion of adaptation of information systems on maternal, neonatal and child health in vulnerable populations	... an adapted information system	UNICEF country office reports
	Promotion of dissemination of national and subnational information for equity-based decision making	... reports on equity-based plans and programmes executed	National health and nutrition plan

<b>Strategic objective 2. To collaborate in the building of local capacity and local management processes with an equity perspective.</b>			
<b>Strategic area</b>	<b>Activity</b>	<b>Base indicator: % of countries with ...</b>	<b>Sources of verification</b>
Advocacy and resource mobilisation	Advocacy for the inclusion of equity in health plans, programmes and public policies	... national policies and plans with a perspective of equity for vulnerable groups	National health and nutrition plan document  UNICEF country office reports
	Promotion of resource mobilisation to support effective health interventions for vulnerable populations	... public funding applied to vulnerable groups	
Improvement of quality of care and expansion of interventions	Development of a strategy for the identification, dissemination and incorporation of health interventions and practices in national plans	... evidence-based interventions and practices incorporated in maternal, neonatal and child health standards	
	Promotion of improvement of the quality and safety of maternal, neonatal and child care in the context of the continuum of care according to national standards		

<b>Strategic objective 3. To promote social and community mobilisation in the implementation of interventions focussed on the reduction of maternal, neonatal and child morbidity and mortality in the context of the continuum of care.</b>			
<b>Strategic area</b>	<b>Activity</b>	<b>Base indicator: % of countries that ...</b>	<b>Sources of verification</b>
Intersectorality for dealing with determinants	Promotion of social and community mobilisation in the context of intersectorality for maternal, neonatal and child care	... develop social mobilisation plans in the context of intersectorality	MICS, DHS, other health/nutrition surveys
	Development of culturally	... implement communication	UNICEF country office reports

	appropriate communication for development strategies	for development strategies in maternal, neonatal and child health	
Community-based interventions	Development of community intervention strategies for maternal, neonatal and child health care	... implement community interventions for maternal, neonatal and child care	National health and nutrition plan  UNICEF country office reports

**Strategic objective 4. To contribute to the leadership of strategic alliances committed to the health of mothers and children in order to fight inequalities and inequities.**

Strategic area	Activity	Base indicator: % of countries with ...	Sources of verification
Intersectorality for dealing with determinants	Strengthening of national intersectoral alliances for the reduction of maternal, neonatal and child mortality, with emphasis on vulnerable groups	... alliances created for the reduction of maternal, neonatal and child mortality	Documents of joint declarations, joint publications  UNICEF country office reports

### **Prioritisation of countries**

In order to select the priority countries in which to work in an independent project, using the equity perspective and focussing on vulnerable groups, the following selection criteria were used:

1. Maternal mortality rate greater than 100 per 100,000 live births
2. Neonatal mortality rate greater than 15 per 1,000 live births
3. Under-five mortality rate greater than 30 per 1,000 live births
4. Data from international databases on inequities in income distribution, mortality rates and access to health services
5. Existence of vulnerable population

Based on these criteria, the priority countries are:

- |             |             |
|-------------|-------------|
| - Haiti     | - Paraguay  |
| - Guyana    | - Honduras  |
| - Bolivia   | - Nicaragua |
| - Guatemala | - Ecuador   |

### **Monitoring of implementation in country programmes**

Based on the strategic activities that UNICEF will support in the priority countries of the region, for each area identified we will monitor strategic indicators that show the political commitment and will to act aimed at reducing maternal and neonatal mortality in vulnerable groups.

**Strategic objective 1. To contribute to LAC countries in the development of methodologies for diagnosis and situation analysis of their national and subnational population, focussed on equity and vulnerable groups.**

Activity	Priority country base indicator	Sources of verification
Incorporation of maternal and neonatal indicators adapted to vulnerable groups in the health information system	Percentage of maternal, neonatal and child indicators in the information system by vulnerable group	National statistical report on health and nutrition document
Systematisation of national and subnational information, with visibility of vulnerable groups	Percentage of programmes for presentation/dissemination of maternal and neonatal information regarding vulnerable groups	National health and nutrition plan
Systematisation of regulatory documents with equity-based decision taking	Percentage of regulatory documents with equity-based decision taking	Health and nutrition regulatory documents

**Strategic objective 2. To collaborate in the building of local capacity and local management processes with an equity perspective.**

Activity	Priority country base indicator	Sources of verification
Sensitisation of national, subnational and local authorities for formulation of equity-based plans	Percentage of health plans and programmes that include the equity perspective	National health and nutrition plan document
Sensitisation of national, subnational and local authorities for increasing public investment with a health equity perspective	Percentage of health plans and programmes with equity-based public funding	Public funding report document
Promotion of incorporation of evidence-based quality and safe care practices in national standards in the context of the continuum of care	Percentage of maternal and neonatal standards with evidence-based practices	Documents regulating care
Strengthening of the operation of national committees for the analysis of maternal deaths with an equity perspective	Number of reports of meetings of the committee for analysis of maternal deaths with an equity perspective	Reports of the national committee for the analysis of maternal deaths
Implementation of research protocols to generate evidence-based interventions	Number de programmes for the presentation/dissemination of results of research on evidence-based practices	Research protocols relating to evidence-based practices

**Strategic objective 3. To promote social and community mobilisation in the implementation of interventions focussed on the reduction of maternal, neonatal and child mortality in the context of the continuum of care.**

Activity	Priority country base indicator	Sources of verification
Implementation of a programme for community surveillance of maternal and neonatal health articulated with social mobilisation	Coverage of application of community surveillance of maternal, neonatal and child health	
Implementation of communication strategies with culturally appropriate key messages regarding maternal, neonatal and child care	Percentage of mothers who recognise danger signs (maternal/neonatal/child)	National health plans MICS, DHS, other health/nutrition surveys, documents of social and community mobilisation programmes
Execution of community prenatal home visit plans for maternal and infant care	Coverage of prenatal home visits	
Execution of community postnatal home visit plans for maternal, neonatal and child care	Coverage of postnatal home visits up to the third day	

<b>Strategic objective 4. To contribute to the leadership of strategic alliances committed to the health of mothers and children in order to fight inequalities and inequities.</b>		
<b>Activity</b>	<b>Priority country base indicator</b>	<b>Sources of verification</b>
Strengthening of national alliances for the reduction of maternal, neonatal and child mortality, with emphasis on vulnerable groups	Number of documents of intersectoral alliances that include equity in their analysis	Documents of joint declarations, joint publications  Birth registration system report document
Promotion of dissemination of the legal framework for the protection and rights of women and children, with emphasis on vulnerable groups	Number of documents of alliances with civil society actors for maternal and neonatal care	
Creation of strategies for early registration of births in vulnerable populations	Coverage of births registered during the first week after birth	

### **Strategic coordination of the functions and responsibilities of the agencies in the process of continuous care in maternal and neonatal health**

United Nations agencies and the World Bank have provided collaboration at global, regional and country level for contributing to the reduction of maternal and under-five deaths. This harmonisation and synergy of programme activities is consolidated in the region of Latin America and the Caribbean, with the organisation of technical working groups and technical assistance regarding the problem of maternal, neonatal and child mortality.

These groups are led by the work of the agencies of the region, and countries demand implementation of activities that is coordinated and harmonised with national plans.

### **General activities of the agencies in the strengthening of national capacity**

The cooperation agencies will work with governments and civil society to improve national capacity through:

- Technical assistance in health plans aimed at goals 4 and 5 of the MDGs, with a perspective of rights, equity and interculturality, and based on evidence.
- Technical assistance in communication strategies with incorporation of key health practices for mothers, newborns and children under five years of age.
- Strategies for the mobilisation of public and cooperation funds for maternal, neonatal and child health, with an equity perspective.
- Strategies for the expansion of coverage of reproductive health care and maternal, neonatal and child health care, with family planning services, qualified attendance during birth and emergency obstetric, neonatal and paediatric care, articulated to crosscutting themes such as adolescents, HIV and STIs.
- Strengthening of the monitoring and evaluation systems.
- Dissemination of successful programme experience and lessons learned in the region.

- Technical exchange among the countries of the region.

Following the commitment assumed by the cooperation agencies for the region, strategic coordination actions are proposed based on their institutional advantages and knowledge:

- PAHO-WHO: support for strategic planning (including map of guidelines / critical path for the reduction of maternal mortality, clinical standards, standards and guidelines, capacity building, maternal and neonatal audits, and framework monitoring).
- UNFPA: provision of supplies, equipment (especially for family planning and EmONC), support for capacity building, support for surveys, censuses and monitoring models in the subjects of adolescents, reproductive health, social determinants and gender issues.
- UNICEF: support to community-based initiatives and interventions, community-based monitoring and evaluation (especially MICS, and related to capacity building), supply of equipment, especially for maternal and neonatal health, and planning of national implementation of education of children.
- World Bank: support for funding, poverty alleviation and the social determinants perspective.

## Tentative roles and functions

<b>Areas of action</b>	<b>Strategies to be applied</b>	<b>Lead agencies</b>
Sexual and reproductive health with crosscutting gender	Development of strategic plans Training Advocacy Communication strategy Strategy for the involvement of men	UNFPA/WHO UNFPA/UNICEF/PAHO UNFPA UNFPA/UNICEF UNFPA
Community-based interventions	Contraception education Equipment for community care Home visits Community surveillance Community-based education strategy (individual, group, community) Community mobilisation Development and implementation of the community neonatal and maternal component of IMCI Implementation of IMCI Development of community support groups Breastfeeding and nutrition strategy	UNFPA/UNICEF/PAHO UNICEF UNICEF/PAHO UNICEF UNICEF  UNICEF/PAHO PAHO/UNICEF  PAHO/UNICEF  PAHO/UNICEF
Health centre-based interventions	Contraception and family planning Post-abortion management EmONC Incorporation of the neonatal and maternal component in IMCI in the context of continuous care Implementation of community IMCI Home visits Training of personnel Equipment for obstetric, neonatal and paediatric care Introduction of evidence-based practices Maternity homes Breastfeeding and nutrition strategy Expansion of coverage of care System of referral and counter-referral	UNFPA WHO/PAHO PAHO/UNFPA PAHO/UNICEF  PAHO/UNICEF UNICEF/PAHO PAHO/UNICEF UNICEF/UNFPA PAHO/UNICEF/UNFPA UNICEF PAHO/UNICEF PAHO/UNICEF/UNFPA PAHO/UNICEF/UNFPA
Adolescents	Adolescent health policies Immunisation School health initiative Education strategy (includes HIV, contraception, nutrition)	PAHO/UNICEF/UNFPA PAHO/UNICEF PAHO/UNICEF UNICEF/PAHO/UNFPA
Social determinants perspective	Strategy of advocacy for attending basic needs Communication for development strategy Repositioning of the perspective based on equity, rights, gender and violence	PAHO/UNICEF/UNFPA PAHO/UNICEF/UNFPA UNICEF/UNFPA
Monitoring and evaluation	Implementation of mortality analysis committees National and subnational database Population surveys National information system Creation of community surveillance	PAHO/UNICEF/UNFPA
Advocacy and resource mobilisation	Maternal and neonatal health communication strategy Strategy of advocacy for maternal and neonatal health Campaign for safe motherhood International Women's Week Breastfeeding Week	UNICEF/UNFPA PAHO/UNICEF/UNFPA UNICEF/UNFPA UNFPA PAHO/UNICEF/UNFPA

## **Evidence-based practices**

Evidence-based practices for maternal and child care are interventions whose application is focussed on the user, not just the illness or process, in accordance with the greatest scientific validity available.

Implementation of these practices entails a criterion of quality and safety in maternal and neonatal care.

The interventions presented were selected based on current knowledge of their scientific evidence for incorporation in national care plans according to their current feasibility. These practices are analysed in the context of the continuum of care by life cycle, by type of intervention and by place of care.

Among the interventions cited, those with potential for reducing the delays in receiving effective care in the immediate postpartum period, a critical period of maternal and neonatal death, stand out.

- Delay 1: Recognition and seeking of timely help
  - Community mobilisation
  - Childbirth preparation plan
- Delay 2: Transportation to first-level care
  - Financial incentive schemes
  - Communication technology
  - Transportation/referral strategies
- Delay 3: Receiving quality care in the first level of care
  - Maternity homes linked to basic obstetric care (EmONC), identification of danger signs
  - Qualified personnel to attend to EmONC and neonatal reanimation
  - Perinatal audits
- Delay 4: Transportation to referral level
  - Financial incentives
  - Emergency transportation systems
- Delay 5: Receiving quality care at the referral levels
  - Care by qualified personnel in complete EmONC
  - Post-reanimation management
  - Perinatal audits

		Continuum of care by life cycles				
		Preconception care	Prenatal and during childbirth	Neonatal care	Postpartum, postneonatal and child care	
Continuum of care by type of intervention	Promotional	Prevention de early pregnancy C4D	Childbirth plan Breastfeeding Healthy practices in the home Home visit by community personnel Differentiated care for the pregnant adolescent Clean birth  C4D	ENC Immediate breastfeeding Control of temperature Care for newborn with low birth weight  C4D	Home visit by community personnel Care of umbilical cord Control of temperature Exclusive breastfeeding Care for newborn with low birth weight Healthy practices Recognition of danger signs Initial care and referral Spacing of births  C4D	Care in the family/community
	Preventive	Supplementation - Folic acid - Iron Domestic violence Contraception Immunisations  IEC	Childbirth plan Increase of weight due to BMI Prenatal visit / prenatal care: -tetanus immunisation -intermittent presumptive treatment for malaria -screening and management of: - HIV - syphilis - micronutrients - iron - calcium/aspirin - hypothyroidism - deworming Care by qualified personnel Maternity homes	Immediate neonatal care Late clamping of the umbilical cord Immediate breastfeeding	Third-day postnatal visit Postpartum supplementation - vitamin a - iron Neonatal screening for hypothyroidism Kangaroo care method for LBW Immunisations	Services with extension of care/coverage
	Curative	Post-abortion management Detection & treatment of sexually transmitted infections Chronic illnesses MTCT-HIV and syphilis	Detection of asymptomatic bacteriuria Antibiotic in PROM Nifedipine in premature labour Prenatal corticoids Surveillance of labour with partogram Labour attended by trained personnel Active management of childbirth	Neonatal reanimation (air/oxygen) Immediate neonatal care Late clamping of the umbilical cord Immediate breastfeeding	Detection of danger signs Early diagnosis and treatment of maternal, neonatal and child complications	Clinical care Primary referral
		Emergency obstetric care	Emergency neonatal and paediatric care			Continuum of care by place of care

## **Conclusions**

UNICEF is fulfilling the institutional responsibility of repositioning the equity perspective aimed at vulnerable groups. At present, it is recognised with more evidence that the statistical burden represented by the deaths of mothers and newborns in marginal periurban, rural, aboriginal and ethnic, migrant and excluded population groups, among others, has an important impact on the mortality rates of the countries and of the region itself.

From the perspective of rights for children, equity is understood as access to the opportunity to survive, develop and reach their potential without discrimination, differentiation or favouritism, independently of their gender, race, religious belief, social situation, physical attributes, geographic location or other situation that identifies them.

The health equity perspective reorients the attention of decision takers in order to incorporate in their plans and programmes objective actions aimed at vulnerable groups.

Visualisation of these groups in the country information systems, at national, subnational and local level, is definitive for diagnosing their situation with regard to maternal and child health.

Decision taking based on this evidence will permit mobilising additional equity-based resources that will allow overcoming bottlenecks and obstacles, facilitating access to health service provision.

Each strategic area of this strategic orientation considers the inherent institutional potentialities and strengths of UNICEF, based on its institutional capacity for contributing to the reduction of maternal and child mortality in the region of Latin America and the Caribbean.

In this context, the technical capacity of the country offices should respond to the needs and priorities that have been identified with regard to the health of mothers, newborns and children. Technical support from the Regional Office will focus on special attention to incorporation of the equity perspective in national plans and programmes, improvement of human resources, and formulation and adaptation of standards, guidelines, methods and tools, in addition to the dissemination of information, including evidence-based interventions and best practices in care, giving priority to vulnerable groups.

It is equally important to strengthen the existing coordination mechanisms of the countries and the technical cooperation among countries. These technical cooperation mechanisms should give visibility to the equity perspective within the continuum of care for the sensitisation of political, social and economic actors with the aim of improving care for vulnerable groups.

# ANNEXES

## **Technical bases of evidence-based practices**

### **Practices prior to pregnancy**

#### **Surveillance of nutritional status with the body mass index (BMI) prior to pregnancy**

A body mass index of less than 20 is associated with malnutrition. Prior to pregnancy, it is a predictor of low birth weight (LBW) and intrauterine growth retardation (IUGR) when the woman becomes pregnant.

#### **Folic acid supplementation**

Reduces the incidence of neural tube defects by 72% (42-87%).

#### **Prevention and treatment of anaemia with iron**

Iron-deficiency anaemia in the female adolescent is associated with greater risk of anaemia during pregnancy. It has also been associated with alterations of the cognition function and memory, reduced school performance, and depression of the immune function with an increase in infection rates.

#### **Detection and treatment of sexually transmitted infections (STIs) prior to pregnancy**

In women, chlamydia y gonorrhoea can cause pelvic inflammatory disease, which can contribute to infertility or problems with pregnancy. In males, gonorrhoea can cause epididymitis, and can cause infertility. HIV kills or damages the cells of the immunological system of the body, leading to serious infections and death, and is transmitted during pregnancy, labour and breastfeeding. Prevention of HPV by vaccination can reduce cancer of the cervix, vulva, vagina and anus. In males, HPV can cause cancer of the anus and penis.

#### **Detection and treatment of chronic illnesses (obesity, diabetes)**

Psychiatric disturbances, emotional disturbances, bad school performance and withdrawal from school, prolonged treatments, cardiovascular illness.

### **Practices during pregnancy**

#### **Prenatal control**

Prenatal control represents an opportunity for increasing access to childbirth in safe conditions, in an environment of obstetric emergency and qualified institutional neonatal care. It has been reported that there are fewer complications during pregnancy and childbirth, less pre-eclampsia, urinary tract infection, postpartum anaemia and maternal mortality, as well as fewer cases of LBW.

#### **Use of the CLAP/SMR perinatal clinical record (PCR) and perinatal card**

PCR data processing strengthens the capacity for self-evaluation of perinatal care, makes personnel recognise the importance of complete documentation of health actions and observations, and provides perinatal care centres with an agile and easily used tool for operational research.

**Weight gain during pregnancy**

There is strong evidence that supports an association between weight gain during pregnancy and the following results: premature birth, low birth weight, macrosomia, newborns who are large for their gestational age and newborns who are small for their gestational age. There is also evidence of more frequent adverse results during labour and childbirth.

**Immunisation with tetanus toxoid, considering prior vaccination status**

In populations in which the incidence of tetanus is high, this can reduce neonatal mortality by 35-58% and reduce the incidence of neonatal tetanus by 88-100%.

**Screening and treatment of cases of syphilis**

Reduction of foetal mortality and abortion, depending on its prevalence.

**Detection and treatment of asymptomatic bacteriuria**

Asymptomatic bacteriuria is strongly associated with premature birth and LBW. The mother may suffer pyelonephritis, hypertension, pre-eclampsia and possibly maternal and/or foetal death.

**Prevention and treatment of anaemia with iron during pregnancy**

Iron deficiency anaemia in the pregnant female is a cause of maternal and perinatal death. It is also strongly associated with premature birth and LBW. Studies indicate that iron supplementation for women during pregnancy has beneficial effects on perinatal results.

**Prevention de pre-eclampsia and eclampsia**

This reduces low birth weight and premature birth. It is associated with a reduction of 8% in premature births, 14% reduction of perinatal death and 10% reduction of IUGR.

**Detection and treatment of sexually transmitted infections**

Diseases such as chlamydia, gonorrhoea, syphilis, trichomoniasis and bacterial vaginosis can be treated and cured with antibiotics during pregnancy, reducing vertical transmission.

**Detection and treatment of chronic illnesses (diabetes, obesity)**

Diabetes during pregnancy is associated with foetal death and with birth with macrosomia, trauma, respiratory problems, hypoglycaemia, hyperbilirubinemia and metabolic problems. There is strong evidence of an association between congenital anomalies y poor control of glycaemia during pregnancy.

**Deworming in areas of high prevalence**

This reduces maternal anaemia and its complications, without evidence of teratogenic effects in the foetus with the use of albendazole.

**Detection and treatment of group B streptococcus**

Prophylactic therapy initiated at least four hours before childbirth reduces the incidence of infection and neonatal mortality due to group B streptococcus (125-131).

**Detection and treatment of periodontal disease**

Periodontal disease is associated in pregnancy with pre-eclampsia, and in the newborn with premature birth, LBW and IUGR.

**Detection, prevention and management of domestic violence**

Violence reduces motivation and morale, causes physical and psychological injury, depression and post-traumatic stress, and is a cause of premature birth and foetal and/or maternal death.

**Practices during childbirth****Clean and safe childbirth attendance practices (with qualified personnel)**

Births attended by qualified personnel and taking place in a health service have fewer complications and present less perinatal and neonatal morbidity and mortality.

**Accompanying the mother during labour and childbirth**

The continuous presence of a support person during labour and childbirth reduces labour, the need for a caesarean section, instrumental childbirth and the need for painkillers, and in the newborn gives an Apgar score >7 five minutes after birth.

**Erythromycin in PROM before birth at less than 37 weeks**

Statistically significant reduction of chorioamnionitis, neonatal morbidity including infection (pneumonia), use of surfactant, use of oxygen and abnormality in cerebral ultrasound before the high.

**Nifedipine in premature labour**

Nifedipine has been more effective and safer than other tocolytics for the threat of premature birth, and its oral administration is very advantageous. It prevents RDS, intraventricular haemorrhage and jaundice.

**Prenatal corticosteroids to induce pulmonary maturation**

It has been shown that the administration of prenatal betamethasone or dexamethasone significantly reduces RDS by 36-50% and neonatal mortality by 37-40%. It also reduces the risk of intraventricular haemorrhage by 40-70%. The persistence of ductus arteriosus and evidence suggest that they can protect against neurological consequences. A single dose is more beneficial compared to multiple doses.

**Surveillance of labour using a partogram**

This reduces unnecessary interventions and perinatal complications.

### **Caesarean section in podalic presentation in newborns with LBW**

Less neonatal morbidity and mortality, less asphyxia and trauma at birth compared to vaginal birth in newborns with LBW.

### **Zidovudine to reduce the risk of vertical transmission of HIV**

The use of antiretrovirals significantly reduces the vertical transmission of HIV infection from mother to child, together with other interventions such as elective caesarean section and use of infant formula in all of those exposed.

### **Modified active management of the third period**

It has been shown that the use of “uteroretractores” reduces bleeding and the number of transfusions to the mother, and increases the risk of placental retention and anaemia in the newborn. Oxytocics double the frequency of placental retention.

### **Late clamping of the umbilical cord**

Late clamping of the umbilical cord, carried out after 2-3 minutes, is physiological and increases neonatal hematocrit by as much as 50% when compared to early clamping. It increases the iron reserves of the newborn, reducing the prevalence of anaemia in the first 4-6 months of life. It also improves cerebral oxygenation in premature newborns during the first 24 hours of life.

### **Neonatal reanimation with surrounding air**

Surrounding (regular) air is as good as 100% oxygen for the reanimation of asphyxiated newborns, reducing their mortality.

### **Immediate care for the normal newborn**

Routine and immediate care for healthy newborns prevents hypothermia, hypoglycaemia, anaemia, hemorrhagic illness of the newborn, eye infection, change or loss of a newborn, and delay of exclusive breastfeeding.

### **Care of the umbilical cord**

Application of an antiseptic solution such as triple dye (Tween 80, gentian violet and **noflavine sulphate** or alcohol has been effective, although chlorhexidine or iodopovidone can also be used.

Traditional care of the umbilical cord with application of human milk does not seem to have adverse effects and is associated with faster detachment. Application of alcohol or chlorhexidine delays detachment. During epidemics of omphalitis triple dye has been most effective for its prevention, but can delay detachment.

### **Skin care at birth**

The surface of the skin, the vernix and the amniotic fluid protect the newborn against bacterial invasion at birth.

## **Practices after childbirth**

### **Neonatal screening for hypothyroidism**

Very early diagnosis and treatment of confirmed cases of hypothyroidism reduce or eliminate the risk of suffering the illness.

### **Detection and treatment of retinopathy of prematurity (ROP)**

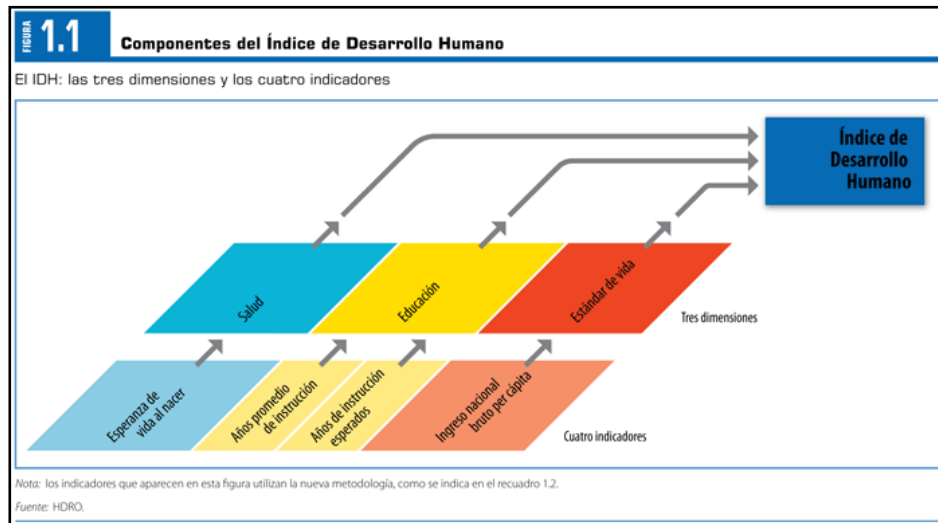
Prevention of exposure to high levels of oxygen, by controlled use of oxygen or pulse oxymetry, can reduce the number of newborns with serious and irreversible phases.

### **Early home visits for newborn care**

Several studies have shown that early home visits for newborn care are effective for reducing neonatal mortality in high-risk populations. They have also shown improvements in the key practices of neonatal care, such as initiation of breastfeeding, exclusive breastfeeding, skin-to-skin contact, delaying bathing and improving hygiene, as well as hand washing with clean water and soap and care of the umbilical cord.

## The Human Development Index<sup>20</sup>

The first *Human Development Report* introduced a new way of measuring development by means of a combination of indicators of life expectancy, educational achievement and income in a composite Human Development Index, the HDI (see Box 1, below). The innovative feature of the HDI was the creation of a single statistic to serve as a reference framework for both social development and economic development. The HDI defines a minimum and maximum value for each dimension (called *objectives*) and then shows the position of each country in relation to these objective values, expressed as a number between 0 and 1.



The life expectancy at birth component used by the HDI is calculated using a minimum value of 20 years and maximum value of 83.2 years, which is the maximum value observed for the indicators of the countries in the period 1980-2010. Therefore, the longevity component for a country whose life expectancy at birth is 55 years would be 0.554.

The education component of the HDI is now measured by years of education of adults over 25 years of age and the expected years of education for school-age children. The mean years of education is calculated by duration of study at each education level (for more detailed information, see Barro and Lee, 2010). Expected years of education is determined by education by age in all education levels and the school-age population present in each of those levels. The indicators are normalised using a minimum value of zero and the maximum values given by the real maximum values observed in the countries during the observed time series, that is, 1980-2010. The education index is the geometric mean of the two indexes.

The decent living standard component is measured by per capita GNI (USD PPP) instead of per capita GDP (USD PPP). The HDI uses the income logarithm to reflect how the importance of income decreases as the GNI increases. Subsequently, through the geometric mean, the scores of the three dimensional indexes of the HDI are summed to form a composite index.

<sup>20</sup> <http://hdr.undp.org/es/estadisticas/idh>; accessed on 15 November, 2010.

**2000-2010 Human Development Index trends for the  
countries of Latin America and the Caribbean**

Classification by HDI	Index	
	Value	
	2000	2010
<b>Very high human development</b>		
4. USA	0.893	0.902
8. Canada	0.867	0.888
<b>High human development</b>		
45. Chile	0.734	0.783
46. Argentina	0.734	0.775
52. Uruguay	0.716	0.765
54. Panama	0.703	0.755
56. Mexico	0.698	0.750
59. Trinidad and Tobago	0.685	0.736
62. Costa Rica	0.684	0.725
63. Peru	0.675	0.723
73. Brazil	0.649	0.699
75. Venezuela	0.637	0.696
77. Ecuador	0.642	0.695
78. Belize	-	0.694
79. Colombia	0.637	0.689
80. Jamaica	0.665	0.688
<b>Medium Human Development</b>		
88. Dominican Republic	0.624	0.663
90. El Salvador	0.606	0.659
95. Bolivia	0.593	0.643
96. Paraguay	0.593	0.643
106. Honduras	0.552	0.604
115. Nicaragua	0.512	0.565
116. Guatemala	0.514	0.560
<b>Low Human Development</b>		

# BUDGET

**2011-2015 BUDGET: PROJECT FOR REDUCTION OF MATERNAL, NEONATAL AND CHILD MORTALITY FOR EIGHT  
PRIORITY COUNTRIES OF LATIN AMERICA AND THE CARIBBEAN  
UNICEF**

<b>Area</b>	<b>Description</b>	<b>Quantity</b>	<b>Unit</b>	<b>Duration</b>	<b>Unit</b>	<b>Unit price USD</b>	<b>Total budget USD</b>
<b>Human resources</b>	Regional specialist en maternal, neonatal and child mortality, P3, to coordinate work with vulnerable groups	2	Person	60	Months	7.500	900.000
	Heath specialists based in eight priority countries, responsible for local coordination of UNICEF work with vulnerable groups	8	Person	60	Months	6.100	2.928.000
	Support for the production, adaptation and dissemination of one situation analysis document for eight priority countries	1	Person	3	Months	5.000	15.000
	Support for the adaptation of information systems for eight priority countries	1	Person	3	Months	5.000	15.000
	Support for the production, adaptation and dissemination of one advocacy document	1	Person	3	Months	5.000	15.000
	Consultant to develop key maternal, newborn and child health messages for eight priority countries	1	Person	3	Months	5.000	15.000
	Consultant to develop report on good practices in maternal,	1	Person	3	Months	5.000	15.000

Area	Description	Quantity	Unit	Duration	Unit	Unit price USD	Total budget USD
Contracts	newborn and child health						
	Printing of report on good practices in maternal, newborn and child health	2.000	Copies			120	240.000
	Reproduction of technical documents, guides and protocols in Spanish and indigenous languages	25	Copies			25.000	625.000
	Contract with an academic institution to carry out research on inequities in maternal, newborn and child health in eight priority countries in LAC	3	Study			75.000	225.500
	Translation of study on inequities in maternal, newborn and child health in eight priority countries in LAC to other languages	25	Copies			2.500	62.500
Travel	Missions to eight priority countries in LAC	80	Trips	4	Days	1.850 (varies by country)	304.000
	In-country transportation for field work	56				850	47.600
	Other transportation expenses	5				3.000	15.000
Training	National sensitisation workshop on maternal, newborn and child health in each priority country	8		3	Days	50.000	400.000
	Regional training workshop on equity and maternal, newborn	1		3	Days	80.000	80.000

Area	Description	Quantity	Unit	Duration	Unit	Unit price USD	Total budget USD
Various	and child health for health authorities of each country						
	Regional training workshop on surveillance of maternal, newborn and child health	1		3	Days	85.000	85.000
	Regional workshop on good practices in maternal, newborn and child health	1		2	Days	80.000	400.000
	Annual regional workshop for monitoring and evaluation of activities	5		2	Days	80.000	400.000
	Printing of study on inequities in maternal, newborn and child health in LAC	1.000	Copies			2.500	2.500.000
	Printing of study on inequities in maternal, newborn and child health in LAC in other LAC languages	500	Copies			2.500	1.250.000
	Monitoring and evaluation activities	5				80.000	400.000
	Administrative and logistical expenses (5% of budget subtotal)					471.193	471.193
	<b>Subtotal</b>						<b>9.838.292,89</b>
	<b>Possible cost recovery (7%)</b>						<b>688.680,50</b>
<b>Total</b>						<b>10.526.973,39</b>	

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