# MATERNAL, NEWBORN AND CHILD HEALTH IN THE AMERICAS

## A REPORT ON THE COMMITMENTS TO WOMEN'S AND CHILDREN'S HEALTH

International Federation of Red Cross and Red Crescent Societies

CANADIAN RED CROSS

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

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Cover photo: Sonia Komenda/CRC

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## INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES

*Strategy 2020* voices the collective determination of the International Federation of Red Cross and Red Crescent Societies (IFRC) to move forward in tackling the major challenges that confront humanity in the next decade. Informed by the needs and vulnerabilities of the diverse communities with whom we work, as well as the basic rights and freedoms to which all are entitled, this strategy seeks to benefit all who look to Red Cross Red Crescent to help to build a more humane, dignified, and peaceful world.

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**Saving lives, changing minds.**

Over the next ten years, the collective focus of the IFRC will be on achieving the following strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disasters and crises
2. Enable healthy and safe living
3. Promote social inclusion and a culture of non-violence and peace

## CANADIAN RED CROSS

The Canadian Red Cross works with partner Red Cross and Red Crescent Societies around the world to meet the Millennium Development Goals of reducing preventable deaths of children under the age of five, and to improve maternal health. The Canadian Red Cross has been active in maternal, newborn and child health (MNCH) since 1997, and supports programs in some 20 countries. Since 2005, Canadian Red Cross supported MNCH programs have reached more than 12 million people directly, and have indirectly benefited another 40 million. Forty thousand trained Red Cross volunteers have contributed to the achievement of health program objectives. **www.redcross.ca**

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The Pan American Health Organization (PAHO), founded in 1902, is the world's oldest international public health agency. It provides technical cooperation and mobilizes partnerships to improve health and quality of life in the countries of the Americas. PAHO is the specialized health agency of the Inter-American System and serves as the Regional Office for the Americas of the World Health Organization (WHO). Together with WHO, PAHO is a member of the United Nations system. **www.paho.org**

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# EXECUTIVE SUMMARY

Through its network of National Red Cross Red and Crescent Societies, the International Federation of Red Cross and Red Crescent Societies (IFRC) has been supporting and implementing health initiatives related to reproductive, maternal, newborn and child health (MNCH) for over 20 years. These MNCH initiatives include community programmes that promote healthy behaviours, increase vaccinations, monitor the growth of children and prevent malnutrition, diarrhea and respiratory diseases. Also, the IFRC works with partners to increase universal access to care for mothers, children and other vulnerable people.

The reasoning behind investing in MNCH stems from the IFRC's *Strategy 2020*, which sets ambitious goals for health. These goals are to build national society capacity to enable safe and healthy living, respond appropriately to health emergencies and crises, reduce vulnerabilities, build resilient communities and position the Red Cross Red Crescent as a leading strategic partner in global health. A key strategic aim focuses on building resilience. In terms of health, this can be addressed on an individual, community, national or global level; however, it is important to look at some of the most vulnerable populations such as women and children. The importance of MNCH is addressed in the IFRC's global Strategic Operational Framework for health (2011–2015).

In the next five years, the IFRC will focus on developing a more coherent approach to MNCH as part of integrated community health programming and to contribute to the achievement of Millennium Development Goals (MDGs) 4 and 5. So far, there has been some success in child health and achieving the MDGs in the Americas region; however, many countries still have a long way to go because progress has not been equitable. This lack of progress in the region, especially in maternal health, needs to be addressed by looking at these immense disparities to ensure lower mortality rates of mothers and of children under five years of age. A strong connection needs to be made with National Societies to ensure they have the support they need to help them achieve these goals.

This project, an IFRC initiative from the Americas Zone health programme, sought to map current Red Cross Red Crescent MNCH programming and MNCH-related activities conducted by National Societies, Partner National Societies, governments and external organizations, as well as document models, review gaps, identify policy and funding trends in MNCH in the region, and identify MNCH needs in the Americas. A research delegate in Americas Zone office in Panama conducted this research. The methodology included the use of surveys (online and electronic document format), formal interviews and meetings to gather the necessary information from relevant stakeholders. Additional background research was conducted to examine strategies and statistics regarding the subject matter and to identify the individual needs of priority countries in terms of MNCH and other potential related areas in health. This research was conducted from January to April 2012 and has been compiled in this report along with recommendations and analysis on the current situation and future possibilities for the region. This report will serve as a base for a feasible three-year plan of action to promote and scale-up Red Cross Red Crescent MNCH programming in the Americas, which will respond to the IFRC's *Long Term Planning Framework - the Americas Zone 2012-2015* and *America's Framework for Action (2012-2016)*.

In order to contribute to the development of a regional framework for Red Cross Red Crescent MNCH programming in the Americas and a three-year action plan, information has been compiled in this report on MNCH projects or activities being implemented by National Societies in the Americas, including those supported by Partner National Societies. Existing regional Red Cross health networks in the Caribbean, Central and South America serve as a mechanism for coordination, collaboration and communication between National Societies, in liaison with IFRC zone and regional health staff. The report also provides information on the level of coordination between Red Cross Red Crescent partners at the national level and the extent of National Societies' collaboration and coordination with their ministries of health and key international or non-governmental organizations to determine where partnerships can be improved, and to strengthen the auxiliary role of National Societies.

The mapping initiative identified the top five countries most in need of MNCH programming: Haiti, Guatemala, Bolivia, Guyana and Honduras. Additionally, Guyana is the only country out of the top five not prioritized by external partners and Partner National Societies for MNCH programming.

The initiative also identified a lack of MNCH specific funding in the coming years. Currently, no MNCH Partner National Society programming has guaranteed funding beyond 2013, other than Haiti. More efforts need to be dedicated to seek funding specific to MNCH in future years, especially for the top five countries identified as being in need of MNCH programming.

Even though National Societies are highly committed to MNCH, less than 40 per cent of National Societies are implementing activities in the post-natal period. Health-related programming instead tends to focus more on hygiene promotion, sexual and reproductive health, and nutrition. This may be due to such topics being more mainstream or common health topics or related to funding priorities. Greater focus on post-natal and neonatal health could help prevent neonatal deaths.

Supporting National Societies in developing or updating their MNCH strategies or objectives is key since only nine National Societies have active MNCH staff and only two National Societies have made pledges to support MNCH work.

When looking at inequalities in health, most of the disparities in MNCH in the top five countries in need are found within ethnic groups, especially indigenous populations. In Bolivia, Guatemala, Guyana, Honduras and Panama, the worst statistics for maternal and child indicators are found in indigenous districts or zones with high indigenous populations.

This study provides a picture of the current situation of Red Cross Red Crescent women's and children's health and MNCH programming in the Americas region. The study has been conducted in the hopes of helping National Societies and the IFRC identify the importance of MNCH and prioritize key areas of work to improve the health of mother and children and, therefore, help achieve MDGs 4 and 5 by 2015.

# KEY FINDINGS AND RECOMMENDATIONS

This report evaluated the current situation of MNCH in the Americas. After taking into account the work of National Societies, Partner National Societies, governments and external partners, key findings and recommendations were determined.

## 1

The countries that are most in need of MNCH programming are, in order, Haiti, Guatemala, Bolivia, Guyana and Honduras.

## 2

Guyana is the only country out of the top five countries in need that is not prioritized by external partners and Partner National Societies for MNCH programming. It is experiencing a severe lack of maternal healthcare activities to address the high maternal mortality ratio. It is also facing major MNCH disparities in a specific region - the interior.

**RECOMMENDATION:** More programming priority and support should be given for Guyana - especially for maternal health and in the hinterland region.

## 3

Most of the activities implemented by Red Cross Red Crescent are preventative — focusing on dissemination of knowledge and health promotion. Red Cross Red Crescent is supporting the government's implementation of curative MNCH activities.

**RECOMMENDATION:** Continue communication and coordination with governments to ensure that both community and institutional MNCH are covered. Develop cooperation strategies with governments to ensure complementary work between preventative care and curative care.

## 4

The region in which most National Societies are implementing MNCH is South America.

**RECOMMENDATION:** Use South America's MNCH experience for lessons learned that can be applied to other regions. Facilitate communication between National Societies on MNCH programming and support cross-regional health networking.

## 5

National Societies are committed to working with their governments and implementing MNCH activities; however, their needs are not being fulfilled by Partner National Societies due to a lack of MNCH-specific funding in the coming years. Partner National Societies cannot help National Societies with project funding and resource mobilization because they themselves do not have guaranteed funding from donors to extend their current MNCH projects.

## 6

Currently, no Partner National Society MNCH programming has guaranteed funding beyond 2013, other than Haiti.

**RECOMMENDATION:** Dedicate more efforts to seek MNCH-specific funding in future years, especially for the top five countries in need.

## 7

The only two countries in which Partner National Societies are not supporting the implementation of MNCH programs are Brazil and Suriname. Suriname ranks eighth in need of MNCH, third in the Americas for infant death ratio and is in high need of education on health practices such as breast-feeding. The Suriname national society does not have health staff specifically dedicated to MNCH.

**RECOMMENDATION:** MNCH, especially health promotion activities and infant health, should be prioritized in Suriname by Partner National Societies and external partners. Also, provide training on MNCH to the Suriname Red Cross to increase its capacity to implement activities and projects.

## 8

Red Cross Red Crescent is a community-based health implementing agent for MNCH. Through its wide network of volunteers and experience in CBHFA, it has the tools to support the government in implementing MNCH programmes at a community level.

**Recommendation:** Continue to support building the capacity of Red Cross Red Crescent volunteers on MNCH to ensure access to MNCH resources and knowledge to everyone, especially at a community level.

## 9

The gap in newborn health programming is present in the Americas, and more pronounced in the Caribbean. Less than 40 per cent of National Societies are implementing activities in the post-natal period, which could help prevent neonatal deaths.

**Recommendation:** Increase basic post-natal care and/or visits conducted by National Societies to ensure that hard to access and vulnerable communities have access to these services.

## 10

Programming trends are more focused towards HIV prevention and care and sexual and reproductive health; however, this type of programming does not reach all parts of the continuum of care.

**RECOMMENDATION:** More needs to be done from all actors on the curative side of MNCH to address the gaps that are present.

## 11

Many National Societies are interested in implementing or continuing their implementation of MNCH. However only nine National Societies have active MNCH staff and only two National Societies have made pledges to support MNCH work.

**RECOMMENDATION:** Support National Societies in developing or updating their MNCH strategies or objectives. Provide technical support to National Societies that are implementing or are interested in implementing MNCH but do not have MNCH staff.

## 12

External partners support the implementation of MNCH programs in seven more countries than Partner National Societies and National Societies, in addition to the 13 countries in which they both implement MNCH.

## 13

Ten organizations have MNCH projects in Bolivia, nine in Haiti, and eight in Honduras. Bolivia and Haiti are a priority for 16 agencies and organizations, and Honduras for 14.

**RECOMMENDATION:** National Societies should coordinate with external partners in the seven countries in which MNCH work is present and collaborate on MNCH projects or support external partners with MNCH-related activities, especially if the National Societies does not have on-going MNCH projects.

## 14

In the disparity analysis, the data on equity, whether taking into account wealth or residence, indicated that the main issue is lack of access to health services. This lack of access is due to several reasons including social exclusion of the ethnic population, lack of funding for services, or geographical isolation.

The disparities in MNCH are greater between differences in wealth than place of residence.

**RECOMMENDATION:** Use the Red Cross Red Crescent volunteer network to increase communication with municipal/regional health delivery points about MNCH needs in poor, ethnic and remote communities. Also, use Red Cross Red Crescent volunteers that are part of hard to access communities to provide MNCH care in places where governments and external partners may not have access. Perform a needs assessment to identify the communities with the hardest access to health services and provide capacity building on MNCH.

## 15

Most of the disparities in MNCH in the top five countries in need are found within ethnic groups, especially indigenous populations. In Bolivia, Guatemala, Guyana, Honduras and Panama, the worst statistics for maternal and child indicators are found in districts or zones with high levels of indigenous populations.

**Recommendation:** Develop Red Cross Red Crescent tools to address MNCH issues in indigenous communities. Support National Societies to develop an indigenous MNCH strategy for areas with high levels of indigenous populations.

# METHODS

**The following types of interventions were used:**

**SURVEY:** A survey composed of various questions addressing MNCH programming (and other related programmes) was sent to all 35 National Societies in the Americas. The survey was also sent to several Partner National Societies and overseas branches in the Caribbean. The survey encompassed questions about governments' commitments to MNCH and the relationship between governments and National Societies to determine how a National Society perceives the government's work. To address any potential bias on the part of the National Societies, a separate literature review was conducted to confirm governments' commitments to MNCH. The survey was developed in Spanish, French and English and distributed online (using Google docs) and by e-mail (Microsoft Word document format).

**FORMAL INTERVIEWS:** Interviews were conducted with key stakeholders in MNCH in the Americas region such as National Societies, Partner National Societies and external partners. The purpose of the interviews was to get more in-depth information on programming or policies they may be implementing. Most of the interview questions were sent by e-mail and some were conducted in person.

**FORMAL AND INFORMAL MEETINGS:** Meetings were held with internal and external experts on the subject matter to help direct research on the topic of MNCH or their specific area of expertise (e.g. water and sanitation, nutrition, violence prevention, HIV prevention etc.)

**LITERATURE/REPORT REVIEW:** A literature/report review was conducted to analyse the current policies and strategies being put forth by various actors in MNCH (e.g. *IFRC's Strategy 2020,* PAHO MNCH strategy, etc.). A review of existing government health strategies or policies was also conducted to complement National Societies' responses on government commitment from the survey. Most of this research was internet based and the rest was conducted by contacting National Societies, Partner National Societies and other actors on the subject matter.

**STATISTICS RESEARCH:** Research was conducted to find the statistics for the main MNCH indicators in order to identify the needs of every country. Data from the World Health Organization (WHO), United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Pan American Health Organization (PAHO) and the United Nations Development Programme (UNDP) was used to acquire the most recent and complete data.

**GRAPHS AND TABLES:** Specific graphs and tables were constructed from information gathered through primary sources and extensive desk review conducted by the author as indicated.

# RESULTS

## The Current MNCH Situation

In the Americas, health is becoming a priority, especially with the deadline to reach the MDGs approaching in the next few years. Progress has been made towards achieving MDG 4, with a reduction in deaths among children under the age of five from 52 percent in 1990 to 23 percent in 2009[1]. However, many countries are still experiencing great disparities in health that affect the most vulnerable populations, including women and children. MDG 5, improving maternal health, is still an issue in the Americas with the region average remaining at a ratio of 140 out of 100 000 live births[2]. Also, as seen in Figure 1, the Americas region has not seen a significant decrease in maternal mortality as compared to other regions such as South-East Asia. This confirms that MNCH should be considered a priority issue in the Americas.

To map MNCH activities in the region, an analysis of statistical data available on MNCH was conducted to better understand the current MNCH situation in the region and identify priority countries that are in the most need of MNCH support.

Research was conducted for all 35 countries in the Americas where the Red Cross Red Crescent works, using the 11 indicators from the WHO's *Commission on Information and Accountability for Women's and Children's Health*:

- maternal mortality ratio
- under-five child mortality, with the proportion of newborn deaths
- children under five who are stunted
- unmet need for family planning
- antenatal care coverage
- antiretroviral prophylaxis among HIV-positive pregnant women
- skilled attendant at birth
- post-natal care for mothers and babies
- exclusive breastfeeding for six months
- three doses of the combined diphtheria, pertussis and tetanus (DPT) vaccine
- antibiotic treatment for pneumonia.

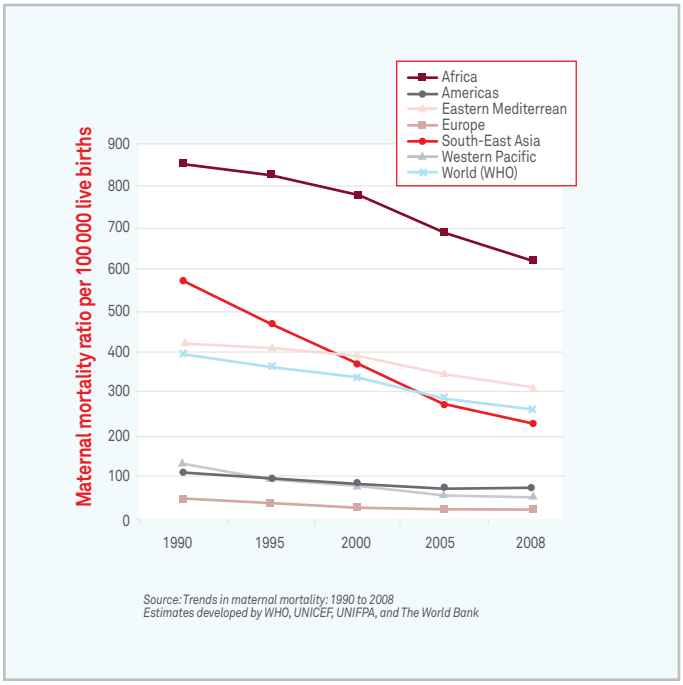


**Figure 1.** Global Maternal Mortality Ratio Trends – Source: WHO, 1990 - 2008

Also, additional statistics from UNICEF were accumulated to evaluate, more in-depth, the fields of child health, maternal health, immunization, water and sanitation, malnutrition, HIV and equity. To get a better perspective of the development situation in each country, the human development index (HDI) was also taken into consideration in the analysis.

When looking at UNICEF basic indicators of under-five mortality rate, neonatal mortality rate and maternal mortality ratio for the region, Haiti is the most in the need in most of the indicators. The discrepancy between Haiti and the rest of the region is especially noticeable when looking at the under-five mortality rate and the reported maternal mortality ratio, which are 152 and 300 respectively. While Haiti's high numbers stand out, other countries are also struggling. For example, within the malnutrition indicators, more specifically for children under the age of five suffering from being moderately or severely underweight or stunted (WHO), Guatemala is the most in need. The countries most in need of programming for early initiation of breastfeeding and exclusive breastfeeding for the first six months are Paraguay (21 per cent) and Suriname (2 per cent).

| INDICATOR | TOP FIVE COUNTRIES WITH THE HIGHEST UNDER-FIVE, NEONATAL AND MATERNAL MORTALITY RATE IN THE AMERICAS | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Under-five Mortality Rate | Haiti- 165 | Bolivia - 54 | Guatemala - 32 | Suriname - 31 | Guyana - 30 |
| Neonatal Mortality Rate | Haiti - 27 | Trinidad and Tobago - 23 | Guyana - 22 | Bolivia - 22 | Dominican Republic - 17 |
| Maternal Mortality Ratio (adjusted) | Haiti – 300 | Guyana – 270 | Bolivia – 180 | Ecuador – 140 | Guatemala/ Honduras/ El Salvador – 110 |

**Table 1.** Top five countries with the highest under-five, neonatal and maternal mortality rate in the Americas. Source: UNICEF, 2012.

The regional average for the under-five mortality rate is 23, and 11 for the neonatal mortality rate. As seen in Table 1, certain countries often appear in the top five in need for each indicator. Haiti ranked first in all three indicators. Guyana ranked fifth, third and second in the indicators for under-five mortality, neonatal mortality and maternal mortality, respectively. This indicates that the need is great in child and maternal health in Haiti and Guyana.

Looking at the under-five mortality rate, three out of the top five countries are from the Caribbean. The highest ranked countries for the neonatal mortality rate are mostly from the Caribbean; two are from English-speaking Caribbean and two are from Latin Caribbean. Also, the need to address neonatal deaths, specifically, is quite apparent when observing Figure 2 since, in the Americas, 48 per cent of under-five deaths occur during the neonatal period of 28 days after birth. The two countries with the highest rates of maternal mortality are from the Caribbean, the next two are from South America and the next three from Central America. The need to prevent under-five, neonatal and maternal deaths in the Caribbean is clearly visible.

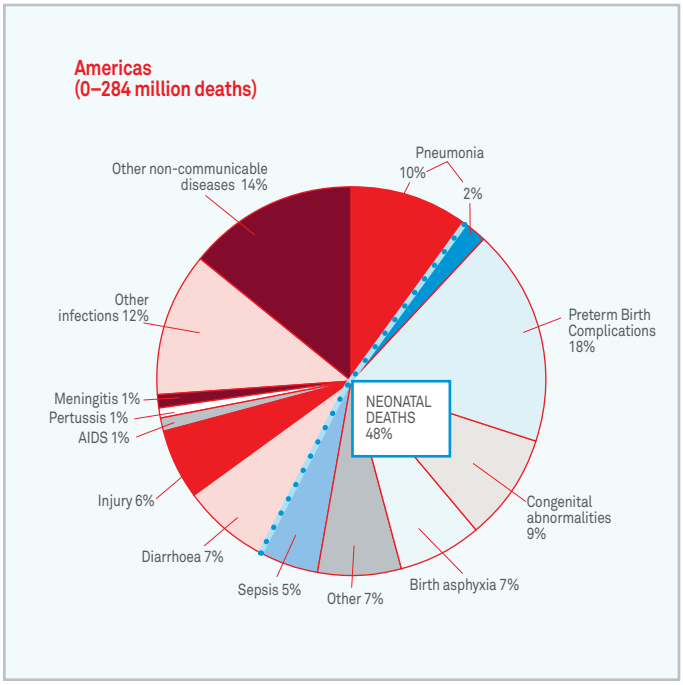


**Figure 2.** Causes of child deaths (under 5) - Source: Global, regional, and national causes of child mortality in 2008: a systematic analysis. Robert E Black, et al. Lancet 2010

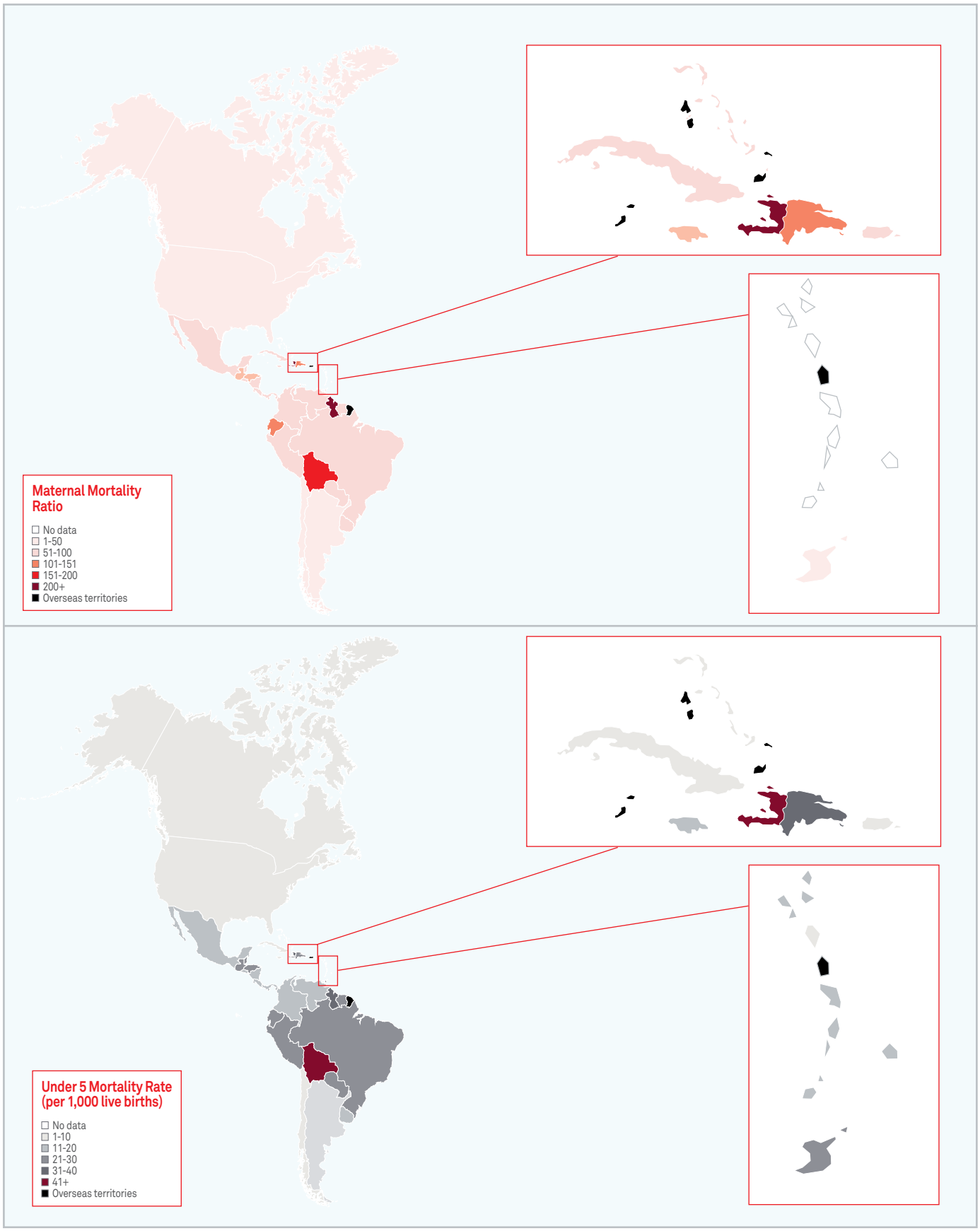


**Figure 3.** Maternal Mortality Ratio and Child Mortality Rate Maps in the Americas. Source: UNDP, 2010

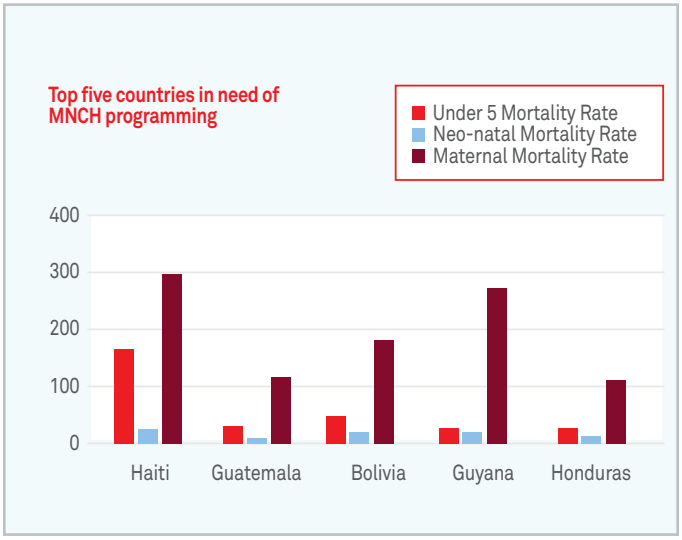


**Figure 4.** Top five countries in need of MNCH programming
Source: UNICEF, 2010.

**To calculate the top five countries with overall needs in MNCH, 11 UNICEF and WHO indicators were chosen**:

- under-five mortality rate
- infant mortality rate
- neonatal mortality rate
- under-five underweight percentage
- under-five stunted percentage
- DPT immunization coverage
- maternal mortality ratio
- antenatal visits (at least four times)
- skilled attendant at birth
- unmet need for family planning
- contraceptive prevalence rate.

Each indicator was appointed a scale and attributed points from zero to five based on need: five being the most in need and zero not being in need. (See Annex A for full scale and point system and list of results in order of need for all 35 countries.) The scale for each indicator was tailored to the statistics of the region (based on the highest and lowest statistics for each indicator) because global scales are too high for the Americas. Therefore, the WHO scale was only used for under-five mortality. Summing all the points from each indicator considered and ranking the 35 countries in the region resulted in the following top five countries (in order): Haiti, Guatemala, Bolivia, Guyana and Honduras. Out of the top five priority countries, two are from Central America, two from Caribbean and one from South America. Therefore, MNCH priority is quite spread out within the Americas region, as can be seen in Figure 3 above.

The next countries in the top ten are, in order, Ecuador, Nicaragua, Suriname, Belize and El Salvador. Two are from the Caribbean, two from Central America and one from South America. Therefore, of the top ten countries in need, four are from Central America, three from the English speaking Caribbean (the islands, not the mainland countries), one is from Latin Caribbean and two are from South America. This indicates, when taking into account the top ten for all MNCH indicators, that Central America is most in need. However, as seen in Figure 4 and mentioned previously, Haiti has the highest overall statistics and, therefore, received many more points compared to all other countries.

Many English-speaking Caribbean countries appear low on the list because, due to missing data, points could not be appointed for all indicators. Antigua and Barbuda, St-Kitts, St-Vincent, Granada and Dominica have data missing for six indicators and Bahamas for four. Therefore, due to this lack of data, it is difficult to assess the real need of the English-speaking Caribbean using the indicators chosen. The bottom five countries, or the ones less in need, not counting the ones with four or more indicators missing, are Cuba, Chile, USA, Costa Rica and Canada. This indicates that the countries with the least need are distributed throughout the Americas just like the ones most in need.


**Figure 5.** HDI Value Ranking in the Americas - Source: UNDP, 2010.

Furthermore, the points were separated into maternal health and child health indicators to identify potential need discrepancies between these two areas. The analysis identified two countries that are doing very well in terms of maternal health and poorly in child health: Panama and Saint Lucia. Both countries have ten points each for child health indicators and only one and zero respectively for maternal indicators. This indicates a wide gap between maternal and child health in these two countries.

To get a better perspective on how the MNCH needs of the top five countries compares to the overall development ranking of all 35 countries in the region, a cross analysis was conducted. According to the HDI, only one country, Haiti, is considered to have low human development. Five countries are classified with medium human development (from lowest to highest): Guatemala, Nicaragua, Honduras, Guyana and Bolivia (See Annex B for full list of all 35 countries). Some countries ranked differently using the HDI compared to the MNCH priority. While Haiti and Guatemala are in the same positions, Nicaragua has a lower HDI ranking and yet is not one of the top five for MNCH (Nicaragua is seventh). Bolivia is three spots higher on the MNCH priority scale than on the HDI. This may signify that in overall statistics, Bolivia ranks lower, yet its MNCH needs are a lot higher.

As seen in Figure 5, overall, Central America and the Caribbean have the most countries classified with medium human development with four and three from each sub-region, respectively. The Caribbean is the only sub-region with a country facing low human development. Therefore, according to the HDI, Central America and the Caribbean are most in need for overall development.

## Survey to National Societies

As part of the mapping of MNCH activities in the Americas region, an online survey was sent out to all 35 National Societies. The survey, which consisted of 12 main questions, addressed several topics. The first questions addressed MNCH strategies and resources available to the National Society, as well as specific MNCH and MNCH-related activities that the National Society is implementing and on their scale. The next questions tackled the issue of the National Society's needs, capacity and support for MNCH activities and projects. The last questions asked about the National Society's perception of government commitment to MNCH. It is important to note that the analysis is based on total number of responses received and not on all 35 National Societies in the region, unless noted. (Refer to Annex C for full questions from the survey.)

In total, 22 out of 35 National Societies responded to the survey, which represent an overall response rate of 63 per cent. However, the response rate per region varied, as seen in Table 2. South America had the best response rate with 80 per cent of National Societies responding to the survey. North America had the worse response rate of 0 per cent; however, Canadian Red Cross and American Red Cross health representatives stated that their organizations are not currently implementing MNCH programs domestically. (See Annex D for the list of countries that responded per region.) Three responses were received from Partner National Societies and government representatives: British Red Cross Overseas Branch in the Caribbean, French Red Cross and the Belizean Ministry of Health. These three responses were excluded from the survey analysis; however, they were included in the analysis of government and Partner National Society support for MNCH work.

| REGION | YES | NO | % |
|---|---|---|---|
| Caribbean | 9 | 7 | 56% |
| Central America | 5 | 2 | 71% |
| South America | 8 | 2 | 80% |
| North America | 0 | 2 | 0% |

**Table 2.** National Society responses per region in the Americas. Source: MNCH Survey to National Societies, March 2012

### Questions 1, 2 and 3

The first three questions in the survey focus on MNCH resources and implementation. To determine National Societies' commitment to health in general, question 1 asked if the National Society had a health plan or a strategic plan that includes health: 86 per cent of National Societies that responded confirmed they have a health strategy or part of their national strategy includes health. Question 2 determined that 64 per cent are implementing specific MNCH activities, as seen in Figure 6. Most of the MNCH activities are being implemented by National Societies in South America (29 per cent and the fewest in North America (0 per cent). Question 3 focused on the human resources dedicated for MNCH within each National Society. Only nine National Societies (41 per cent) have a person responsible for MNCH, making it challenging to ensure the progress of MNCH in those National Societies that do not have dedicated human resource capacity for MNCH.

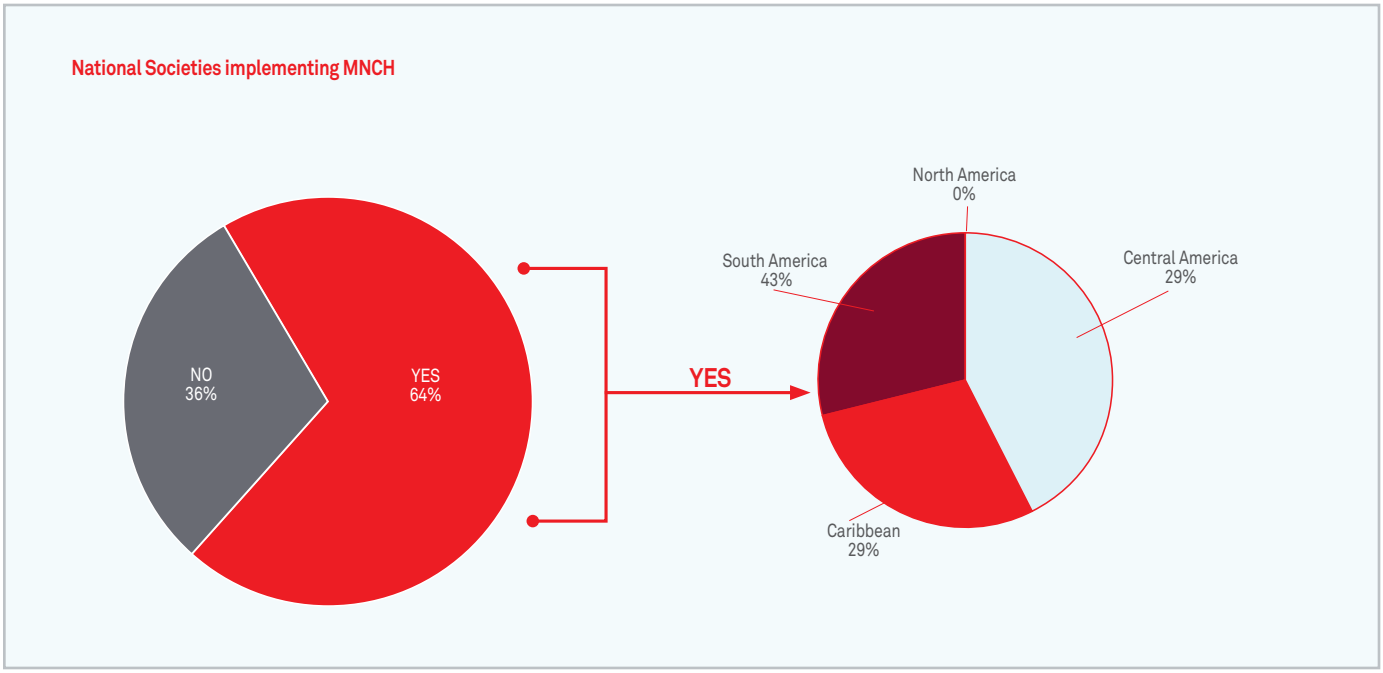


**Figure 6.** National Societies Implementing MNCH. Source: MNCH Survey To National Societies, March 2012.

## Questions 4, 5 and 6

Questions 4, 5 and 6 directly relate to the types of MNCH activities or related activities that are being implemented. Based on knowledge of previous MNCH work in the region and advice from CRC's Health Advisor and IFRC's regional health coordinators, 13 types of activities were selected (see Annex C for full list of activities). Question 4 asked which of the 13 MNCH activities are being implemented by National Societies and their scope (nationally, regionally/ at certain branches, Partner National Society bilateral projects or no implementation by National Societies).

| SCOPE | THE HIGHEST PERCENTAGES PER CATEGORY |
|---|---|
| Nationally | Health and hygiene promotion - 68% |
| Regionally (at certain branches) | Sexual and reproductive health and Other - 19% |
| Partner National Society bilateral projects | Nutrition - 36% |
| No implementation by National Societies | Antenatal care - 73% |

**Table 3.** Highest implementation rates for MNCH activities in the Americas. Source: MNCH Survey to National Societies, March 2012.

Health and hygiene promotion is the highest MNCH activity with 68 per cent of National Societies implementing this type of program nationally and 5 per cent at branch level. The second highest activity is sexual and reproductive health with 55 per cent of National Societies implementing it nationally and 19 per cent at branch level. This means a total of 73 per cent and 74 per cent of National Societies are implementing health and hygiene promotion and sexual and reproductive health activities, respectively. Health and hygiene promotion touches all of maternal, newborn and child health because this type of promotion ensures that mothers and children know how to identify signs of danger and do not suffer from sicknesses such as acute respiratory infections, diarrhea, measles, malaria and malnutrition, which are the top five of most prominent causes of deaths for children under the age of five in Latin America and the Caribbean, and the world[3].

On the other hand, antenatal and post-natal care and post-natal visits to newborns and mothers are the lowest activities with 27 per cent, 32 per cent and 36 per cent implementation overall respectively. This means that overall, less than one third of National Societies are implementing MNCH activities directed at maternal health before and right after birth and ensuring that all stages of the continuum of care[4] are being put into practice. Furthermore, more than half of the National Societies chose "none" for nine of the 13 activities. This signifies that overall, there is a low implementation rate of these types of activities as seen in Figure 7. Partner National Society bilateral projects focus the most on nutrition with 36 per cent of National Societies implementing these types of activities. The two other prominent categories for Partner National Society bilateral MNCH activities at branch level are post-natal visits and referrals for maternal care with 32 per cent and 27 per cent implementation, respectively.

Since half of National Societies answered that they implement "other" types of MNCH activities, it can be concluded that the 13 activities chosen for the survey did not cover the full scope of MNCH work being implemented in the Americas region. These other activities, as stated by the National Societies are cancer screening, integrated management of childhood illnesses (IMCI), accident prevention, sexual rights promotion, oral health, early motherhood programs, food security and epidemic control. While most of these are directly related to MNCH, some — such as oral health, accident prevention and epidemic control — are broader in scope.

Question 5 focused on 12 MNCH-related activities. The most implemented related activity is first aid with 95 per cent of National Societies conducting activities either nationally, at branch level or through Partner National Society bilateral projects. This type of training and capacity building permits communities to be more resilient and able to provide care to family and friends within their communities, especially to mothers and young children, when healthcare institutions are too far away[5]. HIV prevention and care and prevention of communicable diseases are being implemented by 77 per cent of National Societies, indicating that big efforts are being made to promote preventative care.

Partner National Society projects are the most focused on food security with 27 per cent of National Societies implementing those activities. Violence prevention (VP) and psycho-social support (PSP) are also high with 24 per cent implementation rates. Conversely, gender activities have the lowest implementation rates with only 55 per cent. Also, out of the 12 activities, only four received a response of "none" by more than 40 per cent of the National Societies. Therefore, National Societies are much more active in these activities than the MNCH activities from question 4.a, as seen in Figure 8.

Almost three-quarters (73 per cent) of National Societies answered that they are not implementing other types of activities, as demonstrated in Figure 8. Therefore, the scope of the activities presented in the survey corresponded to the activities actually being implemented by National Societies. However, several other areas of work were brought up by National Societies, including community health, MNCH in indigenous zones, Club 25 (which encourages voluntary safe blood donations from youth[6]), human rights and international humanitarian law (IHL), monitoring and evaluation, and safe blood donations. The Guatemalan Red Cross was the only responder to mention including specific indigenous-focused activities in its MNCH work.

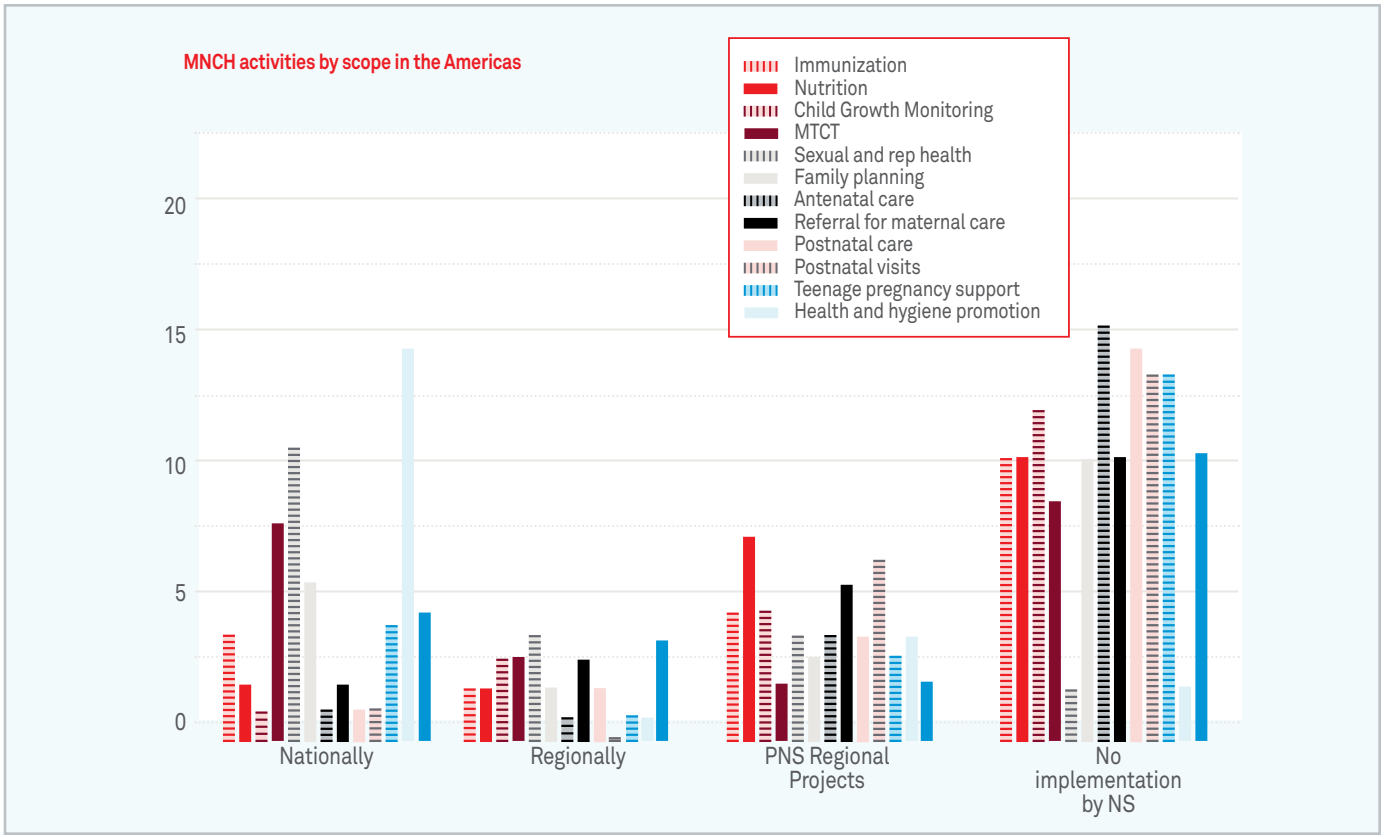


**Figure 7.** MNCH activities by scope in the Americas (question 4.a). Source: MNCH Survey to National Societies, March 2012

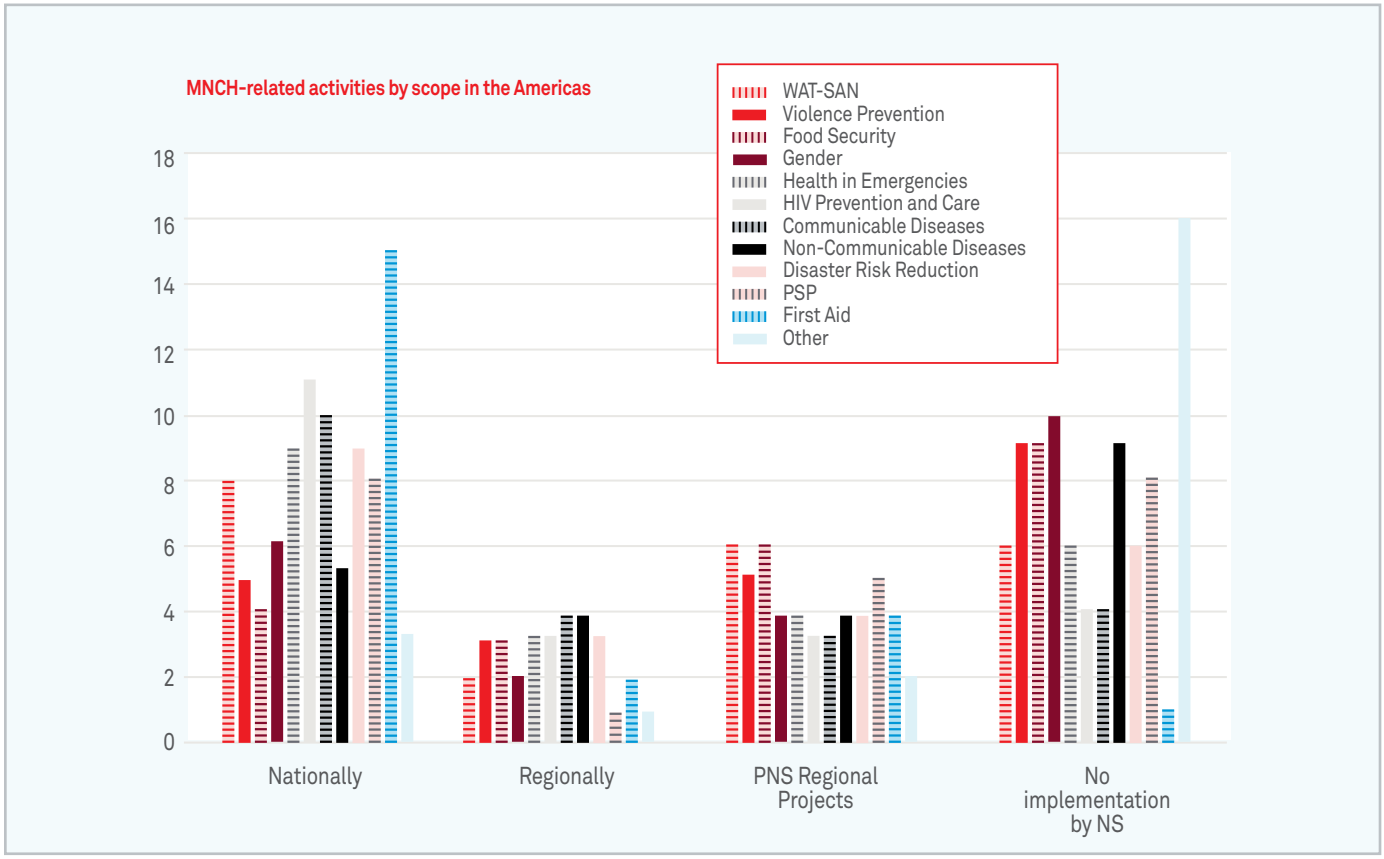


**Figure 8.** MNCH-related activities by scope in the Americas (question 5.a). Source: MNCH Survey to National Societies, March 2012.

| SCOPE | THE HIGHEST PERCENTAGES PER CATEGORY |
|---|---|
| Nationally | First aid - 68% |
| Regionally (at certain branches) | Non-communicable diseases - 18% |
| Partner National Society bilateral projects | Food security - 27% |
| No implementation by National Societies | Other - 73% |
| | Gender - 45% |

**Table 4.** Highest implementation rates for MNCH-related activities in the Americas. Source: MNCH Survey to National Societies, March 2012.

Question 6.a addressed the work of National Societies in health in emergencies. The survey found that 68 per cent of National Societies are implementing this type of program and 5 per cent answered "other," as seen in Figure 9 below. Peru, one of the National Societies that answered "other", is working in emergencies but focusing its work on water and sanitation, which is related to health but still considered a separate area of work. Question 6.b focused on MNCH activities within the health in emergencies programs. Out of the National Societies who replied "yes" to question 6.a, 67 per cent responded that they have MNCH components as demonstrated in the second pie chart of Figure 9. Three responded that they have "other" types of activities including Nicaragua which provides PSP in shelters and Peru which, once again, specified that its work is aimed towards the control of epidemics and water and sanitation rather than direct MNCH components. Overall, out of the National Societies who are implementing health in emergencies programs, 50 per cent of them are in South America.

Therefore, this region is focusing its emergencies work on mothers and children. The Caribbean and Central America represent 31 per cent and 19 per cent of National Societies respectively.

## Questions 7 and 11

Questions 7 and 11 focused on the capacity of National Societies to implement five specific MNCH activities and programmes, as shown in Figure 10. The choice of answering "other" was also provided. National Societies show the highest capacity for Community Based Health and First Aid (CBHFA) with 19 of them (86 per cent) implementing this activity.

Also, 77 per cent of National Societies have the support of their health department in implementing MNCH. A health department ensures funding and human resources for health and, therefore, most likely for MNCH. The activity showing the lowest capacity is health service delivery point, with only four National Societies providing this activity. Based on the responses, National Societies do not have the necessary infrastructure capacity to provide or run a clinic or health centre to ensure that health services are provided. The National Societies could work with governments that want to ensure access and could provide the health service delivery points.

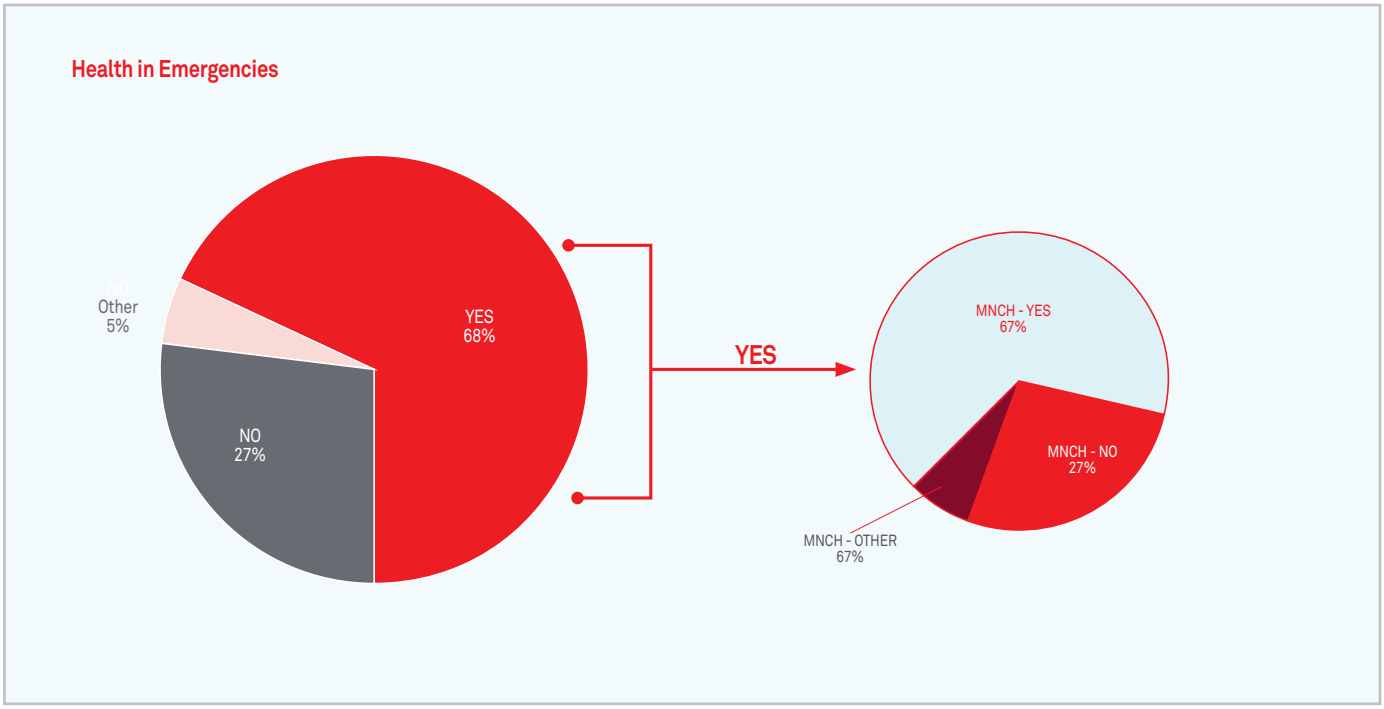


**Figure 9.** Work of National Societies in Health in Emergencies in the Americas. Source: MNCH Survey to National Societies, March 2012.

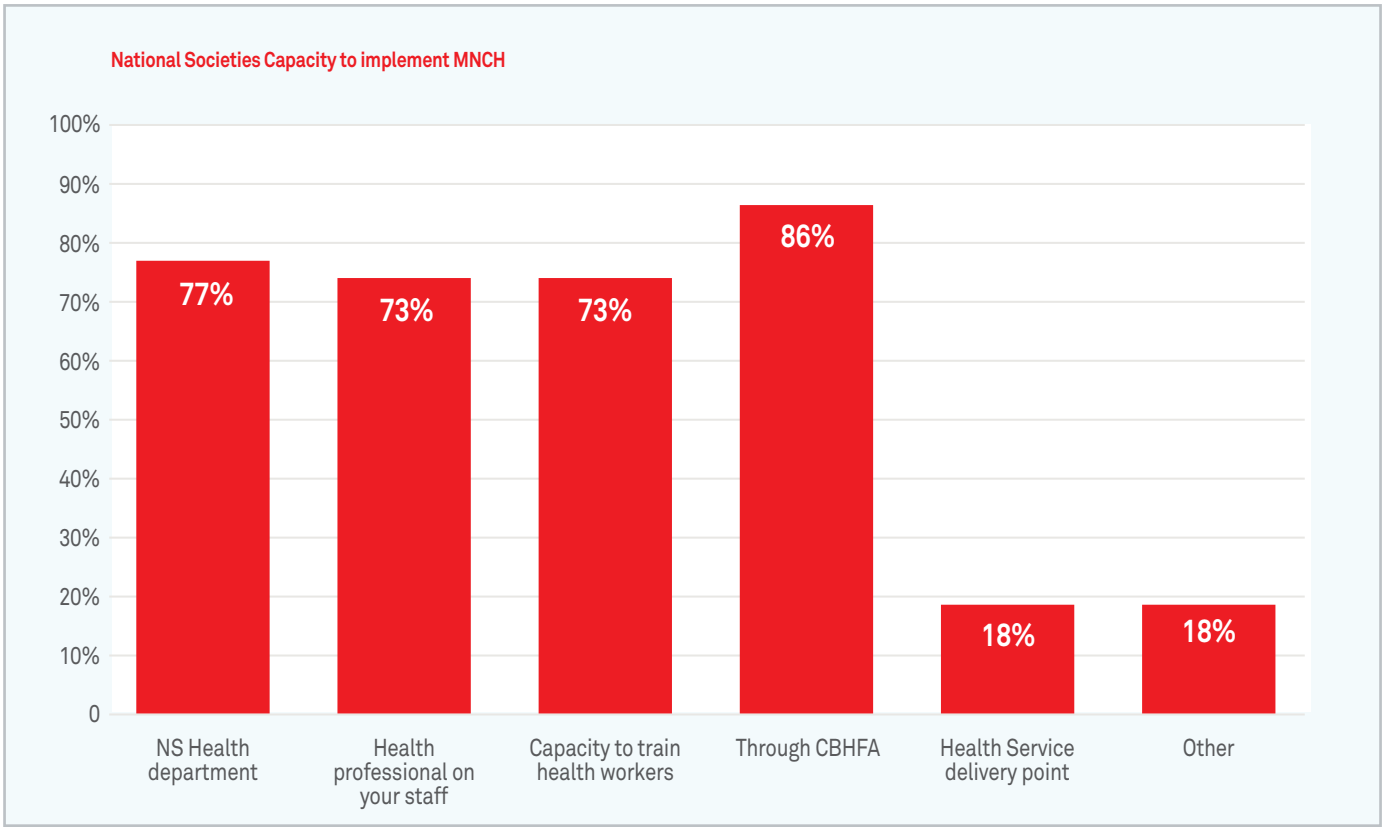


**Figure 10.** National Societies Capacity to Implement MNCH in the Americas. Source: MNCH Survey to National Societies, March 2012.

Moreover, 18 per cent answered that they had other types of capacity to implement MNCH. Bolivia stated that it has an IMCI strategy that gives it the capacity to work in communities. Also, both El Salvador and Venezuela responded that their "other" capacities are "the communities they work in". Therefore, the knowledge and support from the communities is important to those two National Societies to be able to implement MNCH. Lastly, Belize also has a disaster risk reduction program that helps with possible MNCH programming.

After evaluating the capacity of the National Societies, question 11 addressed the need of the National Societies to be able to implement MNCH activities. The question included six types of support that could increase their capacity (listed in Figure 11) and a possibility to answer "other". The highest need for support identified was resource mobilization, which received a 95 per cent response rate or 21 out of 22 National Societies, as seen in Figure 11. Also, 91 per cent of National Societies answered that they require project funding support — more resources and help to handle them. The lowest need for support is for networking support at 64 per cent. This low need is possibly due the fact that there are a few Red Cross Red Crescent health networks already functioning in the region of the Americas. These are networks such as REDCAMP Salud in Central America, and the Southern Cone health network and the Caribbean Red Cross Health Network (CRCHN) covering the English-Speaking Caribbean. Also, only 68 per cent answered that they need support in developing policies. This reflects the fact that 86 per cent of National Societies that responded confirmed that they have a health strategy or that part of their national strategy includes health and, therefore, they would not need support developing policies and/or strategies.

Almost one quarter (23 per cent) of National Societies responded that they need other types of support. For example, the Honduran Red Cross stated that it needs support to improve the communication process for behaviour change — more specifically, the use of practical examples versus theoretical methods. The Nicaraguan Red Cross requires support in capacity building to find funding for sustainable MNCH programs. The last three "other" answers were left blank. Since not all respondents specified what kind of "other" support they need, more information and research is needed to clarify the needs.

In summary, the National Societies' capacity is high for programs such as CBHFA but is lacking in providing or running health delivery points. Finally, National Societies require financial support and assistance to mobilize those resources appropriately.

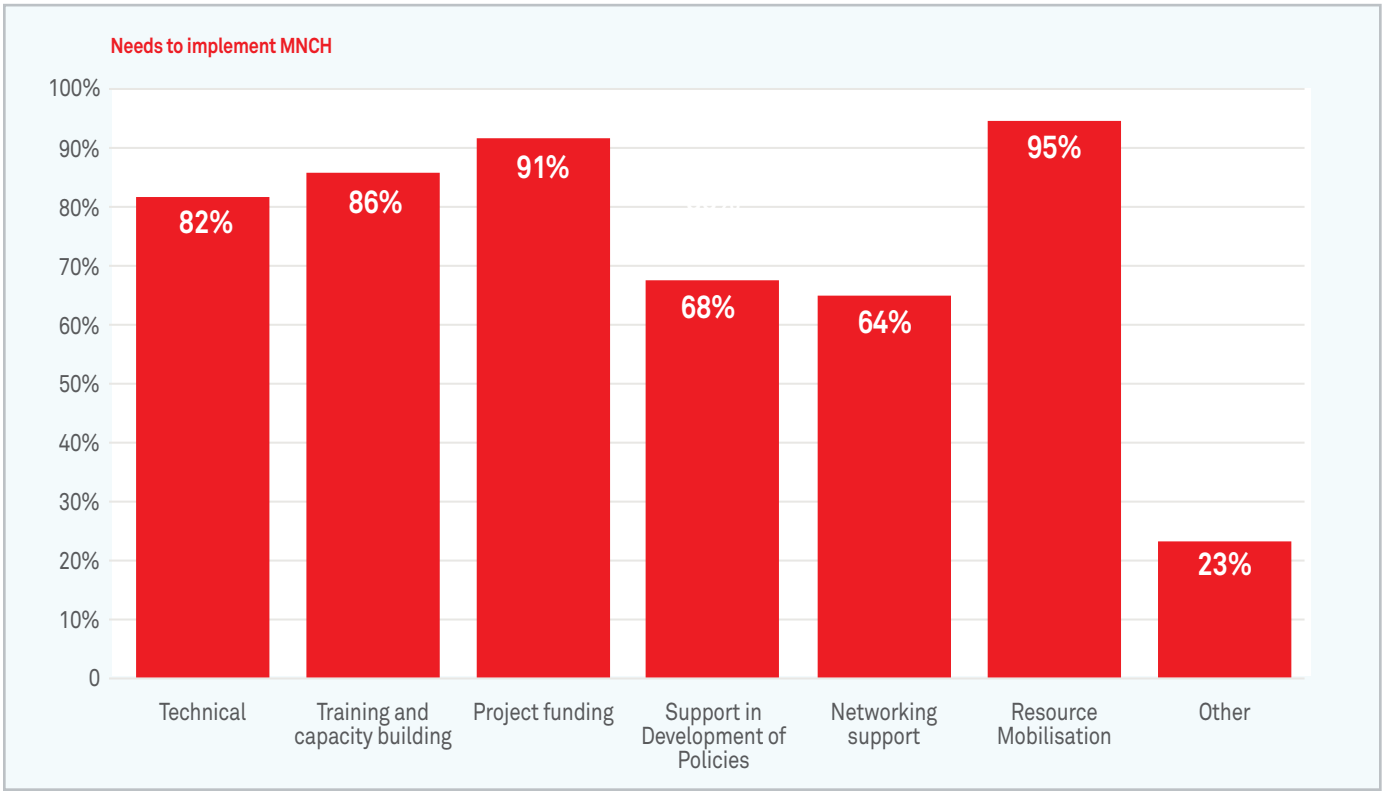


**Figure 11.** Support required to implement MNCH programming in the Americas. Source: MNCH Survey to National Societies, March 2012.

## Question 8

Question 8 was designed to identify future trends in National Societies MNCH work. The question asked National Societies to rank from one to ten the likelihood that they would pursue MNCH projects and/or activities in the future. With six respondents answering "ten", five answering "nine" and two answering "eight", as seen in Figure 13, 59 per cent consider it "very likely" that they would pursue MNCH in the future. Therefore, with 67 per cent of National Societies already implementing MNCH activities and only 59 per cent considering it "very likely" that they will implement them in the future, MNCH activities could decrease by 8 per cent in the near future.

The remaining 41 per cent ranked future commitment between "four" and "seven", with no National Societies choosing between "one" and "three". This indicates that these National Societies have some interest in MNCH in the future but it is not considered a high priority. From a regional perspective, out of those who answered "eight" to "ten", five were from Central America and four from South America and the Caribbean. This signifies a high interest for MNCH in Central America since all five countries from that region that responded to the survey will consider MNCH in their future plans.

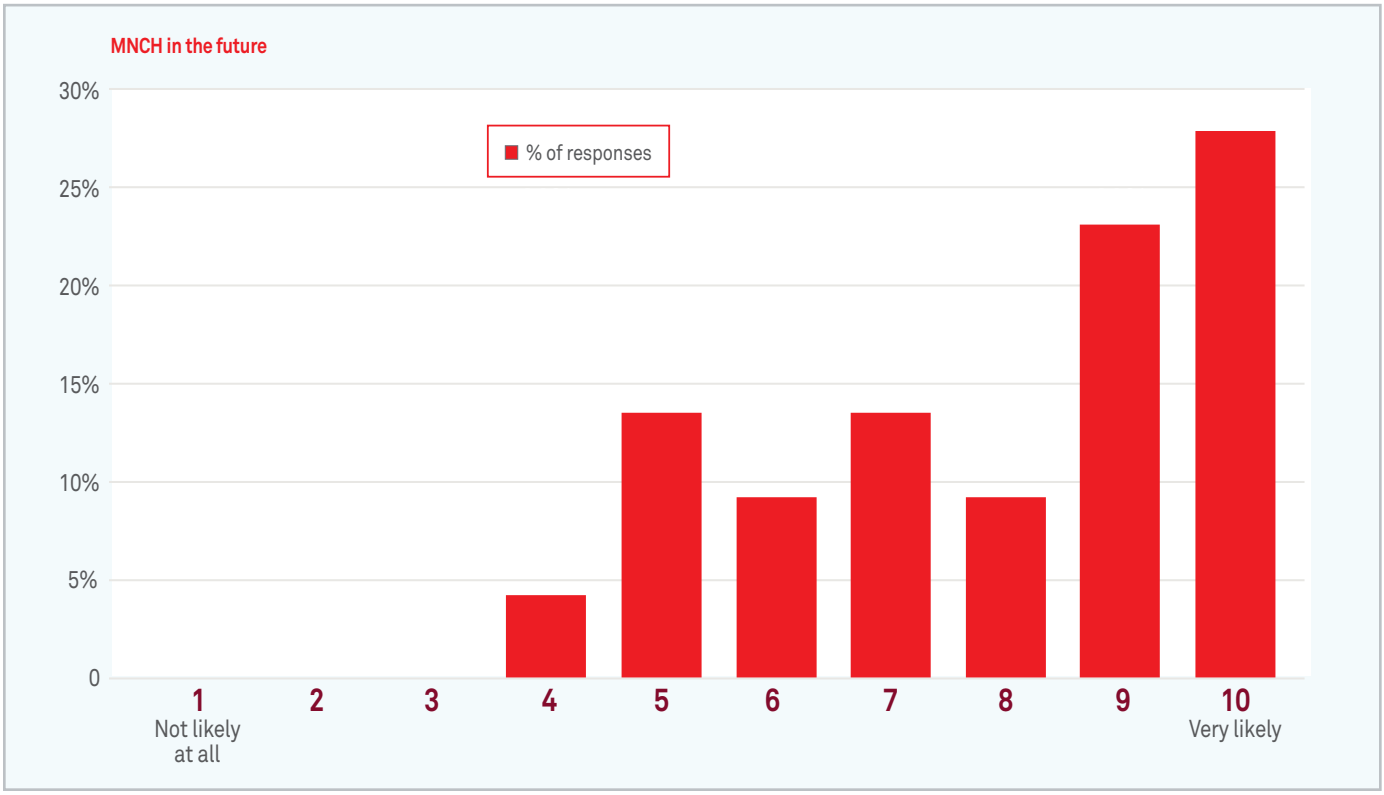


**Figure 12.** Likelihood of implementing MNCH in future years in the Americas. Source: MNCH Survey to National Societies. March 2012.

### Questions 9, 10 and 12

Questions 9, 10 and 12 focused more on governance support from inside the National Societies, the relationship between National Societies and governments, and National Societies' perception of government activities. Question 9 asked if the National Society should be working with the government to improve MNCH. All National Societies that responded consider cooperation with the government very important for successful MNCH projects. Therefore, the Red Cross Red Crescent role as an auxiliary to government is well reflected in this response. Question 10 addressed the internal barriers to implementing MNCH programming by asking if there is governance support coming from the headquarters for MNCH projects or activities. Most National Societies (73 per cent) stated that they had governance support from their headquarters. However, six National Societies stated that they did not have support from headquarters. Five of out those six are from English-speaking Caribbean: Grenada, Trinidad and Tobago, Suriname, Bahamas, and Antigua and Barbuda. This signifies that only 45 per cent (four out of nine that responded) of National Societies from the English-speaking Caribbean have internal support for MNCH.

Question 12 asked the National Society to rate its own government's commitment to MNCH on a scale from one to ten. This question was included to determine how National Societies' perceptions of governments' commitments compared to actual commitments. Over half (59 per cent) consider their government's commitment to be between an "eight" and a "ten"; therefore, they consider their government to be "highly committed". Eight out of 22 (37 per cent) answered between "six" and "seven", indicating they consider their government to be committed to MNCH but not "highly" committed. Therefore, it can be concluded those National Societies may consider that MNCH is not the highest priority but still a priority for the government. As seen in Figure 13, only one response provided a ranking between "one" and "five." Since 63 per cent of governments have a MNCH strategy or are implementing MNCH projects, and 59 per cent of National Societies stated that their government is very committed to MNCH, the perception of National Societies compared to actual government commitment is realistic.

In conclusion, most National Societies in the Americas are prioritizing health and over half are implementing MNCH activities. Most activities being implemented by the Red Cross Red Crescent are preventative in nature with education and advocacy on health issues such as hygiene, nutrition and sexual health. The biggest needs are related to funding and resources to be able to continue their MNCH programming. National Societies' perception of the government is very positive as all National Societies think they should be working with the government on MNCH and that their governments are committed to supporting MNCH activities. Finally, more than half of the National Societies in the Americas plan to implement MNCH activities and/or programmes in the future.

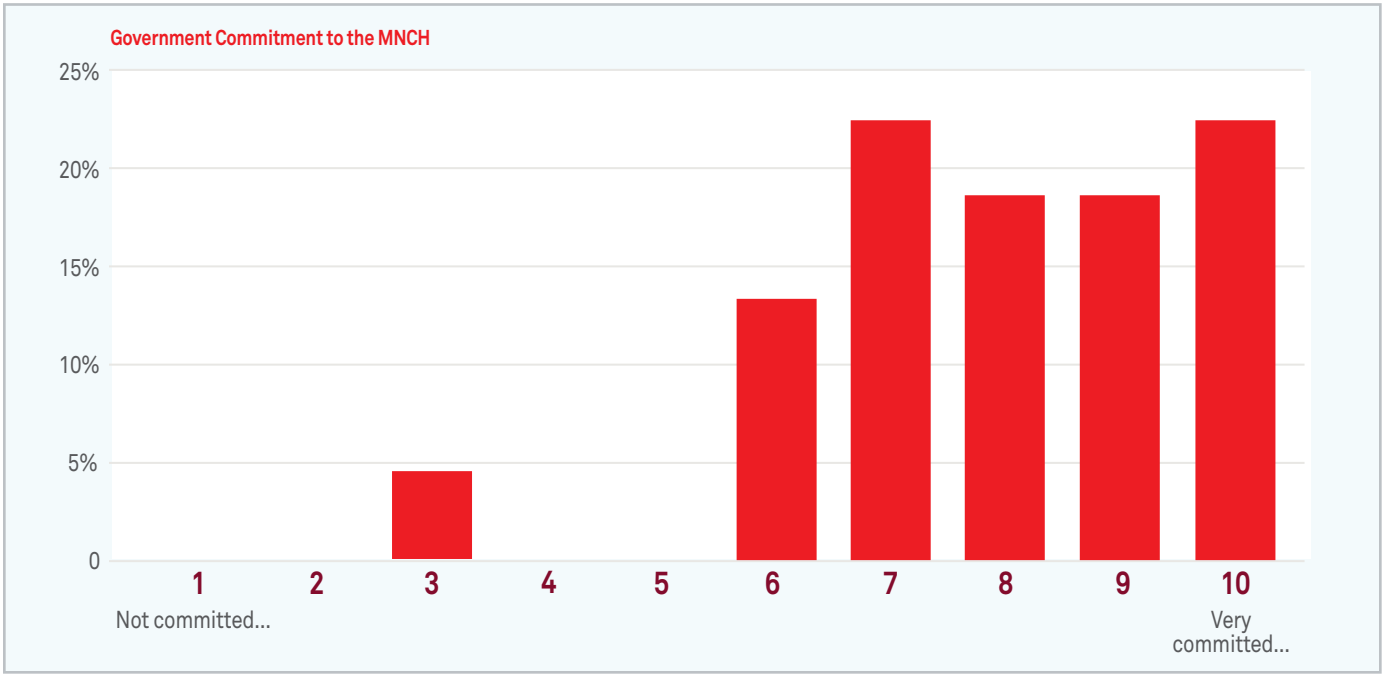


**Figure 13.** National government commitment to MNCH in the Americas. Source: MNCH Survey to National Societies. March, 2012.

## Partner National Societies Priorities and Commitments

Partner National Societies are key partners of National Societies to help support the implementation of projects and activities. Partner National Societies in the Americas work in different areas and have different priorities. Information was gathered from seven Partner National Societies by e-mail, through the survey sent to National Societies, or by meeting them in person. The seven Partner National Societies — American Red Cross (AmCross), British Red Cross, Canadian Red Cross, Finnish Red Cross, French Red Cross, Norwegian Red Cross and Spanish Red Cross — were chosen because of their present or past involvement in MNCH or MNCH-related projects.

The countries in which Partner National Societies conduct development programs were identified as well as the presence of Partner National Societies in those countries. Haiti and Colombia each have six Partner National Societies working in their countries. Three National Societies — Panama, Paraguay and Honduras — have three Partner National Societies working in their respective countries. The only two National Societies (that are not Partner National Societies themselves) with whom the seven Partner National Societies are not working are Brazil and Suriname - although other Partner National Societies not considered in this research may be working in those countries.

As seen in Figure 14, Partner National Societies support MNCH or MNCH-related activities in 21 out of 35 National Societies — 60 per cent of the Americas. Five out of seven of Partner National Societies are currently supporting MNCH projects in six countries (17 per cent of the Americas). Even though most Partner National Societies are supporting MNCH projects, each has its own priorities and has chosen specific countries to work in.

The five Partner National Societies currently supporting MNCH projects and/or activities are Canadian Red Cross, Finnish Red Cross, French Red Cross, Norwegian Red Cross and Spanish Red Cross. The countries in which Partner National Societies are implementing the projects and/or activities are Bolivia, Guatemala, Haiti, Honduras, Nicaragua and Paraguay. Half (50 per cent) of the countries in which MNCH projects are being supported are from Central America. Therefore, there has been a clear focus on Central America from the Partner National Societies standpoint. Canadian Red Cross has the most MNCH projects, with four active projects, and has a history of supporting the implementation of MNCH programming in the Americas through primary healthcare activities in Honduras and Nicaragua post hurricane Mitch.


**Figure 14.** Partner National Societies - MNCH activities and projects in the Americas. Data extracted from primary sources of information.

| NS | PNS | TIMELINE |
|---|---|---|
| Bolivia | Canadian Red Cross | 2011-2012 |
| Guatemala | Norwegian Red Cross | 2008- 2012 |
| Haiti | French Red Cross<br>Canadian Red Cross | 2010- Current<br>2011-2016 |
| Honduras | Canadian Red Cross/<br>Finnish Red Cross | 2006-2013 /<br>2010-2012 |
| Nicaragua | Canadian Red Cross | 2012-13 (one year extension, from 2006) |
| Paraguay | Spanish Red Cross | 2008- 2012 |

**Table 5.** Partner National Society MNCH projects in the Americas. Data extracted from primary sources of information. (This table does not include MNCH-related projects such as CBHFA and Water & Sanitation – for those see Annex E.)

Haiti and Honduras are the only countries in which more than one Partner National Society is working on MNCH project. In Haiti, the Canadian Red Cross is working in the Sud-Est departments and the French Red Cross is working in Port-au-Prince and Petit-Goave. In Honduras the Canadian Red Cross is working in Copán and Santa Bárbara and the Finnish Red Cross is working in Marcala, La Paz. Therefore, the societies are complementing each other in their MNCH work by covering different regions but supporting similar activities.

As seen in Table 5, Partner National Societies have been working in MNCH in certain regions for many years — in Honduras and Nicaragua since 2006 (but have been present since post-Mitch) and Guatemala and Paraguay since 2008. Some other projects have started more recently, such as the Finnish Red Cross project in Honduras in 2010 and the Canadian Red Cross project in Bolivia in 2011.

Most of the MNCH projects will end between 2012 and 2013; however, the Norwegian Red Cross, Finnish Red Cross and Canadian Red Cross are looking for funding to extend their projects but do not yet have confirmation from donors. Norwegian Red Cross is funded by the Norwegian Agency for Development Cooperation (NORAD) and is applying for future funding for 2013–2016 to continue its work in Guatemala. Norwegian Red Cross is moving away from IMCI and starting to use CBHFA as part of its methodology while still focusing on MNCH. Finnish Red Cross is looking to extend its support until 2015; however, the funding has not been confirmed. Currently, the Canadian Red Cross is investigating future partnerships with other stakeholders within the Americas and means for strengthening existing ones, including current MNCH programming in Haiti.

Canadian Red Cross is looking at extending its MNCH projects in the future by developing strategic partnerships with actors like the Pan American Health Organization (PAHO) to discuss possibilities for collaboration. Canadian Red Cross is also looking at the possibility of integrating the fields of MNCH and VP to reduce risk of violence, injuries and mortality for mothers and children and possibly seek joint funding for program review. French Red Cross is currently supporting the implementation of its project in Haiti. There is no planned end date for the project as of yet since the society is working with ten healthcare centers in two vulnerable earthquake-affected regions. Lastly, Spanish Red Cross is not sure if it will extend its project in Paraguay after 2012.

Partner National Societies are supporting the implementation of MNCH-related projects in the following areas: VP, disaster risk reduction (DRR), HIV prevention and care, water and sanitation, first aid, CBHFA, disease prevention, health promotion and access, food security, gender, PSP, and disaster preparedness. Some of these areas have a direct or indirect impact on women's and children's health and, therefore, affect MNCH indicators in the countries where these types of activities are being implemented (the full list of MNCH-related projects that Partner National Societies are supporting can be found in Annex E.) The MNCH-related activity that is supported the most by Partner National Societies is DRR. This trend could open doors for MNCH programs or components to be integrated into DRR practices. The Partner National Society supporting MNCH-related projects in the most countries is Spanish Red Cross, followed by AmCross. These two Partner National Societies are very active in the Americas region, working with 14 and eight National Societies respectively.

In summary, Partner National Societies are supporting many MNCH and MNCH-related projects in the Americas, with more than half of the National Societies being reached by diverse programs based on individual country needs. Out of the seven Partner National Societies chosen for this study, five are supporting the implementation of MNCH projects. Therefore, Partner National Societies are making MNCH in the Americas a priority. However, Partner National Societies may face a lack of funding to continue or expand their MNCH projects after 2012, based on donor trends or other factors affecting funding. In hopes of continuing their MNCH work, some are looking into collaborating with external partners such as PAHO and seeking extensions from current donors.

## External Partners: Priorities and MNCH Activities

Beyond the Red Cross Red Crescent's work on MNCH, multiple external partners have an impact on MNCH in the Americas region. To evaluate the involvement of external partners, 17 agencies and organizations were selected from NGOs, public-private partnerships, UN agencies and government agencies and departments to cover different sources of MNCH initiatives. While these agencies and organizations were chosen based on their thematic focus on women and children as an organization, it should be noted that their priorities may or may not encompass MNCH specifically or even health as a thematic issue.

The 17 agencies and organizations chosen for this project are PAHO, World Food Programme (WFP), World Vision, Plan International, U.S. Agency for International Development (USAID), Spanish Agency for International Development Cooperation (AECID for its acronym in Spanish), European Commission's Humanitarian Aid Office (ECHO), Canadian International Development Agency (CIDA), OXFAM, the Micronutrient Initiative (MI), Global Alliance for Vaccines and Immunization (GAVI), Save the Children and four UN agencies: UNICEF, UNFPA, UN WOMEN and UNDP. This list covers organizations and agencies working in the 35 countries where the Red Cross is present in Americas as well as Montserrat — a priority country for the British government's Department for International Development (DFID). The rest of the overseas territories were not considered even though there is UN agency presence in those countries since there is no specific country priority within the UN system[7].

To determine where these 17 agencies are investing their funds, an internet-based research was conducted. When reviewing all of the priority countries for MNCH in the Americas, a few are a priority for multiple agencies and organizations. Bolivia and Haiti are considered a priority as 16 out of 17 organizations have projects or are funding projects in these two countries. Furthermore, Honduras is an area of priority for 14 organizations and agencies (82 per cent), Nicaragua for 13 (75 per cent) and Guatemala and Peru for 12 (71 per cent). The regional focus for the top priority countries is somewhat divided with one from the Caribbean (Haiti), three from Central America (Honduras, Guatemala, Nicaragua) and two from South America (Bolivia, Peru); however, Central America has been slightly more prioritized with external partners. As seen in Figure 15, overall priority seems to be higher in Central America and the Andean region. (See Annex G for full list of countries in order of priority based on number of agencies and organizations.)

The lowest priority countries for external organizations are Belize, Canada and the USA with only four agencies working in those countries, and all four of those are UN agencies present in all member countries. Two of these low priority countries, Canada and the USA, are considered developed countries according to the HDI[8,9] and are often project funders; therefore, this may be the cause of low external partner priority for these countries.

Even though all 17 chosen agencies and organizations have a thematic focus around mothers and/or children, not all are implementing or supporting specific MNCH projects in specific countries. This does not mean that some of the organizations are not funding or supporting MNCH projects in another capacity. Based on internet research and information gathered from representatives from the 17 agencies and organizations, ten of them (59 per cent) are implementing MNCH projects in various countries: CIDA, USAID, Plan International, World Vision, UNPFA, WFP, PAHO, MI, Save the Children and GAVI. These ten agencies and organizations represent NGOs, UN Agencies and public-private partnerships; therefore, it can be concluded that MNCH projects are a priority across the board. UNFPA and PAHO are implementing or supporting MNCH projects in the most countries with 17 and 11 respectively. In terms of coverage, the agencies and organizations are implementing MNCH projects in 21 of the 35 countries in the Americas where Red Cross Red Crescent is active.


**Figure 15.** External Partner Priority Countries. Data collected through desk review conducted by the author. For more information, please refer to the National Society's web site.

| ORGANIZATIONS | COUNTRIES IN WHICH MNCH PROGRAMS ARE BEING IMPLEMENTED |
|---|---|
| CIDA | Bolivia, Honduras, Haiti, Nicaragua |
| USAID | Nicaragua, Guatemala, Honduras, Belize, Haiti, Dominican Republic, Chile, Ecuador, Peru, Bolivia |
| Plan | Bolivia, Honduras, Guatemala, Haiti |
| World Vision | Bolivia, Chile, Ecuador, Dominican Republic, El Salvador, Mexico, Honduras, Nicaragua |
| UNPFA | Guatemala, Honduras, Nicaragua, Chile, Colombia, Costa Rica, Panama, Dominican Republic, Haiti, Sub region of the Caribbean, Ecuador, Bolivia, Venezuela, Uruguay, Paraguay, Peru, El Salvador |
| WFP | Bolivia, Colombia, Nicaragua, Honduras, Haiti, Guatemala |
| PAHO | Bolivia, Colombia, Peru, Ecuador, Paraguay, Guatemala, Nicaragua, Honduras, Guyana, Dominican Republic, El Salvador |
| MI | Bolivia, Guatemala, Haiti |
| GAVI Alliance | Bolivia, Cuba, Guyana, Haiti, Honduras, Nicaragua |
| Save the Children | Bolivia, Dominican Republic, Guatemala, Haiti, Nicaragua |

**Table 6.** MNCH projects of external partners. Data collected through desk review conducted by the author. For more information, please refer to the Organization's website.

The results also identified that MNCH is a priority focus within certain countries. Ten organizations have or support MNCH projects in Bolivia, nine in Haiti, and eight in Honduras. As mentioned previously, Bolivia and Haiti are priority countries overall for 16 agencies and organizations and Honduras for 14. Therefore, since 59 per cent (Bolivia), 53 per cent (Haiti) and 47 per cent (Honduras) of agencies and organizations have or support MNCH projects in those countries; it means that, on average, over half consider MNCH to be a priority area of focus within those priority countries. Two other countries have a significant amount of agencies and organizations implementing or supporting MNCH projects — Nicaragua and Guatemala — with eight and seven, respectively. This signifies that out of the top five countries in terms of the number of agencies and organizations implementing MNCH projects, three are in Central America, one is in South America and one is in the Caribbean. Therefore, MNCH projects seem to be prioritized in Central America. Additionally, within Peru — a priority country for 12 out of 16 agencies (75 per cent) —only three agencies and organizations are supporting or implementing MNCH projects. Furthermore, only two of the three organizations (UNFPA and USAID) have identified Peru as their priority country and implement or support MNCH projects. Therefore, only 16 per cent of agencies that consider Peru a priority are implementing or supporting MNCH projects in that same country.

The following agencies and organizations — UNWOMEN, UNDP, UNICEF, OXFAM, DFID, AECID, ECHO — do not have specific MNCH projects in specific countries even though DFID, UNICEF, UNPD and AECID mention MNCH in their focus areas of work. UNWOMEN and OXFAM are more focused on human rights issues, violence against women and gender equality[10, 11]. DFID and ECHO, in the Americas, are more focused on preparedness and response to disasters and emergencies[12, 13]. UNDP focuses more on overarching goals such as supporting the achievement of the MDGs[14]. Finally, while UNICEF's focus areas are early child development and children and HIV AIDS[15], no specific projects could be found. However, support of MNCH is evident because UNICEF is part of global partnerships and initiatives such as the Partnership on MNCH (PMNCH) that joins over 450 members to work on MNCH[16], and has a published reports and strategies on MNCH[17].

Furthermore, many external partners have demonstrated initiative to keep MNCH on their agenda in the coming years. For example, CIDA, as part of its Aid Effectiveness Agenda[18], has identified priority themes including MNCH. The Canadian government has committed to "providing $1.1 billion in new funding between 2010 and 2015. Canada is also providing $1.75 billion in on-going spending on maternal and child health programming, a total contribution of $2.85 billion"[19]as part of its commitment to the Muskoka Initiative to mobilize global action to reduce maternal and infant mortality[20]. Also, the UN Agencies are all committed to supporting the achievement of the MDGs by 2015. UNPFA even has its own strategic plan to work on the achievement of MDG 5 from 2011–2013[21]. Finally, PAHO has launched an initiative in partnership with CIDA called "Improved Health for Women, Children and Marginalized Populations," working in 11 countries in the Americas with wider gaps in MNCH from 2011 until 2014[22]. These specific commitments and strategies on MNCH demonstrate the high level of interest of supporting MNCH in the future.

In conclusion, external partners play an important role in the Americas region and complement the work of the Red Cross. Priority countries are distributed around the region; however, some are definitely considered more of a priority than others, especially Haiti and Bolivia with 94 per cent of agencies and organizations considering those countries to be a priority. MNCH is being implemented by 59 per cent of the agencies and organizations reviewed in 60 per cent of the 35 countries where the Red Cross is active in the Americas.

# DISCUSSION

## Gaps Based on Current Need

Through a statistical analysis, based on UNICEF and WHO indicators, five countries were identified as top priority for MNCH. These are, in order, Haiti, Guatemala, Bolivia, Guyana and Honduras. After comparing these with the current MNCH activities of National Societies, Partner National Societies and external partners, certain gaps were found.

Firstly, out of the 14 National Societies that are implementing MNCH activities, five of them are within the five priority countries. External partners have invested in MNCH projects in all five priority countries as well. However, all are conducting different activities at different levels.

Out of the five priority countries, Haiti has the most need by far, and it is addressed by all actors. The Haitian Red Cross is working in MNCH, especially with immunization, sexual and reproductive health, family planning and hygiene and health promotion. Therefore, it conducts preventative types of activities in MNCH. Partner National Societies in Haiti are addressing MNCH through their work with healthcare centers around Port-au-Prince, Petit-Goâve and in the Sud-Est department, as well as many MNCH-related activities including VP, water and sanitation, gender, food security and DRR, amongst others. External partners are also the most active in Haiti. All 17 external partners taken into consideration for this study are working in Haiti; therefore, a wide range of MNCH activities are being provided. However, Haiti remains a very vulnerable country since the data still indicates great need for MNCH work and human development since it is the lowest ranked on the HDI list and the only country in the Americas to be classified as having "low human development"[23].

The need to reduce maternal mortality in Haiti and Guyana is quite high since they have a maternal mortality ratio of 300 and 270 respectively. However, when looking at National Societies, Partner National Societies and external partner MNCH activities, it is apparent that Haiti is considered a very high priority, especially since the earthquake, yet Guyana is not considered as high priority for MNCH activities despite its need. Guyana is the only country of the top five in which a Partner National Society is not implementing MNCH. Three Partner National Societies are working in Guyana on MNCH-related themes, such as violence prevention and HIV prevention, but this does not address the gap in maternal health. Also, only two out of 16 external partners are working in Guyana: PAHO and GAVI, but their work is much more focused on children's health, with activities such as immunization and IMCI. Even with that focus, Guyana still remains very high in priority for child indicators since it is in the top five for under-five, infant and neonatal deaths, and third in the Americas for children under the age of five who are underweight (10.8 per cent)[24]. Also, the Guyana Red Cross focuses its health work mostly on sexual and reproductive health, HIV prevention and care, maternal referrals and health and hygiene promotion. These types of activities have a direct impact on maternal health and are helping close the gap in maternal health. However, even within National Societies, there is still a lack of maternal care compared to prevention activities. When looking at the continuum of care through time in Figure 16, maternal health activities being implemented by the Guyana Red Cross, Partner National Society and external actors mostly focus on the "before pregnancy", "motherhood" and "childhood" stages in preventative manners, but are not addressing the need for care for mothers during and right after pregnancy.

Child health is progressing well in Latin America and the Caribbean with a reduction of 29 per cent in under-five mortality rate from 1990 to 2009[25]. However, there are still some gaps to be considered when looking at child health indicators being addressed by different actors. Guatemala and Suriname, according to UNICEF indicators, is doing very poorly in nutrition since, in Guatemala, as much as 19 per cent of children are moderately or severely underweight, up to 48 per cent suffer from moderate or severe stunting and, in Suriname, only 2 per cent of children are breastfed exclusively for the first six months of life[26]. In Guatemala, this need is met by the Guatemalan Red Cross implementing nutrition education and food security activities regionally. To complement the Red Cross Red Crescent work to improve nutrition in Guatemala, seven external partners, including WFP and MI, specialized in food security and nutrition are working to prevent malnutrition.

On the other hand, Suriname is under-represented since it is one of two countries where the Partner National Societies chosen for the study are not working in any capacity. Information on other Partner National Societies' activities in Suriname could not be found. The need for child health programs is made evident by the fact that Suriname places third for infant deaths and fourth for under-five deaths in the Americas[27]. The Suriname Red Cross is not working on nutrition education but is implementing food security activities on a national level. External partners including ECHO, CIDA, OXFAM and UN Agencies are working in Suriname; nevertheless, none of them are focusing on MNCH. There is a general lack of focus from the different actors on health promotion to ensure healthy habits and health practices are known throughout Suriname.

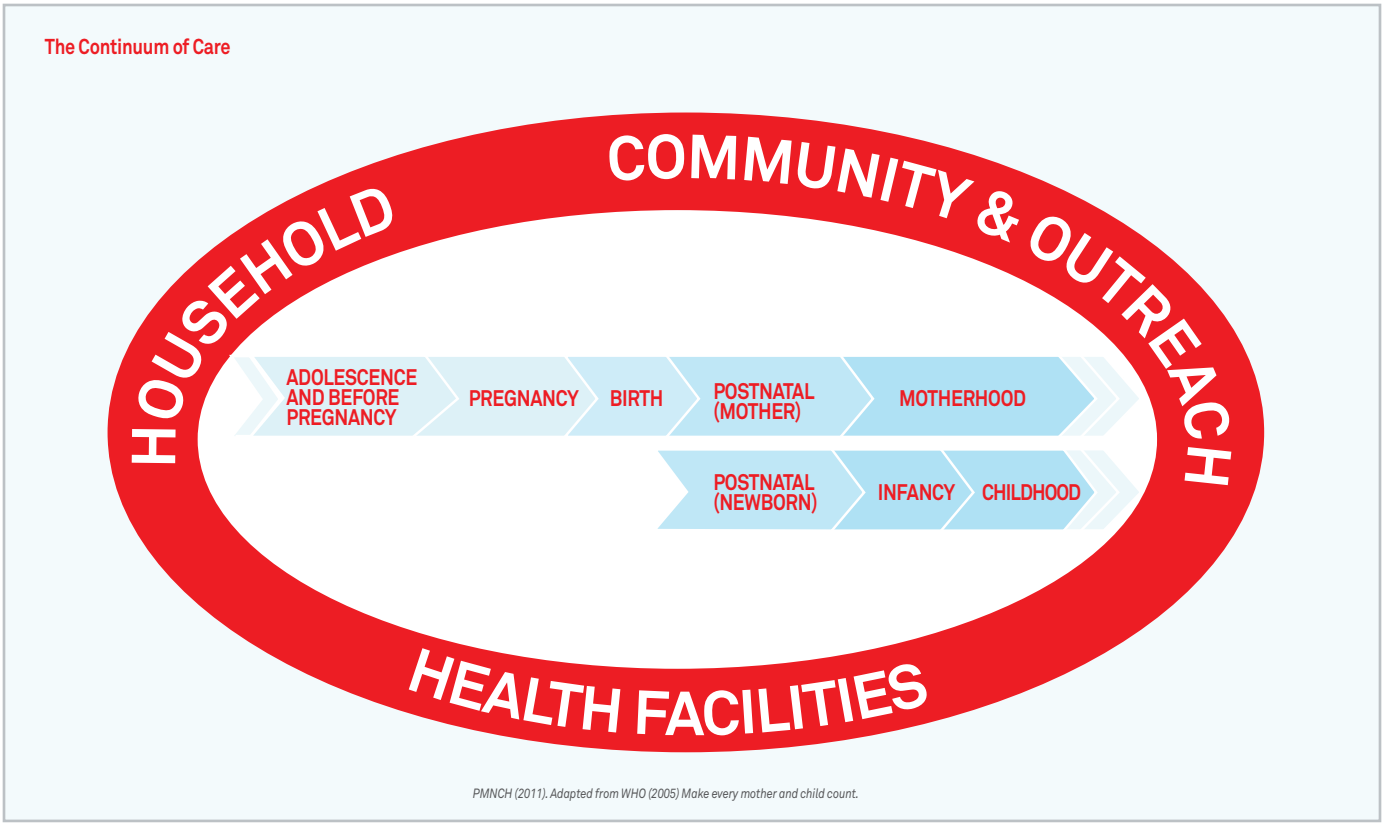


**Figure 16.** The Continuum of Care through time. Source: PMNCH, 2011

Addressing newborn deaths should be considered a priority in the Americas since almost 50 per cent of under-five deaths are in the neonatal period. The main causes of newborn death are due to birth complications[28]; a gap exists between those causes and the percentage of births attended by a healthcare professional. For example, out of the five top countries, only Guyana has over 70 per cent of births attended by a healthcare professional. In the other four countries, less than three-quarter of the births in their respective countries are attended by healthcare professionals. The lack of qualified staff attending births can dramatically increase the rates of newborn deaths since, if a complication occurs, there is no one to help the newborn survive.

Since the analysis of data clearly shows a need to prevent under-five and newborn deaths in the Caribbean, it was important to determine how this need is being addressed in the Caribbean. Out of the National Societies that responded to the survey, only one out of eight from English-speaking and Latin Caribbean is implementing activities such as post-natal care and post-natal mother and newborn visits that could prevent neonatal deaths. Therefore, while the Caribbean has some of the highest neonatal mortality rates in the region, the Caribbean National Societies are not implementing many MNCH components that could address this issue. In that region, MNCH activities are more focused on sexual and reproductive health and HIV prevention and care, which mostly address maternal health needs and not necessarily newborn health needs. Partner National Societies are also not focusing on activities that would specifically target the neonatal period. None of the Partner National Societies considered in this study are implementing MNCH in the Caribbean.

In summary, the gaps for the region are mostly evident in certain countries such as Haiti, Suriname and Guyana — all situated in the Caribbean. Also, the gap in newborn health programming is present in the Americas, and is more pronounced in the Caribbean. The programming trends are more focused towards HIV prevention and care, and sexual and reproductive health; however, this type of programming does not reach all parts of the continuum of care. More needs to be done from all actors on the curative side of MNCH to address present gaps.

## Gaps within the Movement

The International Red Cross Red Crescent Movement has many components including National Societies, Partner National Societies, the IFRC secretariat and the ICRC. Since the IFRC has more of an overall regional support role, and the International Committee of the Red Cross (ICRC) focuses on conflict-affected areas, this study focused on the priorities and work of National Societies and Partner National Societies in the Americas. Although Partner National Societies and National Societies form part of the same Red Cross Red Crescent Movement, it is of critical importance to identify gaps in programming and coordination to help prevent inefficiencies and to ensure that the Red Cross Red Crescent is reaching the most vulnerable populations. This can be challenging in an environment where every National Society and Partner National Society has its own mission, objectives and strategies. This part of the report will discuss the differences and similarities between MNCH programming being implemented by National Societies compared to projects supported by Partner National Societies.

Partner National Societies are supporting MNCH projects in six countries. Within those six countries, five National Societies are implementing MNCH. Therefore, Partner National Societies and National Societies are implementing MNCH in five of the same countries: Haiti, Honduras, Nicaragua, Guatemala and Bolivia. These countries represent four out of the five identified as in need of MNCH work. On the other hand, Partner National Societies support MNCH-related projects in all 14 countries in which National Societies are implementing MNCH, except for Venezuela, Uruguay and Argentina.

Overall, Partner National Societies and National Societies priorities are differentiated across the sub-regions within the Americas. Partner National Societies are focusing 50 per cent of their MNCH support to projects in Central America whereas National Societies are implementing 43 per cent of their MNCH activities in South America. Paraguay is the only country in which Partner National Societies are supporting MNCH but the National Society is not. In Paraguay, the Spanish Red Cross is working with a NGO called Kuna Aty and not with the Paraguayan Red Cross; therefore, in this case, the Partner National Society is not providing direct support to the National Society.

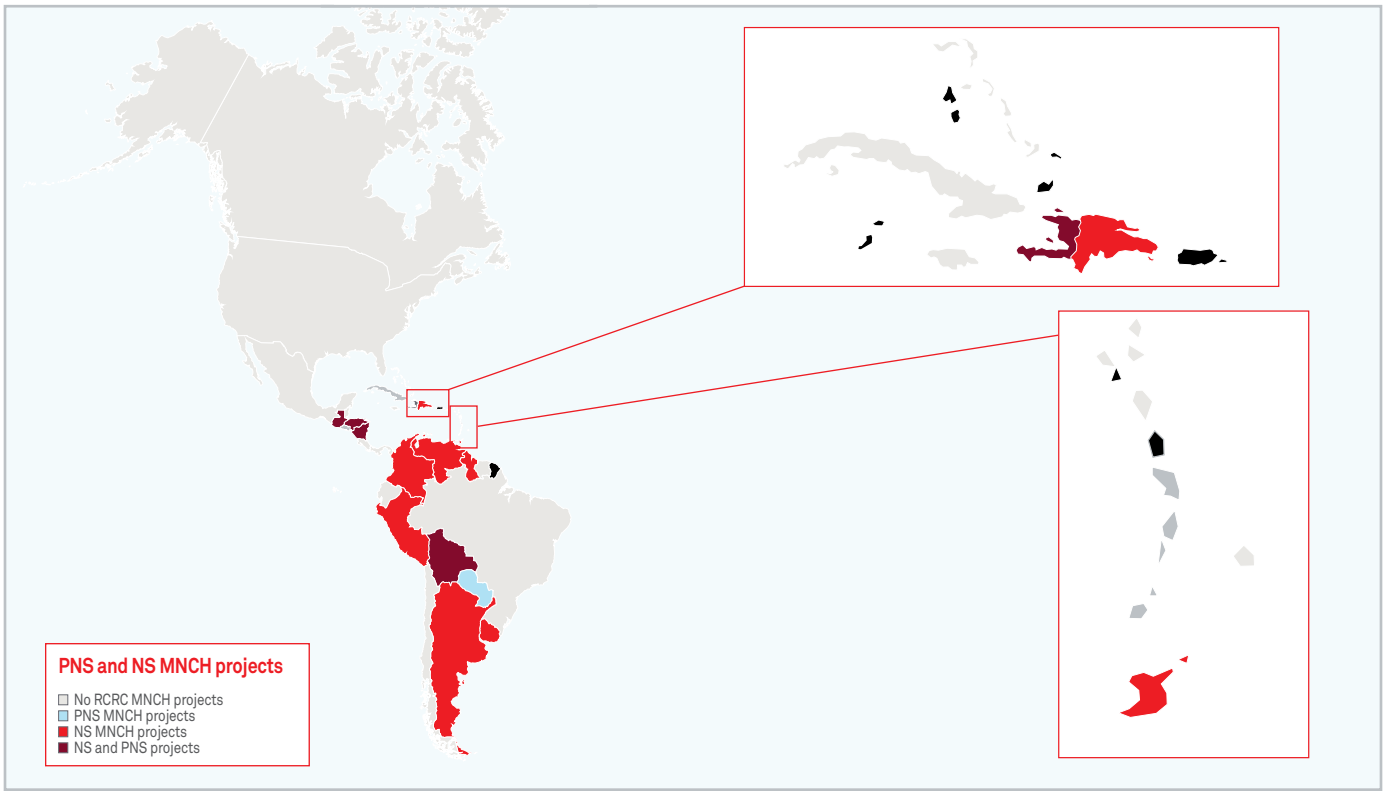


**Figure 17.** Partner National Societies compared to National Societies - MNCH projects. Information gathered from primary sources of information.

Partner National Societies and National Societies cooperate based on their objectives, priorities and needs assessments as well as funding streams. Overall, Partner National Society support is more focused on nutrition and food security as well as providing a referral system for maternal care. A total of 73 per cent of National Societies are implementing health and hygiene promotion and 74 per cent sexual and reproductive health activities. Therefore, in terms of thematic areas of work, while Partner National Societies and National Societies have different priorities overall, these activities support each other in bettering the health of women and children.

In Haiti, the Partner National Societies are supporting and complementing the National Society's MNCH programming to reinforce sexual and reproductive health with gender, VP, health and hygiene promotion to prevent communicable and non-communicable diseases, CBHFA and water and sanitation. In Guyana there are several gaps in MNCH implementation as most of the care is directed towards sexual and reproductive health and HIV prevention and there is a lack of MNCH community or institutional care (there is only a referral system provided by the National Society). In Peru, many of the MNCH activities are in related fields such as water and sanitation, health and hygiene promotion, and nutrition. However, there are no programs supporting MNCH curative care to help reduce mortality and morbidity. In Trinidad and Tobago, the Partner National Societies' support to the National Society's MNCH and MNCH-related activities is complementary: HIV prevention and care supports the prevention of mother-to-child-transmission (PMTCT) and sexual and reproductive health, and DRR promotes health and hygiene promotion. Nicaragua also has well-coordinated activities in MNCH because IMCI, supported by Partner National Societies, focuses on nutrition, post-natal care and immunization while gender-focused programs help support family planning.

Another important aspect to consider was the coordination within the Red Cross Red Crescent on the future of MNCH projects in the region. Since many projects and activities are being sustained by Partner National Societies, the National Societies may not have the capacity to continue with the implementation of the MNCH work once the funding from the PNS ends. Based on the survey, the Honduras, Guatemala, Nicaragua and Bolivia National Societies have a very high interest in pursuing MNCH work in the future. However, the projects in Bolivia, Nicaragua and Guatemala are finishing in either 2012 or 2013, with uncertainty about further funding. Since most Partner National Societies' MNCH projects in the region are in their final stages, this creates a gap between the current interest by National Societies to implement MNCH and support from Partner National Societies for MNCH projects and activities. Therefore, this could create an issue for National Societies such as Guatemala, Bolivia and Honduras to continue prioritizing MNCH because Partner National Societies support most or even all MNCH activities within their respective countries.

In the case of Honduras, Finnish Red Cross is looking to extend its project until 2015; however, the funding has not been confirmed. The Canadian Red Cross is considering the further extension of its project in Honduras. Furthermore, this gap is widened when taking into consideration the need for National Societies to keep implementing MNCH. As stated in the survey, most National Societies indicated that the type of support they need the most is resource mobilization support and funding support. With none of the Partner National Societies' projects having funds for more than 2013 at this moment, it would be hard to satisfy that need if the funding is not guaranteed or available at all.

On the other hand, gaps in commitment to MNCH were found on the side of the National Societies at the 31st International Conference of the Red Cross and Red Crescent that took place in Geneva in December of 2011. Conference members were invited to submit voluntary pledges to undertake specific actions and, in the area of health, they were given the possibility to commit to health inequities or healthcare in danger. In the Americas, only two National Societies pledged to commit to MNCH: Honduras and Canadian Red Cross with the support of the Canadian government. Some National Societies also made MNCH-related pledges like working on tuberculosis and AIDS. However, seeing that 14 National Societies are implementing MNCH, two pledges do not represent much commitment from National Societies. Therefore there is a gap between the interest and implementation of certain MNCH activities and actually committing to it in the future.

## Gap Analysis of Top Five Countries in Need of MNCH programming

Based on the implementation of the 12 MNCH activities included in the survey to National Societies and the information provided by Partner National Societies, an analysis of the top five countries in need of MNCH (identified earlier on in the study) was conducted to find possible gaps in the MNCH programming in those countries.

### Haiti

National Society and Partner National Society MNCH activities in Haiti focus on health and hygiene promotion, sexual and reproductive health (including family planning), nutrition education and immunization. However, there is less focus on MNCH care, such as antenatal or prenatal care, home visits, teenage pregnancy support or child growth monitoring. This focus on prevention in MNCH and less on community healthcare could be due to the fact that since the earthquake there have been 470,000 cases of cholera reported in Haiti with 6,631 attributable deaths[29]. Therefore, it is important to continue work on prevention to ensure that no other outbreak of this magnitude occurs. Also, since up to half a million vulnerable people are estimated to still be living in camps or temporary shelter[30], it is hard to work at a community level since the community structures are not yet set or in existence. However, it must be noted that there was a dramatic scale-up in funding after the earthquake and many of these activities did not exist before this event.

### Guatemala

In Guatemala, the National Society is supported by Partner National Society projects for ten of the 12 activities from the survey. The only gaps in Partner National Society and National Society cooperation are found in antenatal care and teenage pregnancy support. Both of these activities support the period during pregnancy; therefore, there is a gap in the continuum of care that needs to be addressed to ensure less complications at birth. IMCI is also supported by the Partner National Society; therefore, child health is covered with the prevention of illnesses. This activity is important for Guatemala due because of the high child malnutrition rates[31]. Also, the Norwegian Red Cross includes CBHFA as part of the project methodology, which provides support to many MNCH activities within the communities and increases the capacity of the Guatemalan Red Cross.

### Bolivia

The Partner National Society and National Society cooperate to cover ten out of 12 MNCH activities. Eight of the activities implemented by the Bolivian Red Cross are supported by the Partner National Society. The two remaining activities — health and hygiene promotion, and epidemic control — are implemented nationally by the National Society. Out of the 12 activities, the gap in MNCH is in implementing PMTCT and teenage pregnancy support. Even though the contraceptive prevalence rate, as reported by WHO, is quite high at 60.5 per cent (which is close to the regional average of 72.4 per cent[32]), teenage pregnancy support should be more of a priority due to the fact that, in Bolivia, 14 per cent of adolescent women have experienced pregnancy[33]. In addition, Bolivia is ranked third in the Americas, according to UNICEF data, for unmet need for family planning, with 20 per cent of women in a union not wanting to conceive but still getting pregnant. Also, the HIV prevalence rate is 0.2 per cent[34], below the regional average of 0.5 per cent[35]; therefore, this explains why PMTCT could be considered less of a priority for the National Society in Bolivia compared to other MNCH components.

### Guyana

The Guyana Red Cross is implementing only four of the 12 indicators — PMTCT, sexual and reproductive health, referral for maternal care and health, and hygiene promotion — and IMCI as an "other" activity. IMCI, implemented by the Guyana Red Cross, helps to prevent childhood illnesses and, therefore, contributes to child health. Partner National Societies are not supporting any MNCH activities in Guyana. Partner National Societies support HIV prevention and VP programs, which link to the National Society's MNCH programming related to sexual and reproductive health. However, the lack of support by Partner National Societies for MNCH programming makes the gap in MNCH work quite visible in Guyana. More specifically, there is a significant gap in maternal health programming since IMCI and community-based training focus on care for young children. With one of the highest maternal mortality ratios in the region (second after Haiti with 270), Red Cross Red Crescent should be focusing more of its activities on maternal health to ensure the health and well-being of mothers and the achievement of MDG 5 by 2015.

### Honduras

Honduras is the only country that is receiving direct MNCH support from two Partner National Societies. The Partner National Societies cooperate with the Honduran Red Cross on all of the 12 activities and they are also working on nutrition monitoring to complement the nutrition education. Canadian Red Cross supports the Honduran government's community health program AIN-C. Finnish Red Cross supports HIV prevention and care in certain regions of Honduras, linked to the National Society's MNCH activities. This signifies that no gaps can be identified for the MNCH work in Honduras implemented by Partner National Societies and the National Society. However, since March 2012, the CRC has stopped direct support in preparation to close the project by September 2012. Also, funding for the Finnish Red Cross MNCH project in Honduras is ending in 2012. This means that unless these projects get extended, the Honduran Red Cross will no longer have the funds to continue all the MNCH activities implemented until now and a major gap in MNCH care will exist in Honduras.


Photo courtesy of Danielle Lessard, Canadian Red Cross

# CASE STUDY

## Haiti: Community Based Health and First Aid (CBHFA) as a platform for MNCH

Community Based Health and First Aid (CBHFA) is an integrated primary health care approach to community health promotion developed by the International Federation of the Red Cross and Red Crescent Societies (IFRC). It enables target communities to become healthier and more resilient thus playing a vital part in IFRC's Strategy 2020 and contributing to Millennium Development Goals 4, 5, 6 and 7.

The CBHFA's multi-prolonged approach identifies and addresses community health priorities, emphasizes health promotion and disease prevention, prepares volunteers to respond to disasters, and strengthens local first aid skills. It mobilizes communities to use simple, locally adapted tools to address their own health priorities and empower them to be in charge of their own community's development.

Maternal, newborn and child health is a component of the CBHFA "Disease Prevention and Health Promotion" module. Topics such as community health education and promotion, family planning, safe motherhood, care of the newborn, nutrition, immunization and vaccination campaigns among others which teach volunteers how to support households and community groups to adopt healthy behaviours.

In Haiti, the Haitian Red Cross Society (HRSC) is strengthening its community health programming using the CBHFA approach in partnership with the IFRC and seven Partner National Societies including the British Red Cross, Canadian Red Cross, Finnish Red Cross, French Red Cross, German Red Cross, Italian Red Cross, and the Norwegian Red Cross.

CBHFA projects in Haiti focus on mother and child health, disease prevention, hygiene promotion, violence prevention and disaster risk reduction. All of these projects range from one to five years, with most in the two to three year range, and are benefitting more than 65,000 rural and urban households across the country. The Haitian Ministry of Public Health and Population (MSPP) is also committed to training 10,000 community health workers over the next 5 years. By implementing the CBHFA approach and emphasizing the MNCH component, community volunteers and households will be empowered to develop and implement their own solutions to local health challenges and build the health of the community by focusing on a key part of the life cycle – where maternal and child health meet.

## Gaps outside the Movement

When identifying gaps in the MNCH work implemented by the Movement, it is important to also consider the impact and contribution of other actors such as external partners and governments. Avoiding gaps in MNCH work when taking into account all the stakeholders, donors and beneficiaries becomes challenging because each partner has its own motives and priorities. Therefore, the work of actors outside the Movement was cross-examined against work by Partner National Societies and National Societies to determine the level of coordination and efficiency for MNCH.

External partners are implementing MNCH in 19 countries plus 13 countries in the sub-region of the English-speaking Caribbean. Therefore, the only countries in which they are not implementing MNCH are Argentina, Canada and USA. The Red Cross Red Crescent covers that gap by implementing MNCH in Argentina — the only country in which the Red Cross Red Crescent is implementing MNCH and external partners are not. Based on the number of external organizations working on MNCH in a given country, the priority countries for external partners for MNCH are Bolivia, Honduras, Haiti, Nicaragua and Guatemala, in that order. The priority countries for the Movement (the countries where National Societies and Partner National Societies work the most or have the most activities) are Honduras, Bolivia, Guatemala, Nicaragua and Haiti. Therefore, the overall priorities for external partners and the National Societies and Partner National Societies are the same but ranked in a different priority. Both the Movement and external partners have a big focus on Honduras and Bolivia. In addition, external partners implement MNCH in seven more countries than Partner National Societies and National Societies (total of 20), in addition to the 13 countries in which they both implement it, as seen in Figure 18.

Those seven countries are Cuba, Chile, Costa Rica, Mexico, Belize, Ecuador and El Salvador. This closes the needs gap for MNCH because Ecuador, Belize and El Salvador are all ranked in the top ten and Mexico is twelfth. The only country in the top ten that is not covered by the Movement nor external partners is Suriname. Since the need is high in Suriname, especially for life saving practices such as exclusive breast-feeding for the first six months (only 2 per cent observe this practice), there is a gap in MNCH programming. In Guyana, one of the countries most in need of MNCH programming, PAHO and GAVI are working on projects involving immunization and IMCI, which helps fulfil the gap created by the lack of Partner National Society support in that country. This type of programming is mostly aimed at children and not on maternal health where the most need is, creating a gap in programming. Guyana is still a low priority for external partners in general since only two of 16 organizations analyzed are conducting MNCH.

One of the most important contributors to MNCH on a national level is the government of each respective country in the Americas. With governments committed to MNCH, there is easier access to communities and national systems and services that benefit MNCH projects and activities. Governments have MNCH strategies or projects in 21 countries, ten of which are the same countries that have Red Cross Red Crescent projects: Honduras, Haiti, Guatemala, Colombia, Paraguay, Guyana, Peru, Venezuela, Uruguay and Argentina. Most of the countries in which both Red Cross Red Crescent and governments are implementing MNCH are in South America. Therefore, those ten National Societies have the support of their governments in the implementation of MNCH.

Governments are implementing MNCH in 11 countries in which Red Cross Red Crescent is not. On the other hand, Red Cross Red Crescent is implementing MNCH in four countries where the government does not have a specific MNCH strategy or plan, including high priority countries such as Bolivia, Nicaragua and Dominican Republic. Therefore, Red Cross Red Crescent helps to close the gap in MNCH programming in those countries. It should be noted that while the governments of Bolivia and Nicaragua do not have specific MNCH strategic plans or projects, they have developed different ways to fulfil the MNCH need. For example, five of 12 priorities in the national health plan for Nicaragua are directly related to MNCH. By prioritizing the health of mothers and children in their national plan and focusing its overall health goal on MNCH, the government is closing the gap. Also, the Nicaraguan government has an objective to include and integrate indigenous communities into community health. Furthermore, the Bolivian government, even without a specific MNCH strategy, has based its objectives on achieving universal access to all and reducing social exclusion in health. They have also implementing three forms of free care aimed mainly at mothers and children since 1994 to reduce health disparities within the country[36]. Therefore, they are directly targeting the most vulnerable and marginalized populations, which are mostly women and children, and in Bolivia's case, the indigenous[37].

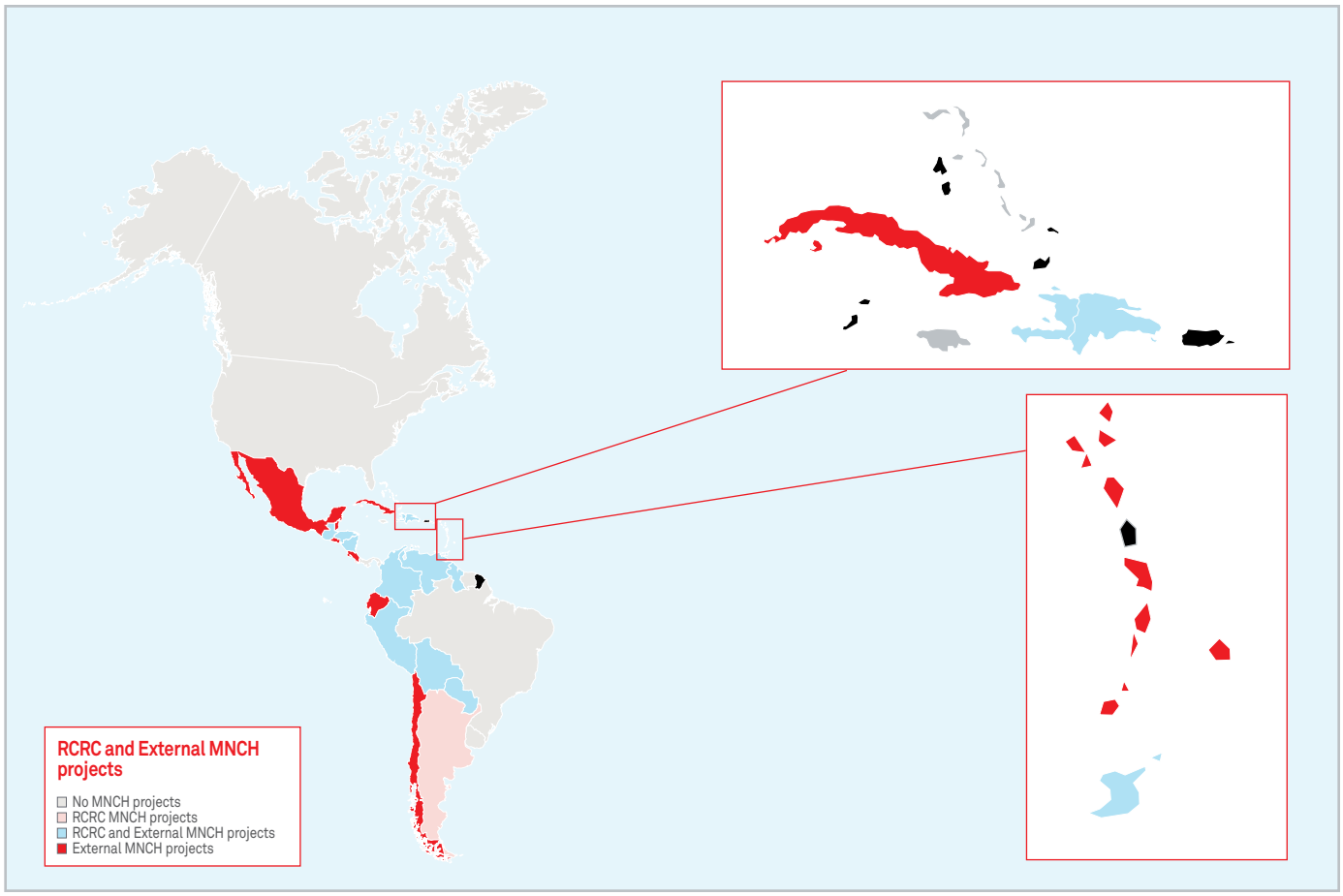


**Figure 18.** Red Cross Red Crescent and External Partner MNCH Projects. Information gathered from different sources of information.

When analysing the gaps between Red Cross Red Crescent and government commitments to MNCH, it was important to consider if the National Societies were aware of their government's commitment. Question 12 of the survey to National Societies asked them to rate the government's commitment to MNCH. The National Societies' perception of government commitment is mostly on track when looking at MNCH projects that are still active and will be active in the next years. Out of the 14 National Societies that consider their government's commitment very high, 12 match their government's actual commitment. The only ones that stated they thought their government is highly committed but in reality it is not fully committed to MNCH specifically are Trinidad and Tobago and Costa Rica. Even though the government may undertake some MNCH activities, no strategies or plans have been identified to support this commitment. The only National Society that answered "low commitment", Antigua and Barbuda, was also correct since its government has not identified specific MNCH strategies. The two other countries that have MNCH strategies that are still active in the next years — Paraguay, and Saint Vincent and the Grenadines — did not answer the survey; therefore, the National Societies' perception could not be determined.

## Coordination within the Top Five Countries in which External Partners Implement MNCH

The top five countries in which external partners are implementing MNCH were analysed to determine how Red Cross Red Crescent is coordinating with both external partners and governments.

### Bolivia

In Bolivia, external partners are mostly focusing on preventing diseases (focused on children) and nutrition promotion and education, which supports the work of the National Society. Also, CRC has partnered with MI for its MNCH project in support of the Bolivian Red Cross. The Bolivian government, as part of its national health strategy, promotes social inclusion in health, which ensures that the most vulnerable communities are reached and gives access to Red Cross Red Crescent and external partners to work within these communities.

### Honduras

There is good coordination in Honduras between Red Cross Red Crescent and external partners. CIDA is funding a Red Cross Red Crescent program and WFP and GAVI are supporting MNCH with food security and immunization projects. WFP is working with the Honduran Red Cross by providing food supplements that are being distributed in communities where the National Society works. In addition, the Honduran government has a national MNCH strategy that has a specific focus on newborn health and institutional care. Therefore, the government's work in institutional settings and the Red Cross Red Crescent and external partner community health focus ensure full coverage of health services.

### Haiti

External partners in Haiti are working on sexual and reproductive health, nutrition and food security, which complements Red Cross Red Crescent healthcare services and health and hygiene promotion activities. Disease control and prevention is also an important theme, especially after the cholera outbreak in Haiti in 2010. Both external partners and the Red Cross Red Crescent are working in this area to prevent further spread of diseases. Also, the Haitian government has partnered with organizations to provide maternal and child curative care in the health centres, complementing the Movement's prevention work.

### Nicaragua

The activities in Nicaragua are harmonized between external partners and the Movement since they both tackle nutrition issues as well as gender issues related to sexual rights and sexual and reproductive health. In addition, WFP provides school meals, which makes for healthier children, which in turn helps with IMCI that Nicaraguan Red Cross is implementing. The Nicaraguan government is actively working to reduce child and maternal mortality, chronic malnutrition and the prevalence of respiratory infections and diarrhoeal diseases. This helps close the gap in the causes of child mortality that, as seen in Figure 2, are highly related to those two types of illnesses. Also, the government's work is supporting the Nicaraguan Red Cross in implementing IMCI and programs for nutrition education.

### Guatemala

In Guatemala, external partners and the Guatemalan Red Cross are complementing each other's work. The National Society is implementing IMCI and external partners are working on preventing diseases and providing access to health services. Also, external partners and the government have committed projects to specifically target indigenous populations, which help the Movement with its work with the most vulnerable. Furthermore, external partners are addressing the need to improve nutrition by working on preventing malnutrition and providing micronutrients to communities in need and where children suffer from stunting. The Guatemalan government has identified in its national health plan the importance of reducing maternal and child mortality and of contributing to the reduction of child malnutrition. These government commitments help the Red Cross Red Crescent implement community MNCH monitoring and IMCI activities.

| COUNTRY | NS | PNS | EXTERNAL PARTNERS | GOVERNMENT |
|---|---|---|---|---|
| Haiti | YES | YES | 56% | National MNCH strategy/plan |
| Guatemala | YES | YES | 44% | National MNCH strategy/plan |
| Bolivia | YES | YES | 63% | MNCH insurance |
| Guyana | YES | NO | 13% | MNCH project (PAHO support) |
| Honduras | YES | YES | 50% | National MNCH strategy/plan |

**Table 7.** Comparison of all actors for top five countries in need. Source: MNCH Survey to National Societies. March, 2012.

In summary, with the involvement of so many actors, it is a challenge to coordinate and avoid gaps in MNCH programming. When comparing all the different actors for the top five countries in need, as shown in Table 7, it is clear that all the National Societies are committed to MNCH. However, the commitment from Partner National Societies and external partners in Guyana is clearly lacking. On the other hand, the largest number of external partners (63 per cent) is working on MNCH in Bolivia where the government does not have a MNCH strategy but offers healthcare services specifically for mothers and children. Overall, the biggest gap found from outside and inside Red Cross Red Crescent is the lack of MNCH programming specifically focusing on maternal health in Guyana and, on a smaller scale, Suriname. On the other hand, external partners and the Movement are implementing MNCH projects that support government initiatives and strategies. With the large number of organizations working in Haiti, Bolivia, Honduras, Nicaragua and Guatemala, there is a lot of coordination and support coming from different stakeholders to ensure the success of the MNCH projects in those countries.

Maribel conducting a home visit as part of her volunteer tasks.

# CASE STUDY

## Bolivia: Confronting cultural barriers with MNCH

Despite improvements in the health situation over the last 20 years, Bolivia continues to have the second worst health indicators in Latin America[38]; maternal and infant mortality rates are the highest in the region after Haiti. Malnutrition is one of the most important public health problems in Bolivia, with chronic malnutrition affecting 1 in 3 Bolivian children. Many children suffer from micronutrient deficiencies resulting in high levels of anemia. Limited access to a wide variety of food, safe drinking water and basic sanitation, the restricted availability of health information for parents and overall economic hardship, all contribute to malnutrition, especially in peri-urban and rural areas of the country.

While public health services are available in rural zones, they do not adequately meet the needs of Bolivia's poorest and most excluded populations.[39] Rural areas have the largest indigenous populations, and these groups face more severe degrees of poverty and mortality than non-indigenous groups.[40] While non-indigenous regions have already achieved the Millennium Development Goal for births assisted in health facilities, indigenous regions have the lowest levels of institutional deliveries.[41]

The Bolivian Red Cross (BRC) targets the largely indigenous populations of the peri-urban areas of the Potosí and Cochabamba departments through its maternal and child health interventions. With the support of the Canadian Red Cross, the BRC created a project called Maternal and Child Health and Nutrition First. The objective of the project is to support the Bolivian Ministry of Health's Multisectorial "Zero Malnutrition" Program by improving the health and nutritional status of children under 5 years and pregnant women. This project trained Red Cross volunteers and community health volunteers in community health strategies to promote healthy practices in the community and in the home. Through home visits, community health fairs, mothers' group discussions and workshops on food preparation, volunteers are able to extend the coverage of health services in underserved communities.

Maribel Bautista Contreras is a Bolivian Red Cross volunteer who has been particularly dedicated in her work with the Maternal and Child Health and Nutrition First project. She is a community health volunteer who is responsible for conducting home visits where she provides nutrition and health counselling to 25 families with children under the age of 5 years in the Villa Mecanicos community of Potosí. Every week, she goes from home to home, tracking the height and upper arm circumference of children to make sure they are growing adequately and identifying cases of malnutrition. She also provides information on nutrition and micronutrients, how to detect signs of illness, and when to go to the health centre. At community health fairs initiated by the project, Maribel gives families information on how to prepare healthy meals. She also distributes feeding bowls to families with children under two years old, which indicate the quantity of food to give the child depending on their age, and the frequency.

Maribel's strong commitment to improving the health of her community has in part been the result of health events in her own life that have inspired her to take action. When Maribel was five years old, she experienced a temporary paralysis in her body for an unknown reason. Because of economic and cultural reasons, Maribel's family was reluctant to take her to the hospital, *"Because of the distance where they lived, it was preferable to see the traditional healer and hope that the problem would go away by itself."* Maribel eventually regained movement in her body, but the paralysis remained in one of her knees, and she lost the ability to walk. At 5 years of age, she began to use a crutch to help her walk. While she has since received medical attention, the problem in her knee could not be remedied, and she continues to rely on the use of a crutch today.


MNCH volunteers with the Bolivian Red Cross in Cochabamba. All photos courtesy of the Bolivian Red Cross

In rural communities, especially those that are predominantly indigenous, cultural barriers often exist to institutionalized medicine. There may be language barriers in institutional health settings which can deter families from using these services. Families may also fear that their traditional health practices will not be respected.[42] Maribel uses herself as an example to motivate mothers and fathers who are reluctant to see a doctor to seek timely medical attention in a health facility. She explains the danger of waiting to receive care by telling her own story, knowing that in her case, if she had sought medical attention right away she could be walking normally today.

She also helps reduce these barriers by accompanying mothers to receive medical care when they are pregnant.

Because Maribel works in her own community, families know and trust her. The community she lives in is not well designed physically for people with mobility issues, yet she has remained dedicated in her work despite these challenges. Her commitment to her community is clear to the families she serves.

As pointed out by Jose Michel Alarcón, National Health Director at the Bolivian Red Cross, "*The advantages of working with community volunteers are that they know the community, because they often live in the community where the Bolivian Red Cross works. They speak the same language, for example, Quechua, which facilitates communication with the community. They also know the priority health problems of the community.*"

This project has allowed the Bolivian Red Cross to work more closely with volunteers and populations that are vulnerable to malnutrition in peri-urban areas of the Potosi and Cochabamba and to improve health outcomes in these regions. For the BRC, this project has been an opportunity to show that they can work effectively not only in the area of disaster relief and risk management, but also that of maternal, neonatal and child health.

# CASE STUDY
## Honduras: Involving men in MNCH

The MNCH project in Honduras called REDES (meaning "Networks"), was implemented starting in 2006 by the Honduran Red Cross (HRC), in partnership with the Canadian Red Cross (CRC), the Honduran Ministry of Health and municipal organizations. Together, the partners are working towards achieving Millennium Development Goals 4 and 5, to reduce child mortality and improve maternal health. Through the project, Red Cross volunteers, health personnel, and community leaders are trained to educate community members on health and nutrition of children, and encourage healthy practices such as exclusive breastfeeding, and how to prevent diseases, such as diarrhea, that have harmful effects on children. Communities are also educated on recognizing the danger signs during pregnancy and childbirth, as well after the birth of the newborn and children under five years old.

In Honduras, there are large disparities in the health status of people living in urban and rural settings. In remote areas, women and children are particularly vulnerable to health risks. The lack of health services and information in these communities reduces women's demand for health services and the likelihood that they will seek medical attention during pregnancy, childbirth and after giving birth. Traditional norms about women and men's roles assign women the responsibility of caring for their family's health but do not allow them the power to make decisions. The unequal status of men and women also means that women often do not have the resources to access the services needed to assure their own good health, and that of their children.

Recognizing the important relationship between unequal gender relationships and health, the REDES project aims to strengthen community and government networks for improving MNCH, while promoting more equal practices and behaviours between men and women in support of family health. In order to do this, the project developed a gender strategy to encourage men to take part more actively in MNCH. Health support groups for men were developed, to reach out and provide men with the education they need to support and protect their family's health, and make informed health-related decisions. Three gender booklets for training were also published on the participation of men in MNCH, the empowerment of women in decision making, and the inclusion of gender in institutional programs and policies. These booklets have helped the Honduran Red Cross volunteers and staff learn about gender and health issues and incorporate the gender perspective into their work in the communities.

In the rural communities of Copán and Santa Bárbara targeted by REDES, many men have started taking on new roles, as active and engaged advocates of maternal, newborn and child health. Don Ramon is one of these men. In his rural village in Copán, Don Ramon volunteers as a monitor for the Integrated Community Child Health National strategy and as a traditional birth attendant. When his sister died giving birth, he had to raise her daughter as his own. When his own wife gave birth to their children, the option of going to a birthing clinic was non-existent, and so he learned to assist during the home delivery. Don Ramon is challenging the views on gender roles held by most people in his communities. His leadership has made him a model for other men in his community. He is trusted among the women and men in the surrounding villages as a knowledgeable person in matters of pregnancy, birth and post-partum issues. He also has another talent — the ability to capture key messages presented in workshops in the form of songs. In his village, he recites his songs which promote gender equality and promotion of health. The REDES project recorded 16 of these songs on a CD and invites him to perform at health fairs with his group "The Eagles".

Neria Evora is another dedicated volunteer with the REDES Project. She has worked as a volunteer with Colinas branch of the Honduran Red Cross for nearly 30 years. Through the REDES Project, she was trained in themes related to gender and health, that she now replicates with other volunteers and community members. She has seen first hand how a gender focused strategy is needed to improve MNCH: "In our communities, the father's attitude can determine the life of the woman, the future of a child. Here, we see

Don Ramon is a community health monitor and a traditional birth attendant in a rural village in Copán, Honduras. Photo courtesy of the Canadian Red Cross

women and children die because of the patriarchal tradition that characterizes our culture. Working with gender is fundamental in decreasing maternal mortality, teenage pregnancy, in changing the role of men and in reducing female subordination." Neria added that when male partners are involved in their partners' pregnancy, women are more likely to seek institutionalized health care, which is key part of reducing maternal and child mortality and morbidity.

Neria is now spearheading the creation of a municipal gender committee, which involves government and non-governmental actors involved in health, education and development. They are working together to form a municipal gender policy and to create a network of community leaders that will be trained in gender issues so that they can scale up their work for gender equality in the municipality.

Neria and Don Ramon's stories show the vital role of Red Cross volunteers in building bridges between the families of these remote Honduran communities with local health services and shows how working with a gender equality approach is essential to achieving MNCH goals.

## Disparities in MNCH

As IFRC's report *Eliminating Inequities in Health: Every Woman and Every Child Counts* addresses in chapter 2, progress towards reaching MDG 4 and 5 does not always identify the ones most in need; it disguises burdens[43]. Populations in rural areas or in the fifth quintile of houses do not always have access to the healthcare system and, therefore, are more vulnerable to health risks. *The Millennium Development Report 2011* states: "Despite real progress, we are failing to reach the most vulnerable". This becomes an issue because the MDGs look at averages; therefore, the needs of certain populations within a country are not visible. In the Americas, these disparities exist within MNCH especially where there are large rural or indigenous populations.

Several indicators were researched and compiled to obtain a clear picture of the disparity within the top five countries in need. The three indicators used to calculate disparity were the under-five mortality rate, the maternal mortality ratio and the percentage of births attended by skilled health personnel. For each indicator, different social determinants of health were taken into consideration to determine disparity, including income and residence. More specifically, data was collected, when available, for every indicator, from the worst and best regions (lowest and highest number of deaths or percentage), from the first and fifth quintile of households, and from rural and urban areas. Also, Panama was used as a case study to examine disparity as it is considered to be a more developed country in Central America, is ranked 58th in the world and is considered to have high human development, according to the HDI[44]. It was also chosen based on the availability of data on equity.

### Haiti

Haiti has faced many challenges in development over the years and disasters hitting the country, such as the 2010 earthquake, have created many disparities within the population. Haiti is the poorest country in the Americas with 80 per cent of the population under the poverty line[45] and the only country in the region with "low human development" according to the HDI. Haiti is also largely a rural country with only 53 per cent of the population living in urban areas[46]. This makes access to health services more challenging since healthcare is extremely limited in rural areas[47] and is not prepared to handle emergencies related to MNCH.

The situation regarding births attended by skilled health personnel is severe in Haiti, especially when looking at the wealth of the population compared to the care they are receiving. As seen in Table 8, in the poorest part of the population, only 6 per cent of births are attended by trained medical staff. On the other hand, in the richest part of the population, the percentage climbs to 68 per cent. This makes for a difference ratio of 11.3. With a difference so high, the poorest mothers giving birth have a high chance of suffering from complications and dying at birth because of the lack of skilled staff present. The rural/urban ratio is not as high at 3.1; therefore, it is evident that in Haiti, health inequalities are mostly based on wealth more than on the residence of the population.

### Guatemala

Guatemala, ranked 131st on the HDI, is a country where the health status of the population, especially children, is at risk. It has the highest percentage of children under five years of age suffering from moderate and severe stunting in the Americas at 48 per cent. This means that almost half of the children under five are malnourished or are not getting the right nutrients to grow properly. Guatemala also has a diverse ethnic population including the Mayan, Xinca and Garifuna cultures. Over 4.4 million Guatemalans are of Mayan decent, which makes 41 per cent of the population of indigenous decent[48]. The population is also very impoverished: 56 per cent live in poverty and in all the country's departments, except in the metropolitan region, one of every two inhabitants live in poverty[49]. These factors all contribute to inequalities in health throughout the country. The under-five mortality rate in the first quintile, as seen in Figure 19, is 2.4 times worse than from the fifth quintile. And, since the mortality rate is even higher in the second quintile, the difference ratio rises to 2.7. As for the differences between under-five deaths in rural and urban settings, the disparity is not as pronounced with the rate being 66 in rural areas and 45 in urban areas.

For skilled attendance at birth, a similar pattern was identified in which wealth had a bigger impact on health indicators than the location of the population. In other words, the difference ratio between the first (9.3 per cent) and fifth quintile (91.5 per cent) is almost ten times worse, compared to the ratio between rural (30 per cent) and urban (66 per cent) at 2.2 times worse. As seen in Figure 20, the people who can afford medically trained staff have them

attend almost 100 per cent of births, whereas the attendance of medically trained staff in the poorest part of the population drops to less than 10 per cent. The indigenous population is also suffering from disparities in MNCH. The under-five mortality rate is more than double within the indigenous population compared to the national average. For maternal health the situation is more severe. Within non-indigenous populations there is a maternal mortality ratio of 70 and within indigenous population that number is tripled. The average of indigenous populations of 211 is almost double the national average of 110. This suggests that the indigenous population of mothers, which comprises almost half of the population, is at a much greater risk of dying than the rest.

There could be several reasons for the health issues in impoverished, rural and indigenous communities in Guatemala. Access could be an issue for certain populations because of the difficulty for some to travel from remote communities, get transportation or lack of knowledge on when to seek medical attention. The National Survey on Living Conditions (ENCOVI 2000) reported that only 10.7 per cent of the adult population seeking healthcare travels less than 60 minutes to obtain health services[50]. Therefore, a minimal part of the population has easy access to health services. Another factor that also creates a barrier for child and women to receive treatment are the costs of treatment. There are the direct costs that poor families cannot afford to pay for services, but also the opportunity costs of giving up time that would be spent working on chores or going to work in order to seek treatment. In summary, Guatemala's health system needs to address inequalities based on ethnicity and income to ensure all women and children have an equal opportunity for a healthy life.

| PERCENTAGE OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL | | | | | |
|---|---|---|---|---|---|
| First quintile | Fifth quintile | Difference ratio | Rural | Urban | Difference ratio |
| 68 | 6 | 11.3 | 15 | 47 | 3.13 |

**Table 8.** Percentage of births attended by skilled personnel in Haiti. Source: WHO Country Health Profile – Haiti, 2012.


**Figure 19.** "Guatemala: Inequalities in Health, Nutrition and Population" Source: World Bank, 2003

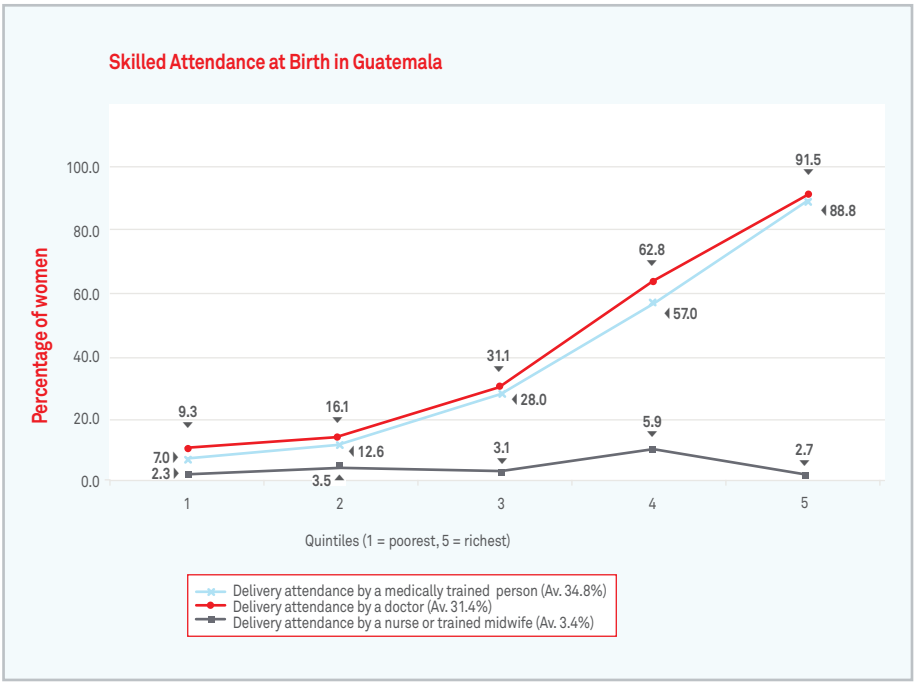


**Figure 20.** "Guatemala: Inequalities in Health, Nutrition and Population", Source: World Bank, 2003

# CASE STUDY

## Guatemala: Targeting indigenous populations through MNCH

The Guatemalan Red Cross has implemented the Mother and Child Health Care Program, with support from the Norwegian Red Cross, since 2005 following the devastation of tropical storm Stan in southwestern Guatemala. The program was expanded to the primarily indigenous communities in the northwestern region of Guatemala where rates of maternal and infant mortality are the highest.

Maternal and child health programming is a priority given the high levels of vulnerability and inequality that exist, particularly amongst the indigenous populations. Statistics for Guatemala indicate that 75% of the indigenous population lives in poverty, 27% of which live in extreme poverty. They live often in remote communities with a lack of basic infrastructure and services. Women in particular have limited access to health services due to the far distances needed to travel to seek care, the lack of access or control over economic resources to travel the distance, the need to be accompanied by the male head of the household, in addition to the discrimination and lack of respect for culture and beliefs that the indigenous face at clinics.

The program covers ten different communities in San Marcos and Quetzaltenango in the South West part of the country. Fifteen volunteers, giving support 19 days per month, help Community Volunteers to implement mother and child health care activities. In order to improve health practices, the project aims to create a culture of knowledge sharing between the women and communities leaders in the villages on how to prevent undernourishment and other child diseases, how to care for pregnant women, and how to carry out health promotion activities. One of many activities of the project is to form Mother Support Groups, where certain women volunteer to be Counseling Mothers, whose role is to lead support groups, inform other women of the community about healthy practices, and to conduct house visits and provide direct follow up with women who need additional support. In the Mother Support Groups, a Guatemalan Red Cross volunteer and a Counseling Mother meet with a group of women to discuss topics such as breastfeeding, complementary feeding, vaccination, family planning and danger signs. Another activity is the Growth Monitoring and Promotion sessions where Guatemalan Red Cross Volunteers, along with the Counseling Mothers, weigh the children, measure their development and promote healthy behaviors. Since the project began, participating mothers report that the health of their children has improved.

Santos Rufina García Lopez (41) has five children and lives in Tuichilupe, a small village of Comitancillo, San Marcos. She comes from a poor, Mayan family from the Guatemalan Western Highlands. She married when she eighteen years old and had four children. Her husband died five years ago, leaving her alone with her kids. "I was very sad for a long time", says Santos Rufina. She is now part of the Guatemalan Red Cross Mother and Child Health Care Project and is the Community Counseling mother for her village.

Mothers attending a mothers support group session

Santos Rufina with husband Ramiro Perez and Juanita, their three year old daughter.
Photos courtesy of Mari Aftret/Røde Kors MØRTVEDT, Norwegian Red Cross.

Santos Rufina is now remarried and with her husband Ramiro Perez (40) has a three year-old daughter. "It means a lot to me that I can help others and show them everything the Red Cross has taught me. I am also so grateful for everything the Red Cross is doing with the Health Committee because in my heart I know that the activities they plan would improve the way we live".

One of the things that surprised Santos is that a couple can decide and plan the number of children they have. Now, as a Counseling Mother, she is able to speak with other women, but more importantly, she can talk with her sixteen years old daughter not only about the importance of delaying her first sexual relation but also about family planning methods.

Juanita Florencia Pérez García (3) is Santos Rufina youngest child. Her mother explains that Juanita use to be malnourished but has gained weight since they joined the project. Santos Rufina, her husband, four children (16, 15, 12, 7) and Juanita are happy together. The mother says: "Juanita is a lot healthier now than she was before the Red Cross came to help us with the lessons, the growth monitoring and the home visits. I am so grateful,–that she likes to go with me to the project because she plays with the other children that come with their parents. My daughter is now a lot stronger than before and I am able to give her better food than before. She was born underweight, but now she is healthy and happy. I am very glad. My husband is nice to me and my family. He helps us and my life is so much better with him and the help of the Red Cross Volunteers".

The Mother and Child Health program of the Guatemalan Red Cross is very important for addressing the needs and inequalities of women in Guatemala and is helping mothers to increase their knowledge and improve their family practices so they can live a healthier and more productive life.

## Bolivia

Health in Bolivia has been a challenge due to social exclusion caused by many factors. According to a PAHO study on Bolivia, the rural population is excluded from adequate services by factors such as female illiteracy, poverty, geographic barriers, gender inequality, historic discrimination against the indigenous people and inadequate housing, which account for 60 per cent of the exclusion[51]. Additionally, Bolivia has the largest estimated indigenous population in the Americas, with 62 per cent[52] of the population being Quechua, Aymara, Chiquitano or Guaraní. Inequalities are increased within these populations because poverty is more severe and extreme among indigenous populations[53]. When looking at MNCH data, it is evident that these disparities exist within the country. For example, as seen on Figure 21, infant mortality has historically and is currently higher in indigenous departments.

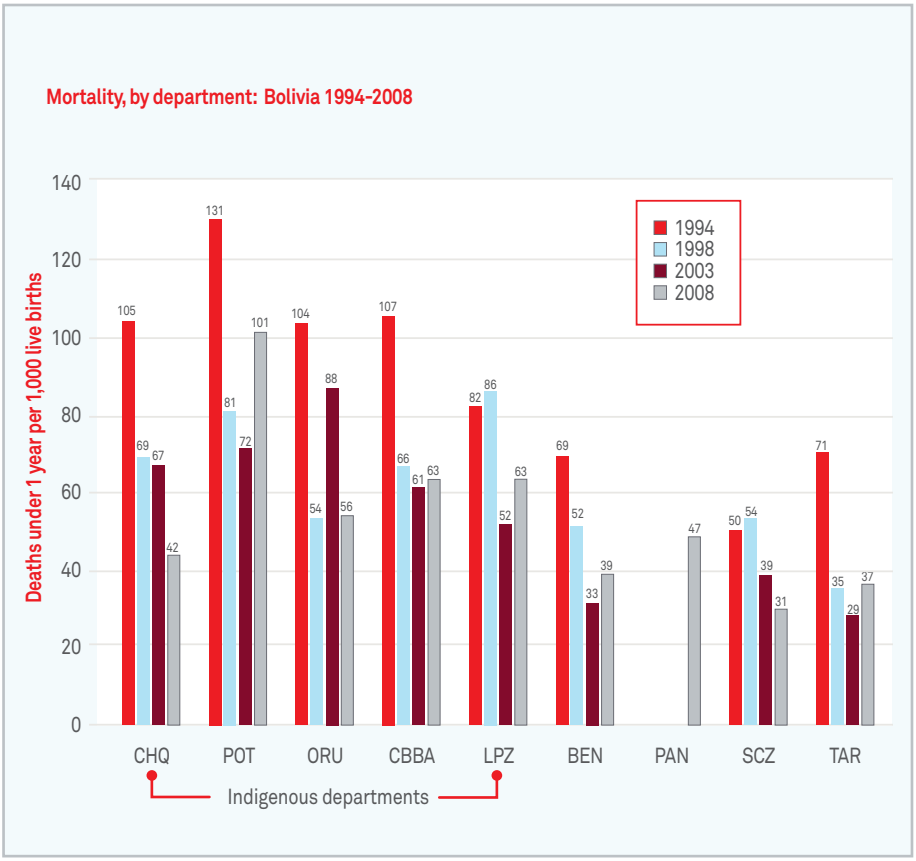


**Figure 21.** Mortality rate by department in Bolivia 1994-2008. Source: FOCAL - Prepared by Erika Silva and Ricardo Batista, 2010.

The difference ratio between the highest mortality ratio, Potosi at 101, and the lowest, Santa Cruz at 31, is 3.3 times worse. The statistics for under-five mortality are very similar with Potosi at 72 and Santa Cruz at 21. As for maternal mortality, Potosi also has the highest ratio in Bolivia with 352 deaths per 100 000 live births. That amount compared to the lowest, Tarjia with a ratio of 124, gives a difference ratio of 2.8 between the worse and the best region in Bolivia. This means that children in Potosi have over twice the risk of dying before their fifth birthday compared to children in Santa Cruz. Certain factors that could determine the disparities in health between different departments are poverty and ethnic groups. When looking at overall wealth, the difference is more extreme between the first (116) and fifth (31) quintile for under-five deaths — 3.7 times worse. The departments with the highest poverty rate are Potosi, Chuquisaca and Pando, while Santa Cruz and Tarija present the lowest rates[54]. In Potosi, in 2001, the extreme poverty rate was 67 per cent[55] higher than the national average. This poverty was one of the causes for Potosí to have approximately 41,110 children under the age of five suffering from chronic malnutrition in 2008[56]. Also, the departments of La Paz, Cochabamba, Potosí, Oruro and Chuquisaca have the highest indigenous concentration[57]. This indicates that the health disparities are occurring in the poorest regions as well as areas that have a concentration of indigenous populations. These populations are being left behind by the health system and, therefore, the most vulnerable people in Bolivia, such as women and children, are suffering even more because of social exclusion.

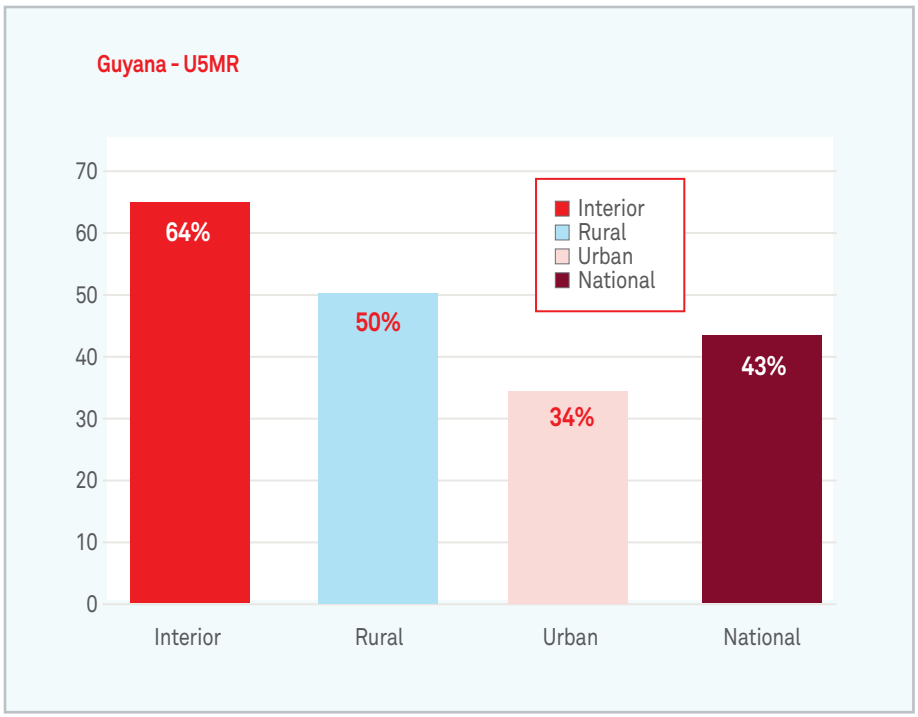


**Figure 22.** Guyana and Suriname, Country Programme Document 2012-2016 Source: UNICEF, 2011.

## Guyana

Guyana is experiencing disparity in health and other areas due to rural isolation of certain communities. Additionally, the majority of Guyana's poor live in rural areas, while extreme poverty is concentrated in the interior regions. Roughly 29 per cent of the total population can be further classified as being extremely poor. The interior, also called the hinterland region, is mostly rural and is sparsely populated with limited health infrastructure. The Amerindian group, representing 9 per cent of the total population, mostly lives in the hinterland and this is the group most affected by poverty and having the most issues with social inclusion and equity[58].

On the other hand, almost 90 per cent of Guyana's population lives along a narrow strip of the coastline, which is the administrative, agricultural, commercial and industrial hub of the country[59]. When looking at child mortality, Region 8 (Potaro-Siparuni) has the highest rate (99) and Region 2 (Pomerron-Supenaam) the lowest rate (42). Region 8 is located in the interior and has the lowest population in the country with 10,095 people[60]. A World Bank poverty study based on the 2002 Population and Housing Census classified Region 8 as part of the "bottom or very poor group" and ranked it as the poorest among all[61]. Being so sparsely populated and in a situation of extreme poverty creates tremendous challenges for access to healthcare. What makes access even more challenging in Guyana is the high rate of 200 patients per doctor, and that 80 per cent of the doctors are situated in region 4, the wealthiest region[62]. This makes access to doctors and healthcare services a big issue in the hinterland region because the services and human resources are simply not there. According to the Ministry of Health (MoH), the national averages for stunting are 10 per cent but rates are as high as 25 per cent among Amerindian Guyanese children[63]. This confirms not only a geographical exclusion from health but also a disparity in health according to ethnicity.

The under five mortality rate (U5MR) within different regions also shows signs of disparity. As seen in Figure 22, in 2009 the U5MRin the interior was the highest (64), followed by rural (50) and then urban (34). This signifies that children from the interior have almost twice the risk of dying then children from urban areas yet, as previously mentioned, the access to healthcare services is very limited in the interior. The disparity in Guyana also contributes to the high maternal mortality rate. The percentage of births attended by health personnel is only 76.5 per cent in the hinterland compared to the national level of 92 per cent[64]. Women are also more at risk to contract HIV/AIDS in the interior because knowledge of HIV/AIDS prevention is only 89 per cent, compared to the 97 per cent national average[65]. In summary, disparity in health in Guyana is quite particular. It is not solely based on wealth, ethnicity or rural/urban trends but is focused on one particular geographic region — the interior. The hinterlands are home to Amerindians, impoverished populations and rural inhabitants. With a general lack of access and more specifically the lack of health infrastructure, services and staff, this region is suffering from exclusion. There must be a greater focus on this region in the coming years to ensure the well-being of the populations living within it.

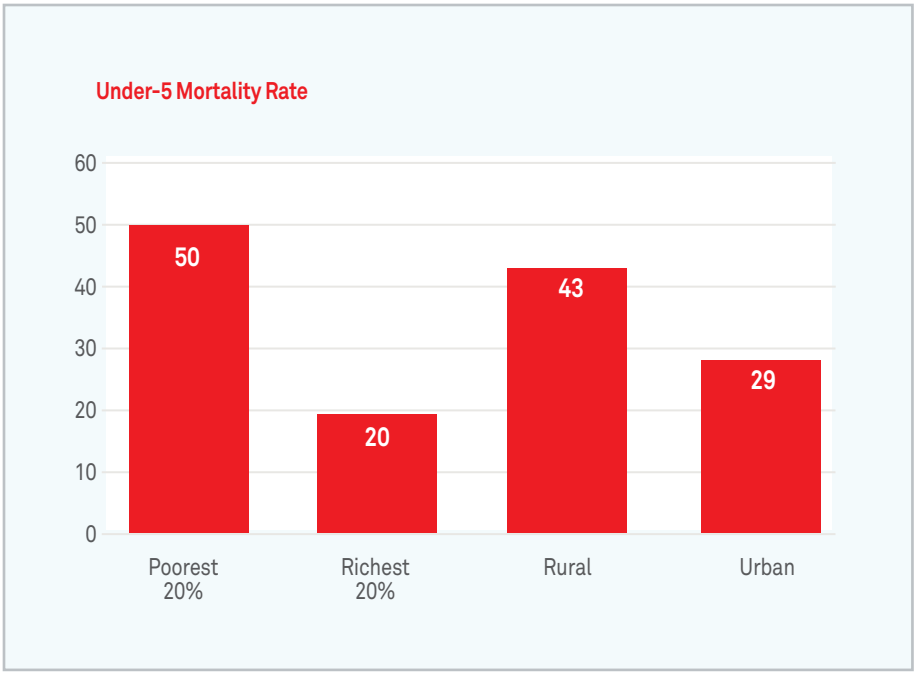


**Figure 23.** Under- Five Moartility rate in Honduras. Source: WHO, 2011

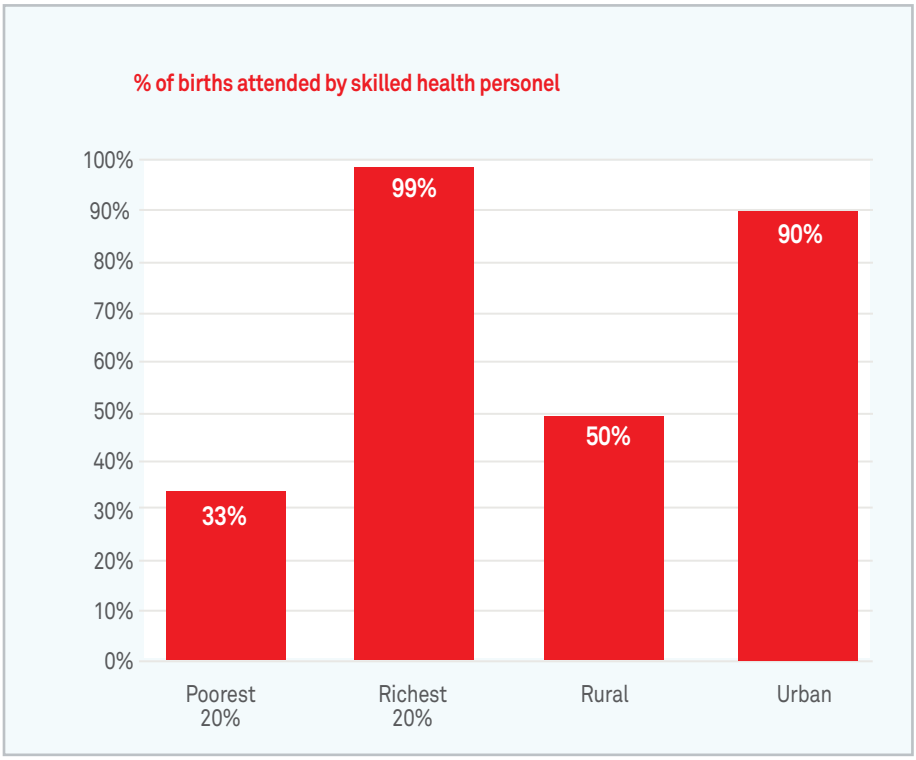


**Figure 24.** Percentage of births attended by skilled personnel. Source: WHO, 2011.

## Honduras

Honduras has a very diverse population with eight distinct ethnic groups including several indigenous and afro-descendant populations. The ethnic population accounts for 460 000 inhabitants; however, they live in some of the most deprived areas in Honduras[66]. Honduras is also one of the poorest countries in the region: 22.7 per cent of the population in 2007 was living in households with per capita income of $1 or less per day and 80 per cent of them were living in rural areas[67]. These determinants are affecting the access to health services in Honduras. For example, the U5MR is the highest (61) in the department of Copán and the lowest (23) in the San Pedro Sula metropolitan area, which results in a difference ratio of 2.7. This means that in Copán, which is much more rural, children under the age of five are at a triple risk of mortality compared to San Pedro Sula — an urban centre that is the second biggest city after Tegucigalpa[68]. Mayas Chorti is also the most prominent indigenous population in the Copán department[69]. Additionally, the U5MR for the poorest 20 per cent of the population is 50 and for the richest 20 per cent it is 20, which results in a difference ratio of 2.5. As Figure 24 demonstrates, the difference between rural and urban inhabitants is not as pronounced as the difference between incomes; however, the disparity still exists.

Figure 23 shows the disparity in the percentage of births attended by skilled health personnel. Mothers in the 20 per cent of the poorest part of the population only have 33 per cent attendance compared to 99 per cent in the 20 per cent of the richest population. This situation is partly due to the fact that a large part of the poor population lives in remote areas with difficult access. Many poor indigenous communities, such as the Chorti, live in areas in the Copán and Ocotepeque departments where road access is difficult[70]; which poses many challenges for those communities in accessing a health centre.

According to the *2005-2006 Honduras Demographic and Health Survey*, 80 per cent of women in the poorest quintile of the population reported issues with accessing healthcare due to a lack of funds for transportation (See Figure 25). This indicates that a significant barrier is created between poor and rural communities to access healthcare. These difficulties cause as much as 58 per cent of women living in rural areas with six or more children to have home deliveries[71], which put them at high risk when giving birth and also indicates a lack of access to health services during birth. In Honduras, the lack of access for maternal care is coupled with low knowledge of diseases. A World Bank estimate in 2006 suggested that only 30 per cent of the female population aged 15–24 had comprehensive, correct knowledge about HIV. In recent years, the government has identified these disparities and projects from the Inter-American Development Bank (IDB) and the Canadian Red Cross have supported the construction of health centres in remote and rural areas. However, efforts must continue to ensure the achievement of MDG 4 and 5 by addressing financial and geographical barriers.

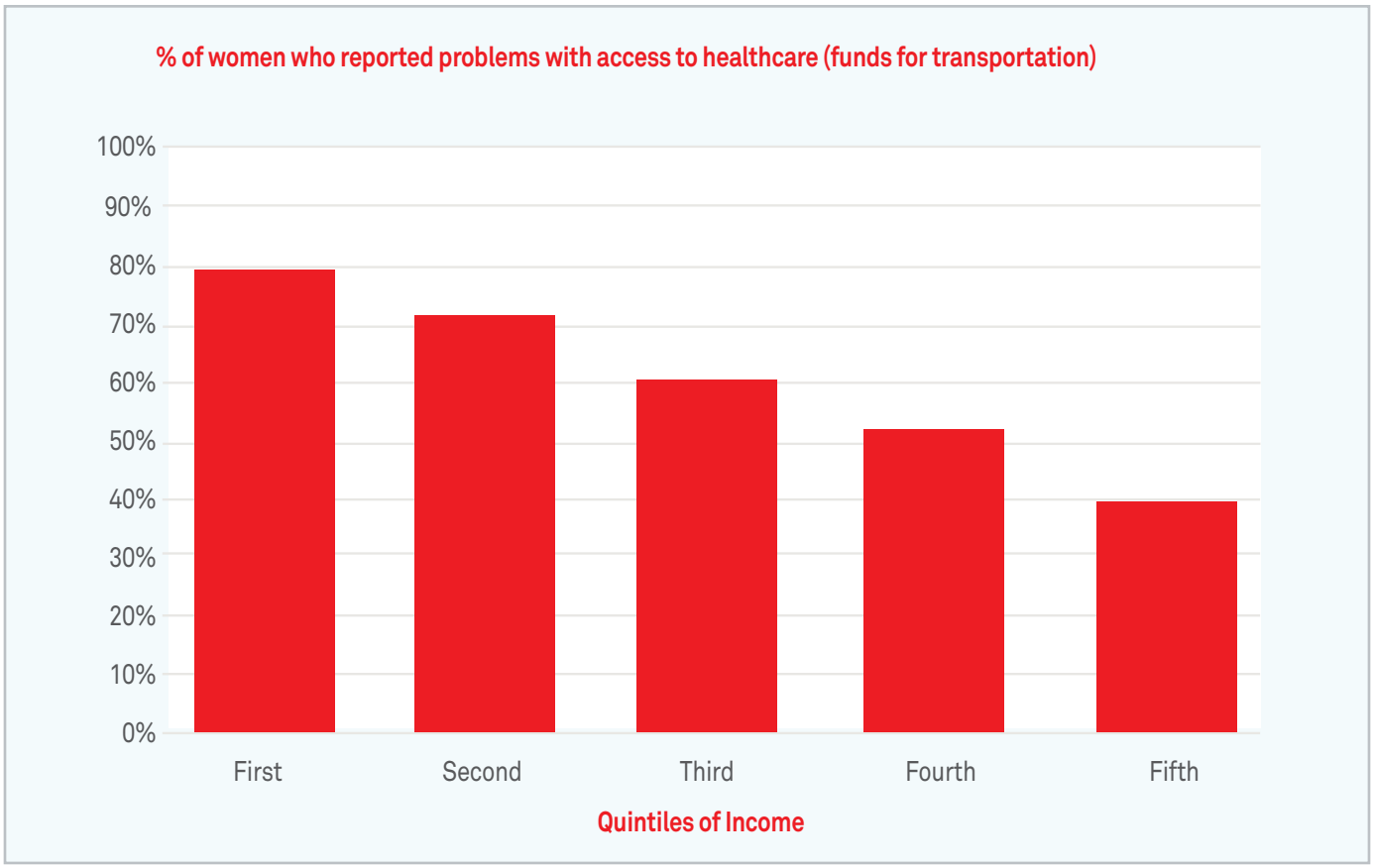


**Figure 25.** Honduras Demographic and Health Survey, Data Source: 2005-2006

# CASE STUDY
## Colombia: Working in MNCH in a conflict area

In Colombia the socio-political situation, economic conditions and natural hazards come together dramatically at times, creating considerable social vulnerability. Although Colombia is emerging as a middle income country, it is one of the most unequal countries in the world. National statistics therefore do not reflect areas of the country, like municipalities along the pacific coast of Colombia, with substantially higher rates of child mortality, maternal mortality and other health indicators than the national average. These areas are often also severely affected by the conflict, and authorities have little or no access. This positions the Colombian Red Cross as sometimes the only organization that can combine its unique access with its focus on community based work.

Since 2010, the Colombian Red Cross, with support from the Norwegian Red Cross, has been working in the municipality of Guapi, department of Cauca on the pacific coast of Colombia, providing healthcare to vulnerable communities located along the Napi, Guapi and San Francisco rivers. The communities affected by the internal conflict Colombia have experienced it for almost 50 years, impacting their health and access to health services. The long period of conflict, combined with an overall lack of resources and public health services, makes it very difficult for families to travel to the municipal capital to receive required healthcare. As a consequence, a large percentage of the population has not received any type of healthcare for years. Pregnant women for example often receive no prenatal controls in a health institution and the majority of them have their births at home with traditional birth attendants that have received little or no formal training.

As a response to this situation, the Colombian Red Cross operates mobile health units (MHUs) along the rivers in Guapi. The MHUs deploy for up to twelve (12) days at a time, visiting two to three different communities for three (3) days each. Communities close to where the MHU is located walk or take canoes to the MHU to receive dental and medical care, along with psychological support and basic healthcare training. Community health committees are trained to provide basic first aid, prevention and treatment of illnesses such as diarrhea and respiratory infections, and detection of key signs of health risk. The Colombian Red Cross project team, consisting of health professionals and volunteers, also work with youth by providing them with information on sexual and reproductive health and supports local community councils with drafting project proposals for presentation to local government authorities.

Photos courtesy of the Norwegian Red Cross.

**Maternal and child health is a main focus of the project which includes a diversity of activities:**

**Maternal health:**

- Training about danger signs during pregnancy that require urgent clinical care
- Training of traditional birth attendants and provision of a safe delivery kit
- Promotion of prenatal control
- Training on reproductive health and family planning

**Child health:**

- Training of the health committees and families on prevention and treatment of common childhood illnesses such as respiratory infections and diarrhea
- Setting up community oral rehydration and respiratory infection centers managed by the health committees
- Monitoring of the growth of children by the community and referrals of children with unsatisfactory growth to the municipal nutrition center

It is unlikely that the Colombian government will provide health services in the near future to these communities and the Colombian Red Cross, over the long term, may not have the capacity to continue to support the MHUs. The project prioritized community mobilization and health promotion and education to support longer term sustainability of the project in terms of improved health knowledge, behaviour change and community organization.

# CASE STUDY
## Health Disparities in Panama

Panama can be considered an example for the region as far as achieving the MDGs. Since 2005, Panama has been considered as having high human development on the Human Development Index and within Latin America it has ranked eighth. The government has committed to health by spending 6.4 per cent of its Gross Domestic Product (GDP) in public health[72]. Thanks to this funding, it has managed to lower its U5MR from 31 in 1990 to 23 in 2010 and its maternal mortality ratio from 200 in 1980 to 60 in 2010[73], below the regional average of 107.

However, despite this great progress to achieve the MDGs, Panama suffers from great inequalities in income, which cause even bigger disparities in health. Based on MoH statistics, it is evident that women and children have been particularly affected by these inequalities in indigenous districts. For maternal mortality, out of the twelve provinces, the three indigenous provinces — Kuna Yala, Ngobe Bugle and Embera Wounaan — are ranked last (see Figure 26). The Embera Wounaan province, home to the Embera indigenous people, is ranked last with a ratio of 433 deaths per 100 000 live births. This suggests more than a twelve-fold difference between this province and Chiriquí (34) and Panama (41) which have the lowest ratios. A ratio of 433 is significantly higher than the global average of 260 (WHO 2008) and the regional averages of all global regions but Africa.

The disparity in child health is also very severe in Panama. The U5MR in the best region, Los Santos, is at 12.4 and rises up to 62.3 in the indigenous district of Ngobe Bugle. This means that indigenous Ngobe Bugle children are five times more at risk to die before their fifth birthday than those in the part of Panama with the best U5MR. Additionally, the U5MR in all three indigenous districts is higher than the regional average of 23.

Overall, the indigenous populations of Panama are experiencing severe disparities in health, and disparities specifically affecting women and children. Even though the government has invested in health, most of the funds are being directed towards infrastructure in urban areas and not to provide better healthcare service in indigenous districts. With more than 80.5 per cent of Panama's indigenous people living below the poverty line, more needs to be done to ensure that they have access and can afford proper health services. Panama is developing fast as an international hub for services with the Panama Canal[74]. However, Panama's most vulnerable populations, the indigenous, are suffering from mortality rates worse than many less developed countries.

Overall, from the disparity analysis, it can be concluded that in most cases, income was the biggest determinant in health. The differences between the first and fifth quintile are generally higher than between rural and urban populations. What has been made evident by this analysis is that despite the lower mortality rates and higher rates of access to healthcare services in the Americas, compared to other parts of the developing world, disparities in health are present. This inequity is affecting the most vulnerable populations which, in the case of the Americas, are the poor and ethnic minorities such as the indigenous. This kind of disparity reveals the inequality in access to healthcare and services for these vulnerable people and puts women and children from these groups more at risk of mortality and morbidity.

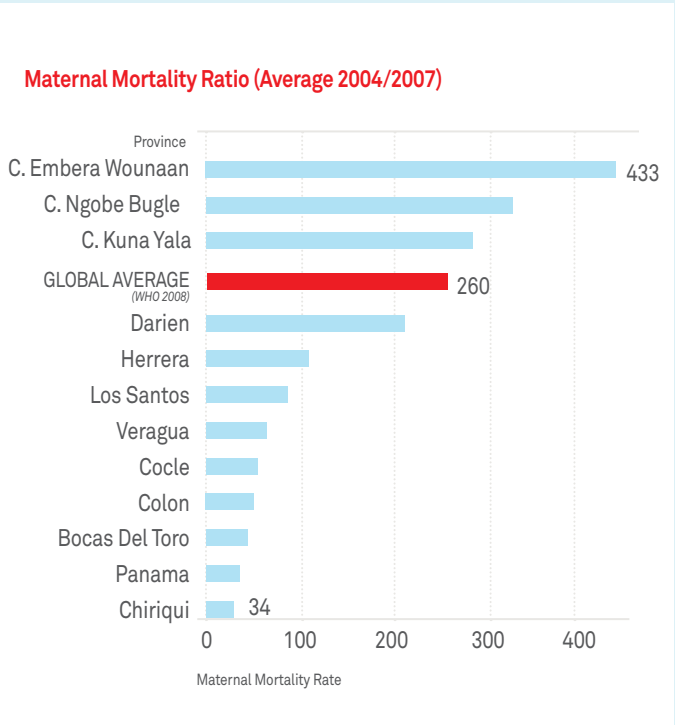


**Figure 26.** Maternal mortality per province in Panama. Source: Ministry of Health (Panama), 2008.

# NEXT STEPS

Red Cross Red Crescent is very dedicated to improving the health and well-being of vulnerable people, as stated in *Strategy 2020*. Taking into consideration the populations targeted by the MDGs, some of the most vulnerable people in the world are women and children. The status of MNCH in the Americas has been improving in the past decades; however, great disparities have formed in health systems around the region. These disparities have proved to create many challenges for the Red Cross Red Crescent. Attending to mothers and children in some countries requires addressing social exclusion, cultural practices and access issues amongst other challenges.

Nevertheless, Red Cross Red Crescent is working with governments and external partners to ensure that the best possible care is available for mothers and children. Some MNCH projects have been active since 2006 and many are currently looking to extend their work. Tools and methodologies such as CBHFA and IMCI have permitted National Societies to implement MNCH activities and increase their capacity to do so. Now, all that is left is to support National Societies in continuing these MNCH initiatives.

All Red Cross Red Crescent actors including Partner National Societies, National Societies and the IFRC need to revise their efforts and ensure that they are supporting the countries that are most in need while providing the services that contribute the most to decreasing mortality among women and children. The steps the Red Cross Red Crescent is taking towards addressing MNCH in the Americas is a way forward for achieving the MDGs by 2015 and, beyond that, helping societies develop through healthy women and children.

# ANNEX A – SCALE AND RESULTS OF STATISTICAL ANALYSIS OF MNCH INDICATORS

| INDICATOR | 5 POINTS | 4 POINTS | 3 POINTS | 2 POINTS | 1 POINT |
|---|---|---|---|---|---|
| Under-five mortality rate | 200 + | 100 to 199 | 50 to 99 | 10 to 50 | n/a |
| Under-one mortality rate | 41 + | 31 to 40 | 21 to 30 | 11 to 20 | n/a |
| Neonatal deaths | 26 + | 19 to 25 | 13 to 18 | 7 to 12 | n/a |
| Under-five underweight | 17 + | 13 to 16 | 9 to 12 | 5 to 8 | n/a |
| Under-five stunted | 51 + | 41 to 50 | 31 to 40 | 21 to 30 | 15 to 20 |
| DPT immunization | less than 65 % | 66 to 70 % | 71 to 75 % | 76 to 80 % | 81 to 85 % |
| Maternal mortality ratio | 200 + | 151 to 200 | 101 to 150 | 81 to 100 | 60 to 80 |
| Antenatal — at least four times | 1 to 40 % | 41 to 60 % | 61 to 70 % | 71 to 80 % | 80 to 85 % |
| Skilled attendant at birth | 1 to 40 % | 41 to 60 % | 61 to 70 % | 71 to 80 % | 80 to 85 % |
| Unmet need for family planning | 29 % + | 22 to 28 % | 15 to 21 % | 8 to 14 % | 1 to 7 % |
| Contraceptive prevalence rate | less than 40 % | 41 to 45 % | 46 to 50 % | 51 to 55 % | 56 to 60 % |

## Calculation of priority countries for MNCH based on statistics in each category

| POSITION | COUNTRY | TOTAL POINTS | CHILD INDICATOR TOTAL | MATERNAL INDICATOR TOTAL | UNDER-FIVE MORTALITY RATE | UNDER-ONE MORTALITY RATE | NEONATAL MORTALITY RATE | UNDER-FIVE UNDER-WEIGHT | UNDER-FIVE STUNTED | DPT IMMUNIZATION | MATERNAL MORTALITY RATIO | ANTENATAL - AT LEAST FOUR TIMES | SKILLED ATTENDANT AT BIRTH | UNMET NEED FOR FAMILY PLANNING | CONTRACEPTIVE PREVALENCE RATE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Haiti | 49 | 26 | 23 | 4 | 5 | 5 | 5 | 2 | 5 | 5 | 4 | 4 | 5 | 5 |
| 2 | Guatemala | 30 | 15 | 15 | 2 | 3 | 2 | 4 | 4 | 0 | 3 | n/a | 4 | 4 | 4 |
| 3 | Bolivia | 24 | 12 | 12 | 3 | 5 | n/a | 0 | 2 | 2 | 4 | 2 | 2 | 3 | 1 |
| 4 | Guyana | 23 | 13 | 10 | 2 | 3 | 4 | 3 | 1 | 0 | 5 | n/a | 1 | n/a | 4 |
| 5 | Honduras | 20 | 11 | 9 | 2 | 2 | 3 | 2 | 2 | 0 | 3 | 0 | 3 | 3 | 0 |
| 6 | Ecuador | 18 | 10 | 8 | 2 | 2 | 2 | 2 | 2 | 0 | 3 | 4 | 1 |  | 0 |
| 7 | Nicaragua | 17 | 11 | 6 | 2 | 3 | 2 | 2 | 2 | 0 | 2 | 2 | 2 | 0 | 0 |
| 8 | Suriname | 15 | 9 | 6 | 2 | 3 | 2 | 2 | 0 | 0 | 2 | n/a | 0 | 0 | 4 |
| 9 | Belize | 15 | 8 | 7 | 2 | 2 | 2 | 0 | 2 | 0 | 2 | n/a | 0 | n/a | 5 |
| 10 | El Salvador | 15 | 9 | 6 | 2 | 2 | 2 | 2 | 1 | 0 | 3 | 2 | 1 | 0 | 0 |
| 11 | Trinidad and Tobago | 13 | 9 | 4 | 2 | 3 | 4 | 0 |  | 0 | 0 | 0 | 0 | n/a | 4 |
| 12 | Mexico | 11 | 7 | 4 | 2 | 2 | 2 | 0 | 1 | 0 | 2 | 0 | 0 | 2 | 0 |
| 13 | Panama | 11 | 10 | 1 | 2 | 2 | 2 | 2 | 2 | 0 | 1 | 0 | 0 | 0 | n/a |
| 14 | Saint Lucia | 10 | 10 | 0 | 2 | 2 | 2 | 3 | 1 | 0 | n/a | 0 | 0 | 0 | n/a |
| 15 | Dominican Rep. | 10 | 8 | 2 | 2 | 3 | 3 | 0 |  | 0 | 2 | 0 | 0 | 0 | 0 |
| 16 | Paraguay | 10 | 8 | 2 | 2 | 3 | 2 | 0 | 1 | 0 | 2 | 0 | 0 | n/a | 0 |
| 17 | Peru | 9 | 6 | 3 | 2 | 2 | 0 | 0 | 2 | 0 | 2 | 0 | 1 | 0 | 0 |
| 18 | Barbados | 9 | 8 | 1 | 2 | 2 | 2 | 2 | 0 | 0 | 1 | n/a | 0 | n/a | 0 |
| 19 | Venezuela | 8 | 7 | 1 | 2 | 2 |  | 0 | 1 | 2 | 1 | n/a | 0 | n/a | n/a |
| 20 | Jamaica | 8 | 6 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 2 |  | 0 | 0 | 0 |
| 21 | Colombia | 8 | 6 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 |
| 22 | Argentina | 7 | 6 | 1 | 2 | 2 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| 23 | Uruguay | 6 | 6 | 0 | 2 | 0 | 2 | 2 | 0 | 0 | 0 | n/a | 0 | n/a | 0 |
| 24 | Bahamas | 6 | 6 | 0 | 2 | 2 | 2 | n/a | n/a | 0 | 0 | n/a | 0 | 0 | n/a |
| 25 | Brazil | 6 | 6 | 0 | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | n/a | 0 |
| 26 | Saint Vincent | 6 | 6 | 0 | 2 | 2 | 2 | n/a | n/a | 0 | n/a | n/a | 0 | n/a | n/a |
| 27 | Grenada | 4 | 4 | 0 | 2 | 0 | 2 | n/a | n/a | 0 | n/a | n/a | 0 | n/a | n/a |
| 28 | Dominica | 4 | 4 | 0 | 2 | 2 | 0 | n/a | n/a | 0 | n/a | n/a | 0 | n/a | n/a |
| 29 | Canada | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | n/a | 0 | n/a | 0 |
| 30 | Costa Rica | 2 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | n/a | 0 | n/a | n/a |
| 31 | USA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | n/a | 0 | 0 | 0 |
| 32 | Chile | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | n/a | 0 | n/a | 0 |
| 33 | Cuba | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | n/a | 0 | n/a | 0 |
| 34 | Barbuda and Antigua | 0 | 0 | 0 | 0 | 0 | 0 | n/a | n/a | 0 | n/a | n/a | 0 | n/a | n/a |
| 35 | Saint Kitts and Nevis | 0 | 0 | 0 | 0 | 0 |  | n/a | n/a | 0 | n/a | n/a | 0 | n/a | n/a |

# ANNEX B – HDI VALUE

| HDI RANK | COUNTRY | YEAR: 2011 |
|---|---|---|
| .. | Very high human development | |
| .. | High human development | |
| .. | Medium human development | |
| .. | Low human development | |
| 44 | Chile | 0.805 |
| 45 | Argentina | 0.797 |
| 47 | Barbados | 0.793 |
| 48 | Uruguay | 0.783 |
| 51 | Cuba | 0.776 |
| 53 | Bahamas | 0.771 |
| 57 | Mexico | 0.77 |
| 58 | Panama | 0.768 |
| 60 | Antigua and Barbuda | 0.764 |
| 62 | Trinidad and Tobago | 0.76 |
| 67 | Grenada | 0.748 |
| 69 | Costa Rica | 0.744 |
| 72 | Saint Kitts and Nevis | 0.735 |
| 73 | Venezuela (Bolivarian Republic of) | 0.735 |
| 79 | Jamaica | 0.727 |
| 80 | Peru | 0.725 |
| 81 | Dominica | 0.724 |
| 82 | Saint Lucia | 0.723 |
| 83 | Ecuador | 0.72 |
| 84 | Brazil | 0.718 |
| 85 | Saint Vincent and the Grenadines | 0.717 |
| 87 | Colombia | 0.71 |
| 93 | Belize | 0.699 |
| 98 | Dominican Republic | 0.689 |
| 104 | Suriname | 0.68 |
| 105 | El Salvador | 0.674 |
| 107 | Paraguay | 0.665 |
| 108 | Bolivia (Plurinational State of) | 0.663 |
| 117 | Guyana | 0.633 |
| 121 | Honduras | 0.625 |
| 129 | Nicaragua | 0.589 |
| 131 | Guatemala | 0.574 |
| 158 | Haiti | 0.454 |

# ANNEX C – MNCH SURVEY TO NATIONAL SOCIETIES

## Maternal, Newborn, Child Health (MNCH) Questionnaire / Cuestionario de Salud materna, neonatal, e infantil (SMNI) / Sondage portant sur santé maternelle, néonatale et infantile (SMNI)

Please fill out this survey about MNCH in the Americas. This survey should take about 10–15 minutes to complete. If you have any questions, please email Sonia Komenda at *sonia.komenda@ifrc.org* Por favor llenar este cuestionario sobre SMNI en las Americas. Este cuestionario debería tomar alrededor de 10–15 minutos para completar. Si tiene alguna pregunta, favor enviar un correo electrónico a Sonia Komenda (*sonia.komenda@ifrc.org*). S'il-vous-plaît remplir ce sondage sur la SMNI dans les Amériques. Ce sondage devrait prendre environ 10–15 minutes à compléter. Si vous avez des questions, s'il-vous-plaît envoyer un courriel à Sonia Komenda à *sonia.komenda@ifrc.org*

### * Required

National Society / Sociedad Nacional / Société nationale * _____

Name / Nombre / Nom * _____

Position/ Posición / Position * _____

Contact Information/ Información de contacto/ Coordonnées *

Email/ Telephone // Correo/ Teléfon // Courriel/ Téléphone _____

_____

1. Do you have a national health plan or a strategic plan that includes health? / ¿Tienen un plan de salud o una estrategia nacional que incluye salud? / Avez-vous un plan de santé ou une stratégie nationale qui inclut la santé? *
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non

2. Are you implementing MNCH activities or programmes? / ¿Están implementando SMNI en sus actividades or programmes? / Mettez-vous en oeuvre la SMNI dans vos activités ou programmes? *
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non
   - ☐ N/A

3. a) Do you have a person who is responsible for maternal and child health activities in your National Society? / ¿Tienen una persona responsable de los actividades de salud materna e infantil en su Sociedad Nacional? / Avez-vous une personne responsable des activités en santé maternelle et infantile dans votre Société nationale? *
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non

   b) If yes, provide contact information / Si sí, indique los datos de contacto / Si oui, s'il-vous-plaît fournir les coordonnées. Name and Email/ Telephone --- Nombre y Correo/ Teléfono --- Nom et Courriel/ Téléphone

_____

4. a) What activities are you implementing in maternal and child health and on what scale? / ¿Qué actividades están implementando en la salud materno-infantil y en qué escala? / Quelles activités avez-vous mis en oeuvre en santé maternelle et infantile et à quelle échelle? *

| | NATIONALLY/NIVEL NACIONAL/ NIVEAU NATIONAL | REGIONALLY/ NIVEL REGIONAL/ NIVEAU RÉGIONAL | PNS REGIONAL PROJECTS/ PROYECTOS REGIONALES DE SNP/ PROJETS RÉGIONAUX DE SNP | NONE/ NINGUNO/ AUCUN |
|---|---|---|---|---|
| Immunisation/ Inmunización/ Vaccination | ☐ | ☐ | ☐ | ☐ |
| Nutrition education and support/ Educación y apoyo en nutrición/ Education et appui en nutrition | ☐ | ☐ | ☐ | ☐ |
| Child growth monitoring/ Monitoreo del crecimiento infantil/ Contrôle de la croissance des enfants | ☐ | ☐ | ☐ | ☐ |
| Prevention of mother to child HIV transmission / Prevención de la transmisión del VIH madre al niño / Prévention de la transmission du VIH de la mère à l'enfant | ☐ | ☐ | ☐ | ☐ |
| Sexual and Reproductive health/ Salud sexual y reproductiva/ Santé sexuelle et reproductive | ☐ | ☐ | ☐ | ☐ |
| Family planning/ Planificación familiar/ Planification familiale | ☐ | ☐ | ☐ | ☐ |
| Antenatal care/ Atención prenatal/ Soins prénatals | ☐ | ☐ | ☐ | ☐ |
| Referral for maternal care/ Referencia para la atención materna/ Référence pour soins maternels | ☐ | ☐ | ☐ | ☐ |
| Postnatal care/ Atención post-natal/ Soins postnatal | ☐ | ☐ | ☐ | ☐ |
| Postnatal mother and newborn visits/ Visitas a la madre y al recién nacido/ Visite postnatales à la mère et l'enfant | ☐ | ☐ | ☐ | ☐ |
| Teenage pregnancy support/ Apoyo al embarazo adolescente/ Soutien des grossesses d'adolescentes | ☐ | ☐ | ☐ | ☐ |
| Health and hygiene promotion/ Promoción de la salud y de la higiene/ Promotion de la santé et de l'hygiène | ☐ | ☐ | ☐ | ☐ |
| Other/ Otro/ Autre | ☐ | ☐ | ☐ | ☐ |

If "other", please specify/ Si "otro", por favor, especifique/ Si «autre», s'il-vous-plaît préciser. _____

_____

4. b) If you are implementing MNCH activities, name the region(s)/communities/branches you are working in/ Si están implementando actividades de SMNI, indique regiones/comunidades/filiales en las cuales están trabajando/ Si vous mettez en œuvre des activités de SMNI, nommez les régions/communautés/ filiales dans lesquelles vous travaillez. Please specify what element of MNCH is being implemented in what province/ Favor, especifique qué elementos de la SMNI se están aplicando y en qué departamento/ S'il-vous-plaît préciser quel élément de la SMNI est mis en œuvre dans quelle province.

_____

_____

_____

5. a) What activities are you implementing that support MNCH and on what scale? / ¿Qué actividades que están implementando, están apoyando la atención materno-infantil y en qué escala? / Quelles activités qui appuient la santé maternelle et infantile mettez-vous en œuvre et à quelle échelle? *

| | NATIONALLY/NIVEL NACIONAL/ NIVEAU NATIONAL | REGIONALLY/ NIVEL REGIONAL/ NIVEAU RÉGIONAL | PNS REGIONAL PROJECTS/ PROYECTOS REGIONALES/ PROJETS RÉGIONAUX | NONE/ NINGUNO/ AUCUN |
|---|---|---|---|---|
| Water, Sanitation and Hygiene promotion/ Agua y Saneamiento/ Eau et assainissement | ☐ | ☐ | ☐ | ☐ |
| Violence prevention/ Prevención de la violencia/ Prévention de la violence | ☐ | ☐ | ☐ | ☐ |
| Food Security/ Seguridad Alimentaria/ Sécurité alimentaire | ☐ | ☐ | ☐ | ☐ |
| Gender/ Género/ Genre | ☐ | ☐ | ☐ | ☐ |
| Health in Emergencies/ Salud en Emergencias/ La santé dans les situations d'urgence | ☐ | ☐ | ☐ | ☐ |
| HIV prevention and care/ Prevención y atención del VIH / Prévention et soins du VIH | ☐ | ☐ | ☐ | ☐ |
| Communicable Diseases/ Enfermedades Transmisibles/ Maladies transmissibles | ☐ | ☐ | ☐ | ☐ |
| Non-Communicable Diseases/ Enfermedades no transmisibles/ Maladies non transmissibles | ☐ | ☐ | ☐ | ☐ |
| Disaster Risk Reduction (DRR)/ Reducción de riesgos de desastres/ Réduction des risques de catastrophes | ☐ | ☐ | ☐ | ☐ |
| Psychosocial support/ apoyo psicosocial/ Appui psycho-social | ☐ | ☐ | ☐ | ☐ |
| First Aid/ Primeros Auxillos/ Premiers secours | ☐ | ☐ | ☐ | ☐ |
| Other/ Otro/ Autre | ☐ | ☐ | ☐ | ☐ |
| Other/ Otro/ Autre | ☐ | ☐ | ☐ | ☐ |

If "other", please specify/ Si "otro", por favor, especifique/ Si «autre», s'il-vous-plaît préciser. _____

_____

5. b) If you are implementing MNCH activities, name the region(s)/community/branch you are working in/ Si están implementando actividades de SMNI, indique las regiones/comunidades/filiales en las cuales están trabajando/ Si vous mettez en œuvre des activités de SMNI, nommez les régions/communautés/filiales dans lesquelles vous travaillez. Please specify what element of MNCH is being implemented in what province/ Favor, especifique qué elementos de la SMNI se están aplicando y en qué departamento/ S'il-vous-plaît préciser quel élément de la SMNI est mis en œuvre dans quelle province.

_____

_____

_____

6. a) Do you have an emergency health component within your health program? / ¿Tienen el componente de salud en emergencias dentro su programa de salud? / Avez-vous une composante de la santé en situation d'urgence au sein de votre programme de santé? *
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non
   - ☐ Other: _____

6. b) If yes, are interventions in maternal and child health considered in your disaster and crisis response? / Si sí, ¿Consideran intervenciones en salud materna e infantil en su respuesta a desastres y crisis ? / Si oui, sont des interventions en matière de santé maternelle et infantile considérées dans votre réponse aux catastrophes et aux crises?
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non
   - ☐ Other: _____

7. What is your capacity to implement MNCH activities? / ¿Cuál es su capacidad para ejecutar actividades de SMNI? / Quelle est votre capacité à mettre en œuvre des activités de SMNI? * Click all that apply/ Haga clic en todas las que correspondan/ Cliquez sur toutes les cases pertinentes
   - ☐ NS Health department/ Departamento de Salud de la sociedad nacional/ Département de la santé de la société nationale
   - ☐ Health professional on your staff/ Profesional de la salud en el personal/ Professionnel en santé membre du personnel
   - ☐ Capacity to train health workers/ Capacidad para formar a los trabajadores de salud/ Capacité de former les travailleurs de santé
   - ☐ through CBHFA / por SPAC / par PSSBC
   - ☐ Health service delivery point (health centre/ clinics - run by Red Cross)/ Puntos de entrega de servicios de salud (centros de salud / clínicas - dirigidos por la Cruz Roja)/ Point de distribution des services de santé (centers de santé / cliniques - gérés par la Croix-Rouge)
   - ☐ Other: _____

8. How likely are you to consider MNCH in your next phase/ future plans? / ¿Qué posibilidades hay que considerarán SMNI en su siguiente fase o en sus planes para el futuro? / Quelle est la probabilité que vous considériez la SMNI dans votre prochaine phase / des projets d'avenir? *

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Not likely at all/ No es probable en absoluto/ Pas du tout probable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Very Likely/ Muy probable/ Très probable |

9. In your opinion, should the Red Cross be working with government in improving access to MNCH? / En su opinión, la Cruz Roja debría estar trabajando con el gobierno en mejorar el acceso a la SMNI?/ À votre avis, la Croix-Rouge devrait-elle travailler en collaboration avec le gouvernement dans l'amélioration de l'accès à la SMNI? *
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non
   - ☐ Don't Know/ No lo sé/ Je ne sais pas

10. Is there governance support from your NS headquarters for addressing MNCH? / ¿Existe un apoyo de gobernanza de la sede de la Sociedad Nacional para abordar SMNI? / Existe-il un appui de la gouvernance du siège de votre société nationale pour aborder la SMNI? *
   - ☐ Yes / Sí / Oui
   - ☐ No / No / Non
   - ☐ Don't Know/ No lo sé/ Je ne sais pas

11. What do you think you would need if you were to implement an MNCH program? / ¿Qué piensa usted que sería necesario si fuera a implementar un programa de SMNI? / Que pensez-vous que vous auriez besoin si vous étiez à mettre en oeuvre un programme de SMNI? * Click all that apply/ Haga clic en todas las que correspondan/ Cliquez sur toutes les cases pertinentes
   - ☐ Technical support/ Apoyo técnico/ Appui technique
   - ☐ Training and capacity building/ Formación y capacitación/ Formation et renforcement des capacités
   - ☐ Project Funding/ Financiamiento del proyecto/ Financement de projets
   - ☐ Support in developing policies or procedures/ Apoyar en la elaboración políticas o procedimientos/ Appui à l'élaboration de politiques ou de procédures
   - ☐ Networking Support/ Apoyo a las Redes/ Appui aux réseaux
   - ☐ Resources mobilisation support/ Apoyo a la movilización de recursos/ Appui à la mobilisation des ressources
   - ☐ Other: _____

12. How would rate your government's commitment to MNCH? / ¿Cómo calificaría el compromiso de su gobierno para salud materna e infantil? / Comment évaluez-vous l'engagement de votre gouvernement en SMNI?

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Not committed at all/ No compromete en absoluto/ Pas du tout engagé | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Very committed/ Muy comprometido/ Très engagé |

# ANNEX D – LIST OF NATIONAL SOCIETIES THAT ANSWERED THE SURVEY

| REGION | NATIONAL SOCIETIES | RECEIVED | % PER SUB REGION |
|---|---|---|---|
| Central America | Costa Rican Red Cross | YES | 71% |
| | Guatemalan Red Cross | YES | |
| | Honduran Red Cross | YES | |
| | Mexican Red Cross | | |
| | Nicaraguan Red Cross | YES | |
| | Red Cross Society of Panama | | |
| | Salvadorian Red Cross Society | YES | |
| Latin Caribbean | Belize Red Cross Society | YES | 75% |
| | Cuban Red Cross | | |
| | Dominican Red Cross | YES | |
| | Haiti Red Cross Society | YES | |
| English speaking Caribbean | Antigua and Barbuda Red Cross | YES | 50% |
| | The Bahamas Red Cross Society | | |
| | The Barbados Red Cross Society | YES | |
| | Dominica Red Cross Society | | |
| | Grenada Red Cross Society | YES | |
| | The Guyana Red Cross Society | YES | |
| | Jamaica Red Cross | | |
| | Saint Kitts and Nevis Red Cross Society | | |
| | Saint Lucia Red Cross | | |
| | Saint Vincent and the Grenadines Red Cross | | |
| | Suriname Red Cross | YES | |
| | The Trinidad and Tobago Red Cross Society | YES | |
| South America | Bolivian Red Cross | YES | 100% |
| | Colombian Red Cross Society | YES | |
| | Ecuadorian Red Cross | YES | |
| | Peruvian Red Cross | YES | |
| | Venezuelan Red Cross | YES | |
| Southern Cone | Argentine Red Cross | YES | 60% |
| | Chilean Red Cross | YES | |
| | Brazilian Red Cross | | |
| | Paraguayan Red Cross | | |
| | Uruguayan Red Cross | YES | |

# ANNEX E – PARTNER NATIONAL SOCIETIES: MNCH-RELATED PROJECTS

| | CRC | NRC | SRC | FIRC | FRRC | AM-CROSS | BRC | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Water and sanitation (WatSan) | 1 | 1 | | | 1 | 1 | | **3** |
| Violence Prevention (VP) | 1 | | 1 | | 1 | | | **3** |
| Distaster Risk Reduction (DRR) | 1 | | | 1 | 1 | | 1 | **4** |
| HIV | | | | 1 | | 1 | 1 | **3** |
| First aid/ Community-Based Health and First Aid (CBHFA) | 1 | | | 1 | 1 | | 1 | **3** |
| Health promotion/ access | 1 | 1 | 2 | | | | | **3** |
| Food security | | | 1 | | 1 | | | **2** |
| Gender | 1 | | 1 | | 1 | | | **3** |
| Disease prevention | | | 1 | | 1 | | | **2** |
| Psycho-Social Support (PSP) | | | | | 1 | | 1 | **2** |
| Disaster preparedness | 1 | | | | | 1 | | **2** |

**Partner National Societies:**

**CRC:** Canadian Red Cross
**NRC:** Norwegian Red Cross
**SRC:** Spanish Red Cross
**FiRC:** Finnish Red Cross
**FrRC:** French Red Cross
**AmCross:** American Red Cross
**BRC:** British Red Cross

# ANNEX F – EXTERNAL PARTNERS LIST PER COUNTRY

| CURRENT MNCH STRATEGIES OR PROJECTS | YEARS |
|---|---|
| Brazil | As of 2008 |
| Colombia | As of 2007 |
| El Salvador | 2010-2014 |
| Grenada | 2012-2015 |
| Haiti | As of 2008 |
| Honduras | 2008-2015 |
| Paraguay | 2009-2012 |
| Peru | 2009-2015 |
| Uruguay | 2010-2030 |
| Saint Vincent | As of 2006 |

# ANNEX G – LIST OF CURRENT GOVERNMENT STRATEGIES OR PROJECTS

| LOCATION | ORGANIZATION | TOTAL NUMBER OF ORGANIZATIONS |
|---|---|---|
| Antigua and Barbuda | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Argentina | AECI, UN Agencies | 5 |
| Bahamas | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Barbados | DFID, OXFAM, UN Agencies | 6 |
| Belize | UN Agencies | 4 |
| Bolivia | PAHO, WFP, World Vision, Plan, USAID, AECI, ECHO, CIDA, OXFAM, UN Agencies, MI, GAVI, Save the Children | 16 |
| Brazil | World Vision, Plan, USAID, AECI, OXFAM, UN Agencies | 9 |
| Canada | UN Agencies | 4 |
| Chile | World Vision, ECHO, OXFAM, UN Agencies | 7 |
| Colombia | WFP, World Vision, Plan, USAID, AECI, ECHO, CIDA, UN Agencies | 11 |
| Costa Rica | World Vision, AECI, OXFAM, UN Agencies | 7 |
| Cuba | WFP, AECI, OXFAM, UN Agencies, GAVI | 8 |
| Dominica | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Dominican Republic | World Vision, Plan, USAID, AECI, OXFAM, UN Agencies, Save the Children | 10 |
| Ecuador | WFP, World Vision, Plan, USAID, AECI, ECHO, OXFAM, UN Agencies | 11 |
| El Salvador | WFP, World Vision, Plan, USAID, AECI, OXFAM, UN Agencies, Save the Children | 11 |
| Grenada | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Guatemala | WFP, World Vision, Plan, USAID, AECI, OXFAM,UN Agencies, MI, Save the Children | 12 |
| Guyana | PAHO, DFID, USAID, UN Agencies, GAVI | 8 |
| Haiti | PAHO, WFP, World Vision, Plan, USAID, AECI, ECHO, CIDA, OXFAM, UN Agencies, MI, GAVi, Save the Children | 16 |
| Honduras | PAHO, WFP, World Vision, Plan, USAID, AECI, CIDA, OXFAM, UN Agencies, GAVI, Save the Children | 14 |
| Jamaica | DFID, USAID, UN Agencies | 6 |
| Mexico | World Vision, USAID, AECI, OXFAM, UN Agencies | 8 |
| Nicaragua | PAHO, WFP, World Vision, Plan, USAID, AECI, OXFAM,UN Agencies, GAVI, Save the Children | 13 |
| Panama | World Vision, AECI, OXFAM, UN Agencies | 7 |
| Paraguay | Plan, USAID, AECI, OXFAM, UN Agencies | 8 |
| Peru | WFP, World Vision, Plan, USAID, AECI, ECHO, CIDA, OXFAM, UN Agencies | 12 |
| Saint Kitts and Nevis | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Saint Lucia | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Saint Vincent and the Grenadines | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Suriname | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Trinidad and Tobago | ECHO, CIDA, OXFAM, UN Agencies | 7 |
| Uruguay | AECI, UN Agencies | 5 |
| USA | UN Agencies | 4 |
| Venezuela | USAID, AECI, UN Agencies | 6 |
| Montserrat* | DFID, UN Agencies | 5 |

*Non Red Cross Red Crescent country

# ANNEX H - GOVERNMENT PRIORITIES AND COMMITMENTS

Since Red Cross Red Crescent National Societies act as auxiliaries to their governments, as per the seven fundamental principles, it is important to take into consideration what governments are currently planning and implementing in health policy and plans. More specifically, it is important to determine every government's commitment to MNCH programs and strategies knowing that women and children are one of the most vulnerable populations within the Americas region[75]. Governments have the political power to influence where the strategic directions are heading and, therefore, influence the well-being and health of women, newborns and children.

Internet research was conducted to identify health priorities within the 35 governments in countries where National Societies are present. It was found that 80 per cent of the countries in the Americas have a national health strategy or plan. More specifically, only overall national health strategies or plans were counted in this calculation; therefore, health strategies for specific themes such as work safety, sexual and reproductive rights or oral health were not counted since they only focused on a particular theme and did not encompass health as a whole. Furthermore, out of the 35 countries taken into consideration, 11 per cent do not have a national health strategy or plan and 8 per cent had no data available. Three of the four countries that do not have a specific strategy related to health are from English-speaking Caribbean: Barbados, Saint Lucia, and Trinidad and Tobago. The fourth is Argentina, which has several plans and strategic directions on different themes such as sexual and reproductive health, health in prison environments and maintaining a healthy lifestyle[76]. Yet, an overarching national strategy for health could not be found. The last three countries, Cuba, Saint Kitts and Nevis, and Haiti did not have any available information online about their national health strategies. However, the Haiti Red Cross health representative confirmed that the Haitian government is in the review process of its strategic plan.

Even though health has been a priority for 80 per cent of governments, as determined by their having developed health strategies, only a little more than half have kept these strategies current. As illustrated in Table 9, 16 of the countries with a national health strategy have current strategies. Also, 21 per cent of the national health strategies do not have any dates specified; therefore, they could still be current. This signifies that 57 per cent and up to 78 per cent of governments with health strategies or plans could have ongoing objectives in the area of health. Even though all regions but North America have the same number of countries with current strategies, the percentage represented per region differs. As seen in Table 10, the highest percentage within a region is Central America with 71 per cent and the lowest is the Caribbean with 31 per cent. This indicates that the governments in Central America have kept health as a priority because they have kept their health strategies updated. In the Caribbean only 31 per cent of countries have current health strategies. In addition, three of the four countries that do not have health strategies and all three countries with no data about their health plans are from the Caribbean: Haiti, Cuba, Saint Kitts and Nevis. This signifies that countries in the Caribbean have not been able to keep their strategies current or they have not yet managed to initiate or publish a national health strategy. However, it also has to be taken into consideration that updated information may not be available online for those countries.

| | NATIONAL HEALTH STRATEGY | % | CURRENT NATIONAL HEALTH STRATEGY | % |
|---|---|---|---|---|
| YES | 28 | 80% | 16 | 57% |
| NO | 4 | 11% | 7 | 25% |
| No data/ Not specified | 3 | 9% | 6 | 21% |

**Table 9.** Government Health Strategies/ Plans. Data collected through desk review conducted by the author on strategies through countries' Ministry of Health.

Within each national health strategy or plan, there are different objectives and key areas of work based on each government's priorities and the population's needs (as identified by the government). The following four areas are prominent in the health strategies with 45 per cent of the strategies mentioning them in their objectives or strategic goals: management and organization of the health sector and/or system, nutrition, maternal health, and providing quality care. Based on those results, it can be determined that governments want to focus on the actual functioning of the health system and the quality of the services provided, rather than the actual content of the services. However, the most prominent area is child health, identified in 48 per cent of the health strategies as a priority. Therefore, an MNCH component is one of the top priorities in government health strategies around the region. Other MNCH components can be considered a priority since maternal health and nutrition/food security are in the top five as well. Nutrition, as an area of work in MNCH, is important for mothers and children as their nutrition can greatly affect their health and development. Several areas related to MNCH are also present in the strategies such as sexual and reproductive health, immunization and health promotion, at 31 per cent, 28 per cent and 24 per cent respectively. Equity, mentioned in 28 per cent of the strategies, is important to MNCH because it usually targets marginalized and vulnerable groups which are often women and children. The countries that have included equity in their strategies are Chile, Brazil, Colombia, Costa Rica, Dominican Republic, Mexico, Paraguay and Saint Lucia. Half of the countries that mention equity are from South America. Amongst other prominent areas of work, universal access to healthcare is a priority for 31 per cent of the strategies. Universal access can tie in to equity in terms of giving the opportunity to everyone, no matter what ethic group they are a part of, the economic situation they are in, or the geographical area they live in. Only one strategy, Guatemala's, mentioned traditional medicine as part of their objectives, which shows a lack of health objectives reflecting the high proportion of indigenous populations in the Americas region —10 per cent of the total population according to a World Bank Study[77] and at higher percentages in many countries including Bolivia, Ecuador, Guatemala, Mexico and Peru[78]. Also, only two strategies mention gender and healthy habits — themes that are related to MNCH — which represents only 3 per cent of the total strategies. Since trends such as unhealthy eating habits and gender inequality within societal norms magnify health inequities that affect women and children[79], it is interesting to see such little focus on these types of issues in national health strategies.

| | CENTRAL AMERICA | CARIBBEAN | SOUTH AMERICA | NORTH AMERICA |
|---|---|---|---|---|
| Number of countries | 5 | 5 | 5 | 1 |
| Total number w/ in region | 7 | 16 | 10 | 2 |
| % | 71% | 31% | 50% | 50% |

**Table 10.** Current government national health strategies by region. Data collected through desk review conducted by the author through countries' Ministry of Health.

| REGION | MATERNAL HEALTH | % FROM REGION | CHILD HEALTH | % FROM REGION |
|---|---|---|---|---|
| South America (n=10) | Colombia, Peru, Uruguay | 30% | Ecuador, Peru, Venezuela | 30% |
| Caribbean (n=16) | Dominica, Grenada, Guyana, Saint Lucia, Saint Vincent, Trinidad and Tobago, Dominican Republic | 44% | Dominica, Guyana, Saint Lucia, Saint Vincent, Trinidad and Tobago, Dominican Republic | 44% |
| Central America (n=7) | Panama, Guatemala, Honduras | 43% | Panama, Guatemala, Honduras | 43% |
| North America (n=2) | Canada | 50% | Canada, USA | 100% |

**Table 11.** Countries with Maternal and Child health in their National Health Strategies. Data collected through desk review conducted by the author through countries' Ministry of Health.

Out of all of the areas identified, gender and human rights are the MNCH components the least mentioned, with 3 per cent.

As illustrated in Table 11, other than countries in North America, which are at 100 per cent for including maternal health in their national health strategies and 50 per cent for child health, the rest of the regions are around 30-40 per cent. Maternal health is included in 13 strategic plans including seven from the Caribbean, three from South America, three from Central America, and one from North America. Child health is included in 14 strategic plans including seven from the Caribbean, three from South America, three from Central America, and two from North America. This adds up to 46 per cent and 50 per cent of countries with national health strategies or plans that mention maternal health and child health, respectively, as a priority or within their objectives. This entails that almost half of all national health strategies include MNCH as a priority or objective. There are also 24 per cent of governments that consider community health in their objectives and strategies, including Belize, Mexico, El Salvador, Grenada, Saint Vincent, Trinidad and Tobago, the USA, and Honduras. Community health is often an important component of MNCH since the most vulnerable women and children are often found in communities with little access to health services or basic health education. Other community health components are not as prominent such as rural health and home visits, which only make up 7 per cent of health strategies or plans. Curative care programs such as IMCI are also only present in 7 per cent of the strategies. Since one-third of national strategies consider "universal access" as a main component of their strategy or plan, it means that they must consider both institutional and community health to ensure the accomplishment of this goal. Overall, several areas related to MNCH are prominent in the strategies, as demonstrated in Figure 27, especially nutrition and maternal and child health, yet some are not such as gender and healthy habits.

Some governments have shown their commitments towards MNCH even more by developing strategies specifically related to MNCH. As shown in Table 12, 13 out of 35 countries (37 per cent) have developed MNCH strategies. Out of the 13 with MNCH strategies, five are from South America. Eight countries have been involved in or lead MNCH projects or programs, but have not developed a strategy specific to MNCH. This shows a certain degree of interest in MNCH and of commitment to tackle the MNCH issues in their countries. On the other hand, 14 countries do not have an MNCH strategy or projects/programs. This means 40 per cent of countries in the Americas are not working directly on MNCH. However, this does not mean that they do not have MNCH components in other strategies or programs since the research strictly looked at MNCH-specific strategies and projects/programs. Honduras, Panama and Guatemala have MNCH strategies, demonstrating government commitment to MNCH and that MNCH is a priority for those governments in Central America, which, as mentioned before, have the highest percentage (71 per cent) of national health strategies compared to countries in the sub-region.

| GOVERNMENTS WITH MNCH STRATEGY | |
|---|---|
| Yes | Argentina, Belize, Brazil, Ecuador, Salvador, Guatemala, Guyana, Honduras, Panama, Paraguay, Peru, Uruguay, Venezuela |
| Programs or projects, not specific strategy | Bahamas, Barbados, Bolivia, Canada, Colombia, Grenada, Guyana, Haiti, Saint Vincent, USA |
| No | Bolivia, Antigua and Barbuda, Chile, Costa Rica, Dominica, Dominican Republic, Jamaica, Mexico, Nicaragua, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago |
| No data | Cuba |

**Table 12.** Governments in the Americas with an MNCH Strategy. Data collected through desk review conducted by the author through countries' Ministry of Health.

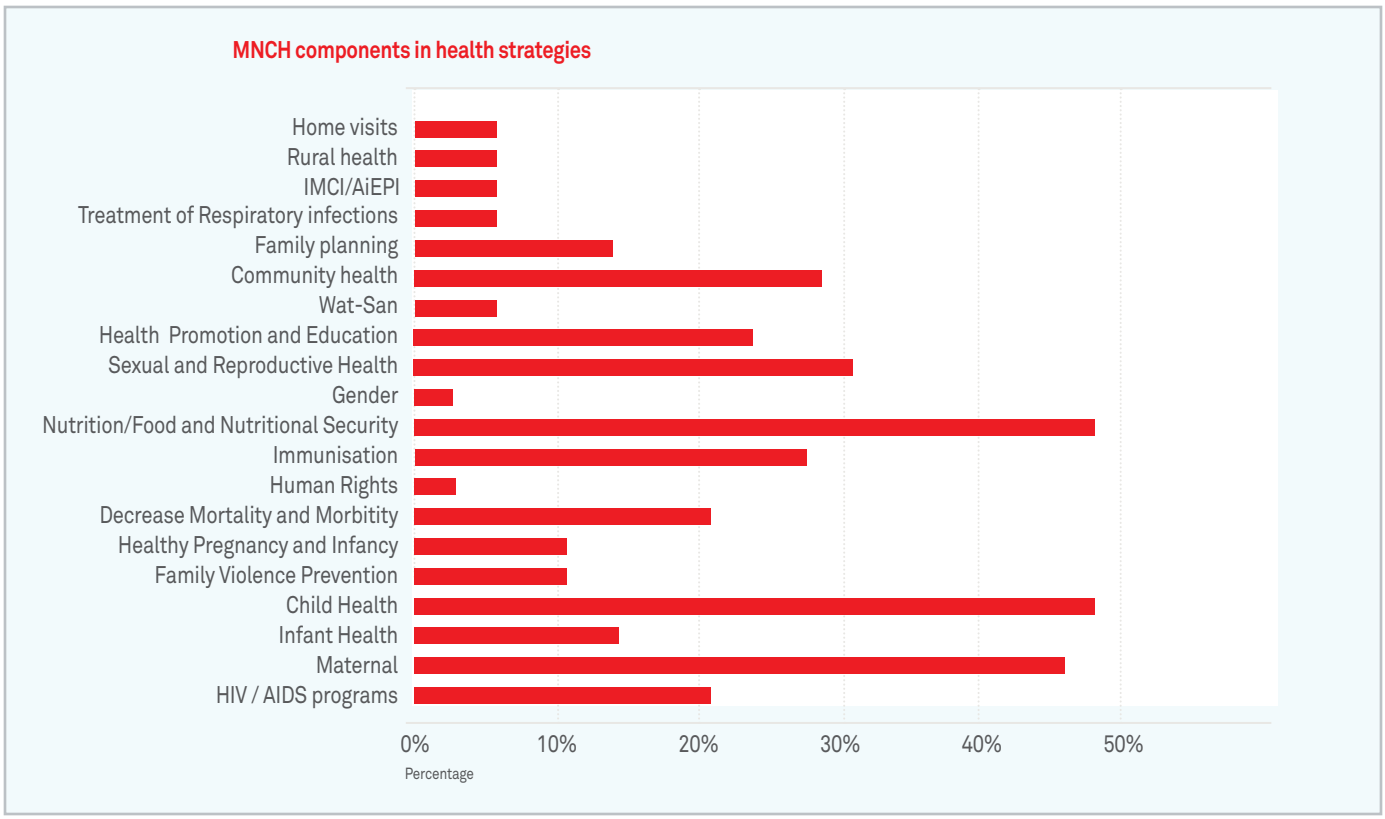


**Figure 27.** MNCH components in National Health Strategies. Data collected through desk review conducted by the author through countries' Ministry of Health.

While governments have committed to insert MNCH into their priorities, some have struggled to keep their strategies current. Half, or ten, of the MNCH strategies and/or projects are still current as of 2012; therefore, the governments of these countries are still actively implementing MNCH activities and/or following objectives directly related to MNCH. The biggest commitment for an MNCH strategy has been made by Uruguay with its strategy stretching until 2030. Also, Honduras, Peru and Granada have committed to work on MNCH until at least 2015 in their own strategies. A quarter (25 per cent) of the countries do not have current MNCH strategies and/or projects but they have had one in the past. Guatemala and Guyana had MNCH strategies, but they ended in 2008 and 2010 respectively. In addition, six of the countries have not specified the timeline for their strategies; therefore, up to 30 per cent of those MNCH strategies could still be active. (See Annex F for the list of current MNCH strategies.)

Several of the top five priority countries have made MNCH commitments through projects and programmes. In Haiti, the government is working on an MNCH project with the support of the Canadian government, working on providing obstetric care for women and primary care for children[80]. Guyana has a MNCH project supported by PAHO working on IMCI and immunization since 2001[81]. Bolivia does not have an MNCH program but its health strategy is very much focused on participatory and community health as well as including everyone in the healthcare system. To try and reduce health disparities, the Bolivian government, since 1994, has implemented the following three health insurance plans as part of their official health policies: National Maternal and Child Insurance (SNMN); Basic Health Insurance (SBS); and Universal Maternal and Child Insurance (SUMI)[82]. Bolivia, Haiti or Guyana do not have current MNCH strategies, only programs, showing a lack of MNCH policy development in high priority countries.

Key areas of work were also identified through the analysis of the MNCH strategies and projects. Out of all the topics and themes, 20 key focus areas were identified within the MNCH strategies. As seen in Figure 28, two areas, immunization and maternal and child care, are the most prominent across the MNCH strategies and projects with 30 per cent of them mentioning those areas. Maternal and child care are prominent because many strategies and projects focus on primary care for mothers and especially children, whether in institutions or communities. Breastfeeding is also a focus in MNCH strategies and projects with 25 per cent working on breastfeeding education and /or promotion. Six other key areas - antenatal care, sexual and reproductive health, IMCI, MNCH training for staff, nutrition and obstetrical care - are a focus for 15 per cent of the MNCH strategies and projects.

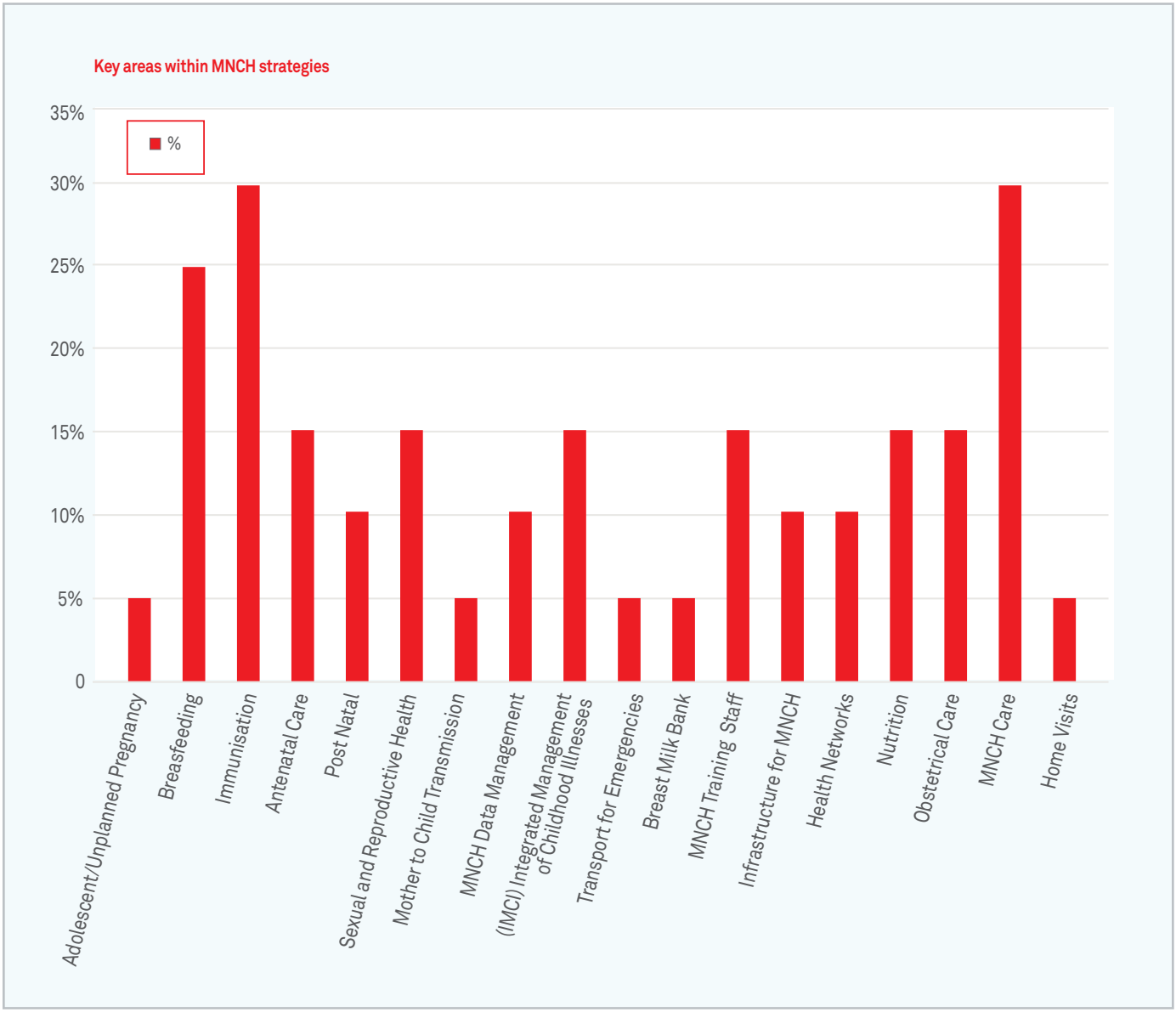


**Figure 28.** Key Areas within MNCH. Data collected through desk review conducted by the author.

In summary, the governments in the Americas have identified health as a priority in most cases. Since 80 per cent have developed national health strategies, 37 per cent have developed MNCH strategies, and 26 per cent have implemented MNCH projects, it is evident that MNCH is a topic of focus recognized by governments. Issues most addressed within these strategies and plans are immunization, MNCH care, and nutrition and food security. Mother and child health as well as nutrition and food security have the highest prominence within national health strategies, which confirms the importance of MNCH to governments. However, many government strategies or projects on MNCH are not current and, therefore, need to be updated to include new trends in health inequities and services offered. Analysis of government commitments to MNCH indicates that the focus of activities is both on institutional health and community health. However, more health strategies mention the healthcare system as a priority (45 per cent) than community health (24 per cent). Therefore, government priorities are more centered on the institutional side of health to provide the best quality service as possible at health delivery points to its population.

# ANNEX I – ACRONYMS AND DEFINITIONS

**AECID** – Spanish acronym for Spanish Agency of International Cooperation for Development

**AIDS** – Acquired immune deficiency syndrome

**AMCROSS** – American Red Cross

**CBHFA** – Community based health and first aid

**CIDA** – Canadian International Development Agency

**CRC** – Canadian Red Cross

**DFID** – Department for International Development

**DRR** – Disaster Risk Reduction

**ECHO** – European Commission's Humanitarian Aid Office

**GAVI** – Global Alliance for Vaccines and Immunization

**HDI** – Human Development Index

**HIV** – Human Immunodeficiency virus

**IFRC** – International Federation of the Red Cross and Red Crescent Societies

**IMCI** – Integrated Management of Childhood Illnesses

**MDG** – Millennium Development Goals

**MI** – The Micronutrient Initiative

**MNCH** – Mother, Newborn and Child Health

**MoH** – Ministry of Health

**NGOS** – Non-governmental organizations

**NORAD** – Norwegian Agency for Development Cooperation

**PAHO** – Pan American Health Organization

**PMNCH** – Partnership on Mother, Newborn and Child Health

**PSP** – Psycho-social support

**U5MR** – Under-five mortality rate

**UN** – United Nations

**UNDP** – United Nations Development Program

**UNFPA** – United Nations Population Fund

**UNICEF** – United Nations International Children Emergency Fund

**UN WOMEN** – United Nations Development Fund for Women

**USA** – United States of America

**VP** – Violence Prevention

**WB** – World Bank

**WFP** – World Food Programme

**ADULT PREVALENCE RATE:** Percentage of adults (15-49 years) living with HIV/AIDS as of end-2001. (UNICEF)

**ANTENATAL CARE:** Percentage of women aged 15-49 years attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives). (UNICEF)

**CONTRACEPTIVE PREVALENCE:** Percentage of women in union aged 15-49 years currently using contraception. (UNICEF)

**DPT3:** Percentage of infants that received three doses of diphtheria, pertussis (whooping cough) and tetanus vaccine. (UNICEF)

**HUMAN DEVELOPMENT INDEX (HDI) VALUE:** A composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, knowledge and a decent standard of living. (UNDP)

**INFANT MORTALITY RATE:** Probability of dying between birth and exactly one year of age expressed per 1,000 live births. (UNICEF)

**MATERNAL MORTALITY RATIO:** Annual number of deaths of women from pregnancy-related causes per 100,000 live births. (UNICEF)

**NEONATAL MORTALITY RATE:** Number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period

**SKILLED ATTENDANT AT DELIVERY:** Percentage of births attended by skilled health personnel (doctors, nurses or midwives). (UNICEF)

**STUNTING:** Moderate and severe - below minus two standard deviations from median height for age of reference population. (UNICEF)

**UNDER-FIVE MORTALITY RATE:** Probability of dying between birth and exactly five years of age expressed per 1,000 live births. (UNICEF)

**UNDERWEIGHT:** Moderate and severe - below minus two standard deviations from median weight for age of reference population; severe - below minus three standard deviations from median weight for age of reference population. (UNICEF)

**UNMET NEED FOR FAMILY PLANNING:** Women with unmet need for family planning for limiting births are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children. (WHO)

# REFERENCES


1 UN (2011, July 7). The Millenium Development Goals Report 2011. Retrieved from http://www.un.org/millenniumgoals/MDG2011_la_EN.pdf

2 WHO (2012). *Trends in maternal mortality: 1990 2010*. Retrieved from http://apps.who.int/irisbitstream/10665/44874/1/9789241503631_eng.pdf

3 UNICEF(2003, April 20). *The big picture.* Retrieved from http://www.unicef.org/health/index_bigpicture.html

4 WHO PMNCH (2011, September). PMNCH Fact Sheet: *RMNCH Continuum of care.* Retrieved from http://www.who.int/pmnch/about/continuum_of_care/en/index.html

5 IFRC (2012, March 26). *Community health volunteers empower the young and old to help themselves.* Retrieved from http://www.ifrc.org/en/news-and-media/news-stories/asia-pacific/china/community-health-volunteers-empower-the-young-and-old-to-help-themselves/, March 26 2012

6 IFRC (n.d.) *International Club 25: new blood for the world.* Retrieved from http://www.ifrc.org/en/what-we-do/health/blood-services/international-club-25-new-blood-for-the-world/

7 UNDP (n.d.) About us. Retrieved from http://www.undp.org/content/undp/en/home/operations/about_us.html

8 UNDP (2013) Canada, Country Profile: *Human Development Indicators.* Retrieved from http://hdrstats.undp.org/en/countries/profiles/CAN.html

9 UNDP (2013)United States, Country Profile: *Human Development Indicators.* Retrieved from http://hdrstats.undp.org/en/countries/profiles/USA.html

10 UN WOMEN (2011). Focus Areas. Retrieved from http://www.unwomen.org/focus-areas/

11 OXFAM (2013). Issues We Work On. Retrieved from http://www.oxfam.org/en/about/issues

12 ECHO (2012, September 13). About Us. Retrieved from http://ec.europa.eu/echo/about/presentation_en.htm

13 DFID (n.d.) Where We Work. Retrieved from http://www.dfid.gov.uk/Where-we-work/?tab=1

14 UNDP (n.d.). About us. Retrieved from http://www.undp.org/content/undp/en/home/operations/about_us.html

15 UNICEF (n.d.). What We Do. Retrieved from http://www.unicef.org/whatwedo/index.html

16 PMNCH (2013). PMNCH Who we are.Retrieved from http://www.who.int/pmnch/about/en/

17 UNICEF (2012, June 21). Maternal Health. Retrieved from http://www.unicef.org/health/index_maternalhealth.html

18 CIDA (2012, June 21). Aid Effectiveness Agenda. Retrieved from http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/FRA-825105226-KFT

19 CIDA (2012, November 11). MNCH, Canada's Leadership. Retrieved from http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/FRA-127113657-MH7

20 CIDA (2010, August 03). G8 Muskoka Declaration Recovery and New Beginnings. Retrieved from http://www.canadainternational.gc.ca/g8/summit-sommet/2010/muskoka-declaration-muskoka.aspx?lang=eng&view=d

21 UNPFA (n.d.) New Strategic Direction – Strategic Plan: 2011-2013. Retrieved from http://www.unfpa.org/public/about/pid/4631

22 CIDA (2013, February 26). *Project Browser: Project profile for Improved Health for Women, Children and Marginalized Populations.* Retrieved from http://www.acdi-cida.gc.ca/cidaweb%5Ccpo.nsf/projEn/A035033001

23 UNDP (2012, October 15). Human Development Index Value (HDI). Retrieved from http://hdrstats.undp.org/en/indicators/103106.html

24 UNICEF (2003, February 25). *Country Statistics: Guyana.* Retrieved from http://www.unicef.org/infobycountry/guyana_statistics.html

25 UN (2011, July 7). The Millenium Development Goals Report 2011. Retrieved from http://www.un.org/millenniumgoals/MDG2011_la_EN.pdf

26 UNICEF (2003, February 25). Country Statistics: *Suriname.* Retrieved from http://www.unicef.org/infobycountry/suriname_statistics.html

27 Ibid.

28 Black, Robert E et al. (2010). *Global, regional, and national causes of child mortality in 2008: a systematic analysis.* The Lancet, 375 (9730), 1969-1987. doi: 10.1016/S0140-6736(10)60549-1.

29 Centers for Disease Control and Prevention (2010, October 22.) Cholera Confirmed in Haiti. October 21, 2010 Retrieved from http://www.cdc.gov/haiticholera/situation/

30 IFRC (2012, February 01). Haiti - Operations update n° 29, Haiti - Earthquake (MDRHT008). Retrieved from http://adore.ifrc.org/Download.aspx?FileId=22559

31 UNICEF (2003, February 25). Country Statistics: *Guatemala.* Retrieved from http://www.unicef.org/infobycountry/guatemala_statistics.html

32 UNFPA (2010, September). *How Universal is Access to Reproductive Health? A review of the evidence.* Retrieved from http://www.unfpa.org/public/home/publications/pid/6526

33 Bolivia. Ministerio de Salud y Deportes & Instituto Nacional de Estadistica (INE) (2008). *Encuesta Nacional de Demografia y Salud* 1998 by M. Gutierrez Sardan, L. H, Ochoa & A. Gomez Vargas. Retrieved from http://www.measuredhs.com/pubs/pdf/FR99/00FrontMatter.pdf

34 CIA World Factbook (2009). HIV/AIDS – Adult Prevalence Rate. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/fields/print_2155.html

35 The Lancet (2008). *HIV/AIDS in Latin America and the Caribbean.* 372, (9635), 263. doi: 10.1016/S0140-6736(08)61082-X.

36 Silva, E., Batista, R., Canadian Foundation for the Americas., & Gibson Library Connections, Inc. (2010). *Bolivian maternal and child health policies: Successes and failures.* Ottawa, Ont: FOCAL.

37 Ibid.

38 Ibid.

39 Ibid.

40 Ibid.

41 Ibid.

42 Ibid.

43 IFRC (2011). *Eliminating Health Inequalities: Every Woman and Every Child Counts.* Geneva: IFRC, p. 21.

44 UNDP (2013). *Panama - Country Profile: Human Development Indicators* Retrieved from http://hdrstats.undp.org/en/countries/profiles/PAN.html

45 CIA World Fact book (2013, April 18). Haiti. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html

46 Ibid.

47 Anderson, F., Morton, S., Naik, S., & Gebrian, B. (2007). *Maternal Mortality and the Consequences on Infant and Child Survival in Rural Haiti.* Maternal and Child Health Journal, 11, 4, 395-401.

48 U.S. Agency for International Development (USAID) & Pan American Health Organization (PAHO) (2007, February) *Health Systems Profile: Guatemala* (3rd ed.). Washington, D.C: PAHO

49 Ibid.

50 World Bank (2003, June) *Guatemala: Inequalities in Health, Nutrition and Population.* by Ooman, H., Lule, E., Vazirani, D.& Chhabra, R. Retrieved from http://siteresources.worldbank.org/INTPRH/Resources/GuatemalaPROF.pdf

51 Silva, E., and Batista, R. (2010). *Bolivian maternal and child health policies: Successes and failures.* Ottawa, Ont: FOCAL, p. 11.

52 The World Bank (2013). *Bolivia Highlights: Indigenous Peoples, Poverty and Human Development in Latin America: 1994-2004.* Retrieved from http://go.worldbank.org/ZX284CZC80

53 Instituto Nacional de Estadistica. (2008). *Estadísticas Nacionales de Bolivia 2008.* Bulletin no.64. La Paz.

54 UNICEF (n.d.) Situation of poverty in the country. Retrieved from http://www.unicef.org/bolivia/resources_2332.htm

55 UNDP (2010). Human Development in the department of Potosí. Retrieved from http://www.pnud.bo/webportal/Portals/0/Bol_05_Pts_Eng.pdf

56 Ibid.

57 International Labour Organization (n.d.). Bolivia. Retrieved from http://www.ilo.org/indigenous/Activitiesbyregion/LatinAmerica/Bolivia/lang--en/index.htm

58 OHCHR (2012, February 24). *Government of Guyana Response to the United Nations Expert Mechanism on the Rights of Indigenous Peoples.* Retrieved from http://www.ohchr.org/Documents/Issues/IPeoples/EMRIP/Declaration/Guyana.doc

59 PAHO (2009). *Guyana Country Cooperation Strategy 2010-2015.*

60 Bureau of Statistics Guyana. *Chapter 3: Population redistribution and internal migration.* Table 3.4: Population Density: Guyana: 1980 – 2002.

61 The World Bank (2005). *A Poverty Map For Guyana: Based on the 2002 Population and Housing Census.*

62 International Monetary Fund (2006). *Guyana: Poverty Reduction Strategy Paper Progress Report.* Washington, D.C., p. 11.

63 UNICEF (n.d.) Guyana: Early Childhood Years. Retrieved from http://www.unicef.org/guyana/children_5030.htm

64 UNICEF (2012, February 10). Guyana and Suriname, Country Programme Document 2012-2016.

65 Ibid.

66 PAHO (2009, February). *Health Systems Profile: Honduras (3rd ed.).* Washington, DC: PAHO

67 Ibid.

68 World Gazetteer (n.d.) Honduras: largest cities and towns and statistics of their population. Retrieved from http://world-gazetteer.com/wg.php?x=&men=gcis&lng=en&des=wg&geo=-97&srt=npan&col=abcdefghinoq&msz=1500&pt=c&va=&srt=pnan

69 Wessendorf, K. (2009). *The Indigenous World, 2009* (p. 116). Copenhagen: International Work Group for Indigenous Affairs.

70 Ch'orti' People (n.d.) Retrieved April 18, 2013) from Wikipedia: http://en.wikipedia.org/wiki/Ch'orti'_people

71 PAHO (2009, February). *Health Systems Profile: Honduras (3rd ed., p.5).* Washington, DC: PAHO

72 PAHO (n.d.) Millennium Development Goals – Panama. Retrieved from http://www.paho.org/english/mdg/cpo_panama.asp

73 Ibid.

74 Ibid.

75 UNICEF (n.d.) Humanitarian Action for Children The Americas and Caribbean. Retrieved from http://www.unicef.org/hac2011/hac_tacro.html

76 Argentina, Ministry of Health (n.d.) Programas y Planes. Retrieved from http://www.msal.gov.ar/index.php/programas-y-planes

77 Hall, G., & Patrinos, H. A. (2005). *Indigenous people, poverty and human development in Latin America: 1994-2004.* Basingstoke: Palgrave Macmillan, p. 1.

78 Ibid.

79 IFRC (2011). *Eliminating Health Inequalities: Every Woman and Every Child Counts.* Geneva, IFRC, p. 21.

80 Canada Haiti Action Network (n.d.). *UN Agencies and CIDA Announce New Maternal and Child Health Program in Haiti.* Retrieved from http://canadahaitiaction.ca/content/un-agencies-and-cida-announce-new-maternal-and-child-health-program-haiti

81 PAHO Guyana Office (n.d.) Maternal and Child Health: Addressing the Unfinished Agenda. Retrieved from http://www.guy.paho.org/maternal.html

82 Silva, E., and Batista, R., (2010). *Bolivian maternal and child health policies: Successes and failures.* Ottawa, Ont: FOCAL, p. 2.

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