

Addressing reproductive and maternal health in Latin America and the Caribbean – initiatives underway

Abstract

Increased focus on reproductive and maternal health not only benefits the mother and her newborn child, but it can also strengthen families and communities. Family planning allows women to space their pregnancies, and can delay pregnancy in younger women, who often face an increased risk of complications. Ensuring safe pregnancies and childbirth is critical. Maternal deaths are the second biggest killer of women of reproductive age. Despite the increase in contraceptive use over the years, many women still do not have access to modern contraceptive methods. In sub-Saharan Africa, e.g., one in four women who wish to delay or stop childbearing does not use any family planning method. In Latin America and the Caribbean (LAC: *focal point of the present paper*), 62% of women aged 15-49 want to avoid a pregnancy; however, 22% of these women (23 million in 2014) are not using an effective contraceptive method. Such women (defined as having an “*unmet need*” for family planning/modern contraception), account for a disproportionately high 75% of all unintended pregnancies in the region. This situation places young people (especially those in the poorest and most marginalized communities) at high risk for HIV/AIDS infection and unwanted pregnancy. Presently, many reproductive and maternal health programs (both in ‘*governmental*’ as well as ‘*non-governmental/private*’ sectors) are on move in LAC. Such programs provide reproductive and maternal health services to those in need. One such initiative is: “*Family Care International (FCI) program of the Management Sciences for Health (MSH)*” which advocates for improved sexual, reproductive, maternal, newborn, and adolescent health and rights in LAC. This writing aims at outlining the framework of working mechanism within which the FCI program functions in LAC. Data used in this work are ‘*qualitative*’ and ‘*secondary*’ in nature and method of data analysis is ‘*descriptive*’; with focus on “*case study*” approach.

Keywords: reproductive and maternal health, Latin America and the Caribbean, HIV/AIDS, unwanted pregnancy, unmet need, contraceptive methods, evidence-based advocacy, capacity-building and unintended pregnancy

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Introduction

According to the World Health Organization (WHO) estimates, due to complications of pregnancy and child birth, nearly 830 women died every day in the year 2015. Most of these deaths occurred in countries with low and/or inadequate infrastructural settings in the health sector. Equipped with adequate care, health providers could have been prevented many of such deaths. Common causes of death are:

- a. Haemorrhage
- b. Hypertension
- c. Infections

There are also indirect causes which pertain to interactions between pre-existing medical conditions and pregnancy. Maternal mortality is a health indicator that shows very wide gaps between rich and poor, urban and rural areas, both between countries and within them.¹

Materials and methods

This writing aims at outlining the framework of working mechanism within which the FCI program of the MSH operates in LAC. It touches upon management aspect of the maternal and reproductive health program, including “*specific strategies*” adopted and “*networking and collaboration mechanisms*” established. Also, the paper gives overview of reproductive and maternal health situation in the LAC region/countries. In terms of methodology employed in this paper, data used in this work are ‘*qualitative*’ and ‘*secondary*’ in nature: collected from government publications, books, book chapters, journal articles, research reports, and Internet resources. Method of data analysis is ‘*descriptive*’, involving “*desk-based research*”. Further, there are several ongoing maternal and reproductive health projects in LAC region. However, the author of this paper has chosen to study only the FCI program of the MSH as a “*case study*”. In case studies, the number of unit to be studied is small, but they (*case studies*) examine a social unit deeply and thoroughly. In view of this, detailed program description of the FCI is given in this paper.

Reproductive and maternal health in LAC: present scenario

Women with socioeconomic disadvantages are less likely to have contact with the health system during one of the most critical times in their lives: 'pregnancy' and 'childbirth'. The data indicate that disadvantaged women have less access across the continuum of antenatal visits and birth attendance, but particularly troubling are the very low levels of health care utilization around the time of birth, the most vulnerable period for mother and child. Birth services must be available 24 hours a day, seven days a week and include referrals for birth and obstetric complications and emergencies. Quality birth services are a critical component of addressing the poorer health outcomes, including maternal mortality, among the most vulnerable women.²

In LAC, vulnerable women face various barriers to accessing routine reproductive health care, resulting in an unmet need for contraception, unintended pregnancies and undiagnosed STIs and cancers. This section of the paper deals with reproductive and maternal health status in LAC region. Data (divided in two parts, viz., "statement of the problem" and "current situation") have been presented under different three sub-headings, namely: (a) Equity in Reproductive Health, (b) Equity in Maternal Health, and (c) Equity in Neonatal Health. Discussion follows below:

Equity in reproductive health

Unmet need for contraception

Statement of the problem: In every country in LAC with available data, the prevalence of unmet need for contraception is higher among the poorest and least educated women, although recent progress in some countries shows that it is possible to address these persistent inequities.

Current situation: Women from the poorest quintile have an unmet need for contraception that is four times higher than the wealthiest in El Salvador, Guatemala, Bolivia and Panama, and more than twice as high in Belize, Colombia, Costa Rica, Peru and Suriname. Further, in Costa Rica, El Salvador, Guatemala, Panama, Peru and Suriname, women with no education have an unmet need for contraception that is at least twice as high as that of women with secondary or higher education.

Inequalities in wealth and education level, along with ethnicity, affect women's abilities to access to quality sexual and reproductive health (SRH) rights and services. This in turn creates differential health outcomes among socioeconomic groups, with vulnerable women largely bearing the brunt of unplanned and mistimed pregnancies, as well as abortion-related complications and long term disabilities. Consequently, existing gaps in access to effective contraception and safe abortion are highly inequitable. Among indigenous populations, especially, inhabiting rural or remote areas, women do not enjoy comprehensive access to convenient, affordable or culturally appropriate reproductive health services and education.³

Sexually Transmitted Infections (STIs)

Statement of the problem: Gender inequality contributes to increasing the vulnerability of women to acquiring HIV and other STIs; indigenous women and women who live in poverty are particularly vulnerable given the superposition of gender inequality, socioeconomic exclusion and discrimination and their limited access

to health services that cater specifically to their needs. This suggests that policies to increase social equity and access to health services may serve to mitigate the transmission of HIV and STIs in the region. This is particularly true for indigenous women and women who live in poverty, who are particularly vulnerable to acquiring HIV and other STIs.

Current situation: A high prevalence of HIV has been found among indigenous populations in Brazil, Mexico, Peru and Venezuela.²

Cancer prevention and treatment

Statement of the problem: Women living in poverty and who have low levels of education bear most of the burden of cervical cancer in Latin America. More programs are needed to suit the specific needs of disadvantaged female populations. In addition to improving the financial and geographic accessibility of health services, initiatives should seek to improve general knowledge about the prevention and treatment of cervical cancer, and to alter social norms to create supportive environments that motivate women to seek screening.²

Current situation: Women from ethnic minorities may also face more barriers to obtaining cancer screenings and experience higher incidence of cervical cancer and related mortality than other groups, as found in Brazil and Colombia. Breast cancer has become the leading cause of cancer-attributed deaths for women in most countries in the LAC region. Low levels of education and income and belonging to a minority ethnicity are associated with lower coverage of mammograms and other screenings. The lack of supplies and equipment and shortages of trained personnel are key barriers that limit the effectiveness of breast cancer screening programs, creating inequitable access to diagnosis and treatment of breast cancer. Health policies should consider expanding coverage for breast cancer under public health plans to improve equity in access to diagnosis and treatment.³

Equity in maternal health

Antenatal visits

Statement of the problem: When a woman is pregnant, it is important for her to have regular check-ups with a midwife or doctor. These check-ups are called "antenatal care" or "antenatal visits". Antenatal means before birth. Antenatal visits can prevent complications. A small minority of pregnant women develop complications such as hypertension and diabetes. Early diagnosis means they can be properly monitored and treated.³

Current situation: Although 90% of women in Latin America and the Caribbean have at least four antenatal visits during their last pregnancy, large inequalities exist. In Haiti and Nicaragua, the difference in having at least four antenatal visits between the poorest and wealthiest women is greater than 30 %age points (51 and 88 % in Haiti and 61 and 92 in Nicaragua). In Bolivia (63 and 84 per cent) and Panama (74 and 97 %), the gaps are between 20 and 23 %age points.

In Haiti and Panama, less than half of women with no education have at least four antenatal visits (41 % in Panama, 50 % in Haiti). Other countries with a low proportion of women with no education who receive at least four antenatal visits are Suriname (52 %), Nicaragua (56 %) and Bolivia (57 %).

Research studies suggest that pregnant women from minority ethnicities have unequal utilization of antenatal care. In Brazil,

various studies have noted that Afro-descendant women have less than the recommended number of antenatal care visits, are less likely to receive the recommended antenatal procedures and examinations and their care is of lower quality. Similar findings have been documented for indigenous women in Guatemala, especially those who do not speak Spanish.

The barriers that obstruct indigenous and Afro-descendant women from obtaining antenatal care are likely connected to broader trends of discrimination and vulnerability that affect these populations. In addition to the unequal utilization of antenatal care, the statistics do not reflect the quality of those services, but studies show that poorer women receive substandard antenatal care.²

Skilled birth attendance

Statement of the problem: A birth attendant, also known as “skilled birth attendant” (“SBA”), is a midwife, physician, doctor, nurse, or other health care professional who provides basic and emergency health care services to women and their newborns during pregnancy, childbirth and the postpartum period. Most obstetric complications could be prevented or managed if women had access to a skilled birth attendant during childbirth. Improvements in the coverage of the proportion of births attended by skilled health personnel and their provision of care contribute to declines in maternal mortality.⁴

Current situation: Gaps in skilled birth attendance exist for women from different wealth, geographic and education demographics. These gaps are most apparent in Haiti, where only 10 % of women from the poorest quintile and 14 % of those with no education have skilled birth attendance. Inequalities in utilization of skilled birth attendance are particularly marked by wealth. The gap between the poorest and the wealthiest is 75 %age points in Guatemala, 69 in Haiti, 42 in Bolivia and 41 in Honduras. In Peru, despite having 90 per cent of skilled birth attendance, women from the poorest wealth quintile lag behind the wealthiest by 32 %age points.

The greatest gaps between rural and urban women are in Guatemala (41 percentage points), Haiti (35 %age points) and Bolivia (26 %age points). Great gaps exist in utilization of skilled birth attendance by education level, particularly in Guatemala (65 %age points), Panama (56), Haiti (47) and Honduras.

Indigenous and Afro-descendant women experience greater barriers to skilled birth attendance. According to available data, only 30% of indigenous women in Guatemala and 57% of indigenous women in Nicaragua were attended by skilled birth personnel in comparison with 70 and 81 % of non-indigenous women in their respective countries. Skilled birth attendance for indigenous women in Mexico and Peru has increased throughout the past decade. Although gaps have decreased, ethnic inequalities still remain in that countries.²

Caesarean sections

Statement of the problem: “*Caesarean section*” is the delivery of a baby through a surgical incision in the mother’s abdomen and uterus. In certain circumstances, Caesarean section is scheduled in advance. Caesarean section is one of the most common surgeries in the world, with rates continuing to rise, particularly in high- and middle-income countries. Although it can save lives, caesarean section is often performed without medical need, putting women and their babies at-risk of short- and long-term health problems. A new statement from the World Health Organization (WHO) underscores the importance

of focusing on the needs of the patient, on a case by case basis, and discourages the practice of aiming for “*target rates*”.

Caesarean section may be necessary when vaginal delivery might pose a risk to the mother or baby (for example, due to prolonged labour, foetal distress, or because the baby is presenting in an abnormal position). However, caesarean sections can cause significant complications, disability or death, particularly in settings that lack the facilities to conduct safe surgeries or treat potential complications.⁵

Current situation: Despite the exorbitant increase in caesarean sections in the LAC region, this life-saving surgery occurs less frequently among women in the poorest quintiles and with no education. Low provision of caesarean sections may indicate that not all women who need one will receive an emergency caesarean section. Haiti is the only country in the region where the national average of caesarean sections, at 6%, is below 10%. In addition to Haiti, less than 10% of women from the poorest quintiles in Bolivia, Guatemala, Guyana, Honduras, Nicaragua and Peru deliver by caesarean section.²

Maternal mortality

Statement of the problem: Maternal mortality refers to deaths due to complications from pregnancy or childbirth. Almost all maternal deaths can be prevented. The Ending Preventable Maternal Mortality (EPMM) initiative targets and strategies are grounded in a human rights approach to maternal and newborn health. It focuses on eliminating significant inequities that lead to disparities in access, quality and outcomes of care within and between countries. Concrete political commitments and financial investments by country governments and development partners are necessary to meet the targets and carry out the strategies for the EPMM.⁶

Current situation: Regional statistics mask inequalities in maternal health outcomes between and within LAC countries. Inequities in maternal health outcomes exist between women of different:

- i. Socioeconomic backgrounds
- ii. Ethnicities
- iii. Age groups

Several studies have associated poverty and low levels of education with a greater likelihood of maternal mortality and morbidity. Other studies have documented higher maternal morbidity and mortality ratios among indigenous and Afro-descendant women:

- A. A 2010 report noted that Afro-Brazilian women in Paraná state, Brazil had triple the risk of maternal death as did women of predominantly European descent.
- B. It has been estimated that indigenous women in Guatemala may have a maternal mortality ratio that is three times that of their non-indigenous counterparts.

The vast majority of maternal deaths throughout LAC are preventable with quality obstetric care during pregnancy, delivery and postpartum. Further, “*unsafe abortions*” are a major source of maternal morbidity and mortality throughout the region. The practice of unsafe abortion perpetuates social inequality among poor or marginalized women. These trends also reflect regional gender inequalities; women must undergo potentially dangerous procedures to access their reproductive rights, but abortion laws do not affect the men involved in unwanted pregnancies and the policies serve

to establish family planning as a 'women's issue'. The expansion of access to abortion would most directly benefit women from low-income, rural and other vulnerable groups and thus aid in mitigating regional inequities in maternal health outcomes.²

Anaemia in pregnancy

Statement of the problem: 'Anemia' is a medical condition in which there is not enough healthy red blood cells to carry oxygen to the tissues in the body. When the tissues do not receive an adequate amount of oxygen, many organs and functions are affected. Anemia during pregnancy is especially a concern because it is associated with low birth weight, premature birth and maternal mortality. Women who are pregnant are at a higher risk for developing anemia due to the excess amount of blood the body produces to help provide nutrients for the baby. Anemia during pregnancy can be a mild condition and easily treated if caught early on. However, it can become dangerous, to both the mother and the baby, if it goes untreated.⁷

Current situation: Studies over the past decade in the Latin American and Caribbean region have repeatedly shown an association of anaemia with low socioeconomic position.²

Foetal deaths and stillbirths

Statement of the problem: "Foetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any evidence of life.⁸ 'Stillbirth', on the other hand, refers to a pregnancy loss after 20 weeks of gestation.⁹ again, a 'miscarriage' (or spontaneous abortion) refers to a pregnancy loss before 20 weeks. If the age is not known, then a baby weighing 350 or more grams is considered a stillbirth.

Current situation: Foetal deaths are associated with low utilization of antenatal care and low levels of maternal education. Stillbirths are mostly underreported and are associated with maternal mortality.²

HIV and syphilis during pregnancy

Statement of the problem: All women should be screened for HIV and syphilis early in pregnancy. All women who have syphilis should be offered testing for HIV infection. Coordinated prenatal care and treatment are vital.¹⁰

Current situation: Inequity in access to screening and treatment for HIV and syphilis during pregnancy is most commonly experienced by women with low education levels and from poorer demographics.²

Equity in neonatal health

Perinatal care and neonatal mortality

Statement of the problem: Perinatal care is intended to evaluate maternal risks of pregnancy, provide appropriate counselling, and an opportunity to maximize maternal health status prior to conception. Neonatal mortality, on the other hand, is defined as a death during the first 28 days of life (0-27 days). The neonatal mortality rate (NMR) differs from the perinatal mortality rate in the sense that it focuses only on deaths among live births and covers a longer period after birth.¹¹

Current situation: Among countries with disaggregated data, the perinatal mortality rate (PMR) is highest among Bolivian women with no education (66 deaths per 1,000 live births). Gaps in the

neonatal mortality rate (NMR) by urban or rural residence are small. In some countries, the NMR is higher in urban areas. One exception is Bolivia, where the NMR is 17 %age points higher in rural than in urban areas. Studies show that indigenous and Afro-descendant populations have higher NMRs than other population groups. Further, decline in neonatal mortality in Brazil has been smaller among Afro-descendant populations than among other groups. Differences in neonatal mortality have been explained in part by poverty, inadequate antenatal care and socioeconomic inequality.

Studies in Brazil have shown that poorer health outcomes among Afro-descendant children (including higher prevalence of low birth weight, preterm and small-for-gestational age, and higher early neonatal and infant mortality) were attributable to differences in the quality of antenatal care. In Chile, a statistically significant relationship was found between poverty and foetal and neonatal mortality, with significantly higher rates among the Mapuche population. However, despite socioeconomic disadvantages and other documented health inequalities, a well-established antenatal control program contributed to reducing the impact of social inequalities in health between "indigenous infants" and "non-indigenous infants".²

Early initiation of breastfeeding

Statement of the problem: "Breastfeeding" has many health benefits for both the mother and infant. Provision of mother's breast milk to infants within one hour of birth is referred to as "early initiation of breastfeeding" and ensures that the infant receives the colostrum, or "first milk", which is rich in protective factors. Breastfeeding has also been associated with higher intelligence quotient (IQ) in children. Current evidence indicates that skin-to-skin contact between mother and infant shortly after birth helps to initiate early breastfeeding and increases the likelihood of exclusive breastfeeding for one to four months of life as well as the overall duration of breastfeeding.¹²

Current situation: In contrast to indicators for service utilization and health outcomes, overall, women who are poorer, less educated, rural and indigenous initiate breastfeeding earlier and breastfeed for longer durations. Nonetheless, this is not an issue for complacency as some of the available evidence indicates a downward trend in breastfeeding.

The lowest prevalence of early initiation of breastfeeding is among the wealthiest women in El Salvador (21%) and Brazil (27%). In El Salvador and Peru, women in the poorest quintile initiate breastfeeding early at twice the prevalence found among the wealthiest: 71 versus 35% in Peru and 42 versus 21% in El Salvador. Although in most countries, the poorest women initiate breastfeeding earlier than other women in their countries, 62% of wealthier women in Colombia start early compared to 51% of the poorest.

In Bolivia, Dominican Republic, Honduras, Panama and Suriname, women with no education and those with primary education initiate breastfeeding earlier than women with secondary or higher education. Further, Both in Guatemala and Panama, the prevalence of early initiation of breastfeeding are higher among indigenous populations than among other groups (60 % in Guatemala and 63% in Panama).

Although indigenous women throughout the region maintain high breastfeeding prevalence, downward trends among certain groups, both in the national median duration and in exclusive breastfeeding, are a cause for concern. Breastfeeding duration and exclusivity in LAC vary due to numerous factors including socioeconomic position, education and geography.²

Postnatal care for mothers and newborns

Statement of the problem: The postnatal period is a critical phase in the lives of mothers and newborn babies. Most maternal and infant deaths occur during this time. The days and weeks following childbirth (the postnatal period) are a critical phase in the lives of mothers and newborn babies. Most maternal and infant deaths occur in the first month after birth: almost half of postnatal maternal deaths occur within the first 24 hours, and 66% occur during the first week.¹³

Current situation: There are great variations between countries in the %age of newborns who receive postnatal care within two days after birth. In Colombia, it is only 7%. The lowest percentage of newborns with postnatal care is Colombian children of all income groups (below 8%) and Haitian newborns of the four lowest income groups (ranging between 9 and 20%). The widest gaps between the poorest and the wealthiest are in Bolivia (46 percentage points), Haiti (35), Honduras (24) and Panama (24).

Postnatal care is lower for rural newborns, with the lowest coverage found among rural Haitian newborns (14%). The widest gaps are in Bolivia (26 %age points), Paraguay (21), Panama (18), Dominican Republic (16), Haiti (15) and Honduras (14).

In all countries, postnatal care is less frequent among newborns whose mothers have no education, particularly in Haiti (9%). The gaps between newborns whose mothers have no education and those with secondary or higher education are as large as 51 %age points in Panama, 39 in Bolivia, 29 in Honduras, 22 in El Salvador and 20 in Peru. In Panama, 100% of Afro-descendant newborns receive care within two days after birth, but indigenous children lag 30 percentage points behind, with only 70% of newborns receiving postnatal care.²

Results and discussion

Results

Women with socioeconomic disadvantages are less likely to have contact with the health system during one of the most critical times in their lives: pregnancy and childbirth. The data indicate that disadvantaged women have less access across the continuum of antenatal visits and birth attendance, but particularly troubling are the very low levels of health care utilization around the time of birth, the most vulnerable period for mother and child. Birth services must be available 24 hours a day, seven days a week and include referrals for birth and obstetric complications and emergencies. Quality birth services are a critical component of addressing the poorer health outcomes, including maternal mortality, among the most vulnerable women. Vulnerable women face various barriers to accessing routine reproductive health care, resulting in an unmet need for contraception, unintended pregnancies and undiagnosed sexually transmitted infections (STIs) and cancers.²

The reproductive and maternal health situation prevailing in LAC countries requires increased attention on reproductive and maternal health services. Equally important is to ensure that women have access to such services which is often hindered due to several factors, including lack of knowledge and awareness, poor transportation facilities, etc.

The Family Care International (FCI) program of the Management Sciences for Health (MSH) advocates at the global, country, and community levels, for improved sexual, reproductive, maternal,

newborn, and adolescent health and rights. Launched by MSH in January 2016, this new program builds on a formidable history of effective evidence-based advocacy and capacity-building by (FCI), a leading global advocate for women's health and rights for three decades. FCI's programs and many of its international and US-based staff have become part of MSH, reinforcing reproductive, maternal, newborn, and adolescent health as an integrating theme that extends across MSH's work to strengthen health systems for greater health impact.¹⁴

Management of initiatives taken under FCI program of the MSH has been, in greater details, discussed below:

- a) **About the MSH:** The MSH works in the LAC region through a variety of programs that range from strengthening management skills and systems within the public and private health sectors to supporting health facilities to improve quality and access to health services for women, men, and children, including immunization, family planning, and HIV & AIDS prevention and care.¹⁵
- b) **Mission and vision of the MSH:** (1) Mission: Saving lives and improving health of the world's poorest and most vulnerable people by closing the gap between knowledge and action in public health. (2) Vision: A world where everyone has the opportunity for a healthy life.¹⁵
- c) **Overview of the project:** In partnership with UNFPA's Latin American and Caribbean Regional Office, the FCI Program of MSH provides technical assistance and advocates for strategies and commitments to improve reproductive, maternal, newborn, and adolescent health in LAC region.¹⁵ The program aims to:
 1. Strengthen national and regional capacity to deliver quality services to adolescents according to regional adolescent sexual and reproductive health standards.
 2. Strengthen midwifery leadership and organizations in LAC by supporting their capacity to implement small grants, provide competency-based education and to strengthen the leadership of young midwives.
 3. Fosters commitments towards safe motherhood through technical assistance to the Regional Task Force on Maternal Mortality Reduction (GTR for its Spanish acronym), of which MSH is an Executive Committee Member.
 4. Work with GTR member agencies to reach agreement on content of the updated Strategic Consensus on Maternal Mortality Reduction.
 5. Increase visibility of respectful maternity care in the region.
 6. Promote integration of intercultural maternal health standards of care.
 7. Strengthen implementation of regional maternal mortality surveillance and response guidelines.
- d) **Practices:** The MSH applies its health systems strengthening approach through the following four practices:
 - i. Advocacy: advancing sound, evidence-based health policy decisions, sharing our experiences and best practices from the field, and increasing the health focus of coalitions and international groups concerned with broader development issues.

- ii. Capacity Building: people-centered approach, focusing on people at all levels of the health system: (a) individuals who make decisions about their health, (b) community health workers who bring services close to the home, (c) facility health workers who administer essential health services, and (d) government officials who set standards and allocate resources.
- iii. Evidence: programs are designed and implemented based on public health evidence that is applied to the local needs and priorities of the countries, institutions, and population groups, aiming to strengthen health systems and achieve the greatest health impact.
- iv. Innovation: strong health systems to deliver “life saving care” on a large scale.

The MSH applies these practices at all levels: from the household to the community, to the health facility, to national authorities. Also, it may apply these practices to all sectors: (a) public, (b) private, and (c) social.¹⁵

e) Initiatives: The MSH works on crosscutting issues that are essential to saving lives and improving health. These issues are at the core of MSH’s health systems and health area work. This takes the MSH closer to its vision of working toward a world where “everyone has the opportunity for a healthy life”. They also get at our core belief that health is a human right, realized progressively through equitable access to health care for all. Further, universal health coverage and gender are at the center of post-2015 frameworks for sustainable health development goals. Priority initiatives of the MSH are:

- i. Gender: The MSH believes that health is a human right and, thus, promotes equal access to all aspects of healthcare for women and girls and continuously seeks to identify and address gender norms that limit equal access to health. It is committed to supporting gender integration through our program implementation and advocacy efforts and are continually assessing and revising our approaches to align with international best practices and to respond to local needs in order significantly impact health outcomes for all.
- ii. Universal Health Coverage: The MSH supports universal health coverage for all, especially for the poorest and most vulnerable people. It works toward equitable access to essential health services at an affordable cost. Universal Health Coverage (UHC) is complete health sector reform. The MSH believes strong health systems are essential to achieving universal health coverage.
- iii. No More Epidemics: It is campaign that brings together partners from the business community, academia, and civil society to work with governments and multilateral institutions to ensure we are better protected from epidemics.
- iv. Youth: The MSH actively works at the national, provincial and local level to shape and promote youth-friendly health policies, with a primary focus on regions of Africa, Asia, and LAC. It takes an integrated approach, establishing strong sustainable health systems, to improve and expand access to quality health services for youth (ages ten to 29); engage them as leaders, advocates, and peer-educators in the health sector; and encourage local capacity building and shared decision-making power.

The MSH is paying special attention to addressing health issues that disproportionately affect young people including HIV&AIDS, and family planning and reproductive health. It conducts youth-

centric sexual and reproductive health work in urban and rural areas across Africa, Asia, and countries in LAC.¹⁵

The MSH believes in supporting young people’s leadership potential, capacities, and abilities to influence peers, communities, and future generations to live healthy lives and contribute to improved community well-being. Its programs target youth directly through leadership training and increasing access to health services, and indirectly through health systems strengthening and capacity building.

The MSH is paying special attention to addressing health issues that disproportionately affect young people including HIV & AIDS, family planning, malaria and tuberculosis. It realizes the positive impact that occurs when youth reach out to youth especially in the area of HIV & AIDS and other sensitive health matters.¹⁵ Capitalizing on this benefit, the MSH is actively engaging youth through the following means:

- A. Empowering youth to create changes in policy and practices that are barriers to accessing health care;
- B. Increasing young people’s awareness of their sexual and reproductive health rights (SRHR);
- C. Building youth skills in leadership, management, and governance;
- D. Training “peer educators” who function as community advocates; and
- E. Establishing partnerships with other organizations including the International Youth Alliance for Family Planning (IYAAP) and the International Planned Parenthood Federation (IPPF).

f) Health areas: The MSH focuses its health systems strengthening work on the following key priority health areas:

- i. HIV & AIDS
- ii. Tuberculosis
- iii. Family Planning & Reproductive Health
- iv. Maternal, Newborn, and Child Health
- v. Malaria and other Communicable Diseases
- vi. Chronic Diseases.

g) Health systems: Strengthening health systems is the most sustainable way of improving health and saving lives at large scale. The MSH pursues its mission by building high-impact, sustainable, locally-owned health systems. It applies its expertise across six health systems building blocks, as identified by the World Health Organization (WHO):

- i. Leadership, Management, and Governance,
- ii. Health Service Delivery,
- iii. Human Resources for Health,
- iv. Pharmaceutical Management,
- v. Health Care Financing, and
- vi. Health Information.

The MSH focuses on achieving the greatest health results and serving those most in need. Its pathway to results allows it and its country partners to:

- A. Focus on interventions that work best in project design, implementation, and evaluation;
- B. Foster country-led and country-owned programs to create sustainable health systems; and
- C. Harness the strength of all sectors: public, private, and civil society--to work together as a unified whole.

h) Mechanism of health service delivery: The MSH employs a health systems approach to assist LAC countries to deliver evidence-based interventions and to improve the quality of service delivery. It promotes local and country ownership and strengthens whole systems, including ministries of health, district health offices, health facilities, and communities. It works with local partners to ensure that providers are consistently able to deliver essential health services to clients day after day, from household to hospital.

i) Collaborating partners: Followings are collaborating partners of the MSH:

- a. Government Donors: Since 1971, The MSH has been a trusted partner to government agencies, bilateral donors, development banks, and international organizations working to reach the world's most vulnerable people with essential health products and services. With your support, we build local capacity to create sustainable health systems, delivering value for money at every step along the way.
- b. Private Donors: The MSH partners with foundations and corporations to strengthen health systems around the world. It works to scale up innovations that deliver "life-saving products and services" to those who most need them.
- c. Collaborating Partners: Saving lives and improving health is not something we can do alone. The MSH has established strong relationships with partners around the world. By sharing knowledge, exchanging skills, and leveraging our resources, it is working to create lasting solutions to the world's most challenging health problems.

The MSH partners with governments and non-governmental organizations (NGOs) to improve the efficient and equitable use of financial resources to advance health system outcomes in terms of health status, equity, quality financial protection, and people's satisfaction. It works with countries to allocate financial resources for health and increase access to quality services through evidence-based and sustainable health financing strategies.¹⁵

Discussion

The MSH, a global health ("non-profit" in nature) organization, uses proven approaches developed over 40 years to help leaders, health managers, and communities in developing nations build stronger health systems for greater health impact. It works to save lives by closing the gap between knowledge and action in public health. Since its founding in 1971, the MSH has worked in over 150 countries with policy-makers, health professionals, and health care consumers to improve the quality, availability and affordability of health services. Working with governments, donors, nongovernmental organizations, the private sector, and health agencies in LAC, it responds to priority health problems such as:

- a) HIV & AIDS; tuberculosis
- b) Malaria

- c) Maternal, newborn and child health
- d) Family planning and reproductive health
- e) Chronic non-communicable diseases, such as cancer, diabetes, and lung and heart disease.

Through strengthening capacity, investing in health systems innovation, building the evidence base, and advocating for sound public health policy, the MSH is committed to making a lasting difference in global health. Its aspiration is: "working shoulder-to-shoulder with local colleagues and partners and empowering them for success".¹⁵

Conclusion

Although many countries throughout LAC have enacted efforts to expand health services for poor and vulnerable populations; health inequity remains widespread in the region, especially for 'women', 'infants' and 'children'. The FCI program of the MSH has strived to narrow these gaps and inequalities. The MSH advocates for increased resources for global health; (a) advancing sound, evidence-based health policy decisions globally, (b) sharing experiences and best practices from the field, and (c) increasing the health focus of coalitions and international groups concerned with broader development issues.

Most importantly, the MSH strives to deliver sustainable results through strong monitoring and evaluation practices that inform management decisions in all of our projects. In addition, it uses implementation research for testing the most appropriate technical innovations to expand and to bring to scale evidence-based interventions in complex health systems. In many settings, where MSH works, health leaders must overcome limited resources, weak infrastructure and personnel shortages. They may be emerging from armed conflict or natural disaster. The MSH has been developing innovative solutions for over the years.¹⁵

The paper concludes that the motto of the MSH (*Stronger Healthy System. Greater Health Impact*) holds true in view initiatives undertaken to further reproductive and maternal health in LAC countries. However, much more needs to be done, as evidences indicate that "women in LAC are likely to be affected more severely by the consequences of unwanted pregnancy and unsafe abortion".

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Conflict of interest

The author of this paper (Dr. Santosh Kumar Mishra) declares that there is no financial interest involved and that no conflict of interest exists.

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