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MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMS

This report of the Director analyzes the activities carried out by the Pan American Health Organization during the period 1985–1988 in compliance with "the Organization's Action Policy with Respect to Population Matters," approved by the XXX Meeting of the Directing Council in 1984.

The document has two objectives: first, to analyze the activities carried out by the Organization pursuant to the mandates from 1984 and 1985, and second, to point out the lines of work that should be emphasized in the coming years in light of the socio-economic, demographic, and health trends in the Region.

Analysis of the activities carried out reveals that the objectives adopted in 1984 are still in effect. The report analyzes the achievements obtained with respect to regional maternal and child health goals, in addition to the constraints that persist and call for sustained efforts. These include difficulties related to intersectoral coordination, articulation of international cooperation, and the organization and quality of health services for children and women of reproductive age.

The pressing problem of maternal mortality is stressed, the true magnitude of which is beginning to be revealed in the first research carried out pursuant to mandates from the Governing Bodies. Also pointed out is the growing importance of the population of adolescents and young people because of its magnitude and health risks.

With respect to both problems, the report emphasizes the need to formulate concrete plans at the country and Organization level with assessable goals, so as to increase the availability and quality of services within the framework of local health system development.

In addition to analyzing the activities carried out during the period from 1984 to the present, the Executive Committee is asked to confirm the lines of work that have been followed, or to propose additional guidelines, bearing in mind the impediments to rapid progress that exist in this field.

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MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMS

I. BACKGROUND

The present document has been prepared by the Secretariat pursuant to Resolution XVIII of the XXXI Meeting of the PAHO Directing Council (1985), "Maternal and Child Health and Family Planning Programs," which in paragraph 2.b requested the Director to present a second progress report, which is hereby submitted to the 101st Meeting of the Executive Committee for its consideration.

This report also takes into account Resolution IX of the XXXII Meeting of the Directing Council (1987), which emphasizes the need to provide women with access to adequate services in order to ensure a maternity process without risks and thereby diminish mortality and morbidity in the reproductive period.

II. SALIENT FACTS AND TRENDS FOR THE PERIOD 1980-2000

Major differences in levels and trends of the demographic indicators continue to persist in the Region in 1988, both between countries and between geographical areas and socioeconomic strata within the countries, largely because of the serious crisis affecting the Region (Table 1).

Despite the efforts that have been made, a major problem continues to be the lack or poor quality of statistical data, which cannot be analyzed or utilized to design and reorient the services and care that are being provided to groups at greatest risk.

In the analysis of demographic perspectives for the period from now to the year 2000, it is still important that consideration be given to population growth, life expectancy, spatial distribution, fertility, mortality, and distribution of the population in terms of specific variables.

According to the latest United Nations report of population estimates and projections, in 1984 (1) Latin America was the second most rapidly growing area in the world as a result of a moderate but continuous decline in mortality and a rapidly falling birth rate over the two last decades. Population growth around 1987 is estimated at 2.3%, which means that it will double in 30 years. It is expected that the growth rate will continue to decline, reaching a level of 1.67% by the year 2000 (2).

Life expectancy in Latin America and the Caribbean during the period 1985-1990 is around 64 years (Table 2). Among the countries with the greatest increases are Honduras, Nicaragua and Peru, and among those with the least, Costa Rica, Cuba, Jamaica, Uruguay, and Venezuela. The change in the first three countries may be attributed to the successful

control of childhood diseases through simple, high-impact technologies. Nevertheless, a special effort will be required in order to attain the internationally set goal of 70 years by the year 2000. Costa Rica, Cuba, Jamaica, Uruguay, and Venezuela, on the other hand, have been concerned with controlling the factors associated with early perinatal mortality and the degenerative diseases of advanced age--tasks that entail the use of high-level medical technology and changes in the lifestyles of the population, both of which are difficult in Latin America and take a long time to show results.

Mortality in children and women from causes associated with the reproductive process not only reflects the excessive biological and psychosocial loss in terms of deaths but also indicates the severity of the social cost and serves to predict the quality of life and the future prospects for those who survive.

In Latin America and the Caribbean, child mortality continued to decline in the first five years of the 1980s except in Panama, the Dominican Republic, Guadeloupe, and Guyana. The most notable declines during that period were in Chile, Jamaica and Trinidad and Tobago. The lowest figure recorded was 9.2 per 1,000, and the highest, 68.5 per 1,000 (Table 3).

Other sources report data that confirm, at least initially, the deterioration that the crisis has caused in the health of children, especially among the very poor. For example, of eight countries which at the world level have shown increases in child mortality, five are in Latin America, and of 28 that have reported increases in malnutrition, 10 are in the Region. If we discount the increases that might be attributed to improvements in registration, the sensitivity of child mortality as an indicator of socioeconomic conditions is confirmed (3).

Bolivia, Brazil, Colombia, Haiti and Nicaragua did not report official data to PAHO between 1980 and 1985. This lack of information corresponds to a population of 169.6 million--47.2% of the population of Latin America. This is perhaps the most notable aspect of the analysis, and represents the most urgent challenge to be dealt with in the short term. On the other hand, it should be pointed out that of the 25 countries that reported data to the regional system, 17 have already achieved the goal of reducing child mortality to less than 30 per 1,000 live births by the year 2000.

Despite the declines in child mortality rates, they continue to be excessive in some countries and social groups. Thanks to advances in the control of diarrhea, acute respiratory infections, and diseases preventable by vaccination, there has been a significant decline in child deaths from these causes in almost all the countries. Deaths due to perinatal causes have moved up to first place in 21 countries in the Region. A decline in these rates can only be achieved through fertility regulation on the basis of risk, and through broad coverage through services for prenatal, delivery, and newborn care.

Maternal mortality, like child mortality, reflects differences in health and living conditions and is a good indicator of socioeconomic conditions and of the coverage and quality of services provided to women of reproductive age. Some of the PAHO/WHO-supported research has shown that underregistration of maternal deaths is higher than that registered, as well as deficient certification of the causes. In the Region there are 34,000 maternal deaths registered each year, which probably means, in light of the foregoing, that the real figure is more than 68,000. Abortion and its complications continue to cause approximately 30% of maternal deaths (Table 4).

The risk of women dying from causes associated with maternity is estimated at 1:73 for South America; 1:140 for the Caribbean; 1:6,366 for the United States of America and Canada; and 1:9,850 for Northern Europe (4). While not discounting the macrosocial factors that act as determinants, it can be said that most maternity-associated deaths in our Region could be prevented through organized and adequately planned actions by the health services. The existence of high maternal mortality in a country or region cannot fail to be a serious warning of possible inadequacies in the coverage and/or quality of health services for women. It should also be seen as an expression of the disadvantages faced by a sizable portion of the Region's female population in fulfilling their fundamental rights (5) (see Annex).

Overall fertility in the Region has been declining for all the countries in the last 20 years (5.9 to 4.0 children per woman), but this level still almost doubles the figures in the more developed countries. Age-specific fertility has fallen, especially among women over 30; there has been a moderate drop in the 20-to-24 year group and a very modest decline in women under 20. Estimates up to the end of the century show sustained declines for all the countries (Table 5).

These changes in fertility mean that for women under 20 there is a proportional increase in fertility and that in the years to come there will be an increase in the absolute number of births, given the larger number of cohorts who will be reaching reproductive age. If current socioeconomic conditions continue, there will be a large number of adolescent pregnancies occurring in unstable unions without social support systems, which increases the risk of psychosocial imbalances as well as of disease and death for mothers and their children.

Pregnancies in the extreme ages of reproductive life, high parity and pregnancies less than two years apart--especially when health services are insufficient--continues to be a major risk factor. This phenomenon is observed in all social strata, especially the lower educational and socioeconomic levels. There have been improvements in the educational level of women in the Region, but much still remains to be done.

The population distribution will continue to have an important proportion of youngsters. Adolescents and young people between 15 and 24 years of age will represent approximately 20% of the total population,

which in absolute numbers will mean around 124 million by the year 2000. Earlier onset of menarche, later marriages, changing values as a result of urbanization, cultures brought into contact by migration and new transportation routes, and the decline of the extended family are all factors that will increase the risks for this age group. These added risks will call for services for the prevention and treatment of accidents, suicides, drug abuse, alcoholism, sexually transmitted diseases, pregnancies, abortions, and births in the younger population.

Increasing urbanization is the most important demographic phenomenon in Latin America in the current decade, and it is estimated that 76% of the total population will live in cities by the end of the century (Table 6). The extent of this phenomenon is seen in the emergence of megalopolises and the hoardes of recent immigrants that surround them. It is predicted that by the end of the century there will be nine cities with populations of more than 5 million, and 14 of them will have between 2 and 5 million (6). The social implications of this situation, which will reflect the conflicts at the family and individual levels, are only too well known. They are an index of the political, social, and economic difficulties that make it impossible to forecast or regulate the movement of human groups from rural to urban areas.

The consequences are clear: explosive growth in a limited territory without adequate infrastructure offers an inhospitable habitat for a population that is urgently pressing for changes from the life they had where they came from. The sectors of education and health are most affected by this demographic phenomenon; all efforts to provide services in satisfactory quantity and quality are threatened by the growth that is taking place from one day to the next. There will doubtless be mounting pressure on the Governments of the Region to meet the basic needs of the people in their cities. In addition, the urban and surrounding areas will have to provide jobs for the increasing numbers of young people, estimated at between 4 and 5 million, who enter the labor market annually.

Nor can we overlook the large-scale involuntary external and internal migrations associated with political conflicts in the Region, or the voluntary migrations dictated by the search for opportunities to escape from extreme poverty. The living conditions of these groups, consisting mainly of women and children, are worse than those of the urban migrants. Their situation of instability makes it difficult for them to gain access to and receive basic services, which are sometimes even denied them because of their illegal status.

Children in irregular situations, living in the streets or without families, are an increasingly serious problem in Latin America. UNICEF has estimated that in 1986 this population numbered 20 million--children who are denied their fundamental rights, leading to the well-known social consequences: child abuse, prostitution, exploitation, and sale of children (7). Among the survivors, many will be incapable of loving and building a family because they never received affection as children (8).

III. ANALYSIS OF THE STRATEGIES FOR ACTION APPROVED BY THE GOVERNING BODIES IN 1984 AND 1985

Based on the program priorities of the Organization set forth in the Basic Principles for Action for 1987-1990, the strategies and activities have centered on: 1) the development of infrastructure for the health services through the mobilization of national and international resources, the definition of intersectoral activities and national programs, and support for the development of local health systems (SILOS); 2) attention to priority problems, in this case of women of reproductive age and children, for whom application of the risk approach was set as a priority and for whom normative criteria were developed focusing on the most urgent problems and conditions to be dealt with: prenatal monitoring, delivery care, care of normal and low-weight newborns, and fertility regulation; and 3) the management of knowledge through the dissemination of scientific and technological information on important aspects of maternal and child health and family planning.

To meet this challenge will call for a far-reaching transformation in the health system and services in order to improve coverage and the quality of care with equity, efficiency, effectiveness, and the participation of society. To this end, comprehensive guidelines have been developed for studying the conditions of efficiency that will enable those responsible for units and local systems to become familiar with the standards for organization of the services. All the actions mentioned in the present report have had this frame of reference. The following sections contain an analysis of the progress made jointly by the countries, the Organization, and international cooperation agencies in executing the principal lines of action recommended, some cases two or more strategies being combined under a single heading.

1. To formulate and apply population policies adapted to the particular socioeconomic development plans

The role of the Organization in the execution of this strategy is limited to promoting the participation of the health sector in the design and implementation of population policies, for which purpose it also sponsors its delegates' participation in international conferences where these issues are debated. Through direct technical cooperation and the dissemination of information the countries are kept up to date and provided with frequent material on aspects of legislation in the area of population and family planning.

According to the information available as of February 1987 in the United Nations data base on population policies of the United Nations, of 33 countries in the Region that had responded to the surveys, 14 expressed concern about the levels of natural population growth and were taking steps to reduce it. Among these countries were Antigua, Barbados, Dominica, Dominican Republic, Grenada, Haiti, Honduras, Jamaica, Mexico, Peru, Saint Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines,

and Trinidad and Tobago. Although not all of them have enunciated policies specifically on population, the education, health, and other economic and social development sectors are working together to achieve a reduction.

The remaining 19 countries have taken the decision not to intervene in this demographic variable, since they consider that their current level of growth is satisfactory. With regard to the spatial distribution of the population, 22 countries have attempted to stem the flow of migration to the large cities and nine of them have not intervened in this situation. Only two have taken steps to stimulate internal migration to rural areas.

At the present time no country has legal barriers to the use of contraceptive measures.[1] Of 33 countries surveyed, 27 directly support family planning activities, four provide indirect support, and two do not offer services at the government level (9). In Latin America and the Caribbean, more than 90% of the population live in countries where the Government provides support for family planning services based on the exercise of a fundamental human right--to improve health and contribute to the quality of life of individuals and the well-being of families.

2. To improve the quality and use of demographic data and statistics in the services for the identification of population-related health problems and the need for services, and for identification of the groups at greatest risk so that health planning and programming can be improved

The lack, or doubtful quality, of the information collected by some of the services in the Region, coupled with the limited analysis and the little use made of it in formulating and evaluating health policies and programs, continues to be a problem at the end of the 1980s. This situation limits the use of statistics for timely identification of health problems in high-risk groups that would make it possible to define the needs for services and their structure.

It has been noted that external financing for maternal and child health and family planning programs has promoted more extensive and better use of demographic and health data, since the diagnosis of maternal and child health is an indispensable aspect of financing proposals. Despite pro- gress in Argentina, Brazil, Chile, Colombia, Mexico, Panama, Peru and Uruguay, among others, in the identification of extreme poverty or high-risk areas and groups, there is clear evidence that data of this kind are not always being used in deciding on the priority action to be taken.

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[1]Abortion is not included as a contraceptive method of fertility regulation.

In April 1985 the Organization created the Health Situation and Trend Assessment (HST) Program, one of whose objectives is to contribute to a better understanding of the health situation by increasing knowledge and improving the use of information at all levels. One of the Program's tasks is to promote more and better use of morbidity and mortality statistics when they are based on acceptable coverage and are of adequate quality and timeliness. In 1988 a regional meeting was held on guidelines and procedures for the analysis of mortality. The discussions centered on research that has been carried out, as well as on the indicator "potential years of life lost" and its utilization. The Program's second task involves the identification of critical areas and factors that affect the timeliness, reliability, quality, and coverage of information. In this regard, work was carried out jointly with the United Nations Statistical Office, the Inter-American Children's Institute, the Organization of American States, and the International Institute of Vital Records and Statistics to study the possibilities for joint action to improve the registration of vital statistics. Inclusion of the health component in household surveys was promoted, and efforts are being made to reintroduce instruction on the completion of birth and death certificates in medical schools. Seminars and international courses were held to improve the quality of registration and the coding of information and, after consultation with the countries, a regional proposal was made for the 10th Revision of the International Classification of Diseases.

In the future, based on the foregoing, efforts should be made to strengthen the countries' capacity to analyze existing data more efficiently. It is extremely important for information on the maternal and child health situation to be updated before the start of the 1990s, and to be regularly kept up to date, in order to have a basis for reshaping the programs and services in response to the identified needs.

3. To promote studies on population dynamics and demographic variables

The demographic variables that have been of priority concern for the Organization during the period 1985-1988 are child mortality, maternal mortality, and health in the large cities--taking the latter as a consequence of internal migration in some of the countries.

During the period, material was published and disseminated on strategies of primary care for children and on child mortality. This material includes not only analytical models on child mortality but, more importantly, the experiences of some of the areas or countries in the Region--for example, Chile, Costa Rica, Cuba, and Neuquén (Argentina)--and it identifies common strategies for intervention that have significantly reduced the problem. The most significant and widely accepted publication in the countries at all levels was La mortalidad de los niños en las Américas (Child Mortality in the Americas), of which more than 5,000 copies have been distributed. In Central America a study of child mortality is being carried out that will contribute methodologies which could be utilized in other countries or regions.

Between 1985 and 1988 a pro-maternity movement developed at the international level, leading to two international conferences: "Maternity with Safety," sponsored by the World Bank, WHO, and UNFPA, and "Better Health through Family Planning," sponsored by WHO, the World Bank, UNICEF, UNDP, the Population Council, and IPPF, held in Nairobi, Kenya, in 1987. These conferences called for immediate action to reduce maternal mortality through the expansion and improvement of comprehensive care for women.

During the same period PAHO convoked two working-group meetings in Washington, D.C., on the subject of maternal mortality, at which studies supported by the Organization in Argentina, Brazil, Colombia, Cuba, Jamaica, and Peru were discussed. It was concluded that the problem of scant information and inadequate certification was common to all the countries studied. In addition, it was considered indispensable that research variables be expanded to include socioeconomic and service factors so that the possible points of intervention could be identified more precisely. As a result, reference documents were prepared for the study and prevention of maternal mortality (5). Also, the document "Study of Maternal Mortality in the Developing Countries" (WHO/FHE 87.7) was translated. These documents will be of help in completing the protocols and enlisting the participation of the service personnel in research on material mortality, as well as in improving the quality of research being done on the subject, thus permitting a comparison with international goals.

In April 1988 the Regional Meeting on the Study and Prevention of Maternal Mortality, held in Sao Paulo, Brazil, established development nuclei as part of national and international networks for the implementation of a plan to reduce maternal mortality. This plan recommends actions aimed at securing political and legislative support as well as the development of mechanisms that will ensure the mobilization and participation of women, communities, and society. Priority will be given to comprehensive care programs for women, especially the strengthening of local health systems in all possible ways, starting at the level of the community and, throughout the system, the identification of women at reproductive risk so that they can be referred to the appropriate levels of treatment. In this connection, it will be necessary to improve the quality of care and to organize the services and their resources so that the health system can respond to the needs, guaranteeing access to family planning, adequate prenatal control, and the basic obstetrical care, especially at the first level of referral. Research on the services and improvement of the information systems that make it possible to follow up and evaluate the work done will be indispensable. To the extent that the foregoing aspects can be implemented, it will be possible to attain the objective of reducing maternal mortality.

The studies under way reveal both a serious lack of information on maternal deaths and errors in the certification of causes; some of the studies have already disclosed up to twice as many deaths as were actually reported. The effect of unregulated fertility, of educational

level, and of quality and access to services as determinants in maternal deaths is being increasingly better documented, which means that the implementation of actions aimed at reducing these factors can no longer be deferred.

The Organization, through its programs in Health Services Development, Health Policies Development, and Maternal and Child Health, provided collaboration for regional and national meetings on the problems of urban areas in Buenos Aires, Argentina (1984), Guayaquil, Ecuador (1985), and Mexico City (1986).

Under the title "Extension of Social Protection to Urban Marginal Groups," a preparatory meeting will be held in Mexico City in June 1988, and a final meeting will be held in Buenos Aires in November of the same year, both with the assistance of the International Social Security Association.

4. To integrate family planning services into maternal and child health services

The integration of maternal and child health services and family planning services is already a reality in most countries of the Region. In those countries where family planning services are accepted by the population and made viable by the political power at the national or state level, family planning activities are a component of women's health programs within the framework of integrated maternal and child health activities. Currently, in addition to the extension of coverage brought about by this integration there is the possibility that the needs of adolescents will be met, and that truly effective preventive actions will be implemented to drastically reduce maternal and perinatal mortality. Those services that received important contributions from family planning programs saw integral improvement and, according to studies by the Maternal and Child Health Program, the impact was felt in all aspects of the services. At the present stage of integration, the quality of the services still needs to be improved. Success with this challenge will require increased accessibility, the selection of adequate technologies, and the reduction of costs, in addition to the promotion of effective participation by the community and other development sectors.

In this context, the strengthening and development of local health systems (SILOS) emerges as the strategy for the operationalization of maternal and child care, making the most effective use of planning and management in accordance with local needs. This situation dovetails with the steps toward decentralization that are being undertaken in several countries of the Region.

At the present time the Organization is working to increase management capability in the health services and to develop integrated local programming. As part of this effort, the Maternal and Child Health Program has assigned priority to training and research activities and to the formulation of criteria that will clearly support the future development of the services.

5. To promote research and financial assistance for manpower training to make maternal and child care and family planning programs viable

Research activities received increased emphasis and resources during the period. The Maternal and Child Health Program, the Latin American Center for Perinatology and Human Development (CLAP), and other PAHO programs are participating in their development. To these efforts are added the support received from the Special Program for Training and Research on Human Reproduction (HRP) and the Family Health Division (FHD) of WHO, UNFPA, and the W. K. Kellogg Foundation, among others.

Because of its contribution of scientific bases for the transformation of health services, health research is being promoted as an instrument for the development of programs, services, and human and health resources for the benefit of human well-being. It also serves as a mechanism for the development of both process and object technologies, with innovation, upgrading, application, and technology transfer being used to improve the services for mothers and children. Research is a powerful mechanism for bringing together the institutions of the sector and those of other sectors in pursuit of health objectives.

The Latin American Center for Perinatology and Human Development continued to work on the development and promotion of epidemiological and operational research for intervention and action, with a heavy component of appropriate technology development and evaluation, through a network of more than 100 maternity services in the Region (Figure 1), covering such subjects as premature birth, frequency of cesarean section, and low birthweight. As a result of this research, 120 scientific articles were published, both in journals of the Organization itself and in international scientific journals. The results supported the development of normative criteria at the country level.

Among the research projects under way or already carried out are the following: in nine countries studies are under way, some of them already noted, on maternal mortality; in 1987, to follow up and evaluate the impact of child survival programs under the health priorities initiative for Central America and Panama, a study of child mortality was initiated in Central America; in three countries an evaluation is being made of household registration of child growth and development, the preliminary data from which confirm that the mother can effectively monitor the growth and development of her children if she is motivated and adequately briefed; in seven countries, in accordance with the local situations, studies are being carried out on risk factors for different population groups, and at least two governments and one institution have reorganized their services based on the results of their investigation; in 10 countries work is under way in the area of family planning and adolescence, including integrated surveys of service coverage, and the findings have made it possible to characterize the exposed groups and redirect the corresponding programs so as to provide them with better support; in 16 countries of the Region, the efficiency of the services being provided to mothers and children has been evaluated at 1,052 sites

of different levels of complexity, and an understanding of the critical situation and of the deficiencies in the services has made it possible to orient cooperation and national efforts so as to improve the organization of the latter; in three countries, support was given for research on the participation of women, which has shown that women take an active part in the improvement of programs; and, finally, ongoing support has been given to the Latin American collaborative study on birth defects which will enable to countries to have national registers and data on the frequency of the most common defects. These 48 studies involve the participation of 21 countries. In all the areas mentioned, efforts are under way to promote multicenter research that will make it possible to establish networks of centers or collaborating groups for the short-term improvement of services provided to the population.

There are a total of 165 Latin American institutions collaborating with HRP/WHO, 16 of which receive resources for institutional development. Of the 25 WHO centers collaborating in the Program's activities, five are in the Region, and 35 scientists serve on the Program's various committees. The areas supported by HRP/WHO are development of new methods, effectiveness and safety, infertility, and psychosocial and services research.

With a view to improving the research protocols, between 1986 and 1987 CLAP held six workshops on methodology for operational and clinical epidemiological research, with the participation of 140 professionals from various disciplines. The expected impact is a growing interest in maternal and child health services research, greater political support for research, and a qualitative improvement in the services.

There is ongoing communication and exchange of data with the U.S. Centers for Disease Control (CDC) and with Westinghouse Health Services, which carry out, jointly with the countries, surveys on the prevalence and use of contraceptives, as well as on the reproductive health of adolescents in Latin America. An effort is being made to disseminate the reports in order to support the processes of decision-making and updating of the health diagnosis.

During the period 1985-1988, research funding by UNFPA remained stable at around US$100,000 a year, that of HRP/WHO, around $2 million a year, and that of PAHO, around $80,000 a year.

The training activities supported by the Regional Maternal and Child Health Program were varied and far-reaching. They included, in particular, training in the administration of maternal and child health programs, project management, introduction to maternal and child public health, perinatal and postnatal growth and development, and adolescence and perinatal health. The activities benefited from the active participation of public health educational institutions in the Region, national institutions, international cooperation agencies, and the already prestigious CLAP teaching programs. It is estimated that these activities involved more than 2,000 professionals from all the countries,

their level of participation depending on the resources available. This group, plus those trained through country projects, made for a total of 12,000 people trained between 1985 and 1988.

Up to now there have been some difficulties in controlling the capabilities and prior background of the participants. It is still common for international fellows to not exactly meet the required conditions and for the groups to be too heterogeneous in terms of capabilities and prior background. Moreover, it is still not possible to ensure that the fellows after their return will actually work in the areas for which they were trained. In 1987 UNFPA conducted an external evaluation of training activities in four countries (Brazil, Honduras, Mexico and Panama) which highlighted the lack of plans for human resource development in both the training and the employing institutions; it was stressed that the training of health service personnel be directed more toward concrete skills that will improve the quality of service delivery.

There is much room for improving the training activities and their quality, both at the regional and the country level. This will call for the participation of Governments and PAHO to control the trainee selection process and follow-up on their subsequent incorporation into the health services system.

It should be recognized that training opportunities in maternal and child health and family planning, especially those carried out with PAHO resources and projects financed by AID, UNFPA, and the W. K. Kellogg Foundation, are becoming the most important resources for meeting manpower development needs. Several countries have spoken up, and initiated efforts jointly with the Maternal and Child Health Program in an effort to integrate the care components, either by extending the periods of training or by developing programs of continuing education.

6. To disseminate information and advisory services in the community in order to achieve its participation

The present report includes activities carried out in the scientific, political, and economic communities and in society at large, since they all in some way and at some time participate in the decision-making process with respect to personal, family, and community reproductive behavior, as well as in regard to the services that are required in order to meet the demand.

During the period from 1985 to 1988 the Organization has attempted--through timely translations and an active program of scientific publications, pamphlets, and scientific and technical material--to create a permanent and growing presence in fulfilling its obligation to keep the community up to date. The library's collection in the area of human reproduction was increased by more than 2,000 titles, thus not only contributing to the program's institutional memory but also placing microfilmed material at the disposal of the countries. Steps were also taken to set up specialized sections on human reproduction and

maternal and child health in the Documentation Centers of the PAHO Country Representative Offices. It is felt that, in order to disseminate and promote knowledge about the technical and scientific aspects of the programs, efforts should be made to reach out on a regular basis to teaching institutions, legislative areas, and the institutions of the education, agriculture, and labor sectors--a task that can only be achieved with the cooperation of the countries.

In some cases, when community participation in health is already a reality, the task of dissemination is the responsibility of the grassroots organizations of the community itself, financed mainly by country projects, UNFPA, and PAHO through the health infrastructure. The Organization participates in drafting the messages, proposing the strategies for dissemination, and selecting the media. At the level of the health services program, conceptual aspects have been developed for social participation in local health systems as well as for a plan of action to provide support for the countries. Through these activities the Maternal and Child Health Program hopes to improve its cooperation in this field.

7. To educate and train young people in sexual matters and family life

The demand for technical cooperation in the field of adolescent health grows constantly, while the health problems that this group faces are getting worse every day. This situation led the Forty-eighth World Health Assembly to agree that the subject be included in the Technical Discussions for 1989 and that beginning in 1991 a program on adolescence be implemented with its own identity and resources.

Since 1985, with a view to forming a critical mass of professionals capable of developing programs and services for adolescents, four seminars were held with the participation of staff from the Organization and national professionals responsible for adolescent services in some of the countries. The last of them, held in April 1988 in Campinas, Brazil, led to the formation of national development nuclei which will make up a network in the Southern Cone and Brazil. Support was provided in Uruguay for 10 courses for educational personnel from the Ministry of Education to develop sex education curricula and teaching materials as well as to explore means of intersectoral cooperation. The methodology will be made available to the countries.

Although there are adolescent care programs in Argentina, Brazil, Chile, Costa Rica, Mexico, Panama, Venezuela, and all the Caribbean countries, they need to be reviewed and brought up to date in terms of both their conceptualization and their strategies and approaches. Accordingly, the Organization has initiated an effort to integrate the activities carried out by the various technical groups. In the area of information, there are two publications: La Salud del Adolescente y el Joven en las Américas and The Health of Adolescents and Youths in the Americas, (Scientific Publication 489). In 1988 the resources required to initiate development in this area were included in the regional programs supported by UNFPA and the W. K. Kellogg Foundation.

The knowledge that is being acquired through the research on adolescent behavior described above will enable the programs and their activities to respond to the identified needs. A certain amount of progress has also been made in the design of educational material for adolescents, which will soon be distributed in the countries.

8. To intensify the Organization's coordination with the agencies of the United Nations system and the governmental and nongovernmental agencies with a view to enlisting a maximum of resources for the support of maternal and child health and family planning programs

The Organization and the Maternal and Child Health Program are continuing to develop their capabilities and diversify their strategies for the mobilization of national and international resources.

It is recognized that the national resources allocated for maternal and child care are infinitely greater than those that could be contributed through external financial and technical cooperation. Technical cooperation promotes the mobilization of national will and its resources, and it serves as a catalyst for actions at the operational level.

The Maternal and Child Health Program maintains a continuous dialogue with the academic community through congresses and pre-congress activities in the areas of gynecology, obstetrics, pediatrics, and public health. This has made it possible to benefit not only from the information that these professionals have to offer but also from their active participation in the programs.

In Latin America and the Caribbean there are nearly 60 maternal and child health and family planning health projects supported by various financial sources in 31 countries in the Region. Still greater efforts are required if these projects are to grow in number and not merely replace national efforts. The resources that these projects generate make activities possible in the areas of training, supervision, equipment, and drug supply, among others. In some countries the projects have made it possible to consolidate the development of jurisdictions and health areas in support of the strengthening of local health services and decentralization.

During the period, efforts were to devoted to mobilizing women's organizations outside the sector to collaborate in the Maternal and Child Health Program. Activities of this nature took place in Honduras, Paraguay and Peru, and it is felt that they may open new perspectives for collaboration that will be multiplied. The schools of public health in Argentina, Brazil, Mexico, and Peru continued to collaborate in training activities, research, and the preparation of materials for manpower development within the programs.

The Latin American Center for Perinatology and Human Development has mobilized national resources by expanding the perinatal network, which at the end of 1987 had more than 100 cooperating nuclei based in maternity services in 27 countries of the Region. They have been the

point of departure for carrying out specific tasks in the countries in the areas of research, education, and health services development, as well as in the formation of national networks starting from the initial nuclei.

With regard to extrabudgetary funds, UNFPA continues to provide the Region with approximately US$7 million annually for the Regional Program and for country projects (Tables 7 and 8). The W. K. Kellogg Foundation provides support on the order of US$380,000 annually for regional activities, plus support, provided directly to the countries, for 31 maternal and child in-service teaching projects. The Carnegie Corporation and the Pew Charitable Trusts have funded a maternal and child health project on the Mexico-United States border with US$500,000 annually (1988-1990). In addition, the Carnegie Corporation contributed $40,000 to develop, as part of the Caribbean Cooperation in Health initiative, a preproposal on maternal and child health for the English-speaking countries. Other proposals developed during the period which are currently under negotiation will make it possible to sustain and even increase the level of extrabudgetary support for the development of national maternal and child health and family planning programs.

The Program provides technical cooperation at the regional, subregional, and country levels for the implementation of maternal and child health projects supported in Central America by the European Economic Community and the Italian Government and carried out by UNICEF within the framework of the Plan for Priority Health Needs in Central America and Panama.

With regard to regular PAHO-country funds for the 1986-1987 biennium, only nine out of 34 countries assigned resources to the area of growth, development, and human reproduction after active promotion and in response to the mandate of the PAHO Governing Bodies. In the 1988-1989 biennium, 26 out of 35 countries have assigned funds for these activities.

In response to the 1984 mandate calling on the Secretariat to coordinate efforts, programmed actions were increased and carried out jointly between units of the Maternal and Child Health Program, other regional programs, WHO/Geneva units, organizations of the United Nations system, and bilateral cooperation and nongovernmental agencies. There is a desire to carry out joint work in all the institutions mentioned--to participate in all stages from early programming to execution, to share technical and financial resources, and to unify the technical messages--with open and timely communication between the professionals who represent them. The cooperation agreements reached some years ago at the regional level are being strengthened, and daily work at the country, subregional, and regional levels is on the increase.

IV. RESULTS

It is difficult to know which changes in the maternal and child health situation can be attributed to technical cooperation and which ones to the daily work of the health sector. However, it is possible to

describe some of the changes observed by citing the activities carried out, especially at the level of the services. At the end of 1987 the following achievements could be mentioned:

Most of the countries have established maternal and child health units and programs of prevention and health promotion and recovery for women and children. Even though these units do not always cover all the interventions that directly affect maternal and child health, there is a general trend toward coordination and integration among those who direct them. Standardization, supervision, training, and evaluation of services are carried out in an increasingly integrated manner.

Use of the risk approach in programming, standardization, and the delivery of services has been expanded considerably. Some of the countries are introducing risk criteria at the local programming level, several use it in patient referral between different levels of care, and almost all of them apply these criteria in the delivery of services to the population through standards designed with this approach in mind.

Ties with the organizations of the United Nations system, bilateral cooperation agencies, and private foundations are becoming stronger and better coordinated. Furthermore, the subregional initiatives have made it possible to exercise and strengthen the mechanisms of cooperation among these institutions and between countries, such as the exchange of human resources, the joint training of personnel, the sharing of audiovisual and educational materials, the joint printing of documents and bibliographical material, and the exchange of experiences.

Despite the decline that has been seen in child mortality in most of the countries and the increase in services for children, access to child growth monitoring programs continues to be difficult, and it is estimated that coverage is only 65%. The surveillance of children's psychosocial development is still a poorly explored area, since there is no agreement on the appropriate instruments to be used or on the most desirable attitude to be encouraged in health personnel for observing and evaluating the process of children's psychosocial maturation. Prevention activities are being stepped up, as is the use of standardized treatment for diarrheal diseases and acute respiratory infections. Nevertheless, there are large groups that still do not have access to these programs, and sustained efforts will be required in order to reduce deaths from these diseases and continue to increase vaccination coverage.

Prenatal care coverage is on the order of 70%. Worthy of notice are the lack of timeliness with which these services are provided, as well as the low concentration and the still inadequate coverage of pregnant women with tetanus vaccination Coverage with institutional delivery and qualified personal is estimated at 75%; mediatory puerperium care is very low; and the prevalence of contraceptive use in women of reproductive age living in conjugal unions is estimated at around 54%--pointing up the need to promote the transition from traditional methods of fertility regulation to more effective ones, and to increase

the use of these methods in sexually active adolescents (10) (Table 9). The acceptance of family planning as an activity integrated into maternal and child health programs has created greater possibilities for the expansion of coverage and the improvement of services. The use of simplified perinatal clinical histories as a an instrument for the surveillance of perinatal health is being increasingly adopted in the countries.

A great deal of research promoted by PAHO and CDC, among other organizations, provides information on the reproductive behavior of adolescents and young people in several countries of the Region (11). Although the need for intersectoral action is recognized, most of the programs are still either too specific for this purpose or else they are the result of actions being carried out for other purposes, which frequently ends up making for isolated interventions or programs of little effectiveness. Hence it is urgent to undertake a comprehensive review of the health of adolescents that will permit a predominantly educational and preventive approach to risk behavior, and to prepare them, among other things, for love, marriage, and family life so that they will not be exposed to unnecessary risks when they manifest their sexuality.

A worldwide evaluation of family planning programs has shown that out of 21 countries in the Region, six were considered to have good programs; seven, fair programs; seven, deficient programs; and one, a very limited program (12).

Evaluation of the efficiency of maternal and child health services at all levels revealed serious organizational problems. Among the categories analyzed (physical plant, human resources and materials, standards and procedures, programming and administration, supplies, community education, and community participation) the greatest problems were found in standards and procedures and in programming. Out of a sample of 425 services evaluated, it was found that 85% of them were rated "unsatisfactory" or "in a critical situation," while only 15% were considered "acceptable" (13) (Table 10).

From all of the foregoing it can be concluded that, despite the economic crisis being experienced by the countries of the Region, for the most part they have been making progress. But it should be kept in mind that there is still a great deal of room for improvement in the progress observed, especially improvements that will lead to transformation of the health services, higher levels of education, and intensified community participation so as to ensure access to services with equity, efficiency, and effectiveness.

Special attention must be given in the future to extending coverage and to improving the quality of services, since the figures for maternal mortality and its preventable causes are an indicator of access to services and of their quality. From what we already know about maternal mortality, the unacceptable figures continue to call for

priority programs and actions if they are to be reduced in the near future. It is also important to use child and maternal mortality as sensitive indicators of the health situation of neglected population groups.

V. CONCLUSIONS

The strategies for action formulated in 1984 and 1985 continue in effect in light of the activities carried out by the countries and the Organization pursuant to the recommendations of the Directing Council on the subject of population and health. At the present time, however, the important issues are to reduce maternal mortality and increase adolescent care, which call for the formulation of plans of action with clearly defined resources.

Plans of action for the reduction of maternal mortality should incorporate activities of the health sector, other sectors, and the community. Among the health sector activities, emphasis should be placed on determining the true magnitude of the problem and on the organization of prenatal, delivery, puerperium, and family planning services, with special attention to improving response capability at the first level of referral.

With regard to adolescent care, action plans should emphasize preventive aspects aimed at reducing or avoiding risk behavior and its devastating effects on the biopsychosocial development of adolescents, which endangers their maturation and integration into developing societies. Such plans should be integrated with the participation of the community, the family, and adolescents themselves, who should be motivated to accept the challenge of their commitment to the future.

A shared commitment of the health and education sectors in addressing the issues of maternal and adolescent health is fundamental. The education of women will enable them to improve their social mobility and integration into development, permitting them to make their own decisions about child-bearing and greatly increasing their ability to raise and care for their children. For adolescent males, it will prepare them to face the challenges that life imposes on them, to share their lives with women under equal conditions and, later, to live as a couple and raise their families on a more solid basis.

The organization of activities in maternal and child care, adolescence, and family planning should take place within the framework of a strategy for the strengthening of local health systems, contributing to their development and dynamization. In local programming, special attention should be given to the identification of groups at risk. Standardization should be the result of judicious selection of technology, bearing in mind the participation of the community. Evaluation of the services' efficiency should be used as the instrument to diagnose their characteristics and the need for reorientation and reorganization. Special attention should be given to the first level of

referral to make it capable of performing basic obstetrical, gynecological, and pediatric functions, so that ambulatory levels and comprehensive care can be complementary. Support should be given to the formation of networks of development nuclei to facilitate the exchange of knowledge, the improvement of research, and the training of human resources to operate the system. Mobilization of the national and international resources required by the process should be continued.

Priority importance should also be given to the coordination of external assistance so that it will provide support for national programs without dispersion of efforts or distortion of objectives. Steps should also be taken to articulate the activities carried out by nongovernmental agencies with national programs. Only to the extent that efforts and resources can be joined in the pursuit of common objectives will there be a chance to achieve them sooner, at an acceptable social cost and with the contribution of the countries.

It is hoped that from the discussion of this report the commitments undertaken collectively in previous years will be reaffirmed and, in addition, that new lines of action will emerge which will make it possible to update current programs and speed up even more the progress being made, in spite of the economic crisis, in protecting and improving the health of mothers and children. This need takes on greater importance as we approach the beginning of the last decade of the 20th century, at the end of which it will be time to evaluate the achievements that have been made toward the goal of health for all by the year 2000.

Table 1

BASIC DATA FOR ANALYSIS OF THE ECONOMY IN THE COUNTRIES OF THE AMERICAS. 1985.

País	Population (in millions)	GDP Per Capita US$	Average Annual Growth Rate	Average Annual Inflation (%)	Life Expectancy at Birth	External Debt in Millions of US$	External Debt per Capita
Haiti	5.9	310	0.7	7.0	54	704	119.3
Bolivia	6.4	470	-0.2	569.1	53	3,972	620.6
Honduras	4.4	720	0.4	5.4	62	2,713	616.5
Nicaragua	3.3	780	-0.2	33.8	59	5,615	1,701.5
Dom. Republic	6.4	790	2.9	14.6	64	3,294	514.6
El Salvador	4.8	820	-0.2	11.6	64	1,736	361.6
Paraguay	3.7	860	3.9	15.8	66	1,780	481.8
Jamaica	2.2	940	-0.7	18.3	73	3,795	1,725.0
Peru	18.6	1,010	0.2	98.6	59	13,688	735.9
Ecuador	9.4	1,160	3.5	29.7	66	9,233	982.2
Guatemala	8.0	1,250	1.7	74	60	2,595	324.3
Costa Rica	2.6	1,300	1.4	36.4	74	4,191	1,611.9
Colombia	28.4	1,320	2.9	22.5	65	14,044	494.5
Chile	12.1	1,430	-0.2	19.3	70	20,221	1,671.1
Brazil	135.6	1,640	4.3	147.7	65	106,730	787.4
Uruguay	3.0	1,640	1.4	44.6	72	3,910	1,303.3
Mexico	78.8	1,973	2.7	62.2	67	97,429	1,109.5
Panama	2.2	2,100	2.5	3.7	72	4,710	2,140.9
Argentina	30.5	2,767	0.2	342.8	70	48,444	1,588.3
Venezuela	17.3	3,080	0.5	9.2	70	32,079	1,854.2
Trinidad and Tobago	1.2	6,020	2.3	7.6	69	1,087	905.8
Total	380.2	-	-	-	-	380,234	1,000
Canada	25.4	13,680	2.4	6.3	76		
USA	239.3	16,690	1.7	5.3	76		

Source: World Development Report 1987. The World Bank. pp. 202 and 232.

Table 2

LIFE EXPECTANCY AT BIRTH (YEARS) IN COUNTRIES IN THE AMERICAS
1980-1985, 1985-1990, and 1995-2000

Country	1980-1985	1985-1990	1995-2000
LATIN AMERICA			
Andean Area			
Bolivia	50.7	53.1	59.4
Colombia	63.6	64.8	66.9
Ecuador	64.3	65.4	67.7
Peru	58.6	61.4	67.0
Venezuela	69.0	69.7	71.0
Southern Cone			
Argentina	69.7	70.6	72.0
Chile	69.7	70.7	72.0
Paraguay	65.1	66.1	67.8
Uruguay	70.3	71.0	72.1
Brazil	63.4	64.9	67.5
Central America a)	64.8	66.5	69.4
Costa Rica	73.0	73.7	74.4
El Salvador	64.8	67.1	71.3
Guatemala	59.0	62.0	67.2
Honduras	59.9	62.6	67.8
Nicaragua	59.8	63.3	68.5
Panama	71.0	72.1	73.3
Mexico	65.7	67.2	69.6
Latin American Caribbean			
Cuba	73.4	74.0	74.7
Haiti	52.7	54.7	58.4
Puerto Rico	74.0	74.7	76.1
Dominican Republic	62.6	64.6	68.1
CARIBBEAN			
Barbados	72.7	73.5	75.1
Guadeloupe	72.4	73.4	74.9
Guyana	68.2	69.8	72.1
Windward Islands b)	69.1	70.4	72.6
Jamaica	73.0	73.6	75.3
Martinique	73.2	74.1	75.5
Other Caribbean c)	70.7	71.8	73.6
Suriname	68.0	69.6	71.9
Trinidad and Tobago	68.7	70.2	72.4
NORTH AMERICA d)	74.4	75.1	76.4
Canada	75.7	76.3	76.8
United States of America	74.3	75.0	76.3

Source: United Nations. World Population Prospects: Estimates and Projections as Assessed in 1984. ST/ESA/SER.A/98. New York, 1986.

a) Includes Belize.
b) Dominica, Grenada, Saint Lucia, St. Vincent and the Grenadines.
c) Anguilla, Antigua and Barbuda, Netherlands Antilles, Bahamas, Cayman Islands, Turk and Caicos Islands, Virgin Islands (US), Virgin Islands (UK), Montserrat, and St. Christopher and Nevis.
d) Includes Bermuda and St. Pierre and Miquelon.

Table 3

CHILD MORTALITY IN COUNTRIES OF THE AMERICAS:
UNITED NATIONS ESTIMATES AND OFFICIAL DATA
PROVIDED TO PAHO

Country	United Nations Estimates[1] 1980-1985	1985-1990	1995-2000	Oficial Data Around: 1980	1985
LATIN AMERICA					
Andean Area					
Bolivia	124	110	74	...	...
Colombia	50	46	39	42.6	...
Ecuador	70	63	52	54.3	40.5
Peru	99	88	66	37.0	33.8
Venezuela	39	36	31	31.7	27.6
Southern Cone					
Argentina	36	32	26	33.2	25.0
Chile	23	20	18	32.7	19.5
Paraguay	45	42	36	63.2	46.0
Uruguay	30	27	23	37.6	29.5
Brazil	71	63	51	81.1	73.7
Central America a)	57	49	37		
Costa Rica	20	18	16	19.1	19.0
El Salvador	70	59	40	53.0	35.1
Guatemala	70	59	40	81.2	68.5
Honduras	82	69	46	23.0	17.4
Nicaragua	76	62	41	42.9	...
Panama	26	23	19	21.7	22.8
Mexico	53	47	37	34.5	33.0
Latin American Caribbean					
Cuba	17	15	11	19.6	16.5
Haiti	128	117	95	...	...
Puerto Rico	17	15	11	18.4	14.9
Dominican Republic	75	65	49	29.7	40.6
CARIBBEAN					
Barbados	14	11	9	22.3	17.3
Guadeloupe	14	12	9	15.3	15.9
Guyana	36	30	22	33.5	36.2
Windward Islands b)	30	27	20		
Jamaica	21	18	14	25.9	9.2
Martinique	14	13	10	11.1	9.4
Other Caribbean c)	26	23	17		
Suriname	36	30	22	34.8	26.7
Trinidad and Tobago	24	20	15	21.7	12.6
NORTH AMERICA d)	11	10	7		
Canada	9	8	7	10.4	7.9
United States of America	11	10	7	12.6	10.6

1/ Source: United Nations. World Population Prospects: Estimates and Projections as Assessed in 1984. ST/ESA/SER.A/98. New York, 1986.

a) Includes Belize.

b) Dominica, Grenada, Saint Lucia, St. Vincent and the Grenadines.

c) Anguilla, Antigua and Barbuda, Netherlands Antilles, Bahamas, Cayman Islands, Turk and Caicos Islands, Virgin Islands (US), Virgin Islands (UK), Montserrat, and St. Christopher and Nevis.

d) Includes Bermuda and St. Pierre and Miquelon.

Table 4

INSTITUTIONAL COVERAGE OF DELIVERY CARE AND MATERNAL MORTALITY IN SOME COUNTRIES IN THE REGION OF THE AMERICAS

Country	Year	Percentage of Deliveries in Institutions	Maternal Mortality per 10,000 Live Births
Netherlands Antilles a)	1983	94.8	2.5
Antigua and Barbuda	1984	86.0 b)	...
Argentina	1981	91.4 c)	6.9
Belize	1984	60.0	4.9
Bolivia	1984	20.0 d)	48.0 d)
Canada	1984	99.0	0.3
Colombia e)	1977-80	54.6	12.6
Costa Rica	1983	92.7	2.6
Cuba	1985	98.8	4.6 f)
Chile	1985	97.7 l)	4.5
Dominica	1983	58.0 g)	5.8 f)
Ecuador	1983	26.9 h)	20.0
El Salvador	1982	50.0 i)	8.5
United States of America	1984	99.0	0.8
Guatemala	1983	22.0	12.3
Haiti	1983	20.0	23.0 f)
Honduras	1983	24.0	5.0
Jamaica	1982	89.0	3.6
Mexico	1981	64.0 i)	8.7
Nicaragua	1984	40.6	4.7
Panama	1984	96.0	4.9
Paraguay	1984	22.0	27.5
Dominican Republic	1980	64.0	7.2
St. Christopher and Nevis	1983	98.0	18.3
Saint Lucia	1983	91.6 j)	2.6
Uruguay	1983	97.2	3.9
Venezuela	1984	98.0	5.9 k)

a) Curacao only. Mortality data from 1981.
b) Births in Holberton Hospital only.
c) Live births in institutions.
d) This figure is based on an estimate that from 80% to 85% of deliveries take place in the community. Mortality data are an estimate for 1980-85.
e) Deliveries and abortions in one year; excludes pregnancies that did not report place of delivery or abortion care. (Result of National Health Study). Mortality data from 1981.
f) 1984 data.
g) Deliveries in hospitals only.
h) Deliveries in institutions of the Ministry of Public Health.
i) Includes all deliveries in health institutions (public, social security, or private).
j) Deliveries in hospitals and health centers.
k) 1983 data.
l) Source: Instituto Nacional de Estadísticas, Anuario de Demografía 1985.

Table 5

OVERALL FERTILITY RATE (FOR WOMEN 15-49 YEARS OF AGE)
IN COUNTRIES IN THE AMERICAS, 1980-1985, 1985-1990, and 1995-2000

Country	1980-1985	1985-1990	1995-2000
LATIN AMERICA			
Andean Area			
Bolivia	6.25	6.06	5.50
Colombia	3.93	3.58	3.00
Ecuador	5.00	4.65	4.00
Perú	5.00	4.49	3.50
Venezuela	4.10	3.77	3.20
Southern Cone			
Argentina	3.38	3.26	2.74
Chile	2.59	2.50	2.37
Paraguay	4.85	4.48	3.75
Uruguay	2.76	2.61	2.38
Brazil	3.81	3.46	2.91
Central America			
Costa Rica	3.50	3.26	2.85
El Salvador	5.56	5.10	4.45
Guatemala	6.12	5.77	4.90
Honduras	6.50	5.59	5.00
Nicaragua	5.94	5.50	4.50
Panama	3.46	3.14	2.65
Mexico	4.61	3.98	3.00
Latin American Caribbean			
Cuba	1.97	1.97	2.10
Haiti	5.74	5.56	5.15
Puerto Rico	2.54	2.44	2.23
Dominican Republic	4.18	3.63	2.81
CARIBBEAN			
Barbados	1.94	2.00	2.08
Guadeloupe	2.55	2.24	2.08
Guyana	3.26	2.75	2.19
Windward Islands a)	3.47	2.86	2.24
Jamaica	3.37	2.86	2.24
Martinique	2.14	2.08	2.08
Other Caribbean b)	2.86	2.55	2.24
Suriname	3.59	2.97	2.25
Trinidad and Tobago	2.88	2.68	2.27
NORTH AMERICA			
Canada	1.71	1.75	1.83
United States of America	1.85	1.91	2.09

Source: United Nations. World Population Prospects: Estimates and Projections as Assessed in 1984. ST/ESA/SER.A/98. New York, 1986.

a) Dominica, Grenada, Saint Lucia, St. Vincent and the Grenadines.

b) Anguilla, Antigua and Barbuda, Netherlands Antilles, Bahamas, Cayman Islands, Turk and Caicos Islands, Virgin Islands (US), Virgin Islands (UK), Montserrat and St. Christopher and Nevis.

Table 6

PERCENTAGE OF THE POPULATION RESIDING IN URBAN AREAS IN COUNTRIES IN THE AMERICAS, 1980, 1985, 1990, and 2000

Country	1980	1985	1990	2000
LATIN AMERICA				
Andean Area				
Bolivia	44.3	47.8	51.4	58.5
Colombia	64.2	67.4	70.3	75.2
Ecuador	47.3	52.3	56.9	64.9
Peru	64.5	67.4	70.2	75.2
Venezuela	83.7	86.6	88.4	90.9
Southern Cone				
Argentina	82.7	84.6	86.2	88.8
Chile	81.1	83.6	85.6	88.6
Paraguay	41.7	44.4	47.5	54.0
Uruguay	83.8	84.6	85.5	87.3
Brazil	67.5	72.7	76.9	82.7
Central America a)	60.4	63.3	65.9	70.6
Costa Rica	46.0	49.8	53.6	60.8
El Salvador	39.3	39.1	39.8	43.6
Guatemala	38.5	40.0	42.0	47.5
Honduras	36.1	40.0	44.0	52.0
Nicaragua	53.4	56.6	59.8	65.9
Panama	50.5	52.4	54.8	60.4
Mexico	66.4	69.6	72.6	77.4
Latin American Caribbean				
Cuba	68.1	71.8	74.9	79.9
Haiti	24.6	27.2	30.3	37.3
Puerto Rico	67.0	70.7	73.9	78.8
Dominican Republic	50.5	55.7	60.4	68.1
CARIBBEAN				
Barbados	40.1	42.2	44.7	51.1
Guadeloupe	43.5	45.7	48.5	55.4
Guyana	30.5	32.2	34.6	41.8
Windward Islands b)	00.0	00.0	00.0	00.0
Jamaica	49.8	53.8	57.6	64.2
Martinique	66.4	71.1	74.7	79.3
Other Caribbean c)	47.7	49.9	52.4	58.7
Suriname	44.8	45.7	47.5	54.1
Trinidad and Tobago	56.9	63.9	69.1	75.0
NORTH AMERICA d)	73.9	74.1	74.3	74.9
Canada	75.7	75.9	76.2	76.9
United States of America	73.7	73.9	74.1	74.6

Source: United Nations. World Population Prospects: Estimates and Projections as Assessed in 1984. ST/ESA/SER.A/98. New York, 1986.

a) Includes Belize.
b) Dominica, Grenada, Saint Lucia, St. Vincent and the Grenadines.
c) Anguilla, Antigua and Barbuda, Netherlands Antilles, Bahamas, Cayman Islands, Turk and Caicos Islands, Virgin Islands (US), Virgin Islands (UK), Montserrat, and St. Christopher and Nevis.
d) Includes Bermuda and St. Pierre and Miquelon.

Table 7

MATERNAL AND CHILD HEALTH/FAMILY PLANNING
PROJECTS FINANCED BY UNFPA AND EXECUTED BY PAHO
1982-1987 (in US$)

	1982	1983	1984	1985	1986	1987
Anguilla	30,619	13,046	1,282	-	7,360	11,800
Antigua	22,118	15,888	13,653	23,147	22,068	16,000
Argentina	-	-	-	-	-	13,700
Belize	-	-	95,305	37,954	23,655	33,940
Bolivia	231,580	394,990	224,332	481,469	388,714	335,000
Brazil	-	136,563	309,634	2,000,316	1,417,913	2,217,290
Virgin Islands (UK)	37,061	26,796	17,108	7,925	15,552	26,200
Cayman Islands	-	-	-	-	-	-
Chile	-	-	-			
Chile	-	32,937	10,474	11,340	7,533	-
Colombia	389,217	953,164	451,595	303,829	162,061	51,000
Cuba	22,451	55,827	37,191	72,315	63,031	149,000
Dominica	18.033	56,909	78,245	60,515	82,032	69,000
Dom. Republic	-	-	73,589	109,408	37,011	80,000
Ecuador	-	-	10,000	338,399	321,954	214,000
El Salvador	7,208	13,542	99,851	24,141	-	-
Grenada	-	-	-	33,616	42,955	67,595
Guatemala	145,110	352,417	481,064	257,867	152,972	84,230
Haiti	445,514	400,610	549,273	554,233	309,284	90,000
Honduras	368,092	414,574	440,746	380,226	217,448	205,340
Jamaica 020	279,825	86,137	278,028	-	-	-
Jamaica 030	1,200	-	15,280	100,309	77,029	45,000
Mexico	562,718	688,398	1,007,574	897,405	374,696	1,292,000
Montserrat	-	4,800	9,827	12,872	1,208	-
Nicaragua	113,309	429,954	902,766	1,072,095	801,284	782,000
Panama 010-021	189,918	240,449	196,811	199,292	109,148	70,000
Panama 020	31,338	32,247	45,319	50,749	49,732	4,000
Paraguay	14,581	185,357	216,844	247,581	113,697	206,000
Peru	223,991	913,708	770,217	151,490	252,832	287,000
Peru (ORT Serv.)	-	-	-	-	14,635	24,000
St. Christopher	43,775	32,418	24,146	35,448	22,400	29,500
Saint Lucia	73,499	68,340	90,782	79,816	25,515	49,100
St. Vincent	77,676	70,232	50,932	24,271	11,385	67,500
Trinidad and Tobago	-	-	-	-	-	-
Turks and Caicos	-	-	10,872	3,110	6,316	8,700
Uruguay	24,249	21,440	-	64,770	19,208	34,700
Venezuela	-	-	-	5,447	4,495	-
Subtotal	3,343,082	5,640,923	6,523,798	7,674,971	5,229,778	6,563,595
Regional	...	...	493,022	625,394	422,800	528,766
Global Total	...	...	7,016,820	8,300,365	5,652,578	7,092,359

Note: 1982-1986 - Final Expenditures and Obligations

1987 - Budget

Table 8

PAHO/UNFPA BUDGET BY EXPENDITURE ITEM
LATIN AMERICA, 1984-1987 (in US$)

	Personnel	Travel	Grant/ Cont.	Training	Equipment	Miscella-neous	Total
Country							
1984	1,424,463	234,199	693,827	1,001,505	3,127,498	300,895	6,782,387
1985	1,186,972	300,637	782,657	1,414,367	3,749,169	470,294	1,904,096
1986	1,105,301	246,842	340,907	1,757,811	1,668,451	243,715	5,363,027
1987	950,669	231,528	438,094	2,732,253	1,845,769	314,409	6,512,722
Total	4,667,405	1,013,206	2,255,485	6,905,936	10,390,887	1,329,313	26,562,232
	17.6%	3.8%	8.5%	26.0%	39.1%	5.0%	
Regional							
1984	329,640	66,000	47,500	10,689	-	39,193	493,022
1985	397,879	97,027	42,385	47,917	8.100	32,086	625,394
1986	192,705	61,100	62,000	70,000	8,550	31,495	422,800
1987	225,364	47,968	22,912	82,550	37,833	112,137	528,764
Total	1,145,588	272,095	174,797	211,156	51,433	214,911	2,069,980
	55.5%	13.1%	8.4%	10.2%	2.5%	10.3%	

Source: Final budget reports.

Table 9

SOME RESULTS OF DEMOGRAPHIC AND HEALTH SURVEYS
1984-1986

Countries	Global Rate Fertility	Prevalence of Use (%)*	Tetanus Vaccinat. Mothers	Prenatal Care	Institutional Care	Puerperium Care
Brazil	3.1	65	38	74	79	-
Costa Rica	3.6	70	18	90	92	81
Colombia	3.4	63	40	72	70	-
Ecuador	4.3	44	38	69	61	-
El Salvador	4.4	47	48	92	-	-
Honduras	5.3	35	22	83	45	28
Panama	4.0	58	-	89	83	81
Paraguay	-	45	-	-	-	-
Peru	4.4	46	16	55	-	-
Dom. Republic	3.8	50	87	95	90	-
Trinidad and Tobago	3.1	53	-	-	-	-

Source: Preliminary Reports, WHS/Respective Countries. PAHO/HPM Archives

* Women of reproductive age, married or in conjugal union

Table 10

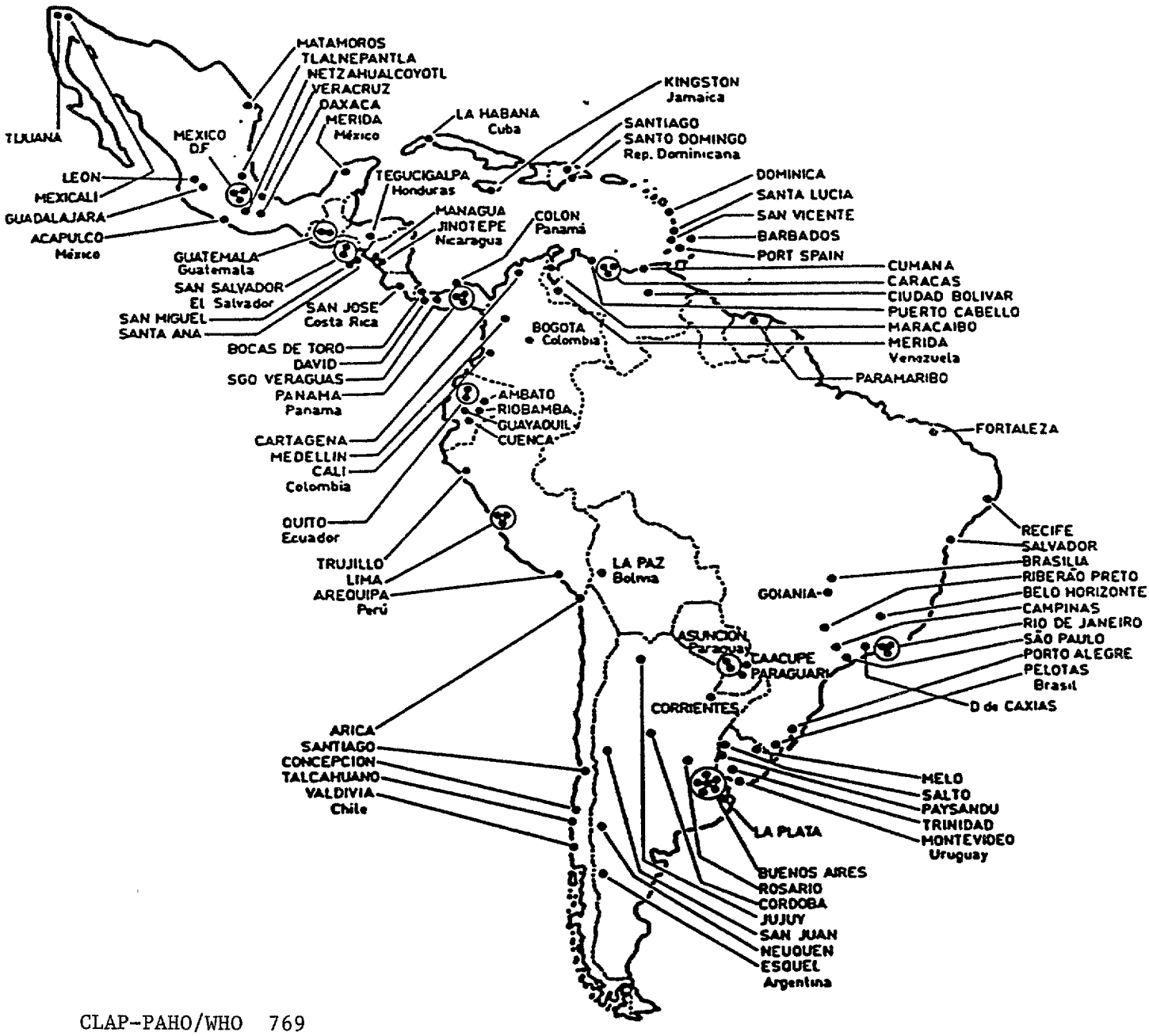
EVALUATION OF EFFICIENCY AND DISTRIBUTION OF FREQUENCY OF SERVICES ACCORDING TO TYPE AND OVERALL VALUE OBTAINED LATIN AMERICAN COUNTRIES, 1985-1987

Type	Total No. of Services Evaluated	Critical Situation		Services Unsatisfactory		Acceptable	
		No.	%	No.	%	No.	%
Health Post	102	19	19	67	65	16	16
Health Center	118	6	5	95	81	17	14
Ambulatory Obstetrical	31	1	3	18	58	12	39
Ambulatory Pediatric	31	5	16	24	77	2	7
Neonatology	40	5	13	29	72	6	15
Obstetric Hospitalization	51	7	14	40	78	4	8
Pediatric Hospitalization	52	7	13	39	75	6	12
Total	425	50	12	312	73	63	15

Source: PAHO/WHO Maternal and Child Health Program, 1987

Figure 1

NATIONAL PERINATOLOGY NUCLEI LINKED TO CLAP
THROUGH JOINT PROGRAM ACTIVITIES



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THE CAUSES OF MATERNAL MORTALITY

Interregional Meeting on the Prevention of Maternal Mortality (Geneva, 11-15 November 1985)

Dr. M. F. Fathalla, the meeting's Chairman, emphasized in his opening address that the causes of maternal deaths are complex. To do this, he described the case of Mrs. X:

> Mrs. X died in the hospital during labor. The attending physician certified that the death was from hemorrhage due to placenta previa. The consulting obstetrician said that the hemorrhage perhaps might not have been fatal if Mrs. X had not been anemic owing to parasitic infection and malnutrition. There was also concern that Mrs. X had only received 500 ml of whole blood, and because she died on the operating table while a cesarean section was being performed by a physician undergoing specialist training. The hospital administrator noted that Mrs. X had not arrived at the hospital until four hours after the onset of severe bleeding, and that she had had several episodes of bleeding during the last month for which she did not seek medical attention. The sociologist observed that Mrs. X was 39 years old, with seven previous pregnancies and five living children. She had never used contraceptives and the last pregnancy was unwanted. In addition, she was poor, illiterate, and lived in a rural area.

Why did Mrs. X die, and how could her death have been prevented? Dr. Fathalla pointed out that there were a number of points at which Mrs. X could have been helped off the road to death. In order to identify these, and to design and implement effective programs, the various kinds of causes need to be understood.

Source: WHO Chronicle, 40(5):177, 1986