1 INTRODUCTION

The health of mothers, newborns, and children is currently at the center of the agendas of multilateral organizations, international cooperation agencies, and governments around the world. This importance is mirrored in the MDGs (Millennium Development Goals), which express the historic consensus of the international community as to which high-priority challenges must be faced to improve the quality of life of people around the world and achieve sustainable development (PAHO/WHO, 2004). All eight MDGs are directly or indirectly related to health, particularly the health of mothers and children, as shown in table 1.

Table 1: Millennium Development Goals

Goals and targets	Indicators
Goal 1: Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	• Proportion of population whose income is below $1 (PPP) a day • Poverty gap ratio (incidence x depth of poverty) • Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	• Prevalence of underweight children (under five years of age) • Proportion of the population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	• Net enrollment ratio in primary education • Proportion of pupils starting grade 1 who reach grade 5 • Literacy rate of 15 to 24-year-olds

Goal 3: Promote gender equality and empower women	
Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015	• Ratio of girls to boys in primary, secondary, and tertiary education • Ratio of literate women to men ages 15 to 24 • Share of women in wage employment in the nonagricultural sector • Proportion of seats held by women in national parliament
Goal 4: Reduce Child Mortality	
Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	• Under-five mortality rate • Infant mortality rate • Proportion of one-year-old children immunized against measles
Goal 5: Improve Maternal Health	
Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio • Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, Malaria, and other diseases	
Target 7: Have halted and begun to reverse the spread of HIV/AIDS by 2015	• HIV/AIDS prevalence, both sexes • Contraceptive use rate • Ratio of school attendance of orphans to school attendance of non-orphans ages 10-14
Target 8: Have halted and begun to reverse the incidence of malaria and other major diseases by 2015	• Prevalence and death rates associated with malaria • Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures • Prevalence and death rates associated with tuberculosis • Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 7: Ensure Environmental Sustainability	
Target 9: Integrate the principles of sustainable development into country policies and programs, and reverse the loss of environmental resources	• Proportion of land area covered by forests • Ratio of area protected to maintain biological diversity to surface area • Energy use (kilograms of oil equivalent) per $1 GDP (PPP) • Carbon dioxide emissions (per capita) and consumption of ozone-depleting chlorofluorocarbons (ODP tons) • Proportion of population using solid fuels
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	• Proportion of population with sustainable access to an improved water source, urban and rural • Proportion of population with access to improved sanitation, urban and rural
Target 11: Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	• Proportion of households with access to secure tenure

Goal 8: Develop a Global Partnership for Development
Target 12: Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction – both nationally and internationally)
Target 13: Address the special needs of the least developed countries (includes tariff-and quota-free access for exports enhanced program of debt relief for HIPC (Heavily Indebted Poor Countries) and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction)
Target 14: Address the special needs of landlocked countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)
Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term
Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries
Target 18: In cooperation with the private sector, make the benefits of new technologies available, especially information and communications

SOURCE: "The Millennium Development Goals: a Latin American and Caribbean perspective" ECLAC, 2005

In this context, maternal, neonatal and child health has ceased to be the object of merely technical consideration and has become one ethical and political imperative. This is due to the fact that despite impressive advances made since the 1950s in the fight against maternal and child mortality, inequality between countries and among different population groups within countries - especially the gap between rich and poor - has increased in the past twenty years, producing stagnation and, in some cases, a relapse in the progress achieved in maternal and child health (WHO, 2005). Moreover, three factors have negatively affected the patterns of maternal and child morbidity and mortality in the LAC Region: (i) the economic crises of the 1980s and late 1990s, which resulted in slow and volatile economic growth, high levels of inflation and unemployment and a decrease in the capacity of the public sector to provide essential health services; (ii) the social crises produced by increasing unemployment and informal economic activity, highly unequal income distribution, and the reduced presence of the State in areas such as education and health; and (iii) the HIV/AIDS pandemic (WHO, 2005; Levcovitz E, Acuña C, 2003; Economic Commission for Latin America and the Caribbean- ECLAC, 2005).

Every year, around 23,000 women die of complications during pregnancy and childbirth in LAC. In twelve countries of the Region, the maternal mortality ratio remains over 100 per 100,000 live births (PAHO/WHO, 2004). Most of these deaths are preventable (Regional Interagency Task Force Strategic Consensus for the Reduction of Maternal Mortality, 2003). Two of the key determinants of high maternal mortality ratios are the delay in access to health care when danger signs go unrecognized, and the lack of access to prompt and quality attention by skilled personnel, both during childbirth and postpartum (PAHO/WHO-USAID, 2004). Most of the women who die are poor, of indigenous origin, uneducated, and from rural areas (PAHO/WHO, 2004; WHO, 2005). These deaths have enormous social, economic, and emotional repercussions for families and communities, and are a determining factor in the generational transmission of poverty.
In 2004, eleven countries in the Americas had an under-five mortality rate of over 40 per 1,000 live births. As a whole, these countries are responsible for approximately 274,000 deaths of children under five years old, which is equivalent to 60.6% of all the deaths for this age group in LAC (PAHO/WHO-USAID, 2004 ECLAC, 2005). Meanwhile, eight countries had under-five mortality rates of fewer than 20 per 1,000 live births. This fact highlights the wide disparities prevailing among countries in the region. Nevertheless, the national averages do not reflect the existing gaps within countries. Ethnicity, income level, and area of residence seem to be the variables most strongly correlated with under-five mortality rate disparities within at least seven countries in the region - Bolivia, Brazil, Colombia, Guatemala, Haiti, Peru, and the Dominican Republic. In the region as a whole, however, access to sanitation and potable water, household income, and the mother's education level remain the most important determinants of under-five mortality. Lack of access to health care is an increasingly important cause of infant and neonatal mortality (PAHO/WHO-USAID, 2004; WHO, 2005).

Rising inequalities in the access to health care explain the stagnation in maternal, neonatal, and infant mortality rates observed in a number of LAC countries, despite of the existence of effective interventions to prevent or to treat the main causes of maternal and child death (WHO, 2005). Exclusion in health - defined as the lack of access of some groups or individuals to the health goods, services, and opportunities that other members of society enjoy (PAHO/WHO, 2003) - remains a challenge that requires urgent attention in most countries of the region.

To address this situation, many governments, multilateral financial institutions, and international technical cooperation agencies have concentrated their efforts on promoting and implementing SPHS for mother, newborn, and child populations. Their goal is to improve access to and quality of MNCH interventions, in turn helping to reach the Millennium Development Goals by the year 2015 (WHO, 2005).

PAHO/WHO has made supporting the countries in their efforts to eliminate exclusion in health, through the extension of social protection in health, a priority for its technical cooperation efforts. Social protection is here understood as the guarantee, granted by society through the State, that an individual or group of individuals can meet its needs and demands for health care through adequate and timely access to health services, without the ability to pay, nor cultural, social, or personal attributes, serving as restrictive factors.[3]

In addition, the reduction of maternal, neonatal and child mortality is a key component of PAHO/WHO's agenda. Recognizing the importance of this issue and its impact in the international context, Member States approved three key resolutions during the 2002 Pan American Sanitary Conference: Resolution CSP26.R.19, Resolution CSP26.R 13-14 and Resolution CSP26.R 10. The first Resolution called for PAHO/WHO and ILO to support and strengthen the extension of social protection in health in Member States as part of their technical cooperation activities. The second resolution urged Member States to make a full commitment to reduce maternal mortality by approving a new regional strategy. And the third Resolution encouraged Member States to support further implementation and strengthening of Integrated Management of Childhood Illness (IMCI) activities in order to improve child health and reduce child mortality in the region. Furthermore, in 2004 PAHO/WHO's 45th Directive Council adopted Resolution CD45.R3, urging Members States to strengthen their political commitment to the Millennium Declaration by developing and implementing national plans to achieve the MDGs.

PAHO/WHO and AECI have agreed to work together to strengthen LAC countries' political, institutional, organizational, and human capacities so that they can extend social protection in health and reduce inequities in the access to health care, in the utilization and financing of health

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services, and in health outcomes (PAHO-AECI Agreement 2005-2007). At the same time, since 1986, USAID and PAHO/WHO have worked together in areas of common interest - among them health systems strengthening and maternal and child health. Similarly, PAHO and SIDA have been working together since 2000 to support the efforts of LAC countries to address social exclusion in health and to develop strategies to extend social protection in health.

Within this framework of cooperation, and eight years from the deadline established for the achievement of the MDGs, it is important to examine how the implementation of health protection schemes and other strategies to extend social protection in health has affected the health of mothers and children. The purpose of this document is to analyze these schemes comparatively, with the goal of understanding why certain strategies perform better than others in guaranteeing access to maternal, neonatal, and child health services. Through this analysis we hope to identify the best mechanisms for achieving universal social protection in health for mothers, newborns, and children.