PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

Provisional Agenda Item 4.9

CD51/12 (Eng.)
1 August 2011
ORIGINAL: SPANISH

PLAN OF ACTION TO ACCELERATE THE REDUCTION OF MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY

Introduction

1. The *Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity* is a further step toward improving women's health, and indirectly contributes to country efforts to achieve Millennium Development Goal (MDG) 5 (*1*).

2. The Plan is based on the preamble of the Constitution of the World Health Organization (WHO), which states that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human without distinction of race, religion, political belief, economic or social condition(*2*)." It is related to the Regional Plan of Action for the Reduction of Maternal Mortality in the Americas (1990) (*3*), the "Population and Reproductive Health" resolution (1998) (*4*), the Regional Strategy for Maternal Mortality and Morbidity Reduction (2002) (*5*), the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (2008) (*6*), and the Plan of Action on Adolescent and Youth Health (2009) (*7*). It also touches on issues dealing with safe hospitals and integrated health services networks (2009) (*8*).

3. Following these commitments by the Member States, maternal mortality significantly decreased throughout the Region in 1990–2010. According to official data from Member States that PAHO publishes in the Basic Health Indicators, that decline was 29% (*9*), while WHO estimates the decrease at 41% (*10*). But in neither case is the estimated decline sufficient for the Region of the Americas to reach MDG 5 by 2015.

4. This Plan of Action proposes that key interventions proven effective in reducing maternal morbidity and mortality in strategic areas be intensified in 2012–2017, in order to promote unrestricted access to high-quality preconception care (including family

planning), as well as to antenatal, childbirth, and postpartum care provided by skilled personnel in the countries, who pursue an intercultural approach in their work.

Background

5. Women's health, and particularly issues related to maternity, have been addressed in several international fora, such as the Conference on Safe Motherhood in Nairobi, Kenya (1987) (*11*), the International Conference on Population and Development in Cairo, Egypt (1994) (*12*), the Fourth World Conference on Women in Beijing, China (1995) (*13*), and the Millennium Summit (2000) (*1*).

6. In 2002 and 2004, the World Health Assembly adopted two resolutions addressing reproductive health—WHA55.19 (*14*) and WHA57.13 (*15*); the WHO Executive Board, in turn, adopted Resolution EB113.R11 (*16*), which is also related to this issue. More recently, the United Nations Human Rights Council, through Resolution R11/8 (2009) (*17*), recognized that preventable maternal morbidity and mortality involves a range of determinants linked to health, development, human rights, and fundamental freedoms. Adopting measures guaranteeing these rights, pursuant to international norms, would help to reduce maternal mortality (*18-24).*

7. At the regional level, maternal mortality has been addressed at several meetings of the PAHO Governing Bodies. In 1990, the 23rd Pan American Sanitary Conference (*3*) approved the Regional Plan of Action for Maternal Mortality and Morbidity Reduction in the Americas. Resolution CSP25.R13 on Population and Reproductive Health (Document CSP25/15) (*4*) was adopted in 1998, and the Regional Strategy for Maternal Mortality and Morbidity Reduction (Document CSP26/14) (*5*) was adopted in 2002.

8. Only four years remain to achieve MDG 5 targets. Based on basic health indicator data PAHO has published (*9*), a further 46% reduction is required to reach the targets; based on WHO estimate models, 34% is required (*10*). Two meetings devoted to the issue in 2010—the Regional Conference of Women Leaders (*26*) and the Women Deliver II Conference (*27*)—emphasized how little has been invested to date to address maternal mortality. In addition, the Group of Eight (G8) added its voice through the Muskoka Initiative (*28*), the United Nations Secretary General called for the implementation of a plan to promote a reduction in maternal mortality (*29*), and the recommendations of the Commission on Information and Accountability for Women's and Children's Health 2011 (*30*) issued recommendations on the problem. PAHO joined this effort at its 50th Directing Council in 2010, giving new impetus to the Safe Motherhood Initiative.

9. The Region's ministers of health stated in paragraph 53 of the Health Agenda for the Americas, 2008-2017, (*31*) that "Sexual and reproductive health is a priority issue in

the Region. It is imperative to provide women with continuous care that begins in the preconception period and continues during pregnancy, childbirth, and the puerperium, including care of the newborn" in order to reduce health inequalities between and within countries.

Situation analysis

10. According to official figures published in the Basic Health Indicators 2010 (*9*) for Latin America and the Caribbean (LAC), there were 9,500 maternal deaths representing a maternal mortality ratio (MMR) of 88.9 per 100,000 live births. Nine of the Region's countries have MMR figures above the regional average: Bolivia, the Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Paraguay, Peru, and Suriname. The majority of these deaths occur during childbirth and in the first hours postpartum. Almost none of the countries are reducing maternal mortality at a sufficient rate to meet the MDG 5 target—including those with lower MMR figures, such as Canada and the United States.

11. Approximately 95% of maternal mortality in LAC can be prevented by using knowledge currently available in the countries. The most frequent causes are pregnancy-induced hypertension (26%), hemorrhage (21%), complications of abortion in unsafe conditions (13%), obstructed labor (12%), sepsis (8%), and other direct causes (15%).

12. Violence against women is another risk factor for maternal death. WHO has demonstrated that 15% to 71% of women are victims of physical and sexual violence perpetrated by their partners (*32*), with 4% to 32% of women suffering violence during pregnancy. In 90% of the cases of violence against pregnant women, the assailant is the biological father (*33*). Although violence is not generally considered as a cause of maternal mortality, three U.S. cities confirmed that it had been the leading cause of death in 20% of cases (*34*). A recent publication argues that disrespect and abuse from health providers constitute other forms of violence against pregnant women, which implies that this constitutes a barrier to health care access (*35*).

13. Many maternal deaths arise from unwanted pregnancies and limited access to contraceptives, as evidenced by the high percentage of unmet contraceptive needs: from 20% to 40% (*9*) in the general population, and even higher among adolescents. The fact that many countries have laws restricting access to contraceptives—a specific example being bans on emergency oral contraceptives (*36*)—compounds this problem. Legal restrictions to abortion in many LAC countries lead women to resort to unsafe abortion as a contraceptive method. The rate of unsafe abortion in LAC is 31 per 1,000 women aged 15-44, in contrast to 22 in the rest of the world. The maternal mortality ratio due to unsafe abortion is three times higher in LAC than in developed regions. (10 versus 3 per 100,000 live births, respectively) (*37*).

14. Coverage figures for antenatal care and care during childbirth may seem high, but obscure existing inequities. For example, only 46% of pregnant women in rural populations have four antenatal check-ups, compared to 74% of urban women (*38*). Other marginalized communities, such as the poor and indigenous and Afro-descendant populations, have lower coverage, poor quality of care, and high MMR rates. In Brazil, for example, adequate antenatal care was observed in 67% of Caucasian, 44.7% of Afro-descendent, and 23.1% of indigenous women (*39*) in Brazil.

15. Often, the antenatal and childbirth care within reach of women fails to meet internationally recommended standards. Preconception monitoring is practically nonexistent in the Region. Furthermore, essential obstetric services are not distributed evenly; they are often of poor quality, due to a lack of personnel trained in needed skills. Moreover, not all institutions can fulfill basic requirements or provide all necessary medicines and supplies, such as laboratory reagents and safe blood. In short, there are deficiencies in coverage, quality, and continuity of care; in the availability of supplies; and in the equitable access to culturally sensitive health services regardless of where a woman lives or what her socioeconomic status is. C-section is a practice that saves lives. WHO estimates that the optimum C-section rate should be around 15%. Increments in the use of C-sections observed in the Region in recent years to levels higher than this optimum rate have increased the risk of maternal and perinatal mortality and morbidity *40*).

16. Severe maternal morbidity has received less study in LAC than maternal mortality. As many as 20 cases of maternal morbidity are estimated to occur for each maternal death recorded (*36*), and up to one quarter of these women may suffer severe and permanent sequelae. Maternal morbidity is concentrated in certain geographical areas and populations in some countries, thus, regional and national morbidity reduction initiatives must be targeted accordingly.

17. The situation analysis and the proposed Plan of Action are consistent with the expected outcomes of the fourth strategic objective of WHO's Medium-term Strategic Plan 2008–2013, particularly expected results 4.1, 4.2, 4.3, 4.4, 4.6, 4.7, and 10.1 for the entire Organization, which correspond to the expected results for the PAHO Strategic Plan for the Region (see Annex C).

Proposal

18. Existing preventable maternal mortality and morbidity reflect current inequities, inequalities, and lack of empowerment for women. Although socioeconomic, cultural, and environmental determinants are key factors in reducing maternal mortality and morbidity, specific measures directly aimed at reducing maternal mortality and morbidity could be adopted in the health sector. These include structuring health services so as to

provide better care for women in the area of family planning and in preconception, antenatal, childbirth, and postpartum care. This Plan of Action directly addresses critical elements that can help prevent maternal deaths and severe morbidity.

19. General objectives of the Plan of Action are:

(a) to help accelerate the reduction in maternal mortality,
(b) to prevent severe maternal morbidity, and
(c) to strengthen surveillance of maternal morbidity and mortality.

20. Four strategic areas and nine interventions of proven benefit to maternal and perinatal health have been identified and prioritized (see Annex A).

21. The plan is to be executed between 2012 and 2017 by strengthening partnerships at different levels, e.g., with the Regional Working Group for the Reduction of Maternal Mortality, scientific societies, academic journals, and civil society.

Strategic area 1: Prevention of unwanted pregnancies and resulting complications.

***Objective 1*:** Increase the use of modern contraceptive methods by women of reproductive age, with emphasis on adolescents.

Effective interventions

- Increase contraceptive coverage (including use of emergency contraceptive methods) and the availability of family planning counseling prior to conception and after an obstetric event.

Goal 1: By 2017, the countries of the Region will have reduced the prevalence of unmet contraceptive needs by 20%.

***Indicators*[1]**

- Rate of use of modern contraceptive methods by women of reproductive age, with a breakdown by age group and urban/rural residence. (Baseline: 60%. Target: 70%.)

[1] At the current time, there is only partial information for fully defining the base lines and targets for some indicators. At the conclusion of the first year of the plan's execution, a review will be conducted to complete the information, and at the same time, this plan will be aligned with the Strategic Objectives and Indicators of the Organization's Strategic Plan 2013-2017.

- Number of countries that have national data on postpartum and/or post-abortion contraceptive counseling and provision of contraceptives by their health services. (Baseline: to be determined. Target: 90%.)
- Percentage of deaths in women due to abortion reduced by 50%. (Baseline: 13%. Target: 7%.)

Activities at the regional level

1.1 Engage in promotion activities with a wide range of actors to address the information, cultural, social, and religious factors that affect the delivery and uptake of family planning services.
1.2 Disseminate: (a) *A global handbook for providers*, (b) *Decision-making tool for family planning clients and providers, and* (c) *Medical eligibility criteria for contraceptive use.*
1.3 Organize training workshops to introduce the above resources.
1.4 Support the contraceptive security initiative for the procurement of contraceptive supplies.

Activities at the national level (to be undertaken by Member States with support from PAHO, and other regional resources).

1.5 Formulate and/or adopt national laws and regulatory frameworks that ensure universal access to modern contraceptive methods.
1.6 Ensure that adolescents have access to information on sexual and reproductive health, especially information on delaying the start of sexual activity in order to make informed choices; work with key partners to facilitate the availability of information resources.
1.7 Promote plans and programs that encourage the spacing of pregnancies.
1.8 Formulate a national family planning plan with its attendant budget to address the needs of different population groups that includes incorporating a culturally sensitive approach.
1.9 Hold training workshops for health workers, with special emphasis on primary health care and contraceptive methods, including emergency contraceptive methods.
1.10 Promote the supply—and supply logistics—of contraceptives, especially at primary health care facilities.
1.11 Promote strengthening of national and local committees on maternal death, and urge that they address the prevention of unwanted pregnancies.
1.12 Implement mass communication strategies on sexual and reproductive health.

Strategic area 2: Universal access to affordable, high-quality maternity services within the coordinated health care system.

Objective 2: Ensure that quality maternal health care services are offered within integrated health systems.

Effective interventions

- Access to affordable, high-quality preconception, antenatal, childbirth, and post-partum care, by level of maternal and perinatal care considering a regionalized approach within the framework of the regionalization of maternal and perinatal care.
- Maternity waiting homes, as appropriate.
- Use of evidence-based practices.
- Timely referral and counter-referral.
- Prevention and detection of intrafamily violence during pregnancy.

Goal 2.1: By 2017, the Region's countries reach a level where four or more antenatal check-ups occur for 70% of pregnancies.

Goal 2.2: By 2017, the Region's countries reach a level where 60% of women have post-partum check-ups during the first seven days after discharge.

Goal 2.3: By 2017, areas with geographical-access problems have adopted the maternity waiting homes strategy.

Goal 2.4: By 2017, the use of selected effective interventions to reduce maternal morbidity and mortality has increased.

Indicators

- Number of countries with 70% coverage of four or more antenatal visits. (Baseline: 50%. Target: 90%.)
- Institutional coverage of deliveries. (Baseline: 89.8%. Target: 93%.)
- Number of countries that have at least 60% coverage for postpartum visit at seven days after delivery. (Baseline: to be determined. Target: 80%.)
- Number of countries that use oxytocics in 75% of institutional births during the third-stage of labor, once the umbilical cord has ceased to pulse. (Baseline: to be determined. Target: 90%.)
- Number of countries that use magnesium sulfate, in addition to interrupting the pregnancy, in 95% of cases of severe preeclampsia/eclampsia in institutional births. (Baseline: to be determined. Target: 90%.)
- Number of countries with safe blood available in 95% of the facilities that provide emergency childbirth care. (Baseline: to be determined. Target: 100%.)
- Number of countries monitoring intrafamily violence during pregnancy in 95% of institutional births. (Baseline: to be determined. Target: 80%.)

- Number of countries with C-section rate above 20% that reduce their C-section rate by at least 20% by 2017. (Baseline:17. Target: 100%.)
- Number of countries with maternal deaths due to obstructed labor. (Baseline 15. Target: 0.)

Activities at the regional level

2.1 Disseminate the WHO evidence-based guidelines encompassing care from preconception through the postnatal period, as well as PAHO's *Guides for the Primary Health Care-Focused Continuum of Care of Women and Newborns*.
2.2 Disseminate the perinatal technologies developed by the Latin American Center of Perinatology (CLAP) and PAHO.
2.3 Disseminate the maternity waiting homes proposal.
2.4 Disseminate manuals on obstetric emergencies and on improving efficiency.
2.5 Disseminate guidelines on early detection, prevention, and treatment of intra-family violence.
2.6 Disseminate the WHO virtual library on sexual and reproductive health.
2.7 Promote successful maternal and perinatal models in the Region, in addition to models taken from the Safe Motherhood Initiative.
2.8 Promote vaccination of pregnant women against H1N1 or other emerging influenza viruses.

Activities at the national level

2.9 Formulate and adopt national laws and regulatory frameworks for universal access to quality maternity services.
2.10 Formulate and execute a national safe motherhood plan that includes an intercultural approach, and its attendant budget, including systems for referral and counter-referral.
2.11 Organize training workshops for health workers focusing on primary health care from preconception through the puerperium.
2.12 Set up maternity waiting homes, where appropriate.
2.13 Ensure that antenatal care covers monitoring of blood pressure, uterine height, maternal weight, anemia, and proteinuria; syphilis/HIV screening; and nutrition counseling and information on warning signs; and ensure that there is an increase in H1N1 influenza and tetanus vaccination coverage.
2.14 Evaluate the efficiency of the primary health care and maternity and perinatal health services and promote their improvement.
2.15 Provide proper reporting and monitoring and supervision of services.
2.16 Organize user-satisfaction surveys.

2.17 Establish policies that promote humanization of care throughout the reproductive cycle, including accompaniment of women during labor and childbirth by persons of their choice.

Strategic area 3: Skilled human resources

Objective 3: Increase the number of skilled personnel in health facilities for preconception, antenatal, childbirth, and postpartum.

Effective interventions

- Increase the availability of skilled health workers for preconception, antenatal, childbirth, and postpartum care in basic and emergency obstetric units.
- Increase the 24-hour availability of staff to attend births and handle obstetric complications.

Goal 3: By 2017, 90% of the Region's countries have 80% coverage of childbirth and postpartum care provided by skilled personnel, as defined by WHO.

Indicators

- Number of countries that have 80% coverage of childbirth care provided by skilled personnel, as defined by WHO. (Baseline: 43. Target: 48.)
- Number of countries that have 80% or higher coverage of postnatal care provided by skilled personnel capable of caring for both mother and newborn, as defined by WHO. (Baseline: 23. Target: 48.)
- Percentage of emergency obstetric care (EmOC) health facilities (basic and comprehensive) that perform an audit of all maternal deaths. (Baseline: to be determined. Target: 90%.)
- Number of countries that annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR. (Baseline: to be determined. Target: 100%.)

Activities at the regional level

3.1 Support the formulation and strengthening of undergraduate and graduate programs that train health workers to provide preconception, maternal (including obstetric emergencies), and perinatal care.

3.2 Prepare training materials for personnel that include the use of new information, technologies, including an intercultural approach, as appropriate.

3.3 Support training programs in professional midwifery and maternal and child health nursing, and include these models of care, with their attendant budget and specific activities, in national health plans.

Activities at the national level

3.4 Identify the number of practicing health personnel by occupational category and competencies, and determine the gap between existing and needed levels for quality care.
3.5 Define the package of essential competencies that health care workers should master to provide preconception, maternal, and perinatal care according to country needs.
3.6 Formulate a national human resources plan with its attendant budget.
3.7 Formulate and implement strategies to provide continuing training for health care workers at different levels of care in preconception, maternal, and perinatal care.
3.8 Create incentives to recruit and retain personnel for underserved populations and rural and remote areas.

Strategic area 4: Strategic information for action and accountability

Objective 4: Strengthen information systems and maternal and perinatal health monitoring in the framework of integrated information and vital statistics systems.

Effective interventions

- Institute and consolidate perinatal and maternal information and monitoring systems.
- Establish committees with community participation to analyze maternal mortality and provide remedies, as appropriate.

Goal 4: By 2017, 60% of the Region's countries have systems capable of generating information on maternal and perinatal health within an integrated and coordinated system of care.

Indicators

- Number of countries where the health system has a functioning perinatal information system. (Baseline: 16. Target: 29.)
- Number of countries where the health system maintains a registry of severe maternal morbidity. (Baseline: to be determined. Target: 80%.)
- Number of countries whose coverage of maternal deaths in vital record systems is 90% or more. (Baseline: to be determined. Target: 100%.)

Activities at the regional level

4.1 Promote the use of perinatal clinical records, with computer support for automated analysis of information and administration of services.
4.2 Promote the dissemination of surveillance systems models, such as the CLAP/PAHO Perinatal Information System.
4.3 Develop materials for training in interpreting surveillance information.
4.4 Promote the strengthening of epidemiological surveillance and the formation of committees to analyze severe maternal mortality and severe morbidity.

Activities at the national level

4.5 Formulate and/or adapt regulatory frameworks for the use of perinatal clinical records.
4.6 Implement a national plan, with its budget, to strengthen information systems and maternal and perinatal health surveillance systems.
4.7 Organize training workshops for health workers on preparing clinical histories and vital statistics certificates, and for analyzing and using this information.
4.8 Establish or strengthen intersectoral committees, with community participation, to analyze and audit maternal mortality and severe morbidity and to develop solutions for the services, as appropriate.
4.9 Allocate the necessary budget and personnel to oversee compliance with standards of care.

22. To develop these strategic areas, PAHO will work with other organizations—using an inter-programmatic approach—to prioritize those countries with most urgent needs and those interventions with the greatest impact, as well as to build networks and mobilize resources. PAHO will provide technical cooperation for the implementation, monitoring, and evaluation of the Plan of Action, and will disseminate it. The Organization will also support the systematization of best practices, encourage sharing of the best experiences, and promote information exchange among the countries.

Monitoring, assessment, and evaluation

23. This Plan of Action promotes the achievement of Strategic Objectives 4[2] and 10[3] of the PAHO Strategic Plan. Expected regional-level results relating to the plan are detailed in Annex C. Monitoring and evaluation of the plan will be in line with the framework of the Organization's results-based management, as well as with its processes

[2] SO 4: To reduce morbidity and mortality and improve health during key stages of the life cycle, including pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.
[3] SO 10: To improve the organization, management, and delivery of health services.

for monitoring and evaluating performance. To this end, progress reports will be prepared every two years, based on the available information.

24. Data will be verified, using sources such as vital statistics, national health surveys, and specific studies designed for this plan. In addition, the following impact indicators will be recorded:

(a) Total maternal mortality ratio (MMR), by cause and age.
(b) Total severe maternal morbidity ratio, by cause.
(c) Maternal Mortality Rate (maternal deaths per 100,000 women aged 15–44).
(d) Number of countries with an MMR of less than 75 (per 100,000 live births) in 2017. (Target: 100%)
(e) Number of countries with MMR greater than 125 (per 100,000 live births) among geographic and ethnic subpopulations of women (i.e. indigenous/non-indigenous; rural/urban) and by subnational level (i.e. department, province, state).

25. There are plans to conduct an assessment during the process aimed at instituting corrective measures as necessary. At the conclusion of the period covered by the plan, an evaluation will be conducted to determine the strengths and weaknesses of overall execution and the factors that account for successes and failures, as well as to determine future actions.

Conclusion

26. Despite attention in the Region to the issue of reducing maternal morbidity and mortality, progress remains inadequate. Although information on cost-effective interventions is available that could prevent more than 80% of maternal deaths, mothers and their children continue to face financial, geographic, social, legal, and attitudinal barriers that impede their access to quality services. PAHO hopes that the approval and implementation of this Plan of Action with the broadest commitment of the countries of the Americas, will allow women and children to exercise their basic rights and will foster social justice.

Action by the Directing Council

27. The Directing Council is requested to review this document and to consider the adoption of the resolution that appears in Annex B.

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Strategic area	Effective interventions	Indicators
1. Prevention of unwanted pregnancies and resulting complications.	• Increase contraceptive coverage (including use of emergency contraceptive methods) and the availability of family planning counseling prior to conception and after an obstetric event.	• Rate of use of modern contraceptive methods by women of reproductive age, with a breakdown by age group and urban/rural residence. (Baseline: 60%. Target: 70%.) • Number of countries that have national data on postpartum and/or post-abortion contraceptive counseling and provision of contraceptives by their health services. (Baseline: to be determined. Target: 90%.) • Percentage of deaths in women due to abortion reduced by 50%. (Baseline: 13%. Target: 7%.)
2. Universal access to affordable, high-quality maternity services within the coordinated health care system.	• Access to affordable, high-quality preconception, antenatal, childbirth, and post-partum care, by level of maternal and perinatal care considering a regionalized approach within the framework of the regionalization of maternal and perinatal care. • Maternity waiting homes, as appropriate. • Use of evidence-based practices. • Timely referral and counter-referral. • Prevention and detection of intrafamily violence during pregnancy.	• Number of countries with 70% coverage of four or more antenatal visits. (Baseline: 50%. Target: 90%.) • Institutional coverage of deliveries. (Baseline: 89.8%. Target: 93%.) • Number of countries that have at least 60% coverage for postpartum visit at seven days after delivery. (Baseline: to be determined. Target: 80%.) • Number of countries that use oxytocics in 75% of institutional births during the third-stage of labor, once the umbilical cord has ceased to pulse. (Baseline: to be determined. Target: 90%.) • Number of countries that use magnesium sulfate, in addition to interrupting the pregnancy, in 95% of cases of severe preeclampsia/eclampsia in institutional births. (Baseline: to be determined. Target: 90%.) • Number of countries with safe blood available in 95% of the facilities that provide emergency childbirth care. (Baseline: to be determined. Target: 100%.) • Number of countries monitoring intrafamily violence during pregnancy in 95% of institutional births. (Baseline: to be determined. Target: 80%.) • Number of countries with C-section rate above 20% that reduce their C-section rate by at least 20% by 2017. (Baseline:17. Target: 100%.) • Number of countries with maternal deaths due to obstructed labor (Baseline 15. Target: 0.)

Strategic area	Effective interventions	Indicators
3. Skilled human resources.	• Increase the availability of skilled health workers for preconception, antenatal, childbirth, and postpartum care in basic and emergency obstetric units. • Increase the 24-hour availability of staff to attend births and handle obstetric complications.	• Number of countries that have 80% coverage of childbirth care provided by skilled personnel, as defined by WHO. (Baseline: 43. Target: 48.) • Number of countries that have 80% or higher coverage of postnatal care provided by skilled personnel capable of caring for both mother and newborn, as defined by WHO. (Baseline: 23. Target: 48.) • Percentage of emergency obstetric care (EmOC) health facilities (basic and comprehensive) that perform an audit of all maternal deaths. (Baseline: to be determined. Target: 90%.) • Number of countries that annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR. (Baseline: to be determined. Target: 100%.)
4. Strategic information for action and accountability	• Institute and consolidate perinatal and maternal information and monitoring systems. • Establish committees with community participation to analyze maternal mortality and provide remedies, as appropriate.	• Number of countries where the health system has a functioning perinatal information system. (Baseline: 16. Target: 29.) • Number of countries where the health system maintains a registry of severe maternal morbidity. (Baseline: to be determined. Target: 80%.) • Number of countries whose coverage of maternal deaths in vital record systems is 90% or more. (Baseline: to be determined. Target: 100%.)

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

CD51/12 (Eng.)
Annex B
ORIGINAL: SPANISH

PROPOSED RESOLUTION

PLAN OF ACTION TO ACCELERATE THE REDUCTION OF MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY

***THE 51st DIRECTING COUNCIL*,**

Having reviewed the Director's report, Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity (Document CD51/12);

Taking into account the proposed international mandates in the Regional Plan of Action to Reduce Maternal Mortality in the Americas (document CSP23/10 [1990]); the resolution "Population and Reproductive Health" (CSP25.R13 [1998]); the Regional Strategy for Maternal Mortality and Morbidity Reduction (CSP26/14 [2002]); Resolutions WHA55.19 (2002), WHA57.13 (2004), and EB113.R11 (2004) on CE148.R14 (Eng.) Page 2 reproductive health, adopted by the World Health Assembly and the WHO Executive Board, respectively; the forums of Nairobi, Kenya (1987), Cairo, Egypt (1994), Beijing, China (1995); the Millennium Declaration (2000), and the Health Agenda for the Americas 2008-2017;

Taking into account Resolution R11/8 of the Human Rights Council of the United Nations (2009), Resolution CD50.R8 of the 50th Directing Council of PAHO (2010), and the technical document "Health and Human Rights" (CD50/12), as well as the high degree of complementarity between this plan and other objectives established in the PAHO Strategic Plan 2008-2012, Amended (Official Document 328 [2009]);

Considering the Global Strategy for Women's and Children's Health, launched by the United Nations Secretary-General in 2010 and the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

Emphasizing that maternal mortality is a manifestation of inequity that affects every country in the Region, that there are cost-effective interventions within the sector to effect the desired reduction that are capable of having a real impact within a short timeframe;

Considering the importance of having a plan of action that makes it possible for Member States to respond effectively and efficiently,

RESOLVES:

1. To endorse the present Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity and to further its consideration in policies, plans, and development programs, as well as in proposals and discussions of national budgets, allowing them to address the issue of improving maternal health.

2. To urge the Member States to:

(a) consider the Health Agenda for the Americas 2008-2017 and the call by the United Nations Secretary General in 2010 to implement a plan to help reduce maternal mortality;

(b) adopt national policies, strategies, plans, and programs that increase women's access to culturally appropriate, quality health services adapted to their needs, including in particular promotion and prevention programs based on primary health care provided by skilled personnel, that integrate preconceptional (including family planning), pregnancy, delivery, and postpartum care, in which, moreover, all of these services are free for the most vulnerable populations;

(c) promote a dialogue between institutions in the public and private sector and civil society to prioritize women's lives as a human rights and development issue;

(d) promote the empowerment of women and the participation and co-responsibility of men in sexual and reproductive health;

(e) adopt a human resources policy that addresses the issue of quantity and quality to respond to the needs of women and newborns, involving entities that train and credential human resources;

(f) improve the capacity to generate information and research on sexual and reproductive health, maternal mortality, and severe maternal morbidity for the development of evidence-based strategies that permit monitoring and evaluation

of their results, in keeping with the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

(g) undertake internal review and analysis of the relevance and viability of this plan in the national context, based on national priorities, needs, and capacities;

(h) advocate for dedicated public budgets, where applicable, based on strategic results, aimed at improving the coverage and quality of care for women and children;

(i) promote the development of social protection programs for women and children.

3. To request the Director to:

(a) support the Member States in implementing the present Plan of Action, in keeping with their needs and their particular demographic and epidemiological characteristics;

(b) promote implementation and coordination of this Plan of Action, ensuring its horizontal nature through programs, the Organization's various regional and subregional offices, and collaboration with and among the countries in the design of strategies and sharing of resources and capacities to implement their women's health plans;

(c) promote and strengthen information systems and maternal health surveillance, including a regional repository available to all stakeholders, and encourage operations research to design relevant strategies and carry out interventions based on the Region's specific needs and contexts;

(d) support the Member States in developing and creating capacities for training appropriately distributing of maternal and neonatal health personnel;

(e) consolidate and strengthen technical cooperation with the committees, organs, and rapporteurships of the United Nations and Inter-American bodies, in addition to promoting partnerships with other international and regional organizations, scientific and technical institutions, organized civil society, the private sector and others, within the framework of the Regional Working Group for the Reduction of Maternal Mortality;

(f) report periodically to the Governing Bodies on progress and constraints in implementing the Plan of Action, as well as on changes made in the Plan to adaptit, as necessary, to new circumstances and needs.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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CD51/12 (Eng.)
Annex C

Report on the Financial and Administrative Implications for the Secretariat of the Proposed Resolution

1. Agenda item: Item 4:9: Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity

2. Linkage to Program Budget:

(a) Area of work:

Strategic Objective 4: "To reduce morbidity and mortality and improve health during key stages of life such as pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals."

RER 4.1 Member States supported through technical cooperation to develop comprehensive policies, plans, and strategies that promote universal access to a continuum of care throughout the life course; to integrate service delivery; and to strengthen coordination with civil society, the private sector, and partnerships with UN and Inter-American system agencies (e.g., NGOs).

RER 4.2 Member States supported through technical cooperation to strengthen national/ local capacities to produce new evidence and interventions; and to improve the surveillance and information systems in sexual and reproductive health, and in maternal, neonatal, child, adolescent, and older adult health.

RER 4.3 Member States supported through technical cooperation to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods.

RER 4.4 Member States supported through technical cooperation to improve neonatal health.

RER 4.6 Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development.

RER 4.7 Member States supported through technical cooperation to implement Reproductive Health Strategies to improve antenatal, perinatal, postpartum, and neonatal care, and provide high-quality reproductive health services.

Strategic Objective 10: To improve the organization, management, and delivery of health services.

RER 10.1 Member States supported through technical cooperation to strengthen health systems based on Primary Health Care, promoting equitable access to health services of good quality, with priority given to vulnerable population groups.

3. Financial implications of this Agenda item:

(a) Total estimated cost of implementing the resolution over the full effective period (rounded to the nearest ten million US dollars; includes expenses for personnel and activities).

The interventions and proposed budgetary impact of this plan of action cannot be shouldered by PAHO alone; consequently, regional, subregional, and national collaboration with other United Nations agencies and other major stakeholders is essential.

The cost of implementing the plan of action is calculated at US$ 10 million for the entire plan.

This includes maintaining the current staff, hiring additional part-time staff, and carrying out activities at the regional, subregional, and national level.

(b) Estimated cost for the 2012-2013 biennium (rounded to the nearnest 10 million US dollars; includes expenses for personnel and activities):

US$ 4 million.

(c) Of the estimated cost given in (b), what portion could be subsumed under existing program activities?:

$600,000 can be subsumed under the existing program activities planned for the 2012-2013 biennium.

4. Administrative implications of this Agenda item:

(a) Indicate at what levels of the Organization measures will be taken:

The work will be undertaken at the country level, and will focus on priority countries and other countries with high maternal mortality figures.

Integration with other programs in the areas of community, family, gender, and indigenous populations, as well as health determinants and health services, will be essential for the Plan.

(b) Additional needs for personnel (indicate the additional needs in terms of the equivalent in full-time positions, specifying the profile for such personnel):

- 1 secretary
- 11 national part-time staff

(c) Time periods (indicate broad time periods for the implementation and evaluation activitities):

2011: Approval of the Plan of Action.

2012-2017: Implementation of the Plan (in phases).

Phase 1 (2011): Preparation of the Plan of Action and monitoring strategy in the four languages of the Region, and establish baseline.

Phase 2 (2012-2013): Establish the baseline, organization of two regional meetings (in Spanish and English). Eleven countries with high maternal mortality rates implement the Plan of Action (national meetings and technical support).

Phase 3 (2014-2015): Mid-term evaluation of the period. Eleven countries continue carrying out the Plan of Action, implementation is monitored, and national meetings are held.

Phase 4 (2016-2017): Final evaluation, presentation of results, and recommendations.

PAN AMERICAN HEALTH ORGANIZATION
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ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES
1. Agenda item: 4.9: Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity.
2. Responsible unit: Family and Community Health/The Latin American Center for Perinatology, Women and Reproductive Health (CLAP-SMR). **3. Preparing officer:** Collaborative effort of the PAHO/WHO Working Group, United Nations agencies, international experts, and other partners.
4. List of collaborating centers and national institutions linked to this Agenda item: • National ministries of health, women, education, youth, and social affairs • Canadian International Development Agency (CIDA, Canada) • Spanish Agency for International Cooperation and Development (AECID, Spain) • U.S. Agency for International Development (USAID, United States) • United Nations Agency for Women (UN Women) • Swedish International Development Agency (ASDI, Sweden) • National Research Center for Maternal and Child Health (CENISMI, Dominican Republic) • Rosarino Center for Perinatal Studies (CREP, Argentina) • Economic Commission for Latin America and the Caribbean (ECLAC) • Adolescent and Youth Confederation of Ibero-America and the Caribbean (CODAJIC) • International Confederation of Midwives (ICM) • Johns Hopkins Bloomberg School of Public Health (United States) • Family Care International (United States) • Latin American Federation of Obstetrics and Gynecology Societies (FLASOG) • International Federation of Gynecology and Obstetrics (FIGO) • United Nations Children's Fund (UNICEF) • United Nations Population Fund (UNFPA) • Maternal and Perinatal Group of Caldas (Colombia) • Inter-American Parliamentary Group (GPI) (Panama) • Alan Guttmacher Institute (United States) • Maternal and Perinatal Specialized Institute (IEMP) (Peru) • National Perinatology Institute (INPER) (Mexico) • National Institutes of Health (NIH) (United States) • Pathfinder International (United States) • Population Council (United States) • University of Antioquia birthing center, Centro Nacer (Colombia) • University of Cuenca, Institute of Medical Sciences (Ecuador)

- University of Chile (Chile)
- Emory University (United States)
- University of Puerto Rico (United States)
- Universidad del Valle (CEMIYA) (Colombia)

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

There are links with paragraphs 2 and 7 of the "Statement of Intent," and with all "Principles and Values" (paragraphs 9 to 12), as well as with the areas of action described in the Health Agenda for the Americas.

Statement of Intent:

Paragraph 2. The Governments reiterate their commitment to the vision of a region that is healthier and more equitable with regard to health, addresses health determinants, and shows improved access to individual and collective health goods and services – a region where each individual, family and community has the opportunity to develop to its greatest potential.

Paragraph 7. The Governments of the Americas emphasize the importance of ensuring that stakeholders and institutions working in health will benefit from a concise, flexible, dynamic, and high-level health agenda that guides their actions, facilitates the mobilization of resources, and influences health policies in the Region.

Principles and values:

Paragraph 9. *Human rights, universality, access, and inclusion*. The constitution of the World Health Organization states that: "enjoyment of the highest obtainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic, or social condition." In order to make this right a reality, the countries should work toward achieving universality, access, integrity, quality, and inclusion in health systems that are available for individuals, families, and communities. Health systems should be accountable to citizens for the achievement of these conditions.

Paragraph 10. *Pan American solidarity*. Solidarity, defined as collaboration among the countries of the Americas to advance shared interests and responsibilities in order to attain common targets, is an essential condition to overcome the inequities with regard to health and to enhance Pan American health security during crises, emergencies, and disasters.

Paragraph 11. *Equity in health*. The search for equity in health is manifested in the effort to eliminate all health inequalities that are avoidable, unjust, and remediable among populations or groups. This search should emphasize the essential need for promoting gender equity in health.

Paragraph 12. *Social participation*. The opportunity for all of society to participate in defining and carrying out public health policies and assessing their outcomes is an essential factor in the implementation and success of the Health Agenda.

Areas of action:

- Strengthen the national health authority.
- Address health determinants.
- Increase social protection and access to quality health services.
- Reduce health inequalities between countries and inequities within countries
- Reduce disease burden and risks.
- Strengthen the management and development of health workers.
- Take advantage of knowledge, science, and technology.
- Enhance health security.

6. Link between Agenda item and Strategic Plan 2008-2012:

The action plan is directly linked with Strategic Objective 4: "To reduce morbidity and mortality and improve health during key stages of life including pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals."

More specifically, this Plan of Action will contribute to achieving the following region-wide expected results: 4.1 "Member States supported through technical cooperation to develop comprehensive policies, plans, and strategies that promote universal access to a continuum of care throughout the life course; to integrate service delivery; and to strengthen coordination with civil society, the private sector, and partnerships with UN and Inter-American system agencies and others (e.g. NGOs)."

4.2 "Member States supported through technical cooperation to strengthen national/local capacity to produce new evidence and interventions, and to improve the surveillance and information systems in sexual and reproductive health, and in maternal, neonatal, child, adolescent, and older adult health."

4.3 "Member States supported through technical cooperation to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods."

4.7 "Member States supported through technical cooperation to implement Reproductive Health Strategies to improve antenatal, perinatal, postpartum, and neonatal care, and provide high-quality reproductive health services."

The plan is also linked to Strategic Objective 10: To improve the organization, management, and delivery of health services.

RER 10.1*:* The Member States supported through technical cooperation to ensure equitable access to health care services of good quality, particularly for vulnerable population groups.

7. Best practices in this area and examples from countries within the Region of the Americas:

In addition to being based on verified successful experiences in the Region, this plan will take advantage of the systematization of the best practices used under the Safe Motherhood Initiative, which is being promoted this year by PAHO.

The Region has had a wide range of successful experiences in reducing maternal mortality, extending from Haiti—where one undertaking reduced maternal in certain areas, provided free access to services and transportation, and ensured that trained midwives provided support to women giving birth (Free Obstetric Services)—to countries such as Brazil, where the adoption of a universal social protection system improved outcomes by reducing maternal mortality (*Unified Health System*/UHS). Under Uruguay's National Integrated Health System (SNIS), a mechanism was adopted whereby payments are linked to achieving milestones in maternal and neonatal care processes and outcomes. The system, which is aided by a software developed by PAHO (the Perinatal Information System), has led to an improvement in maternal and neonatal care. Another activity noteworthy for reducing maternal mortality in remote geographical areas is the creation of more birthing centers in Peru. Incorporating these establishments in the country's integrated health services has improved access to institutional delivery.

8. Financial implications of this Agenda item:

The interventions and proposed budgetary impact of this plan of action cannot be shouldered by PAHO alone; consequently, regional, subregional, and national collaboration with other United Nations agencies and other major stakeholders is essential.

The cost of implementing the plan of action at all levels (interinstitutional, regional, subregional, national and local) is calculated at US$ 10 million for the entire period. This includes retaining current staff, contracting additional staff, and implementing the above-specified activities at all levels, as well as holding regional and national meetings, providing direct support to the countries, and monitoring and evaluating the plan as a whole.

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