



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



36th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 25-27 March 2002

Provisional Agenda Item 9

SPP36/8, Rev. 1 (Eng.)
5 March 2002
ORIGINAL: ENGLISH

REGIONAL STRATEGY FOR MATERNAL MORTALITY AND MORBIDITY REDUCTION

A tragedy in Latin America and the Caribbean is the unnecessarily high death rate of women as a result of complications from pregnancy and childbirth. The overall maternal mortality ratio estimated for those countries is 190 per 100,000 live births. In 1995, this ratio represented some 22,000 maternal deaths. It is important to consider that women in the Latin American and Caribbean countries are still dying from the same causes as women in industrialized countries in the early 20th century. Although maternal mortality ratio has stagnated since the issue of safe motherhood became prominent in the late 1980s and early 1990s, maternal mortality is a public health issue in which little progress has been achieved in recent times, and to which the Subcommittee on Planning and Programming is asked to give consideration.

Knowledge of the causes of maternal disability and death, and of the appropriate interventions in resource-poor settings, has increased considerably. History has shown that the key to reducing maternal mortality lies not in general social and economic development, but in making effective treatment available and accessible. Research results and practical experience have demonstrated that specific health interventions can reduce the incidence and severity of major complications associated with pregnancy, childbirth, and the postpartum period for mothers and their newborns. A more focused approach, concentrating on such cost-effective interventions as Essential Obstetric Care (EOC), skilled attendance at birth, and improved access to quality maternal health care services, is currently being promoted by the Pan American Health Organization (PAHO).

The findings are clear: maternal death is preventable; effective interventions are known; and investment in safe motherhood will reduce maternal and infant death and disability. Safe motherhood interventions are among the most cost-effective in the health sector, particularly at the primary care level. This is especially noteworthy, because poor women in isolated rural communities are the most affected by the lack of basic essential obstetric care, and thus most likely to die in childbirth.

The Subcommittee on Planning and Programming is asked to consider a long-term commitment to the reduction of maternal mortality in the Region, both at the policy and programmatic levels.

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Maternal Mortality and Morbidity: Challenges to Progress in Latin America and the Caribbean

1. Introduction

Compared to other mortality reduction efforts in the Region, maternal mortality is a public health issue in which little progress has been achieved in recent times. While many other health indicators, such as the total fertility rate and the crude birth rate, have dropped sharply over the last two decades, maternal mortality rates and ratios have remained stagnant. The causes are rooted in the inappropriateness of many interventions intended to improve maternal health, as well as in the powerlessness of women. In particular, there is a clear connection between the low status of women and the risk of maternal illness and death. The incidence of maternal death is, therefore, directly related to the rights of women and the communities in which they live.

Following the Safe Motherhood Initiative, which was introduced in Nairobi in 1987, PAHO launched the Regional Plan of Action for the Reduction of Maternal Mortality in the Americas, which was approved in 1990 at the 23rd Pan American Sanitary Conference. The Plan's main objective was to reduce the rates of maternal mortality by 50% or more by the year 2000 through improvement in reproductive health services. It also called for explicit political commitment by the social and economic sectors to develop legislation, implement policy, and undertake programs of action. Despite such effort, there were only minor improvements in the overall situation, especially with regards to impact indicators. Only five countries in the Region reported achieving the 15% reduction targeted for 1995. An evaluation of the Plan indicated that political and financial limitations at the national level hampered its successful implementation. Additionally, several interventions, such as skilled attendance at birth and Essential Obstetric Care (EOC), were not adequately addressed at the programmatic level. It should also be noted that the poor and indigenous populations were ignored when considering women most in need.

In 1997, representatives from governments, donors, nongovernmental organizations (NGOs), and technical experts at the Safe Motherhood Technical Consultation agreed on key interventions for reducing maternal mortality. These interventions are reflected in the Safe Motherhood Action Agenda and include the advancement of safe motherhood through human rights, social and economic change for women, delay of marriage and first birth, and improvement of health sector interventions.

2. Current Situation of Maternal Morbidity and Mortality

2.1 *Epidemiological and Social Context*

The overall maternal mortality ratio estimated for Latin America and Caribbean (LAC) countries is 190 maternal deaths per 100,000 live births. In 1995, this ratio represented some 22,000 maternal deaths. It is important to consider that women in those countries are still dying from the same causes as women in industrialized countries in the early 20th century. These primary medical causes are hemorrhage (25%), sepsis (15%), unsafe abortion (13%), eclampsia (12%), and obstructed labor (8%). These complications are directly related to the lack of access to or utilization of services, services unable to respond to the emergency situations, and incorrect treatments. In addition, approximately half a million women experience preventable chronic health problems after pregnancy and delivery, such as uterine prolapse, fistulas, incontinence, or pain during sexual relations.

Adolescent pregnancy is a critical issue in safe motherhood, as teenage mothers account for a large and disproportionate share of maternal deaths and disabilities. In LAC countries, about one-third of women between the ages of 20 to 24 have had their first pregnancy by age 20. In addition, a pregnancy that is unwanted is more likely to result in health problems for the mother, often because it may lead to unsafe abortion or because young women are less likely to seek appropriate care.

The available data show that abortion is an important contributor to maternal mortality in several countries. It has been recognized as a public health problem, and in some countries is the principal cause of adolescent female mortality. Recent estimates provide an overall figure of 4 million abortions in LAC countries annually, leading to approximately 5,000 deaths (Thonneau, 2001). In Chile, out of every 55 maternal deaths reported in 1998, 14 resulted from complications from abortion, accounting for 25% of all causes of maternal mortality in 1998. These maternal deaths are only the tip of the iceberg; the underlying rates of morbidity linked to unsafe abortions are much higher.

There is increasing evidence to suggest that HIV/AIDS is becoming an important cause of maternal mortality. In the LAC countries, it is estimated that 1.4 million adults and children are currently living with HIV/AIDS. One-quarter of the HIV-positive adults are women. When the burden of disease is further analyzed, the Caribbean is the most severely affected. Haiti has the highest HIV/AIDS rates, and in 1996, 13% of pregnant women tested positive for HIV.

While maternal mortality and morbidity affect women of all social and economic strata, there are a disproportionate number of poor, illiterate women dying, a majority of whom resides in rural areas. Among adolescents, maternal mortality is two to four times higher than among other age groups. Legislation, cultural beliefs, or practices that undervalue women contribute to this disparity by limiting their access to economic resources. Thus, death or disability results from a situation of extreme disadvantage in which many women of the LAC countries find themselves.

2.2 *Where in the Region Are Women Dying?*

The Americas have some of the largest inequities in maternal mortality of any region in the world (see Table 1). For example, there are only 4 maternal deaths per 100,000 live births in Canada, as compared to the rate of 523 in Haiti. Even within Latin America there are great disparities. Chile has a maternal mortality rate of 23 per 100,000 live births, compared to 390 in Bolivia. Official estimates suggest that the rates are lower than 100 per 100,000 live births in Brazil, the Dominican Republic, and El Salvador. However, underreporting of official statistics is a major concern. In a preliminary analysis, the World Health Organization (WHO) has been able to adjust the maternal mortality rates for several countries in order to reflect more accurately the magnitude of the problem. The adjusted rates are shown in Table 1. In addition, maternal mortality varies greatly within countries, reflecting inequities in socioeconomic conditions and access to quality health services. In Bolivia, the maternal mortality ratio varies significantly by geographic region (high plateaus, valleys, plains) and by place of residence (urban, rural). In the rural plateaus, as many as 973 maternal deaths per 100,000 live births were observed for the period 1989-1994, compared to 36.1 maternal deaths per 100,000 live births in urban areas for the same period.

Table 1. Official (1997-1999) and Adjusted (1995) Maternal Mortality Rates for Selected Countries in Latin America and the Caribbean

Country	Maternal Mortality Rate ¹ (maternal deaths per 100,000 live births)	Adjusted Maternal Mortality Ratio ² (maternal deaths per 100,000 live births)
Bolivia	390	550
Brazil	60	262
Canada	4	6
Chile	23	N/a ³
Dominican Republic	80	N/a
Ecuador	74	210
El Salvador	120	183
Guatemala	95	270
Haiti	523	1122
Honduras	108	N/a
Mexico	51	N/a
Nicaragua	118	N/a
Paraguay	114	172
Peru	185	240

¹ PAHO Health Situation in the Americas, Basic Indicators 2001.

² Maternal Mortality Estimates, 1995: Estimates developed by WHO, UNICEF and UNFPA.

³ N.a. = Not available.

3. Lessons Learned

3.1 *Promoting Best Practices and Evidence-based Interventions*

Since 1987, knowledge of the causes of maternal disability and death, and of the appropriate interventions in resource-poor settings, has increased considerably. History has shown that the key to reducing maternal mortality lies not solely in general social and economic development, but also in making effective treatment available and accessible. A more focused approach, concentrating on such cost-effective interventions such as (EOC), skilled attendance at birth, and improved access to quality maternal health care services is currently being promoted by PAHO. Unfortunately, certain interventions known to be effective in addressing the major causes of maternal death, such as the management of abortion complications, have been omitted from safe motherhood programs, largely due to political sensitivity about the issue.

3.1.1 *Basic and Comprehensive Essential Obstetric Care*

Assuring availability of (EOC), both basic and comprehensive, is fundamental to improving maternal health. Over the past decade, more resources have been put into antenatal care than into delivery, immediate postpartum care, and essential care for managing complications. However, the majority of complications and deaths occurred during and immediately after delivery, or from unsafe abortions. Based on the latest scientific evidence, the provision of EOC is emerging as one of the most effective strategies in the reduction of maternal mortality. Basic and comprehensive care facilities are important components of EOC. These facilities include birthing centers with a skilled attendant, necessary supplies, and emergency transportation systems.

3.1.2 *Skilled Attendance at Birth*

Professional delivery care is at the center of most successful efforts to reduce maternal illness and death. The ease and speed with which skilled attendance has been promoted as a global priority is itself an indication of the urgent need to offer key decision-makers an intervention perceived as feasible and effective. This need arises from the failure of earlier priorities, e.g., traditional birth attendant (TBA) training and antenatal “at risk” scoring, to decrease maternal mortality. Women attended by skilled attendants¹ with midwifery skills are more likely to avoid serious complications and to receive treatment early. A key feature of countries that have lowered maternal mortality to a level of less than 100 per 100,000 appears to be that the large majority of babies are delivered by skilled birth attendants. In the 1970s, Chile was able to reduce its maternal mortality by half (from 200 to 100) by providing professional delivery care using a midwifery model in a supportive environment. Skilled attendance at birth is known to make a difference not only in reducing maternal mortality, but also in decreasing perinatal deaths. Nevertheless, research has shown that in some LAC countries there are very large inequities in the availability of skilled attendants at birth. For example, the rural areas of many countries are seriously underserved by skilled attendance.

¹ The term skilled attendant or provider refers exclusively to people with midwifery skills (for example, doctors, midwives, and nurses) who have been trained to proficiency in the skills necessary to provide competent care during pregnancy and childbirth. Skilled attendants must be able to manage normal labor and delivery, recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of the mother and baby for interventions that are beyond their competence or not possible in the particular setting. (Based on “Reduction of Maternal Mortality,” a Joint WHO/UNFPA/UNICEF/World Bank statement. Geneva: WHO, 1999.)

3.1.3 *Quality of Care*

One peculiarity in Latin America and the Caribbean is that the vast majority of deliveries, about 75%, are performed in institutions. Despite these figures, in many countries, maternal and perinatal morbidity and mortality rates are higher than expected for the population at risk, implying poor health care quality. Another dimension of the inequities in health care contributing to maternal mortality is access to cesarean sections. In LAC countries, this procedure is both underutilized and overused. WHO recommends an overall rate of 15%, based on the expected number of women who will face life-threatening complications during labor and delivery. The incidence of cesarean sections in countries can, therefore, serve as an indicator of access to quality obstetric care. For example, in Paraguay, only 6% of rural deliveries were by cesarean section, compared to a rate of 32% in urban areas. In other Latin American countries, rates of cesarean section are increasing and are currently higher than 15% in urban areas. This urban-rural disparity is especially important to note, as it indicates that either women with complications don't have access to services because of financial or geographic barriers, or that health services are not sufficiently equipped or trained to address the problem. In addition, high episiotomy rates have been reported. In Argentina and Uruguay, for every 10 primiparous women giving birth vaginally, 9 are currently receiving an episiotomy in public hospitals. These practices lead to high user dissatisfaction for women delivering in public hospitals in Latin America. They are ineffective interventions, and for many are culturally unacceptable. Obstetrical interventions should be evidence-based, and interventions effective only in high-risk groups should not be used routinely. On the other hand, many practices that have been proven beneficial are neither routinely used nor included in the clinical practice guidelines of maternity hospitals.

3.1.4 *Empowering Women, Their Families and Their Communities*

Women's empowerment is a key strategy for maternal mortality reduction. Enabling women to make their own choices and providing them with adequate information allows them to make critical decisions regarding their health and therefore to exercise their rights. It allows them to recognize danger signs and complications, to follow medical procedures, and to benefit from health education programs. They are more likely to take responsibility for their own health and that of their child, and demand prompt and quality health care for themselves, their families, and their communities. Community empowerment and mobilization creates a supportive environment for increasing intersectoral investment in improving health. For example, recent experiences in Ecuador and Nicaragua have shown that by strengthening communities' ability to identify danger signs during pregnancy and childbirth, as well as to assume responsibility for emergency transport for obstetric and neonatal complications, access to health services has improved. This community action has resulted in maternal mortality and morbidity reduction.

3.2 *Ensuring a Multisectoral Approach*

Maternal mortality can be reduced through the synergistic effect of combined interventions. In many countries in the Region, improvements in the health system are vital since women are dying at the service delivery level due to the lack of an obstetric network that extends from the community to the highest level of care for obstetrical complications. In countries where death and disability from complications of pregnancy and childbirth are all too common, the pursuit of safe motherhood must be based on a multisectoral approach and should be a specific component when collaborating with all parties involved, both inside and outside the government. The multisectoral approach may include education, human rights, transportation, and economic development.

An analysis of the reduction of maternal mortality in Honduras from 1990 to 1997 highlights the multisectoral approach. The ratio decreased by 38%, from 182 to 108 maternal deaths per 100,000 live births (Danel et al. 2000). Key factors identified in reducing maternal mortality in Honduras were: (a) strong national leadership, allocation of resources in promoting social services and health, and prioritization of reduction of maternal mortality; (b) strong community participation; (c) improved availability of EOC services; (d) improved referral of women with obstetric complications during home births; (e) improved referral of women to a skilled attendant; (f) overall increase in deliveries with skilled attendants; (g) improved quality of care.

4. Goals and Objectives

Broadly, the goals of safe motherhood are: to protect and promote reproductive and human rights by reducing global burden of unnecessary illness, disability, and death associated with pregnancy, childbirth, and the neonatal period; to improve conditions for safe and healthy childbirth for women; and to ensure an equal start for children. International partners have mobilized behind the Safe Motherhood Initiative and are committed to achieving the Millennium Summit Declaration goal: reduction of maternal mortality ratios by 75%, from 1990 levels, by 2015.

In addition, within the Region, a medium-term goal of decreasing national maternal mortality ratios to less than 100 maternal deaths per 100,000 live births has been recommended, as well as improving the intra-country ratios as concerns urban-rural disparities.

5. Moving from Lessons to Action: the Regional Strategy

5.1 *Promoting Effective Public Policies and Guidelines at National and Municipal Levels*

Progress in legal and policy frameworks must be achieved nationally, where laws and regulations that directly affect women's lives are passed and enforced. As a result of their participation in international forums, many of the countries in the Region have made concerted efforts to propose legislation supporting the implementation of social protection strategies for women. This includes legislation protecting women against violence. However, much work still needs to be done in terms of promoting and enforcing this legislation. Most countries in the Region have supported policies or standards emphasizing the importance of safe motherhood and a target of reducing maternal mortality by 50% by the year 2000. Bolivia, Brazil, Ecuador, and Mexico have been able to place safe motherhood prominently on the political agenda. The stimulus for action came from high-level political leadership, allied with strong grassroots support expressed through women's advocacy groups. Particularly noteworthy in all countries that have achieved low levels of maternal mortality is the fact that high-level political commitment to the issue is sustained over time, along with the availability of resources.

5.2 *Providing Reproductive Health Services / Ensuring Essential Obstetric Care and Skilled Attendance at Birth*

Promotion of the integration of an array of reproductive health services (e.g., provision of a wide range of contraceptives, maternal and infant care, treatment of sexually transmittable infections, and post-abortion care) should be an essential component of health sector reform, and access to these services should be ensured for all women and men. In addition, increasing attention should be given to the provision of youth-friendly adolescent reproductive health education and services. Adolescent health services are essential, as rates of HIV/AIDS, as well as the fertility rate, in LAC countries are increasing.

It was not until the 1990s that the international community began to realize that deliveries are far safer with professional assistance, and that when a serious problem appears, a pregnant woman should have access to an appropriately equipped health service. In addition, the provision of EOC, as defined by WHO, is a key strategy that directly addresses the medical causes of maternal mortality. With limited inputs, facilities (hospitals and health centers) can become capable of providing EOC. A system should be in place to ensure that staff are available to manage obstetric complications and emergencies (including the provision of cesarean sections and post-abortion care) 24 hours a day, and that the necessary supplies are available, especially in rural areas. Obstetric emergencies should have priority access to the operating room and safe blood

transfusion, and anesthesia services need to be available 24 hours a day, particularly in facilities providing the first level of care.

An important element is availability and access to quality of care. Several studies in the Region have demonstrated that women will not use services if they feel that they have been treated without respect, if the services are not able to respond to their needs, or if they are not of acceptable quality. The availability of quality care is one of the key factors in avoiding delays and not missing opportunities in seeking attention.

5.3 *Increasing Public Demand*

Advocacy, women's and community empowerment, and education are key strategies for increasing public demand for EOC. Provision of maternal health services alone is insufficient to ensure skilled attendance at birth. In order for communities to participate, the health system must be seen as necessary, of good quality, and appropriate. Education on the importance of health promotion, risk identification, and appropriate interventions for such audiences as policymakers, the community, and pregnant women are part of the process required to improve maternal health and decrease maternal mortality. Communities that actively contribute to maternal health programs develop a sense of ownership and a vested interest in their success. Such community partnerships can also help to ensure program demand and sustainability.

5.4 *Building Partnerships and Coalitions*

Achieving a supportive environment for safe motherhood requires collaboration and coordination. Strengthening of national and local capacity and long-term political commitment are needed to achieve this supportive environment.

Within the Region, country-level efforts have been further strengthened through efforts to improve coordination of diverse groups working to reduce maternal mortality. PAHO is the technical secretariat of the Regional Maternal Mortality Interagency Task Force. Members of the Task Force include the United Children's Fund (UNICEF), United States Agency for International Development (USAID), United Nations Population Fund (UNFPA), Inter-American Development Bank (IDB), World Bank, Population Council, Family Care International, and PAHO. The group was convened in 1999. This cooperative endeavor has resulted in enhanced coordination at the programmatic and agency levels, and has improved information-sharing between agencies.

PAHO has initiated activities with professional associations, such as the Latin American Federation of Obstetricians and Gynecologists. A memorandum of understanding was signed in which the Federation agreed to assist in the improvement of reproductive health programs at the national level. PAHO also collaborates with the International

Confederation of Midwives to facilitate national support and coordination of activities to reduce maternal mortality and to standardize norms, protocols, and clinical tools.

5.5 *Strengthening Maternal Morbidity and Mortality Surveillance Systems*

Monitoring and evaluation of programs are essential to the continuation and improvement of efforts to decrease maternal mortality. Evaluation needs to occur at local, national, and regional levels. Indicators and the data on which they are based are the main tools. Surveillance of maternal mortality is also improving, and measuring maternal mortality, particularly at national and local levels, should be feasible in the LAC countries. Maternal mortality committees are increasingly carrying out the identification and investigation of maternal deaths (such as audits) and, based on findings, recommending actions to be taken.

Audits of maternal deaths, provider care, and barriers to care are relatively new techniques not yet fully utilized in developing countries. These audits should be carried out at all levels of the health care system. It is important to note that audits will have little effect if their outcomes are not communicated to individuals, communities, and organizations that can use the data to advocate for positive changes at the health policy or provider level.

The use of criterion-based audits for the management of severe obstetric complications in district hospitals in Jamaica revealed that improvements were most marked in areas of care where the baseline performance fell far below the optimal level, such as in record-keeping, drug use, and clinical monitoring.

5.6 *Financing Reproductive Health Services within Health Sector Reform*

Findings reviewing the cost of providing maternal health services suggest that, for most interventions, care can be provided more economically at the primary care level. Thus, upgrading health centers to provide basic EOC is a cost-effective option. This is particularly noteworthy, as poor women in isolated rural communities are most affected by the lack of basic EOC and thus most likely to die in childbirth. To improve maternal health in developing countries, the model of health care financing must facilitate access and guarantee service quality, including not only an essential package of health services but also a viable referral system and transportation. The key is financial sustainability.

Health costs are an important factor in the decision to utilize services. New models of financing with different forms of cost recovery for health services have been identified in some places as a deterrent to seeking services, especially in the poorer populations. Some countries, most notably, Bolivia, Ecuador and Peru, within their health sector reforms, are implementing universal coverage through health insurance for

maternity care. It is too soon to determine the effectiveness of these schemes in reducing maternal mortality, but it is evident that cost is a deterrent for many if one considers the increase in institutional births since the implementation of these measures.

Bolivia's national insurance program for mothers and children. This is an example of a decentralized financing program. It was introduced in 1996 and calls for the provision of free essential medical care for women of child-bearing age, newborns, and children up to five years of age. It covers selected priority health needs such as birth and antenatal care. Services are reimbursed on a per-service basis by the municipal government. It is estimated that 20% of national revenues are allocated to the municipalities, of which 85% are allocated to "investment purposes"; 3.2% of these investment funds go into a Local Compensatory Health Fund, which reimburses *Seguro Nacional de Maternidad y Niñez* (SNMN) requests. In 1998, the Seguro Básico was launched and additional services, such as coverage for complications of abortion, sexually transmitted infections, and post-abortion care, were included in the package of care. In terms of maternal health outcomes and indicators of maternal health, coverage is low in Bolivia, but there was a demonstrated increase in the utilization of maternal health services (from 16% to 39% for antenatal care and from 43% to 50% for delivery care) following the introduction of the SNMN.

6. Financial Implications

6.1 *Financial Implications for Countries*

WHO and the World Bank have estimated that providing a standard package of maternal and newborn health services would cost approximately US\$ 2.60 per person per year in a low-income country. These costs are primarily for maternal health services (68%), but also include postpartum family planning and basic neonatal care, as well as condom promotion to prevent sexually transmitted infections. Delivering effective maternal health services requires better infrastructure and maternity care services, but does not usually require new facilities.

6.2 *Financial Implications for the Secretariat*

PAHO has allocated resources for the reduction of maternal mortality at the regional and national levels. Since 1997, PAHO has received an average \$350,000 per year from USAID. However, this funding terminates in September 2002. At that time, PAHO will need to identify new resources in order to meet the technical cooperation needs of Member States. In addition, countries in the Region need financial resources to implement evidence-based interventions.

In order to support the implementation of the strategy in 2002 and beyond, the Secretariat anticipates the need for, at a minimum, an additional \$500,000 per biennium.

7. Key Issues for Deliberation

The findings are clear: maternal death is preventable; effective interventions are known; and investment in safe motherhood will reduce maternal and infant death and disability. In order to attain the goal of decreasing national maternal mortality ratios to less than 100 per 100,000 live births, the LAC countries need to focus on the following key areas.

- Safe motherhood interventions are among the most cost-effective in the health sector. Delivering effective maternal health services requires better infrastructure that supports basic and emergency obstetrical services within existing facilities. In most countries, the greatest impact can be achieved through interventions to improve existing community health centers and district hospitals, for example, by training health providers with midwifery skills, especially nursing and midwifery personnel, and purchasing essential obstetric equipment and supplies. In general, costs are lowest, and sustainability greatest, in programs that make use of existing capacity. What are the obstacles to ensuring more equitable and sustainable financing of maternal health services, specifically with regards to maternal mortality reduction?
- The single most critical intervention for safe motherhood is to ensure that a health provider with midwifery skills is present at every birth, and transportation is available in case of an emergency. Skilled attendance can also be viewed more broadly to include the political and policy context in which skilled attendance must operate and the sociocultural influences.
- What actions are necessary to ensure that skilled attendants at birth, together with an enabling environment, are available, especially in such underserved regions such as rural areas?
- Maternal emergencies are extremely difficult to predict. Therefore, all women need access to EOC. Guidelines issued jointly in 1997 by WHO, UNICEF, and UNFPA recommended that for every 500,000 people, there should be four facilities offering basic EOC and one facility offering comprehensive EOC. Reform efforts offer an opportunity to ensure that EOC is an integral part of any improvements in financing, quality, organization, and management systems. What strategies should be developed and implemented by Member States to improve the availability of EOC at the first level of referral, including such components as access to blood supplies, surgery, anesthesia, and skilled personnel to manage obstetric complications?

- Vast discrepancies continue to exist in access to maternal health care between richer and poorer women, urban and rural women, and educated and uneducated women. Many women describe providers in the formal health care system as unkind, and unsympathetic to their values and cultural beliefs. Consequently, many women rely instead on family members or TBAs for antenatal, delivery, and postpartum care. This can lead to fatal delays in seeking care for pregnancy-related complications or the timely detection of complications.
- Member States are urged to recognize that maternal health is of critical importance to overall public health. It must be determined what is needed to: (a) involve women and communities in the design and evaluation of services so that they respond to local needs; (b) engage communities in the efforts to improve women's access to culturally acceptable maternal care; and (c) empower communities, families, and women to implement the actions needed to ensure safe motherhood.
- Partners at all levels need to work toward the development and maintenance of programs that reduce the number of women dying from pregnancy-related causes. Mutual trust, transparency, and capacity-building should characterize partnerships. Local and national governments, health services, professional associations, women's organizations, and other NGOs must be involved and promoted as key partners in the efforts to reduce maternal mortality. What steps must be taken in order to ensure that interagency collaboration occurs when promoting and implementing maternal mortality reduction strategies?

8. Action by the Subcommittee on Planning and Programming

Based on the information presented in this document regarding the situation of maternal mortality in the Region of the Americas, the Subcommittee on Planning and Programming is requested to take the following actions:

- Recommend mechanisms to ensure that Member States make a long-term commitment, both political and programmatic, including financial support, in order to improve the way in which safe motherhood activities are currently being implemented;

- Discuss and endorse the proposed evidence-based interventions designed to reduce maternal mortality;
- Propose strategies to mobilize long-term technical and financial resources at the regional and country levels for the implementation of strategies; and
- Advise the Secretariat on mechanisms for monitoring progress in the reduction of maternal mortality.