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PLAN OF ACTION TO ACCELERATE THE REDUCTION IN MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY: FINAL REPORT

Background

1. In 2011, the 51st Directing Council of the Pan American Health Organization (PAHO) adopted the *Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity* (Document CD51/12), through Resolution CD51.R12, with three main objectives: *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 (*1, 2*). In 2014, in accordance with the monitoring and evaluation tool approved in 2011 *(3)*, the 53rd Directing Council of PAHO took note of the progress report (Document CD53/INF/6) *(4)*.

Analysis of the progress made

2. This report presents how Member States' national plans on maternal health were updated, in accordance with Resolution CD51.R12. It also measures the evolution of the five impact indicators and the 19 progress or outcome indicators, in accordance with the approved monitoring plan. The analysis used official data from the Member States. The publication of that information was somewhat delayed; as a result, the initial data for establishing the baseline were obtained in early 2012, but were for the year 2010. The final data were obtained between December 2016 and October 2017 and are for 2015. Two data sources were used: *a)* for the indicators that encompassed all countries in the Region, the PAHO publication, *Basic Indicators (5, 6)* was used; *b)* for process data, the monitoring and evaluation tool for the 27 countries with more than 7,000 births per year was used. These last data, in particular, have limitations for analysis due to various problems, such as low reporting of coverage, inconsistencies or countries that only reported data at the start (2010) or at the end (2015), which prevented the preparation of reports on trends in those cases.

3. In the period covered by the plan of action, 38% of the countries in the Region updated their national plans for reducing maternal deaths: by 2013 seven countries had done so, with seven more by 2015, and four more in the last two years (2016-2017).

Despite unanimous approval of the plan, the Member States partially aligned with its contents; awareness-raising, therefore, should be made a key component for securing greater convergence in future plans. Such awareness-raising should focus especially on the countries with the highest maternal mortality ratios (MMR), because they are the ones that need to achieve better results and that present the greatest challenges.

4. During the period evaluated (2010-2015), the trend toward reducing maternal mortality was maintained, with an 11.1% reduction in the MMR—a drop seen across all age groups. However, this reduction was in the countries already in a better situation, since those with the highest MMR saw a reduction of only one percentage point above the regional average.

5. The rate of reporting for some of the indicators proposed in the plan was low, and some were neither measured nor reported by countries, especially information broken down by different population subgroups. There was an improvement in reporting by geographical area (states, provinces, municipalities), and by place of residence; however, reporting by ethnic group did not improve. The lack of information in these areas obscures inequities between population groups; this information is needed for more effective measures to reduce maternal morbidity and mortality. This is even more critical in the ten countries with the highest MMR figures, where there is very little or no information available.

6. Due to the countries' disparate criteria for defining severe maternal morbidity (SMM), there is great variability in the SMM data presented, which means that it is necessary to standardize and use precise definitions at the regional level. In the ten countries[1] with the highest MMR, progress on this line has not yet been made.

7. The lack of national-level institutional data on implementation of interventions proven effective for reducing the most frequent components of maternal mortality (hemorrhage, hypertension, and gender-based violence) may have prevented implementation of improvement processes.

8. The maternal and perinatal health information and surveillance systems did not improve sufficiently in the Region in the period evaluated. The number of countries that reported having perinatal and maternal morbidity information systems in operation remains almost unchanged to 2015 and, in the ten countries with the highest MMR, only four in ten report having a system in operation. Accountability on maternal health has also recorded minimal progress in the period studied.

9. Below are the tables on the monitoring, assessment, and evaluation of the impact indicators, as well as the indicators for the four strategic areas.

[1] Ten countries with the highest MMR: Bolivia, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, Peru, and Suriname.

Monitoring, assessment and evaluation of the impact indicators	
Impact indicator, baseline and target	**Achievement status of the indicator**
a) Total maternal mortality ratio (MMR), by cause and age. Baseline: 63.6 per 100,000 (2010). Target: 21% reduction in the period 2010-2017	From the approval of the plan to the present (2015), MMR was reduced by 11%, from 63.6 per 100,000 live births (2010) to 56.6 per 100,000 live births (2015), according to data from 23 of the 27 countries that reported on MMR in 2010 and 2015. Analysis was carried out in eight of the ten countries in Latin America and the Caribbean (LAC) with the highest MMR (Dominican Republic, Guatemala, Guyana, Honduras, Nicaragua, Paraguay, Peru and Suriname) that presented national data for the entire period. In these countries, MMR fell 12%, less than projected since these countries should have seen a larger reduction than the regional average. Maternal death from various causes indicates that hypertension and hemorrhage continue to be the most frequent causes, and there has been a reduction in deaths from the third leading cause (deaths linked to abortion), which fell from 9% in 2010 to 7% in 2015. Deaths from direct causes represented almost 70% of all deaths, while deaths from indirect causes accounted for 28% throughout the period. Of the 20 countries that submitted reports, only two were among the 10 countries with the highest MMR, which does not permit specific analysis. Of the 10 countries with the highest MMR in the Region, only two had maternal mortality data by age group.
b) Total severe maternal morbidity ratio (SMMR), by cause and age. Baseline: 8 countries report the SMMR at the national level. Target: 16 countries will report data on the SMMR by 2017	The severe maternal morbidity ratio (SMMR) indicator, by cause and age, was constructed to help identify severe maternal morbidity. It was reported by 11 of the 27 countries (41%) that indicated they had national data. Data were broken down by cause and age in 10 of the 27 countries (37%). There was significant variability in the SMMR, not only from country to country, but also from year to year in a given country (Colombia, Guyana, Haiti and Honduras). The figures demonstrate major variations in different criteria for categorizing severe maternal morbidity. Although these data had a low level of reliability, countries made the effort to monitor and report these data, so reporting increased by 45% from 2010 to 2015. None of the 10 countries with the highest MMR have records on SMMR.
c) Maternal mortality rate (maternal deaths per 100,000 women aged 15-44). Baseline: 4.4 per 100,000 women aged 15-44 Target: 10% reduction by 2017	The maternal mortality rate for women aged 15-44 in LAC fell from 4.4 (2010) to 4.1 (2015) per 100,000 women of childbearing age (a 7% reduction), while for the group of women aged 15-49, the rate declined from 3.9 in 2010 to 3.4 in 2015.

Monitoring, assessment and evaluation of the impact indicators	
Impact indicator, baseline and target	**Achievement status of the indicator**
d) Number of countries with an MMR of less than 75 (per 100,000 live births) in 2017. Baseline: 16 countries achieve the indicator Target: 20 countries will achieve this indicator by 2017	There was a 7.4% improvement—in 2010, 16 countries achieved this indicator, while in 2015, 18 countries did.
e) Number of countries with MMR greater than 125 (per 100,000 live births) among geographic and ethnic subpopulations of women). Baseline: 15 countries that have at least one subgroup with MMR greater than 125 per 100,000 live births Target: 10 countries that have at least one subgroup with MMR	This indicator was included in the plan of action in order to assess inequities within countries. In the "Departments, provinces or states" subgroup, groups were identified by department or province with MMR greater than 125 per 100,000 live births in 11 countries in 2015. The analysis of the "rural and urban area" subgroup, despite very low reporting (five and two countries, respectively), showed that maternal death in the few countries that reported on this indicator was four times more frequent in rural areas than in urban ones. That proportion of maternal deaths was reduced almost to half by 2015. In the category "ethnic groups," three countries reported groups with more than 125 deaths per 100,000 live births in the Afro-descendant and indigenous population, and two did so in the mestizo population. None of the countries with data recorded white/Caucasian population groups in this indicator. In the 10 countries with the highest MMR, 80% had identified maternal deaths by political division (departments, provinces, etc.) and half of these countries identify deaths according to rural or urban residence. Only 20% identify the deaths according to ethnic group, which limits the possibility of better understanding the impact of inequity and establishing more specific measures for reducing deaths in those groups.

Strategic area 1: Prevention of unwanted pregnancies and resulting complications		
Objective	**Indicator, baseline and target**	**Status**
1. Increase the use of modern contraceptive methods by women of reproductive age, with emphasis on adolescents.	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%	Due to the lack of information on this indicator in the available sources, it was not possible to determine whether or not this indicator was achieved. There was information from only four countries.
	Number of countries that have national data on postpartum and/or post-abortion contraceptive counseling and provision of contraceptives by their health services. Baseline: 30% of countries Target: 90% of countries	This is a complex indicator, with four indicators in one; thus, the baseline was recalculated for each one. In 2010 the postpartum counseling rate was 25.9% (7 in 27 countries); post-abortion counseling was 18.5% (5 in 27 countries), the provision of postpartum contraceptives was 37% (10 in 27 countries) and for post-abortion it was 29.6% (8 in 27 countries). The target was far from being met in the four indicators, with three showing improvement, while one remained the same.
	Percentage of deaths in women due to abortion reduced by 50%. Baseline: 13% Target: 7%	The baseline was corrected from 13% to 8.6% since only 22 countries provided information that made it possible to recalculate the baseline. In 2015, although the proportion of deaths from abortion declined to 6.5%, the target was not met.

Strategic area 2: Universal access to affordable, high-quality maternity services within the coordinated health care system		
Objective	**Indicator, baseline and target**	**Status**
2. Ensure that quality maternal health care services are offered within integrated health systems.	Number of countries with 70% coverage of four or more antenatal visits. Baseline: 50% Target: 90%	The evolution of the countries with respect to this indicator showed that 24 countries reported being above 70% in 2010, versus 36 in 2015. There was a marked improvement in this indicator, but it only reached 73%. Estimates suggest that the target could have been met because some of the 8 countries that did not provide information are known to have antenatal care with 4 or more visits, near the 90% level or greater. Beyond this improvement in the indicator, the monitoring plan did not assess the quality of the visits.

Objective	Indicator, baseline and target	Status
	Institutional coverage of deliveries. Baseline: 89.8% Target: 93%	The percentage of institutional coverage of deliveries was measured according to data from the PAHO publication, *Basic Indicators* (*5*, *6*), rising from a baseline of 89.8% in 2010 to 94.8% in 2015. There was an improvement in the indicator on institutional deliveries, but information is not available to evaluate service quality.
	Number of countries that have at least 60% coverage for postpartum visit at seven days after delivery. Baseline: 5 countries Target: 22 countries (80%)	No information was available on this indicator, since the countries do not typically report this information.
	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: 2 countries Target: 24 countries (90%)	In almost all the countries, it was not possible to obtain the information on this and the following indicators for measuring the quality of maternal care. This is particularly relevant because these indicators are directly related to maternal deaths in the puerperium, or from causes such as hypertensive disorders and hemorrhage, or to gender-based violence, an issue that has taken on great importance in Latin America, and some of these are related to the leading causes of maternal mortality.
	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: 1 country Target: 24 countries (90%)	
	Number of countries with safe blood available in 95% of the facilities that provide emergency childbirth care. Baseline: 5 countries Target: 27 countries (100%)	
	Number of countries monitoring intrafamily violence during pregnancy in 95% of institutional births. Baseline: 0 Target: 22 countries (80%)	

Objective	Indicator, baseline and target	Status
	Number of countries with C-section rate above 20% that reduce their C-section rate by at least 20% by 2017. Baseline: 17 countries Target: 100%	During execution of the plan, the C-section rate remained stable or rose slightly. The indicator was reported by 17 countries in 2010, when 14 countries had C-section rates over 20%. In 2015, 18 countries reported their C-section rate and there was backsliding, since three more countries (total of 17) had C-section rates over 20%. In 2015 alone, one country reduced the rate by over 20% (32%) compared to 2014, but that was not maintained.
	Number of countries with maternal deaths due to obstructed labor. Baseline: 15 Target: 0	In 2010, three countries recorded deaths due to obstructed labor and seven in 2015, an unfavorable development, since the aim was to eliminate deaths from this cause.

Strategic area 3: Skilled human resources		
Objective	**Indicator, baseline and target**	**Status**
3. Increase the number of skilled personnel in health facilities for preconception, antenatal, childbirth, and postpartum	Number of countries that have 80% coverage of childbirth care provided by skilled personnel, as defined by WHO. Baseline: 43 Target: 48	This indicator, which had a baseline of 43 countries in 2010, rose to 44 countries in 2015. Only Aruba did not present data for this indicator; but when it did so in previous years, it was always close to 100%. As a result, this indicator was not achieved, and progress was minor.
	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	This was not consistently measured, since the majority of countries did not systematically compile this information. The baseline was adjusted from 23 countries to 10. In 2015, although the number of countries that reported on this indicator increased, achievement worsened, falling from 10 countries to nine. This is especially serious when a high percentage of maternal deaths occurs in the puerperium.

Objective	Indicator, baseline and target	Status
	Percentage of emergency obstetric care (EmOC) health facilities (basic and comprehensive) that perform an audit of all maternal deaths. Baseline: 22.5% Target: 90%	The response of the countries for measuring this indicator was very low and unreliable. In all the countries, in 2010, 1,576 facilities (total of 12 countries) performed audits of maternal deaths out of a total of 7,020 emergency obstetric care facilities (22.5%). In 2015, information was received from 1,606 facilities (11 countries) that audited maternal deaths out of a total of 6,692 (24), which means that there was almost no improvement. Despite the difficulties obtaining quality data, the indicator improve marginally, but this was almost negligible in statistical terms.
	Number of countries that annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR. Baseline: 60% Target: 100%	This indicator remained constant. In 2010, only 18 of the 27 consulted countries provided information and 16 reported having presented annual reports to the public on maternal mortality. In 2015, 21 countries provided the requested information, but it was the same 16 countries that continued to achieve the indicator.

Strategic area 4: Strategic information for action and accountability		
Objective	**Indicator, baseline and target**	**Status**
4. Strengthen information systems and maternal and perinatal health monitoring in the framework of integrated information and vital statistics systems.	Number of countries where the health system has a functioning perinatal information system. Baseline: 16 Target: 27	The baseline had to be adjusted from 16 countries to 12, based on available information. In 2015, reports were received from 24 countries only 14 of which achieved the indicator. Improvement in the indicator was very poor, and just over half of the target was achieved. Of the 14 countries that have an operational perinatal information system, only four were among the 10 countries with the highest MMR.

Objective	Indicator, baseline and target	Status
	Number of countries where the health system maintains a registry of severe maternal morbidity. Baseline: 2 countries report these data. Target: 80%	In 2015, only three of 23 countries reported having a registry of severe maternal morbidity (whether classified as serious or extremely serious). These data are not consistent with the report on severe maternal morbidity data prepared by 10 countries (three countries confirmed having a system for registering severe maternal morbidity, but 10 reported data for 2015).
	Number of countries whose coverage of maternal deaths in vital record systems is 90% or more. Baseline: Not established Target: 100%	No information was available to evaluate progress.

Measures needed to improve the situation

10. In view of the results achieved and the ongoing challenges, it is essential that both the Member States and the Pan American Sanitary Bureau maintain their commitment and efforts to preserve and strengthen the gains made and to make progress with the unfinished agenda.

11. Due to inequities in the Region and the different care needs of vulnerable groups, the surveillance and monitoring systems and epidemiological analyses carried out by Member States need to measure indicators according to different epidemiological variables (age, ethnic group, residence, income, etc.). This will help target actions to bridge existing gaps, particularly in the ten countries with the highest MMR, by designing interventions that target women (preconception, childbirth, and puerperium), in order to reduce severe maternal morbidity and maternal mortality. By way of example, PAHO has spearheaded processes that have helped reduce maternal deaths, such as: *(a)* the Zero Maternal Deaths by Hemorrhage project, for regions of countries with high levels of maternal death from postpartum hemorrhage; *(b)* deliberate searches for maternal deaths that help to reduce underreporting of deaths; *(c)* surveillance and response to maternal deaths in countries where there is a recurrence of maternal deaths from the same causes; and *(d)* strengthening the use of long-lasting contraceptive methods, especially for vulnerable adolescent populations.

12. Quality assurance and measurement are necessary components to take into account when designing and executing future interventions.

13. In view of the data obtained by Member States for the entire period, it is recommended that monitoring indicators be created from established sources in the countries to improve the information routinely collected and deepen the analysis of women's health care. Monitoring social determinants, for example, would make it possible to establish more efficient measures for vulnerable populations.

14. The aim is for this report's findings, together with the various initiatives and regional and global strategies emphasizing the need to focus on women's health—such as the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, the Sustainable Development Goals and Sustainable Health Agenda for the Americas 2018-2030—to be consistent with future regional plans that address women's health, including the Plan of Action for Women's, Children's and Adolescents' Health 2018-2030 *(7-9).*

Action by the Executive Committee

15. The Executive Committee is invited to take note of this report and make the observations it deems pertinent.

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