AFRICA HEALTH ORGANISATION

2030

AHO PLAN OF ACTION TO ACCELERATE REDUCTION OF MATERNAL MORTALITY AND SEVERE MOBIDITY

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Preface

This Plan of Action proposes that key interventions proven effective in reducing maternal morbidity and mortality in strategic areas be intensified in 2020, 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

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), the International Conference on Population and Development in Cairo, Egypt (1994), the Fourth World Conference on Women in Beijing, China (1995)

AHO 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

Sexual and reproductive health is a priority issue in Africa. 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.

Violence against women is another risk factor for maternal death. AHO has demonstrated that 15% to 51% of women are victims of physical and sexual violence perpetrated by their partners, 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. 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.

Graciano Masauso
Founder, President, Director, CEO
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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.

2. It also touches on issues dealing with safe hospitals and integrated health services networks.

3 It shows AHO's commitment to reducing maternal mortality and morbidity in Africa

4. This Plan of Action proposes that key interventions proven effective in reducing maternal morbidity and mortality in strategic areas be intensified in 2020, 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), the International Conference on Population and Development in Cairo, Egypt (1994), the Fourth World Conference on Women in Beijing, China (1995)

6. AHO 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.

7. In Africa, maternal mortality has been addressed at several meetings of the AHO Governing Bodies.

8. AHO joined efforts in addressing maternal health reduction.

9. Sexual and reproductive health is a priority issue in Africa. 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. There were 9,500 maternal deaths representing a maternal mortality ratio (MMR) of 88.9 per 100,000 live births. Countries are struggling to reduce maternal mortality in Africa.

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

12. Violence against women is another risk factor for maternal death. AHO has demonstrated that 15% to 71% of women are victims of physical and sexual violence perpetrated by their partners, 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. 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.

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% in the general population, and even higher among adolescents. The fact that many countries have laws restricting access to contraceptives specific example being bans on emergency oral contraceptives—compounds this problem. Legal restrictions to abortion in many countries lead women to resort to unsafe abortion as a contraceptive method. The rate of unsafe abortion 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 than in developed regions. (10 versus 3 per100,000 live births, respectively).

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 populations, have lower coverage, poor quality of care, and high MMR rates.

15. Often, the antenatal and childbirth care within reach of women fails to meet internationally recommended standards. Preconception monitoring is practically non-existent. 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 fulfil 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. AHO estimates that the optimum C-section rate should be around 15%. Increments in the use of C-sections observed in recent years to levels higher than this optimum rate have increased the risk of maternal and perinatal mortality and morbidity.

16. Severe maternal morbidity has received less study than maternal mortality. As many as 20 cases of maternal morbidity are estimated to occur for each maternal death recorded, 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 AHO's Medium-term Strategic Plan 2020–2025

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.

21. The plan is to be executed between 2020 and 2030 by strengthening partnerships at different levels, e.g., with the 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 counselling prior to conception and after an obstetric event.

Goal 1: By 2030, the countries of Africa 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%.)

• Number of countries that have national data on postpartum and/or post-abortion contraceptive counselling 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 AHO, 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 postpartum 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 postpartum 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 national level
2.1 Disseminate the AHO evidence-based guidelines encompassing care from preconception through the postnatal period, as well as AHO's *Guides for the Primary Health Care-Focused Continuum of Care of Women and Newborns*.
2.2 Disseminate the perinatal technologies developed by the African Centre of Perinatology (ACP) and AHO.
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 intrafamily violence.
2.6 Disseminate the WHO virtual library on sexual and reproductive health.
2.7 Promote successful maternal and perinatal models, 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 local 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, anaemia, 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 labour 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

Indicators
• Number of countries that have 80% coverage of childbirth care provided by skilled personnel. (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. (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 national 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 local 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 analyse 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 national 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 AHO 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 analyse severe maternal mortality and severe morbidity.

Activities at the local 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 analysing and using this information.
4.8 Establish or strengthen intersectoral committees, with community participation, to analyse 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, AHO 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. AHO 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 of the AHO Strategic Plan. Expected regional-level results relating to the plan are detailed. 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 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. AHO hopes that the approval and implementation of this Plan of Action with the broadest commitment of the countries of Africa, will allow women and children to exercise their basic rights and will foster social justice.

Summary

AHO urges the Members to:

(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.

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Strategic areas

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 postpartum 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 labour, 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 labour (Baseline 15. Target: 0.)
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	• 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

	attend births and handle obstetric complications.	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%.)