



SAFE MOTHERHOOD INITIATIVE (SMI) IN THE AMERICAS



BACKGROUND

Reproductive health disorders account for more than 30% of the entire burden of disease and disability that affects women. The largest proportion of healthy years of life lost by women of childbearing age is due to problems associated with pregnancy and childbirth. Some 300 million women, more than one-quarter of all adult women, suffer from illnesses caused by the reproductive process in the short or long term.

All Member States of the World Health Organization, by ratifying its Constitution and other international and regional treaties, have agreed to protect the right of females of all ages to enjoy the highest attainable standard of health (their "right to health"). In the *Global Strategy on Reproductive Health*, approved by the 57th World Health Assembly (WHA) in May 2004,¹ the WHO Member States agreed that the guiding principle for achieving the objectives of this strategy (including the reduction of maternal mortality caused by unsafe abortions and other practices) is to ensure that teenage and adult women have the opportunity to exercise the basic human rights agreed upon in international accords at Cairo and Beijing, as well as in the other instruments mentioned above. These include:

- The right to enjoy the highest attainable standard of health;
- The right to decide freely on their number of children and spacing of births;
- The right to receive all information related to their health (including sexual and reproductive health);
- The right to have control over matters related to their sexuality;
- The right to decide freely on matters related to their sexual and reproductive health, free of coercion;
- The right to nondiscrimination; and
- The right of everyone to enjoy the benefits of scientific progress and its applications.

The WHO Constitution establishes the following fundamental international principle: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." This means that the WHO Member States have the obligation to guarantee their most vulnerable groups (such as teenage and adult women) the exercise of this and other related human rights. For this reason, the WHO Constitution also states that "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."²

¹ Global Strategy on Reproductive Health, approved by the 57th World Health Assembly (WHA) in May 2004, Geneva. See text at: http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_13-en.pdf .

² The Constitution was approved by the International Health Conference, held in New York 19 June-22 July 1946 and signed on 22 July 1946 by the representatives of 61 States (Peru became a WHO Member State on 11 November 1949). The United Nations International Covenant on Economic,

The Member States of the Pan American Health Organization, in turn, have pointed out that the international and regional treaties, conventions, and standards on human rights offer a unifying conceptual and legal framework of strategies for improving the well-being of the most vulnerable populations, such as teenage and adult women, as well as the means for clarifying the accountability and responsibilities of the various stakeholders in the context of the Millennium Development Goals (MDG).³

Consequently, under the Strategic Plan 2008-2012 approved by all the Member States of PAHO, the Members made the commitment to refer to international and/or regional human rights standards and instruments (technical background documents on human rights prepared by PAHO) when updating and/or drafting new laws, policies, and plans that promote health and reduce gaps in health equity as well as discrimination, including policies and legislation on universal access to sexual and reproductive health (for example, protocols and technical standards) that contribute to attainment of the pertinent Millennium Development Goals. Specifically, these are: Goal 3, to promote gender equality; Goal 4, to reduce by two-thirds between 1990 and 2015 the under-5 mortality rate; Goal 5, to reduce by three-quarters the maternal mortality ratio between 1990 and 2015, Goal 6, to have halted by 2015 and begun to reverse the spread of HIV/AIDS.⁴

The Regional Working Group for the Reduction of Maternal Mortality (RWG) was established in 1998 and tasked with coordinating the efforts of the various technical cooperation agencies. It works to standardize criteria for action and the mobilization of political will, and to develop a follow-up mechanism for national and local monitoring in countries where maternal mortality rates are high.

Social, and Cultural Rights, for its part, protects "...the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12), and the OAS Protocol of San Salvador protects "the right to health" (Article 10). In addition, health protection as a human right is enshrined in 19 of the 35 Constitutions of the PAHO Member States (Bolivia, Brazil, Cuba, Chile, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, and Venezuela).

³ See Pan American Health Organization, Proposed Strategic Plan 2008-2012, Strategic Objective 7, Official Document No. 328, pp. 68-72. Approved by 27th Pan American Sanitary Conference, Washington, D.C., 1-5 October 2007. Available at: <http://www.paho.org/english/gov/csp/od328-full-e.pdf>.

According to the Proposed Strategic Plan 2008-2012, "under current international law, human rights instruments include regional/international 'treaties' or 'conventions' negotiated and formulated by UN and/or OAS Member States and international/regional 'standards' which are guidelines enshrined in declarations, recommendations, and reports issued by the UN/OAS General Assembly, UN High Commissioner for Human Rights, UN Human Rights Council, and UN/OAS treaty bodies, among others."

⁴ Ibid. See Strategic Objectives 4 and 7 in the PAHO Strategic Plan. Available at: <http://www.paho.org/english/gov/csp/od328-obj1-4-e.pdf>, or <http://www.paho.org/english/gov/csp/od328-full-e.pdf>, pp. 49-56, and <http://www.paho.org/english/gov/csp/od328-obj5-8-e.pdf>, or <http://www.paho.org/english/gov/csp/od328-full-e.pdf>, pp. 68-72.

The OAS General Assembly proclaimed 2010 the Inter-American Year of Women (AG/RES. 2322 (XXXVII-O/07)). Its slogan is: "Women and Power: For a World with Equality." The observance will include a review of progress to date and the remaining challenges and obstacles that may be preventing the achievement of full equality between men and women. It will also acknowledge the pioneering role played by the Inter-American Commission of Women in the struggle for civil and political rights and equal opportunity for men and women.

SITUATION ANALYSIS

Every minute, somewhere in the world:

- 1 woman dies of pregnancy-related causes
- 100 women suffer from complications of pregnancy
- 200 acquire a sexually-transmitted disease
- 300 conceive without desiring or planning their pregnancy

Despite the progress made in the past 20 years toward reducing maternal mortality in the Region of the Americas, the figures remain high in many countries:

- 3,240,000 pregnant women in the Region do not have control over their pregnancy
- 3,400,000 do not give birth in a health institution where they receive care in delivery
- 2,980,000 do not have access to care by skilled birth attendants
- 15,000 pregnant women die in the Region each year, according to WHO/UNFPA/World Bank estimates. The Region's infant mortality rate is 19 per 1,000 live births, and the maternal mortality rate is 85 per 100,000 live births, with the latter figure exceeding 100 in eight countries of the Region.⁵

- Maternal mortality is a phenomenon in women who are poor, indigenous, illiterate, and live in rural areas or marginal circumstances. Many women in indigenous, adolescent, and poor populations have unplanned pregnancies. Unfortunately, not all countries have policies, strategies, or sufficient budgetary resources to address the challenge of reducing maternal mortality.

- It is this population group that creates the first link in the chain of poverty. Lack of financial resources to access services, coupled with the latter's inability to adapt, obliges these women to resort to their culture and customs and rely on the services of traditional birth attendants who are not qualified to provide proper care.

- While the causes of maternal mortality in the developed countries are mainly indirect (women with chronic diseases when they become pregnant), maternal deaths in the Americas occur in healthy women who suffer from a direct cause – namely, complications of pregnancy itself, which are almost entirely preventable. A study of direct obstetric causes conducted by PAHO/WHO reveals a variety of

⁵ World Health Organization. World Health Statistics 2009. Geneva.

circumstances that require different interventions. In countries where abortion and its complications are the leading causes of death, there is need to increase coverage of modern contraceptive methods and develop legal mechanisms to ensure that abortion can be performed under safe conditions. In countries where hemorrhage is the leading cause of death, the need is for greater coverage of institutional delivery provided by skilled professionals and for guaranteed access to quality emergency obstetric care and safe blood. And where pregnancy-induced hypertension (toxemia) is the leading cause of death, it is essential not only to increase prenatal care coverage and delivery by skilled personnel, but also to ensure access to effective treatment and quality specialized care.

	Leading causes of death by magnitude of the mortality ratio and availability of services			
	Maternal mortality ratio per 100,000 live births			
	<15	15-49	50-100	>100
Birth control, 75-90% Prenatal approx. 100% Delivery approx. 100%	(A) 1-Indirect 2-Preeclampsia 3-Infections			
Birth control, 55-80% Prenatal period 90-100% Delivery approx. 100%		(B) 1-Abortion 2-Preeclampsia 3-Hemorrhage		
Birth control, 40-70% Prenatal 85-95% Delivery 70-90%			(C) 1-Preeclampsia 2-Hemorrhage 3-Abortion	
Birth control, 20-60% Prenatal 70-90% Delivery 25-90%				(D) 1-Hemorrhage 2-Preeclampsia 3-Obstructed delivery
Countries in: (A) Canada, United States. (B) Chile, Costa Rica, Uruguay, Argentina. (C) Mexico, Venezuela, Panama, El Salvador, Brazil, Colombia, Nicaragua, Dominican Republic, Ecuador, Jamaica. (D) Honduras, Paraguay, Guatemala, Peru, Bolivia, Haiti.				

There is a strong correlation between maternal mortality and lack of institutional delivery care. In some countries of the Region more than 50% of all deliveries are attended at home by unskilled personnel and one-third of pregnant women die at home without receiving care in a health institution.

LINES OF ACTION

In light of the commitments that have been made by all the Member States in international and regional treaties on human rights, it is essential that health care providers be trained; that services have the necessary infrastructure and resources; and that the community be guaranteed access to this care. However, this process is only in its infancy in the Region of the Americas. WHO recommends that medical protocols and technical guidelines be implemented for the effective protection of mothers. Laws and protocols should ensure that teenage and adult women receive the basic information needed for them to make decisions freely and

be supported in the exercise of their right to privacy and confidentiality.⁶ This specialized information should also apply to the diagnosis, treatment, and post-treatment follow-up of women.

National standards, guidelines, and regulations need to be reviewed and reformulated so that they support women's ability to exercise their reproductive and other human rights and fundamental freedoms, pursuant to international human rights norms and standards set forth in the treaties that have been ratified by the PAHO Member States, including: the International Covenant on Civil and Political Rights;⁷ the International Covenant on Economic, Social, and Cultural Rights;⁸ the Convention on the Elimination of All Forms of Discrimination against Women;⁹ the Convention on the Rights of the Child;¹⁰ the American Convention on Human Rights;¹¹ and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (Protocol of San Salvador).¹² A legislative review process of this kind is critical if the Region is to meet the targets that have been set for Millennium Development Goals 4 and 5.

It is important to develop medical protocols and national standards on sexual and reproductive health, especially in the context of family planning and the prevention of unsafe abortions. Such protocols and standards are also key to forestalling negative consequences for teenage and adult women in their exercise of certain basic human rights and fundamental freedoms—consequences that can affect their maternal health status and add to morbidity and mortality.

In short, actions should focus not only on improving health services but on mobilizing a joint effort that brings together societies, women, families, communities, civil society, and governments in building a protective environment that will contribute to healthy motherhood.

OVERALL AIM OF THE INITIATIVE

The purpose of the initiative is to contribute to the well-being of the women and children of the Region and to meeting the pertinent Millennium Development Goals—namely: Goal 3, to promote gender equality; Goal 4, to reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate; Goal 5, to reduce by

⁶ World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems* (OMS), Geneva: WHO, 2003, p. 68. Available at: <http://whqlibdoc.who.int/publications/2003/9241590343.pdf>.

⁷ AG/RES. 2200, 21 ONU GAOR Suppl. (No.16) 52, ONU Doc. A/6316 (1966); entry into force: 23 March 1976.

⁸ AG/RES. 2200A (XXI), 21 ONU GAOR Suppl. (No. 16) 49, ONU Doc. A/6316 (1966); entry into force: 3 January 1976.

⁹ AG/RES. 34/180, 34 U.N. GAOR Suppl. (No. 46) 193, ONU Doc. A/34/46(1979); entry into force: 3 September 1981.

¹⁰ AG/RES. 44/25, Annex, 44 U.N. GAOR Suppl. (No. 49) p. 167, ONU Doc. A/44/49 (1989); entry into force: 2 September 1990.

¹¹ OEA, Off. Rec., OEA/Ser.L./V.II.23 doc. 21 rev. 6 (1979); entry into force: 18 July 1978.

¹²OAS, Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc. 6 rev. 1, no. 69 (1988), signed 17 November 1988; entry into force: 16 November 1999.

three-quarters, between 1990 and 2015, the maternal mortality ratio and Goal 6, to have halted by 2015 and begun to reverse the spread of HIV/AIDS—through advocacy, strategic partnerships, and the generation of knowledge.

OBJECTIVE

To promote and protect the right of women, mothers, and newborns to enjoy the highest attainable standard of health.

SPECIFIC GOALS

1. Develop a movement consisting of advocacy, social mobilization, and the exchange of information and knowledge with a view to putting maternal and neonatal health on the political and public agenda of the countries of the Region, using art and health as a bridge
2. Document and disseminate reports on best practices that contribute to the reduction of maternal mortality in the Americas
3. Hold technical symposia on attaining Millennium Goals 4 and 5, lessons learned, and supporting scientific evidence

ACTIVITIES AT THE REGIONAL AND COUNTRY LEVEL

- Launch of the Initiative at the meeting of the PAHO Directing Council: 27 September 2010
- Exhibit of photographs in Washington, D.C., organized by “la Caixa” Foundation.
- Regional and national contest calling for reports on best practices for reducing maternal mortality
- Regional and national contest calling for photographs with the theme of “Safe Motherhood”
- Regional and national symposia on maternal and neonatal health
- Development of a community of practice to share knowledge and disseminate information about joint activities:
<https://sites.paho.org/hlcp/ims/SitePages/Home.aspx>
- Publication and dissemination of photographs, reports of best practices, and journalism projects in the countries through preparation of a book
- Presentation of reports on best practices and lessons learned at the PAHO Directing Council in September 2011
- Social mobilization campaign at the regional and national levels
- Development and maintenance of the Safe Motherhood Initiative website:
<http://www.new.paho.org/smi>

SCHEDULE

- 27 September
 - Launch of the Initiative at the meeting of the PAHO Directing Council

- Inauguration of the “la Caixa” Foundation photograph exhibit, *Motherhood*, at the Organization of American States (OAS) headquarters
- September 2010–September 2011
 - Regional contest calling for reports on best practices for reducing maternal mortality
 - Regional contest calling for photographs with the theme of “Safe Motherhood”
- October 2010–February 2011
 - Traveling “la Caixa” Foundation photograph exhibit, *Motherhood*, with visits to selected countries
- November/December 2011
 - Launch of book containing photographs and reports on best practices at the Iberia-American Summit
- December 2010–December 2012
 - Implementation of activities
- September 2010–September 2011
 - Regional and national symposia

PARTICIPATING INSTITUTIONS

- Regional Working Group for the Reduction of Maternal Mortality (GTR)
- Inter-American Commission of Women (CIM) of the Organization of American States
- “la Caixa” Foundation

For further information, please visit the SMI website:

<http://new.paho.org/smi>