

Plan of Action to Accelerate the Reduction  
of Maternal Mortality and Severe Maternal Morbidity

MONITORING AND  
EVALUATION STRATEGY



CENTRO LATINOAMERICANO DE PERINATOLOGIA  
SALUD DE LA MUJER Y REPRODUCTIVA  
CLAP/SMR



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# Glosary

## Acronyms

CLAP/WR	Latin American Center for Perinatology/ Women and Reproductive Health
DC	Directing Council
EmOC	Emergency Obstetric Care
ICU	Intensive Care Unit
LAC	Latin American and the Caribbean
LB	Live Birth
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
PAHO	Pan American Health Organization
SRH	Sexual and Reproductive Health
UA	Universal Access
WHO	World Health Organization

## Terms and definitions

**Qualified Personnel:** According to WHO, qualified personnel means any accredited health professional - such as nurses, midwives or doctors, who have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Traditional birth attendants (TBA), trained or not, are excluded from the category of skilled attendant at delivery.

**Basic EmOC:** Essential obstetric care includes initial medical treatment of obstetric and neonatal complications (anticonvulsants, oxytocics and antibiotics, neonatal resuscitation immediate reference), manual procedures (removal of placenta, repair of tears), assisted vaginal delivery, postpartum and post-abortion care.

**Comprehensive EmOC** includes basic care plus the possibility to perform cesarean sections, anesthesia, administration of blood and/or blood products, and management of obstetric complications.

**Severe maternal morbidity** presents when a woman barely survives a life-threatening complication that occurs during pregnancy, childbirth or within 42 days of termination of pregnancy. Another term used in this guide as a synonym is Near Miss.

## Near Miss Criteria

Affected system	Clinical	Laboratory	Interventions
Cardiovascular	Shock Cardiac arrest	Severe hypoperfusion (lactate > 5 mmol/l or > 45 mg/dl) Severe acidosis (pH < 7.1)	Use of continuous vasoactive drugs Cardiopulmonary resuscitation
Respiratory	Acute cyanosis Gasping Severe tachypnea (respiratory rate > 40 bpm) Severe bradypnea (respiratory rate < 6 bpm)	Severe hypoxemia (O2 saturation < 90% for ≥ 60 minutes or PaO2/FiO2 < 200)	Intubation and ventilation not related to anesthesia
Renal	Oliguria non responsive to fluids or diuretics	Severe acute azotemia (creatinine ≥ 300 μmol/l or ≥ 3.5 mg/dl)	Dialysis for acute renal failure
Hematological / Coagulation	Failure to form clots	Severe acute thrombocytopenia (< 50.000 platelets/ml)	Massive transfusion of blood or red cells (≥ 3 units)
Hepatic	Jaundice in the presence of pre-eclampsia	Severe acute hyperbilirubinaemia (bilirubin > 100 μmol/l ó > 6.0 mg/dl)	
Neurological	Prolonged unconsciousness (lasting > 12 hours)/Coma Stroke Uncontrollable fits/status epileptics, total paralysis		
Uterine			Uterine hemorrhage or infection leading to hysterectomy

**Safe Blood:** Packed red cells and blood products from persons with no known risks for exposure to transfusion-transmissible microorganisms (TTM; e.g., malaria, HIV), which have shown to be negative for TTMs after comprehensive testing with a direct assay of viral products (e.g., HBV surface antigen), an indirect assay of viral exposure (e.g., HCV and HIV-1 antibodies) and 'surrogate' assays (e.g., measurement of transaminases, which are non-specific indicators of liver inflammation)

Plan of action to accelerate the reduction  
of maternal mortality and severe maternal morbidity

## MONITORING & EVALUATION STRATEGY

# Plan of action to accelerate the reduction of maternal mortality and severe maternal morbidity

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## Executive Summary

Even when the issue of reducing maternal morbidity and mortality has been addressed in the Region, the results are still insufficient. Although there is knowledge available about cost-effective interventions that could prevent over 90% of the maternal deaths and severe obstetric complications, women and children still face financial, geographic, social, legal and attitudinal barriers which prevent them from accessing quality services.

Many things still need to be done within health services to address gaps related to coverage, quality, and continuity of care, to ensure the availability of supplies and an equitable access to culturally sensitive health services regardless of where a woman lives or of her socioeconomic status.

PAHO is confident that the approval and implementation of the Plan of Action to Ac-

celerate the Reduction of Maternal Mortality and Severe Maternal Morbidity, with the broad commitment of the countries of the Americas, will enable women and children to exercise their core rights, thus fostering social justice.

This document presents a set of indicators to measure progress and to assess the impact of the implementation of the Regional Plan, as well as to allow for comparability of information across local adaptations.

PAHO will give technical support to countries in their monitoring efforts, and will submit biennial regional reports to the Governing Bodies, to provide an analysis of the situation, identify gaps for improvement, and make the changes required to comply with the Plan's goals.

## 1. Introduction

The Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity is a further step towards improving women's health; it indirectly contributes to the countries' efforts to achieve the fifth Millennium Development Goal (MDG 5).

Based on the official data provided by the Member States and published by PAHO in the Basic Health Indicators, the region's maternal mortality rates decreased in the 1990–2010 period; that decline reached 35% in the late 2010. But the estimated decline is still not enough if the Region of the Americas intends to reach MDG 5 by 2015. Approximately 90% of the maternal mortality in LAC could be prevented using knowledge already available in the countries.

Severe maternal morbidity has received less attention in LAC 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 subsequently suffer severe and life-long sequelae.

Often, the antenatal and childbirth care within reach of women fails to meet internationally recommended standards. Preconception monitoring is practically non-existent in the Region. Furthermore, essential obstetric services are unevenly distributed; they are often

of poor quality, due to a lack of personnel trained in the required skills. Moreover, not all institutions are in a position to fulfill all the basic requirements, or to provide all the necessary medicines and supplies, such as laboratory reagents and safe blood.

This Plan of Action proposes that key interventions proven effective in reducing maternal morbidity and mortality in four strategic areas be intensified in 2012–2017, in order to promote unrestricted access to high-quality preconception care (including family planning), as well as to antenatal, childbirth and postpartum care provided by skilled personnel, who pursue an intercultural approach and who respect human and reproductive rights in their work.

The United Nations Secretary General called for the implementation of a plan to promote a reduction in maternal mortality, and established the Commission on Information and Accountability for Women's and Children's Health 2011, in charge of issuing appropriate recommendations. PAHO joined this effort at its 50<sup>th</sup> Directing Council in 2010, giving new impetus to the Safe Motherhood Initiative. Moreover, at its 51<sup>st</sup> Directing Council in September 2011, PAHO unanimously approved the Plan and the relevant resolution to accelerate the reduction of mortality and severe maternal morbidity.

## 2. Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity

Current preventable maternal mortality and morbidity rates reflect the countries' prevailing inequities, inequalities, and lack of empowerment of women. Although there are general socioeconomic, cultural, and environmental determinants factors that may be considered key drivers in the reduction of maternal mortality and morbidity, there are also specific potential measures directly aimed at reducing maternal mortality and morbidity that can be adopted in the health sector. These include structuring health services to provide better care for women in the area of family planning and in preconception, antenatal, childbirth, and postpartum care.

The Plan of Action directly addresses critical elements that can help prevent maternal deaths and severe morbidity, in line with the general objectives below.

- (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.

Four strategic areas and nine interventions with their respective indicators have been identified and prioritized:

**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.

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

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

**Strategic area 3: Skilled human resources**

**Objective 3:** Increase the number of skilled personnel in health facilities with specific expertise in preconception, antenatal, childbirth, and postpartum care.

**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.

The approved resolution asks for progress reports to be prepared every two years based on the information available. Data will be verified using sources such as vital statistics, national health surveys, and specific studies designed for this plan.

Strategic area	Effective interventions	Indicators
1. Prevention of unwanted pregnancies and resulting complications.	<ul style="list-style-type: none"> <li>• Increase contraceptive coverage (including use of emergency contraceptive methods) and the availability of family planning counseling prior to conception and after an obstetric event.</li> </ul>	<ul style="list-style-type: none"> <li>• 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%.)</li> <li>• 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%.)</li> <li>• Percentage of deaths in women due to abortion reduced by 50%. (Baseline: 13%. Target: 7%.)</li> </ul>
2. Universal access to affordable, high-quality maternity services within the coordinated health care system.	<ul style="list-style-type: none"> <li>• Access to affordable, high-quality preconception, antenatal, childbirth, and post-partum care, by level of maternal and perinatal care considering a regionalized approach within the framework of the regionalization of maternal and perinatal care.</li> <li>• Maternity waiting homes, as appropriate.</li> <li>• Use of evidence-based practices.</li> <li>• Timely referral and counter-referral.</li> <li>• Prevention and detection of intrafamily violence during pregnancy.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of countries with 70% coverage of four or more antenatal visits. (Baseline: 50%. Target: 90%.)</li> <li>• Institutional coverage of deliveries. (Baseline: 89.8%. Target: 93%.)</li> <li>• Number of countries that have at least 60% coverage for postpartum visit at seven days after delivery. (Baseline: to be determined. Target: 80%.)</li> <li>• 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%.)</li> <li>• 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%.)</li> <li>• Number of countries with safe blood available in 95% of the facilities that provide emergency childbirth care. (Baseline: to be determined. Target: 100%.)</li> <li>• Number of countries monitoring intrafamily violence during pregnancy in 95% of institutional births. (Baseline: to be determined. Target: 80%.)</li> <li>• 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%.)</li> <li>• Number of countries with maternal deaths due to obstructed labor (Baseline 15. Target: 0.)</li> </ul>
3. Skilled human resources.	<ul style="list-style-type: none"> <li>• Increase the availability of skilled health workers for preconception, antenatal, childbirth, and postpartum care in basic and emergency obstetric units.</li> <li>• Increase the 24-hour availability of staff to attend births and handle obstetric complications.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of countries that have 80% coverage of childbirth care provided by skilled personnel, as defined by WHO. (Baseline: 43. Target: 48.)</li> <li>• 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.)</li> <li>• 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%.)</li> <li>• 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%.)</li> </ul>
4. Strategic information for action and accountability	<ul style="list-style-type: none"> <li>• Institute and consolidate perinatal and maternal information and monitoring systems.</li> <li>• Establish committees with community participation to analyze maternal mortality and provide remedies, as appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of countries where the health system has a functioning perinatal information system. (Baseline: 16. Target: 29.)</li> <li>• Number of countries where the health system maintains a registry of severe maternal morbidity. (Baseline: to be determined. Target: 80%.)</li> <li>• Number of countries whose coverage of maternal deaths in vital record systems is 90% or more. (Baseline: to be determined. Target: 100%.)</li> </ul>

### 3. Monitoring and Evaluation Plan

Monitoring provides the information needed to evaluate the progress of health programs, and allows for the adoption of corrective measures during their implementation. Both monitoring and evaluation are essential management functions that help to strengthen the planning program and improve the effectiveness of actions and interventions aimed at reducing maternal mortality and morbidity.

The main objective is to assess the progress made in reducing maternal morbidity and mortality in Latin America and the Caribbean and to help to implement the corrective measures needed at different stages. This requires strengthening of the on-going monitoring systems. Multiple experiences in the Region have shown that strengthening these systems leads to better action information, while those countries that have chosen casual estimates or surveys have had poorer results.

PAHO will direct its efforts to monitor progress and promote the creation of a key information regional repository on maternal health in compliance with Resolution CD51.R12, as approved by the Member States under the 51<sup>st</sup> PAHO Directing Council. This is intended to provide a core set of comparable indicators to measure both the progress and the impact of the implementation of the regional plan, beyond local adaptations.

PAHO is to submit regional reports to the Governing Bodies biennially, to provide an analysis of the situation, to identify gaps for improvement and to make the amendments required to comply with the Plan goals.

### 4. Definition and description of indicators

The first five of the six tables below define the impact indicators (4.1) and strategic areas (4.2), while Table 6 (4.3) specifies the information that must be collected by the countries to develop the regional indicators.

## 4.1. Impact Indicators

INDICATOR	FORMULA	DEFINITION/OBSERVATIONS
4.1.1 Total maternal mortality ratio (MMR) by cause and age	$\frac{\text{No. of maternal deaths}}{\text{No. of live births}} \times 100,000$	Maternal mortality is any death that occurs during pregnancy, abortion, childbirth and/or the postpartum period, or within 42 days of termination of the obstetric event, irrespective of the duration and site of pregnancy, and resulting from any cause related to or aggravated by pregnancy or its management, but not deriving from accidental or incidental causes
4.1.2 Total severe maternal morbidity ratio by cause and age	$\frac{\text{No. of severe maternal morbidity cases due to pregnancy, childbirth, and puerperium until 42 days of termination of the obstetric event}}{\text{No. of live births}} \times 100,000$	Severe maternal morbidity in a woman who nearly died but survived a complication during pregnancy, childbirth or within 42 days of termination of pregnancy
4.1.3 Maternal mortality rate (maternal deaths per 100,000 women aged 15-44)	$\frac{\text{No. of maternal deaths due to pregnancy, abortion, childbirth, and puerperium until 42 days of termination of the obstetric event}}{\text{No. of women from 15 to 44 years}} \times 100,000$	Proxy that permits evaluation up the effect of contraception because it is based on women of reproductive age. It is not strictly a rate, because the denominator does not include the number of pregnant women
4.1.4 No. of countries with an MMR of less than 75 (per 100,000 live births) in 201. (Target: 100%)	$\frac{\text{No. of countries with MMRs less than 75 per 100,000}}{\text{Total No. of countries}} \times 100$	This indicator aims to assess the maternal mortality gap between countries
4.1.5 No. of countries with MMR greater than 125 (per 100,000 live births) among geographic and ethnic sub-populations of women (i.e., indigenous / non indigenous, rural /urban) and by sub-national level (i.e., department, province, state)	No. of countries with subpopulations with MMRs greater than 125 per 100,000 LBs	This indicator aims to assess the maternal mortality gap within countries

## 4.2. Strategic areas indicators

### 4.2.1 Strategic Area 1: Prevention of unwanted pregnancies and resulting complications

INDICATOR	DEFINITION	OBSERVATIONS
4.2.1.1 a) Rate of use of modern contraceptive methods by women of reproductive age, with a breakdown by age group and urban residence	Number of women aged 15 to 44 years who report using a contraceptive method themselves (or their partners) / Total women aged 15 to 44 years) x 100 (by urban residence)	Breakdown according to age groups 15 to 19, 20 to 24, 25 to 44, and urban areas
4.2.1.1 b) Rate of use of modern contraceptive methods by women of reproductive age, with a breakdown by age group and rural residence	Number of women aged 15 to 44 years who report using a contraceptive method themselves (or their partners) / Total women aged 15 to 44 years) x 100 (by rural residence)	Breakdown according to age groups 15 to 19, 20 to 24, 25 to 44, and rural areas
4.2.1.2 a) Number of countries that have national data on postpartum and/or post-abortion contraceptive counseling by their health services	Number of countries with data regarding postpartum and / or post-abortion contraceptive counseling	The indicator should be separate for post-abortion counseling and postpartum counseling
4.2.1.2 b) Number of countries that have national data on postpartum and/or post-abortion contraceptive provision by their health services	Number of countries with data regarding postpartum and / or post-abortion contraceptive delivery	The indicator should be separate for post-abortion counseling and postpartum counseling
4.2.1.3 Percentage of deaths in women due to abortion	Number of maternal deaths due to abortion / Total number of maternal deaths x 100	

## 4.2.2 Strategic area 2: Universal access to affordable, high-quality maternity services within a coordinated health care system

INDICATOR	DEFINITION	OBSERVATIONS
4.2.2.1 Number of countries with 70% coverage of four or more antenatal visits	Number of countries with 70% coverage of four or more antenatal visits. Total of countries	Number of women who have used antenatal care services at least four times during pregnancy / Total N°. of estimated births
4.2.2.2 Institutional coverage of childbirth	Number of births (vaginal deliveries and cesarean sections) registered in health services / Number of total estimated births X 100	
4.2.2.3 Number of countries that have at least 60% coverage for postpartum care at 7 days after delivery	Number of countries that have at least 60 % coverage (or more) of postpartum care during the 7 <sup>th</sup> day	Number of women with puerperal control between discharge and 7 <sup>th</sup> day postpartum (vaginal deliveries or caesarean) / Total estimated births X 100
4.2.2.4 Number of countries that use oxytocics in 75% of their institutional births during the third-stage of labor, once the umbilical cord has ceased to pulsate	Number of countries that use oxytocics in 75% or more births to prevent postpartum hemorrhage / Total number of countries x 100)	Number of institutional births (including cesarean section) with use of oxytocic (oxytocin, methyletergonovine, misoprostol, etc.) to prevent postpartum haemorrhage / Total number of institutional births (including cesarean section) X 100
4.2.2.5 Number of countries that use magnesium sulfate in 95% of their cases of severe preeclampsia/ eclampsia in institutional births	Number of countries that use magnesium sulfate in 95% of the pregnant women with severe preeclampsia/ eclampsia in health services / Total countries x 100	Number of pregnant women with severe preeclampsia/ eclampsia that receive magnesium sulfate in health services / Total of pregnant women with severe preeclampsia / eclampsia cases x 100
4.2.2.6 Number of countries with safe blood available in 95% of the facilities that provide comprehensive emergency childbirth care	Number of countries where 95% or more of the services that provide EmOC have safe blood available / Total number of countries x 100	Number of countries institutions that provide EmOC and have safe blood available / Total countries institutions that provide EmOC x 100
4.2.2.7 Number of countries monitoring intrafamily violence during pregnancy in 95% of institutional births	Number of countries monitoring intrafamily violence during pregnancy in 95% or more of institutional births / Total countries x 100	Number of institutional births (including cesarean section) in which intrafamily violence is monitored/Total of institutional births (including cesarean section) X 100
4.2.2.8 Number of countries with C-section rate above 20% that reduce the C-section rate by at least 20% by 2017	Number of countries that in 2012 had a C-section national rate above 20% and reduce it by at least 20% by 2017	
4.2.2.9 Number of countries with maternal deaths due to obstructed labor	Number of countries with maternal deaths due to obstructed labor	

### 4.2.3 Strategic area 3:

#### Skilled human resources

INDICATOR	DEFINITION	OBSERVATIONS
4.2.3.1 Number of countries that have 80% coverage of childbirth care provided by skilled personnel, as defined by WHO	Number of countries that have 80% or more coverage of childbirth care provided by skilled personnel, as defined by WHO	
4.2.3.2 Number of countries that have 80% or higher coverage of postnatal care provided by skilled personnel as defined by WHO	Number of countries that have 80% or higher coverage of postpartum care provided by skilled personnel, as defined by WHO	
4.2.3.3 Percentage of emergency obstetric care (EmOC) health facilities (basic and comprehensive) that perform an audit of all maternal deaths	Number of institutions that attend births and perform an audit of maternal deaths / Total number of institutions attending births x 100	
4.2.3.4. Number of countries that annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR	Number of countries that annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR / Total countries of the Region x 100	

### 4.2.4 Strategic area 4: Strategic information for action and accountability

INDICATOR	DEFINITION	OBSERVATIONS
4.2.4.1 Number of countries where the health system has a functioning perinatal information system	Countries using a perinatal information system at a national level	
4.2.4.2 Number of countries where the health system maintains a registry of severe maternal morbidity	Countries that maintain a systematic registry of severe maternal morbidity	
4.2.4.3 Number of countries whose coverage of maternal deaths in vital record systems is 90% or more	Percentage of reported maternal deaths in national health systems	

### 4.3 Information to be completed by the countries for the construction of indicators

Indicators marked in gray will be calculated by PAHO at a regional level in addition to data supplied by countries (other lines).

Country offices are to fill two types of cells:

- a) Cells where the answer is Yes or No, in which case the option that applies to the country should be circled.
- b) Open cells to be answered with a figure, either an absolute number, percentage, ratio or rate, as appropriate.

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
4.1.1 Maternal mortality ratio (MMR)							
4.1.1 a) Total number of maternal deaths							
4.1.1 b) Total number of live births							
Source/year							
4.1.1 c) Number of maternal deaths due to:							
Hypertensive disorders (Total)							
• Pre-eclampsia							
• Eclampsia							
• Chronic hypertension							
Hemorrhage (Total)							
• Hemorrhage second half							
• Hemorrhage postpartum							
Sepsis							
Abortion							
Obstructed labor							
Other (Direct)							
Indirect							
Poorly defined							
Suicide /other violent deaths. Note: these deaths are not currently included in the MMR							
Source/year							
4.1.1 d) Number of maternal deaths by age (Total)							
10-14							
15-19							
20-24							
25-39							
40-44							
45-49							
50 or more years							

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
Source/year							
4.1.2 Total severe maternal morbidity ratio by cause							
4.1.2 a) Total number of severe maternal morbidity cases							
4.1.2 b) N°. of severe maternal morbidity cases							
Severe pre-eclampsia							
Eclampsia							
Hemorrhage requiring hysterectomy and / or 3 or more units of blood and / or stay in the ICU							
Hemorrhage after 20 weeks of gestational age that requiring hysterectomy and / or 3 or more units of blood and / or stay in the ICU							
Postpartum hemorrhage requiring hysterectomy and / or 3 or more units of blood and / or stay in the ICU							
Abortion requiring hysterectomy and / or 3 or more units of blood and / or stay in the ICU							
Sepsis							
Other reasons							
Source/year							
4.1.2 c) Number of maternal morbidity by age (Total)							
10-14							
15-19							
20-24							
25-39							
40-44							
45-49							
50 or more years							
Source/year							

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
4.1.5 Number of countries with MMR greater than 125 (per 100,000 live births) among geographic and ethnic sub-populations of women (i.e. indigenous / non indigenous, rural /urban) and by sub-national level (i.e., department, province, state)							
4.1.5 a) Departments, provinces or states with MMRs greater than 125 per 100,000	Yes No						
4.1.5 b) Rural areas with MMRs greater than 125 per 100,000	Yes No						
4.1.5 c) Urban areas with MMRs greater than 125 per 100,000	Yes No						
4.1.5 d) Indigenous population with MMRs greater than 125 per 100,000	Yes No						
4.1.5 e) Mixed race population with MMRs greater than 125 per 100,000	Yes No						
4.1.5 f) African descent population with MMRs greater than 125 per 100,000	Yes No						
4.1.5 g) Caucasian population with MMRs greater than 125 per 100,000	Yes No						
4.2.1.1 Rate of use of modern contraceptive methods by women of reproductive age (Total)							
4.2.1.1 a) Rate of use of modern contraceptive methods by age							
10 -14							
15 -19							
20 -24							
25 -39							
40 - 44							
45 - 49							
50 years or more							
Source/year							
4.2.1.1 b) Rate of use of modern contraceptive methods by residence							
Urban							
Rural							
Source/year							

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
4.2.1.2 Number of countries that have national data on postpartum and/or post-abortion contraceptive counseling and provision of contraceptives by the health services							
4.2.1.2 a) Does your country have national data regarding postpartum contraceptive counseling?	Yes No						
4.2.1.2 b) Does your country have national data regarding post-abortion contraceptive counseling?	Yes No						
4.2.1.2 c) Does your country have national data regarding the provision of postpartum contraceptives?	Yes No						
4.2.1.2 d) Does your country have national data regarding the provision of post-abortion contraceptives?	Yes No						
Source/year							
4.2.1.3 Percentage of maternal deaths due to abortion reduced by 50%							
4.2.1.3 a) Percentage of maternal deaths due to abortion							
Source/year							
4.2.2.1 Number of countries with 70% coverage of four or more antenatal visits							
4.2.2.1 a) Number of women who have used antenatal care services at least four times during pregnancy							
Source/year							
4.2.2.2 Institutional coverage of births							
4.2.2.2 a) Number of births (vaginal and cesarean section) registered in health services							
Source/year							
4.2.2.3 Number of countries that have at least 60% coverage for postpartum visits at 7 days after birth							
4.2.2.3 a) Number of women with puerperal visit between discharge and 7 <sup>th</sup> postpartum day (vaginal or cesarean section)							

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
Source/year							
4.2.2.4 Number of countries that use oxytocics in 75% of institutional births during the third stage of labor, once the umbilical cord has ceased to pulsate							
4.2.2.4 a) Number of institutional births (including cesarean sections) with use of oxytocic (oxytocin, methylergonovine, misoprostol, etc.) to prevent postpartum hemorrhage							
4.2.2.4 b) Total number of institutional births (including cesarean section)							
Source/year							
4.2.2.5 Number of countries that use magnesium sulfate, in addition to interrupting pregnancy, in 95% of cases of severe preeclampsia/eclampsia in health services							
4.2.2.5 a) Number of pregnant women with severe preeclampsia/eclampsia that receive magnesium sulfate in health services							
4.2.2.5 b) Total number of pregnant women with severe cases of preeclampsia/eclampsia							
Source/year							
4.2.2.6 Number of countries with safe blood available in 95% of the facilities that provide emergency childbirth care							
4.2.2.6 a) Number of institutions that provide CEmOC and have safe blood available							
4.2.2.6 b) Total number of institutions that provide CEmOC							
Source/year							
4.2.2.7 Number of countries monitoring intrafamily violence during pregnancy in 95% of institutional births							
4.2.2.7 a) Number of institutional births (including cesarean section) monitoring intrafamily violence							

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
Source/year							
4.2.2.8 Number of countries with C-section rate above 20% that reduce the rate by at least 20% by 2017							
4.2.2.8 a) C-section rate							
Source/year							
4.2.2.9 Number of countries with maternal deaths due to obstructed labor							
4.2.2.9 a) Number of maternal deaths due to obstructed labor							
Source/year							
4.2.3.1 Number of countries that have 80% coverage of childbirth care provided by skilled personnel, as defined by WHO							
4.2.3.1 a) Percentage coverage of childbirth care provided by skilled personnel, as defined by WHO							
Source/year							
4.2.3.2 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							
4.2.3.2 a) Percentage coverage of postnatal care provided by skilled personnel capable of caring for both mother and newborn, as defined by WHO							
Source/year							
4.2.3.3 Percentage of emergency obstetric care (basic and comprehensive) institutions that perform an audit of all maternal deaths							
4.2.3.3 a) Number of institutions of emergency obstetric care (basic and comprehensive) that perform an audit of all maternal deaths							
4.2.3.3 b) Total number of institutions of emergency obstetric care (basic and comprehensive)							
Source/year							

INDICATOR	COUNTRY						
	YEAR						
	2011	2012	2013	2014	2015	2016	2017
4.2.3.4 Number of countries that annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR							
4.2.3.4 a) Does your country annually present a maternal health report to the public that includes maternal mortality statistics, including the national MMR?	Yes No						
Source/year							
4.2.4.1 Number of countries where the health system has a functioning perinatal information system							
4.2.4.1 a) Does your country have a functioning perinatal information system?	Yes No						
Source/year							
4.2.4.2 Number of countries where the health system maintains a registry of severe maternal morbidity							
4.2.4.2 a) Does your country health system maintain a registry of severe maternal morbidity?	Yes No						
Source/year							
4.2.4.3 Number of countries whose coverage of maternal deaths in vital record systems is 90% or more							
4.2.4.3 a) Number of maternal deaths reported in vital record systems							
4.2.4.3 b) Total number of maternal deaths identified by active case-finding							
Source/year							

