Forum: World Health Organisation

Issue: Combating maternal mortality and inadequate prenatal care in Sub-Saharan Africa

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TOPIC INTRODUCTION

In 2023, a maternal death was something that occurred every two minutes. Each day, 700 women lost their lives to preventable causes related to pregnancy and childbirth. This shows that in many countries, health systems and political commitment are not enough to prevent this type of mortality. In no region of the world is this more evident than in Sub-Saharan Africa. In 2023 alone, the region recorded around 442 maternal deaths per 100,000 live births and accounted for 70% of all maternal deaths globally, with a concerningly high Maternal Mortality Ratio (MMR). As defined by the World Health Organization, the MMR is the number of maternal deaths during a given time period per 100 000 live births during the same time period.[1]

In Sub-Saharan Africa, a woman faces a risk of maternal death of 1 in 55. This is approximately 250 times higher than a woman in Western Europe, where the figure stands at 1 in 14,000[2]. These statistics describe the failure of the international community to extend what has been achieved for many women in the world to those in Less Economically Developed Countries (LEDCs) in Sub-Saharan Africa.

Many of these deaths have been recognized as preventable through timely access to quality prenatal care, skilled healthcare providers, and emergency obstetric services, making this topic increasingly relevant. However, barriers such as poverty, limited healthcare infrastructure, long distances to health facilities, and others often prevent women from receiving the care they require. Strengthening prenatal care services is essential for identifying and managing pregnancy-related complications early, improving maternal and newborn health outcomes, and reducing preventable maternal mortality. Therefore, this highlights the urgent need for action by international actors such as the World Health Organization (WHO).

[1] World Health Organization. “Maternal Mortality.” *World Health Organization*, 2025, https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

[2] UNICEF. “Maternal Mortality.” *UNICEF Data*, UNICEF, Apr. 2025, https://data.unicef.org/topic/maternal-health/maternal-mortality

DEFINITION OF KEY TERMS

Antenatal Care

"Antenatal care is the care provided by skilled health professionals to pregnant women to ensure the health of mother and child during pregnancy and childbirth"[3] Regular antenatal care helps detect pregnancy complications early and is essential for reducing maternal mortality.

Maternal mortality

"The death of a woman while pregnant or within 42 days of termination of pregnancy, excluding those from accidental or incidental cause" [4]

Maternal Mortality Ratio (MMR)

"The maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100 000 live births during the same time period. It depicts the risk of maternal death relative to the number of live births and essentially captures the risk of death from a maternal cause in a single pregnancy (proxied by a single live birth)."[5] The MMR is the standard indicator used to measure maternal mortality and monitor progress towards SDG 3.1.

Perinatal Mortality

"Perinatal mortality is defined as a fetal demise after 20 weeks' gestational age through the first 7 days of neonatal life."[6] Perinatal mortality is closely linked to maternal health, as improved prenatal and delivery care benefits both mothers and newborns.

"Three Delays" model

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[3] World Health Organization. *Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey 2018–2019: Report. Part 3.* World Health Organization, 2021, https://platform.who.int/docs/default-source/mca-documents/policy-documents/policy-survey-reports/srmncah-policysurvey2018-fullreport-pt-3.pdf

[4] National Center for Health Statistics. "NVSS - Maternal Mortality - Evaluation of Changes." *Www.Cdc.Gov*, 30 Jan. 2020, https://www.cdc.gov/nchs/maternal-mortality/evaluation.htm

[5] World Health Organization. "Maternal Mortality Ratio (Per 100 000 Live Births)." *Www.Who.Int*, 2023, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26

[6] "Perinatal Mortality - an Overview | ScienceDirect Topics." *Www.Sciencedirect.Com*, https://www.sciencedirect.com/topics/medicine-and-dentistry/perinatal-mortality

The “Three Delays” Model is a framework used to explain why maternal deaths occur by identifying three critical barriers to timely care: the delay in deciding to seek medical care, delay in reaching a healthcare facility, and the delay in receiving adequate treatment after arriving at the facility. It helps identify where interventions are needed to improve maternal health outcomes.[7] The model basically helps identify where barriers to maternal healthcare exist and where interventions should be focused.

BACKGROUND INFORMATION

Historical Context

Situation Before European Colonisation

Before colonial rule, pregnancy and childbirth in many Sub-Saharan African societies were primarily managed by experienced traditional birth attendants and women who possessed knowledge acquired through apprenticeship and community practice. Rather than relying on centralized medical institutions, communities entrusted maternal care to respected local caregivers.

However, while these community-based systems were well adapted to local customs and available resources, healthcare remained constrained by the medical knowledge and technologies available at the time. While traditional birth attendants were often skilled in managing routine pregnancies and deliveries, they had limited means of treating severe obstetric complications. Conditions such as obstructed labour, postpartum haemorrhage, eclampsia, or severe infections frequently required interventions that were unavailable in pre-colonial settings, including Caesarean sections, blood transfusions, antibiotics, and advanced surgical care.

Consequently, when life-threatening complications arose, both maternal and neonatal mortality remained relatively high. Outcomes also varied considerably between communities, depending on local knowledge, access to medicinal resources, the experience of individual birth attendants, and other conditions.

The Colonial period

During the colonial period, European administrations reorganized healthcare systems to support colonial economic and political objectives rather than the health needs of the broader population. For example, in British Colonial Sub-Saharan Africa, medical facilities, hospitals, and trained healthcare personnel were concentrated in urban centres, administrative capitals, mining

[7] Maternity Worldwide. “The Three Delays Model and Our Integrated Approach.” *Maternity Worldwide*, 2023, https://www.maternityworldwide.org/what-we-do/three-delays-model/

regions, and areas with significant settler populations, where they protected the colonial workforce and reduced the spread of infectious diseases that threatened economic productivity. In contrast, rural communities, where the majority of Africans resided, received limited investment in healthcare infrastructure and often remained dependent on traditional birth attendants due to the absence of hospitals or trained medical professionals.

As a result, many pregnant women, particularly those living in rural areas, had limited or no access to prenatal healthcare, skilled birth attendants, or emergency maternal health services. Routine antenatal care, which is essential for monitoring pregnancies, identifying potential risks, and ensuring safe deliveries, was often unavailable outside urban centres. Consequently, many pregnancy and childbirth complications could not be detected or treated in time, significantly increasing the risk of maternal and neonatal mortality. Furthermore, the unequal distribution of healthcare infrastructure and trained medical personnel established regional disparities in maternal healthcare that endured to modern times.

In comparison, unlike the pre-colonial period, when maternal care was informal and largely provided within local communities, the colonial period introduced a formal healthcare system that was concentrated in urban centres and largely inaccessible to rural populations.

After their independence, many Sub-Saharan African states inherited really underdeveloped rural health systems, leaving millions of women without adequate prenatal care or timely access to essential maternal health services. These inequalities continue to contribute to the disproportionately high maternal mortality rates observed across the region today.

State of healthcare after independence

Following independence, many Sub-Saharan African governments prioritized expanding national healthcare systems to address the inequalities inherited from the colonial period, creating various setbacks from the rapid decolonization. Investments were made in constructing hospitals and health clinics, training doctors, nurses, and midwives, and extending healthcare services to previously underserved rural communities. Maternal and child health became an important component of national public health strategies, with efforts to increase access to prenatal care, skilled birth attendance, and essential maternal health services. These investments contributed to significant improvements over time, with a result of more than 60% of countries in the African region reporting that over 80% of births were attended by skilled health personnel by 2023[8].

Despite these efforts, rapid population growth placed considerable pressure on healthcare systems. As populations expanded, the demand for prenatal care, maternity services, and trained healthcare workers grew faster than many governments could increase healthcare capacity. This

[8] “African Region’s Maternal and Newborn Mortality Declining, but Progress Still Slow.” *WHO | Regional Office for Africa*, 2025, https://www.afro.who.int/news/african-regions-maternal-and-newborn-mortality-declining-progress-still-slow

often resulted in overcrowded facilities, shortages of healthcare personnel, and limited access to quality maternal care, particularly in rural areas where healthcare infrastructure remained underdeveloped, resulting in inaccessible healthcare, especially maternal.

Another factor would be economic challenges, which further hindered progress, with various newly independent states facing high levels of poverty, limited government revenues, and growing debt burdens, therefore restricting their ability to invest in healthcare. Consequently, funding for maternal health facilities, medical supplies, and healthcare personnel frequently fell short of demand.

Although maternal mortality in Sub-Saharan Africa has declined significantly in recent decades, with governmental efforts, progress is still slow. This demonstrates that many of the structural challenges that emerged during and after independence continue to hinder access to adequate prenatal care and safe motherhood across the region.

Structural Adjustment Programs (SAPs) in the 1980s and 1990s

During the 1980s and 1990s, many Sub-Saharan African countries implemented Structural Adjustment Programs (SAPs) as part of loan agreements with international financial institutions such as the International Monetary Fund (IMF) and the World Bank. These programmes sought to stabilize national economies by reducing government expenditure, privatizing state-owned enterprises, liberalizing trade, and encouraging fiscal discipline. One perspective holds that the resulting reductions in public healthcare spending and the introduction of user fees in some countries limited access to affordable healthcare, particularly for low-income and rural populations. According to this view, decreased investment in healthcare infrastructure, medical supplies, and personnel made it more difficult for pregnant women to access prenatal care, skilled birth attendance, and other essential maternal health services, contributing to poorer maternal health outcomes.

Another perspective argues that the primary objective of Structural Adjustment Programs was to restore economic stability and create the conditions for sustainable growth. It is also suggested that stronger public finances would ultimately allow governments to improve healthcare systems over the long term and that shortcomings in maternal healthcare were more closely linked to domestic governance, conflict, and limited administrative capacity than to the reforms themselves[9]. Consequently, the overall impact of Structural Adjustment Programs on maternal healthcare remains the subject of ongoing debate.

The 2000s onwards

[9] Oliver, Helen C. “In the Wake of Structural Adjustment Programs.” *Canadian Journal of Public Health*, vol. 97, no. 3, May 2006, pp. 217–21, https://doi.org/10.1007/bf03405589.

The Millennium Development Goals (2000–2015) made maternal health a global priority, with MDG 5 aimed at reducing maternal mortality and improving access to reproductive healthcare. During this period, maternal mortality rates fell significantly worldwide, including in many Sub-Saharan African countries. The truth is, though, that the target of reducing maternal deaths by 75% was not fully achieved. Since 1990, the maternal mortality ratio has been cut nearly in half. This is an impressive result, but it falls short of the two-thirds reduction that was aimed for[10]

The Sustainable Development Goals continued the efforts of the MDGs with SDG 3.1, aiming to reduce the global maternal mortality ratio (MMR) to fewer than 70 deaths per 100,000 live births[11]. Currently, most Sub-Saharan countries are off track to reach this target, showing the need for urgent action.

To achieve these targets, countries attempted expansion of antenatal care services, trained more midwives and skilled birth attendants, improved access to emergency obstetric care, and increased immunisation and maternal health outreach programmes. International initiatives such as Every Woman Every Child also mobilised funding, technical assistance, and national commitments to strengthen maternal healthcare systems. Despite these efforts, progress has been uneven as mentioned previously, with many countries failing to strengthen their healthcare systems enough to meet the maternal mortality targets set under the MDGs and SDGs.

It would be inaccurate, however, to characterise the situation as stagnant. Although maternal mortality remains a major challenge in the region, there has been a 40% reduction in it since 2000[12], showing the sustained efforts of the international community, although not completely adequate. This means that ensuring resilient mechanisms, such as reliable supplies including the continuous, uninterrupted availability of quality-assured medicines among other things, trained staff, and referral systems, to consistently deliver a full range of prenatal healthcare products and services is central to continuing to turn these numbers around.

The current state of maternal and prenatal healthcare in Sub-Saharan Africa

The state of maternal and prenatal healthcare varies considerably across Sub-Saharan Africa. While countries such as Rwanda have made significant progress by expanding access to prenatal care, increasing the proportion of skilled birth attendance, and reducing maternal mortality, others continue to face serious challenges due to fragile healthcare systems, armed

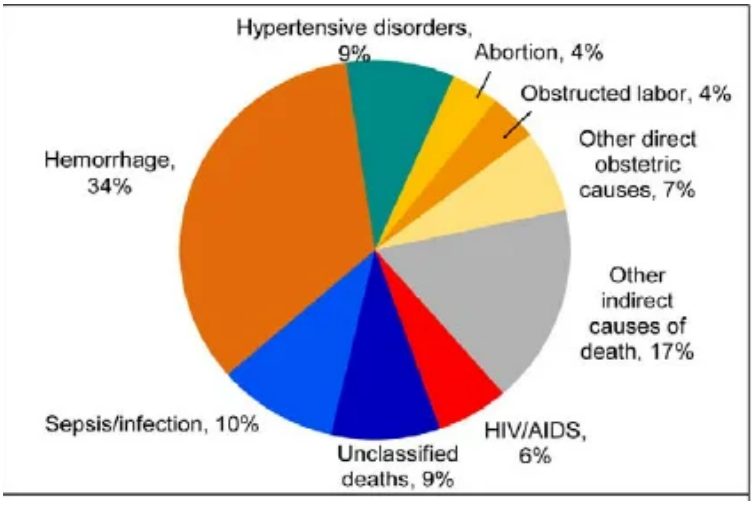
[10] World Vision. “Were the Millennium Development Goals a Success? Yes! Sort Of.” *World Vision International*, 14 Sept. 2015, https://www.wvi.org/united-nations-and-global-engagement/article/were-mdgs-success.
[11] WHO. “SDG Target 3.1: Reduce the Global Maternal Mortality Ratio to Less Than 70 Per 100,000 Live Births.” *Who.Int*, 2021, https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/sdgtarget3-1-reduce-maternal-mortality.
[12] UNICEF. “Maternal Mortality.” *UNICEF Data*, UNICEF, Apr. 2025, https://data.unicef.org/topic/maternal-health/maternal-mortality/.

conflict, and chronic underfunding. Countries affected by prolonged conflict, such as South Sudan and the Democratic Republic of the Congo, continue to experience some of the highest maternal mortality rates in the region, as insecurity frequently disrupts healthcare delivery and limits access to essential maternal services.

Although access to healthcare facilities has improved in many areas, the quality and availability of maternal healthcare remain inconsistent. Many women can reach a clinic or health centre, yet these facilities often lack trained healthcare workers, essential medicines, medical equipment, or emergency obstetric services such as Caesarean sections and blood transfusions. Persistent shortages of skilled healthcare professionals, including midwives, nurses, and doctors, further limit the availability of prenatal care, skilled birth attendance, and postnatal services, particularly in rural and remote communities.

Direct Causes

As maternal deaths remain a crucial issue in the region, the leading direct causes of maternal death include severe postpartum haemorrhage, hypertensive disorders such as pre-eclampsia and eclampsia, sepsis, obstructed labour, and complications resulting from unsafe abortion, as shown in the following pie chart. Most of these conditions are preventable or treatable when women have timely access to quality prenatal care, skilled birth attendants, emergency obstetric services, and appropriate medical interventions. However, gaps in healthcare coverage and limited access to emergency treatment continue to result in preventable maternal deaths. Figure 1: Graph depicting the direct causes of maternal deaths, namely hemorrhage (34%),



sepsis/infection (10%), hypertensive disorders (9%) and other medical factors.[13]

[13] Kinney, Mary V., et al. "Sub-Saharan Africa's Mothers, Newborns, and Children: Where and Why Do They Die?" *PLoS Medicine*, vol. 7, no. 6, 2010, e1000294. Public Library of Science, https://doi.org/10.1371/journal.pmed.1000294

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Social factors

Beyond medical complications, though, maternal mortality is influenced by a range of social and structural factors. Weak healthcare systems, inadequate funding, shortages of trained healthcare professionals, and insufficient medical equipment continue to limit the quality of maternal care throughout the region. Poverty further restricts access to healthcare, as many women cannot afford transportation to health facilities or the user fees associated with seeking treatment. Gender inequality also remains a significant barrier, with women in some communities having limited decision-making power regarding their own bodies or facing restricted access to education and reproductive health information. In addition, HIV/AIDS continues to have a disproportionate impact by increasing the risk of pregnancy-related complications, since infected women are two to three times more likely to experience such complications [14].

High rates of adolescent pregnancy also continue to place additional strain on healthcare systems and increase maternal health risks. Mothers aged 10–19 are more likely to experience eclampsia, pregnancy-induced hypertension, systemic infections, anemia, and preterm delivery compared to women in their twenties. Babies born to teens also face greater risks of low birth weight and severe neonatal conditions [15]. At the same time, social factors such as poverty, limited educational opportunities, child marriage, and restricted access to reproductive healthcare frequently reduce their ability to obtain adequate prenatal care, contributing to poorer health outcomes for both mothers and newborns.

The challenges explained previously are commonly explained through the Three Delays Model, a framework used to understand the factors contributing to maternal deaths. The first delay occurs when women or their families postpone the decision to seek medical care due to financial constraints, limited awareness of pregnancy complications, or cultural and social barriers. The second delay arises when women are unable to reach an appropriate healthcare facility because of long travel distances, poor road infrastructure, or a lack of reliable transportation. The third delay occurs after arriving at a healthcare facility, where shortages of trained staff, essential medicines, blood supplies, medical equipment, or emergency obstetric services may prevent women from receiving timely and appropriate treatment. Addressing all three delays is widely recognized as essential for reducing maternal mortality and improving prenatal healthcare across Sub-Saharan Africa.

Consequences

[14] "HIV and Pregnancy | ViiV Healthcare." *Viivhealthcare.Com*, 2020, https://viivhealthcare.com/about-hiv/living-with-hiv/hiv-in-pregnancy/

[15] World Health Organization. "Adolescent Pregnancy." *World Health Organization*, 10 Apr. 2024, https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy.

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In addition to the tragic loss of lives, inadequate maternal and prenatal healthcare places significant social and economic burdens on families and communities. Maternal illness and death often reduce household income, increase medical expenses, and force family members to leave work or school to provide care or assume additional responsibilities. The consequences also extend to children, as newborns whose mothers die are significantly more likely to experience infant mortality, malnutrition, interrupted breastfeeding, and reduced access to education and healthcare later in life [16].

At the national level, high maternal mortality rates hinder sustainable development by worsening poverty, reducing economic productivity, and placing additional strain on healthcare systems. Poor maternal health also limits women's participation in the labour force and education, reducing the productive capacity of the working class and slowing long-term economic growth. As a result, persistently high maternal mortality rates continue to jeopardise progress toward the 2030 Agenda for Sustainable Development, particularly Sustainable Development Goal (SDG) 3.1, which seeks to ensure healthy lives and reduce the global maternal mortality ratio.

Challenges in resolving the issue

The vast majority of maternal deaths occur in low-resource settings, and most can be prevented. A significant portion is directly linked to the absence of adequate prenatal care, with 10% of women in the region receiving no antenatal care whatsoever, despite the global recommendations.

The World Health Organisation's new recommendation stands at a minimum of eight contacts per pregnancy, with only 7% of women in the Sub-Saharan region meeting the recommendation. Although about 90% of women in the region attend at least one visit, completing all eight is highly challenging due to various systemic and socioeconomic barriers. These include costs, distance for women in rural areas, lack of transport, and others [17].

Limited healthcare workforce capacity also remains a major obstacle to improving maternal health. Many countries continue to experience shortages of midwives, nurses, obstetricians, and other skilled healthcare professionals, particularly in rural and remote areas. The uneven distribution of healthcare workers often leaves communities without access to skilled birth attendance or emergency obstetric care

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[16] Council, Research, et al. "Evidence on the Consequences of Maternal Mortality." *Nih.Gov*, National Academies Press (US), 2025, https://www.ncbi.nlm.nih.gov/books/NBK225436.

[17] Shibeshi, Abdu Hailu, et al. "A Multilevel Analysis of Receipt of Adequate Antenatal Care and Its Determinants Among Pregnant Women in 11 Sub-Saharan African Countries: Insights from Recent Demographic and Health Surveys." *Clinical Epidemiology and Global Health*, 13 Sept. 2025, p. 102185, https://www.sciencedirect.com/science/article/pii/S2213398425002751, 10.1016/j.cegh.2025.102185.

Social and cultural barriers

Finally, social and cultural barriers continue to restrict access to maternal healthcare in some communities. Deep-rooted gender inequality often limits women's autonomy in making decisions about their own health, including whether and when to seek medical care. Practices such as child marriage and early pregnancy increase health risks while also reducing the likelihood that young girls will have the education or independence needed to access maternal health services.

In addition, limited female education can reduce awareness of pregnancy-related complications and the importance of skilled care during childbirth. Cultural beliefs and traditional practices surrounding pregnancy and delivery may also discourage the use of formal healthcare facilities, favouring home births or reliance on untrained birth attendants. In some cases, fear of discrimination, lack of female healthcare providers, or pressure from family members further prevents women from seeking timely prenatal and postnatal care.

These social norms are often resistant to change, making them particularly challenging to address through healthcare policy and infrastructure improvements alone.

Role of armed conflict

During armed conflict, a phenomenon at large in the Sub-Saharan Africa region, the destruction of healthcare infrastructure, with armed forces often damaging or destroying hospitals, clinics, roads, and medical supply networks, is detrimental to the issue at hand. These kinds of actions by the forces that lead to the destruction of infrastructure make emergency referrals during obstetric complications much harder, among other issues.

Armed conflict and political instability also often result in the large-scale displacement of populations, forcing many women to flee their homes as refugees or become internally displaced persons (IDPs). Displacement frequently disrupts access to essential prenatal, maternal, and postnatal healthcare, as health facilities may be damaged, understaffed, or entirely inaccessible. Women living in refugee camps or informal settlements for internally displaced persons often face overcrowded conditions, shortages of medical supplies, and limited access to skilled birth attendants or emergency obstetric care. These challenges increase the risk of pregnancy-related complications, unsafe deliveries, and preventable maternal and neonatal deaths, making displaced women among the most vulnerable populations in Sub-Saharan Africa.

In countries affected by armed conflict, governments often divert a significant proportion of resources toward military expenditure, reducing the funding available for healthcare systems, including maternal and prenatal health services. As a result, hospitals and maternity facilities become underfunded, shortages of healthcare workers and essential medical supplies worsen, and access to prenatal care and emergency obstetric services declines. Although humanitarian organizations and United Nations agencies frequently provide emergency maternal healthcare in

conflict-affected areas, their efforts are often limited by funding shortages and restricted access in conflict zones. Consequently, many women continue to face significant barriers to receiving adequate maternal healthcare, increasing the risk of preventable maternal and neonatal deaths.

MAJOR COUNTRIES AND ORGANIZATIONS INVOLVED

Democratic Republic of Congo (DRC)

The Democratic Republic of the Congo (DRC) faces one of the most complex maternal health crises in Sub-Saharan Africa, where decades of armed conflict have compounded the effects of weak healthcare infrastructure and widespread poverty. In many conflict-affected provinces, insecurity has damaged health facilities, displaced communities, and disrupted the delivery of essential maternal and prenatal healthcare, leaving many women unable to access services before or during childbirth. The country's underdeveloped transport networks further hinder access to healthcare, particularly in remote rural areas where medical facilities and trained personnel are scarce.

Nigeria

Nigeria has one of the highest maternal mortality rates in the world and accounts for the largest number of preventable maternal deaths globally. Despite government efforts to improve maternal healthcare, access to adequate prenatal services remains uneven, particularly in rural and underserved areas. Persistent inequalities within the healthcare system, shortages of skilled healthcare workers, and financial barriers continue to limit access to quality maternal care for many women. Although Nigeria has adopted policies aimed at reducing maternal mortality and expanding maternal health services, progress has been uneven, making the country a key stakeholder in discussions on strengthening healthcare systems and improving access to prenatal and maternal care across Sub-Saharan Africa. Nigeria has introduced measures such as the Basic Health Care Provision Fund (BHCPF) and the Midwives Service Scheme (MSS) to improve access to maternal healthcare, particularly in underserved communities. While these initiatives have increased access to skilled care in some areas, implementation challenges, funding constraints, and regional disparities have limited their overall impact.

Rwanda

Rwanda is widely recognised as one of Sub-Saharan Africa's leading success stories in improving maternal healthcare, having achieved a reduction in maternal mortality of more than 75% between 1990 and 2015, making it one of the few countries to meet the maternal mortality target under the Millennium Development Goals (MDGs). This progress has been driven by

sustained investment in primary healthcare, an extensive network of community health workers, expanded access to antenatal care, and increased rates of skilled birth attendance. Rwanda's emphasis on strengthening local healthcare systems and ensuring access to maternal services has significantly improved health outcomes and positioned the country as a strong advocate for universal primary healthcare and maternal health reforms across Africa. Rwanda's success has been reinforced through initiatives such as its Community-Based Health Insurance (Mutuelles de Santé), which is basically a program ran via the government and local communities to provide affordable healthcare access to rural and low-income citizens.

South Sudan

South Sudan has one of the highest maternal mortality ratios in the world, reflecting the country's prolonged humanitarian and healthcare challenges. Years of armed conflict and political instability have severely weakened the health system, leaving many communities with limited or no access to healthcare facilities capable of providing prenatal or maternal care. Widespread displacement further disrupts access to essential health services, while poor road networks and inadequate transportation infrastructure make it difficult for pregnant women, particularly in rural areas, to reach medical facilities during emergencies. These persistent challenges continue to hinder national and international efforts to improve maternal health and reduce preventable maternal deaths.

African Union (AU)

The African Union (AU) plays a leading role in coordinating continent-wide efforts to reduce maternal mortality and improve maternal and reproductive healthcare across Africa. Through initiatives such as the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the AU encourages Member States to strengthen healthcare systems, increase investment in maternal health services, and adopt policies that expand access to prenatal, delivery, and postnatal care. The organization has helped elevate maternal health as a regional priority and promote cooperation among African states. However, the effectiveness of its initiatives depends largely on the political commitment, financial resources, and implementation efforts of individual Member States. Through CARMMA and the Maputo Plan of Action, the African Union has proved political commitment to maternal health and encouraged Member States to adopt similar strategies.

United Nations Children's Fund (UNICEF)

The United Nations Children's Fund (UNICEF) plays a central role in improving maternal and newborn health across Sub-Saharan Africa by supporting programmes that expand access to antenatal care, skilled birth attendance, and postnatal services. Its work includes strengthening community health worker networks, upgrading maternity wards, improving the availability of

essential medical supplies, and promoting safe childbirth practices. Through funding, technical assistance, and advocacy, UNICEF works closely with governments and local partners to reduce preventable maternal and neonatal deaths while strengthening national maternal healthcare systems.

World Bank

The World Bank is a major financier of maternal and reproductive health initiatives across Sub-Saharan Africa, supporting the expansion of healthcare systems through loans, grants, and investments in maternal health programmes. Its funding has contributed to the construction and improvement of healthcare facilities, the training of healthcare workers, and the expansion of access to essential maternal and prenatal services. However, the effectiveness of these investments can be limited by implementation challenges such as weak governance, uneven distribution of resources, limited administrative capacity, and difficulties in sustaining programmes after external funding ends. The World Bank has done the aforementioned through numerous maternal health projects through initiatives such as the Global Financing Facility (GFF).

World Health Organisation

The World Health Organization (WHO) sets international standards for maternal and prenatal healthcare and provides technical guidance to governments and healthcare providers to improve maternal health outcomes worldwide. The organization develops evidence-based clinical guidelines, supports maternal death surveillance and response systems, advises governments on national maternal health policies, and assists countries in strengthening healthcare systems and workforce capacity. Through these efforts, the WHO plays a key role in supporting the achievement of Sustainable Development Goal (SDG) 3.1, which aims to reduce the global maternal mortality ratio and ensure access to quality maternal healthcare.

TIMELINE OF EVENTS

DATE	DESCRIPTION OF EVENT
18 December 1979	The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the UN General Assembly[18]

[18] United Nations Office on the High Comissioner for Human rights. “Convention on the Elimination of All Forms of Discrimination Against Women New York, 18 December 1979.” *Ohchr*, United Nations, 18 Dec.

10-13 February 1987	Launch of the Safe Motherhood Initiative at the Safe Motherhood Conference in Nairobi, Kenya, marking the first global campaign to reduce maternal mortality.[19]
8 September 2000	Adoption of the United Nations Millennium Declaration (UNGA Resolution 55/2), which established the Millennium Development Goals, including MDG5: "Improve Maternal Health"[20]
2003	Ethiopia Health Extension program
11 July 2003	African Union Member States adopted the Abuja Declaration, committing to allocate at least 15% of national budgets to healthcare.[21]
7 May 2009	Launch of CARMMA (Campaign on Accelerated Reduction of Maternal Mortality in Africa) at the 4th Conference of African Union Ministers of Health in Addis Ababa [22]
September 2010	Global Strategy for Women's and Children's Health [23]
1 January 2016	Sustainable Development Goals come into force, specifically SDG 3.1, aiming to reduce the global MMR.[24]

1979, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women.

[19] "Safe Motherhood - an Overview | ScienceDirect Topics." *Www.Sciencedirect.Com*, https://www.sciencedirect.com/topics/medicine-and-dentistry/safe-motherhood

[20] "Document Viewer." *Un.Org*, 2025, https://docs.un.org/en/A/RES/55/2

[21] African Union. *The Abuja Proclamation.* Organization of African Unity, Apr. 2001, https://au.int/sites/default/files/newsevents/workingdocuments/44462-wd-TheAbujaProclamation.pdf

[22] "Campaign on Accelerated Reduction on Maternal Mortality in Africa (CARMMA) | African Union." *Au.Int*, https://au.int/en/sa/carmma

[23] World Health Organization. "Global Strategy for Women's, Children's and Adolescents' Health Data Portal." *Platform.Who.Int*, 2023, https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data.

[24] WHO. "SDG Target 3.1: Reduce the Global Maternal Mortality Ratio to Less Than 70 Per 100,000 Live Births." *Who.Int*, 2021, https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/sdgtarget3-1-reduce-maternal-mortality

11 March 2020	WHO declares COVID-19 a pandemic, disrupting antenatal care, skilled birth attendance, and maternal health services[25].
28 November 2022	Start of "Re-Strengthening CARMMA 2021–2030" [26]

RELEVANT UN RESOLUTIONS, TREATIES AND EVENTS

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Adopted by the United Nations General Assembly in 1979, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is often described as the International Bill of Rights for women. The Convention recognizes that discrimination against women extends to healthcare and obliges States to eliminate barriers that prevent women from accessing appropriate medical services. Under it, states are required to ensure equal access to healthcare, including services related to pregnancy, childbirth, and the postnatal period. When women are denied or are completely unable to access adequate prenatal care, skilled birth attendance, or essential maternal health services, they are disproportionately exposed to preventable illness and death, reinforcing gender-based discrimination and inequality. CEDAW successfully established women's access to maternal healthcare as a human right and strengthened the legal obligations of States. However, its impact has varied significantly, as implementation and enforcement depend on national governments

UN General Assembly Resolution 55/2

The UN General Assembly Resolution 55/2, more commonly known as the Millennium Declaration (or Millennium Development Goals (MDGs)), was a document adopted in September 2000 by 147 Heads of State and Government. It established a global consensus on fundamental values, including a commitment to reduce maternal mortality by 75% by the year 2015. Despite global improvements, only 9 countries achieved the MDG 5 target. Overall, between 1990 and

[25] Cucinotta, Domenico, and Maurizio Vanelli. "WHO Declares COVID-19 a Pandemic." *Acta Bio-Medica: Atenei Parmensis*, vol. 91, no. 1, 19 Mar. 2020, pp. 157–160. *National Library of Medicine*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7569573/, 10.23750/abm.v91i1.9397.

[26] "Re-Strengthening CARMMA 2021 – 2030." *Carmma*, 2021, https://carmma.au.int/en/news/updates/2020-08-31/re-strengthening-carmma-2021-2030.

2015, maternal mortality fell by 44%[27], showing progress, yet still significantly lower than the initial goal, especially in a region like Sub-Saharan Africa, where progress was uneven but crucial.

Maputo Protocol

The Maputo Protocol was adopted in July 2003, and it entered into force on the 25th of November 2005. This protocol is the treaty of the African Union on the rights of women on the continent, acting as the main legal instrument for the protection of the rights of women and girls in Africa. Specifically, Article 14 covers sexual and reproductive health and rights, and includes the requirement for all African states to strengthen prenatal, delivery and postnatal healthcare services by mandating reproductive health rights. The Maputo Protocol strengthened the legal protection of women's reproductive rights across Africa and encouraged reforms in national legislation. However, inconsistent implementation and limited healthcare capacity have prevented many states from fully meeting its obligations

UN General Assembly Resolution 65/1

Resolution 65/1 of the General Assembly, namely: “Keeping the Promise: united to achieve the Millennium Development Goals”, was adopted in 2010, reaffirming international commitments made to achieving the MDGs, including maternal health targets. The resolution called for increased investment in maternal and reproductive healthcare, welcoming the African Union’s Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). This kind of “investment” includes, but isn’t limited to, strengthening health systems and expanding access to skilled birth attendance. However, progress depended largely on the willingness and capacity of individual states to translate these commitments into concrete action.

UN General Assembly Resolution 70/1

This Resolution was adopted by the GA in September 2015, establishing the 2030 Agenda for Sustainable Development, or the 17 Sustainable Development Goals (SDGs). This resolution created SDG 3.1, aiming to reduce the global maternal mortality ratio to fewer than 70 deaths per 100,000 live births by 2030. In 2023, the MMR in low-income countries was 346 per 100,000 live births, versus 10 per 100,000 in high-income nations [28]. These figures illustrate the substantial gap that remains in achieving the SDG 3.1 target, particularly in low-income countries, where maternal mortality rates continue to exceed the 2030 goal by a wide margin.

Human Rights Council Resolution 60/18

[27] World. “Maternal Deaths Fell 44% Since 1990 – UN.” *Who.Int*, World Health Organization: WHO, 12 Nov. 2015, https://www.who.int/news-room/detail/12-11-2015-maternal-deaths-fell-44-since-1990-un
[28] World Health Organization. “Maternal Mortality.” *World Health Organization*, 2025, https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

This Resolution was adopted by the Human Rights Council on October 7 2025, during its 60th session, discussing the topic of preventable maternal mortality and morbidity and human rights. Although not directly about the situation in Sub-Saharan Africa, it holds importance, as it recognises that preventable maternal mortality is not just a healthcare issue but a human rights issue. Under this resolution, states have obligations to ensure access to prenatal care, skilled birth attendance and emergency obstetric care for all women. This framing strengthens arguments that Sub-Saharan African states and the international community must treat maternal mortality as a rights violation. As a recently adopted resolution, its long-term impact is still developing. Nevertheless, it strengthens the recognition of maternal mortality as a human rights issue and may encourage greater state accountability.

PREVIOUS ATTEMPTS TO SOLVE THE ISSUE

Safe Motherhood Initiative

The Safe Motherhood Initiative is a global public health effort launched in 1987 and convened by the World Health Organisation, the World Bank, and the United Nations Fund for Population Activities (UNFPA), to reduce maternal and neonatal mortality, particularly in low-income countries. It focuses on ensuring women receive proper pregnancy care and emergency assistance. The initiative began at an international conference in Nairobi, Kenya, in response to alarming rates of maternal deaths. The original goal was to reduce global maternal mortality by 50% by the year 2000, and although that ambitious goal was not achieved, the movement fundamentally succeeded by placing women's reproductive rights and maternal survival firmly on the global political agenda

Campaign on Accelerated Reduction of Maternal Mortality in Africa

The African Union’s flagship campaign of accelerating maternal mortality reductions, launched in 2009. The campaign encourages Member States to prioritise maternal and reproductive healthcare within national development agendas by increasing investment in prenatal, delivery, and postnatal services, expanding access to skilled birth attendants and emergency obstetric care, and strengthening national healthcare systems. CARMMA also promotes political commitment, public awareness, and accountability, encouraging governments to adopt policies and allocate sufficient resources to improve maternal health outcomes in line with global development goals

Every Woman Every Child

A global movement coordinating governments, NGOs, and private actors to reduce preventable maternal and child deaths. It was launched in September 2010 by former UN Secretary General Ban Ki-moon during the Millennium Development Goals Summit. In 2015, the

initiative was updated to align with the 2030 Agenda for Sustainable Development under the Global Strategy for Women's, Children's and Adolescents' Health, with continued support from Secretary-General António Guterres. The initiative works by encouraging countries and partners to make measurable national commitments, mobilising financial and technical support, and monitoring progress through the Global Strategy to strengthen maternal, newborn, child, and adolescent health worldwide. This initiative did in fact mobilise international funding, however, progress once again remains uneven due to countries being affected by conflict and other issues.

Ethiopia Health Extension Program

Launched in 2003, Ethiopia's Health Extension Program sought to improve access to healthcare by deploying trained health extension workers (HEWs) to rural communities. These government-employed workers provide basic maternal, child, and preventive healthcare services at the community and household level, including antenatal care, health education, family planning, and referrals for facility-based deliveries. By bringing essential services closer to underserved populations, the programme contributed to increased use of maternal health care. However, challenges such as uneven quality of care and low postnatal care coverage persisted, highlighting the need for continued investment in the programme. Overall, it did substantially improve access to healthcare in the country, though still facing barriers like uneven progress.

Mobile Health (mHealth) Platforms in Kenya and Nigeria

Countries such as Kenya and Nigeria have introduced mobile apps and SMS-based mHealth platforms that are digital health solutions to deliver healthcare services, track patient data and improve communication between patients and medical professionals. Platforms like Kenya's "Malaica" offer remote consultations, offering women easily accessible healthcare. In Nigeria, initiatives like the "Digital Mom Project" provide personalised self-care support to address health crises for women unable to reach healthcare facilities. These initiatives have expanded access to maternal health information and support, particularly in underserved communities, although their effectiveness remains dependent on access to mobile technology, internet connectivity, and digital literacy.

POSSIBLE SOLUTIONS

Addressing Social Determinants

Addressing the underlying social determinants of maternal mortality is essential for achieving long-term improvements in maternal and prenatal healthcare. National governments, in cooperation with international organizations such as UNICEF, the World Health Organization (WHO), and local civil society organizations, should implement public awareness campaigns promoting the importance of prenatal care, skilled birth attendance, proper nutrition during

pregnancy, and the recognition of pregnancy-related complications. Governments should also invest in improving female literacy, expanding access to education for girls, and strengthening community outreach programmes led by community health workers. Such initiatives can empower women to make informed healthcare decisions, seek antenatal care earlier and more regularly, and reduce social barriers that prevent access to maternal healthcare.

Reducing Financial Barriers

Financial barriers remain one of the primary obstacles preventing women from accessing maternal healthcare. Governments should introduce or expand free maternal healthcare services covering prenatal care, childbirth, emergency obstetric care, and postnatal services. The expansion of national health insurance schemes, alongside targeted subsidies or conditional cash transfer programmes for low-income households, can further reduce out-of-pocket healthcare costs and encourage women to seek medical care throughout pregnancy rather than only during emergencies. Moreover, a major financial difficulty for women in rural areas are the travel costs. Therefore, governments should introduce similar services like the ones previously mentioned, for travel costs.

Expand Access to Prenatal Care

Governments should increase the number of maternal health clinics and strengthen primary healthcare systems, particularly in rural and underserved communities where access to healthcare remains limited. This should be accompanied by investments in trained healthcare workers, essential medicines, and basic medical equipment to ensure that facilities can provide quality maternal care. Mobile healthcare units and community outreach programmes can deliver antenatal services directly to remote populations, allowing for regular check-ups, health education, and early detection of pregnancy complications. At the same time, referral systems should be strengthened through improved ambulance services, clear referral protocols, and better communication between community health workers and hospitals, ensuring that women with high-risk pregnancies can be transferred quickly to facilities capable of providing emergency obstetric care.

Utilisation of Digital Health Technologies

Digital health technologies can complement traditional healthcare services by improving communication between patients and healthcare providers, particularly in remote areas. Mobile health (mHealth) applications, SMS appointment reminders, telemedicine services, and electronic health records can encourage attendance at prenatal appointments, support patient monitoring, and enable healthcare workers to identify high-risk pregnancies earlier. To make this possible, governments should implement teaching women and girls basic digital literacy through campaigns supported by international actors.

Increase International Cooperation

While donor states and international organizations already support maternal healthcare initiatives across Sub-Saharan Africa, greater international cooperation remains essential. This could include joint funding for maternal health programmes, training for healthcare workers carried out by the WHO, support for infrastructure upgrades by actors like the World Bank, and deliveries of essential medical supplies by agencies such as UNICEF. Regional cooperation through the African Union could also help countries share best practices, coordinate cross-border health campaigns, and improve data-sharing to reduce maternal mortality and strengthen prenatal care across the region.

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