Maternal mortality

Maternal mortality – the death of a woman during pregnancy, childbirth, or within 42 days of the termination of pregnancy – is an important indicator of a woman's health status and to assess health system's performance. The Sustainable Development Goals set a target of reducing the global maternal mortality ratio to less than 70 per 100 000 live births by 2030. In LAC, around 7 400 maternal deaths occurred in 2019, most of them preventable (WHO, 2022[1]).

In 32 LAC countries, maternal mortality ratio (MMR) averaged 97 deaths per 100 000 live births in 2020, substantially higher than the 10 deaths per 100 000 live births in OECD countries (Figure 3.10). Estimates show Chile with low MMRs of 22, with high MMRs present in Haiti at 435, followed by Bolivia and Saint Kitts and Nevis with 217 and 179, respectively.

Despite high rates in certain countries, a reduction of -3.2% in maternal mortality has been achieved in the LAC region between 2000 and 2020, yet far below the reduction in OECD countries of -27% in the same period. In Nicaragua and Colombia MMR decreased by around 50%. Nevertheless, during the same period MMR increased in 17 countries, with Grenada (111%), Dominica (100%), Saint Lucia (83%), Saint Vincent and the Grenadines (78%), Belize (75%) and Barbados (73%) experiencing increases of more than 70%.

Across 31 LAC countries, maternal mortality is generally inversely related to the coverage of skilled birth attendance (Figure 3.11). This can be clearly seen since the country with the highest MMR, Haiti, was also the country with the lowest proportion of births attended by a skilled health professional (42%). On the other side, countries like Saint Kitts and Nevis, Guyana, and Suriname show high skilled birth attendance coverage (97% or more) but a relatively high MMR (all over 115), indicating challenges with quality of care. At the same time, most countries (25) had more than 95% of births attended by skilled health professionals.

Higher coverage of antenatal care (at least four times) is associated with lower MMRs, indicating the effectiveness of antenatal care across countries (Figure 3.12). Cuba deviates from the trend by having a low coverage of antenatal care (only 80% of pregnant women receives at least four visits) but a relatively low MMR of 50. Oppositely, Peru and the Dominican Republic show antenatal care coverage above 92% but MMR over 90 deaths per 100 000 live births, which might be linked with lower rates of skilled birth attendance but also with quality-of-care issues.

Risk of maternal death can be reduced through family planning, better access to high-quality antenatal care, and delivery and postnatal care by skilled health professionals. Addressing disparities in the provision of these essential reproductive health services to underserved populations must be included in any strategy. Furthermore, the broad health systems strengthening and universal health coverage agenda, along with multisectoral action (e.g. women's education, tackling violence) are collaborative efforts which are crucial to reducing maternal deaths in the LAC region (WHO et al., 2018[2]).

Definition and comparability

Maternal mortality is defined as the death of a woman while pregnant or during childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes. This includes direct deaths from obstetric complications of pregnancy, interventions, omissions, or incorrect treatment. It also includes indirect deaths due to previously existing diseases, or diseases that developed during pregnancy, where these were aggravated by the effects of pregnancy. Maternal mortality is here measured using the maternal mortality ratio (MMR). It is the number of maternal deaths during a given time per 100 000 live births during the same time. There are difficulties in identifying maternal deaths precisely. Many countries in the region do not have accurate or complete vital registration systems, and so the MMR is derived from other sources including censuses, household surveys, sibling histories, verbal autopsies, and statistical studies. Estimates should therefore be treated cautiously.

References

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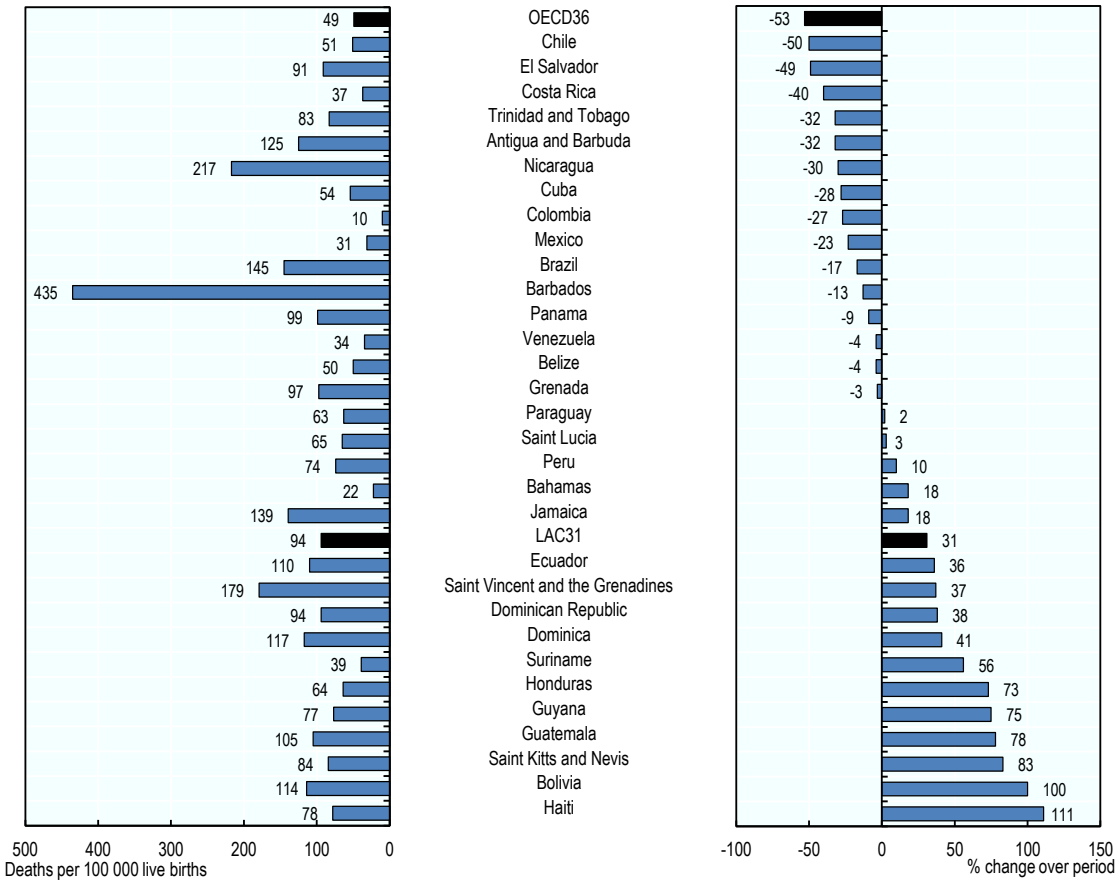
WHO et al. (2018), *Survive, Thrive, Transform. Global Strategy for Women's, Children's and Adolescents' Health: 2018 report on progress towards 2030 targets*, World Health Organisation, https://www.everywomaneverychild.org/wp-content/uploads/2018/05/EWECGSMonitoringReport2018.pdf. [2]

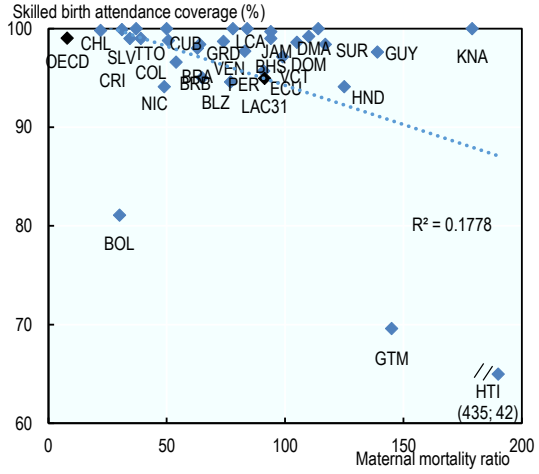
Figure 3.10. Estimated maternal mortality ratio, 2020, and percentage change since 2000



Source: Bill and Melinda Gates Foundation (2021), OECD Health Statistics 2022.

StatLink https://stat.link/5syfk3

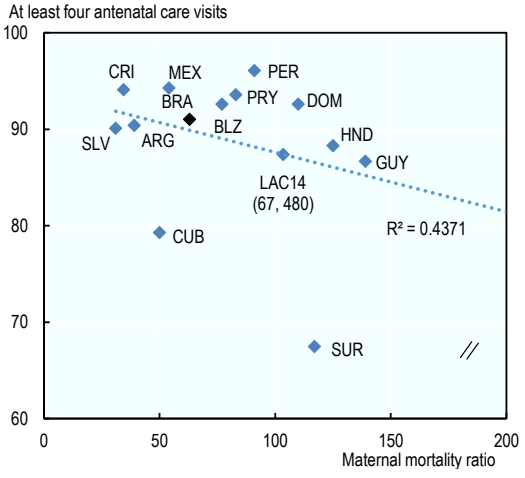
Figure 3.11. Skilled birth attendant coverage and estimated maternal mortality ratios, latest year available



Source: WHO GHO 2019.

StatLink https://stat.link/de4nuq

Figure 3.12. Antenatal care coverage and maternal mortality, latest year available



Source: WHO GHO 2019.

StatLink https://stat.link/7pqn9e