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 also 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 7 600 maternal deaths occurred in 2015, most of them preventable. The main causes of maternal death were haemorrhage after birth and gestational hypertension, and were concentrated in countries with higher fertility rates, more poverty and less access to high-quality health care services (GTR, 2017[17]).

In 31 LAC countries, maternal mortality ratio (MMR) averaged 83 deaths per 100 000 live births in 2017, substantially higher than the 8 deaths per 100 000 live births in OECD countries (Figure 3.20). Estimates show Chile and Uruguay with low MMRs of less than 17, but others such as Haiti have 480, followed by Guyana and Bolivia with 169 and 155, respectively.

Despite high rates in certain countries, a reduction of 26% in maternal mortality have been achieved in the LAC region between 2000 and 2017, however below the reduction in OECD countries of -40% in the same period. Belize, Chile, Bolivia and Ecuador decreased MMR by over 50%. Nevertheless, during the same period MMR increased in five countries: Saint Lucia (36%), Dominican Republic (19%), Haiti (10%), Venezuela (5%) and Jamaica (4%).

Across 16 LAC countries, maternal mortality is inversely related to the coverage of skilled births attendance (Figure 3.21). Although most countries (11) had more than 95% of births attended by skilled health professionals, 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 Guyana, Venezuela and Suriname show high skilled birth attendance coverage (96% or more) but relatively high MMR (all over 120), probably evidencing quality of care problems.

Higher coverage of antenatal care (at least four times) is associated with lower MMR, indicating the effectiveness of antenatal care across countries (Figure 3.22). Grenada moves away from the trend by having a low coverage of antenatal care (only 67% of pregnant women receives at least four visits) but a relatively low MMR of 25. Oppositely, Bolivia and Guyana show antenatal care coverage above 85% but MMR over 150 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 that are crucial to reduce maternal deaths in the LAC region (WHO et al., 2018[18]).

Definition and comparability

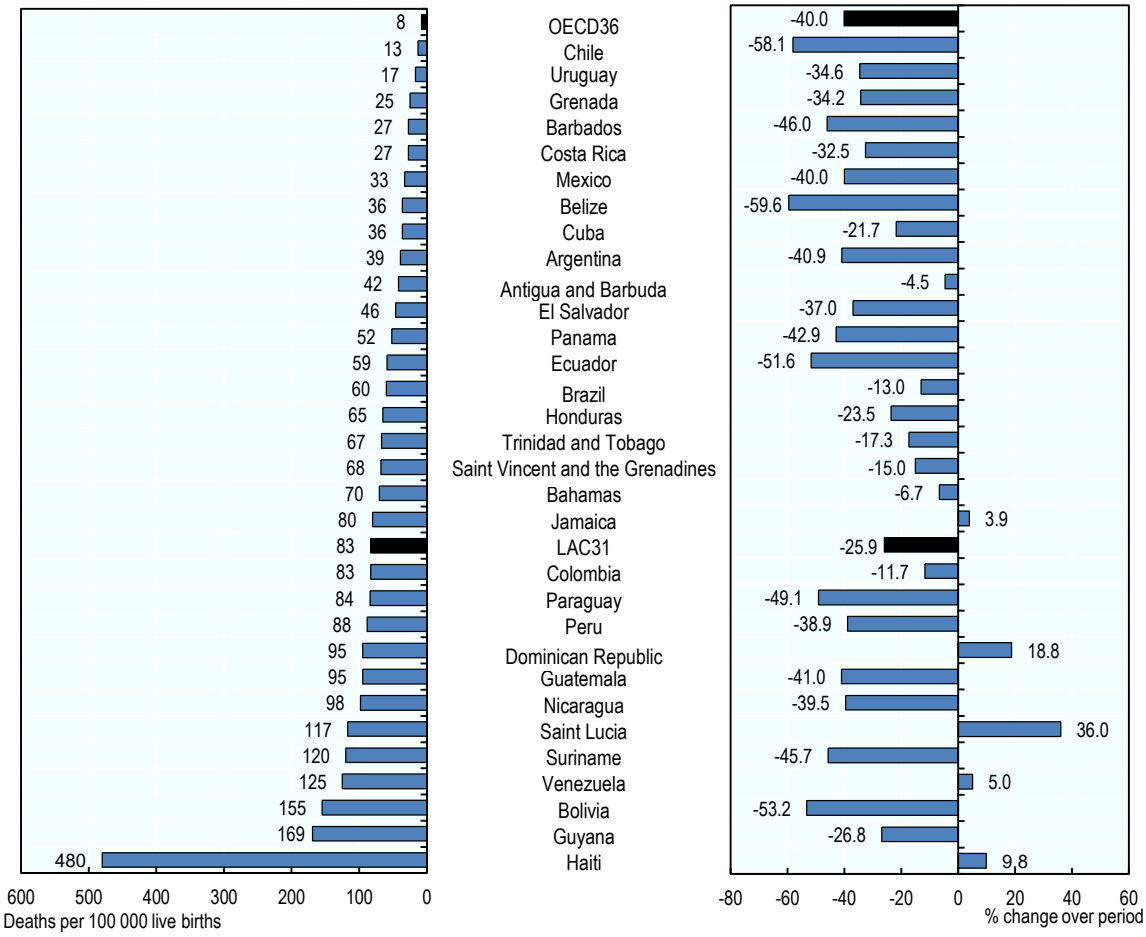
Maternal mortality is defined as the death of a woman while pregnant or during childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental 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 period per 100 000 live births during the same time period. 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. Because of this, estimates should be treated cautiously.

References

[17] GTR (2017), *Panorama de la Situación de la Morbilidad y Mortalidad Maternas: América Latina y el Caribe*, Grupo de Trabajo para la Reducción de la Mortalidad Materna. Naciones Unidas, *https://lac.unfpa.org/sites/default/files/pub-pdf/MSH-GTR-Report-Esp.pdf*.

[18] 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 Organization, Geneva, *https://www.everywomaneverychild.org/wp-content/uploads/2018/05/EWECGSMonitoringReport2018.pdf*.

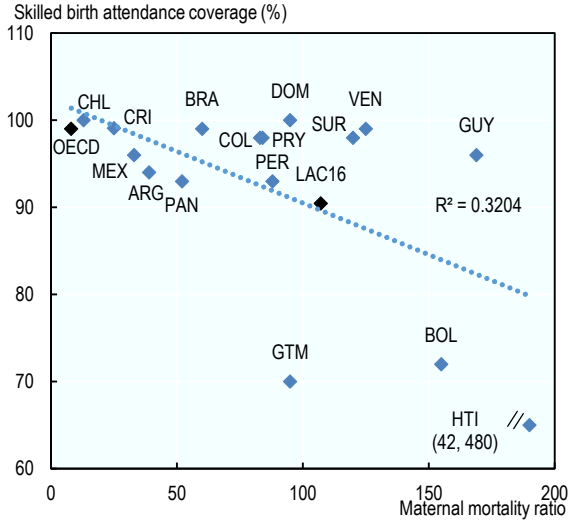
Figure 3.20. **Estimated maternal mortality ratio, 2017, and percentage change since 2000**



Source: WHO GHO 2019.

StatLink https://stat.link/t01xry

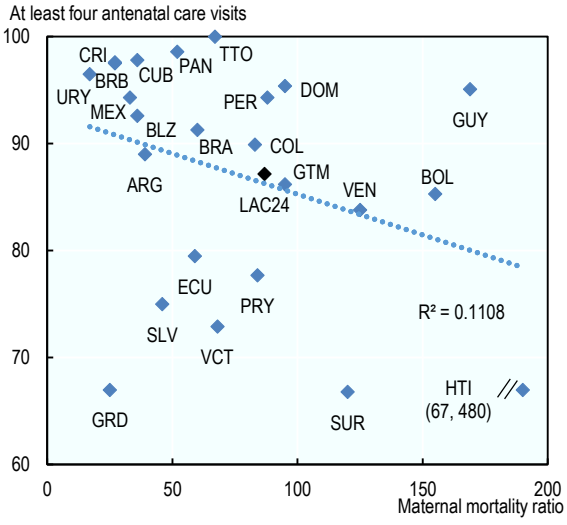
Figure 3.21. **Skilled birth attendant coverage and estimated maternal mortality ratios, latest year available**



Source: WHO GHO 2019, Ministry of Health for Costa Rica.

StatLink https://stat.link/k3jz8n

Figure 3.22. **Antenatal care coverage and maternal mortality, latest year available**



Source: WHO GHO 2019.

StatLink https://stat.link/ku5pio