

MATERNAL MORTALITY

Pregnancy and childbearing, whilst offering women opportunities for personal development and fulfilment, also present inherent risks. 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 and status. 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.

Almost 303 000 maternal deaths were estimated to have occurred worldwide in 2015 and a woman's lifetime risk of maternal death – the probability that a 15-year-old woman will die eventually from a maternal cause – is 0.56, that is one woman in 180 (WHO, 2015b).

The leading causes of deaths are severe bleeding after childbirth, infections, high blood pressure during pregnancy and unsafe abortion. The majority of these deaths are preventable, and occur in resource-poor settings (WHO, 2015b). Fertility and maternal mortality have strong associations with economic development and GDP. Risk of maternal death can be reduced through family planning, better access to high-quality antenatal, intrapartum and postnatal care by skilled health professionals.

Maternal mortality ratio (MMR) averaged around 140 deaths per 100 000 live births in lower-middle and low income Asia-Pacific countries in 2015, more than four times the upper-middle income Asia-Pacific countries average, and more than ten times the high-income Asia-Pacific countries average (Figure 3.20, left panel). Estimates for 2015 show a small group of countries – Hong Kong, China; Australia; Japan; Singapore and the Republic of Korea – with very low MMRs of less than 10, but a group of countries including Papua New Guinea and Nepal had high MMRs at 200 or more deaths per 100 000 live births. About one-fifth of the world's maternal mortality burden occurred in India and Pakistan alone.

Despite high ratios in certain countries, significant reductions in maternal mortality have been achieved in Asia-Pacific over the last 15 years (Figure 3.20, right panel). The MMR declined by more than 50% between 2000 and 2015 across lower-middle and low income Asia-Pacific countries. Cambodia and the Lao PDR showed the largest reductions among countries reporting high ratios in 2000. According to a study (WHO, 2014a), Cambodia's success is related to reduced fertility through wider use of contraceptives and increased coverage of antenatal care and skilled birth attendance – achieved through increasing the number of midwives and facilities providing Emergency Obstetric and Newborn Care.

Across countries, maternal mortality is inversely related to the coverage of skilled births attendance (Figure 3.21). Bangladesh, the Lao PDR and Papua New Guinea reported that less than one in two live births are

attended by skilled health professionals (see indicator “Pregnancy and birth” in Chapter 5). These countries have relatively high MMRs above 176 deaths per 100 000 live births.

Higher coverage of antenatal care (at least four times) is associated with lower maternal mortality, indicating the effectiveness of antenatal care across countries (Figure 3.22). Addressing disparities in the unmet need of family planning and providing essential reproductive health services to underserved populations may also substantially reduce maternal deaths in the region (UNESCAP, 2017).

To improve quality of care, maternal death surveillance and response (MDSR) has been implemented in countries. MDSR is a continuous cycle of identification, notification and review of maternal deaths followed by actions to prevent future death. Global survey of national MDSR system instigated in 2015 provides baseline data on status of implementation. The implementation status of countries in WPRO (Cambodia, China, Fiji, Laos PDR, Malaysia, Mongolia and Papua New Guinea) can be seen at: www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/.

Definition and comparability

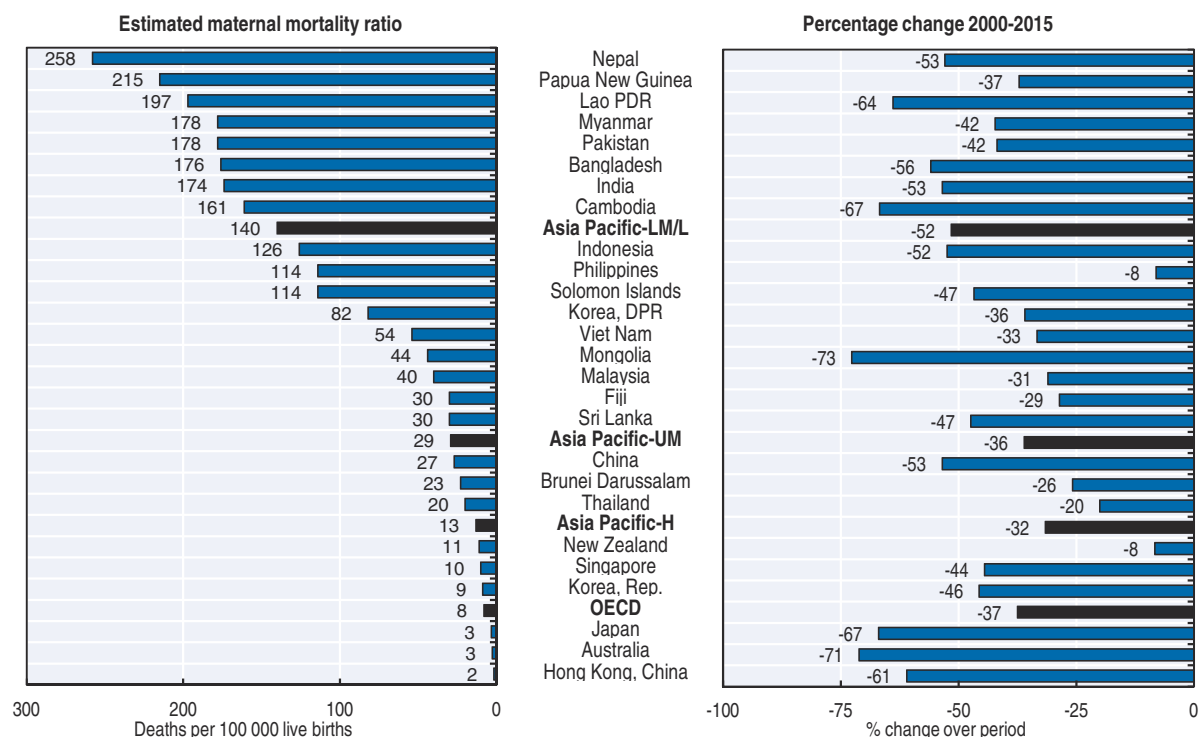
Maternal mortality is defined as the death of a woman while pregnant or during childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes (WHO, 2015b).

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.

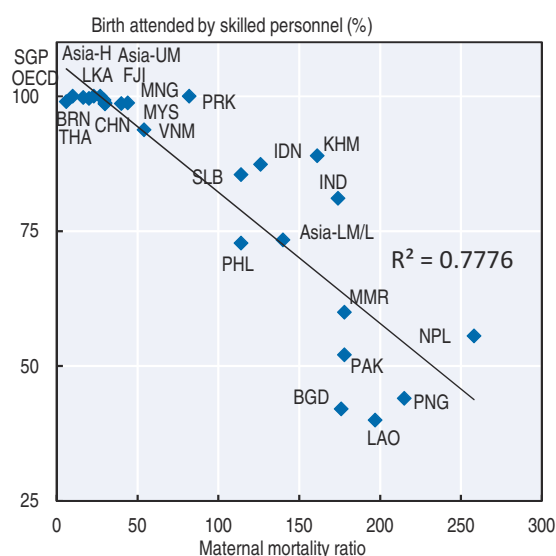
3.20. Estimated maternal mortality ratio, 2015 (or latest year available), and percentage change since 2000



Source: OECD Health Statistics 2018; WHO (2018); Health facts of Hong Kong 2017.

StatLink <http://dx.doi.org/10.1787/888933867303>

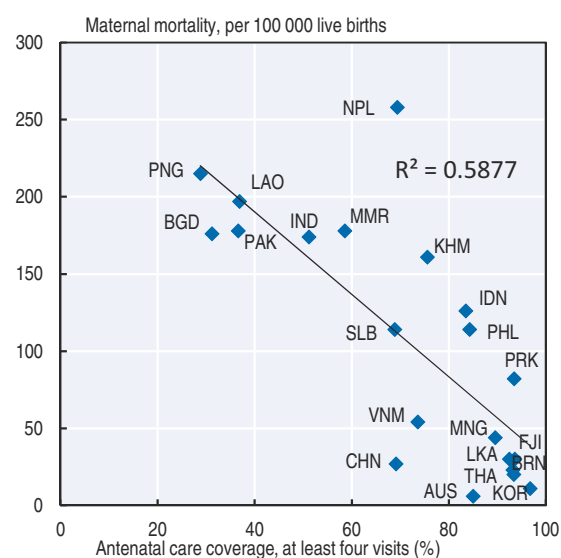
3.21. Skilled birth attendant coverage and estimated maternal mortality ratios, latest year available



Source: OECD Health Statistics 2018; WHO (2018); WHO GHO 2018.

StatLink <http://dx.doi.org/10.1787/888933867322>

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



Source: WHO GHO 2018; National survey on children for India for 2013-14.

StatLink <http://dx.doi.org/10.1787/888933867341>



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