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# Overview of the Situation of Maternal Morbidity and Mortality: Latin America and the Caribbean

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This document presents an interagency evidence-based framework for addressing the grave problem of maternal morbidity and mortality in Latin America and the Caribbean. The principles and policies of each agency are governed by the relevant decisions of its governing body. Each agency implements the interventions described in this document in accordance with its principles and policies and within the scope of its mandate.

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# Acronyms

<b>AECID</b>	<i>Spanish Agency for International Cooperation for Development</i>	<b>MMEIG</b>	<i>UN Maternal Mortality Estimation Inter-Agency Group</i>
<b>CARICOM</b>	<i>Caribbean Community</i>	<b>MMR</b>	<i>maternal mortality ratio</i>
<b>CLAP/SMR</b>	<i>The Latin-American Center for Perinatology, Woman and Reproductive Health</i>	<b>MSH</b>	<i>Management Sciences for Health</i>
<b>COMISCA</b>	<i>Commission of Health Ministries of Central America and the Dominican Republic</i>	<b>OHCHR</b>	<i>Office of the United Nations High Commissioner for Human Rights</i>
<b>FCI</b>	<i>Family Care International</i>	<b>PAHO</b>	<i>Pan American Health Organization</i>
<b>FLASOG</b>	<i>Latin American Federation of Obstetrics and Gynecology Societies</i>	<b>PLANEA</b>	<i>Andean Plan for the Prevention of Adolescent Pregnancy</i>
<b>GDP</b>	<i>Gross Domestic Product</i>	<b>RELAC SIS</b>	<i>Latin American and Caribbean Network to Strengthen Health Information Systems</i>
<b>GTR</b>	<i>Regional Task Force for the Reduction of Maternal Mortality</i>	<b>RMC</b>	<i>respectful maternity care</i>
<b>ICPD</b>	<i>International Conference on Population and Development</i>	<b>SDG</b>	<i>Sustainable Development Goals</i>
<b>IEB</b>	<i>International Education Institute of Brazil</i>	<b>UNFPA</b>	<i>United Nations Population Fund</i>
<b>MDG</b>	<i>Millennium Development Goals</i>	<b>WHO</b>	<i>World Health Organization</i>





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# Executive Summary

Since 1998, the Regional Task Force for the Reduction of Maternal Mortality (GTR, for its Spanish acronym) has promoted interagency collaboration for the implementation of policies and programs to reduce maternal mortality in Latin America and the Caribbean. The task force is comprised of United Nations technical agencies, bilateral and multilateral cooperation organisms, nongovernmental organizations, and professional associations. The GTR promotes a joint and common vision to combat maternal deaths by optimizing technical cooperation within countries and across agencies. In 2003, the GTR spearheaded a broad consultation process that resulted in a policy declaration, the *Interagency Strategic Consensus for the Reduction of Maternal Morbidity and Mortality in Latin America and the Caribbean*. This document, endorsed by the region's governments, espoused agreed-upon evidence-based priorities for the reduction of maternal morbidity and mortality during the 2004-2014 decade. The Strategic Consensus has served as a frame of reference for the design and implementation of national plans to reduce maternal mortality, through the harmonization of technical strategies within countries and between the different participating agencies.

The current document presents a panorama of the state of maternal health in the region and reaffirms the advances and lessons learned from the previous decade, in an effort to support countries to identify new priorities and challenges for the reduction of maternal mortality in the framework of the 2030 Agenda. This panorama emerges at a critical time. At the regional level, governments made significant commitments to reducing maternal mortality during the First Regional Conference on Population and Development in Montevideo (2013). Governments renewed this commitment in 2015 with the

adoption of the Montevideo Consensus' Operational Guide, which outlines a concrete roadmap for reducing maternal mortality in the region. In addition, the Santo Domingo Consensus, reached during the 2013 Regional Conference on Women, and the Regional Gender Agenda, reached during the XIII Conference on Women in 2016, are technical-political documents that aim to mainstream gender in the implementation of the Sustainable Development Agenda. At the global level, 2015 marked the deadline for attaining the Millennium Development Goals (MDGs). By 2015, no country in the region had achieved the MDG 5A target to reduce the maternal mortality ratio by three quarters between 1990 and 2015.

In Latin America and the Caribbean, thousands of women still lose their lives every year from preventable causes related to pregnancy and childbirth. Many more suffer complications and experience long-term health issues that affect the quality of their lives. Indigenous and Afro-descendant women, as well as women with lower incomes and fewer years of formal education often lack access to family planning services and skilled birth attendance. In many communities, indigenous women are three times more likely to die from causes related to pregnancy and childbirth than are non-indigenous women living in the same communities. These inequities in accessing care, and the resulting loss of life, violate women's right to health, which includes safe maternal care. A mother's death has deep emotional, social and economic repercussions on the surviving family; following the death of their mother, newborns are less likely to survive, other children are less likely to remain in school, and the family is more likely to suffer financial consequences from loss of productivity and income.

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The GTR reaffirms the evidence-based strategies for preventing maternal death outlined in the Strategic Consensus, which include the need to strengthen national health systems at every level, ensure adequate financing for public health services, and increase high-quality, accessible and affordable services. The current panorama seeks to highlight the significant challenges in the region and to urge countries to respond to them as follows: reduce inequities by increasing investment in the health of the most vulnerable communities;

guarantee the rights of adolescents and youth to a healthy life; reinforce maternal mortality surveillance and response systems; and focus on public policies with a rights-based and gender perspective. The agencies that make up the GTR support the underlying principles and strategies of rights and accountability, social determinants of health and governance, intercultural care, and intersectoral collaboration.









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# Overview of the Situation of Maternal Morbidity and Mortality: Latin America and the Caribbean

## 1. Introduction

The human right to health, articulated in numerous international conventions, protocols, and declarations signed by countries in the LAC region, is reflected in national constitutions, which affirm their obligations to respect, protect, and fulfill this right for their citizens. The right to health<sup>†</sup> includes the right to maternal health. An indicator of women's unequal status in society and weak health care systems, maternal mortality, together with child mortality, is a proxy for social inequality. In 2009, the United Nations Human Rights Council issued a resolution stating that preventable maternal death constitutes a grave human rights violation and is a social, rather than an individual, problem.<sup>1</sup> (See Annex A for terminology, as used in this document.)

The Latin America and Caribbean region is among the most unequal regions in the world in terms of income inequality. While countries in the region have experienced significant economic development, the richest 10% of people in the region own 71% of the region's wealth.<sup>2</sup> Such wide income inequality continues to limit access to quality health services for vulnerable or socially marginalized groups, such as indigenous communities and those of African descent, people with fewer years of education, those in the lower income quintiles, and people living in rural areas and in the periphery of large cities. Most countries in the region are classified as middle income, and do not qualify for significant foreign aid because, in theory, they have enough domestic financing to cover their national health

needs. Consequently, governments face the challenge of setting their priorities in health, broadening their commitments, and improving the efficiency of their health services and systems through the adoption of evidence-based practices.

Since 1998, the Regional Task Force for the Reduction of Maternal Mortality (*Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna*, GTR, for its Spanish acronym) has promoted interagency collaboration for the implementation of policies and programs to reduce maternal mortality in Latin America and the Caribbean. The GTR is comprised of United Nations technical agencies, bilateral and multilateral cooperation organisms, non-governmental organizations, and professional associations.

In 2003, the GTR spearheaded a broad consultation process that resulted in a policy declaration, the *Interagency Strategic Consensus for the Reduction of Maternal Morbidity and Mortality in Latin America and the Caribbean*. This document, endorsed by the region's governments, promoted a set of agreed priorities and strategies, based on the best available evidence, for the reduction of maternal morbidity and mortality for the next decade (2004-2014). The Strategic Consensus has served as a frame of reference for the design and implementation of national maternal mortality reduction plans, and the harmonization of technical strategies among different agencies. Between 2004 and 2014, the Strategic Consensus aimed to:

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<sup>†</sup> The key elements in the right to health are availability, accessibility, acceptability, and quality of services.

- Foster interagency dialogue and the development of a common strategic framework for the reduction of maternal morbidity and mortality;
- Achieve greater coherence of national policies and interventions based on the best available scientific information;
- Focus on the support and provision of quality services, prioritizing skilled birth attendance and promoting evidence-based interventions;
- Strengthen maternal mortality surveillance and response systems; and
- Encourage intersectoral collaboration and the exchange of lessons learned within and between countries.

The panorama presented in this document reaffirms the advances and lessons learned through program implementation in the previous decade to help countries identify priorities for the reduction of maternal mortality in the framework of the Sustainable Development Goals (SDGs). In addition, it offers guidelines for governments and different institutional actors to harmonize their efforts to reduce maternal mortality in the period 2018–2025.

The GTR presents this panorama at a critical time in which global development has undergone a paradigm shift. When the global Millennium Development Goals (MDGs) ended in 2015, no country in the region had achieved the MDG 5A target to reduce the maternal mortality ratio by three quarters between 1990 and 2015. The region made progress on some MDG indicators,<sup>3</sup> including family planning and contraception, prenatal care, and skilled birth attendance. However, in 2016, the region as a whole had a maternal mortality ratio (MMR) of 60.8 maternal deaths for every 100,000 live births,<sup>4</sup> which signifies a 56.6% reduction from 1990 levels (140 maternal deaths for every 100,000 live births), well below the target of 75%.<sup>†</sup>

In September 2015, United Nations member states adopted the Sustainable Development Goals (SDGs), which prioritize the reduction of maternal mortality. The *Global Strategy for Women's,*

*Children's and Adolescents' Health* (2016–2030) offers a framework to make this priority operational.

At the regional level, the First Regional Conference on Population and Development in Montevideo (2013) resulted in joint commitments to reduce maternal mortality. In 2015, governments renewed their commitments to reduce maternal morbidity and mortality with the adoption of the Operational Guide. In addition, the Santo Domingo Consensus, signed during the 2013 Regional Conference on Women, and the Regional Gender Agenda, approved at the XIII Conference on Women in 2016, are policy documents that aim to mainstream gender in the implementation of the Sustainable Development Agenda (see Annex B on “The international context for the reduction of maternal mortality and morbidity: Conceptual frameworks and global and regional strategies”).

The maternal mortality panorama presented herein seeks to: contribute to the achievement of the described global and regional initiatives; highlight new challenges and conceptual developments; and build the scientific evidence base. This panorama highlights the issues of rights and accountability, social determinants of health, governance, inter-cultural health and the importance of intersectoral collaboration. This document is aligned with the *Strategy for Universal Healthcare Access and Coverage*, the Montevideo Consensus and the *Global Strategy for Women's, Children's and Adolescents' Health*, adopted in September 2015.<sup>5,6,7</sup>

Latin America and the Caribbean must overcome several persistent challenges to improve women's sexual and reproductive health and end maternal morbidity and mortality. Such challenges include consistently high maternal mortality ratios and adolescent pregnancy rates; low quality and disrespectful care during pregnancy, childbirth and the postnatal period; and limited access to family planning services and contraception. Within their borders, countries still grapple with extreme inequalities in access to health care among population groups, with marginalized groups facing the most barriers to health care. This document

† Each country reports its MMR to PAHO. The United Nations Maternal Mortality Estimation Inter-Agency Group, based on defined international standards to guarantee comparability between countries, estimates the MMR of LAC to be 68 maternal deaths for every 100,000 live births.



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encourages concerted action among countries in Latin America and the Caribbean to develop, adapt, and implement the SDGs, and to comply

with regional and global commitments to reach universal health coverage and access to reproductive health care.

## *2. The Context of Maternal Morbidity and Mortality in Latin America and the Caribbean*

In 2015, the UN Maternal Mortality Estimation Inter-Agency Group (MMEIG) estimated the absolute number of maternal deaths in LAC at 7,300. Yet, progress towards improving maternal health has been uneven between and within countries. Of the 13 countries in LAC, the Bahamas, Bolivia, the Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, Panama, Paraguay, Suriname and Venezuela have an MMR above the regional average—between 89 and 359 for every 100,000 live births.<sup>8</sup> These countries also have high fertility rates, high poverty levels, and insufficient coverage and quality of care. Although no country achieved by 2015 the desired 75% reduction in this indicator, 12 countries reduced maternal mortality by more than half.<sup>8</sup>

Most of these maternal deaths are preventable. Access to quality maternal health care would prevent 54% of these deaths and universal access to family planning could prevent an additional 29% of maternal deaths.<sup>9</sup> The most frequent causes of maternal mortality in the region are hemorrhage (23.1%), pregnancy-induced hypertension (22.1%), indirect causes (18.5%), other direct causes (14.8%), complications associated with unsafe abortion (9.9%), and sepsis (8.3%).<sup>10</sup> Among the estimated 3.6 million adolescent pregnancies in the region in 2016, 1.4 million (39%) resulted in abortion, most of them clandestine and unsafe.<sup>11</sup> The indirect causes of maternal mortality have increased disproportionately in some countries, partly due to insufficient coverage and quality of prenatal care, and lack of access to modern contraceptives for women who do not wish, or are not able because of health reasons, to have more children. For example, 36% of adolescents in Latin America and the Caribbean have an unmet need for contraception.<sup>11</sup>

In El Salvador, women in the lowest income quintile have 3.9 times greater unmet need for contraception than those in the highest quintile; similarly, women in the lowest income quintile in Guatemala have 3.8 times greater unmet need for contraception. In Bolivia and Panama the unmet need for contraception is 3.6 times greater in the lowest income quintile. In Costa Rica, El Salvador, Guatemala, Panama, Peru and Suriname, women without a formal education have more than twice the unmet need for contraception than women who have completed at least high school.<sup>12</sup>

In the region, for every woman who dies from complications during pregnancy, childbirth, or the postpartum period, approximately another 20 (around 1.2 million women) every year suffer severe complications with long-term health impacts that may eventually result in death.<sup>5</sup> The number of women with serious morbidity related to pregnancy and childbirth varies according to the health facility, from 3 to 38 cases for every maternal death. In some hospitals, the morbidity rate is almost double the global average of 20 cases of serious morbidity for every maternal death. Although there have been some efforts to document serious maternal morbidity,<sup>†</sup> an essential strategy for preventing maternal deaths, few countries have implemented a standard to regularly record and analyze this indicator. Annex C shows the differences between the number of recorded maternal deaths in 1990 and estimated maternal deaths in 2015.

Inequity in access to high quality, respectful maternal health care within countries remains a challenge with human rights implications. The Latin America and the Caribbean region is one of the most unequal in the world, with 10 of 15

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† The Latin American Center for Perinatology, Woman and Reproductive Health designed a registration system—based on variables defined by the World Health Organization—that provides healthcare professionals with guidelines for the care of pregnant women, with the aim of anticipating and preventing these cases and documenting them.

countries having the highest levels of income inequality.<sup>13</sup> Maternal morbidity and mortality are exacerbated by inequity in income (income per capita), low educational attainment, malnutrition, lack of safe drinking water, low or uneven public health spending, geographical area of residence, membership in indigenous or Afro-descendant groups, and disability status, among other factors. Eleven out of 23 countries reported maternal mortality ratios equal to or greater than 125 maternal deaths per 100,000 live births in sub-national districts, and 7 countries reported even greater mortality in ethnic populations.<sup>14</sup> Weak health information systems and lack of disaggregated data complicate efforts to measure and take actions to remedy these inequalities.

Women living in poverty and from indigenous and Afro-descendant communities often experience inadequate and discriminatory care. They also face geographical, economic, cultural and social barriers to accessing quality services, and their social status is associated with higher mortality and morbidity.<sup>15</sup> Women seeking health services often find that health providers do not recognize or respect their culture and do not communicate in their language. After experiencing discriminatory and offensive treatment, women may find health services unacceptable and stop going to the health facility altogether. Countries with larger populations of indigenous peoples or Afro-descendants in Latin America (Bolivia, Brazil, Guatemala, Ecuador, Haiti, Mexico, Peru, and Dominican Republic) have the highest levels of MMR in the region or in the absolute number of deaths, as in the case of Brazil and Mexico. Even within countries, the MMR of indigenous and Afro-descendant women is significantly higher than for the rest of the population. For example, in Bolivia, the 2011 national study of maternal mortality showed that 68% of maternal deaths occurred in indigenous populations,<sup>16</sup> and Guatemala reported an MMR three times higher among indigenous than non-indigenous women.<sup>16</sup>

Similarly, studies in Brazil have found that in the state of Parana, women of African descent were three times more likely to die from maternity-related causes than other women.

The majority of countries still have not achieved universal access to essential reproductive health services. The region maintains the highest rate of unwanted pregnancy, 56%,<sup>17</sup> in the world and still has an unmet need for contraception between 19% for women in the highest income quintile to 31% for women in the lowest income quintile, indicating limited access to and use of contraception. About 32% of pregnancies in the region end in abortion.<sup>18</sup>

As of 2017, the Zika epidemic had affected 48 countries and territories in the Americas through local, mosquito-borne transmission of the virus.<sup>†</sup> In addition, five countries (Argentina, Canada, Chile, United States of America, and Peru) had reported sexually transmitted Zika cases. Between 2015-2017, 26 countries and territories reported 3,125 cases of the congenital syndrome associated with the Zika virus infection; the large majority of these cases were reported in Brazil (2,653).<sup>19</sup>

Zika response has focused on vector control to reduce the spread of disease among the general population and pregnant women, more specifically, to prevent potential harm to fetuses and newborns. However, governments should prioritize access to sexual and reproductive health and family planning services, especially for women who want to postpone pregnancy. Similarly, governments should strengthen efforts to provide comprehensive care, including mental health care, to mothers and caregivers of children with congenital syndrome. The financial repercussions of Zika on mothers and families with children affected by congenital syndrome remain unknown.

The total fertility rate in Latin America and the Caribbean is 2.15 children per woman, a notable decrease from 3.02 during the 1990-1995 period<sup>20</sup> and less than the global average of 2.53 children per

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† Anguilla, Antigua and Barbuda, Argentina, Aruba, Barbados, Belize, Bolivia, Bonaire, Brazil, Colombia, Costa Rica, Cuba, Curacao, Dominica, Dominican Republic, Ecuador, El Salvador, French Guiana, Granada, Guadalupe, Guatemala, Guyana, Haiti, Honduras, Jamaica, Martinique, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Bart's, Saint Martin, Saint Vincent and the Grenadines, Saint Lucia, St Kitts and Nevis, Saint Maarten, Saint Eustatius and Saba, Suriname, Trinidad and Tobago, Turks and Caicos Islands, United States, US Virgin Islands and Venezuela.

woman. Yet, this decrease has not been even across age groups. For example, the adolescent birth rate has remained relatively stable over the last two decades. Almost 2 million children, 13% of births, are born to adolescent mothers.<sup>21</sup> The adolescent birth rate in Latin America and the Caribbean is 73.2 live births per 1,000 women 15 to 19 years old, much greater than the global average of 48.9 per 1,000 and the average for developing countries of 52.7 per 1,000. The region's adolescent birth rate is almost double the levels for other regions, and is only surpassed by Sub-Saharan Africa, where it reaches 103 live births per 1,000 women ages 15 to 19. High adolescent birth rates are closely related to abuse and sexual violence, and, therefore, constitute a double social debt for adolescents.<sup>21</sup>

Adolescent pregnancies present a risk for the biopsychosocial health of young women and their children, especially for younger teenagers. In fact, pregnancy and childbirth are among the main causes of death for adolescent women ages 15 to 19 years in Latin America and the Caribbean.<sup>22</sup> The risk of maternal mortality for women 15 years and younger can be double or triple than that of women aged 15-to-19, the three main causes are: (1) hypertensive disorders, (2) late maternal deaths due to pregnancy or childbirth complications, and (3) unsafe abortions.<sup>23</sup>

Due to the effects of the demographic dividend, the size of the adolescent population will increase during the coming decades, and the availability of education and sexual and reproductive health services will impact achievement of the development goals.<sup>24</sup> In the region, adolescents still face barriers to accessing sexual and reproductive health services, and less than 10% of adolescents regularly use effective contraceptive methods. Although many countries in the region have established policies, guidelines and programs to support the sexual and reproductive health services and rights of adolescents, studies show that these are not generally supported by dedicated budget lines or by evidence-based strategies to improve the provision and universal access of adequate and timely quality services. Also, legal barriers persist in some countries and there is a need to strengthen intersectoral approaches and alliances, and to encourage enabling environments for adolescent sexual and reproductive rights.

The quality of care in reproductive health still requires considerable improvement; in particular, technologies and medical interventions continue to be overused. For example, health facilities have disproportionately increased the use of Cesarean section, which while it is considered a key obstetric intervention that saves lives, it can also unnecessarily put women and their babies at risk. In Latin America, almost four out of ten deliveries end in a Cesarean section (38.9%), well above the level recommended by WHO (between 10% and 15%).<sup>25</sup> In Brazil, for example, 54% of deliveries are through Cesarean section. The proportion of Cesarean section deliveries is increasing even in countries with a historical prevalence of normal deliveries, such as Bolivia, where Cesarean section deliveries rose from 14.6% in 2008 to 19% in 2012, or Peru, where they increased from 15.8% to 25% in the same period. On the other hand, Haiti, the country with the highest maternal mortality in the region, has a Cesarean section delivery rate of 5.5%, below the recommended levels, which indicates the inequity in access to essential obstetric care.

Abortion continues to pose a serious public health problem in the region. Annually it is estimated that 6.5 million abortions are performed in unsafe, high-risk conditions.<sup>26</sup> The rate of abortions performed under high-risk conditions is 31 abortions per 1,000 women between 15 and 44 years of age, versus 22 in the rest of the world; and the MMR due to abortions in high-risk situations is three times higher in Latin America and the Caribbean than in developed regions (10 and 3 maternal deaths per 100,000 live births, respectively).<sup>27</sup> The safety level of the procedure is directly related to the socioeconomic status of the woman, the capacity of the service provider, and the conditions in which the abortion is performed, thus, access to abortion is also affected by health care inequity. According to an analysis by the Guttmacher Institute,<sup>28</sup> the Caribbean is the region with the highest abortion rate, 6.5 for every 1,000 women between 15 and 44 years of age. Even though the abortion rate has substantially decreased from 46 during 1990-1994 to 27 per 1,000 women during 2000-2014 in developed countries, the reduction in developing countries (39 to 37 per 1,000 women in the same period) has been insignificant.<sup>27</sup>

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### 3. Lessons Learned in the 2004-2014 Decade

#### 3.1 Policies and Approaches that Contributed to the Reduction of Maternal Morbidity and Mortality

##### THE RIGHT TO HEALTH

Pregnant women's lack of access to acceptable, affordable, equitable and high-quality health services is a violation of their right to life, health, equity and non-discrimination. Maternal death and disabilities are generally preventable and the direct result of discriminatory laws and practices, the failure to establish and maintain operational health systems and services, and the lack of accountability.

In the past ten years, countries in the LAC region have incorporated rights-based principles and standards in their constitutions and laws; 18 countries refer specifically to the right to health and another five include social protection in health as a basic principle of the healthcare system. Countries that have prioritized maternal mortality have experienced significant and sustained reductions in their corresponding mortality rates. In spite of the requirements established by MDG 5 for maternal health, and the subsequent SDG target 3.1 for maternal mortality reduction, preventing maternal mortality remains a very low priority for many countries in the region.<sup>29</sup>

##### SOCIAL DETERMINANTS OF HEALTH

Social determinants of health refer to the different factors that may contribute positively or negatively to the health of individuals and communities.<sup>30,31</sup>

Social determinants are structural and intermediate; structural determinants refer to individuals' socioeconomic status and the political context. Intermediate determinants include material and psychosocial circumstances, biological factors, and the behavior of individuals, as well as the healthcare system itself.

The unequal distribution of determinants of health among the different social groups creates a hierarchy: the lower the socioeconomic position of an individual, the worse their health tends to be (social gradient of health).<sup>†</sup> Countries can move towards reducing health inequities by addressing the social determinants of health. This involves a commitment to universal health care access and coverage, the inclusion of a health approach in every policy, and targeting the most disadvantaged populations. In this sense, the countries in the region have been pioneers by approving two fundamental documents: the Strategy for Universal Access to Health and Universal Health Coverage<sup>32</sup> and the Plan of Action on Health in all Policies.<sup>33</sup> Addressing persistent inequities requires identifying target populations, tailoring strategies to address their needs, establishing the appropriate service delivery mechanisms and platforms, and allocating the necessary resources.

In Bolivia and Ecuador, for example, the right to health approach includes the concepts of equity, gender, diversity and interculturality, as well as the social determinants of health. The new constitutions of these countries emphasize the interrelation of health and development, recognize cultural pertinence, and guarantee free access to health care services for all at every level. Consistent with its constitution, Ecuador established the National Plan for "Good Living" 2009-2013,<sup>‡</sup> which prioritizes the reduction of maternal mortality.

##### POLICIES TO ELIMINATE ECONOMIC BARRIERS TO HEALTH CARE ACCESS

Three basic strategies improve access to health services, an essential step in reducing maternal mortality: increased investment in health (as a percentage of GDP); reduced out-of-pocket spending; and the establishment of social protection policies to achieve universal health coverage.<sup>34</sup> Costa Rica,

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† As an intermediate factor, the health care system and the way it is structured can be an important contributor to inequities in health. The reduced access to health services and the limited or reduced quality care plans for individuals of disadvantaged social classes, apart from constituting a determinant, are also violations of their human rights.

‡ *Buen vivir* (*sumaq kawsay* in Quechua), or "good living," originates from an indigenous tradition that values cultural sensitivity and living harmoniously in community and nature and resists competition, a distinctive feature of market-driven capitalism. Achieving *buen vivir* requires balancing social, cultural, environmental and economic issues.





Cuba, Chile, and Uruguay have enacted these types of policies and successfully reduced their maternal and child mortality rates. However, countries with more heterogeneous populations and greater inequities have experienced obstacles in implementing these types of strategies.

Since 2000, countries in the region have experienced notable economic growth and extreme poverty reduction. From 2005 to 2010, total health expenditure as a percentage of GDP increased from 6.8% of GDP in 2005 to 7.2% in 2010.<sup>35</sup> This correlated with the establishment or expansion of programs that aimed to reduce or eliminate economic barriers to health service access for the poorest segment of the population.<sup>†</sup>

According to studies on Brazil, Chile, Colombia, Jamaica, Mexico and Peru, over 90% of people have health insurance. Strategies to increase coverage have included: decentralization of services (Brazil and Peru); free health insurance for low-income families (Bolivia, Mexico, Peru); recognition of universal health care as a constitutional right and expansion of existing programs (Brazil and Chile); and private sector participation (Colombia).<sup>36</sup>

Researchers must still collect evidence to measure the impact of other social policies, such as conditional cash transfers to families living in poverty, on the demand for maternal health services during the last decade (Bolivia, Ecuador, Mexico, and Peru).

#### **IMPROVING THE AVAILABILITY OF DATA FOR DECISION-MAKING**

Strong, sustainable health programs depend on robust data. In recent years, efforts to strengthen national vital statistics systems have led to higher quality, timely maternal mortality data, fewer recorded incidences of “undefined” causes of death, and greater transparency and accessibility of data. Overall, more reliable evidence is available

for analysis and public policy decision-making.<sup>\*</sup> Some countries now offer online birth certificate registration and immediate access to identity documents, facilitating newborns’ enrollment in social programs. Yet, the reliability of maternal and neonatal mortality statistics varies among countries, and some have significant under-registration of deaths.<sup>37</sup>

Several governments in the region have dedicated special efforts and resources to improve information systems and administrative registries. However, gaps in data collection and analysis of the health situation and determinants of vulnerable populations remain, such as indigenous and Afro-descendant peoples, particularly at the sub-national level. Over the last decade, surveys and censuses have incorporated these variables and national information systems have started to include disaggregated data, such as age, sex, ethnicity, place of residence and socio-economic factors. To support these efforts, UN agencies and multilateral institutions have undertaken research on health determinants, conducted surveys, and provided technical assistance on the health determinants of indigenous and Afro-descendant populations in the region, using an equity, human rights and gender lens. This information is critical to better inform public policies and programming, and achieve more equitable access to health care.

Maternal mortality epidemiological surveillance and response is essential to understand why, how and where maternal deaths occur and to prevent them in the future. The region has shown progress in the implementation of these systems. For example, Colombia launched a web based surveillance system that is linked with the registry of vital records.

In spite of advances in maternal death surveillance, countries still need to decentralize evaluation and

† Argentina extended its *Plan Nacer* (Newborn Plan) in 2007 to the whole country, and Brazil expanded the Health for Families Program (*Programa Salud de la Familia*) to the country’s most remote areas. Other free national insurance programs include: Bolivia’s 2002 Universal Maternal-Child Insurance (*Seguro Universal Materno Infantil*); Mexico’s Popular Insurance (*Seguro Popular*); and Peru’s 2009 Law on Universal Health Assurance (*Ley Marco de Aseguramiento Universal en Salud*).

‡ Through the Regional Plan of Action for Strengthening Vital and Health Statistics, PAHO provides technical assistance to countries that are improving their health information systems. PAHO works with countries to improve quality and coverage, cooperation between countries, and collaboration among international agencies and stakeholders that work to improve data collection and analysis. The Latin American and Caribbean Network for the Strengthening of Healthcare Information Systems (RELACIS) was officially launched in 2010 to support efforts to strengthen health information systems in the PAHO/USAID project, in partnership with MEASURE Evaluation.



analysis of maternal and neonatal morbidity and mortality data to subnational and local contexts to help identify local determinants and propose targeted solutions.<sup>38</sup> To support these efforts, the GTR developed the Guidelines for Maternal Death Surveillance and Response: Region of the Americas,<sup>39</sup> in line with global maternal mortality surveillance guidelines.<sup>40</sup> The regional guidelines are adapted to the current needs and challenges in LAC and—along with case studies for Brazil, Colombia, El Salvador, Jamaica, and Mexico—are being used to strengthen the capacity of countries to monitor and respond to maternal and neonatal deaths, especially in rural and indigenous communities.<sup>†</sup>

#### **POLICIES FOR MATERNAL MORTALITY REDUCTION**

Over the last decade, many governments in the region implemented maternal mortality reduction policies. The key elements of these policies are described below:

##### **Quality of Care and Skilled Health Care Personnel**

A well-functioning health system requires a robust network of skilled, integrated, and adequately distributed health workers at all levels. Countries must create an enabling environment for health workers to be effective. Health workers need well-equipped facilities, essential medicines, sexual and reproductive health supplies, reference and counter-referral mechanisms, and affordable emergency transportation so that patients can reach essential services. In the region, the number of qualified health workers is insufficient to meet the needs of the population. Health personnel are concentrated in urban areas or migrate to countries with better working conditions. Recruiting and retaining qualified health professionals to serve poor or rural communities with the highest maternal mortality rates remains a challenge. Deploying professional midwives is a cost-effective strategy to address gaps in skilled personnel and ensure improved quality of care.<sup>41</sup> Governments should put in place incentives and improve working

conditions to retain healthcare workers in low-resource settings.

##### **Service Acceptability and Intercultural Approach**

An intercultural approach to health care involves respecting the culture and traditions of indigenous and Afro-descendent persons so they feel comfortable accessing care and following health provider recommendations. In 2014, UNFPA, in partnership with Family Care International (FCI) and other actors, supported the development of Intercultural Maternal Health Standards in six countries: Bolivia, Chile, Colombia, Ecuador, Panama and Venezuela. These standards are a tool to promote the adoption of best practices to overcome cultural barriers to care and improve maternal health in indigenous communities.

Traditional midwives still attend many births in rural areas in several countries. It is important to note that Bolivia and Ecuador have implemented strategies to include traditional midwives as part of the health team, and have fostered coordination of traditional midwives and health facilities as part of the health network. Many countries, such as Bolivia and Peru, have responded to cultural barriers to care by adopting childbirth practices, such as vertical delivery, that respect the traditions of indigenous peoples, and building maternity waiting homes near secondary level hospitals.

##### **Adolescent-friendly Health Services**

Even though national maternal mortality reduction plans do not specifically refer to the special needs of pregnant adolescents, countries have made significant progress in developing policies and programs to prevent adolescent pregnancy. In 2008, the Ministries of Health of the Andean Region launched the Andean Plan for the Prevention of Adolescent Pregnancy (Plan Andino para la Prevención del Embarazo en Adolescentes, PLANEA), which includes Bolivia, Chile, Colombia, Ecuador, Peru and Venezuela.\* Lessons and best practices from the Andean region have informed efforts in

† In partnership with the LAC Neonatal Alliance and the University of West Indies, GTR conducted a survey on maternal mortality epidemiological surveillance systems in the region, which has served to make concrete recommendations on how to address gaps and improve maternal and neonatal services.

‡ With funding from the Spanish Agency for International Cooperation and Development (AECID), UNFPA provided technical support to the Ministries of Health of the Andean Region, through ORAS-CONHU, to develop and launch the plan in partnership with ORAS-CONHU, OIJ and FCI.

Central America and the Dominican Republic, where the Commission of Health Ministries of Central America and the Dominican Republic (COMISCA), ratified the Regional Strategic Plan for Adolescent Pregnancy Prevention in 2015.<sup>†</sup> In addition, both the Caribbean and Southern Cone countries also have adopted and launched strategic frameworks to prevent and reduce unintended adolescent pregnancies.

These regional policies and plans have served to advance implementation of evidence-based policies in sexual and reproductive health and rights, including access to quality adolescent-friendly services or adolescent spaces, access to counselling and contraceptives, HIV prevention, comprehensive sexuality education, youth participation, prevention of sexual violence, particularly in girls below 15 years old, using a multisectoral and rights approach.

Universal and timely access to contraception is particularly difficult for adolescents. Low adolescent contraceptive use is evidenced by the high rate of adolescent fertility (75.5 live births for every 1,000 women, 15 to 19 years of age), surpassed only by Sub Saharan Africa (117.8 per 1,000). Over the last decade, more countries in the region have developed policies, programs and standards that target the specific sexual and reproductive health needs of adolescent girls and boys. In support of these efforts, in 2014, UNFPA, PAHO and FCI, with regional experts and national adolescent program directors from 21 LAC countries, developed standards for implementing and monitoring adolescent sexual and reproductive health services.\* English speaking Caribbean countries replicated this strategy at local health facilities in 2015 and 2016. In October 2015, the Chilean and Colombian Ministries of Health conducted surveys to assess the quality and measure the effective coverage of adolescent-friendly services, based on these standards.

#### **Monitoring and Accountability Systems**

Numerous initiatives provide examples of promising practices for monitoring maternal health programs

in the region. In Ecuador, following ministerial guidelines, service facilities monitor a set of indicators related to maternal health services and report to the Minister of Health on the status of these indicators on a monthly basis. Costa Rica established national and local maternal mortality committees to discuss causes of maternal deaths and strategies to prevent them. Argentina gathers data on maternal health service indicators through the on-line Perinatal Information System or SIP-Management. In Brazil, *Red Cigüeña's* (Stork Network) responds to phone calls from patients regarding their experiences in health facilities; the program uses these citizen reports to monitor quality of services.<sup>§</sup>

Community participation helps to improve documentation of maternal and neonatal mortality, especially in regions outside urban centers, and to identify possible factors associated with these occurrences.<sup>42</sup> Sexual and reproductive health and maternal mortality observatories in Argentina, Chile, Dominican Republic, Guatemala, Mexico, and Uruguay provide spaces for interaction between civil society and government. These observatories help to position women's health in national agendas and consolidate civil society demands for stronger political and financial commitment to sexual and reproductive health. Examples such as budget analysis of maternal programs by the Mexican Maternal Mortality Observatory, and local user committees in Ayacucho, Peru, demonstrate the capacity of citizens to engage in accountability for maternal and newborn health and rights, and their power to influence improvements in service supply and demand.

In line with the Global Strategy for Women's, Children's and Adolescents' Health, Bolivia, Brazil, Guatemala, Haiti, Mexico and Peru developed and implemented roadmaps to strengthen multi sector accountability processes for maternal and child mortality prevention programs.

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† With support from UNFPA, CLAP-SMR/PAHO-OMS, UNICEF and the World Bank.

‡ It is an adaptation of the WHO Global Standards: Global Standards for quality health care services for adolescents, 2015. Available at: [http://www.who.int/maternal\\_child\\_adolescent/documents/global-standards-adolescent-care/en/](http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/)

§ IEB reports, available at: <http://www.ieb.usp.br/>



**Figure 1: Essential Health Care Interventions by Critical Life Stage**

*Proposed by the Global Strategy for Women's, Children's and Adolescents' Health, 2015*

	<b>HOSPITALS</b>	<b>PRIMARY AND SECONDARY CARE</b>	<b>COMMUNITY-BASED CARE</b>
<b>Adolescents and Women</b>	<p>Sexual and reproductive health, including comprehensive package of family planning methods</p> <p>Hospital care for adolescent diseases and injuries</p> <p>Sexual and reproductive health services</p>	<p>Sexual and reproductive health, including the comprehensive provision of family planning methods</p> <p>Healthy adolescent development</p> <p>Prevention of high-risk behaviors, diseases and accidents</p> <p>Annual check-ups and access to routine care</p>	<p>Contraceptive services</p> <p>Pre-conception care: nutrition, vaccinations, prevention of use of tobacco, drugs, alcohol, gender-based violence and harmful practices</p> <p>Promotion of healthy behaviors in adolescence</p> <p>Social protection mechanisms for adolescents of both genders</p> <p>Comprehensive sexuality education</p>
<b>Pregnancy</b>	<p>Comprehensive care for the prevention and management of complications during pregnancy</p>	<p>Prenatal care to prevent and manage complications</p> <p>Care for spontaneous or incomplete abortions</p>	<p>Counseling and childbirth preparation, nutritional supplements, education about spacing between children, family planning/contraception within prenatal care</p>
<b>Labor and Delivery</b>	<p>Skilled birth attendance</p> <p>Comprehensive care for mothers and newborns experiencing complications</p>	<p>Skilled birth attendance</p> <p>Basic care for mothers and newborn babies with complications</p>	<p>Promotion of facility deliveries, maternity waiting homes in remote areas, referral and support, including communications and transport</p>
<b>Puerperium</b>	<p>Essential newborn care</p> <p>Care for underweight or sick newborns</p> <p>Care for mothers who suffered complications</p>	<p>Essential care for newborns</p> <p>Care for underweight or sick newborns</p> <p>Postpartum care for mothers</p>	<p>Essential care for newborns</p> <p>Postpartum care services</p> <p>Family planning and reproductive health as part of postpartum care</p> <p>Postnatal care home visits for mothers and newborns</p>
<b>Child</b>	<p>Hospital care for boys and girls with serious diseases</p>	<p>Prevention and management of infant diseases</p>	<p>Promotion of optimal practices for childcare in home settings</p>
<p><i>Intersectoral interventions: improvement in life and labor conditions, including dwellings, drinking water and sanitation, education, opportunities for women and girls, nutrition, secure and healthy work environments for men and women (including pregnant women), human rights protection, humanitarian interventions</i></p>			

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## 3.2 Provisions of and Demand for Reproductive, Maternal and Neonatal Health Services

### THE LIFE COURSE APPROACH, INTEGRATION AND PRIMARY HEALTHCARE

The life course approach examines how past events and social conditions at different points in the life cycle impact the health and risk for disease of an individual, a population, or future generations. Factors that influence a person or population's health trajectory include socioeconomic status, nutrition, health behaviors, exposure to toxins or environmental devastation, and stress. The life course approach to maternal health integrates effective health interventions and services for women, men, girls and boys, from pre-conception through pregnancy and childbirth, to the immediate postnatal and infancy periods, and continuing later with adolescent health care.<sup>43</sup> Newborn care is critical, considering that in Latin America and the Caribbean, 60% of deaths before the age of 5 occur during the first year of life, and 50% of those during the first 28 days. Figure 1 describes this life course approach, which is included in the most recent Global Strategy for Women's, Children's and Adolescents' Health.

Experience and evidence from the past decade have confirmed that effective interventions that save women's and newborns' lives already exist. Greater efforts are needed to integrate these interventions within health services throughout the continuum of care, including pre-conception care, prenatal care, and delivery and postpartum care, for both the mother and the newborn.

The region has made advances in integrating women's primary health care with family planning services, from prenatal care to prevention of vertical HIV transmission and care for HIV-positive pregnant women and their newborn babies. Now, further efforts must focus on systematizing and institutionalizing integration in a universal way,

so that integration becomes standard practice, ensuring that all services have access to the planning, service delivery and monitoring and evaluation tools that are already available and in use.

### ACCESS, USE AND QUALITY OF CONTRACEPTIVE SERVICES

In Latin America and the Caribbean, 65% of reproductive-aged women would like to prevent pregnancy. However, 24 million women have an unmet need for contraception, and 18 million do not utilize any method. According to current estimates, if all sexually active adolescents and adult women had access to modern contraceptives, there would be 400,000 fewer unintended pregnancies and 600,000 fewer induced (unsafe) abortions. Many maternal deaths could be prevented as a result. Therefore, access to counselling and ensuring a variety of contraceptive methods including the long-term reversible contraceptives (LARCs) are central to ensuring the right to decide freely the number, spacing and timing of their children, and therefore contribute to the reduction of maternal morbidity and mortality and to ensure the full exercise of sexual and reproductive rights and gender equality.

Currently, contraceptive use<sup>†</sup> within countries varies greatly, so the region needs to reduce these inequities and ensure all women and their partners have access to quality sexual and reproductive health information and services,<sup>‡</sup> that are timely and culturally pertinent, so that they can make informed decisions about if and when to have children. UNFPA's Global Programme to Enhance Reproductive Health Commodity Security represents a successful example of contraceptive access; the initiative provides a structure of rational, planned and sustainable approaches to promote the use of modern and effective contraceptive methods. Also, key partners and stakeholders have established the ForoLAC,<sup>§</sup> which implements advocacy and governmental and civil society engagement strategies to improve access to reproductive health supplies.

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† In Brazil, Mexico and the Dominican Republic, modern and more effective methods such as hormonal and surgical contraception are prevalent while a significant proportion of contraceptive users in Andean countries still rely on natural methods.

‡ The elements of quality of care are availability, affordability, and acceptability. See also the glossary at the end of this document.

§ The *Latin American and Caribbean Forum for Reproductive Health Commodity Security (ForoLAC)* provides an opportunity for partners in the region to share experiences and strategies to improve access to reproductive health commodities. For more information, consult: <http://www.rhsupplies.org/working-groups/forolac.html>

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### ACCESS, USE AND QUALITY OF PRENATAL CARE

Among women aged 15-49 years old who gave birth in 2014 in Latin America and the Caribbean, 97% received prenatal care from a qualified health worker (doctors, nurses, and childbirth attendants) at least once during their pregnancy.<sup>3</sup> However, a single prenatal visit is insufficient. WHO recommends at least four prenatal visits to improve maternal and neonatal health outcomes. Given the slow progress in maternal mortality reduction and the increase in maternal deaths from indirect causes, it is critical to consider quality of care and to implement strategies to expand coverage. Prenatal care is the entry point to ensure skilled birth attendance and access to emergency maternal and neonatal obstetric care. The region has improved practices related to prenatal care. Some of the strategies that governments and communities have put in place include evidence-based protocols for women and providers to agree on birthing plans; health networks maintaining a list of pregnant women and organizing outreach activities to reach these women; and continuous training of personnel in respectful maternity care. Examples include Argentina's "Te escucho" program to build health team capacity on respectful care and gender equality, and the institutionalization of a birthing plan in Ucayali, Peru using an intercultural approach, which makes provisions for linking prenatal care with delivery at facilities by skilled birth attendants. These efforts have resulted in an increase in the number of prenatal visits. However, quality of care remains a challenge. Health services should include continuous in-service training opportunities for their personnel to ensure compliance with the most up-to-date evidence-based guidelines and protocols to care for the specific needs of each patient.

### ACCESS, USE AND QUALITY OF SKILLED BIRTH ATTENDANCE

The observed discrepancies between the high coverage rates<sup>†</sup> for skilled birth attendance and high maternal mortality in several countries indicate a problem with the quality of services

provided. Although there is clear scientific evidence on effective interventions to improve maternal health and reduce maternal morbidity and mortality, a gap between evidence and clinical practice continues to exist. In fact, several studies show that providers are not putting effective interventions in practice, resulting in poor quality care.<sup>44</sup>

According to an analysis of the model of the *three delays* that lead to a maternal death, most maternal deaths are due to the *third delay*, which is a health system-related delay. Deaths are a result of poor quality care or lack of timely emergency obstetric care. In Mexico and the Dominican Republic, for example, these health system failures result in 75% to 80% of maternal deaths.

Ecuador, El Salvador, Guatemala, Honduras, Mexico (Chiapas), and Nicaragua are implementing interventions in low-resource settings to improve the quality of maternal and neonatal care services.<sup>‡</sup> Specifically, these countries are improving the quality of essential obstetric and newborn care in secondary and tertiary-level hospitals. Facilities have established systems to monitor services, equipment and supplies on a routine basis and to implement quality improvement plans, for example, related to the active management of the third stage of labor and neonatal care (screenings, heat, prophylaxis).

### ACCESS, USE AND QUALITY OF CARE DURING AN OBSTETRIC EMERGENCY

Proper and timely management of obstetric emergencies that pose significant threats to women's lives significantly reduces maternal morbidity and mortality. Pregnancy-induced hypertension, postpartum hemorrhage and complications related to unsafe abortion account for more than 60% of maternal deaths in the region. Most deaths related to postpartum hemorrhage occur in the first 24 hours after childbirth.<sup>45</sup> Preventing and treating postpartum hemorrhage would reduce maternal deaths significantly. Women who develop extreme maternal morbidity, require access to specialized care.

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<sup>†</sup> In Latin America and the Caribbean, the proportion of births attended by skilled personnel has increased 11% since 1990. In 2014, 92% of deliveries in the region were attended by a skilled birth attendant. Overall, 18 countries have over 95% rate of births attended by skilled personnel; and 10 are between 90% and 95%; Bolivia, Honduras and Nicaragua are between 80% and 90%, and Guatemala and Haiti, below 70%, need to redouble their efforts.

<sup>‡</sup> Iniciativa Salud Mesoamérica (Mesoamerican Health Initiative), Inter-American Development Bank.

Primary health care is the gateway to specialized services with the capacity to respond to complex cases and provide timely and adequate care tailored to each woman's needs. Essential obstetric care, accessible for all women at the primary and secondary levels, facilitates referrals to health facilities that are well-equipped to address high complexity cases, consequently, reducing incidences of maternal mortality.<sup>46</sup> The implementation of functioning health systems—based on the Three Delays and Safe Motherhood models—and coordination among health facilities and community-based care have enabled diagnosis, timely treatment and appropriate referrals of women and newborns experiencing complications most commonly linked with maternal and neonatal death. In addition, adoption of protocols that include active monitoring of severe maternal morbidity has facilitated the early detection of potentially fatal complications, and improved effective management of these complications.<sup>†</sup>

The Latin American Center for Perinatology (CLAP) and the Latin American Federation of Societies of Obstetrics and Gynecology (FLASOG), UNFPA and the University of Antioquia's Centro NACER developed a training module for the management of obstetric emergencies, particularly prevention and treatment of obstetric hemorrhage. As part of this strategy, PAHO incorporated high and low fidelity simulators to the Zero Maternal Deaths by Hemorrhage project and conducted trainings in Bolivia, Guatemala, Haiti, Honduras, Peru and the Dominican Republic, which improved provider response to postpartum hemorrhage.<sup>47</sup> UNFPA has supported the establishment of training centers in Cuba and Panama. Several online training courses in this issue has also been developed and implemented in several countries.

A biomedical model, centered on diagnosing and treating individual illness in hospitals, still dominates health care practice in the region, overshadowing the role of primary health care and public health that focus on prevention and healthy behaviors. The development of integrated health care delivery networks is still in its early stages. It is necessary to strengthen primary health care—in partnership with civil society—to respond to citizens' rights, needs, and demands.

### **RESPECTFUL MATERNITY CARE (RMC)**

Growing evidence confirms that disrespectful and abusive treatment can lead to harmful repercussions for maternal and neonatal health and affect women's decision to seek skilled care in the future. Obstetric violence<sup>48</sup> has serious consequences for the mother, her children and families, and even for the service providers themselves. In September 2014, WHO issued a statement on "The prevention and elimination of disrespect and abuse during facility-based childbirth." Other organizations have proposed initiatives and developed instruments to explicitly address this obstacle to accessing quality maternal health care and realizing basic human rights.<sup>49</sup>

An RMC survey conducted by Jhpiego through USAID's Maternal and Child Integrated Program, and which included nine countries from Latin America and the Caribbean,<sup>\*</sup> found promising experiences. One such example is Brazil's National Program for the Humanization of Birth, a campaign to promote RMC that gives awards to recognize efforts to improve the humanization and quality of maternity care.

† Uruguay and Guatemala (in the Rubel Tzul community) implemented pilot programs that included active monitoring of maternal morbidity of women attended by traditional birth attendants, to ensure timely referral to emergency obstetric care, with promising results.

‡ <https://www.k4health.org/toolkits/rmc/survey-rmc-country-experiences>



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## 4. Conclusions

Over the past two decades, the Latin America and the Caribbean region has made significant progress in reducing maternal morbidity and mortality. Most governments in the region now recognize that maternal mortality constitutes a grave public health problem and are adopting and implementing evidence-based policies, programs and interventions to reduce maternal death and disability. High-level political support for health system strengthening is required if we are to achieve universal health coverage. So are evidence-based policies, increased financial investments in cost effective reproductive, maternal and child health interventions, qualified health care providers, including midwives, and stronger maternal mortality surveillance and response systems.

At the same time, the region has also experienced a growth in social movements advocating for using an intercultural approach to transform birth into a respectful and humane experience, ensuring transparency and accountability. In recent years, many countries have committed to decreasing unintended adolescent pregnancies and their drivers, such as early marriage, sexual violence and limited access to integrated sexual and reproductive health services including effective contraceptives and education.

However, disparities in health outcomes persist. Vulnerable and excluded populations often still lack access to quality reproductive, maternal and

neonatal healthcare. In some countries, restrictive legislation prevents women and adolescents from accessing comprehensive sexual and reproductive health services and fully exercise their reproductive rights. Health systems are not sufficiently equipped to respond to the main direct causes of maternal deaths including unsafe abortion. An increasing number of maternal deaths are due to pre-existing conditions aggravated by pregnancy. The overuse of medical interventions remains a challenge in the region: elevated rates of C-sections can be a risk factor for maternal death. Finally, the region has not addressed the issue of equal access to care; while free or low cost public services exist in many countries, many women still do not have access to quality, life-saving care. In order to make universal health care a reality, governments must increase human resources for health and adequate deployment of skilled providers, particularly professional midwives, strengthen health systems, foster the implementation of human rights-based policies, and improve quality of care.

The GTR reaffirms its commitment to support countries and stakeholders to achieve their sustainable development goals, particularly to make universal access and coverage of quality sexual and reproductive health and rights a reality in Latin America and the Caribbean.

*No one will be left behind.*



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# Additional References

## *Annex A: Glossary*

### **ACCEPTABILITY**

All health facilities and the goods and services they provide must be respectful of medical ethics and be culturally appropriate. This means they must also be sensitive to gender issues and to needs related to the life cycle.

### **ACCESSIBILITY**

Health facilities and the goods and services they provide should be accessible to the entire population. Accessibility is measured by four dimensions: non discrimination, physical accessibility, economic accessibility (affordability) and access to relevant information.

### **ADOLESCENTS**

Following the United Nations definition, in this document, adolescents are understood to be between 10 and 19 years of age and youths are those between 15 and 24 years.

### **AVAILABILITY**

There must be a sufficient number of facilities, goods and services as well as health programs.

### **DIVERSITY APPROACH**

Recognizes the different capacities, characteristics and needs possessed by people and the many human groups that make up a society and a certain culture. The absence of exclusion and discrimination based on any kind of difference between individuals or groups, by age, gender, ethnicity, disability or other status, should be guaranteed in health care. Furthermore, services should be adapted according to the functional capabilities of individuals. In the field of sexual and reproductive health, for example,

it is essential that health personnel recognize that all human beings are sexual beings and that there are different sexual orientations and identities. The implementation of this approach implies respect, tolerance and non violence against people due to their differences.

### **EQUITY APPROACH**

Allows for the compensation and correction of certain inequities in access to resources and opportunities, promoting social inclusion and integration, and the human development of those who have historically been discriminated against and excluded from social and economic development. The application of this approach entails applying measures that favor the people who are in the most vulnerable condition and require special conditions to reduce differentiated health risks.

### **GENDER APPROACH**

Promotes the questioning and breaking down of those social and cultural patterns that support inequities based on gender differences and create spaces that facilitate the construction of identities for both men and women whose essential meaning is self realization and the overcoming of inequities. To achieve this, health care personnel should avoid reproducing gender stereotypes, relationships of subordination and discrimination between men and women and, instead, commit to strengthening egalitarian relationships that help overcome gender gaps.



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### **HUMAN RIGHTS APPROACH**

This approach is based on recognizing all individuals as right holders. This means that the person is seen as an active subject and not as a mere receiver of actions. It thus seeks to break with the charitable, welfare schemes and arbitrary or discretionary interventions. Discriminatory facts, whether by distinction, exclusion or restriction, the object or outcome of which is a violation of human rights must be eliminated. In this context, health services must involve respect for the dignity of individuals and their right to autonomy and to participation, among others.

### **INTERCULTURALITY**

In health is understood as the ability to act in a balanced way between different knowledge, beliefs and cultural practices with regard to health and sickness, life and death, and to biological, social and relational aspects. The latter are understood as not only the visible environments, but also the spiritual, cosmic dimension of health. Dialog and recognition of this diversity are a fundamental human right. The crux of this concept consists of guaranteeing that differences do not become discrimination but rather are recognized and exploited as sources of knowledge, thought and life experiences in society.

### **MATERNAL MORTALITY**

Refers to the death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to the pregnancy or aggravated by it or its care but not from accidental or incidental causes. Maternal mortality ratio (MMR) refers to the number of maternal deaths per 100,000 live births.

### **POTENTIALLY FATAL COMPLICATIONS**

Problems involving a wide variety of clinical situations that may endanger the lives of women during pregnancy, childbirth or the postpartum period. A WHO summary guide mentions five complications of this nature: severe postpartum hemorrhage, severe preeclampsia, eclampsia, sepsis or severe systemic infection, and uterine rupture.

### **RESPECTFUL MATERNITY CARE**

A human right of every childbearing woman in every health system. The treatment women receive can empower and comfort them or result in injury or emotional trauma. In many contexts, women do not use the services for fear of maltreatment.

### **SEVERE MATERNAL MORBIDITY**

A severe complication that occurs during pregnancy, childbirth and/or the puerperium that threatens the life of the woman or requires immediate attention in order to avoid death.<sup>†</sup> It is synonymous with extreme maternal morbidity, extremely serious maternal morbidity or near miss. The study and analysis of this is complementary to the investigation of maternal deaths to improve the quality of maternal health services.

### **SOCIAL DETERMINANTS OF HEALTH**

The specific characteristics and the ways in which an individual's social conditions affect their health. Social determinants are both socio individual, such as the individual's health practices, capacity and skills for adaptation, as well as those derived from the social structure, including poverty, education, work, gender and socioeconomic status. The former are known as proximal determinants and the latter as structural or distal determinants. Social determinants of health explain most health inequities the unfair and preventable differences within a country or between countries with regard to the health situation.

### **WOMEN OF REPRODUCTIVE AGE**

Refers to all women aged 15 to 49 years old. In some census and survey estimates, the upper limit is taken as 44 years. Recently, it has been recommended that the total fertility ratio include the age ranges of 15 to 44 and 15 to 49. It is common for births to girls under 15 years of age to be added to the group of 15 to 19 years; and those of women over 49 years, to births in the 45 to 49 year old group.<sup>50</sup>

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<sup>†</sup> Maternal Mortality Committee FLASOG. Santa Cruz de la Sierra, Bolivia, April 2007.



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## Annex B: The International Context for the Reduction of Maternal Mortality and Morbidity

### Conceptual Frameworks and Global and Regional Strategies

Reducing maternal mortality has been a priority on the international development agenda for the past fifteen years. Based on the Millennium Development Goals agreed on by the international community, maternal health is conceived not only as a human right, but also as a synonym for development. The international framework provides not only ethical and political support to reducing maternal mortality but also strengthens the commitment and provides opportunities to develop joint work strategies globally and in the region. This aims to guarantee compliance with the agreements and achievement of the goals on maternal health and sexual and reproductive health in the different national agendas.<sup>†</sup>

Over the last fifteen years, the international community has incorporated new approaches to improve maternal health including human rights, equity and accountability, life course approaches and the social determinants of health, with a gender and intercultural perspective. This new approach allows for the individual with their conditions and their needs to be placed at the center of health policies and programs.

The Global Strategy for Women's and Children's Health launched in 2010<sup>‡</sup> highlights the importance of using effective measures to strengthen the continuum of care, reviews the progress made and promotes new efforts to facilitate advances towards achieving the goals set in MDGs 4 and 5. Providing continuity to this initiative, and seeking to achieve maximum performance of the existing resources, whether financial, human, material or informational, in 2011, the WHO established a Commission on Information and Accountability on women's, girls' and boys' health

to accelerate the advances related to the "Every Woman, Every Child" global initiative.<sup>§</sup> In 2015 a new version of the Strategy was launched, as discussed below.<sup>§</sup>

To contribute to the improvement of the work to take place in the region between 2011 and 2015, PAHO developed the Regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Morbidity, with four strategic areas: (a) Prevention of unwanted pregnancies and resulting complications; (b) Universal access to high quality maternity services within the coordinated health care system; (c) Skilled human resources; and (d) Strategic information for action and accountability.<sup>§</sup>

The Human Rights Council provided fundamental support for the work on the prevention of maternal mortality with the publication of a report with technical guidelines about the human rights and accountability approach to motherhood and maternal morbidity.<sup>§</sup> The report includes the concepts of availability, accessibility, acceptability, quality, sustainability and participation, which are indispensable for the comprehensive human rights approach. It also outlines the enormous potential of this approach to improve health equity for women and provides a series of recommendations for work at all levels. It argues that sexual and reproductive health, including safe motherhood, require recognition of the fact that maternal mortality and morbidity are a human rights issue and, therefore, the deaths and serious injuries suffered by women during pregnancy and childbirth should be recognized as being preventable.

During the *Women Deliver* Conference in Bangkok in 2013, a group of organizations and key stakeholders conducted a technical consultation on goals and strategies to End Preventable Maternal Mortality (EPMM). This movement underlines the importance of maternal survival being included in

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† In particular, the ICPD regional agenda after 2014—the Montevideo Consensus on Population and Development (2013), and the Sustainable Development Goals.

‡ For additional information see: [http://www.who.int/pmnch/activities/jointactionplan/201009\\_gswch\\_sp.pdf](http://www.who.int/pmnch/activities/jointactionplan/201009_gswch_sp.pdf)

§ For additional information refer to: <http://www.everywomaneverychild.org/global-strategy-2argentina>

the context of the right to health care and being the highest sanitary priority throughout the life course. EPMM strategy goals are based on human rights and the imperative to eliminate inequities that lead to disparities in access to and quality of services. At a global level, the EPMM strategy established a goal of an average of 70 per 100,000 live births for the maternal death rate by 2030. For the same year, no country should have a maternal mortality rate greater than 140 per 100,000, which is twice the world average. For countries with a maternal mortality rate less than 420 per 100,000 live births, in 2010, they (most countries) should reduce this by at least two thirds by 2030.<sup>53</sup>

In the region, the first Regional Conference on Population and Development held in Montevideo in 2013 stands out. It was during this conference that joint commitments to reduce maternal mortality were negotiated. The following agreements reached in the Montevideo Consensus on Population and Development are particularly important: adopting a regional agenda on population and development for Latin America and the Caribbean, based on the Cairo Program of Action and its monitoring and the key actions for its further implementation beyond 2014; guaranteeing the effective participation of civil society and social movements in the implementation, monitoring and evaluation of the Cairo Program of Action after 2014, incorporating the measures agreed to in the Consensus; raising a proposal at the next meeting of the Statistical Conference of the Americas for the harmonization of health indicators for the region, in particular sexual and reproductive health indicators, to facilitate the comparison and analysis of regional trends.<sup>†</sup> In 2015, the commitment of the countries that participated in this meeting was renewed, with the adoption of the operational guide, which follows on from the regional concepts and commitments.

The Santo Domingo Consensus of the Regional Conference on Women reached in 2013 includes the countries' commitment in relation to maternal health and reducing maternal mortality. Since 1977, the Regional Conferences on Women in

Latin America and the Caribbean have also been essential inter governmental forums for advancing and consolidating gender equality and the human rights of women in the region. In 2016, the 40th anniversary of the regional conferences on women coincides with the newly released 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDG). At the XIII conference held in October 2016 in Montevideo, Uruguay, its operational strategy was expected to be designed in tune with the 2030 Agenda and the consensus prior to this Conference.

The initiative, A Renewed Promise in the Americas: To Reduce Inequities in Reproductive, Maternal and Child Health (2013) is a regional movement centered on addressing the inequities affecting the most disadvantaged populations, with improved monitoring and analysis of information, and greater collaboration of the public and private sectors. To date, 32 governments of the Americas have signed this commitment, which aims to eliminate preventable child deaths and ensure a healthy start to the lives of boys and girls.

In partnership with UNFPA and WHO, the International Confederation of Midwives prepared a publication, The State of the World's Midwifery 2014,<sup>40</sup> which analyzes the worldwide practice of this profession. The publication is accompanied by an advocacy strategy and a toolbox to strengthen the role of professional midwives in health services and highlights the capacity of midwives to reduce maternal and infant mortality.\*

In recent years, the WHO has been working to further the promotion of respectful maternity care. To this end, four investigations were carried out. Likewise, the declaration, The Prevention and Elimination of Disrespect and Abuse during Facility based Childbirth, was launched at the United Nations General Assembly in 2014. This was translated into 12 languages and backed by more than 80 organizations, including the International Federation of Gynecologists and Obstetricians, the International Confederation of Midwives and the United States Agency for International

† <https://www.cepal.org/en/publications/21860-montevideo-consensus-population-and-development>

‡ [http://www.familycareintl.org/UserFiles/File/SoMWy\\_Toolkit\\_Spanish\\_Dec3\\_2014.pdf](http://www.familycareintl.org/UserFiles/File/SoMWy_Toolkit_Spanish_Dec3_2014.pdf)

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Development. The document states that *“Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination”*.<sup>52</sup>

In 2015, United Nations member states agreed on the 2030 Agenda for Sustainable Development, in which goal number 3 is “Ensure healthy lives and promote well being for all at all ages”. This goal includes the need to achieve universal health coverage, access to sexual and reproductive health services, as well as quality and affordable vaccines and medicines. Reducing maternal and child mortality remains a central challenge in the new agenda.

The updated Global Strategy for Women’s, Children’s and Adolescents’ Health, launched in September 2015, supports the Sustainable Development Goals (SDGs) related to the health of women, boys, girls

and adolescents as part of a more integrated development framework in which all countries will be supported to achieve and maintain their health goals. It also includes a more comprehensive approach that transcends reductions in mortality with a vision of a healthy life for all throughout the life cycle. This new version has been discussed in broad consultation since the beginning of 2015, leading to its approval in September 2015. (Annex D).

As for equal access for vulnerable groups and those in situations of exclusion, the United Nations International Expert Group on Intercultural Health promotes equal access to health, and the Standards are an important contribution to this goal in the region. Likewise, the Commission on Intercultural Health of ORAS-CONHU, supports the Intercultural Maternal Health Standards. This work is part of the agreements reached at the UN Permanent Forum on Indigenous Issues.

## Annex C: Regional Trends in Maternal Mortality

Figure 2: Number of Maternal Deaths and Maternal Mortality Ratio (per 100,000) Registered and Estimated Live Births, 1990 and 2015<sup>†</sup>

	Maternal Mortality Ratio, 1990 ( <i>per 100,000 live births</i> )	Total Number of Deaths, 1990	Estimated Maternal Mortality Ratio, 2015 ( <i>per 100,000 live births</i> )	Estimated Total Number of Deaths, 2015
<b>LATIN AMERICA AND THE CARIBBEAN</b>	135	16,000	67	73,000
<b>LATIN AMERICA</b>	126	14,000	60	66,000
<b>CARIBBEAN</b>	276	2,300	175	1,300

<sup>†</sup> Source: Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>



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## *Annex D: The SDGs and the New Global Strategy for Women's, Children's and Adolescents' Health<sup>†</sup>*

Following the end of the Millennium Development Goals (MDG) era in 2015, governments adopted the Sustainable Development Goals (SDGs). Unlike the MDGs, these goals are the result of a broad global consultation process that included governments, civil society, technical experts, youth, the private sector and other stakeholders. The 17 interrelated goals, which will guide the development agenda over the next 15 years, cover all areas of human development.\*

Accompanying this process, the United Nations Secretary General launched the updated Global Strategy for Women's, Children's and Adolescents' (2016-2030) in September 2015.<sup>‡</sup> This is a human-centered roadmap to enable the implementation of the SDG agenda, particularly in relation to the three goals related to sexual, reproductive, maternal and neonatal health:

**Objective 3:** Ensure healthy lives and promote well being for all at all ages.

**Objective 5:** Achieve gender equality and empower all women and girls.

**Objective 10:** Reduce inequality within and among countries.

The Strategy is organized around three themes: (a) survive, that is, ending preventable maternal, child and adolescent mortality; (b) thrive, enabling newborns, boys, girls and adolescents to reach their physical, mental and social potential; and (c) transform, with the goal of generating a people centered movement for changes in the health and sustainable development of women, children and adolescents.

The Global Strategy proposes seven transformative actions based on the principles of human rights and equity, which recognize the right of every person around the world to enjoy their human rights and live with dignity, security and without discrimination, oppression and persecution. These seven actions are:

1. Realize potential and increase opportunities.
2. Obtain and sustain progress through national leaders and their resources.
3. Strengthen the resilience and effectiveness of health systems.
4. Achieve intersectoral partnerships for health and sustainable development.
5. Address inequities and fragilities in all sectors.
6. Accelerate progress through innovation and research.
7. Increase accountability with national data and initiatives at all levels.

The transformative actions influence the multiple factors affecting the realization of rights, including the social determinants of health, the life cycle approach, and the role of the health-supporting sectors. While reproductive, maternal, newborn, children and adolescent's health are at the center of the Strategy, its scope is much broader and intersectoral.

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<sup>†</sup> <http://crowd360.org/shaping-the-future-for-healthy-women-and-children/>

<sup>‡</sup> Available at: <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>

<sup>§</sup> Available at: <http://apps.who.int/gho/data/node.gswcah>

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