El Rol de la anticoncepcion en la reduccion de la Mortalidad Materna en America Latina

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PHO

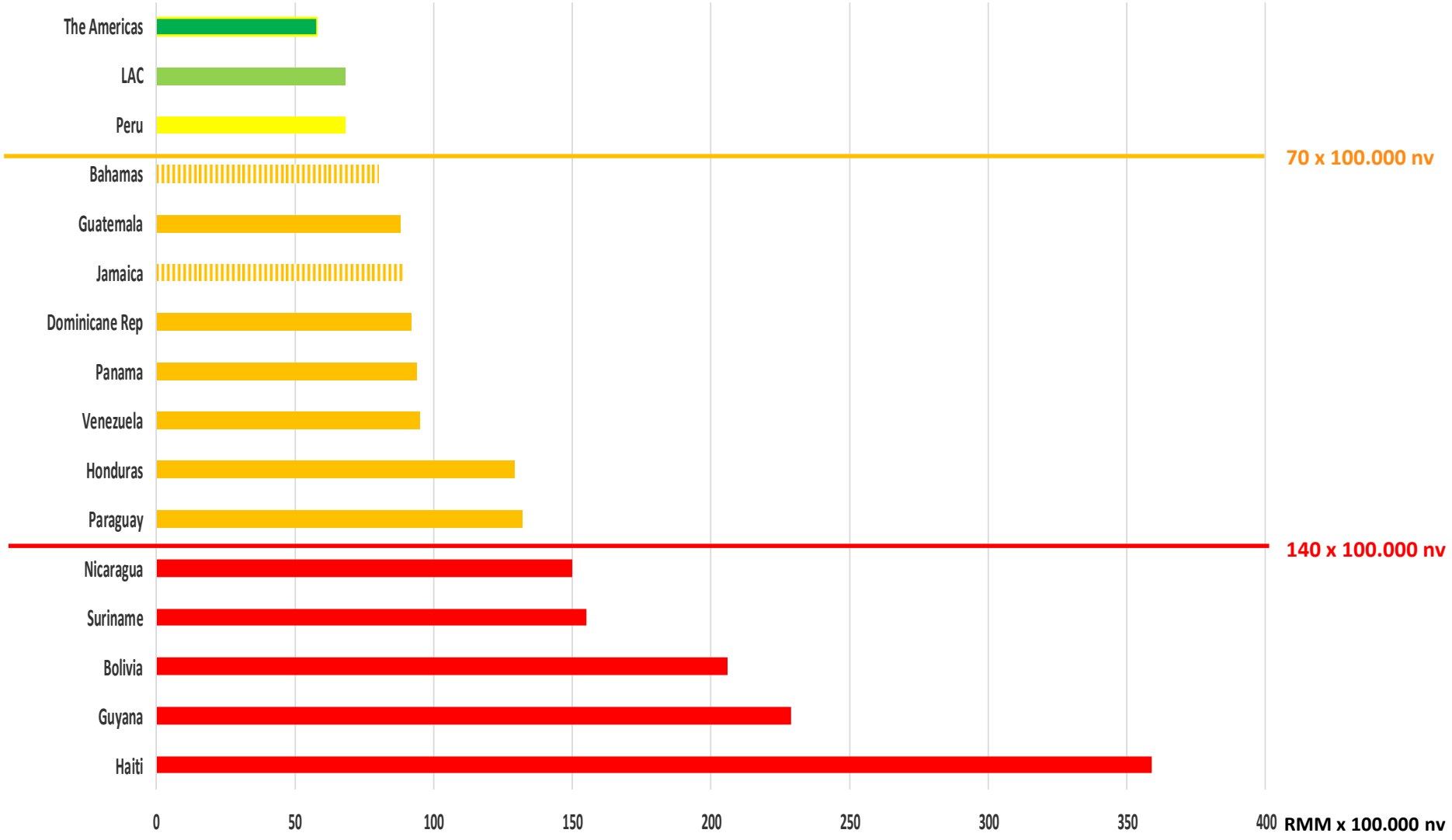
WHO

CENTRO LATINOAMERICANO DE PERINATOLOGÍA
SALUD DE LA MUJER Y REPRODUCTIVA - CLAP/SMR

Family planning is one of the most cost-effective investments a country can make in its future. It offers a range of potential benefits that encompass **economic development**, **maternal and child health**, **education**, and **women's empowerment**.

Ayşe Akin. Moazzam Ali. Celebrating the 25th anniversary of the International Conference on Population and Development: A perspective from Turkey. International Journal of Gynecology & Obstetrics. https://doi.org/10.1002/ijgo.13029

Países con RMM por encima de las medias regionales, 2015



Fuente: WHO. Trends in maternal mortality 1990 – 2015

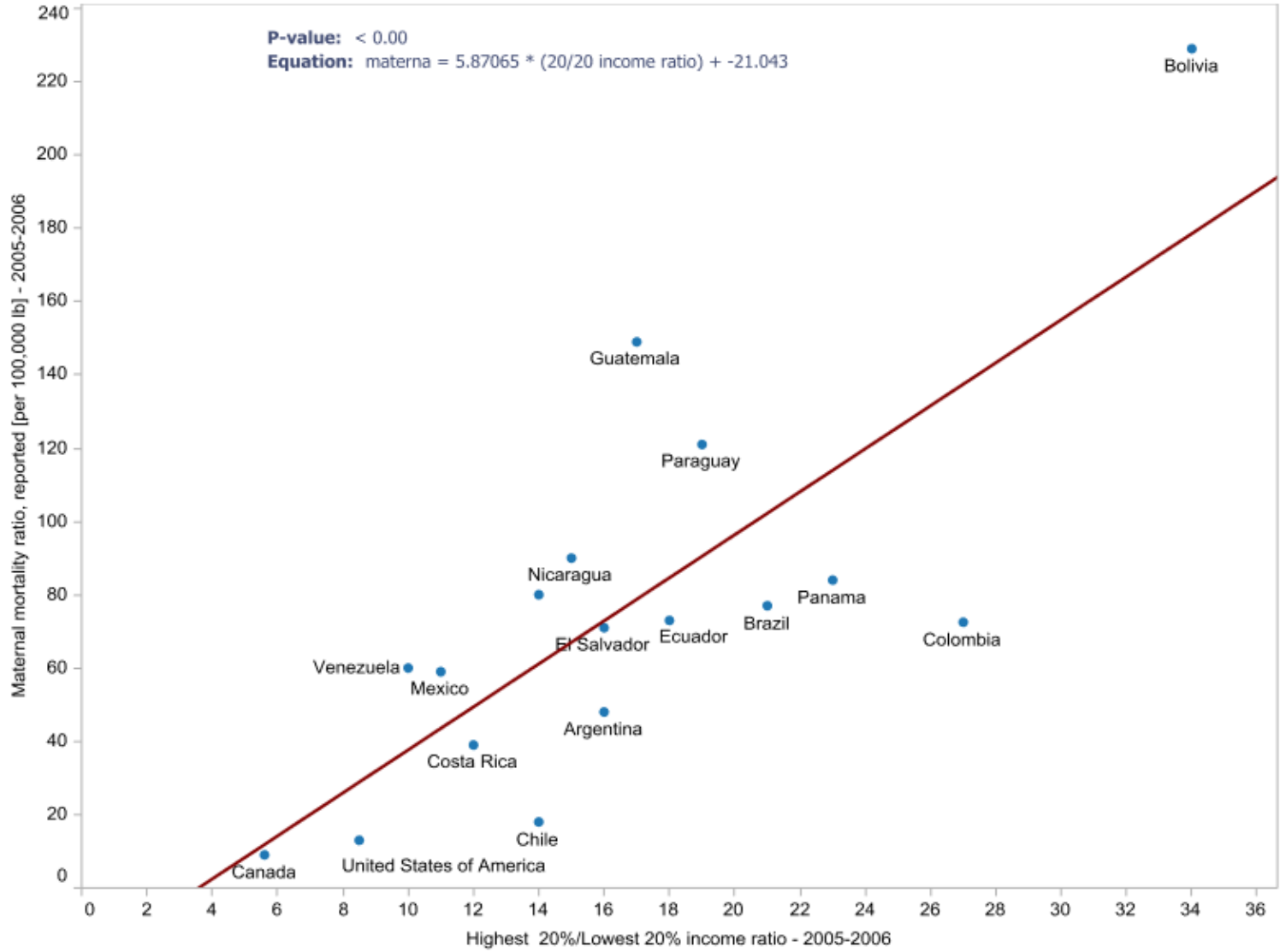
Indicadores seleccionados países de LAC con IDH ranqueados mas allá de la posición 100

Año / País	2015		2017	2017	2015
	IDH *	Ranking IDH	Cuidado antenatal debajo de la media regional (88,3%) de	Atención institucional del parto debajo de la media regional (94,8%) de	RMM por encima de la media regional (52 por 100.000 nv)
Belice	0,715	101	> 88,3%	93,2%	< 52
R. Dominicana	0,715	101	> 88,3%	> 94,8%	**92**
Surinam	0,714	103	66,8%	80%	**155**
Paraguay	0,679	112	77,4%	> 94,8%	**132**
El Salvador	0,666	116	75,1%	> 94,8%	**54**
Bolivia	0,662	119	> 88,3%	71,4%	**206**
Guyana	0,636	124	> 88,3%	90%	**229**
Nicaragua	0,631	125	68%	88,5%	**150**
Guatemala	0,627	128	43%	66%	**88**
Honduras	0,606	131	> 88,3%	79%	**129**
Haití	0,483	163	67%	50%	**359**
Perú	0,734	84	> 88,3%	91,9	**68**

- De un total de 188 países se seleccionaron aquellos países de las Américas que se ubicaron por encima del puesto 100

Fuentes: Índice de Desarrollo Humano – IB OPS 2017 – WHO Trends in Maternal Mortality Estimates 1990 - 2015

Maternal Mortality ratio [per 1,000 lb] and the highest 20%/ lowest 20% income ratio, estimated 2006



Fuente: PAHO Regional Health Observatory

ENFOQUE EN LA POBLACIÓN MÁS POBRE Y DESFAVORECIDA DE MUJERES, NIÑAS, NIÑOS Y ADOLESCENTES

SALUD MATERNA

ACCESO A CUIDADOS PRENATALES. PARAGUAY 2008

(Según lengua que se habla en el hogar)

Porcentaje de mujeres que tienen 4 visitas prenatales

GUARANÍ | GUARANÍ Y ESPAÑOL | ESPAÑOL | PROMEDIO

PARTOS ATENDIDOS POR PERSONAL DE SALUD CAPACITADO

MUJERES INDÍGENAS | MUJERES NO INDÍGENAS

MORTALIDAD MATERNA

Se ha registrado una **mayor proporción de morbilidad y mortalidad materna en mujeres indígenas que en mujeres no indígenas.**

MORTALIDAD NEONATAL

Los estudios muestran una alta mortalidad neonatal en los grupos indígenas y afrodescendientes

La reducción de la mortalidad neonatal en Brasil ha sido **menor en las poblaciones afrodescendientes** que entre otros grupos. Los niños y niñas afrobrasileros tienen más bajo peso al nacer, mayor prematuridad y mayor mortalidad neonatal e infantil que los niños y niñas de otros grupos

SALUD INFANTIL Y NUTRICIÓN

En Ecuador, la mortalidad infantil en áreas rurales indígenas es **cerca del doble** que la de los niños no indígenas.

DESNUTRICIÓN CRÓNICA EN GUATEMALA

Guatemala es el país con la más alta prevalencia de desnutrición en América Latina y El Caribe

Comparativo entre niños indígenas y no indígenas.

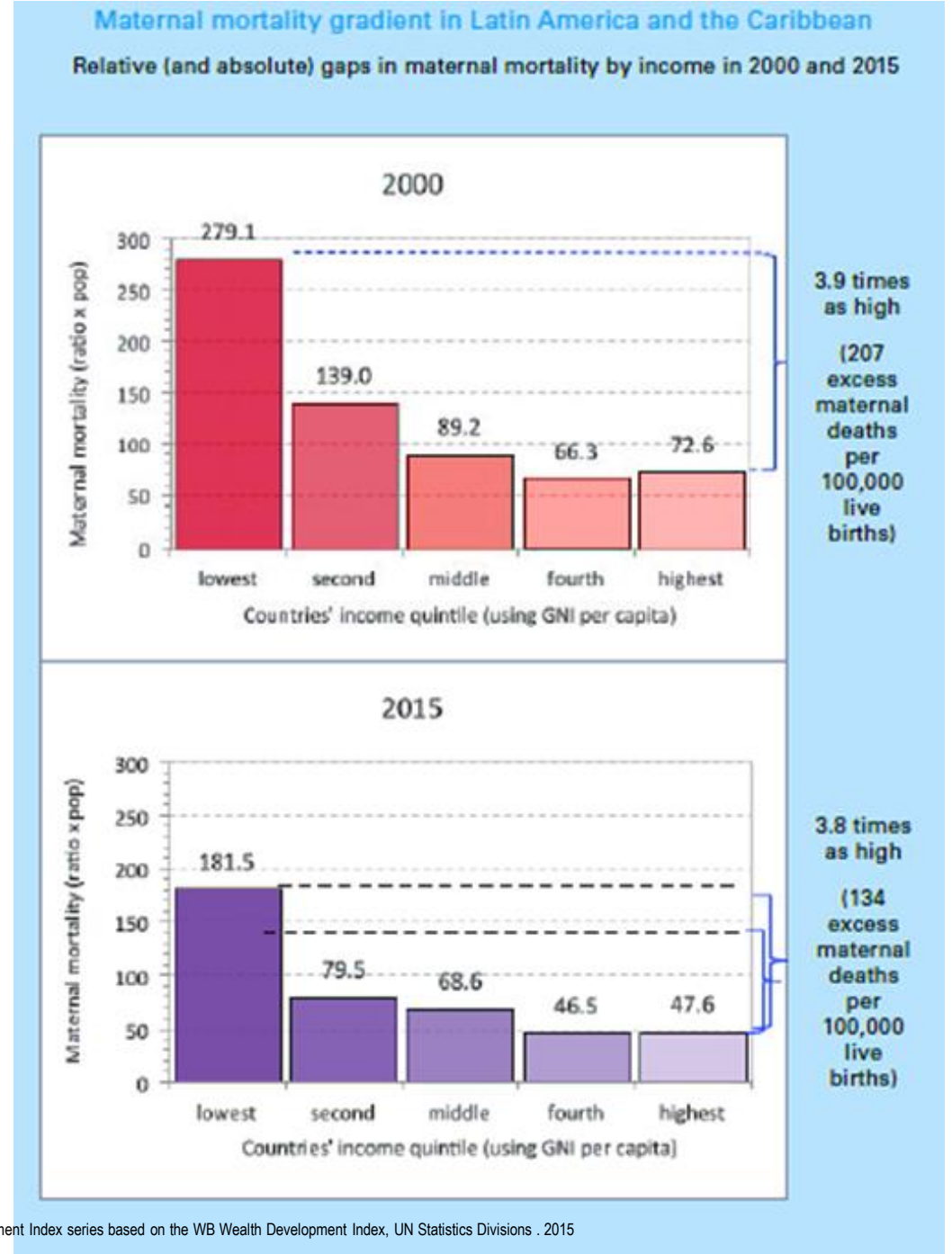
PERÚ Y MÉXICO HAN TENIDO UN GRAN PROGRESO EN EL ACCESO A SERVICIOS DE SALUD MATERNA PARA POBLACIONES INDÍGENAS

- En la era de los ODM, la indigencia y la pobreza se redujeron, pero la inequidad no se redujo.

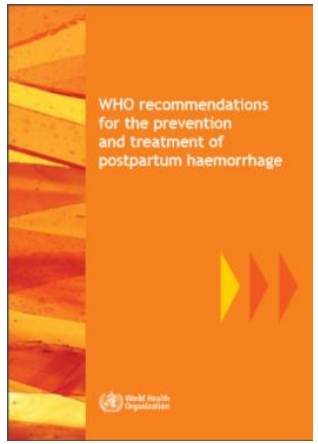
Inequidades en la mortalidad materna en ALC

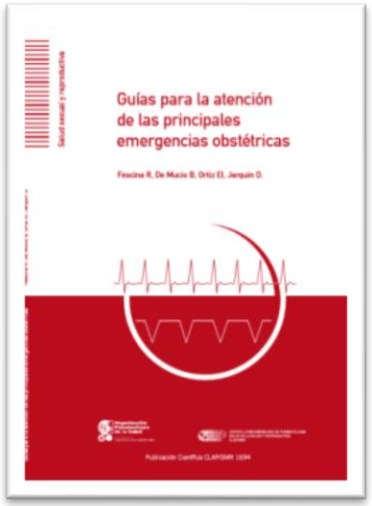
El único ODM al que no llegó ningún país de la región fue el ODM 5: su Objetivo 5 A (reducir MM en un 75% de 1990 a 2015)

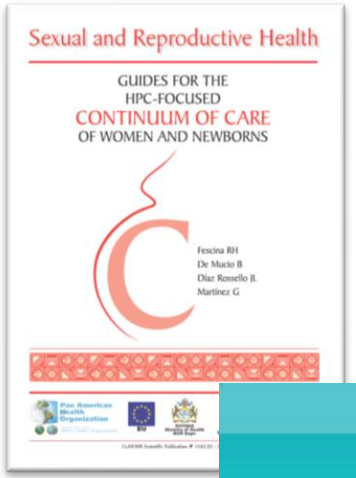
- Mientras los esfuerzos de los países no tengan en cuenta un enfoque basado en las desigualdades, no será posible lograr la eliminación de las muertes por causas prevenibles.



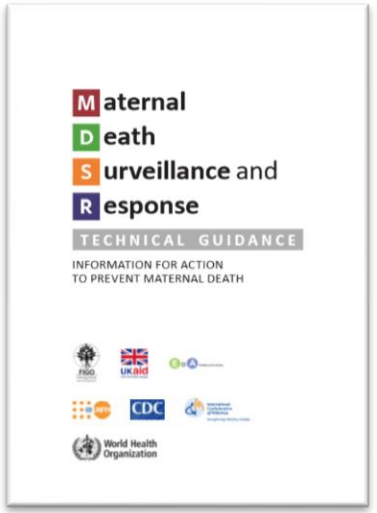
WHO/UNICEF/UNFPA/WB/UNDP 2015. Trends and levels of maternal mortality2015. For GNI per capita UNDP, Human Development Index series based on the WB Wealth Development Index, UN Statistics Divisions . 2015

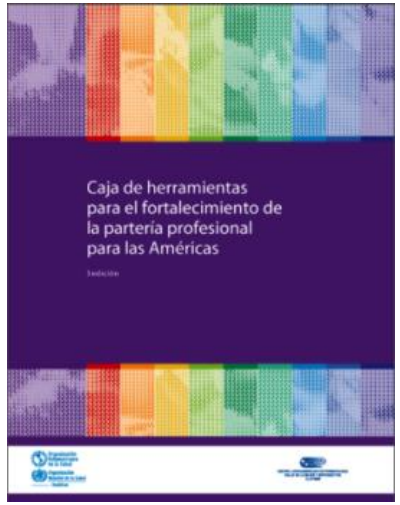

WHO recommendations
for the prevention
and treatment of
postpartum haemorrhage

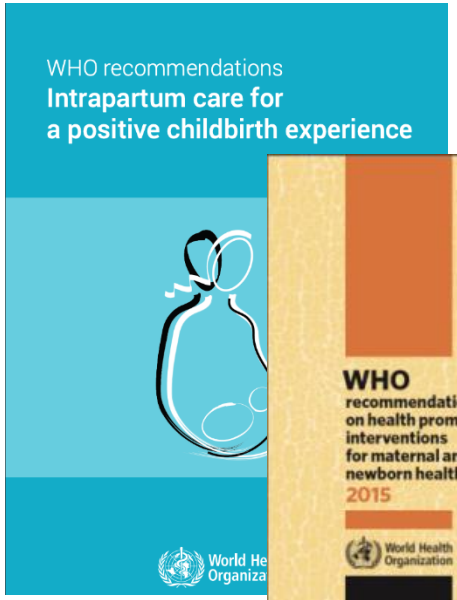

Guías para la atención
de las principales
emergencias obstétricas

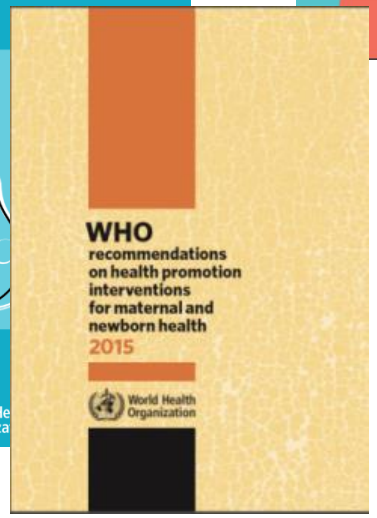

Sexual and Reproductive Health
GUIDES FOR THE
HPC-FOCUSED
CONTINUUM OF CARE
OF WOMEN AND NEWBORNS


Recomendaciones de la OMS sobre
atención prenatal para una
experiencia positiva del embarazo

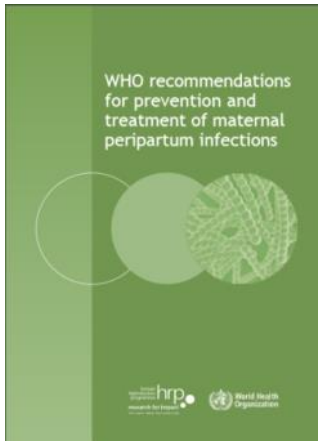

Maternal
Death
Surveillance and
Response
TECHNICAL GUIDANCE
INFORMATION FOR ACTION
TO PREVENT MATERNAL DEATH

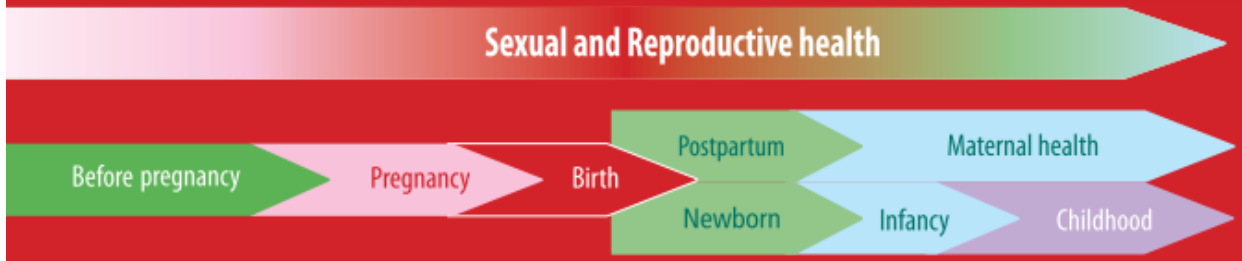

Caja de herramientas
para el fortalecimiento de
la partería profesional
para las Américas


WHO recommendations
Intrapartum care for
a positive childbirth experience


WHO
recommendations
on health promotion
interventions
for maternal and
newborn health
2015


Recomendaciones de la OMS para la
conducción del
trabajo de parto


WHO recommendations
for prevention and
treatment of maternal
peripartum infections



Packages of Interventions

for Family Planning, Safe Abortion care, Maternal, Newborn and Child Health

World Health Organization

Childbirth care

Interventions at Home/COMMUNITY level	Key supplies and commodities needed
■ Companion of choice to support the woman to attend a facility ■ Support for care for the rest of the family ■ Support for transport	■ Job aids ■ Birth and emergency cards
Childbirth care at FIRST LEVEL FACILITY	**Key supplies and commodities needed**
All of the above plus: ■ Care during labour and delivery □ Diagnosis of labour □ Monitoring progress of labour, maternal and fetal well-being with partograph □ Companion of choice to support the woman □ Infection prevention □ Supportive care and pain relief □ Detection of problems and treatment of complications (e.g. malpresentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection) □ Delivery and immediate care of the newborn baby □ Initiation of breastfeeding □ Newborn resuscitation □ Active management of third stage of labour ■ Immediate postpartum care of mother □ Monitoring and assessment of maternal well being, prevention and detection of complications (e.g. hypertension, infections, bleeding, anaemia) ■ Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction; breech presentation, episiotomy, repair of genital tears, manual removal of placenta) ■ Pre-referral management of serious complications (e.g. obstructed labour, fetal distress, preterm labour, severe peri- and postpartum haemorrhage) ■ Support for the family if maternal or perinatal death ■ Counselling for family planning including insertion of IUDs	All of the above plus: ■ Delivery set ■ Oxytocin ■ Partograph ■ Sphygmomanometer ■ Stethoscope ■ Thermometer ■ Vacuum extractor ■ Gloves ■ IV fluids ■ Parenteral antibiotics and MgSO4 ■ Analgesia ■ Oxygen ■ Newborn suction device ■ Newborn resuscitation device ■ Home-based maternal record ■ IUDs ■ Insecticide treated bednets ■ Magnesium sulphate ■ Calcium gluconate ■ Vitamin K
Situational	**Key supplies and commodities needed**
All of the above plus: ■ Vitamin A administration for mother ■ HIV testing and counselling ■ Prevention of mother-to-child transmission of HIV by mode of delivery, guidance and support for chosen infant feeding option ■ Care for HIV positive women/ART	All of the above plus: ■ Vitamin A ■ Antiretroviral drugs ■ Cotrimoxazole
Childbirth care at REFERRAL FACILITIES	**Key supplies and commodities needed**
All of the above plus: ■ Treatment of severe complications in childbirth and in the immediate postpartum period, including caesarean section, blood transfusion and hysterectomy) ■ Induction and augmentation of labour ■ Management of other obstetric complications	All of the above plus: ■ Surgical kit ■ Anaesthetic medicines and medical devices ■ Blood and blood transfusion kits ■ Laboratory equipment for biochemical and microbiological tests

Postpartum care

Interventions at Home/COMMUNITY level	Key supplies and commodities needed
■ Information and counselling on self care at home, nutrition, safer sex, breastfeeding, family planning, healthy lifestyle including harmful effects of smoking and alcohol use ■ Support for exclusive breastfeeding ■ Safe disposal / washing of pads ■ Support for rest and less work load ■ Malaria prevention and management of malaria ■ Support for complication with prevention measures and treatments ■ Family planning / birth spacing ■ Recognition of dangers signs, including blues / depression ■ Awareness of signs of domestic and sexual violence and referral ■ Support for women living with HIV/AIDS including ART ■ Reporting birth and death (vital registration) ■ Use of insecticide treated bed nets	■ Counselling, health education and promotion materials ■ Home-based maternal records ■ Insecticide treated bed nets (ITN) ■ Job aids ■ Contraceptives including condoms ■ Birth and emergency cards
Postpartum care at FIRST LEVEL FACILITY	**Key supplies and commodities needed**
All of the above plus: ■ Assessment of maternal wellbeing including maternal nutrition ■ Prevention and detection of complications (e.g. infections, bleeding, anaemia) ■ Anaemia prevention and control (iron and folic acid supplementation) ■ Provision of contraceptive methods ■ Treatment of some problems (e.g. mild to moderate anaemia, mild puerperal depression, mastitis) ■ Pre-referral treatment of some problems (e.g. severe postpartum bleeding, puerperal sepsis) ■ Recording and reporting	All of the above plus: ■ Sphygmomanometer ■ Stethoscope ■ Thermometer ■ On site tests (Hb, HIV, syphilis) ■ Vaccines (TT) ■ Basic oral medicines ■ IV fluids ■ Antibiotics, MgSO4, oxytocin ■ Gloves ■ Analgesia ■ Oxygen ■ Magnesium sulphate ■ Calcium gluconate
Situational	**Key supplies and commodities needed**
All of the above plus: ■ Antiretroviral treatment (ART) ■ Treatment of uncomplicated malaria	All of the above plus: ■ Antiretroviral drugs ■ Antimalarial drugs
Postpartum care at REFERRAL FACILITY	**Key supplies and commodities needed**
All of the above plus: ■ Treatment of all complications □ severe anaemia □ severe postpartum bleeding □ severe postpartum infections □ severe postpartum depression ■ Tubal ligation and vasectomy ■ Contraceptive implants	All of the above plus: ■ Surgical kits ■ Anaesthetic medicines and medical devices ■ Laboratory equipment for biochemical and microbiological tests ■ Blood and blood transfusion sets
Situational	**Key supplies and commodities needed**
All of the above plus: ■ Treatment of complicated malaria	All of the above plus: ■ Antimalarial drugs

WHAT IS NEEDED?

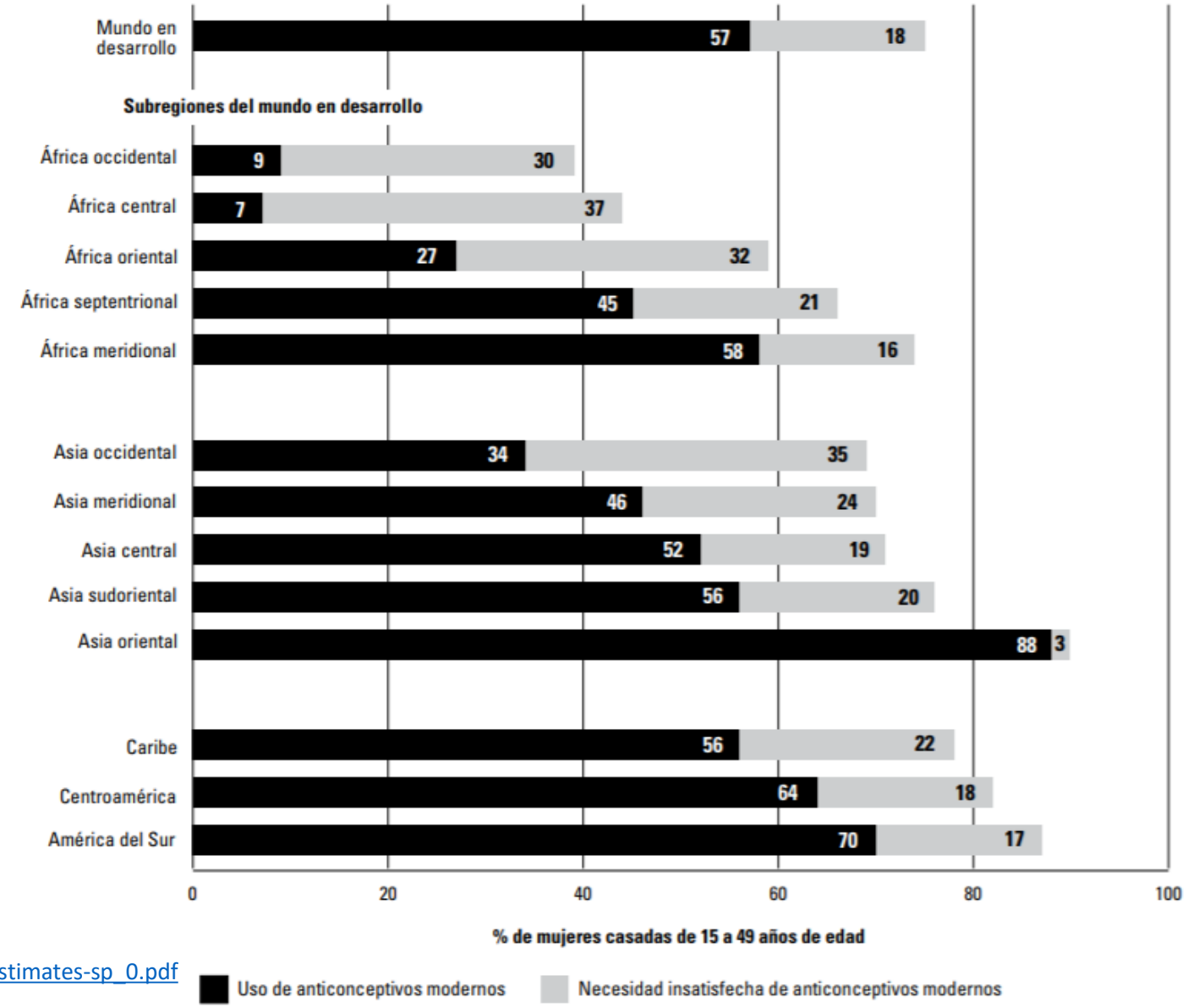
- **Political will & commitment**
- **Health & wellbeing:** nutrition, education, water sanitation & hygiene
- **Contraception & safe abortion services**
- Efforts to **reach everyone, everywhere**
- **Strong health systems** with trained health workers & essential medicines
- **Improved access to quality care** before, during & after childbirth
- **Accountability:** every death must be counted & its cause recorded

NO WOMAN SHOULD DIE IN PREGNANCY AND CHILDBIRTH

JUNE 29, 2017 | INFOGRAPHIC

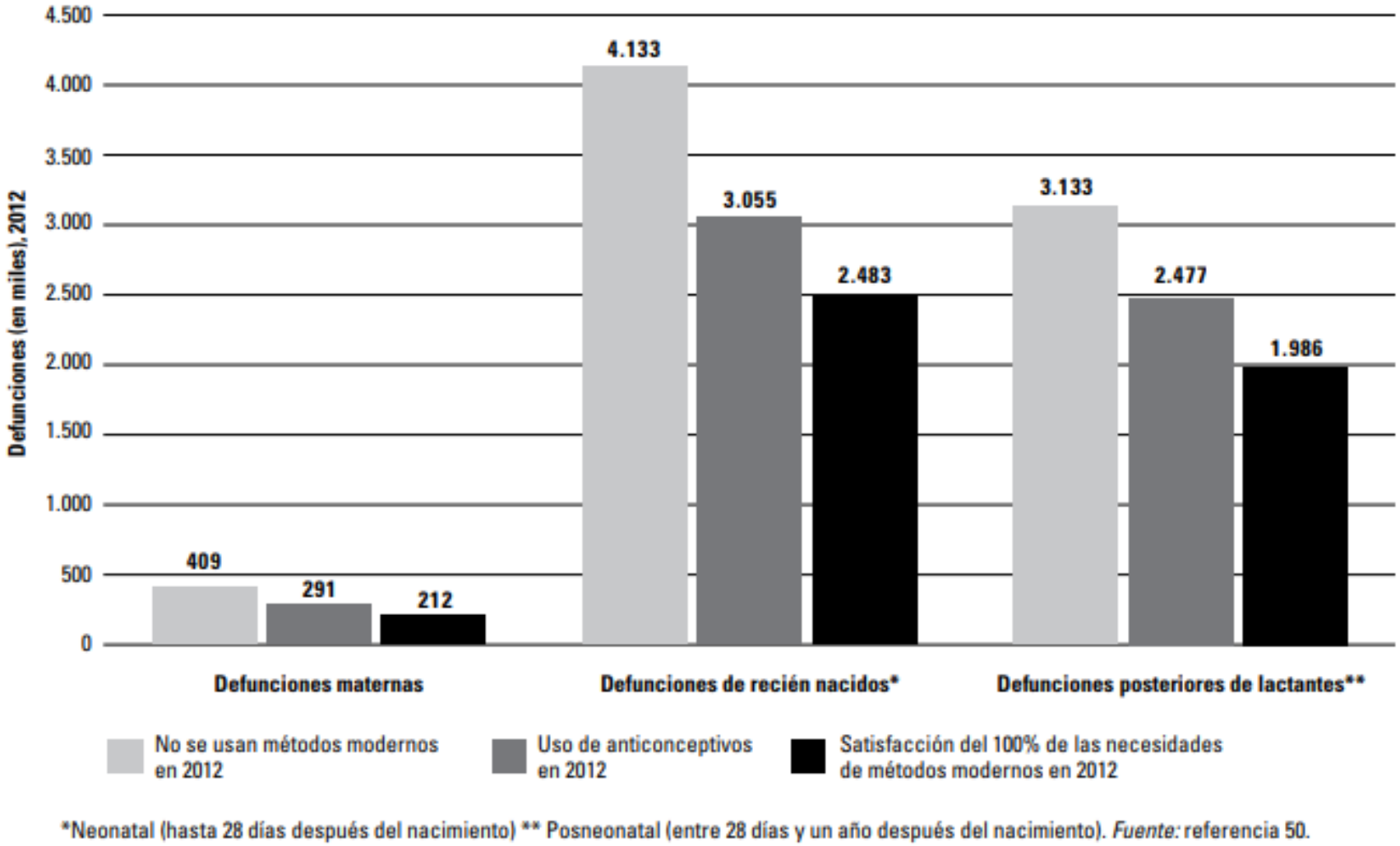
Necesidad insatisfecha de anticoncepción moderna, 2017

GRÁFICO 3. En 2012, hay grandes variaciones entre subregiones del mundo en desarrollo en cuanto al nivel de necesidad insatisfecha y de uso de anticonceptivos modernos por las mujeres casadas.



https://www.guttmacher.org/sites/default/files/report_pdf/aiu-2012-estimates-sp_0.pdf

GRÁFICO 6. El uso de anticonceptivos modernos previene defunciones de madres y lactantes.



*Neonatal (hasta 28 días después del nacimiento) ** Posneonatal (entre 28 días y un año después del nacimiento). *Fuente:* referencia 50.

https://www.guttmacher.org/sites/default/files/report_pdf/aiu-2012-estimates-sp_0.pdf


¿ANTICONCEPTIVOS PARA VOS?
NO QUERIDA, SI NO VENÍS CON TU MAMÁ NO TE PUEDO ATENDER...
A VER... ¡LA QUE SIGUE!
¡NO! MEJOR LA RUBIA DE ATRÁS...
PERO...
¿YO?
...NO, QUERIDA, LA SEÑORA
maitena

THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS

IMPLEMENTATION OF THE REGIONAL STRATEGY AND PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH 2010-2018

Pan American Health Organization

World Health Organization Americas

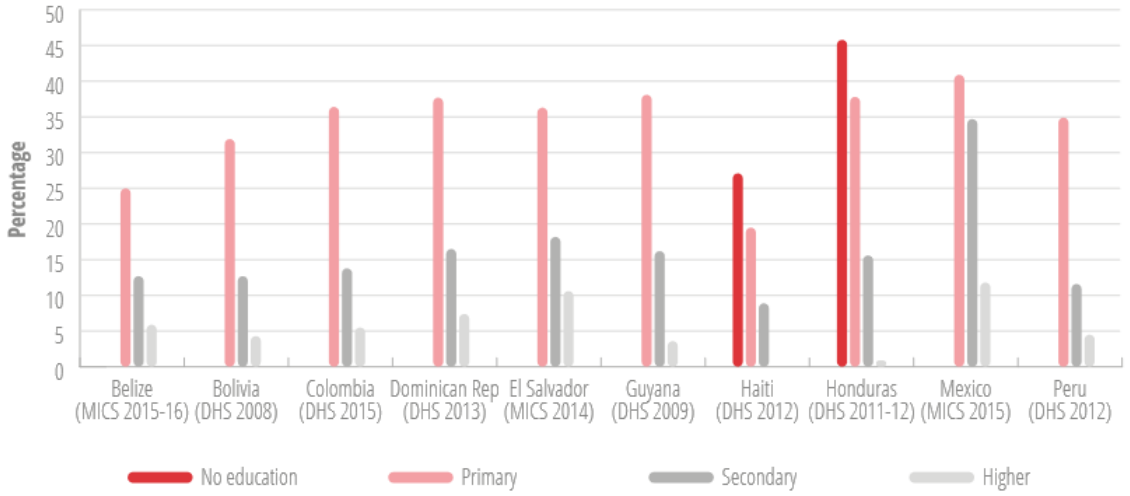
EVERY WOMAN EVERY CHILD

525 Twenty-third Street, NW
Washington, DC 20037, USA
Tel: +1 (202) 974 -3000
www.paho.org

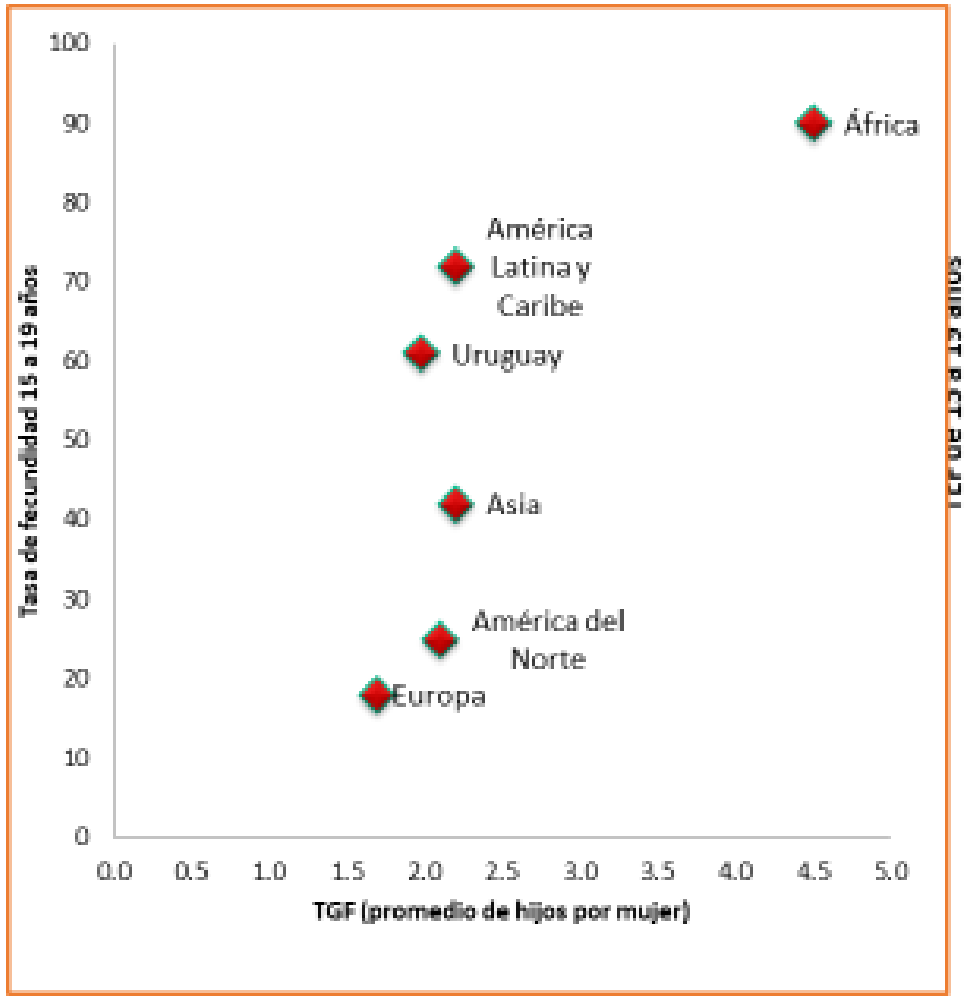
Figure II.21: Median age of sexual initiation of females aged 20-24 years in selected countries of Latin America and the Caribbean, by level of education, 2011-2015

Source: (91).

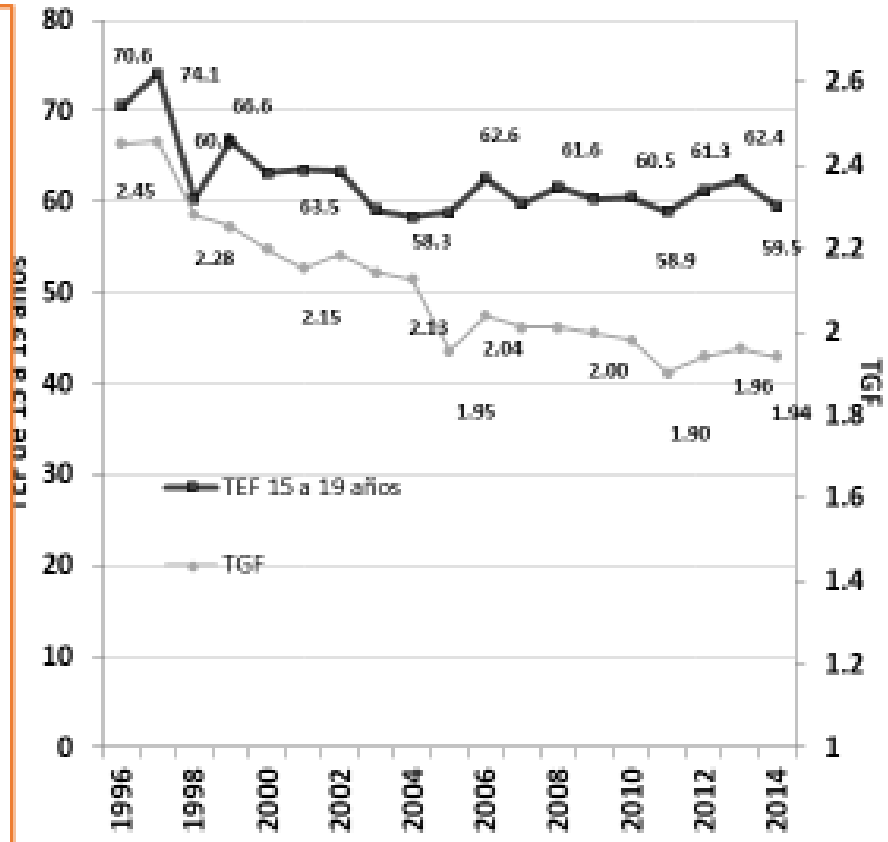
Figure II.25: Percentage of adolescents aged 15-19 years who had begun childbearing, by education level, in selected countries of Latin America and the Caribbean, 2008-2016



La brecha de fecundidad temprana aumenta.



Fuente: Rodríguez, J. (2014). CEPAL-CELADE

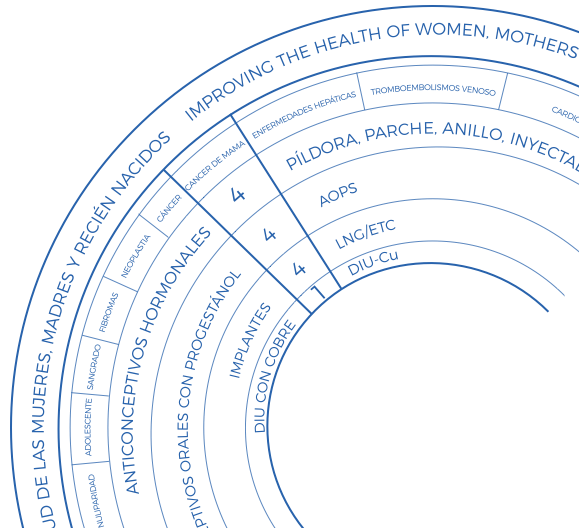


Fuente: Varela, De Rosa, Doyenart y Lara, elaboración propia a partir de Estadísticas Vitales, Censo s de Población y Viviendas y Proyecciones de Población, MSP y INE, Programa de Población-FCS-Udelar

CUADRO 1. Porcentaje de madres adolescentes por grupo etario, tipo de residencia (urbana o rural) y origen (indígena o no) en algunos países seleccionados de América Latina y el Caribe, 2010-2011

País (año del censo)	Grupo de edad (años)	PORCENTAJE DE MADRES ADOLESCENTES					
		Indígenas			No indígenas		
		Urbana	Rural	**Total**	Urbana	Rural	**Total**
Brasil (2010)	15–17	10,6	22,9	**18,7**	6,4	8,6	**6,8**
	18–19	26,8	46,9	**39,4**	18,2	26,6	**19,5**
	15–19	17,0	31,6	**26,4**	11,1	15,2	**11,8**
Costa Rica (2011)	15–17	8,5	20,3	**17,0**	5,3	6,7	**5,7**
	18–19	23,6	42,1	**36,1**	17,0	22,2	**18,4**
	15–19	15,2	28,7	**24,7**	10,0	12,6	**10,8**
Ecuador (2010)	15–17	9,0	9,6	**9,5**	8,3	11,9	**9,6**
	18–19	28,9	34,2	**32,9**	25,2	34,1	**28,1**
	15–19	17,4	18,5	**18,3**	15,0	20,3	**16,8**
México (2010)	15–17	6,3	7,4	**6,9**	5,7	7,1	**6,0**
	18–19	23,4	27,4	**25,3**	20,6	25,8	**21,6**
	15–19	13,2	14,8	**14,0**	11,6	14,2	**12,2**
Panamá (2010)	15–17	16,9	20,5	**19,6**	5,7	8,9	**6,7**
	18–19	38,8	54,2	**49,7**	19,1	28,6	**21,7**
	15–19	26,0	32,4	**30,7**	11,3	16,2	**12,7**
Uruguay (2010)	15–17	6,0	4,1	**6,0**	4,6	4,9	**4,6**
	18–19	20,2	25,8	**20,4**	16,9	21,9	**17,1**
	15–19	11,6	12,5	**11,6**	9,3	11,3	**9,4**

MEJORANDO LA SALUD DE LAS MUJERES, MADRES Y RECIÉN NACIDOS



https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-017-0345-y?site=reproductive-health-journal.biomedcentral.com

Caffe et al. Reproductive Health (2017) 14:83
DOI 10.1186/s12978-017-0345-y

Reproductive Health

COMMENTARY Open Access

Looking back and moving forward: can we accelerate progress on adolescent pregnancy in the Americas?

Sonja Caffe[1*], Marina Plesons[2], Alma Virginia Camacho[3], Luisa Brumana[4], Shelly N. Abdool[4], Silvia Huaynoca[5], Katherine Mayall[6], Lindsay Menard-Freeman[7], Luis Andres de Francisco Serpa[8], Rodolfo Gomez Ponce de Leon[9] and Venkatraman Chandra-Mouli[10]

Abstract: Adolescent fertility rates in Latin America and the Caribbean (LAC) remain unacceptably high, especially compared to the region's declining total fertility rates. The Region has experienced the slowest progress of all regions in the world, and shows major differences between countries and between subgroups in countries. In 2013, LAC was also noted as the only region with a rising trend in pregnancies in adolescents younger than 15 years. In response to the lack of progress in the LAC region, PAHO/WHO, UNFPA and UNICEF held a technical consultation with global, regional and country-level stakeholders to take stock of the situation and agree on strategic approaches and priority actions to accelerate progress. The meeting concluded that there is no single portrait of an adolescent mother in LAC and that context and determinants of adolescent pregnancy vary across and within countries. However, lack of knowledge about their sexual and reproductive health and rights, poor access to and inadequate use of contraceptives resulting from restrictive laws and policies, weak programs, social and cultural norms, limited education and income, sexual violence and abuse, and unequal gender relations were identified as key factors contributing to adolescent pregnancy in LAC. The meeting participants highlighted the following seven priority actions to accelerate progress:
1. Make adolescent pregnancy, its drivers and impact, and the most affected groups more visible with disaggregated data, qualitative reports, and stories.
2. Design interventions targeting the most vulnerable groups, ensuring the approaches are adapted to their realities and address their specific challenges.
3. Engage and empower youth to contribute to the design, implementation and monitoring of strategic interventions.
4. Abandon ineffective interventions and invest resources in applying proven ones.
5. Strengthen inter-sectoral collaboration to effectively address the drivers of adolescent pregnancy in LAC.
6. Move from boutique projects to large-scale and sustainable programs.
7. Create an enabling environment for gender equality and adolescent sexual and reproductive health and rights.

Keywords: Adolescent pregnancy, Equity, Latin America and the Caribbean

Seven priority actions to accelerate progress:

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2. Design interventions **targeting the most vulnerable groups**, ensuring the approaches are adapted to their realities and address their specific challenges.
3. **Engage and empower youth to contribute** to the design, implementation and monitoring of strategic interventions.
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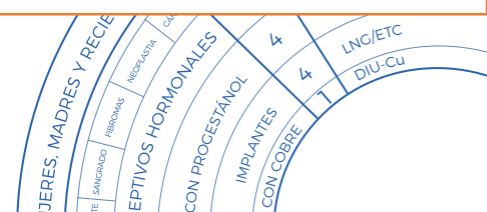
6. Move from boutique projects to **large-scale** and sustainable programs.
7. Create an **enabling environment for gender equality** and **adolescent sexual and reproductive health and rights**



https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-017-0345-y?site=reproductive-health-journal.biomedcentral.com

Global

BENEFICIOS DE SATISFACER PLENAMENTE LAS NECESIDADES DE ANTICONCEPTIVOS

Si todas las adolescentes que necesitan anticonceptivos modernos los usaran, el total de embarazos se reduciría de **21** a **15** millones.

Los embarazos no planeados se reducirían en **6** millones por año (59%), lo que resultaría en:

—**2.1** millones de embarazos no planeados menos, una reducción del 62%;

—**3.2** millones de abortos inducidos menos (una disminución del 5[illegible]% de los cuales **2.4** millones habrían sido inseguros); y

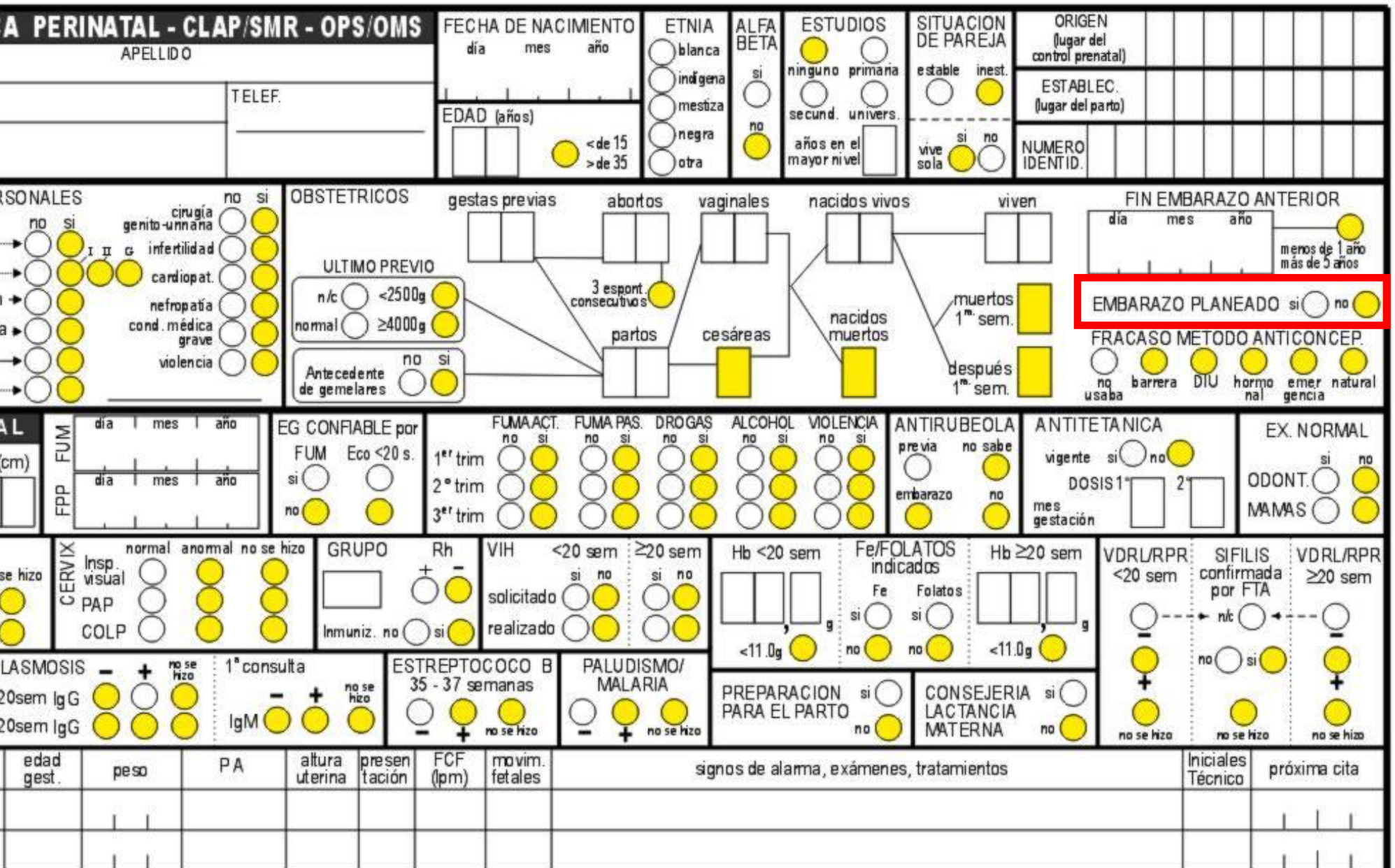
—**700,000** abortos espontáneos de embarazos no planeados menos, una disminución del 60%.

•Las muertes maternas —aquellas debidas a complicaciones del embarazo y el parto— en mujeres de 15 a 19 años disminuirían del nivel actual de **17,000** por año a **11,500**

5.500 adolescentes muertas menos

Un mayor uso de anticonceptivos modernos entre las adolescentes que no desean quedar embarazadas evitaría embarazos no planeados, salvaría vidas y mejoraría la salud.

https://www.guttmacher.org/es/fact-sheet/haciendo-cuentas-satisfacer-necesidades-anticoncepcion-de-las-adolescentes


A PERINATAL - CLAP/SMR - OPS/OMS
APELLIDO
TELEF.
FECHA DE NACIMIENTO
día mes año
EDAD (años)
< de 15
> de 35
ETNIA
blanca
indígena
mestiza
negra
otra
ALFA BETA
si
no
ESTUDIOS
ninguno
primaria
secund.
univers.
años en el mayor nivel
SITUACION DE PAREJA
estable
inest.
vive sola
si
no
ORIGEN (lugar del control prenatal)
ESTABLEC. (lugar del parto)
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violencia
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partos
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más de 5 años
EMBARAZO PLANEADO si no
FRACASO METODO ANTICONCEP.
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AL
(cm)
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día mes año
EG CONFIABLE por
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FUMA ACT.
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3er trim
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no sabe
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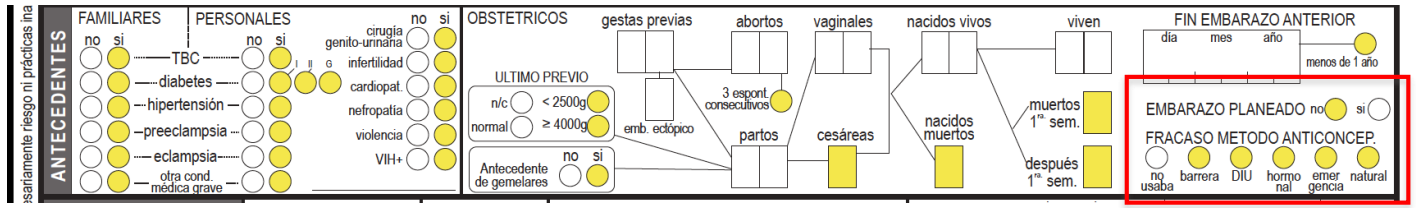
ANTITETANICA
vigente
DOSIS 1ª
2ª
mes gestación
EX. NORMAL
ODONT.
MAMAS
se hizo
CERVIX
Insp. visual
PAP
COLP
normal
anormal
no se hizo
GRUPO
Rh
Inmuniz. no si
VIH
<20 sem
≥20 sem
solicitado
realizado
Hb <20 sem
<11.0g
Fe/FOLATOS indicados
Fe
Folatos
Hb ≥20 sem
VDRL/RPR <20 sem
SIFILIS confirmada por FTA
VDRL/RPR ≥20 sem
n/c
no se hizo
LASMOSIS
20sem IgG
20sem IgG
1ª consulta
IgM
ESTREPTOCOCO B
35 - 37 semanas
PALUDISMO/ MALARIA
PREPARACION PARA EL PARTO
CONSEJERIA LACTANCIA MATERNA
edad gest.
peso
PA
altura uterina
presentación
FCF (lpm)
movim. fetales
signos de alarma, exámenes, tratamientos
Iniciales Técnico
próxima cita


ANTECEDENTES
FAMILIARES
PERSONALES
no si
TBC
diabetes
hipertensión
preeclampsia
eclampsia
otra cond. médica grave
I II G
cirugía genito-urinaria
infertilidad
cardiopat.
nefropatía
violencia
VIH+
OBSTETRICOS
gestas previas
abortos
vaginales
nacidos vivos
viven
ULTIMO PREVIO
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≥ 4000g
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partos
cesáreas
nacidos muertos
muertos 1ra. sem.
después 1ra. sem.
Antecedente de gemelares
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día mes año
menos de 1 año
EMBARAZO PLANEADO no si
FRACASO METODO ANTICONCEP.
no usaba
barrera
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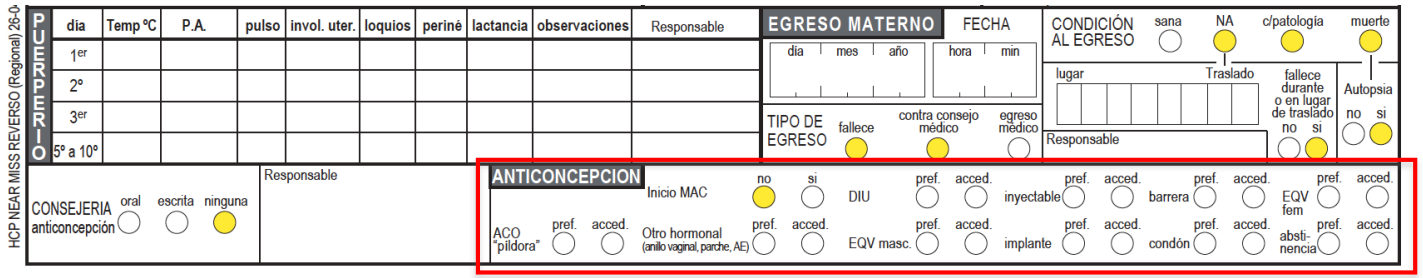
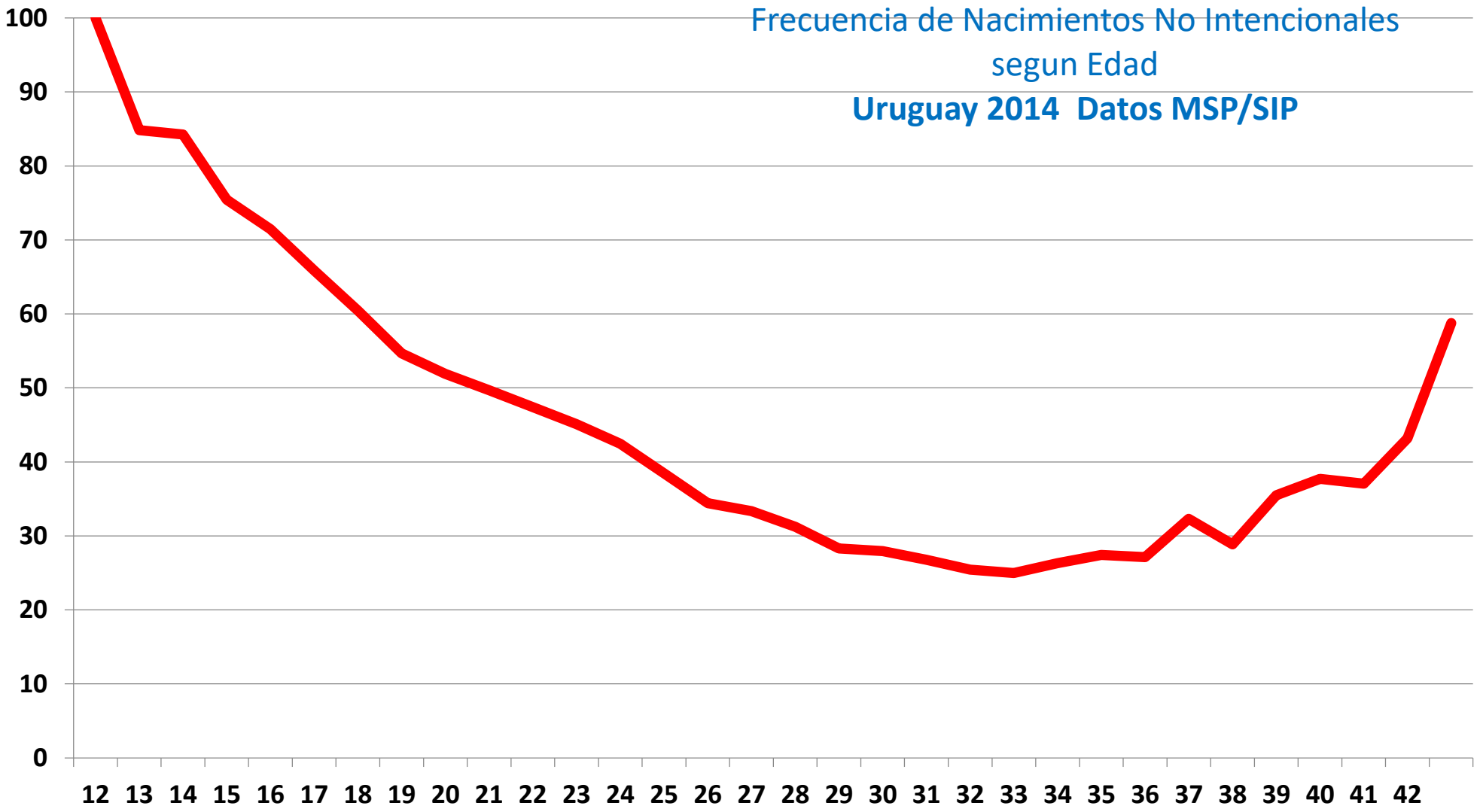
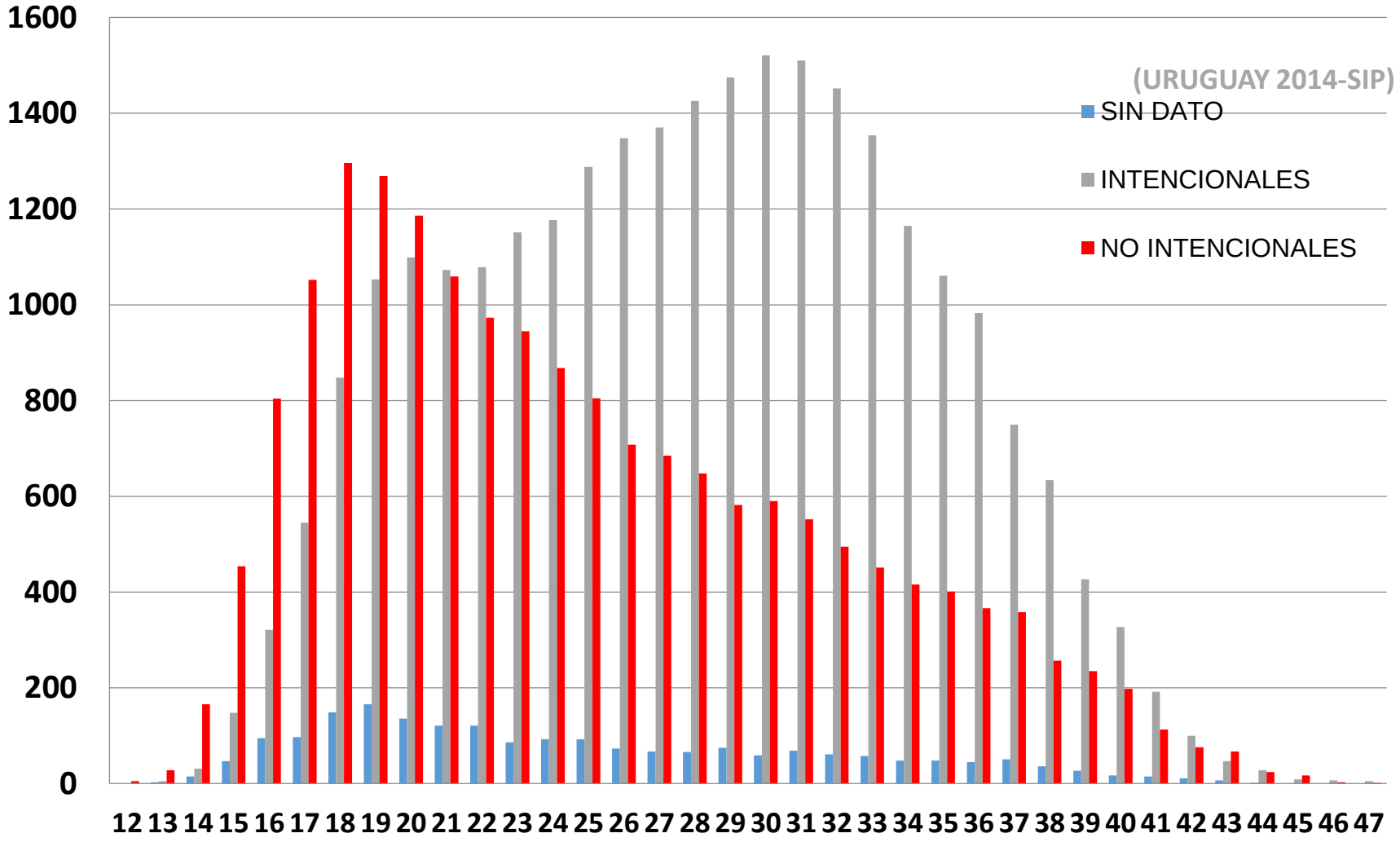
hormonal
emergencia
natural


HCP NEAR MISS REVERSO (Regional) 26-0
PUERPERIO
dia
Temp °C
P.A.
pulso
invol. uter.
loquios
periné
lactancia
observaciones
Responsable
1er
2°
3er
5° a 10°
EGRESO MATERNO
FECHA
día mes año
hora min
TIPO DE EGRESO
fallece
contra consejo médico
egreso médico
CONDICIÓN AL EGRESO
sana
NA
c/patología
muerte
lugar
Traslado
fallece durante o en lugar de traslado
no si
Autopsia
no si
Responsable
CONSEJERIA anticoncepción
oral
escrita
ninguna
Responsable
ANTICONCEPCION
Inicio MAC
no si
DIU
pref. acced.
inyectable
barrera
EQV fem
ACO "píldora"
Otro hormonal (anillo vaginal, parche, AE)
EQV masc.
implante
condón
abstinencia

Hasta los 19 años más del 60% son No intencionales

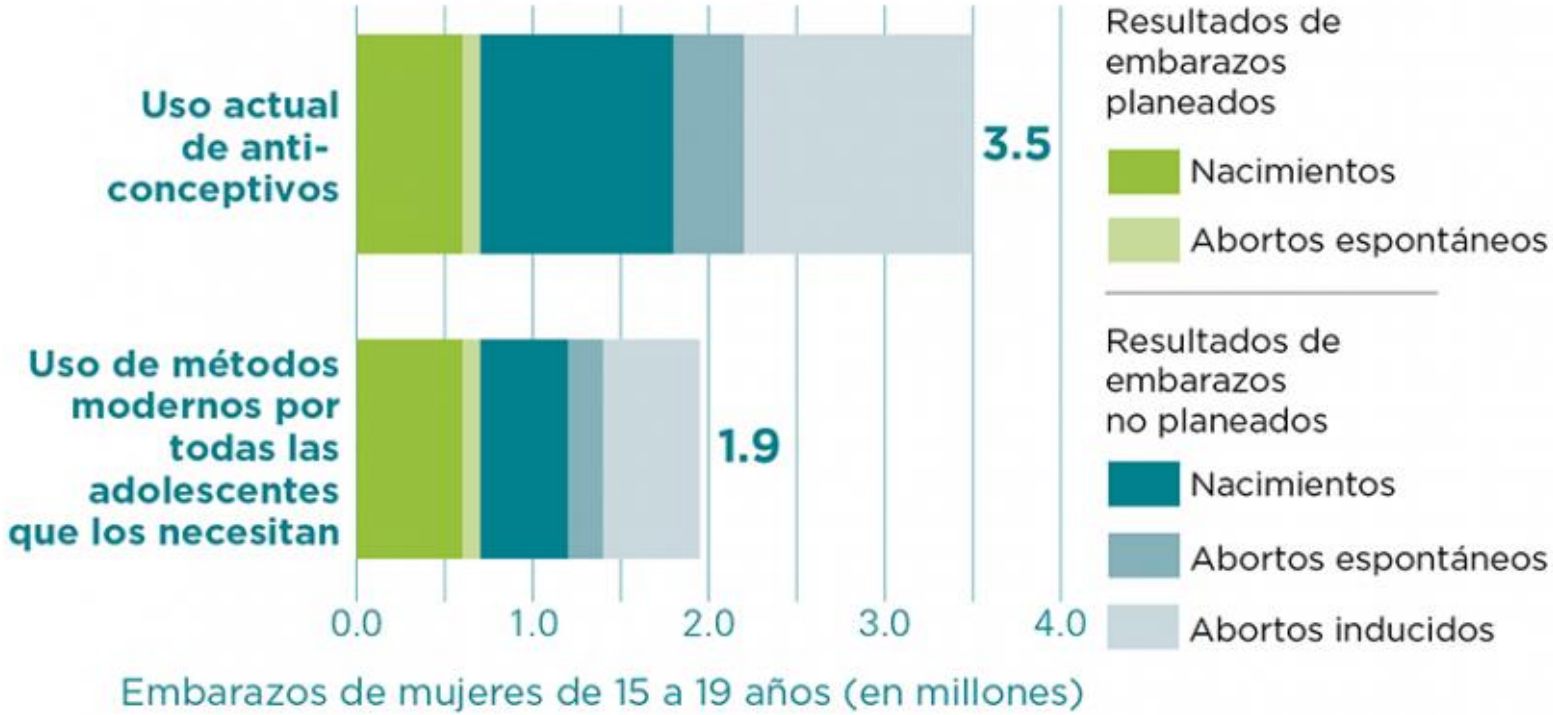


Momentos elegidos y no elegidos para concebir



SATISFACER LAS NECESIDADES ANTICONCEPTIVAS DE LAS ADOLESCENTES

Mejorar y expandir los servicios anticonceptivos en América Latina y el Caribe resultaría en 1.6 millones menos de embarazos no planeados.

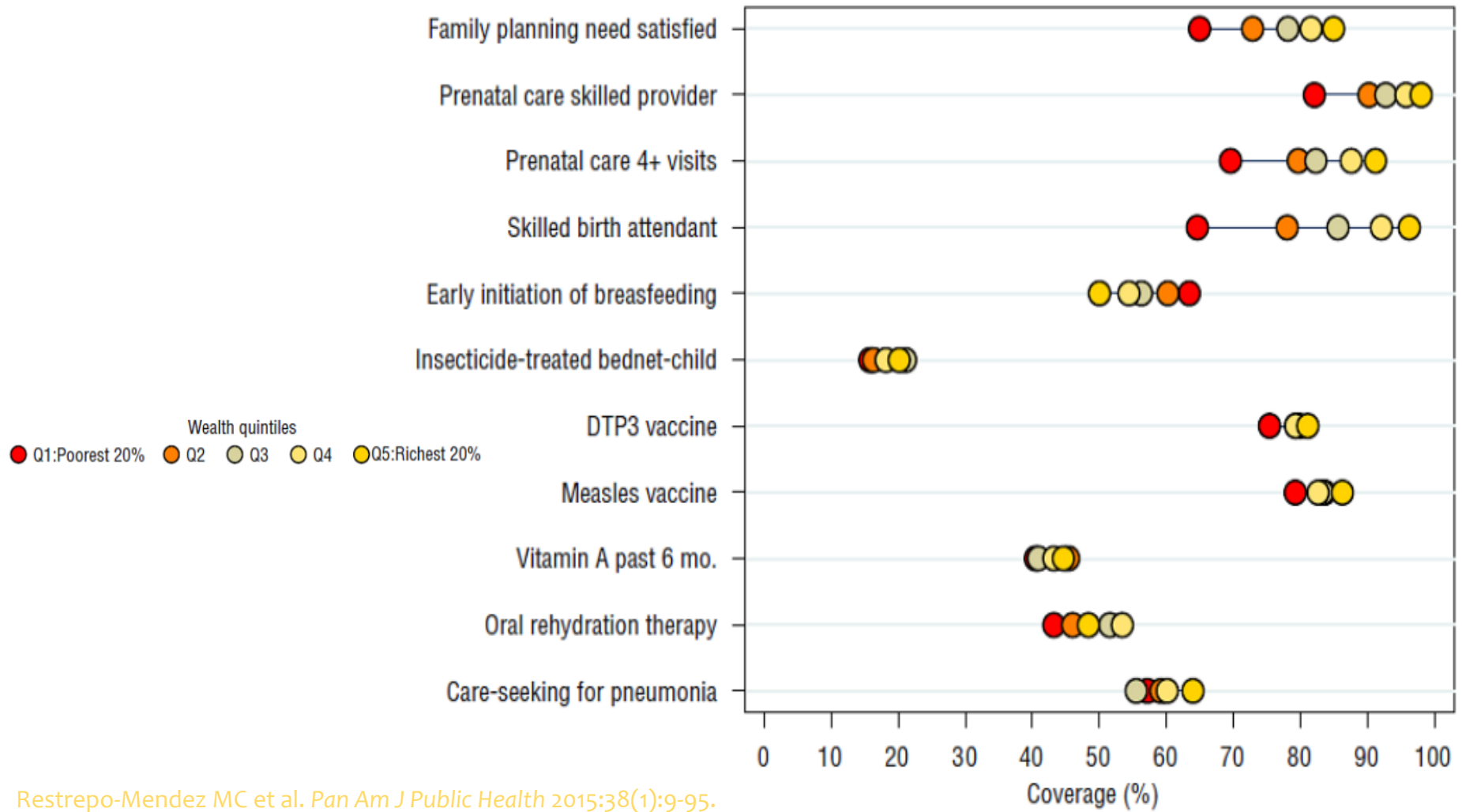


NOTAS: Los embarazos no planeados no se eliminan en el escenario de uso completo porque algunas mujeres experimentan fallos de los métodos anticonceptivos. Los abortos espontáneos incluyen los mortinatos.

www.guttmacher.org

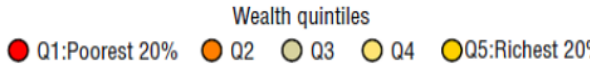
Organización Panamericana de la Salud | Organización Mundial de la Salud Américas | UNA PROMESA RENOVADA | RELACSIS

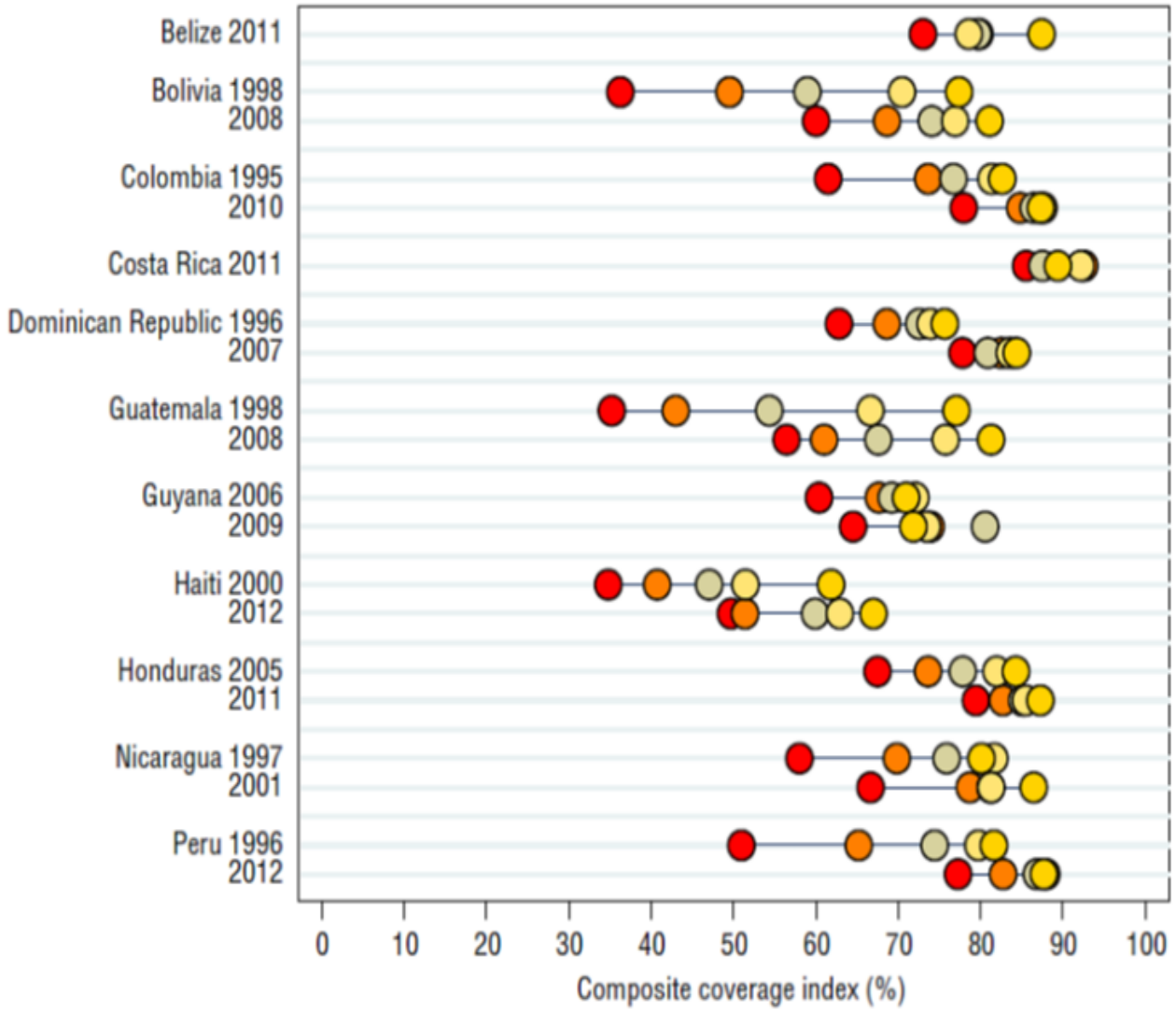
Mean coverage levels of various reproductive, maternal, neonatal, and child health interventions according to wealth quintiles in recent surveys of 11 countries in Latin America and the Caribbean, 2001–2012



Restrepo-Mendez MC et al. *Pan Am J Public Health* 2015:38(1):9-95.

National composite coverage index, stratified by wealth quintiles, for 11 countries in Latin America and the Caribbean, by year(s)





CCI = weighted average of 8 interventions

equal weights to 4 stages in the continuum of care

- family planning
- maternal and newborn care
- immunization
- case management of sick children

$$\frac{1}{4}\left(\mathrm{FPS}+\frac{\mathrm{SBA}+\mathrm{ANCS}}{2}+\frac{2\mathrm{DPT3}+\mathrm{MSL}+\mathrm{BC}}{4}+\frac{\mathrm{ORT}+\mathrm{CPNM}}{2}\right)$$

family planning needs satisfied (FPS), skilled birth attendant (SBA), antenatal care with a skilled provider (ANC), three doses of diphtheria–pertussis–tetanus vaccine (DPT3), measles vaccination (MLS), tuberculosis vaccination (BCG), oral rehydration therapy among children with diarrhea (ORT), and pneumonia care seeking (CPNM)

Restrepo-Mendez MC et al. *Pan Am J Public Health* 2015:38(1):9-95.

Contraceptive use in Latin America and the Caribbean with a focus on long-acting reversible contraceptives: prevalence and inequalities in 23 countries

Rodolfo Gomez Ponce de Leon, Fernanda Ewerling, Suzanne Jacob Serruya, Mariangela F Silveira, Antonio Sanhueza, Ali Moazzam, Francisco Becerra-Posada, Carolina V N Coll, Franciele Hellwig, Cesar G Victora, Aluisio J D Barros

Summary

Background The rise in contraceptive use has largely been driven by short-acting methods of contraception, despite the high effectiveness of long-acting reversible contraceptives. Several countries in Latin America and the Caribbean have made important progress increasing the use of modern contraceptives, but important inequalities remain. We assessed the prevalence and demand for modern contraceptive use in Latin America and the Caribbean with data from national health surveys.

Methods Our data sources included demographic and health surveys, multiple indicator cluster surveys, and reproductive health surveys carried out since 2004 in 23 countries of Latin America and the Caribbean. Analyses were based on sexually active women aged 15–49 years irrespective of marital status, except in Argentina and Brazil, where analyses were restricted to women who were married or in a union. We calculated contraceptive prevalence and demand for family planning satisfied. Contraceptive prevalence was defined as the percentage of sexually active women aged 15–49 years who (or whose partners) were using a contraceptive method at the time of the survey. Demand for family planning satisfied was defined as the proportion of women in need of contraception who were using a contraceptive method at the time of the survey. We separated survey data for modern contraceptive use by type of contraception used (long-acting, short-acting, or permanent). We also stratified survey data by wealth, area of residence, education, ethnicity, age, and a combination of wealth and area of residence. Wealth-related absolute and relative inequalities were estimated both for contraceptive prevalence and demand for family planning satisfied.

Findings We report on surveys from 23 countries in Latin America and the Caribbean, analysing a sample of 212 573 women. The lowest modern contraceptive prevalence was observed in Haiti (31·3%) and Bolivia (34·6%); inequalities were wide in Bolivia, but almost non-existent in Haiti. Brazil, Colombia, Costa Rica, Cuba, and Paraguay had over 70% of modern contraceptive prevalence with low absolute inequalities. Use of long-acting reversible contraceptives was below 10% in 17 of the 23 countries. Only Cuba, Colombia, Mexico, Ecuador, Paraguay, and Trinidad and Tobago had more than 10% of women adopting long-acting contraceptive methods. Mexico was the only country in which long-acting contraceptive methods were more frequently used than short-acting methods. Young women aged 15–17 years, indigenous women, those in lower wealth quintiles, those living in rural areas, and those without education showed particularly low use of long-acting reversible contraceptives.

Interpretation Long-acting reversible contraceptives are seldom used in Latin America and the Caribbean. Because of their high effectiveness, convenience, and ease of continuation, availability of long-acting reversible contraceptives should be expanded and their use promoted, including among young and nulliparous women. In addition to suitable family planning services, information and counselling should be provided to women on a personal basis.

Funding Wellcome Trust, Pan American Health Organization.

Lancet Glob Health 2019; 7: e1227–35

See Comment page e1169

Latin American Center for Perinatology/Women's Health and Reproductive Health of the Pan American Health Organization (CLAP/WR-PAHO/WHO), Montevideo, Uruguay (R G Ponce de Leon PhD, S J Serruya PhD, M F Silveira PhD); International Center for Equity in Health (ICEH), Federal University of Pelotas, Pelotas, RS, Brazil (F Ewerling PhD, C V N Coll PhD, F Hellwig MSc, Prof C G Victora MD, Prof A J D Barros PhD); Faculty of Medicine, Federal University of Pelotas, Pelotas, RS, Brazil (F Ewerling, M F Silveira, C V N Coll, F Hellwig, C G Victora, Prof A J D Barros); Pan American Health Organization (PAHO), Washington, DC, USA (A Sanhueza MD, F Becerra-Posada PhD); and Department of Reproductive Health and Research (RHR), World Health Organization, Geneva, Switzerland (A Moazzam PhD)

Correspondence to:
Prof Aluisio J D Barros, International Center for Equity in Health (ICEH), Federal University of Pelotas, Pelotas, RS 96020-220, Brazil
abarros@equidade.org

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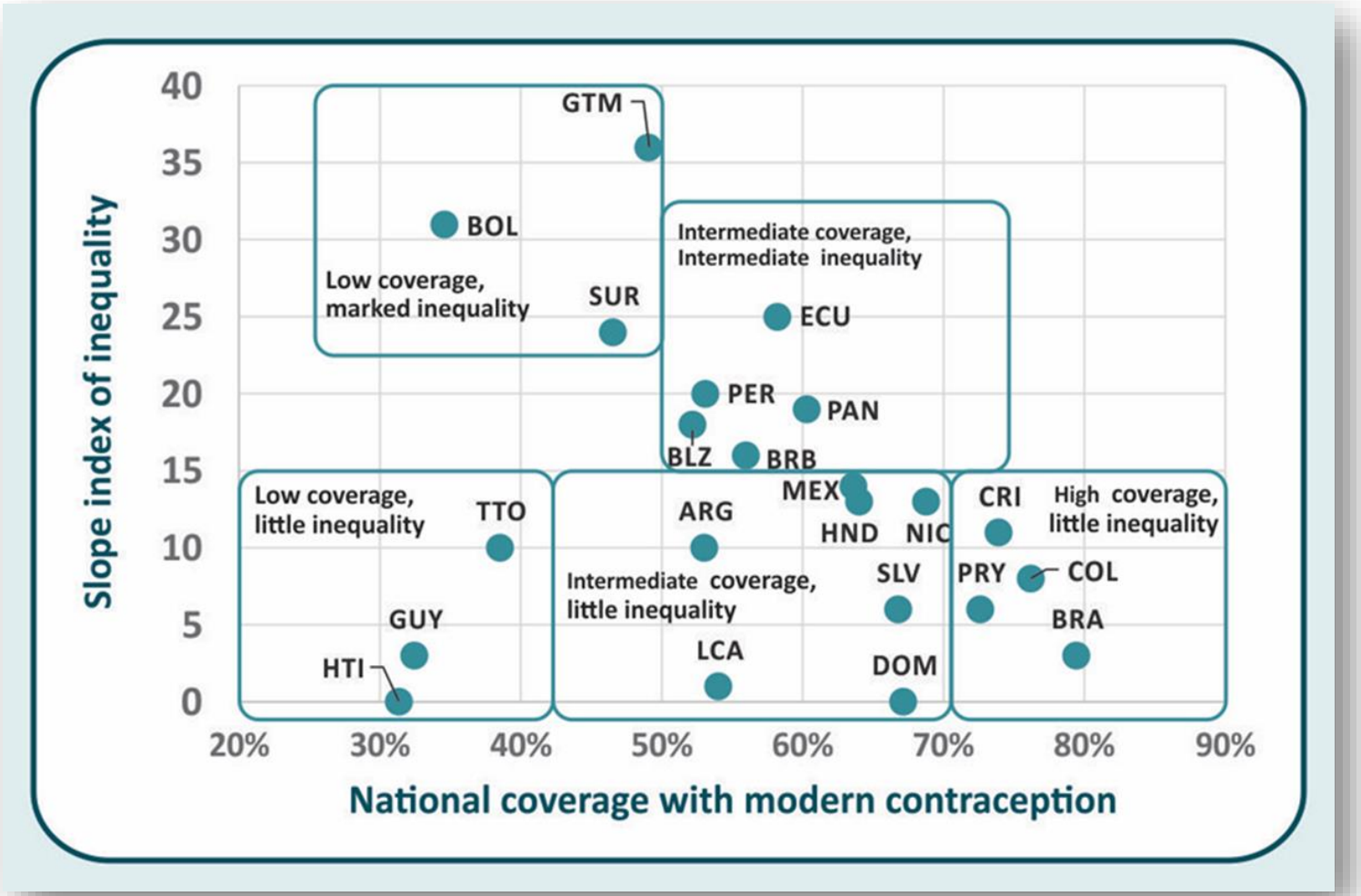
Lancet Glob Health 2019; 7: e227–35

See Comment page e169

Latin American Center for Perinatology/Women's Health and Reproductive Health of the Pan American Health

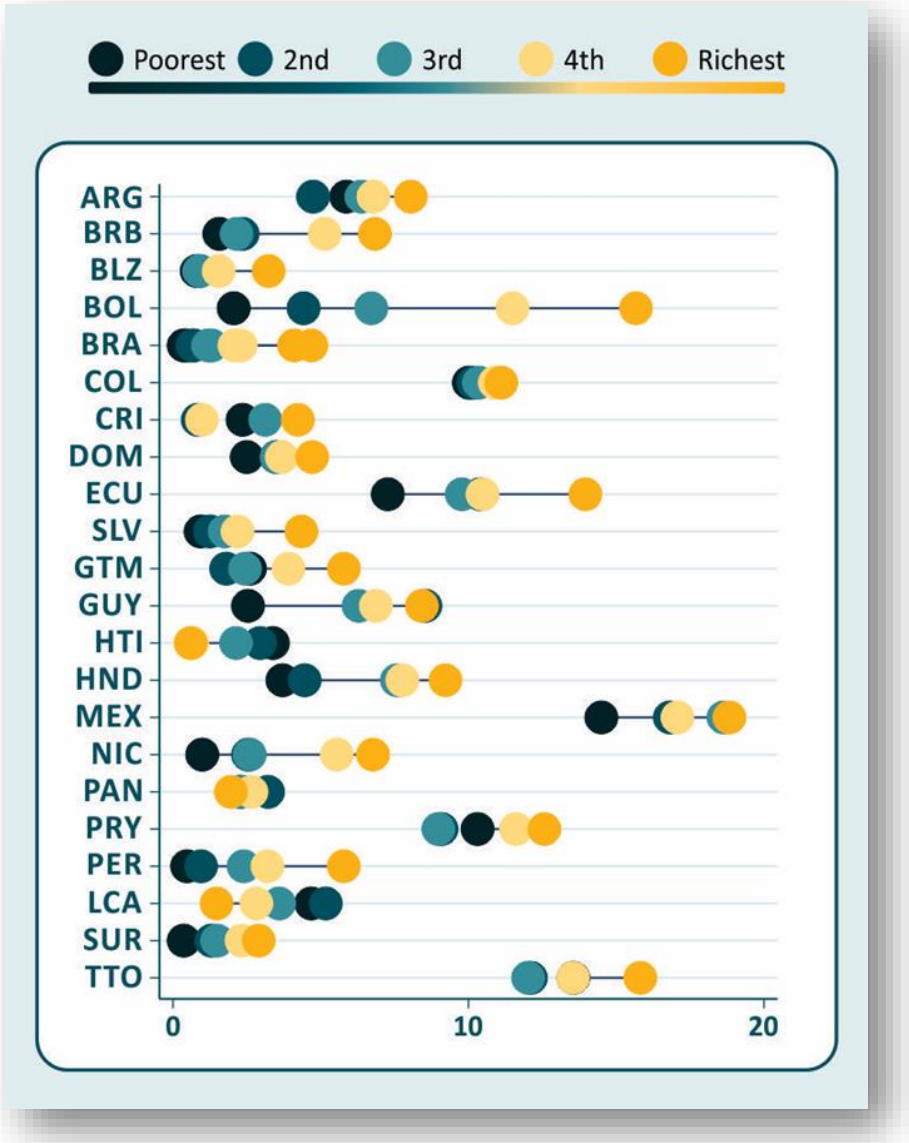
23 países en **LAC**, **212.573** mujeres.

Cobertura con métodos modernos entre todas las mujeres sexualmente activas.



Desigualdades relacionadas con la riqueza en la cobertura anticonceptiva moderna, de acuerdo con los niveles de cobertura nacional. El índice de inequidad expresa la diferencia en los puntos porcentuales entre la cobertura en la parte superior e inferior de la escala de riqueza.

Cobertura con LARC entre todas las mujeres sexualmente activas, por quintil de riqueza



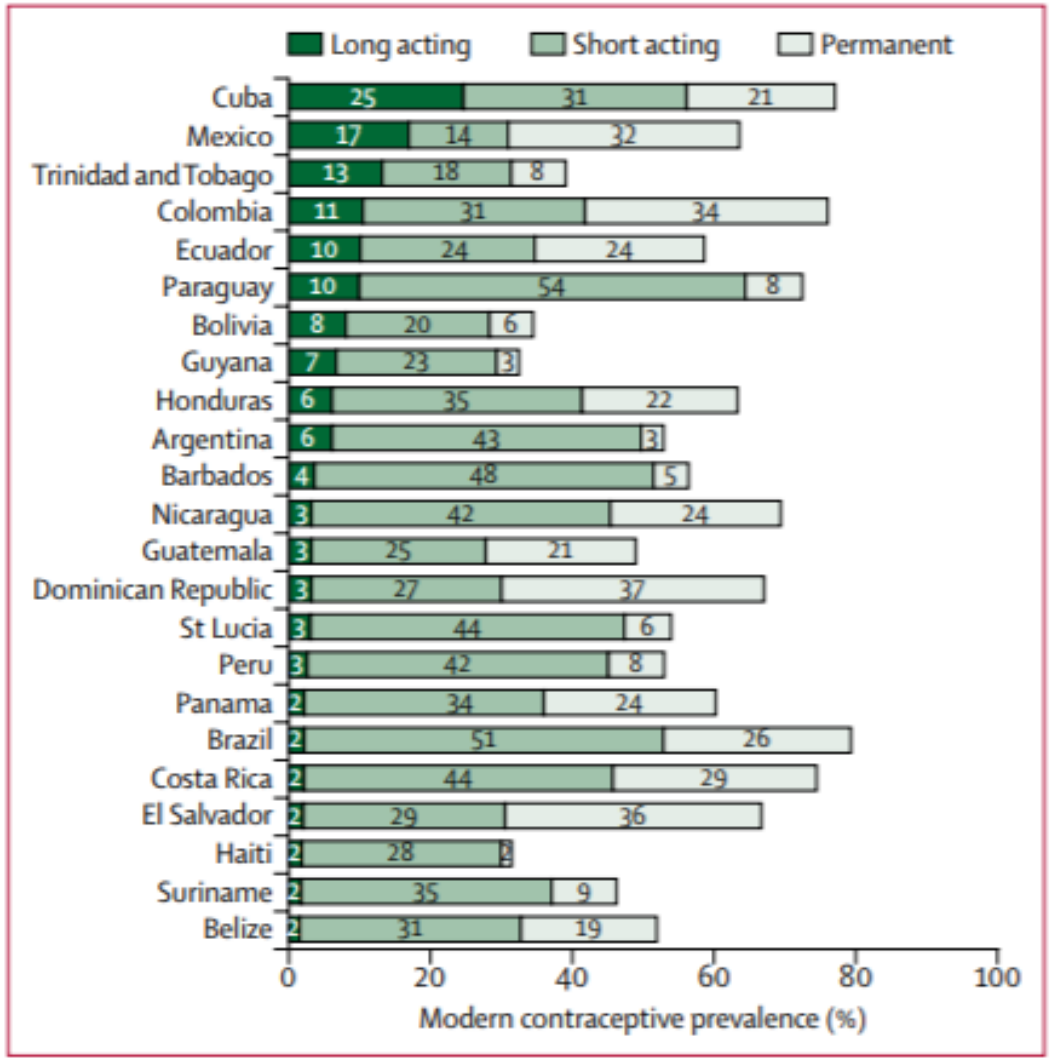


Figure 2: **Modern contraceptive prevalence according to the type of contraceptive method being used (long acting, short acting, or permanent) among sexually active women by country**

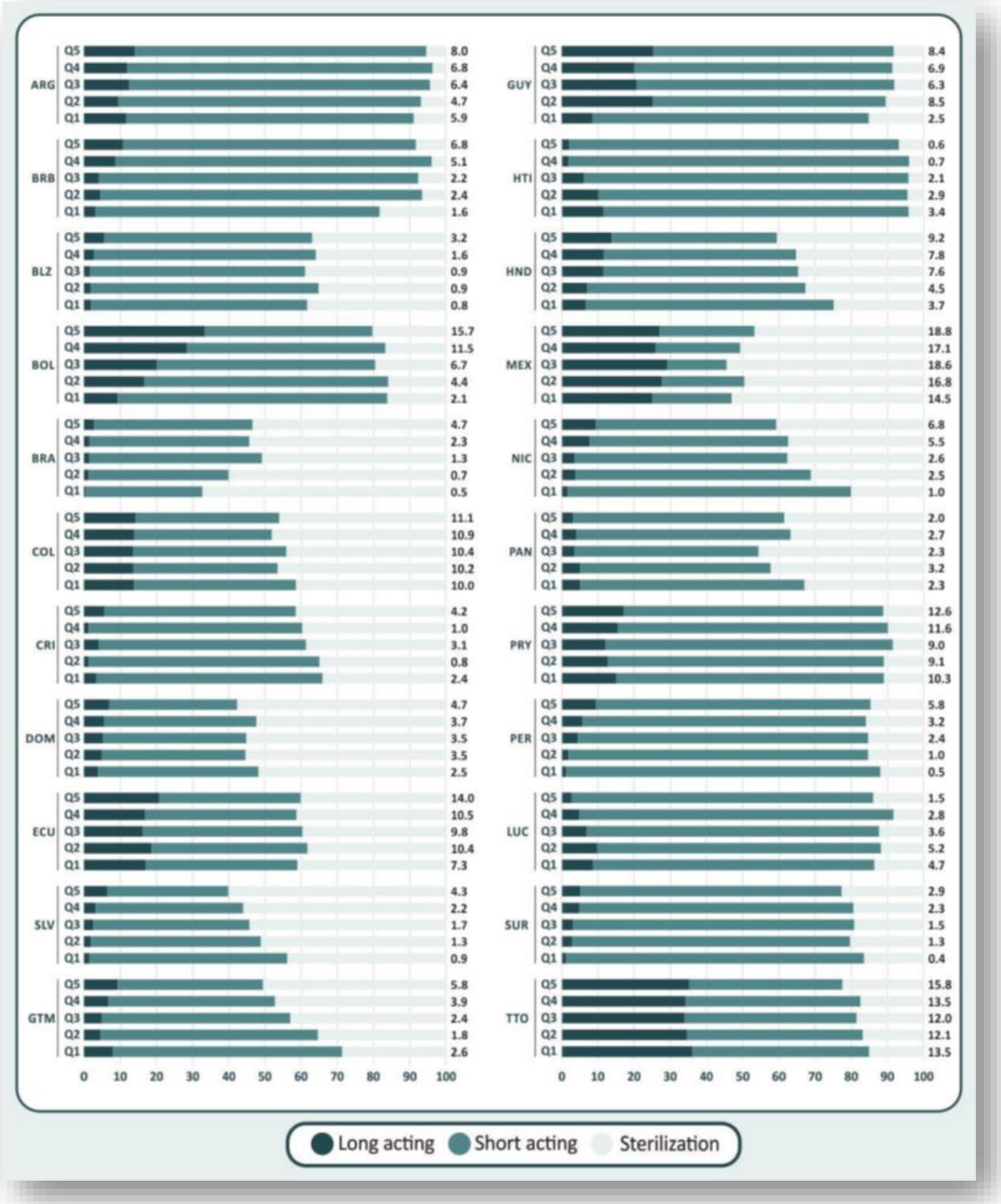
Estimates for Argentina and Brazil are restricted to women married or in a union. All other estimates are based on sexually active women irrespective of marital status (see appendix for SEs of the estimates).

La **menor** prevalencia anticonceptiva moderna de **Haití** (31-3%) y **Bolivia** (34-6%); las **desigualdades** eran amplias en Bolivia.

El uso de LARC fue inferior al 10% en 17 de los 23 países. Sólo Cuba, Colombia, México, Ecuador, Paraguay y Trinidad y Tobago tenían más del 10% LARC.

México fue el único país en el que la LARC se utilizaba con más frecuencia que los métodos de acción corta.

Las mujeres mas jóvenes, indígenas, mas pobres, rurales y que no tienen educación mostraron un uso particularmente bajo de LARC.



Cobertura por país entre todas las mujeres sexualmente activas, por quintil de riqueza

Uso de LARC debería ampliarse y promoverse su uso entre las mujeres jóvenes, rurales indígenas y nulíparas.

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DOI: 10.1002/ijgo.13029

BRIEF COMMUNICATION
Obstetrics

WILEY GYNECOLOGY OBSTETRICS FIGO

Celebrating the 25th anniversary of the International Conference on Population and Development: A perspective from Turkey

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[2]Woman-Child Health and FP, Research and Implementation Center, Ankara, Turkey
[3]Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland

*Correspondence
Ayşe Akin, Public Health Department, Faculty of Medicine, Baskent University; Director of Woman-Child Health and FP, Research and Implementation Center, Ankara, Turkey.
Email: ayseakin@gmail.com

KEYWORDS: Family planning; ICPD; Maternal health; Reproductive health; Turkey; Unmet needs

This year marks the 25th anniversary of the ground-breaking International Conference on Population and Development (ICPD) held in Cairo in 1994, and of its Programme of Action that emphasized the human rights aspects of health for all individuals at all ages.[1]

Family planning is one of the most cost-effective investments a country can make in its future. It offers a range of potential benefits that encompass economic development, maternal and child health, education, and women's empowerment.[2]

In preparation for the 25th anniversary of the ICPD in November 2019, the United Nations Population Fund (UNFPA) convened a global consultation in Ankara, Turkey in June 2019, to develop plans for addressing any unmet needs for family planning, with a view to achieving Agenda 2030 and the Sustainable Development Goals (SDGs).[3]

In the past, Turkey had high maternal mortality rates due to unwanted pregnancies and unsafe abortions. Two subsequent liberal legislative changes in fertility regulation, and the provision of outreach family planning services, have led to a substantial decrease in the proportion of maternal deaths, and a remarkable improvement in maternal and newborn health.

In 1965, following 10 years of strong advocacy efforts, the first population planning law was accepted in Turkey, and contraception practices in the country were legalized to decrease unintended pregnancies.[4] In this legislation, induced abortion was only accepted on medical grounds. To generate sound scientific evidence to legalize access to safe abortion, a joint WHO research operation was developed in Turkey, and led by one of the authors (AA). The results, along with strong advocacy efforts, convinced the Ministry of Health to legalize abortion up to 10 weeks of gestation and also authorised nurse midwives to provide modern family planning methods including IUD insertion.[4] This had a marked impact on maternal morbidity and mortality.[5] The contraceptive prevalence rate for any method in Turkey increased from 22.1% in 1963[6] to 74% in 2019,[7] while the total fertility rate (calculated as the average number of children per woman) decreased from 6.20 in 1965 to 2.08 as of the latest estimates.[8] Finally, the proportion of total maternal deaths which were caused by unsafe abortions also decreased from 53% to 2%.[9]

Turkey has made considerable progress in terms of respecting reproductive health and rights, and in meeting the family planning needs of individuals and families.

Experiences from Turkey offer three key lessons: Firstly, gender equality should always be the priority to improve health; secondly, access to family planning and to induced abortion is a human rights issue, therefore these have to be monitored very closely to ensure that they are universally accessible to all who need them and that services are of a high quality. Finally, decreasing unmet needs is a multisectoral task engaging and involving scientific evaluations, continuous collaborations with different stakeholders, and public awareness through consistent advocacy efforts.

On the 25th anniversary of the ICPD, all principles of ICPD remain valid and relevant. We hope that the Nairobi Summit will bring all stakeholders to agree on concrete actions to accelerate the implementation of the ICPD Programme of Action, which is critical to achieving the UN's SDGs by 2030, and to protect the gains made and advance the ICPD agenda to ensure that no one is left behind.

1965

- Contraceptive prevalence 22.1% in 19636 to 74% in 2019
- Total fertility rate 6.20 in 1965 to 2.08
- Maternal Deaths caused by unsafe abortions 53% to 2%.

Experiences from Turkey *offer three key lessons:*

Firstly, **gender equality** should always be the priority to improve health;

secondly, **access to family planning and to induced abortion is a human rights issue**, therefore these have to be monitored very closely to ensure that they are universally accessible to all who need them and that services are of a high quality.

Finally, **decreasing unmet needs is a multisectoral task** engaging and involving scientific evaluations, continuous collaborations with different stakeholders, and public awareness throughconsistent advocacy efforts.

SATISFACER LAS NECESIDADES DE SERVICIO MEJORA LA SALUD

• Proveer a **todas las mujeres** y a sus recién nacidos los servicios que necesitan conforme a los estándares recomendados por la OMS, resultaría en importantes mejoras en materia de salud.

• Si **toda la necesidad insatisfecha de anticoncepción moderna** en **América Latina y el Caribe** fuera satisfecha,

2/3 de reducción de embarazos no planeados

de **14** millones a **5** millones por año,

de **6** millones a **2** millones de nacimientos no planeados

de **6** millones a **2** millones de abortos

• **Si se combinara la provisión completa de anticoncepción moderna con una atención adecuada para todas las mujeres embarazadas y los recién nacidos**, habría una reducción del **75% en las muertes maternas** (de **7,000** a **2,000** por año) y neonatales (de **100,000** a **25,000** por año).

https://www.guttmacher.org/es/fact-sheet/haciendo-cuentas-satisfacer-necesidades-anticoncepcion-de-las-adolescentes

SE NECESITA MEJOR INVERSIÓN

Hoy estos servicios cuestan anualmente **6.8 mil millones** U$ en LAC **($1.7** anticoncepción y **$5.1** servicios de salud materna y neonatal.)
Satisfacer las necesidades de anticoncepción moderna de todas las mujeres en la región costaría **2.4 mil millones U$** anualmente.

Satisfacer la necesidad actual de atención materna y neonatal costaría **6.7 mil millones** U$ anualmente.
Satisfacer completamente la necesidad de anticoncepción moderna de las mujeres reduciría estos costos relacionados con el embarazo en **2.6 mil** millones U$, a **$4.1 mil** millones. Esto se debe a que al reducir los embarazos no planeados menos mujeres y recién nacidos requerirán atención, lo cual hace que otras inversiones en servicios de salud sean más accesibles.

Satisfacer completamente las necesidades de servicios de anticoncepción y de salud materna y neonatal en América Latina y el Caribe costaría un total de **$6.5 mil millones** al año, lo que generaría ahorros con respecto a lo que actualmente se gasta en la provisión de una atención menos integral.

Cada dólar adicional invertido en anticoncepción reduciría en 4 dólares el costo de los servicios de salud materna y neonatal en América Latina y el Caribe

Costaría **10 dólares por persona al** año satisfacer completamente la necesidad tanto de anticoncepción moderna como de servicios de salud materna y neonatal en América Latina y el Caribe.

https://www.guttmacher.org/es/fact-sheet/haciendo-cuentas-satisfacer-necesidades-anticoncepcion-de-las-adolescentes

Cuando 2 + 2 **no** es 4

HOY ……. 1,7 + 5,1 …….. 6.8 mil millones

Cubriendo las necesidades de PF y Salud Materna

2,4 + 6,7 ……..**9,1 mil millones**

Pero la **anticoncepción ahorra 2,4 mill millones en costos de los embarazos no planeados**

Por lo que la ecuación final queda

2,4 + 4,1 …….. **6,5 mil millones**

HOJA INFORMATIVA

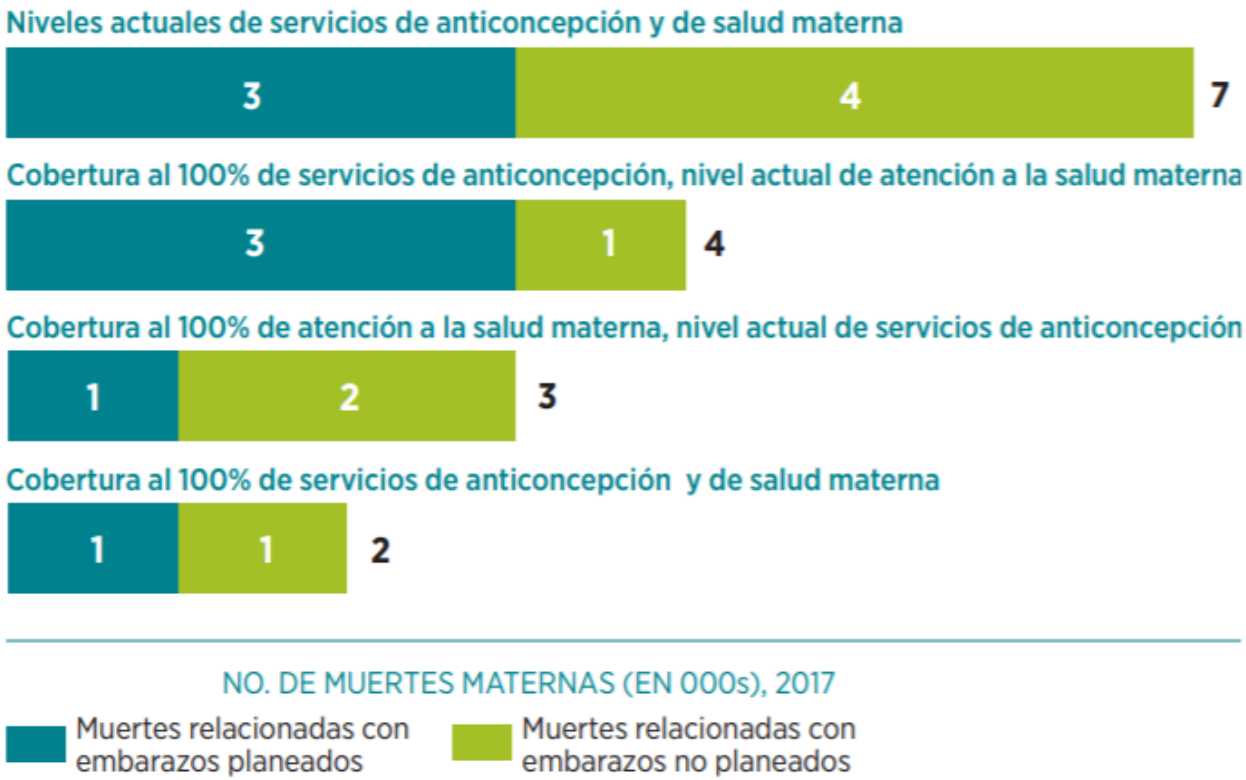
HACIENDO CUENTAS:

Invertir en anticoncepción y salud materna y neonatal en América Latina y el Caribe

GUTTMACHER INSTITUTE

MORTALIDAD MATERNA

Invertir de manera conjunta en servicios de anticoncepción y de salud materna y neonatal previene más muertes maternas que invertir solamente en uno de estos dos tipos de atención.



Sobrevivir , Prosperar y Transformar

MEJORANDO LA SALUD DE LAS MUJERES, MADRES Y RECIÉN NACIDOS

Organización Panamericana de la Salud

Organización Mundial de la Salud

Centro Latinoamericano de Perinatología Salud de la Mujer y Reproductiva - CLAP/SMR

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