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REVIEW ARTICLE

Evaluation of maternal mortality in Ecuador between 2012 and 2022: impact and results of ESAMyN

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ABSTRACT

Introduction: maternal mortality constitutes a critical public health indicator and reflects social inequalities and deficiencies in health systems.
Objective: to evaluate the impact of the ESAMyN regulation on the reduction of maternal mortality in Ecuador between 2012 and 2022.
Methods: a retrospective review was conducted using databases from the Ministry of Public Health, the National Institute of Statistics and Census, SciELO, Scopus, and Google Scholar, focusing on articles published between 2020 and 2024 related to maternal mortality and health policies. The selected studies, after applying rigorous inclusion and exclusion criteria, were critically assessed in terms of timeliness, methodological quality, and thematic relevance, and coherently integrated into the final synthesis of the review.
Development: findings show that, despite the implementation of ESAMyN in 2016, Ecuador continues to have one of the highest maternal mortality rates in the region. The main causes were gestational hypertension, postpartum hemorrhage, and eclampsia. The regulation introduced perinatal care standards, hospital certification, and promotion of humanized childbirth, but results were heterogeneous. Gaps in access to services, territorial inequalities, and limitations in human resources persist. Evidence suggests that the regulation has partially contributed to improving the quality of care, although it has not achieved a sustained reduction in mortality.
Conclusions: the analysis confirms that the ESAMyN regulation represents progress in maternal care but requires strengthening in coverage, equity, and sustainability to achieve an effective reduction in maternal mortality.

Keywords: Perinatal Care; Health Status Indicators; Maternal Mortality; Public Health.

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INTRODUCTION

Maternal health is part of the right to health, and maternal and infant death are expressions of the inequitable social condition of women and the weak functioning of health systems. This situation has an impact not only at the family level but also in the economic and legal spheres of a population.[1] Gynecological and obstetric emergencies are among the leading causes of death in the female population, with high incidence—particularly in underdeveloped or developing countries—and the death of a mother and her newborn remains deeply concerning.[2]

Maternal mortality is a serious public health problem influenced by social determinants of health and intersecting with gender and human rights issues. In 2015, the 193 UN Member States, along with civil society, academia, and the private sector, adopted the 2030 Agenda for Sustainable Development. Sustainable Development Goals (SDGs) 3 and 5 address this challenge by seeking to ensure healthy lives, promote well-being for all ages, and achieve gender equality by ending all forms of discrimination against women and girls.[3,4]

According to the World Health Organization (WHO), in 2018 approximately 342,900 women died worldwide from maternal complications, with over 50 % occurring in Asian and African countries. The most common complications during pregnancy, childbirth, and the postpartum period include preeclampsia, hemorrhage, and sepsis, with frequencies varying across countries. In Latin America, Mexico reports the highest number of maternal deaths, with the latest report citing 1,268 cases. Although reductions have occurred, maternal deaths remain frequent among marginalized populations with limited access to adequate prenatal care—a reality common across several countries in the region.[5]

In Ecuador, hypertensive disorders and preterm birth are common complications in adolescent pregnancy. Risk factors include ages between 14 and 19 years, being a single mother, having completed high school education, high blood pressure, unemployment, and poverty. This issue represents a public health challenge with significant social and economic implications for young women and their communities. The COVID-19 pandemic has exacerbated these difficulties by hindering access to health services.[6]

At the national level, since 2006 the National Institute of Statistics and Censuses (INEC) has included a question on maternal mortality in the death certificate form as a mechanism for reporting such deaths. Similarly, the Ministry of Public Health (MSP) has implemented processes and regulations for maternal death notification, as well as created systems for data storage and epidemiological investigation. Notably, every maternal death must be reported within the first 24 hours of its occurrence.[7]

Since 2007, the MSP and INEC have annually conducted an active search for maternal deaths to obtain uniform data and eliminate underreporting. This process aims to standardize case counts and control the statistical quality of death reports for women aged 10 to 49 years, using both information sources (INEC and MSP). Although the age range may seem broad, it is the range established by institutions for registration purposes.[7] Given this context, the present review was developed with the objective of evaluating the impact of the ESAMyN policy on maternal mortality reduction in Ecuador between 2012 and 2022.

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METHODS

Study Design

A retrospective, descriptive, cross-sectional systematic review was conducted following PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. The objective was to evaluate maternal mortality in Ecuador between 2012 and 2022, analyzing the impact of the implementation of the ESAMyN (Healthcare Facilities Friendly to Mothers and Newborns) policy. The design focused on integrating official data and scientific literature to identify trends, risk factors, and outcomes of health policies applied in the country.

Information Sources and Search Strategy

Data were obtained from official records of the Ministry of Public Health (MSP) and the National Institute of Statistics and Censuses (INEC), complemented by scientific literature from SciELO, Scopus, and Google Scholar. Institutional documents, epidemiological reports, and academic articles related to maternal mortality in Ecuador were included. Secondary references from bibliographies and gray literature (technical and regulatory reports) providing relevant data on ESAMyN implementation and outcomes were also reviewed.

The search was performed using a structured algorithm with keywords and Boolean operators. Terms included: "maternal mortality" AND "Ecuador," "maternal mortality ratio," "obstetric causes" AND "ESAMyN," and "maternal mortality" AND "Ecuador." Boolean operators AND and OR were used to combine and expand results, while truncation and quotation marks refined precision. Articles in Spanish and English published between 2012 and 2022 were considered, without geographic restriction, to ensure broad and representative coverage.

Selection Process

The selection process followed PRISMA recommendations. Initially, approximately 500 records were identified in the consulted databases. After duplicate removal and title/abstract screening, the sample was reduced to 220 potentially relevant articles. Full-text reading subsequently excluded studies lacking clinical or methodological relevance. Ultimately, 37 documents and articles meeting established quality and relevance criteria were included. The process was illustrated using a PRISMA flow diagram depicting identification, screening, eligibility, and inclusion phases.

Studies and documents published within the defined timeframe that directly addressed maternal mortality in Ecuador, its causes, and ESAMyN implementation were included. Original articles, systematic reviews, official reports, and case reports with verifiable maternal mortality data were accepted. Duplicates, articles without full-text access, irrelevant publications, studies outside the temporal range, and those lacking Ecuador-specific data were excluded.

Data Extraction and Analysis

Data extraction was performed systematically using an analysis matrix designed to collect key variables: year of registration, number of maternal deaths, maternal mortality ratio, direct and indirect obstetric causes, implemented health interventions, and outcomes associated with the ESAMyN policy. A qualitative synthesis of findings was conducted, integrating information into thematic categories (direct obstetric causes, indirect causes, impact of health policies, ESAMyN outcomes). Where studies presented homogeneous quantitative data, an exploratory meta-analysis was considered; however, methodological and population heterogeneity limited this approach, leading to a comparative narrative synthesis. Integration of results enabled identification of common patterns, discrepancies, and knowledge gaps, offering a critical and updated perspective on the topic.

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RESULTS

Maternal death refers to the death of a woman during pregnancy or within 42 days of its termination, due to causes related to pregnancy or its management, excluding accidental causes. The maternal mortality ratio measures the frequency of these events in women aged 10 to 49 years relative to the total number of live births estimated and constitutes a key indicator of maternal program performance.[7]

Maternal deaths recorded in 2012

205 maternal deaths were reported (204 timely maternal deaths, 1 late maternal death). The ESAMyN policy had not yet been implemented. The maternal mortality ratio was 60,20, decreasing from 70,44 in 2011. The highest rate in the study period occurred in 1993 (96,13), while the lowest was recorded in 2004 (36,83). In 2012, Guayas province reported the highest number of maternal deaths (30) with a ratio of 36,63, while Bolívar had the highest ratio (148,87). Nationally, 205 maternal deaths were recorded with a ratio of 60,20. No maternal deaths were reported in Galápagos, Undesignated Zone, or Abroad. Direct obstetric causes accounted for 171 deaths (83,41 %) with a ratio of 50,21, with gestational hypertension with significant proteinuria as the leading cause. Indirect obstetric causes caused 28 deaths (13,66 %) with a ratio of 8.22, while unspecified obstetric causes totaled 6 deaths (2,93 %) with a ratio of 1,76.[8]

To reduce maternal and neonatal mortality, the Ministry of Public Health (MSP) implemented the National Accelerated Reduction Plan, which includes surveillance and investigation of maternal and neonatal deaths, activation of the National Maternal Death Committee, implementation of the Essential Obstetric and Neonatal Care Network (CONE), and technical support to provinces through monthly supervision and evaluation. Additionally, the "Assured Availability of Contraceptive Supplies (DAIA)" project is executed. Most deaths result from preterm births, respiratory problems, low birth weight, and complications such as preeclampsia-eclampsia—often stemming from inadequate prenatal care. These situations reflect historical underinvestment in the health sector, which the current government is working to correct.[9]

Maternal deaths recorded in 2013

158 maternal deaths were reported (155 timely, 3 late). ESAMyN was still not in place. The maternal mortality ratio was 45,71, down from 60,20 in 2012. The highest rate remained in 1993 (96,13), and the lowest in 2004 (36,83). In 2013, Guayas had the highest number of deaths (26) with a ratio of 31,86, while Chimborazo had the highest ratio (128,88). Nationally, 155 maternal deaths were reported with a ratio of 45,71 (~46 per 100,000 live births). No deaths were recorded in Galápagos, Undesignated Zone, or Abroad. Direct obstetric causes accounted for 121 deaths (76,58 %) with a ratio of 35,69, led by gestational hypertension with proteinuria. Indirect causes represented 28 deaths (17,72 %) with a ratio of 8,26. Unspecified causes totaled 6 deaths (3,80 %, ratio 1,77), and late maternal deaths were 3 (1,90 %, ratio 0,88).[10]

A salary reduction for senior public sector officials, mandated by Executive Decree No. 601, allowed the allocation of USD 21 million to hire over 1,000 physicians to improve care for women and reduce maternal mortality. This measure aims to reinforce health investment and contribute to achieving Millennium Development Goals related to maternal mortality. In 2013, Ecuador reported 155 maternal deaths. To address this, an exhaustive audit of cases was conducted, and the SIVE Preventable Deaths Information System was implemented, improving identification and registration of maternal deaths and enabling action plans to reduce mortality.[11]

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Maternal deaths recorded in 2014

169 maternal deaths were reported (166 timely, 3 late). ESAMyN was still not implemented. The maternal mortality ratio was 49,15, increasing from 45,71 in 2013. The highest rate remained in 1993 (96,13), and the lowest in 2004 (36,83). To standardize international calculation, Resolution 001-2014 of the Interinstitutional Health Statistics Commission (CIES)—in collaboration with MSP, the Coordinating Ministry of Social Development, the National Civil Registry Directorate, the National Planning Secretariat, and INEC—defined maternal deaths as those occurring during pregnancy, childbirth, or up to 42 days postpartum. These are divided by total births and multiplied by 100,000. In 2014, Guayas recorded the highest number of deaths (38) with a ratio of 46,73, while Zamora Chinchipe had the highest ratio (142,20). Nationally, 166 maternal deaths were recorded with a ratio of 49,16. No deaths were reported in Galápagos, Undesignated Zone, or Abroad.[12]

Direct obstetric causes were the main contributor, with 121 deaths (72,89 %) and a ratio of 35,83, with postpartum hemorrhage as the leading cause. Indirect causes accounted for 38 deaths (22,89 %, ratio 11,25). Unspecified causes totaled 7 deaths (4,22 %, ratio 2,07). Late maternal deaths were 3 (1,78 %, ratio 0,89).[12]

Starting in 2014, the active maternal death search procedure incorporated a list of suspected causes of death. Databases were queried, and reports of suspected cases were generated, prompting epidemiological investigation by MSP maternal death committees. Data on pregnancy-, childbirth-, and postpartum-related deaths that are not necessarily maternal (e.g., accidental or incidental causes) were also included.[7]

Maternal deaths recorded in 2015

183 maternal deaths were reported (150 timely, 33 late). ESAMyN was still not in effect. In 2015, improvements in the Intentional Search and Reclassification of Maternal Deaths (BIRMM) allowed identification of new late maternal deaths. The maternal mortality ratio was 44,58, decreasing from 49,16 in 2014. The highest rate remained in 1993 (96,13), and the lowest in 2004 (36,83). In 2015, Guayas reported the highest number of deaths (32) with a ratio of 39,47, while Esmeraldas had the highest ratio (104,90). Nationally, 150 maternal deaths were reported with a ratio of 44,58 (~45 per 100,000 births). Carchi, Galápagos, Undesignated Zone, and Abroad reported no deaths. Direct obstetric causes accounted for 121 deaths (80,67 %), with eclampsia as the leading cause. Late maternal deaths were the second cause (33 deaths, 18,03 %), followed by indirect causes (26 deaths, 17,33 %) and unspecified causes (3 deaths, 2 %).[13]

Regarding the four strategic axes, in prevention and promotion it was noted that many mothers did not know where to seek care upon becoming pregnant, prompting a campaign to raise awareness that pregnancy always carries risk. In obstetric care, 17 Type C Health Centers were inaugurated nationwide, and construction began on 13 additional centers in Guayas—the province most affected by maternal deaths. Due to economic constraints, a USD 20 million budget was allocated to hire specialist physicians, which proved insufficient. To address this, public sector salaries were regulated, and a study was planned to reduce senior officials' wages to hire all necessary professionals.[14]

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Maternal deaths recorded in 2016

154 maternal deaths were reported (133 timely, 21 late). The ESAMyN policy was implemented this year—officially titled "Certification of Health Facilities as Friendly to Mothers and Newborns," issued by MSP. The maternal mortality ratio was 39,63, decreasing from 44,58 in 2015. The highest rate remained in 1993 (96,13), and the lowest in 2004 (36,83). In 2016, Guayas reported the highest number of deaths (32) with a ratio of 39,57, while Esmeraldas had the highest ratio (105,68). Nationally, 133 maternal deaths were recorded with a ratio of 39,67 (~40 per 100,000 births). No deaths were reported in Cañar, Napo, Pastaza, Galápagos, Undesignated Zone, or Abroad. Direct obstetric causes caused 98 deaths (76,68 %), with eclampsia as the leading cause. Indirect causes totaled 34 deaths (25,56 %), late maternal deaths were 21 (13,64 %), and unspecified causes represented 1 death (0,75 %).[15]

ESAMyN is an Ecuadorian policy designed to certify health facilities as "Friendly to Mothers and Newborns" to reduce maternal and neonatal mortality and morbidity. The policy establishes guidelines to ensure high-quality, warm, continuous, relevant, and comprehensive care for mothers and newborns, in alignment with constitutional mandates and the Comprehensive Health Care Model. Implemented in Ecuador as an adaptation of WHO and UNICEF's Baby-Friendly Hospital Initiative (BFHI), ESAMyN aims to protect, support, and promote breastfeeding while also emphasizing friendly, humanized care for mothers.[16]

Until 2015, the initiative was part of the National Strategy for Promotion, Protection, and Support of Breastfeeding under the Nutrition Area. However, in 2015, criteria for friendly and humanized care during pregnancy, labor, childbirth, and postpartum were incorporated. The strategy's scope was also expanded to the entire National Health System, applying to hospitals and health centers attending births in the Public and Complementary Health Networks.[16]

Maternal deaths recorded in 2017

211 maternal deaths were reported (143 timely, 68 late). The maternal mortality ratio was 42,80, an increase from 39,63 in 2016. The highest rate remained in 1993 (96,13), and the lowest in 2004 (36,83). Pastaza province recorded the highest rate (111.28 deaths per 100,000 live births). Direct obstetric causes accounted for 96 deaths (67,13 %), with gestational hypertension with proteinuria as the most common. Indirect causes represented 45 deaths (25,56 %), late maternal deaths were 68 (31,47 %), and unspecified causes totaled 2 deaths (1,4 %).[17]

For the second consecutive year, the provinces of Napo, Orellana, and Pichincha (excluding Quito canton)—part of MSP Zone 2—achieved the "Zero Maternal Mortality" goal through actions under the Maternal and Neonatal Mortality Reduction Strategy. To address this public health issue, MSP developed strategic lines to improve care quality in its health facilities.[18]

To strengthen primary care and promote health and disease prevention, the "Neighborhood Doctor and Integrated Health Team Strategy" was launched. This strategy offers an integral view of individual, family, and community health centered on local determinants. It encourages active citizen and local authority participation to resolve health problems within the Family, Community, and Intercultural Comprehensive Health Care Model (MAIS-FCI). The strategy includes two intervention cycles—one for vulnerable patients and another for priority patients—that can run simultaneously. The "Neighborhood Doctor" strategy provides care through an integrated health team comprising a general physician, a nursing professional, and a Primary Health Care Technician (TAPS), supported by a first-level specialist. This team conducts intensive screening to identify priority patients—such as pregnant women and those at high risk—who receive prioritized care.[19]

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Maternal deaths recorded in 2018
221 maternal deaths were reported (137 timely, 84 late). The maternal mortality ratio was 41,1 per 100,000 live births—a 1,7 percentage point decrease from 2017. Chimborazo province reported the highest rate in 2018 (127,6 deaths per 100,000 live births). Direct obstetric causes accounted for 103 deaths (75,2 %), with ectopic pregnancy as the leading cause. Indirect causes totaled 33 deaths (24,1 %), and late maternal deaths were 84. Unspecified causes represented 1 death (0,7 %).[20,21]

In Ecuador, the lack of unified protocols for obstetric patient management and limited primary care coverage have led many women to seek private care for pregnancy, childbirth, and postpartum follow-up—potentially compromising care quality due to fragmented specialist integration and delayed complication prevention. Despite advances in vital statistics registration and underreporting correction, the country has not significantly reduced maternal mortality. This issue primarily affects poor, Indigenous, Afro-Ecuadorian women and those living in rural and urban-marginal areas, with the highest maternal mortality rates observed among women aged 20–24 years. Job instability and lack of financial resources hinder access to quality prenatal care and adequate home environments, contributing to high maternal mortality.[20]

Maternal deaths recorded in 2019
228 maternal deaths were reported (123 timely, 105 late). The maternal mortality ratio was 37,0 per 100,000 live births—a 4,4 % decrease from 2018. Morona Santiago reported the highest rate (99,3 deaths per 100,000 live births). Direct obstetric causes accounted for 82 deaths (66,7 %), with gestational hypertension with proteinuria as the leading cause. Indirect causes totaled 33 deaths (26,8 %). Late maternal deaths reached 105.[22]

Through a Ministerial Agreement, the manual "Notification, Quality Audit of Care, and Action Plans for Maternal Death Cases" was approved to guide health facilities in capturing, notifying, responding to, auditing, and developing action plans for maternal deaths. This manual standardizes procedures and methodologies used by national and local teams, supporting decision-making on maternal health programs and improving care quality and access. Based on the "Integrated Epidemiological Surveillance System Manual" (SIVE-Preventable Mortality), the document compiles and systematizes information to define methodologies and tools facilitating self-analysis and responsive measures to reduce maternal deaths.[23]

Maternal deaths recorded in 2020
217 maternal deaths were reported (191 timely, 26 late). The maternal mortality ratio was 57,6 per 100,000 live births—an increase of 20,6 points from 2019. Provinces with the highest number of deaths by place of occurrence were Guayas, Manabí, Pichincha, Chimborazo, and Azuay. Leading causes were hypertensive disorders (31,9 %), obstetric hemorrhages (17,4 %), and indirect causes (36,23 %).[24]

With hospitals overwhelmed by the COVID-19 pandemic, women faced difficulties accessing the health system. An MSP report revealed an increase in maternal mortality in 2020. INEC data confirmed the pandemic's impact, including a record number of abortion-related deaths.[25]

Maternal mortality in the country increased, approaching traffic accident death rates—partly due to health service congestion during the pandemic. Vaccination is expected to improve service delivery. INEC noted that 2020 death figures are provisional and may be adjusted with future records. The "Intentional Search and Reclassification of Maternal Death" process between INEC and MSP remains incomplete.[26]

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Maternal deaths recorded in 2021

190 maternal deaths were reported (144 timely, 46 late). The maternal mortality ratio was 43,8 per 100,000 live births—a 13,8-point decrease from 2020. Direct obstetric causes represented 38,4 % of deaths, with gestational hypertension with proteinuria as the leading cause. Indirect causes constituted 33,7 %, followed by late maternal deaths (24,2 %). Unspecified causes represented 3,7 %.[27] Among the challenges remaining on Ecuador's public policy agenda, the 2022–2031 National Development Plan (PDS) identifies five clear challenges—with corresponding impact indicators and strategies—one of which is reducing the maternal mortality ratio.[28]

In 2021, MSP launched several initiatives to reduce maternal deaths, notably the National Plan for Maternal and Neonatal Mortality Reduction and the National Maternal and Neonatal Health Strategy. These focused on strengthening prenatal and childbirth care through quality controls and trained personnel, improving maternity and hospital infrastructure and equipment, and establishing obstetric intensive care units. Access to contraceptives and sexual education was promoted, maternal health monitoring systems were optimized, and community interventions were developed with health promoters and local committees. Awareness campaigns were conducted, and mobile brigades were deployed to serve women in rural and Amazonian areas, adapting services to Indigenous cultural practices.[29]

Maternal deaths recorded in 2022

155 maternal deaths were reported (112 timely, 43 late). The maternal mortality ratio was 33,9 per 100,000 live births—a 9,6-point decrease from the previous year and the lowest figure since 2004 (36,83). Direct obstetric causes accounted for 75 deaths (48,4 %), with gestational hypertension with proteinuria as the leading cause. Late maternal deaths (after 42 days postpartum) totaled 43 (27,7 % of all deaths).[29,30]

In 2022, MSP continued implementing and expanding 2021 initiatives. The National Plan for Maternal and Neonatal Mortality Reduction focused on improving prenatal and childbirth care, strengthening obstetric intensive care units, and training staff in obstetric and neonatal emergencies. Hospital infrastructure was upgraded, Emergency Obstetric Units (UOE) were expanded, contraceptive availability and family planning services were increased, and sexual and reproductive health education programs were reinforced.[29]

Evidence indicates that maternal mortality is a statistical term reflecting deaths during pregnancy, childbirth, or postpartum; these statistics often indicate a country's development level. High percentages suggest a health system with uncontrolled indicators and insufficient preventive measures.[31]

A mother's death is not only a statistic and tragedy but also a community consequence. As Chachalo Sandoval et al.,[31] note, women in low-income households play a crucial reproductive and productive role, as most Ecuadorian women assume primary household responsibilities—a pattern observed across the region.[32]

In Ecuador, hypertensive disorders of pregnancy are a leading cause of death. WHO states that most maternal deaths are preventable, and preeclampsia-related complications remain unacceptably high—a global public health problem.[33] In this context, Rodríguez Plasencia et al.,[34] note that global efforts to ensure sovereignty, peace, and Latin American integration aim to substantially reduce mortality rates, with maternal death being a key indicator. Yet approximately 830 women still die daily from preventable pregnancy- and childbirth-related causes.

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Bonilla Ledesma et al.,[6] highlight that adolescents are the most vulnerable group, with risk factors including sociodemographic characteristics—ages 14–19, single motherhood, high school education, high blood pressure, unemployment, and poverty. This phenomenon reflects not only a public health challenge but also significant social and economic implications for young women and their communities—exacerbated by the COVID-19 pandemic, which intensified barriers to essential health services and pregnancy prevention.

The COVID-19 pandemic represented a setback in public health, hindering access to care—especially for pregnant women, who faced limitations in managing risk-free pregnancies. As Acosta Espinosa,[35] notes, the pandemic exposed harsh realities, with Ecuador maintaining one of the highest maternal mortality rates in the Americas, marked by profound social inequities and adequate prenatal care coverage of only 24,6 %.

Moreno-Martín et al.,[36] emphasize that maternal mortality is a key health indicator revealing gender inequity in decision-making and social exclusion. Severe obstetric morbidity demands urgent medical intervention to prevent maternal death, with mortality representing only the visible tip of the iceberg—since for every death, many more women suffer complications.

Lapo-Talledo,[37] corroborates that maternal deaths disproportionately affect vulnerable groups, with ethnic minority women facing higher risks of intrahospital death from childbirth-related causes. The author stresses the need for continued research to inform public health, social, and educational strategies aimed at eradicating this problem and guaranteeing women's rights, integrity, and lives.

CONCLUSIONS

Maternal mortality remains a global health problem with significant implications for healthcare systems. In Ecuador, various annual strategies have been implemented to reduce its rates, though results have fallen short of expectations. The ESAMyN policy—designed to improve care during childbirth and postpartum—was initially seen as a solution, but despite investments in training and infrastructure, mortality increased after its implementation. The year 2020 was critical due to the COVID-19 pandemic, which restricted access to health services for pregnant and reproductive-age women. By 2022, maintaining 2021 measures without major updates led to a decline in deaths. It is essential for the population to understand national statistics to design sustainable strategies and raise awareness among women of reproductive age about public service guarantees. Internationally, this issue has driven the scientific community to intensify research to prevent and eradicate maternal deaths, making it a priority to generate evidence supporting effective health policies and practices.

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