Reduction of maternal mortality in Colombia: The impact of health policies from 1985 to 2007

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ABOUT THIS PROGRAM:

FOCAL’s Health program proposes to use analytical tools in order to produce fact-based evidence about the degree of inequalities and inequities in health and their main determinants among marginalized populations such as Indigenous Peoples and Afro-descendants in Bolivia, Colombia and Peru. This initiative will assist in the identification of policy gaps for the development, discussion and exchange of more accurate health policy ideas.

Reform efforts that have been undertaken in Colombia, and are underway today, are giving local governments more power to deliver more focused and effective policies. Despite these efforts, the results have fallen far short, confining improvements in access and supply of health services to urban and surrounding areas while leaving rural and marginalized populations to face growing levels of inequalities and inequities.
Executive summary

Since health reform began in Colombia, deliveries assisted by qualified personnel in hospitals have risen to 90.7 per cent and 93.5 per cent of expectant mothers are cared for through prenatal monitoring. Mandatory insurance coverage and health spending have both increased. Nevertheless, advances in the reduction of maternal mortality obtained prior to the reforms (1995) have ceased and deteriorated.

Official figures for 2007, not corrected for underreporting,¹ show a maternal mortality ratio of 75.6 deaths per 100,000 live births. This figure does not reflect the marked disparities among regions and population groups where maternal mortality ratios reach close to 200 deaths per 100,000 live births.

In 2004, the Ministry of Social Protection responsible for health in Colombia established an “Action Plan” which has had very poor results. The plan is extremely inadequate because of the very limited coverage of regional entities by insuring agencies.

The following recommendations are presented as measures that the Ministry could adopt in order to achieve significant reductions in mortality rates.

Recommendations:

- Maternal health as a national priority: Educational and promotional campaigns could be developed to expose the problem of maternal mortality and create a national state of awareness.

- Research on quality of care: Applied research investigating aspects of the quality of maternal services could be promoted in order to establish clear lines of action.

- Implementing protocol and training human resources: Mandatory national programs in continuing education could be developed for all health professionals responsible for maternal health-care services.

- Primary care and home activities: The development of primary care activities is highly recommended, especially in regional entities with highly vulnerable populations.
Introduction

The World Bank classifies Colombia as a median income country. In 2007, its Gross Domestic Product (GDP) per capita was US$3,250 and health spending represented 7.1 per cent of the GDP. Colombia’s 42 million inhabitants have a literacy rate of 93 per cent and are distributed across 32 departments and 1,101 municipalities.

According to official statistics, the average level of health insurance coverage is approximately 90 per cent although it should be kept in mind that most of the insured population has restricted service coverage. According to Profaamilia’s latest study on Demography and Health carried out in 2005, 90.7 per cent of deliveries were assisted by doctors or nurses in hospitals and 93.5 per cent of expectant mothers attended prenatal monitoring. Nevertheless, the substantial maternal mortality figures observed make the issue a high priority problem for public health in Colombia.

Health reforms have prioritized the extension of mandatory health insurance coverage and significantly increased the total spending on health, including coverage of prenatal care and delivery by professionals. Nevertheless, the improvements achieved in maternal mortality before the reforms not only ceased, but also regressed. A very high level of maternal mortality continues today.

Figures on maternal mortality in Bogotá and Antioquia (2007) are also noteworthy as they show a higher rate of maternal mortality for women who are under a subsidized regime than uninsured women. The official figures that are not corrected for underreporting show a maternal mortality rate of 75.6 deaths per 100,000 live births.

This policy paper analyzes patterns of maternal mortality in Colombia from 1985 to 2007 and their connection with changes in health policies during this period, the great variations observed at the departmental level and the phenomena of underreporting. Thereafter it will identify policy options that could lead to finding suitable answers to this important issue.
Health reform

Since the 2003 passage of Law 100, health reform in Colombia has established universal mandatory health insurance with two regimes: one is contributory for those who have a work contract or the resources to pay, and one is subsidized for the poor. While universal coverage is achieved, the uninsured are euphemistically referred to as “linked” and are cared for in public hospitals at the state’s expense. The two regimes offer different levels of service coverage in that subsidized regimes cover less services. The reform created insurance brokers (Health Development Companies, EPS in the Spanish acronym) responsible for organizing and contracting networks of service providers (Service Providing Institutions, IPS in the Spanish acronym).

The system operates through two central means: a standardized health service plan called the Mandatory Health Plan (POS in the Spanish acronym) that is offered to all insured people; and a Per Capita Payment Unit (UPC in the Spanish acronym) acknowledging insurers.

Both the total of the UPC and the content of the POS were established by the National Council for Social Security in Health. The council is made up of representatives from almost all of the stakeholders in the system: the government, insurers, service providers, unions, employers and pensioners. When adjustments were made with Law 1122 in 2007, the council took on an advisory role and its previous functions were undertaken by a new entity, the Health Regulatory Commission.

The contributing UPC has a per capita adjustment for age and sex, which functions as an “insurance premium.” By contrast, the subsidized UPC does not have this type of adjustment, although a percentage is added in remote areas.

In order to guarantee insurance administration, the law created the EPSs as new stakeholders for providing health insurance and creating service networks. Service providers are either in-house or contracted out and are made up of public and private service providers that are either for-profit or not-for-profit.

Although the Law explicitly sets out the goal of offering the same POS to the entire population, it accepts a period of transition when the subsidized POS will be inferior to the contributing POS. Currently, the subsidized POS completely covers events at the first and fourth levels of complexity but only partially covers a group of events at the second and third levels. The subsidized UPC equals approximately 60 per cent of the contributing UPC. Nevertheless, the Constitutional Court has demanded that the Health Plans for both regimes soon become equal. Since 2004, so-called partial subsidies were introduced that offer a service package for 40 per cent of the subsidized UPC that is even more reduced than the fully subsidized POS.

In the 17 years since the introduction of the Law 100, documentation shows that the profound imbalance between the system’s financial incentives and the absence of incentives for positive health results has generated negative behaviour that puts the quality of care at risk. All of the stakeholders are submitted to a system in which the invoicing of services is fundamental for guaranteeing profitability. This is the case even in public hospitals, which now fall under the same types of incentives since they have been transformed into social companies of the state.

Maternal mortality in Colombia

Colombia presents a high level of maternal mortality with a ratio of 75.6 deaths per 100,000 live births (2007). This is unacceptable for a country with the level of development, health insurance, institutional delivery care, prenatal care coverage and health spending that Colombia has. The mortality ratio is 11 times greater than in Canada, five times higher than in Chile and double that of Argentina and Cuba. The figure corrected for underreporting could be close to 100 deaths.
A better understanding of the significance of this figure can be obtained by analyzing patterns over a period of many years, by studying differences in diverse population groups, by identifying changes in the registration system for vital statistics and by relating patterns of maternal mortality to changes in health policies.

Above all, two central points must be taken into account in order to reasonably interpret the statistics. The first is the underreporting of maternal deaths in official statistics. It is very possible that secular underreporting may have diminished as institutional delivery care has increased. However, underreporting continues and is greater in Colombia’s less developed areas, such as Chocó, La Guajira and the departments of Antioquia and Amazonia. The estimate of maternal mortality corrected for underreporting is close to 100 deaths per 100,000 live births, which cannot be dismissed.

Second, it should be noted that Colombia’s National Statistics Department (DANE in its Spanish acronym) made improvements to death certification and registration systems in 1997. The effects from those improvements were first felt in 1998.

It is also important to note that institutional delivery care and prenatal monitoring have increased in a sustained way since their measurement was initiated in 1986 for the Demography and Health Studies. Between 1986 and 2005, the proportion of institutional deliveries assisted by doctors or nurses rose from 71 per cent to 90.7 per cent. In 2005, 93.5 per cent of expecting mothers were under prenatal care.

Despite these statistics, patterns of maternal mortality are very disturbing. Rubén Darío Gómez analyzed patterns of maternal mortality in Colombia between 1985 and 2002 as part of a broader study on preventable mortality. Based on DANE’s official statistics, a clear tendency toward a reduction of mortality can be observed between 1985 and 1996. Nevertheless, that tendency was interrupted in 1996 and started to show a clear deterioration (see Figure A in the Appendix). It is important to keep in mind that the implementation of the reform plan began in 1995. The deterioration that has continued since 1998 may reflect both greater mortality and the effects of better reporting. Given the changes in the registration system, the data before and after 1998 must be analyzed separately.

In 2004, the Ministry of Social Protection recognized the seriousness of the situation and established

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**Table 1**

<table>
<thead>
<tr>
<th>Country</th>
<th>Maternal Mortality Ratio*</th>
<th>GDP dedicated to health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Canada</td>
<td>7</td>
<td>10.1</td>
</tr>
<tr>
<td>Chile</td>
<td>14</td>
<td>6.2</td>
</tr>
<tr>
<td>Colombia</td>
<td>75.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Cuba</td>
<td>37.3</td>
<td>10.4</td>
</tr>
</tbody>
</table>

*Note: This is the most recent available information (Argentina, 2004; Canada, 2005; Chile, 2003; Colombia, 2007; Cuba, 2005). It is compared with the 2007 GDP for each country.


itemid=119.
an “Action Plan” to tackle maternal mortality but the actions put forward have been extremely inadequate. The coverage of regional entities by insuring agencies has been very limited and the plan’s impact has been minimal. Maternal mortality showed a slight decrease between 2000 and 2003 but almost remained stationary after that. In other words, the entire country does not feel the impact of the “Action Plan.” In 2003, the official figure was 77.8 deaths per 100,000 live births whereas in 2007 it was 75.6 deaths.

According to the Ministry of Social Protection, the “Action Plan” centres on 11 prioritized regional entities (departments). On the whole, these regional entities were able to reduce maternal mortality by 16.76 per cent between 2004 and 2007. Nevertheless, maternal mortality increased in three departments: Bolívar, Boyacá and Valle del Cauca.

**Maternal mortality and insurance**

Another important analysis would look at the pattern of maternal mortality for each insurance regime; unfortunately, the necessary national data is not available. However, information from Bogotá and Antioquia can give an approximate picture. In 2007 in Bogotá, the maternal mortality ratio within the subsidized regime was 65.4 deaths per 100,000 live births, while the ratio within the contributing regime was 40.4 and it was 32.6 for uninsured women. In Antioquia, the ratio for the subsidized regime was 56.8 deaths per 100,000 live births, 22.6 for the contributing and 56.8 for the uninsured.7

The available information does not allow us to determine the cause of the important differences in the maternal mortality ratio based on different insurance regimes. They could be due to differences between the women affiliated with the different regimes —age, socioeconomic level, etc.— or the differences in the quality of services.

The information from the epidemiological monitoring system for Antioquia also provides details on maternal mortality including characteristics of the mother’s residence and education. It confirms what is observed in universal statistics: maternal mortality is much higher in rural zones and is inversely related to education. While the maternal mortality ratio was 64.9 deaths per 100,000 live births in rural areas, in the urban area it was 36.5 deaths. Women without any education had a ratio of 222.4 deaths whereas women with higher education had 22.6 deaths per 100,000 live births.

**Adolescent pregnancy**

Childbirth is considered a heightened risk for mothers younger than 18 years of age at the time of delivery. In 1990, the rate for adolescent pregnancy was 70 per 1,000 women between the ages of 15 and 19 in Colombia. In 2005, it rose to 90 pregnancies per 1,000 teenage women. Twenty-two per cent of the country’s adolescents have been pregnant at some time. This figure rises in cases of displacement.

A combination of circumstances usually occurs in adolescent pregnancies, creating an environment of additional risk: instability in the couple’s relationship, emotional conflicts, a lack of preparation for motherhood and late consultation with the health system. A significant portion of these may be unwanted pregnancies. Though adolescent pregnancy is not necessarily a health risk in itself, it tends to occur in conditions, such as poverty, malnutrition, family instability and displacement, which all generate additional risks.

**Quality of services**

Though pregnancy complications are difficult to prevent, evidence from the scientific literature shows that providing good quality health services can prevent maternal death from these complications.
This involves timely access to health services with qualified professional care and the availability of the necessary means of treatment, such as blood banks, operating rooms, etc.

The three delays model developed by Columbia University is very useful for identifying significant causes of maternal death and alternative actions.

The first delay focuses on the lack of awareness of warning signs by the mother and her family and their delay in deciding to consult health agents. This delay is clearly related to education levels and cultural aspects.

The second delay deals with the time it takes from the moment the woman makes the decision to seek consultation to when she arrives at the health facility. This delay is related to the distance to an appropriate health facility as well as transportation: means of transportation, availability, cost and the ability to pay.

The third delay deals with the time elapsed between the mother’s arrival at the health facility and the initiation of appropriate treatment. Administrative procedures, the lack of “triage” systems for giving priority of care to patients who need it and the lack of specialists, blood banks or operating rooms all fall under this third category. It is also related to poor quality of care and includes inadequate adherence to standards, care protocol and interventions based on evidence from service providers and health personnel. This third delay is also related to the poor infrastructure of health services, reference systems and human resource distribution.

Though this model is widely used in Colombia, data for estimating the relative importance of each of the delays is not available at the national level. Nevertheless, it is possible to use information from the department of Antioquia, which features varied geographical conditions as it extends from the Andean area to the Atlantic coast, has large and medium cities as well as small towns, and has areas with difficult access to health services as well as others with relatively developed health services. The different conditions found in this department are generally similar to those in the rest of the country. In Antioquia in 2007, the third delay was the most frequent, followed by the first (see Figure 2).

![Figure 2: Delays contributing to maternal mortality in Antioquia, 2007](image)

*Note: The total is greater than 100 because one single case can have more than one delay. Also, a small number of cases do not have information on delays.


A systematic review of the scientific literature on the performance of the Colombian health system shows that there are serious shortcomings in the quality of services offered. These shortcomings are related to the system’s emphasis on financial incentives which are not balanced by incentives to produce positive health results. This emphasis leads to exorbitant cost controls, non-ethical conduct and the invoicing of unnecessary services. This situation could be affecting the quality of maternal services. An important
study by the University of Antioquia together with the Universidad Industrial of Santander and Colombia’s Attorney General documents how excessive cost controls by insurers encourage practices that affect the quality of care and generate serious ethical dilemmas for health professionals. There may be problems in human resource training as well but unfortunately there are no studies to rely on, only anecdotal evidence.

**Causes of maternal mortality**

The analysis of the causes of maternal mortality adds important elements to understand the current situation. The high number of obstetric deaths by unspecified causes and the preponderence to hemorrhages, hypertension and sepsis (see Table 2) place the quality of care in doubt, especially when there is such a high percentage of coverage for prenatal and institutional delivery care. According to available evidence, the complications of pregnancy, delivery and puerperium are difficult to prevent. Nevertheless, deaths from said complications are preventable through timely, good quality care.

| Table 2 |
| Main causes of maternal mortality in Colombia, 2007 |
| Total | 536 |
| Other obstetric conditions that are not classified elsewhere (O95-O99) | 178 |
| Edema, proteinuria and hypertension disorders in pregnancy, delivery and puerperium (O10-O16) | 112 |
| Complications in labour and delivery (O60-O75) | 95 |
| Complications related mainly to puerperium (O85-O92) | 50 |
| Pregnancy terminated by abortion (O00-O08) | 48 |
| Specific causes in other areas (A34X, B200-B24X, C58X, D392, E230, F530-F539, M830) | 31 |
| Maternal care related to the fetus and the amniotic cavity and possible problems during delivery (O30-O48) | 19 |
| Other pregnancy-related disorders (O20-O29) | 3 |


**Maternal mortality in marginalized populations**

We must certainly look beyond Colombia’s average maternal mortality ratio to try to obtain a better understanding of the situation. Immense differences are found when patterns of maternal mortality are observed among different regional entities (departments) where the situation is much more serious than the country’s average ratio of 75.6 deaths per 100,000 live births (see Table 3).

Thirteen of the departments have a mortality ratio that is higher than the national average; in eight of these, a medium or high proportion of the population is Indigenous Peoples or Afro-descendents. In the 11 other departments and the capital district, which are below average, only one department has a high proportion of Afro-descendents (more than 21 per cent).
The eight departments with the highest maternal mortality ratios are between 1.5 and 2.6 times the national average, and between two and 4.8 times higher than the lowest ratio in Colombia as observed in Santander.

Unfortunately vital statistics are not differentiated by ethnicity but it is possible, with reservations at least, to offer the hypothesis that maternal mortality is especially serious for Indigenous Peoples and Afro-descendents. These groups are associated with poverty and low levels of education but the situation is worse for those who are located in inhospitable areas where communication is difficult, such as the Pacific coast departments of Cauca, Chocó and Nariño, the desert departments such as La Guajira and the expansive areas with low population density such as Caquetá.

### Table 3

<table>
<thead>
<tr>
<th>Department</th>
<th>2007 Maternal deaths</th>
<th>Ratio per 100,000 live births</th>
<th>Department</th>
<th>2007 Maternal deaths</th>
<th>Ratio per 100,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chocó*</td>
<td>11</td>
<td>194.72</td>
<td>Huila</td>
<td>15</td>
<td>71.51</td>
</tr>
<tr>
<td>Córdoba*</td>
<td>38</td>
<td>174.91</td>
<td>Valles*</td>
<td>42</td>
<td>69.44</td>
</tr>
<tr>
<td>La Guajira*</td>
<td>20</td>
<td>162.92</td>
<td>Atlántico</td>
<td>26</td>
<td>64.36</td>
</tr>
<tr>
<td>Caquetá</td>
<td>11</td>
<td>150.75</td>
<td>Cesar</td>
<td>13</td>
<td>63.9</td>
</tr>
<tr>
<td>Putumayo*</td>
<td>7</td>
<td>139.89</td>
<td>Tolima</td>
<td>14</td>
<td>63.65</td>
</tr>
<tr>
<td>Magdalena</td>
<td>31</td>
<td>139.51</td>
<td>Risaralda</td>
<td>8</td>
<td>59.8</td>
</tr>
<tr>
<td>Cauca*</td>
<td>22</td>
<td>128.47</td>
<td>Cundinamarca</td>
<td>21</td>
<td>56.32</td>
</tr>
<tr>
<td>Boyacá</td>
<td>22</td>
<td>112.22</td>
<td>Norte Santander</td>
<td>12</td>
<td>55.13</td>
</tr>
<tr>
<td>Sucre*</td>
<td>16</td>
<td>106.37</td>
<td>Bogotá</td>
<td>57</td>
<td>48.62</td>
</tr>
<tr>
<td>Meta</td>
<td>16</td>
<td>103.35</td>
<td>Caldas</td>
<td>6</td>
<td>45.65</td>
</tr>
<tr>
<td>Bolivar*</td>
<td>29</td>
<td>96.71</td>
<td>Antioquia</td>
<td>39</td>
<td>42.18</td>
</tr>
<tr>
<td>Nariño*</td>
<td>21</td>
<td>94.46</td>
<td>Santander</td>
<td>13</td>
<td>40.67</td>
</tr>
<tr>
<td>Quindío</td>
<td>6</td>
<td>85.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total / Average ratio</strong></td>
<td><strong>536</strong></td>
<td><strong>75.57</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


*Departments where a medium to high proportion of the population are Indigenous Peoples or Afro-descendents. In La Guajira more than 22 per cent of the population is indigenous as are between six and 21 per cent in Cauca, Córdoba, Nariño, Putumayo and Sucre. In Bolivar, Cauca, Chocó and Valles more than 21 per cent of the population are Afro-descendents.

**Note:** Departments with less than 300,000 inhabitants are not included in this table but are included in the total number of deaths and the average ratio.

### Conclusions

According to the Pan American Health Organization (PAHO) and the World Health Organization (WHO), and the opinions of many experts, the health situation of any country can be determined by the maternal survival marker better than by the life expectancy. If the maternal mortality rate drops, it can be assumed that the population’s other health problems are improving. On the other hand, when maternal mortality remains constant, other attempts at improving the population’s health will definitely have very little effect on the population’s well-being. Every year, more than 22,000 women in Latin America and the Caribbean die from complications during pregnancy and childbirth. Most of these deaths could have been prevented if appropriate interventions had been made during pregnancy, delivery and the postnatal period.

The levels of maternal mortality in Colombia are unacceptable given the country’s level of development, the current insurance coverage and the magnitude of spending on health, including institutional care at birth and prenatal monitoring.13 No matter how one looks at it, the “Action Plan” carried out by the Ministry of Social Protection has been limited and inadequate. It has not produced the necessary impact to lower levels of maternal mortality, which have remained stagnant.

Colombia’s current health policy is focused on insurance, neglecting primary care programs and health education. Further, the emphasis on financial incentives affects the quality of services by
encouraging extreme cost control measures that can lead to reductions in the workforce, delays in timely referrals to specialists or to higher levels of complexity and, in general, the non-fulfilment of care protocols. In addition, the health care that insurers provide is limited to institutional care to respond to demand in services (with multiple barriers); they do not consider outreach actions at the level of the community or household.

There are immense differences among mothers who are at risk of death, depending on their socioeconomic level and region. The situation of these women reflects an important flaw in the national policy to reduce health inequalities, which must be dealt with by using effective and aggressive action. The following recommendations put forth measures that the Ministry could adopt in order to achieve significant reductions in mortality rates.

**Recommendations**

The following recommendations are measures that the Ministry of Social Protection could adopt in order to achieve a significant reduction in mortality rates.

1. **Maternal health as a national priority**: Maternal health needs to become an important national priority, accompanied by active media campaigns to raise community awareness about the problem and possible solutions. Educational and promotional campaigns could be developed to highlight the problem of maternal mortality and the great social impact of each death. These campaigns could mobilize society around protecting the lives of mothers and could lead to enhanced national awareness about the unacceptability of any maternal death. It is also necessary to focus attention on those regions that show the greatest levels of maternal mortality.

2. **Research on quality of care**: Priority could be given to applied research that investigates aspects of the quality of maternal services. When working to determine the main causes of maternal mortality, researchers could focus on deficiencies, which could lead to the proposal of specific interventions. There is a need to identify what is lacking in the quality of human resources and institutional arrangements that will allow the development of corrective measures.

3. **Implementing protocol and training human resources**: A plan could be implemented to prepare human resources through training that addresses identified problems. Further, it would be important to develop mandatory national programs in continuing education for all health professionals responsible for maternal care services. It would also be important to demand the fulfilment of care protocols.

4. **Primary care and home activities**: Primary care programs with active citizen participation could be re-established as well as work in the community and in homes, especially in regions with highly vulnerable populations.
Endnotes

1 Underreporting occurs mainly in Colombia’s rural areas and in areas with dispersed populations where access to health services is difficult. Not many deaths are reported in these areas. Despite this, the departments that are concentrated in these areas show higher ratios of maternal mortality.
3 Partial subsidy means a proportion of the value of the Subsidized Payment Unit per Capita UPC-S that is destined to jointly finance content in the subsidized Mandatory Health Plan, POS-S (Agreement 267 dated 2004).
4 According to the National Statistics Department (DANE), 10 departments have maternal mortality ratios higher than 100 and seven have more than 120 deaths.
5 The Ministry of Social Protection and the National Statistics Department have commissioned an investigation documenting this phenomenon at the level of different regional entities, but it has not been released yet.
7 It is government policy that membership in the subsidized regime be directed at the poorest population. Members of the contributing regime have formal employment while “linked” or non-members are usually those without formal employment who are not poor enough to be a priority for state subsidies. The differences in mortality ratios may be due to differences in the pregnant women, their education, rural residence, etc. On the other hand, they may be due to differences in the quality of care but to date there is no available evidence to clarify which one is the most important factor.
8 Systems for selecting patients based on their level of seriousness in order to refer them to the type of service that they need.
11 Anecdotical evidence includes expert opinions, press publications or statements that are not substantiated by rigorous research.
12 More than 22 per cent of the population in La Guajira are Indigenous Peoples as are between 6 and 21 per cent of the population in Cauca, Córdoba, Nariño, Putumayo and Sucre. In Bolívar, Cauca, Chocó and Valle more than 21 per cent of the population are Afro-descendents.
13 Between 1991 and 1997 public spending on health grew six times in constant pesos. This increase is unprecedented in Colombia’s health history. As a percentage of the GDP, the total health cost rose from 6.2 per cent in 1993 to 9.6 per cent in 1997 before dropping to around 7 per cent. Today it is at 7.7 per cent.
Appendix

Figure A
Maternal Mortality Ratio (RMM in its Spanish acronym) per 100,000 live births, Colombia 1985-2002

Mortalidad Materna

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