Maternal Mortality, Social Determinants and Sustainable Development Goals

Policy Position Statement

Key messages:

Maternal mortality continues to be a major challenge to global health systems and the vast majority of maternal deaths are preventable.

Maternal mortality is impacted by the social determinants of health such as poverty, income, education, gender inequity, racism, access to healthcare and health status. Investments in prevention to mitigate the impacts of the social determinants on maternal mortality is required.

Maternal mortality remains a major health and human rights issue for women and girls globally. Australia should use its international authority to work towards reductions in maternal mortality globally.

Key policy positions:

1. The implementation and extension of existing commitments to gender equity.
2. Support for comprehensive provision of accessible and affordable sexual and reproductive health including abortion access, antenatal and postnatal care, and abortion in global development aid programmes.
3. Capacity building of the health workforce and resourcing to ensure acceptable quality of care.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA International Health and Women's Health Special Interest Groups

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Maternal Mortality, Social Determinants and Sustainable Development Goals

Policy position statement

PHAA affirms the following principles:

1. Maternal mortality rates which includes the death of women and girls during pregnancy, after the termination of pregnancy and following childbirth are unacceptably high.[1] These deaths also disproportionately affect women and girls in low and lower-middle income countries.[2]
2. The "three delays" that impact on maternal mortality are:
    a. Delay in seeking appropriate medical help for an obstetric emergency due to cost, lack of recognition of an emergency, poor education, and gender inequality.
    b. Delay in recognising and reaching an appropriate facility for reasons of distance, infrastructure and transport.
    c. Delay in receiving adequate care when a facility is reached, due to shortages in staff, or in electricity, water and medical supplies.[3]
3. Most maternal mortality is preventable if the mother has timely and affordable access to a skilled health professional.[4] Experiences and perceptions among women of poor-quality maternity care also influences care-seeking behaviour.[5, 6]
4. There are a range of other social determinants beyond access to appropriate health care which significantly impact maternal mortality rates, including poverty, income, education, gender inequity, racism and health status. A continued shift away from the biomedical approach is required to tackle maternal mortality in order to achieve Sustainable Development Goal (SDG) 3.1.[2, 7]

PHAA notes the following evidence:

5. The World Health Organization (WHO) estimates that 287,000 maternal deaths occurred worldwide in 2020. The maternal mortality ratio in developing countries, at 430 deaths per 100,000 live births, was approximately 33 times higher than in developed countries, at 13 per 100,000 live births.[2] The lifetime risk of maternal death in low-income countries is also 1 in 49, compared to 1 in 5,300 in high-income countries.[4] In 2020, almost 95% of all maternal deaths occurred in low and lower middle-income countries.[2]
6. The Programme of Action of the United Nations International Conference on Population and Development in 1994 first made explicit the right of every woman to safe pregnancy and childbirth.[8]
7. The global community failed to fulfil Millennium Development Goal 5a: to reduce the maternal mortality ratio by three quarters by 2015.[9] Progress has remained slow in relation to ongoing global targets with SDG Goal 3.1: to reduce maternal mortality to less than 70 deaths per 100,000 live births by 2030 also not on track to be met.[2, 10]
8. The maternal mortality ratio declined globally by about 34% between 2000 and 2020. However, from 2015 to 2020 the maternal mortality ratio only reduced from 227 to 223 deaths per 100,000 live births.[11] Specifically, during this period maternal mortality rates remain stagnant in Western Europe

and North America, and there was an increase in the mortality rates in Latin America and the Carribbean.[4]

9. Poor quality of care is a major factor in maternal mortality. Two reports from 2018 suggest that up to 60% of maternal deaths occurred due to poor quality of care rather than a lack of healthcare utilisation.[12,13]

10. Equity of access to caesarean sections is crucial to prevent maternal morbidity and mortality, however inappropriate usage, or provision with poor quality, can be a contributor to maternal and child morbidity and mortality.[12-14]

    a. A population caesarean section rate that appears adequate can mask inequity, where some groups experience overuse and others a dire lack of access; in some countries the disparity is increasing between the richest and the poorest women. Audits of facilities with high caesarean section rates have found both a significant proportion of unjustified use, as well as within-facility disparities in use between different populations. Inappropriate use of a caesarean section can direct scarce healthcare resources into relatively healthy populations, increasing morbidity and mortality elsewhere.[14]

    b. Women who undergo caesarean sections in low and lower-middle income countries experience maternal and neonatal mortality rates of up to one percent, which is 40 to 100 times higher than rates seen in high-income countries.[14]

    c. The timeliness of caesarean sections also affect mortality: the majority of caesareans performed in sub-Saharan Africa are done as emergencies, despite the increased risk of complications in emergency caesareans; in particular when performed later in labour they have up to 12 times the mortality of scheduled caesarean sections.[14]

11. Accurate measurement of maternal mortality is important in achieving targets for mortality reduction and many countries still lack a complete civil registration and vital statistics (CRVS) system.[15]

12. Common causes for maternal injury and mortality include excessive blood loss, infection, high blood pressure, unsafe abortion and obstructed labour. Indirect causes include anaemia, malaria and heart disease.[16] Though the biomedical complications of pregnancy, childbirth and postpartum cause maternal mortality. Research has highlighted that reducing the mortality rate can no longer be constrained by the biomedical causes and attention needs to be given to societal factors, including the systematic, environmental, cultural, economic, and political factors.[6, 7, 17] These factors contribute to the vulnerability of women to maternal mortality.[17]

13. Maternal mortality is impacted and influenced by the social determinants of health such as poverty, income, education, gender inequity, racism, access to healthcare and health status.[2,7] The intersectionality of these factors continues to exacerbate the maternal health inequalities experienced.[6]

    a. **Gender inequity:** Due to power structures in society and reflected in the neglect of reproductive rights, which leads to an unmet need for family planning and increased unsafe, emergency practices.[18] The rights of women and girls to access safe, timely, quality and affordable reproductive and sexual health care services are not prioritised.[2] Progress made towards achieving SDG 5: gender equality will have significant flow on effects to achieving SDG 3.1.[19]

    b. **Violence against women:** Impacts maternal mortality through physical and sexual violence, lack of contraceptive choice, risk of sexually transmitted infections and HIV, and more frequent

unwanted pregnancies.[2, 20]

c. **Racism:** Impacts maternal mortality through poorer access to and standard of care and there is a need for culturally appropriate services for women.[6] States have a core obligation to fulfil the right to non-discriminatory access to maternal health services. Black women also have significantly higher death rates compared to White and Hispanic women in the USA.[21]

d. **Education and employment:** Educated women and girls have more stable employment, higher incomes, better nutritional status, are better able to identify danger signs during pregnancy, bear fewer children and are more likely to marry later.[7]

e. **Access to health care and commodities (i.e. contraception) and health status:** South Asia has the lowest proportion of women who are attended at least once during pregnancy or birth by a skilled health professional.[22] Obstetric violence plays a significant role in health care outcomes for women before, during, and after pregnancy and it also impacts future utilisation of health services.[23] Poor quality of health care has been evidenced to cause more maternal deaths compared to non-utilisation of services.[11] Women's perceptions and experiences of utilising health services during and after pregnancy need to be improved.[5] Women and girls with pre-existing health conditions such as malaria, hypertension and HIV/AIDS are also at a higher risk of mortality.[16]

f. **Health status, poverty and food insecurity:** The poor are more likely to die when compared to the affluent.[4] Maternal deaths are not proportional and instead occur more commonly amongst women and girls of lower socio-economic status in low and lower-middle income countries.[2] Malnourished women have a mortality risk that is two times higher than well-nourished women, and food insecurity was heightened during the covid pandemic.[24] Lack of access to family planning leads to unplanned pregnancies and increases the probability of other poor pregnancy outcomes including newborn deaths.[18]

14. Additional contributing factors in recent years include:

g. **Humanitarian emergencies:** 100 million people were forcibly displaced in 2022 alone and the numbers have been increasing rapidly due to violence, conflict and weather-related events. 42 million of these displaced people were women and girls. A lack of access to sexual and reproductive health services and information is a leading cause of morbidity and mortality in this population group, as around "60% of maternal deaths or childbirth among adolescent girls occur in conflict or disaster contexts."[25]

h. **COVID-19 pandemic:** an analysis of the effects of the pandemic on maternal and perinatal outcomes found that maternal outcomes worsened during the pandemic with an increase in maternal deaths.[26]

15. In 2023 the UN Women reported global progress towards achieving for SDG 5. The report highlighted that there are still a number of data gaps, meaning the progress snapshot is incomplete.

16. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 1 – No Poverty, Goal - 2 Zero Hunger, Goal 3 – Good Health and Wellbeing and Goal 4 – Quality Education, Goal 5 – Gender Equality, Goal 15 – Peace, Justice and Strong Institutions, Goal 17 – Partnerships for the Goals.

PHAA seeks the following actions:

17. The Australian government should continue to implement its current commitments to gender

equity in policies and programs, but these commitments should also be expanded to accelerate progress. Focus also needs to be given to improving data collection and monitoring of targets and indicators related to gender equality to ensure that progress can be effectively measured.

18. The Australian government should focus on improving quality of care through capacity building and increasing access to high-quality and affordable sexual and reproductive health services and resources (including abortion access, antenatal and postnatal care).
19. The Australian government should also prioritise supporting and building the capacity of low and lower-middle income countries in the Asia/pacific region and beyond to improve their quality-of-care provision.

PHAA resolves to:

i. Strengthen links with Global Reproductive Rights Associations and People's Health Movement groups, especially in neighbouring countries in the Asia/Pacific region.

ii. Advocate to promote Australia's role in improving the safety, access to services, and opportunities for leadership for women, especially in the developing world, through increases in Foreign Aid.

iii. Provide information and education on voluntary family planning and reproductive health through family planning associations in each state and through the UNFPA.

iv. Advocate for skilled birth attendance at antenatal care and access to emergency postnatal care.

v. Assist in building capacity for health service delivery and workforce retention in the health sector in developing countries.

vi. Assist the Government in improving their data collection systems in relation to maternal, infant and child health and mortality as outlined in the WHO Strategies toward ending preventable maternal mortality.[28]

vii. Advocate for global initiatives to intensify policy intervention for maternal mortality. These need to focus on maternal health in developing countries, supporting the right of every woman to safe pregnancy and childbirth, family planning, safe abortion and reduction of the maternal mortality rate.[7]

(Adopted 2011 and revised 2015, 2018, 2021 and 2024)

References

1. World Health Organization. ICD-11 International Classification of Diseases for Mortality and Morbidity Statistics: Reference Guide: WHO; 2023. Available from: https://icdcdn.who.int/icd11referenceguide/en/html/index.html
2. World Health Organization. Maternal mortality [Internet]. 2024 [cited 2024 2 May]. Available from: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
3. Actis Danna V, Bedwell C, Wakasiaka S, Lavender T. Utility of the three-delays model and its potential for supporting a solution-based approach to accessing intrapartum care in low- and middle-income countries. A qualitative evidence synthesis. Glob Health Action. 2020;13(1):1819052. doi:10.1080/16549716.2020.1819052
4. United Nations Children's Fund. Maternal mortality [Internet]. 2024 [cited 2024 2 May]. Available from: https://data.unicef.org/topic/maternal-health/maternal-mortality/
5. Jolly Y, Aminu M, Mgawadere F, van den Broek N. "We are the ones who should make the decision" – knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. BMC Pregnancy and Childbirth. 2019;19(1):42. doi:10.1186/s12884-019-2189-7

6. Bohren MA, Iyer A, Barros AJD, Williams CR, Hazfiarini A, Arroyave L, et al. Towards a better tomorrow: addressing intersectional gender power relations to eradicate inequities in maternal health. EClinicalMedicine. 2024;67:102180. doi:10.1016/j.eclinm.2023.102180
7. Souza J, Day L, Rezende-Gomes A, Zhang J, Mori R, Baguiya A, et al. A global analysis of the determinants of maternal health and transitions in maternal mortality. The Lancet Global Health. 2023;12 doi:10.1016/S2214-109X(23)00468-0
8. United Nations Population Fund. International Conference on Population and Development [Internet]. n.d. [cited 2024 2 May]. Available from: https://www.unfpa.org/icpd
9. United Nations. The Millennium Development Goals Report 2015: UN; 2015. Available from: https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20%28July%201%29.pdf
10. Oladapo OT, Nihlén Å. Maternal health in a dramatically different world: tailoring actions to achieve targets for 2030 and beyond. Lancet Glob Health. 2024;12(2):e185-e187. doi:10.1016/s2214-109x(23)00545-4
11. Raina N, Khanna R, Gupta S, Jayathilaka CA, Mehta R, Behera S. Progress in achieving SDG targets for mortality reduction among mothers, newborns, and children in the WHO South-East Asia Region. The Lancet Regional Health - Southeast Asia. 2023;18 doi:10.1016/j.lansea.2023.100307
12. Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet. 2018;392(10160):2203-2212. doi:10.1016/S0140-6736(18)31668-4
13. National Academies of Sciences, Engineering, and Medicine. 2018. *Crossing the global quality chasm: Improving health care worldwide.* Washington, DC: The National Academies Press. doi:https://doi.org/10.17226/25152.
14. Boatin AA, Ngonzi J, Ganyaglo G, Mbaye M, Wylie BJ, Diouf K. Cesarean delivery in low- and middle-income countries: A review of quality of care metrics and targets for improvement. Semin Fetal Neonatal Med. 2021;26(1):101199. doi:10.1016/j.siny.2021.101199
15. World Health Organization. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division: WHO; 2023. Available from: https://iris.who.int/bitstream/handle/10665/366225/9789240068759-eng.pdf?sequence=1
16. World Health Organization. Maternal health [Internet]. n.d. [cited 2024 2 May]. Available from: https://www.who.int/health-topics/maternal-health#tab=tab_1
17. Sheikh J, Allotey J, Kew T, Khalil H, Galadanci H, Hofmeyr GJ, et al. Vulnerabilities and reparative strategies during pregnancy, childbirth, and the postpartum period: moving from rhetoric to action. eClinicalMedicine. 2024;67:102264. doi:https://doi.org/10.1016/j.eclinm.2023.102264
18. Coulson J, Sharma V, Wen H. Understanding the global dynamics of continuing unmet need for family planning and unintended pregnancy. China Popul Dev Stud. 2023;7(1):1-14. doi:10.1007/s42379-023-00130-7
19. World Health Organization. Accelerate progress towards reducing maternal, newborn and child mortality in order to achieve Sustainable Development Goal targets 3.1 and 3.2 WHO; 2024. Available from: https://apps.who.int/gb/ebwha/pdf_files/EB154/B154_CONF4-en.pdf
20. Grose RG, Chen JS, Roof KA, Rachel S, Yount KM. Sexual and Reproductive Health Outcomes of Violence Against Women and Girls in Lower-Income Countries: A Review of Reviews. The Journal of Sex Research. 2021;58(1):1-20. doi:10.1080/00224499.2019.1707466
21. Khalil A, Samara A, O'Brien P, Coutinho CM, Quintana SM, Ladhani SN. A call to action: the global failure to effectively tackle maternal mortality rates. Lancet Glob Health. 2023;11(8):e1165-e1167. doi:10.1016/s2214-109x(23)00247-4
22. Kaphle S, Vaughan G, Subedi M. Respectful Maternity Care in South Asia: What Does the Evidence Say? Experiences of Care and Neglect, Associated Vulnerabilities and Social Complexities. Int J Womens Health. 2022;14:847-879. doi:10.2147/ijwh.S341907
23. Sever M, Uluşen M. Obstetric violence in pregnancy and childbirth as a violation of women's human rights. European Journal of Midwifery. 2023;7(Supplement 1). doi:10.18332/ejm/172498
24. Shenoy S, Sharma P, Rao A, Aparna N, Adenikinju D, Iloegbu C, et al. Evidence-based interventions to reduce maternal malnutrition in low and middle-income countries: a systematic review. Front Health Serv. 2023;3:1155928. doi:10.3389/frhs.2023.1155928

25. Soeiro RE, de Siqueira Guida JP, da-Costa-Santos J, Costa ML. Sexual and reproductive health (SRH) needs for forcibly displaced adolescent girls and young women (10–24 years old) in humanitarian settings: a mixed-methods systematic review. Reproductive Health. 2023;20(1):174. doi:10.1186/s12978-023-01715-8
26. Chmielewska B, Barratt I, Townsend R, Kalafat E, van der Meulen J, Gurol-Urganci I, et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. Lancet Glob Health. 2021;9(6):e759-e772. doi:10.1016/s2214-109x(21)00079-6
27. UN Women, United Nations Department of Economic and Social Affairs. Progress on the Sustainable Development Goals: The gender snapshot 2023: UN Women; 2023. Available from: https://www.unwomen.org/en/digital-library/publications/2023/09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2023
28. World Health Organization. Strategies toward ending preventable maternal mortality (EPMM): WHO; 2015. Available from: https://www.who.int/publications/i/item/9789241508483