

# 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. The vast majority of maternal deaths are preventable.

Maternal mortality is impacted by the social determinants of health: poverty, education, employment, access to health care, and health status. Maternal mortality remains a major health and human rights issue for women and girls globally.

Australia can use its international authority to work towards reductions in maternal mortality.

**Key policy positions:** PHAA will advocate for:

1. The implementation 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 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

**Date adopted:** 23 September 2021

# Maternal Mortality, Social Determinants and Sustainable Development Goals

## Policy position statement

### PHAA affirms the following principles:

1. 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 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, electricity, water and medical supplies.<sup>21</sup>
2. The delivery of poor quality maternity care is an influential factor on care-seeking behaviour.<sup>22-24</sup>

### PHAA notes the following evidence:

3. The World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA) and the World Bank estimate that 295,000 maternal deaths occurred worldwide in 2017. The maternal mortality ratio in developing countries, at 462 deaths per 100,000 live births, was approximately 42 times higher than in developed countries, at 11 per 100,000 live births.<sup>1</sup>
4. 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.<sup>2</sup>
5. The focus on maternal mortality increased substantially with the introduction of the United Nations Millennium Declaration (Millennium Development Goal 5). The target was to reduce the maternal mortality ratio by three quarters from 1990 to 2015 but progress was slow (though Bangladesh and Rwanda achieved considerable success) and in many developing countries the target could not be achieved.<sup>3, 4</sup>
6. The new Sustainable Development Goal 3 targets include reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.<sup>1,5</sup>
7. 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) systems.<sup>6</sup>
8. The Global Burden of Disease study has undertaken a detailed analysis of vital registration data to identify misclassified deaths from causes such as maternal mortality.<sup>7</sup>
  9. The maternal mortality ratio declined globally by about 38% between 2000 and 2017.<sup>1</sup> Furthermore, 10 million women suffer infection and long-term injuries and 15% of maternal deaths occur in the 15-19 years age group.<sup>8</sup>
  10. Maternal mortality is impacted and influenced by the social determinants of health: poverty, education, employment, access to health care, health status and gender equity.
    - a. **Gender inequity:** from power structures in society and reflected in neglect of reproductive rights, which leads to an unmet need for family planning and increased unsafe, emergency practice.
    - 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.<sup>1,9</sup>
    - c. **Racial inequality, poverty and racism:** impact maternal mortality<sup>10</sup> and there is a need for culturally appropriate services for women.<sup>11</sup> The poor are more likely to die when compared to the affluent.<sup>12</sup> States have a core obligation to fulfil the right to non-discriminatory access to maternal health services.
    - d. **Education and employment:** Educated women have employment and incomes; better nutritional status; are better able to identify danger signs during pregnancy; bear fewer children and are more likely to marry later.<sup>13</sup>
    - 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.<sup>14</sup> Pre-existing health conditions such as malaria, hypertension and HIV/AIDS also contribute to maternal deaths.<sup>15</sup>
    - f. **Humanitarian emergencies:** 65 million people were forcibly displaced (the largest since WW2) in 2015 with a quarter of those being women and girls, aged 15-49.<sup>16</sup> A lack of access to sexual and reproductive health (SRH) services and information is a leading cause of morbidity and mortality in this population group.<sup>17</sup>
    - g. **COVID-19 pandemic:** A systematic review and meta-analysis in the Lancet Global Health on the Effects of the pandemic on maternal and perinatal outcomes found that maternal outcomes worsened during the pandemic with an increase in maternal deaths.<sup>18</sup>
  11. Maternal mortality – the death of women during pregnancy, childbirth, or in the 42 days after delivery is most frequently caused by obstetric hemorrhage, during or after delivery, followed by eclampsia, sepsis, complications of unsafe abortion and indirect causes such as cardiovascular disorders, malaria and HIV.<sup>3</sup>
  12. Poor maternal nutrition contributes to at least 20% of maternal deaths and 800,000 neonatal deaths. Lack of access to family planning leads to unplanned pregnancies and increases the probability of other poor pregnancy outcomes including newborn deaths.<sup>19,20</sup>

13. Implementing this policy would contribute towards achievement of UN Sustainable Development Goals 3: Good Health and Wellbeing.

**The Public Health Association of Australia resolves to undertake the following actions:**

14. To strengthen links with Global Reproductive Rights Associations and People's Health Movement groups especially in neighbouring countries in the Asia/Pacific region.
15. To 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.
16. To provide information and education on voluntary family planning and reproductive health through family planning associations in each state and through the UNFPA.
17. To advocate for skilled birth attendance at antenatal care and access to emergency postnatal care.
18. To assist in building capacity for health service delivery and workforce retention in the health sector in developing countries.
19. To assist Government to improve systems for data collection with regard to maternal, infant, child health and mortality.
20. To 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.<sup>7</sup>

**ADOPTED 2011, revised 2021**

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