

Maternal Health White Paper Addendum: 2020 Update

In 2016, the 17 Sustainable Development Goals replaced the Millennium Development Goals as the guiding document for international development efforts. These include SDG target 3.1, to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births. Under the MDGs, the goal of a 75% reduction was not achieved, although it was reduced by about 38%.¹ The 2017 global MMR was estimated at 211,² although countries' actual MMRs range both much higher and much lower.

By 2017, Sub-Saharan Africa was the only region with an estimated high MMR of 542 per 100,000 live births.³ Northern Africa, Oceania (excluding Australia and New Zealand), Southern Asia, and South-Eastern Asia had a moderate MMR, estimated at 100-299.⁴ Latin America and the Caribbean, Europe and Northern America had the lowest MMR with an estimated average of fewer than 100 maternal deaths.⁵ However, in those less developed countries, the MMR has a high estimate of 415,⁶ which is equivalent to 40 times the rate of some countries in Europe. Regarding the estimated lifetime, in the least developed countries where there are an estimated 130,000 maternal deaths for 2017, or 1 per 56 live births.⁷ While in the Sub-Saharan Africa region the lifetime risk of the maternal death was 1 in 37, and in Austria and New Zealand it was only 1 in 7800.⁸

Global estimates place the number of maternal deaths in 2017 at 295,000, compared to 451,000 in 2000.⁹ The annual average of the reduction rates at the global level during 2000-2017 was 2.9%,¹⁰ which is insufficient to meet MMR reduction targets. Accurate and regular data collection across countries using different definitions and systems has been a major challenge, leading to a lack of recent data in some regions.¹¹

Despite the challenges of collecting standard information in a comprehensive way, World Health Organization (WHO) analysis showed that very close to 73% of all maternal deaths between 2003 and 2009 occurred due to direct obstetric causes, while indirect ones accounted for 27.5% of deaths with known causes.¹² Among them, hemorrhage (27.1%) was the main direct cause of death in the world, hypertension (14%) was the second most frequent direct cause, followed by sepsis (10.7%) and abortion (7.9%), stroke and other direct causes (12.8%) also accounted for a percentage of global deaths.¹³ Regarding indirect causes, the study suggests that more than 70% of them are the consequence of pre-existing disorders such as HIV.¹⁴

¹ WHO ET AL., TRENDS IN MATERNAL MORTALITY: 2000-2017 44 (2019) [hereinafter WHO, TRENDS 2017], available at <https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/>.

² *Id.* at 32.

³ *Id.* at 33.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.* at 32.

¹⁰ *Id.* at 41.

¹¹ LALE SAY ET AL., GLOBAL CAUSES OF MATERNAL DEATH: A WHO SYSTEMATIC ANALYSIS e330 (2014), available at [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(14\)70227-X/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70227-X/fulltext) (open access, electronic publication).

¹² *Id.* at e327.

¹³ *Id.*

¹⁴ *Id.* at e327-28.

The disparities in MMR overall are also reflected in the causes of maternal deaths. Regionally, hemorrhage represents 36.9% of deaths in Northern Africa, while only 16.3% in developed regions.¹⁵ Hypertension caused up to 22.1% of deaths in Latin America and the Caribbean. Almost all deaths from sepsis were registered in developing countries, but especially in the Southern Asia region (13.7%).¹⁶ Thus the three largest causes in maternal deaths are hemorrhage, hypertension, and sepsis.¹⁷

International institutions continue to count deaths caused by abortion as maternal deaths. Their estimates attribute 0.8% of maternal deaths to abortion in Eastern Asia, while in Latin America and the Caribbean, and Sub-Saharan Africa they are estimated at the higher rates 9.9% and 9.6%, respectively. Although each death is a tragedy, they account for a relatively small proportion of maternal deaths. Moreover, for reasons explained in the white paper, abortion is fundamentally different from childbirth or miscarriage in that it is an elective procedure; it is not why women die in childbirth. Describing the tragic deaths of women following abortion as being due to “unsafe abortion,” abortion rights advocates and institutions that support them suggest that legalizing abortion is necessary to reduce maternal mortality.

Not only does legalization not guarantee maternal (and certainly not perinatal) safety in fragile healthcare systems, but it also does not lower maternal mortality. If abortion were necessary to reduce maternal mortality, countries like Chile would not have reduced their MMR. Instead, Chile implemented a coverage of pregnancy control and professional care in childbirth, the best in Latin America.¹⁸ In fact, despite claims that banning abortion does not reduce abortion numbers, Chile’s post-abortion complication numbers also dropped over time, compared to stable rates of other types of complications.¹⁹

Moreover, South Africa observed an increase in maternal mortality just after abortion was legalized,²⁰ which took place around the height of the AIDS crisis, a major factor for maternal mortality. Legalizing abortion did not ensure appropriate care for HIV+ mothers to ensure their safe delivery. On the other hand, countries like Kenya have significantly decreased their maternal mortality rates from 545 in 2007 to 342 in 2017 without legalizing abortion and instead prioritizing interventions that prevent and manage complications—which can also help women who undergo illegal abortions (whereas legalizing abortion does nothing to make birth safer).²¹ Restrictive laws

¹⁵ *Id.* at e327.

¹⁶ *Id.* at e328.

¹⁷ *Id.*; see also NATIONAL ABORTION FEDERATION, CLINICAL POLICY GUIDELINES 53, 60 (2020), available at <http://prochoice.org/resources/clinical-policy-guidelines/>. The clinical guide describes hemorrhage as one of the “most serious immediate complications of an abortion procedure”, *id.* at 60, and notes that uterine perforation, which has a risk of sepsis and bleeding, “can lead to significant morbidity” and “may be difficult to identify,” *id.* at 53.

¹⁸ See generally Maria Teresa Valenzuela et al., *Aborto ¿Es un problema de salud pública en Chile en el Campo de la Salud Materno-Perinatal?*, 145 R. Med. Chile 1013-1020 (2017) available at https://scielo.conicyt.cl/scielo.php?script=sci_arttext&pid=S0034-98872017000801013.

¹⁹ Elard Koch, *Impact of Reproductive Laws on Maternal Mortality: The Chilean Natural Experiment*, 80 LINACRE Q. 151, 156-58 (2013).

²⁰ *South Africa: Maternal and Perinatal Health Profile*, WHO, http://www.who.int/maternal_child_adolescent/epidemiology/profiles/maternal/zaf.pdf. The Choice on Termination of Pregnancy Act, which liberalized a previously restrictive abortion law, was adopted in 1996 and came into effect in 1997. See generally Choice on Termination of Pregnancy Act 92 of 1996 (S. Afr.). It has since been amended.

²¹ *Maternal Mortality Ratio—Kenya*, WORLD BANK, <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=KE>.

can reduce abortion when social policies that integrate adequate health and a social security system for all are implemented, as Chile's experience shows.

In those countries where abortion is or was prohibited for the purpose of protecting women's health, motherhood, and prebirth human life during the pregnancy, international institutions and abortion rights organizations have promoted the idea that it is bans, and not poor healthcare infrastructures, that make abortion promotes unsafe, and therefore cause high rates of maternal mortality (despite its relatively low share of attributed maternal deaths).²² However, there is no direct scientific evidence that finds a direct cause-effect relationship between laws that restrict abortion and maternal health.²³ Rather, developing countries such as those in the Latin American and African regions are frequently pressured to implement these policies.

To achieve SDG 3.1, the focus should be rightly on the interventions which will help the most women to carry and deliver their children safely, not on controversial policies which lack consensus and do not address the underlying reasons why women die in childbirth. Those interventions, described in the white paper, are: 1) prenatal care; 2) skilled birth attendants; 3) adequately equipped birthing facilities; and 4) healthcare delivery system infrastructure, including education and transportation. Since the white paper's publication, the WHO has doubled its recommended prenatal visit number to eight, which it states can reduce the MMR by eight maternal deaths per 1000 births.²⁴

²² Koch, *supra* note 19, at 152.

²³ *Id.*

²⁴ New guidelines on antenatal care for a positive pregnancy experience, WHO (Nov. 7, 2016), <https://www.who.int/reproductivehealth/news/antenatal-care/en/>.