

Editorial

Maternal Mortality: Preventable But Persistent

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INTRODUCTION

Maternal mortality is defined by WHO as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes”¹. The global maternal mortality ratio (MMR) is 197 deaths per 100,000 live births, with an estimated 260,000 women dying worldwide from preventable pregnancy and childbirth complications. This is equivalent to over 700 maternal deaths every day, and approximately one every two minutes. The MMR is dropped 40% since year 2000 when the rate was 328 deaths per 100,000 live births². There is geographic disparity showing low- and lower-middle-income countries account for over 90% of these deaths². Sub-Saharan Africa and Southern Asia accounted for around 87% (225 000) of the estimated global maternal deaths in 2023. Sub-Saharan Africa alone represents about 70% (182,000 deaths), and Southern Asia accounts for 17% (43,000 deaths) of the global total². Oceania (excluding Australia and New Zealand)

and Central and Southern Asia reported moderate MMRs with 173 and 112 respectively. Australia and New Zealand had the lowest MMR, estimated at 3 per 100,000 live births in 2023². In the United States, 649 women died of maternal causes in 2024, corresponding to an MMR of 17.9 per 100,000 live births, compared with 18.6 in 2023³. Even in a country, there is variation of MMR in different regions which could be due to variation of health determinants such as antenatal care utilization, delivery by skilled health personnel, and postpartum care⁴.

The international target aims to reduce the global MMR to less than 70 maternal deaths per 100,000 live births by 2030². Although there is a decline of maternal mortality in 2000 and 2023, there are disparities between regions and between rural and urban areas⁵. Eastern Europe showed a 75% reduction from an MMR of 38 to 9 deaths per 100,000 live births. Southern Asia achieved a 71% reduction from an MMR of 405 down to 117. Sub-Saharan Africa also secured a substantial 40% reduction in MMR between 2000 and 2023².

This editorial critically examines the persistent challenge of maternal mortality, a major and

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largely preventable global public health problem that continues to claim lives worldwide.

Causes of Maternal Mortality

Maternal mortality arises from complications during pregnancy, childbirth, and the postpartum period². Despite significant medical advances, preventable complications such as postpartum haemorrhage, infections, preeclampsia and eclampsia, unsafe abortion, and delivery-related issues such as obstructed labour continue to claim lives, especially in low-resource settings. The tragedy lies not only in the occurrence of these maternal deaths but in the fact that most of them are entirely preventable^{2,6}. Postpartum haemorrhage is frequently connected to placenta accreta spectrum disorder (PAS), such as placenta accreta, placenta increta, and placenta percreta⁷. Moreover, the devastating sequelae of obstructed labour present a morbidity burden that far outnumbers maternal mortality. Severe complications can occur such as vesicovaginal fistula (VVF), pelvic nerve compression and extensive vaginal scarring leading to dyspareunia. It can also lead to secondary amenorrhoea resulting from massive postpartum haemorrhage (Sheehan's syndrome). These complications impose profound physical trauma to the patient through severely compromising patients' functional capacity and quality of life⁸.

The indirect causes of maternal mortality are pre-existing diseases or non-obstetric conditions exacerbated by the normal physiological demands of pregnancy include anaemia, malaria, and other systemic illness such as cardiac diseases, hepatic disease, neurological disorders, and other associated medical conditions, sometimes leading to disseminated intravascular coagulations (DIC) with intractable life threatening haemorrhages and septicaemia with multi organ failures^{9,10,11}. A study in Karachi, Pakistan found that indirect causes accounts for 27% (26/96) of maternal deaths and among them, cardiac and hepatic diseases accounted for 12 cases representing 46% of this group⁹. Other risk factors contributing to maternal mortality include maternal age, parity, twin pregnancies, history of prior medical illness, low education, inadequate antenatal care and delayed referrals^{12,13}.

Measures to Prevent Maternal Mortality

Approximately 74-98% of maternal deaths could be prevented, even in low-income countries if all

women had access to the emergency obstetric care for preventing or treating pregnancy and birth complications in particular emergency obstetric care¹⁴. A timely access to skilled healthcare providers and high-quality medical services are the centre point in preventing maternal mortality. Thus, regular antenatal visit is crucial for safe childbirth¹⁵. Measures to improve maternal safety focus on standardized clinical tools, coordinated multidisciplinary care, proactive team communication and training, and clear patient education to recognize life-threatening complications early⁶. Access to quality care during pregnancy, childbirth, and the postnatal period is vital to reduce the MMR. Thus, it needed to improve coverage and reduce in high-risk pregnancies¹⁰. In rural area, there is limited access to health care facility, more prevalent on low-middle income countries¹⁷. Additionally, poor infrastructure and transportation system in the rural area are a contributing factor for maternal death¹⁶. A national survey in Bangladesh found that 19% of maternal deaths occurred in transit and 33% of women who died from maternal causes sought care from three or more different places, indicating substantial shuttling between facilities. These findings highlight important gaps in emergency transportation and referral systems, including delays in recognising complications, decision making, and reaching appropriate care¹⁷. Moreover, a lack of skilled health professionals, including doctors, nurses, and midwives, leads to delayed complication recognition and poor care-seeking decisions^{17,18}. The skilled health professionals can recognize the emergency early, provide life-saving treatments and drastically reduce preventable maternal and newborn deaths. They are able to ensure a safe delivery^{2,10}. Therefore, qualified health professionals with adequate training and adequate provision of equipment are required to enhance MMR reduction¹⁹. Introduction of global maternal and child health programs aim to protect the health of mothers and babies, help to reduce maternal mortality^{10,20}. Poverty reduction strongly supports this goal because low-income limits access to care, nutrition, and education. Addressing economic barriers works alongside clinical interventions is required to improve maternal survival rates¹⁰. Good hygiene practice is necessary to prevent pregnancy related infection as well as taking evidence-based measures during labour or leaking and treating early signs of infection is necessary^{2,16}.

CONCLUSION

Most maternal deaths are preventable through timely access to high-quality, evidence-based care and effective health systems. With appropriate policies, adequate resources, and sustained commitment, maternal mortality can be substantially reduced. Governments and health-sector leaders must act together to address this persistent burden by strengthening antenatal care, improving access to quality emergency obstetric care, investing in a skilled maternal health workforce, and expanding access to services in underserved and rural communities. Global health agencies also have an important role in providing financial and technical support to accelerate progress towards global maternal mortality reduction targets. These editorial calls attention to the urgent need for coordinated global and local action, evidence-based interventions,

and robust accountability mechanisms to ensure that maternal mortality is not merely recognised as preventable but actively prevented through sustained commitment and health-system reform. This requires addressing inequitable access to healthcare, regional and rural–urban disparities, socioeconomic determinants, and persistent gaps in policy implementation.

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Conflict of Interest

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Authors Contribution

All authors contributed to the conception, drafting, critical revision, and approve the final version of manuscript for publication.

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