Targets for maternal mortality reduction have been set under the Sustainable Development Goals (1). However, obtaining reliable information on the levels and causes of maternal mortality, and thus measuring progress towards elimination of preventable maternal deaths, remains a challenge.

Maternal deaths, particularly those in early pregnancy, are underreported even in countries with good civil registration systems. In countries with weak health systems and poor registration of vital events, national mortality rates reports are usually based on statistical modelling. Estimates of global and national maternal mortality ratios are published periodically (2). While national maternal mortality estimates are useful for advocacy purposes, they do not provide sufficient information for targeted actions to reduce maternal mortality.

The first step towards ending preventable maternal deaths is an understanding of exactly why a woman died. The World Health Organization’s (WHO) “Application of ICD-10 to deaths during pregnancy, childbirth, and the puerperium: ICD-Maternal Mortality” (ICD-MM) is intended “to facilitate the consistent collection, analysis and interpretation of information on maternal deaths” (3). Pasha and colleagues (4) report on a prospective surveillance of 158,205 pregnancies in seven sites in sub-Saharan Africa, South Asia and Central America. Health care providers assigned cause of death for the 221 maternal deaths in this cohort. These clinically assigned causes of death were compared with those assigned by computer-based algorithms based on ICD-MM. Levels of agreement between clinically assigned causes of death for haemorrhage (76.5%) and preeclampsia/eclampsia (62.5%) were better than that for infection (36.2%).

Is improved classification of medical causes of maternal deaths sufficient for targeted actions to prevent similar deaths in the future? In this study, most mothers who died received antibiotics and oxytocin or misoprostol, irrespective of the medical cause of death. ICD MM does not include obstructed labour as a cause of maternal death - women with obstructed labour die of haemorrhage or infection. While oxytocin or misoprostol is appropriate for managing postpartum haemorrhage, clearly uterotonic use could be dangerous in obstructed labour.

To reduce maternal mortality, national maternal mortality ratios and medical causes of maternal death are not enough. It is equally, if not more important, to know the woman’s personal story and the precise circumstances preceding her death. Where was she when she died? Did she and her family recognise that she needed emergency care? Was care available to her and was it of good quality? Were there obstacles to her accessing care? While researchers strive towards developing better methods of estimates and classification, women continue to die.

The WHO and partners therefore promote Maternal Death Surveillance and Response (MDSR) as an approach to end preventable maternal mortality (5). MDSR, a continuous action cycle for monitoring and responding to maternal deaths, has evolved from maternal death reviews and stresses on the need to notify and review every maternal death, and to implement corrective action in response to findings. While implementing MDSR at national level can be challenging, corrective actions taken following even one death is a step in the right direction.

1. <http://www.un.org/sustainabledevelopment/health/>
2. World Health Organization (2015): Trends in maternal mortality: 1990 to 2015 estimates by WHO, UNICEF, UNFPA, World Bank group and the United Nations Population Division <http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1>
3. World Health Organization (2012) The WHO application of ICD-10 to deaths during pregnancy, childbirth and puerperium: ICD MM. <http://apps.who.int/iris/bitstream/10665/70929/1/9789241548458_eng.pdf?ua=1>
4. Pasha O et al (BJOG to be completed)
5. <http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/>