

The Importance of Maternal Health for National Development

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Introduction

Maternal health refers to the physical, mental, and social well-being of women during pregnancy, childbirth, and the postnatal period. It also includes access to reproductive healthcare before pregnancy because nutrition, chronic illness, contraception, infection prevention, and pregnancy planning can influence later outcomes. Maternal health is therefore not limited to what happens inside a delivery room. It reflects the quality of a country's healthcare system, the status of women, the availability of education, and the fairness with which public resources are distributed.

A country cannot achieve sustainable development when pregnancy and childbirth continue to expose large numbers of women and girls to preventable death or disability. Maternal illness can disrupt family income, increase medical expenses, affect newborn survival, interrupt the education of other children, and place additional pressure on relatives and public services. When a mother dies, the consequences may continue for years through reduced household stability, lost earnings, and poorer health and educational outcomes for her children.

The World Health Organization describes the current level of maternal mortality as “unacceptably high.” Approximately 260,000 women died from causes related to pregnancy or childbirth in 2023. This equaled more than 700 deaths each day, or approximately one maternal death every two minutes. About 92% of these deaths occurred in low- and lower-middle-income countries, and most were preventable (World Health Organization [WHO], 2025a).

Maternal health was formally recognized as a global development priority under Millennium Development Goal 5. The two targets were to reduce the maternal mortality ratio by three quarters between 1990 and 2015 and to achieve universal access to reproductive health by 2015. Considerable progress occurred, but the world did not achieve the intended reduction. The global maternal mortality ratio declined by approximately 45% during the Millennium Development Goal period, which was substantial but still far below the 75% target (United Nations, 2015; WHO, 2018).

The Millennium Development Goals have now been replaced by the Sustainable Development Goals. Sustainable Development Goal 3.1 seeks to reduce the global maternal mortality ratio to fewer than 70 deaths per 100,000 live births by 2030. Goal 3.7 promotes universal access to sexual and reproductive healthcare, while Goal 5.3 calls for the elimination of child, early, and forced marriage. These goals recognize that maternal health, reproductive rights, gender equality, education, and national development are inseparable.

One major factor affecting maternal health is child marriage. Marriage before age 18 can expose girls to early pregnancy, interrupted education, limited decision-making power, intimate partner violence, and restricted access to healthcare. However, child marriage is not the only cause of poor maternal health. Poverty, weak health systems, gender discrimination, inadequate transportation, shortages of skilled professionals, conflict, malnutrition, and limited reproductive services also contribute. A comprehensive solution must address child marriage while strengthening the broader social and healthcare conditions that determine whether women and girls survive pregnancy safely.

Maternal Health as a Measure of Development

Maternal mortality is often used as an indicator of national development because most maternal deaths can be prevented through timely and effective healthcare. A country with reliable primary care, skilled birth attendance, emergency obstetric services, blood supplies, transportation, referral systems, and trained healthcare professionals is more capable of preventing deaths from pregnancy complications.

The maternal mortality ratio also reveals inequalities that may be hidden by national averages. Women living in wealthy urban areas may have access to hospitals, specialists, and emergency transportation, while women in remote or poor communities may have to travel for hours to receive basic care. Differences may also exist according to race, ethnicity, income, migration status, disability, or age.

The global maternal mortality ratio was estimated at 197 deaths per 100,000 live births in 2023, compared with 328 in 2000. This represents important progress, but it remains almost three times higher than the Sustainable Development Goal target of fewer than 70 deaths per 100,000 live births (WHO et al., 2025).

Progress has also been uneven. Some countries have developed strong maternal-health systems and reduced deaths substantially, while others continue to experience serious shortages of facilities, professionals, medicines, and reliable health information. Fragile states and areas affected by armed conflict face particularly difficult conditions because health facilities may be damaged, transportation may become unsafe, and trained workers may leave.

A high maternal mortality rate is therefore rarely the result of one medical problem. It reflects a combination of clinical risks and structural weaknesses. A woman may develop bleeding after childbirth, but whether she survives may depend on whether the family recognizes the danger, whether transport is available, whether a hospital has blood, and whether trained staff respond quickly.

Major Causes of Maternal Death and Illness

The direct medical causes of maternal death include severe bleeding, hypertensive disorders such as pre-eclampsia and eclampsia, infections, complications of delivery, blood clots, and complications associated with unsafe abortion. Indirect causes include conditions such as heart disease, anemia, diabetes, malaria, and HIV that may be worsened by pregnancy.

Severe postpartum hemorrhage can become fatal within a short period when appropriate medicines, blood transfusion, surgery, and trained professionals are unavailable. Hypertensive disorders require early recognition during antenatal care and rapid treatment when severe symptoms develop. Infections may be reduced through hygiene, safe delivery practices, antibiotics, and timely management.

Many maternal complications cannot be predicted with certainty. A woman may appear healthy throughout pregnancy and still experience a life-threatening emergency during childbirth. For this reason, every pregnancy requires access to quality care rather than services being reserved only for women who are already considered high risk.

Maternal health also includes the prevention and treatment of long-term illness. Women may survive childbirth but experience chronic pain, incontinence, anemia, infertility, depression, anxiety, obstetric fistula, or disability. National policies that focus only on whether a woman survives can overlook these serious consequences.

Mental health is particularly important. Pregnancy loss, difficult childbirth, financial pressure, intimate partner violence, lack of social support, and newborn illness may contribute to depression or anxiety. Maternal healthcare should therefore address emotional well-being as well as physical complications.

Understanding Child Marriage

Child marriage is generally defined as a formal marriage or informal union involving a person younger than 18. Although boys may also marry before adulthood, girls account for most child marriages and usually experience the more serious consequences.

Child marriage is a violation of human rights because children are often unable to provide free, full, and informed consent to marriage. The practice can restrict a girl's right to education, health, safety, equality, and participation in decisions about her future.

Older estimates suggested that approximately 700 million women alive at the time had married before age 18. More recent UNICEF estimates indicate that approximately 640 million girls and women alive today were married during childhood. Globally, about one in five young women aged 20 to 24 entered marriage or a union before age 18. Although the prevalence has declined, progress is

not occurring rapidly enough to eliminate child marriage by 2030 (United Nations Children's Fund [UNICEF], 2023).

The figure of 39,000 child marriages per day, which appeared in the original essay, came from an estimate published in 2013. Current organizations generally describe the burden through prevalence and population estimates rather than continuing to use that older daily figure. UNFPA reported in 2025 that 19% of girls marry before age 18 and approximately 4% before age 15 (United Nations Population Fund [UNFPA], 2025).

Child marriage is concentrated in particular regions but is not limited to one religion, culture, or country. It occurs in parts of South Asia, sub-Saharan Africa, Latin America, the Middle East, East Asia, Europe, and North America. Its prevalence is frequently higher in communities affected by poverty, insecurity, low school enrollment, gender inequality, and limited legal protection.

Why Child Marriage Continues

Poverty is one of the strongest factors associated with child marriage. Families experiencing serious financial hardship may consider marriage a way to reduce household expenses or secure economic support. In some settings, marriage payments or dowry practices may also influence decisions.

However, poverty does not fully explain the practice. Child marriage is also sustained by gender norms that place greater value on a girl's role as a wife and mother than on her education, career, or independence. Families may believe that marriage protects family honor, prevents premarital relationships, or provides physical and economic security.

The absence of accessible secondary schools can increase the risk. When schools are far away, unsafe, expensive, or considered poor in quality, families may see little benefit in keeping girls enrolled. Menstruation-related stigma, inadequate sanitation, harassment, and household responsibilities can further encourage girls to leave school.

Conflict, displacement, climate emergencies, and food insecurity may also increase pressure for early marriage. Families living in dangerous environments sometimes believe that marriage will protect a girl from violence or provide another household to support her. In practice, marriage may expose her to new forms of abuse, dependence, and reproductive risk.

Weak law enforcement is another problem. Many countries formally establish 18 as the minimum age for marriage, but exceptions may be permitted with parental, religious, or judicial approval. Births and marriages may not be registered, making age difficult to verify. A legal ban has limited value if officials, families, and community leaders do not enforce it.

Child Marriage and Early Pregnancy

Marriage frequently leads to pressure for early childbearing. A married adolescent may be expected to demonstrate fertility soon after the wedding, even when she wishes to delay pregnancy. She may have limited knowledge about contraception or lack the power to negotiate its use.

An estimated 21 million pregnancies occur each year among girls aged 15 to 19 in low- and middle-income countries, and approximately half are unintended. These pregnancies result in an estimated 12 million births annually. Complications of pregnancy and childbirth remain among the leading causes of death for girls aged 15 to 19 worldwide (WHO, 2024a).

Adolescent mothers face increased risks of eclampsia, puerperal endometritis, and systemic infection compared with women aged 20 to 24. Their babies face higher risks of low birth weight, preterm delivery, and serious newborn complications (WHO, 2024a).

The risk is not caused by age alone. It is intensified by malnutrition, anemia, poverty, lack of antenatal care, inadequate birth spacing, delayed emergency treatment, and restrictions on decision-making. A married girl may require permission from her husband or in-laws before visiting a healthcare facility. She may also lack money, transportation, or confidential services.

It is inaccurate to assume that every girl younger than 18 will experience a medical complication or that all adult pregnancies are safe. The evidence instead shows that adolescent pregnancy carries elevated risks and that married adolescents often face social barriers that make those risks more difficult to manage.

Access to Maternal Healthcare

Good maternal outcomes depend on access to care before, during, and after childbirth. Antenatal care can identify anemia, hypertension, infection, malnutrition, abnormal fetal growth, and other risks. It can also provide vaccination, counseling, birth planning, and information about danger signs.

Child brides may use maternal-health services less frequently than women who marry as adults. A study covering Afghanistan, Bangladesh, India, Nepal, and Pakistan found that marriage before 18 was associated with lower use of antenatal care, skilled birth attendance, facility delivery, and postnatal care after adjustment for other factors (Kamal & Ulas, 2022).

Research in Liberia and Sierra Leone also found associations between marriage before 18 and several adverse reproductive and maternal-health outcomes. Women who married before age 15 were particularly vulnerable in some measures of antenatal care and institutional delivery, although the strength of the associations varied according to country and social circumstances (Reisz et al., 2024).

These findings should be interpreted carefully. Child marriage often occurs alongside poverty, limited

education, rural residence, and gender inequality. These conditions may independently reduce access to healthcare. Fan and Koski's (2022) systematic review concluded that child marriage is associated with numerous health outcomes but warned that much of the available research is cross-sectional and cannot always prove direct causation.

The appropriate conclusion is that child marriage is both a marker and a potential cause of disadvantage. Ending it is important, but improved health also requires accessible and respectful services for girls who are already married or pregnant.

Education and Maternal Health

Education is one of the strongest protective factors for girls. A girl who remains in school is more likely to marry later, understand health information, gain employment, and participate in household decisions. She may also be more able to recognize pregnancy danger signs, seek skilled care, and make informed decisions about contraception.

Child marriage often interrupts education because married girls are expected to manage domestic duties, become pregnant, or move away from their school. Some schools exclude pregnant or married students, while others fail to provide the practical support needed for them to continue.

The connection operates in both directions. Leaving school can increase the likelihood of early marriage, while early marriage can make returning to school difficult. Policies should therefore address school retention and marriage prevention together.

Girls who complete secondary education tend to marry later, have fewer and healthier children, participate more in paid employment, and invest more in the health and education of the next generation. These benefits support households as well as national economic development (World Bank, 2017a).

Education should not be presented only as a method for turning girls into more productive workers or healthier mothers. It is a right in itself. Nevertheless, the wider developmental benefits make investment in girls' schooling one of the most effective national strategies for improving health and reducing poverty.

Intimate Partner Violence and Limited Autonomy

Girls who marry older men may enter relationships with unequal power. Differences in age, education, income, and social authority can reduce a girl's ability to make decisions about sex, contraception, pregnancy timing, healthcare, and household spending.

Child marriage is associated with an increased risk of intimate partner violence in many settings. A

2024 global analysis estimated that 24% of ever-partnered girls aged 15 to 19 had experienced physical or sexual intimate partner violence during their lifetime, while 16% had experienced it during the previous year. Rates were higher in lower-income countries and in settings with high child-marriage prevalence and low secondary-school enrollment (Sardinha et al., 2024).

Violence can directly damage maternal health through physical injury, unwanted pregnancy, sexually transmitted infection, miscarriage, and delayed healthcare. It can also produce anxiety, depression, trauma, and social isolation.

A longitudinal study in Uttar Pradesh and Bihar found that child marriage was associated with poorer mental-health outcomes among adolescent girls. The findings demonstrate that the effects of early marriage are not confined to pregnancy complications but may also involve emotional distress and reduced well-being (Aggarwal et al., 2023).

Healthcare professionals should be trained to recognize violence and respond safely. Screening alone is insufficient if a clinic cannot offer confidentiality, referral services, legal support, or protection. Girls may face serious consequences if a violent partner discovers that they disclosed abuse.

Intergenerational Effects

Maternal health affects newborns and children as well as women. A mother who experiences severe anemia, infection, hypertension, or malnutrition may face a higher risk of premature birth or a low-birth-weight infant. A child who loses a mother may experience disruptions in nutrition, healthcare, attachment, and education.

Child marriage can also contribute to repeated pregnancies over a longer reproductive period. Closely spaced births may limit a mother's ability to recover nutritionally and increase the demands placed on household resources.

The effects may continue across generations. Research in sub-Saharan Africa has associated maternal child marriage with poorer health and developmental outcomes among children, although education, wealth, healthcare access, and other social conditions help explain these relationships (Efevbera et al., 2017).

This intergenerational pattern shows why maternal health is central to national development. Policies that protect one adolescent girl can influence the health, education, and economic security of her future children.

Economic Consequences for Countries

Poor maternal health reduces economic participation when women die, become disabled, or spend

long periods recovering from complications. Families may sell property, borrow money, or withdraw children from school to meet healthcare expenses.

The loss extends beyond direct medical costs. Women perform paid work, agricultural labor, household management, childcare, and community activities. Much of this contribution is unpaid and may be overlooked in economic statistics, but its loss can seriously affect household survival.

Child marriage also limits earnings by interrupting education and restricting employment. A World Bank and International Center for Research on Women analysis estimated that women who married as children earned approximately 9% less, on average, than they would have if they had married later. The study also concluded that ending child marriage could produce large benefits through reduced population growth, improved health, increased earnings, and lower pressure on public budgets (World Bank, 2017b).

A country that invests in maternal healthcare and girls' education is therefore investing in human capital. Healthy women are more able to continue education, participate in the workforce, care for their families, and contribute to community life.

Strengthening Maternal Healthcare Systems

Preventing maternal deaths requires functioning healthcare systems. Every woman should have access to respectful antenatal care, skilled support during childbirth, emergency obstetric treatment, and postnatal follow-up.

Countries need sufficient numbers of trained midwives, nurses, physicians, anesthetists, laboratory personnel, and community health workers. Rural professionals require safe working conditions, fair compensation, equipment, medicines, and reliable referral pathways.

Emergency care must include the ability to manage hemorrhage, hypertension, infection, obstructed labor, and other major complications. Facilities should have essential medicines, surgical capacity, oxygen, blood supplies, and transportation.

Healthcare quality is as important as physical access. Women may avoid facilities where they expect humiliation, discrimination, neglect, unofficial fees, or procedures performed without consent. Respectful maternity care protects dignity, privacy, informed decision-making, and freedom from abuse.

Postnatal care should not end immediately after delivery. Many serious complications occur during the days and weeks after childbirth. Women need assessment for bleeding, infection, blood pressure problems, breastfeeding difficulties, mental distress, and recovery from surgery or birth injuries.

Preventing Child Marriage

Legal reform is necessary but cannot work alone. Countries should establish 18 as the minimum age of marriage without broad exceptions and create reliable systems for birth and marriage registration.

Laws must be enforced consistently. However, punishment should not be designed in ways that place already-married girls at greater risk, separate them from their children, or prevent them from obtaining healthcare. Protection, education, and support should remain central.

Keeping girls in school is one of the most important strategies. Governments can remove tuition and examination costs, provide safe transportation, improve sanitation, prevent harassment, and offer financial support to families experiencing poverty.

Girls also need comprehensive, age-appropriate education about relationships, consent, contraception, pregnancy, and healthcare. Information should not be limited to unmarried adolescents because married girls often have significant unmet needs for reproductive services.

Economic support can reduce the pressure that encourages families to arrange early marriages. Cash-transfer programs, livelihood assistance, scholarships, and social protection may help families keep girls in education.

Community engagement is essential. Parents, religious leaders, teachers, health workers, and local officials may influence beliefs about marriage. Programs should create respectful discussion while maintaining the principle that girls have the right to safety, education, health, and meaningful participation in decisions about their lives.

Men and boys must also be involved. Child marriage cannot be eliminated by placing the entire responsibility on girls. Boys should learn about consent, gender equality, shared responsibility, nonviolent relationships, and reproductive health.

WHO's 2025 guideline recommends coordinated action to end child marriage, extend girls' education, and improve access to adolescent-responsive sexual and reproductive healthcare. These measures are most effective when they address both individual needs and the structural conditions that restrict girls' choices (WHO, 2025b).

Supporting Girls Who Are Already Married

Prevention programs must not neglect girls who are already married, pregnant, or parenting. These girls may be among the most isolated members of their communities and may not be reached through school-based programs.

Healthcare facilities should provide confidential and nonjudgmental services. Married adolescents

need contraception, antenatal care, skilled birth attendance, postnatal services, mental-health support, and protection from violence.

Education systems should create pathways for married and pregnant students to remain enrolled or return after childbirth. Flexible schedules, childcare, remote learning, and protection from discrimination may help them continue their education.

Programs should also strengthen girls' social networks. Safe spaces, mentoring, peer groups, legal assistance, and vocational training can reduce isolation and improve their ability to make informed decisions.

Supporting married girls is not the same as accepting child marriage. It recognizes that girls should not lose access to healthcare and opportunity because prevention efforts did not reach them in time.

Government and International Responsibility

Governments carry the primary responsibility for maternal health. National plans should set measurable targets, allocate budgets, train health workers, monitor inequalities, and ensure that policies reach underserved communities.

Reliable data are necessary for accountability. Maternal deaths should be reviewed to identify avoidable failures such as delayed referral, shortage of blood, inaccurate diagnosis, or lack of transportation. The purpose should be to improve systems rather than simply assign blame.

International organizations and donors can provide technical and financial support, particularly in countries affected by poverty, conflict, and humanitarian emergencies. However, programs should strengthen national systems rather than create short-term services that disappear when external funding ends.

Maternal-health policies should also involve women and adolescents in their design. Policymakers cannot assume that they understand every obstacle faced by rural women, refugees, girls with disabilities, ethnic minorities, or adolescent mothers. Meaningful participation can reveal barriers that official statistics overlook.

Conclusion

Maternal health is an essential concern for national development because the health of women influences children, families, communities, healthcare systems, and economies. Preventable maternal deaths indicate more than a clinical failure. They reveal weaknesses in education, transportation, gender equality, social protection, and public administration.

The global reduction in maternal mortality since 2000 demonstrates that progress is possible.

However, approximately 260,000 women still died from pregnancy- and childbirth-related causes in 2023. The burden remains concentrated in countries and communities with the fewest resources.

Child marriage is an important part of this challenge. It is a violation of human rights that can expose girls to early pregnancy, interrupted education, restricted autonomy, intimate partner violence, and lower use of maternal-health services. Nevertheless, child marriage should not be treated as the only cause of poor maternal outcomes. Even adult women face serious risks when health systems lack trained professionals, emergency facilities, medicines, blood, transportation, and respectful care.

Effective action requires a combined strategy. Governments must prevent child marriage, keep girls in school, enforce protective laws, expand reproductive services, address gender-based violence, and support families experiencing poverty. They must also provide quality care before pregnancy, during childbirth, and throughout the postnatal period.

Girls who are already married or pregnant must not be ignored. They need confidential healthcare, education, social support, and opportunities to regain control over their futures.

Improving maternal health is not simply an act of compassion toward individual women. It is an investment in national stability, economic productivity, human capital, and equality. When women and girls can survive pregnancy, make informed reproductive decisions, complete their education, and participate fully in society, countries become healthier and more capable of sustainable development.

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