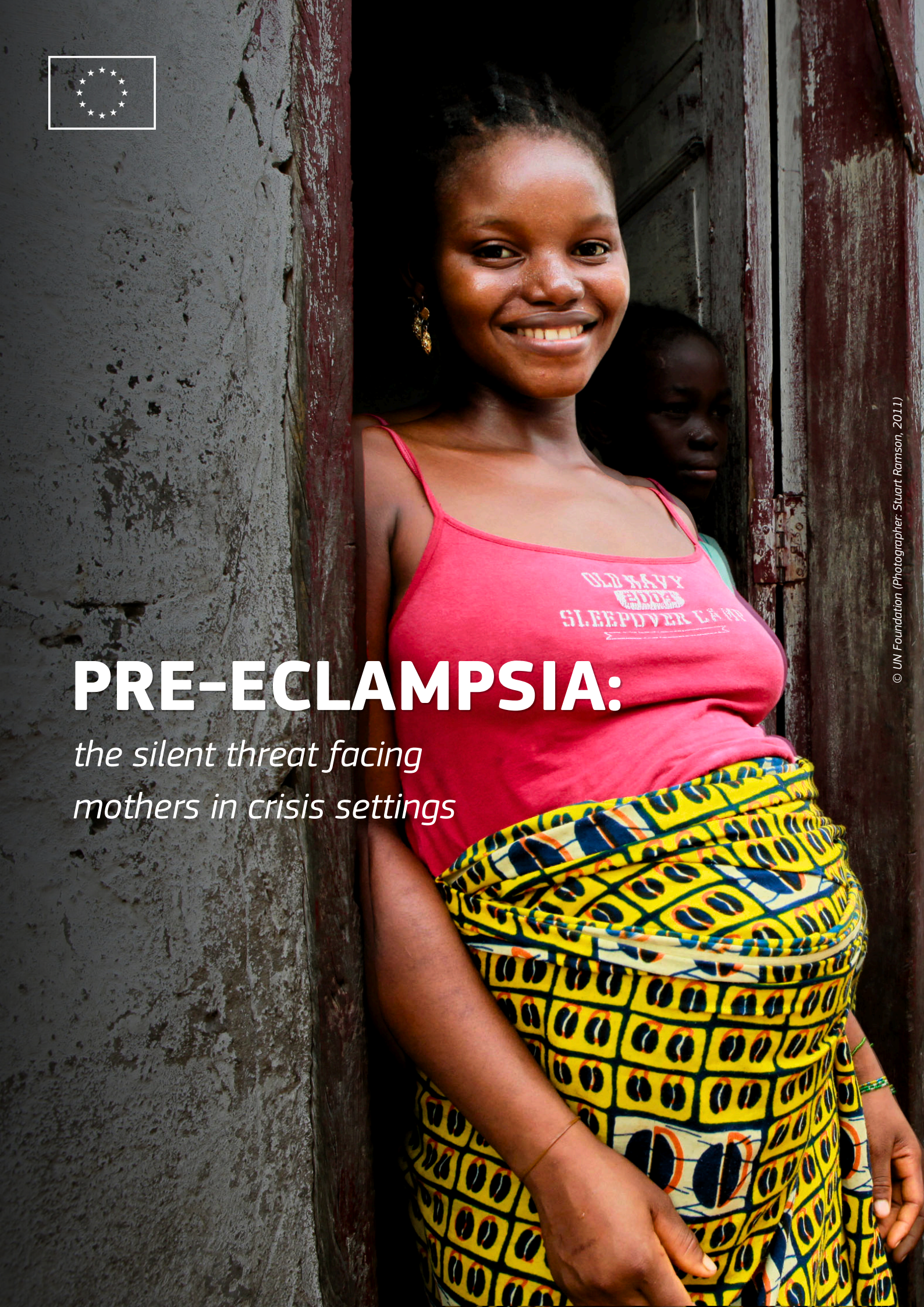


PRE-ECLAMPSIA:

the silent threat facing mothers in crisis settings

*Source: WHO Pre-eclampsia Fact Sheet, 2023

Every second, somewhere in the world, a woman gives birth. In a well-lit hospital room in a European city, with a monitor tracking her baby's heartbeat and a midwife nearby. In a displacement camp at the edge of a conflict zone, in the dark, far from any clinic. In a rural village where the nearest road, passable by vehicle, washes out in the rainy season. **The biology of pregnancy is universal. The chance of surviving is not.**

Since the year 2000, the global rate of women dying in childbirth has fallen by 40%. That is genuine progress – the result of decades of investment in healthcare systems, trained midwives, and access to essential medicines. But the Sustainable Development Goals (SDGs) target of fewer than 70 maternal deaths per 100,000 live births by 2030 would require an annual reduction in mortality nearly seven times faster than the current rate. Progress has stalled.

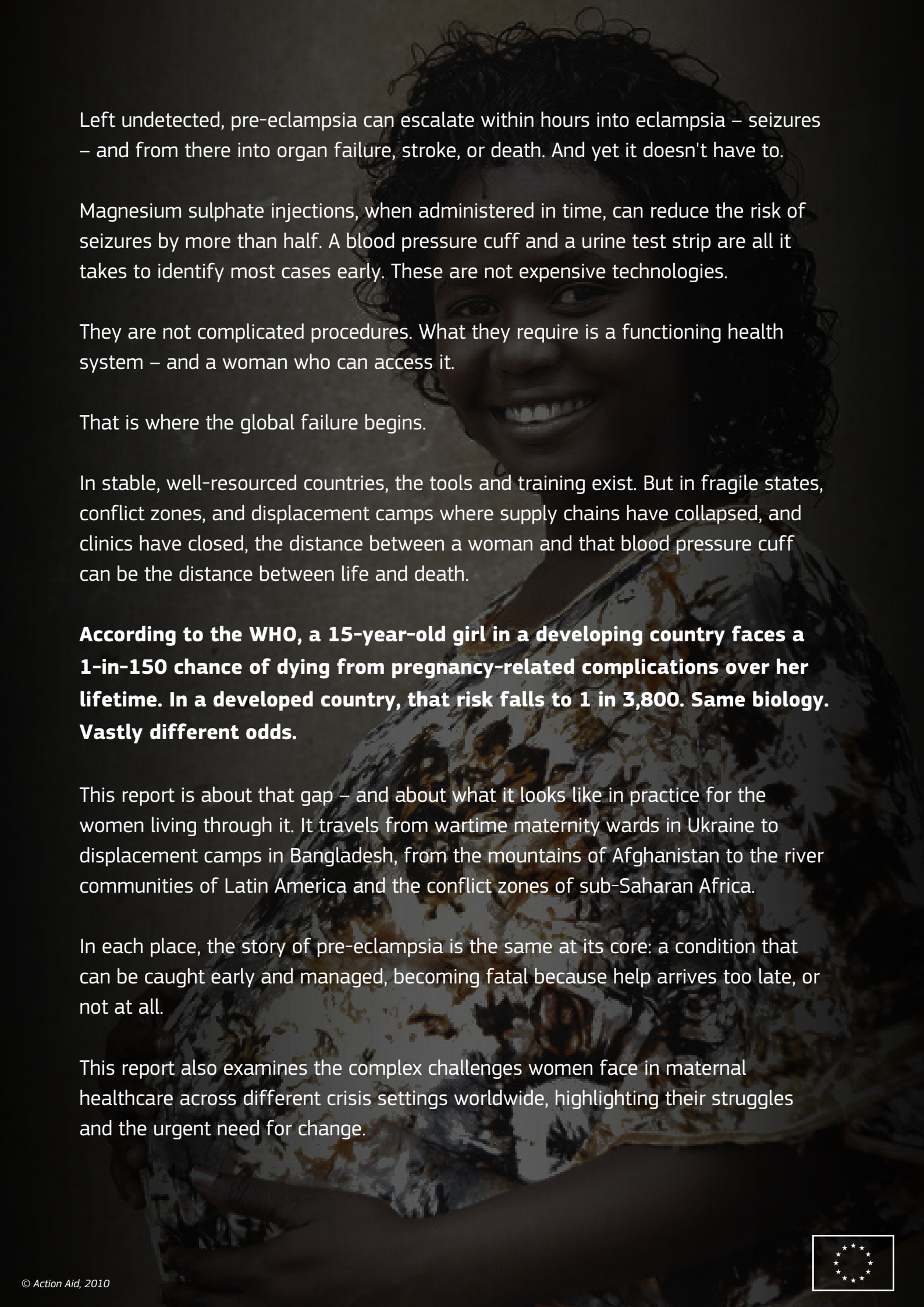
And the women paying the highest price are almost always the ones who were already carrying the heaviest burden.

Pre-eclampsia sits at the centre of that injustice.

- Pre-eclampsia affects **3–8% of all pregnancies worldwide – around 10 million women every year**. (WHO, December 2025)
- Hypertensive disorders in pregnancy cause approximately **42,000 maternal deaths per year – around 16% of all maternal deaths globally**. (WHO, 2023)
- Beyond the mother: **an estimated 500,000 babies lose their lives to these disorders annually**.

These are not abstract figures. They are daughters, sisters, first-time mothers, women in the middle of their lives.

What makes pre-eclampsia so devastating is not its complexity – it is its silence. The condition typically develops after 20 weeks of pregnancy and can arrive with no warning at all. A headache. Swollen ankles. A brief blur at the edge of vision. Symptoms easily mistaken for the ordinary discomforts of a difficult pregnancy, a night of poor sleep, or the heat. A woman might dismiss them. Her family might reassure her. Even overstretched health workers might not immediately recognise the danger.



Left undetected, pre-eclampsia can escalate within hours into eclampsia – seizures – and from there into organ failure, stroke, or death. And yet it doesn't have to.

Magnesium sulphate injections, when administered in time, can reduce the risk of seizures by more than half. A blood pressure cuff and a urine test strip are all it takes to identify most cases early. These are not expensive technologies.

They are not complicated procedures. What they require is a functioning health system – and a woman who can access it.

That is where the global failure begins.

In stable, well-resourced countries, the tools and training exist. But in fragile states, conflict zones, and displacement camps where supply chains have collapsed, and clinics have closed, the distance between a woman and that blood pressure cuff can be the distance between life and death.

According to the WHO, a 15-year-old girl in a developing country faces a 1-in-150 chance of dying from pregnancy-related complications over her lifetime. In a developed country, that risk falls to 1 in 3,800. Same biology. Vastly different odds.

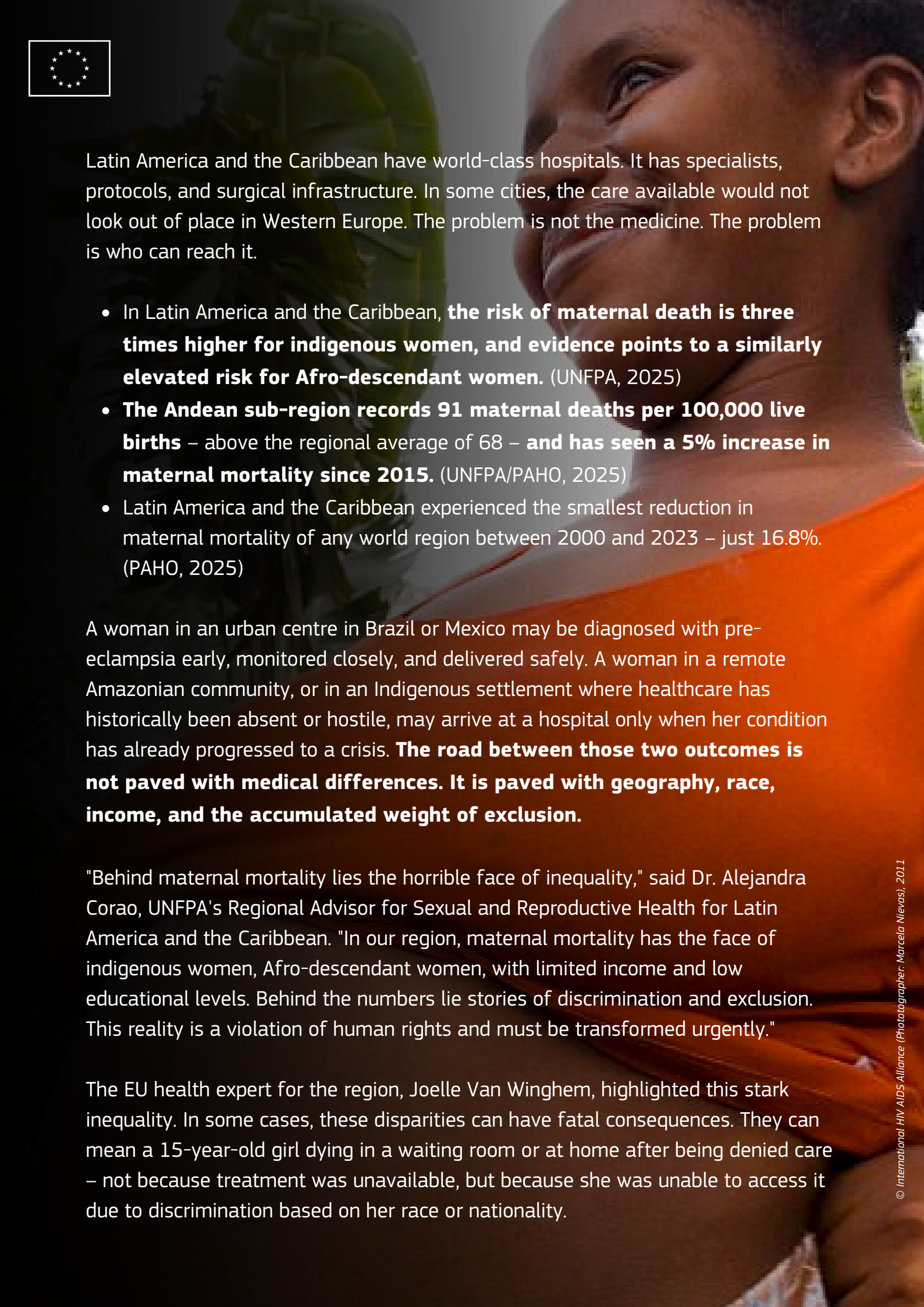
This report is about that gap – and about what it looks like in practice for the women living through it. It travels from wartime maternity wards in Ukraine to displacement camps in Bangladesh, from the mountains of Afghanistan to the river communities of Latin America and the conflict zones of sub-Saharan Africa.

In each place, the story of pre-eclampsia is the same at its core: a condition that can be caught early and managed, becoming fatal because help arrives too late, or not at all.

This report also examines the complex challenges women face in maternal healthcare across different crisis settings worldwide, highlighting their struggles and the urgent need for change.

LATIN AMERICA AND THE CARIBBEAN: WHERE INEQUALITY DECIDES OUTCOMES

In LAC, **the danger of pre-eclampsia is often shaped by inequality** - for many women in rural, Indigenous, migrant, or crisis-affected communities, distance, discrimination, and **limited access to healthcare can delay lifesaving care**.



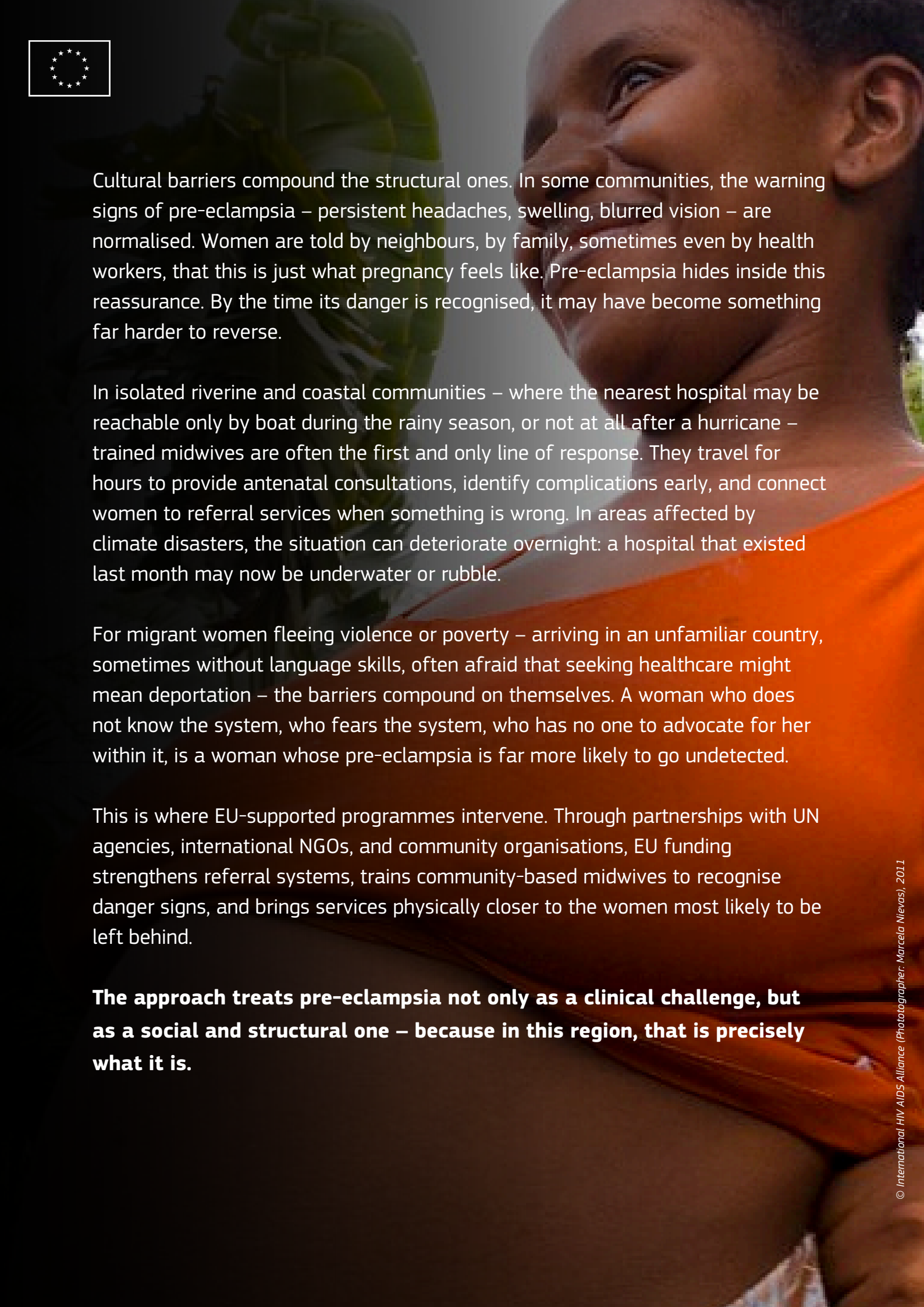
Latin America and the Caribbean have world-class hospitals. It has specialists, protocols, and surgical infrastructure. In some cities, the care available would not look out of place in Western Europe. The problem is not the medicine. The problem is who can reach it.

- In Latin America and the Caribbean, **the risk of maternal death is three times higher for indigenous women, and evidence points to a similarly elevated risk for Afro-descendant women.** (UNFPA, 2025)
- **The Andean sub-region records 91 maternal deaths per 100,000 live births** – above the regional average of 68 – **and has seen a 5% increase in maternal mortality since 2015.** (UNFPA/PAHO, 2025)
- Latin America and the Caribbean experienced the smallest reduction in maternal mortality of any world region between 2000 and 2023 – just 16.8%. (PAHO, 2025)

A woman in an urban centre in Brazil or Mexico may be diagnosed with pre-eclampsia early, monitored closely, and delivered safely. A woman in a remote Amazonian community, or in an Indigenous settlement where healthcare has historically been absent or hostile, may arrive at a hospital only when her condition has already progressed to a crisis. **The road between those two outcomes is not paved with medical differences. It is paved with geography, race, income, and the accumulated weight of exclusion.**

"Behind maternal mortality lies the horrible face of inequality," said Dr. Alejandra Corao, UNFPA's Regional Advisor for Sexual and Reproductive Health for Latin America and the Caribbean. "In our region, maternal mortality has the face of indigenous women, Afro-descendant women, with limited income and low educational levels. Behind the numbers lie stories of discrimination and exclusion. This reality is a violation of human rights and must be transformed urgently."

The EU health expert for the region, Joelle Van Winghem, highlighted this stark inequality. In some cases, these disparities can have fatal consequences. They can mean a 15-year-old girl dying in a waiting room or at home after being denied care – not because treatment was unavailable, but because she was unable to access it due to discrimination based on her race or nationality.



Cultural barriers compound the structural ones. In some communities, the warning signs of pre-eclampsia – persistent headaches, swelling, blurred vision – are normalised. Women are told by neighbours, by family, sometimes even by health workers, that this is just what pregnancy feels like. Pre-eclampsia hides inside this reassurance. By the time its danger is recognised, it may have become something far harder to reverse.

In isolated riverine and coastal communities – where the nearest hospital may be reachable only by boat during the rainy season, or not at all after a hurricane – trained midwives are often the first and only line of response. They travel for hours to provide antenatal consultations, identify complications early, and connect women to referral services when something is wrong. In areas affected by climate disasters, the situation can deteriorate overnight: a hospital that existed last month may now be underwater or rubble.

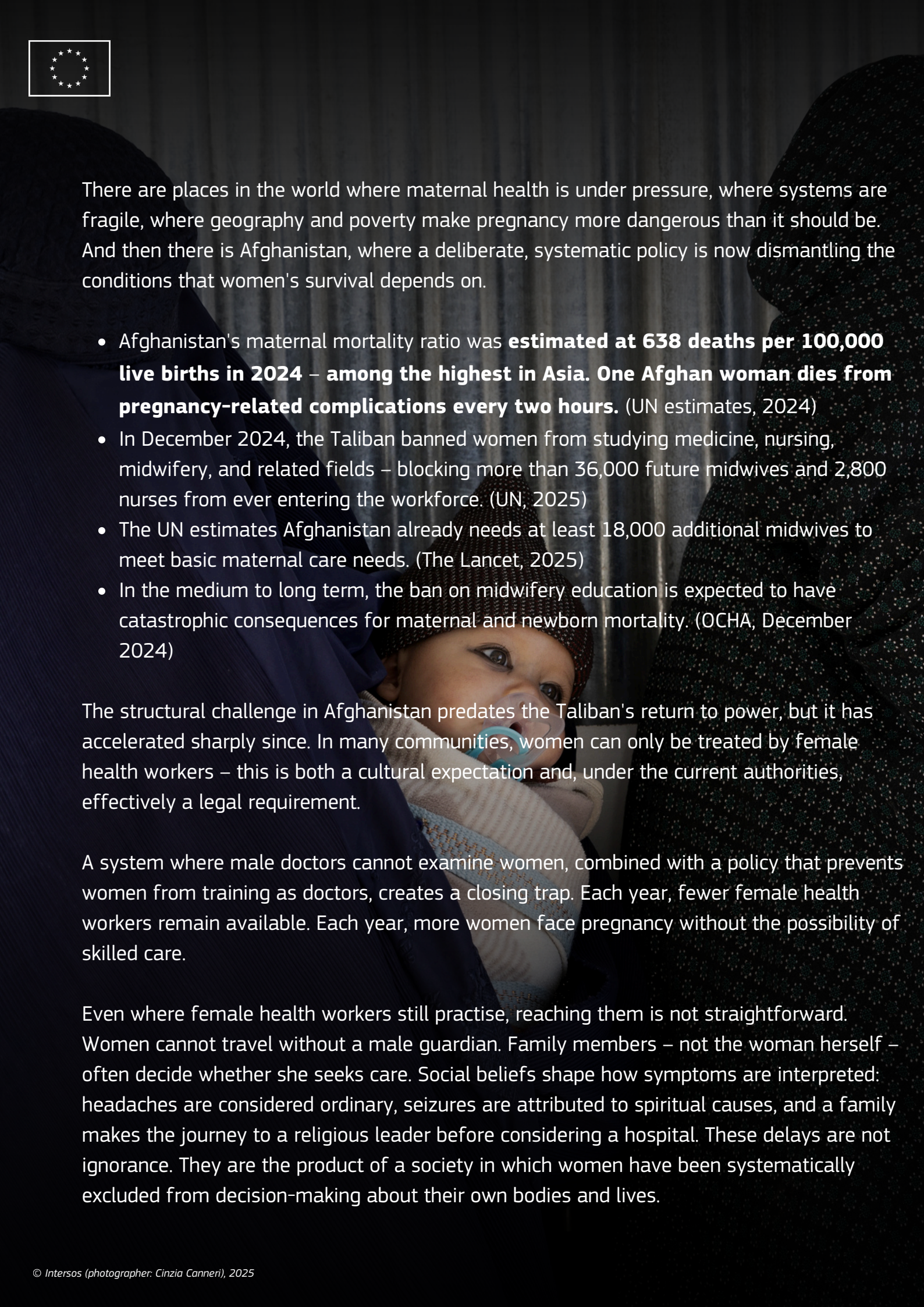
For migrant women fleeing violence or poverty – arriving in an unfamiliar country, sometimes without language skills, often afraid that seeking healthcare might mean deportation – the barriers compound on themselves. A woman who does not know the system, who fears the system, who has no one to advocate for her within it, is a woman whose pre-eclampsia is far more likely to go undetected.

This is where EU-supported programmes intervene. Through partnerships with UN agencies, international NGOs, and community organisations, EU funding strengthens referral systems, trains community-based midwives to recognise danger signs, and brings services physically closer to the women most likely to be left behind.

The approach treats pre-eclampsia not only as a clinical challenge, but as a social and structural one – because in this region, that is precisely what it is.

AFGHANISTAN: A RAPIDLY WORSENING CRISIS FOR WOMEN'S HEALTHCARE

Restrictions on women's mobility, education, and access to female health workers **are creating a rapidly worsening crisis for maternal healthcare**. Many women cannot travel freely to seek prenatal care, while the ban on women studying medicine threatens the future availability of female doctors, nurses, and midwives - critical for maternal and reproductive health services in the country.



There are places in the world where maternal health is under pressure, where systems are fragile, where geography and poverty make pregnancy more dangerous than it should be. And then there is Afghanistan, where a deliberate, systematic policy is now dismantling the conditions that women's survival depends on.

- Afghanistan's maternal mortality ratio was **estimated at 638 deaths per 100,000 live births in 2024 – among the highest in Asia. One Afghan woman dies from pregnancy-related complications every two hours.** (UN estimates, 2024)
- In December 2024, the Taliban banned women from studying medicine, nursing, midwifery, and related fields – blocking more than 36,000 future midwives and 2,800 nurses from ever entering the workforce. (UN, 2025)
- The UN estimates Afghanistan already needs at least 18,000 additional midwives to meet basic maternal care needs. (The Lancet, 2025)
- In the medium to long term, the ban on midwifery education is expected to have catastrophic consequences for maternal and newborn mortality. (OCHA, December 2024)

The structural challenge in Afghanistan predates the Taliban's return to power, but it has accelerated sharply since. In many communities, women can only be treated by female health workers – this is both a cultural expectation and, under the current authorities, effectively a legal requirement.

A system where male doctors cannot examine women, combined with a policy that prevents women from training as doctors, creates a closing trap. Each year, fewer female health workers remain available. Each year, more women face pregnancy without the possibility of skilled care.

Even where female health workers still practise, reaching them is not straightforward. Women cannot travel without a male guardian. Family members – not the woman herself – often decide whether she seeks care. Social beliefs shape how symptoms are interpreted: headaches are considered ordinary, seizures are attributed to spiritual causes, and a family makes the journey to a religious leader before considering a hospital. These delays are not ignorance. They are the product of a society in which women have been systematically excluded from decision-making about their own bodies and lives.

Against this backdrop, EU-funded partners like the Italian NGO EMERGENCY have built something remarkable: **a system of care that functions within these constraints rather than despite them.** At the Anabah Maternity Centre, all services are provided free of charge. Blood pressure and urine screening are available at the primary care level. Referral systems for suspected pre-eclampsia operate alongside obstetric high-dependency care for critical cases. Free transport is provided from many health centres. Every clinical function is led by women.

- **From 2017 to 2025, 1,146 women with severe pre-eclampsia were treated at the Anabah Maternity Centre, with 14 maternal deaths. In a country with one of the world's highest maternal mortality burdens, this is evidence that even fragile systems can hold.**

F. is 20 years old, from Salang. Her baby girl was born yesterday. Her husband has been in Iran for two months; she has not heard from him. During her pregnancy, food was scarce. At night, the women in her household did not leave the house – there was no one to protect them. When her legs began to swell, and headaches came, the women in her village told her it was normal. They had experienced the same thing. Everything would be fine.

But pre-eclampsia hides precisely inside what women are told to ignore. F. did reach care. She received check-ups, vitamins, and treatment. She delivered safely. And now she says something that carries more force than any statistic:
"If I meet a pregnant woman complaining of a headache, I will never tell her it is normal. I will tell her to go immediately to a hospital."

T. is around 18 or 20 years old, from Parwan province. She delivered twins yesterday. At seven months pregnant, her legs began to swell. A doctor told her to elevate her feet, but did not check her blood pressure. She moved from one facility to another. Still, no one checked it. When she finally arrived at the EMERGENCY hospital in Panjshir, her blood pressure was 200/120 – a life-threatening crisis that had gone unnoticed for far too long. She was admitted immediately, treated with intravenous medication, and labour was induced. Her twins were born alive. What she remembers most is not the fear. It is the moment someone finally understood what was happening.

"They checked my blood pressure right away."

Such a simple sentence. Such an enormous difference.

BANGLADESH AND THE ROHINGYA CAMPS: WHERE DISPLACEMENT NARROWS EVERY MARGIN

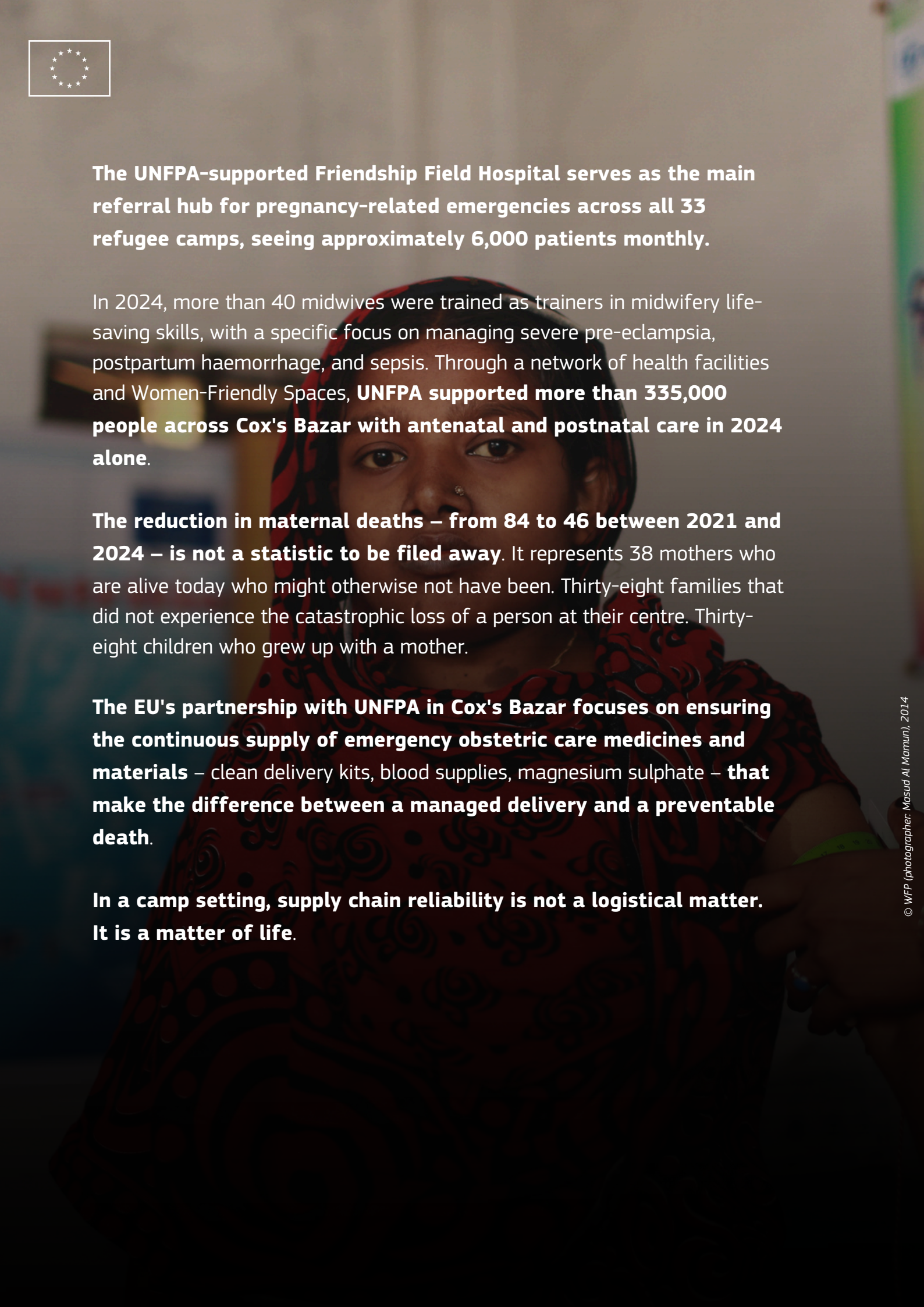
In the Rohingya camps in Cox's Bazar, **displacement, unsafe travel, and limited access to healthcare continue to put pregnant women at risk,** while maternal mortality and complications such as **pre-eclampsia remain alarmingly high**.

Cox's Bazar, in southeastern Bangladesh, is home to the largest refugee settlement on earth. More than a million Rohingya people live there, displaced from Myanmar after campaigns of mass violence that the United Nations has described as genocide. Among them are tens of thousands of women who are pregnant at any given time – **women** who have survived unimaginable trauma, who live in dense, overcrowded camps with limited sanitation and scarce healthcare, and **who face one of the most dangerous environments in the world to become a mother**.

- In 2024, **46 maternal deaths were recorded in the Rohingya camps in Cox's Bazar –** a figure that represents **a 45% reduction since 2021, from 84 deaths, thanks to UNFPA-supported interventions**. (UNFPA Bangladesh, 2025)
- Despite progress, **3 to 5 mothers still die each month in the camps from pregnancy-related complications** – equivalent to a maternal mortality rate of approximately 179 per 100,000 live births. (UNFPA, 2025)
- The prevalence of pre-eclampsia and eclampsia among women in the camps is estimated at 24%. (Bangladesh Maternal and Newborn Health Survey, 2026)

A pre-eclampsia prevalence of 24% is extraordinarily high. The global figure, according to the WHO, is 3-8%. In Cox's Bazar, the combination of factors that drive pre-eclampsia risk – malnutrition, anaemia, young maternal age, first pregnancies, stress, limited antenatal care – is concentrated in a single, overcrowded, under-resourced setting. The camps are not an unfortunate accident of geography. They are the product of political decisions, and the women inside them bear the consequences.

The barriers to care are multiple and intersecting. Clinics are not always open. Transport is limited. Movement after dark is unsafe. **Decisions about seeking care are often made not by the woman herself, but by her husband or male relatives, and financial constraints, fear of the unfamiliar, and the sheer exhaustion of displacement all shape those decisions in ways that can delay care until it is almost too late**.



The UNFPA-supported Friendship Field Hospital serves as the main referral hub for pregnancy-related emergencies across all 33 refugee camps, seeing approximately 6,000 patients monthly.

In 2024, more than 40 midwives were trained as trainers in midwifery life-saving skills, with a specific focus on managing severe pre-eclampsia, postpartum haemorrhage, and sepsis. Through a network of health facilities and Women-Friendly Spaces, **UNFPA supported more than 335,000 people across Cox's Bazar with antenatal and postnatal care in 2024 alone**.

The reduction in maternal deaths – from 84 to 46 between 2021 and 2024 – is not a statistic to be filed away. It represents 38 mothers who are alive today who might otherwise not have been. Thirty-eight families that did not experience the catastrophic loss of a person at their centre. Thirty-eight children who grew up with a mother.

The EU's partnership with UNFPA in Cox's Bazar focuses on ensuring the continuous supply of emergency obstetric care medicines and materials – clean delivery kits, blood supplies, magnesium sulphate – **that make the difference between a managed delivery and a preventable death**.

In a camp setting, supply chain reliability is not a logistical matter. It is a matter of life.

UKRAINE: WHEN WAR DISMANTLES ROUTINE

In Ukraine, **war has turned routine maternal care into a race against time**. For women experiencing complications such as pre-eclampsia, damaged infrastructure, attacks in frontline areas, and disrupted access to hospitals **can delay lifesaving treatment within critical hours**.

Before February 2022, Ukraine had spent two decades steadily reducing its maternal mortality rate. Clinics had been modernised, protocols updated, and midwives trained. Pregnancy in Ukraine had become measurably safer.

The Russian invasion did not change the biology of pre-eclampsia. It changed whether women could survive it.

- **Maternal mortality in Ukraine rose by 37% between 2023 and 2024 –** from 18.9 to 25.9 deaths per 100,000 live births. (UNFPA/WHO, December 2025)
- **Since the full-scale invasion, more than 80 maternity and neonatal facilities have been damaged or destroyed. Over 2,760 healthcare sites have been affected nationwide.** (UNFPA, 2025)
- In 2025 alone, 3,222 cases of pre-eclampsia were registered in Ukraine. (Ukraine Ministry of Health, 2025)

The numbers tell part of the story. The rest lies in details that statistics cannot hold. Ambulances attacked by drones as they cross frontline areas. Hospitals without electricity for days at a time. A woman whose blood pressure suddenly spikes – who knows she needs urgent care – is facing roads that have become battlegrounds. A condition that can deteriorate within hours, and a war that steals those hours first.

UNFPA data shows that, alongside the rise in maternal deaths, the crisis has driven a 44% increase in uterine ruptures and a 12% rise in hypertension during pregnancy. **In some frontline regions of Ukraine, caesarean section rates are now among the highest in Europe – a marker not of medical preference, but of a health system under unbearable strain.**

Viktoriia is 34 years old, from Sumy. She had been trying for a long time to become a mother. At 25 weeks into a long-awaited twin pregnancy, her blood pressure suddenly spiked, and she was rushed to the Sumy Regional Clinical Perinatal Centre – a facility supported by UNFPA and the European Commission.

"I was in shock," she recalls. **"I thought everything was normal with me. The pregnancy was good. I did not feel sick. Nothing hurts."**

Doctors warned that if her condition worsened, they might have to induce labour. Her twins weighed less than one kilogram each. For weeks, Viktoriia counted time in the smallest possible units.

"Every week, I just prayed. One week passed – and that was already great."

Today, her daughters Adelina and Karolina are growing. They smile. They are learning their first words.

In a wartime maternity ward, that is not a small thing. It is what humanitarian support is built to protect: not only survival, but the fragile continuation of ordinary life.

To continue caring for pregnant women under bombardment, UNFPA has supported the construction and operation of underground maternity wards.

In the Kherson City Perinatal Centre, 118 babies were delivered underground in 2024. In Sumy, another bunkerised ward operates beneath the same city where a missile struck a UNFPA-supported maternity hospital in October 2025.

"Safe childbirth must be protected even in war, and international humanitarian law is clear: health facilities, health workers and patients must never be targets."
– Florence Bauer, UNFPA Regional Director for Eastern Europe and Central Asia.

YEMEN: WHERE CONFLICT AND CULTURE COMPOUND THE DANGER

In Yemen, **conflict, limited access to healthcare, and social norms continue to put pregnant women at risk.** Many women receive no antenatal care, while distance, movement restrictions, and the lack of female health providers can delay lifesaving treatment for complications such as pre-eclampsia.

In Yemen, more than a decade of war has not only damaged the health system. It has hollowed it out. Facilities have been bombed, staff have fled or gone unpaid for months, and supply chains for basic medicines have collapsed. What remains functions in spite of everything – through the dedication of health workers who stay, and through the lifeline of international humanitarian support.

- **Yemen's maternal mortality ratio stood at 183 deaths per 100,000 live births in 2020 – among the worst in the region.** In 2023, an estimated 1,642 women died from pregnancy-related causes. (WHO/Our World in Data, 2025)
- **Three women die every day from pregnancy-related causes in Yemen.** (WHO, 2025)
- Only 46.9% of births in Yemen occur in health facilities. Nearly 30% of women receive no antenatal care at all. (Yemen Health Surveys)

The WHO has confirmed that preventable complications – including pre-eclampsia and eclampsia – remain among the leading direct causes of maternal death in Yemen. In a country where fewer than half of all women give birth with skilled assistance, where supply chains for magnesium sulphate are intermittent at best, and where entire regions go months without a functioning maternal healthcare facility, pre-eclampsia does not need to be a severe case to be a fatal one.

But in Yemen, the clinical picture cannot be separated from the cultural one. Social norms profoundly shape when – and whether – a woman seeks care. In many communities, a woman cannot travel without her husband's permission or a male escort. Movement restrictions, particularly for women, can make it impossible to reach a clinic, even when the will to go exists. When symptoms appear, the first response is often to wait, to consult family, to pray – before any consideration of medical attention.

"What saves a woman's life in cases of pre-eclampsia can be something as simple as having her blood pressure measured in time," says EU health expert on the ground, Halim Boubaker.

EU health expert on the ground, Halim Boubaker, tells a compelling story: imagine a mother of five who has experienced five uncomplicated pregnancies. When symptoms of pre-eclampsia emerge during her sixth pregnancy – swelling, headaches, and elevated blood pressure – she assumes they are nothing to worry about, trusting her previous experiences. Her family depends on her. Her husband sees no reason for alarm. She dismisses the signs.

This is precisely why pre-eclampsia can be so dangerous: its warning signs may be overlooked until the condition becomes severe. The risks are often compounded in communities where women face barriers to seeking care or are expected to endure discomfort without complaint. In remote areas of Yemen, EU-trained, EU-supported midwives may travel for days on donkeys to reach isolated communities and perform simple yet potentially life-saving checks, such as measuring blood pressure and testing urine for protein.

The shortage of female health workers makes this worse. In Yemen, as in Afghanistan, cultural and religious norms mean many women will only be examined by another woman. Where female health workers are absent – which in conflict-affected areas is increasingly common – women do not seek care. They wait.

Since April 2024, EU-supported UNFPA programming in Yemen has reached more than 600,000 women and girls with reproductive health services. Trained midwives travel to remote areas with mobile clinics, carrying the basic tools – blood pressure cuffs, urine strips, magnesium sulphate – that represent the difference between detecting a crisis early and encountering it too late. In a country this broken, a trained midwife with a bag of supplies is not a small intervention. It is infrastructure.

IN AFRICA, SURVIVAL DEPENDS ON REACHING CARE IN TIME

Across sub-Saharan Africa, pregnancy is still shadowed by the possibility that a treatable complication can become fatal simply because help arrives too late. **Maternal mortality remains among the highest in the world, not only because of disease itself, but because conflict, poverty, displacement, and fragile health systems turn ordinary medical emergencies into life-or-death races against time**. For women developing pre-eclampsia, survival often depends less on the severity of the condition than on whether someone can detect it early enough – and whether a road, a clinic, a midwife, or an ambulance still exists when she needs it most.

Every one of those absences has a face behind it – a woman who set out too late, a family that waited one day too long, a health worker who could not get through. What looks, from a distance, like a statistical problem is, up close, a series of individual moments in which the wrong thing was unavailable at the wrong time.

- **Around 70% of the world's maternal deaths occur in Africa.**
- **In 2023, 135,000 women died from pregnancy and childbirth-related causes in West and Central Africa alone – more than half of global maternal deaths.** (UNICEF WCAR Report, 2025)
- In the Democratic Republic of Congo, hypertensive disorders – including pre-eclampsia and eclampsia – account for 10% of maternal deaths. The DRC is among the eight countries that together contribute more than half of global maternal deaths. (FIGO/WHO)
- **Nigeria, the DRC, and Chad together account for 74% of all maternal deaths in West and Central Africa.** (UNICEF, 2025)

In eastern DRC, where fighting between armed groups has displaced millions and periodically made entire regions inaccessible to humanitarian workers, women frequently begin antenatal care only around the 34th week of pregnancy. By then, a condition like pre-eclampsia may have been developing silently for months. Many health centres lack the most basic detection tools – a functioning blood pressure monitor, urine test strips, and a supply of magnesium sulphate. Pre-eclampsia is often discovered only once convulsions have already begun. And even then, survival depends on whether a woman can be physically moved to a facility capable of treating her.

Health workers in eastern DRC describe women being evacuated over long distances on damaged roads, through areas of active insecurity, sometimes in vehicles without fuel, sometimes without vehicles at all. A humanitarian team that cannot cross a frontline cannot reach a woman in crisis.

A treatable condition becomes fatal not because the treatment is unknown or unavailable everywhere, but because the road to the hospital cannot be crossed in time.

Nigeria, for example, is where the scale of this crisis becomes most viscerally apparent. It is Africa's most populous nation, home to one in six of the continent's people – and it bears a burden of maternal death that is without parallel anywhere on earth.

According to WHO estimates, Nigeria records 512 maternal deaths per 100,000 live births and ranks second globally in absolute maternal deaths; in 2020 alone, 82,000 women lost their lives to pregnancy-related complications. To put that figure in context: in 2015, the total number of maternal deaths across all 46 of the world's most developed countries combined was 1,700. Nigeria lost more than 34 times that number in a single year.

Pre-eclampsia and eclampsia are among the leading direct causes of those deaths. **An estimated 10% of all pregnancies in Nigeria are complicated by hypertension – a figure that points to the scale of the pre-eclampsia burden in a country of over 220 million people.** Yet the condition continues to go undetected at alarming rates, for reasons that are structural rather than medical. According to the 2024 Nigeria Demographic and Health Survey, while antenatal care coverage has improved to 63%, only 46% of births are attended by skilled health personnel – meaning more than half of Nigerian mothers remain unattended during the most critical hours of childbirth.

The gap between urban and rural Nigeria is its own crisis within a crisis. In cities, a woman with rising blood pressure may reach a tertiary hospital, see a specialist, be screened and treated. In rural northern states –where poverty is deepest, where roads become impassable in the rainy season, where the nearest equipped facility may be a day's journey away – pre-eclampsia simply progresses. Symptoms are normalised. Families wait. By the time a woman is referred, she may already be in crisis. Research from rural Lagos found that the majority of women presenting with maternal complications had been referred from mission homes, traditional birth attendant centres, or home deliveries – most of those referrals not done in time, resulting in late presentation of complications that were, in principle, preventable.

A Nigerian woman faces a 1-in-22 lifetime risk of dying during pregnancy or childbirth. In the most developed countries, that risk is 1 in 4,900. The same disparity. The same biology. A gap so wide it should be impossible to look at without asking who decided it was acceptable.

In other parts of West Africa, the barriers are different but no less deadly.

Women may live hours from the nearest facility with emergency obstetric capacity. Transport costs are often prohibitive for families already surviving on almost nothing. Armed groups or insecurity may block referrals entirely in conflict-affected areas. And because pre-eclampsia can present so quietly – persistent headaches dismissed as tiredness, swelling attributed to heat, blurred vision normalised – many women do not understand that they are in danger until the condition has escalated into eclampsia.

In response to this, humanitarian teams are increasingly using illustrated awareness materials – tools that do not require literacy, designed for communities where danger signs are routinely overlooked – to help women and families recognise when to seek care before seizures begin. The approach is low-cost, local, and evidence-based. It works because it meets women where they are, in the language they speak, with images they can understand.

EU-funded partners across conflict-affected regions in West Africa and the DRC support maternal healthcare through mobile outreach, antenatal consultations, emergency referrals, community awareness campaigns, and the training of midwives and frontline health workers.

In places where health systems are collapsing under the weight of conflict and displacement, even the availability of a single blood pressure monitor, a vial of magnesium sulphate, fuel for an ambulance, or a trained midwife can mean the difference between a woman surviving her pregnancy or not.

WOMEN BEHIND THE SYSTEMS

Statistics can tell us how many women die. They cannot tell us who those women were. They cannot tell us what it felt like to count weeks in a wartime maternity ward, or to be told by everyone around you that your headache is ordinary, or to arrive at a hospital with a blood pressure of 200/120 and discover that no one had thought to check it until now.

The stories in this report – of Viktoriia in Sumy, F. in Salang, T. in Parwan, the unnamed women in Rohingya camps and river communities across Latin America – are not unusual. They are representative of millions. What makes them different from the stories that end in loss is sometimes a trained midwife, sometimes a functioning blood pressure cuff, sometimes a referral system that worked, and sometimes simply the fact that someone took a symptom seriously.

F., from Salang, survived her pregnancy despite being told by every woman around her that her swelling and headaches were normal. She received care. She recovered. And what she now says she will do if she meets another pregnant woman with a headache captures, in one sentence, everything this report is about: **"I will never tell her it is normal. I will tell her to go immediately to a hospital."**

T., from Parwan, moved from facility to facility with a blood pressure of 200/120, which no one checked. When she finally arrived at EMERGENCY's hospital in Panjshir, they checked it immediately. Her twins are alive. What she remembers is not the weeks of being overlooked. It is the moment she finally felt seen.

"They checked my blood pressure right away."

A sentence this short should not carry this much weight. But it does – because sometimes the line between neglect and care is not a complex intervention or an expensive technology. It is someone taking a symptom seriously. A midwife recognising danger. A referral is working as it should. **A health system – however fragile, however underfunded, however battered by conflict or policy – responding in time.**

And sometimes, that is enough for a mother to survive, for children to go home with her, and for a story not to end in loss.

THE DIFFERENCE THE EU MAKES

The impact of the European Union extends beyond stronger hospitals, safer roads, and more doctors within Europe itself. Through solidarity, humanitarian funding, technical cooperation and partnerships with international and local organisations, **Europe is committed to advancing access to life-saving healthcare for women and girls – in places where health systems are collapsing under war, displacement, poverty, or isolation**.

Behind the €114 million the European Union allocated to sexual and reproductive health and gender-based violence response in 2025 are not programmes or budgets or logistical frameworks. There are individual moments. A mobile clinic arriving by boat during Mali's rainy season. A trained midwife carrying urine strips and magnesium sulphate into a displacement camp in Yemen. A woman doctor in Afghanistan, where only women can treat women, and the future of female healthcare has been banned from the classroom. A referral ambulance crossing insecure roads in eastern Congo. A high-risk ward in Cox's Bazar where Rohingya women with severe hypertension are stabilised before labour begins.

Each of these moments is small from the outside. None of them is small from the inside.

Across crisis settings, EU-supported partners sustain sexual and reproductive health services that would otherwise disappear entirely: antenatal consultations, emergency obstetric care, referrals, mobile clinics, psychosocial support, nutrition assistance, and the training of midwives and frontline health workers. In humanitarian settings, these are not secondary services. They are often the only barrier between a manageable complication and a maternal death.

The logic of pre-eclampsia care is medically simple: detect high blood pressure early, test urine for protein, monitor symptoms, and refer quickly if danger signs appear. But in conflict settings, even these basic steps can vanish. A blood pressure cuff may not exist.

Fuel may run out before an ambulance reaches a village. Roads may be flooded, mined, or blocked. Hospitals may lack electricity, medication, or staff. Women may see a health worker only once during their entire pregnancy.

That single visit becomes critical.

This is why EU-supported programmes increasingly focus not only on hospitals, but on the earliest possible point of detection: community outreach, mobile antenatal care, awareness campaigns on danger signs, referral systems, and midwifery training. In emergency settings, routine screening during pregnancy is one of the most effective and lowest-cost interventions available – because pre-eclampsia often develops silently, and a woman may feel perfectly healthy until seizures begin.

- **Yemen: 600,000+ women and girls accessed reproductive health services through EU/UNFPA-supported facilities since April 2024.**
- **Bangladesh: Maternal deaths in Rohingya camps fell by 45% between 2021 and 2024, from 84 to 46 deaths per year.**
- **Afghanistan: 1,146 women with severe pre-eclampsia were treated at the EU-supported Anabah Maternity Centre between 2017 and 2025, with 14 maternal deaths.**

The impact is often measured in moments that never become statistics. Pre-eclampsia is preventable. It is manageable. It is, in the vast majority of cases, survivable – when the conditions are in place to detect and treat it.

Women are not dying because this condition cannot be treated. They are dying because, too often, help comes too late.

Sometimes the difference the EU makes is no larger than a single blood pressure reading taken at the right moment. And sometimes – for a mother holding her child for the first time, for the children who will grow up with her – that is everything.

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