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Editorial

Saving Indonesian Women: Why Preventable Maternal Deaths Must No Longer Be Accepted

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A nation cannot claim progress while pregnancy, childbirth, and the weeks after delivery remain a passage through avoidable danger. "Save Indonesian Women" must therefore be more than a campaign slogan. It must become a standard by which health systems, professional organizations, governments, hospitals, communities, and families are judged. The experience of East Java shows that maternal survival can improve when data are converted into coordinated action. It also delivers a sobering warning: declining mortality is not the same as a completed mission.

Between 2023 and 2025, the maternal mortality ratio in East Java fell from 93.34 to 82.56 and then to 68.70 per 100,000 live births. The recorded number of maternal deaths declined from 499 in 2023 to 484 in 2024 and 399 in 2025. These figures represent progress. Yet the deeper message lies within the audit findings. Among maternal deaths reviewed in 2024, 66% were classified as preventable; in 2025, the proportion rose to 69%. Improvement in the headline number, therefore, coexisted with a persistent burden of deaths that the system itself considered avoidable.

The pattern of mortality makes complacency impossible. In the available 2025 profile, 67% of deaths occurred during the postpartum period, compared with 19% during pregnancy and 14% during labor. More than nine in ten deaths occurred in hospitals. Most women were aged 20–33 years, and the largest single group was experiencing a first pregnancy. These findings challenge a familiar but inadequate assumption: that bringing a woman to a hospital is, by itself, sufficient protection. Survival depends not merely on arrival, but on timely recognition, competent stabilization, effective treatment, clear escalation, safe referral, and vigilant follow-up after birth.

The audit identified weaknesses that are painfully concrete. Inadequate follow-up was the most frequently recorded medical factor, followed by inadequate management of the primary condition and delay in starting treatment. Other problems included limited facilities, inaccurate diagnosis, infection acquired during care, and unavailable medicines. The non-medical findings were equally revealing: failure to follow treatment advice, poor coordination and communication during care, refusal of treatment, cultural or religious barriers, geographical constraints, and financing difficulties. These should not be read as reasons to blame women. They are signals that trust, communication, access, continuity, and

shared decision-making remain part of clinical safety.

East Java's response has been built around a principle that deserves national attention: maternal mortality is not owned by one hospital, one profession, or one government office. The PENAKIB Forum emerged from the Grahadi Declaration of 19 October 2013, was formalized through a gubernatorial decree in 2016, and has continued through renewed mandates for 2023–2024 and 2025–2029. Its architecture links maternal and perinatal audit teams, expert councils, community empowerment, primary services, referral services, and advocacy to regional leaders. Institutional continuity matters because preventable deaths rarely arise from a single mistake; they emerge from breaks between people, places, and decisions.

The strongest feature of this model is its insistence that audit must lead to repair. Maternal and perinatal surveillance reviews are linked to quality-improvement collaboratives, case-based workshops, hospital and district mentoring, and revision of clinical practice guidance. Priority areas include pre-eclampsia and eclampsia, postpartum hemorrhage, and neonatal asphyxia. The program also promotes competency development at the primary-care level, structured referral, monitoring of care bundles, and follow-up of recommendations. This is the difference between collecting mortality data and governing mortality reduction: every reviewed death must produce an assigned action, a responsible institution, and a timetable for change.

Digital innovation has supported this effort. The E-DETIK application enables community-based self-assessment for early detection of high-risk pregnancy. Recorded users increased from 159 in May 2024 to 1,026 in April 2025. Technology, however, is valuable only when it is connected to human response. A positive screen must trigger counseling, verification, referral, and continuity of care. For the same reason, the "one obstetrician–one primary health center" mentoring concept is important: it moves specialist knowledge beyond tertiary hospitals and strengthens the first point at which risk can be recognized.

Progress has not been uniform. From 2024 to 2025, maternal deaths decreased in 23 districts or cities, increased in nine, and remained unchanged in six. Jember recorded the largest reduction, while Malang showed the largest increase. This variation is not a statistical footnote. It argues against uniform interventions imposed without regard to local patterns. Districts require tailored analysis of delays, workforce capability, referral routes, communication failures, and community barriers. Areas that improve should become learning sites; areas that deteriorate require targeted, transparent support.

Saving Indonesian women must also extend beyond pregnancy. The same East Java initiative recognizes cervical cancer prevention as part of a continuum of women's health. The dossier reports that cervical screening using HPV testing and self-sampling reached only about 7% in 2023. Pilot programs targeted 5,500 women in Surabaya and 923 in Sidoarjo and reported successful self-sampling in 99.9% of participants. HPV vaccination coverage for the first dose increased from 93.8% in 2023 to 100.8% in 2024. These efforts show how screening, vaccination, laboratory networks, education, and referral can be connected rather than delivered as isolated projects.

The national lesson is clear. Indonesia does not need another temporary campaign that disappears when an event ends. It needs durable provincial and district systems that make preventable death visible, reviewable, and actionable. Data must guide priorities. Clinical standards must be implemented, not merely issued. Specialists must mentor frontline teams. Communities must be treated as partners. Leaders must be accountable for closing recommendations. Above all, every woman must be protected across the entire continuum—from adolescence and preconception to pregnancy, childbirth, postpartum recovery, and later-life cancer prevention.

To save Indonesian women is to reject the idea that avoidable death is inevitable. East Java has shown that collaboration can move the numbers. The remaining task is harder: to ensure that every improvement becomes permanent, every district advances, and every reviewed death changes the care received by the next woman. That is not only a health objective. It is a national obligation. Its success will be measured in women who live.

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