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CASE REPORT

Conflict-Related Disruption of Maternal Health Services: A Case Report of Maternal Death in Transit Due to Obstructed Labour in Somalia

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Abstract: Maternal mortality remains a major public health challenge in fragile and conflict-affected settings, where insecurity can disrupt referral pathways, skilled birth attendance, and timely emergency obstetric care. This case report describes a maternal death in transit from a remote nomadic community in Mahas District, Hirshabelle State, Somalia, and uses the Three Delays Model to frame the health-system failures contributing to the outcome. A 22-year-old primigravida woman developed prolonged labour at home under the care of a traditional birth attendant. The nearest district health facility had reportedly been non-functional for approximately six months because of insecurity and armed conflict, leaving no nearby access to skilled obstetric assessment or emergency obstetric care. As her condition deteriorated, the family attempted referral to Baladweyne Regional Hospital, but she died during transport before reaching the facility. Based on the reported history and clinical course, the death was most consistent with obstructed labour complicated by delayed access to emergency obstetric care. This case illustrates how conflict-related facility closure, weak referral systems, transport barriers, and lack of antenatal and skilled delivery care can combine to create a fatal second delay. It highlights the need for context-specific strategies to maintain essential maternity services in insecure districts, strengthen referral transport and communication, improve community recognition of obstetric danger signs, and protect emergency obstetric care for remote and nomadic populations.

Keywords: maternal mortality, obstructed labour, armed conflict, emergency obstetric care, referral delay, Somalia, Three Delays Model, health system disruption

Introduction

Maternal mortality remains a major global public health challenge, particularly in fragile and conflict-affected settings where access to essential maternal and emergency obstetric services is limited. Despite global progress, an estimated 287,000 women died from maternal causes in 2020, and most deaths occurred in low- and lower-middle-income countries.[1] Somalia continues to experience one of the highest maternal mortality burdens globally, with persistently low coverage of skilled birth attendance, facility delivery, and timely postnatal care.[1–3] These gaps are especially harmful in obstetric emergencies, where delays in recognition, referral, and treatment can rapidly become fatal.

Armed conflict can worsen maternal risk by disrupting health service delivery, damaging infrastructure, displacing healthcare workers, interrupting supply chains, increasing transport insecurity, and reducing access to life-saving services.[4,5] In Somalia, these disruptions occur within an already fragile health system in which rural, nomadic, and internally displaced populations often face additional barriers to skilled care. Recent Somalia-specific evidence shows that facility delivery remains low and that distance, nomadic residence, lack of antenatal care, and socioeconomic disadvantage are associated with reduced use of maternal health services.[2,3,6,7]

Obstructed labour is a major direct cause of maternal morbidity and mortality and remains an important contributor to preventable maternal death in low-resource settings.[8] It occurs when the presenting fetal part cannot descend through the

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birth canal despite adequate uterine contractions. Without timely intervention, obstructed labour may result in uterine rupture, postpartum hemorrhage, sepsis, fetal death, and maternal death.[8,9] The Three Delays Model provides a useful framework for understanding maternal deaths in such contexts, including delay in deciding to seek care, delay in reaching an appropriate facility, and delay in receiving adequate care after arrival.[10]

This case report describes the death of a 22-year-old primigravida woman from a remote nomadic community in Mahas District, Hirshabelle State, Somalia, who died during referral after prolonged labour in the setting of conflict-related closure of the nearest health facility. The case is presented to illustrate how conflict-related health service disruption can transform a treatable obstetric emergency into a fatal outcome by breaking the maternal care pathway before definitive care is reached.

Case Presentation

A 22-year-old primigravida woman from a remote nomadic community in Mahas District, Hirshabelle State, Somalia, developed labour pain at home on 22 February 2026. According to family members, she had not received antenatal care during the pregnancy because of limited access to healthcare services in the area. Labour was initially managed at home by a traditional birth attendant.

The nearest district health facility in Mahas had reportedly been non-functional for approximately six months because of insecurity and armed conflict in the area. As a result, the patient had no access to nearby skilled birth attendance, labour monitoring, emergency obstetric assessment, or referral stabilization when labour failed to progress.

Her labour became prolonged, and the family reported progressive maternal exhaustion and worsening general condition. Because there was no functioning local facility, the decision was made to transport her to Baladweyne Regional Hospital, the nearest available referral hospital. During the journey, her condition deteriorated further, and she died in the early morning of 23 February 2026 before reaching the hospital.

No formal hospital examination, imaging, operative findings, laboratory investigations, or autopsy confirmation were available because the patient died before arrival at the referral center. Based on the history of prolonged labour, failure of labour to progress, absence of skilled obstetric intervention, and the reported clinical course, the death was considered most consistent with obstructed labour complicated by delayed access to emergency obstetric care.

Discussion

This case highlights the intersection between obstetric emergency, health system fragility, and armed conflict in a remote Somali setting. Although obstructed labour is a well-recognized and largely preventable cause of maternal death, timely survival depends on skilled attendance, functional referral systems, transport availability, and access to emergency obstetric care.[8,9] In this case, each of these protective factors was absent or severely weakened.

The analytical value of this case lies in illustrating a complete breakdown of the maternal care pathway. The patient began labour without antenatal care, received home-based support from a traditional birth attendant, had no nearby functioning district facility, and died during transport before reaching definitive care. This sequence shows how a structural second delay can become fatal when conflict closes the first point of skilled obstetric contact and forces referral over long distances.

The case can be interpreted through the Three Delays Model.[10] The first delay may have occurred because labour began at home without antenatal linkage or skilled birth planning. The second delay was the most prominent because the nearest district facility was non-functional, requiring transport to a distant referral hospital. The third delay could not be assessed because the patient died before reaching the hospital, but the absence of any opportunity for definitive obstetric intervention demonstrates how delays before arrival can prevent care entirely.

Conflict likely played a central role in the fatal pathway. Armed conflict is known to weaken health systems through facility closure, insecurity, staff displacement, disrupted transport routes, interrupted supply chains, and reduced service utilization.[4,5] In maternal health, these disruptions are especially harmful because obstetric emergencies are time-sensitive and often require immediate intervention. The closure of the nearest health facility in Mahas removed the local point of skilled obstetric care and transformed referral into a high-risk journey rather than a coordinated emergency pathway.

The patient's nomadic background added another layer of vulnerability. Mobile and hard-to-reach populations may face long travel distances, limited antenatal contact, delayed recognition of danger signs, poor transport availability, and weak continuity with formal health services. Somalia-specific studies have shown that rural and nomadic residence, distance to facilities, lack of antenatal care, and socioeconomic barriers are associated with lower use of maternal health services.[6,7,11] In this case, the absence of antenatal care reduced opportunities for risk identification, birth preparedness, counseling on danger signs, and planning for facility-based delivery.

The role of traditional birth attendants in remote and underserved communities should be interpreted carefully. In many fragile settings, traditional attendants may remain the only accessible support during childbirth. However, prolonged labour requires urgent obstetric assessment and often operative delivery, which cannot be provided in a home setting. Continued labour without skilled assessment likely increased the risk of dehydration, exhaustion, infection, uterine rupture, hemorrhage, shock, and fatal deterioration.[8,9] This case therefore illustrates not only the limitation of home-based childbirth support but also the failure of the surrounding referral system to provide a timely pathway to skilled care.

The broader literature from fragile and conflict-affected settings supports this interpretation. Conflict-related disruption of health services has been associated with reduced access to reproductive, maternal, newborn, and child health services and increased mortality risk among women and children.[4] Similar health-system failures are especially consequential when they affect emergency obstetric care, because delays in intervention can lead directly to preventable death.[8–10] In such environments, maternal death is often not only the result of the obstetric complication itself but also of the health system's inability to provide timely recognition, transport, stabilization, and definitive care.

This case also reflects the wider maternal health realities in Somalia. National evidence indicates that many births still occur outside health facilities and that skilled birth attendance, antenatal care, and postnatal care coverage remain limited.[2,3,6] In major Somali towns, home delivery has been associated with poor knowledge of facility delivery, lack of antenatal care, absence of counseling on place of delivery, financial barriers, and distance to facilities.[11] These barriers are likely more severe in remote and insecure districts where facility functionality and referral transport are disrupted.

Several operational implications emerge from this case. First, essential maternity services should be protected during insecurity through contingency planning, minimum service packages, and rapid restoration of district-level delivery care. Second, referral systems should include emergency transport arrangements, communication between community-level actors and referral hospitals, and clear pathways for obstetric danger signs. Third, community-level education should strengthen early recognition of prolonged labour, timely referral, and birth preparedness among remote and nomadic populations. Fourth, district health authorities and partners should identify areas where facility closure creates referral deserts and develop temporary outreach, mobile, or stabilization mechanisms until routine services resume.

This report has important limitations. It is a single case report based on family history and the reported clinical course rather than hospital-based clinical documentation. No examination findings, partograph, laboratory investigations, imaging, operative notes, or autopsy findings were available because the patient died before reaching the referral hospital. The case is therefore best understood as a narrative, verbal-autopsy-like reconstruction of maternal death during prolonged labour that was most consistent with obstructed labour. These limitations restrict diagnostic certainty but do not diminish the public health relevance of the case as an example of preventable maternal mortality linked to conflict-related service disruption.

Future research in Somalia should document maternal deaths occurring before facility arrival, evaluate referral pathway failures in insecure districts, assess the impact of facility closure on obstetric outcomes, and examine barriers faced by nomadic and hard-to-reach communities. Such evidence would support more targeted risk management, emergency referral planning, and health-system resilience strategies in conflict-affected regions.

Conclusion

This case report demonstrates how armed conflict can indirectly contribute to maternal death by disrupting access to essential obstetric services. In this patient, prolonged labour managed at home, closure of the nearest health facility, and delayed referral to a distant hospital resulted in death before definitive care could be reached. The case adds an individual-level illustration of how conflict-induced service disruption can create a fatal second delay in emergency

obstetric care. Preventing similar deaths in remote and conflict-affected areas of Somalia requires protection of district maternity services, functional emergency referral transport, community-level recognition of obstetric danger signs, and continuity of basic and comprehensive emergency obstetric care during insecurity.

Declaration of Generative AI Use

During the preparation of this work, the authors used ChatGPT to support language clarity and readability. The authors reviewed, edited, and verified the content and take full responsibility for the accuracy, integrity, and final version of the manuscript.

Ethics and Consent

Written informed consent for publication of this case report was obtained from the patient's husband, who was the next of kin and legally authorized representative to provide consent on the patient's behalf after the patient's death. The consent process was documented according to local institutional procedures, and all identifying information has been removed to preserve confidentiality. According to local institutional guidance, formal ethics committee approval is not required for a single anonymized case report. The authors confirm that the preparation and reporting of this case were conducted in accordance with the ethical principles of the Declaration of Helsinki.

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Disclosure

The authors declare no conflicts of interest in this work.

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