

# Maternal Deaths

*With what price we pay for the glory of motherhood.*

**Isadora Duncan** (1877 – 1927), dancer



Although pregnancy and childbirth are natural processes, many women suffer poor health and even death as a result of the process of becoming a mother. This is particularly true of the developing world. In South Africa, the notification of maternal deaths is required by law and the National Committee for the Confidential

Enquiry into Maternal Deaths regularly reports on the causes of these deaths, and makes recommendations in an attempt to improve the situation. The first report was published in 1997. The latest report covers the period 2005-2007 and makes for sad reading.<sup>1</sup>

The first striking finding is that there has been an increase of 20.1% in the number of deaths, when compared with the previous report period (2002–2004). Although partly a result of better reporting practices, the increase must be attributed mainly to non-pregnancy related infections, particularly HIV. The impact of the HIV pandemic is evident throughout the report, with the institutional maternal mortality rate ten times higher for HIV-positive than for HIV-negative women. The wider availability of antiretroviral therapy makes a significant portion of the deaths, due to AIDS, avoidable. There has been an increase in clearly avoidable deaths from 9.1% of the non-pregnancy-related infections and 4.5% of the AIDS deaths in 2002-2004, to 23.4% of non-pregnancy-related infections and 17.6% of AIDS deaths. The antiretroviral therapy programme must therefore be expanded more rapidly.

Some good news is that deaths related to hypertensive complications of pregnancy has been reduced by 13.7%, hopefully because of better management of hypertension in pregnancy.

Eighty per cent of clearly avoidable maternal deaths were due to the complications of hypertension, obstetric haemorrhage, pregnancy-related sepsis and non-pregnancy-related infections. The ways to prevent such deaths are known. Specific management protocols have been developed, and these have even been included in the recommendations provided in the previous issues of the report. Despite this, the most important avoidable factor is still substandard care (i.e. the lack of adherence to standard protocols). Clearly, training and support will play an important role in achieving better protocol adherence and care. Interestingly, the report notes that the most effective method of outreach has been shown to be on-site face-to-face teaching by a respected clinician. This is where family physicians, particularly in the rural areas, can play an important role.

A cause for concern is that level 1 and 2 facilities reported a relatively high number of deaths when compared with level 3 facilities. The report begs the question: “Are the level 1 and 2 hospitals not referring the patients because the problem is not recognised or there is no transport available, or are the level 3 institutions not accepting the referrals as they have no space?” Lack of transport when needed was indeed cited as the cause in 10% of deaths, but there also seems to be an acute shortage of tertiary beds to support level 1 and 2 referrals, particularly in the Free State.

As always, many patient-related factors played a part. The most obvious was risky sexual behaviour, leading to high HIV infection rates. Lack of attendance at antenatal clinics was mentioned, as well as delay in seeking help when needed. All are avoidable factors and related to patient and community education. Although a large proportion of women did attend clinics, health workers failed to intervene. In other words, these were missed opportunities. This is particularly relevant to HIV-infected women and women with hypertension or other pre-existing medical conditions.

Health facility managers and clinicians working with pregnant women should read the report. Almost 39% of deaths were considered to be clearly avoidable within the health care system (patient-oriented factors excluded). The recommendations below, taken from the report, should be supported and actively implemented, where possible, by family physicians:

1. Improving health care provider knowledge and skills in providing emergency care and ensuring adequate screening and treatment of the major causes of maternal death.
2. Improving quality and coverage of reproductive health services, namely contraceptive and termination of pregnancy services.
3. Management provision of staffing and equipment norms, transport and availability of blood for transfusion.
4. Community involvement and empowerment regarding maternal, neonatal and reproductive health in general.

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## Reference

1. Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa. National Committee for the Confidential Enquiry into Maternal Deaths. Pretoria: Department of Health. <http://www.doh.gov.za/docs/reports/2007/savingmothers.pdf>