

# Understanding the Confidential Enquiry into Maternal Deaths: A TAC briefing

3 October 2006

*“Every woman who becomes pregnant and continues with her pregnancy does so in the expectation of delivering a healthy child and the joy and satisfaction of watching the child grow. Surely, it is the duty of society and the health care profession to do the utmost to fulfil this expectation?”*

-- Confidential Enquiry into Maternal Deaths, Department of Health, 2006.

On 19 September the Department of Health released *Saving Mothers – Report on Confidential Enquiries into Maternal Deaths in South Africa - 2002 - 2004*. A maternal death is defined as a woman dying during childbirth or within 42 days of delivery or termination of pregnancy. There were 3,406 recorded maternal deaths during the period covered by the report. AIDS is the biggest single cause of recorded death. 662 deaths were directly attributed to AIDS, 316 to pneumonia and 104 to TB.

About one in a thousand South African women die during childbirth, termination of pregnancy or a short time thereafter. Relatively few deaths occur this way, though it is not an insignificant cause of death –it far exceeds the 327 total malaria deaths<sup>1</sup> during the same three year period for example. Nevertheless, the CEMD helps us understand what is happening to female health. It gives us a greater understanding of the effects of a deteriorating public health-care system and the HIV epidemic on women.

## **Deaths due to AIDS**

The evidence suggests that many more deaths were due to AIDS than were recorded as such. The HIV status of over half the women who died was unknown. For those whose status was known, 78% were HIV-positive. This is much higher than the HIV prevalence rate among pregnant women. It is therefore likely that the HIV prevalence rate of the unknown deaths was also very high. Given that AIDS was responsible for the deaths of 662 of the 1,228 women whose HIV status was known (i.e. more than 50% of known HIV-positive women died of AIDS) the role that AIDS played in the deaths of women of unknown status was significant. This also further confirms that the reason HIV-related deaths are underestimated in South Africa's mortality data is because the status of most people who die is unknown.

According to Statistics South Africa, deaths recorded due to maternal conditions increased from 1997 to 2001, decreased in 2002 and then increased in 2003 and 2004. The agency states “The death rate from maternal conditions more than doubled between 1997 and 2004.”<sup>2</sup>

## **A failing health system**

The report also shows some of the shortcomings in the health system. According to the report 37% of maternal deaths were avoidable. The biggest single health system cause of avoidable deaths was “lack of appropriately trained staff” followed by “lack of specific health care facilities” (in other

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1 Department of Health. 2005. *Malaria Statistics 1999-2005*, July 2005.

2 Statistics South Africa. 2006. *Adult Mortality (Age 15-64) Based on Death Notification and Data in South Africa: 1997-2004*.

words – no intensive care beds or emergency diagnostic services). Many deaths occurred at level 1 and 2 hospitals which has led the report to question why patients in life-threatening situations were not referred to higher level hospitals where they could have received more sophisticated care.

But what is disturbing is that the report classifies only 9% of non-pregnancy related infections (i.e. HIV, pneumonia, TB etc.) as avoidable. This is unacceptable: there are medicines for controlling HIV infection and for curing pneumonia and TB; death due to these diseases in most cases should be considered avoidable. The report actually admits “Few of the non-pregnancy related infections were thought to have been avoidable by the assessors, although deaths due to non-pregnancy related infections are potentially preventable.” As explained in the report, most of the period covered preceded the implementation of the *Comprehensive Care Management and Treatment Plan for HIV and AIDS* released on 19 November 2003. Had antiretroviral treatment been made available three or four years earlier, as demanded by treatment activists, many more lives could have been saved.

Consequently, most maternal deaths were possibly avoidable, and certainly more than 37%. Women died due to the shortcomings of the public health system, with its unendurable queues, medicine shortages, poor diagnostics and poorly trained, overworked staff.

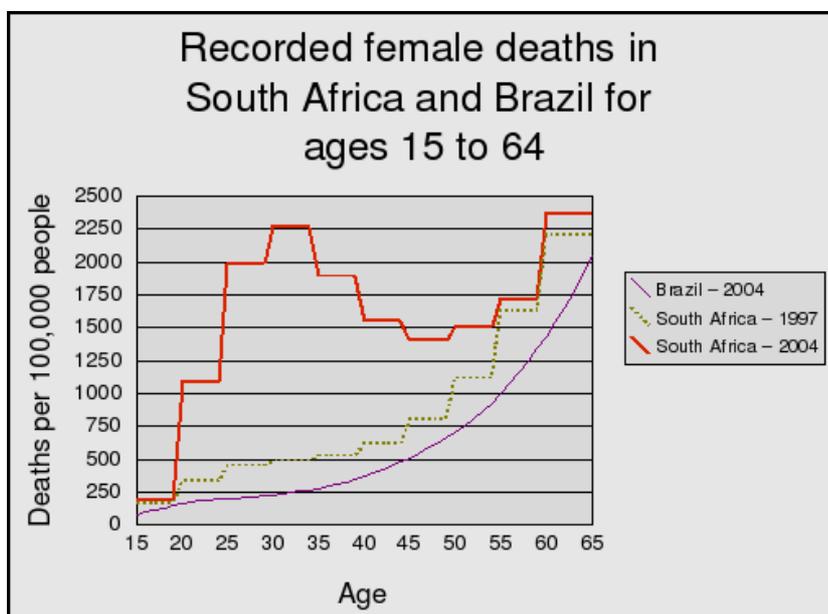
Another important point made by the report is this:

“Delay in seeking help was the most common patient related avoidable factor. The exact meaning of this is hard to establish ... Independent research has indicated that most of the delays [in patients seeking help] are due to the inability to access transport especially at night leading to delay, rather than lack of knowledge or concern by the patient.”

This points to the need for more clinics closer to patients and improved transport systems. More clinics obviously implies training and employing more health workers as well as more investment in health care infrastructure.

### ***A reflection of the crisis of female mortality***

The CEMD is a reflection of the crisis of female mortality in South Africa. We have produced the following graph using information from Statistics South Africa and the Brazilian statistics agency, *Instituto Brasileiro de Geografia e Estatística*.



The graph examines female deaths by age per 100,000 people. It compares South Africa in 2004 to Brazil in 2004 and South Africa in 1997. Note how deaths in South Africa have risen between 1997 and 2004. More importantly, note how the age-pattern of deaths has changed. The graph shows that by 2004, the proportion of female South Africans dying between the ages of 30 to 34 was almost the same as those dying between the ages of 60 to 64. Not shown in this graph is that by 2000, the absolute number of South Africans dying in their 30s and 40s exceeded those dying in their 60s and 70s.

## ***Recommendations***

The report makes ten critical recommendations and establishes targets for monitoring their implementation. Here they are (simplified and abbreviated):

1. There should be standardised protocols for managing the important conditions causing maternal deaths. Doctors and midwives should be trained to use these protocols.
2. Pregnant women should be informed, screened and appropriately managed for diseases, including HIV, sexually transmitted infections, TB, pneumonia etc. The report states that all health institutions offering maternity care must provide comprehensive care management and treatment of HIV and AIDS. This implies the provision of antiretroviral treatment, but the report goes into no further detail on this critical issue, which is a serious flaw.
3. The referral process between hospitals must be clarified and used properly – across all provinces.
4. Emergency transport must be available for pregnant women, post partum women and their babies in case of complications.
5. Staffing and equipment norms must be established for every health facility caring for pregnant women.
6. Blood for transfusion must be available at every clinic where caesarian sections are performed.
7. Contraceptives and education about them must be provided. Deaths from unsafe abortions must be reduced.
8. The correct use of the partogram (a measurement tool used to assess the progress of labour) must become standard at every health institution conducting births.
9. Anaesthesia skills must be improved especially at level 1 hospitals.
10. Women, families and communities must be mobilised to participate actively in programmes to improve reproductive, maternal and neonatal health.

The CEMD is a call to action. It will be the job of civil society to monitor that the Department of Health starts implementing these recommendations. If the Department continues to fail to implement them, then mass mobilisation and the courts will be needed to ensure that the Constitutional rights to health-care of women are met.

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