Quality of care responsible for soaring maternal deaths – report

The National Department of Health (NDoH) is moving across provinces to centralise obstetric skills to a handful of district hospitals, urgently briefing district healthcare chiefs and ensuring they have sufficient blood supplies in a bid to further lower the 63% rise in caesarean section deaths due to bleeding between 2008 and 2014.

This was said by Dr Yogan Pillay, NDoH Deputy Director-General of Strategic Health Programmes, who added that provinces were being told to buy and/or dedicate ambulances for quicker interfacility transport of pregnant women and sick infants. He was speaking days after the figures, described as 'scandalous and a disgrace', were published in the *SAMJ* last month.

The report, from the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), came soon after the National Committee on Perinatal Mortality (NaPeMMCo) and Committee on Mortality and Morbidity in Children under Five (Child CoMMiC) reports, also completed last year and highlighting high numbers of avoidable deaths. It blames a low skill set among junior and inexperienced doctors, especially in rural under-resourced areas where they perform emergency or unnecessary caesarean sections, too often without supervision or proper obstetric/anaesthetic care. Findings include delays in calling for help with ongoing bleeding, inappropriate discharges from post-theatre recovery, and poor monitoring in postnatal wards.

Pillay said that while maternal and newborn/under-5 mortality had been reduced overall (mainly due to prevention of mother-to-child HIV transmission and improved antiretroviral drug and adherence interventions), 'we've clearly been less successful with other causes of maternal mortality'

The first author of the article, NCCEMD deputy chairperson Dr Sue Fawcus, said the figures were alarming because causes had been highlighted previously. 'It's got worse and cannot be explained by the increase in C-sections – there's something else going on with quality of care.' (Public sector C-sections rose by 30% from 2008 (181 405) to 2012 (236 149), raising suspicions that many were medically unnecessary.) Pillay said that while maternal and newborn/under-5 mortality had been reduced overall (mainly owing to prevention of mother-to-child HIV transmission and improved antiretroviral drug and adherence interventions), 'we've clearly been less successful with other causes of maternal mortality'. Safe C-section care had been centralised in the Free State, with dramatically improved results over 12 months. The template of key recommendations was being implemented in KwaZulu-Natal and North West and would soon move to the other six provinces. 'We're insisting interventions get to every health district,' Pillay said.

Dr Yogan Pillay, NDoH Deputy Director-General of Strategic Health Programmes.

'Far more interventionsist'

The NDoH team, led by national health minister Dr Aaron Motsoaledi, had begun their interventions in the struggling Sekhukhune district in Limpopo and was, at the time of writing, arranging dates with the health chiefs in North West and the Eastern Cape. Pillay said the recommendations of all three reports were being implemented, one of which was the purchase of continuous positive airway pressure (CPAP) machines, 35 of which had already been delivered to as many district hospitals, with another 30 'on the way'. Echoing the report, he said far too many newborns were still dying of asphyxia, so an audit to find out which hospitals did not have CPAP machines was immediately ordered. 'We've been far more interventionist over the past 3 years than previously, when we merely provided the information and hoped provinces would do the right thing,' he admitted.

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Fawcus said that C-section deliveries should only be done for good medical reasons. 'It's a major operation and should not be performed lightly,' she added. Dr Stefan Gebhardt, head of general specialist services at Tygerberg Hospital, said that junior doctors were not always skilled enough to do complicated C-sections, but there were often no more senior or experienced doctors available to help out. Bleeding only started after the abdomen was closed and the patient was in the recovery room, while pregnant women did not show signs of blood loss until it was very late. The bleeding was often missed because it was into the abdomen, and the blood pressure and pulse rate remained normal for a long period. Peter de Jong, a consulting gynaecologist at Groote Schuur Hospital and the University of Cape Town, described the figures as 'a scandal; it's a disgrace. You need to have people explain what those preventable factors are in the rural areas and what is being done about it. There has to be accountability.'

The three national committee chairpersons, Prof. Jack Moodley of the NCCEMD, Dr Natasha Rhoda of the NaPeMMCo and Dr Neil McKerrow of Child CoMMiC, outlined the key drivers of the three mortality groups to all NDoH departmental heads at a workshop early this year. Obstetric haemorrhage and safer C-sections emerged as top priorities.

Earlier this year *Izindaba* reported on a total absence of supervisory support

in Limpopo, where the NCCEMD found that 10% of all C-section patients died due to anaesthesia in 2014. Unsupervised community service doctors with no anaesthetic training were performing on average between two and three C-sections per week in the province's 70 mainly rural district hospitals, conducting spinal blocks with no airway skills, no intubation equipment and insufficient drugs.

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