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Maternal mortality — we have a lot to answer for

The National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) recently submitted its second 'Saving Mothers' report for the triennium 1999 - 2001, and the message is not good. Far too many pregnant mothers continue to die unnecessarily from perfectly avoidable causes, and doctors who care for pregnant women have a lot to answer for.

To be fair, others also share in this responsibility: nurses, hospital administrators, health departments, inadequate public infrastructure and the patient herself. The emergencies that led to the death of mothers in the report most frequently occurred in the puerperium (one would guess in the first few hours postpartum), pointing to inadequate monitoring by the doctor and the nursing staff. Among the factors deemed to have contributed significantly to maternal deaths is a category labelled 'administrative', which presumably includes shortages of supplies (antibiotics, blood products, basic equipment), inadequate staffing arrangements, and a host of other possibilities.

Deaths due to pregnancy-related causes account for nearly 60% of all maternal deaths, with 1 in 3 due to hypertensive syndromes, and 1 in 5 to obstetric haemorrhage and sepsis. With proper obstetric management, all of these are eminently avoidable causes, and the question arises as to why doctors and nurse practitioners fail to intervene appropriately.

One reason may be that doctors and other providers involved in the care of pregnant women lack the necessary experience, and are at a loss when confronted with these obstetric challenges. To meet this need and in response to the first NCCEMD report, the Department of Health published the *Policy and Management Guidelines for Common Causes of Maternal Deaths,* which was distributed in 2001. It provides an extremely helpful and remarkably user-friendly roadmap for the management of obstetric emergencies, and ought to be a permanent fixture in the labour rooms, operating theatres and recovery rooms of every obstetric facility without specialist support.

One other publication has just come out which ought to be in the coat-pocket of every non-specialist doctor caring for women. Conceived as 'a portable guide for on-the-spot care in obstetrics and gynaecology', the *Handbook of Obstetrics and Gynaecology* (edited by Zephne van der Spuy and John Anthony and published by Oxford University Press) contains a wealth of well-organised information on the diagnosis and management of obstetric and gynaecological illness, and should serve as an indispensable bedside reference source for the general doctor.

Unfortunately, none of these aids will be of any use without moral commitment on the part of the provider to deliver the very best care of which he or she is capable. Nonchalance and failure to exercise due vigilance in the care of the woman in labour all too often contribute to the high maternal mortality toll, and it is high time that doctors and other providers are held accountable for such loss.

The UK's pioneering triennial Confidential Enquiries into Maternal Deaths were initiated in 1952. Since then, there has been a steady decline in the maternal mortality ratio (MMR), which has halved about every 10 years to its current level of 6 - 7 per 100 000 live births.[1,2] The ratio for South Africa has not been determined and remains unknown, but is estimated by the NCCEMD to lie between 175 and 200. A study comparing the MMRs of the various regions of the Americas from Canada to South America[3] found that the MMR is strongly reflective of the socioeconomic inequalities of countries. Even in Europe, strong differentials have been recorded between countries with unequal socioeconomic status.[4] We cannot therefore simply compare ourselves with the UK, although we can draw lessons from their experience.

There are other examples to be emulated. Zambian workers[5] stress the importance of regular institutional maternal mortality review meetings as a means of surveillance to identify organisational weaknesses and to spot areas of substandard clinical care. They advise that 'a maternal mortality review meeting can be an important tool for improving essential obstetric services in a district hospital. It can easily and directly correct some substandard care factors, has a high educational value for staff, and leads to a better understanding of maternal mortality for everyone involved.'

From Nigeria[6] comes the report of how political adventurism and the collapse of public services can lead to the deterioration of the MMR despite the best efforts and intentions of the professionals. In this study, the investigators compared the MMRs of two 10-year periods at the University of Nigeria Teaching Hospital in Enugu. Period I encompassed the years 1976 - 1985. At the start of period II, 1991 - 2000, the medical school launched the Safe Motherhood Initiative. The investigators conclude that 'since the launching of the Safe Motherhood Initiative, the MMR . . . has increased 5-fold as a result of institutional delays and deterioration in the living standards of Nigerians.' They cite as further reasons staff demotivation and emigration, and deficiencies in transportation and communication. The two decades under study were separated by periods of political instability and military dictatorship.

The lessons are clear. To contain and reduce South Africa's MMR, the providers must do their bit, and so must the state.

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Editor

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