MATERNAL DEATHS FROM OBSTETRIC HAEMORRHAGE

Saving Mothers report 2020-2022:

599 deaths (16.4%) from haemorrhage

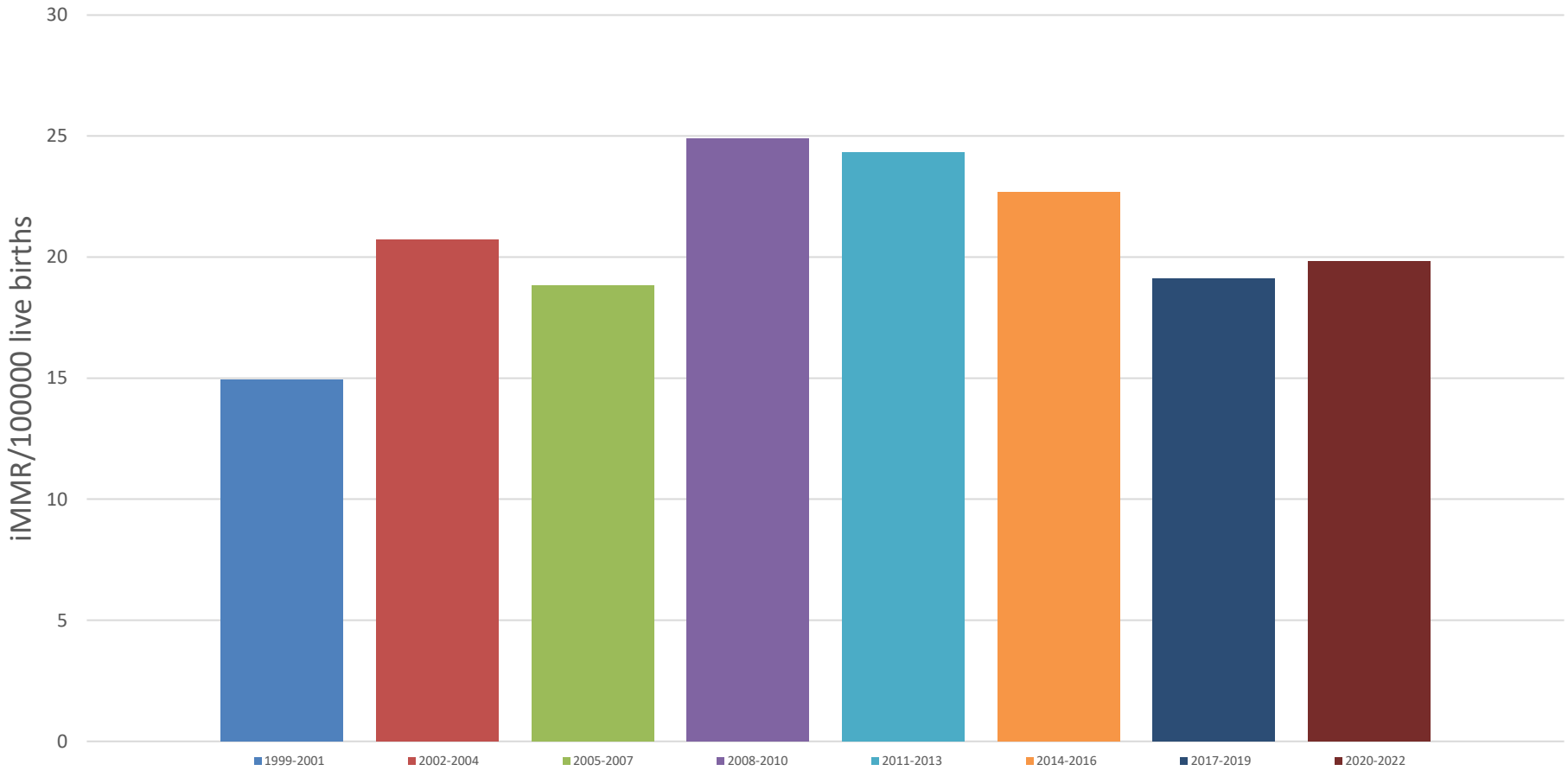
Second most frequent cause of overall MMR

SA: NUMBERS, RATES, TRENDS

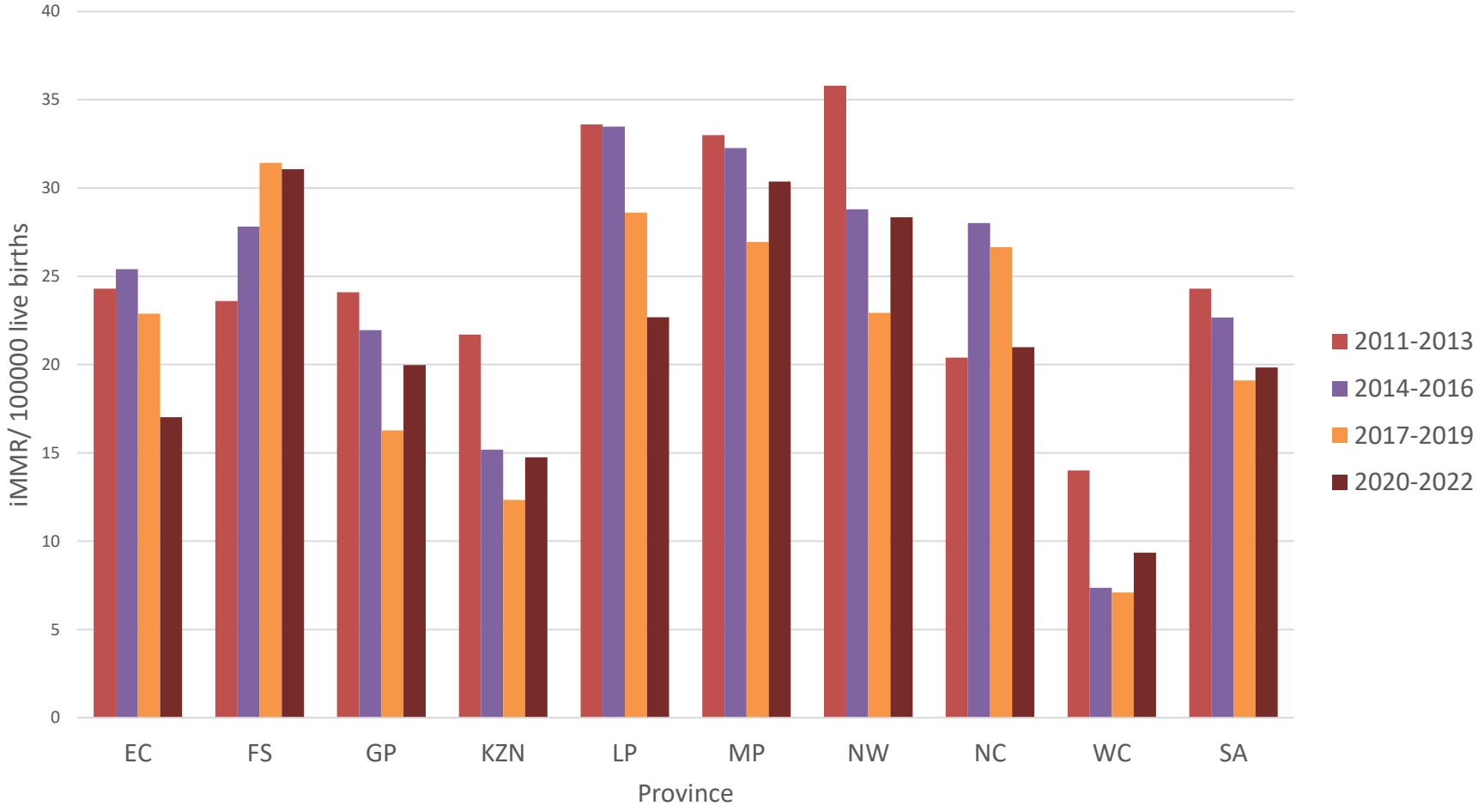
	Numbers	Haemorrhage iMMR (per 100,000 LBs)
2002-2004	442	19.5
2005-2007	491	18.8
2008-2010	688	24.9
2011-2013	684	24.3
2014-2016	635	23.1
2017-2019	544	19.1
2020-2022*	599	19.8

* iMMR: 19.3 (2020); 23.3 (2021); 16.7 (2022).

Trends in OH iMMR 1999-2022



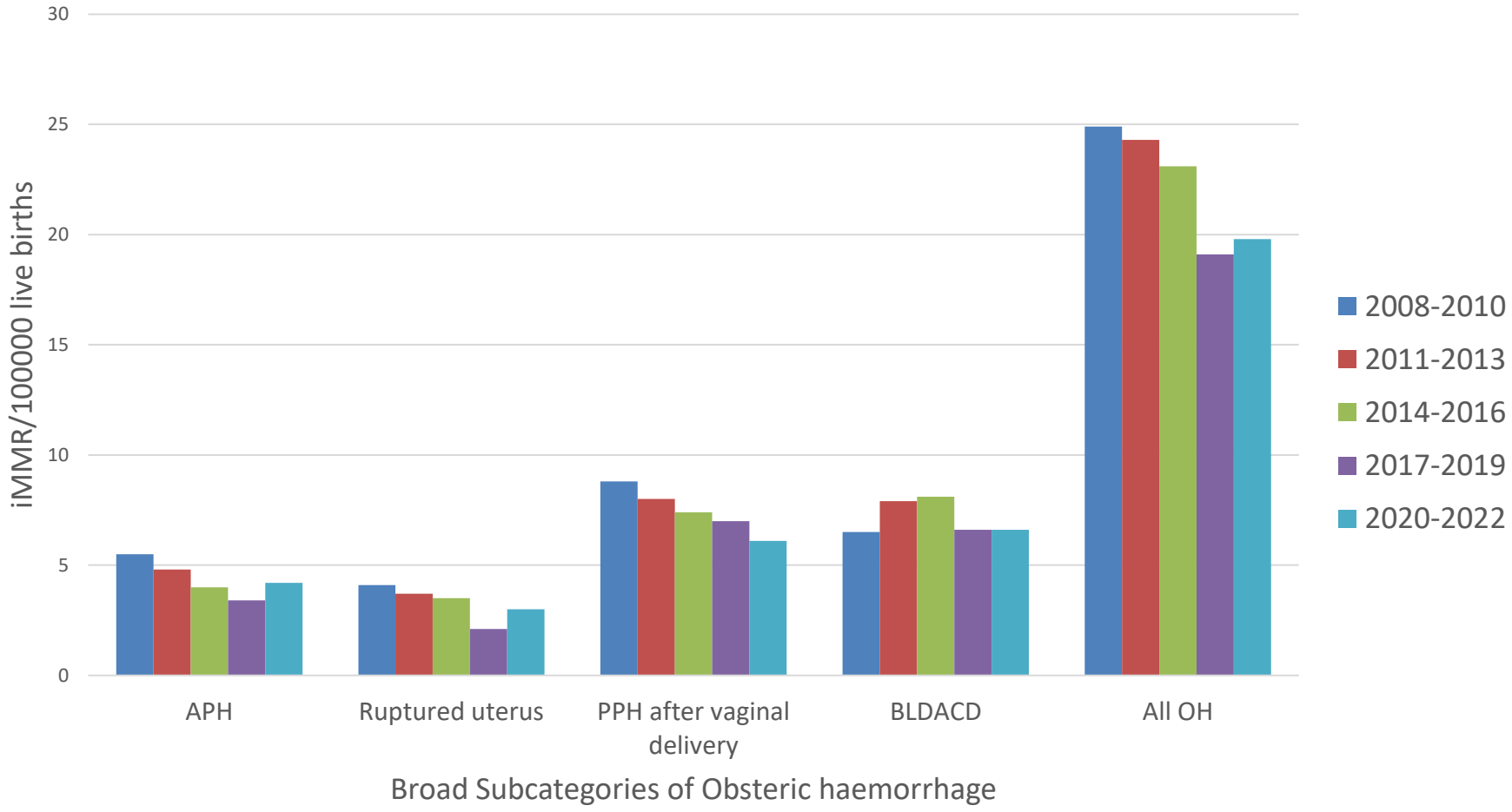
Provincial trends in OH iMMR over four triennium



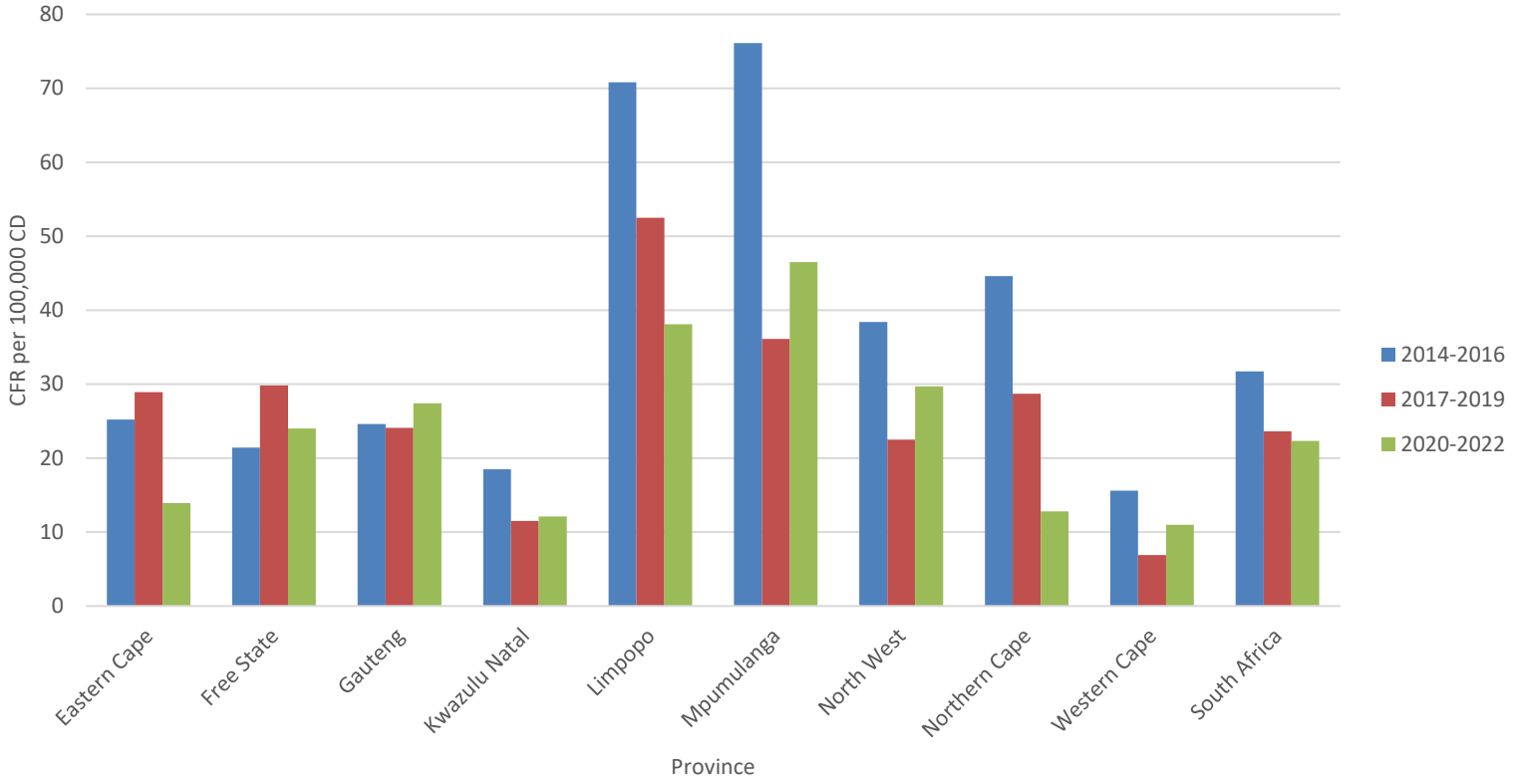
Causes of Obstetric Haemorrhage deaths in SA

	2020-2022			2017-2019		
	N	**(%)**	**MMR**	**N**	**(%)**	**MMR**
Bleeding at / after C section	**198**	**(**33.1)	6.6	**189**	(34.7)	6.6
PPH *(atony, retained placenta, trauma)*	**184**	(30.7)	6.1	**198**	(36.4)	7.0
APH *(Abruptio placenta, Placenta praevia)*	**127**	(21.2)	4.2	**96**	(17.6)	3.4
Ruptured uterus *(scarred and unscarred uterus)*	**90**	(15.0)	3.0	**61**	(11.2)	2.1
TOTAL	**599**	**(100)**	**19.8**	**544**	**(100)**	**19.1**

Trends in sub-categories OH for 5 triennia (2008-2022)



Provincial Comparison of BLDACD CFR per province 2014-2022



LEVEL OF CARE (n=599)

Level of Care	Number	%	MMR
Home / outside	15	2.5	*No denominator*
CHC	21	3.5	5.7
District hospital	167	27.9	13.2
Regional Hospital	186	31.1	22.8
Tertiary/National central hospital	174	29	44.7
Private	36	6.0	*No denominator*

85.5% were Avoidable

- **Patient related – 35.4%** *(xx% delays seeking care; xx% unbooked)*

- **Administration related- 69.8%.** *(8.5% lack blood; 11.4% lack transport inst-inst ; 13.4% lack staff, 18.5% lack skill, 12.2% overburdened services)*

- **Health worker related - CHC 41%, DH-83.2% , L2-74.4% , L3- 61% .** *(Problem recognition all levels esp CHC/DH; not referred (DH); Substandard care (all levels)*
- **Inadequate resuscitation- xx%**

Conclusion

- Deaths from OH and iMMR increased in 2020-2022 to become the second most common cause of MD
- The increase occurred in 2020 and 2021, probably due to the collateral effects of the Covid pandemic, but in 2022 numbers were lower than pre-pandemic.
- Wide inequities between provinces remain.
- 85.5% of OH MDs were preventable within the health system

Key Recommendations (1)

- Protect maternity services in future pandemics.
- Implement E Motive nationally.
- Focus on preventing and treating anemia in pregnancy as well as in childhood and adolescence; addressing heavy menstrual bleeding in women, screening and treatment of chronic infections, and adequate nutrition. This requires advocacy.
- Inequities in outcomes between provinces require attention to staffing levels and clinical governance.
- No woman should be discharged from labour ward to the postnatal area if Systolic BP is <100 and/or Pulse is =>110 and/or ongoing bleeding

Key Recommendations (2)

- Resume implementation of ESMOE/EOST training, Safe CD audit and protocol, updated PPH algorithms in view of E Motive and new SA Maternity Care guideline, use of NASG and Massive Obstetric Haemorrhage Transfusion Protocol
- Direct Telephonic / IT links for 24-hour specialist support to district hospital doctors.
- Develop training package for CHWs and WBOTs, to sensitise communities to problem of PPH.
- Work with Ambulance services to ensure appropriate prioritisation of bleeding patients and availability of urgent paramedic assisted ambulances.