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Maternal Mortality – HIV and unsafe abortion – a silent epidemic

Marion Stevens

In August 2011, the international organisation Human Rights Watch (HRW) released a report on Maternal Mortality in South Africa, “‘Stop making excuses’: Accountability for maternal health care in South Africa’. The report (HRW, 2011a) pinpointed failure in accountability frameworks and systemic weaknesses in public health facilities in several municipal districts where an unacceptably high rate of maternal mortality has been documented in the Eastern Cape, the province reported to have the worst record for maternal mortality. While reduction of the mortality rate is a health priority set by the government, the report describes some deeply distressing systemic trends that undermine the possibility of improving maternal mortality and the provision of maternal care that is within internationally accepted norms, including abuse, neglect, corruption and negligence and lack of responsibility at appropriate levels to take the necessary steps to address the problems. The HRW report is important reading for those concerned with understanding the reasons why such a high number of pregnant women die in health care facilities during childbirth in South Africa and the remedies to address the problem. Another reason why the HRW report holds importance is that it gives a voice to the vulnerable women who have experienced abuse and neglect in the public health-care system and draws attention to the need for complaints be heard for redress, and the importance of wider accountability mechanisms in healthcare regulation to intervene against abuse of women by the health care system.

Introduction

This review of the 66-page HRW report describes the main finding and offers an analysis of some of the patient-care and health systems’ issues behind South Africa’s lack of progress in reducing maternal mortality. In introducing the findings of its research, the HRW states that there are a number of policies and initiatives in place which indicate a clear commitment to women’s health and reduction in maternal mortality that should be showing results. Ninety two percent of women attend antenatal care and 87% deliver their babies in health facilities. South Africa is one of the only sub-Saharan countries where maternity care is free and where legal abortion facilities exist for women who choose to terminate pregnancy. South Africa also introduced a system of confidential enquiries into maternal deaths (CEMDs) in health care facilities which is conducted every three years.¹ The CEMDs are a critical means of accessing, monitoring and analysing what the main causes of deaths of mothers during childbirth² are and to thereby also act to resolve the problems to prevent their recurrence.

The HRW report cites the result of the most recent CEMD and points out that the National Department of Health has readily acknowledged the country’s lack of progress in reversing maternal mortality. As South Africa’s maternal mortality ratio has more than quadrupled over the past decade, the effectiveness of accountability structures to improve oversight and correct health system deficiencies is, therefore, all the more critical.

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The HRW documents maternity care failures that include abuse of maternity patients by health workers and sub-standard care in Eastern Cape Province, that put women and their newborns at high risk of death or injury. It examines shortcomings in the tools used by health authorities to identify and correct health system failures that contribute to poor maternal health and means of redress. The most important of these is possibly the failure to act on the CEMD recommendations and the lack of accountability by Government for implementation of these.

Confidential Enquiries into Maternal Deaths

The government has been generating and releasing statistics on maternal mortality in confidential enquiries since 1998, and perhaps given its own findings, the HRW's revelations may not have come as a surprise. The HRW report apparently angered the National Department of Health as it was a large research project which reputedly did not show anything new (confidential informant).

Agnes Odhiambo, Africa women's rights researcher at HRW, notes in the report:

"The government admits that it has a big problem on its hands and wants to do better. But for all South Africa's good intentions, policies and strategies on paper won't save women's lives without strong accountability systems to make sure policies are carried out" (HRW, 2011b).

The findings of the last published confidential enquiry are therefore important. As the fourth such report, it made findings that confirm that the increase in maternal mortality has continued. It showed that in the last triennium (2005–2007) there has been a 20.1% increase in the number of maternal deaths reported, compared with the previous triennium (2002–2004) (DoH, 2011). The 'big five' causes of maternal death have remained the same, namely non-pregnancy related infections – mainly AIDS (43.7%), complications of hypertension (15.7%), obstetric haemorrhage (antepartum and postpartum haemorrhage) (12.4%), pregnancy-related sepsis (9.0%) and pre-existing maternal

disease (6.0%).³ Non-attendance and delayed attendance at the health institutions were the most common patient-orientated problems reported.

The CEMD findings of poor transport facilities, insufficient resources and tools to do the work, lack of emergency health care facilities and lack of appropriately trained staff as major administrative problems are corroborated in the HRW report. The most frequent avoidable health care provider factors were failure to follow standard protocols, poor problem recognition and initial assessment and, as the HRW report notes, included the problem of patient neglect by health care providers.

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Assessors noted that 38.4% of the deaths were clearly avoidable within the health care system (patient-orientated factors being excluded). Complications of hypertension, obstetric haemorrhage, pregnancy related sepsis and non-pregnancy related infections were responsible for four out of five of avoidable deaths.

Further, the CEMD observed that the mortality rate of HIV-positive women was nearly 10 times the rate of HIV-negative women, but preventable direct obstetric causes made up a significant proportion of deaths in both groups.

The last CEMD report (DoH, 2011:X1) made recommendations to address the problems in four main areas: knowledge development, quality of care and coverage of reproductive health services, establishing norms and standards and community involvement. It also issued the following more specific recommendations that government aim at:

- "Improving health care provider knowledge and skills in providing emergency care and ensuring adequate screening and treatment of the major causes of maternal death.
- Improving quality and coverage of reproductive health services, namely contraceptive and termination of pregnancy services.
- [Improving] Management provision of staffing and equipment norms,

- transport and availability of blood for transfusion.
- [Increasing] Community involvement and empowerment regarding maternal, neonatal and reproductive health in general.”

The HRW report notes that while many of the problems it raises are contained in the most recent CEMD, it questions the accountability mechanisms and the responsiveness of the health system to the need for reform when there are no sanctions for failure to fully implement CEMD recommendations and it states that:

“Maternal reviews are an important accountability mechanism, but are useful if the information gathered is used to ensure that systemic problems with the provision of care are not repeated” (HRW, 2011:23).

While recognising the value of the CEMD reports, the HRW report also notes that South Africa does not use accepted UN and international indicators which would assist it to introduce the standard of health care needed to ensure that the preventable causes of death are checked. Further, the HRW raises the concern that South Africa does not have reliable statistics to generate an accurate Maternal Mortality Ratio, suggesting that the reporting system on maternal mortality urgently needs to be improved.

Access to abortion services is decreasing due to declining numbers of operational, designated termination of pregnancy clinics.

Looking at another crisis that is unfolding, are maternal deaths that are the direct result of the attrition of termination of pregnancy services. The need for better quality and more widespread provision of termination of pregnancy services is mentioned in the CEMD recommendations. It is not, however, explicitly raised in the HRW report and I don't believe it should be excluded from analysis of maternal mortality rate trends.

In March 2011 in a response to parliamentary question, the National Department of Health (NDoH) revealed that the number of abortions in state facilities had declined dramatically between 2009 and 2010. Of the 545 525 abortions at state institutions since

2004, 84 478 were in 2009 and 38 321 in 2010. Access to abortion services is decreasing due to declining numbers of operational, designated termination of pregnancy clinics. One of the overwhelming facts that led to abortion law reform in 1996 was the Medical Research Council study in 1994 which showed that 425 women-black women-died from illegal and unsafe abortions in that year. We changed our law in 1996 and provided access to abortions and the deaths from unsafe abortions decreased by 90%, with only 34 deaths in 2004.

The NDoH loaded the full version of the maternal mortality report of deaths from 2005–2007 on to their website during December, 2011. The data is chilling.

“There is a 44% increase in deaths due to abortion with some 598 women dying from abortion and pregnancy related sepsis in the period 2005–2007. Eighty-nine per cent of women who died from abortion and were tested for HIV were found to be seropositive. Furthermore, the figures for septic abortion in this chapter may be an underestimate, because there were another 58 deaths associated with abortion where AIDS was considered to be the primary cause. According to Department of Health figures, Choice of Termination of Pregnancy services may be in decline, and this could be a factor in promoting unsafe abortion practices and an increase in septic abortion mortality. This needs further investigation (DoH, nd).

Some 70% of first trimester abortions are provided by nurses or midwives in South Africa. They are undervalued and unsupported and clearly a class of provider under threat. In my experience, being an abortion provider is not something many health professionals talk about candidly when asked about their work, as it is a stigmatised service. Similarly when faced with an unwanted pregnancy, many women are faced with a deep conundrum and find that it does not make for easy conversation. It is easier to talk about being HIV positive and I am curiously aware of colleagues and friends who are open about their HIV status who find talking about their unintended pregnancies very difficult. South Africa's HIV prevention of Mother-to-Child transmission

programmes, seldom implement or address the second focal point which is the prevention of unintended pregnancies. The focus is rather on the safe and happy delivery of a baby, and recently we have included ensuring that the woman or mother has access to treatment. The country's new National HIV Strategic Plan (SANAC, 2011) has no indicators to address fertility management, whether the quality of contraception or abortion care in relation to HIV as part of their prevention programming. We live in a society which is still deeply troubled by the reality that 50% of pregnancies are unplanned (Alan Guttmacher Institute, nd) and that many women choose to have an abortion.

It is April 2012, and the data from 2008–2010 have not been released yet. Given the correlation between declining safe and legal services and maternal mortality from illegal abortion services, there is cause for concern that needs to be registered in tracking the high maternal mortality rate in South Africa.

HRW highlights abuse of pregnant women

The HRW report draws sharp attention to the fact that the dimension of quality of care and clinical care have not received much attention, and that much of the attention in policy has been placed on the barriers of access to care.

The findings are located in a human rights framework which makes a clear demand for effective and appropriate measures to be implemented that will allow for redress by those at the receiving end of unethical treatment and abuse. The report was based on group and individual interviews with maternity patients, families, community caregivers, health and human rights experts, health workers, government officials, and representatives of donor and international agencies. These interviews were conducted between August 2010 and April 2011. While its findings corroborate the widespread perception that the health system is failing to meet the health care needs of South Africa's population, the HRW also highlights the particular problems experienced by vulnerable women, HIV-positive pregnant women and

pregnant undocumented workers and refugee women in accessing quality care.

The findings of abuse and maltreatment by the health facilities where HRW conducted research extend across the daily practices of health care workers, systemic failures and the unethical behaviour of healthcare and other workers. Poor communications and problems of informed consent (particularly for women who underwent caesarean section), was a widely reported problem, particularly relating to the lack of explanation for deaths of mothers or babies (reportedly the Dept of Health's biggest complaint). Three dozen informants, many being refugees, reported that ambulances they requested never arrived. More than 50% of women interviewed reported having experienced both physical and verbal abuse, and of being roughly treated, three-quarters reported verbal abuse, most being refugees or HIV-positive women. Refugee women reported that treatment or medicine was withheld without bribes.

More than 50% of women interviewed reported having experienced both physical and verbal abuse, and of being roughly treated

Health worker responses and Government responses to the HRW indicated demoralisation, lack of resources and tools, that health facilities are stretched to capacity, and that there is under-staffing. Some said that the 'rough' treatment in labour wards was necessary, which has called into question the quality of training of nurses. Systemic problems come up as the main culprit with the failure to introduce and implement the policies on complaints by overworked nurses, a provincial care centre which is not sign-posted, and the lack of monitoring and analysis of the complaints that were received. One health worker's response was that he was not surprised by the complaints when health facilities built to take 500 patients a month in the 1970s now take several thousand patients.

The impact of abuse and neglect, according to the HRW, is that many women felt they would rather stay away from health care facilities than seek assistance. They said they were afraid of what treatment would be given to them, of the neglect

and a repeat of the humiliation they had gone through.

Testimonies

A woman living with HIV who delivered at home with near-fatal consequences told HRW that:

“My uncle advised me to call the ambulance when labour started but I did not want to go to the hospital. I was scared of how I would be treated. I hear the nurses are very rude and they are too rough. After giving birth I developed serious problems. I was bleeding too much and I couldn’t breathe properly. Luckily the HIV treatment centre took me to hospital, and eventually I got treated” (HRW 2011b).

Abeba M, a refugee from Ethiopia living in Port Elizabeth, related to HRW her experience of a particularly bad example of neglect and abuse. She developed severe high blood pressure when she was 28 weeks pregnant and went to a district hospital for treatment but left because nurses treated her badly. She returned after her condition worsened. Even though her whole body was swollen and she was in great pain, a scan for diagnosis and further treatment was delayed for 10 days.

the abuses can lead to delay in diagnosis and treatment, and in turn to increased morbidity and mortality

On the day of the procedure, she said that she was in a weak condition and that nurses swore at her and insulted her. “Now you are saying you are sick and next year you will come with another pregnancy.” When she bled on the floor, she was ordered to clean up her “mess” (HRW, 2011b).

Abeba was afraid that she and her foetus would die. When she called for help one night and said she was in pain, a nurse said “I know, and what do you want me to do?” Abeba said the nurse continued “playing a gospel song on her cellphone and dancing”. Abeba said she did not complain because neither did she know to whom to complain, nor did she believe that her complaint would be investigated (HRW, 2011b).

In another testimony the HRW heard that Babalwa M’s private doctor referred her to a district hospital for obstetric care because she had serious asthma. But when she went into labour in June 2010, she said that she had hesitated to go to the hospital because she was afraid that nurses would “quarrel me and send me back home without help,” as she had heard happened to other women she knew (HRW, 2011b).

After about 12 hours of labour, Babalwa went to the hospital but the health staff did not attend to her for about an hour and a half. “The sister said I was lying about being in labour and sent me to the waiting area” (HRW, 2011b). A doctor examined her three hours later, but it was too late. She delivered a stillborn baby. Neither the doctor nor the nurse explained what may have caused the stillbirth. “I was unhappy about the way I was treated; being told that I was lying,” she said. “What is still painning me most is that I don’t know what killed my baby.” Babalwa said she did not complain to the hospital (HRW, 2011b).

“They say the patient has rights but when you are there [in the hospital] you don’t feel it. People don’t know their rights. You don’t know what questions to ask, or who to ask.”

The HRW report (2011a) exposes the negative experiences of pregnant women:

“who said that they had experienced physical and verbal abuse at the hands of public health workers, including pinching, slapping, and rough handling during labour. They also described treatment delays; nurses who ignored calls for help; and facilities that denied referral letters for pregnancy or childbirth-related problems, left women unattended for long periods after delivery, discharged women inappropriately and sent them home without pain medication or antibiotics, sometimes after Caesarean births, and refused them admission, sometimes without examining them, when they were in labour.”

HRW noted that the mistreatment of maternity patients not only causes unnecessary suffering but it also has contributed to poor maternal health outcomes, as the abuses can lead to delay in diagnosis and

treatment, and in turn to increased morbidity and mortality.

“These abusive practices are a particular concern in South Africa, where almost 87 percent of deliveries are in health facilities,” Odhiambo said (HRW, 2011a).

The HRW has called on the national and Eastern Cape provincial governments to do more to identify the barriers to quality health care and for that information to be applied to strengthen the health care system.

It also warned that even though South African health workers work under difficult circumstances, these cannot be a reason to justify the abuse or interference with patient complaint mechanisms. HRW argues that health workers need support to do their jobs well, and the reforms that are needed to allow them to do so should be informed by patient experiences.

The organisation called on the South African national and Eastern Cape provincial governments to condemn all abuse of women seeking maternity care, and to take immediate steps to strengthen accountability to ensure women’s right to safe and dignified maternity care. HRW (2011b) has urged both national and provincial governments to:

- “improve complaint procedures to solicit needed information and provide remedies;
- ensure that health workers are involved in devising strategies to address systemic problems that lead to complaints;
- develop systems to assess patterns of complaints and address systemic problems.”

Odiambo (HRW, 2011b) states:

“The point of the complaint system is to show that South Africa cares enough about women’s lives to fix the problems. When accountability and oversight mechanisms don’t function, South Africa is ignoring the insights of the people who know best what’s wrong with maternal health care: the maternity patients themselves.”

A recommendation made by the HRW to the national Government is that the amended Health Act needs to be tabled in Parliament

without delay. The Bill contains a provision for an Office of Health Standards Compliance, which would assure responsibility for addressing the systemic failures raised in the CEMD and the HRW report and for complaints that arise more broadly in the health care system.

Concluding remarks

South Africa is unlikely to meet the United Nations (UN) Millennium Development Goals commitment to reduce maternal deaths by 75% between 1990 and 2015 (HRW, 2011a). The maternal mortality ratio increased from 150 deaths per 100,000 live births in 1998 to 625 in 2007, with HIV playing a role in many of the deaths, according to government reports. The HRW report notes that it is estimated that 4 500 women die each year in South Africa due to preventable and treatable pregnancy and childbirth-related causes. South Africa has many of the building blocks in place to reverse the trend in high maternal mortality by applying and implementing its policies. The rise in maternal deaths from abortions in recent years has coincided with a decline in the number of designated termination of pregnancy facilities. The increase in septic abortions is probably linked to a rise in unsafe abortion practices, but the exact relationships between these phenomena require further research.

The maternity care failures and ineffective complaint mechanisms in Eastern Cape are shown to undermine the right to a remedy, under national and international law. They contribute to violations of the rights to life, health, and freedom from cruel, inhuman, and degrading treatment. The HRW has urged the national government and its provinces to uphold the rights under national, regional and international and laws and human rights treaties. The HRW report findings need to be acted upon. The National Health Insurance Policy Document has been released, and the HRW report flags some critical points of concern that must be addressed in the proposed upgrading and improvement it proposes to healthcare delivery and standards for pregnant women and in meeting its commitment to women’s rights to health.

Notes

- Confidential enquiries into maternal deaths are defined as:

“systematic multidisciplinary anonymous investigation of all or a representative sample of maternal deaths occurring at an area, region (state) or national level, which identifies the numbers, causes and avoidable or remediable factors, associated with them. Through the lessons learnt from each woman’s death, and through aggregating the data, confidential enquiries provide evidence of where the main problems in overcoming maternal mortality lie and an analysis of what can be done in practical terms, and highlight the key areas requiring recommendations for health sector and community action as well as guidelines for improving clinical outcomes” (DoH, 2011:viii).
- Maternal deaths are defined as:

“deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (DoH, 2011:ix).
- There has been a significant decrease (14%) in the institutional (within health care facilities) Maternal Mortality Ratio (MMR) for complications of hypertension. This report shows a large increase (21%) in maternal deaths due to non-pregnancy related infections. In terms of age, it found that women under 20 years were at greater risk of dying due to complications of hypertension, whereas women 35 years and older were at greater risk of dying of obstetric haemorrhage, ectopic pregnancies, embolism, acute collapse and pre-existing medical disease (DoH, 2011).

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