Early Pregnancy Deaths in South Africa Saving Mothers 2020-2023

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Summary of data: numbers of deaths

- 269 early pregnancy deaths (17% decrease from 2017-19)

- 103 deaths due to ectopic pregnancy (13% decrease)
- 166 deaths due to miscarriage (19% decrease)

- These numbers are a modest underestimate due to some missing data from a few provinces
- Lowest numbers since 2008-10 triennium
- There is concern that some deaths happened at home during the height of the COVID-19 pandemic and were never recognised or reported as maternal deaths

Classification of ectopic deaths

- Less than 20 weeks 88%
- More than 20 weeks 12%

Classification of miscarriage deaths

• Septic miscarriage	64%
• Haemorrhage (non-traumatic)	19%
• GTD	7%
• Following legal TOP	5%
• Uterine trauma	4%
• Unsafe miscarriage (illegal TOP)	16%

Summary of data: HIV as risk factor

- HIV status-large proportion unknown: Ectopic 39%, miscarriage 40%
- Where HIV status known:
- Ectopic 68% positive
- Miscarriage 55% positive

Summary of data: final cause of death

- Ectopic deaths: 66% hypovolaemic shock 17% septic shock
- Miscarriage deaths: 56% septic shock, 31% hypovolaemic shock

Summary of data: Avoidability of deaths

- Ectopic deaths 82% suboptimal care
- 45% clearly avoidable (57% in 2017-19)

- Miscarriage deaths 61% suboptimal care
- 28% clearly avoidable (34% in 2017-19)

Conclusion

- Miscarriage and Ectopic pregnancy deaths if put together as an early pregnancy death category comprise the 5th most common causal category of maternal deaths
- The deaths occurred at all levels of hospital
- Many women bled to death in hospitals due to sub-standard care
- There was no resuscitation attempted in 23% of ectopic deaths and 16% of miscarriage deaths
- Anaesthesia was only administered in 38% of ectopic deaths and 45% of miscarriage deaths indicating missed opportunities for surgery

- Unsafe / illegal TOPs still a contributor
- HIV important risk factor

Conclusion

- Unsafe / illegal TOPs still a contributor
- HIV important risk factor
- More intensive and committed care needed on presentation to facilities
- New approaches to FP and safe TOP needed

Recommendations

1. Family planning and contraception services (including emergency contraception) must be promoted in all communities and must be made more accessible to those who would benefit from them, including teenagers. Contraception services must be integrated into care services for HIV and other chronic diseases

2. Communities must be educated about booking early for antenatal care, recognising and acting on danger signs in early pregnancy, and how to access safe TOP

Recommendations

3. There must be regular training of doctors and nurses in the recognition and emergency resuscitative management of circulatory shock in the context of early pregnancy. This should include regular “fire drills” on the management of shock
4. Casualty departments must have clear policies ensuring that shocked gynaecological patients are given equal priority and attention by casualty staff compared to any other category of shocked patient

Recommendations

5. There must be regular training of doctors and nurses on the recognition and management of different types of miscarriage, including indications and technique for evacuation of the uterus, and criteria for referral to specialist level

6. All health facilities must either provide termination of pregnancy (TOP) services or have a clear referral facility for TOP, based on an agreed district referral pattern, to ensure that all women have access to free and safe TOP. Medical TOP must be available at but not restricted to dedicated TOP clinics.

Recommendations

7. There must be regular training of doctors and nurses on the recognition of ectopic pregnancy and its management, particularly the need for immediate surgery if the patient is shocked

8. Facility managers must ensure that all doctors and nurses are aware of their professional and ethical responsibilities when on-duty, and must hold them accountable when these responsibilities are neglected.