

Good, but not good enough



On 8 September 2000 the global community (including South Africa) declared its commitment to 'create an environment – at the national and global levels alike – which is conducive to development and to the elimination of poverty'.¹ This led to the adoption of eight goals, the Millennium Development Goals (MDGs). Two of these directly impact on maternal and child health, namely MDG-4: reduce child mortality, and MDG 5: improve maternal health. Specific targets were set for each goal; for MDG 4 it is a reduction by two-thirds, between 1990 and 2015, in the under-5 mortality rate; and for MDG-5 it is a reduction by three-quarters, between 1990 and 2015, in the maternal mortality ratio (MMR).²

In November 2006, a report entitled *Opportunities for Africa's Newborns*³ was presented to the Pan African Parliament in Midrand, Gauteng. The fact file contained in the report states that each year in Africa:

- 30 million women become pregnant
- around 250 000 women die of pregnancy-related causes
- approximately 1 million babies are stillborn
- at least 1 million babies die in their first month of life; and about half a million die on their first day
- another 3.3 million African children will die before their 5th birthday
- 4 million low-birth-weight babies and others with neonatal complications may live, but not reach their full potential

The President, Dr Gertrude Mongella, stated: 'Every country in Africa adds to a catalogue of loss composed of too many maternal, newborn, and child deaths. Yet this loss does not have to be inevitable. At least two-thirds of newborns and a similar proportion of mothers and children, could be saved with cost-effective interventions that already exist in the policies of most countries, but do not reach the poor'.³

Where does South Africa lie?

Fortunately, South Africa has various databases from which valuable information can be gleaned. The *South African Health Review* of 2006⁴ summarises the data. According to DHIS data the MMR is given as 110/100 000 live births for 2003, the perinatal mortality rate as 40/1 000 births for 2000, the neonatal death rate as 15/1 000 live births, the infant mortality rate as 48/1 000 live births and the under-5 mortality rate as 73/1 000 live births. These rates must be treated with caution because some of the data derive from the 2003

Demographic and Health Survey and Statistics South Africa, which has been questioned, and the data given are considerably lower than other sources of data. For example, the 2003/4 *Health Review* reported the infant mortality rate as 59/1 000 live births and the under-5 mortality rate as 100/1 000 live births⁵ and the MMR is estimated as a minimum of 147/100 000 live births by the *Saving Mothers 2002 - 2004* report, and given that in all provinces the MMR has increased, despite the acknowledged under-reporting of deaths, the actual MMR is more likely to be between 200 and 300/100 000 live births.⁶

Although considerably lower than in most other African countries, the trend of mortality rates in South Africa is upwards, and we are not anywhere near achieving MDGs 4 and 5. The HIV/AIDS epidemic is an important reason for the lack of achievement of the MDGs relating to health. *Saving Mothers 2002 - 2004* reports AIDS as the biggest single cause of maternal mortality,⁶ the perinatal mortality in HIV-infected women is twice that HIV-negative women,⁷ and *Saving Children 2005* reported that where the HIV status was known 4 out of 5 deaths of children in health institutions were HIV related.⁸ However, that need not be the case; maternal deaths due to AIDS can be prevented, infant infections prevented and infected children effectively treated.

Dr Francisco Songane, Director of the Partnership for Maternal, Newborn and Child Health, in the foreword to *Opportunities for Africa's Newborns* states: 'The health of newborn babies has fallen between the cracks. Governments, international agencies, programme implementers, and donors have been more likely to address women's health, children's health or infectious diseases through separate, often competitive, "vertical" programmes. This has not helped countries build strong, integrated health systems. One specific side effect has been the void of newborn care in many key programmes.'³

The big question is how to integrate and scale-up effective interventions to reduce maternal, neonatal and child mortality. These are two separate actions, integration and scaling-up. The *Saving Mothers 2002 - 2004* report illustrates the very poor implementation of recommendations to reduce maternal mortality.⁹

March 2007 sees the 26th Priorities in Perinatal Care Conference in South Africa. These research conferences, initiated in 1981 by Professor Alan Rothberg and currently ably run by Professor Eckhart Buchmann, have as their aim to identify the priority causes of maternal and perinatal deaths and to provide ways of reducing

these causes. Those who attend the conferences are a mixture of (alphabetically) epidemiologists, health care administrators (often from the national and provincial departments of health), midwives, neonatal nurses, obstetricians, paediatricians and rural doctors. The group is mainly health care providers from the public and academic health sectors, and attendances have grown to now average between 250 and 300 delegates. This is truly integration between academia and service and across many health disciplines.

During the 26 years, delegates have heard, debated and criticised research aimed at improving care to pregnant women and their children. Many programmes aimed at reducing perinatal mortality that are standard today were first presented at the Priorities Conferences, for example, the Perinatal Education Programme, the Perinatal Problem Identification Programme, the Confidential Enquiries into Maternal Deaths, the maternal 'near misses', the Better Births Initiative, kangaroo mother care and its implementation, neonatal resuscitation programmes, nasal continuous positive airway pressure (CPAP), basic antenatal care, and the Child Health Care Problem Identification Programme, to name a few. The group produces proceedings that are updated yearly and contains all the papers presented from the second conference. These are extremely valuable local data and have enabled the monograph entitled *Intrapartum Care in South Africa: A Review and Guidelines*¹⁰ to be written based on South African research and experience.

Has this made a difference? The short answer must be no, the net trend of mortality rates in maternal, neonatal and child mortality is upwards. If we had made a difference, why are the mortality rates increasing? Yet there are examples of success, such as the implementation of kangaroo mother care. In those places implementing KMC, a reduction of approximately 30% in neonatal mortality of neonates weighting between 1 000 g and 2 000 g has been reported.¹¹ What has happened? The programmes are

there, have been tested locally and work, but they have not been integrated into the health care system and not been implemented on a large enough scale to reach the poor.

A new challenge for the Priorities group is to research; the integration of programmes its delegates have already shown to be effective into the health care system, particularly at the primary level of care; and the scale-up process so that the integrated programmes reach 90% plus of the population so that they can truly make a difference. The place to start is with screening for HIV infection, treating HIV-infected women to save their lives, preventing transmission, and detecting, supporting and treating HIV-infected infants.

R C Pattinson

*MRC Maternal and Infant Health Care Strategies
Research Unit
Department of Obstetrics and Gynaecology
University of Pretoria*

1. United Nations General Assembly. United Nations Millennium Declaration: resolution adopted by the General Assembly 55/2. 8th Plenary Meeting, 8 September 2000. www.un.org/millennium/declaration/ares552e.htm (accessed 4 February 2007).
2. Millennium Project. www.unmillenniumproject.org/ (accessed 4 February 2007).
3. Lord D, Wake R, Elder L, Grear K, Antayhua A. *Opportunities for Africa's Newborns*. New York: Partnership of Maternal, Newborn and Child Health, 2006: 2.
4. Day C, Gray A. Health and Related Indicators. In: Ijumba P, Padarath A, eds. *South African Health Review 2006*. Durban: Health Systems Trust, 2006: 369-506. www.hst.org.za (accessed 4 February 2007).
5. Bradshaw D, Nannan N. Mortality and morbidity among women and children. In: Ijumba P, Padarath A, eds. *South African Health Review 2006*. Durban: Health Systems Trust, 2006: 127-150. www.hst.org.za (accessed 4 February 2007).
6. Lourens A, Pattinson RC. Changing patterns of maternal death 1998-2004. In: Pattinson RC, ed. *Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002-2004*. Pretoria: Government Printer, 2006: 30-47.
7. Van Hoorick L, Pattinson RC. The impact of HIV infection on perinatal mortality in south-west Tshwane. Paper presented at the Priorities in Perinatal Care Conference, Mossel Bay, 2007.
8. Patrick M, Stevens C, Krug A. *Saving Children 2005*. Pretoria: Pretoria University Press, 2007.
9. Mangate L. Progress made with the implementation of the recommendations from Saving Mothers 1999-2001. In: Pattinson RC, ed. *Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002-2004*. Pretoria: Government Printer, 2006: 305-321.
10. Farrell E, Pattinson RC, eds. *Intrapartum Care in South Africa: A Review and Guidelines*. Pretoria: Pretoria University Press, 2006: 56: 438-441.
11. Pattinson RC, Bergh A-M, Malan AF, Prinsloo R. Does kangaroo mother care save lives? *J Trop Pediatr* 2006; 56: 438-441.