REPUBLIC OF SOUTH AFRICA

MILLENNIUM DEVELOPMENT GOALS

Goal 5
Improve maternal health

UNDP

The South Africa I know, the home I understand

Contents

List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ARV	Antiretroviral
HAART	Highly active antiretroviral therapy
HIV	Human Immune Deficiency Virus
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
PMTCT	Prevention of mother-to-child transmission
SADHS	South Africa Demographic and Health Survey
STI	Sexual transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

5.1 Targets and indicators

Target 5A: Reduce by three quarters between 1990 and 2015, the under-five mortality rate	**Performance summary:** Not achieved **State of supportive environment:** Fair
Target 5B: Achieve by 2015 universal access to reproductive health	**Performance summary:** Possible to achieve **State of supportive environment:** Good
Standard MDG indicators	5.1. Maternal mortality ratio
	5.2. Proportion of birth attended by skilled health personnel
	5.3. Contraceptive prevalence rate (couple year protection rate)
	5.4. Adolescent birth rate
	5.5. Antenatal care coverage rate (at least one visit and at least four visits)
	5.6. Unmet need for family planning
Domesticated indicators	5.7. Use of modern contraceptive methods by sexually active women
	5.8. Percentage of last live birth in health facility in South Africa
	5.9. Delivery rate in facility to women under 18 years
	5.10. Antennal visit per antenatal client

5.2 Facts and figures

Improve maternal health					
Goal 3 Indicators	**1994 baseline (or closest year)**	**Current status 2010 (or nearest year)**	**2015 target**	**Target achievability**	**Indicator type**
Maternal mortality ratio	369 *(2001)*	625 *(2007)*	38	Unlikely	MDG
Proportion of births attended by skilled health personnel	76,6 *(2001)*	94,3 *(2009)*	≈100	Possible	MDG
Contraceptive prevalence rate (couple year protection rate)	25,2 *(2001)*	33,4 *(2009)*			MDG
Antenatal care coverage (at least one visit and at least four visits)	76,6 *(2001)*	102,8 *(2009)*	≈100	Achieved	MDG
Use of modern contraceptive methods by sexually active women	61,2 *(1998)*	64,6 *(2003)*	70	Unlikely	Domestic

5.3 Background

Thousands of women throughout the world do not experience pregnancy and childbirth as the joyful event that it should be, but as times of suffering which sometimes even result in death. In developing countries in particular, maternal death constitutes a tragedy of vast proportions. Yet, until recently, those who set national and international priorities have ignored the problem, since those who suffer most are often poor, illiterate and politically powerless.

Globally, more than half a million women die each year due to complications relating to pregnancy and childbirth. Of the estimated 536 000 worldwide maternal deaths in 2005, developing countries accounted for more than 99%. About half the maternal deaths (265 000) occurred in sub-Saharan Africa alone and one third took place in South Asia (187 000) (UNICEF 2008). Thus, sub-Saharan Africa and South Asia accounted for 84% of global maternal deaths, with hemorrhage being the leading cause of death in these regions. Sepsis, prolonged or obstructed labor, hypertensive disorders of pregnancy, especially eclampsia, and complications of unsafe abortions, claim further lives.

Sub-Saharan Africa suffers from the highest maternal mortality ratio at 920 maternal deaths per 100 000 live births, followed by South Asia with a MMR of 500. This compares with a MMR of eight in industrialised countries. The countries with the highest MMRs are Sierra

Leone (2 100 maternal deaths per 100 000 live births), Niger (1 800), Afghanistan (1 800), Chad (1 500), Somalia (1 400), Angola (1 400), Rwanda (1 300), and Liberia (1 200) (UNICEF 2008).

In recent years, the scale of suffering associated with pregnancy and childbirth has become more widely recognised, as well as the crucial fact that much of this suffering is preventable. A study noted that the increased interest in maternal health shown by national governments and international agencies may be attributed to many factors (Adekunle, Filippi, Graham, Onyemunwa & Udjo 1990). The study noted that one of these stimulants, the posing of a basic question – "where is the M in MCH?" (Rosenfield & Maine 1985), is intended to generate concern in the wider issues of maternal health and to challenge the focus on outcomes in the infant and child as the motivating factor for improving the well-being of women (Howard 1987). In addition, the study noted that that specific question also helped to draw attention to maternity care services with regard to provision and utilisation.

The framework for reproductive health and rights derived from principles recognised in the United Nations Charter and the Universal Declaration of Human Rights, as well as other internationally accepted frameworks on human rights (UNFPA 1997). Article 16 of the Convention on the Elimination of All forms of Discrimination Against Women states the following: "States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and … shall ensure … [and the] same right freely to choose a spouse and to enter into marriage only with their free and full consent … [and the] same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means [needed] to exercise these rights…" (UNFPA 1997). South Africa ratified this treaty and the Millennium Development Goal 5: Improve maternal health may be viewed in this context.

South Africa established a National Ministerial Committee on Confidential Enquiries into Maternal Deaths in 1997 to study and provide recommendations on maternal mortality. The other two Ministerial Committees dealt with recommendations on perinatal and under-five morbidity and mortality. The three Ministerial Committee reports showed unacceptably high infant, child and maternal mortality in South Africa. The first comprehensive report on maternal deaths was published in October 1999. The second report covered the period 1999–2001 and the third report covered the period 2002–2004. The fourth report, Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa, covered the 2005–2007 triennium and showed clear trends by comparing data with a previous report. Some of the findings and key recommendations of this report are also included in this study.

5.4 Introduction

The internationally agreed quantitative target with regard to improving maternal health has two components:

- Reduce by three quarters, between 1990 and 2015 the maternal mortality ratio. The indicators for monitoring progress in this regard are the maternal mortality ratio and the proportion of births attended by skilled health personnel;
- Achieve by 2015 universal access to reproductive health. The indicators for monitoring progress in this regard are the contraceptive prevalence rate, as well as antenatal care

coverage. Progress in the improvement of maternal health in South Africa will be presented using the above indicators.

5.5 Maternal health

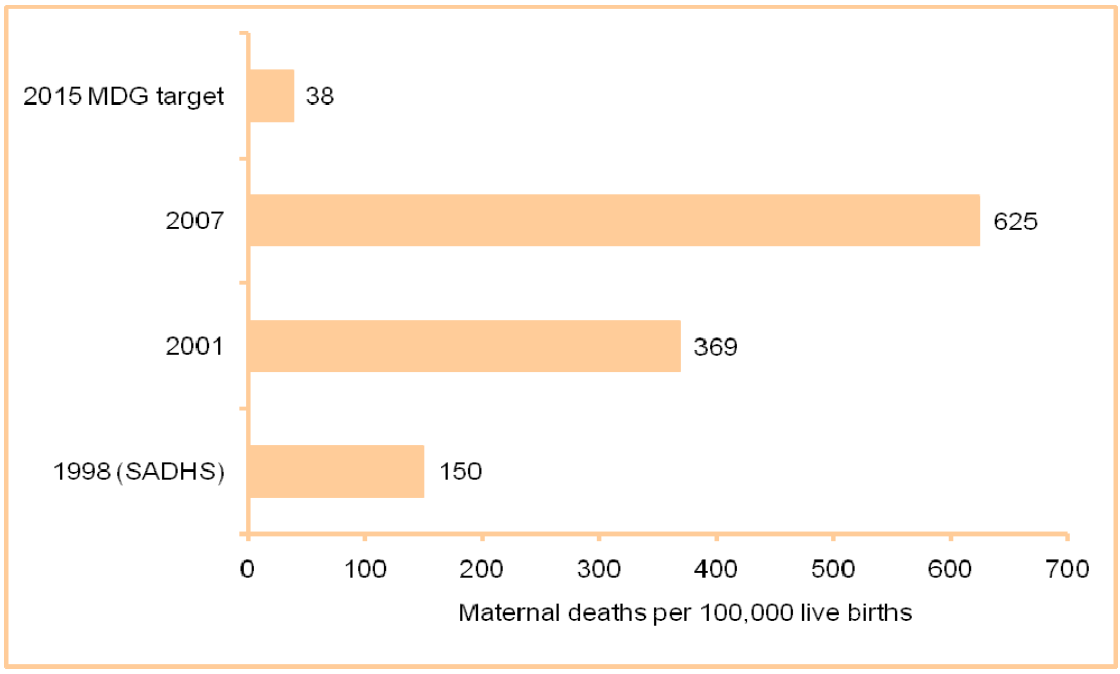
Indicator : maternal mortality ratio

According to the World Health Organisation, a maternal death is the death of a woman while pregnant, or within 42 days of termination of the pregnancy, irrespective of the duration and state of the pregnancy, or from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. One of the conventional measures of maternal mortality is the maternal mortality ratio defined as the number of maternal deaths per 100 000 live births.

Information on the MMR in South Africa is sparse with usually cited estimates coming from the South Africa Demographic and Health Surveys. The MMR based on the 1998 South Africa Demographic and Health Surveys was 150 per 100 000 live births for the approximate period of 1992–1998 (Department of Health, Medical Research Council & ORC Macro 1999). Furthermore, although maternal mortality questions were included in the 2003 South Africa Demographic and Health Survey, maternal mortality estimates were not provided in the full report of the survey. Thus, the benchmark estimate of the MMR in South Africa in this study is based on the 1998 South Africa Demographic and Health Survey. Using this benchmark, South Africa should attain a level of maternal mortality ratio of 38 per 100 000 live births by 2015 if the country were to meet the internationally set target for this goal. Progress on this goal will be examined.

From the questions on deaths in the household, as well as those that were pregnancy-related in the 2001 South Africa Population Census and the 2007 Community Survey, this study computed the maternal mortality ratio after adjusting for errors in the data. The results are presented in Figure 5.1. As seen in the graph, MMR appears to have increased from 150 per 100 000 live births in 1998 to 369 per 100 000 live births in 2001 and to 625 per 100 000 live births in 2007. The current level of maternal mortality (625/100 000 live births) is far higher than the MDG target of 38 per 100 000 live births by 2015.

Figure 5.1: Maternal mortality ratio in South Africa since 1998, and the 2015 MDG target



Sources: *1998 South Africa Demographic and Health Survey,* Department of Health*; 2001 Population Census, 2007 Community Survey,* Statistics South Africa

Table 5.1: Comparison of institutional maternal mortality ratios 2002–2004, and 2005–2007

	2002–2004	2005–2007
Material Mortality Ratio per 100 000 live births	145,5	152,2

Source: *Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa*

The data in Table 5.1 shows that the institutional maternal mortality rate in South Africa in the 2002–2004 triennium was 145 deaths per 100 000 live births, increasing to 152 per 100 000 live births during the 2005–2007 triennium. The 2005–2007 Saving Mothers Report also notes that in most provinces in South Africa, there were increases in the number of maternal deaths reported. However, the increases in the reported number of deaths could probably have been due to a combination of factors which included better reporting and/or an actual increase in deaths (Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa).

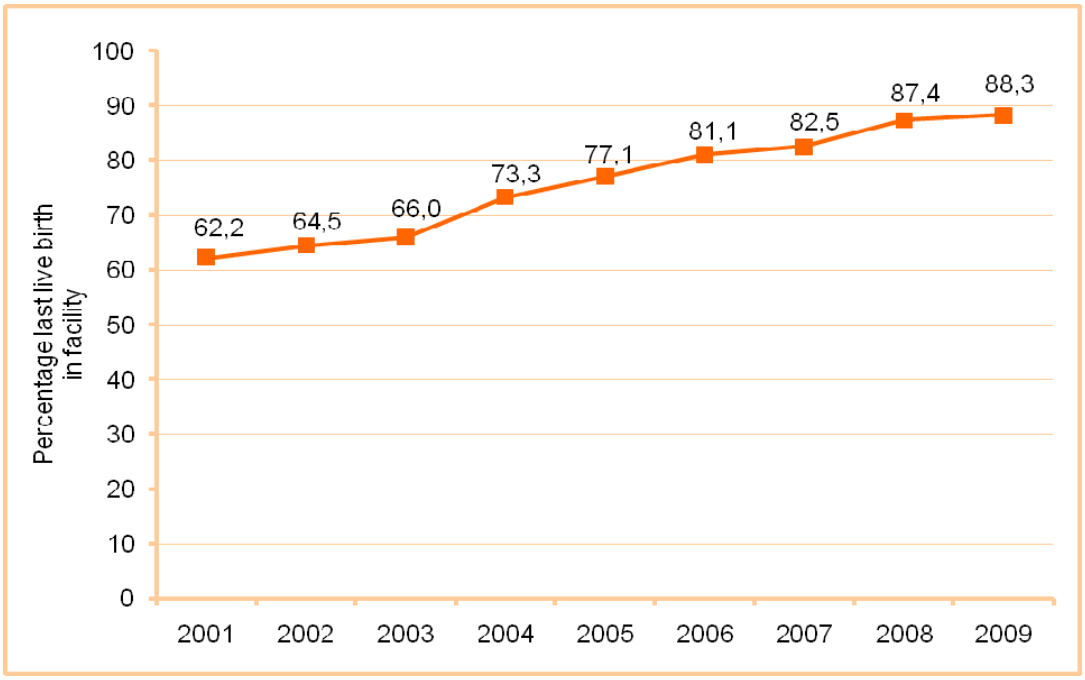
The 2005–2007 Saving Mothers Report further indicated that the five major causes of maternal death remained the same during 2005–2007 and 2002–2004 and were: non-pregnancy-related infections – mainly AIDS (43,7%), complications of hypertension (15,7%), obstetric hemorrhage (antepartum and postpartum haemorrhage, 12,4%), pregnancy-related sepsis (9,0 %), and pre-existing maternal disease (6,0%). However, compared with the previous triennium there had been a 20,1% increase in the number of deaths reported. The incidence of deaths due to hypertension was significantly reduced, indicating an improvement in institutional management (Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa).

5.6 Percentage of births in facilities

The type of medical assistance received during delivery has an impact on reproductive health, and hence maternal mortality. The percentage of women whose live births occurred in a health facility provides an indication of the percentage of births attended to by skilled health personnel. The data in Figure 5.2 and Table 5.2 is based on the delivery rate at facilities from the District Health Information System of the Department of Health. This will act as a proxy for the '*Percentage of last live birth in health facility*' indicator. The data shows that the percentage of women in South Africa whose live births occurred in a health facility increased from 62,2% in 2001 to 88,3% in 2009. As shown in Table 5.2, similar increases occurred in all the provinces. The few cases where the delivery rate at facilities exceeded 100% may have been caused by an underestimate in the number of all expected deliveries in the target population (see Figure 5.2 and Table 5.2).

Indicator: Percentage of last live birth in health facility in South Africa

Figure 5.2: Percentage of last live birth in health facility, 2001–2009



Source: *District Health System,* Department of Health

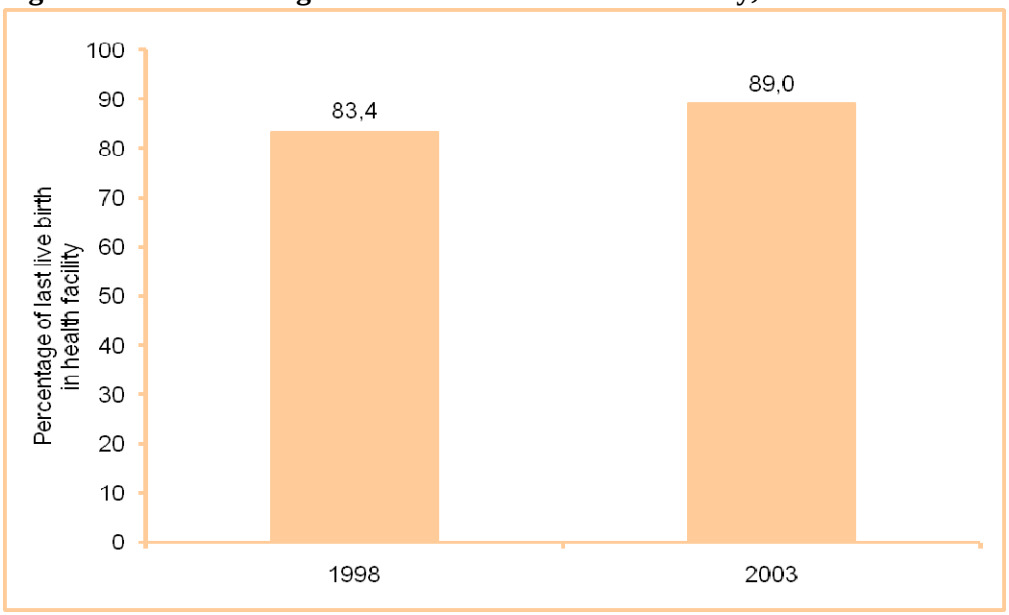
Table 5.2: Percentage of last live birth in health facility in South Africa by province, 2001–2009

Province	Year								
	2001	2002	2003	2004	2005	2006	2007	2008	2009
Western Cape	72,2	65,0	71,3	75,9	81,4	88,2	91,5	95,2	95,9
Eastern Cape	55,1	58,4	57,6	68,9	68,4	68,4	66,4	68,2	70,7
Northern Cape	67,9	67,4	69,0	73,9	76,8	81,3	84,7	89,5	90,2
Free State	65,9	65,6	67,3	72,5	75,2	73,4	76,6	78,8	76,7
KwaZulu-Natal	62,7	62,2	60,7	65,9	67,2	74,0	74,2	79,7	82,5
Gauteng	55,8	70,1	75,2	84,5	90,0	98,0	101,8	107,2	106,2
North West	60,4	59,4	59,9	62,5	69,2	70,5	73,5	79,6	79,5
Mpumalanga	62,1	60,5	61,3	71,6	81,9	84,9	90,1	96,6	92,1
Limpopo	69,6	71,2	71,7	81,1	87,1	89,5	90,2	97,0	98,3

Source: *District Health Information System, Department of Health*

To complement the study of this indicator, data from the South Africa Demographic and Health Surveys conducted in 1998 and 2003 is also used. According to the 2003 SADHS report, 89% of women had their last live birth in a health facility in 2003, an increase from 83% in 1998 (Figure 5.3). However, a substantial percentage of women (17%) are not attended to by skilled personnel during delivery (Department of Health, Medical Research Council & ORC Macro 2007).

Figure 5.3: Percentage of last live birth in health facility, 1998 and 2003



Source: *2003 South Africa Demographic and Health Survey Report*, Department of Health

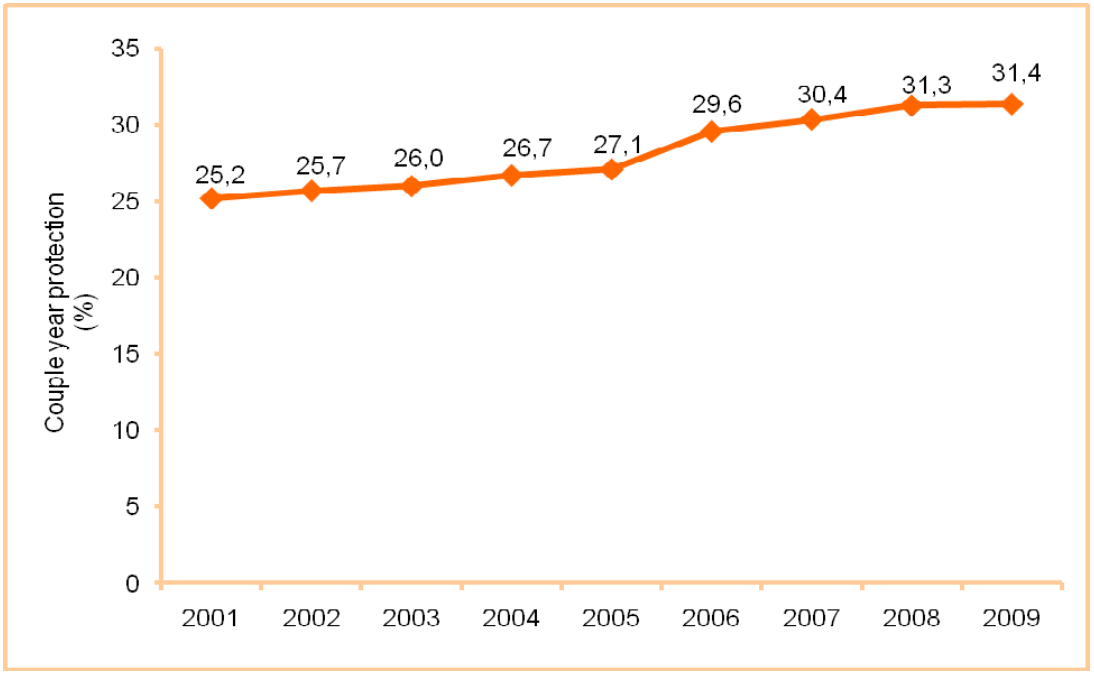
5.7 Contraceptive prevalence

Contraceptive use is an aspect of, and promotes reproductive health, since contraceptive use mitigates against unwanted and high risk pregnancies. High risk pregnancies are detrimental to women's health and can exacerbate maternal mortality in a population.

Indicator: Contraceptive prevalence rate (couple year protection rate) and use of modern contraceptive methods by sexual active women

The couple year protection rate is a proxy for the contraceptive prevalence rate. The couple year protection rate is the rate at which couples (specifically women) are protected against pregnancy using modern contraceptive methods including sterilisations. The target for the couple year protection rate in South Africa is 70%. Figure 5.4 and Table 5.3 provide for the couple year protection rates in South Africa, and by province for 2001 to 2009, respectively. The couple year protection rates in South Africa have been fairly stable, with an average close to 30% since 2001. The exception to this pattern has been the Western Cape where these rates increased sharply to 59,3% in 2007.

Figure 5.4: Couple year protection rates 2001–2009



Source: *District Health Information System*, Department of Health

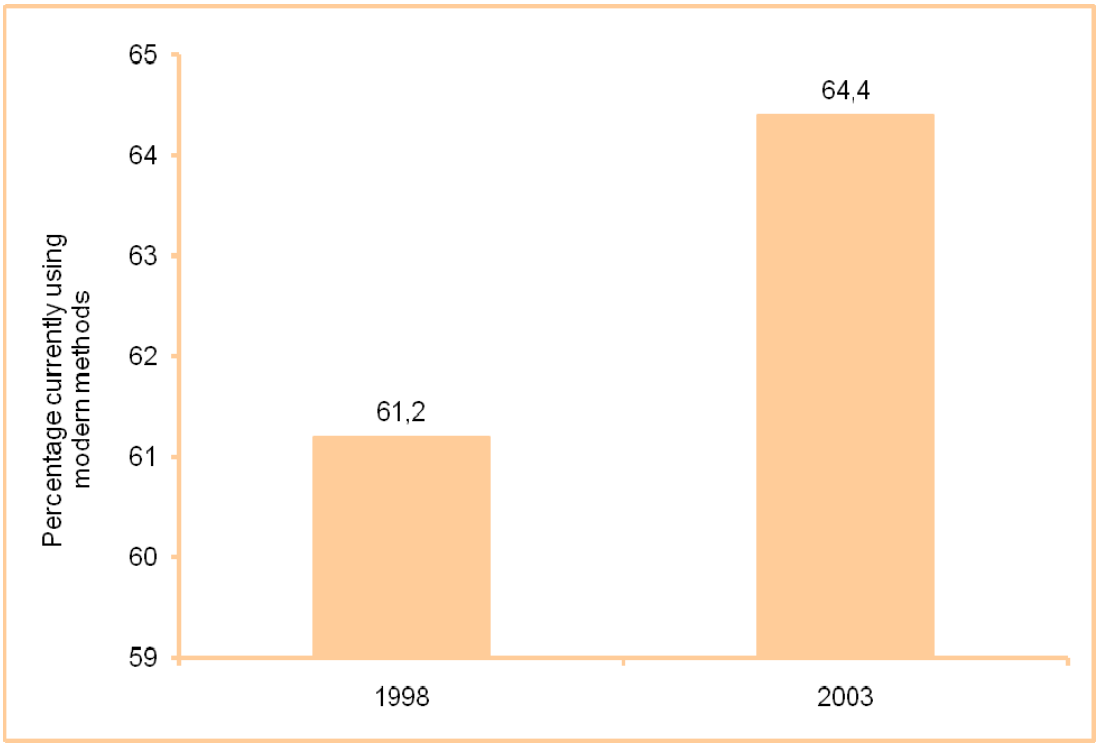
Furthermore, the 2003 SADHS Report indicates that the modern contraceptive prevalence rate among sexually active women increased from 61% in 1998 to 65% in 2005 (Figure 5.5).

Table 5.3: Couple year protection rates by province 2001–2009

Province	Year								
	2001	2002	2003	2004	2005	2006	2007	2008	2009
Western Cape	31,5	33,1	34,3	39,4	38,6	46,3	59,3	63,9	60,5
Eastern Cape	31,1	29,4	28,5	27,5	27,5	27,7	28,3	32,4	33,0
Northern Cape	28,9	29,5	32,0	32,6	32,4	35,6	35,8	37,7	36,7
Free State	29,2	29,1	29,9	27,5	30,1	31,5	31,6	33,1	32,6
KwaZulu-Natal	17,0	19,1	20,6	20,1	20,1	24,4	24,5	24,5	24,7
North West	33,3	30,5	29,1	29,0	30,1	26,9	25,8	25,6	26,3
Gauteng	19,3	19,8	19,9	22,8	23,8	27,9	26,8	28,2	28,9
Mpumalanga	24,4	23,1	23,2	23,7	23,4	24,1	27,2	29,2	33,7
Limpopo	32,8	35,4	34,5	34,3	34,8	36,0	35,7	36,6	36,8

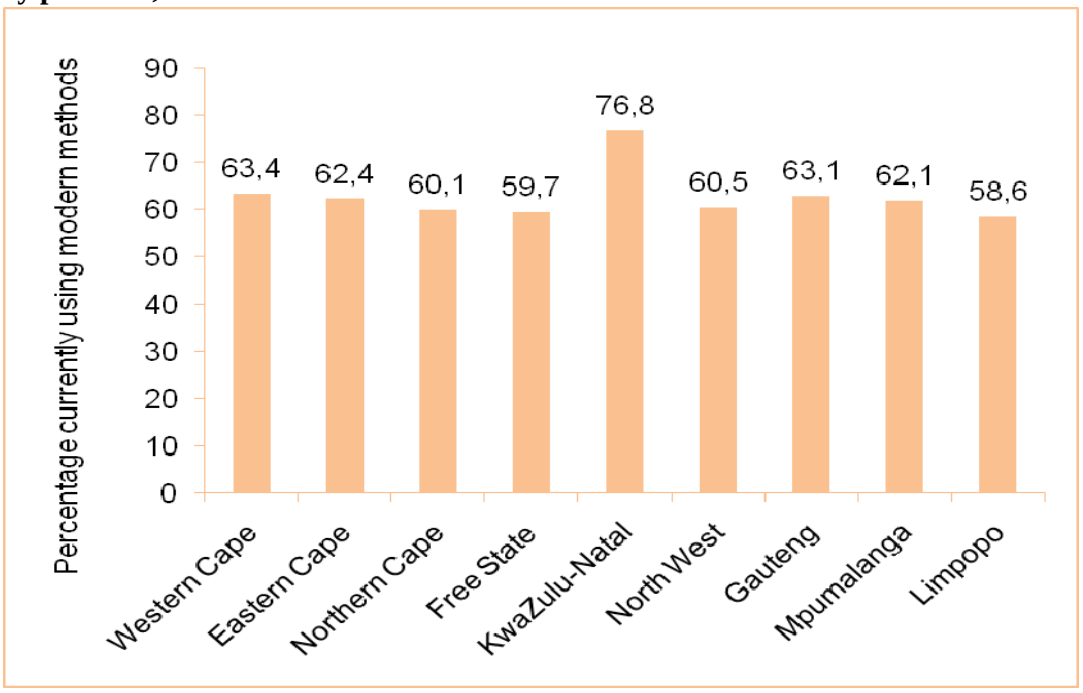
Source: *District Health Information System*, Department of Health

Figure 5.5: Percentage of sexually active women using modern contraceptive methods 1998 and 2003



Source: *1998 and 2003 South Africa Demographic and Health Survey Report*, Department of Health

Figure 5.6: Percentage of sexually active women using modern contraceptive methods by province, 2003



Source: *2003 South Africa Demographic and Health Survey Report,* Department of Health

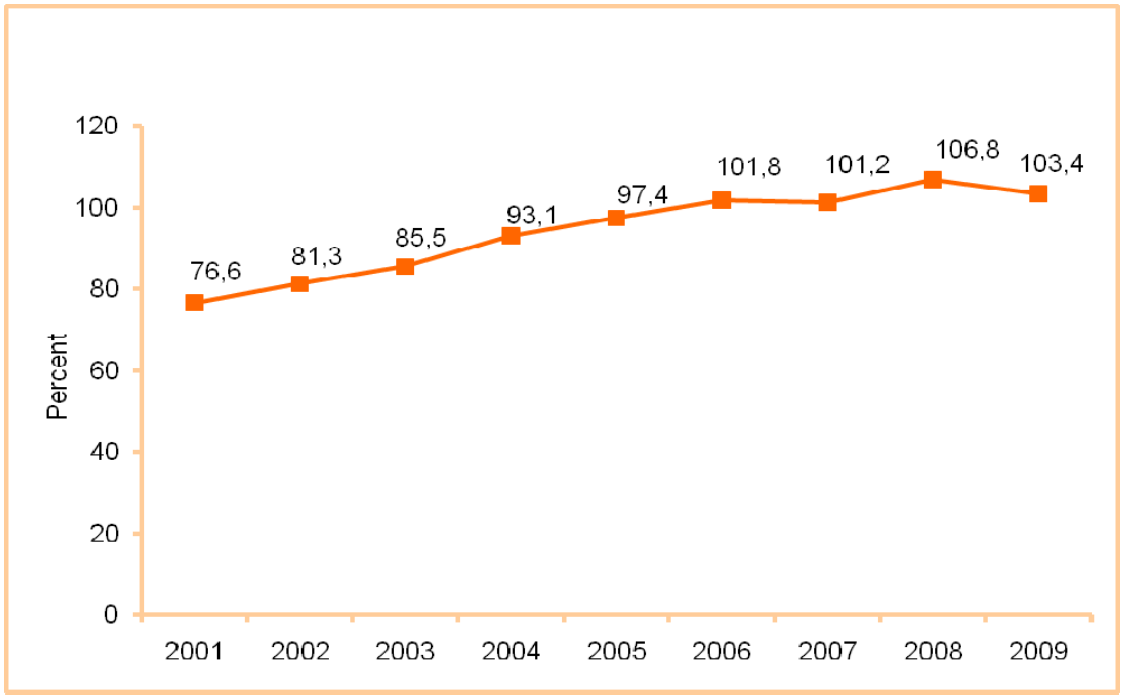
Figure 5.6 shows the percentage of sexually active women using modern contraceptive methods by province for the year 2003. Only two provinces have a prevalence rate below 60%, which are Limpopo with 58,6% and Free State with 59,7%. Of all the provinces, KwaZulu-Natal has the highest contraceptive prevalence. The rest of the provinces have a contraceptive prevalence ranging from 60,1% to 63,4%, which is quite high.

5.8 Antenatal care

Indicator: Antenatal care coverage (at least one visit and at least four visits)

Access to and utilisation of antenatal care services have an impact on pregnancy outcome, child survival and maternal health. As shown in Figure 5.7 and Table 5.4, the use of antenatal care during pregnancy is currently high in South Africa. Figure 5.7 shows that 97% of pregnant women utilised antenatal care during 2005. However, it should be noted that the data in Figure 5.7 and Table 5.4 show antenatal coverage of above 100% for some of the provinces. This may have been caused by an underestimate of the population of potential ANC clients in the catchment area.

Figure 5.7: Percentage of women who attended an antenatal care facility at least once during pregnancy, 2001–2009



Source: *District Health System,* Department of Health

Table 5.4: Percentage of women who attended an antenatal care facility at least once during pregnancy, by province, 2001–2009

Province	Year								
	2001	2002	2003	2004	2005	2006	2007	2008	2009
Eastern Cape	79,8	80,9	83,9	87,5	82,7	80,4	71,5	82,6	87,2
Free State	81,0	78,7	74,6	80,1	85,0	87,3	90,3	914	85,0
Gauteng	78,6	85,8	98,1	115,8	124,3	130,1	135,6	145,7	134,2
KwaZulu-Natal	60,7	76,3	85,2	95,0	99,7	112,5	109,7	111,0	102,6
Limpopo	85,6	88,8	87,1	93,7	96,9	91,4	89,3	96,3	99,1
Mpumalanga	93,5	96,4	92,0	104,6	109,5	109,9	107,5	110,0	106,7
North West	87,8	78,5	77,0	67,2	79,8	87,5	89,3	92,2	97,4
Northern Cape	72,4	76,1	74,5	76,2	86,8	94,0	96,3	102,3	95,6
Western Cape	69,7	66,9	72,0	73,6	77,9	87,1	97,1	99,7	94,4

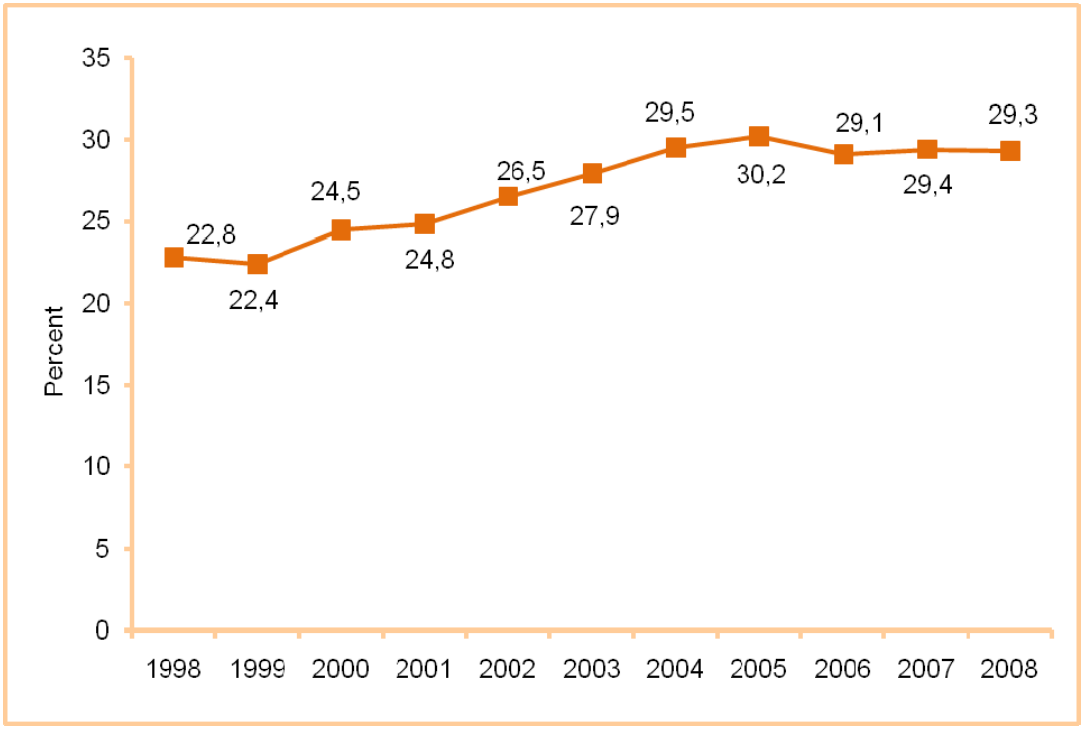
Source: *District Health Information System,* Department of Health

5.9 HIV prevalence among antenatal women

In South Africa the period 1998 to 2008 was largely characterised by an incremental pattern in HIV prevalence, as shown by the antenatal prevalence estimates presented in Figure 5.8. However, HIV prevalence appears to have either stabilised or declined after 2007 in some provinces of South Africa (see Table 5.6). The Saving Mothers 2005–2007 Report states that the true impact of HIV and AIDS on the pregnant population is now becoming apparent in South Africa. The report further states that, compared with the previous triennium (2002–

2004), there was an increase in the number of maternal deaths reported in South Africa (Department of Health, 2008).

Figure 5.8: HIV prevalence among antenatal women aged 15 to 49 years, 1998–2008



Source: *National Antenatal Sentinel HIV and Syphilis Prevalence Survey,* Department of Health

Table 5.5: HIV status of maternal deaths for the period 2005–2007 compared with the period 2002–2004

HIV status	2005–2007		2002–2004	
	Number	%	Number	%
Positive	1 884	46,2	1 226	36,0
Negative	511	12,5	351	10,3
Unknown	1 682	41,3	1 829	53,7

Source: *Saving Mothers (2005-2007) Report,* Department of Health

Table 5.6: HIV prevalence among antenatal women aged 15 to 49 years by province, 1998–2008

Province	Year										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Western Cape	5,2	7,1	8,7	8,6	12,4	13,1	15,4	15,7	15,1	15,3	16,1
Eastern Cape	15,9	18,0	20,2	21,7	23,6	27,1	28,0	29,5	28,6	28,8	27,6
Northern Cape	9,9	10,1	11,2	15,9	15,1	16,7	17,6	18,5	15,6	16,5	16,2
Free State	22,8	27,9	27,9	30,1	28,8	30,1	29,5	30,3	31,1	31,5	32,9
KwaZulu-Natal	32,5	32,5	36,2	33,5	36,5	37,5	40,7	39,1	39,1	38,7	38,7
North West	21,3	23,0	22,9	25,2	26,2	29,9	26,7	31,8	29,0	30,6	31,0
Gauteng	22,5	23,9	29,4	29,8	31,6	29,6	33,1	32,4	30,8	30,5	29,9
Mpumalanga	30,0	27,3	29,7	29,2	28,6	32,6	30,8	34,8	32,1	34,6	35,5
Limpopo	11,5	11,4	13,2	14,5	15,6	17,5	19,3	21,5	20,6	20,4	20,7

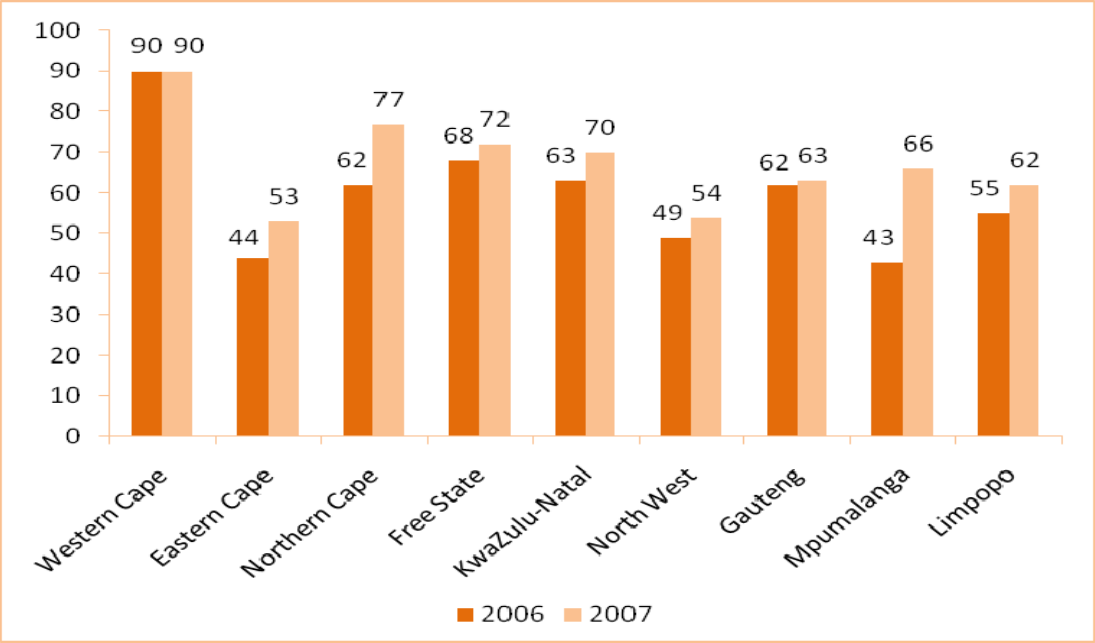
Source: *District Health Information System,* Department of Health

The data presented in Table 5.5 shows the HIV status of women who died in the triennium 2002–2004 compared with the triennium 2005–2007, as covered by the Confidential Enquiry into Maternal Deaths in South Africa. The data shows that 46,2% of the women who died of maternal causes were HIV-positive during 2005–2007 compared with 36,0% during 2002–2004. The Saving Mothers (2005–2007) Report further shows that 59% of maternal deaths were tested for HIV infection from 2005–2007, up from 46,3% in the last triennium. Furthermore, 79% of those who were tested in 2005–2007 were HIV infected. The steady increase in testing could be a reflection of the expansion of the Prevention of Mother to Child Transmission Programme (PMTCT) (Department of Health 2008).

5.10 Prevention of mother-to-child transmission of HIV

Data in Figure 5.9 shows the percentage of HIV pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission of HIV in 2006 and 2007. There was an overall increase of 6% in the percentage of women who received ARVs from 2006 to 2007. Northern Cape and Mpumalanga had the largest increases, 15% and 12%, respectively.

Figure 5.9: Percentage of HIV positive pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission



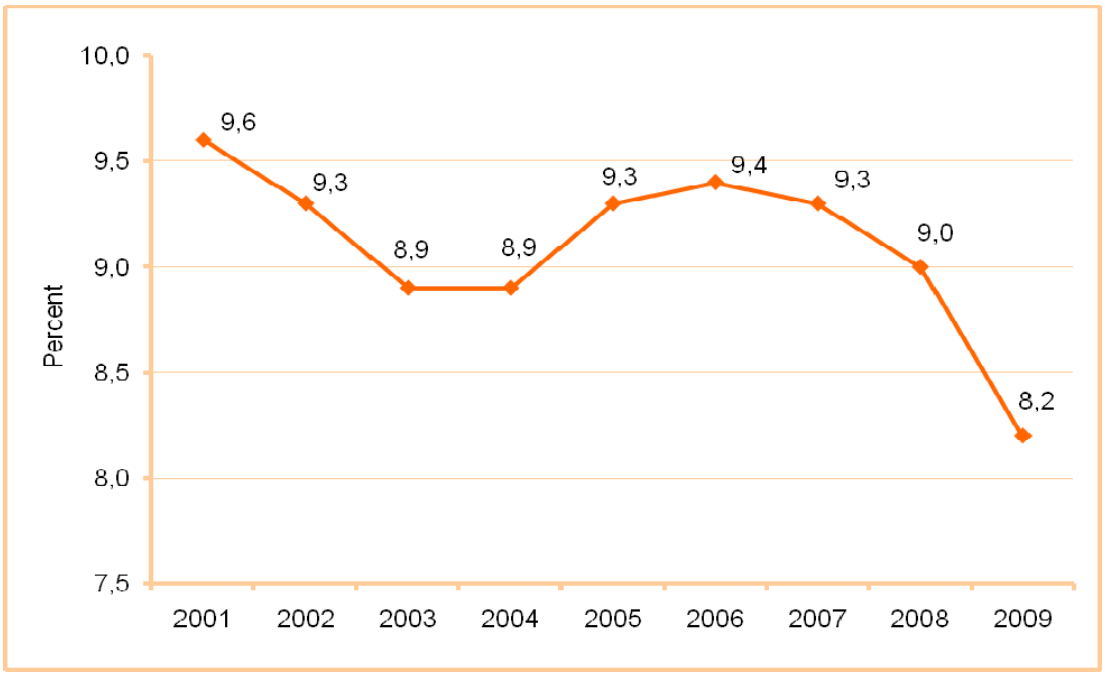
Source: *Progress Report on Declaration of Commitment on HIV/AIDS, Republic of South Africa. Reporting period January 2006–December 2007.* Department of Health (2008)

5.11 Teenage motherhood

Indicator: Adolescent birth rate and delivery rate in facilities of women aged under 18 years

The delivery rate in facilities of women aged under 18 years can be used as a proxy for the adolescent birth rate. The data in Figure 5.10 and Table 5.7 show the delivery rate in health facilities in South Africa and by province, respectively. This indicator is computed as a percentage of the deliveries in health facilities of women under 18 years to the total number deliveries of all women in the facility per annum. The percentage of deliveries for women aged under 18 years in health facilities declined from 9,6% in 2001 to 8,2% in 2009. Evidently, the percentage of deliveries for women under 18 years has declined to a level of 10% or less in 2009 in all the provinces in South Africa (see Table 5.7). The sharp disparity between the rates for the Free State during 2001 to 2004 and the rates for the other provinces could be due to lower reporting in the Free State during that time period.

Figure 5.10: Percentage of birth deliveries for women under 18 years in health facilities 2001–2009



Source: District Health System, Department of Health

Table 5.7: Percentage of deliveries for women under 18 years in health facilities by province 2001–2009

Province	Year								
	2001	2002	2003	2004	2005	2006	2007	2008	2009
Western Cape	7,5	7,9	8,0	8,2	8,4	8,7	8,3	8,2	7,3
Eastern Cape	12,4	11,2	9,9	9,2	9,9	10,2	10,8	11,0	10,0
Northern Cape	11,3	9,9	9,1	10,3	10,5	10,0	10,4	9,9	10,4
Free State	1,0	0,6	0,6	0,6	5,6	8,6	8,4	8,5	8,2
KwaZulu-Natal	9,6	9,6	9,0	9,1	9,5	9,4	9,3	9,4	8,8
Gauteng	9,4	8,9	8,5	8,6	8,4	9,4	8,8	7,4	6,0
North West	9,6	8,5	8,9	8,4	8,6	9,4	10,1	9,6	8,8
Mpumalanga	13,0	12,8	13,0	13,9	12,9	10,1	10,3	10,0	10,4
Limpopo	10,6	11,2	11,0	9,9	9,9	8,8	8,5	8,4	8,2

Source: *District Health System,* Department of Health

5.12 Termination of pregnancy rate at facility

Indicator: Unmet need for family planning

Table 5.8: Termination of the pregnancy rate at facility by province

Province	2008 (%)	2009 (%)
Western Cape	20,2	17,7
Eastern Cape	16,1	13,9
Northern Cape	1,7	1,4
Free State	10,4	8,5
KwaZulu-Natal	7,7	7,8
Gauteng	18,2	28,8
North West	8,7	6,9
Mpumalanga	4,0	3,4
Limpopo	12,9	11,6
RSA	**11,1**	**11,1**

Source: *District Health System,* Department of Health

The termination of the pregnancy rate at facility can be used as a proxy for the unmet need of family planning. Data on the termination of the pregnancy rate at facility for all provinces for 2008 and 2009 is shown in Table 5.8. There has been no change in the overall rate of the termination of the pregnancy rate at facility between the two reported years in South Africa. However, a closer look at provincial patterns indicates that all the provinces, except for Gauteng, experienced a decline in the termination of the pregnancy rate at facility rates from 2008 to 2009.

5.13 Key challenges in improving maternal health

South Africa's Constitution (108/1996) is based on international standards that recognise the fundamental principles of human dignity, equality, human rights and freedom for all, as well as healthcare, security and access to health information, and are enriched in the Bill of Rights that forms part of South Africa's Constitution (Mosaic 2008). According to the Bill of Rights, sexual and reproductive rights include the following:

- The right to life;
- The right to freedom and security;
- The right to equality;
- The right to privacy and confidentiality;
- The right to freedom of thought; and
- The right to information and education.

Cooper *et al* (2004) observed that South African reproductive health policies and the laws that underwrite them are among the most progressive and comprehensive in the world in

terms of the recognition that they give to human rights, including sexual and reproductive rights.

Reviewing the progress made in reproductive health and rights in the first 10 years of democracy in South Africa, Cooper *et al* (2004) observed that, despite important advances, significant changes in women's reproductive health status are difficult to discern, given the relatively short period of time and the multitude of complex factors that influence health, especially inequalities in socioeconomic and gender status. Gaps in the implementation of reproductive health policies and in service delivery remain and need to be addressed in order for meaningful improvements in women's reproductive health status to be achieved.

A recent assessment of South Africa's progress in reproductive health and rights indicated that while South Africa has a range of progressive sexual and reproductive health and rights policies and legislative provisions, it is not reflected in adequate services. Services are not integrated and there are inequalities benefiting urban areas. There are specific concerns regarding the provision of services within very narrow parameters. Vertical transmission services tend to serve unborn babies as opposed to women who are choosing to be pregnant. Sexual and fertility intentions are also not well managed in relation to contraception, abortion and sterilisation. Some HAART drugs are also contra-indicated in pregnancy and breastfeeding and this has enabled practices which are not inclusive of patients' rights (Stevens *et al* 2008).

5.14 Policies and programmes in place in South Africa to improve maternal health

Cooper *et al* (2004) have highlighted major legislative and policy changes influencing reproductive health in South Africa as follows:

- **1994**
  - The Department of Health established partnerships to plan, process and review the HIV/AIDS Policy, focusing on the prevention of new HIV infections and treatment of AIDS-related opportunistic infections.
  - Free public health services for pregnant women and children under six years of age.
- **1995**
  - Government ratifies the United Nations Convention on the Elimination of All Forms of Discrimination against Women.
- **1996**
  - The Choice on Termination of Pregnancy Act (Act No. 92 of 1996) provides a legal framework for the provision of abortion services.
- **1997**

- Maternal death made a notifiable condition; Standing National Committee for Confidential Enquiries into Maternal Deaths.

- Patients' Rights Charter launched, giving patients the knowledge and right to address issues of equality in health care services.

- **1998**

  - New Population Policy introduced, delinked from population growth.

  - South African National AIDS Council formed.

  - Domestic Violence Act (Act No. 116 of 1998) passed.

- **1999**

  - Prevention of mother-to-child transmission of HIV programmes introduced in the Western Cape.

- **2000**

  - National Guidelines for the Cervical Screening programme launched.

- **2001**

  - PMTCT programme introduced in Gauteng.

- **2002**

  - Treatment Action Campaign and Children's Rights Centre win a court application ordering government to implement a comprehensive PMTCT programme to prevent mother-to-child HIV transmission and to roll out PMTCT services countrywide.

  - National Contraception Policy Guidelines launched.

  - Government approves the provision of HIV post-exposure prophylaxis to survivors of rape in public sector facilities.

- **2003**

  - Government approves a plan to provide antiretroviral drugs to people with AIDS through public sector health services.

- **2004**

  - Sexual assault legislation under review to amend the definition of rape and enforce heavier sentences.

Notable policy frameworks influencing reproductive health in South Africa since 2004 include the following:

- **2006**

  - Broad framework for HIV and AIDS and STI Strategic Plan for South Africa 2007–2011.

- **2007**

  - A policy on quality in health care for South Africa.

  - HIV and AIDS and STI Strategic Plan for South Africa 2007–2011.

- **2008**

  - A policy and guidelines for the implementation of the PMTCT programme.

5.15 Key actions required to fast track the achievement of Goal 5

The recommendations provided by the Saving Mothers 2005–2007 Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa are recommended in this study as key actions required to fast track the achievement of MDG 5 in South Africa. These 10 critical recommendations are as follows:

- There should be standardised protocols to manage the important causes of maternal deaths. Doctors and midwives should be trained to use these protocols.
- Training in practical obstetrical and surgical skills should be imparted to all health professionals working in maternity units. Anaesthesia skills must be improved, especially at level one hospitals.
- Pregnant women should be informed, screened and appropriately managed for diseases, including HIV, STIs, tuberculosis, pneumonia etc.
- The referral process between hospitals must be clarified and used properly across all provinces.
- Postnatal care must be strengthened.
- Staffing and equipment norms must be established for every health facility caring for pregnant women.
- Blood for transfusion must be available at every clinic where caesarean sections are performed.
- Contraceptives and education about it must be provided.
- Death as a result of unsafe abortions must be reduced.

- Women, families and communities must be mobilised to actively participate in programmes to improve reproductive, maternal and neonatal health. (Department of Health, 2008).

5.16 Conclusion

South Africa's reproductive health policies and the laws that underwrite them are among the most progressive and comprehensive in the world in terms of the recognition that they give to human rights, including sexual and reproductive rights (Cooper *et al* 2004). While South Africa has a range of progressive sexual and reproductive health and rights policies and legislative provisions, it is not reflected in adequate services (Stevens *et al* 2008). The maternal mortality ratio in South Africa is high and still increasing. The current level of maternal mortality is far higher than the Millennium Development target of 38 per 100 000 live births by 2015. Despite the high level of maternal mortality, over 90% of pregnant women currently have access to antenatal care in South Africa and with a contraceptive prevalence of over 60%; South Africa has about the highest contraceptive prevalence rate in sub-Saharan Africa.

5.17 References

Adekunle C, Filippi V, Graham W, Onyemunwa P, & Udjo E. 1990. *Patterns of maternity care among women in Ondo State, Nigeria*. In, Hill AG. (ed): Determinants of health and mortality in Africa.

Cooper D, Morroni C, Orner P, Moodley J, Harries J, Cullingworth L & Hoffman M. 2004. Ten years of democracy in South Africa: documenting transformation in reproductive health policy and status. Reproductive Health Matters 12(24): 70-85. http://goliath.ecnext.com/coms2/summary_0199-3557620_ITM

Demographic and Health Surveys Further Analysis Series, no. 10, pp1-45.

Department of Health, Medical Research Council & ORC Macro. 1999. *South Africa Demographic and Health Survey, 1998*. Pretoria: Department of Health.

Department of Health. 1999. South Africa Demographic and Health Survey, 1998. Pretoria: Department of Health.

Department of Health, Medical Research Council & ORC Macro. 2007. South Africa Demographic and Health Survey 2003. Pretoria: Department of Health.

Department of Health. 2008. Saving Mothers: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa, 2005–2007. Pretoria: Department of Health.

Department of Health. 2008. Progress Report on Declaration of Commitment on HIV/AIDS, Republic of South Africa. Reporting Period January 2006–December 2007. Prepared for the United Nations General Assembly Special Session on HIV and AIDS. Department of Health: Pretoria.

Howard D. 1987. *Aspects of maternal morbidity: the experience of less developed countries*, In, Jeliffe, DB & Jeliffe EFP (eds) Advances in Maternal and Child Health vol 7, 1–35. Oxford: Clarendon.

Human Sciences Research Council. 2007. Proposal on Indicators for monitoring and evaluating the implementation of the Children's Act in South Africa. HSRC. Monograph.

MOSAIC. 2008. *Your guide to sexual and reproductive health and freedom from abuse*.

www.moasic.org.za/SRH1.pdf

Rosenfield A, & Maine D. 1985. The coverage of maternity care: A critical review of available information. *World Health Statistics Quarterly*, 38(3), 267–273.

Stevens M. 2008. The Fourth Public Health Association of South Africa Conference, 2–4 June 2008, Cape Town.

UNFPA. 1997. The State of the World Population Report 1997.
http://www.unfpa.org/swp/1997/chapter1.htm

UNICEF. 2008. The State of the World's Children Report 2008.
http://www.unicef.org/sowc08/