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Maternal Health[1]

"Maternal mortality and morbidity continue to exact a terrible toll on women, and especially impoverished women, in many countries worldwide. Some 287,000 women died of maternal causes in 2010, and between 10 and 15 million more suffer debilitating complications annually, severely affecting their well-being. The World Health Organization (WHO) estimates that from 88% to 98% of maternal deaths are preventable. Millennium Development Goal 5 calls for a 75% reduction in maternal mortality ratios from 1990 levels and universal access to reproductive health by 2015".

- Guidance Document to the UN Human Rights Council, Sept 2012

1. Introduction

According to the World Health Organization (WHO), maternal health refers to "the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour".[2] As is clear from the above, maternal health is by no means guaranteed. Research conducted by the WHO indicates that this perilous state of affairs, particularly in sub-Saharan Africa, is a consequence of limited access to both skilled routine and emergency care. There is a paucity of primary health services and very little in the way of crisis intervention and treatment in the public health sector. This lack compromises the health and well-being of both mothers and their children.

2. The Millennium Development Goals

The Millennium Development Goals (MDG) were adopted by the United Nations in 2001, and are commonly accepted as a framework for measuring developmental progress. The eight MDGs – which range from halving extreme poverty rates to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015 – form a blueprint agreed to by all the world's countries as well as the world's leading development institutions. The MDGs strive to ameliorate the plight of the world's poorest people. The health-related MDGs involve reducing child and maternal mortality, as well as HIV/AIDS, malaria, tuberculosis and other diseases by 2015. Goal 5 seeks to improve maternal health, and is divided into two parts: A focuses on the reduction by three quarters of the maternal mortality ratio, while B focuses on the achievement of universal access to reproductive health.[3]

These goals resonate with sections 27, 28 and 29 of the Bill of Rights of the South African Constitution, which set out the obligations of the state in terms of social and economic rights; it is effectively these rights that constitute the key social determinants of health. These include health-care services, food security, clean water and sanitation, as well as social security. The Constitution allows for the progressive realization of these rights as the necessary resources become available. However, Section 27 states, without qualification, that no one may be refused emergency medical treatment.[4]

At a special event at the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), African heads of state pledged new commitments for reducing maternal mortality, recognizing the need to accelerate progress on child and maternal health targets in

an African context.[5] At the time of the UN Summit on Sustainable Development held in Rio de Janeiro, Brazil in mid July 2012, the World Bank commented that "although most African countries are off-track on most of the MDGs, the continent has arguably been making the greatest progress towards the goals. The poverty rate has been declining at about one percentage point a year, with some evidence that child mortality in Africa, after stagnating for some time, is beginning to fall sharply".[6]

3. Pre-term Maternal Health

Proper health-care during pregnancy, birth and the post-natal period is essential. There are several indicators for maternal health during pregnancy and at the time of birth. These include adequate nutrition for expectant mothers; effective antenatal care; early initiation of breastfeeding; family knowledge of danger signs in pregnancy; access to emergency obstetric and neo-natal care; and a skilled attendant present at every birth.[7] However, for those who live in poverty, and especially those who live in poor circumstances in remote areas, this is frequently not the case. A UNICEF study shows – unsurprisingly – that people living in poverty frequently have the poorest diets, live in the most crowded and dangerous conditions, and have the highest exposure to illness. The study reveals that on average only one in four women in the poorest 20% of households has access to a skilled birth attendant, compared to nine out of ten of those in the top 20% of households in the same country. Furthermore, "infectious diseases are characteristically diseases of the poor and vulnerable, who lack access to basic prevention and treatment interventions".[8]

South African society is characterized by a high incidence of maternal poverty as well as a high number of non-marital births, which further compromise maternal well-being. The breakdown of the extended family and the support it provides for mothers means that many mothers give birth to and rear children in isolated circumstances without inter-generational support. This also means that the child-care training and the passing on of maternal skills from one generation to the next is frequently absent.

Moreover, access to health care services during pregnancy and post-partum in terms of distance and the costs of transport, may be difficult in both urban and rural areas. Furthermore, not all public health-care facilities have the relevant medical technology and testing equipment necessary to identify potential problems. This means that in difficult pregnancies referrals may be made too late. There are also very few obstetric ambulances. [9] Such difficulties in accessing health-care also translate into a paucity of ante-natal and post-natal counselling and care.

Another cause of concern is teenage pregnancies, which result in 36% of maternal deaths despite only constituting 8% of pregnancies. Young girls may be physically ready to conceive, but not necessarily ready to deliver. There is much anecdotal evidence to suggest that many young girls seek out medical help only late in their pregnancies. This may be due, in part, to the high levels of sexual abuse in our society, which leads some girls to try to hide their pregnancies, and which – if the abuse is within the family – makes it difficult for them to turn to those nearest them for help.

4. The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)

Although South Africa was one of the last countries to introduce the CARMMA Campaign, President Zuma said at the African summit in Addis Ababa, Ethiopia earlier this year that South Africa had developed a national 'dashboard' to implement the campaign, which includes eliminating mother-to-child transmission of HIV; expanding access to maternity waiting homes; dedicated obstetric ambulances to transport women in labour to the most appropriate and accessible health care facility; training of medical staff to deal with child birth emergencies which compromise the health and well-being of both the mother and infant[10]; and the promotion of the presence of birth companions during labour. Furthermore, the campaign promotes the post–natal review of mothers and babies six days after delivery, which would provide the opportunity for an assessment of any difficulties and the consequent provision of the appropriate health and/social service intervention.[11] The campaign also supports the training of 'lactation' consultants as support for new mothers. All these improved services, more trained midwives, and properly implemented and sustained comprehensive immunization programmes, would do much to ensure improved maternal and

child survival.[12]

5. Mental Health and Well-Being

Many new mothers experience post-partum depression. While the so called 'baby blues' may be short-term, they may become more chronic. Dr Crick Lund, head researcher for the Mental Health and Poverty Project, argues that research shows that the prevalence of post-natal depression is much higher in rural areas than in urban surroundings. "Poverty is one of the main drivers. These women are living under conditions of extreme poverty and multiple deprivations. People in poorer communities are at greater risk of problems which impact on the higher rate of post-natal depression."[13] Lund goes on to say that other contributing factors to post-natal depression include lack of emotional support, unemployment, breakdown of family structures, HIV and Aids, and limited access to social and health services. "It is vitally important that state hospitals integrate a basic assessment for mental health in pregnant women as part of the routine check-up. Women should be screened for depression and anxiety during pregnancy and then referred to counsellors if necessary."[14]

Furthermore, Dr Simone Honikman, founder of the Peri-natal Mental Health Project at Mowbray Maternity Hospital in Cape Town, says that an audit and internal evaluation process showed that almost 35% of 5 000 women screened at the facility presented signs of post-natal depression.[15] Socio-economic circumstances play a clear role in maternal depression and impact greatly on the quality of nurture new mothers are able to give their infants. This points to the urgent need to give priority to the realization of socio-economic rights. The quality of nurture children receive has major consequences for their physical and psychological well-being, which in turn plays a determining role in the kind of society we are 'growing'. Furthermore, the realization of these socio-economic rights is a constitutional imperative, as section 28 of the Bill of Rights guarantees children the right to "basic nutrition, shelter, basic health-care services and social services".[16]

6. Conclusion

Studies conducted by UNICEF[17] and confirmed by the experiences of hospitals such as St Mary's District Hospital in Mariannhill, Kwa-Zulu Natal, confirm that directing resources at preventive and treatment programmes for the poorer and more remote communities – who have limited access to health information and services – provides the highest return on health investments for mothers and their children.

A healthy cohort of young mothers, with access to information, resources and treatment, is a fundamental step to a healthy nation. If the family is the basic building-block of society, it is fair to say that maternal health is a basic building-block of the family.

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[1] Dr Douglas Ross, the CEO of St Mary's Hospital in Mariannhill, Kwa-Zulu Natal presented a paper on 'Maternal Health' at a Roundtable Discussion on this topic hosted by CPLO, World Vision and the Catholic Health Care Association. Dr Ross is also the Chairperson of CATHCA. This paper owes much to his presentation and to the discussion which followed

[2] WHO Fact Sheet 2013

[3] 'We can end Poverty by 2015' Millennium Development Goals-A Gateway to the UN System's Work on the MDG

[4] Prof Louis Reynolds, Opinion on IFAISA, October 2012

[5] CARMMA is discussed further below.

[6] Bua News 2nd July 2012

[7] Some medical practitioners include the delayed birth of a family's first child, and a gap of three years between each child, as indicators of maternal health and well-being.

[8] Global Report for Research for the Control of Infectious Diseases of Poverty www.whqlibdoc.who.int/publications/2012/9789241564489

[9] There is a shortage of specialized ambulances for both paediatric and obstetric emergencies, so even if emergency transportation reaches the patient it may not be equipped to deal with the emergency at hand. This issue was raised on the CPLO Roundtable on Child Morbidity and Mortality held in October 2012 and the CPLO, World Vision, CATHCA Roundtable held in March 2013.

[10] Birth trauma may result in disability which, properly managed, could have been avoided.

[11] Dr Douglas Ross Presentation at the CPLO, World Vision and CATHCA Roundtable on Maternal Health, 20th March 2013
[12] SA Info 29th January 2013
[13] 'Depression rampant among poor' Subashni Naidoo, The Times, 8th February 2009
[14] A/Prof Crick Lund is the Director of the Centre for Public Mental Health and an Associate Professor in the Department of Psychiatry and Mental Health at UCT
[15] 'Integrating Mental Health Care in South Africa', Policy Brief 6, Centre for Public Mental Health, UCT, November 2008
[16] Section 28 (1)(c) of the Bill of Rights of the Constitution, Act 108 of 1996
[17] UNICEF Report on the Millennium Development Goals, Goal 5: Improve Maternal Health *www.unicef.org/mdg/maternal.html*