

The State of Maternal Mortality in South Africa

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Maternal mortality is a fundamental public health issue and Millennium Development Goal Five deals with an improvement in maternal health. Despite much extensive legislation pertaining to sexual and reproductive health and rights (SRHR), South Africa has been dogged by rising pregnancy-related deaths, leapfrogging its maternal mortality to new heights which renders meeting its MDG target of 38 per 100,000 live births in 2015 unlikely. A problem besetting maternal mortality in South Africa has to do with the fact the actual levels of maternal mortality are questionable given the varied estimations that have been put forward over the years by different organizations and researchers. The aim of the article is to highlight the state of maternal mortality in South Africa and reasons for its upward trend. The Post -2015 Development Agenda accords both maternal health and SRHR key prominence, thereby reaffirming the need for reliable maternal mortality estimates in the future.

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The death of girls and women from pregnancy-related complications and during childbirth are termed maternal deaths and it has always been a public health concern. However, its inclusion in the Millennium Development Goals (MDGs) as a separate Goal, namely Goal Five, gives it global prominence. In 2004 deaths due to pregnancy and childbearing accounted for 14% of deaths in the reproductive cohort globally (WHO, 2009). The biggest disparity between rich and poor countries is captured in the maternal mortality ratio as 99% of the more than half a million maternal deaths every year occur in developing countries. Maternal conditions were the most important leading cause of death in low and middle-income countries in 2004. Complications of pregnancy and childbirth are the leading cause of death in young women aged between 15 and 49 in developing countries (WHO, 2009). The disparities in maternal mortality levels between developed countries and developing countries has galvanized attention to the neglect of this area, making it a valid policy concern to the international development community (UNFPA, 2009).

Maternal mortality has been on an upward trend in recent years in some Southern African countries including South

Africa. MDG Goal Five deals with an improvement in maternal health and its target is a three-quarters reduction in the maternal mortality ratio between 1990 and 2015. Despite much extensive legislation pertaining to sexual and reproductive health and rights (SRHR), South Africa has been dogged by rising pregnancy-related deaths; its maternal mortality has leapfrogged to new heights which mean that it is unlikely to meet its MDG target of 38 per 100,000 live births in 2015. A problem besetting maternal mortality in South Africa has to do with the fact the actual levels of maternal mortality are questionable given the varied estimations that have been put forward over the years by different organizations and researchers. The aim of the article is to highlight the state of maternal mortality in South Africa and reasons for its upward trend given sweeping reproductive health legislation based on SRHR. The article starts with a contextualization of maternal mortality followed by a review of global and regional levels. A discussion of the reproductive health legislation and a review of different maternal mortality estimates follow. Lastly, reasons for the upward trend in maternal mortality are considered.

A contextualization of maternal mortality

MDG Five has a set target of a 75% reduction in maternal mortality by 2015 and it succinctly states that no women should die while giving birth but in reality 280 000 women die annually during childbirth. Furthermore, every year 40 million women give birth at home in the absence of skilled birth attendants (Save the Children, 2013). Maternal deaths have justly been labelled 'avoidable deaths' given the medical know how to date and are seen to constitute the 'most basic of inequities' given their higher incidence among poor and rural women (UNFPA, 2009; Ronsman & Graham, 2006). The term maternal death refers to "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (WHO, 1992, p.134). Maternal deaths may be induced by direct causes such as obstetric complications of pregnancy, delivery and puerperium or indirectly by on-going diseases or diseases that develop during the pregnancy that are worsened by the pregnancy (Winikoff, Carignan & Bernardik (1991). The most universal measure of maternal mortality is the maternal mortality ratio (MMR) which is the number of maternal deaths per 100,000 live births. Child mortality and maternal mortality are inter-connected in a unique way as the death of the mother has a strong bearing on the death of her young child, the increased risk of death being four-fold (UNICEF, 2012). A study from Bangladesh that analysed the probability of child survival to age ten when linked to the parent's mortality found that if the mother is alive, the probability of the child surviving to age ten is 89%, but that it falls to 25% if the mother dies (IOL News, 2013). Reducing child mortality is another MDG goal and it is another public health concern given the high levels in sub-Saharan African compared to the rest of the developed world.

Estimates of maternal mortality ratios for South Africa have been long questioned in the context of designating cause of death within the confines of the country's

HIV/AIDS epidemic. HIV/AIDS is seen to operate as both a direct and indirect cause of maternal mortality. As a direct obstetric cause, it could lead to complications such as anaemia, post-partum haemorrhage and puerperal sepsis. As an indirect cause, it heightens exposure to opportunistic infections such as pneumonia, tuberculosis and malaria (Mcintyre, 2003). The Saving Mother's Report for 2005-2007 found that HIV/AIDS was responsible for 43.7% of maternal deaths with the figure as high as 37.6% for the Eastern Cape. Furthermore, the Report added that in the absence of the HIV epidemic, South Africa's MMR would mirror that of other middle - income countries such as Brazil, Argentina and Thailand (Department of Health, 2011a).

Data problems besetting MMR estimates

A limiting factor in ascertaining maternal mortality is the inevitable fact that maternal deaths boil down to an extremely small number of cases, that is, they are about 5% as common as infant deaths. This causes national estimates to be erratic, a situation that is further compounded at a regional level, especially when household surveys are used as data sources. Furthermore, in those countries where the overall numbers of maternal deaths are very small, inconsequential changes in the numerator can impact unevenly on the maternal mortality ratio (AbouZahr, 2011). In most developing countries, estimates of maternal mortality are non-existent, outdated or of extremely poor quality. These shortfalls in estimates at a country level have led to global research institutes or bodies putting forth maternal mortality estimates for different countries. AbouZahr (2011) has cautioned that global estimates are dogged by suspicions, because they are often drawn up independently, in the absence of country-level experts.

In South Africa concerns over reliable maternal mortality data have long been voiced. The statistical system in South Africa before 1994 was largely dysfunctional and "deeply distorted" as it undertook data collection for only three population groups, that is, Whites, Coloureds and Indians and left out the African population who composed 70% of

the population (Statistics South Africa, 2000). Adar & Stevens (2000) early in 2000 noted that a key challenge confronting South Africa is that inadequate data on women's health issues stymies policy formulation. The 2009 Lancet Health in South Africa Series pointed out that reliable data for women and children were lacking and that substandard data affects both policy-making and programme intervention. Furthermore, they pointed out that such data gaps and lags impede progress at a time when a redress of the situation could put the country on track to possibly achieve Goal 5. Hence, they recommended an improvement in maternal health as one of their three areas of prioritization (Mayosi, Lawn, van Niekerk, Bradshaw, Abdool Karim & Coovadia, 2012).

The absence of reliable estimates in the past must also be blamed on the fact that a Demographic and Health Survey (DHS) has not taken place in South Africa since 2003 even though the 2003 DHS fell short in its attempt to put out an MMR estimate owing to deficient data. South Africa's lack of reliable maternal mortality estimates makes it difficult to track progress in MDG 5. Blaauw & Penn-Kekana (2010) also warn that estimates from individualized studies do not allow for the observance of trends. Worst still deficient data hinders effective interventions by planners (Udjo, 2006). Furthermore, quality data on maternal health indicators are an intrinsic part of the accountability process is intrinsic to the provision of maternal health care (Blaauw & Penn-Kekana, 2010; Human Rights Watch, 2011).

Global and regional trends in maternal mortality

A glimpse of global trends is given by the WHO, UNICEF, UNFPA & World Bank (2010) study that put the number of maternal deaths in 2008 at 358 000 with 99% (355 000) maternal deaths occurring in developing countries. Regionally, sub-Saharan Africa and South Asia accounted for 87% (313 000) of global maternal deaths, with nearly three-fifths of maternal deaths (204 000) taking place in sub-Saharan Africa. HIV/AIDS accounted for 9% of maternal deaths in sub-Saharan

Africa. The global MMR was 260 maternal deaths per 100,000 live births in 2008; for developed countries, it was 14 and for developing countries, 290. Among developing regions, sub-Saharan Africa had the highest MMR of 640 maternal deaths per 100 000 live births in 2008. The estimated largest percentage increases in MMR between 1990 and 2008 occurred in five countries, namely, Botswana (133%), Zimbabwe (102%), South Africa (80%), Swaziland (62%) and Lesotho (44%) (WHO *et al.*, 2010).

The 5th MDG calls for a 75% reduction in the MMR between 1990 and 2015 and requires an average reduction of 5.5% annually from the 1990 levels. Thus far, the global average percentage decline was 2.3 % whilst it was only 1.7% for the sub-Saharan bloc, which is well below the desired level. Of those countries whose MMR exceeded 1000 in 1990, 30 countries worldwide and 23 countries in sub-Saharan Africa have made insufficient or no progress (WHO *et al.*, 2010). There have been many evaluations of South Africa's progress with regard to its MDG targets for Goal 5. Way back in 2009, the 2009 Lancet Health in South Africa Series maintained that progress in MDG indicators for both Goals 4 and 5 were not good (Mayosi *et al.*, 2012). Chopra, Daviaud, Pattison, Fonn & Lawn (2009) likewise added that South Africa 'falls well short' in achieving MDG 5 evidenced on 2009 projections. Both the 2010 South African Millennium Development Goal country report and the 2011 Human Rights Watch report concluded that Goal 5 was unattainable (UNDP, 2010; Human Rights Watch, 2011). Even South Africa's institutional maternal mortality ratio (which only covers maternal deaths that occur in a public health care facility) signal a departure from the MDG target of 38 as the institutional MMR rose from 151.77 per 100 000 live births in 2005-2007 to 176.22 in 2008 -2010 (Department of Health, 2011a; 2012c). The Mother's Index which is compiled annually by Save the Children (2013) ranks 176 countries in terms of how they fare with regard to women's health, children's health, educational levels, economic well-being and women's participation politically. South

Africa ranked a mere 77 while Tunisia and Libya were ranked ahead of South Africa (56th and 57th respectively). Sub-Saharan Africa carries the worst risk with the ten tail end countries located in this region, namely, Cote d'Ivoire, Chad, Nigeria, Gambia, Central African Republic, Niger, Mali, Sierra Leone, Somalia and DR Congo.

Growing concerns about maternal deaths

The high number of maternal deaths in South Africa has been brought up many times over. Following the reforms in reproductive health, the country's high maternal mortality ratio was identified as a major population concern in its Population Policy introduced in 1998 (Department of Welfare & Population Development, 1998). Way back in 2000, Adar & Stevens (2000) maintained that the number of maternal deaths were wantonly high despite the influence of HIV/AIDS. The 2009 Lancet Health in South Africa Series labelled maternal mortality one of the 'colliding epidemics' which South Africa still endured fifteen years into its democratic existence (Mayosi *et al.*, 2012). Furthermore in 2010 the Minister of Health signed a performance appraisal contract with the President pertaining to four issues, the one being to decrease maternal and child mortality (Motsoaledi, 2012). Following this, three national committees were set up, one dedicated to maternal health. In a scathing report published in 2011 Human Rights Watch decried high levels of MMR in South Africa despite the country having the highest per capita health expenditure in sub-Saharan Africa, progressive reproductive health legislation that explicitly endorsed the right to health, antenatal care attendance rate of 92% and where approximately 87% of all deliveries take place in healthcare amenities (Human Rights Watch, 2011; Moszynski, 2011).

Sexual and reproductive health and rights (SRHR) in South Africa

The dawn of the new democracy in South Africa heralded the introduction of the most liberal and inclusive reproductive health legislation that was couched in human rights and sexual and reproductive health rights (SRHR) (Cooper, Morroni, Orner,

Moodley, Harries, Cullingworth & Hoffman (2004). More importantly, the fundamentals of South Africa's sexual and reproductive health policy were initially enunciated in the Reconstruction and Development Programme and therefore a forerunner to the international pronouncements made at the International Conference on Population Development (ICPD) in Cairo 1994 and the Fourth World Conference on Women (FWCW) in Beijing 1995 (Adar & Stevens 2000). This has led to reforms in reproductive health, pertaining to contraception, legalized abortion, maternal health, female cancers, violence and HIV/AIDS. In 1994 the Primary Health Care approach was adopted, free health care for pregnant women and children under six was introduced, maternal death were reclassified as a notifiable condition and the National Committee for Confidential Enquiries into Maternal Deaths was set up. In 1995 a directorate of Mother, Child and Women's Health was established (Cooper *et al.*, 2004). South Africa's Population Policy introduced in 1998 departed from its previous ambit focussing on population control to honing in on the empowerment of women and the inclusion of men in reproductive health matters (Department of Welfare & Population Development, 1998).

South Africa's performance in certain areas is notable. The focus on maternal and child health was evidenced by the construction of more than 1300 new primary health care facilities (Chopra *et al.*, 2009). One of the successes that the country can boast of is the fact that antenatal attendance is as high as 92% and that 87% of deliveries occur in health facilities (Human Rights Watch, 2011). The Confidential Enquires system of analysing maternal deaths has been operational in South Africa since 1996. (Cooper *et al.*, 2004).

Contraception provision was historically shrouded in suspicion but the new National Framework and Guidelines for Contraception Services announced in 2001 departed from the previous policy stance of "family planning" and aimed to increase women's choice and access to health services. By 1994 there existed over 65 000 contraception service points in the country

and contraceptive prevalence was over 60% (Cooper *et al.*, 2004; WHO, 2011). The 1996 Choice on Termination of Pregnancy Act allowed for termination on request for pregnancies of 12 weeks or less gestation which were to be provided by a doctor or certified midwife. The Act was bold and unequivocally stated that every woman has the right to a safe abortion regardless of her age. Its focus was to provide free Termination of Pregnancy (TOP) services to the mainly poor black women (Cooper *et al.*, 2004; Sangonet, 2012). Abortion was legalized in 1997 and the use of certified midwives to perform first trimester abortions was aimed at broadening access. Two years after the passing of the Act, a decrease in serious abortion-related mortality from 16.5 % in 1994 to 9.55 in 1999 was recorded (Cooper *et al.*, 2004). A subsequent amendment to the Act in 2003 put forward three important measures aimed at fulfilling its mandate of increasing access to black women. Firstly, it permitted any health facility with a 24-hour maternity service to offer first trimester abortion services and rescinded the need for ministerial permission. Secondly, it permitted all registered nurses who have completed the prescribed TOP training course and not only midwives to provide first trimester terminations. Thirdly, mifepristone was approved for the use in medical abortions up to eight weeks of pregnancy. The Amendment led to 38 clinics and 174 hospitals tasked to provide terminations (Cooper *et al.*, 2004).

Maternal mortality estimates in South Africa

Over the years, many different estimates of maternal mortality have been put forward and there are significant differences amongst them. In 1998 maternal mortality was estimated by the Department of Health to be 150 per 100, 000 live births which was not only the lowest in sub-Saharan Africa but was well below the international goal of 245 per 100,00 live births for the year 2015 (Udjo, 2006). Hogan, Foreman, Naghavi, Ahn, Wang, Makela, *et al.*, (2010) estimate that the MMR in South Africa as follows: 280 in 1980, 121 in 1990, 155 in 2000 and 237 in 2008. The WHO *et al.*, (2010:34) put the MMR in South Africa in

2008 at 410 per 100, 000 live births. South Africa's Minister of Finance in his 2010 Medium Term Budget Policy Statement described South Africa's maternal mortality as "high and rising" having increased from 369 in 2001 to 625 in 2007. The report ascribed the ascendancy of maternal mortality to HIV prevalence, complications arising from hypertension and shortfalls in obstetric services (National Treasury, 2010).

Based on the 2001 Census, Garenne, McCaa & Nacro (2008) put the MMR at 542 per 100, 000 live births in 2001 and recounted that their estimate is close to the figure of 575 obtained by Dorrington. Based on the 2007 Community Survey, Garenne, McCaa & Nacro (2009) estimated MMR to be 702 per 100,000 live births in 2007 which was a 29% rise over the 2001 figure. Maternal mortality estimates put forth estimates by Udjo & Lalthapersad-Pillay (2014) differs from both Garenne, (2008; 2009); Hogan *et al.*, (2010) and the WHO *et al.*, (2010) estimates. Using the same data sources as Garenne *et al.*, (2008; 2009), national estimates by Udjo and Lalthapersad-Pillay (2014) were 463 in 2001 and 764 in 2007. The Health Data Advisory and Co-ordination Committee (HDACC) that was set up to support the Negotiated Service Delivery Agreement (NSDA) acknowledges the fact that maternal mortality levels are contentious, owing to bias present in data and the poor recording of maternal deaths. They therefore recommended that the cause of death from Vital Registration adjusted for under-registration of deaths and misclassification of obstetric causes as ill-defined causes, be used to monitor maternal mortality ratio. Accordingly they set the baseline figure for the maternal mortality ratio at 310 for 2009 and the target for 2014 is 270 (Department of Health, 2012a). However, critics have questioned the exactness of the Vital Registration data as a data source (Udjo & Lalthapersad-Pillay, 2014). A conclusion that can be drawn from all these different estimates is that South Africa's MMR from all sources for 2001 exceeds the global estimate of 260 and that for developing countries (290) whilst the 2007 estimate surpasses that of sub-Saharan Africa (640).

Possible reasons for South Africa's high MMR

South Africa is classified by the World Bank as a middle income country and ranked as a medium human development country whose Human Development Index was 0.629 in 2012. It also spends 3.9% of its GDP on health (UNDP, 2013). Different reasons have been advanced to explain the upward trend of maternal mortality in South Africa. Some attribute it to HIV/AIDs whilst others see it as a by-product of improved reporting. South Africa's maternal mortality is anomalous given its expenditure on health (namely, 3.9% of GDP), the frequency of usage of health care facilities, its liberal reproductive health legislation and impressive indicators in terms of the uptake of antenatal care, and the proportion of deliveries that take place in health care facilities (Human Rights Watch, 2011). The factors responsible for high levels of maternal mortality cannot be disentangled from the inadequacies and inefficiencies that beset the health care system. Misgivings have been expressed at the expenditure on health vis-à-vis the improvement in health outcomes (Mayosi *et al.*, 2012; Chopra *et al.*, 2009). Several shortcomings have been levelled at South Africa's health care system which include huge patient volumes especially at district level, a lack of accountability on the part of management, low staff morale, lack of proper administrative and financial management, poor remuneration for some medical personnel, inadequate infrastructure and supplies, bureaucratic mismanagement as well as racial and geographic inequities (Mayosi *et al.*, 2012; Motsoaledi, 2012; Cooper *et al.*, 2004; Department of Health, 2010; Human Rights Watch, 2011).

The nature of maternal deaths in South Africa is that a large number of the women who died had received some health care through antenatal care and delivery at a health facility which implies that some of the deaths could have been avoided. The 2005-2007 Report found that 38.4% of the 4077 maternal deaths that occurred within the health care system were clearly avoidable (Department of Health, 2011a). The 2008-2010 Report found that 30.2% of

maternal deaths were avoidable ones (Department of Health, 2012c). Other reasons advanced by the Confidential Enquiries into maternal deaths include poor transport facilities, lack of proper health care facilities and lack of appropriately trained staff, the latter being responsible for an inability to follow standard procedures and poor initial assessment and diagnosis (Department of Health, 2011a).

Delivery of contraception and abortion services

Research unequivocally shows that providing women with choice is empowering as access to contraception and safe abortion services allow women to decide on the number of children they wish to have, the spacing of births and most importantly to avoid unwanted pregnancy (McCarthy & Maine, 1992). Research shows that planned pregnancies can help prevent close to 32% of maternal deaths (Osman, 2012). In South Africa, access to contraception is part of a two-pronged strategy to reduce child and maternal mortality, as well as to address high rates of teenage pregnancy (Department of Health, 2011b).

In South Africa the severity of the country's HIV/AIDS epidemic caused family planning and contraception to be side-lined with condom distribution being prioritised (Mail & Guardian, 2013). Contraception services is one component of family planning and despite every public health facility catering for basic contraceptives services, the efficacy of contraception services has long been questioned. However, an evaluation in 2008 of public sector facilities tasked to provide safe abortions found that only 52% were functional (Osman, 2012). Shortcomings identified in public sector facilities include poor service delivery in rural areas that hamper rollout, lack sufficient supplies, insufficient supply of information about contraception, limited knowledge and use of emergency contraception and substandard fertility management services (Cooper *et al.*, 2004; Osman, 2012). Also, the contraception method mix is narrow and is confined to hormonal methods (especially the long term injectable methods) and the

provision of condoms. Other methods such as implants are not provided and methods such as intra-uterine contraceptive devices are available at a few public health sector facilities, forcing potential users to turn to private sector facilities. Also the skills and training of frontline staff has been overlooked (Mail & Guardian, 2013; Osman, 2012). Young women also experience difficulties accessing family planning services which feed into the country's high teenage pregnancy rate. In 2009 nearly 80 000 girls under the age of 18 fell pregnant and even though the figure fell to 70 000 in 2010, it is still high (City Press, 2012).

The provision of abortion services has not been problem free. Although the Choice on Termination of Pregnancy Act is devoid of age restrictions, age still comes into play for young service users. Even knowledge about abortion is less than desired even though it was legalized in 1997. A study in 2006 found almost 30% of women still thought that abortion was illegal (Morrone, Myer & Tibazarwa, 2006). Despite the law change allowing free and legal abortion, it has not curtailed unsafe abortions and many young girls and women still chose to use the services of unprofessional service providers who illegally advertise their services at places such as taxi ranks and traffic intersections. A study by the South African Medical Research Council in 2010 found that 48.5% of abortions conducted on women aged between the ages of 13 and 19 occurred outside a hospital or clinic and can be termed unsafe (Osman, 2012). The number of deaths caused by unsafe abortions cannot be correctly quantified due to a lack of data (Sangonet, 2012). For the period 2005-2007, the Saving Mother's Report found that of these avoidable deaths, 25.7% were due to unsafe abortion. The number of women that died of a septic miscarriage was 186, 23% of which were due to unsafe abortion (Osman, 2012).

Harries, Cooper, Myer, Bracken, Zweigenthal & Orner (2007) also highlight the crucial role that the attitude of providers of health services play in terms of access to reproductive health services. Stigmatization and marginalization around the termination issue has not dissipated

(Ludman, 2012). It is common behaviour for public sector health care providers to admonish young women seeking legal termination and even to refuse them on the grounds that the weekly abortion quotas have been met (Sangonet, 2012). Another challenge is the shortage of health care personnel willing to provide abortions (Cooper *et al.*, 2004.) Even the physical locality of facilities providing free abortion services is imperfect. Inroads have been made by the Western Cape authorities in putting forth medical guidelines for abortion, as well disseminating information on those hospitals and clinics that provide abortion services. For the rest of the country, the system of abortion services provision is haphazard with some terminations being done at research outlets. The latest statistics show the number of legal abortions carried out in public facilities numbered 77 771, amounting to a 31% increase over the 2010 figure. However, only 1380 were in respect of women under the age of 18 which can be partially apportioned to the judgemental attitude of health care workers towards young women who opt for terminations (Ludman, 2012).

Conclusion

The shared view is that in South Africa extensive reproductive health legislation has not been accompanied by an improvement in women's health. Poor implementation and inefficient delivery strategies are fingered as the main culprit for this setback (Adar & Stevens, 2000; Cooper *et al.*, 2004; Human Rights Watch, 2011). Problems of accessibility and availability of family planning services epitomised the delivery of reproductive health policy. Equally flawed was the implementation of the Choice on Termination of Pregnancy Act, and its failure to curb cases of illegal abortions (Sangonet, 2012). In context of South Africa's sweeping sexual and reproductive health and rights (SRHR), the perceived outcomes need to be monitored and evaluated, as well as the state of SRHR in the country, bearing in mind that unplanned pregnancies add to the tally of maternal deaths and maternal morbidity.

South Africa's lack of reliable maternal mortality estimates must be positioned in terms of its commitment to SRHR as it is futile to introduce sweeping reproductive health legislation if their outcomes are not monitored and evaluated. Boosting knowledge of SRHR is essential for guiding women to improved health outcomes. Ineffective implementation and delivery strategies to operationalize reproductive health legislation did not allow for full expression of government's commitment to SRHR, failed to better women's health and to tackle the country's high teenage pregnancy rate.

In the 2011 State of the Nation Address, President Zuma reaffirmed government's pledge to maternal health and promised a renewed focus on expanding the scope of reproductive health rights, mainly the provision of services related to contraception and teenage pregnancies. The new policy seeks to promote an integral sexual and reproductive health service as part of the primary health care approach within a district health system. SRHR is to be endorsed by the Department of Health to spearhead integration in prevention, treatment and care and to consolidate the previous separate unit to achieve the MDGs. Furthermore, a human rights ethos is to be applied equally to both health service providers and service recipients (Department of Health, 2011b). The new contraception policy scheduled for 2013 spelt out five priorities. Firstly, improve the quality of services, broaden the choice of contraceptive methods to include copper intrauterine devices and hormonal implants and train to frontline staff. Secondly, better communication to aid knowledge and the availability of family planning. Thirdly, "dual protection" strategies to deal with unwanted pregnancies and protection against HIV infection. Fourthly, partnering with civil society and lastly, tracking progress (Mail & Guardian, 2013).

In February 2014 the Minister of Health announced the introduction of the subdermal contraceptive device, which is inserted by a medical professional under the skin of the upper arm, will be available at all public hospitals free of charge. The new device is hailed as providing protection

from pregnancy for three years and as well as allowing conception weeks after its removal. The Minister of Health has dubbed the new roll-out as the "biggest family planning programme South Africa has ever seen and that the contraception device gives women freedom to control their lives" (News 24, 2014). Furthermore nurses have been trained on how to insert the device with a further 4000 earmarked for training. The results forthcoming from this programme has important family planning policy implications for the rest of Africa (News 24, 2014).

The United Nations Millennium Declaration of 2000 enjoined all signatories to commit resources to meeting certain deliberate targets by 2015. One such resource has to be up-to-date data for tracking progress in terms of indicators. The fundamentality of data for intervention purposes was stressed in the Campaign for Accelerated Reduction of Maternal and Child Mortality (CARMMA) that the African Union adopted. South Africa has taken the first step by setting up the HDACC to oversee the quality for data but this does not go far enough. Other policy measures undertaken by the South African government include:

- Endorsing the Campaign for Accelerated Reduction of Maternal and Child Mortality (CARMMA). CARMMA also focuses on unwanted pregnancies in adolescents, the latter being instrumental in pushing up both maternal and neonatal deaths (Mayosi *et al.*, 2012; Department of Health, 2012b); and
- Drawing up the Maternal, Newborn, Child and Women's Health and Nutrition Strategic Plan (MNCWH), 2012-2016 (Department of Health, 2012c).

South Africa's upward trend in maternal mortality coupled with its lack of reliable estimates on maternal mortality is not in sync with the country's classification as a middle income country and a medium human development (HDI) one. One reason for the country's lack of reliable maternal mortality estimates is the fact that it failed to conduct a Demographic and Health (DHS) a decade after the 2003 one. The

problem of an absence of maternal mortality data is not confined to South Africa alone but is endemic of most developing countries and in particular sub-Saharan Africa. Furthermore, the issue on the need for reliable maternal mortality estimates should not be bogged down by dissent on the rigor of estimates produced or arguments about 'how high is high', the methodology applied and the data sources used. Such debates should not detract from admittance that South Africa's MMR has been upward bound and that the country is nowhere close to reaching its MDG target. Such neglect is harmful as it can be viewed as a failure to address the most basic of inequities (Ronsman & Graham, 2006).

The Post-2015 Development Agenda accords both maternal health and SRHR key prominence, thereby reaffirming the need for reliable maternal mortality estimates in the future. The importance of maternal mortality as a health issue is evidenced in its inclusion in the Post-2015 Development Agenda and 16 targets focus specifically on health. The health goal has five targets and two pertain to girls and women, the one goal being to reduce maternal mortality and the other to provide universal access to sexual and reproductive health services and rights, both of which reside within Goal 4. One example of a potential impact envisaged by the Post-2015 Development Agenda is that by 2030, the world would have 4.4 million more women who would otherwise have died during pregnancy or childbirth, labelling it a social ill that has to be eradicated (UN, 2013). Lessons gleaned from the MDG process must be logically applied to the Post-2015 Development Agenda and the lesson that South Africa must take is the acknowledgment that it needs to have reliable maternal mortality estimates to justly address health outcomes and concerns. Thus the logical conclusion stemming from South Africa's conundrum on maternal mortality estimates will be to undertake a Demographic and Health Survey (DHS) that will shed light on the true state of fertility, family planning, and maternal and child health in South Africa. At another level, South Africa is a member

of the BRICS association of countries which is gaining international recognition and South Africa is the only member of the grouping that failed to provide a figure for maternal mortality ratio in the 2013 Joint BRICS Statistical Publication (National Statistics Office of the BRICS Group, 2013). Such a situation does not augur well for South Africa's public health sector and more especially the relative health standing of its citizens vis-a-vis the BRICS members.

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