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Countdown to 2015: Status of MDG 5 in India and South Africa

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ABSTRACT

The World Health Organization constitution declares that it is a fundamental right of every human being to enjoy the highest standard of health regardless of their racial, religious, and political or socio economic background. Challenges in not attaining the Alma Ata declaration by the year 2000 brought governments together in signing a Millennium Declaration at the 2000 Millennium Summit. Eight millennium development goals (MDGs) with time controlled targets to measure progress were listed. MDG 5 identified two targets for assessing progress in improving maternal health: reducing the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015, and achieving universal access to reproductive health by 2015. The leading cause of maternal deaths worldwide is due to obstetric haemorrhage. Other direct causes of maternal deaths are due to ectopic pregnancy, embolism and causes related to use of anaesthetic. The World Health Organization (WHO) has recognised priority medicines for maternal health which form an essential constituent for combating maternal health complications. Sub-Saharan Africa and South Asia account for 84% of global maternal deaths, with haemorrhage as the leading cause of death in these regions. South Africa is a middle income country under the WHO Africa region, with a well-developed private sector and a stable macro-economy. Regrettably, South Africa appears amongst the 68 priority countries that have not made progress in reducing the maternal mortality rate since 1990. India, a lower middle income country also features amongst the 68 priority countries that have made insufficient progress in reducing their maternal mortality rate. With the countdown to 2015 drawing closer, the India and South Africa have a pressing obligation to take evocative steps to significantly decrease maternal mortality.

Keywords: Millennium development goal, maternal mortality, essential medicines, India, South Africa

INTRODUCTION

The Right to Health

The Universal Declaration of Human Rights under article 25 states that everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including medical care and necessary social services; additionally, women in maternity are entitled to special care and assistance.[1] Furthermore, the constitution of the World Health Organization (WHO) declares that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition".[2] Taking this into account, the year 1978 marked the assertion of the Alma Ata declaration at the WHO Geneva International Conference on Primary Health Care. The aim at this time was to address the need for imperative action by all governments, all health and development workers, and the world community "To protect and promote the health of all people of the world by 2000".[3] It is of importance to note that endorsing the right to health sequentially involves respecting and fulfilling human rights and also envisages the integration of a human rights-based approach in health development.[4]

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Launching of Millennium Development Goals (MDGS)

Conversely, challenges in not achieving the Alma Ata declaration within the envisioned time frame of the year 2000 led to the launching of a vision of Millennium Development Goals (MDGs) to improve the well-being of society, adopted by 189 United Nations member states at the 2000 Millennium Summit.[5] The Millennium Declaration listed eight Millennium Development Goals (MDGs) and time-controlled targets by which progress could be measured by 2015.[6] MDG 5 identified two targets for assessing progress in improving maternal health: reducing the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015, and achieving universal access to reproductive health by 2015.[7] The United Nations (UN) Human Rights Council has drawn more attention to the right to survive pregnancy, which is a subject bearing not only on advancement but also on human rights.[8] The UN Secretary-General's Global Strategy on Women's and Children's Health[9] and the ensuing Commission

on Information and Accountability for Women's and Children's Health have placed emphasis on reinforcement of accountability as an important but neglected approach for improving women's and children's health and reducing maternal mortality.[10] To connect accountability with human rights, the Commission developed its accountability framework on the right to health, fairness in health and gender rights.[11]

Global causes of Maternal Deaths

Maternal mortality is defined as 'the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or exasperated by the pregnancy or its management'.[7] Maternal mortality ratio (MMR) portrays the risk of maternal death relative to the number of live births.[6] The leading cause of maternal deaths worldwide is due to obstetric haemorrhage (24%), mostly during or just after delivery, largely preventable through skilled care during childbirth; followed by sepsis (15%); complications of unsafe abortion(13%) and eclampsia (12%). Other direct causes (8%) of maternal deaths are due to ectopic pregnancy, embolism and causes related to use of anaesthetic. Indirect causes (20%) are commonly due to infectious diseases such as malaria, TB and HIV/AIDS.[12]

Accessibility of Medicines

WHO has approved priority medicines for maternal health which form an essential constituent for combating maternal health complications.[13] Accessibility of medicines to the population in acceptable quantities, dosages and quality, and at affordable prices, is important. Unfortunately, disadvantages arise for patients from the public sector due to occasional unavailability of these priority medicines as a result of high costs and poor distribution systems.[14] It is required that countries keep a track record of medicines that are available as a way of measuring key indicators which influence the outcomes of maternal health. Under the Doha Declaration, the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement specifies that "Protection and enforcement of intellectual property rights should promote technological innovation, as well as the transfer and dissemination of technology, to the mutual advantage of producers and users of such technology and in a manner conducive to social and economic welfare".[15] In as much as countries should be bound by TRIPS this should not be the only guiding document when public health is at stake. As a result a provisional agreement, referred to as 'TRIPS flexibilities', incorporates provisions which permit governments to exercise measures to encourage public health and access to essential medicines such as priority medicines for maternal health.[16]

The Situation in Africa and South East Asia

Sub-Saharan Africa and South Asia account for 84% of global maternal deaths, with haemorrhage as the leading cause of death in these regions. Inevitably, countries with the highest number of maternal deaths are those with the largest populations. The lifetime risk of maternal death in the developing world as a whole is 1 in 76 compared with 1 in 8,000 in the developed world.[17] Giving birth is especially risky in Southern Asia and sub-Saharan Africa, where most women deliver without skilled care. The leading causes of maternal mortality in developing regions are haemorrhage and hypertension, which together account for half of all deaths in expectant or new mothers. Indirect causes, including malaria and HIV/AIDS are more common in sub-Saharan Africa.[18] The vast majority of these deaths are avoidable; haemorrhage, for example, which accounts for over a third of maternal deaths, can be prevented or managed through a range of interventions administered by a skilled health-care provider with adequate equipment and supplies.[19]

South Africa Maternal Health issues

South Africa is in the WHO African region and is an upper middle income country according to the World Bank classification.[20] The Human Development Index (HDI) Report provides a collective assessment of three basic components of human development: health, education and income. The HDI was created to emphasize that people and their capabilities should be the ultimate criteria for assessing the development of a country, not economic growth alone. South Africa's HDI is 0.619, which places it 123rd out of 187 countries.[22] The WHO Country health profile statistics for South Africa show a maternal mortality ratio of 410 per 100,000 live births as a country average in 2009.[23] South Africa's Gross Domestic Product (GDP) per capita in US$ is $9790 and the percentage GDP expenditure on public health is estimated at 8.5%[23]. While South Africa has an urban infrastructure, a well-developed private sector and a stable macro-economy, it suffers inequality in education, specifically as regards access to formal education and access to quality health care.[21] Regrettably, South Africa appears amongst the 68 priority countries that have not made progress in reducing the maternal mortality rate since 1990.[7]

Indian Maternal Health issues

India is a country in the WHO South East Asian region and, according to global classification by the World Bank, is a lower middle income country.[20] The HDI for India is 0.547 which ranks it 134th out of 187 countries.[22] India's Gross Domestic Product (GDP) per capita is US$2,930 and the percentage GDP expenditure on public health is estimated at 4.2%. The WHO Country health profile estimates show that

India has a maternal mortality ratio of 230 per 100,000 live births as a country average in 2009.[24] According to the Countdown to 2015 Decade report India also features amongst the 68 priority countries that have made insufficient progress in reducing their maternal mortality rate.[7]

Comparison of Health Profiles between India and South Africa

Table 1 shows the comparison of health profiles between India[24] and South Africa.[23] From the profile shown it is important to note that there is a high level of maternal mortality from both countries. Additionally, South Africa has a higher regional maternal mortality ratio of 620 deaths per 100,000 live births in comparison to India's 240 deaths per 100,000 live births in 2009. The presence of skilled birth attendants and doctors shows a lower country average for India showing 13.3% and 6% respectively in comparison to 40.8% and 7.7% for South Africa. Under the statistics for India there is a higher extent of inequality for access to health care, showing 37% of births attended by skilled birth attendants in rural areas in comparison to 73% in urban areas. South Africa shows 85% of births attended by skilled birth attendants in rural areas in comparison to 94% in urban areas showing more progress in narrowing the margin of this disparity. The South African government has regulations set in place to make internship and community service an obligatory requirement for all health care professionals to qualify for registration under their respective statutory health professional council. Placement for internship in the public sector is controlled by the department of health which results in allocation of a significant number of health care professionals to rural areas.[25] India does not have such registration requirements as mandatory[26] hence the shortage of skilled health professionals available to attend to births, particularly in the rural areas.[24]

Table 1: Health profiles of India and South Africa

Selected Indicators	India[24]	South Africa[23]
Location	WHO South East Asia region	WHO African region
Total population	1,198,003,000	50,110,000
Life expectancy at birth m/f (years)	63/66	54/55
Total expenditure on health as % of GDP (2009)	4.2	8.5
Maternal mortality ratio per 100,000 live births	Country: 230 Regional: 240 Global: 260	Country: 410 Regional:620 Global: 260
Prevalence of HIV per 1,000 adults	3	178
Health workforce: Nurses and midwives (%)	Country: 13.0 Regional: 13.3	Country: 40.8 Regional: 10.9
Physicians	Country: 6.0 Regional: 5.4	Country: 7.7 Regional: 2.3
Births attended by skilled health personnel (%)	Country:47 Regional:49	Country:91 Regional:49
Inequalities in health service utilisation for birth attendants by skilled health personnel (%):	Rural:37 Urban:73	Rural:85 Urban:94
Antenatal Care (4 + visits) (%)	Country:50 Regional: 52	Country: 56 Regional:44
Contraceptive prevalence	Regional:57	Regional: 26

The three Delays and Antenatal Care

The prevention of maternal mortality can be targeted at three levels: prevention of unwanted pregnancy, prevention of obstetric complications, and prevention of maternal death once complications have arisen[27]. The 'three delays' framework holds that delay in the decision to seek care, delay in accessing health care and timelines, and delay in quality of care on reaching health care facility contribute to a high mortality rate.[28] A delay in the decision to seek care is often due to reasons such as failure to recognise complications and social barriers such as lack of decision making abilities, lack of resources and the cultural beliefs and practices surrounding childbirth and delivery as preference may be given to consulting a local traditional healer [29].A delay in accessing health care can be influenced by factors such as poor roads and transport systems. A delay in receiving quality health care is often due to inadequate facilities, supplies, finances and training of health personnel. [27, 29] The antenatal period is an important time for reaching women with interventions and information that foster their health, well-being and survival including that of their infants.[27, 30] At least four antenatal care visits during pregnancy are recommended by the United Nations Population Fund (UNFPA) and the WHO as the minimum necessary to provide important services such as diagnosis and treatment of hypertension in pregnancy as this prevents maternal health complications namely eclampsia.[30]

Success achieved in some Countries

According to the MDG 2011 report, the estimates of maternal mortality globally show that Eastern Asia, Northern Africa, South-Eastern Asia and Southern Asia have made the greatest strides in reducing maternal mortality. Between 1990 and 2008, 90 countries showed declines in their maternal mortality ratios of 40% or more, while another 57 countries reported at least some gains.[19] Progress is evident from countries such as Bangladesh and Ethiopia, which have achieved reducing maternal mortality by efficient development of policies and strategies aimed at increasing access to effective interventions, such as the prioritisation of a national safe maternal initiative by both the government and donors, where they focused on recruiting more doctors, nurses and trained birth attendants showing feasibility of positive results in committed countries.[18, 19] As a way forward South Africa and India can adopt and reinforce the strategies that these countries have put into operation.

As a region sub-Saharan Africa remains furthest from meeting the MDG of maternal health, whereas individual African countries such as Ethiopia, a low income country, are making sufficient progress towards improving maternal health and other MDGs.[31] In some parts of Ethiopia over half the girls are married by the age of fifteen with expectations of bearing children, and they have a high risk of encountering complications, often leading to maternal death.[19,31] However, targeted interventions by the Ethiopian Ministry of Health and its partners resulted in improving maternal health by training and deployment of more than 30,000 female health extension workers (HEWs) in order to provide maternal patients with maternal health care and forefront referrals for patients with complications to health facilities, particularly in remote rural areas.[31] Due to these initiatives, maternal mortality in Ethiopia has decreased by almost 30% in the past 10 years. The MDG Review Summit reported that maternal mortality has considerably declined over the last decade in Ethiopia, from 937 maternal deaths per 100,000 births in 2000 to 673 maternal deaths per 100,000 births in 2010.[32] In 1987, a Safe-Motherhood Strategy was launched as a project in Bangladesh among six other countries by international agencies and governments together with WHO and UNFPA with the aim of increasing worldwide awareness of the challenges of maternal mortality and to increase coverage of births attended by a skilled health professional.[33] Bangladesh was largely influenced by cultural practices, compounded by the relatively high cost of seeking care, meaning that most women gave birth at home and relied on traditional birth attendants to assist during delivery. Following the implementation of this strategy, the percentage of women using a health care facility to give birth increased to nearly 40%. Additionally, the percentage of births with a caesarean section to save the mother's life also increased, from nearly zero in the early 1990s to 5% or more in 2005.[34]

The progress made by the above mentioned countries can be attributed to the influence of modification in the knowledge, attitudes and practices of the relevant communities from which positive change with regard to improving maternal health was noted. Several factors influence how health care workers receive information, interpret it and use it in interactions with their patients.[35] A thorough understanding of these factors is important in order to improve the effectiveness of how information and health services can be delivered to the patients. The Knowledge Attitudes Practices (KAP) model assumes that increased knowledge will lead to new attitudes and therefore changed practice. However, there are limitations to this model as knowledge, beliefs and attitudes though interrelated do not necessarily envisage similar actions.[36] A health care professional is trained to apply the principles that pertain to treatment and professional consultation with patients. At a personal level, however, he or she also subscribes to cultural values and norms within the community in which he or she resides. This can be used positively to effect a change in the attitudes of the community pertaining to maternal health by initiating educational programmes with the leadership of the community.

Moreover, for a community to be willing to forfeit their beliefs and practices surrounding maternal health there must be recognition of the impact of the problem within that immediate community, as exemplified by Bangladesh.[33,34]

CONCLUSION

Gender equality and the empowerment of women form the core of the MDGs and are thus imperative preconditions for overcoming poverty, hunger and disease.[37] The education of women is crucial in facilitating their empowerment in making informed decisions about seeking antenatal care, family planning and use of contraception.[38] The dearth of legal accountability for maternal deaths caused by health system malfunction, socio-economic inequality and discriminatory societal customs negatively influences successfully reducing maternal mortality. Maternal deaths do not only involve a tragic loss of life, but also collectively represent profoundly ingrained gender discrimination and social injustice.[39] From the 56th session of the Commission of the status of women held in New York in February 2012, it is promising to note that both India and South Africa have agreed to work jointly with the international community in the empowerment of rural women.[40,41] The maternal health indicators of a nation echo its hard work and ethos to advocate and protect women's dignity and basic human rights. Therefore, a high incidence of maternal mortality indicates a breach of international legal obligations to protect women's most important human rights: their rights to life, health, reproductive autonomy, equality and non-discrimination.[42] India and South Africa have a pressing obligation to take evocative steps to significantly decrease maternal mortality by fully executing national policies on maternal health and holding those responsible for the failure of its policies accountable.[40-42] With the countdown to 2015 drawing closer, examples of success stories from other countries mentioned in this article highlight that there are lessons to be learned and knowledge to be pooled among countries that are succeeding and those still struggling to improve maternal health.[43]

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