IMPACT OF MATERNAL MORTALITY AND MORBIDITY ON ECONOMIC DEVELOPMENT

Woodrow Wilson International Center for Scholars’
GHI
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Dr N. Xundu – Embassy of South Africa,
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OUTLINE

- Contextual space
- Continental Initiatives
  - Macroeconomics of Sexual and Reproductive in Africa
  - Socio-demographic factors
  - The good news about Africa
- South African situation
  - Socioeconomic demographics
  - Maternal mortality and morbidity in South Africa
  - Health systems solutions
  - Government commitments and targets
- Conclude - Beyond health systems: “Turning resources into results for people”.

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Context

- **Global**
  - Sensitised and energised universe
    - G8 Muskoka Declaration
    - Joint Plan of Action for Women’s and Children’s Health of the SG - UN
    - Outcomes of the recent Mothers Deliver conference held in Washington, D.C. a few weeks ago
    - Global Health Initiative of the Obama Administration
    - XVIII International AIDS Conference recently held in Vienna, Austria
    - Upcoming UN High-Level Meeting “MDG + 10 Summit” in September
  - **Continent**
    - Declaration: ‘Action for Accelerated Achievement of Maternal, Newborn and Child Health and Development’ – Call for action
    - Adoption of the Women’s Decade: 2010 -2020
      - “From Agenda to Action - Turning Resources into Results for People”
      - Panel of leaders – Chaired by Mr Kofi Anan
Spirit of CARMMA

- Not about some "intangible energy"
- Specific advocacy strategy – launched in May 2009 – to raise awareness and build links with international campaigns
- “Africa cares: No Woman Should Die while giving Life”
- Positive messaging, acknowledging and building on successes, and intensifying high-impact interventions
- Promoting sustainable financing
- Strengthening partnerships
- Buttresses and bolsters continental policies and strategies
  - Maputo plan of action (2007 – 2015) for operationalisation of existing frameworks (recently extended from 2010 to coincide with MDG period
- Launched in about 20 countries in the continent to date
MACROECONOMICS OF SEXUAL AND REPRODUCTIVE HEALTH IN AFRICA

- Quantifying productivity gains of preventing maternal deaths
- Family planning
  - Preventing unwanted pregnancies
  - Promoting declines in fertility
  - Reducing induced and unsafe abortions
  - Reducing other health expenditures
  - Reducing infant mortality related to teenage pregnancies
  - Improved gross national product
- Maternal mortality and morbidity (MMM)
  - Quantified cost of maternal deaths and disabilities in lost productivity gains
  - Women make up to 70% of Africa’s labour force – overrepresented in agriculture sector – producing 80% of food in rural areas
  - Death and disability is a direct cost to the economy in these regions
MACROECONOMICS OF SEXUAL AND REPRODUCTIVE HEALTH IN AFRICA

- Gender dynamics of the labour force
  - Gender inequality remains an issue within the labour markets
    - Higher unemployment rates than men
    - Poor access to labour markets
      - Employment-to-population rates lower than male counterparts
    - Vulnerable employment (unpaid care work)
      - Heavily engaged in household activities
    - Insecure employment with low earnings and low productivity – mostly not by choice
      - Differences in skills, work experience and sheer discrimination (social norms)
      - Rural-to-urban migration of men
      - Limited access to technical support
      - Poor access to credit (<10% of all credit and 1% of total credit goes to agriculture)
      - Low land ownership and ownership of low quality land than men
lower remuneration compared to male counterparts – especially in Northern Africa

- Gender wage differential is high – women earn 17% less than men (occupation, age, education, work experience, job tenure, training, seniority in job, segregation in job, etc)
  - Sometimes not justified by the above – just sheer discrimination
  - Regulations, practices concerning work and family life, etc

- Working poverty - Working but also fall below poverty line
- Poverty-induced child labour

Physical infrastructure is an important factor
- Roads, bridges, schools, clinics, social care, general community-social infrastructure not supportive to gainful employment for women and the economy

- Serious issues regarding equality and opportunity
- There are opportunities for intervention along the whole continuum of care on maternal mortality and morbidity for the benefit of women, families, communities, and indeed economies
SOCIO-DEMOGRAPHIC FACTORS

- Population in most African countries are young
  - Children < 15 years = 42% of population
  - Up to 30 years = 70% of the population
    - High fertility rates, high rates of teenage pregnancies
    - Large but poor undernourished families
    - High rates of HIV infection & mother-to-child transmission

- About 20% survive on < US$1 a day

- Half the population in Africa lives in extreme poverty and a third in hunger

- Inequality, lack of respect for people’s rights, poverty, lack of social protection, cultural values and practices, weak health systems are important determinants of maternal morbidity and mortality in the continent

- Health systems issues
  - Inadequate health force
  - Shortage of midwives
  - Weak intersectional collaboration
  - Poor service delivery and utilisation
  - Inadequate health financing
  - Poor coordination of interventions
  - Unfavourable legislations
AFRICA AS AN ECONOMIC FRONTIER – SOME GOOD NEWS

- Discover of oil, gas, precious metals and other resources
- Increasing trade within the continent and internationally
- Economic growth expected to climb after the recent economic growth slump
- Turnover of African banks and cooperates is increasing
- Domestic revenues and foreign direct investment, remittances and ODA climbed steadily over the last decade
- Progress with MGDs slow: although necessary, economic growth and increased trade are not sufficient for genuine progress!
  - Improvement in the quality of life of every African woman, child and man
  - Is the growth exclusive? Does it reinforce and result in inequality?
  - Has it failed people in rural areas or people in search of work?
- How do we turn the oil, gold, diamonds, and gas into results?
REPUBLIC OF SOUTH AFRICA
Provinces

- Limpopo
- Mpumalanga
- North West
- Gauteng
- Free State
- KwaZulu-Natal
- Northern Cape
- Western Cape
- Eastern Cape
SOUTH AFRICA

- Mid-year population estimates for 2010
  - 49.99 million (was 44.819 at last census in 2001)
  - 51% of population female (25.66 million)
  - Of the 9 provinces; Gauteng (GP) and KwaZulu Natal (KZN) have the largest share
    - 22.4% and 21.3% respectively
  - Nearly one third is aged < 15 years
    - Most of whom are in KZN
  - Outmigration from the mostly rural provinces of Eastern Cape and Limpopo to GP and Western Cape, driven by economic activity
  - Life expectancy at birth at 53.3 years for males and 55.2 years for females
  - Infant mortality rate at 46.9 per 1,000 live births (decline from 51 in 2001)
  - Fertility declined from 2.86 per woman in 2001 to 2.38 in 2010 (1.4% to 1.06%)
  - Overall HIV prevalence at 10.5% and 17% for adult population (15-49)
Black African are in majority (39.68 – 79%)

Increased economic activity recently

- Manufacturing industry
- Mining and quarry industry
- Finance, real estate and business services industry
- Wholesale, retail, motor trade and accommodation industry and general government services have some contribution

31 million are in age-group 15-64

- Labour force is 17.5 million
- Employed = 12.7 million (labour force participation 54.3%)
  - 9.3 in formal sector
  - 2.1 informal sector
  - 710 in agriculture
  - 1.1 million in private households
- Unemployed = 4.3 million
- Unemployment rate of = 23.6%
- Uneconomically active 14.3 million
  - Students, homemakers, ill, disabled, too young, too old, discouraged

Provincial variations - Gauteng province biggest employer

Majority in elementary jobs
Health system causes
Data Review

MDG 4 Progress

MDG 5 Progress

Maternal mortality per 100,000 live births

- United Nations estimates
- SADHS 1998
- NCCEMD 2004
- Census 2001

MDG 5 target: 38
Data Review – why do they die?

Why do children and newborns die?

- Neonatal, 30%
- Infections, 6%
- Pneumonia, 6%
- Diarrhoea, 11%
- Other child, 11%
- Sepsis and meningitis, 2%
- HIV & AIDS, 35%
- Injuries, 5%

Why are babies stillborn?

- Unexplained stillbirth, 39%
- Spontaneous preterm labour, 10%
- Other, 4%
- Infections, 5%
- Antepartum haemorrhage, 15%
- Intrapartum asphyxia and birth trauma, 14%
- Other, 2%

Why do mothers die?

- Non-pregnancy related infections such as AIDS, TB, pneumonia, 38%
- Hypertension, 19%
- Haemorrhage, 13%
- Pre-existing medical disease, 6%
- Sepsis, 8%
- Other, 16%

Why do children and newborns die?

- Injuries, 5%
- HIV & AIDS, 35%
- Other, 2%
- Congential, 3%
- Birth asphyxia, 6%
- Preterm, 13%
- Spontaneous preterm labour, 4%

Aaron's work presented above the graphs is not required.
Each year in South Africa:

- At least 1,600 mothers die due to complications of pregnancy and childbirth
- 20,000 babies are stillborn and another 22,000 die before one month of age
- In total, at least 75,000 children die before their fifth birthday

Toll of over 260 deaths every day!

Due to South Africa’s ‘Big 5’

- Pregnancy and childbirth complications
- Newborn illness
- Childhood illness
- HIV & AIDS
- Malnutrition
Coverage of services

See page 6-7 of the report
Health system causes

Top 5 health system causes of death

- Lack of use of health care facilities
- Lack of transport to and from institutions
- Inadequate facilities
- Inadequate skills
- Lack of caring attitude

4 of the 5 are quality of care issues!
In South Africa there is a paradox

High coverage

but

Poor outputs

Thus, we must integrate and simplify the programmes already available within the district health system to improve the quality of care for mothers and their children
Common strategies

**Community strategy**
- Provide appropriate education to community (health care messages)
- Teach how to use health care institutions appropriately

**Healthcare managers strategy**
- Provide adequate transport between institutions
- Provide adequate facilities in appropriate sites
- Provide appropriate equipment and drugs
- Provide staffing norms and ensure the positions are filled

**Healthcare provider strategy**
- Ensure they have adequate and appropriate skills for position
- Ensure have appropriate attitude
- Ensure morbidity and mortality audits occur in all institutions
It can be done!

- Policy makers
  - Folate supplementation
- KMC
  - Managers and providers
- PMTCT
  - Providers (Witbank)
- Training – BANC
  - Teaching institutions
Deaths due to Neural Tube Defects

Folate fortification of bread
# Kangaroo Mother Care

A study on the impact of Kangaroo Mother Care (KMC) on Neonatal Death Rate (ENND) for babies weighing 1-2 Kg shows a reduction of approximately 30%.

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Test for heterogeneity: OR = 7.21, df = 9 (P > 0.05), P = 0.0%
Test for overall effect: Z = 5.04 (P < 0.0005)

~30% reduction ENND 1-2Kg in sites using KMC
85% of mothers are now being tested.

85% of mothers are now being tested.

Counseling changed:
- individual, focussed
- 'opt out' testing encouraged

Only 15% of mothers agreed to testing:
- group only
- 'opt in'
- poor understanding

Deaths:
- 79% < 1 year of age
- 79.4% HIV-related
- PCP predominates (44%..)

Failure of PMTCT
CURRENT S.A.GOV'T TARGETS

- As the part of the outcomes-based approach of the current approach
  - Health is under the Human development cluster as “Outcome 2”
  - National Department of Health identified four key priorities for the administration period; viz.,
    - Increasing life expectancy
    - Combating HIV and AIDS
    - Decreasing burden of disease from Tuberculosis
    - Improving Health Systems Effectiveness
  - Increasing life expectancy includes
    - Decreased maternal mortality ratio from current estimated value of 400-625 per 100,000 live births to 100 or less by 2014
      - Increasing access to health services
      - Increase antenatal care bookings
      - Increase access to postnatal care services
      - Enhanced skills of birth attendants
      - Improved adherence to clinical guidelines
      - Increase rate of reviews of maternal and perinatal deaths
BEYOND HEALTH SYSTEMS: TURNING RESOURCES INTO RESULTS FOR PEOPLE

- Women need to be given greater access to access to, control and ownership of resources and revenues to increase the scope and quality of progress in Africa
  - African leaders need to implement plans to improve women's' access to these

- Women need to be at the center of climate-proofed development strategies
  - Women have proved effective in mobilising communities to respond to and prepare for climate change and natural disasters

- Empowered women are the key to increasing agricultural productivity
  - Better access to good quality land, technical support and credits

- Harness women’s entrepreneurship in formal and informal economies
  - Supportive regulatory environment through inclusion and protection of women
  - CEOs to increase share of women in management and board positions

- Connected women are key to developing strong knowledge economies
  - Will lead to more competitive technology and better trained workforce

- Strategies for economic growth should address poverty and inequality
  - Women to be given better say in developing planning
BEYOND HEALTH SYSTEMS: “TURNING RESOURCES INTO RESULTS FOR PEOPLE”

- Educated women will empower Africa
  - Gender gaps in education are a major brake on Africa’s economic development
- Gender discrimination is a major break on development
  - Societies that discriminate on the basis of gender pay the cost of greater poverty, slower economic growth, weaker governance and lower living standards
  - Build gender equity standards and targets on strategies for growth and poverty reduction
- Women add value to discussions on policy and the use of resources
  - More efficient in managing household budgets, loans and savings if given the opportunity
  - Women are highly effective as executives in the private and public sectors
- African women must be adequately represented in international fora
  - To create synergies, reduce apathy and speak for vulnerable groups
BEYOND HEALTH SYSTEMS: TURNING RESOURCES INTO RESULTS FOR PEOPLE

- Regional solidarity among women adds value
  - Feminisation of institutions brings radical change to the way in which women’s issue are dealt with

- Protection of women should be at the heart of security arrangements
  - Women are particularly vulnerable in situations of conflict
  - Sexual abuse, gender-based violence tend to increase
  - Governments and partners should adopt zero-tolerance approach to sexual and other forms of gender-based violence

- African leaders need to advocate for fulfillment of commitments
  - African leaders to honour their own commitments in to bring a stronger international case for shared responsibility and mutual accountability for economic and social progress in Africa
  - Commitments to Africa are commitments to its girls and women

- Women empowerment should be a specific objective of partnerships

- Policy coherence should be built with Africa’s women in mind
GLOBAL HEALTH INITIATIVE

- Welcome developments in this regard
- Note the principles, targets, commitments, strategies, approach
- We would like to see more multilayered harmonisation at global, regional, national and local level
Thank you!

Everyone has a role to play to save the lives of mothers, babies and children