Abstract

Since the Alma Ata Declaration on Primary Health Care, South Africa has striven, in particular, to promote the health of women and children. As the world focuses on the Millennium Development Goals of 2015, achievements resulting from efforts in this area over the past 30 years are recognised, while lessons learned are identified where necessary. There have been several successes in maternal, child and women’s health and nutrition, including: free access to Primary Health Care; free health care to pregnant and lactating women and to children under the age of six; prevention of vertical transmission of HIV; high immunisation coverage rate due to the Expanded Programme on Immunisation; eradication of deaths due to polio and measles; and implementation of the Choice on Termination of Pregnancy Act and the Primary School Nutrition Programme. Furthermore, diarrhoeal diseases have diminished, respiratory infections have become manageable and common foods have been fortified with micronutrients. On the other hand, challenges include a shortage of health care workers, poverty and HIV infection. Although efforts in these areas need to be increased, the impact of HIV has been of such a magnitude that it is unlikely that the Millennium Development Goals for maternal and child mortality will be met by 2015. Recommendations made in this chapter aim to increase efforts in maternal, newborn, child and women’s health, and to address issues such as violence against women and children.

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Introduction

Maternal and child health have been part of many international and national conversations for several years. The South African government placed maternal, child and women’s health as a priority in its health care system programmes. This chapter on maternal, child and women’s health should be seen in the context of the 2006 South African Health Review.\(^1\) The intention of this chapter is to paint a picture of where South Africa is 30 years after Alma Ata, and what remains to be done in order to reach the goal of ‘Health for All’.

In 1978, the joint World Health Organization (WHO) / United Nations Children's Fund (UNICEF) conference on Primary Health Care (PHC) at Alma Ata made a declaration aimed at improving the health of nations.\(^2\) A number of approaches to PHC have been attempted including that of growth monitoring, oral rehydration, breastfeeding and immunisation (GOBI), which later with family planning, female literacy and female health added, became GOBi-FFF.\(^3\) This approach has largely been abandoned, and the Integrated Management of Childhood Illnesses (IMCI) approach has been embraced, with emphasis being placed on integration for sustainability and effectiveness of maternal and child health services.\(^4\) Since then, pregnancy management has followed with an integrated approach, namely the Integrated Management of Pregnancy and Childbirth (IMPAC), whose aim is to improve the skills of professional birth attendants.\(^5\)

Women and children, but particularly children, were the focus of attention as these programmes aimed to protect and promote their right to health and well-being. The slogan ‘My name is today’ emphasised the need to urgently, and immediately address the plight of children in the face of malnutrition, diarrhoea and pneumonia. Since there were high incidence rates of communicable diseases, immunisation programmes were instituted for children and pregnant women. These were given the collective title of the Expanded Programme on Immunisation (EPI).

In 1987, the Safe Motherhood Initiative (SMI) was launched in Nairobi, Kenya with the aim of focusing on maternal survival and healthy child bearing.\(^6\) It was assumed that newborn health is an integral part of positive reproductive outcome, with family planning being promoted as one of the components of SMI. In 1990, the United Nations (UN) adopted the World Summit Goals. This was the commitment that nations of the world gave to the UN Convention on the Rights of the Child.\(^6\) In 1994, the International Conference on Population and Development advanced a recommendation for the promotion of the health and development of populations, especially for women.\(^7\) Access to information on contraception / family planning was considered to be the right of all couples. In 1995, the Fourth World Conference on Women in Beijing, China identified women’s health and rights as a priority for countries to advance.

In 2000, the UN General Assembly Special Session adopted the Millennium Development Goals (MDGs), with specific targets that Member States have to attain by 2015.\(^8\) Two of these goals relate to reproductive health, while a third relates to HIV, malaria and other preventable diseases, and its impact on the health of women and children, in particular. The MDG goal 4 has a target of reducing child mortality by two thirds by the year 2015, while that of the MDG goal 5 is to reduce the maternal mortality ratio by 75%, both from the 1990 baseline.

The MDGs provide an opportunity for the world to put into reality its commitment towards women and children’s health and well-being. The process indicators for maternal health are: antenatal care coverage; antenatal visits per patient; births assisted by trained health personnel; caesarean section rate; and the proportion of women who received tetanus toxoid injections. Maternal outcome indicators are maternal mortality ratio and number of maternal deaths. Perinatal mortality is the perinatal outcome indicator for maternal health.\(^9\)

South African background

In 1978, at the time of Alma Ata, a picture could be painted of women and children as being among the most oppressed and marginalised in South Africa. Malnutrition and poverty were prevalent and violence and neglect against women and children were rife. Limitation of movement and employment opportunities caused women to be separated from their families. Separate development ensured that unequal health care services were offered on the basis of race.

Children died from preventable causes because of poor sanitation, unsafe water, and inadequate immunisation against preventable diseases such as tetanus, measles, pertussis and polio. Feeding schemes for children in certain areas were functional, but were often erratic and not coordinated. Family planning services were offered, but were driven with population control in mind for Blacks (which included Africans, Coloureds and Indians). Child care assistance was differentially implemented according to race.

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\(^{a}\) A detailed review of international and national perspectives on PHC are contained in Chapter 1 and Chapter 2.
During the apartheid-era there were no statistics for maternal and child mortality for the whole country, but each homeland kept its own statistics. Boes published the causes of maternal deaths for the period 1980-82.\textsuperscript{10} This was the first attempt at understanding the magnitude of the problem. Many women died from pregnancy related causes, including unsafe abortion. Although the Abortion and Sterilisation Act (Act 2 of 1975) permitted safe abortion under certain conditions, the requirements for accessing these services made it impossible for many women, especially those in rural and underserved areas, to benefit from it.\textsuperscript{11}

A number of non-governmental organisations (NGOs) were set up to support PHC, including the National Progressive Primary Health Care Network (NPPHCN) of South Africa, which was formed in April 1987. Many of those who worked in these projects were subjected to State security surveillance and harassment. However, communities worked tirelessly at improving health with little in terms of State resources. The absence of indicators made it difficult to demonstrate progress.

\section*{Maternal health}

South Africa adopted the SMI in 1987, which includes components such as, antenatal care, skilled attendance at birth, safe and hygienic delivery and family planning.\textsuperscript{5} With the dawn of democracy, the freedom to travel and work wherever one wanted started to undermine efforts for strengthening some of these SMI components, especially in the rural areas, which face great challenges. Nurses and midwives who were the backbone of the health service in the rural areas left for better opportunities elsewhere.

One of the first policies of the new government was the institution of free health care to pregnant and lactating women and to children under the age of six. The impact of this policy was the increase in access to PHC as the financial obstacle to health care was largely overcome, though women and children still had to travel to their nearest PHC site, which could be costly.\textsuperscript{12}

The majority of women and children within the public health system in rural areas depend on nurses and midwives for their health care needs.\textsuperscript{13} The 1998 South Africa Demographic and Health Survey (SADHS) showed that both antenatal care coverage (over 90%), and delivery in the presence of a skilled attendant were high (over 80%).\textsuperscript{13} Maternal and perinatal mortality indicators remain high, pointing to probable low quality of care during pregnancy and childbirth.

In 1997, the Minister of Health made maternal deaths notifiable and appointed a National Committee for the Confidential Enquiry into Maternal Deaths (NCCEMD). The committee investigates the causes of death related to pregnancy and makes recommendations regarding the prevention of future deaths. The process of maternal death notification and enquiry is aimed at promoting examination of these deaths at the level of the institution and is a quality of care audit tool. It culminates in a report entitled ‘Saving Mothers’. These reports on maternal deaths are a major step toward improving the quality of maternity care. The process identifies the deficiencies in response to pregnancy and its complications, and affords the opportunity to learn from the adverse outcome.

These investigations yielded information for the overall improvement of the health system.\textsuperscript{14,15} They helped to identify the leading causes of death for 2002-04, which were non-pregnancy-related infections (37.8%), hypertension (19.1%), obstetric haemorrhage (13.4%), pregnancy-related sepsis (8.3%), pre-existing maternal disease (5.6%) and early pregnancy losses, being abortion and ectopic pregnancy (4.9%).\textsuperscript{16}

All the Saving Mothers reports contain general recommendations with regard to the prevention of the majority of deaths.\textsuperscript{14-16} These recommendations are aimed at the general improvement of the health system. The common issues relate to transport, voluntary counselling and testing (VCT), clinical management and availability of blood products for emergencies.

The second report specifically established targets to be achieved for the reduction of maternal deaths as many of the initial recommendations were not fully implemented.\textsuperscript{15} There was an increase in the number of maternal deaths per year during the triennium of the second report. Similarly, the third report confirmed the increase in maternal deaths.\textsuperscript{16} Deaths associated with non-pregnancy-related infections (e.g. HIV infection) had overtaken the deaths from hypertension complications as the leading cause of maternal mortality. Some of the recommendations of the third report are shown in Box 1.
Box 1: Key recommendations from Saving Mothers, 2002-2004

- Protocols on the management of important conditions causing maternal deaths must be available and utilised appropriately in all institutions where women deliver. All midwives and doctors must be trained on the use of these protocols.
- All pregnant women should be offered information on screening for and appropriate management of communicable and non-communicable diseases.
- Criteria for referral and referral routes must be established and utilised appropriately in all provinces.
- Emergency transport facilities must be available for all pregnant and postpartum women and their children with complications (at any site).
- Staffing and equipment norms must be established for each level of care and for every health institution concerned with the care of pregnant women.
- Blood for transfusion must be available at every institution where caesarean sections are performed.
- Contraceptive use must be promoted through education and service provision and the number of mortalities from unsafe abortion must be reduced.
- Correct use of the partogram should become the norm in each institution conducting births. A quality assurance programme should be implemented, using an appropriate tool.
- Skills in anaesthesia should be improved at all levels of care, particularly at level one hospitals.
- Women, families and communities at large must be empowered, involved and participate actively in activities, projects and programmes aiming at improving maternal and neonatal health, as well as reproductive health in general.


Two of the greatest challenges to health in general and maternity care specifically are lack of human resources and the HIV infection epidemic. As previously illustrated, HIV has had a direct impact on maternal mortality and morbidity, and has exacerbated the lack of human resources through direct infection of many health personnel.

HIV infections are the key reason why South Africa is unlikely to achieve the MDG target of reducing maternal deaths by 75% by 2015. The recent ‘Countdown to 2015’ conference placed South Africa as one of the countries deemed unlikely to meet the 2015 deadline.17 Up to the beginning of 2008 emphasis on the prevention of mother-to-child transmission (PMTCT) meant that women were not treated for their own health, but for the good of the unborn child. With the roll out of the antiretroviral treatment (ART) programme, women are starting to access the care they deserve. The annual antenatal surveys show that although the level of infection appears to have stabilised at high levels of around 30% in the younger age group (<19 years), there seems to be a drop in the HIV prevalence from 15.9% in 2005 to 12.9% in 2007.16,18 A summary of progress made with maternal health and the challenges still to be faced are contained in Box 2.

Perinatal health

Good child health starts in early pregnancy, with optimisation of maternal health and screening, and treatment of conditions that are likely to affect the development of the foetus.

Many babies die within the first four weeks of life with most deaths due to infections, hypertension and obstetric haemorrhage leading to premature delivery.19 Non-attendance for antenatal care is a contributory factor in some cases. Mismanagement of labour leading to asphyxia is also a factor.

The Perinatal Problem Identification Programme (PPIP) produces reports which highlight the preventable deaths in South Africa.20 The causes of death are prematurity, birth asphyxia, unexplained stillbirths and HIV, which also contribute to increased unexplained stillbirths, preterm deliveries and abortions.21 Hypertension and abruption also contributed to poor neonatal outcomes.20 The PPIP is currently run in sites that elect to be involved based on interest, and it covers about 20% of births in South Africa. Regular and wider reporting using this tool will assist in documenting progress in this area.

The Perinatal Education Programme (PEP), a free distance learning course for health workers, is an innovative tool for the improvement of perinatal care.22 It should be used for the ongoing updating of health care professionals, especially in under-served and under-resourced areas. The programme has been utilised by health care workers outside South Africa and its manuals are updated regularly to remain current.

Perinatal and neonatal indicators of health are collected through the District Health Information System (DHIS). Although there are still problems in collation and analysis of the data, as well as the use of the data by some programme managers, it is an indispensable tool for district health
Maternal, Newborn and Child Health: 30 Years On

Box 2: Summary of maternal health successes and challenges

<table>
<thead>
<tr>
<th>Successes</th>
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<tbody>
<tr>
<td>Maternal deaths are notifiable and there is a system for enquiry at each health service delivery level into the deaths.</td>
</tr>
<tr>
<td>Progress has been made in PHC in maternal health, but the target of the MDG goal 5 is unlikely to be reached.</td>
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<tr>
<td>South Africa has a large programme for the prevention of transmission of HIV to the foetus or newborn.</td>
</tr>
<tr>
<td>Antenatal care is provided for the majority of women, including VCT for HIV and other conditions.</td>
</tr>
<tr>
<td>HIV is the leading cause of mortality, thus early diagnosis and management is essential.</td>
</tr>
<tr>
<td>Highly active ART (HAART) and dual therapy PMTCT are established.</td>
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<tr>
<td>A high proportion of deliveries are with trained attendants.</td>
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<table>
<thead>
<tr>
<th>Challenges</th>
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<tbody>
<tr>
<td>Shortage of skilled attendance must be improved through recruitment, training and retention strategies.</td>
</tr>
<tr>
<td>HIV and other leading causes of morbidity and mortality must be urgently and comprehensively addressed.</td>
</tr>
<tr>
<td>Women’s rights to health must be protected irrespective of their pregnancy state; treatment of HIV must be for the woman herself.</td>
</tr>
<tr>
<td>Maternal mortality must be reduced through the implementation of the recommendations, including improvement in skills and competencies of health care workers.</td>
</tr>
<tr>
<td>The health system must provide support for transport and emergency care.</td>
</tr>
<tr>
<td>Contraception services at all levels of care need strengthening.</td>
</tr>
</tbody>
</table>

Source: Compiled by author.

management. Details of perinatal and neonatal deaths are contained in Chapter 16 on Health and Related Indicators.

The identified gaps that need to be addressed in order for neonatal mortality and morbidity to be reduced are: effective antenatal care; proper management of labour; and prevention of low birth weight. The changes that must be effected are not complex and can be implemented by all health care workers including midwives to improve perinatal health care.

The appointment of ministerial committees on neonatal and child mortality and morbidity in 2008, is a bold step in bringing newborn and child health to the fore of national priorities. These committees will improve the nature and quality of the data to be collected on morbidity and mortality.

Prevention of mother-to-child transmission of HIV

HIV is the greatest challenge facing PHC in South Africa. The key to prevention of babies being infected from their mothers lies in identification of HIV-positive mothers. The latest data show that less than 70% of antenatal women are tested for HIV, although 92% of pregnant women attend antenatal clinics. In general, the percentage of women tested for HIV has increased over the past few years, but in some districts there has been a decrease in coverage in spite of the high prevalence of HIV. Once HIV-positive mothers are identified, interventions can take place. The PMTCT programme has been implemented with varying degrees of success in the various provinces. Nevirapine uptake has continued to improve from 52% in 2005/06 to 62% in 2006/07. There has been progress from no antiretroviral (ARV) drugs, to single dose nevirapine, to dual drug prophylaxis (zidovudine and nevirapine). This dual prophylaxis has the potential to reduce transmission of HIV but needs ongoing support to be provided for the many midwives who are the backbone of perinatal care. The shortage of midwives in the public sector threatens the success of this programme. Breastfeeding when mixed with other feeding promotes transmission of HIV; it is therefore important that exclusive formula or breastfeeding be adhered to.

PMTCT holds the greatest opportunity for promoting infant and child health and having an HIV-free generation of children. For women whose CD4 cell count is below 200, it serves as an entry point to comprehensive management with ART. The requirements placed on women to be on ART are challenging (e.g. issues such as counselling, a doctor-initiated treatment plan, shortage of nurses and inadequate laboratory support). A major challenge is community mobilisation for support of women and children with HIV infection. The stigma makes it difficult for affected individuals to seek help and support. A supportive informed community would make a positive difference in the lives of women and children. Box 3 contains a summary of the future actions to improve perinatal health.
Box 3: Summary of future action to improve perinatal health

- Perinatal health programmes are part of the maternal and child health services, and PMTCT should be integrated into regular antenatal care services.
- Common causes of neonatal deaths are prematurity, infection, birth asphyxia and HIV. Improved management of labour can help prevent these and health workers should be trained in the proper conduct of labour and the puerperium.
- Perinatal morbidity and mortality can be prevented using basic skills as highlighted by the Saving Babies and Saving Mothers reports.
- The PMTCT programme has the potential to prevent a significant proportion of perinatally acquired HIV infection, especially with the implementation of the dual drug prophylaxis programme.
- Community mobilisation must be strengthened in order to reduce stigma and improve voluntary testing for HIV infection.
- ARV prophylaxis must be coordinated so that no baby is exposed to the virus during pregnancy, child birth and the neonatal period.

Source: Compiled by author.

Child health

After ratifying the UN Convention on the Rights of the Child, South Africa established a mechanism for monitoring the promotion and protection of the rights of children through the National Programme of Action for Children in South Africa. This programme has a steering committee and consists of senior officials of the Departments of Justice, Social Development, Education, Safety and Security and the Presidency, as well as NGOs represented by the National Children’s Rights Committee. The task of the committee is to coordinate societal intervention in the best interest of the child, and to help government and society fulfil their mandate to protect, promote and preserve children’s rights. The committee reports to the Presidency.

Free health care to children under the age of six

Prior to 1994 payment was required for health services and this meant that many children, because of poor socio-economic conditions, would delay in accessing health care services with consequent morbidity and mortality. Within the first 100 days of his presidency, President Mandela announced the implementation of free health care to pregnant and lactating women and to children under the age of six. With that proclamation, many women and children were better able to access PHC and other services.

With the restructuring of the public sector after 1994 the national Department of Health (NDoH) established the Maternal Child and Women’s Health and Human Genetics directorate. This was later restructured to the Maternal, Child and Women’s Health and Nutrition Cluster in order to address the challenges that women and children face. As a marginalised group, women and children needed a dedicated programme to facilitate improvement in their health status.

Child survival and development are intimately linked with maternal health.

One of the key policy changes introduced by the newly established cluster was the IMCI approach. IMCI recognises the importance of the environment and it emphasises family ownership for healthy behaviour. It also recognises that childhood illnesses are often interconnected. The IMCI approach requires intensive training for the change in attitude of health workers, and empowers health professionals with new skills for the case management approach. It incorporates early and simple management of common childhood illnesses (e.g. malnutrition, diarrhoea and pneumonia) as well as some area specific conditions (e.g. violence, injuries). The programme has components for community and institutional interventions and therefore needs to be implemented by various child care providers. As an example of the importance of the environment in child health, an outbreak of diarrhoea in Mpumalanga in 2007 highlighted the need for vigilance in monitoring the quality of water.

According to recent reports, HIV is the leading cause of deaths in children outside of the neonatal period. Tuberculosis (TB) is a significant re-emerging contributor to infant morbidity and mortality, as in other parts of the continent. These epidemics need increased attention and more resources because of the complexity of their management.

The leading causes of childhood deaths, in a facility-based child mortality audit system were malnutrition, diarrhoeal diseases and respiratory infections. HIV infection plays an important role in these deaths. The audit showed that many causes are preventable and could have been prevented at household and health facilities levels. Distance from cities, in general, impacts on child survival, as health facilities in rural areas face challenges of attracting staff.
There are a number of preventable or modifiable factors in child mortality and morbidity and they require changes at all levels. An analysis of the location of the preventable factors in child deaths, according to the 2005 and 2006 Saving Children reports are shown in Table 1.\textsuperscript{30,34}

<table>
<thead>
<tr>
<th></th>
<th>2005 (%)</th>
<th>2006 (%)</th>
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<tbody>
<tr>
<td>Home</td>
<td>21.5</td>
<td>30.8</td>
</tr>
<tr>
<td>Clinic</td>
<td>14.8</td>
<td>13.5</td>
</tr>
<tr>
<td>Admission and</td>
<td>27.2</td>
<td>21.5</td>
</tr>
<tr>
<td>emergency care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td>25.5</td>
<td>28.0</td>
</tr>
<tr>
<td>Other</td>
<td>10.9</td>
<td>6.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Patrick and Stephen, 2007;\textsuperscript{30} Stephen and Patrick, 2008.\textsuperscript{34}

There is doubt whether enough effort is made to educate the communities about the basics of IMCI. The community mobilisation as envisaged by the Alma Ata Declaration and in the spirit of progressive PHC is lacking. As the socio-economic circumstances become more difficult, more children become victims. The poor conditions in informal settlements are likely to contribute to the morbidity and mortality seen among children, especially in times of disasters such as fires and floods. South Africa has also seen an increase in refugees, with all the associated challenges of displaced families and communities and lack of infrastructure.

Another community aspect is the loss of one or both parents, which makes children vulnerable to loss of education, security and love. There is no coordinated effort to counsel and support these children and weak community structures. In a few areas NGOs run projects to care for orphans and other vulnerable children. The government, through the Department of Social Development, provides grants for the care of orphans and other vulnerable children. However, teachers and minders at schools often have neither skills nor adequate resources to cope with the increased burden of emotional trauma these children experience, long before the parent(s) die. Anecdotal evidence is that these children, though having access to government grants once orphaned, are unable to fend off relatives who then make themselves available as long as the grant money lasts.

Another social emergency that needs urgent and integrated attention is child abuse, which is a priority for the National Programme of Action for Children in South Africa. As the social circumstances continue to be harsh, children become more vulnerable to exploitation, violence and neglect. Community-based initiatives for the care and protection of children are needed for the prevention, early detection and management of child abuse.

Given the current progress in reducing childhood deaths, South Africa is one of the countries not on track to meeting the MDG in relation to under-5 mortality.\textsuperscript{35} HIV is the single largest contributor to mortality and is linked with malnutrition with both compromising the immune system.\textsuperscript{31,32} Other important diseases are respiratory tract infections and diarrhoeal diseases.

**Expanded Programme on Immunisation**

The EPI has made good progress in increasing coverage with vaccines. There has been a marked improvement in the achievements of EPI over the past decade. These include:

- maintenance of high immunisation coverage rate;
- reduction of neonatal tetanus;
- reduction of deaths from measles with marked reduction of measles cases;
- achievement of polio-free status; and
- implementation of the ‘Reach Every District’ strategy with community mobilisation.

Although immunisation coverage nationally is high according to the DHIS, there are districts with only 60% full immunisation coverage, and the 2003 SADHS reports lower coverage overall.\textsuperscript{36,37}

The EPI coverage includes vaccines against measles, diphtheria, pertussis, tetanus, polio, TB, hepatitis B and *Haemophilus influenzae*. The success of the EPI has led to the total elimination of measles deaths and reduction in measles cases among children. Through the ‘Kick Out Polio’ campaign, South Africa reached the desired status of being declared polio-free in 2006. UNICEF, WHO and other national and international organisations continue to support this initiative with human, financial and logistical resources for the strengthening of surveillance.

The immunisation coverage for the various communicable diseases has remained high. This is important to maintain as children need to be protected in cases of disease breakouts in the neighbouring countries or from imported cases.

The Department of Health (DoH) will introduce the rotavirus (diarrhoea) and pneumococcal (pneumonia) vaccines soon, further reducing the chance of death from diarrhoeal and respiratory infections respectively.\textsuperscript{38}
Integrated Nutrition Programme

Malnutrition is one of the important causes of childhood mortality and over 60% of children who died in 2006 were underweight for their age, and nearly 35% were severely malnourished. Malnutrition among children in South Africa has been prevalent because of poverty. Zere and McIntyre found that stunting was a common form of malnutrition, and the poorest provinces had the highest rates of malnutrition. In the National Food Consumption Survey (NFCS), factors that determined amount of nutrients received by children included the socio-economic status of caregiver(s), education of the caregiver(s) and number of household members who are working.

The programme for nutrition has made a lot of progress despite various challenges. As a result of the NFCS, micronutrient fortification of basic foods was implemented, thus making a major intervention in the diet of many people in the country. This helps to address neural tube defects, associated with folic acid deficiency, and physical and mental development due to iodine deficiency. Iodine deficiency was addressed through iodination of table salt. Despite these interventions, the 2003 SADHS and the 2005 NFCS showed that there are still problems with vitamin A coverage, and that the prevalence of vitamin A and iron deficiencies are still high.

Identifying children nutritionally at risk poses a challenge. In a study involving 134 children that sought to find out how well PHC workers targeted at-risk children for supportive programmes, Schoeman et al. found that health care workers were not good at picking up nutritionally at-risk children. The 2003 SADHS showed that only 68% of children had their Road-to-Health Charts. It is therefore difficult to estimate the level of malnutrition and food supplementation among children.

The Infant and Young Child Feeding Policy has been developed through consultation with many stakeholders. Various international documents were consulted, so that the policy should be as comprehensive and practical as possible. The documents included the International Code of Marketing of Breastmilk Substitutes, Global Strategy for Infant and Young Child feeding, Baby-Friendly Hospital Initiative and the Convention on the Rights of the Child.

The implementation has to take into consideration the prevention of HIV transmission to the child. Mixed feeding in breastfeeding infants of HIV-infected women will promote transmission. Breastfeeding is encouraged and is the mainstay for infant feeding, however, data from the 1998 and 2003 SADHS revealed the low prevalence in the country as shown in Table 2.

Table 2: Infant feeding rates, 1998 and 2003

<table>
<thead>
<tr>
<th></th>
<th>1998 SADHS (%)</th>
<th>2003 SADHS (draft) (%)</th>
</tr>
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<tbody>
<tr>
<td><strong>Exclusive breastfeeding</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 3 months</td>
<td>10.4</td>
<td>11.9</td>
</tr>
<tr>
<td>4 - 6 months</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Not breastfed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 3 months</td>
<td>16.6</td>
<td>20.1</td>
</tr>
</tbody>
</table>

Source: Department of Health, 2002; and 2004.

It is evident that exclusive breastfeeding is still not widely practised nationally. This may be because women have to work, as well as having other people assist in looking after their children. It is almost impossible for the grandmother not to give a newborn some fluids other than breast milk if the mother is not available. Exclusive breastfeeding therefore becomes a challenge in extended households. Only a change in the social arrangements within families will significantly alter the feeding practices. Making it more acceptable to breastfeed in public will also lead to women feeling more comfortable to continue breastfeeding.

The Primary School Nutrition Programme (PSNP) has helped many children from poor households. It is accessible to all children, but those with little or no food to eat before school derive the greatest benefit from the meals provided. However, the differential implementation of this project saw some children not benefiting from the programme. Communities were also not meaningfully engaged, with the result that the developmental benefits were not realised. PSNP was aimed at strengthening the growth and nutrition of school-going children. While the impact was unquestionable, problems of procurement and accountability affected the programme negatively. Some of the key initiatives linked to nutrition are shown in Box 4.
Box 4: Summary of nutrition initiatives (actual and proposed)

- The Infant and Young Child Feeding Policy was developed.
- Breastfeeding is encouraged and the Baby Friendly Hospital Initiative is used to promote healthy feeding practices.
- Micronutrient fortification of basic foods has been implemented in order to promote child growth.
- The PSNP has been instituted in order to combat malnutrition.
- Breastfeeding rate is low and must be promoted through societal orientation so that feeding in public is acceptable.
- Exclusive breast or formula feeding must be supported and promoted.
- The Infant and Child Feeding policy has taken into consideration global trends and recommendations, in the context of the high HIV prevalence and PMTCT.
- PHC principles underlie the IMCI initiative, especially the nutrition directed activities. The community component of IMCI needs to be implemented with vigour so that it may make a difference in reducing morbidity and mortality among children.

Source: Compiled by author.

Women’s health

The following policies and regulations promote women’s health.

- Free health care to pregnant and lactating women and to children under the age of six years - it improved access to care for this section of the population.
- Free PHC - the government abolished user fees in South Africa, thus improving access to PHC.
- Choice on Termination of Pregnancy Act (Act 92 of 1996) - women have a choice in deciding whether to terminate pregnancy under safe conditions.
- Choice on Termination of Pregnancy Amendment Act (Act 38 of 2004) - this act makes it easier to designate facilities. Registered nurses can also be trained for termination of pregnancy (TOP).
- Sterilisation Act (Act 44 of 1998) - for women capable of giving consent, only the consent of the woman requesting sterilisation is required. It also provides for women incapable of consenting. It safeguards the right to bodily integrity.
- Notification of and confidential enquiry into maternal deaths - causes of maternal deaths are investigated and reported to the Minister of Health. It concentrates on preventable factors.
- Cervical cancer screening - the policy provides for three cervical smears at intervals of 10 years, starting at 30 years of age in women at low risk for cervical cancer.
- National policy guidelines on contraception - provides guidance for the provision of contraception.

Cervical Screening

Screening for precancerous lesions has been adopted, as cancer of the cervix is one of the leading cancers among women. The recommendation is for three papsmears in a lifetime in asymptomatic women, starting at the age of 30. In women infected with HIV, it is recommended that screening tests should be done every three years. Another intervention to lessen cervical cancer is to immunise against HPV (human papillomavirus) infection, a sexually transmitted infection (STI), which is a precursor to cervical cancer. Consideration should be given to the introduction of HPV vaccine among young children (before sexual activity), although currently the high cost of the vaccine will be a factor against implementation.

Choice on termination of pregnancy

The Choice on Termination of Pregnancy Act allows for any pregnant woman to request pregnancy termination, without having to obtain permission from partner, guardian or health professional, up to 20 weeks of pregnancy. It also allows registered midwives to perform pregnancy termination. Before the enactment of the Choice on Termination of Pregnancy Act, unsafe abortion was one of the major causes of death among women, especially those from disadvantaged communities. Access to second trimester TOP services is also limited. The Choice on Termination of Pregnancy Amendment Act, passed in 2008 after a court challenge, makes designation less cumbersome, while allowing registered nurses who have been trained to provide TOP services up to 12 weeks gestation. Some facilities designated to provide TOP services under the Choice on Termination of Pregnancy Act are not yet operational. However, there has generally been an increase in the proportion of health facilities providing TOP services between 2000 and 2003 as shown in Table 3.


e Personal communication, J Merckel, Reproductive Rights Alliance, December 2003.
Table 3: Termination of pregnancy service provision by province, 2000 and 2003

<table>
<thead>
<tr>
<th>Province</th>
<th>Designated facilities</th>
<th>Number of functioning facilities</th>
<th>Functioning facilities (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Public and Private</td>
</tr>
<tr>
<td>EC</td>
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<td>FS</td>
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<tr>
<td>SA</td>
<td>292</td>
<td>306</td>
<td>92</td>
</tr>
</tbody>
</table>

Source: Personal communication, J Merckel, Reproductive Rights Alliance, December 2003.

As highlighted in Table 3, major steps need to be taken to have designated facilities functional. KwaZulu-Natal and Mpumalanga have less than 50% of their facilities functional. The lack of functional facilities has led to many backstreet operators flourishing in an environment where there is stigma associated with TOP. Despite this, the impact of the implementation of the Choice on Termination of Pregnancy Act has seen a marked reduction of maternal deaths and morbidity. 14-16,48-50

Contraception

Recent data shows a moderately high contraceptive prevalence rate. 10 However, more emphasis on contraception is required especially with the high levels of HIV. 51,52 With the rise in women accessing TOP services, there is concern that prevention of unwanted or risky pregnancies should be pursued at all levels of care.

According to the preliminary report of the 2003 SADHS, there are more women desiring permanent sterility compared to the findings from the 1998 SADHS. 13,37 Knowledge about contraception has declined. Only 46% of women had heard about female sterilisation, compared to 68% in 1998. These reports also show that contraceptive use has also declined, with 71% of women having ever used contraception in 2003 compared to 75% in 1998.

Violence against women

Violence against women has been the theme of National Women’s Day events since 1994. South Africa has a very high prevalence of abuse of women, including rape. Violence against women is a serious challenge to community and societal life. It comes in the form of physical and emotional violence, abuse, neglect and trafficking.

Although it may be reasoned that increased awareness leads to increased reporting, there is enough reason to suspect that the reported increase is real. The extreme nature of the violence is alarming and occurs at all ages. 53,54 In a national study on femicide in South Africa, Mathews et al. established that almost 50% of women killed violently die at the hands of their intimate partner. 54 The rate of femicide was different in race groups, but on average a woman was killed every six hours by her intimate partner.

There are various efforts to combat this scourge, with departments cooperating to create an environment for the protection of women and children. The Department of Justice has established various projects for protection of women’s rights. The interdepartmental forum for tackling violence against women encourages the social clusters to work together. However, the justice system was shown to be inefficient in holding the perpetrators accountable for the crimes against women and there is no evidence that the proportion of perpetrators convicted has increased.

A number of recommendations have been made for the justice system including:

- establishment of a public crime database;
- training of investigating officers in the handling of female murders;

14,16,48-50

51,52

13,37

1998 SADHS. 13,37

13,37

13,37

10

53,54

54

53,54

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53,54
development of and training in guidelines for the investigation of female murders;

- improvement of mortuary and police information systems;

- monitoring of dockets by police and prosecutors, ensuring that investigations are thorough and timeous;

- more use of DNA specimen results in evidence;

- DoH to improve postmortem services especially in rural areas;

- gun control to be vigorously reinforced;

- reduction of substance abuse; and

- prioritisation of the reduction of domestic violence.  

**Youth**

Young people are faced with challenges of development including those around issues of sexuality. Some issues in health that must be addressed are teenage pregnancy, STIs (including HIV), violence and drugs. Other threats to youth health are poverty, trafficking for cheap labour, sex and TB.

The National Adolescent Friendly Clinic Initiative (NAFCI) is a programme which encourages facilities to be sensitive to the needs of young people. Teenage pregnancy and STIs are the major targets for this public health intervention. The fertility among adolescents, according to the 2003 SADHS, varied from region to region and population group. High levels of fertility among the youth and adolescents were seen in the poorer provinces, while Gauteng and Western Cape had the lowest fertility rates in youth. The quote in Box 5 illustrates this clearly.

**Box 5: Adolescent fertility**

“The proportion of adolescents who have ever been pregnant rises rapidly with age, from 2% at age 15 to 35% at age 19. The data show considerable variation in adolescent fertility by region, education and population group. Rural adolescents tend to start childbearing earlier than urban adolescents. Gauteng has the lowest proportion (10%) of women aged 15-19 who had ever been pregnant, while Mpumalanga has the highest proportion (25%). Other provinces with high levels of early pregnancy are Northern Province [Limpopo], Eastern Cape, and the Northern Cape. There is a strong negative association between education and teenage pregnancy. Coloured teenagers have the highest levels of adolescent pregnancy (19%) while whites and Asians had the lowest levels (2% and 4% respectively)”.


Teenage pregnancies also highlight the difficulty of practising safer sex among young people, when HIV infection is so prevalent. The consistent use of condoms would prevent both teenage pregnancy and HIV infection.

Although knowledge seems to be adequate, the knowledge does not seem to translate into changed practice. Added to this is the paucity of contraception promotion in the public electronic and printed media nationally.

HIV is also a major threat. The use of condoms seems to be inconsistent. There is also a need to promote contraception through the public media, as failure to use condoms seems to be high. Some NGOs, both national and international, attempt to communicate with young people, however, some communities are still uncomfortable with discussing sexuality with youth.

Young people face violence even in schools, as highlighted by the snippets from Human Rights Watch (see Box 6).

**Box 6: Snippets from Human Rights Watch**

“I didn’t go back to school for one month after I came forward. Everything reminds me, wearing my school uniform reminds me of what happened. I have dreams. He [the teacher] is in my dreams. He is in the classroom laughing at me. I can hear him laughing at me in my dreams. I sometimes have to pass down the hall where his classroom was. I thought I could see him, still there. I was scared he’ll still be there”.

- PC, age fifteen, sexually assaulted by teacher at school

“All the touching at school, in class, in the corridors, all day everyday bothers me. Boys touch your bum, your breasts. Some teachers will tell the boys to stop and they may get a warning or detention, but it doesn’t work. Other teachers just ignore it. You won’t finish your work because they are pester ing you the whole time”.

- MC, age fourteen, sexually harassed at school

“I can’t understand how nobody saw anything or helped my child. The school has caretakers, where were they? I don’t feel she is safe at school”.

- Mother of LB, a nine-year-old girl who was gang-raped at school by older classmates

South Africa, by ratifying the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), pledged to protect and promote the rights of women and girls to bodily and psychological (i.e. emotional) integrity, and access to education. From the snippets quoted it is apparent that schools are places of violence against women and children, especially against the girl-child. There is also an increase in violent crimes among young people in and out of school. Girl-children are vulnerable to sexual abuse and exploitation. With the violence against them, many survivors of sexual violence fail to progress in school.

Girls often bear the hurt and ‘shame’ of sexual violence in silence, having learned submission as a survival skill. Girls may be ignored when they report sexual abuse or harassment. They then either submit to a particular young
man or teacher, so that they will be protected from the rest of the male members. As it has been stated by the Human Rights Watch, “In South Africa, state failure to address the problems of rape, sexual abuse, and sexual harassment of girls at school has a discriminatory impact and effectively denies girls their right to education”. It is a tragedy that in South Africa, women and girls still feel threatened.

Conclusion

There are many challenges to be faced before the objectives of the Alma Ata Declaration can be achieved. The past 30 years have seen achievements in South Africa, however, the period has also seen new challenges that diverted focus to the extent that many health workers are not familiar with the Alma Ata Declaration. Over the 30 years since Alma Ata, progress has been made in improving the health of women and children in South Africa. Policies and programmes that support PHC have been developed and these have had a positive impact on the health and well-being of women and children. The establishment of special national committees on maternal and child health, as well as neonatal mortality prevention is a major step towards achieving the MDGs goals 4 and 5.

The crisis in professional health staffing is a major challenge in the face of increased disease burden due to HIV. Maternal mortality has increased because of non-pregnancy related infections, primarily HIV. Prevention must be the mainstay of the fight against HIV. The emergence of resistant strains of TB also contributes to the reversal of gains made in maternal and child health in South Africa. The IMCI maximises health resources and saves the lives of children. The introduction of ART for children and their mothers holds promise for child survival. Progress in immunisation has been made and breastfeeding and oral rehydration must be further encouraged. Violence against women and children must be addressed through intersectoral collaboration and community participation. Youth of both sexes need support and protection against violence, exploitation and marginalisation.

Initiatives to improve women’s health, especially in reproductive health must continue. There has been no progress in improving family planning and female literacy, and contraceptive technology must be made more accessible. Youth programmes must be strengthened, along with participatory approaches to health education. Unless more effort is made in improving maternal, newborn and child health, the MDGs will remain beyond South Africa’s reach.
References


