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Maternal and Child Health Programme

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NATIONAL TREASURY

SAVINGS@WORK
GOVERNMENT SPENDING REVIEWS

South Africa is not meeting the Millennium Development Goal's target for reducing maternal mortality

An important target included in the United Nations Millennium Development Goals (UN MDGs) was to reduce by 75% the global maternal mortality ratio by 2015. Statistics on the achievement of the MDGs show that by 2015 the global maternal mortality ratio had fallen by nearly half which comes short of the 75% target set by the United Nations. Current statistics for most developing countries show that maternal mortality is still on the rise. In South Africa in particular, the maternal mortality ratio is currently 112.6 deaths per 100,000 live births. This is relatively good as compared with other upper middle income countries in sub-Saharan Africa, but is still a far cry from the MDG 5 target of 38 deaths per 100,000 live births for South Africa. The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year. This is high and demonstrates the possibility of structural inefficiencies in the free maternal healthcare policy that is currently being pursued in South Africa.

The maternal and child healthcare policy - past and present

The free maternal and child healthcare policy (MCH) was introduced in South Africa in 1994 as one of the first policies of the post-apartheid South African government. It formed part of a series of social policies which aimed to reduce inequalities in health status and access to health care of South Africans. It is administered by the National Department of Health under its HIV and Aids, Tuberculosis, and Maternal and Child Health programme. This programme is expected to receive R 16 018.6 million in 2016/17 and a total of R 55 305.7 million over the 2016/17 to 2018/19 Medium Term Expenditure Framework (MTEF) period.

Some maternal health challenges in South Africa

Pregnancy complications

In South Africa, it is estimated that for every woman who dies of a pregnancy related complication, 20 more pregnant women suffer from maternal morbidity including diseases such as vesico-vaginal fistulae which may be severe and lead to long term disabilities. According to the Saving Mothers report (2011-2013), non-pregnancy related infections such as HIV/AIDS, Hypertension, and Haemorrhage still account for the largest number of maternal deaths South Africa, with HIV/AIDS being the main cause. Hypertensive complications during pregnancy are the second largest cause (18.1%) followed by obstetric haemorrhage (13.8%).

Lack of services

In addition, challenges with healthcare administration and poor access to transportation have also been sighted as intermediate causes of high maternal deaths. These are reflected in poor ambulance transport and lack of intensive care services for expectant mothers.

Healthcare personnel Challenges

Challenges with the healthcare personnel which account for the increases in these otherwise avoidable maternal deaths include poor initial assessment and diagnosis of cases especially at secondary levels of care, failure to follow standard protocols at primary and secondary levels and poor monitoring of patients at all levels of care.

The increased availability of maternal services is not increasing women's use of them

Currently, most pregnant women in South Africa receive some form of antenatal care during pregnancy. However a significant proportion deliver without the assistance of a health professional, and access to safe abortion and emergency referral are still low for many women in the country. Although the free MCH has led to increased utilisation of existing antenatal and paediatric services, it does not appear to have influenced the number of deliveries within health facilities. Empirical evidence from various studies conducted on the MCH show that although it could potentially help to improve access to and the quality of maternal health services, free maternal health care, on its own, is not enough to reduce the high rate of maternal mortality in South Africa.

Gaps in implementing the maternal and child health care policy

Some important gaps that research has identified in the implementation of the MCH include:

- 40% of all maternal deaths in South Africa are avoidable as they relate to community, clinical, and administrative factors.
- National data show that 61 per cent of under-five deaths are linked to avoidable factors related to failures of the health system.
- Improving the quality of health services at the primary care level, with timely referral of patients to higher levels of the health system when necessary must be given higher priority.
- Compromised treatment and quality of healthcare by the various public health care providers in South Africa remains a threat to the accessibility of health care services by pregnant women.
- Inadequate physical infrastructure, resources, equipment, and appropriate medicines for pregnant women and their babies.
- Extremely high patient to staff ratio in most community health centres as a result of gaps in the implementation of the policy. This means that the policy has led to a desirable increase in the use of public health centres, without necessarily increasing the number of medical staff available to attend to expectant mothers in the health facilities. This results in long waiting hours for most expectant women at the health centres, even for those with emergency cases.

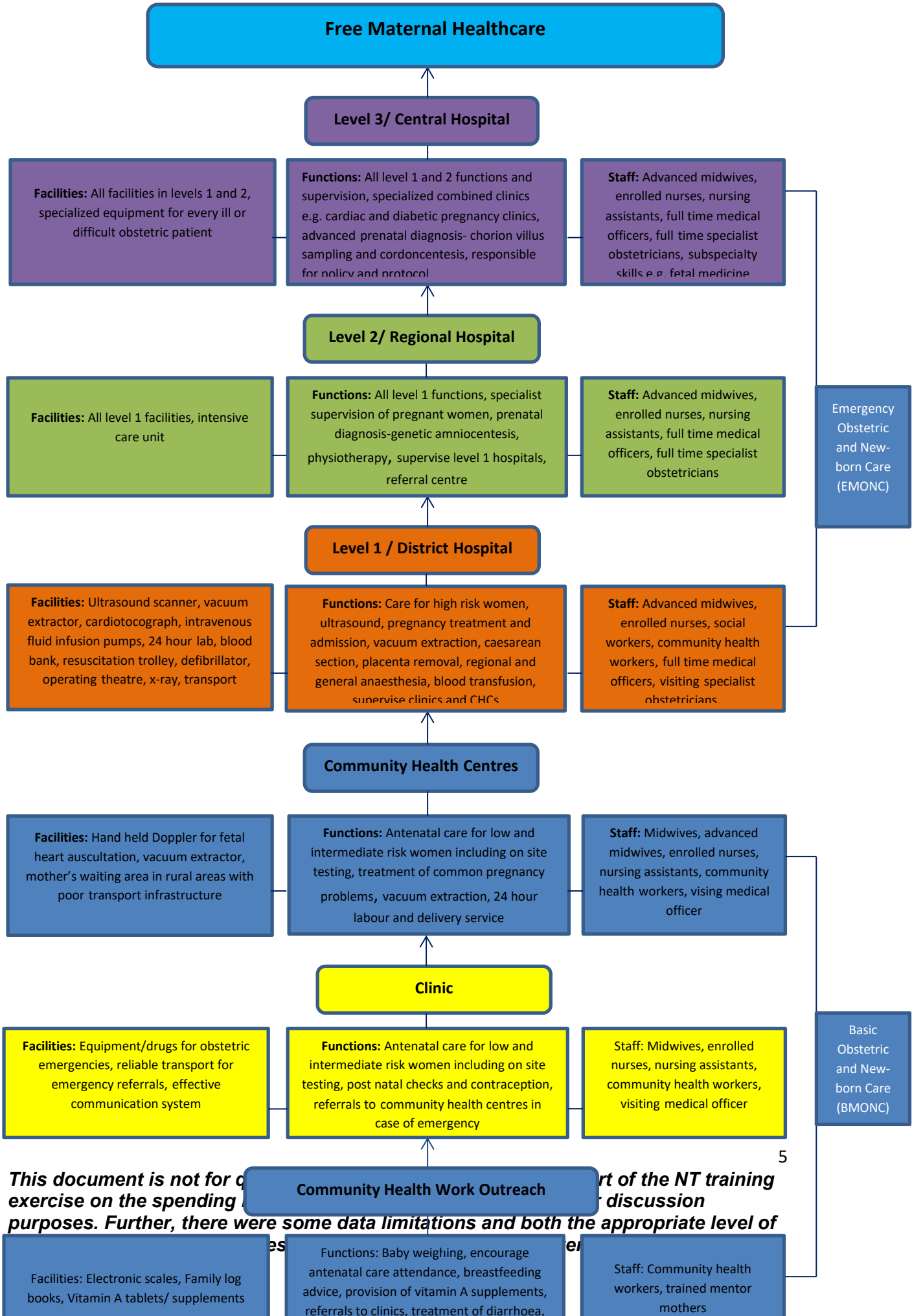
How is maternal and child healthcare provided?

A health system is a structure within which people, institutions, and organizations interact to mobilize and allocate resources for preventing and treating diseases and injuries among the population. The pillars of the South African healthcare system therefore include the health workforce, health information systems, medicines and technology, finance, and leadership and governance. All these different actors play pivotal roles which are essential to efficient healthcare service delivery in South Africa.

Healthcare in South Africa is very diversified, ranging from the most basic primary health care, offered free by the state, to highly specialised, hi-tech health services available in both the public and private sector. However, the public sector is stretched and under-resourced in some places. While the state contributes about 40% of all expenditure on health, the public health sector is under pressure to deliver services to about 80% of the population. There are 4 200 public health facilities in South Africa. The clinic-patient ratio is about 13 718. This exceeds the WHO benchmark of 10 000 people per clinic.

The government's policies for improving maternal health and reducing HIV rely on services delivered at the primary health care level in clinics and community health centres rather than in hospitals, mainly as a way of increasing access to services. These include sexual and reproductive health and rights services, such as contraception, testing and treatment of sexually transmitted infections, HIV testing and treatment, and, essentially, early access to antenatal care. Weakness in the management of public health facilities and systems, insufficient investment, especially in poorer regions of the country, deteriorating infrastructure, stock shortages of medicine and a staffing crisis in the public sector have entrenched past inequities in access to and quality of health care services. Those living in rural areas (43.6% of the population) are often the worst hit by challenges in the public healthcare sector. For instance, they are served by only 12% of the country's doctors and 19% of nurses. Furthermore, profound inequalities persist between the private and public health systems in terms of infrastructure and resources. Nearly 83% of the population relies on the public health system, yet the private health care sector employs the majority of health care professionals and spends nearly 60 times more per patient. Further disparities exist between South Africa's nine provinces and the 52 health districts. Divergent rates of spending on health care provision have been noted, with a documented correlation between lower rates of maternal mortality and districts with higher per capita spending on district health services. At the provincial level, varying maternal mortality ratios relating to deaths in health care facilities in 2012/13 highlight a low of "8.7 per 100,000 live births in the Western Cape to 177.9 per 100,000 live births in Limpopo. Mpumalanga was the only province to show a worsening in the maternal mortality ratio in health facilities from 135 in 2011/12 to 175.8 in 2012/13". A shortage of health care professionals also accords a challenge to the South African health system as adequate staffing and quality of care is necessary to improve "maternal survival" and other key objectives of the primary health care system. While South Africa is struggling with a shortage of health professionals in the public sector, poor management, including unfilled vacancies due to freezing of posts and delayed recruitment exacerbate staff shortages.

Public healthcare facilities and their inter-linkages in providing free maternal healthcare



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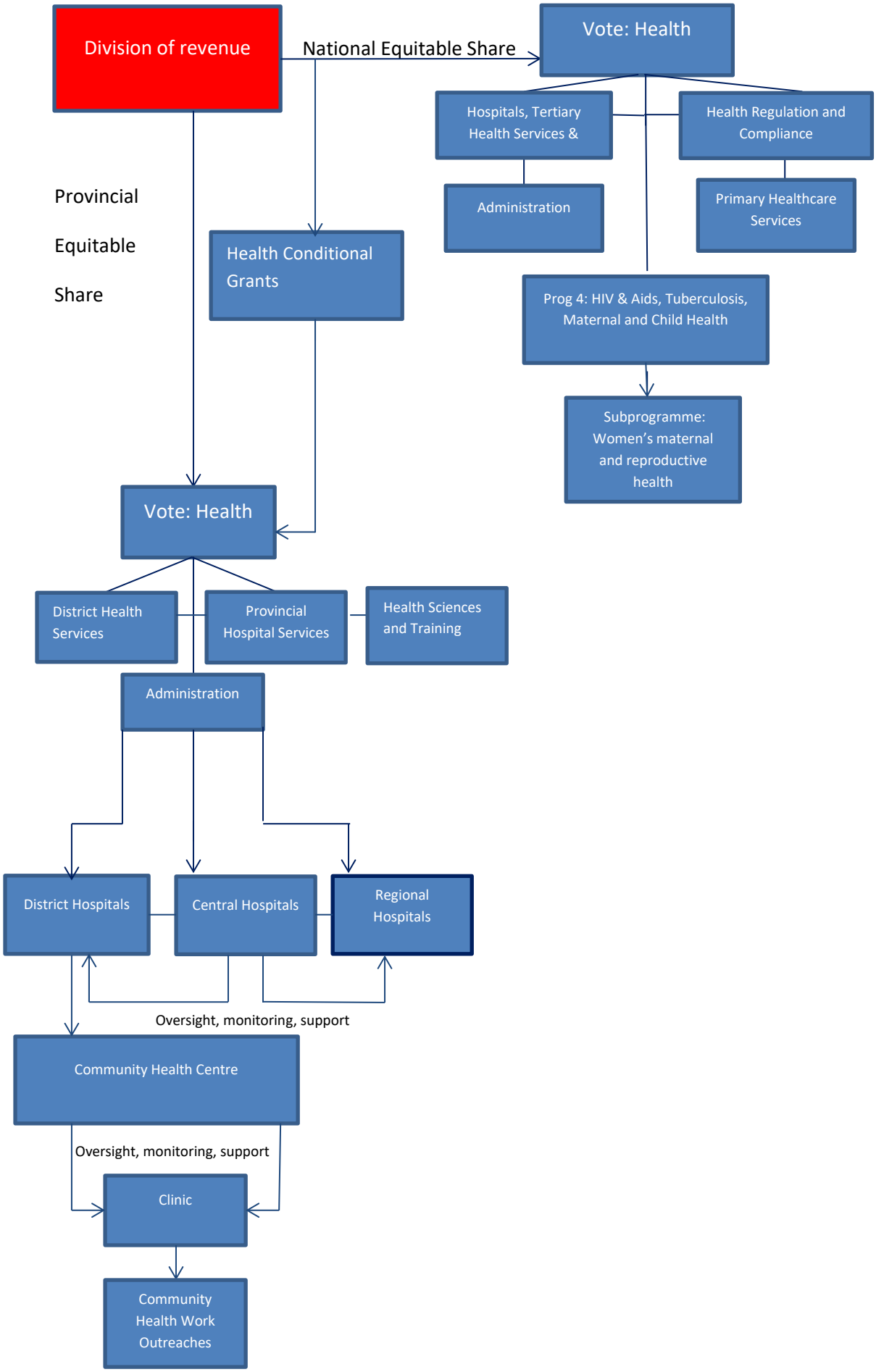
Tracing the funding for free maternal healthcare

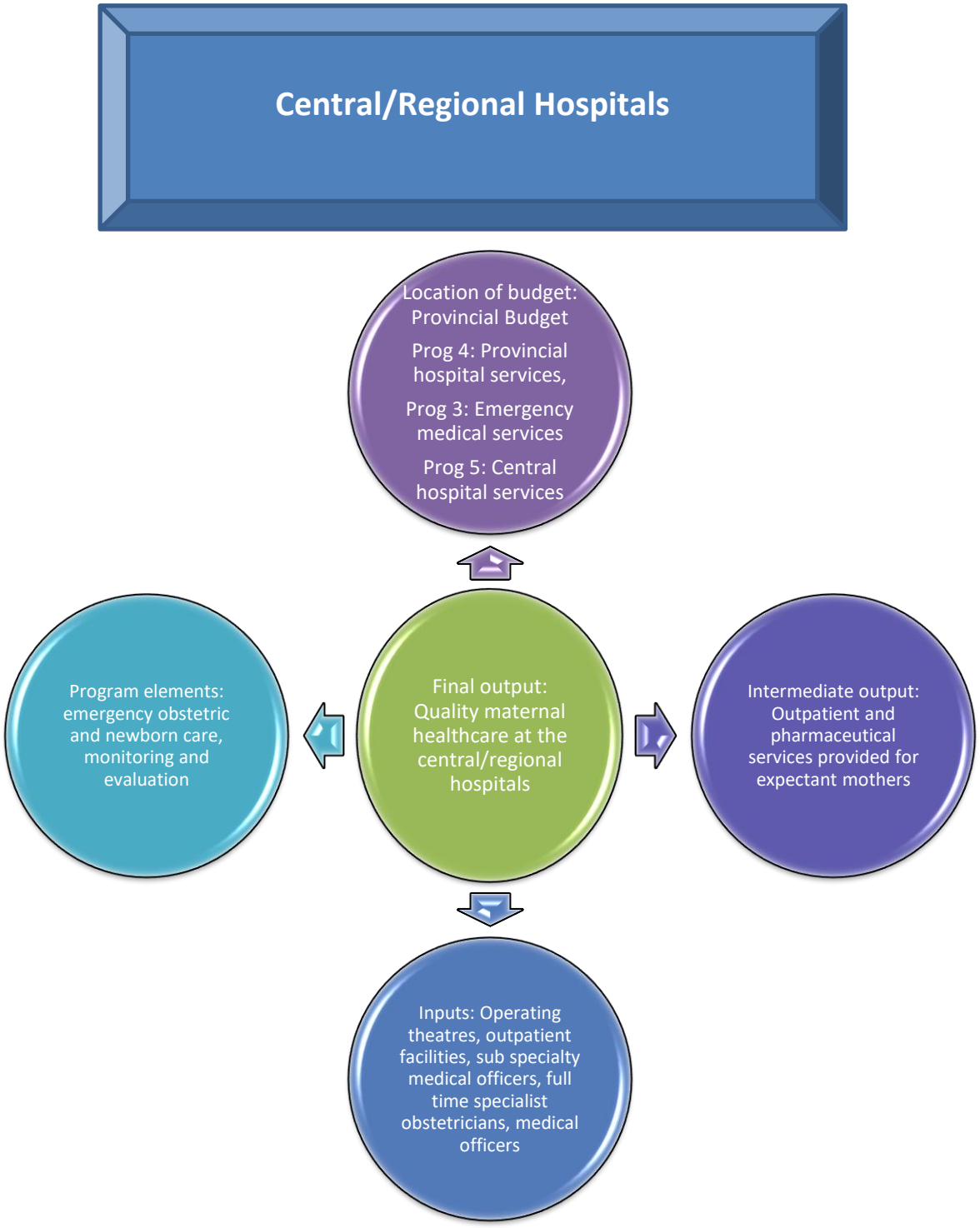


The role of National Department of Health in providing free maternal healthcare

The overarching goal of the Maternal and Child Healthcare programme is to reduce both the maternal and infant mortality ratios in South Africa. The log frame shows that the provision of free

MCH is a shared responsibility at both the National and Provincial levels of Government. The National Department of Health transfers the funding to the Provincial Departments of Health which in turn disburse the funding to the various public healthcare facilities through the districts. The Provincial Departments of health are also responsible for deploying healthcare professionals to the various health centres. Both National and Provincial Departments of health are responsible for providing policy, direction, funding, strategy, monitoring and evaluation for the programme.

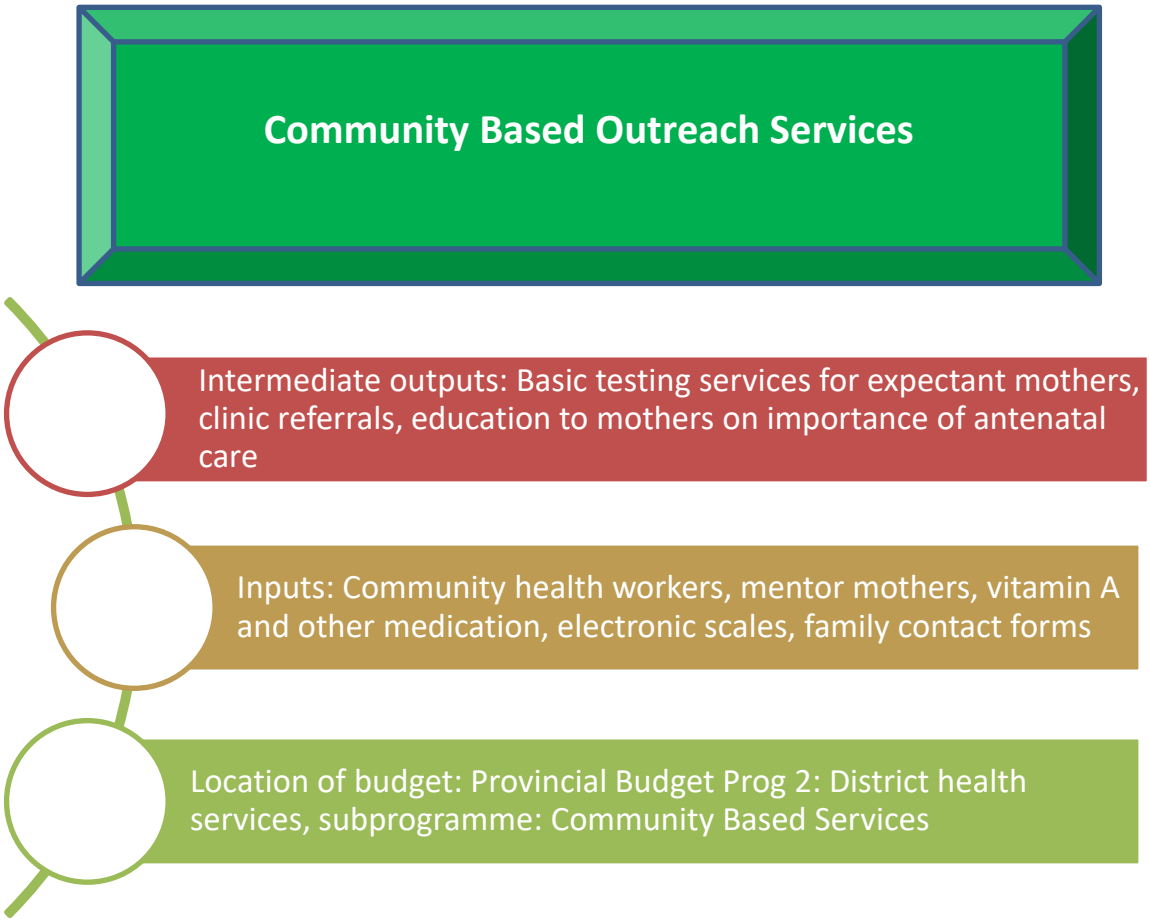
The role of Central hospitals in providing free maternal healthcare



The free MCH service is delivered at the various public healthcare facilities which include the central hospitals, district hospitals, community health centres, and clinics. After confirming a patient's

pregnancy, medical personnel in the various public healthcare centres schedule and provide antenatal care for the patient. As per the norms and standards of providing antenatal care, expectant mothers are not expected to wait beyond 90 minutes to receive medical attention. However in most central hospitals pregnant women sometimes wait as much as 8 hours to receive medical attention in the central hospitals. The staff to patient ratio in most central hospitals also far exceeds the ratio set by the World Health Organization. Although the central hospitals should provide emergency transportation to convey pregnant women to the hospitals within 60 minutes, most hospitals do not have adequate transportation to respond to all emergency requests in a timely manner.

The role of Community Based Outreach teams in providing free maternal healthcare



The Community Based Outreach Services offered by mentor mothers and community health workers constitute one of the most effective ways through which MCH is delivered. This scheme employs the services of 'Mentor mothers' who are elderly women in the community with significant experience with pregnancy and childbirth. These 'Mentor mothers' visit the homes of pregnant women living within a 10 kilometre radius from their homes to check on them as their pregnancies progress. Thus they are usually the first point of contact for expectant mothers, providing a more intimate approach to the provision of MCH. They play a vital role in the administration of MCH in that they encourage mothers to be to attend antenatal care and educate them on the dos and don'ts of a safe pregnancy.

They are also able to detect abnormalities in the early stages of pregnancy as they conduct simple preliminary tests on the pregnant women in their homes.

Inconsistencies in data capturing deter expenditure analysis

The expenditure analysis for this study was severely hindered because there was no uniform mode of capturing expenditure data for the various public healthcare institutions on the basic accounting system (BAS). The different institutions captured information on medicines, infrastructure, antenatal care, specialist care, vaccines and delivery differently. Thus, it was not possible to establish a pattern of expenditure for the public health facilities to be able to analyse expenditure trends. As a result of this, the study on free maternal healthcare does not include an expenditure analysis.

Costing model discoveries

The costing model focused on using costs associated with administration, medical personnel and medical supplies which form the bulk of maternal care provision requirements to cost maternal care in public health facilities.

Target population

The costing model anticipated universal coverage in the provision of free maternal and child healthcare. This is because it was introduced in 1994, and formed part of a series of social policies which aimed to reduce inequalities in health status and access to health care of South Africans.

Costing from whose perspective?

This costing study estimated costs from a health service provider perspective. This perspective was chosen to provide relevant cost information to government as the programme is funded by the state. As a result, patient cost viewpoints were not considered by this study.

Which costs were included?

The financial cost of providing maternal care was estimated using the public expenditure review approach. The recurrent costs considered in the study included compensation of employees' costs, medical supplies costs, training costs and travel and accommodation costs for visiting medical officers. Capital costs included the costs of training. These costs have been estimated for the 2016 MTEF period. A breakdown of costs included is outlined in the table below:

Table 1.1- Identifying costs associated with providing maternal care

Type of cost	Identification of cost	Measurement		Valuation	
		Measurement	Information source	Valuation	Information source
Recurrent costs					
Personnel	Administration, medical personnel	Percentage of time spent on different activities	Guidelines for maternity care in South Africa 2007	% time spent on maternal care per year X annual salary	Persal data
Medical	Folic Acid,	Average no. of	Guidelines	No. of	Pharmacies

supplies	tetanus vaccine, ferrous sulphate, antiretroviral drugs	medicines required per patient	for maternity care in South Africa 2007	medicines given per pregnancy X cost of each medicine	
Travel and accommodation	Car hire, hotel accommodation, food and per diem	No. of trips, no. of nights in accommodation	Web search		Program expenditure records
Fixed costs					
Training	Courses attended	Number of trainees	Department Planning documents	Number of training courses offered per year X cost per course	Educational institutions

Based on the information provided, estimates of administration and personnel costs for the 2016 MTEF period are captured in the table below. Administration costs include costs of administrative staff of both National and Provincial Departments of health who provide support to the MCH programme. The personnel costs include costs of trained medical personnel who provide maternal services to patients in public healthcare facilities. In order to obtain the costs for the 2016 MTEF the costs obtained in 2016/17 financial year were adjusted by 1 + the inflation rates for 2017/18 and 2018/19.

Table 1.2: Personnel costs of providing maternal care for 2016 MTEF period

Maternal care component	2016 MTEF cost
1. **Administration**	R 45 088 164.75
2. **Central Hospital**	R 9 473 189
3. **District Hospital**	R 11 624 281.25
4. **Community Health Centre**	R 4 285 347
5. **Clinic**	R 3 293 669

Table 1.2 above shows that the personnel costs associated with providing maternal care differ across the different types of public healthcare facilities. This is mainly because medical personnel in the different facilities dedicate varying amounts of time to providing maternal care as a result of differences in workload. For example, in a central hospital a grade 1 nursing assistant spends 40% of her time per week providing maternal care while a nursing assistant in a clinic spends as much as 80% of her time per week performing the same duty. The costs of providing maternal care also differ by type of personnel. For instance, a grade 1 medical officer spends only about 20% of her time per week providing maternal care irrespective of where the service is offered, while an obstetrician/gynaecologist spends 80% of her time per week providing maternal care. This can be attributed to the fact that the grade 1 medical officer is a generalist while the obstetrician/gynaecologist specialises in providing care for women.

This study found that although medical specialists are based in the major hospitals at the central and district levels, several dire maternal cases are reported at the community health centres where there are no medical specialists and where visiting medical officers rarely attend.

Providing quality maternal healthcare in South Africa is very important. There is the need to provide quality care to ensure the protection of the lives of both mothers and children, in order to make significant and sustained progress towards reducing by 75% the maternal mortality ratio in South Africa.

Sources:

- *Guidelines for Maternity Care in South Africa 2013*
- *2016 Estimates of Provincial Expenditure*
- *2016 Estimates of National Expenditure*
- *DPSA Cost of Living Adjustment 2015*
- *National Department of Health Strategic Plan 2014*
- *Millennium Development Goals country report 2013- The South Africa I know, the home I understand*
- *BAS data*
- *Persal Data*