



CHILD MORTALITY COMMITTEE LAUNCH – A CHANCE MISSED



The expensive Gauteng launch by the health department of two new expert committees probing the country's mortality crisis in infants and children under 5, was labelled by one insider as a 'PR exercise and a wasted chance to get started'.

Among the 30 experts flown from all over the country for the lavish launch, the insider said Health Minister Manto Tshabalala-Msimang selectively trumpeted health care delivery successes among women and children but ignored harsh realities.

Nothing was said about the committee's terms of reference or what resources were being committed to the belated but much-welcomed initiative. It is being regarded warily by obstetricians rendered skeptical by political 'massaging' of earlier maternal mortality data that came from a similar exercise.

Of the latest venture the *Izindaba* source said, 'It was basically a media launch when it could have been much more substantial and productive. We could have broken into committee and interrogated terms of reference, financing and statistical support, for example. It was a golden opportunity for dialogue – we were all there!'

Health MECs, representatives of WHO, UNICEF, UNDP and UNAIDS and journalists heard Tshabalala-Msimang pointedly request the committees to hold their first meeting

'within the next 3 weeks'. She added that she wanted their first report 'within 6 months' and thereafter annually.

Manto delivers – just the good stuff

In her speech she cited antenatal clinic attendance (94% of mothers attending at least once during pregnancy), PMTCT uptake (60%) and vitamin A supplementation (100% for infants of 6 - 11 months) as shining examples of delivery. There was no reference to research showing 1 in 5 baby deaths in South Africa to be 'completely avoidable', PMTCT coverage of just one-third of the country, nor of HIV/AIDS accounting for more than half of non-obstetric causes of maternal deaths.¹

Research by the country's top paediatricians, epidemiologists and HIV experts paints a far more sober picture of broad mother and child health care delivery, while several dramatic incidents of neonatal and infant deaths have dominated newspaper headlines.

A KwaZulu-Natal study in June last year showed that, of 2 900 deliveries, less than half of women who were HIV positive identified themselves as such at their 6-week 'wellness visit' and that the transmission rate among them was 30%.¹ A combination of maternal denial and seroconversion late in pregnancy (with concomitant high viral load) is aggravating the high incidence of mother-to-child infections.

Tshabalala-Msimang's only concession to the worsening mortality rates for infants and children under 5 (60/1 000 and 95/1 000 respectively)¹ was that, 'while significant progress has been made in addressing the challenges of maternal and infant mortality in the country, we believe there is still more that needs to be done'. While

the perinatal and infant mortality committees are new, the maternal mortality committee was 'freshened up' because the 3-year terms of several incumbents had expired.

Each committee will consist of 15 members chosen to 'reflect the demographics of the country and various expertise' in the health sector. The committees will help collate and interpret data, record the causes of deaths and contributing factors, and classify each death incident accordingly.

The minister added, 'They will thereafter make recommendations of the measures that need to be taken to address preventable causes and factors'. She conceded this was 'an enormous task' requiring dedication on the part of the committee members and co-operation from various role players within the national health system.

'We need information to filter through from facilities where incidents are first reported up to the national level to enable these committees to have most accurate information that they can work on.'

Besides the UK, South Africa is the only other country in the world that has instituted and sustained confidential enquiries into maternal deaths. The *Izindaba* source described the older Saving Mothers committee as 'extremely effective', but emphasised that it had taken '7 or 8 years' to deliver its findings.

Please don't massage our data

Its first report stirred debate in the obstetric community when maternal deaths were not attributed to HIV/AIDS (cited only as a contributory factor), raising questions about the utility of the data for prevention and treatment planning. 'It was perceived as government trying to massage the



mortality data in a certain way. This makes the independence and objectivity of the new committees vital. Getting the terms of reference up front becomes really important,' the source said.

All the experts on the new committees were committing themselves 'in a positive, constructive way. We want to give government the benefit of the doubt, but I will say Monday was a lost opportunity by being turned into a PR launch,' the source added.

Tshabalala-Msimang said 'considerable progress' had been made over the past 10 years in determining the causes of maternal mortality through the work of the National Committee on Confidential Enquiry into Maternal Deaths.

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Last year's HIV/AIDS conference in Durban, where she dramatically sidelined her former deputy and darling of HIV/AIDS activists, Nozizwe Madlala-Routledge, before boycotting it altogether, produced some alarming and pertinent research.

Professor Nigel Rollins (head of paediatric and child health at the University of KwaZulu-Natal) and Dr Harry Moultrie (Harriet Shezi Clinic, Chris Hani Baragwanath Hospital) showed how badly the system is failing mothers and children.

Rollins' field research revealed huge HIV-positive status under-reporting among new mothers at their 6-week 'wellness visit' to clinics and non-existent HIV tracking between antenatal care check-up clinics and maternity hospitals.

Moultrie told *Izindaba* that this severe lack of communication between the antenatal clinic, the hospital and the immunisation clinic meant that 'nobody has the slightest idea of which children have HIV or which should be getting co-trimoxazole prophylaxis' (which reduces mortality by as much as 43%). Moultrie recommended mandatory HIV testing at the 6-week child immunisation clinic and a doubling of HIV testing for pregnant women. He said failure to do this would result in 'an unstoppable wave of child mortality'. He estimated that the public health sector was reaching 26 000 children, or 1 in 6 needing drug therapy.

The lack of public sector tracking and record keeping also emerged from a comprehensive research audit of Durban's 4 regional hospitals. This showed that despite infants accounting for most paediatric deaths (63%), nearly 75% of all deaths had 'no information' on PMTCT provision.¹

South Africa is 1 of only 9 countries in the world where the child mortality rate is increasing instead of decreasing, mainly because of AIDS. The Medical Research Council (MRC) *Saving Babies* report last year said 1 in 5 baby deaths was 'completely avoidable', adding that 23 000 babies die annually in the first month of their lives – with thousands more stillborn. One MRC contributor compared this to a daily crash of 4 minibuses full of passengers, killing all on board.

Manto fails to provide 'coherent picture'

In a linked but unprecedented development, Parliament's usually compliant health committee on 26 February reprimanded Tshabalala-Msimang for failing to provide a coherent picture of progress in implementing dual therapy for PMTCT.

The committee instructed her to return when better prepared. 'I'm not satisfied with this presentation. Let's get another better, clear, succinct submission that we can understand,'

said ANC committee chairman James Ngculu, prompting an apology from the minister.

MPs were provided with copies of the Government's new 83-page policy guidelines on the therapy as she began speaking. Ngculu expressed frustration at the quality of the information and the tardiness of the documentation members had received. He said it was impossible for the committee to deal with the issue at hand. 'I would have thought there would be a document that specifically addresses (the issue),' he said.

Statistical modelling has shown that dual therapy will reduce mother-to-child HIV transmission from 35% to 10%, meaning that the number of infants infected during childbirth would drop from about 70 000 to 30 000 annually across the country.

HIV Clinicians Society chief, Dr Francois Venter, says two-thirds of all HIV-positive infants require ART by 10 months of age and a full one-third die of AIDS within their first year of life. 'Basically if we get PMTCT right we'll obliterate the need to expand the programme for children. There are only about 60 cases of paediatric HIV in America – we have far more than that in Johannesburg alone,' he said.

Every paediatric infection prevented today would save on treatment needed in a year's time.

Venter said the entire PMTCT and antenatal care delivery systems needed urgent strengthening and broadening before dual therapy could have the desired effect.

He described just over 30% PMTCT coverage for the entire country as 'an absolute disgrace'. The new committees will be 'harmonised' across the southern African region with the idea of 'critically looking at mortality' being generally welcomed, in spite of existing fears.

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1. Bateman C. Mandatory testing a 'human rights imperative'. *S Afr Med J* 2007; 97: 565-567.