Saving South African babies

Pregnancy is usually a happy event crowned by the birth of a healthy baby. But sad individual experiences and statistics show that in a number of cases what should be a happy occasion can turn out to be a devastating experience. In South Africa the perinatal loss of children is regrettably high compared with rates in developed countries.

The large Perinatal Problem Identification Programme (PPIP) was therefore launched with the objective of identifying the major causes of perinatal mortality in South Africa, and the most common avoidable factors, missed opportunities and substandard care. Seventy-three sentinel sites, grouped into three categories (the metropolitan areas, cities and towns, and rural areas), provided the data. Pattinson reports on behalf of the sentinel sites (pp. 445 and 450). Strategies for reducing perinatal mortality without enduring major costs are proposed by the Saving Babies Group in an editorial (p. 434).

These data are unique in that most of the input is from non-academic hospitals, giving a reflection of the true perinatal care situation in South Africa. However, weaknesses acknowledged are that hospitals supplying PPIP data are likely to be of higher standard than those not supplying data, that the data are not population-based, and that the data exclude births from private institutions.

A high low-birth-weight rate (LBWR) was found at all sites, characteristic of a developing country where the majority of the population is poor. The LBWR is two to three times higher than in a developed country. High rates of death due to intrapartum asphyxia and birth trauma at all sites, but especially in the cities and towns and rural areas, are cause for great concern. There are a disturbing number of unexplained intrauterine deaths recorded in the survey. Concurrent with the rise in the incidence of unexplained macerated intrauterine deaths has been the rise of the HIV/AIDS epidemic. It has been well described that a pregnant woman who is HIV-infected has an almost four times greater chance of having a stillbirth and two times greater risk of preterm labour.

Key strategies regarded as implementable solutions are proposed, namely ensuring that sites that manage labour, conduct births, care for premature infants or provide antenatal care have the necessary equipment and protocols, and that the health care providers are appropriately trained. There is also a need to move to a system where the time and point at which the woman confirms that she is pregnant also becomes her first antenatal visit, where she can be classified according to risk.

Dreaming 'to rest'

A new African health care delivery model that is affordable and sustainable has been developed with the aid of a multinational agency. This African Medical Renaissance model, named *Phumula*, which in Zulu means 'to rest', is situated in the rolling hills of KwaZulu-Natal outside Pietermaritzburg (p. (p. 423).

This pilot project was developed with the assistance of members of the community including Zulu elders and sangomas. The buildings are all made of thatch and there is a resident thatcher and thatch cutters. Patients lie on rugs on the earth floor. Relatives or mothers of children sleep on rugs next to the patients, for whom they cook, and whom they wash and feed. There is a weaving hut to make rugs and blankets, bricks are made on site and a volunteer occupational therapist has set up a craft shop. Provision has been made for a school and for religious worship.

This model has similarities with the home-based care model of Hospice and other hospitals in which patients are looked after by family or other carers who stay in the hospital or close by. Since its estimated costs are a fraction of those of conventional hospitals the editors were most interested in publishing this communication so that it could perhaps be applied much more widely. However, the question of sustainability was uncertain and we entered into correspondence with the author. It transpires that the project is indeed real, but, the author confessed, only in his own mind. We therefore take delight in publishing it as a dream worthy of reality!

CPD or else!

The *SAMJ* correspondence column has carried letters from practitioners who lament the introduction of continuing professional development (CPD) requirements and its imposition on their lives. The most frequent refrain has been the potential loss of prescribing rights by elderly doctors who wish to continue prescribing for themselves or their families. At our request, the chairman of the CPD Committee of the Medical and Dental Professions Board has supplied an update on the CPD situation (p. 424).

One useful matter clarified by Dr McCusker is that provision has been made for a separate registration category for doctors who are engaged in non-clinical practice. Whatever our individual views about the desirability or otherwise of CPD, as one of those ideas that are sweeping the globe it is here to stay.

Cost-effective medicine

Several papers deal with aspects relating to costs of medical care (pp. 416, 419, 420). The capacity of individuals and of funders to pay for all possible medical interventions is becoming increasingly limited. The challenges that face societies in addressing some of these difficult decisions involving rationalisation and rationing are addressed by Benatar and Fleischer in a thoughtful editorial (p. 433).

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