

## Perinatal statistics – some good news



Perinatal and maternal health statistics are used extensively as markers for the effectiveness of health service provision in a country. Because of their importance in this role, several of the rates were incorporated into the Millennium Development Goals (particularly Goals 4 and 5). In Minister Trevor Manuel's forward to the Millennium Development Goals, Country Report 2013<sup>[1]</sup> compiled by Statistics South Africa (SA), he highlighted the lack of consensus on the actual levels of maternal mortality because of different data sources and methodology; however, he acknowledged that SA was lagging behind that particular target. The official 2010 figure was 269/100 000 live births, which is seven-fold greater than the 2015 goal of 38/100 000 live births. The report indicated that SA was unlikely to achieve its 2015 target for maternal deaths, but was likely to achieve the target of 100% of births being attended by skilled health personnel by 2015. According to Statistics SA, our infant mortality rate was 38/1 000 live births in 2010, with the 2015 target being 18/1 000 live births. Approximately 40% of our <5-year-old mortality is made up of neonatal deaths, therefore if SA is going to effectively reduce <5 mortality, it will have to substantially reduce its neonatal mortality rate.

In this issue of the *SA Journal of Child Health (SAJCH)*, the changes in perinatal health statistics over a 22-year period in a rural area of KwaZulu-Natal have been meticulously documented.<sup>[2]</sup> The importance of the information contained in this research is that the data refer to a health region or district rather than a health facility, thus providing insights into the changing pattern of health indices within a community. What is clearly evident from the information provided is the role that HIV/AIDS and its management (or lack thereof) have played in determining the initial deterioration and subsequent improvement in the recorded health indices. What is pleasing to see is the progressive and maintained decline in all three indices of neonatal wellbeing since about 2004; neonatal mortality, stillbirth and perinatal mortality rates have declined but have only been below the 1990 rates since 2008. A similar pattern is observed in maternal mortality, although the yearly fluctuations are greater. In general, the change in the statistics is a welcome trend, but one should not be complacent about a continued decline in mortality rates as there is a suggestion from the figures provided that the decline is plateauing off. It is likely that it will become more and more difficult to ensure continued falls in mortality unless there is an improvement in health professionals' training in neonatology, an improvement in staffing in the maternity sections and an assurance that equipment is maintained.

Although the majority of the statistical trends are welcomed, there are several that might be of concern. Despite an improvement in the percentage of antenatal clinic registrations, some 15% of pregnant mothers did not attend a single antenatal clinic (ANC) before delivery, and only a third booked at an ANC before 20 weeks of gestation. Furthermore, there has been a fall in the percentage of clinic deliveries from 24% in 1990 to 6% in 2012, which reflects

an increase in the burden of deliveries that must be borne by the district hospital. As the authors indicate, this increase in mothers delivering at the district hospital has been associated with an increase in the caesarean section rate, probably to the benefit of the child through a reduction in neonatal asphyxia and meconium aspiration. However, the shift in deliveries from the health clinics to the district hospital must be associated with the appropriate increase in staff and equipment so as to prevent unattended deliveries and delays in obtaining caesarean sections, and to ensure appropriate ante- and postnatal care. It is hoped that the current article will stimulate other health regions to undertake similar studies so that more accurate and realistic perinatal health indices are obtained countrywide.

Audits such as the one referred to above are essential if we are to understand the effectiveness and value of our healthcare and of specific management protocols. Therefore, audits should be an integral part of all healthcare delivery. It is not surprising that we often forget that we are required to get appropriate ethical and health authority approval prior to submitting such research to journals for publication. The *SAJCH*, together with a number of other SA journals, formally agreed in 2012 to follow the recommendations of the International Committee of Medical Journal Editors (ICMJE), which in its detailed recommendations on article writing and publishing states: 'The Methods section should include a statement indicating that the research was approved or exempted from the need for review by the responsible review committee (institutional or national). If no formal ethics committee is available, a statement indicating that the research was conducted according to the principles of the Declaration of Helsinki should be included.'<sup>[3]</sup> The *SAJCH* will only publish articles in which the authors make it clear that they have abided by the ICMJE recommendations. These recommendations only refer to scholarly work being submitted for publication and thus for possible inclusion in the public domain. Audits conducted within departments or hospitals for internal use only do not fall within these criteria.

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