Chapter 36
Maternity Care, Maternity Guidelines, and the BANC Checklist

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ABSTRACT

The area of care of the BACIS program is maternal health. This is one of the priority areas in the health system in South Africa. It is an area that also has targets that have been set under the Millennium Development Goals and Sustainable Development Goals of the United Nations. The first section of the chapter, after the introduction, presents data on this issue of maternal healthcare. Data is important because it allows us to understand the extent of the problem as well as to set targets. From the data we also get to understand the various contributors and factors to this issue, factors including administration-related factors, patient-related factors, and health provider-related factors. After the data follows the discussion of the guidelines themselves. The chapter is also partitioned between content on maternal mortality and content on perinatal mortality, which are important quality measures in maternal and neonatal care.

INTRODUCTION

This chapter covers the topics of the Basic Antenatal Care Checklist, the Guidelines for Maternity Care in South Africa, and strategies currently in use by the National Department of Health for improving the quality of maternal health services in South Africa. The sections up next present data on this issue, then in the latter sections of the chapter the discussion moves to the maternal health guidelines themselves.

DOI: 10.4018/978-1-6684-6299-7.ch036

ANTENATAL CARE AND THE QUALITY OF MATERNAL SERVICES

Maternal and Perinatal Mortality as Quality Indicators

Maternal mortality and perinatal mortality are the ultimate indicators of the quality of maternal care services. Maternal mortality refers to loss of mothers and perinatal mortality refers to loss of unborn or newborn babies. According to the following two World Health Organisation reports (WHO 2007; WHO, UNICEF, UNFPA & The World Bank 2007), the data for maternal and perinatal mortality around the world were as follows:

- In South Africa, in 2004 the maternal mortality rate was estimated at approximately 400 per 100 000 live births and perinatal mortality was at 28 per 1000 live births. This is similar to other developing countries. For example, India had a maternal mortality rate of about 450 per 100 000 live births and perinatal mortality of about 64 per 1000 live births in the same period, while Brazil had a maternal mortality rate of 110 per 100 000 live births and a perinatal mortality rate of 17 per 1000 births in the same period.
- The maternal mortality rates for developed countries are typically less than 20 per 100 000 live births. For example, the USA had a maternal mortality rate of about 11 per 100 000 live births and a perinatal mortality rate of about 7 per 1000 live births, in the same period.

These maternal and perinatal mortality outcomes from the developing countries are not meeting the targets set in the Sustainable Development Goals. One of the major contributors to maternal mortality in South Africa, are HIV related complications. According to the National Department of Health (2006; 2008), HIV related complications account for about 20% of maternal deaths. To address this problem, the country has undertaken the widespread roll out of the PMTCT programme for HIV positive mothers (Goga, Dinh & Jackson 2012).

Reduction of Maternal Mortality in Developed Countries

In the 1870s the maternal mortality rate in most of the European countries was greater than 600 per 100 000 live births (De Brouwere et al. 1998). Sweden was the first country in Europe to recognise the problem of maternal mortality and to take action. In Sweden it was found that most maternal deaths were avoidable if home deliveries were attended to by a trained midwife. They then embarked on training of midwives, which took time. By 1900, 78% of home deliveries in Sweden were attended by trained midwives while, in 1860, less than 40% of births were attended by trained midwives. The midwives were supervised by local public health doctors who were called in cases of serious complications and were also accountable for official reports. Only about 2% of births took place in hospitals. By the early 1900s the maternal mortality rate in Sweden had dropped significantly, being estimated at 228 per 100 000 live births.

After the Second World War the capacity of hospitals to handle emergencies further lowered the maternal mortality rate to about 85 per 100 000 live births. “It was not until 1949 that confidential enquiries into maternal deaths drew attention to other causes of maternal mortality that could be avoided by methods of prophylaxis and treatment.” (De Brouwere, et al 1998: p773). This new awareness and