

# Consolidating strategies to promote maternal & infant health in the Eastern Cape: Responding to & Moving beyond Millennium Development Goals (MDG's)

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*Welcome to the*

University of the Western Cape

Respice Prospice



# Outline of Presentation

1. Painting Picture: Maternal health in Africa
2. Maternal morbidity/mortality in SA and in Eastern Cape
3. Infant morbidity/mortality in SA and in Eastern Cape
3. International and Regional influences on MDG's
4. Consolidating Strategies: what to achieve beyond MDG's
5. Conclusion and Recommendations
6. Discussion and Questions with audience

# Painting the picture

- ❑ “Look at your own mother in the eye, and you will see how important a mother is...” (Fathalla, 1989).
- ❑ “A woman who gives birth in Africa opens her own coffin” (Katzive, 2003)
- ❑ “Being pregnant in Africa makes bungy-jumping & skydiving to look safer...” (unknown)
- ❑ Childbirth is a universally celebrated event and an occasion for dancing, fireworks, flowers or gifts. Yet for many thousands of women each day, childbirth is experienced not as the joyful event it should be but as a private hell that may end in death”. (Royston and Armstrong, 1989, p.9).



**SAVING MOTHERS**  
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# Introduction: Maternal Health in Africa

- ❑ Africa faces a challenge in meeting the UN MDG's 4,5,6 to improve maternal and child health outcomes and reduction of HIV infections.
- ❑ Women die during childbirth from preventable deaths. The lifetime risk of a woman to die from complications of pregnancy in Africa is highest in the world, with Sub-Saharan leading the pack.
- ❑ A girl born today isn't likely to live much past the age of 50 in Botswana, Central African Republic, Lesotho, Sierra Leone, Swaziland DRC and Zambia while in Japan female life expectancy is over 87 yrs old.
- ❑ In Somalia, only 1% of women use modern contraception. Rates are 5% less in Angola, Chad, Eritrea, Guinea and Niger.

# Introduction...

- ❑ Most African countries have no maternal & newborn health plan that determines work force distribution and staffing norms on ratio of HW to the population or deliveries.
- ❑ The quality and quantity gaps in coverage of midwifery workforce (Hofmeyer et al, 2011).
- ❑ Coverage gap: eg, out of 452 birth complications that happen every day in SA, 172 occur in rural areas. 43.6% of the SA population live in the rural areas, but are only served by 12% of doctors and 19% of nurses.
- ❑ In SA saving mothers' reports, substandard management care are health workers related factors contributed to the avoidable maternal deaths (SA Department of health, 2001, 2004, 2007, 2010).

# Introduction...

- ❑ Sub-Saharan Africa accounts for 18 of the 20 lowest ranking countries on skilled attendance at delivery
- ❑ The shortage of qualified health workforce in Africa has been highlighted as one of the bottlenecks to achieving the MDG's.
- ❑ Education & Training of maternal health work force inadequate eg. Midwives. WHO and UN confirms that midwives are guaranteed to save lives of mothers and newborns if are adequately trained and skilled.

# Introduction....

## **Midwifery teachers in Africa**

- No clinical experience prior to teaching & no exposure to clinical environment at all during as part of teaching.
- No teaching qualification and or understanding of adult learning.
- Professional and academic qualifications low & overworked eg Tanzania

(Ayo, 2006;Dennis-Antwi,2010; Thomson, 2002,)

## **Midwifery Education & Regulation:**

- Forty seven Africa health academic institutions last performed curriculum review 10yrs ago.
- In Zimbabwe, one midwifery book, no mannikins
- Staff shortage across health institutions

(Fullerton, Johnson & Vivo, 2010)



# Introduction.....

- ❑ Midwifery profession not regulated by midwives in most countries in Africa but administered under ministry of health. This is in contrast of ICM global standards (ICM, 2010)
- ❑ Lack of professional socialization of students because of mentor shortage (Andrews & Chilton, 2000)
- ❑ No uniformity on Midwifery programmes across and within a country

Who is a midwife? Is there African midwife? A place for core midwifery competencies in Africa? The standards are questionable

# SAVING MOTHERS

*Essential Steps in the  
Management of  
Common Conditions  
Associated with  
Maternal Mortality*

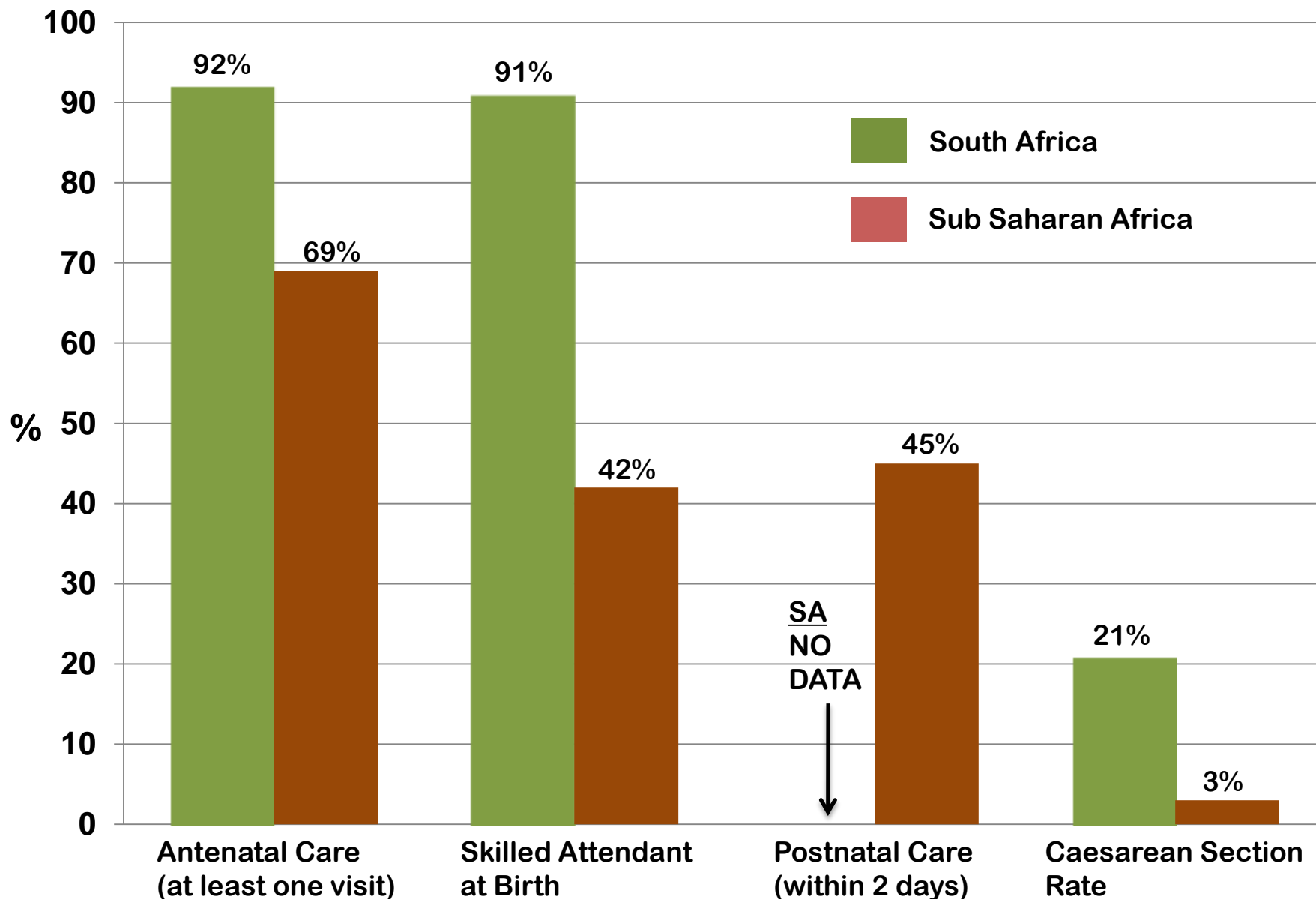
**South Africa  
and Eastern  
Cape: The state  
of mothers**

# RELEVANT POLICIES TO IMPROVE MATERNAL HEALTH IN SA

- ❑ **1994** Free health care for pregnant women and children under 6 years
- ❑ **1997** Implementation of Choice of Termination of Pregnancy Act.(1996)
- ❑ **1998** Maternal deaths notifiable by law (1997) and National Confidential Enquiry into Maternal Deaths (NCCEMD) initiated.
- ❑ **2010** PMTCT policy revised
- ❑ **2012** PHC Re-engineering including district specialist teams
- ❑ **2012** NHI

*“Enabling political environment”*

## Coverage of Key Maternal Health Interventions in South Africa



Source: - Opportunities for Africa's Newborn. J. Lawn. Cape Town 2006  
- SAHR 2010

An illustration of a woman with short dark hair, wearing a purple top and a gold hoop earring, gently holding a baby. The baby is looking up at her. The background is a soft yellow. The entire illustration is framed by a thick red border.

# **Saving Mothers**

**Third Report on Confidential  
Enquiries into Maternal Deaths in  
South Africa  
2002 - 2004**

**Executive Summary**



**health**

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

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**AIDS HELPLINE  
0800-0123-22**

# SOUTH AFRICA: NCCEMD

- **NCCEMD**: a ministerial committee of experienced personnel representing obstetrics, midwifery, anaesthesia, and the 9 different provinces, with department of health administrative support.
- **The Enquiry is Confidential** and different from medico-legal or disciplinary processes.



## The process of Confidential Enquiry into Maternal Deaths

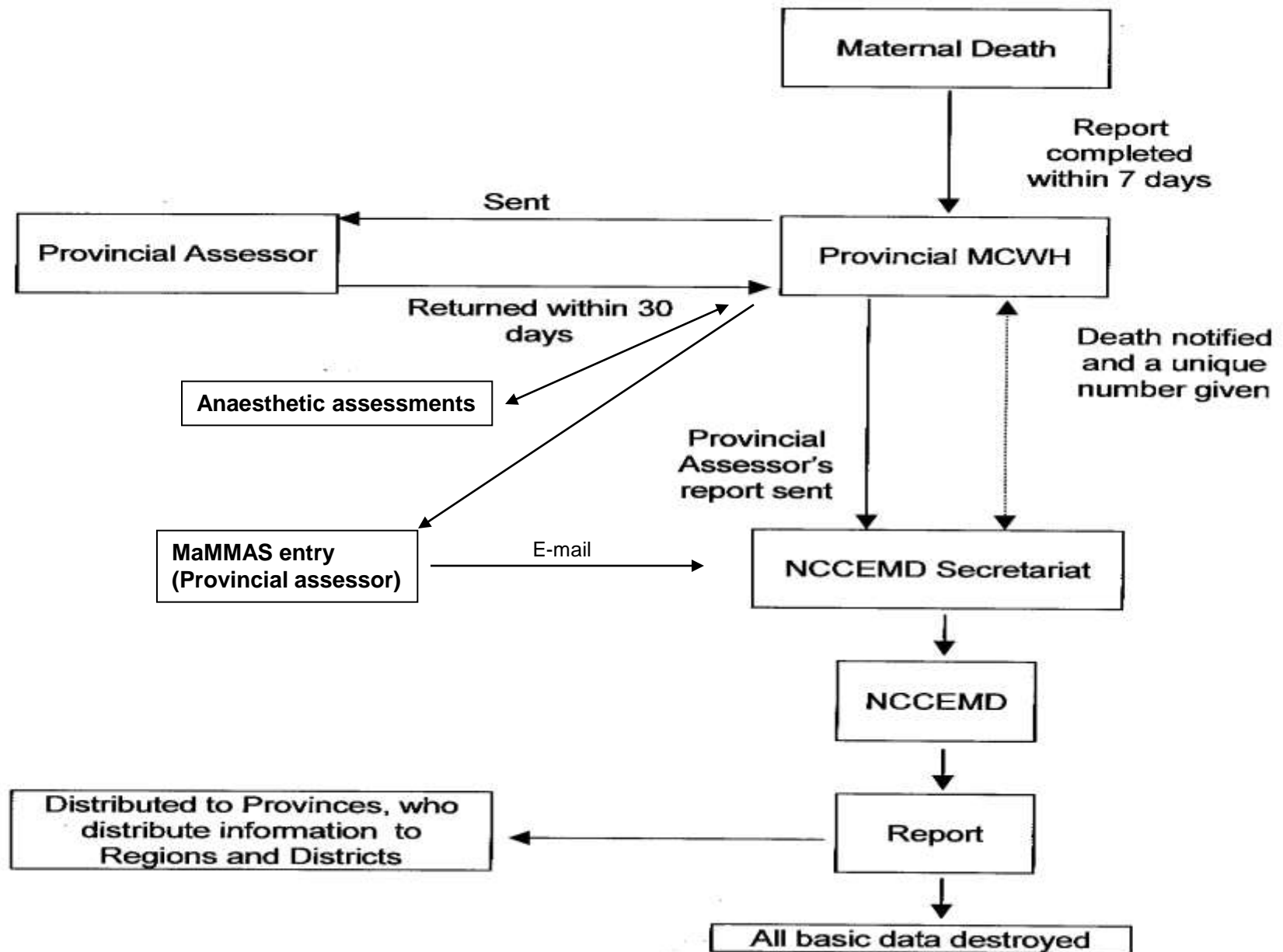
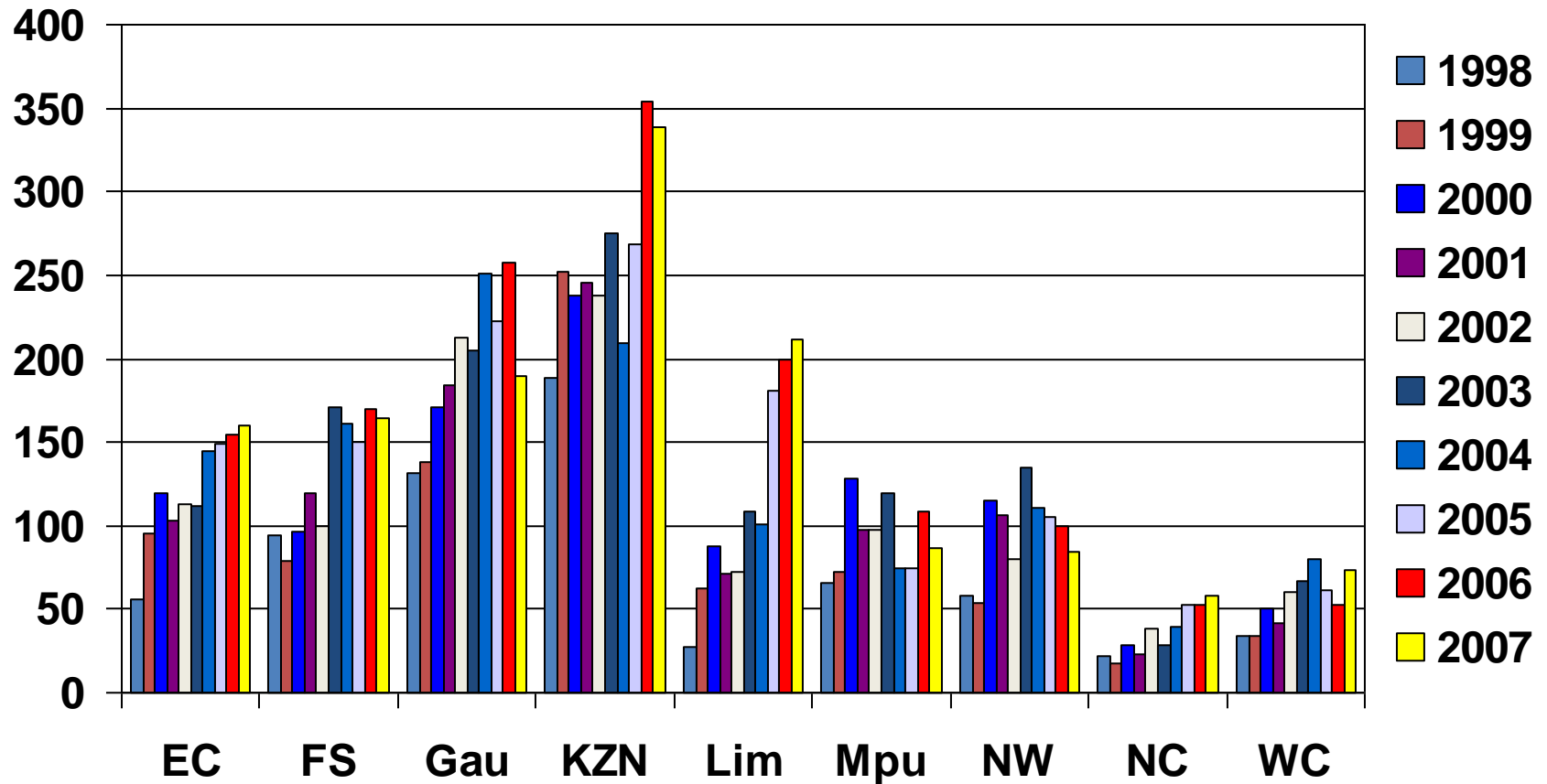
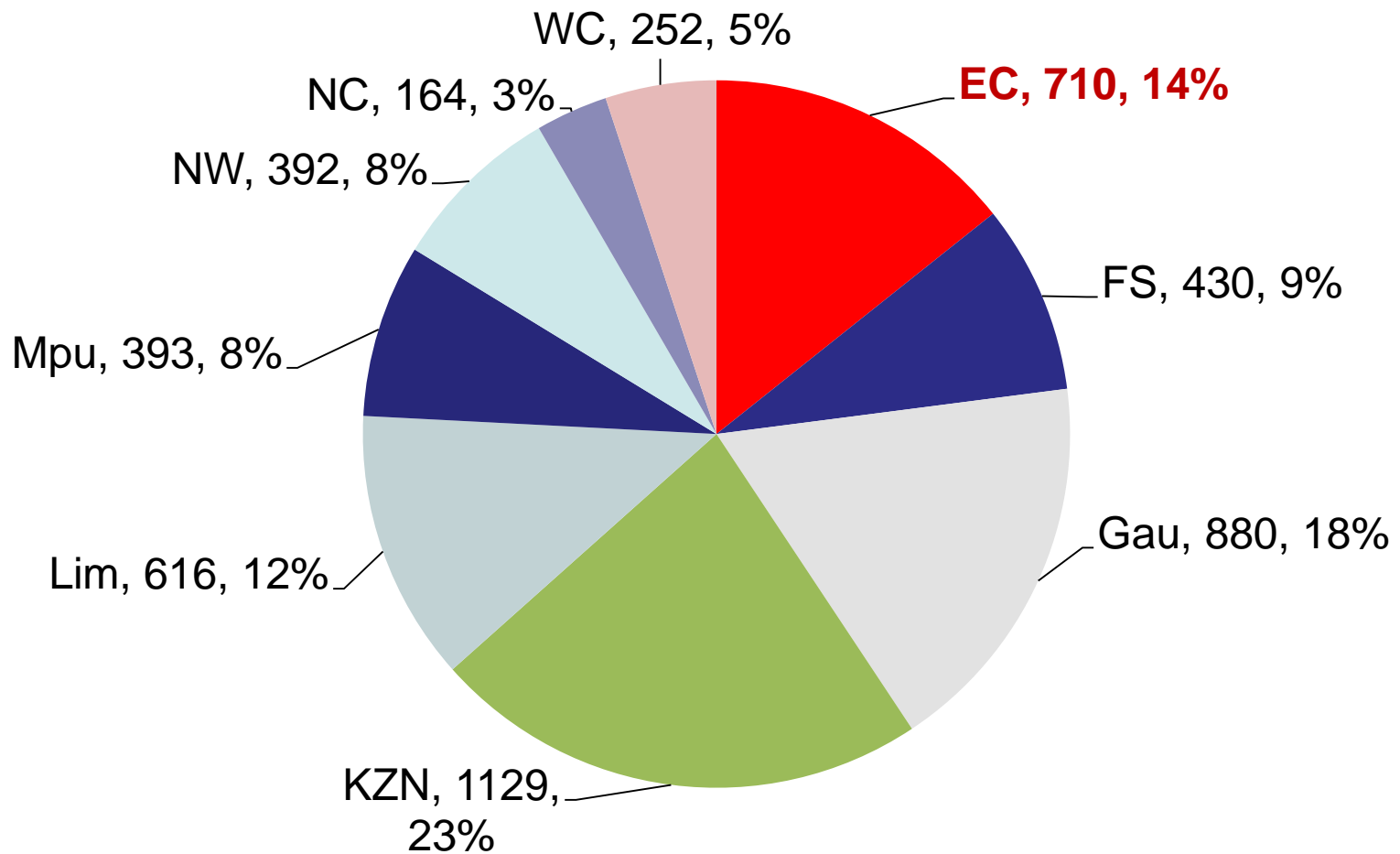


Figure 1.1. Number of maternal deaths reported per province 1998-2007



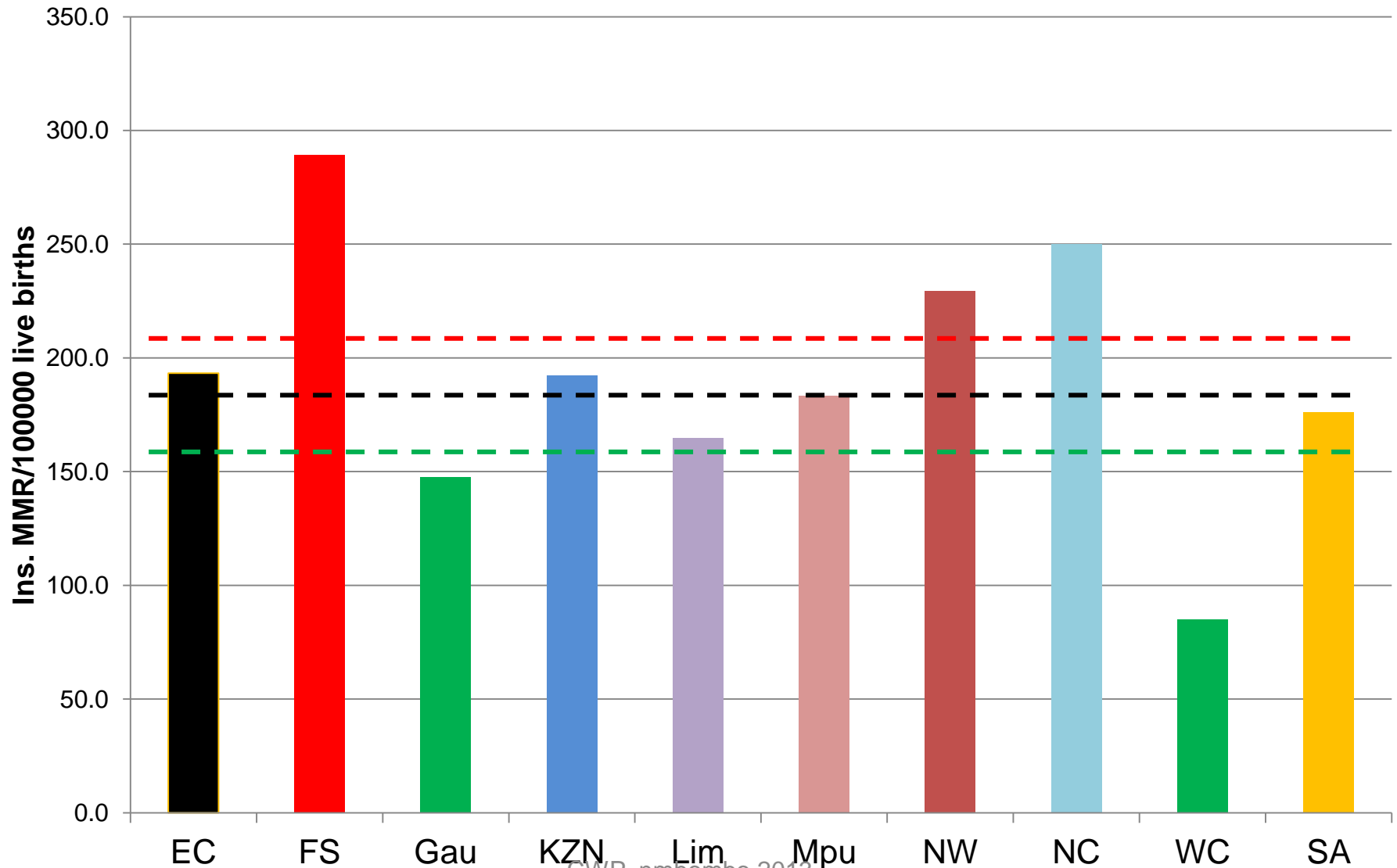


# Maternal Deaths per Province 2008-2010

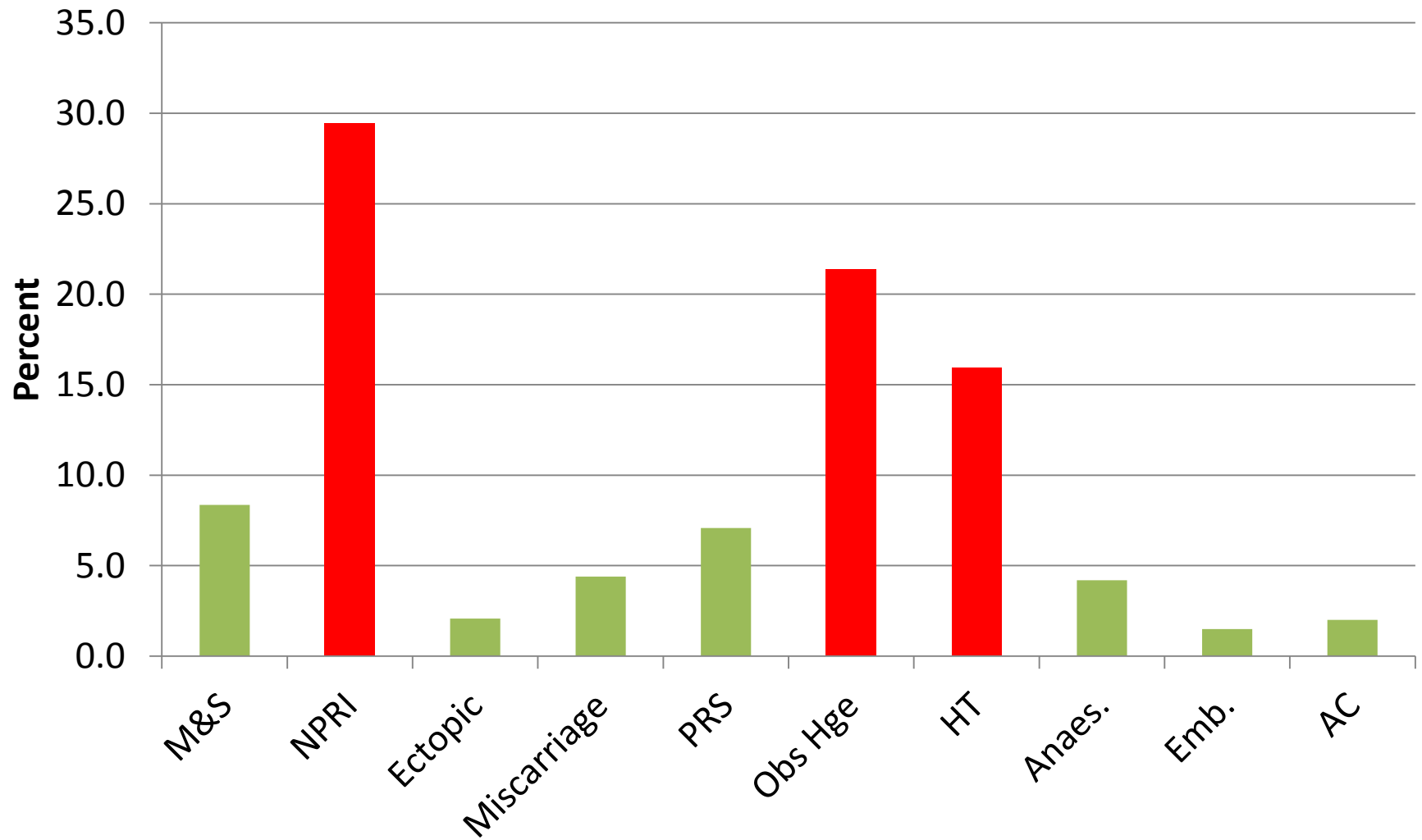


# Health Facility MMR per province

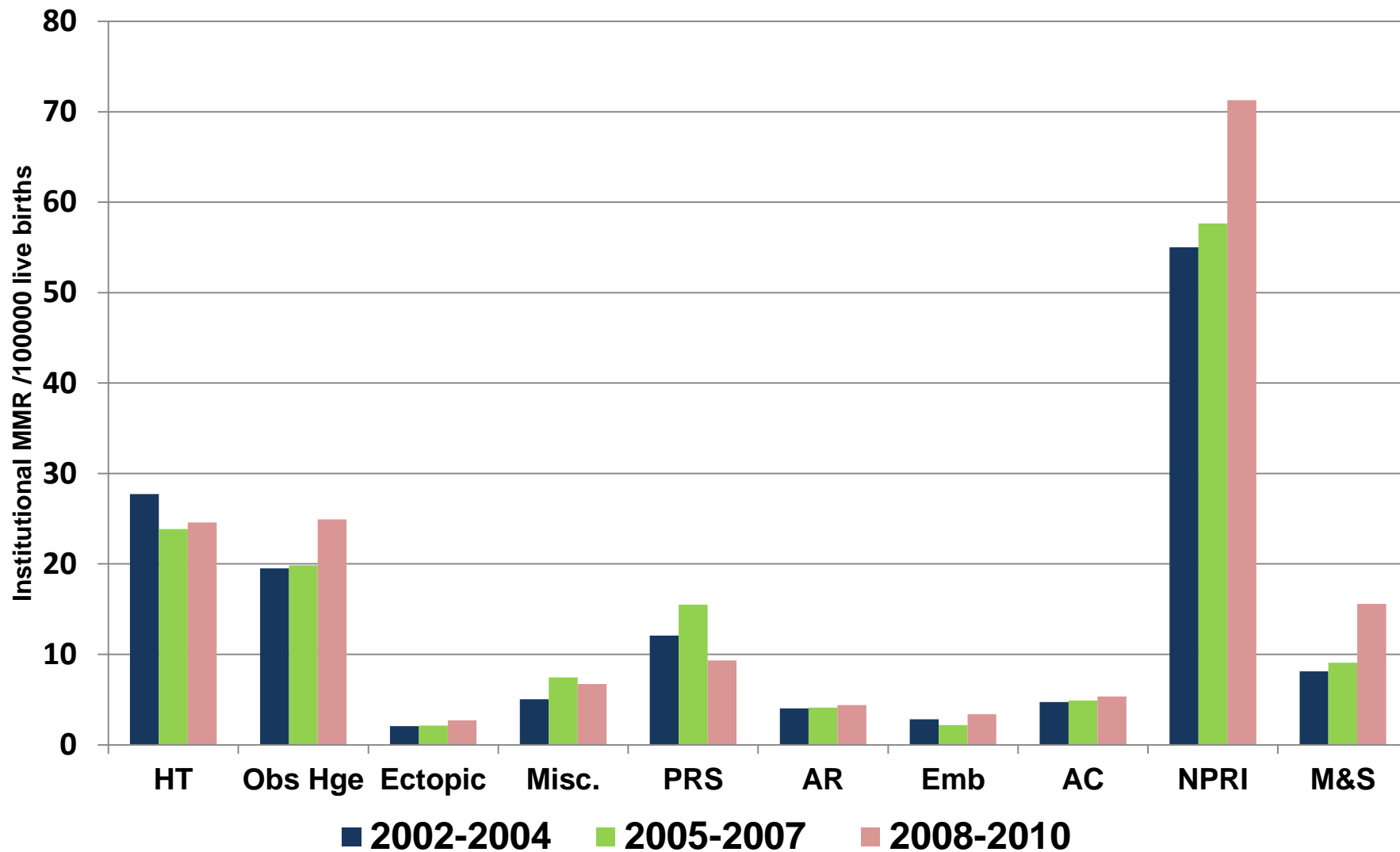
## 2008-2010



# Underlying causes as a proportion of avoidable deaths



# Trends in underlying causes of maternal deaths in SA 2002-2010



# Distribution of the underlying cause of death and age category in SA: 2008-2010

Cause of death	< 20 %	20 - 24 %	25 - 29 %	30 - 34 %	35 - 39 %	40 - 44 %	45+ %
M&S	10.0	20.7	22.3	20.2	17.7	8.6	0.5
NPRI	4.9	18.4	33.1	24.9	15.2	2.8	0.6
Ectopic	2.7	14.7	28.0	37.3	13.3	2.7	1.3
Misc.	5.4	26.3	28.5	16.7	21.5	1.6	0.0
PRS	12.0	23.3	22.1	24.4	12.8	3.9	1.6
Obs Hge	6.8	17.3	23.4	23.4	18.2	8.9	2.0
HT	14.7	22.7	22.2	18.1	15.9	5.2	1.0
Anaes.	18.2	26.4	14.9	22.3	13.2	3.3	1.7
Emb.	8.6	18.3	23.7	19.4	16.1	12.9	1.1
AC	8.8	10.8	33.1	23.6	15.5	7.4	0.7

xxxxx	15% above general pregnant population
xxxxx	Between 15% above and below general pregnant population
xxxxx	15% below national general pregnant population

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# Underlying conditions

- **HIV & AIDS**

- 80% maternal deaths tested for HIV
- 70% of those tested were HIV positive
- Pneumonia, TB, PCP pneumonia, Meningitis most commonly associated

- **Obstructed labour**

- 10% women who went into labour

- **Anaemia**

- 43% women who died and haemoglobin value known

# Avoidable factors, missed opportunities and substandard care

- **Patient related**
  - Accessing health care services
  - Unsafe miscarriages
- **Administrative**
  - Transport between facilities
  - Access to ICU
  - Access to blood
  - Inadequate staff
- **Health care providers**
  - Not assess patients properly
  - Delay in referral
  - Not follow standard protocols

# WHY IS THERE NO IMPROVEMENT?

- **Community factors** not identified or addressed by Confidential Enquiry
- Clinical focus instead of public health and **Health System** management focus
- The “**Quality gap**” *NB: Human Resource issues-emigration, training.* (SA health review 2010)
- The “**Equity gap**” *NB: Urban vs Rural and Public vs Private Inequities.* (SA health review 2010)
- The “**KNOW-DO**” gap



# The “KNOW-DO” gap:

- ❑ Recommendations made but with **no implementation strategy**, indicators or targets.
- ❑ Lack of clarity about **whose responsibility** it is to implement the recommendations

# Strategies to address 'know-do' gap

- ❑ Implementation to include Performance Appraisal of health managers
- ❑ Linkages: National Blood transfusion Service / fridges
- ❑ Human resources:
  - Training in emergency obstetric and neonatal care (ESMOE)
  - District MCH teams / outreach
- ❑ New HIV strategy
- ❑ Client friendly services

# RECOMMENDATIONS FROM SAVING MOTHERS

## 2008-2010 Triennium: **5 H's**

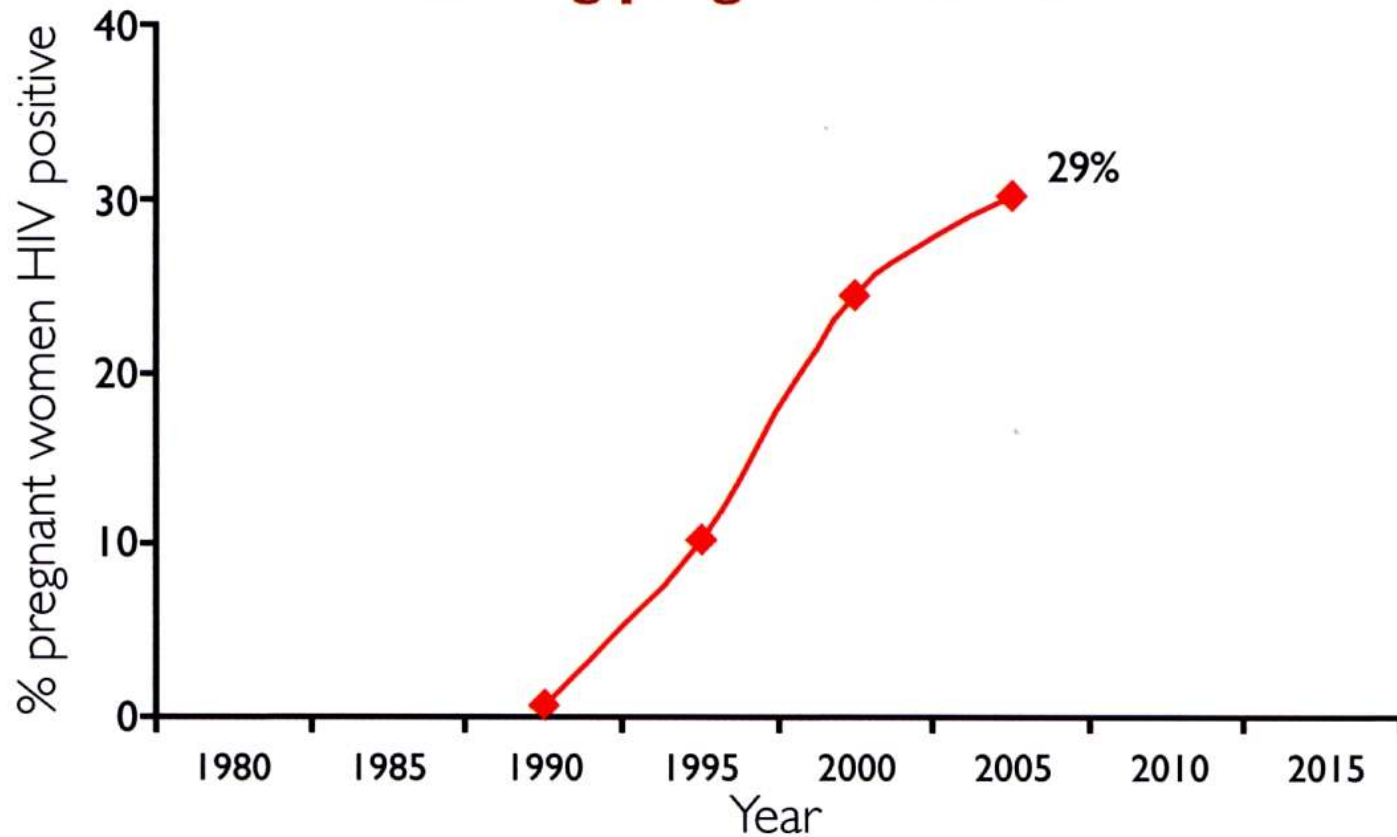
### Prioritisation of interventions

- Reduce deaths due to **HIV/AIDS**
- Reduce deaths due to **Haemorrhage**
- Reduce deaths due to **Hypertension**
- Improve **Health worker training**
- Strengthen **Health System**

# HIV and AIDS

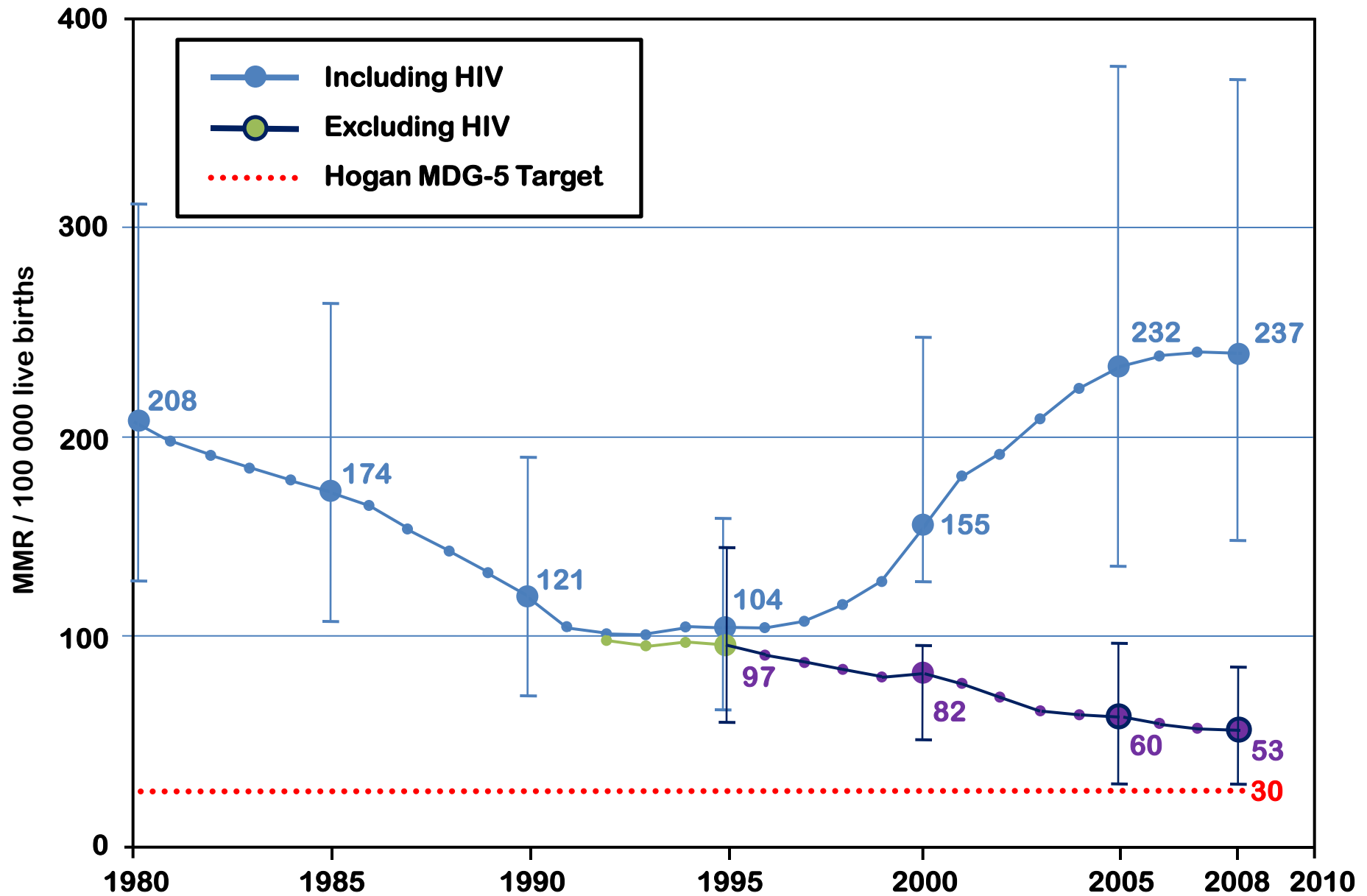
- ❑ Promote the “Know your status” and “plan your pregnancy” messages in communities and in the health sector
- ❑ Ensure every maternity facility is able to screen for HIV infection and perform early initiation of HAART therapy; and to recognise and treat co-infections, especially respiratory infections.

**Figure 1c: MDG 6 - HIV infections  
among pregnant women**



Source: Bradshaw D, Buchmann E, Chopra M, Jooste P, Kerber K et al Every death counts. Saving the lives of mothers, babies and children in South Africa. 2008 report

## MMR Estimates for South Africa, with and without HIV



# Haemorrhage (bleeding)

A doctor must be called to assess and coordinate further treatment of all women who are suspected of bleeding more than 1 litre

Monitoring after C section, must be improved in terms of frequency of observations and action on abnormal observations.

# Hypertension

- ❑ Antenatally, all maternity facilities must provide calcium supplementation to all women and ensure the detection, early referral and timely delivery of women with hypertension in pregnancy
- ❑ Severe hypertension, imminent eclampsia, eclampsia and HELLP syndrome must be recognised as life threatening conditions (Major Alerts) requiring urgent attention.
- ❑ Promotion of Family Planning Services in the population at large (women, their partners, families and communities)



# Health worker training

- ❑ Train all health care workers involved in maternity care in the ESMOE (Essential Steps in the Management Of Obstetric Emergencies) and obstetric anaesthetic module
- ❑ Train all health care workers who deal with pregnant women in HIV advice, counselling, testing and support (ACTS), initiation of HAART, monitoring of HAART and the recognition, assessment, diagnosis and treatment of severe respiratory infections.

# Health system strengthening

- Ensure 24 hour access to functioning emergency obstetric care (EmOC) both basic and comprehensive
- Ensure accessible and appropriate contraceptive services for all women which are integrated into all levels of health care and which must be available on site for women post-miscarriage and postpartum women



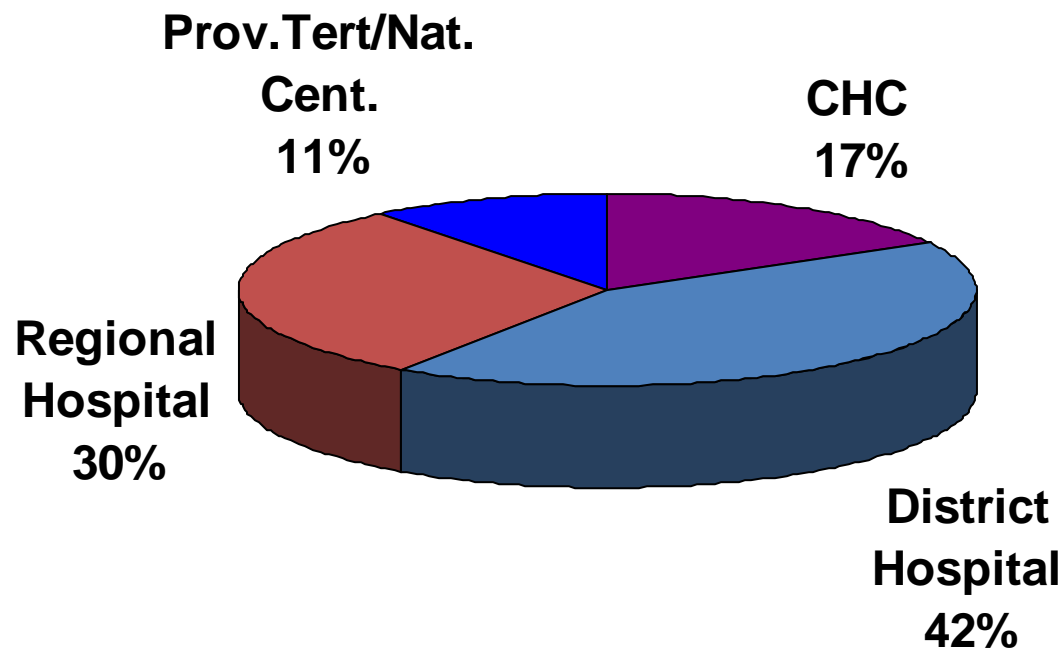
# **SAVING BABIES**

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# TOTAL NUMBER OF BRITHS IN HEALTH CARE FACILITIES 2004-2009

PROVINCE	2004	2005	2006	2007	2008	2009	Total
EC	111,268	117,307	121,204	113,564	121,132	133,601	728,076
Free State	53,235	57,065	59,159	59,843	60,066	55,470	344,838
Gauteng	182,858	188,436	195,629	203,055	205,287	211,507	1,186,772
KZN	192,475	207,403	212,373	207,532	217,364	214,713	1,251,861
Limpopo	105,093	118,600	127,100	128,297	134,680	129,568	743,338
Mpu	67,039	75,069	75,635	73,044	79,461	78,463	448,711
NW	56,748	62,624	67,471	65,588	68,004	63,908	384,343
N.Cape	22,882	23,023	23,590	23,379	23,914	23,254	140,042
WC	90,942	93,204	98,566	103,961	99,581	104,295	590,549
<b>TOTAL</b>	882,540	942,732	980,727	978,263	1,009,489	1,014,779	5,,808,530

# Distribution of deliveries in South African public institutions (DHIS data)



# PERCENTAGE OF WOMEN GIVING BIRTH WHO ARE UNDER 18YRS

PROVINCE	2004	2005	2006	2007	2008	2009
EC	8.9	10.0	10.0	10.2	9.9	8.9
Free State	0.6	5.2	7.4	7.4	7.5	7.8
Gauteng	8.2	8.1	8.9	8.1	7.2	5.9
KZN	8.7	9.1	8.6	8.7	8.8	8.4
Limpopo	9.9	9.7	8.3	8.0	8.0	7.6
Mpu	13.5	12.4	9.5	10.1	9.5	9.3
NW	8.3	7.7	8.4	9.1	8.6	7.8
N.Cape	6.2	6.0	5.9	6.4	6.2	4.5
WC	7.3	7.6	7.9	7.2	7.2	5.9

# STILL BRITHS PER 1000 DELIVERIES

## 2004-2009

PROVINCE	2004	2005	2006	2007	2008	2009
EC	28.1	28.7	26.4	25.8	22.0	22.0
Free State	31.1	29.8	29.1	31.3	29.0	29.9
Gauteng	22.3	20.2	21.5	19.8	20.8	10.1
KZN	26.5	26.0	25.7	25.0	22.6	23.7
Limpopo	21.5	20.9	22.3	22.5	23.4	22.9
Mpu	23.3	22.9	23.9	25.3	23.9	26.3
NW	22.2	21.3	22.8	24.3	24.3	28.0
N.Cape	25.5	23.9	24.7	24.4	24.5	22.4
WC	19.1	19.9	19.7	21.2	18.3	27.1

**EAERLY NEONATAL DEATHS PER 1000 LIVE BRITHS (early neonatal  
mortality rate)  
2004-2009**

PROVINCE	2004	2005	2006	2007	2008	2009
EC	16.3	17.1	14.0	13.3	13.0	11.2
Free State	10.2	8.3	8.2	9.7	9.1	10.1
Gauteng	8.1	8.8	7.8	7.4	7.8	8.6
KZN	9.2	7.9	8.2	5.4	5.9	5.0
Limpopo	11.8	10.5	11.5	11.0	9.8	10.4
Mpu	10.4	8.4	9.4	11.2	10.2	10.3
NW	10.9	10.1	10.3	9.2	9.3	9.4
N.Cape	10.5	8.8	11.0	10.9	10.4	9.3
WC	6.4	6.6	5.7	5.1	4.1	4.5



**PERINATAL MORALITY RATE (Stillbirths and Neonatal deaths per 1000  
deliveries  
2004-2009**

PROVINCE	2004	2005	2006	2007	2008	2009
EC	43.9	45.3	40.0	38.8	34.6	33.1
Free State	41.0	38.1	37.1	40.7	37.8	39.7
Gauteng	30.1	28.8	29.1	27.1	28.5	18.7
KZN	35.4	33.7	33.7	30.3	28.4	28.6
Limpopo	33.0	31.2	33.5	33.3	32.9	33.1
Mpu	33.4	31.2	33.0	36.1	33.8	36.3
NW	32.9	31.1	32.9	33.3	33.4	37.2
N.Cape	35.8	32.5	35.4	35.1	34.6	31.5
WC	25.4	26.3	25.3	26.2	22.3	31.5

DISTRICT	LIVE BIRTHS	TOTAL DEATHS	MMR	SBR	ENNDR	PNMR
A Nzo	21 763	48	220.6	19.6	11.4	30.8
Amathole	90 104	191	212.0	20.7	12.5	32.9
C Hani	40 234	41	101.9	20.5	7.6	27.9
Cacadu	18 524	11	59.4	20.0	8.0	27.9
N Mandela	68 134	111	162.9	19.9	0.9	20.8
OR (NHI site	103 019	281	272.8	26.1	0.5	26.5
Ukhahlamba	17 326	27	155.8	19.2	10.2	29.3
LOWEST	2779 Metsweding	1 Metsweding	36 Metsweding	8.6 Metsweding	0.5 OR	20.4 Winelands
HIGHEST	186 290 CPT metro		325.9 Frances, NC	39.2 Amajuba KZN	250.8 Metsweding GP	257.2 Metsweding GP
SA	2 761 951	CWP nmbombo 2013 179.5		23.3	9.7	32.7

## PLACE OF DEATH OCCURRENCE BY AGE GROUP in EC 2006-2008

	STILLBIRTHS	ENND 0-6days	LATE NND 7-28d	Post NND 1-11m	Infant <1yr
<b>TOTAL</b>	<b>2 565</b>	<b>1742</b>	<b>919</b>	<b>9931</b>	<b>15 157</b>
<b>Hospital</b>	1998 (78%)	1361 (78%)	559 (61%)	4532 (46%)	8450(56%)
<b>Home/Other</b>	177 (7%)	146 (8%)	193 (21%)	3189(32%)	3705(24%)
<b>Missing</b>	390 (15%)	235 (13%)	167 (18%)	2210(22%)	3002 (20%)

# Underlying Cause of Deaths in SA

- **Neonatal 31%**
  - Preterm 9%
  - Birth Asphyxia 6%
  - Infectious Conditions ^%
  - Other non-infections 4%
  - Congenital abnormalities 3%
  - Unspecified 3%
- **Diarrhoea 22%**
- **Lower Respiratory Infections 17%**
- **Ill-defined Natural 12%**
- **Other childhood conditions 10%**
- **HIV/AIDS 4%**
- **Sepsis & Meningitis 2%**
- **Injuries 2%**

# **RECOMMENDATIONS AND STRATEGIES TO IMPROVE INFANT MORBIDITIES & MORTALITIES**

## **A: Improve access to appropriate healthcare:**

- Appointment of clinicians at regional level
- Improve transport system for patients & referral route
- Constant health messages conveyed to community, client/patient, health care provider

## **B: IMPROVE QUALITY OF CARE**

- Improve training of health workers
- Guidelines & protocols to be adhered to
- Postnatal care
- Normalisation of HIV infection as any chronic disease

# **RECOMMENDATIONS AND STRATEGIES TO IMPROVE INFANT MORBIDITIES & MORTALITIES**

## **C:ADEQUATE RESOURCES**

- Staffing and equipment norms
- Provide adequate number of hospital beds

## **D:AUDITING & MONITORING**

- Improve data collection and review

## **E: SPECIFIC MATERNAL & NEONATAL INTERVENTIONS**

- Unexplained uterine deaths
- Deaths related to spontaneous preterm birth
- Deaths due to intrapartum asphyxia
- Maternal hypertension, heamorrhage, HIV
- Unplanned pregnancies



# Global & Regional Influences on Maternal Health

- Maputo Plan of Action
- CARMMA (AU campaign on accelerating reduction of maternal morbidity & mortality in Africa)
- Protocol on Rights of Women in Africa (ACHPR)
- UN Global Strategy for Women's and Children's Health
- Who Nursing and Midwifery education scale up plan 2010 - 2020
- UN Resolution for Maternal Mortality to be a human rights issue
- AU Africa Health Strategy 2007-2015
- Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive



# Introduction: Solution

- A strong health system with adequate appropriately trained health workers, accessible and affordable to all, could bring maternal morbidity and mortality in the developing world to the low levels found in the developed world.
- Managing the inequities eg. Provision of free quality services (NHI in SA)
- Political will with proper financing of MCH services
- Almost 90% of maternal deaths, and 60% of new born could be prevented when midwives possess appropriate skills that can save women and children (ICM, 2011; WHO, 2006; Campbell & Graham, 2006).
- Midwives are the backbone of the health system. They are the first contact with women.

# Scaling up best practices

## Bottom 4 Countries on breastfeeding

Somalia; Coitre de Voire; Equitarial Gunea; Botwana

## Top 4 Countries on breastfeeding

Malawi; Madagascar; Peru; Solom Islands

## Skilled health personnel

- Norway highest, while only a third of births are attended in Niger.
- In Ethiopia only 6% of births are attended. Compare that to 99% in Sri Lanka and 95 percent in Botswana.
- **SA:** confidential enquiries on maternal deaths

# **COUNTRIES COMMITTED TO Emergency Obsteric & Neonatal Care (EmONC) Standards**

- Cameroon
- Guinea
- Malawi
- Mauritania
- Sudan
- Tanzania
- Uganda

# Solutions

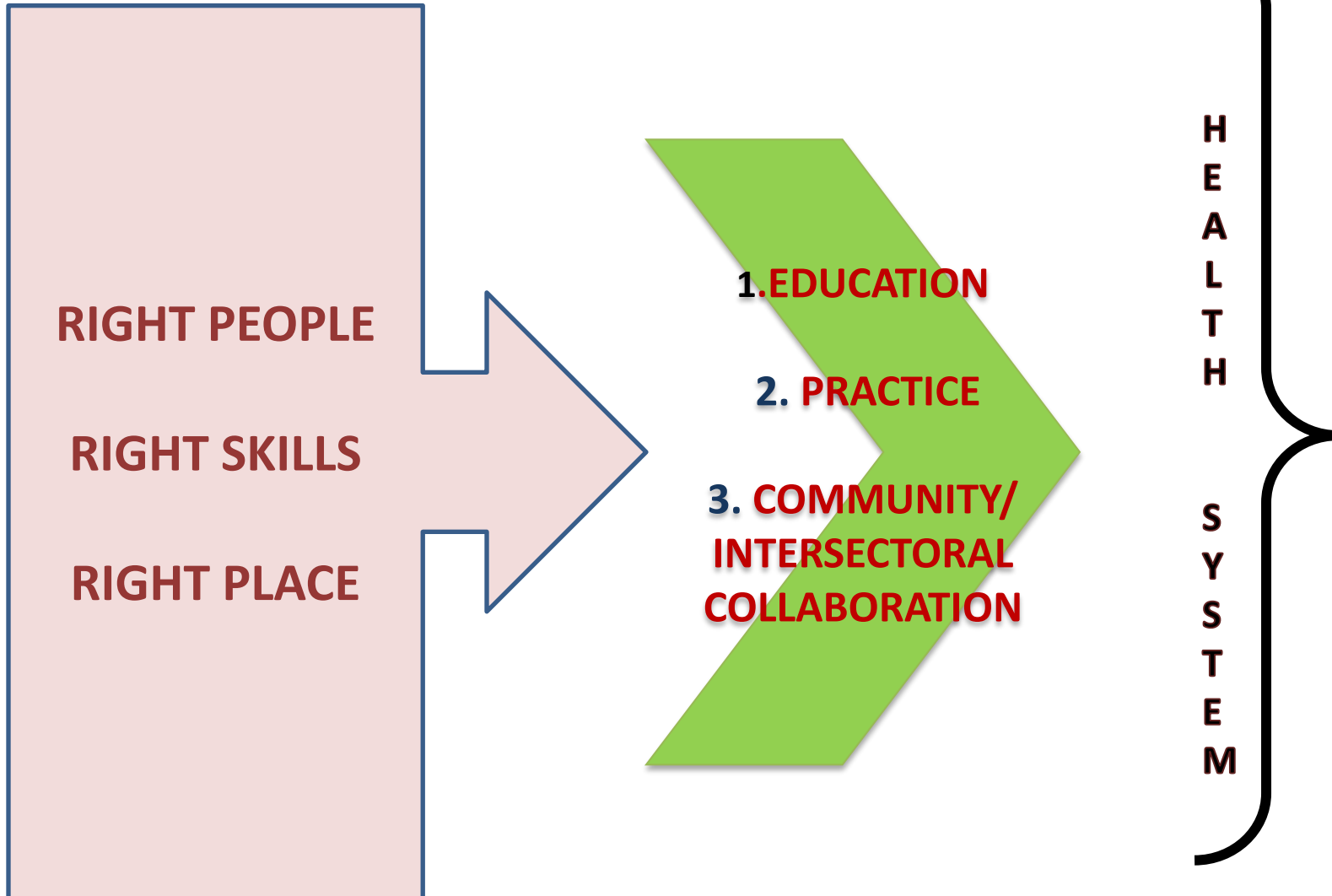
“Health services depend on having the right **people**, with the right **skills**, in the right **place**”

WHO (2006:1)

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# Consolidating Strategies

## INTERVENTIONS



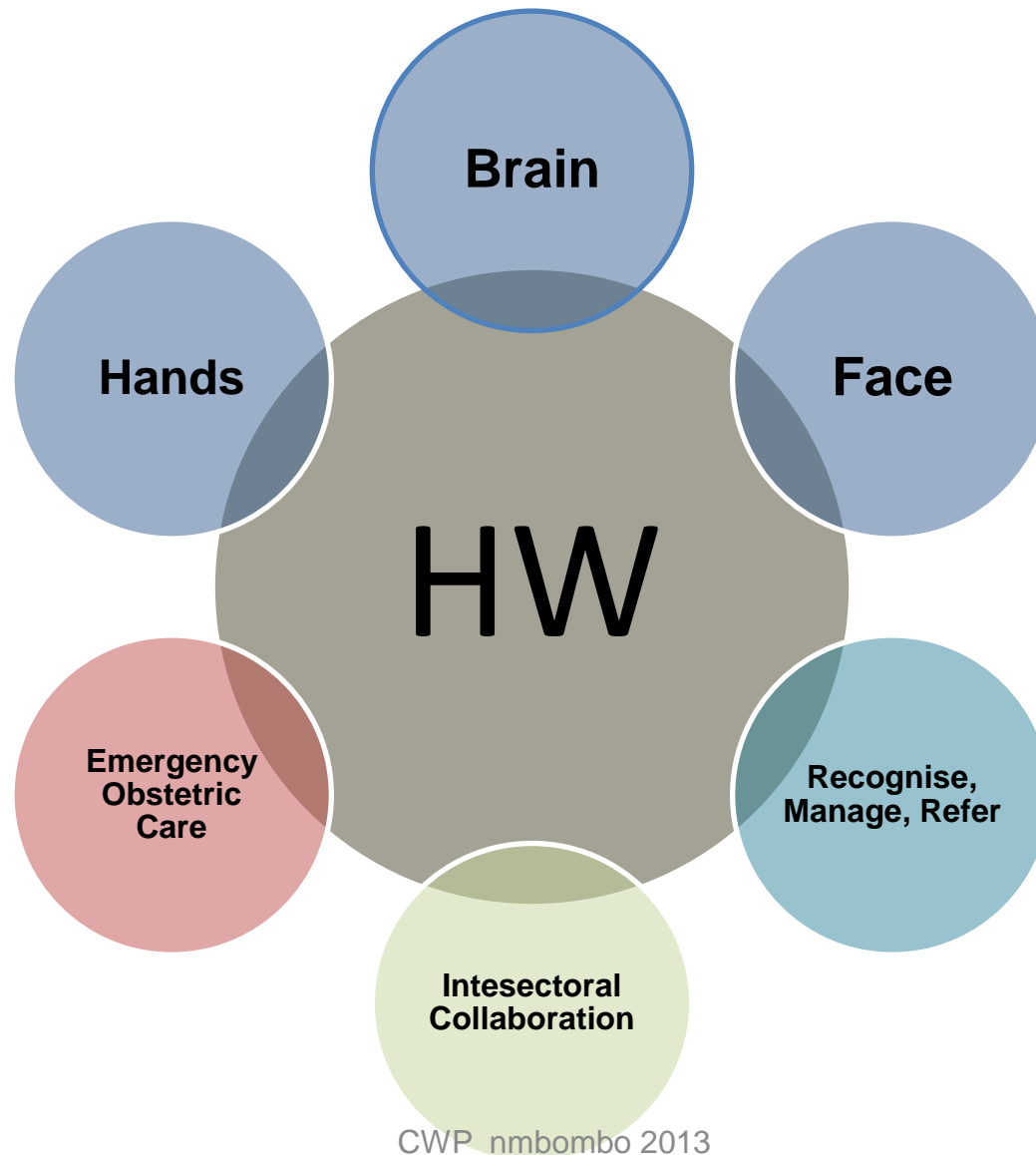
# Defining health system

## HEALTH SYSTEM BUILDING BLOCKS (WHO, 2007)

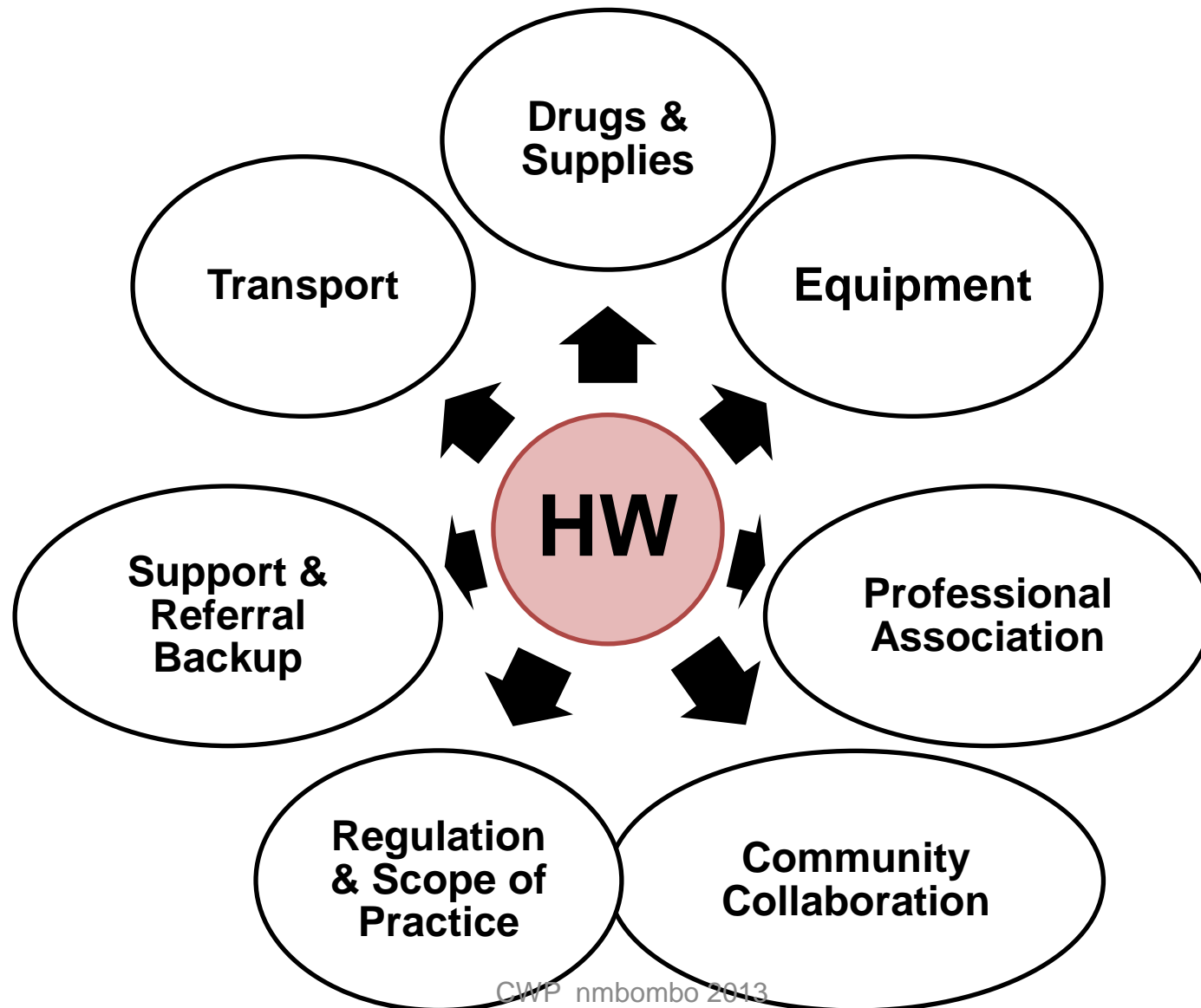
- ☐ Policies
- ☐ Leadership & governance
- ☐ Financial resources
- ☐ Human resources
- ☐ Information systems
- ☐ Supply chain management
- ☐ Services rendered

Hoffman ,S.,Røttingen, J., Bennett, S., Lavis,J., Edge ,J., Frenk, J (2012) ; Gilson L., (2011)

# RIGHT PEOPLE



# RIGHT PLACE





# WHO STANDARDS of the Right Place (Mali study)

- UN international standard of 5 emergency obstetric and neonatal care centres per 500,000 population, 4 basic EmONC and 1 comprehensive EmONC.
- Well staffed and functioning emergency care centers.
- Functioning & well monitored centers can decrease perinatal deaths as well.
- Prompt access to comprehensive sites have been shown to reduce mortality
- Coverage and equitable distribution: rural and urban; Community based and tertiary level

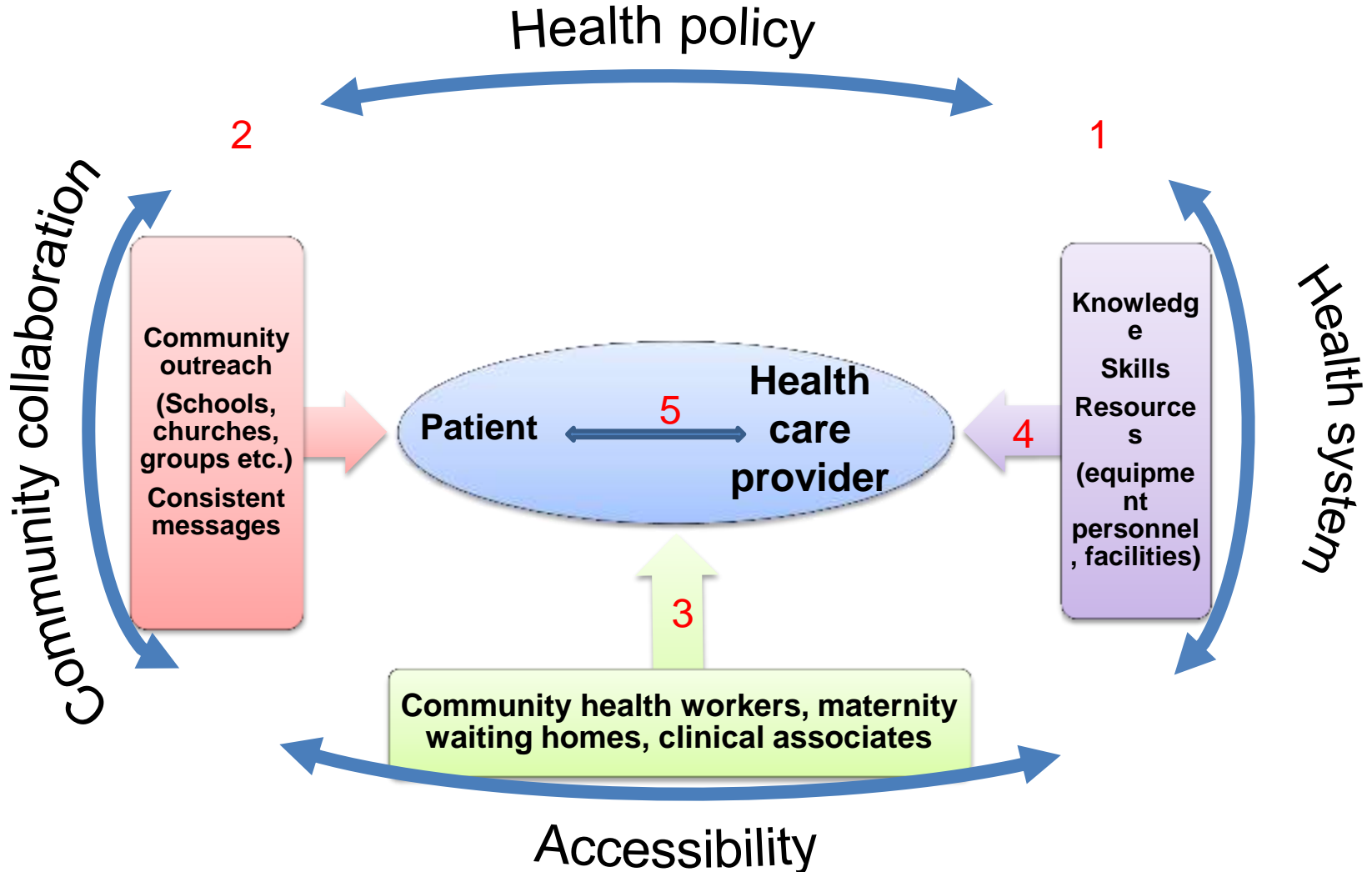
Fournier, P., Dumont, A., Tourigny, C., Dunkley, G, (2009) Improved access to comprehensive emergency obstetric care and its effect on institutional maternal mortality in rural Mali.

# INTERSECTORAL COLLABORATION: Community engagement

- Community interventions influence women's decision to deliver a child in a health facility across 6 African countries, namely, Malawi, Tanzania, Kenya, Burkina Faso; Ghana, Ivory Coast.
- The influences were similar across the 6 settings, illustrating the influence that indicators of community-level socioeconomic development, female autonomy, and fertility norms have on individual health-seeking behavior.

Stephenson, R., Baschieri, A., Clements, S., Hennink, M., Madise, N., (2006). Contextual Influences on the Use of Health Facilities for Childbirth in Africa

# Implementing intervention



**“AFRICA CARES: NO WOMAN SHOULD DIE WHILE GIVING LIFE”**



## **Role of Parliament: CARMMA**

- ❑ MMR in Africa will have to be reduced from between 500 and 1 500 to 228 per 100 000 live births to meet the target of reducing by three quarters, between 1990 and 2015 the maternal mortality ratio.
- ❑ MDG5 calls for the achievement, by 2015, of universal access to reproductive health.
- ❑ MDG 4 requires Member States “to reduce by two thirds, between 1990 and 2015 the under-five mortality rate
- ❑ MDG 4 and 5 are standard to measure the human development level of any country, region or continent.

# Role of Parliament: CARMMA

- ❑ Fourth Session of the African Union (AU) Conference of Ministers of Health held in Addis Ababa, Ethiopia in May 2009, under the theme:- “Universal Access to Quality Health Services: Improve Maternal, Neonatal and Child Health”, launched the Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA). The campaign was launched under the slogan “Africa Cares: No Woman Should Die While Giving Life!”
- ❑ The Fifteenth Ordinary Session of the African Union Assembly held in Kampala, Uganda in July 2010, under the theme “Maternal, Infant and Child Health and Development in Africa” endorsed CARMMA.
- ❑ The decisions of the Assembly included amongst others a list of Actions on Maternal, Newborn and Child Health and Development in Africa by 2015, which Heads of State and Government committed to

# CARMMA: Objectives

- ❑ To enhance **political leadership** and commitment at national and continental levels.
- ❑ identify and work with national champions to mobilize support and participation at national level.
- ❑ To raise and maintain awareness as well as appropriate responses at global, continental, regional and national levels.
- ❑ To build linkages with global campaigns, which seek to ensure (a) the establishment of new innovative mechanisms and (b) the appointment by the UN Secretary General of someone to advocate for the reduction of maternal and child mortality.
- ❑ To promote the recognition of maternal mortality as a key indicator of a well-functioning health system.
- ❑ To promote **exchange of experiences and practices** and to adopt and replicate best practices of countries, which have significantly reduced maternal and child mortality.

# CARMMA: Commitments

- ❑ Advocacy for increased resources for maternal and child health should be strengthened with due emphasis on domestic resources.
- ❑ All countries to devote a week in November called the “CARMMA week” to further focus attention on the health of women and children.
- ❑ Task shifting within the health team and between levels of care should be encouraged in response to some of the challenges of the health system.
- ❑ Women’s rights and SRHR should be promoted as a means of contributing to improving maternal health.
- ❑ Maternal, newborn and child mortality audits should be prioritized by all Member States in order to strengthen operational research and provide input into program planning.



# CARMMA: Commitments

- ❑ Increased utilization of ICTs for health should be undertaken.
- ❑ Recognize the key role of nutrition (services and programmes) in pregnancy, and PMTCT (prevention of mother to child transmission of HIV).
- ❑ Promotion of breastfeeding as recommended by the World Health Assembly decision should be prioritized to improve child survival.
- ❑ Waiving user fees for maternal and child health should be promoted across Member States.
- ❑ National Health Insurance Schemes should be developed, especially providing coverage for the vulnerable and marginalized population.

# CARMMA: Commitments

- ☐ Improve logistics support to community health extension workers particularly with mobility and communication to facilitate service provision
- ☐ Recognize the key role of nutrition (services and programmes) in pregnancy, and PMTCT (prevention of mother to child transmission of HIV).
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# CARMMA: Commitments

- ❑ National Health Insurance Schemes should be developed, especially providing coverage for the vulnerable and marginalized population.
- ❑ Improve logistics support to community health extension workers particularly with mobility and communication to facilitate service provision in hard to reach locations.
- ❑ Improve transportation infrastructure while exploring practical transport systems/mechanisms to increase access to services
- ❑ Promptly finalize modalities for the proposals for the establishment of CARMMA adopted model clinics.

# CARMMA: SOUTH AFRICA

- ☐ Family planning services.
- ☐ Advocacy and health promotion for early antenatal care and attendance/ booking.
- ☐ Allocating dedicated obstetric ambulances to every sub-district to ensure prompt transfer of women in labour and women and children with obstetric and neonatal emergencies to the appropriate level of care.
- ☐ Establishment of maternity waiting homes.
- ☐ Essential Steps in Management of Obstetric Emergencies (ESMOE) to doctors and midwives.
- ☐ Intensifying midwifery education and training.

# CARMMA: SOUTH AFRICA

- ☐ Promoting and supporting exclusive breastfeeding for at least 6 months.
- ☐ Providing facilities for lactating mothers (boarder mothers) in health facilities where children are admitted.
- ☐ Promotion of Kangaroo Mother Care (KMC) for stable low birth weight babies at all levels of care.
- ☐ Advocacy for appropriate care and support for pregnant women and lactating mothers in the workplace.
- ☐ Improving immunization and vitamin A coverage.

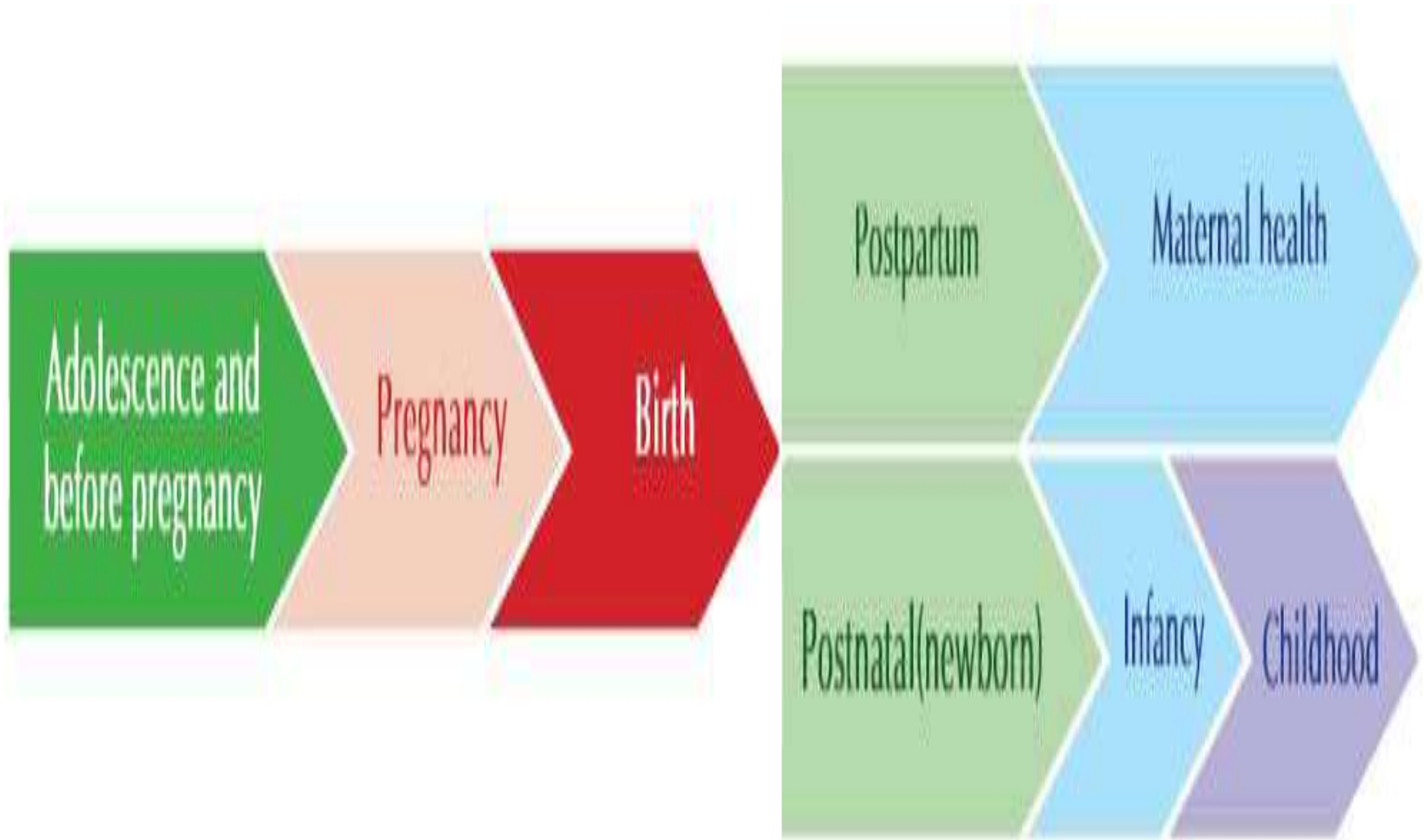
# CARMMA: SOUTH AFRICA

- ☐ Intensifying management of severe malnutrition in health facilities.
- ☐ Intensifying case management of sick children through: improving implementation of key family practices including diarrhoea management at home
- ☐ Strengthening implementation of IMCI
- ☐ Eliminating Mother to Child Transmission of HIV

# Conclusion

- We have the knowledge, tools to improve maternal and neonatal health outcomes, but how do we move from rhetoric to systems that deliver
- Community mobilization and women empowerment are essential
- Stakeholder collaboration: parliamentarians as representative of people in government have a major role to influence policy and question government service delivery
- Measuring mortality and integration of services are one of competencies essential in African context
- Urgency to improve education & training and competencies of health workers, especially midwives
- Political commitment in the existing initiatives eg. Maternal & neonatal mortality audit teams.
- Budget, resources, staffing and equipment norms to be established
- A preventable maternal death is an injustice, a human rights issue.

# Target for intervention





# Acknowledgement

- NCCEMD and Eastern Cape maternal death assessors
- NaPeMMCo
- Dept MCWH
- Prof Sue Fawcus

**“AFRICA CARES: NO WOMAN  
SHOULD DIE WHILE GIVING LIFE”**

**THANK YOU  
ENKOSI  
ASANTE  
MERCI**