

SOUTH AFRICA'S NATIONAL STRATEGIC
PLAN FOR A CAMPAIGN ON ACCELERATED
REDUCTION OF MATERNAL AND CHILD
MORTALITY IN AFRICA (CARMMA)

*“South Africa cares: No
woman should die while
giving life”*



health

Department:
Health
REPUBLIC OF SOUTH AFRICA





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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
AUC	African Union Commission
ART	Antiretroviral Therapy
CARMMA in Africa	Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa
CBO	Community Based Organization
CHC	Community Health Centre
CTOP	Choice on Termination of Pregnancy
CSO	Civil Society Organization
EOST	Emergency Obstetric Simulation Training
ESMOE	Essential Steps in Management of Obstetric Emergency
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
KMC	Kangaroo Mother Care
MCH	Maternal and Child Health
MCWH	Maternal Child and Women's Health
MDG	Millennium Development Goal
NGO	Non Governmental Organization
OPD	Out Patient Department
PMTCT	Prevention of Mother to Child Transmission
PHC	Primary Health Care
SAINC	South African Initiative on Neonatal Care
STI	Sexually Transmitted Infection
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights

TB	Tuberculosis
TL	Tubaligation
WHO	World Health Organization

INTRODUCTION

1. High maternal, perinatal and under-five morbidity and mortality are some of the formidable development challenges in Africa. The disturbing part is that the large number of deaths is due to preventable causes. The World Health Organization (WHO) estimates that worldwide, as many as 1500 women die every day due to complications related to pregnancy or childbirth. Similarly, 10 000 babies die per day within the first month of life and an equal number of babies are born dead. More than 90% of these deaths occur in developing countries, most of them in Africa. Although Africa is home to 10% of the global population, it contributes to almost half of all child deaths worldwide.
2. The maternal mortality ratio in Africa will have to be reduced from between 500 and 1 500 to 228 per 100 000 live births for the continent to meet the target of reducing by three quarters, between 1990 and 2015 the maternal mortality ratio. The second target of Millennium Development Goal (MDG) 5 calls for the achievement, by 2015, of universal access to reproductive health. The MDG 4 requires Member States "to reduce by two thirds, between 1990 and 2015 the under-five mortality rate". It should be noted that MDG 4 and 5 are used as a standard to measure the human development level of any country, region or continent.
3. It is against this background that the 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!"
4. 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 undertake. The first action reads as "*We Commit to Launch CARMMA in our countries and broaden it as an advocacy strategy for the promotion of Maternal, Newborn and Child Health and involve all key stakeholders such as the women, children and young people, persons with disabilities, parliamentarians, community and religious leaders, civil society organizations, the media, and the private sector and institutionalize an annual CARMMA week in solidarity with the women and children of Africa for the next four years*".

THE SOUTH AFRICAN SITUATION ON MATERNAL, PERINATAL AND UNDER-FIVE MORTALITY

5. Maternal, perinatal and under-5 mortality in South Africa remain unacceptably high. According to November 2011 National Department of Health's Report of the Health Data Advisory and Coordination Committee, the figures for Maternal Mortality Ratio, Under-five, Infant and Neonatal Mortality Rate are 310/100 000, 56/1000, 40/1000 and 14/1000 live births respectively. The 2015 MDG target for Maternal Mortality Ratio and Under-five mortality rate is 38/ 100 000 and 20/1000 live births based on 1998 Demographic and Health Survey base line of 150/100 000 and 59/ 1 000 live birth respectively.
6. Since its inception, the Saving Mothers Report identified five major causes of maternal deaths as:
 - Non-pregnancy related infections mainly AIDS (50%)
 - Obstetric haemorrhage (14%)
 - Complications of hypertension (14%)
 - Pregnancy related infections (5%)
 - Complications of pre-existing medical conditions such as cardiac conditions, diabetes etc (9%)
7. Forty (40%) percent of all maternal deaths are avoidable. These are related to community, administrative and clinical factors. The consequences of maternal mortality are well documented e.g. the effect on children's lives, the family, the community, the economic status of the country. Much pain and suffering is caused when mothers die in childbirth.
8. Studies on disease burden for under-five children conducted in the country revealed the following as the commonest causes of under-five deaths:
 - AIDS related deaths including TB (40%)
 - Diarrhoeal diseases (11%)
 - Pneumonia (6%)
 - Severe malnutrition (5%)
 - Deaths during neonatal period (18%)
 - Low Birth Weight (12%)
 - Infections (3%) and
 - Birth Asphyxia (3%)

CAMPAIGN ON ACCELERATED REDUCTION OF MATERNAL AND CHILD MORTALITY (CARMMA)

9. CARMMA is an initiative of the African Union Commission (AUC) to promote and advocate for renewed and intensified implementation of the Maputo Plan of Action for Reduction of Maternal Mortality in Africa and for the attainment of MDG 5. Although the principal focus of CARMMA is maternal mortality, it also includes reduction of child mortality. The 15th Session of the Ordinary Session of the AU Assembly recommended that issues of newborn and children be covered in CARMMA and for the development of the practical strategies.
10. CARMMA derives its significance from previous commitments made by African Heads of States on Maternal Health such as the 2005 Continental Policy Framework on the Promotion of Sexual and Reproductive Health and Rights (SRHR) in Africa, the Maputo Plan of Action (2006- 2010), extended to 2015, the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis, and Malaria services in Africa (2006 - 2010) also extended to 2015, the Africa Health Strategy (April 2007- 2015); the international consensus on MDG 5 and others.
11. **The campaign currently focuses on four key areas:**
 - *Building on-going efforts particularly best practices;*
 - *Generating and providing data on maternal and newborn deaths;*
 - *Mobilizing political commitment and support of key stakeholders including national authorities and communities to mobilize additional domestic resources in support of maternal and newborn health and mobilizing communities to let them know that everyone has role in improving maternal and child health and reduction of maternal and child deaths; and*
 - *Accelerating actions aimed at the reduction of maternal, infant and child mortality in Africa.*
12. CARMMA is designed to be nationally driven and owned, and to enjoy strong support and partnership from several United Nations bodies, bilateral interests, foundations and nongovernmental organizations and other stakeholders and partners.

THE GOAL OF THE CAMPAIGN IN SOUTH AFRICA

13. The goal of the campaign in South Africa is to accelerate the reduction of maternal and child morbidity and mortality through accelerated implementation of evidence-based interventions essential to improve maternal health and child survival.

GENERAL OBJECTIVE

14. To accelerate implementation of key recommendations and strategies to reduce maternal and child morbidity and mortality through effective advocacy for quality maternal and child health care, health system strengthening, community empowerment and involvement and effective collaboration with partners and relevant stakeholders.

SPECIFIC OBJECTIVES

15. The objectives of CARMMA as outlined by the African Union Commission are:
 - 15.1. To enhance political leadership and commitment at national and continental levels.
 - 15.2. To identify and work with national champions to mobilize support and participation at national level.
 - 15.3. To raise and maintain awareness as well as appropriate responses at global, continental, regional and national levels.
 - 15.4. 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.
 - 15.5. To promote the recognition of maternal mortality as a key indicator of a well-functioning health system.
 - 15.6. To promote exchange of experiences and practices and to adopt and replicate best practices of countries, which have significantly reduced maternal and child mortality.

TARGETS AND INDICATORS

16. The targets and indicators for CARMMA in South Africa are in line with the MDG4 (Reduce child mortality) and MDG 5 (Improve maternal health),

as harmonized with the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights (2007 – 2015).

Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicators:

- Under-five mortality rate
- Infant mortality rate
- Immunisation coverage at one year of age.
- Proportion of 1 year-old children immunized against measles
- Life expectancy at birth for males and females
- Access to quality child survival services

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicators:

- Maternal mortality ratio
- Incidence of unsafe abortion reduced
- Proportion of births attended by skilled health personnel
- Access to quality safer motherhood services
- Contraceptive prevalence rate (Couple year protection rate)
- Adolescent birth rate
- Antenatal care coverage (At least one visit and at least four visits)

Target 5.B: Achieve, by 2015, universal access to reproductive health

- HIV, STI, Malaria and SRH services integrated into primary health care
- Strengthened community-based STI/HIV/AIDS/STI & SRHR services
- Family planning repositioned as key strategy for attainment of MDGs
- Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing
- Resources for SRHR increased

- SRH commodity strategies for all SRH components achieved

CURRENT PROGRESS OF CARMMA AT THE AFRICAN UNION LEVEL

17. About 36 African Union Member States have launched CARMMA from May 2009 to May 2012, when CARMMA was launched in South Africa. Countries that have already launched CARMMA have submitted annual Reports to the African Union Commission. A special meeting on CARMMA was held at the Fifth Session of the African Union Conference of Ministers of Health held in Windhoek, Namibia in April 2011. The meeting agreed on the following:
 - a. To continue to cover issues of newborn and children in CARMMA as recommended by the 15th Session of the Ordinary session of the AU Assembly.
 - b. The Ministries of Health to provide leadership for CARMMA, despite the multi-sectoral approach to ensure sustainability.
 - c. Advocacy for increased resources for maternal and child health should be strengthened with due emphasis on domestic resources.
 - d. All countries to devote a week in November called the “CARMMA week” to further focus attention on the health of women and children.
 - e. 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.
 - f. Women’s rights and SRHR should be promoted as a means of contributing to improving maternal health.
 - g. 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.
 - h. Increased utilization of ICTs for health should be undertaken.
 - i. Recognize the key role of nutrition (services and programmes) in pregnancy, and PMTCT (prevention of mother to child transmission of HIV).
 - j. Promotion of breastfeeding as recommended by the World Health Assembly decision should be prioritized to improve child survival.
 - k. Waiving user fees for maternal and child health should be promoted across Member States.
 - l. National Health Insurance Schemes should be developed, especially providing coverage for the vulnerable and marginalized population.
 - m. Improve logistics support to community health extension workers particularly with mobility and communication to facilitate service provision

in hard to reach locations.

- n. Improve transportation infrastructure while exploring practical transport systems/mechanisms to increase access to services.
- o. Promptly finalize modalities for the proposals for the establishment of CARMMA adopted model clinics.

KEY COMPONENTS OF CARMMA IN SOUTH AFRICA

18. The following are the key components of CARMMA in South Africa:
- a) Strengthen and promote access to comprehensive SRHR services, with specific focus on family planning services.
 - b) Advocacy and health promotion for early antenatal care and attendance/booking.
 - c) Improve access to Skilled Birth Attendants by:
 - 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.
 - d) Strengthening Human Resources for Maternal and Child Health by:
 - Providing training on Essential Steps in Management of Obstetric Emergencies (ESMOE) to doctors and midwives.
 - Intensifying midwifery education and training.
 - e) Improve child survival by:
 - 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.
 - 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 in all primary health care facilities
- Strengthening clinical skills for the management of severe diseases including pneumonia and diarrhoea in referral facilities

f) Intensifying management of HIV positive mothers and children by:

- Improving access to treatment for both mothers and children
- Improving management of co-infections and
- Eliminating Mother to Child Transmission of HIV

IMPLEMENTATION PLAN OF THE KEY COMPONENTS OF CARMMA IN SOUTH AFRICA

KEY COMPONENTS	ACTIVITES	EXPECTED OUTCOME
1). Strengthening access to comprehensive SRHR services, with specific focus to family planning	<ul style="list-style-type: none"> • Promote provision of family planning services to every woman who comes into contact with health care provider e.g OPD, Medical ward, ART, TB, etc. 	Increased access and quality to family planning services.
	<ul style="list-style-type: none"> • Fast track capacity building of health care providers on integrated SRHR services including family planning, sexual assault, cervical cancer, screening. 	
	<ul style="list-style-type: none"> • Revive in-service training for the family planning programme. 	
	<ul style="list-style-type: none"> • Build capacity of community health workers to support family planning services. 	
	<ul style="list-style-type: none"> • Promote male and female condoms as part of dual protection against unplanned pregnancy and STIs, • T/L must be accessible post-delivery for all women who request it before discharge 	
	<ul style="list-style-type: none"> • Ensure availability of contraceptive commodities in all health care settings, including emergency contraception. 	
	<ul style="list-style-type: none"> • Empower Civil Society Organisations and communities to demand family planning services 	
	<ul style="list-style-type: none"> • Advertise family planning widely (local radio, news papers, TV) 	
<ul style="list-style-type: none"> • Develop relevant IEC materials on family planning in all languages, including Braille 		

KEY COMPONENTS	ACTIVITES	EXPECTED OUTCOME
2) Advocacy and promotion of early antenatal care attendance/ booking	<ul style="list-style-type: none"> Empower CSO and communities at large on importance of early antenatal attendance/ booking and regular follow-ups 	Increased rate of booking for Antenatal care on confirmation of pregnancy and regular follow-ups
	<ul style="list-style-type: none"> Advertise antenatal care services widely (local radio, news papers, TV) 	
	<ul style="list-style-type: none"> Develop relevant IEC materials on the importance of early and regular antenatal care attendance in all languages, including braille 	
3) Improve access to Skilled Birth Attendance through:	<ul style="list-style-type: none"> Ensure that all sub-district have an obstetric ambulance. Ensure that the planned patient transport is fully functional at all times Effective coordination of emergency obstetric ambulances 	Reduced transfer time.
i) Allocation of obstetric ambulances to every facility where deliveries are conducted ii) Establishment of maternity waiting homes, where necessary	<ul style="list-style-type: none"> Ensure all district hospitals delivering women have MWH 	
4) Strengthening Human Resources for Maternal and Child Health through:	<ul style="list-style-type: none"> ESMOE and EOST training for all doctors and Midwives in facilities providing maternity care services. 	All Drs and Midwives providing maternity care are skilled to provide emergency obstetric care
a. Training on Essential Steps in Management of Obstetric Emergencies (ESMOE) for doctors and midwives	<ul style="list-style-type: none"> Maintenance of a register for ESMOE trained health professionals 	Statistics on health-care workers trained on ESMOE and EOST maintained
b. Strengthening midwifery education and training	<ul style="list-style-type: none"> Establishment of a task team to look into staffing, bed and equipment norms. Facilitate and support the increase in number of midwives rendering MCWH services 	Staffing and equipment norms established and implemented
	<ul style="list-style-type: none"> Conduct an audit of midwives Develop plans to strengthen midwifery in the public health sector 	Data on available and practising midwives

KEY COMPONENTS	ACTIVITES	EXPECTED OUTCOME
<p>5) Improve child survival through:</p> <p>a) Promotion of breast-feeding,</p> <p>b) Provision of facilities for lactating mothers (boarder mother) in health facilities where children are admitted</p> <p>c) Promotion of Kangaroo Mother Care (KMC) for low birth weight babies</p>	<ul style="list-style-type: none"> Promotion of Breast Feeding as recommended by the World Health Organisation (WHO) Adopt the South African Initiative on Neonatal Care (SAINC) Orient of managers and train health care providers in implementation of SAINC Implementation of KMC for low birth weight babies in all facilities 	Reduction in Malnutrition and improvement in Child survival.
<p>d) Advocating for appropriate care and support of pregnant women and lactating mothers in the workplace</p>	<p>Assess status of facilities for mother and baby friendliness. Ensure support for pregnant women and lactating mothers in the workplace</p>	Mother and baby friendly workplaces established and maintained
<p>6) Intensifying management of HIV positive pregnant women and mothers and HIV infected and affected children through:</p> <p>I.Improved access to HIV treatment for both mothers and children</p> <p>II.Improved management of co infections</p> <p>III.Elimination of Mother to Child transmission of HIV by 2015</p>	<p>Implement the Action Framework on eliminating mother to child transmission titled, 'No child born with HIV by 2015 and improving the health and well being of mothers, and babies in South Africa</p> <p>Increase the number of NimART trained nurses to initiate ART and provide support.</p> <p>Ensure efficacious regimens for HIV positive pregnant women and women of child bearing age and children</p>	<p>All eligible HIV positive women initiated on ART</p> <p>Reduced morbidity and mortality from HIV and AIDS related conditions</p> <p>Reduced new HIV infections with less than 2% HIV transmission at 6 weeks and less than 5% transmission at 18 months of age</p>





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