OPENING SPEECH BY MINISTER OF HEALTH, DR JOE PHAAHLA, MP, TO THE FIRST INTERNATIONAL MATERNAL NEWBORN HEALTH CONFERENCE (IMNHC)
INTERNATIONAL CONVENTION CENTRE, CAPE TOWN
09 MAY 2023

Greetings to Deputy Minister of Health, Dr S Dlomo
The Premier of Western Cape, Hon Winde
Minister of Health from Liberia.
Minister of Health from Equatorial Guinea
MEC of Health, Western Cape, Dr NomaFrench Mbombo
WHO Acting Assistant Director General and AlignMNH co-chair, Dr Anshu BANERJEE-
WHO Country Representative, Dr Owen. Kaluwa
UNFPA – Regional Office Representatives Mr Thulani Mbatha
Technical Director UNFPA, Dr Julitta Onabanjo
Regional Director ESARO for UNFPA, Ms Lydia Zigomo
Associate Director of Health, Maternal Newborn Child Adolescent Health, UNICEF, Luwei Pearson
UNICEF South Africa Representative, Christine Muhigana
FP2030 – Executive Director- Dr Samu Dube

Let me start by acknowledging AlignMNH steering Committee for proposing a scientific approach to review collective action by countries to respond to the global challenge of high maternal and neonatal mortality rates.

I have noted the objectives of the conference which include collaboration, coordination, cross-country learning, and alignment within the maternal and newborn health community, sharing

successes and effective implementation strategies, and identify promising solutions to improve maternal and newborn health and prevent stillbirths, reviewing and recognising country, regional, and global progress toward MNH targets and milestones, prioritising actions to accelerate progress towards meeting the 2030 Sustainable Development Goals and developing the next generation of leaders.

As part of my contribution to the agenda and the overall objectives of the conference, allow me to refer you to several global initiatives that started the journey some decades ago. These include the progress made through implementation of the Maputo declarations, Partnerships in maternal, neonatal and child health initiatives and recently the Global Leaders' Network. The difference now is the time pressure, we cannot continue at the current pace if we are envisioning to end preventable maternal and newborn deaths by 2030.

Recently in 2018, countries converged in Nairobi for the International conference on population Development (ICDP) (commonly known as Nairobi Commitments) which set forth a vision to achieve gender equality, promote, respect, and fulfil human rights and reproductive freedom for all. Maternal and newborn experience cannot be a pleasurable moment for families unless if it happens in the free, safe, respectful environment. As indicated in the theme of this conference "Aligning *Together. Accelerating Together. Saving Lives Together*.

"As different countries, stakeholders, private sector we need to join hands to create safe and pleasurable motherhood across the globe irrespective of where one lives or economic situation you find yourself in. It is even more critical that we support families from the countries

with severe humanitarian challenges. I am aware that amongst us there are representations from such countries, and they continue to join forces with other member states to respond to the agenda of ending preventable maternal mortality (EPMM) and implementing every newborn action plan (ENAP. Let's put our hands together for those countries.

While SDG goal 3 targets sounds ambitious and unachievable, every effort must be taken to continue to strive to achieve the reduction of Maternal Mortality Ratio to less than 70 maternal deaths per 100,000 live births, end preventable deaths of children under 5 years of age to at least as low as 25 per 1,000 live births and to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five by 2030.

I am also aware that the ENAP/EMPP community developed the 90/09/80/80 targets which are 90% coverage in women accessing ANC services, 90% coverage of deliveries conducted by skilled birth attendant, 80% coverage of women accessing postnatal care services and 80% coverage on management of small and sick newborns which aims to keep us focused. While the full progress report will be launched immediately after this session, allow me to congratulate countries that have reached the targets. It is crucial that moments and opportunities like this are used to share and celebrate the learnings from others which is one of the objectives of this conference. Some countries made significant progress initially, but the progress has now plateaued or even worsened in some areas. Unexpected pandemics such as COVID 19, the climate change and the challenging economic circumstances add to the complexities of the clinical interventions required to respond

to the challenges. The advent of the implementation of the Universal Health Coverage in the provision of high quality maternal and newborn health care is an essential component, which will assist us to regain momentum through universal access to care irrespective of the excessive costs of health care. It is therefore opportune that this first International Maternal Newborn Health Conference has been convened, to review and disseminate evidence, assess progress, and determine specific priorities that need to be addressed.

It is my conviction that we need to share the South African journey of responding to the challenges that we are facing in the maternal and neonatal health service areas. It was never easy; it gives me pleasure to note that South Africa reached 80% coverage for post-natal care and 80% coverage to access to management of small and sick neonates. It has become even more complex to respond to the remaining challenges to achieve the targets. The challenges remaining are Access to ANC visits is at 76% against the 90% target and, Access to skilled birth attendant is 78.3% against the 90% target. Other challenges responding to Gender-based violence including violence against pregnant women and children remains prevalent. High teenage pregnancy rate with the age of young girls falling pregnant becoming younger and younger.

Despite the challenges faced, there continue to be a bright light at the end of the dak tunnel. Through integration of HIV care into routine maternal and newborn care, vertical transmission of HIV infection has been reduced from almost 30% in 2002 to less than 3% in 2022. Under-five mortality declined from a high of 81 per 1,000 live births in 2003 to 28 per 1,000 live births in 2020. This decline is attributed to a reduction

in deaths due to HIV/AIDS. Purposeful efforts of strengthening HIV management and ART programme to prevent vertical transmission was implemented across the country. This is one of the true success stories of our PMTCT program which will hopefully assist in eliminating vertical transmission of the disease and improve neonatal survival and thriving rates. The other contributors to the success are the introduction of new childhood vaccines, and improvements programmes addressing social determinants of health such as social grants to children and vulnerable pregnant women, which have also contributed to the food security among others.

We continue to battle serious problems of prematurity and intrapartum-related trauma which remain the leading causes of death. Hypertension and obstetric haemorrhage remain challenges contributing to maternal deaths. Infections from TB and HIV, re-emergence of previously eradicated conditions, play a part in both maternal and neonatal deaths. We are also realising the increasing congenital abnormalities that have now become contributing factors which require more robust interventions.

The broader goals of reducing maternal and neonatal mortality are what we still need to focus on. The iMMR declined from 147,3 deaths per 100,000 live births in 2011 to 93,1 deaths per 100,000 live births in 2019 but increased during 2020/2021 because of both direct maternal deaths due to COVID-19 and indirect deaths resulting from disruption to health services during the pandemic.

When looking at the trend, Maternal Mortality Ratio (MMR) declined from 276 per 100,000 live births in 2007 to 87 per 100,000 in 2018. I will not do justice to this if I omit to talk about the stillbirth rate that

remains high at around 20 per 1,000 births in health facilities. This is a matter that needs our focused, collective, and urgent intervention.

The interventions that are required will include, but not limited to broad multisectoral, socio-economic interventions aimed at empowering women, as well as implementation of specific focussed interventions within the health sector. As government we have worked hard to address some of the social determinants of health which is only possible through ongoing multisectoral action. To mitigate factors that exacerbate vulnerability of young women and children such as poverty, the government has introduced child support grants, The introduction of grants has led to the reduction of dependency of the young women on men, for the sake of livelihood, thus preventing unplanned and unwanted pregnancies.

The fight against the social ills such as teenage pregnancy, which contribute towards early school drop-out, and consequently leading to inability to finish school and by that not being able to find jobs, the department has partnered with the department of education through integrated school health programme. It is through this programme that there has been an increased access to sexual and reproductive services for the children as young as early as 12 years. Our sister department of Education has really come to the party by keeping pregnant teenage mothers in school, supporting young people in tertiary education through the higher health program. The department has developed strategies to improve the economic conditions for women, young girls and people living with disabilities. Department of Health ensures that all women of all ages have unhindered realisations and access to Sexual & Reproductive Health rights and services. Our

commitment to multisectoral action illustrated by the fact that these and other departments represented in our country delegation to this conference.

We are convinced that the main real problem solver for our problems, is the health system strengthening to ensure and assure access to universal health coverage. This makes a stronger case for our unrelenting drive toward the finalisation of the National Health Insurance legislative process.

The health system strengthening becomes our golden target because weaker health systems undermine universal health coverage. In this connection, we need a stronger governance and leadership from all levels including at all levels, good management of medicines, vaccines and commodities, research and development, appropriately skilled human resources for health that good numbers, infrastructure development. Of the other areas of health system strengthening, It is worth reemphasising that health facility infrastructure for providing quality care for mothers and children remains a challenge in some settings, and more needs to be done to ensure that our health infrastructure is adequate.We have on our part responded to some of the urgent needs, and one such responses was the prevention of avoidable maternal and neonatal mortality, through the we have establishment of the Ministerial Committees which focus on monitoring maternal, perinatal and child deaths and on making recommendations for how these deaths can be prevented.

This government must be applauded for having joined the nations of the world by removing user fees at PHC, thus ensuring that mothers

have unhindered access to basic health services. Provision of free services for all pregnant women and children up to five years of age has been critical in improving access to antenatal, intrapartum, and post-natal care for all mothers and new-borns. Emphasis has also been placed on ensuring that all equipment, medicines, and other consumables required to implement the maternal and newborn package of care are in place in all health facilities and service points. Availability of key medicines is monitored on a weekly basis using a digital platform.

With regard to ensuring that every pregnant woman and her infant access a full package of MNCH services, we have introduced some key interventions such as Basic Antenatal Care Plus (8 ANC visits & early antenatal booking), integration of HIV care including universal ART into MNCH services, routine postnatal care (including immunisation & promotion of early exclusive breastfeeding for newborns) and increased access to Sexual and Reproductive Health Services including safe Termination of pregnancy.

Skilled health workforce development has also been key with considerable investment in training of doctors, midwives, and other cadres on the Essential Management of Obstetric Emergencies, Management of the Small and Sick Newborns and Helping Babies Breath. Improving access to information has also been key. Audit of maternal deaths and perinatal review meetings based on health facility data have been used to identify and respond to the top causes of morbidity and mortality.

Mothers and their families have been provided with reliable information

and the opportunity to provide feedback (compliments and complaints) through the roll-out of MomConnect. We are proud that more than 4.5 million mothers have received messages and support through MomConnect. We also ensure that every newborn receives a Road-to-Health booklet which contains messages that support all aspects Early Childhood Development including nurturing care, breastfeeding promotion, and immunisation.

These are indeed ambitious objectives, but I have no doubt that the combined expertise, commitment, and energy of the delegates who have assembled here will be able to make significant progress and set in motion many interventions that will bear fruit in coming years.

In conclusion, it is my pleasure today to welcome you to South Africa, to the City of Cape Town and to this the first International Maternal Newborn Health Conference. and would therefore like to wish you well over the next few days of deliberations.

I thank you.