Gender is my Agenda CAMPAIGN

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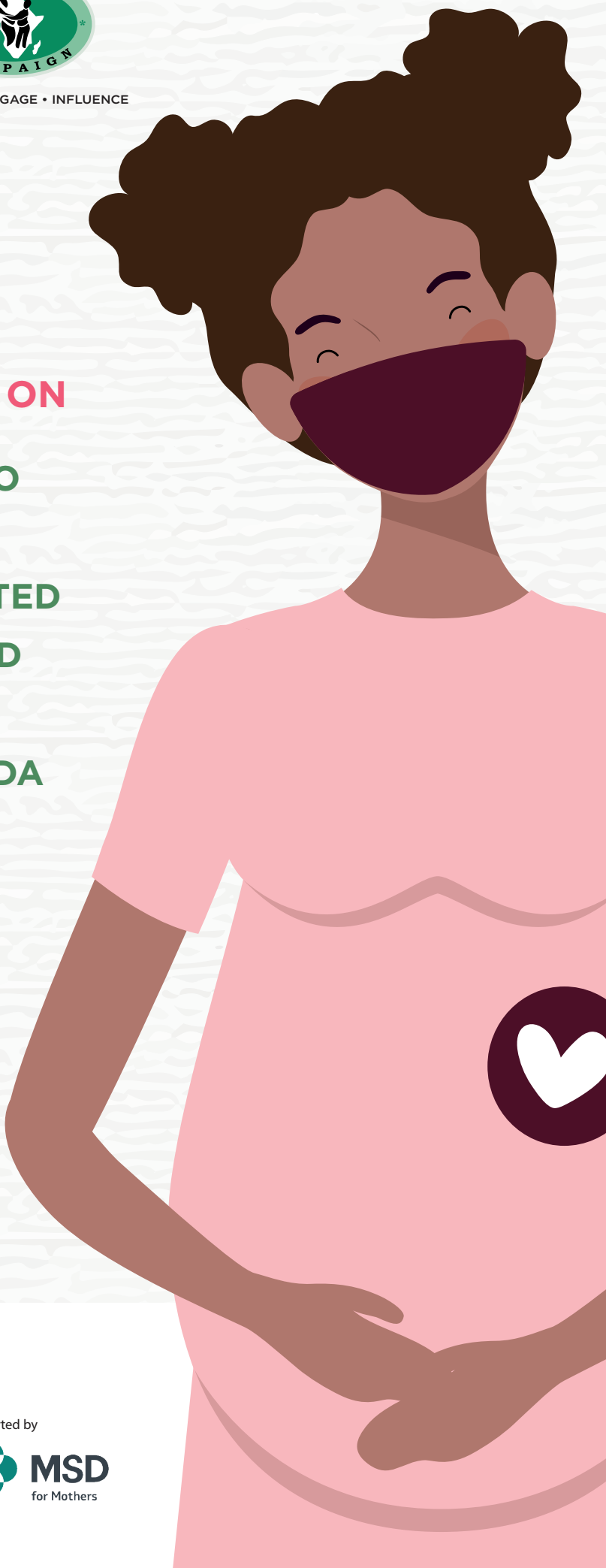
PHASE II: PROGRAM IMPLEMENTATION REPORT ON

STRATEGIC ENGAGEMENT TO INFORM AFRICA REGIONAL ADVOCACY FOR ACCELERATED ACTION FOR MATERNAL AND NEONATAL MORTALITY REDUCTION TO MEET AGENDA 2063 AND SDG 3 TARGETS

Synthesized Reports for
NIGERIA, SENEGAL, KENYA, ZIMBABWE



Femmes Africa Solidarité

Africa Leadership Forum

Supported by MSD for Mothers

EXECUTIVE SUMMARY

A review of data from the 2017 African Health Statistics shows that many Sub-Saharan Africans still suffer from the highest maternal mortality ratio – an average of 533 maternal deaths per 100,000 live births, or 200,000 maternal deaths a year, despite the global reduction in Maternal Mortality Rate (MMR). The maternal deaths are due to several risk factors and gaps in the maternal health care system and, the advent of the COVID-19 has further exacerbated those pre-existing challenges.

It is against this background that MSD for Mothers (MfM), in collaboration with the Gender is My Agenda Campaign (GIMAC) network, organized a continent-wide advocacy to support and promote a strategic engagement for national and regional advocacy aimed at promoting accountability and responsibility for accelerated action for maternal and neonatal mortality reduction to meet agenda 2063 and SDG3 targets across the Member States of the African Union.

The first phase of the Regional Advocacy project was implemented by engaging Maternal Health stakeholders and policymakers in Nigeria, Senegal and at the African Union level in five (5) different virtual dialogues to identify the gaps in the Maternal Health Care System. And the project activity report and key ask were presented at the 37th GIMAC consultative meeting in February 2021.

This second phase of the Regional Advocacy project focused primarily on deepening in-country advocacy around the major recommendations and outcomes of the first phase. Findings in the field during the implementation of this phase revealed the under-reporting of maternal health data in the four implementing countries as opposed to the data obtainable on the Africa Health Statistics (AHStat). It also revealed the lack of technical and advocative capacity of Maternal Health Care Operators and Managers in providing leadership, accountability and data collection as an appropriate feedback mechanism.

The project also brought out the role and importance of TBAs and CBAs and how Maternal Health Care Managers require a new mindset for the engagement and linkage of TBAs/CBAs to the Maternal Health Care System. A concept that the Society of Gynaecology and Obstetrics of Nigeria (SOGON) was able to buy-into due to the obvious negative implications of eliminating TBAs/CBAs on maternal health.

Some of the major recommendations to Heads of States/Government include;

1. Provision of appropriate leadership in the passage and implementation of the MPDSR bill in Nigeria and the expansion of the 2005 Reproductive Health Law in Senegal to accommodate contemporary issues and needs of Maternal Health System in the country. Similar approach should also be adopted in other Member States;
2. Strengthening existing maternal and neo-natal data reporting system in both private

and public health facilities through appropriate budget allocation and release of funds;

3. formalise the linkage of Traditional Birth Attendants (TBAs) into the Maternal Health System through skills enhancement and upgrade programs as their importance cannot be over-emphasised or ignored.

in order for the Members States to implement recommendations 1-3 above, development partners and donors should provide appropriate advocacy and technical support to strengthen their maternal health systems and agencies.

The outcome of this project would be presented and discussed at a high-level meeting (HLM) in January 2022 and during the 38th GIMAC consultative meeting in 2022 through effective engagement and advocacy with appropriate organs of the African Union to get appropriate response from African Leaders and Member States that will promote accountability and responsibility.

In 2020, 55% more maternal deaths and more than triple the number of neonatal deaths were recorded as a result of severe limitation of access to essential health services due to COVID-19.

1.0 INTRODUCTION

In continuation of the effort to accelerate maternal and neo-natal health reduction in Africa and given the robust dialogue series held both at national and continental levels during Phase I of the Regional Advocacy project, this Phase II consolidated the collaboration and synergy built during the first phase, using lessons learnt, outcomes and recommendations from the dialogue series.

One major recommendation of these dialogues was the need to include TBAs/ CBAs in the fight against Maternal Mortality in the countries. According to WHO , " For so long as women give birth without the assistance of a trained birth attendant, TBA training will provide the potential to decrease maternal and child mortality and morbidity, by dispelling ignorance, decreasing harmful ritual practices and promoting safe practices."

Another major outcome of the dialogues was the need to advocate for the passage and implementation of Reproductive Health Laws the country and; to replicate the dialogue series in other African countries, and advocacy on strengthening the healthcare system among member state through the African Union Commission (AUC).

In order to address these 3 major outcomes, the implementing partners conducted a countrywide fact-finding field visit which brought to light the weaknesses in the coordination and linkage of TBAs into the healthcare system. The visits also revealed the lack of technical and advocative capacity of Maternal Health Care Operators and Managers in providing leadership, accountability and data collection as an appropriate feedback mechanism.

" For so long as women give birth without the assistance of a trained birth attendant, TBA training will provide the potential to decrease maternal and child mortality and morbidity, by dispelling ignorance, decreasing harmful ritual practices and promoting safe practices."

As proposed in Phase I, the desk review on the maternal health care system was replicated and implemented by Youth Horizons and GIMAC Young Women of Kenya and Rosaria Memorial Trust of Zimbabwe. The outcome of the engagement with the Maternal Healthcare Actors and findings of the desk research in Kenya and Zimbabwe are presented in the Section below

2.0 COUNTRY ENGAGEMENT & KEY OUTCOMES

2.1 Field Visit In Nigeria And Senegal

In Nigeria, a major outcome of phase one activity is to identify states that have attempted to link TBAs within their communities to Primary Health Care and whose efforts required further investigation. These states include Cross Rivers, Ekiti, Kogi, Ogun and Ondo States. These states were understudied by conducting field visits to the maternal health key actors in the State Ministry of Health to capture their MPDSR framework and, TBA engagement processes, structures, and coordination and, harvest the best practices adopted by the States that have made TBA linkage a success in their States.

This visit was embarked upon in collaboration with the Society of Gynaecology and Obstetrics of Nigeria (SOGON). The importance of passing the National and State MPDSR in informing policy planning, service delivery and accountability towards ending preventable maternal and neonatal mortality.

After the visits, outcome of our finding was presented as an advocacy letter was sent to the National Health Council and the Office of the Vice President highlighting;

a. the key outcomes and the need to take a critical look at the formation, importance and activities of CBAs/ TBAs and how they can be effectively linked into the Maternal Health System referencing the TBA linkage framework deployed in Ondo and Ekiti states.
b. That State Governors should provide/ take appropriate leadership with the passage and implementation of the bill at the state level so that sufficient resources can be made available at the community, local and state levels.

c. A review of the existing MPDSR Bill to mandate the following;

1. Appropriate sanctions for violation of any part of the bill;
2. The incorporation of private health facilities in the MPDSR bill;
3. The Community MPDSR which should also include data from CBAs/ TBAs.

(See APPENDIX II for the detailed findings in Nigeria)

In Senegal, five (5) Regions were visited to identify the challenges and opportunities for the involvement of community stakeholders in the health system. These regions included: Dakar, Thies, Louga, Diourbel and Matam. They represent urban, rural or very remote areas, which enables a comparative analysis of optimal mother and child health care.

The field visit aimed at identifying the factors favouring home delivery, the attitudes of women towards the traditional birth attendant approach; and the complementary roles that the various local and community actors play in reducing maternal and neonatal mortality.

There was a significant decrease in maternal and neonatal deaths from 2017 to 2019.

In addition, a desk review was carried out to collect raw data related to maternal and neonatal deaths from 2017 to 2020 using the District Health Information Software 2 (DHIS2). There was a significant decrease in maternal and neonatal deaths from 2017 to 2019. The review also showed that women aged 25 and above are the most affected age group by maternal deaths, with a percentage of 69% of cases in the country. In 2020, 55% more maternal deaths and more than triple the number of neonatal deaths were recorded as a result of severe limitation of access to essential health services due to COVID-19.

As concerns the 2005 Reproductive Health Law whose implementing order is not yet in force, research and advocacy actions have been initiated with the help of a Woman MP assuming the functions of Vice-president of the National Assembly in charge of Social Affairs and Health to aid the review of the law. **(See APPENDIX II for the detailed findings in Senegal)**

2.2 BASELINE STUDY IN KENYA AND ZIMBABWE

The desk research in **Kenya** revealed that although the Government in 2013, introduced the Free Maternity Service (FMS) policy which was meant to help improve access to quality maternal health care possible for all women in the country. The FMS policy lacked accountability and proper implementation across the country.

The desk review in **Zimbabwe** also showed that legislation of the country has several Acts backed by National Policy documents and strategies that protect the maternal health of women and their unborn children.

From both desk research it is evident that the problem with Maternal Health Systems does not lie within policy frameworks but with implementation. The common gaps identified in both countries include:

- Lack of accountability framework to ensure the implementation of existing policies
- Health workforce gaps (There is a mismatch between the supply of

health workers and the absorption of trained health workers)
- Lack of financial protection for low-income groups to access healthcare
- Over reliance on donor funding
- Inequality in healthcare delivery and;
- Limited access to healthcare facilities and services

In addressing these gaps, two strategies were proposed;

a. Strengthening social accountability mechanisms by mobilizing and building the capacity of the citizens to conduct effective policy analysis and implementation monitoring/tracking and to participate effectively in budget making and tracking processes in their communities
b. Creating and sustaining advocacy platforms and innovations for reaching out to state actors including lawmakers and building effective engagement frameworks especially for the full realization of the WHO's Health Systems Framework: service delivery, human resources for health, health information systems, medical products and technologies, financing, and leadership and governance.

The three Key Asks for Governments and policymakers in Kenya and Zimbabwe include:

1. **Implementing existing policies and guidelines** e.g., the FMS policy in Kenya and the National Maternal and Neonatal Health Strategy of Zimbabwe.
2. **Inclusion and Training of TBAs, Community Health Volunteers, Village Health Workers and midwives in healthcare:** Although, the use of traditional birth attendants was abolished in Kenya after maternity services were declared free. It is no news that women especially in rural communities use them up to date. Policymakers should advocate for the use of TBAs as CHEWs. With help from the government, TBAs and VHWs can be trained to offer healthcare services to complement doctors and nurses.
3. **Need to improve the quality of healthcare services offered in healthcare facilities:** Most facilities lack resources to employ specialists, purchase medical equipment, medicines and other supplies and attend to emergencies. The government should therefore increase healthcare funding to meet these needs. Further, there is a need for healthcare facilities to offer specialized care to suit the different needs of women including women with disabilities, adolescent women, women living with HIV and refugee women among others.

The baseline reports of Kenya and Zimbabwe; and the Lived Experiences of women in Kenya is detailed in Appendix IV

3.0 NEXT STEPS

Further to the field visits in Nigeria and Senegal and, the desk review in Kenya and Zimbabwe, a high-level advocacy meeting at the regional level was being proposed aimed at;

1. sharing with the rest of Africa findings, field lessons and recommendations on the causes of continued maternal deaths and strategies to further bring down maternal and child mortality by 2030;
2. encouraging Member States to improve on accountability around maternal health care by strengthening the legal framework to ensure proper reporting and monitoring of maternal health issues across the country.
3. advocating for an all-inclusive MPDSR Bill across Africa
4. Strengthening the data collection system by building the technical capability of health `care workers directly involved in data collection and analysis

This will be followed by Experts Forum that will discuss strategies, resource mobilisation, capacity building, partnership development, and dissemination of best practices/ approaches aimed at a drastic reduction of maternal and perinatal mortality in Africa.

Encouraging Member States to improve on accountability around maternal health care by strengthening the legal framework to ensure proper reporting and monitoring of maternal health issues across the country.

4.0 CONCLUSION

These challenges, exacerbated by the COVID-19 pandemic need to be addressed in order to make evidence-based decisions that can reduce maternal and child death and adequately track and measure progress towards attaining SDG 3.1.

This regional advocacy project has shown that to reduce maternal and neo-natal mortality in Africa, there is a need to establish; why such deaths occur, what went wrong, what we could have done differently, who we can hold accountable, and for what. These questions can only be answered through data which is the only evidence upon which maternal stakeholders and policymakers can act.

The two common challenges in the maternal health care system across Nigeria, Senegal, Kenya and Zimbabwe are: Poor Data Collection Mechanisms and Lack of Accountability (Poor Legal Framework and Surveillance System). These challenges, exacerbated by the COVID-19 pandemic need to be addressed in order to make evidence-based decisions that can reduce maternal and child death and adequately track and measure progress towards attaining SDG 3.1.

Since the MPDSR has been identified as an important tool in addressing data collection and accountability, Member States need to review and strengthen the MPDSR law, to be more inclusive and capture data from both public and private facilities. Member States need to also provide the health workforce with technical support and aids through appropriate budget allocation and release of funds.

The study recommends the provision of appropriate leadership in the passage and implementation of the MPDSR bill in Nigeria and the expansion of the 2005 Reproductive Health Law in Senegal to accommodate contemporary issues and needs of Maternal Health System in the country. Similar approach should also be adopted in other Member States;

Finally, this study reinforced the importance of TBAs in addressing the challenges in Maternal Health System. The field visits exposed that there is a manpower shortage in the MCHS and the TBAs cannot be wished away because pregnant women in both rural and peri-urban communities patronise their services. Rather than completely eliminating them, the Member States can leverage on skills enhancement and upgrade programs for TBAs; and reassign them as Community Extension Workers and/or give them alternative vocational skills. In order for the Members States to implement recommendations 1-3 above, development partners and donors should provide appropriate advocacy and technical support to strengthen their maternal health systems and agencies.

APPENDIX I: SUMMARY OF FINDINGS IN NIGERIA
SUMMARIZED FIELD ENGAGEMENT REPORT FOR NIGERIA

Below is a tabular summary of the field visit to the 5 selected states in Nigeria.

	CROSS RIVERS	EKITI	KOGI	OGUN	ONDO
STATUS	1. The MPDSR was instituted into the audit of the Maternal Health Care System (MHCS) of the State in 2015.	1. The MPDSR was inaugurated in 2018 but has not been passed into law in the state.	1. The MPDSR bill was passed into an executive law at the State National Assembly in 2018 through the intervention of the Maternal Child Surveillance Program (MCSP).	1. The MPDSR started in 2015 with 18 PHCs Facilities and has been scaled up to about 40 facilities which are mostly secondary health facilities.	1. MPDSR started with the Confidential Enquiries into Maternal Deaths in Ondo State (CEMDOS) bill which was passed into law in 2010 under the ABIYE program (Safe Motherhood) which started in 2009.
	2. The state is on the verge of drafting the MPDSR Bill.	2. The MPDSR Activities in the state include the Development of annual reports, training of medical record officers and, Reviewing all reported deaths in the State.	2. The Kogi State MPDSR law incorporates the reporting activities of public health, private health and TBAs.	2. The SMoH engages TBAs through the Alternate Medicine Board.	2. CEMDOS criminalizes non-reporting of maternal death with a six (6) months jail term.
		3. No bill supports TBA engagement but the SMoH engages with registered TBAs across the State	3. The state currently does not have any engagement framework with Traditional Birth Attendants, but the TBAs have been captured and identified as a part of the Community MPDSR in the MPDSR Bill of the State.	3. TBAs are selected for engagement based on: Level of education, Years of experience and any form of Formal training.	3. The State launched the AGBEBIYE Initiative to create a platform for TBAs and FBBAs/ Mission Homes to collaborate with the government to reduce the MMR in the state in 2012.
		4. The States engagement with TBAs involves registration, training, and structured referrals to PHCs during complications.		4. The Alternate Medicine Board engages the TBAs in capacity building and training on the monthly reporting form.	4., The TBA engagement of the state includes providing; monetary Incentives on every referral initiated, Free alternative Vocational Skills training as an exit strategy and access to micro-financing.
		5. All registered TBAs in the State have Mandatory Certifications (Diploma courses in Community Birth Attendance and Registration with the Midwives Professionals and Skilled Birth Attendants of Nigeria			5. The TBAs are mandated to have certifications.
CHALLENGES	1. non-Notification and non-reporting of maternal death by Facilities on the MPDSR platform	1. The state does not have the MPDSR bill	1. Lack of resources and technical support to ensure the successful implementation of the MPDSR Bill	1. Lack of MPDSR Bill has made initialization of surveillance and reporting difficult both at the public facilities and PHCs	1. The CEMDOS law does not include perinatal deaths
	2. There is a disconnect between the public and private MPDSR.	2. There is a disconnect between the public and private MPDSR	2. Inconsistent reporting and review of death cases by public health facilities at the facility-level MPDSR (the State has not been reporting since January 2021)	2. There is a disconnect between the Public MPDSR system and the private MPDSR system; there are no data from private health facilities.	2. Community MPDSR is not active;
	3. Poor sustainability /transition plan of projects by Donor Agencies e.g. The saving motherhood project by Pathfinder.	3. The State doesn't report the data from TBAs in the MPDSR.	3. Nonexistence of the Community MPDSR although it has been captured in the law.	3. The Alternate medicine law does not provide appropriate regularity and punitive measure for misbehaviour	3. There are gaps in Private MPDSR as only a few Private facilities are reporting.

	CROSS RIVERS	EKITI	KOGI	OGUN	ONDO
RECOMMENDATIONS	1. The health care financing should be strengthened to cover all maternal care services for pregnant women including transport to the health facility	1. Develop a TBA Engagement framework and code of conduct to intensify the monitoring and implementation of TBA activities in the State	1. The need for the urgent provision of resources and technical support to ensure continuous successful implementation of the MPDSR Bill	1. Although there is an existent code of ethics, the board will need to develop a specific code of ethics for TBAs outside the existing general code for traditional practitioners.	1. Upgrading the CEMDOS law into MPDSR law by including perinatal deaths.
	2. Ensure Community MPDSR works out in all the LGAs of the state	2. TBAs/FBBAs should be Incentivized (Compensations and benefits)	2. Ensure the implementation of the Community MPDSR	2. Health Care Financing scheme with the involvement of the private sector especially the manufacturers in the state.	2. Strengthening Community MPDSR through engagement with Community leaders, family heads and religious leaders
		3., Develop a working MPDSR feedback mechanism by instituting the State Steering Committee that works in synergy with the facility and technical MPDSR committee	3 . Private health facilities should be explicitly included in the MPDSR bill and implementation strategy	3. The use of technology such as apps for effective data collection by/to the facilities monthly/ routinely	3. Ensure MPDSR reports of Private Facilities are also captured, by mandating private facilities to create an MPDSR desk office
			4, The SMOH should develop a TBA Engagement framework and code of conduct to intensify the monitoring and implementation of TBA activities in the State and their inclusion in the Community MPDSR	4, To address the issue of manpower shortage especially for delivery, Skills enhancement and upgrade programs should be introduced for CHEWs, and TBAs is very necessary (See, Practice, Master)	4. Continue to allow CBAs/ TBAs to take vaginal deliveries but guided by a Guideline/Code of Conducts
			5. Advocacy for Mandatory certifications and training for TBAs		
ADVOCACY OPPORTUNITY	1. Advocacy with the State MoH to draft the MPDSR Bill to incorporate the reporting activities of the TBAs and private medical practitioners	1. Advocacy with the State MoH to draft the MPDSR Bill to incorporate the reporting activities of the TBAs and private medical practitioners.	1. Advocacy for proper reporting and notification of maternal death by Facilities on the MPDSR platform	1. ALF working with MSD for mothers can advocate and liaise with the Commissioner in the drafting of the Ogun State MPDSR Bill that will incorporate the reporting activities of the TBAs and private medical practitioners	1. Advocacy with the State MoH to draft Code of Conduct to guide the activities of CBAs/TBAs/FBBAs
	2. Advocacy with the State House of Assembly (Parliament) to approve the bill and pass it to law.	2. Advocacy with the State House of Assembly (Parliament) to approve the bill and pass it to law.	2. Advocacy for the implementation of Community MPDSR in all the LGAs of the state	2. The need to advocate for the review of the Alternate Medicine law as some parts of the law are no longer realistic e.g., the referral pathway, the governance etc.	
	3. Advocacy with the Office of the Governor to sign the MPDSR bill.	3. Advocacy with the Office of the Governor to sign the MPDSR bill.	3. Providing support in the provision of devices and equipment for data capturing and review	3. Provision of support in terms of strengthening human resources under MPDSR.	
	4. Advocacy for the implementation of Community MPDSR	4. Advocacy for the implementation of Community MPDSR in all the LGAs of the state	4. Advocacy with the State MoH to draft Code of Conduct to guide the activities of CBAs/TBAs/ FBBAs		
	5. Provision of devices and equipment for data capturing and review	5. Advocacy with the State MoH to draft Code of Conduct to guide the activities of CBAs/TBAs/FBBAs	5. Advocacy for Mandatory certifications and training for TBAs		
	6. Periodic training of MPDSR officers for proper reporting and notification on the MPDSR platform	6. Advocacy for the Inclusion of Traditional Birth Attendants (TBA) in the list of registered Community Birth Attendants (CBAs) in the state.	4. Provision of devices and equipment for data capturing and review and periodic training of MPDSR officers.		

OGUN STATE FIELD ENGAGEMENT REPORT

OGUN STATE MATERNAL HEALTH STAKEHOLDER'S ENGAGEMENT REPORT SUMMARY

DATE: APRIL 21ST AND 22ND, 2021

> Traditional Birth Attendants refer near-death patients to tertiary hospitals, while some Traditional Birth Attendants are pure herbalists, who use concoctions that have no scientific backing.

1.0 Attendance: The two days meeting had in attendance a total of 15 persons including; the Director Primary Health Care Board, the MPDSR Focal Person, MPDSR Desk officer, Registrar/Sec Alternate Medicine Board, SOGON Representative and the ALF Team.

2.0 Objectives:
The objective of this field visit is to deepen in-country advocacy around the major recommendations and outcomes of the stakeholders' dialogues held in the first phase of the project. The overall aim is to promote accountability and responsibility for accelerated action for maternal and neonatal mortality reduction to meet agenda 2063 and SDG3 targets across the member states of the African Union.

3.0 Observations/key issues of MPDSR Management Framework:
The MPDSR started five (5) years ago in 2015 with 18 PHCs Facilities and has been scaled up to about 40 facilities which are mostly secondary health facilities.

The State's MPDSR implementation strategy is designed after the National MPDSR Strategy which operates at three (3) levels. These are; the MPDSR State Steering Committee (SSC). the SUB-SSC, and the facility MPDSR Committee.

Major challenges with the MPDSR are:

1. Lack of support from Funding Partners and Donors:
2. Shortage of manpower;
3. Low rate of deaths reviewed which has made making an informed decision about MHCS challenging;
4. The lack of MPDSR Bill has made initialization of surveillance and reporting difficult both at the Government hospital, PHCs and TBA on the importance of data collection, collation and reporting.
5. Many public health facilities are yet to accept the MPDSR as a concept for improvement of MHCS;
6. Lack of cooperation to turn in data by PHCs;
7. There is a disconnect between the Public MPDSR system and the private MPDSR system; therefore, there are no data from private health facilities;
8. MPDSR tools do not include all data to be captured.

4.0 Key issues on TBA Engagement Framework:

The MoH engages TBAs through the Alternate Medicine Board. The Board leverages the existing TBA coordinating structure in the community to mobilize and register them. Some of the major criteria for selecting TBAs for engagement are; Level of education, Years of experience and any form of Formal training. After which, the Alternate Medicine Board engage them in capacity building and training on the monthly reporting form. TBAs are selected and classified into 4 categories based on the selecting criteria.

The major challenges facing the board in terms of engaging TBAs are:

1. The Alternate medicine law does not provide appropriate regularity and punitive measure for misbehavior;
2. TBAs refer near-death patients to tertiary hospitals, while some TBAs are pure herbalists, who use concoctions that have no scientific backing.
3. Lack of cooperation between Community Birth Attendants and TBAs;
4. Inadequate capacity in terms of human resources and facilities has necessitated the need to consider TBAs as maternal manpower reservoir

5.0 Post Visit Activities:

An appreciation/feedback letter was written to the Commissioner of health. The letter further reinstates ALF's intention to support the state in addressing major issues relating to advocacy. Also, we developed a flow chart that explicitly explained the TBA engagement structure according to our findings which were attached to the letter.

6.0 Agreed lines of action:

1. Conduct research to determine the MMR and use same to streamline their engagement in the State maternal Health Value Chain.

2. Introduction of Pre-training knowledge Gap analysis for TBAs.
3. Although there is an existent code of ethics, the board will need to develop a specific code of ethics for TBAs outside the existing general code for traditional practitioners.
4. Health Care Financing scheme with the involvement of the private sector especially the manufacturers in the state.
5. The use of technology such as apps for data collection. Google form was suggested for capturing routine data from the PHCs, the link to the form will be sent to the facilities monthly/routinely;
6. To address the issue of manpower shortage especially for delivery, Skills enhancement and upgrade programs should be introduced for Community Health Extension Workers (CHEWs), and TBAs is very necessary (See, Practice, Master);
7. Nurses should be trained to take on some activities of Doctors (E.g., cesarean Section) in the case of locations where Doctors are hard to find.

7.0 Future Advocacy opportunities for MSD for Mothers and ALF

1. ALF working with MSD for mothers will advocate and liaise with the commissioner of health in the drafting of the Ogun State MPDSR Bill that will incorporate the reporting activities of the TBAs and private medical practitioners;
2. The need to advocate for the review of the Alternate Medicine law as some parts of the law are no longer realistic e.g., the referral pathway, the governance etc;
3. One of the problems with MPDSR management is resources for data collection, coordination of statutory meetings and monitoring. MSD for Mothers can therefore provide support in terms of strengthening human resources under MPDSR;
4. Provision of devices and equipment for data capturing and review and periodic training of MPDSR officers.

EKITI STATE FIELD ENGAGEMENT REPORT

EKITI STATE MATERNAL HEALTH STAKEHOLDER'S ENGAGEMENT REPORT SUMMARY

DATE: JUNE 06TH AND 07TH, 2021

1.0. Attendance: The two days meeting was attended by the member of staff of the Department of Planning, Research and Statistics, Director Nursing Services, Director Hospital Services, Representatives from the Office of the Commissioner, and the ALF Team.

2.0. Objectives:

The objective of this field visit is to deepen in-country advocacy around the major recommendations and outcomes of the stakeholders' dialogues held in the first phase of the project. The overall aim is to promote accountability and responsibility for accelerated action for maternal and neonatal mortality reduction to meet agenda 2063 and SDG3 targets across the member states of the African Union.

3.0. Observations/key issues of MPDSR Management Framework:

The Maternal and Perinatal Death Surveillance and Response scheme Started in 2018 and got inaugurated the same year and started highlighting MPDSR plans for the state. The MPDSR Structure has a chairman and a co-chair. The HMIS Officers, Reproductive health officers, Directors of nursing services state ministry of health, Director of nursing services from all facilities, the hospital management board and representatives from different facilities are part of the structure. There are 326 PHCs (no Skill birth Attendants) 72 Secondary health facilities and 2 public Tertiary facilities in the State all of which are involved in the MPDSR scheme.

The MPDSR carries out two major functions; Access the situation surrounding a reported Death Case and Identifying the underlying causes of death.

The MPDSR Activities in the state are the Development of Annual reports; Training of medical record officers at the facilities; and reviewing reported death cases.

Major challenges with the MPDSR are:

1. Lack of MPDSR bill;
2. Disparities in data submitted;
3. The MPSR Structure in the State does not support feedback to facilities on decisions and actions taken on data submitted.

4.0. Key issues on TBA Engagement Framework:

The State Ministry of health currently do not have a bill that supports TBA engagement, but the ministry engages with registered TBAs across the State, this engagement involves registration, training, and structured referrals to PHCs during complications.

The Criteria for Registration are:

1. Must be a Faith-Based Birth Attendant (FBBA) affiliated with a church, the pastor of the church will have to initiate the registration of the FBBA
2. The pastor writes an application letter with the letterhead of the church which will be sent to the director of the Primary Heath Board for verification.
3. Must have a minimum of SSCE
4. Must possess Community Birth Attendant (CBA) certification from EDE and UI (NDE consultancy program, DIPLOMA in CBA)
5. TBAs must fill and submit the SMoH TBA engagement form
6. TBAs must select a date for inspection of the site
7. The site must have a road channel, delivery room and resting room
8. TBAs receive Certification from the SMoH when these criteria are met (The SMoH Certificate is renewed yearly).

5.0. Post Visit Activities:

An appreciation/feedback letter was written to the Commissioner of Health. The letter detailed most of our findings during the visit and further shared with the ministry good practices worth emulation found in the four other states visited.

6.0. Agreed lines of action:

1. Develop a TBA Engagement framework and code of conduct to intensify the monitoring and implementation of TBA activities in the State
2. TBAs/FBBAs should be Incentivized (Compensations and benefits)
3. Develop a working MPDSR feedback mechanism by instituting the State Steering Committee that works in synergy with the facility and technical MPDSR committee.

7.0. Future Advocacy opportunities for MSD for Mothers and ALF

1. Advocacy with the State MoH to draft the MPDSR Bill to incorporate the reporting activities of the TBAs and private medical practitioners.
2. Advocacy with the State House of Assembly (Parliament) to approve the bill and pass it to law.
3. Advocacy with the Office of the Governor to sign the MPDSR bill.
4. Advocacy for the implementation of Community MPDSR in all the LGAs of the state.
5. Support in drafting a Code of Conduct that will guide the activities of CBAs/TBAs/FBBAs.

6. Advocacy for the Inclusion of Traditional Birth Attendants (TBA) in the list of registered Community Birth Attendants (CBAs) in the state.

The overall aim is to promote accountability and responsibility for accelerated action for maternal and neonatal mortality reduction to meet agenda 2063 and SDG3 targets across the member states of the African Union.

ONDO STATE FIELD ENGAGEMENT REPORT

ONDO STATE MATERNAL HEALTH STAKEHOLDER'S ENGAGEMENT REPORT SUMMARY

DATE: JUNE 22ND AND 23RD, 2021

1.0. Attendance: The two days meeting was attended by the member of staff of the Department of Family Health, Department of Planning, Research and Statistics, the OSPHCDA and the ALF Team.

2.0. Objectives:

The objective of this field visit is to deepen in-country advocacy around the major recommendations and outcomes of the stakeholders' dialogues held in the first phase of the project. The overall aim is to promote accountability and responsibility for accelerated action for maternal and neonatal mortality reduction to meet agenda 2063 and SDG3 targets across the member states of the African Union.

3.0. Observations/key issues of MPDSR Management Framework:

MPDSR started with the Abiye program (Safe Motherhood), with the intention of auditing maternal deaths. To achieve this, Confidential Enquiries into Maternal Deaths in Ondo State (CEMDOS) was set up in 2010 when the CEMDOS bill was passed. The bill criminalizes not reporting maternal death with a six (6) months jail term. CEMDOS is the current system through which the states collects and review data on maternal death-related issues. The CEMDOS law and the implementation strategy will have to be reviewed to include

perinatal death for it to translate into MPDSR. CEMDOS is established across the state at the primary, secondary, tertiary and private levels. It is in every sec facility and all PHCs have a functioning MPDSR/CEMDOS system.

Major challenges with the MPDSR are:

1. The CEMDOS law does not take into cognizance perinatal deaths;
2. Community MPDSR is not active
3. There are gaps in Private MPDSR as only a few Private facilities are reporting
4. There are issues of incomplete data and omissions in facility reports.
5. There is a disconnect between the Public MPDSR system and the private MPDSR system; therefore, there are no data from private health facilities;
6. MPDSR tools do not include all data to be captured.

4.0. Key issues on TBA Engagement Framework:

CEMDOS first (1st) report in 2012 revealed that those maternal deaths were majorly originating from referred cases from TBA/FBBA/CBAs to government facilities. In other to address this, the government in 2012 launched the AGBEBIYE Initiative to create a platform for TBAs and FBBAs/Mission Homes to collaborate with the government to reduce the MMR in the state.

The government decided to leverage the TBAs/CBAs as partners by registering them, training them, giving them alternative vocational skills and giving them a standing order not to take deliveries but rather refer pregnant women to the PHCs for a token. The current administration through the CHIPs initiative will provide business start-up/expansion funds and also recruit more health workers/professionals to address major issues of lack of manpower.

The two major identified challenges the government has in engaging TBAs are:

1. There is no law to back up the AGBEBIYE initiative thereby making discontinuity easy for a new administration. The CHIPs initiative if not backed by law will eventually be scrapped by the next administration;
2. Most TBAs that have been given the alternative vocation skill training went back to TBA practice because they could not manage the business and some because there was no fund for start-up or business expansion

5.0. Post Visit Activities:

An appreciation/feedback letter was written to the Permanent Secretary. The letter detailed most of our findings during the visit and further shared with the ministry good practices worth emulation found in the four other states visited.

6.0. Agreed lines of action:

1. The need to Upgrade the CEMDOS law into MPDSR law by including perinatal deaths
2. Strengthening Community MPDSR through engagement with Community leaders, family heads and religious leaders
3. Ensure MPDSR reports of Private Facilities are also captured, by mandating private facilities to create an MPDSR desk office.
4. Continue to allow CBAs/TBAs to take vaginal deliveries but guided by a Guideline/ Code of Conducts
5. Support the SMoH by providing entrepreneurship training for registered CBAs/ TBAs under the CHIPS Initiative in accessing the CBN/NIRSAL-AGSMEIS loan which can be used for business start-up or expansion.
6. To address the issue of manpower shortage especially for delivery, Skills enhancement and upgrade programs should be introduced for Community Health Extension Workers (CHEWs), and TBAs is very necessary (See, Practice, Master)
7. Nurses should be trained to take on some activities of Doctors (E.g., caesarean Section) in case of locations where Doctors are hard to find;

7.0. Future Advocacy opportunities for MSD for Mothers and ALF

1. Advocacy with the State MoH to draft a Code of Conduct to guide the activities of CBAs/TBAs/FBBAs
2. Advocacy to the House of Assembly to upgrade the CEMDOS law into MPDSR law by including perinatal deaths

“

Nurses should be trained to take on some activities of Doctors (E.g. cesarean Section) in case of locations where Doctors are hard to find;

KOGI STATE FIELD ENGAGEMENT REPORT

KOGI STATE MATERNAL HEALTH STAKEHOLDER'S ENGAGEMENT REPORT SUMMARY DATE: JUNE 10TH AND JULY 2ND, 2021

1.0. Attendance: The two days meeting had in attendance a total of 8 persons including the Director Public Health Care, the MPDSR Focal Person, MPDSR Desk officer, HMIS officer, and the ALF Team.

2.0. Objectives:
The objective of this field visit is to deepen in-country advocacy around the major recommendations and outcomes of the stakeholders' dialogues held in the first phase of the project. The overall aim is to promote accountability and responsibility for accelerated action for maternal and neonatal mortality reduction to meet agenda 2063 and SDG3 targets across the member states of the African Union.

3.0. Observations/key issues of MPDSR Management Framework:
The MPDSR bill was passed into an executive law at the State National Assembly in 2018 through the intervention of the Maternal Child Surveillance Program (MCSP), which engaged in systemic dialogue with the State Government and Ministry of Health between 2017 and 2018.

The Kogi State MPDSR law incorporates the reporting activities of public and private health facilities and the TBAs. Rotary International with support from the German government and the Federal Ministry of Health assisted in developing an electronic reporting platform where facilities can report on Maternal and Perinatal Deaths. The reporting structure of the state is divided into two; - Paper documentation at the facility level and; - electronic reporting.

The State's MPDSR implementation strategy is designed after the National MPDSR Strategy which operates at three (3) levels. These are; the MPDSR State Steering Committee (SSC), the Facility MPDSR Committee and the Community MPDSR Committee.

Major challenges with the MPDSR are:

1. Lack of resources and technical support to ensure the successful implementation of the MPDSR Bill;
2. Irregular meeting of the State Steering Committee Meeting;
3. Inconsistent reporting and review of death cases by public health facilities at the facility-level MPDSR (the State has not been reporting since January 2021);
4. Nonexistence of the Community MPDSR although it has been captured in the law.

4.0. Key issues on TBA Engagement Framework:
The state currently does not have any engagement framework with Traditional Birth Attendants, but the TBAs have been captured and identified as a part of the Community MPDSR in the MPDSR Bill of the State.

5.0. Post Visit Activities:

An appreciation/feedback letter was written to the Commissioner of health. The letter further reinstates ALF's intention to support the state in addressing major issues relating to advocacy as stated in section 7.0 below.

6.0. Agreed lines of action:

1. There is the need for the urgent provision of resources and technical support to ensure continuous successful implementation of the MPDSR Bill;
2. The implementation of the Community MPDSR and ensuring it is put to practice in all LGAs of the state;
3. Private health facilities should be explicitly included in the MPDSR bill and implementation strategy;
4. The SMOH should develop a TBA Engagement framework and code of conduct to intensify the monitoring and implementation of TBA activities in the State and their inclusion in the Community MPDSR;

7.0. Future Advocacy opportunities for MSD for Mothers and ALF

1. One of the problems with MPDSR management is resources for data collection, coordination of statutory meetings and monitoring. MSD for Mothers can therefore provide support in terms of strengthening human resources under MPDSR;
2. Provision of devices and equipment for data capturing and review and periodic training of MPDSR officers;
3. ALF with support from MSD for Mothers can assist the state in designing a TBA Engagement Framework for a better implementation of the Community MPDSR.

APPENDIX II: SUMMARY OF FINDINGS IN SENEGAL
SUMMARY OF FINDINGS IN SENEGAL

The following is a summary of the findings on the challenges and opportunities for involving community stakeholders in the accelerated reduction of maternal and neonatal mortality.

	DAKAR	THIES	DIOURBEL	LOUGA	MATAM
Specificity of the regions	- Capital city hosting most of the healthcare facilities - 12 health districts - 99 maternal deaths were recorded in 2020 with 86.9% of audits - 320 neonatal deaths were recorded in 2020 with 39.4% of audits - Most populated region - Sufficient presence of qualified personnel - Most roads are usable - More community stakeholders	-closest to Dakar (70) kilometres - 09 health districts - 87 maternal deaths were recorded in 2020 with 88.5% of audits - 374 neonatal deaths were recorded in 2020 with 21.4% of audits of these deaths - Strong presence of community stakeholders. - Quite qualified staff - Quite satisfactory accessibility of the roads	-145 kilometres from Dakar to the centre of the country - Rural and agricultural area - 04 health districts - 86 maternal deaths were recorded in 2020 with 82.6% of audits - 652 neonatal deaths were recorded in 2020 with 9.0% of audits - Limited qualified personnel - Good presence of community stakeholders - Practicable roads except in remote areas - Strong influence of religious leaders	218 kilometres from Dakar to the north - Rural and Sahelian area - 08 health districts - 57 maternal deaths were recorded in 2020 with 75.0% of audits - 146 neonatal deaths were recorded in 2020 with 19.2% of audits - Limited qualified personnel - Very good presence of community stakeholders and presence of TBAs. - Roads usable except in remote areas	- 514 kilometres from Dakar to the north-east - Rural and agricultural area - 04 health districts - 56 maternal deaths were recorded in 2020 with 36.0% of audits - 51 neonatal deaths were recorded in 2020 with 27.5% of audits - Insufficient qualified personnel - Good presence of community stakeholders and presence of TBAs. - Moderately practicable roads
Diversity of community stakeholders	**Same in the 5 regions**				
	The Bajenu Gox, the community relays, the midwives, the religious chiefs, the community stakeholders in promotion and prevention, the neighbourhood or village chiefs, the Ndijadiou gox, the family counsellors, the advocacy spokespersons of the Siggil Jiggeen Network, the home care providers.				
Roles of community stakeholders	**Same in the 5 regions** • Monitoring from the beginning of the pregnancy until the delivery and the follow-up of antenatal care (ANC) visits, the minimum required is 4 visits • Raising awareness on pregnancy-related hazards and acting as a relay between the midwife and the pregnant woman • Encouraging and promoting childbirth in a healthcare facility and at the same time fighting against home deliveries • Raising awareness on testing to prevent mother-to-child transmission • Supporting after pregnancy, monitoring of the child, weighing and acquisition of the health record as well as compliance with the vaccination schedule • Managing the difficulties to maintain privacy on unwanted pregnancies • Raising awareness on early marriage and pregnancy in certain areas • Raising awareness on birth spacing and close pregnancies • Raising awareness on the use of impregnated mosquito nets • Organising home visits, talks, community dialogues and advocacy • Monitoring and alerting at the community level. • Advocacy with religious leaders for family planning and birth spacing • Ad hoc awareness-raising activities in places of worship.				
Existence of TBAs	Non-existence of TBAs	Non-existence of TBAs	Existence of TBAs in some remote localities but the listing	Existence of TBAs in the region, especially in the more remote areas. -They are somewhat hidden from the health staff and in practice too.	Some echoes of their existence in some remote villages
Factors favouring home childbirths	- Socio-cultural beliefs - Lack of resources for care costs - Poor preparation for childbirth - Poor reception and care conditions are sometimes judged negatively and conveyed within the community.	- The problem of geographical inaccessibility - Lack of means and preparation for childbirth - Socio-cultural beliefs - Difficult access to transportation means	-Lack of means with the quite high costs of childbirth - Geographical inaccessibility to health structures - Reception and care in health facilities often considered negative by the community - Socio-cultural beliefs embedded in certain areas - Difficulty of access to means of transport	-Community, traditional or customary beliefs -The problem of accessibility to health structures -The problem of means - Accidents (unplanned deliveries)	The geographical inaccessibility problem - Lack of means and planning for childbirth - Customary beliefs - Inaccessible means of transport

	DAKAR	THIES	DIOURBEL	LOUGA	MATAM
The impact of TBAs	• TBAs are an obstacle to the eradication of home deliveries, which can lead to maternal and neonatal deaths. • Community stakeholders are doing their utmost to dissuade pregnant women from using their services. • The regions of Diourbel, Louga and Matam, which reported their existence, all aim to remedy this problem as soon as possible. • At the community level, midwives are trained to deal with this issue and just for unplanned deliveries.				
Factors identified in the regularity of community-based actions A real problem of the regularity of actions is noted most of the time in most of the regions and the reasons are similar and linked to the lack of logistic and financial resources	- A monthly or quarterly schedule is drawn up with the midwife with specific objectives - Better regularity due to the multitude of partners present - Lack of continuity of service packages after the withdrawal of partners	- Regular activities in some areas with some adequate organisation and methodology - Less regular in other areas especially in the period of the pandemic due to instructions and precautions taken - Lack of regularity is sometimes due to insufficient resources and the end of the project by partners. - Lack of remuneration or financial and logistical support	- Regularity deficiencies noted after the withdrawal of partners and with the COVID-19 setting - Good regularity in the packages of activities put in place in collaboration with the ICP or the midwife.	- Regular activities in collaboration with the health system - Quarterly schedules developed with the medial region and districts - Regularity reported with or without partners - Planning according to the priorities selected by the ICP or the midwife - Nevertheless, better regularity with partners	- Regularity of activities except during pandemic periods - Lack of resources limiting and making it difficult to execute schedules
The Challenges for Community Stakeholder Action	- No remuneration at all - Means to carry out the activities	- Directly entering into contracts with community stakeholders. - Capacity building of stakeholders through quality training - Equipped headquarters for better organisation - Management and communication tools - Relevant and funded activity packages - Formal remuneration	-Reorganisation and restructuring of stakeholders. - Formal recognition at the system level behind the community health unit - Review the criteria for selecting stakeholders.	- Means to carry out the activities - Motivation and working capital for the activity packages - Capacity building in regular training packages - Formal recognition in the health system.	- the logistics needed to carry out the activities properly - transport to access the most remote areas - Capacity building
Recommendations	-Revaluing the commitment of community stakeholders and making specific budgets available -Training and strengthening their information, monitoring and follow-up tools -Documenting their experience to share and learn from their improved involvement in reducing maternal and neonatal mortality	- Involvement of CVACi in the advocacy programme - Travel to the districts to meet with stakeholders and Regional Head Doctors (MCRs) for better involvement and sustainability of actions. - Approach the districts for the mapping of community stakeholders. - Motivate morally and help the stakeholders in the visibility of the actions - Propose concrete activity packages to the stakeholders to better guide their intervention	- Mapping of partners to harmonise the work - Formalise the network of stakeholders through the MSAS with contracts - Advocate a policy of support for community stakeholders. - Organise a regular consultation framework - Put in place an appropriation of strategies that have proved their worth. - Involve the community health unit - Better involve the community component in health management policies.	-Involve the regional governor in projects to fight maternal and neonatal mortality. - Advocate for the construction of a passable road to remedy the problems of referral and recourse - Strengthen the number of ambulances that can reach the sites in case of emergency - Involve community watch and alert committees. - Adopt a more community-based approach to health management - Organise visits to the districts to meet community players directly. - Provide better support to the stakeholders and above all involve all the CBOs in the locality. - Create a formal directory of community stakeholders and formalise it.	- Provide stakeholders with more resources so that they can reach remote areas. - Make the most of community dynamics by providing them with quality training but also by motivating them if they are not paid. - Provide logistics and means of transport to the stakeholders, but also to the health centres and dispensaries, which are the first levels of referral. - Convert TBAs into midwives by providing them with quality training.

TABULAR SUMMARY OF MATERNAL DEATHS REVIEWED IN SENEGAL

Table 1: Regional distribution of Registered Maternal deaths and % of deaths audited in 2020

Medical Regions	Total number of maternal deaths in 2020	% audited maternal deaths in 2020
Dakar	99	86.9%
Diourbel	86	82.6%
Fatick	26	96.2%
Kaffrine	35	100.0%
Kaolack	61	100.0%
Kédougou	29	90.0%
Kolda	40	75.0%
Louga	57	75.0%
Matam	56	36.0%
Saint-Louis	53	51.0%
Sédhiou	37	100.0%
Tambacounda	102	98.0%
Thiès	87	88.5%
Ziguinchor	29	43.5%
Senegal	**797**	**81.8%**

Table 2: Share of adolescent girls aged 15-19 and young women aged 20-24 in maternal mortality per Region

Regions	Age Groups		
	15-19	20-24	25 and above
Dakar	5%	12%	83%
Diourbel	6%	18%	76%
Fatick	14%	14%	73%
Kaolack	18%	20%	62%
Louga	19%	15%	67%
Matam	19%	19%	63%
ST louis	15%	19%	66%
Tambacounda	24%	16%	61%
Thiès	1%	20%	79%
Ziguinchor	17%	7%	76%
Kaffrine	3%	22%	75%
Kédougou	23%	29%	48%
Sédhiou	8%	16%	76%
Kolda	19%	35%	47%
Senegal	**13%**	**18%**	69%

CONSULTATIONS WITH COMMUNITY ACTORS IN THIES

DATE: 4th, 5th and 27th August 2021

Format: Regional focus group with one representative from each district in the Region of Thies

Attendance: The meeting was attended by nine (9) community players, the RH Coordinator and two FAS representatives.

Overall objectives: To gain insights into the involvement of community actors and understand the major challenges of involving community actors in the locality from which to build advocacy for an accelerated reduction of maternal and neonatal mortality in Senegal.

Findings: There is a good presence of community actors in the locality involved in maternal health and care, but they are facing a significant lack of resources. That is more frustrating and alarming as the community actors are heavily assigned with important responsibilities they cannot deliver in and for the community. That include awareness and preventive measures for maternal and neonatal deaths. It has also been noted the existence of funding programmes that take some of the community actor's engagements, but they are rather limited and only cover activity participation fees. In addition, at the closing of those programmes, there are rare opportunities to continue the community engagements which represent a lack of consolidating their efforts. The presence and commitment of these actors constitute a major opportunity to be exploited for a significant improvement in maternal and child health.

Lastly, the region of Thies has a low experience of traditional birth attendance and they are rather supporting the national vision of eliminating the practice

CONSULTATIONS WITH COMMUNITY ACTORS IN LOUGA

DATE: 2nd and 15th September 2021,

Format: Group interview with the regional management team
Attendance: The meeting was attended by nine (9) executives from the medical region team and the two FAS representatives, among others:

Overall objectives: to get a much more global picture of the community actors involvement problems in maternal and child health as well as understanding the challenges and opportunities to build the advocacy for an accelerated reduction of maternal and neonatal mortality in Senegal.

Findings: The meeting saw the representativeness of each district around the medical region. It was noted a working synergy and close collaboration of the community actors with the medical region authorities through its reproductive health coordinator and the health Posts. A fairly good organization of community actors was observed although there is a critical lack of technical and financial resources. As they do not have an operating budget and therefore have to do with the means at hand, combined with personal or family concerns, despite their commitment they will not be able to be constant.

The emphasis on volunteering and a lack of consideration due to the fact that they are not top health graduates are believed to be at the root of them.

But it should be noted that they constantly undergo sustained training and professional training from different partners and in various programs and areas of intervention. Some of them have enormous skills in dealing with health problems at the community level. They also have the advantage of being known, chosen, and listened to by their community.

SRMNIA-NUT INTEGRATED SUPERVISION MISSION
SRMNIA –NUT INTEGRATED SUPERVISION

20-24 SEPTEMBER 2021 DAKAR MEDICAL REGION

DATE : 20 to 24 September 2021, Dakar Medical Region
Format : Field visits

Attendance : About 50 people are made up of members of the DSME, the Dakar Medical Region, the Health District, the representative of the NGO Femmes Africa Solidarité and technical and financial partners.

At the invitation of the DSME, the NGO FAS took part in the integrated supervision mission on the national strategic plan for maternal, neonatal, child, adolescent and youth health (SRMNIA) and Nutrition (NUT).

The purpose of this first mission in the Dakar Medical Region was to monitor and assess the SRMNIA-NUT implementation indicators enabling to measure the progress of the maternal and child health programmes to guide decision-making and adjust interventions. The Monitoring and periodic performance evaluation are key components of the SRMNIA strategy, especially since Dakar has experienced a decline in performance.
Selected hospitals, health centres, health posts and private clinics in the 12 districts of the Dakar Region were visited by the various teams formed. During each visit, the teams spoke with the medical staff of the various maternity and neonatal units. At the end of the visit, open discussions were held with the heads of the centres to share observations and suggestions in order to formulate commendations.

Overall, the supervision mission was welcomed by all the field players and the conclusions were encouraging for the majority of the health centres visited.

The following points were raised:

Strengths	Weaknesses	Recommendations
• Availability and engagement of SRMNIA-N stakeholders (partners, service providers, community players, civil society, etc.) in the fight against COVID-19; • Staff availability (both nurses & midwives in more than 80% of healthcare centres; • The organisation of data entry days to improve the completeness of data as well as monitoring of data entry by programme managers; • Establishment of committees to fight against maternal and neonatal deaths and to strengthen the operation of SONU blocks; • Reinforcement of communication; • Awareness-raising caravans led by the Bajenu Gox.	• Frequent shortages of vital products; • Insufficient bed capacity (maternity and paediatrics) of certain healthcare centres leading to difficulties in the implementation of the referral & counter-referral system and risks of an increase in the number of maternal, • Poor functionality of the SONU blocks • Poor communication on nutrition/ child health; • Insufficiency of rolling stock (ambulance); • The persistent belief in certain taboos; • Late recourse to care • Mobility of qualified human resources; (gynaecologist, midwives, nurses); • Failure to carry out an audit of neonatal deaths • Insufficient number of specialists to deal with obstetric and paediatric emergencies; • Non-capitalisation of data from hospitals, private, faith-based and community healthcare centres;	• Ensure availability of intakes (Vitamin A, Albendazole, Amoxicillin, ORS / Zinc) and screening equipment; • Assess needs for the functionality of SONU designated centres; • Set up a regulation mechanism for the referral & counter-referral system; • Conduct monthly audits on maternal and neonatal deaths and near-misses; • Systematize the audit of maternal and neonatal deaths and follow-up on the recommendations of these audits; • Ensure the supervision of community players on the quality of SRMNIA / NUT data management • Share the good practices in your health districts with the Medical Regions and the DSME; • Advocate training and refresher programmes for health post midwives in the huts on the community file; • Set up a light neonatal unit at healthcare centre level; • Build service providers' capacity on the community FP file; • Capitalize on SRMNIA / NUT data at the community level.

APPENDIX III: FIELD ENGAGEMENT GUIDE

This appendix contains the field engagement guide for Nigeria and Senegal

STAKEHOLDERS ENGAGEMENT GUIDE (NIGERIA)

STAKEHOLDERS ENGAGEMENT GUIDE	
1	**LOCATION:**
2	**DATE:**
3	**PARTICIPANTS :** Honourable Commissioner for Health, Executive Secretaries, Directors, Coordinators, Desk Officers and TBA representatives.
4	INTRODUCTION : Meeting Objectives, Acknowledgement.
5	A brief update on the Maternal Health Care System of the State
6	The Maternal and Perinatal Death Surveillance and Response (MPDSR) framework in the state.

7	TBA engagement processes to the Maternal Health Care System (MHCS) : I. What are the criteria for the selection of TBAs (who are these TBAs) ? II. What is the rationale for the TBA engagement ? III. Is there a separate Policy for the TBA engagement ? IV. What is role allocation within the engagement (TBA and Government) ? V. What are the limitations to these TBA roles in the MHCS ? VI. What kind of resources were deployed in the management of the TBA engagement ? (E.g. financial inventives) VII. Is there a sustainability plan for the TBA engagement ?
8	Is there any obstacle to this approach ?
9	Are there noticeable gaps in the implementation of this approach ?
10	What has the State Government done to address these gaps ?
11	What are the benefits of TBA engagement with MHCS
•	Give data-driven results/success stories such as MMR reduction, Number of TBAs involved, Number of TBAs trained, Acceptance by other stakeholders such as Medical Doctors.
12	Other Remarks

QUESTIONNAIRE DES ACTEURS COMMUNAUTAIRE (SENEGAL)

Nom:……..… Prénom:…… Fonction:……

I. Implication des acteurs communautaire

1. En tant que acteurs communautaires, quel rôle jouez-vous dans la lutte contre la mortalité maternelle et néonatale dans votre localité ?
2. Comment menez-vous vos activités dans la lutte contre la mortalité maternelle et néonatale?
3. Vos activités sont-elles régulières en matière de santé maternelle et néonatale surtou dans les crises sanitaires en l'occurrence la pandémie de la covid 19 ?
4. Etes- vous rémunérés durant la mise en œuvre de ces activités ?
   ……
5. Si non pourquoi ?.....
6. Quels sont les défis que vous rencontrez pour la pérennisation des activités de lutte contre la mortalité maternelle et néonatale dans la communauté ?
7. A votre avis quelle serait la bonne stratégie pour une meilleure implication des acte que vous
   êtes ?.....

II. Implication des Accoucheuses Traditionnelles

1) Notre programme s'intéresse à la question liée à la pratique des AT. Qu'en savez-vous de ces pratiques
   ?.....
2) En connaissez-vous des zones ou ces AT existent dans votre localité
   ?.....
3) A votre avis quels sont les facteurs favorisants les accouchements à domicile dans votre
   localité ?.....
   .....
4) Quelle est votre attitude par rapport aux accoucheuses traditionnelles ?
5) Pensez-vous que ces dernières ont un apport positif dans la prise en charge des accouchements à domicile dans votre communauté ?.....
6) Pourriez-vous nous dire le rôle complémentaire des différends acteurs de votre localité en matière de santé maternelle et néonatale (acteurs communautaires, leade communautaires, etc.) ?

QUESTIONNAIRE DE DSME (SENEGAL)

Nom:…… Prenom:……. Fonction:…….

I. Plaidoyer de la loi 2005 portant sur la santé de la reproduction

1) En tant qu'autorité de tutelle en santé maternelle et néonatale ou en êtes-vous par rapport au plaidoyer de la loi 2005 portant sur la santé de la reproduction ?
2) Quels sont les obstacles liés à sa vulgarisation et à son application?
3) Quelles sont les stratégies mises en place pour le plaidoyer de la Loi 2005?

II. Collecte, analyse et documentation des causes de décès maternels et néonatals

1) Avez-vous déjà des données disponibles sur les décès maternels et néonatals allant de la période de 2018-2020 ?
2) Etes-vous dans les dispositions de nous accompagner dans le processus de collecte, d'analyse et de documentation des causes de décès maternels et néonatals?
3) Si oui comment ?.....

III. Implication des acteurs communautaires

1) Qui considérez-vous comme acteurs communautaires de santé ?.....
2) Quel est le degrés d'implication des acteurs communautaires en matière de santé maternelle et néonatale au Sénégal ?.....
3) Quelles sont leurs actions ?.....
4) Quels sont les défis actuels auxquels ils sont confrontés dans la mise en œuvre de leurs activités ?
5) Quelles sont leurs principales activités dans la communauté en matière de santé maternelle et néonatale particulièrement dans ce contexte de la covid 19 ?
6) Quels sont les moyens mis à leurs dispositions pour la mise en œuvre de leurs activités ?.....
.....
7) Quelles sont les stratégies mises en place pour relever les défis de leurs implications au Sénégal
?.....
8) Citez-nous 4 à 5 recommandations pour une meilleure implication de ces acteurs communautaires?.....
.....

IV. Implication des Accoucheuses Traditionnelles

1) Notre programme s'intéresse à la question liée à la pratique des AT. Qu'en savez-vous de ces pratiques
?.....
2) En connaissez-vous des zones ou ces AT existent dans le pays ?.....
3) Qu'en est-il de leur nombre au Sénégal ?.....
4) A votre avis quels sont les facteurs favorisants les accouchements à domicile au Sénégal?
5) Quelle est votre attitude par rapport aux accoucheuses traditionnelles ?.....
6) Pensez-vous que ces dernières ont un apport positif dans la prise en charge des accouchements à domicile dans votre communauté ?.....

QUESTIONNAIRE DES ACTEURS COMMUNAUTAIRES DE SANTÉ (SENEGAL)

Nom: ……. Prenom:……. Fonction:……

I. Implication des acteurs communautaire

1) Qui considérez-vous comme acteurs communautaires de santé ?.....
2) Quel est le degrés d'implication des acteurs communautaires en matière de santé maternelle et néonatale dans votre région ?.....
3) Quelles sont leurs actions ?.....
4) Quels sont les défis actuels auxquels ils sont confrontés dans la mise en œuvre de leurs activités ?.....
5) Quels sont les activités que vous menez dans votre communauté en matière de santé maternelle et néonatale ?.....
6) Quels moyens disposez-vous pour la mise en œuvre de vos activités ?.....
7) Quelles sont les stratégies mises en place pour relever les défis de votre implication dans votre région ?.....
8) Citez-nous 4 à 5 recommandations pour votre meilleure implication ?.....

II. Implication des Accoucheuses Traditionnelles

1) Notre programme s'intéresse à la question liée à la pratique des AT. Qu'en savez-vous de ces pratiques ?.....
2) En connaissez-vous dans votre zone ?.....
3) Qu'en est-il de votre région ?.....
4) Pensez-vous que des perspectives de leur implication peuvent être engagés pour la réduction accélérée de la mortalité maternelle et néonatale ?.....
5) A votre avis quels sont les facteurs favorisants les accouchements à domicile dans votre région et particulièrement dans le contexte de crise sanitaire tel que le covid?
6) Quelle est votre attitude par rapport aux accoucheuses traditionnelles ? …….

Pensez-vous que ces dernières pourraient avoir un apport positif dans la prise en charge des accouchements à domicile dans votre communauté?.....

APPENDIX IV: NATIONAL BASELINE REPORT IN KENYA AND ZIMBABWE BASELINE REPORT OF KENYA

National Baseline Report on Maternal Health in Kenya

BACKGROUND

Maternal and perinatal mortality remains a major public health concern globally with more than 289,000 maternal deaths, 2.6 million stillbirths and 2.7 million neonatal deaths occurring each year. In Kenya the current Maternal Mortality Ratio (MMR) is 362 maternal deaths per 100,000 live births, and the still birth rate of 23 deaths per 1000 live births is far below the target of 147 maternal mortality per 100,000 live births and 12 stillbirths per 1000 live births respectively.

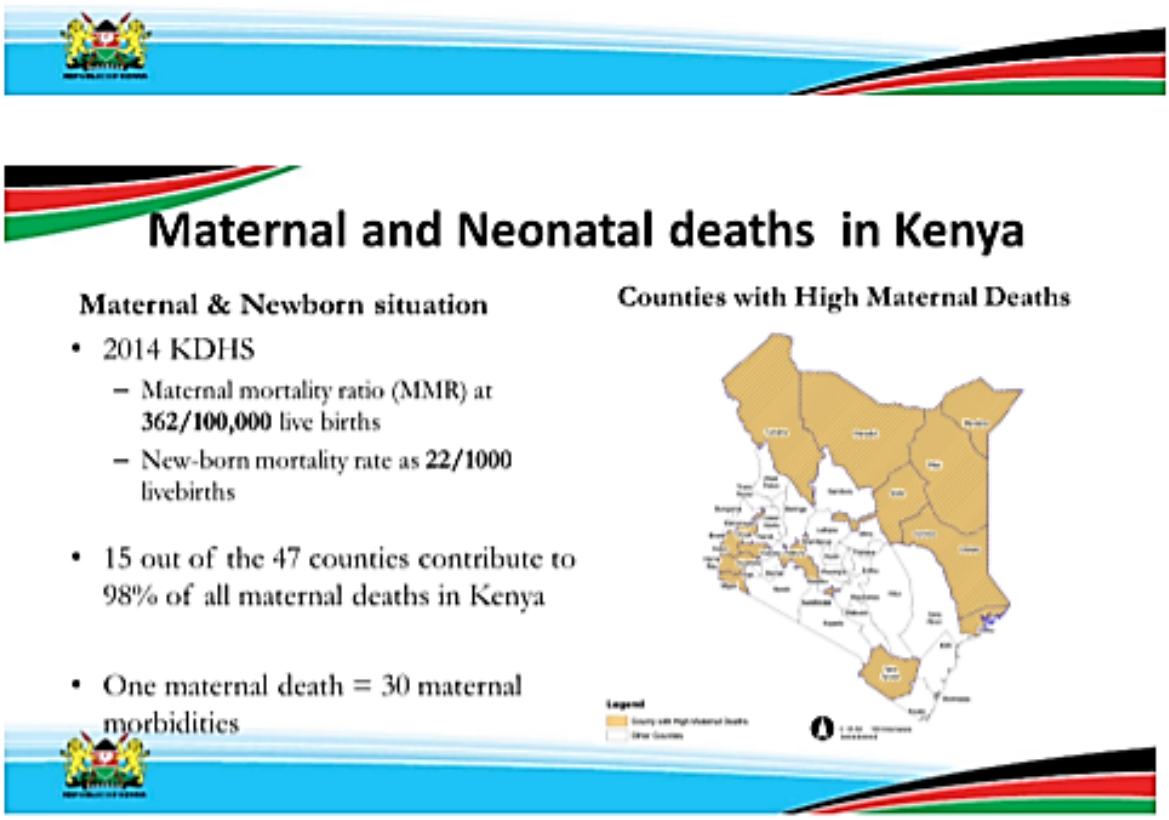
SDG 3 targets to reduce the global maternal mortality ratio to less than 70 per 100,000 live births. With the current 5% rate of Kenya's MMR reduction rate, it will take the country 18 more years to get to this target.

When will Kenya reach the SDG target of 70 maternal deaths per 100,000 livebirths at different average annual rates of reduction?

Average Annual Rate of Reduction	Estimated Year SDG Target Reached
5%	2048
7.5%	2038
10%	2032
12.5%	2029
15%	2027

Estimated calculations using 2017 data collected from African Health Stats as baseline.

In order to reach the SDG goal by 2030, the MMR will need to reduce at an average annual rate of 11%.



2018 Data from Ministry of Health National Dialogue

Gaps in the healthcare service provision

Limited access to healthcare facilities and services. Women do not give birth under the care of skilled health providers. These high rates of maternal deaths are attributed to well-known and preventable causes. They include obstructed labour, complications of unsafe abortion, infections, haemorrhage, and high blood pressure. According to United Nations Population Fund data these are some of the leading causes of maternal deaths in Kenya.

Most of these deaths could be avoided if the mother is managed at a health facility by a qualified health professional. Unfortunately, most women living in rural communities have difficulties in accessing proper healthcare as in the case of Shirleen.

I started experiencing labour pain late at night past curfew time. I could not access hospital and decided to seek the help of a nearby traditional midwife. The midwife had not undergone any formal training on maternity care or any healthcare service. When I got there, the midwife started attending to me even without protective equipment like gloves. The hygiene in that birth space was quite poor. In the morning after curfew elapsed, the baby and I had to be taken to the hospital for examination .According to the doctor, I had severe vaginal and uterus tears that needed immediate attention. I was admitted due to excessive bleeding. Although I recovered after the treatment, I lost my baby after a week due to secondary infections, among them, being tetanus"

Shirleen,Igeero village , Matayos SubCounty

Gaps in healthcare delivery: There is a strong need to address inequality in the distribution of health services as there are unequal services in rural and urban areas. Within those broad areas there may be further inequalities, as even in urban areas, slum areas or neighbourhoods on the edges of cities may have less access to quality healthcare than populations that live in wealthier areas of the city or closer to the city centre. Further there are broader questions of gender and access to care. Where women are not able to control household finances, they may be unable to access and pay for lifesaving care.

Health workforce gaps: There is a mismatch between the supply of health workers and the absorption of those trained health workers in Kenya. Many of them are not incentivized

professionally or financially to stay in the system where they are trained. These health workers may leave for other countries or prefer to stay in urban areas depriving rural areas of a surplus of trained health workers

Gaps between words and actions: Several of the small working groups pointed to accountability as a serious issue, as there are gaps between the existing policies and implementation. For instance, the free Maternity service policy is not being implemented. Healthcare providers stated that this would be hard to implement especially when healthcare facilities have limited resources.

"I am a community Health Volunteer in Gongoni area, and I help women with reproductive health related issues including contraceptives, maternal services. More women are now accessing maternal health services but most of them still opt for home delivery for several reasons including access to facility and cost of delivery. The existing Linda Mama program that is supposed to cater for all cost of delivery for women only caters for free maternal care, but other personal effect woman is supposed to purchase at their own cost . Remember without these requirements the women cannot access the free care, hence women who are poor are left to deliver at home. Community health volunteers are calling upon the government to make the free healthcare services a reality."

Salma Iddi Mwatela, Community Health Volunteer ,Gongoni area

Effects of covid-19 on access to maternal health services in Kenya

COVID-19 was declared a public health emergency of international concern on 30th January 2020 and declared a global pandemic on the 11th of March 2020. According to Nation, a Kenyan daily Newspaper. The COVID-19 pandemic reversed the maternal gains the country was beginning to make.

Dr Estelle Sidze, lead researcher on Maternal, Neonatal and Child Health at African Population and Health Research Centre (APHRC) outlined potential scenarios of how responses to Covid-19 would affect maternal and child health services. "Crowding out of services with rising cases, diversion of health personnel, re-prioritisation of resources meant for maternal and child health services and lack of proper guidelines to continue 'safe' delivery of services at health facilities and communities," she stated .She emphasises that increase in coverage of skilled deliveries, immunisation and family planning are key to lowering maternal and neonatal mortality rates.

MATERNAL HEALTH POLICY ENVIRONMENT

Free Maternity Service policy, 2013

Kenya joined other African countries in the abolishment of delivery fees in all public health facilities through a presidential directive signed into effect on June 1, 2013. Through the Free Maternity Service policy, public health facilities are reimbursed for costs incurred while providing delivery services through a capitation fund provided by the Ministry of Health. This was meant help improve access to quality maternal health care possible for all women in the country.

An abstract of a study conducted on the effect of Kenya's free maternal health care policy on the utilization of health facility delivery services and maternal and neonatal mortality in public health facilities observed immediate and sustained increase in the use of skilled care during pregnancy and childbirth within 2 years of implementing Free Maternity Service Policy in Kenya. The study took place in three counties, Turkana, Wajir, and Kilifi, all of which serve an estimated population of 3million of which 23% comprise of women of reproductive ages. These counties also rank among the top 15 counties that contribute to the country's maternal and perinatal death burden and represent 3 of the larger 8 regions in Kenya, namely coast, the rift valley, and north eastern regions. An observational retrospective study was conducted in the 3 counties targeting 127 public health institutions out of the total 267 in the 3 counties.

The findings of the observational study suggest that the hospital cost is the main expense incurred by most women and their families whilst seeking maternity care services and a barrier to maternity care utilisation. Overall, Free Maternity Service Policy, as a health financing strategy, has exhibited the potential of realizing the full beneficial effects of maternal morbidity and mortality reduction in Kenya.

Opportunities for strengthening policies in response to maternal health in Kenya

The adequacy of pre-existing healthcare infrastructure, human resources for health, and supply of medical commodities ought to be addressed before waiver of delivery fees

given the high demand of services that comes with fees abolishment. As a signatory to the Abuja Declaration, Kenya committed itself to allocating at least 15% of the national budget to the health sector. However, close to two decades after signing the declaration, government funding for health care has remained consistently below 8% of the national annual budget. The national reproductive health strategy in Kenya notes that there are gaps in funding reproductive health services in Kenya (MOH, 2016).
To avert the factors contributing, there is need for intense advocacy for full implementation of supportive policies and policy frameworks both domestic and external. Health systems strengthening. Advocacy efforts must be strengthened to ensure governments compliance to available laws, treaties, declarations and policies. Some of the available strategies include:

Strengthening Social accountability mechanisms – mobilize and build the capacity of the citizens to conduct effective policy analysis and implementation monitoring/tracking and to participate effectively in budget making and tracking processes in their communities
Create and sustain advocacy platforms and innovations for reaching out to state actors including law makers and building effective engagement frameworks especially for full realization of World Health Organization's six health systems framework namely: service delivery, human resources for health, health information systems, medical products and technologies, financing, and leadership and governance

Key Asks for Governments and policy makers
Implementation of the Free Maternity Service policy, 2013
In 2013, Kenya abolished maternity fees. However, in some hospitals, women are still required to pay money to access the scarce resources. The government should therefore ensure this policy is implemented accordingly to ensure women from low-income households can access healthcare.

Inclusion and Training of TBAs , Community Health Volunteers and midwives in healthcare

Use of traditional birth attendants was abolished in Kenya after maternity services were declared free. However, women especially in rural communities use them up to date. Poverty, cultural practices, and a shortage of primary healthcare services are forcing women to seek the help of untrained traditional birth attendants, despite the serious risks involved. Policy makers should advocate for the use of TBAS . With help from the government, TBAS can be trained to offer healthcare services to complement doctors and nurses

Need to improve the quality of healthcare services offered in healthcare facilities

The quality of healthcare offered within healthcare facilities is low. Most facilities lack resources to employ specialists, to purchase medical equipment and to attend to emergencies. The government should therefore increase healthcare funding to meet these needs. Further, there is a need for healthcare facilities to offer specialized care to suit the different needs of women including women with disability, adolescent women, women living with HIV and refugee women among others.

STORIES FROM KENYA

Negligence by healthcare Providers

Khadija narrating her story to a community volunteer

"have two children aged 2 years and 4 months. My experience in both pregnancies has not been the same. During my first delivery I went to a nearby facility at night after experiencing labor. The doctors and nurses in facility were present however none of them paid attention to me because mine did not look like an emergency to them.

My second born I gave birth at home because I feared being neglected again . My experience was no better because delivery at home is risky and birth attendants are not skilled but I thought this was a better option . In my area there is only one facility where I can access maternal health services , this means getting access to services like immunization and contraceptives is a nightmare.

I urge the county and national governments to monitor and evaluate services being provided at the maternity section and ensure regular check ins because women are really suffering during delivery and others even loose their lives and children. When doctors and nurses are not paid or compensated, they take it on patients and neglect them. "I

Poor referral mechanisms between health facilities

"I was in labour pain and was rushed to a nursing hospital they scanned me and found out that the baby was not in a good condition. They saw it's an emergency and referred me to another hospital because they did no have the right equipment.

Unfortunately I got there they didn't attend to me as well. I had to try another hospital again. Upon being attended to, my baby had died and was removed out of my womb. This would have been avoided if the first hospital had the right equipment and effective healthcare providers".

Adise Mamo , Eastleigh Nairobi

Refugees Access to maternal healthcare services

"I am a refugee in Kenya residing in Eastleigh.I was unable to access quality services due to my refugee status. I did not have some documents which were misplaced during the movement. For me to get help I needed to do all the registrations. Language barrier was also another issue.

The healthcare officials neglected me despite being in labor for a long time. When it became worse, they now helped me but it was too late.

The baby was tired and stressed and when I gave birth she passed on after 4 hours . I urge healthcare providers to treat refugees just like normal people. They too have a right to good healthcare services"

Farhiya Mohamed, Refugee in Kenya

Elphas sharing his wife's experience

" Jackline went into labor and died due to inability to access transportation services. She came from Funyula Sub-County's rural areas characterized by constant flooding. The few roads in this area are not accessible by cars and even sometimes motorbikes. In cases of emergencies, ambulances have nowhere to pass.

The Covid-19 restrictions imposed by the government in Kenya worsened the situation since the normally available Boda Boda operators were nowhere to be found when Jackline went into labor.

Jackline was forced to walk on foot to the hospital. She was in so much pain as she walked to the hospital. We had no other option. On reaching the hospital the nurse examined her only to find out that the she was experiencing a premature separation of the placenta from the uterus. She had lost a lot of blood and later died of excessive bleeding. This could have been prevented if she cold have easy access to healthcare facilities"

Elphas Ndeke (Jackline's husband), Funyula Sub-County

Adolescents' Access to maternal healthcare

Afraid of seeking antenatal care ....will I be judged?

17 year old Fauzia was brought up in a Christian family where sex was illegal and sex education was a taboo. She knew nothing about contraceptives so when she got pregnant at such a young age, she was frustrated. Fauzia got pregnant and was scared .

What will her church and parents say? She refused to seek medical services . She instead got advice to get an abortion. Coming from a slum , healthcare related information was scarce. She therefore went through unsafe abortion that led her to bleed to death.

Fauzia's case is one among many other cases especially in low income areas like slums where safe abortion services are not available and the young people don't have information about contraceptives.

Mariam narrating her sisters experience

Mariam (Fauzias Sister), Kibera Slums

Ann speaking to Lucy on maternal health

"I started having sex without any knowledge about reproductive sexual health. No one had ever taken time to educate us girls living in the slums. I believed in myths like condoms cause cancer and other methods of contraceptives can cause infertility. I got pregnant at the age of 14.

I was afraid to go for antenatal clinics because I thought people would judge me. I was so ashamed. I also never had fare to go. I couldn't afford healthy nutritious meals because life in the slums was for survival. I was quite emaciated and when I gave birth my baby was malnutritioned. The baby was very weak and later died. The doctor said the baby died from breathing difficulties as it didn't have the energy to breath.

If I had the right resources, I would have taken care of myself better and the baby would be healthy. I urge the governments to make maternal health services accessible, especially to adolescent young girls living in low income area like slums." **Lucy Wambui ,Mathare Slums Nairobi**

Experiences with Traditional Birth Attendants

'I started experiencing labor pain late at night past curfew time. I could not access hospital and decided to seek the help of a nearby traditional midwife . The midwife had not undergone any formal training on maternity care or any healthcare service. I was scared but I wanted my baby to be delivered. When I got there, the midwife started attending to me even without protective equipment like gloves. The hygiene in that birth space was quite poor.

In the morning after curfew elapsed, the baby and I had to be taken to the hospital for examination .According to the doctor, I had severe vaginal and uterus tears that needed immediate attention. I was admitted due to excessive bleeding. Although I recovered after the treatment, I lost my baby after a week due to secondary infections, among them, being tetanus . This was the most painful experience I ever had, I wish the midwife had been trained on safe delivery.

Shirleen,Igeero village , Matayos SubCounty

Doreen interviewing Ann on her experience

Use of Traditional herbs in place of modern medicine

Tabby explaining her experience with the TBA

"My name is Tabby , I am 19 years old and a mother of 2. My first child died one year ago and currently am mother to 1. I carried my baby to term and through the process I was healthy and fine. When my labor pains began at night I decided to call a traditional Birth Attendant known as **"Wakandaji"** to help me deliver.

Since in my community we believe in birth attendants and healers I opted for that. We even believe traditional medicine because it has no chemicals. So when my baby came out looking pale and yellow, she gave us some traditional medicine in form of herbs. The baby got worse and died 48 hours later.

I wish I took her to the hospital maybe she could still be alive today. I encourage women to go to hospital so that they don't loose their children like I did .

What do the community healthcare providers have to say?

'Free' Maternal health care is NOT really free

"I am a community Health Volunteer in Gongoni area and I help women with reproductive health related issues including contraceptives, maternal services. More women are now accessing maternal health services but most of them still opt for home delivery for a number of reasons including access to facility, transport and cost of delivery.

Salma sharing experiences of community health

The existing Linda Mama program that is supposed to cater for all cost of delivery for women only caters for free maternal care but other personal effect woman is supposed to purchase at their own cost . Remember without these requirements the women cannot access the free care, hence women who are poor are left to deliver at home. Community health volunteers are calling upon the government to train us on maternal health care to address the healthcare worker's scarcity. We also ask them to make the free healthcare services a reality."

HIV Stigma scares women from coming to hospital

"I am a nurse working at Mjanaheri Medical Centre . In regards to maternal health care the number of women accessing the services has relatively increased from past years for example here in my facility in a month we have approximately 115 women accessing services.

Through the support of community health workers we are able to reach out to women living with disabilities, and living with HIV. However there challenges for women who are HIV positive once they become aware of their status due to stigma and discrimination they stop accessing maternal services , putting their life and that of the un born child at risk.

It is important that we healthcare providers create awareness on the available maternal services i.e. antenatal care, HIV Testing and importance of women delivering in the facility . This will help more women seek these services.

Khadija Omar, Nurse , Mjanaheri Medical Center

Voice of Kenyan Government leadership

Her Excellency Margaret Kenyatta

Margaret Kenyatta is perhaps best known for 'Beyond Zero' – an initiative governed by the fundamental belief that **'No woman will die while giving birth'**

She says her campaign will fulfil the dreams of every parent to celebrate the birth of their children and the safety of the mothers.

During an interview ahead of the marathon , she said the thought of women walking long distances before and after birth rejuvenates her energy to run to raise awareness and funds to support maternal health care in the country.

"The long distances that women walk to give birth or after giving birth is the inspiration behind First Lady Margaret Kenyatta's Beyond Zero Campaign."

Being a mother of three, The First Lady says the pain of losing a child is unpalatable hence her determination to continue doing her best to ensure every county has maternal health services, fully equipped and with skilled care providers.

Her target is to raise Sh600 million to equip mobile clinics for 27 counties.

Her Excellency Margaret Kenyatta, First Lady of the Republic of Kenya

Voice of local community leadership

"My name is Abdullah Rashid am a village elder here in Kilifi and a father of four children. My wife and sister are victims of hospital negligence and it cost them their lives.

When my wife was giving birth to our second child I took her to the hospital at night to access the maternal services. She had been well the entire period and no causes for alarm. After finishing up with hospital formalities she was taken to ward section where her labor pains continued but no one attended to her.

I decided to move my wife from that facility to a private clinic .By the time we reached there her blood pressure was high and doctors requested for an emergency C-section. After 3 days of delivery she lost her life.

Having been a victim, I have tried to raise this issues during our local leadership meetings at ward level want the government to intervene to save lives of women. If the government works with local leaders like me, We can improve the situation"

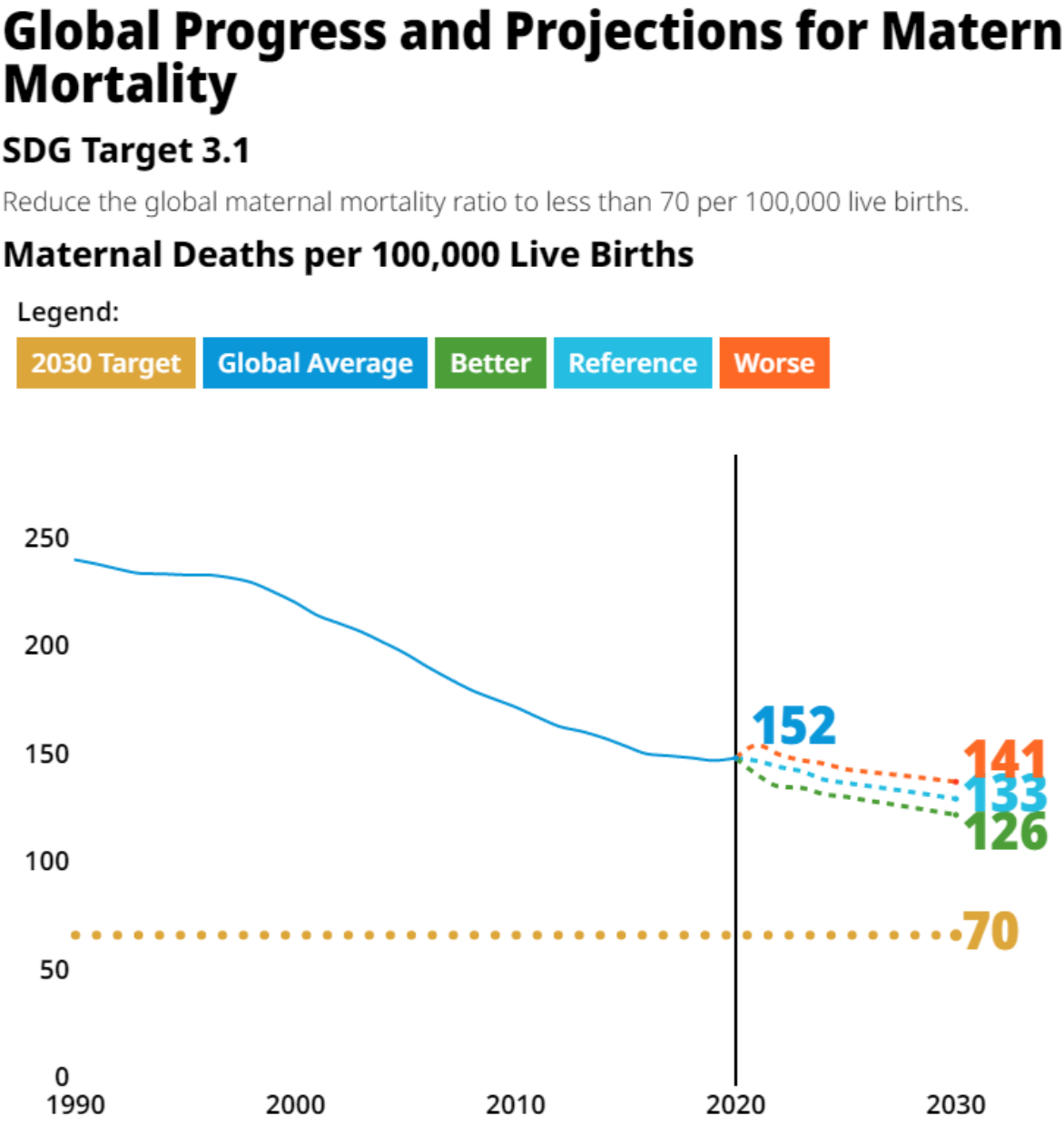
Abdullah Rashid ,village elder Kilifi

BASELINE REPORT OF ZIMBABWE

National Baseline Report on Maternal Health in Zimbabwe

INTRODUCTION

Maternal mortality has been a global health challenge which has been decreasing in a decreasing rate. In 2020, the global maternal mortality ratio was 152 deaths per 100,000 live births, up from 151 deaths per 100,000 live births in 2019. This trajectory projects 133 deaths per 100,000 live births in 2030, nearly double the SDG target (Bill and Melinda Gates Foundation, 2021).



Ensuring good maternal and neonatal health has been one of the key priorities in Zimbabwe's health sector. While the mortality rate is still unacceptably high, progress is being made to ensure that no woman or child dies during birth. However, this has been significantly affected with the health sector in Zimbabwe is still recovering from decades of significant challenges including inadequate financing, shortages of qualified staff, poor infrastructure and obsolete equipment amongst a host of others. The Zimbabwean Maternal Mortality Rate as compared to the global average remains high, according to the Multiple Indicator Cluster Survey of 2019, Zimbabwe has a maternal mortality ratio of 462 deaths per 100,000 live births, and a neonatal mortality rate of 32 deaths per 1000 live births. While this is an improvement from the 614/100 000 live births for maternal deaths recorded in 2014, the slow rate of improvement indicate that Zimbabwe is unlikely to meet the SDG target for reducing maternal mortality.

The emergencies of the COVID 19 pandemic has threatened to derail the progress that has been recorded over the years in reducing Maternal Mortality Rate. Many families are facing increased poverty as a result of being unable to work during the continued imposing of lockdown and other COVID induced travel restrictions. Many pregnant women and girls will be unable to afford the costs of transport to health facilities to give birth. This is increasing the probability of home births with unskilled care which is placing women and girls at risk of maternal mortality and morbidity with devastating consequences for the baby, including risk of mother to child transmission of HIV.

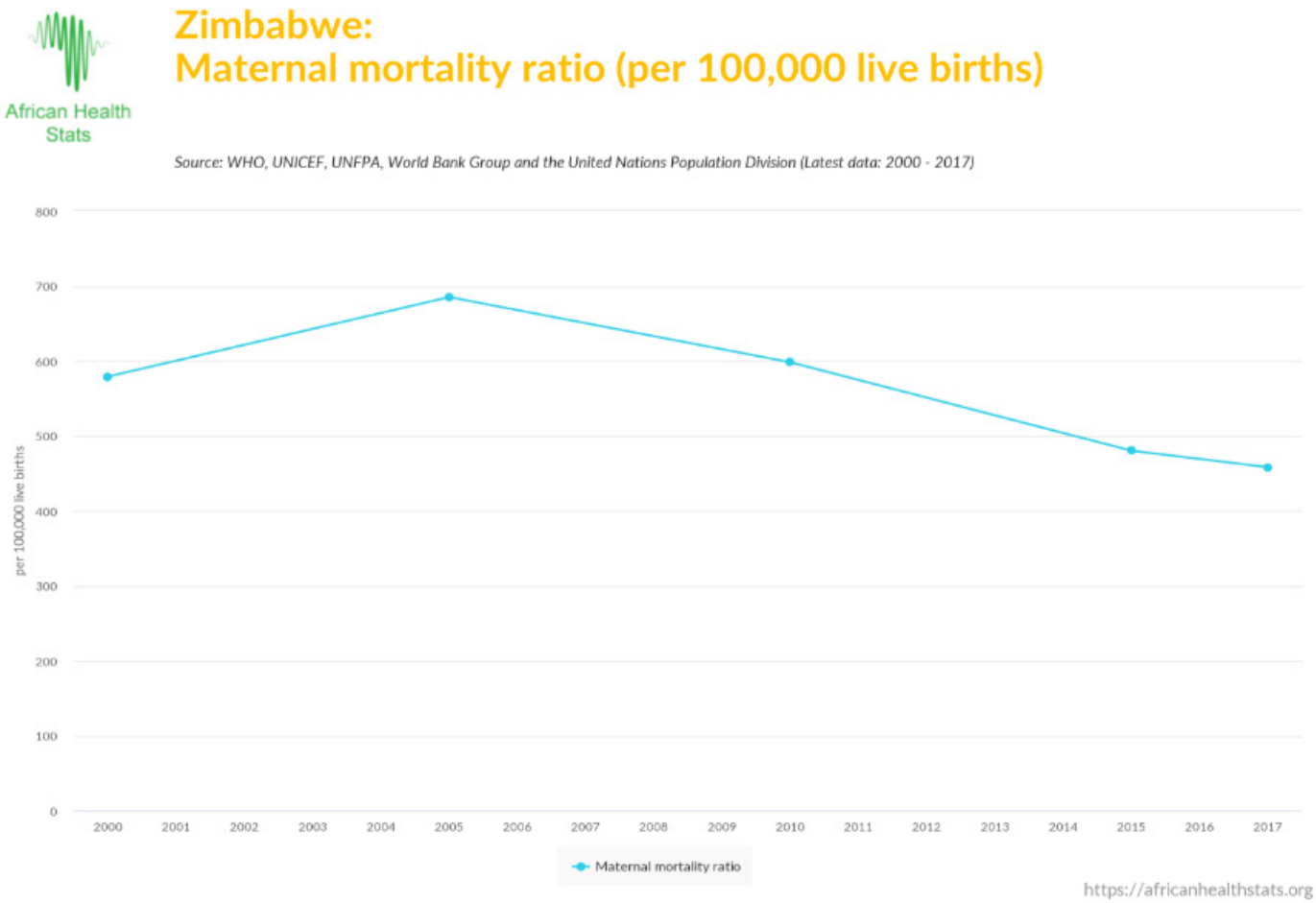
The global position also reflects what is happening in different countries especially in sub-Saharan Africa. The SDG target is to reach a rate of 70 deaths per 100,000 live births in 2030, which seems to be a long reach considering the situations in different countries which includes Zimbabwe.

ZIMBABWE STATISTICS

Maternal Mortality Ratio

The Maternal Mortality Ratio (MMR) is the rate at which women die from maternal causes and is measured as the number of maternal deaths per every 100,000 live births. As of 2019 the MMR in Zimbabwe is 462 deaths per 100,000 live births (African Health Stats, 2019). At this rate Zimbabwe will reach the SDG target in 2163 which is more than a millennial from 2021.

> Zimbabwe has a maternal mortality ratio of 462 deaths per 100,000 live births, and a neonatal mortality rate of 32 deaths per 1000 live births.

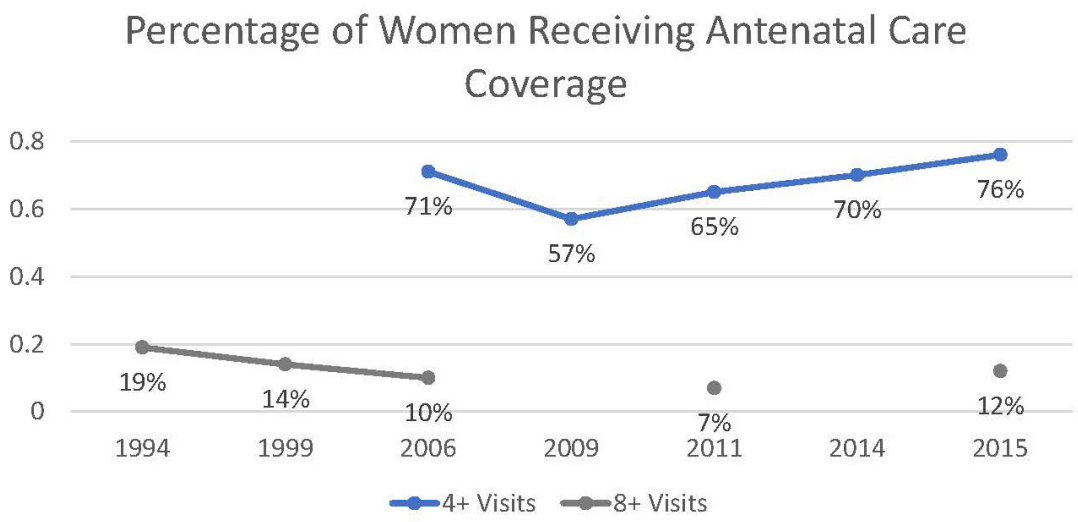


From 2000 to 2017, the Zimbabwean MMR declined by 20.9% from 579 to 458 deaths per 100,000 live births. This translates to an average annual rate of reduction of 1.4%. At this rate Zimbabwe will reach the SDG target in 2163 which is more than a millennial from 2021. In order to reach the target, Zimbabwe's rate of reduction has to increase to 13%, which is only possible if drastic changes are made in the health system of the country.

Antenatal Care

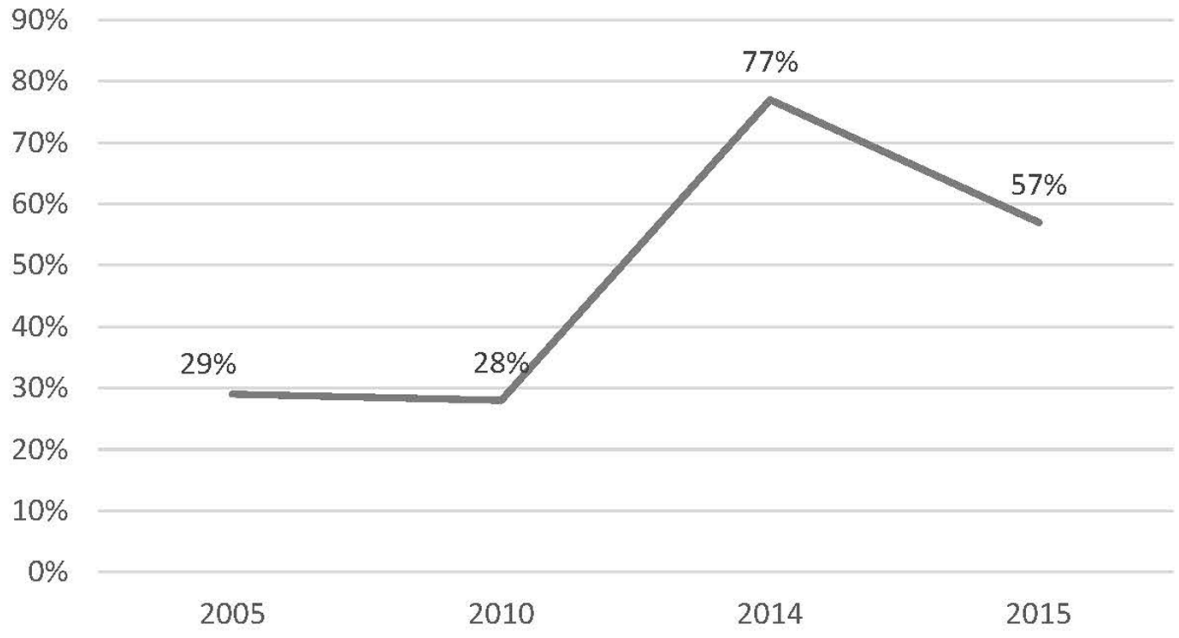
Antenatal Care is the heath control or health checks that are done routinely to pregnant women to ensure that their health and that of their babies is protected. WHO recommends that a woman should at least have 4 visits for check-ups (antenatal care assessments) over the course of her pregnancy (World Health Organisation, 2007). Over the past years the percentage of women aged 15 to 49 with a live birth who have received antenatal care has been fairly increasing. As of 2015, 76% of the women in Zimbabwe have been receiving the WHO requirement of 4 visits and only 12% have had more than 8 visits (African Health Stats, 2019).

The drastic drop in 2009 shows the effect of political and economic instability to the health care system as Zimbabwe was experiencing hyperinflation and it was just after the 2008 elections which had caused political instability within the country.



Postpartum Care Coverage for Mothers

Postpartum Care Coverage for Mothers: This refers to the number of women in the early postnatal period (the first 48 hours after birth) who received a check-up—measured as the proportion of the total number of women aged 15-49 who had a live birth in the last 3 to 5 years prior to the survey



The statistics in Zimbabwe as of between 2005 and 2015 show us that the postpartum care had increased by a tremendous amount in 2014 and drastically dropped in 2015 by 20% (African Health Stats, 2019). The increase in 2014 can be attributed to the country's efforts to achieve its 2007-2015 National Maternal and Neonatal Health Road Map as it was reaching its deadline without achieving its plan to better the healthcare system for mothers and their babies.

Births Attended by Skilled Health Personnel

Births Attended by Skilled Health Personnel: The percentage of births that take place in the presence of a skilled healthcare worker who is qualified to attend to births (i.e. midwives, nurses, or doctors). Traditional birth attendants are not included.

Year	Percentage of Births Attended by Skilled Health Personnel
1994	69%
1999	73%
2006	69%
2009	60%
2011	66%
2014	80%
2015	78%

The number of births recorded over the years which have been attended by skilled health personnel has been fairly high. However, according to the world bank data as of 2020, 68% of the Zimbabwean population live in the rural areas (The World Bank, 2021). This then leaves a gap in the statistics as many women in rural Zimbabwe have traditional birth attendants, due to religion and the births of their children are only recorded when they are older when they now want to access education.

ZIMBABWE POLICY ENVIRONMENT

The legislation of Zimbabwe has several Acts that protect the maternal health of women and their unborn children (Ministry of Health and Child Care Zimbabwe, 2017)which includes: Medical Dental and Allied Professionals Act, Public Health Act, Termination of Pregnancy Act and Disabled Persons Act. These Acts are further followed up by national policy documents and strategies such as;

- The National Maternal and Neonatal Health Strategy for 2017 to 2021
- Guidelines for conducting maternal and perinatal death audits.
- The National Maternal and Perinatal Death Review Committee which sits every quarter
- Guidelines on Key Interventions for Improving Perinatal and Neonatal Health Outcomes in Zimbabwe
- Guidelines on Youth Friendly Clinical SRH Service Provision
- National Standard Training Manual on ASRH
- Implementation of the National Cervical Cancer Screening and Management

> Government introduced user fee exemptions in public facilities for selected services, including for pregnant and lactating women, children under the age of 5 years and elderly persons above 70 years of age (Ministry of Health and Child Care Zimbabwe, 2017).

programme through VIAC.

- Launched the Health Development Fund (HDF) which is supporting implementation of all Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions (including procuring blood and blood related products meant to assist women with pregnant related complications).
- Developed an electronic Maternal and Perinatal Death Notification System
- Developed and rolled out production of the Reproductive, Maternal, Newborn and Child Health (RMNCH) Scorecard
- Commissioned the following studies whose results/ findings are currently being used to inform implementation of various low cost and high impact Sexual and Reproductive Health Interventions:
    - National Integrated Health Facility Assessment – 2010
    - National Service Availability and Readiness Assessment – 2014
    - National Adolescent Fertility Study – 2016

The above strategies show that the problem with Zimbabwe's health systems in terms of maternal health does not lie within policy frameworks but with implementation. It is important to address the gaps in the system so as to increase the rate of reduction of the Maternal Mortality Rate.

GAPS IN THE HEALTHCARE SYSTEM

The healthcare system in Zimbabwe has a lot of gaps which are even highlighted in the National Maternal and Neonatal Health Strategy for 2017 to 2021, which if addressed, the SDG target of 70 deaths per 100 000 live births will be achieved in the next few decades. These gaps include

i. **Lack of financial protection for low income groups to access healthcare:** Government introduced user fee exemptions in public facilities for selected services, including for pregnant and lactating women, children under the age of 5 years and elderly persons above 70 years of age (Ministry of Health and Child Care Zimbabwe, 2017). However, there are hidden costs (Out-of-pocket (OOP) payments) that one will incur in order to access these services and a few institutions will offer free medication after consultations. Some of the facilities continue to charge user-fees for maternal services and they are not penalized although it is against government policy. Moreover, maternal services are free for just primary care but anything beyond that one will have to pay to get the service. In the Zimbabwe Demographic and Health Survey 2015 women were asked about the challenges they faced in accessing health care in terms of getting permission to go to the doctor, getting money for advice or treatment, distance to a health facility and not wanting to go alone. The most commonly reported problems were obtaining money to pay for treatment (43%), and distance to the health facility (33%) (Zimbabwe National Statistics Agency and ICF International, 2016).
ii. **Over reliance on donor funding:** most hospitals/ health institutions in Zimbabwe rely on donor funding in order to run as government financing is not adequate which hinders the service provision from being sustainable. Due to this funding crisis, the country still has a few very good public hospitals and **under equipped clinics** that are not enough to provide services to poor rural communities.
iii. **Shortage of staff:** the health sector has been understaffed leaving a lot of gaps, decreasing the quality of services and increasing the levels of human errors when it comes to maternal care. The majority of nurses and midwives in Zimbabwe are notorious for being temperamental, which usually comes as a result of heavy workloads and low pay showing low levels of motivation for the staff in the sector. Moreover, according to the study done by the Ministry of Health and Child Care, most nurses lack in competence for emergency obstetric and neonatal care, which results in a critical skills gap in the delivery of quality Maternal, Newborn and Child Health (MNCH) services. The ZDHS 2015 study revealed that all the maternal deaths that were reviewed in the study were institutional and avoidable, were due to the 3rd

> In times of emergencies like the COVID 19; authorities must decide to ensure women and girls have to access antenatal care, maternity waiting homes and skilled medical care to give birth. They should also allow for medical and social support in the postpartum period and ensure access to medication and health care.

Agency and ICF International, 2016).

iv. **Underutilization of existing structures of the village health workers (VHWs):** Village health workers are volunteers who are selected by the village elders and are in charge of 100 households in each village. They play a critical role in the primary health care system in Zimbabwe and receive a short term training, a bicycle and a $14 incentive per month from the government. However, they are not permitted to provide some important interventions such as the life-saving antibiotics for acute respiratory infections (ARI) amongst other things (Ministry of Health and Child Care Zimbabwe, 2017). Their trainings are not extensive enough to provide more dynamic health services. The databases for VHWs are inconsistent mainly due to the fact that it is voluntary and this poses challenges to the provision of support and follow up

v. **Religious beliefs and cultural norms:** a lot of the women, who do not go to health facilities for safe delivery, do not do so due to religious beliefs and/or cultural norms. There are still a lot of misconceptions about seeking professional medical services in some religious sects especially the apostolic sect where it is unreligious to do so. The churches are usually notorious for letting their women give birth in shrines and when complications arise, they try to pray it away which usually results in either the mother or child or both lose their lives or survive and have to live with some health complications.

KEY ASKS TO GOVERNMENT

With all this in minds we recommend that government should carry out its National Maternal and Neonatal Health Strategy (Ministry of Health and Child Care Zimbabwe, 2017) by:

1. Implementing existing policies and guidelines so as to provide free, quality maternal health services which includes the provision of the full package of emergency obstetric care, management of pre-eclampsia and eclampsia, haemorrhage and sepsis, which are the major causes of maternal morbidity and mortality, as well as the management of HIV and AIDS as an indirect cause of maternal mortality;
2. In times of emergencies like the COVID 19; authorities must decide to ensure women and girls have to access antenatal care, maternity waiting homes and skilled medical care to give birth. They should also allow for medical and social support in the postpartum period and ensure access to medication and health care.
3. Holding health workers accountable for any mal-practice, and the scaling up of mentorship in order to enhance and reinforce health worker skills in dealing with obstetric emergencies.
4. Scaling up funding and finding other sustainable means to finance the health sector, so as to make healthcare more affordable especially to those in poor resource communities
5. Building more hospitals and clinics that provide integrated services
6. Availing well-equipped ambulances, re-orient health workers on life-saving skills to support patients during referral, and re-orienting the provincial MDSR committees so as to standardize the conduct of maternal deaths audits and on the classification of causes of deaths
7. Providing all the necessary facilities in order for caesarean section to be performed on the pregnant women who need it. This includes infrastructure, equipment, medicines and other supplies, a reliable power source and water supply, as well as the human resources. The latter include the doctors and anaesthetists with the right skills, confidence and attitude, as well as the other theatre staff to complete the full team.
8. Utilising and scaling up the work done by village health workers in order to provide primary health care services as well as increasing their incentives
9. Prioritising the Sexual and Reproductive Health of women by providing quality maternal services especially in emergency context such as the Covid-19 pandemic.