NGOCC

For Gender &
Development

NGOCC NETWORK SUBMISSIONS TO

The Committee on Health, Community Development and Social Services

Report of the Auditor General on the Provision of Comprehensive Emergency Obstetric and Newborn Care in Maternal Health

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1. Introduction

This submission is being made on the premise that maternal health is important because of the ripple effect that comes with caring for mothers. As put forward by Sarah Brown, wife of the former Prime Minister of England, 'If we fix things for mothers- and we can- we can fix so many other things that are wrong in this world.' NGOCC strongly agrees with these sentiments as when a mother is able to demonstrate leadership during pregnancy by caring for herself and her unborn child, she directs her community likewise- to care for themselves and the next generation. Further, maternal health can significantly impact the state of the newborn mortality rate – which is also a UN Millennium Development Goal. Reducing the newborn mortality rate creates an environment in communities that values human life from as early as pregnancy, as we eliminate needless newborn deaths.

This paper starts by giving a background of NGOCC before giving the situation of maternal health from a global to regional and national level context. It further explains the identified interventions from the global level up to the country level. The paper further offers NGOCC's observations regarding the report of the Auditor General on the provision of comprehensive emergency obstetric and newborn care and gives comments on the findings. The paper ends with recommendations based on the observations made.

2. Background of NGOCC

The Non-Governmental Organisations' Coordinating Council (NGOCC) is an umbrella organization which was established in 1985 after the United Nations Conference on women held in Nairobi, Kenya. Currently, NGOCC has 104 member organisations of which 47 are Non-Governmental Organisations' (NGOs) and 57 are Community Based Organisations (CBOs), with presence in all the 10 provinces of Zambia.

NGOCC's vision is **"A society where women fully participate and benefit from social, economic, political and cultural development".**

On behalf of the 104 Member Organisations, NGOCC would like to express its gratitude to this honourable committee for the opportunity to appear before it and share its views on the report of the Auditor General on the provision of comprehensive emergency obstetric and newborn care in maternal health.

3. Situational Analysis of Maternal Health

Globally, addressing maternal and neonatal mortality remain important health issues for most developing countries. Literature shows that more than 75 percent of these deaths are due to five causes, all of which are treatable and these are hemorrhage, obstructed labour, sepsis (infection), eclampsia (convulsions) and unsafe abortion[1]. Most maternal deaths occur during the third trimester of pregnancy and during the first week after delivery, with the first and second day after delivery representing the highest risk to the mother[2]. Although the number of maternal deaths worldwide has decreased, Africa accounts for a large proportion of the deaths. In 2013 about 289,000 women worldwide died during pregnancy or childbirth, and of those deaths 62 percent occurred in sub-Saharan Africa[3]. Further, it has been found that in 2013, the maternal mortality ratio in developing countries was 230 women per 100,000 births, versus 16 women per 100,000 in developed countries. Globally, 3 million newborns die each year and there are 2.6 million stillbirths, with Africa accounting for more than half of both numbers[4].

The poor state of maternal health in Africa is eventually leading to high maternal deaths and has been attributed to poverty[5]. It is asserted that for mothers as well as for their infants, the risk of dying during or shortly after birth is 20 to 50 percent higher for the poorest than for the richest quintile of the population[6]. To put this into perspective, in Chad, just 1% of the poorest pregnant women get antenatal care, compared with 48% of wealthy women. Furthermore, there are more chances of adolescent girls (ages 15-19) falling pregnant in Africa compared to developed countries and this increases pregnancy related complications. The probability that a 15-year-old woman will eventually die from a maternal cause is 1 in 3,700 in developed countries versus 1 in 160 in developing countries[7].

The situation in Zambia is even worse than the average figures for developing countries indicate. The maternal mortality rates between 2007 and 2016, have only reduced from 591/100,000 to 398/100,000 live births[8], which is still almost double the regional average. The infant mortality rate reduced from 75/1000 to 45/1000 live births[9]. While there has been a reduction in these figures, the rate of reduction has been too slow to meet the MDG targets of reducing maternal and infant mortality rates to 162/100,000 and 37.5/1000 live births respectively by the end of 2015. Note that Zambia failed to meet both of these goals.

[1] WHO (2000). Managing complications in pregnancy and child birth: a guide for midwives and doctors.
[2] Ronsmans C, Graham WJ (2006). Maternal mortality: who, when, where, and why. Lancet.
[3] WHO, UNFPA, World Bank and UN Population Division (2014). Trends in Maternal Mortality: 1990 to 2013.
[4] Ibid.
[5] UNICEF (2010). Leading and underlying causes of maternal mortality.
[6] Ibid.
[7] Ibid.
[8] 2007 ZDHS
[9] 2013/14 ZDHS

Given the high maternal and infant mortality rates, multiple UN agencies have highlighted the importance of reducing maternal deaths globally, especially in Sub Saharan Africa and it has been demonstrated that the use of Emergency Obstetric and Newborn Care (EmONC) is a vital component in achieving this goal[10]. UN agencies also emphasise the importance of gender equality, which includes enforcing the basic right of women and girls to access medical care[11].

> *Emergency Obstetric and Newborn Care refers to the care of women and newborns during pregnancy, delivery and the time after delivery (UN).*

In 1997, WHO, UNICEF and UNFPA published Guidelines for Monitoring the Availability and Use of Obstetric Services (UN Guidelines). These guidelines define specific process indicators to measure the "minimum acceptable" level of access to EmONC in any given region[12]. The UN Guidelines divide health facilities into two groups, basic and comprehensive EmONC facilities, based on their ability to perform defined signal functions. Basic EmONC facilities can:

1. Administer parenteral antibiotics
2. Administer parenteral oxytocics
3. Administer parenteral anticonvulsants
4. Perform manual removal of placenta
5. Perform removal of retained products
6. Perform assisted vaginal delivery

Comprehensive EmONC facilities can perform all six basic functions plus Caesarean section, anesthesia and blood transfusion. The UN Guidelines recommend at least four basic EmONC facilities and one comprehensive EmONC facility for every 500,000 people in the population[13]. Based on the above guidelines, the UN asserts that women in emergency situations must have access to EmONC, as it is essential to saving lives of mothers and newborns worldwide, especially in developing countries, like Zambia.

Studies done in some parts of Zambia indicate that access to EmONC in the country is limited. That is, not all the six services under the basic EmONC are offered by most health centers and also not all hospitals have the capacity to provide comprehensive EmONC[14].

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[10] UN (2007). The Millennium Development Goals Report.
[11] Ibid.
[12] UN Guidelines for monitoring the availability and use of obstetric services. New York: United Nations Children's Fund; 1997.
[13] Ibid.
[14] Adam C. Levine, Regan H. Marsh, Sara W. Nelson, Lynda Tyer-Viola, and Thomas F. Burke (2008). Measuring access to emergency obstetric care in rural Zambia.

4. NGOCC Observations and Comments on the Findings

From the report, it can be clearly concluded that the provision of Emergency Obstetric and Newborn Care in Zambia is generally not meeting the demand and needs of the population. This suggests that the majority of expectant women are not receiving treatment for their obstetric complications leading to the high maternal and infant mortality rates currently prevailing in the country. This further suggests that access to EmONC in the country is challenging as evidenced by the modest improvements in maternal and neonatal mortality over the past 10 years.

Among others causes, NGOCC finds that the lapses in the delivery of quality EmONC services in the country have been attributed to the lack of national commitment and financial support, poorly functioning health systems, weak referral systems, weak human resource development and the inadequate and/or non-functioning required equipment. These attributions are supported by the findings in the report such as the low number of staff and their qualifications in the health facilities providing EmONC services, inadequate and non-functional equipment in the health facilities sampled and the lack of a risk assessment, especially as it relates to referrals. The risk assessment is critical for effective referrals which involve clear communication among staff at the local level, transportation for complicated obstetric cases to referral hospitals, coordinated care among the different levels of health facilities and assurance of quality of care at all levels. The risk assessment on the referrals -will further help in analysing how effective the referrals of newborn babies from Levy Mwanawasa hospital to UTH, which is more than 5km away, are. A distance of 5km for an emergency transfer is against the WHO referral distance standard. We sadly note that the situation is much worse in rural areas where the distances between clinics/ rural health centers and hospitals are vast.

Zambia is signatory to the Abuja declaration that requires member states to progressively allocate at least 15 percent of the total national budget to the health sector. Further, Zambia was signatory to the Millennium Declaration of 2000 which had a focus on reducing maternal and neonatal mortalities. The declaration pointed out that key interventions to reducing the above mortalities were family planning, skilled care for all deliveries and access to emergency obstetric care for all women with life threatening complications. However, NGOCC's analysis of the national budget allocations to the health sector over the last four years shows that allocations to the health sector have been dwindling. That is, in 2013, the sector was allocated 11.3 percent, 9.9 percent in 2014, 9.6 percent in 2015 and 8.3 percent in 2016[15]. This shows a lack of commitment on part of government to improve the sector in general and hence the low improvements in the maternal and neonatal mortalities over the years.

Further, we note that the audit was conducted in the urban districts of Solwezi, Ndola, Kitwe, Kabwe and Lusaka only and yet the findings are quite depressing. It is well known that the situation in areas of rural Zambia must be much worse than in the areas of the evaluated

[15] 2013, 2014, 2015 and 2016 Budget Speeches.

institutions. EmONC services should be available to all Zambian women in opposition of being exclusively obtainable in urban areas.

Further, the findings of the Audit report indicate that there is non-adherence to the minimum acceptable standards set by the UN for quality provision of EmONC services. This suggests that the services of EmONC being offered in most health facilities are not complete and this also brings in issues around the quality of services being provided in these facilities.

5. Recommendations

Based on the foregoing, NGOCC recommends the following:

1. There is urgent need for the government to progressively increase the allocations to the health sector and prioritise maternal health programmes.
2. Further, we urge the government to focus on the human resources providing EmONC services in the country. Developing and maintaining an adequate health workforce requires planning, recruitment, education, deployment and support to health workers. Of particular emphasis here is the need to train health workers in the provision of EmONC services in order to enhance access to and quality of the service provided. Further appraisal of health workers and stock-taking of health care staff that have been trained in EmONC needs to be undertaken regularly in order to ensure deployment of the trained personnel to their respective positions and act upon shortfalls.
3. After investing in the capacitation and training of EmONC personnel, government should follow up on the deployment situation so that it is possible to account for the investments.
4. Coupled with human resource is the need for adequate and functioning EmONC equipment.
5. There is urgent need for the government to undertake a risk assessment of the EmONC package, especially as it relates to referrals. Furthermore, there is need to conduct quality of care assessments regularly. These assessments will help the government as well as development partners to create actionable plans.
6. Further, to address the inadequate infrastructure and shortage of staff to provide the service, we recommend that in the short term, more infrastructure be constructed such as maternity wards in both clinic/health centers as well as hospitals. In the long term, we recommend the construction of specialised maternal health facilities and that staff be deployed permanently in these facilities. Following the model of already existing specialised cancer clinics, planning efforts should be directed in the same manner when it comes to addressing maternal and newborn health problems.

5. Conclusion

Given the gaps in the provision of EmONC services in the country, the need to scale up efforts towards satisfactory and quality maternal health services cannot be over emphasised. This will go a long way in reducing both maternal and infant mortalities that are currently unacceptably

high. Therefore, NGOCC strongly urges the government and development partners to prioritise funding to the health sector and pay particular attention to maternal health programmes. We further remind all stakeholders that investment in maternal health is not only a political and social imperative, but is cost effective. Healthy mothers lead to healthy families and societies, strong health systems and healthy economies.

WE HUMBLY SUBMIT.