AU Campaign on Accelerated Reduction of Maternal Mortality (CARMMA)

AFRICA CARES: No Woman Should Die While Giving Life!

AFRICAN UNION COMMISSION
DEPARTMENT OF SOCIAL AFFAIRS
Plan of Presentation

• Regional Frameworks on SRH
• Maputo Plan of Action
• Five-Year Review of MPoA
• What is CARMMA?
• Why CARMMA?
• What is the Added Value of CARMMA?
• Who are the Partners of CARMMA?
• How did we select 2009 countries?
• What is the Progress in CARMMA?
• What are the Results or follow up Actions?
• Why Integrate Child Health into CARMMA
• The way forward
Regional Frameworks on Women’s and Children’s Health

• Continental Sexual and Reproductive Health and Right Policy 2005
• The Maputo Plan of Action on Sexual and Reproductive Health and Rights which was endorsed by the African Union (AU) in 2006.
The Maputo PoA

• Integration of HIV/STI, Malaria and sexual and reproductive health (SRH) services into primary health care;
• Strengthening of Community-Based STI/HIV/AIDS and SRHR Services.
• Repositioning family planning;
• Providing youth-friendly services;
• Unsafe abortion;
• Quality safe motherhood;
• Resource mobilization;
• Commodity security; and,
• Monitoring and evaluation. The Plan is premised on SRH in its fullest context as defined at ICPD.
Five-Year Review 2010

- Integration of STI/HIV, Malaria and SRH Services into PHC Plans 3/4 of countries;
- Global funding for family planning has declined, with limited support for repositioning of FP;
- Youth-friendly services have been positioned as key strategy for youth empowerment, needs of young people is still a challenge,
- About half of countries have frameworks for reduction of unsafe abortion,
- Two thirds of countries have strategies to reduce unwanted pregnancies; to improve access to safe motherhood & child survival services.
- More than 90% of countries have roadmaps, with almost 80% having operation plans, and PMTCT has been scaled up in more than three quarters of countries, with significant coverage for HIV+ mothers;
- More than 50% of countries have strategies and are implementing interventions for strengthening of community-based STI/HIV/AIDS and SRHR Services
- Resources were very limited, mostly from the general health budget. Few countries have budget lines for SRHR and FP.
What is CARMMA?

• Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)' is an African Union Commission (AUC) initiative to promote and advocate for renewed and intensified implementation of the Maputo Plan of Action for Reduction of Maternal Mortality in Africa and for the attainment of the MDG 5.
Why CARMMA?

• Recognition that reducing maternal mortality in most African countries by 75% in comparison with 1990 figures, by 2015 as recommended in the MDG 5, is a daunting challenge.

• Threats to Women’s Health from global financial crisis and economic meltdown
What is the Added Value of CARMMA?

• Building on-going best practices;
• Generating and providing data on maternal and newborn deaths;
• Mobilization of political commitment and support of key stakeholders and communities for additional resources and involvements;
• Accelerating actions to reduce maternal and associated infant mortality.
Who are the Champions and Partners of CARMMA?

- AUC and the National Governments – President and Vice, First Ladies, Ministers, Parliamentarians
- Birth Attendants, Community Health Workers, Nurses & Midwives; and Doctors
- UN Agencies (WHO, UNICEF, FAO, UNAIDS, UNIFEM, UNFPA), the World Bank,
- Bilateral Partners (USAID, DFID),
- CSOs (IPPF, White Ribbon Alliance, MNCH Coalition, Save the Children, etc.),
- Academia, Community and Religious leaders Professional Associations, Artist and the Media, and the Private sector
- Everyone has a role
What is the Progress in the Launching of CARMMA?

• Continental launch of CARMMA by the African Union (AU) Ministers of Health in May 2009,

• Eight African countries were jointly selected by Governments/AUC/UN to launch in 2009-2010: Ethiopia, Malawi, Mozambique, Ghana, Nigeria, Rwanda, Senegal and The Chad.
How did we select 2009 Countries?

• High mortality ratios,
• Low gender development index,
• Ready political commitment.
• Countries were selected to demonstrate Results
• Ensuring sub-regional balance.
What is the Progress in CARMMA?

• **36 countries** have successfully launched CARMMA.

• In 2009, eight launched CARMMA: Mozambique, Malawi, Rwanda, Nigeria, Swaziland and Ghana, Namibia and the Chad.

• In 2010, Eighteen countries launched CARMMA: Ethiopia, Sierra Leone, Central Africa Republic, Cameroon, Uganda, Lesotho, Mauritania, Zambia, Zimbabwe, Guinea Bissau, Senegal, Gambia, Eritrea, Angola, Togo, Benin, Eritrea and Kenya
What is the Progress in CARMMA?

- In 2011, Botswana, Liberia, Democratic Republic of Congo, Gabon, Tanzania, Equatorial Guinea, Burundi, Burkina Faso, Tunisia and Niger launched CARMMA.
- Many more countries will launch.
What is the Progress in CARMMA?

• More countries that have promised to launch in 2011: Egypt, Sudan, Tunisia, South Africa and Mali.

• Many more countries will follow because “No Woman Should Die Giving Life”
Spreading the news:
Status of the CARMMA launch
(March 2012)

Countries that have launched CARMMA
Countries that are preparing to launch CARMMA
What are the Results or follow up Actions?

- Renewed and Intensified Efforts, and National mobilization
- Launching in all Districts or States – Malawi, Chad, Rwanda and Nigeria
- Adoption of District Hospitals for strengthening with private sector - Malawi
- Instituted Maternal Mortality monitoring indicators – Swaziland
- Resource Mobilization – Chad
- Free medical services for pregnant mothers and infants – Sierra Leone and Nigeria
Review of implementation strategies across member states

- 54% of countries who have launched CARMMA have developed national road maps for implementation

- Most road maps are integrated into the National MNCH road maps or SRHR strategic plans

- 92% of countries have carried out activities that have fostered political commitment

- Countries have fostered political involvement via adoption of first ladies, parliament members, governors, female professional associations, religious leaders and even presidents as CARMMA champions
Review of implementation strategies across member states cont...

• Strategies such as social mobilization, development of partnerships and capacity building of health workers are the most popular across member states.

• Health systems strengthening at PHC level, development of M&E systems and integration of HIV, RH and FP services are being implemented by about 50% of member states.

• However with respect to provision of sustainable funding for MNCH and SRHR only 17% of member states responded positively.
Overview of Implemented CARMMA Strategies Across the Continent

Integration of HIV, AIDS, RH, FP
Capacity Building of HW
M&E Systems
HSS at Pry Level
Sustainable Funding
Partnerships
Social Mobilization
Advocacy for Political Commit.
CARMMA Nat. Road Map

Yes
No
In progress
Challenges

• Funding limitations
  – No specific budget line for maternal health

• Weak health systems
  – Shortage of skilled personnel
  – Inadequate number of well equipped basic obstetric care centers
  – Stock outs of RH commodities due to weak LMIS and supply management
  – Poor infrastructure in health Facilities
  – Weak referral systems
Challenges cont...

• Low demand for health care
  – Cultural and religious believes hinder promotion of family planning
  – Low male involvement in SRHR issues
  – Poor access to services due to bad roads
  – Poor transport and communication facilities

• Political uprisings and change in government
  – Removal of political figure serving as CARMMA champion

• Weak M&E systems /HMIS
  – Inadequate progress monitoring
Resource Mobilization

• Only 17% of countries made have some form of sustainable funding which in reported to be inadequate

• Funding for MNCH from national budgets is often limited and embedded in SRH budgets

• The bulk of the funding for MNCH still comes from international development partners

• In 61% of countries there is no sustainable funding for MNCH or health in general and no foreseeable plan in immediate sight
Percentage of Countries that have conducted National Maternal Mortality Audits Since CARMMA Launch

- Yes: 54
- No: 17
- In progress: 29
Why are mothers and children dying?

<table>
<thead>
<tr>
<th>Maternal death</th>
<th>Child death</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct causes</strong></td>
<td>• Neonatal conditions</td>
</tr>
<tr>
<td>- Unsafe abortion</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td>- Hemorrhage</td>
<td>• Diarrheal diseases</td>
</tr>
<tr>
<td>- Infections</td>
<td>• Malaria</td>
</tr>
<tr>
<td>- Obstructed labour</td>
<td>• HIV and AIDS</td>
</tr>
<tr>
<td>- Hypertensive diseases of pregnancy</td>
<td>• Vaccine preventable diseases</td>
</tr>
<tr>
<td><strong>Indirect causes</strong></td>
<td>Under nutrition .. &gt;30%</td>
</tr>
<tr>
<td>- Poor nutritional status of girls &amp; women</td>
<td></td>
</tr>
<tr>
<td>- HIV, TB, Malaria, heart diseases</td>
<td></td>
</tr>
<tr>
<td>- Domestic violence</td>
<td></td>
</tr>
</tbody>
</table>
Strong association

MMR and Skilled Attendance

![Graph showing the relationship between maternal deaths per 100,000 live births and the percentage of skilled attendance at birth. The graph indicates a strong association with R² = 0.74.]
Most babies with asphyxia die during the first day.

Most very small/premature babies die during the first day/week.

Babies dying of infection can die at any time after day 1 through day 28 especially after day 7.

Time of death in Mothers

**Timing of Maternal Death**

- **During pregnancy**
- **≥ 24 hrs after delivery**
- **Day 2-7 after delivery**
- **Week 2-6 after delivery**

Overall progress in reducing under-5 mortality BUT little progress in reducing newborn deaths

Source: Lawn JE et al, Lancet 2005
HIV related deaths in children <5 years 2008 (WHS 2010)

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swaziland</td>
<td>49.0%</td>
</tr>
<tr>
<td>South Africa</td>
<td>45.7%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>21.2%</td>
</tr>
<tr>
<td>Namibia</td>
<td>18.2%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>16.9%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>14.0%</td>
</tr>
<tr>
<td>Malawi</td>
<td>13.7%</td>
</tr>
<tr>
<td>Zambia</td>
<td>11.9%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>8.5%</td>
</tr>
<tr>
<td>ESAR</td>
<td>7.5%</td>
</tr>
<tr>
<td>Uganda</td>
<td>5.0%</td>
</tr>
<tr>
<td>Kenya</td>
<td>4.7%</td>
</tr>
<tr>
<td>Eritrea</td>
<td>4.4%</td>
</tr>
<tr>
<td>Botswana</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>2.8%</td>
</tr>
<tr>
<td>Burundi</td>
<td>2.4%</td>
</tr>
<tr>
<td>Angola</td>
<td>1.8%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
### Proportion of Maternal deaths due to HIV in ESAR

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated MMR</th>
<th>Lifetime risk of MD, I in:</th>
<th>Proportion of Maternal deaths due to HIV %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>190</td>
<td>180</td>
<td>77.9</td>
</tr>
<tr>
<td>Eritrea</td>
<td>280</td>
<td>72</td>
<td>6.6</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>470</td>
<td>40</td>
<td>------</td>
</tr>
<tr>
<td>Kenya</td>
<td>530</td>
<td>38</td>
<td>13.9</td>
</tr>
<tr>
<td>Lesotho</td>
<td>530</td>
<td>62</td>
<td>58.9</td>
</tr>
<tr>
<td>Malawi</td>
<td>510</td>
<td>36</td>
<td>31.8</td>
</tr>
<tr>
<td>Mozambique</td>
<td>550</td>
<td>37</td>
<td>25.5</td>
</tr>
<tr>
<td>Namibia</td>
<td>180</td>
<td>160</td>
<td>50.1</td>
</tr>
<tr>
<td>Rwanda</td>
<td>540</td>
<td>35</td>
<td>5.0</td>
</tr>
<tr>
<td>South Africa</td>
<td>410</td>
<td>100</td>
<td>42.5</td>
</tr>
<tr>
<td>Swaziland</td>
<td>420</td>
<td>75</td>
<td>75.1</td>
</tr>
<tr>
<td>Tanzania</td>
<td>790</td>
<td>23</td>
<td>11.1</td>
</tr>
<tr>
<td>Zambia</td>
<td>470</td>
<td>38</td>
<td>37.0</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>790</td>
<td>42</td>
<td>52.7</td>
</tr>
</tbody>
</table>

**Source:** WHO, UNICEF, UNFPA, World Bank Estimates 1990-2008
Contraceptive rates and rates of unmet needs for family planning in ESAR countries (WHS 2010)
Integration is rational ..... 

- Indivisibility of the MDGs and links between MDGs 4, 5 and 6.
- Africa faces Concurrent crisis- inadequate progress on MDGs 4, 5,6 (off track)
- MNCH platform - responses should be taken out of isolation
- MNCH services provided through same/similar channels
- Common health system needs (often Weak health systems limit potential for progress)
- More overlap in core target populations
- Similar underlying gender/cultural/social factors
- Gaps- coverage, quality, equity
Consensus for maternal, newborn and child health by PMNCH (2009-2015)

• **Political leadership** and **community engagement**
• **Effective health systems** that deliver a package of high quality interventions in key areas along the continuum of care
• **Removing barriers to access**, with services for women and children being free at the point of use where countries choose
• Skilled and motivated **health workers** in the right place at the right time, with the necessary infrastructure, drugs, equipment and regulations
• **Accountability** at all levels for credible results
UNSG’s Global strategy

• UN Secretary General Global Strategy for Women’s and Children’s Health to reinforce commitments and collective efforts to accelerate progress toward reaching MDG 4 and 5

• Support role of the H4+ (UNICEF, UNFPA, WHO, the WB, UNAIDS) in implementing the UN SG strategy at the country level
The way forward

• All countries should launch CARMMA
• Increase domestic resources – Private Sector
• Coordination of multi-sectoral and multi-agency Partnerships – Under national leadership
• Involve all stakeholders, incl. CSOs and Communities
• Implement follow-up actions to reduce maternal mortality – Health systems, FP
• Integrated RMNCH because of the linkages
• Monitoring of progress – With data and indicators.