ADDRESS BY THE MEC FOR HEALTH, DR SM DHLOMO, AT THE PRESENTATION OF A REPORT BY PATH ON MATERNAL AND NEWBORN HEALTH TECHNOLOGY INITIATIVE

26 November 2010,

Department of Health Head of Dept –Dr S Zungu

Partners from PATH

Senior Management at different levels

Partners, colleagues, friends;

Ladies and gentlemen

Our government puts it succinctly when it articulates our commitments to improve health outcomes. During the presentation of the MDG report in September we said; 'Our health is our life and MDGs 3, 4 and 5 are our life. South Africa feels the burden of disease with the scourge of HIV and AIDS stubbornly reversing gains made in life expectancy. To address this, our priority is to improve the health profile of all South Africans.'

It is in this regard that today we very gladly receive a report back from PATH, our partners in improving the quality of maternal and newborn care and thereby

contributing to Saving Mothers and Babies. The introduction of new technologies and techniques and monitoring of the impact of these are critical components of essential maternal and newborn care

In accepting the report and assessing PATH's intervention we have to be reminded of the MNTI project objectives which are:

Objective 1: Expand accessibility, availability, and use of appropriate and effective Neonatal Resuscitator Devices (NRD) to populations in need.

Objective 2: Expand lifesaving training for birth attendants (focused on nurses/midwives and physicians) to include partographs, AMTSL, and neonatal Resuscitation

Objective 3: Increase accurate reporting of cause-specific maternal and neonatal Mortality through use of a participatory assessment process designed to identify feasible methods of capturing data in an appropriate manner for intervention evaluation and program monitoring.

Objective 4: Develop an evidence base in South Africa for the coverage, occupational safety, relative cost and cost savings, feasibility, and acceptability of

AMTSL using Oxytocin-filled Uniject devices for preventing PPH, across a range of service delivery settings. Effectiveness of the Uniject will also be assessed and if effective, this information will be needed to convince policymakers and practitioners to include AMTSL as a routine practice.

We consider it appropriate indeed that we receive this report just few days after STATISTICS SOUTH AFRICA released their own **Mortality and causes of death in South Africa, 2008: Findings from death notification; released 18 November 2010.** Here we got to know that in the Province of KwaZulu Natal in the year 2008, a total of **592 073** people died and that 7, 7% of those deaths occurred among infants, 45 316 to be precise. What is striking from this report is that children under 5 years continue to die unnecessarily!

I think it is also worth mentioning that according to the same report 26, 1% of all deaths occur in the ages 30–44 years. We can also pinpoint that female deaths exceeded male deaths at ages 20–34. This report that gives us the national picture of how things are in the country says the highest number of deaths for both 2007 and 2008 occurred in KwaZulu-Natal, followed by Gauteng and Eastern Cape in this order 22,8% of deaths in KwaZulu-Natal, 19,6% in Gauteng and 14,0% in the Eastern Cape.

As highlighted, the top ranking main group of causes of death has been *certain infections and parasitic diseases*, comprising over a quarter (26,4%) of all deaths, which includes 712 deaths due to *multidrug-resistant tuberculosis* (MDR-TB) and 135 deaths due to *extensively drug-resistant tuberculosis* (XDR-TB).

The *intestinal infectious diseases* is highlighted as the leading underlying natural causes of death for those aged 0–14 (contributing 21,8% of all deaths in this age group). The second leading underlying cause of death for those aged 0–14 years was *influenza and pneumonia*

The leading cause of death for neonatal deaths in 2008 was *respiratory and cardiovascular disorders specific to the perinatal period*, accounting for 45,3% of all neonatal deaths. This was followed by *disorders related to length of gestation and foetal growth* (11,9%), *other disorders originating in the perinatal period* (10,5%) and *infections specific to the perinatal period* (10,2%). All these causes contributed nearly 80% (77,9%) of deaths in this period.

For the post-neonatal period, the first two leading causes of death accounted for half of all causes (*intestinal infectious diseases* contributed 30,6% and *influenza and pneumonia* contributed 19,4%). *Certain disorders involving the immune mechanism* ranked sixth, *tuberculosis* seventh and *HIV disease* ninth.

My dear colleagues the horrific picture, as painted above, may be with us for a very long time to come if we do not come up with interventions and embrace good intentioned partners like PATH. Today we are very thankful that there is now a very strong cordial working relationship between the Department of Health and MNTI not only at provincial, but at district levels as well. What is clear today is that the overarching message is one of optimism. All of us can take immediate steps to move towards the achievement of better outcomes in maternal and child health and to sustain such achievements.

Through this association we have noted positive developments in critical areas, vis:

- Identification and training of the mentors in 13 district hospitals because of their major support to their fellow midwives, and on site.
- We now have evidence based practices that are standardized in these hospitals e.g. Active Management of the Third Stage of Labour.
- Tere is improved midwives' interests and awareness of data management and finding solutions to problems when analyzing data. Close working relationships with Facility Information Officers.
- Increased managers' awareness of the essential equipment and supply needs for provision of basic midwifery care.
- Capacity building : improved and strengthened life saving skills have been noted.

- Neonatal Resuscitation: From the formative assessment done by MNTI at the beginning of the project, a training strategies and learning approach were designed.
- 13 mentors from the hospitals in the three districts having been trained to support at their institutions.
- The revival of basic maternity and newborn care as well as stimulation of interest in improving knowledge and skills.
- Implementation of new standards by the mentors.
- Fostering partnership between doctors and midwives.
- Improved reporting systems: the culture to use the Perinatal Problem Identification Programme audit system have been cultivated amongst the clinicians in institutions, which will again improve neonatal and maternal care

We are also very thankful for the ongoing monitoring and support as MNTI team continue to provide monthly supervisory support to districts. During their visits, MNTI facilitators also engage with the managers to ensure the smooth running of the project and support to the clinicians.

Allow me to make the following points as we move ahead;

First, we need unfailing commitment and leadership at hospital level. From heads of institution and heads of maternity sections, right down to the ward level. Only with this commitment can we sustain the fragile gains we have made, and make further progress.

Second, we need investment. We need more dedicated nurses who are committed to services, we need a new nurse, and we need to find better ways of channeling their positive energies in proven cost-effective interventions and new technologies delivered through a well-functioning health system.

A health system that provides universal coverage of services for reproductive, maternal and child health and removes financial and other barriers to care. A health system that has a sound health information system that measures results.

Third, we need to be smart and build synergies through an integrated approach, delivering services centered on women and children, with a focus on the vulnerable and disadvantaged. MDGs 4, 5 and 6 are interrelated and contribute to other MDGs for gender equity, education, environment, and poverty reduction. Investing Maternal and Child Health will bring a great return on investment and improve sustainability.

Fourth, we need a social compact and leadership from all partners at all levels to design, implement and monitor the commitments and promises of all stakeholders. We must measure results and hold each other accountable for our pledges and actions.

Action is what we need to take right now. Action we need to take together. Only then will we make the progress we seek.

Thank you.