DOCUMENTING GOOD PRACTICES IN MATERNAL, NEW BORN AND CHILD HEALTH (MNCH) INTERVENTIONS
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ART</td>
<td>Antiretroviral</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>AU</td>
<td>African Union</td>
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<td>AUC</td>
<td>African Union Commission</td>
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<tr>
<td>CARMMA</td>
<td>Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa</td>
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<td>CPRs</td>
<td>Contraceptive Prevalence Rates</td>
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<td>DPT</td>
<td>Diphtheria, Pertussis and Tetanus</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>EPI</td>
<td>Environmental Performance Index</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MNCH</td>
<td>Maternal Newborn and Child Health</td>
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<td>MPoA</td>
<td>Maputo Plan of Action</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>PMTCT</td>
<td>Preventing Mother-to-child Transmission of HIV</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>RECs</td>
<td>Regional Economic Communities</td>
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<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<td>SIAs</td>
<td>Supplementary Immunisation Activities</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>WHO</td>
<td>World Health Organization</td>
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In May 2009 the AUC launched, the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), a campaign that seeks to motivate stakeholders and Members States to accelerate the response to the issues of maternal, newborn and child health as identified in the Maputo Plan of Action (MPoA) for the Operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR).

With a significant majority of African Union Member States having launched CARMMA at the national level and implementing its core strategies, the good news that an impressive 41 per cent decline in maternal mortality in Africa from 1990 to 2010 has been recorded, provides further impetus to step up action.

While indeed substantial progress has been recorded, women on the continent still face a “one in 39” lifetime risk of dying due to pregnancy or child-birth related complications, which remains unacceptable. Consequently the need exists to identify what has worked well, disseminating the critical information in the hope that it can be adapted as may be appropriate, across the continent to facilitate the desired change in MNCH status.

The publication showcases concrete steps being taken to implement evidence-based, cost-effective interventions to address the primary causes of maternal, newborn and child mortality. Indeed, Africa can generate homegrown solutions to its problems, which are not completely alien to the continent as some of them are consistently being used to drastically cut down the mortality and morbidity in many countries.

It is my sincere hope that by documenting these laudable practices, Member states and stakeholders can identify relevant and adaptable practices to improve MNCH status on our continent.

Dr. Mustapha Sidiki Kaloko
Commissioner for Social Affairs
African Union Commission
The documentation of good practices on MNCH considers 11 thematic areas, namely, Social franchising, Outsourcing services, Midwifery education, Emergency obstetric care, Task-shifting, Human Resources for Health, Community initiatives, use of ICTs, CSO engagement, Girl Education, Safe Abortion, Health Care Equity and Maternal Death Audits. These important interventions, when harnessed, can act as high-impact and low cost means of addressing the burden of MNCH in Africa.

The African Union Commission wishes to express its appreciation to all the developmental partners that have continued to support MNCH programmes and interventions on the continent, especially of this publication. They include – in no particular order; the UNFPA, GAVI Alliance, Ipas (Africa), Marie Stopes International (MSI), AIDS Accountability International (AAI), the Elizabeth Glaser Pediatric AIDS Foundation, PMNCH, SAfAIDS and the Population Media Center.

The Commission looks forward to continuous result oriented collaboration with the broad range of partners to engender a conducive environment for MNCH in Africa.
Maternal, Newborn and Child morbidity and mortality are extremely high in Africa, thereby casting a high burden on the continent’s socio-economic well-being.

The African Union Commission (AUC) recognizes fully that the status of women and children, whose (health) indicators represent potent proximate indicators, central to social and human development, a key determinant of equitable and sustainable economic growth and development. The AUC firmly believes that sustained economic growth, peace and stability would not be realized without addressing persistent gender inequalities, social exclusion and poor health outcomes on the continent.

The Continental Policy Framework on SRHR was adopted by the AU under decision no; EX.CL/225 (VIII), in 2005 in response to the call for the reduction of maternal and infant morbidity and mortality in Africa. It was developed as Africa’s contribution to the implementation of the Programmes of Action of the International Conference on Population and Development (ICPD) as reproductive health and the rights of women as well as men were among the key priority objectives of the ICPD. Furthermore, the continental SRHR policy framework was aimed at accelerating action on the implementation of the MDGs, particularly those related to health, including MDGs 4, 5 and 6. In 2006, the AU under Executive Council declaration no; EX.CL/Dec.516 (XV) adopted the Maputo Plan of Action (MPoA) for the implementation of the SRHR Policy Framework.

Following a successful review of the implementation of the Maputo Plan of Action in 2010, the 15th Session of the Ordinary AU Assembly whose Summit was held in Kampala, mandated the AUC (under declaration Assembly/AU/Decl.1(XV)) to report annually on the status of MNCH in Africa until 2015. In furtherance of the foregoing, the AUC wishes to supplement the status of MNCH Report in Africa by documenting interventions with good practice in order to share knowledge on what works, where and how. The specific objectives of the documentation are:

- To promote sharing of evidence-based practices that have shown to be successful in improving reproductive and maternal, newborn and child health outcomes;
- To stimulate national program enhancement and maximization of available resources by acting as a mechanism for continuous learning, feedback, reflection and analysis of what did and did not work, how it worked and why; and
- To promote scaling up/replication of proven critical success factors and lessons learnt so as to increase coverage of quality services and accelerate progress towards universal access to good MNCH services.

The sharing of experiences among AU Member States and beyond shall accelerate the current efforts to reduce the MNCH burden in Africa.
PROGRAM THEME

Maternal Health

COMPONENTS

- Midwifery Education and Professional Development
- Creation of Midwifery Data Base
- Maternity Waiting Homes
- Community Based Approach to Increase Utilization of Maternal Health Services
- Civil Society Engagement in Prevention of Obstetric Fistula
- Reforming Laws and Expanding Access to Safe Abortion Services
MATERNAL HEALTH

Midwifery Education and Professional Development

BASIC INFORMATION

In South Sudan, there is a large gap in skilled human resource workforce particularly midwives and their capacity to deliver effective and efficient health care. The recently conducted South Sudan Household Survey (2010) reveals that “skilled birth attendants” (SBA) attend to only 10% of births in South Sudan. Antenatal coverage stands at a low of 16% and contraceptive prevalence rate is less than 3.5%, yet unmet need is low across the board.

In order to increase the numbers of professional midwives and strengthen midwifery services, efforts are underway through technical and financial support to four national health training Institutes to implement midwifery education programmes including the first ever college in the new Republic to offer diploma education for nurses and midwives; technical assistance to revise and develop the diploma and enrolled midwifery curricula to be aligned with the international midwifery education standards and essential basic midwifery competencies developed by the International Confederation of Midwives. Support also includes provision of scholarships to pursue midwifery education for 37 South Sudanese nationals at three colleges in Uganda and one privately managed health training institute in South Sudan.

RESULTS

270+

Students

This practice has resulted in four national health training institutes with increased capacity to manage midwifery and nursing education programmes; over 200 midwifery students and 70 nursing students pursuing studies at national health training institutes supported through the initiative; strengthened capacity of the Ministry of Health to manage nursing and midwifery services.

432

Members

National and 10 State level associations established with over 432 members enrolled to promote nursing and midwifery professions and contribute to improving maternal health across South Sudan.

KEY ELEMENTS OF SUCCESS

Major factors that facilitated the progress included: strong partnership and collaboration among agencies under the leadership of the Ministry of Health. This partnership ensured maximum use and leverage available resources. There is also political commitment from governmental authorities which facilitated the work of all partners and ensured the necessary requirements and governmental processes were met and smoothly addressed.

LESSONS LEARNT

This initiative is very relevant since it is aligned with the Health Sector Strategy to ensure that programme remains relevant and is in keeping with national priorities. This is a good practice that demonstrates partner response to country needs and priorities. This partnerships has ensured coordination of activities so as to reduce duplication and ensure maximum use of resources and the need to prioritize activities so as not to overwhelm countries.

IMPLEMENTATION PARTNERS

MATERNAL HEALTH

Creation of Midwifery Data Base

BASIC INFORMATION

The Government of Ethiopia’s (GOE) Human Resource for Health Strategic Plan (2010-2015) focuses on training and educating as many health professionals as possible (sometimes referred to as the “flooding” strategy). To implement this new strategy, the Government has established more training institutions. For example, the number of midwifery training institutions has increased from five in 2000 to 30 in 2011. Currently there are 11 universities that are offering midwifery training at BSc level while the rest are providing diploma level training. The Government of Ethiopia has put a target of training 8,635 midwives by 2015. However Ethiopia requires 19,489 midwives by 2015 to meet the needs of the growing population (State of the World Midwifery Report June 2011).

Although there has been an increase in the number of midwives graduating from the training institutions, lack of midwifery data is one of the gaps that has been identified at all levels including in the midwifery association and has affected recruitment of members. Different government departments and partners have been quoting different data. There has also been a high level of attrition by midwives from Ministry of Health to NGOs and also by joining other professions within Ministry of Health. In order to address the above issues, a census was conducted to:

- Identify the number and profile of midwives in service areas such as educational institutions and health facilities (private, public and NGO)
- Identify the number of midwife students in all colleges and universities (in government and private institutions) including their addresses
- Assess the available opportunities and challenges of midwives in educational institutions, private and public health facilities especially with respect to upgrading their professional career
- Identify membership status of midwives and midwife students

In the census a total of 4,332 midwives and 7037 midwife students were registered and fed into a database system. The data base is allocated in the Ethiopia Midwifery Association and will be updated every three months to capture new graduates and those who will be leaving the profession.

RESULTS

- Data base is now in place and shows that there has been an increase in the number of available midwives
- The data base also showed variation in the availability of midwives in each region as can be seen on the next graph and it also shows that the number of midwives in each region has increased considerably compared to the 2009 data
- Using the data base, Ethiopia is in the process of developing its own State of Ethiopia Midwifery Report
TREND OF AVAILABLE WORKFORCE + ACCELERATED MIDWIVES PROGRAMME:
SOURCE ETHIOPIA MIDWIFERY ASSOCIATION DATA BASE (2010 – 2012)

MIDWIVES IN ETHIOPIA: SOURCE EMA DATA (2012)
KEY ELEMENTS OF SUCCESS

Major factors that facilitated the progress included: strong partnership and collaboration among agencies under the leadership of the Ministry of Health. This partnership ensured maximum use and leverage available resources. There is also political commitment from governmental authorities which facilitated the work of all partners and ensured the necessary requirements and governmental processes were met and smoothly addressed.

LESSONS LEARNT

The census process provides avenue for gathering information on why there was low retainership in the profession and thus has allowed for adequate planning and putting mechanisms in place to encourage intending and existing midwives to take up the profession.

IMPLEMENTATION PARTNERS

Ethiopia Midwifery Association, SIDA, and Federal Ministry of Health (Ethiopia).

SOURCE

UNFPA
MATERNAL HEALTH

Maternity Waiting Homes

BASIC INFORMATION

The Eastern Cape (EC) in South Africa has a large rural population and high maternal mortality rates. Previous reports have shown a significant increase in maternal deaths over the years from 1998 to 2000. The same trend was observed over the period 2001 to 2003. The period 2003-2004 saw the sharpest increase from 129-209. This was followed by a small decrease to 181 in 2005. However, since then there has been a steady increase, to 268 deaths in 2009. Following the establishment of the National Committee on the Confidential Enquiry into Maternal Deaths report (Saving Mothers Report 2005-2007), a number causative factors have been uncovered. These include delay in seeking help at health facilities as one of the factors that contributed to increasing maternal deaths in the country. The report also highlighted delay in seeking medical help in 26.7% of maternal death cases. In the 2008 – 2010 Saving Mothers Report, a delay in seeking medical help was cited in 28.8 % of maternal deaths.

One of the measures taken was the establishment of the Maternity Waiting Home (MWH) in an effort to bridge the geographical distance to obstetric health care services. These are residential facilities located within hospital perimeters for pregnant women that live far from health service points. They are to a large extent used by women staying in deep rural areas, where there is no access to reliable transport. Some of these rural places do not have, appropriate road infrastructure, to enable cars/ambulances to transport their clients from their homes in the hour of need especially those defined as ‘high risk’. The facilities provide easy and timely access to health care services where appropriate management of pregnancy, including emergency services when complications arise, delivery and postnatal care is provided.

RESULTS

- Maternity waiting homes offered opportunities and additional emphasis is placed for education and counseling regarding pregnancy, delivery and care of the newborn and family.

- Observed a decline in number of complications during delivery and maternal deaths as at-risk mothers attend hospital at an early stage and stay at the waiting facilities and reported better pregnancy outcomes than women admitted directly from the community.

KEY ELEMENTS OF SUCCESS

The programme is boosted by the fact that maternity waiting home admission is free of charge and facility is within short (walking) distance of delivery facility, enabling mothers to arrive at delivery facility timely when in labour.

LESSONS LEARNT

Maternity waiting homes are effective strategy to ensure timely and appropriate health care for mother and the new born baby should complications arise. Identifying the causes of MNCH mortality is not sufficient, action has to be taken. Utilizing outcomes of maternal deaths and confidential enquiries to improve MNCH is a good practice.

IMPLEMENTATION PARTNERS

Government of the Republic of South Africa
MATERNA L HEALTH

Community Based Approach to Increase Utilization of Maternal Health Services

BASIC INFORMATION

Djibouti has one of the highest maternal mortality ratios in North Africa, estimated at 300 maternal deaths per 100,000 live births in 2008. The contraceptive prevalence rate is 17.8 and approximately 93% of women have undergone female genital mutilation. Compared to other North African countries, Djibouti has also one of the highest prevalence of HIV/AIDS in the Arab States region. Although the population is less than a million, they are scattered with limited access to health services. Contributing to the high MMR is limited access to health services. Health centres are not well distributed and are far from many women. Emergency transferring of woman from health centres to tertiary or Emergency Obstetric Care (EmOC) services may take up to ten hours. Additionally, women may not be able to afford the transport costs. One key intervention in the national health development plan of the country was improving the physical and financial access to services particularly Emergency Obstetric Care (EmOC).

To improve the responsiveness of the health system and improve quality of care, UNFPA supported a community-based initiative to increase the utilization of maternal health services. The objectives of this initiative were to:

➤ Reduce financial obstacles to quality reproductive health services

➤ Strengthen and improve community organization around maternal health

➤ Enhance the collaboration between rural communities and the health care providers, particularly mobile units

The pilot programme targeted rural communities that were either nomadic or semi-nomadic (with populations not exceeding 30,000 inhabitants; approximately 7,000 inhabitants who are women in reproductive age; and 2,700 under-five children). The initiative generated strong adhesion among community members. The programme led to formation of committees that were made up of 10 persons (8 women and 2 men). The programme also allowed for the collection of financial resources from local sources and creation of community based funds (mutuelles) of approximately USD300-500. These funds were designed to empower these committees and build their capacity in financial management issues.

RESULTS

48% - 100%

Health facility births

➤ Increased number of pregnant women who were using health facilities to give birth. Health facility births that used to range from 10% - 15% in 2008 have now reached 48% -100% in 2012 (MoH field reports)

42

Communities

➤ Scaling-up of the programme to cover more remote and needy areas in the North and South of Djibouti. The programme started in 16 communities and has now reached more than 42 communities

3

Monthly visits –
Southern areas

2

Monthly visits –
Northern areas

➤ Increased activities of the mobile health teams in the participating communities, as the relation of the community organizations with the health teams were strengthened. The mobile teams are taking three monthly visits in the two Southern areas and two visits to each site in the three Northern areas. Strengthened community efforts to identify and invite pregnant women to join the program
The strong cohesion engendered by community engagement facilitated increased community participation and access to relevant services.

**KEY ELEMENTS OF SUCCESS**

**SOURCE**

UNFPA.
MATERNAL HEALTH

Civil Society Engagement in Prevention of Obstetric Fistula

**BASIC INFORMATION**

The maternal mortality ratio in Mozambique is 500/100,000 live births and 36.8% of those deaths occur among the 15-24 years young women (2007), mostly among the poor, illiterate and rural girls and women. For every woman who dies of maternal related causes, at least 20 women are estimated to experience a maternal morbidity; of which obstetric fistula is one of the most severe forms. It is estimated that 2,000 new cases of obstetric fistula occur annually in Mozambique. The existence of obstetric fistula and its causes and consequences are unknown in most segments of society, and therefore women in Mozambique can be living with this socially and physically disabling condition for years and many die of complications. Lack of information associated with taboos and misconceptions, limited access to health facilities and poverty leaves women vulnerable to fistula and victims are often left without any assistance and marginalized in their own communities. Until recently medical services to treat or improve the condition were very few and outreach to fistula survivors was very limited, and there was no national strategy and plan to address the problem.

**RESULTS**

- This intervention contributed to increase the access and utilization of quality reproductive health services particularly that of maternal and newborn health services and family planning services

**LESSONS LEARNT**

This intervention reinforced the linkages between community and health services which is strategically important to promote the access to reproductive health care. Besides, the initiative not only introduced a “new” maternal health risk/complication to many participants, it also facilitated a vital debate and discussion among participants from affiliated NGOs regarding their own role in its prevention and its inclusion in ongoing community-based interventions.

**IMPLEMENTATION PARTNERS**

Forúm Mulher and Affiliated NGOs.
MATERNAL HEALTH

Reforming Laws and Expanding Access to Safe Abortion Services

BASIC INFORMATION

Ethiopia fares poorly on numerous reproductive health indices. Major concerns include high fertility (4.8 children per woman, according to the latest DHS survey), high maternal mortality (estimated at 676 deaths per 100,000 live births), and low contraceptive prevalence (estimated at 27 percent). As in many sub-Saharan African countries, unsafe abortion is a leading cause of maternal mortality and morbidity. A 2008 study of the magnitude of abortion concluded that only 27% of the total 382,000 annual abortions were conducted safely in health-care facilities. Abortion was then subject to severe legal restrictions, permitted only to save the life of the pregnant woman, and safe abortion was very inaccessible. As a result, unsafe abortion used to contribute to a third of the maternal deaths in the country.

Despite these challenges, Ethiopian leaders recognized the serious toll unsafe abortion was taking, thanks largely to a strong body of hospital-based and other studies documenting its extent and impact. In 2004, as part of extensive revision of its penal code to align with its new Constitution, the Ethiopian government liberalized access to abortion as a strategy for reducing maternal mortality and morbidity and protecting women’s reproductive rights.

RESULTS

- Revision of the country’s abortion law and the development of technical guidelines for health providers

5,000

Health care workers

- More than 5,000 health care workers have been trained in and safe abortion care is now available at approximately 600 service delivery sites, in both the public and private sectors

200,000

Women

- In 2012, more than 200,000 Ethiopian women obtained safe abortion care through government and private health facilities

15%

Women presenting with abortion complications

- The proportion of women presenting with abortion complications reduced to only 15%, the remaining 85% receiving safe abortion services

84%

Clients receiving abortion-related care
Political will to address the issue was bolstered by the government’s previous endorsement of international and regional agreements addressing women’s reproductive health and rights, as well as the country’s rights-based constitution. The abortion law reform followed concerted, evidence-based advocacy over a period of years by a broad-based coalition representing government and civil-society stakeholders, including the medical and legal professions, women’s groups and others. It also reflected political leaders’ recognition of their obligations under a number of national policies and international agreements relating to women’s health and rights.

The strategy of revising restrictive abortion laws and introducing safe abortion services on a national scale, implemented with such success in Ethiopia, is equally relevant to other African countries. According to the World Health Organization (WHO), more than a quarter of the global total of unsafe abortions occurs in Africa (WHO, 2011). Of the nearly 48,000 women who die each year from complications of unsafe abortion, 29,000 are in Africa. More than 60 percent are young women under the age of 25, in the prime of their lives (WHO, 2007). Apart from the large numbers of women who die, many more survive with short- and long-term debilitating conditions, including infertility.

The Federal Ministry of Health, Regional Health Bureau, Ipas.
PROGRAM THEME

Maternal and Newborn Health

COMPONENTS

→ National Maternal and Newborn Deaths Audit
MATERNAL AND NEWBORN HEALTH

National Maternal and Newborn Deaths Audit

BASIC INFORMATION

In Mozambique, the maternal mortality ratio is 500/100,000 live births. Lack of bio-medical information, difficulties in access and use of services, and social aspects, such as gender and intergenerational inequalities, and specific local norms and beliefs, leave women and girls vulnerable to various sexual and reproductive health complications. The country does not have sufficient health facilities and faces shortage of skilled staff to adequately respond to the approximately 1 million children born each year. The government recognizes the importance of investing in the reduction of maternal mortality and the need for evidence base in doing so.

In order to address the issue, Committees on Maternal and Newborn Audit Deaths were established at the national, provincial and district levels in 2010. This qualitative audit mechanism entails an in-depth systematic review of maternal and newborn deaths to find out their underlying health, social and other contributing factors.

This intervention provides a platform to have an open discussion on remediable causes of maternal and newborn mortality without blaming health care providers. The death audits have been instrumental in reducing obstetric and neonatal deaths complications in health facilities and serves to permanently monitor and evaluate the policies related to maternal and newborn health in the country. This intervention introduced for the first time ever in Mozambique a comprehensive form to register qualitative information related to maternal and newborn health/deaths.

RESULTS

- A specific database of maternal and newborn deaths was developed.
- A better understanding of the importance of analyzing and keeping record of the causes of maternal and newborn deaths among the medical personnel and related members of civil society.
- Medical personnel and health managers consider the audit as an essential tool that will allow them to better avoid maternal and newborn deaths caused by similar situations.

LESSONS LEARNT

Maternal and newborn death audits empower health authorities to better understand and take appropriate measures to improve the management of obstetric and neonatal complications in health facilities.

IMPLEMENTATION PARTNERS

Ministry of Health and UNFPA.

SOURCE

UNFPA.
PROGRAM THEME
Sexual and Reproductive Health

COMPONENTS

- Social Franchising
- Behavior Change Communication, The Sabido Methodology
Social Franchising

BASIC INFORMATION

Social franchising is based upon a model of franchising commonly used within the commercial sector. It typically involves the granting of a license by a social enterprise (the franchisor, often an NGO) to another person or company (the franchisee) to allow them to create demand using the branding of the social enterprise. The resulting franchise enables the franchisee to market the franchisors’ products or services from their own outlets. The franchisee must follow standard operating procedures, subsequent to formal training and accreditation.

Social franchising provides a service delivery channel to significantly increase coverage of high quality and effective sexual reproductive health services. Private health providers represent a major source of health care in developing countries and there is a strong likelihood of continued growth in the next decade. Several studies indicate that a significant proportion of poor people use private health providers for most of their health care needs. By engaging the private sector, social franchising enables sexual and reproductive health organizations to introduce services in underserved areas rapidly and cost-effectively. Social franchising also enables sexual and reproductive health organizations to increase the use of existing services by improving their quality or marketing them appropriately.

RESULTS

1,775

Health Service Providers

Social franchising was introduced to the sexual reproductive health sector in the 1990’s. By the end of 2011, it was reported that there were 27 social franchises in 19 countries in Africa. First launched in Kenya in 2004, social franchising has been implemented in over 1,775 health service providers in 10 countries. The year 2012 will witness 10 more countries to start similar programmes.

LESSONS LEARNT

The positive results observed in these pioneer countries can be spread to the whole continent if the concept of social franchising is replicated in all AU Member States.

IMPLEMENTATION PARTNERS

Medical Services International.

SOURCE

Medical Services International.
SEXUAL AND REPRODUCTIVE HEALTH

Behavior Change Communication, The Sabido Methodology

**BASIC INFORMATION**

Sabido is a unique methodology of long-running serialized melodramas, written and produced in participating countries in local languages, in order to create characters that gradually evolve into positive role models for the audience to bring about changes in social norms with regard to the issues being addressed. By transmitting values through the growth and development of characters while keeping an emphasis on the entertainment value of the serial, the Sabido methodology manages to simultaneously attract large and faithful audiences and stimulate thoughtful discussions. By engaging audiences in riveting, dramatic stories, PMC is able to not only deliver important social and health information and messages to huge audiences, but is ultimately able to motivate them to change their behavior. The Sabido methodology has proven to be one of the most effective behavior change strategies. The Whole Society Strategy utilizes the most prominent forms of media and social organizing in a society to deepen the audiences’ understanding of the issues being addressed in the dramatic series.

**RESULTS**

45

**Countries**

- Forty five countries throughout Africa, Asia and Latin America have used the methodology to produce serialized melodramas using the Sabido methodology
- There is strong evidence that the strategy has led to elevation of women’s status, reduced birth rates, and improved health of the women in the audiences and their children

40%

**Use of modern family planning methods**

- Among married women in the Amhara region of Ethiopia, current use of modern family planning methods went from a baseline of 14% to 40% among listeners against 25% among non-listeners

2/3

**People seeking reproductive health and family planning services**

- In four northern states of Nigeria two-thirds of people seeking reproductive health and family planning services cited as their reason for coming to the clinic. The first such program in the country served as the primary motivation to seek fistula repair services for 54% of new clients to fistula repair centers in Kano and Kaduna states of Nigeria
A policy framework is created for each project. This is a document that summarizes the laws and national policies with regard to the subjects to be addressed by the drama. This framework will also make note of any international conventions or treaties with regard to reproductive health and child welfare to which the country is a signatory. Once compiled, this policy framework is used as a guide in the development of the drama, in that it dictates the context within which the drama must operate.

Program listeners

- Data gathered from clinic clients in 2005 indicated that between 29% and 39% of clinic clients listened to such a program in Sudan, which dealt with reproductive health issues and the elevation of the status of women and girls.

Listeners

- 96% of listeners to the first program in Burkina Faso could identify at least one place that provided family planning/reproductive health services, compared to 80% of non-listeners.

Mean desired number of children

- A program in Rwanda had significant effects on changing desired family size among those who were listening to it. At baseline, the mean desired number of children for all respondents was 3.61 (females 3.73, males 3.44), and this decreased significantly to 2.94 by the endline survey, with both females and males showing similarly significant decreases (females 3.02, males 2.81).
PROGRAM THEME

Adolescent Sexual and Reproductive Health

COMPONENTS

→ Girls Discussion Forum on Sexual and Reproductive Health
ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Girls Discussion Forum on Sexual and Reproductive Health

BASIC INFORMATION

Mozambique has a large youth population (66.6 per cent is under 24 years old) facing fast challenges related to employment, education and, not least, sexual and reproductive health. Their particular vulnerabilities increase the risk of sexual reproductive health-related illness and mortality.

Young girls and women are particularly vulnerable which is evident in the high rate of teenage marriages and pregnancies (41 per cent of girls between 15-19 years are either mothers or pregnant), the fact that 36.8 per cent of the total number of maternal deaths (500 per 100,000 live births) occurs among women aged 15-24 years, and the high HIV prevalence among girls and young women, who are four times more likely to be infected.

A discussion forum provides girls and young women with a comfortable space to talk about their sexual and reproductive health problems and experiences, and to learn about their rights than boys and young men.

RESULTS

☛ The intervention has proved to have had a positive impact on a high number of young women; improving their self-esteem and their level of decision making with respect to their sexual reproductive health.

☛ The involvement of boys and men in the forums is a positive result as they often constitute a part of the problem or the issues that the women and girls have with respect to making choices related to sexual and reproductive health.

LESSONS LEARNT

This activity is successful in its own terms, but given the poverty and impending employment challenges for girls, it provides an answer to certain aspects of the challenges. Converting girls’ power in the private sphere needs to be followed up with interventions to promote advocacy for effective relevant services and well-resourced policies and answer to all. In other words, it must be linked to other development oriented programs.

IMPLEMENTATION PARTNERS

AMODEFA (Mozambique’s family planning association – Planned Parenthood affiliate).
PROGRAM THEME

HIV Prevention and Treatment

COMPONENTS

→ Increasing Access to Sexual Minorities
HIV PREVENTION AND TREATMENT

Increasing Access to Sexual Minorities

BASIC INFORMATION

In order to increase access to HIV prevention, treatment and support services for marginalized group, LGBTI groups, in 2 communities in Zimbabwe, the project employed a cocktail of approaches/strategies, tools, materials and systems. The project used HIV, gender and its SRHR programmes as an entry point to address issues of LGBTI in these communities and the project has since been well received in these two communities. In addition to this strategy, the project employed capacity development, information production and dissemination, creation of alliances and partnerships, and transformative community dialogues as strategies to address key drivers of homophobia in these communities.

In addition, attitudes and perceptions of service providers towards LGBTI groups have hindered their ability and willingness to provide prevention, treatment and care services to LGBTI groups. Socially and culturally the act has been condemned hence increased homophobic tendencies among community members. It is against this background that this project was implemented.

RESULTS

Community members

- A baseline study was successfully conducted in four rural communities in Zimbabwe and a total of 106 community members participated. The communities participated at every stage of the project, from its inception to its implementation, monitoring and final evaluation.

200

CBVs trained

- 200 CBVs were trained who are providing relevant and appropriate information through door to door initiatives
- Increased access and uptake of HIV prevention, treatment and care services; increased knowledge around sexuality differences that will result in positive attitudes and perceptions about sexual minorities and strengthened community capacity primarily LGBTI groups to influence local policies and practices that hinder access to services for sexual minorities.

KEY ELEMENTS OF SUCCESS

Project activities include dissemination meetings at both national and regional levels to share such results and this enhances programme replicability.

LESSONS LEARNT

This project can be replicated elsewhere as long as gender, HIV and SRHR issues are used as entry points.

IMPLEMENTATION PARTNERS

SAF AIDS.
PROGRAM THEME
Immunization

COMPONENTS
→ Financing and Procurement of Vaccines
IMMUNIZATION

**Financing and Procurement of Vaccines**

**BASIC INFORMATION**

From 2013, African countries are launching large-scale ‘catch up’ campaigns in measles-rubella, and countries are self-financing the introduction of the vaccine in their routine immunization programmes. Seven African countries will be piloting the best ways to deliver HPV vaccine to girls together with other interventions that benefit their lives. These demonstration projects will pave the way for countries to build capacity and infrastructure needed to vaccinate girls nationwide. With the support from GAVI, African countries are accelerating the roll-out of new vaccines against the major killers of children, such as pneumonia and diarrhea. Finally, African businesses are showing increasing interest in providing financial resources, advocacy, and core business skills to advance routine immunization coverage in Africa.

**RESULTS**

$600m

*Cases of malaria managed by CHWs*

- $600 million was expended in 2008, mostly to purchase vaccines for 72 eligible low- and lower-middle-income countries to accelerate the adoption of new and underused vaccines in poor countries; over. Most of these countries introduced Hep B and Hib vaccines, and are poised to introduce rotavirus and pneumococcal vaccines.

- The pneumococcal advance market commitment, an innovative financing model that subsidizes pharmaceutical companies for the development and production of new vaccines.

**LESSONS LEARNT**

The pneumococcal advance market commitment subsidy is meant to reduce the risk for pharmaceutical companies of investing in products for developing country markets with limited purchasing ability, and is only paid once a vaccine meeting certain specifications is purchased by eligible developing countries (or donors on their behalf) at a pre-set price. The subsidy covers an agreed volume of vaccines, after which a predetermined and lower long-term price (also called ‘tail price’) is offered to countries. This aims to ensure the vaccine’s use is sustained beyond the duration of the subsidy.

**IMPLEMENTATION PARTNERS**

GAVI, UNICEF and Country Governments.
PROGRANM THEME

Human Resources for Health

COMPONENTS

• Task shifting for maternity and family planning Services
• Managing PMTCT at the District Level
• Performance Based Financing of Community Health Workers
HUMAN RESOURCES FOR HEALTH

Task Shifting for Maternity and Family Planning Services

BASIC INFORMATION

Globally, over 75% of doctors and 60% of nurses serve in urban areas where less than 55% of the global population lives. This disparity stems from a higher number of training institutions, health facilities and/or opportunities for higher income in urban areas. As a result, many rural communities lack adequate access to services traditionally delivered by highly qualified health professionals. Empowering mid-level service providers to deliver services traditionally provided by highly qualified health professionals has the potential to significantly improve the health of and access to a wider variety of health care. They have often undertaken between two and three years of higher training, and form a significant proportion of the total health workforce in many low income countries. In nine countries south of the Sahara, for example, mid-level providers equal or outnumber physicians.

RESULTS

90%

Caesarean deliveries

- Mid-level service providers with surgical training perform approximately 90% of caesarean deliveries in district hospitals in Malawi

84%, 92%

Major obstetric surgeries

- In Mozambique and Tanzania, 84% and 92% of major obstetric surgeries respectively are completed by mid-level service providers with surgical training

- Ethiopia has also employed tasks-shifting technique in clinical family planning services delivery

LESSONS LEARNT

Mid-level service providers especially those with natural affiliations to the target communities are more cost effective and sustainable in providing certain critical MNCH services.

IMPLEMENTATION PARTNERS

Marie Stopes International
Managing PMTCT at the District Level

BASIC INFORMATION

In line with its national plan for virtual elimination of pediatric HIV, Zimbabwe’s Ministry of Health and Child Welfare (MOHCW) adopted and nationalized a PMTCT district focal person (DFP) model to support Zimbabwe’s national PMTCT program in 2011. The goal of this program is to utilize DFPs, who are experienced community health workers, to support the MOHCW district health teams in implementing the revised 2010 WHO PMTCT guidelines at maternal and child health facilities. The purpose of the DFPs was to prioritize PMTCT at the facility level to achieve Zimbabwe’s goal of reducing the rate of mother-to-child transmission of HIV to less than 5% by 2015. This strategy grew out of discussions between the MOHCW and EGPAF Zimbabwe and provided additional training to district-level senior nurses to support the strengthening of PMTCT service delivery. The DFPs monitor PMTCT service delivery while providing on-site mentorship and training to health care workers on PMTCT interventions. The key aim of these activities is to improve PMTCT service uptake and retention rates, address program bottlenecks, and document program achievements and lessons learned. Provincial medical directors were also involved in the DFP recruitment process and program implementation.

RESULTS

97%

HIV-exposed infants receiving CTX

DFPs are also reporting strengthened linkages to the community and piggyback on community events led by other partners to ensure PMTCT messages are included.

KEY ELEMENTS OF SUCCESS

This program was facilitated by a strong partnership between EGPAF and the MOHCW, as well as focused government support. Early coordination with and ownership of the DFP cadre and model by MOHCW leadership at the national and provincial levels was critical to their smooth implementation and acceptance in districts. Moreover, involving the district health executive and provincial MOHCW staff during support visits enhanced their ownership of and accountability for site-level performance.

LESSONS LEARNT

The DFP model is being closely monitored and documented for the benefit of other settings that may wish to employ a similar strategy. Because the DFP role is envisioned to be phased out after its fifth year of implementation, it is potentially a realistic approach in countries that are able to invest in short-term strategies to accelerate improvements in PMTCT service delivery, without making long-term financial commitments that could potentially be unsustainable. Additionally, since DFPs are embedded within the district MOH structure, such a model could be adopted by any country with district MOH health teams, without the need for establishing parallel management structures.

IMPLEMENTATION PARTNERS

Zimbabwe’s Ministry of Health and Child Welfare (MOHCW) and The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).
Performance Based Financing of Community Health Workers

BASIC INFORMATION

To address the current inequality in access to health care, a performance based financing (PBF) approach at community level, in four health districts. This aims at reducing infant and child morbidity and mortality through the management of major childhood illnesses including immunization, and promotion of Essential Family Practices (EFP). At operational level, terms of reference were designed and signed between the Head of health center, the Village Chief and the Community Health Workers (CHW) who liaise the community and the health system. To ensure sustainability, incentives are paid to CHWs depending on their performance.

RESULTS

1,087

Community health workers trained

1,087 community health workers including 41% women were identified and trained on the full intervention package at community level (facilitation techniques, management of malaria, diarrhea, ARI and malnutrition cases, promotion of essential family practices). 57% of CHW offer the full package while 43% offer the promotion package After 12 months of implementation, 112,560 under-five boys and girls benefited from access to health in 461 villages.

26,772

Cases of malaria managed by CHWs

Over a twelve-month period, 26,772 cases of malaria, 5,964 of diarrhea and 7,520 of ARI were managed by CHWs. These are respectively 59% of malaria cases, 17% of ARI and 13% of diarrhea cases treated as compared to the cases expected during the last 12 months as per our working assumption.

KEY ELEMENTS OF SUCCESS

The approach is based on a partnership between the health district representing the Ministry of Health, the municipality, and UNICEF.

LESSONS LEARNT

The sustainability of the system established implies an actual commitment of all stakeholders at community level, from the CHWs to the mayors, through health center managers. A partnership to establish a continuum of the PBF approach across the health system should improve the effectiveness of the programme by better addressing issues of referral and supervision.

IMPLEMENTATION PARTNERS

Ministry of Health (MOH) and UNICEF.
PROGRAM THEME
Health System Strengthening

COMPONENTS

Integration of HIV and SRH Services
Integration of HIV and SRH Services

BASIC INFORMATION

Lesotho has very high attendance of at least one antenatal care (ANC) visit of 91.8% and high rates of HIV testing and counseling of pregnant women of more than 95% of pregnant women attending ANC, allowing for good opportunity of HIV-positive women within the MCH setting. Most women prefer to receive services in the MCH setting rather than in more general departments, so the integration of PMTCT and HIV services in MCH is well-received by program beneficiaries. Extreme human resources for health shortages and frequent rotation of healthcare workers create systemic challenges. Baseline data collected from October to December 2008 showed that only 60% of women eligible to receive the minimum package of PMTCT received it, and only 18% of treatment-eligible HIV-positive pregnant women were initiated on ART.

RESULTS

94

Nurses trained

- 94 nurses were trained in the six districts where the project was implemented, greatly increasing the capacity of their clinics to initiate eligible women on ART. Currently this approach has been rapidly scaled throughout Lesotho with good success.

100%

Eligible women initiated on treatment

- After the “one door approach” was implemented, 100% of the women found to be eligible for treatment after a positive HIV test were initiated on treatment. Women who were not eligible for ART for their own health were given the minimum PMTCT package. The percentage of eligible women initiated on ART at MCH doubled between the first quarter of 2009 and the second quarter of 2010.

KEY ELEMENTS OF SUCCESS

This program was successful due to the MOH’s national policy of integrating PMTCT into maternal, neonatal, and child health services. This policy seeks to integrate services through roll-out of an integrated training package, mentorship, supportive supervision and quality improvement programs. In addition, Lesotho has had high success rates in routine HIV testing and counseling and PMTCT, so the program could focus its energies and resources on one aspect: limiting transmission of HIV from mothers to children and ensuring that HIV-positive pregnant women and their children receive appropriate HIV care and treatment.

LESSONS LEARNT

This program improved maternal and child health by expanding ARV prophylaxis and ART coverage for HIV-positive women and providing more PMTCT services to reduce mother-to-child HIV transmission and improve child health. Furthermore, placing maternal, neonatal, and child health nurse-midwives in each of the 14 general care hospitals greatly enhanced the capacity of these hospitals to provide ARVs through MCH services on a long-term basis. These health workers will remain at the hospitals, serving as mentors and technical assistance providers for other healthcare workers to normalize quality integrated PMTCT and MCH services.

This model is easily replicable – in countries or districts with MCH and PMTCT services that are not integrated, placing and training healthcare workers to provide PMTCT services within the MCH context will increase facility and population coverage of PMTCT services. So far the model has been scaled up throughout Lesotho.

IMPLEMENTATION PARTNERS

EGPAF in collaboration with UNICEF.
PROGRAM THEME

Health Care Financing

COMPONENTS

→ Removing User Fees for Maternal and Child Health Services
Bringing the FHCI to life was a massive project that required the collaboration of the Ministry of Health and Sanitation (MoHS), local authorities and other government entities, civil society and development partners who all supported its implementation.

Key Elements of Success

The successful implementation of the FHCI in Sierra Leone and the lessons that have been learned provide a ready platform for understanding how to strengthen central and district level health care systems to deal with problems that cannot be tackled by PHUs. Modalities are being put in place to strengthen these levels. This initiative has also illustrated how political will, removal of user fees, and improvements in facilities, supplies and human resources can increase demand for, and use of, health care and other basic services to reduce inequities for women and children. The FHCI initiative has also laid the groundwork for the development of a national health financing strategy that may eventually include a national social insurance scheme that can provide protection and care for all people in Sierra Leone.

Lessons Learnt

The Government of Sierra Leone.

Basic Information

For many years Sierra Leone held the unenviable position of last place in the UN Human Development Index because of its alarming health indicators. Maternal and child deaths peaked in 2000 with 1,800 mothers dying for every 100,000 live births and 286 children under five dying for every 1,000 live births, the highest levels globally.

It is against this background that a Free Health Care Initiative (FHCI) for children under five years of age, pregnant women and lactating mothers was introduced in Sierra Leone in April 2011 to further the aims of the country’s Health Sector Strategic Plan and its Poverty Reduction Strategy Paper (PRSP II). Before introduction of free health care (FHC) in Sierra Leone, 88 per cent of citizens said that their inability to pay was the greatest barrier to accessing care when sick. The FHCI outlines how prospects for women and children can be positively altered by delivering an essential package of health care services free of charge through public health facilities to ensure a significant improvement in maternal and child health.

Results

150%

Improvement in maternal complications

A year after the inception of FHC, data collected by the health information system reflected a 150% improvement in maternal complications managed at health facilities and a 61% reduction in the maternal case fatality rate in that first year of FHC compared with the previous period.

214%

Increase in medical care for children

Medical care for children under five has increased by 214%, and the case fatality rate for malaria in public hospitals has fallen dramatically by approximately 90 per cent. At the same time, the number of acceptors of modern family planning methods at facilities rose by 140%.

Implementation Partners

The Government of Sierra Leone.
Conclusion

The good practices are a method or technique that had consistently shown results superior to those achieved with other means, and that can be used as benchmarks on our continent. The African Union Commission recognizes that knowledge constitutes a valuable intangible asset for creating and sustaining competitive advantages. In order to preserve this knowledge, African Countries need to develop robust Knowledge Management Systems. It should also be noted that this shared knowledge shall generate different viewpoints, thereby, ensuring that these Good Practices evolve to become better as more improvements are discovered.

It is therefore the expectation that the evidence presented in this piece would be adequately interrogated and adapted for the common good of not only women and children, but the overall African community.