STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD WITHIN THE FAMILY HEALTH PROGRAMME 2007-2011

MINISTRY OF HEALTH
JAMAICA

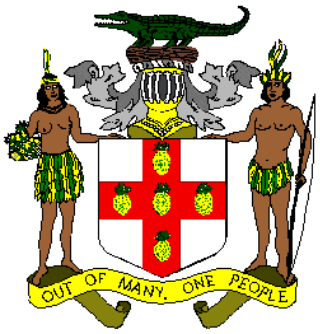

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TABLE OF CONTENTS

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD

INTRODUCTION

Since the launch of the safe motherhood initiative in 1987, experts at several international fora have agreed that the problems of maternal mortality and morbidity need to be addressed urgently. More specifically, the plan is to achieve the Millennium Summit Declaration Goal of the reduction of maternal mortality ratios by 75%, from the 1990 levels, by the year 2015, reduce intra-country disparities and reduce maternal morbidity (26th Pan American Sanitary Conference, 2002). The achievement of this goal will have different implications for different countries; however, all countries are expected to reduce maternal mortality and morbidity to levels where they no longer constitute a public health problem (UNFPA, n.d.).

Each year, more than 500,000 women worldwide die from complications of pregnancy and childbirth. The majority of these deaths, 99%, occur in developing countries and are largely preventable (WHO, 2004). Additionally, for every woman who dies, 30 suffer long-lasting injuries and illness (Family Care International, 2005). These deaths and injuries have implications beyond the affected women to the social and economic welfare of their families and communities. There is the possibility of reduced survival of children in the family, poor school performance of surviving children and loss of productivity and income (Regional Interagency Task Force for the Reduction of Maternal Mortality).

In Latin America and the Caribbean, maternal mortality has stagnated at approximately 190 per 100,000 live births with inter and intra-country disparities. This occurs in an environment where an average 75%-80% of deliveries are attended by a skilled person implying poor access to or ineffective care (26th Pan American Sanitary Conference, 2002; Regional Interagency Task Force for the Reduction of Maternal Mortality). Cost-effective interventions for the reduction of the incidence and severity of complications associated with pregnancy, childbirth and the postpartum period are known. Research and experience in maternal health for more than a decade have demonstrated this and that the interventions are feasible even in poor countries. Such interventions are a supportive policy environment, basic and comprehensive Essential Obstetric Care (EOC), skilled attendance at birth, improved access to high quality maternal health services, safe motherhood health promotion, the monitoring and evaluation of progress and establishment of multi-sectoral linkages (26th Pan American Sanitary Conference, 2002).

The potential benefits from the investments in Safe Motherhood extend beyond the improvement of women's health to increased labour supply, productive

capacity and exert a positive impact on community and national economy. On the other hand, unwanted or unplanned pregnancies and poor maternal health result in death, disability and interfere with women's social and economic life thereby contributing to poverty. A maternal death is not only a personal tragedy but is a significant loss to the nation, the community and the family which when taken together represent an enormous cost. Safe motherhood is an important measure to ensure that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth.

THE JAMAICAN CONTEXT

Between 1996 and 2004, the proportion of hospital births increased from 86% to 95% respectively with 40% occurring in the types A and B facilities where there are specialist obstetric services. Skilled attendance at birth was also reported at 91%. This indicates that women have become more aware of the need for essential obstetric care and have self selected the type of facility in which they wish to deliver.

Jamaica's Reproductive Health Programme has been strengthened with the support of technical co-operation from agencies such as the United Nations Population Fund, USAID, PAHO and others. Significant achievements have included:

- Continued routine antenatal clinics with an average of 4 visits per client
- On-going in-service education for doctors and nurses on safe motherhood and reproductive health
- The use of antenatal registers to document all clients and identify the high risk women
- The use of a referral system from primary care to high risk antenatal clinics or to the types A and B hospitals in all parishes for continued care
- The implementation of weekly high risk antenatal clinics conducted by Obstetricians or Obstetric residents in all parishes
- The introduction of home visits to antenatal women and high risk antenatal clients within 1 week post delivery in most parishes
- The introduction of a system for antenatal clients to by pass the Casualty Department and be seen directly on the labour ward in the type A and B hospitals after 24 weeks of pregnancy if there are problems
- The introduction of the "Act Now" cards given to <u>all</u> antenatal clients detailing the danger signs in pregnancy which requires them to go directly to hospital
- Expansion and equipping of the maternity wards in some type B hospitals (Spanish Town, Mandeville, St. Ann's Bay) and the up-grading of some type C facilities such as Annotto Bay, Princess Margaret and May Pen hospitals to include Obstetricians and /or Paediatricians on staff.
- Placement of additional Obstetric staff at St. Ann's Bay and Savanna-la-mar hospitals

- The establishment of a system both in hospitals and at the regional level, to routinely review all maternal deaths including the social factors pertaining to delays in seeking and accessing care.
- The change in legislation to make the Emergency Contraceptive Pill an over the counter (List 2) drug to improve access and help in reducing total fertility
- Development of a system of surveillance for maternal deaths following its classification as a Class 1 notifiable event in 1998
- Auditing of eclampsia cases at VJH since 2002 to review case management
- Distribution of WHO IMPAC guidelines on the Management of Obstetric Emergencies to all hospitals
- Conduction of a Criterion Based Clinical Audit of Obstetric care in the Type B hospitals
- Revision of the Obstetric Record in hospitals for improvement in data collection and analysis

Based on the Millennium Development Goal (MDG), Jamaica articulated a Reproductive Health Strategic Plan which sought to lower total fertility rate from 2.8 to 2.4 and MMR from 106 to 80 by the year 2005. Recent studies have shown that MMR in Jamaica is slowly trending downwards. At the end of 2005, the maternal mortality ratio for Jamaica was approximately 95 per 100,000 live births. The major causes of death continue to be hypertensive disease/ eclampsia, haemorrhage and sepsis. However, these direct causes have been declining over the past 4 years but indirect causes such as HIV/AIDS, violence, and other chronic conditions such as obesity, sickle cell disease and cardiac disease have been increasing.

Total fertility rate has also declined to 2.5 and of significance is the fact that teenage fertility has also shown a decrease from 112 per 1,000 to 79 per 1,000 as reported in the Reproductive Health Survey of 2002.

The results of the Maternal and Neonatal Program Effort Index (MNPI), a tool for assessing current health care services and tracking progress over time indicate that Jamaica has a relatively strong national policy on safe motherhood and well developed curricula for training health care providers. The MNPI ratings were made out of 100 and the results were as follows; service delivery 59; access to safe motherhood services 82, with an average of 72 for rural access and 89 for urban; care received 80, with average of 88 for newborn care, 75 for antenatal care and 76 for delivery care. Family planning services were rated at 76 and policy and support functions at 61 but commitment to policies was rated at 56. Policies regarding personnel capable of providing maternal health services were 78 and a similar rating was given for abortion complications.

The overall rating for maternal and neonatal health services was 69 compared to the average of 56 for the 49 countries involved in the MNPI study. These ratings indicate that in general, Jamaican women, despite the disparity in urban rural access and resource constraints, do have reasonable access to most types of

service. The most accessible services are newborn care and some family planning services.

Notwithstanding commendable progress, several challenges remain which threaten the achievement of Safe Motherhood targets. There remains a severe shortage of trained midwifery staff to manage pregnant women in the community and the hospitals. There are 46% of the cadre of public health nurses and 49% of the cadre of midwives at post with an annual attrition rate of some 15%.
Also of major concern are:

- Surveillance – timeliness, completeness and accuracy of reporting
- Provision of quality care – standardized national protocols for treatment and referral, inadequate use of the partograph, availability of adequate staff, supplies, blood products, equipment and transportation
- Health promotion – generating demand for services, appropriate health seeking behaviours and delays reduction, on-going public education, absence of a "goodwill ambassador" for Safe Motherhood
- Supportive policy environment – safe abortions, reorientation of services to use health auxiliaries to monitor labour and delivery

POLICY

The Policy framework for safe motherhood has been influenced by global initiatives to improve maternal and infant health in the context of equity, poverty reduction and human rights. The International Conference on Population and Development (ICPD) in Cairo saw governments pledging to reduce the number of maternal deaths by half by the year 2000 and in half again by 2015. In 2005 the Fourth World Conference on Women (FWCW) reiterated the ICPD commitments.

Globally, governments have agreed to undertake two main actions:

1. To develop a comprehensive national strategy to ensure universal access for all individuals and couples of appropriate ages throughout their life cycle to a full range of high quality, affordable sexual and reproductive health services, which include family planning, through the primary health care system and no later than 2015 with particular attention to maternal and emergency obstetric care especially in underserved areas; and

2. To establish or strengthen integrated safe motherhood programmes within the context of primary health care, with goals and target dates to reduce maternal mortality and morbidity by one half of 1990 levels by year 2000 and by a further one half by 2015.

Elements of Policy

Governments are obligated through their policy frameworks to address the causes of poor maternal health through their political, health and legal systems.

The policy framework should promote the provision of comprehensive reproductive health services which should include:

- Family planning services
- Counselling and information
- Education on safe motherhood
- Promotion of maternal nutrition
- Prenatal care and counselling
- Adequate delivery assistance in all cases by skilled persons
- Neonatal care including exclusive breastfeeding for six months
- Postnatal care
- Care for obstetric emergencies including referral for high risk pregnancy
- Childbirth, abortion complications and abortion related care.

Additionally, the framework should also facilitate sustainable capacity and infrastructure building with adequate staffing and the appropriate skills mix.

Major Challenges for Policy

The major challenges for policy are in the area of implementation. These challenges can include limitations in the degree of commitment to the policy; the provision of resources, human, financial and material for policy implementation and the availability of support functions for monitoring, evaluation and research. Deficiencies in these areas can stymie policy implementation.

Objectives

The objectives for the Safe Motherhood Programme are embodied in the 2000 United Nations Millennium Development Goals. They are aimed at poverty reduction and are built upon the agreements and commitments that governments made in the 1990s at the ICPD and FWCW Conferences. The specific maternal and child mortality goals are:

1. Reduction of maternal mortality ratios by three quarters by the year 2015

2. Provision of access to reproductive health services by 2015 and

3. Reduction of infant and child mortality rates by two thirds by 2015

Strategies

The major strategy is to strengthen reproductive health and family planning policies and improve planning and resource allocation.

In spite of the strong maternal health policies demonstrated by the MNPI, there are gaps in policy implementation which should be identified and examined to determine the most appropriate action to be taken. The following strategies are required to facilitate improved policy adoption and implementation:

1. Determination of the feasibility of policy implementation against availability and application of resources, in particular, their sufficiency and efficiency
2. Identification of operational barriers to policy financing and implementation and measures for resolution
3. Develop advocacy measures to strengthen policies and increase the allocation of resources
4. Promote commitment to policy by engaging the public through media statements by key government officials

QUALITY OF CARE

Safe motherhood implies the ability of a woman to undertake pregnancy, and childbirth, if and when desired, without injury to herself or her child. Evidence shows that motherhood can be made safer for all women (Ransom and Yinger, 2002). To ensure this, women must have access to and use high quality obstetric care throughout their pregnancy, but especially during and immediately after childbirth when most complications arise. Therefore, not only should this care be available but women should be able to reach such care and have skilled care givers respond appropriately in a timely fashion.

Elements of Quality of Care

Strategic elements for Provision of Safe Motherhood services are Essential Obstetric Care (EOC), skilled care givers and high quality care. EOC should be provided at two levels: Basic EOC and Comprehensive EOC. Basic EOC must be available for all women. Requirements include a birthing facility with a suitably trained care giver, appropriate supplies and a system for rapid transfer of the client to Comprehensive care, including fully equipped ambulances in all regions, should complications arise. Comprehensive EOC provides interventions for high risk pregnancies and complications during and following delivery to include the requirements for surgical and specialist interventions

Another and perhaps the most critical element for Safe Motherhood is a skilled care giver who must be able to manage normal labour and delivery, recognize the onset of complications, begin emergency care and oversee the transfer of the

client to more specialised care. The attendant must have access to an effective and efficient referral system and appropriate transportation options.

Quality of care is based on adequacy, appropriateness of care and client satisfaction. The skilled attendant is supported by an enabling environment that includes adequate supplies, equipment, infrastructure, the use of appropriate technology, efficient referral, communication and transportation.

Ensuring Quality of Care

Requirements to ensure quality of care for Safe Motherhood (Ransom and Yinger, 2002) include:

- Upgrading the quality of the care at health facilities to include providers' technical and interpersonal skills, motivation and performance
- Establishing national protocols for treating common obstetric emergencies
- Training health personnel in the early recognition of complications
- Providing adequate and sustainable amounts of drugs, blood products, supplies, equipment and staff
- Providing 24 hour emergency obstetric care
- Ensuring effective and efficient communication between communities and health facilities, within and between different levels of health care facilities
- Including practical aspects of treating obstetric emergencies in the curricula of health providers

Major Challenges for Quality of Care in Jamaica

The major challenges identified in the provision of high quality obstetric care in Jamaica are inadequate clinical and managerial governance; limited access to service sites for both provider and client; inadequate resources including staff, equipment, blood products and supplies; new and relatively inexperienced Regional Maternal-Perinatal Mortality Committees; inefficient implementation of the referral system; socio-economic factors which strain resources in the health sector; and inadequate customer service.

Objective

The major objective is to reduce maternal mortality and morbidity by creating an enabling environment for the provision of widely accessible high quality obstetric care.

Strategies

The strategies are focused on standardizing care, building staff skills, providing resources and ensuring access to care. The specific strategies are:

1. Standardize the quality of care for all pregnant women
2. Provide skilled health care personnel capable of detecting and caring for maternal problems and emergencies
3. Increase the availability of safe blood and blood products
4. Ensure available, realistic staff cadres according to level of health care facility
5. Upgrade infrastructure, equipment and supplies in keeping with changing requirements and technology
6. Determine and implement minimum requirements for Safe Motherhood at each service level
7. Enable direct and rapid communication between and among health workers in different facilities
8. Improve the speed and efficiency of transportation between health facilities
9. Develop a plan to ensure quality obstetric care during/following disasters for example an influenza epidemic

SURVEILLANCE

Surveillance is essentially a process which provides timely information/monitoring through ongoing and systematic collection, analysis and interpretation of outcome specific data, in this case maternal mortality, for use in planning, implementation and evaluation of public health practices. Maternal mortality and morbidity are of major public health concern and their occurrence requires specific actions for reduction.

Surveillance of maternal mortality allows for trends and outcomes to be analysed, strategies to be developed to improve outcomes, the evaluation of interventions applied, improvements in data quality and collection and the identification of risk factors and risk groups. Surveillance is an important tool which if used consistently and effectively can contribute to significant reductions in the underreporting of maternal mortality, misclassification of maternal deaths and evaluation of obstetric care.

Elements of the Surveillance System

Defined structures and processes are required to support ongoing surveillance. In that regard there are four main elements that are essential for the functioning of the system:

1. Definition of the selected health related events under surveillance and their public health importance
2. The defined purpose and objectives of the surveillance system, which generally are to prevent, protect, control and facilitate response to the health event

3. Components and processes of the system to facilitate timely detection, reporting and assessment at the various administrative levels on the events
4. Resources – human, financial and technical- to operate the system.

The Surveillance Process

The surveillance process can be outlined in eight basic steps that are widely applicable to the evaluation of any public health concern including maternal mortality. The steps are sequential and each is essential for the efficient and effective operation of the surveillance system. The eight identified steps are as follows:

i. Routine collection of basic demographic data
ii. Design and use of a user friendly system for systematic essential data collection. This requires clear definition of the essential data.
iii. Identify and train personnel to operate the system
iv. Implement specific reporting procedures within and among system levels
v. Analyse data to determine trends and outcomes
vi. Implement programmes/interventions based on the analysis
vii. Assess programme process by monitoring and evaluating its responsiveness, efficiency and effectiveness etc.
viii. Utilise the findings/feedback to improve assessment capability and the surveillance system

Major Challenges in the Surveillance System

The major challenges identified in the Jamaican surveillance of maternal mortality is the limited compliance with the requirement to within 24 hours give notification of maternal deaths and the absence of a standardised mechanism at regional and national levels for conducting surveillance that will lead more easily to the identification of gaps and converting this knowledge into action. In order to improve the situation the following objective and related strategies were identified:

Objective:

To strengthen the process of case identification, analysis and review by standardizing and improving the efficiency of surveillance at the regional and national levels

Strategies

The strategies to reduce the identified time lag are threefold and are focused on measures to address critical inputs relating to staff, guidelines, institutional collaboration and data collection systems.

The specific strategies to be undertaken are as follows:

1. Re-sensitize health staff and other stakeholders to the importance of and complying with the notification of maternal deaths within 24 hours

2. Establish clear case definition and procedures for surveillance of maternal death and promote its adherence among health staff

3. Improve active case finding by implementing the following actions:
    - Identification and submission by the Medical Records Officer of the dockets of all women 10-50 years who have died for weekly review by the HAS Officer
    - Strengthen alliances and liaison both internally in the Ministry of Health with the Standards and Regulation Unit, Medical Officers of Health, and National Surveillance Unit, as well as with the private sector health institutions, funeral parlours and the forensic pathologist.
    - Conduct a review of the case finding and reporting process to increase its efficiency. The recommended process for the communication on maternal deaths among the HAS Officer, Medical Officer of Health, Senior/ Public Health Nurses, Regional Surveillance Officer/Epidemiologist and Regional Technical Director is outlined in Maternal Mortality Clinical Summary, Appendix A.
    - Review and revise the data collection process including forms to provide more comprehensive and relevant data/information. In this regard the development of four forms is recommended. The respective forms are identified below and drafts of each are appended at Appendices B-E.

    i. Maternal Mortality Home Visit and Antenatal Report to be completed by the public health nurse or hospital midwife conducting the visit. See Appendix B.
    ii. Maternal Mortality Case Review Summary to be completed by the doctor or obstetrician who was in attendance. See Appendix C.
    iii. Maternal Mortality Post mortem Summary to be completed by the pathologist or regional surveillance officer and a copy of the report attached. See Appendix D.
    iv. Maternal Mortality Registrar General's Department Notification List Review. See Appendix E.

HEALTH PROMOTION

Health Promotion seeks to promote healthy lifestyles in target populations and to focus on preventable risks. Health promotion in the context of safe motherhood sets out to empower women, families and communities, to take action to ensure that women go through pregnancy, labour and delivery without harm to themselves or their child.

Elements of Health Promotion

Three main strategies are employed in Health Promotion. They are:

- enabling individuals and communities
- creating supportive environments; and
- advocacy to create the essential conditions for health (WHO/AFRO, 2002).

Enabling individuals and communities seeks to equip women with the information and skills to make their own choices and decisions to prevent ill health, enhance and protect healthy behaviour. It therefore allows them to exercise their rights to safe motherhood. Armed with the requisite knowledge and skills women are more likely to take responsibility for their own health and that of their unborn children. They will be empowered to demand high quality care for themselves, their families and communities (26th Pan American Sanitary Conference, 2002). Enabling is achieved mainly through health education, information, education and communication (IEC) and social mobilization which will allow the woman to follow doctor's orders, recognize danger signals in pregnancy and take the appropriate action. She will also be knowledgeable about where services are available and how to access them in a timely manner.

To encourage a supportive environment for the woman, safe motherhood health promotion programmes should involve fathers, family members and the community in recognising the danger signals and facilitating access to care. It also provides opportunities for communities to understand the issues of Safe Motherhood and mobilize and agitate for resources.

Advocacy is designed to garner political commitment and support, social acceptance and systems support (WHO/AFRO, 2002) for safe motherhood. It is usually carried out through activities such as lobbying, social marketing, information, education and communication (IEC) and community organizing. A well designed advocacy programme can be an important measure to push for the institution and maintenance of the essential conditions for maternal health throughout the health system.

Major Challenges for Health Promotion

The major challenges identified for Safe Motherhood health promotion in Jamaica are:

- inadequate education on safe motherhood for provider, client and the public
- less than optimum provider client interaction
- poor health seeking behaviour on the part of clients
- inefficient implementation of referral protocols and
- gender bias in the approach to the promotion of safe motherhood.

Objectives

Major objectives are to increase education, information and communication on safe motherhood among clients and the general public and to empower women, families and communities to participate in Safe Motherhood initiatives to reduce maternal mortality and mortality.

Strategies

Strategies to empower women, families and communities towards Safe Motherhood include improving their health-seeking behaviour through strengthening knowledge & skills, building a supportive environment and strengthening linkages among stakeholders.

Specific strategies to be undertaken are:

1. Learn from and build on previous research to inform Safe Motherhood health promotion

2. Adopt a life-cycle and a team approach to Safe Motherhood health promotion

3. Design and conduct a Public Education Campaign, via existing media and technology, to increase individual health seeking behaviours and inform about emergency obstetric care

4. Promote effective, efficient referral in the health system

5. Promote a client friendly environment at all health facilities

6. Reorient health services to promote increased participation of men and communities in safe motherhood programmes

7. Lobby for the implementation of agreed Safe Motherhood initiatives in the public and private sectors

8. Advocate and lobby for an improved regulatory framework to support Safe Motherhood

9. Promote links and partnerships between health and non-health sectors to promote Safe Motherhood

10. Use of a “goodwill ambassador” for safe motherhood

11. Use of an educational take home record for pregnant women

The Ministry of Health National Strategic Plan 2007-2010 is based on Government of Jamaica national development policies and regional and international health and development guidelines and incorporates strategies and actions for the achievement of safe motherhood. The Plan utilises an integrated and lifecycle approach to population wellbeing and health. The cumulative effect of other policies and actions relating to the management of the health systems, physical environment, individual health, human resources, population health, equity and wellness promotion will facilitate and support progress towards the defined targets for safe motherhood by 2011.

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
SWOT ANALYSIS
POLICY

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Government's commitment to achieving MDGs # 4 and 5 Good infrastructure – basic core services (antenatal clinics etc.) through a network of some 345 health centres and 18 hospitals	Staff shortage especially of midwives and public health nurses Reliable transportation services lacking - shortage of ambulances Human resource management re: - Adequate staff management - Staff assignment and utilisation - Competency for the identification of patients at risk -In-service training protocols absent Referral Issues - Private referral to public health care system (use of blue card) lacks standardisation Councils – Nursing, Medical in terms of their contribution to policy etc. Access to care difficult – distance, terrain, operational clinic hours Basic comprehensive minimum services lacking in some facilities Implementation of user fees prohibitive for preventive services	Availability of Donor Support Agreement to adopt Millennium Development Goals Existence of Councils – Medical and Nursing etc. Establishment of a working group on Abortion Policy Establishment of a National maternal Mortality Committee Discussion on managed migration of health care workers	Continued existence of a high level of STI/HIV infection and their debilitating effects on mothers and children Limitation in access to medication for HIV/AIDS and other chronic conditions due to the cost of drugs Non-adherence/non-compliance by clients to the required attendance at health facilities or drug regimes Economic constraints in the national economy which place limits on the financial allocation to the health sector and resources requiring significant foreign exchange output.

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
SWOT ANALYSIS
QUALITY OF CARE

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Presence of a cadre of skilled care givers, for example obstetricians and midwives, in both the public and private health sectors Well established and organized health care infrastructure at Primary and Secondary levels distributed islandwide Existence of excellent policy and practice guidelines • Population Policy • Jamaica 2015: A framework and action plan for improving effectiveness, collaboration and accountability in the delivery of social policy • MCH Manuals Established, effective Referral System	Inadequate Clinical & Managerial Governance in both the public and private health sectors resulting in: • Communication barriers between primary and secondary care facilities • Poor linkages between health programmes, institutions, providers and public and private sectors • Non-adherence to established protocols by providers and clients Limited access to service sites for both provider and client because of poor public transportation system and high cost of transportation Inadequacy of resources - staff, equipment, and supplies - which compromises quality of care	Training to increase clinical and managerial capacity Obstetric manual in development VJH Guidelines for Management of Obstetric Emergencies can be used as framework for national guidelines Modernize communication systems for primary and secondary health care facilities Reorient and reorganize Maternal and Child Health Care Increase recruitment, remuneration and incentives for qualified personnel to stem attrition and fill vacancies in the short term	Migration of skilled and experienced health care personnel to countries with better economies such as USA, Canada, England, Cayman Islands deplete local human resources The Caribbean Single Market, offering the free movement of skilled personnel, is likely to further deplete local human resources Natural disasters, such as hurricanes and floods, damage health and other infrastructure, cause dislocation and • negatively impact service delivery • impede access to facilities by staff and clients Inconsistencies/gaps between existing standards & practice

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
SWOT ANALYSIS
QUALITY OF CARE (contd.)

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Strong political commitment to and support for Safe Motherhood	• 52.5% midwifery posts filled • 54% PHN posts filled • 137.5% medical posts filled • 73.8% Registered Nursing posts filled • Inadequate supplies of blood & blood products • Long waiting hours Inadequately functioning Regional Maternal-Perinatal Mortality Committees Inefficient implementation of referral system between primary and secondary care and between public and private health sectors Socio-economic factors, such as violence and unemployment, which strain resources in the health sector Inadequate customer service associated with negative attitudes and behaviour of clients, providers and gatekeepers	Train larger numbers of health care personnel in the medium to long term to satisfy local and overseas demand • Establishment of new school of midwifery at Spanish Town Hospital • Scholarships for nurses through NHF support Strengthen all Regional Maternal-Perinatal Mortality Committees Establish National Maternal Mortality Committee Review and streamline referral system Advocate for improved socio-economic conditions Educate clients, providers and gatekeepers about rights and responsibilities Reorient the Health Education Programme to include issues of safe motherhood Commitment of support from UN Agencies – PAHO, UNFPA, UNICEF	Administrative and technical support not always forthcoming Violence which limits access to care, increases health care costs and negatively impacts mortality and morbidity statistics Limitation in budgetary allocation due to economic constraints

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
SWOT ANALYSIS
SURVEILLANCE

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Established surveillance system: - maternal death a Class 1 Notifiable Health Event - Hospital Active Surveillance (HAS) in place Established National Maternal Mortality Committee Participation of some private institutions in surveillance Some policies in place to facilitate case diagnosis, for example, post mortems on all maternal deaths Maternal Mortality Review Committees in Regional health Authorities	Incomplete case finding Inadequate/incomplete and late case reporting and investigation Untimely case review and assessment Gaps in the data collection forms - upgrading needed Absence of standard database to facilitate appropriate data management Low compliance – e.g. reporting of maternal deaths as a Class 1 Health Event	Establishment of Standards and Regulation Branch to regulate, monitor, licence private maternity centres Available MOH and MIS Department websites to facilitate data management Existence of professional organisations, for example, Medical Association (MAJ), Association of General Practitioners (AGP), GRABHAM Society to facilitate alliances with private sector caregivers Increased advocacy for addressing issues of unsafe abortions Development of reporting system from the community level upwards	Lack of political will to address issues of unsafe abortions Inadequate integration between public sector primary and secondary care facilities Inadequate collaboration between public and private health care institutions Inadequate resources, especially, human resources Non-compliance with policies Medico-legal issues and concerns – ongoing and new

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
SWOT ANALYSIS
HEALTH PROMOTION

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Existence of a national health promotion policy and manual Initiatives to institutionalize Health and Family Life Education at all levels of the Education System Availability of good Safe Motherhood educational material, for example Act Now Cards Good local and international research data showing maternal mortality and morbidity trends, best practices and cost effective strategies Good infrastructure to facilitate health promotion activities Political commitment to and support for safe motherhood on the part of the MOH Existing alliances with entities such as the Coalition for Better Parenting, Early Childhood Commission, National Health Advisory Committee, etc. that facilitate dissemination of safe motherhood information	Current Health Promotion Policy does not include Safe Motherhood Education policy does not prepare children for safe motherhood Inadequate emphasis on health promotion for safe motherhood in provider training programmes Lack of emphasis on counselling for promotion of safe motherhood in provider client interaction Poor health seeking behaviour on the part of clients which results in delay in obtaining Essential Obstetric Care Inefficient implementation of referral services and lack of feedback which negatively impact health promotion activities Gatekeepers, for example security guards, obstruct access to care thus negating health promotion efforts	Prepare family health manual to focus on safe motherhood Integrate safe motherhood into • the National Health Promotion Policy • Health and Family Life Education in schools • Workplace and community health promotion programmes Educate the public on rights and responsibilities for safe motherhood including male involvement Health workers can reclaim position of influence in the community through greater involvement with institutions and groups Intra and intersectoral collaboration • Partnering with HIV/AIDS programmes to promote safe motherhood • Collaboration with the Ministry of Education in Health and Family Life Education	Lack of human and financial resources which curtail programmes Litigation arising from increased awareness of rights on the part of clients

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
SWOT ANALYSIS
HEALTH PROMOTION (contd.)

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Peer Educators in communities Experienced Health Educators at Parish level	Gender bias in the approach to the promotion of safe motherhood with little emphasis on the role of men Poor attitudes of health care providers	• Creation of alliances with the media Planned merger of Health Promotion/Education and Public Relations Unit Access to experienced behaviour change communication team at the Ministry of Health because of HIV programme Commitment for support from UN agencies	

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
POLICY

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
Reduce Jamaica's maternal mortality ratio (MMR) by 75% to 25-26 maternal deaths per 100,000 live births by the year 2015	To provide a legal and regulatory framework for the delivery of safe motherhood services that is accessible, equitable, cost effective, sustainable, of high quality and is protective of the human rights of all pregnant women	Policy Development: - Identify areas requiring new Policy guidelines informed by research, audits, advocacy etc. - Identify modifications needed in existing policies - Co-ordinate with the promotion component of the Safe Motherhood Programme to provide information and education on policy measures and initiatives to all stakeholders and to obtain feedback.	Develop relevant policies to impact quality of care, surveillance and promotion aspects. For example outline policy guidelines for the development of norms and standards of care Collaborate with the surveillance and promotional areas of the Safe Motherhood programme to ensure policy implementation Develop an implementation framework to guide RHAs	2008 2007 2008	Ministry of Health (HSP & I Division)
	To improve the quality of data on the causes of maternal deaths to enable appropriate interventions to reduce mortality	Revitalize existing policy for maternal deaths to have post mortems	Ensure the performance of post mortems on all maternal deaths	2007	Ministry of Health (FHS, HP/E, Surveillance Units)

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
POLICY (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
Reduction of maternal mortality in the postpartum and post abortion period	To provide adequate postpartum and post abortion care within defined time periods to reduce their morbidity and mortality	Development of specific policy provisions to improve the quality of care in the postpartum and post abortion period	Develop policies to provide for: 1. Home visiting within 6 days for women post delivery 2. Review within 2 weeks by a health care worker of low risk women who delivered Advocate for legislation to prevent unsafe abortions	January 2008 January 2008 December 2009	Ministry of Health/Regional Health Authority (RHA) Ministry of Health
Reduction of maternal mortality during the period of delivery	Development of a policy to guide the provision of skilled attendants at all births.	Determine the skills and capacity of the skilled attendants that must be present at all births.	Develop policies that address qualification, certification and standardization of midwifery tutors. This policy must be informed by a review of the current midwifery curriculum which should be revised to reflect the evidence base of Jamaica's maternal and perinatal mortality and morbidity data.	2010	Ministry of Health (HRM & CS) Office of the CNO and Nursing Council

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
POLICY (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
	Review and revise the Human Resource Policy for nursing and midwifery to ensure consistency with identified gaps re training needs and skills etc. to improve maternal health	Develop the policies to address critical areas of human resource such as: - Manpower plan - Competencies - Curriculum content - Career path - Deployment/distribution - Managed Migration - Skills mix & use of auxiliaries	Develop policy guidelines for: - Required staffing at the various levels of the health system to achieve and maintain safe motherhood - Placement and distribution of nurse midwives, midwives and CHAs - Retention of nurse midwives, midwives and CHAs - Curriculum content/competencies - Career path.	2007/2008	Ministry of Health (HRM & CS, Office of the CNO) NAJ
	Monitor and evaluate the implementation of all safe motherhood policies to determine their efficacy and contribution in reducing maternal morbidity and mortality	Determine the critical personnel and data for assessing policy implementation in antenatal and maternal services and facilities	Identify the criteria and the frequency of review to assess safe motherhood policy implementation Design and implement monitoring and evaluation plan	2009	Ministry of Health/Regional Health Authority (RHA)

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
QUALITY OF CARE

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
To achieve millennium maternal mortality ratio target of 25-26 maternal deaths per 100,000 live births by the year 2015	To reduce Maternal mortality and morbidity in keeping with the timeframes set by the Millennium Development Goals Given the slow downward trend in Jamaica's MMR and the ratio of 95 per 100,000 live births in 2005, realistic MMR targets are: 76/100,000 by 2008 60/100,000 by 2010 42/100,000 by 2015 25/100,000 by 2020 The Ministry of Health National Strategic Plan 2007-2010 projects a MMR of 80/100,000 by 2011	Development of norms and standards for quality of care given to all pregnant women. Capacity building to eensure the ability to detect and care for maternal complications and emergencies	Develop National Protocols for managing common Obstetric emergencies and conditions (see Appendix) Train and continuously upgrade skills of all obstetric staff Strengthen Regional Maternal and Perinatal Mortality Committees Train staff to detect and respond appropriately to problems during labour and delivery Ensure ready availability of Medical and Surgical consultations 24 hours every day Equip Comprehensive EOC facilities to do C/Sections within 30 minutes of decision.	September 2007 Ongoing December 2007 2008-Ongoing 2007 2008/2009	Grabham Society Ministry of Health, RHA/MOH RHA/MOH RHA RHA RHA

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
QUALITY OF CARE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
			Provide anaesthesia, blood bank, laboratory, ultra-sound, and radiology services 24 hrs every day at Comprehensive EOC facilities (Type B hospitals & above)	2010	MOH/RHA
			Establish domiciliary units in all hospitals for follow up of all high risk discharges	2008	MOH/NBTS/RHA
		Provision of supplies and staff to increase the availability of safe blood island wide	Provide equipment for blood donation and storage at all type A,B,C delivery facilities in collaboration with	2008/2009	MOH/NBTS
		The Ministry of Health National Strategic Plan 2007-2010 blood collection targets are: 30,000 units 2006-2007 5% increase 2007-2008 and 2008-2009 35,000 Units 2009-2010 37,500 units 2010-2011	National Blood Transfusion Service	2008/2009	MOH/NBTS
			Ensure adequate staff to man blood donation sites	Ongoing	RHA
			Encourage fathers to be donors		

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
QUALITY OF CARE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
		Build the capacity and numbers of skilled attendants through training, upgrading skills and recruitment of midwives and staff nurses/midwives The Ministry of Health National Strategic Plan 2007-2010 targets 95% coverage of pregnant women delivered by trained personnel and 70% post-natal coverage by 2011	Review midwifery curriculum to reflect the evidence base of Jamaica's maternal and perinatal mortality and morbidity data. Provide continuous education of midwives to include annual refresher courses Improve remuneration, working conditions and incentives to encourage staff retention	2010 2007 2008/2009	MOH RHA MOH
		Manpower planning to provide realistic staff cadre according to the level of health care facility The Ministry of Health National Strategic Plan 2007-2010 has indicated targets to increase cadre to align it with excess numbers of doctors and nurses as well as to reduce vacancies for nurses and midwives	Review and revise the placement of midwives and nurse/midwives to increase efficiency and effectiveness in delivery of maternal care Recruit additional midwives and staff nurses/midwives Identify the ideal cadre for each level of and individual Health facility based on international guidelines for ratio of staff to pregnant women and deliveries per facility	2007- 2008 2007-2011 2009	MOH/RHA MOH/RHA MOH (Dir HRM&CS/ CNO)

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
QUALITY OF CARE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
			Identify shortfall in staffing levels for each level and individual facility	2007-2008	RHA
			Provide optimum ratio of staff to patients at each facility	2010	MOH/RHA
	To ensure that every Health care facility has appropriate infrastructure, equipment and supplies for maternal and perinatal care	Infrastructure development to ensure that determined minimum requirements are in place at each service level.	Inspect physical plants at all primary and secondary health care facilities and identify and document their needs	2008	RHA
			Upgrade and continue maintenance of the facilities	Ongoing	RHA
			Determine and provide vital equipment, drugs and supplies required for antenatal, intrapartum and postnatal care at each service level	2008-2010	RHA
	To improve communication between health facilities	Strengthening of technology	Have IT specialist evaluate the communication system and procure equipment accordingly	2008	Ministry of Health/ RHA
		Enable direct and rapid communication among health workers in different facilities	Modernize the telephone systems in keeping with identified needs	2008	RHA

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
QUALITY OF CARE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
			Revise and standardize referral forms to provide essential, relevant information	2008	MOH
			Train all health care providers in referral protocols	2008	RHA
			Update and distribute maternal record books to include private antenatal care providers	June 2007	MOH/RHAs
		Improve the speed and efficiency of transportation between health facilities.	Identify required financial and human resources	2007	MOH
			Increase the fleet of ambulances	2008	MOH
			Equip the ambulances with ventilator, oxygen, suction and vital signs monitors.	2008	MOH/RHA
			Have a minimum of two skilled persons accompany patient; (emergency personnel and RN/midwife)	2007	MOH/RHA

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
SURVEILLANCE

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
MMR of 25-26 per 100,000 Live Births by 2015	Improve timeliness of case notification	Re-sensitize hospital staff and other stakeholders through training programmes to comply with notification requirements for maternal deaths Revise case definition for surveillance and promote its adherence	Implement 2 re-sensitisation sessions per year in each RHA	2007- 2011 July 2007	Regional Health Authorities – Regional Technical Directors National Maternal Mortality Committee
	Improve active case finding and investigation	Implement new guidelines for case finding and reporting Standardisation of the process for case finding	Review and adapt reporting chain guidelines including the identification of responsible officers and time frames. (Appendix 1) Review and adapt investigation procedures Improve case finding by: Reservation by Medical Records Officer of the dockets of all deaths of women 10-50 years old for review by the HAS Officer on a weekly basis	July 2007 2007 -2011	National Maternal Mortality Committee Regional Health Authorities – Regional Technical Directors Regional Health Authorities – Regional Technical Directors Parishes – MOH, SMO Medical Records Supervisor

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
SURVEILLANCE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
			Strengthen alliances with private providers of maternal care through	2007 -2011	National Maternal Mortality Committee Family Health Services Unit
			- Routine training and sensitisation through MAJ, AGP Regional meetings	2007 - 2011	Standards and Regulations –MOH Regional Technical Directors
			- Involvement in annual Meetings and case reviews as appropriate	2007 (June)	RHAs/ MOH
			- Development of guidelines for high risk referral and monitoring	2007 -2011	National Maternal Mortality Committee
			- Development of alliances with funeral parlours to notify health departments re deaths of women 10-50 years of age	January 2007 -2011	Regional Health Authorities – Regional Technical Directors Parish MOs(H)
			- Liaising with DMO and forensic pathologist for post mortems	2007 - 2011	RHAs Regional Technical Directors Parish MOs(H)
			Provide updates and continuing education for forensic pathologists		MOH

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
SURVEILLANCE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
	Improve case review and reporting	Develop terms of reference for regional case review meetings and maternal mortality review	Develop terms of reference for National maternal mortality reviews Implement revised data collection forms (Appendices B-E): - Maternal Mortality Home Visit and Antenatal Report - Maternal Mortality Case Review Summary - Maternal Mortality Post Mortem Summary. - Maternal Mortality Registrar General's Department Notification List Review forms Develop appropriate software/database to collect, analyse and disseminate data/ information	July 2007 January 2007 June 2007	National Maternal Mortality Committee Regional Technical Director Regional Epidemiologist (SERHA) MIS

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
SURVEILLANCE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
			Develop mechanisms to monitor and review recommendations and targets (of national & regional reviews)	December 2007	National Maternal Mortality Committee MOH - SITU
			Establish webpage on the MOH website with surveillance tools, i.e. data base forms, analyzed data etc.	January 2008 -2011	National Maternal Mortality Committee MOH - SITU
			Maintain and update webpage	2008-2011	MOH - SITU
	Improve death certification process	Monitoring (ongoing)	Review death certificates of all maternal deaths to ensure accurate reporting	January 2007 -2011	Parish – MOs(H), SMO Medical Records Supervisor Regional Maternal Mortality Committees
			Share confirmed case listing with the Registrar General's Department (RGD).	January 2007 -2011	National Mortality Committee Surveillance Unit – National Surveillance Officer
	Strengthen record management	Improve record storage and archiving of death dockets	Acquire appropriate record storage equipment Assign personnel and provide guidelines for storage of records and dockets	January 2008 -2011	Regional Health Authorities – Regional Directors Parish - MOs(H), CEO and PM

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
SURVEILLANCE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITY
	Improve utilisation of maternal mortality and morbidity information for strengthening programme management	Ongoing monitoring and evaluation for programme development	Clarify goals and objectives of routine maternal mortality review	July 2007	Regional Health Authorities – Regional Technical Directors
			Examine/develop programmes to address avoidable factors identified	January 2007 -2011	Regional maternal Mortality Committee
			Develop guidelines for near miss surveillance	July 2007	National Maternal Mortality Committee
			Regions with less than 3 deaths per quarter to include near-miss surveillance of leading complications of pregnancy especially eclampsia, haemorrhage and puerperal sepsis	January 2008 -2011	Regional Health Authorities – Regional Technical Directors Regional Maternal Mortality Committees
	Train and sensitise the community and health personnel on the importance of surveillance	Public education and Training	Sensitise the public on the reasons and purpose of surveillance of maternal deaths	2008 -2011	MOH, RHAs
			Engage and promote community co-operation in the reporting of maternal deaths and identification of areas for skill improvement in the delivery of maternal health	January 2008 -2011	RHAs – Regional Technical Directors Regional Epidemiologist/RSO Regional Health Promotion Specialist/ Officer Parish MOH

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
SURVEILLANCE (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITIES
			Sensitise primary and secondary care personnel on the reasons and purpose of surveillance as well as to: - Their roles and responsibilities - The use of reporting forms, database and software - The reporting format - Time frame for reporting	January 2007 -2011	Regional Health Authorities – Regional Technical Directors Regional Epidemiologist/RSO Regional Health Promotion Specialist/ Officer Parish MOH
	Improve monitoring and evaluation of the surveillance system	Stakeholder Feedback Disseminate comprehensive case summaries to MOH, parish of residence and institution of death for information and action Conduct independent surveys of maternal mortality every 2-3 years to evaluate surveillance system	Put in place a system to monitor the submission, address gaps and follow-up action on the comprehensive case summaries forwarded to MOH, health departments and institution of Discuss and review findings of the maternal mortality survey to identify gaps, strengths and the actions to be taken.	January 2007 -2011 2007 -2011	Regional Health Authorities – Regional Technical Directors Regional Epidemiologist/RSO National Surveillance Officer National Maternal Mortality Committee

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD
STRATEGIC FRAMEWORK
HEALTH PROMOTION

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITIES
To contribute to the decrease of maternal morbidity and mortality in keeping with the MDG by application of health promotion strategies	To improve health-seeking knowledge & skills of the population relating to Safe Motherhood	Learn from and build on previous research studies in the areas of: • Surveillance • Reproductive Health • Maternal mortality and morbidity outcomes • Safe Motherhood best practices	Conduct periodic workshops to update staff on new findings	Ongoing	MOH/RHA
			Conduct research on facilities utilization, client satisfaction, and best practices etc. and use the results to provide feedback for policy development, modification, and improvements in quality of care, surveillance and promotional programmes	Ongoing	MOH/RHA
			Encourage staff to participate in continuing education activities	Ongoing	RHA
		Adopt a life-cycle approach to health promotion	Conduct evidence-based interventions for different stages of the lifecycle, e.g. HFLE for pre-adolescent/adolescent/youth/ older persons	2008-2011	MOH/RHA
			Train peer educators to work with special groups on issues of safe motherhood • Adolescents • Men • PLWHAs	2008-2009	MOH - H P& P

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD

STRATEGIC FRAMEWORK
HEALTH PROMOTION (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITIES
	To empower women, families and communities to participate in Safe Motherhood initiatives to reduce maternal mortality and morbidity	Conduct a Public Education Campaign via existing media and technology to build individual health seeking behaviours and impact safe motherhood skills	Develop culturally sensitive communication materials for clients to include messages about when to access care, high risk conditions (obesity, elderly mothers, cardiac pts. etc.), sites for attended birth and available transportation options	2008	MOH – HP&P
			Develop key standardized health messages on safe motherhood for the general public.	2008	MOH – HP&P
		Reorient health services to promote increased participation of men in safe motherhood	Train all health care providers in ethics and communication skills	2008	MOH/RHA/Parishes
			Train health personnel to communicate with men about safe motherhood	2008	MOH/RHA/Parishes
			Sensitize men about their role in personal and family health and responsibility in safe motherhood including at the workplace and community	2008-2011	MOH/RHAs
			Promote the attendance of spouses at antenatal and postnatal clinics and at deliveries.	2007-2011	RHAs/Parish Health Depts.

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD

STRATEGIC FRAMEWORK
HEALTH PROMOTION (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITIES
	To promote effective utilization of emergency obstetric care	Institute Public Education Campaign about emergency obstetric care	Develop key standardized health messages for the public about dangers signs in pregnancy e.g. bleeding, epigastric pain, flashing lights	2007	MOH – HP&P
			Provide Public Service Announcements regarding use of emergency obstetric services	2008-2011	MOH/RHAs/Parish Health Depts.
			Sensitize the public about responsibility for own care	2008-2011	MOH/RHAs/Parish Health Depts.
		Promote client centredness at all health facilities	Develop a profile of good customer services for implementation at all facilities	2008	MOH/RHAs/Parish Health Depts.
			Promote customer service training for all health personnel	2008-2011	MOH/RHAs/Parish Health Depts.
			Sensitize health care workers about patient access issues	2008-2011	MOH/RHAs/Parish Health Depts.
			Advocate for the development of “waiting” facilities in close proximity to hospitals for use by pregnant women during natural or man-made disasters, for example, hurricanes.	2007-2008	MOH/RHAs

STRATEGIC FRAMEWORK FOR SAFE MOTHERHOOD

STRATEGIC FRAMEWORK
HEALTH PROMOTION (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITIES
	Promote improved postpartum and post-abortion care	Promote effective, efficient referral systems	Advocate for development of user-friendly referral form	2007-2008	MOH-HSP&I/RHAs
			Promote links with clients at community level via community health workers.	2007-2011	MOH/RHAs/Parish Health Depts.
		Institute Public Education Campaign about safe postpartum and post abortion care using existing media and technology	Develop key standardized health messages for the public about postpartum and post-abortion care	2007	MOH-HP&P
			Build individual knowledge and promote appropriate behaviours through education about danger signals following delivery and abortion	2008-2011	MOH/RHAs/Parish Health Depts.
	To strengthen inter and intra-sectoral collaboration for the promotion of Safe Motherhood	Promote links with health and non-health sectors	Convene an advocacy committee of stakeholders to lobby for development of safe abortion policy	2007-2008	MOH/ National Maternal Mortality Committee
			Form a health promotion advocacy group for Safe Motherhood	2008	MOH – HP&P/FHU

STRATEGIC FRAMEWORK
HEALTH PROMOTION (contd.)

GOAL	OBJECTIVES	STRATEGIES	KEY ACTIVITIES	TIME FRAME	RESPONSIBILITIES
			Advocate for the review of roles and authorities of Councils and professional bodies in relation to quality assurance for safe motherhood.	2008	MOH
		Forge partnerships for promoting Safe Motherhood	Integrate safe motherhood messages into family planning , dental, MCH, curative services, environmental health (PHI)	2007-2011	MOH/NFPB
			Partner with HIV/AIDS, Violence prevention, Chronic NCD programmes, NFPB, Disabilities Commission, Women's Groups private sector and other agencies to promote safe motherhood	2007-2011	MOH-HP&P/FHU

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APPENDIX A

MINISTRY OF HEALTH

JAMAICA

MATERNAL MORTALITY CLINICAL SUMMARY

Data will be collected on all deaths that occur during pregnancy or within one year after termination of pregnancy

DEMOGRAPHIC INFORMATION

HOME/HOSPITAL_____

DOCKET NO._____

1. PATIENT'S INITIALS_____

2. RESIDENCE _____

DISTRICT / PARISH

. DATE OF DEATH ___/___/___ AGE AT DEATH _____ DATE OF DELIVERY ___/___/___

day mon yr day mon yr

TIME OF DEATH_____ am/pm

PLACE OF DELIVERY (_ **ONLY ONE**)

Type A public hospital [1] Type B public hospital [2] Type C hospital [3]

Cottage hospital [4] Public maternity centre [5] Private maternity centre [6]

Private hospital [7] Home [8] other [9] (specify) _____

AUTOPSY REQUESTED : Yes [1] No [2] Unknown [9]

AUTOPSY REPORT AVAILABLE: YES [1] NO [2] DATE AUTOPSY PERFORMED:___/___/___

WHERE AUTOPSY PERFORMED: _____

DATE OF ADMISSION (1) _____ Reason: [1] delivery [2] other specify_____

DATE OF DISCHARGE (1)_____ DISHCARGE DIAGNOSIS_____

DATE OF ADMISSION (2) _____ Reason: [1] delivery [2] other specify_____

DATE OF DISCHARGE (2)_____ DISHCARGE DIAGNOSIS_____

DATE OF ADMISSION (3) _____ Reason: [1] delivery [2] other specify_____

DATE OF DISCHARGE (3)_____ DISHCARGE DIAGNOSIS_____

DATE OF ADMISSION (4) _____ Reason: [1] delivery [2] other specify_____

DATE OF DISCHARGE (4)_____ DISHCARGE DIAGNOSIS_____

COMPLICATION/RISK FACTOR 1_____

COMPLICATION/RISK FACTOR 2_____

COMPLICATION/RISK FACTOR 3_____

WAS PATIENT TRANSFERRED [1] NO [2] YES, SPECIFY FROM WHERE _____

DATE TRANSFERRED _____ TIME OF ARRIVAL _____

PLACE OF DEATH: [1] ICU [2]TYPE A HOSPITAL [3]TYPE B HOSPITAL [4]TYPE C HOSPITAL

[5] PRIVATE FACILITY [6] HOME [7] OTHER, SPECIFY_____

PREGNANCY HISTORY (enter number of events; if none, enter zero "0")

Number of **previous** pregnancies (**excluding** current pregnancy) ____

Outcomes 1. full term live births ____ 2. premature live births (<2500g) ____ 3. stillbirths ____

4. spontaneous abortions ____ 5. induced abortions ____ 6. ectopic pregnancies ____

7. trophoblastic diseases ____

PREVIOUS COMPLICATIONS OF PREGNANCY_____

_____

DELIVERY INFORMATION

DATE ADMIITED FOR DELIVERY ____/____/____ DATE THIS PREGNANCY TERMINATED ____/____/____

ATTENDANT AT DELIVERY (_ **ONLY ONE** Or the Most Highly Trained Attendant IF MORE THAN ONE)

nana/self [1] district midwife[2] registered nurse/midwife [3] obstetrician [4]

other med. pract. [5](specify)_____ other trained personnel [6] (specify)_____

_____

31. METHOD OF DELIVERY (_ **ONLY ONE**)

Vaginal-spontaneous [1] Vaginal-induced [2] Caesarean-emergency [3] Caesarean-elective [4] Undelivered [5]

32. PRESENTATION: Cephalic [1] Breech [2] Other [3](specify)_____ Not Known [9]

33. BIRTHWEIGHT: _____LBS/KG 34. SEX: Male[1] Female [2] Not Known [9]

35. WAS ANAESTHETIC USED: No [0] Yes, local [1] Yes, general [2]

36. IF YES, WHO ADMINISTERED IT: Nurse anaesthetist [1] Resident [2] Specialist [3]

25. GESTATION AT PREGNANCY TERMINATION/MATERNAL DEATH:_____ Weeks from LMP [99] not known

26. OUTCOME OF THIS PREGNANCY (_ **ONLY ONE**)

died undelivered [0] full term live birth [1] premature live birth [2] stillbirth [3]

spontaneous abortion [4] induced abortion [5] ectopic pregnancy [6] trophoblastic disease [7]

multiple gestation (specify all outcomes using code numbers from above) [8] twin 1 _____ [9] twin 2 _____

27. If liveborn, did infant survive: Yes [1] No [2]28. If no, date of death_____

CLINICAL SUMMARY

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNED_____ POSITION _____ DATE____/____/____

APPENDIX B

MINISTRY OF HEALTH

JAMAICA

MATERNAL MORTALITY HOME VISIT AND ANTENATAL REPORT

INSTRUCTIONS: To be completed by a PHN, community midwife covering the decedent's community of residence or hospital midwife[1] by visiting with next of kin of the deceased to determine what occurred prior to the patient's death.

Offer your condolences and explain to the relatives that in an effort to prevent maternal deaths we visit the relatives of all women who died during pregnancy and childbirth to better understand what problems the patient had and how the health services can better provide for these needs so that these problems can be avoided in the future.

DEMOGRAPHIC INFORMATION

PATIENTS NAME_____ RESIDENCE_____
DISTRICT / PARISH

DATE OF DEATH ___/___/___ AGE AT DEATH _____ DATE OF DELIVERY ____/____/____
day mon yr day mon yr

MARITAL STATUS (_ **ONLY ONE**)

[1] Married [2] Common-law [3]Visiting [4] Other, specify _____ [9] Unknown

PLACE OF DEATH _____/_____ HOME [ ]
District/parish

NEXT OF KIN INTERVIEWED:(CHECK ALL THAT APPLY)

[1] spouse/consort [2] mother [3] father [4] sibling [5] other relative, specify _____

[6] other non relative, specify_____ [8] relationship not stated

Respondents knowledge:

a. Were you present when the patient died? [1] Yes [2] No

b. If no, How long before death did you see her? _____

c. Who told you about her death? [1] spouse/consort [2] relative [3] doctor [4] nurse [5] other_____

d. Was this person with her when she died? [1] Yes [2] No

e. How long after her death did you hear about it? _____

f. Before (name) was pregnant for the last time, was she generally well? [1] Yes [2] No [9] Not known

If no, what problems was she having_____
_____

Antenatal care:

1. Did (name) attend antenatal clinic [1] Yes [2] No [9] Not Known

2a. If no, do you know why she did not go? no [1] not known [9] yes [2](specify)_____
_____

2b. If yes, where did she attend, specify name of :

a)_____ health centre b)_____ hospital c)_____ private doctor

3. How many visits did she make _____ 4. Date of last visit _____

5. Did (name) have a maternal record card: [1] Yes [2] No [9] Not Known

6. Had (name) been referred elsewhere to see a doctor: [1] Yes [2] No [9] Not Known

7. If yes, where was she referred _____

8. Did she go [1] Yes [2] No [9] Not Known

9. Was she seen by a doctor when she went [1] Yes [2] No [9] Not Known

10. Was she advised to enter hospital [1] Yes [2] No [9] Not Known

11. Was she admitted to hospital [1] Yes [2] No [9] Not Known

12. If Yes, where admitted _____

13. Was she told tat she had high blood pressure [1] Yes [2] No [9] Not Known

[1] **To complete antenatal care record of women seen in the high risk antenatal clinics at hospital**

Prior to going into hospital (if died in hospital) or prior to the most recent illness, did the patient complain of any of the following symptoms:

before going into labour or before delivery (antepartum)(_ ALL THAT APPLY)

[01] severe headaches	[02] visual disturbance (seeing spots, seeing double, blindness)	
[03] epigastric pain (stomach aches)	[04] fits (seizures)	[05] severe abdominal pain
[06] swelling of face or hands	[07] high fever	[08] extremely short of breath
[09] yellow skin or eyes	[10] vaginal bleeding	[11] severe chest pain
[12] long labour (more than 12 hours)	[13] coughing up blood	[14] severe pain in calves or legs

if died after delivery, ask about (_ ALL THAT APPLY)

[15] severe bleeding	[16] bad smelling discharge	[17] if c-section, reopened wound
[18] red, swollen wound	[19] severe abdominal pain	

INFORMATION FROM THE ANTENATAL CARE PROVIDER(S) IDENTIFIED BY THE RELATIVES

[1] HEALTH CENTRE: date 1ST visit ___/___/___ date last visit___/___/____ gestat 1st visit _____ no. visits _____

Blood Pressure (Last on Record)_____/_____ Oedema: [1] Yes [2] No [9] Not known

Albuminuria (Highest Level) _____

Other complications:_____

Was patient referred for additional care: [1] Yes [2] No [9] Not known If yes, date referred _____/____/____

Reason for referral_____

Was patient followed up to ensure attendance: [1] Yes [2] No [9] Not known

[2] PRIVATE MD: date 1ST visit ___/___/___ date last visit___/___/____ gestat 1st visit _____ no. visits _____

Blood Pressure (Last on Record)_____/_____ Oedema: [1] Yes [2] No [9] Not known

Albuminuria (Highest Level) _____

Other complications:_____

Was patient referred for additional care: [1] Yes [2] No [9] Not known If yes, date referred _____/____/____

Reason for referral_____

Was patient followed up to ensure attendance: [1] Yes [2] No [9] Not known

[3] HOSPITAL/high risk ANC: date 1ST visit ___/___/___ date last visit___/___/___ gestat 1st visit _____ no. visits _____

Blood Pressure (Last on Record)_____/_____ Oedema: [1] Yes [2] No [9] Not known

Albuminuria (Highest Level) _____

COMPLICATIONS AND OTHER MEDICAL PROBLEMS (IF ANY):

_____

_____

SCREENING TEST RESULTS

HB: _____ [9] not known/not done

HIV test result: [1] positive [2] negative [9] not k known/not done

VDRL test result: [1] positive [2] negative [9] not known/not done

SIGNED (PHC RM) _____ POSITION _____

DATE____/____/____

SIGNED (SHC RM) [1]_____ POSITION _____

DATE____/____/____

APPENDIX C

MINISTRY OF HEALTH

JAMAICA

MATERNAL MORTALITY CASE REVIEW SUMMARY

INSTRUCTIONS: To be completed on all deaths during pregnancy or within one year after termination of pregnancy once case review has been completed. The summary, with supporting documents are then shared with (1) institution in which the death occurred (2) parish of residence of the mother (3) the Ministry of Health.

DEMOGRAPHIC DATA

PATIENT'S INITIALS_____ AGE AT DEATH _____ TOTAL PREGNANCIES, INCL THIS ONE _____

DATE OF DEATH ___/___/___ (day mon yr) DATE OF DELIVERY ___/___/____ (day mon yr) DAYS DELIVERY-DEATH _____

PARISH OF RESIDENCE_____ PLACE OF DEATH _____/_____ (DISTRICT / PARISH) HOME [ ]

ANTENATAL INFORMATION

SOURCE OF ANTENATAL CARE: [1] HEALTH CENTRE [2] HOSPITAL [3] PRIVATE DOCTOR [9] NOT KNOWN

TOTAL NUMBER OF ANTENATAL VISITS, ALL SITES _____ (ENTER ZERO IF NO ANTENATAL CARE)

Was patient referred to high risk clinic? [1] yes [2] no NUMBER OF VISITS TO HIGH RISK CLINIC_____

REASON FOR REFERRAL _____

CLINICAL INFORMATION

PLACE OF DELIVERY (CHECK **ONLY ONE**)

[1] Type A public hospital [2] Type B public hospital [3]Type C hospital
[4] Cottage hospital [5] Public maternity centre [6] Private maternity centre
[7] Private hospital [8] Home [9] Other (specify) _____

METHOD OF DELIVERY (CHECK **ONLY ONE**)

[1] Vaginal-spontaneous [2] Vaginal-induced [3] Caesarean-emergency [4] Caesarean-elective [5] Undelivered

WAS ANAESTHETIC USED: [0] No [1] Yes, local [2] Yes, general

OUTCOME OF THIS PREGNANCY (CHECK **ONLY ONE**)

[0] died undelivered [1] full term live birth [2] premature live birth [3] stillbirth
[4] spontaneous abortion [5] induced abortion [6] ectopic pregnancy [7] trophoblastic disease
[8] multiple gestation (specify all outcomes using code numbers from above) [8] twin 1 _____ [9] twin 2 _____
If liveborn, did infant survive: [1] Yes [2] No If no, date of death_____

WAS PATIENT ADMITTED BEFORE GOING INTO LABOUR: : [1] Yes [2] No

REASON FOR ANTEPARTUM ADMISSION _____

DATE OF MOST RECENT ADMISSION (1) _____

Reason: [1] delivery [2] other specifiy_____

DISHCARGE DIAGNOSIS_____

COMPLICATION/RISK FACTOR 1_____

COMPLICATION/RISK FACTOR 2_____

COMPLICATION/RISK FACTOR 3_____

WAS PATIENT TRANSFERRED [1] NO [2] YES, SPECIFY FROM WHERE _____

DATE TRANSFERRED _____ TIME OR ARRIVAL _____

PLACE OF DEATH: [1] ICU [2]TYPE A HOSPITAL [3]TYPE B HOSPITAL [4]TYPE C HOSPITAL
[5] PRIVATE FACILITY [6] HOME [7] OTHER, SPECIFY_____

CAUSE OF DEATH

TIME OF DEATH [1] MATERNAL (pregnant – 42 days post partum) [2] LATE MATERNAL DEATH (43-364 days)

SOURCE OF INFORMATION (_ALL THAT APPLY) Death Certificate [1] Autopsy Report [2] Clinical Diagnosis [3]

UNDERLYING CAUSE_____

INTERMEDIATE CAUSE_____

IMMEDIATE CAUSE_____

CLASSIFICATION OF DEATH [1] DIRECT [2] INDIRECT [3] CO-INCIDENTAL [9] not classified

QUICK CODES – DIRECT DEATHS

[11] GESTATIONAL HYPERTENSION [12] HEMORRHAGE [13] EMBOLISM [14] ABORTION [15] INFECTION [16] OTHER DIRECT

QUICK CODES – INDIRECT DEATHS

[21] CARDIAC DISORDER [22] SICKLE CELL DISEASE [24] DIABETES MELLITUS [25] HIV/AIDS [26] RESPIRATORY DISORDER [27] SUICIDE [28] OTHER INDIRECT

QUICK CODES – CO INCIDENTAL DEATHS

[31] HOMICIDE [32] MVA [33] OTHER CO-INCIDENTAL including non pregnancy related medical complications

EVALUATION OF THE ASSESMENT TEAM

AVOIDABLE FACTORS PRESENT: [1] NO [2] YES , IF YES, SPECIFY ALL THAT APPLY

[1] DELAY 1 (PATIENT DID NOT RECOGNIZE PROBLEM)

_____

[2] DELAY 2 (PATIENT DELAY SEEKING CARE)

_____

[3] DELAY 3 (DELAYED ACCESS TO CARE – COST, TRANSPORTATION, OTHER COMMUNITY ISSUES)

_____

[4] DELAY 4 (DELAY RECEIVING APPROPRIATE CARE ONCE IN THE INSTITUTION)

_____

DETAIL SOURCES BELOW IF DELAY 4

[41] providers of care at time of death (training, quality, availability)

_____

[42] decision making process (recognition of serious problem, correct diagnosis, consultation process)

_____

[43] actions taken (e.g. referral, emergency obstetric care, appropriate treatment)

_____

[44] delays in referral (e.g. transport, money, permission, physical environment)

_____

[45] facilities (e.g. quality, blood, anaesthesia, supplies, drugs)

REVIEW TEAM DATE OF REVIEW ____/____/____

Obstetrician _____ [1] Midwife_____ [2]

Epidemiologist_____ [3] MO(H)_____ [4]

MO(H)_____ [5] Other_____ [6]

Other_____ [7] Other_____ [8]

DATE SUMMARY SENT TO MO(H) PARISH OF RESIDENCE____/____/____

DATE SUMMARY SENT TO HOSPITAL OF DEATH____/____/____

DATE SUMMARY SENT TO MINISTRY OF HEALTH____/____/____

APPENDIX D

MINISTRY OF HEALTH

JAMAICA

MATERNAL MORTALITY POST MORTEM SUMMARY

INSTRUCTIONS: To be completed by pathologist or regional surveillance officer from the post mortem findings on any death investigated of a female 10-50 years of age whose death is suspected as being pregnancy related.

DEMOGRAPHIC INFORMATION

PLACE OF DEATH_____ DOCKET NO._____

PATIENT'S INITIALS_____ DATE OF DEATH ___/___/___ AGE AT DEATH _____

CLINICAL INFORMATION

Complications

_____

_____

_____

Other Medical Problems/Risk Factors present

_____

_____

_____

CAUSE OF DEATH

IMMEDIATE CAUSE_____

INTERMEDIATE CAUSE_____

INTERMEDIATE CAUSE_____

UNDERLYING CAUSE_____

Other significant conditions

_____

_____

AUTOPSY DONE BY:

[1] DM PATHOLOGIST – MINISTRY OF HEALTH/UHWI [2] DM PATHOLOGIST – MINISTRY OF JUSTICE

[3] DMO [4] OTHER MEDICAL OFFICER DATE OF AUTOPSY ___/___/___

REPORT COMPLETED BY:

[1] INVESTIGATING OFFICER [2] SURVEILLANCE OFFICER [3] OTHER, SPECIFY

_____

SIGNATURE _____ DATE COMPLETED ___/___/_____

APPENDIX E

MINISTRY OF HEALTH

JAMAICA

MATERNAL MORTALITY RGD NOTIFICATION LIST

INSTRUCTIONS: To be completed by regional surveillance officer from the CASE REVIEW SUMMARY and forwarded to the CEO, REGISTRAR GENERAL'S DEPARTMENT on a quarterly basis

[1] FIRST QUARTER [2] SECOND QUARTER [3] THIRD QUARTER [4] FOURTH QUARTERR

REGION REPORTING	**[1]SE [2] NE [3] W [4]S**		**DATE REPORT**	
NAME OF DECEDENT	DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH Immediate Intermediate Underlying	