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Department of Health

EXPANDED TERMS OF REFERENCE FROM THE MATERNAL, CHILD AND WOMEN=S HEALTH COMMITTEE

- Develop a national programme for the delivery, organisation and management of health services for mothers, newborns, children(up to the age of 18 years, including adolescents) and women.

1.1. Establish a conceptual framework for service delivery which integrates the following components:
- target groups
- levels of care
- elements of the services(programmes to be delivered)

Which is supported by
- an organisation structure

1.2. Locate the programme and the MCWH Unit within the context of a workable philosophy, goals, aims and objectives of the MCWH system.

1.3. Make recommendations to achieve the objectives based on the needs of the target groups and guided by principles underlying service delivery which promote optimal health.

1.4. Define realistic targets for elements in the programme and specify indicators and time-scales which can be used to monitor progress towards attainment of these targets.

- Make proposals for the establishment of the national MCWH Unit within the Department of Health, with special reference to its structure, functions and staffing.

- Locate both the service and the unit within a comprehensive national health system and link with other relevant sectors and with other organisations concerned with the promotion of the well-being of mothers, children and women.

GUIDE TO THE DOCUMENT

This is a confidential report and should not be circulated or quoted prior to consultation with the Minister of Health.

Terms used in this document are defined.

Strategies proposed are dependent on deployment of staff who are adequately and appropriately trained for delivery of services at all levels.

Special issues are considered within the framework for comprehensive service delivery and organisation.

Micro planning for the different levels of service will be undertaken by the respective organisational structures.

THE PROPOSALS ARE BASED ON THE FOLLOWING ASSUMPTIONS

- The major challenge in South Africa is to reach everybody with a minimum set of high quality essential services and to give priority to those populations that have the highest mortality rates.

- Resources should be allocated as first priority for the care of mothers and young children and resources should be provided as first priority to those most in need.

- Criteria need to be developed for giving priority to deprived areas. Basic Epidemiological information and data will used to prioritize interventions for target groups and populations.

- Emphasis will be placed on cost effective activities which have the greatest impact on goals.

- Equity is the first priority and the most vulnerable, must be focussed on first.

- Health problems that result in maximum mortality and morbidity must be tackled first and given financial resources.

- An operational plan for the proposed plan will be implemented through a phased approach which is based on consultation, and on determined needs and available resources.

- Services will be delivered on the basis of acceptable standardised protocols of management and referral which will be developed through consultation and consensus.

- Standards of health care provision and management and referral protocols for maternal and newborn services will be applied as documented in the manuals of the perinatal Education Programme(PEP) for all levels of health service delivery.

  These management protocols should be followed at all times.

- The National Maternal, Child and Women=s Health (MCWH) Unit will later need to define standards expected for other groups.

- The National Committee will meet with other committees and groups to discuss areas of mutual concern.

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Submissions were also received from many organisations and individuals.

EXECUTIVE SUMMARY

The proposals made in this document are based on a number of assumptions, the most important of which are:

- Equity is the first priority and the most vulnerable must be focussed on first. Health services will give priority to those groups, populations and regions, which have been the most seriously affected in the past and therefore have the highest mortality rates and other evidence of deprivation.

- Health problems that result in the highest morbidity and mortality must be tackled first and given financial resources. Emphasis will be on cost-effective activities which have the greatest impact on goals.

- An operational plan for this proposal will be implemented through a phased approach based on consultation, and on determined needs and available resources.

TERMS OF REFERENCE

The terms of reference of the Maternal, Child and Women=s Health(MCWH) Committee were expanded as follows:

Develop a national programme for the delivery, organisation and management of health services for mothers. Newborns , children (up to the age of 18 years, including adolescents) and women.

1.1. Establish a conceptual framework for service delivery which integrates the following components: target groups, levels of care and elements of the services(programmes to be delivered) and which is supported by an organisational structure.

1.2. Locate the programme and the MCWh Unit within the context of a workable philosophy, goals, aims and objectives of a MCWH system.

1.3. Make recommendations to achieve the objectives based on the needs of the target groups and guided by principles underlying service delivery which promote optimal health.

1.4. Define realistic targets for elements in the programme and specify indicators and time-scales which can be used to monitor progress towards attainment of these targets.

Make proposals for the establishment of a National MCWH Unit within the Department of Health, with special reference to its structure, functions and staffing.

Locate both the service and the unit within a comprehensive national health system and link both with other relevant sectors and organisations concerned with the promotion of the well-being of mothers, children and women.

CONTEXT

The plan is located in the context of the Reconstruction and Development Programme.

MCWH PRIORITIES IN THE RDP

The pursuit of optimum health for mothers, women and children is one of the principal goals of the RDP and the National Health Plan. The key programmes of MCWH are identified in these policy documents. These include political support for international conventions, free health care(pregnant women, children <6), immunisation, reduction of morbidity and mortality form common diseases, improved nutrition, health education for priority issues, increased and enhanced reproductive health services, development of comprehensive women=s health care services, effective measures against HIV/AIDS and sexually transmitted diseases, protection against abuse and violence, enactment of appropriate legislation, and finally, redirected training and education for health workers.

The people-centred approach of the RDP resonates perfectly with the philosophical underpinnings of Alma Ata. Accordingly MCWH programmes can draw nourishment from the resources of the RDP and, in turn, facilitate the achievement of its goals for children, mothers and women.

A SITUATION ANALYSIS of health status, service delivery and utilisation provides an overview of the current situation of MCWH.

We do not know enough about how many women and children die and why they die. Despite this, limited data do enable an identification of priority areas for action. A national health information system is therefore a prerequisite for proper planning, monitoring and evaluation.

African women often suffer and die from common preventable diseases, and a large part of their sickness and death occurs when the normal process of child-bearing and child birth go wrong. For the level of economic development, we have an unacceptably high maternal mortality rate; this is especially so for black women in particular those in rural areas.

The major causes of death related to pregnancy are hypertensive disease, bleeding, infections and

ruptured uterus. Illegal abortions results in death. Conditions which allow legalised abortion are restrictive and public awareness of the procedures to follow is minimal. Antenatal, delivery and postnatal services are often inaccessible, and even when available they can be inadequate. Iron deficiency has an adverse effect on the mother and baby.

Sexually transmitted diseases are common, and HIV/AIDS has reached epidemic proportions. Cervical cancer often presents late thus requiring costly treatment but with poor outcome. Health education, especially in the area of reproduction is non existent or ineffective; fertility rates are threefold higher in blacks than in Whites. On the other hand, infertility is also a problem, leading to social isolation and psychological and physical abuse for women. Malnutrition in rural regions, and rape and battery are serious health problems.

Black babies and children often suffer needlessly and die early; this is so because they frequently fall prey to ordinary diseases which are easily preventable or treatable. Perinatal, infant and child mortality rates are high with marked disparities between the races, the regions and between the urban and rural areas. Perinatal mortality is the single largest cause of the death of infants and children. Newborn babies suffer the effects of maternal disorders, therefor hypertension, sepsis, infections, abruptio placentae, haemorrhage, pre-term labour and unexplained still births are the most frequent causes of perinatal deaths. Good antenatal care and improved services for delivery can reduce the incidence of these problems.

Low birth weight are prone to serious diseases in the first weeks of birth and are likely to fail to achieve their potential for growth and development in later life. About 10 - 19% of Black babies born in hospitals are low birth weight. Beyond the neonatal period, the major causes of infant mortality are diarrhoea and respiratory diseases. The latter two, together with perinatal causes, viral diseases, congenital defects and ill-defined causes, account for just over 90% of all infant deaths. Children beyond infancy die from a similar range of diseases; malnutrition and infection are especially important in pre-school children. Accidents are also responsible for much injury and death in this age group.

Morbidity data are very weak. Diarrhoea, respiratory infections, allergies, malnutrition (protein-energy malnutrition and micro-nutrient deficiencies), poisoning, and child abuse are undoubtedly common . Vaccine preventable diseases are on the decline though tuberculosis and measles are prominent causes of morbidity. Pertussis may be a hidden but serious problem. HIV/AIDS is looming large on the horizon. Disabilities and handicap are inadequately provided for by the health and welfare services.

Adolescents are vulnerable to an array of psycho social problems such as teenage pregnancy, sexually transmitted diseases, HIV/AIDS, substance abuse, violence, trauma, smoking and alcoholism .

There is an ample record available to show that health services are often inappropriate, inadequate

or inaccessible for mothers, women and children.

PHILOSOPHY, GOALS, AIMS, OBJECTIVES, TARGETS, INDICATORS

These provide the philosophical foundations, the medium and long term goals, the broad aims, and the measurable objectives and indicators for the promotion of health and delivery of services for mothers, children and women. They are based on the principles enshrined within numerous international agreements, declarations, conventions and charters, and recent national proposals, in particular, those in the Reconstruction and Development Programme, relating to the claims of mothers, children an d women to health as a basic right, and to their rights of protection, care and assistance. A set of principles to guide the service delivery is proposed. Taken together, they constitute a consistent paradigm in which there exist ideals to aspire towards, a vision of MCWH for the near future, a mission for improving health within the next three to five years and signpost to pace progress.

GOALS FOR MCWH

The goals for the protection and promotion of the health of mothers, children, adolescents and women in South Africa, are as follows:

FOR MOTHERS:

To ensure access to high quality antenatal care, and quality care during after delivery to

mothers and their babies

To implement a population-based system of service delivery for mothers and their babies which strives to achieve agreed objectives

FOR CHILDREN:

To enable each child to reach his/her maximum potential within the resources available, and to enable as many children as possible to reach adulthood with their potential uncompromised by illness, disability, environmental hazard or unhealthy lifestyle

FOR ADOLESCENTS:

To ensure access to relevant and appropriate information, community support and health services, which enable adolescents to cope with the rapid physical and psychological changes that occur during this period, and which expose them to the dangers of aberrant psychological behaviour and disorders

FOR ALL WOMEN:

To achieve optimal reproductive and sexual health(mental, physical and social) for all women and men across the life-span of individuals
To raise the status of women, their safety, health and quality of life

MEASURING AND MONITORING: OBJECTIVES, TARGETS, INDICATORS

Clear objectives are necessary in order to establish health and development outcomes which are measurable. Maternal, Child and Women-s Health services at all levels, from primary to quaternary, are urgent need, with the emphasis on the former. This task is already underway with many clinics and health centres being constructed. Both quantity and quality of services provided at these facilities have to be addressed.

High quality primary, secondary and tertiary care, centred on a district-based system, for pregnant women and their newborns, with protocols for management suited to national requirements(e.g, the perinatal education programme) and unambiguous referral criteria, should be established within the next 3-5 years. These services must be subject to regular audit and must keep the interests and comfort of their clients always at the forefront, the latter should maintain patient-held records. Specific health status objectives relevant to this country are, a reduction if rates of maternal and perinatal mortality, a decrease in prevalence of preterm delivery and low birth weight, and the promotion of exclusive breast feeding.

For children, the aim is to markedly lower late neonatal, infant and under 5 mortality rates, primarily through decreasing deaths and sickness from preventable disorders such as acute respiratory infections, diarrhoea, malnutrition(including micro-nutrient deficiencies), neonatal asphyxia-tetanus-trauma and congenital syphilis, measles, pertussis, tuberculosis, malaria, hepatitis B and HIV. We should also target poliomyelitis, severe malnutrition, and rhematic fever for elimination. Childhood injury can be drastically reduced. Other critical objectives include diminution in disability, handicap, child abuse, and ill health among school children. HIV/AIDS care and support require special attention as do school health and mental health services. Growth-monitoring could be integrated into PHC services.

Adolescents require more health promotion programmes and targeted health care services at all levels, especially in communities and schools, and in particular directed at psycho social problems. Interventions should improve physical health, enhance body-image and self esteem, encourage healthy lifestyles and family cohesion, and facilitate autonomous decision making.

Reproductive health services could be integrated into PHC facilities. Health education and services should enable the reduction of unwanted pregnancies, offer access to acceptable methods of fertility regulation, and decrease mortality and morbidity from unsafe abortions.

The attainment of these aims and objectives has to be formalised into a set of achievable targets reached within realistic time periods(say by 3 years and by 5 years) and monitored by specific indicators.

The targets and indicators are categorised under the following: preventative health services, reductions in morbidity, control of diseases of children and women, strengthening of infrastructure, provision of services, coverage by services, utilisation of health services, and process and quality of care indicators.
These indicators form the backbone of a National Health Information System.

CONCEPTUAL FRAMEWORK FOR DELIVERY AND MANAGEMENT OF HEALTH SERVICES

The Maternal, Child and Women-s Health Committee(MCWH) of the Department of Health devised a conceptual framework for delivery and management of health services for these targets

groups.

Health services for mothers, children and women will be delivered as part an integrated comprehensive health system(horizontal approach) and supported by an organisation and management structure which is vertical in emphasis, but linked to the rest of the service administration at each political level.

A clear and rapid pathway of referral and feedback along a hierarchy skills and levels of service is implicit.

The conceptual framework for the delivery of services to mothers, children and women is represented by the following diagram:

The A Axis represents Elements of Services(or Programmes) which may include school health services, nutrition programmes, expanded programmes on immunisation, oral health, tuberculosis, diarrhoea control, acute respiratory infections, teenage pregnancy etc. Priority concerns of each target group (Axis B) will determine the nature of these service elements. It must be stressed that these service elements will not be vertical programmes(unless decided by the Minister) but will be delivered through integrated services. By ›integration‹ is meant a unity in location, unity in facility, unity in personnel, and unity in time of provision.

The B Axis represents the Target Age Groups which comprise the life span of mothers and children and women.

The C Axis represents the Level of Care and is further summarised in the Table below:

C-AXIS: LEVEL OF CARE

POLITICAL LEVEL	TYPE OF CARE	FACILITY
National	Quaternary	Selected level 3 hospitals
Provincial	Tertiary level of referral	Level 3 hospital
District council	Secondary level of referral	Level 2 hospital
District sub-structure	Primary level of referral	Level 1 hospital
Community	First level of medical care	Community health centres, clinics
Home	Self and community based care	Outreach CHWs

NB Quaternary = super specialist care

DELIVERY OF HEALTH SERVICES

This proposal presents a balanced and integrated system of health facilities comprised of clinics, community health centres and three levels of hospitals, linked by referral patterns designed to be flexible, but in general to match type, severity and prevention of disease, and the need for health promotion and rehabilitation, with the most appropriately trained health personnel. The system supports home care at one end, and at the other, restricts certain select services to a few national sites for management of rare and expensive disorders. The functions, services offered, infrastructure, and staffing for each type of facility are given in some detail, highlighting the integrated delivery of services. Although these facilities are targeted primarily at mothers, pregnant women, newborns, young children, older children and adolescents, and women, they are woven seamlessly into the fabric of a national system for all.

ORGANISATION AND MANAGEMENT

The delivery of health services for mothers, children and women, is optimised through a coherent framework of interconnected administrative units established at all levels, from national, provincial, regional, to district. The composition of these MCWH units together with their collaborative links and functions, (including policy making, planning, implementation of programmes and contributions to training of health personnel) are detailed for each level. The framework provides for a cascading system of responsibility and authority from the centre to the periphery, and facilitates a centripetal flow of data, information and experiences from the community inwards to government. This bidirectional process ensures that the needs of people shape the health system by helping translate experience into policy and reinforces the integrative, co-ordinating and equalising functions at national level. The organisational structure promotes and sustains integrated health services at delivery sites by providing vertical support.

These structures operate at the following levels:

POLITICAL LEVEL	HEALTH ADMINISTRATION	ORGANISATIONAL STRUCTURES
National	Department of Health	MCWH Unit/Advisory Group
Provincial	Provincial Health Department	Provincial MCWH Management Team/Advisory Group
District Council	DC Health Department	DC MCWH Management Team/Advisory Group
District Subdirectorate	DSS Health Department	DSS MCWH Management Team/Advisory Group
Community	Clinic Committees	Community Health Forum
Home	Civic and other community organisations	Health Desk

Health administration departments at each level are separate from service delivery facilities and will have their own budgets.

Administration at each level will be facilitated by establishing structures for intersectoral co-ordination(**Development Committees),** for obtaining advice from a wide range of experts(**Advisory Groups)** and for management and supervision of services**(MCWH Units of Health Management Teams).**

SPECIAL NEEDS AND ISSUES

Priority conditions of mothers, children and women will be provided through the services described above. However, other problems which are less well recognised or appreciated, may slip through the net. It is therefore necessary to identify and support such needs, eg, child abuse, rape, disability, homelessness, teenage pregnancy, mental health, oral health, school health, substance abuse, injury and violence.

Other special issues include the formulation of guidelines for free care for children under 6 years and pregnant women, elements of a proposed free package for children under 6 years, the role of Academic Health Complexes for MCWH, and the role of the private sector and NGO-s in MCWH.

IMPLEMENTATION

The proposals in this Report will be enriched by contributions from many sectors within the government, from people who are the intended beneficiaries, form lay and professional bodies, from non - governmental organisations, from religious and cultural groups, and from numerous other institutions which have the interests of mothers, children and women, at heart. Intra sectoral liaison is given special attention in the text. It is inevitable that obstacles will arise as the process of seeking ans incorporating this wide range of view gets under way. This section determines priorities and interventions for beneficiaries, identifies the likely obstacles and suggest strategies to overcome them.

This section also specifically lists the recommendations in this report which can be implemented soon, within the constraints imposed by the current political, economic and social environments.

It concludes with a brief account of the job description of a certain key personnel who, it is recommended, should be appointed soon.

GLOSSARY

A glossary of terms and definitions which are important in this report is included.

APPENDICES

These were submitted by individuals experienced in the subject at the request of the MCWH Committee. They do not, in their entirety necessarily represent the views or recommendations of the MCWH Committee, but are included because they provide an informed account of the specific health issue.

A. PRIORITIES

ARI
Diarrhoeal diseases
Tuberculosis
Abuse
Disability
Children in difficult circumstances
Childhood injury
Teen pregnancy
Substance abuse
Rape and battery
HIV/AIDS
Menopause
Infertility
Abortion

S ORGANISATION OF SPECIAL SERVICES

School health
Adolescent health
Antenatal care
Oral health
Genetics
Mental health
Private/public sector interface
Incorporation of the Private Sector into a Comprehensive Reproductive Health Service
Road-to- Health Card
Women-s health card
Carcinoma of the cervix

S OTHER CONCERNS

Rheumatic fever
Hepatitis B
Gay and lesbian health

S REPRODUCTIVE HEALTH REVIEW
S LEGISLATION
S SITUATION ANALYSIS
S PERINATAL EDUCATION PROGRAMME MANUALS

CONTEXT

The plan is located in the context of the Reconstruction and Development Programme.

The numerous international agreements, declarations, and charters relating to the right of mothers, children and women to health as a basic right, and to their rights to protection, care and assistance, form the philosophical foundation of the plan.

A set of principles to guide the service delivery is proposed.

A **Situation Analysis** of health status, service delivery and utilisation provides an overview of the current situation of MCWH.

Goals, Aims, Objectives and Targets have been developed as a measure of progress towards implementation of the plan. The selected indicators target mortality, morbidity, nutrition, coverage and strengthening or establishing infrastructure.

Consideration of those priority conditions (such as ARI, abuse, disability) which need special attention to reduce mortality and morbidity are considered in Special Needs. This section also deals with other concerns(such as homelessness, substance abuse, teen pregnancy) and other areas in need of intervention(such as mental health and genetics).

These concerns are detailed in appendices and will be emerged into the framework for comprehensive service delivery.

Health goals and proposed indicators for their measurement are detailed in **Measuring and Monitoring** and will be prioritised for inclusion in national health information system.
Special Issues in a plan for MCWH service delivery are free care for children under 6 and pregnant women, and the roles of academic health service complexes, the private sector and non-governmental organisations. Principles for each of these issues have been proposed.

A **Strategy for Implementation** has been presented.

This includes the process of intra-sectoral liaison and gives some indication of the interface issues which have to be discussed with other committees and units in the Department of Health.

Obstacles to implementation are anticipated and strategies for overcoming these are presented. The specific steps towards operationalisation are proposed together with a guide to the principles which should underpin the formulation of a set of forms for health information.

The report is presented again the background of defined terminology contained in a **Glossary** and detailed submissions are included as **Appendices**.

Several tasks which require immediate action have been identified for effective implementation of the plan. These include development of supply and logistics, costing of services and development of intersectoral linkages, especially with the National Plan for Action for Children.

Note: *The report has been prepared by a committee comprised of representatives of maternal, child and women's health respectively.*

CHAPTER 1

PRIORITIES OF THE RDP

PRIORITIES OF THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME

- Promotion of the UN Convention on the Rights of the Child
- Provision of free health care to improve antenatal care, delivery and postnatal care in the public sector and to children under 6 years of age
- Reduction of maternal mortality, perinatal mortality, infant mortality and under 5 mortality rates
- Expansion of immunisation coverage
- Eradication of poliomyelitis and neonatal tetanus
- Reduction in the incidence of moderate and severe dehydration from diarrhoeal disease in children under five years of age
- Reduction in mortality from diarrhoeal disease in children under five years of age
- Reduction in mortality from acute respiratory infections
- Promotion of breastfeeding
- Reduction in levels of malnutrition-related illnesses
- Development of an education programme for scholars, adolescents and teachers around health promotion, including sexuality, safe sexual practises and substance abuse
- Improvement in universal access to antenatal, delivery and postnatal care, and to reproductive health services
- Enabling women to take control of their reproductive health and their reproductive lives
- Enabling women to have the right to choose whether or not to terminate pregnancy according to their beliefs
- Protecting the right of health workers to refuse participation in termination of pregnancy according to their beliefs
- Development of comprehensive women-s health care services, including contraceptive services, which will be geared towards the needs of all women throughout their life-span
- Giving priority to cost-effective affordable screening programmes for diseases which affect women (such as carcinoma of the cervix)
- Enactment of a law protecting women against rape and battery
- Training and reorientation of health workers and public officials to correct any negative attitudes to women
- Establishing programmes to combat the spread of sexually transmitted diseases(STDs) and acquired immune deficiency syndrome(AIDS)
- Protection of children and women against all forms of violence

CHAPTER 2

SITUATION ANALYSIS

- HEALTH STATUS
- HEALTH POLICY
- HEALTH SERVICES
- HEALTH SERVICE ORGANISATION
- REFERENCES

WOMEN

MAJOR CAUSES OF DEATH IN MOTHERS

- HYPERTENSIVE DISORDERS OF PREGNANCY
- BLEEDING
- PROLONGED LABOUR
- ABORTION
- ANAEMIA
- UNCONTROLLED FERTILITY

Women=s health issues cannot be separated from issues of social development and an individual=s right to improve her health status. A broad range of health issues must be addressed including maternal mortality, abortion, contraception, HIV and sexually transmitted diseases, infertility and violence. Additionally, perinatal health services as a bridge between the health of mother=s and infants.

The official maternal mortality rate, the major indicator of socio-economic conditions and health care in society excludes, 55% of women. Women who reside in the former Aindependent homelands@ and who have the least access to health care probably have a maternal mortality rate of 200 per 100 000 compared to the official rate of 32. Many maternal deaths from important causes such as pre-eclampsia, bleeding and infection can be prevented by quality primary care.

Abortion is a major cause of morbidity and mortality. Figure 1.2 illustrates the situation of abortion in South Africa as reported by the Department of Health National Health and Population Development. The majority of abortions are carried out illegally. This is because the procedures of procurement of legal abortion are currently restrictive and public awareness on the Act is minimal. A more realistic estimate of the number of unsafe abortions performed in South Africa is 200 000 to 300 000 per year.

The established contraceptive prevalence rate fkor South Africa is approximately 72%. Only two methods are available commonly from most clinics in South Africa i.e. injectible and oral contraceptives. IUCDs are offered mostly in urban centres or in fixed referral clinics in rural area. Sterilisation services are often logistically difficult for women to access and long waiting lists exist for this service in the state sector. Surgical contraceptive is not generally easily available. Condoms are not promoted for family planning purposes. The rate of high use of injectable contraceptives amongst black women is an issue that raises concern. The current statistics show that 70 - 80 % of all black female clients use injectable contraceptives as compared to 10% of all white female clients.

Sexually transmitted diseases(STDs) and their related consequences are common health problems in South Africa. However no national figures are available. Studies of women attending family planning and antenatal clinics have shown prevalence rates ranging from 5% to 16% for chlamydia (Assessment of Reproductive Health Services in South Africa, Focussing on Family Planning, 1994).

STDs have specific implications for women=s and infant›s health. It is commonly associated with pelvic inflammatory disease (PID) with resulting tubal occlusion and infertility. Congenital syphilis is a major preventable form of perinatal morbidity and mortality. More over women with STD are far more likely to contract HIV/ AIDS.

Although major urban centres have STD clinics where they offer treatment fee of charge, in all other health facilities people pay for treatment of STDs. STD services are run as a vertical programme, with the DOH providing to local authorities to cover the costs of the services.

The HIV/AIDS epidemic is growing rapidly in South Africa. The HIV rate is increasing most rapidly among women this has been clearly shown by the national antenatal surveys (Table 1). The highest rates are in Natal/KwaZulu, especially among the African population. The highest incidence rate for HIV sero-positivity is seen in younger age group in South Africa than in most other countries.

PROGRESSION OF THE HIV EPIDEMIC AMONG ANTENATAL MOTHERS ATTENDING ANC CLINIC IN SOUTHERN AFRICA

(Rate as % of population)

Year	Prevalence (%)
1990	0.76
1991	1.49
1992	2.69
1993	4.69

EPI Comments, 1994

Infertility is a common but often unacknowledged problem within South Africa which often results in the social isolation, psychological and even physical abuse of the affected women. The commonest cause of infertility is pelvic inflammatory disease, secondary to sexual transmitted diseases(STD). In addition unsafe abortions may also result in chronic pelvic inflammatory disease leading to secondary infertility.

There id inadequate information on the prevalence of infertility in South Africa but gauging from the rate of prevalence of STD and unsafe abortions, one can only believe that is a public health problem, An estimate from the Western Cape puts the incidence of infertility at 22% (unpublished data, personal communications, Dr carol Thomas). Infertility services are very restricted within the public health facilities and women have to meet strict social criteria before any investigations are initiated. Most people, both women and men who would like to be investigated and treated but must meet the costs of private care. Moreover, information from the recently concluded review of a series of reproductive health services indicates that health worker knowledge regarding infertility may be inadequate and that a number of public service health workers do not have empathetic attitudes towards women who need investigations for infertility (Assessment of Reproductive Health Services in South Africa, Focussing on Family

Planning, 1994).

The perinatal mortality rate is a good indicator of health of the mother during pregnancy and the health care mother and child received during pregnancy, delivery and the postpartum period. In 1989, the perinatal mortality rate (PNMR) was estimated at 23,3 per 1000 births in the ARepublic of South Africa@, a rate that may be applicable to the white population. However, estimate for regions int he former homelands range from 60 per 1000 births (Lebowa, 1998) to 38 (Kwa Zulu, 1987) (Buchman, Steenekamp et al; Wilkinson 1990, Wilkinson 1991). In the Transkei, an 8 year survey revealed PNMR of 43-55 per 1000 births (Irwig and Ingle). Peri-urban areas such reported rates in the range of 29.9 (Cape Town) to 54.6 (Durban) (Dommise, Power et al, Ross), while the Cape Province had a PNMR of 27 per 1000 births from the same period. The actual figure for urban areas is probably close to the estimate in the Durban clinics and King Edward Hospital, 55 per 1000.

- Cervical cancer is recognised globally as a major cause of illnesses and death among women. In South Africa, information on cervical cancer is insufficient. There are no provincial or community based figures that provide a comprehensive picture on the impact of cervical cancer on families. As in other countries where there are no screening programmes, cervical cancer often presents late thus requiring more costly treatment but having a poorer outcome. The Cancer Registry of South Africa estimates the incidence of cervical cancer national to be 8.6 per 100 000 women, but the estimate excludes the TBVC areas (Fonn et al, Women=s Heath Project, 1993). Figure 1.13 and table 1.12 provides and indication of the rate of reported cervical cancer by race. The majority of patients in South Africa present fat none-curable stages. Additionally, high rates of cytological abnormalities have been reported among teens (Fonn et al, Women=s Health Project, 1993).

Rape and Battery. It is estimated that 1 in 6 South African females are battered either physically or psychologically. Health services providers often feel hopeless when faced with domestic battery, and fail to pro-actively intervene.

INFANT AND CHILD HEALTH

MAJOR CAUSES OF DEATH

- PNEUMONIA
- DIARRHOEA
- BIRTH TRAUMA AND ASPHYXIA
- VACCINE-PREVENTABLE DISEASES
- MALARIA (IN SOME AREAS)
- MALNUTRITION

The infant mortality rate(IMR) is widely used as an index of the state of child health, a sensitive indicator of the overall health of the community, and a good proxy for environmental and socio-economic conditions in particular population. The national IMR for South Africa was reported as 126 per 1000 live births in 1960, 91 per 1000 in 1980 and 71 per thousand in 1992 population groups, excluding formerly independent homelands, put the rate at 7.3 per 1000 for Whites, 13.5 for Indians, 28.0 for Coloureds and 52.8 for Africans. The rate in the former A independent homelands@, though not accurately known, is estimated at 59.8 per 1000, but some consider it to be in the order of 70 - 100 per 1000 (Koumans).

Six diseases accounted for more than 90% of the known causes of death in the first year of life during 1989 (Table 2). In the same year , perinatal causes were responsible for 23.3% of all infant deaths, up from a figure of 16.7% in 1986.

SOUTH AFRICA ESTIMATED INFANT DEATHS AND (MORTALITY RATES PER 1000 LIVE BIRTHS) BY MAJOR CAUSE, 1986 - 1989

	1986		**1987**	**1998**		**1989**
	Deaths	**Deaths**	**Deaths**	**Deaths**		
PERINATAL	15149 (16.7)	(19.30)(24.3)	17720 (23.3)	22536		22071
INTEST INFECTIONS	9993 911.0)	8769 (9.5)	8199 (8.9)	(7.2)	6769	
RESPIRATORY DISEASE	4876 (5.4)	5385 (5.9)	4619 (5.0)(4.1)		3883	
VIRAL DISEASES	1361 (1.5)	1629 (1.8)	1161 (1.3)	(0.80)	765	
CONGENITAL DEFECTS	1222 (1.4)	(1.7)	1539 (1.6)(1.2)	1459		1168
LIVE BIRTHS	907277		919979	925569		946578
KNOWN CASES	36388		39175	42315		138826
ILL-DEFINED	5226		5073	273		395
ALL CAUSES	41614		44248	42588		39221

The above six named causes:				
as % of all causes	80.6	81.4	92.1	91.4
as % of known causes	92.2	92.0	92.7	92.3

Reliable child mortality data for children 1 - 4 years of age are not available foe South Africa. Deaths during this period reflect problems with malnutrition and infection. Diarrhoea accounts for nearly 20%, while ARI accounts for about 10% of all childhood mortalities in South Africa. Some 17 000 die from dehydration due to diarrhoea, while 8 500 die from pneumonia. These figures however, are a gross underestimate of the true situation. The true numbers could easily be twice three times this figure since data from the most frequently affected population in South Africa are checkered and incomplete.

Child mortality is a measure of the tip of the iceberg for child morbidity. Diarrhoea disease and *respiratory infections* and allergies undoubtedly outnumber all other disease entities in both ambulatory facilities and hospital admissions. Primary care services for other preventable diseases have not been adequate. For example, a recent national review of the Expanded Programme on Immunisations was conducted was conducted throughout South Africa. Nationally, vaccine coverage for <1 year old ranged from just over 60 % for BCG, 75% for measles and 80% for both polio and diphtheria/pertussis (National Review EPI [SA]).

Children with disabilities such as mental retardation, deafness and blindness present a considerable burden for their care-givers and require special attention in health care planning.

Protein energy malnutrition manifests predominantly as stunning and, to a much lesser extent, in Marasmus and Kwashiorkor. There is evidence to show that Ainvisible@ malnutrition, that is, stunting, affects 30 - 40 percent of black children (Anthropometric survey in primary schools in the RSA: 1994). Apart from the propensity to infections, these children may not reach their intellectual potential.

ADOLESCENTS

Lack of education and unemployment are a major problem of the youth in South Africa. The social consequences of these factors is erosion of self esteem. The outcome are a waste of human resource waste and high rate of dependency. With these come a

series *psycho-social illnesses* which include: teenage pregnancy, STD, substance abuse, violence trauma otherwise now referred to as Aneo-morbidity@.

Teenage pregnancy is one of the most expensive health problems of youth. The consequences of teenage pregnancy, as shown in the national survey of youth in South Africa, include dropping out of school, option for low income jobs, and low self esteem.

Evarrat and Orkin (1993) among all races, 29 percent of teenagers who have children had their first child before the age of eighteen. Among Africans this figure is 33 percent.

Flischer has shown that among all South Africans between 10 and 19 years, 57 percent of deaths were due to *injuries*; of these 30 percent are results of *homicide* and 27 percent or *road accidents* (predominantly pedestrians for African and Coloureds and occupant injuries for Whites).

Other areas of concerns are *smoking, alcohol and illegal drug use, sexual behaviour, and HIV infections.*

II HEALTH POLICY

Policy about health service at the district level was poorly developed because of:

- lack of a rational, national planning framework
- complicated and uncoordinated health authorities and facilities
- unnecessary demands on tertiary services.

Previous policy had no focus on comprehensive maternal, child and women=s health provided in a comprehensive setting, no recognised need for services for adolescents.

The Population Development Programme was conceptualised as a demographic programme with the stated aim to improve the quality of life for all South Africans, but many people consider the programme to be a population control programme.

III HEALTH SERVICES

Under the apartheid system, health care was characterised by fragmentation, duplications and administrative complexity, resulting in resource mis-allocation and internal inefficiency of public programmes.

National programme like family planning, nutritional advice, tuberculosis control were vertical and fragmented.

Health facilities were inequitably distribution: 70 health facilities served a population of 500,000 in Johannesburg and 10 facilities served 3 million people in Soweto.

Health services focussed on curative rather than preventive activities. Only 1.34% of registered specialists were in community health.

Two-thirds of the registered doctors were in the private sector serving only 20% of the population.

Of the 55 million urban population, only 20% have a minimal water supply and only 35% minimal sanitation.

Of the 13 million rural population, an estimated 30 - 40% have access to adequate water supplies and less than 10% have adequate sanitation.

IV HEALTH SERVICE ORGANISATION

Health services ware organised and directed to the white minority in the form of subsidised curative care in sophisticated public tertiary care hospitals, while limited access to basic health services and low-quality care were provided to the poor.

Services were organised via complicated array of 14 departments separated by racial/population groupings.

The national health administration had a 3 tier system of State, provincial and municipality authorities stratified according to race and colour.

Proportionately very little resources were allocated for primary health care activities over which there was very little community participation and involvement.

have traditionally implemented its strategies in support of its policies, to the detriment of the development of a equitable health service for the majority of the citizen of South Africa.@

AThe National Health Administration appeared to have no deliberate managerial development programmes for the various levels of the health system. Human Resources of Health training was devoid of considerations of overall National Health needs and was no community orientated.@

(Management Development for the National Health Service in Post-Apartheid South Africa)

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C H A P T E R 3

PHILOSOPHY, PRINCIPLES FOR SERVICES, GOALS , AIMS, OBJECTIVES AND TARGETS

A. PHILOSOPHY

B. PRINCIPLES FOR PROVISION OF SERVICE

C. GOALS

D. AIMS

E. MAJOR OBJECTIVES AND TARGETS

F. SUPPORTING OBJECTIVES AND TARGETS

PHILOSOPHY, GOALS, AIMS, OBJECTIVES, TARGETS AND INDICATORS

These provide the philosophical foundations, the medium- and long-term goals, the broad aims and the measurable objectives and indicators for the promoting of health

and delivery of service for mothers, children and women. They are based on the principle enshrined within an array of international conventions and recent national proposals, in particular those in the Recontraction and Development Programme. Taken together, they constitute a consistent paradigm in which there exists ideals to aspire towards, a vision of MCWH for the near future, a mission for improving health within the next three to five years and signposts to pace progress.

PHILOSOPHY

During this time of renewal and unfolding of democracy, the mothers, children and women of South Africa, have an incontestable right to justice, peace and freedom, a special claim to the resources and riches of this land, and open access to the generosity of its people. This higher call to the conscience of our country arises from their wider exposure and deeper suffering during generations of neglect, discrimination and racism. For these reasons, the health of the nation will be measured, in the years to come, by the reduction of want, under and disease, and the increase in well-being, of its children, mothers and women. There are huge disparities in wealth, income and social services in South Africa. These lead to inequities in health and development for the majority. For democracy to succeed these inequities have to be reduced substantially.

There are numerous international agreements, declarations, conventions and charters of modern civilisation which embody the quintessential hopes of people for a better life on earth. The promotion and protection of the rights of mothers, women and children to health as a basic human right are enshrined in these international conventions. They all attest to the philosophy that foundations of freedom, justice and peace are built on the inherent dignity and on the inalienable rights of all members of the human family. This dignity is enhanced and these rights are fulfilled when social progress guarantees the well-being of the individual and the community.

The attainment of a healthy life is both a driving force and an end result of such social progress.

The above-mentioned declarations also identify children as deserving of particular safeguards, care and assistance, because of their immaturity and vulnerability. An investment in the health of children is an investment in the future of the nation. The

strength of a health system is reflected in the health status of children as young children are especially vulnerable in times of conflicts, natural disasters and economic hardship. Reduction of mortality in children therefore is a sensitive indicator of equity in health and social justice.

There are large numbers of children who have been driven to the fringes of society; they live in exceptionally difficult circumstances and therefore require special consideration.

The basic human rights and freedoms due to all children have been denied to children in South Africa, who instead have been treated with scant respect and subjected to violence, discrimination and racism. Women have endured an equal, if not greater pain.

Maternal health, especially in deprived areas, has to be vastly improved through greater attention as both maternal morbidity and mortality are at levels which reflect past neglect. Women=s reproductive health is crucial to achieving gender equity and enhancing the role and status of women is society. Access to reproductive health information and service affects are improvements in health status, in personal decision-making and self-esteem, in educational attainment, in employment opportunities and in access to economic resources.

One of the results of women=s unequal status in society is poor female reproductive health, This is especially relevant where there are different standards of sexual and reproductive choices for women and men, and when women have few realistic alternatives to childbearing as a means of obtaining social status.

Adolescence is a period of exploratory behaviour when choices are made with regard to activities of lifestyle such as eating, smoking, use of alcohol and drugs and sexual behaviour. These choices may have lifelong consequences. Actions to reduce risk-taking behaviour in all adolescents, but especially those who are truly dysfunctional, require innovative strategies. Adolescence is a key developmental period in which potential for prevention through delivery of comprehensive integrated services is great. Yet adolescents are very poorly served by health services globally and in South Africa.

Together with men, women and children constitute the family which is the abiding unit of social cohesion and the fundamental group in communities. It is the natural environment for the growth and development of children and for the stability of mothers and fathers. Their family therefore deserves protection. The status of women influences the strength of the family and women are often marginalised. Therefore the care of women is a major social concern.

Men also have a particular role to play in women=s reproductive health because in many cultures they are the decision-makers and they control access to resource needed for health-care.

Women=s health is compromised wherever they suffer discrimination in terms of access to education, health service, information and resource, and where there is gender inequity within families and communities. Such gender-based inequity poses a threat not only to the health of women themselves but also to the health of families and communities and thereby to the goals of sustainable development.

In addition to factors external to the individual and the family, such as all forms of discrimination (including racial, gender, economic and class discrimination), there are important personal behaviour factors that can impact negatively on the health of mothers, children, adolescents and women. Poor choices by women and men in decision-making relating to their sexual and reproductive function can have serious consequences for their health.

Recognition of these consequences will emphasise the importance of personal, family and community education that encourages responsible decision-making in sexuality and reproductive health. Accordingly, the creation of maximum opportunities for women and children to achieve optimum health is a central goal of enlightened nations.

The basic pre-requisites for health of children, mothers and women, are peace, shelter, education, food, income and a stable eco-system. Health services for children, mothers and women are an important facet of this broader dimension of human development. In order to achieve progress with symmetry, in societies with diverse historical groups, the provision of health services should be undertaken with due regard to traditions and cultural values which do not conflict with, but enhance the harmonious development of children and women. Health services should give priority to those groups, populations and regions which have been the most seriously affected in the past and therefore have the highest mortality rates and other evidence of deprivation. The most vulnerable are mothers and young children, and among these are present, but often hidden, those who are in greater need. They are deserving of first attention by policy makers.

A number of laws provide the legal framework for promoting the survival, development and protection of children. The Alma Ata Declaration forms the basis of the philosophy of the health care approach, which is expanded in documents from the WHO Regional Office in Brazzaville and from the Organisation of Africa Unity.

Within the country, the maternal and child health programme is located in general development policies which are aimed at promoting access to an adequate standard of living. The Reconstruction and Development Programme is an instrument for transforming government and society. It aims to deepen democracy by removing the veil which obscures the methods of political decision making and by making the processes of governance both visible and accountable. Democracy is further

strengthened by rooting the RDP firmly in development. Its people-centred approach ensures that the poor and disadvantaged are both participants and beneficiaries of the development process.

The key programmes of the RDP are focussed on meeting basic needs of rural and urban communities, maximising human resource potential, enlarging the economy and spreading its benefits, and democratising the state and society and its institutions. Indeed the first ten of the twenty fund allocations for 1994/5 deal with health or health-related projects. The people-centred approach of the RDP resonates perfectly with the philosophical nourishment from the resources of the RDP and, in turn, facilitate the achievement of its goals for children, mothers and women. The spirit of the RDP is a thrust to reduce disparities and achieve equity, this is also the essence of the MCHW programme.

B. PRINCIPLES FOR PROVISION OF SERVICES

The health care delivery system aims to ensure the provision of a service which:

- reaches all mothers, children, adolescents and women; with the focus on the most vulnerable first i.e. women during pregnancy and child birth, and children < 6 years.

- is delivered at all levels of care with a focus on the district level and with

flexibility in micro planning;

- is directed at population groups in the mos deprived areas as a matter of urgency.
- facilitates access by patients at the nearest available health facility which provides the most appropriate level of race;
- is linked with the rest of the system through appropriate referral strategies and management protocols;
- is integrated with the rest of the health service;
- is supported by appropriate institutions in society, such as schools, and
- is based on the primary health care approach.

Services for mothers, children, adolescents and women should therefore:

- Function with a comprehensive health care system
- Tackle, in the first instance, those health problems which result in maximum mortality and morbidity
- Be available, acceptable and accessible to all through a system in which appropriate levels of care are provided at facilitates accessible to patients
- Be effective and efficient in promoting health, and in identifying and helping those in need
- Combine promotive, preventive, curative, and rehabilitative care of the best quality in a workable and affordable system
- Provide good diagnostic facilities for the preventive and curative care of individual and communities

- Facilitate immediate referral to the appropriate level of care

Health service delivery to mothers, children and women should aim to enhance the scope of primary health care through:

- using MCWH as an entry point for health services so as to strengthen the entire system
- health promotion
- community involvement
- promotion of improved house hold food security and proper nutrition
- adequate supply of safe water and basic sanitation
- control of communicable diseases
- appropriate treatment of common diseases and injuries
- reduction of mortality in both mothers and children
- provision of essential drugs and vaccines, and
- provision of a basic infrastructure which includes electrification, housing, education and literacy, security, opportunities for employment and recreation for all citizens.
- provision of critical services

Such services should be based on:

- allocation of financial resources in accordance with needs of people and regions, and within agreed national norms of equity in health services
- a partnership between communities, community-based organisations (including traditional birth attendants and leaders and community health workers, advocacy groups),government health service, non-governmental health services, health personnel educators, academic and research institutions, private health organisations and practitioners, and representatives of other sectors;
- integration of the present fragmented health services that have resulted from apartheid legislation into a single national health service with equitable conditions of service for its employees;
- promotion of equity (including gender equity);

- adherence to the Convention on the Rights of the Child;
- recognition that reproductive rights are fundamental human rights;
- advocacy, including a lobby for increased resources for mothers, children and women;
- a system in which the health service is accountable to its clients; has measurable outcomes, and has the household as the focus for origisation of services, and supports these households and communities appropriately;
- maximum coverage of population groups, identified by defined geographical areas, with reasonable access to facilities and referral institutions.
- the district as the basic management unit within an interactive system
- effective district management teams, with appropriate training and with career development opportunities;
- micro planning at district level;
- intersectoral collaboration (with sectors such as education) where appropriate
- a recognition that information and education (especially about financial allocations, public health issues, appropriate technologies, community participation and available services) is essential to empower all levels of health service, individuals and communities, in decision-making;
- an acknowledgement that individuals and families will take responsibility for decision and actions related to their own health.
- In delivery of such services, the highest ethical standards must be maintained and services should be conducted with due regard to patient privacy, confidentiality, care courtesy.
- ***NOTE****: The following principles have been developed by the Community Child Health Group within the British Paediatric Association and the MCWH Committee recommends that they should also be adopted in South Africa:*
- **When they are well , children need a service that:**

  enables their parents and families to protect them from disease and environmental hazards and to promote their good health;

  is performed by health professionals who are sensitive to the special needs of children at all ages;

  provides counselling for parents and for young people appropriate to their understanding ,

  acts to create a safe heath environment.

When they are ill or thought to be ill, children need a service that:

ensure that their parents know when to seek help and how to find it;

provides 24 hour access in emergencies

supports parents in the care of their child;

is provided by staff who are of children of all ages and sensitive to the special needs of children because of their age and differing maturity-

C. GOALS

Mothers, children, adolescents and women, who form the majority of the population, are vulnerable to disease, disability, malnutrition and early death from preventable causes, and their survival needs to be assured. Within these groups mothers and children are the most vulnerable, and , further, among them are those in greatest need. Moreover there are large parts of the country which are the worst affected by poverty and human suffering.

FOR MOTHERS

To ensure access to high quality antenatal and postnatal care and quality care during and after delivery to mothers and their babies which strives achieve agreed objectives

FOR CHILDREN

To enable each child to reach his\her maximum potential within the resources available, and to enable as many children as possible to reach adulthood with

their potential uncompromised by illness, disability, environmental hazard or unhealthy lifestyle.

FOR ADOLESCENTS

To ensure access to relevant and appropriate information, community support and health services which enable adolescents to cope with the rapid physical and which expose them to the dangers of aberrant psycho social behaviour and disorders

FOR WOMEN

To achieve optimal reproductive and sexual health (mental, physical and social) for all women and their partners across the life- span of individuals

To raise the status of women, their safety, health and quality of life

D. AIMS

FOR ALL

To assess and meet the health needs of all mothers, children, adolescents and women

To promote equity of health outcome for all mother, children, adolescents and women in the population

To provide resource for health to the most vulnerable groups, population and regions, and amongst these for those n greatest need, as a matter of priority and urgency.

To develop a system which strives to achieve agreed goals and targets for all

To prevent disease and treat it in its early stage through screening and surveillance and specific interventions

To promote healthy nutrition and prevent malnutrition in mothers, children, adolescents and women

To manage and treat the health care problems of mothers, children, adolescent, and women

To enable mothers, children, adolescents and women to make informed choices through education and information

To strengthen and where necessary establish adequate health care infrastructure for the provision of maternal, child and women-s health service to meet the needs of all, with priority for those most in need

To ensure easy access to a population-based system of service delivery that will allow mothers to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant

To measure progress towards equity of service delivery and to audit quality of care by establishing a population-based information system for measuring the health status of mothers, children, adolescent and women

To monitor the effectiveness and to audit quality of services

To promote the development and training of personnel for provision o f quality health services for mothers children, adolescents and women

To strengthen and where necessary establish adequate health care infrastructure for the provision of maternal child and women-s health services to meet the needs of all, with the best chance of having a health infant
To measure progress towards equity of service delivery and to audit quality of care by establishing a population system for measuring the health status of mothers children adolescents and women

To monitor the effectiveness and to audit quality of services

To promote the development and training of personnel for provision of quality health services for mothers children adolescents and women

FOR MOTHERS

To ensure survival of mothers and their newborn through pregnancy and childbirth

To promote safe pregnancies, labour ,childbirth, pre-and post-natal care of women

To provide essential service necessary for the reduction of maternal and perinatal mortality

To reduce the physical mental and social morbidity that results from high risk pregnancies

FOR CHILDREN

To protect all children especially those in difficult circumstance

To promote survival of young children

To monitor and promote growth and development of children

To provide essential service necessary for the reduction of maternal and perinatal mortality

To establish early diagnosis through screening in order to minimise disability and handicap

To promote school health services

To identify and provide services for children with special needs

To provide children of all ages with information and life-skills which will enable them to make informed choices and will protect them from abuse

FOR ADOLESCENTS

To provide health education and preventatives services for healthy adolescents

To provide optimal out-patient medical and rehabilitative service for adolescents with physical and emotional problems at all level of the health care delivery system as appropriate

To ensure the creation of transitional programmes as a link between paediatric obstetric gynaecology psychiatric and other adult specialised and psychiatric services for adults

To provide training for health workers in the field of adolescence

To undertake evaluation of difference programme models with a view to improve adolescent health and health care

FOR WOMEN

To ensure that women can access appropriate health care service that will allow them to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant

To ensure that all women have access to information and service that allow them to have

- a responsible and satisfying sex life; and
- the capacity to reproduce and the freedom to decide if, when and how often to do so

MAJOR OBJECTIVES, INDICATORS AND TARGETS

The major objectives focus on reduction in the ultimate manifestations of ill-health of mothers, Women and children and are as follows:

1. REDUCTION OF INFANT AND UNDER-5 CHILD MORTALITY RATES

Indicators

Infant mortality rate
Under 5 mortality rate
Stillbirth rate

Early neonatal death rate

! **REDUCTION IN PERINATAL AND MATERNAL MORTALITY RATES**

Indicators

Perinatal mortality rate
Maternal mortality rate
Abortion related maternal mortality ratio

3. **REDUCTION OF SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN UNDER 6 YEARS**

Indicators
Underweight prevalence
Stunting prevalence
Wasting prevalence

4. **REDUCTION IN MORBIDITY FROM IMMUNISABLE DISEASES**

Indicators

Incidence of notifiable diseases

MAJOR OBJECTIVES

In year 1, baseline data will be established.

Targets for year 3 (1998) and year 5 (2000) are presented.

	Year 3	Year 5
1. **REDUCTION IN INFANT CHILD MORTALITY**		

1.1	Reduction of infant mortality rate	50%	30%
1.2	Reduction of under 5 mortality	75%	45%
1.3	Reduction of perinatal deaths by	20%	50%
2.	**REDUCTION IN MATERNAL MORTALITY**	**20%**	**50%**
3.	**REDUCTION OF SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN UNDER 6 YEARS**		
3.1	Eliminate severe malnutrition	50%	75%
3.2	Reduce moderate malnutrition	50%	75%
4.	**REDUCTION IN MORBIDITY FROM NOTIFIABLE DISEASES**		
4.1	Eradication of polio	No cases	
4.2	Reduction of neonatal tetanus to fewer that one case per 100,000 in all districts	100%	
4.3	Reduction in measles deaths	100% By 95%	By 95%
4.5	Reduction in measles cases to fewer than 4000 per year for 5 consecutive years beginning 1996		

F. SUPPORTING OBJECTIVE AND TARGETS

These objectives support the major objectives, viz

1. REDUCTION OF INFANT AND UNDER-5 CHILD MORTALITY RATES

2. REDUCTION IN MATERNAL MORTALITY

3. REDUCTION OF SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN UNDER 6 YEARS

4. REDUCTION IN MORBIDITY FROM NOTIFIABLE DISEASES

Furthermore, there are two other major objectives concerned with reducing morbidity and promoting well-being. These are:

5. REDUCTION IN PRIORITY CONDITIONS OF MOTHERS, CHILDREN AND WOMEN THROUGH IMPROVEMENT IN COVERAGE

6. STRENGTHENING AND ESTABLISHING INFRASTRUCTURE

Indicator for each is listed in the section entitled AMEASURING AND MONITORING@.

***NOTE**: In year 1, baseline level of agreed targets will be established. Thereafter the targets to be achieved by Year 3 are as follows:*

1. REDUCTION OF INFANT AND UNDER-5 CHILD MORTALITY RATES		
	Year 3	**Year 5**

1.1	Reduction diarrhoea		
	- deaths	By 40%	By 70%
	- cases	By 10%	By 25%
1.2	ORT use rate from existing level by 1995	80%	95%
1.3	Reduction in deaths due to acute LRTI	By 20%	By 50%
1.4	Reduction in perinatal death and morbidity from syphilis	50%	80%
1.5	Reduction in perinatal mortality rate from perinatal asphyxia and from birth trauma	20%	50%

2. REDUCTION IN MATERNAL MORTALITY RATES

2.1	Pregnant women receiving antenatal care increased from existing level to	70%	100%
2.2	Deliveries in institutions by trained birth attendants increased from existing level to	75%	90%
2.3	Deliveries in institutions	50%	75%

3. REDUCTION OF SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN UNDER 6 YEARS

Promote growth promotion and monitoring for children under 2 at community level		
Promote exclusive breast feeding for 4 - 6 months	75%	100%

4.	**REDUCTION IN MORBIDITY FROM IMMUNISABLE DISEASES**	
	Immunization status	90%
	Coverage for each vaccine	

5. IMPROVED COVERAGE WITH SELECT SERVICES FOR CHILDREN, ADOLESCENTS, MOTHERS AND CHILDREN

5.1	Reduction in preterm delivery and low birth weight	20%	50%
5.2	Access to fertility regulation services for all requiring it from existing level to	80%	100%
5.3	Decrease the proportion of births in women below 16 years from existing level to less than	5%	2%
5.4	Decrease the proportion of births in girls between 16 - 18 years from existing level to less than	10%	5%
5.5	Contraceptive prevalence rate to be increased from existing level to	70%	85%
5.6	Increased coverage with Vitamin A prophylaxis in children 9 months to 3 years, in Vitamin A deficient areas	100%	
5.7	Information on sexuality and life skills to children	40%	90%

6. ESTABLISHING/STRENGTHENING INFRASTRUCTURE

6.1	Implementation of protocols of management in antenatal, intrapartum, postnatal and neonatal care as detailed in the Perinatal Education Programme (PEP) both administratively and through appropriate health personnel education training programmes	70%	100%
6.2	Establish norms and standard for patient referral between levels of the service	100%	
6.3	Ensure client acceptability of the maternal and neonatal services	70%	100%
6.4	Access to information and fertility regulation for all, from existing level to	80%	100%
6.5	To establish a district-based system for maternal and neonatal care	100%	
6.6	Possession of Road to health card 100%	100%	
6.7	Patient-retained health records	80%	90%
6.8	Proportion of schools with school health service	70%	100%
6.9	Proportion of children with special needs who receive appropriate services 70%	100%	
6.10	Provision of training for health workers in the field of adolescence	100%	
6.11	Districts to have reliable demographic data	90%	100%
6.12	District microplans drawn up 100%		
6.13	Establish health facilities in deprived areas	100%	

TARGETS TO BE DEVELOPED FOR THE FOLLOWING:

- To ensure client acceptability of the maternal and neonatal services

- To provide quality antenatal care, quality labour and delivery care

- To provide health education and preventative services for adolescents

- To provide standardised client-held antenatal and labour records for all pregnant women

- To reduce disability and subsequent progression to handicap with special reference to physical, mental and developmental handicap

- To decrease the prevalence of child abuse by:
  - providing units of expertise
  -developing capacity within social services for the management of child abuse
  -training health care providers
  -developing teams of professionals in each district/region

- Proportion of children who have been subjected to sexual or physical violence, who receive good quality care at the appropriate level of service

- To reduce the mortality and morbidity from childhood injury

- To ensure that all HIV positive mothers and their infants have access to appropriate care and interventions which reduce mother to infant transmission

- Proportion of women who have been subjected to sexual or physical violence, who receive good quality care at the appropriate level of service

- Provision of services for farm workers (targets, indicators)

CHAPTER 4

CONCEPTUAL FRAMEWORK

CONCEPTUAL FRAMEWORK

Health services for mothers, children and women will be delivered as part of integrated

comprehensive health delivery system(horizontal approach) which is population-based. This system will be supported by an organisation and management structure which is vertical in emphasis and is linked to the rest of health service administration at each level of governance.

A clear and rapid pathway of referral and feedback along a hierarchy of skills and levels of service is also implicit.

The conceptual framework for the delivery of services to mothers, children and women of reproductive age is represented by the following diagram:

SERVICE DELIVERY (A, B AND C AXES)

A-AXIS: ELEMENTS OF SERVICES (PROGRAMMES)

These are detailed in the text and include:

FOR ALL:	comprehensive integrated health care services for disability, mental health, STDs (including HIV), communicable disease control(including HIV), oncology, genetics
FOR MOTHERS:	antenatal, intrapartrum and post partum care
FOR CHILDREN:	comprehensive child health services (including neonatal care and adolescent health services) Priority attention to EPI, CCD, ARI, Nutriotion, School Health Services for children with special needs and for those in difficult circumstances
FOR WOMEN:	adolescent health, violence, reproductive health (including FP), STD/HIV, surgical contraception, cancer screening

B-AXIS : LEVEL IN MCH LIFE-SPAN

mothers
newborns
young children (0-<3, 3 - <6)
older children (including scholars and homeless children)
adolescents
women of reproductive age
women beyond reproductive age

C-AXIS: LEVEL OF CARE

POLITICAL LEVEL TYPE OF CARE FACILITY

national	quaternary care	selected level 3 hospitals
provincial/tertiary level of district council	secondary level of referral	level 3 referral hospital
district sub-structure	primary level of referral	level 2 hospital
community	first level of medical care	community health centre/clinic
home	self- and community based care	outreach CHWs

NOTE:

- Provision of type of care at any level may be delegated to facilities at another level where appropriate
- More than one type of care may be provided at a facility in accordance with local community need and facilitation of accessibility.

SUPPORT

These structures operate at the following levels:

POLITICAL LEVEL	HEALTH ADMINISTRATION	ORGANISATION STRUCTURES
National	Department of Health	MCWH Unit Advisory Group
Provincial	Provincial Health Department	Provincial MCWH Management Team Advisory Group
District Council	DC Health Department	DC MCWH Management Team Advisory Group
District Sub-structure	DSS Health Department	DSS MCWH Management Team Advisory Group
Community	Clinic Committees	Community Health Forum
Home	Civic and other Community Organisations	Health Desk

The integrated service delivery is supported by a separate ORGANISATION AND MANAGEMENT SYSTEM which provides vertical support for the service trough:

Defined organisation structures

Delineation of organisational functions including:

Planning of support for service delivery
Planning and management of programmes
Planning and management training

This system is also responsible for OTHER MANAGEMENT FUNCTIONS which include:

- management of change
- management of resources
  (finances, personnel, facilities, drugs and equipment)
- support through information, education and communication (with appropriate formats in relation to target group capacities and to include training in schools/curriculum change);
- monitoring and evaluation
- health information systems, information management and epidemiological analysis
- supply and logistics
- transport and communication
- community organisation
- intra- and intersectoral collaboration

CHAPTER 5

DELIVERY OF SERVICES

DELIVERY OF HEALTH SERVICES TO MOTHERS, CHILDREN, AND WOMEN

MCWH services will be delivered as part of comprehensive integrated system at all levels of care. For each level, functions are proposed. Delivery of services is also described in relation to service activities, staffing and facilities.

Mothers, children and women represent more than 73% of the population. They are the target of a population - based integrated health services which strives for equity through providing coverage of the whole population through a comprehensive strategy which has the components of promotion, prevention, cure and rehabilitation.
This should be taken into consideration in planning for a more appropriate proportion in the allocation of resources and facilities of MCWH within the integrated system.

Health services will, as a matter of priority, be directed for the most vulnerable groups and to the most deprived areas. Epidemiological data, where such information exists, and reasonable assumptions where it does not, will provide the criteria for definitions of vulnerability and deprivation. Some criteria which may be used are:

mortality rates (MMR, IMR, U5MR, PMR)

morbidity rates (measles, diarrhoea, ARI, malnutrition, TB, HIV)

health services availability (basic, essential MCWH services for the following: rural and high population density region, informal settlement, farm workers, homeless)

education *(female education)*

income.

A. DELIVERY OF SERVICES: FUNCTIONS

! NATIONAL DEPARTMENT OF HEALTH.

MCWH services for rare or complex disorders and problem in need of super -speciality *(quaternary*) services.

! PROVINCIAL DEPARTMENT OF HEALTH.

FACILITY: LEVEL 3 HOSPITAL

Tertiary care
(*at level 3 hospitals in a given province and in adjacent provinces which have no tertiary care facility)*

Sub- specialist support
(for other levels of care within the province)

Primary and secondary care to the immediate community.

Facilitation of referral
(to and from this level of care with feedback)

Co- ordination of care
(between this level and other levels in the province)

Medical support services

Provision of diagnostic and therapeutic support services
(Including diagnostic laboratories, blood banks, transport services)

Advice
(to welfare services, special needs and to other sector concerned with the well-being of mothers, women and children)

Social and welfare support services

! DISTRICT COUNCIL DEPARTMENT OF HEALTH

FACILITY: LEVEL 2 HOSPITAL

Secondary care
(second level of referral at level 2 hospital)

Co-ordination of delivery of care
(with other levels in the province and district)

Specialist support
(for health care delivery at district level and for in service training)

! DISTRICT SUB-STRUCTURE DEPARTMENT OF HEALTH

FACILITY LEVEL 1 HOSPITAL

Provision of 24 hours service
(*acute problems, obstetrics service for high- risk pregnancies and deliveries)*

Specialist consultations and management of referrals

Chronic diseases
(control and management)

Diagnostic and therapeutic support services
(radiology, basic biochemistry and haematology)

! COMMUNITY LEVEL CARE

FACILITY: COMMUNITY HEALTH CARE

Delivery of integrated comprehensive MCWH
(with daily extended access and attention to priority problems)

Complete obstetrics services
(for low risk mothers and their newborns with appropriate referral)

Emergency care
(including obstetrics, gynaecological and neonatal emergency care)

Referral of MCWH problems

Screening and early detection of disability

Provision of on-site medical support services
(Laboratory for STD/HIV and TB screening)

Health promotion and illness prevention

Health surveillance and data collection for simple epidemiological analysis

Integration with community- based health facilities

Organisation and delivery of outreach services

Support for basics services
(such as housing, water, sanitation, refuse removal)

Support for visiting specialists

Intersectoral collaboration
(eg education and agriculture)

Community and NGO liaison

FACILITY: CLINIC

Delivery of integrated comprehensive MCWH
(with daily extended access to all components of health care and including promotion, prevention and management with referral of minor problems and ailments)

Emergency care

On-site services for rapid STD/HIV screening *(depending on available technology*)

Health surveillance and data collection

Provision of medical support services
(on-site RPR testing)

Linkage between clinic and health centre/district services

Facilitate community outreach and integration

Support for the provision of basic services
(clean water, sanitation, refused disposal, and housing)

Liaison with community health committees

! HOME

Involves the individual child or women herself, the parents, other family members, caregivers, teachers and other community members

and is supported by

health projects of community- based organisation and extensions of the health services in:

! maintenance of good health and fostering of healthy lifestyles
(including sexual behaviour)

! early recognition and management of minor ailments, problems and life-threatening issues

! prevention and promotion

! support for special needs
(such as disability, abuse, unwanted pregnancies)

! tracing of births, death and high risk groups

! providing information and support to enable communities to access appropriate care for each of these conditions and problems

! participation in community- based and social mobilisation health related activities

! early recognition of pregnancy and its antenatal, intra partum and postpartum complications

B. DELIVERY OF SERVICES: ACTIVITIES, STAFFING AND FACILITIES

S NATIONAL

1. ACTIVITIES

Include bone marrow, liver, and heart transplantation for children.

2. STAFFING

Based on level of expertise and experience

3. FACILITIES

Based on available financing, technology and technical support

Number of facilities and nature of services provided varies with the disorder

Some quaternary services may be delegated to level 3 hospitals

Access to these services will be based on equity and other criteria yet to be developed

S **PROVINCIAL**

HEALTH SERVICES FACILITY: LEVEL 3 HOSPITAL

1. SERVICES

1.1 GENERAL

Sub-specialist services
(second level referral in-patient and out- patient services in paediatrics, obstetrics and gynaecology)

Day care, emergency care

Intensive care

Other specialist services:
Surgical services
(*general and sub-speciality including orthopaedic, ophthalmic, ENT, plastic surgery)*

Radiotherapy

Specialised psychological services

Disability care

Respite care

Advice
(to relevant education, welfare and labour departments)

Management of abused and battered women and children

Sub- specialist support
(for district council and district sub-structure levels through clinical servicesand support for in- service training)

Social services

1.2 SPECIFIC CONCERNS FOR TARGET GROUPS

1)PREGNANT WOMEN

Tertiary obstetrics care
(including intensive care)

2)NEWBORNS

Neonatal care

Post delivery care for high risk infants
(Ventilation support, parental nutrition, placement of chest drains and catheters, ultra sound examination, blood pressure monitoring)

3)CHILDREN

Interdisciplinary medical services for learning disorders

Education and learning resources

Services for developmental problems and behavioural disorders

Genetic services
(audiology, ophthalmic, other)

4)ADOLESCENTS

Multi disciplinary services for substance abuse, trauma, suicides, neurological and cardiac diseases

Multi disciplinary services for pregnant adolescents

5)WOMEN

Ambulatory and in-patient sub specialist gynaecology services
(including oncology, in vitro fertilisation, micro-surgery, colposcope and treatment for cervical pathology)

Abortion services
(including therapeutic abortions after 12 weeks of gestation, treatment of abortion complications)

Referral clinics
(*for contraception and STD problems, surgical contraception, treatment of rape survivors and battered women)*

1.3 HEALTH CARE SERVICES ALLIED TO CLINICAL MEDICINE

Speech therapy, physiotherapy, neuro-developmental therapy, occupational therapy, play therapy, music therapy, clinical psychology, social work, therapeutic dietetics

1.4 *MEDICAL SUPPORT SERVICES*

Pathology, pharmacology, radiology, genetic counselling

1.5 *SOCIAL AND WELFARE SUPPORT SERVICES*

2. STAFFING

Medical:
Specialists and sub-specialists
(*obstetricians, gynaecologists, neonatologists, paediatricians, surgeons, psychiatrists, other sub-specialists required at this level)*

Registrars in specialist training
Medical officers and interns

Nursing:
Nurses specially trained for specialist and sub-speciality care for MCWH
(*paediatric nurses, advanced paediatric nurses, advanced midwives, other specialist nurses where needed (eg oncology, advanced neonatal nurses, etc)*
Midwives, general nurses

Staff in health care services allied to clinical medicine

Staff for medical support services

Staff for other support services
(including management of facilities)

3. FACILITIES

3.1LEVEL 3 HOSPITAL- BASED

Accident and emergency department

Facilities for tertiary care:
Ambulatory care
Day care
Intensive care
Rehabilitation
Radiotherapy

Medical support facilities:
Radiotherapy
Ultrasound
Blood bank

Diagnostic laboratory services
(*including specialised laboratory facilities for STD screening which liaises with the National STD Reference Centre)*

X-ray department

Management facilities: (may have to be centrally located)
Cold chain central store
Pharmacy stores
Equipment for disabled persons
Repair and maintenance department
Medical stores for equipment

Facilities for adequate communication

3.2 SPECIAL FACILITIES FOR TARGET GROUPS

1)MOTHERS
Antenatal ward and clinics
Admission ward
Labour ward with monitoring equipment
Postnatal ward
Intensive care

2)NEWBORNS
Resuscitation area
Intensive care unit
Special care nursery
Observation nursery
Parent room

3)CHILDREN
Comprehensive in-patient and ambulatory care facilities for children to include:
In-patient facilities and beds for:
Intensive care
(*including special facilities for neonatal tetanus)*
paediatric medical care
(*including accommodation for the management of infectious gastro-intestinal, respiratory and nutritional diseases)*

Child psychiatry

Surgical care
(*including ophthalmic and ENT surgery, burns unit)*
Accommodation for mothers/ caregivers

4)ADOLESCENTS

Multi disciplinary in-patient adolescent units
(*including facilities for socialising and for schooling)*

Facilities for psychiatric care, management of substance abuse

5)WOMEN

Ambulatory and in-patient facilities to include beds for:
in vitro fertilisation
women with reproductive health problems STD
abortion- related pathology
oncology and radiotherapy
plastic surgery, microsurgery, endoscopy

Day care surgical contraception facilities

Treatment of rape survivors

3.3 LINKED TO LEVEL 3 HOSPITAL

Respite care facilities

Specialised community groups or association support of specific health problems

1)PREGNANT WOMEN
Centre with obstetrics facilities

2)**NEWBORNS**
Neonatal care facilities for first level care

3)CHILDREN
Child development centre
Centre for interdisciplinary management of abuse

4)ADOLESCENTS
Centre for management of drug and alcohol abuse

Residential care for young adolescent mothers

5)WOMEN
Refuges for battered women

S DISTRICT(METROPOLITAN) COUNCIL AREA

FACILITY: LEVEL 2 HOSPITAL

1. SERVICES

1.1GENERAL

Secondary referral out-patient and in-patient services

Day care and emergency services

Surgical services
(*general, orthopaedic, ophthalmic, ENT, plastic surgery)*

Psychiatric and psychological services

Disability services

Services for management of abuse

Specialist services
(*to support facilities and in-service training at district level)*

Social services

1.2 SPECIAL CONCERNS OF TARGET GROUPS

1)PREGNANT WOMEN
Complete obstetric services
Intensive care facilities in the labour ward
Cardiotocograph monitoring
Assisted vaginal deliveries
Caesarean sections

2)NEWBORNS
Advanced resuscitation
High risk care
(*including open and closed incubators care, oxygen therapy and monitoring, nasogastric feeding, intravenous therapy, antibiotic treatment, prevention of apnoea of immaturity, phototherapy, policy to prevent nosocomial infections)*

Neonatal intensive care units
(*where population density warrant such placement)*

3)CHILDREN
Medical services for children with learning difficulties
Educational and learning resources for children
Services for children with development problems and behavioural disorders
Audiology and ophthalmology services

4)ADOLESCENTS
Multi disciplinary services for substance abuse
Multi disciplinary services for pregnant adolescents

5)WOMEN
Ambulatory services and anti-patient services
(*for gynaecology, colposcope and treatment for cervical pathology, surgical contraception)*
Referral clinics
(*for contraceptive and STD problems*
Abortion services
(*for therapeutic abortions and abortion complications, day care abortions after 12 weeks of gestation)*

1.3 HEALTH CARE SERVICES ALLIED TO CLINICAL MEDICINE

Physiotherapy, occupational therapy, play therapy, clinical psychology, social work, therapeutic dietetics

1.4 MEDICAL SUPPORT SERVICES

Pathology, pharmacy, radiology(including X-ray unit), genetic counselling

2. STAFFING

Medical:
Specialists
(*obstetricians, gynaecologists, paediatricians, anaesthetists, general surgeon, family medicine specialists)*
District surgeons
Registrar in specialist training, medical officer and interns

Nursing:

Nurses specially trained for specialist and sub-speciality care for women and children
(*Paediatric nurses, advanced paediatric nurses, advanced midwives, other specialist nurses where needed such as advanced neonatal nurses)*
Midwives
Primary health care trained nurses

Staff in health care services allied to clinical medicine

Staff for medical support services

Staff for management of facilities

3. FACILITIES

3.1LEVEL 2 HOSPITAL-BASED

Level 2 hospital including:
accident and emergency department
ambulatory facilities
day care facilities
in-patient services
rehabilitation department
social ane welfare support services
appropriate laboratory services

3.2SPECIAL CONCERNS OF TARGET GROUPS

1) MOTHERS
Antenatal, delivery and postpartum services
Intensive care in labour ward

2) NEWBORNS
Resuscitation area
Intensive care
Special care nursery
Low care nursery

3) CHILDREN
Facilities for comprehensive specialist care (excluding sub-specialist facilities)

In-patient facilities to include bed for:
paediatric medical care
(*management of infectious diseases and priority conditions such as gastrointestinal, respiratory and nutritional*

disorders)

General surgical care
(*including a burns unit)*
Facilities for psychiatric and ENT surgery
Accommodation for mothers/ caregivers

4) ADOLESCENTS

Limited special accommodation
Basic families for psychiatric services
Facilities for alcohol and drug treatment and rehabilitation

5) WOMEN

Adulatory and in-patient facilities for gynaecology, colposcope to include beds for:
Women with reproductive health problems
(*including tubal surgery, abortion related problems, STDs including HIV/AIDS)*
Cervical pathology treatment facilities
Referral clinics
(*for contraception and STD problems)*
Day care facilities
(*Including facilities for abortion after 12 weeks of gestation, surgical contraception facilities)*

3.3 LINKED TO LEVEL 2 HOSPITAL

Respite care facilities

Specialised community groups or associations for support of specific health problems

Basic for child developmental assessment and intervention

Refuges for battered women

Facilities for the assessment and management of abuse, rape and battery

S DISTRICT SUB-STRUCTURE

FACILITY: LEVEL 1 HOSPITAL

1. SERVICES

1.1GENERAL

Health promotion

Prevention of disease

Recognition and management of common and life-threatening diseases
(*Including provision of 24 hour medical, surgical and psychiatric service for acute and life-threatening problems of mothers, children and women)*

Periodic visits of specialists
(*ophthalmologists, psychiatrists, paediatricians, physicians, obstetricians/ gynaecologists, tuberculosis specialists)*

Management of chronic diseases

Liaison with social services

Laboratory services
(*including basic STD services for rapid HIV and RPR testing)*

Radiology

1.2SPECIAL CONCERNS FOR TARGET GROUPS

1) PREGNANT WOMEN
Complete comprehensive obstetric services
(*for normal mothers and newborns, and for moderate and high risk pregnancies)*

Caesarean section
Treatment of medical problems during pregnancy
Foetal monitoring

2) NEWBORNS
Resuscitation
(*including intubation)*
Routine newborn care
Management of minor problems
Promotion of breast feeding
Phototherapy
Emergency care of sick or small newborns
Immunisation and good follow-up care

3) CHILDREN
Delivery of services for priority problems
(*including diarrhoeal disease, ARI, abuse, nutritional deficiencies, tuberculosis, HIV/AIDS, disability)*
Special services for children with special needs
(*such as chronic illnesses, disabilities, abuse, mental handicap)*
Developmental screening and surveillance; developmental diagnosis

4) ADOLESCENTS

Multi disciplinary services for pregnant adolescents
Special services to manage substance abuse

5) WOMEN

Comprehensive reproductive health services
(*including cervical cancer diagnosis and treatment including colposcope, biopsy and treatment of pathology, routine surgical procedures, surgical contraception and IUCD fitting)*
Management of infertility
(*investigation and appropriate management and referral)*
Abortion services
(*including management of complications of abortions, therapeutic abortion after 12 weeks of gestation)*
Management of upper genital trac infections
HIV/ AIDS care
(*including management of complication of HIV infection and care of AIDS patients)*
Management of rape and battery
(*including in-patient services for rape survivors and battered women)*

3. STAFFING

Medical:
Medical officers (full- and part-time)
Part-time GPs with skills in MCWH service delivery
Family medicine specialists in training
Dentist
Visiting specialists
District surgeons (full- or part-time)

Nursing:
Midwives, advanced midwives, nurses with MCWH skills
Staff nurses, enrolled nursing assistants
Psychiatric nurses

Medical support staff:
-Pharmacist, laboratory technician, radiographer, physiotherapist

Staff compliment to include staff with knowledge and skills for:
-the clinical management of MCWH;
-monitoring and evaluation of services (epidemiology, biostatistics and health information systems);
-organisation and management of services and programmes;
-provision of in-service training for other health workers.

Co-ordinator of rehabilitation team
(*ideally a therapist, but may be a health professional with special skills in rehabilitation)*

4) FACILITIES

Level 1 hospital facilities to include:

Labour ward
(*with resuscitation area and facilities to do Caesarean sections)*

Small nursery
(*with bassinettes, closed incubators, oxygen sources and head box, overhead radiant warmer, phototherapy unit, resuscitation equipment and scale)*

Area/room for mother-baby support
(*follow-up clinic and breast feeding support for mothers and young infants)*

Support facilities
(*including ambulance, security, maintenance section)*

On-site obstetric are for normal mothers
(*including provincial for antenatal care and delivery of normal mothers in community health centres in the grounds of the hospital or nearby)*

S COMMUNITY

FACILITIES: COMMUNITY HEALTH CENTRES AND CLINIC

SERVICE FACILITY: COMMUNITY HEALTH CENTRE

1. SERVICES

1.1GENERAL

Twenty-four hour services for the following activities:
Emergency care
(*care and management of common and life-threatening medical, surgical and psychiatric emergencies)*

Minor surgery
(*repair of tears, wounds, fractures)*
Overnight stays
(*for management of problems such as ARI, management of dehydration, pelvic inflammatory diseases)*

Ambulance service for referral

1.2SPECIAL CONCERNS OF TARGET GROUPS

1) PREGNANT WOMEN

Antenatal care
(*At least one visit during each trimester (end of first trimester, end of second trimester and at 36 weeks of pregnancy); syphilis screening and treatment to be carried out at first visit. In cases where there are no facilities for on-site screening, results to be available within one week of the first visit.)*

Total obstetric management of normal patients
Emergency management of patients with obstetric complications
Treatment of common problems of pregnancy
Manual removal of placenta
Vacuum extraction

Contraceptive and breastfeeding counselling
(*At least twice during antenatal visits)*
Services for the management of the intermediate risk pregnant woman
Post natal check
(*including contraceptive and breastfeeding counselling within ten days of delivery)*

2) NEWBORNS

Care for normal newborns
Care for sick newborns
Emergency management
(*of patients with neonatal complications)*

3) CHILDREN

Health promotion
(*through health education, especially on breastfeeding and nutrition)*

Developmental screening
Prevention of disease

(*through immunisation, growth monitoring, nutrition education and vitamin A supplementation where appropriate)*

Improve hygiene in home
(*through education)*

Recognition and management of common and life-threatening conditions

Management of chronic diseases

School health services
(in catchment area, with involvement of teachers, pupils, parents)

Screening and care of pre-school children
(*in pre-school centres with community involvement)*

4) ADOLESCENTS

Supervising delivery of services for school health, adolescent health

Comprehensive adolescent health services
(*Including management of substance abuse, identification and management of psychological problems)*

Counselling and support services for HIV positive adolescents

Abortion services
(*including abortion counselling, therapeutic abortions through day care services, management of complications of abortions)*

Comprehensive reproductive health services
(*including management of grade 3 upper genital tract infections, special provision for young adolescent mothers)*

5) WOMEN

Abortion services
(*including counselling, therapeutic abortions through day care services, provision of abortion services before 12 weeks of gestation, management of complications of abortions)*

Comprehensive reproductive health services
(*which include contraceptive services, emergency contraception, prevention, detection and management STDs and HIV, early diagnosis of pregnancy and delivery of normal pregnancies, antenatal care, self-examination of the care breast to be taught, screening for genital tract cancers, primary and secondary prevention of infertility, management of grade 3 upper genital tract infections)*

Counselling for request for termination of pregnancy

Preliminary assessment of infertility prior to referral

Detection and management of abuse

Referral

(*for surgical contraception of IUCD fitting if service not available in clinic, referral to hospital for termination of pregnancy after 12 weeks of pregnancy, management of abuse)*

Prevention, recognition and management of common medical conditions *(including hypertension, diabetes, tuberculosis, osteoarthritis)*

2. **STAFFING**

Nursing:

Professional nurses, enrolled nurses, primary care trained nurses
Midwives and advanced midwives
Paediatric and neonatal nurse practitioners

Medical:

Medical officer
Primary care trained doctors
Family medicine practitioners with MCWH skills
Private general practitioners

Primary health care team

(*including environmental health officer/assistant, laboratory assistants, community nutritionists, health promoter, oral hygienist, pharmacy assistant, community -based rehabilitation workers(with capacity to do pre -and post test counselling and HIV tests) social work assistant)*

Community health workers

(*including community-based rehabilitation workers, TBA:s and community based distributors of contraceptives - supported by community health centre but working in community)*

Support staff:

Clerical staff
Cleaning staff
Security staff
Drivers

3)**FACILITIES**

Community health centre facilities including:

Basic diagnostic facilities

(*including laboratory facilities for STD screening as set out in the national STD and AIDS strategy, X-rays)*

Support facilities
(*electricity / gas power, working toilets and running water, good security, maintenance workshop)*

Essential equipment
(*including refrigerators)*

Communications and transport
(*telephone, radio, fax, ambulance, 4-WD vehicle in certain areas, bicycles)*

Serum storage and pharmacy

On-site facilities for patients
(*garden, safe play area for children, herding facilities provision of a waiting mothers- area within the ground of the facility)*

Records / demography/ map process

SERVICE FACILITY: CLINIC

1. SERVICES

1.1GENERAL

Health promotion

Prevention of health problems
(*immunisation growth monitoring, nutrition, contraception and antenatal care)*

Management of acute and chronic diseases

Referral

1.2SPECIFIC CONCERNS OF TARGET GROUPS

1)PREGNANT WOMEN
(*See details for minimum antenatal care in Appendix 1)*
antenatal care
syphilis
postnatal check
breast feeding check

2)NEWBORNS
Care for normal newborns
Management of emergencies

3)CHILDREN
Recognition and management of common and life-threatening conditions
(*including congenital syphilis, low birth weight babies, diarrhoea, acute respiratory infections, fevers, skin and eye disorders, nutritional deficiencies (food supplementation) tuberculosis, STDs including HIV/ AIDS, disability(rehabilitation), accidents and poisonings, parasitises)* Abuse services
(*including detection, management, notification and referral of abuse (including sexual abuse) in children)*

4)ADOLESCENTS
School -based and school-linked clinics for adolescents

5)WOMEN
Prevention, recognition and management where appropriate of important health problems
(*including STDs, HIV/AIDS, TB abnormal uterine bleeding, breast and reproductive tract cancers, abuse and unwanted pregnancies)*
Comprehensive reproductive health services
(*including family planning services provision)*
Abuse services
(*detection and management and referral)*

Prevention, recognition and management of common medical conditions

2) STAFFING

Nursing:
professional nurses, enrolled nurses, primary care trained nurses, nurses with training in antenatal care and postnatal care (PEP manual), some trained as EBHC trainers.

Medical:
Visiting medical officers

Community health:
Community health facilitators

CHWs working in the community, NOT in the clinic

Support staff:
Clerical staff
Cleaning staff
Security staff
Drivers

3) FACILITIES

Clinical facilities to include:
Oral rehydration facilities
Sterile delivery packs
Communications
(radio and telephone)
Electricity / gas power
Refrigerator
Working toilets and running water
Good security
Essential equipment
Transport

S HOME

1. SERVICES

Services to this level are provided through outreach services, community-based health care and self-care.

Activities to be undertaken to provide, promote and improve MCWH at home/ community level: CHWs to identify high risk families to special care, especially early complications of pregnancy, child birth, common childhood diseases.

2. STAFFING

Community health:
Trained traditional birth attendants
(*where these are practising)*

Home visiting staff:
(*from either neighbourhood community clinic, or health centre or from mobile or outreach*

services)

Trained community health workers:
(*may include special categories such as community-based distributors of contraceptives, community-based rehabilitation workers)*

Community members:
(*teachers, shopkeepers, traditional healers trained as CHWs)*

3. FACILITIES
Use of community buildings or rooms as satellite clinics or health posts

These may include pre-school centres and schools.

C. DELIVERY OF SERVICES: SPECIAL NEEDS

Health services for mothers, children and women will be delivered through a comprehensive integrated strategy which is supported by a vertical organisation and management structure which is linked to administrative structures at each political and health administration level.

Within this system, special attention needs to be given to priority conditions and concerns in order to reduce morbidity and mortality, and thus improve the overall well-being of mothers, women and children.

The priority conditions thus identified include:
acute respiratory tract infections in children
dehydrating infectious diarrhoeal disease
malnutrition
tuberculosis
rheumatic fever
childhood injury
abuse of children
uncontrolled fertility
rape and battery of women
disability
mental handicap

Other issues of concern for women and children include :
homelessness and refugees
children in difficult circumstances
substance abuse
sexually transmitted diseases (including HIV/AIDS)
hepatitis B, and

teenage pregnancy.

The areas of MCWH which are in need of greater attention within an integrated MCWH service delivery framework are:
oral health
mental health(including emotional and behavioural disorders)
Adolescent health
school health
gay and lesbian health, and
genetics.
These issues have all been considered by the committee and need to be integrated into the service delivery framework as the burden of delivery of health services related to these problems is borne by the staff delivery of health services related to these problems is borne by the staff delivering services to mothers, children and women.

They are considered in greater detail in the main document and in the appendices.

CHAPTER 6

ORGANISATION AND MANAGEMENT

! ORGANISATION AND MANAGEMENT OF SERVICES FOR MATERNAL, CHILD AND WOMEN=S HEALTH

The organisation and management of MCWH services will be optimised through a coherent framework of interconnected administrative units established at all political levels of governance, from national, through provincial and regional to the district.

The Health Administration Departments at each level will separate from the service facilities and will have their own budget.

They will be located within the political framework of administration and will provide support for the delivery of services through a system with vertical emphasis.

At each level of health administration there will be structures with defined functions in relation to organisation and management of services for mothers, children and women.

These include linkages to structures for:

- for intersectoral co-ordination(development committees)
- for regularly obtaining advice from a wide range of expertise and concerned stakeholders(advisory groups); and
- for day-to-day management and supervision of services(MCWH Units of Health Management Teams).

It is important that the MCWH Units have representation in the PHC subcommittees of the Development Committees at each level of political governance to discuss and advice on distribution of resources at each level.

Advisory groups will be formed at each health administrative level to assist the MCWH Units in adapting policy, problem solving and overcoming pitfalls or obstacles if these arise. Such groups will draw on local expertise from academic institutions, professional bodies, NGOs, CBOs, other sectors and community leaders.

Core members of the MCWH Unit will serve on Health Management Teams at each level and will be responsible for supervision, audit and technical support of the MCWH services within their area of administration.

ORGANISATION AND MANAGEMENT STRUCTURE AT ALL LEVELS

POLITICAL LEVEL	HEALTH ADMINISTRATION	SER
NATIONAL GOVERNMENT Director General: Health National Services & Programmes Division Other Divisions	Department of Health Advisory Committee MCWH Unit: Director Maternal, Child, Women=s Health & Liaison sub-units: Deputy directors	Quaternary
PROVINCIAL ADMINISTRATION Development Committee PHC subcommittee	Provincial Health Department MCWH Unit Advisory Group Management Team Representative	Provincial Tertiary Ho
DISTRICT COUNCIL Development Committee PHC subcommittee	District Council - Advisory Group Health Department - Management Team MCWH Unit Advisory Group	Second Le Referral Ho
DISTRICT SUBSTRUCTURE COUNCIL Development Committee PHC subcommittee	District Substructure Health Department MCWH Unit Advisory Committee Management Team Representative	Community
COMMUNITY ORGANISATION Development Unit	Community Health Forum MCWH Group Community based health care	Community Clinic outre Satellite Cli Mobile Clin

The services will be based on a set of norms and standards which will conform with those developed for all comprehensive and integrated service delivery within the national health service.

For maternal, child and women=s health services, the following is a suggested minimum set of norms for service delivery:

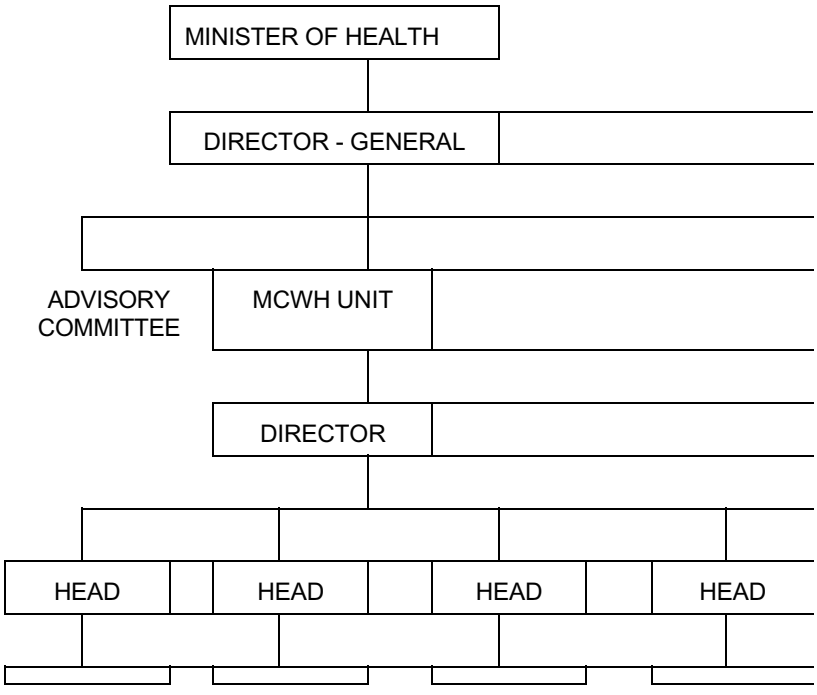
- 1 community health centre : 25 000 rural population
- 1 community health centre : 50 000 urban population
- 1 first level hospital: 250 000 rural population
- 1 first level hospital: 500 000 urban population

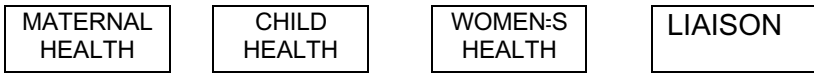
Other norms and standards will be decided by the MCWH Unit in conjunction with the relevant departments, committees, and bodies of expertise and experience.

NATIONAL DEPARTMENT OF HEALTH

1. ORGANISATIONAL STRUCTURES

The organisational structures for this level of administration include a NATIONAL MCWH UNIT and a NATIONAL MCWH ADVISORY COMMITTEE





1.1 NATIONAL MCWH UNIT

A National MCWH Unit will be established by the Department of Health. It requires very high level of management - at director level. It also warrants separate placement within the National Department of Health and not merely as one of nine programmes.

Such organisational emphasis will facilitate the allocation of an appropriate proportion of resources to this important constituency of the health service which will provide for more than 73% of the population.

MCWH UNIT
(DIRECTOR)

ADVISORY GROUP

MATERNAL HEALTH SUB UNIT HEAD	CHILD HEALTH SUB UNIT HEAD	SUB UNIT HEAD	S
Antenatal Care	Neonatal Care and Child Care	Adolescent Health	T
Intra partum Care	EPI + Liaison	Violence against women	I
Post Partum Care	CDD +Liaison	Women=s rights Legislation + Liaison	I
Perinatal Care	ARI + liaison	FT	I
	Nutrition + Liaison	Surgical Contraception	I
Audit	School Health Educare	STD/HIV + Liaison	I
Liaison ! STD/HIV ! GE NE TI CS	STD/HIV +Liaison	Child/Adolescent Psychology Counselling	I

	Children in difficult circumstances	Audit
	Disabilities	
	Integration	
	Audit	

The National MCWH Unit will be established by the Department of Health and will develop a system for co-ordination and collaboration with relevant units, Divisions and Programmes in the Department for specific M.C.W.H. policy formulation and management of a comprehensive M.C.W.H service. The DIRECTOR will have responsibilities for the four sub-units.

The National MCWH Unit will develop regular coordination and collaboration for specific policy formulation and monitoring of a comprehensive MCWH service with key role players in relevant Units, Divisions and Programmes in the Department of Health.

These include;

Provincial Health Liaison
Policy Coordinating Unit
(Esp health promotion and public information)
Human Resource Planning
Registration, Regulations and Epidemiology

and within the National Services and Programmes Divisions to include the following Units:

Vaccines
EPI
Communicable Disease Control
STD/HIV/AIDS
Nutrition
Disabilities
Genetic Services

The relationship of the MCWH Unit to implementation and monitoring of a National Plan of Action

for Children will also have to be considered in the near future.

The MCWH Unit will have three sub-units, each of which will be concerned with the major target age groups, viz maternal health, child health and women=s health.

Furthermore some aspects of MCWH care require such complex, constant negotiation and integration with other sections of the Department of Health that six areas separated off for liaison as a fourth sub-unit.

These are liaison with:

- training institutions
- international organisations
- provincial departments
- monitoring and health information systems
- procurement of equipment and supplies
- health promotion

The responsibilities of each of these sub-units is indicted on the organogram overleaf.

The MCWHUnit will have a Director who will have responsibility for four sub-units.

The work of four programmes listed in the proposed organogram for the National Health System as *national programmes independent of MCWH* falls largely on staff working in MCWH services.

These are NUTRITION, EPI, STD/HIV, and COMMUNICABLE DISEASE CONTROL.

For these programmes, it is recommended that there be liaison staff to function at the interface between the relevant MCWH sub-unit ans the respective programme.

As the management of acute lower respiratory tract infection and diarrheal diseases in children are important priorities, they will be placed directly under the Child Health sub-unit of MCWH.

The MCWH Unit will continue the policy development and planning work of the present MCWH Committee.

The **FUNCTIONS OF THE MCWH UNIT** will be to:

- formulate policy and strategies in consultation with provinces
- develop priority programmes
- review and suggest amendments to national legislation
- develop norms and standards
- facilitate research
- undertake national budgetary allocation
- monitor and evaluate services and training
- monitor a National Plan of Action for Women and Children

Details of these functions are discussed below.

The Staff of the MCWH Unit should include:

HEALTH PROFESSIONALS

Director
Deputy-Director for each sub-unit
2 chief nursing service managers for each sub-unit
1-2 social scientists for the Unit
1 counselling psychologist

3-4 liaison officers

ADMINISTRATIVE STAFF

1 assistant director(administration)
3 administrative officers
1 secretary
3 clerks
1 typist

CONSULTANTS

Medical specialists should be appointed in an advisory capacity to each sub-unit. These consultants will be drawn form public sector health services, research institutions and the national pool of joint staff appointees to academic service complexes.

The **BUDGET** for the National MCWH Unit will be approximately R5,75m. This will include R2,25m per sub-unit(incl R0,74m per sub-unit for administration) and a director=s budget of R0,5m.

The allowances for consultants will be drawn from the respective sub-unit budgets.

1.2 *NATIONAL MCWH ADVISORY GROUP*

The wide range of MCWH activities requires constant guidance and inputs from expert and experienced persons in South Africa.

MEMBERSHIP

An advisory group (which could include some members of the present MCWH Committee) will have representatives from:

academic hospitals
professional associations
research bodies
provincial departments
private sector
non-governmental organisations
other ministries(such as education, welfare)
The RDP
youth organisations
international organisations
community leadership at various levels

Each sub-unit will have a small core advisory group of 4 - 6 persons which would have the power to co-opt experts for specific focussed tasks.

Representatives of the core advisor groups(approximately 20 persons) and the MCWH Unit (approximately 6 persons) should meet every 3 - 6 months to discuss changes in a wide variety of technical matters and to reach consensus on prioritization.

This group will be chaired by the MCWH Director.

RESPONSIBILITIES

Periodic review of policy documents
Development of new policy and management protocol statements
Yearly progress review
Scrutiny of audit reports from the three sub - units
Review of obstacle to progress which may appear

2. FUNCTIONS

2.1POLICY DEVELOPMENT

The National MCWH Unit will be responsible for:

Development of policy:

- for children aged birth - 18 years
- for obstetric and neonatal care
- on adolescent health
- on comprehensive reproductive health services
- on women=s health

Co-ordination of all policies:

With other levels of the organisation, with other departments(within health sector) and with other sectors

The MCWH Unit should work closely with the National AIDS Programme and with the following sectors:

Education
Welfare

Law
Labour
Sport and recreation

Provision of vertical support to the appropriate level of service delivery

International liaison

Monitoring progress of policy implementation

Dissemination of national policy to provincial level

Proposal of appropriate legislation for policy implementation

Development of policies to address new problems and the introduction of new strategies and interventions.

NOTE: APolicy@ includes issues of financing, personnel, services, drugs, facilities, equipment, programmes

2.2.PLANNING GENERAL

The National MCWH Unit to perform the following planning functions:

Integration and coordination of

- services for children aged birth to 18 years
- obstetric and neonatal services
- adolescent health services
- reproductive health services
- women=s health services

Acquisition of data for planning

Regular audit of services to inform allocation of resources through development of standardised audit programme

Definition of standards of service management

Liaison with private sector to facilitate care for all women and children in both private and public facilities

Design a system for implementation of service audit and quality assurance

Monitor health status and utilisation of health service

As part of their work and at an early stage, the MCWH Unit will be asked to undertake the

following activities:

FOR MOTHERS

- Acceptance and implementation of protocols of management for antenatal, labour, postnatal and neonatal care as provided in the Perinatal Education Programme(PEP)
- Training of midwives and doctors in the use of PEP
- Co-ordination of decentralised programmes for advanced diploma midwives(ADMs)(DEPAM) which will be provided at sub-regional level
- Design of a standardised patient-carried card that includes antenatal care and labour information. This is to be done in consultation with those presently using such cards.
- Design of a standardised in-patient maternity and neonatal documentation
- Design of a computerised maternal and neonatal audit programme. This is to include information on perinatal and maternal deaths including avoidable factors, caesarean section rates and community assessments of services rendered (through community health committees). An audit system currently in practice that can be consulted is that used in Kalafong Hospital.

FOR CHILDREN

1)Input into vital registration system especially with regard to birth registration and notification process

- Design of standardised Road-to-Health client-retained card for national use

- Participation in intersectoral linkages with

  welfare
  education
  educare
  media
  law
  labour
  sport and recreation

- Promotion of advocacy in relation to the implementation of the Convention on Child Rights

2)Work with international agencies(eg UNICEF, WHO, UNFPA)

FOR WOMEN

1)Design a standardised women=s health card for use in both the public and private sector.
2)In conjunction with the National AIDS/STD Programmes, design a standard card for contact tracing of STDs.
3)Development of a population -based HIS to collect data for agreed health indicators.
4)Work with international agencies(eg UNICEF, WHO, UNFPA)

2.3. MANAGEMENT: PROGRAMMES

National MCWH Unit to undertake the following functions in relation to organisation and management of programmes:

Develop programmes for service delivery for women and children

Develop national programmes for priority problems in accordance with need.

Coordinate special concerns related to women and children within the national programmes(such as AIDS, EPI, CDD, ARI, Safe Motherhood, Reproductive Health, TB, STD)

Monitor , evaluate and research programmes

Disseminate programmes to provincial and district level

Support implementation of services at other levels of the health care system through the development of standardised protocols of management and referral, and support for relevant health personnel training

FOR MOTHERS

! Programmes for mothers includes the full range of maternity and neonatal services

FOR CHILDREN

1) Coordination with other national programmes in the development of management and referral protocols for priority conditions including diarrhoeal disease, acute respiratory infections malnutrition,
   - ! Liaison with other departments and sectors in planning health care interventions for addressing priority concerns including breastfeeding, child abuse, mental health, oral health, school and educare
   - ! Coordination of health services for children with special needs
   - ! Coordination of health services for children in institutions and in custody
   - ! Development of a system of screening and surveillance for child health

FOR ADOLESCENTS

1) Planning and coordination of services to meet the following priority conditions and concerns:
   - Problems related to sexual activities
   - Teen pregnancy
   - STDs including HIV infection
   - Drug problems
   - Alcohol-related problems
   - Sports injuries
   - Mental health
   - Physical and sexual abuse
   - School learning difficulties
   - Chronic conditions
   - Growth and sex maturation problems
   - Gynaecological problems

FOR WOMEN

- To develop programmes based on the recommendation put forward in the National South African and WHO Assessment of Family Planning and Reproductive Health Services.
- To develop home-based care programmes for HIV patients
- In consultation with key role players to develop policy on priority women=s health issues including:
  - Establishing and coordinating guidelines for a national cervical screening programme
  - Evaluating the outcomes of different models for a cervical cancer screening currently being implemented.
  - Safe legal abortion services
  - Improved provision of contraception including surgical contraception for men and women and emergency contraception.
  - Guidelines for the provision of new methods of contraception
  - Prevention of HIV spread to women and neonates(as set out in the National AIDS and STD strategy).
  - Prevention and management of infertility.
  - Development of new policy for other key areas.
  - Violence against women (covering rape, battery, sexual abuse of children, etc.).
  - Menopausal service provision
  - Commercial sex workers
  - Reproductive health service provision for people with disabilities including the mentally ill
  - Reproductive health services which addresses the needs of the elderly

2.4.MANAGEMENT TRAINING

The National MCWH Unit to plan for the following training activities related to programmes which should de delivered at provincial level:

Develop and adapt modules for training courses
Development of training programmes to enable clinic and district services to audit their work
Facilitating the development of a core training group for women and children=s health services
Development of norms and standards for training
Production, review and evaluation of training materials
Development of training manuals for management of services for women and children
Provision of adequate training in management and administration at all levels
Coordination of in-service training for all health workers
Coordination of foreign/overseas training in MCWH with human resource planning

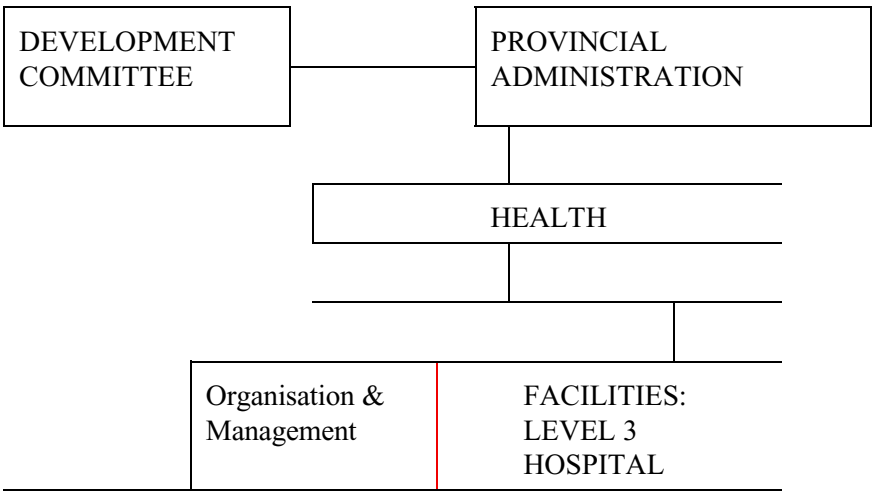
Such training activities are well-developed for mothers for mothers and newborns where training will be based on the Perinatal Education Programme(PEP) and the Decentralised Education Programme for Midwifery Education (DEPAM).

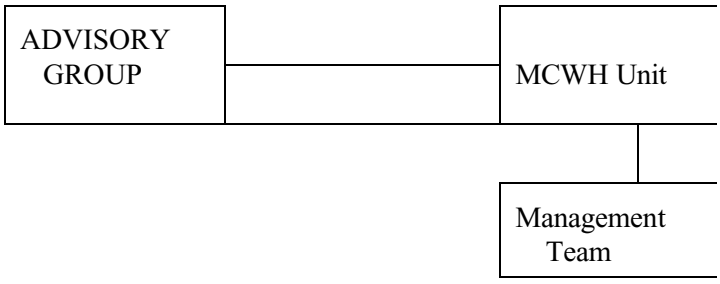
Similar programmes will be developed for children, adolescents and women.

II. PROVINCIAL DEPARTMENT OF HEALTH

ORGANISATIONAL STRUCTURES

At provincial level there will be two separate organisational structures - a PROVINCIAL DEVELOPMENT COMMITTEE and a PROVINCIAL MCWH UNIT.





A PROVINCIAL DEVELOPMENT COMMITTEE will be formed at the political level. This committee will have representatives from all sectors and which will be concerned with planning and financial allocation.