JUSTIFICATION OF THE INNOVATION

The burden of maternal deaths is of great concern in Cameroon. Among various causes, is the fact that before 2011, in all health facilities including those in the northern region of Cameroon, pregnant women were expected to pay in advance for care related to delivery and management of obstetric complications. This prevented access to care for poor women or caused significant delays in the decision to use health facilities, thus leading to an increase in maternal and neonatal mortality in the poorest areas in Cameroon.

To address this issue, the Ministry of Health and partners introduced an innovative approach in the northern region of Cameroon, the prepositioning of obstetric kits (birthing kit and emergency caesarean bag) in health facilities. These kits have general use items and medicines for normal vaginal delivery and caesarean delivery respectively. The strategy aims to reduce maternal and neonatal mortality by reducing the third delay (time lost between reaching the facility and initiation of treatment) to access care, especially delayed treatment of obstetric complications and deliveries in these facilities.
Maternal mortality continues to rise in Cameroon, with data reporting an increase of 352 maternal deaths per 100,000 live births from 1998 to 2011 with 430 deaths per 100,000 live births (DHS II, 1998) to 669 maternal deaths per 100,000 live births (DHS III, 2004) then 782 deaths per 100,000 live births (DHS IV, 2011).

Many factors have limited the access of women to safe delivery, to quick and effective management of obstetric complications particularly in the northern regions of Cameroon. They include widespread poverty, high out of pocket expenditures to buy prescription for facility births, high rates of illiteracy, ignorance, the low socio-economic status of women, the lack of social security, poor service, no plan of preparation for childbirth and related complications, no systematic use of partographs to monitor labour, a lack of qualified and competent staff and many unhealthy reproductive sociocultural practices. DHS(2011) showed 64% deliveries were conducted by skilled birth attendants and the richest quintile had nine times higher rate than the poorest quintile. Similarly national rate of caesarian deliveries was four percent with rural rate of two percent. Overall 35 percent women quoted lack of money as a reason for not seeking timely care(35.5 percent in Adamawa, 40.7 percent in Far North and 43.5 percent in North.

To accelerate the reduction of maternal and neonatal mortality, pregnant women need to have prompt access to care for delivery and the systematic management of obstetric complications, without the advance payments. The prepositioning of obstetric kits was thus implemented since 2011 as an innovative approach in areas of Adamawa, the North and Far North. Women who are not able to immediately pay for the birthing kit or caesarean bag would have the opportunity to benefit from recovery costs generated by facility. This strategy was supported by the Ministry of Health, through a circular (ministerial statutory instrument).

OBJECTIVE

The aim of the strategy of the prepositioning of obstetric kits is to contribute to reducing maternal mortality and newborn mortality in the regions of Adamawa, North and Far North.

It aims to achieve the following:

• Encourage women to give birth in health facilities
• Increase the number of births attended by skilled personnel
• Detect complications early and provide the necessary support
• Reduce the delay of care in health facilities (third delay)
• Prevent bleeding that occurs after childbirth (post-partum haemorrhage)

STRATEGY/IMPLEMENTATION

Since 2011, the strategy has been implemented in three northern regions (Adamawa, North and Far North). In the Far North, it covered 4 of the 28 health districts in the region (Kaélé, rural Maroua, Mokolo and Yagoua). From 2012 to 2013 it was extended to nine other health districts (Bogo, Bourha, Guidiguis, Kar-hay, Kousseri Maga, rural Maroua, Mora and Moutourwa). In 2014, it is envisaged to be expanded to health districts in Moulvoudaye and Koza.
The obstetric kits are made affordable through the pooling of contributions from health facilities and development partners. The birthing kit costs 6000 CFA francs (USD 12), which includes the management of obstetric complications, infection, eclampsia and repair of tear or episiotomy. Caesarean bags include all medicines and disposables required for an emergency case that cost 40,000 CFA francs (USD 80).

Implementation includes the following strategies:

- Ensuring immediate availability and accessibility of standardized obstetric and caesarean kits in targeted health facilities through a system of cost-sharing
- Training and adequate motivation of health workers in obstetric and neonatal care emergency
- Enforcement of active management of the third stage of labour (AMTSL) by trained health workers
- Auditing of maternal deaths in health facilities

Cost-sharing is based on:

- The availability and use of birth plans and partographs
- Prepositioning of delivery and caesarean kits in health facilities
- Active management of the process of removing the placenta and membranes, to reduce bleeding after childbirth

All these actions are accompanied by:

- Advocacy and community mobilization
- Establishment of a mechanism for strengthening governance to reduce theft through staff motivation
- Setting up a system of compensation for loss of kits or their constituent parts.

**PROGRESS AND RESULTS**

The following results have been observed:

- Average annual coverage rates in skilled delivery have risen to 32.9 per cent (DHS 2011) from 26 per cent (DHS III, 2004).
- The percent of caesarean deliveries out of all births have improved (4.1 per cent in 2011, 5.7 per cent in 2012 and 5 per cent in 2013).
- Good participation of health workers and women in the project through good annual average utilization rate of delivery kits (89.33 per cent), total reimbursement of delivery kits (97.87 per cent) and debt recovery—recovery of fees owed for the kits (96.27 per cent).
- The principle of ‘serve before being paid’ is respected in most cases.
- Rates of maternal deaths in health facilities have decreased (0.50 per cent in 2011, 0.27 per cent in 2012 and 0.36 per cent in 2013).
- Rates of neonatal deaths in health facilities decreased (23.48 per cent in 2011, 1.77 per cent in 2012 and 0.98 per cent in 2013).
• Improved use of AMTSL (90.6 per cent) rate
• Increase in the number of audited maternal deaths although still low (57.4 per cent)

LESSONS LEARNT

Key lessons learnt during the implementation of the project are:

• The strategy makes it easier for mothers to access care and helps reduce delays in the care of women in labour in health facilities.
• Understanding the importance of emergency kits by emergency medical personnel is essential for the real impact of the strategy on reducing mortality.
• Maintaining an acceptable recovery rate of kits is one of the cornerstones of the sustainability of the strategy.
• A communication strategy is essential for the mobilization of stakeholders and beneficiaries in favour of the strategy.
• Monitoring and supervision are essential for the consolidation of the strategy.
• Stock-outs of obstetric kits and the supply of the emergency bag are barriers to the success of the strategy.

CONCLUSION

A brief assessment of the strategy of pre-positioning of obstetric kits in health facilities indicates that significant progress has been made, particularly in the case of caesareans performed in the two years since the strategy’s implementation. Efforts are being made for staff training especially in peripheral health facilities, to further improve the management of complications responsible for maternal mortality.

Scaling up the strategy will require strengthening the management of the national centre (CENAME) to ensure the continuous availability of supplies of medicines. Within the framework of a national strategy, support from the government to the private nonprofit sector should be considered as this can be done by providing a general subsidy for obstetric care. However, expanding the strategy to include the private sector would require a thorough analysis of operational and investment costs so that benefits of reduction of out of pocket expenditures for obstetric kits are not lost.

RECOMMENDATIONS AND NEXT STEPS

• Building on the positive experience of the Northern region, the MOH is scaling up the strategy to other regions in the country.
• Strengthening the referral system will contribute to the reduction of the second delay (time lost in travel from home to the health facility).
• The private sector needs to be involved in the implementation of the strategy; however, a thorough analysis of the economic viability and the cost to the women it serves should first be carried out.
• Strengthening the existing monitoring system in health facilities through prepositioned kits strategy.
FOR MORE INFORMATION

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Country project funded through a grant from Swedish International Development Cooperation Agency (Sida)

DATA SOURCES: Circular Letter on the MOH strategy; Presentation of the pre-positioned Kits Midwifery in the northern regions of Cameroon

In a joint effort to improve the health and save the lives of women and children, UNAIDS, UNFPA, UNICEF, UN Women, WHO and The World Bank are working as the H4+

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