

MCH Day Celebration 21 February 2024

Cambodia Emergency Obstetrics and Newborn Care Review (EmONC) – Progress and Challenges



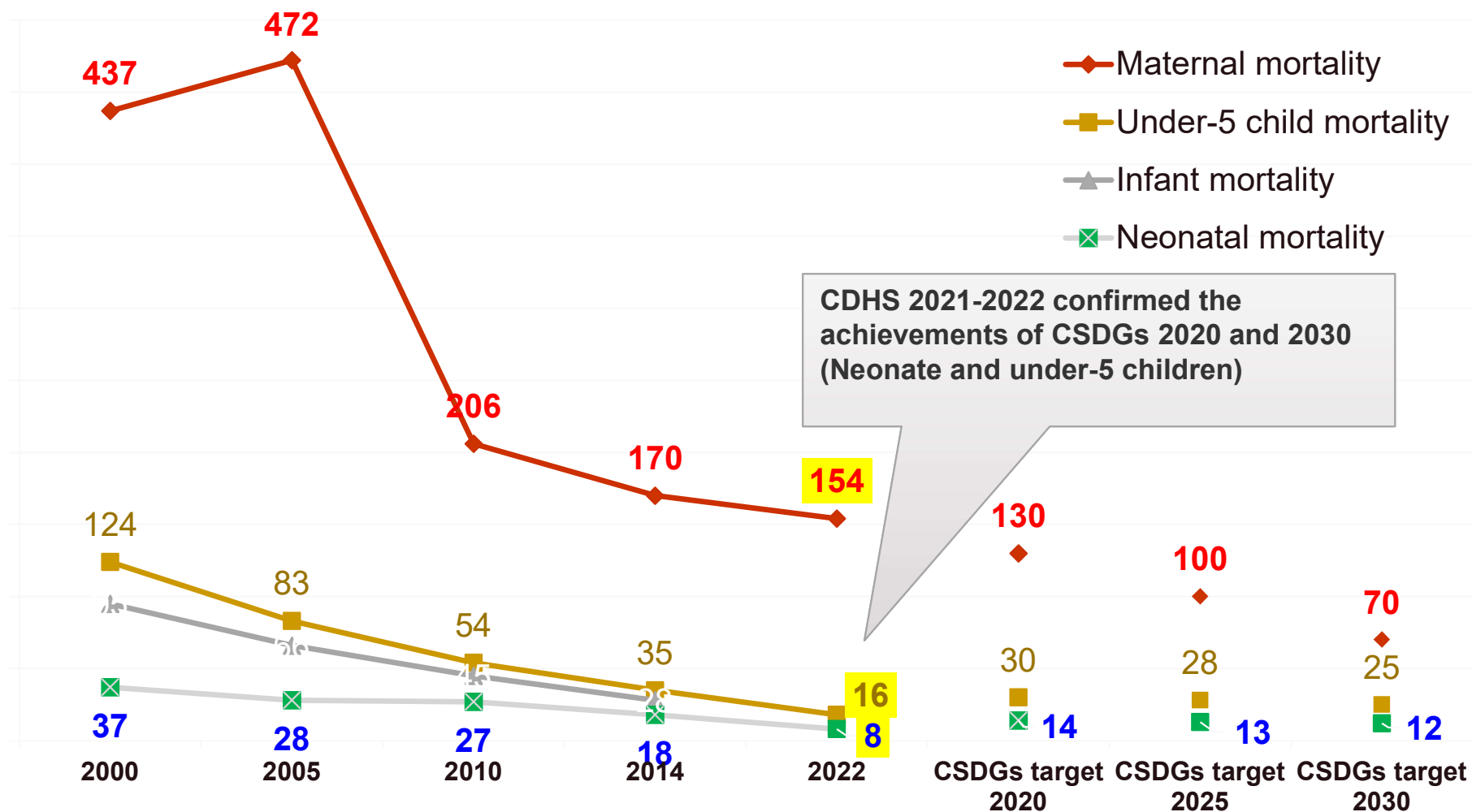
Presented by:




Outline

- Objectives
- Introduction: The EmONC 2020 Review
- Progress: Findings on EmONC Signal Functions
- Challenges: Summary of Key Findings
- Key Recommendations
- Next Steps

Impact result: Trend of maternal, neonatal & under-5 child mortality in Cambodia, 2000-2022



KINGDOM OF CAMBODIA
NATION - RELIGION - KING

MINISTRY OF HEALTH



**Fast Track Initiative Road Map
for Reducing Maternal and
Newborn Mortality
2016-2020**

May 2016

Core components:

- 1- Skill birth attendance
- 2- **Emergency obstetric and newborn care (EmONC)**
- 3- Newborn care
- 4- Family planning
- 5- Safe abortion

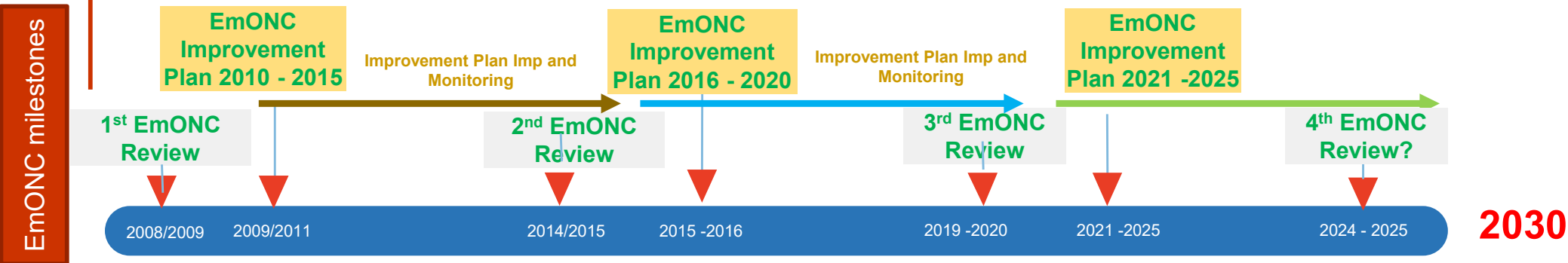
Enabling components:

- 6- Removing financial barriers to access health services
- 7- Behavior change communication

Intro: Cambodia EmONC Baseline Study/Review

II. EmONC Improvement Plan

Timeline



Policy and Programme Progress

Policy change

Structural change

Quality and functions

Advocacy

Objectives – EmONC 2019-2020 Review

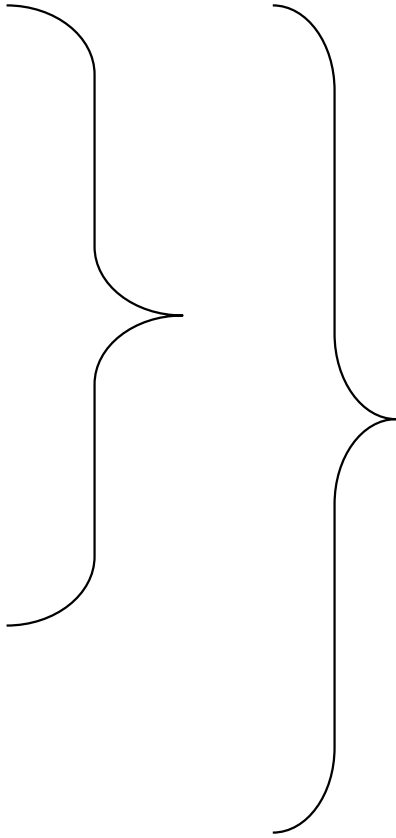
- To share the progress and challenges from the EmONC Review 2020
- To discuss what can be done to improve EmONC coverage and quality



Progress - EmONC Signal Functions Review 2020



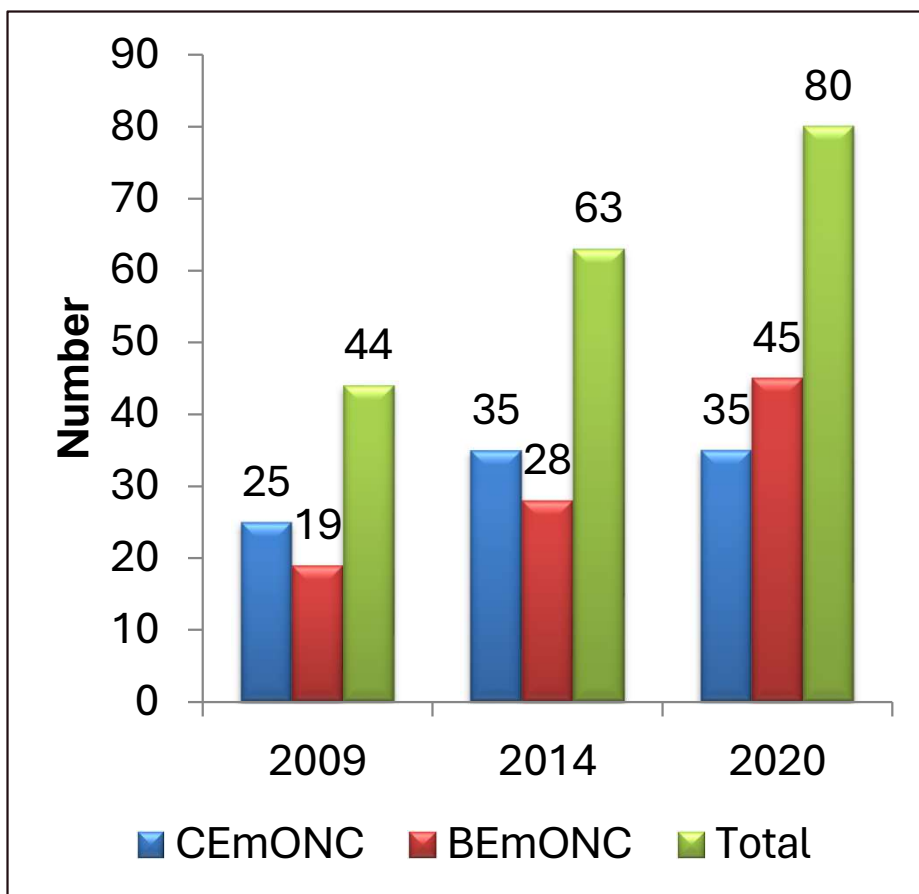
Signal Functions of BEmONC and CEmONC

1. Parenteral antibiotics
 2. Parenteral oxytocics
 3. Parenteral anticonvulsants
 4. Manual removal of the placenta
 5. Removal of retained products
 6. Assisted or instrumental vaginal delivery
 7. Neonatal resuscitation
 8. Blood transfusion
 9. Cesarean delivery / Cesarean section
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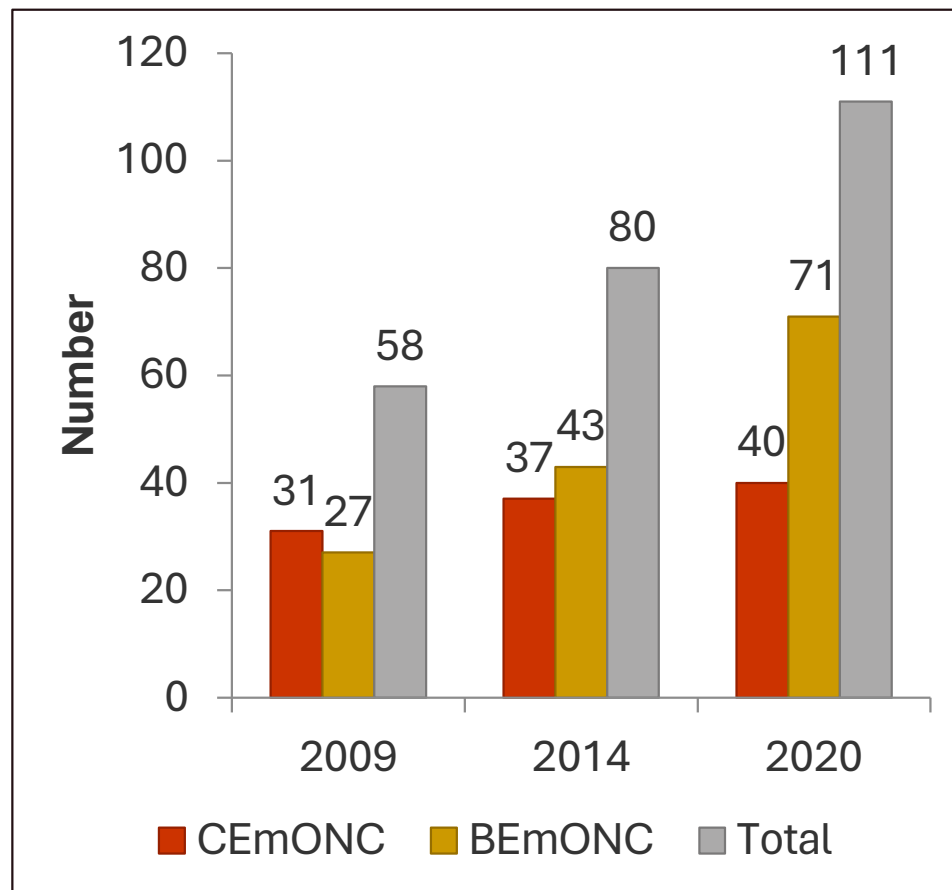
Basic EmONC Facility 1-7 Comprehensive EmONC Facility 1-9

Availability of functional EmONC Facilities

3-months prior the review

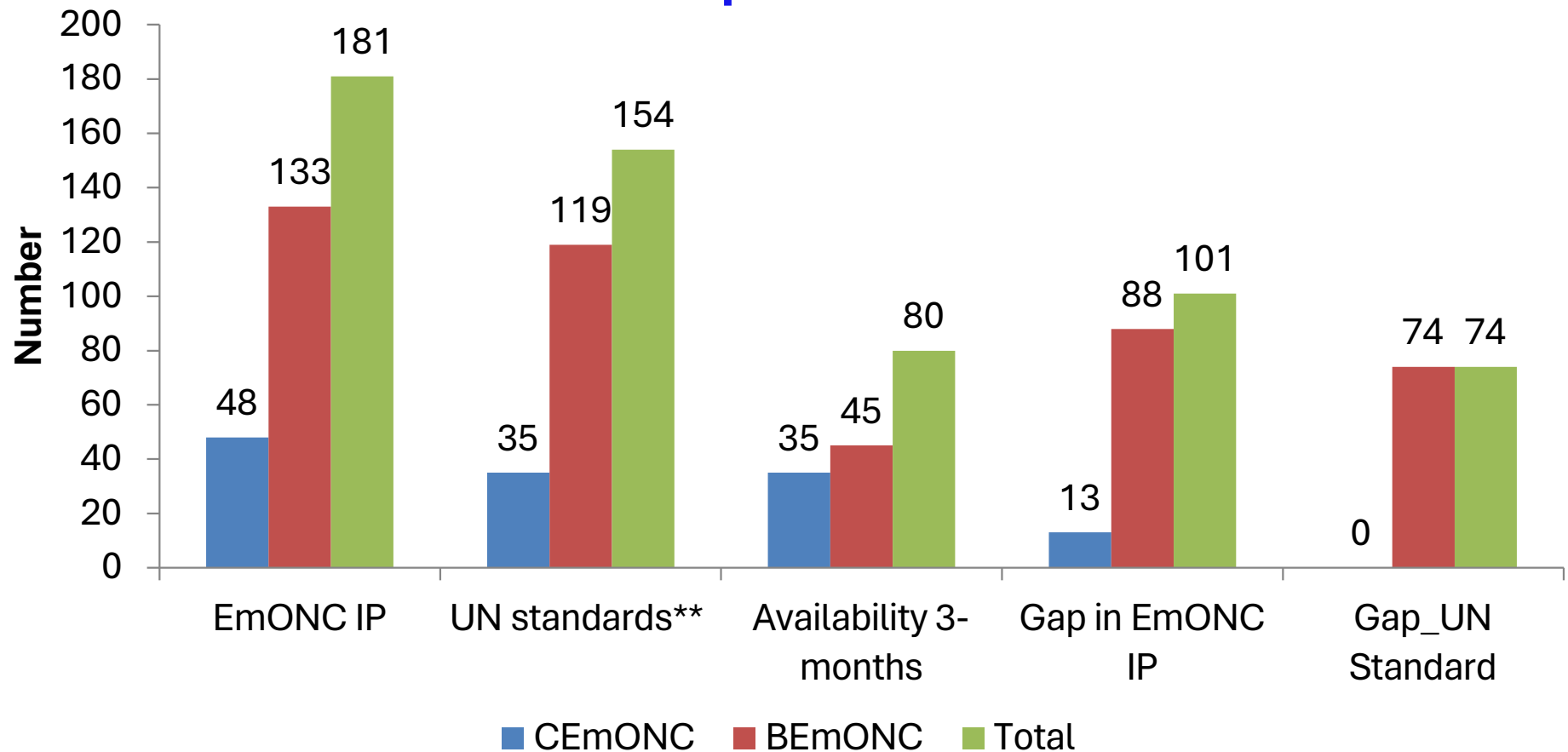


12-months prior the review



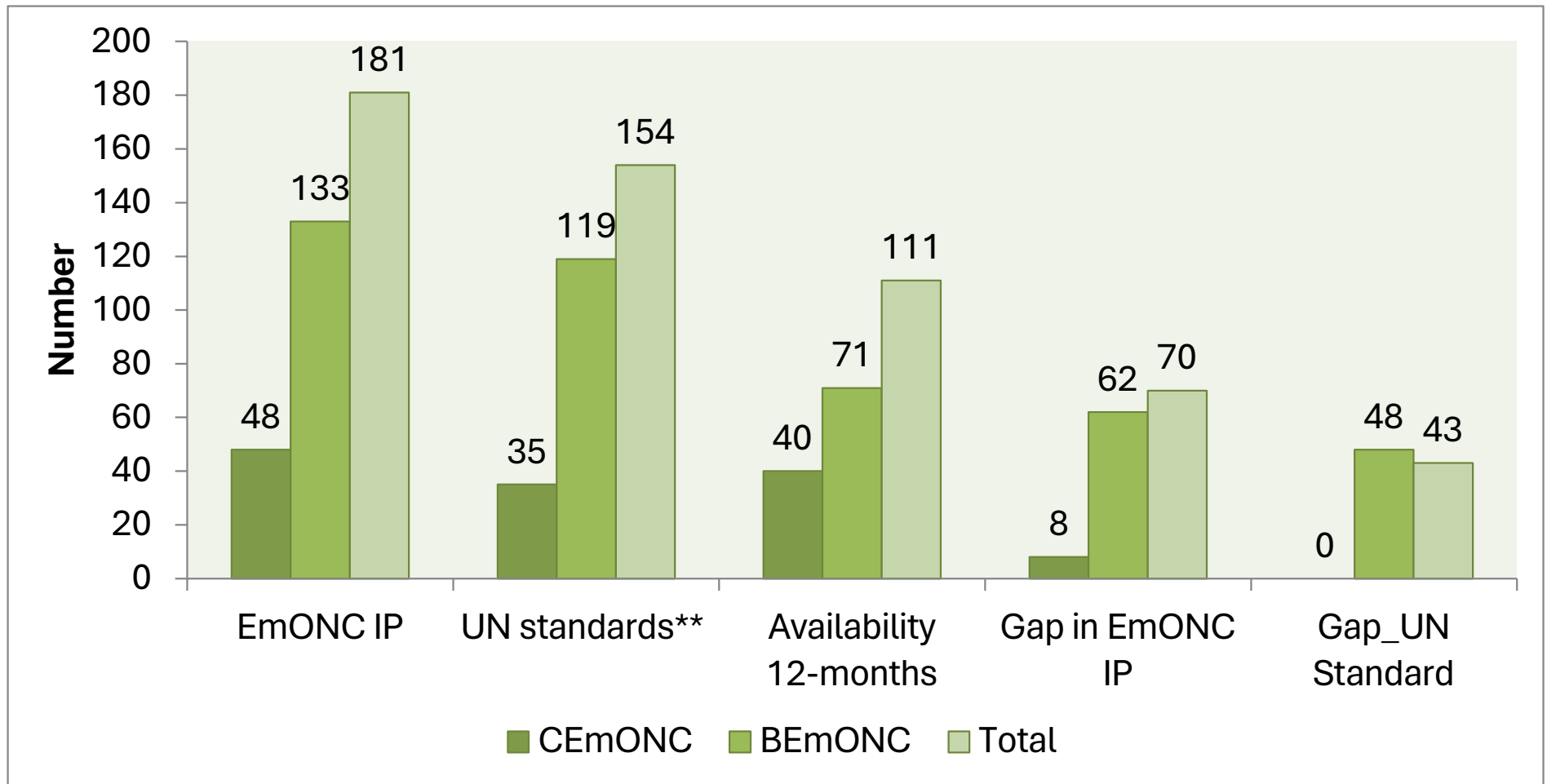
Availability and Gap of functional EmONC Facilities across Cambodia

3-months prior the review



Availability and Gap of functional EmoNC Facilities across Cambodia

12-months prior the review



Challenges – Key Findings

- BEmONC facilities slowly increased, should be a priority
- CEmONC is clustered in urban setting
- There are needs to increase the utilization of the services
- Quality is improved, but requires more
- Structural deficiencies - health workers, equipment and supplies, health information systems, and transport and referral



Key Recommendations

- Mid-term review of the EmONC Improvement Plan (2021-2025). Maintain the vision of ***a network of > 160 functional EmONC*** facilities
- Extending the timeframe to perform the seven signal functions from 3 to 12 months
- Allow other selected facilities to perform a minimum EmONC package to address main causes of deaths
- Consider including private facilities into the network
- Ongoing training and coaching
- Strengthen routine data systems on maternal and perinatal deaths – MPDSR for resources and quality improvement
- Community participation to increase utilisation – vulnerable groups

THE NEW MPDSR MATERIALS TO SUPPORT IMPLEMENTATION

This document is a practical step by step guidance, relevant to establish a framework to assess the burden of maternal deaths, stillbirths and neonatal deaths, including trends in numbers and causes of death and on how to link maternal and perinatal death reviews.

MPDSR

Can improve the quality of maternal and perinatal care, which is an essential to achieve Universal Health Coverage.



LINK TO THE RESOURCE:

<https://www.who.int/publications/i/item/9789240036666>

The Three Delays Model

3 delays that contribute to maternal death

3. Delay in receiving care

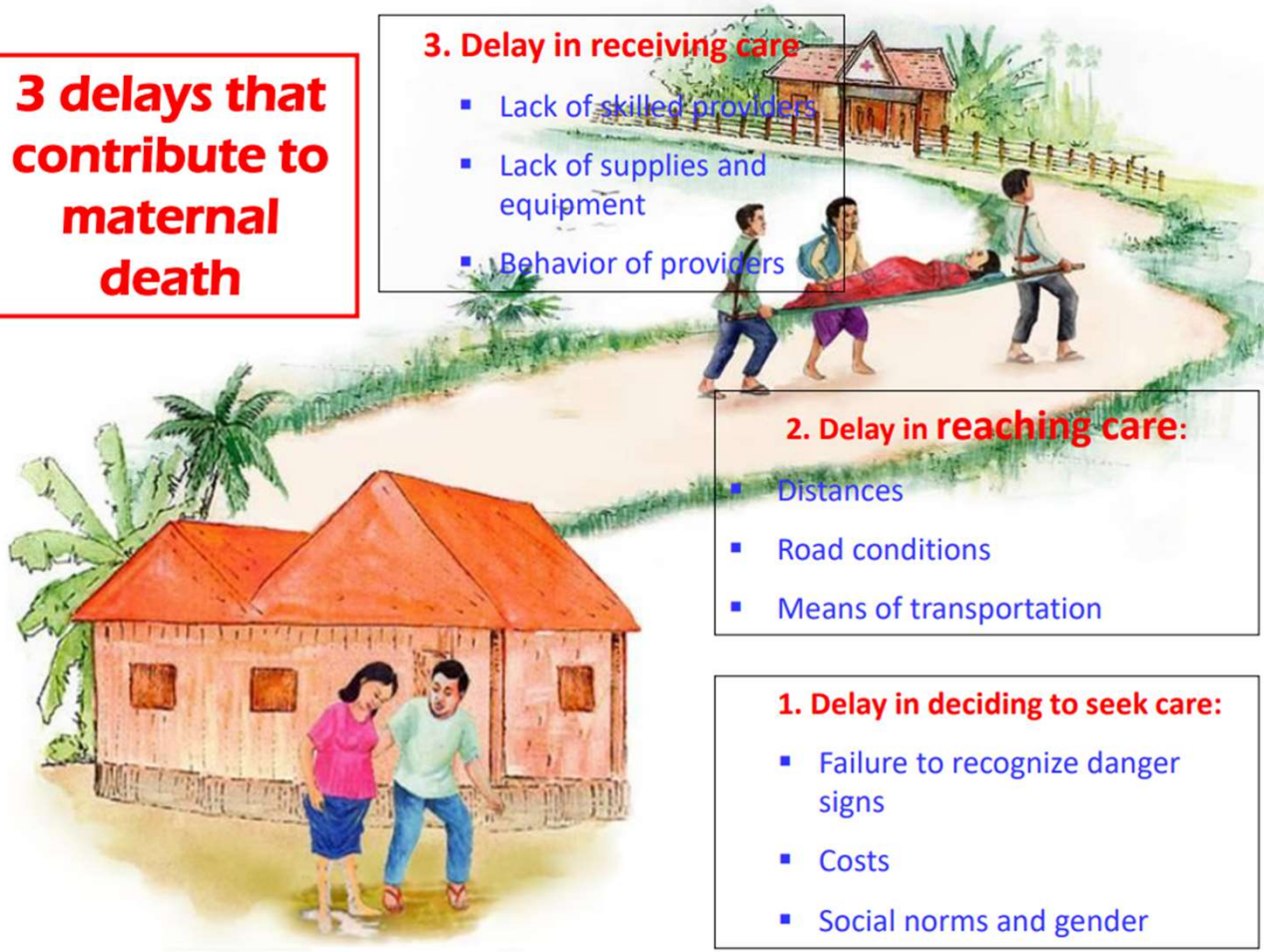
- Lack of skilled providers
- Lack of supplies and equipment
- Behavior of providers

2. Delay in reaching care:

- Distances
- Road conditions
- Means of transportation

1. Delay in deciding to seek care:

- Failure to recognize danger signs
- Costs
- Social norms and gender



Sample MPDSR - PPH Response Plan –Delay 3

Modifiable Contributing Factors	Response	Responsible	Target & Time	Follow-up/Progress
Staff is incompetent on active third stage management of labour	Train staff on the AMTSL	Training Unit Chief	100% of midwives trained on AMTSL in Six months	Chief of Ward – maternity – Training report
Staff is incompetent on PPH management	Train staff on PPH management	Training Unit Chief	100% of midwives and physicians trained on PPH in Six months	Chief of Maternity Ward – Training Report
Lack of timely referral to higher level	Create timely referral system	Hospital Director & Chief of Maternity Ward, community and authority leaders	At least one ambulance, companion team, supplies during transportation by next month	Hospital Director & Chief of Maternity Ward – monitoring tool Community and authority leaders – meeting
Lack of Blood supplies and medicines	Ensure adequate blood and medicine supplies	Lab Chief and Pharmacist	At least 2 pints/sacks of blood and 5 PPH kit in place in next month	Lab Chief and Pharmacist – monitoring tool

Next steps/ Suggestions:

- Each province should conduct own EmONC assessment
 - Scale up training and Coaching EmONC functions – main cause of maternal and perinatal mortality
 - Update protocol and curriculum for MPDSR and training and establish facility-based committees
 - Mobilize resources for the implementation
 - Communities and authority participation for service utilization, improvement and referral
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Photo from Care Cambodia Maternity Waiting Home

Thank You