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"Mozambique-Canada Maternal Health Project: Progress and Prospects during a Pandemic" *Script to accompany slide presentation*

Nazeem Muhajarine: Good morning, everyone.

[slide 1, title page] I would like to begin with some thanks. First to the staff of USask International office, Dr Ramaswamy and her capable staff. It is wonderful to see your annual gathering, People Across the World, reaching the heights that it has each year.

I also want to thank profoundly the entire team of the Mozambique-Canada Maternal Health project. Several of you, the Canadian contingent as well as two colleagues from Mozambique, are joining us this morning. I personally consider myself indeed lucky to be working with such smart, hard-working and nice people. I want to acknowledge that without your work and contributions, frankly, it would be difficult to have much to say. We would also like to thank our funder, Global Affairs Canada, for their ongoing support and commitment to this work. We especially thank our colleagues from GAC who are here with us today.

I want to acknowledge that I am a newcomer to these lands. Newcomer is a relative term, bounded by the scope of time, history. I arrived here in Saskatoon in 1990; and have enormously benefitted from people who have come before me, going back to thousands of years, of course. I pay my respect to our Indigenous brothers and sisters. All my relations.

[move to slide 2] Dr Jessie Forsyth and I are going to do the honours this morning. Our talk is divided into three parts. I will start with a quick rationale for the project and describe the key strategic areas we are focusing on. Then I will pass it on to Jessie. She will describe how our project responded to Covid and also tell you about what we have accomplished to date. Then, I will come back and finish off with some current reflections about lessons learned.

[move to slide 3] Canada-Mozambique Maternal Health Project is a bold, community and systems engaged development and women's empowerment initiative. It is fundamentally centred on improving lives of women and girls, by

working in the communities they live, in the facilities they use, and in the health systems where decisions are made that impact their lives. The "Engaging Communities and Health Workers for Sexual, Reproductive, Maternal and Newborn Health" project is a 5-year project that began in 2017 and is nearing the end of its 4th year. [move to slide 4] U of Saskatchewan has had a long-standing, deep relationship with Mozambique. Specifically, in Inhambane province, in the southern part of the country. We will get to this a little bit more but for now it is suffice to say that our presence in Mozambique runs more than 2 decades in the past.

I would like to quickly set up the rationale for this project. [move to slide 5] This slide show the life-time risk of the chance that a 15-year old girl will die from a pregnancy-related cause. A 15-year old girl in Mozambique has a 3% chance of dying from a pregnancy-related cause, compared to the world average of 0.56%, and just 0.01%--that is 1 in 10,000--in Canada.

[move to slide 6] Next map shows the maternal mortality ratio world-wide. The SDG target 3.1 is to reduce maternal mortality to less than 70 deaths per 100,000 live births globally, and to less than 140 deaths in all countries. Mozambique's maternal mortality ratio was 489 in 2015. So you see we have some ways to go to meet that SDG target.

I don't want to be-labour the point here, the enormous need that is out there for our project, but I do want to show two more visuals regarding gender inequality. [move to slide 7] This map shows the gender inequality index, 0 to 1, 0 being equality between the two genders and 1 being perfectly unequal, from the Human Development report, 2015. The index is composed of three indicators, reproductive health, women's empowerment and economic status. With an index metric of 0.56 Mozambique sits in the more unequal half of the distribution.

[move to slide 8] So what type of a world do we envision for women and girls in particular? This next chart shows three scenarios: in the top horizontal bar represent how many women and girls would we lose if things were like in the past; second scenario, middle bar: what is the status like today, and, third, what would it be if all countries were like the countries of the EU or Canada? We still have 300,000 moms dying each year in childbirth—that is 830 per day. Meanwhile in EU and Canada we lose 11,000 mums each year, about 27 times fewer deaths compared to the world average currently!

[move to slide 9] This is the context into which we step-in with our Mozambique-Canada Maternal Health Project. Let me quickly sketch the project to you before I hand it over to Jessie.

[move to slide 10] We are working to alleviate women and girls living conditions and to better align the health care system to their needs in one of the lowest resourced countries in the world.

Our project in Inhambane has us working with 20 rural communities and the health care system, shoulder to shoulder, to improve maternal and newborn health.

For the past 20 years in our work in Mozambique, we have taken quite a bottom-up approach, working with women and in communities directly. A strong foundation for this work was set by the 15 years of work by the Training for Health Renewal program, or THRP for short. THRP was a training program, that we ran from 2001 to 2014, which included building infrastructure, that trained health workers in community-based settings, in addition to their classroom and clinic-based training, again funded by the Canadian Government.

Our current project is predicated on benefits flowing in both directions. This doesn't mean that the benefits that are accruing, are in equal proportion; not at all. Nonetheless, there are benefits flowing to USask, its students, staff and researchers as well as to women and girls in Inhambane, their wider communities, and the health care system there. There are also benefits to the scientific world, and to many other similar international development projects and decision-makers all over the globe.

[move to SLIDE 11] Aligning with each of the three integrated areas of focus of our project, shown in previous slide, we have three intermediate outcomes show here. They speak to, first, increasing demand for health and pregnancy related services by women and girls; second, to meet that demand we want to strengthen and increase the capacity of health system; and third, we want to create new knowledge and understanding about effectiveness of our interventions, related to both in first and second focused areas, and disseminate them widely.

I will now pass to Jessie to give an update on how the project handled Covid, and also to give more detail on two of the three key strategic areas of work.

…[TO JESSIE *Jessie Forsyth*

[move to slide 12] Thanks very much, Nazeem, and thanks to everyone for joining us here today. As I start to speak about the challenges of COVID-19 in Mozambique and the project's response, I am aware that one, albeit limited, "opening" that the pandemic has created is the possibility for online gatherings like these that enable some conversations, at least, to take place across a range of differences and divides as we continue to work through global and local experiences and knowledges alongside one another.

In Mozambique generally, the COVID-19 pandemic had been slow moving until just this past month when the total number of infections, and deaths, more than doubled and the number of active cases increased more than 7-fold: as of Jan. 31, Mozambique had 14,328 active cases and 38,654 total cases, which represented an increase from only 1,809 active cases and 18,642 total cases on Dec. 31. The total deaths reported as of Jan. 31 was 367 in comparison with 166 as of Dec. 31.

	Dec. 31, 2020	**Jan. 31, 2021**
Total cases	18,642	38,654
Active cases	1,809	14,328
Total deaths	166	367

These numbers will still sound quite low to people in Canada but they represent a situation in which the health system here is already working at full capacity in responding to the pandemic and there's concern about how the system will continue to cope if numbers continue to increase at a similar pace.

We know vaccines may start becoming available for health workers as early as next month, according to a statement from the Minister of Health, and additional vaccines are expected through COVAX and possibly through the African Union and the Africa CDC vaccination programs by May or June but details aren't yet known.

I think it's important. However, to note that Mozambique's overall response had been swift, initially, by closing schools and borders in late March once

cases had been detected in South Africa, before any cases had been reported in Mozambique. Those measures were followed by 3 month-long States of Emergency starting April 2/20 after which the government declared an ongoing State of Public Calamity that remains in effect.

Mozambique has not yet entered a full lockdown nor has domestic travel been severely restricted. Instead, the state emphasis has been focussed on slowing the rates of transmission by enforcing basic prevention measures while keeping key sectors of the economy operating. So the push has been for individuals, communities, and organizations to follow measures on hand washing, use of masks, and social distancing in particular. At present, however, we're seeing the government and health system really struggle to contain and respond to the spread of infection.

[move to slide 13] Within the project, we also acted quickly to modify operations and think through how to respond proactively while keeping our team and project partners. By late March, we had made internal changes to enable remote working wherever possible and to restrict office traffic; we'd made change in our programming, especially with communities and health workers, to scale up prevention by reducing group interactions and increasing COVID-19 education; and in our partnership with the Provincial Directorate of Health to directly support their COVID-19 response however possible.

So in both community and health system programming, we now incorporate COVID-19 prevention teaching into all activities. Monthly community meetings and school activities have all been on hold since last April, but our Community Support Workers – who are really our front-line workers – have continued to meet with smaller groups in order to disseminate COVID-19 information and preventive materials, hold health education sessions, support ongoing work in microprojects, and to support those women and girls in each community who are experiencing pregnancy or nearing childbirth.

In health system programming, we initially put all clinical continuing education on hold until the team could assess how to implement training safely and we restricted the number of participants in any single session. We were able, however, to continue disseminating hospital materials and equipment to the health facilities in our 5 target districts and, importantly, continue with our construction plans. As a result – as we'll see shortly – the project managed to complete construction of all new health infrastructure during COVID, which may be one our most notable achievements to date.

In relation to DPSI, we've supported training and strategy sessions for health workers and managers on COVID-19 and maternal health in particular, test sample collection throughout the province, and PPE procurement.

[move to slide 14] If we could now step back a bit and consider the project overall, I'd like to highlight some key achievements as examples of the project's progress over the past 4 years.

In the 1st strategic area of gender-sensitive community engagement for improved health and well-being, I'll point out just 5 achievements.

- 1st, we've developed active health committees with all 20 partner communities, involving 58% women members & leaders
- Through those strong committees, we've held ongoing mutual learning sessions in all 20 communities on SRMNH topics (totaling 694 sessions to date, which is well ahead of the overall project target of 240).
- We've established 20 microprojects – 1 in each community – that are led by women and help generate income as well as increase social status and public acknowledgement of women's strengths and contributions
- We've also held community economic development workshops for represenatives from all communities and training sessions on individual microprojects (36 in total)
- And we've developed 20 support networks of community-based caregivers.

Each of these activity areas really interrelate to create the basis for stronger, more responsive, gender-sensitive communities that are better able to promote sexual and reproductive health and rights amongst their members.

[move to slide 15] This slide shows a few images of the microprojects. As a reflection of the commitment of community leadership and the strength of community involvement, 10 of the 20 microprojects were actually set up this past year, during COVID. The majority are flour grinders (image on the right), which have proven to be reliable sources of income and greatly reduce the physical labour, often borne by women, of grinding corn by hand. In the top left we see a chicken production project being set up and, beneath, the building of safe latrinas. The project's focus on social determinants of health is a crucial component in strengthening communities' and women's and girls' well-being and the microprojects, which are defined and developed by the

communities themselves, are core to linking healthy pregnancies and deliveries with wider determinants.

[move to slide 16] In the 2nd strategic area of health systems strengthening, our work focusses on a combination of human resources and infrastructure. On the people side, we support initial and continuing education in priority SRMNH areas.

- Our work has included 30 clinical continuing education courses in managing obstetrical complications; newborn resuscitation and emergency newborn care; safe abortion care; and MCH data management;
- 228 on-site continuing education sessions (above topics plus ambulance, SOP and hospital equipment use);
- And 27 continuing education courses in MCH nursing student supervision, SAAJ (sexual and reproductive health services for youth), COVID-19 and maternal health

All our training promotes gender-sensitive health practice that results in "humanized care".

[move to slide 17] Here we see moments in on-site, practical training in newborn resuscitation at the Massinga District Hospital (on the left) and the practical component of a community-based sexual and reproductive health and rights training course for health teachers.

[move to slide 18] The project also supports initial training courses in Mother and Child Health Nursing and Preventive Medicine. 3 cohorts have graduated and 5 courses are ongoing. The image at the top right is of the newest cohort of MCH graduates at the Massinga Health Training Centre, taken in Dec./20 soon after training institutes were able to re-open.

And the bottom left image shows the 1st visit of UofS medical students through the Making the Links program who supported a health and gender training session during their time in Inhambane.

[move to slide 19] The last area I'll touch on is construction. Although we experienced delays in the preparation stages, the construction itself – which began with digging 4 boreholes last Feb. – came to a successful completion and handover in December. As a result, Inhambane province now has 4 new rural maternity clinics, each with its own borehole, and 3 new maternity waiting homes. All infrastructure is outfitted with solar electrification systems and fully

equipped for use. In this slide, we see the initiation and completion of borehole construction on the right and the new 12-bed maternity waiting home at the Vilankulo Rural Hospital on the left.

[move to slide 20] Significantly, each of our 5 target districts now has new health infrastructure. The Governor of Inhambane, Daniel Chapo – who we see in the top right image – has expressed his deep appreciation to the project and to the Government of Canada for making these building projects become a reality. He personally inaugurated each of the 7 sites in the last weeks of Dec. and passed on a congratulatory message from the President of Mozambique who also acknowledged the quality of the work and the strength of Canada's long-term partnership with Mozambique. I'd like to point out the new maternity clinic in Tevele, Massinga (top left), because this is where the 1st community partnership began in early years of THRP, our predecessor project; Getting to this stage has involved many years of community engagement and commitment and it's really just a pleasure for our whole team to continue working with the community of Tevele as they move into health system partnering at the very local level.

With that, I'll hand it back to Nazeem. Thanks very much.

….[Back to Nazeem]

[SLIDE 21] Out third strategic area: research and dissemination. We have three major studies—Maternal Experience Study, Maternal Near miss Study, and Maternal waiting homes study. We wait for another day to speak in detail about any of these studies, but for now, I will make two points. One, the findings from the maternal experience study in round 1, has been used within our ongoing programming. In doing so, we have closed the loop on evidence, from our own study, informing our programming. Second, the MWH study is a collaboration with the WHO, Gronigen University in Amsterdam, and the London School of Hygiene, in the UK, and our aim at the end of this study is to have WHO revise their global guidelines for MWH implementation and use. Recently we received word from Health Policy and Planning journal that our comprehensive systematic review of global literature on MWH effectiveness was accepted for publication; in that paper we presented a 6-point plan for further work on MWHs. [SLIDE 22]

[SLIDE 23] When I pause and reflect on what has contributed to our success in this defining partnership between U of Saskatchewan and Inhambane province

in Mozambique, 20 years running and still going strong, five things come to mind: first, Longevity – by which I mean long-term commitment. This is not a one-off project-based work. We are in for the long-haul, through thick and thin as it were.

Second, Commitment of leaders, organizations and communities, at defined and multiple levels, e.g. Ministry of health, Government of Canada, Department of Global Affairs to district level leaders and college and department at USask and ultimately the leadership in the communities that we work in as well.

Third, Openness to adaptation and change. There are many examples of this which I don't have time to get into. Fourth, Friendships, both professional and personal kind. This last point is under-appreciated, usually taken as a given, but it is the glue that keeps two partnership like this alive and well over long time.

Fifth and last, Mutual Benefit – and this is so important. All parties, especially those in Mozambique should benefit. But also Canada, here the U of Saskatchewan, by extension, have, and need to benefit from this partnership as well.

It has been a privilege to share our work in Mozambique with you. Coming back to where we started, this work would not be possible without the history we have, commitment and dedication of legions of people. For that we thank you all.

Thank you for listening. We will be happy to take questions at the Q&A session.

The end.