

**REPORT OF THE MATERNAL CHILD AND WOMEN'S
HEALTH SUMMIT**

**25 August 2009,
Birchwood Conference Centre**



DEPARTMENT OF HEALTH
Republic of South Africa

Table of Contents

1.	Background	3
1.1.	Purpose and structure of meeting	3
1.2.	Structure of this report	4
2.	Findings of the three Committees	5
2.1.	Summary	5
2.2.	Trends	5
2.3.	Avoidable deaths	6
2.4.	Underlying factors	7
2.5.	Recommendations	7
3.	Implementing the recommendations	7
3.1.	Implementation bottlenecks	7
3.2.	Recommendations	8
4.	Conclusion	9
5.	APPENDICES	10
5.1.	Recommendations	10
5.2.	Participant List	20

1. Background

South Africa is not making optimal progress towards meeting the Millennium Development Goals related to maternal and child health¹. Ministerial Committees were established to provide audits on maternal, perinatal and child mortality and to make recommendations on how to reduce maternal and childhood morbidity and mortality in South Africa.

The Minister of Health invited key stakeholders in maternal and child health to hear the findings of these three Ministerial Committees. These included the Minister for Women, Children and People with Disabilities provincial MECs for Health, programme managers from the National and Provincial Departments of Health, as well as development partners, multilateral agencies and other key stakeholders. It was the first such summit on maternal and child health in South Africa, and also provided the first opportunity for the Minister of Health, Dr Aaron Motsoaledi to interact with provincial programme managers in particular to hear what they considered their bottlenecks to improving service delivery as well as their solutions.

1.1. Purpose and structure of meeting

The purpose of the meeting was to obtain consensus on key bottlenecks to achieving the health-related MDGs for women and children.

The two main objectives of the meeting were:

- To understand the bottlenecks as managers; and
- To identify the best means to implement the ministerial committee recommendations at facility level.

The meeting was opened by Deputy Minister Dr Molefe Sefularo. The Minister of Health Dr Aaron Motsoaledi gave the keynote address which was followed by a short address by the Minister of Women, Youth, Children and People with Disabilities, Ms Noluthando Mayende-Sibiya.

The meeting heard reports from the Three Ministerial Committees, presented by the chairs of the committees. These were:

- The Committee on Morbidity and Mortality in Children under Five Years (CoMMiC), first report, April 2009. Presented by Dr Neil McKerrow
- Saving Mothers: Fourth Comprehensive Report (2005-2007). Presented by Prof. Jack Moodley, from the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD).
- Recommendations from the National Perinatal and Neonatal Morbidity and Mortality Committee 2008 (NPNMMC). Presented by Prof. Sithembiso Velaphi.

¹ MDG 4: Reduce mortality of children under 5 years of age by two thirds (1990 to 2015)

MDG 5: Reduce maternal mortality by three quarters (1990 to 2015)

The reports covered major findings as regards number, distribution and cause of deaths. They also identified causes of avoidable death as well as recommendations to reduce morbidity and mortality in the three groups. Breakaway groups then discussed and reported back on the major bottlenecks to strengthening maternal, neonatal and child health. The meeting concluded with a discussion on key actions that can be taken to remove obstacles to improving maternal and child mortality.

1.2. Structure of this report

This brief report describes the findings of the three Ministerial reports in terms of numbers, cause of death and avoidable deaths. It then merges the recommendations of the reports with those from the breakaway groups.

The reason for this is that the breakaway groups diverged somewhat from their mandate, which was to discuss the challenges of *implementing* the recommendations of the Ministerial Committees. Much of the discussion in the breakaway groups – as reported in the plenary - focussed on discussing and elaborating on the recommendations of the three reports. Thus they focused more on service delivery problems and challenges - or first order challenges - rather than implementation challenges, or second order challenges.

This report therefore combines the recommendations of the three reports and those of the breakaway groups on ways to reduce maternal, infant and child mortality. It then extracts from the plenary reports and discussion, ideas that were raised around implementation or second order challenges.

2. Findings of the three Committees

The three reports showed unacceptably high infant, child and maternal mortality. The findings on estimated numbers of deaths, leading causes and avoidable factors are summarised in Table 1 below.

2.1. Summary

TABLE 1: DEATH, CAUSE OF DEATH AND AVOIDABLE FACTORS

	Maternal	Perinatal	Children Under five
Annual number of deaths (estimated)	1,400	22, 000	60,000
Direct causes of death	Hypertension 15.7% Haemorrhage 12.4% Ectopic pregnancy 1.4% Abortion 3.4% Pregnancy-related sepsis 5.6% Anaesthetic-related 2.7% Embolism 1.4% Acute collapse 3.2%	Immaturity-related 46% Asphyxia-hypoxia 29% Infection 10% Congenital abnormalities 8%	Gastroenteritis Acute respiratory infection TB HIV Neonatal conditions
Indirect or underlying causes	AIDS 23.1% Other non-pregnancy-related infections 20.6% Pre-existing maternal disease 6%		Malnutrition and HIV were underlying causes in 60% and 50% (respectively) of all under five deaths.
Avoidable deaths – modifiable factors, missed opportunities and sub-standard care	38.4% of all deaths clearly avoidable	43% of neonatal deaths probably avoidable	Location of modifiable factors: Home - 36.8% PHC -13.4%A&E - 17.5% Wards - 27.7% in the wards

2.2. Trends

The Saving Mothers report (2005-2007) was the only one of the three reports that was able to show clear trends by comparing data with a previous report. The main causes of death remained the same, however, compared with the previous triennium (2002-2004) there had been a 20.1% increase in the

number of deaths reported. This was related to an increase in non-pregnancy related infections, primarily HIV. More positively, the incidence of deaths due to hypertension was significantly reduced, indicating an improvement in institutional management.

2.3. Avoidable deaths

Both the Saving Mothers and the Perinatal Mortality reports provided information on the percentage of deaths that could have been avoided by modifying actions of patients, health care providers and facility administrators. It was estimated that 38.4% of maternal deaths were clearly avoidable and 43% of neonatal deaths were 'probably' avoidable.

Patient-oriented avoidable factors were considered to be no antenatal care, infrequent antenatal care, delay in seeking medical help and unsafe abortion. Patient-oriented avoidable factors were estimated to account for approximately 45.9% of avoidable maternal deaths and 24.5% of avoidable neonatal deaths, and 15% of *all* neonatal deaths.

Avoidable factors, resulting from weak **administration**, included transport problems (home to institution; between institutions), lack of health care facilities; lack of ICU facilities, lack of blood, lack of appropriately trained staff and communication problems. These were estimated to account for approximately 29.9% of avoidable maternal deaths and 12% of *all* neonatal deaths. Lack of blood had more than doubled as an avoidable factor in the latest Saving Mothers report compared with the previous triennium.

For mothers, **health worker-related** factors included poor emergency management and resuscitation skills. Saving Mothers showed that this category was responsible for 24.2% of avoidable deaths. For neonates, health worker-related issues were inadequate management plans for neonatal care, foetal distress not detected (with or without monitoring), and prolonged second stage labour with no monitoring and inadequate neonatal resuscitation. These factors were estimated to account for 16% of *all* neonatal deaths.

The Child Mortality report described 'modifiable factors' among over eight thousand deaths from Child PIP data, 2005-2007. For each child death during this period there were, on average more than two occurrences of sub-standard care. These included factors in the home and community such as delay in seeking care, inappropriate nutrition and inappropriate home treatment. Modifiable factors by clinical personnel included inadequate assessment, delay in referral, and inadequate management of rehydration. Administrator modifiable factors included lack of transport, beds, ICU facilities, health care professionals and poor communication.

In terms of place (2007 data), 36.8% of modifiable factors occurred in the home/community, 13.4% in primary health clinics, 17.5% in admission and emergency, and 27.7% in the wards. Between 2005 and 2007 there was a significant decrease in modifiable factors in admission and emergency and a significant increase in home/community-related factors.

2.4. Underlying factors

The Saving Mothers report pointed to the growing and significant contribution that HIV is playing in maternal mortality. It noted that HIV infection increases the risk of maternal death approximately ten times and without it, the institutional maternal mortality rate would be similar to other middle-income countries such as Brazil, Argentina and Thailand.

The Child Mortality report showed that malnutrition was an underlying factor in 60% of under-five deaths, and HIV in at least 50% of under-five deaths. The report quoted the MRC's National Burden of Disease study from 2002 that attributed 40% of deaths in children under five to HIV and AIDS.

2.5. Recommendations

The three committees made recommendations for reducing maternal, infant and child mortality. These were both specific recommendations for clinical interventions and training, and general recommendations for strengthening the health system to deliver maternal and child health services. Indicators and targets are described for many interventions. The breakaway groups added to these from the perspective of health workers and managers.

Key areas for improvement are:

- Data management: Strengthening and standardising birth and death registration, also including events in the community – and using this data to improve quality of care;
- Norms and standards :Clarifying norms and standards for staffing and equipment at every level of care;
- Implementation of policy and guidelines: Ensuring that policy and guidelines are made available in written form in all facilities and that staff are trained to implement them;
- Clinical care: Improve the quality of clinical care by scaling up training of nurses and midwives, particularly 'bedside' training; fire drills etc.
- Infrastructure: Improving infrastructure and resources such as emergency transport, availability of blood etc.

The recommendations from the reports and from the breakaway groups are described in more detail in section 6.1 below.

3. Implementing the recommendations

The summit identified critical areas for health system improvement and made recommendations in this regard. Clear calls were made to clarify policy, norms, standards and guidance in specific areas; and to strengthen training and improve facilities and resources. These ideas are not new. The challenge is to ensure that these recommendations are implemented.

3.1. Implementation bottlenecks

There was a consensus at the summit that although policies and guidance require strengthening in some areas, they were generally adequate. However, even where resources and infrastructure are adequate, serious

implementation bottlenecks remain. Some of these second order problems were identified in both the plenary and breakaway groups as:

- Lack of coordination, particularly at national level: multiple programmes trying to address the same issue; policies not always harmonised.
- Lack of familiarity with policies and guidelines.
- Poor supervision: supervisors overburdened and lacking time to supervise all programmes. Lack of accountability or consequences for poor performance.
- Lack of leadership and accountability at all levels.

3.2. Recommendations

Recommendations from the breakaway groups and the plenary discussions on implementation flow from the above:

- National level must issue policy statements on core strategies to reduce perinatal deaths; ensure clarity on roles of national, provinces and districts;
- Minister must request - from all MEC's and HOD's - action plans with timeframes that will implement the recommendations from this summit. This must be included in their KPA's.
- Medical managers must implement the recommendations at facility level. (include in KPA's)
- Provincial managers must ensure staffing norms are met; ensure equipment is available and working; strengthen the training of health workers;
- National guidelines and policies must be distributed to all facilities.
- A complete review of human resources for health must be conducted. This should come up with staffing norms. Unfreeze all posts.
- Strategies to ensure leadership and accountability to be built into the Performance Management Development System (PMDS). Institute rewards for good performance and non-rewards for bad performance;
- Community awareness campaigns must mobilise communities and ensure they are informed and active in maternal and child health issues.
- Health worker mobilisation. Campaigns to mobilise health workers by health workers. For example a local campaign organised by midwives to inform them of new information and guidelines and mobilise them to implement them.
- Best practices must be shared within provinces and districts.
- Use available quality improvement tools such as PPIP and CHIP at facility level to remove implementation bottlenecks.

4. Conclusion

The death toll of mothers and children is cause for alarm.

As Dr Motsoaledi remarked in his keynote address “It’s definitely not acceptable that mothers should die from avoidable causes when they are supposed to be celebrating the bringing of life to earth”. He told the summit that the death of just one mother creates ripple effects in the community. “It brings poverty, social, psychological and economic disruption,” he said. “Children stand a better chance with their mothers alive. [Maternal deaths] simply cannot be allowed any further.”

Scaling up maternal, neonatal and child health services has the potential to save many lives. A recent article in *The Lancet*², based on the data from these three reports, uses a modelling tool to estimate the number of lives that could be saved by increasing coverage of maternal and child health interventions. They show that 11,500 neonates could be saved by scaling up existing packages and interventions. Scaling up dual therapy PMTCT and improving infant feeding could save the lives of an additional 37,200 children.

Meeting participants made a commitment to saving the lives of mothers, babies and children. All agreed: it must be done.

Funding and technical support

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² Chopra, Lawn et al, op cit

5. APPENDICES

5.1. Recommendations

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
1. POLICY/ STRATEGY		
1.1 General	<ol style="list-style-type: none"> 1. Policy needed from National Department of Health on PPIP and CHIP 2. Clear guidance is needed on HIV status information on the RthC. 3. Ensure clarity on roles of national, provinces and districts 4. The MNCWH strategy must be fast-tracked 5. DoH must develop clear priority messages on child survival interventions 6. Service transformation plan must be aligned with current MNCWH priorities 7. National Department of Health must issue policy statements on core strategies to reduce perinatal deaths 	
1.2 Task shifting	<ol style="list-style-type: none"> 8. HAART initiation: Policy and guidelines on nurse initiation of HAART to be finalised 	<ol style="list-style-type: none"> 1. Expanded role for community health workers in the community and as a bridge between the facility and the community <ol style="list-style-type: none"> a. needs to be formalised and standardized b. package of interventions should include priorities like TB,

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
		Immunisation, death notification postnatal visits for mothers etc
2. LEGISLATION		
	<p>9. Fast track the legislation around marketing of breast milk substitutes.</p> <p>10. Legislation to prevent use of mortality audit information for purposes of litigation.</p>	
3. GUIDELINES		
3.1 New guidelines	<p>11. Under-5: Introduction and rollout of standardised management and referral guidelines for general practitioners.</p> <p>12. Revise guidelines to include nurse initiation of HAART</p>	
3.2 Implementing existing guidelines	<p>13. Guidelines for managing key conditions must be part of pre-service training curriculum</p> <p>14. Guidelines must be made available by NDOH in written form at all facilities and training be undertaken so that they are implemented.</p> <p>15. Midwives, doctors and other health workers must be trained on the use of guidelines.</p>	

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
3.3 Monitoring guidelines	16. Monitor implementation of guidelines through mortality review process	
4. NORMS AND STANDARDS		
	17. Staff and equipment norms must be established for every level of care.	
5. HUMAN RESOURCES		
5.1 Numbers/recruitment	<ul style="list-style-type: none"> 18. Increase institutional production of midwives per year 19. Unfreeze moratorium on posts 20. Fill vacant posts 21. Increase numbers of Facility Information Officers and District Information Officers 22. Use retired nurses 23. Develop strategies to recruit and retain nurses and midwives. 	
5.2 New cadres/posts	24. Create posts for regional clinicians	<ul style="list-style-type: none"> 2. Community structures must be in place to create awareness <p>Community health workers must be trained for MCWH</p>

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
5.3 Training	25. Review training curriculum 26. All health professionals working in maternity units need training in practical obstetrics and surgical skills – especially at Level 1 institutions 27. Interns - skills in emergency care must be improved (ESMOE) 28. Two year training course for midwives 29. Promote training green epaulettes 30. Training to improve clinical skills for 6 key interventions in obstetric and neonatal care 31. Training in triage, assessment and resuscitation of critically ill children 32. Training nurses to initiate HAART 33. More bedside than classroom training. 34. Conduct 'fire-drills eg neonatal resuscitation 35. Post natal care training needed for doctors, midwives and nurses	3. Develop curricula for community health workers for training on tasks agreed in task-shifting strategy eg data collection, service delivery 4. Training of community health workers for task-shifted roles 5. Empower and involve women, families and communities at large for active participation in activities, projects and programmes in maternal and neonatal health
5.3 Retention strategies	36. Incentive package for midwives 37. Strategies needed to deal with stress, exhaustion and burnout	

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
5.5 Human resources review	38. HR review should review structures and come up with staffing norms etc	
6.SERVICE DELIVERY		
6.1 Strengthen services	39. Strengthen primary health care 40. Strengthen existing child survival programmes such as CHW, INP, EPI, PMTCT, IMCI, EDL, 10 steps for management of severe malnutrition. 41. Strengthen post natal care 42. Promote contraception use through education and service provision 43. Reduce number of mortalities from unsafe abortion. 44. All women should be offered information on prevention and screening for and management of key conditions 45. Aggressive marketing of breastfeeding	6. Adoption and implementation of household and community component of IMCI
6.2 Referral	46. Strengthen emergency referral and treatment capacity in all health facilities. 47. Clear criteria for referral and referral routes must be established	
6.3 Integration	48. There is a need to integrate existing child survival programmes.	

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
	49. Integrate the following with MNCW programmes <ul style="list-style-type: none"> - HIV – sexual and reproductive health – contraception – role of PFMA, male condoms 11 per adult. - Abortion – decreased access – 70%-43%, role of OSD, medical abortion - Mental health - depression - Cancers - TB 	
7. INFRASTRUCTURE		
	50. Emergency transport for pregnant women, ill children and neonates must be available 51. Use non functional facilities as step down for mothers and children 52. Reactivation of closed hospitals;	
8.MEDICAL PRODUCTS AND TECHNOLOGIES		
	53. Blood for transfusion must be available at every institution where caesarean sections are performed	

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
9. FACILITY MANAGEMENT		
	<p>54. Hospital revitalization committee – no clinicians; lagging behind in terms of numbers and disease burden;</p> <p>55. Improve hospital management particularly infection control – CEO’s must take responsibility</p>	<p>7. Clinic committees should be established</p> <p>8. Clinic committees must and include traditional healers</p>
10. MONITORING AND EVALUATION		
10.1 Monitoring – new	<p>56. Improve data quality and communication with DHIS.</p> <p><u>Under 5</u></p> <p>57. Introduce a standardised children’s ward admission and discharge register.</p> <p>58. Develop integrated data tool for child health programmes</p>	<p>9. Traditional healers and community health workers can be trained for notification of deaths in the community.</p> <p>10. CHW and community structures should be utilized to create awareness on death notification processes at community level</p>
10.2 Monitoring – strengthen or modify	<p>59. Standardised birth and death registers must be established and used throughout the country.</p> <p>60. Systems must include provincial committees and data collection personnel at district level.</p> <p>61. Notification - Capacity for implementation must be based in district rather than province. Validations must occur at district and provincial level</p>	

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
	<p><u>Under 5</u> 62. Strengthen the DHIS and Vital registration process by modification of Road to Health card to support completion of community death notification form. 63. Strengthen the DHIS and Vital registration process by modification of death notification and death report forms</p>	
<p>10.3 Assessing quality of care</p>	<p>64. Use available PPIP and ChIP tools at all facilities 65. Integration of PPIP and ChIP into monitoring 66. ChIP be adopted as an audit tool by the department 67. Involve quality assurance personnel from the hospitals and unit managers. 68. Involve regional clinicians 69. Use indicators from DHIS to improve quality of care 70. Regular documented morbidity and mortality meetings (medical managers must attend). 71. Sites should be accredited for their quality of care.</p> <p><u>Perinatal</u> 72. Process audits of antenatal cards, partograms, neonatal care.</p> <p><u>Under 5</u> 73. Introduce a monthly mortality audit for each hospital-related death 74. Triennial survey and audit of community-related</p>	

CATEGORY	A.SUPPLY- SIDE	B.COMMUNITY LEVEL
	deaths including social autopsy and verbal autopsy	
10.4 Accreditation	75. Accreditation of facilities e.g. use LINC 76. Need to revisit accredited sites for HAART initiation	11. Accreditation for community health workers
11. FINANCING		
	77. Improve financial management 78. Ring-fence budgets for priority programmes	
12. INTERSECTORAL COLLABORATION		
	79. This should include the involvement of: other Departments contributing to Social determinants of Health like Water and Sanitation; Human Settlement; Women, Children and Disabilities; Environmental; Social services other development agencies 80. Address gender issues , including gender-based violence, stigma and discrimination, role of male partners	12. Include civil society organisations

13. IMPLEMENTING THESE RECOMMENDATIONS	
	<ul style="list-style-type: none"> • Minister must request from all MEC's and HOD's – action plans with timeframes that will implement the recommendations from this summit - (include in KPA's) • Medical managers to implement the recommendations (include in KPA's) • Integrate existing maternal and child survival programmes by harmonising policies • Communicate Best Practices • Mobilise health workers (especially midwives), community health workers and community members around maternal and child health.

5.2. Participant List

Based on signed attendance register at Summit

No.	Last Name	First Name	Title	Organisation/ Designation	Landline
1	Amos	Sebolelo Annah	Dr	NDoH - CM: Maternal, Child and Women's Health	012 312 0097
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87	Mohlabi	Rheinett	Ms	NDoH - Director: Child and Youth Health	012 312 0199
88	Mokgalagadi	Yvonne	Ms	NDoH - Deputy Director	012 312 0510
89	Mokgothu	Seipone Margaret	Ms	North West Health: Deputy Dir: HIV Prevention	018 397 2600
90	Mokoete	K.E	Ms	NDoH USAID	
91	Mokokoane	Mojela	Mr	Free State Health: HIV Programme Coordinator	051 447 2194
92	Molepo	Matlou Cecilia	Dr	Limpopo Health and Social Development: Acting General Manager	015 293 6082
93	Mollo	Solly	Mr	NDoH - assisting with shuttle	-
94	Moloko	E.T.C	Dr	NDoH	012 312 0266
95	Molupe	Rebecca	Ms	NDoH - Assist Dir: Women's Health and Genetics	012 312 0296
96	Monokoane	Sam	Mr	DGMH Maternal Death Committee	012 521 4461
97	Monyemore	Barbara	Dr	NDoH - Deputy Dir: Women's Health and Genetics	012 312 0192
98	Moodley	Jagidesa	Dr	NCCEMD Member	
99	Moodley	Vimla	Ms	NDoH - Director Health Promotion	012 312 0165
100	Motsoaledi	Aaron	Dr	National Minister of Health	012 312 0825
101	Motswasele	Motlalepula Dinah	Ms	North West Health: Assist Dir: PMTCT	018 397 2600
102	Moyo	J.B	Ms	Bula Monyako	011 422 3563
103	Mpama	Nosipho	Ms	KZN Health: Principal Technical Advisor	033 846 7221
104	Mpe	Refilwe	Ms	Limpopo Health: Manager: Women's Health	015 293 6042
105	Mphek	E.	Ms	Bula Monyako	011 472 3567
106	Mpisi	Joe	Mr	NEHAWU - Provincial Chairperson	011 336 1508
107	Mpuntsha-Motau	Loyiso	Ms	SA National Blood Service - Chief Executive Officer	011 761 9112
108	Mseleku	Thamsanqa D	Mr	DG - National Department of Health	012 312 3196
109	Mseti	Elizabeth	Ms	NDoH - Assist Dir - Directorate: Child and Youth Health	012 312 0994
110	Msibi	Bafana	Mr	NDoH - Deputy Dir - Directorate: Women's Health and Genetics	012 312 0318
111	Mubaiwa	Victoria	Dr	KZN Health : MCWH & PMTCT Manager	033 395 2914
112	Mudzahani	Leonard	Mr	NDoH - Deputy Dir	012 312 0016
113	Mukuvisi	Duvai	Dr	JHPIEGO	
114	Mulaudzi	Mphelekedzeni	Dr	COMMIC - Vice Chair Person	012 373 1009
115	Myburgh	Erica	Ms		012 312 0032
116	Mzila	Nomathemba Joyce	Ms	KZN Health: Principal Technical Advisor, Mental Health	033 846 7008
117	Mzolo	Nokuzoia Cynthia	Ms	Centre for Rural Health	031 260 4625
118	Nematenda	Godfrey	Mr		012 300 5495

No.	Last Name	First Name	Title	Organisation/ Designation	Landline
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120	Ngake	Sebotse	Ms	NDoH - Deputy Dir - Directorate: Child and Youth Health	012 312 0094
121	Ngidi	W.H	Ms		
122	Ngubane	Gugu	Dr	HLSP - Project Manager	012 424 9760
123	Ngwetjana	Patricia	Ms	Limpopo Health - District Manager	014 718 1700
124	Nkosi	Elphas	Mr	Mpumalanga Health: Deputy Director	013 766 3264
125	Nokwe	Delhia Miyakazi	Ms	Eastern Cape Health: Director:	040 608 0814
126	Nondanyana	Thandiswa	Ms	N-Cape Health: PMTCT-Coordinator	053 830 0635/6
127	Nsibande	Dudu	Ms	MRC	031 207 4700
128	Ntuli	Nhlanhla	Mr	NDoH - Acting Cluster Manager: HIER	012 312 0783
129	Nyathikazi	Deliwe	Ms	President: SOMSA	015 293 6026
130	Nyati-Mokotso	Lindiwe	Ms	NCape Health: Director	053 830 0635/6
131	Pearce	Bronwyn	MS	JHHESA	012 366 9300
132	Phungula	Prudence Pinky	Ms	KZN Health: Senior Technical Advisor	033 395 2116
133	Pillay	Gillian	Ms	SABC - Media	011 714 5137
134	Pillay	Yogan	Dr	NDoH - DDG: strategic Health Programme	012 312 0614
135	Pinini	Zukiswa	Dr	Gauteng Health and Social Development - Clinical Manager: HAST	011 355 3408
136	Pityana	Lindiwe	Ms	Professional Nurse	053 830 0613
137	Pretorius	Riani	Ms	Free State Health: Senior Dietitian	051 447 2194
138	Ramdial	Mayuri	Dr	RHRU - Deputy Dir: HIV Management	031 261 8840
139	Ramokolo	Vundli	Ms	Medical Research Council - Scientist	021 938 0454
140	Ramoshai	Mokibelo Sophy	Ms	Limpopo Health and Social Development: Manager	015 290 9126
141	Reddy	Jennifer	Dr	2000+ UK	
142	Reid	Sandy	Ms	Zoe-Life PMTCT Manager	031 209 4446
143	Richards	Florie Netty	Ms	N-Cape Health: EPI Coordinator	053 830 0612
144	Ritchie	Myles	Ms	HLSP - Technical Advisor	012 424 9760
145	Robenson	Precious	Ms	NDoH - Deputy Dir - Women's Health and Genetics	012 312 3323
146	Rogers	Roxana	Ms	USAID - Director	012 452 2000
147	Sebati	Matlepe Kenneth	Mr	NAPWA - Prov Coordinator	053 832 3477
148	Sefularo	Molefi	Dr	National Deputy Minister of Health	
149	Segaga	Seefane Grace	Ms	Limpopo Health and Social Development: Provincial EPI Coordinator	015 293 6000
150	Sekgobela	M	Ms	D ED DAFF	012 319 732?
151	Shapu	Merriam Lakile	Ms	Free State Health: Assist Manager: Women's Health	051 435 8688
152	Shilumani	Masenyani Watson	Dr	Limpopo Health and Social Development: Senior Manager	015 290 9266
153	Shuping	Digogodi	Ms	Free State Health: PMTCT & MCWH Programme Coordinator	051 447 6477
154	Sithole	P.J	Ms	PMTCT NDoH	012 312 0266
155	Sivnannan	Keshika	Ms	NDoH - Assist Dir: Women's Health and Genetics	012 312 0269
156	Sodlula	Mary Nomkitha	Ms	Eastern Cape Health - MCWH	043 707 6766
157	Somtjato	M. Ihema	Ms	D FS DoH	058 713 2996
158	Spies	Lenore	Ms	KZN Health: Manager: Nutrition Prog	033 395 2740/ 033 395 2726

No.	Last Name	First Name	Title	Organisation/ Designation	Landline
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162	Thuntsi	Mary	Ms	N-Cape Health: Director: DHS	053 830 0517
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164	Tshitauzi	Gilbert	Mr	NDoH - Deputy Dir - Directorate: Nutrition	012 312 0418
165	Van den Heever	Johann	Mr	NDoH - Deputy Dir - Directorate: Child and Youth Health	012 312 3174
166	Van der Merwe	Susara Maria	Ms	Mpumalanga Health: Provincial Nutrition Manager	013 766 3413
167	Velapi	Sithembiso	Prof	Chris Hani Baragwaneth Hospital	011 933 8000
168	Vieira	Winnie	Ms	NDoH - Cluster: Maternal, Child and Women's Health	012 312 0188
169	Wilson	Tim	Dr	Consultant	
170	Worrall-Clare	Kurt	Mr	HASA	011 478 0156
171	Zeeman	Helecine	Ms	NDoH - Director	012 312 0363