Draft Operational Plan to Reduce Maternal and Neonatal Mortality In Liberia

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by:
Subcommittee on Maternal Mortality Reduction
MOHSW, WHO, UNICEF, UNFPA, Africare, Merlin, MDM, PSI, LPMM, USAID

DRAFT OF OPERATIONAL PLAN TO REDUCE MATERNAL AND NEONATAL MORTALITY IN LIBERIA

1. SITUATION ANALYSIS OF MATERNAL AND NEWBORN HEALTH

Globally, each year, nearly 600,000 women die and 50 million suffer illness and disability because of complications associated with pregnancy and child birth. Reducing maternal mortality requires coordinated long term efforts. Actions are needed within facilities and communities in society as a whole, in health systems and at the level of national legislation and policy. Further, interactions among the interventions in these areas are critical to reducing maternal mortality and to building and supporting momentum for change.

Many factors affect the ability of women and newborns to survive pregnancy and childbirth. Collective and creative strategies are needed to mobilize resources and generate popular support and political will that are critical to achieving sustainable improvements in maternal and newborn health. It is increasingly recognized that high rates of maternal and newborn mortality are the result of problems in the health sector. However a variety of other issues related to gender, socio-cultural values, and the economic circumstances of households, communities and national political will also contribute to the high rates of maternal and newborn mortality. Other factors which also contribute to maternal and newborn mortality are: delays in recognizing problems, deciding to seek care, reaching care and receiving care. Therefore, to decrease mortality rates, various components of society must mobilize and form collaborative alliances to promote maternal and newborn health and to bring about changes at multiple levels.

The great majority of maternal deaths are preventable when low to moderate technology and education are available. The impact of maternal death and illness on a nation's economic productivity, health of family and loss of personal fulfillment of the individual woman is considerable. Liberia's health care delivery system collapsed due to the 14 years of civil war. The consequences of the war, such as health infrastructure destruction and a high rate of quality staff attrition from the health sector diminished the Government's capacity to respond to the challenges related to the reduction of maternal and newborn morbidity and mortality. Liberia, like many African countries in Sub-Saharan Africa, has very high maternal and neonatal mortality, estimated at 994/100,000 live births and 66/1000 live births respectively (LDHS 2007). These deaths are attributed to direct obstetric causes, namely hemorrhage, complications of unsafe abortion, infections, hypertensive disorders of pregnancy (eclampsia) and obstructed labor. Some women who survive these complications develop life-long disabilities such as vesico/recto vaginal fistulae and secondary infertility.

The incidence of teenage pregnancy in the country is a major cause for concern. Many of the teenage mothers are between 12-14 years and are at risk for numerous

complications associated with pregnancy. The increasing number of illegal and unsafe abortions adds another horrific dimension to this complex situation. The health needs of adolescents are not being met. Adolescents are more likely to engage in unprotected sex, which can result in pregnancy or sexually transmitted infections (STIs), including human immunodeficiency virus (HIV). Most adolescent pregnancies are unwanted and are more likely to end in induced unsafe abortions. The attitudes of parents and that of service providers in the public sector who are not willing to provide services to adolescents compound the plight of adolescents. Although there is a National Reproductive Health Policy, it does not adequately address issues related to adolescent reproductive health (RH). Adolescent SRH services are currently available only through the initiatives of a few NGOs. Sexually transmitted infections (STI) are also on the increase. Even though syndromic management is being carried out in some clinics and a reporting mechanism put in place, there is a need to strengthen such mechanisms. Prevention of mother to child transmission (PMTCT) of HIV is an important component of the response to reduce maternal and newborn morbidity and mortality. In 2006 the National AIDS and STI Control Program (NACP) in collaboration with the World Health Organization (WHO) conducted a HIV sentinel survey among pregnant women attending antenatal clinics in nine counties of the country. A total of 4216 blood samples were collected and tested for HIV. Out of the total sample, two hundred and thirty nine (239) samples tested positive for the HIV antibodies. The overall prevalence rate was reported as 5.7%. However it should be noted that at the Martha Tubman Hospital in the Eastern Region the prevalence rate was as high as 9.0%. When the HIV prevalence rate among the various age groups was analyzed, women between the ages of 30-34 had the highest prevalence rate at 6.8%. There are approximately 74 sites offering voluntary counseling and testing (VCT) and 15 sites providing prevention of mother to child transmission (PMTCT) services.

Young girls and women are also subjected to sexual violence, including rape. It is estimated that one half to two thirds of women were sexually assaulted in most communities during the civil crisis. Reports available reveal that all ages from 2 years to 80 years were raped. Gender based violence assessments led by the Ministry of Health and Social Welfare and WHO in 2005 and 2006 revealed that the most common form of sexual gender based violence was rape, which constituted 74% of the various forms of gender based violence identified during the civil conflict.

Antenatal care (ANC) services are not easily accessible to many communities throughout the country. Approximately 40% of the population lives less than five kilometers from a health facility (MOHSW, 2006). Many catchment communities are situated seven or eight hours walk from the nearest clinic. Although most women have one or more antenatal care visits, only 11% of deliveries occur in health facilities (LDHS, 2007)manned by qualified health practitioners. Eighty nine percent of all deliveries occur either in the community or in facilities that are not staffed by qualified health care personnel. Labor and delivery are integral stages of the pregnancy and childbirth period. These stages are also very critical and essential to the successful outcome of a pregnancy. Like other components of maternal, newborn and child health care, there are many shortcomings in Liberia. The use of the partograph as the monitoring tool is extremely low in nearly all parts of the country. Another limitation is the lack of uniformity in the existing partographs. The MOHSW has printed and disseminated standardized partograph forms to partners, but some partners are using their individually designed partograph forms. There is also inconsistency in using the standardized partograph forms by health facilities which have adopted them. In terms of

obstetric history, most often the history is incomplete, a situation frequently related to the lack of logistics, especially the requisite chart forms or even the record book. Most health facilities have delivery record books or ledgers but the recording of information is often not consistent. Sometimes information recorded on the mother's home based card, which is kept by the pregnant woman is not recorded in the delivery book, creating information gaps. Information on the newborn is also not completely recorded; sometimes the Apgar score is recorded but not all the variables are noted. The birth process is also not fully documented. Training in life saving skills at health facilities as well as in communities is currently being implemented by the MOHSW and some local and international NGOs.

The needs are numerous, but with proper coordination, they can be adequately addressed. The MOHSW has to ensure that the monitoring and other tools to improve the progress of labor and monitor pregnancy must be strictly adhered to and used at all times. Basic tools like the manual vacuum aspirator (MVA), drugs and supplies, both medical and non-medical items are required to improve the quality of labor and delivery care. Community based initiatives will complement and boost interventions at the level of the health facilities. Complications leading to disability and death among pregnant women in Liberia are unacceptably high. This appalling health status is characterized by low life expectancy at birth and very high infant, childhood and maternal mortality rates. The lack of proper care for the newborn is one of the leading causes of neonatal death in Liberia. Neonatal mortality is also associated with complications such as fetal distress, prolonged labor, prolapsed cord and other conditions that could be prevented or treated by health care providers. But due to the lack of competent staff, inadequate equipment and supplies, and a poor communication network, this problem continues to be on the increase.

A Rapid Maternal Health Needs Assessment (LPMM, 2005) conducted in a few health facilities in Montserrado County revealed that the high maternal mortality in Liberia is due to a combination of several factors, prominent factors were the following:

- Lack of adequate transport system
- Inadequate EMOC and support facilities (i.e., screening rooms for pregnant women, lack of or inadequate space for conducting delivery and short stay);
- Inadequate supply of essential drugs and medical commodities;
- Lack of essential equipment for providing services;
- Lack of or limited ability of health workers to perform essential life-saving skills;
- Deep-rooted traditional beliefs and harmful practices affecting quality reproductive health care;
- Poor communication skills and inaccurate information amongst health workers and the population relative to reproductive health care services.

The postnatal care period is of particular significance in enabling Liberia to move towards the attainment of the Millennium Development Goals (MDG). For the most part, care given during the postnatal period is mainly focused on the newborn and not on the mother; although more than 75% of mothers who deliver in health facilities return at least a month following the delivery. The situation is even more hazardous in communities where there are no skilled birth attendants to address complications that may arise. Additionally, there are no facilities available to handle mental conditions, such as depression, related to the postpartum period.

The Safe Motherhood Management Protocols define the minimum level of services to be offered during the postpartum period. But, these protocols remain unimplemented. Current interventions are seriously limited, particularly during the first 24hrs. Immediately after the delivery the emphasis is placed on hygiene of the mother and ensuring the disposal of the placenta. Micronutrient supplementation has been initiated; though this is still on a very low scale. Post abortion care (PAC) is also very limited and not many health care providers have the required skills to provide PAC.

Family Planning, identified as an essential component of primary and reproductive health care plays a major role in reducing maternal and newborn morbidity and mortality in Liberia. Currently diversified Family Planning Services are not well accepted in a pill dominant, Depo-Provera and condom exclusive service, with a national contraceptive prevalence rate of 11% (LDHS 2007). With the high infant and maternal mortality rates, low acceptance rates for family planning, high incidence of malnutrition among children and other social problems of poverty, illiteracy and cultural constraints, the need to have service providers trained to offer family planning services through informed choice is paramount. Currently, service providers are not trained to administer a range of family planning services. Consequently they offer the services that clients request and services that they can administer rather than services based on their assessment. Clients request the methods they know about and like. Given the opportunity to choose what is best suited and available, their choices may be different and diversified. Service Providers skills need to be updated to enable them to provide a full range of services. Additionally, longer lasting methods of contraception should be made available.

The strength, weakness, opportunities and threats (SWOT) analysis is depicted as follows:

Strengths:

- Basic health care packages developed and being implemented
- RH program in place
- IMCI strategy implementation
- National Health Policy developed
- Decentralization of services
- Increased partnership and donor support
- Integration of health programs at service delivery point
- Increased health budget from 8% (2006) to10% (2007) and rising
- National HIV/AIDS Programme in place, including PMTCT
- 70% increase in existing Health Facilities offering ANC
- National functional RH coordinating body (RHTC)
- Increased political will and commitment
- Female president
- HRH plan developed

Weaknesses:

- Inconsistent use of partograph
- Inadequate incentives for health workers
- Health needs of adolescents not identified and not met
- Safe Motherhood Protocols not implemented

- Lack of skilled health service providers
- Inadequate newborn care
- Micronutrient supplementation at low scale
- Inaccessible health facilities
- Poor access to RH information and services
- Poor quality MNH care
- Weak health system (HMIS)
- Poor referral system and road network
- Unavailability of essential equipment/drugs/supplies
- Lack of family planning national policy
- Inadequate supplies of material resources/logistics
- Inadequate provision of 24 hour services at Health Facilities
- Weak monitoring and evaluation(M &E); including operational research
- Poor linkage between formal health system and community
- Lack of data for adequate planning on adolescent health
- Inadequate training institutions for health professionals
- Inadequate MNH program at community level

Opportunities:

- Communication in some facilities
- Increased national security
- Elected government with political will for health
- Donor support
- Revised population policy

Threats:

- Increased turnover of trained RH staff
- Gaps in service delivery due to emergency NGOs pull out of Liberia
- Lack of family and community commitment
- Deeply rooted traditional beliefs and harmful practices
- Culture that isolates men's participation in MNH counseling, emotional support

Vision: The Outcome of every pregnancy will result in a healthy mother and newborn.

General objective: To reduce maternal and neonatal mortality by 15% and begin to reverse the increasing mortality trend by 2010

Specific Objective 1: To provide skilled attendants for all RH services at all levels of the health care system

Specific Objective 2: To ensure the availability, accessibility of quality services to 70% of pregnant women and newborns

Specific Objective 3: To strengthen/reinforce the referral system to respond to obstetric and neonatal complications at all levels of the healthcare system.

Specific Objective 4: To ensure the availability/accessibility of quality family planning services to people of reproductive age.

Specific Objective 5: To advocate for safe Maternal and Newborn Care at all levels of program planning and implementation

2. Overarching Strategies to reduce maternal and neonatal mortality

Four pillars have been identified to reduce maternal and newborn mortality in Liberia:

- Availability of skilled birth attendants at all levels of the health care delivery system
- Availability of 24 hours emergency obstetric and neonatal care services
- Strengthening the referral system at all levels of service delivery
- Provision of family planning commodities and services

1) Availability of skilled birth attendants at all levels of the health care delivery system:

Maternal mortality rate is high in Liberia and according to the Demographic Health Survey (DHS) 2007 it has near doubled since the last survey (2000). According to the same survey, child health has improved but newborn death is responsible for more than 60% of Infant Mortality Rate.

The ideal of skilled attendants at each birth is a far cry from reality in Liberia. Several factors contribute to this dire situation. Over the past three decades the number of practicing physicians in Liberia has dwindled from over 800 to less than 50.The burden of frontline service provision rests on the mid level health professionals(Registered Nurses, Physician's Assistants, Certified midwives and Licensed Practical Nurses) to provide comprehensive services including reproductive health care services. They are obliged to meet these demands without the benefit of skills upgrade through regular refresher, in-service or post graduate courses. Attrition of staff, lack of necessary equipment and supplies (including essential drugs), lack of and poor condition of facilities and access roads and bridges contribute greatly to the unavailability of skilled attendants at more than 80% of deliveries.

In-service training (skills update) of doctors and mid level service providers must be accomplished as soon as possible. Pre-service curricula must be revised to include the updated skills given in in-service training. Basic training programs must be expanded and increased to produce the largest possible compliment of service providers in a timely manner. Priority (in numbers) will be given to midwifery training. Attractive incentive packages must be developed and offered to retain staff.

2) Availability of 24 hours emergency obstetric and neonatal care services:

The capacity to provide emergency obstetrical and neonatal care is a dire need in Liberia. Apart from the severe shortage and lack of adequate skills among doctors and mid level professionals, there are other critical shortcomings that need urgent attention. There is shortage of physical structures. Those that exist need renovation and equipment to offer the standard of care required. Appropriate medical supplies,

essential drugs are also needed. National protocols and policies to guide and mandate standards of care are not yet in place. In addition a strong supervisory mechanism must be put in place to ensure that the infrastructure for emergency response is in place and readiness when an emergency occurs. This includes all of the above: physical structures adequately staffed and provided with equipment, supplies and drugs and services which are closely monitored and supervised to operate under strict adherence to national standards and protocols. .

3) Strengthening the referral system at all levels of service delivery:

The severe destruction to social infrastructure in Liberia makes access to service delivery points to seek care difficult and sometimes impossible. Where roads exist, they are at varying levels of disrepair and in many cases impassable during the rainy season. This same destruction has left service delivery points poorly equipped and widely spaced apart. Referral hospitals are also poorly staffed and equipped. Vehicles and other modes of quick transportation and communication e.g., telephones and radios are not available. To compound this people are not informed to recognize danger signs and communities are not empowered to establish mechanism for communication and transport.

Efforts must be made to help rural communities to access skilled and emergency care in a timely manner. These will include bringing high risk and other maternity clients nearer to service delivery points before delivery, establishing communication and transport systems, raising awareness of communities to identify and intervene in high risk or complicated situations in a timely manner. This will include putting in place resources to ensure timely emergency community action. Emergency planning to strengthen infrastructure, repair and building of roads, bridges must be undertaken.

4) Provision of Comprehensive Family Planning services:

Multiparity and unplanned pregnancies are among the prime predisposing factors that contribute to high maternal mortality in Liberia. The recent DHS reveal that a large percentage of women do not desire to have anymore children but do not practice FP due to ignorance and/or lack of access to FP services. Adolescent pregnancy is among the highest in the world. Acceptor rate for Family Planning (FP) is low with a correspondingly low CYP. The methods used are predominantly pills and injections. Use of condoms is predominantly associated with the prevention of STI & HIV. Other methods are insignificantly available and utilized. Service providers are not competent to provide a variety of services and do not counsel clients for the methods available.

A variety of focused approaches must be utilized to increase accessibility and availability of quality FP services. Service providers must be prepared to offer a variety of FP methods and to counsel and refer when necessary for all methods available in Liberia so that informed choices may be exercised by clients. This must be supported by the provision of a full line of contraceptive methods to the clients through competence of service providers, provision of equipment, supplies and information. This includes adherence to strict standards for ensuring high quality services through monitoring and supervision and the enforcement of protocols and policies. An efficient logistics system which ensures adequate supply of contraceptives to service delivery points including outlets for social marketing must be established.

3. Milestones:

The milestones are based on current population estimates as reflected in the table below.

	Current	Year 1 (short term)	Year 3 (medium term)	Year 5 (Long term)
Estimated Population	3,280,000	?	?	?
Women of childbearing age (25%)	820,000	25% of year 1 pop	25% of year 3 pop	25% of year 5 pop
Pregnant women (5%)	164,000	5% of year 1 pop	5% of year 3 pop	5% of year 5 pop
Pregnant women attending ANC	79% (129,560)	85%	95%	100%
Deliveries in Health facilities	11% (18,040)	15%	25%	35%
Caesarean sections	5% (8,200)	5% of year 1 Deliveries	5% of year 3 Deliveries	5% of year 5 Deliveries
Total number of CMs	290	375	545	715
Number of CMs in rural areas	116	169	300	465
Doctors in clinical practice	26	36	56	76

Some Assumptions:

- By year 3 BPHS implemented in (at least 70%) of all health facilities
- By year 5 access to basic health care is 100% (HF not more than two hours away)
- All primary health care facilities have at least one CM
- A standardized community health workers program including that for TTM in place nationwide

The table above indicates that annually, over 160,000 deliveries are expected in the country. Approximately 15% of these deliveries are expected to be performed at the level of health facilities (24,000 +) and 5% (8000 +) will require surgical intervention at the level of a comprehensive EMONC health facility.

The current facility based estimate for institutional delivery stands at 11%, implying that there has to be an increase of 4% more to obtain institutional delivery rate of 15% with the emphasis on delivery by a skilled birth attendant (doctor, nurse or certified midwife with the requisite skills to do normal deliveries and promptly manage complications that may arise).

4. **Annual Work Plan – 2008**

				Year 1											
			TARGET	1	2	3	4	5	6	7	8	9	10	11	12
Pillar 1: Skilled Birth Attendants for all levels of the health care delivery system in place															
Objective 1: To provide skilled attendants for all RH services at all levels of the health care system.															
Activities 1 : ***In-Service Training***															
1.1.1.	Develop Comprehensive Curriculum														
	1.1.1.1	Medical Doctors													
	1.1.1.2	BSN, RNM, PA, RN, CM, LPN													
	1.1.1.3	X-Ray Tech													
	1.1.1.4	Lab Tech													
	1.1.1.5	OR Tech													
	1.1.1.6	Nurse Anesthetist, Pharmacist													
1.1.2	Increase the number of LSS training sites														
	1.1.2.1	Montserrado county- Redemption Hospital	1												
	1.1.2.2	Identify and upgrade a third training site l	1												
1.1.3	Training of Trainers {BSN, RNM, PA, RN, CM, LPN}														
	1.1.3.1	Upgrade National Trainers to Master Trainers in LSS	10												
	1.1.3.2	Train Additional National Trainers in LSS	60												
1.1.4	Training of Service Providers														
	1.1.4.1	Identify and train medical doctors requiring Surgical Skills Training													
	1.1.4.2	Training of Service Providers {PA, RN, RNM, CM, LPN} : - 5 Rotating National Trainers will train 8 service providers every 2 weeks per cycle (2 weeks=10cycles) per 5 months = 80 (Ten Teaching Sessions) - Training of Service Providers: 8 per training cycle per 6 cycles at 1 site = 48 service providers trained during TOT 80 + 48 = 128 trained service providers	128												
	1.1.4.3	X-Ray Tech – Identify and Train													
	1.1.4.4	Lab Tech – Identify and Train													
	1.1.4.5	OR Tech – Identify and Train													
	1.1.4.6	Nurse Anesthetist, Pharmacist – Identify and Train													
1.1.5	Training of Supervisors														
	1.1.5.1	Develop/upgrade integrated supervisory tool													

	1.1.5.2	Train county RH supervisors	30													
	1.1.5.3	Train National supervisors (FHD, NMCP, NACP, NDS)	15													
Activities 2 : ***Pre-service Training***																
1.2.1	Support running costs of health training institutions including payment of teachers salaries		TNIMA, Phebe, Dogliotti MC													
1.2.2	Increase the number of Teaching Schools and their capacity															
	1.2.2.1	Advocate for construction/re-habilitation and furnishing of at least two additional health training institutions	Zorzor (Lofa), Zwedru (Grand Gedeh),													
	1.2.2.2	Advocate for incorporating Midwifery course in Ganta School of Nursing (Nimba)	1													
	1.2.2.3	Increase the capacity of the current teaching schools: 20 Medical Doctors/year, 85 Midwives /year, 20 Nurse Midwives /year (dormitory, classroom...)	TNIMA, Phebe, Dogliotti MC													
1.2.3	Improve the quality of the training - teaching standards															
	1.2.3.1	Review curricula to include in- service skills training														
	1.2.3.2	Disseminate and implement the rewiewed curricula in each training school														
1.2.4	Improve the quality of the teaching - Human and Material Resources															
	1.2.4.1	Provide adequate numbers of teachers per discipline														
	1.2.4.2	Provide educational materials including visual aids														
	1.2.4.3	Provide pratical instructors per practice sites														
	1.2.4.3	Provide 1 car/school to do student practical supervision in the health facilities	TNIMA, Phebe, AM Dogliotti													
1.2.5	Strenghten the school supervision															
	1.2.5.1	Support the Nursing Board to do regular assesment on Nursing and Midwifery Schools														
	1.2.5.2	Support the Liberia Medical Board to do regular assesment of Dogliotti Medical School														
Activities 3: ***Increase and retain number of Human Ressources in MNCH services***																
1.3.1	Provide scholarship for the training															
	1.3.1.1	Certified Midwives in TNIMA & Phebe School of Nursing & Midwifery	85													
	1.3.1.2	Registered nurses midwives at Phebe	20													
	1.3.1.3	Provide scholarships to train at least 20 medical doctors per year at the AM Doglotti College of Medicine	20													
1.3.2	Implement Human Ressource Policy															
	1.3.2.1	Advocate for increment of salaries for all professional cadres of health workers (LPN=175, CM=250, RN=350, PA=350, RNM=400, BSN=500, MD=1500)	USD/month													
	1.3.2.2	Advocate for ressources to motivate and retain staff especially in rural service (housing, transportation allowance)														
1.3.3	Continue and upgrade by 25% the current incentive package															

Pillar 2: Emergency Obstetric and Neonatal Care																
Objective 2 : To ensure the availability, accessibility of quality services to 70% of Pregnant Women & New Borns																
Activities 1 : ***Health infrastructural rehabilitation/development***																
2.1.1	Increase number of EmONC facilities:															
	2.1.1.1	One Basic EmONC facilities per district (=health center)	88													
	2.1.1.2	One comprehensive EmONC per county (=hospital)	15													
2.1.2	Construction of at least 2 Basic EmONC health facilities in the under served areas in 2 counties		Nimba & Lofa													
2.1.5	Establish one blood bank per county		15													
2.1.6	Establish one neonatal unit in each county hospital		15													
2.1.7	Establish one laboratory per health center		88													
Activities 2 : ***Equipment, Supplies, Medicals and Drugs***																
2.2.1	Training in forecasting in RH supplies															
	2.2.1.1	Train in each county : the Pharmacist, the Reproductive Health Supervisor, the County Health Officer	45													
	2.2.1.2	Train national RH managers, Pharmacists, NACP/NMCP key staffs and NDS Drugs Manager	15													
2.2.2	Strengthening current distribution system															
2.2.3	Support the central Health Information System to track RH commodities															
2.2.4	Develop and implement Standard Operating Procedures															
Activities 3: ***Review and update the national standardized guidelines and protocols for MNCH***																
2.3.1	Support the Reproductive Health Technical Comittee to review, update and standardize the national policies and guidelines															
	2.3.1.1	Establish the guidelines based on perinatal approach (Focusd antenatal care, labor, delivery, postpartum, newborn care and post abortion care) in collaboration with NACP, NMCP, EPI program														
	2.3.1.2	Produce and disseminate the updated policies and guidelines at all levels of program planning and implementation														
	2.3.1.3	Train the National Level Managers on implementation of the policies and guidelines	15													
	2.3.1.4	Train the County RH Supervisor on the implementation of the National policies and guidelines on MNCH	30													
2.3.2	Support the Reproductive Health Technical Committee to review, update and standardize the national protocols															
	2.3.2.1	Produce and disseminate the updated protocols at all levels of program, planning and implementation														
	2.3.2.2	Train the MNCH service providers on the national protocols	450													

Activities 4 : ***Supervise, monitor and evaluate the Health Facilities and the County RH supervisors***																	
2.4.1	Supervise, monitor and evaluate the Health Facilities by the County MNCH Supervisors																
	2.4.1.1	Appoint 2 Maternal Newborn and Child Health Supervisors per county	30														
	2.4.1.2	Provide one car for the Reproductive Health Supervisors per county	15														
	2.4.1.3	Provide one motobike for the Reproductive Health Supervisors per county	15														
	2.4.1.4	Provide fioul and maintenance for the car and the motobike															
	2.4.1.5	Review and standardize supervisory check list for MNCH services (facilities and communities)															
	2.4.1.6	Do monthly supervision in each MNCH facility by the County MNCH Supervisor															
	2.4.1.7	Support the Data Analyst in each county															
	2.4.1.8	Collect and analyse monthly facility morbidity report															
	2.4.1.9	Provide and analyse monthly county report on MNCH															
	2.4.1.10	Develop a county response strategy to address the identified problems															
2.4.2	Supervise, monitor and evaluate the Reproductive Health activities of the County by Family Health Division																
	2.4.2.1	Appoint 4 additional persons in Family Health Division	4														
	2.4.2.2	Provide 2 additional cars for the Family Health Division	2														
	2.4.2.3	Review and standardize supervisory check list for County Reproductive Health Activities															
	2.4.2.4	Do quaterly supervision in each county by Family Health Division															
	2.4.2.5	Support the National Data Analyst															
	2.4.2.6	Collect and analyse monthly county report															
	2.4.2.7	Develop national monthly report on MNCH															
	2.4.2.8	Develop a national response strategy to address the identified problems															
Pillar 3: Referral System																	
Objective 3: To strengthen/reinforce the referral system to respond to obstetric and neonatal complications at all levels of the healthcare system.																	
Activities 1 : ***Emergency response system***																	
3.1.1	Establish Maternity Waiting Homes																
	3.1.1.1	Establish Maternity Waiting Homes nearer to each health center for High Risk patients	88														
	3.1.1.2	Encourage establishment of Maternity Waiting Homes or lodging nearer to each clinics for patients needing to deliver in health facilities															
	3.1.1.3	To train the MNCH service provider in Maternity Waiting House use (High Risk patient detection)															

	3.1.1.4	To ensure the comitment of Community, Community Development Council and local associations (women associations,...) for the provision of food and personal effects for their relatives														
	3.1.1.5	To budget the maintenance of the Maternity Waiting Homes in the County Health Plan														
	3.1.1.6	To train the county admininistrator and county RH supervisor for the management of the Maternity Waiting Homes	30													
	3.1.1.7	Train TTMs for the educational sesions for of the Maternity Waiting Homes	166													
3.1.2	Establish/strengthen radio communication system between, clinics, health centers and hospitals															
	3.1.2.1	Equip and maintain each Basic EmONC facilities with radio(+/- power source) + communication package : cell phone, scratch card	88													
	3.1.2.2	Equip and maintain each Comprehensive EmONC facility with radio + communication package : cell phone, scratch card	15													
	3.1.2.3	Equip each clinic under network with a communication package : cell phone, scratch card, and recharge allowance														
	3.1.2.4	Select and train 2 radio operators per equiped facility	206													
	3.1.2.5	Advocate and collaborate with the Cell phone providers for phone network linking all service delivery points														
3.1.3	Establish ambulance system															
	3.1.3.1	Provide and maintain 1 vehicle ambulance per Comprehensive EmONC facilities (hospitals)	15													
	3.1.3.2	Provide and maintain 1 motorcycle ambulance per Basic EmONC facilities (Health Centers)	88													
	3.1.3.3	Provide fuel for vehicle and gas for motorcycle														
	3.1.3.4	Budget for maintenance, fuel and gas in the County Health Plan														
	3.1.3.5	Appoint and train 4 drivers per vehicle ambulance	60													
	3.1.3.6	Appoint and train 2 drivers per motorcycle ambulance	176													
Activities 2: ***Awareness and sensitization, and resource mobilization to support referral system***																
3.2.1	Implement a national and local campaign on recognizing and referring the patients with major causes of maternal and newborn death															
3.2.2	Create awareness on the need to establish community financial schemes															
3.2.3	Encourage community involvement and mobilization in case of emergency situation (hammock, transport union)															
3.2.4	Develop birth prepared plan at household and community level															
Activities 3: ***Roads***																
3.3.1	Encourage the community involvement to maintain access road															
3.3.2	Advocate and collaborate with the Ministries of Public Works, Internal Affairs and Rural Development for road network linking all service delivery points															

*Activities 4:**Collaborative Community Networking***																		
3.4.1	Strengthen Community Development Council																	
3.4.2	Encourage establishment of community emergency response committee																	
3.4.3	Sensitize the population on dangers signs of pregnancy , labor, delivery and postpartum																	
3.4.4	Train TTMs in Home Base Life saving skills, emphasizing on early detection of complications and timely referral																	
3.4.5	Promote health facilities delivery		Increase by 25% / year															
Pillar 4: Family Planning																		
Objective 4: To ensure the availability/accessibility to quality family planning services to people of reproductive age.																		
*Activities 1 : **Contraceptive Security***																		
4.1.1	Training in forecasting in FP supplies																	
	4.1.1.1	Train in each county : the Pharmacist, the Reproductive Health Supervisor, the County Health Officer	45															
	4.1.1.2	Train national RH managers, Pharmacists, NACP/NMCP key staffs and NDS Drugs Manager	15															
4.1.2	Procurement of the commodities																	
4.1.3	Strengthening current distribution system																	
4.1.4	Support the central Health Information System to track RH commodities																	
4.1.5	Develop and implement Standard Operating Procedures																	
*Activities 2 : **Increase the FP methods use***																		
4.2.1	Increase the demand																	
	4.2.1.1	Advocate for the autonomy of the woman in decision making on Family Planning																
	4.2.1.2	Advocate for the autonomy of the adolescent in decision making on Family Planning																
	4.2.1.3	Encourage male involvement																
	4.2.1.4	Develop and distribute IEC/BCC materials																
	4.2.1.5	Establish Outreach service by Community Based Distributors (condoms and pills)																
4.2.2	Increase the number of FP outlets																	
4.2.3	Promote Emergency Contraception																	
	4.2.3.1	Train service provider	450															
	4.2.3.2	Procure the methods																
*Activities 3 : **Promote Informed Choice***																		
4.3.1	Expand Contraceptive Method Mix																	
	4.3.1.1	Oral Contraceptives,																
	4.3.1.2	Injectable Contraceptives																

	4.3.1.3	IUD (several types)														
	4.3.1.4	Implant														
	4.3.1.5	Barrier methods: Condoms (male and female), diaphragme, cervical cap, ..														
	4.3.1.6	Spermicides														
	4.3.1.7	Permanent method (surgical methods)														
	4.3.1.8	Natural methods														
4.3.2	Advocacy for the procurement and promotion of all the methods															
4.3.3	Train service providers on utilization and promoting informed choice		450													
*Activities 4 :**Promote Adolescent Sexual and reproductive health care services***																
4.4.1	Collaborate with the Ministry of Education to increase and strengthen Family Life Education in schools															
4.4.2	Promote Adolescent friendly services in community and health facilities															
	4.4.2.1	Develop standards on Adolescent friendly services														
	4.4.2.2	Train service providers	450													
	4.4.2.3	Establish Adolescent Friendly Services in community and health facilities	35/year													
	4.4.2.4	Provide essential drugs, commodities and supplies for AFS														
	4.4.2.5	Produce and distribute IEC/BCC materials on AFS														
Objective 5 : To advocate for maternal and Newborn Care at all levels of program planning and implementation																
*Activities 1 : **Undertake resource mobilization for MNCH care***																
5.1.1	Accessing donor funding															
	5.1.1.1	Proposal development														
	5.1.1.2	Stakeholder conferences														
5.1.2	Promote and sustain strategic partnerships on MNCH care															
	5.1.2.1	Continue to involve NGO in MNCH service delivery														
	5.1.2.2	Continue to involve the private sector in MNCH service delivery														
	5.1.2.3	Seek for increase support from the UN and other international bodies														
	3.1.2.4	Promote greater community participation on MNCH care														
5.1.3	Fund raising															
	5.1.3.1	Create a list of potential donors														
	5.1.3.2	Develop and disseminate solicitation materials														
	3.1.3.3	Set quarterly targets to raise funds														
*Activities 2: **Support Implementation of the MNMR plan***																
5.2.1	Merge MNMR plan with the National Health Plan															
5.2.2	Merge Maternal and Neonatal Mortality Reduction Plan with County Health Plan															

5.2.3	Mandate all the NGOs to implement the National MNMR plan																
Activities 3: ***Reinforce communication & awareness ON MNCH***																	
5.3.1	Support communication on MNCH																
	5.3.1.1	Launch the international week for Combating Maternal and Newborn Mortality															
	5.3.1.2	Launch the international week for Promoting Midwifery															
	5.3.1.2	Develop and disseminate bulletins on Maternal and Neonatal Health															
	5.3.1.3	Implement the National Reproductive Health Communication Strategy															
	5.3.1.4	Updating the Nation by the President Office on MNCH every quarter	Quarterly														
5.3.2	Strengthen awareness at all levels on MNCH																
	5.3.2.1	Encourage male involvement on MNCH															
	5.3.2.2	Encourage community involvement (including leaders,…) on MNCH															
	5.3.2.3	Develop birth prepared plan at household and community level															
	5.3.2.4	Develop and promote the use of various communication methods and means (traditional modes, media, drama, role place, …)															
	5.3.2.5	Collaborate with the Ministry of Education to increase and strengthen Family Life Education in schools	Quarterly														