Ministry of Health

National Maternal Health and Mortality Reduction Priority Plan

July 2019 - September 2020

Suriname

Contents

Foreword

Preventing maternal morbidity and mortality is a high priority for Suriname.

To improve maternal health and to prevent maternal mortality, reinforcing universal access to care during preconception, pregnancy, delivery and the postnatal period for all women, and targeting vulnerable groups, intensified efforts are required.

Improving the quality of care on all levels is a key issue to be addressed. However, strengthening health insurance coverage, awareness raising, promoting family planning and birth spacing, prevention and management of teenage pregnancies, addressing social determinants, community and men involvement, are crucial elements as well.

To ensure multi sectoral coordination and accountability, a national steering committee on maternal health and mortality reduction will be in charge to closely monitor planned interventions and regularly review the plan.
It is the responsibility of all sectors and partners to reduce maternal mortality and establish a strong multi sectoral coordination.

During the implementation of the current plan, a long term strategic and operational plan is being developed for the period 2020-2025, respectively 2020-2022, incorporating the interventions proposed in this plan.

In view of universal access, we are committed to improve maternal health and to reduce and prevent deaths in Suriname.

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Director of Ministry of Health

Acronyms

ANC	Antenatal Care
BOG	Bureau of Public Health
HiAP	Health in All Policies
PAHO	Pan American Health Organization
RGD	Regional Health Service
MAMS	Maternal Mortality Committee Suriname
MICS	Multi-Indicator Custer Survey
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNH	Maternal Newborn Health
MOH	Ministry of Health
MZ	Medical Mission
NHIS	National Health Information System
NHSP	National Health Strategic Plan
NMR	Neonatal Mortality Rate
SRH	Sexual Reproductive Health
SMNA	Safe Motherhood Needs Assessment
SZF	State Health Insurance
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Introduction

1.1. Background

Maternal mortality is a global, regional and national concern. Complications during pregnancy, childbirth and postpartum period are the cause worldwide for maternal deaths. Most of these deaths can be prevented. Maternal morbidity and complications during child birth are a main cause for stillbirths and newborn deaths (1, 2, 3).
In line with the Sustainable Development Goals (SDGs), the regional target is to considerably reduce maternal mortality by 2030, ensuring that the reduction will positively affect all population groups, with a special focus on the most vulnerable. (4)

> ***"For each mother who dies, there is a family that suffers, a community that becomes weaker, a country that gets poorer"***
>
> PAHO Director, Carissa F. Etienne

The Global strategy for women, children and adolescents (2016-2030) and the strategic plan for ending preventable maternal deaths (WHO, 2015), target a reduction of maternal mortality ratio < 70 for all countries by 2030, and the regional plan of action for women, children and adolescents (2018-2030) has set its target at <30. The aim is to have an equitable MMR for vulnerable populations at subnational level, ensuring that the reduction will positively affect all population groups, with a special focus on the most vulnerable.

1.2. Rationale

Suriname is amongst the five countries in the region with the highest maternal mortality. To reach the 2030 regional target of 30 per 100,000 live births, the number of deaths has to reduce significantly. Closely related to maternal health are perinatal deaths and stillborn and neonatal death rates which are equally high. There is a need for accountability and coordination of high impact interventions to improve maternal health and reduce maternal deaths in the country.

Globally, maternal and child health efforts have been combined under Safe Motherhood and Newborn Health initiatives and programs. The Government of Suriname has also embarked on a national process of evaluation of the progress made with regards to maternal and neonatal health in order to determine the steps necessary for improvement of maternal and newborn health. This process started with a Safe Motherhood Needs Assessment (SMNA) in 2007, and continued with the development of the National Sexual and Reproductive Health and Rights Policy of Suriname, 2013-2017, the Safe Motherhood and Neonatal Health Action Plan (2013-2016), followed by an evaluation of the Safe Motherhood plan (2017), a maternal and newborn (MNH) health policy and management needs assessment (2018). The needs assessment recommended a second part of the needs assessment, focusing on community satisfaction, which is currently being prepared.

This plan seeks to address priority issues to improve maternal health and reduce maternal mortality, identified in the policy and management MNH needs assessment, two national stakeholder workshops to identify key issues and identify priority interventions (national MNH community health workshop (2018) and MNH SWOT analysis (2019), recommendations from the second national obstetric conference (2019), maternal deaths audits and a literature review.

During the implementation of the current plan, a long term strategic and operational plan is being developed for the period 2020-2025 respectively 2020-2022, incorporating the interventions proposed in this plan.

1.3. Scope

Addressing maternal mortality and morbidity calls for an effective continuum of care that is available for the pregnant woman and her family from the preconception period through the early stages of pregnancy to the postnatal period.

The plan includes priority interventions in the area of contraception/birth spacing, antenatal care, delivery, and postpartum care. Since the majority of maternal deaths had sub standard care, quality of care is a priority issues to be adressed in this plan. However, universal acess to maternal health care is a human right and efforts should be focused on all factors that influence maternal and perinatal health. Maternal health surpasses the boundaries of health care as social determinants play an important role. **Recommendations per sector and level** have been formulated by MOH/BOG-FCHU, MAMS committee and PAHO **(Annex 1).**

Improving maternal health will consquently reduce perinatal deaths and morbidity as they are intrinsically linked.

1.4. Policy framework

The Government of Suriname has committed itself to achieving the Sustainable Development Goals (SDGs), among which a main target is the reduction of maternal mortality. A major guiding strategy is the Global Strategy for Women's, Children's and Adolescents' Health (2016-20130) and its regional plan of action for Women's, Children's and Adolescents' Health (2018-2030). As a PAHO memberstate, Suriname approved the regional plan of action in 2018, which includes a human rights based, equitable reduction of maternal mortality.

The 2019-2028 National Health Sector Strategic Plan introduced a new model of care which is a Primary Health Care (PHC), based on a health system supported by the strategy for Universal Health and aimed at increasing access, coverage, efficiency, equity and quality, and people-centeredness. In addressing the social determinants of health, health inequities and the SDG-2030 health agenda, the Government of Suriname embraced a 'Health in All Policies Approach' (HiAP) (NHSP 2019-2028).

Alhough focussing on priority interventions, this action plan is alligned with the NHSP, global and regional strategy and plan for Women's, Children's and Adolescents' Health.

The National Sexual and Reproductive Health and Rights Policy of Suriname, 2013-2017, is currently being updated and the adolescent health strategic plan is being finalized.

2. Situation analysis

2.1. Maternal and perinatal mortality in Suriname

As previously mentioned, Suriname is amongst the five countries in the region with the highest maternal mortality. The maternal mortality ratio (MMR) is estimated at 120 (2017) (5) and corresponds with the MMR of 130 of the maternal mortality survey in Suriname (2010-2014) (6), with an average of 12 maternal deaths per year (2010-2018). To reach the 2030 regional target of 30, the number of deaths has to reduce significantly.

Maternal morbidity and complications during child birth are closely related to stillbirths and newborn deaths (1 ,2, 3). Suriname also has a very high stillborn rate of 15.6 still births per 1,000 babies born (2016/2017).(7,8) The still birth rate is the second highest of the region.(9) The neonatal mortality rate is high as well and estimated to be 12 per 1,000 live births (MICS, 2018).

The maternal mortality ratio (MMR) is not the same everywhere in Suriname, as not all population groups are exposed to the same risks. The maternal mortality ratio is the highest amongst women residing in the rural interior (MMR 160), followed by the urban areas Paramaribo and Wanica (MMR 145), the rural coastal area (MMR 120) and

the Nickerie area (MMR 80). The highest percentage of the deaths is among the Maroon ethnic group (37%) and the poorer population groups (69%).(6). Preliminary data on ethnic disparities shows that women of Maroon ethnicity had the highest maternal mortality ratio (184 per 100,000 live births) and the highest still birth rate (25 per 1,000 babies born) (2016/ 2017).(7)

Maternal mortality occurs during pregnancy, childbirth and the post-partum period. Most women die during the post-partum period (63%) and the majority of deaths (84%) occur in health care facilities, mainly in urban hospitals. (6)

The main causes of death amongst women are infections (27 %) (obstetric (9%) and non-obstetric sepsis (18 %), bleeding (20%), high blood pressure (14%), indirect causes, other than non-obstetric sepsis (14%).

Factors associated with poor maternal health outcomes

Substandard care in health facilities. Most maternal deaths occurred in hospitals (84%) and were due to third delay, meaning that the health care provided in the health care facility was insufficient. A major concern is that substandard care factors were observed in 95% of all maternal deaths and were mostly related to health professionals (delay in diagnosis, delay in treatment and inadequate monitoring of patients). Substandard care factors most likely resulted in death in 47% of the cases (6, 11), 13 % of the population reported to be dissatisfied with the services.

Lack of postnatal care. Most of the deaths occurred in the post-partum period (63%), suggesting that the quality of postnatal care is inadequate (6). There is no standardized national postnatal care program or guideline (on for example the recommended timing of discharge, frequency of visits). Early post-partum home visits during the first week after birth are rather an exception than the rule, as these visits are only received by a relatively small group of women who delivered in primary health care services. Women who deliver in the hospital receive no postnatal care until they visit the hospital, mostly one-week after delivery. (14, 15)

Insufficient health insurance. The new health care insurance law in 2014 was established to promote equal health care for every citizen. However, several women experience barriers in obtaining their insurance card, which leads to delayed antenatal care and a high risk of obstetric complications. (13, 14, 15) One of the public hospitals that receives the lower socio-economic groups, (‘s Lands Hospital), reported that 9% of all women who delivered during 2017 were not insured. (16) Preliminary data on maternal deaths (2015 and 2018) show that 15% of the women were not insured.(18). Another study shows that amongst the women with a stillbirth in 2017 17 % did not have a health care insurance.(7)
During 2018, women with risk pregnancies referred from the interior by Medical Mission, reported severe delay in obtaining healthcare insurance and therefore timely access to care. Several referred women with risk pregnancies did not receive any care prior to delivery.(17) The major barriers in accessing free health insurance often include a lack of information on how to obtain a health care insurance card and/or the proper social support networks for guidance through the required procedure.(15) In addition, health care insurance does not cover all required essential medication and does not cover post-natal care home visits. (12,15)

Other financial issues. Even if women have obtained their insurance card, those with a lower socio-economic status have a lack of funds for transportation to or within the capital city Paramaribo (second delay), costs for temporary residence and unexpected medical costs (14,15,19). 27 % of clients reported co-payment. (19)

Geographical accessibility (14,15, 19) also contributes to insufficient care. Among 15% of maternal deaths, a delay in transportation was reported (6) (19) Insufficient referral and counter-referral mechanisms between health centers and hospitals play an important role in the quality of care (14, 15).

Facts about maternal deaths

Suriname is amongst the five countries in the region with the highest maternal mortality ratio.

Majority of deaths
In hospitals
Among Maroon ethic group
Among poorer population groups
During post-partum period

Substandard care factors in health facilities and **insufficient postnatal care** are major concerns

15% of maternal deaths did not have a **health insurance** (2015 – 2018)

The women who died did not all have **access** to the health care they needed

Insufficient antenatal care. There is a decrease of pregnant women who attend at least one antenatal visit from 95 to 87% between 2010 and 2018.(20) This may be a consequence of the economic crisis, the insurance access issue and other socio-economic factors. Only 56% of pregnant women had a visit during the first trimester. In 85% the key standards of antenatal care quality were met (such as for example the measurement of blood pressure). (20)

Anemia, obesity, diabetes and hypertension are known risk factors for maternal morbidity and mortality and stillbirths. The population in Suriname has an increased risk due to biological and environmental factors. Hindustani and Maroon women are especially susceptible to obesity, diabetes and hypertensive disorders, while African-descendent Maroon and Creole women have the highest risk of severe anemia.(21) Preventative strategies can reduce severe complications, including improve health awareness, promote lifestyle changes and improve nutrition.(2, 3, 21)

Family planning and contraception. In 39% of women in union modern contraception methods are used and 31% contraceptive needs are not met.(20) Family planning with modern methods is essential to prevent unintended pregnancies and closely spaced pregnancies, and will lead to less unsafe abortions and less adverse maternal and perinatal outcomes (2, 3, 27).

Many abortions take place in private clinics and hospitals and doctors are not required to report on performed abortions, although the law prohibits the termination of a pregnancy for other reasons than medical indication. There are however estimates, based on an unpublished report of the Lobi Foundation, of approximately 8,000 - 10,000 cases annually (12).

Adolescent birth rates (< 20 years) Adolescent pregnancies have higher risks of complications, including unsafe abortions in unwanted pregnancies (25). The adolescent birth rate[1] is 64 and particularly high in less educated population groups, those living in the interior (159), amero-indian 124) and maroon (99) (20). The % of women/girls who had a life birth < 18 years old (early child bearing) was 13.2 % (national), rural interior (54.8 %), amero Indian (26.6) and maroon ethic groups (22 %). The percentage of adolescents who are not able to meet the need for

1 The adolescent birth rate is the annual number of live births to adolescent women per 1,000 adolescent women.

contraception is 75% among the unmarried and 60% among the married and cohabitating relationships.(20) To reduce teenage pregnancies and the identified disparities, it is important to provide free youth-friendly services for sexual and reproductive health, provide free modern methods of contraception, improve health literacy, strenghten community-based outreach services and involve men. (2, 3, 4, 15, 27)

Insufficient awareness and healthy behavior during preconception, pregnancy delivery and postpartum period contributes to poor health outcomes. Among 7% of maternal deaths, treatment refusal, and 22% poor compliance to treatment was reported (6). Community and men involvement and participation in maternal health to reinforce the voice of the community, through localized planning, engaging in advocacy for universal access to maternal health services, community mobilization and support of pregant women in the family and the community, is insufficient. Health awareness raising, community and men involvement and participation need to be addressed as a priority (14,15,19).

Traditional practices and cultural norms play a role in certain ethnic groups. Use of traditional medicines was reported by 9% of women, mainly the Maroon ethnic group in Latour (20%) (19). An example is the consumption of *pimba*, which due to mal-absorption leads to high levels of iron deficiency anemia and aggravates the severity of post-partum bleeding and severe infections. In addition, due to anemia, *pimba* also contributes to premature birth. (21)

Gender based violence. 3% experienced domestic violence during pregnancy (19).

Factors associated with poor maternal health outcomes

- **Substandard care in health facilities, especially linked to quality of care provided by health personnel**
- **Lack of national postnatal care program**
  - Frequency and standards not defined
  - Early discharge from hospital
  - Only postnatal home visits for first line deliveries
- **Financial accessibility**
  - **Health insurance** coverage of pregnant women
  - Costs of transport
  - Unexpected costs
  - Certain essential medicines are not on the national medicine list
- **Geographical accessibility**
  - Remote areas
  - Public transport
  - No maternity waiting home for the coastal area population
- **Acceptability of services**
  - Waiting times/opening hours
  - Unfriendly behavior of the health care workers
  - Cultural barriers
- **Referral and counter-referral** issues between primary, secondary and tertiary health care facilities
- **Lack of birth spacing and unmet need for modern contraception**
- **Teenage pregnancies, unmet need for modern contraception, and insufficient adolescent reproductive health programs**
- **Risk factors of anemia, obesity, diabetes and hypertension**
- **Insufficient awareness and healthy behavior** during preconception, pregnancy delivery and postpartum period
- **Insufficient community and men involvement and participation**
- Insufficient health education
- Insufficient involvement of influential community members and men (localized planning, community platforms)
- Domestic violence
- **Traditional practices/cultural norms (for example consumption of *pimba*).**

3. Health systems response

(6, 12, 13, 14, 15, 16, 17, 18, 19)

Health services. At primary level, maternal health services (antenatal care, delivery and postnatal care) are provided by 63 healthcare services of the Regional Health Services (RGD) throughout the coastal area, 51 primary health clinics and health posts throughout the interior of the Medical Mission, and aproximately 150 private clinics with general physicians. All health facilities of the Medical Mission and 17 clinics of the RGD provide delivery services.

Six hospitals provide care at secondary and one at tertiary level. Of the two (2) private and three (3) public hospitals, four (4) are located in the capital Paramaribo, one in Nickerie District and one in Marowijne District.

The majority (> 90%) of deliveries are carried out at hospital level. The Medical Mission refers a high percentage of pregnant women at risk to Paramaribo for ANC and deliveries. In 2018, the Medical Mission opened a maternity waiting home for women with high risk pregnancies who have been referred from the interior.

Quality of care. As mentioned above, substandard care in maternal health services is reported to be a major issue on all levels, including national quality standards, evidence-based guidelines, monitoring of patients, multi-disciplinary consultation, ongoing in-service training of staff, respectful maternity care, assessment and systematic monitoring of quality of care and adequate referral and counter-referral mechanisms.

Health workforce. In the hospitals, a total of 14 gyneacologists are operational, together with midwives, general practitioners, obstetric nurses and supporting nursing staff. In 17 of the RGD clinics, midwives are present, performing outreach antenatal and postnatal services to the healthcentres of their area.

No national community healthworker network exists which provides maternal newborn health services, such as awareness raising and homevisits of pregnant and postnatal women.

No regulatory framework is in place for on-going education of gynecologists, doctors and midwives.

The midwife school (COVAB) delivers aproximately 20-25 midwives every 3 years, and since 2018, a one year education of obstetric nursing is implemented by COVAB for nurses (20 in 2018 and 12 in 2019). The Medical Mission has their own training curriculum and school for health assistants who reside in the interior (GZAs).

Health promotion. Health awareness raising in maternal health issues needs to be reinforced. There is no national program for community involvement and participation in maternal health. The Medical Mission started to implement community platforms to reinforce community involvement through several catchment areas of their clinics.

Health Information System. A national health information system reporting national data on maternal health is not available. However, individual institutions and private physicians are collecting various data, which are currently not centralized.

There is no legal framework for reporting maternal death as a notifiable event (within 24 hours and zero mortality reporting) and the death certificate does not contain a pregnancy check-box. Maternal deaths are often reported late, sometimes months afterwards.

The Bureau of Public health (BOG) is performing surveillance of maternal deaths through visits to hospitals. In addition, the National Maternal Mortality Committee Suriname (MAMS) has been carrying out maternal deaths review and response (MDSR). MDSR is in the process of being institutionalized in health facilities, including verbal autopsies in the community, and needs further considerable efforts.

Medical products and technologies. Not all essential medicines needed for maternal health are on the essential medicine list and certain equipment and the maintenance thereof have been reported to be insufficient.

Health financing. As mentioned above, the new Health Insurance Act was established in 2014 to promote equal health care for all citizens. However, several women experience barriers in obtaining their insurance card from the State Health Insurance (SZF). All insurance schemes (public and private) cover access to preconception, antenatal and delivery care for women. However, there is often no full coverage of care offered in the insurance packages, such as home visits for postnatal care, health promotion interventions, coverage of all methods of family planning and health care for pregnancy for girls 16 years or younger.

Funding for several maternal health interventions are insufficient and resources mobilization based on this joint action plan is recommended.

Leadership and governance. Accountability for maternal deaths needs to be reinforced and the multi-sectoral coordination response to address main causes and underlying factors of maternal mortality, is insufficient. An evaluation of the Safe Motherhood and Newborn Health Action Plan 2012-2016 was carried out end 2017. Most stakeholders were not or only slightly familiar with the Plan of Action. None of the stakeholders reported being actively or consciously involved with the development or implementation of the Plan. (17) A national steering committee with related work groups (e.g. on quality of care, maternal health and mortality reduction) are being installed by MOH to strengthen multi sectoral coordination **(annex 2).**

National regulatory frameworks and guidelines to ensure that maternal health is sufficiently adressed are insufficient and there is no systematic institutionalized monitoring and supportive supervision of health service provision.

4. Purpose and Objectives of the plan

Purpose: Improved maternal health and reduction of maternal mortality and morbidity

General Objectives:

1. Prevent maternal mortality and morbidity through improved planning and coordination, accountability, quality of care and health promotion interventions.
2. Prioritize interventions to prevent maternal mortality and morbidity through improved availability and use of strategic information.

5. The Action Plan

This Action Plan covers a 15 month period, from July 2019 - September 2020 and focusses on priority interventions to promote maternal health and prevent maternal deaths. Outcomes, outputs and key interventions are formulated in the following areas **(annex 3):**

- Multisectoral planning and coordination
- Availability, accesibility, acceptability and quality of maternal health services
- Health promotion, including community participation and involvement, to increase awareness and demand for maternal healh services
- Increased access and use of modern contraceptive methods, including amongst adolescents
- Strategic information, including maternal deaths surveillance, review and response.

6. Coordination, Funding, Monitoring and Evaluation

In order to ensure an intensified effort to improve interventions to prevent maternal morbidity and mortality, joint planning, monitoring and reviews are essential. To reinforce accountability and multi sectoral coordination, a national steering committee on maternal health and mortality reduction will be in charge to closely monitor planned interventions and to review the plan biannually based on evidence, including MAMS recommendations.

Work groups on quality of care, health promotion and maternal deaths surveillance and review and perinatal health information/data, will develop implementation plans and report progress to the steering committee. Focal points from without the health sector and other stakeholders are being identified to ensure multi sectoral collaboration (**see annex 3**: **organigram of maternal health and mortality reduction steering committee).**

Since the time frame of the plan is one year, key output indicators have been selected which should be measured quarterly.

Maternal mortality will be closely monitored through institutionalization of maternal deaths surveillance review and response. As no national health information system is in place for reporting national data on maternal health, the perinatal health information system designed by PAHO will be introduced nationwide.

Budget estimates are made for the various interventions. The plan will be updated regularly according to the budget needs and fund availability per stakeholder, clearly demonstrating budget gaps. Budget gaps will incite to proceed with fund mobilization.

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Annex 1 Recommendations to all sectors and levels to improve maternal health and prevent maternal deaths

(1, 2, 6, 12, 13, 14, 15, 22, 23, 24, 25, 26)

To reduce maternal mortality, multi sectoral action and accountability are key to ensure universal access to obstetric care for all women, targeting vulnerable groups. Participation of all sectors and on all levels is essential to reduce maternal mortality (2, 3, 4, 14, 15). Improving the quality of care and the introduction of standardized qualitative postnatal care are currently the key issues that need to be addressed (6).

Parliament:

- Request and monitor multi sectoral action and accountability for maternal health and mortality reduction interventions
- Improve health insurance coverage for maternal health (access and coverage)

Ministry of Health

- Coordinate multi sectoral planning & monitoring
  - Install a steering committee for maternal health and mortality reduction
  - Develop a national strategy to ensure universal access to care, ensuring that high-quality reproductive, maternal health care is available, accessible and acceptable to all who need it
  - Coordinate resources mobilization based on a joint action plan
  - Strengthen accountability mechanisms
    Promote a multi sectoral response to address main causes and underlying factors of maternal mortality
  - Ensure targeting vulnerable groups and strive for equity.
- Improve health insurance coverage for maternal health (access and complete package of obstetric services)
- Reinforce maternal deaths surveillance and review and maternal near miss approach
  - Investigates each maternal death
  - Make maternal deaths a notifiable event through legislation
  - Mandatory autopsy of each death of women of reproductive age
  - Ensure that all maternal deaths and near miss are counted and reviewed (facility and community level)
  - Prioritize recommendations to prevent future deaths.
- Improve the quality of care through development of maternal health quality standards and develop a quality of care committee and a regulatory framework to monitor the quality of care delivered
- Scale up high-impact effective interventions that address the most prevalent causes of death
- Develop national training curriculum for prevention and management of obstetric emergencies for obstetric care providers, and ensure training of national trainers (per health institution)
- Revise and/or develop policies, guidelines and regulator frameworks to ensure that maternal health is effectively addressed (such as national postnatal care guideline, referral and counter-referral guidelines between the first and second line etc.)
- Reinforce health promotion, including prevention of anemia, diabetes, obesity and hypertension
- Introduce routine data collection on maternal and perinatal health indicators, by supporting introduction of perinatal health information system (PAHO)
- Reinforce availability of staff to support the maternal health program

Ministry of Finances

- Allocate adequate resources and effective health care financing

Ministry of Regional Affairs

- Reinforce community engagement and participation

Ministry of Social Affairs

- Reinforce support for the (near) poor during pregnancy and the postnatal period in identified population groups with high mortality and morbidity rates

Ministries of Education and of Sports and Youth

- Reinforce life skill programs for adolescents to prevent teenage pregnancies

State Health Insurance (Staatsziekenfonds)

- Ensure timely health insurance coverage of all pregnant women, including information on how to obtain the health insurance
- Include all recommended medical supplies in the national guidelines for obstetric management in the national essential drug list (for example tranexamic acid)
- Include health promotion interventions and postnatal home visits in the health insurance package

Professional associations (association for gynecology, midwives and VMS)

- Support planning and coordination of maternal health and mortality reduction interventions
- Support development of national guidelines in obstetric care
- Support in and pre-service training of health providers
- Regulatory framework with on-going education and training of gynecologists, doctors and midwives

MAMS Committee

- Official installation of the MAMS committee with obligations and responsibilities
- Review all maternal deaths, following the review on health facility level
- Systematically share periodical recommendations after maternal deaths reviews

Health providers (hospitals, RGD, MZ, private physicians)

- Strengthen the quality of care through implementation of quality standards and performance measures
  - Ongoing in-service training of staff in emergency obstetric care
  - Implementation of evidence-based guidelines
  - Promote respectful maternity care
  - Assessment and systematic monitoring of quality of care
  - Reinforce monitoring of patients, including implementation of the early warning score and a medium care
  - Reinforce multidisciplinary consultation
  - Organize effectively tasks of skilled obstetric providers, to allow full attention for patient care
  - Reinforce availability of medical supplies and equipment, including maintenance
  - Implement adequate referral and counter referral mechanisms
- Implement adequate referral and counter referral mechanisms
- Institutionalize maternal deaths surveillance, review and response and introduce maternal near miss approach
- Strengthen preconception care and improve access to family planning & promotion of birth spacing (integration in antenatal, postnatal and child health programs)
- Strengthen antenatal care
- Implement standardized postnatal care
- Free youth-friendly services for sexual and reproductive health

- Provide adequate health information
- Primary health care facilities (RGD and MZ):
- Reinforce capacity and demand for normal deliveries at RGD health centers, ensuring sufficient availability of obstetric care providers
- Promote community and men involvement and participation in contraception, adolescent reproductive health and maternal health
- Promote early postnatal home visits for all deliveries
- Reinforce availability of public health staff to coordinate the maternal health program

Educational institutes (midwife school, training for obstetric nursing (COVAB), medical faculty, SPAOGS)

- Sufficiently integrate emergency obstetric care, and new approaches/evidence-based interventions (for example MDSR and near miss approach etc.), in the training curriculum

Universities:

- Engage in research in the area of maternal health

Employers and private sector

- Workplace friendly environment for maternal health

Donors

- Support financially the national plan for maternal health and mortality reduction

UN organizations

- Technical and financial support for maternal health and mortality reduction

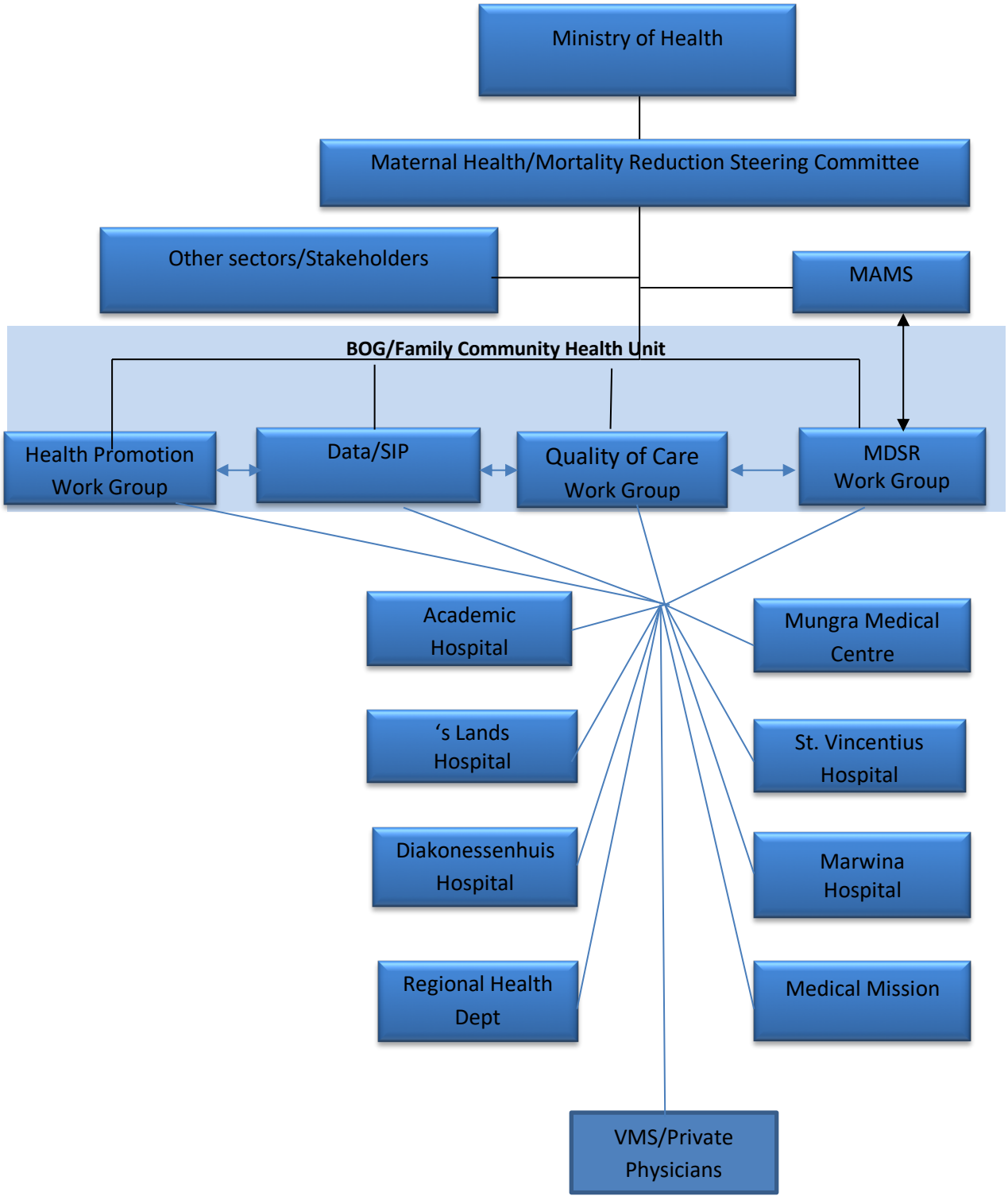
Community/Civil Society (community-based organizations, NGOs, religious organizations, and others)

- Engage in localized planning and support for maternal health, community mobilization and engage in advocacy for quality maternal health services
- Involve disadvantaged groups in planning

Men/Partners & Families

- Support women in safe motherhood and promote birth spacing
- Participate in the development of delivery preparedness plan
- Facilitate to visit timely antenatal and postnatal care and delivery
- Support in needs/household duties

Annex 2: Organization Chart for Coordination of Maternal Health and Mortality Reduction - Draft 2019



Annex 3. Action plan: Priority Interventions Maternal Health and Mortality Reduction, July 2019- Sept 2020

Ongoing	End of activity

Completed	Ongoing	Not started

in bold: priority interventions

Results	Activity	July – Sep 19	Oct - Dec 19	Jan-March 2020	Apr - June 2020	July - Sept 2020	Status	Budget needed (estimation USD)	Responsible	Partners/ Support
Outcome I: Enhanced multisectoral planning and monitoring of policies/strategies and operational plans related to maternal health										
OUTPUT 1.1: National maternal health strategies and plans developed, monitored and implemented and improved coordination between stakeholders										
Output 1.1 indicator	**% of annual MNH Operational plan implemented**	**> 20 %**	**> 40 %**	**> 60 %**	**> 70 %**	**> 80 %**				
1.1.1 Improved joint planning and coordination with key stakeholders	**Create maternal health and mortality steering committee** to support NMH planning and monitoring (monthly meetings)							-	MVG	PAHO
	Regular meetings of work groups of QOC, MDSR, SIPS/Data, health promotion, reporting to steering committee							-	BOG/FCHU	PAHO
	Use maternal health website for information sharing							-	MAMS/BOG-FCHU	All partners
	Document best practices and data (semestral maternal health bulletin)								BOG/FCHU	All partners
	Update & monitor **NMH action plan with priority interventions** (July 2019 – Sept 2020)								BOG/FCHU	PAHO
	Develop m**aternal/newborn health strategic plan (2020-2025)& operational plan (2002-2023)**, including M&E plan							**11,000**	BOG/FCHU	PAHO

	Increase staff to coordinate and support scaling up of the maternal health program at the Bureau of Public Health (OG)/Community Health Unit and Epidemiology Dept, including MDSR							**13,000**	MVG	TBD
Sub Total Output 1.1								**24,000**		
Output 1.2.	**Resources mobilization of maternal health reinforced**									
Output 1.2 indicator	**nbr of proposals submitted for maternal health**		at least 1	at least 2	at least 3	at least 3				
1.2.1 Improved resources mobilization covering MNH planned interventions	Develop proposals to cover financial gaps							**4,000**	BOG/FCHU	All partners
Subtotal Output 1.2								**4,000**		
Outcome II.Availability, accessibility, acceptability and quality of maternal health services reinforced										
Output 2.1.	**Standardization of maternal health services and national obstetrical protocols (first and second line) have been updated/developed**									
Output 2.1. Indicator:	nbr of obstetric (emergency) care protocols developed/validated	> 1	> 2	> 3	> 4	> 5				
2.1.1. National standards for quality of care in maternal health available	Develop n**ational standards for quality of care** for maternal health based on WHO guidelines							**2,000**	BOG/FCHU	QOC group/association of gynecology & midwives/PAHO
2.1.2. Definition of maternal health services package for RGD, including B-EMONC, based on midwife competencies	Develop evidence based national **maternal health services delivery package per level (**including B-EMONC and based on midwife competencies)							**3,000**	RGD	QOC group/association of gynecology & midwives/BOG/FCHU/ PAHO

2.1.3. National protocols for maternal health/ obstetric care, focusing on main causes of obstetric morbidity and mortality, developed	Elaboration/updating of **national protocols/emergency charts** for antenatal care, postnatal care, (early) monitoring, fluxus, hypertensive disorders, sepsis, sickle cell anemia, and other main causes of obstetric morbidity and mortality							**7,000**	BOG-FCHU	QOC workgroup-PAHO/association of gynecology & midwives
	Multiply protocols and emergency charts							**3,000**	BOG-FCHU	PAHO/ other partners
	Develop app with clinical protocols, etc							**3,000**	BOG-FCHU	PAHO/other partners
	Adapt/translate **IMPAC protocol for RGD**							**6,000**	RGD	QOC group/association of gynecology & midwives/PAHO
	Inventory and developing of **newborn** protocols (physical examination, early newborn care, care of the sick newborn, IMNCI)							**3,000**	BOG-FCHU	
2.1.4. All health facilities apply early monitoring tools (SEOWS)	**Introduce early monitoring tools (SEOWS)** in all health facilities and monitor use							**1,000**	Hospitals/MZ and RGD	QOC workgroup
SubTotal Output 2.1.								**28,000**		
Output 2.2. Reinforced capacity of health providers in maternal health, with focus on emergency obstetric care										
Output 2.2. indicator:	> % staff providing obstetric care (midwives, GPs) have been trained annually in national obstetrical protocols, focusing on emergency care		**> 50 %**	**> 60 %**	**> 70 %**	**> 80 %**				
2.2.1. 80 % staff providing obstetric care providers have been trained in national obstetrical protocols, focusing on emergency obstetric care	**Regular national training in obstetric emergency obstetric care** (3-4 topics per semester for all staff- monthly 1 day trainings of 30 staff)							**12,000**	BOG/FCHU	QOC group/association of gynecology & midwives/PAHO
	Monthly in health facility training of obstetric health providers (semestriel program per health facility)							-	Hospitals/RGD/ MZ	QOC group/association of gynecology & midwives/PAHO
	Training of trainers course for staff of institutions who will provide ongoing emergency obstetric care trainings							**7,000**	BOG/FCHU	QOC group/association of gynecology & midwives/PAHO

	Introduce **e-learning module** for obstetric health providers							**15,000**	health efoundation/ Perisur	QOC group/association of gynecology & midwives/PAHO
	Annual Training of all GZA's of the medical mission in IMPAC							**25,000**	MZ	PAHO/Other partners
	Training of **private GPs** in antenatal care and postnatal care protocol							**4,000**	BOG/FCHU	QOC group/association of gynecology & midwives/PAHO/ SPAOGS
	supply hospitals and RGD with simulation dolls							**9,000**	PAHO	Other partners
2.2.2. Midwife school and obstetric nursing (COVAB) provide training in emergency obstetric care	**Integrate training on emergency situations into obstetric education**							**4,000**	Nursing school	association of gyneacology & midwives/PAHO
	Support midwife school with simulation dolls							**1,000**	PAHO	
Sub Total Output 2.2.								**77,000**		
Output 2.3.Monitoring of quality of care for maternal health has been reinforced										
Output indicator 2.3	% of health facilities perform monthly monitoring of quality of care		**25 %**	**50%**	**60%**	**70%**				
2.3.1.Quality of care assessments and supportive supervision implemented in all health facilities	Perform **assessment of essential conditions for maternal health** in all hospitals (**VCE tool PAHO**)							**7,000**	Hospitals	QOC WG/PAHO/BOG-FCU
	Develop monitoring **checklists for quality of care** (supervision and intervision checklists first and second line)							**2,000**	BOG/FCU	QOC WG
	QI committee per health facility to **include midwives** and perform **monthly internal supportive supervision**							-	Hospitals/ RGD/ MZ	QOC WG

	Develop **quality of care improvement plans per health facility** (based on VCE, MDSR, near miss review and supervision)							-	Hospitals/ RGD/MZ	QOC WG
Sub Total Output 2.3								**9,000**		
Output 2.4. Reinforced referral and counter referral & communication between first and second line										
Output indicator 2.4	Guidelines for referral/counter-referral system developed and maternal waiting home accessible for all eligible women			ref proto availab le	mat wait h accessi ble RGD					
2.4.1. Reinforcement of the referral and counter-referral system supported	**Develop guidelines for improvement of referral system** (pilot with slands/RGD)							**2,000**	BOG/FCU	QOC WG/PAHO
2.4.2.Maternity waiting home available	MZ and RGD establish collaboration for **maternity waiting home** for population of interior and remote coastal area							**1,000**	RGD/MZ	Donors
Sub Total Output 2.4								**3,000**		
Output 2.5. Health facilities have adequate medical supplies and equipment, with focus on obstetric emergencies										
Output indicator 2.5	Increase of % of health facilities with adequate supplies to manage obstetric emergencies (tracer drugs)					**25% increase**				
2.5.1.Essentiel medical supplies and equipment to manage obstetric emergencies available in all health facilities	**All medical supplies of obstetric protocols, to be included in the national essential drug list (tranexamic acid, antibiotics) etc.)(**to be covered by health insurances)							-	SZF/MOH	
	Emergency boxes are present with all necessary material/medication for emergency situations							-	Hospitals/MZ/ RGD	
	Equip medium care units with monitors for high risk patients							**20,000**	Hospitals	Donors
	Equip medium care units with infusion pumps							**15,000**	Hospitals	Donors

	Non-Pneumatic Shock Garments provided in all health facilities with delivery facilities (**buy replacement in 2020**)							11,000	Hospitals/MZ/ RGD	PAHO
Sub Total Output 2.5								**46,000**		
Output 2.6 Blood supplies available for obsteric emergencies										
Output indicator 2.6	Increase of % of hospitals reporting delay in blood supplies in case of obstetric emergencies					**20% increase**				
2.6.1 Support to blood bank to improve availability of blood supplies	Situation analyses availability of blood supplies for obstertric emergencies							-	MVG	TBD
	Support bloodbank with blood drives for maternal health							**5,000**	**MVG**	TBD
Sub Total Output 2.6								**5,000**		
Output 2.7 Advocacy to reinforce health insurance coverage of pregnant women carried out										
Output indicators	**Nbr of health facilities monitoring health insurance coverage**		**50 %**	**60%**	**>90 %**	**>90 %**				
2.7. Advocacy for lack of health insurance coverage of the poor and impact on maternal health/perinatal outcomes	**Document and monitor impact of non-coverage by health insurance** of pregnant women on the maternal/perinatal health outcomes							**1,500**	BOG/FCHU	PAHO
	Carry out advocacy to improve health insurance coverage for pregnant women, including inclusion of PNC home visits (maternity care), medication, adolescents < 16, etc							**1,500**	MVG	QOC group/PAHO
	Awareness raising concerning access to health insurance							-	SZF	RGD/MZ
Sub Total Output 6.1								**4,500**		
Outcome III. Prevention of unplanned (adolescent) pregnancies and the risk of resulting complications through increased access and use of modern contraceptive methods										
Output 3.1. Acces and use of modern contraceptives has been reinforced										

Output indicator 3.1	% of primary health care facilities providing family planning service package (counselling, guidance in contraceptive decision-making and contraceptions, incl. LARCs)			10 % increase		20 % increase				
3.1.1 Family planning services promoted and available, incl. LARCS	Reinforce **promotion for and integration of family planning** in all relevant services (PNC, EPI, etc)							**5,000**	RGD/MZ/St. Lobi	
	Implement roadmap to introduce Long-Acting Reversible Contraception							**2,500**	BOG/FCHU	UNFPA/PAHO
	Strengthen counselling skills of health care workers through refresher training in decision-making tool for family planning							**5,000**	UNFPA	BOG/FCHU/RGD/MZ
Subtotal Output 3.1								**12,500**		
Output 3.2: CSE program has been reinforced for in and out of school youth										
Output indicator 3.2	# of new in school or out of school adolescent health programs			**1**	**2**	**3**				
3.1.2. Improved coverage of adolelescent sexual and reproductive health and rights programs for in and out of school youth	Evaluate existing ARSHR programs							**10,000**	MOH/BOG	PAHO/UNFPA
	Scale up adolescent reproductive health & rights programs							**50,000**	MOH/BOG	PAHO/UNFPA and other partners
Sub Total Output 3.2								**60,000**		
Outcome IV: Awareness and demand for maternal and newborn health services increased through reinforcement of health promotion/community participation and involvement										
Output 4.1. Reinforce information, education, communication and demand for maternal health services										
Output indicator 4.1	% of interventions of health promotion plan implemented		15 %	20%	40%	60%				

4.1.1. Health promotion for maternal/newborn health, with focus on priority and vulnerable communities reinforced	**Community/Client based maternal/newborn health needs assesment,** with focus on vulnerable groups							**8,000**	BOG/FCHU	Health promotion WG/PAHO
	Develop national **health promotion plan** for maternal newborn health, including a health education plan							**3,500**	BOG/FCHU	Health promotion WG/PAHO
	Develop IEC materiel for maternal health (national pregnancy books, app, etc)							**20,000**	BOG/FCHU	Health promotion WG/PAHO
	Implementation of health education for maternal health with focus on priority communities/groups reinforced							**15,000**	RGD/MZ/ hospitals	Health promotion WG/PAHO
	Implement **localized planning in maternal health** (training of community leaders in maternal health issues) (initial pilot in 4 priority communities in the coastal area)							**4,000**	RGD	Health promotion WG/RO/PAHO
	Implementation of pilot program of centred pregnancy groups in first line							**11,000**	RGD	PERISUR
	Introduce birth preparedness plans							**2,000**	RGD/MZ/ hospitals	BOG/FCHU-PAHO
Sub Total Output 4.1								**63,500**		
Outcome V Strategic information for action and accountability for maternal health standardized and reinforced										
OUTPUT 5.1: Maternal health and perinatal information and surveillance systems developed and strengthened, and data used for decision making										
Output 5.1 indicator:	% of health facilities providing maternal health system services report to SIP (disaggregate primary and secondary HF)			**20%**	**30%**	**40%**				
5.1. National Perinatal Information System introduced and operational (SIP)	**See detailed SIP implementation plan**									
	Customize database for Suriname, install SIP on server, perform pre-testing and adaptation if needed							**5,000**	MVG-BOG/FCHU	PAHO
	Assess need for hardware & provide according to needs							**30,000**	BOG/FCHU	TBD
	Print paper based data collection tool/Berebuku Form							**2,000**	MVG	

	Training of trainers (MZ, RGD, hospitals) of health facilities							6,000	PAHO	BOG/FCHU
	Training of all staff involved in SIP per health facility and technical support							10,000	BOG/FCHU	PAHO
	Technical support (consultant) to insitutions introducing SIP (asess needs, develop SOP)								PAHO	BOG/FCHU
	Semestral presentation of data to steering committee and WGs and use for decision-making							-	BOG/FCHU	PAHO
	Review meeting of the pilot phase of the SIP implementation							-	BOG/FCHU	PAHO
Sub Total Output 5.1								**53,000**		
OUTPUT 5.2: Maternal deaths and severe maternal morbidity/near miss surveillance and response (MDSR/SMMSR) are institutionalized and recommendations are implemented and monitored										
Output Indicator 5.2.	**% of health facilities with delivery services which perform MDSR, plan and implement corrective actions (disaggregate hospitals, RGZ, MZ)**		**> 50 %**	**> 70 %**	**> 80 %**	**> 90 %**				
5.2.1 MDSR and **near miss approach** has been institutionalized and is operational on all levels	**Make maternal death a notifiable event with weekly (online) reporting of (zero) maternal deaths by all health institutions**							-	MVG	BOG/EPI
	Develop policies/laws, national guidelines and tools for active case detection, including: * law to include pregnancy check box on C form * law to introduce autopsy of maternal death * guidelines and tools for **i**ntentional search of maternal deaths among women of reproductive age * guidelines and tools for maternal death review and follow-up of recommendations							3,000	MVG	BOG/EPI- PAHO
	Institutionalize MDSR in all health facilities							2,000	Hospitals, RGD, MZ	BOG/FCHU- PAHO
	Institutionalize registration and review/response of near miss by hospitals							2,000	Hospitals, RGD, MZ	BOG/FCHU- PAHO
	Install focal points and create MDSR/near miss commitees in hospitals, RGD, MZ							-	Hospitals, RGD, MZ	MVG
	Regular training/briefing of focal points of hospitals, RGD, MZ in active case detection, MDSR, near miss aproach							4,000	BOG/FCHU	BOG/FCHU- PAHO-MAMS

	Verbal autopsy at community level of maternal deaths and near miss by RGD and MZ							1,000	RGD/MZ	MAMS for initial support
5.2.2. Data of maternal deaths/near miss are being used for decision-making and advocacy	Summarize and f**ollow up recommendations of maternal deaths and near miss reviews in improvement plans** by hospitals, RGD and MZ							-	Hospitals, RGD and MZ	QOC WG
	Elaborate report of maternal deaths 2010- 2018 and annual report 2019		2010-2018	2019				-	BOG/EPI &MAMS	BOG/FCHU
	Identify and target **priority communities/health facilities** based on MDSR, near miss and studies							-	BOG/FCHU	Partners
	Recommendations from studies on SUROSS and IUVD etc., available and used for decision-making							-	Researchers	MVG
Sub Total Output 5.2								**12,000**		
TOTAL								**373,000**		