Evaluation Report

Evaluation of Safe Motherhood and Neonatal Health Plan of Action 2013-2016.

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Contents

INTRODUCTION

Background

Safe Motherhood refers to the promotion and protection of the right to the highest attainable standard of health of women, mothers and newborns. Safe Motherhood should be addressed as a human right, focusing on factors that influence maternal and neonatal health and laying the foundation for an integrated, inter-sectoral approach. Safe motherhood surpasses the boundaries of health care and includes issues that are rights related, e.g. nutrition, education and protection from violence.

In 2012 a Plan of Action for improvement of health of mothers and children, the Safe Motherhood and Neonatal Health Plan of Action covering the period of 2013-2016, was developed under coordination of the Family and Community Health Department of the Bureau of Public Health (BOG) with support from UN agencies. This Plan of Action was preceded by a Safe Motherhood Needs Assessment in 2007, which provided most of the national data on which this plan was based.

This Safe Motherhood and Newborn Health Action Plan is therefore guided by principles of human rights and gender, as well as multi-disciplinary approaches towards quality and functional referral systems and principles of preventive services for health promotion.

The plan considers the findings of the Safe Motherhood Needs Assessment and the achievements of the health systems response, while addressing the gaps identified in the following areas: availability of family planning services, adolescent pregnancy, start of and continued antenatal care visits for all pregnant women, including adolescents, intra-partum and post-partum care and attention to newborns including children born premature or with low birth weight.

Currently, this Plan of Action, which provided a framework for health care providers and other relevant stakeholders at all levels of care regarding health of mothers and newborns is expired and a new one needs to be developed, in line with the period of the National Development Plan (NOP), an outline for development issues during the period of the current Government administration.

In the set-up of the Plan of Action 2013-2016, periodic updating and reviewing to incorporate developments and changing needs within the Suriname health system, was envisaged. However, due to various reasons, this did not take place during the implementation period.

The main reason probably being that an M&E plan, which would have allowed for this review and possible updates, was not developed. Also, the lack of a policy on Maternal and Newborn Health hampered the formulation of clear national goals and targets to which these updates should be reflected.

This, of course seriously impacted on the possibilities of the Government to identify challenges and draw lessons learned that could help to inform a next plan.

Evaluation

"Evaluation is the systematic acquisition and assessment of information to provide useful feedback about some object." [1]

There is broad consensus that the major goal of evaluation should be to influence decision-making or policy formulation through the provision of empirically-driven feedback.

Imperative to the whole undertaking is to ensure as much as possible impartiality, accuracy, objectivity and the validity of the information generated.

To adequately answer the most important evaluation question, being "the improvement or lack thereof during the period of implementation," there needs to be a baseline. Since this baseline is lacking in the current situation, answering this question will be a challenge. The SMNA results of 2007 can be accepted as the best available information to serve as an imperfect baseline.

Purpose:

The purpose of this evaluation exercise is to gather information that will allow for drawing lessons learned, challenges and opportunities related to the formulation of a new Plan of Action for the period 2018-2022.

Scope: The scope of this evaluation then is to capture an overview of the impressions of the main partners in the process. This would include results as much as possible and perceptions regarding implementation, buy in and relevance.

[1]file:///C:/Users/Ingrid/Documents/My%20Documents/Documents/Documents/My%20Documents/Types%20of%20Evaluation.pdf

Central questions:

The central questions that should be answered through this evaluation exercise are: what was the level of implementation and monitoring of the SMNH Plan of Action (fully/ partially/ marginally /at all)? Which opportunities and constraints impacted on this?

Specific questions are:

- Were there any broad changes in service provision – during the period?
  - Were these changes – caused by/linked to the requirements included in the Plan of Action?
  - What, in the Plan of Action or outside it, caused or prevented the change?
- What are participants' (organizations) perceptions of the extent to which the BOG has been able to ensure buy-in of the Plan of Action with the stakeholders.
- What are participants' (organizations) perceptions of the extent to which the BOG has been able to adequately monitor its implementation?
- What are the field participants perceptions on the relevance of the Plan for their organization?

Evaluation partners: the evaluation partners are selected as the most frequently mentioned and most important partners included in the PoA

1. The Ministry of Health (HQ) — Monitoring
2. The Family and Community Health Department of the BOG — Monitoring
3. Hospitals (5) — Field implementation
4. RGD — Field implementation
5. Medical Mission — Field implementation
6. Elsje Finck Sanichar Nurses Training Institute — Field implementation
7. Midwives Training Institute — Field implementation

Methodology:

The evaluation will be qualitative, consisting of open-ended questionnaires, individually administered to knowledgeable persons in management positions at the mentioned institutions. To encourage impartiality and objectivity of the information, it will be tried to interview 2 persons per organization, so the information gathered reflects multiple views.

Two evaluation questionnaires were developed for this purpose. The questionnaire for the field partners covered level of knowledge of the Plan, inclusion during development, level of implementation and perceived relevance of the Plan of Action for the organization.

The questionnaire for the Ministry of Health/BOG covered the perception of enabling and disabling factors linked to the implementation and monitoring of the plan and indications for the way forward.

Data collection for the evaluation started on October 20 and lasted till November 7.

Face to face interviews were held with one or two persons per organization, dependent on the availability of the persons. In some instances, follow-up e-mail responses were requested to complete or better understand responses.

Nine (9) Field Organizations were included in the survey of which all five hospitals in the country, both Primary Health Care Organizations and 2 Training Institutes for medical staff, namely the Elsje Finck Sanichar, COVAB Institute for Training of Nurses and related professions and the Training Institute for Midwives.

On the monitoring level, the Bureau of Public Health, the primary responsible organization for monitoring, the Director of the ministry and the Planning and Monitoring Department of the Ministry of Health were included. The Director of the Ministry was included, partly because of her background as the previous Head of the Family and Community Health Department at the BOG, partly to get an overall take of the view of the MOH regarding the issue.

EXECUTIVE SUMMARY

This report provides findings from the Evaluation of the Safe Motherhood and Neonatal Health Plan of Action, a four-year plan developed by the BOG in 2012 with support from UN agencies in the country. The evaluation was conducted by an individual consultant, hired by the PAHO, in collaboration with the BOG.

The purpose of the 4-year plan was to streamline and increase stakeholder involvement towards the process of reducing maternal and child - especially neonatal- mortality and morbidity, which remain challenges for the country and to create long-lasting impact on the health of women and children.

Method: To achieve the results, evaluation respondents were selected from the stakeholders included in the Plan of Action. The selected stakeholders included all hospitals in the country, both Primary Health Care Organizations and two training institutes for health care workers. Secondly, the MOH/BOG was questioned on the issues of M&E of the Plan.

Two questionnaires were developed (one for the field and one for the MOH/BOG) and, dependent on the number of respondents, one or two semi-structured qualitative interviews took place at each site. To increase completeness and objectivity, the preference for 2 respondents per site was indicated, however, this was not reached at every site. At 3 institutions there was only one- though very knowledgeable- respondent.

Key Findings

Most of the organizations were not or only slightly familiar with the Plan of Action. None reported being actively or consciously involved with its development or implementation. Many of the activities in the plan though, appear to have been implemented by the organizations that these were assigned to.

The most important issues that were mentioned by the field relate to:

- The low impact of the mandatory health insurance law. All organizations report continued high numbers of uninsured women. This impacts especially prenatal care for pregnant women.
- Lack of nationally agreed guidelines and protocols to guide service provision.

Monitoring of the plan was seriously deficient. This seems to have impacted more on the involvement of the organizations, than actual implementation of activities. The BOG indicated lack of clarity on mandates and job description and lack of staff as the main

reasons for the lack of involvement during the past years of the implementation of the Plan of Action.

Conclusion: Findings suggest that the long standing relative independence of health care organizations has impacted positively on progress towards improving maternal and neonatal health. They have decided on measures that needed to be taken to that end and have implemented without specific guidance of the MOH. The MOH needs to work to streamline efforts in this area and provide organizations with support that they need and are requesting, specifically national guidelines and protocols on all levels of care and input on dealing with the high levels of uninsured women and the impact this has on the health and wellbeing of them and their newborns.

We can reasonably assume, that progress will continue with or without a Plan of Action, however, issues like data collection and quality control will be seriously hampered.

SAMENVATTING:

Dit verslag bevat de resultaten van een evaluatie van het veilig moederschap en Neonataal Plan van Actie, een vijfjaren plan dat in 2012 is ontwikkeld door het Bureau Openbare Gezondheidszorg (BOG) met ondersteuning van de UN-organisaties in het land. De evaluatie werd uitgevoerd door een individuele consultant die werd aangetrokken door de PAHO, in samenwerking met het BOG.

Het doel van het 5-jaren plan was om de activiteiten in de sector op elkaar af te stemmen en de betrokkenheid van de deelnemende organisaties bij het reduceren van maternale en neonatale sterfte en ziekte te vergroten. Dit om deze uitdaging voor het land om te buigen en een blijvende positieve invloed op het leven en de gezondheid van vrouwen en kinderen te bewerkstelligen.

Methode: Om de resultaten te bereiken, zijn de evaluatie respondenten geselecteerd uit de stakeholders die opgenomen zijn in het plan van actie. De geselecteerde organisaties zijn: alle vijf ziekenhuizen in het land, beide instellingen voor primaire gezondheidszorg en twee opleidingsinstituten voor gezondheidswerkers. Ten tweede is het Ministerie van Volksgezondheid en het BOG opgenomen voor het bevragen van de monitoring van het plan.

Er zijn twee vragenlijsten ontwikkeld (een voor de organisaties en een voor het ministerie) en, afhankelijk van het aantal respondenten, hebben er een of twee semigestructureerde kwalitatieve interviews plaatsgevonden bij elke organisatie. Om volledigheid en objectiviteit te vergroten, is er gevraagd om 2 respondenten per organisatie. Bij drie instellingen was dat niet het geval en vond het gesprek plaats met één - erg capabele - respondent.

Belangrijkste bevindingen:

De meeste organisaties zijn niet of slechts marginaal bekend met het plan van actie. Geen van de bevraagde organisaties was actief of bewust betrokken bij de ontwikkeling of uitvoering van het plan. Het blijkt dat vele van de activiteiten echter wel zijn uitgevoerd door de organisaties.

De belangrijkste problemen die door de organisaties genoemd zijn, betreffen:

- De geringe impact van de wet op de basiszorgverzekering. Alle organisaties noemen niet afnemende hoge aantallen niet-verzekerde vrouwen. Dit heeft vooral invloed op de prenatale screening.

- Gebrek aan nationale richtlijnen en protocollen voor dienstverlening.

Monitoring van het plan schoot ernstig tekort. Dit lijkt meer invloed te hebben gehad op de bekendheid van en betrokkenheid met het plan, dan op uitvoering van met het plan overeenkomende activiteiten. Het BOG gaf onduidelijkheid over mandaten en taakomschrijvingen en personeelsgebrek aan als belangrijke redenen voor het gebrek aan betrokkenheid bij de uitvoering van het plan gedurende de afgelopen jaren.

Conclusie: De indruk bestaat dat de relatieve onafhankelijkheid van de gezondheidsinstellingen ertoe geleid heeft, dat de uitvoering van activiteiten gericht op verbetering van de maternale en neonatale gezondheid voortgang heeft gevonden, ondanks de afwezigheid van leiding vanuit het MOH/BOG. De instellingen hebben, op basis van beschikbare inzichten besluiten genomen over maatregelen die moeten worden uitgevoerd en dat zonder specifieke ondersteuning door het Ministerie van Volksgezondheid. Het Ministerie heeft nu de taak om deze activiteiten te helpen stroomlijnen en de organisaties de steun te geven die ze nodig hebben en waar ze om vragen, in het bijzonder de beschikbaarheid van richtlijnen en protocollen op alle niveaus van zorg en hoe om te gaan met de grote aantallen vrouwen zonder geldige ziektekostenverzekering en het effect dat dit heeft op de gezondheid en het welzijn van hun en hun nieuwgeborenen.

Het is redelijkerwijs aan te nemen, dat er vooruitgang zal worden geboekt met of zonder een Plan van Actie, echter zaken als datacollectie en controle op de kwaliteit van zorg kunnen daardoor ernstig belemmerd worden.

FINDINGS

Below the findings are reported, mostly structured around the questions as these are phrased in the questionnaires.

Please indicate your level of familiarity with the Safe Motherhood and Neonatal Health Plan of Action 2013-2016

The first question regarded the level of familiarity with the document. As can be seen from the figure below, 4 organizations indicate having no knowledge whatsoever of the plan, 4 of the 9 organizations indicated having some knowledge of the plan or at least its existence. The ones who have some knowledge of the plan included both primary health care organizations and 2 of the 5 hospitals. One training institute (COVAB) indicated that they had quite recently learned of the existence of the plan through a colleague who is involved with its implementation and who mentioned it in the context of development of the curriculum for a course for ob/gyn nurses. (For the further results, this will be considered a "no" since the coverage period of the plan had already expired when they learned of its existence).

Three organizations mentioned having seen a copy of the draft plan years ago, while 1 mentioned they have heard that such a plan exists. None of the respondents could recall having seen a final copy of the Plan or having been asked to read it or to indicate if and how they were going to use it. As they worded it:

"I never had the impression that we were supposed to do something with it, no one ever asked me to respond to the existence of the plan."

"I understood that people were not ready with the plan. We were supposed to be waiting for further instructions. These never came. I have also never seen a final copy of the plan."

"There was, in my opinion no expectation from anyone that something should really be done with this plan."

	Not at all	Somewhat	Familiar	Very familiar	Other
S' Lands		X			
St. Vincentius	X				
AZP	X				
Mungra MC	X				
Diakonessen		X			
Medical Mission		X			
RGD		X			
COVAB					X
MIDWIVES	X				

Figure 1: Level of familiarity with the Safe Motherhood and Neonatal Health Plan of Action 2013-2016.

One organization, the Diakonessenhuis Hospital, indicated that they were involved in the development of the Plan of Action. The involvement was in the form of presence at a meeting during which the Plan was presented and discussed. The other ones who were aware that there was a Plan, had seen a draft copy or had heard of the existence of the Plan. There was no involvement in the process and no indication from the Ministry on how to work with the Plan of Action:

"I think we might have been involved with the process through attendance from staff from the hospital at workshops where the plan was discussed."

"Some elements of the Plan of Action are included in the annual planning of the Medical Mission from the past years."

All organizations indicate that they are not aware if their organization had contributed to implementation of the Plan. If it was the case, it was unawares.

None of the respondents could (or would) provide an answer on the question whether the Plan of Action adequately reflected the national priorities regarding Safe Motherhood. They were not sure

"have we agreed on national priorities on safe motherhood?" and *"that should be something that we all agree on. If we have not agreed on the Plan, how can we answer this question?"*

Regarding the relevance of the Plan for the organization, the respondents had to think long to provide an answer. s'Lands Hospital indicated that they think that it generally is relevant, since the priorities that are in a Plan of Action for improvement of Safe Motherhood, should reflect the priorities of all organizations that are providing maternal and neonatal health services.

One respondent answered: *"It is impossible to say yes or no if you are not aware of the content. It probably does reflect issues that everyone in the field would agree are important".*

The Medical Mission indicated that the Plan in itself is not considered relevant to the priorities of the organization, since it did not help determine these priorities.

The respondents who did have knowledge on the existence of the Plan of Action, have not knowingly contributed to the implementation of the Plan. They therefore cannot affirmatively answer any question regarding support that they have received. Organizations have received outside support for strengthening of services. The Sint Vincentius Hospital mentioned training and material from the "PERISUR" project.

That project lasted until October 2016 and included, among other things the program of "Pregnant Together". In the context of that program, health workers received training in improving information provision and other services to pregnant women and were introduced to/strengthened in knowledge of the concept of the preconception period.

The support was not considered sufficient, especially related to equipment. The responsible persons mentioned having received 2 transport incubators, however, they still need more incubators to provide adequate care to newborns. Requests made to hospital management can most often not be honored, due to lack of financial resources at the hospital.

Generally, it was difficult to provide an answer to this question. Respondents were not sure whether any help the institute had received, could be phrased as support to the implementation of a plan they were not aware of.

What do you think are the most important issues that should be included in a new Safe Motherhood Plan of Action?

Although most of the respondents experienced challenges wording what the previous plan meant for their organizations or understanding why they knew so little about it, they clearly had no reservations mentioning issues that they struggle with and that they would very much like to see addressed in a new Plan of Action. Responses to this question are listed below, categorized by interviewer in random order. The impression exists, that respondents took this question as an opportunity to list a number of issues that they are dealing with on a daily basis. The BOG should have to take a careful look at these issues to identify how these can best be included in a Plan of Action. It can be derived from the responses, that the issue of uninsured women and access to prenatal screening is a point of concern for many health care providers and needs urgent attention.

<u>Education</u>

"Education and Information"

"Community Education"

Access to and quality of pre-natal care

"Making prenatal care accessible for all pregnant women"

"Deal with the issue of health insurance"

"Make basic health insurance free for all pregnant women or at least make pre-natal care free of charge"

"We are currently doing an assessment on the number of women that are coming for delivery without having received prenatal care and the outcomes of those pregnancies. This is an urgent issue."

"Do something with the results of maternal mortality audits. Not just do them, but have a system to implement lessons learned. Include also neonatal mortality audits"

"The social aspect of pregnancy: housing services for women with a referral. Currently women are not receiving care because they do not have a place to stay during a high-risk pregnancy"

"Make health insurance for pregnant women mandatory"

"Improve quality of pre-natal care. Provide the women with necessary information regarding the delivery and post-partum."

"Allow midwives to do prenatal screening. Currently it is done by ob/gyn, but they lack the time to provide information and really listen to and address concerns of the women."

"Make pre-natal controls available for every woman. They miss screening appointments because they lack money for the bus."

Staff capacity building

"Make re-licensing of health workers mandatory, develop a system of continuing education, not just for nurses, but also for pediatricians, internal medicine doctors, obstetricians/gynecologists and midwives."

"More trainings for staff"

"Make midwives education more competency based and increase the number of enrollees per hospital"

"Ensure enough capacity in the workforce"

"Women do not get information on hygiene, feeding etc. and this impacts on quality of care because sometimes they come back after a few days with the baby malnourished."

"More training in providing breastfeeding"

Postnatal care

"Postnatal care"

Coordination and guidelines

"Guidelines for fluxus, pre-eclampsia and eclampsia"

"Respectful maternal care"

"Develop a system of neighborhood and/or home visits for providing information to pregnant women"

"Integrated care. Currently the link between the ob/gyn and the midwives is weak. Needs to be strengthened."

"Put pressure on general physicians to stick to protocols and refer women to the ob/gyn in an early stage. They refuse to do so, with the consequence that women suffer unnecessarily. "

"There needs to be cooperation between training institutes and the work field. Field should provide institutes with input on what to include in curriculum."

The following question regarded all activities that were included in the SMNH Plan of Action 2013-2016, as they were assigned to different levels of health care providing organizations (sometimes covering different levels or sectors). The activity list was presented to the relevant organizations with the following question:

Has your organization implemented any of the following projects/activities in the past 5 years?

PRIMARY HEALTH CARE INSTITUTIONS

ACTIVITY	MEDICAL MISSION	RGD	MMC*
Provide training in FP counseling skills for health care providers in primary and preventive health care.	YES	All midwives are trained but implementation is lagging.	One or two staff members have followed DMT training
Improve screening for and treatment of medical conditions, including STI, chronic diseases and eating disorders for all clients, specifically adolescents.	YES	No update in screenings except on diabetes care	
Provide targeted health education regarding substance abuse, risk assessment, and essential nutrition	YES	No	
Include provision of folic acid supplements in treatment protocols for those considering pregnancy.	YES	Dependent on the doctor in charge. If someone who wishes to become pregnant comes to the midwife, it is recommended.	
Provide training in national standards, guidelines and protocols for antenatal care.	YES	Last done by midwifery training institute together with Midwifes Professional Group in 2015	
Ensure continued education, based on national ANC Guidelines	YES. Due to financial constraints, this is not happening as consistently as planned.	No	
Map the needs of the staff and necessary equipment for ANC in order to improve access to ANC services	YES	No	
Ensure procurement of equipment according to national ANC guidelines.	YES. Due to financial constraints, lagging behind need.	No	

Advocate to decrease financial, insurance and administrative (bureaucratic) barriers to ANC access	YES	No	
Implement ANC education campaigns for women in reproductive period, including healthy lifestyles before and during pregnancy and danger signs during pregnancy)	YES	No	
Conduct capacity building for staff, including those working in the field of monitoring and evaluation.	YES	Not known	
Provide training for perinatal staff in National Clinical Guidelines for Perinatal Care (Gynecology, Obstetrics and Neonatology).	Training is being provided based on MM guidelines, since there are no national guidelines.	Midwives can participate in national trainings	
Advocate for increased numbers of workers (expansion of workforce)	YES	There were recently requests for applications for health educators.	
Revive and strengthen breastfeeding program	YES	Currently being done	Yes. Very actively restarting the program.

Figure 2: overview of implemented activities by PHC Organizations
(* MMC is not a primary health care organization, but the midwives working at the hospital do implement these activities).

TRAINING INSTITUTIONS

ACTIVITY	EFS/COVAB	MIDWIVES
Provide training in FP counseling skills for health care providers in primary and preventive health care.	Partly. Some information on FP is included in the curriculum, but no counseling.	YES, students in past years have finished DMT module
Provide training in national standards, guidelines and protocols for antenatal care.	Where they exist: yes.	YES, included in curricula
Update the curriculum of the medical faculty, nursing and midwifery training institutions, health assistants training, according to national ANC guidelines.	Curriculum is periodically updated based on WHO guidelines.	Currently ongoing
Ensure continued education, based on national ANC Guidelines	Id.	YES. where possible persons (midwives) who have attended training are invited to present to students
Provide training for perinatal staff in National Clinical Guidelines for Perinatal Care (Gynecology, Obstetrics and Neonatology).	Planning is to start in Jan.2018 with a course for gynecological/obstetric nurse.	Yes, included in curricula
Update the curricula of the medical faculty, medical nurse and midwife's colleges according to the national guidelines.	According to WHO guidelines	Yes. currently process ongoing to make training competency based
Update/review the curricula and perform training for postnatal care based on National standards, guidelines and protocols, including AMTL.	Included in curriculum of specialty course that is planned to start in Jan.2018	Yes. based on existing guidelines. sometimes lecturer dependent.

Figure 3: Overview of implemented activities by Training Institutes

HOSPITALS

ACTIVITY	MMC	RKZ	SLANDS	DIAKONESSEN	AZP
Include provision of folic acid supplements in treatment protocols for those considering pregnancy.	No.	Yes	Yes	Yes	No protocols for pre-conceptional care
Map the needs of the staff and necessary equipment for ANC in order to improve access to ANC services	Has happened.	Yes. In kader van PERISUR-project	Yes	Yes, but there is still a shortage on midwives. Midwives do not get compensated for prenatal screening, they are not included in health insurance scheme	YES
Ensure procurement of equipment according to national ANC guidelines.	Elementary equipment is procured as much as possible. No funds for more sophisticated equipment	Requests have been done. Can often not be honored due to financial constraints. In past 5 yrs. department has received 2 CPAP instruments, 1 monitor and 2 transport incubators .	Yes, dependent on availability of funds	Yes	No guidelines, so cannot answer
Advocate to decrease financial, insurance and administrative (bureaucratic) barriers to ANC access	yes, happened. Also for preconception care (except of IUD that women ask for, but cannot afford	Is done incidentally. Needs more attention. Women report at the last moment for delivery which causes difficult situation for midwives	Yes, yes, yes! Still many uninsured women who often because of this have not gotten prenatal care. Come at last moment.	We have noticed increase in women with the new health insurance system, but the problem with women having no insurance and not attending prenatal screening remained, so there are still barriers.	Want to do this, have started process of data collection to be able to sustain any requests. Many women still wait till delivery has set in or if things go wrong

					before seeking help
Assess the use of the maternal health card as means of communication between the different levels of health care provision (primary, secondary).	Is being used. Women are referred to ob/gyn with the green card.	The ob/gyn have their own pre-natal cards. The green card is attached to that card. Sometimes, if a patient comes with the card, the gyn takes the information from the card and gives it back to the woman.	Do not use green card	The Diakonessenhuis has their own prenatal cards. The Gen Phys do use the green cards.	Do use the green card.
Conduct capacity building for staff, including those working in the field of monitoring and evaluation.	No level of M&E in hospital itself. All data is transferred to BOG	Yes. When possible, staff attend training, mostly outside of the hospital.	No	Yes	Yes. In house.
Advocate for increased numbers of workers (expansion of workforce)	Not really. There is a shortage, but work with available staff	Yes, we constantly do	No. They have enough personnel	Yes	
Provide training for perinatal staff in National Clinical Guidelines for Perinatal Care (Gynecology, Obstetrics and Neonatology).	Happens where possible	Yes. Training in neonatal support	Yes	Yes	In house training. Not coordinated, more ad hoc character.
Update the curricula of the medical faculty, medical nurse and midwife's colleges according to the national guidelines.	NA	NA	NA	Hospital is not content with the Midwifery Training. Need to include new guidelines and protocols in curriculum. Curriculum is outdated, must be	No national guidelines. When students are working at the hospital, issues that are due to lack of learning are

				made more competency based.	discussed with the student, not with the institute.
Ensure continued education and appropriate incentives and training based on National Guidelines	Yes. Staff is allowed to attend training were possible. Disadvantage because of distance to Par'bo	Yes. There is training when possible, no special incentives.	Yes. Where possible staff is encouraged to attend training	The Diakonessenhuis tries as much as possible to take part in trainings presented by the MOH. Does provide inhouse training also.	Id. training is provided, but not based on national guidelines
Update/review the curricula and perform training for postnatal care based on National standards, guidelines and protocols, including AMTL.	Through enrolling staff in midwives training	NA	No national standards	Tries to stay informed and keep up to date with national changes	Id.

Figure 4: Overview of implemented activities by Hospitals

These findings seem to suggest, that most of the activities in the Plan of Action have in some form been implemented by the relevant organizations during the past 5 years.

Issues where there clearly has been no activity on the level of one of the primary health care organizations seem to be on health education targeting pregnant women and capacity building for staff.
Both organizations and the MMC that also provides this primary care level service, mention their IYCF activities as growing and evolving very well. There are trainings for service providers, there is outreach were possible and women are responding well.

At the level of training institutions, the lack of national guidelines and standards seems to be hampering development of adequate curricula and means of evaluation of the students. They also sustain the lack of coordination between the trainers and the field, with the latter showing signs of discontent, but not being able to adequately communicate which knowledge and competencies are exactly required.

The hospitals provide a diverse picture. As could be expected, several hospitals and sometimes several specialists in hospitals, apply their own rules to issues like prenatal screening including the use of the green card. The card is used in some capacity in 3 of the 5 hospitals.

Both primary and secondary health care organizations lament the high numbers of women who still have no health insurance and as a consequence choose to skip or delay prenatal screening, with possibly negative outcomes for mother and newborn.

AZP notices that the majority of women who do not have insurance is referred to the AZP if possible. If the woman reports at a hospital and labor has already set in, the woman is assisted through the delivery and then referred to the Ministry of Social Affairs to recover the costs for the delivery.

Many hospitals provide training to their staff on an adhoc basis. In the absence of national guidelines, training opportunities are sometimes created based on availability of trainers (national /regional experts) and/or needs assessment of staff. If training is organized by the Professional Group (e.g. SPAOGS/VERENIGING VOOR VERLOSKUNDE), staff is also allowed to participate. All organizations mention the need for national guidelines and protocols to support service delivery and the establishment of a system of continuous education for all disciplines involved in maternal and newborn care.

Both primary and secondary institutions mention lack of financial means as main reasons for not being able to provide optimal care (i.e. lack of incubators and other equipment, sometimes lack of staff).

Could you pls. indicate 2 activities that were included in the previous PoA that your organization would be able to implement within the next 2 years?

"pre-conception care"

"Postnatal care where even women who had their delivery in the hospital, can come to the RGD for care."

Any other comments:

"Midwifes working at the RGD still do not have HIV kits, while being confronted regularly with women coming in, already in delivery and who have never attended prenatal screening"

"We need the field to inform us of changes, so we can update our curricula."

As mentioned, besides responses from the field, there were also interview meetings with staff from the MOH/BOG. The respondents were 2 persons from the BOG who were essentially responsible for the monitoring of the Plan of Action, the Director of the Ministry of Health and the head of the Planning and Monitoring Department of the Ministry of Health.

MINISTRY OF HEALTH/BOG

ACTIVITY	**Status**	**Explanation**
Review the contraceptives currently included on the Essential Medicines List and introduce new contraceptives as necessary.	Started	Exercise conducted with UN agencies in July 2017 in exploring introduction of LARC. Not yet added to list.
Advocate for and support introduction of comprehensive, age – and development appropriate sexual reproductive health rights education in school curricula at elementary and secondary school level.	Started	In 2017 in cooperation with MinEd HFLE programme. Planned to be introduced with new HFLE programme
Provide support to PHC service providers for development of targeted community interventions with emphasis on socially vulnerable populations	Started	In conjunction with IYCF strategy. This strategy will be adapted to include other issues.
Strengthen the capacities of community leaders and local NGOs in order to promote SRHR and safe motherhood,	Not impl	
Engage mass media in order to promote SRHR and safe motherhood.	Started	On an adhoc basis, i.e. 1 production on breast feeding
Devise monitoring and evaluation tools for the programmatic measures for preconception period (Quality indicators, data collection, responsibilities for performing evaluation).	Not impl	
Provide training in national standards, guidelines and protocols for antenatal care.	Partly	Training provided in Obstetric protocols for midwives and obstetric care providers
Update the curriculum of the medical faculty, nursing and midwifery training institutions, health assistants training, according to national ANC guidelines.	Not impl	

Ensure continued education, based on national ANC Guidelines	Started	CBE training provided for nurses. There is no actual program for continued education.
Develop and implement national standards, guidelines and protocols at all levels of care	Not impl	
Map the needs of the staff and necessary equipment for ANC in order to improve access to ANC services	Not impl	Hospitals are primarily responsible for this and should cover this based on their own capabilities
Ensure procurement of equipment according to national ANC guidelines.	Not impl	Is dependent on each facility. Hospitals are largely autonomous in making decisions and do that based on their own financial means
Implement ANC education campaigns for women in reproductive period, including healthy lifestyles before and during pregnancy and danger signs during pregnancy)	Partly	The IYCF program partly covers healthy lifestyle habits. Education material developed for this program. Survey conducted among women re knowledge of danger signs. Results not yet translated to policy or programs.
Assess the use of the maternal health card as means of communication between the different levels of health care provision (primary, secondary).	Started	Start was made with development of maternal card that would include data that is currently being collected through the green card. Currently use is assumed based on request for the card.
Devise monitoring and evaluation tools for the preventive programmatic measures for ANC (Quality indicators, data collection, responsibilities for performing evaluation)	Not impl	
Conduct capacity building for staff, including those working in the field of monitoring and evaluation.	Partly	MOH has provided some training opportunities in M&E
Support capacity building for NHIS for collection, processing, analyzing and reporting of ANC data	Started	Is expected to be done fully through implementation of SIPS. Currently in start-up phase
Provide training for perinatal staff in National Clinical Guidelines for Perinatal Care (Gynecology, Obstetrics and Neonatology).	Partly	CBE training provided for midwives. More training planned for 2018.
Update the curricula of the medical faculty, medical nurse and midwife's colleges according to the national guidelines.	Not impl	

Ensure continued education and appropriate incentives and training based on National Guidelines	Not impl	There is no functioning system for continuing education.
Develop and implement auditing methodology for perinatal and maternal mortality.	Partly	Joint activity between MOH, Ob/Gyn of AZP and other Ob/Gyn. Currently only maternal mortality audits
Adapt and implement a perinatal information system	Started	SIPS-project started in 2016
Update/review the curricula and perform training for postnatal care based on National standards, guidelines and protocols, including AMTL.	Not impl	
Strengthen and expand available capacity of staff and equipment based on needs assessment for improved access to postnatal care services	Started	Opportunity explored for hiring persons with SAO certificate on maternity care to supplement institutional maternity care
Revive and strengthen breastfeeding program	Implemented	IYCF program implemented.
Ensure procurement of equipment and commodities, including vaccines, for postnatal care with regular medical checkups, as part of the standard for U-5 care	Partly	Only vaccines are provided. Guidelines developed for standardized U-5 care. Pilot completed. Implementation currently delayed.
Develop and implement a database for registration of all infants, including all cases of neonatal mortality	Started	Included in SIPS plan
Develop an electronic database to capture births and children under 5, as well as immunization records and implement for use within institutions for preventive health care)	Not impl	There have been scattered initiatives (First Lady, Immunization program). No integrated effort so far.
Develop and implement education and awareness campaigns to improve utilization of the under 5 care system especially by vulnerable and hard to reach groups	Partly	ECD kits are available. Distribution and organization are not yet up to par.
Develop M&E tools for measuring progress for the postnatal care system)	Not impl	

Figure 5: Overview of implemented activities by MOH/BOG

Comparing the achievements in this list, with those in the list of the field organizations, it becomes clear, that one of the major areas where there has been no improvement is in the availability of nationally agreed protocols and guidelines and M&E tools.

There have been many training activities, but a cohesive, integrated plan for assessing training needs and providing training and follow up to different groups of workers is missing.

Below an overview of the respondents and responses on the following questions/issues.

Most important achievements of the Plan of Action:

"The fact that we were able to formulate a plan; that we made a choice. That in itself can be considered an achievement because it means that we are working to create an overview. The challenge is to implement it all. The practical side. A plan alone cannot do that.

"Things that are working well, people are starting to understand the need for training and are now using training opportunities more often."

"Awareness was created for the need for a systematic approach."

Most important challenge (s) that have impacted on implementation of the POA.

"*The fact that Safe Motherhood is still relatively unknown"*

"Human Resource/ Finances. Staff can be attracted if enough financial means"

"BOG cannot do everything. People need to know what their responsibilities are."

Most important challenge (s) that have impacted on monitoring and evaluation of the POA

"The missing M&E and implementation plan"

"Human resources/ funds that were not made available by the Government"

"The fact that the administrative department not has been cultivated to adequately support the program department"

"Time and human resources. Conducting monitoring takes a toll on both time and resources. You need people to help. There should be a special department on mother and child care, especially maternal and newborn health. Now this issue hangs everywhere and nowhere."

"There also need to be a mandate for the people who will conduct the monitoring activities. What are they allowed to do if they notice that things are not happening? Who are they allowed to speak to? All of this need to become clear."

Remedial measures could/should be taken to improve results for a next Plan of Action

"*Cohesion within the Government and between all stakeholders needs to increase. "*

"Need to work on good governance and linking of other things that affect safe motherhood like, mental health, transport etc."

"The Plan should be carried by the whole BOG, not just by Family and Community Health. Other departments like Food inspections, Epidemiology, TB, Administration should be included and understand their responsibility for supporting implementation."

"Increase knowledge sharing between departments so that even small steps forward can be noticed and appreciate even small steps forward."

"The development of an M&E plan is absolutely essential. Working planned and structural."

"Introduce the plan properly to stakeholders"

"Do not be too ambitious"

"Be realistic/critical about the timing for activities in the plan to be implemented. Make a good planning. So far, activities have been implemented "by accident."

What support, if any (within the existing institutional structure or with minor institutional changes) does the MOH/BOG need in order to optimize results

"Strengthen human resources."

"Draft an M&E plan from the start of the program"

"Implementation should be guided by a steering group that the BOG can call upon to support when necessary"

"Implementation should be made a priority"

"Strengthen the whole organization"

Any other comments

"I hope that this plan will be more realistic than the previous. "

CONCLUSIONS

The central questions that should be answered through this evaluation exercise are: what was the level of implementation and monitoring of the SMNH Plan of Action (fully/ partially/ marginally /at all)? Which opportunities and constraints impacted on this?

Specific questions are:

- *Were there any broad changes in service provision – during the period?*

o *Where these changes – caused by/linked to the requirements included in the Plan of Action?*

o *What, in the Plan of Action or outside it, caused or prevented the change?*

A few things can be mentioned to answer the question whether there were any broad changes in service provision and behavior during the period. Generally, there are no parameters to answer this question definitely because of the lack of reliable baseline data. There are however, things that have started or been improved during the period of which a few are mentioned here: the introduction of mandatory health insurance, the start of maternal mortality audits, the development of SIPS, the PERISUR project, the start of the development of obstetric protocols, the Infant and Young Child Feeding project; the start of the CBE project for midwives, the data gathering exercises that took place i.e. the study to detect and act upon Danger Signs during pregnancy that was conducted.

Unfortunately, it is from many activities not traceable when they started exactly or what their status was at the start of the Plan period, which makes it impossible to pin them to the implementation period of the Plan of Action. The above-mentioned lack of a baseline negatively impacted on this aspect of the evaluation.

It can be considered safe to say that any changes in the period did not happen due to the existence or under guidance of the Safe Motherhood Plan of Action. As the findings suggest, more than half of the organizations were not aware of the existence of the Plan and those who were aware, did not report having used the plan to inform any decision made by the organization. We can therefore safely assume, that any links to the plan were not purposed.

The Plan cannot be credited with causing any changes, but can also be assumed to not have prevented any changes in service provision of the organizations. The situation as presented by the respondents, presents a picture of a Plan of which people were not aware and that was therefore not instrumental to any decisions made by the organizations in relation to Safe Motherhood.

What appears from the responses, it that most of the activities that are included in the Plan of Action have been implemented in some form during the past 5 years. This warrants the careful conclusion that there has been progress in the process of improving safe motherhood. The challenge for the coming period is to align the activities, capture and share good practices and provide support where possible.

- **What are participants' (organizations) perceptions of the extent to which the BOG has been able to ensure buy-in of the Plan of Action with the stakeholders.**

The responses suggest that there has been no level of buy-in at all. Only one organization indicated involvement during the process of development.

The BOG acknowledges that there has been no active process towards involvement of stakeholders during the development process.

- **What are participants' (organizations) perceptions of the extent to which the BOG has been able to adequately monitor its implementation?**

None of the respondents recall any contact with the BOG regarding the Plan of Action or having received any instruction or guidance regarding its implementation. It can therefore be safely assumed that the monitoring of the plan was seriously lacking.

The responsible person at the BOG confirmed this situation and mentioned lack of clarity regarding the mandate as the main reason.

- **What are the field participants perceptions on the relevance of the Plan for their organization?**

Given the above described situation, it will not come as a surprise, that organizations have not considered the Plan relevant to their organizational purposes and activities. As mentioned before, most of the activities in the plan have been implemented, which indicates basic agreement between the BOG and the field organizations regarding the priorities for safe motherhood.

The answer to the central evaluation questions than can be phrased as follows:

The Safe Motherhood and Neonatal Health Plan of Action as a Plan was not implemented since the stakeholders where not familiar with the Plan. Despite this, the results that were envisaged at the outset of the Plan can mostly be considered to have been reached, because most of the activities in the plan were implemented during the past 5 years. The level can be described as **partially.**

The level of monitoring of the plan though, was seriously lacking to non-existent.

Issues that impacted on this have been indicated above and can be summarized as a lack of staffing and oversight and not sufficient clarity among and between staff on responsibilities and job description and mandates at the BOG.

On the positive side, the relative independence of health care institutions and the available capacity and knowledge there and history of independent decision making regarding the issue, allowed them to continue working on improvement of service provision, without specific guidance from the side of the MOH.

Although not the focus of this exercise, some conclusions regarding the content of what was presented by the organizations are included here:

- Access to and use of care seem to be negatively impacted by structural issues like coverage for health insurance. Problems with health insurance pose challenges to institutes, especially with regard to prenatal screening. This has the secondary effect that one hospital is being overburdened, because all other seem to refer uninsured patients to that hospital, i.c. AZP.
- Health workers still feel undervalued and underused. Midwives in more than one hospital voice concerns regarding the fact that they are best positioned to provide prenatal screening, but the insurance scheme does not allow them to do that. Some report adverse outcomes for the health of mother and newborn, because of this. They also mention lack of equipment to adequately do the job and protect themselves.
- The lack of nationally agreed guidelines and protocols poses a challenge for the service provision and for education and training institutes.
- The influence of the MOH on procurement for the institutions is minimal. This warrants a different approach to this issue in a next Plan of Action. Inclusion of situations over which there is no control, is not sound policy.

Also, the clear impression is, that the organizations **want** to be involved and want to work towards standardization and quality indicators for care. This needs to be acknowledged and acted upon by MOH/BOG.

RECOMMENDATIONS:

- Ensure a proper process of information to and buy-in by the field for all future activities (i.e. develop a communication plan for the Plan of Action 2018-2022)
- Distinguish in the new plan between priority actions and other actions
- Make development of protocols along a nationally agreed concept and access of pregnant women to prenatal screening priority actions
- Ensure use of concise language and clear, concrete activity descriptions
- Link the Plan of Action to a nationally agreed framework for Safe Motherhood
- Develop an M&E plan that is easy to understand and implement for both field stakeholders as the BOG
- Draft annual implementation plans
- Consider providing extensive M&E training for staff members with dedicated assignment for this plan
- Ensure the new plan is linked to the broader issues that affect maternal health, i.c. Non-Communicable Diseases and mental health.
- Recognize the policy implications of information gathered through this report and strive for the development of a Mother and Child policy a.s.a.p.
- Consider establishing a maternal health body with clear responsibilities that can oversee and help steer implementation and monitoring of the Plan of Action.

Attachment 1: respondents per organization.

Hospitals		
	Diakonessen	Ruth Mangroe, Nursing Director
		Sien van Schoor, Midwife Coordinator
	s'Lands Hospital	Suze Holband, Nursing Director
	Academic Hospital	Lachmi Kodan, Gynecologist, Obstetrician
		An van Holt, Sub Midwifery Coordinator
	L. Mungra Medical Centre Nickerie	Cleopatra Jessurun, Medical Director
		S Diran, Nursing Director
		A. Pelswijk, Midwife Coordinator
	St. Vincentius Hospital	Zr. Joeroeja, Midwife Coordinator
		Zr. Emanuel, Head of the Incubator Department
Primary Health Care Organizations	Medical Mission	Edward van Eer, Director
		Loraine Yau, Medical Director
	Regional Health Services	L. Overman, Midwife Coordinator
Training Institutes	Midwifery Training Institute	Filia Macnack, Coordinator
	EFS COVAB, Training Institute for Nurses	Mrs. Bamoeje, Manager Basis Opleiding
		Claudia. Palas, Coordinator Curriculum Development

	NAME	**POSITION**
MINISTRY OF HEALTH	Maureen Wijngaarde- Van Dijk	Director
	Wendy Emanuelson-Telgt	Head Planning Department
BOG	Inder Gajadien	Head FCH Unit
	Marjorie Vredeberg	Ass. Programme Manager SRH

Attachment 2. Questionnaires for field partner

QUESTIONNAIRES FOR EVALUATION SMNH PLAN OF ACTION

Date: Organization: Name respondent: Position respondent:

1. Please indicate your level of familiarity with the Safe Motherhood and Neonatal Health Plan of Action 2012-2016.
   - ☐ Not at all (skip to Q8)
   - ☐ Somewhat (heard about it)
   - ☐ Familiar
   - ☐ Very familiar (part of organizations planning/monitoring and/or evaluation)
   - ☐ Other_____

2. Please describe your organization's involvement in the preparation of the SMNHA Plan of Action

_____
_____
_____
_____

3. Please describe your organization's involvement in the implementation of the SMNHA Plan of Action

_____
_____
_____
_____

4. Does the Plan of Action, in your opinion, adequately reflect the national priorities regarding Safe Motherhood?

_____
_____
_____
_____

5. Is the SMNH Plan of Action relevant to the priorities of your organization?

☖ No, not at all

☖ Somewhat

☖ Yes

5 a. If yes, in what way? _____
_____

5 b. If no, why not? _____
_____

6. What kind of support- if any and from any source- has your organization received regarding the implementation of the Plan of Action?

_____
_____
_____

7. Was this support sufficient? Pls. explain. If none or not sufficient. Pls. explain what kind of support you would have needed.

_____
_____
_____

8. What do you think are the most important issues that should be included in a new Safe Motherhood Plan of Action? _____
_____
_____

9. Has your organization implemented any of the following projects/activities in the past 5 years?
   See separate sheet

10. Could you pls. indicate 2 activities that were included in the previous POA, that your organization would be able to implement within the next 2 years?

_____
_____
_____

11. Any other comments

_____
_____
_____

Attachment 3: Questionnaire for MOH/BOG

QUESTIONNAIRE BOG/MOH

Date:
Organization:
Name respondent:
Position respondent:

1. Please indicate your level of familiarity with the Safe Motherhood and Neonatal Health Plan of Action

   _____
   _____
   _____

2. Please indicate your level of responsibility for the monitoring and/or evaluation of the Plan of Action 2012-2016

   _____
   _____
   _____

3. Which of the following activities/projects has your organization implemented during the past 5 years?

   See separate sheet

4. Please indicate what you consider the most important achievement(s) in relation to the PoA

   _____
   _____
   _____
   _____

5. Please indicate what you consider the most important challenge (s) that have impacted on implementation of the POA_____

   _____
   _____

_____
_____

6. Please indicate what you consider the most important challenge (s) that have impacted on monitoring and evaluation of the POA _____
_____
_____
_____

7. Please indicate what remedial measures could/should be taken in order to improve results for a next Plan of Action _____
_____
_____
_____

8. What support, if any (within the existing institutional structure or with minor institutional changes) does the MOH/BOG need in order to optimize results?
_____
_____
_____

9. Any other comments
_____
_____
_____

Attachment 4: List of planned activities from SMNH Plan of Action 2013-2016

Has your organization implemented any of the following projects/activities in the past 5 years?

				Provide training in FP counseling skills for health care providers in primary and preventive health care.	
				Improve screening for and treatment of medical conditions, including STI, chronic diseases and eating disorders for all clients, specifically adolescents.	
				Provide targeted health education regarding substance abuse, risk assessment, and essential nutrition	
				Review the contraceptives currently included on the Essential Medicines List and introduce new contraceptives as necessary.	
				Include provision of folic acid supplements in treatment protocols for those considering pregnancy.	
				Advocate for and support introduction of comprehensive, age – and development appropriate sexual reproductive health rights education in school curricula at elementary and secondary school level.	
				Provide support to PHC service providers for development of targeted community interventions with emphasis on socially vulnerable populations	
				Strengthen the capacities of community leaders and local NGOs in order to promote SRHR and safe motherhood,	
				Engage mass media in order to promote SRHR and safe motherhood.	
				Devise monitoring and evaluation tools for the programmatic measures for preconception period (Quality indicators, data collection, responsibilities for performing evaluation).	
				Provide training in national standards, guidelines and protocols for antenatal care.	
				Update the curriculum of the medical faculty, nursing and midwifery training institutions, health assistants training, according to national ANC guidelines.	
				Ensure continued education, based on national ANC Guidelines	
				Develop and implement national standards, guidelines and protocols at all levels of care.	
				Map the needs of the staff and necessary equipment for ANC in order to improve access to ANC services	
				Ensure procurement of equipment according to national ANC guidelines.	
				Advocate to decrease financial insurance and administrative (bureaucratic) barriers to ANC access	
				Implement ANC education campaigns for women in reproductive period, including healthy lifestyles before and during pregnancy and danger signs during pregnancy)	

				Assess the use of the maternal health card as means of communication between the different levels of health care provision (primary, secondary).	
				Devise monitoring and evaluation tools for the preventive programmatic measures for ANC (Quality indicators, data collection, responsibilities for performing evaluation)	
				Conduct capacity building for staff, including those working in the field of monitoring and evaluation.	
				Support capacity building for NHIS for collection, processing, analyzing and reporting of ANC data	
				Provide training for perinatal staff in National Clinical Guidelines for Perinatal Care (Gynecology, Obstetrics and Neonatology).	
				Update the curricula of the medical faculty, medical nurse and midwives colleges according to the national guidelines.	
				Ensure continued education and appropriate incentives and training based on National Guidelines	
				Develop and implement auditing methodology for perinatal and maternal mortality.	
				Adapt and implement a perinatal information system	
				Update/review the curricula and perform training for postnatal care based on National standards, guidelines and protocols, including AMTL.	
				Advocate for increased numbers of workers (expansion of workforce)	
				Strengthen and expand available capacity of staff and equipment based on needs assessment for improved access to postnatal care services	
				Revive and strengthen breastfeeding program	
				Ensure procurement of equipment and commodities, including vaccines, for postnatal care with regular medical checkups, as part of the standard for U-5 care	
				Develop and implement a database for registration of all infants, including all cases of neonatal mortality	
				Develop an electronic database to capture births and children under 5, as well as immunization records and implement for use within institutions for preventive health care	
				Develop and implement education and awareness campaigns to improve utilization of the under 5 care system especially by vulnerable and hard to reach groups	
				Develop M&E tools for measuring progress for the postnatal care system)	

YELLOW= training institutions

BLUE= primary health care institutions

GREEN= secondary health care institutions

ORANGE= Ministry of Health