

Ministry of Health Suriname



SURINAME

**National Safe Motherhood and
Newborn Health Action Plan**

2013-2016

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ACRONYMS

AMTL	Active Management of Third Stage Labor
ANC	Ante Natal Care
BOG	Bureau of Public Health
FP	Family Planning
PAHO	Pan American Health Organization
PHC	Primary Health Care
RGD	Regional Health Service
IMR	Infant Mortality Rate
MICS	Multi Indicator Custer Survey
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MSA	Ministry of Social Affairs
MZ	Medical Mission
NHIS	National Health Information System
NMR	Neonatal Mortality Rate
PMTCT	Prevention of Mother to Child Transmission
PNMR	Perinatal 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

FOREWORD

While there has been progress with regards to addressing maternal mortality in Suriname, child, and especially neonatal, mortality remains a challenge. In order to achieve the Millennium Development Goals in 2015, and to have long-lasting impact on the health of women and children, the government of Suriname needs to develop a national Maternal and Child Health Policy.

One of the first activities towards this goal is the development of this Safe Motherhood and Neonatal Health Action Plan 2013-2016, which provides a framework for health care providers and other relevant stakeholders at all levels of care with regard to health of mothers and newborns.

This action plan includes a activity planning by stakeholder responsibility and budgeting for the period, starting in July 2013 until December 2014. The plan will be reviewed and updated periodically in order to incorporate developments and changing needs within the Suriname health system.

EXECUTIVE SUMMARY

Globally, maternal health complications are responsible for a high number of deaths of women as well as the deaths of infants. These deaths can be prevented by improved maternal health, adequate nutrition for the mother and adequate equitable access to quality health care before, during and after pregnancy and childbirth. Efforts to ensure the highest attainable standard of health for women, mothers and newborns have been consolidated under Safe Motherhood and Newborn Health Initiatives.

Suriname has made significant progress with safe motherhood and newborn health since 2000, which is reflected in the decrease of the Maternal Mortality Rate from 153 to 82.5 (2011) and from 20.2 to 15.1 (2011) of the Infant Mortality Rate. However, in order to achieve the Millennium Development Goals, effective interventions and best practices must be implemented. These MDGs, which have been set as a benchmark by the United Nations to eradicate worldwide poverty, include a 75% reduction in maternal and child mortality by 2015. At the current rate Suriname will not meet these targets.

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.

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 takes into account 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, e.g. 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. National guidelines and protocols for each of the stages of the continuum as well as adequate insurance options are among the high priority aims of the Safe Motherhood and Newborn Health Action Plan.

The development process of this plan has been a collaborative effort of local and international partners. The plan includes targets, objectives and specific activities for each of the phases in the “continuum of care” and outlines the organizations responsible for execution of the included activities. Collaboration between these organizations and with other stakeholders will be necessary to establish linkages between care in the different phases of pregnancy and to prevent duplication of services provided.

The plan is one of the components of the National Maternal and Child Health Policy, to be developed by the Ministry of Health in the near future. The plan will be reviewed and updated periodically to incorporate developments and emergent needs in the Suriname health system.

SAMENVATTING – DUTCH EXECUTIVE SUMMARY

Complicaties binnen de maternale zorg zijn wereldwijd verantwoordelijk voor een groot aantal sterfgevallen onder vrouwen alsook onder zuigelingen. Deze sterfgevallen kunnen worden voorkomen door een betere gezondheid van moeders, adequate voeding van de moeder en geschikte gelijkwaardige toegang tot kwalitatief goede gezondheidszorg tijdens de zwangerschap en bevalling. Inspanningen om het hoogst haalbare niveau van gezondheid voor vrouwen, moeders en pasgeborenen te waarborgen zijn vastgelegd in Safe Motherhood en Newborn Health Initiatives.

Suriname heeft aanzienlijke vooruitgang geboekt met Veilig Moederschap (Safe motherhood) en de gezondheid van pasgeborenen, wat blijkt uit de daling van het moederlijk sterftcijfer van 153 naar 82,5 (2011) en van het zuigelingensterftcijfer van 20.2 naar 15.1 (2011). De millenniumdoelstellingen (MDG's), zijn die door de Verenigde Naties zijn ingesteld als een criterium met betrekking tot het wereldwijd uitroeien van armoede. Om deze MDG's echter te bereiken, moet de overheid meer effectieve interventies en best practices implementeren. Het striven is om een vermindering van 75% in de moeder-en kindersterfte te hebben bereikt in 2015, maar in het huidige tempo zal Suriname deze streefcijfers niet halen.

Safe Motherhood verwijst naar de bevordering en bescherming van het recht op het hoogst haalbare niveau van gezondheid van vrouwen, moeders en pasgeborenen. Safe Motherhood moet worden benaderd als een mensenrecht, gericht op factoren die van invloed zijn op de gezondheid van moeders en pasgeborenen. Het plan legt de basis voor een geïntegreerde, intersectorale aanpak. Veilig moederschap overschrijdt de grenzen van het gezondheidszorgsysteem en omvat aspecten die gerelateerd zijn aan rechten zoals het recht op voeding, onderwijs en bescherming tegen geweld.

Het Safe Motherhood en Newborn Health actie plan is dan ook gebaseerd op mensenrechten en gender principes, en is gericht op een multidisciplinaire aanpak om goede kwaliteitzorg te bieden en functionele doorverwijzing systemen. Het Safe Motherhood en Newborn Health actie plan steunt verder op principes van de preventieve zorg voor de bevordering van de gezondheid van de mens.

Het plan neemt de bevindingen van de Safe Motherhood Needs Assessment in acht, alsook de resultaten die geboekt zijn uit voorgaande interventies. Het plan besteed aandacht aan gebieden waarin nog veel gezondheidswinst te behalen is zoals adequate en continue

beschikbaarheid van gezinsplanningsdiensten, preventie van tienerzwangerschappen, vroege start en continuering van zwangerschapscontrole voor alle zwangere vrouwen, inclusief adolescenten, kwaliteit de zorg gedurende de bevalling en de kraamperiode en voldoende aandacht voor pasgeborenen inclusief prematuur of met een laag gewicht geboren kinderen.

Nationale richtlijnen en protocollen voor elk van de fasen van het continuüm, alsmede een adequate verzekering opties behoren doelen die in het Safe Motherhood en Newborn Health Action Plan een hoge prioriteit hebben.

Het actie plan is ontwikkeld middels samenwerking van lokale en internationale partners. Het bevat doelstellingen en specifieke activiteiten voor elk van de fasen in het "continuüm van zorg" en geeft de organisaties aan die verantwoordelijk zijn voor de uitvoering van de opgenomen activiteiten. Samenwerking tussen deze organisaties en met andere belanghebbenden zal nodig zijn om grotere effectiviteit van de zorg tot stand te brengen in ieder van de verschillende fasen van de zwangerschap en om onnodige duplicatie in de dienstverlening te voorkomen.

Het plan is één van de onderdelen van het Nationale moeder-en kindzorg beleid, dat in de nabije toekomst ontwikkeld wordt door het ministerie van Volksgezondheid. Het plan wordt periodiek geactualiseerd op basis van ontwikkelingen en opkomende behoeften in het Suriname gezondheidssysteem.

BACKGROUND

Introduction

In the developing world a quarter of all adult women suffer from an illness or injury related to pregnancy and/or childbirth. The social and economic cost of disabilities and deaths resulting from these illnesses and injuries – to families, communities, the labor force and countries – is significant. Loss of income, due to health problems, as well as the cost of treatment can drive women and their families into debt. As women tend to spend their income on improving family wellbeing, the consequences of pregnancy and/or childbirth

related conditions can be especially severe for children. In many developing countries a woman functions as the head of household and her poor health can cause severe problems for her dependents.

Maternal health complications are responsible for the deaths of women and also for the deaths of infants. Worldwide, especially in developing countries, maternal health complications account for the death of millions of infants in the first week of life as well as for a high number of stillborn infants. At least 30 to 40% of infant deaths are the result of inadequate care during pregnancy and delivery. These deaths could be avoided with improved maternal health, adequate nutrition for the mother and adequate equitable access to quality health care during pregnancy and childbirth.

In addition to the mother's nutritional status before and during pregnancy, her age, the number of pregnancies/parity, a short birth interval and third trimester complications, including hemorrhage, all seriously affect neonatal health. As in maternal health, socio-economic factors as mother's education level, limited resources and decision-making power play an important role as well. Both premature birth and low birth weight have a negative impact on the survival of newborns. Low birth weight is also attributed to poor maternal health and nutrition, resulting in death, infection, malnutrition or long-term visual, hearing or learning disabilities or mental retardation.

Data on maternal and child health from the Multi Indicator Cluster Survey (MICS), the National Health Information System (NHIS) and the Bureau of Public Health (BOG) surveillance and mortality data shows that pregnancy related care in Suriname is relatively good. The vast majority of pregnant women receives antenatal care, which includes blood, urine and blood pressure examination, from skilled health care workers and deliver their baby within health care facilities with support of skilled birth attendants¹.

Data on maternal morbidity is scarce and dispersed among the institutions delivering primary and secondary health care in general. Information on maternal mortality is more accessible and shows a decrease in the number of maternal deaths from 15 in 2000 to 8 in 2011. Hence there is a significant reduction in the maternal mortality ratio (MMR) over this period, from 153 to 82.5 per 100.000 live births.

The perinatal mortality rate (PNMR), which covers the period from the 22th week of pregnancy until the first seven days after birth, has decreased from 35.8 in 2000 to 27.2 in

¹ Government of Suriname & UNICEF, Multiple Indicator Cluster Survey, 2010.

2011, and the neonatal mortality rate (NMR), which covers the first 28 days of life, has decreased from 13.4 (131 deaths) in 2000 to 11.2 (109 deaths) in 2011. In addition, the early NMR (deaths occurring during the first seven days of life per 1,000 live births) decreased from 11.3 in 2000 to 9 in 2011. These numbers contribute to a decrease in the Infant Mortality Rate (IMR) from 27 in 2000 to 23.3 in 2009 and 15.1 in 2011.

While the progress that has been made with regards to both maternal and child mortality is encouraging, at the current rate Suriname is not on track to achieve the 2015 Millennium Development Goals, which are 56.5 for the MMR and 10 for the IMR. In order to implement effective interventions and best practices in all stages of maternal and child care and to reach the set targets, the Suriname Ministry of Health needs to develop a National Maternal and Child Health Strategic Policy. In recognition of the dire need for guidance for all relevant stakeholders to address the existing gaps in the short and medium term, a Safe Motherhood and Newborn Health Action Plan has been developed. This Action Plan includes targets, objectives and specific activities for each of the periods in the “continuum of care” related to the health and wellbeing of women and newborns, namely the preconception, antenatal, delivery, postpartum and neonatal period.

The Action Plan was developed by a Technical Working Group under the direction of the Bureau of Public Health, with the support of relevant UN organizations (UNICEF, UNFPA, PAHO). The document was presented to stakeholders including MOH and BoG staff, pediatricians, gynecologists, pediatric nurses, midwives, general practitioners, registered nurses and health assistants from the Regional Health Service (RGD) and Medical Mission (MZ), as well as representatives from civil society and other government institutions for input at various times throughout the process. A consultant was engaged to complete the document in collaboration with the Technical Working Group in May 2013.

This plan will be updated periodically to incorporate developments and emergent needs in the Suriname health system. Further discussions with relevant stakeholders, including groups not previously included in the consultations e.g. insurance company representatives, civil society and members of the intended target groups such as adolescents, will contribute to future iterations of this document.

Guiding Principles

The key principles of the current Action Plan, as described in Annex 1, are:

- Human Rights and gender-based approaches, with full appreciation of the rights of women and their families to be fully informed and included in all decision making

- Multidisciplinary and multi-dimensional services
- High quality and functioning referral system, which includes effective communication at all levels.
- Inclusion of preventive services for health promotion
- Use of appropriate technologies and evidence based procedures
- Respect for privacy and dignity of women, as well as confidentiality of the health information
- Culturally acceptable approaches and services

Rationale

Millions of premature deaths, illnesses and injuries can be avoided by helping women prevent unwanted pregnancies and receive appropriate reproductive health care. Timely identification and addressing of health problems can help to prevent the higher cost of treating more serious, previously undetected health conditions and of providing health care and social services for women with long-term disabilities.

Good maternal health services can strengthen the entire health system. When a health facility is equipped to provide essential obstetric care – such as blood transfusions, anesthesia and surgery – it can also better respond to accidents, trauma and other medical emergencies in the community. Also, when women receive appropriate care during pregnancy and childbirth they are more likely to seek services to ensure the health of their children as well as address other health problems and family planning.

One of the simplest and most effective interventions is breastfeeding. Breastfeeding provides an ideal source of nutrients and protects children from infections for the first few years. Breastfeeding is also beneficial for children’s neurological development. As such, breastfeeding should thus be incorporated in Safe Motherhood initiatives.

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 continues with the development of this Safe Motherhood and Newborn Health Action Plan.

SMNA findings can be categorized as follows:

- Programme Development
 - Consolidation of all Safe Motherhood related activities in a national Safe Motherhood Program;
 -
- Capacity strengthening of Health Care workers
 - Creation of opportunities for continued training and education of health workers, with focus on life saving skills;
 -
- Quality and access to services
 - Standardization of the perinatal care through introduction of national guidelines and protocols;
 - Development of digital patient files and training staff of staff in use of these files for improved patient tracking and data collection for programming
 - Evaluation and strengthening of functioning referral systems;
 - Introduction of methods for quality control and supervision;
 - Introduction of the partogram for monitoring of labor;
 - Establishment of a central registry of maternal deaths or suspected maternal deaths and introduction of maternal mortality and perinatal audits.
 - Update and procurement of essential equipment where necessary
- Community empowerment
 - Development of a comprehensive system for education of the woman and her family on care for herself and the newborn and family planning for spacing and delaying pregnancies;

Scope

Safe Motherhood refers to the promotion and protection of the right to the highest attainable standard of health of women, mothers and newborns². This concept covers the consecutive development stages in the lifetime of a woman and child: the pre-conception, antenatal, delivery, postpartum and neonatal period. All of these periods provide excellent opportunities to intervene for optimization of the health outcomes of pregnancy and childbirth. While Safe Motherhood includes a focus on the neonatal period, efforts to

² Safe Motherhood Initiative In the Americas Operational Plan, PAHO 2010.

<http://new.paho.org/ims/index.php?lang=en>. Accessed 20 May 2013.

improve newborn health and survival are often named separately to ensure appropriate emphasis on this component.

Safe Motherhood should be addressed as a human right and efforts should focus on the factors that influence maternal and neonatal health. It also lays the foundation for an integrated, intersectoral approach as it links contributing factors with the human rights embedded in many international conventions and national constitutions. Consequently, safe motherhood surpasses the boundaries of health care and also includes nutrition, a safe environment, education, participation, freedom from discrimination and protection from violence and abuse. All of these issues are rights related, especially for girls and women and are the basis for safe motherhood.

Due to the nature of the pregnancy process, it is not always possible to predict which women or newborns will develop complications, or at which stage of the pregnancy and infant period. Addressing perinatal mortality and morbidity therefore calls for an effective continuum of care that is available for the pregnant woman and the family from the preconception period through the early stages of pregnancy to the postnatal period including timely and appropriate management of pregnancy related complications. Caregivers at each level of care must be sufficiently qualified to effectively manage life-threatening complications, for both the mother and the infant. The continuum also includes the transfer of appropriate information between the various levels of health care. Perinatal care should be focused on clients' needs for health services and should involve women in the decision-making process and respect their privacy and dignity. As pregnancy and childbirth are natural processes, they should be as culturally acceptable and family oriented as possible³.

Existing Declarations, Strategies and Initiatives

The constitution of the Republic of Suriname states that everyone has the right to health and that it is the responsibility of the government to promote health by systematically improving living and working conditions and to give information on the protection of health⁴. Within this responsibility the Government of Suriname has ratified a number of international agreements that support its intentions to provide all Surinamese inhabitants, including women and children, with access to health care, health education and promotion,

³ Ministry of Health Republic of Macedonia, Improving Maternal and Infant Health Macedonian Safe Motherhood Strategy, October 2010. [http://www.unicef.org/tfymacedonia/SM_strategy_final_ENG\(1\).pdf](http://www.unicef.org/tfymacedonia/SM_strategy_final_ENG(1).pdf). Accessed 19 May 2013.

⁴ Government of Suriname, Constitution of Suriname, Article 36.

and gender equality. Among these are the Human Rights Convention, the Program of Action of the International Conference on Population and Development, the Convention on the Rights of Children, the Convention for the Elimination of All Forms of Violence against Women, the Beijing Declaration and Platform for Action and the World Summit (2005).

In 1987, during a conference in Nairobi, sponsored by the WHO, World Bank and UNFPA the Safe Motherhood Initiative (SMI) was launched. This initiative was seen as a major milestone in the race to reduce the burden of maternal mortality throughout the world, particularly in developing countries⁵. A series of global conferences, including the International Conference on Population and Development in Cairo, Egypt in 1994, followed the launch of the SMI. At these conferences, maternal mortality and morbidity was reemphasized as an urgent health priority. Governments from around the world pledged to ensure access to a range of high-quality, affordable reproductive health services, including safe motherhood and family planning, particularly to vulnerable and underserved populations. In 1995, the Fourth World Conference on Women in Beijing gave substantial attention to maternal mortality and reiterated the commitments made at the Cairo conference.

Following these conferences governments around the world agreed to develop comprehensive national strategies to ensure universal access to all individuals and couples of appropriate ages throughout the life cycle to a full range of high quality, affordable sexual and reproductive health services, with particular attention to maternal and emergency obstetric care. They also committed to establishing or strengthening integrated safe motherhood programs⁶.

The Government of Suriname has committed to achieving the Millennium Development Goals (MDGs), which were endorsed in 2000 in an effort to reduce poverty worldwide. Included in these MDGs are the reduction of child and maternal mortality by 75 percent between 1990 and 2015 (MDG 4 and 5, respectively).

Suriname is also a participant in the “Safe Motherhood Initiative in the Americas”, which was launched in 2010 by PAHO as a call to countries in the region to double their efforts to achieve the Millennium Development Goal 5, reduction of Maternal Mortality⁷. Suriname has also taken note of the Regional Strategy and Plan of Action for Neonatal Health within the

⁵ Worldbank, Safe Motherhood and Maternal Health. <http://go.worldbank.org/V5EPGZUL40>. Accessed 20 May 2013.

⁶ Safe Motherhood, International Commitments. <http://www.safemotherhood.org/priorities/international-commitments.html>. Accessed 20 May 2013.

⁷ Safe Motherhood Initiative, PAHO. <http://new.paho.org/ims/index.php?lang=en>

Continuum of Maternal, Newborn and Child Care, which was developed by PAHO in 2008⁸. The Minister of Health reaffirmed the country's commitment towards achieving the MDG's, specifically MDG 4 and 5, with equity, when he signed the Pledge: Committing To Child Survival: A Promise Renewed.

The 2012-2016 National Health Sector Plan notes that while Suriname has made significant progress with regards to the Maternal Mortality goal, the child mortality rate remains visibly off track towards the desired target of a reduction of two-thirds by 2015. The plan refers to several barriers to access to adequate services and suitable support infrastructure, specifically in the remote areas⁹. Similarly, the Suriname Development Plan 2011 – 2015 emphasizes the importance of comprehensive care towards improved health of all Surinamese citizens, including women and children¹⁰. This Development Plan addresses issues regarding improving access to health care, increasing availability of skilled professionals, mainstreaming healthy lifestyles and special attention to safe and healthy food and drinking water and to gender issues and family life.

⁸ Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn and Child Care, PAHO, 2008.

⁹ Ministry of Health Suriname, National Health Sector Plan 2011-2018. October 2011.

¹⁰ Government of Suriname, Suriname Development Plan 2011 – 2015

DESCRIPTION OF THE CURRENT SITUATION

Current Status of Maternal and Neonatal Health in Suriname

During the past years, a number of efforts have been undertaken to assess the national situation regarding maternal and child health. These include the previously mentioned Safe Motherhood Needs Assessment¹¹ and a Situation Assessment and Analysis of Children's Rights in Suriname¹². In addition, preliminary research on perinatal and infant mortality has taken place and in 2010/2011 a survey in selected communities was conducted to acquire information about risks relating to pregnancy and childbirth among the general population¹³. These evaluations have provided relevant information with regards to the status of maternal and child health in the different stages as outlined below.

Maternal Health

Preconception

Preconception covers the time between childhood and (first) pregnancy, as well as the periods between pregnancies in the life of a woman. The focus is, understandably, on the reproductive period during which issues of Sexual Reproductive Health (SRH) such as Family Planning (FP) and preparation for childbirth take on greater importance. Other areas of importance are prevention and control of sexually transmitted diseases (STIs), prevention of anemia, folic acid supplementation and management of pre-existing chronic diseases such as Diabetes Mellitus, hypertension, epilepsy and sickle cell disease).

According to the most recent MICS data¹⁴, use of modern contraceptives has hardly increased over the past 5 years in Suriname. Currently, the national contraceptive prevalence rate is 47.6% (compared to 45.6% in 2006) with variations from 49.3% in urban areas, 50.6% in rural coastal areas to 25.3% in the rural interior (almost exclusively inhabited by maroon and indigenous women). Contraceptive commodities are universally available, since coverage is provided by health insurance schemes. They are also available for those paying out of pocket. The practice of providing only one cycle of oral contraceptives per visit

¹¹ Ministry of Health/Bureau of Public Health. Safe Motherhood Needs Assessment 2007-2008, 2009.

¹² UNICEF and Government of Suriname. Situation Assessment and Analysis of Children's Rights in Suriname, 2010.

¹³ Ministry of Health Suriname and UNFPA. De Gezondheid van Moeder en Kind in de Maternale Periode in 5 Gemeenschappen in Suriname, 2013.

¹⁴ Government of Suriname & UNICEF, Multiple Indicator Cluster Survey, 2010.

to women, as is common at the Regional Health Authorities and the Medical Mission, and through SZF, needs urgent revision as this impacts consistent use. Women in the interior face the additional disadvantage of a very limited arsenal of FP commodities, which may expose them to unnecessary health challenges.

Lack of an abortion registration system limits knowledge about actual numbers. Many abortions take place in private clinics and hospitals and doctors are not required to report on abortions performed, although the law prohibits the termination of a pregnancy for other reasons than medical indication. Understandably, official numbers are not available; there are however estimates, based on an unpublished report of the Lobi Foundation, of approximately 8,000 - 10,000 cases annually¹⁵.

Young women often face barriers related to stigma and confidentiality when trying to access Family Planning commodities. The latest available national adolescent birth rate of 73.7¹⁶ reflects persistent need of access to and education on Family Planning for this group.

Access to Family Planning is being increased by provision of training in FP counseling for all RGD nurses and all Health Assistants of the Medical Mission. Currently, information and education on safe sex is mostly related to HIV prevention. Information on pregnancy prevention and safe pregnancy is often absent and is not embedded in the general service provision of the PHC clinics. As the importance and the advantage of folic acid supplements is being recognized, protocols are being developed based on currently ongoing research. Education for women wanting to become pregnant is an area that needs more focus. Protocols are in place for women who want to become pregnant but are known to suffer from Diabetes Mellitus to ensure the switch from oral medication to insulin with the appropriate guidance, before pregnancy.

In general there is need for stronger emphasis on health education in the preconception period, as well as during the next stages of pregnancy and motherhood, conducted in cooperation between education and health authorities and community based organizations.

Antenatal

Counseling during the prenatal period can alert women and family members to danger signs, encourage women to take better care of themselves and provide women with the opportunity to voice their concerns. The goal of antenatal care (ANC) is to prepare for birth

¹⁵ Ministry of Health Suriname/Bureau of Public Health, National Sexual Reproductive Health Policy, 2012.

¹⁶ NHIS/Ministry of Health.

and parenthood as well as to prevent, detect, alleviate, or manage the three types of health problems during pregnancy that affect mothers and babies. These include complications of the pregnancy itself, pre-existing conditions that worsen during pregnancy and the effects of unhealthy lifestyles. ANC also provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of the newborn, promotion of early, exclusive breastfeeding, and assistance with planning for optimal spacing in order to improve pregnancy outcomes.

Essential interventions in ANC include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunization, and identification and management of infections including HIV, syphilis and other sexually transmitted infections. ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing¹⁷.

There are some challenges in access for adolescents who get pregnant, since the health insurance schemes do not cover costs related to pregnancy for women 16 years or younger. These young women need to apply for the government card, which can be a lengthy process. Clients apparently find ways to compensate for this delay, as mothers' age at birth does not seem to have a negative influence on the total number of visits. 68.1% of mothers younger than 20 years get minimal 4 visits, compared to the total average of 66.8%. SMNA¹⁸ data showed that only one third of pregnant women had a first antenatal visit within the first trimester. Contrary to the age of the mother, the wealth quintile of the mother does seem to negatively impact the number of visits. MICS 4 results clearly indicate that more women in the 2 highest quintiles reported minimal 4 prenatal visits (70% and 73%) compared to women in the 2 lowest quintiles (59% and 69%)¹⁹. Currently the total antenatal care coverage is approximately 95%, with minimal differences between the coastal and rural interior areas. The proportion of women receiving antenatal care at least once is 95%; however, only around 67% of women receive the target number of 4 visits for normal pregnancies, spaced at regular intervals, beginning as early as possible in the first trimester, as recommended by

¹⁷ http://www.who.int/pmnch/media/publications/aonsectionIII_2.pdf "Opportunities for Africa's Newborns" .¹⁷ Ministry of Health/Bureau of Public Health. Safe Motherhood Needs Assessment 2007-2008, 2009.

¹⁷Government of Suriname & UNICEF, Multiple Indicator Cluster Survey. 2006.

the World Health Organization. This percentage needs to be increased to at least 90% of all pregnant women.

Relevant action is needed to identify the remaining approximately 5% of women who do not receive antenatal care at all or are otherwise missed by the system and determine the reasons for this, as well as for increasing the numbers of antenatal visits per woman. The recent study “Gezondheid van Moeder en Kind” discusses the consequences of risk factors such as financial issues, lack of health insurance and low risk assessment on Maternal and Child Care²⁰.

The vast majority of women obtain antenatal care from a doctor (71%), nurse/midwife (19%) or a community health worker (4%). A small proportion of women (3%) received no antenatal care whatsoever²¹. Among the service providers of antenatal care are also included traditional birth attendants, (mostly) women who provide services to Maroon women in the interior. Although not registered and not officially recognized as such, the role of this group should also be considered when evaluating quality and coverage of antenatal care.

Minimal services that should be offered to women during antenatal care visits are blood pressure measurement, urine testing for bacteraemia and proteinuria, blood testing to detect syphilis, HepB, HIV and severe anemia and weight/height measurement (optional). From the MICS data, 94 % of women that received antenatal care, reported that a blood sample was taken during antenatal care visits, 97 % reported that their blood pressure was checked, 95 % that urine specimen was taken and in 92 % of cases all three services were received. The proportion of women receiving all three services is higher in the rural interior (95.1%) than in rural coastal areas or in urban areas (91.7%).

The previously mentioned lack of uniformity for antenatal screening is apparent throughout the whole system and impacts the monitoring of the quality of the services offered to clients.

Delivery

Three quarters of all maternal deaths occur during delivery and the immediate postpartum period. The single most critical intervention for Safe Motherhood is to ensure that a competent health worker with midwifery skills is present at every birth, and that transport is available to a referral facility for obstetric care in case of emergency²². High quality delivery

²⁰ Ministry of Health Suriname and UNFPA. De Gezondheid van Moeder en Kind in de Maternale Periode in 5 Gemeenschappen in Suriname, 2013.

²¹ Government of Suriname & UNICEF, Multiple Indicator Cluster Survey. 2010.

²² Government of Suriname & UNICEF, Multiple Indicator Cluster Survey. 2010.

services at the maternity level and effectively functioning referral systems guarantee the most appropriate care for all pregnant women and their babies. Skilled care during the continuum of pregnancy, delivery and puerperium reduces the number of perinatal and neonatal mortality as well as it reduces morbidity.

It is essential that women, communities and families recognize the importance of delivery care for all births. At local levels for this care to be effective, skilled birth attendants must be fully integrated into referral systems with adequate backup that connects from home to health center and to hospitals if necessary. Increasing the proportion of births that are delivered in health facilities is an important factor in reducing the health risks to both the mother and the baby. Proper medical attention and hygienic conditions during delivery can reduce the risks of complications and infection that can cause morbidity and mortality to either the mother or the baby.

Overall, about fifteen per cent of all pregnancies will result in complications. Most complications occur randomly across all pregnancies, both high- and low-risk. They cannot be accurately predicted and most often cannot be prevented, but they can be treated.

For every woman who dies, an estimated 15 to 30 women suffer from chronic illnesses or injuries as a result of their pregnancies. Several of these injuries or illnesses can be significantly prevented through Emergency Obstetric Care. Basic Emergency Obstetric Care includes the availability of specific pharmaceuticals namely antibiotics, oxytocic, anticonvulsants as well as the ability to manually remove the placenta or other retained products and assist a vaginal delivery. Comprehensive Emergency Obstetric Care includes all Basic Emergency Obstetric Care functions plus Caesarean Section and Blood transfusion. WHO/PAHO, UNICEF and UNFPA recommend that all women must have access to Essential Obstetric Care consisting of Basic Emergency Obstetric Care or Comprehensive Emergency Obstetric Care.

Annually approximately 10,000 children are born in Suriname. According to MICS 2010 about 93 % of women in the survey were assisted by skilled personnel during delivery. This percentage is lowest in the rural interior at 77%. The data showed that a doctor assisted 54 % of the women surveyed and 36 % was assisted by a nurse/midwife. 92% of the women who gave birth delivered their babies in a health facility. Possibly related to the centralized location of the hospitals, urban women are more likely to give birth in a health facility than rural women.

Suriname has five (5) health care facilities, which offer Basic or Comprehensive Emergency Obstetric Care, meeting the WHO requirement. As four of these are located in Paramaribo and one in Nickerie, the western coastal district, many women (especially those living in the rural interior) have to travel more than one hour to reach one of these facilities in order to access this care. At the time the SMNA was conducted, none of the Primary Health Care facilities was equipped to provide Basic Emergency Obstetric Care and there was a shortage of ambulances to cover the distances.

As the figure below shows, the Maternal Mortality Ratio in Suriname has decreased from 153/100,000 (2000) to 82.5/100,000 (2011), although the years in between showed considerable fluctuations.

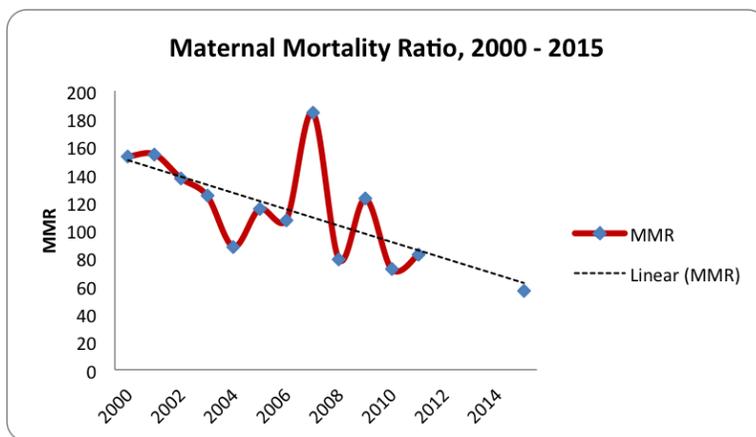


Figure 1: Maternal Mortality Ratio, 2000 – 2015²³

The leading causes of maternal mortality in Suriname are:

- Pregnancy induced hypertension and the associated disorders (edema, proteinuria and eclampsia) (24.2 %),
- Complications of labor and delivery (fluxus postpartum) (18.5%),
- Abortive outcomes of pregnancies (11.5%)
- Complications related to puerperium (thrombosis) (10.2%).
- Complications related to delivery (solution placenta) (7.6%)

Adequate monitoring of maternal deaths and critical clinical events is limited by the lack of a system permitting confidential and open discussion about the strengths and weaknesses of the maternal care system. In addition there is no unified and networked database across maternities at facility level. The absence of national guidelines and protocols, including those

²³ Punwasi, W. Doodsoorzaken in Suriname. Ministry of Health/Bureau of Public Health (Epidemiology Department). 2009.

for the delivery care, to be used and monitored at hospital as well as at PHC facility level, is another important gap when it comes to quality of maternal and neonatal care. As a result of this absence, facilities either do not use any protocols or use internal facility or organization specific protocols. The lack of any inspection or monitoring and evaluation of these protocols creates insufficient insights with regard to the compliance and the level of quality of maternal and new born care.

Postpartum

Postpartum care is important, as most of the maternal deaths occur in this period. The risk is the highest during the first twenty-four (24) hours and remains high throughout the second week after delivery.

From childbirth through hospital discharge mother and newborn receive care together. After discharge from the maternity ward, their care is typically taken over by a different team of health care professionals. To ensure that mother and infant are in good health, health care workers must provide postpartum care that can detect and manage problems at an early stage, support breastfeeding and provide advice on good nutrition and self-care. Emotional support is also an important component of postpartum care. This period also provides the opportunity for child health care and family planning information and services. In the postpartum period, the mother needs information and counseling on the care of the baby (incl. breastfeeding and immunization), physiological changes in her body (including signs of possible problems), self-care (hygiene and healing), sexual life, contraception, birth spacing and maternal nutrition. In addition, the mother requires health care for suspected or manifest complications, emotional and psychological support from health care providers, partner and family, logistic support (time to care for the baby, help with domestic tasks) and protection from abuse/violence.

In Suriname, postpartum care can be divided in:

- Immediate postpartum care during hospitalization
- Immediate postpartum check-up in hospitals, which is limited to 1-2 days after delivery.
- Late postpartum care, which refers to care within 1 week after discharge.

Data from the SMNA²⁴ shows that in one of the hospitals 30% of women who gave birth left the hospital within 24 hours of delivery and over 50% of women left after 1 day. Only 10% of

²⁴ Ministry of Health/Bureau of Public Health. Safe Motherhood Needs Assessment 2007-2008, 2009.

mothers stayed in the hospital longer than 1 day. The SMNA²⁵ shows that around 90% of the patients were invited for late postpartum care. 89 % of these visits occurred within one month. The content of the service offered during the visit (physical examination of mother and/or child) was not standardized and showed variations between institutions. All clients who were interviewed reported having their blood pressure measured and being asked about abnormal hemorrhage. They also received family planning advice. About 20% of the women claimed they were examined externally or had a vaginal examination. In 83% of the cases health workers inquired about breastfeeding practices, and in 73% of the cases they educated the mother regarding the care for the baby. In the interior, 3 out of the 5 Traditional Birth Attendants interviewed reported referring both mother and child to the MM health facility immediately after delivery. Postpartum care at home is almost non-existent, and is not included in the insurance scheme. There is a very limited coverage for postpartum care through private insurance.

Due to the absence of structured care and home visits by midwives, the initiative to seek care for the mother or the newborn in case of complications is completely up to the woman or her family. It is critical that women, their families and communities are knowledgeable of the danger signs during this period, as postpartum hemorrhage, puerperal infections such as sepsis and eclampsia are potential risks and are the major causes of maternal death.

A recent study on the health of mother and child during pregnancy, delivery and childbirth and puerperium showed that in general most women knew intuitively when their pregnancy and health was endangered²⁶. They were able to name very serious health situations, which would require them to seek medical care.

Of all the cases of postpartum hemorrhage reported in the SMNA²⁷ 89.9% occurred in hospitals. Patients with increased antepartum risk are referred to the hospitals for delivery. 52.6% of these cases suffered from a postpartum hemorrhage of 1000 ml or more, including 14% with blood loss 1500 ml or more.

The absence of national guidelines and protocols, e.g. with regard to Active Management of the Third stage of Labor (AMTL), limits the level of quality of care. As with many interventions, some knowledge exists, but due to the lack of guidance through protocols

²⁵ Ministry of Health/Bureau of Public Health. Safe Motherhood Needs Assessment 2007-2008, 2009.

²⁶ Ministry of Health Suriname and UNFPA. De Gezondheid van Moeder en Kind in de Maternale Periode in 5 Gemeenschappen in Suriname, 2013.

²⁷ Ministry of Health/Bureau of Public Health. Safe Motherhood Needs Assessment 2007-2008, 2009.

health workers may not structurally apply evidence-based interventions. In addition, the lack of continuous education contributes to weaknesses in the delivery of maternal and neonatal care during delivery and in puerperium.

Neonatal Health

Neonatal mortality is the basic indicator to measure the development of newborns and the quality of care that they receive. Neonatal death is usually caused by infections, asphyxia, prematurity and congenital malformations. All of these conditions can be addressed and need extensive, highly specialized medical care in the first days of life, to reduce or prevent neonatal mortality. Neonatal mortality is especially dependent on the quality of care within the health system, specifically during the perinatal period. Overall interventions that reduce and prevent maternal deaths can also prevent the death of infants at birth, due to infections, hypothermia and poor management of asphyxia. Some newborns need essential newborn care, provided as soon as possible after birth by professional health care workers attending the birth. In these cases, health care workers must be able to establish effective referral and transportation for more specialized care, to prevent delay in management of complications, causing death, chronic illness or disability.

Of the infants needing special care, those born pre-term and/or with low birth weight are in greater need of special attention. It has been proven that where needed highly technological interventions save the lives of newborns. On the other hand there are evidence-based cost effective interventions that serve the majority of healthy born infants. When the birth is properly managed, most newborns will not need special care. The basic care that all neonates need consists of cleanliness at birth, warmth, early and exclusive breastfeeding, eye-care, immunization and resuscitation. Therefore the availability of skilled personnel at the local health facility level with the ability to provide around-the clock services is among the recommended modes of service delivery. This must be combined with community outreach, to increase healthcare workers' understanding of the needs of the community and to lay the foundation for effective family community care.

Clear guidelines and protocols in the health care system on antenatal, intra-partum and postnatal care at all levels are important measures to establish a minimum level of care, to save the lives of newborns and provide them with the best possible health. Therefore there is an urgent need for the continuous availability of skilled health care providers and knowledgeable families and communities that collaborate around pregnancy, delivery and postpartum period.

Proper medical attention and hygienic conditions during delivery are important measures to reduce the risks of complication and infection that can cause morbidity and mortality to mother and/or newborn. Delivery in health facilities supports reducing these risks.

The neonatal mortality rate calculates the number of deaths during the first 28 days of life per 1,000 live births and is a major contribution to child mortality. This rate increased from 13.4 in 2000 to 16 in 2009. The Early Neonatal Mortality Rate, which reflects deaths occurring during the first seven days of life per 1,000 live births, increased from 11.3 in 2000 to 12.9 in 2009. Preliminary data from research²⁸ shows that the main risk factors for neonatal mortality were related to breech presentation or transverse lie, low birth weight, and prematurity of less than 37 weeks of gestation; the latter, accounting for at least 60% of all (early) neonatal deaths. The age of the mother, twin or triple pregnancies and ethnicity are mentioned as relative risk factors for these neonatal deaths. Although these data are collected from hospital-based deliveries, currently data on newborns needing special attention such as neonatal intensive care or care in incubators is not available.

To what extent anemia, pre-eclampsia and socio-economic factors also play an important role is yet to be determined. These are factors that relate to the quality of antenatal care and knowledge of the pregnant mother and family and community members and their ability to act on situations that threaten the life and health of mother and child.

Perinatal audits, currently not conducted, must provide the necessary in-depth information to address the above-mentioned issues regarding perinatal and early neonatal mortality.

In general, the absence of national guidelines and protocols, with regard to pregnancy and antenatal care, delivery, postpartum and neonatal care significantly impact the quality of care and survival of newborns. Current on-going discussions within the government indicate recognition of the need to establish a neonatal intensive care unit and related standards, guidelines and protocols to address the high percentage of neonatal deaths. Continuous education of medical and nursing/midwifery staff in health care centers and hospitals remains an utmost priority in order for mothers and children to benefit from evidence based interventions. Implementation of the planned reforms at the RGD and MZ, such as XX and XX are expected to contribute to consistent approach with regards to primary care.

²⁸ Samenvatting Prospectief Onderzoek naar de perinatale en zuigelingen sterfte in Suriname (POPZIS) Symposium: op weg naar het bereiken van de Millenium Development Goals voor het terugdringen van de perinatale en zuigelingen sterfte (2010 - 2014)

HEALTH SYSTEMS RESPONSE

Service Delivery and Insurance

The Suriname Health System consists of sixty-eight (63) health care facilities operating throughout the coastal area under responsibility of the Regional Health Services, fifty-six (56) primary health clinics and health posts throughout the interior, under the responsibility of the Medical Mission, and approximately one-hundred and forty-six (146) private clinics at the Primary Care Level. Five (5) hospitals provide care at the secondary level. Of the two (2) private and three (3) public hospitals, four (4) are located in the capital Paramaribo and one in the District of Nickerie. Only one of the hospitals in Paramaribo and the one in Nickerie have an emergency department.

The Regional Health Services is a state foundation, which offers health care via public primary care facilities, staffed by general physicians and health practitioners who provide primary care services to residents of Suriname's coastal areas. Persons who are classified as "the poor and near-poor" by the Ministry of Social Affairs (MSA) utilize the RGD services the most. State Health Insurance Foundation (SZF) enrollees also may choose an RGD doctor as their general practitioner. RGD clinics provide family planning services and vaccinations. RGD also provides health education on nutrition, breast-feeding and basic sanitation together with the "under 5" clinic activities and prenatal care.

The Medical Mission is comprised of a group of religious NGOs, co-funded by the government, who provide first-level care for residents of the rural interior living in traditional settings along the main rivers, many only reachable by river or small aircraft. Health care is provided by health assistants via a network of polyclinics coordinated by a coordination center in Paramaribo. MZ provides deliveries of newborns and preventive health services such as antenatal consultations and health care for children under five. This includes education on nutrition, breastfeeding, sexually transmitted infections (including HIV/AIDS) and basic sanitation.

Private clinics operate mainly in the urban areas and are supported through private insurance schemes or out-of-pocket money. Most general physicians in the country are in private practice and provide services to people who are covered by the SZF, private insurances, private companies or to self-paying patients.

Persistent gaps in access to and uptake of health care provision towards (pregnant) women, mothers and infants are often related to access to insurance schemes and coverage provided by insurance schemes. All insurance schemes cover access to pre-conception, antenatal and delivery care for women. However, often there is no full coverage of care offered in the insurance packages. Some forms of contraceptives are not or only partially covered e.g. female sterilization. In general, family planning is not covered universally.

According to results from the Safe Motherhood Needs Assessment, some 30% of interviewed women mentioned that, although they were insured, they had to make additional payments for antenatal services, which could lead to delays in access to necessary health care. These figures are confirmed by the results of the survey on Health of Mother and Child in the Perinatal Period²⁹. Women with a medical insurance card of the Ministry of Social Affairs can only access secondary health care in one of the two State Hospitals. Coverage through this scheme depends on the economic status of the cardholder. For the “near poor” category coverage is limited to 6 months and 6 doctor visits. Cardholders in the “poor” category have coverage for 1 year and doctor visits are unlimited during that period. Both categories, however, require an extension or renewal procedure, sometimes causing unnecessary and unwanted delay of the next visit. In addition, coverage of infant care is limited. The largest health insurer, the SZF, considers infants automatically covered through the mother’s insurance during the first 3 days after birth. Thereafter, the infant needs to be registered. If registration is delayed, dependent on the level of care the infant will need, this leaves parents in some cases with large bills for types or periods of care that are not covered. This holds especially true for those mothers who are voluntary insured at the SZF. Other health insurance companies have similar restrictions with regard to the insurance of hospitalized newborns. The insurance of pregnant adolescents, who are up till their pregnancy covered by the health insurance of their parents, is discontinued as soon as they become pregnant. Similar to pregnant adolescents who are uninsured, they need to apply for a health card through the Ministry of Social Affairs.

An additional factor impacting access to and uptake of health care is unfamiliarity of certain health care providers with the availability of social services. As a result, patients who may be eligible for a health card through the Ministry of Social Affairs may not obtain health coverage in a timely manner.

²⁹ Ministry of Health Suriname and UNFPA. De Gezondheid van Moeder en Kind in de Maternale Periode in 5 Gemeenschappen in Suriname, 2013.

Interventions that have been undertaken towards improvement of Safe Motherhood and neonatal health during the past five years include:

- Upgrade of the Mother and Child Centre at the 's Lands Hospital to include PMTCT interventions;
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- Procurement of incubators, ambulances and other equipment for maternal and neonatal care at the PHC level;
- Capacity building of primary health care workers in Family Planning counseling;
- Training of midwives (23 graduated in 2006, 19 in 2010 and 20 were scheduled to graduate in January 2013)
- Implementation of the PMTCT program for counseling and treatment of mothers living with HIV and the protection of the unborn child against vertical transmission of HIV and syphilis.

SAFE MOTHERHOOD AND NEWBORN ACTION PLAN

The Government of Suriname has committed to achieving the Millennium Development Goals (MDGs), which were endorsed in 2000 in an effort to reduce poverty worldwide. Included in these MDGs are the reduction of child and maternal mortality by 75 percent between 1990 and 2015 (MDG 4 and 5, respectively).

This Action Plan reflects the commitment of the Government of Suriname to improve maternal and child health. Specifically, this plan includes activities in all phases of the continuum of care, which will contribute to the achievement of MDG 4 and 5.

The preconception period focuses on the use of up to date information promoting sexual and reproductive health by all families. The target for the antenatal period consists of access to and use of modernized antenatal healthcare services by all women. The delivery period emphasizes access to and use of standardized relevant and appropriate high quality delivery services for women and families. The postpartum period focuses on access to a basic package of health care services for women and infants during the first year postpartum.

Targets, expected outcomes, indicators, specific objectives and activities for each stage are outlined in the following matrix. Also indicated are the organizations responsible for the execution of these activities. These organizations will need to follow up as needed to achieve the targets and outcomes associated with the responsibilities under their purview. They will need to collaborate with each other and other stakeholders to establish linkages between the different stages of pregnancy and with other programs in order to prevent duplication. In addition, a Monitoring & Evaluation plan will need to be developed to accompany this action plan to establish and track the appropriate indicators.

Safe Motherhood and Newborn Health Action Plan

Preconception Period					
Target 1: All women, men and adolescents including those socially vulnerable receive and make use of up to date information promoting sexual and reproductive health and in particular safe motherhood and perinatal health					
Expected outcomes: 1.1. All women, men and adolescents have improved access to information and practice healthy lifestyle, safe sex and family planning 1.2. All women, men and adolescents have access to and make use of high quality services regarding family planning, and prevention and management of STI's 1.3. Socially vulnerable women, men and adolescents receive tailor-made information and have access to services specifically targeted to their needs.					
Indicators: <ul style="list-style-type: none"> • % of PHC providers providing FP counseling according to standards • % of adolescents and young people (10-24yrs) who reported condom use during their last sexual intercourse with a partner who is not their spouse or common law partner. • % of women in their reproductive period who use dual protection • % of women able practicing pre-conceptual healthy life-styles • Prevalence of STI's (Chlamydia Trachomatis, HPV and Gonorrhoea, HIV) amongst adolescents and young people • % of primiparae who used contraceptives prior to first pregnancy • % of pregnancies in adolescents (prior to turning 19 years of age) 					
Specific Objective	Activities	Institutions	2013/2014	Deadline	Budget USD
Strengthened capacities for SRH education for the primary health care workers	Provide training in FP counseling skills for health care providers in primary and preventive health care	BOG	6,000	Ongoing, 2013	6,000 (2013)
Improved quality of and access to SRH services	Improve screening for and treatment of medical conditions, including STI, chronic diseases and eating disorders for all clients, specifically adolescents	BOG		2016	10,000 per annum
	Provide targeted health education regarding substance abuse, risk assessment, and essential nutrition	BOG/NGO's/ MIN of EDUCATION	21,500	Ongoing	21,500 in 2013
	Review the contraceptives currently included on the Essential Medicines List and introduce new contraceptives as necessary	MOH/PHC Organizations/ BOG	3,000	2014	3,000
	Include provision of folic acid supplements in treatment protocols for those considering pregnancy	MOH/PHC organizations	10,000	2014	10,000
Enhanced school SRH curricula	Advocate for and support introduction of comprehensive , age – and development appropriate sexual reproductive	BOG/MIN OF EDUCATION		2015	3,000

	health rights education in school curricula at elementary and secondary school level				
Increased community capacities to exercise their SRH rights with emphasis on the needs of socially vulnerable populations	Provide support to PHC service providers for development of targeted community interventions with emphasis on socially vulnerable populations	BOG/MEDICAL MISSION/RGD/GP	10,000	2016	10,000 per annum
	Strengthen the capacities of community leaders and local NGOs in order to promote SRHR and safe motherhood	BOG	10,000	2016	10,000 per annum
	Engage mass media in order to promote SRHR and safe motherhood	BOG	10,000	2016	10,000 per annum
Monitoring and evaluation of the quality of care during the preconception period	Devise monitoring and evaluation tools for the programmatic measures for preconception period (Quality indicators, data collection, responsibilities for performing evaluation)	BOG		2016	4,000
Antenatal Period					
Target 2: All women have access to and use appropriate, quality antenatal health care services.					
Expected outcomes: 2.1. Safe motherhood services are provided in an integrated manner including primary and secondary level care (e.g. cervical cancer, STI/HIV/ Family Planning) 2.2. Pregnant women and their families make timely and appropriate use of antenatal care services 2.3. At risk pregnancies are detected at an early stage and are referred to the appropriate level of care					
Indicators: <ul style="list-style-type: none"> • % of pregnant women with a filled in maternal health card at delivery according to ANC checklist • % of pregnant women referred to secondary health care, disaggregated by indication for referral. • % of women tested positive for STI, including HIV before 16 weeks of pregnancy • % of pregnant women who use antenatal services in the first trimester of pregnancy (disaggregated by age, ethnicity, district and type of insurance) • % of pregnant women with at least 4 ANC visits • % of congenital malformations detected prior to delivery 					
Specific Objective	Activities	Institutions	2013/2014	Deadline	Budget
Strengthened capacities of health professionals (Health Assistants, General Physicians, Midwives and gynecologist in primary and secondary health care)	Provide training in national standards, guidelines and protocols for antenatal care	BOG	10,000	As of mid 2014	20,000
	Update the curriculum of the medical faculty, nursing and midwifery training institutions, health assistants training, according to national ANC guidelines	ADEK UNIVERSITY, ELSJE FINK SANICAR COLLEGE, MM, MIDWIFERY SCHOOL	2,000	2014	2,000

	Ensure continued education, based on national ANC Guidelines	SPAOGS, VVV, MM		2016	20,000 per annum
Improved quality of and access to ANC health care services	Develop and implement national standards, guidelines and protocols at all levels of care	BOG	20,000	2013 & 2014	20,000
	Map the needs of the staff and necessary equipment for ANC in order to improve access to ANC services	BOG/NZR	7,500	2014	7,500
	Ensure procurement of equipment according to national ANC guidelines	NZR/MOH/PHC institutions		2016	tbd
	Advocate to decrease financial insurance and administrative (bureaucratic) barriers to ANC access	MOH/SOZAVO		2015	3,000
Improved level of ANC awareness, with special focus on vulnerable groups	Implement ANC education campaigns for women in reproductive period, including healthy lifestyles before and during pregnancy and danger signs during pregnancy	BOG	50,000	2013 & 2014	50,000
Monitoring and evaluation of the quality of ANC	Assess the use of the maternal health card as means of communication between the different levels of health care provision (primary, secondary)	BOG	5,000	2014	5,000
	Devise monitoring and evaluation tools for the preventive programmatic measures for ANC (Quality indicators, data collection, responsibilities for performing evaluation)	BOG	4,000	2014	4,000
	Conduct capacity building for staff, including those working in the field of monitoring and evaluation	MOH/NZR		2015	5,000
	Support capacity building for NHIS for collection, processing, analyzing and reporting of ANC data	MOH		2015	10,000

	Delivery Period
	Target 3: All women and families have access to and use standard, relevant high quality delivery services, appropriate to their evaluated risk status during pregnancy and to their general health.
	<p>Expected outcomes:</p> <p>3.1. All health care systems ensure access and provide high quality delivery care services in a family-friendly environment</p> <p>3.2. Adequate distribution and retention of delivery health staff based on local needs and in line with international standards</p> <p>3.3. The capacity of delivery health staff is up to date using appropriate knowledge and procedures based on international evidence, rights and national guidelines</p> <p>3.4. High risk deliveries are conducted at the appropriate level of care, based on a national standard of care</p> <p>3.5. An audit system for perinatal and maternal mortality is established according to a predefined methodology, which contributes to the improvement of the access and quality of services.</p>

	Indicators: <ul style="list-style-type: none"> • % of maternities certified within the framework of the Baby Friendly Hospital Program • % of staff, whose last refresher training took place within the last 2 years • % of maternities, which work according to the newly adopted National Guidelines • % of patients with completed medical records according to national standards for maintaining medical records • % of at risk pregnancies, which are delivered at secondary level • % of deliveries with skilled birth attendance • % of premature deliveries conducted at lower levels of care (prior to 34th week of pregnancy) • % of newborns with an Apgar Score of less than 7 in the 5th minute after birth • % of mothers practicing breastfeeding on hospital discharge 				
Specific Objective	Activities	Institutions	2013/2014	Deadline	Budget
Strengthened capacities of the perinatal medical staff and relevant government officials	Provide training for perinatal staff in National Clinical Guidelines for Perinatal Care (Gynecology, Obstetrics and Neonatology)	NZR/BOG	6,000	2015	6,000
	Update the curricula of the medical faculty, medical nurse and midwives colleges according to the national guidelines	MOH/ TRAINING INSTITUTIONS		2015	2,000
	Ensure continued education and appropriate incentives and training based on National Guidelines	MOH/TRAINING INSTITUTIONS		2015	tbd
Improved quality and access to universal perinatal care services	Map the needs of the staff and necessary equipment for improved perinatal care services	NZR	7,500	2014	7,500
	Develop and implement national standards, protocols and guidelines for perinatal care	BOG/NZR		2015	45,000
	Ensure procurement of equipment for perinatal care according to the National guidelines and the standards for all levels of care	NZR		2016	tbd
Monitoring and assessing the quality of perinatal care and indicators of perinatal health	Support capacity building for NHIS for collection, processing, analyzing and reporting of perinatal care data	MOH		2016	10,000 per annum
	Develop and implement auditing methodology for perinatal and maternal mortality	BOG	15,000	2014	15,000
	Adapt and implement a perinatal information system	BOG	10,000	2015	20,000
Postnatal Period (Maternal and Neonatal Care)					
Target 4: All women and infants have access to a basic package of health services during the first year postpartum					
Expected outcomes:					

	<p>4.1. A standardized communication and referral system between the first and second level of care and vice versa is established</p> <p>4.2. Integration of relevant SRH services in post natal period (cervical cancer screening, family planning, postpartum depression, HIV/STI care) has taken place</p> <p>4.3. A monitoring system in place for the postnatal period between 0-28 days with the ability to provide postpartum care at recommended intervals</p> <p>4.4. Post-natal women practice exclusive breastfeeding at least for 6 months</p> <p>4.5. All Infants with special needs (pre-mature births, congenital malformations) have access to appropriate care</p> <p>4.6. Vulnerable mothers and infants benefit from appropriate special services (home visits, social and mental health services, nutritional support etc.)</p> <p>4.7. All newborns are screened according to national standards for high incidence/prevalence conditions (including for specific risks e.g. hypothyroidism, phenylketonuria and others)</p>				
	<p>Indicators:</p> <ul style="list-style-type: none"> • % of infants exclusively breastfed in the first 6 months of life • % of infants with completed vaccination • % of primary and preventive care institutions fulfilling criteria for baby-friendliness • % of infants with special needs benefiting from appropriate services • % of newborns screened according to national standards 				
Specific Objective	Activities	Institutions	2013/2014	Deadline	Budget
Strengthened capacities of the postnatal healthcare workers	Update/review the curricula and perform training for postnatal care based on National standards, guidelines and protocols, including AMTL	Training institutes/MOH/ PHC institutions	2,000	2014	2,000
	Advocate for increased numbers of workers (expansion of workforce)	Training institutes/MOH/ PHC institutions		2015	tbd
Improved quality of and access to postnatal health services	Strengthen and expand available capacity of staff and equipment based on needs assessment for improved access to postnatal care services	NZR/MOH/ PHC institutions	7,500	2014	7,500
	Revive and strengthen breastfeeding program	NZR/MOH/ PHC institutions	15,000	2015	15,000 per annum
	Ensure procurement of equipment and commodities, including vaccination, for postnatal care with regular medical checkups, as part of the standard for U-5 care	NZR/MOH/ PHC and secondary care institutes		ongoing	tbd
Monitoring and assessing the quality of postnatal care and indicators of perinatal health	Develop and implement a database for registration of all infants, including all cases of neonatal mortality	MOH/SOZAVO/NZR/PHC		2016	tbd
	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	BOG/CBB/PHC		2016	tbd

	Develop and implement education and awareness campaigns to Improve utilization of the under 5 care system especially by vulnerable and hard to reach groups	BOG	50,000	2013 & 2014	50,000
	Develop M&E tools for measuring progress for the postnatal care system	BOG	4,000	2015	4,000

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